2022
Community Health Needs Assessment

Sutter Health
CPMC
California Pacific
Medical Center

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Executive Summary

Background

California Pacific Medical Center (CPMC) is affiliated with Sutter Health, a not-for-profit parent of not-for-profit and for-profit companies that together form an integrated healthcare system located in Northern California. The system is committed to health equity, community partnerships and innovative, high-quality patient care. Over 65,000 employees and associated clinicians serve more than 3 million patients through our hospitals, clinics and home health services.

CPMC serves the City and County of San Francisco with its three acute care campuses and one ancillary campus. To develop the 2022 Community Health Needs Assessment (CHNA), CPMC participated in a collective needs assessment process as a member of the San Francisco Health Improvement Partnership (SFHIP), a collaborative body whose mission is to improve community health and wellness in San Francisco through collective impact. SFHIP is comprised of mission-driven anchor institutions, health equity coalitions, the San Francisco Department of Public Health, funders, and educational, faith-based, healthcare, and other service provider networks and institutions. The 2022 CHNA process was facilitated by Harder+Company Community Research, an independent California-based evaluation company with expertise in community participation.

SFHIP's *San Francisco Community Health Needs Assessment 2022* serves as the foundation for CPMC's 2022 Community Health Needs Assessment (this document). The processes and findings described within this document refer to those of SFHIP's 2022 needs assessment.

Introduction

This 2022 CHNA report exists as the product of committed and generous community leaders and the communities from which each contributor to this work came. We intentionally sought to center the voice of San Franciscan community members possessing a multitude of life experiences through qualitative focus groups, using available quantitative data from numerous external sources to further portray the current state of health and wellness in San Francisco. Though imperfect, our hope is that this report, painted through coalition focus groups, external data review, and countless planning meetings, illustrates meaningfully the woven story of San Francisco's health landscape.

Our Community: Population Description

The convergence of the cultures and histories of the communities within San Francisco continues to distinguish the city from others. Ranked as the 13th most populous city in the U.S., approximately 815,201 people live in San Francisco. The demographics of the city highlight the vast array in experiences therein, with people aged 25 to 34 making up the largest age demographic in the city at 23%. 43% of San Franciscans speak a language apart from English at home, and residents on average report a higher life expectancy, at 83 years of age, than the national average. Even so, steep disparities persist across racial and ethnic demographic groups. For example, Black residents have an average life expectancy of 73.1 years, 9.9 years less than the general city population. Likewise, the population of Black people who reside in San Francisco has dropped 43% over the past three decades. These trends point to the ways in which San Francisco's population story exists within a larger context of events such as the toxic exposure resulting from Hunters Point Shipyard and the teardown of the Fillmore neighborhood.

COVID

The COVID-19 pandemic has presented a context for the present CHNA incomparable to any previous report. Against the backdrop of an ongoing battle against COVID-19 cases and related deaths, many community leaders, organizations, and coalitions of San Francisco used existing networks and created new communication and coordination such as never before. One resource hub, initiated by the Latino Task Force and contributed to by various entities, remains a tangible reminder of the power of community-led action. However, the COVID-19 pandemic also highlighted new and existing disparities between communities. The disproportionate burden of COVID-19 cases on Latinx people and COVID-19-related deaths among Black, Latinx, and Asian communities illustrate this.

Our Community's Strengths

Participants throughout the 2022 CHNA process emphasized connections to the myriad communities and cultures in San Francisco as vital. Local community centers, culturally and linguistically relevant community-based organizations (CBOs), places of worship, and cultural districts all served as trusted spaces identified by community leaders. Alongside San Francisco's general above-average performance compared to the state and nation in benchmarks such as number of healthcare facilities, several noticeable features of community culture and connectedness make the city stand out.

Our Community's Health Needs

However, many obstacles remain that prevent all San Franciscans from reaching their greatest potential. Throughout this CHNA cycle, three primary health need umbrellas emerged: **access to care**, **behavioral health**, and **economic opportunity**. Though distinct, each health need exists as a complex network of highly relevant interconnecting health concerns, issues, and topics such as housing, mental health, and linguistically appropriate services. Amid this network of overlapping health issues, each health need is also intertwined and compounded by structural racism and inequity.

Conclusion

The 2022 CHNA sought to foreground the strengths of the community and ask community leaders what can be done to improve health. Community strength is imperative to sustain the well-being of residents in ways beyond the reach of the mainstream healthcare system. Despite these strengths, there are persistent health needs that must be addressed to support community health and well-being including access to care, behavioral health, and economic opportunity. Recommended next steps to support the improvement of these health needs include intentional effort in community engagement, cultural humility, and financial investment.

Dedication

This CHNA is dedicated to the communities of San Francisco. We especially extend our gratitude to the Asian, Black, Indigenous, Latinx, and Pacific Islander communities that have contributed to the development of this report by sharing their lived experiences navigating the healthcare systems in San Francisco. Furthermore, we extend our gratitude to the San Francisco community organizations who shared how they support their communities by celebrating cultura, ceremony, family, and spirit. Thank you.

Introduction

The Community Health Needs Assessment (CHNA)

The Affordable Care Act (ACA) requires that nonprofit hospitals conduct a community health needs assessment (CHNA) every three years.[1] To meet these requirements, the CHNA must:

- Define the community it serves
- Assess the health needs of that community
- Take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of, or expertise in, public health
- Be made widely available to the public

In addition to fulfilling these requirements, the CHNA is an opportunity to better understand the unique needs and stories of San Franciscans. We also hope it will guide the priorities of San Francisco's healthcare institutions, policies, and practices.

This CHNA was done as part of the San Francisco Health Improvement Partnership (SFHIP). We are committed to gathering community perspectives on the impact of structural racism and see the CHNA as an opportunity to advance health and health equity. We have endeavored to apply a racial equity lens to all data collection, analysis, synthesis, and reporting. Identifying the highest priority needs for the CHNA while recognizing the historic and continued harm of racism, informs our community investments and helps us develop strategies aimed at making long-term, sustainable change. As a result, this prioritization allows us to deepen the strong relationships we have with other organizations that are working to improve community health.

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This Year's CHNA

The 2022 CHNA was an opportunity to connect with the community and ask what has not worked and what can be done differently to improve our community's health. Past CHNAs have raised health needs that persist to this day, many rooted in racist structures, practices, and biases within the overarching healthcare system. This report explicitly recognizes protracted patterns of health disparities and seeks to elevate community-driven solutions that interrupt these patterns. The COVID-19 pandemic reinforced that even the most recent healthcare issues can easily be added to the list of health disparities. These factors have guided our data collection, analysis, review of results, and the report.

We start with the commonly held recognition that the nature of structural racism is a leading factor in persistent health disparities. To guide and frame the importance of understanding racism as the base of health inequity, we offer the following operational definitions of racism and health equity:

[1] Internal Revenue Service (IRS). (2021). Community Health Needs Assessment for Charitable Hospital Organizations – Section 501(r)(3). https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3

Racism: "A system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call *race*), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources."

- Camera Jones, MD, MPH, PhD[2]

Health equity: "*Health equity* or *equity in health* is the ideal that everyone has a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential. Health equity is the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, geographically, or by other means of stratification."

- World Health Organization[3]

As Dr. Camara Jones explains, "Group differences in health status arise on at least three levels: differences in quality of healthcare; differences in access to healthcare; and differences in underlying exposures, opportunities, stresses, resources, and risks that make some individuals and populations sicker than others in the first place."[4] It is within this context that our data collection approach included focus groups with the three San Francisco Health Equity Coalitions (i.e., the African American Health Equity Coalition, the Asian & Pacific Islander Health Parity Coalition, and the Chicano/Latino/Indígena Health Equity Coalition), as well as insurers and funders.

We looked to the Health Equity Coalitions to provide information on their clients, participants, and community members. Recognizing the trusted and culturally syntonic relationship that the Health Equity Coalitions have with and within their respective communities was also a way for the CHNA to instill equity into the overall process by including them as true partners.

Equipped with expertise arising out of the nexus of their professional work areas and lived experiences in San Francisco's many communities, focus group participants shared about local community strengths, needs, and recommendations. In combination with this live qualitative data collection, we also reviewed interviews with 15 community leaders that were conducted as part of Kaiser Permanente's San Francisco CHNA, and quantitative data summarizing the health trends and disparities for San Francisco. Out of this constellation of qualitative and quantitative data collection and review, community voices clearly coalesced around three umbrella health needs that are addressed in greater detail in this report:

Access to care

Behavioral health

Economic opportunity

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[2] Jones, Camara P. (2003). "Confronting institutionalized racism." *Phylon 50,* 7-22.

[3] World Health Organization. (2022). Social Determinants of Health. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

[4] Jones, Camara P. (2014). "Systems of power, axes of inequity: Parallels, intersections, braiding the strands." *Medical Care 52,* 571-575. https://journals.lww.com/lww-medicalcare/Fulltext/2014/10001/Systems_of_Power,_Axes_of_Inequity__Parallels,.12.aspx

Access to care, behavioral health, and economic opportunity are similar to the health needs raised in previous CHNAs, are broad enough to incorporate several of the disparities impacting Black, Indigenous, and People of Color (BIPOC) communities, and provide multiple ways for healthcare institutions to independently and collaboratively have a positive impact. In this report, we will continue to connect the identified needs and proposed solutions to work that is equity-driven and explicitly anti-racist.

Connection to Past CHNAs

Community Health Needs Assessments have been instrumental in magnifying the health needs and disparities of San Francisco communities. They have also reflected the evolution of what is considered within the realm of healthcare and public health systems to address. Past CHNA reports, for example, have highlighted symptom-level health issues of concern, such as healthy eating and access to care, yet have not addressed the root cause of these health issues nor the inequities in prevalence and care among the diverse communities in San Francisco.

The most recent CHNA in 2019, however, shifted to focus on the social determinants of health that underpin many common health concerns among San Francisco residents. The 2019 CHNA also identified two foundational issues contributing to local health needs: racial health inequities and poverty.

The table below highlights past CHNAs and offers an opportunity to compare health needs over time.

This CHNA builds on these, by explicitly tying health needs to the systemic racism embedded in healthcare systems. We are clear that societal structures – of politics, education, housing, employment, justice, and including healthcare – continue to exacerbate inequities stemming from a system that oppresses and ignores the health needs of BIPOC communities.

Similarly, poverty continues to be emphasized as an urgent factor contributing to health disparities in San Francisco. Past assessments balanced the disproportionate rate of trauma and discrimination experienced by BIPOC communities engaging in high levels of resilience and adaptability. This CHNA builds on this by noting the tiring and detrimental effect of "resilience" on BIPOC communities. While necessary as a coping mechanism and therefore viewed in a positive light, the unending need to be resilient can, in itself, contribute to health disparities. This report aims to both celebrate community strengths and highlight needs that are rooted in long-term oppression.

Health Needs Identified in Past San Francisco CHNAs	
2019 [5]	**Health Needs** • 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** • Poverty • Racial health inequities

[5] Available at https://www.sutterhealth.org/for-patients/community-health-needs-assessment

2016 [6]	**Priority Health Needs** • Access to care • Healthy eating and physical activity • Behavioral health **Health Needs** • 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 **Foundational Issues** • Economic barriers to health • Racial health inequities
2013	**Health Needs** • Ensure safe and healthy living environments • Increase healthy eating and physical activity • Increase access to high-quality healthcare and services

CHNA Methods

The methods used for this CHNA are summarized here. Please see the Appendix for a more detailed account.

Partners

This CHNA was conducted as part of the San Francisco Health Improvement Partnership (SFHIP), a collaborative body whose mission is to improve community health and wellness through collective impact. SFHIP is comprised of mission-driven anchor institutions, health equity coalitions, the San Francisco Department of Public Health, funders, and educational, faith-based, healthcare, and other service provider networks and institutions. This year's CHNA process was facilitated by Harder+Company Community Research, an independent California-based evaluation company with expertise in community participation.[7]

Data Collection and Analysis

To assess community strengths, needs, and solutions, five focus groups were conducted. Three were with the San Francisco Equity Coalitions (the African American Health Equity Coalition, Asian & Pacific Islander Health Parity Coalition, and Chicano/Latino/Indígena Health Equity Coalition), one was with

[6] Available at https://www.sutterhealth.org/for-patients/community-health-needs-assessment

[7] Harder+Company Community Research. https://harderco.com

funder agencies (including Blue Shield of California Foundation, California HealthCare Foundation, Hirsch Philanthropy Partners, Metta Fund, Northern California Grantmakers, The California Wellness Foundation, and Zellerbach Family Foundation), and the final focus group was with San Francisco health insurers (including Anthem, Blue Shield, Canopy Health, Kaiser Permanente, and San Francisco Health Plan). Information was also included from the 15 key informant interviews conducted as part of the Kaiser CHNA with San Francisco service providers, nonprofit groups, and government agencies.

Quantitative data came from publicly available reports and data portals, including those published by the San Francisco Department of Public Health and the City and County of San Francisco. The specific sources are included with each data point. For all metrics, we used the most recently available public data that included as many race/ethnicity groups as possible. There is clearly a need for more data collection and reporting that delineates all communities, even — or especially — those that are considered "small"; many disparities are likely invisible among those not being counted.

Even more than usual, data recency is an issue in this report. The COVID pandemic has impacted population health and demographics, diminishing data relevancy even more quickly than usual. Therefore, we tried to avoid using any data collected before the pandemic began in 2020 and suggest considering the impact of COVID, which almost always exacerbated disparities, when interpreting all quantitative data.

Community Voice

Throughout the process of assessing San Francisco's health needs, we have prioritized community voices. This means that the report frequently uses direct quotes rather than summarizing, paraphrasing, or reinterpreting the strengths, needs, and suggestions that came from community members. Similarly, we only use quantitative data about the health needs that directly connects to concerns raised in the focus groups and interviews.

This also led us to include "community recommendations" for each of the health needs and conclude the report with overarching suggestions. The focus groups and interviews specifically asked for solutions. These portions of the report should be foregrounded as what community members would like to see those with relevant resources – healthcare organizations, health departments, hospital-based community services groups, insurers, foundations, and others – do to improve access to care, support behavioral health, and strengthen economic opportunity.

Our Community: Population Description

San Francisco boasts a vibrant fabric woven of colorful threads comprised of the many diverse communities that call the city home. However, a long history of othering, marginalization, and minoritization also permeates the city. Structural racism against Black, Indigenous, and People of Color (BIPOC) has haunted the history of the city, appearing across myriad topics for generations. Though ever-present, this racism has particularly reared its head during critical points in time, presenting itself more viscerally and tangibly through a legacy of dark historical landmarks.

This disenfranchisement of San Francisco communities of color takes place against a national backdrop of events, such as the **enslavement** of African peoples, the battle for **land sovereignty** resulting in the loss

> *"In San Francisco that's such a small geography, we have an opportunity to really do some special things here…If we want to keep driving improvement and change, and the opportunity to really shine as a community, there's a lot we could do if we leaned into working together more."*
>
> *~ Community service provider*

and displacement of Native people, the **Chinese Exclusion Act of 1882**, and Japanese **internment** during World War II.[8]

Yet, examples of systemic racism also directly punctuate San Francisco's historic and contemporary contexts. The emergence of "sundown towns" across the suburbs; the presence of the KKK in San Francisco soon after *The Birth of a Nation's* film release; the environmental damage, toxic exposures, and loss of jobs from the Hunters Point Shipyard; and the city-sponsored teardown of the Fillmore neighborhood, serve as reminders for the city's legacy of oppression.

Operating under state law for urban redevelopment, the City of San Francisco declared the Western Addition blighted, and destroyed the Fillmore, San Francisco's most prominent Black neighborhood and business district. In doing so, the City of San Francisco closed 883 businesses, displaced 4,729 households, destroyed 2,500 Victorian homes, and damaged the lives of nearly 20,000 people. The city then left the land empty for many years. (California Task Force to Study and Develop Reparation Proposals for African Americans)[9]

Even now, the California Office of the Attorney General's annual Hate Crimes Report recounts continued racially motivated crime in San Francisco.[10] Anti-Black crimes are the most prevalent, as they have been in the past; 513 were reported in 2021, a 13% increase over the previous year. Hate crimes against Asian Americans and Pacific Islanders have also increased. Preliminary data from the San Francisco police department showed incidents where police believe an anti-Asian bias played a role jumped from nine in 2020 to 60 in 2021. These figures are likely an undercount.

Community Profile

San Francisco City and County has **815,201** residents living within its 46.9 square miles of land area.[11] It is the 13th most populous city in the country. San Francisco is the second most densely populated city in the country (after New York City), with 18,633 people per square mile. By total area, San Francisco is geographically the smallest county in California, which contributes to the high cost of living, property costs, and the corollary impact on housing disparities.

