



San Francisco Community Health Needs Assessment 2022

Table of Contents

Introduction	3
<i>The Community Health Needs Assessment (CHNA)</i>	4
<i>This Year's CHNA</i>	4
<i>Connection to Past CHNAs</i>	5
<i>CHNA Methods</i>	6
Executive Summary	7
Our Community: Population Description	9
<i>Community Profile</i>	10
<i>CHNA in the Context of COVID</i>	14
Our Community's Strengths	17
Our Community's Health Needs	21
<i>Access to Care</i>	22
<i>Behavioral Health</i>	27
<i>Economic Opportunity</i>	32
Conclusion	37
Methods Appendix	40
<i>About the Community Health Needs Assessment (CHNA)</i>	41
<i>CHNA Leadership</i>	41
<i>Community Assessment</i>	42
<i>Health Need Selection</i>	42



Introduction



The Community Health Needs Assessment (CHNA)

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

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

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

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

This Year's CHNA

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

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

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

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

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

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

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



Access to care



Behavioral health



Economic opportunity

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

Connection to Past CHNAs

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

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

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

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

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

Health Needs Identified in Past San Francisco CHNAs

Health Needs

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

[2019](#)

Foundational Issues

- Poverty
- Racial Health Inequities

Priority Health Needs

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

Health Needs

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

[2016](#)

Foundational Issues

- Economic barriers to health
- Racial health inequities

Health Needs

- Ensure safe and healthy living environments
- Increase healthy eating and physical activity
- Increase access to high-quality healthcare and services

[2013](#)

CHNA Methods

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

Partners

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

Data collection and analysis

To assess community strengths, needs, and solutions, five focus groups were conducted. Three were with the San Francisco Equity Coalitions (the African American Health Equity Coalition, Asian & Pacific Islander Health Parity Coalition, and Chicano / Latino / Indígena Health Equity Coalition), one was with funder agencies (including Blue Shield of California Foundation, California HealthCare Foundation, Hirsch Philanthropy Partners, Metta Fund, Northern California Grantmakers, The California Wellness Foundation, and Zellerbach Family Foundation), and the final focus group was with San Francisco health insurers (including Anthem, Blue Shield, Canopy Health, Kaiser Permanente, and San Francisco Health Plan). Information was also included from the 15 key informant interviews conducted as part of the Kaiser CHNA with San Francisco service providers, nonprofit groups, and government agencies.

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

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

Community voice

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

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

A note about art and images

Art is another way that people share their communities' strengths, struggles, needs, and ideas. Throughout this report, we have included images of San Franciscans and their creative accomplishments, each credited to their source.

Many murals were used with permission of Precita Eyes Muralists (<http://www.precitaeyes.org>), whose mission echoes a hope for all of the information in this CHNA report:

to enrich our environments through community collaborations; reflecting the communities' specific concerns, joys, and triumphs.

Executive Summary



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

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

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

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

Our Community's Health Need. However, many obstacles remain which prevent all San Franciscans from reaching their greatest potential. Throughout this CHNA cycle, three primary health need umbrellas emerged: [access to care](#), [behavioral health](#), and [economic opportunity](#). Though distinct, each health need exists as a complex network of highly relevant interconnecting health concerns, issues, and topics like housing, mental health, and linguistically appropriate services. Amid this network of overlapping health issues, the reality remains that each uniquely exists as deeply intertwined and heavily compounded by structural racism and inequity.

Conclusion. The 2022 San Francisco Community Health Needs Assessment sought to uplift the strengths of the community and ask community leaders what can be done to improve health. Community strength is imperative to sustain the well-being of residents as the community knows how to connect with one another in ways that mainstream healthcare systems have failed to embrace. Despite these strengths, there are persistent health needs that must be addressed to support community health and well-being including access to care, behavioral health, and economic opportunity. Recommended next steps to support the improvement of these health needs include intentional effort in community engagement, cultural humility, and financial investment.



Dedication. This CHNA is dedicated to the communities of San Francisco. We especially extend our gratitude to the Asian, Black, Indigenous, Latinx, and Pacific Islander communities that have contributed to the development of this report by sharing their lived experiences navigating the healthcare systems in San Francisco. Furthermore, we extend our gratitude to the San Francisco communities for sharing how they step in and be the support they need for their own communities by celebrating cultura, ceremony, family, and spirit in all aspects of the work. Thank you.



Our Community: Population Description

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

~ Community service provider

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

This disenfranchisement of San Francisco communities of color takes place against a national backdrop of events, such as the **enslavement** of African peoples, the battle for **land sovereignty** resulting in the loss and displacement of Native people, the **Chinese Exclusion Act of 1882**, and Japanese **internment** during World War II ([Found SF](#)).

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

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

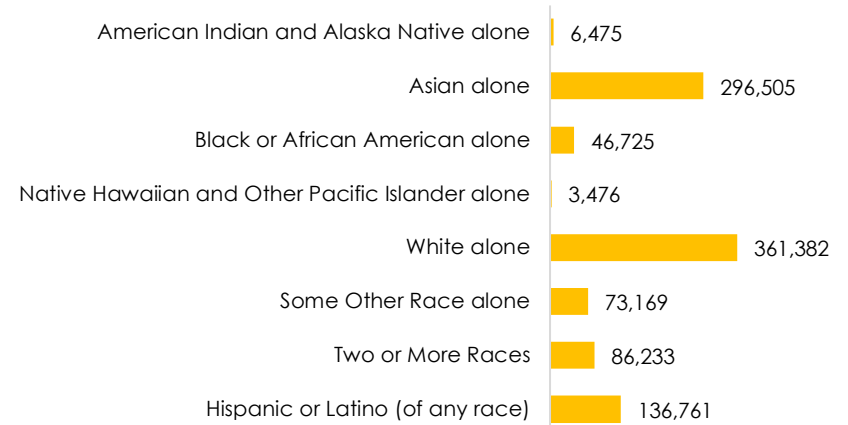
Even now, the California Office of the Attorney General's annual Hate Crimes Report ([here](#)) recounts continued racially motivated crime in San Francisco. Anti-Black crimes are the most prevalent, as they have been in the past; 513 were reported last year, a 13% increase. Hate crimes against Asian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

Community Profile

San Francisco City and County has **815,201** residents living within its 46.9 square miles of land area (U.S. Census Bureau, V2021, available [here](#)). It is the 13th most populous city in the country. San Francisco is the second most densely populated city in the country (after New York City), with 18,633 people per square mile. By total area, San Francisco is geographically the smallest county in California, which contributes to the high cost of living, property costs, and the corollary impact on housing disparities.

