SAINT FRANCIS MEMORIAL HOSPITAL
2019 Community Health Needs Assessment
A message from

David Klein, President and CEO of Saint Francis Memorial Hospital, and Harris Goodman, M.D., Chair of Saint Francis Memorial Hospital Board of Trustees.

The purpose of the Community Health Needs Assessment (CHNA) is to identify and prioritize significant health needs of the community served by Saint Francis Memorial Hospital. The priorities identified help to guide the hospital’s community health improvement programs and community benefit activities as well as its collaborative efforts with other organizations that share our mission to improve health. This CHNA report meets the requirements of the Patient Protection and Affordable Care Act (and California of Senate Bill 697) that not-for-profit hospitals conduct a community health needs assessment at least once every three years.

Saint Francis Memorial Hospital shares a commitment to improve the health of our community and conducts the CHNA in partnership with the City and County of San Francisco through the San Francisco Health Improvement Partnership (SFHIP). The 2019 San Francisco Community Health Needs Assessment describes the process and findings and identifies five significant community health needs and two overarching foundational issues that contribute to health needs.

The 2019 CHNA included a review of population health data, an assessment of assessments, deliberations between the San Francisco Health Improvement Partnership and engagement of community members not represented in the quantitative data. There are no known information gaps that limit the ability of this CHNA to assess the community’s health needs. The assembled data, information, and analyses provide a comprehensive identification and description of significant community health needs. In addition to this data collection effort, the hospital invited written comments on the 2016 CHNA report and Implementation Strategy, both in the documents and on the website where they are widely available to the public. No written comments have been received.

The CHNA identifies five health needs that heavily impact disease and death in San Francisco. The community health needs described in detail in the report are:

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

The CHNA also identifies two overarching foundational issues that contribute significantly to local health needs:

1) Racial health inequities
2) Poverty
San Francisco, at roughly 47 square miles, is the most densely populated large city in California. Between 2011 and 2018, San Francisco grew by almost eight percent to 888,817 persons outpacing population growth in California (6 percent). By 2030, San Francisco’s population is expected to total more than 980,000. The population is aging and the ethnic shifts continue with an increase in the Asian and Pacific Islander population, increase in multiethnic population and a decrease in the Black/African American population. Although San Francisco has a relatively small proportion of households with children (19 percent) compared to the state overall (34 percent), the number of school-aged children is projected to rise. As of 2017, San Francisco is home to 67,740 families with children, 26 percent of which are headed by single parents. There are many neighborhoods within San Francisco. Health status varies by neighborhood, economic status, ethnicity, age and other factors.

Since 2016, the overall health in San Francisco has improved:

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

**Impact of Actions Taken Since 2016 CHNA**

<table>
<thead>
<tr>
<th>Priority Health Need Addressed: Access to Care, Behavioral Health, Healthy Eating and Physical Activity</th>
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</thead>
<tbody>
<tr>
<td><strong>STRATEGY OR ACTIVITY 1: Tenderloin Health Improvement Partnership</strong></td>
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</table>

**Program Description**

Since 2014, Saint Francis Memorial Hospital and the Saint Francis Foundation collaborated to serve as the backbone for a place-based, collective impact approach to addressing the social determinants of health in the Tenderloin. [Collective Impact](https://www.saintfrancisfoundation.org/where-we-invest/tenderloin-health-improvement-partnership/our-model/) is a model for large scale social change requiring a common agenda, shared measures, aligned activities, continuous communication, and a strong backbone. Working with more than 100 multi-sector partners and with a [Community Advisory Committee (CAC)](https://www.saintfrancisfoundation.org/where-we-invest/tenderloin-health-improvement-partnership/our-model/) of neighborhood leaders, TLHIP partners have aligned around five pathways to health:

1. Active, Vibrant, Safe and Clean Shared Spaces
2. Behavioral Health
3. Resident Health
4. Economic Opportunity and Affordable Retail
5. Housing Access

To learn more about the TLHIP Logic Model for improving health outcomes for Tenderloin residents, visit [https://www.saintfrancisfoundation.org/where-we-invest/tenderloin-health-improvement-partnership/our-model/](https://www.saintfrancisfoundation.org/where-we-invest/tenderloin-health-improvement-partnership/our-model/).
Saint Francis Memorial Hospital was recognized as a national leader in the field of Community Health by the American Hospital Association (AHA) through the 2018 Foster G. McGaw Prize. This distinguished award honors TLHIP’s innovative upstream interventions and impact on social determinants in the Tenderloin community. TLHIP is a vehicle to engage multisector partners and help foster coordination between government, business, and non-profit sectors, work with community, and co-create solutions to deliver a deeper impact.

- 62 Community Advisory Committee meetings and multisector community-wide convenings facilitated by TLHIP backbone to set the common agenda and increase communication, alignment, and strategy development.
- Supported 50+ local, community serving organizations, including 5 anchor institutions, who are now leading neighborhood improvement efforts.
- Increased community capacity, supporting community partners to attend national conferences on measurement and evaluation; equity, leadership and collaboration; and, nutrition and food security.
- Based on 2017 survey, 95% of partners value the support that the TLHIP Backbone team provides. 87% of partners report that TLHIP provides an effective approach for achieving impact. 89% of partners report that neighborhood alignment has increased as a result of TLHIP.

