MILLS-PENINSULA MEDICAL CENTER

2019 Community Health Needs Assessment

Acknowledgments

HEALTHY COMMUNITY COLLABORATIVE (HCC) MEMBERS

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  Bindi Gandhi, MA, Manager, Community Health Manager, South Bay
  Kayla Gupta, MPH, Community Health Coordinator, South Bay
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1. Executive Summary

Mills-Peninsula Medical Center (MPMC) and its partners in the Healthy Community Collaborative (HCC) of San Mateo County are pleased to have produced the 2019 Community Health Needs Assessment (CHNA).

The HCC consists of representatives from nonprofit hospitals, the county's health department and human services agency, and other public entities. The collaborative was created in 1995 to identify and address the shared health needs of the community. Since its formation, the HCC has conducted nine community health needs assessments for San Mateo County. The 2019 CHNA builds upon the earlier assessments.

The goals of the 2019 CHNA are to provide insight into the health of the community, prioritize local health needs, and identify areas for improvement. With this information, HCC members will individually and collectively develop strategies to tackle critical health needs as well as improve the overall health and well-being of community members. The assessment findings may also be used as a guideline for funding, policy, and advocacy efforts. In addition, the Hospital Consortium of San Mateo County, which includes the leadership of local hospitals and the health department, will provide direction to the HCC to ensure alignment with countywide priority health initiatives.

This 2019 CHNA report documents how the current CHNA was conducted, describes the related findings, and shares the results of strategies implemented by MPMC to address the needs identified in 2016 by the previous assessment.

COMMUNITY HEALTH NEEDS ASSESSMENT BACKGROUND

In addition to helping generate shared priorities around community health, HCC members also use the 2019 CHNA to fulfill key state and federal mandates, as described below:

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

shall be updated at least once every three years.[1]

The Patient Protection and Affordable Care Act, enacted March 23, 2010, includes requirements for nonprofit hospitals that wish to maintain their tax-exempt status. Regulations finalized December 31, 2014, also provide guidance related to section 501(r) of the Internal Revenue Code. These regulations mandate that all nonprofit hospitals conduct a CHNA every three years. The CHNA must be conducted by the last day of a hospital's taxable year, and the hospital must make the CHNA report widely available to the public. The CHNA must also gather input from public health experts, local health departments, and community members—including representatives of low-income, medically underserved, or other high-need populations.[2]

The CHNA process, completed in fiscal year 2019 and described in this report, was conducted collaboratively by HCC members in compliance with current state and federal requirements. The 2019 CHNA will serve as the basis for implementation strategies to address identified health needs. This CHNA report and associated Implementation Strategy report will be adopted and made public by December 31, 2019. The hospital organization's 2019 Form 990, Schedule H, will be filed on or before the 15th day of the fifth month after the end of the 2019 taxable year.

PROCESS AND METHODS

To gather information for its local planning needs and to meet state and federal mandates, the HCC took the following approach to complete the 2019 CHNA.

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

To assess community health trends, the HCC directed its consultant, Actionable Insights (AI), to obtain secondary data from a variety of sources (*see Attachment 2: Secondary Data Sources for a complete list*). Primary data were obtained through direct community input: (a) key informant

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

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

interviews with local health experts, (b) focus groups with community leaders and representatives, and (c) focus groups with residents. These discussions sought to answer five primary questions:

- What are the most important/pressing health needs in San Mateo County?
- What drivers or barriers are impacting the top health needs?
- To what extent is health care access a need in the community?
- To what extent is mental health a need in the community?
- What policies or resources are needed to impact health needs?

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

In the fall of 2018, AI synthesized primary qualitative research and secondary and longitudinal data to create a list of health needs for the HCC. AI then filtered that list against a set of criteria to identify the significant needs of the community.

These criteria included:

1. Indicator meets the definition of a "health need." (*See Definitions box.*)
2. At least two data sources were consulted.
3. a. Three or more direct indicators show worsening trends.
   b. If not (a), two or more direct indicators fail the benchmark by 5 percent or more.
   c. If not (b), the issue was prioritized by at least one third of key informants and focus groups.

DEFINITIONS

Benchmark: The California state average or the Healthy People 2020 aspirational goal (when available), whichever is more stringent.

Data source: A statistical data set, such as those found throughout the California Cancer Registry, or a qualitative data set, such as the material resulting from the interviews and focus groups AI conducted for the HCC.

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

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

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

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

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

Health risk: A behavioral, social, environmental, economic, or clinical care factor that impacts health. May be a social determinant of health.

The CEO of Mills-Peninsula Medical Center (MPMC) invited senior leadership to review the list of identified community health needs and, based on their knowledge and experience working with the community, rank each need in order of importance. The rankings from each senior leader were averaged together to produce MPMC's final list of 2019 Prioritized Health Needs.

2019 PRIORITIZED HEALTH NEEDS

Based on the previously described process and methods, AI and MPMC produced a ranked list of the most pressing health needs for the hospital. The 2019 prioritized health needs, from highest to lowest, are:

- **Mental Health and Well-Being.** The community prioritized mental health and well-being, including substance use, in almost all focus groups and key informant interviews. Depression, poor mental health, binge drinking, deaths from drug overdose, and the adult substance use–related emergency-department visit rate have all recently increased in San Mateo County. Chronic liver disease and cirrhosis was the #9 cause of death in the county, followed by drug-induced death at #10. (*See the table "Top 10 Causes of Death" on page 10.*) Suicide ranked #11.[3]

- **Housing and Homelessness.** Housing is one of the chief concerns of the community and was prioritized by almost all focus groups and key informants. The median rent in San Mateo County is significantly higher than the state average and has been increasing. The proportion of county residents who recently have experienced housing instability has risen. Affordable housing (assisted housing units) is relatively scarce in the county compared with the state overall. The community described experiencing stress related to the high cost of housing.

- **Healthy Lifestyles.** The community prioritized healthy lifestyles. This health need involves concerns about diabetes, obesity, and fitness, diet, and nutrition. Diabetes ranks among the top 10 causes of death in San Mateo County. The prevalence of diabetes and obesity are both on the rise. County statistics for adult diabetes prevalence and youth fruit/vegetable consumption are significantly worse than state averages. Adults of low socioeconomic status fail state benchmarks for overweight/obesity.

- **Health Care Access and Delivery.** Community input suggests that health care is often unaffordable in San Mateo County. There are downward trends in the proportion of children who have a usual place for medical check-ups, the proportion of employed county residents whose jobs offer health benefits, and residents' perceptions of the ease of access to specialty care. Residents of low socioeconomic status are more likely than higher-status groups to have health care access issues.

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[3] County of San Mateo. (2017). Health Status Profile.

- **Cancer.** Cancer is the leading cause of death in San Mateo County. Overall cancer prevalence and the incidence rates for melanoma and breast, uterine, and prostate cancers are significantly higher than state benchmarks. Certain ethnic groups in the county experience disparities, including African Ancestry and Latinx populations.[4, 5]

- **Communicable Diseases.** The rates of acute hepatitis B and pertussis cases in San Mateo County are significantly higher than state benchmarks, and the rate of tuberculosis cases is greater (worse) than the Healthy People 2020 aspirational goal. Influenza/pneumonia is one of the top 10 causes of death in the county.[6]

- **Oral/Dental Health.** The community prioritized oral health, citing a lack of access to high-quality dental services and/or dental insurance in San Mateo County. The proportion of county residents without insurance that pays for some or all routine dental care has been rising. Low reimbursement rates and complicated billing procedures may have driven many providers away from accepting Denti-Cal, which seems to have contributed to significant income disparities in oral health.

- **Food Insecurity**. The county's population has been experiencing food insecurity at an increasing rate, which is already significantly higher than the state benchmark. The proportion of individuals receiving SNAP benefits,[7] as well as the percentage receiving free meals and/or supplies from food banks, has also been rising.

- **Asthma/Respiratory Conditions.** Asthma prevalence in San Mateo County is significantly worse than benchmarks and increasing. Conditions correlated with higher rates of asthma (e.g., overweight/obesity and smoking) are significantly higher among people of low socioeconomic status. COPD, bronchitis, and emphysema rates are twice as high as the state average and rising. Chronic lower respiratory disease and influenza/ pneumonia are both among the top 10 causes of death in the county.

- **Neighborhood and Built Environment.** This need includes access to food and recreation, community and family safety, community infrastructure and housing quality, natural environment/climate, and transportation and traffic. Proportions of healthy food stores and WIC-authorized[8] food stores, drinking water violations, as well as statistics for public transit access, road network density, and flood vulnerability in San Mateo

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[4] In keeping with the *Status of African/African Ancestry Health* report, published in partnership with the Black Leadership Kitchen Cabinet of Silicon Valley, the term "African Ancestry" refers to all people of African descent. The sources from which ethnicity data are provided may use the terms "Black" and/or "African-American" in their surveys and studies.
[5] The term Latinx is employed as a gender-neutral and inclusive way to refer to people of Latin American or Hispanic descent.
[6] This health need tied in ranking with one that precedes it on the list. *See Section 6: Identification and Prioritization of Community Health Needs for additional details.*
[7] The Supplemental Nutrition Assistance Program (SNAP), formerly known as food stamps, provides federal assistance to eligible low-income individuals and families.
[8] The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) is a federally funded health and nutrition program. https://www.cdph.ca.gov/Programs/CFH/DWICSN/Pages/Program-Landing1.aspx

County are all significantly worse than state averages. Ethnic and income disparities are evident in almost all aspects of this health need.[9]

Further details on each prioritized health need, including statistical data and citations, are included in the complete 2019 CHNA report. For reference, the table below lists the leading causes of death in San Mateo County in 2017 alongside state rates and national objectives.

Top 10 Causes of Death, San Mateo County

Rank	Cause	San Mateo County Rate	California Rate	National Objective
1	All cancers	124.6	143.8	161.4
2	Coronary heart disease	59.6	93.2	103.4
3	Alzheimer's disease	29.9	32.1	*
4	Stroke	25.8	34.7	34.8
5	Chronic lower respiratory disease	21.2	33.3	*
6	Accidents (unintentional injuries)	20.8	29.1	36.4
7	Flu and pneumonia	12.9	15.2	*
8	Diabetes	12.9	20.6	**
9	Chronic liver disease and cirrhosis	8.5	12.1	8.2
10	Drug-induced deaths	7.9	11.8	11.3

Age-adjusted rates per 100,000 people.
** Indicates no Healthy People 2020 National Objective has been established yet.*
*** National Objective is based on both underlying and contributing causes of death, which requires use of multiple cause of death files. California's data exclude multiple/contributing causes of death.*
Source: County of San Mateo, Health Status Profile, 2017.

NEXT STEPS

After making this CHNA report publicly available by December 31, 2019, MPMC will solicit feedback and comments about the report until two subsequent CHNA reports are posted. The hospital will also develop an implementation plan based on the 2019 CHNA results; the plan must be adopted by the Sutter Health board and made public by May 15, 2020.

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[9] This health need tied in ranking with one that precedes it on the list. *See Section 6: Identification and Prioritization of Community Health Needs for additional details.*

2. Introduction/Background

The members of the Healthy Community Collaborative (HCC) of San Mateo County are pleased to have produced the 2019 Community Health Needs Assessment (CHNA).

The HCC consists of representatives from nonprofit hospitals, County Health Department and Human Services, and public agencies. The collaborative was created in 1995 to identify and address the shared health needs of the community. Since its formation, the HCC has conducted nine community health needs assessments for San Mateo County.

CHNA PURPOSE

The goals of the 2019 CHNA are to provide insight into the health of the community, prioritize local health needs, and identify areas for improvement. With this information, HCC members will individually and collectively develop strategies to tackle critical health needs as well as improve the health and well-being of community members. The assessment findings may also be used as a guideline for funding, policy, and advocacy efforts. In addition, the Hospital Consortium of San Mateo County, which includes the leadership of local hospitals and health department, will provide direction to the HCC to ensure alignment with countywide priority health initiatives.

The 2019 CHNA builds upon the findings of the 2016 CHNA (*see Section 8: Evaluation Findings from 2016–2018 Implemented Strategies*) and previous assessments (1995, 1998, 2001, 2004, 2008, 2011, and 2013). The 2019 report documents how the current CHNA was conducted and describes the related findings. As with prior CHNAs, this assessment also highlights San Mateo County's assets and resources (*see Section 7: Community Resources*).

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

In addition to helping generate shared priorities around community health, HCC members also use the 2019 CHNA to fulfill key state and federal mandates.

SB 697 AND CALIFORNIA'S HISTORY OF ASSESSMENTS

California Legislative Senate Bill 697, enacted in 1994, stipulates that private nonprofit hospitals submit an annual report to the Office of Statewide Health Planning and Development that shall include, but shall not be limited to, a description of the activities that the hospital has undertaken to address identified community needs within its mission and financial capacity. Additionally, the hospital shall describe the process by which they involved the community (community groups and local government officials) in helping identify and prioritize community needs to be addressed. This community needs assessment shall be updated at least once every three years.[10]

PATIENT PROTECTION AND AFFORDABLE CARE ACT

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

The CHNA report must document how the assessment was conducted, including the community served, who was involved in the assessment, the process and methods used, and the significant community health needs that were identified and prioritized as a result of the assessment. The CHNA must also gather input from public health experts, local health departments, and community members—including representatives of low-income, medically underserved, or other high-need populations.[11]

The CHNA process, completed in fiscal year 2019 and described in this report, was conducted collaboratively by HCC members in compliance with current state and federal requirements. The 2019 CHNA will serve as the basis for implementation strategies to serve identified health needs. This CHNA report and associated Implementation Strategy report will be adopted and made public by December 31, 2019. The hospital organization's 2019 Form 990, Schedule H, will be filed on or before the 15th day of the fifth month after the end of the 2019 taxable year.

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

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

SUMMARY OF THE 2016 CHNA

In 2016, Mills-Peninsula Medical Center participated in a collaborative process to identify significant community health needs and to meet IRS and SB 697 requirements. During that CHNA process, 21 needs were identified. MPMC addressed the top three in its 2016–2018 implementation strategies:

- Health Care Access and Delivery
- Oral/Dental Health
- Emotional Well-Being

The full 2016 CHNA report is posted on Sutter Health's website.[12]

For the 2019 CHNA, the HCC built upon existing work by starting with a list of health needs identified during the 2016 CHNA. Updated secondary data were collected for these health needs. Community input added health needs to the list and prompted the HCC to delve deeper into questions about health care access, delivery, barriers to care, and solutions. The CHNA team also specifically sought to understand mental health needs in the community due to the strong interest in this topic expressed by community leaders.

WRITTEN PUBLIC COMMENTS ON THE 2016 CHNA

To offer the public a means to review and provide written feedback on the 2016 CHNA, Sutter Health posted a PDF of the Mills-Peninsula Medical Center report and solicited comments on the Community Health Needs Assessment page of its website.[13] Sutter Health also accepts input at the email address SHCB@sutterhealth.org. The website and email address will allow for written public comments on the 2019 CHNA as well.

At the time the 2019 CHNA report was completed, Sutter Health had not received any written comments about the 2016 CHNA report. Sutter Health will continue to track submissions and ensure that all relevant comments are reviewed and addressed by appropriate staff.

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[12] https://www.sutterhealth.org/pdf/for-patients/chna/mpsh-2016-chna.pdf
[13] https://www.sutterhealth.org/for-patients/community-health-needs-assessment

3. About Mills-Peninsula Medical Center

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

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

Over the past five years, Sutter Health has committed nearly $3.7 billion to care for patients who couldn't afford to pay, and to support programs that improve community health. Our 2018 commitment of $734 million includes unreimbursed costs of providing care to Medi-Cal patients, traditional charity care, and investments in health education and public benefit programs. For example: In 2018, Sutter Health invested $435 million more than the state paid to care for Medi-Cal patients. Medi-Cal accounted for 19 percent of Sutter Health's gross patient service revenues in 2018. Sutter Health proudly serves more Medi-Cal patients in its Northern California service area than any other health care provider.

As the number of insured people grows, hospitals across the U.S. continue to experience a decline in the provision of charity care. In 2018, Sutter Health's investment in charity care was $89 million.

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

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

More information about Mills-Peninsula Medical Center[14] and the Menlo Park Surgical Hospital campus[15] is available on the Sutter Health website.

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

COMMUNITY BENEFITS

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

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

COMMUNITY SERVED

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

SAN MATEO COUNTY

In 2017, an estimated 771,410 people resided in San Mateo County, making it the 14th largest in California by population. The county occupies 455 square miles of land on the peninsula south of San Francisco, with the San Francisco Bay to the east and the Pacific Ocean to the west. The county also includes nearly 58 miles of coastline and 292 square miles of water.[16]

Redwood City is the largest city in the county by area, and Daly City is the largest city in the county by population (with over 107,000 residents, or 14 percent of the county's total). The county's main regions, cities, and towns are identified in the following table.[17]

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[16] County of San Mateo. *2015–2017 County Profile*.
[17] San Mateo County Economic Development Association. (2018). *San Mateo County Cities and Chambers*.

MAIN REGIONS, CITIES, AND TOWNS IN SAN MATEO COUNTY

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

San Mateo County also includes the following unincorporated towns and areas, many of which are located in the Coastside area: Broadmoor, Burlingame Hills, Devonshire, El Granada, Emerald Lake Hills, Fair Oaks, Highlands/Baywood Park, Ladera, La Honda, Loma Mar, Los Trancos Woods/Vista Verde, Menlo Oaks, Montara, Moss Beach, North Fair Oaks, Palomar Park, Pescadero, Princeton, San Francisco International Airport, San Gregorio, South Coast/Skyline, Sequoia Tract, Skylonda, Stanford Lands, and West Menlo Park.[18]

(*See map on the next page*.)

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

Map of San Mateo County

Nearly 22 percent of the population in San Mateo County is under the age of 18, and 15 percent is 65 years or older. The median age is 39.5 years old. San Mateo County is also highly diverse. Notably, residents of "some other race" (i.e., one not specifically called out in data sets) are the third largest racial group, accounting for 11 percent of the population. More than half (58 percent) of the population is White, and nearly one third is Asian (30 percent). One quarter (25 percent) of residents have Latinx heritage. More than one third (37 percent) of San Mateo County residents are foreign-born.[19]

Approximately 9 percent of the county's population lives in a linguistically isolated household,[20] marked by wide geographic differences. For example, less than 1 percent of the population in parts of Woodside lives in a linguistically isolated household, compared with more than 50 percent in parts of Daly City, South San Francisco, and Redwood City/North Fair Oaks.

RACE/ETHNICITY, SAN MATEO COUNTY

Race/Ethnicity	Total % of County*
White	57.8
Asian	30.1
Latinx (of Any Race)	25.1
Some Other Race	11.3
Multiracial	5.0
African Ancestry	3.4
Native Hawaiian/Pacific Islander	2.0
American Indian/Alaskan Native	1.0

** Percentages do not add up to 100 percent because people may identify as more than one race/ethnicity. Source: U.S. Census Bureau. American Community Survey, 5-Year Estimates, 2012–2016.*

Two key social determinants, income and education, have a significant impact on health outcomes. San Mateo County has one of the highest annual median incomes in the country and one of the highest costs of living. As displayed in the following chart, about half of the population live in households with incomes of $100,000 or more, about one-fourth in households with incomes between $50,000 and $100,000, and another fourth below $50,000.

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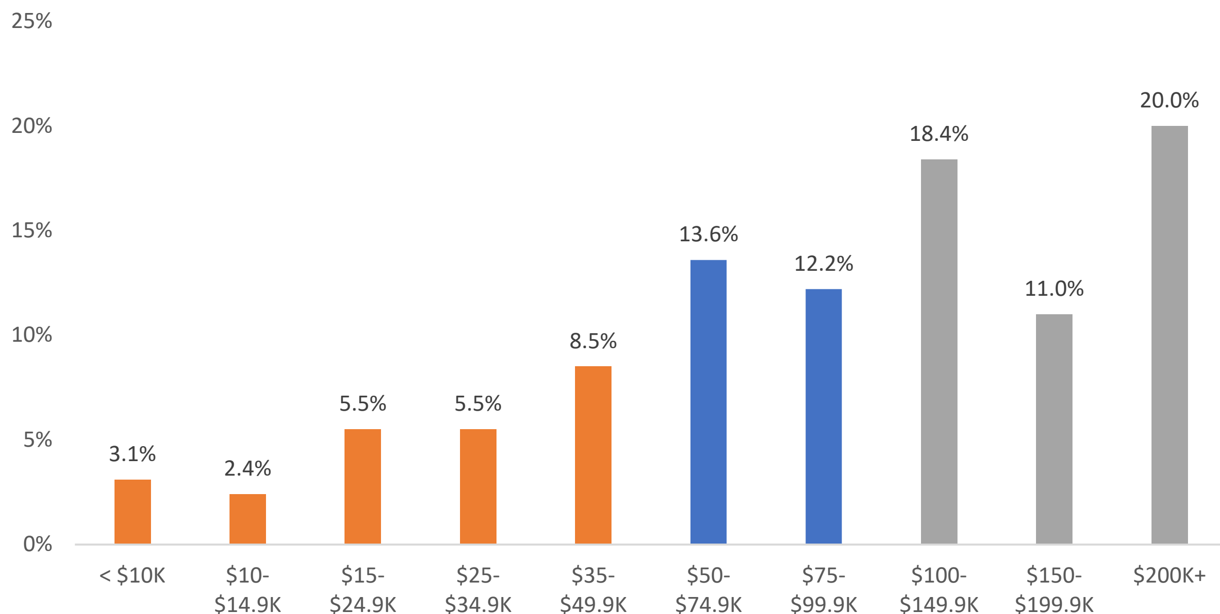
[19] U.S. Census Bureau. American Community Survey, 5-Year Estimates. (2012–2016).
[20] Defined as a household where no one aged 14 years or older speaks English "very well." U.S. Census Bureau. American Community Survey, 5-Year Estimates. (2012–2016).

By comparison, the 2018 Self-Sufficiency Standard for a two-adult family with two school-aged children in San Mateo County was $111,191.[21]

Housing costs are high: The 2018 median home price is $1.4 million, and the median rent is $4,150 per month in San Mateo County.[22] Despite the fact that half of households in the county earn more than $100,000 per year, nearly one in five (19.8 percent) county residents lives below 200 percent of the Federal Poverty Level ($23,760 for an individual, $32,040 for two adults, and $48,600 for a family of four). In addition, almost one third of the children in San Mateo County are eligible for free or reduced-price lunch (32.9 percent).[23] Approximately one in every 14 people (7.2 percent) in the community is uninsured.[24]

Households by Income Range, San Mateo County



Source: U.S. Census Bureau. American Community Survey, 5-Year Estimates, 2012–2016. Table S1901.

For 20 years, the U.S. Health Resources and Services Administration has used the Area Deprivation Index (ADI) to measure the lack of basic necessities in communities. The current ADI combines 17 indicators of income, education, employment, and housing quality. The ADI

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[21] The Insight Center for Community Economic Development. *Family Needs Calculator.* (2018). Retrieved May 2019 from https://insightcced.org/2018-family-needs-calculator/

[22] Zillow, data through October 31, 2018. https://www.zillow.com/san-mateo-county-ca/home-values/

[23] National Center for Education Statistics, NCES-Common Core of Data. (2015–2016).

[24] U.S. Census Bureau. American Community Survey, 5-Year Estimates. (2012–2016).

and percentile scores are calculated for San Mateo County using Census Block Group[25] level data (BroadStreet 2018). In general, the greater the percentile number, the worse the area is doing. Exceptions to that rule are median gross rent and median monthly home cost, where lower percentiles indicate higher rent and housing costs. Area percentiles and indicator values that are worse than California are indicated in **bold red**.

AREA DEPRIVATION INDEX, SAN MATEO COUNTY

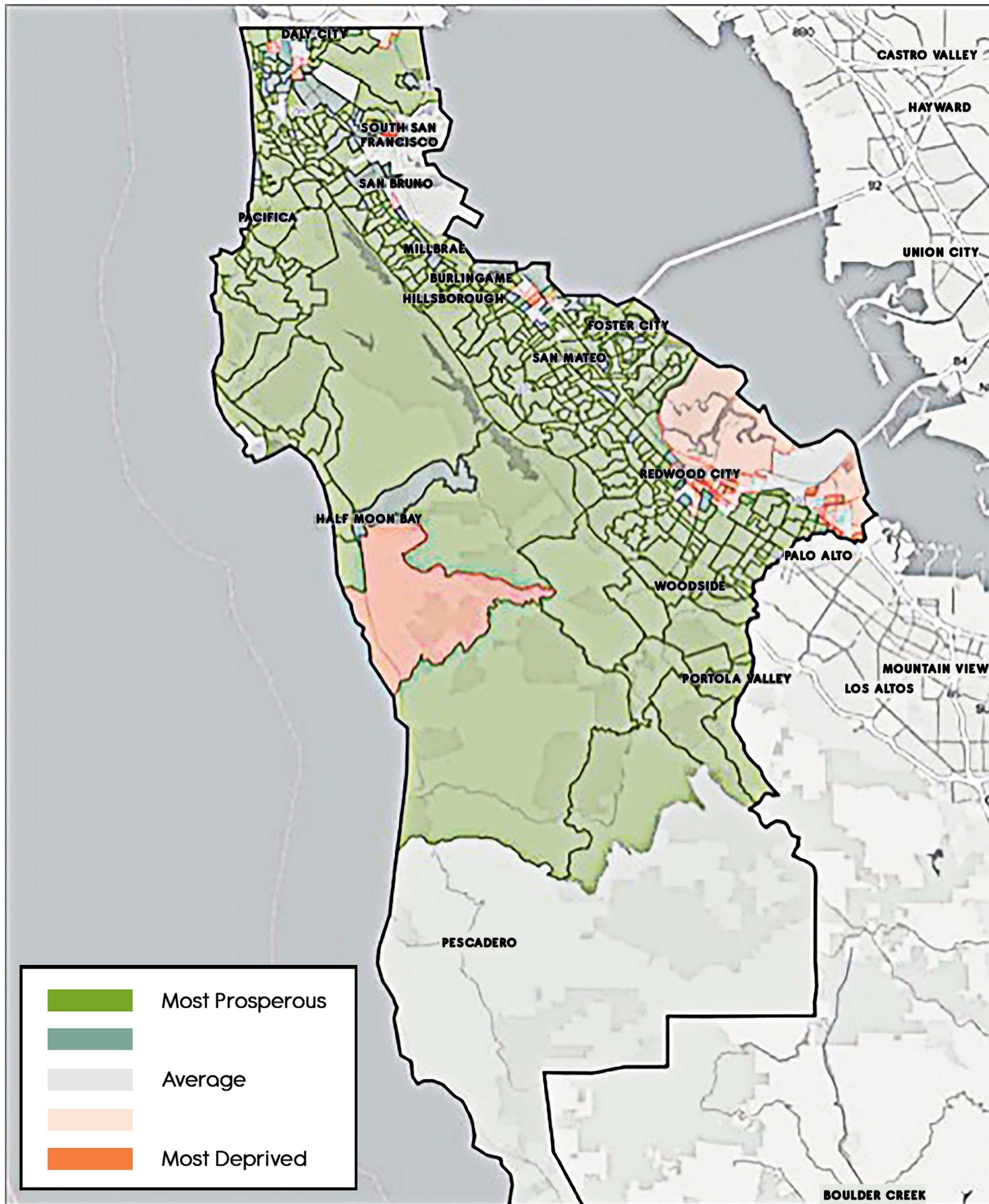
Indicator Name	County Percentile	County Value	CA State Percentile	CA State Value
Area Deprivation Index	**12**	**78.2**	**49**	**98.1**
Families below poverty level	40	4.6%	64	11.9%
High school diploma/GED, adults ≥ age 25	55	88.6%	74	81.9%
Owner-occupied housing units	62	59.1%	68	54.1%
Households without a motor vehicle	53	5.3%	62	7.5%
Crowded households (>1 person per room)	88	7.5%	89	8.3%
Households without complete plumbing	**53**	0.4%	52	0.4%
Households without a telephone	53	1.7%	59	2.2%
Income disparity (log scale)	21	1.4	36	2.2
Median family income	9	$114,857	32	$74,913
Median gross rent	**6**	**$1,830**	17	$1,313
Median home value	2	$845,300	11	$441,468
Median monthly home cost	**6**	**$2,462**	20	$1,768
Population below 150% of poverty threshold	32	13.3%	59	25.9%
Single parent households with children < age 18	46	16.8%	67	23.8%
Less than high school education, adults ≥ age 25	74	6.6%	84	10.0%
Unemployment, ≥ age 16	45	5.6%	68	8.9%
Employed in white collar occupations, ≥ age 16	29	68.3%	47	60.5%

Percentages of total population. Source: American Community Survey 5-Year estimates, 2013–2017.

[25] A Census Block Group is smaller than a Census Tract, but larger than a Census Block. In urban areas, a Census Block is generally equivalent to a city block, but in suburban and rural areas may be defined by the Census in other ways. A Census Block Group encompasses multiple, usually contiguous, Census Blocks. (U.S. Census Bureau. [2018]. *Geography Program Glossary.*)

The map below shows the ADI score by Census Block Group. Colors are used to differentiate block groups that are more prosperous from those that are more deprived. The most prosperous areas are **green**, and the most deprived areas are **dark orange**. Colors for the block groups are based on the percentile range into which the block group falls.

Area Deprivation Index Map, San Mateo County



Source: Community Commons, using U.S. Census Bureau, American Community Survey data (2013–2017) and Census Block Group level data (BroadStreet 2018).

4. Assessment Team

HOSPITALS AND OTHER PARTNER ORGANIZATIONS

The following health systems and organizations collaborated to prepare the 2019 CHNA:

- County of San Mateo Human Services Agency
- Dignity Health Sequoia Hospital
- Kaiser Permanente, San Mateo Area (Redwood City and South San Francisco Kaiser Foundation Hospitals)
- Lucile Packard Children's Hospital Stanford
- Peninsula Health Care District
- San Mateo County Health
- Stanford Health Care
- Sutter Health (Mills-Peninsula Medical Center and Menlo Park Surgical Hospital)
- Verity Health System (Seton Medical Center and Seton Coastside)

IDENTITY AND QUALIFICATIONS OF CONSULTANTS

Actionable Insights (AI), LLC, an independent, local research firm, completed the CHNA. For this assessment, AI assisted with CHNA planning, conducted primary research, collected secondary data, synthesized primary and secondary data, facilitated the processes of identification and prioritization of community health needs and assets, and documented the processes and findings into a report. The project managers for this assessment were Jennifer van Stelle, PhD, and Melanie Espino, the co-founders and principals of Actionable Insights. AI has conducted community health needs assessments for more than 25 hospitals during the 2019 CHNA cycle.

5. Process and Methods

The Healthy Community Collaborative (HCC) of San Mateo County members worked together to fulfill the primary and secondary data requirements of the CHNA. The CHNA data collection process took place over 11 months and culminated in this report. The phases of the process are depicted below.

The HCC contracted with Actionable Insights (AI) to review secondary statistical and survey data from San Mateo County Health, as well as to collect secondary quantitative (statistical) data from other sources and primary qualitative data through key informant interviews and focus groups.

SECONDARY DATA COLLECTION

AI analyzed over 400 quantitative health indicators to assist the HCC with understanding the health needs in San Mateo County and assessing priorities in the community. AI collected data from existing sources using the Community Commons data platform,[26] the CHNA.org data platform, and other online sources, such as the California Department of Public Health and the U.S. Census Bureau.

In addition, AI collected quantitative and qualitative secondary data from multiple San Mateo County sources, including:

- County of San Mateo Adolescent Report 2014–2015
- Get Healthy San Mateo County, End Hunger Workgroup 2016
- San Mateo County Health, Behavioral Health and Recovery Services Survey 2016

San Mateo County Health provided AI with data from its systems, including data on infectious diseases, chronic diseases, births and deaths, and emergency department visits. San Mateo County Health also supplied AI with data from its 2018 Health and Quality of Life Survey (*see box on next page*), as well as associated state and national benchmarks from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System and other sources.

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[26] Powered by University of Missouri's Center for Applied Research and Environmental System (CARES) system, www.communitycommons.org

As a further framework for the assessment, the HCC asked AI to address these questions in its analysis:

- How do these indicators perform against accepted benchmarks (Healthy People 2020 objectives and statewide averages)?
- Are there disparate outcomes and conditions for people in the community?

Healthy People is an endeavor of the U.S. Department of Health and Human Services that has provided 10-year national objectives for improving the health of Americans based on scientific data spanning 30 years. Healthy People sets national objectives or targets for improvement. The most recent set of objectives are for the year 2020. Year 2030 objectives are currently under development.[27]

INFORMATION GAPS AND LIMITATIONS

A lack of secondary data limited AI and the HCC in their ability to fully assess some of the identified community health needs. These limitations included:

- Adequacy of community infrastructure (sewerage, electrical grid, etc.)
- Adult use of illegal drugs and misuse/abuse of prescription medications (e.g., opioids)
- Alzheimer's disease and dementia diagnoses
- Diabetes among children
- Experiences of discrimination among vulnerable populations
- Health of undocumented immigrants (who do not qualify for subsidized health insurance and may be underrepresented in survey data)
- Hepatitis C
- Mental health disorders
- Oral/dental health
- Suicide among LGBTQI youth

SAN MATEO COUNTY HEALTH AND QUALITY OF LIFE SURVEY

The 2018 San Mateo County Health and Quality of Life Survey was conducted among 1,581 adults through a countywide random sample, with additional oversampling on the Coastside, among low-income residents, and among African Ancestry and Pacific Islander communities to augment samples and enhance reliability of the data. A multimodal approach was used to capture responses, with 47.8 percent of surveys being conducted via landline telephones, 23.4 percent via cell phones, and 28.7 percent online. The 2018 San Mateo County Health and Quality of Life Survey addressed a variety of issues, including health risk behaviors, prevention services, and quality of life indicators, using many questions from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System. Many questions in this survey were administered in the 1998, 2001, 2004, 2008, and/or 2013 community assessments, allowing for trending of these indicators.

[27] U.S. Department of Health and Human Services. Healthy People 2020. http://www.healthypeople.gov

COMMUNITY INPUT

Actionable Insights conducted primary research for this assessment. AI used three strategies for collecting community input: key informant interviews with health and community-service experts, and focus groups with professionals, and focus groups with residents.

Primary research protocols were generated by AI in collaboration with the HCC, based on facilitated discussion among the HCC members about what they wished to learn during the 2019 CHNA. The HCC sought to build upon prior CHNAs by focusing the primary research on the community's perception of mental health (identified as a major health need in the 2016 CHNA) and their experience with health care access and delivery (also identified as a major health need in 2016). Relatively little timely quantitative data exists on these subjects.

AI recorded each interview and focus group as a standalone piece of data. Recordings were transcribed, then the team used qualitative research software tools to analyze the transcripts for common themes. AI also tabulated how many times health needs had been prioritized by each of the focus groups or described as a priority in a key informant interview. The HCC used this tabulation to help assess community health priorities.

Across the key informant interviews and focus groups, AI solicited input from more than 60 community leaders and representatives of various organizations and sectors. These representatives either work in the health field or in a community-based organization that focuses on improving health and quality of life conditions by serving those from IRS-identified high-need target populations.[28] In the list below, the number in parentheses indicates the number of participants from each sector.

- San Mateo County Health (3)
- Other San Mateo County employees (from Behavioral Health and Recovery Services, Human Services Agency, Office of Education, etc.) (10)
- Other public employees (from cities, school districts, etc.) (5)
- Other hospitals, clinics, and health care systems (6)
- Mental health, substance use, and violence prevention providers (4)
- Other nonprofit community-based organizations (33), including those serving children, youth, seniors, parents, ethnic minorities, and other vulnerable populations, such as immigrants, those experiencing homelessness, those experiencing food insecurity, and those suffering from dementia, mental health, and substance use disorders
- Community groups, including collaboratives and coalitions (1)
- Faith-based (1)
- Business sector (1)

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

See Attachment 1: Community Leaders, Representatives, and Members Consulted for the names, titles, and expertise of these leaders and representatives along with the date and mode of consultation (focus group or key informant interview). See Attachment 6: Qualitative Research Protocols for protocols and questions.

