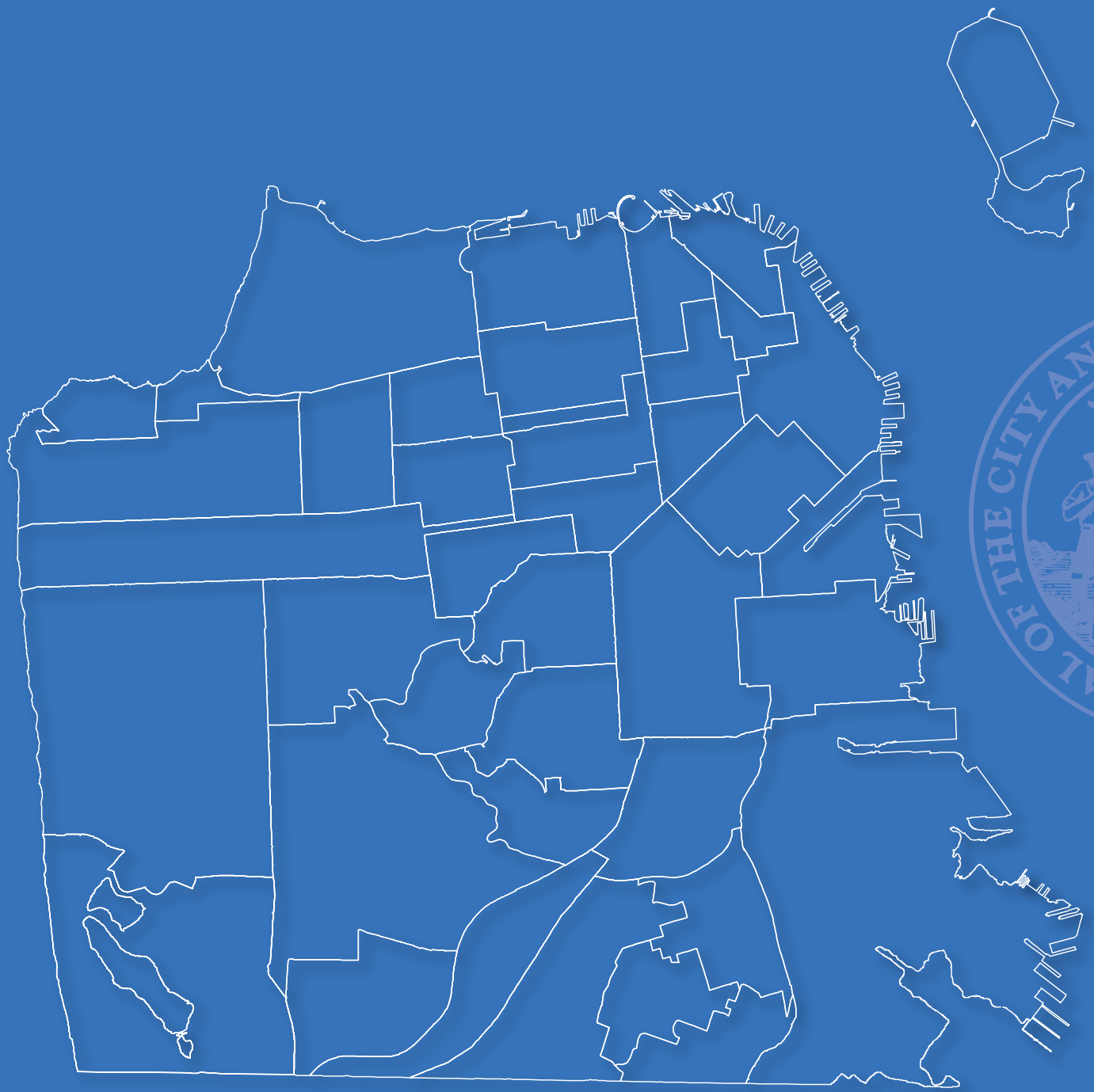
San Francisco Community Health Needs Assessment 2016



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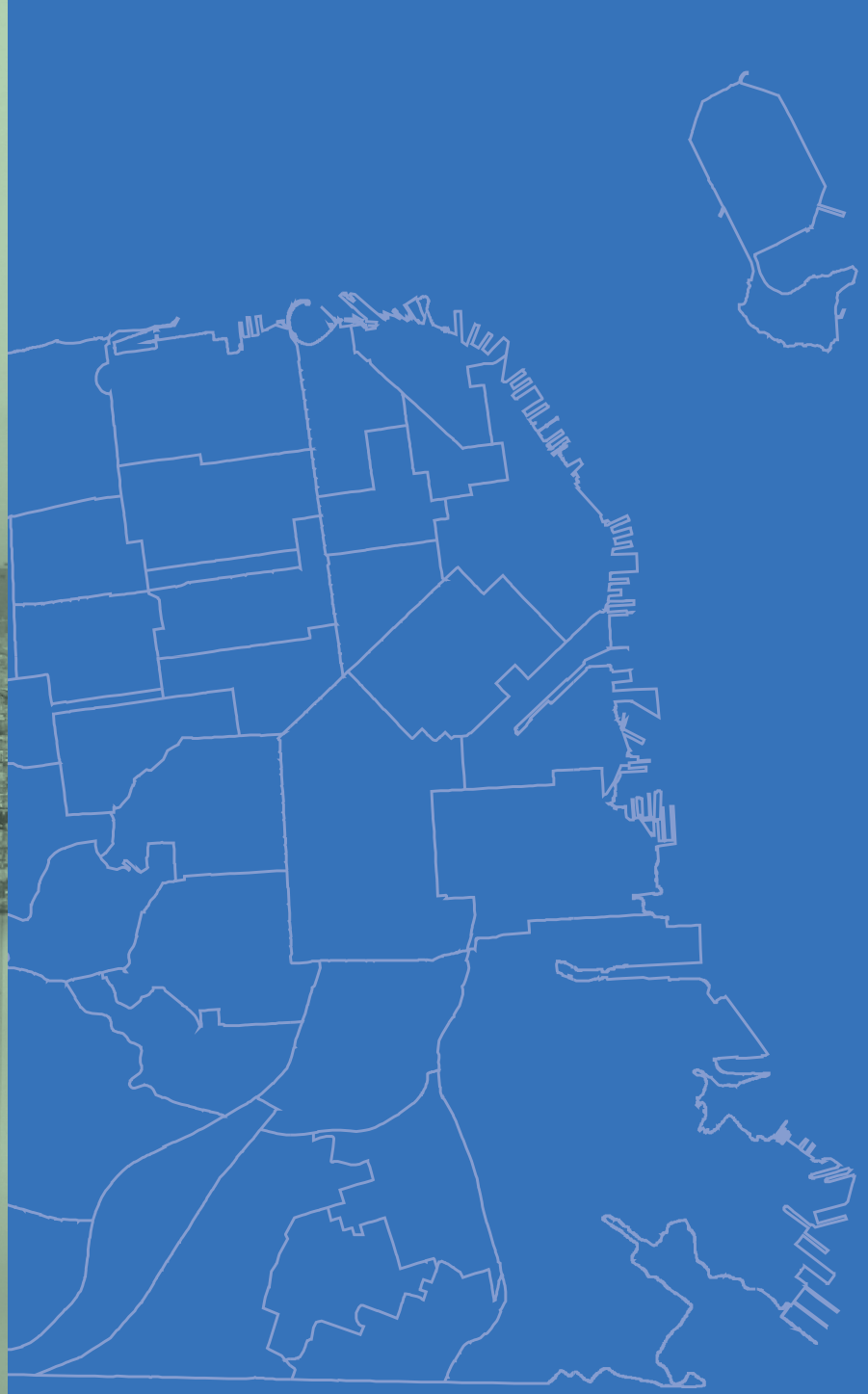

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A Message from SFHIP

It is our pleasure to share with you the 2016 San Francisco Community Health Needs Assessment. On behalf of the members of San Francisco Health Improvement Partnership (SFHIP), we hope you find this information useful in planning and responding to the needs of our community.

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 of San Francisco's non-profit hospitals' Community Health Needs Assessments and Hospital Community Benefit Plans.

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

Several health needs surfaced through this assessment including: healthy eating, physical activity, psychosocial health, substance abuse, access to culturally and linguistically appropriate health care services, safety and violence prevention, and housing stability and homelessness. Additionally, economic barriers to health and major health inequities were identified 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.

Estela Garcia DMH, Abbie Yant RN, MA, *SFHIP Co-Chairs;* and Kevin Grumbach MD, former *SFHIP Co-Chair*

A Message from the Director of Health

I am pleased to present the 2016 Community Health Needs Assessment (CHNA) for San Francisco.

I am pleased to present the 2016 Community Health Needs Assessment (CHNA) for San Francisco. In 2011, the Health Department began our journey to achieve Public Health Accreditation. Accreditation will signify that DPH is meeting national standards for ensuring essential public health services and improving and protecting the health of the public. Collaboration with the San Francisco Health Improvement Partnership (SFHIP) and completion of the CHNA are essential to accreditation and to continued capacity building and, ultimately, improved health in San Francisco.

The 2016 CHNA takes a comprehensive look at the health of San Franciscans through an extensive data review process of a broad range of variables affecting health outcomes. A CHNA is completed once every three years and is an important tool for informing decision makers about San Franciscans' health status, identifying key health priorities for the city/county, and gaining a better understanding of health disparities and inequities.

Our health jurisdiction has a long tradition of engaging the community in our planning, from identifying policy changes to improving health outcomes (e.g. reduced rates of smoking and new HIV infections), and have developed new ways to measure the health of our environment and community. Like previous endeavors, this CHNA and the success of the planning processes that follow are dependent on the community voices we heard and I am especially thankful for the contributions of community groups that partnered with us and look forward to future collaborations.

Again, all of our accomplishments can be directly credited to the voices of the community members who contributed to this CHNA and the exceptionally dedicated staff and leadership at SFDPH and our SFHIP partners. I am grateful for their enduring commitment to this public health mission that we share and thank them for their ongoing efforts to protect and promote the health of all San Franciscans.