TLHIP Impact Reports for 2014 – 2018 are available at: [https://www.saintfrancisfoundation.org/highlight/category/tlhip-resources-reports/](https://www.saintfrancisfoundation.org/highlight/category/tlhip-resources-reports/)

### Priority Health Need Addressed: Access to Care

**STRATEGY OR ACTIVITY 1: Tenderloin Health Services**

**Program Description**

HealthRIGHT 360 THS is located at the Glide Methodist Church in the Tenderloin District of San Francisco and provides primary care, mental health, HIV/AIDS and recovery services to adults. THS works with Saint Francis Memorial Hospital through the hospital’s ED Navigator and Healthy San Francisco (HSF) programs to provide inpatients and outpatient services for HSF participants that identify THS as their medical home.
<table>
<thead>
<tr>
<th>Fiscal Years Active</th>
<th>FY 2016</th>
<th>FY 2017</th>
<th>FY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Health Needs Addressed</td>
<td>Access to Care</td>
<td>Behavioral Health</td>
<td>Healthy Eating and Physical Activity</td>
</tr>
<tr>
<td>Program Performance / Outcomes</td>
<td>SFMH THS HSF IP 2; Out Pt.141. Total Unduplicated Patient Count: 1,559; Medical and Behavioral Total Visits: 9,448 (Medical: 7090; Behavioral Health: 2,358). This includes 221 patients who were enrolled in HSF.</td>
<td>Total Unduplicated Patient Count: 1664. Total Medical and Behavioral Health Visits: 9,848 (Medical: 8,133; Behavioral Health: 1,715).</td>
<td>Total Unduplicated Patient Count: 3,615. Total Medical and Behavioral Health Visits: 10,462 (Medical: 8,635; Behavioral Health: 1,827). This includes 221 patients who were enrolled in HSF.</td>
</tr>
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STRATEGY OR ACTIVITY 2: Healthy San Francisco

Program Description
Healthy San Francisco is a program to provide a system of health care services to the uninsured. Healthy San Francisco links participants with a Medical Home, a clinic that provides primary care, social services, case management and preventative care. Healthy San Francisco has approximately 13,615 participants enrolled in 35 medical homes and participating hospitals (according to online FY16-17 annual report). Saint Francis actively supports Healthy San Francisco through its partnership with Tenderloin Health Services. The numbers of person enrolled in Healthy San Francisco has declined as eligible individuals enroll in MediCal.

<table>
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</tr>
<tr>
<td>Program Performance / Outcomes</td>
<td>Health access through the medical home for average of 426 individuals per month for July 2015 – June 2016.</td>
<td>Provided hospital services for 246 persons. THS HSF enrollment 426 unduplicated patients.</td>
<td>Provided hospital services for 176 persons. THS HSF enrollment 221 unduplicated patients.</td>
</tr>
</tbody>
</table>

STRATEGY OR ACTIVITY 3: Patient Navigator Program

Program Description
Because of various barriers to primary care, the Emergency Department is the primary source of care for many MediCal and uninsured. The hospital partners with HealthRIGHT360's Tenderloin Health Services to provide patient navigator services. The Patient Navigator works...
closely in coordination with hospital case management, financial counseling departments and community-based clinics to case find and assist patients transitioning out of the hospital setting into appropriate medical homes, including primary and/or specialty care appointments. This iteration of the program builds on previous navigator programs which began in FY2010 as partnership with the San Francisco Health Plan and Department of Public Health.

<table>
<thead>
<tr>
<th>Fiscal Years Active</th>
<th>X FY 2016</th>
<th>X FY 2017</th>
<th>X FY 2018</th>
</tr>
</thead>
</table>

| Other Health Needs Addressed | X Access to Care | q Behavioral Health | q Healthy Eating and Physical Activity |

| Program Performance / Outcomes¹ | FY 2016: Of the 1068 encounters, 752 appointments were made or 70%. Show rates included 73% at Tenderloin Health Services (THS). | FY 2017: Of the 1,233 encounters in FY17, 911 appointments were made or 74%. Show rates included 68% at Tenderloin Health Services (THS), 63% at Tom Waddell Health Clinic (TWHC), 72% Curry, and 87% at St. Anthony. | FY 2018: Of the 733 encounters in FY18, 553 appointments were made or 75%. Show rates included 69% at Tenderloin Health Services (THS), 62% at Tom Waddell Health Clinic (TWHC), 73% Curry, and 93% at St. Anthony. |

### STRATEGY OR ACTIVITY 4: Rally Family Visitation Services

**Program Description**

Rally Family Visitation Program provides a safe and secure structured environment in which children can visit with their court-ordered non-custodial parent when there is a high level of conflict, including domestic violence, between divorced/separated parents, as well as when they have been removed from the care of their parents and have become dependents of the court. The goal of the program is to ensure the safety of children and adult victims. The program serves predominantly low-income families.

<table>
<thead>
<tr>
<th>Fiscal Years Active</th>
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</tr>
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</table>

| Other Health Needs Addressed | X Access to Care | q Behavioral Health | q Healthy Eating and Physical Activity |

| Program Performance / Outcomes¹ | Provided a secure and safe environment for visits, ensured children have access to both parents in a healthy environment, and ensured safety for victims of domestic violence while at Rally: FY 2016: 3,772 Exchanges, 3,005 hours of supervised, facilitated and therapeutic visits. Provided 325 intakes to approximately 800 families. | FY 2017: 3,000 Exchanges, 2,000 hours of supervised, facilitated and therapeutic visits. Provided 300 intakes to approximately 800 families. | FY 2018: 3,000 Exchanges, 2,000 hours of supervised, facilitated and therapeutic visits. Provided 300 intakes to approximately 800 families. |

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¹ For more information on outcomes and metrics, please refer to the detailed report on the program's performance.
1. All program outcomes are reflective of the timeframe (fiscal years) indicated by the boxes checked in the ‘Fiscal Years Active’ section of the table for each program.