Race/ethnicity

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



Source: Census Bureau QuickFacts

In the past three decades, about 275,000 Black Californians have left expensive coastal cities to move inland or to other states. During the same timeframe, the Black populations of some of California's historically Black neighborhoods in cities across California have plunged: Compton by 45%, San Francisco by 43%, and Oakland by 40%. ([California Task Force to Study and Develop Reparation Proposals for African Americans](#))

Historic Population of San Francisco

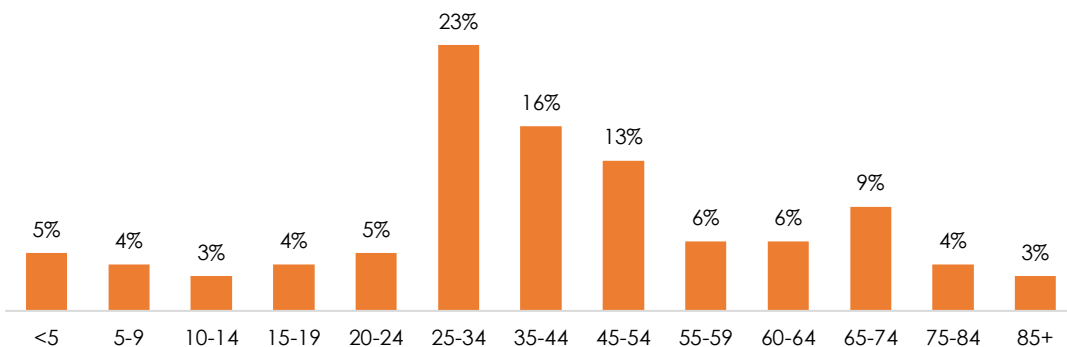
	Census Year			
	1900	1940	1980	2020
Hispanic or Latino, any race(s)	3%	4%	13%	16%
Asian or Pacific Islander alone	<0.1%	<0.1%	1%	0.4%
Black alone or in combination	<0.1%	<0.1%	0.2%	0.6%
European Ancestry	1%	1%	2%	2%
Mexican American	1%	2%	5%	6%
Native American/Indigenous alone	<0.1%	<0.1%	0.1%	0.5%
Salvadoran American	<0.1%	0.2%	1%	2%
Native American alone	<0.1%	<0.1%	0.4%	0.2%
Asian alone	5%	4%	21%	34%
Chinese American	4%	3%	12%	21%
Filipino American	—	0.5%	5%	4%
Indian American	—	<0.1%	0.3%	2%
Japanese American	0.5%	1%	2%	1%
Korean American	—	<0.1%	0.5%	2%
Vietnamese American	—	—	1%	1%
Black alone	0.4%	1%	12%	5%
Specific African Ancestry	—	—	0.1%	0.5%
West Indian or Brazilian Ancestry	—	—	0.2%	0.2%
Other African American	—	—	12%	4%
Pacific Islander alone	—	—	0.4%	0.3%
White alone	93%	91%	53%	39%
Eastern European American	2%	7%	8%	7%
Italian American	5%	9%	5%	4%
Middle Eastern/Central Asian American	0.1%	1%	1%	2%
Portuguese or Brazilian American	0.4%	0.6%	0.5%	0.3%
Spain or Spanish speaking America	—	0.2%	1%	0.3%
Other European American	86%	73%	36%	27%
Non-Hispanic Other	—	<0.1%	0.2%	0.8%
Two or more races	—	—	—	5%
White and Asian	—	—	0.5%	2%
White and Black	—	—	0.1%	0.6%

Source: Decennial Census

Age

San Franciscans have a median age of 38.3 years (source: Table S0101, 2020 American Community Survey 5-Year Estimates, available [here](#)). 13% are under 18 years and a similar proportion (16%) are age 65 and over.

Age distribution

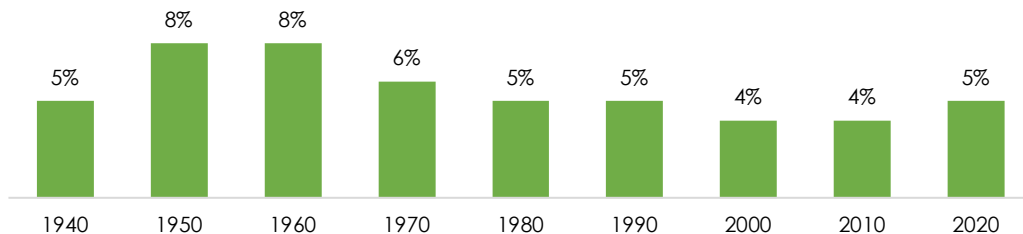


Source: Table DP05, 2020 ACS 5-Year Estimates Data Profiles, available [here](#)

Children

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

Age (under 5 years) distribution over time

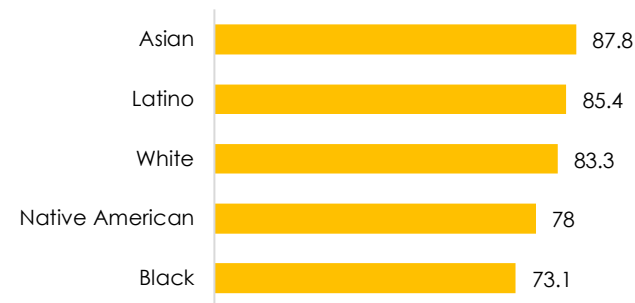


Source: decennial census, available [here](#)

Life expectancy

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

Life Expectancy in Years (years)

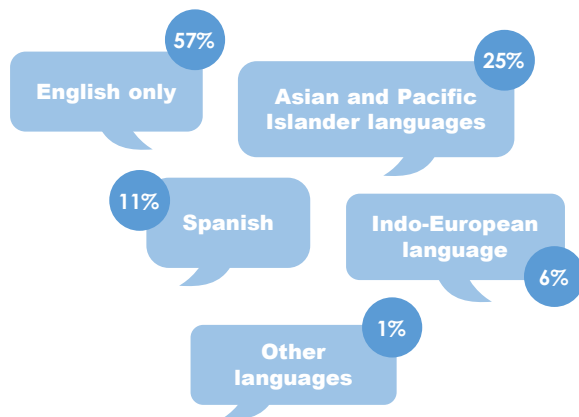


Source: Robert Wood Johnson Foundation, County Health Rankings (2017-2019), available [here](#)



Languages spoken

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

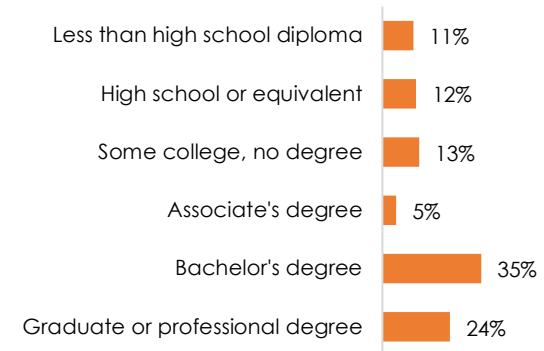


Language spoken at home		
English only	479,645	57%
Spanish	88,425	11%
Indo-European language	50,325	6%
French, Haitian, or Cajun	9,326	1%
German or other West Germanic languages	4,769	0.6%
Russian, Polish, or other Slavic languages	14,526	2%
Other Indo-European languages	21,704	3%
Asian and Pacific Islander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

Source: table C16001, American Community Survey, 2020, available [here](#).

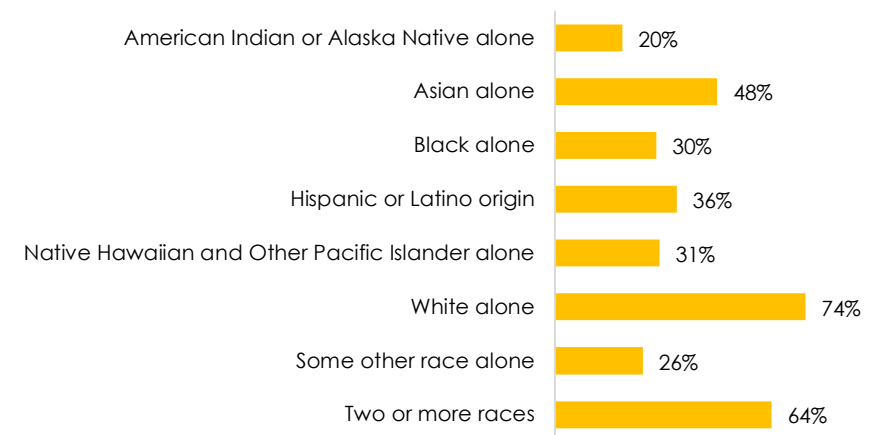
Education

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



Source: Table S1501, 2020 American Community Survey 5-Year Estimates

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



Source: Table S1501, 2020 American Community Survey 5-Year Estimates

CHNA in the Context of COVID

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

As shared by SFHIP members, in many ways, San Francisco organizations rose to the challenge, quickly creating "[resource hubs](#)", first started by the Latino Task Force, to provide COVID testing and vaccinations, in addition to a broader base of support services such as rental assistance, programs for children, and referrals to mental health services. In the midst of great need and confusion, confounded by closure or limited availability in the many usual places of care and community, hubs simplified and removed barriers to access. People working the hubs spoke the language of their clients and often came from the neighborhoods, facilitating quick trust-building and reaching communities where they were.

