2022
Community Health Needs Assessment

Sutter Health
Mills-Peninsula
Medical Center

ACKNOWLEDGEMENTS

The Community Health Needs Assessment (CHNA) could not have been completed without the many hours of dedication, tremendous input, and financial support from the hospitals with which Sutter Health Mills-Peninsula Medical Center (MPMC) collaborated. MPMC wishes to acknowledge the following organizations for their representatives' contributions to promoting the health and well-being of San Mateo County:

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  Sharan Johal, Senior Community Benefit Specialist

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  Joey Vaughan, Manager of Community Partnerships
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  Emily Gudaitis, MPH, Community Relations Specialist

- Stanford Health Care
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  Bindi Gandhi, Community Health Director, Bay Area
  Lisa Hom, Community Health Manager, South Bay
  Kayla Gupta, Community Health Coordinator, South Bay

- Sutter Health Palo Alto Medical Foundation
  Lisa Hom, Community Benefit Manager - Bay Medical Foundations, External Affairs

These organizations also collaborated in preparing the 2022 CHNA. In addition, MPMC gratefully acknowledges Actionable Insights, LLC, which prepared this report on behalf of MPMC.

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1. EXECUTIVE SUMMARY

Sutter Health Mills-Peninsula Medical Center (MPMC) is pleased to have produced the 2022 Community Health Needs Assessment (CHNA).

To identify and address the critical health needs of the community, the Healthy Community Collaborative of San Mateo County (HCC) formed in 1995. The HCC brought together representatives of nonprofit hospitals, public health departments, and other local organizations. Every three years between 1995 and 2019, MPMC collaborated with the HCC to conduct an extensive CHNA.

In 2020, a nonprofit healthcare system member of the HCC was acquired by a for-profit company.[1] Beginning in 2021, four of the remaining nonprofit hospitals/healthcare systems across San Mateo and Santa Clara counties,[2] with additional support from the Palo Alto Medical Foundation (a nonprofit multi-specialty group), formed an informal collaborative to conduct a dual-county, triennial CHNA in compliance with current federal requirements. The 2022 CHNA builds upon the earlier assessments.

The goals of the 2022 CHNA are to provide insight into the health of the community, prioritize local health needs, and identify areas for improvement. With this information, the collaborating hospitals will individually and collectively develop strategies to tackle critical health needs as well as improve the overall health and well-being of community members. The assessment findings may also be used as a guideline for funding, policy, and advocacy efforts.

This 2022 CHNA report documents how the current CHNA was conducted, describes the related findings, and shares the results of strategies implemented by MPMC to address the needs identified in 2019 by the previous assessment.

COMMUNITY HEALTH NEEDS ASSESSMENT BACKGROUND

In addition to helping generate shared priorities around community health, the collaborating hospitals also use the 2022 CHNA to fulfill key state and federal mandates, as described below:

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[1] Woo, E. (2020). "AHMC Healthcare finalizes purchase of Seton Medical Center." *San Jose Mercury News.* Retrieved from https://www.mercurynews.com/2020/08/14/ahmc-healthcare-finalizes-purchase-of-seton-medical-center/

[2] The four entities are El Camino Hospital, Lucile S. Packard Children's Hospital Stanford, Stanford Health Care, and Sutter Health.

> California Legislative Senate Bill 697, enacted in 1994, stipulates that private nonprofit hospitals submit an annual report to the Office of Statewide Health Planning and Development that shall include, but shall not be limited to, a description of the activities that the hospital has undertaken to address identified community needs within its mission and financial capacity. Additionally, hospitals shall describe the process by which they involved community groups and local government officials in helping identify and prioritize community needs to be addressed. This community needs assessment shall be updated at least once every three years.[3]
>
> The Patient Protection and Affordable Care Act, enacted March 23, 2010, includes requirements for nonprofit hospitals that wish to maintain their tax-exempt status. Regulations finalized December 31, 2014, also provide guidance related to section 501(r) of the Internal Revenue Code. These regulations mandate that all nonprofit hospitals conduct a CHNA every three years. The CHNA must be conducted by the last day of a hospital's taxable year, and the hospital must make the CHNA report widely available to the public. The CHNA must also gather input from public health experts, local health departments, and community members—including representatives of low-income, medically underserved, or other high-need [i.e., vulnerable[4]] populations.[5]

The CHNA process, completed in fiscal year 2022 and described in this report, was conducted collaboratively by the hospitals in compliance with current state and federal requirements. The 2022 CHNA will serve as the basis for MPMC's implementation strategies to address identified health needs. This CHNA report and associated Implementation Strategy report will be adopted and made public by December 31, 2022. The hospital organization's 2022 Form 990, Schedule H, will be filed on or before the 15th day of the fifth month after the end of the 2022 taxable year.

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[3] California Office of Statewide Health Planning and Development. (1998). Not-for-Profit Hospital Community Benefit Legislation (Senate Bill 697), Report to the Legislature. Retrieved November 2018 from https://oshpd.ca.gov/wp-content/uploads/2018/07/SB-697-Report-to-the-Legislature-Community-Benefit.pdf

[4] California Department of Health Care Access and Information (2022). *HCAI Factsheet Hospital Community Benefits Plans: Vulnerable Populations*. Retrieved from https://hcai.ca.gov/wp-content/uploads/2022/03/Hospital-Community-Benefits-Plans-Program-Vulnerable-Populations-Fact-Sheet-February-2022-ADA.pdf

[5] U.S. Federal Register. (2014). Department of the Treasury, Internal Revenue Service, 26 CFR Parts 1, 53, and 602. Vol. 79, No. 250, December 31, 2014. Retrieved November 2018 from https://www.govinfo.gov/content/pkg/FR-2014-12-31/pdf/2014-30525.pdf

PROCESS AND METHODS

To gather information for its local planning needs and to meet state and federal mandates, the collaborating hospitals took the following approach to complete the 2022 CHNA.

For the purposes of the assessment, "community health" was not limited to traditional health measures. The hospitals also considered indicators relating to the quality of life (e.g., access to healthcare, affordable housing, food security, education, and employment) and to the physical, environmental, and social factors that influence the health of the county's residents. This broader definition reflects the collaborating hospitals' philosophy that many factors affect community health and that community health cannot be adequately understood without consideration of trends outside the realm of healthcare.

To assess community health trends, the hospitals directed their consultant, Actionable Insights (AI), to obtain secondary data from a variety of sources (*see Attachment 2: Secondary Data Indicators for a complete list*). Primary data were obtained through direct community input: (a) interviews with local experts and (b) focus groups with community residents and people who serve residents. These discussions sought to answer four primary questions for each health need identified by interviewees and focus group participants:

- How do you see this need playing out in the community?
- Which populations are experiencing inequities with respect to this need?
- How has this need changed in the past few years; how were things going prior to the pandemic, and how are they going now?

DEFINITIONS

Benchmark: The California state average.

Data source: Either a statistical dataset, such as those found throughout the California Cancer Registry, or a qualitative dataset, such as the material resulting from interviews and focus groups.

Direct indicator: A statistic that explicitly measures a health need. For example, the lung cancer incidence rate is a direct indicator of the cancer health need.

Health condition: A disease, impairment, or other state of poor physical or mental health that contributes to a poor health outcome.

Health indicator: A characteristic of an individual, population, or environment that is subject to measurement (directly or indirectly) and can be used to describe one or more aspects of the health of an individual or a population.

Health need: A poor health outcome and its associated risk(s), or a risk that may lead to a poor health outcome.

Health outcome: A snapshot of a disease/health event in a community that can be described in terms of both morbidity (illness or quality of life) and mortality (death).

- What is needed (including models/best practices) to better address this need?

To determine participants' health priorities, key informants and focus group members voted on their community's needs from a list derived from the previous CHNA. AI then tabulated how many focus groups and key informants chose each health need as a priority.

In the fall of 2021, AI synthesized primary qualitative research and secondary and longitudinal data to create a list of health needs for the collaborating hospitals. AI then filtered that list against a set of criteria to identify the significant needs of the community.

These criteria included:

1. Indicator meets the definition of a "health need." (See Definitions box.)
2. At least two data sources were consulted.
3. Must be prioritized by multiple focus groups or key informants, or two or more direct indicators must:
    a. exhibit documented inequities by race; or
    b. show worsening trends; or
    c. fail the benchmark by 5 percent or more.

Senior leadership of Mills-Peninsula Medical Center (MPMC) reviewed the list of identified community health needs and, based on their knowledge and experience working with the community, separated the needs into two priority categories based on their importance. Their review and consensus prioritization produced MPMC's final list of 2022 Prioritized Health Needs.

PRIORITIZED 2022 COMMUNITY HEALTH NEEDS

Based on the previously described process and methods, AI and MPMC produced a list of the most pressing health needs for the hospital, separated into highest and moderate priority groups. The 2022 prioritized health needs, categorized by priority and listed alphabetically within each priority group, are:

Highest Priority

- **Behavioral Health:** The community prioritized behavioral health, including mental health and substance use, in most focus groups and nearly all key informant interviews. The pandemic's negative effect on mental health was one of the strongest themes from the qualitative data. Statistics suggest that youth mental health is an issue: for example, the self-harm injury hospitalization rate for youth ages 0-17 is significantly higher than the state's rate. In addition, drug overdose mortality has been rising overall in San Mateo County. There are disparities associated with behavioral health, including suicidal ideation and drug overdose deaths. Racism and discrimination as well as fear and mistrust of treatment pose barriers to BIPOC community members seeking help for behavioral health issues.
- **Economic Security:** The community placed a high priority on economic security, including income, education, and food security. Nearly one-third of Silicon Valley households are not meeting economic self-sufficiency standards. COVID created more economic insecurity for those who lost work and specifically impacted low-income essential workers, many of whom were Latinx and/or undocumented. Key informants and focus group participants mentioned that county residents often lost childcare during the pandemic, which affected their ability to work. Education generally correlates with income; thus, educational statistics that differ by race/ ethnicity are particularly concerning, such as the county's lower proportions of BIPOC students who met or exceeded English-language arts and math standards, and who completed college-preparatory courses.
- **Healthcare Access & Delivery:** Most key informants and focus group participants identified access and delivery as a priority health need. They felt there was a lack of access to primary and specialty care, especially for middle- and low-income community members and for youth. San Mateo County residents who are BIPOC experience significantly worse health than residents of other races, such as preventable hospital stays, which may be a sign of inequitable access to high-quality care. Experts indicated that they had mixed experiences with telehealth, which rose substantially during the pandemic. While telehealth can overcome transportation barriers, experts worried about the digital divide and patients' lack of privacy. The need for healthcare workforce training to deliver care in a sensitive manner was another common theme among key informants and focus group participants.
- **Housing & Homelessness:** More than half of all focus groups identified housing and homelessness as a top community priority. Housing costs and other costs of living in San Mateo County are extremely high. Most feedback about housing from key informants and

focus group participants concerned housing affordability, which is worse in the county than the state. CHNA participants said high housing costs are driving out-migration as well as overcrowding, the latter of which they noted can contribute to the spread of infectious diseases, including COVID. The county's homelessness numbers also rose in 2019 (the most recent homeless count).

Moderate Priority

- **Cancer:** Mortality rates for cancer in San Mateo County are better than state benchmarks. However, indicators of concern include rates of breast cancer incidence, prostate cancer incidence, childhood cancer incidence, and rising prostate cancer mortality. There are socioeconomic and racial/ethnic disparities in cancer detection, treatment, and outcomes, which the National Cancer Institute attributes to a variety of factors, including institutional racism and conscious or unconscious bias among care providers, as well as barriers such as low income, low health literacy, lack of insurance, and lack of transportation.
- **Climate/Natural Environment:** Climate issues have risen to the fore over the past three years, including climbing temperatures, more extreme weather, flooding, and wildfires. San Mateo County is at significantly greater risk of heat waves, as well as coastal and river flooding, than the state as a whole. Poor air quality may also be increasing asthma prevalence in the county. Both focus group participants and key informants mentioned the adverse effects of environmental issues, particularly on low-income and BIPOC individuals, not only related to physical health but also with regard to the mental and financial stress of evacuation due to floods or wildfires.
- **Community Safety:** Community safety includes violent crime, domestic violence, and other forms of intentional injury. While many community safety statistics are better in San Mateo County than the state, the rate of rape in Silicon Valley is higher than the state. The homicide rate among the county's Black population is also higher than the state rate, which may, in part, be attributed to residential segregation. Among the county's youth, bullying and harassment, including cyberbullying, are worse than state rates, especially for BIPOC youth. Some experts expressed concern about COVID-related stress contributing to domestic violence and/or sexual abuse; one mentioned that virtual visits made it harder for patients experiencing domestic violence to obtain both confidentiality and safety.
- **Diabetes & Obesity:** Although diabetes deaths appear to be trending down in San Mateo County, the trend for adult obesity has been worsening. The lack of physical activity was cited as a driver of obesity by multiple key informants, primarily in the context of the pandemic's interference with regular activities; related to this issue, the walkability index is worse for the county than the state overall. The county's BIPOC middle- and high-

schoolers are much less likely to meet healthy body composition and fitness standards than middle- and high-school students statewide. The American Diabetes Association has suggested that racism is a root cause for disparities in diabetes outcomes in minority populations.

- **Maternal & Infant Health:** Most maternal and infant health statistics in both counties are better than state benchmarks. However, inequities in maternal and infant health exist: For example, teen births are significantly higher among young Latinas in the county compared to their peers statewide. CHNA participants felt that BIPOC people who are pregnant or have recently given birth need improved access to care. A maternal and child health expert indicated that these inequities may also be traced back not only to healthcare access and delivery barriers but also to social determinants of health such as racism.
- **Sexually Transmitted Infections:** Although statistics on sexually transmitted infections are better than the state for San Mateo County, there are concerning trends, including the rate of syphilis and the rate of chlamydia incidence among youth. The Centers for Disease Control and Prevention suggest that income inequality, poverty, lack of employment, relative lack of education, and distrust of the healthcare system (whether due to shame or stigma, experience or fear of discrimination, or other reasons) affect the ability of individuals to remain sexually healthy.
- **Unintended Injuries/Accidents:** One expert noted an increase in falls among older adults, although San Mateo County's statistics are not worse than the state's. Road network density and traffic volume were both significantly higher in the county than state averages. One consequence of high traffic volume can be motor vehicle, bicycle, and pedestrian accidents. Racial inequities in accident rates have been found nationwide, and are attributed in part to unequal access to safe transportation.

Further details on each prioritized health need, including statistical data, are included in the complete 2022 CHNA report.

NEXT STEPS

After making this CHNA report publicly available by December 31, 2022, Mills-Peninsula Medical Center will solicit feedback and comments about the report until two subsequent CHNA reports are posted. The hospital will also develop an implementation plan based on the 2022 CHNA results; the plan must be adopted by the Sutter Health board and made public by May 15, 2023.

2. INTRODUCTION & BACKGROUND

Sutter Health Mills-Peninsula Medical Center (MPMC) is pleased to have produced the 2022 Community Health Needs Assessment (CHNA).

To identify and address the critical health needs of the community, the Healthy Community Collaborative of San Mateo County (HCC) formed in 1995. The HCC brought together representatives of nonprofit hospitals, public health departments, and other local organizations. Every three years between 1995 and 2019, MPMC collaborated with the HCC to conduct an extensive CHNA.

In 2020, a nonprofit healthcare system member of the HCC was acquired by a for-profit company.[6] Beginning in 2021, four nonprofit hospitals/healthcare systems across San Mateo and Santa Clara counties,[7] with additional support from the Palo Alto Medical Foundation (a nonprofit multi-specialty group), formed an informal collaborative to conduct an extensive, dual-county, triennial Community Health Needs Assessment (CHNA) in compliance with current state and federal requirements (see details below). Although not required, the benefits of collaborating on the CHNA are multifold, including the leveraging of various sets of knowledge, shared understanding of health needs in our service area, and reduced burden on the community for participation in the assessment.

CHNA PURPOSE

The goals of the 2022 CHNA are to provide insight into the health of the community, prioritize local health needs, and identify areas for improvement. With this information, the collaborating hospitals will individually and collectively develop strategies to tackle critical health needs as well as improve the health and well-being of community members. The assessment findings may also be used as a guideline for funding, policy, and advocacy efforts.

The 2022 CHNA builds upon the findings of the 2019 CHNA (see Section 8: Evaluation Findings from 2016–2018 Implemented Strategies) and previous assessments (1995, 1998, 2001, 2004, 2008, 2011, 2013, and 2016). The 2022 report documents how the current CHNA was conducted

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[6] Woo, E. (2020). "AHMC Healthcare finalizes purchase of Seton Medical Center." *San Jose Mercury News.* Retrieved from https://www.mercurynews.com/2020/08/14/ahmc-healthcare-finalizes-purchase-of-seton-medical-center/

[7] The four entities are El Camino Hospital, Lucile S. Packard Children's Hospital Stanford, Stanford Health Care, and Sutter Health.

and describes the related findings. As with prior CHNAs, this assessment also highlights San Mateo County's assets and resources (see Section 7: Community Resources).

Note that, for the purposes of this assessment, "community health" was not limited to traditional health measures. The collaborating hospitals also considered indicators relating to the quality of life (e.g., access to healthcare, affordable housing, food security, education, and employment) and to the physical, environmental, and social factors that influence the health of the county's residents. This broader definition reflects the hospitals' philosophy that many factors affect community health and that community health cannot be adequately understood without consideration of trends outside the realm of healthcare.

In addition to helping generate shared priorities around community health, the collaborating hospitals also use the 2022 CHNA to fulfill key state and federal mandates.

SB697 AND CALIFORNIA'S HISTORY OF ASSESSMENTS

California Legislative Senate Bill 697, enacted in 1994, stipulates that private nonprofit hospitals submit an annual report to the Office of Statewide Health Planning and Development that shall include, but shall not be limited to, a description of the activities that the hospital has undertaken to address identified community needs within its mission and financial capacity. Additionally, the hospital shall describe the process by which they involved the community (community groups and local government officials) in helping identify and prioritize community needs to be addressed. This community needs assessment shall be updated at least once every three years.[8]

PATIENT PROTECTION AND AFFORDABLE CARE ACT

The 2019 CHNA will serve in meeting Internal Revenue Service (IRS) CHNA requirements pursuant to The Patient Protection and Affordable Care Act. The Affordable Care Act, enacted March 23, 2010, includes requirements for nonprofit hospitals that wish to maintain their tax-exempt status. Regulations finalized December 31, 2014, also provide guidance related to section 501(r) of the Internal Revenue Code. These regulations mandate that all nonprofit hospitals conduct a CHNA every three years. The CHNA must be conducted by

[8] California Office of Statewide Health Planning and Development. (1998). Not-for-Profit Hospital Community Benefit Legislation (Senate Bill 697), Report to the Legislature. Retrieved from https://oshpd.ca.gov/wp-content/uploads/2018/07/SB-697-Report-to-the-Legislature-Community-Benefit.pdf

the last day of a hospital's taxable year, and hospitals must make the CHNA report widely available to the public.

The CHNA report must document how the assessment was conducted, including the community served, who was involved in the assessment, the process and methods used, and the significant community health needs that were identified and prioritized as a result of the assessment. The CHNA must also gather input from public health experts, local health departments, and community members—including representatives of low-income, medically underserved, or other high-need [i.e., vulnerable[9]] populations.[10]

The CHNA process, completed in fiscal year 2022 and described in this report, was conducted collaboratively by MPMC and other hospitals in compliance with current state and federal requirements. The 2022 CHNA will serve as the basis for implementation strategies to serve identified health needs. This CHNA report and associated Implementation Strategy report will be adopted and made public by December 31, 2022. The hospital organization's 2022 Form 990, Schedule H, will be filed on or before the 15th day of the fifth month after the end of the 2023 taxable year.

SUMMARY OF THE 2019 CHNA

In 2019, Mills-Peninsula Medical Center participated in a collaborative process to identify significant community health needs and to meet IRS and SB 697 requirements. During the CHNA process, 10 needs were identified. MPMC addressed the following four needs in its 2019–2021 implementation strategies:

1. Healthcare Access and Delivery
2. Mental Health and Well-Being
3. Oral/Dental Health
4. Housing and Homelessness

[9] California Department of Health Care Access and Information (2022). *HCAI Factsheet Hospital Community Benefits Plans: Vulnerable Populations*. Retrieved from https://hcai.ca.gov/wp-content/uploads/2022/03/Hospital-Community-Benefits-Plans-Program-Vulnerable-Populations-Fact-Sheet-February-2022-ADA.pdf

[10] U.S. Federal Register. (2014). Department of the Treasury, Internal Revenue Service, 26 CFR Parts 1, 53, and 602. Vol. 79, No. 250, December 31, 2014. Retrieved from https://www.govinfo.gov/content/pkg/FR-2014-12-31/pdf/2014-30525.pdf

The full 2019 CHNA report is posted on Sutter Health's website.[11]

WRITTEN PUBLIC COMMENTS TO THE 2019 CHNA

To offer the public a means to review and provide written feedback on the 2019 CHNA, Sutter Health posted a PDF of the Mills-Peninsula Medical Center report and solicited comments on the Community Health Needs Assessment page of its website.[12] Sutter Health also accepts input at the email address SHCB@sutterhealth.org. The website and email address will allow for written public comments on the 2022 CHNA as well.

At the time the 2022 CHNA report was completed, Sutter Health had not received any written comments about the 2019 CHNA report. Sutter Health will continue to track submissions and ensure that all relevant comments are reviewed and addressed by appropriate staff.

[11] https://www.sutterhealth.org/pdf/for-patients/chna/mpmc-2019-chna.pdf

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

3. ABOUT MILLS-PENINSULA MEDICAL CENTER

Mills-Peninsula Medical Center (MPMC) and its Menlo Park Surgical Hospital (MPSH) campus are affiliated with Sutter Health, a not-for-profit network of hospitals, physicians, employees, and volunteers who care for more than 100 Northern California towns and cities. Together, the hospitals are creating a more integrated and affordable approach to caring for patients.

Sutter Health's mission is to enhance the well-being of people in the communities it serves through a not-for-profit commitment to compassion and excellence in healthcare services.

In 2021, Sutter Health committed nearly $900 million to care for patients who couldn't afford to pay, and to support programs that improve community health, including unreimbursed costs of providing care to Medi-Cal patients, traditional charity care, and investments in health education and public benefit programs. For example: In 2021, Sutter Health invested $557 million more than the state paid to care for Medi-Cal patients. Sutter Health proudly serves more Medi-Cal patients in its Northern California service area than any other healthcare provider.

As the number of insured people grows, hospitals across the U.S. continue to experience a decline in the provision of charity care. In 2021, Sutter Health's investment in charity care was $91 million.

Throughout its healthcare system, Sutter Health partners with and supports community health centers to ensure that those in need have access to primary and specialty care. Sutter Health also supports food banks, youth education, job training programs, and services that provide counseling to domestic violence victims.

Every three years, Sutter Health hospitals participate in a comprehensive and collaborative Community Health Needs Assessment, which identifies local healthcare priorities and guides community benefit strategies. The assessments help ensure that MPMC invests community benefit dollars in a way that targets and addresses real community needs.

More information about Mills-Peninsula Medical Center[13] and the Menlo Park Surgical Hospital (MPSH) campus[14] is available on the Sutter Health website.

[13] https://www.sutterhealth.org/mills

[14] https://www.sutterhealth.org/menlo

COMMUNITY BENEFITS

Everyone deserves access to high-quality healthcare. Each year, Sutter Health invests in partnerships in its local community. MPMC helps to provide care for people without health insurance, to bolster the services offered by other local healthcare facilities, and to extend vital programs and services for underserved populations and the broader community. Meeting the healthcare needs of the whole community, including people with economic or other barriers to access, is a cornerstone of MPMC's not-for-profit mission.

MPMC community benefit programs and activities address critical health needs identified in its service area. The programs provide treatment and/or otherwise promote the health and well-being of community members by building partnerships and collaborating with local nonprofit organizations; offering educational programs; conducting research; and providing monetary grants to nonprofits focused on community clinics, senior adult or LGBTQI programs, or healthcare interventions for underserved and/or uninsured populations.

COMMUNITY SERVED

The collaborating hospitals relied on the Internal Revenue Service's definition of the community served by a hospital as "those people living within its hospital service area." A hospital service area comprises all residents in a defined geographic area and does not exclude low-income, underserved, or otherwise vulnerable populations. MPMC and its MPSH campus are located in San Mateo County and serve the entire county.

San Mateo County comprises 19 cities and more than two dozen unincorporated towns and areas. The county had approximately 746,752 residents in 2019. The county occupies 455 square miles of land on the peninsula south of San Francisco, with the San Francisco Bay to the east and the Pacific Ocean to the west. The county also includes nearly 58 miles of coastline and 292 square miles of water.[15] Redwood City is the largest city in the county by area, and Daly City is San Mateo County's largest city by population, with just over 106,000 people (14% of the county's total). The population of the county is substantially more dense than the state, with 9,206 people per square mile compared to 8,486 per square mile in California. The median age in San Mateo County is 40.3 years old. Over 20% of the county's residents are under the age of 18, and nearly 16% are 65 years or older.[16]

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[15] County of San Mateo. 2015–2017 County Profile.

[16] Census data in prior paragraph from https://www.census.gov/quickfacts.

Main Regions, Cities, and Towns in San Mateo County

North County	Mid-County	South County	Coastside
Brisbane	Belmont	Atherton	Half Moon Bay
Colma	Burlingame	East Palo Alto	
Daly City	Foster City	Menlo Park	
Millbrae	San Carlos	Portola Valley	
Pacifica	San Mateo	Redwood City	
San Bruno		Woodside	
South San Francisco			

San Mateo County also includes the following unincorporated towns and areas, many of which are located in the Coastside area: Broadmoor, Burlingame Hills, Devonshire, El Granada, Emerald Lake Hills, Fair Oaks, Highlands/Baywood Park, Ladera, La Honda, Loma Mar, Los Trancos Woods/Vista Verde, Menlo Oaks, Montara, Moss Beach, North Fair Oaks, Palomar Park, Pescadero, Princeton, San Francisco International Airport, San Gregorio, South Coast/Skyline, Sequoia Tract, Skylonda, Stanford Lands, and West Menlo Park.[17]

(See map on the next page.)