KEY INFORMANT INTERVIEWS

Between April and June 2018, AI conducted primary research via key informant interviews with 19 San Mateo County experts from various organizations. These experts included the deputy chief of the county health system, community clinic managers, and clinicians. Interviews were conducted in person or by telephone for approximately one hour. AI asked informants:

- What are the most important/pressing health needs in San Mateo County?
- What drivers or barriers are impacting the top health needs?
- To what extent is health care access a need in the community?
- To what extent is mental health a need in the community?
- What policies or resources are needed to impact health needs?

FOCUS GROUPS

Professionals and Community Leaders

Four focus groups were conducted with a total of 45 professionals and community leaders from April to May 2018. The questions were the same as those used with key informants.

Details of Focus Groups With Professionals

Topic	Focus Group Host/Partner	Date	Number of Participants
Social determinants of health	San Mateo County Human Services Agency	4/27/18	18
Community and family safety	Before Our Very Eyes/Bay Area Anti-Trafficking Coalition	5/8/18	9
Older adults	Sequoia Wellness Center	5/10/18	11
Homeless population	LifeMoves	5/24/18	7

Residents

AI conducted five resident focus groups with a total of 45 residents between April and June 2018. The discussions centered on the same five questions as the key informants, which AI modified appropriately for each audience.

Nonprofit hosts, such as the Peninsula Conflict Resolution Center, recruited participants for the groups. To provide a voice to the community it serves in San Mateo County, and in alignment with IRS regulations, the focus groups targeted residents who are medically underserved, low-income, or of a minority population.

DETAILS OF FOCUS GROUPS WITH RESIDENTS

Topic	Focus Group Host/Partner	Date	Number of Participants
Older adults	The Villages of San Mateo County	4/18/18	8
Young adults	Cañada College	5/9/18	5
Spanish-speaking older adults	Peninsula Family Services Agency, North Fair Oaks Senior Center	5/16/18	12
LGBTQI issues	Pride Center	5/17/18	10
Pacific Islanders	Peninsula Conflict Resolution Center	6/12/18	10

2019 Resident Participant Demographics

A total of 45 community members participated in the focus group discussions across San Mateo County. AI asked all participants to complete an anonymous demographic survey. The results:

- 41 percent of respondents were Latinx, 25 percent were White, 18 percent were Pacific Islander, 5 percent were Asian, 5 percent were African Ancestry, and the rest were of multiple ethnicities.
- 20 percent of respondents were age 25 or younger, and 50 percent were age 65 or older.
- 73 percent were female, 22 percent were male, and 5 percent were gender-nonconforming.
- 68 percent reported having an annual household income of less than $49,000 per year, which is below the 2018 California Self-Sufficiency Standard[29] for San Mateo County for two adults with no children ($67,243). Half were low-income (i.e., Medi-Cal eligible[30] or earning less than $25,000). This demonstrates a high level of need among participants in an area where the cost of living is extremely high compared with other areas of California.

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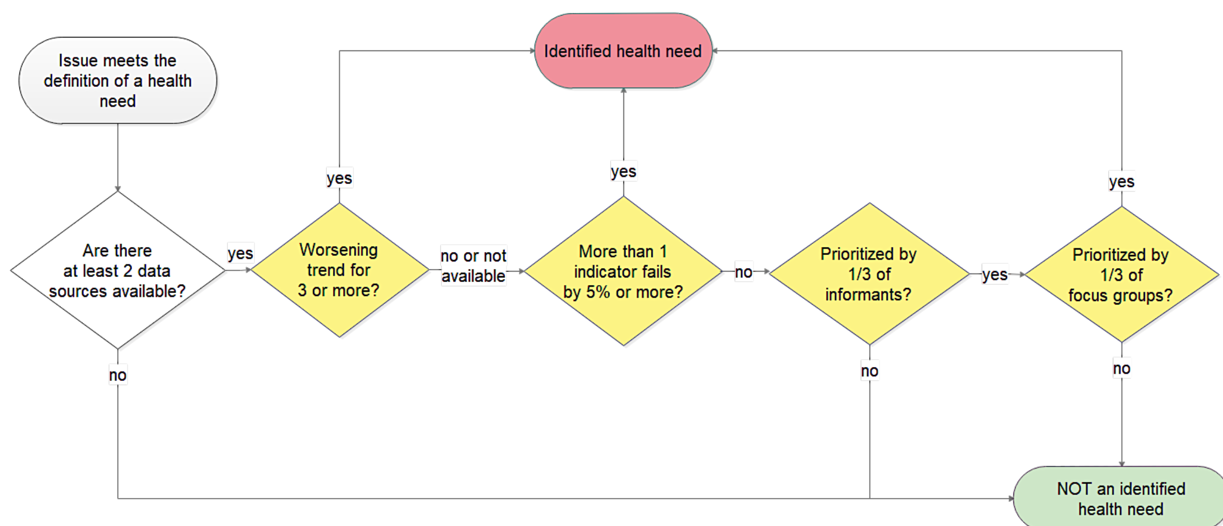
[29] The Insight Center for Community Economic Development. *Family Needs Calculator.* (2018). Retrieved May 2019 from https://insightcced.org/2018-family-needs-calculator/

[30] Earned below 138 percent of the Federal Poverty Level ($16,753 for an individual, $22,108 for two adults, $34,638 for a family of four). California Department of Health Services. Medi-Cal Eligibility. (2018). Retrieved from https://www.dhcs.ca.gov/services/medi-cal/Pages/DoYouQualifyForMedi-Cal.aspx

6. Identification and Prioritization of Community Health Needs

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



CRITERIA

1. **Indicator meets the definition of a "health need."**
2. **At least two data sources were consulted.**
3. **a. Three or more direct indicators show worsening trends.**

   b. If not (a), two or more direct indicators fail the benchmark by 5 percent or more.

   c. If not (b), prioritized by at least one third of key informants and focus groups.

Actionable Insights (AI) analyzed secondary data, including the 2018 San Mateo County Health and Quality of Life Survey, and qualitative data from focus groups and key informant interviews on a variety of health and health-related issues. In the fall of 2018, AI then synthesized the data for each issue and applied the criteria described on the previous page to evaluate whether it qualified as a significant community health need.

This process led to the identification of 10 community health needs that fit all three criteria. The list of needs, in priority order, appears on the next page, followed by summarized descriptions.

(*For further details about each of these health needs, including statistical data, see Attachment 4: Secondary Data Tables.*)

PRIORITIZATION OF HEALTH NEEDS

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

HOSPITAL PRIORITIZATION PROCESS AND RESULTS

The CEO of MPMC invited senior leadership to review the health needs list provided by AI. They ranked each item on the list in order of importance based on their knowledge and experience working with the community. The individual rankings from

DEFINITIONS

Benchmark: The California state average or the Healthy People 2020 aspirational goal (when available), whichever is more stringent.

Data source: A statistical data set, such as those found throughout the California Cancer Registry, or a qualitative data set, such as the material resulting from the interviews and focus groups AI conducted for the HCC.

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

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

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

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

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

Health risk: A behavioral, social, environmental, economic, or clinical care factor that impacts health. May be a social determinant of health.

each senior leadership member were averaged together to produce the final ranked list of 2019 Prioritized Health Needs.

Based on the criteria described above, MPMC prioritized the following 10 health needs, which are listed in priority order, from highest to lowest. Needs marked with an asterisk (*) tied in ranking and appear in alphabetical order next to their equal. Summary descriptions of each health need appear below and on subsequent pages.

1. **Mental Health and Well-Being**
2. **Housing and Homelessness**
3. **Healthy Lifestyles**
4. **Health Care Access and Delivery**
5. **Cancer***
6. **Communicable Diseases***
7. **Oral/Dental Health**
8. **Food Insecurity**
9. **Asthma/Respiratory Conditions***
10. **Neighborhood and Built Environment***

SUMMARY DESCRIPTIONS OF 2019 PRIORITIZED COMMUNITY HEALTH NEEDS

MENTAL HEALTH AND WELL-BEING

Mental health (a need that includes emotional well-being and substance use) is one of the strongest priorities of the community consulted. The community prioritized it as a top health need for San Mateo County in almost all focus groups and key informant interviews. Depression, poor mental health, binge drinking, deaths from drug overdose, and the adult substance use-related emergency-department visit rate have all been increasing in the county. The proportions of county residents who currently drink alcohol or have used marijuana/hashish recently are significantly higher than benchmarks. Chronic liver disease and cirrhosis is the #9 cause of

death in the county, followed by drug-induced death at #10; both are higher than suicide at #11.[31]

Mental Health and Emotional Well-Being

What Is the Issue?

While there is no single definition, researchers agree that well-being entails having positive emotions or moods, not feeling overwhelmed by negative emotions, and experiencing life satisfaction, fulfillment, and "positive function." Well-being looks beyond happiness to include a person's ability to:

- View the past, present, and future in a positive way.
- Have positive relationships with parents, siblings, life partners, and peers who can provide support in difficult times.
- Find and engage in activities in the present moment.
- Understand and feel the greater impact of personal actions and activities.
- Have goals, ambitions, and achievements that provide a sense of satisfaction, pride, and fulfillment.[32]

Mental health—emotional and psychological well-being, and the ability to cope with normal, daily life—is key to personal wellness, healthy relationships, and the ability to function in society.[33] Mental health and good physical health are closely related. Common mental health disorders such as depression and anxiety can affect people's ability to care for themselves, and chronic diseases can lead to negative impacts on mental health.[34] Mental health issues affect a large number of Americans: The Mayo Clinic estimates that in 2015 roughly 20 percent of U.S. adults were coping with a mental illness.[35]

Why Is It a Health Need?

Although neither is worse than benchmarks, depression and poor mental health have been increasing among residents of San Mateo County. However, depression is significantly higher than the state average among Latinx and African Ancestry residents, as well as people who live on the Coastside. County residents of low socioeconomic status experience depression more often than residents of higher socioeconomic status. Results from the county's 2018 Health and Quality of Life survey suggest that various mental health and well-being indicators are

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[31] County of San Mateo. (2017). Health Status Profile.
[32] Centers for Disease Control and Prevention. (2016). *Health-Related Quality of Life: Well-Being Concepts*.
[33] Office of Disease Prevention and Health Promotion. (2018). *Mental Health and Mental Disorders*.
[34] Lando, J., & Williams, S. (2006). *A Logic Model for the Integration of Mental Health Into Chronic Disease Prevention and Health Promotion* in Preventing Chronic Disease. 2006 Apr; *3*(2): A61.
[35] Centers for Disease Control and Prevention. (2018). *Learn About Mental Health*.

worsening, from insufficient sleep and inadequate social/emotional support to feelings of loneliness/isolation, fear, anxiety, and panic. Residents are seeking professional help for mental/emotional problems at a higher rate than in the past. Survey results also indicated that residents of low socioeconomic status are disproportionately experiencing inadequate social/emotional support.

Youth self-harm exceeds the state average among youth of Native American and "Other" ethnicities.[36] The county's Adolescent Report found that nearly one in five adolescent girls reported being harassed or bullied online, as did over one in 10 adolescent boys. It was also found that nearly two in five adolescent girls and almost one quarter of adolescent boys reported having suicidal thoughts. However, San Mateo County Health indicates that the crude suicide rate in the county was highest for middle-aged adults (aged 45–64), and nearly three quarters of the suicides in the county between 2010 and 2015 were male. However, the county's overall suicide rate is not worse than the benchmark.

In focus groups and interviews, residents and representatives of various vulnerable groups (e.g., LGBTQI, Pacific Islanders, individuals experiencing homelessness) expressed a greater need for mental health care. Economic insecurity (including housing instability) was also discussed as a driver of poor mental health and substance use.

"We can put on as many supports as we want, but we know—especially if you're looking at the literature around trauma, around depression, around anxiety, and PTSD—[patients] need one-on-one therapy. Like, that's huge, and paying Marriage and Family Therapists is hard. They're the highest salaries, and there are dwindling funds for direct services for mental health." —Key informant

A common theme in community input was the co-occurrence of poor mental health and substance use. Community members frequently identified stigma as a barrier to both mental health care and substance use treatment, both in acknowledging the need for care (i.e., facing negative cultural perceptions/taboos, either internalized or imposed by family and/or friends) and in seeking and receiving care (i.e., experiencing stigma from providers delivering care).

The community expressed concern about a lack of providers and services (for mental health and for alcohol and drug treatment) and identified the need for co-location of physical and mental/behavioral health services. These concerns were stated without reference to payer type (public vs. private). Mental health professionals also discussed the issue of burnout due to vicarious trauma experienced by staff and the concern that physical health clinicians may not have the knowledge or resources to address mental health.

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[36] "Other" is a U.S. Census category for ethnicities not specifically called out in data sets.

Substance Use

What Is the Issue?

The use of alcohol, tobacco, and other substances (legal and illegal) affects not only the individuals using them, but also their families and communities. Smoking cigarettes, for instance, can harm nearly every organ in the body and cause a variety of diseases, including heart disease.[37] Exposure to secondhand smoke can create health problems for nonsmokers.[38] Substance use can lead or contribute to other costly social, physical, mental, and public health problems, including domestic violence, child abuse, suicide, traffic accidents, and HIV/AIDS.[39]

In recent years, advances in research have resulted in a variety of effective evidence-based strategies to treat addictions. Brain-imaging technology and the development of targeted medications have helped to shift the perspective of the research community with respect to substance use.[40] More and more, substance use is seen as a disorder that can develop into a chronic illness requiring lifelong treatment and monitoring.

Why Is It a Health Need?

The proportions of county residents who drink alcohol or have recently used marijuana or hashish are significantly higher than benchmarks. The greatest proportions of current drinkers are Coastside residents and county residents who earn higher incomes (i.e., more than 400 percent of federal poverty limits). Coastside residents are also overrepresented among those who used marijuana or hashish recently, as are 18- to 39-year-olds. A significantly higher proportion of Asian/Pacific Islander residents used marijuana/hashish recently compared to residents of other ethnicities.[41]

"[Substance use] is a big concern, because it's one thing if you're just using at a party on a Saturday, but it's another if you're coming to school high, and you're using it to self-medicate either for anxiety, depression, or just because you think that's what kids do." —Key informant

Although binge drinking is only slightly higher in the county than the state, it is on the rise. Chronic liver disease/cirrhosis mortality is slightly higher than the state average as well, and it is among the top 10 causes of death in San Mateo County. Smoking rates countywide are better

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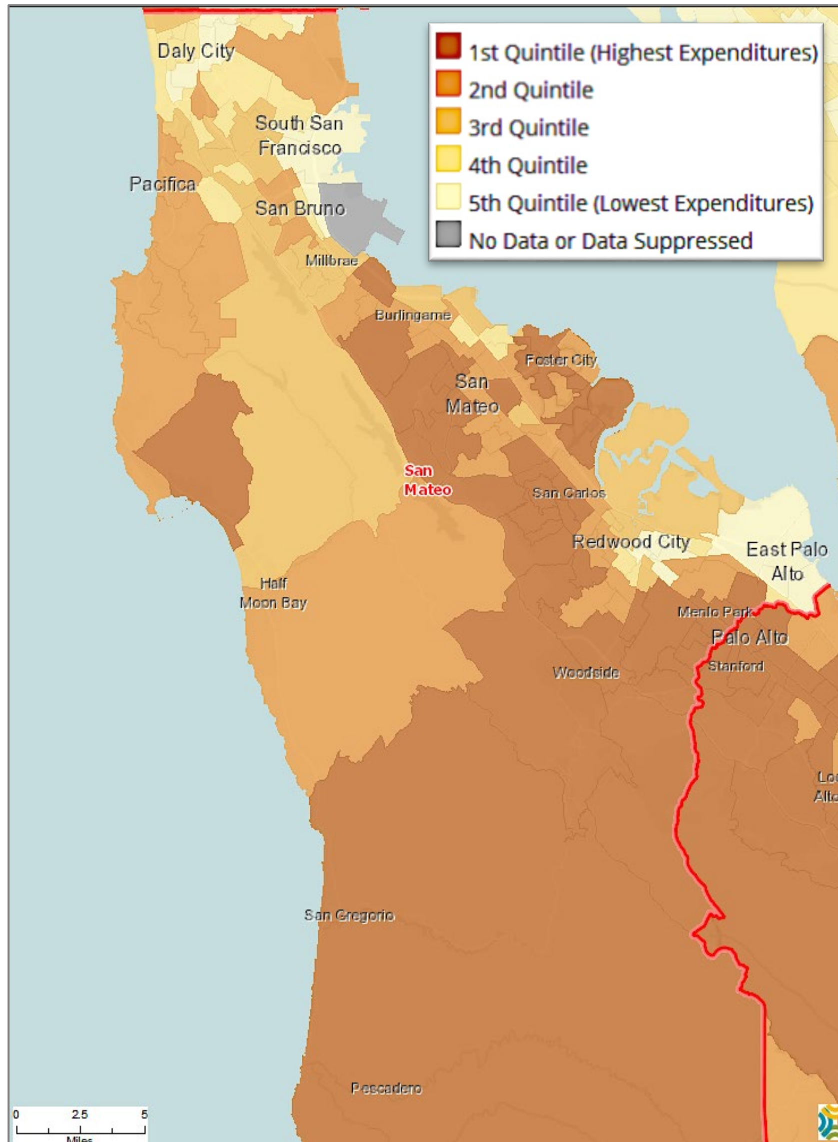
[37] Centers for Disease Control and Prevention, (2018). *Health Effects of Cigarette Smoking.*
[38] American Lung Association (2017). *Health Effects of Secondhand Smoke.*
[39] World Health Organization (2018). *Management of Substance Abuse.*
[40] Office of Disease Prevention and Health Promotion (2018). *Substance Abuse.*
[41] Although medical marijuana sales were legalized in California in 1996, recreational marijuana sales were illegal before January 1, 2018. The data on marijuana use presented in this report do not capture legal recreational use.

than benchmarks and have been decreasing; however, vaping (e-cigarette use) is significantly higher than the state average among county residents aged 18–39.

Drug-induced death is the #10 cause of death in San Mateo County; higher than suicide, which is #11. The county's rate of deaths from drug poisoning has also been rising.[42] Concurrently, the substance use-related emergency department visit rate has increased among the county's adults (aged 20–64) as it dropped among youth (aged 10–19).

Alcoholic Beverage Expenditures, San Mateo County



Spending as a percentage of food-at-home expenditures by census tract. Sources: Nielsen Site Reports, 2014. Community Commons, 2018.

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[42] County of San Mateo. (2017). Health Status Profile.

HOUSING AND HOMELESSNESS

What Is the Issue?

The U.S. Department of Housing and Urban Development defines affordable housing as that which costs no more than 30 percent of a household's annual income. Spending greater sums can result in the household being unable to afford other necessities, such as food, clothing, transportation, and medical care.[43] The physical condition of a home, its neighborhood, and the cost of rent or mortgage are strongly associated with the health, well-being, educational achievement, and economic success of the people who live inside.[44] Further, a 2011 study by Children's Health Watch found that "[c]hildren in families that have been behind on rent within the last year are more likely to be in poor health and have an increased risk of developmental delays than children whose families are stably housed."[45]

Homelessness correlates with poor health: Poor health can lead to homelessness, and homelessness can lead to poor health.[46] People who are experiencing homelessness have been shown to have more health care issues than people who are not. They also suffer from preventable illnesses at a greater rate, experience longer hospital stays, and have a greater risk of premature death.[47] A National Health Care for the Homeless study found that the average life expectancy for a person without permanent housing was at least 25 years less than that of the average U.S. citizen.[48] Thus, it is vital that health care systems monitor local homeless populations and identify their health needs.

NEW CALIFORNIA LAW REQUIRES HOMELESS DISCHARGE PLANNING

SB 1152, which took effect on January 1, 2019, requires hospitals statewide to modify existing patient discharge policies and practices to better support people who are experiencing homelessness.

The law requires hospitals to:

- Discharge the patient to a sheltered location (resources permitting) or a location chosen by the patient.
- Supply the patient with transportation to that location (within 30 miles of the hospital).
- Offer the patient a meal, weather-appropriate clothing, and screening for communicable diseases.
- Provide the patient with referrals to available treatment, support services, and other community resources. (Hospitals must have a written plan for coordinating referrals with local agencies and service providers.)

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[43] U.S. Department of Housing and Urban Development. (2018). *Affordable Housing.*

[44] Pew Trusts/Partnership for America's Economic Success. (2008). *The Hidden Costs of the Housing Crisis.* See also: The California Endowment. (2015). *Zip Code or Genetic Code: Which Is a Better Predictor of Health?*

[45] Children's Health Watch. (2011). Behind Closed Doors: The Hidden Health Impacts of Being Behind on Rent.

[46] National Health Care for the Homeless Council. (2011). Care for the Homeless: Comprehensive Services to Meet Complex Needs.

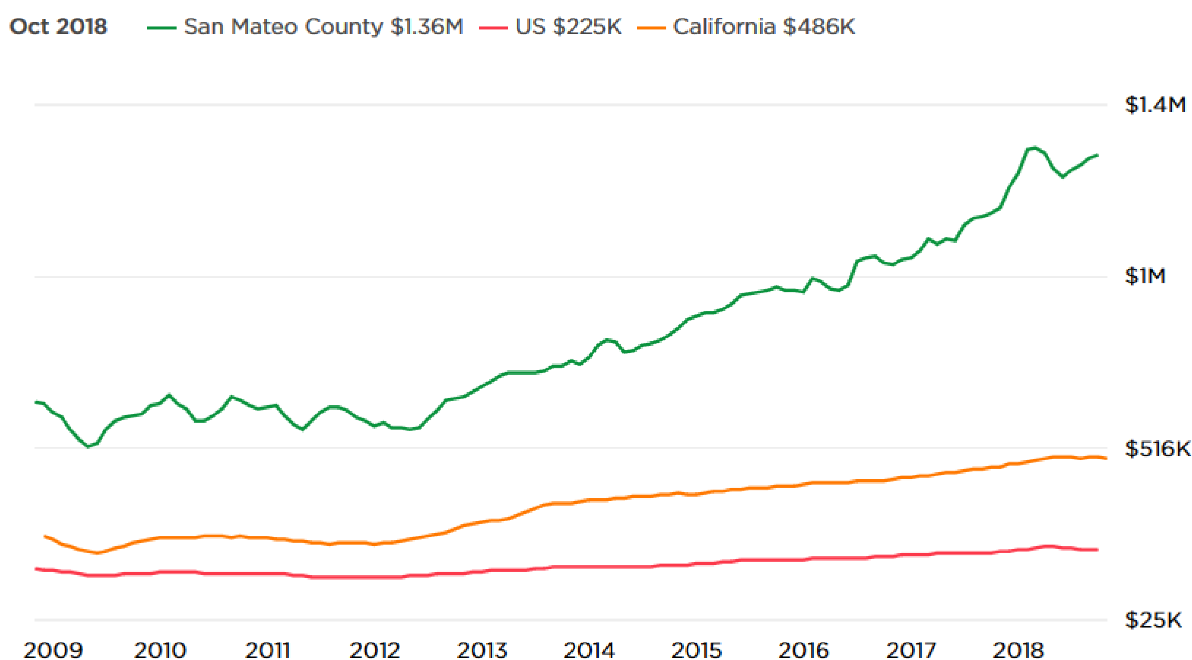
[47] O'Connell, J.J. (2005). Premature Mortality in Homeless Populations: A Review of the Literature. Nashville, TN: National Health Care for the Homeless Council.

[48] National Coalition for the Homeless. (2009). *Health Care and Homelessness.*

Why Is It a Health Need?

Housing and homelessness is a chief concern of the community and was prioritized as a health need by almost all focus groups and key informants. The community described stress about the high costs of housing (mortgage and rent) as another major priority; in more than two thirds of focus groups and key informant interviews, housing was mentioned in conjunction with mental health. Multiple populations of concern are unable to afford housing in San Mateo County, or may be experiencing either homelessness or housing instability. Further, community input signaled a growing call for help with basic needs among those with middle incomes for whom services are lacking because they do not qualify for most assistance programs.

MEDIAN HOME SALE PRICE, ALL HOMES



Source: Zillow. San Mateo County Home Prices and Values, 2009–2018.

The median rent in San Mateo County is significantly higher than the state average and has been increasing. The number of county residents who have experienced housing instability in the past two years has been rising, as has the proportion of residents sharing housing costs with a non-partner for the sake of affordability. The community reported people moving within or exiting the area due to increased cost of living. Compared to 2013, a greater proportion of Health and Quality of Life survey respondents in 2018 indicated they were seriously considering leaving the county due to the cost of living. The number of assisted housing units available is lower than the state average, suggesting that affordable housing is relatively scarce.

"There are just a lot of stressors that people are facing these days—the competitiveness, even with the job market, the need to make enough money to live. Then our lower-income families ... are working two and three jobs, and who is home tending the children? Because [parents] are out trying to make a living so they can pay for the rent, pay for the food, pay their portion of what it costs to live in a house with three other families." —Key informant

HEALTHY LIFESTYLES

Healthy Lifestyles was identified as a top health need by 25 percent of key informants and over 20 percent of focus groups. This need includes diabetes, obesity, and fitness, diet, and nutrition. Diabetes and obesity are on the rise in San Mateo County; statistics for adult diabetes prevalence and youth fruit/vegetable consumption are significantly worse than state averages.

Diabetes

What Is the Issue?

Diabetes refers to a category of diseases that affects how the body uses glucose (blood sugar), the body's primary source of fuel.[49] Type 1 diabetes and Type 2 diabetes are chronic, with Type 2 diabetes accounting for roughly 90 percent of all diagnosed cases, and Type 1 diabetes accounting for approximately 5 percent. Gestational diabetes accounts for the rest.[50] The Centers for Disease Control and Prevention (CDC) estimates that 30 million people in the U.S. have diabetes and an additional 84 million U.S. adults are pre-diabetic. The more serious health complications of diabetes include heart disease, stroke, kidney failure, adult-onset blindness, and lower-extremity amputations.

Although Type 1 diabetes is generally believed to be caused by a combination of genetic and environmental factors[43] and cannot be prevented, Type 2 diabetes and pre-diabetes (higher-than-normal blood glucose levels) are the result of the body losing its ability to generate sufficient insulin to maintain and regulate a healthy blood sugar level. Risk factors for Type 2 diabetes include being physically inactive, being overweight, being age 45 or older, having a close family member with Type 2 diabetes, and having pre-diabetes. Additionally, certain ethnic groups (African Ancestry, Latinx, Native American, Pacific Islanders, and some Asian groups) are at a higher risk of Type 2 diabetes.

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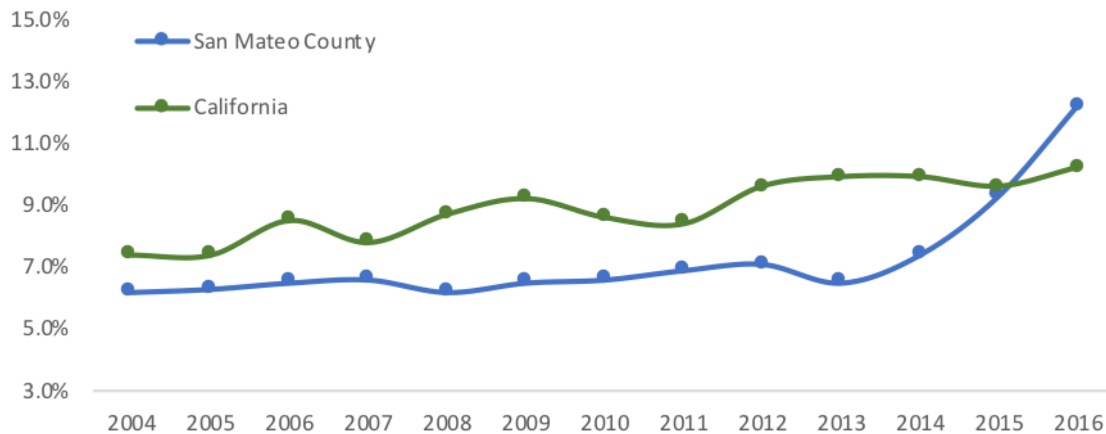
[49] The Mayo Clinic (2018). *Diabetes Overview.*
[50] Centers for Disease Control and Prevention (2018). *Diabetes Quick Facts.*

Diabetes is costly. The CDC estimates the annual medical costs and lost work/wages attributable to diabetes is in excess of $300 billion annually, and overall medical costs for those diagnosed with diabetes are twice as high as for those who do not have diabetes.

Why Is It a Health Need?

Diabetes ranks among the top 10 causes of death in San Mateo County. Adult diabetes prevalence is significantly higher than the California benchmark and has been trending up.

Diabetes Prevalence, Adults



Sources: Centers for Disease Control and Prevention (state: 2004–2015, county: 2004–2010). California Health Interview Survey, 2011–2015 (county). Behavioral Risk Factors Surveillance System, 2016 (state). San Mateo County Health and Quality of Life Survey, 2018 (county).

Adult diabetes prevalence is highest among residents of low socioeconomic status and of African Ancestry. African Ancestry and Pacific Islander residents visited emergency departments for diabetes at rates higher than those other ethnic groups. Diabetes management among the county's Medicare patients is slightly worse than the state benchmark.

"Diabetes just kind of runs rampant. And with our Hispanic, our Latino population, I see—along with our African-American and maybe our Pacific Islander community as well—children who are overweight. And probably that is one of the indicators that could lead towards being diagnosed with Type 2 diabetes earlier." —Key informant

Diabetes was identified as a top health need by more than 15 percent of key informants. Some key informants expressed concern about the rising number of children and youth being diagnosed with diabetes. Others identified diabetes as an issue among individuals experiencing homelessness, noting for example that keeping insulin (a hormone that controls blood sugar, required for diabetes management) cool is much more difficult for someone who doesn't have regular access to a refrigerator.

Obesity

What Is the Issue?

When someone consumes more calories than they use for everyday activity and exercise, their bodies store the excess calories as fat.[51] When someone's weight surpasses the healthy standard for their height, that person is described as overweight or obese. Both conditions are measured by body mass index (BMI), a metric ratio of weight divided by the square of height.[52] Risk factors of obesity, in addition to unhealthy diet and inactivity, include genetic factors, underlying medical issues, family models, social and economic factors, and hormonal changes due to lack of sleep, pregnancy, or age. Smoking cessation and the side effects of certain medications can also contribute to obesity.[47] Further, food insecurity and obesity often co-exist because "both are consequences of economic and social disadvantage."[53]

Nearly one in five children and nearly two in five adults in the U.S. are obese.[46] Being obese or overweight increases an individual's risk for diabetes, hypertension, stroke, and cardiovascular disease. Obesity can also contribute to poor mental health (anxiety, depression, low self-esteem), stigma, and social isolation. Among children and youth, obesity can also increase the likelihood of bullying.[46, 47]

Why Is It a Health Need?

Overall obesity rates are high in San Mateo County, but do not fail benchmarks. However, the Latinx population has significantly higher proportions of overweight and obese adults and youth than the benchmarks. This is driven, in part, by low fruit/vegetable consumption (based on statistical data) and possibly by physical inactivity (reported by the community). African Ancestry adults also significantly exceed the benchmarks for overweight and obesity. Perhaps unsurprisingly, given the association between obesity and food insecurity, adults of low socioeconomic status also fail benchmarks for overweight and obesity.

The community expressed concern about obesity among youth and young adults, emphasizing that healthy habits of diet and activity begin in childhood and are strongly affected by family models, access to recreation, and the food environment. (*See also the Neighborhood and Built Environment health need description.*)

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[51] The Mayo Clinic. (2018). *Obesity*.
[52] Centers for Disease Control and Prevention. (2018). *Overweight and Obesity*.
[53] Food Research and Action Center. (2015). *Food Insecurity and Obesity*.

Fitness, Diet, and Nutrition

What Is the Issue?

The benefits of fitness and a healthy, nutritious diet are commonly known and well-documented. As noted by the Centers for Disease Control and Prevention, "physical activity fosters normal growth and development, can reduce the risk of various chronic diseases, and can make people feel better, function better, and sleep better."[54] Getting regular exercise can help people of all ages combat obesity, reduce the risk of cardiovascular disease, Type 2 diabetes, some cancers, and a host of other physical issues.[55] Regular exercise can also help to strengthen bones and muscles, prevent falls for older adults, and increase an individual's chances of living longer.[56]

Likewise, the benefits of a healthy diet include preventing high cholesterol and high blood pressure, reducing the risks of developing diseases such as cancer and diabetes, and helping to reduce the risks of obesity, osteoporosis, and dental cavities.[57] For children and adolescents, a nutritious diet helps with growth and bone development, as well as improved cognitive function.[58]

In spite of the well-known benefits, most people do not meet the recommended healthy food and exercise guidelines. Most significantly, a poor diet and lack of regular exercise can lead to childhood and adult obesity, a serious and costly health concern in the U.S. that often results in some of the leading causes of preventable death.[59]

Why Is It a Health Need?

Youth in San Mateo County consume fruits/vegetables at rates significantly lower than the state average, and rates for Latinx youth and youth of "Other" ethnicities[60] are even worse. Nearly one in five residents participating in the county's 2018 Health and Quality of Life survey reported consuming sugar-sweetened beverages daily; this proportion rose to more than one in four among residents of low socioeconomic status. Breastfeeding, which contributes to a healthy diet for infants, is significantly lower among mothers of African Ancestry than the state benchmark. Finally, as noted by professionals in one of the focus groups, individuals who've had teeth removed have difficulty eating, which contributes to a poor diet; over one in five Health and

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[54] Centers for Disease Control and Prevention. (2018). *Physical Activity Basics.*
[55] The Mayo Clinic. (2016). Exercise: 7 Benefits of Regular Physical Activity.
[56] Harvard Health Publishing/Harvard Medical School. (2013). Balance Training Seems to Prevent Falls, Injuries in Seniors.
[57] United States Department of Agriculture. (2016). *Why Is It Important to Eat Vegetables?*
[58] World Health Organization. (2018). Early Child Development: Nutrition and the Early Years.
[59] Centers for Disease Control and Prevention. (2016). *Childhood Obesity Causes and Consequences*. See also: Centers for Disease Control and Prevention. (2018). *Adult Obesity Causes and Consequences*.
[60] "Other" is a U.S. Census category for ethnicities not specifically called out in data sets.

Quality of Life survey respondents reported that three or more of their permanent teeth had been removed due to tooth decay or gum disease. This figure rose to one in three among residents of low socioeconomic status.

"What [people] are struggling with the most is … having sort of environmental and policy systems in place that make it easy to be active and feed kids a healthy diet." —Key informant

Countywide, the proportion of adults who engage in no vigorous physical activity at all has been increasing since 2013, and the proportion of those who engage in a set of healthy behaviors (do not smoke cigarettes, are not overweight [based on BMI], exercise at least three times per week for at least 20 minutes each time, and eat five or more servings of fruit/vegetables per day) has been decreasing.

Community input included notions about cultural differences in diet and formal exercise, lack of time (or, in some cases, space) for cooking or recreation, and issues of access to healthy food in schools and other institutions, such as homeless shelters and senior centers. The community also discussed environmental factors that contribute to physical inactivity and poor diet/nutrition, such as the built environment, stress, and poverty. (*See also the Neighborhood and Built Environment and the Mental Health and Well-Being health need descriptions*.)

HEALTH CARE ACCESS AND DELIVERY

What Is the Issue?