Race/Ethnicity

About four in ten San Franciscans identify as white (41%), three in ten as Asian (34%), one in ten as mixed race (10%), and 5% as Black. 16% identify as Hispanic or Latino of any race. This pattern has changed dramatically over the decades, with increases in the percent of San Franciscans identifying as Asian and Hispanic and decreases in the percent identifying as Black or African American.[12]

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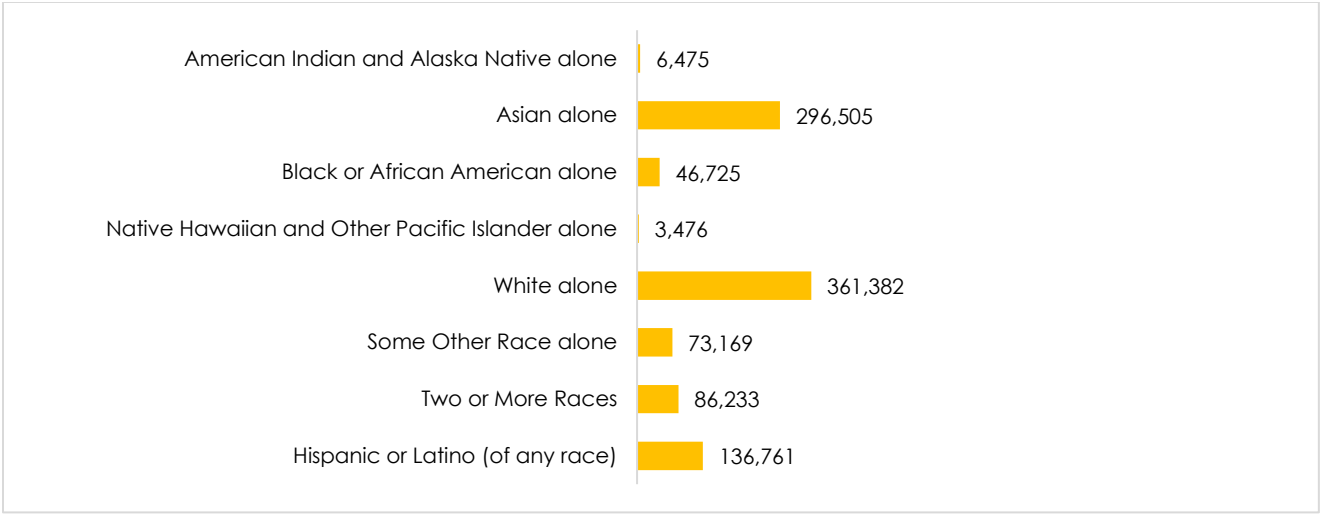
[8] Found SF. https://www.foundsf.org/index.php?title=Category:Racism

[9] California Department of Justice, Office of the Attorney General. (2022). California Task Force to Study and Develop Reparation Proposals for African Americans. https://oag.ca.gov/system/files/media/ab3121-reparations-interim-report-2022.pdf

[10] California Department of Justice, Office of the Attorney General. (2022). 2021 Hate Crime in California. https://openjustice.doj.ca.gov

[11] United States Census Bureau, V2021. https://www.census.gov/quickfacts/fact/dashboard/sanfranciscocountycalifornia/PST045221

[12] United States Census Bureau. https://www.census.gov/quickfacts/sanfranciscocountycalifornia



In the past three decades, about 275,000 Black Californians have left expensive coastal cities to move inland or to other states. During the same timeframe, the Black populations of some of California's historically Black neighborhoods in cities across California have plunged: Compton by 45%, San Francisco by 43%, and Oakland by 40%.[13]

Historic Population of San Francisco [14]				
	Census Year			
	1900	**1940**	**1980**	**2020**
Hispanic or Latino, any race(s)	3%	4%	13%	16%
Asian or Pacific Islander alone	<0.1%	<0.1%	1%	0.4%
Black alone or in combination	<0.1%	<0.1%	0.2%	0.6%
European Ancestry	1%	1%	2%	2%
Mexican American	1%	2.%	5%	6%
Native American/Indigenous alone	<0.1%	<0.1%	0.1%	0.5%
Salvadoran American	<0.1%	0.2%	1%	2%
Native American alone	<0.1%	<0.1%	0.4%	0.2%

[13] California Department of Justice, Office of the Attorney General. (2022). California Task Force to Study and Develop Reparation Proposals for African Americans. https://oag.ca.gov/system/files/media/ab3121-reparations-interim-report-2022.pdf

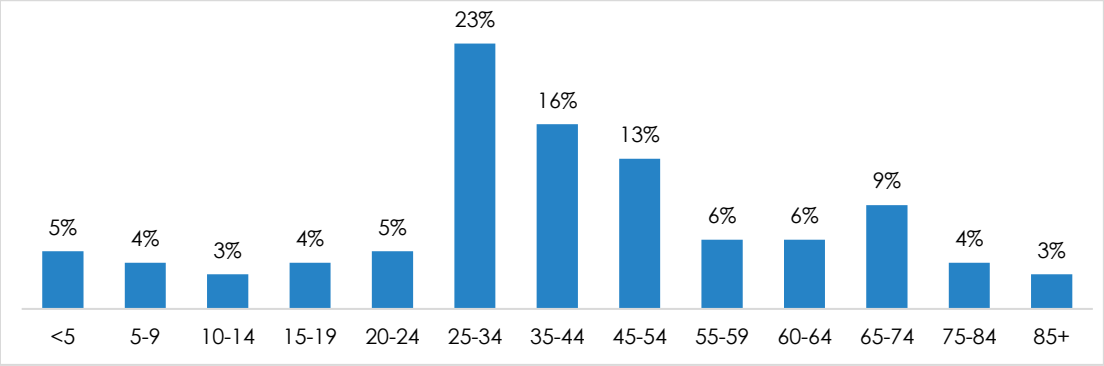
[14] Bay Area Census. Decennial census data. http://www.bayareacensus.ca.gov/counties/SanFranciscoCounty.htm

Asian alone	5%	4%	21%	34%
Chinese American	4%	3%	12%	21%
Filipino American	—	0.5%	5%	4%
Indian American	—	<0.1%	0.3%	2%
Japanese American	0.5%	1%	2%	1%
Korean American	—	<0.1%	0.5%	2%
Vietnamese American	—	—	1%	1%
Black alone	0.4%	1%	12%	5%
Specific African Ancestry	—	—	0.1%	0.5%
West Indian or Brazilian Ancestry	—	—	0.2%	0.2%
Other African American	—	—	12%	4%
Pacific Islander alone	—	—	0.4%	0.3%
White alone	93%	91%	53%	39%
Eastern European American	2%	7%	8%	7%
Italian American	5%	9%	5%	4%
Middle Eastern/Central Asian American	0.1%	1%	1%	2%
Portuguese or Brazilian American	0.4%	0.6%	0.5%	0.3%
Spain or Spanish speaking America	—	0.2%	1%	0.3%
Other European American	86%	73%	36%	27%
Non-Hispanic Other	—	<0.1%	0.2%	0.8%
Two or more races	—	—	—	5%
White and Asian	—	—	0.5%	2%
White and Black	—	—	0.1%	0.6%

Age

San Franciscans have a median age of 38.3 years.[15] 13% are under 18 years and a similar proportion (16%) are age 65 and over.

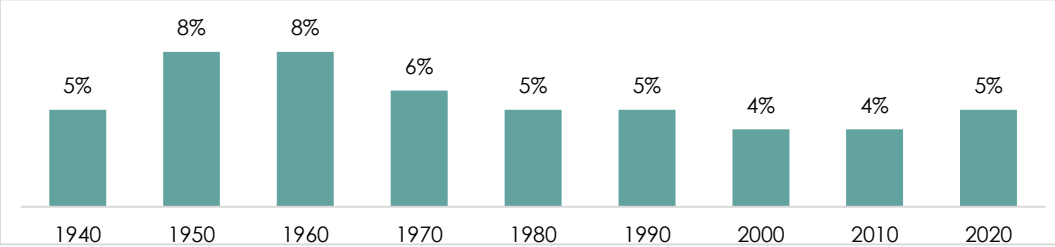
Age distribution[16]



Children

San Francisco is the most childless major city in the U.S. Just 13% of the city's population is under 18.

Age (under 5 years) distribution over time[17]



Life Expectancy

Overall life expectancy is high in San Francisco, with the typical resident living to 83 years.[18] This is higher than the life expectancy in the U.S. of 77.3 years[19] and in California of 80.9 years.[20] However, the average length of life varies widely by race/ethnicity.

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[15] United States Census Bureau. (2020). American Community Survey, 5-Year Estimates. Table S0101. https://data.census.gov/cedsci/profile?g=0500000US06075

[16] United States Census Bureau. (2020). American Community Survey, 5-Year Estimates. Table DP05. https://data.census.gov/cedsci/table?t=Age%20and%20Sex&g=0500000US06075&tid=ACSST5Y2020.S0101

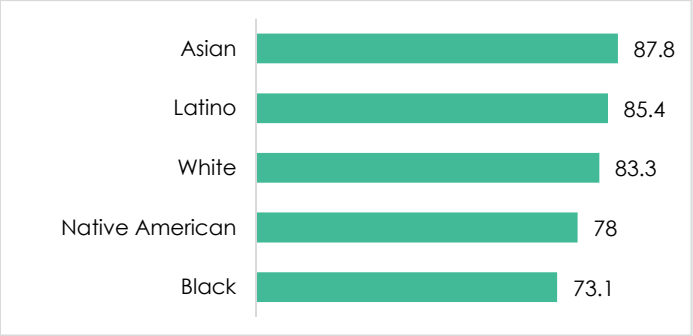
[17] Bay Area Census. Decennial census data. http://www.bayareacensus.ca.gov/counties/SanFranciscoCounty40.htm

[18] City and County of San Francisco. Health Disparities Dashboard. https://sf.gov/data/health-disparities-dashboard

[19] Center for Disease Control and Prevention. (July 2021). National Vital Statistics System (NVSS) Vital Statistics and Rapid Release, Report No. 015. https://www.cdc.gov/nchs/data/vsrr/VSRR015-508.pdf

[20] Center for Disease Control and Prevention. (Feb 2022). National Vital Statistics System (NVSS) Vital Statistics and Rapid Release, 70:18. https://www.cdc.gov/nchs/data/nvsr/nvsr70/nvsr70-18.pdf

Life Expectancy in Years (years)[21]



Languages Spoken[22]

Almost half of San Franciscans (43%) speak a language other than English at home.

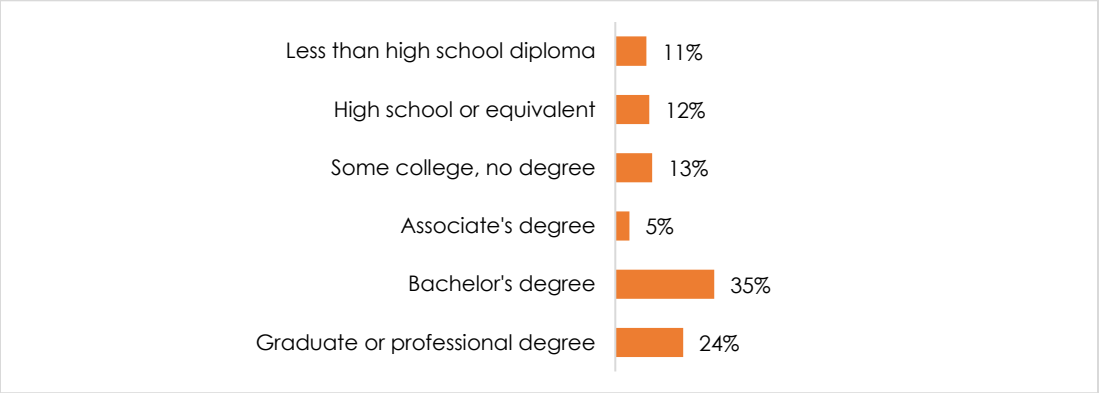
Language spoken at home		
English only	479,645	**57%**
Spanish	88,425	**11%**
Indo-European language	50,325	**6%**
French, Haitian, or Cajun	9,326	1%
German or other West Germanic languages	4,769	0.6%
Russian, Polish, or other Slavic languages	14,526	2%
Other Indo-European languages	21,704	3%
Asian and Pacific Islander languages	208,220	**25%**
Chinese (including Mandarin, Cantonese)	150,440	18%
Korean	6,691	1%
Tagalog (including Filipino)	22,334	3%
Vietnamese	11,456	1%
Other Asian and Pacific Island languages	17,299	2%
Other languages	8,974	**1%**
Arabic	3,911	0.5%
Other and unspecified languages	5,063	0.6%

[21] Robert Wood Johnson Foundation, County Health Rankings (2017-2019). https://www.racecounts.org/county/san-francisco/

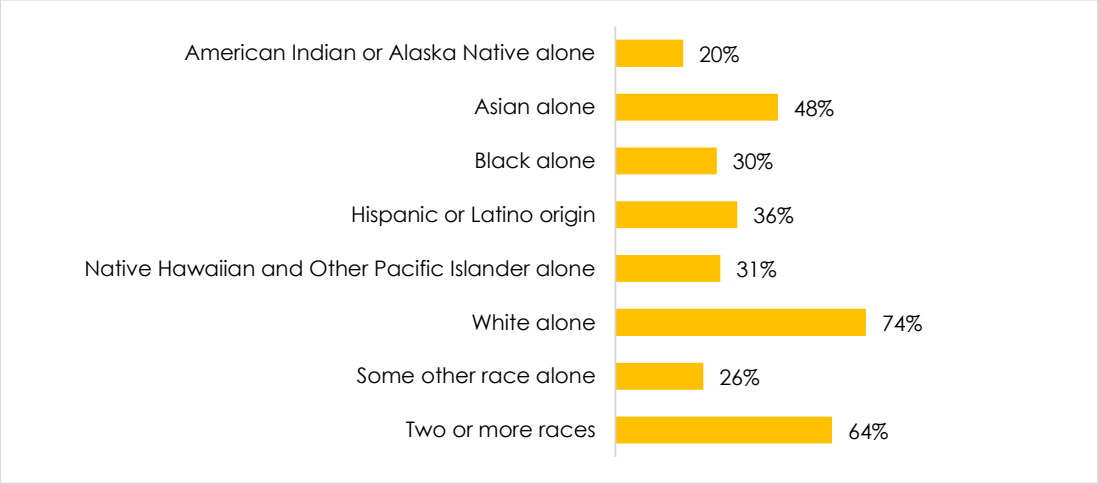
[22] United States Census Bureau. (2020). American Community Survey, 5-Year Estimates. Table C16001. https://data.census.gov/cedsci/table?q=Language%20spoken%20at%20home%20san%20francisco%202020&tid=ACSST5Y2020.S1601&moe=false

Education[23]

More than half (59%) of San Franciscans age 25 and over have at least a college degree.



However, rates of higher education expose large disparities by race/ethnicity.



CHNA in the Context of COVID

This CHNA was conducted in the midst of the global SARS-CoV-2 coronavirus (COVID) pandemic, which highlighted San Francisco's strengths, needs, and disparities.

As shared by SFHIP members, in many ways, San Francisco organizations rose to the challenge, quickly creating "resource hubs,"[24] first started by the Latino Task Force, to provide COVID testing and vaccinations, in addition to a broader base of support services such as rental assistance, programs for children, and referrals to mental health services. In the midst of great need and confusion, confounded by closure or limited availability in the many usual places of care and community, hubs simplified and

[23] United States Census Bureau. (2020). American Community Survey, 5-Year Estimates. Table S1501. https://data.census.gov/cedsci/table?t=Educational%20Attainment&g=0500000US06075&tid=ACSST5Y2020.S1501

[24] Mission Local. "Are 'resource hubs,' a pandemic lifeline for many, here to stay?" December 9, 2021. https://missionlocal.org/2021/12/are-resource-hubs-a-pandemic-lifeline-for-many-here-to-stay/

removed barriers to access. People working the hubs spoke the language of their clients and often came from the neighborhoods, facilitating quick trust-building and reaching communities where they were.

"COVID hit, and this group of folks – thank God we formed, because then we were able to build the connections with the county, the health department…We know how to support our own community. And we also let the county know these are the needs of our community."

~ Asian & Pacific Islander Health Parity Coalition member

"Seeing people that look like you is important. It was really important to hear from African American doctors during this pandemic about COVID, much more than other scientists that are represented on TV."

~ African American Health Equity Coalition member

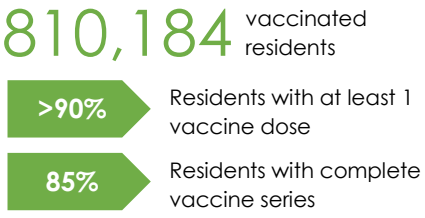
While the hubs were focusing on community needs, San Francisco healthcare systems were learning and training their staff to fight COVID, deploying new protocols as the CDC learned more about the disease. San Francisco Department of Public Health (SFDPH) coordinated the distribution of COVID patients to ensure no hospitals were overrun.

In December 2020, the first COVID vaccine was distributed to healthcare staff. In January 2021, the San Francisco hospital systems (Dignity Health, Kaiser Permanente, Sutter Health, and UCSF Health) mobilized with SFDPH and the Department of Emergency Management to set up mass vaccination centers across the city – in the Bayview, Ingleside, and SOMA at the Moscone Convention Center. These centers were open seven days a week, vaccinating over 300,000 people in five months and helping San Francisco to become the first major city to reach an 80% vaccination rate.

Community vaccination efforts occurred in almost every corner of the city. To ensure that vaccine education came from neighborhood providers and was offered in a low-pressure setting, vaccinations were offered in partnership with community clinics, to pair clinical capacity with trusted messengers. Mobile efforts targeted unhoused seniors, those living in SROs, and permanent supportive housing residents.

Because of this collaboration between the community, healthcare, and government partners, over 90% of San Franciscans have been vaccinated. The partnerships that were forged out of necessity led, in several cases, to positive health impacts and showed promise for future equitable collaborations to reduce community health disparities.

COVID Vaccination status, updated through July 2022 [25]



"The good outcomes that we're seeing with vaccinations…was done because we all came together as a community. And we were part of a collective…I think that's something to be really, really, really valued."