[17] San Mateo County Assessor-County Clerk-Recorder and Chief Elections Officer. (2015). *Roster of Towns and Cities Located in San Mateo County.*

Hospital Primary Service Area Map

The ethnic makeup of San Mateo County is extremely diverse, with the non-white population representing about 62% of its total population.

Race/Ethnicity in Hospital Service Area

Race/Ethnicity	San Mateo County Total Percent of County (Alone or in Combination with Other Races)*
American Indian/Alaskan Native	0.1%
Asian	30.1%
Black	2.2%
Hispanic/Latinx	24.2%
Pacific Islander/Native Hawaiian	1.3%
White	37.8%
Multiracial	4.0%
Some Other Race	0.4%

Source: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2015–2019.
*Percentages do not add to 100% because they overlap.

More than 34% of residents in San Mateo County are foreign-born. This percentage is higher than the foreign-born populations statewide (27%) and nationwide (14%).[18]

Our community earns some of the highest annual median incomes in the U.S., but also bears some of the highest costs of living. Median household income is $130,820 in San Mateo County, far higher than California's median of $82,053.[19] Yet the California Self-Sufficiency Standard,[20] set by the Insight Center for Community Economic Development, suggests that many households in San Mateo County are unable to meet their basic needs.[21] (The Standard in 2021 for a family with

[18] Data from https://www.census.gov/quickfacts

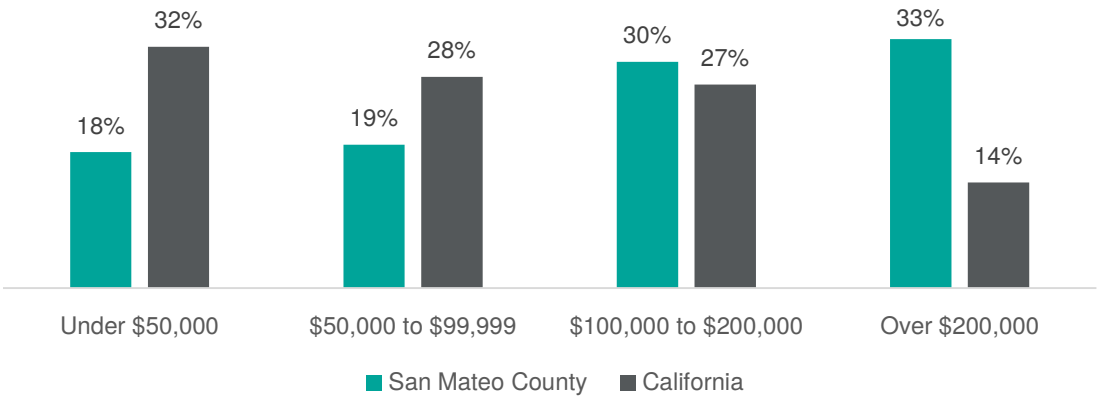
[19] U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2015–2019.

[20] The Federal Poverty Level, the traditional measure of poverty in a community, does not take into consideration local conditions such as the high cost of living in the San Francisco Bay Area. The California Self-Sufficiency Standard provides a more accurate estimate of economic security in San Mateo County.

[21] Center for Women's Welfare, University of Washington. (2021). *Self-Sufficiency Standard Tool.* "Family" is considered as two adults, one infant and one school-age child. http://www.selfsufficiencystandard.org/node/44

two children was $166,257 in San Mateo County County.) The minimum wage in San Mateo County[22] was $14–$15.90 per hour in 2021, where self-sufficiency requires an estimated $34–$39 per hour. California Self-Sufficiency Standard data show a 26% increase in the cost of living in San Mateo County between 2018 and 2021, while the U.S. Bureau of Labor Statistics reports only a 3.3% per year average increase in wages in the San Jose-San Francisco-Oakland combined statistical area (which includes San Mateo County) between 2019 and 2021.

Area Household Income Ranges



Source: Census Reporter, https://censusreporter.org/profiles (American Community Survey, 2015–2019).

Housing costs are high: In 2021, the median home price was $1.6 million[23] and the median rent was $2,451 in San Mateo County. In San Mateo County, 26% of the children are eligible for free or reduced-price lunch and close to one quarter (22%) of children live in single-parent households. About 4% of people in our community are uninsured.

Judging by the Neighborhood Deprivation Index, a composite of 13 measures of social determinants of health such as poverty/wealth, education, employment, and housing conditions, the county's population overall is healthier than the national average.[24] Although San Mateo

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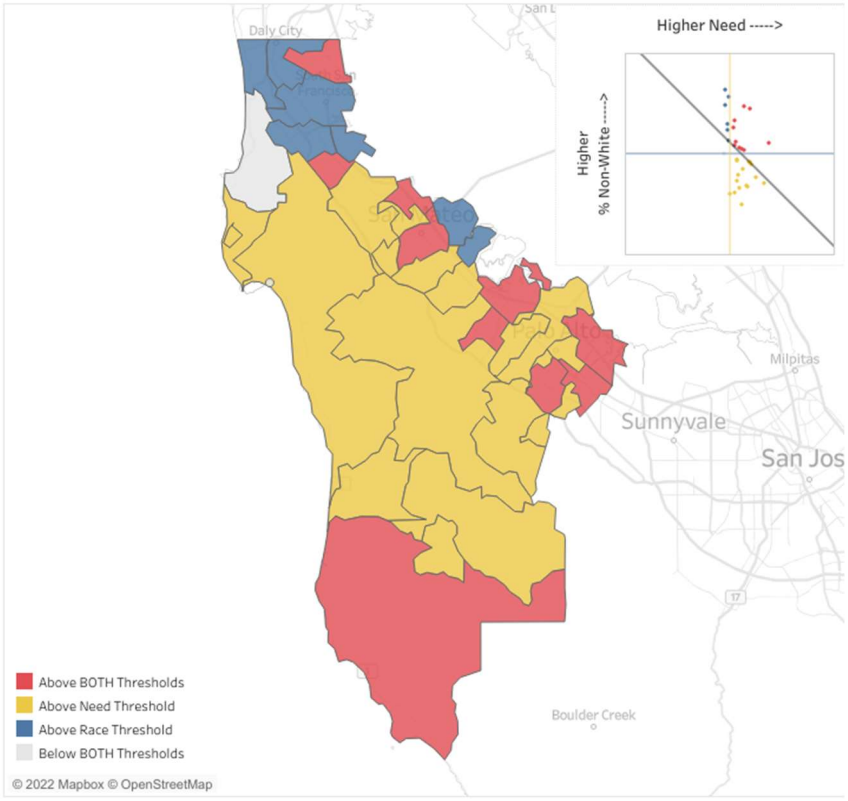
[22] Bay City News Foundation. (2021). Several San Mateo County cities hike minimum wage for 2021. *The Daily Journal.* Retrieved from https://www.smdailyjournal.com/news/local/several-san-mateo-county-cities-hike-minimum-wage-for-2021/article_47e4717a-4f0b-11eb-ac74-6fa7c18ed062.html

[23] Redfin. (2021.) *San Mateo County Housing Market.* Retrieved from https://www.redfin.com/county/343/CA/San-Mateo-County/housing-market

[24] The Neighborhood Deprivation Index consists of 13 indicators and ranges from -3.5 to 3.5; scores above zero are considered worse. The U.S. is scored at 0.0, while San Mateo County is scored at -0.8. For more information, see originators: Messer, L.C., Laraia, B.A., Kaufman, J.S., Eyster, J., Holzman, C., Culhane, J., Elo, I., Burke, J.G. & O'Campo, P. (2006). The development of a standardized neighborhood deprivation index. *Journal of Urban Health*, 83(6):1041-1062. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3261293/

County is quite diverse and has substantial resources (see *Attachment 3: Assets and Resources*), there is significant inequality in its population's social determinants of health and health outcomes. For example, the Gini Index, a measure of income inequality[25], is higher in certain Zip Codes compared to others (see map below).

Correlation Between Income Inequality & Non-White Population, By Zip Code



Note: Parts of San Mateo County exhibit income inequality (red and yellow areas). In many places where income inequality is high, non-white community members are also in the majority (red areas). "Need Threshold" is the U.S. Gini Index, 0.4. "Race Threshold" is 50% non-white.

Certain areas also have poorer access to high speed internet (e.g., Zip Codes 94305, 94074), or to walkable neighborhoods (e.g., Zip Codes 94021, 94060, 94074), or jobs (e.g., Zip Codes 94014, 94015, 94044). In our assessment of the health needs in our community, we focus particularly on disparities and inequities within our community rather than simply in comparison to California or the nation as a whole.

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[25] The Gini index "measures the extent to which the distribution of income… among individuals or households within an economy deviates from a perfectly equal distribution." Zero is absolute equality, while 100 is absolute inequality. Organisation for Economic Co-operation and Development (OECD). (2006). *Glossary of Statistical Terms*. Retrieved from https://stats.oecd.org/glossary/detail.asp?ID=4842

4. ASSESSMENT TEAM

HOSPITALS AND OTHER PARTNER ORGANIZATIONS

The following health systems and organizations collaborated to prepare the 2022 CHNA:

- El Camino Health
- Lucile Packard Children's Hospital Stanford
- Stanford Health Care
- Sutter Health (including Menlo Park Surgical Hospital, Mills-Peninsula Medical Center, and Palo Alto Medical Foundation)

IDENTITY AND QUALIFICATIONS OF CONSULTANTS

Actionable Insights, LLC, an independent local research firm, completed the CHNA.

For this assessment, AI assisted with CHNA planning, conducted primary research, collected secondary data, synthesized primary and secondary data, facilitated the processes of identifying community health needs and assets, and documented the processes and findings into a report.

The project managers for this assessment were Melanie Espino and Jennifer van Stelle, PhD, the co-founders and principals of Actionable Insights (AI). AI conducted community health needs assessments for seven hospitals during the 2021–2022 CHNA cycle. More information about Actionable Insights is available on the company's website.[26]

[26] https://actionablellc.com/

5. PROCESS AND METHODS

The hospitals and health systems listed in Section 4 formed an informal collaborative to work together to fulfill the primary and secondary data requirements of the CHNA. The CHNA data collection process took place over ten months in 2021 and culminated in this report. The phases of the CHNA process are depicted below and described in this section.

The members of this collaborative contracted Actionable Insights (AI) to collect primary qualitative data — through key informant interviews and focus groups — and secondary qualitative and statistical data. Together, AI and the members of the informal collaborative ("the study team") conducted the assessment.

SECONDARY DATA COLLECTION

Data sources were selected to understand general county-level health, specific vulnerable populations, and to fill previously identified information gaps. Also, data on potential health disparities by sub-county geographic area and ethnicity were analyzed. These data were used to inform our health needs lists.

The team collected and analyzed over 250 quantitative health indicators from existing sources using the public Community Health Data Platform sponsored by Kaiser Permanente and other online sources, such as KidsData.com, the California Department of Public Health and the U.S. Census Bureau, as well as the two county public health departments. Findings from the previous community health needs assessment (2019), reports from Joint Venture Silicon Valley, and available sub-county data (cities and neighborhoods) were also used whenever available to increase understanding of the health needs in San Mateo County and to assess priorities in the community.

For the CNHA, local data were compared to state benchmarks (California averages and rates) to help determine the severity of a health problem and to identify disparities. The following questions were asked:

- How do these indicators perform against accepted benchmarks?
- What are the inequitable outcomes and conditions for people in our community?

PRIMARY DATA COLLECTION (COMMUNITY INPUT)

The study team designed three strategies for collecting community input: key informant interviews with health experts and community service experts, focus groups with professionals who represent and/or serve the community or residents, and a dual-county focus group with community members. Individuals representing vulnerable[27] populations (including low-income, minority, and medically underserved) were included.[28]

To ensure consistency across every interview and focus group, the study team generated research protocols. The study team sought to build upon prior CHNAs by focusing the primary research on topics and subpopulations that are less well understood by the statistical data. For example, the experiences of the Black population in San Mateo County are often obscured by statistics that represent an entire county's population rather than the Black population as a particular sub-group. The 2022 study team specifically convened a focus group of Black professionals to better understand through this primary qualitative research.

Actionable Insights conducted the key informant interviews and focus groups for this assessment. AI recorded each interview and focus group. Recordings were transcribed and qualitative research software tools were used to analyze the transcripts for common themes. AI also tabulated how many times health needs were prioritized by each of the focus groups or described as a priority in a key informant interview. The study team used this tabulation to help assess community health priorities.

In all, the study team solicited input from nearly 100 community members, community leaders, and representatives of various organizations and sectors. These representatives either work in the health field or in a community-based organization that focuses on improving health and quality of life conditions by serving those from vulnerable populations.

Key Informant Interviews

In March and April 2021, Actionable Insights spoke with nine experts from various organizations in San Mateo County.[29] Interviews were conducted virtually via Zoom for approximately one hour. Prior to each interview, participants were asked to complete a short online survey, in which they

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[27] California Department of Health Care Access and Information (2022). *HCAI Factsheet Hospital Community Benefits Plans: Vulnerable Populations*. Retrieved from https://hcai.ca.gov/wp-content/uploads/2022/03/Hospital-Community-Benefits-Plans-Program-Vulnerable-Populations-Fact-Sheet-February-2022-ADA.pdf

[28] The IRS requires that community input include the low-income, minority, and medically underserved populations.

[29] One interviewee represented an organization that works in both San Mateo and Santa Clara counties.

were asked to identify the health needs they felt were the most pressing among the people they serve. Interviewees could choose up to three needs from the list of needs presented to them, which had been identified in one or both counties in 2019, or could write in needs that were not on the combined 2019 list. Also in the survey, participants were advised of how their interview data would be used and were asked to consent to be recorded.[30] Finally, participants were offered the option of being listed in the report and were asked to provide some basic demographic information (also optional).

The discussions centered around four questions for each health need that was prioritized by interviewees:

- How do you see this need playing out in the community?
- Which populations are experiencing inequities with respect to this need?
- How has this need changed in the past few years; how were things going prior to the pandemic, and how are they going now?
- What is needed (including models/best practices) to better address this need?

AI sent a similar survey to focus group participants, and asked focus groups the same questions during discussion (modified appropriately for each audience).[31] Focus group discussions centered on the needs that had received the most votes from prospective participants in the online pre-survey. *See Attachment 4: Qualitative Research Protocols for complete protocols and questions, including pre-surveys. See Attachment 1: Community Leaders, Representatives, and Members Consulted for a list of key informants and focus group or interview details.*

Focus Groups

AI conducted seven focus groups in San Mateo and Santa Clara counties[32] with a total of 76 professionals and four residents between April and June 2021. Study group members and/or nonprofit hosts recruited participants for the groups. The questions were the same as those asked of key informants.

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[30] Only individuals who consented to be recorded were interviewed.

[31] Only individuals who consented to be recorded were included in focus groups. To preserve their anonymity, community members who participated in the clinic patients focus group were not offered the option of being listed in the report.

[32] The sets of participants in dual-county focus groups were balanced to represent communities in both San Mateo and Santa Clara counties.

List of Focus Groups Conducted for CHNA 2022

Topic	Focus Group Host/Partner	Date	Number of Participants
Adult mental/behavioral health	El Camino Health & Sutter Health	4/12/2021	13
Health equity	Stanford Health Care	4/14/2021	10
Safety net clinics and their patients	Stanford Health Care & Sutter Health	4/26/2021	12
Youth mental health	Lucile S. Packard Children's Hospital-Stanford	4/29/2021	12
San Mateo County social services	Samaritan House	5/12/2021	10
Health of safety net clinic patients*	Gardner Health Services	6/7/2021	4
Black health	Bay Area Community Health Advisory Council (BACHAC)	6/14/2021	7

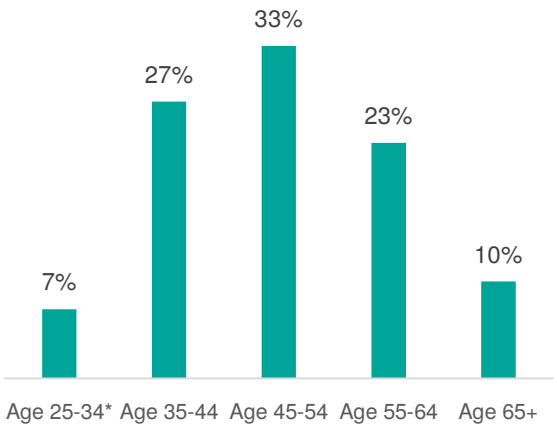
* Indicates resident/community member group.

CHNA Participant Demographics

A total of 77 people participated in focus groups or interviews for the CHNA. More than three out of every four (77%) participated in dual-county research (i.e., represented both San Mateo and Santa Clara counties). The remainder (23%) represented San Mateo County only.

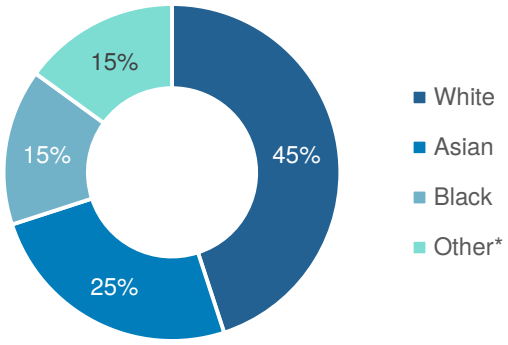
The charts on the next page show the age ranges of participants, as well as their race; note that individuals could choose more than one race (N=73). One in five participants (20%) were of Hispanic/Latinx ethnicity (N=75). Over two-thirds of participants (69%) identified as female, with the rest identifying as male (N=75). On average, participants were aged 49 (N=73).

Participant Age Groups



* One participant was 24 years of age.

Participant Racial Groups



* "Other" includes American Indian/AK Native & Native HI/Pacific Islander.

INFORMATION GAPS AND LIMITATIONS

A lack of data limited our ability to fully assess some health issues that were identified as community needs during the 2022 CHNA process. Conducting the 2022 CHNA presented unique challenges for data collection:

1. As was the case across the nation due to the COVID-19 pandemic, public health departments' epidemiologists lacked sufficient resources to conduct data analyses in the same way they had in years past. This affected our ability to assess data on infectious diseases, cancer, etc.
2. Our CHNA, as it has since 2012, employed data from the publicly available Kaiser Permanente Community Health Needs Dashboard. As of 2021, the platform no longer provides data breakdowns by race/ethnicity and instead simply offers correlations between race and poor health outcomes (which are presented in this report).

In both cases, when current data were lacking, Actionable Insights relied on data from our previous CHNA.

3. Finally, because of the pandemic, it was not safe to bring community members together in person. Moreover, while it was possible to conduct focus groups and interviews virtually (i.e., via Zoom), the most vulnerable community members often did not have access to the technology needed for a virtual meeting. Also, nonprofit partners advised that the

community was severely stressed (financially and emotionally) by the pandemic and felt it was inappropriate to burden them with CHNA data collection requests. Although Actionable Insights was able to conduct one focus group with safety net clinic patients, in order to best represent the perspectives and experiences of low-income, minority, underserved, and other vulnerable community members during the pandemic, they spoke with a wide array of nonprofit staff who work with vulnerable populations. We acknowledge this as a limitation in our 2022 CHNA data.

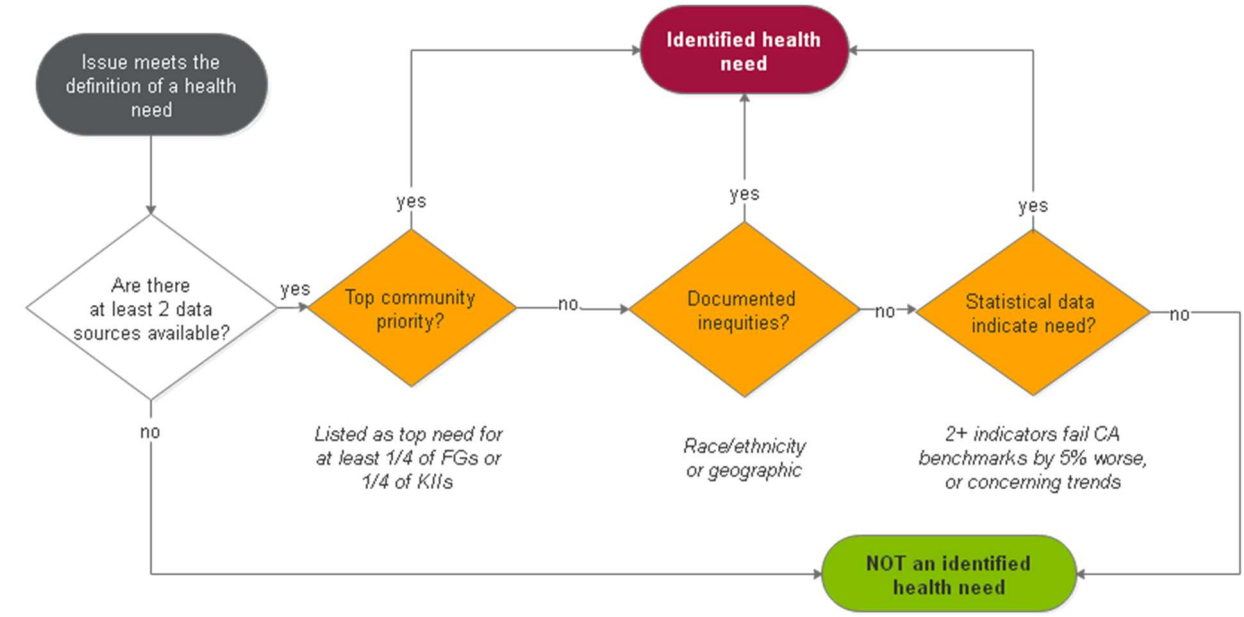
Lastly, some indicators are difficult to measure or are just emerging. Statistical information related to these topics was scarce:

- Youth cigarette and e-cigarette use
- Recent marijuana use and related behavioral health data
- Domestic violence and related community safety data
- Impact of social media on adolescent mental health
- Cognitive decline data, including Alzheimer's Disease prevalence rate and hospice admissions for dementia
- Caregiver impact data (unpaid care, health effects)
- Oral health data
- Data on experiences of discrimination
- Data breakdowns by income/socioeconomic status
- Data on economic inequities within key zip codes

6. IDENTIFICATION AND PRIORITIZATION OF COMMUNITY HEALTH NEEDS

In the analysis of quantitative and qualitative data, many health issues surfaced. To be identified as one of the community's prioritized health needs, an issue had to meet certain criteria, as depicted in the diagram and described below. (See Definitions box on the next page for terms and definitions.)

What goes on the list?
Sutter Health's health needs criteria (decision tree)



To be identified as one of the community's prioritized health needs, an issue had to meet the following criteria:

1. Fits the definition of a "health need." (See Definitions box, next page.)
2. At least two data sources were consulted.
3. Must be prioritized by multiple focus groups or key informants, or two or more direct indicators must:
    a. exhibit documented inequities by race; or
    b. show worsening trends; or
    c. fail the benchmark by 5 percent or more.

Actionable Insights (AI) analyzed secondary data and qualitative data from focus groups and key informant interviews on a variety of health and health-related issues. In the fall of 2021, AI then synthesized the data for each issue and applied the criteria described on the previous page to evaluate whether it qualified as a significant community health need.

This process led to the identification of 11 community health needs that fit all three criteria. The list of needs, in priority order, appears on the next page, followed by summarized descriptions.

(For further details about each of these health needs, see Section 6, Identification and Prioritization of Community Health Needs.)

PRIORITIZATION OF HEALTH NEEDS

The IRS CHNA requirements state that hospitals must identify and prioritize significant health needs of the community. As described in Section 5: Process and Methods, Actionable Insights solicited qualitative input from focus groups and interview participants about which needs they thought were the highest priority (most pressing). AI and the collaborating hospitals used this input to identify the significant health needs listed in this report. Therefore, the health needs list itself reflects the health priorities of the community.

HOSPITAL PRIORITIZATION PROCESS AND RESULTS

Senior leadership of Mills-Peninsula Medical Center (MPMC) reviewed the list of identified community health needs and, based on their knowledge and experience working with the community, separated

DEFINITIONS

Benchmark: The California state average.

Data source: Either a statistical dataset, such as those found throughout the California Cancer Registry, or a qualitative dataset, such as the material resulting from interviews and focus groups.

Direct indicator: A statistic that explicitly measures a health need. For example, the lung cancer incidence rate is a direct indicator of the cancer health need.

Health condition: A disease, impairment, or other state of poor physical or mental health that contributes to a poor health outcome.

Health indicator: A characteristic of an individual, population, or environment that is subject to measurement (directly or indirectly) and can be used to describe one or more aspects of the health of an individual or a population.

Health need: A poor health outcome and its associated risk(s), or a risk that may lead to a poor health outcome.

Health outcome: A snapshot of a disease/health event in a community that can be described in terms of both morbidity (illness or quality of life) and mortality (death).

the needs into two priority categories based on their importance. Their review and consensus prioritization produced MPMC's final list of 2022 Prioritized Health Needs.

Based on the process described above, MPMC prioritized the following 11 health needs, which are categorized by priority and listed alphabetically within each priority group. Summary descriptions of each health need appear below and on subsequent pages.

