To provide feedback about this Community Health Needs Assessment, email CHNA-communications@kp.org.
Acknowledgements

Many individuals and organization participated in the success of this Community Health Needs Assessment.

Healthy Marin Partnership (HMP) was established in 1995 to complete a triennial community health needs assessment (CHNA) required of all not-for-profit hospitals by the California Office of Statewide Health Planning and Development. The HMP, chaired by Patricia Kendall, RN, Medical Group Administrator, Kaiser Permanente San Rafael Medical Center, includes all the acute care hospitals in Marin County as well as the Marin County Health and Human Services Department, Marin Community Foundation, Marin County Office of Education and representatives of the business community. HMP has been coordinating the completion of each triennial CHNA since 1995. The participation of the HMP members, community leaders and residents in the community convening enhanced the accuracy and usefulness of the community health needs assessment for the organizations who will use it to create even healthier communities in Marin County.

Partner hospitals have worked closely together throughout the CHNA to insure the CHNA complied with the requirements of the Affordable Care Act and included data on which to build effective implementation strategies. Members of the CHNA Work Group include:

- Healthy Marin Partnership
  - Teri Rockas, Project Manager
  - Health Education & Promotion, Member Outreach, Kaiser Permanente

- Kaiser Permanente
  - Andrea Michelsen, Community Benefit/Community Health Manager
  - Shan Magnuson, Community Benefit/Health Specialist

- Marin General
  - Jamie Maites, Director of Communications
  - Beth McDermott, Marketing Specialist

- Novato Community Hospital
  - Mary Strebig APR, Manager, Communications & Community Benefit
  - Sutter West Bay Region Employer Marketing

- Marin Health and Human Services
  - Rochelle Ereman, MS, MPH, Community Epidemiology Program Chief

Consultants

- Human Impact Partners was instrumental in supporting the community health need prioritization process by presenting extensive data in a useful way and facilitating a meaningful conversation that resulted in community priorities on which future decisions can be based.
- The Marin County Health and Human Services Department has provided invaluable support with data, technical assistance and participation in the CHNA Work Group.
- Selma Abinader provided thorough and insightful key informant interviews.
- Cío Hernández, MFT, kept the community assessment grounded through the focus groups in English and Spanish.
- This report was written by Lynn H. Baskett, consultant.
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I. EXECUTIVE SUMMARY

A. Community Health Needs Assessment (CHNA) background
The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, added new requirements, which nonprofit hospital organizations must satisfy to maintain their tax-exempt status under section 501(c)3 of the Internal Revenue Code. One such requirement added by ACA, Section 501(r) of the Code, requires nonprofit hospitals to conduct a community health needs assessment (CHNA) at least once every three years. As part of the CHNA, each hospital is required to collect input from designated individuals in the community, including public health experts as well as members, representatives or leaders of low-income, minority, and medically underserved populations and individuals with chronic conditions. While Kaiser Permanente has conducted CHNAs for many years to identify needs and resources in our communities and to guide our Community Benefit plans, this new legislation has provided an opportunity to revisit our needs assessment and strategic planning processes with an eye toward enhanced compliance and transparency and leveraging emerging technologies. The CHNA process undertaken in 2013 and described in this report was conducted in compliance with these new federal requirements.

B. Summary of Prioritized Needs
As a result of extensive data collection, key informant interviews, and community focus groups, residents and community leaders in Marin County identified the following health needs, in priority order:

1. Mental health
2. Substance abuse
3. Access to health care/medical homes/health care coverage
4. Socioeconomic status (income, employment, education level)
5. Healthy eating and active living (nutrition/healthy food/food access/physical activity)
6. Social supports (family and community support systems and services; connectedness)
7. Cancer
8. Heart disease

The needs were identified as community priorities as part of the community convening coordinated by the Healthy Marin Partnership, which includes all the acute care hospitals in Marin County. The community convening included over 30 community residents, public health experts and community leaders.

C. Summary of Needs Assessment Methodology and Process
As has been done in Marin since 1996, and in partnership with Healthy Marin Partnership (HMP), Marin’s hospitals (Marin General, Novato Community and Kaiser Permanente) worked together to complete the CHNA. The process has included:

- Review of a comprehensive list of 153 indicators including data from:
  - Center for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010
• Centers for Disease Control and Prevention and the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2008
• Center for Disease Control and Prevention and National Cancer Institute, State Cancer Profiles, 2005-2009
• Centers for Disease Control and Prevention, National Diabetes Surveillance System, 2009
• US Census Bureau, American Community Survey, 5-Year Estimates, 2006-2010
• US Census Bureau, American Community Survey, 3-Year Estimates, 2012
• US Department of Agriculture, 2002 Food Security Assessment tools
• California Health Interview Surveys
• California Department of Public Health, Death Profiles by Zip Code, 2008-2010
• California Department of Education, California Healthy Kids Survey (CHKS), 2001-2007, 2009-2010
• California Department of Education, California FITNESSGRAM 2007-2011.
• California Office of Statewide Health, Planning and Development (OSHPD), Patient Discharge Data, 2011-2011
• California Department of Alcohol Beverage Control, September, 2012 raw data weekly export
• Marin Community Development Agency, Marin County Affordable Housing Inventory, 2008
• Marin County Child Care Commission, Marin County Child Care Master Plan 2008-2013, 2008
• Marin County Community Development Agency, Marinmap.org (transportation routes and access)

• Key Informant Interviews
• Focus Group meetings
• Community resident and leader convening

Findings have been compared to state and national averages and, when possible, have been mapped by census track to show different rates in geographic areas across the County.

The Kaiser Permanente San Rafael hospital service area includes the County of Marin plus a small part of Sonoma County, including the cities of Petaluma, Sonoma and surrounding areas. Through use of the KP CHNA Data Platform it was determined that the impact of the part of Sonoma County included in the hospital service area was not significant enough to change the resulting health needs identified. And in fact, the two counties as a whole had very similar health needs. Three of the top four priority community health needs for Sonoma County are priorities for Marin County. Ten of 13 health needs identified by Sonoma County health experts and community representatives are also identified health needs in Marin County.
II. INTRODUCTION/BACKGROUND

A. Purpose of the Community Health Needs Assessment (CHNA) Report
This report was written in order to comply with federal tax law requirements set forth in Internal Revenue Code section 501(r) requiring hospital facilities owned and operated by an organization described in Code section 501(c)(3) to conduct a community health needs assessment at least once every three years. The required written plan of Implementation Strategy is set forth in a separate written document. At the time that hospitals within Kaiser Foundation Hospitals conducted their CHNAs, Notice 2011-52 from the Internal Revenue Service provided the most recent guidance on how to conduct a CHNA. This written plan is intended to satisfy each of the applicable requirements set forth in IRS Notice 2011-52 regarding conducting the CHNA for the hospital facility.

B. About Kaiser Permanente (KP)
Founded in 1942 to serve employees of Kaiser Industries and opened to the public in 1945, Kaiser Permanente is recognized as one of America’s leading health care providers and nonprofit health plans. We were created to meet the challenge of providing American workers with medical care during the Great Depression and World War II, when most people could not afford to go to a doctor. Since our beginnings, we have been committed to helping shape the future of health care. Among the innovations Kaiser Permanente has brought to U.S. health care are:

- Prepaid health plans, which spread the cost to make it more affordable
- A focus on preventing illness and disease as much as on caring for the sick
- An organized coordinated system that puts as many services as possible under one roof—all connected by an electronic medical record

Kaiser Permanente is an integrated health care delivery system comprised of Kaiser Foundation Hospitals, Kaiser Foundation Health Plan, and physicians in the Permanente Medical Groups. Today we serve more than 9 million members in nine states and the District of Columbia. Our mission is to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve. Care for members and patients is focused on their total health and guided by their personal physicians, specialists, and team of caregivers. Our expert and caring medical teams are empowered and supported by industry-leading technology advances and tools for health promotion, disease prevention, state-of-the-art care delivery, and world-class chronic disease management. Kaiser Permanente is dedicated to care innovations, clinical research, health education, and the support of community health.

C. About Kaiser Permanente Community Benefit
For more than 65 years, Kaiser Permanente has been dedicated to providing high-quality, affordable health care services and to improving the health of our members and the communities we serve. We believe good health is a fundamental right shared by all and we recognize that good health extends beyond the doctor’s office and the hospital. It begins with healthy environments: fresh fruits and vegetables in neighborhood stores, successful schools, clean air, accessible parks, and safe playgrounds. These are the vital signs of healthy communities. Good health for the entire community, which we call Total Community Health, requires equity and social and economic well being.
Like our approach to medicine, our work in the community takes a prevention-focused, evidence-based approach. We go beyond traditional corporate philanthropy or grantmaking to pair financial resources with medical research, physician expertise, and clinical practices. Historically, we’ve focused our investments in three areas—Health Access, Healthy Communities, and Health Knowledge—to address critical health issues in our communities. For many years, we’ve worked side-by-side with other organizations to address serious public health issues such as obesity, access to care, and violence. And we’ve conducted Community Health Needs Assessments to better understand each community’s unique needs and resources. The CHNA process informs our community investments and helps us develop strategies aimed at making long-term, sustainable change—and it allows us to deepen the strong relationships we have with other organizations that are working to improve community health.

D. Kaiser Permanente’s approach to Community Health Needs Assessment

About the new federal requirements

Federal requirements included in the ACA, which was enacted March 23, 2010, stipulate that hospital organizations under 501(c)(3) status must adhere to new regulations, one of which is conducting a CHNA every three years. With regard to the CHNA, the ACA specifically requires nonprofit hospitals to: collect and take into account input from public health experts as well as community leaders and representatives of high need populations—this includes minority groups, low-income individuals, medically underserved populations, and those with chronic conditions; identify and prioritize community health needs; document a separate CHNA for each individual hospital; and make the CHNA report widely available to the public. In addition, each nonprofit hospital must adopt an Implementation Strategy to address the identified community health needs and submit a copy of the Implementation Strategy along with the organization’s annual Form 990.

SB 697 and California’s history with past assessments

For many years, Kaiser Permanente hospitals have conducted needs assessments to guide our allocation of Community Benefit resources. In 1994, California legislators passed Senate Bill 697 (SB 697), which requires all private nonprofit hospitals in the state to conduct a CHNA every three years. As part of SB 697 hospitals are also required to annually submit a summary of their Community Benefit contributions, particularly those activities undertaken to address the community needs that arose during the CHNA. Kaiser Permanente has designed a process that will continue to comply with SB 697 and that also meets the new federal CHNA requirements.

Kaiser Permanente’s CHNA framework and process

Kaiser Permanente Community Benefit staff at the national, regional, and hospital levels worked together to establish an approach for implementing the new federally legislated CHNA. From data collection and analysis to the identification of prioritized needs and the development of an implementation strategy, the intent was to develop a rigorous process that would yield meaningful results.

Kaiser Permanente, in partnership with the Institute for People, Place and Possibility (IP3) and the Center for Applied Research and Environmental Studies (CARES), developed a web-based CHNA data platform to facilitate implementation of the CHNA process. Because data collection, review, and interpretation are the foundation of the CHNA process, each CHNA includes a review of secondary and primary data.
To ensure a minimum level of consistency across the organization, Kaiser Permanente included a list of roughly 100 indicators in the data platform that, when looked at together, help illustrate the health of a community. California data sources were used whenever possible. When California data sources weren’t available, national data sources were used. Once a user explores the data available, the data platform has the ability to generate a report that can be used to guide primary data collection and inform the identification and prioritization of health needs.

In addition to reviewing the secondary data available through the CHNA data platform, and in some cases other local sources, each KP hospital collected primary data through key informant interviews, focus groups, and surveys. They asked local public health experts, community leaders, and residents to identify issues that most impacted the health of the community. They also inventoried existing community assets and resources.

Each hospital/collaborative used a set of criteria to determine what constituted a health need in their community. Once all of the community health needs were identified, they were all prioritized, based on a second set of criteria. This process resulted in a complete list of prioritized community health. The process and the outcome of the CHNA are described in this report.

In conjunction with this report, Kaiser Permanente will develop an implementation strategy for each health need identified. These strategies will build on Kaiser Permanente’s assets and resources, as well as evidence-based strategies, wherever possible. The Implementation Strategy will be filed with the Internal Revenue Service using Form 990 Schedule H.

III. COMMUNITY SERVED

A. Kaiser Permanente’s definition of community served by hospital facility
Kaiser Permanente defines the community served by a hospital as those individuals residing within its hospital service area. A hospital service area includes all residents in a defined geographic area surrounding the hospital and does not exclude low-income or underserved populations.

B. Map and description of community served by hospital facility

Kaiser Foundation Hospital (KFH)-San Rafael
99 Montecillo Road
San Rafael, CA 94903
(415) 444-2000
The KFH-San Rafael service area comprises Marin County and the southern portion of Sonoma County, including the cities of Petaluma and Sonoma. Cities in Marin County include Belvedere, Corte Madera, Fairfax, Larkspur, Mill Valley, Novato, Ross, San Anselmo, San Rafael, Sausalito, and Tiburon and the coastal towns of Stinson Beach, Bolinas, Point Reyes, Inverness, Marshall, and Tomales.

**KFH-SAN RAFAEL COMMUNITY SNAPSHOT**

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>81.94%</td>
</tr>
<tr>
<td>Latino</td>
<td>16.68%</td>
</tr>
<tr>
<td>African American</td>
<td>2.38%</td>
</tr>
<tr>
<td>Asian and Pacific</td>
<td>5.33%</td>
</tr>
<tr>
<td>Native American</td>
<td>0.36%</td>
</tr>
<tr>
<td>Other or Multiple</td>
<td>10.29%</td>
</tr>
</tbody>
</table>

Data Source: US Census Bureau, 2006-2010 American Community Survey 5-Year Estimate. KFH-San Rafael Service Area Data
<table>
<thead>
<tr>
<th>KFH-San Rafael Data</th>
<th>California Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population</td>
<td>352,544</td>
</tr>
<tr>
<td>36,627,288</td>
<td></td>
</tr>
<tr>
<td>Median age</td>
<td>44</td>
</tr>
<tr>
<td>34.9</td>
<td></td>
</tr>
<tr>
<td>Over 65</td>
<td>15.47%</td>
</tr>
<tr>
<td>11.08%</td>
<td></td>
</tr>
<tr>
<td>Linguistically isolated</td>
<td>10.31%</td>
</tr>
<tr>
<td>19.9%</td>
<td></td>
</tr>
<tr>
<td>On time high school graduation</td>
<td>91.68%</td>
</tr>
<tr>
<td>82.27%</td>
<td></td>
</tr>
<tr>
<td>Children living in poverty</td>
<td>9.22%</td>
</tr>
<tr>
<td>19.06%</td>
<td></td>
</tr>
<tr>
<td>Median household income</td>
<td>$89,268</td>
</tr>
<tr>
<td>$60,883</td>
<td></td>
</tr>
<tr>
<td>Income less than 200% FPL</td>
<td>18.67%</td>
</tr>
<tr>
<td>32.83%</td>
<td></td>
</tr>
<tr>
<td>No high school diploma</td>
<td>9.36%</td>
</tr>
<tr>
<td>19.32%</td>
<td></td>
</tr>
<tr>
<td>Medi-Cal/Medicaid recipients</td>
<td>8.6%</td>
</tr>
<tr>
<td>18.07%</td>
<td></td>
</tr>
<tr>
<td>Unemployment rate</td>
<td>6.16%</td>
</tr>
<tr>
<td>9.0%</td>
<td></td>
</tr>
<tr>
<td>Uninsured</td>
<td>10.0%</td>
</tr>
<tr>
<td>17.92%</td>
<td></td>
</tr>
<tr>
<td>Lack source of consistent primacy care</td>
<td>11.33%</td>
</tr>
<tr>
<td>14.23%</td>
<td></td>
</tr>
<tr>
<td>Diabetes prevalence</td>
<td>5.59 per 100,000 population</td>
</tr>
<tr>
<td>Diabetes hospitalizations</td>
<td>3.94 per 100,000 population</td>
</tr>
<tr>
<td>Childhood diabetes hospitalizations</td>
<td>5.7 per 100,000 population</td>
</tr>
<tr>
<td>Asthma prevalence</td>
<td>16.9 per 100,000 population</td>
</tr>
<tr>
<td>Heart disease prevalence</td>
<td>7.1 per 100,000 population</td>
</tr>
<tr>
<td>Poor mental health (self-reported)</td>
<td>17.28%</td>
</tr>
<tr>
<td>14.21%</td>
<td></td>
</tr>
</tbody>
</table>

Unless otherwise noted, data is from American Community Survey 5-Year Estimates, 2006-2010 US Census Bureau


2 Countywide data; not available for KFH-San Rafael Service Area

3 American Community Survey 3-Year Estimates, 2008-2010, US Census Bureau

4 California Health Interview Survey (CHIS), 2009

5 Center for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010


While Marin County is a healthy and affluent county compared to California as a whole, the sub-county quantitative data and community input illustrate that there are disparities in socioeconomic status that impact the capacity of some residents to make healthy choices and maximize their health potential.

IV. WHO WAS INVOLVED IN THE ASSESSMENT

As has been done in Marin since 1996, and in partnership with Healthy Marin Partnership (HMP), Marin’s hospitals (Marin General, Novato Community and Kaiser Permanente) worked together to complete the CHNA.
A. Consultant Roles

Below is a list of consultants who were involved in the CHNA and their roles. Human Impact Partners: data collection, presentation and facilitation of community prioritizing process

1. Rochelle Ereman, MS, MPH: epidemiologist with the Marin Health and Human Services Department who guided the collection of data held by the County health department and worked with Human Impact Partners to insure the quality of the overall data in the CHNA
2. Abinader Group: conducted 25 key informant interviews including public health experts
3. Cio Hernández, MFT: conducted seven focus groups which generated 103 English and 50 Spanish responses
4. Lynn H. Baskett, MBA: participated in the CHNA workgroup with the representatives of the Marin hospitals and County health department and compiled the CHNA report.
5. WestEd: administered the California Healthy Kids Survey on behalf of the Marin hospitals and County school districts

B. Consultant Qualifications

Human Impact Partners’ mission is to increase the consideration of health and equity in decision-making. We raise awareness of and collaboratively use innovative data, processes and tools that evaluate health impacts and inequities in order to transform the policies, institutions and places people need to live healthy lives.

As research indicates that 55% of health status is determined by social and environmental conditions, the fundamental premise of this work is that decision makers must understand how community-level factors, such as housing, land use, and transportation systems, affect health and health disparities in order to take action to improve those conditions, and thereby improve health. To this end, HIP conducts research on health outcomes and disparities as well as on the social and environmental conditions that drive those outcomes and disparities. This research has been used in Health Impact Assessments, Health in All Policies projects, and Community Health Needs Assessments. Human Impact Partners has conducted these analyses on the local, state and federal levels with experience in communities across the country, from Hawaii to Maine. HIP’s findings have been integrated into policy, planning and project decisions that improve health outcomes and reduce health disparities. Founded in June 2006, HIP is an independent non-profit corporation (501(c)3) based in Oakland, California. Dr. Jonathan Heller, a co-founder and Co-Director, and HIP has a staff of eight full-time employees.