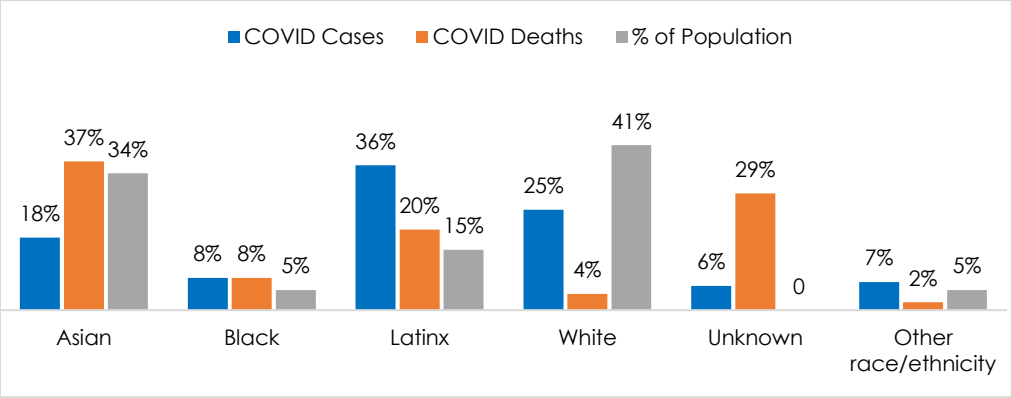
~ Community service provider

[25] City and County of San Francisco. (2022). COVID-19 vaccinations by neighborhood. https://sf.gov/data/covid-19-vaccinations-neighborhood

The pandemic has also been a time of increased needs. As has been the case around the world, the pandemic exacerbated existing health and economic disparities, linked to discriminatory housing policies like redlining and urban renewal, as well as housing conditions, job opportunities, and healthcare access.

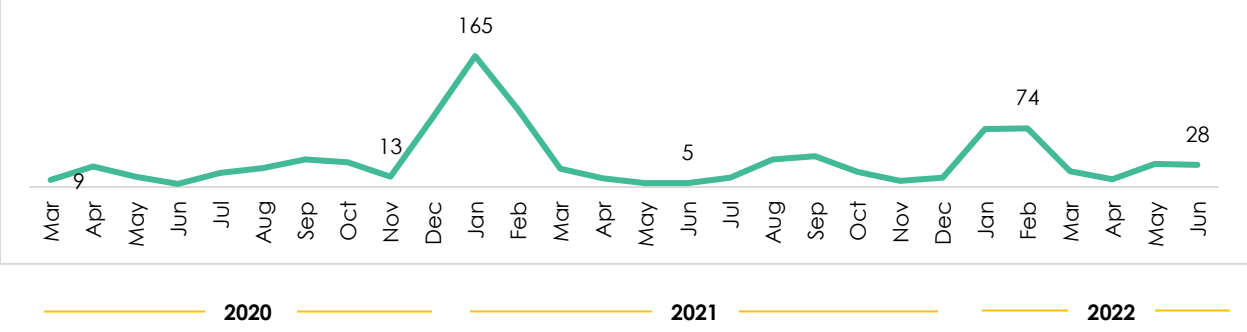
> *"Our COVID heat map looks like our chronic disease heat map, and our asthma heat map looks like our food desert heat map, which all looked like our redlining map from 1932. They are all playing out, I would say, on the foundation of structural racism, and they are just kind of built on top of it."*
>
> *~ San Francisco government staff*

COVID cases disproportionately impacted Latinx people, while deaths from COVID were higher in the Asian, Black, and Latinx communities.



Through June 2022, there have been 928 COVID deaths in San Francisco.

COVID deaths in San Francisco[26]



[26] City and County of San Francisco. (2022). COVID-19 cases and deaths. https://sf.gov/data/covid-19-cases-and-deaths

SFHIP members, representing many San Francisco service providers and community organizations, have many lessons learned from the experience assessing needs and providing services during the pandemic. These focused on communication, a tailored approach, and coordination, grounded in knowledge of and connection to our myriad communities and cultures.

Suggestions for **communication** included:

- Compiling resource lists from nonprofits and city to get a clear picture of what services are offered
- Coordinating citywide among health systems and CBOs
- Support navigating between competing business and community priorities

Suggestions for **connecting to communities** included:

- Going to the places people already are
- Having medical/subject matter experts who share the language, culture, and relationship with communities
- Supporting CBOs who hold trusted relationships with community members

Our Community's Strengths

A host of strengths stamp the fabric of San Francisco's many vibrant communities. Although the primary purpose of the CHNA is to raise community needs, these needs manifest amid myriad strengths, including collaboration, authentic community engagement, a high concentration of primary care physicians, and deeply rooted community and faith-based organizations. Naming the strengths that community members highlighted helps to contextualize the health needs described in the next section, as well as to provide the foundation for addressing them.

During focus groups with San Francisco community members and leaders, participants noted their interconnectedness and support – with each other and with healthcare organizations. Rich cultural and traditional practices punctuate the communities throughout the city. Alongside well-established community organizations, a commitment to organize for common flourishing adds to the richness of a shared sense of community among city residents.

Equipped with crucial cultural and linguistic capabilities, an authentic understanding of the communities in which they are embedded, and a consequent trust-based partnership with the communities they serve, community-based organizations (CBOs) shine in their ability to connect with "hard-to-reach populations" of San Francisco. Focus group participants particularly spoke to and highlighted the ways community and organizational leaders effectively leaned into collaborative efforts with other CBOs, as well as into their own communities. In this, San Francisco communities are strong and community organizations and leaders know how to reach people in meaningful and health-promoting ways.

"San Francisco is very collaborative… working with health departments, working with other hospitals, working with government agencies and insurance alike; I think that's a huge strength within the region that's not seen in a lot of other places."

~ San Francisco insurer

"We really know how to come together. When they say, "It takes a village," that's a real thing here."

~ African American Health Equity Coalition member

"For us, we definitely bring cultura, ceremonia, which is a very important part of our community and healing. And, thankfully, we're blessed with having connections. For example, we have Mayan healers in our community…I think ceremonia has become as important as every other level of medicinas that we offer to our communities."

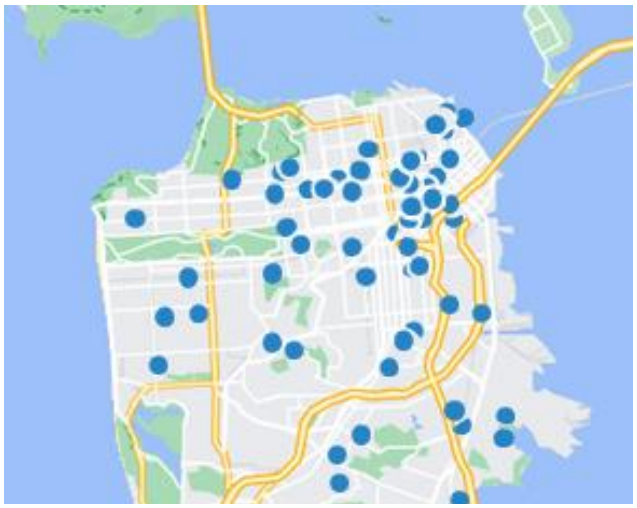
~ Chicano/Latino/Indígena Health Equity Coalition member

"We toss around the world resiliency a lot, but it really does apply; there's a sense of cultural belonging even in the face of great adversity. Whether that's health or economics, or some other thing, we feel a sense of connectedness, kind of like a protectiveness around us that is very much intergenerational and applies to us in our peer groups and our families and our neighborhoods and our larger communities that…helps us get through difficult times, that helps keep us healthy in terms of both mental health, physical health, and in moving forward in our lives."

~ Chicano/Latino/Indígena Health Equity Coalition member

Healthcare Facilities

San Francisco hosts a number of medical facilities. According to the City and County of San Francisco, there are 78 healthcare facilities within the city limits.[27] Of these, 38 are classified as community clinics, 23 are designated a community health network, four as free clinics, and 13 as general acute care hospitals. In fact, according to the Kaiser Permanente Data Platform, San Francisco ranks higher than the state and national average for the number of facilities.[28]



"In terms of community providers, they're so dedicated. I mean, folks have been working in their positions for decades…20, 30 years, that's not uncommon. And we all know each other. And people are really, really in it and may have worked with families for generations. And so it's really great to be able to see that community impact long term."

~ Asian & Pacific Islander Health Parity Coalition member

[27] City and County of San Francisco. (2021). Health Care Facilities Map. https://data.sfgov.org/Health-and-Social-Services/Health-Care-Facilities-Map/dakv-kk95

[28] Kaiser Permanente Community Health Data Platform. https://public.tableau.com/app/profile/kp.chna.data.platform/viz/CommunityHealthNeedsDashboard/Starthere

Community Centers and Trusted Spaces

There are also many community centers available to residents of San Francisco. There are 13 community centers within the city, such as the Arab Cultural and Community Center and the Gene Friend Recreation Center.[29] These community centers serve as trusted spaces for residents to hold meetings and events within their communities. These spaces are also resource hubs that connect residents to important support and services in their area.

The list below is comprised of officially recognized community centers; however, it is important to also highlight the work that is occurring among community members, especially during the pandemic. For example, collaboration between the Samoan Community Development Center and Samoan churches supported access to vaccines, testing, and a food pantry. Despite successes during COVID, some centers were forced to close their services during the pandemic.

- Arab Cultural and Community Center
- Buchanan YMCA
- Crissy Field
- Gene Friend Recreation Center
- Mama Calizo's Voice Factory
- Mission Bay Conference Center
- Parque de los Niños Unidos
- Precita Valley Community Center
- SF Green Space at EEFG
- Southeast Community Facility
- The Center SF

> *"When we have a project, we meet together – like the health fair, we have been doing this for the past 26 years. And everyone puts aside their agency interests and then really makes this health fair together."*
>
> *~ Asian & Pacific Islander Health Parity Coalition member*

Places of Worship

Similar to community centers, there are numerous places of worship in San Francisco that also serve as trusted spaces for community members to seek support and resources. According to YWAM San Francisco, there were approximately:[30]

- 282 Evangelical churches
- 93 Protestant churches
- 56 Buddhist temples
- 54 Roman Catholic churches
- 17 Orthodox churches
- 17 synagogues
- 5 Hindu temples
- 5 mosques
- 4 interfaith centers
- 1 Shinto temple
- 1 Bahai temple
- 27 uncategorized churches
- 28 others (either do not fit in the previous categories or could not be determined)

[29] Community Centers in San Francisco. https://www.sanfrancisco.org/community-centers?page=

[30] YWAM San Francisco. https://www.ywamsanfrancisco.org/religious-places-of-san-francisco

"When COVID hit us, we reached out to community and networked with them and then supported them…The temple is a place that many decided to go. The temple community is the best one that they can reach out to."

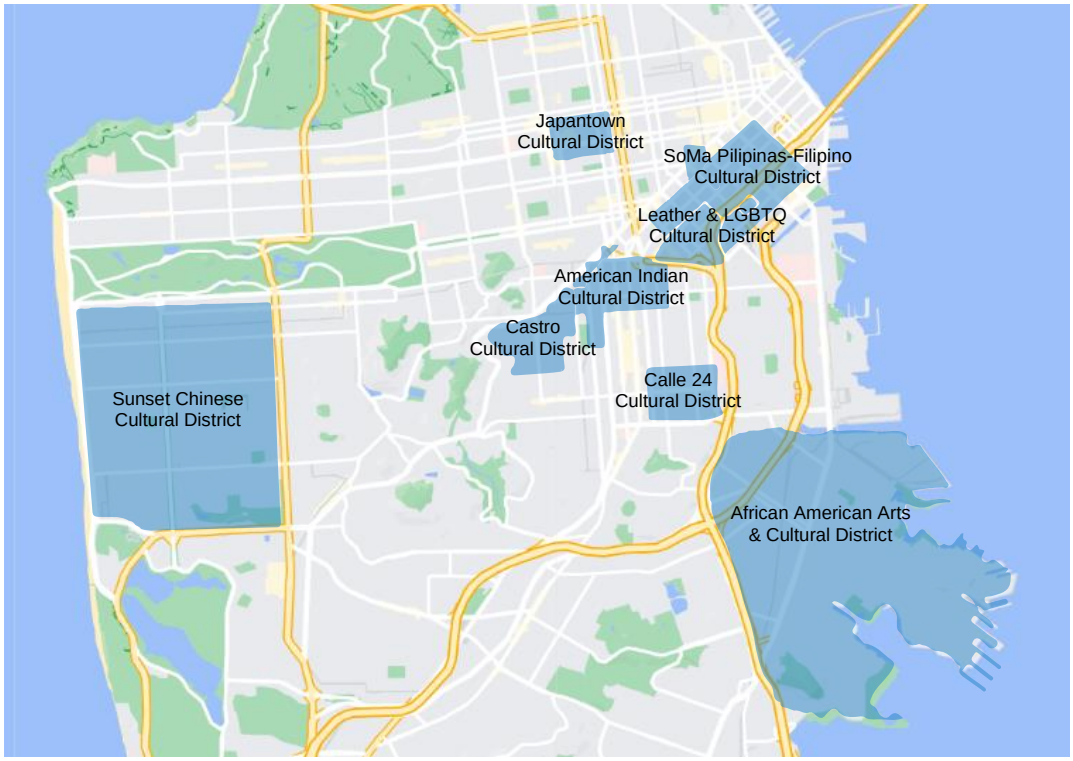
~ Asian & Pacific Islander Health Parity Coalition member

Cultural Districts

San Francisco has nine officially recognized cultural districts, supported by voter-approved funds passed in 2018 through Proposition E.[31] According to the Castro LGBTQ Cultural District, a cultural district is "a specific area within San Francisco that embodies a unique cultural heritage because it contains a concentration of cultural and historic assets and culturally significant enterprise, arts, services, or businesses, and because a significant portion of its residents or people who spend time in the area or location are members of a specific cultural or ethnic group that historically has been discriminated against, displaced, and oppressed."[32] These spaces enabled community members to connect with and support one another, especially during the pandemic.

"A big strength in our community is that a lot of our workers like the providers, the people that do the work, are from the community. And a lot of folks have had to leave because of lack of affordable housing or the wage stuff. But with, as we're talking about the COVID situation, it's like this really hit everybody. And so being able to provide health access means the people I work with, my teachers they're reflective of me."

~ Chicano/Latino/Indígena Health Equity Coalition member



[31] City and County of San Francisco. https://sfelections.sfgov.org/sites/default/files/Documents/candidates/Nov%202018/LT_E.pdf

[32] Castro LGBTQ Cultural District. https://castrolgbtq.org

Our Community's Health Needs

"The disparities are consistent enough in pattern, and widespread enough. There are very few conditions that don't have a disparity and the disparity almost always looks exactly the same…Having programs related to individual conditions just seems like a form of denial. If it's happening with conditions that literally have nothing to do with each other from a physiologic perspective, then it's not the medicine. It may be the delivery of the medicine, but it's not the condition itself…We just need to admit what it is. It is that medicine and healthcare are active and involved participants in the structural racism that is endemic in the country."

~ San Francisco government staff

"What gets people to show up is a familiar face. Someone who's always in the community. Someone who's willing to help. Someone who's greeting them. Someone who's not overlooking them. Someone who's not judgmental."

~ African American Health Equity Coalition member

Access to Care

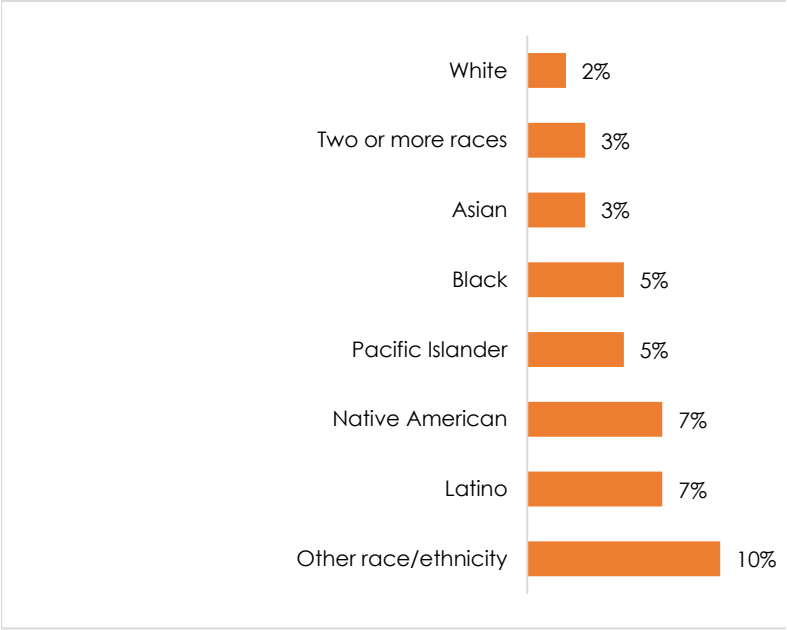
Access to care refers to the right to welcoming, accessible, affordable, culturally grounded, and linguistically responsive acute and preventative healthcare. Welcoming care is delivered in local neighborhoods, by healthcare professionals who are from the communities they are serving, are grounded in anti-racism and interpersonal bias, have knowledge of the community's historic relationship with the healthcare system, and are equitably compensated for their work. There is a special focus on care that is welcoming to communities who have been – and continue to be, as exemplified by COVID rates and response – marginalized and harmed by care, including Black, Indigenous, and People of Color (BIPOC) communities, and gender and sexual orientation diverse communities. Addressing access to care also includes tackling barriers such as language, transportation, insurance, cost, childcare, and long wait times.

Intersection with structural racism:

- Current and historic broken trust with communities who have been harmed by medical professionals and systems.
- Central/static location of healthcare services.
- Healthcare providers' lack of training (e.g., in anti-racism and bias) and inequitable compensation (e.g., for work in community clinics compared to larger medical centers).

Although insurance coverage in San Francisco is generally high, with only 4% of people uninsured thanks to the Affordable Care Act and Healthy San Francisco, coverage varies widely by race/ethnicity.