Highest Priority

- Behavioral Health
- Economic Security
- Healthcare Access and Delivery
- Housing and Homelessness

Moderate Priority

- Cancer
- Climate/Natural Environment
- Community Safety
- Diabetes and Obesity
- Maternal and Infant Health
- Sexually Transmitted Infections
- Unintended Injuries/Accidents

COVID-19

In late 2019, a new coronavirus (SARS-CoV-2) appeared. It causes a respiratory illness that is now called COVID-19.[33] The ensuing pandemic has been a health event of historic proportions.[34] By August 1, 2022, COVID-19 had caused an estimated 6,398,907 deaths worldwide and 1,026,937 deaths nationwide, the latter representing over 0.3% of the U.S. population.[35] In

[33] "COVID-19" stands for coronavirus disease 2019. Centers for Disease Control and Prevention. (2020). *COVID-19: Identifying the source of the outbreak.* Retrieved from https://www.cdc.gov/coronavirus/2019-ncov/science/about-epidemiology/identifying-source-outbreak.html

[34] Hiscott, J., Alexandridi, M., Muscolini, M., Tassone, E., Palermo, E., Soultsioti, M., & Zevini, A. (2020). The global impact of the coronavirus pandemic. *Cytokine & Growth Factor Reviews*, 53, 1–9. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7254014/

[35] The New York Times. (2022). World coronavirus cases. *The New York Times.* Retrieved from https://www.nytimes.com/interactive/2021/world/covid-cases.html and Moore, D. (2021). *Happy New Year 2022!* U.S. Census Bureau. Retrieved from https://www.census.gov/library/stories/2021/12/happy-new-year-2022.html

absolute terms, the COVID-19 pandemic has surpassed the 1918 influenza (H1N1) pandemic, which killed 550,000 Americans (0.5% of the U.S. population at that time).[36]

The COVID-19 pandemic shows signs of continuing for the foreseeable future. In San Mateo County, the numbers of COVID-19 cases and deaths peaked several times throughout 2020, 2021, and 2022.[37] However, vaccinations—which began in early 2021—appear to be mitigating local hospitalizations and deaths. Below are the latest COVID-19 statistics for San Mateo County, as of August 1, 2022:

- Cases:
    - Cumulative total cases[37]: 169,169
    - Seven-day average number of daily cases[37]: 265
    - Seven-day average rate of daily cases[37]: 35 per 100,000 people
    - 14-day average of hospitalized patients[38]: 59.4
- Infections, testing, and wastewater:
    - Rate of infection since January 2020[37]: 1 in 5 people
    - Current rate of spread (R-eff[39]): 0.94 vs. 0.98 statewide[40]
    - Seven-day average test positivity rate[38]: 11.1%
    - All SARS-CoV-2 virus concentration (normalized)[41]: 0.00053 (Silicon Valley)
- Deaths:[37]
    - Rate of deaths since January 2020: 1 in 972 people
    - Cumulative total deaths: 789
    - Seven-day average number of daily deaths: 0
    - Seven-day average rate of daily deaths: 0.04 per 100,000 people
- Vaccinations[37]:

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[36] Noymer, A., & Garenne, M. (2000). The 1918 influenza epidemic's effects on sex differentials in mortality in the United States. *Population and Development Review*, *26*(3), 565–581. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2740912/. And Centers for Disease Control and Prevention. (2019). 1918 Pandemic (H1N1 virus). Retrieved from https://www.cdc.gov/flu/pandemic-resources/1918-pandemic-h1n1.html

[37] The New York Times. (2022). California Coronavirus Tracker. *The New York Times.* Retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html

[38] COVID19.CA.GOV. (2022). *Tracking COVID-19 in California.* Retrieved from https://covid19.ca.gov/state-dashboard/#location-san_mateo

[39] "R-eff is the average number of people an infected person will infect. … Value less than 1 means decreasing spread. Value greater than 1 means increasing spread." San Mateo County Health. (2022). *County Data Dashboard.*

[40] CalCAT. (2022). *California COVID Assessment Tool.* Data retrieved from https://calcat.covid19.ca.gov/cacovidmodels/

[41] California Department of Public Health. (2002). *CDPH Wastewater Surveillance Network Dashboard.* Retrieved from https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/CalSuWers-Dashboard.aspx

- Fully vaccinated (all ages): 85%
- Fully vaccinated (age 65+): 95%
- Vaccinated and received a booster (all ages): 59%
- Vaccinated and received a booster (age 65+): 83%

Because COVID is a new virus, many health effects and healthcare needs are still emerging. This CHNA report summarizes what the participating hospitals know so far about the health condition and its social determinants. To capture the effects of COVID on the community, the hospitals collaborating on the 2022 community health needs assessment conducted various focus groups and interviews, including a focus group dedicated to health equity.[42] We also chose to add "documented ethnic and/or geographic disparities and inequities" to our criteria for identifying community health needs in 2022. The hospitals will continue to monitor and address health effects, trends, and healthcare needs of COVID-19 as they learn more about the disease, its progression, and its short- and long-term impacts.

The pandemic has exacerbated existing inequities in the health and welfare of vulnerable populations in the U.S., causing disproportionate illness and mortality for people in minority racial and ethnic groups (i.e., Black, Indigenous, and people of color: BIPOC),[43] people with certain pre-existing health conditions,[44] people living in crowded conditions,[45] and people who are classified as

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[42] CHNA participants, including those in the health equity focus group, are listed in Attachment 1.

[43] Marshall, W. F. (2020). *Coronavirus infection by race: What's behind the health disparities?* Mayo Clinic. Retrieved from https://www.mayoclinic.org/diseases-conditions/coronavirus/expert-answers/coronavirus-infection-by-race/faq-20488802

[44] Arumugam, V. A., Thangavelu, S., Fathah, Z., Ravindran, P., Sanjeev, A. M. A., Babu, S., Meyyazhagan, A., Yatoo, M. I., Sharun, K., Tiwari, R. and Pandey, M. K. (2020). COVID-19 and the world with co-morbidities of heart disease, hypertension and diabetes. *Journal of Pure Applied Microbiology*, *14*(3):1623–1638. See also Lui, B., Samuels, J. D., & White, R. S. (2020). Potential pathophysiology of COVID-19 in patients with obesity. Comment on Br J Anaesth 2020; 125:e262–e263. *British Journal of Anaesthesia*, *125*(3), e283–e284. Retrieved from https://bjanaesthesia.org/article/S0007-0912(20)30439-6/pdf

[45] Arango, T. (2021). "We Are Forced to Live in These Conditions": In Los Angeles, Virus Ravages Overcrowded Homes. *The New York Times.* Retrieved from https://www.nytimes.com/2021/01/23/us/los-angeles-crowded-covid.html See also: California Institute for Rural Studies. (2018). *Farmworker Housing Study and Action Plan for Salinas Valley and Pajaro Valley.* Retrieved from https://www.co.monterey.ca.us/home/showdocument?id=63729 And Jiménez, M. C., Cowger, T. L., Simon, L. E., Behn. M., Cassarino, N., Bassett, M. T. (2020). Epidemiology of COVID-19 Among Incarcerated Individuals and Staff in Massachusetts Jails and Prisons. *JAMA Network Open*. *3*(8):e2018851. Retrieved from https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2769617 And Gebeloff, R., Ivory, D., Richtel, M., Smith, M., Yourish, K., Dance, S., Fortiér, J., Yu, E., & Parker, M. (2020). The Striking Racial Divide in How COVID-19 Has Hit Nursing Homes. *The New York Times.* Retrieved from https://www.nytimes.com/article/coronavirus-nursing-homes-racial-disparity.html

"essential workers" (at higher risk of workplace exposure).[46] Approximately one in 10 people who were infected experience "long COVID," a set of lingering symptoms including "fatigue, body aches, shortness of breath, difficulty concentrating" that lasts a year or more.[47]

Perhaps the most far-reaching impacts of COVID-19 are socioeconomic. The government mandates shutting down or limiting activities in major industries (tourism, hospitality, brick-and-mortar retail and services, etc.) exacerbated the inequities experienced by many of the vulnerable populations identified above. Women, BIPOC, young people (ages 16–24), and those with low income (usually defined as less than 80% of the area median income) or without college degrees have also been impacted by job loss, housing insecurity, food insecurity, and other difficulties, all of which are likely to persist.[48,49] Women in particular left the workforce in large numbers in 2020 and 2021, when school closures created a need for child care, a responsibility much more likely to fall on their shoulders than men's.[50]

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[46] Campbell, J. (2020). "What Are Essential Services and Jobs During the Coronavirus Crisis?" *Huffington Post*. Retrieved from: https://www.huffpost.com/entry/what-are-essential-services-jobs_l_5e74eaacc5b6f5b7c543370c See also: Reitsma, M. B., Claypool, A. L., Vargo, J., Shete, P. B., McCorvie, R., Wheeler, W. H., Rocha, D. A., Myers, J. F., Murray, E. L., Bregman, B., Dominguez, D. M., Nguyen, A. D., Porse, C., Fritz, C. L., Jain, S., Watt, J. P., Salomon, J. A., & Goldhaber-Fiebert, J. D. (2021). Racial/Ethnic Disparities in COVID-19 Exposure Risk, Testing, and Cases at the Subcounty Level in California. *Health Affairs*, *40*(6). Retrieved from https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.00098

[47] Komaroff, A. L. (2021). *The tragedy of long COVID.* Weblog, Harvard Health Publishing, Harvard Medical School. Retrieved from https://www.health.harvard.edu/blog/the-tragedy-of-the-post-covid-long-haulers-202010152479

[48] Udalova, V. (2021). Initial Impact of COVID-19 on U.S. Economy More Widespread Than on Mortality. America Counts: Stories Behind the Numbers. U.S. Census Bureau. Retrieved from https://www.census.gov/library/stories/2021/03/initial-impact-covid-19-on-united-states-economy-more-widespread-than-on-mortality.html See also: Gould, E. & Kassa, M. (2020). Young workers hit hard by the COVID-19 economy. Economic Policy Institute. Retrieved from https://www.epi.org/publication/young-workers-covid-recession/

[49] Ferreira, F. H. G. (2021). *Inequality in the Time of COVID-19*. International Monetary Fund. Retrieved from https://www.imf.org/external/pubs/ft/fandd/2021/06/inequality-and-covid-19-ferreira.htm See also: Perry, B. L., Aronson, B., & Pescosolido, B. A. (2021). *Pandemic precarity: COVID-19 is exposing and exacerbating inequalities in the American heartland.* Proceedings of the National Academy of Sciences, February 2021, *118*(8). Retrieved from https://www.pnas.org/content/118/8/e2020685118 Specific to California, see Bohn, S., Bonner, D., Lafortune, J., & Thorman, T. (2020). *Income Inequality and Economic Opportunity in California.* Public Policy Institute of California. Retrieved from https://www.ppic.org/wp-content/uploads/incoming-inequality-and-economic-opportunity-in-california-december-2020.pdf

[50] Bateman, N., & Ross, M. (2020). Why has COVID-19 been especially harmful for working women? Brookings Institute. Retrieved from https://www.brookings.edu/essay/why-has-covid-19-been-especially-harmful-for-working-women/

The inequitable health and economic outcomes can be attributed, in part, to structural and institutional racism.[51] BIPOC community members may cope with toxic stress due to their experiences of discrimination. The physical toll this can take on their bodies has no equivalent among white Americans. The inflammation from toxic stress contributes to greater comorbidities among the BIPOC population in the U.S. compared to whites.[52] BIPOC individuals are also more likely to work higher-risk and/or low-wage jobs,[53] in part due to employment discrimination,[54] and to live in crowded or substandard conditions and impoverished neighborhoods, in part due to

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[51] Garcia, M. A., Homan, P. A., García, C., & Brown, T. H. (2020). The color of COVID-19: structural racism and the pandemic's disproportionate impact on older racial and ethnic minorities. *The Journals of Gerontology: Series B*. Retrieved from https://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=1735&context=sociologyfacpub

See also: Pirtle, W. N. L. (2020). Racial capitalism: a fundamental cause of novel coronavirus (COVID-19) pandemic inequities in the United States. *Health Education & Behavior*. *47*(4):504–508. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7301291/

[52] Adler, N. E., & Rehkopf, D. H. (2008). U.S. Disparities in Health: Descriptions, Causes and Mechanisms. *Annual Review of Public Health*, 29:235–252. See also Logan, J. G., & Barksdale, D. J. (2008). Allostasis and allostatic load: expanding the discourse on stress and cardiovascular disease. *Journal of Clinical Nursing*, *17*(7b), 201–208. Retrieved from https://onlinelibrary.wiley.com/doi/pdf/10.1111/j.1365-2702.2008.02347.x And see Schulz, A. J., Mentz, G., Lachance, L., Johnson, J., Gaines, C., & Israel, B. A. (2012). Associations between socioeconomic status and allostatic load: effects of neighborhood poverty and tests of mediating pathways. *American Journal of Public Health*, *102*(9), 1706–1714. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3416053/

[53] See various articles related to essential workers and risk during the COVID-19 pandemic:

- Gould, E., & Shierholz, H. (2020). Not everybody can work from home: Black and Hispanic workers are much less likely to be able to telework. *Working Economics Blog* by the Economic Policy Institute. Retrieved from https://www.epi.org/blog/black-and-hispanic-workers-are-much-less-likely-to-be-able-to-work-from-home/
- Greenberg, J. (2020). Blacks, Hispanics less likely to have jobs where they can work from home. *PolitiFact* by The Poynter Institute. Retrieved from https://www.politifact.com/factchecks/2020/jun/16/desiree-rogers/blacks-hispanics-less-likely-have-jobs-where-they-/
- Krisberg, K. (2020). Essential workers facing higher risks during COVID-19 outbreak: Meat packers, retail workers sickened. *The Nation's Health* by the American Public Health Association. Retrieved from https://www.thenationshealth.org/content/50/6/1.1.
- Liu, J. (2020). Covid-19 patients twice as likely to be working from an office instead of home, CDC finds. *MakeIt* by CNBC. Retrieved from https://www.cnbc.com/2020/11/10/cdc-covid-19-patients-twice-as-likely-to-work-from-office-vs-home.html
- Dorman, P., & Mishel, L. (2020). A majority of workers are fearful of coronavirus infections at work, especially Black, Hispanic, and low- and middle-income workers. Economic Policy Institute. Retrieved from https://www.epi.org/publication/covid-risks-and-hazard-pay/
- Kinder, M. (2020). Essential but Undervalued: Millions of health care workers aren't getting the pay or respect they deserve in the COVID-19 pandemic. Brookings. Retrieved from https://www.brookings.edu/research/essential-but-undervalued-millions-of-health-care-workers-arent-getting-the-pay-or-respect-they-deserve-in-the-covid-19-pandemic/

[54] See meta-analysis: Neumark, D. (2018). Experimental research on labor market discrimination. *Journal of Economic Literature, 56*(3), 799-866. Retrieved from https://www.nber.org/system/files/working_papers/w22022/w22022.pdf

historical red-lining policies and present-day housing discrimination.[55] All of these issues contribute to poorer health outcomes for BIPOC community members than white people for nearly all health conditions, including COVID-19 infection.

With regard to economic outcomes, people of color are more likely to have less formal schooling than whites, in part due to education discrimination[56] and in part because they are more likely to attend segregated, underperforming schools.[57] This, combined with possible employment discrimination, makes it more likely that they'll earn less, too.[58]

In addition to its impact on individuals and their families across the nation, the COVID-19 pandemic required hospitals and health systems to adapt and shift rapidly. The pandemic necessitated many changes in hospitals' operating procedures, including significantly increased use of telehealth and pandemic-related healthcare services, at the same time that hospitals faced supply shortages, outbreaks and burnout among staff, and extreme financial challenges that

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[55] Iton, A., & Ross, R. K. (2017). Understanding How Health Happens: Your Zip Code Is More Important Than Your Genetic Code. In *Public Health Leadership* (pp. 83–99). Routledge. Retrieved from https://zums.ac.ir//files/socialfactors/files/Public_Health_Leadership-Strategies_for_Innovation_in_Population_Health_and_Social_Determinants-2.pdf#page=84 See also: Acevedo-Garcia, D., Noelke, C., & McArdle, N. (2020). *The Geography of Child Opportunity: Why Neighborhoods Matter for Equity*. Diversitydatakids.org, Institute for Child, Youth and Family Policy, The Heller School for Social Policy and Management, Brandeis University: Waltham, MA. Retrieved from https://www.diversitydatakids.org/sites/default/files/file/ddk_the-geography-of-child-opportunity_2020v2.pdf

[56] Adair, J. K. (2015). *The impact of discrimination on the early schooling experiences of children from immigrant families.* Washington, DC: Migration Policy Institute. Retrieved from

https://www.migrationpolicy.org/research/impact-discrimination-early-schooling-experienceschildren-Immigrant-families See also Benner, A. D., & Graham, S. (2011). Latino Adolescents' Experiences of Discrimination Across the First 2 Years of High School: Correlates and Influences on Educational Outcomes. *Child Development*, 82(2), 508–519. https://doi.org/10.1111/j.1467-8624.2010.01524.x

[57] Reardon, S.F., Weathers, E.S., Fahle, E.M., Jang, H., & Kalogrides, D. (2019). *Is Separate Still Unequal? New Evidence on School Segregation and Racial Academic Achievement Gaps.* Retrieved from https://cepa.stanford.edu/content/separate-still-unequal-new-evidence-school-segregationand-Racial-academic-achievement-gaps

[58] Rodgers, W. M. (2019). Race in the labor market: The role of equal employment opportunity and other policies. *RSF: The Russell Sage Foundation Journal of the Social Sciences*, 5(5), 198–-220. Retrieved from https://www.rsfjournal.org/content/rsfjss/5/5/198.full.pdf

strained their capacity.[59] Many other industries also faced financial challenges.[60] The pandemic's substantial negative economic impact on communities should not be underestimated.

While the hospitals acknowledge the negative health effects of COVID-19 itself, this CHNA report focuses on identifying the broader health inequities and socioeconomic consequences of COVID-19 in San Mateo County.

SUMMARIZED DESCRIPTIONS OF 2022 PRIORITIZED COMMUNITY HEALTH NEEDS

The processes and methods described in Section 5: Process and Methods resulted in the prioritization of 11 community health needs (*see list on page 35*). The descriptions of each need below summarize the data, statistics, and community input collected during the community health needs assessment. COVID-19 illness is treated separately in this report; see pages 35-42. For the sources of the statistical indicators, when not provided in footnotes, see *Attachment 2: Secondary Data Indicators List.*

Behavioral Health

Behavioral health, which includes mental health and trauma, as well as consequences such as substance use, ranked high as a health need, being prioritized by five out of seven focus groups and nearly all key informants.

The pandemic's negative effect on mental health was one of the strongest themes from the qualitative data. Many experts spoke of depression, anxiety, trauma, and grief among all populations and reported increased demand for services; however, children and adolescents were of particular concern. Before the pandemic's advent, statistics suggest that youth mental health was an issue: for example, San Mateo County's self-harm injury hospitalization rate for youth ages 0-17 (50.1 per 100,000) is significantly higher than the state's rate (22.4 per 100,000).

Recent survey data from San Mateo County Public Health show that self-reported mental/behavioral health is at its worst since measurement began in 1998, including the

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[59] Grimm, C.A. (2021). *Hospitals Reported That the COVID-19 Pandemic Has Significantly Strained Health Care Delivery.* U.S. Department of Health and Human Services, Office of Inspector General. OEI-09-21-00140. Retrieved from https://oig.hhs.gov/oei/reports/OEI-09-21-00140.pdf . See also Kaufman, Hall & Associates. (2021). *Financial Effects of COVID-19: Hospital Outlook for the Remainder of 2021.* American Hospital Association. Retrieved from https://www.aha.org/system/files/media/file/2021/09/AHA-KH-Ebook-Financial-Effects-of-COVID-Outlook-9-21-21.pdf

[60] See, for example, Bauer, L., Broady, K., Edelberg, W., & O'Donnell, J. (2020). *Ten facts about COVID-19 and the U.S. economy.* The Brookings Institution. Retrieved from https://www.brookings.edu/research/ten-facts-about-covid-19-and-the-u-s-economy/

proportions of respondents reporting chronic depression (over 33%) and binge drinking (16%).[61] Experts noted the lack of mental health providers and addiction services overall, especially those providing services in non-English languages. The county's health department reported that "half of SMC adults would not know where to access treatment for a drug-related problem; [a] significant increase since 1998 when it was 34.8%."[61]

Key informants and focus group attendees, all of whom participated in the CHNA after the pandemic began, described youth isolation and lack of interaction with peers as preventing normal adolescent development. They also suggested that many students were anxious about returning to school, in part because of the chance of infection. While data before the pandemic already indicated that youth behavioral health was a concern, experts described an increase in youth suicide attempts, especially by overdose with prescription medications, that seemed to occur beginning about three months into the pandemic. Drug overdose deaths have been rising overall in San Mateo County, from less than 8 per 100,000 people in 2016 to about 11 per 100,000 in 2019.

Statistics suggest that there are disparities associated with behavioral health. For example, drug overdose deaths among San Mateo County's Black population (24 per 100,000) occur at nearly twice the rate as all Californians (14 per 100,000). According to San Mateo County Health, illegal drug use is more common among young adults (ages 18-39), individuals who identify as LGBTQ, and populations with low income and/or low levels of education.[62] The health department also found that alcohol use is higher in the county (59%) compared to the state (52%), although the county's level is significantly lower than it was in 1998 (67%).[62] Alcohol use is higher among residents of the Coastside, as is marijuana use, which has been on the rise in the county overall (from 13% in 2018 to 16% in 2022).[62] The prevalence of vaping is twice as high in the county (6%) than the state (3%) and is more common among young adults (ages 18-39), individuals who identify as LGBTQ, the Latinx population, residents of the southern part of the county, and populations with low income.[62]

Suicidal ideation occurs at a much higher proportion among the county's Pacific Islander (30%) and multiethnic (22%) 9th and 11th graders than for all California 11th graders (16%). The county's health department indicated that for San Mateo County adults, suicidal ideation was more

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[61] San Mateo County Health, Office of Epidemiology & Evaluation. (2022). *2022 San Mateo County Health & Quality of Life Survey – Summary of Survey Results.*

[62] San Mateo County Health, Office of Epidemiology & Evaluation. (2022). *2022 San Mateo County Health & Quality of Life Survey – Summary of Survey Results.*

common among Pacific Islanders, individuals who identify as LGBTQ, individuals who live in the northern part of the county, young adults, and the low-income population.[62] The county's white suicide rate for all ages remains persistently higher (11.0 per 100,000) than the state rate (10.5 per 100,000).[63] Experts, however, note that "racial and ethnic minorities have less access to mental health services than do whites, are less likely to receive needed care and are more likely to receive poor quality care when treated."[64] An expert on the historical context of such disparities suggests that "racism and discrimination," as well as "fear and mistrust of treatment," pose barriers to BIPOC community members seeking help for behavioral health issues. The expert also notes that overrepresentation in the criminal justice system "suggests that rather than receiving treatment for mental illness, BIPOC end up incarcerated because of their symptoms."[65] Among the statistical data available for this CHNA, juvenile felony arrests (for ages 10-17) are substantially higher for Black (39.8 per 1,000) and somewhat higher for Latinx youth (5.9 per 1,000) in San Mateo County than for California youth overall (4.1 per 1,000).

> *"I think one of the questions is how do we, as hospital systems, commit to parity, to equity in terms of access to mental health support, knowing it really is the primary health need of our families right now across the country and within San Mateo and Santa Clara counties."*
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> *— Health Equity Focus Group Participant*

Community members made clear connections between COVID-related economic insecurity causing stress and anxiety, especially for those who lost jobs or saw their incomes affected. African immigrants were one group singled out by experts as experiencing behavioral health

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[63] We note that suicides account for more than half of all U.S. gun deaths (Gramlich, J. [2022]. *What the data says about gun deaths in the U.S.* Pew Research Center. Retrieved from https://www.pewresearch.org/fact-tank/2022/02/03/what-the-data-says-about-gun-deaths-in-the-u-s/). Further, firearm training among U.S. adults has not increased significantly since 1994 when it was around 60%, and only 15% of firearm owners in 2015 reported their training included suicide prevention information (Rowhani-Rahbar, A. et al. [2017]. Formal firearm training among adults in the USA: results of a national survey. *Injury Prevention*, 24(2).). Finally, recent survey data from San Mateo County Health indicate that although the proportion of respondents who reported having a firearm in/around their home has been declining, proportions have not declined among Black respondents, Coastside residents, individuals who identify as LGBTQ, and populations that have higher income or have at least some college education.

[64] McGuire, T. G., & Miranda, J. (2008). New evidence regarding racial and ethnic disparities in mental health: policy implications. *Health Affairs (Project Hope)*, 27(2), 393–403. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3928067/

[65] Perzichilli, T. (2020). The historical roots of racial disparities in the mental health system. *Counseling Today*, American Counseling Association. Retrieved from https://ct.counseling.org/2020/05/the-historical-roots-of-racial-disparities-in-the-mental-health-system/

issues at a high rate, in part due to job losses during the pandemic. Experts also said that youth worried about the economic hardships of their families and sought employment themselves to reduce the burden on their families.

Experts spoke to the fact that the mental health and addiction services systems have historically been siloed, which has resulted in a lack of coordinated, comprehensive treatment. Further, some noted that many hospitals no longer provide mental health services, and there are very few inpatient psychiatric beds for acute/high needs. Experts stated that services for people without health insurance can be expensive and difficult to access.

Economic Security

Nearly all focus groups and three quarters of all key informants identified economic security, including income, education, and food security, as a top community priority. Participants identified Daly City, East Palo Alto, North Fair Oaks, and the Coastside as areas of concern related to economic insecurity. Data available on economically precarious households shows that while 50% of California households in which the most educated adult has only a high school diploma or GED struggle economically statewide, this proportion is much higher among households in San Mateo County (64%). Nearly one-third of Silicon Valley households are not meeting economic self-sufficiency standards. Recent survey data from San Mateo County Health indicate that more than one in five (21%) respondents reported that their personal financial situation was fair or poor, more than at any other time since measurement began in 1998.[66] Individuals who were more likely to respond this way included BIPOC (in particular, people of Black, Latinx, and Pacific Islander populations), individuals who identified as LGBTQ, residents of the southern part of the county, and populations that are low-income or have low levels of education.[66] Nearly 45% of respondents indicated they had considered relocating due to the high cost of living, again the highest proportion since measurement began; BIPOC, young adults (ages 18-39), and individuals from low-income populations were more likely than others to report this.[66]

Furthermore, in seven out of 50 school districts in Silicon Valley, more than 50% of students are eligible for free- or reduced-price meals (a proxy for poverty). Experts expressed special concern for older adults in the northern part of the county who are experiencing food insecurity. According to San Mateo County Health, food insecurity was the highest reported in 2022 (5%) and over 12% of respondents had received food from a food bank, church, or other organization.[66] In our 2019

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[66] San Mateo County Health, Office of Epidemiology & Evaluation. (2022). *2022 San Mateo County Health & Quality of Life Survey – Summary of Survey Results.*

CHNA report, poverty and food insecurity statistics illustrated inequities by race/ethnicity. The county's health department reports that food insecurity is higher among BIPOC (in particular, people of Black, Latinx, and Pacific Islander populations), individuals who identified as LGBTQ, and populations that are low-income or have low levels of education.[66] Economic precariousness can force people to choose between paying rent and accessing healthcare; it can also lead to homelessness and the many barriers to health that unhoused individuals face.