Access and delivery was prioritized by 25 percent of key informants and more than 20 percent of focus groups, and it was discussed in all interviews and focus groups. Access to comprehensive, quality health care is important for health and for increasing the quality of life for everyone.[61] Components of access to care include insurance coverage, adequate numbers of primary and specialty care providers, and timeliness. Components of delivery of care include quality, transparency, and cultural competence/cultural humility. Limited access to health care and compromised health care delivery impact people's ability to reach their full potential, negatively affecting quality of life. As reflected in statistical and qualitative data, barriers to receiving quality care include lack of availability, high cost, lack of insurance coverage, and lack of cultural competence on the part of providers. These barriers to accessing health services lead to unmet health needs, delays in receiving appropriate care, and inability to get preventive services.

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[61] Office of Disease Prevention and Health Promotion. (2015). http://www.healthypeople.gov

Why Is It a Health Need?

Although San Mateo County has high rates of available primary care, dental, and mental health providers overall, it has significantly poorer access to "other" primary care providers (nurse practitioners, physician assistants, etc.) than the state benchmark. The proportion of employed county residents whose jobs offer health benefits has also declined. Community input suggests that health care is often unaffordable. People who do not receive health insurance subsidies may lack insurance and the funds to pay for medical care, despite the availability of the county's Affordable Care for Everyone program. Since 2013, there has been a reduction in the proportion of children who have a usual place for medical check-ups. Ease of access to specialty care (e.g., dental, mental health, and substance use treatment) has been declining as well.

Latinxs, Pacific Islanders, and residents of "Other" races[62] have the lowest rates of health insurance. Residents of low socioeconomic status are more likely than higher-status groups to have health care access issues, such as no health insurance, an inability to afford medication, inadequate transportation to medical appointments, and a lack of recent health screenings (e.g., dental exams or colorectal cancer testing). Participants in 10 different focus groups and interviews said they believe that undocumented immigrants are accessing health care (including oral health, obstetrics, and general medical services) less often in recent years due to fear of being identified and deported. Professionals specifically cited a drop in patient visits.

"[Finding a Medi-Cal provider has] always been a problem, but I think it's getting worse. As a result, [youth] end up using urgent care and ERs for what should be primary care. So, we're seeing more of that. In terms of timely access for mental health, I think that is in dire straits. I constantly get requests by teachers and families that say, 'I'm concerned. The young person is showing definite signs of anxiety and depression, and we can't get in with a psychiatrist or a therapist." —Key informant

Community input also included concerns about the supply of primary and specialty care providers in the county, which participants connected to both longer wait times for appointments and lower levels of attention exhibited by providers during appointments, possibly due to overwork. Community members voiced the need for health care providers to spend more time simply listening and expressing empathy to patients. The community also identified the need for training and greater diversity among health care providers to best serve certain populations and to offer greater cultural competence/humility.

Community input additionally identified the need for better one-on-one partnerships between health providers and patients from vulnerable populations (e.g., patients of color, LGBTQI patients, patients experiencing homelessness, and patients with mental or physical disabilities)

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[62] "Other" is a U.S. Census category for ethnicities not specifically called out in data sets.

to reduce stereotyping and implicit bias among providers, as well as to increase empowerment among these patients with regard to their own health and health treatment plans. Finally, qualitative data indicated a lack of knowledge among community members about where to go for answers about health insurance and health care systems and a lack of understanding in regard to the information doctors provided patients.

CANCER

What Is the Issue?

Cancer is a generic term used to describe a condition in which abnormal cells divide uncontrollably, invading and killing healthy tissue. These abnormal cells can metastasize to other parts of the body via the blood and lymph systems. There are more than 100 kinds of cancer, and cancer is the second leading cause of death in the U.S., following heart disease.[63, 64] High-quality screening can serve to reduce cancer rates; however, complex factors contribute to disparities in cancer incidence and death rates among different ethnic, socioeconomic, and otherwise vulnerable groups.

Research has found that health disparities related to cancer contribute to higher, avoidable death rates among low-income and ethnic minority populations nationwide. These disproportionalities may be exacerbated by delivery issues in cancer screening and follow-up.[65] While personal, behavioral, and environmental factors are significant (e.g., smoking, exposure to known carcinogens), the most important risk factors for cancer are lack of health insurance and low socioeconomic status.[66]

Why Is It a Health Need?

Cancer is the leading cause of death in San Mateo County with overall cancer prevalence being significantly higher than in the state benchmark. Incidence rates for certain cancers (melanoma, prostate, uterine, and breast) are also worse in the county than in the state.

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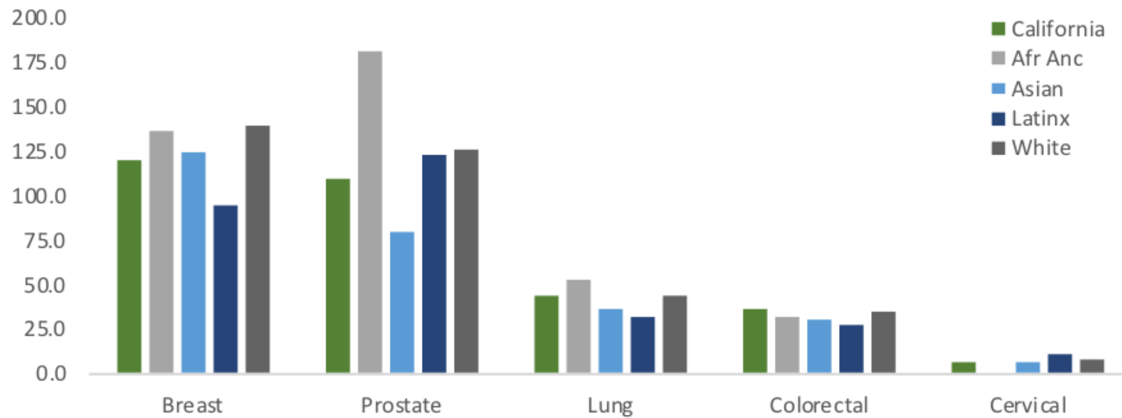
[63] Centers for Disease Control and Prevention. (2018). *How to Prevent Cancer or Find It Early*.
[64] Centers for Disease Control and Prevention. (2017). *Leading Causes of Death*.
[65] Fiscella, K., et al. (2011). Eliminating Disparities in Cancer Screening and Follow-Up of Abnormal Results: What Will It Take? *Journal of Health Care for the Poor and Underserved*, *22*(1): 83–100.
[66] National Cancer Institute. (2018). *Cancer Disparities*.

SELECTED CANCER INCIDENCE RATES BY ETHNICITY, SAN MATEO COUNTY



Rates per 100,000 people. Breast and cervical cancer incidence rates are for females only. Prostate cancer incidence rate are for males only. Source: State Cancer Profiles, 2010–2014.

Significant ethnic disparities in cancer occurrences by site are seen for White, African Ancestry, and Latinx populations. Unhealthy behaviors that increase cancer risk, such as binge drinking and lack of regular vigorous physical activity, are on the rise. Additionally, breast cancer screenings (mammograms) have decreased countywide. Cancer was prioritized by fewer than 15 percent of focus groups and was not prioritized by key informants.

COMMUNICABLE DISEASES

What Is the Issue?

Communicable diseases are transmitted via contact with an infected person and their discharge (i.e., blood, saliva, etc.). Infectious diseases such as viral hepatitis, influenza, and tuberculosis remain a major cause of illness, disability, and death in the U.S., despite the introduction and general availability of vaccines. Prevention of infectious diseases (e.g., through education and/or vaccines) is significantly less costly than their treatment. A variety of agencies monitor infectious diseases, identify outbreaks/epidemics, and distribute resources to combat them.[67]

[67] U.S. Government Accountability Office. (2004). Emerging Infectious Diseases: Review of State and Federal Disease Surveillance Efforts.

Why Is It a Health Need?

Infectious diseases are a health need in San Mateo County as evidenced by significantly higher rates of acute hepatitis B, pertussis, and tuberculosis cases compared to benchmarks. The proportion of kindergarteners with overdue immunizations is also somewhat higher than the state benchmark. Influenza/pneumonia is among the top 10 causes of death in San Mateo County. Infectious diseases were not prioritized by the community.

ORAL/DENTAL HEALTH

What Is the Issue?

Good oral/dental health contributes to an individual's overall health (the ability to taste, chew, and swallow) and social function (the ability to speak and make facial expressions to show feelings and emotions).[68] Maintaining oral/dental health requires routine self-care, including brushing with a fluoride toothpaste and flossing, as well as regularly receiving professional dental treatment.[69] Conversely, unhealthy behaviors such as substance use (including tobacco and drugs such as methamphetamines), poor dietary choices, and not brushing, flossing, or regularly seeing a dentist can result in conditions ranging from cavities or gum disease to cancer.[70] As with other health needs, various factors can create barriers to accessing dental services for different ethnic, socioeconomic, and otherwise vulnerable groups. The primary access factors are lack of insurance, low socioeconomic status, and fear of dental treatment.[71]

Why Is It a Health Need?

Oral/Dental Health was prioritized as a health need by the community in two-thirds of focus groups and more than 20 percent of key informant interviews. Feedback related to oral health usually concerned the lack of access to high-quality dental services (children, parents, young adults, and older adults) and/or lack of dental insurance (young adults and older adults).

More than 25 percent of adults in San Mateo County lack dental insurance. Even though this is better than the state rate of dental insurance, the proportion of residents who report having no dental insurance that pays for some or all routine dental care has been rising since 2008. Insurance that covers routine care as well as dental surgery (e.g., wisdom tooth extraction and root canals) is perceived to be expensive, and wait times for appointments can be long.

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[68] National Institute of Dental and Craniofacial Research. (2000). *Oral Health in America: A Report of the Surgeon General*.
[69] The Mayo Clinic. (2016). Oral Health: Brush Up on Dental Care Basics.
[70] Office of Disease Prevention and Health Promotion. (2018). *Oral Health*.
[71] Centers for Disease Control and Prevention. (2017). *Disparities in Preventive Dental Care Among Children in Georgia*. See also: Harvard Health Publishing/Harvard Medical School. (2015). *Dental Fear? Our Readers Suggest Coping Techniques*.

The supply of oral health providers in San Mateo County is perceived to be low, especially providers who accept Denti-Cal; key informants stated that low reimbursement rates and complicated billing procedures have driven many oral health providers away from accepting it. Although reported ease of accessing dental care has worsened, statistics show the ratio of dentists-to-residents has improved. Key informants also noted that Federally Qualified Health Centers (FQHCs) are the only organizations that receive a higher reimbursement rate for dental services. However, the ratio of FQHCs-to-residents is significantly worse in the county than it is statewide. The situation is most problematic on the Coastside, where residents have access to only one FQHC and one private dental clinic accepting new Denti-Cal patients.

Disparities exist in San Mateo County. About half of county residents of low socioeconomic status have not received a recent dental exam, which is significantly worse than the state. Similarly, a key informant indicated that 60 percent of children on Medi-Cal/Denti-Cal have not seen a dentist in more than a year. Service providers also believe residents aren't going to the dentist because there's a lack of awareness about how important oral health is to overall health.

"The wait times for adults with Denti-Cal can be a year and a half to get a primary care dental appointment, just to see preventive care. It's better for kids … but those with special needs, those who need more involved kind of care … we're sending kids out of county, to Santa Clara, Gilroy. And that has its own challenges, of course, for the family." —Key informant

Finally, a driver of poor oral health is drinking water violations. Drinking water violations in San Mateo County's community water systems were flagged as an issue. Lack of access to clean drinking water affects physical health in a variety of ways, including the potential for acquiring communicable diseases and the increased likelihood of consuming sugar-sweetened beverages instead of water, which is associated with both obesity and tooth decay. Key informants on the Coastside specifically addressed the issue of contaminated drinking water in certain coastal communities. (*See also the Neighborhood and Built Environment health need description*.)

FOOD INSECURITY

What Is the Issue?

Food insecurity is defined as the "lack of consistent access to enough food for an active, healthy life."[72] Various factors may have an impact on food insecurity, such as employment/income, ethnicity, and disability status. Hunger and food insecurity are related but distinct concepts; hunger is the physical discomfort related to "prolonged, involuntary lack of food," while food

[72] U.S. Department of Agriculture, Economic Research Service. (2018). *Food Security in the U.S.*

insecurity refers to a "lack of available financial resources for food at the household level."[73, 74] Measurements of various levels of food insecurity, from marginal to low or very low, include anxiety about food insufficiency, household food shortages, reduced "quality, variety, or desirability" of food, diminished nutritive intake, and "disrupted eating patterns."[75]

In 2017, approximately one in eight Americans experienced food insecurity, of which more than one third were children.[76] People who are food-insecure may be more likely to experience various poor health outcomes/health disparities, including obesity. Children experiencing food insecurity are also at greater risk for developmental complications and/or delays than other children. In addition, food insecurity may have a detrimental impact on children's mental health.

Why Is It a Health Need?

San Mateo County's population experiences food insecurity at a rate significantly higher than the benchmark, and more 2018 Health and Quality of Life survey respondents were food insecure than respondents of any prior iteration of the survey. The proportions of county residents receiving SNAP benefits[77] and other government assistance, as well as free meals and/or supplies from food banks, have been increasing. Yet significantly greater proportions of food-insecure adults and children are ineligible for assistance than the same populations at the state level.

"It's a vicious circle, in the sense that, not being able to address significant cost needs, [people] very often cut on food. And by cutting the food, they're putting their health at risk, and if the circle comes back, health risks are actually increasing their [financial burden]." —Key informant

Fewer than 15 percent of key informants specifically prioritized food insecurity as a health need in the community, and it was not prioritized by focus groups. However, food insecurity was discussed in the context of economic security and/or nutrition in one third of interviews and focus groups. Community members said that food insecurity is worsening as the costs of housing rise and that many residents must choose between paying their rent and buying groceries or medicine. (*See also the Housing and Homelessness health need description.*)

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[73] Feeding America. (2018). *What Is Food Insecurity?*
[74] U.S. Department of Agriculture, Economic Research Service. (2018). *Definitions of Food Security.*
[75] Healthy People 2020. (2018). *Food Insecurity.*
[76] Feeding America. (2018). *What Is Food Insecurity?*
[77] The Supplemental Nutrition Assistance Program (SNAP), formerly known as food stamps, provides federal assistance to eligible low-income individuals and families.

ASTHMA/RESPIRATORY CONDITIONS

What Is the Issue?

Respiratory disorders affect a person's ability to breathe. Asthma, chronic obstructive pulmonary disorder (COPD), pneumonia, and lung cancer are among the most common of respiratory disorders.[78] Asthma is an inflammation of the airways, causing them to swell and narrow, and is characterized by episodes of reversible breathing problems.[79] Symptoms can range from mild to life-threatening. Asthma attacks can cause a range of issues from simple wheezing to extreme breathlessness.[80] Proper asthma management can include access to asthma specialists, the regular use of "controller" medication, access to "quick-relief" medication, and avoidance of asthma triggers such as poor outdoor air quality, pollen, mold, smoke and its residue, animal dander, and pest-generated allergens.[81]

According to the American Lung Association, "the most common risk factors for developing asthma [are] having a parent with asthma, having a severe respiratory infection as a child, having an allergic condition, or being exposed to certain chemical irritants or industrial dusts in the workplace."[82]

Why Is It a Health Need?

Asthma/respiratory conditions were not prioritized by the community. This is a health need in San Mateo County based on worsening trends and the significantly higher prevalence of various respiratory conditions compared to state and national benchmarks. Asthma prevalence is increasing among both children and adults in the county—and is significantly worse than benchmarks. Among various ethnic groups, adult asthma prevalence is highest for African Ancestry and Latinx residents. Certain drivers of respiratory conditions, such as smoking and overweight/obesity, are significantly higher among the population of low socioeconomic status.

COPD, bronchitis, and emphysema are also rising countywide and occur in proportions twice as high as the state benchmarks. Looking at data across the county, COPD, bronchitis, and emphysema are highest on the Coastside. Additionally, the rates of pertussis and tuberculosis, infectious diseases that affect the respiratory system, are significantly higher than benchmarks. Finally, both chronic lower respiratory disease and influenza/pneumonia are among the top 10 causes of death in the San Mateo County.

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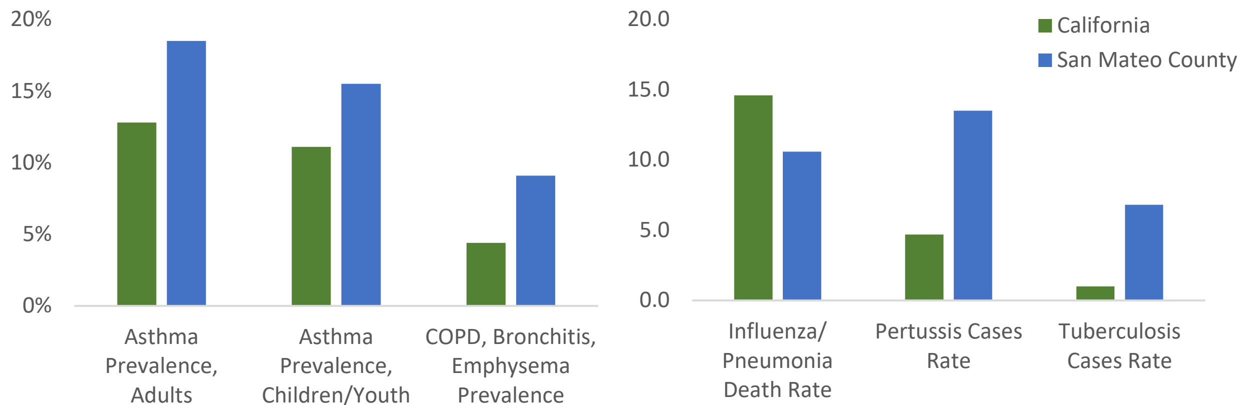
[78] U.S. National Library of Medicine. (2018) *Lung Disease.*
[79] The Mayo Clinic. (2018). *Asthma Overview.*
[80] Centers for Disease Control and Prevention. (2018).
[81] Asthma and Allergy Foundation of America. (2018). *Asthma Capitals 2018.*
[82] American Lung Association. (2018). *Asthma Risk Factors.* 2018.

Selected Respiratory Indicators, San Mateo County



Rates 100,000 people. Sources: Prevalence data: Behavioral Risk Factors Surveillance System, 2016, and San Mateo County Health and Quality of Life Survey, 2018. Other data: California Department of Public Health (death rate, 2014–2016; cases rates, 2016).

NEIGHBORHOOD AND BUILT ENVIRONMENT

Neighborhood and built environments are a health need in San Mateo County as evidenced by statistical data. This need includes access to food and recreation, community and family safety, community infrastructure and housing quality, natural environment/climate, and transportation and traffic. Proportions of healthy food stores and WIC-authorized[83] food stores, as well as statistics for drinking water violations, public transit access, road network density, and flood vulnerability are all significantly worse than state averages. Ethnic and income disparities are evident in almost all aspects of this health need.

Access to Food and Recreation

What Is the Issue?

The U.S. Surgeon General's report Vision for a Healthy and Fit Nation 2010 described how different elements of a community can support residents' healthy lifestyles. The various components of the physical environment, including sidewalks, bike paths, parks, and fitness facilities that are "available, accessible, attractive and safe" all contribute to the extent and type of residents' physical activities.[84] Other community elements supporting healthy lifestyles include local stores that sell fresh produce. Residents are more likely to experience food

[83] The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) is a federally funded health and nutrition program. https://www.cdph.ca.gov/Programs/CFH/DWICSN/Pages/Program-Landing1.aspx
[84] Centers for Disease Control and Prevention (2009). *Healthy Places*.

insecurity in communities where fewer supermarkets exist, grocery stores are farther away, and there are limited transportation/transit options.[85]

The Centers for Disease Control and Prevention recommends policies and environments that support behaviors aimed at achieving and maintaining healthy weight in settings such as workplaces, educational institutions, health care facilities, and communities.[86] For example, the availability of healthy and affordable food in retail and cafeteria-style settings allows people to make better food choices throughout the day. Otherwise, they may settle for caloric foods of low nutritional value.[87]

Why Is It a Health Need?

Data indicate that the county has significantly lower proportions of healthy food stores and WIC-authorized food stores compared to the state. According to Get Healthy San Mateo County 2016, less than one third of food stores in low-income neighborhoods meet "basic quality and affordability standards." The proportion of fast food restaurants in the county is slightly higher than the state and trending up.

A significantly smaller proportion of county residents live within half a mile of a public transit stop compared to the proportion of state residents. Community input describes public transit access as poor all across the county, especially for Coastside residents and older adults whose homes are not near transit lines. Streets could be safer: Pedestrian accident deaths are slightly higher than the benchmark, with Latinx deaths from pedestrian accidents significantly higher.

Community and Family Safety

What Is the Issue?

Violence and intentional injury are related to poorer physical and mental health for the victims, the perpetrators, and the community at large.[88] Crime in a neighborhood causes fear, stress, unsafe feelings, and poor mental health. In one study, people who reported feeling unsafe to go out during the day were much more likely to experience poor mental health.[89] As reported by the World Health Organization, even apart from any direct physical injury, victims of violence have been shown to suffer from a higher risk of depression, substance use, anxiety, reproductive

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[85] Healthy People 2020. (2018). *Food Insecurity.*
[86] Healthy People 2020. (2015). *Nutrition and Weight Status*.
[87] Centers for Disease Control and Prevention. (2015). *Healthy Food Environments*.
[88] Krug, E.G., Mercy, J.A., Dahlberg, L.L., & Zwi, A.B. (2002). The World Report on Violence and Health. *The Lancet*, *360*(9339), 1083–1088.
[89] Guite, H.F., Clark, C., & Ackrill, G. (2006). The Impact of the Physical and Urban Environment on Mental Well-Being. *Public Health*, *120*(12), 1117–1126.

health problems, and suicidal behavior.[90] Additionally, just being exposed to violence has been linked to negative effects on people's mental health, including post-traumatic stress disorder, as well as a greater propensity to exhibit violent behavior themselves.[91]

Why Is It a Health Need?

Nearly one third of youth surveyed for San Mateo County's Adolescent Report stated that they saw violence in their schools and/or communities, and only about half expressed that they felt safe in their communities. Nearly one in five adolescent girls reported having been harassed or bullied online, as did more than one in 10 adolescent boys.

Community and family safety is closely related to behavioral health. Although the community did not prioritize safety as a specific need, it came up in the majority of discussions regarding mental health and well-being (including discussions of mental health, stress, trauma/PTSD, and drug and alcohol use).

Economic stressors that affect food insecurity and housing instability were identified by multiple sources as drivers of domestic violence. Human trafficking in the county is an emerging problem, which experts rooted in issues that are not being appropriately addressed: chronic homelessness/housing insecurity and related economic stressors; chronic alcohol and drug use, or exposure to the same, in the home; domestic violence, abuse, or neglect; and/or poor mental health/self-esteem.

"The Community and Family Safety [need] is really interesting, because I don't feel like our community feels unsafe—because they don't know. So, I think that's what my struggle is, like relating it as a community safety issue. It's like, if you're not in the know, then you don't think that this is a problem, and your bubble is intact."
—Focus group participant

There are substantial ethnic disparities in community and family safety in San Mateo County. Data show that Latinx residents experience domestic violence at a significantly higher rate than others, exceeding the state average. Residents of African and Native American ancestry are the victims of assault at significantly higher rates than others, both populations nearly double the state average. The White population has the highest rate of youth intentional injury, exceeding the state average.

With regard to the risk of justice involvement and ethnic disparities, Latinx and African Ancestry students in San Mateo County are expelled from school at rates twice as high as the

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[90] World Health Organization. (2017). *10 Facts About Violence Prevention*.
[91] Ozer, E.J., & McDonald, K.L. (2006). Exposure to Violence and Mental Health Among Chinese American Urban Adolescents. *Journal of Adolescent Health, 39*(1), 73–79.

state benchmark. Additionally, Native American and African Ancestry students are suspended from school at higher rates than the state average.

The County of San Mateo Adolescent Report 2014–2015 further described juvenile justice involvement: “African-Americans have the highest juvenile arrest rate of 48 per 100,000 … compared to 3.1 per 100,000 for their white counterparts … [and] Hispanics make up 50 percent of juvenile felony arrests. … Issues with racial profiling, discrimination, and lack of opportunity may influence these outcomes.”

Community Infrastructure and Housing Quality

What Is the Issue?

Community infrastructure includes access to transportation, clean water, adequate sewer/septic systems, and safe housing, all of which are crucial to health. Adequate community infrastructure may also include access to media (e.g., libraries and/or internet), community gathering places, well-maintained pedestrian access (crosswalks/sidewalks), and clean and functional curbs and gutters. [92, 93] Lack of housing quality includes exposure to lead-based paint, asbestos, and other domestic toxins, as well as inadequate plumbing or kitchen facilities.[94] Residents of communities in which adequate infrastructure and quality housing exists tend to feel safer and experience greater community cohesion and interpersonal trust. They also are more likely to be physically and mentally healthy.[95]

Why Is It a Health Need?

Drinking water violations in San Mateo County’s community water systems were flagged as an issue. Lack of access to clean drinking water affects physical health in a variety of ways, including the potential for acquiring communicable diseases and the increased likelihood of consuming sugar-sweetened beverages instead of water, which is associated with both obesity and tooth decay. Key informants on the Coastside specifically addressed the issue of contaminated drinking water in certain coastal neighborhoods. (*See also the Oral/Dental Health health need description*.)

Key informants were also concerned about the inefficiency of street lights and sidewalks, which affects pedestrian access. Furthermore, both road network density and asthma prevalence miss benchmarks. Although more road miles per acre of land can be perceived as positive, when coupled with the rising asthma rates it may be seen as a net negative. In addition, because public

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[92] Rural Health Information Hub. (2017). *Social Determinants of Health*.
[93] Latino Coalition for a Healthy California. (2018). *Healthy Physical Environments*.
[94] Community Commons. (2018). http://www.communitycommons.org
[95] Latino Coalition for a Healthy California. (2018). *Healthy Physical Environments*.

transit access is lower than the state average, the confluence of indicators suggests issues with community infrastructure. Supporting this point, multiple key informants and focus group participants noted the poor transportation access on the Coastside.

In the county's 2018 Health and Quality of Life survey, the proportion of residents who rated the physical environment of their community as fair or poor increased slightly. Although housing quality does not appear to be an issue in the county based on statistical data,[96] the number of assisted housing units available is below the state average, which suggests that affordable housing is relatively scarce. Indeed, CHNA participants frequently discussed the relative lack of affordable housing and the poor quality of the affordable housing that is available in the county.

Natural Environment/Climate

What Is the Issue?

Living in a healthy environment is critical to quality of life and physical health. The Office of Disease Prevention and Health Promotion reports that globally nearly 25 percent of all deaths and disease can be attributed to environmental issues. Those environmental issues include air, water, food, and soil contamination, as well as natural and technological disasters.[97] For people whose health is already compromised, exposure to environmental issues can compound their problems.[98] Recent reports on climate change highlight the importance of considering environmental health in the context of climate health, which is projected to have increasing influence on sea levels, air quality, the severity of natural disasters such as fires, flooding, and droughts, and patterns of infectious diseases.[99]

Why Is It a Health Need?

Although air quality measures in San Mateo County are better than state benchmarks, asthma prevalence is significantly worse and increasing among children and adults. The county also has a significantly higher than the state average density of roads; particulates from traffic can contribute to asthma. (*See also the Asthma/Respiratory Conditions health need description*.)

San Mateo County is also significantly more vulnerable to flooding than the state average. Low-lying areas such as Foster City and parts of Redwood City, as well as areas of the county that are close to creeks, are much more prone to flooding.[100]

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[96] Neither the indicator of severe housing problems nor the indicator of substandard housing units exceeds their respective benchmark in San Mateo County compared to the state.
[97] Office of Disease Prevention and Health Promotion. (2018). *Environmental Health.*
[98] Morris, G., & Saunders, P. (2017). The Environment in Health and Well-Being. *Oxford Research Encyclopedias.*
[99] U.S. Global Change Research Program. (2018). Fourth National Climate Assessment.
[100] Federal Emergency Management Agency, Managing Floodplain Development Through the NFIP, Appendix D, 1998.

Some community members expressed concern about climate change, but natural environment/climate was not prioritized by the community.

Transportation and Traffic

What Is the Issue?

According to the U.S. Department of Transportation, 13.6 million motor vehicle crashes killed nearly 33,000 people in 2010 and injured 3.9 million more. The major contributors to motor vehicle crashes include drunken driving, distracted driving, speeding, and not using seat belts. Increased road use correlates with increased motor vehicle accidents, and more traffic (road congestion) causes travel delays, greater fuel consumption, and higher greenhouse gas emissions via vehicle exhaust.[101, 102] Vehicle exhaust is a known risk factor for heart disease, stroke, asthma, and cancer. Thus, it is important to monitor the miles traveled by vehicles over time to better understand the various potentially adverse health consequences.[103]

The benefits of ecofriendly alternative transport such as walking or riding a bicycle include improving health, saving money by not having to purchase a car or gasoline, and producing less impact on the environment. Combining alternative transport with traffic countermeasures can both improve health and reduce traffic-related injuries in communities.

Why Is It a Health Need?

Transportation and traffic was discussed by community members and experts, but was not prioritized. Although there has been an increase in San Mateo County residents commuting to work via public transport, a significantly smaller proportion of county residents live within half a mile of a public transit stop than other state residents.

However, the community described public transit access as poor all across the county, especially for Coastside residents, for individuals—particularly older adults—whose homes are not near transit lines, and for commuters (students and workers) who must travel long distances.

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[101] Cohen, P. (2014, October 8). *Miles Driven and Fatality Rate: U.S. States, 2012.* Sociological Images [web log].
[102] U.S. Department of Transportation, National Highway and Traffic Safety Administration. (2015). *The Economic and Societal Impact of Motor Vehicle Crashes, 2010 (Revised*), DOT HS 812 013. 2015 (revised). See also: Centers for Disease Control and Prevention. (2017). *Motor Vehicle Safety: Cost Data and Prevention Policies*, which suggests that the figures have not changed significantly since 2010.
[103] Health Matters in San Francisco. (2008). *Heavy Traffic Can Be Heartbreaking.*

"We just don't have good public transportation. … For example, we had a woman who had a 1 o'clock appointment in Burlingame with rape trauma services. She lived in Menlo Park. She called at 9 o'clock and said that she had missed her bus because it was early, and she couldn't make her 1 o'clock appointment. So, she was taking an entire day off for a 50-minute session with a peer counselor—and that is a barrier to care."
—Focus group participant

On-demand transportation is growing; community professionals suggested that older adults are more hesitant of trying it than others and that non-English speakers do not have the same kind of access due to communication issues.

Latinx residents have a significantly higher pedestrian mortality rate than other county residents, and their rate also surpasses the Healthy People 2020 aspirational goal. Additionally, the county's road network density is significantly higher than the state average; community input describes long commutes with congested traffic as the norm. In some cases, long commutes are the result of traffic jams not actual distance; in other cases, long commutes are due to workers living farther away from jobs because they've been priced out of the local housing market. Key informants connected long commutes to increased stress and poor health outcomes.

For further details on the 2019 Prioritized Health Needs, including statistical data and sources, see the data tables found in Attachment 4: Secondary Data Tables.

7. Community Resources

In San Mateo County, community-based organizations, government departments and agencies, hospitals and clinics, and other entities strive to address many of the health needs identified by this assessment. Hospitals and clinics are listed below. Key resources available to respond to community health needs are listed in Attachment 5: Community Assets and Resources.

EXISTING HEALTH CARE FACILITIES

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

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

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

EXISTING CLINICS

Many community health care clinics in San Mateo County are funded in part by nonprofit hospitals, private donors, and health care districts.

- Belle Air School Health Clinic
- Belle Haven Clinic
- Daly City Youth Health Center
- Fair Oaks Clinic
- Lucile Packard Foundation for Children's Health Teen Health Van
- Ravenswood Family Health Center
- Samaritan House
- San Mateo Medical Center Clinics (*for locations, see the clinics guide*[104])
- Sequoia Teen Health Center at Sequoia High School

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

8. Evaluation Findings from 2016–2018 Implemented Strategies

In 2016, Mills-Peninsula Medical Center participated in a collaborative process to identify significant community health needs and to meet IRS and SB 697 requirements. During the CHNA process, 21 needs were identified. MPMC addressed the top three in its 2016–2018 implementation strategies:

- Health Care Access and Delivery
- Oral/Dental Health
- Emotional Well-Being

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

An overall summary of these strategies for the years 2016–2018 is below, followed by tables highlighting a subset of activities used to address each prioritized health need.

Mills-Peninsula Medical Center Programs: From 2016 to 2018, MPMC supported several health care and coverage, workforce training, and research programs to increase access to appropriate and effective health care services and address a wide range of specific community health needs, particularly impacting vulnerable populations.

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

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

Grant Making: For over 10 years, MPMC has shown its commitment to improving community health through a variety of grants to charitable and community-based organizations. Successful grant applicants fit within funding priorities with work that examines social determinants of health and/or addresses the elimination of health disparities and inequities. From 2016 to 2018, MPMC awarded 84 grants amounting to a total of $4,039,637 in service of 2016 health needs.

In-Kind Resources: MPMC's commitment to community health means reaching out far beyond its patients to improve the health of its communities. Volunteerism, community service,

and providing technical assistance and expertise to community partners are critical components of MPMC's approach. From 2016 to 2018, MPMC donated several in-kind resources in service of 2016 implementation strategies and health needs, including lab tests, breast screenings, mammogram readings, prostate screenings, Hepatitis B vaccinations, grant review for annual awards by professional staff, and surgical facilities, supplies, and the services of nurses and technicians.

Collaborations and Partnerships: MPMC has a long legacy of sharing its most valuable resources: its knowledge and talented professionals. By working together with partners (including nonprofit organizations, government entities, and academic institutions), these collaborations and partnerships can make a difference in promoting thriving communities that produce healthier, happier, more productive people. From 2016 to 2018, MPMC engaged in several partnerships and collaborations in service of 2016 implementation strategies and health needs, including Gatepath, Peninsula Family Services, and Samaritan House.

IMPLEMENTATION STRATEGY EVALUATION OF IMPACT BY HEALTH NEED

2016 HEALTH NEED: HEALTH CARE ACCESS AND DELIVERY

The percentage of people who reported their health as "fair" or "poor" increased as incomes decreased. One in five San Mateo County residents lives below 200 percent of the Federal Poverty Level. Uninsured and underinsured community members have difficulty accessing and encounter long waits for needed health care from community clinics for both primary and specialty care.