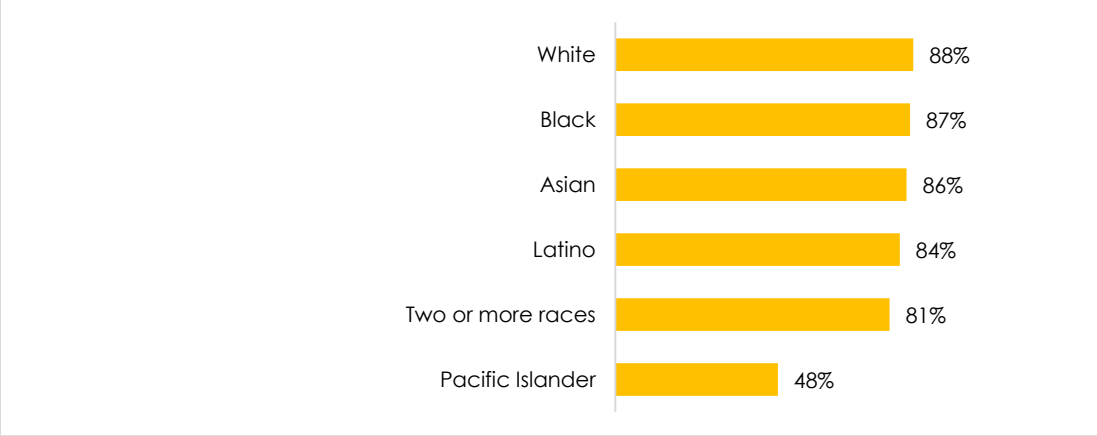
Uninsured People[33]



> *"We now have circumstances where people's housing stability has been jeopardized, and then their access to insurance has been jeopardized…We're watching and learning to see…how many more "have-nots" are coming from the circumstances of the pandemic."*
>
> *~ Community service provider*

Most San Franciscans (87%) have a usual source of healthcare. However, only half as many Pacific Islanders (48%) do.

Usual Source of Care[34]



[33] United States Census Bureau. (2019). American Community Survey, 5-Year Estimates. Table S2701.

[34] UCLA Center for Health Policy Research. California Health Interview Survey, 2011-2019. http://askchisne.ucla.edu

"That's one of our bigger challenges, how we get the services to the communities and not have them always have to come to us."

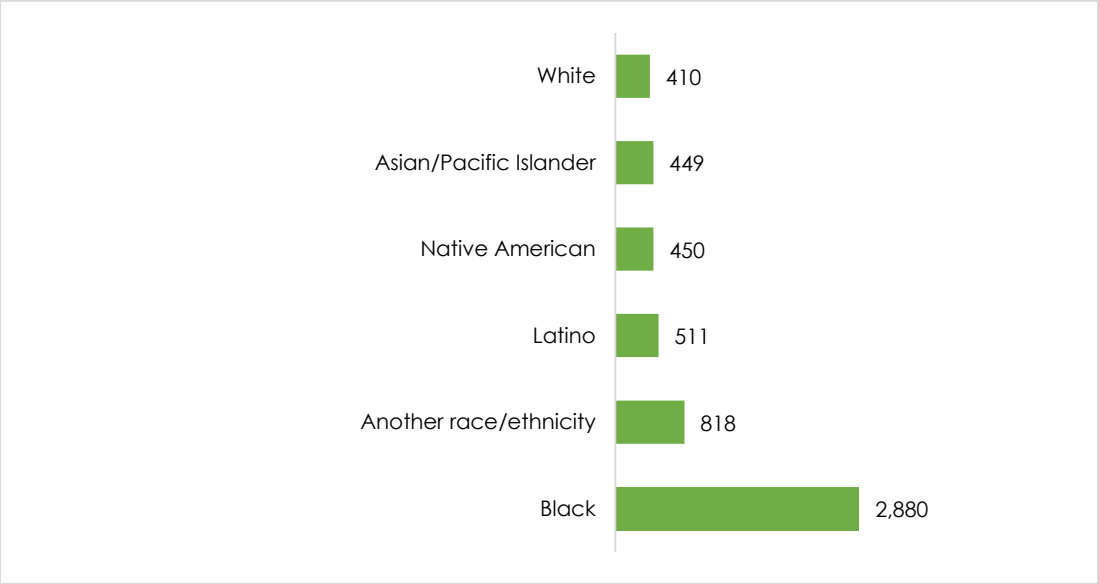
~ San Francisco insurer

"For the queer community…the system definitely still perpetuates access issues, just from the insurer standpoint…for folx receiving culturally competent care from their PCP. There's a lot of gaps."

~ San Francisco insurer

Latinx populations saw 101 more preventable hospitalizations per 100,000 people than their white counterparts; for Black populations, this disparity was even starker, with 2,470 more preventable hospitalizations per 100,000 people.

Preventable Hospitalizations per 100,000 people[35]



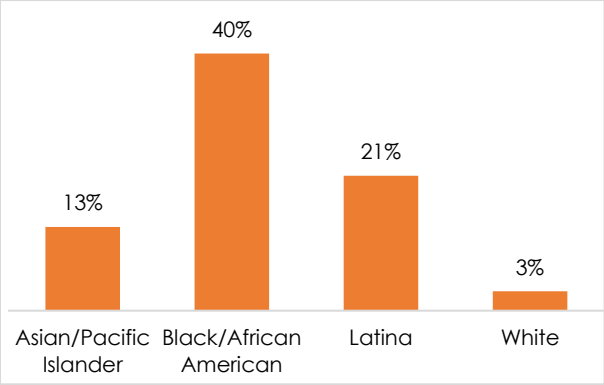
"One of the big things is the community's unwillingness to seek help or accept help. So this is especially true with mental health because of the stigma. But then there are other health concerns where folks just either are unwilling to seek help or don't seek help until it's desperately needed. At which time, the severity of it becomes more difficult to manage."

~ Asian & Pacific Islander Health Parity Coalition member

[35] Office of Statewide Health Planning and Development, 2017-2019. Available at Race Counts: https://www.racecounts.org/county/san-francisco/

An annual population-based survey of California residents with a live birth found that many reported experiencing racism at least "somewhat" during their care.

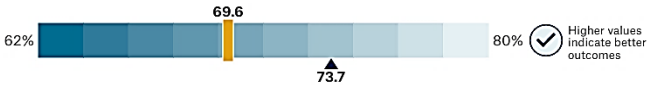
Very or somewhat experienced racism during prenatal care[36]

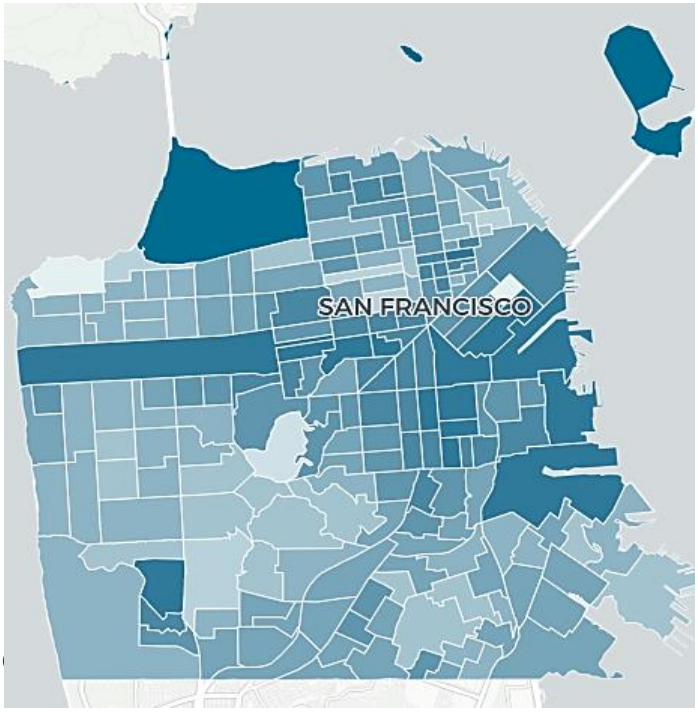


> *"There's a ton of data about who is and who's not getting what they need. I don't know that we are accepting what I think is fairly well documented, that the inequity is an inequity in social environment and social resources, but it is also an inequity in care. We are just not delivering the same care to all groups."*
>
> *~ San Francisco government staff*

Compared to other major cities, fewer adults aged 18 and over in San Francisco reported visiting a doctor for a routine checkup in the past year.

Adults 18+ who reported visiting a doctor for routine checkup[37]





> *"In terms of referral systems, within San Francisco, there's a large waitlist, like we said, for mental health, for kids, for any sort of specialty service. There's a lot of things to navigate, and the ability to actually navigate those and/or who is providing those navigation services, isn't really delineated."*
>
> *~ San Francisco insurer*

[36] City and County of San Francisco. Maternal and Infant Health Assessment (MHNA) Survey, 2018-2020. https://www.sfdph.org/dph/files/MCHdocs/Epi/2022/MIHA_San_Francisco_data_2018-2020_FINAL.pdf

[37] City Health Dashboard. https://www.cityhealthdashboard.com/ca/san%20francisco/metric-detail?metric=1581&metricYearRange=2019%2C+1+Year+Modeled+Estimate&dataRange=city

Community Recommendations

Strengthen healthcare organizations' commitment to, engagement in, and elevation of culturally and linguistically responsive approaches, practices, policies, and staffing, including having members of the community be part of the leadership and care teams.	*"This sense of feeling cared for or valued is also quality of care…Studies have already told us, that folks of color aren't always treated the same when they go into medical facilities; Black women's pain is not seen the same way by doctors as a white woman's pain. They think that you can take more pain or that you're maybe exaggerating what you're experiencing."* *~ San Francisco government staff* *"There's a real lack of focus on repairing and restoring trust…Just because you stated that you are now doing it, doesn't mean that the years and years of that voice not being heard or the real, lived experiences of discrimination are not going to be infiltrating people's ability to truly access healthcare."* *~ San Francisco insurer*
More support for community clinics, with training for community members and pay equity for those working in these clinics.	*"What's needed is more efforts toward supporting our Black students who want to become medical professionals, doctors."* *~ African American Health Equity Coalition member* *"They take away our trained clinicians because we can't compete with their salary…I think we're all competing with each other. Training for the next generation of healthcare practitioners is really important. This is actually an opportunity to go into the communities that are less represented and have their young people trained so more people can be helped."* *~ Community service provider*
Focus on neighborhood-based clinics, close to where people live, i.e., healthcare coming to where people are rather than people needing to come to an unfamiliar place when they are at their most vulnerable.	*"What's come up a lot is culturally affirming spaces, places where you feel seen, valued, and don't have to be ashamed of who you are, or what you're eating, or your preferred method of mental health practices…It's really about where do I feel welcome to be my authentic self?"* *~ San Francisco government staff*
Collaborations and pilot projects to improve initiating and sustaining care.	*"The other big one is long-term accountability. Health insurance typically operates on one to two year contracts. And when we're talking about social determinants of health and systemic oppression, hundreds of years have built where we are today. Our ability to invest in ways that we know we should, outside of a grant focus, is so hard, because then it becomes A1c, and measuring small differences, as opposed to actually focusing on the systems and the changes that we know need to happen."* *~ San Francisco insurer*

Task force that incorporates input from communities and community clinics.	*"Healthcare is not one-size-fits-all; taking an equity-based approach is important, considering that, although as humans, we may have many similarities, we also have differences across cultures, nationalities, and religions…It's about your interactions with people, and knowing how to converse with them and address their needs."* *~ African American Health Equity Coalition member* *"We know that our connection is only as strong as our ability to communicate. There are folks who want to do this work, but just don't have the right pathway in. Who's going to build capacity so that there's representation in all of these groups to really be able to have representation at a table?"* *~ Community service provider*

Behavioral Health

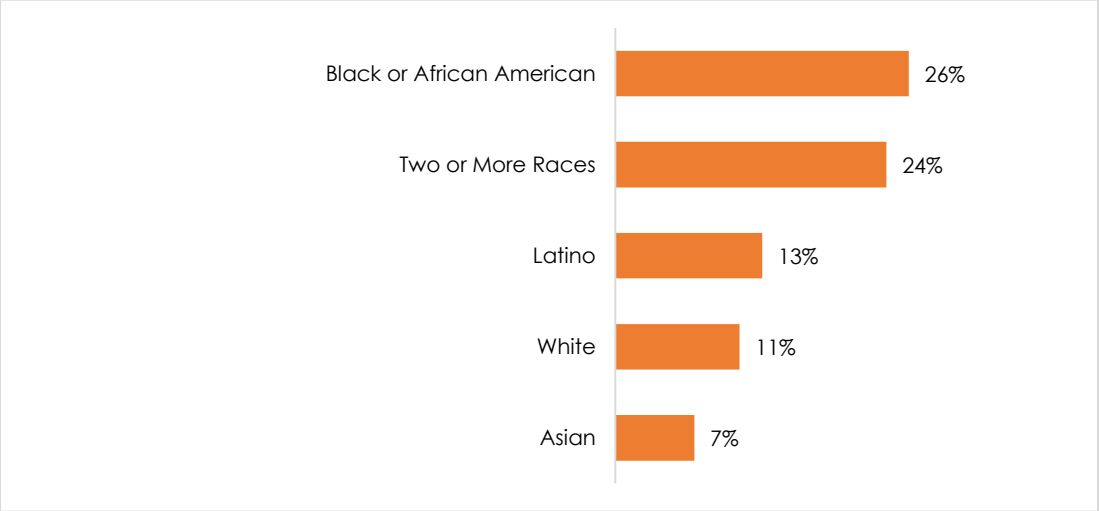
Behavioral health as a community health need refers to access, availability, and affordability of mental health and substance use disorder professionals and services. Additionally, it refers to substance access, use, and availability of support for substance misuse. The behavioral health need references the lack of community assets to support mental health such as cultural traditions, language, community events, and trusted spaces (e.g., faith-based institutions, schools, etc.) and how they are not recognized as supportive and accessible behavioral and mental health services.

In San Francisco, surveyed Black communities report the highest percentage of serious psychological distress; surveyed Asian communities reported the lowest.

Intersection with structural racism:

- Behavioral health systems do not yet embrace the protective nature of community and culture.
- BIPOC providers are burnt out and experiencing compassion fatigue. Better support systems are needed to support the providers from the communities they serve.
- Police have historically been the first to respond to people in mental health crisis, leading to the incarceration of those who need mental health support. This disproportionately impacts BIPOC communities.

Percent who reported serious psychological distress during past year[38]



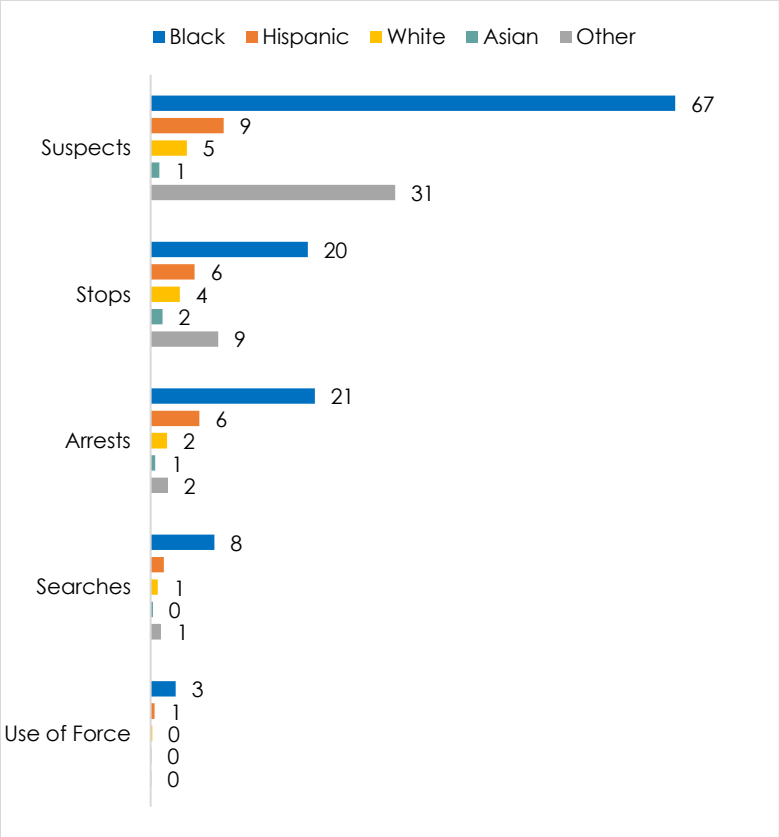
[38] UCLA Center for Health Policy Research. California Health Interview Survey, 2015-2020. https://ask.chis.ucla.edu/ask/SitePages/AskChisLogin.aspx?ReturnUrl=%2fAskCHIS%2f_layouts%2fAuthenticate.aspx%3fSource%3d%252FAskCHIS%252F&Source=%2FAskCHIS%2F

"Mental health has been one of those things where you really feel helpless…Especially when folks are having a particularly hard day or some kind of psychotic break, they can't even engage in services."

~ Community service provider

Black/African Americans are overrepresented, per capita, in every interaction with law enforcement. For example, in the first quarter of 2022, there were 67 Black/African Americans reported as crime suspects for every 1,000 Black/African American residents, compared to five of every 1,000 white residents.

Number of Law Enforcement Interactions, by per capita race/ethnicity[39]



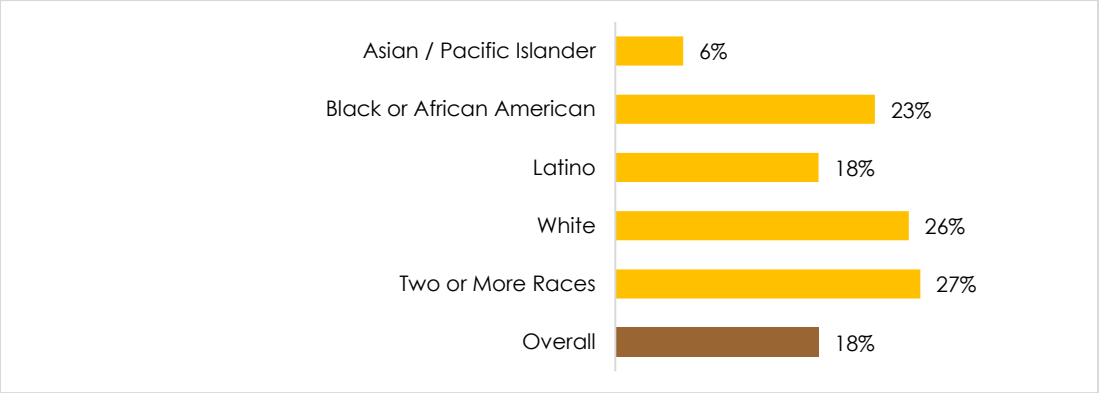
"As we've known forever and ever, it's only the Black kids that are getting arrested...It's those systems that really, really take a toll on people...How do we think about changing those racial disparities around justice; and it links up with health issues as well. There's the safety issue initially. But then there's a lot of people who are just disengaged from school, disengaged from their community...How do we engage people in their lives again?"