> *"The way I see it play out, both in my administrative role and also my clinical role, is that people will continue to prioritize their economy, their work day or their ability to actually put food on the table above their health. And we see that play out in a myriad of different ways, including the negative outcomes on their health."*
>
> *— Safety Net Focus Group Participant*

Income inequality in Silicon Valley is 1.5 times higher than the state level. Education generally correlates with income; therefore, educational statistics that differ by race/ethnicity are particularly concerning. Smaller proportions of San Mateo County's BIPOC 11th graders meet or exceed grade-level English-language arts and math standards versus California's 11th graders overall. Related to these statistics, much smaller proportions of San Mateo County's BIPOC high school graduates completed college-preparatory courses compared to high school graduates statewide. In our 2019 CHNA report, we described similar inequities in educational attainment.

11th Grade Students Meeting ELA/Math Standards; Completing College Prep Courses

	California	San Mateo County	San Mateo County							
			Asian	Black	Filipinx	Latinx	Multi	Nat Am	Pac Isl	White
ELA	57%	**66%**	81%	36%	64%	39%	77%	43%	34%	78%
Math	32%	**45%**	82%	24%	52%	28%	71%	33%	25%	72%
College Prep	47%	**54%**	80%	21%	44%	39%	64%	--	26%	67%

Qualitative data showed that COVID created more economic insecurity for those who lost work and specifically impacted low-income essential workers, many of whom were Latinx and/or undocumented. Key informants and focus group participants mentioned that county residents often lost childcare during the pandemic, which affected their ability to work; according to the Public Policy Institute of California, this affected women significantly more than men. Women were also

"overrepresented in both frontline and hardest-hit sectors" of the economy.[67] Before the pandemic, the cost of childcare may also have been a limiting factor; the annual costs of infant child care (ages 0-2) and pre-K child care (ages 3-5) were substantially higher in San Mateo County ($21,847 and $16,305, respectively) than the state averages ($17,384 and $12,168, respectively).

Healthcare Access and Delivery

Healthcare access and delivery, which affects various other community health needs, was identified as a top health need by five of seven focus groups and half the key informants in San Mateo County. Experts and county residents felt there was a lack of access to primary and specialty care (oral health and mental health were specifically named), especially for middle- and low-income community members. Recent survey data from San Mateo County Health indicates that uninsured respondents who have unresolved dental issues are more likely to be BIPOC (in particular, people of Black, Latinx, and Pacific Islander populations), individuals who identified as LGBTQ, residents of the southern part of the county, middle-aged (ages 40-64) and populations that are low-income.[68]

Healthcare access may be especially problematic for youth in the community: In San Mateo County schools, the ratio of students to each school nurse (4,464 to one) substantially exceeds the state ratio (2,410 to one). The county's ratio of other primary care providers (i.e., not primary care physicians) is also worse (2,130 to one) than the state's ratio (1,480 to one). In addition, San Mateo County community members who are Black, Indigenous, or other people of color (BIPOC) experience significantly worse health than residents of other races; for example, a higher rate of preventable hospital stays among Native American (27,270 per 100,000 Medicare enrollees) and Black (3,686 per 100,000 Medicare enrollees) community members versus the state rate (3,358 per 100,000 Medicare enrollees) may be a sign of inequitable access to high-quality care.

Many key informants and focus group participants connected healthcare access with economic insecurity. For example, some mentioned that low-income residents might be required to prioritize rent and food over healthcare. Some reported that low-income and undocumented community members especially have difficulty accessing insurance. Affordability, both of insurance premiums and of healthcare itself, especially preventive care, was a particular concern. According to San

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[67] Bohn, S., Cuellar Mejia, M., & Lafortune, J. (2021). Multiple Challenges for Women in the COVID-19 Economy. *Public Policy Institute of California.* Retrieved from https://www.ppic.org/blog/multiple-challenges-for-women-in-the-covid-19-economy/

[68] San Mateo County Health, Office of Epidemiology & Evaluation. (2022). *2022 San Mateo County Health & Quality of Life Survey – Summary of Survey Results.*

Mateo County Health, young adults (ages 18-39), residents of the northern part of the county, Latinxs, Pacific Islanders, and populations that are low-income or have low levels of education were more likely to lack health insurance, while older adults (age 65+), individuals who live on the Coastside, Pacific Islanders, and populations that are low-income are the most likely to lack dental insurance.[68] In 2021, CHNA participants identified the lack of information about healthcare costs for patients as another barrier to accessing care.

> *"I personally have a problem accessing healthcare because I'm a single parent, I don't earn [only] the minimum wage. And for that reason, I don't qualify by their standards, because according to them, I'm making so much money that I don't qualify. And it's not worth it for me to pay $500 for health insurance or dental insurance where the individual plan - it has a lot of exclusions."*
>
> *— Clinic Patient Focus Group Participant*

Experts indicated that they had mixed experiences with telehealth, which rose substantially during the pandemic. While telehealth can overcome transportation barriers, experts worried about the digital divide and patients' lack of privacy. They also expressed concern about the lower reimbursement rate for telephone appointments (i.e., without video). Once in-person appointments were more common again, transportation returned as a barrier to care for those living on the Coastside. County health department survey respondents who were more likely to report lack of transportation as a barrier to getting medical care included residents of the southern part of the county, Latinxs, individuals identifying as LGBTQ, young adults (ages 18-39), and populations that have low income or low levels of education.[69]

The need for healthcare workforce training to deliver care in a sensitive manner was a common theme among key informants and focus group participants. Training areas identified included: LGBTQ+ sensitivity and education about issues specific to the population, trauma-informed care, and greater respect/efforts for patients with mental health issues, who are low-income, lack digital and/or English literacy, or are monolingual non-English speakers. Other delivery issues included the education of healthcare workers around public charge issues and the need for greater language capacity. Limited English proficiency can restrict healthcare access.

Systemic issues such as low Medi-Cal reimbursement rates and the annual requirement for Medi-Cal patients to re-verify their eligibility to retain coverage were specific concerns. Experts

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[69] San Mateo County Health, Office of Epidemiology & Evaluation. (2022). *2022 San Mateo County Health & Quality of Life Survey – Summary of Survey Results.*

expressed concern about the use of the emergency department for non-emergent issues among immigrants, the unhoused population, and individuals who lack insurance, which speaks to the inequity in access to healthcare among these groups. Health system navigation was called out as especially difficult for farmworkers and other immigrants who are not familiar with U.S. health systems.

Access issues related to persons with disabilities arose among San Mateo County key informants and focus group participants. In particular, there was discussion about the difficulty people with disabilities have in affording and accessing care.

Access issues related to oral health arose as well. In addition to issues described above (lack of access to dental insurance, disparities in unresolved dental issues among individuals without insurance), an oral health expert described the lack of preventive dental care for low-income and underserved populations as well as the need to integrate oral healthcare into whole-person care. The oral health expert also noted that low-income pregnant women often do not know they have dental insurance benefits while pregnant, and identified this as an opportunity for better education.

Housing and Homelessness

More than half of all focus groups identified housing and homelessness as a top community priority. Housing costs and other costs of living in San Mateo County are extremely high; the median home rental cost of $2,451 is more than 40% higher than the median state home rental cost of $1,689. Moreover, while homeowners statewide are spending approximately 31% of their income on their mortgages, homeowners in San Mateo County are spending more than 39% of their income on their mortgages. Recent survey data from San Mateo County Health found that over 24% of respondents were sharing housing costs in order to limit expenses, the highest proportion since measurement began.[70] Individuals who were more likely to report sharing housing costs included Pacific Islanders, Latinxs, young adults (ages 18-39), individuals who identified as LGBTQ, residents of the northern part of the county, and populations that are low-income or have low levels of education.[70]

Most feedback about housing from key informants and focus group participants concerned housing affordability. The housing affordability indices[71] for San Mateo County is lower (i.e., worse)

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[70] San Mateo County Health, Office of Epidemiology & Evaluation. (2022). *2022 San Mateo County Health & Quality of Life Survey – Summary of Survey Results.*

[71] The housing affordability index has a base of 100; figures above 100 indicate better affordability and those below 100 indicate less-affordable areas, where “median income is not high enough to purchase a median valued home.” See Krivacsy, K. (2018). The Delicate Balance between Housing Affordability, Growth, and Income. *ESRI ArcGIS Blog*,

(67.2) than that of the state (88.1). CHNA participants reported the difficulty individuals in poverty—who were described as more likely to be BIPOC—have in affording housing. Focus group participants mentioned out-migration from the area due to the high cost of housing, and some described the difficulty of recruiting employees for the same reason. In San Mateo County, homelessness rose in 2019 (the most recent homeless count). Experts noted that during COVID, landlords may have evicted families with undocumented members because they expected that these families would not seek legal protections.

> *"Earlier last year, I was working in the COVID hotels and I was having people come in who... said that COVID was a godsend because it's the first time in 20 years that they had ever been able to have a roof over their head and have… three square [meals] a day."*
>
> *— Health Equity Focus Group Participant*

Other CHNA participants said high housing costs are driving overcrowding, which they noted can contribute to the spread of infectious diseases, including COVID. However, housing quality is also a concern; for example, a greater percentage of children ages 0-5 in San Mateo County (1.7%) have moderately high blood lead levels than the percentage of California children overall (1.2%).

Cancer

Mortality rates for cancer in San Mateo County are better than state benchmarks. However, indicators of concern include the breast cancer incidence rate among San Mateo County women (138.1 per 100,000) compared to California women overall (120.9 per 100,000), the prostate cancer incidence rate among San Mateo County men (94.1 per 100,000) compared to California men overall (92.8 per 100,000), and rising prostate cancer mortality rates in San Mateo County, which reached 14.6 per 100,000 in 2019 (up from 13.9 in 2016).

In addition, the rate of cancer incidence among children ages 0-19 is slightly higher in the county (18.6 per 100,000) than the state (18.2 per 100,000) and highest among Asian/Pacific Islander children (18.9 per 100,000). Our 2019 CHNA report indicated that, compared to California residents, Black residents of both counties have a higher incidence of breast cancer, lung cancer, prostate cancer, and a higher prevalence of cancer of all sites combined, while Latina residents have a substantially higher incidence of cervical cancer. According to recent survey data from San

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December 14, 2018. Retrieved from https://www.esri.com/arcgis-blog/products/esri-demographics/analytics/the-delicate-balance-between-housing-affordability-growth-and-income

Mateo County Health, mammography screening levels have been trending down since 2013 and are now at approximately 78%.[72] The respondents who are least likely to have had a mammogram in the past two years include Asians, Latinxs, individuals who identify as LGBTQ, and populations that have low income or have low levels of education.[72]

The National Cancer Institute acknowledges socioeconomic and racial/ethnic disparities in cancer detection, treatment, and outcomes. It attributes these to a variety of factors, including institutional racism and conscious or unconscious bias among care providers, as well as barriers such as low income, low health literacy, lack of insurance, and lack of transportation. It also acknowledges the role of neighborhoods in cancer risks (e.g., when a neighborhood has poor access to affordable healthy food, residents are more likely to be obese, which is a cancer risk factor). The Institute states, "Reducing or eliminating some cancer disparities in the pursuit of health equity will require policy changes to overcome systemic social, racial, and/or institutional inequalities."[73]

Climate/Natural Environment

Climate issues have risen to the fore over the past three years, including climbing temperatures, more extreme weather, flooding, and wildfires. San Mateo County is at significantly greater risk of heat waves (with an index of 12.9 vs. 4.7 for California overall) as well as coastal and river flooding (with indices of 5.8 and 4.1, respectively) than the state as a whole (with indices of 0.7 and 2.1, respectively). Both focus group participants and key informants mentioned the adverse effects of environmental issues, particularly on low-income and BIPOC individuals, not only related to physical health but also with regard to the mental and financial stress of evacuation due to floods or wildfires.

> *"Some [coastal] communities not only had to go through the epidemic, but also fires — evacuations for days, if not weeks. There's people that were going through a fire evacuation while as a result, someone in their family also ended up with COVID because people had to go to hotels [as evacuation shelters]… And also there was the flooding, too. There were more evacuations because of that. So you have communities that have been hit, not one, not twice, but three times. And so now*

[72] San Mateo County Health, Office of Epidemiology & Evaluation. (2022). *2022 San Mateo County Health & Quality of Life Survey – Summary of Survey Results.*

[73] National Cancer Institute. (2020). *Cancer Disparities.* Retrieved from https://www.cancer.gov/about-cancer/understanding/disparities

we're going to have communities that are going to be struggling not only financially, but emotionally as well."

— Coastside Expert

Road network density (20.8 road miles per square mile of land) and traffic volume (2,194 vehicles per meter of roadway) were both significantly higher in San Mateo County than state averages (18.0 and 1,991 respectively). The environmental cost of high traffic volume includes air pollution, which can aggravate asthma. An expert in Black health cautioned about high rates of asthma in areas with poor air quality. Such place-based inequities may be related to historical systemic housing discrimination (e.g., red-lining).[74] Statistics suggest that asthma prevalence among people of all ages is higher in San Mateo County (9.5%) than in the state (8.8%). Child asthma diagnoses are also higher in San Mateo County (17.2%) than among all California children (14.3%). Overall, the annual number of unhealthy air days has been rising in Silicon Valley, from zero in 2016 to 14 days in 2020.

Community Safety

Community safety includes violent crime, domestic violence, and other forms of intentional injury. While many community safety statistics are better in San Mateo County than the state, the rate of rape in Silicon Valley (40 per 100,000 people) is higher than the state (39 per 100,000) and rising. In addition, the homicide rate is significantly higher among the Black population in the county (13 per 100,000 people) than the state rate (5 per 100,000). This latter difference may, in part, be attributed to residential segregation[75], which has been shown to be related to structural discrimination (see Housing and Homelessness description).

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[74] Iton, A., & Ross, R. K. (2017). Understanding How Health Happens: Your Zip Code is More Important Than Your Genetic Code. In *Public Health Leadership*, Callahan, R.F. & Bhattacharya, D., eds. (pp. 83-99). New York, NY: Routledge. Retrieved from https://zums.ac.ir//files/socialfactors/files/Public_Health_Leadership-Strategies_for_Innovation_in_Population_Health_and_Social_Determinants-2.pdf#page=84. See also: Duncan, D. T., & Kawachi, I. (Eds.). (2018). *Neighborhoods and Health.* Oxford, UK: Oxford University Press.

[75] Knopov, A., Rothman, E.F., Cronin, S.W., Franklin, L., Cansever, A., Potter, F., Mesic, A., Sharma, A., Xuan, Z., Siegel, M. and Hemenway, D. (2019). The role of racial residential segregation in black-white disparities in firearm homicide at the state level in the United States, 1991-2015. *Journal of the National Medical Association*, 111(1), pp.62-75. Retrieved from https://www.researchgate.net/profile/Anita-Knopov/publication/326323244_The_Role_of_Racial_Residential_Segregation_in_Black-White_Disparities_in_Firearm_Homicide_at_the_State_Level_in_the_United_States_1991-2015/links/5bee3267299bf1124fd5e3f3/The-Role-of-Racial-Residential-Segregation-in-Black-White-Disparities-in-Firearm-Homicide-at-the-State-Level-in-the-United-States-1991-2015.pdf

In San Mateo County, bullying and harassment, including cyberbullying, are worse for 7th graders (38%) and 9th graders (33%) than all California students in those grades (34% and 31%, respectively).[76] San Mateo County's 9th graders are also nearly twice as likely to fear being beaten up at school (5%) than all California 9th graders (3%).[53] Two experts noted that the shift to virtual education during the pandemic benefited youth who had been bullied at school, and said that some did not want to return when schools reopened. Indeed, rates of bullying and harassment at school are higher for most non-white youth in San Mateo County versus the state. In addition, cyberbullying rates (occurring four or more times in a year) are higher for the county's BIPOC youth (7% for Native American students, 5% for Black and Latinx students) than middle-schoolers in California overall (4%).[53]

According to recent survey data from San Mateo County Health, although the proportion of respondents who reported having a firearm in/around their home has been declining, proportions have not declined among Black respondents, Coastside residents, individuals who identify as LGBTQ, and populations that have higher income or have at least some college education.[77]

Some experts expressed concern about COVID-related stress contributing to domestic violence and/or sexual abuse; one mentioned that virtual visits made it harder for patients experiencing domestic violence to obtain both confidentiality and safety. There are disparities in domestic violence: Black children ages 0-17 in San Mateo County are more likely to be the subject of a substantiated child abuse case (8.8 per 1,000) than children statewide (7.5 per 1,000). Researchers attribute these disparities to differences in family circumstances that put children at greater risk of abuse (e.g., being young and/or single parents, experiencing poverty).[78] Building on the differences in child abuse statistics, the county's Black children (ages 0-20) are also more likely to be in foster care (12.7 per 1,000) than are California children on average (5.3 per 1,000). Many researchers have noted that children placed in foster care are at greater risk of contact with the juvenile justice system.[79] Statistics show that juvenile felony arrests (age 10-17) are much

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[76] Note, comparable data are not available for Santa Clara County.

[77] San Mateo County Health, Office of Epidemiology & Evaluation. (2022). *2022 San Mateo County Health & Quality of Life Survey – Summary of Survey Results.*

[78] Font, S. A., Berger, L. M., & Slack, K. S. (2012). Examining racial disproportionality in child protective services case decisions. *Children and Youth Services Review,* 34(11), 2188-2200. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3439815/. See also: Black Child Legacy Campaign. (2021). *Child Abuse and Neglect.* Retrieved from https://blackchildlegacy.org/resources/child-abuse-and-neglect/

[79] See, for example, Cutuli, J.J., Goerge, R.M., Coulton, C., Schretzman, M., Crampton, D., Charvat, B.J., Lalich, N., Raithel, J., Gacitua, C. and Lee, E.L., 2016. From foster care to juvenile justice: Exploring characteristics of youth in three cities. *Children and Youth Services Review*, 67, pp.84-94. Retrieved from https://www.aisp.upenn.edu/wp-content/uploads/2020/11/From-Foster-Care-to-Juvenile-Justice.pdf . And see Yi, Y., & Wildeman, C. (2018). Can foster

higher for Black youth (39.8 per 1,000) and somewhat higher for Latinx youth (5.9 per 1,000) in San Mateo County than for California youth overall (4.1 per 1,000). These disparities for young people can lead to inequities, not just in their experience of community safety but in their ability to succeed in school and in life.[80]

> *"... especially for our patients who are in situations with violent partners it was great to have the in-person encounter as a sort of legitimate reason for that patient to get away from the partner, to be able to speak with a provider confidentially. And now with virtual visits, it's really hard to be able to discreetly ensure that confidentiality; that person has to do that visit from a home or someplace where it's a little harder for you to directly ask if it's a safe place to talk, and also for them to really be as inclined to set up visits for check-ins for safety."*
>
> *— Health Equity Focus Group Participant*

Diabetes and Obesity

One-quarter of key informants and one focus group identified diabetes and obesity as top health needs. Although diabetes deaths appear to be trending down in San Mateo County, recent survey data indicate that diabetes prevalence has increased to over 10%.[81] Also, the trend for adult obesity has been worsening, with more than one in four adults (26%) assessed as obese in 2022.[81] Key informants and focus group participants identified the need for nutrition education, particularly from a young age. Some key informants further noted the cost of healthy food as a barrier to good nutrition.

According to the county's health department, health behaviors in general (not smoking, not overweight, adequate fruit/vegetable consumption, and regular exercise) have been decreasing since 2001, with fewer than 3% of recent survey respondents engaging in all four behaviors.[81] The lack of physical activity was cited as a driver of obesity by multiple key informants, primarily in the

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care interventions diminish justice system inequality?. *The Future of Children*, 28(1), 37-58. Retrieved from https://files.eric.ed.gov/fulltext/EJ1179175.pdf

[80] Gallegos, A. H., & White, C. R. (2013). Preventing the School-Justice Connection for Youth in Foster Care. *Family Court Review*, 51(3), 460-468. And see: Foster, M. & Gifford, E. (2004). "The Transition to Adulthood for Youth Leaving Public Systems: Challenges to Policies and Research," in *On the Frontier of Adulthood: Theory, Research, and Public Policy*, eds. Richard A. Settersten, Jr., Frank F. Furstenberg, Jr., & Rubén G. Rumbaut. Chicago: University of Chicago Press.

[81] San Mateo County Health, Office of Epidemiology & Evaluation. (2022). *2022 San Mateo County Health & Quality of Life Survey – Summary of Survey Results.*

context of the pandemic's interference with regular activities. Associated with this concern, the walkability index in San Mateo County (10.2) is worse than the state's (11.0). Experts on the Coastside specifically mentioned the lack of public parks. The county's BIPOC middle- and high-schoolers are much less likely to meet healthy body composition and fitness standards than middle- and high-school students statewide.

5th, 7th, and 9th Grade Students Meeting All Fitness Standards; Having Unhealthy Body Composition (BC)

	California[82]		San Mateo County		San Mateo County									
					Asian		Black		Latinx		Pac. Isl.		White	
Gr.	Fit.	BC	Fit.	BC	Fit.	BC	Fit.	BC	Fit.	BC	Fit.	BC	Fit.	BC
5th	24%	22%	**32%**	**17%**	41%	7%	24%	24%	18%	28%	--	45%	41%	8%
7th	30%	21%	**37%**	**15%**	51%	6%	23%	23%	23%	26%	20%	38%	48%	8%
9th	34%	19%	**35%**	**13%**	51%	4%	29%	29%	24%	21%	24%	31%	46%	7%

Community members expressed dissatisfaction with the quality of the food supply, especially for those reliant on food from food pantries or institutions such as schools. Data show that, among the venues from which community members can obtain food, there are no supercenters and club stores, which sell fresh produce, in San Mateo County, compared to the state average of 48.1 per 1,000 people. Further, and perhaps related to the lack of produce access, a smaller proportion of children ages 2-11 in the county eat adequate amounts of fruits and vegetables daily (24%) compared to children statewide (35%). Multiple residents made the connection between unhealthy eating and mental health.

> *"I also see people who say, 'Oh, I'm pre-diabetic,' as they're eating a doughnut, and that transcends culture, age, education, wealth, neighborhood, whether you are shopping in a grocery store or [eating] at a restaurant or you grow your own vegetables. ...And until we can help people get in touch with what's going on in their head and their heart when they put something in their mouths, [diabetes] is going to continue to be a big issue."*
>
> *— Clinic Patient Focus Group Participant*

[82] Fitness statistics are of students who meet or exceed the standard; body composition statistics are of students who are in the "unhealthy" category.

Our 2019 CHNA report identified disparities in diabetes and obesity, with local Black and Latinx populations experiencing obesity at higher rates than the state. The county's health department indicated disparities in diabetes prevalence among respondents of a recent survey, with Blacks, Pacific Islanders, residents of the northern part of the county, individuals who identify as LGBTQ, and populations that have low income or have low levels of education more likely to report having diabetes than others.[83] Although key informants and focus group participants did not connect diabetes and obesity with health disparities or inequities, experts writing on behalf of the American Diabetes Association describe placing "socioeconomic disparities and the other [social determinants of health] downstream from racism—which we posit is a root cause for disparities in diabetes outcomes in marginalized and minoritized populations."[84]

Maternal and Infant Health

Most maternal and infant health statistics in both counties are better than state benchmarks. However, inequities in maternal and infant health exist: For example, teen births are significantly higher among young Latinas (19 per 1,000) in San Mateo County than all females ages 15-19 statewide (17 per 1,000). A maternal and child health expert suggested that cultural norms and access issues may play into these differences.

As another example, low infant birth weight is a more frequent issue among Asian (8%) and Black (9%) babies born in San Mateo County than all babies statewide (7%). CHNA participants felt that BIPOC people who are pregnant or have recently given birth need improved access to care. A maternal and child health expert indicated that these inequities may also be traced back not only to healthcare access and delivery barriers but also to social determinants of health such as racism.