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

- Asian & Pacific Islander Health Parity Coalition member

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

- African American Health Equity Coalition member

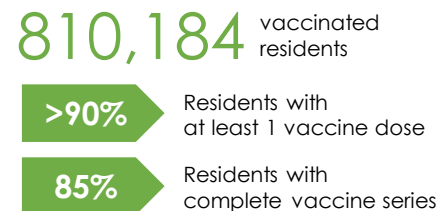
While the hubs were focusing on community needs, San Francisco healthcare systems were learning and training their staff to fight COVID, deploying new protocols as the CDC learned more about the disease. SFDPH coordinated the distribution of COVID patients to ensure no hospitals were overrun.

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

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

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

COVID Vaccination status, updated through July 2022



Source: <https://sf.gov/data/covid-19-vaccinations-neighborhood>

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

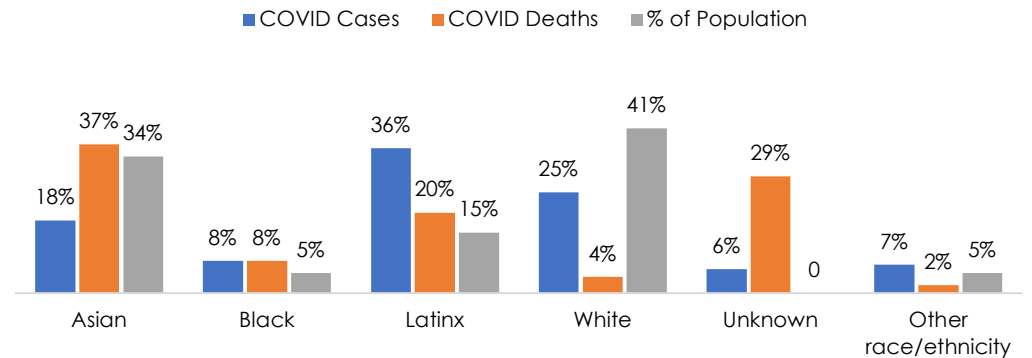
- Community service provider

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

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

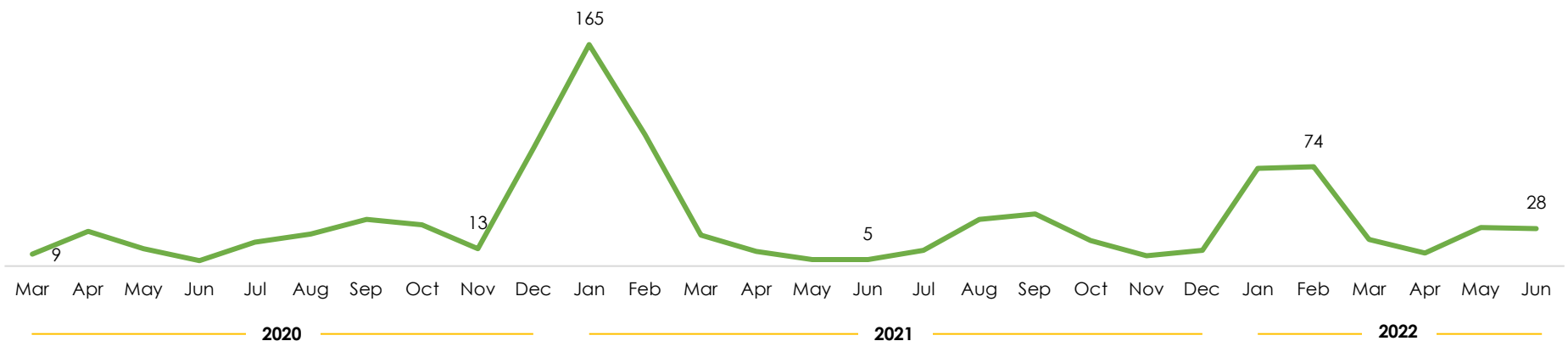
- San Francisco government staff

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



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

COVID deaths in San Francisco



[Source](#) City and County of San Francisco

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

Suggestions for **communication** included:

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

Suggestions for **connecting to communities** included:

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





Our Community's Strengths

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

~ Chicano / Latino / Indígena Health Equity Coalition member

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

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

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

- San Francisco insurer

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

- Chicano / Latino / Indígena Health Equity Coalition member

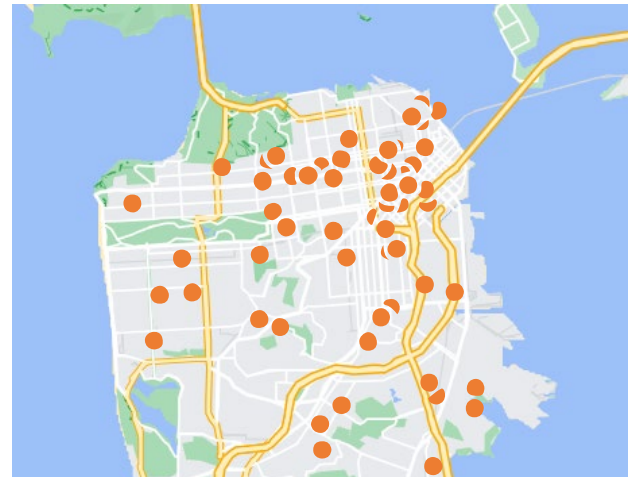
Equipped with crucial cultural and linguistic capabilities, an authentic understanding of the communities in which they are embedded, and a consequent trust-based partnership with the communities they serve, community-based organizations (CBOs) shine in their ability to connect with "hard-to-reach populations"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

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

- African American Health Equity Coalition member

Healthcare facilities

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



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

- Asian & Pacific Islander Health Parity Coalition member

Community centers and trusted spaces

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

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

- Crissy Field
- Gene Friend Recreation Center
- Lucchesi Park
- Mama Calizo's Voice Factory
- Mission Bay Conference Center
- Parque de los Niños Unidos
- Precita Valley Community Center
- SF Green Space at EEGG
- Southeast Community Facility
- The Center SF

"When we have a project, we meet together like the health fair, we have been doing this for the past 26 years. And everyone put aside their agency interests and then really make this health fair together."