Rochelle Ereman, MS, MPH has dedicated the past 20 years of her career serving women and children in the health field, working primarily in the area of prevention of illness and disease. She is currently head of the Community Epidemiology Program at the County of Marin Department of Health and Human Services. During her tenure as Marin County’s Community Epidemiology Program Chief, she has managed the first county-wide health survey, worked to improve data surveillance for the Health Division, and directed breast cancer research projects for the County. She is currently the Principal Investigator of the Department of Health & Human Services breast cancer research project. Prior to her work in the Community Epidemiology Program she served as the Maternal and Child Health Director for Marin County for 4 years. She has conducted clinical research in the area of human lactation at the University of California at Davis, ran 3 prenatal clinics in Yolo County, and was an associate lecturer at the University of California at Davis in Community Nutrition. Her current research is focused on the
epidemiology of breast cancer in Marin County, an area with historically elevated incidence rates, and the translation of epidemiologic concepts to the community.

Abinader Group LLC began in Oakland California in 2002 as Selma Abinader and Associates. Selma Abinader founder and CEO brings to the consulting firm an entrepreneurial spirit and passionate commitment to service. For over 35 years Selma Abinader has supported more than 100 nonprofit and community groups, educational organizations, and government agencies on their journey of growth and change. Some of Abinader Group clients include: Santa Clara County Public Health Department, Healthy Marin Partnership, Health in All Policies Task Force, Bay Area Regional Health Inequities Initiative, California Department of Public Health, Berkeley Public Schools, Community Health Councils Long Beach, Westside Community Services San Francisco. Abinader Group specializes in cultivating leadership, building collaborative capacities, formulating short and long-term strategies, evaluating results and impact, promoting inclusive decision making, developing high performance teams and facilitating organizational change. Our ultimate goal is for groups to develop the capacity, drive, and innovation to focus and sustain the benefits to the communities they serve over time.

Cío Hernández, MFT, is the Licensed Mental Health Practitioner for Marin County Department of Health and Human Services, Community Health and Prevention Services. She works with communities to get their health needs met, advocating for health equity issues and other community health needs as taught to her by local community members. She currently sits on the Institutional Review Board for Kaiser Foundation Research Institute, serves on the First Five Marin Children and Families Commission, teaches Human Diversity, Law and Ethics, Issues with HIV, Clinical Supervision, and other classes for Gerry Grossman Seminars, runs a small private practice specializing in Eye Movement Desensitization Reprocessing, and just started a doctoral program in Health Care Leadership at UC Davis. Ms. Hernández has won awards for her work with sexual abuse of children, child abuse prevention, and curriculum development of Internet Crimes Against Children. Her H&HS webcast, CONNECT! may be seen on the Maringchannel.org & Youtube.com, educating viewers on a variety of important health and wellness topics.

Lynn H. Baskett, MBA, is a health care consultant with Lynn H. Baskett Consulting. Ms. Baskett was the VP/Executive Director of the John Muir Health, Community Health Alliance from 2000 to 2012. She was responsible for system-wide community benefit planning and public reporting, developing community partnerships to address unmet health needs, language assistance, and cultural competence services as well as government affairs. The Community Health Alliance includes the Seniors Services department, the Mobile Health Clinic, the Ronald McDonald Care Mobile (a mobile dental clinic), the Faith and Health Partnership and the Community/School Nurse programs. Ms. Baskett graduated from Wittenberg University and received her MBA in health administration from Cornell University. All her work experience has been in health care including positions at St. Elizabeth’s Hospital, Boston; Los Medanos Community Hospital, Pittsburg, California; and the Hospital Council of Northern and Central California, a hospital trade association.

WestEd is a national nonprofit research, development, and service agency that works with education and other communities to promote excellence, achieve equity, and improve learning for children, youth, and adults. Healthy Marin Partnership contracted with WestEd to administer the California Healthy Kids Survey (CHKS) to 5th, 7th, 9th and 11th graders every two years. CHKS measures student behaviors and resiliency. A customized Marin-specific module was developed with the Marin County Office of Education and administered along with the core module. CHKS was required until 2010. Without hospital support through Healthy Marin Partnership to fund the administration of CHKS, there would be no reliable data on youth behaviors.
V. PROCESS AND METHODS USED TO CONDUCT THE CHNA

A. Community Input

Individuals with special knowledge of, or expertise in, public health that provided input included:

- Larry Meredith, Ph.D, Director, Marin County Health and Human Services Department
- Rochelle Ereman, MS, MPH, Community Epidemiology Chief, Marin County Health and Human Services Department
- Jennifer Reinks, Ph.D., Faculty, Family Health Outcomes Project, University of California, San Francisco
- Tom Peters, Ph.D., former Director, Marin County Health and Human Services Department, previously XXX, San Francisco Public Health Department, currently President, Marin Community Foundation
- Mathew Willis, MD, MPH, Marin County Health and Human Services Department, Public Health Officer
- D.J. Pierce, Marin County Health and Human Services Department, Chief of Division of Alcohol, Tobacco & Other Drugs

These public health experts participated in key informant interviews. Drs. Meredith, Reinks and Willis also participated in the HMP-coordinated community convening. Ms. Ereman was also a consultant to the CHNA work group and process.

From April 23, 2012 to June 11, 2012 Selma Abinader of Abinader Group conducted 25 phone interviews of stakeholders selected by HMP leadership. Stakeholders interviewed were HMP leadership and representatives from hospital and health organizations, public health experts, funding institutions, government, business, education, and community based agencies.

Key informants, community physicians and those participating in the HMP-coordinated community convening included 44 Marin County residents and leaders representing key populations as follows. Most of the key informants also participated in the community convening.

<table>
<thead>
<tr>
<th>Population</th>
<th>Representatives</th>
<th>Leaders</th>
<th>Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medically Underserved</td>
<td>8</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Low Income</td>
<td>12</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Minority</td>
<td>13</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Chronic Diseases</td>
<td>5</td>
<td>4</td>
<td>9</td>
</tr>
</tbody>
</table>

Focus groups, led by Marin Health and Human Services, were held in Marin City, Novato, Canal, San Geronimo, West Marin, Whistlestop and at the Youth Leadership Institute between April 16 and May 9, 2012. The survey asked focus group participants about: important health issues they, their families, and their communities faced; what they saw as healthy and unhealthy about their communities; and what they’d change in their communities to make them healthier. A total of 103 English and 50 Spanish responses were obtained.
Focus groups included 144 community residents representing the following groups:

<table>
<thead>
<tr>
<th>Location</th>
<th># Participants</th>
<th>Medically Underserved</th>
<th>Low Income</th>
<th>Minority</th>
<th>Chronic Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pt. Reyes/West Marin</td>
<td>13</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>San Geronimo</td>
<td>15</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Marin City</td>
<td>39</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Novato</td>
<td>12</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>San Rafael/Canal area</td>
<td>33</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whistlestop</td>
<td>16</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Youth Leadership Institute</td>
<td>16</td>
<td>X</td>
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Additional description of the community representatives and leaders who provided input in the CHNA is included in the table below. Additional details on key informant interviews and focus groups can be found in the Appendix:

- Attachment J Summary of Focus Group Feedback
- Attachment K Summary of Key Informant Interviews
## Informant

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<th>Informant</th>
<th>Position: Role in Community</th>
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</table>
| Anne Hosfeld       | • Novato Community Hospital CAO  
                     • Registered Nurse |                      |                    |                    |                               |                               |                     |                  |                        |                |                      |                                    |                |                             |
| Cynthia Murray     | • North Bay Leadership Council CEO  
                     • First 5 Sonoma board member  
                     • Health Action Sonoma board member  
                     • Previous Marin County Board of Supervisors |                      |                    |                    |                               |                               |                     |                  |                        |                |                      |                                    |                |                             |
| Jon Friedenberg    | • Marin General Hospital, Chief Fund & Business Dev. Officer |                      |                    |                    |                               |                               |                     |                  |                        |                |                      |                                    |                |                             |
| Larry Meredith     | • Marin County H&HS, Director  
                     • Previously with San Francisco public health department  
                     • Ph.D. in public health |                      |                    |                    |                               |                               |                     |                  |                        |                |                      |                                    |                |                             |
| Lorne Needle       | • United Way of Bay Area, vice president  
                     • Previously with Youth Leadership Institute | R                    | R                  |                    |                               |                               |                     |                  |                        |                |                      |                                    |                | L                           |
<p>| Mary Jane Burke    | • Marin County Office of Education, superintendent |                      |                    |                    |                               |                               |                     |                  |                        |                |                      |                                    |                | L                           |</p>
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<td>• Kaiser Permanente San Rafael, medical group administrator• Agricultural Inst. of Marin board member• Lifehouse Agency board member• Marin County ROP board member• Marin County Trauma task force • Marin County Emergency Medical Care task force• Marin Economic Forum board member• Registered Nurse</td>
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B. Data and Methodology Used to Conduct the CHNA

Human Impact Partners (HIP) went through a five-step process to identify the health needs and health drivers that are priorities for the county.

1. HIP identified indicators for inclusion in the CHNA analysis.

HIP compiled a full list of potential indicators from the following source databases:

- Center for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010
- Centers for Disease Control and Prevention and the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2008
- Center for Disease Control and Prevention and National Cancer Institute, State Cancer Profiles, 2005-2009
- Centers for Disease Control and Prevention, National Diabetes Surveillance System, 2009
- US Census Bureau, American Community Survey, 5-Year Estimates, 2006-2010
- US Census Bureau, American Community Survey, 3-Year Estimates, 2012
HIP combined these indicators to come up with a list of 153 indicators that ranged from health outcomes, like asthma and heart disease, to demographics and measures of socio-economic status, health care access and clinical care, employment, housing, park and food access, and many others.

With input from the HMP CHNA sub-committee, HIP then identified a set of criteria by which the 153 indicators could be evaluated to reduce the list to an appropriate number and mix of indicators for sub-county assessment. The criteria included:

- Whether the indicator exceeded any benchmark specified for the indicator (e.g., California State averages, Healthy People 2020);
- Whether the indicator or data was high, low or no value in terms of informing the CHNA about issues in Marin County;
- Whether reliable data are available for the indicator at a sub-county level (e.g., reliable data, limited data, or no data);
- Whether the indicator had been considered in the 2010 CHNA

HIP applied the criteria to each of the 153 indicators. To do this HIP conducted limited research. Whenever possible, HIP obtained data from the Kaiser Permanente Community Health Needs Assessment Data Platform (CHNA.org/KP) database to inform these criteria. Based on this criteria analysis, HIP identified a set of 25 indicators, for which HIP would gather sub-county data. Sub-county data was of particular interest to the local hospitals for several reasons:

- Richer understanding of health needs in the County
- Increased ability to target interventions to communities with most need
- Local knowledge of vulnerable populations where county-wide aggregated data would disguise the sub-population health needs
- Ability to track changes over time by collecting sub-county data that had also been collected in past CHNAs.

Before proceeding with data collection, HIP facilitated a meeting of the HMP CHNA sub-committee and several others (e.g., the Director of Marin County Health and Human Services), during which participants provided feedback on the subset of indicators, discussed data sources and finalized the indicators.
2. HIP collected data on countywide and sub-county indicators.

With the final lists of indicators generated, HIP proceeded to collect data. HIP used data from the Kaiser Permanente Community Health Needs Assessment Data Platform (CHNA.org/KP) database when possible. When appropriate benchmarks were available, HIP compared data against those and assessed disparities by demographic factors.

To provide context for the sub-county data provided, HIP prepared a report that included countywide data that included demographic and health indicators at this larger geographic scale. Examples of indicators included in this report are: population, population density, age, race/ethnicity, linguistic isolation, employment, overcrowding, median household income, leading causes of death, tobacco use, Medi-Cal enrollment, medically underserved populations and areas, and health professional shortage areas.

Sub-county data were compiled on “indicator sheets” that included the following elements: the indicator name, a descriptive title, the geographic unit of analysis, a map showing sub-county variation, a data table, an interpretation of the data, any available benchmarks and a description of how Marin compared to the benchmark for the indicator, data sources and methods, and any limitations of the indicator or data.

HIP collected data for the full countywide indicator list that included: the type of indicator (e.g., chronic disease, air quality, or housing), Marin County’s performance for the indicator, San Rafael Service Area’s performance (where available), the benchmark value, and a categorization of the strengths and weaknesses of the indicator and data.

HIP met with the HMP CHNA sub-committee as well as the full HMP leadership team to present preliminary data results and to gather feedback. Indicator sheets were revised based on this feedback and finalized.

3. HIP created Health Needs Summaries

HIP compiled a set of Health Needs Summaries. These represent health outcomes for which the County as a whole or a part of the County is performing poorly against a benchmark, along with the associated “upstream” drivers of that health outcome. The Summaries include County estimates compared to statewide estimates (when available) for health outcomes and proximal and distal health drivers. The Summaries were informed by the following inputs:

- Data from the list of 153 indicators;
- The sub-county and county-wide analyses;
- Key informant interview data (compiled by Abinader & Associates);
- Focus group survey data (provided by Marin Health and Human Services; summarized by HIP).

The Health Need Summaries were produced for health outcomes where the indicator performed poorly against available benchmarks:

1. Asthma
2. Cancer
3. Childhood diabetes hospitalizations
4. Falls (seniors)
5. Heart disease  
6. Mental health  
7. Substance abuse  
8. Car/bicycle/pedestrian traffic injuries  
9. HIV  
10. Life expectancy  

As part of the process of compiling the Health Needs Summaries, HIP reviewed the key informant interview summaries and the focus group survey findings summaries to understand the extent to which the health outcomes and health drivers came up in these forums.

While the 11 health outcome needs above met the threshold criteria of poor performance against available benchmarks, the following needs did not come up in the focus groups or key informant interviews: car/bicycle/pedestrian traffic injuries, HIV, life expectancy, self-rated health. *To be included in the final list of identified community health needs, a health need must be confirmed by two sources of data.*

HIP referenced literature on the social and environmental determinants of health to compile the list of the proximal and distal health drivers that are associated with the health outcomes included in the health needs summaries. Data regarding these determinants of health were included in the Health Need Summaries.

4. HIP defined and applied prioritization criteria to health outcome needs.

HIP and the HMP leadership developed and finalized nine criteria by which the health outcome needs would be ranked. Scoring criteria used to prioritize the health outcome needs above included the following:

1. Indicators show poor performance: County is performing poorly as a whole compared to a benchmark  
2. Indicators show poor performance: Disproportionate impact on health status of one or more subpopulations  
3. Severity of disease outcomes  
4. Magnitude of poor performance: Many people are impacted  
5. Need includes outcomes and drivers in that addressing the drivers will be preventative for the outcomes (i.e., Will changing this reduce future medical care need for chronic diseases in Marin?)  
6. Need includes outcomes and drivers in that addressing it will likely impact more than one health outcome  
7. There are strategies for addressing the need locally that can be implemented within the County with a high likelihood of meaningful improvement in the health issue  
8. Need arose in key informant interviews  
9. Need arose in focus groups

A scoring matrix was created to tally the rankings for each health outcome need. The HMP CHNA sub-committee reviewed the outcome of this analysis, feedback was provided and incorporated, and the scoring matrix was finalized. (See “Criteria and Scoring Matrix” for the specific rankings, Appendix, Attachment I).
5. HIP facilitated an in-person meeting of HMP and many community partners to come to consensus on prioritized health needs.

HIP facilitated a half-day discussion regarding the above-described data to rank the health needs. Participants were asked to rank both health outcomes and health drivers.

Participants came to consensus on the health outcomes and drivers that are priority health needs for the County. A vote at the end of the three-hour community convening resulted in the following prioritized list of health needs:

1. Mental health
2. Substance abuse
3. Access to health care/medical homes/health care coverage
4. Socioeconomic status (income, employment, education level)
5. Healthy eating and active living (nutrition/healthy food/food access/physical activity)
6. Social supports (family and community support systems and services; connectedness)
7. Life expectancy gap*
8. Cancer
9. Heart Disease

*Reducing the life expectancy gap was acknowledged as an important goal for HMP to monitor over time. There was also acknowledgement that programs targeted for any of the health needs would also support the goal of eliminating the life expectancy gap in Marin so it is not included in the final list of priorities.

C. Data limitations and information gaps

The KP common data set includes a robust set of nearly 100 secondary data indicators that, when taken together, enable an examination of the broad health needs faced by a community. However, there are some limitations with regard to this data, as is true with any secondary data available. Some data were only available at a county level, making an assessment of health needs at a neighborhood level challenging. Moreover, disaggregated data around age, ethnicity, race, and gender are not available for all data indicators, which limited the ability to examine disparities of health issues within the community. Lastly, data are not always collected on a yearly basis, meaning that some data are several years old.

Specific data that were not available that would have deepened the analysis and informed future decision making include:

1. Sub-county data for some of the indicators where the county level data was better or worse than the benchmark data and local knowledge confirms there are variations at the sub-county level that weren't reflected in the county-wide data.
2. Data that would show the benefits of current community benefit contributions and the importance of maintaining current programs or the negative impact of reducing current programs
3. Sub-county crime related data.
4. Data on sexual abuse (adult or children)
5. Data on how many health care practices are still accepting Medi-Cal patients
6. Data on neighborhood completeness (i.e., how close people live to the goods and services they need to live healthy lives).
VI. IDENTIFICATION AND PRIORITIZATION OF COMMUNITY’S HEALTH NEEDS

A. Definition of Health Need

For the purposes of the CHNA, Kaiser Permanente defines a health need as:

- a poor health outcome and its associated health driver(s) or
- a health driver associated with a poor health outcome where the outcome itself has not yet arisen as a need.

Health needs arise from the comprehensive identification, interpretation, and analysis of a robust set of primary and secondary data.

In addition, the health need must be confirmed by more than one indicator and/or data source and perform poorly against a defined benchmark, if available. The community perception of the need as a priority was also carefully considered.