> *"The Black and Pacific Islander populations have continued to shoulder a lot of layers of disparity and inequity,... which we already saw in our maternal, child, and adolescent health indicators, whether it was low birth weight or exclusive breastfeeding."*
>
> *— Public Health Expert*

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[83] San Mateo County Health, Office of Epidemiology & Evaluation. (2022). *2022 San Mateo County Health & Quality of Life Survey – Summary of Survey Results.*

[84] Ogunwole, S. M. & Golden, S. H. (2021). Social Determinants of Health and Structural Inequities—Root Causes of Diabetes Disparities. *Diabetes Care*, Jan. 2021, 44 (1): 11-13. Retrieved from https://care.diabetesjournals.org/content/44/1/11

Sexually Transmitted Infections

Although statistics on sexually transmitted infections are better than the state for San Mateo County, there are concerning trends. Rates of syphilis are increasing in the county (from less than 6% in 2012 to more than 10% in 2018), and chlamydia incidence is on the rise among youth ages 10-19 as well (from 435.7 per 100,000 in 2012 to 476.3 per 100,00 in 2018). The Centers for Disease Control and Prevention suggest that income inequality, poverty, lack of employment, relative lack of education, and distrust of the healthcare system (whether due to shame or stigma, experience or fear of discrimination, or other reasons) affect the ability of individuals to "stay sexually healthy."[85]

Unintended Injuries/Accidents

One expert noted an increase in falls among older adults, although San Mateo County's statistics are not worse than the state's. Road network density (20.8 miles of road per square mile of land) and traffic volume (2,194 vehicles per meter of roadway) were both significantly higher in San Mateo County than state averages (18.0 and 1,991, respectively). One consequence of high traffic volume can be motor vehicle, bicycle, and pedestrian accidents. In our 2019 CHNA report, San Mateo County Latinxs of all ages were at higher risk for pedestrian accident deaths than individuals of other ethnicities, and their pedestrian accident mortality rate was higher than the benchmark. Racial inequities in accident rates have been found nationwide, and are attributed in part to unequal access to safe transportation.[86] The absence of sidewalks in low-income neighborhoods is another factor related to inequities in pedestrian accident rates nationally.[87]

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[85] Centers for Disease Control and Prevention. (2020). *STD Health Equity.* Retrieved from https://www.cdc.gov/std/health-disparities/default.htm

[86] Hamann, C., Peek-Asa, C., & Butcher, B. (2020). Racial disparities in pedestrian-related injury hospitalizations in the United States. BMC public health, 20(1), 1-7. Retrieved from https://link.springer.com/article/10.1186/s12889-020-09513-8 and

[87] Lu, W., McKyer, E.L.J., Lee, C., Ory, M.G., Goodson, P., & Wang, S. (2015). Children's active commuting to school: an interplay of self-efficacy, social economic disadvantage, and environmental characteristics. *International Journal of Behavioral Nutrition and Physical Activity.* 12(1):29. Retrieved from https://ijbnpa.biomedcentral.com/articles/10.1186/s12966-015-0190-8

7. COMMUNITY RESOURCES

In San Mateo County, community-based organizations, government departments and agencies, hospitals and clinics, and other entities strive to address many of the health needs identified by this assessment. Hospitals and clinics are listed below. Key resources available to respond to community health needs are listed in *Attachment 3: Community Assets and Resources*.

EXISTING HEALTHCARE FACILITIES

- AHMC Seton Medical Center and Seton Coastside
- Dignity Health Sequoia Hospital*
- Kaiser Foundation Hospital–Redwood City*
- Kaiser Foundation Hospital–South San Francisco*
- Lucile Packard Children's Hospital Stanford*
- Mills Health Center
- Stanford Health Care*
- Sutter Health (Mills-Peninsula Medical Center and Menlo Park Surgical Hospital)*

Beyond providing excellent clinical care to their members, nonprofit hospitals (marked with an asterisk [*] above) invest in the community with a variety of strategies, including:

- Providing in-kind expertise, training, and education for health professionals
- Financial assistance (charity care)
- Subsidies for qualified health services
- Covering unreimbursed Medi-Cal costs
- Community benefit grants for promising and evidence-based strategies that impact health needs identified through the CHNA

EXISTING CLINICS

- Belle Air School Health Clinic
- Belle Haven Clinic
- Daly City Youth Health Center
- Fair Oaks Clinic
- Lucile Packard Foundation for Children's Health Teen Health Van
- Ravenswood Family Health Center
- Samaritan House
- San Mateo Medical Center Clinics (for locations, see the clinics guide[88])
- Sequoia Teen Health Center at Sequoia High School

[88] https://www.smchealth.org/smmc-guide-clinics

8. EVALUATION FINDINGS FROM 2019–2021 IMPLEMENTED STRATEGIES

This section is based on the 2019–2021 Implementation Strategy that described how Mills Peninsula Medical Center planned to address significant health needs identified in its 2019 Community Health Needs Assessment (CHNA). The 2019 CHNA identified ten community health needs. Working within its mission and capabilities, Mills Peninsula Medical Center selected the following needs to address in its Implementation Strategy:

1. Healthcare Access and Delivery
2. Mental Health and Well-Being
3. Oral/Dental Health
4. Housing and Homelessness

In the Implementation Strategy (IS) process, Mills-Peninsula Medical Center (MPMC) planned for and drew on a broad array of resources and strategies to improve the health of its communities and vulnerable populations, such as grant making, in-kind resources, collaborations, and partnerships, as well as several internal MPMC programs, including charitable health coverage programs, future health professional training programs, and research.

Based on the years 2019 to 2021, an overall summary of these strategies is below, followed by tables highlighting a subset of activities used to address each prioritized health need.

Mills-Peninsula Medical Center Programs: From 2019 to 2021, MPMC supported several healthcare and coverage, workforce training, and research programs to increase access to appropriate and effective healthcare services and address a wide range of specific community health needs, particularly impacting vulnerable populations.

Medi-Cal: Medi-Cal is the California Medicaid health coverage program for families and individuals with low incomes and limited financial resources. MPMC provided services for Medi-Cal beneficiaries, both members and nonmembers.

Medical Financial Assistance: The Medical Financial Assistance (MFA) program provided financial assistance for emergency and medically necessary services, medications, and supplies to patients with a demonstrated financial need. Eligibility is based on prescribed levels of income and expenses.

Grant Making: For over 10 years, MPMC has shown its commitment to improving community health through a variety of grants to charitable and community-based organizations. Successful

grant applicants fit within funding priorities with work that examines social determinants of health and/or addresses the elimination of health disparities and inequities. From 2019 to 2021, MPMC awarded 99 grants amounting to a total of $3,832,062 in service of 2019 health needs.

In-Kind Resources: MPMC's commitment to community health means reaching out far beyond its patients to improve the health of its communities. Volunteerism, community service, and providing technical assistance and expertise to community partners are critical components of MPMC's approach. From 2019 to 2021, MPMC donated several in-kind resources in service of 2019 implementation strategies and health needs, including lab tests, breast screenings, mammogram readings, and surgical facilities, supplies, and the services of nurses and technicians.

Collaborations and Partnerships: MPMC has a long legacy of sharing its most valuable resources: its knowledge and talented professionals. By working together with partners (including nonprofit organizations, government entities, and academic institutions), these collaborations and partnerships can make a difference in promoting thriving communities that produce healthier, happier, more productive people. From 2019 to 2021, MPMC engaged in several partnerships and collaborations in service of 2019 implementation strategies and health needs, including Gatepath, Peninsula Family Services, and Samaritan House.

IMPLEMENTATION STRATEGY EVALUATION OF IMPACT BY HEALTH NEED

The Implementation Strategy provided details of actions the hospital intended to take, including programs and resources it planned to commit. The tables below highlight the 2019, 2020, and 2021 impacts achieved by the programs that Mills Peninsula Medical Center featured in its 2019–2021 Implementation Strategy.

Name of Program, Activity, or Initiative	**Samaritan House**
Description	MPMC and Samaritan House (SH), a comprehensive safety-net health and social services organization, have partnered for more than two decades to create access to primary medical care and dental care for more than 2,500 uninsured residents living in poverty in San Mateo County. MPMC provides SH with grant funding and uncompensated services such as screenings and mammograms. The support allows SH to extend, free of charge, comprehensive multi-specialty outpatient medical care in: cardiology, dermatology, endocrinology, gynecology, neurology, nephrology, nutrition, orthopedics, psychiatry, rheumatology, and diagnostic testing. For advanced specialty care, thepartnership allows MPMC specialists to see SH patients in their offices, and its medical personnel serve as volunteers at SH Free Clinics throughout the year.
Goals	• Ensure primary health care access for patients who have not established primary care relationships. • Provide SH Free Clinic with supportive services to enable the deliveryof primary healthcare and health screenings. • Provide vulnerable patients assistance with core services.
Anticipated Outcomes	Sustain ongoing access to primary health care at SH health clinic and provide vulnerable patients with core services.
2019–2021 Impact	6,260 persons served 1,1926 encounters 11,357 meals provided 1,859 vaccines provided

Name of Program, Activity, or Initiative	**Operation Access**
Description	MPMC partners with Operation Access to provide access to diagnostic screenings, specialty procedures, and surgical care at no cost for uninsured Bay Area patients who have limited financial resources. MPMC physicians volunteer their time to provide these free surgical services, while the hospital donates the use of its operating rooms. MPMC also provides a grant to support Operation Access's operating costs.
Goals	Increase health care equity for uninsured and underserved patients facing barriers to getting the outpatient surgical and specialty care thatthey need, by providing the resources and promoting the medical volunteerism needed for the donation of these services.
Anticipated Outcomes	Increase number of timely surgical procedures and diagnostic services provided to uninsured and underserved patients
2019–2021 Impact	163 people served 195 encounters 195 surgeries, diagnostic procedures, etc.

Name of Program, Activity, or Initiative	**Senior Focus**
Description	Mills-Peninsula Medical Center's Senior Focus offers a variety of programs and services to help older adults and their caregivers leadmore active and well-balanced lives. These programs include the following: • Adult Day Health Center: Comprised of both the Adult Day Health Program and Alzheimer's and Dementia Day Health Program; these programs provide individualized health care services under the direction of the participant's Primary Care Provider. • Family Caregiver Support Program: Offers classes, counseling, support groups and resources specifically for caregivers; this programcan also help locate resources for participants. • Health Promotion and Education: Comprised of both the Diabetes Empowerment Education Program (DEEP) and the Wise & Well Program; these programs offer health education, health screenings, and counseling with a nurse for participants. • Senior Volunteer Programs: Comprised of the Foster Grandparent Program and RSVP; these programs connect adults 55 years and older with non-profit volunteer opportunities.
Goals	Encourage and support a healthy lifestyle, quality of lifeand independence for older adults and their caregivers
Anticipated Outcomes	Maintain the number older adults living in community settings rather than skilled nursing facilities and increase the well-being of caregivers.
2019–2021 Impact	2,256 people served 29,646 encounters 54 connected to mental health services 246 connected to social services 30,197 connected to transportation services 141 classes, workshops, or support group meetings provided 76 community events provided 176 health screenings provided

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 improve care transitions and reduce future hospitalization. It helps them to manage their health/illness symptoms, manage their medications, coordinate their care, planfor the future, and live the kind of life they want. MPMC supports the program, providing funding towards the care of the people who enroll in the program in the San Mateo County service area. 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 staffcontinues 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 manager 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 inself-managing advanced chronic illness.
2019–2021 Impact	682 people served

Name of Program, Activity, or Initiative	**Grants and Sponsorships Addressing Healthcare Access and Delivery**
Description	Grants and sponsorships are decided annually based on community need. Selected executed grants and sponsorships will be reported at year end. Examples of organizations that may receive grants or sponsorships to address Access to Care are RotaCare Coastside Clinic and Daly City Youth Center.
Goals	Expand the county's safety net by making health care services more readily available to publicly insured and uninsured populations.
Anticipated Outcomes	Increase affordable, accessible health care services for uninsured and underinsured patients by supporting community-based organizations that develop/expand clinical services, outreach programs, and health education workshops to ensure that the needs of the underserved populations are met.
2019–2021 Impact	20,687 people served

Mental Health and Well-Being

Name of Program, Activity, or Initiative	Grants and Sponsorships Addressing Mental Health and Well-Being
Description	Grants and sponsorships are decided annually based on communityneed. Selected executed grants and sponsorships will be reported atyear end. Examples of organizations that may receive grants or sponsorships to address Mental Health and Well-Being are Gatepath and Caminar.
Goals	Promote mental health and well-being in the broader community and at-risk communities
Anticipated Outcomes	Examples: • Increase substance use disorder treatment services • Increase age appropriate art therapy services • Increase integrated treatment services for clients with co-occurring substance use disorder and mental health problems.
2019–2021 Impact	26,210 persons served

Oral and Dental Health

Name of Program, Activity, or Initiative	Grants and Sponsorships Addressing Oral/Dental Health
Description	Grants and sponsorships are decided annually based on communityneed. Selected executed grants and sponsorships will be reported atyear end. Examples of organizations that may receive grants or sponsorships to address Oral and Dental Health are Ravenswood Dental and Sonrisas
Goals	Expand the county's safety net by making dental/oral health care services more readily available to publicly insured and uninsured populations.
Anticipated Outcomes	Increase affordable, accessible oral/dental health care services for uninsured and underinsured patients by supporting community-based organizations that develop/expand clinical services, outreach programs, and health education workshops to ensure that the needs of the underserved populations are met.
2019–2021 Impact	23,094 persons served 12,631 health screenings

Housing and Homelessness

Name of Program, Activity, or Initiative	Grants and Sponsorships Addressing Housing and Homelessness
Description	Grants and sponsorships are decided annually based on communityneed. Selected executed grants and sponsorships will be reported atyear end. Examples of organizations that may receive grants or sponsorships to address Housing and Homelessness are HIP Housing and Home & Hope.
Goals	Prevent homelessness and counter displacement by increasing thecounty's access to healthy, stable and affordable housing.
Anticipated Outcomes	Increase affordable housing opportunities for unhoused and under housed individuals by supporting community-based organizations that develop/expand housing services to ensure that the needs of the community are met.
2019–2021 Impact	4,644 persons served

9. CONCLUSION

Sutter Health Mills-Peninsula Medical Center (MPMC) worked with local hospital and health system partners, pooling expertise and resources, to conduct the 2022 Community Health Needs Assessment. By gathering secondary data and conducting new primary research as a team, the partners were able to understand the community's perception of health needs as well as prioritize health needs with an understanding of how each compares against benchmarks. MPMC further prioritized health needs in its area based on a set of defined criteria.

The 2022 CHNA, which builds upon prior assessments dating to 1995, meets federal (IRS) and California state requirements.

Next steps for the hospital:

- Ensure the 2022 CHNA is adopted by the Sutter Health board and made publicly available on the Sutter Health website by December 31, 2022.[89]
- Monitor community comments on the CHNA report (ongoing).
- Select priority health needs to address using a set of criteria.
- Develop strategies to address priority health needs.
- Ensure strategies are adopted by the Sutter Health board and filed with the IRS by May 15, 2023.

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

10. LIST OF ATTACHMENTS

1. Community Leaders, Representatives, and Members Consulted
2. Secondary Data Indicators List
3. Community Assets and Resources
4. Qualitative Research Protocols
5. IRS Checklist

ATTACHMENT 1: COMMUNITY LEADERS, REPRESENTATIVES, AND MEMBERS CONSULTED

The list below contains the names of leaders, representatives, and members who were consulted for their expertise in the community. Leaders were identified based on their professional expertise and knowledge of vulnerable groups including low-income populations, minorities, and the medically underserved. Interviewees and focus group participants discussed health needs in both San Mateo and Santa Clara counties unless otherwise noted (i.e., designated "SMC").

ID #	Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
Organizations							
1	Interview	Kristina Lugo, Vice President, Individual and Family Services, Avenidas	Senior health needs	1	Low-income, medically underserved	Leader	3/9/2021
2	Interview	Yogita Thakur, Chief Dental Officer, Ravenswood Family Health Network	SMC: Oral health	1	Low-income, medically underserved	Leader	3/11/2021
3	Interview	Arlae Alston, Program Director, Puente de la Costa Sur & unnamed team member	SMC: Coast-side health needs	2	Low-income, medically underserved, minority	Leader	3/15/2021
4	Interview	Alex Golding, Lead Case Manager & Clinical Data Coordinator, San Mateo County Pride Center	SMC: LGBTQ+	1	Medically underserved, minority	Leader, representative	3/24/2021

ID #	Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
			health needs				
5	Interview	Ken Cole, Agency Director, County of San Mateo Human Services Agency	SMC: Basic needs	1	Low-income	Leader	3/25/2021
6	Interview	San Mateo County Health	SMC: Public health	1	Low-income, medically underserved	Leader	3/25/2021
7	Interview	Anand Chabra, MD, Medical Director, Family Health Services, San Mateo County Health	SMC: Maternal/ teen health	1	Low-income, medically underserved	Leader	4/5/2021
8	Interview	Michelle de Blank, Supervising Attorney, Family Advocacy Program, Legal Aid Society of San Mateo County	SMC: Social determinants of health	1	Low-income	Leader	4/8/2021
9	Focus Group	Hosts: El Camino Health & Sutter Health	Adult mental/ behavioral health	13	Medically underserved	(see below)	4/12/2021
		Attendees:					

ID #	Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
		Zena Andreani, Program Manager-Crisis Intervention and Suicide Prevention Center, StarVista				Leader	
		Mark Cloutier, CEO, Caminar				Leader	
		Scott Gilman, Director of Behavioral Health and Recovery Services, San Mateo County Health				Leader	
		Ashley Hartoch, Complex Care Manager, Stanford Health Care				Leader	
		Tiffany Ho, MD DFAPA, Behavioral Health Medical Director, County of Santa Clara Health System				Leader	
		Susan Houston, Vice President of Older Adult Services, Peninsula Family Service				Leader	
		Lauren Johnson, Manager, Community Engagement, Scrivner Center For Mental Health & Addiction Services, El Camino Health				Leader	

ID #	Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
		Teresa Johnson, Teresa Johnson, Director Food & Nutrition Services, The Health Trust				Leader	
		Mego Lien, Prevention Services Division Manager, County of Santa Clara Behavioral Health Services Department				Leader	
		Lan Nguyen, Program Manager, Santa Clara County Behavioral Health Services Department - Suicide and Crisis Services				Leader	
		Dr. Munisha Vohra, MA, LCSW, Director of Clinical Services, Community Overcoming Relationship Abuse				Leader	
		Program Manager , LMFT, Momentum for Health				Leader	
		Next Door Solutions to Domestic Violence				Leader	

ID #	Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
10	Focus Group	Host: Stanford Health Care	Health equity	10	Medically underserved, minority	(see below)	4/14/2021
		Attendees:					
		Steven Adelsheim, Director, Stanford Psychiatry Center for Youth Mental Health and Wellbeing, Stanford Department of Psychiatry and Behavioral Sciences				Leader	
		David Chang, Clinical Assistant Professor, Department of Medicine, Division of Primary Care and Population Health; also Assistant Health Officer, San Mateo County Health, Division of Public Health, Policy, & Planning				Leader	
		Sang-ick Chang, M.D., MPH, Associate Dean and Division Chief, Primary Care & Population Health, Stanford Medical School				Leader	

ID #	Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
		Meenadchi Chelvakumar, Clinical Assistant Professor, Primary Care Provider, Stanford/Ravenswood Family Health Network				Leader	
		Ryan Padrez, Assistant Clinical Professor of Pediatrics; Medical Director, Stanford University School of Medicine; The Primary School				Leader	
		Loto Reed, Program Specialist, Wellness and Community Engagement, Stanford University				Leader	
		Stephen Richmond, Clinical Assistant Professor, Stanford University				Leader, representative	
		Baldeep Singh, Clinical Chief, Stanford Internal Medicine, Co-Director, Pacific Free Clinic				Leader	
		Clinical Associate Professor, Stanford Healthcare				Leader	
		Stanford University Division of Primary Care and Population Health				Leader	

ID #	Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
11	Focus Group	Host: Stanford Health Care & Sutter Health	Safety Net Clinics	12	Low-income, medically underserved	(see below)	4/26/2021
		Attendees:					
		Anupama Balakrishnan, Chief Medical Officer, Indian Health Center of Santa Clara Valley				Leader	
		Alma Burrell, Associate Director, Roots Community Health Center				Leader	
		Will Cerrato, Clinics Manager, San Mateo Medical Center / RotaCare Free Clinics				Leader	
		Parneet Dhindsa, MPH, Planned Parenthood Mar Monte				Leader	
		Poorva Kamath, Medical Director, AACI				Leader	
		Stephanie Kleinheinz, CEO, School Health Clinics of Santa Clara County				Leader	

ID #	Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
		Haleh Sheikholeslami, Medical Director/MD, Peninsula Healthcare Connection				Leader	
		Chief Executive Officer, Ravenswood Family Health Network				Leader	
		Medical Director of Healthcare Services, Samaritan House				Leader	
		Gardner Health Services				Leader	
		North East Medical Services				Leader	
		San Mateo Medical Center				Leader	
12	Focus Group	Host: Lucile S. Packard Children's Hospital-Stanford	Youth Mental Health	12	Medically underserved	(see below)	4/29/2021
		Attendees:					

ID #	Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
		Arash Anoshiravani, Medical Director, Teen Van, Stanford School of Medicine				Leader	
		Vinney Arora, Executive Director, My Digital TAT2				Leader	
		William Blair, MVLA Wellness Coordinator, MVLA School District				Leader	
		Judith Gable, LCSW, Director of Collaborative Counseling Program, Acknowledge Alliance				Leader	
		Melissa Guariglia, PsyD, School-Based & Clinical Services Department Director, StarVista				Leader	
		Vicki Harrison, MSW, Program Director, Center for Youth Mental Health and Wellbeing, Stanford Department of Psychiatry & Behavioral Sciences, Stanford University School of Medicine				Leader	

ID #	Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
		Jamila McCallum, Regional Director, Edgewood San Mateo, Edgewood Center for Children and Families				Leader	
		Ron Pilato, Chief Psychologist and Training Director, Community Health Awareness Council (CHAC)				Leader	
		Nkia Richardson, Executive Director, CASA of San Mateo County				Leader	
		Marico Sayoc, Executive Director, Counseling and Support Services for Youth				Leader	
		Executive Director, Adolescent Counseling Services				Leader	
		Uplift Family Services				Leader	
13	Focus Group	Host: Samaritan House	SMC: Social Services	10	Low-income	(see below)	5/12/2021
		Attendees:					

ID #	Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
		Jenifer Clark, Research & Evaluation Specialist, First 5 San Mateo County				Leader	
		Judith Guerrero, Executive Director, Coastside Hope				Leader	
		Raymond Hodges, Director, County of San Mateo Department of Housing				Leader	
		Jill Jacobson, Executive Director, Boys & Girls Club of the Coastside				Leader	
		Marya Ouro-Gbeleou, Program Director, Daly City Partnership; Daly City Community Service Center				Leader	
		Jen Overholt, Director of Impact, JobTrain				Leader	
		LaTrice Taylor, Associate Director, Programs & Services, Samaritan House				Leader	
		Ophélie Vico, Community Health Manager, Puente de la Costa Sur				Leader	

ID #	Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
		Director of Nutrition, Second Harvest of Silicon Valley				Leader	
		YMCA Community Resource Center				Leader	
14	Focus Group	Host: Bay Area Community Health Advisory Council (BACHAC)	Black Health	7[90]	Minority, medically underserved	(see below)	6/14/2021
		Attendees:					
		Dieter Bruno, Chief Medical Officer, Dignity Health-Sequoia Hospital				Leader, representative	
		Davina Hurt, Councilwoman & Board member of CARB/BAAQMD, City Of Belmont and California Air Resources Board/Bay Area Air Quality Management District				Leader, representative	

[90] One attendee did not give permission to be listed in this appendix.

ID #	Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
		Lisa Tealer, Executive Director, Bay Area Community Health Advisory Council (BACHAC)				Leader, representative	
		Bay Area Community Health Advisory Council				Leader, representative	
		Bay Area Community Health Advisory Council				Leader, representative	
		Unity Care Group				Leader, representative	
Community Residents							
15	Focus Group	Host: Gardner Health Services	Health clinic patients	4	Low-income, medically underserved	Members	6/7/21

ATTACHMENT 2: SECONDARY DATA INDICATORS LIST

Category	Indicator	Indicator Description	Data Source
Behavioral Health	11th Graders Who Had Depression-Related Feelings in the Previous Year	Estimated percentage of public school students in grade 11 in the previous year, felt so sad or hopeless almost every day for two weeks or more that they stopped doing some usual activities	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2020.
Behavioral Health	11th Graders Who Seriously Considered Attempting Suicide in the Previous Year	Students in grade 11 who seriously considered attempting suicide in the previous year	WestEd, California Healthy Kids Survey (CHKS) & Biennial State CHKS. California Dept. of Education. 2020.
Behavioral Health	7th Graders Who Had Depression- Related Feelings in the Previous Year	Estimated percentage of public school students in grade 7 who, in the previous year, felt so sad or hopeless almost every day for two weeks or more that they stopped doing some usual activities	WestEd, California Healthy Kids Survey. California Department of Education. 2020.

Category	Indicator	Indicator Description	Data Source
Behavioral Health	7th Graders Who Have Consumed Alcohol 7 or More Times in Their Lifetimes	Estimated percentage of public school students in grade 7 who have ever consumed one or more full drinks of alcohol, by grade level and number of occasions	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019.
Behavioral Health	7th Graders Who Used Alcohol or Drugs in the Previous Month	Estimated percentage of public school students in 7th grade who have used alcohol or drugs in the past month	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019.
Behavioral Health	7th Graders Who Used Marijuana 20-30 Days in the Previous Month	Estimated percentage of public school students in 7th grade who have used marijuana for 20-30 days out of the previous month	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019.
Behavioral Health	7th Graders with a Low Level of Caring Relationships with Adults at School	Estimated percentage of public school students in grade 7 who have a low level of caring relationships with adults at school, by level of agreement	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019.

Category	Indicator	Indicator Description	Data Source
Behavioral Health	9th Graders Who Had Depression- Related Feelings in the Previous Year	Estimated percentage of public school students in grade 9 who, in the previous year, felt so sad or hopeless almost every day for two weeks or more that they stopped doing some usual activities	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2020.
Behavioral Health	9th Graders Who Have Consumed Alcohol 7 or More Times in Their Lifetimes	Estimated percentage of public school students in grade 9 who have ever consumed one or more full drinks of alcohol, by grade level and number of occasions	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019.
Behavioral Health	9th Graders Who Seriously Considered Attempting Suicide in the Previous Year	Estimated percentage of public school students in grade 9 who seriously considered attempting suicide in the previous year	WestEd, California Healthy Kids Survey (CHKS) & Biennial State CHKS. California Dept. of Education. 2020.
Behavioral Health	9th Graders Who Used Alcohol or Drugs in the Previous Month	Estimated percentage of public school students in 9th grade who have used alcohol or drugs in the past month	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019.