- Asian & Pacific Islander Health Parity Coalition member

Places of worship

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

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



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

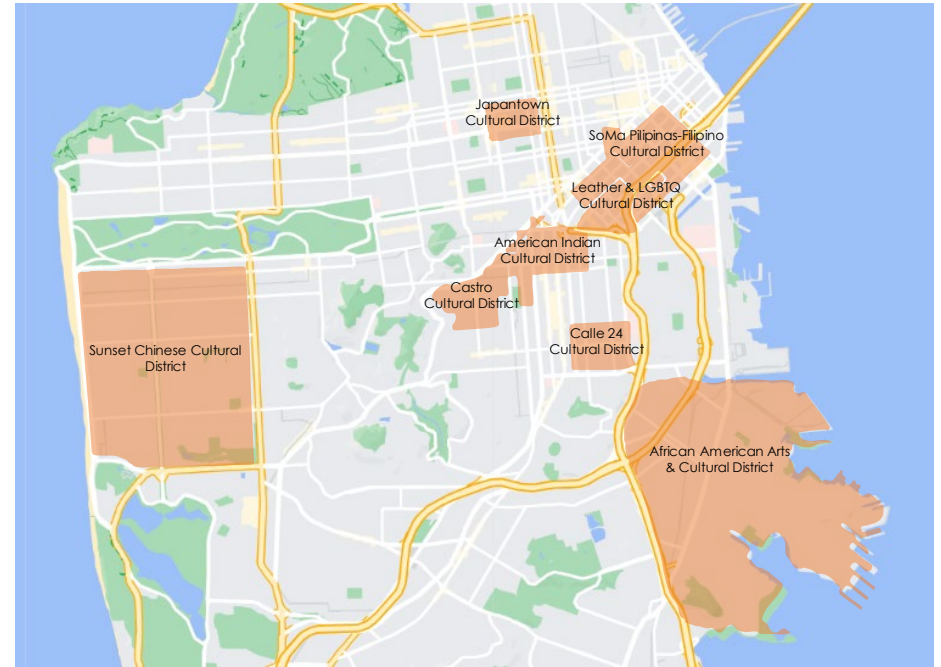
- Asian & Pacific Islander Health Parity Coalition member

Cultural districts

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

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

- Chicano / Latino / Indigena Health Equity Coalition member






Our Community's Health Needs

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

~ San Francisco government staff



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

African American Health Equity Coalition member



Access to Care

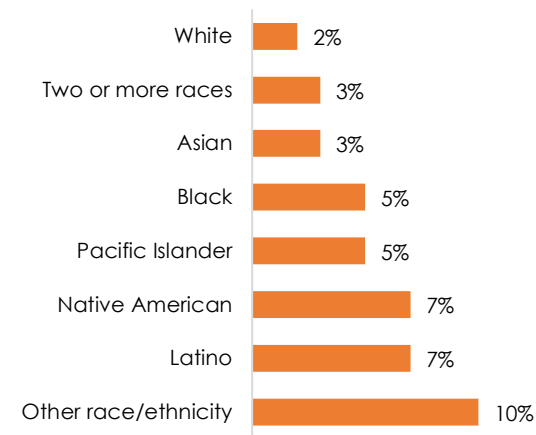
Access to care refers to the right to welcoming, accessible, affordable, culturally grounded, and linguistically responsive acute and preventative healthcare. Welcoming care is delivered in local neighborhoods, by healthcare professionals who are from the communities they are serving, are grounded in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

Intersection with structural racism

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

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

Uninsured People



Source: American Community Survey 5-Year Estimates, Table S2701, 2019)

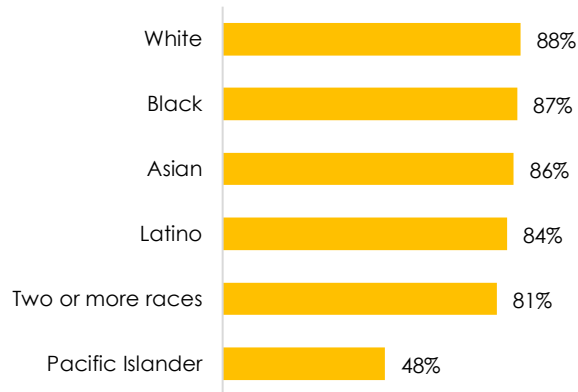
"We've now have circumstances where people's housing stability has been jeopardized, and then their access to insurance has been jeopardized...We're watching and learning to see...how many more "have nots" are coming from the circumstances of the pandemic."

– Community service provider



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

Usual Source of Care



Source: California Health Interview Survey, 2011-2019

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

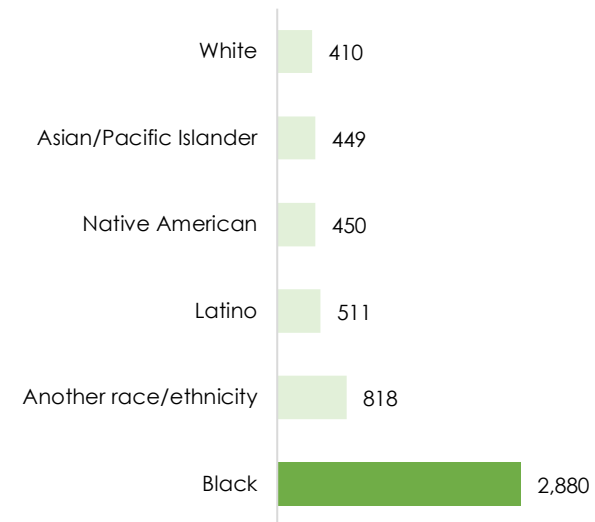
- San Francisco insurer

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

- San Francisco insurer

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

Preventable Hospitalizations per 100,000 People



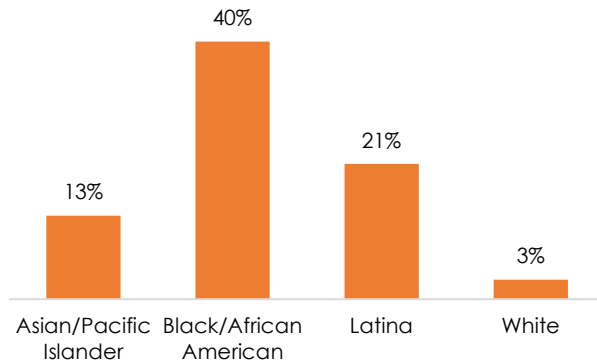
Source: Office of Statewide Health Planning and Development via Race Counts, 2017-19, available [here](#)

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

- Asian & Pacific Islander Health Parity Coalition member

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

Very or somewhat experienced racism during prenatal care



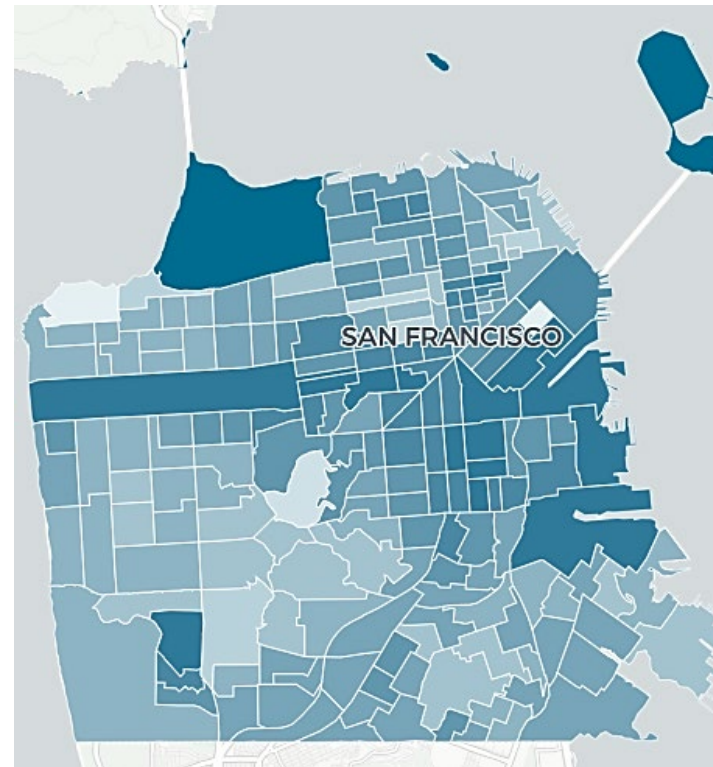
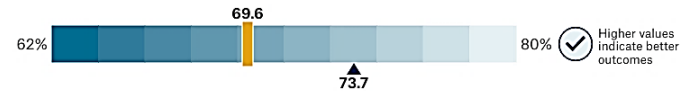
[Source:](#) Maternal and Infant Health Assessment (MIHA) Survey, 2018-2020)

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

- San Francisco government staff

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

Adults 18+ who reported visiting a doctor for routine checkup



[Source:](#) City Health Dashboard

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

- San Francisco insurer

Community recommendations

Strengthen healthcare organizations' commitment to, engagement in, and elevation of culturally and linguistically responsive approaches, practices, policies, and staffing, including having members of the community be part of the leadership and care teams.