B. Process And Description Of Community Priorities

Eleven health outcome needs were identified which performed less well than the available benchmarks. Only seven of these health outcome needs met the threshold criteria of being identified in the quantitative data as well as either the focus groups or the key informant interviews or both:

1. Asthma
2. Cancer
3. Childhood diabetes hospitalizations
4. Falls (seniors)
5. Heart disease
6. Mental health
7. Substance abuse

At the HMP community convening four health drivers were identified as priorities for the community:

1. Access to health care
2. Healthy eating and active living
3. Socioeconomic status (income, employment, education level)
4. Social supports

HMP community convening participants came to consensus on the health outcomes and drivers that are priority health needs for the County. A vote at the end of the three-hour community convening resulted in the following prioritized list of health needs:

1. Mental Health is a health need with a greater percentage of adults reporting poor mental health and higher suicide rates than California and Healthy People 2020. Possible causes, among others, include the high cost of living, disparities in income, lack of access to health insurance coverage, health care and mental health services.
2. Substance Abuse (alcohol and other drugs) is a health need possibly due to easy access to alcohol and other drugs; prevailing social norms, prevalence of youth who drink alcohol,
use drugs and smoke; adults with poor mental health; income disparities; high cost of living; and lack of access to health care and coverage.

3. **Access to health care/medical homes/insurance coverage** is a health need because of its impact on obtaining timely and effective treatment for all health outcome needs such as cancer, heart disease, asthma, mental health, substance abuse and diabetes.

4. **Socioeconomic status** (income, employment, education level) is a health need because of its impact on the ability to access preventive health care and treatment for all health needs and the widely accepted correlation between socioeconomic status and overall health status.

5. **Healthy eating and active living** is a health need because of its potential positive impact on health outcomes such as obesity, cancer, heart disease, mental health and diabetes.

6. **Social supports** including family and community support systems and services and an individual’s feeling of connectedness are a health need because of their impact on health outcomes such as mental health, substance abuse, access to health care services and falls.

7. **Cancer** is a health need possibly related to youth tobacco use and smoking prevalence, low income, and lack of access to health care and coverage. Based on the quantitative data, African American males have a higher rate of cancer prevalence of all types and African Americans, Asians and Hispanics have a higher mortality rate from cancer than non-Hispanic whites.

8. **Heart Disease** is a health need possibly related to obesity, access to healthy food, proportion of residents getting moderate or vigorous daily exercise, tobacco use, low income and lack of access to health care and coverage

At the HMP community convening, reducing the life expectancy gap was acknowledged as an important goal for HMP to monitor over time. There was also acknowledgement that programs targeted for any of the health needs would also support the goal of eliminating the life expectancy gap in Marin so it is not included as a separate priority.

Community resources available to respond to each community identified health need are listed in the Health Need Summaries in the Appendix, Attachments A-H. See Section V for additional detail on process and criteria.

**VII. CONCLUSION AND NEXT STEPS**

The CHNA will be used to develop implementation strategies to address the health needs prioritized by the community. It will also be used to further our partnerships with other hospitals and community based organizations working to improve the total health of the communities we all serve.

Additional data can be found on the Healthy Marin Partnership website: http://www.healthymarinpartnership.org/MCNA/MCNA-2013/toc.htm
## Appendix

### Health Need Summaries

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<td>V. Key Informant Interview Summary</td>
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Attachment A Health Need 1: Mental Health

*Mental Health* is a health need with a greater percentage of adults reporting poor mental health and higher suicide rates than California and Healthy People 2020. Possible causes, among others, include the high cost of living, disparities in income, lack of access to health insurance coverage, health care and mental health services.

**Geographic Unit of Analysis:** Census tract, California Health Interview Survey, 2005
Suicide Rate in Marin County, CA

California Department of Health Death Profiles by Zip Code
Health Outcomes:

- Percent of adults with poor mental health
  - 17.4%, compared to 14.3% in California
- Number and rate of adults who report that they needed help for emotional/mental health problem or use of alcohol/drugs
  - 21.5% of adults. No state benchmark available.
- Suicide rate, per 100,000
  - 12.8, compared to 9.8 in California (Healthy People 2020 goal = 10.2)

Health Drivers:

Proximal health drivers

- Cost of living (High costs of living increases stress and may prevent regular medical visits to treat and manage mental illness.)
  - Percent of adults paying greater than 30% of total household income on housing (rent or mortgage)
    - 45.6% compared to 47.0% in California
    - Disparities: Canal area of San Rafael (72.6%), Marin City (60.2%), and Bel Marin Keys (57.8%) are the top 3 areas with the highest percent of adults overpaying for housing.
  - Percent of households paying more than 45% of income on housing and transportation costs combined
    - 56.3%, compared to 48.4% in the SF-Oakland-Fremont region
  - Percent of households spending more than 15% of income on transportation
    - 20.7%, compared to 17.8% in the SF-Oakland-Fremont region
  - Percent of households in overcrowded conditions
    - 2.5% of housing units overcrowded, compared to 8.0% in California
    - Disparities: The Canal area of San Rafael is very overcrowded compared to other communities, with its two tracts having 10.7% and 40.5% of their residents in overcrowded conditions. In the latter tract, about half of those living in overcrowded conditions are in severely overcrowded conditions.
  - Supply of affordable housing
    - 3.8% of Marin County’s housing units categorized as affordable housing. No state benchmark available.
  - Total monthly cost of a minimal-cost market basket of food for a family of four (2 adults and 2 children)
    - Market basket average cost $213.07 per month, compared to $144.40 in the U.S.
    - Disparities: The San Geronimo Valley area ($240-$255), Bolinas ($238), Fairfax ($236), and San Anselmo ($236) generally had the highest market basket costs in the county, while Larkspur ($200), Corte Madera ($204), and Novato ($178-$201) generally had the lowest average market basket costs.
  - Access to subsidized child care
    - 2,094 unmet subsidized child care slots (189 for ages 0-2, 78 for ages 3-5, and 1,827 for ages 6-13). No statewide data available.
- Social support (Community can provide both material and emotional support in times of stress.)
  - Percent of adults who report having sufficient social or emotional support
    - 82.8%, compared to 75.0% in California
Distal health drivers

- Education (Higher levels of education may support better coping mechanisms for mental health problems.)
  - Percent of population who did not graduate high school
    - 8.2%, compared to 19.3% in California
    - Disparities: 63.1% in the Canal area of San Rafael
  - Percent of population who obtained a Bachelor’s degree or higher
    - 54.1%, compared to 30.1% in California
    - Disparities: 7.5% in the Canal area of San Rafael

- Health care access
  - Lacking current health insurance coverage
    - 9.0% of adults aged 18-64, compared to 16.0% in California
    - 2.2% of children aged 0-18, compared to 5.7% in California
    - Disparities: Parts of Muir Beach and Strawberry have greater than 30% of residents uninsured
  - Lacking a consistent source of primary care
    - 10.4%, compared to 14.2% in California

- Income/Income inequality (Low incomes and high income inequality can lead to stress and poor mental health. Low income may also prevent regular medical visits to treat and manage mental illness.)
  - Median Household Income
    - $89,268, compared to $60,016 in California
    - Disparities: Highest income tract is in Ross, while the lowest ratio is in the Canal area of San Rafael (23.4% of the median household income of Ross)
    - Disparities: Gini index (a measure of income inequality where zero expresses perfect equality and one expresses maximum inequality) is 0.50, compared to 0.47 in California
  - Unemployment
    - 6.7%, compared to 10.9% in California
  - Percent of residents with incomes below 200% of the Federal Poverty Level
    - 17.2%, compared to 32.8% in California
    - Disparities: The two tracts of the Canal area of San Rafael (47.6% and 64.7%), Marin City (39%), and one tract in Novato (34.6%) have poverty rates greater than the State.

Focus Groups:
- Frequently mentioned

Key Informant Interviews:
- Yes

Healthy Marin Partnership Community Convening Priority
- Yes

Assets
- Community hospitals (5)
- Community health centers (5)
- Marin H&HS Community Mental Health Services (CMHS)
- Suicide Prevention and Crisis Line
- National Association for the Mentally Ill (NAMI)
• Bay Area Community Resources
• Hickleberry House
• CorStone (formerly Center for Attitudinal Healing)
• Compassionate Friends of Marin Bereavement Support
• Buckelew Programs
• APPLE FamilyWorks
• Center Point
• Family Service Agency of Marin
• Boyer House
• Canal Alliance
• Jewish Family & Children’s Services
• Novato Youth and Family Services
• Novato Youth Center
• Marin Advocates for Children
• Overeaters Anonymous
• Food Addicts in Recovery
Attachment B  Health Need 2: Substance Abuse

Substance Abuse (alcohol and other drugs) is a health need possibly due to easy access to alcohol and other drugs; prevailing social norms, prevalence of youth who drink alcohol, use drugs and smoke; adults with poor mental health; income disparities; high cost of living; and lack of access to health care and coverage.

High School Student's Alcohol Consumption in Marin County, CA

Geographic Unit of Analysis: School district, California Healthy Kids Survey 2009-2010
Alcohol use in Marin County over time, 2001-2009

Benchmarks
Healthy People 2020 has two relevant targets:
- 94.4% for the proportion of 12-17 year olds who had never used alcohol in their lives and refrained from using alcohol for the first time in a given year (SA-2.1); and
- 30.5% of high school seniors reporting that they never used alcoholic beverages (SA-2.3).

Health Outcomes:
- Proportion of adults who drank [5+] alcoholic beverages in one sitting in the past year
  - 34.9%, compared to 31.0% in California
  - Disparities: The San Geronimo Valley and San Anselmo are two areas that have particularly high binge drinking rates, with 61.8% and 79.8% of adults having engaged in binge drinking, respectively.
- Proportion of adults who have used drugs (not including tobacco)
  - 24.7% of adults. No state benchmark available.
- Proportion of youth who have drank alcohol
  - 7th graders: 13%, compared to 13% in California
  - 9th graders: 25%, compared to 24% in California
  - 11th graders: 48%, compared to 33% in California
  - Disparities: For 7th graders, Ross Valley Elementary had the highest district-wide alcohol consumption prevalence (20%), while Larkspur (2%), Kentfield (7%), and Reed Union (7%) had relatively low consumption rates. The ranges of prevalence for 9th and 11th graders were smaller.
- Proportion of youth who have used alcohol or drugs (not including tobacco)
  - 7th graders: 17%, compared to 16% in California
  - 9th graders: 30%, compared to 29% in California
  - 11th graders: 55%, compared to 39% in California
Disparities: For 7th graders, the range of alcohol or drug use varied enormously, with Larkspur only seeing 2% of 7th graders having used alcohol or drugs, while 83% of Lagunitas’s 7th graders had used them. For 9th and 11th graders, the ranges were not nearly as large, but usage among 11th graders was higher than among 9th graders.

- Tobacco use
  - 8.8% (adult) and 4.7% (youth), compared to 13.6% and 4.2% in California

Health Drivers:

Prefix: Proximal health drivers
- Alcohol access
  - Number and density of alcohol outlets, including liquor stores
    - 1.37 per every 1,250 people in Marin County. No state benchmark available, however, if taking only liquor stores into account, the San Rafael service area has 113.9 stores per 100,000, and California has 73.3 stores per 100,000.
    - Disparities: Alcohol outlets generally follow along major road arterials, with fewer in rural areas.
- Coexisting and associated diseases
  - Percent of adults with poor mental health
    - 17.4%, compared to 14.3% in California
  - Number and rate of adults who report that they needed help for emotional/mental health problem or use of alcohol/drugs
    - 21.5% of adults. No state benchmark available.
  - Suicide rate, per 100,000
    - 12.8, compared to 9.8 in California (Healthy People 2020 goal = 10.2)
- Social support
  - Percent of adults who report having sufficient social or emotional support
    - 82.8%, compared to 75.0% in California

Distal health drivers
- Education (Higher levels of education may support better coping mechanisms that reduce stress and substance abuse.)
  - Percent of population who did not graduate high school
    - 8.2%, compared to 19.3% in California
    - Disparities: 63.1% in the Canal area of San Rafael
  - Percent of population who obtained a Bachelor’s degree or higher
    - 54.1%, compared to 30.1% in California
    - Disparities: 7.5% in the Canal area of San Rafael
- Health care access
  - Lacking current health insurance coverage
    - 9.0% of adults aged 18-64, compared to 16.0% in California
    - 2.2% of children aged 0-18, compared to 5.7% in California
    - Disparities: Parts of Muir Beach and Strawberry have greater than 30% of residents uninsured
  - Lacking a consistent source of primary care
    - 10.4%, compared to 14.2% in California
- Income/Income inequality (Low incomes and high income inequality can lead to stress and substance abuse.)
  - Median Household Income
    - $89,268, compared to $60,016 in California
- **Disparities**: Highest income tract is in Ross, while the lowest ratio is in the Canal area of San Rafael (23.4% of the median household income of Ross)
- **Disparities**: Gini index (a measure of income inequality where zero expresses perfect equality and one expresses maximum inequality) is 0.50, compared to 0.47 in California
  - Unemployment
    - 6.7%, compared to 10.9% in California
  - Percent of residents with incomes below 200% of the Federal Poverty Level
    - 17.2%, compared to 32.8% in California
    - **Disparities**: The two tracts of the Canal area of San Rafael (47.6% and 64.7%), Marin City (39%), and one tract in Novato (34.6%) have poverty rates greater than the State.

**Focus Groups:**
- Infrequently mentioned

**Key Informant Interviews:**
- Yes

**Healthy Marin Partnership Community Convening Priority**
- Yes

**Assets**
- Community hospitals (5)
- Community health centers (5)
- Marin H&HS Alcohol, Drug & Tobacco Programs
- Healthy Communities Consortium
- Marin Treatment Center
- Petaluma People Services Center
- Bay Area Community Resources
- The Marin Institute—Preventing Alcohol Problems
- Marin Services for Women
- Ohlhoff Recovery Services
- Center Point
- Al-Anon and Alateen in Marin County
- Alcoholics Anonymous
- Marin County Fellowship of Narcotics Anonymous
- Helen Vine Detox Center (a program of Buckelew Programs)
Attachment C Health Need 3: Health Care Access

Access to health care/medical homes/insurance coverage is a health need because of its impact on obtaining timely and effective health education, screening, early detection, early intervention and treatment for all health outcome needs such as cancer, heart disease, asthma, mental health, substance abuse and diabetes.

Residents Without Health Insurance in Marin County, CA

Geographic Unit of Analysis: Census tract, California Health Interview Survey
Relevant Data

- Lacking current health insurance coverage
  - 9.0% of adults aged 18-64, compared to 16.0% in California
  - 2.2% of children aged 0-18, compared to 5.7% in California
  - Disparities: Parts of Novato, West Marin County and the Canal area of San Rafael have greater than 16% of residents uninsured with the Canal area having 26.6% of residents uninsured.

- Lacking a consistent source of primary care
  - 10.4%, compared to 14.2% in California

- Proportion of adults who report having poor health
  - 8.1%, compared to 18.3% in California
  - Disparities: Muir Beach (4.4%), and parts of Corte Madera (4.9%), Novato (4.9%), San Rafael (6.5%), and Fairfax (10.8%) had the highest rates of self-reported poor health in the county, and were the only census tracts that had higher rates than the state.
  - Percent of adults with poor mental health
    - 17.4%, compared to 14.3% in California
  - Number and rate of adults who report that they needed help for emotional/mental health problem or use of alcohol/drugs
    - 21.5% of adults. No state benchmark available.
  - Suicide rate, per 100,000
    - 12.8, compared to 9.8 in California (Healthy People 2020 goal = 10.2)

Focus Groups:
- Yes

Key Informant Interviews:
- Yes

Healthy Marin Partnership Community Convening Priority:
- Yes

Assets:
- Community hospitals (5)
- Community health centers (5)
- Enrollment programs and assistance supported by hospitals, community health centers and Marin H&HS
- Kaiser Child Health Plan
- Marin H&HS certified application centers for health coverage enrollment
- Marin Children’s Health Initiative
Attachment D  Health Need 4: Socioeconomic Status

Socioeconomic status (income, employment, education level) is a health need because of its impact on ability to access health protective resources, preventive health care and treatment for all health outcome needs and the widely accepted correlation between socioeconomic status and overall health status.

Poverty in Marin County, CA

**Geographic Unit of Analysis:** Census tract, American Community Survey 5-Year estimates
Educational Attainment in Marin County, CA

Geographic Unit of Analysis: Census tract, American Community Survey 5-Year estimates
Geographic Unit of Analysis: Census tract, American Community Survey 5-year estimates
Linguistically Isolated Population
This indicator reports the percentage of the population aged 5 and older who speak a language other than English at home and speak English less than "very well." This indicator is relevant because an inability to speak English well creates barriers to healthcare access, provider communications, and health literacy/education.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population</th>
<th>Total Linguistically Isolated Population</th>
<th>Percent Linguistically Isolated Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Rafael (Service Area)</td>
<td>332,172</td>
<td>34,233</td>
<td>10.31%</td>
</tr>
<tr>
<td>Marin County</td>
<td>234,483</td>
<td>22,542</td>
<td>9.61%</td>
</tr>
<tr>
<td>California</td>
<td>34,092,224</td>
<td>6,768,923</td>
<td>19.85%</td>
</tr>
<tr>
<td>United States</td>
<td>283,833,856</td>
<td>24,704,752</td>
<td>8.70%</td>
</tr>
</tbody>
</table>

Data Source: U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates.
Source geography: Tract.

The two tracts of the Canal area of San Rafael (47.6% and 64.7%), Marin City (39%), and one tract in Novato (34.6%) have poverty rates greater than the County (17.2%) Education levels are disproportionately low in the Canal area of San Rafael: 63.1% did not graduate from high school compared to 8.2 in the County and 19.3% in California; 7.5% obtained a Bachelor’s degree or higher compared to 54.1% in the County and 30.1% in California.

Relevant Data
- Income (Low income correlates with poorer general health.)
  - Median Household Income
    - $89,268, compared to $60,016 in California
    - Disparities: Highest income tract is in Ross, while the lowest ratio is in the Canal area of San Rafael (23.4% of the median household income of Ross)
- **Disparities:** Gini index (a measure of income inequality where zero expresses perfect equality and one expresses maximum inequality) is 0.50, compared to 0.47 in California
  - Unemployment
    - 6.7%, compared to 10.9% in California
  - Percent of residents with incomes below 200% of the Federal Poverty Level
    - 17.2%, compared to 32.8% in California
    - **Disparities:** The two tracts of the Canal area of San Rafael (47.6% and 64.7%), Marin City (39%), and one tract in Novato (34.6%) have poverty rates greater than the State.