Best regards,

Barbara A. Garcia, *MPA*
Director of Health
San Francisco Department of Public Health
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Acknowledgments

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African American Art and Cultural Center
Asociación Mayab
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Instituto Familiar de la Raza
Larkin Street Youth
LGBT Center
Native American Health Center
On Lok 30th Street Senior Center
Swords to Plowshares
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❖This is a joint Community Health Needs Assessment by these local Hospitals and Jewish Home.
*Community Health Needs Assessment Subcommittee Member. § SFDPH Community Health Needs Assessment and Impact Unit members. Report and data sheet design and production: Kate Godfrey | okaykate.com.

Executive Summary

Welcome to the **2016 Community Health Needs Assessment** (CHNA). The CHNA takes a broad view of health conditions and status in San Francisco. It reviews conditions where San Franciscans are born, grow, live, work and age, local risk and protective factors for health, as well as local disease and death rates.

The CHNA involves four steps:

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

The CHNA is the foundation for each of San Francisco's non-profit hospitals' Community Health Needs Assessments and is one of the prerequisites for Public Health Accreditation. The CHNA also informs city planning processes such as San Francisco's Health Care Services Master Plan.

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

- More than 97,000 residents gained health insurance under the Affordable Act in 2014. Insurance coverage in San Francisco was higher than coverage across the state or nation.
- Overall rates of smoking declined from 20.8% in 1996 to 12.3% in 2014 and are approaching the Healthy People 2020 goal of 12.0%.
- Since 2006, we have had steady declines in HIV diagnoses.
- Between 2007 and 2013, the rates of death due to cardiovascular disease (ischemic heart disease and hypertensive heart disease), cerebrovascular disease, lower respiratory infections, and poisonings and drugs decreased.
- Between 2008 and 2010, the incidence rate of invasive cancers decreased.
- Rates of tooth decay among school children decreased between 2007-08 and 2013-14.

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

- Economic barriers to health
- Racial health inequities

The CHNA identifies 7 health needs that heavily impact disease and death in San Francisco:

- Psychosocial health
- Healthy eating
- Safety and violence prevention
- Access to coordinated, culturally, and linguistically Appropriate Services across the continuum.
- Housing instability/homelessness
- Substance abuse
- Physical activity

Foundational Issues

Economic Barriers to Health

Income generally confers access to resources that promote health—like good schools, health care, healthy food, safe neighborhoods, and time for self-care— and the ability to avoid health hazards —like air pollution and poor quality housing conditions. Page 17 focuses on the Economic Barriers to Health that many San Franciscans face. Find additional data on economics and health in the Economic Environment appendix.

Racial Health Inequities

Health inequities are avoidable differences in health outcomes between population groups. Health inequities result from unevenly distributed systematic social, economic, and environmental obstacles that impact risk, prevention, and

treatment of health problems. Pages 18 and 19 focus attention on racial health inequities among Black/African Americans. Additional data on health inequities are found throughout the appendices.

Health Needs

Psychosocial 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. Pages 20-21 focus on psychological distress and major depression in San Francisco. Find additional data on psychosocial health in the City in the Mental Health, Substance Abuse, and Tobacco Use & Exposure appendices.

Healthy Eating

Poor nutrition contributes to 6 of the top 10 causes of death in San Francisco--heart failure, stroke, hypertension, colon cancer, Alzheimer's, and other dementias--as well as to the 11th top cause of death, diabetes. Page 22 focuses on barriers to healthy eating and drinking. Additional information on healthy eating in San Francisco is found in the Nutrition appendix.

Safety and Violence Prevention

Violence not only leads to serious mental, physical and emotional injuries and, potentially, death for the victim, but also negatively impacts the family and friends of the victim and their community. One out of five residents reports not walking because of fear of violence or crime. Pages 23-24 focus on violent crime and perceptions of safety in San Francisco and their health impacts. Additional data on safety and violence in the City is presented in the Safety appendix.

Access to coordinated, culturally and linguistically appropriate services across the continuum

In 2014, 97,000 residents gained health insurance. However, few, 13%, have a usual place they go to receive care. Access to services is influenced by location, affordability, hours of operation, and cultural and linguistic appropriateness of health care services. Page 25 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 appendix.

Housing Stability/Homelessness

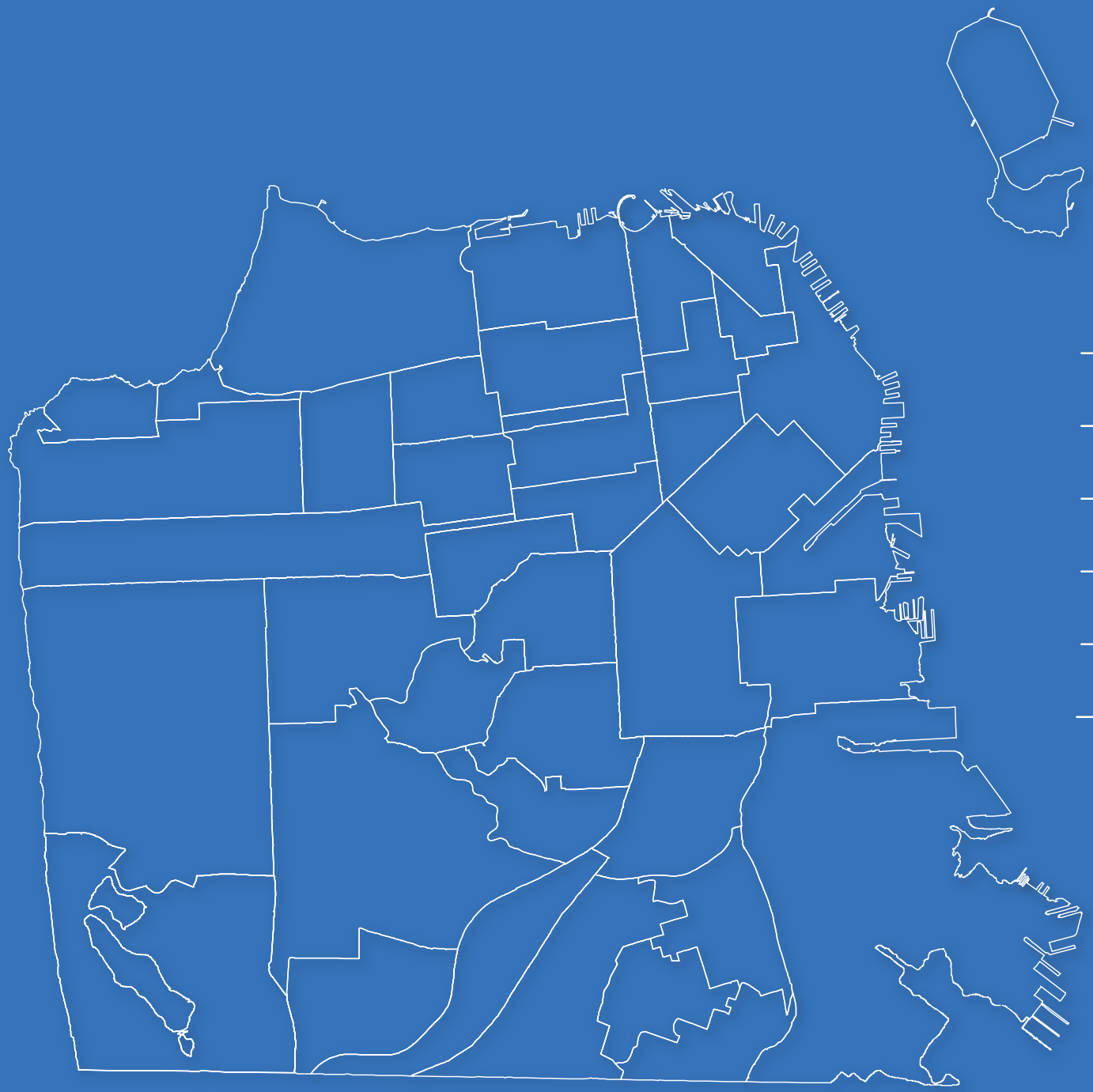
Sub-standard housing quality, overcrowding, housing instability, and homelessness impact health by decreasing opportunity for self-care (sound sleep, home-cooked food, warmth, hygiene) and increasing risk exposure. Between 2000 and 2012, fair market rents increased by 22% and all causes evictions are at a 10-year high. Page 26 provides an overview of the housing stressors in San Francisco. Additional information on housing and health is found in the Housing appendix.

Substance Abuse

Substance Abuse including drugs, alcohol and tobacco, contributes to 7 of the top 10 causes of death in the City—lung cancer, COPD, heart failure, stroke, hypertensive heart disease, Alzheimer's and organic dementias, and poisonings. Pages 27-28 present statistics for substance abuse in San Francisco. Additional data can be found in the Substance Abuse and Tobacco Use and Exposure Appendices.

Physical Activity

A lack of physical activity contributes to 5 of the top 10 causes of death in San Francisco--lung cancer, heart failure, hypertension, colon cancer, dementias--and to the 11th top cause of death, diabetes. 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 examining the amount of physical activity San Franciscans do is presented on page 29. Additional San Francisco data is available in the Physical Activity, Transportation Systems, and Safety Appendices.



The 2016 Community Health Needs Assessment

Purpose & Collaborators

The **2016 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 prerequisites 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.

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.

Approach

The 2016 CHNA was guided by the principles of equity, alignment, promotion of community connections, increasing efficiency, catalyzing and prioritizing action, and understanding assets and alignment of solutions.