STRATEGY #1	Expand access to primary care for low-income families
Activities/ services to address this strategy	Grant funds to Samaritan House were used to support the personnel costs and benefits of new staff at the clinic, nurse practitioner, case manager, insurance, pharmaceuticals, and medical supplies.
Evaluation results	• 3 grants, 3 sponsorships, and $673,355 in-kind donations provided • 4 FTEs funded • 3,854 people served • 14,476 patient visits provided • $1,423,355 total funding provided

STRATEGY #2	Increase community clinics capacities
Activities/ services to address this strategy	Grant funds to San Mateo Medical Center were used to expand access to primary care through the creation of an urgent care service in San Mateo County's Daly City Clinic.
Evaluation results	• $400,000 total funding provided • 1 FTE funded • 1,924 people served • 85% of patients confirmed for active coverage pre-registration • 13% decrease of No-Show appointments
STRATEGY #3	Provide screenings and education
Activities/ services to address this strategy	**Senior Focus**'s Wise and Well Heart Smart program provided monthly blood pressure checks, BMI screenings, comprehensive health screenings, and health education classes. **Circle of Care** program provided a network of support for older adults in San Mateo County. The goal of the program is to ensure that at-risk, elderly adults remain safe and secure in their home after a hospitalization.
Evaluation results	**Senior Focus** • $5,184,688 in contributions • 2,831 screenings to seniors • 2,245 health education classes • 592 comprehensive health screenings • 26 community education events provided 913 people information on health-related topics **Circle of Care** • $1,015,631 monetary contributions provided • 2,263 senior county residents were impacted through the program
STRATEGY #4	Provide free surgical procedures to prevent serious medical complications
Activities/ services to address this strategy	Partnered with Operation Access to provide free of charge surgical procedures to uninsured patients.
Evaluation results	• $648,040 spent • 34 people served • 63 procedures • 11 specialist evaluations

STRATEGY #5	Award grants to nonprofit organizations providing a variety of health-related safety-net services, including senior programs and housing assistance
Activities/ services to address this strategy	Annually, San Mateo County not-for-profit organizations providing health care or health-related services to San Mateo County residents are invited to submit grant applications in three categories: programs for underserved populations; programs for residents with special needs; and services or programs that fulfill an unmet need.
Evaluation results	• $4,039,637 total funding provided • Accomplishments were assessed through the analysis of final reports

2016 HEALTH NEED: ORAL/DENTAL HEALTH

Low-income residents are disproportionately affected because they more often lack dental insurance. They are less likely to get, or bring their child, to a routine dental check-up. Denti-Cal covers only basic services and is accepted by few dental providers in San Mateo County.

STRATEGY	Partner with Family Health Center dental clinic for the benefit of underserved populations in eastern San Mateo County
Activities/ services to address this strategy	• Health fairs promoted dental awareness. Dental screenings were provided during Primary Care visits. • Ravenswood Family Health Center dental clinic provided a wide variety of services to the community, including exams, follow-up treatment, and oral health education.
Evaluation results	• 11,300 children and 7,200 adults received oral health services • Provided oral surgery to 520 patients • Provided oral surgery to 203 patients at local hospital operating rooms • Provided primary dentistry to 500+ special needs children

2016 HEALTH NEED: EMOTIONAL WELL-BEING

The percentage of adults who report mental and emotional health problems is rising and suicide is #11 cause of death in San Mateo County. MPMC's contribution to Senior Focus for this health need is $5,184,688.

STRATEGY #1	Support Senior Focus, a specialized day health care center for people with medical issues or Alzheimer's disease and other forms of dementia.
Activities/ services to address this strategy	Senior Focus offers the Adult Day Health and Alzheimer's program
Evaluation results	• 268 clients served • 21,471 days of attendance • Patient satisfaction rates increased and are between 90.7% and 92.4%
STRATEGY #2	Provide caregiver support services
Activities/ services to address this strategy	Contributions to Senior Focus allows it to offer several programs targeting the senior population, including The Family Caregiver Support Services, providing counseling, support groups, classes, and caregiver forums.
Evaluation results	• 428 people counseled • 631 people participated in support groups, classes, and in caregiver forums • Participant satisfaction rates increased and are between 90.7% and 92.4%
STRATEGY #3	Provide screenings and education
Activities/ services to address this strategy	Senior Focus's Wise and Well Heart Smart program provides monthly blood pressure checks, BMI screenings, health education, and health screenings to seniors.
Evaluation results	• $5,184,688 in contributions • 2,245 people received health education classes • 592 seniors were provided comprehensive health screenings • 26 community education events provided 913 people with information on health-related topics

9. Conclusion

Mills-Peninsula Medical Center (MPMC) worked with its Healthy Community Collaborative (HCC) partners in 2018 and 2019 to conduct the 2019 Community Health Needs Assessment (CHNA).

The 2019 CHNA builds upon health assessments dating to 1995 and meets federally mandated requirements and California state regulations.

MPMC identified priority community health needs using the HCC's pooled expertise and resources to conduct a shared assessment, which included collecting secondary data and conducting new primary research (i.e., community input). The MPMC administrative team then prioritized the health needs based on a set of defined criteria.

Next steps for the hospital:

- Ensure the 2019 CHNA is adopted by the Sutter Health board and made publicly available on the Sutter Health website by December 31, 2019.[105]
- Monitor community comments on the CHNA report (ongoing).
- Select priority health needs to address using a set of criteria.
- Develop strategies to address priority health needs (independently or with HCC partner hospitals).
- Ensure strategies are adopted by the Sutter Health board and made publicly available.

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

10. List of Attachments

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

Attachment 1. Community Leaders, Representatives, and Members Consulted

The list below contains the names of leaders, representatives, and members who were consulted for their expertise in the community. Leaders were identified based on their professional expertise and knowledge of target groups, including low-income populations, minorities, and the medically underserved. CHNA participants included leaders from San Mateo County Health, nonprofit hospital representatives, local government employees, and nonprofit organizations. For a description of members of the community who participated in focus groups, see Section 5: Process and Methods of the CHNA report.

ID #	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
Organizations							
1	Interview	Dr. David Young, Director, San Mateo County Behavioral Health and Recovery Services	Behavioral health	1	Medically underserved	Leader	4/16/18
2	Interview	Bruno Pillet, Vice President of Programs & Services, Second Harvest Food Bank of Santa Clara and San Mateo Counties	Food insecurity	1	Low-income	Leader	4/16/18
3	Interview	Judith Guerrero, Executive Director, Boys & Girls Club of the Coastside	Youth health, coastside	1	Low-income, minority	Leader	4/16/18
4	Interview	Evan Jones, Executive Director, Mid-Peninsula Boys & Girls Club	Youth health, mid-county	1	Low-income, minority	Leader	4/17/18
5	Interview	Dr. Philippe Rey, Executive Director, Adolescent Counseling Services	Adolescent mental health	1	Medically underserved	Leader	4/18/18
6	Interview	Emily Roberts, Chair, San Mateo County Oral Health Coalition	Oral health	1	Medically underserved	Leader	4/18/18

ID #	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
7	Interview	Dr. Karen Li, Wellness Coordinator, Sequoia Union High School District	Youth health, south county	1	Medically underserved	Leader	4/23/18
8	Interview	Gloria Brown, Co-Founder and Member, African American Community Health Advisory Committee	African American health	1	Medically underserved, Minority	Leader, Representative	4/26/18
9	Interview	Maya Altman, Chief Executive Officer, Health Plan of San Mateo	Health care access	1	Medically underserved	Leader	4/27/18
10	Interview	Dr. Anand Chabra, Medical Director at Family Health Services Division, San Mateo County Health	Maternal-child health	1	Health department representative, Medically underserved	Leader	4/27/18
11	Interview	Rita Mancera, Executive Director, and Madeline Kane, Community Health Manager, Puente de la Costa Sur	South coast health	2	Low-income, Medically underserved, Minority	Leader	5/3/18
12	Interview	Kitty Lopez, Executive Director, First 5 San Mateo County	Children ages zero to five	1	Low-income	Leader	5/8/18
13	Interview	Dr. Janet Chaikind, Supervising Physician, Daly City Youth Health Center	Youth health, north county	1	Medically underserved	Leader	5/8/18
14	Interview	Pia Walker, Vice President of Resident Services, MidPen Housing	Housing	1	Low-income	Leader	5/14/18
15	Interview	Thomas N. Robinson, MD, MPH, Irving Schulman, MD, Endowed Professor in Child Health, Professor of Pediatrics and of Medicine and, by courtesy, of	Diabetes and obesity	1	Medically underserved	Leader	5/15/18

ID #	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
		Health Research and Policy, and Director of the Center for Healthy Weight, Stanford University and Lucile Packard Children's Hospital Stanford					
16	Interview	Dr. Helen Wong, Physician, North East Medical Services	North coast health	1	Medically underserved	Leader	5/21/18
17	Interview	Jeneé Litrell, Associate Superintendent, San Mateo County Office of Education	K-12 student health	1	Medically underserved	Leader	5/31/18
18	Interview	Srija Srinivasan, Deputy Chief, San Mateo County Health	Public health	1	Health department representative	Leader	6/11/18
19	Focus Group	**Host:** San Mateo County Human Services Agency	Social determinants of health	18	Low-income, Medically underserved	(see below)	4/27/18
		Attendees:					
		Becky Luong, Program Manager, Abode Services	Social determinants of health			Leader	
		Brian Eggers, Management Analyst, Center on Homelessness, San Mateo County Human Services Agency	Social determinants of health			Leader	
		Chelsea Tercero, Program Director, Redwood Family House & Family Crossroads, LifeMoves	Social determinants of health			Leader	
		Christiana Weidanz, Program Manager, Samaritan House	Social determinants of health			Leader	

ID #	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
		Donna Miller, Associate Program Director, LifeMoves	Social determinants of health			Leader	
		Fatima Soares, Executive Director, Coastside Hope	Social determinants of health			Leader	
		Gloria Flores-Garcia, Associate Executive Director, El Concilio of San Mateo County	Social determinants of health			Leader	
		Heather Bucy, Director of Shelter Services, LifeMoves	Social determinants of health			Leader	
		Jessica Silverberg, Program Manager, San Mateo County Human Services Agency	Social determinants of health			Leader	
		Madeline Kane, Community Health Manager, Puente de la Costa Sur	Social determinants of health			Leader	
		Pastor Bains, Co-Founder/President, Project WeHope	Social determinants of health			Leader	
		Pat Bohm, Executive Director, Daly City Partnership	Social determinants of health			Leader	
		Peter Ehrhorn, Director of Youth Empowerment Services, StarVista	Social determinants of health			Leader	
		Prinsess Futrell, Executive Director, Home and Hope	Social determinants of health			Leader	

ID #	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
		Selina Toy Lee, Director of Collaborative Community Outcomes, San Mateo County Human Services Agency	Social determinants of health			Leader	
		Sylvia Dorsey, Human Services Specialist, Fair Oaks Community Center, City of Redwood City	Social determinants of health			Leader	
		Thuy Le, Medical Partnership Coordinator, Second Harvest Food Bank of San Mateo and Santa Clara Counties	Social determinants of health			Leader	
		Whitney Genevro, Partnership Manager, Second Harvest Food Bank of Santa Clara and San Mateo Counties	Social determinants of health			Leader	
20	Focus Group	**Host:** Before Our Very Eyes/Bay Area Anti-Trafficking Coalition	Community & family safety	9	Low-income, Medically underserved	(see below)	5/8/18
		Attendees:					
		Amanda LeBlanc Freeman, Program Director, Rape Trauma Services	Community & family safety			Leader	
		Anthony Perkins, Detective, San Bruno Police Department	Community & family safety			Leader	
		Elisa Kuhl, Program Manager, Victim Services Division, San Mateo County DA's Office	Community & family safety			Leader	
		Janel Guinane, First Chance & DUI Services, StarVista	Community & family safety			Leader	

ID #	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
		Jerry Lindner, Program Manager, Children & Family Services, San Mateo County	Community & family safety			Leader	
		John Vanek, Human Trafficking Program Coordinator, San Mateo County	Community & family safety			Leader	
		Pamela Estes, Human Trafficking Advocacy Coordinator, San Mateo County	Community & family safety			Leader	
		Rosanna Anderson, Educational Liaison, Foster Youth Services Program, San Mateo County Office of Education	Community & family safety			Leader	
		Susan Houser, BSN, MSN, CPNP, Forensic Interviewer, Sexual Assault Forensic Examiner, Keller Center, San Mateo Medical Center	Community & family safety			Leader	
21	Focus Group	**Host:** Sequoia Wellness Center	Older adults	11	Low-income	(see below)	5/10/18
		Attendees:					
		Anna Kertel, Recreation Supervisor, City of San Carlos Parks and Recreation	Older adults			Leader	
		Bonnie Grim, Program Manager, Peninsula Volunteers, Meals on Wheels	Older adults			Leader	
		Christina Dimas-Kahn, Program Manager, HICAP of San Mateo County	Older adults			Leader	

ID #	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
		Diane Gillen, Clinical Outreach Nurse, Mission Hospice	Older adults			Leader	
		Kathleen Beasley, Branch Manager, Belmont Library	Older adults			Leader	
		Lynne Murphy, Director of Resident Services, Lesley Senior Communities	Older adults			Leader	
		Saili Gosula, Owner/Executive Director, SYNERGY HomeCare	Older adults			Leader	
		Susan Houston, Vice President of Older Adult Services, Peninsula Family Services	Older adults			Leader	
		Suyin Nichols, Resident Services Coordinator, HIP Housing	Older adults			Leader	
		Terri Neill, Principal, Director of Client Relations, Senior Assist of the Peninsula	Older adults			Leader	
		Tricia Halimah, Manager of Community Health, Health & Wellness Center, Sequoia Hospital	Older adults			Leader	
22	Focus Group	**Host:** LifeMoves	Homelessness	7	Low-income, Medically underserved	(see below)	5/24/18
		Attendees:					
		Catilin Esparza, Educational Initiatives Manager, LifeMoves	Homelessness			Leader	
		Corena Rosa, Veterans Care Manager, LifeMoves	Homelessness			Leader	

ID #	DATA COLLECTION METHOD	NAME, TITLE, AGENCY	TOPIC	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
		Eileen Donovan, Case Manager, LifeMoves	Homelessness			Leader	
		Evelyn Reyes, Case Manager, LifeMoves	Homelessness			Leader	
		Johanna Mora, Case Manager, LifeMoves	Homelessness			Leader	
		Vitani Taamu, Housing Specialist, LifeMoves	Homelessness			Leader	
		William Gomez, Associate Program Director, First Step, LifeMoves	Homelessness			Leader	
Community Residents (names of participants withheld)							
23	Focus Group	**Host:** The Villages of San Mateo County	Older adults	8	Low-income	Members	4/18/18
24	Focus Group	**Host:** Peninsula Family Services Agency, North Fair Oaks Senior Center	Spanish-speaking older adults	12	Low-income, Medically underserved, Minority	Members	5/16/18
25	Focus Group	**Host:** Pride Center	LGBTQI issues	10	Medically underserved, Minority	Members	5/17/18
26	Focus Group	**Host:** Cañada College	Young adults	5	Low-income	Members	5/9/18
27	Focus Group	**Host:** Peninsula Conflict Resolution Center	Pacific Islanders	10	Minority	Members	6/12/18

Attachment 2. Secondary Data Sources

The sources of data in the list below were consulted to compile the data tables that underlie this 2019 Community Health Needs Assessment.

1. Area Health Resource File/American Medical Association. 2015.
2. Area Health Resource File/National Provider Identification file. 2016.
3. Business Analyst, Delorme map data, ESRI, & US Census Tigerline Files. 2010, 2016.
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5. California County Health Status Profiles. 2013–2015
6. California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd). 2011–2013.
7. California Department of Education, FITNESSGRAM® Physical Fitness Testing. 2013–2014, 2016–2017.
8. California Department of Education. 2014–2015, 2015–2016, 2016–2017.
9. California Department of Public Health, Birth Cohort-Perinatal Outcome Files. 2009–2014.
10. California Department of Public Health, Breastfeeding Statistics. 2012.
11. California Department of Public Health, Death Public Use Data. 2010–2012, 2010–2015.
12. California Department of Public Health, EpiCenter. 2013, 2014.
13. California Department of Public Health, Immunization Branch. 2015, 2016.
14. California Department of Public Health, Kindergarten Immunization Assessment, 2015–2016 & 2016–2017.
15. California Department of Public Health, Tracking. 2005–2012.
16. California Department of Public Health, Tuberculosis Branch. 2016.
17. California Department of Public Health. 2014–2016.
18. California Office of Statewide Health and Planning (OSPHD). 2011, 2013–2015, 2014.
19. CDC Diabetes Interactive Atlas. 2014.
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22. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (BRFSS). 2005–2009, 2006–2010, 2006–2012, 2011–2012, 2016.
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39. Insight Center for Community Economic Development, 2014.
40. Institute for Health Metrics and Evaluation. 2014.
41. Interactive Atlas of Heart Disease and Stroke. 2012–2014.
42. Mapping Medicare Disparities tool. 2015.
43. Measure of America. 2010–2014.
44. National Center for Education Statistics, NCES - Common Core of Data. 2015–2016.
45. National Center for Education Statistics, NCES -CHR EDFacts. 2014–2015.
46. National Center for Health Statistics - Natality files. 2010–2016.
47. National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2015.
48. National Environmental Public Health Tracking Network. 2014.
49. National Flood Hazard Layer. 2011.
50. National Land Cover Database. 2011.
51. National Oceanic and Atmospheric Administration, North America Land Data Assimilation System (NLDAS). Accessed via CDC WONDER. Additional data analysis by CARES. 2014.
52. National Vital Statistics System. 2004–2010, 2008–2014, 2011–2015.
53. Opportunity Nation. 2017.
54. Safe Drinking Water Information System. 2015.
55. San Mateo County Department of Public Health. 2014–2016, 2015–2016, 2016.
56. San Mateo County Health, Health and Quality of Life Survey. 2018.
57. San Mateo County Health. 2010–2015, 2012–2014, 2015, 2016.
58. Small Area Income and Poverty Estimates. 2016.
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62. US Census Bureau, American Community Survey. 2011–2015, 2012–2016.
63. US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2016.
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69. US Department of Health & Human Services, Centers for Medicare & Medicaid Services. 2015.
70. US Department of Health & Human Services, Centers for Medicare & Medicaid Services, Provider of Services File. March 2018.

71. US Department of Health & Human Services, Health Resources and Services Administration. April 2016.
72. US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2012–2014, 2014.
73. US Department of Labor, Bureau of Labor Statistics. March 2018.
74. US Department, of Housing and Urban Development. 2016.
75. US Drought Monitor, 2012–2014.
76. Zilpy.com, Rental Market Trends. October 2018.

Attachment 3. Secondary Data Indicators List

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
30-Day Readmissions	Healthcare Access & Delivery	Percentage of Medicare fee-for-service beneficiaries readmitted to a hospital within 30 days of an initial hospitalization discharge	Dartmouth Atlas of Health Care. 2014.	2014
Absenteeism Due to Cyberbullying	Neighborhood & Built Environment (Community & Family Safety); Mental Health & Well-Being (Mental Health/Emotional Well-Being)	Percentage of youth who reported being bullied or harassed via the internet, who missed one or more days of school in the past month	County of San Mateo, Board of Supervisors. Adolescent Report 2014-15.	2014-2015
Access to Dentists Rate	Healthcare Access & Delivery; Oral/Dental Health	Number of dentists per 100,000 population	Area Health Resource File/National Provider Identification file. 2016.	2016
Access to Mental Health Care Providers Rate	Healthcare Access & Delivery; Mental Health & Well-Being (Mental Health/Emotional Well-Being)	Mental health care provider rate (Per 100,000 Population)	University of Wisconsin Population Health Institute, County Health Rankings. 2018.	2018
Access to Other Primary Care Providers Rate	Healthcare Access & Delivery	Other primary care provider (e.g., nurse practitioner, physician assistant) rate per 100,000 population	CMS, National Provider Identification. 2017	2017
Access to Primary Care Rate	Healthcare Access & Delivery	Number of primary care physicians per 100,000 population	Area Health Resource File/American Medical Association. 2015. Trend: U.S. Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2014.	2015

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
Accidents (Unintentional Injuries) Death Rate	Unintended Injuries/Accidents	Accidents (unintentional injuries) rate per 100,000 population	California Department of Public Health: 2010-2015 Death Records.	2013-2015
Acute Hepatitis B Cases Rate	Infectious Diseases	Incidence of acute Hepatitis B cases per 100,000 population	California Department of Public Health Immunization Branch. 2015	2015
Adequate Fruit/Vegetable Consumption (Adults)	Healthy Lifestyles (Obesity/Overweight & Diabetes Related Factors); Cancer; Heart Disease/Stroke	Percentage of survey respondents reporting that they eat the recommended number of daily servings of fruits and vegetables	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Adequate/Adequate Plus Prenatal Care	Birth Outcomes	Percentage of births for which prenatal care was begun by the 4th month of pregnancy and 80% or more of recommended visits received	California Department of Public Health: 2009-2014 Birth Cohort-Perinatal Outcome Files.	2013-2015
Adults Age 65+ Living Alone	Social & Community Context; Mental Health & Well-Being (Mental Health/Emotional Well-Being); Neighborhood & Built Environment (Community & Family Safety)	Percentage of respondents who were adults age 65+ who indicated they were living alone	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Adults Needing and Receiving Behavioral Health Care Services	Healthcare Access & Delivery; Mental Health & Well-Being (Mental Health/Emotional Well-Being; Tobacco/Substance Use)	Percentage of adults needing and receiving behavioral health care services	California Health Interview Survey. 2015-2016.	2015-2016

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
Adults with an Associate's Degree or Higher	Education & Literacy; Poverty, Income & Employment	Percentage of the population aged 25 years and older with an Associate's degree or higher	US Census Bureau, American Community Survey. 2012-2016.	2012-2016
Adults with Less than High School Diploma (or Equivalent)	Education & Literacy; Poverty, Income & Employment	Percentage of the population age 25 and older without a high school diploma (or equivalency) or higher.	US Census Bureau, American Community Survey. 2012-16.	2012-2016
Adults with Some Post-Secondary Education	Education & Literacy; Poverty, Income & Employment	Percentage of adults aged 25 to 44 years with at least some post-secondary education	US Census Bureau, American Community Survey. 2012-2016.	2012-2016
Air Quality - Ozone (O3)	Neighborhood & Built Environment (Natural Environment/Climate; Transportation & Traffic); Asthma & Respiratory Conditions	Percentage of days per year with Ozone (O3) levels above the National Ambient Air Quality Standard of 75 parts per billion (ppb)	National Environmental Public Health Tracking Network. 2014.	2014
Air Quality - Particulate Matter 2.5	Neighborhood & Built Environment (Natural Environment/Climate; Transportation & Traffic); Asthma & Respiratory Conditions; Cancer	Percentage of days per year with fine particulate matter 2.5 (PM2.5) levels above the National Ambient Air Quality Standard of 35 micrograms per cubic meter	National Environmental Public Health Tracking Network. 2014.	2014
Alcohol – Binge Drinker	Neighborhood & Built Environment (Community & Family Safety); Mental Health & Well-Being (Tobacco/Substance Use); Cancer; Heart Disease/Stroke; Unintended Injuries/Accidents	Percentage of survey respondents who reported that they have had 5 or more drinks on an occasion (men) or 4 or more drinks on an occasion (women)	San Mateo County Health, Health and Quality of Life Survey. 2018. Benchmark: Behavioral Risk Factor Surveillance System. 2016.	2016, 2018

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
Alcohol – Current Drinker11 QoL† & 24	Mental Health & Well-Being (Tobacco/Substance Use)	Percentage of survey respondents who reported that they have had one or more drinks in the past month.	San Mateo County Health, Health and Quality of Life Survey. 2018. Benchmark: Behavioral Risk Factor Surveillance System. 2016.	2016, 2018
Alcohol-Impaired Driving Deaths	Mental Health & Well-Being (Tobacco/Substance Use); Unintended Injuries/Accidents	Percentage of driving deaths with alcohol involvement	Fatality Analysis Reporting System. 2012-2016.	2012-2016
All Causes of Death Rate	General Health	Age-adjusted rate of death due to all causes per 100,000 population per year	California Department of Public Health: 2010-2015 Death Records.	2013-2015
All Violent Crimes Rate	Neighborhood & Built Environment (Community & Family Safety)	Violent crime rate (per 100,000 population)	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2012-2014.	2012-2014
Alzheimer's Disease (Prevalence)	Dementia & Cognitive Decline	Percentage of the adult population with Alzheimer's Disease	Centers for Medicaid & Medicaid Services. 2015.	2015
Alzheimer's Disease Mortality Rate	Dementia & Cognitive Decline	Age-adjusted rate of death due to Alzheimer's per 100,000 population per year	California County Health Status Profiles. 2013-2015	2013-2015
Ambulance Transport, Behavioral Health	Mental Health & Well-Being (Tobacco/Substance Use)	Percentage of all ambulance transports initiated by a call to 911 in which behavioral health issues were the primary impression (main reason for the call)	County of San Mateo Emergency Medical Services. 911 Calls. 2016-2017.	2016-2017

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
Ambulance Transport, Cardiac Issues	Heart Disease/Stroke	Percentage of all ambulance transports initiated by a call to 911 in which cardiac issues were the primary impression (main reason for the call)	County of San Mateo Emergency Medical Services. 911 Calls. 2016-2017.	2016-2017
Ambulance Transport, Neurological Issues	General Health	Percentage of all ambulance transports initiated by a call to 911 in which neurological issues were the primary impression (main reason for the call)	County of San Mateo Emergency Medical Services. 911 Calls. 2016-2017.	2016-2017
Ambulance Transport, Pain	Mental Health & Well-Being (Mental Health/Emotional Well-Being)	Percentage of all ambulance transports initiated by a call to 911 in which pain was the primary impression (main reason for the call)	County of San Mateo Emergency Medical Services. 911 Calls. 2016-2017.	2016-2017
Ambulance Transport, Respiratory Issues	Asthma & Respiratory Conditions	Percentage of all ambulance transports initiated by a call to 911 in which respiratory issues were the primary impression (main reason for the call)	County of San Mateo Emergency Medical Services. 911 Calls. 2016-2017.	2016-2017
Ambulance Transport, Toxicological Issues	Unintended Injuries/Accidents; Oral/Dental Health	Percentage of all ambulance transports initiated by a call to 911 in which toxicological issues (accidental or intentional poisoning by alcohol, drugs, or other toxins) were the primary impression (main reason for the call)	County of San Mateo Emergency Medical Services. 911 Calls. 2016-2017.	2016-2017
Ambulance Transport, Toxicological Issues	Mental Health & Well-Being (Tobacco/Substance Use)	Percentage of all ambulance transports initiated by a call to 911 in which toxicological issues (accidental or intentional poisoning by alcohol, drugs, or other toxins) were the primary impression (main reason for the call)	County of San Mateo Emergency Medical Services. 911 Calls. 2016-2017.	2016-2017
Ambulance Transport, Trauma (Injury)	Unintended Injuries/Accidents	Percentage of all ambulance transports initiated by a call to 911 in which trauma (injury) was the primary	County of San Mateo Emergency Medical Services. 911 Calls.	2016-2017

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
		impression (main reason for the call)	2016-2017.	
Ambulance Transport, Vascular Issues	Heart Disease/Stroke	Percentage of all ambulance transports initiated by a call to 911 in which vascular issues were the primary impression (main reason for the call)	County of San Mateo Emergency Medical Services. 911 Calls. 2016-2017.	2016-2017
Area with Tree Canopy Cover (pop.-weighted)	Neighborhood & Built Environment (Natural Environment/Climate)	Percentage of land within the report area that is covered by tree canopy	National Land Cover Database. 2011.	2011
Arthritis/Rheumatism	Arthritis	Percentage of survey respondents answering "yes" when asked: "Have you ever suffered from or been diagnosed with any of the following medical conditions: Arthritis or Rheumatism?"	San Mateo County Health, Health and Quality of Life Survey. 2018. Benchmark: Behavioral Risk Factor Surveillance System. 2016.	2016, 2018
Assault (Crime) Rate	Neighborhood & Built Environment (Community & Family Safety)	Assault injuries, rate per 100,000 population	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2012-14.	2012-2014
Assault (Injury) Rate	Neighborhood & Built Environment (Community & Family Safety)	Assault Injuries, Rate per 100,000 Population	California Department of Public Health, California EpiCenter. 2013-14.	2013-2014
Assisted Housing Units Rate (per 10,000)	Housing & Homelessness; Neighborhood & Built Environment (Community Infrastructure & Housing Quality)	HUD-assisted units, rate per 10,000 housing units	US Department, of Housing and Urban Development. 2016.	2016
Asthma	Healthcare Access &	Patient discharge rate per 10,000	Mapping Medicare	2015

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
Hospitalizations Rate (per 10,000 Medicare Beneficiaries)	Delivery; Neighborhood & Built Environment (Natural Environment/Climate); Asthma & Respiratory Conditions	total population for asthma and related complications	Disparities tool. 2015.	
Asthma Patient Discharges, Children/Youth (age 1-19)	Housing & Homelessness; Neighborhood & Built Environment (Natural Environment/Climate); Asthma & Respiratory Conditions	Patient discharge rate (per 10,000 total population) for asthma and related complications for children/youth ages 1-19.	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES. 2011.	2011
Asthma Patient Discharges, Older Adults (age 65+)	Neighborhood & Built Environment (Natural Environment/Climate); Asthma & Respiratory Conditions	Patient discharge rate (per 10,000 total population) for asthma and related complications for adults age 65+.	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES. 2011.	2011
Asthma Prevalence, Adults	Neighborhood & Built Environment (Natural Environment/Climate); Asthma & Respiratory Conditions	Percentage of the adult population with asthma	San Mateo County Health, Health and Quality of Life Survey. 2018. Benchmark: Behavioral Risk Factor Surveillance System. 2016.	2016, 2018
Asthma Prevalence, Children/Youth	Neighborhood & Built Environment (Natural Environment/Climate); Asthma & Respiratory Conditions	Percentage of children and teens with asthma	San Mateo County Health, Health and Quality of Life Survey. 2018. Benchmark: Behavioral Risk Factor Surveillance System. 2016.	2016, 2018
Banking Institutions Rate (per 10,000 pop.)	Housing & Homelessness	Number of banking institutions (commercial banks, savings	County Business Patterns. 2015.	2015

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
		institutions and credit unions) per 10,000 population		
Breast Cancer Death Rate	Cancer	Age-adjusted rate of death among females due to breast cancer per 100,000 population	California Department of Public Health: 2010-2015 Death Records.	2013-2015
Breast Cancer Incidence Rate	Cancer	Annual breast cancer incidence rate (per 100,000 population)	State Cancer Profiles. 2010-2014.	2010-2014
Breastfeeding (Any)	Birth Outcomes; Healthy Lifestyles (Obesity)	Percentage of mothers breastfeeding (any); total in-hospital births.	California Department of Public Health, California Department of Public Health - Breastfeeding Statistics. 2012.	2012
Breastfeeding (Exclusive)	Birth Outcomes; Healthy Lifestyles (Obesity)	Percentage of mothers breastfeeding (exclusively); total in-hospital births.	California Department of Public Health, California Department of Public Health - Breastfeeding Statistics. 2012.	2012
Cancer Mortality Rate (All Types)	Cancer	Age-adjusted rate of death due to malignant neoplasm (cancer) per 100,000 population per year	California Department of Public Health. 2014-2016. Trend: California Department of Public Health: 2010-2015 Death Records.	2014-2016
Cancer Prevalence	Cancer	Percentage of the adult population with cancer	San Mateo County Health, Health and Quality of Life Survey. 2018. Benchmark: Behavioral Risk Factor Surveillance System. 2016.	2016, 2018
Cancer Prevalence (Medicare Population)	Cancer	Percentage of Medicare population with cancer	US Department of Health & Human Services, Centers for Medicare & Medicaid Services. 2015.	2015

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
Cancer Screening – Fecal Occult Blood Stool Test	Healthcare Access & Delivery; Cancer	Percentage of survey respondents, adults age 50+, answering "yes" when asked "Have you had a blood stool test in the past two years?"	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Cancer Screening – FOBT/Sigmoid/Colonoscopy	Healthcare Access & Delivery; Cancer	Percentage of survey respondents, adults age 50-75, answering "yes" when asked "Have you ever had a colorectal cancer screening (FOBT/sigmoidoscopy/colonoscopy)?"	San Mateo County Health, Health and Quality of Life Survey. 2018. Benchmark: Behavioral Risk Factor Surveillance System. 2016.	2016, 2018
Cancer Screening – Mammogram	Healthcare Access & Delivery; Cancer	Percentage of survey respondents, women age 50-74, answering "yes" when asked "Have you had a mammogram in the past 2 years?"	San Mateo County Health, Health and Quality of Life Survey. 2018. Benchmark: Behavioral Risk Factor Surveillance System. 2016.	2016, 2018
Cancer Screening – Mammogram, Medicare Population	Healthcare Access & Delivery; Cancer	Percent female Medicare enrollees with mammogram in past 2 years	San Mateo County Health, Health and Quality of Life Survey. 2018. Benchmark: The Dartmouth Atlas of Health Care. 2015	2015, 2018
Cancer Screening - Pap Test	Healthcare Access & Delivery; Cancer	Percentage of females age 18+ with regular pap test (age-adjusted)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-2012.	2006-2012

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
Cancer Screening - Sigmoid/Colonoscopy, Adults 50+	Healthcare Access & Delivery; Cancer	Percentage of survey respondents, adults age 50+, answering "yes" when asked "Have you ever had a colonoscopy/sigmoidoscopy?"	San Mateo County Health, Health and Quality of Life Survey. 2018. Benchmark: Behavioral Risk Factor Surveillance System. 2016.	2016, 2018
Cervical Cancer Incidence Rate	Cancer	Annual cervical cancer incidence rate (per 100,000 population)	State Cancer Profiles. 2009-2013.	2009-2013
Child Had Recent Dental Exam	Healthcare Access & Delivery; Oral/Dental Health	Percentage of survey respondents with at least one child under the age of 18 living at home, who reported that their child had visited a dentist within the past year	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Child Has Usual Place for Medical Check-ups	Healthcare Access & Delivery; Birth Outcomes	Percentage of survey respondents with at least one child under the age of 18 living at home, who reported that they have a regular place they take their child for medical check-ups	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Child Mortality Rate	General Health	Number of deaths among children under age 18 per 100,000	CDC WONDER mortality data. 2013-2016.	2013-2016
Childcare Arrangement Has Made It Easier for Parent to Accept a Better Job	Poverty, Income, & Employment	Percentage of survey respondents with at least one child under the age of 18 living at home, who reported that their childcare arrangement has made it easier for them to accept a better job	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Childcare Arrangement Has Made It Easier for Parent to Accept a Job	Poverty, Income, & Employment	Percentage of survey respondents with at least one child under the age of 18 living at home, who reported that their childcare arrangement has made it easier for them to accept a job	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
Childcare Arrangement Has Made It Easier for Parent to Attend Education/Training	Education & Literacy; Poverty, Income, & Employment	Percentage of survey respondents with at least one child under the age of 18 living at home, who reported that their childcare arrangement has made it easier for them to attend education/training	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Childcare Arrangement Has Made It Easier for Parent to Keep a Job	Poverty, Income, & Employment	Percentage of survey respondents with at least one child under the age of 18 living at home, who reported that their childcare arrangement has made it easier for them to keep a job	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Children Below 100% FPL	Poverty, Income & Employment	Percent Population Under Age 18 in Poverty	US Census Bureau, American Community Survey. 2012-2016.	2012-2016
Children Eligible for Free/Reduced Price Lunch	Food Insecurity; Healthy Lifestyles (Diet, Fitness & Nutrition; Obesity)	Percentage of public school students eligible for free or reduced-price lunches	National Center for Education Statistics, NCES - Common Core of Data. 2015-2016.	2015-2016
Children in Single-Parent Households	Food Insecurity	Percentage of children that live in households with only one parent present	US Census Bureau, American Community Survey. 2012-2016.	2012-2016
Children Walking or Biking to School	Healthy Lifestyles (Diabetes; Diet, Fitness & Nutrition; Obesity)	Percentage of children walk, bike or skate to school at least occasionally, according to their parent/guardian	California Health Interview Survey. 2015-2016.	2015-2016
Chlamydia Cases (Incidence) Rate	Sexually Transmitted Infections	Chlamydia cases (incidence) rate per 100,000 population	California Department of Public Health, Sexually Transmitted Diseases Control Branch. 2016.	2016
Chronic Liver Disease and Cirrhosis Death Rate	Mental Health & Well-Being (Tobacco/Substance Use)	Chronic liver disease and cirrhosis age-adjusted death rate per 100,000 population	California Department of Public Health: 2010-2015 Death Records.	2013-2015
Chronic Lower Respiratory Disease Death Rate	Asthma & Respiratory Conditions	Chronic lower respiratory disease age-adjusted death rate per 100,000 population	California Department of Public Health: 2010-2015 Death Records.	2013-2015