- **Cost of living** (High cost of living may result in less money available for health promoting activities such as healthy eating and may contribute to greater stress, which is associated with many health outcomes.)
  - Percent of adults paying greater than 30% of total household income on housing (rent or mortgage)
    - 45.6% compared to 47.0% in California
    - **Disparities:** Canal area of San Rafael (72.6%), Marin City (60.2%), and Bel Marin Keys (57.8%) are the top 3 areas with the highest percent of adults overpaying for housing.
  - Percent of households paying more than 45% of income on housing and transportation costs combined
    - 56.3%, compared to 48.4% in the SF-Oakland-Fremont region
  - Percent of households spending more than 15% of income on transportation
    - 20.7%, compared to 17.8% in the SF-Oakland-Fremont region
  - Percent of households in overcrowded conditions
    - 2.5% of housing units overcrowded, compared to 8.0% in California
    - **Disparities:** The Canal area of San Rafael is very overcrowded compared to other communities, with its two tracts having 10.7% and 40.5% of their residents in overcrowded conditions. In the latter tract, about half of those living in overcrowded conditions are in severely overcrowded conditions.
  - Supply of affordable housing
    - 3.8% of Marin County’s housing units categorized as affordable housing. No state benchmark available.
  - Market Basket Total Cost
    - Total monthly cost of a minimal-cost market basket of food for a family of four (2 adults and 2 children)
      - Market basket average cost $213.07 per month, compared to $144.40 in the U.S.
      - **Disparities:** The San Geronimo Valley area ($240-$255), Bolinas ($238), Fairfax ($236), and San Anselmo ($236) generally had the highest market basket costs in the county, while Larkspur ($200), Corte Madera ($204), and Novato ($178-$201) generally had the lowest average market basket costs.

- **Education** (Higher education levels correlate with better overall health.)
  - Percent of population who did not graduate high school
    - 8.2%, compared to 19.3% in California
    - **Disparities:** 63.1% in the Canal area of San Rafael
  - Percent of population who obtained a Bachelor’s degree or higher
- 54.1%, compared to 30.1% in California
- Disparities: 7.5% in the Canal area of San Rafael

Focus Groups:
- Yes

Key Informant Interviews:
- Yes

Healthy Marin Partnership Community Convening Priority:
- Yes

Assets:
- Healthy Marin Partnership
- Community hospitals
- Community health centers
- Workforce Investment Board
- Canal Alliance
- Nuestra Voz, Sonoma Valley
- College of Marin and vocational certification programs
Attachment E  Health Need 5: Healthy Eating, Active Living

Nutrition/food security/healthy food access/physical activity is a health need because of its potential impact on health outcome needs such as cancer, heart disease, mental health and diabetes.

**Elementary School Children's Physical Fitness in Marin County, CA**

![Map of Marin County showing physical fitness rates for 5th grade students in 6 categories of the FITNESSGRAM PFT by district, 2011.](image)

**Geographic Unit of Analysis:** School district

California FITNESSGRAM Physical Fitness Tests were obtained from the California Department of Education's DataQuest website. Students in grades five, seven, and nine take the fitness test. The test has
six parts that show a level of fitness that offers a degree of defense against diseases that come from inactivity. Achievement of the fitness standards is based upon a score falling in the Healthy Fitness Zone (HFZ) for each of six fitness areas: Aerobic Capacity, Body Composition, Abdominal Strength and Endurance, Trunk Extensor Strength and Flexibility, Upper Body Strength and Endurance, and Flexibility. The HFZ represents minimal levels of satisfactory achievement on the tasks.

Low income (incomes less than 200 percent of the Federal Poverty Level) areas of the county experience disparities in their capacity to make healthy eating and activity choices as illustrated below.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Canal area of San Rafael</th>
<th>Marin City</th>
<th>Parts of Novato</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poverty: % with income &lt;200% FPL</td>
<td>64.7, 47.6</td>
<td>39</td>
<td>34.6</td>
<td>17.1</td>
</tr>
<tr>
<td>Food access: % missing all items in Thrifty Food Plan market basket</td>
<td>14</td>
<td>38</td>
<td>10-12</td>
<td>13</td>
</tr>
<tr>
<td>Food access: % missing fresh fruit items in Thrifty Food Plan market basket</td>
<td>9</td>
<td>66</td>
<td>3-4</td>
<td>1</td>
</tr>
<tr>
<td>Food access: % missing fresh vegetables in Thrifty Food Plan market basket</td>
<td>6</td>
<td>66</td>
<td>1-2</td>
<td>9</td>
</tr>
<tr>
<td>Food security: % of adults with income &lt; 200% FPL reporting cutting size or skipping meal</td>
<td>42.5</td>
<td>31.1</td>
<td>17.2</td>
<td>21.5</td>
</tr>
<tr>
<td>Overweight: % adults</td>
<td>14.7</td>
<td>14.9</td>
<td>18.2-46.4</td>
<td>13.5</td>
</tr>
<tr>
<td>Obesity: % adults</td>
<td>21.9</td>
<td>60.2</td>
<td>29.6-38.5</td>
<td>30</td>
</tr>
<tr>
<td>Activity: % adults reporting moderate activity</td>
<td>49.7</td>
<td>62.5</td>
<td>60.5</td>
<td>70.6</td>
</tr>
<tr>
<td>Activity: % adults reporting vigorous activity</td>
<td>31</td>
<td>11.2</td>
<td>33.8</td>
<td>41</td>
</tr>
</tbody>
</table>

Where census track data was available: Canal 1122.01 and 1122.02; Marin City 1290; Novato 1022.03. Where only city and sub parts of Novato data were available, ranges are included for Novato and San Rafael data was used for Canal.

**Relevant Data**
- Overweight and obesity rates
  - Adults:
• Overweight: 30.1%, compared to 33.7% in California
  • Obesity: 13.5%, compared to 22.7% in California
  o Youth overweight or at-risk of overweight
    • 5th graders: 31.0%, compared to 47.9% in California
    • 7th graders: 31.7%, compared to 44.5% in California
    • 9th graders: 30.5%, compared to 40.6% in California

• Nutrition/Food access
  o Grocery store establishments per 100,000
    • 24.6, compared to 22.2 in California
  o Availability of total food items in a minimal-cost market basket of food for a family of four (2 adults and 2 children)
    • Marin stores average percent of missing items was 13%. No statewide data available.
    • Disparities: Lagunitas (48%) and Marin City (38%) have the highest percent of missing items. Alto (4%), San Anselmo (5%), and Fairfax (5%) had the lowest percentages of missing items.
  o Availability of fresh fruit and vegetable items in a minimal-cost market basket of food for a family of four (2 adults and 2 children)
    • The average percent missing fresh fruit items was 11%, while the average percent missing fresh vegetables was 9%. No statewide data available.
    • Disparities: Loma Verde, Fairfax, Point Reyes Station, and Stinson Beach all had an average percent missing fresh fruits and vegetable items of 1%, the lowest in the county. Meanwhile, San Geronimo Valley (58%), Marin City (66%), Waldo Point (68%), Forest Knolls (87%), and Lagunitas (98%) had the highest average percent missing fresh fruits and vegetable items.
  o Fast food restaurant establishments per 100,000
    • 65.0, compared to 69.4 in California

• Physical activity/fitness
  o Proportion of adults getting moderate or vigorous daily exercise
    • 70.6% of adults get moderate exercise, while 41.0% of adults get vigorous exercise. No statewide data available.
    • Disparities: Marin City and more rural parts of the county had lower rates of moderate or vigorous exercise compared to the suburban eastern part of the county.
  o Proportion of youth who are physically fit and meet 6 out of 6 Statewide Physical Fitness Test criteria
    • 42.0% of 5th graders, compared to 25.2% of California 5th graders
    • 44.9% of 7th graders, compared to 32.1% of California 7th graders
    • 46.0% of 9th graders, compared to 36.8% of California 9th graders
  o Park access (percent of population within 0.5 miles of a park)
    • 68%, compared to 58.6% in California
  o Recreation and fitness facility access (establishments per 100,000 people)
    • 24.2, compared to 8.9 in California
  o Walkability measure (percent of population in Walkscore area)
    • 46.0% in San Rafael service area, compared to 84.0% in California

Focus Groups:
• Yes
Key Informant Interviews:
  • Yes
Healthy Marin Partnership Community Convening Priority:
  • Yes
Assets:
  Community hospitals (5)
  Community health centers (5)
  Marin H&HS Healthy Eating Active Living workgroups: Food Systems, Active Living, Early Childhood School and Afterschool Programs
  Boys & Girls Club, Petaluma and Sonoma Valley
  Nuestra Voz, Sonoma
  Novato Unified School District Wellness Programs
  LIFT for Teens-Levantate
  Catholic Charities
  San Geronimo Valley Community Center
  San Rafael School District Healthy School Food Program
  City Parks and Recreation departments
Attachment F  Health Need 6: Social Supports

Social supports including family and community support systems and services and an individual’s feeling of connectedness are a health need because of their impact on health outcomes such as mental health, substance abuse, access to health care services and falls as well as educational achievement and economic stability.

This indicator reports the percentage of adults aged 18 and older who self-report receiving sufficient social and emotional support all of most of the time.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Population (Age 18)</th>
<th>Adults Reporting Adequate Social or Emotional Support</th>
<th>Percent Adults Reporting Adequate Social or Emotional Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Rafael (Service Area)</td>
<td>1,119</td>
<td>916</td>
<td>81.86%</td>
</tr>
<tr>
<td>Marin County</td>
<td>777</td>
<td>643</td>
<td>82.80%</td>
</tr>
<tr>
<td>California</td>
<td>75,228</td>
<td>56,421</td>
<td>75%</td>
</tr>
<tr>
<td>United States</td>
<td>2,744,636</td>
<td>2,204,749</td>
<td>80.33%</td>
</tr>
</tbody>
</table>


Relevant Data
- Social support (Community can provide both material and emotional support in times of stress.)
  - Percent of adults who report having sufficient social or emotional support
    - 82.8%, compared to 75.0% in California
  - Percent of adults with poor mental health
    - 17.4%, compared to 14.3% in California
  - Number and rate of adults who report that they needed help for emotional/mental health problem or use of alcohol/drugs
    - 21.5% of adults. No state benchmark available.
Suicide rate, per 100,000
- 12.8, compared to 9.8 in California (Healthy People 2020 goal = 10.2)
- Access to subsidized child care
  - 2,094 unmet subsidized child care slots (189 for ages 0-2, 78 for ages 3-5, and 1,827 for ages 6-13). No statewide data available.

Focus Groups:
- Mentioned as concern about stress

Key Informant Interviews:
- Yes

Healthy Marin Partnership Community Convening Priority:
- Yes

Assets:
- Community hospitals (4)
- Community health centers (5)
- MH&HS Aging and Adult Services
- Senior centers in various communities
- Community centers in various communities
- Faith communities
- San Geronimo Valley Community Center
- Community Resource Center of Marin
- West Marin Senior Services
- Whistlestop Community Center
- Alzheimer’s Association of Marin
- Building Better Families, Inc. (anger/violence prevention)
- Center for Domestic Peace
- Community Violence Solutions (Rape Crisis Center)
Attachment G  Health Need 7: Cancers

Cancer is a health need possibly related to youth tobacco use and smoking prevalence, low income, and lack of access to health care and coverage. Based on the quantitative data, African American males have a higher rate of cancer prevalence of all types and African Americans, Asians and Hispanics have a higher mortality rate from cancer than non-Hispanic whites.

Breast Cancer Incidence

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population, ACS 2005-2009</th>
<th>Annual Incidence, 2005-2009 Average</th>
<th>Annual Incidence Rate (Per 100,000 Pop.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Rafael (Service Area)</td>
<td>347,213</td>
<td>520</td>
<td>149.70</td>
</tr>
<tr>
<td>Marin County</td>
<td>246,711</td>
<td>373</td>
<td>151</td>
</tr>
<tr>
<td>California</td>
<td>36,308,528</td>
<td>44,768</td>
<td>123.30</td>
</tr>
<tr>
<td>United States</td>
<td>301,461,536</td>
<td>367,783</td>
<td>122</td>
</tr>
</tbody>
</table>


Breast Cancer Age Adjusted Incidence Rate (Per 100,000 Pop.), By County, NCI 2005-2009

Colon and Rectum Cancer Incidence

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population, ACS 2005-2009</th>
<th>Annual Incidence, 2005-2009 Average</th>
<th>Annual Incidence Rate (Per 100,000 Pop.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Rafael (Service Area)</td>
<td>347,213</td>
<td>149</td>
<td>42.90</td>
</tr>
<tr>
<td>Report Area</td>
<td>Total Population, ACS 2005-2009</td>
<td>Annual Incidence, 2005-2009 Average</td>
<td>Annual Incidence Rate (Per 100,000 Pop.)</td>
</tr>
<tr>
<td>------------------------</td>
<td>----------------------------------</td>
<td>--------------------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>San Rafael (Service Area)</td>
<td>347,213</td>
<td>598</td>
<td>172.20</td>
</tr>
<tr>
<td>Marin County</td>
<td>246,711</td>
<td>450</td>
<td>182.50</td>
</tr>
<tr>
<td>California</td>
<td>36,308,528</td>
<td>51,921</td>
<td>143</td>
</tr>
<tr>
<td>United States</td>
<td>301,461,536</td>
<td>456,412</td>
<td>151.40</td>
</tr>
</tbody>
</table>

Health Outcomes:

- All cancer incidence
  - 493.7, compared to 437.9 in California
  - **Disparities**: African American males have a higher rate of all-cancer prevalence compared to non-Hispanic White male residents (1.22 times higher).
- Breast cancer incidence per 100,000
  - 151, compared to 123.3 in California
- Colorectal cancer incidence per 100,000
  - 41.9, compared to 43.7 in California (Healthy People 2020 goal = 38.6 new cases per 100,000)
- Melanoma cancer incidence per 100,000
  - 44.7, compared to 20.7 in California
- Prostate cancer incidence per 100,000
  - 182.4, compared to 142.9 in California
- All cancer mortality per 100,000
  - 143.7, compared to 162.7 in California (Healthy People 2020 goal of 160.6)
  - **Disparities**: The mortality rates among Hispanic, non-Hispanic Black, and non-Hispanic Asian residents are 1.01, 1.53, and 0.64 times the rate of non-Hispanic White residents, respectively.

Health Drivers:

*Proximal health drivers*

- Coexisting and associated diseases
  - Overweight and obesity rates
    - Adults:
      - Overweight: 30.1%, compared to 33.7% in California
      - Obesity: 13.5%, compared to 22.7% in California
    - Youth overweight or at-risk of overweight
      - 5th graders: 31.0%, compared to 47.9% in California
      - 7th graders: 31.7%, compared to 44.5% in California
      - 9th graders: 30.5%, compared to 40.6% in California
  - HIV prevalence, per 100,000
    - 248.8, compared to 345.5 in California
HIV hospitalizations, per 100,000
- 0.9 in San Rafael Service Area, compared to 1.4 in California

Tobacco use prevalence
- Adults: 8.8%, compared to 13.6% in California
- Youth: 4.7%, compared to 4.2% in California

**Distal health drivers**

- Health care access
  - Breast cancer screening: 67.6% of women, compared to 59.0% in California
  - Cervical cancer screening: 65.5% of women, compared to 64.0% in California
  - Colorectal cancer screening: 69.9%, compared to 52.2% in California
  - Lacking current health insurance coverage
    - 9.0% of adults aged 18-64, compared to 16.0% in California
    - 2.2% of children aged 0-18, compared to 5.7% in California
    - *Disparities:* Parts of Muir Beach and Strawberry have greater than 30% of residents uninsured
  - Lacking a consistent source of primary care
    - 10.4%, compared to 14.2% in California
- Income (Cancer rates are higher for lower income populations.)
  - Median Household Income
    - $89,268, compared to $60,016 in California
    - *Disparities:* Highest income tract is in Ross, while the lowest ratio is in the Canal area of San Rafael (23.4% of the median household income of Ross)
    - *Disparities:* Gini index (a measure of income inequality where zero expresses perfect equality and one expresses maximum inequality) is 0.50, compared to 0.47 in California
  - Unemployment
    - 6.7%, compared to 10.9% in California
  - Percent of residents with incomes below 200% of the Federal Poverty Level
    - 17.2%, compared to 32.8% in California
    - *Disparities:* The two tracts of the Canal area of San Rafael (47.6% and 64.7%), Marin City (39%), and one tract in Novato (34.6%) have poverty rates greater than the State.

**Focus Groups:**
- Frequently mentioned

**Key Informant Interviews:**
- Yes

**Healthy Marin Partnership Community Convening Priority:**
- Yes

**Assets:**
- Community hospitals (3)
- Community health centers serving low income residents (4)
- Marin MH&HS Epidemiology Program-Breast Cancer
- American Cancer Society
- Leukemia & Lymphoma Society
- Breast Cancer Coordinating Council of Marin
- Marin Lymphedema Information and Support Group
- Okizu, respite for families with children with cancer
Attachment H  Health Need 8: Heart Disease

*Heart Disease* is a health need possibly related to obesity, access to healthy food, proportion of residents getting moderate or vigorous daily exercise, tobacco use, low income and lack of access to health care and coverage. *Heart disease* is also related to high blood pressure, high cholesterol and heart attacks.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population (Age 18)</th>
<th>Number with Heart Disease</th>
<th>Percent with Heart Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Rafael (Service Area)</td>
<td>268,919</td>
<td>17,028</td>
<td>6.33%</td>
</tr>
<tr>
<td>Marin County</td>
<td>191,000</td>
<td>14,000</td>
<td>7.33%</td>
</tr>
<tr>
<td>California</td>
<td>27,547,000</td>
<td>1,618,000</td>
<td>5.87%</td>
</tr>
</tbody>
</table>

*Data Source: California Health Interview Survey (CHIS), 2009. Source geography: County (Grouping).*

**Percentage of Adults Ever Diagnosed with Cardiovascular Disease, By Region, CHIS 2009**

- Over 8.0%
- 7.1 - 8.0%
- 6.1 - 7.0%
- 5.1 - 6.0%
- Under 5.1%

Also see Health Need Summary 5: Healthy Eating, Active Living, Attachment E

**Health Outcomes:**
- Heart disease prevalence
  - 7.1% of adults, compared to 5.9% in California
- Heart disease mortality, per 100,000
  - 73.8, compared to 131.3 in California

**Health Drivers:**

*Proximal health drivers*
- Air quality (Exposure to air pollution leads to heart disease.)
  - Percent of the population living with 500 feet of a busy roadway
    - 10% of the population. No state benchmark available
    - *Disparities:* Denser suburban areas more exposed compared to more rural communities
- Percent of days exceeding emissions standards for PM$_{2.5}$
  - 5.3% compared to 4.2% in California, though the monitor is very close to Highway 101

- Coexisting and associated diseases
  - Overweight and obesity rates
    - Adults:
      - Overweight: 30.1%, compared to 33.7% in California
      - Obesity: 13.5%, compared to 22.7% in California
    - Youth overweight or at-risk of overweight
      - 5th graders: 31.0%, compared to 47.9% in California
      - 7th graders: 31.7%, compared to 44.5% in California
      - 9th graders: 30.5%, compared to 40.6% in California

- Cost of living (High cost of living can result in lack of money for healthy food, health care and other resources that support a healthy lifestyle.)
  - Percent of adults paying greater than 30% of total household income on housing (rent or mortgage)
    - 45.6% compared to 47.0% in California
    - Disparities: Canal area of San Rafael (72.6%), Marin City (60.2%), and Bel Marin Keys (57.8%) are the top 3 areas with the highest percent of adults overpaying for housing.
  - Percent of households paying more than 45% of income on housing and transportation costs combined
    - 56.3%, compared to 48.4% in the SF-Oakland-Fremont region
  - Percent of households spending more than 15% of income on transportation
    - 20.7%, compared to 17.8% in the SF-Oakland-Fremont region
  - Percent of households in overcrowded conditions
    - 2.5% of housing units overcrowded, compared to 8.0% in California
    - Disparities: The Canal area of San Rafael is very overcrowded compared to other communities, with its two tracts having 10.7% and 40.5% of their residents in overcrowded conditions. In the latter tract, about half of those living in overcrowded conditions are in severely overcrowded conditions.
  - Supply of affordable housing
    - 3.8% of Marin County’s housing units categorized as affordable housing. No state benchmark available.
  - Total monthly cost of a minimal-cost market basket of food for a family of four (2 adults and 2 children)
    - Market basket average cost $213.07 per month, compared to $144.40 in the U.S.
    - Disparities: The San Geronimo Valley area ($240-$255), Bolinas ($238), Fairfax ($236), and San Anselmo ($236) generally had the highest market basket costs in the county, while Larkspur ($200), Corte Madera ($204), and Novato ($178-$201) generally had the lowest average market basket costs.
  - Access to subsidized child care
    - 2,094 unmet subsidized child care slots (189 for ages 0-2, 78 for ages 3-5, and 1,827 for ages 6-13). No statewide data available.