**Community Grants**

The theme for Dignity Health’s Community Grants program focuses on collaboration with an emphasis on responding to significant health needs identified in the CHNA. The goal of the program is to develop strategic partnerships between community-based organizations that link services directly to Dignity Health hospitals; leveraging resources that address priority health issues, and utilize creative strategies that have a direct, positive and lasting impact on the health of disadvantaged individuals and families in our community.

To be eligible for funding, organizations must work in collaboration with a minimum of 3 community partners. Program/Project responds to two or more of the following priority health needs:

1) Access to coordinated, culturally and linguistically appropriate care and services
2) Behavioral Health
3) Healthy Eating and Physical Activity

In FY 2016 through FY 2019, Saint Francis Memorial Hospital awarded 4 grants totaling $340,227. The table below highlights the grantees.

<table>
<thead>
<tr>
<th>Community Grants Table</th>
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</thead>
<tbody>
<tr>
<td><strong>Lead Grant Recipient</strong></td>
</tr>
<tr>
<td>From the Garden to the Table</td>
</tr>
<tr>
<td>SF Recovery Theatre</td>
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<tr>
<td>HealthRight360’s Tenderloin Health Services</td>
</tr>
<tr>
<td>HealthRight360’s Tenderloin Health Services</td>
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</tbody>
</table>
Resources Potentially Available to Address Needs

Resources potentially available to address these needs are vast in San Francisco. The organized health care delivery systems include the Department of Public Health, University of California, Sutter Health, Kaiser Permanente, Chinese Hospital, Dignity Health Saint Francis Memorial Hospital and Dignity Health St. Mary’s Medical Center and the San Francisco Community Clinic Consortium. In addition there are numerous health and social service non-profit agencies, many of which are supported by local government funds. Faith based organizations, private and public school systems and health equity councils also contribute resources to address these identified needs. All of these organizations are represented on the San Francisco Health Improvement Partnership Steering Committee, the CHNA leadership group and CHNA community partners listed on page 5 of the main CHNA report. Additionally, Saint Francis Memorial Hospital partners with HealthRIGHT360 Tenderloin Health Services, The San Francisco Health Plan, Healthy San Francisco, St. Anthony Foundation, Tenderloin Equitable Development Project, Curry Senior Center, Code Tenderloin, TNDC, GLIDE, Boys & Girls Clubs of San Francisco, Tenderloin Community Benefit District, SF Planning, SF Office of Economic and Workforce Development, SF Police Department, Delancey Street Foundation, and other community-based organizations.

The 2019 Community Health Needs Assessment was approved by the Saint Francis Memorial Hospital Community Advisory Committee on May 17, 2019 and adopted by the Saint Francis Memorial Hospital Board of Trustees on June 6, 2019.

The Community Health Needs Assessment is widely available to the public on the hospital’s website and a paper copy is available for inspection upon request the hospital’s Community Health office.

Written comments on this report can be submitted to the hospital’s Community Health office at 900 Hyde Street, San Francisco, CA 94109.

If you have any questions, please contact us at 415-353-6000.

David Klein, M.D.
President/CEO

Harris Goodman, M.D.
Chair, Board of Trustees
# Table of Contents

A Message from SFHIP .............................................. 3
A Message from the Director of Health for the City and County of San Francisco .............. 4
Acknowledgments .................................................. 5
Executive Summary .............................................. 6

**THE 2019 COMMUNITY HEALTH NEEDS ASSESSMENT** .......... 8

- Purpose and Collaborators ........................................ 9
- Approach ............................................................. 10
  - Community Health Status Assessment, ................................ 10
  - Assessment of Prior Assessments .................................. 11
  - Community Engagement ............................................ 11
  - Health Need Identification ........................................ 12
- San Francisco Snapshot ........................................... 13
- Major Findings ..................................................... 15
- Foundational Issues ............................................... 16
  - Poverty .............................................................. 16
  - Racial Health Inequities ........................................... 17
- Health Needs ......................................................... 20
  - Access to Coordinated, Culturally, and Linguistically Appropriate Care and Services ...... 20
  - Food Security, Healthy Eating, and Active Living ....................... 21
  - Housing Security and an end to Homelessness ......................... 24
  - Safety from Violence and Trauma ................................ 26
  - Social, Emotional, and Behavioral Health ............................ 30
- References .......................................................... 35

PHOTOGRAPH: PHOTEVERYWHERE / STOCKARCH.COM
We would like to thank the many individuals including community residents, community-based organizations, and health care partners that contributed to this assessment. A special thank you goes out to the Community Health Needs Assessment and Impact Unit of the San Francisco Department of Public Health for their work on the data analysis and overall project management, and to the Backbone of SFHIP, staffed by the Department of Public Health, the Hospital Council, and the University of California at San Francisco, for their support for the project.