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
Climate & Health - Drought Severity	Neighborhood & Built Environment (Natural Environment/Climate)	Percentage of Weeks in Drought (Any)	US Drought Monitor., 2012-14.	2012-2014
Climate & Health - Heat Index Days	Neighborhood & Built Environment (Natural Environment/Climate)	Percentage of recorded weather observations with heat index values over 103 degrees Fahrenheit.	National Oceanic and Atmospheric Administration, North America Land Data Assimilation System (NLDAS). Accessed via CDC WONDER. Additional data analysis by CARES. 2014.	2014
Climate & Health - Heat Stress Events	Neighborhood & Built Environment (Natural Environment/Climate)	Heat-related Emergency Department Visits, Rate per 100,000 Population	California Department of Public Health, California Department of Public Health - Tracking. 2005-2012.	2005-2012
Climate-Related Mortality Impacts	Neighborhood & Built Environment (Natural Environment/Climate)	median estimated economic impacts from changes in all-cause mortality rates, across all age groups, as a percentage of county GDP	Climate Impact Lab. 2016.	2016
College Preparedness, High School Graduates	Education & Literacy	Percentage of high school graduates who reported taking college preparatory courses in high school	County of San Mateo, Board of Supervisors. Adolescent Report 2014-2015.	2014-2015
Colorectal Cancer Death Rate	Cancer	Age-adjusted rate of death due to colorectal cancer per 100,000 population per year	California Department of Public Health: 2010-2015 Death Records.	2013-2015
Colorectal Cancer Incidence Rate	Cancer	Annual colon and rectum cancer incidence rate (per 100,000 population)	State Cancer Profiles. 2010-2014.	2010-2014
Community Connectedness – Feel Not Very or Not at All Connected	Neighborhood & Built Environment (Community & Family Safety); Social & Community Context; Mental	Percentage of survey respondents who reported that they felt not very or not at all connected to their community	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
	Health & Well Being (Mental Health/Emotional Well-Being)			
Community is Fair/Poor Place to Live	Social & Community Context	Percentage of survey respondents who rated their community as a fair or poor place to live	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Community Tolerance for Racial/Cultural Differences is Fair/Poor	Social & Community Context; Mental Health & Well-Being (Mental Health/Emotional Well-Being)	Percentage of survey respondents who rated their community's tolerance for racial/cultural differences as a fair or poor	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Commute >60 Min.	Housing & Homelessness; Healthy Lifestyles (Diabetes; Diet, Fitness, & Nutrition; Obesity)	Percentage of workers commuting more than 60 minutes	US Census Bureau, American Community Survey. 2012-2016.	2012-2016
Commute to Work - Alone in Car	Neighborhood & Built Environment (Natural Environment/Climate; Transportation & Traffic); Healthy Lifestyles (Diabetes; Diet, Fitness, & Nutrition; Obesity)	Percentage of workers commuting by car, alone	US Census Bureau, American Community Survey. 2012-2016.	2012-2016
Commute to Work – By Public Transit	Neighborhood & Built Environment (Natural Environment/Climate; Transportation & Traffic); Healthy Lifestyles (Diabetes; Diet, Fitness, & Nutrition; Obesity)	Percentage of workers commuting by public transit	US Census Bureau, American Community Survey. 2012-2016.	2012-2016
Commute to Work - Walking/Biking	Healthy Lifestyles (Diabetes; Diet, Fitness, & Nutrition; Obesity)	Reports the percentage of the population that commutes to work by either walking or riding a bicycle	US Census Bureau, American Community Survey. 2012-2016.	2012-2016

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
Computer in Household	Education & Literacy; Poverty, Income, & Employment	Percentage of survey respondents who answered "yes" when asked, "Do you currently have a computer in your household?"	San Mateo County Health, Health and Quality of Life Survey. 2018.	2016
COPD, Bronchitis, Emphysema	Asthma & Respiratory Conditions	Percentage of survey respondents answering "yes" when asked: "Have you ever suffered from or been diagnosed with any of the following medical conditions: COPD or Chronic Obstructive Pulmonary Disease, Including Bronchitis or Emphysema?"	San Mateo County Health, Health and Quality of Life Survey. 2018. Benchmark: Behavioral Risk Factor Surveillance System. 2016.	2016, 2018
Coping and Drug Use, Youth	Mental Health & Well-Being (Tobacco/Substance Use)	Percentage of youth who engaged in positive coping strategies, based on self-reported drug use	County of San Mateo, Board of Supervisors. Adolescent Report 2014-2015.	2014-2015
Coronary Heart Disease Death Rate	Heart Disease/Stroke	Age-adjusted rate of death due to coronary heart disease per 100,000 population per year	California Department of Public Health: 2010-2015 Death Records.	2010-2015
Cost Burden – Renters	Housing & Homelessness; Poverty, Income & Employment	Renters Spending 30% or More of Household Income on Rent	US Census Bureau, American Community Survey. 2012-2016.	2012-2016
Cost Burdened Households	Housing & Homelessness; Poverty, Income & Employment	Percentage of households where housing costs exceed 30% of income	US Census Bureau, American Community Survey. 2012-2016.	2012-2016
Crime in Neighborhood is Getting Much/a Little Worse	Neighborhood & Built Environment (Community & Family Safety)	Percentage of survey respondents indicating that the problem of crime in their neighborhood over the past two years has gotten much/a little worse	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
Current Smoker	Asthma & Respiratory Conditions; Mental Health & Well-Being (Tobacco/Substance Use); Cancer; Heart Disease/Stroke; Healthy Lifestyles (Diabetes); Oral/Dental Health	Percentage of survey respondents answering “yes” when asked: “Do you smoke cigarettes now?”	San Mateo County Health, Health and Quality of Life Survey. 2018. Benchmark: Behavioral Risk Factor Surveillance System. 2016.	2016, 2018
Current User of E-Cigarettes (Vaping)	Asthma & Respiratory Conditions; Mental Health & Well-Being (Tobacco/Substance Use)	Percentage of survey respondents answering “Every Day” or “Some Days” when asked: “Do you NOW use e-cigarettes or other electronic "vaping" products "Every Day," "Some Days," or "Not At All"?”	San Mateo County Health, Health and Quality of Life Survey. 2018. Benchmark: Behavioral Risk Factor Surveillance System. 2016.	2016, 2018
Cyberbullying	Neighborhood & Built Environment (Community & Family Safety); Mental Health & Well-Being (Mental Health/Emotional Well-Being)	Percentage of youth who reported being bullied or harassed via the internet	County of San Mateo, Board of Supervisors. Adolescent Report 2014-2015.	2014-2015
Deaths by Suicide, Drug, or Alcohol Poisoning (Rate)	Mental Health & Well-Being (Mental Health/Emotional Well-Being; Tobacco/Substance Use)	Age-adjusted rate of death due to intentional self-harm (suicide), alcohol-related disease, and drug overdoses per 100,000 population	National Vital Statistics System. 2011-2015.	2011-2015
Delayed or Had Difficulty Obtaining Care	Healthcare Access & Delivery	Percentage of adults who reported delaying or having difficulty obtaining care for any reason	California Health Interview Survey. 2013-14.	2013-2014
Dental Insurance	Healthcare Access & Delivery; Oral/Dental Health	Percentage of survey respondents reporting they have dental insurance	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Depression Among Medicare Beneficiaries	Mental Health & Well-Being (Mental Health/Emotional	Percentage of Medicare beneficiaries with depression	US Department of Health & Human Services,	2015

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
	Well-Being)		Centers for Medicare and Medicaid Services. 2015.	
Diabetes Death Rate	Healthy Lifestyles (Diabetes; Obesity)	Age-adjusted rate of death due to diabetes per 100,000 population per year	California Department of Public Health: 2010-2015 Death Records.	2013-2015
Diabetes Discharges (% of Total Discharges)	Heart Disease/Stroke; Healthy Lifestyles (Diabetes; Obesity)	Percentage of total patient discharges for diabetes-related complications.	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES. 2011.	2011
Diabetes Discharges, Children/Youth (age 1-19)	Healthy Lifestyles (Diabetes; Obesity)	Percentage of total patient discharges among children and teens (age 1-19) for diabetes-related complications	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES. 2011.	2011
Diabetes Discharges, Older Adults (age 65+)	Healthy Lifestyles (Diabetes; Obesity)	Percentage of total patient discharges among older adults (age 65+) for diabetes-related complications	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES. 2011.	2011
Diabetes Hospitalizations Rate (per 10,000)	Heart Disease/Stroke; Healthy Lifestyles (Diabetes; Obesity)	Age-adjusted discharge rate (per 10,000 population) for diabetes	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES. 2011.	2011
Diabetes Management	Heart Disease/Stroke;	Percentage of diabetic Medicare	Dartmouth College	2014

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
(Medicare Patients with Hemoglobin A1c Test)	Healthy Lifestyles (Diabetes; Obesity)	patients who have had a hemoglobin A1c (hA1c) test, a blood test which measures blood sugar levels, administered by a health care professional in the past year	Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care. 2014.	
Diabetes Prevalence, Adults	Heart Disease/Stroke; Healthy Lifestyles (Diabetes; Obesity)	Percentage of the adult population with diabetes	San Mateo County Health, Health and Quality of Life Survey. 2018. Benchmark: Behavioral Risk Factor Surveillance System. 2016.	2016, 2018
Did Not Eat Breakfast	Food insecurity	Percentage of students reporting not having eaten breakfast in the past day	County of San Mateo, Board of Supervisors. Adolescent Report 2014-2015.	2014-2015
Difficulty Getting in to See a Doctor	Healthcare Access & Delivery	Percentage of survey respondents who reported that they had difficulty getting in to see a doctor.	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Diphtheria, Tetanus, and Pertussis Vaccine (% of All Kinder)	Infectious Diseases	Percentage of kindergarten students who reported receiving the Diphtheria, Tetanus, and Pertussis Vaccine	California Department of Public Health, Kindergarten Immunization Assessment, 2015-2016 & 2016-2017.	2016-2017
Disconnected Youth	Neighborhood & Built Environment (Community & Family Safety); Social & Community Context; Mental Health & Well-Being (Mental Health/Emotional Well-Being); Unintended Injuries/Accidents	Percentage of teens and young adults ages 16-24 who are neither working nor in school	Measure of America. 2010-2014.	2010-2014

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
Discrimination Due to Mental Health Problems, Youth	Social & Community Context; Mental Health & Well-Being (Mental Health/Emotional Well-Being)	Likelihood of youth feeling discriminated against based on one or more mental health problems	County of San Mateo, Board of Supervisors. Adolescent Report 2014-2015.	2014-2015
Discrimination Due to Physical Disabilities, Youth	General Health, Social & Community Context	Likelihood of youth feeling discriminated against based on one or more physical disabilities	County of San Mateo, Board of Supervisors. Adolescent Report 2014-2015.	2014-2015
Doctor's Visit – Could Not Afford	Healthcare Access & Delivery; Poverty, Income & Employment	Percentage of survey respondents answering "yes" when asked, "Was there a time during the past 12 months when: You needed to see a doctor, but could not because of the cost?"	San Mateo County Health, Health and Quality of Life Survey. 2018. Benchmark: Behavioral Risk Factor Surveillance System. 2016.	2016, 2018
Domestic Violence Hospitalizations Rate	Neighborhood & Built Environment (Community & Family Safety)	Rate of non-fatal hospitalizations for domestic violence incidents among females aged 10 years and older per 100,000 population	California EpiCenter. 2013-2014.	2013-2014
Domestic Violence Rate	Neighborhood & Built Environment (Community & Family Safety); Mental Health & Well-Being (Mental Health/Emotional Well-Being)	Domestic violence injuries, rate per 100,000 population (females age 10+)	California Department of Public Health, California EpiCenter. 2013-2014.	2013-2014
Drinking Water Violations	Neighborhood & Built Environment (Access to Food/Recreation; Community Infrastructure & Housing Quality); Healthy Lifestyles (Diabetes); Oral/Dental Health	Presence or absence of health-based violations in community water systems over a specified time frame	Safe Drinking Water Information System. 2015.	2015
Driving Alone to Work,	Neighborhood & Built	Percentage of the civilian non-	US Census Bureau,	2012-

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
Long Distances	Environment (Natural Environment/Climate; Transportation & Traffic); Healthy Lifestyles (Diabetes; Diet, Fitness, & Nutrition; Obesity)	institutionalized population with long commutes to work, over 60 minutes each direction	American Community Survey. 2012-2016.	2016
Drug-Related Death Rate	Mental Health & Well-Being (Tobacco/Substance Use); Unintended Injuries/Accidents	Age-adjusted drug overdose mortality rate (from all drugs) per 100,000 people; separate for includes both ICD 10 codes and coroner cases, and only ICD 10 codes	CDC WONDER mortality data. 2014-2016.	2014-2016
Early Latent Syphilis Cases (Incidence) Rate	Sexually Transmitted Infections	Early latent syphilis cases (incidence) rate per 100,000 population	California Department of Public Health, Sexually Transmitted Diseases Control Branch. 2016.	2016
Early Syphilis Rates (Men)	Sexually Transmitted Infections	Early syphilis rates (primary, secondary, early latent)	Trend: San Mateo County Health. 2016.	2016
Effective Drug/Alcohol Prevention, Youth	Mental Health & Well-Being (Tobacco/Substance Use)	Percentage of teen survey respondents who reported that their schools provided effective drug and alcohol prevention services	County of San Mateo, Board of Supervisors. Adolescent Report 2014-2015.	2014-2015
Effective Sex Education	Birth Outcomes; Sexually Transmitted Infections	Percentage of teen survey respondents who reported that they feel they are making informed decisions about sex and their sexuality	County of San Mateo, Board of Supervisors. Adolescent Report 2014-2015.	2014-2015
Elder Index, Single Older Adult Renter	Poverty, Income, & Employment	The total annual income needed for an older adult living alone in a rental property in San Mateo County in 2011	Insight Center for Community Economic Development, 2014.	2014
Eligible Students Not Participating in School Breakfast Programs	Food insecurity	Percentage of eligible students not participating in school breakfast programs	Get Healthy San Mateo County. Food Insecurity in San Mateo County. End Hunger Workgroup, October 14, 2016.	2016

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
Eligible Students Not Participating in School Lunch Programs	Food insecurity	Percentage of eligible students not participating in school lunch programs	Get Healthy San Mateo County. Food Insecurity in San Mateo County. End Hunger Workgroup, October 14, 2016.	2016
Engage in Healthy Behaviors	Cancer; Heart Disease/Stroke; Healthy Lifestyles (Diabetes; Diet, Fitness & Nutrition; Obesity), Heart Disease/Stroke; Cancer	Percentage of survey respondents who reported they engage in "healthy behaviors" (do not smoke cigarettes, are not overweight [based on BMI], exercise at least three times per week for at least 20 minutes each time, eat five or more servings of fruit/vegetables per day)	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
ER Visit Rate, Asthma	Asthma & Respiratory Conditions	Average crude Emergency Room visit rate (per 1,000 people) for asthma	San Mateo County Health. 2012-2014.	2012-2014
ER Visit Rate, COPD	Asthma & Respiratory Conditions	Age-adjusted rate of emergency department visits for COPD per 10,000 population	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2013-2015.	2013-2015
ER Visit Rate, Diabetes	Healthy Lifestyles (Diabetes)	Average crude Emergency Room visit rate (per 1,000 people) for diabetes	San Mateo County Health. 2012-2014.	2012-2014
ER Visit Rate, Heart Failure	Heart Disease/Stroke	Average crude Emergency Room visit rate (per 1,000 people) for heart failure	San Mateo County Health. 2012-2014.	2012-2014
ER Visit Rate, Hypertension	Heart Disease/Stroke	Average crude Emergency Room visit rate (per 1,000 people) for hypertension	San Mateo County Health. 2012-2014.	2012-2014
ER Visit Rate, Ischemic Heart Disease	Heart Disease/Stroke	Average crude Emergency Room visit rate (per 1,000 people) for ischemic heart disease	San Mateo County Health. 2012-2014.	2012-2014
ER Visit Rate, Myocardial Infarction	Heart Disease/Stroke	Average crude Emergency Room visit rate (per 1,000 people) for myocardial	San Mateo County Health. 2012-2014.	2012-2014

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
		infarction		
ER Visit Rate, Stroke	Heart Disease/Stroke	Average crude Emergency Room visit rate (per 1,000 people) for stroke	San Mateo County Health. 2012-2014.	2012-2014
ER Visit Rate: Mental Health Issues	Mental Health & Well-Being (Mental Health/Emotional Well-Being)	Age-adjusted rate of Emergency Room visits due to mental health issues per 100,000 population	Office of Statewide Health Planning and Development. 2013-2015.	2013-2015
Ethnic Discrimination – Emotional Upset	Social & Community Context	Percentage of survey respondents who answered "yes" when asked, "Within the past 30 days, have you felt emotionally upset--for example, angry, sad, or frustrated--as a result of how you were treated based on your race?"	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Ethnic Discrimination – Physical Symptoms	Social & Community Context	Percentage of survey respondents who answered "yes" when asked, "Within the past 30 days, have you experienced any physical symptoms--for example, a headache, an upset stomach, tensing of your muscles, or a pounding heart--as a result of how you were treated based on your race?"	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Exercise Opportunities	Neighborhood & Built Environment (Access to Food/Recreation); Healthy Lifestyles (Diabetes; Diet, Fitness, & Nutrition; Obesity)	Percentage of population with adequate access to locations for physical activity.	Business Analyst, Delorme map data, ESRI, & US Census Tigerline Files. 2010, 2016.	2016
Experienced Depressive Symptoms (Average Days/Month)	Mental Health & Well-Being (Mental Health/Emotional Well-Being)	Average number of days per month that survey respondents reported that they felt sad, blue, or depressed	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Experiencing Difficulty	Mental Health & Well-Being	Percentage of survey respondents	San Mateo County	2018

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
in Fear, Anxiety, or Panic	(Mental Health/Emotional Well-Being)	indicating they are experiencing difficulty in the area of fear, anxiety, or panic	Health, Health and Quality of Life Survey. 2018.	
Experiencing Difficulty in Getting Along with People Outside the Family	Mental Health & Well-Being (Mental Health/Emotional Well-Being)	Percentage of survey respondents indicating they are experiencing difficulty in the area of getting along with people outside the family	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Experiencing Difficulty in Isolation or Feelings of Loneliness	Mental Health & Well-Being (Mental Health/Emotional Well-Being)	Percentage of survey respondents indicating they are experiencing difficulty in the area of isolation or feelings of loneliness	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Experiencing Difficulty in Relationships with Family Members	Mental Health & Well-Being (Mental Health/Emotional Well-Being)	Percentage of survey respondents indicating they are experiencing difficulty in relationships with family members	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Expulsions Rate (per 100 students)	Education & Literacy; Neighborhood & Built Environment (Community & Family Safety); Social & Community Context	Rate of expulsions per 100 enrolled students	California Department of Education. 2016-2017.	2016-2017
Fair/Poor Access to Affordable Housing	Housing & Homelessness	Percentage of respondents who rated the availability of affordable housing in their community as fair or poor	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Fair/Poor Access to Child Health Services	Healthcare Access & Delivery	Percentage of respondents who rated the ease with which they are able to get child health services in their community is fair/poor	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Fair/Poor Access to Dental Care	Healthcare Access & Delivery; Oral/Dental Health	Percentage of respondents who rated the ease with which they are able to get dental care in their community is fair/poor	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
Fair/Poor Access to Health Care	Healthcare Access & Delivery	Percentage of respondents who rated the ease with which they are able to get the health care services they need as fair/poor	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Fair/Poor Access to Help for Substance Abuse	Healthcare Access & Delivery; Mental Health & Well-Being (Tobacco/Substance Use)	Percentage of respondents who rated the ease with which they are able to get help for substance abuse in their community is fair/poor	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Fair/Poor Access to Mental Health Services	Healthcare Access & Delivery; Mental Health & Well-Being (Mental Health/Emotional Well-Being)	Percentage of respondents who rated the ease with which they are able to get mental health services in their community is fair/poor	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Fair/Poor Access to Social Services	Healthcare Access & Delivery; Social & Community Context	Percentage of respondents who rated the ease with which they are able to get social services in their community as fair/poor	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Falls Among Older Adults: Deaths	Unintended Injuries/Accidents	Deaths due to unintentional falls among older adults (age 65+) per 100,000	San Mateo County Health. 2016.	2016
Falls Among Older Adults: ED Visits	Unintended Injuries/Accidents	Emergency department visits due to unintentional falls among older adults (age 65+) per 100,000	San Mateo County Health. 2016.	2016
Falls Among Older Adults: Hospitalizations	Unintended Injuries/Accidents	Hospitalizations due to unintentional falls among older adults (age 65+) per 100,000	San Mateo County Health. 2015.	2015
Family's Financial Situation is Fair/Poor	Poverty, Income, & Employment	Percentage of survey respondents who rated as fair or poor their personal or family's financial situation, in terms of being able to afford adequate food and housing, and to pay the bills they currently have	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Family's Financial Situation is	Poverty, Income, & Employment	Percentage of survey respondents who indicated that, compared to a	San Mateo County Health, Health and	2018

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
Somewhat/Much Worse than Prior Year		year ago, they and their family are financially somewhat or much worse	Quality of Life Survey. 2018.	
Fast Food Restaurants Rate	Neighborhood & Built Environment (Access to Food/Recreation); Healthy Lifestyles (Diabetes; Diet, Fitness, & Nutrition; Obesity)	Fast food restaurants, rate (per 100,000 population)	US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2016.	2016
Federally Qualified Health Centers Rate	Healthcare Access & Delivery	Federally qualified health centers, rate per 100,000 population	US Department of Health & Human Services, Centers for Medicare & Medicaid Services, Provider of Services File. March 2018.	2018
Felt Healthy and Full of Energy (Average Days/Month)	Mental Health & Well-Being (Mental Health/Emotional Well-Being); General Health	Average number of days per month survey respondents indicated they felt healthy and full of energy	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Felt Worried/Tense/ Anxious (Average Days/Month)	Mental Health & Well-Being (Mental Health/Emotional Well-Being)	Average number of days per month that survey respondents reported feeling worried, tense, or anxious	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Firearm Kept in or around Home	Neighborhood & Built Environment (Community & Family Safety); Unintended Injuries/Accidents	Percentage of survey respondents answering "yes" when asked: "Do you have a firearm kept in or around the home (including garage, outdoor storage area, truck, or car)?"	San Mateo County Health, Health and Quality of Life Survey. 2018. Benchmark: Behavioral Risk Factor Surveillance System. 2016.	2016, 2018
Firearm-Related Death Rate	Neighborhood & Built Environment (Community & Family Safety); Unintended Injuries/Accidents	Number of deaths due to firearms per 100,000 population	CDC WONDER mortality data. 2012-2016.	2012-2016
First Trimester Prenatal Care	Birth Outcomes	Percentage of mothers who received prenatal care within the first 14 weeks	California Department of Public Health: 2009-	2013-2015

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
		of their pregnancy	2014 Birth Cohort-Perinatal Outcome Files.	
Flood Vulnerability	Neighborhood & Built Environment (Natural Environment/Climate)	Estimated number of housing units within the special flood hazard area (SFHA) per county	National Flood Hazard Layer. 2011.	2011
Flu Shot in Past Year – Adults 65+	Healthcare Access & Delivery; Asthma & Respiratory Conditions; Infectious Diseases	Percentage of survey respondents age 65+ answering "yes" when asked, "Have you had a flu shot in the past year?"	San Mateo County Health, Health and Quality of Life Survey. 2018. Benchmark: Behavioral Risk Factor Surveillance System. 2016.	2016, 2018
Food Assistance Program Participation	Food insecurity	Percentage of eligible food- insecure individuals participating in food assistance programs, by city	Get Healthy San Mateo County. Food Insecurity in San Mateo County. End Hunger Workgroup, October 14, 2016.	2016
Food Desert Population	Neighborhood & Built Environment (Access to Food/Recreation); Healthy Lifestyles (Diabetes; Diet, Fitness, & Nutrition; Obesity)	Percent population with low food access	US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2015.	2015
Food Environment Index	Neighborhood & Built Environment (Access to Food/Recreation); Healthy Lifestyles (Diabetes; Diet, Fitness, & Nutrition; Obesity)	Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)	US Department of Agriculture Food Environment Atlas, Map the Meal Gap from Feeding America. 2015.	2015
Food Insecure Population Ineligible for Assistance	Food Insecurity	Estimated percentage of the total population that experienced food insecurity at some point during the report year, but are ineligible for State or Federal nutrition assistance	Feeding America. 2014.	2014
Food Insecure	Food Insecurity	Estimated percentage of the	Feeding America. 2014.	2014

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
Population Ineligible for Assistance - Children		population under age 18 that experienced food insecurity at some point during the report year, but are ineligible for State or Federal nutrition assistance		
Food Insecurity Rate	Food Insecurity; Birth Outcomes; Healthy Lifestyles (Diabetes; Diet, Fitness, & Nutrition; Obesity)	Estimated percentage of the population that experienced food insecurity at some point during the year.	San Mateo County Health, Health and Quality of Life Survey. 2018. Benchmark: Feeding America. 2016	2016, 2018
Food Insecurity Rate – Children under 18	Food Insecurity; Birth Outcomes; Healthy Lifestyles (Diabetes; Diet, Fitness, & Nutrition; Obesity)	Estimated percentage of the population under age 18 that experienced food insecurity at some point.	Feeding America. 2014.	2014
Food Store Quality/Affordability	Neighborhood & Built Environment (Access to Food/Recreation); Healthy Lifestyles (Obesity/Overweight & Diabetes Related Factors)	Percentage of food stores meeting basic quality and affordability standards	Get Healthy San Mateo County. Food Insecurity in San Mateo County. End Hunger Workgroup, October 14, 2016.	2016
Form of Marijuana Use	Mental Health & Well-Being (Tobacco/Substance Use)	Percentage of survey respondents who indicated they had used each of various forms of marijuana	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Frequent Mental Distress	Mental Health & Well-Being (Mental Health/Emotional Well-Being)	Percentage of adults reporting 14 or more days of poor mental health per month	Behavioral Risk Factor Surveillance System. 2016.	2016
Frequent Physical Distress	General Health	Percentage of adults reporting 14 or more days of poor physical health per month	Behavioral Risk Factor Surveillance System. 2016.	2016

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
Future Cost of Living	Neighborhood & Built Environment (Transportation & Traffic); Housing & Homelessness	Estimated percentage of annual income that households will spend on housing and transportation	Get Healthy San Mateo County. Food Insecurity in San Mateo County. End Hunger Workgroup, October 14, 2016.	2016
Gonorrhea Cases (Incidence) Rate	Sexually Transmitted Infections	Gonorrhea cases (incidence) rate per 100,000 population	California Department of Public Health, Sexually Transmitted Diseases Control Branch. 2016.	2016
Grocery Stores Rate	Neighborhood & Built Environment (Access to Food/Recreation); Healthy Lifestyles (Diabetes; Diet, Fitness, & Nutrition; Obesity)	Grocery stores, rate (per 100,000 population)	US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2016.	2016
Handling Conflict	Neighborhood & Built Environment (Community & Family Safety)	Percentage of teen respondents who did not know non-violent ways to deal with conflict	County of San Mateo, Board of Supervisors. Adolescent Report 2014-2015.	2014-2015
Have Ever Felt Depressed for 2 Years or More	Mental Health & Well-Being (Mental Health/Emotional Well-Being)	Percentage of survey respondents answering “yes” when asked “Have you had two years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?”	San Mateo County Health, Health and Quality of Life Survey. 2018. Benchmark: Behavioral Risk Factor Surveillance System. 2016.	2016, 2018
Have Ever Sought Professional Help for Drug Related Problem	Healthcare Access & Delivery; Mental Health & Well-Being (Tobacco/Substance Use)	Percentage of survey respondents who reported they ever sought professional help for a drug-related problem	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Have Ever Sought Professional Help for	Mental Health & Well Being (Mental Health/Emotional	Percentage of survey respondents who reported they ever sought	San Mateo County Health, Health and	2018

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
Mental/Emotional Problem	Well-Being)	professional help for a mental/emotional problem	Quality of Life Survey. 2018.	
Have No Dental Insurance Coverage that Pays for Some or All of Routine Dental Care	Oral/Dental Health	Percentage of survey respondents answering "no" when asked, "Do you have any kind of dental insurance coverage that pays for some or all of your routine dental care, including dental insurance, prepaid plans such as HMOs, or government plans such as Health Plan of San Mateo/MediCal?"	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Head Start Program Facilities Rate (per 10,000 pop. 0-5)	Education & Literacy	Head start programs rate (per 10,000 children under age 5)	US Department of Health & Human Services, Administration for Children and Families. 2018.	2018
Health Professional Shortage Area – Dental	Healthcare Access & Delivery; Oral/Dental Health	Percentage of the population that is living in a geographic area designated as a dental "Health Professional Shortage Area" (HPSA), defined as having a shortage of dental health professionals.	US Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administration. April 2016.	2016
Healthcare Costs (Medicare Reimbursements per Enrollee)	Healthcare Access & Delivery	Average Medicare reimbursements, in dollars, per enrollee	Dartmouth Atlas of Health Care. 2015	2015
Heart Disease Death Rate	MAIN: Neighborhood & Built Environment (Natural Environment/Climate); Mental Health & Well-Being (Tobacco/Substance Use); Heart Disease/Stroke	Age-adjusted rate of death due to heart disease per 100,000 population per year	California Department of Public Health. 2014-2016.	2014-2016
Heart Disease	Heart Disease/Stroke	Hospitalization rate for coronary heart	Interactive Atlas of Heart	2012-

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
Hospitalizations Rate (per 1,000 pop.)		disease among Medicare beneficiaries aged 65 years and older for hospital stays occurring between 2012 and 2014, per 1,000 population	Disease and Stroke. 2012-2014.	2014
Heart Disease Prevalence	Neighborhood & Built Environment (Natural Environment/Climate); Mental Health & Well-Being (Tobacco/Substance Use); Heart Disease/Stroke	Percentage of adults aged 18 and older that self-report having been diagnosed with heart disease by a doctor	California Health Interview Survey. 2014.	2014
Heart Disease, Heart Attack – Ever Had/Diagnosed	Heart Disease/Stroke	Percentage of survey respondents who answered "yes" when asked "Have you ever suffered from or been diagnosed with any of the following medical conditions: Heart Disease, Such as Congestive Heart Failure, Angina, or a Heart Attack?"	San Mateo County Health, Health and Quality of Life Survey. 2018. Benchmark: Behavioral Risk Factor Surveillance System. 2016.	2016, 2018
Heart Failure (Medicare Population)	Heart Disease/Stroke	Percentage of Medicare enrollees treated for heart failure in year	US Department of Health & Human Services, Centers for Medicare & Medicaid Services. 2015.	2015
Heart Failure Emergency Room Visit Rate (per 10,000 pop.)	Heart Disease/Stroke	Emergency room visits due to heart failure, age-adjusted, per 10,000 population	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2013-2015.	2013-2015
Heart Failure Hospitalizations Rate (per 10,000 pop.)	Heart Disease/Stroke	Hospitalization rate for heart failure, age-adjusted, per 10,000 population	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2013-2015.	2013-2015
Hepatitis B Vaccine (%	Infectious Diseases	Percentage of kindergarten students	California Department of	2016-

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
of All Kinder)		who reported receiving the Hepatitis B Vaccine	Public Health, Kindergarten Immunization Assessment, 2015-2016 & 2016-2017.	2017
High Blood Pressure - Unmanaged	Heart Disease/Stroke	Percent adults with high blood pressure not taking medication	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2006-10.	2006-2010
High Blood Pressure Medication Use	Heart Disease/Stroke	Percentage of survey respondents who reported having hypertension, who indicated that they are currently taking medication to control high blood pressure	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
High Cholesterol Medication Use	Heart Disease/Stroke	Percentage of survey respondents who reported having high cholesterol, who indicated that they are currently taking medication to lower their blood cholesterol level	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
High Cholesterol Prevalence, Adults	Heart Disease/Stroke	Percentage of survey respondents answering “yes” when asked, “Has a doctor, nurse or other health care professional ever told you that you have high cholesterol?”	San Mateo County Health, Health and Quality of Life Survey. 2018. Benchmark: Behavioral Risk Factor Surveillance System. 2016.	2016, 2018
High School Graduation Rate (percent of cohort)	Education & Literacy	On-time high school graduation rate per cohort	National Center for Education Statistics, NCES -CHR EDFacts. 2014-2015. Trend: California Department of Education. 2014-2015.	2014-2015

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
High Speed Internet	Education & Literacy; Neighborhood & Built Environment (Community Infrastructure & Housing Quality); Poverty, Income & Employment	Percentage of population with access to high-speed internet	FCC Fixed Broadband Deployment Data. 2016.	2016
High Stress on Typical Day	Mental Health & Well-Being (Mental Health/Emotional Well-Being)	Percentage of survey respondents identifying their stress level as "high" on a "typical" day	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
History of Mental Health Issues	Mental Health & Well-Being (Mental Health/Emotional Well-Being)	Percentage of survey respondents who reported a history of problems with mental/emotional illness	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
HIV Hospitalizations Rate	Sexually Transmitted Infections	Age-adjusted discharge rate (per 10,000 population) for HIV	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES. 2011.	2011
HIV Prevalence	Sexually Transmitted Infections	Number of persons aged 13 years and older living with a diagnosis of human immunodeficiency virus (HIV) infection per 100,000 population.	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2015.	2015
HIV/AIDS Deaths Rate	Sexually Transmitted Infections	Rate of death due to HIV and AIDS per 100,000 population	National Vital Statistics System. 2008-2014.	2008-2014
Home Ownership	Housing & Homelessness; Poverty, Income & Employment	Percentage of self-reported home owners	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Homicide Rate	Neighborhood & Built Environment (Community & Family Safety); Mental Health & Well-Being	Number of deaths due to homicide per 100,000 population	CDC WONDER mortality data. 2010-2016.	2010-2016

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
	(Mental Health/Emotional Well-Being)			
Households with No Vehicle	Poverty, Income & Employment	Percentage of households with no motor vehicle	US Census Bureau, American Community Survey. 2012-2016.	2012-2016
Housing Costs	Housing & Homelessness	Cost of housing	Get Healthy San Mateo County. in San Mateo County. End Hunger Workgroup, October 14, 2016.	2016
Housing Unstable in Past 2 Years	Housing & Homelessness	Percentage of survey respondents who reported that they had been homeless at least once in the past two years	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Hypertension/High Blood Pressure Prevalence, Adults	Heart Disease/Stroke	Percentage of the adult population with hypertension/high blood pressure	San Mateo County Health, Health and Quality of Life Survey. 2018. Benchmark: Behavioral Risk Factor Surveillance System. 2016. Data without benchmark: California Health Interview Survey. 2016.	2016, 2018
Importance of Spirituality	Mental Health & Well-Being (Mental Health/Emotional Well-Being)	Percentage of survey respondents who answered, “Very important” when asked, “How important is spirituality in your life?”	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Inadequate Prenatal Care	Birth Outcomes	Percentage of mothers who, on their child's birth certificate, reported receiving prenatal care only in the third trimester of their pregnancy	San Mateo County Health. 2010-2015.	2010-2015