"This sense of feeling cared for or valued is also quality of care...Studies have already told us, that folks of color aren't always treated the same when they go into medical facilities; Black women's pain is not seen the same way by doctors as a white woman's pain. They think that you can take more pain or that you're maybe exaggerating what you're experiencing."

- San Francisco government staff

"There's a real lack of focus on repairing and restoring trust...Just because you stated that you are now doing it, doesn't mean that the years and years of that voice not being heard or the real, lived experiences of discrimination are not going to be infiltrating people's ability to truly access healthcare."

- San Francisco insurer

More support for community clinics, with training for community members and pay equity for those working in these clinics.

"What's needed is more efforts toward supporting our Black students who want to become medical professionals, doctors."

- African American Health Equity Coalition member

"They take away our trained clinicians because we can't compete with their salary...I think we're all competing with each other. Training for the next generation of healthcare practitioners is really important. This is actually an opportunity to go into the communities that are less represented and have their young people trained so more people can be helped."

- Community service provider

Focus on neighborhood-based clinics, close to where people live, i.e., healthcare coming to where people are rather than people needing to come to an unfamiliar place when they are at their most vulnerable.

"What's come up a lot is culturally affirming spaces, places where you feel seen, valued, and don't have to be ashamed of who you are, or what you're eating, or your preferred method of mental health practices...It's really about where do I feel welcome to be my authentic self?"

- San Francisco government staff

Collaborations and pilot projects to improve initiating and sustaining care.

"The other big one is long-term accountability. Health insurance typically operates on one to two year contracts. And when we're talking about social determinants of health and systemic oppression, hundreds of years have built where we are today. Our ability to invest in ways that we know we should, outside of a grant focus, is so hard, because then it becomes AIC, and measuring small differences, as opposed to actually focusing on the systems and the changes that we know need to happen."

- San Francisco insurer

Task force that incorporates input from communities and community clinics.

"Healthcare is not one-size-fits-all; taking an equity-based approach is important, considering that, although as humans, we may have many similarities, we also have differences across cultures, nationalities, and religions...It's about your interactions with people, and knowing how to converse with them and address their needs."

- African American Health Equity Coalition member

"We know that our connection is only as strong as our ability to communicate. There are folks who want to do this work, but just don't have the right pathway in. Who's going to build capacity so that there's representation in all of these groups to really be able to have representation at a table?"

- Community service provider



We already have challenges in getting our community members to come and get mental health services, get therapy, get counseling. But if we have folks who speak their language that are licensed to do that or supervised by a licensed person, I think then you'll have more community members feel safe, feel they can access these mental health services.

Asian & Pacific Islander Coalition member



Behavioral Health

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

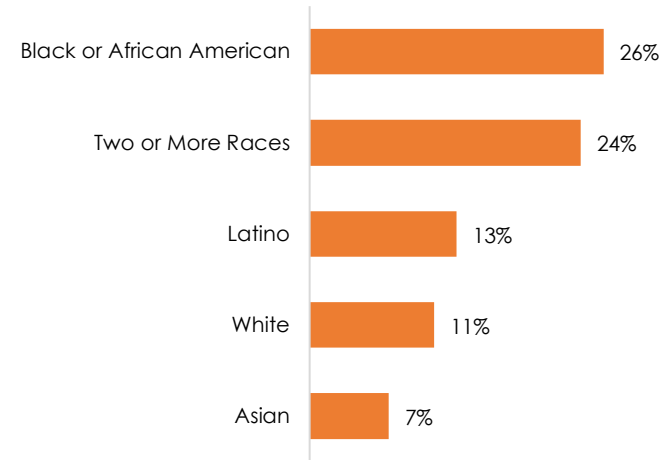
Intersection with structural racism

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



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

Percent who reported serious psychological distress during past year



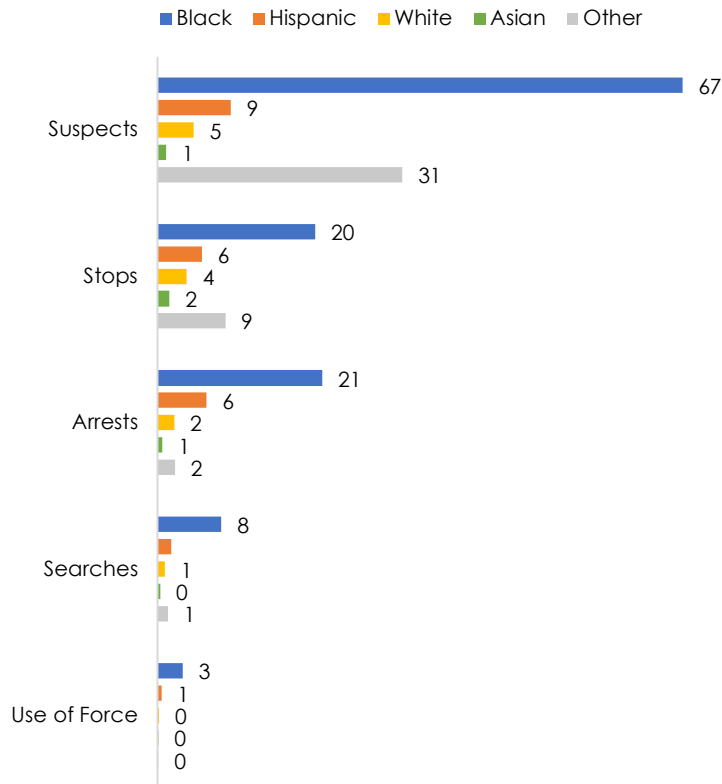
Source: California Health Interview Survey, 2015-2020, available [here](#)

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

- Community service provider

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

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



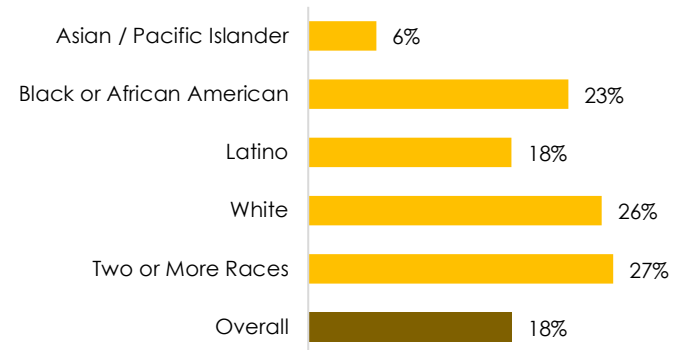
Source: San Francisco Police Department Quarterly Activity and Data Report, quarter 1 2022

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

- Community service provider

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

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



Source: Advancement Project California; Race Counts, 2022. California Health Interview Survey (2011-2019) data. Available [here](#)