~ Community service provider

Additionally, there are racial disparities in accessing support and care for mental/emotional or alcohol/drug issues, with people who identify with two or more races most likely to have visited a mental health professional and Asian/Pacific Islander San Franciscans the least.

[39] San Francisco Police Department. Quarterly Activity and Data Report, Quarter 1 2022. https://www.sanfranciscopolice.org/sites/default/files/2022-06/SFPDQADR-Quarter12022-20220610.pdf

Adults Who Got Help for Mental/Emotional or Alcohol/Drug Issues (%)[40]



"For mental health…among our Asian immigrant population, I think just from their country of origin, mental health was not really recognized culturally in the same way that we do."

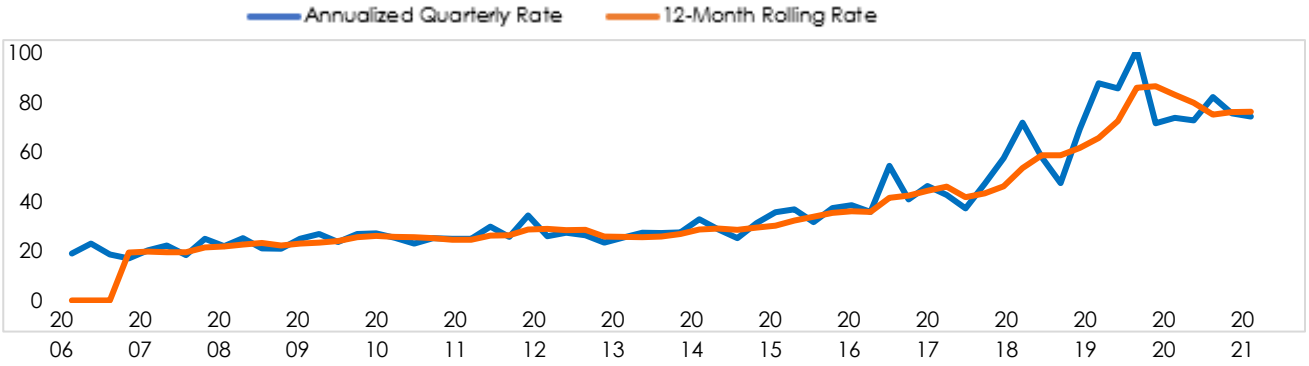
~ Asian & Pacific Islander Health Parity Coalition member

"Mental health...also goes with substance use and abuse, and the overdoses that we've had in these last two years during COVID. I attribute all of that to everything – COVID, isolation, anti-Blackness; and just also depression, anxiety, trauma."

~ African American Health Equity Coalition member

San Francisco experienced 443 opioid-related overdose deaths in 2020, the highest rate in California. This represents a 203% increase from 2018.

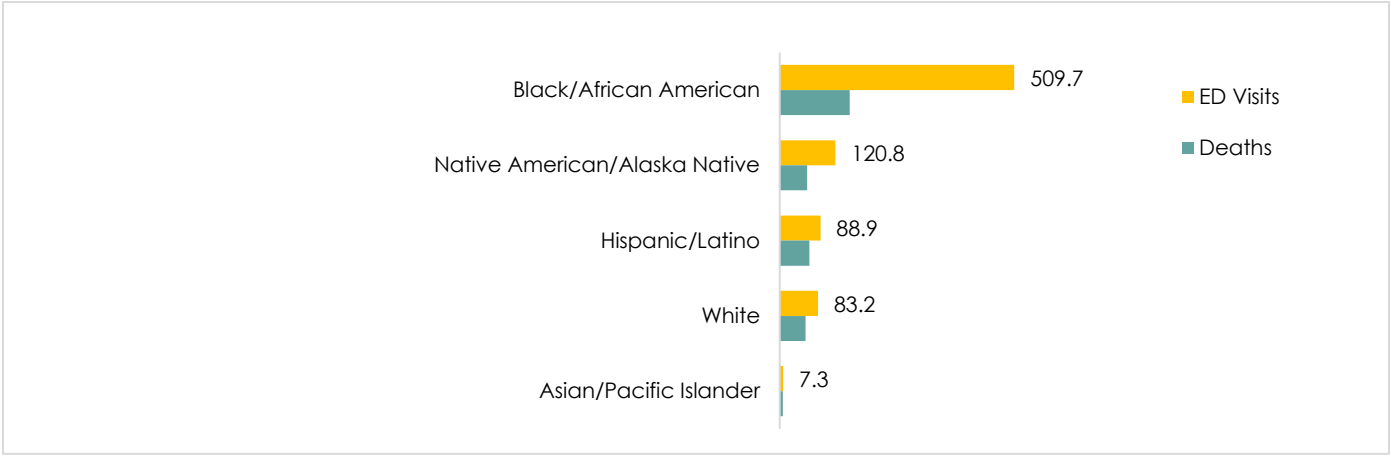
Opioid-Related Overdose ED Visits, age-adjusted rate per 100,000 residents[41]



[40] UCLA Center for Health Policy Research. California Health Interview Survey, 2011-2019. Available at Race Counts: https://www.racecounts.org/county/san-francisco/

[41] California Department of Health Care Access and Information – Emergency Department Data; California Department of Public Health, Center for Health Statistics and Informatics Vital Statistics, Multiple Cause of Death and California Comprehensive Death Files. https://skylab.cdph.ca.gov/ODdash/?tab=Home

Opioid-Related Overdose Emergency Department Visits and Deaths, age-adjusted rate per 100,000 residents, 2020[42]



Community Recommendations

Mental health and substance use must be addressed as a health issue, with more holistic solutions.	*"Mental health is so narrowly defined. So, what is the bigger umbrella that we need to have in terms of self-care? And what does that look like for different people – whether it is somebody practicing yoga or somebody that's practicing prayer, but they're both doing something that is relevant to them. And so how do we create the space for that?"* *~ San Francisco government staff*
Recognize the need for more clinicians of color, serving in their own communities, and receiving pay equity compared to those serving in larger healthcare organizations.	*"For our community, workforce in the mental health field is almost nonexistent for licensed practitioner or licensed therapist. That is where the city can invest in more or support folks who are already licensed to provide either more clinical supervision to staff members who are on the path to being licensed."* *~ Asian & Pacific Islander Health Parity Coalition member*
Increased funding for BIPOC community-based mental health interventions, with a focus on care with low access barriers.	*"The good thing about the Affordable Care Act is that a lot more people have access to healthcare and mental health is being covered by the Affordable Care Act…However, we have not had enough time to train more professionals to provide a service that the insurance company pays for."* *~ Community service provider*
Targeted mental health support for people of color.	*"I want to add an acknowledgement that our strength to deal with the stress or the traumas that we're going through is not evidence that mental services are not needed."* *~ African American Health Equity Coalition member*

[42] Ibid.

Economic Opportunity

Economic opportunity refers to the financial and socioeconomic conditions that allow for an individual and community to effectively afford the tangible and intangible materials and resources necessary to thrive, including affordable housing. These materials and resources intertwine with various social determinants of health located in a community, taking into account the systemic conditions that perpetuate unequal access to positive economic outcomes among historically and/or systematically under-resourced populations such as undocumented, BIPOC, and gender and sexual orientation diverse communities.

In addition to affordable housing, economic opportunity includes (but is not limited to) exposure to environmental and climate-related factors and/or hazards, and the ability to obtain nutrient-dense, culturally relevant food. Affordable housing closely intertwines with economic opportunity, and refers to housing that effectively enables occupants to experience a reasonable level of safety and shelter, with consideration around the housing's cost, quality, and availability. It also refers to how issues with maintaining safe and affordable housing relate to spikes in rent, living in households with many people and extended families, and making decisions among essentials to maintain rent.

Intersection with structural racism:

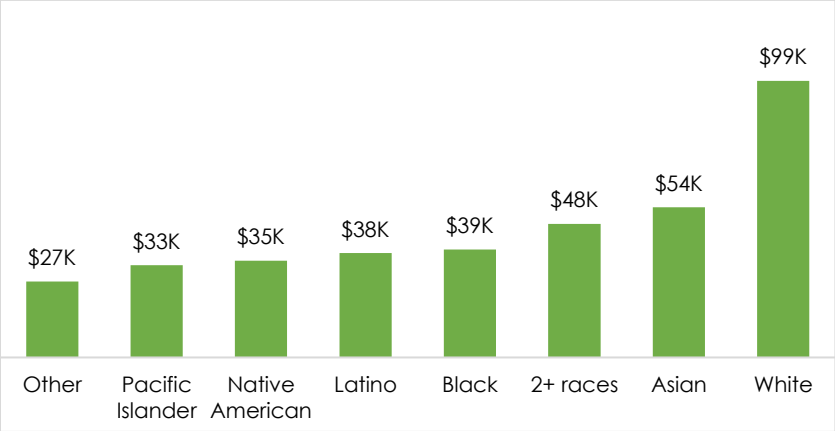
- Limited access to wealth-building resources through practices like historical redlining in BIPOC neighborhoods and Homeowners Association loan practices.
- Limited access to educational opportunities and their consequent employment opportunities through the school-to-prison pipeline disproportionately impacting BIPOC students.
- Criminal history has a strong negative effect on an individual's economic opportunity. BIPOC communities are disproportionately detained, searched and arrested by the police in San Francisco, which creates a significant barrier to economic opportunity.

"In a city like San Francisco that is among the top 10, 15 world destinations, you still have communities…who are the most impoverished, who are living in SRO's, who are eating Cup of Noodle at night for dinner…You may get some opportunities – there might be a health fair, you might get a wellness bag – but you're still living in a community that does not have a major grocery store…That's the reality of…how poverty manifests in the community, violence, substance abuse."

~ Community service provider

Per capita income in San Francisco varies widely by race/ethnicity, with white San Franciscans averaging almost twice the income of those in the next highest group (Asian Americans) and three times the income of Pacific Islanders.

Per Capita Income[43]

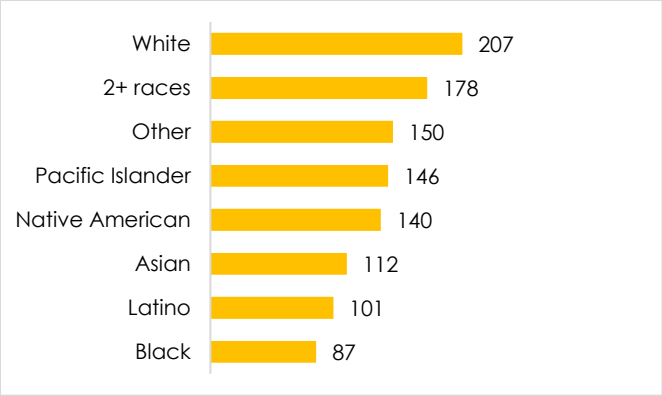


"Within economic disparities, in particular immigrants, are really at grave risk. They didn't get to share in the benefits that we received from the government for extra money that we were given [during COVID]. They remained isolated and without work or at great risk with work and continued to feel at risk for deportation. And so risks and adversity and disparities compounded on each other."

~ Chicano/Latino/Indígena Health Equity Coalition member

Black San Franciscans are less likely to be in higher paying managerial positions.

Employment as Officials or Managers per 1,000 people[44]



[43] United States Census Bureau. (2019). American Community Survey, 5-Year Estimates. Tables B19301B-1. Available at Race Counts: https://www.racecounts.org/county/san-francisco/

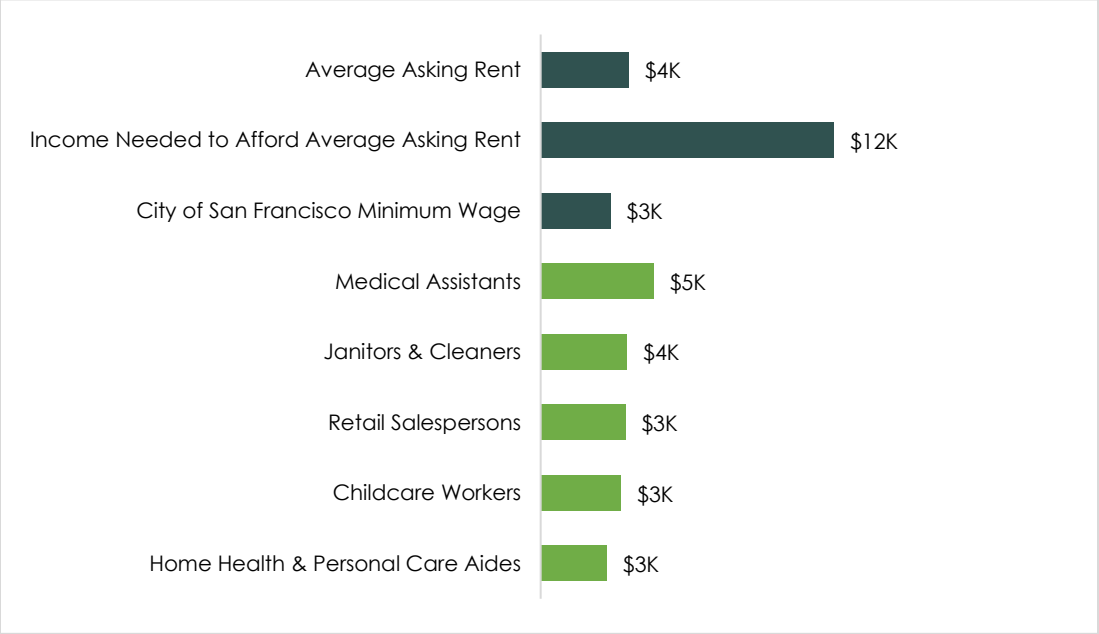
[44] United States Census Bureau (2019). American Community Survey, 5-Year PUMS Estimate. Available at Race Counts: https://www.racecounts.org/county/san-francisco/

"All of it is, for me, poverty and social determinants of health…I think all of that stems from racism. In this case, I'm going to say anti-Black racism, as an underlying major issue and factor in what is the social determinants. We have the biggest split around poverty for Black folks in San Francisco."

~ African American Health Equity Coalition member

Renters need to earn 4.2 times the minimum wage to afford the average asking rent in San Francisco County.

Who Can Afford Rent[45]



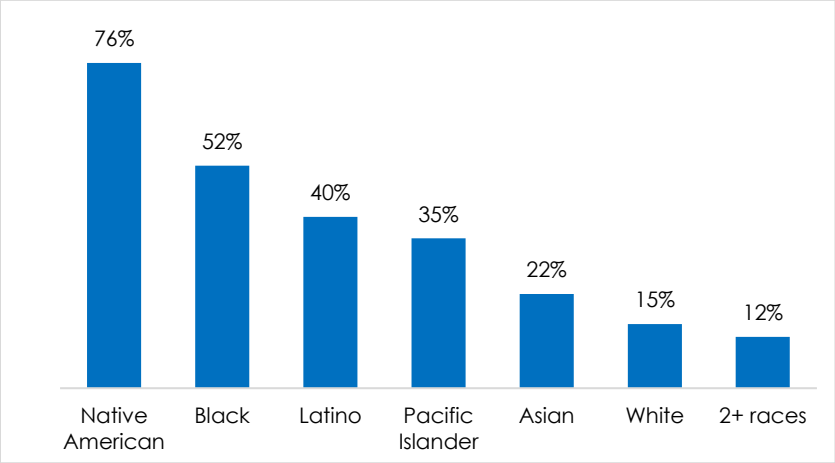
"It has to do with affordable housing, because a lot of my clients live [with] a lot of people, they live in small units, the whole family. So, before COVID, it was probably okay. But because during COVID everybody stayed home and you're talking about sometimes the family of five or six people in small quarters. So that's caused a lot of stress."

~ Asian & Pacific Islander Health Parity Coalition member

[45] California Housing Partnership. San Francisco County Housing Need Report 2022, page 4. https://chpc.net/?sfid=181&_sf_s=san%20francisco&_sft_resources_type=housing-need+level-county

The homeownership rate is 38% in San Francisco, compared to the national average of 64%.[46] Among those seeking to purchase a home, a much higher proportion of people of color are denied mortgage applications.