- Nutrition/Food access
  - Grocery store establishments per 100,000
    - 24.6, compared to 22.2 in California
Availability of total food items in a minimal-cost market basket of food for a family of four (2 adults and 2 children)
- Marin stores average percent of missing items was 13%. No statewide data available.
- **Disparities**: Lagunitas (48%) and Marin City (38%) have the highest percent of missing items. Alto (4%), San Anselmo (5%), and Fairfax (5%) had the lowest percentages of missing items.

Availability of fresh fruit and vegetable items in a minimal-cost market basket of food for a family of four (2 adults and 2 children)
- The average percent missing fresh fruit items was 11%, while the average percent missing fresh vegetables was 9%. No statewide data available.
- **Disparities**: Loma Verde, Fairfax, Point Reyes Station, and Stinson Beach all had an average percent missing fresh fruits and vegetable items of 1%, the lowest in the county. Meanwhile, San Geronimo Valley (58%), Marin City (66%), Waldo Point (68%), Forest Knolls (87%), and Lagunitas (98%) had the highest average percent missing fresh fruits and vegetable items.

Fast food restaurant establishments per 100,000
- 65.0, compared to 69.4 in California

**Physical activity/fitness**
- Proportion of adults getting moderate or vigorous daily exercise
  - 70.6% of adults get moderate exercise, while 41.0% of adults get vigorous exercise. No statewide data available.
  - **Disparities**: Marin City and more rural parts of the county had lower rates of moderate or vigorous exercise compared to the suburban eastern part of the county.

Proportion of youth who are physically fit and meet 6 out of 6 Statewide Physical Fitness Test criteria
- 42.0% of 5th graders, compared to 25.2% of California 5th graders
- 44.9% of 7th graders, compared to 32.1% of California 7th graders
- 46.0% of 9th graders, compared to 36.8% of California 9th graders

Park access (percent of population within 0.5 miles of a park)
- 68%, compared to 58.6% in California

Recreation and fitness facility access (establishments per 100,000 people)
- 24.2, compared to 8.9 in California

Walkability measure (percent of population in Walkscore area)
- 46.0% in San Rafael service area, compared to 84.0% in California

**Tobacco use prevalence**
- Adults: 8.8%, compared to 13.6% in California
- Youth: 4.7%, compared to 4.2% in California

**Distal health drivers**
- Education (Lower socioeconomic status has been correlated with higher rates of heart disease.)
  - Percent of population who did not graduate high school
    - 8.2%, compared to 19.3% in California
    - **Disparities**: 63.1% in the Canal area of San Rafael
  - Percent of population who obtained a Bachelor’s degree or higher
    - 54.1%, compared to 30.1% in California
    - **Disparities**: 7.5% in the Canal area of San Rafael

**Health care access**
Current health insurance coverage
- 9.0% of adults aged 18-64, compared to 16.0% in California
- 2.2% of children aged 0-18, compared to 5.7% in California
- Disparities: Parts of Muir Beach and Strawberry have greater than 30% of residents uninsured

Lacking a consistent source of primary care
- 10.4%, compared to 14.2% in California

Percent not taking medication among those with diagnosed with hypertension
- 17.7%, compared to 30.3% in California

Income/Income inequality (Lower socioeconomic status has been correlated with higher rates of heart disease. Income inequality has been associated with obesity, which can lead to heart disease.)
- Median Household Income
  - $89,268, compared to $60,016 in California
  - Disparities: Highest income tract is in Ross, while the lowest ratio is in the Canal area of San Rafael (23.4% of the median household income of Ross)
  - Disparities: Gini index (a measure of income inequality where zero expresses perfect equality and one expresses maximum inequality) is 0.50, compared to 0.47 in California

Unemployment
- 6.7%, compared to 10.9% in California

Percent of residents with incomes below 200% of the Federal Poverty Level
- 17.2%, compared to 32.8% in California
- Disparities: The two tracts of the Canal area of San Rafael (47.6% and 64.7%), Marin City (39%), and one tract in Novato (34.6%) have poverty rates greater than the State.

Transportation (Walking, biking and use of public transit result in more physical activity than driving and more public transit may reduce driving and improve air quality.)
- Percent of the population living near a regional transit hub or a local bus route
  - 14% of the population lives near a transit hub and 51% lives near a local bus route. No state benchmark available
- Percent of the population driving alone to work
  - 66.7%, compared to 73% in California

Focus Groups:
- Frequently mentioned

Key Informant Interviews:
- Yes

Healthy Marin Partnership Community Convening Priority
- Yes

Assets
- Community hospitals (5)
- Community health centers (6)
- American Heart Association
<table>
<thead>
<tr>
<th>Health needs</th>
<th>Cancer</th>
<th>Asthma</th>
<th>Heart Disease</th>
<th>Mental Health</th>
<th>Substance Abuse</th>
<th>Childhood Hospitalizations</th>
<th>Falls (seniors)</th>
<th>Life expectancy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Criteria</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicators show poor performance: County is performing poorly as a whole compared to a benchmark (0-2)</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>N.D.</td>
<td>0</td>
</tr>
<tr>
<td>Indicators show poor performance: Disproportionate impact on health status of one or more subpopulations (0-2)</td>
<td>1</td>
<td>N.D.</td>
<td>N.D.</td>
<td>2</td>
<td>1</td>
<td>N.D.</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Severity of disease outcomes (0-2)</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Magnitude of poor performance: Many people are impacted (0-2)</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Need arose in key informant interviews (0/1)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Need arose in focus groups (0-2)</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Need includes outcomes and drivers in that addressing the drivers will be preventative for the outcomes (i.e., Will changing this reduce future medical care need for chronic diseases in Marin?) (0-2)</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Health needs</td>
<td>Cancer</td>
<td>Asthma</td>
<td>Heart Disease</td>
<td>Mental Health</td>
<td>Substance Abuse</td>
<td>Childhood Diabetes Hospitalizations</td>
<td>Falls (seniors)</td>
<td>Life expectancy</td>
</tr>
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<td>Criteria</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Need includes outcomes and drivers in that addressing it will likely impact more than one health outcome (0-2)</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>There are strategies for addressing the need locally that can be implemented within the County with a high likelihood of meaningful improvement in the health issue (0-2)</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTAL</strong> (Maximum score possible = 17)</td>
<td>10</td>
<td>13</td>
<td>13</td>
<td>15</td>
<td>10</td>
<td>10</td>
<td>6</td>
<td>10</td>
</tr>
</tbody>
</table>

Scoring Key:
0 = Less need (e.g., less disparity, fewer people impacted, fewer ways to address need)
1 = Intermediate need
2 = Most need (e.g., poorest county-wide performance, most severe outcomes)
During focus groups on healthy eating, active living in Marin City, Novato, Canal, San Geronimo, West Marin, Whistle and at the Youth Leadership Institute that were held between April 16 and May 9, 2012, a survey was conducted to obtain input into the Community Health Needs Assessment. The survey asked respondents about: important healthy issues they, their families, and their communities faced; what they saw as healthy and unhealthy about their communities; and what they’d change in their communities to make them healthier. A total of 103 English and 50 Spanish responses were obtained.

Some notes to keep in mind as this summary of survey results is reviewed:

1) Survey respondents were taking part in focus groups about healthy eating/active living and were therefore “primed” to discuss food and exercise in their survey responses;
2) Spanish survey responses appeared to be ‘standardized’ in that the same language was used by many respondents in response to questions about what is healthy or unhealthy about their communities. We believe that Spanish speaking respondents may have been selecting from a list of choices, whereas the English speaking respondents were given blank space to write their responses.

Human Impact Partners reviewed and analyzed survey responses that had been compiled into a spreadsheet for common themes, which are summarized below. After the most common themes are summarized, responses are categorized into three groups – Community resources/infrastructure, Health behaviors, and Health outcomes. Within each of those groupings, the themes are listed in order of their frequency in responses.

**English Survey Responses (n=103) – High Level Summary/Themes**

*General themes raised*
- Food: eating healthy and unhealthy; cost; access (60)
- Parks: access/walking safety (45)
- Exercise/physical activity (29)
- Transportation: public transit, roads (23)
- Mental health, stress, substance abuse (alcohol, drugs) (21)
- Employment/jobs (18)
- Obesity (17)
- Housing: affordability, conditions, overcrowding (17)
- School (17)
What are important health issues?
- Active living
- Stress
- Obesity
- Diabetes
- Cancer
- High Blood Pressure

What is healthy about your community?
- Good access to lots of parks, trails, beaches
- Schools

What is unhealthy about your community?
- Access to fast food
- Need more/better sidewalks and bike lanes
- Need more jobs
- Need more affordable housing

What would you change in your community to make it healthier?
- More access to healthy food – farmers’ markets, grocery stores
- More access to affordable food
- More public transit (to parks, healthy food, etc.)

Spanish Survey Responses (n=50) – High Level Summary/Themes

General themes raised
- Housing (39)
- Safety (35)
- Jobs/financial situation (34)
- Transportation (29)
- Immigration (20)
- Food (10)
- Obesity (10)
- Asthma (7)
- Health/medical care/health insurance (7)
- Allergies (7)
- Diabetes (7)
- Access to goods and services (7)
- Parks/ walking (5)
- Exercise/ physical activity/ walkability (5)
- Nerves/stress/ depression/ alcohol abuse (4)
- Flu/ cold (3)

**Most common responses**

What are important health issues?
- Housing is in bad condition
- Safety/gangs/fear of walking alone at night
- Obesity
- Diabetes
- Allergies
- Asthma
- Flu

In your community, what supports you to stay healthy?
- Employment/jobs
- Need more security
- Transportation
- Parks

In your community, what prevents you from staying healthy?
- Employment/unemployment/financial situation/lack of money prevents ability to buy food
- Housing/ lack of affordable housing
- Housing not being in good condition
- Safety
- Access to goods and services
- Transportation/ lack of public transportation
- Immigration

What would improve your ability to obtain what you need to stay healthy?
- More healthy eating/more fruits and vegetables
- Have a better income to afford better food/nutrition
- Better financial situation/income to afford healthy food and pay for healthcare
- More security
- Need more light in parks
- Do more exercise/ exercise every day
Key Informant Interview Findings

Community Health Needs Assessment of Marin County 2013

Healthy Marin Partnership
Marin General Hospital
Kaiser Permanente San Rafael
Sutter Novato Community Hospital

Prepared By:
Abinader Group
October 2012
Background and Overview

Since 1996 Healthy Marin Partnership (HMP) has been conducting triennial Marin County community health needs assessments that identify and address key countywide issues. The HMP assessments have focused community discussion on health impacts “upstream”. These assessments recognize that addressing and improving the built environment will have a positive impact on health disparities and trends in disease and conditions for all residents. HMP assessments have tracked a set of four lifestyle issues that underlie the leading causes of death in Marin: high-risk alcohol use, tobacco use, diet and physical activity. Focusing on these four lifestyle issues community assessments considered various community factors and social determinants of health. Assessments also considered the influence that public policy and organizational practices can have in these areas and in general on the health and well being of Marin.

With the passage of the Affordable Care Act, the hospitals in Marin County are being asked to complete community health needs assessments in order to retain their 501(c)(3) status. These community health needs assessments (CHNA) must include:

- Data Research and Prioritization of Identified Health Needs
- A Report on Findings
- An Implementation Plan

To inform data research and analysis Health Marin Partnership (HMP) contracted with the Abinader Group to coordinate and perform key stakeholder interviews and create a report on the data outcomes.

From April 23, 2012 to June 11, 2012 Selma Abinader of Abinader Group conducted twenty-five phone interviews of stakeholders selected by HMP leadership. Stakeholders interviewed were HMP leadership and representatives from hospital and health organizations, funding institutions, government, business, education, and community based agencies (Appendix pg 42).

Prior to interviews, participants received a letter of explanation detailing HMP’s process and project as well as the specific interview questions (Appendix pg 43). Questions were designed to collect qualitative data on the:

- Underserved populations or areas in Marin
- Factors/challenges in achieving and maintaining good health
- Current capacities and gaps within health care systems
- Best and promising practices
- Opportunities for enhancing the health care system capacity to address challenges and gaps

This report contains an analysis of the qualitative data findings from key informant interviews. The data has been analyzed and presented by interview question, sector responses and key themes. Through the compiled
data the report seeks to give a narrative picture of health opportunities and challenges facing Marin and key strategies for achieving greater health impact.

**Executive Summary**

Health equity is achieving the highest level of health for all people. Health equity entails focused societal efforts to address avoidable inequalities by equalizing the conditions for health for all groups, especially for those who have experienced socioeconomic disadvantage or historical injustices.

The commitment of key informants to health equity is clearly reflected in their definitions of health care challenges and needed actions. Respondents from all sectors spoke about the insufficiencies, inequities, and limitations of the current health care system. Many highlighted both the environmental factors and individual approaches to achieving the highest level of health for all people in Marin.

Communities identified by respondents as the most affected by health disparities included Latinos, Asians (specifically Vietnamese, Laotian and Cambodian) and racial minorities. Among these groups chronic disease and obesity were described as the most common health issues.

Seniors were the population of most concern among the majority of respondents. In Marin 30% of residents are over the age of 60 and with the graying of Marin the health care needs of this population are growing.

The fragmentation and limitations of the current health care system are affecting access to care for everyone and most specifically for Latino, Asian, minority and senior populations. Health care providers and to a lesser degree community agencies are working in isolation, guarding their access to limited and insufficient resources. The high cost of health care coverage and inadequate reimbursement rates makes health care a privilege for some but not everyone’s right.

Having sufficient services to meet residents needs helps to equalize conditions for health. Health equity is further realized when all community members can go anywhere to get health care. This requires a system wide capacity for providing culturally appropriate services in a client’s primary language. This also requires adequate care for residents facing multiple health challenges or needing specialized care.

Health care system insufficiencies identified by respondent include the:
• Amount of primary care and family doctors to meet community needs
• Availability of accommodations and appropriate services for people with disabilities, mental illness or drug and alcohol addiction
• Accessibility of dental care for youth and adults
• Affordability of permanent and transitional housing

The whole community is better served when providers work holistically in a client-centered approach. By linking health care systems we are better able to connect with people throughout their health care journey. This enhances an individual’s capacity to make healthy choices, to access appropriate treatment, and to receive the support they need to prevent disease progression and hospital readmission.

For individuals the correlation between good health, income, education and employment status is widely understood. Being underemployed, unemployed, uninsured, underinsured, low income and having low educational attainment and limited English speaking ability restricts an individual’s choice within an already challenging health care environment. Changing the fundamental systems that maintain poverty to systems that are committed to community health is key. This requires working upstream to change and implement policies and environmental conditions that effect health.

Best practices are data driven. Respondents want to learn from local successes in crime reduction, school achievement and other areas of progress. Rigorous communication on data and impact is needed so that Marin can identify and adequately address community wide problems through policy, environmental change and individual behavior choice.

Health is not a cultural norm in Marin County where the healthy choice is the easy choice. Not all organizational leaders are bought into or unified around a prevention health agenda that helps to equalize the environmental conditions that affect everyone’s health.

Health Care leaders need to step back and ask the community how to best collaborate to create the conditions for a healthy active life. There are informal community groups that support each other and can be great contributors in supporting a healthy community. Great benefits can be realized by working with local community agencies, churches and non-traditional partners. These groups are best able to outreach and help build on community strengths.

For a community to use their power to create change they need to have the capacity and tools to take advantage of the opportunities that exist to improve

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Much has been learned about the actual or distal (as opposed to the proximal) causes of death and disease, including social and economic conditions that impair health and make it hard to avoid health risks. Therefore, it is no longer sufficient to expect that reforms in the medical care delivery system (for example, changes in payment, access and quality) alone will improve the public’s health. Large proportions of the U.S. disease burden are preventable. The failure of the health system (which includes medical care and governmental public health) to develop and deliver effective preventive strategies is taking a large and growing toll not only on health, but on the nation’s economy.

For the Public’s Health: Investing in a Healthier Future
http://www.nap.edu/catalog.php?
the health and safety of all residents. The Health Department and other organizations can help communities see how the built environment is intimately interconnected to the health and safety of residents. Community leadership training and engagement for people of color and other low-income communities can build their capacity to advocate for environmental policy change.

Marin has 1400 non-profits. The way services are provided is fragmented. Everyone is to some degree viable but is competing for a shrinking pool of funds. Exploring opportunities for integrating services, blending siloed funding and for supporting and directing resources to the most impactful organizations are approaches worth exploring. Implementing a systematic way to outreach and enroll people in community benefit programs can help to maximize the federal resources coming to Marin.

The IOM report referenced above speaks to health and economic impacts of not addressing the multiple determinants of health effectively. That reforms in the medical care delivery system alone will not improve health. They propose that the negative economic and health impacts can be reduced when health care related sectors agree on and deliver effective prevention strategies. Strategies that target the actual and distal causes of death and disease, including social and economic conditions that impair health and make it hard to avoid health risks.

Respondents reflected this understanding by proposing solutions where coordination and collaboration among all sectors becomes a foundational element. Respondents felt that health equity would be well served when everyone creates and advocates for a unified proactive health policy agenda and develops a health strategy that engages the whole community in caring for and supporting health for all people.
Use and Benefits of the Report

HMP hopes to build from previous community work in developing the 2013 CHNA. The data gather and analyzed from these interviews will help in prioritizing health needs and framing the implementation plan.