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

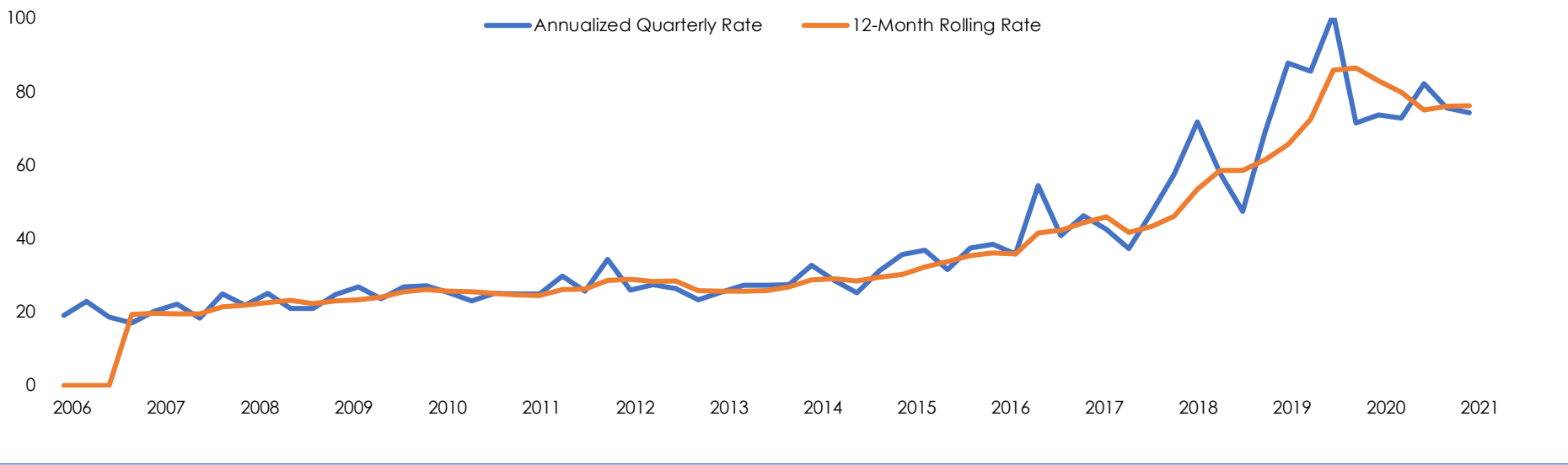
- Asian & Pacific Islander Health Parity Coalition member



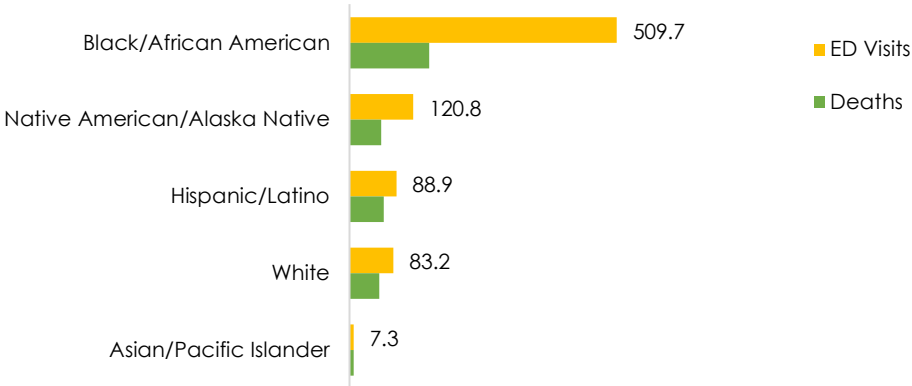
San Francisco experienced 443 opioid-related overdose deaths in 2020, the highest rate in California. This represents a 203% increase from 2018.

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

Opioid-Related Overdose ED Visits, Age-Adjusted Rate per 100,000 Residents



Opioid-Related Overdose Emergency Department Visits and Deaths, age adjusted rate per 100k residents, 2020



Source: California Department of Health Care Access and Information - Emergency Department Data; CDPH Center for Health Statistics and Informatics Vital Statistics, Multiple Cause of Death and California Comprehensive Death Files, available [here](#)

Community recommendations

Mental health and substance use must be addressed as a health issue, with more holistic solutions.

"Mental health is so narrowly defined. So what is the bigger umbrella that we need to have in terms of self-care? And what does that look like for different people — whether it is somebody practicing yoga or somebody that's practicing prayer, but they're both doing something that is relevant to them. And so how do we create the space for that?"

- San Francisco government staff

Recognize the need for more clinicians of color, serving in their own communities, and receiving pay equity compared to those serving in larger healthcare organizations.

"For our community, workforce in the mental health field is almost nonexistent for licensed practitioner or licensed therapist. That is where the city can invest in more or support folks who are already licensed to provide either more clinical supervision to staff members who are on the path to being licensed."

- Asian & Pacific Islander Health Parity Coalition member

Increased funding for BIPOC community-based mental health interventions, with a focus on care with low access barriers.

"The good thing about the Affordable Care Act is that a lot more people have access to healthcare and mental health is being covered by the Affordable Care Act...However, we have not had enough time to train more professionals to provide a service that the insurance company pays for."


- Community service provider

Targeted mental health support for people of color.

"I want to add an acknowledgement that our strength to deal with the stress or the traumas that we're going through is not evidence that mental services are not needed."

- African American Health Equity Coalition member





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

Community service provider



Economic Opportunity

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

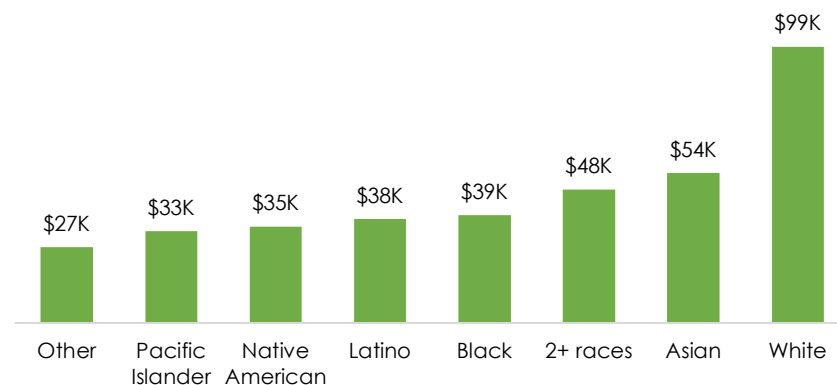
In addition to affordable housing, economic opportunity includes (but is not limited to) exposure to environmental and climate-related factors and/or hazards, and the ability to obtain nutrient-dense, culturally relevant food. Affordable housing closely intertwines with economic opportunity, and refers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

Intersection with structural racism

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

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

Per Capita Income (\$)



Source: American Community Survey 5-Year Estimates, Tables B19301B-I, 2019, available [here](#)

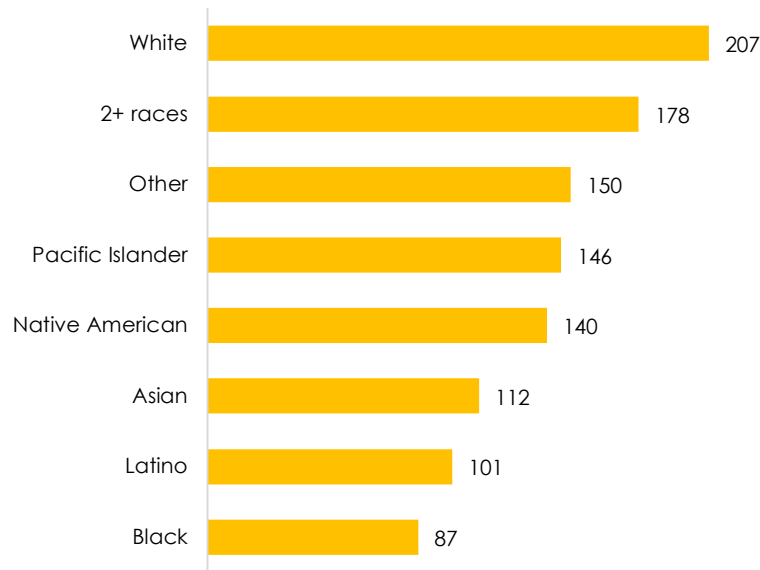
"Within economic disparities, in particular immigrants, are really at grave risk. They didn't get to share in the benefits that we received from the government for extra money that we were given [during COVID]. They remained isolated and without work or at great risk with work and continued to feel at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