Denied Mortgage Applications (%)[47]



> *"We have the country's biggest wealth, and we have enormous poverty, and we have huge disparities along race lines…It's hard, when you're in the group of people that have a lot, to put yourself in someone else's shoes and have perspective."*
>
> *~ San Francisco funder*

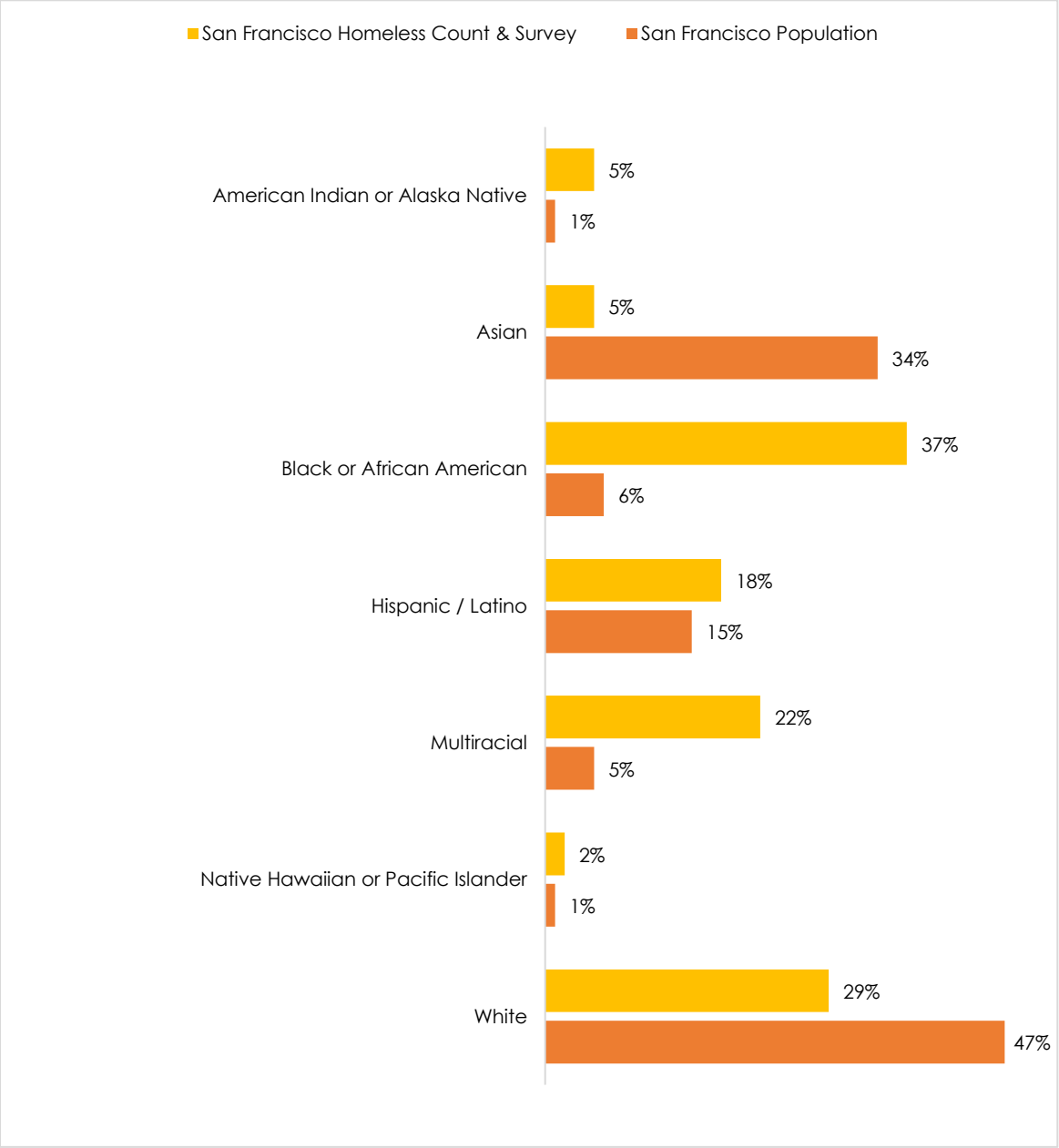
The largest proportion of people experiencing homelessness in San Francisco are Black or African American (37%) even though they comprise only 6% of the population overall. The San Francisco Planning Department's Jobs-Housing Fit Report found that there is an unmet need for 106,000 housing units: 56,500 affordable units and 49,500 moderate need units.[48] Meeting this need would require increasing San Francisco's housing production many times greater than its historical production capacity of 2,950 units per year, to about 10,600 units per year, for ten years.

[46] Kaiser Permanente Community Health Data Platform. https://public.tableau.com/app/profile/kp.chna.data.platform/viz/CommunityHealthNeedsDashboard/Starthere

[47] Home Mortgage Disclosure Act, 2018-2019. Available at Race Counts: https://www.racecounts.org/county/san-francisco/

[48] San Francisco Planning Department. (2020). Jobs-Housing Fit Report. https://sfplanning.org/sites/default/files/resources/2021-11/Jobs-Housing_Fit_Report_2020.pdf

Race/Ethnicity of San Francisco Homeless Community[49]



[49] San Francisco Department of Homelessness and Supportive Housing. (2019). San Francisco Homeless Count & Survey, Comprehensive Report. Available at https://hsh.sfgov.org/wp-content/uploads/2020/01/2019HIRDReport_SanFrancisco_FinalDraft-1.pdf

Community Recommendations

Multi-level advocacy regarding housing policies that disproportionately impact communities of color in San Francisco, including recommendations from the Latino Task Force's 2022 Street Needs Assessment + El Proyecto Dignidad[50]	*"Right now, I'm looking for housing [for a community member] around Chinatown. They live eight in the family… Now they find out you pay more than almost $3,000 for two bedrooms. So they try to stay in affordable housing, but they cannot get anything at all for the past three years. So it's difficult."* *~ Asian & Pacific Islander Health Parity Coalition member* *"There's a Black out-migration report that was done about San Francisco that talks about how many Black families and Black people were moved out of San Francisco areas at a time when there was only like 12% of African Americans in San Francisco. And now it's down to something like 4%. When you look at the jails, the jails are more populated by Black folks. How is that possible out of 4% of Black people in San Francisco?"* *~ African American Health Equity Coalition member*
Workforce development and job training, especially for jobs in community healthcare and behavioral health.	*"It's just that much more work to be a peer counselor or community navigator because it's just too much work and not enough money; we can't pay them enough for them to be able to not drive Uber and help the community…It's harder to find the next generation of providers because they get into other fields that can make more money."* *~ Community service provider*
Provide emotional and psychological support for individuals and families experiencing housing insecurity.	*"Housing [is] not just the actual physical place of housing, of a home where you know that you'll be safe from inclement weather or from the outdoors or a place for your stuff. It's the stress of not being housed…The emotional, mental, traumatic kind of outcomes from just having to sleep on the streets. Is your stuff going to get taken? Is someone going to come mess with you? Is it going to be really cold or really hot? Is someone going to tell me to move? All of that, night after night, that's a nightmare."* *~ Community service provider*

[50] Latino Task Force. 2022 Street Needs Assessment + El Proyecto Dignidad. https://www.ltfrespuestalatina.com/_files/ugd/bbc25b_99f10a84713449bd9e24e1ec89bb1c0c.pdf

CPMC's Evaluation of Impact of Implemented Strategies 2019-2021

An important component of this CHNA report is an evaluation of the impact of the actions that were taken since CPMC finished conducting its immediately preceding CHNA to address the significant health needs identified three years ago. This section is based on the 2019–2021 Implementation Strategy Plan that described how CPMC planned to address significant health needs identified in the 2019 Community Health Needs Assessment. The tables below highlight some of the impacts achieved for each of the programs for which CPMC provided services and/or resources in 2019, 2020, and/or 2021.

The 2019 CHNA identified five health needs, all of which CPMC planned to address:

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

Access to Coordinated, Culturally and Linguistically Appropriate Care and Services

Name of Program, Activity, or Initiative:	**Mission Bernal Clinics (formerly St. Luke's Health Care Center)**
Description	CPMC's Mission Bernal Clinics provides a full range of obstetric and gynecological care at its Women's Center; well-baby care, well-child care, and care for ill or injured children at its Pediatric Clinic; and primary, acute and chronic care at its Adult Internal Medicine Clinic for teenagers and adults. Clinicians and staff are bilingual in English and Spanish, ensuring culturally and linguistically competent care. Without the clinics, many of these patients would have to use services at Zuckerberg San Francisco General and its public clinics, facilities that are operating at full capacity. The clinics' services also counter limited access that may be caused by primary care providers being less likely to serve Medi-Cal beneficiaries due to low government reimbursement rates.
Goals	Expand the city's safety net and bridge gaps in accessibility by making services more readily available to publicly insured and uninsured populations, and making those services culturally and linguistically appropriate.
Anticipated Outcomes	Increase culturally and linguistically appropriate healthcare services for uninsured and underinsured patients residing in communities south of Market Street in San Francisco, such as the Mission, Bayview Hunters Point, Downtown/Civic Center, Visitacion Valley and Excelsior – some of the neighborhoods identified as having the highest disparities related to important socioeconomic determinants of health.
2019–2021 Impact	Population served (ranges reflect variations over the three-year period): Gender: 74-85% Female, 15-26% Male Race: 32-35% White (including Hispanic), 8% Black/African American, 1% Native American/Alaskan Native, 7-14% Asian/Pacific Islander, 45-48% Other/Unknown

Ethnicity: 54-59% Hispanic, 39-44% Non-Hispanic, 2-3% Unknown
Preferred language: 57-62% English, 35-40% Spanish, 3% Other
Insurance coverage: 7-22% Medicare or Medicare Managed Care, 47-54% Medi-Cal or Medi-Cal Managed Care, 31-40% Private insurance, 0-1% Self-pay

	2019	2020	2021*
Patients served	11,489	7,098	4,944
Patient visits	34,105	22,527	14,539

*In April 2021, CPMC transferred the adult and pediatric clinics to Mission Neighborhood Health Center.

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

Description

BCHC offers routine preventative and urgent pediatric care in one of San Francisco's most medically underserved neighborhoods, and addresses prevalent community health issues such as weight control and asthma management. BCHC focuses on keeping infants, children and adolescents healthy, and on closely managing their care when they are ill. The center is particularly attuned to the impact of community violence and childhood trauma on children's mental and physical health. The clinic offers psychological and case management services to families. Dental services are provided through South of Market Health Center at their main facility.

The clinic was started as a collaboration between CPMC, Sutter Pacific Medical Foundation, and CPMC Foundation. In 2014, clinic ownership was transferred to South of Market Health Center (SMHC), and we were jointly awarded a grant to transition BCHC to become a Federally Qualified Health Center. CPMC continues to be the hospital and specialty partner for BCHC and continues to help fund operational costs as well as construction costs connected to the clinic's modernization plan. CPMC and SMHC will work together to ensure that kids in the Bayview have access to high-quality care while ensuring the clinic's long-term sustainability.

Goals

Improve access to high-quality healthcare close to home for uninsured and underinsured children residing in the Bayview Hunters Point district of San Francisco, regardless of ability to pay.

Anticipated Outcomes

Increase pediatric care, psychological, and case management services for children and families of Bayview Hunters Point.

2019–2021 Impact

	2019	2020	2021
Persons served	767	950	909
Patient visits	2,453	3,370	2,523
Persons connected to mental health services	n/a	155	90

Name of Program, Activity, or Initiative: **Healthcare Coverage Enrollment Assistance**				
Description	Program staff assist eligible CPMC patients and their families to enroll in assistance programs such as Medi-Cal, Healthy Families, and county programs.			
Goals	Make healthcare services more readily available to previously uninsured populations and reduce the financial burden of medical bills.			
Anticipated Outcomes	Increased access to more timely high-quality preventive care, primary care, and specialty care services.			
2019–2021 Impact		2019	2020	2021
	Persons enrolled in Medi-Cal, Healthy Families, or county programs	1,416	927	841
	Additional persons enrolled in AIDS Drug Assistance Program or in Office of AIDS Health Insurance Premium Payment Program	382	270	257

Name of Program, Activity, or Initiative: **Coming Home Hospice**				
Description	CPMC's Coming Home Hospice provides 24-hour care for terminally ill clients and their families in a caring, homelike setting. CPMC ensures that high-quality residential hospice care is accessible to terminally ill patients regardless of their ability to pay, by covering the difference between the full cost of providing these services and patient revenue. Services include medical and nursing care, psycho-social counseling, spiritual counseling, religious services, massage therapy, medication monitoring and assistance, personal care assistance, laundry services, recreational activities and entertainment.			
Goals	Increase access to quality hospice care and support for those for whom home is no longer an option, regardless of ability to pay.			
Anticipated Outcomes	Increase quality hospice care services and support.			
2019–2021 Impact	Population served (ranges reflect variations over the three-year period): Race/ethnicity: 59-64% White, 22-32% Asian, 4-10% Black/African American, 4-7% Hispanic Language: English, Cantonese			
		2019	2020	2021
	Persons served	165	152	103
	Low-income	40%	43%	44%

Name of Program, Activity, or Initiative:	**African American & Sister to Sister Breast Health Program and Mission Bernal Campus Breast Health Partnerships**

Description

CPMC's African American & Sister to Sister Breast Health Program offers women mammography screening and all the subsequent breast health diagnostic testing and treatment they may need at no cost. Early detection allows for better treatment outcomes and longevity of life. Partnership organizations such as HealthRIGHT 360, San Francisco Free Clinic, and Clinic by the Bay refer uninsured, underinsured, disadvantaged and at-risk women for mammography services.

The Breast Center at the Mission Bernal Campus promotes breast health in underserved communities by partnering with neighborhood clinics and community agencies, including Southeast Health Center, Mission Neighborhood Health Center, and Bay Area Cancer Connections. Included in the metrics below are services provided through CPMC grants to Bay Area Cancer Connections, one of the principal organizations referring women to the Mission Bernal Campus Breast Center for services, as well as grants to Shanti Project for care navigation services.

Goals

Increase early breast cancer detection by providing access to no-cost mammography screening for uninsured women who live in San Francisco.

Reduce barriers to quality care.

Anticipated Outcomes

Increase early mammography screenings for women in need.

Increase care navigation services for women who face particular challenges in completing treatment.

2019–2021 Impact

	2019	2020	2021
Persons served by CPMC's AABH & Sister to Sister Program	112	75	94
Persons served by Bay Area Cancer Connections (grant)	261	219	190
Patient visits at CPMC campuses	644	588	566
Screenings provided	396	508	412

CPMC grant to Shanti Project's Margot Murphy Women's Cancer Program provided care navigation services, prioritizing women who faced particular challenges in completing treatment due to being low-income, uninsured/underinsured, with limited English proficiency, and/or from immigrant populations:

Persons provided with care navigation services	474	346	350
Taxi vouchers to medical appts and other critical errands	3,330	3,641	3,273
Persons case-managed	245	346	350
Persons connected to mental health services	13	6	n/a
Persons connected to social services	250	214	85
Wellness classes/support group meetings offered	252	n/a	80

Name of Program, Activity, or Initiative: **Operation Access**				
Description	CPMC partners with Operation Access and the San Francisco Endoscopy Center to provide access to diagnostic screenings, specialty procedures, and surgical care at no cost for uninsured Bay Area patients who have limited financial resources. CPMC physicians volunteer their time to provide these free surgical services, while the hospital donates the use of its operating rooms. CPMC also provides grant funding to support Operation Access's operating costs.			
Goals	Increase healthcare equity for uninsured and underserved patients facing barriers to getting the outpatient surgical and specialty care that they need, by: • Providing the resources and promoting the medical volunteerism needed for the donation of these services; • Increasing culturally competent case management; • Providing medical interpreters to facilitate donated care.			
Anticipated Outcomes	Increase number of timely surgical procedures and diagnostic services provided to uninsured and underserved patients.			
2019–2021 Impact		2019	2020	2021
	Number of persons served	143	80	73
	Operating room procedures	49	20	28
	GI procedures	45	33	24
	Minor procedures, radiology	45	14	7
	Specialist evaluations, physical therapy	29	28	18
	Volunteering physicians	47	29	36
	Client compliance rate (patients who show up on time and prepared for appointments)	97%	96%	96%
	Median wait time from referral to specialty visit	76 days	89 days	79 days
	Patients very satisfied or satisfied with their experience	99%	97%	98%
	Patients reporting improved health	96%	95%	93%
	Patients reporting improved ability to work	96%	95%	93%
	Patients reporting improved quality of life	96%	95%	92%

Name of Program, Activity, or Initiative: **Lions Eye Foundation**	
Description	Lions Eye Foundation and CPMC partner together to provide highly specialized eye care procedures free of charge to people without insurance or financial resources.
Goals	Provide access to highly specialized eye care for people without insurance or financial resources.
Anticipated Outcomes	Increase eye care procedures/services for uninsured, low-income patients residing in San Francisco.