Category	Indicator	Indicator Description	Data Source
Behavioral Health	9th Graders Who Used Marijuana 20-30 Days in the Previous Month	Estimated percentage of public school students in 9th grade who have used marijuana for 20-30 days out of the previous month	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019.
Behavioral Health	9th Graders with a Low Level of Caring Relationships with Adults at School	Estimated percentage of public school students in grade 9 who have a low level of caring relationships with adults at school, by level of agreement	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019.
Behavioral Health	Adults with 1-3 Adverse Childhood Experiences	Estimated percentage of adults 18 and older exposed to one to three adverse childhood experiences before age 18, by household type	UC Davis Violence Prevention Research Program, tabulation of data from the California and American Community Survey. 2020.
Behavioral Health	Adults with 4 or More Adverse Childhood Experiences	Estimated percentage of adults 18 and older exposed to four or more adverse childhood experiences before age 18, by household type	UC Davis Violence Prevention Research Program, tabulation of data from the California and American Community Survey. 2020.

Category	Indicator	Indicator Description	Data Source
Behavioral Health	Children with 2 or More Adverse Experiences (ages 0-17, parent reported)	Estimated percentage of children ages 0-17 who have experienced two or more adverse experiences	Population Reference Bureau, analysis of data from the National Survey of Children's Health and the US Census Bureau, American Community Survey. 2012-16. (Jan. 2021).
Behavioral Health	Current Smokers	Percentage of adults who are current smokers	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2020.
Behavioral Health	Deaths Due to Chronic Liver Disease and Cirrhosis	Percentage of deaths that occurred due to liver disease and Cirrhosis	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Behavioral Health	Deaths of Despair	Rate of deaths of despair	National Center for Health Statistics. 2018.
Behavioral Health	Drug Induced Deaths	Percentage of deaths that occurred due to drugs	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Behavioral Health	Drug Overdose Deaths	Percentage of deaths that occurred due to drug overdoses	National Center for Health Statistics - Mortality Files. 2017-19.

Category	Indicator	Indicator Description	Data Source
Behavioral Health	Excessive Drinking	Percentage of Adults Drinking Excessively	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2020.
Behavioral Health	Frequent Mental Distress, Adults (14+ days per month)	Percentage of adults who report frequent mental distress (14 or more mentally unhealthy days) in the past 30 days	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2018.
Behavioral Health	Impaired Driving Deaths	Estimated deaths that occurred due to impaired driving	National Highway Traffic Safety Administration Fatality Analysis Reporting System. 2015-19.
Behavioral Health	Insufficient Sleep	Percentage of population with insufficient sleep	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2018.
Behavioral Health	Mental Health Hospitalizations among Children (ages 5-14) (per 1,000)	Number of hospital discharges for mental health issues per 1,000 children and youth ages 5-14	California Office of Statewide Health Planning and Development special tabulation; California Dept. of Finance, Population Estimates and Projections. 2020.
Behavioral Health	Mental Health Hospitalizations among Youth (ages 15-19) (per 1,000)	Number of hospital discharges for mental health issues per 1,000 children and youth ages 15-19	California Office of Statewide Health Planning and Development special tabulation; California Dept. of Finance, Population Estimates and Projections. 2020.

Category	Indicator	Indicator Description	Data Source
Behavioral Health	Mental Health Providers	Number of mental health providers per populations of 100,000	Chronic Conditions prevalence State/County Level: All Beneficiaries by Age, 2007-2018
Behavioral Health	Opioid Overdose Deaths	Estimated deaths that occurred due to opioid overdose deaths	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2017-2019.
Behavioral Health	Poor Mental Health (days per month)	Average Number of Mentally Unhealthy Days per Month	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2020.
Behavioral Health	Population 65 & Older Living Alone	Estimated number of the population who is 65 and older that are living alone	U.S. Census Bureau, American Community Survey. 2015-19.
Behavioral Health	Ratio of Students to School Psychologists	Ratio of the number of students compared to the number of number of school psychologists	California Dept. of Education, Staff Assignment and Course Data (Jan. 2020) & DataQuest (Mar. 2019).
Behavioral Health	Social Associations (per 10,000)	Estimated number of social Associations per 10,000 people	U.S. Census Bureau, County Business Patterns. 2018.

Category	Indicator	Indicator Description	Data Source
Behavioral Health	Suicide Deaths	Rate of Deaths due to Suicide	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2017-2019.
Behavioral Health	Youth Self-Harm Injury ED Visits (age 0-17)	Percent of youth self-harm reported in children ages 0-17	California Department of Public Health, California EpiCenter. 2015.
Behavioral Health	Youth Self-Harm Injury Hospitalization	Percent of hospitalizations reported from youth self-harm	California Department of Public Health, California EpiCenter. 2015.
Cancer	Breast Cancer Incidence	Estimate number of Breast Cancer incidents that were reported	National Cancer Institute State Cancer Profiles. 2013-17.
Cancer	Breast Cancer Screening (Mammogram)	Estimated number of breast cancer screenings (mammograms) performed	U.S. Centers for Medicare & Medicaid Services, Mapping Medicare Disparities Tool. 2018.

Category	Indicator	Indicator Description	Data Source
Cancer	Cancer Incidence among Children (ages 0-19)	The amount of cancer incidents that occurred among children ages 0-19	National Cancer Institute, Surveillance, Epidemiology, and End Results (SEER) Program Research Data (Nov. 2018); U.S. Cancer Statistics Working Group, U.S. Cancer Statistics Data Visualizations Tool (Jun. 2018).
Cancer	Colorectal Cancer Incidence	Estimate number of Colorectal Cancer incidents that were reported	National Cancer Institute State Cancer Profiles. 2013-17.
Cancer	Deaths Due to All Cancers	Estimated number of deaths reported that were caused by all cancers	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Cancer	Deaths Due to Colorectal Cancer[3]	Estimated number of deaths that occurred due to colorectal cancer	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.

Category	Indicator	Indicator Description	Data Source
Cancer	Deaths Due to Female Breast Cancer	Estimated number of deaths that occurred due to female breast cancer	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Cancer	Deaths Due to Lung Cancer	Estimated number of deaths that occurred due to lung cancer	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Cancer	Deaths Due to Prostate Cancer	Estimated number of deaths that occurred due to prostate cancer	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Cancer	Lung Cancer Incidence	Estimated number of incidents reported that occurred due to lung cancer	National Cancer Institute State Cancer Profiles. 2013-17.
Cancer	Prostate Cancer Incidence	Estimated number of incidents reported that occurred due to prostate cancer	National Cancer Institute State Cancer Profiles. 2013-17.
Climate/ Natural Environment	% Change in Mean Travel Time to Work (minutes) - Silicon Valley	The change in mean travel time to work in the silicon valley by percent	U.S. Census Bureau, American Community Survey. 2015-19.

Category	Indicator	Indicator Description	Data Source
Climate/ Natural Environment	Air Pollution: PM2.5 Concentration (parts per million)	Percentage of Days Exceeding Standards, Pop. Adjusted Average	Harvard University Project (UCDA). 2018
Climate/ Natural Environment	Asthma Hospitalizations among Children (ages 0-4) (per 10,000)	Rate of asthma hospitalizations per 10,000 children/youth, by age group (0-4)	California Breathing, tabulation of data from the California Office of Statewide Health Planning and Development. 2020.
Climate/ Natural Environment	Asthma Hospitalizations among Children (ages 5-17) (per 10,000)	Rate of asthma hospitalizations per 10,000 children/youth, by age group (5-17)	California Breathing, tabulation of data from the California Office of Statewide Health Planning and Development. 2020.
Climate/ Natural Environment	Asthma Prevalence, Adults	Percent Adults with Asthma	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Climate/ Natural Environment	Asthma Prevalence, All Ages	Percent of population with asthma	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.

Category	Indicator	Indicator Description	Data Source
Climate/ Natural Environment	Asthma Prevalence, Seniors Aged 65+	Percent of population 65 and older with asthma	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Climate/ Natural Environment	Children Ever Diagnosed with Asthma (ages 1-17)	Percentage of children ages 1-17 whose parents report that their child has ever been diagnosed with asthma	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Climate/ Natural Environment	Coastal Flooding Risk	Coastal Flooding Risk Index	FEMA Hazards Index. 2020.
Climate/ Natural Environment	Deaths Due to Chronic Lower Respiratory Disease	Rate of deaths due to Chronic Lower Respiratory Disease	UCLA Center for Health Policy Research, California Health Interview Survey. 2020.
Climate/ Natural Environment	Drought Risk	Drought Risk Index	FEMA Hazards Index. 2020.
Climate/ Natural Environment	Heat Wave Risk	Heat Wave Risk Index	FEMA Hazards Index. 2020.

Category	Indicator	Indicator Description	Data Source
Climate/ Natural Environment	Respiratory Hazard Index	Respiratory Hazard Index	EPA National Air Toxics Assessment. 2014.
Climate/ Natural Environment	River Flooding Risk	River Flooding Risk Index	FEMA Hazards Index. 2020
Climate/ Natural Environment	Road Network Density (miles of road per square mile of land)	Total road network density in terms of road miles per square mile	Environmental Protection Agency, EPA Smart Location Database. 2011.
Climate/ Natural Environment	Traffic Volume (per meter of roadway	Average traffic Volume per meter of roadway	EJSCREEN: Environmental Justice Screening and Mapping Tool. 2019.
Climate/ Natural Environment	Travel Time to Work (minutes) - Silicon Valley	How much time is taken in minutes traveling to work	U.S. Census Bureau, American Community Survey. 2015-19.
Climate/ Natural Environment	Tree Canopy Cover	Population Weighted Percentage of Report Area Covered by Tree Canopy	U.S. Geological Survey, National Land Cover Database. 2016.

Category	Indicator	Indicator Description	Data Source
Climate/ Natural Environment	Workers Commuting by Transit, Biking or Walking	Percentage of commuters commuting by transit, biking or walking	U.S. Census Bureau, American Community Survey. 2015-19.
Climate/ Natural Environment	Workers Driving Alone to Work	Percentage of worker who drive alone to work	U.S. Census Bureau, American Community Survey. 2015-19.
Climate/ Natural Environment	Workers Driving Alone with Long Commutes	Percentage of workers with long commute who drive alone to work	U.S. Census Bureau, American Community Survey. 2015-19.
Community Safety	7th Graders Bullied or Harassed at School in the Previous Year	Estimated percentage of public school students in grade 7 who were bullied or harassed at school for any reason in the previous year	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019.
Community Safety	7th Graders Cyberbullied 4 or More Times in the Previous Year	Estimated percentage of public school students in grade 7 who had mean rumors or lies spread about them on the internet by other students in the previous year, by number of occasions	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019.

Category	Indicator	Indicator Description	Data Source
Community Safety	7th Graders Who Consider Themselves Gang Members	Estimated percentage of public school students in grade 7 who consider themselves gang members	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019.
Community Safety	7th Graders Who Feared Being Beaten Up at School on 4 or More Occasions in the Previous Year	Estimated percentage of public school students in grades 7 who were afraid of being beaten up at school in the previous year, by number of occasions	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019.
Community Safety	7th Graders Who Feel Very Unsafe at School	Level of perceived school safety among public school students in grade 7	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019.
Community Safety	9th Graders Bullied or Harassed at School in the Previous Year	Estimated percentage of public school students in grade 9 who were bullied or harassed at school for any reason in the previous year	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019.

Category	Indicator	Indicator Description	Data Source
Community Safety	9th Graders Cyberbullied 4 or More Times in the Previous Year	Estimated percentage of public school students in grade 9 who had mean rumors or lies spread about them on the internet by other students in the previous year, by number of occasions	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019.
Community Safety	9th Graders Who Consider Themselves Gang Members	Estimated percentage of public school students in grade 7 who consider themselves gang members	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019.
Community Safety	9th Graders Who Feared Being Beaten Up at School on 4 or More Occasions in the Previous Year	Estimated percentage of public school students in grades 9 who were afraid of being beaten up at school in the previous year, by number of occasions	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019.
Community Safety	9th Graders Who Feel Very Unsafe at School	Level of perceived school safety among public school students in grade 9	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019.

Category	Indicator	Indicator Description	Data Source
Community Safety	Children in Foster Care (ages 0-20) (per 1,000)	Number of children and youth under age 21 in foster care per 1,000	Webster, D., et al. California Child Welfare Indicators Project Reports. UC Berkeley Center for Social Services Research. 2019.
Community Safety	Children with Substantiated Cases of Abuse or Neglect (ages 0-17) (per 1,000)	Number of substantiated cases of abuse and neglect per 1,000 children under age 18	Webster, D., et al. California Child Welfare Indicators Project Reports, UC Berkeley Center for Social Services Research. 2019.
Community Safety	Deaths Due to Homicide	Percentage of Deaths due to homicide	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Community Safety	Domestic Violence-Related Calls for Assistance among Adults (ages 18-69) (per 1,000)	Number of domestic violence calls for assistance per 1,000 population	California Dept. of Justice Criminal Justice Statistics Center, Domestic Violence-Related Calls for Assistance (Jul. 2019); California Dept. of Finance, Population Estimates and Projections. 2019.

Category	Indicator	Indicator Description	Data Source
Community Safety	Felony Arrests among Juveniles (ages 10-17) (per 1,000)	Number of juvenile felony arrests per 1,000 youth ages 10-17	California Dept. of Justice, Crime Statistics: Arrests; California Dept. of Finance, Population Estimates and Projections. 2019.
Community Safety	Firearm Related Deaths Rate	Number of firearm related deaths (per 100,000 pop.)	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Community Safety	Median Length of Stay (months) in Foster Care among Children Entering Foster Care (ages 0-17)	Median length of stay in foster care, in months, for children under age 18	Webster, D., et al. California Child Welfare Indicators Project Reports. UC Berkeley Center for Social Services Research. 2019.
Community Safety	Rapes Rate - Silicon Valley	Rate of rapes in the Silicon Valley (per 100,000 pop.)	California Department of Justice; California Department of Finance. 2018.
Community Safety	Violent Crimes Rate	Violent crime rate (per 100,000 pop.)	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2014-18.

Category	Indicator	Indicator Description	Data Source
COVID-19	14-day average number of hospitalized patients	Number of people hospitalized daily, 14-day average	COVID19.CA.GOV. (2022). *Tracking COVID-19 in California*. Retrieved from https://covid19.ca.gov/state-dashboard/#location-san_mateo
COVID-19	All SARS-CoV-2 virus concentration (normalized)	SARS-CoV-2 RNA concentrations in wastewater, reported as normalized to a human fecal indicator, Pepper Mild Mottle virus (SARS-CoV-2/PMMoV)	California Department of Public Health. (2002). *CDPH Wastewater Surveillance Network Dashboard*. Retrieved from https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/CalSuWers-Dashboard.aspx August 2, 2022.
COVID-19	Cumulative total cases	Cumulative count of total number of cases of COVID-19	The New York Times. (2022). California Coronavirus Tracker. *The New York Times.* Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html January 2020 to August 1, 2022.
COVID-19	Cumulative total deaths	Cumulative count of total number of deaths from COVID-19	The New York Times. (2022). California Coronavirus Tracker. *The New York Times.* Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html January 2020 to August 1, 2022.

Category	Indicator	Indicator Description	Data Source
COVID-19	Current rate of spread (R-eff)	Average number of people an infected person will infect. Value less than 1 means decreasing spread. Value greater than 1 means increasing spread.	CalCAT. (2022). *California COVID Assessment Tool.* Data retrieved from https://calcat.covid19.ca.gov/cacovidmodels/ August 2, 2022.
COVID-19	Fully vaccinated (age 65+)	Cumulative percentage of population (of county or state) age 65 or older who have received one (J&J) or two (mRNA) vaccinations	The New York Times. (2022). California Coronavirus Tracker. *The New York Times*. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html August 2, 2022.
COVID-19	Fully vaccinated (all ages)	Cumulative percentage of population (of county or state) who have received one (J&J) or two (mRNA) vaccinations	The New York Times. (2022). California Coronavirus Tracker. *The New York Times*. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html August 2, 2022.
COVID-19	Rate of deaths since January 2020	Ratio of total number of people who have died from COVID-19 compared to region's population (county or state)	The New York Times. (2022). California Coronavirus Tracker. *The New York Times*. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html January 2020 to August 1, 2022.

Category	Indicator	Indicator Description	Data Source
COVID-19	Rate of infection since January 2020	Ratio of total number of people who have been infected with COVID-19 compared to region's population (county or state)	The New York Times. (2022). California Coronavirus Tracker. *The New York Times*. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html January 2020 to August 1, 2022
COVID-19	Seven-day average number of daily cases	Number of new daily cases, seven-day average	The New York Times. (2022). California Coronavirus Tracker. *The New York Times*. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html August 2, 2022.
COVID-19	Seven-day average number of daily deaths	Number of deaths daily, seven-day average	The New York Times. (2022). California Coronavirus Tracker. *The New York Times*. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html August 2, 2022.
COVID-19	Seven-day average rate of daily cases	Rate of new daily cases per 100,000 people, seven-day average	The New York Times. (2022). California Coronavirus Tracker. *The New York Times*. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html August 2, 2022.

Category	Indicator	Indicator Description	Data Source
COVID-19	Seven-day average rate of daily deaths	Rate of daily deaths per 100,000 people, seven-day average	The New York Times. (2022). California Coronavirus Tracker. *The New York Times*. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html August 2, 2022.
COVID-19	Seven-day average test positivity rate	Percentage of COVID-19 tests reported as positive, seven-day average	COVID19.CA.GOV. (2022). *Tracking COVID-19 in California*. Retrieved from https://covid19.ca.gov/state-dashboard/#location-san_mateo
COVID-19	Vaccinated and received a booster (all ages)	Cumulative percentage of population (of county or state) who have received one (J&J) or two (mRNA) vaccinations and a booster shot (if last vaccination was at least six months prior)	The New York Times. (2022). California Coronavirus Tracker. *The New York Times*. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html August 2, 2022.
COVID-19	Vaccinated and received a booster (age 65+)	Cumulative percentage of population (of county or state) age 65 or older who have received one (J&J) or two (mRNA) vaccinations and a booster shot (if last vaccination was at least six months prior)	The New York Times. (2022). California Coronavirus Tracker. *The New York Times*. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html August 2, 2022.

Category	Indicator	Indicator Description	Data Source
Diabetes and Obesity	5th Graders Body Composition at Health Risk (worst rating)	Percent of 5th graders whose body composition health is at risk	California Department of Education, FITNESSGRAM® Physical Fitness Testing. 2018-19.
Diabetes and Obesity	5th Graders Meeting All Fitness Standards	Percentage of public school students in grade 5 meeting six of six fitness standards	California Dept. of Education, Physical Fitness Testing Research Files. 2018.
Diabetes and Obesity	7th Graders Body Composition at Health Risk (worst rating)	Percent of 7th graders whose body composition health is at risk	California Department of Education, FITNESSGRAM® Physical Fitness Testing. 2018-19.
Diabetes and Obesity	7th Graders Meeting All Fitness Standards	Percentage of public school students in grade 7 meeting six of six fitness standards	California Dept. of Education, Physical Fitness Testing Research Files. 2018.
Diabetes and Obesity	7th Graders Who Did Not Eat Breakfast in the Previous Day	Estimated percentage of public school students in grade 7 who did not eat breakfast in the previous day	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019-20.
Diabetes and Obesity	9th Graders Body Composition at Health Risk (worst rating)	Percent of 9th graders whose body composition health is at risk	California Department of Education, FITNESSGRAM® Physical Fitness Testing. 2018-19.

Category	Indicator	Indicator Description	Data Source
Diabetes and Obesity	9th Graders Meeting All Fitness Standards	Percentage of public school students in grade 9 meeting six of six fitness standards	California Dept. of Education, Physical Fitness Testing Research Files. 2018.
Diabetes and Obesity	9th Graders Who Did Not Eat Breakfast in the Previous Day	Estimated percentage of public school students in grade 9 who did not eat breakfast in the previous day	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019-20.
Diabetes and Obesity	Convenience Stores (per 1,000 population)	Rate of Convenience Stores per populations of 1,000	U.S. Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2016.
Diabetes and Obesity	Deaths Due to Diabetes	Percent of deaths due to diabetes	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Diabetes and Obesity	Diabetes Prevalence	Percentage Adults with Diagnosed Diabetes (Age-Adjusted)	Centers for Medicare & Medicaid Services. 2017.

Category	Indicator	Indicator Description	Data Source
Diabetes and Obesity	Diabetes, Share of Hospitalizations among Children (ages 0-17)	Percentage of hospital discharges among children ages 0-17 for diabetes	California Office of Statewide Health Planning and Development custom tabulation. 2019.
Diabetes and Obesity	Exercise Opportunities	Percent of the population that live in close proximity to a park or recreational facility	Esri Business Analyst. 2020.
Diabetes and Obesity	Food Environment Index	Food Environment Index	US Department of Agriculture, Economic Research Service, USDA - Food Environment Atlas. 2020.
Diabetes and Obesity	Fruit/Vegetable Consumption among Children (age 2-11), 5 or More Servings in Previous Day	Estimated percentage of children ages 2-11 who eat five or more servings of fruits and vegetables (excluding juice and fried potatoes) daily	UCLA Center for Health Policy Research, California Health Interview Survey. 2018.
Diabetes and Obesity	Grocery Stores (per 1,000 population)	Grocery Stores rate (Per 100,000 Population)	US Department of Agriculture, Economic Research Service, USDA - Food Environment Atlas. 2020.
Diabetes and Obesity	Low Access to Grocery Store (percent population)	Percentage of population with low access to a grocery store	US Department of Agriculture, Economic Research Service, USDA - Food Environment Atlas. 2020.

Category	Indicator	Indicator Description	Data Source
Diabetes and Obesity	Obesity (Adult)	Percentage of adults who were ever diagnosed with diabetes	National Center for Chronic Disease Prevention and Health Promotion. 2018.
Diabetes and Obesity	Physical Inactivity (Adult)	Percent Population with no Leisure Time Physical Activity	National Center for Chronic Disease Prevention and Health Promotion. 2018.
Diabetes and Obesity	Supercenters & Club Stores (per 1,000 population)	Supercenters & Club Stores rate (per 1,000 population	US Department of Agriculture, Economic Research Service, USDA - Food Environment Atlas. 2016.
Diabetes and Obesity	Walkability Index	Walkability Index	U.S. Environmental Protection Agency, EPA Smart Location Mapping. 2012.
Economic Security	11th Graders Meeting or Exceeding Grade-Level CAASPP Standard in English Language Arts	Percentage of 11th Graders Meeting or Exceeding Grade-Level CAASPP Standard in English Language Arts	California Dept. of Education, Test Results for California's Assessments. 2020.
Economic Security	11th Graders Meeting or Exceeding Grade-Level CAASPP Standard in Mathematics	Percent of 11th Graders Meeting or Exceeding Grade-Level CAASPP Standard in Mathematics	California Dept. of Education, Test Results for California's Assessments. 2020.

Category	Indicator	Indicator Description	Data Source
Economic Security	7th Graders with a Low Level of Meaningful Participation at School	Estimated percentage of public school students in grade 7 who have opportunities for meaningful participation at school, by low level of agreement	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019-20.
Economic Security	7th Graders with a Low Level of School Connectedness	Estimated percentage of public school students in grade 7 who have low levels of school connectedness	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019-20.
Economic Security	9th Graders with a Low Level of Meaningful Participation at School	Estimated percentage of public school students in grade 9 who have opportunities for meaningful participation at school, by low level of agreement	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019-20.
Economic Security	9th Graders with a Low Level of School Connectedness	Estimated percentage of public school students in grade 7 who have low levels of school connectedness	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019-20.
Economic Security	Adults Without a College Degree	Percent of adults who did not receive a college degree	U.S. Census Bureau, American Community Survey. 2015-19.

Category	Indicator	Indicator Description	Data Source
Economic Security	Adults Without a High School Diploma	Percent of adults who did not receive a high school diploma	U.S. Census Bureau, American Community Survey. 2015-19.
Economic Security	Annual Cost of Childcare for Infants Ages 0-2 in a Childcare Center	Estimated annual cost of full-time licensed child care for infant children ages 0-2	California Child Care Resource and Referral Network, California Child Care Portfolio. 2020.
Economic Security	Annual Cost of Childcare for Preschoolers Ages 3-5 in a Childcare Center	Estimated annual cost of full-time licensed child care for preschool children ages 3-5	California Child Care Resource and Referral Network, California Child Care Portfolio. 2020.
Economic Security	Children Eligible for Free and Reduced-Price Lunch	Percentage of children who are eligible for free and reduced-price lunch	National Center for Education Statistics, NCES - Common Core of Data. 2018-19.
Economic Security	Children in Single-Parent Households	Percentage of Children who reside in Single-Parent households	U.S. Census Bureau, American Community Survey. 2015-19.

Category	Indicator	Indicator Description	Data Source
Economic Security	Children in Working Families for Whom Licensed Childcare is Available (ages 0-12)	Percentage of children ages 0-12 in working families whom are able to access licensed childcare	California Child Care Resource and Referral Network, California Child Care Portfolio (Apr. 2020); U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16. public use Microdata. 2020.
Economic Security	Children Living in Food Insecure Households (ages 0-17)	Percentage of children living in food insecure household under the age of 18	Gundersen, C., et al. Map the Meal Gap 2019. Feeding America. 2019.
Economic Security	Children Living in Poverty	Percent Population Under Age 18 in Poverty	U.S. Census Bureau, American Community Survey. 2015-19.
Economic Security	Children Without Secure Parental Employment (ages 0-17)	Estimated percentage of children under age 18 living in families where no resident parent worked at least 35 hours per week, at least 50 weeks in the 12 months prior to the survey	Population Reference Bureau, analysis of data from US Census Bureau, American Community Survey. 2012-16. microdata files. 2019.
Economic Security	Economically Precarious Households by Education Level, High School Diploma or GED	Percent of Economically Precarious Households with Education Levels of High School Diploma or GED	The Self-Sufficiency Standard for California, Center for Women's Welfare, University of Washington. 2021.