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
Income Inequality (Gini Coefficient)	Poverty, Income & Employment; Social & Community Context	This indicator reports income inequality using the Gini coefficient. Gini index values range between zero and one. A value of one indicates perfect inequality where only one house-hold has any income. A value of zero indicates perfect equality, where all households have equal income	US Census Bureau, American Community Survey. 2012-2016.	2012-2016
Infant Mortality Rate (per 1,000 births)	Birth Outcomes	Number of all infant deaths (within 1 year), per 1,000 live births	CDC WONDER mortality data. 2010-2016.	2010-2016
Influenza/Pneumonia Death Rate	Asthma & Respiratory Conditions; Infectious Diseases	Age-adjusted rate of death due to influenza/pneumonia per 100,000 population per year	California Department of Public Health. 2014-2016. Cause of Death: California Department of Public Health: 2010-2015 Death Records.	2014-2016.
Injury Deaths Rate	Neighborhood & Built Environment (Community & Family Safety); Unintended Injuries/Accidents	Number of deaths due to injury per 100,000 population	CDC WONDER mortality data. 2012-2016.	2012-2016
Insufficient Sleep	Mental Health & Well-Being (Mental Health/Emotional Well-Being)	Percentage of adults who report fewer than 7 hours of sleep on average	San Mateo County Health, Health and Quality of Life Survey. 2018. Benchmark: Behavioral Risk Factor Surveillance System. 2016.	2016, 2018
Ischemic Heart Disease (Medicare Population)	Heart Disease/Stroke	Percentage of Medicare population with ischemic heart disease	US Department of Health & Human Services, Centers for Medicare & Medicaid Services. 2015.	2015
Job Does Not Offer Health Benefits	Healthcare Access & Delivery; Poverty, Income,	Percentage of employed respondents who reported that their job offered no	San Mateo County Health, Health and	2018

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
	& Employment	health benefits	Quality of Life Survey. 2018.	
Job Offers Health Benefits for Employee Dependents	Healthcare Access & Delivery; Poverty, Income, & Employment	Percentage of employed respondents who reported that their job offered health benefits for their dependents	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Juvenile Arrest Rate	Neighborhood & Built Environment (Community & Family Safety)	Arrests of individuals under age 18 per 100,000	County of San Mateo, Board of Supervisors. Adolescent Report 2014-2015.	2014-2015
Juvenile Felony Arrests	Neighborhood & Built Environment (Community & Family Safety)	Percentage of arrests of individuals under age 18 for felonies	County of San Mateo, Board of Supervisors. Adolescent Report 2014-2015.	2014-2015
Kindergarteners with All Required Immunizations	Infectious Diseases	Percentage of kindergarten students who reported receiving all required immunizations	California Department of Public Health, Kindergarten Immunization Assessment, 2015-2016 & 2016-2017.	2016-2017
Kindergarteners with Overdue Immunizations	Infectious Diseases	Percentage of kindergarten students who reported having overdue immunizations	California Department of Public Health, Kindergarten Immunization Assessment, 2015-2016 & 2016-2017.	2016-2017
Know Where to Access Treatment for a Drug-Related Problem if Needed	Healthcare Access & Delivery; Mental Health & Well-Being (Tobacco/Substance Use)	Percentage of survey respondents who indicated they knew where to access treatment for a drug-related problem if they or someone in their family needed it	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Lack of Affordable Housing	Housing & Homelessness	Percentage of households with “unaffordable housing”	Get Healthy San Mateo County. Food Insecurity in San Mateo County. End Hunger Workgroup,	2016

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
			October 14, 2016.	
Lack of Consistent Source of Primary Care	Healthcare Access & Delivery	Percentage without regular doctor	University of California Center for Health Policy Research, California Health Interview Survey. 2011-2012.	2011-2012
Lack of Dental Insurance Coverage	Healthcare Access & Delivery; Oral/Dental Health	Percentage of adults aged 18 years and older that self-report they do not have dental insurance.	California Health Interview Survey. 2015-2016.	2015-2016
Lack of Health Care Coverage	Healthcare Access & Delivery; Poverty, Income & Employment	Percent of survey respondents answering "No" when asked, "Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare?"	San Mateo County Health, Health and Quality of Life Survey. 2018. Benchmark: Behavioral Risk Factor Surveillance System. 2016.	2016, 2018
Lack of Healthy Food Stores	Neighborhood & Built Environment (Access to Food/Recreation); Healthy Lifestyles (Diabetes; Diet, Fitness, & Nutrition; Obesity)	Percentage of the population that do not live in close proximity to a large grocery store or supermarket	US Department of Agriculture. USDA Food Access Research Atlas. 2014.	2014
Lack of Insurance Prevented Dental Care	Oral/Dental Health; Healthcare Access & Delivery	Percentage of survey respondents indicating that they or a family member(s) have dental problems they cannot take care of because of a lack of insurance	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Lack of Meaningful Connections to Community (Youth)	Social & Community Context; Mental Health & Well-Being (Mental Health/Emotional Well-Being)	Student self-reported rate of "meaningful connections" in their community	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Lack of Social or Emotional Support	Social & Community Context; Mental Health &	Percentage of adults aged 18 years and older that self-report having	Behavioral Risk Factor Surveillance System.	2006-2012

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
	Well-Being (Mental Health/Emotional Well-Being)	insufficient social and emotional support.	2006-2012.	
Lack of Transportation Interfered with Access to Health Care	Healthcare Access & Delivery; Neighborhood & Built Environment (Transportation & Traffic)	Percentage of respondents who answered "yes" when asked, "Was there a time during the past 12 months when lack of transportation made it difficult or prevented you from seeing a doctor or making a medical appointment?"	San Mateo County Health, Health and Quality of Life Survey. 2018. Benchmark: Behavioral Risk Factor Surveillance System. 2016.	2016, 2018
Lack Support	Social & Community Context; Mental Health & Well-Being (Mental Health/Emotional Well-Being)	Percentage of survey respondents who reported that they had someone they could turn to if they needed or wanted help "little/none of the time."	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Level of Stress	Mental Health & Well-Being (Mental Health/Emotional Well-Being)	Percentage of survey respondents reporting various levels of stress during their typical day	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
LGBTQI	Social & Community Context	Percentage of survey respondents who identified as gay, lesbian, or bisexual	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Life Expectancy at Birth (in Years)	Healthcare Access & Delivery; Social & Community Context; General Health	Average life expectancy at birth in years	Institute for Health Metrics and Evaluation. 2014.	2014
Liquor Store Access Rate	Neighborhood & Built Environment (Community & Family Safety; Transportation & Traffic); Mental Health & Well-Being (Tobacco/Substance Use); Cancer; Heart	Liquor stores, rate (per 100,000 population)	US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2016.	2016

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
	Disease/Stroke; Unintended Injuries/Accidents			
Living in Health Professional Shortage Area - Primary Care	Healthcare Access & Delivery	Percentage of the population living in a geographic area designated as a "Health Professional Shortage Area" (HPSA), defined as having a shortage of primary medical care, dental or mental health professionals.	US Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administration. April 2016.	2016
Living in Owner-Occupied Housing	Housing & Homelessness; Poverty, Income & Employment	Percentage of homeowners	US Census Bureau, American Community Survey. 2012-2016.	2012-2016
Local Employment Opportunities are Fair/Poor	Poverty, Income, & Employment	Percentage of survey respondents who considered the employment opportunities that exist in this area to be fair or poor.	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Low Birth Weight	Neighborhood & Built Environment (Natural Environment/Climate); Mental Health & Well-Being (Tobacco/Substance Use); Birth Outcomes	Percentage of total births that are low birthweight (under 2500 grams)	National Center for Health Statistics - Natality files. 2010-2016. Data without benchmark: San Mateo County Health, 2010-2015.	2010-2016
Low Fruit/Vegetable Consumption (Adult)	Cancer; Healthy Lifestyles (Diabetes; Diet, Fitness, & Nutrition; Obesity; Diabetes)	Percentage of adults age 18 and older who self-report consuming less than 5 servings of fruits and vegetables each day	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2005-2009.	2005-2009
Low Fruit/Vegetable Consumption (Youth)	Healthy Lifestyles (Diabetes; Diet, Fitness, & Nutrition; Obesity;	Percent population age 2-13 with inadequate fruit/vegetable consumption	University of California Center for Health Policy Research, California	2011-2012

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
	Diabetes)		Health Interview Survey. 2011-12.	
Lung Cancer Death Rate	Cancer; Mental Health & Well-Being (Tobacco/Substance Use)	Age-adjusted rate of death due to lung cancer per 100,000 population per year	California Department of Public Health: 2010-2015 Death Records.	2013-2015
Lung Cancer Incidence Rate	Mental Health & Well-Being (Tobacco/Substance Use); Cancer	Age-adjusted incidence rate of lung cancer per 100,000 population per year	State Cancer Profiles. 2010-14.	2010-2014
May Move Due to Cost of Living	Housing & Homelessness Poverty, Income, & Employment	Percentage of survey respondents reporting that they had considered leaving the county in the past year due to the cost of living	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Measles, Mumps, and Rubella Vaccine (% of All Kinder)	Infectious Diseases	Percentage of kindergarten students who reported receiving Measles, Mumps, and Rubella Vaccine	California Department of Public Health, Kindergarten Immunization Assessment, 2015-2016 & 2016-2017.	2016-2017
Median Age	Dementia & Cognitive Decline	Population median age	US Census Bureau, American Community Survey. 2012-16.	2012-2016
Median Household Income	Poverty, Income & Employment	Median Household Income is the income where half of households in a county earn more and half of households earn less	Small Area Income and Poverty Estimates. 2016.	2016
Median Rent, 2 Bedroom ($)	Housing & Homelessness	Median rent, in dollars, for a two-bedroom unit	Zilpy.com, Rental Market Trends. October 2018.	Oct-18
Medication – Could Not Afford	Healthcare Access & Delivery; Poverty, Income & Employment	Percentage of survey respondents answering “yes” when asked, “Was there a time during the past 12 months when: You Needed to Purchase Medication, But Could Not Because of the Cost?”	San Mateo County Health, Health and Quality of Life Survey. 2018. Benchmark: Behavioral Risk Factor Surveillance System. 2016.	2016, 2018

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
Melanoma Incidence Rate in Men	Cancer	Age-adjusted incidence rate of melanoma among males per 100,000 population per year	California Cancer Registry Fact Sheet, California Department of Public Health, 2008-2012.	2008-2012
Melanoma Incidence Rate in Women	Cancer	Age-adjusted incidence rate of melanoma among females per 100,000 population per year	California Cancer Registry Fact Sheet, California Department of Public Health, 2008-2012.	2008-2012
Mental Health Emergency Room Visit Rate (per 10,000 pop.)	Mental Health & Well-Being (Mental Health/Emotional Well-Being)	Emergency room visits due to mental health, age-adjusted, per 10,000 population	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2013-2015.	2013-2015
Mortality – Premature Deaths (Years of Potential Life Lost)	Healthcare Access & Delivery; Social & Community Context; General Health	Years of potential life lost, rate per 100,000 population	University of Wisconsin Population Health Institute, County Health Rankings. 2014-2016.	2014-2016
Motor Vehicle Accidents	Neighborhood & Built Environment (Transportation & Traffic); Unintended Injuries/Accidents	Counts of injuries due to motor vehicle collisions	County of San Mateo Emergency Medical Services. 2016-2017.	2016-2017
Motor Vehicle Crash Death Rate	Neighborhood & Built Environment (Transportation & Traffic); Unintended Injuries/Accidents	Number of motor vehicle crash deaths per 100,000 population	CDC WONDER mortality data. 2010-2016. Data without benchmark: County of San Mateo Emergency Medical Services. 2016-2017.	2010-2016, 2016-2017
Needing Mental Health Care	Mental Health & Well-Being (Mental Health/Emotional Well-Being)	Percentage of adults who self-report that there was ever a time during the past 12 months when they felt that they might need to see a professional	University of California Center for Health Policy Research, California Health Interview Survey.	2013-2014

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
		because of problems with their mental health, emotions, nerves, or use of alcohol or drugs.	2013-2014.	
Neighborhood Safety is Fair/Poor	Neighborhood & Built Environment (Community & Family Safety)	Percentage of survey respondents who rated the safety, security, and crime control in their neighborhood to be fair or poor	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
No HIV Screening	Sexually Transmitted Infections	Percentage of adults age 18-70 who self-report that they have never been screened for HIV	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-2012.	2011-2012
No Recent Dental Exam (Youth)	Healthcare Access & Delivery; Oral/Dental Health	Percent Youth Without Recent Dental Exam	University of California Center for Health Policy Research, California Health Interview Survey. 2013-14.	2013-2014
Number of Years Without Health Coverage	Healthcare Access & Delivery	Average number of years that survey respondents were without health insurance	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Obesity (Adult)	Asthma & Respiratory Conditions; Cancer; Heart Disease/Stroke; Healthy Lifestyles (Obesity)	Percentage of survey respondents who are obese (Body Mass Index [BMI] greater than or equal to 30.0, based on self-reported height and weight)	San Mateo County Health, Health and Quality of Life Survey. 2018. Benchmark: Behavioral Risk Factor Surveillance System. 2016.	2016, 2018
Obesity (Youth)	Asthma & Respiratory Conditions; Heart Disease/Stroke; Healthy Lifestyles (Obesity)	Percentage of children in grades 5, 7, and 9 ranking within the "High Risk" category for body composition on the Fitnessgram physical fitness test	FITNESSGRAM® Physical Fitness Testing. 2016-2017.	2016-2017

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
Older Dependents in Home who Cannot Live Alone	General Health; Housing & Homelessness	Percentage of survey respondents who answered "yes" when asked, "Do you currently have any older dependents, such as parents, aunts, or uncles living in your household because they are unable to live alone?"	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Opioid Prescription Drug Claims	Mental Health & Well-Being (Tobacco/Substance Use)	Number of Medicare Part D prescription claims for opiates as a percentage of total Medicare Part D prescription drug claims	US Department of Health & Human Services, Centers for Medicare and Medicaid Services. 2015.	2015
Opportunity Index (score 1-100)	Poverty, Income & Employment; Social & Community Context	Opportunity Index score, a measure of community well-being, for which scores range between 0 (indicating no opportunity) and 100 (indicating maximum opportunity)	Opportunity Nation. 2017.	2017
Other Drugs	Mental Health & Well-Being (Tobacco/Substance Use)	Percentage of survey respondents who reported having used any illicit drugs	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Ovarian Cancer Death Rate	Cancer	Age-adjusted rate of death among females due to ovarian cancer per 100,000 population per year	California Cancer Registry Fact Sheet, California Department of Public Health, 2008-2012.	2008-2012
Overweight (Adult)	Cancer; Heart Disease/Stroke; Healthy Lifestyles (Obesity)	Percentage of adults age 18 and older who self-report that they have a Body Mass Index (BMI) between 25.0 and 30.0 (overweight)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12.	2011-2012
Overweight (Youth)	Heart Disease/Stroke; Healthy Lifestyles (Obesity)	Percentage of children in grades 5, 7, and 9 ranking within the "Needs Improvement" category (Overweight)	California Department of Education, FITNESSGRAM®	2013-2014

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
		for body composition on the Fitnessgram physical fitness test	Physical Fitness Testing. 2013-14.	
Overweight Adults	Healthy Lifestyles (Obesity)	Percentage of survey respondents who are overweight (calculated Body Mass Index based on self-reported height and weight)	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Overweight/Obese Adults	Asthma & Respiratory Conditions; Cancer; Heart Disease/Stroke; Healthy Lifestyles (Obesity)	Percentage of adults who are overweight or obese (calculated Body Mass Index based on self-reported height and weight)	San Mateo County Health, Health and Quality of Life Survey. 2018. Benchmark: Behavioral Risk Factor Surveillance System. 2016.	2016, 2018
Pain Interfered with Usual Activities (Average Days/Month)	Mental Health & Well-Being (Mental Health/Emotional Well-Being); General Health	Average number of days per month survey respondents indicated that pain made it hard for them to engage in their usual activities	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Pancreatic Cancer Mortality in Men	Cancer	Age-adjusted rate of death among males due to pancreatic cancer per 100,000 population per year	California Cancer Registry Fact Sheet, California Department of Public Health, 2008-2012.	2008-2012
Pancreatic Cancer Mortality in Women	Cancer	Age-adjusted rate of death among females due to pancreatic cancer per 100,000 population per year	California Cancer Registry Fact Sheet, California Department of Public Health, 2008-2012.	2008-2012
Parent/Family Supervises Child After School	Neighborhood & Built Environment (Community & Family Safety); Social & Community Context	Percentage of survey respondents with at least one child under the age of 18 living with them, who reported that a parent or family member supervises their child after school	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Park Access	Heart Disease/Stroke	Percent population within 1/2 mile of a park	US Census Bureau, Decennial Census. ESRI Map Gallery. 2010.	2010

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
Pedestrian Accident Death Rate	Neighborhood & Built Environment (Transportation & Traffic); Unintended Injuries/Accidents	Pedestrian accident, age-adjusted mortality rate (per 100,000 population)	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, California Department of Public Health - Death Public Use Data. 2010-2012.	2010-2012
Pediatric Asthma Hospitalizations Rate (per 10,000 pop.)	Neighborhood & Built Environment (Natural Environment/Climate); Asthma & Respiratory Conditions	Age-adjusted hospitalization rate (per 10,000 population) due to pediatric asthma	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2013-2015.	2013-2015
Perception of Safety, Youth	Neighborhood & Built Environment (Community & Family Safety); Mental Health & Well-Being (Mental Health/Emotional Well-Being)	Percentage of teen survey respondents who reported feeling safe in their community	County of San Mateo, Board of Supervisors. Adolescent Report 2014-2015.	2014-2015
Persons Age 65+ in Poverty	Poverty, Income & Employment	Percentage of adults age 65+ in poverty	US Census Bureau, American Community Survey. 2012-2016.	2012-2016
Persons Under 18 in Poverty	Poverty, Income & Employment	Percentage of children under age 18 in poverty	Small Area Income and Poverty Estimates. 2016.	2016
Pertussis Cases Rate	Asthma & Respiratory Conditions; Infectious Diseases	Pertussis rates per 100,000 population	California Department of Public Health Immunization Branch. 2016.	2016

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
Physical Environment of Community is Fair/Poor	Neighborhood & Built Environment (Community Infrastructure & Housing Quality)	Percentage of survey respondents rating the physical environment of the community as fair or poor	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Physical Inactivity (Adult)	Cancer; Heart Disease/Stroke; Healthy Lifestyles (Diabetes; Diet, Fitness, & Nutrition; Obesity)	Percentage of adults age 20 and over reporting no leisure-time physical activity	CDC Diabetes Interactive Atlas. 2014. Trend: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2013.	2013, 2014
Physical Inactivity (Youth)	Heart Disease/Stroke; Healthy Lifestyles (Diabetes; Diet, Fitness, & Nutrition; Obesity)	Percentage of children in grades 5, 7, and 9 ranking within the "High Risk" or 'Needs Improvement' zones for aerobic capacity on the Fitnessgram physical fitness test	FITNESSGRAM® Physical Fitness Testing. 2016-2017.	2016-2017
Pneumonia Vaccine Ever Received (Age 65+)	Healthcare Access & Delivery; Asthma & Respiratory Conditions; Infectious Diseases	Percentage of survey respondents age 65+ answering “yes” when asked, “Have you ever received the pneumonia vaccine?”	San Mateo County Health, Health and Quality of Life Survey. 2018. Benchmark: Behavioral Risk Factor Surveillance System. 2016.	2016, 2018
Polio Vaccine (% of All Kinder)	Infectious Diseases	Percentage of kindergarten students who reported receiving the polio vaccine	California Department of Public Health, Kindergarten Immunization Assessment, 2015-2016 & 2016-2017.	2015-2016, 2016-2017
Poor Dental Health	Oral/Dental Health	Percent adults with poor dental health	Centers for Disease Control and Prevention,	2006-2010

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
			Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2006-2010.	
Poor Mental Health (Average Days/Month)	Mental Health & Well Being (Mental Health/Emotional Well-Being)	Average number of mentally unhealthy days reported in past 30 days (age-adjusted)	San Mateo County Health, Health and Quality of Life Survey. 2018. Benchmark: Behavioral Risk Factor Surveillance System. 2016.	2016, 2018
Poor or Fair Health	Healthcare Access & Delivery; General Health	Percentage of adults that self-report having poor or fair health	San Mateo County Health, Health and Quality of Life Survey. 2018. Benchmark: Behavioral Risk Factor Surveillance System. 2016.	2016, 2018
Poor Physical Health (Average Days/Month)	General Health; Healthcare Access & Delivery	Average number of days per month survey respondents indicated their physical health was not good	San Mateo County Health, Health and Quality of Life Survey. 2018. Benchmark: Behavioral Risk Factor Surveillance System. 2016.	2016, 2018
Poor Physical or Mental Health Interfered with Usual Activities (Average Days/Month)	Mental Health & Well-Being (Mental Health/Emotional Well-Being); General Health	Average number of days per month survey respondents indicated that poor physical or mental health made it hard for them to engage in their usual activities	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Poor Sleep (Average Days/Month)	Mental Health & Well Being (Mental Health/Emotional Well-Being)	Average number of days in the past month that survey respondents reported they felt they didn't get enough sleep	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Population Below	Poverty, Income &	Percentage of the population living in	US Census Bureau,	2012-

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
100% FPL	Employment	households with income below the Federal Poverty Level (FPL)	American Community Survey. 2012-2016.	2016
Population Below 200% FPL	Poverty, Income & Employment	Percentage of population with income at or below 200% FPL	US Census Bureau, American Community Survey. 2012-2016. Trend: San Mateo County Health, Health and Quality of Life Survey. 2016	2012-2016, 2018
Population Below 200% FPL, Adults 65+	Poverty, Income & Employment	Percentage of survey respondents who are older adults (age 65+) whose income is at or below 200% FPL	San Mateo County Health, Health and Quality of Life Survey. 2018. Benchmark: Behavioral Risk Factor Surveillance System. 2016.	2016, 2018
Population in Linguistically Isolated Households	Education & Literacy; Social & Community Context	Percent of population living in households in which no member 14 years old and over (1) speaks only English or (2) speaks a non-English language and speaks English "very well." In other words, all members 14 years old and over have at least some difficulty with English.	US Census Bureau, American Community Survey. 2012-2016.	2012-2016
Population Receiving Medicaid	Healthcare Access & Delivery; Poverty, Income & Employment	Percent of insured population receiving Medicaid	US Census Bureau, American Community Survey. 2012-2016.	2012-2016
Population with Any Disability	Healthcare Access & Delivery; Social & Community Context; General Health	Percent population with a disability	US Census Bureau, American Community Survey. 2012-2016.	2012-2016
Population with Limited English Proficiency (age 5+)	Education & Literacy; Healthcare Access & Delivery; Poverty, Income & Employment	Population above the age of 5 who reported speaking English less than "very well," as classified by the U.S. Census Bureau	US Census Bureau, American Community Survey. 2012-2016.	2012-2016

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
Premature Death, Racial/Ethnic Disparity Index	Healthcare Access & Delivery; Social & Community Context	Summary measure of disparity (Index of Disparity) in premature death on the basis of race and ethnicity	National Vital Statistics System. 2004-2010.	2004-2010
Pre-Term Births	Birth Outcomes	Percentage of total births that are pre-term (occurring before 37 weeks of pregnancy)	U.S. Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2012-2014.	2012-2014
Preventable Hospital Events (% of Total Discharges)	Healthcare Access & Delivery	Age-adjusted discharge rate (per 10,000 population)	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES. 2011.	2011
Preventable Hospital Events Rate (per 1,000 Medicare Beneficiaries)	Healthcare Access & Delivery	Number of hospital stays for ambulatory-care sensitive conditions per 1,000 Medicare enrollees	Dartmouth Atlas of Health Care. 2015. Trend: California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES. 2011	2011, 2015
Primary & Secondary Syphilis Cases (Incidence) Rate	Sexually Transmitted Infections	Primary & secondary syphilis cases (incidence) rate per 100,000 population	California Department of Public Health, Sexually Transmitted Diseases Control Branch. 2016.	2016
Prostate Cancer Death Rate	Cancer	Age-adjusted rate of death among males due to prostate cancer per 100,000 population	California Department of Public Health: 2010-2015 Death Records.	2013-2015
Prostate Cancer Incidence Rate	Cancer	Annual prostate cancer incidence rate (per 100,000 population)	State Cancer Profiles. 2010-14.	2010-2014

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
Public Transit Stops	Neighborhood & Built Environment (Access to Food/Recreation; Community Infrastructure & Housing Quality; Natural Environment/Climate; Transportation & Traffic); Healthy Lifestyles (Diet, Fitness, & Nutrition; Obesity)	Percentage of the population living within 0.5 miles of a transit stop	EPA Smart Location Database. 2013.	2013
Rape (Crime) Rate	Neighborhood & Built Environment (Community & Family Safety)	Rape rate (per 100,000 population)	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2012-2014.	2012-2014
Reading At or Above Proficiency	Education & Literacy	Percentage of grade 4 ELA test scores at or above standard	California Department of Education. 2015-2016.	2015-2016
Receiving Government Assistance	Food insecurity; Healthcare Access & Delivery; Poverty, Income, & Employment	Percentage of respondents who answered "yes" when asked, "Do you currently receive any type of government assistance?"	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Recent Dental Exam	Healthcare Access & Delivery; Oral/Dental Health	Percent of survey respondents answering "Visit[ed] in past year" when asked "About how long has it been since you last visited a dentist for a routine check-up?"	San Mateo County Health, Health and Quality of Life Survey. 2018. Benchmark: Behavioral Risk Factor Surveillance System. 2016.	2016, 2018
Recent Marijuana Use	Mental Health & Well-Being (Tobacco/Substance Use)	Percentage of survey respondents who reported that they had used	San Mateo County Health, Behavioral	2016

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
		marijuana in the past month	Health and Recovery Services. Knowledge, Attitudes, and Behaviors Regarding Marijuana. 2016.	
Recent Primary Care Visit (at least 1 visit past year)	Healthcare Access & Delivery	Percentage of adults aged 18 years and older that visited a primary care clinician at least once within the past year	California Health Interview Survey. 2015-2016.	2015-2016
Received Informal Food Support	Food Insecurity; Birth Outcomes; Healthy Lifestyles (Diabetes; Diet, Fitness, & Nutrition; Obesity)	Percentage of survey respondents who indicated that they had gone to a food bank or otherwise received free meals in the past year	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Recreation and Fitness Facilities Rate	Neighborhood & Built Environment (Access to Food/Recreation); Heart Disease/Stroke; Healthy Lifestyles (Diabetes; Diet, Fitness, & Nutrition; Obesity)	Recreation and fitness facilities, rate (per 100,000 population)	US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2016.	2016
Regular Vigorous Physical Activity (Adults)	Healthy Lifestyles (Obesity/Overweight & Diabetes Related Factors); Cancer; Heart Disease/Stroke; Healthy Lifestyles (Diabetes; Diet, Fitness & Nutrition; Obesity)	Percentage of survey respondents who indicated that they engage in vigorous physical activity three or more times per week.	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Reliability of Public Transit	Neighborhood & Built Environment (Transportation & Traffic)	Percentage of survey respondents reporting they could rely on public transit to get to work, appointments, and shopping	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Residential	Social & Community	Residential Segregation is the index	US Census Bureau,	2012-

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
Segregation Index—Black/White (score 0-100)	Context	of dissimilarity where higher values indicate greater residential segregation between black and white county residents. The residential segregation index ranges from 0 (complete integration) to 100 (complete segregation)	American Community Survey. 2012-2016.	2016
Residential Segregation Index—Non-White/White (score 0-100)	Social & Community Context	Residential segregation is the index of dissimilarity where higher values indicate greater residential segregation between non-white and white county residents. The residential segregation index ranges from 0 (complete integration) to 100 (complete segregation)	US Census Bureau, American Community Survey. 2012-2016.	2012-2016
Respiratory Hazard Index (score)	Neighborhood & Built Environment (Natural Environment/Climate; Transportation & Traffic); Asthma & Respiratory Conditions	Respiratory Hazard Index, for which scores greater than 1.0 mean respiratory pollutants are likely to increase risk of non-cancer adverse health effects over a lifetime	EPA National Air Toxics Assessment. 2011.	2011
Rheumatoid Arthritis or Osteoarthritis: Medicare Population	Arthritis	Percentage of the Medicare population with rheumatoid arthritis or osteoarthritis	US Department of Health & Human Services, Centers for Medicare & Medicaid Services. 2015.	2015
Road Network Density (Acres)	Neighborhood & Built Environment (Community Infrastructure & Housing Quality; Natural Environment/Climate; Transportation & Traffic)	Total road network density (road miles per acre)	Environmental Protection Agency, EPA Smart Location Database. 2011.	2011
Robbery (Crime) Rate	Neighborhood & Built Environment (Community & Family Safety)	Robbery rate (per 100,000 population)	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by	2013-2014

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
			the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2012-2014.	
School Enrollment Age 3-4	Education & Literacy	Percentage of population age 3-4 enrolled in school	US Census Bureau, American Community Survey. 2012-2016.	2012-2016
Self-Sufficiency Standard, Single Parent Family	Poverty, Income, & Employment	The self-sufficiency standard (dollar amount) for a single parent with two children (one preschool-aged and one school-aged) in San Mateo County in 2014	Insight Center for Community Economic Development, 2014.	2014
Seriously Considered Suicide	Mental Health & Well-Being (Mental Health/Emotional Well-Being)	Percentage of adults aged 18 years and older that self-report having seriously thought about committing suicide	California Health Interview Survey. 2015-2016.	2015-2016
Severe Housing Problems	Housing & Homelessness	Percentage of households with one or more of the following housing problems: Housing unit lacks complete kitchen facilities; Housing unit lacks complete plumbing facilities; Housing unit is severely overcrowded (> 2 persons per room); or Household is severely cost burdened (all housing costs represent >50% of monthly income)	US Census Bureau, American Community Survey. 2011-2015.	2011-2015
Share Housing Costs with Non-Partner for Affordability	Housing & Homelessness	Percentage of respondents who reported sharing housing costs with someone other than a spouse or partner in order to limit expenses	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
Smoking in Home	Asthma & Respiratory Conditions; Cancer	Percentage of survey respondents who answered "yes" when asked "Do you or does another member of your household currently smoke in your home?"	San Mateo County Health, Health and Quality of Life Survey. 2018. Benchmark: Behavioral Risk Factor Surveillance System. 2016.	2016, 2018
SNAP Benefits (Households)	Food Insecurity; Healthy Lifestyles (Diet, Fitness, & Nutrition; Obesity)	Estimated percentage of households receiving Supplemental Nutrition Assistance Program (SNAP) benefits	US Census Bureau, American Community Survey. 2012-2016.	2012-2016
Social Associations (per 10,000 pop.)	Social & Community Context; Mental Health & Well-Being (Mental Health/Emotional Well-Being)	Number of social associations (e.g. civic organizations, recreational clubs and facilities, political organizations, labor organizations, business associations, professional organizations) per 10,000 population	County Business Patterns. 2015.	2015
Soft Drink Consumption	Healthy Lifestyles (Diabetes; Diet, Fitness, & Nutrition; Obesity); Oral/Dental Health	Percentage of adults that self-report drinking a soda or sugar sweetened beverage at least once daily	California Health Interview Survey. 2014.	2014
Stroke Death Rate	Heart Disease/Stroke	Age-adjusted rate of death due to cerebrovascular disease (stroke) per 100,000 population	California Department of Public Health. 2014-2016. Cause of Death: California Department of Public Health: 2010-2015 Death Records.	2010-2015, 2014-2016
Stroke Hospitalizations (per 1,000 Medicare Beneficiaries)	Heart Disease/Stroke	Hospitalization rate for Ischemic stroke among Medicare beneficiaries aged 65 years and older for hospital stays occurring between 2012 and 2014, per 1,000 population.	Interactive Atlas of Heart Disease and Stroke. 2012-2014.	2012-2014

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
Stroke Prevalence	Heart Disease/Stroke	Percentage of population diagnosed with stroke	San Mateo County Health, Health and Quality of Life Survey. 2018. Benchmark: Behavioral Risk Factor Surveillance System. 2016.	2016, 2018
Stroke Prevalence (Medicare Population)	Heart Disease/Stroke	Percentage of the Medicare fee-for-service population diagnosed with stroke	Centers for Medicare and Medicaid Services. 2015.	2015
Substance-Related Emergency Department Visits Rate	Mental Health & Well-Being (Tobacco/Substance Use)	Emergency Department visit rate (per 100,000 people) for substance-related issues	California Department of Public Health EpiCenter California injury data online. 2014.	2014
Substandard Housing Units	Housing & Homelessness; Neighborhood & Built Environment (Community Infrastructure & Housing Quality)	Percent occupied housing units with one or more substandard conditions	US Census Bureau, American Community Survey. 2012-2016.	2012-2016
Sugar-Sweetened Beverage Consumption (Adults)	Healthy Lifestyles (Obesity/Overweight & Diabetes Related Factors); Oral/Dental Health	Percentage of survey respondents reporting that they consume sugar-sweetened beverages daily	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Sugar-Sweetened Beverage Consumption (Youth)	Healthy Lifestyles (Obesity/Overweight & Diabetes Related Factors); Oral/Dental Health	Percentage of youth age 12-17 drinking one or more sugar-sweetened beverages per day	County of San Mateo, Board of Supervisors. Adolescent Report 2014-2015.	2014-2015
Suicidal Ideation	Mental Health & Well-Being (Mental Health/Emotional Well-Being)	Percentage of teen survey respondents who reported having suicidal thoughts	County of San Mateo, Board of Supervisors. Adolescent Report 2014-2015.	2014-2015

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
Suicide Death Rate	Mental Health & Well-Being (Mental Health/Emotional Well-Being)	Age-adjusted rate of death due to intentional self-harm (suicide) per 100,000 population	National Vital Statistics System. 2011-2015.	2011-2015
Suspensions Rate (per 100 students)	Education & Literacy; Neighborhood & Built Environment (Community & Family Safety); Social & Community Context	Rate of suspensions per 100 enrolled students	California Department of Education. 2016-2017.	2016-2017
Taking Prescription Medication for Asthma	Asthma & Respiratory Conditions	Percentage of survey respondents who indicated that they are taking prescription medication for asthma	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Teen Births Rate	Birth Outcomes	Number of births per 1,000 female population ages 15-19 Number of births per 1,000 female population ages 12-14 (trend and data without benchmark)	National Center for Health Statistics - Natality files. 2010-2016. Trend and data without benchmark: San Mateo County Health, 2015.	2010-2016, 2015
Teeth Removed Due to Poor Oral Health	Healthy Lifestyles (Obesity/Overweight & Diabetes Related Factors); Oral/Dental Health	Percentage of survey respondents who reported that three or more of their permanent teeth had been removed due to tooth decay or gum disease	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Truancy	Neighborhood & Built Environment (Community & Family Safety); Education & Literacy	Percentage of students who reported being truant during the school year	County of San Mateo, Board of Supervisors. Adolescent Report 2014-2015.	2014-2015
Trust Local Government Seldom/Never	Social & Community Context	Percentage of survey respondents who indicated that they seldom or never trusted local government to work for the best interest of their	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
		community.		
Tuberculosis Cases Rate	Asthma & Respiratory Conditions; Infectious Diseases	Tuberculosis incidence rate per 100,000 population	California Department of Public Health Tuberculosis Branch. 2016.	2016
Unemployment Rate	Poverty, Income & Employment	Percentage of the civilian non-institutionalized population age 16 and older that is unemployed (non-seasonally adjusted)	US Department of Labor, Bureau of Labor Statistics. 2018 - March.	2018
Uninsured Children	Healthcare Access & Delivery; Poverty, Income & Employment	Percentage of children aged less than 18 years of age without health insurance coverage	US Census Bureau, American Community Survey. 2012-2016.	2012-2016
Uninsured Population	Healthcare Access & Delivery; Poverty, Income & Employment	Percent uninsured population	US Census Bureau, American Community Survey. 2012-16.	2012-2016
Unintentional Drowning/Submersion Death Rate	Unintended Injuries/Accidents	Unintentional deaths due to drownings/submersions, rate per 100,000 population	California Department of Public Health EpiCenter California injury data online. 2013.	2013
Unintentional Poisoning Death Rate	Unintended Injuries/Accidents	Unintentional poisoning deaths, rate per 100,000 population	California Department of Public Health EpiCenter California injury data online. 2013.	2013
Use Other Tobacco Products	Mental Health & Well-Being (Tobacco/Substance Use); Cancer; Heart Disease/Stroke; Oral/Dental Health	Percentage of survey respondents who answered “yes” when asked, “Do you currently use other tobacco products such as cigars, pipes, chewing tobacco, or snuff?”	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
Used Marijuana or Hashish Recently	Asthma & Respiratory Conditions; Mental Health & Well-Being (Tobacco/Substance Use)	Percentage of survey respondents who reported that they had used marijuana or hashish in the past month	San Mateo County Health, Health and Quality of Life Survey. 2018. Benchmark: Behavioral Risk Factor Surveillance System. 2016.	2016, 2018
Usual Source of Dental Care	Healthcare Access & Delivery; Oral/Dental Health	Percentage of respondents who reported having a usual source of dental care	San Mateo County Health, Health and Quality of Life Survey. 2018.	2018
Uterine Cancer Incidence Rate	Cancer	Age-adjusted incidence rate of uterine cancer among females per 100,000 population per year	California Cancer Registry Fact Sheet, California Department of Public Health, 2008-2012.	2008-2012
Vacant Housing Units	Housing & Homelessness	Vacant housing units, percent	US Census Bureau, American Community Survey. 2012-2016.	2012-2016
Varicella Vaccine (% of All Kinder)	Infectious Diseases	Percentage of kindergarten students who reported receiving the varicella vaccine	California Department of Public Health, Kindergarten Immunization Assessment, 2015-2016 & 2016-2017.	2015-2016, 2016-2017
Walkable Destinations	Neighborhood & Built Environment (Access to Food/Recreation; Transportation & Traffic); Heart Disease/Stroke; Healthy Lifestyles (Diabetes; Diet, Fitness, & Nutrition; Obesity)	Percentage of the population that live in close proximity to a park, playground, library, museum or other destinations of interest	Center for Applied Research and Environmental Systems. 2012-2015.	2012-2015
WIC-Authorized Food Stores Rate	Neighborhood & Built Environment (Access to	This indicator reports the number of food stores and other retail	US Department of Agriculture, Economic	2011

Indicator Name	Health Need	Indicator Description	Data Source	Year(s)
	Food/Recreation); Healthy Lifestyles (Diabetes; Diet, Fitness, & Nutrition; Obesity)	establishments per 100,000 population that are authorized to accept WIC Program (Special Supplemental Nutrition Program for Women, Infants, and Children) benefits and that carry designated WIC foods and food categories	Research Service, USDA - Food Environment Atlas. 2011.	
Witnessing Violence at School	Neighborhood & Built Environment (Community & Family Safety); Mental Health & Well-Being (Mental Health/Emotional Well-Being)	Percentage of teen survey respondents who reported seeing violence at their schools	County of San Mateo, Board of Supervisors. Adolescent Report 2014-2015.	2014-2015
Witnessing Violence in Community	Neighborhood & Built Environment (Community & Family Safety); Mental Health & Well-Being (Mental Health/Emotional Well-Being)	Percentage of teen survey respondents who reported seeing violence in their community	County of San Mateo, Board of Supervisors. Adolescent Report 2014-2015.	2014-2015
Youth Experiencing Bullying, Prevalence	Neighborhood & Built Environment (Community & Family Safety)	Percentage of public school students in grades 7, 9, 11, and non-traditional students reporting whether in the past 12 months they have been harassed or bullied at school for any reason	California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd). 2011-2013.	2011-2013
Youth Intentional Injury Rate	Neighborhood & Built Environment (Community & Family Safety)	Intentional injuries, rate per 100,000 population (youth age 10 - 19)	California Department of Public Health, California EpiCenter. 2013-14.	2013-2014
Youth Intentional Self-Harm-ER Visits (per 10,000 pop.)	Neighborhood & Built Environment (Community & Family Safety); Mental Health & Well-Being (Mental Health/Emotional Well-Being)	Emergency department visit rate per 10,000 for intentional self-harm in youth ≤18 years old	California Office of Statewide Health and Planning (OSPHD). 2014.	2014

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Legend

Statistical data tables compare San Mateo County data to California state benchmarks or Healthy People 2020 aspirational goals, whichever is more stringent.