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

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

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

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

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

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

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

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

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

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

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

Best regards,

Grant Colfax, MD
Director of Health
San Francisco Department of Public Health
City and County of San Francisco

PHOTOGRAPH: MIKE HOFFMAN
Acknowledgments

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San Francisco Health Improvement Partnership

Community Health Needs Assessment 2019 | 5
Welcome to the **Community Health Needs Assessment** (CHNA). The CHNA takes a broad view of health conditions and status in San Francisco. In addition to providing local disease and death rates, this CHNA also provides data and information on social determinants of health—social structures and economic systems which include the social environment, physical environment, health services, and structural and societal factors.

The CHNA involves four steps:

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

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

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

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

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

- Racial health inequities
- Poverty

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

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

**Foundational Issues**

**Racial Health Inequities**

Health inequities are avoidable differences in health outcomes between population groups. Health inequities result from both the actions of individuals (health behaviors, biased treatment by health professionals), and from the structural and institutional behaviors that confer health opportunities or burdens based on status. For example, the uneven distribution of wealth and resources determines the level of health those getting the least of these resources can achieve. Pages 17–19 include data on a few improvements to health and determinants of health and point to where more work needs to be done to address the structural and institutional racism in San Francisco. Additional data on health inequities are found throughout the Community Health Data pages.
Poverty

Enough income generally confers access to resources that promote health—like good schools, health care, healthy food, safe neighborhoods, and time for self-care—and the ability to avoid health hazards—like air pollution and poor quality housing conditions. Page 16 focuses on the economic barriers to health that many San Franciscans face. Find additional data on economics and health in the Economic Environment data page.

Health Needs

Access to Coordinated, Culturally and Linguistically Appropriate Care and Services

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

Food Security, Healthy Eating and Active Living

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

Housing Security and an End to Homelessness

Housing is a key social determinant of health.1 Housing stability, quality, safety, and affordability all have very direct and significant impacts on individual and community health. Much of California, and especially the Bay Area, is currently experiencing an acute shortage in housing, leading to unaffordable housing costs, overcrowding, homelessness and other associated negative health impacts. Between 2011 and 2015, the Bay Area added 501,000 new jobs—but only 65,000 new homes. An estimated 24,000 people in San Francisco live in crowded conditions and about 7,500 homeless persons were counted in San Francisco. Pages 24–25 provide an overview of the housing stressors in San Francisco. Additional information on housing and health is found in the Housing data page.

Safety from Violence and Trauma

Violence not only leads to serious mental, physical and emotional injuries and, potentially, death for the victim, but also negatively impacts the family and friends of the victim and their community. Persons of color are more likely to be victims of violence, to live in neighborhoods not perceived to be safe and to receive inequitable treatment through the criminal justice system. Pages 26–29 focus on violence and trauma, their determinants and health impacts in San Francisco. Additional data on violence and trauma in the City are presented in the Crime and Safety data page.

Social, Emotional, and Behavioral Health

Mental health is an important part of community health. In San Francisco the number of hospitalizations among adults due to major depression exceed that of asthma or hypertension. Presence of mental illness can adversely impact the ability to perform across various facets of life—work, home, social settings. It also impacts the families, caregivers, and communities of those affected. Substance abuse including drugs, alcohol and tobacco, contributes to 14 of the top causes of premature death in the City—lung cancer, Chronic Obstructive Pulmonary Disease, HIV, drug overdose, assault, suicide, breast cancer, heart failure, stroke, hypertensive heart disease, colon cancer, liver cancer, prostate cancer, and Alzheimer’s. Pages 30–34 focus on psychological distress, major depression, and substance abuse in San Francisco. Find additional data on social, emotional and behavioral health in the City in the Mental Health, Substance Abuse, and Tobacco Use and Exposure pages.
The 2019 Community Health Needs Assessment (CHNA) takes a comprehensive look at the health of San Francisco residents by presenting data on demographics, socioeconomic characteristics, quality of life, behavioral factors, the built environment, morbidity and mortality, and other determinants of health status.

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

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

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

A life course approach considers one’s lived experience and health throughout the lifespan, within the context of their history, environment, family, community, society, and culture. Certain events and exposures (i.e. trauma, racism, poverty, environmental factors, etc.) during sensitive time periods in early life can have long-term impacts on development and health.1

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

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

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

Through review of the information provided by these sources, SFHIP identified San Francisco’s health needs.

Community Health Status Assessment
Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.2 While biology, genetics, and access to medical services are largely understood to play an important role in health, social-economic and physical environmental conditions are now known to be major, if not primary, drivers of health.2-4 These conditions are known as the Social Determinants of Health and are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world.5
Recognizing the essential role social determinants of health play in the health of San Franciscans, the Community Health Status Assessment examined population level health determinant and outcome variables. We used the San Francisco Framework for Assessing Population Health and Equity, which is a modified version of the Public Health Framework for Reducing Health Inequities published by the Bay Area Regional Health Inequities Initiative to guide variable selection.\textsuperscript{3} We ranked and selected available variables based on the Results Based Accountability criteria for indicator selection — communication power (ability to communicate to broad and diverse audiences), proxy power (says something of central significance), and data power (available regularly and reliably), as well as the ability to examine health inequities and current use by stakeholders. Furthermore, we hosted meetings throughout 2017 to gather feedback on indicators from experts and community representatives. In all, 171 variables were analyzed. We present the results from all analyses in 30 Community Health Data pages.