Respondents were also asked to share the benefits that they hoped would be realized through this process. Possible benefits sought to:

- Provide access to data that provides a true picture of the state of our county. Data that identifies the true needs of the underserved, the impact of our current efforts, and all facets of the problems we face in improving health outcomes
- Help to focus and galvanize HMP leadership to work together on new and enhanced opportunities that achieve greater health impact
- Acknowledge the strengths and opportunities found in the crossover between health care systems and providers, insurance brokers, community groups, and the business community to close the health care gap
- Act as a vehicle for highlighting health priorities and coalescing all sectors of the community to consider the implications of the data and how to contribute (collective impact)
- Provide direction for allocating resources
- Inform the building of an integrated continuum of care that is committed to serving the community at large
- Facilitate community discussions to connect data with their own experiences and determine appropriate and relevant approaches to improving community health
- Welcome and accommodate all individuals to be part of designing solutions including people with disabilities and non English speakers
- Understand the health care communities contribution to the overall economy both directly and indirectly
- Build community will to mobilize and take action
The Report and How It Is Organized
This report presents an analysis of the qualitative data gathered through the key informant interviews. Common themes emerged when analyzing the perspectives shared for each question and across related questions. These themes tell the story of current health conditions in Marin: who’s at risk and why, future trends to watch, strategies to consider, and best practices to build upon or replicate.

The data analysis results are broken down and displayed by Section. Questions relating to each Section are displayed on Section title pages. The themes that emerged from the analysis and a summary of the perspectives shared are also discussed. Common themes across all questions are highlighted in the “Data Highlights” on pages 5 and 6.

The breath and depth of the qualitative data made results difficult to quantify. The terms “Many”, “Several”, and “Few” are used as a reflection of the degree to which a particular response was shared. “Many” refers to responses shared by most respondents. “Many” can include repeated responses from the same individual or repeated responses from an array of interviewees. “Several” refers to responses shared by at least 50% of respondents. “Several” also includes repeated responses from the same individual or repeated responses from an array of interviewees. “Few” reflects responses that were not universally held and usually referenced by only one or two respondents.

The color-coding within each Section distinguishes HMP member responses form other key informant responses. This color-coding system is explained in each Section’s introductory paragraph. The narrative also contains references to the background materials contained in the appendix. Responses to question 15 “How do you see yourself using the results of this assessment” are located on page 39.
Section A
This section details responses from questions two, three and four. Question one was used to capture the respondents’ name. Input focused on population groups with the greatest health challenges. It also identified the common health issues and environmental factors affecting communities with the greatest disparities. Tables precede a narrative description of the responses for each question. The tables show the number of times respondents mentioned a factor, health concern, or population group.

Question 2: In Marin County, which population groups have the greatest challenges in achieving and maintaining good health? Top 5 responses are:

<table>
<thead>
<tr>
<th>Factor</th>
<th>All Sectors</th>
<th>HMP</th>
</tr>
</thead>
<tbody>
<tr>
<td>At poverty line or below (14) Low income (14)</td>
<td>28</td>
<td>14</td>
</tr>
<tr>
<td>Seniors (11) rural (1) LGBT (1) socially isolate (1) fixed income (1) with disabilities (2)</td>
<td>17</td>
<td>10</td>
</tr>
<tr>
<td>Immigrants (7) Latino (2) Asian (2), Undocumented (3) Ethic minorities (1)</td>
<td>15</td>
<td>6</td>
</tr>
<tr>
<td>• Concern with undocumented receiving care while pregnant but not after</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uninsured, under</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>Under insured</td>
<td>10</td>
<td>2</td>
</tr>
</tbody>
</table>

Question 3 - What are the most critical and common health issues among these populations? Top 5 responses are:

<table>
<thead>
<tr>
<th>Issue</th>
<th>All Sectors</th>
<th>HMP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes (13): Youth (1); Seniors (1)</td>
<td>15</td>
<td>3</td>
</tr>
<tr>
<td>Obesity (8): Youth (2); Eating disorders (1)</td>
<td>11</td>
<td>2</td>
</tr>
</tbody>
</table>
Mental Health (7); Depressed kid (2) | 9 | 2
Hyper Tension | 7 | 1
Chronic Disease (5); Aging with CD (1) | 6 | 5

**Question 4 - What factors are contributing to their health care challenges?** Please share both individual and systemic/environmental factors. The top 3 responses are:

<table>
<thead>
<tr>
<th>All Sectors</th>
<th>HMP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social determents of health/environmental factors (4) racism (1) access to affordable food (general) (2) seniors (1), affordable medications particularly for seniors (1) poverty (7) safe places to play (2), Housing conditions (3) safe, clean, affordable, close to hubs (1) mold, bacteria, dirt, dust (1) costs (1), Marketing of unhealthy foods</td>
<td>27</td>
</tr>
<tr>
<td>Poor health habits (3) nutrition/unhealthy eating (8) lack of physical exercise (6) smoking (1)</td>
<td>18</td>
</tr>
<tr>
<td>Cultural competent health care (11) Language barriers (1) In hospitals, mental illness, undocumented (1) Accommodation for disabled (2)</td>
<td>15</td>
</tr>
</tbody>
</table>
### Question 2 - In Marin County, which population groups have the greatest challenges in achieving and maintaining good health?

<table>
<thead>
<tr>
<th>Question</th>
<th>All Respondents</th>
<th>HMP</th>
</tr>
</thead>
<tbody>
<tr>
<td>At poverty line or below (14) Low income (14)</td>
<td>28</td>
<td>14</td>
</tr>
<tr>
<td>Seniors (11) rural (1) LGBT (1) socially isolate (1) fixed income (1) with disabilities (2)</td>
<td>17</td>
<td>10</td>
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<tr>
<td>Immigrants (7) Latino (2) Asian (2), Undocumented (3) Ethnic minorities (1)</td>
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<tr>
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<td>12</td>
<td>5</td>
</tr>
<tr>
<td>Under insured</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Marin City</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>People of Color (3)/African American (3) Racial minorities (1)</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Canal</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>West Marin</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Unemployed/Underemployed</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>• Age and wage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Novato</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Mentally Ill (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seniors (1)</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Disabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Particularly Latinos and Asians- less resources--secondary challenges with language and cultural competency (1) Low income under 60 (1)</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
Question 2 - In Marin County, which population groups have the greatest challenges in achieving and maintaining good health?

Respondents identified many factors as inhibitors to achieving and maintaining good health. Economic status is cited as a key challenge. Other factors affecting health include living at the poverty line or below, being uninsured or underinsured and being unemployed or underemployed. A few respondents predict that the numbers of those unable to meet health insurance co-pays has increased with the economic downturn.

Seniors, immigrants, and racial minorities are the populations most identified as struggling with access to health care. Since Marin has a significant aging population many respondents are concerned about the health care system capacity to address senior health needs and challenges. Specific subgroups of concern are seniors living in rural areas, LGBT seniors, seniors living on fixed incomes and mentally ill or disabled seniors.

Immigrants and the undocumented were groups identified as facing significant health challenges. Latino and Asian immigrants were highlighted specifically as well as other ethnic groups and racial minorities. Canal, Novato and Marin City, localities with the greatest concentration of African American and Latino residents, were also cited.

A few respondent comments help to illuminate specific challenges affecting ethnic minorities in Marin County:

- Immigrants live in neighborhoods that are dangerous and polluted with less access to healthy foods
- Asian groups are often lumped together even though significant differences exist. Chinese and Japanese communities are more established and have knowledge about healthy lifestyles. More recent immigrants, Vietnamese, Laotian, and Cambodian have greater health care access challenges.
• Limited translations services at health care settings requires family members to translate
• Language line is impersonal and there is often no follow up,
• Health Care partnership has eliminated the opportunity for people to go outside of Marin to providers that speak their language

• Undocumented immigrants can receive personal health care during pregnancy but not after which puts the mother’s health at risk
• Latinos and Asians living with disabilities are challenged by limited resources, language barriers and cultural competency

Additional groups or localities facing health challenges include:

• Southern Marin
• Youth
• West Marin
• Mentally Ill

• People with disabilities
• LGBT
• Homeless

One respondent suggests that no segment has achieved good health. A culture of health where the healthy choice is the easy choice is not embedded anywhere in Marin County.
Question 3 – What are the most critical and common health issues among these populations?

<table>
<thead>
<tr>
<th>Question</th>
<th>All Respondents</th>
<th>HMP</th>
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</thead>
<tbody>
<tr>
<td>Diabetes (13)</td>
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<tr>
<td>Youth (1)</td>
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<tr>
<td>Seniors (1)</td>
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<td>Obesity (8)</td>
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<td>Mental Health (7)</td>
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<td>Depressed kid (2)</td>
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<td>Hyper Tension</td>
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<tr>
<td>Aging with CD (1)</td>
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<td>Alzheimer’s (3)</td>
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<tr>
<td>Condition</td>
<td>Count</td>
<td>Rate</td>
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<td>-----------------------------------------------</td>
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<tr>
<td>Injury (1)</td>
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<tr>
<td>Falls for seniors (1)</td>
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<td></td>
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<tr>
<td>Chronic pain (1)</td>
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<td>Dental issues for elderly and poor (1) Adults (1)</td>
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<tr>
<td>Stroke</td>
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<tr>
<td>Cancer</td>
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<tr>
<td>Influenza and pneumonia</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Suicide</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>
Question 3 - What are the most critical and common health issues among these populations?

For populations with the greatest health disparities chronic disease and obesity are identified as critical and common health issues. Chronic diseases including diabetes, hypertension, asthma/respiratory disease, heart disease, and stroke and are emphasized as the most prevalent health issues. The correlation between chronic disease, obesity and overall health makes these two issues of critical importance.

Areas of secondary concern include specific populations and critical health issues. Among youth obesity and eating disorders, mental health and substance abuse are discussed. For seniors, Alzheimer’s, dementia, and fall injuries are highlighted. With adults, dental issues, mental health, suicide, substance abuse and cancer are identified as health issues needing attention.
Question 4 - What factors are contributing to their health care challenges? Please share both individual and systemic/environmental factors.

<table>
<thead>
<tr>
<th>Question</th>
<th>All Respondents</th>
<th>HMP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social determents of health/environmental factors (4) racism (1) access to affordable food (general) (2) seniors (1), affordable medications particularly for seniors (1) poverty (7) safe places to play (2), Housing conditions (3) safe, clean, affordable, close to hubs (1) mold, bacteria, dirt, dust (1) costs (1), Marketing of unhealthy foods</td>
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<td>Poor health habits (3) nutrition/unhealthy eating (8) lack of physical exercise (6) smoking (1)</td>
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<tr>
<td>Lack of knowledge about healthy and healthy lifestyle choices (9), about risks (1) non English speaking/culturally competent (3)</td>
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<tr>
<td>Lack of access to health care (7); limited or not preventive care (1) limited dental (1) mental health, substance abuse, chronic disease services (1) need to go long distances to get care a deterrent until really serious (1), Immigration status—not eligible, Transportation to health care and support services (6) Child Care access (2)</td>
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<td>Life style choices (6)---reactive rather than proactive (1) related to choices in the environment (1) related to income (1) economic downturn (1), Health not a priority: have access but don’t prioritize health</td>
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<td>Education level, Employment status (Unemployed or Underemployed)</td>
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<tr>
<td>Stress (4) from sustaining services for aging parent or disabled youth (1) high cost of living (1) multiple stressors (1)</td>
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<td>3</td>
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<td>Substance Abuse, Smoking, and Alcohol (5) social norms support drinking in youth (1)</td>
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<td>Affordable health care (2), underfunding of health care (1), Provider capacity to address future needs (1) No health insurance</td>
<td>9</td>
<td>5</td>
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<tr>
<td>Social Isolation</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>
Question 4 - What factors are contributing to their health care challenges? Please share both individual and systemic/environmental factors.

Respondents equally reference factors relating to the social determinants of health and individual behavior choices. Social determinants discussed include:

- Substandard housing conditions
- Poverty
- Unemployment / underemployment
- No access to affordable health care services
- Undefined immigration status
- No safe places to play
- Racism
- Marketing of unhealthy foods
- Limited access to affordable food and medications (especially seniors)

The most noted individual behavior factors included unhealthy eating, lack of physical exercise, poor health habits, lower education levels, tobacco use and substance use.

Several respondents also cite life style choices as a key factor, mainly being reactive rather than proactive about personal health care and having resources but not seeing health care as a priority. Several respondents saw the negative health impacts of stress on both adults and youths as a key challenge. Substance abuse, smoking and alcohol use among youth and adults were mentioned as coping mechanisms that greatly impact health.

Respondents describe cultural factors as inhibitors to community health and wellbeing. Comments about cultural competence, language barriers and a lack of information about or accommodation of undocumented residents with disabilities or mental illness highlight many systematic challenges. Others described the lack of knowledge among different communities about health risks and healthy lifestyle choices as a key factor in determining individual behavior challenges.
Section B

Question 6 - What strategies/programs are most successful in addressing these factors/challenges and why?

Question 7 - Which factors are outside your purview to address but are essential to maintaining the good health of your patients or target groups?

Question 8 – Have you seen good examples/models in other places that address factors that are outside your purview that you are interested in?

Question 9 - What other factors/challenges or gaps are important to maintaining good health?

Question 13 - What is one action or strategy that if taken would catalyze other actions to impact the health challenges for these population groups (have a multiplier effect, leverage the action of others)?

Section B details responses from questions six, seven, eight, nine, and thirteen. Respondents were asked to reflect and build on the factors and challenges highlighted in the previous questions. They were also asked to highlight programs and strategies and best practices that would impact these challenges.

The insights shared by respondents for all questions were grouped by thematic area. Thematic areas are listed below. Theme order descends by the numbers of responses emphasizing each area. Thematic areas discussed in the following narrative are:

- Availability And Access To Appropriate Care including:
  - Gaps in Health Care Services
  - Access to Transitional and Home Based Health Care
  - Barriers and Challenges to Accessing Care
- Working Upstream—Focusing On Prevention
  - Promoting Health Equity
Creating a Culture of Health

- Full System Of Care: Wrap Around Care
- Building Community Capacity
- Understanding The Real Contributors/ Factors Affecting Health
- Healthy Economy Equals A Healthy Community
- Maximizing The Benefit Of The Health Care Act And Charity Dollars

Within each thematic area stakeholder responses are divided into subcategories of: current conditions, proposed solutions and best practices. Health Marin Partnership member responses are highlighted in blue.

Availability and Access to Appropriate Care

Responses spoke to the insufficiencies, inequities, and limitations of the current health care system. This was a concern of respondents from all sectors. Feedback about health care availability and accessibility is broken out in the following subheadings:

- Gaps in Health Care Services
- Access to Transitional and Home Based Health Care
- Barriers and Challenges to Accessing Care

For each of these subheadings additional detail relating to current conditions, proposed solutions and best practices is provided.

Current Conditions: Gaps in Health Care Services

Underfunding of health care services affects affordability and limits provider’s capacity to address current and future health care needs. There are insufficient numbers of primary care and family doctors to meet current demands. Specialty care is limited and often only available to privately insured clients who pay out of pocket. Dental services are also limited especially for children 0-5.

People living with disabilities, mental health challenges and drug or alcohol addiction have difficulty with accessing needed support. Mental health, smoking cessations, and drug treatment services are not seen as part or available as primary health care services.

Proposed Solutions

- Provide financial incentive to attract primary care and family doctors to Marin
- Create and connect each community member with a medical home
- Expand the medical volunteer model for specialty care where specialists divide the burden
- Use evolving technologies to create and provide affordable care options. (ex. use social media to connect with new moms to help them get the information needed to make health care decisions)
- Connect health care and social services to work intentionally and collaboratively to serve individuals
- Create more closed environments like the Indian Health Centers or small town environments
- Increase dental care services through community clinics; provide dental education for parents
• Create a Dental van.
• Integrate mental health and drug addiction diagnosis into primary health care services. Include affordable and evidence based education, outpatient treatment, therapy services and housing as part of an individual’s health management plan.
• Increase affordable drug treatment services for youth
• Provide more efficient and affordable psychiatric care

Best Practices
• Health department programs that address smoking, obesity and bike safety
• Well Baby Clinics
• Affordable child care
• El Camino adult dental program
• STD home testing kits
• Regionalization of public health labs—economies of scale
• Community Clinic dental services
• Santa Cruz use of child care revenue
• Mental health services in San Mateo
• Healthy Eating and Active living in Sonoma

Current Conditions: Access to Transitional and Home Based Care
Chronic disease in the elderly is about treatment not prevention. Limited support services impact a senior’s ability to access appropriate health care and live independently. Improvements are needed in managing chronic disease particularly with seniors living at home.

Seniors are often embarrassed to ask for health care resources and have difficulty understanding discharge plans. Some only have catastrophic insurance or supplemental insurance without full support for their basic health needs. The elderly are often isolated and unable to move from their current homes to an affordable setting that fits their needs. This is especially true for seniors who are social isolated, disabled or living in a rural community.

Another area of concern is the lack of transition support from hospital to home for the homeless and uninsured. There is a need for transitional housing to support independent living. Section 8 vouchers for transitional housing are not available. Without emphasis on building new affordable housing and increasing transition support the county cannot address this surmounting need.

Proposed Solutions
• Expand senior services to include transportation, affordable housing, surrounding transportation hubs, childcare, and in home health care services
• Provide sufficient resources to create a system of support for the uninsured and others to manage their chronic disease at home. (Ex. access to diabetes educators, cultural competency cross-training for
providers at every level to ensure patients understand their treatment plan, medications, and health status.)

- Increase number of programs to support transition needs including transitional housing for the homeless
- Progressive plans around transitional housing
- Developing accessible and affordable housing that is integrated into local communities

Best Practices

- Homeward Bound, temporary housing to get people back on their feet
- San Francisco Aging and Disability Resource Program (ADRC) where aging division and disability providers communicate on an equal level
- Transition housing for the homeless
- Project Independence that provides a medical home for the elderly and supports self-sufficiency to say healthy at home
- Marin Community Foundation Advisory Group for the Aging

Current Conditions: Barriers and Challenges to Accessing Care

Responses to Question 2 identified the many barriers and challenges to accessing care. Environmental factors linked with good health include socioeconomic status, educational attainment, and employment status. Responses to Question 2 also emphasized the lack of culturally competent programs to address the growing needs of non-English speakers.