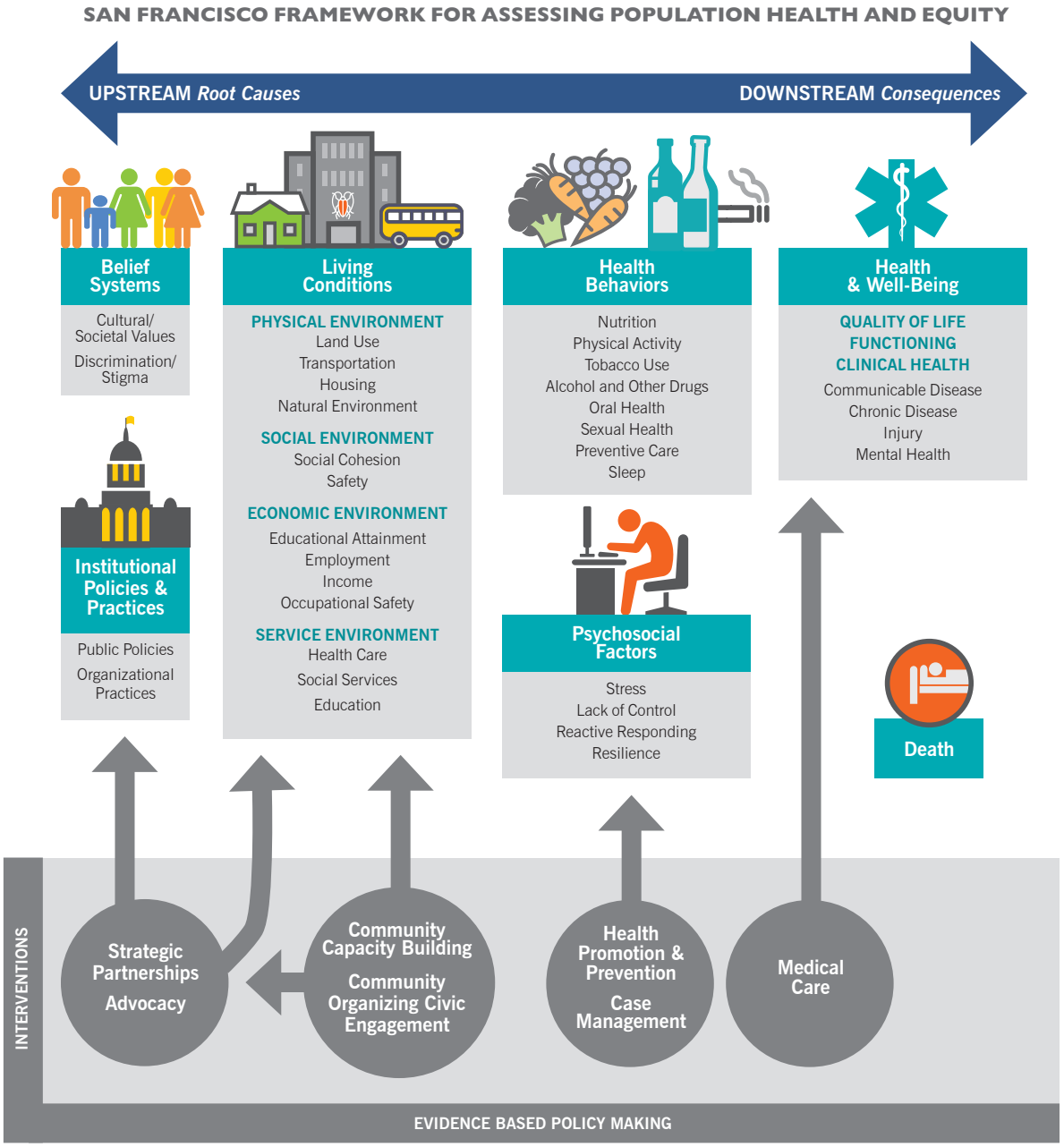
The 2016 CHNA collected information on the health of San Franciscans via three methods — **Community Health Status Assessment, Assessment of Previous Assessments,** and **Community Engagement**. Through review of the information provided by these sources SFHIP identified San Francisco's health needs.

Community Health Status Assessment

Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.[1] 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.[1, 2, 3] 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.[4]

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** (pictured at right), 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.[5] 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.[6] In all, 177 variables were analyzed.

We present the results from all analyses in **28 community health data appendices** and in the **Community Health Data Summary appendix**.



Approach

Assessment of Prior Assessments

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

We included assessments in the analysis if …

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

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

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

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

Community Engagement

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

- Identify San Franciscan's health priorities, especially those of vulnerable populations
- Obtain data on populations for which we have little quantitative data
- Build relationships between the community and SFHIP
- Meet the regulatory requirements including the IRS rules for Charitable 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

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

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

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

- Advancing Justice of the Asian Law Caucus
- African American Art and Cultural Center
- Asociación Mayab
- CARECEN
- Filipino American Development Foundation
- Instituto Familiar de la Raza
- Larkin Street Youth
- LGBT Center
- Native American Health Center
- On Lok 30th Street Senior Center
- Swords to Plowshares
- Transitions Clinic

We facilitated all meetings using two Technology of Participation techniques — Focused Conversation and Consensus Workshop.[7] The main question we asked of participants was *What actions can we take –including residents, community groups, and SFHIP – to improve health?* Participants were also asked about the assets and barriers which exist in their communities regarding health.

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

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

Further details on the methods and findings are available in the Community Engagement Appendix.

Approach

Health Need Identification

To identify the most significant health needs in San Francisco, SFHIP steering committee, and SFHIP Community Health Needs Assessment Subcommittee met on October 8, and November 4th, 2015.

Participants identified health needs through a multistep process. First participants reviewed data and information from the Community Health Status Assessment, the Assessment of Prior Assessments, and the Community Engagement, as well as the health priorities from the 2012 Community Health Improvement Plan. Then, using the Technology of Participation approach to consensus development, participants engaged in small group focused discussions about the data. Finally, participants developed consensus on the health needs. (**Figure A**) Throughout the process needs were screened using pre-established criteria (**Figure B**).

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

The two foundational issues identified were:

- Economic barriers to health
- Racial health inequities

The seven health needs identified were:

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

Data describing part of each of the foundational issues and health needs are located in the Major Findings section and in the appendixes.

SFHIP will use the CHNA findings to further prioritize the seven identified health needs and develop goals, objectives and strategies for collaborative action to improve the health of San Francisco residents.

Figure A: Consensus development steps

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

Figure B: Health need screening criteria

Health need is confirmed by more than one indicator and/or data source
Need performs poorly against a defined benchmark(s)

Health needs include health outcomes of morbidity and mortality as well as behavioral, environmental, clinical care, social and economic factors that impact health and well-being.

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San Francisco Snapshot

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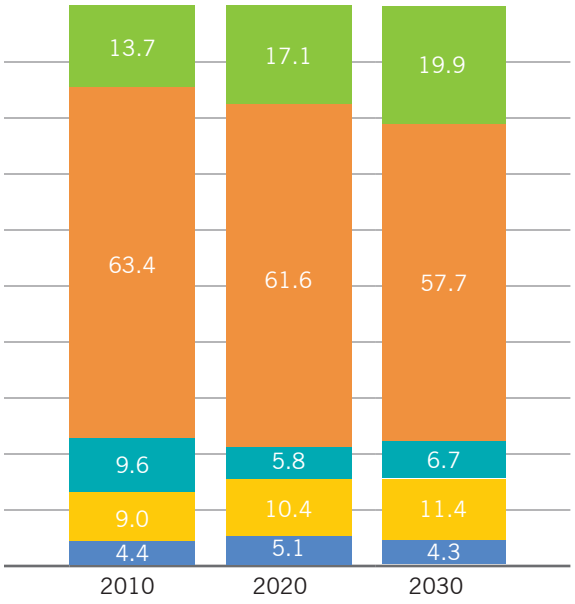
Population Growth

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

Population by age group as a percentage of the total population projections, SF, 2010–30[4]



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

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

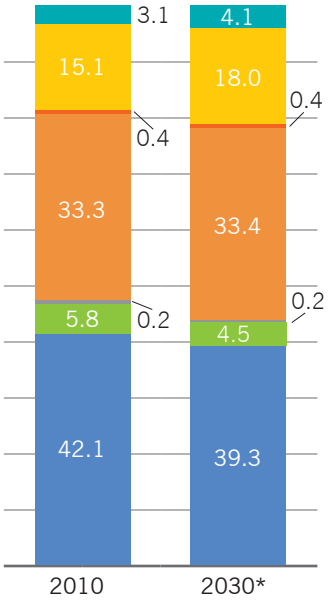
An Aging Population

The proportion of San Francisco's population that is 65 years and older is expected to increase from 13.7 percent in 2010 to 19.9% in 2030.[4] The proportion of the population 75 years and older will increase from 6.9% to 9.8%. At the same time, it is estimated that the proportion of working age residents (25 to 64 years old) will decrease from 63 percent in 2010 to 57.7 percent in 2030. This shift could have implications for the provision of social services.