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

**Assessment of Prior Assessments**

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

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

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

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

**Community Engagement**

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

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

The 2019 CHNA includes 4 categories of focus groups.
Health Need Identification

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

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

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

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

Data describing part of each of the foundational issues and health needs are located in the Major Findings pages and in the various Community Health Data pages.
**Population Growth**
San Francisco is the cultural and commercial center of the Bay Area and is the only consolidated city and county jurisdiction in California. At roughly 47 square miles, it is the smallest county in the state, but is the most densely populated large city in California (with a population density of 17,352 residents per square mile) and the second most densely populated major city in the US, after New York City.\(^1\)

Between 2011 and 2018 the population in San Francisco grew by almost 8 percent to 888,817 outpacing population growth in California (6 percent).\(^2\) By 2030, San Francisco’s population is expected to total more than 980,000.

**An Aging Population**
The proportion of San Francisco’s population that is 65 years and older is expected to increase from 17 percent in 2018 to 21% in 2030; persons 75 and over will make up about 11% of the population.\(^3\) At the same time, it is estimated that the proportion of working age residents (25 to 64 years old) will decrease from 61 percent in 2018 to 56 percent in 2030. This shift could have implications for the provision of social services.

**Ethnic Shifts**
Population growth is expected for all races and ethnicities except for Black/African Americans who are projected to drop from 4.9 percent of the population in 2018 to 4 percent in 2030.\(^3\) Asians and Whites will remain the most populous groups and will grow as a percentage of the overall population. Population growth is expected to be lower for Latinx and Pacific Islanders and Latinx are expected to drop from 15.1 to 14.8 percent of the population.

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

**Families and Children**
Although San Francisco has a relatively small proportion of households with children (19 percent) compared to the state overall (34 percent), the number of school-aged children is projected to rise.\(^2,5\) As of 2017, San Francisco is home to 67,740 families with children, 26 percent of which are headed by single parents.\(^5\) There are approximately 132,330 children under the age of 18.\(^2\) The number of school-aged children is projected to rise by 24 percent by 2030.\(^2\) The neighborhoods with the greatest proportion of households with children are: Seacliff, Bayview Hunters Point, Visitacion Valley, Outer Mission, Excelsior, Treasure Island, and Portola (all over 30%).\(^1\)
**Major Findings**

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

The following infographics highlight aspects of each issue and need.

**Foundational Issues**

<table>
<thead>
<tr>
<th>Issue</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poverty</td>
<td>16</td>
</tr>
<tr>
<td>Racial Health Inequities</td>
<td>17</td>
</tr>
</tbody>
</table>

**Health Needs**

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

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

People who live in communities with higher income disparity are more likely to die before the age of 75 than people in more equal communities.\(^2\)

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

### Household Income

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

### Employment Disparities

San Francisco has significant disparities in employment rates between Whites and Black/African Americans.\(^3\)

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

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

### Median Income

- White household median income is over **$111k**
- Black/African American household median income is **$28k**

### Income Inequality and Health

**San Francisco has the highest income inequality in California.**

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

**Low income impacts lifetime health, beginning with pregnancy and birth.**

Lower-income children in San Francisco experience higher rates of asthma, hospitalization, obesity, and dental caries.\(^10-12\)

Low-birth weight is highest among low-income mothers.\(^13\)
Two types of racialized social interaction, interpersonal and structural racism, play a role the racial health disparities seen in San Francisco.

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

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

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

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

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Who Better for...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teen Birth</td>
<td>Between 2007 and 2016 the teen birth rate for first time moms decreased from 34% to 10% among Black/African American women in San Francisco.² In that same time, the proportion of mothers who had a college education when they delivered their first baby increased by 16 percentage points.²</td>
</tr>
<tr>
<td>Mortality</td>
<td>Mortality rates decreased for all in San Francisco. However, rates decreased the most for Black/African Americans (15%) (vs. 11% for Pacific Islanders, 12% for Whites, 14% for Asians and Latinx). Decreased rates among Black/African Americans were primarily due to decreases in ischemic heart disease, lung cancer, assault, and HIV.¹² Life expectancy also grew for all San Francisco with the largest gains seen by Black/African Americans. (+3 years between 2005–2007 and 2015–2017 vs +2 years for others).</td>
</tr>
<tr>
<td>High School Graduation</td>
<td>Graduation rates increased for all between 2012 and 2017. The biggest gains were seen among Black/African Americans (8%), and Pacific Islanders (12%) while rates for Latinx (4%), Whites (3%) and Asians (4%) were more modest.³</td>
</tr>
<tr>
<td>Childhood Caries</td>
<td>Between 2007–2012 and 2012–2017, rates of untreated tooth decay among kindergarteners decreased the most for Black/African Americans (26% to 19%).⁶</td>
</tr>
</tbody>
</table>

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

Between 1990 and 2005, the proportion of very low income households increased from 55% to 68%.¹⁸

The strong association between poverty and health would suggest that the poorer remaining Black/African American population is more likely to have poor health than the previous more mixed-income population.
### Major Findings

#### Foundational Issues

<table>
<thead>
<tr>
<th>Basic Requirements for a healthy life span</th>
<th>Prebirth/Infancy</th>
<th>Childhood</th>
<th>Adolescence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Healthy diet</td>
<td>Adequate income, Engaged with school, Social network, Adequate housing, Healthy diet, Safety</td>
<td>Mistakes corrected Schools well-resourced School success</td>
</tr>
<tr>
<td></td>
<td>Prenatal care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Racial Health Inequities

#### K-3 Suspensions

- **2.4%** suspension rate for Black/African Americans vs **0.1%** for White SFUSD Students

#### Student Proficiency

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

#### Nutrition

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

#### Food Insecurity among Pregnant Women in San Francisco

- **86%** among Latinx women
- **19.5%** among Black/African American women
- **6.6%** among Asian and Pacific Islander women

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

#### Full-Term Birth

- Full-term birth more likely for Whites (93%) than Black/African Americans (86%).