Proposed Solutions

To address these barriers and challenges respondents suggested the following:

- Patient navigators to support low income, undocumented, non English speaking residents in accessing services
  - Social workers and Promotores facilitating access to services. They can begin the eligibility process and then transfer paperwork to facilitate authorization and stop the need for repeat visits
- Flexible doctor, clinic and hospital appointment hours
- 24/7 advice line and elder abuse hotline
- Transportation and cab vouchers
- Safe routes for aging and differently abled
- Enhancing the cultural competency of current programs and creating new programs to meet ethnic minorities health needs
- Include eating disorders in unhealthy behaviors related to healthy eating and active living

Best Practices

- Promotores
- Vans to transport people to needed services
- Stage Coach in West Marin
- San Geronimo Recreation Center that provides established hours for community use, school recreation programs and health and wellness programs
Working Upstream to Achieve Health Equity

All sectors contributed comments about focusing efforts on prevention and policy initiatives at the federal, state and local level. This section is broken up in the following subsections:

- Promoting Health Equity
- Creating a Culture of Health

For each of these subheadings additional detail relating to current conditions, proposed solutions and best practices is provided.

Current Conditions: Promoting Health Equity

One respondent called for the de-segregation of health care so poor kids can have the same quality of care as others. Other systemic factors affecting health that respondents identified include:

- Cost of health care coverage
- Access to care
- Availability of accommodations
- Affordability
- Cultural competence – especially for certain localities and linguistic groups

In their feedback respondents emphasized low income communities as being greatly affected by health inequities. Some respondents described low income neighborhoods as dangerous, polluted environments with less access to healthy foods, education, childcare, affordable or healthy housing, and transportation.

The need for affordable housing and for transitional housing to support independent living continues to grow. The County norm is to not build new housing and Section 8 vouchers for transitional housing are unavailable in Marin.

Marin County is seen a progressive county, where politics can be leveraged to win policy victories to address these systemic factors. Limited resources and competing priorities are often barriers to working together to create a common vision and a unified policy agenda.

Proposed Solutions

Upstream strategies supporting health care equity might:
• Change the fundamental systems that create poverty to systems that are committed to community health
• Join with others to create a unified proactive policy agenda and speak with one voice.
• Support existing coalitions like Marin Kids to use their combined muscle to push for state and federal policy change; funding coalition building
• Lobby the federal government to fund more clinics for the poor
• Push policies that facilitate adequate reimbursement for health care services
• Develop a health strategy that focuses on geography and specific population groups
• Address the undocumented person’s fear of being reported when requested sliding scale documentation at FCHQ
• Facilitate partnerships between Promotores, non profits, and community clinics to ensure that wherever a person enters the system they can get needed services
• Collaborate with the housing authority and other agencies to identify creative ways to meet basic housing needs
• Address corporate engineering of cheap, available, tasty unhealthy foods, address barriers to healthy eating
• Conduct marketing campaigns in high risk communities to support healthy eating and active living
• Push cities and counties to conduct green audits
• Support youth leadership to address harassment and bullying specifically with LGBT youth
• Support policies and funding for physical education in schools

Best Practices
• Focus efforts on policy change similar to the tobacco tax to achieve greatest impact. Remove tax subsidies for the corn industry. Tax sugar sweetened beverages and hydrogenated oil products to support health care costs. Use community tax dollars to support health care.
• Health care reform
• Equalize the pay rate for Medicaid
• School/Law Enforcement partnership using data to identify collective agenda with year in review

Current Conditions: Creating a Culture of Health
Health is not a cultural norm in Marin County. Everyone is not engaged in creating the systemic changes needed to make the healthy choice the easy choice. Not all organizational leaders are bought into or unified around a prevention health agenda. Efforts are still primarily focused on individual behavior change or disease specific advocacy. Some people are unwilling to make prevention a priority even with appropriate resources and education.

Proposed Solutions
• Support disease specific groups to broader their focus to include prevention
• Blend siloed funding allowing programs to address the complex conditions that can’t be treated serially. Every door a person enters could provide them with access to the right services.
• Engage everyone who has influences over children and patients in supporting a culture of health.
• Make healthy eating and active living a desirable social norm for everyone
• Identify goals and catalyze the community to support targeted campaigns. (i.e. every child in Marin has health insurance)
• Introduce a progressive health prevention curriculum in every grade
• Promote employee wellness programs that support health eating and active living and work life balance
• Provide physical activity programs that everyone can afford and access
• Continue to focus efforts on influencing personal behavior choices; provide training on healthy cooking
• Engage disease specific groups as ambassadors of a common message regarding prevention
• Create a communication strategy that supports changing cultural norms regarding health
• Bring together the collective interests of First Five
• Educate the public on the importance of immunization in protecting the whole community

Best Practices
• Expand Play Fair model to other events and venues
• Blue Ribbon Group in Novato
• Community and school gardens
• Huckleberry Youth programs focused on health education
• Working with local stores to display healthy foods
• Collective impact model used by Office of Education and community foundations
• Kaiser’s Thrive Initiative

Full System Of Care: Wrap Around Care
Many respondents from hospital and government sectors advocated for a system of wrap around care to prevent readmission that includes prevention services with pre and post hospital support services.

Current Conditions
Wrap around services are key to preventing readmission, supporting recovery and helping patients maintain independence. Although everyone would benefit from wrap around services, one respondent identified offenders and the precariously housed as populations that would benefit the most.

Proposed Solutions
• Link patients to a medical home
• Hospital to home discharge planner
• Health and social service team in place to track progress, educate patient on medications and share information
• Integrate care so hospital and medical groups are synchronization
• Increase communication and alignment between health care providers in the county (physicians and hospital systems)
• Provide different response programs that can customize an interventions to an individual’s particular set of conditions
• Have courts support offenders to participate in health care wrap around programs
• Enhance coordination between hospitals and community provide
• Use group settings such as recreation centers for social support and health information
• Electronic health records

Best Practices
• Medical Home model of wrap around care
• St. Vincent De Paul
• Ritter House - food, housing, medical and follow-up for the homeless
• Community Clinics
• Thriving Families Network
• Link independent office practices and hospitals through the electronic health system information exchange

**Building Community Capacity**
Health Care organizations, community based agencies and government respondents saw building community capacity as a key strategy to supporting community health.

**Current Conditions**
A few respondents spoke to the community's right to create and implement their own effective solutions. This requires a commitment to and appreciation of the strengths of a community with a diverse mix of individuals and competencies.

By understanding the political and social structures that affect their community residents can become their own advocates. Community leaders can most effectively communicate and inform change efforts at a community level.

Community connections, cohesiveness and attachments are eroding as children move from elementary school to middle school. Middle schools are often larger and outside the students neighborhood. With both parents working, parents are less present on campus and less connected to other families. Youth are left with little access to adult supervision. By middle school many youth have fallen between the cracks.

**Proposed Solutions**
• Mentor government and agency staff to go beyond the boundaries of their training and profession to support community self-determination, facilitate equally in relationships between community members and service providing systems.
• Community driven coordination of limited resources
• Fund the formation of community partnerships and collaborations
• Get nail salon workers together to talk about safety and green practices
• Sponsor wellness services, literacy and after school programs at recreation centers
• Provide opportunities in school settings to teach kids about health and safety using evidence-based interventions.

**Best Practices**
• City of Ross has resources to address health care needs
• Promotores put power in the hands of local people
Understanding The Real Contributors/ Factors Affecting Health

All sectors saw the benefits of deeply understanding the story behind the data.

Current Conditions

Best practices are data driven. Respondents want to learn from local successes in crime reduction, school achievement and other areas of progress. Rigorous communication on data and impact is needed so that Marin can identify and adequately address community wide problems.

It’s often unclear who benefits from resources and funding. We might be spreading resources too thin. It’s important to understanding what works and to assess the impacts. Small county data is often aggregated with multi county data, which can provide a comparison but not locally specific information. It would be helpful to break out the data to squeeze out a deeper understanding of what is going on. More specific data can help focus resources on health outcomes we can prevent instead of going for a broad agenda with minimal impact. Specific and local data can help to identify the programs that work for different groups.

Proposed Solutions

Distilling the data will help reveal the reasons:

- For high numbers of Emergency room admissions
- People participate in risky behaviors resulting in DUls and adverse health outcomes
- We are doing well in some areas and not so well in immunizations and colon cancer screenings
- That motivate our life style choices and our relationships
- We formulate a particular attitude towards health
- Why income relates to health care access
- What are the social, political, and economic barriers to people of color and immigrants

Best Practices

- Using health equity criteria in making allocation decisions

Healthy Economy Equals A Healthy Community

Respondents from the hospitals, community based agencies and funding organizations contributed comments below.

Current Conditions

- Good health directly correlates to a person’s poverty level, education, and employment.
- Personal service industry workers are most often uninsured and working several jobs to earn a living wage.
- Public health policies are sometimes inhibiting business development.

Proposed Solutions

Respondent’s suggestions on building a health economy:
• Keep youth attending and graduating from high school
• Provide a living wage for personal service workers and address the potential health and environmental health impacts of their professions
• Ensure that people with mental illness and substance abuse issues have jobs that are self sufficient and productive contributors to the economy
• Provide access to health insurance, education and literacy programs

Best Practices
• Create individual Development Account programs where $2000 is initially invested then increased to $4000
• Sponsor EAR Federal matching funds program to support opening a small business, continuing education, or purchasing a home
• San Francisco Housing Trust Fund

Maximizing The Benefit Of The Health Care Act And Charity Dollars
Respondents from the hospitals and funding organizations contributed comments below.

Current Conditions
The hospital mission is to focus on medical care not prevention. Hospital dollars including public benefits dollars are to fund treatment. Under enrollment in benefits programs is not drawing the maximum federal dollars to Marin.

Proposed Solutions
• Maximize the Federal benefits by implementing a systemic way to outreach and enroll people in these programs.

Best Practices
• San Francisco program for managing public enrollment
Section C

Question 10 - What opportunities exist within your own system that presents significant opportunities for addressing these challenges and improving community health?

Question 11 - What opportunities exist within hospital systems that present significant opportunities for addressing these challenges and improving community health?

Question 12 - What opportunities exist within community based agencies and groups that present significant opportunities for addressing these challenges and improving community health?

Responses for questions 11 and 12 are grouped by thematic area. Responses from question 10 are incorporated into these thematic areas.

Question 11 asked respondents to identify the opportunities within hospital systems that provide significant opportunities for improving health: The thematic areas that emerged from the analysis of these responses are:

- Working upstream
- Collaboration and Coordination of Services
- Wrap Around Care
- Adequate Services to Meet Needs

Question 12 asked respondents to identify the opportunities that exist within community based agencies that provide significant opportunities for improving health. Thematic areas include:

- Collaboration and Coordination of Services
- Enhancing Impact, Sustainability, and Adequacy of Care
- Adequate Services And Support
- Economic Viability of Community Members
Questions 11 - What opportunities exist within hospital systems that present significant opportunities for addressing these challenges and improving community health?

Respondents from all sectors were asked to respond to this question. Responses are grouped by thematic area. Each thematic area contains highlights on current situations and opportunities. Comments from hospital system respondents are highlighted in brown. Responses from HMP members are in blue or have a blue *. Responses from all other sectors are listed in black.

Thematic areas include:

- Working upstream
- Collaboration and Coordination of Services
- Wrap Around Care
- Adequate Services to Meet Needs

**Working upstream**

The health care industry focus is typically on treatment not prevention so they are less motivated to work upstream. Hospitals are in the business of primarily addressing patients who are already sick. There are very few incentives for hospitals to work on prevention.

Hospitals are in a double bind. If they are successful in promoting community health there will be less need for hospitals and the services they provide (2). Hospitals may not agree that health is outside the walls of the hospital. However, community health improvement comes from not just focusing primarily on injury and disease care but also on supporting healthy lifestyles.

Different hospitals have different ideas and policies about prevention. We might achieve better outcomes and lower health care costs if prevention was conducted in a systematic way in all hospitals. Kaiser has a strong interest in prevention and sees that their employee wellness programs are good for their bottom line. People in health care delivery need to be role models for practicing prevention and promoting healthy lifestyles.*

Health care at its core should not be dominated by the business model but by patient care. Reimbursement systems however inhibit providing a range of care that people need. Hospitals are currently paid by the visit instead of care needed.
Overall health and wellbeing needs to be the main emphasis and an integral part of treatment. Health care systems continue to consolidate and get bigger. The millions raised to build, remodel or seismically retrofit hospitals should be used to provide better patient care.

Opportunities
- Part of healthcare is working with our counterparts in the community. Providing funding as well as patient support so that both hospital and community programs collaborate in promoting health. * (1/2)
- Better patient care drives the hospital business model and decisions on resource allocations and fundraising
- All hospitals in Marin adopt a cradle to grave spectrum of care to reach at least 50% of the population and reduce costs.
- Sponsoring employee wellness programs so that hospital personnel should (can) be role models for healthy life styles for patients* (2)

Collaboration and Coordination of Services
The need for revenue creates an environment of competition rather than cooperation among health care providers. For example certified stroke centers are competing for patients because it’s a source of revenue.

Tremendous opportunities to maintain health exist outside the hospital setting and the doctor’s office. Hospitals and communities working together can minimize years of disability and chronic disability.

We need to step back and ask the community how we can collaborate to better create the conditions for a healthy active life within communities. By working more closely with community clinics, health care providers, county governments and other social service providers, hospitals can ensure that patients are supported to comply with treatment preventing hospital readmission or progression of their disease. (2/2).

Federally Qualified Health Clinics (FQHC) play an essential role in providing community-based health care. (2/2) Resources are stretched and hospitals need a way to address community health needs through decentralization. Consideration should be given to using community benefits to ensure that these clinics have the needed resources to do their best work
Hospitals need to differentiate and have their specialties without competing. Promoting more public/private health care partnerships is key. We seem to have drawn a line in the sand as if we are doing totally separate work. Enhancing these types of partnerships is a good idea. The public sector can learn a lot from the private sector and vice versa. Sharing and contracting with private health care can help better serve the community needs.

Wrap Around Care
It’s harder to realize health benefits if you are not a patient in a collective health system. Patients who are uninsured or episodic often use emergency rooms as primary care providers (2). Complex chronic illness is not well managed well. We need to know who’s showing up in the ER and why so we can take measures to direct these patients to appropriate care.

We need to figure out how to connect with people throughout their health care journey. Providing a transition from treatment to the community, connecting hospitals to community and blending treatment and social services is a new world for many hospitals. Hooking patients up with a medical home, advice nurse and other medical support can help provide a patient with support services to prevent readmission. * (1/1/1) However, there are many challenges in getting these patients to utilize a medical home even when one is assigned. *

Health Care (HC) and Social Services (SS) are two separate systems and only cross along certain points. Increased collaboration between HC and SS is already happening but we need more SS staff in hospitals and better coordination with SS agencies in the community.

It’s important to define the future of health care and the opportunities that technology presents for home diagnosis or connecting with specialists outside California. Health information exchange is often limited and incomplete. We need to improve discharge procedures so that there is a better use and sharing of medical records and health care information.

Opportunities
- Create medical homes and/or assign primary care providers for all patients. Include one stop shopping clinics that are networked with the hospitals. This maximizes a patient’s ability to realize health benefits * (1/2)
- Have triage care or case management services for patients in emergency rooms to direct patient to their primary care provider. This would preserve the use of emergency rooms to address urgent and emergency care * (1/1)
- Create benchmarks to track patients who are receiving preventative care *
- Determine future trends in hospital care and opportunities that technology presents for enhanced patient care.
- Hospitals agreeing on and supporting each other’s specialties.
- Establish and fully utilize electronic health records
• Have health information exchange as part of the hospital system to track the movement of patients *

Adequate Services to Meet Needs

The health care system is a broken system and hospitals are struggling to do their best. They reach out in the ways they can. The community needs to have respect and compassion for the tough work hospitals do often with limited resources

Hospitals are reimbursed by bed counts. Health care in the United States provides less care for twice the cost of other industrialized nations with worse health outcomes. The current medical model is one of supply and demand. Referrals have risen while revenues are decreasing. Hospitals must raise funds to address demands.

Currently there is fragmentation between financing plans and care delivery. Sometimes tests, protocols and interventions requested that are medically required and appropriate are not provided because of the financial implications. Sometimes the goal to provide compassionate equitable delivery systems is compromised when profits are needed to keep up buildings and pay staff.

There is a great need for specialty care particularly for orthopedic surgeries. The medical volunteer program is one means to expand hospital care. Hospitals provide insurance, equipment and facilities for medical volunteers to conduct surgeries and procedures at their site. However, not every surgeon is interested in local volunteering. And hospitals are responsible if patients need hospitalization, which could be supported through community benefits dollars.

Hospitals would benefit from a better understanding of community needs, issues, problems and solutions. Children’s health is of particular concern. Every child having access to early health care is important to good health outcomes. Including dental care as part of well baby childcare would also help. Not all children in Marin have access to dental care. Pediatric dental care at community clinics has helped increase access but there is still a need. Having federal laws that require each child entering school to have dental exams should be considered but it is also dependent on whether every child can access affordable health care.

In Marin 30% of residents are over the age of 60 and the demographic is growing. More than half of Marin residents over the age of 85 have dementia. There is very little going on in the county for the elderly. * We do not have a system wide assessment of elderly needs and gaps in services and support. * For example, there is no transportation aimed at that this demographic. We can better address Senior needs with an understanding of the Medical/Medicare pod. Specifically who is benefiting, how their care is being accessed and managed.
and who is falling between the cracks. * The Health Care system and community partners need to determine a plan and coordinate efforts to address the rapidly growing needs of this population.

Hospitals are providing little support to and focus on the homeless and persons with mental illness. The challenge is how to support these populations once they leave the hospital to stay healthy and not be readmitted.

Even though minorities are not a large population it's important to facilitate their ability to access health care. We need to develop creative solutions for ensuring that the undocumented are getting care. Often times the undocumented are suffering from the effects of traumatic backgrounds. These community members can be further traumatized when experiencing the barriers and inequities in accessing culturally competent care. Hospitals have limited capacity to provide culturally competent support so that people understand their treatment and health maintenance plan. * The system would benefit by having qualified clinicians and nurses who can work with any group but have the language capacity to service a particular population.

When the undocumented only receive care during pregnancy, we are unable to address the mother’s unhealthy life style choices and health issues from pre pregnancy that are affecting the baby’s health.

Health information doesn’t match the patient’s level of understanding particularly patients who are non-English speaking, elderly, or young. Hospitals need to be more in tuned with the level of the health care literacy of our patients.

Hooking the uninsured and underinsured with a smaller size facility like a community clinic could help prevent the use of the ER or hospital visits for primary care.

**Opportunities**

- Dedicate resources to assessing community needs, issues, problems, and solutions
- Assess elderly needs system wide and fill in the gaps in health care and support services*
- Convene agencies serving aging populations i.e. housing, hospitals, home health agencies and community agencies to determine how they will partner to address elderly needs*
- Drill down and create systems and services to support transition programs for the homeless and those with mental illness
- Create a safety net strategic plan with community organizations to explore grant making
- Develop the medical volunteer program as one means to expand hospital care.
- Create an infrastructure for donated services and provider contributions
- Use RotoCare as a best practices model to provide urgent care for the uninsured.
Replicate the volunteer visitation program that provides peer to peer support for people living with disabilities.