Ethnic Shifts

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

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



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

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

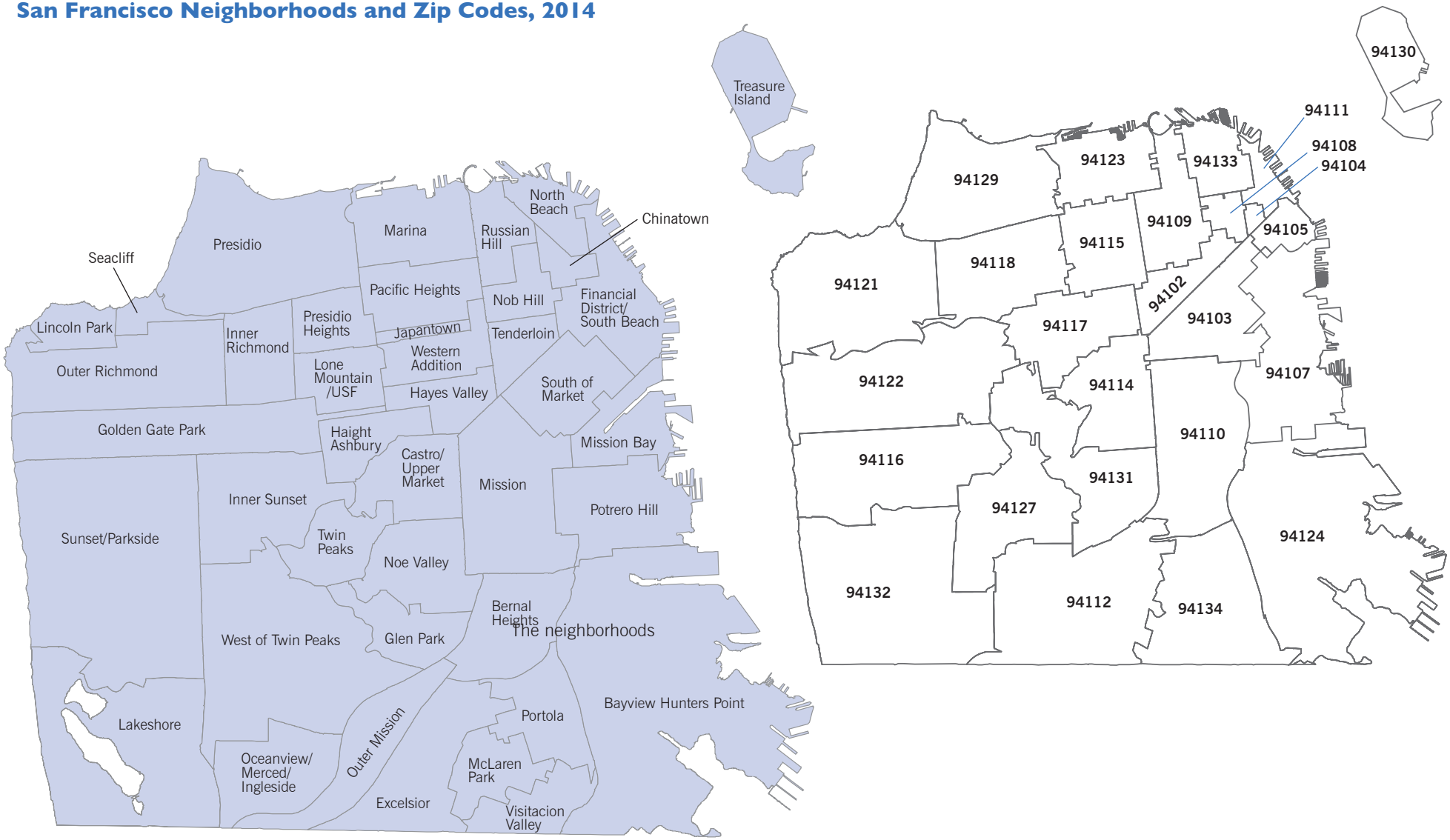
Families and Children

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

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

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

San Francisco Neighborhoods and Zip Codes, 2014



*Additional detail on San Francisco geographies are available in the Using This Report Appendix.

Major Findings

The 2016 Community Health Needs Assessment identified two foundational issues and seven health needs.

The following infographics highlight aspects of each issue and need.

Foundational Issues

Health Needs

Economic Barriers to Health

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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.

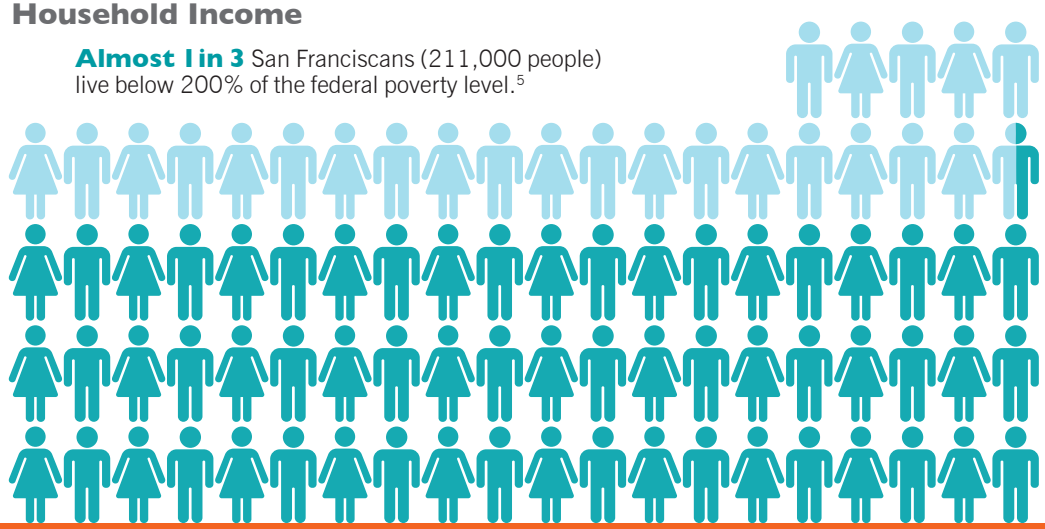
Low income groups are at greater risk of a wide range of health conditions than higher income groups, and have a shorter life expectancy.[1]

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]

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

Household Income

Almost 1 in 3 San Franciscans (211,000 people) live below 200% of the federal poverty level.[5]



For a family of four, the federal poverty level is $48,500.[6]
14% of children live in poverty.[2]

Employment Disparities

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

Less than 5% of White San Franciscans are unemployed.

Almost 18% of Black/African Americans are unemployed.[7]

Black/African Americans are less than half as likely as Whites to have at least a Bachelor's degree and 5 to 10 times more likely to have less than a high school education.[5]

Median Income

In San Francisco, there is significant inequality in household income between races.[8]

White household median income is over **$100k**

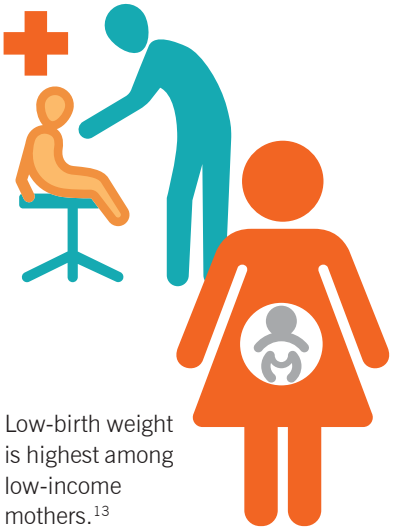
Black/African American household median income is **$30k**

Income Inequality and Health

San Francisco has the highest income inequality in California. Between 2007 and 2014, the widening income gap was driven primarily by increasing incomes among the highest earners while incomes among lower earners stagnated.[9]

The wealthiest 5% of households in SF earn 44 times more than the poorest 20% of households.[5]

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]

Racial Health Inequities

Health inequities are avoidable differences in health outcomes between population groups. Health inequities result from unevenly distributed systematic social, economic, and environmental obstacles that impact risk, prevention, and treatment of health problems.[1-2] **Health inequities are issues of social justice and human rights.**[2]

Obstacles to health are unevenly distributed between race/ethnic groups in San Francisco. While health inequities are felt by all racial and ethnic communities, Black/African Americans experience inequities to a greater degree.

Black/ African American residents disproportionately live in poverty; lack access to a healthy diet; experience and witness violence; fall behind in education; are unemployed; are homeless; and experience negative effects of substance abuse and mental illness.Frequent and or prolonged challenges can result in toxic stress which disrupts brain and organ development in young children, and increases risks for serious cognitive and chronic health conditions over the lifetime.[4, 5]

All San Franciscans do not have equal opportunity for good health.

In San Francisco, **a persistent, consistent pattern** emerges when examining health data by race and ethnicity: Black/African American (B/AA) residents face the greatest social, economic, and environmental hardships and consequently have the highest rates of acute and chronic disease, injury, and disability, and ultimately lower life expectancy.

Unevenly distributed obstacles to health

Variable	White	B/AA
No prenatal care in first trimester[6]	5%	36%
Children 0-18 living in poverty*[7]	2%	48%
Not exclusively breastfed in first weeks[6]	9%	33%
Child neglect or abuse, age 0-18[8]	5/10,000	40/10,000
Not proficient on English language standardized test in 3rd grade[9]	19%	76%
Did not meet 5th grade Fitness standards[10]	26%	48%
Did not graduate from high school[11]	16%	63%
Unemployed[12]	4%	18%
Arrests[13]	45%	40%
Homelessness[14]	39%	36%

*poverty = household income <100% FPL

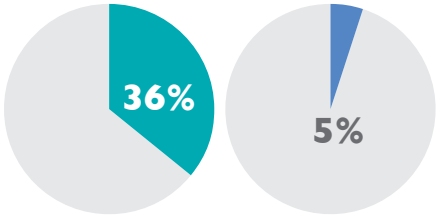
Whites and Black/African Americans make up similar percentages of arrested and homeless persons but **there are 7 times more White than Black/African American residents** in San Francisco.[13]

Health inequities

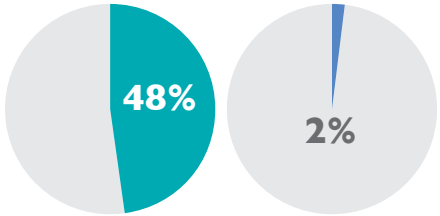
Variable	White	B/AA
Unintended pregnancy[6]	18%	69%
Born Preterm[15]	7%	16%
Asthma hospitalizations at ages 0-4[16]	11/10,000	72/10,000
Experienced cavities by kindergarten[17]	17%	40%
Overweight or obese by 5th grade[18]	23%	50%
Overweight/obese as an adult[19]	33%	60%
Emergency room visits due to assault[20]	39/10,000	241/10,000
Diabetes hospitalization[16]	6/10,000	40/10,000
Disability[19]	26%	41%
Major depression hospitalization[16]	9/10,000	14/10,000
Have high blood pressure[19]	18%	47%
Invasive Cancer[21]	451/100,000	571/100,000
Tuberculosis[22]	3/100,000	22/100,000
Years of life expectancy[23]	81	71

On average, Black/African American residents live **10 years less** than Whites, **14 years less** than Asian and Pacific Islanders, and **11 years less** than Latinos(as).[23]

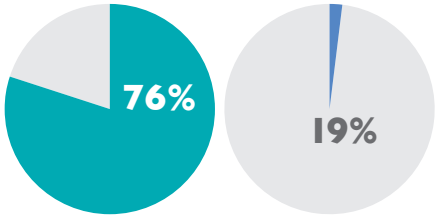
Hurdles to a healthy life start early in San Francisco.