#### 5th Grade Obesity

- **75%** Black/African American
- **65%** Filipino
- **66%** Latinx
- **22%** White
- **23%** Asian

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San Francisco Health Improvement Partnership

Community Health Assessment & Profile 2019 | 18
The median income in San Francisco varies greatly by race/ethnicity. Typically, Whites earn 4x more than Black/African Americans in San Francisco.3

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

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

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

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

Median Household Income
The median income in San Francisco varies greatly by race/ethnicity. Typically, Whites earn 4x more than Black/African Americans in San Francisco.3

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

Access is influenced by availability of providers, location, affordability, hours, and cultural and linguistic appropriateness of health care services. Accessible health care can prevent disease and disability, detect and treat illnesses, maintain quality of life, and extend life expectancy.

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

While access to health care in San Francisco is better than many other places, significant disparities exist by race, age, and income.

**Many San Franciscans do not access health care**

San Francisco's population now numbers **over 880,000 people**.

**Fewer Uninsured**

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

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

**Young adults are at risk.**

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

**Different Levels of Prenatal Care**

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

**Preventable Hospitalizations and Emergency Room Visits**

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

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

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

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

**From the community we heard...**

"Cultural competency doesn’t happen with just a class or a one-day training."

"Healthcare professionals need to be from the community and actually know the culture of the community."

"Community-based organizations serve a critical role in small, data-sparse cohorts, by informing public health efforts and bringing resources to multicultural communities."

San Francisco Health Improvement Partnership

Community Health Needs Assessment 2019 | 20
Many do drink sugary drinks. Two thirds of high school students and one third of young adults regularly consume soda.8

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

21 days/187 days The number of days seniors/persons with disabilities must wait to start getting home delivered meals.6

616 The number of persons waiting for enrollment at a food pantry.33

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

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

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

Not all have a kitchen to cook in. Over 21,000 occupied housing units in San Francisco do not have complete kitchen facilities.
Regular exercise extends lives.
The World Health Organization (WHO) recommends that children and adolescents, age 5 to 17 years, should do at least one hour of moderate-to-vigorous physical activity daily, while adults, age 18 years and above, should do at least 150 minutes of moderate-intensity physical activity, 75 minutes of vigorous-intensity physical activity, or an equivalent combination of moderate and vigorous activity throughout the week.\textsuperscript{15}

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

Walking is a simple, affordable way for people to get around. A walkable city provides a free and easy way for people to incorporate physical activity into their daily lives as they walk to work, to school, to the market, to transit or other nearby services, or just for fun.\textsuperscript{17}

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

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

Major Findings
Health Needs

Food Insecurity, Healthy Eating, and Active Living

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

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

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

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

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

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

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

Aerobic fitness is 10 percentage points lower for economically disadvantaged students\textsuperscript{27}

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

There are gaps in school and workplace supports for physical activity  

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

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

There are gaps in neighborhood resources for physical activity  

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

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

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

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

Housing production has declined in the Bay Area

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

Overcrowding

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

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

Homelessness

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

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

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

Overcrowding can increase risk for infectious disease.5

Source: SF Planning Analysis of US Census and ACS Data

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

Moving can result in:

- Loss of employment
- Difficult school transitions
- Increased transportation costs
- Loss of health protective social networks

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

4 full-time minimum wage jobs to afford a “fair market rate” ($3,121) 2-bedroom unit
6 full-time minimum wage jobs to afford a “median market rate” ($4,725) 2-bedroom unit

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

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

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

Violence not only leads to serious mental, physical and emotional injuries and, potentially, death for the victim, but also negatively impacts the family and friends of the victim and their community.

Community violence decreases the real and perceived safety of a neighborhood disrupting social networks by inhibiting social interactions, causing chronic stress among residents who are worried about their safety, and acting as a disincentive to engage in physical activity outdoors.5-8

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

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

<table>
<thead>
<tr>
<th>Crime</th>
<th>San Francisco</th>
<th>California</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homicide</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Rape</td>
<td>41</td>
<td>37</td>
</tr>
<tr>
<td>Robbery</td>
<td>364</td>
<td>143</td>
</tr>
<tr>
<td>Aggravated assault</td>
<td>301</td>
<td>267</td>
</tr>
</tbody>
</table>

*Number of crimes per 100,000 residents.

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

Violent Crime Rate

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

122 males died violent deaths between 2015 and 2017.

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

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

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

Emergency room visit rates13

Black/African American 7.5 times higher
Pacific Islanders 4 times higher
Latinx 2 times higher than among other San Francisco residents.