Category	Indicator	Indicator Description	Data Source
Economic Security	Economically Precarious Households by Education Level, Less Than High School	Percent of Economically Precarious Households with education levels Less Than High School	The Self-Sufficiency Standard for California, Center for Women's Welfare, University of Washington. 2021.
Economic Security	Economically Precarious Households by Education Level, Some College or Associate's	Percent of economically precarious households with education levels of some college or associate's	The Self-Sufficiency Standard for California, Center for Women's Welfare, University of Washington. 2021.
Economic Security	Economically Precarious Households by Employment Status, Full Time Full Year, 2 Adults	Percent of economically precarious households with employment status of full time, full year and with 2 adults	The Self-Sufficiency Standard for California, Center for Women's Welfare, University of Washington. 2021.
Economic Security	Economically Precarious Households by Employment Status, Not in Workforce, 2 Adults	Percent of economically precarious households with employment status of not being in the workforce with 2 adults	The Self-Sufficiency Standard for California, Center for Women's Welfare, University of Washington. 2021.
Economic Security	Economically Precarious Households by Employment Status, Part Time Part Year, 2 Adults	Percent of economically precarious households with employment status of part time, part year, and with 2 adults	The Self-Sufficiency Standard for California, Center for Women's Welfare, University of Washington. 2021.

Category	Indicator	Indicator Description	Data Source
Economic Security	Economically Precarious Households by Gender (men)	Percent of economically precarious households with men	The Self-Sufficiency Standard for California, Center for Women's Welfare, University of Washington. 2021.
Economic Security	Economically Precarious Households by Gender (women)	Percent of economically precarious households with women	The Self-Sufficiency Standard for California, Center for Women's Welfare, University of Washington. 2021.
Economic Security	Elementary School Proficiency Index	Elementary School Proficiency index	HUD Policy Development and Research. 2016.
Economic Security	Food Insecure	Percentage of Total Population with Food Insecurity	Gundersen, C., et al. Map the Meal Gap 2019. Feeding America. 2019.
Economic Security	Free and Reduced-Price Lunch Enrollment	Percentage of Total Population with Reduced- Price Lunch	National Center for Education Statistics, NCES - Common Core of Data. 2017-18.
Economic Security	High School Graduates Completing College Preparatory Courses	Percentage of public school 12th grade graduates completing courses required for UC and/or CSU entrance, with a grade of C or better..	California Dept. of Education, Graduates by Race and Gender (May 2018).
Economic Security	Income Inequality	Number of the total population with income inequality	U.S. Census Bureau, American Community Survey. 2015-19.

Category	Indicator	Indicator Description	Data Source
Economic Security	Income Inequality - Gini Index	Gini Index Value	U.S. Census Bureau, American Community Survey. 2015-19.
Economic Security	Job Proximity Index (neighborhood)	Job proximity index	U.S. Department of Housing and Urban Development Policy Development and Research. 2014.
Economic Security	Math Scores (3rd graders)	Average 3rd grade math scores	Stanford Education Data Archive. 2018.
Economic Security	Median Household Income	Median household income	U.S. Census Bureau, American Community Survey. 2015-19.
Economic Security	On-Time High School Graduation	Percent of High Schoolers who graduated on time	Dept of Education ED Facts & state data sources. 2015-16.
Economic Security	Poverty Rate	Rate of the population in poverty	U.S. Census Bureau, American Community Survey. 2015-19.
Economic Security	Preschool Enrollment	Percentage of Population age 3-4 Enrolled in preschool	U.S. Census Bureau, American Community Survey. 2015-19.

Category	Indicator	Indicator Description	Data Source
Economic Security	Ratio of Students to Academic Counselors (N students per counselor)	Number of public school students per full-time equivalent (FTE) pupil support service personnel, by type of personnel (Academic Counselor)	California Dept. of Education, Staff Assignment and Course Data (Jan. 2020) & DataQuest. 2019.
Economic Security	Reading Below Proficiency (4th grade)	Percent of 4th graders reading below proficiency	California Department of Education. 2019.
Economic Security	Reading Scores (3rd graders)	Percent of 3rd graders reading below proficiency	Stanford Education Data Archive. 2018.
Economic Security	SNAP Enrollment	Percent Population Receiving SNAP Benefits	U.S. Census Bureau, American Community Survey. 2015-19.
Economic Security	Students Not Completing High School	Percentage of public high school students who do not complete high school, based on the four-year adjusted cohort dropout rate	California Dept. of Education, Cohort Outcome Data (Jun. 2017) & Adjusted Cohort Graduation Rate and Outcome Data. 2019.
Economic Security	Students Truant from School (per 100 enrolled)	Number of K-12 public school students reported as being truant at least once during the school year per 100 students	California Dept. of Education, Truancy Data. 2016.

Category	Indicator	Indicator Description	Data Source
Economic Security	Unemployment Rate	Rate of population who are unemployed	US Department of Labor, Bureau of Labor Statistics. 2018.
Economic Security	Young People Not in School and Not Working	Percentage of young people ages 18-24 who are not in school and not working	U.S. Census Bureau, American Community Survey. 2015-19.
Healthcare Access and Delivery	Children Living in Limited English-Speaking Households (ages 0-17)	Estimated percentage of children ages 0-17 living in households in which (i) no person age 14 or older speaks English only, and (ii) no person age 14 or older who speaks a language other than English speaks English very well	Population Reference Bureau, analysis of U.S. Census Bureau American Community Survey public use microdata. 2018.
Healthcare Access and Delivery	Children with Health Insurance Coverage (ages 0-18)	Estimated percentage of children ages 0-18 with and without health insurance coverage at the time of survey, by type of insurance and age group	U.S. Census Bureau, American Community Survey Summary Files and Public Use Microdata. 2018.
Healthcare Access and Delivery	Deaths Due to Cerebrovascular Disease (Stroke)	Rate of deaths due to Cerebrovascular Disease (Stroke)	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2017-19.

Category	Indicator	Indicator Description	Data Source
Healthcare Access and Delivery	Deaths Due to Coronary Heart Disease	Rate of deaths due to Coronary Heart Disease	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2017-19.
Healthcare Access and Delivery	Flu vaccinations (Medicare enrollees)	Percent of Medicare enrollees who received the flu shot	U.S. Centers for Medicare & Medicaid Services, Mapping Medicare Disparities Tool. 2018.
Healthcare Access and Delivery	Heart Disease Deaths	Rate of deaths due to Heart Disease	CDC, Interactive Atlas of Heart Disease and Stroke. 2016-18.
Healthcare Access and Delivery	High Speed Internet	Percent of population with high speed internet	U.S. Census Bureau, American Community Survey. 2015-19.
Healthcare Access and Delivery	Kindergarteners with All Required Immunizations	Percent of Kindergarteners with All Required Immunizations	California Dept. of Public Health, Immunization Branch, Kindergarten Data and Reports. 2019.
Healthcare Access and Delivery	Limited English Proficiency	Percent of population with limited English Proficiency	U.S. Census Bureau, American Community Survey. 2015-19.

Category	Indicator	Indicator Description	Data Source
Healthcare Access and Delivery	Medicaid/Public Insurance Enrollment	Percent of population enrolled in Medicaid/ Public insurance	U.S. Census Bureau, American Community Survey. 2015-19.
Healthcare Access and Delivery	Other Primary Care Providers (not PCPs) (N people per provider)	Ratio of people per provider for other primary care providers (not PCPs)	U.S. Centers for Medicare & Medicaid Services, National Provider Identification database. 2020.
Healthcare Access and Delivery	Percent Uninsured	Percent Uninsured Population	U.S. Census Bureau, American Community Survey. 2015-19.
Healthcare Access and Delivery	Population Over Age 75 with a Disability	Percent population over the age of 75 with a disability	U.S. Census Bureau, American Community Survey. 2015-19.
Healthcare Access and Delivery	Population with Any Disability	Percent population with any disability	U.S. Census Bureau, American Community Survey. 2015-19.
Healthcare Access and Delivery	Premature Death (years of potential life lost before age 75)	Years of Potential Life Lost, Rate per 100,000 Population	National Center for Health Statistics - Mortality Files. 2017-19.

Category	Indicator	Indicator Description	Data Source
Healthcare Access and Delivery	Premature Mortality Rate (under age 75, age-adjusted)	Mortality Rate for population under 75 years old	National Center for Health Statistics - Mortality Files. 2017-19.
Healthcare Access and Delivery	Preventable Hospital Stays (Medicare enrollees)	Age-Adjusted Discharge Rate (Per 10,000 Pop.)	U.S. Centers for Medicare & Medicaid Services, Mapping Medicare Disparities Tool. 2018.
Healthcare Access and Delivery	Primary Care Physicians Rate	Rate of Primary Care Physicians per 100,000 population	Health Resources and Service Administration Area Resource File. 2016-18.
Healthcare Access and Delivery	Ratio of Students to School Nurses	Number of public school students per full-time equivalent (FTE) pupil support service personnel, by type of personnel (School Nurse)	California Dept. of Education, Staff Assignment and Course Data (Jan. 2020) & DataQuest (Mar. 2019).
Healthcare Access and Delivery	Ratio of Students to School Speech/Language/Hearing Specialists	Ratio of Students to School Speech/Language/Hearing Specialists	California Dept. of Education, Staff Assignment and Course Data (Jan. 2020) & DataQuest (Mar. 2019).
Healthcare Access and Delivery	Uninsured Children	Percentage of children who are not covered by health insurance.	U.S. Census Bureau, American Community Survey. 2015-19.

Category	Indicator	Indicator Description	Data Source
Healthcare Access and Delivery: Oral Health	Dentists Rate	Dentists per population of 100,000	U.S. Department of Health & Human Services, Health Resources and Services Administration, Area Resource File. 2019.
Healthcare Access and Delivery: Oral Health	Never Had Dental Exam (ages 2-11)	Percent of Children Ages 2-11 who had never received a dental exam	University of California Center for Health Policy Research, California Health Interview Survey. 2015-16.
Housing and Homelessness	Children Living in Crowded Households (ages 0-17)	Estimated percentage of children under age 18 living in households with more than one person per room of the house	Population Reference Bureau, analysis of U.S. Census Bureau American Community Survey public use Microdata. 2019.
Housing and Homelessness	Children with Blood Lead Levels of 4.5-9.49 mcg/dL, among Those Tested (ages 0-5)	Percentage of children/youth ages 0-5 with blood lead levels between 4.5-9.49 micrograms per deciliter, among those screened	California Dept. of Public Health, California's Progress in Preventing and Managing Childhood Lead Exposure & Childhood Lead Poisoning Prevention Branch Blood Lead Data. 2019.

Category	Indicator	Indicator Description	Data Source
Housing and Homelessness	Children with Blood Lead Levels of 4.5-9.49 mcg/dL, among Those Tested (ages 6-20)	Percentage of children/youth ages 6-20 with blood lead levels between 4.5-9.49 micrograms per deciliter, among those screened	California Dept. of Public Health, California's Progress in Preventing and Managing Childhood Lead Exposure & Childhood Lead Poisoning Prevention Branch Blood Lead Data. 2020.
Housing and Homelessness	Children with Blood Lead Levels of at least 9.5 mcg/dL, among Those Tested (ages 0-5)	Percentage of children/youth ages 0-5 with blood lead levels of at least 9.5 micrograms per deciliter, among those screened	California Dept. of Public Health, California's Progress in Preventing and Managing Childhood Lead Exposure & Childhood Lead Poisoning Prevention Branch Blood Lead Data. 2019.
Housing and Homelessness	Children with Blood Lead Levels of at least 9.5 mcg/dL, among Those Tested (ages 6-20)	Percentage of children/youth ages 6-20 with blood lead levels of at least 9.5 micrograms per deciliter, among those screened	California Dept. of Public Health, California's Progress in Preventing and Managing Childhood Lead Exposure & Childhood Lead Poisoning Prevention Branch Blood Lead Data. 2020.
Housing and Homelessness	Homeownership Rate	Percent of population that are homeowners	U.S. Census Bureau, American Community Survey. 2015-19.
Housing and Homelessness	Housing Affordability Index	Housing Affordability Index	Esri Business Analyst. 2020.

Category	Indicator	Indicator Description	Data Source
Housing and Homelessness	Median Rental Cost	Median rental cost in dollars per month	U.S. Census Bureau, American Community Survey. 2015-19.
Housing and Homelessness	Moderate Housing Cost Burden	Percent of moderate housing cost burden	U.S. Census Bureau, American Community Survey. 2015-19.
Housing and Homelessness	Neighborhood Deprivation Index	Neighborhood Deprivation Index	UCDA calculation with U.S. Census Bureau, American Community Survey data. 2019.
Housing and Homelessness	Overcrowded Housing	Percent of population living in houses with more than one person per room of the house	U.S. Census Bureau, American Community Survey. 2015-19.
Housing and Homelessness	Percent of Income for Mortgage	Percent of income spent on home mortgage	Esri Business Analyst. 2020.
Housing and Homelessness	Population Density (people per square mile)	Population Density measured in people per square mile	US Department of Labor, Bureau of Labor Statistics. 2018.
Housing and Homelessness	Residential Segregation - Black/White	Residential Segregation Index amongst Black and White population	U.S. Census Bureau, American Community Survey. 2015-19.

Category	Indicator	Indicator Description	Data Source
Housing and Homelessness	Residential Segregation - Non-White/White	Residential Segregation Index amongst Non-White and White population	U.S. Census Bureau, American Community Survey. 2015-19.
Housing and Homelessness	Severe Housing Cost Burden	Percent of population with a severe housing cost burden	U.S. Census Bureau, American Community Survey. 2015-19.
Housing and Homelessness	Severe Housing Problems (one or more of: overcrowding, high costs, lack of kitchen, lack of plumbing)	Percent of population with one or more of the following severe housing problems; overcrowding, high costs, lack of kitchen or lack of plumbing	U.S. Census Bureau, American Community Survey. 2015-19.
Housing and Homelessness	Students Recorded as Homeless at Some Point during the School Year	Percentage of public school students recorded as being homeless at any point during a school year	California Dept. of Education, Coordinated School Health and Safety Office custom tabulation & California Basic Educational Data System. 2019.
Maternal and Infant Health	Babies Born at a Very Low Birthweight	Percentage of infants born at very low birthweight (less than 1,500 grams or about 3 lbs., 5 oz)	California Dept. of Public Health, Birth Statistical Master Files; CDC WONDER, Natality Public-Use Data. 2019.

Category	Indicator	Indicator Description	Data Source
Maternal and Infant Health	Babies Born to Mothers Who Received Prenatal Care in the First Trimester	Percent of Babies Born to Mothers Who Received Prenatal Care in the First Trimester	California Dept. of Public Health, Birth Statistical Master Files. 2020.
Maternal and Infant Health	Babies Breastfed Exclusively in Hospital	Percent of babies breastfed exclusively in the hospital	California Dept. of Public Health, In-Hospital Breastfeeding Initiation Data. 2019.
Maternal and Infant Health	Babies Breastfed in Hospital (at Any Time)	Percent of babies breastfed in the hospital at any time	California Dept. of Public Health, In-Hospital Breastfeeding Initiation Data. 2019.
Maternal and Infant Health	Infant Deaths (per 1,000 live births)	Rate of infant deaths per 1,000 live births	US Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administration. 2020.
Maternal and Infant Health	Population Under Age 18	Percent of the population is younger than 18 years old	U.S. Census Bureau, American Community Survey. 2015-19.
Maternal and Infant Health	Preterm Births	Percent of births taken place before mother was at full term	US Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administration. 2016-18.

Category	Indicator	Indicator Description	Data Source
Maternal and Infant Health	Teen Births (per 1,000 females ages 15-19)	Number of births per 1,000 young women ages 15-19	California Dept. of Public Health, Birth Statistical Master Files; California Dept. of Finance, Population Estimates and Projections, 2000-2009, 2010-2060; CDC WONDER, Natality Public-Use Data. 2019.
Sexually Transmitted Infections	Chlamydia Incidence	Chlamydia rates per 100,000 people, 2007-2016, Santa Clara County	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2018.
Sexually Transmitted Infections	Chlamydia Incidence among Youth (ages 10-19)	Number of chlamydia infections per 100,000 youth ages 10-19	California Dept. of Public Health, Sexually Transmitted Diseases Control Branch custom tabulation (Jan. 2020); Centers for Disease Control and Prevention, Sexually Transmitted Disease Surveillance (Oct. 2019); U.S. Census Bureau, National Population by Characteristics: 2010-2019 (Jun. 2019) & National Intercensal Tables: 2000-2010 (Sept. 2018)

Category	Indicator	Indicator Description	Data Source
Sexually Transmitted Infections	Gonorrhea Incidence among Youth (ages 10-19)	Number of gonorrhea infections per 100,000 youth ages 10-19	California Dept. of Public Health, Sexually Transmitted Diseases Control Branch custom tabulation (Jan. 2020); Centers for Disease Control and Prevention, Sexually Transmitted Disease Surveillance (Oct. 2019); U.S. Census Bureau, National Population by Characteristics: 2010-2019 (Jun. 2019) & National Intercensal Tables: 2000-2010 (Sept. 2018).
Sexually Transmitted Infections	HIV Prevalence (not including AIDS), Age 13 and Over	Rate of HIV infections (not including AIDS) per 100,000 people age 13 and over	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2018.
Sexually Transmitted Infections	HIV/AIDS Prevalence	HIV/AIDS rates (Per 100,000 Pop.)	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2018.
Sexually Transmitted Infections	Syphilis	Syphilis rates (per 100,000 people)	California Department of Public Health, Sexually Transmitted Diseases Control Branch, All STDs Tables, California, 2018
Unintended Injuries/ Accidents	Falls Deaths (ages 65+)	Falls death rate amongst elderly ages 65 and older (per 100,000)	California Department of Public Health, California EpiCenter. 2019.

Category	Indicator	Indicator Description	Data Source
Unintended Injuries/ Accidents	Falls ED Visits (ages 0-12)	Falls ED visit rate amongst children ages 0-12 (per 100,000)	California Office of Statewide Health Planning and Development special tabulation; California Dept. of Finance, Population Estimates and Projections. 2020.
Unintended Injuries/ Accidents	Falls ED Visits (ages 65+)	Falls ED visit rate amongst adults 65 and older (per 100,000)	California Department of Public Health, California EpiCenter. 2019.
Unintended Injuries/ Accidents	Falls Hospitalizations (ages 0-12)	Falls hospitalization rate amongst children ages 0-12 (per 100,000)	California Office of Statewide Health Planning and Development special tabulation; California Dept. of Finance, Population Estimates and Projections. 2020.
Unintended Injuries/ Accidents	Falls Hospitalizations (ages 65+)	Falls hospitalization rate amongst adults 65 and older (per 100,000)	California Department of Public Health, California EpiCenter. 2019.
Unintended Injuries/ Accidents	Injury Deaths (Intentional and Unintentional)	Age-Adjusted Rate of unintentional injury deaths (per 100,000)	California Office of Statewide Health Planning and Development special tabulation; California Dept. of Finance, Population Estimates and Projections. 2020.
Unintended Injuries/ Accidents	Motor vehicle crash deaths	Age-adjusted number of deaths due to motor vehicle crashes per 100,000 population	NCHS National Vital Statistics System. 2015-2019.

Category	Indicator	Indicator Description	Data Source
Unintended Injuries/ Accidents	Motor vehicle crash ED visits age 0-12	Motor vehicle crash ED visit rate amongst children ages 0-12 (per 100,000)	California Office of Statewide Health Planning and Development special tabulation; California Dept. of Finance, Population Estimates and Projections. 2020.
Unintended Injuries/ Accidents	Pedestrian accident deaths	Age-adjusted number of deaths due to pedestrian accidents per 100,000 population	NCHS National Vital Statistics System. 2015-2019.
Unintended Injuries/ Accidents	Poisoning – share of hospitalizations among children ages 0-17	Percentage of hospital discharges among children ages 0-17 for poisoning	California Office of Statewide Health Planning and Development custom tabulation (Sept. 2019).
Unintended Injuries/ Accidents	Poisoning accidents ED visits age 0-12	Poisoning accident ED visit rate amongst children ages 0-12 (per 100,000)	California Office of Statewide Health Planning and Development special tabulation; California Dept. of Finance, Population Estimates and Projections. 2020.
Unintended Injuries/ Accidents	Traumatic injuries – share of hospitalizations among children ages 0-17	Percentage of hospital discharges among children ages 0-17 for traumatic injuries	California Office of Statewide Health Planning and Development custom tabulation (Sept. 2019).

ATTACHMENT 3: COMMUNITY ASSETS AND RESOURCES

Programs and resources available to meet identified community health needs are listed on the following pages.

ACCESS TO HEALTH CARE RESOURCES

Healthcare Facilities and Agencies

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

Hospitals and Health Systems	City/Region
Kaiser Foundation Hospital Redwood City	Redwood City
Kaiser Foundation Hospital South San Francisco	South San Francisco
Lucile S. Packard Children's Hospital Stanford	Palo Alto
Menlo Park Surgical Hospital	Menlo Park
Mills Health Center	San Mateo
Mills-Peninsula Medical Center	Burlingame
Peninsula Healthcare District	
San Mateo County Medical Center	San Mateo
Sequoia Healthcare District	
Sequoia Hospital	Redwood City
Seton Medical Center/Seton Coastside	Daly City/Moss Beach
Stanford Health Care	Palo Alto

Clinics*	City/Region
Arbor Free Clinic, Cardinal Free Clinics	Menlo Park
Belle Air School Health Clinic	San Bruno
Clinic by the Bay	San Francisco
Daly City Youth Health Center	Daly City
Lucile S. Packard Children's Hospital Stanford	Mobile Health Services
Planned Parenthood	Multiple locations; see URL.
Ravenswood Family Health Center	East Palo Alto
RotaCare Bay Area	Half Moon Bay and Daly City
Samaritan House Free Clinic	San Mateo and Redwood City
San Mateo Medical Center Clinics	Multiple locations; see URL.
Sequoia Teen Health Center	Sequoia High School, Redwood City
Student Health Clinic	Belle Air School (San Bruno Park School District)

*Does not include private healthcare services. Please utilize 2-1-1 for lists of those clinics.

Oral Health Resources

- Ravenswood Family Dentistry
- Samaritan House Dental clinic
- San Mateo County Health: Dental Services
- San Mateo County Dental Society
- San Mateo County Oral Health Coalition
- Sonrisas Dental Health Half Moon Bay and San Mateo

Other General Healthcare Resources

- CareSolace
- Community Gatepath
- Community Health Education Programs

    - See Hospitals and Health Systems
- Daly City Partnership Social Services
- Daly City Peninsula Partnership Collaborative, Health Aging Response Team
- Edgewood Center for Children and Families
- Family Caregiver Alliance (FCA)
- Get Healthy San Mateo County
- Get Up & Go, Escorted senior transportation
- Health Benefits Resource Center
- The Latino Commission
- Kaiser Permanente Education Theater Program
- Mental Health Association of San Mateo County
- Mid-Peninsula Boys & Girls Club
- Mission Hospice & Home Care
- Northeast Medical Services (NEMS)
- Ombudsman Services of San Mateo County
- Pacifica Collaborative
- Pathways & Home Health & Hospice
- Peninsula Library System
- Puente de la Costa Sur
- Redi-wheels program
- San Mateo County Paratransit Coordinating Council
- San Mateo County Access and Care for Everyone (ACE) health plan
- San Mateo County Access to Care for Everyone Program Supports
- San Mateo Medical Association Community Service Foundation
- SCAN Foundation
- STEPS dues subsidy program

RESOURCES BY IDENTIFIED HEALTH NEED (LIST A)

Agency or Organization	Cancer	Climate/Natural Environment	Maternal & Infant Health	Sexually Transmitted Infections	Unintended Injuries/Accidents
American Cancer Society	X				
Bay Area Cancer Connections (incl. Gabriella Patser Program)	X				
Colon Cancer Community Awareness campaign	X				
Joy Luck Club	X				
Relay For Life	X				
Samaritan House, Breast Care Clinic	X				
“Look Good, Feel Better”	X				
County of San Mateo Office of Sustainability		X			
The Watershed Project		X			
First 5 San Mateo County			X		

Agency or Organization	Cancer	Climate/Natural Environment	Maternal & Infant Health	Sexually Transmitted Infections	Unintended Injuries/Accidents
La Leche League			X		
March of Dimes			X		
Mid-Coastal CA Prenatal Outreach Program			X		
Nursing Mothers Counsel			X		
Preeclampsia Foundation			X		
San Mateo County Health Department Black Infant Health Project			X		
San Mateo County Health Department Nurse-Family Partnership program			X		
San Mateo County Health Department Pre-to-3 Program			X		
San Mateo County Health Department WIC			X		

Agency or Organization	Cancer	Climate/Natural Environment	Maternal & Infant Health	Sexually Transmitted Infections	Unintended Injuries/Accidents
Sequoia Hospital Lactation Center			X		
American Lung Association					
Breathe California Smoking Cessation Classes					
Health Connected				X	
Peer Health Exchange				X	
San Mateo County Fall Prevention Coalition					X
San Mateo County Poison Control					X

RESOURCES THAT ADDRESS MULTIPLE HEALTH NEEDS (LIST B)

Agency or Organization	Behavioral Health	Community Safety	Diabetes & Obesity	Economic Security	Housing/ Homelessness
12-step recovery programs	X		X		
Acknowledge Alliance	X				
Adolescent Counseling Services	X				
ALICE: Filipino organization		X			
American Board for Child Diabetics			X		
Asian American Recovery Services	X	X			
Bay Area Community Health Advisory Council			X		
Boys & Girls Clubs of North San Mateo County	X				
Caminar	X				
Catholic Charities	X				
Cleo Eulau Center	X				

Agency or Organization	Behavioral Health	Community Safety	Diabetes & Obesity	Economic Security	Housing/ Homelessness
Coastside Adult Day Health Center	X				
Coastside Hope				X	X
Community Overcoming Relationship Abuse (CORA)	X	X			X
Daly City Community Services Center	X	X	X	X	X
Daly City Peninsula Partnership Collaborative	X	X	X	X	X
Daly City Youth Health Center	X	X	X		
Edgewood Center for Children & Families	X	X		X	
El Centro de Libertad	X	X			
Elder Abuse Prevention Task Force		X			
Fair Oaks Community Center				X	X
Freedom House	X				

Agency or Organization	Behavioral Health	Community Safety	Diabetes & Obesity	Economic Security	Housing/ Homelessness
Fresh Lifelines for Youth	X	X		X	
Friends for Youth	X				
Health Right 360 San Mateo	X				
HIP Housing					X
Home & Hope					X
Job Train				X	
Latino Commission	X				
LifeMoves	X	X		X	X
Mental Health Association of San Mateo County	X				
National Alliance on Mental Illness/San Mateo County	X				
Niroga Institute	X				
North Peninsula Food Pantry & Dining Center of Daly City				X	

Agency or Organization	Behavioral Health	Community Safety	Diabetes & Obesity	Economic Security	Housing/ Homelessness
One Life Counseling Center	X				
Pacific Stroke Association			X		
Pacifica Resource Center				X	X
Peace Development Fund		X			
Peninsula Bridge				X	
Peninsula Conflict Resolution Center		X	X		
Peninsula Family Service	X		X	X	
Peninsula Kidpower, Teenpower, Fullpower		X			
Pre-to-3 Program			X		
Puente de la Costa Sur	X		X	X	X
Rape Trauma Services	X	X			
Ravenswood Family Health Center	X		X		
Rebuilding Together Peninsula					X

Agency or Organization	Behavioral Health	Community Safety	Diabetes & Obesity	Economic Security	Housing/ Homelessness
SafeKids Coalition of Santa Clara and San Mateo Counties		X	X		
Samaritan House			X	X	X
San Mateo County Behavioral Health and Recovery Services Clinics	X				
San Mateo County Human Trafficking Initiative		X			
San Mateo County Pride Center	X	X			
San Mateo Police Activities League			X		
Second Careers Employment Program				X	
Second Harvest Food Bank				X	
Sequoia Strong	X		X		
Sitike Counseling Center	X				
StarVista	X				

Agency or Organization	Behavioral Health	Community Safety	Diabetes & Obesity	Economic Security	Housing/ Homelessness
Streets Alive! Parks Alive!			X		
Strong for Life			X		
Via Heart Project					
Women's Recovery Association	X				
YMCA	X		X	X	X
Youth Mental Health First Aid Training	X				
Community/Senior Centers					
Adaptive Physical Education Center (Redwood City)			X		
Fair Oaks Adult Activity Center (Redwood City)			X	X	
Little House Activity Center (Menlo Park)			X	X	
San Carlos Adult Community Center			X		

Agency or Organization	Behavioral Health	Community Safety	Diabetes & Obesity	Economic Security	Housing/ Homelessness
Twin Pines Senior & Community Center (Belmont)			X	X	
Veterans Memorial Senior Center (Redwood City)			X		

ATTACHMENT 4: QUALITATIVE RESEARCH PROTOCOLS

CHNA KII Protocol - Professionals (60 min.)