36% of Black/African American mothers **do not receive prenatal care** in the first trimester. Only 5% of white mothers do not.[6]

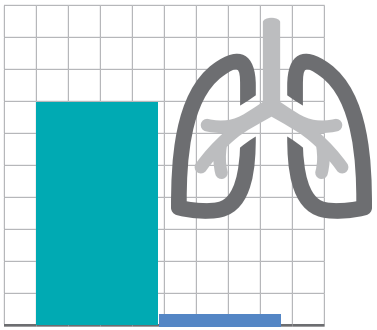


48% of Black/African American children **live in households earning less** than 100% of the federal poverty level. Only 2% of white children do.[7]



76% of Black/African American 3rd graders **score lower than proficient** on English Language standardized tests. Only 19% of white students do.[9]

Health Inequities also start early in San Francisco.



The rate of **asthma hospitalizations** among Black/African American children **0 to 4 years of age is 6.5 times higher** than among White children.[16]

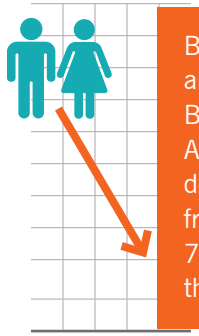
50% of Black/African American 5th graders are overweight or obese.

Black/African American 5th graders are **2 times more likely** to be overweight or obese than white 5th graders.[18]

2.4 times more Black/African American children **have cavities** by kindergarten than White children.[17]

The Black/African American Exodus from San Francisco.[24-25]

Since a high of nearly 88,000 in 1970, outmigration has led to notable declines in the Black/African population.



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

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

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

Psychosocial Health

Mental Health is part of community health. Mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to the community.[1,2]

Mental illness, by contrast, includes all diagnosable mental disorders or conditions that are characterized by alterations in thinking, mood, or behavior associated with distress and or impaired function. Mental disorders include depression, schizophrenia, anxiety, injuries to the brain, dementias, intellectual disabilities, developmental disorders, and substance abuse.[1]

Risk factors for mental health disorders include individual (e.g. genetics, stress, thinking patterns) and environmental (e.g., social, cultural, economic) factors.[1,3,4] Mental illness is elevated among certain vulnerable populations such as the homeless, the incarcerated, and those leaving the child welfare system.[5,6] Social disadvantage is also a prominent risk factor for mental disorder.[7,8]

Mental Health is an important part of community health. Mental illnesses, including substance use disorders, are the leading causes of years lived with disability worldwide.[9] Presence of mental illness can adversely impact the ability to perform across various facets of life—work, home, social settings, and it also impacts the families, caregivers, and communities of those affected.[4] Depressed youth are more likely to engage in risk-taking behaviors including using drugs, practicing unsafe sex, attempting suicide, and running away from home and are less likely to succeed in school and possibly later life.

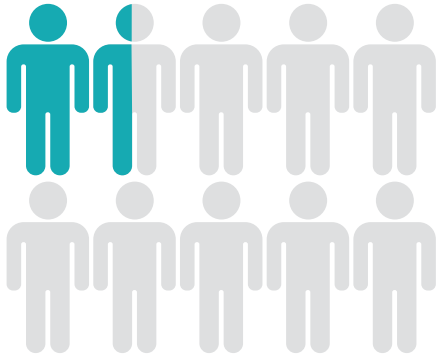
Adult psychological distress is reported more often among certain populations.

Serious psychological distress is reported by **9% of adults** and some groups experience even greater frequency.[10]

Lower income residents are 2.5 times more likely to experience distress than residents from wealthier households (10% compared to 4%).[11]

55% of chronically homeless individuals acknowledge having a psychological or emotional condition.[12]

23% of all City residents report needing emotional help and support although some groups less often reported the need.[10]



Only **10%** of Asian and Pacific Islander residents report needing help.[13]

Hospitalizations in San Francisco[14]

to treat major depression among adults occurred 1,852 times during the three years between 2012 and 2014.

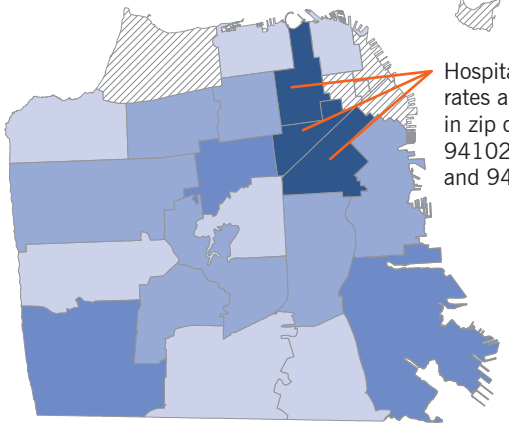
The number of hospitalizations for major depression exceeded that of adult asthma or hypertension.

Major depression hospitalization rates are elevated among Whites, Black/African Americans, and certain age groups:

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

Asian and Pacific Islanders are the least likely to be hospitalized for major depression: **27 hospitalizations**/100,000.

Age-adjusted major depression hospitalization rates for adults age 18-plus, 2012–14[14]



Hospitalization rates are highest in zip codes 94102, 94103, and 94109.

Psychosocial Health

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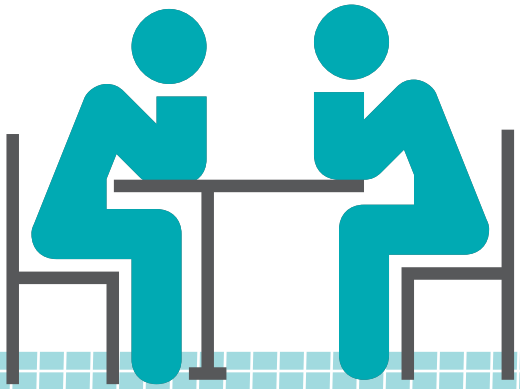
Suicide is the 8th leading cause of death in San Francisco.[15]

337 San Franciscans committed suicide in the four years between 2010 and 2013.

Whites have the highest rates of suicide (19 per 100,000). Despite low hospitalization rates and low reporting of needing help, Asian and Pacific Islanders have the second highest rates of suicide (9 per 100,000).

Suicide completion is most common among men (**75%**).

49 is the average age of death for those who complete suicide.



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

53% of Gay or Lesbian students report prolonged sadness — twice the rate of heterosexual students (24%).[16]

35% of Filipino and **37%** of Latino students report prolonged sadness.[16]

26% of San Francisco high school students report episodes of prolonged sadness.[16]

17% of Filipino, Latino, and White high school students consider suicide.[16]

13% of high schoolers and **15%** of middle schoolers consider suicide.[16]

Addressing high rates of psychological distress requires a culturally sensitive approach.

Ethnic groups show differences that are complex and may represent stigma, lack of availability of culturally competent services, or other barriers preventing access to needed preventative and treatment services.

Asian and Pacific Islander residents report needing help less often and are less often hospitalized for depression, but have the second highest rate of suicide.[13]

White residents have higher rates of accessing hospitalization services, but also higher rates of completing suicidal acts.[14,15]

Black/African American residents have the highest rate of hospitalization for major depression.[14]

Healthy Eating

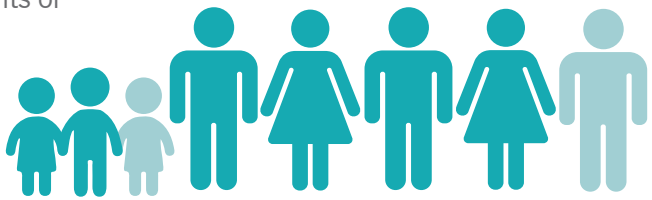
Good nutrition means getting the right amount of nutrients from healthy foods and drinks. Good nutrition is essential from infancy to old age.

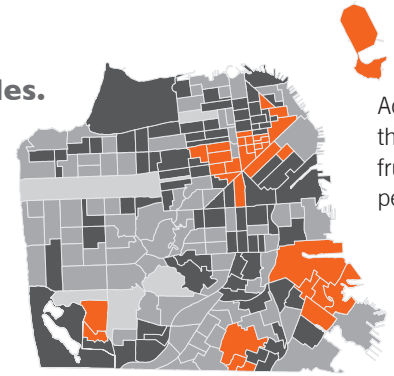
The USDA's MyPlate.org recommends that fruits and vegetables make up atleast half of our plate, or approximately five servings a day.[1]

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.[7]

Many San Franciscans do not eat enough fruits and vegetables.
2 out of 3 youth and **4 out of 5 adults** do not eat 5 or more servings of fruits or vegetables daily.[4,5]





Many San Franciscans do not drink enough water. 1 out of 3 adults drinks less than 4 glasses of water per day.[6]
Many do drink sugary drinks. 1 out of 3 adults consume at least one sugar sweetened beverage a day.[6]

Barriers to Healthy Eating

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

Many cannot afford healthy foods. 44% of adults living below 200% of the federal poverty level are not able to afford enough food at some time during the year.[8]

Not everyone has access to a kitchen. According to the American Community Survey, approximately 20,756 occupied housing units in San Francisco do not have complete kitchen facilities.[9]

Healthy foods are not evenly distributed across the city. While some neighborhoods, including Chinatown, have a dense array of food options, others, especially Oceanview/Merced/Ingleside, Bayview Hunters Point, Visitation Valley, and Treasure Island have less access to healthy food outlets.[10]

Not cooking is the new normal. On average, San Francisco area households spend **48% of their food dollars** on foods and non alcoholoic beverages prepared away from home, such as meals from restaurants, and school or workplace cafeterias, or vending machines.[11]

Unfamiliar fruits and vegetables are scary. Childcare providers participating in the Child and Adult Care Food Program who serve low income children in San Francisco report that children are unwilling to eat unfamiliar fruits and vegetables.