Recruit nurses and social workers that speak Asian languages.

Provide culturally competent education that helps folks understand the basics about having and maintaining good health.*

Consider outpatient treatment as a critical component of care for the homeless, mentally ill, elderly, and those with chronic conditions.

Create health information that matches the health care literacy of patients.

**Question 12 - What opportunities exist within community groups and agencies that present significant opportunities for addressing these challenges and improving community health?**

Respondents from all sectors were asked to respond to this question. Responses are grouped by thematic area. Input from community groups and agencies are highlighted in brown. Responses from HMP members are highlighted in blue. Responses from all other sectors are in black.

Thematic areas include:

- Collaboration and Coordination of Services
- Enhancing Impact, Sustainability, and Adequacy of Care
- Adequate Services And Support
- Economic Viability of Community Members

**Collaboration and Coordination of Services**

The service providing system is fragmented and not linked. Working in isolation and guarding resources causes competition. The whole community can be better served if we work together holistically in a client centered approach. Focus on what each of us does really well and connect with others doing similar work. This requires that we look beyond specific jobs and focus on the needs of clients.

Community based agencies want to increase collaboration with the community foundation and their partners to address community issues as they arise. A collaboration that broadens diversity increases the type of staff and the organizations involved.

For a community to use their power to create change they need to have the capacity and tools to take advantage of the opportunities that exist to improve the health and safety of all residents. The Health Department and other organizations can help communities see how the built environment is intimately
interconnected to the health and safety of residents. Community leadership training and engagement for people of color and other low-income communities can build their capacity to advocate for environmental policy change. Community leadership training and engagement for people of color and other low-income communities can build their capacity to advocate for environmental policy change.

Readmission rates to the hospitals can be lowered by hospitals building partnerships with non-profits for health education, health care delivery and peer counseling. Caseworkers at hospitals and clinics can help to hook patients up to services and support the hospitals capacity to provide wrap around services. Wrap around services would require providers with bilingual and multilingual capacity. Strategies to prevent readmission and support home care need to include home modification, care giving online registry, etc. Coordinating service with providers of episodic care is also important.

HHS has a grant program to support the transiting of the elderly and patients with chronic disease from the hospital to home. The grant focus is coordinating follow up services to prevent readmission and progression of disease.

Housing support for underserved populations would benefit from expanded collaboration with other protected groups and underserved populations to work on housing issues. Connecting hospital administration and medical professionals with peer driven health models can provide needed support to disabled communities.

Healthy eating and active living efforts would benefit from partnerships with marketing firms. HMP is raising awareness about healthy lifestyle choices but doesn’t have the same bully pulpit as advertisers. The Bicycle coalition has changed the face of Marin (biking paths, walking groups, parks). This is the kind of coalition that is needed to support healthy living choices.

Opportunities

- Create agencies with the authority to link all elements of community health systems. An agency that has goodwill and perseverance and can convene and facilitate all systems to talk together.
- Community based agencies want to increase collaboration with the community foundation and their partners to address community issues as they arise
- Healthy Marin.Org, Novato Blue Ribbon Commission, Bicycle coalition and other coalitions are possible models of support capacity building and healthy living.
- Adopt a health in all policies lens for decision making and policy development
- Community leadership training and engagement for people of color and other low-income communities
• Hospitals partnering with non-profits for health education, healthcare delivery and peer counseling. Also partnering with providers of episodic care.
• Caseworkers with bilingual or multilingual capacity at hospitals and clinics to help hook patients up to services and support the hospital’s capacity to provide wrap around services.
• Housing support for underserved populations would benefit from expanded collaboration with other protected groups and underserved populations to work on housing issues.
• Connecting hospital administration and medical professionals with peer driven health models can provide needed support to disabled communities.
• Partner with marketing firms
• Build coalitions like the Bicycle coalition to support healthy living choices.

Enhancing Impact and Sustainability of Care
Marin has 1400 non-profits. The way services are provided is fragmented. Everyone is to some degree viable but is competing for a shrinking pool of funds. There are opportunities for integrating services to better serve the community.

Marin community foundation is impacting health by funding non-profits that are key contributors to the safety net. Their strategic planning efforts will help determine the key areas in the county to focus on. The strength of the safety net reflects the degree to which funders listen to the non-profits. Fostering a partnership rather than a parental approach.

Funding agencies could help to achieve health equity by financially supporting and directing resources to the top 50-100 most impactful organizations. That is not to say that other agencies should close their doors but funding agencies should agree on concentrating resources on organizations that are creating the greatest impact.

There are not strong advocate groups working together on a shared health equity platform. Funders can promote, support and nurture health advocacy by bringing together all the advocacy grantees and asking what additional support is needed beyond funding to advance change.

Designing strategies to achieve health equity would benefit from discussions about the connection between how policy decisions are made and their effects on poverty. United Way is convening a group that is looking at how we can do more and work differently to achieve this goal. The United way can connect Marin leaders and residents with the current coalition or create a Marin version to address institutional poverty.
The county government is providing less direct services than it historically has. Community Clinics are doing some of the capacity building now. To be a flourishing community health centers and clinics need additional resources. A strategic plan is needed to define the safety net and clearly delineate roles and responsibilities of the county health department and the community.

The value and impact of investing resources in school environments to promote health is highly noted. The challenge and energy directed to keeping schools open makes it difficult to bring people together to implement a coordinated systemic approach to health that is informed by best practices.

School gardens have made a significant impact on children’s approach to eating and on staff’s approach to health. Helping gardens become a health model in school systems and training parents on healthy lifestyles are strategies worth exploring.

**Opportunities**

- Fund agencies, support and direct resources to the top 50-100 most impactful organizations, focus on the greatest needs
- Foster equitable partnerships between foundations and non profits
- Funders bringing together all the advocacy grantees to understand the type and level of support needed to advance change.
- Expand current United Way coalition efforts to eliminate poverty and include county leadership and residents of Marin, or convene a separate Marin County coalition to eliminate poverty
- Develop a strategic plan that defines the safety net and clearly delineates county health department versus community roles and responsibilities.
- Partner with coastal health alliance to explore school based health centers
- Make school gardens a school health model
- Train parents on healthy lifestyles

**Adequate Services And Support**

A community approach works best in Marin. Being more attuned to community life can help with ensuring prevention and intervention support meets community needs.

There are informal communities that support each other who have the potential and capability to be great contributors in supporting a healthy community. Great benefit could be realized by working with local community agencies, churches and non-traditional partners. These groups are best able to outreach and help build on community strength. Hospitals have a large number of health care professionals who might be interested in volunteering services in the community.
Housing is a major contributor to health. There are many seniors that are isolated and living on their own. They are often living in home situations that don’t meet their needs. We need to create ways for isolated seniors to be engaged and part of the community. Partnering with West Marin Senior Services can build on the strong connection they have with the senior population. Some other examples include meals on wheels, friendly visitors, pen pal letters from school kid, matching elderly living in big homes with others in the community, etc.

Health equity is realized when all community members can go anywhere to get health care. A system wide capacity for providing culturally appropriate services in a client’s primary language. Promotores are effective health brokers. They are natural community leaders that work together and share information and resources and training. (2X). They help folks access resources and galvanize communities to do their own work. What we need are community members willing to do the groundwork to advocate for these system wide health policies.

Today’s homeless population does not fit the tradition view of homeless people. Homeless populations range from those with some resources to the indigent. Zero reimbursement for health care for the homeless is not the best model. We need to shift our view and create more relevant models and resources for care that include housing and transportation.

The Marin LGBT community has the potential to support each other from youth to seniors. The LGBT Community Organization’s strategic planning process will help to define future directions for community organization. Service providers need to look to the LGBT community to help clarify how to reach the next generation.

There is growing interest in the community about supporting healthy living lifestyles. Examples of some strategies are: all doctors in Marin issuing an RX for walks in the park, Farmers markets doubling the food stamp value if you use them at farmers markets.

Opportunities
- Hospitals partnering with local community agencies, churches and non-traditional partners who are best positioned to outreach and help build on community strength.
- Identify health care professionals interested in volunteering services in the community.
- Create ways for isolated seniors to be engaged and a part of the community. Some examples include meals on wheels, friendly visitors, pen pal letters from school kid, matching elderly living in big homes with others in the community, etc.
- Partnering with West Marin Senior Services can build on the strong connection they have with the senior population.
- Create system wide capacity for providing culturally appropriate services in a client’s primary language.
- Expand Promotores model
• Provide aggressive education so that the undocumented feel secure to access health care services
• Create more relevant models for homeless health care that include housing and transportation
• Service providers look to the LGBT community to help clarify how to reach the next generation.
• All doctors in Marin issue an RX for a walk in the park
• Farmers markets doubling the food stamp value if you use them at farmers markets

Economic Viability of Community Members
The county health department can have a dual positive impact on the economic viability of communities. For businesses they can help business operations and facilitate the rapid expansion of local business. For residents the health department can provide guidelines for healthy eating, create a rating system for healthy places, and educate communities and businesses on ways to improve environments.

It’s important to help people understand what wealth means and how to create wealth within the community. Teach people how to manage a bank account, to make wise investments, to start a business or to get training. People need tools and education to move into an income bracket to live a healthy life. Changing laws and helping immigrants to work legally is key. One strategy is to develop job-training programs and partner with higher education (community colleges and universities) to create career ladders that start at a low-income level and move up.

Improving education in these four areas will better prepare children for future employment opportunities and raise their earning potential:

• Early child education and care
• Close the achievement gap
• Get more students into science and math
• Prepare youth for technical jobs

The 3-week algebra immersion academy, worksite mentoring programs, North Bay Science Fair are all good examples of these types of programs. Supporting 80 students in after school programs to get to college will benefit 100 people in their neighborhood.

Opportunities
• HHS supports viability of communities by promoting rapid business expansion, providing guidelines and educating the community and businesses on healthy living
• Create a tool kit and training on how to create personal and community wealth
• Change laws to support legal working status for immigrants
• Create job training programs and partnerships with educational institutions that provide career ladder mobility
• Enhance educational opportunities that prepare children for future employment
Section D

Question 14 - What criteria would you like us to consider as we prioritize identified health needs?

Responses detailing the criteria for prioritizing health needs were grouped by thematic area. The thematic areas include the following:

- Rates
- Criteria/Causes
- Trends
- Strategies

Question 15 - How do you see yourself or yourself using the results of this assessment?

Responses detailing the ways respondents will use the results of the assessment were grouped by thematic area. The thematic areas include:

- Change internal organizational practice
- Increase partnership / collaboration
- Community Focus & Accountability
- Addressing Disparities or service gaps
- Address Current Realities
- Strategic Planning / Prioritization
- To target funding opportunities
### Question 14 - What criteria would you like us to consider as we prioritize identified health needs?

<table>
<thead>
<tr>
<th>Sector</th>
<th>Rates</th>
<th>Criteria/Causes</th>
<th>Trends</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital / Clinics</strong></td>
<td>• Killer diseases and their precursors</td>
<td>• Greatest impact</td>
<td>• Need based - dental care, mental health, specialized care</td>
<td>• Targeted strategies</td>
</tr>
<tr>
<td></td>
<td>• Collect good data. Track immunizations. Screen for colon cancer.</td>
<td>• Environmental factors - contributing elements, home conditions, lifestyle, relationships with others</td>
<td>• Location and type of services offered</td>
<td>• Learn from successes</td>
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<td></td>
<td>• Data on obesity</td>
<td>• Income and access to care</td>
<td>• Number of uninsured</td>
<td>• Culture, diet, exercise patterns, attitudes toward health</td>
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<td></td>
<td>• Relative and attributive risk by population. Numbers and percentages.</td>
<td>• Frequency of occurrence</td>
<td>• Who’s ending in ER and why?</td>
<td>• Utilize aging trends data to be smartly proactive about future needs</td>
</tr>
<tr>
<td></td>
<td>• Breakdown by group. Look at overall impact and specific population</td>
<td>• Educational attainment and obesity rates</td>
<td>• Who’s costing the hospital the most and why? (x2)</td>
<td>• Low hanging fruit</td>
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<td></td>
<td>• Magnitude of impact (2)</td>
<td>• Gaps</td>
<td>• Who is affecting the health care system most?</td>
<td>• Increase access and support for community and providers</td>
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<td>• Prevalence</td>
<td>• Improve access and conditions for disenfranchised</td>
<td>• Data on ER admissions, DUI, etc.</td>
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<td>• Financial analysis—greatest impact</td>
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<td>• Population demographics – age, race, etc.</td>
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<td>• Access to health care for low income</td>
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<td><strong>Health Organizations</strong></td>
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<td>• Interventions with greatest impact (x2)</td>
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<td>• Collectively invest our resources</td>
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<td>• Focus our resources</td>
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<td>• Greatest Impact</td>
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<td></td>
<td>• Promotores-- invest in collective effort skills and training.</td>
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<td><strong>Community Based</strong></td>
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<td><strong>Organizations</strong></td>
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<td>Sector</td>
<td>Rates</td>
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<td>Trends</td>
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<tr>
<td>Government</td>
<td>• Greatest disparity – lower socioeconomic (1/2)</td>
<td>• Segment data to show distinctions among and between groups</td>
<td>• Who affects health care system most?</td>
<td>• Sustainability</td>
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<td></td>
<td>• Highest incidence</td>
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<td>• Communication strategy to support a culture of health</td>
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<td>• Seniors – compare assessments and census</td>
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<td>• Dementia</td>
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<td>• Populations at greatest risk-historically underserved</td>
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<tr>
<td>Business</td>
<td>• Marin data and aggregate with multi counties</td>
<td>• Most easily preventable diseases</td>
<td>• Who affects health care system most?</td>
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<td></td>
<td>• Mortality rates</td>
<td>• Greatest impact</td>
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<td></td>
<td>• Rates of hospital admission</td>
<td>• Identify gaps</td>
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<tr>
<td>Funding Organizations</td>
<td>• Poverty</td>
<td>• Low income</td>
<td>• Health equity to determine resource allocations</td>
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<td></td>
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<td>• What drives the cost of care down?</td>
<td>• Funding prevention efforts for those driving health care costs</td>
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<td>• Evidence based interventions or systemic strategies with a positive impact on health outcomes</td>
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<td>• Community input on the plan and activities in process</td>
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</tbody>
</table>
Question 15 - How do you see yourself or yourself using the results of this assessment?
The responses in blue represent HMP members

<table>
<thead>
<tr>
<th>Sectors</th>
<th>Change internal org practice</th>
<th>Increase partnership / collaboration</th>
<th>Community Focus &amp; Accountability</th>
<th>Addressing Disparities or service gaps</th>
<th>Address Current Realities</th>
<th>Strategic Planning / Prioritization</th>
<th>To target funding opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital / Clinic</td>
<td>• Change practices to alleviate gaps.</td>
<td>• Increase collaboration</td>
<td>• Community benefit accountability</td>
<td>• Identifying disease prevalence.</td>
<td>• Clearly identify the need for downstream focus</td>
<td>• Inform decisions about community benefit funding</td>
<td>• Facilitate access to funding</td>
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<td></td>
<td></td>
<td>• Coordinate dental services</td>
<td>• Data driven</td>
<td>• Understanding care system and how to route people to the proper site for care</td>
<td>• Support need for more focus on evidence based interventions</td>
<td>• Identify funding trends</td>
<td>• Fund collaborative impact work</td>
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<td>• Understanding safety net care needed to for working poor and the poor</td>
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<td>• Prioritize needs</td>
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<td>• Identifying the deficiencies in dental care</td>
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<td>• Identify and align with other’s priorities</td>
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<td>• Identify areas of greatest impact</td>
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<td>• Identify current efforts and leverage points</td>
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<td>• Identify barriers to access</td>
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<td>• Inform prioritization dialogue</td>
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<td>• Demographics - Are we meeting needs now and in the future?</td>
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<td>Health Org</td>
<td>• Make the case to fund care and specifically specialty care through community benefits funding, HHS, auto desk or the banks</td>
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<td>• Will help to decide funding priorities</td>
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<td></td>
<td>• Provides a framework emphasizing community / organizational capacity building, advocacy and support.</td>
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<tr>
<td>Sectors</td>
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<tr>
<td>Government</td>
<td>• Blend community policy issues and collaborate.</td>
<td>• Dovetail health efforts for seniors.</td>
<td>• Identify the point of contact.</td>
<td>• Creating need for Safety nets</td>
<td></td>
<td>• Inform planning efforts</td>
<td>• Guiding budget process and prioritizing investments</td>
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<td></td>
<td>• Collaborate or mobilize resources, work with the community</td>
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<td>• inform communicating health messages.</td>
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<td>• Helps understand county populations to inform our strategies.</td>
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<td>• Inform planning efforts and informing community needs.</td>
<td></td>
<td></td>
<td>• Strategic directions</td>
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<td></td>
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<td>• Inform strategic planning</td>
<td></td>
<td></td>
<td>• Facilitates integration with other community priorities</td>
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<tr>
<td>Funding Organizations</td>
<td>• Inform staff to guide work</td>
<td>• Adds value to HMP conversation</td>
<td>• Support program initiatives, policy agendas, existing programs and priorities</td>
<td></td>
<td></td>
<td>• Pool our resources to support a common framework for funding including the hospitals</td>
<td>• Influence grant making process</td>
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<td>• Support program initiatives, policy agendas, existing programs and priorities</td>
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<td>• Inform strategic planning</td>
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<td>• Pool our resources to support a common framework for funding including the hospitals</td>
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<tr>
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<td>• Will inform decisions</td>
<td>• Highlight connection between healthy economies and a healthy communities</td>
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<td>• Inform our public policy work</td>
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<tr>
<td></td>
<td>• Share with employers – address employee needs</td>
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<td>• Inform our public policy work</td>
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<td>• Inform our public policy work</td>
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<td>• Inform our public policy work</td>
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<tr>
<td>Community Based</td>
<td>• Drives data</td>
<td>• Inform the community</td>
<td>• Greatest use of resources</td>
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<td>• Inform our public policy work</td>
<td>• Helpful for funding</td>
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<tr>
<td>Organizations</td>
<td>• Evaluate indicators for alignment</td>
<td>• Can speak with more accuracy.</td>
<td>• Doing advocacy and outreach</td>
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<td></td>
<td>• Decision making</td>
<td>• Help make a case</td>
<td>• Long term planning and focus (x2)</td>
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<td>• Inform service delivery</td>
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<td>• Helps funders set guidelines or prioritize resources</td>
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Appendix
## HMP Interview Respondents

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<td>Others</td>
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<td>Government</td>
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