Definitions:

- Incidence rate: Rate of new cases within a specific time period
- Mortality rate: Rate of deaths from a given condition compared with a specified population
- Prevalence: Proportion of a population with a given condition
- Age-adjusted rate: Statistically modified rate that eliminates the effect of different age distributions in the populations

Conventions:

- Core indicators are separated from drivers by a heavy border.
- Certain indicators are available by ethnicity, which shows disparities in certain populations. Those tables follow each of the overall health need tables if available.
- Rates are per 100,000 unless otherwise noted.
- Data are rounded to the tenths if available. If the data point is less than 1.0, then it is presented to the hundredths.
- Data that are worse than benchmarks are in **bold**.
- Data that are 5% (not five percentage points, but five percent) worse than benchmarks are marked with a diamond (◆).
- Data where trends are available denoted with the dagger (†) symbol.
- Benchmark values represent the California state average except where noted:
  - Benchmark values with the (^{H}) superscript indicate that the Healthy People 2020 benchmark is more stringent than the state average.
  - Benchmark values with the (^{US}) superscript indicate that figure represents the national (United States) average rather than the state average; this occurs in cases where the state average was not made available.
- Indicator details, including the definition and original source, may be found in "Secondary Data Indicators" list provided separately.
- We use the shorthand "Afr / Afr Anc" for the term "African/African Ancestry" or "of African descent" to refer to all African people. Please note that the data sources from which ethnicity data are provided may use the terms "Black" and/or "African-American" in their surveys and studies. The term African ancestry is more inclusive and emphasizes the connectedness of all African people.
- We use the shorthand "Hisp / Lat (Any Race)" for the term "Hispanic / Latinx (Any Race)," "Pac Isl" for the term "Pacific Islander," and "Native Am" for the term "Native American."

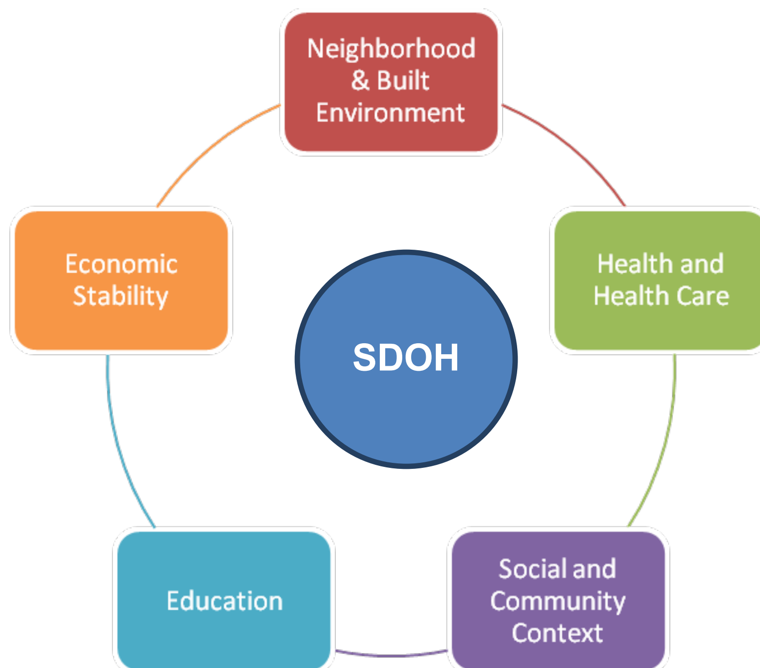
Social Determinants of Health

Health needs in the social determinants of health category are those which impact our health by way of our social and physical environments. The Healthy People 2020 framework organizes its research on social determinants of health in five domains:

1. **Economic Stability:** Employment, Food Insecurity, Housing Instability, Poverty
2. **Education:** Early Childhood Education and Development, Enrollment in Higher Education, High School Graduation, Language and Literacy
3. **Health and Health Care:** Access to Health Care, Access to Primary Care, Health Literacy
4. **Neighborhood and Built Environment:** Access to Foods that Support Healthy Eating Patterns, Crime and Violence, Environmental Conditions, Quality of Housing
5. **Social and Community Context:** Social Cohesion, Civic Participation, Discrimination, and Incarceration

The data tables found in this section all pertain to these five domains.

Figure 1, Social Determinants of Health Domains



Adapted from HealthyPeople.gov

Education & Literacy

Table 1, Statistical Data for Education & Literacy

Indicators	Year(s)	SMC	Benchmark	Desired ↑↓
High School Graduation Rate (percent of cohort)[1† & 2]	2014-2015	88.1%	[H]87.0%	↑
Reading At or Above Proficiency[2]	**2015-2016**	**♦56.0%**	**[H]63.7%**	↑
School Enrollment Age 3-4[1]	2012-2016	62.5%	48.6%	↑
Adults with an Associate's Degree or Higher[2]	2012-2016	54.5%	39.8%	↑
Adults with Less than High School Diploma (or Equivalent)[1]	2012-2016	11.4%	17.9%	↓
Adults with Some Post-Secondary Education[2]	2012-2016	76.1%	63.6%	↑
Expulsions Rate (per 100 students)[2]	2016-2017	0.06	0.08	↓
Head Start Program Facilities Rate (per 10,000 pop. 0-5)[1]	**2018**	**♦2.6**	**5.9**	↑
High Speed Internet[2]	2016	98.9%	95.4%	↑
Population in Linguistically Isolated Households[1]	2012-2016	8.9%	8.9%	↓
Population with Limited English Proficiency (age 5+)[1]	2012-2016	18.4%	18.6%	↓
Suspensions Rate (per 100 students)[2]	2016-2017	4.9	5.9	↓

Trends (†)

Certain indicators have been measured longitudinally. Below are the trend directions for indicators with trend data available.

- Childcare Arrangement Has Made It Easier for Parent to Attend Education/Training[11]: Decreasing
- Computer in Household[11]: Mixed (increasing, but decrease since 2013)
- High School Graduation Rate[1]: Flat since 2012

Race & Ethnicity

Certain indicators are available by ethnicity, which shows disparities in certain populations.

Table 2, Statistical Data for Education & Literacy by Ethnicity

Indicators	Bench-mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
High School Graduation Rate (percent of cohort)[2]	H87.0%	92.2	♦**77.3**	96.8		♦**73.3**		94.6	**80.4**
Adults with Less than High School Diploma or Equivalent[1]	17.9%	3.6%	11.0%	8.3%	14.1%	♦**26.6%**	♦**36.8%**	8.0%	♦**32.9%**
Reading At or Above Proficiency[2]	H63.7 %	75%	♦**34%**	79%	♦**30%**			74%	♦**31%**
Population with Limited English Proficiency (age 5+)[1]	18.6%	11.0%	0.19%	14.2%	0.54%	0.13%	7.4%	0.51%	♦**35.4%**

Blank cells indicate that data were unavailable.

Data without Benchmarks

Certain indicators were available that had no statewide or national comparison. These data are described below.

- Computer in Household: Nearly 90% of Quality of Life survey respondents countywide (N=1,581) reported that they had a computer at home.[11] This was reported in smaller proportions by respondents with a high school diploma or less (68%), and individuals earning less than 200% FPL (69%).[11]
- College Preparedness, High School Graduates: "In 2012, [only] 52% of high school graduates reported taking college preparatory courses in high school."[13]
- Truancy: "In 2012, 63% of students attending non-traditional schools reported being truant during the school year."[13]

Food Insecurity

Table 3, Statistical Data for Food Insecurity

Indicators	Year(s)	SMC	Benchmark	Desired ↑↓
Food Insecure Population Ineligible for Assistance[1]	**2014**	**♦39%**	**22%**	↓
Food Insecure Population Ineligible for Assistance - Children[1]	**2014**	**♦46%**	**29%**	↓
Food Insecurity Rate[11† & 23]	**2016, 2018**	**♦9.1%**	**H6.0%**	↓
Food Insecurity Rate – Children under 18[1]	2014	19.3%	25.3%	↓
Children Eligible for Free/Reduced Price Lunch[1†]	2015-2016	32.9%	58.9%	↓
Children in Single-Parent Households[2]	2012-2016	22.0%	31.8%	↓
SNAP Benefits (Households)[1† &2]	2012-2016	3.7%	9.4%	↓

Trends **(†)**

Certain indicators have been measured longitudinally. Below are the trend directions for indicators with trend data available.

- Children Eligible for Free/Reduced Price Lunch[1]: Falling since 2012-13
- Food Insecurity[11]: More respondents were food-insecure than in any prior survey (1998-2013).
- SNAP Benefits (Households)[1]: Rising since 2008
- Received Informal Food Support[11]: Increasing
- Receiving Government Assistance[11]: Increasing

Race & Ethnicity

Certain indicators are available by ethnicity, which shows disparities in certain populations.

Table 4, Statistical Data for Food Insecurity by Ethnicity

Indicators	Bench-mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Food Insecurity Rate[11 & 24]	H6.0%		**♦7.5%**	***♦7.2%**					

Blank cells indicate that data were unavailable. * Indicates that survey combined Asian/Pacific Islander.

Other Populations

Certain indicators are available by age, income or education level, or geography, and show disparities in certain populations.

Table 5, Statistical Data for Food Insecurity by Age, Income, Education, or Geography

Indicators	Bench-mark	Age 0-5	Age 6-17	Age 18-64	Age 65+	≤ High School	Some College	≥ B.A./B.S. Degree	≤ 200% FPL
Food Insecurity Rate[11 & 24]	H6.0%								♦**10.4%**

Blank cells indicate that data were unavailable.

Data without Benchmarks

Certain indicators were available that had no statewide or national comparison. These data are described below.

- Food Access:
    - Did Not Eat Breakfast: About "69% of non-traditional students reported not having eaten breakfast in the past day."[13]
- Food Assistance Programs:
    - Received Informal Food Support: More than 6% of Quality of Life survey respondents countywide (N=1,581) indicated that they had gone to a food bank or otherwise received free meals in the past year.[11] This figure was higher among low-income respondents (17%) and respondents from the Coastside (12%).[11]
    - Eligible Students Not Participating in School Lunch Programs: Nearly one third (31%) of students eligible to participate in school lunch programs are not participating.[14]
    - Eligible Students Not Participating in School Breakfast Programs: Nearly two thirds (64%) of students eligible to participate in school breakfast programs are not participating.[14]
    - Food Assistance Program Participation: "About half of eligible food-insecure individuals participate in food assistance programs."[14] "There are significant gaps in participation in cities like Daly City, N[orth] F[air] O[aks], E[ast] P[alo] A[lto], San Mateo [and] Redwood City."[14] It appears there is "[m]ore exploration to be done in cities like Millbrae, Foster City, San Bruno, [and] Brisbane."[14]

Health Care Access & Delivery

Table 6, Statistical Data for Health Care Access & Delivery

Indicators	Year(s)	SMC	Benchmark	Desired ↑↓
Access to Dentists Rate[1† &12]	2016	101.2	82.3	↑
Access to Mental Health Care Providers Rate[1]	2018	300.9	280.6	↑
Access to Primary Care Rate[1† &12]	2015	102.9	78.0	↑
Access to Other Primary Care Providers Rate[12]	**2017**	**♦35.6**	**52.2**	↑
Adults Needing and Receiving Behavioral Health Care Services[20†]	2015-2016	58.4%	60.5%	↓
Lack of Consistent Source of Primary Care[1]	2011-2012	10.4%	14.3%	↓
Preventable Hospital Events (% of Total Discharges)[1]	2011	8.6%	9.9%	↓
Preventable Hospital Events Rate (per 1,000 Medicare Beneficiaries)[1† & 12]	2015	21.9	36.2	↓
30-Day Readmissions[2]	2014	13.7%	14.4%	↓
Asthma Hospitalizations Rate (per 10,000 Medicare Beneficiaries)[2]	2015	2.0	2.4	↓
Cancer Screening – Mammogram, Medicare Population[11† & 25]	2016, 2018	67.0%	59.5%	↑
Cancer Screening – Mammogram[11† & 24]	2016, 2018	86.0%	82.4%	↑
Cancer Screening – Pap Test[1]	2006-2012	82.1%	78.3%	↑
Cancer Screening – FOBT/Sigmoid/Colonoscopy[11 & 24]	2016, 2018	80.4%	71.4%	↑
Cancer Screening - Sigmoid/Colonoscopy, Adults 50+[11† & 24]	2016, 2018	77.3%	40.1%	↑
Delayed or Had Difficulty Obtaining Care[20†]	2013-2014	17.3%	21.2%	↓
Doctor's Visit – Could Not Afford[11† & 24]	2016, 2018	5.8%	11.4%	↓
Federally Qualified Health Centers Rate[1]	**2018**	**♦1.7**	**2.7**	↑
Flu Shot in Past Year – Adults 65+[11 & 24]	2016, 2018	73.9%	58.1%	↑
Health Professional Shortage Area – Dental[2]	2016	0.0%	13.2%	↓
Health Care Costs (Medicare Reimbursements per Enrollee)[12]	2015	$7,473	$9,100	↓
Lack of Dental Insurance Coverage[2]	2015-2016	26.0%	38.5%	↓
Lack of Health Care Coverage[11† & 24]	2016, 2018	8.6%	12.9%	↓
Lack of Transportation Interfered with Access to Health Care[11† & 24]	2016, 2018	7.2%	[US]8.3%	↓
Life Expectancy at Birth (in Years)[2]	2014	83.1	80.8	↓
Living in Health Professional Shortage Area - Primary Care[1]	2016	0.0%	5.1%	↓
Medication – Could Not Afford[11† & 24]	2016, 2018	7.7%	[US]14.9%	↓

Indicators	Year(s)	SMC	Benchmark	Desired ↑↓
Mortality – Premature Deaths (Years of Potential Life Lost)[1]	2014-2016	3,552	5,862	↓
No Recent Dental Exam (Youth)[1]	2013-2014	1.2%	18.5%	↓
Pneumonia Vaccine Ever Received (Age 65+)[11 & 24]	2016, 2018	76.0%	72.4%	↑
Poor or Fair Health[11† & 24]	2016, 2018	13.3%	17.8%	↓
Poor Physical Health (Average Days/Month) [11† & 12]	2016, 2018	2.7	3.5	↓
Population Receiving Medicaid[1]	2012-2016	15.2%	26.6%	↓
Population with Any Disability[1]	2012-2016	8.3%	10.6%	↓
Population with Limited English Proficiency (age 5+)[1]	2012-2016	18.4%	18.6%	↓
Premature Death, Racial/Ethnic Disparity Index[2]	**2004-2017**	**♦52.1**	**36.8**	↓
Recent Dental Exam[11 & 24]	2016, 2018	78.9%	66.8%	↑
Recent Primary Care Visit (at least 1 visit past year)[2]	**2015-2016**	**70.6%**	**72.4%**	↑
Uninsured Children[2]	2012-2016	9.6%	10.4%	↓
Uninsured Population[1†]	2012-2016	**♦7.2%**	**H0.0%**	↓

Trends (†)

Certain indicators have been measured longitudinally. Below are the trend directions for indicators with trend data available.

- Access to Dentists Rate[1]: Rising since 2010
- Access to Primary Care Rate[1]: Mixed, but generally rising since 2010
- Adults Needing and Receiving Behavioral Health Care Services[20]: No significant change
- Cancer Screening – Mammogram, Medicare Population[11]: Increasing
- Cancer Screening – Mammogram[11]: Decreasing
- Cancer Screening – Fecal Occult Blood Stool Test[11]: Increasing
- Cancer Screening - Sigmoid/Colonoscopy, Adults 50+[11]: Increasing
- Child Had Recent Dental Exam[11]: Increasing
- Child Has Usual Place for Medical Check-ups[11]: Decreasing since 2013
- Delayed or Had Difficulty Obtaining Care[20]: Flat compared to prior value
- Difficulty Getting in to See a Doctor[11]: No clear trend
- Doctor's Visit – Could Not Afford[11]: No significant change
- Fair/Poor Access to Social Services[11]: No significant change
- Fair/Poor Access to Child Health Services[11]: Increasing since 2008
- Fair/Poor Access to Dental Care[11]: Increasing
- Fair/Poor Access to Help for Substance Abuse[11]: Increasing
- Fair/Poor Access to Mental Health Services[11]: Increasing

- Fair/Poor Access to Health Care[11]: No clear trend
- Have Ever Sought Professional Help for Drug Related Problem[11]: Flat
- Job Does Not Offer Health Benefits[11]: Increasing
- Job Offers Health Benefits for Employee Dependents[11]: Slightly increasing
- Know Where to Access Treatment for a Drug-Related Problem if Needed[11]: Increasing
- Lack of Health Care Coverage[11]: Decreasing since 2008
- Lack of Transportation Interfered with Access to Health Care[11]: No significant change
- Medication – Could Not Afford[11]: Decreasing
- Number of Years Since Had Health Coverage[11]: Decrease from 2013
- Poor or Fair Health[11]: Increasing since 2008
- Preventable Hospital Events Rate (per 1,000 Medicare Beneficiaries)[1,12]: Falling since 2008
- Receiving Government Assistance[11]: Increasing
- Uninsured Population[1]: Decreasing

Race & Ethnicity

Certain indicators are available by ethnicity, which shows disparities in certain populations.

Table 7, Statistical Data for Health Care Access & Delivery by Ethnicity

Indicators	Bench-mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Lack of Consistent Source of Primary Care[1]	14.3%	5.8%	8.0%				10.8%		**♦17.0%**
Cancer Screening – FOBT/Sigmoid/Colonoscopy[11 & 24]	71.4%			*74.5%					
Doctor's Visit – Could Not Afford[11 & 24]	11.4%		10.4%						
Lack of Health Care Coverage[11 & 24]	12.9%			***♦14.5%**					**♦16.5%**
Lack of Transportation Interfered with Access to Health Care[11 & 24]	[US]8.3%								**♦12.0%**
Medication – % Could Not Afford[11 & 24]	[US]14.9								13.2
Uninsured Population[1]	[H]0.0%	**3.6%**	**♦9.9%**	**♦5.8%**	**♦11.2%**	**♦8.8%**	**♦15.6%**	**4.7%**	**♦14.6%**

Blank cells indicate that data were unavailable. * Indicates that survey combined Asian/Pacific Islander.

Other Populations

Certain indicators are available by age, income or education level, or geography, and show disparities in certain populations.

Table 8, Statistical Data Related to Health Care Access & Delivery by Age, Income, Education, or Geography

Indicators	Bench-mark	Age 0-5	Age 6-17	Age 18-64	Age 65+	≤ High School	Some College	≥ B.A./B.S. Degree	≤ 200% FPL
Cancer Screening – FOBT/Sigmoid/Colonoscopy[11 & 24]	71.4%					**68.2%**			**71.0%**
Doctor's Visit – Could Not Afford[11 & 24]	11.4%								10.9%
Lack of Health Care Coverage[11 & 24]	12.9%					**♦21.5%**			
Lack of Transportation Interfered with Access to Health Care[11 & 24]	[US]8.3%								**♦15.7%**
Medication – % Could Not Afford[11 & 24]	[US]14.9								**♦18.0**
Recent Dental Exam[11 & 24]	66.8%								**♦51.1%**

Blank cells indicate that data were unavailable.

Data without Benchmarks

Certain indicators were available that had no statewide or national comparison. These data are described below.

- Access to Dentists: Almost 82% of Quality of Life survey respondents countywide (N=1,581) reported having a usual source of dental care.[11] This was the case for a smaller proportion of respondents earning less than 200% FPL (57%).[11]
- Access to Health Services:
  - Fair/Poor Access to Health Care: About 10% of Quality of Life survey respondents countywide (N=1,581) reported that the ease with which they are able to get the health care services they need is fair/poor.[11] This was reported in greater proportions by respondents earning less than 200% FPL (24%) and Latinx respondents (18%).[11]
  - Job Does Not Offer Health Benefits: More than one quarter of Quality of Life survey respondents countywide (N=1,581) who were employed reported that their job offered no health benefits.[11] This was reported in greater proportions by Latinxs (35%), south county respondents (36%), and individuals earning less than 200% FPL (56%).
  - Child Has Usual Place for Medical Check-ups: Of Quality of Life survey respondents who had at least one child under age 18 living in their household,

nearly 94% reported that they have a regular place they take their child for medical check-ups.[11] This was reported in smaller proportions by respondents with a high school diploma or less (87%), and individuals earning less than 200% FPL (87%).

- Access to Physicians:
    - Difficulty Getting in to See a Doctor: About 11% of Quality of Life survey respondents countywide (N=1,581) indicated they had difficulty seeing a doctor.[11] This affected greater proportions of respondents earning less than 200% FPL (20%) and Latinx respondents (17%).[11]
- Fair/Poor Access to Social Services: Over 21% of Quality of Life survey respondents countywide (N=1,581) rated the ease with which they are able to get social services in their community as fair or poor.[11] Greater proportions of Latinx (29%), low-income (30%), and African ancestry (34%) respondents rated social services access as fair/poor.[11]
- Dental Insurance:
    - Dental Insurance: About two thirds of Quality of Life survey respondents countywide (N=1,581) reported having dental insurance.[11] This was the case for smaller proportions of respondents earning less than 200% FPL (42%) and older adult (65+) respondents (44%).[11]
    - Lack of Insurance Prevented Dental Care: About 30% of Quality of Life survey respondents countywide (N=1,581) indicated that they or a family member(s) have dental problems they cannot take care of because of a lack of insurance.[11] This affected greater proportions of Latinx respondents (44%) and adults age 18-39 (45%).[11]

Housing & Homelessness

Table 9, Statistical Data for Housing & Homelessness

Indicators	Year(s)	SMC	Benchmark	Desired ↑↓
Assisted Housing Units Rate (per 10,000)[1]	**2016**	**♦235.9**	**352.4**	↓
Asthma Patient Discharges, Children/Youth (age 1-19)[1]	2011	3.8%	4.3%	↓
Banking Institutions Rate (per 10,000 pop.)[2]	2015	3.2	2.7	↑
Commute >60 Min.[1]	2012-2016	8.9%	11.3%	↓
Cost Burdened Households[1]	2012-2016	39.3%	42.8%	↓
Cost Burden – Renters[18†]	2012-2016	48.2%	56.5%	↓
Living in Owner-Occupied Housing[18†]	2012-2016	56.4%	49.8%	↑
Median Rent, 2 Bedroom ($)[19†]	**2018**	**♦3,495**	**2,150**	↓
Severe Housing Problems[2]	2011-2015	24.1%	27.3%	↓
Substandard Housing Units[1]	2012-2016	41.8%	45.6%	↓
Vacant Housing Units[1]	2012-2016	4.7%	7.9%	↓

Trends (†)

Certain indicators have been measured longitudinally. Below are the trend directions for indicators with trend data available.

- Fair/Poor Access to Affordable Housing[11]: No clear trend
- Cost Burden – Renters[18]: No change
- Home Ownership (living in owner-occupied housing)[18]: No significant change
- Housing Unstable in Past 2 Years[11]: Increasing
- Median Rent, 2 Bedroom[19]: Increasing
- May Move Due to Cost of Living[11]: Mixed; increasing since 2013
- Share Housing Costs with Non-Partner for Affordability[11]: Increasing since 2008

Data without Benchmarks

Certain indicators were available that had no statewide or national comparison. These data are described below.

- Affordable Housing:
    - Fair/Poor Access to Affordable Housing: Over 80% of the Quality of Life survey respondents countywide (N=1,581) rated the availability of affordable housing in their community as fair or poor.[11] The proportion rating affordable housing availability as fair/poor was 87% among both Whites and African ancestry respondents.[11]

- Lack of Affordable Housing: Fully “80% [of] low-income households have unaffordable housing.”[14]

- Homelessness: Three percent of the Quality of Life survey respondents countywide (N=1,581) reported that they had been homeless at least once in the past two years.[11] Respondents most likely to report having been homeless in the past two years are adults age 18-39 (8%) and Asian/Pacific Islanders (7%).[11]
- Home Ownership: Over 60% of the Quality of Life survey respondents countywide (N=1,581) reported owning a home.[11] Much smaller proportions of Latinx (36%) and low-income (33%) respondents reported owning a home.[11]
- Housing Costs:
    - Share Housing Costs with Non-Partner for Affordability: Over 21% of the Quality of Life survey respondents countywide (N=1,581) reported sharing housing costs with someone other than a spouse or partner in order to limit expenses.[11] Respondents most likely to report sharing costs in this way were of African ancestry (31%), Latinx (36%), and adults age 18-39 (37%).[11]
    - Housing Costs: “Housing costs increased nearly 70% in the past 5 years.”[14]
    - Future Cost of Living: “In the next 24 years[,] low income households will spend 67% of income on housing and transportation.”[14]
- Older Dependents: Nearly 12% of Quality of Life survey respondents countywide (N=1,581) reported that they had older dependents living in their household because these older individuals were unable to live alone.[11] This was reported in higher proportions by adults age 18-39 (21%), and Asian/Pacific Islanders (23%).[11]

Neighborhood & Built Environment

Access to Food/Recreation

Table 10, Statistical Data for Access to Food/Recreation

Indicators	Year(s)	SMC	Benchmark	Desired ↑↓
Drinking Water Violations[2]	**2015**	**♦1.0**	**0.8**	↓
Exercise Opportunities[12]	2016	96.2%	89.6%	↑
Fast Food Restaurants Rate[1†]	**2016**	**82.5**	**78.7**	↓
Food Desert Population[1]	2015	9.9%	13.4%	↓
Food Environment Index[12]	2015	8.9	8.8	↑
Grocery Stores Rate[1†]	2016	25.3	21.8	↑
Lack of Healthy Food Stores[2]	2014	9.9%	13.4%	↑
Public Transit Stops[2]	**2013**	**♦13.4%**	**16.8%**	↑
Recreation and Fitness Facilities Rate[1†]	2016	14.9	10.2	↑
Walkable Destinations[2]	2012-2015	54.8%	29.0%	↑
WIC-Authorized Food Stores Rate[1]	**2011**	**♦10.5**	**15.8**	↑

Trends (†)

Certain indicators have been measured longitudinally. Below are the trend directions for indicators with trend data available.

- Fast Food Restaurants Rate[1]: Rising since 2013
- Grocery Stores Rate[1]: Rising since 2013
- Recreation and Fitness Facilities Rate[1]: Mixed.

Community & Family Safety

Table 11, Statistical Data for Community & Family Safety

Indicators	Year(s)	SMC	Benchmark	Desired ↑↓
All Violent Crimes Rate[1]	2012-2014	227.6	403.2	↓
Assault (Crime) Rate[1]	2012-2014	139.0	239.2	↓
Assault (Injury) Rate[1]	2013-2014	181.6	289.4	↓
Domestic Violence Rate[1]	2013-2014	4.3	4.9	↓

Indicators	Year(s)	SMC	Benchmark	Desired ↑↓
Homicide Rate[12]	2010-2016	2.5	5.0	↓
Rape (Crime) Rate[1]	2012-2014	20.5	21.4	↓
Robbery (Crime) Rate[1]	2013-2014	66.7	137.9	↓
Youth Intentional Injury Rate[1]	2013-2014	166.2	209.7	↓
Alcohol – Binge Drinker[11† & 24]	**2016, 2018**	**16.9%**	**16.3%**	↓
Disconnected Youth[12]	2010-2014	9.9%	14.4%	↓
Domestic Violence Hospitalizations Rate[2]	2013-2014	4.2	4.9	↓
Expulsions Rate (per 100 students)[2]	2016-2017	.06	.08	↓
Firearm Kept in or around Home[11† & 24]	2016, 2018	16.8%	32.7%	↓
Firearm-Related Death Rate[12]	2012-2016	4.3	7.9	↓
Injury Deaths Rate[12]	2012-2016	35.1	47.6	↓
Liquor Store Access Rate[1†]	2016	6.8	10.7	↓
Suspensions Rate (per 100 students)[2]	2016-2017	4.9	5.9	↓
Youth Experiencing Bullying, Prevalence[4]	2011-2013	30.8%	33.8%	↓
Youth Intentional Self-Harm-ER Visits (per 10,000 pop.)[5]	2014	7.9	10.9	↓

Trends (†)

Certain indicators have been measured longitudinally. Below are the trend directions for indicators with trend data available.

- Alcohol – Binge Drinker[11]: Increasing
- Community Connectedness – Feel Not Very or Not at All Connected[11]: No significant change
- Crime in Neighborhood is Getting Much/a Little Worse[11]: Decreased (improved) since 2013
- Firearm Kept in or around Home[11]: Flat
- Juvenile Arrest Rate: Declined from 1998 to 2011[13]
- Liquor Store Access Rate[1]: Falling since 2014
- Neighborhood Safety is Fair/Poor[11]: No change
- Parent/Family Supervises Child After School[11]: Increasing

Community Infrastructure & Housing Quality

Table 12, Statistical Data for Community Infrastructure & Housing Quality

Indicators	Year(s)	SMC	Benchmark	Desired ↑↓
Assisted Housing Units Rate (per 10,000)[1]	**2016**	**♦235.9**	**352.4**	↓
Drinking Water Violations[2]	**2015**	**♦1.0**	**0.8**	↓
High Speed Internet[2]	2016	98.9%	95.4%	↑
Public Transit Stops[2]	**2013**	**♦13.4%**	**16.8%**	↑
Road Network Density (Acres)[1]	**2011**	**♦3.7**	**2.0**	↓
Substandard Housing Units[1]	2012-2016	41.8%	45.6%	↓

Trends (†)

Certain indicators have been measured longitudinally. Below are the trend directions for indicators with trend data available.

- Physical Environment of Community is Fair/Poor[11]: Slight increase

Natural Environment/Climate

Table 13, Statistical Data for Natural Environment/Climate

Indicators	Year(s)	SMC	Benchmark	Desired ↑↓
Air Quality - Ozone (O3)[2]	2014	29.8%	42.0%	↓
Air Quality - Particulate Matter 2.5[2]	2014	8.2%	10.7%	↓
Area with Tree Canopy Cover (pop.-weighted)[2]	2011	17.0%	8.3%	↑
Asthma Hospitalizations Rate (per 10,000 Medicare Beneficiaries)[2]	2015	2.0	2.4	↓
Asthma Patient Discharges, Children/Youth (age 1-19)[1]	2011	3.8%	4.3%	↓
Asthma Patient Discharges, Older Adults (age 65+)[1]	**2011**	**♦1.1%**	**0.8%**	↓
Asthma Prevalence, Adults[11† & 24]	**2016, 2018**	**♦18.5%**	**12.8%**	↓
Asthma Prevalence, Children/Youth[11† & 24]	**2016, 2018**	**♦15.5%**	**US11.1%**	↓
Climate & Health - Drought Severity[1]	2012-2014	92.6%	92.8%	↓
Climate & Health - Heat Index Days[1]	2014	0.0	2.7	↓
Climate & Health - Heat Stress Events[1]	2005-2012	4.1	11.1	↓
Climate-Related Mortality Impacts[2]	2016	0.0%	8.4%	↓

Indicators	Year(s)	SMC	Benchmark	Desired ↑↓
Flood Vulnerability[2]	**2011**	**♦5.7%**	**3.7%**	↓
Respiratory Hazard Index (score)[2]	2011	1.8	2.2	↓
Commute to Work - Alone in Car[1]	2012-2016	69.4%	73.5%	↓
Commute to Work – By Public Transit[18†]	2012-2016	10.1%	5.2%	↑
Driving Alone to Work, Long Distances[2]	2012-2016	38.1%	39.3%	↓
Heart Disease Death Rate[22†]	2014-2016	55.4	89.1	↓
Heart Disease Prevalence[2]	2014	5.6%	7.0%	↓
Low Birth Weight[12]	**2010-2016**	**6.9%**	**6.8%**	↓
Pediatric Asthma Hospitalizations Rate (per 10,000 pop.)[5]	2013-2015	5.6	9.8	↓
Public Transit Stops[2]	**2013**	**♦13.4%**	**16.8%**	↑
Road Network Density (Acres)[1]	**2011**	**♦3.7**	**2.0**	↓

Trends (†)

Certain indicators have been measured longitudinally. Below are the trend directions for indicators with trend data available.