"Some children just won't eat the different vegetables…" —*Healthy Apple Program, San Francisco Children's Council*

"We offer a lot of fruit and vegetables, but the kids are scared of them…" —*San Francisco Food Vendor*

Safety and Violence Prevention

Violence not only leads to serious mental, physical and emotional injuries and, potentially, death for the victim, but also negatively impacts the family and friends of the victim and their community. Witnessing violence is linked to lifelong negative physical, emotional and social consequences.[1-4]

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]

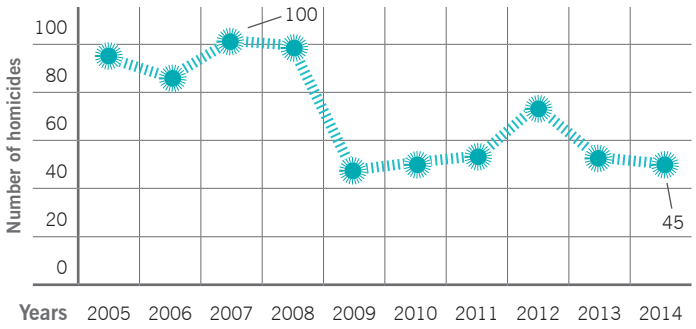
Children are particularly vulnerable. Witnessing and experiencing violence disrupts early brain development and causes longer term behavioral, physical, and emotional problems, including perpetrating or being a victim of violence, depression, suicide attempts, smoking, obesity, high-risk sexual behaviors, school absenteeism, unintended pregnancy, eating disorders, and alcohol and drug abuse.[1-4]

Violence is rarely caused by a single risk factor but instead by the presence of multiple risk factors. Some risk factors for violence are: poverty, poor housing, illiteracy, alcohol and other drugs, mental illness, community deterioration, discrimination and oppression, and experiencing and witnessing violence.[9-11]

Violent Crime is a Concern in San Francisco.

From 2007 to 2014 the rate of homicides decreased however, violent crime rates are high and exceed California rates. And, aggravated assaults are at a 10-year high.[12]

The number of homicides decreased from 2007 to 2014



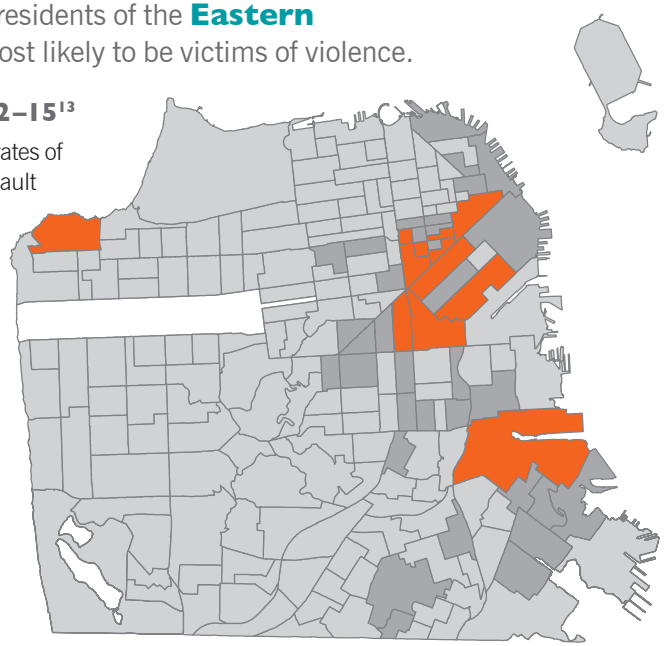
Crime	SF	CA
Homicide	8	5
Rape	42	24
Robbery	580	150
Aggravated assault	570	240

*Number of crimes per 100,000 residents.

Men, people of color, and residents of the **Eastern neighborhoods** are most likely to be victims of violence.

Violent Crime Rate, 2012–15[13]

Violent crime rates (shown) and rates of emergency room visits due to assault are highest in the Eastern Half of the City. Residents are less likely to feel safe in these neighborhoods.



155 males died violent deaths between 2010 and 2013. Violence is the **6th** leading cause of death among Black/African American men in the City. Violence kills men in their prime years. **36** was the average age at death for men who died violently.[14]

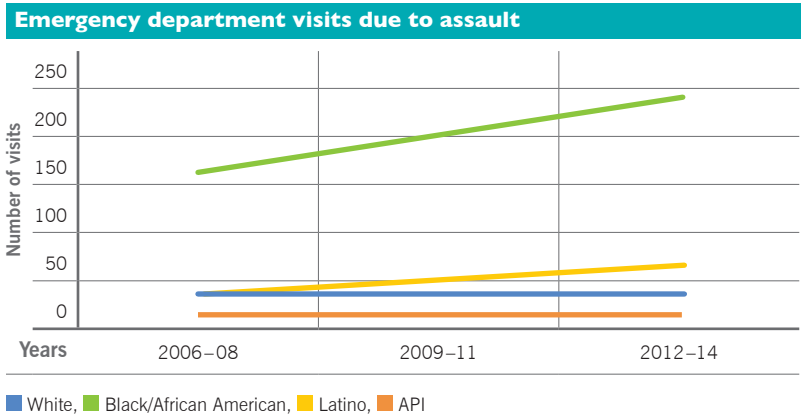
Some data suggest an uptick in violence in the home. Since 2008, the rate of 911 calls reporting **domestic violence has increased by 21 percent**, to 953 calls per 100,000 residents in 2014. **36%** of these calls reported injuries.[15]

But, simultaneously, substantiated **cases of child abuse have decreased by 50%** from 260 to 120 incidents per 100,000 children.[16]

Safety and Violence Prevention

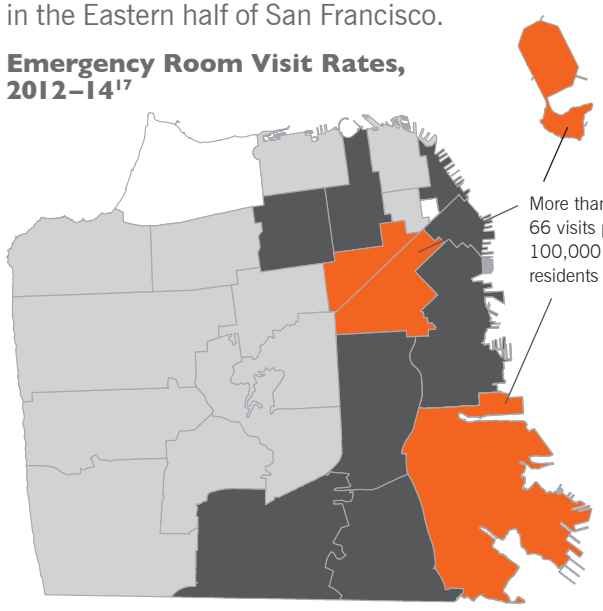
Emergency room visits due to assault[17]

Emergency room visits due to assault increased between 2006–08 and 2012–14.



The rate of emergency room visits due to assault are highest in the Eastern half of San Francisco.

Emergency Room Visit Rates, 2012–14[17]



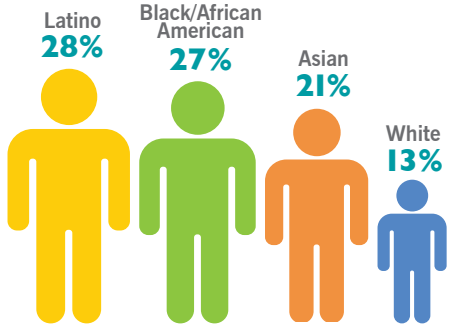
Emergency room visit rates are **1.2 times** higher among Latinos and **5 times** higher among Black/African Americans than other San Francisco residents.

Perceived Safety in San Francisco

Many do not feel safe in their neighborhoods.

18% of residents feel unsafe walking alone at night.[18]

Women (27%) are 2x more likely to feel unsafe at night than men (12%).[18]

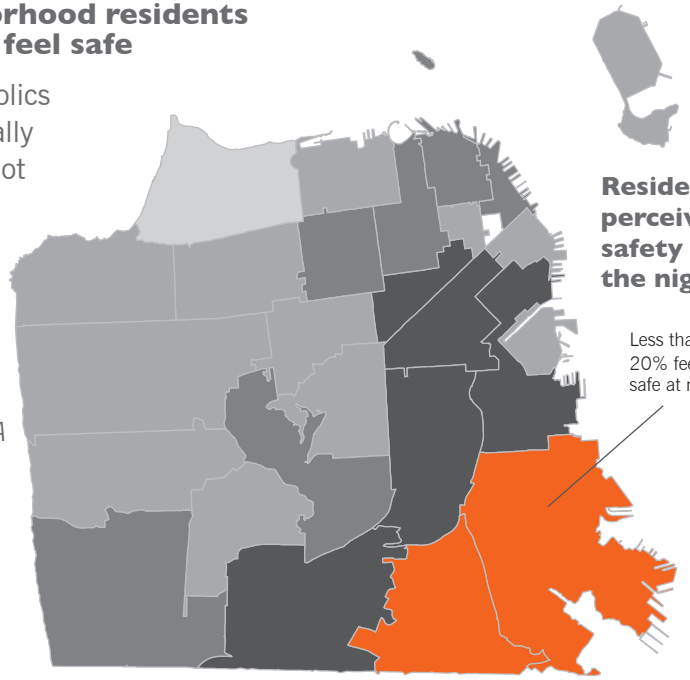


Asians, Latinos, and Black/African Americans are more likely to feel unsafe walking at night than Whites.[18]

Eastern Neighborhood residents are less likely to feel safe

"Drug addicts, alcoholics on the street, especially with grandson. It is not a good environment for them especially right now. Very dangerous, there are shootings at night time."
—SF resident at CHNA community meeting

Residents perceived safety during the night, 2013[18]



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

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Healthy People 2020 defines access to health care as "the timely use of personal health services to achieve the best possible health outcomes."[1]

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.[2]

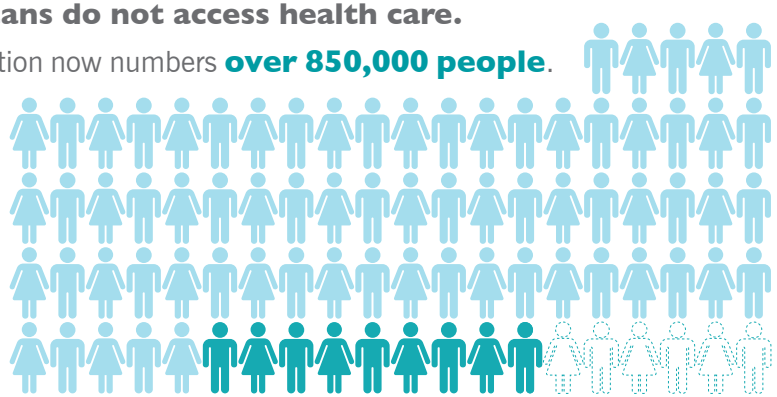
From a population health perspective, regular access to quality health care and primary care services also reduces the number of unnecessary emergency room visits and hospitalizations and can save public and private dollars.