Perceived Safety in San Francisco

White 59%
Asian & Pacific Islander 47%
Black/African American 43%
Latinx 38%

Residents perceived safety during the day, 201715

56.74% 97.92%
Cases of child abuse have decreased in San Francisco since 2009. However, in 2017 there were 509 cases of substantiated child maltreatment in San Francisco. The majority of child abuse cases are due to neglect.17

In addition to a history of violence in family and community, maltreatment arises from the confluence of other preventable risk factors including:18

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

- **Social and Social Economic Status Inequality**
  San Francisco has the 6th highest income disparities in the US.20

- **Low Levels of Education**
  Only 24–26% of Black/African American, Pacific Islander and Asian residents have a bachelors degree or higher. 32% of Latinx, 43% of Asian and 74% of White residents.19

- **Parenting Stress**
  28% of Latinx births in San Francisco are unintended, 24% of Black/African American, 20% of Asian, and 12% of White.22
  27% of Latinx new mothers in San Francisco experience prenatal depression, 21% of Black/African American, 12% of Asian, and 10% of White.22

- **High Residential Instability**
  According to 2016 data, 2,512 or 4% of SFUSD students are homeless.21 Less than 25% of Black/African American, Latinx, and Native American residents own their homes.23

- **Social Isolation and Lack of Social Support**
  In San Francisco 18% of Households have minors compared to 36% in California.19

- **Substance Abuse or Mental Health Issues**
  27–30% of Latinx, Black/African American and White residents report needing help with mental health or Drug Use Problems. 11% of Asian reported needing help.24

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The FBI has identified SF as one of the worst areas in the country for the commercial exploitation of children. 673 survivors of human trafficking were identified in SF in 2017.39

- **33%** of persons trafficked in commercial sex were minors
- **71%** of those who are trafficked are women, cigger or transgender people.
- **33%** of victims were born in the Bay Area.
- **70%** of survivors were people of color with the largest groups being Black/African Americans and Latinx.

The rate of substantiated maltreatment among Black/African Americans is significantly higher suggesting a need for greater support.

Child abuse costs the city $226.5 million per year in healthcare, criminal justice, child welfare, and education costs and lost lifetime productivity.18

The rate of substantiated maltreatment per 1,000 children in San Francisco 2007–2017
In San Francisco, steps have been taken to combat the school-to-prison pipeline. However, Black/African American, and Latinx students are still more likely to be suspended or expelled and, with Samoan youth, are more likely to be arrested.

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

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

Contributors to the school-to-prison pipeline include:

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

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

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

**Major Findings**

**Health Needs**

**Safety from Violence and Trauma**

**Measure of School Discipline:**

<table>
<thead>
<tr>
<th>SFUSD K–12 Suspension Rate, 2012–17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
</tr>
<tr>
<td>8.00</td>
</tr>
<tr>
<td>7.00</td>
</tr>
<tr>
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<tr>
<td>1.00</td>
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<tr>
<td>0.00</td>
</tr>
</tbody>
</table>

- Black/African American
- All
- American Indian / Alaskan Native
- Asian
- Filipino
- Latinx
- Native Hawaiian / Pacific Islander

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

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

Samoan youth make up 3% of the bookings, but only account for less than 1% of the youth population.

Zip code 94124, which roughly covers the Bayview neighborhood, was home to nearly 22% of all of the youth booked at Juvenile Hall in 2017.
Black/African American and Latinx persons are disproportionately detained, searched and arrested by the police in San Francisco.\textsuperscript{25-28}

Incarceration harms the mental and physical health of the incarcerated and that of non-incarcerated partners and children. Mass incarceration also compromises the community health and contributes to racial health inequities.\textsuperscript{29}

At the population level, inequalities in incarceration impact employment and health which themselves further influence incarceration.\textsuperscript{30}

Black/African American defendants experience delays in the criminal adjudication process, are convicted of more serious crimes and receive longer sentences than White defendants.\textsuperscript{32}

### Officer Initiated Detentions, 2017

<table>
<thead>
<tr>
<th>% of the Population</th>
<th>Detentions (Stops)</th>
<th>Searches</th>
<th>Arrests</th>
<th>% of the Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>60.0%</td>
<td>4.2</td>
<td>33.5</td>
<td>33.1</td>
<td>4.1</td>
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<tr>
<td>50.0%</td>
<td>4.8</td>
<td>37.3</td>
<td>40.8</td>
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<tr>
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<tr>
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<td>14.9</td>
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<td>20.6</td>
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</tr>
<tr>
<td>10.0%</td>
<td>31.3</td>
<td>42.5</td>
<td>41.1</td>
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<tr>
<td>0.0%</td>
<td>15.2</td>
<td>30.4</td>
<td>5.1</td>
<td>4.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>% of the Population</th>
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</thead>
<tbody>
<tr>
<td>60.0%</td>
<td>16.0</td>
<td>52.5</td>
<td>21.8</td>
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<td>5.2</td>
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<tr>
<td>30.0%</td>
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<tr>
<td>20.0%</td>
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<td>5.2</td>
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<tr>
<td>10.0%</td>
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<td>17.7</td>
<td>16.4</td>
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<td>16.0</td>
<td>16.4</td>
<td>15.2</td>
<td>4.7</td>
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### Officer Initiated Traffic Stops, 2017

<table>
<thead>
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<th>% of the Population</th>
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<th>Searches</th>
<th>Arrests</th>
<th>% of the Population</th>
</tr>
</thead>
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<td>60.0%</td>
<td>16.0</td>
<td>52.5</td>
<td>21.8</td>
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<tr>
<td>50.0%</td>
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<td>36.3</td>
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<tr>
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<td>5.2</td>
</tr>
<tr>
<td>10.0%</td>
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<td>16.4</td>
<td>5.5</td>
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<tr>
<td>0.0%</td>
<td>16.0</td>
<td>16.4</td>
<td>15.2</td>
<td>4.7</td>
</tr>
</tbody>
</table>

Criminal History has a “ripple effect”

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

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

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

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

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

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

While Black/African Americans make up 5% of the population in San Francisco, in 2017 they accounted for \textsuperscript{33%} of officer initiated (non-dispatched) detentions and \textsuperscript{19%} of officer initiated traffic stops.
Mental health and well-being are crucial to supporting, maintaining, and optimizing quality of life. The presence of mental illness can adversely impact the ability to function at work, at home, and in social settings and impacts individuals as well as their respective families and communities.