2019–2021 Impact		2019	2020	2021
	Persons served	426	244	385
	Patient visits	4,414	3,761	3,545
	General surgical procedures	245	196	376
	Laser surgeries	229	211	150
	Intravitreous injections for macular degeneration and eye complications due to diabetes	764	653	769
	Number of diagnostic tests (OCTs, B-scans, angiograms, etc.)	3,221	2,450	3,297

Name of Program, Activity, or Initiative:	**Advanced Illness Management (AIM) Program**
Description	Sutter Health's Advanced Illness Management (AIM) program provides customized support for patients with advanced chronic illnesses in order to manage their health/illness symptoms, manage their medications, coordinate their care, plan for the future, and live the kind of life they want. CPMC supports the program, providing funding towards the care of people who enroll in the program in San Francisco. Once the AIM team understands the patient's health issues, lifestyle, and personal preferences, they work with the patient to tailor a care plan, ease the transition from hospital to home, and provide continuing over-the-phone support and in-person visits in the home or at the doctor's office as needed. If the patient returns to the hospital, AIM staff continues to support the patient there. The AIM team also provides support for the patient's family and helps them understand anything about the patient's condition that the patient wants them to know.
Goals	Help chronically ill patients better manage their health/illness through skilled, respectful coaching and care tailored to their needs.
Anticipated Outcomes	Increase coaching services and support for patients who need help in self-managing advanced chronic illness.
2019–2021 Impact	Population served (ranges reflect variations over the three-year period): Women 53-59%, Men 41-47% Age: 18-64 (16-21%), 65-74 (15-26%), 75+ (57-65%) Insurance type: Commercial 7-13%, Medi-Cal 10-11%, Medicare 50-66%, Medicare/Medi-Cal 6-11%, Other PPS Payors 11-17%

	2019	2020	2021
New enrollees in the program	234	201	135
Persons transitioned to home/self-care from hospital	14%	9%	7%
Persons transitioned to home healthcare service	61%	59%	60%

Name of Program, Activity, or Initiative: **Medi-Cal Managed Care Partnerships**	
Description	A key part of CPMC's Medi-Cal program is the Medi-Cal Managed Care partnership with North East Medical Services (NEMS) community clinic and San Francisco Health Plan (SFHP), a licensed community health plan that provides affordable healthcare coverage to over 130,000 low- and moderate-income San Francisco residents. Working together with NEMS, CPMC serves as the hospital partner for these Medi-Cal beneficiaries who select NEMS as their medical group through San Francisco Health Plan, providing them with inpatient services, hospital-based specialty and ancillary services, and emergency care. CPMC also provides access to quality services at the Mission Bernal Campus for patients who select Hill Physicians or Brown & Toland as their medical group through San Francisco Health Plan. Additionally, CPMC provides lab services free of charge for NEMS patients in order to further improve access and support NEMS and their patients.
Goals	Improve access to quality services for publicly insured people in San Francisco.
Anticipated Outcomes	More Medi-Cal patients residing in San Francisco will receive timely, high-quality healthcare services.
2019–2021 Impact	CPMC continued to serve as the hospital provider for about one-third of SFHP's total membership, who otherwise may have faced difficulties in accessing a comprehensive, coordinated care network. 2019 / 2020 / 2021 North East Medical Services enrollees: 35,336 / 38,878 / 41,008 Brown & Toland enrollees: 1,523 / 1,444 / 1,431 Hill Physicians enrollees: 1,559 / 1,698 / 1,882 NEMS patients served with free lab services: ≈16,000 / ≈14,000 / ≈16,000

Name of Program, Activity, or Initiative: **Grants and Sponsorships Addressing Access to Coordinated, Culturally and Linguistically Appropriate Care and Services**	
Description	Grants and sponsorships are decided annually based on community need. Selected executed grants and sponsorships will be reported at year-end.
Goals	Expand the city's safety net by making healthcare services more readily available to publicly insured and uninsured populations, and making those services culturally and linguistically appropriate.
Anticipated Outcomes	Increase affordable, accessible, culturally and linguistically appropriate healthcare services for uninsured and underinsured patients by supporting community-based

	organizations that develop/expand clinical services, outreach programs, and health education efforts to ensure that the needs of underserved populations are met.
2019–2021 Impact	Over the three-year period, CPMC provided grants to organizations such as APA Family Support Services, Bay Area Cancer Connections, Clinic by the Bay, Conard House, Inc., Curry Senior Center, Designing Justice + Designing Spaces, GLIDE Foundation, HealthRIGHT 360, Kimochi, Inc., Latino Task Force/Mission Language and Vocational School, Maitri Compassionate Care, Mission Neighborhood Health Center, North East Medical Services, Planned Parenthood Northern California, San Francisco Community Clinic Consortium, San Francisco Community Health Center, San Francisco Free Clinic, San Francisco Village, Self-Help for Elderly, Shanti Project and St. Anthony Foundation. Through grant support to organizations such as these, CPMC contributed to the following services being provided:

	2019	2020	2021
Health screenings provided	4,612	233,000	302,000
Transportation services/vouchers provided	4,480	4,700	4,500
People seen by a primary care provider	1,091	3,600	8,900

Name of Program, Activity, or Initiative: **HealthFirst**

Description

HealthFirst is a center for prevention and education located at CPMC's Mission Bernal Campus, and serves patients in chronic disease management by integrating community health workers (CHWs) into the multidisciplinary healthcare team. CHWs are culturally and linguistically competent as they are recruited from the same community as the patients that HealthFirst serves. CHWs provide health education, assist patients to improve their self-management skills, and encourage them to receive timely and comprehensive care.

CHWs teach community workshops in healthy eating to parents of children at risk for obesity in the South of Market, Mission, and Bayview Hunters Point districts. They also teach classes on nutrition designed to manage chronic adult diabetes.

Goals

Manage chronic illness with cost-effective, quality care by providing prevention, outreach, and education services in a primary care setting that is culturally and linguistically appropriate for uninsured and underinsured patients residing in communities south of Market Street in San Francisco.

Anticipated Outcomes

Improve patients' self-management skills through culturally and linguistically appropriate services and health education.

2019–2021 Impact

	2019	2020	2021
Total patients served	816	830	652
Patient visits	1,982	2,780	2,061
Diabetes patients served	336	321	233
Eye exams	175	105	64
Foot exams	200	93	98
Albumin/creatinine ratio tests	284	128	142
Patients with A1c controlled (<9%)	87%	86%	85%
Asthma patients served	332	261	222
Spirometry tests	221	discontinued due to COVID	
Patients with up-to-date asthma action plans	100%	100%	100%

Name of Program, Activity, or Initiative: **Grant to Meals on Wheels**

Description

Meals on Wheels San Francisco (MOWSF) helps low-income, homebound seniors to age safely at home by providing nourishing meals, safety support, and interpersonal and community connections.

MOWSF was providing 83% of home-delivered meals in San Francisco, but its facility could not keep pace with demand as the city's senior population grows. The CPMC grant supported the organization to build and equip a 45,000 square foot

	meal production facility that includes a full-capacity, commercial kitchen for food preparation, storage, access space and distribution yard.
Goals	Disrupt a system of hidden senior hunger, poverty and isolation. Provide the San Francisco community with a substantially enhanced safety net by providing low-income, isolated, homebound seniors and adults with disabilities with two nutritious meals per day, social work assistance and an array of support services allowing them to prosper in their homes.
Anticipated Outcomes	Efficiently increase meal production capacity. Enhance ability to prepare medically tailored meals and offer culturally appropriate meal options, including plant-based menus.
2019–2021 Impact	July 2019 – New facility broke ground in July 2019. October 2020 – Facility opened and has remained in full operation.

	2019	2020	2021
Seniors and adults with disabilities served	4,700	4,800	5,600
Additional food-insecure quarantined individuals in the City's COVID-quarantined individuals IQ Food Program who received groceries and meals (70% Latinx)	--	--	20,450
Meals delivered	2.1 million	2.2 million	2.8 million
Nutrition assessments/education provided	2,784	1,324	3,100

Name of Program, Activity, or Initiative: **Grant to Community Health Resource Center (CHRC)**	
Description	CHRC collaborates with over 20 different healthcare centers in San Francisco, providing supportive services to thousands of clients through the many free or low-cost programs, screenings and counseling services that are available to anyone in the community. Programs include dietitians, social work counseling, nutrition guidance, community health screenings, educational lectures including monthly wellness events, health information and local resources, employee and group wellness presentations, and support groups. Services are offered free, at a reduced cost, or on a sliding scale. In CHRC's Nutrition Counseling program, the team of highly qualified registered dietitians is available by appointment for nutrition counseling and diet review, with the goal of establishing a diet balanced for all life stages. Nutritionists are cross-trained to meet the nutritional needs and provide guidance for a variety of conditions, concerns and goals. Dietitians are also trained to address weight management concerns specific to age through a number of healthy, supportive treatment options. Dieticians also bring their knowledge to the community by presenting to a variety of community groups.

Goals	Increase knowledge and awareness regarding healthy eating and help patients to effectively meet their goals as they relate to nutrition and diet.
Anticipated Outcomes	Increase high-quality, professional supportive services, tools and information for healthy eating among San Francisco residents.
2019–20218 Impact	

	2019	2020	2021
Appointments with a registered dietitian	2,541	2,590	3,207
Health screenings related to diet/exercise and lifestyle change (BMI, glucose, etc.)	2,644	1,151	1,411
Attendees at nutrition/exercise/lifestyle classes and presentations, including health fair (may include duplicates)	6,036	1,453	4,737

Name of Program, Activity, or Initiative:	**Grants and Sponsorships Addressing Food Security, Healthy Eating, and Active Living**
Description	Grants and sponsorships are decided annually based on community need. Selected executed grants and sponsorships will be reported at year-end.
Goals	• Enhance health and well-being by providing nutritious meals, groceries, and/or food choices to those in need. • Facilitate behavioral changes of adults and children in homes, schools, worksites, and communities that will lead to the consumption of healthier foods and increased physical activity. • Identify and respond to risk factors such as obesity and inactivity that have been linked to cardiovascular disease, stroke, diabetes, gallbladder disease, osteoarthritis, and certain cancers. • Establish a culture of health consciousness among adults and children.
Anticipated Outcomes	• Increase knowledge and awareness regarding healthy eating and physical activity among adults and children through culturally relevant tools and information. • Increase children's and adults' access to healthy and nutritious foods. • Increase children's and adults' participation in various forms of exercise through exercise and fitness programs. • Increase referral and case management for children who are at risk of poor nutrition, obesity, and obesity-related diseases.
2019–2021 Impact	Over the three-year period, CPMC provided grants to support organizations such as Family Connections Centers, Jewish Community Center of San Francisco, Project Open Hand, and William McKinley Elementary School. Through grant support to organizations such as these, CPMC contributed to the following services being provided:

	2019	2020	2021
People provided with nutrition education	4,483	3,500	7,000
Meals provided to those in need	2.36 million	2.4 million	3 million

Name of Program, Activity, or Initiative: **Grant to Compass Family Services**				
Description	Compass Family Services operates programs that provide year-round services to homeless families and families at imminent risk for homelessness. Programs include: • Compass Connecting Point, a Family Resource Center: centralized drop-in center with childcare providing assessment, shelter placement, counseling, and referral services for families facing a housing crisis. • Compass Family Shelter: emergency shelter, with on-site supportive services and long-term follow-up care. • Compass Clara House: 18-month transitional housing with comprehensive supportive services for homeless families. • Compass Children's Center: nationally accredited early childhood education and childcare center for homeless and extremely low-income infants and toddlers. • Compass SF HOME: intensive support services combined with rent subsidies to help families avert homelessness. • Compass Clinical Services: critical mental health services to clients. • Twitter NeighborNest: state-of-the-art technology lab with on-site childcare to help families bridge the technological divide. • OneHome: free affordable housing search website that makes it easier to find and apply for available housing.			
Goals	Assist families in securing and maintaining permanent housing. Help families address barriers to economic self-sufficiency. Support the healthy development of children and families. Address mental health and substance abuse problems.			
Anticipated Outcomes	• Help homeless or at-risk families achieve housing stability, economic self-sufficiency, and well-being; 90% of families remain stably housed after 12 months. • Provide homeless or at-risk children with full-time infant and toddler care and pre-school, with achievement of age-appropriate skills upon graduation from the program and readiness to enter kindergarten. • Provide mental health services to children or parents, with demonstrable improvement in the overall functioning and mental health of participating individuals.			
2019–2021 Impact		2019	2020	2021
	Total people served / connected to social services	5,802	6,548	5,086
	People receiving mental health services	265	337	593
	People receiving case management services	781	260	959
	People placed in interim or permanent housing	510	640	713
	Meals provided	41,038	37,947	n/a
	Number of class/workshop/support group meetings	723	223	n/a

Name of Program, Activity, or Initiative:	**Grants and Sponsorships Addressing Housing Security and an End to Homelessness**
Description	Grants and sponsorships are decided annually based on community need. Selected executed grants and sponsorships will be reported at year-end.
Goals	End homelessness. Stabilize individuals and families at risk for homelessness.
Anticipated Outcomes	• Provide transitional or permanent/stable housing and additional resources to address the causes of homelessness. • Provide comprehensive supportive services to individuals and families who are homeless or at risk for homelessness to stabilize their housing status. • Increase availability and/or accessibility of safe, affordable housing.
2019–2021 Impact	Over the three-year period, CPMC provided grants to organizations such as Compass Family Services, Conard House, Episcopal Community Services of San Francisco, Hamilton Families, Homeless Prenatal Program, and Larkin Street Youth Services. Through grant support to organizations such as these, CPMC contributed to the following services being provided:

	2019	2020	2021
People placed in homeless shelters	155	650	--
People placed in temporary or permanent housing	1,583	3,000	--
People placed in interim housing (including shelters)	--	--	550
People placed in permanent/stable housing	--	--	2,000

Name of Program, Activity, or Initiative:	**Grants and Sponsorships Addressing Safety from Violence and Trauma**
Description	Grants and sponsorships are decided annually based on community need. Selected executed grants and sponsorships will be reported at year-end.
Goals	Ensure that every child and adult is protected and our community is safe from child abuse and other forms of violence; prevent child abuse and domestic violence and reduce their devastating impact through supportive services, education, and policy advocacy.
Anticipated Outcomes	• Increase high-quality services for victims of child abuse and domestic violence. • Increase student/caregiver/community education programs on child abuse and how to prevent it. • Increase support services to at-risk parents, families, and individuals.
2019–2021 Impact	Over the three-year period, CPMC provided community grants to organizations such as Huckleberry Youth Programs and Safe & Sound. Through grant support to organizations such as these, CPMC contributed to the following services being provided: 2019 — 2020 — 2021 People receiving case management services: 1,800 — 3,000 — 3,800

Name of Program, Activity, or Initiative: **Kalmanovitz Child Development Center (KCDC)**	
Description	CPMC's Kalmanovitz Child Development Center provides diagnosis, evaluation, treatment and counseling for children and adolescents with learning disabilities and developmental or behavioral problems caused by prematurity, autism spectrum disorder, epilepsy, Down syndrome, attention deficit disorder, or cerebral palsy. Its comprehensive assessments and ongoing therapy programs include the following disciplines: Developmental/Behavioral Pediatrics; Psychology and Psychiatry; Speech/Language and Auditory Processing; Occupational Therapy; Behavior Management Consultations; Early Intervention/Parent-Infant Program; Social Skills Groups; Feeding Assessment and Therapy; Assessment and Therapy for the Neonatal Intensive Care Unit and Assessment for the Follow-Up Clinic; Educational Assessment, Therapy and Treatment. These services provided at reduced or no cost to families are particularly important since children from low-income families have a 50% higher risk of developmental disabilities; early identification and treatment can change the course of these children's lives. Besides operating its own clinics, KCDC also extends its services to a large number of at-risk children and brings services to them in their community by partnering with local schools and other community organizations, such as De Marillac Academy and Sacred Heart Cathedral Preparatory. De Marillac Academy is a tuition-free independent Catholic school serving low-income fourth-to-eighth-grade students in San Francisco's Tenderloin District, where many children suffer from post-traumatic stress disorder impacting their ability to learn. In a unique program that goes beyond the daily classroom setting, clinical and family support services are provided by KCDC to help children process those experiences and overcome the emotional challenges that often accompany them. Speech and language pathologists provide more intensive services as needed at the school; occupational therapy is done at KCDC locations.
Goals	Help children and youth in San Francisco to thrive and live up to their full potential by providing early multidisciplinary assessment and treatment for children with one or more conditions that affect their growth and development, regardless of the patient's ability to pay.
Anticipated Outcomes	Increase services for children with one or more conditions that affect their growth and development.
2019–2021 Impact	

	2019	2020	2021
Persons served at two San Francisco clinic locations	1,352	1,311	1,230
Persons served at De Marillac Academy	119	95	100
Patient visits (clinic locations only)	15,853	13,252	16,842

Name of Program, Activity, or Initiative: **Grant to Community Health Resource Center**	
Description	CHRC collaborates with over 20 different healthcare centers in San Francisco, providing supportive services to thousands of clients through the many free or low-cost programs, screenings and counseling services that are available to anyone in the community. Programs include dietitians, social work counseling, nutrition guidance, community health screenings, educational lectures including monthly wellness events, health information and local resources, employee and group wellness presentations, and support groups. Services are offered free, at a reduced cost, or on a sliding scale. CHRC's Behavioral/Mental Health Services by a licensed team of professionals offer support to individuals, groups and families looking for emotional or practical guidance and support for a wide range of needs. Fees for services are on a sliding scale. Counseling sessions may include: Individualized Needs Assessment to help clarify and prioritize the patient's most urgent concerns in order to develop goals and identify possible solutions; Short-term Emotional Support where counselors help align resources and make recommendations; Resource and Referral where a social worker can help connect the patient with other resources and agencies such as insurance, housing, reduced billing options for utilities, transportation, as well as a wide range of specific community support; Psychotherapy based on individual needs; and Follow-up Support. Examples of past support groups/programs include the Cancer Buddy Program that connects recently diagnosed cancer patients with trained volunteer cancer survivors; the Stroke Survivor Support Group designed to aid the recovery of stroke survivors at any stage by providing a safe and supportive atmosphere where individuals are able to share their experiences; and the Liver Cancer Support Group, where those living with liver cancer, family members, loved ones, and caregivers are provided with emotional and social support, education, and shared experience in an open, accepting environment. Educational classes offered by the CHRC social workers include topics such as advanced healthcare directives, bereavement, care for givers, and dementia.
Goals	Improve the mental health and well-being of San Francisco residents.
Anticipated Outcomes	Increase behavioral/mental health services and connectivity to needed social services for San Francisco residents.
2016–2018 Impact	

	2019	2020	2021
Appointments for behavioral health/social work services	4,008	3,835	3,917
Attendees at stress management/emotional health classes	158	n/a	n/a
Stroke support group sessions (with 6-10 attendees each)	12	n/a	n/a

Name of Program, Activity, or Initiative:	**Psychiatry Residents Serving at Community-Based Organizations**
Description	As part of CPMC's health professions education program, CPMC psychiatry residents provide services one day per week to patients in need of behavioral health services at community-based organizations and public institutions, including San Francisco Free Clinic (first-year residents), HealthRIGHT 360's Clayton/Haight Addictions Campus (third-year residents), and San Quentin Prison (where third-year residents participate in telepsychiatry sessions serving a wider California prison population at prisons where no psychiatrists are on staff). As trainees, psych residents are part of a treatment team and under the supervision of an attending physician. These organizations provide treatment for substance use disorder and other mental health problems, and/or social support and re-entry services for incarcerated/ formerly incarcerated clients to help them to attain self-sufficiency and continued recovery.
Goals	Improve the mental health and well-being of at-risk populations by making high-quality services more readily available.
Anticipated Outcomes	Increase mental health and substance abuse services for at-risk populations.
2016–2018 Impact	In 2019, psychiatry residents provided an estimated 900 encounters at all three sites. After activities were on hold in 2020 due to the COVID-19 pandemic, they resumed in 2021 with an estimated 340 encounters provided at San Francisco Free Clinic and San Quentin Prison.