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 850,000 people**.

While over **97,000 San Franciscans** gained health insurance in 2014 under the Affordable Care Act, an estimated 7.3% of residents, **60,877, still do not have health insurance**.[3-4]



13% do not have a usual place to go for medical care.[5]

41% of adults have not had a routine check-up in the past year.[5]

42% have not had a flu shot in the past year.[5]

40% of women ages 18–44 have not received counseling or information about birth control from a doctor or medical provider in the past year.[5]

22% of women with public safety net insurance do not receive timely prenatal care.[6]

35% of adults have not seen a dentist in the past year.[5]

60% of Denti-Cal eligible infants ages 0–3 years do not access to dental care.[7]

Young adults are at risk. Young adults 18 to 34 years of age and people of color are less likely to be covered by insurance.[4]

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

Those with limited English proficiency are more likely to report problems understanding a medical situation, trouble understanding labels, and bad reactions to medications.[10]

From the community we heard:

"Interpreting for mental health is hard. It makes things more complicated when you have three people in a session."

"The Arab community is a very diverse community with differing needs... It is important to have infrastructure that understands religion and culture."

"Its important to have health professionals who mirror me."

Different Levels of Prenatal Care

In 2012 **95%** of mothers with private insurance received prenatal care in the first trimester.[6]

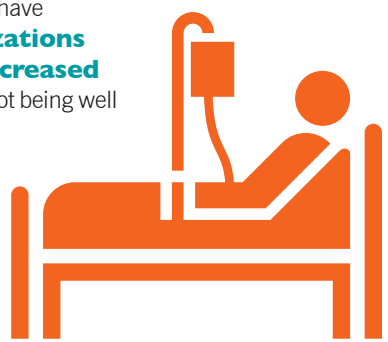
Only **78%** of those with Medi-Cal received early prenatal care.[6]

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 diabetes and hypertension have increased** — potentially indicating that these conditions are not being well managed at the population level.[8]

Preventable hospitalizations and ER visits are **significantly higher among Black/African Americans** compared to all other ethnicities in San Francisco. Similarly preventable ER visits are much higher among adults 18 to 24.[9]



Housing Stability/ Homelessness

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Shelter is a basic human need.

Sub-standard housing quality, overcrowding, housing instability, and homelessness impact health by decreasing opportunity for self-care (sound sleep, home-cooked food, warmth, hygiene) and increasing risk exposure.[1]

Housing instability and homeless-ness compound health risks for vulnerable population groups (e.g. low income, seniors, disabled, mentally ill) in San Francisco.[1]

Housing budget gaps

Those who pay more than **30% of their income** on housing costs are at risk for foreclosure, eviction, or homelessness if they experience a dip in income.[2]

Those paying over 50% are at extreme risk.

Spending a high proportion of income on rent also means fewer resources are available for other needs including food, heating, transportation, health care, and childcare.[1]

Quality

From 2013-15, **81% of the 186 homes** inspected as part of the Supplemental Nutrition Program for Women Infants and Children (WIC) had environmental health hazards.[3]

Over Crowding

51,000 people in San Francisco live in crowded conditions.[4]
Living in overcrowded conditions can increase risk for infectious disease, noise and fires.[1]

Displacement

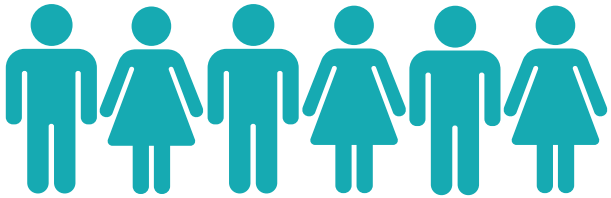
The number of all-cause evictions have steadily increased since 2010. **In 2014–15 there were 2,120 evictions.[5]**
Moving can result in the loss of employment, difficult school transition, increased transportation costs, and the loss of health protective social networks.[1]

Homelessness

Over 7,500 people are homeless in San Francisco. 18% reported eviction, increased housing costs, or foreclosure as the primary reason for homelessness.[6]
Among the many dangers homeless persons face, including those in temporary housing are — safety, storing medications, eating healthfully, and going to the doctor, are difficult when trying to find a place to sleep each night.[7-8]

Housing Affordability

Between 2000 and 2012, the median rent in San Francisco **increased by 22%**.[9]

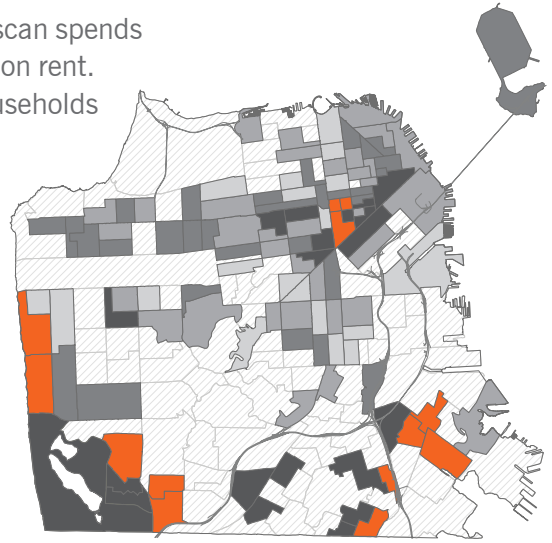


It takes **6 working adults** earning minimum wage to afford a 2-bedroom, market rate apartment.[5]

A typical San Franciscan spends **41%** of their income on rent.
22% of all renter households spend more than 50% on rent.[4]

Renter households whose gross rent is 50 percent or more of household income[4]

- Excluded due to small sample size
- 9.0–17.1%
- 17.2–22.9%
- 23.0–29.4%
- 29.5–37.9%
- 38.0–59.1%



Substance Abuse

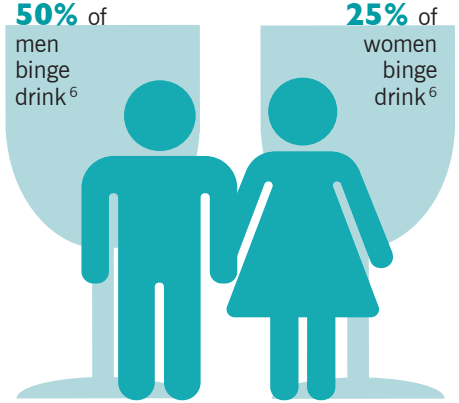
Many factors affect the decision to start and continue using tobacco, alcohol and other drugs.

Factors include: substance abuse among friends and family, poor academic performance, unstable family and social relationships, exposure to abuse, availability, exposure to advertising, mental illness, and poverty.[1]

The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental and public health problems. The earlier a person begins to use drugs and alcohol, the more likely he or she is to develop serious problems. Harms associated with substance abuse include: unintended pregnancy and STD transmission, poor academic performance, cognitive functioning deficits, motor vehicle crashes, violence, mental and behavioral disorders (unipolar depressive disorders, epilepsy, and suicide), injury and death.[2-8] Unintentional poisoning is now the leading cause of injury death among adults nationwide, surpassing motor vehicle accidents.[8] In 2012, alcohol was associated with 31% of motor vehicle crashes.[7]

Binge drinking is defined as…

five or more drinks for men,
four or more drinks for women,
consumed on one occasion.



Substance abuse has serious consequences in San Francisco.

Substance abuse is **a risk factor for 7 of the top ten causes of death in the City:** lung cancer, COPD, heart failure, stroke, hypertensive heart disease, Alzheimer's and organic dementias, and poisonings.[9]

The number of hospitalizations due to acute and chronic alcohol abuse is greater than for diabetes, hypertension, or COPD.[10]

Between 2012 and 2014,
2,394 hospitalizations and
4,647 emergency room visits resulted from acute and chronic alcohol abuse. That's 798 hospitalizations and 1,549 emergency room visits per year.[10-11]

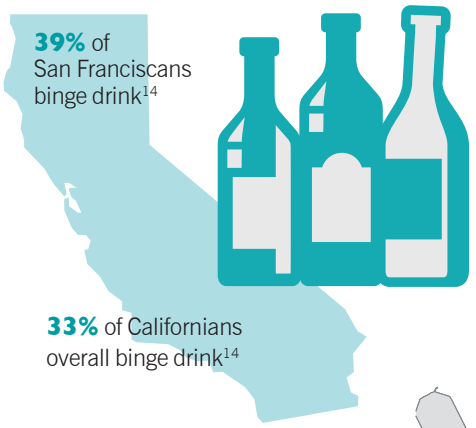
Between 2012 and 2014,
the Sobering Center received almost
13,000 Emergency Room diversions
due to alcohol intoxication.[12]

Drug and alcohol abuse contribute to homelessness in San Francisco.