- Chicano / Latino / Indígena Health Equity Coalition member



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

Employment as Officials or Managers per 1,000 People



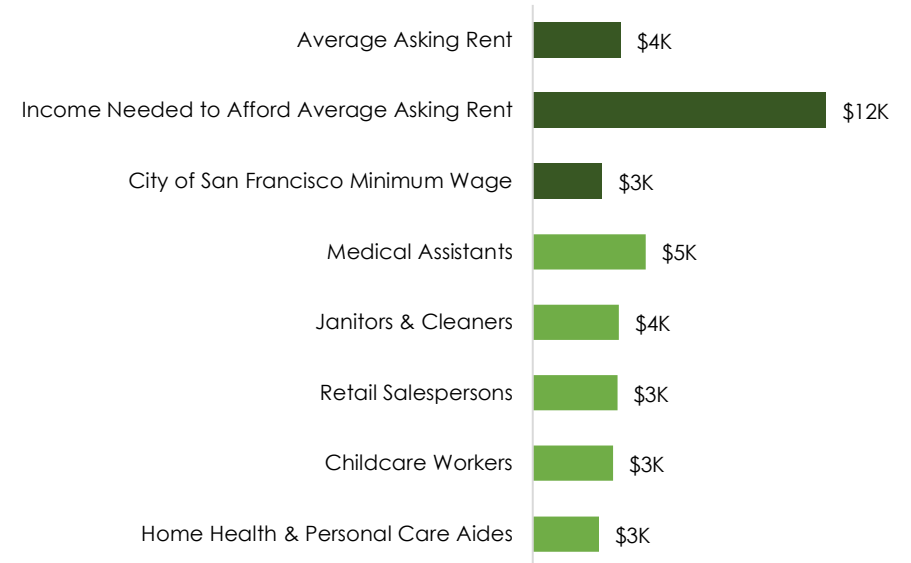
Source: American Community Survey 5-Year PUMS Estimate, 2019, available [here](#)

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

- African American Health Equity Coalition member

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

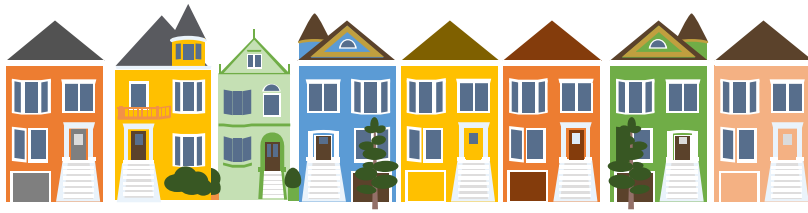
Who Can Afford Rent



Source: California Housing Partnership. San Francisco County Housing Need Report 2022, page 4, [here](#)

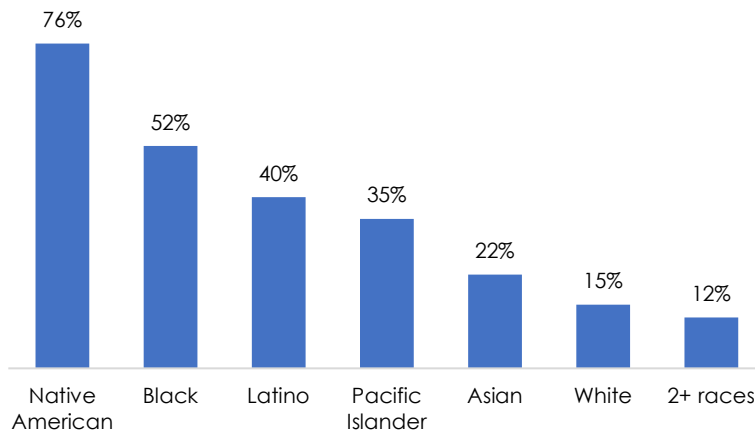
"It has to do with affordable housing, because a lot of my clients live [with] a lot of people, they live in small units, the whole family. So, before COVID, it was probably okay. But because during COVID everybody stayed home and you're talking about sometimes the family of five or six people in small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

- Asian & Pacific Islander Health Parity Coalition member



The homeownership rate is 38% in San Francisco, compared to the national average of 64% (Kaiser Permanente Community Dashboard Portal, [here](#)). Among those seeking to purchase a home, a much higher proportion of people of color are denied mortgage applications.

Denied Mortgage Applications (%)



Source: Home Mortgage Disclosure Act, 2018-2019, available [here](#)

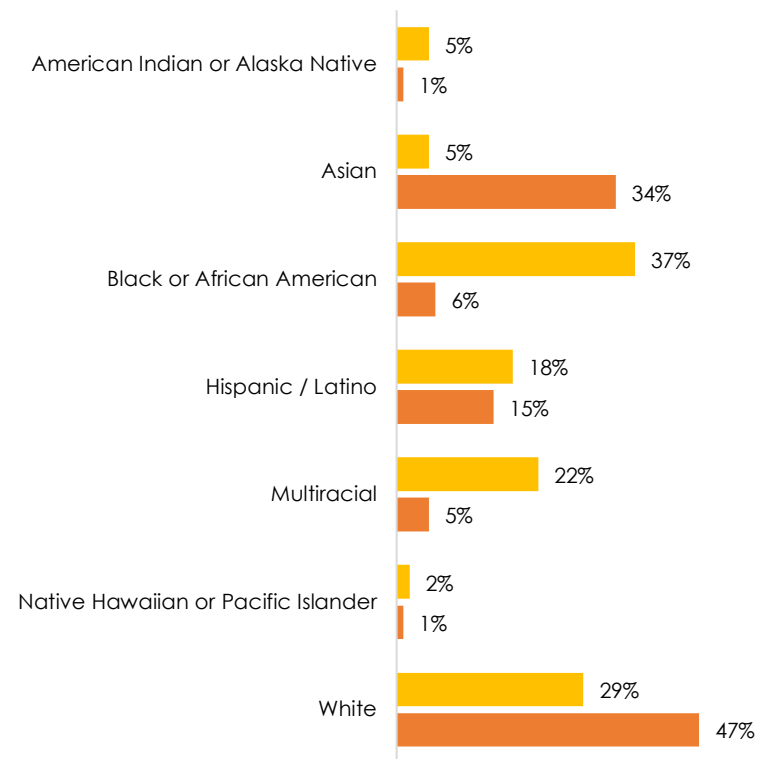
"We have the country's biggest wealth, and we have enormous poverty, and we have huge disparities along race lines...It's hard, when you're in the group of people that have a lot, to put yourself in someone else's shoes and have perspective."

- San Francisco funder

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

Race/Ethnicity of San Francisco Homeless Community

■ San Francisco Homeless Count & Survey ■ San Francisco Population



Source: San Francisco Homeless Count & Survey, Comprehensive Report. San Francisco Department of Homelessness and Supportive Housing. Available [here](#)

Community recommendations

Multi-level advocacy regarding housing policies that disproportionately impact communities of color in San Francisco, including recommendations from the Latino Task Force's 2022 Street Needs Assessment + El Proyecto Dignidad (available [here](#)).

"Right now, I'm looking for housing [for a community member] around Chinatown. They live eight in the family... Now they find out you pay more than almost \$3,000 for two bedrooms. So they try to stay in affordable housing, but they cannot get anything at all for the past three years. So it's difficult."