Name of Program, Activity, or Initiative:	**Grants and Sponsorships Addressing Social, Emotional, and Behavioral Health**
Description	Grants and sponsorships are decided annually based on community need. Selected executed grants and sponsorships will be reported at year-end.
Goals	Promote mental health and the healthy development of children and families in both the broader community and at-risk communities; prevent child abuse and domestic violence.
Anticipated Outcomes	• Increase re-entry social support services that empower formerly incarcerated residents to attain economic self-sufficiency, continued recovery, and creation of a stable living environment by building skills, accessing resources, and modeling professional behavior. • Increase substance use disorder treatment services that are gender-responsive and welcoming to people of any gender identity.

	• Increase support to families in need of resources, such as employment training, parent education classes, housing, child care, and shelters. • Increase intensive assessment, counseling, and referral services to help families and individuals avert homelessness. • Increase mental health services to homeless and at-risk youth. • Increase linguistically and culturally appropriate support groups and counseling. • Increase early childhood education for at-risk families. • Increase integrated treatment services for clients with co-occurring substance use disorder and mental health problems. • Increase integration of behavioral health services into existing primary care settings for at-risk San Francisco residents.
2016–2018 Impact	Over the three-year period, CPMC supported organizations such as Edgewood Center for Children and Families, Larkin Street Youth Services, and Elder Care Alliance, dedicating extra funds to address youth mental health due to the impacts of the COVID-19 pandemic on the mental health and well-being of children and adolescents. Through such grant support, CPMC contributed to the following services being provided: People who received mental health services: 2019: 3,531; 2020: 7,200; 2021: 7,200 People who received substance use services: 2019: 103; 2020: 1,200; 2021: 1,200

Name of Program, Activity, or Initiative:	**Psychiatry Residency & Psychology Intern Training Program**
Description	As a multi-campus teaching hospital, CPMC offers educational experience to physicians through its residency training programs, which include Psychiatry. Psychology interns and fellows also receive training while working in locations such as Kalmanovitz Child Development Center, Adult In-Patient, and Women's Health Initiative. CPMC usually trains 16 psychiatric residents, 10 psychology interns, and 2 psychology fellows annually.
Goals	The next generation of mental/behavioral healthcare professionals will receive world-class training/educational experience.
Anticipated Outcomes	Increase number of well-trained psychiatrists and psychologists and the availability of these services in the future.
2016–2018 Impact	Each year, CPMC trained 15-16 psychiatric residents, 10 psychology interns, and 2-4 psychology fellows.

Conclusion

The 2022 Community Health Needs Assessment aimed to ask what we can do – and highlight and recommend and fund – *differently* to improve our community's health. City residents and leaders shared that San Francisco has many strengths; community organizations and neighborhood groups know how to reach people in meaningful and health-promoting ways that have helped sustain them through challenging times.

Despite myriad resources, San Francisco also has some serious health needs, disparities, and systemic challenges. **Access to care**, **behavioral health**, and **economic opportunity** were the three that rose to the top, rooted in the racist structures, practices, policies, and biases that permeate our country and institutions, even in San Francisco. These health needs are broad enough to incorporate several of the disparities impacting BIPOC communities, and provide multiple ways for healthcare institutions to – both independently and collaboratively – have a positive impact.

> *"There's a lot of community leadership that has sprung up over the last year that should be leveraged."*
>
> *~ San Francisco government staff*

Community members shared what they hope can be done to begin working on these needs and disparities, highlighting that all San Franciscans will be healthier if we build on community resources and assets. To do this, they suggested providing specific types of support:

- Community Engagement
- Cultural Humility
- Financial Investment

Community Engagement

Healthcare organization engagement, partnership, and trust-building through authentic relationship outreach in communities. Examples of this could include joining convenings of neighborhood stakeholders and connecting communities with healthcare, research, clinical training, and policy development resources.

"I get that hospitals, by virtue of an economy of scale, need to have a broad mainstream approach. But if there's a way for them to have flexibility, to recognize that community health approaches or approaches that are community-based are far more effective in potentially reducing health disparities."

~ Chicano/Latino/Indígena Health Equity Coalition member

"[The City] has done some grants focused on community leadership and community innovations. That's a really good place to start…And, there's a bunch of different collaboratives and groups that meet on a regular basis that folks can attend their meetings and get the pulse of the community and find ways to partner with them. I would say, respect the work that's already happening and tap into how to expand and elevate and lift that up versus being competitive and starting new programs and trying to fund stuff that community's already leading."

~ Community service provider

Cultural Humility

Healthcare organization commitment, engagement, and elevation of cultural humility in approaches, practices, policies, and staffing. Examples of this could include honoring lived experience and taking the time needed to authentically work with people and organizations who need it most.

"People are not being believed, they're not being treated appropriately. So how are you going to trust an institution that you think doesn't want you here and is going to…not give you appropriate care? I mean, literally not give you appropriate care, literally. We're in-between a rock and a hard place around that."

~ African American Health Equity Coalition member

"We need health fairs all throughout the city. Yes, we want to get people swag bags, groceries, do their blood pressure. Yes, those are good. That's baseline…But that's not a strong demonstration of addressing health inequities. It's good, but that's not going to get us to mutual respect for culture in a predominately white institution."

~ Community service provider

Financial Investment

Healthcare organization funding and funding opportunities for groups with roots in the community. Examples of this could be alignment of funders to investment in community leadership for people with lived experience and for building fundraising capacity, especially for small grassroots organizations.

"It's the relationships that the community-based organizations are building in the community where they're located that really matter. And the [healthcare institutions] recognizing that they need community-based organizations because we are an extension of their hand to the community. How do you value that? You pay the community through the CBOs, give them millions, because the CBOs are in community and they are the ones that are touching the community folks, literally."

~ Asian & Pacific Islander Health Parity Coalition member

"There is also a capacity-building piece in neighborhoods. How do we support folks and residents in the neighborhood who have a different kind of stake in the neighborhood to do, and also create, economic and civic opportunity, at the same time to really empower the neighborhood to do this work? So it's not always like, 'Oh yeah, we're going to hire these people with these degrees and they're going to do this thing.' It's like, 'How do you build assets and capacity, recognizing those existing relationships in the neighborhood?'"

~ Community service provider

These suggestions for support do not seek to stand as a comprehensive text, but have rather emerged as a list of key findings and recommendations gained through rich conversations with those who live, work, play, and dream within the City and County of San Francisco. Our hope is that this body of work adds to the rich network of reports, findings, and advocacy efforts already well underway in these communities, positively impacting the health landscape for San Franciscans for years to come.

Next Steps and Solicitation for Public Comments

This CHNA report will be publicly available by December 31, 2022 (https://www.sutterhealth.org/for-patients/community-health-needs-assessment). California Pacific Medical Center will also develop an Implementation Strategy Plan based on the CHNA results, which will be filed with the IRS by May 15, 2023. The implementation plan will address each health need identified in the CHNA, building on current assets and resources. The plan will incorporate evidence-based strategies wherever possible and take into account Sutter Health goals and metrics.

Feedback and comments about the 2022 CHNA and/or 2022-2024 Implementation Strategy Plan can be submitted to SHCB@sutterhealth.org and will be considered as part of the community input component in the development of CPMC's 2025–2027 CHNA.

CPMC requested written comments from the public on its 2019 Community Health Needs Assessment and corresponding Implementation Strategy Plan through its website. At the time of the development of this CHNA report, CPMC had not received any written comments. However, input from the broader community was considered and taken into account when identifying and prioritizing the significant health needs of the community we serve for the 2022 CHNA through the process documented in this report. CPMC will continue to use its website as a tool to solicit for public comments, and will ensure that these comments are considered community input in the development of future CHNAs.

Appendix: Methods

About the Community Health Needs Assessment (CHNA)

The Affordable Care Act (ACA) was enacted in March 2010 to make health insurance available to more people, expand the Medicaid program, and support innovative medical care delivery to lower healthcare costs. The ACA also requires that nonprofit hospitals conduct a community health needs assessment (CHNA) every three years. The IRS code for Charitable Hospital Organizations, Section 501(r)(3)(A), is where this requirement is enshrined in law.[51] To meet these requirements, the CHNA must:

- Define the community it serves
- Assess the health needs of that community
- Take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health
- Be made widely available to the public

In addition to fulfilling these requirements, the CHNA in San Francisco is an opportunity for hospitals and community agencies to better understand the unique needs and stories of San Franciscans.

We are committed to gathering community perspectives on the impact of structural racism and see the CHNA as an opportunity to advance health and health equity. We have endeavored to apply a racial equity lens to all data collection, analysis, synthesis, and reporting. Identifying the highest priority needs for the CHNA while recognizing the historic and continued harm of racism, informs our community investments and helps us develop strategies aimed at making long-term, sustainable change, allowing us to deepen the strong relationships we have with other organizations that are working to improve community health.

CHNA Leadership

The San Francisco CHNA was conducted as part of the San Francisco Health Improvement Partnership (SFHIP), a collaborative body whose mission is to improve community health and wellness in San Francisco through collective impact. SFHIP is comprised of mission-driven anchor institutions committed to leveraging their economic power to improve community health and well-being; health equity coalitions grounded in the lived experience and resilience of communities experiencing health inequities; funders dedicated to improving community health; and educational, faith-based, healthcare, and other service provider networks and institutions making a difference in the everyday lives of residents.

- African American Health Equity Coalition
- Asian & Pacific Islander Health Parity Coalition
- Chicano/Latino/Indígena Health Equity Coalition
- Chinese Hospital
- Dignity Health
- Instituto Familiar de la Raza

[51] Internal Revenue Service (IRS). (2021). Community Health Needs Assessment for Charitable Hospital Organizations – Section 501(r)(3). https://www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r

- Kaiser Permanente
- Rafiki Coalition
- Richmond Area Multi-Services, Inc. (RAMS)
- Saint Francis Memorial Hospital
- San Francisco Community Clinic Consortium
- San Francisco Department of Public Health
- San Francisco Human Services Network
- San Francisco Unified School District
- St. Mary's Medical Center
- Sutter Health California Pacific Medical Center
- University of California, San Francisco

Previous San Francisco CHNAs have been led by the San Francisco Department of Public Health (SFDPH). Due to the COVID-19 pandemic, however, SFDPH could not serve as the backbone to the 2022 CHNA process and report writing as they have in the past. SFHIP, with support through the Hospital Council, brought on a consultant, Harder+Company Community Research, to lead this work.

Harder+Company Community Research[52] is a nationally recognized leader in high-quality evaluation for learning and action with a team of over 45 researchers throughout California, reflecting the major regions of the state. The firm's staff offer deep experience assisting hospitals, health departments, and other health agencies on a variety of efforts, including conducting needs assessments, developing and operationalizing strategic plans, engaging and gathering meaningful input from community members, and using data for program development and implementation. Harder+Company offers considerable expertise in broad community participation, which is essential to the CHNA processes.

In addition, Kaiser Permanente San Francisco Medical Center needed to follow new guidance from their national organization and conducted their own CHNA. As outlined below, this was done in close partnership with the rest of SFHIP, including sharing data and getting feedback on the health needs.

Community Assessment

Primary qualitative data

To identify the community's strengths, health needs, and suggested solutions, focus groups were conducted between September and December 2021 with the following five groups:

- African American Health Equity Coalition
- Asian & Pacific Islander Health Parity Coalition
- Chicano/Latino/Indígena Health Equity Coalition
- Funders (including Blue Shield of California Foundation, California HealthCare Foundation, Hirsch Philanthropy Partners, Metta Fund, Northern California Grantmakers, The California Wellness Foundation, and Zellerbach Family Foundation)
- Insurers (including Anthem, Blue Shield, Canopy Health, Kaiser Permanente, San Francisco Health Plan)

[52] https://harderco.com

Key informant interviews were conducted as part of the Kaiser Permanente CHNA between July and September 2021, with people from the following 15 organizations:

- Bayview YMCA
- Compass Family Services
- GLIDE Foundation
- Huckleberry Youth Programs
- Kaiser Permanente – Greater San Francisco
- La Casa de las Madres
- Lavender Youth Recreation Center (LYRIC)
- Mission Economic Development Agency
- NEMS (North East Medical Services)
- On Lok 30th Street Senior Center
- Richmond Area Multi-Services, Inc. (RAMS)
- San Francisco AIDS Foundation
- San Francisco Department of Public Health
- San Francisco Human Rights Commission
- San Francisco Unified School District

Focus groups and interviews were conducted in a semi-structured manner, using a discussion guide developed with the SFHIP CHNA subcommittee (complete guides included below). Equity coalition participants received a $30 gift card as an acknowledgment of their time.

All groups and interviews were online or through telephone calls. The conversations were recorded, professionally transcribed, and entered into the qualitative research software Dedoose. After all the focus groups and key informant interview summaries were completed, the research team used software tools to analyze the qualitative data. All community strengths, health needs, and suggested solutions that were mentioned were tabulated. The team then made a complete list of all of the mentioned topics, counted how many groups or informants listed those conditions, and noted how many times they had been prioritized by participants. This qualitative data analysis was designed to identify emergent themes.

Secondary Quantitative Data

To contextualize community input and provide background on the demographics and health of San Franciscans, the CHNA included quantitative data from myriad sources, including national sources such as the American Community Survey, Race Counts, and the California Health Interview Survey (CHIS), as well as local sources such as Data SF and City Health Dashboard. The Kaiser Permanente data platform also provided local data compiled from approximately 100 publicly available indicators.

Health Need Selection

To identify the most significant health needs in San Francisco, SFHIP'S CHNA subcommittee collectively reviewed the quantitative and qualitative data and findings over the course of several meetings. Each health need for which the committee had data was considered and discussed. SFHIP then reviewed the comprehensive findings. They engaged in a robust discussion about the data, including the connection of each potential need to the San Francisco CHNA goal to elevate the impact of systemic racism. Finally, participants voted on the health needs. Subsequent discussions clarified the names and definitions of the needs. This process yielded three health needs:

- Access to care
- Behavioral health
- Economic opportunity

Focus Group Discussion Guide Used for Health Equity Coalitions

Group description
Date
Meeting link
Language
Facilitator and notetaker
Logistic notes

Introduction

Hi everyone. My name is [name]. Thank you for talking with us today. And thank you to ____ for helping to organize this.

We are helping the hospitals and community groups in San Francisco learn how to help people in our community be as healthy as they can be. It is called a *community health needs assessment* and is something that the hospitals do every 3 years.

We will talk for about an hour today. Before we start, I want to share some suggestions for us [*show slide with this information*]:

- There are no right or wrong answers. You are the experts about your community.
- Everyone's opinion counts. It is fine to have a different opinion than other people, and we want you to share, even if it is different.
- We want everyone to have an equal chance to talk, so please try not to interrupt anyone.
- Please ask questions if you are not sure what we mean by something.
- Because we only have an hour and a lot to talk about, I may need to move us to the next topic sort of abruptly to get to all the questions.
- Everything we talk about today is confidential. That means that, when we write a report for the hospitals and community groups doing the CHNA that says what the community's health needs are, we will *not* tell anyone your name.
- I am taking notes while we talk, so there may be times when I'm quiet as I'm writing down what you're saying.
- We'd also like to record our conversation and have the recording transcribed (or written out) to make sure we get everything you say right. Is that okay?
- Finally, in appreciation for your time, you will all get a $30 gift card to a place you get to choose from a list of a bunch of different options. We will email you more details about this following our conversation.

Do you have any questions before we start?

[If agreed on, **turn on recording**. If not, continue to take notes.]

Discussion Questions

- To start, could everyone please share their first name. And could you also please put the community, neighborhood, or organization that they are from ***in the chat***.
    1. [H+Co starts and picks next person; each person picks the next person. Keep track of who has not yet gone.]
    2. [If asked, we would like names so that we can use them in the discussion, but will not include them in our summary.]
    3. [If speaking to leaders of community organizations] *Probe*: How do you think the communities you serve or represent describe themselves?
- We want to learn about what helps you, your families, and your communities strong and healthy. What are your communities' **strengths**; for example, what is your community good at doing to keep each other strong and healthy?
    1. What about San Francisco overall; what makes us strong? What are we good at doing to keep everyone healthy?
    2. [Keep discussion focused on strengths; if bring up needs, ask to hold until later.]
- On the other hand, what do you think are the 1 or 2 biggest **health needs** in your community; for example, what gets in the way of your families and communities being as healthy as they can be?
    1. [This is a key question, so spend a little time here.]
    2. Did these health needs change because of the COVID pandemic? If so, how – for example, did the needs get better or worse? Did COVID make any new needs or make some needs go away?
    3. [probe if time] Three years ago, we talked to people about their health needs like we are doing with you today. They talked about health needs like: getting healthcare, having enough food, housing, safety, and mental health. There were also two big things that people thought needed to be fixed for everyone in San Francisco to be healthy: poverty and unequal access to healthcare for people in different race and ethnic groups. Do you think all these are still the top health needs? If no, what changed?
- What would you like to see healthcare organizations (like health departments, hospitals-based community services groups, or foundations) do to help with these needs?
    1. [If need clarification on these groups' roles] These groups often have staff dedicated to community outreach, budgets to help communities, and are big enough to make an impact if they all work together with the community.
    2. Would these ideas be the same for everyone?
- What do you think are one or two of the biggest **challenges** to fixing each of these needs?
    1. [If time permits, go through each need: 2019 (access to care, food security, housing, safety, behavioral health, poverty, racial health inequities) + others group mentioned.]
    2. Are these challenges the same for all communities or are there some challenges that are different for your/other communities?

Thank you! Those are all the questions. Is there anything you would like to share?