PREP

- Schedule call, send survey and main questions [*minimum: 1 week ahead of time*].
- 48 hours before:
    - Review the individual's background on LinkedIn and/or their organization's website; review their survey response (health needs they identified).
    - Send reminder email; remind them of their survey response (most pressing needs among those they serve) and the main questions.
        - If they didn't respond to the survey, include the link and ask them to respond ASAP before the interview.

INTRODUCTION (5 MIN.)

[Start recording from the beginning of the session.]

- Welcome and thanks
- What the project is about:
    - Identifying health needs in our community, including social determinants of health (called the Community Health Needs Assessment or CHNA).
    - A CHNA is required of all non-profit hospitals in the U.S. every three years. The report based on this assessment will be a snapshot in time; this report will be published next year (in 2022) and consulted through 2025.
    - Will inform investments that hospitals make to address community needs.
- Our interview is scheduled for sixty minutes -- does that still work for you?
- Today's questions:
    - Better understand the needs you identified as most pressing in [San Mateo and/or Santa Clara] [County/counties]
    - Which populations are experiencing inequities related to the needs
    - How things may have changed in the past few years (trends)
    - Any models or best practices you know of for addressing the needs
    - Areas of concern
    - *[If not one of the needs identified:]* Your expertise as it relates to the community's needs

    - *[If not one of the needs identified:]* Your comments on how the pandemic has affected the people you serve
- What we'll do with the information you tell us today:
    - Will record so that we can get the most accurate record possible
    - Will not share the audio itself; transcript will go to hospitals
    - Hospitals will make decisions about which needs they can best address
    - We can keep anything confidential, even the whole interview. Let me know any time.
    - *[First half depends on their survey response:]* Plan to name *you/your organization* in the report where we list all the experts we consulted, but will not attach your name to any quotes we might use.
- Any questions before I begin? [If we don't have the answer, commit to finding it and sending later via email.]

Kick on Zoom recording!

HEALTH NEEDS DISCUSSION (35 MIN.)

You identified [*read list*] as the most pressing needs for the people you serve. For each of these needs, I'll ask you four things [*read only **bold text** to introduce this section*]:

1. Please describe **how you see the need playing out**, including how well the need is being addressed right now and what barriers might exist to seeing better outcomes.

Probe: Who is addressing the need? [*Prompts for barriers if they are having trouble thinking of any:* Income/economic issues, language, culture/stigma, lack of awareness/education, policies/laws, budget cuts, lack of community resources, geographic location (DUAL COUNTY -- between counties?), transportation, housing, addiction, stress, being victims of abuse/bullying/crime]

2. This may overlap the previous question, but I'll ask you to identify **which populations are experiencing inequities** with respect to the need (that is, who are better or worse off than others) and explain their situation.

[*Prompts for populations if they are having trouble thinking of any*: DUAL COUNTY -- between counties?, income/education level, housing status, language, immigration status, age, ethnicity, sexual orientation, gender identity, disability status, geographic location]

3. Third, to say **how things may have changed** in the last few years (since we know that the data always lag what is happening now). What emerging trends or areas of concern do you see? Think about how things were going prior to the emergence of COVID-19, and also how they are now, with the impact of the pandemic.

4. Finally, I'll ask you to explain **what you feel is needed to better address this need**, including **any models or best practices for addressing the need.** *Probe*: Who should be doing that (addressing this need)? [*Prompts if needed:* Practices you have observed within your health system or organization, in our county agencies, national practices you've heard about, or practices you've read about in literature.]

OK, let's get started. For [name first need], [start at Q1; address all four questions, then go back to Q1-4 with second need, again with third need, then go on to the questions below.]

<u>Only if</u> their expertise was not related to one or more of the needs chosen:

FURTHER DISCUSSION: THEIR EXPERTISE (5-10 min.)

You were invited to share your expertise/experience about [*e.g., substance use disorder, senior health, or homelessness*]. Let's talk a little about that; how does it relate to the community's health needs?

<u>Only if</u> COVID was not chosen as a need/was not discussed in the context of other needs:

FURTHER DISCUSSION: CORONAVIRUS PANDEMIC (5-10 min.)

I know you didn't identify the coronavirus as a specific need; would you mind...

- Telling me about the effects of the pandemic you may be seeing among the people you serve (not just among those who were ill with COVID)?

- What inequities are you seeing?
- How have things changed since COVID began?

ADDITIONAL COMMENTS (time permitting)

We have a few minutes left; is there anything else you would like to add regarding community health needs? Anything else we can convey to the hospitals?

REQUEST FOR ASSISTANCE WITH ASSETS LIST (2 min.)

The IRS requires that we get feedback from the community on potential resources available to address these health needs. We are compiling a list of resources by health need later this spring, which will be based on 2-1-1's list. **Would you be willing to review a list at that time, related to your area of expertise, and give us feedback?** For example, we may ask whether the resources seem sufficient or if there are resources available that we have missed. *[Make a note as to whether they agree or not.]*

CLOSING (1 min.)

You can look for the hospitals' CHNA reports to be made publicly available on their individual websites in the second half of 2022.

If anything occurs to you later that you would like to add to this interview, please feel free to send me an email.

Thank you so much for contributing your expertise and experience to the CHNA.

CHNA FG Protocol - Professionals (90 min.)

PREP

- Schedule group of 8-10 participants. If needed, create recruitment email/flyer for hospital rep. Ahead of time, send participants:
    - Pre-focus group survey and main questions [*minimum: 1 week ahead of time*].
    - FG date, time, and Zoom login information
    - Advise that the session will be recorded
- 48 hours before, prepare:
    - Review the individuals' backgrounds on LinkedIn and/or their organizations' websites; review their survey responses (health needs they identified).
    - Send reminder email; if any didn't respond to the survey, include the link and ask them to respond ASAP before the focus group.
    - Ensure you have PDF of agenda/questions ready.

INTRODUCTION (10 MIN.)

[Start recording from the beginning of the session.]

- Hello everyone. Today we are hosting a focus group about health here in our county. This session will run until [*time*].
- My name is ____ and I'm with Actionable Insights, a local consulting firm. When we start our discussion in a few minutes, we will call on you and ask you to say your name before speaking.
- What the project is about:
    - Identifying health needs in our community, including social determinants of health (called the Community Health Needs Assessment or CHNA)
    - The report based on this assessment will be a snapshot in time, required of all non-profit hospitals in the U.S. every three years; this report will be published next year (in 2022) and consulted through 2025
    - Will inform investments that hospitals make to address community needs
- Today's questions: *show slide*
    - Better understand the needs you identified as most pressing in [San Mateo and/or Santa Clara] [County/counties]
    - Which populations are experiencing inequities related to the needs
    - How things may have changed recently (trends)

    - Any models or best practices you know of for addressing the needs
    - Areas of concern
    - *[If not one of the needs identified:]* Your expertise as it relates to the community's needs
    - *[If not one of the needs identified:]* Your comments on how the pandemic has affected the people you serve
- What we'll do with the information you tell us today:
    - We are recording this group so that we can make sure to get your words right.
    - Will not share the video itself; transcript or notes will go to hospital
    - When we are finished with all of the focus groups, we will read all of the transcripts and summarize the things we learn. We will also use some quotes so that the hospital can read your own words. We will not use your name when we give them those quotes.
    - If for any reason you are deciding that you do not want to participate, it is OK to leave the meeting now. No hard feelings!
- Guidelines:
    - We know you have other commitments and we really appreciate you taking the time out of your day to be here. It is my job to move us along to keep us on time. I may interrupt you; I don't mean any disrespect, but it is important to get to all of the questions so we can finish on time.
    - We understand that you may have distractions on your end; we ask that you do the best you can to remain present, and let us know through the chat if you absolutely need to step away.
    - It's OK to disagree, but please be respectful. We want to hear from everyone. Really want your personal opinions and perspectives, even – especially! – if they aren't the same as everyone else's.
- Any questions before I begin? [If we don't have the answer, commit to finding it and sending later via email.]

HEALTH NEEDS DISCUSSION (45 MIN.)

As a group, you identified [*read list*] as the most pressing needs for the people you serve -- these are the needs that got the most votes in the pre-survey. For each of these needs, I'll ask you four things [*read only* ***bold text*** *to introduce this section*]:

1. *[Facilitators call on participants one by one.]* "Please say your first name, and then describe **how you see the need playing out**, including how well the need is being addressed right now and what barriers might exist to seeing better outcomes. You can choose to pass if you didn't vote for the need and don't have anything to say about it."

Probe: Who is addressing the need? [*Prompts for barriers if they are having trouble thinking of any:* Income/economic issues, language, culture/stigma, lack of awareness/education, policies/laws, budget cuts, lack of community resources, geographic location (DUAL COUNTY -- between counties), transportation, housing, addiction, stress, being victims of abuse/bullying/crime]

2. This may overlap the previous question, but I'll ask you to identify **which populations are experiencing inequities** with respect to the need (that is, who are better or worse off than others) and explain their situation.

[*Prompts for populations if they are having trouble thinking of any*: DUAL COUNTY -- between counties?, income/education level, housing status, language, immigration status, age, ethnicity, sexual orientation, gender identity, disability status, geographic location]

3. Third, to say **how things may have changed** in the last few years (since we know that the data always lags what is happening now). What emerging trends or areas of concern do you see? Think about how things were going prior to the emergence of COVID-19, and also how they are now, with the impact of the pandemic.

4. Finally, I'll ask you to explain **what you feel is needed to better address this need**, including **any models or best practices for addressing the need.** *Probe*: Who should be doing that (addressing this need)? [*Prompts if needed:* Practices you have observed within your health system or organization, in our county agencies, national practices you have heard about, or practices you have read about in literature.]

OK, let's get started. For [name first need], [start at Q1; address all four questions, then go back to Q1-4 with second need, again with third need, then go on to the questions below.]

<u>Only if</u> their expertise was not related to one or more of the needs chosen:

FURTHER DISCUSSION: THEIR EXPERTISE (5-10 min.)

You were invited to share your expertise/experience about [*e.g., substance use disorder, senior health, or homelessness*]. Let's talk a little about that; how does it relate to the community's health needs?

<u>Only if</u> COVID was not chosen as a need/was not discussed in the context of other needs:

FURTHER DISCUSSION: CORONAVIRUS PANDEMIC (5-10 min.)

I know you didn't identify the coronavirus as a specific need; would you mind...

- Telling me about the effects of the pandemic you may be seeing among the people you serve (not just among those who were ill with COVID)?
- What inequities are you seeing?
- How have things changed in the last few years (both prior to COVID, and since COVID began)?

ADDITIONAL COMMENTS (time permitting)

We have a few minutes left; is there anything else you would like to add regarding community health needs? Anything else we can convey to the hospitals?

REQUEST FOR ASSISTANCE WITH ASSETS LIST (2 min.)

The IRS requires that we get feedback from the community on potential resources available to address these health needs. We are compiling a list of resources by health need later this spring, which will be based on 2-1-1's list. **Would you be willing to review a list at that time, related to your area of expertise, and give us feedback?** For example, we may ask whether the resources seem sufficient or if there are resources available that we have missed. *[Make a note as to whether they agree or not.]*

CLOSING (1 min.)

Thank you for contributing your expertise and experience to the CHNA.

You can look for the hospitals' CHNA reports to be made publicly available on their individual websites in the second half of 2022.

If anything occurs to you later that you would like to add to this discussion, please feel free to send me an email.

CHNA Zoom[91] FG Protocol - Community Members (90 min.)

PREP

- Work with host to schedule group of 8-10 participants. If needed, create recruitment email/flyer for host. Ahead of time, have host send participants:
    - Pre-focus group health needs survey [depending on group]
    - FG date, time, and Zoom login information
    - Advise that the session will be recorded
- Prepare:
    - PDF of agenda/questions
    - Review pre-survey responses
    - PDF of health needs list (including definition of healthcare access) [if no pre-survey]
    - Zoom poll of health needs [if no pre-survey]

INTRODUCTION (10 MIN.) [Start recording from the beginning of the session.]

- Hello everyone. Today we are hosting a focus group about health here in our county. This session will run until [*time*].
- My name is ____ and I'm with Actionable Insights, a local consulting firm. When we start our discussion in a few minutes, we will call on you and ask you to say your name before speaking.
- Purpose:
    - You are here today to let nonprofit hospitals know what the biggest health needs are in our county.
    - This is called the Community Health Needs Assessment (CHNA), which is required every three years by the IRS, so it is an official, public report.
    - Hospitals will use this to plan how they will use their resources to improve health and wellness in our county.
- Today's questions: *show slide*
    - What are the needs?
        - Which groups of people are doing better or worse when it comes to the needs?

[91] If planning to do a What'sApp FG, can revise this protocol.

        - What can hospitals/health systems do to improve health in the community?
    - We will also talk about your pandemic experience and what you think the long-term effects will be (not just on health, but overall).
    - Lastly, we will get your perspective about equity and cultural competence when it comes to healthcare.
- Confidentiality:
    - We are recording this group so that we can make sure to get your words right.
    - We will only use first names here -- you will be anonymous. (If you want to use a fake name that's OK, too!)
    - Will not share the video itself; transcript will go to hospital.
    - When we are finished with all of the focus groups, we will read all of the transcripts and summarize the things we learn. We will also use some quotes so that the hospital can read your own words. We will not use your name when we give them those quotes.
    - If for any reason you are deciding that you do not want to participate, it is OK to leave the meeting now. No hard feelings!
- Guidelines:
    - We know you have other commitments and we really appreciate you taking the time out of your day to be here. It is my job to move us along to keep us on time. I may interrupt you; I don't mean any disrespect, but it is important to get to all of the questions so we can finish on time.
    - We understand that you may have distractions on your end; we ask that you do the best you can to remain present, and let us know through the chat if you absolutely need to step away.
    - If no pre-survey: You have a choice of a $25 credit to Amazon or Target. Please chat your email address to my colleague [*name*] now, along with your choice. If you don't tell her which one you prefer, we'll send you an Amazon credit.
    - It's OK to disagree, but please be respectful. We want to hear from everyone. Really want your personal opinions and perspectives, even – especially! – if they aren't the same as everyone else's.
- Any questions before we begin? [If we don't have the answer, commit to finding it and sending later via email.]

HEALTH NEEDS DISCUSSION (45 MIN.)

If no pre-survey: We are going to show you a list of health needs in our county from 2019. [*show slide*] You'll see that there are regular physical health conditions, like cancer (we added COVID), and other kinds of needs, like food insecurity and housing. We're going to read the needs, then put up a poll for you to choose the you think are the most urgent and important in your community. [Read off needs, then launch zoom poll. Give people 2 min. to complete.]

If collected by pre-survey, start here: As a group, you identified [*read list*] as the most important needs in your community -- these are the needs that got the most votes in the pre-survey. For each of these needs, I'll ask you four things [*read only **bold text** to introduce this section*]:

1. *[Facilitators call on participants one by one.]* "Please say your first name, and then describe **what the need looks like in your community**, including what barriers might exist to people having better outcomes. You can choose to pass if you didn't vote for the need and don't have anything to say about it."

[*Prompts for barriers if they are having trouble thinking of any:* Income/economic issues, language, culture/stigma, lack of awareness/education, policies/laws, budget cuts, lack of community resources, geographic location, transportation, housing, addiction, stress, being victims of abuse/bullying/crime]

2. This may overlap the previous question, but I'll ask you to identify **what groups of people are better or worse off than others** for that need and explain how or why.

[*Prompts for populations if they are having trouble thinking of any*: income/education level, housing status, language, immigration status, age, ethnicity, sexual orientation, gender identity, disability status, geographic location]

3. Finally, I'll ask you to describe, for that need, **what you think the people in charge should do to support, enhance, facilitate, or fund** to help communities become healthier / improve everyone's lives.

OK, let's get started. For [name first need], [start at Q1; address all three questions, then go back to Q1-3 with second need, then again with third, then go on to the questions below.]

YOUR PANDEMIC EXPERIENCE (15 min.)

We all know that the coronavirus has been really disruptive to our normal lives since March of 2020. Specifically, we want to hear about your experience with getting healthcare since then. First, we'll review the answers to the poll questions, then we'll talk more.

- Poll question results:
    a. What is your health insurance status? *[Describe results].*
    b. Do you have a doctor you see regularly? *[Describe results].*
    c. Has the pandemic made it more or less difficult to access the healthcare you need? *[Describe results].*

Tell us more about how the pandemic affected your ability to access healthcare.

[Potential probes] Tell us more about your reasons for putting off a regular appointment or not seeing a provider for something that went wrong. Tell us your opinion of virtual appointments. How did you like them? What was good about them (maybe even better than an in-person appointment)? What about them could be improved?

- **Not only thinking about healthcare, but more generally:** What do you think the long-term impact of the pandemic will be on you, your family, and your friends and neighbors?

YOUR PERCEPTION OF EQUITY ISSUES (20 min.)

As you probably know, people have been talking about issues of equity much more than ever before. "Equity" means fairness and unbiased treatment. When it comes to healthcare, what's your perspective about equity and cultural competence? For example:

- What do you think are the barriers to everyone having the same access to healthcare?
- What do you think are the barriers to everyone getting the same quality of healthcare?
- We've heard that not all providers know how to care for people in a respectful and culturally competent way. What do you think those providers are missing? What do you think they need to learn?
- What can hospitals and health systems do to best address equity for you and the people in your community?

CLOSING (1 min.)

Thank you for contributing your opinions and experience to the CHNA.

You can contact us if you want any more information about the assessment. If anything occurs to you later that you would like to add, please feel free to send me an email.

ATTACHMENT 5: IRS CHECKLIST

Section §1.501(r)(3) of the Internal Revenue Service code describes the requirements of the CHNA.

Federal Requirements Checklist		Regulation Section Number	Report Reference
A. Activities Since Previous CHNA(s)			
Describes the written comments received on the hospital's most recently conducted CHNA and most recently adopted implementation strategy.		(b)(5)(C)	Section #2
Describes an evaluation of the impact of any actions that were taken, since the hospital facility finished conducting its immediately preceding CHNA, to address the significant health needs identified in the hospital facility's prior CHNA(s).		(b)(6)(F)	Section #8
B. Process & Methods			
Background Information			
Identifies any parties with whom the facility collaborated in preparing the CHNA(s).		(b)(6)(F)(ii)	Section #4
Identifies any third parties contracted to assist in conducting a CHNA.		(b)(6)(F)(ii)	Section #4

Federal Requirements Checklist				Regulation Section Number	Report Reference
	Defines the community it serves, which: • Must take into account all patients without regard to whether (or how much) they or their insurers pay for care or whether they are eligible for assistance. • May take into account all relevant circumstances including the geographic area served by the hospital, target population(s), and principal functions. • May *not* exclude medically underserved, low-income, or minority populations who live in the geographic areas from which the hospital draws its patients.			(b)(i) (b)(3) (b)(6)(i)(A)	Section #3
	Describes how the community was determined.			(b)(6)(i)(A)	Section #3
	Describes demographics and other descriptors of the hospital service area.				Section #3
	Health Needs Data Collection				
		Describes data and other information used in the assessment:		(b)(6)(ii)	
		a. Cites external source material (rather than describe the method of collecting the data).		(b)(6)(F)(ii)	Attachment 2
		b. Describes methods of collecting and analyzing the data and information.		(b)(6)(ii)	Section #5
		CHNA describes how it took into account input from persons who represent the broad interests of the community it serves in order to identify and prioritize health needs and identify		(b)(1)(iii) (b)(5)(i) (b)(6)(F)(iii)	Section #5

Federal Requirements Checklist				Regulation Section Number	Report Reference
		resources potentially available to address those health needs.			
		Describes the medically underserved, low-income, or minority populations being represented by organizations or individuals that provide input.		(b)(6)(F)(iii)	Section #5
		a. At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) or a State Office of Rural Health.		(b)(5)(i)(A)	Section #5 & Attachment 1
		b. Members of the following populations, or individuals serving or representing the interests of populations listed below. (Report includes the names of any organizations - names or other identifiers not required.)		(b)(5)(i)(B)	Section #5 & Attachment 1
		I. Medically underserved populations		(b)(5)(i)(B)	Section #5 & Attachment 1
		II. Low-income populations		(b)(5)(i)(B)	Section #5 & Attachment 1
		III. Minority populations		(b)(5)(i)(B)	Section #5 & Attachment 1
		c. Additional sources (optional) – (e.g. healthcare consumers, advocates, nonprofit and community-based organizations, elected officials, school districts, healthcare providers and community health centers).		(b)(5)(ii)	Section #5 & Attachment 1

Federal Requirements Checklist				Regulation Section Number	Report Reference
		Describes how such input was provided (e.g., through focus groups, interviews or surveys).		(b)(6)(F)(iii)	Section #5 & Attachment 1
		Describes over what time period such input was provided and between what approximate dates.		(b)(6)(F)(iii)	Section #5 & Attachment 1
		Summarizes the nature and extent of the organizations' input.		(b)(6)(F)(iii)	Sections #5-6 & Attachments 1, 4
C. CHNA Needs Description & Prioritization					
	Health needs of a community include requisites for the improvement or maintenance of health status both in the community at large and in particular parts of the community (such as particular neighborhoods or populations experiencing health disparities).			(b)(4)	Section #6
	Prioritized description of significant health needs identified.			(b)(6)(i)(D)	Section #6
	Description of process and criteria used to identify certain health needs as significant and prioritizing those significant health needs.			(b)(6)(i)(D)	Section #6
	Description of the resources potentially available to address the significant health needs (such as organizations, facilities, and programs in the community, including those of the hospital facility.			(b)(4) (b)(6)(E)	Attachment 3

Federal Requirements Checklist		Regulation Section Number	Report Reference
D. Finalizing the CHNA			
CHNA is conducted in such taxable year or in either of the two taxable years immediately preceding such taxable year.		(a)1	Section #9
CHNA is a written report that is adopted for the hospital facility by an authorized body of the hospital facility (authorized body defined in §1.501(r)-1(b)(4)).		(b)(iv)	Section #9
Final, complete, and current CHNA report has been made widely available to the public until the subsequent two CHNAs are made widely available to the public. “Widely available on a web site” is defined in §1.501(r)-1(b)(29).		(b)(7)(i)(A)	By 12/31/2022
a. May not be a copy marked “Draft”.		(b)(7)(ii)	By 12/31/2022
b. Posted conspicuously on website (either the hospital facility’s website or a conspicuously-located link to a web site established by another entity).		(b)(7)(i)(A)	By 12/31/2022
c. Instructions for accessing CHNA report are clear.		(b)(7)(i)(A)	By 12/31/2022
d. Individuals with Internet access can access and print reports without special software, without payment of a fee, and without creating an account.		(b)(7)(i)(A)	By 12/31/2022
e. Individuals requesting a copy of the report(s) are provided the URL.		(b)(7)(i)(A)	By 12/31/2022

Federal Requirements Checklist				Regulation Section Number	Report Reference
		f. Makes a paper copy available for public inspection upon request and without charge at the hospital facility.		(b)(7)(i)(B)	By 12/31/2022

Further IRS requirements available:

- §1.501(r)-3(b)(iv) and (v): separate and joint CHNA reports
- §1.501(r)-3(d): requirements that apply to new hospital facilities, transferred or terminated hospital facilities, and newly acquired hospital facilities
- §1.501(r)-3(a)(2) and (c): implementation strategy requirements