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

Social isolation can be a precipitating factor for suicidal behavior.
Individuals who experience isolation in their lives are more vulnerable to suicide than those who have strong social ties with others. Impaired quality of life, Disability, Hospitalization, Institutionalization, Incarceration, Suicide, self-injury, and/or death.

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

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

**Depression is the most common mental illness.**
Depressive symptoms are common among San Francisco school-aged youth.

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

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

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

**Between 2013 and 2015, 14.4% of pregnant women reported prenatal depressive symptoms in San Francisco.**
Prenatal depression greatly affects the quality of care given to the infant. **14.4% of pregnant women reported prenatal depressive symptoms** in 2013-2015.

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

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

**Hispanic and Black/African American women** are more likely to report prenatal depressive symptoms than White or Asian women.
Hospitalizations in San Francisco to treat major depression among adults occurred 2,631 times during the three years between 2014 and 2016.7

The number of hospitalizations for depressions exceeded that for hypertension (2,296), asthma (1,017).7

Adults aged 18-24 years are the most likely to be hospitalized due to major depression followed by 45-54 years.7

Age-adjusted rate of hospitalizations due to major depression among Black/African Americans is almost 5 times higher than among Asian & Pacific Islanders who have the lowest rate (23.79 vs 4.93 per 10,000 residents).7

Age-adjusted Mortality Rates due to Suicide by Race/Ethnicity in San Francisco, 2015 – 2017 8

Suicide is the 12th leading cause of death in San Francisco.8


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

Suicide completion is 3 times more common among men than women (14.22 vs 4.95 per 100,000 population).

The suicide rate is the highest in the Castro Neighborhood.
## Major Findings
### Health Needs

### Social, Emotional, and Behavioral Health

#### Alcohol abuse is common in San Francisco

2 out of 5 (40%) adults reported binge drinking in 2014–2015.13

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

8.37% of SFUSD high school students reported binge drinking in 2013–2017.12

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

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

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

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

Risk factors for use among children and adolescents include:

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

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

- Poor academic performance
- Cognitive functioning deficits
- Unintended pregnancy
- HIV and other sexually transmitted diseases
- Hepatitis C
- Motor vehicle crashes
- Violence
- Child abuse
- Crime, homicide
- Chronic diseases including liver disease and certain cancers (e.g. colorectal, liver, breast, prostate)
- Mental and behavioral disorders (unipolar depressive disorders, epilepsy, suicide) 11

#### Youth in San Francisco are at risk of substance abuse

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

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

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

#### Drug and alcohol abuse contribute to homelessness in San Francisco

15% of homeless persons reported drug and alcohol use as their primary cause of homelessness in 2017.13

65% of chronically homeless persons reported alcohol or substance use.
Between 2014 and 2016, 8,552 emergency room visits resulted from alcohol abuse and 8,245 from drugs.7

Rates of Emergency Room Visits by Ethnicity and Age, 2012-20167

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

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

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

Age-adjusted rate per 10,000

13.4 - 214.3

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

Age-adjusted Mortality Rates due to Drug Use Disorders by Race/Ethnicity in San Francisco, 2015–20178


Neighborhoods with larger Black/African American populations like Tenderloin and South of Market also have much higher emergency room visit and death rates due to drug abuse.8
San Francisco spends nearly $400 million a year on tobacco-related costs, including medical expenses, loss of productivity, and secondhand smoke exposure.14

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

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

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

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

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

San Francisco Health Improvement Partnership

E-cigarette use

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

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

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

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

2014: prohibition of the use of electronic cigarettes wherever smoking of tobacco products is prohibited.

2016: raised the minimum age to purchase tobacco products from 18 to 21.

2018: banned flavored tobacco products sales including flavored electronic tobacco pods.

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

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

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

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

San Francisco Health Improvement Partnership

Community Health Needs Assessment 2019 | 34
Executive Summary

1. “Housing And Health: An Overview Of The Literature,” Health Affairs Health Policy Brief, June 7, 2018. DOI: 10.1377/ hpb20180313.396577

Approach


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

San Francisco Snapshot


Poverty


Racial Health Inequities


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


2. San Francisco Department of Public Health and the San Francisco Planning Department, “San Francisco Health Care Services Master Plan. October 2013.” https://www.sfdph.org/dph/files/mtgsGrps/FoodSecTaskFrc/docs/FSTF-Budget-Re-


4. American Communities Survey. 2017


7. SFPDHSFUSD-SFDS Kindergarten Oral Health Screening Program. 2015.


Food Insecurity, Healthy Eating, and Active Living


5. WIC Program Eat SF WIC participant survey, 2017.


11. USDA Economic Research Service

12. https://waterfill.me/


References

Housing Security and an end to Homelessness


Safety from Violence and Trauma


References


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


Social, Emotional, and Behavioral Health