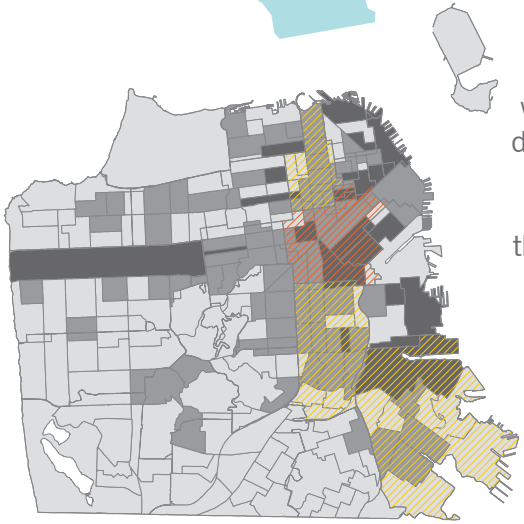
18% of homeless persons report drug and alcohol abuse as the primary cause of their homelessness.[13]

62% of chronically homeless persons have a drug or alcohol abuse condition.[13]

2 out of 5 San Franciscans binge drink.



15% of total food expenditures in the home are for alcohol.[15]



Neighborhoods with the highest density of off-sale alcohol outlets coincide with those with higher rates of hospitalizations and emergency room visits due to alcohol.

Off-sale alcohol license density and alcohol-related ER visits among adults*[11,16]

ER visits due to alcohol per 10,000 residents (adjusted)
0.00–17.50, 17.51–26.11, 26.12–70.63

Off-sale alcohol licenses per 1,250 residents
0–1, 2–3, 4–56

*Retail outlets authorized to sell beer, wine, or spirits for consumption off the premises where sold.

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

Between 1996-2012, the smoking rate declined by 41%.[17] However, 11% of San Franciscans still smoke.[14] Young adults, people of color, low income earners and LGBTQ residents are disproportionately affected by tobacco.

Young adults 18 to 24 years are more likely to smoke than those 25 and older (16% vs 10%).[18]

Gay and Lesbian students are more likely to smoke than their heterosexual peers (11% vs. 9%).[19]

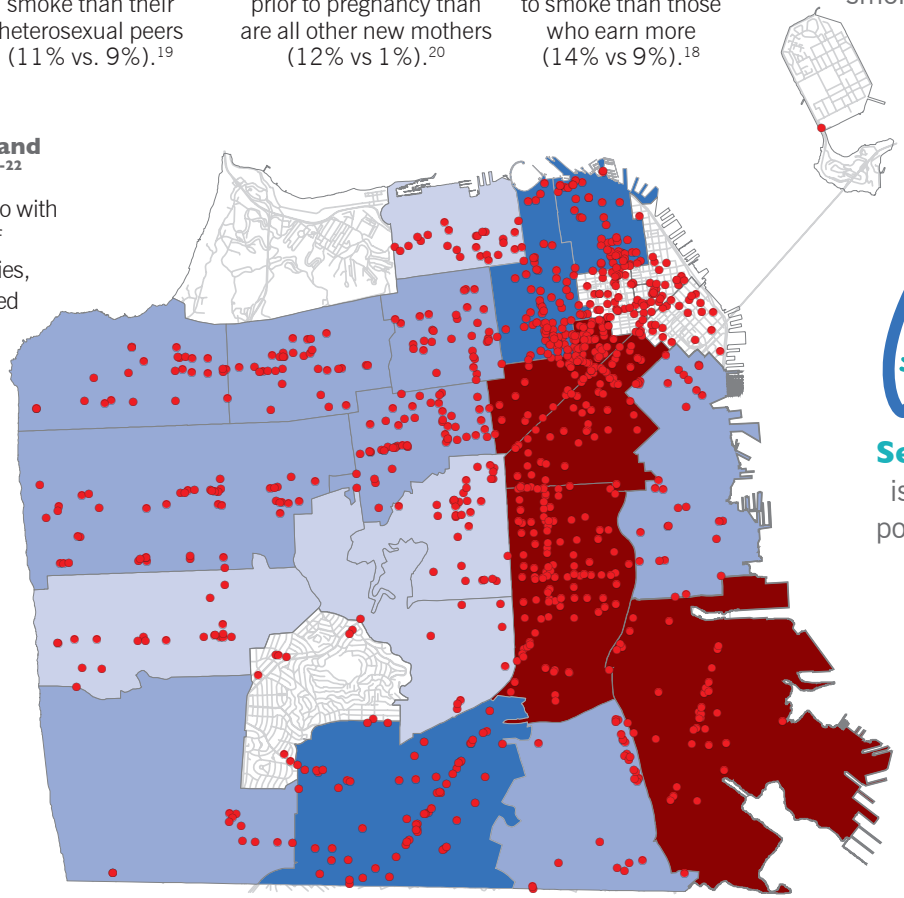
Black women are more than 12 times more likely to be smokers prior to pregnancy than are all other new mothers (12% vs 1%).[20]

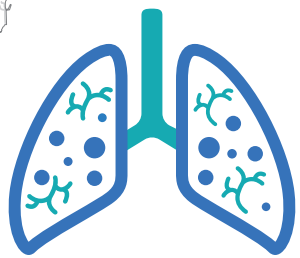
Lower income earners are 45% more likely to smoke than those who earn more (14% vs 9%).[18]

San Francisco spends nearly **$400 million a year on tobacco-related costs,** including medical expenses, loss of productivity, and secondhand smoke exposure.[23]

Tobacco Retailers and Current Smokers[21-22]

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





Secondhand smoke is a problem in densely populated San Francisco. In 2014, **40% of residents** experienced at least some degree of drifting smoke into their home.[24]

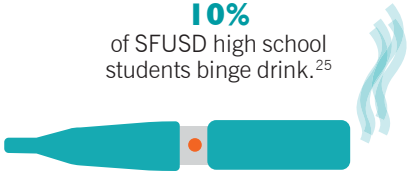
Youth in San Francisco are at risk of substance abuse.

28% of SFUSD high school students smoke marijuana. SFUSD students are more likely to smoke marijuana than their national peers (23%).

14% of SFUSD high school students use methamphetamines, inhalants, ecstasy or cocaine.

11% of SFUSD high school students abuse prescription drugs.

10% of SFUSD high school students binge drink.[25]



The Rise of E-cigarettes

There is growing concern that electronic cigarettes may cause addiction among non-smokers and reverse decades of anti-smoking efforts. Between 2011 and 2012, the percentage of youth using e-cigarettes nationally increased from 4.7 to 10 %.[26]

In San Francisco **17%** of high school students tried e-cigarettes while only 8% used cigarettes.[27]

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.[1]

Just 2.5 hours of moderate intensity aerobic physical activity each week is associated with a gain of approximately three years of life. [2]

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.[3]

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

Scheduled daily physical activity at childcare centers varies **from less than 45 minutes to more than 2 hours**.[4]

Fewer than 1 in 5 high school students is active 60 minutes each day.[5]

Only 25% of adults spend enough time physcially active by walking for transport and **33%** of by walking for leisure.[6]

Many San Franciscans don't walk.

47% of Kindergarten students live within a mile of school, but only 28% of kindergarten students walk or bike to school.[7]

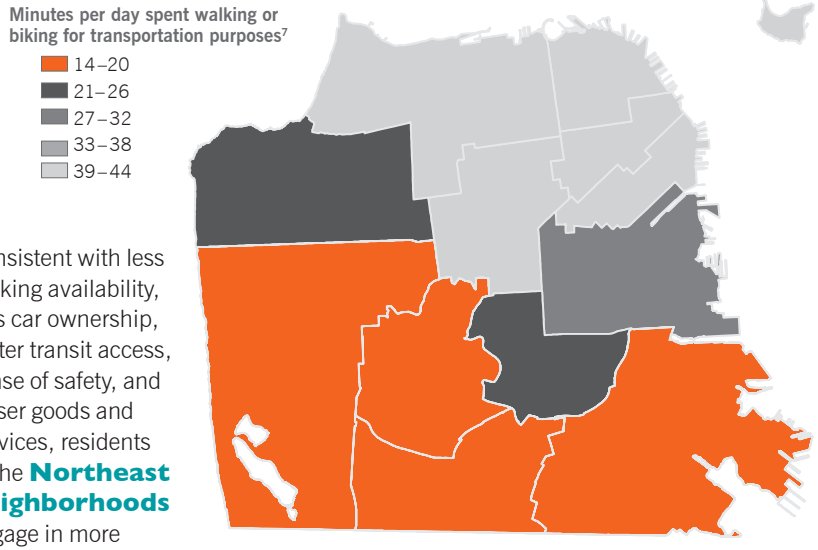
42% of 5th graders live within a mile of school, but only 25% of 5th graders walk or bike to school.[7]

The **6 main barriers** to walking in San Francisco are: lack of time, violence or criminal activity, unclean sidewalks, hills or steep streets, medical conditions, and speeding vehicles.[6]

1 out of 3 older adults reports a medical condition as a main barrier to walking.[6]

14% of adults report not walking because of fear of violence or crime.[6]

Neighborhood resources for physical activity



Consistent with less parking availability, less car ownership, better transit access, sense of safety, and closer goods and services, residents in the **Northeast neighborhoods** engage in more walking and biking each day than those in Southern neighborhoods.

The average adult in Northeast San Francisco spends 40 minutes per day walking or biking for daily errands, and meets his or her recommended minutes of physical activity with these trips alone.[8]

In other parts of San Francisco, such as Bayview Hunters Point and Ocean View, **the average adult spends as little as 15 minutes** walking or 4biking for transportation.[8]

"I pray to god for protection, walking in a dangerous neighborhood counteracts the value and health of walking. I drive more. I fear for my life when I'm on the street." *—SF resident, CHNA community engagement meeting*

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Community Health Needs Assessment Appendices

The folllowing documents can be found in the second half of this report:

San Francisco Community Health Needs Assessment 2016

Prepared by the San Francisco Department of Public Health, Population Health Division

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CHINESE HOSPITAL
Caring for the Community for the Next 100 Years

Dignity Health
Saint Francis Memorial Hospital

Dignity Health
St. Mary's Medical Center

Hospital Council
of Northern & Central California
Excellence Through Leadership & Collaboration

JEWISH HOME
Jewish Senior Living Group

KAISER PERMANENTE

Sutter Health
CPMC
We Plus You

UCSF Health