- Asian & Pacific Islander Health Parity Coalition member

"There's a Black out-migration report that was done about San Francisco that talks about how many Black families and Black people were moved out of San Francisco areas at a time when there was only like 12% of African Americans in San Francisco. And now it's down to something like 4%. When you look at the jails, the jails are more populated by Black folks. How is that possible out of 4% of Black people in San Francisco?"

- African American Health Equity Coalition member



Workforce development and job training, especially for jobs in community healthcare and behavioral health.

"It's just that much more work to be a peer counselor or community navigator because it's just too much work and not enough money; we can't pay them enough for them to be able to not drive Uber and help the community...It's harder to find the next generation of providers because they get into other fields that can make more money."

- Community service provider

Provide emotional and psychological support for individuals and families experiencing housing insecurity.

"Housing [is] not just the actual physical place of housing, of a home where you know that you'll be safe from inclement weather or from the outdoors or a place for your stuff. It's the stress of not being housed...The emotional, mental, traumatic kind of outcomes from just having to sleep on the streets. Is your stuff going to get taken? Is someone going to come mess with you? Is it going to be really cold or really hot? Is someone going to tell me to move? All of that, night after night, that's a nightmare."

- Community service provider

Conclusion



“There's a lot of community leadership that has sprung up over the last year that should be leveraged.”

- San Francisco government staff

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

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

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

- Community Engagement
- Cultural Humility
- Financial Investment

Community Engagement

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

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

- Chicano / Latino / Indígena Health Equity Coalition member

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

- Community service provider



Cultural Humility

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

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

- African American Health Equity Coalition member

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

- Community service provider



Financial Investment

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

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

- Asian & Pacific Islander Health Parity Coalition member

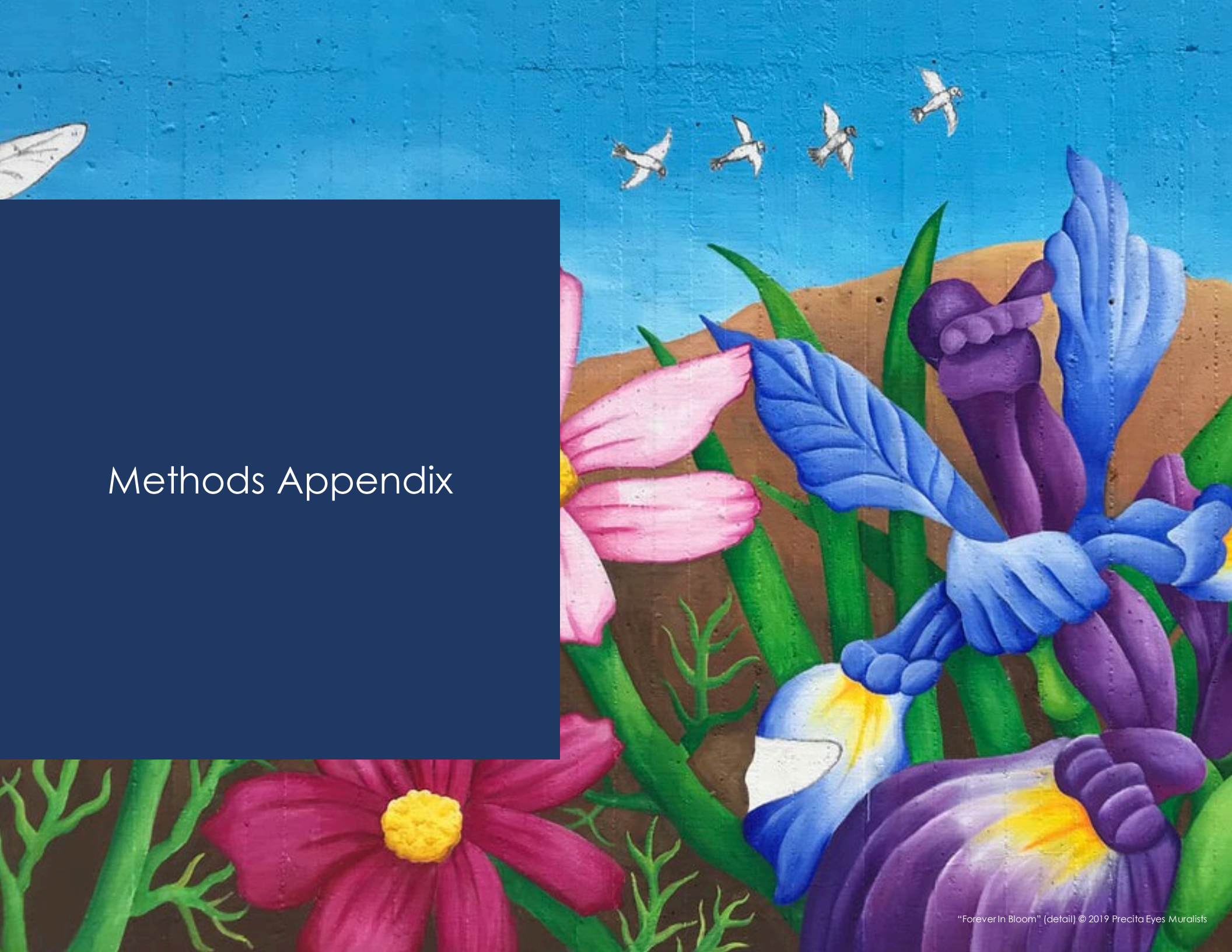
"There is also a capacity-building piece in neighborhoods. How do we support folks and residents in the neighborhood who have a different kind of stake in the neighborhood to do, and also create, economic and civic opportunity, at the same time to really empower the neighborhood to do this work? So it's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

- Community service provider



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

Methods Appendix



About the Community Health Needs Assessment (CHNA)

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

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

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

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

CHNA Leadership

The San Francisco CHNA is conducted as part of the **San Francisco Health Improvement Partnership (SFHIP)**, a collaborative body whose mission is to improve community health and wellness in San Francisco through collective impact. SFHIP is comprised of mission-driven anchor institutions committed to leveraging their economic power to improve community health and well-being; health equity coalitions grounded in the lived experience and resilience

of communities experiencing health inequities; funders dedicated to improving community health; and educational, faith-based, and service provider networks and institutions making a difference in the everyday lives of residents.

- African American Health Equity Coalition
- Asian & Pacific Islander Health Parity Coalition
- Chicano/Latino/Indígena Health Equity Coalition
- Chinese Hospital
- Dignity Health
- Instituto Familiar de la Raza
- Kaiser Permanente
- Rafiki Coalition
- Richmond Area Multi-Services, Inc. (RAMS)
- Saint Francis Memorial Hospital
- San Francisco Community Clinic Consortium
- San Francisco Department of Public Health
- San Francisco Human Services Network
- San Francisco Unified School District
- St. Mary's Medical Center
- Sutter Health California Pacific Medical Center
- University of California, San Francisco

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

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

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

Community Assessment

Primary qualitative data

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

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

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

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

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

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

Secondary quantitative data

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

Health Need Selection

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

- Access to care
- Behavioral health
- Economic opportunity

San Francisco 2021-22 Community Health Needs Assessment

Focus Group Discussion Guide | Health Equity Coalitions

Group description
Date
Meeting link
Language
Facilitator and notetaker
Logistic notes

Introduction

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

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

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

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

Do you have any questions before we start?

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

Discussion Questions

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

Thank you! Those are all the questions. Is there anything you would like to share that we did not talk about?



harderco.com

Harder+Company Community Research works with public- and social-sector organizations across the United States to learn about their impact and sharpen their strategies to advance social change. Since 1986, our data-driven, culturally responsive approach has helped hundreds of organizations contribute to positive social impact for vulnerable communities. Learn more at www.harderco.com.