- Asthma Prevalence, Adults[11]: Increasing
- Asthma Prevalence, Children/Youth[11]: Increasing
- Commute to Work – By Public Transit[18]: Increasing
- Heart Disease Death Rate[22]: Decreasing

Transportation & Traffic

Table 14, Statistical Data for Transportation & Traffic

Indicators	Year(s)	SMC	Benchmark	Desired ↑↓
Commute to Work - Alone in Car[1]	2012-2016	69.4%	73.5%	↓
Commute to Work – By Public Transit[18†]	2012-2016	10.1%	[H]5.5%	↑
Driving Alone to Work, Long Distances[2]	2012-2016	38.1%	39.3%	↓
Motor Vehicle Crash Death Rate[12]	2010-2016	5.3	8.5	↓
Pedestrian Accident Death Rate[1]	**2010-2012**	**♦1.4**	**[H]1.3**	↓
Public Transit Stops[2]	**2013**	**♦13.4%**	**16.8%**	↑
Road Network Density (Acres)[1]	**2011**	**♦3.7**	**2.0**	↓
Air Quality - Ozone (O3)[2]	2014	29.8%	42.0%	↓
Air Quality - Particulate Matter 2.5[2]	2014	8.2%	10.7%	↓
Lack of Transportation Interfered with Access to Health Care[11 & 24]	2016, 2018	7.2%	[US]8.3%	↓
Liquor Store Access Rate[1†]	2016	6.8	10.7	↓
Respiratory Hazard Index (score)[2]	2011	1.8	2.2	↓
Walkable Destinations[2]	2012-2015	54.8%	29.0%	↑

Trends (†)

Certain indicators have been measured longitudinally. Below are the trend directions for indicators with trend data available.

- Reliability of Public Transit[11]: No clear trend
- Commute to Work – By Public Transit[18]: Increasing
- Lack of Transportation Interfered with Access to Health Care[11]: No significant change
- Liquor Store Access Rate[1]: Falling from 2014

Race & Ethnicity

Certain indicators are available by ethnicity, which shows disparities in certain populations.

Table 15, Statistical Data for Neighborhood & Built Environment by Ethnicity

Indicators	Bench-mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Assault (Injury)[1]	289.4	173.7	♦**564.9**	61.0		♦**551.1**			**303.5**
Domestic Violence[1]	4.9	4.3							♦**7.4**
Pedestrian Accident Death Rate[1]	[H]1.3	1.2	0.0	0.0	0.0	1.0		0.0	♦**1.9**
Youth Intentional Injury[1]	209.7	♦**288.7**		41.7					158.8
Heart Disease Prevalence[1]	6.3%	♦**8.3%**					1.5%		2.6%
Lack of Transportation Interfered with Access to Health Care[11 & 24]	[US]8.3%								♦**12.0%**
School Expulsions Rate (per 100 students) [1]	0.1	0.0	♦**0.2**	0.0		0.0		0.1	♦**0.2**
School Suspensions Rate (per 100 students) [1]	6.8	2.5	♦**17.0**	1.3		♦**10.2**		4.5	**7.1**
Youth Experiencing Bullying, Prevalence[4]	33.8%	28.6%	30.6%	30.8%	32.5%	20.7%	31.7%	26.0%	**33.9%**
Youth Intentional Self-Harm-ER Visits (per 10,000 pop.)[5]	10.9	9.4	3.3	5.9*		♦**42.6**	♦**12.3**		7.1

Blank cells indicate that data were unavailable. * Indicates that survey combined Asian/Pacific Islander.

Other Populations

Certain indicators are available by age, income or education level, or geography, and show disparities in certain populations.

Table 16, Statistical Data for Neighborhood & Built Environment by Age, Income, Education, or Geography

Indicators	Bench-mark	Age 0-17	Age 18-39	Age 18-64	Age 65+	≤ High School	Some College	≥ B.A./B.S. Degree	≤ 200% FPL
Alcohol – Binge Drinker[11 & 24]	16.3%		♦**28.4%**						
Lack of Transportation Interfered with Access to Health Care[11 & 24]	[US]8.3%								♦**15.7%**

Blank cells indicate that data were unavailable.

Data without Benchmarks

Certain indicators were available that had no statewide or national comparison. These data are described below.

Access to Food/Recreation

- Food Store Quality/Affordability: “On av[erage,] 20-30% of [food] stores in low income neighborhoods meet the basic quality and affordability standards” in San Mateo County.[14]

Community & Family Safety

- Bullying:
  - Cyberbullying: Nearly one in five (19%) “of [teen] females reported being bullied or harassed via the internet compared to 11% of [teen] males” (N=3,284).[13]
  - Absenteeism Due to Cyberbullying: A total of “11% of [teen] respondents who reported being bullied or harassed via the internet missed one or more days of school in the past month” (N=3,284).[13]
- Community Connectedness:
  - Community Connectedness – Feel Not Very or Not at All Connected: About one third of Quality of Life survey respondents countywide (N=1,581) reported that they felt not very or not at all connected to their community.[11] Higher proportions of men (41%) and Asian/Pacific Islander (40.5%) respondents felt this way.[11]
  - Adults Age 65+ Living Alone: Nearly 36% of Quality of Life survey respondents countywide (N=1,581) who were adults age 65+ indicated they were living alone.[11] This was indicated by greater proportions of older adult women and middle income (200-400% FPL) respondents than others.[11]

- Handling Conflict: Over one third (37%) of teen respondents did not know non-violent ways to deal with conflict (N=3,284).[13]
- Juvenile Arrests:
  - "African Americans have the highest juvenile arrest rate of 48 per 100,000 in 2011 compared to 3.1 per 100,000 for their white counterparts."[13]
  - "Hispanics make up 50% of juvenile felony arrests… Issues with racial profiling, discrimination, and lack of opportunity may influence these outcomes."[13]
- Perception of Safety:
  - Neighborhood Safety is Fair/Poor: About 10% of Quality of Life survey respondents countywide (N=1,581) rated the safety, security, and crime control in their neighborhood to be fair or poor.[11] Fair/poor ratings were more likely to be given by respondents with a high school diploma or less (21%) and low-income respondents (19%).[11]
  - Perception of Safety, Youth: "Only 53% of all [teen] respondents reported feeling safe in their community" (N=3,284).[13]
  - Crime in Neighborhood is Getting Much/a Little Worse: Close to 16% of Quality of Life survey respondents countywide (N=1,581) believed the problem of crime in their neighborhood was getting much or a little worse.[11] Coastside respondents were more likely to say crime is getting work in their neighborhood (21%).[11]
- Truancy: "In 2012, … 63% of students attending non-traditional schools reported being truant during the school year."[13]
- Witnessing Violence at School: "28% of [teen] respondents reported seeing violence at their schools" (N=3,284).[13]
- Witnessing Violence in Community: "30% of [teen] respondents reported seeing violence in their community" (N=3,284).[13]

Community Infrastructure & Housing Quality

- Physical Environment of Community is Fair/Poor: About 12% of Quality of Life survey respondents countywide (N=1,581) considered the physical environment in their community to be fair or poor.[11] Double or greater proportions of south county residents (24%), Latinxs (25%), and African ancestry (27%) respondents felt this way.[11]

Natural Environment/Climate

- Low Birth Weight: Multiple births (e.g., twins) are more likely to be low birth weight; countywide, 5.1% of singleton births were low birth weight.[11]

Transportation & Traffic

- Commute to Work – By Public Transit: Among the population commuting for work, men and adults age 45-54 are least likely to use public transportation.[18]

- Future Cost of Living: "In the next 24 years[,] low income households will spend 67% of income on housing and transportation."[14]
- Motor Vehicle Accidents: The leading mechanism of injury for adults 18-65 is motor vehicle collisions.[16]
- Reliability of Public Transit: About 60% of Quality of Life survey respondents countywide (N=1,581) reported that they could rely on public transportation to get to work, appointments, and shopping.[11] Only about half that proportion (34%) of Coastside respondents felt they could rely on public transit for such tasks.[11]

Poverty, Income & Employment

Table 17, Statistical Data for Poverty, Income & Employment

Indicators	Year(s)	SMC	Benchmark	Desired ↑↓
Children Below 100% FPL[1*]	2012-2016	9.7%	21.9%	↓
Income Inequality (Gini Coefficient)[1]	2012-2016	0.5	0.5	↓
Median Household Income[12]	2016	$107,075	$67,715	↑
Persons Age 65+ in Poverty[18†]	2012-2016	6.8%	10.3%	↓
Persons Under 18 in Poverty[12]	2016	7.7%	19.9%	↓
Population Below 100% FPL[1*]	2012-2016	7.7%	15.8%	↓
Population Below 200% FPL[1* & 11†]	2012-2016, 2018	19.8%	35.2%	↓
Population Below 200% FPL, Adults 65+[11† & 24]	2016, 2018	23.2%	[US]28.2%	↓
Unemployment Rate[1†]	2018	2.2	4.2	↓
Adults with an Associate's Degree or Higher[2]	2012-2016	54.5%	39.8%	↑
Adults with Less than High School Diploma (or Equivalent)[1]	2012-2016	11.4%	17.9%	↓
Adults with Some Post-Secondary Education[2]	2012-2016	76.1%	63.6%	↑
Cost Burden – Renters[18†]	2012-2016	48.2%	56.5%	↓
Cost Burdened Households[1]	2012-2016	39.3%	42.8%	↓
Doctor's Visit – Could Not Afford[11† & 24]	2016, 2018	5.8%	11.4%	↓
High Speed Internet[2]	2016	98.9%	95.4%	↑
Households with No Vehicle[1]	2012-2016	5.3%	7.6%	↓
Living in Owner-Occupied Housing[18†]	2012-2016	56.4%	49.8%	↑
Lack of Health Care Coverage[11† & 24]	2016, 2018	8.6%	12.9%	↓
Medication – Could Not Afford[11† & 24]	2016, 2018	7.7%	[US]14.9%	↓
Opportunity Index (score 1-100)[2]	2017	64.5	51.9	↑
Population Receiving Medicaid[1]	2012-2016	15.2%	26.6%	↓
Population with Limited English Proficiency (age 5+)[1]	2012-2016	18.4%	18.6%	↓
Uninsured Children[2]	2012-2016	9.6%	10.4%	↓
Uninsured Population[1†]	2012-2016	**♦7.2%**	**[H]0.0%**	↓

* 2014 Federal Poverty Level (FPL) for a family of 4 was $23,850 per year. 2014 San Mateo County Self-Sufficiency Standard for a family of 4 was $89,440.

Trends (†)

Certain indicators have been measured longitudinally. Below are the trend directions for indicators with trend data available.

- Childcare Arrangement Has Made It Easier for Parent to Accept a Job[11]: Decreasing
- Childcare Arrangement Has Made It Easier for Parent to Accept a Better Job[11]: Decreasing
- Childcare Arrangement Has Made It Easier for Parent to Attend Education/Training[11]: Decreasing
- Childcare Arrangement Has Made It Easier for Parent to Keep a Job[11]: Decreasing
- Computer in Household[11]: Mixed (increasing, but decrease since 2013)
- Cost Burden – Renters[18]: No change
- Doctor's Visit – Could Not Afford[11]: No significant change
- Family's Financial Situation is Fair/Poor[11]: No change
- Family's Financial Situation is Somewhat/Much Worse than Prior Year[11]: No significant change
- Home Ownership (living in owner-occupied housing)[18]: No significant change
- Job Does Not Offer Health Benefits[11]: Increasing
- Job Offers Health Benefits for Employee Dependents[11]: Slightly increasing
- Lack of Health Care Coverage[11]: Decreasing since 2008
- Medication – Could Not Afford[11]: Decreasing
- Local Employment Opportunities are Fair/Poor[11]: Decreasing
- Persons Age 65+ in Poverty[18]: Increasing
- Population Below 200% FPL[11]: Increasing
- Population Below 200% FPL, Adults 65+[11]: Increasing
- Receiving Government Assistance[11]: Increasing
- Unemployment Rate (average annual)[1]: Falling since 2010
- Uninsured Population[1]: Decreasing

Race & Ethnicity

Certain indicators are available by ethnicity, which shows disparities in certain populations.

Table 18, Statistical Data for Poverty, Income & Employment by Ethnicity

Indicators	Bench-mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Children Below 100% FPL[1]*	21.9%	3.5%	♦**24.0%**	5.4%	17.1%	21.1%	21.6%	4.7%	18.9%
Population Below 100% FPL[1]*	15.8%	6.76%	♦**16.7%**	5.6%	10.5%	♦**16.8%**	15.5%	7.2%	13.6%
Adults with Less than High School Diploma	17.9%	3.6%	11.0%	8.3%	14.1%	♦**26.6%**	♦**36.8%**	8.0%	♦**32.9%**

Indicators	Bench-mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
or Equivalent[1]									
Doctor's Visit – Could Not Afford[11 & 24]	11.4%		10.4%						
Medication – % Could Not Afford[11 & 24]	[US]14.9								13.2
Uninsured Population[1]	[H]0.0%	**3.5%**	**♦9.9%**	**♦5.8%**	**♦11.2%**	**♦8.8%**	**♦15.6%**	**4.7%**	**♦14.6%**

Blank cells indicate that data were unavailable. * Indicates 2014 Federal Poverty Level (FPL) for a family of 4 was $23,850 per year. 2014 San Mateo County Self-Sufficiency Standard for a family of 4 was $89,440.

Other Populations

Certain indicators are available by age, income or education level, or geography, and show disparities in certain populations.

Table 19, Statistical Data for Poverty, Income & Employment by Age, Income, Education, or Geography

Indicators	Bench-mark	Age 0-5	Age 6-17	Age 18-64	Age 65+	≤ High School	Some College	≥ B.A./B.S. Degree	≤ 200% FPL
Doctor's Visit – Could Not Afford[11 & 24]	11.4%								10.9%
Medication – % Could Not Afford[11 & 24]	[US]14.9								**♦18.0**

Blank cells indicate that data were unavailable.

Data without Benchmarks

Certain indicators were available that had no statewide or national comparison. These data are described below.

- Computer in Household: Nearly 90% of Quality of Life survey respondents countywide (N=1,581) reported that they had a computer at home.[11] This was reported in smaller proportions by respondents with a high school diploma or less (68%), and individuals earning less than 200% FPL (69%).[11]
- Cost of Living:
  - Self-Sufficiency Standard, Single Parent Family: The self-sufficiency standard for a single parent with two children (one preschool-aged and one school-aged) in San Mateo County in 2014 was $80,588.[15]
  - Elder Index, Single Older Adult Renter: The total annual income needed for an older adult living alone in a rental property in San Mateo County in 2011 was $29,438.[15]
  - May Move Due to Cost of Living: Approximately 38% of the Quality of Life survey respondents countywide (N=1,581) reported that they had considered leaving the

county in the past year due to the cost of living.[11] Respondents most likely to have considered leaving the county due to cost of living were African ancestry (53%), Latinx (54%), and adults age 18-39 (54%).[11]

- Employment and Benefits:
  - Local Employment Opportunities are Fair/Poor: About 15% of the Quality of Life survey respondents countywide (N=1,581) considered the employment opportunities that exist in this area to be fair or poor.[11] More than twice the proportion of respondents on the Coastside felt this way (34%), and 26% of African ancestry respondents felt this way.[11]
  - Job Does Not Offer Health Benefits: More than one quarter of Quality of Life survey respondents countywide (N=1,581) who were employed reported that their job offered no health benefits.[11] This was reported in greater proportions by Latinxs (35%), south county respondents (36%), and individuals earning less than 200% FPL (56%).[11]
- Home Ownership: Over 60% of the Quality of Life survey respondents countywide (N=1,581) reported owning a home.[11] Much smaller proportions of Latinx (36%) and low-income (33%) respondents reported owning a home.[11]
- Income and Finances:
  - Population Below 200% FPL: About 17% of the Quality of Life survey respondents countywide (N=1,581) reported earning below 200% of the Federal Poverty Limit.[11] This was reported in greater proportions by respondents with a high school diploma or less (51%) and Latinxs (35%).[11]
  - Family's Financial Situation is Fair/Poor: About 19% of the Quality of Life survey respondents countywide (N=1,581) considered their personal or family financial situation to be fair or poor.[11] This was reported in greater proportions by Latinx (31%) and African ancestry respondents (32%).[11]
  - Persons Age 65+ in Poverty: Of persons age 65+ living in poverty, Latinxs and individuals of multiple ethnicities are overrepresented, as are individuals age 75+.[18]

Social & Community Context

Table 20, Statistical Data for Social & Community Context

Indicators	Year(s)	SMC	Benchmark	Desired ↑↓
Disconnected Youth[12]	2010-2014	9.9%	14.4%	↓
Expulsions Rate (per 100 students)[2]	2016-2017	0.06	0.08	↓
Income Inequality (Gini Coefficient)[1]	2012-2016	0.5	0.5	↓
Lack of Social or Emotional Support[2]	2006-2012	22.3%	24.7%	↓
Life Expectancy at Birth (in Years)[2]	2014	83.1	80.8	↑
Mortality – Premature Deaths (Years of Potential Life Lost)[1]	2014-2016	3,552	5,862	↓
Opportunity Index (score 1-100)[2]	2017	64.5	51.9	↑
Population in Linguistically Isolated Households[1]	2012-2016	8.9%	8.9%	↓
Population with Any Disability[1]	2012-2016	8.3%	10.6%	↓
Premature Death, Racial/Ethnic Disparity Index[2]	**2004-2017**	**♦52.1**	**36.8**	↓
Residential Segregation Index—Black/White (score 0-100)[12]	2012-2016	56.3	55.7	↓
Residential Segregation Index—Non-White/White (score 0-100)[12]	2012-2016	37.0	37.5	↓
Social Associations (per 10,000 pop.)[2]	**2015**	**6.4**	**6.5**	↑
Suspensions Rate (per 100 students)[2]	2016-2017	4.9	5.9	↓

Trends (†)

Certain indicators have been measured longitudinally. Below are the trend directions for indicators with trend data available.

- Adults Age 65+ Living Alone[11]: Flat
- Community Connectedness – Feel Not Very or Not at All Connected[11]: No significant change
- Community is Fair/Poor Place to Live[11]: No significant change
- Community Tolerance for Racial/Cultural Differences is Fair/Poor[11]: Decreasing
- Fair/Poor Access to Social Services[11]: No significant change
- Lack Support[11]: Increasing since 2008
- Parent/Family Supervises Child After School[11]: Increasing
- Trust Local Government Seldom/Never[11]: No significant change

Data without Benchmarks

Certain indicators were available that had no statewide or national comparison. These data are described below.

- Fair/Poor Access to Social Services: Over 21% of Quality of Life survey respondents countywide (N=1,581) rated the ease with which they are able to get social services in their community as fair or poor.[11] Greater proportions of Latinx (29%), low-income (30%), and African ancestry (34%) respondents rated their social services access as fair/poor.[11]
- Community is Fair/Poor Place to Live: Just under 10% of Quality of Life survey respondents countywide (N=1,581) considered their community as a fair or poor place to live.[11] Greater proportions of south county residents (17%), Latinx residents (17%), and African ancestry residents (20%) felt this way.[11]
- Community Connectedness:
    - Community Connectedness – Feel Not Very or Not at All Connected: About one third of Quality of Life survey respondents countywide (N=1,581) reported that they felt not very or not at all connected to their community.[11] Higher proportions of men (41%) and Asian/Pacific Islander (40.5%) respondents felt this way.[11]
    - Adults Age 65+ Living Alone: Nearly 36% of Quality of Life survey respondents countywide (N=1,581) who were adults age 65+ indicated they were living alone.[11] This was indicated by greater proportions of older adult women and middle income (200-400% FPL) respondents than others.[11]
    - Lack of Meaningful Connections to Community (Youth): “Students attending non-traditional schools reported lower rates of meaningful connections in their community” than students attending traditional schools.[13]
- Experiences of Discrimination:
    - Ethnic Discrimination – Physical Symptoms: The Quality of Life survey asked respondents whether they had recently experienced any physical symptoms as a result of how they were treated based on their race. Overall, less than 7% of Quality of Life survey respondents countywide (N=1,581) said they had experienced such physical symptoms.[11] However, nearly 18% of African ancestry respondents and over 11% of Asian/Pacific Islander respondents reported experiencing such physical symptoms as a result of how they were treated based on their race.[11]
    - Ethnic Discrimination – Emotional Upset: Similarly, just over 10% of Quality of Life survey respondents countywide (N=1,581) said they had experienced emotional upset as a result of how they were treated based on their race.[11] Nearly 25% of African ancestry respondents, 14% of Latinx respondents, and 14% of Asian/Pacific Islander respondents reported experiencing such emotional upset as a result of how they were treated based on their race.[11]

- Discrimination Due to Mental Health Problems, Youth: “Youth who have mental health problems… are more likely to have felt discriminated against than youth who have no mental health problems” (N=3,284).[13]
- Discrimination Due to Physical Disabilities, Youth: “Youth who have …physical disabilities are more likely to have felt discriminated against than youth who have no …physical disabilities” (N=3,284).[13]

- Lack Support: About 14% of Quality of Life survey respondents countywide (N=1,581) reported that they had someone they could turn to if they needed or wanted help “little/none of the time.”[11] These proportions were higher (i.e., worse) for respondents earning less than 200% FPL (32%) and respondents with a high school diploma or less (31%).[11]
- LGBTQI: About 6% of Quality of Life survey respondents countywide (N=1,417) identified as gay, lesbian, or bisexual.[11]
- Community Tolerance for Racial/Cultural Differences is Fair/Poor: Just under 10% of Quality of Life survey respondents countywide (N=1,581) considered the level of racial/cultural tolerance in their community to be fair or poor.[11] Greater proportions of African ancestry residents (21%), low-income residents (15%), and Latinx residents (15%) felt this way.[11]
- Trust Local Government Seldom/Never: Nearly 18% of Quality of Life survey respondents countywide (N=1,581) indicated that they seldom or never trusted local government to work for the best interest of their community.[11] More than twice as many low-income respondents (39%) felt this way.[11]

Health Conditions

Health conditions are those topics that impact individual health, including health behaviors such as alcohol and drug use, mental health, and diseases or conditions.

Arthritis

Table 21, Statistical Data for Arthritis

Indicators	Year(s)	SMC	Benchmark	Desired ↑↓
Arthritis/Rheumatism[11† & 24]	**2016, 2018**	**♦22.0%**	**19.0%**	↓
Rheumatoid Arthritis or Osteoarthritis: Medicare Population[21†]	2015	22.4%	27.6%	↓

Trends (†)

Certain indicators have been measured longitudinally. Below are the trend directions for indicators with trend data available.

- Arthritis/Rheumatism[11]: Increasing
- Rheumatoid Arthritis or Osteoarthritis, Medicare Population[21]: Increasing

Other Populations

Certain indicators are available by age, income or education level, or geography, and show disparities in certain populations.

Table 22, Statistical Data for Arthritis by Age, Income, Education, or Geography

Indicators	Bench-mark	Age 0-5	Age 6-17	Age 18-64	Age 65+
Arthritis/ Rheumatism[11 & 24]	19.0%			14.8%	**♦47.0%**

Blank cells indicate that data were unavailable.

Asthma & Respiratory Conditions

Table 23, Statistical Data for Asthma & Respiratory Conditions

Indicators	Year(s)	SMC	Benchmark	Desired ↑↓
Asthma Hospitalizations Rate (per 10,000 Medicare Beneficiaries)[2]	2015	2.0	2.4	↓
Asthma Patient Discharges, Children/Youth (age 1-19)[1]	2011	3.8%	4.3%	↓
Asthma Patient Discharges, Older Adults (age 65+)[1]	**2011**	**♦1.1%**	**0.8%**	↓
Asthma Prevalence, Adults[11† & 24]	**2016, 2018**	**♦18.5%**	**12.8%**	↓
Asthma Prevalence, Children/Youth[11† & 24]	**2016, 2018**	**♦15.5%**	**[US]11.1%**	↓
Chronic Lower Respiratory Disease Death Rate[7]	2013-2015	21.2	33.3	↓
COPD, Bronchitis, Emphysema[11† & 24]	**2016, 2018**	**♦9.1%**	**4.4%**	↓
ER Visit Rate, COPD[5]	2013-2015	8.8	16.4	↓
Influenza/Pneumonia Death Rate[22†]	2014-2016	10.6	14.3	↓
Pediatric Asthma Hospitalizations Rate (per 10,000 pop.)[5]	2013-2015	5.6	9.8	↓
Pertussis Cases Rate[8†]	**2016**	**♦13.5**	**4.7**	↓
Tuberculosis Cases Rate[10†]	**2016**	**♦6.8**	**[H]1.0**	↓
Air Quality - Particulate Matter 2.5[2]	2014	8.2%	10.7%	↓
Air Quality - Ozone (O3)[2]	2014	29.8%	42.0%	↓
Current Smoker[11† & 24]	2016, 2018	5.7%	11.0%	↓
Current User of E-Cigarettes (Vaping)[11 & 24]	2016, 2018	3.0%	3.2%	↓
Flu Shot in Past Year – Adults 65+[11 & 24]	2016, 2018	73.9%	58.1%	↑
Obesity (Adult)[11† & 24]	**2016, 2018**	**25.4%**	**25.0%**	↓
Obesity (Youth)[2]	2016-2017	14.2%	20.1%	↓
Overweight/Obese Adults[11† & 24]	**2016, 2018**	**63.1%**	**61.0%**	↓
Pneumonia Vaccine Ever Received (Age 65+)[11 & 24]	2016, 2018	76.0%	72.4%	↑
Respiratory Hazard Index (score)[2]	2011	1.8	2.2	↓
Smoking in Home[11† & 24]	2016, 2018	7.1%	10.0%	↓
Used Marijuana or Hashish Recently[11 & 24]	**2017, 2018**	**♦13.3%**	**8.5%**	↓

Trends (†)

Certain indicators have been measured longitudinally. Below are the trend directions for indicators with trend data available.

- Asthma Prevalence, Adults[11]: Increasing
- Asthma Prevalence, Children/Youth[11]: Increasing
- COPD, Bronchitis, Emphysema[11]: Increasing
- Current Smoker[11]: Decreasing
- Influenza/Pneumonia Death Rate[22]: Decreasing
- Obesity (Adult)[11]: Increasing
- Overweight/Obese Adults[11]: Increasing
- Pertussis[8]: Trend is mixed
- Smoking in Home[11]: Decreasing
- Taking Prescription Medication for Asthma[11]: Flat
- Tuberculosis Cases Rate[10]: Trending down from 2014 to 2016

Race & Ethnicity

Certain indicators are available by ethnicity, which shows disparities in certain populations.

Table 24, Statistical Data for Asthma & Respiratory Conditions by Ethnicity

Indicators	Bench-mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Asthma Prevalence, Adults[11 & 24]	12.8%		♦**24.7%**						♦**22.3%**
Obesity (Adult)[11 & 24]	25.0%		♦**50.8%**						♦**34.0%**
Overweight/Obese Adults[11 & 24]	61.0%		♦**82.2%**						♦**74.6%**

Blank cells indicate that data were unavailable.

Other Populations

Certain indicators are available by age, income or education level, or geography, and show disparities in certain populations.

Table 25, Statistical Data for Asthma & Respiratory Conditions by Age, Income, Education, or Geography

Indicators	Bench-mark	Male	Age 18-39	Age 18-64	Age 65+	≤ 200% FPL	≤ High School	Southern County	Coast-side
Asthma Prevalence, Adults[11 & 24]	12.8%		♦**24.1%**			♦**23.8%**			
COPD, Bronchitis, Emphysema[11 & 24]	4.4%			♦**8.2%**	♦**12.7%**				♦**14.3%**
Current Smoker[11 & 24]	11.0%		8.1%			6.7%	9.5%		
Current User of E-Cigarettes (Vaping)[11 & 24]	3.2%		♦**7.2%**						
Obesity (Adult)[11 & 24]	25.0%					♦**39.4%**	♦**35.8%**		
Overweight/Obese Adults[11 & 24]	61.0%	♦**70.1%**				♦**71.6%**			
Smoking in Home[11 & 24]	10.0%		♦**11.1%**				♦**12.5%**		
Used Marijuana or Hashish Recently[11 & 24]	8.5%		♦**26.1%**						♦**18.1%**

Blank cells indicate that data were unavailable.

Data without Benchmarks

Certain indicators were available that had no statewide or national comparison. These data are described below.

- Ambulance Transport, Respiratory Issues: Of all ambulance transports initiated by a call to 911, respiratory issues were the primary impression (main reason for the call) in 7.7% of cases.[16]
- Chronic lower respiratory disease was the #5 cause of death in the county.[7]
- ER Visit Rate, Asthma: The average crude Emergency Room visit rate (per 1,000 people) for asthma, countywide, was 294.38. Rates are highest for people of African ancestry (2,966.9 per 100,000) and Pacific Islanders (2,764.6 per 100,000).[11]
- ER Visit Rate, COPD: The average crude Emergency Room visit rate (per 1,000 people) for COPD, countywide, was 35.52. Rates are highest for Pacific Islanders (379.8 per 100,000) and people of African ancestry (282.3 per 100,000).[11]
- Influenza/pneumonia was tied for the #7 cause of death in the county.[7]

Birth Outcomes

Table 26, Statistical Data for Birth Outcomes

Indicators	Year(s)	SMC	Benchmark	Desired ↑↓
Adequate/Adequate Plus Prenatal Care[7]	2013-2015	83.0%	78.3%	↑
First Trimester Prenatal Care[7]	2013-2015	89.8%	83.3%	↑
Infant Mortality Rate (per 1,000 births)[12]	2010-2016	2.9	4.5	↓
Low Birth Weight[12]	**2010-2016**	**6.9%**	**6.8%**	↓
Pre-Term Births[2]	2012-2014	8.5%	9.0%	↓
Teen Births Rate (per 1,000 pop.)[12]	2010-2016	13.1	24.1	↓
Breastfeeding (Any) [1]	2012	97.3%	93.0%	↑
Breastfeeding (Exclusive)[1]	2012	80.4%	64.8%	↑
Food Insecurity Rate[11† & 23]	2016, **2018**	**♦9.1%**	**H6.0%**	↓
Food Insecurity Rate – Children under 18[1]	2014	19.3%	25.3%	↓

Trends (†)

Certain indicators have been measured longitudinally. Below are the trend directions for indicators with trend data available.

- Child Has Usual Place for Medical Check-ups[11]: Decreasing since 2013
- Food Insecurity Rate[11]: More respondents were food-insecure than in any prior survey (1998-2013).
- Received Informal Food Support[11]: Increasing
- Teen Births:[11]
  - The birth rate among 15- to 17-year-old mothers has been declining since 1997. The trend of the birth rate among 12- to 14-year-old mothers is mixed. While the 2015 rate is only one third of the 1998 rate and half of the 2006 rate, there has been a rising trend between 2012 (when the rate was zero) and 2015 (when the rate was 0.4).
  - Rates of teen motherhood have generally declined among all ethnicities since 1997.

Race & Ethnicity

Certain indicators are available by ethnicity, which shows disparities in certain populations.

Table 27, Statistical Data for Birth Outcomes by Ethnicity

Indicators	Bench-mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Infant Mortality Rate (per 1,000 births)[7+]	4.5	2.4	♦**9.3**	2.4*					2.8
Breastfeeding (Any)[1]	93.0%	97.1%	♦**87.2%**	98.3%			**92.4%**	96.1%	97.5%
Breastfeeding (Exclusive)[1]	64.8%	86.3%	67.4%	79.8%			68.8%	81.4%	77.2%
Food Insecurity Rate[11 & 24]	[H]6.0%		♦**7.5%**	***♦7.2%**					

Blank cells indicate that data were unavailable. * Indicates that survey combined Asian/Pacific Islander. + Using older data from 2012-2014 to highlight health disparities by race/ethnicity.

Other Populations

Certain indicators are available by age, income or education level, or geography, and show disparities in certain populations.

Table 28, Statistical Data for Birth Outcomes by Age, Income, Education, or Geography

Indicators	**Bench-mark**	**Age 0-5**	**Age 6-17**	**Age 18-64**	**Age 65+**	**≤ High School**	**Some College**	**≥ B.A./B.S. Degree**	**≤ 200% FPL**
Food Insecurity Rate[11 & 24]	[H]6.0%								♦**10.4%**

Blank cells indicate that data were unavailable.

Data without Benchmarks

Certain indicators were available that had no statewide or national comparison. These data are described below.

- Child Has Usual Place for Medical Check-ups: Of Quality of Life survey respondents who had at least one child under age 18 living in their household, nearly 94% reported that they have a regular place they take their child for medical check-ups.[11] This was reported in smaller proportions by respondents with a high school diploma or less (87%), and individuals earning less than 200% FPL (87%).
- Received Informal Food Support: More than 6% of Quality of Life survey respondents countywide (N=1,581) indicated that they had gone to a food bank or otherwise received free meals in the past year.[11] This figure was higher among low-income respondents (17%) and respondents from the Coastside (12%).[11]

- Inadequate Prenatal Care: Countywide, just 1.6% of births received late (as opposed to adequate) prenatal care.[11]
- Low Birth Weight: Multiple births (e.g., twins) are more likely to be low birth weight; countywide, 5.1% of singleton births were low birth weight.[11]
- Sex Education: About “74% of [teen] respondents reported that they feel they are making informed decisions about sex and their sexuality” (N=3,284).[13]
- Teen Births: The birth rate among teen mothers ages 12-14 is 0.4 per 1,000 and among teen mothers ages 15-17 is 4.3 per 1,000.[11]

Cancer

Table 29, Statistical Data for Cancer

Indicators	Year(s)	SMC	Benchmark	Desired ↑↓
Breast Cancer Death Rate[7]	2013-2015	18.3	19.8	↓
Breast Cancer Incidence Rate[1]	**2010-2014**	**♦136.6**	**120.7**	↓
Cancer Mortality Rate (All Types)[22]	2014-2016	120.3	140.2	↓
Cancer Prevalence[11 & 24]	**2016, 2018**	**♦8.3%**	**5.6%**	↓
Cancer Prevalence (Medicare Population)[21†]	**2015**	**♦8.5%**	**7.5%**	↓
Cervical Cancer Incidence Rate[1]	2009-2013	6.7	[H]7.3	↓
Colorectal Cancer Death Rate[7]	2013-2015	10.7	13.2	↓
Colorectal Cancer Incidence Rate[1]	2010-2014	34.4	37.1	↓
Lung Cancer Death Rate[7]	2013-2015	24.8	30.6	↓
Lung Cancer Incidence Rate[2]	2010-2014	42.7	44.6	↓
Melanoma Incidence Rate in Men[9]	**2008-2012**	**♦32.0**	**27.9**	↓
Melanoma Incidence Rate in Women[9]	**2008-2012**	**♦18.9**	**15.6**	↓
Ovarian Cancer Death Rate[9]	2008-2012	7.6	7.6	↓
Pancreatic Cancer Mortality in Men[9]	**2008-2012**	**♦12.5**	**11.7**	↓
Pancreatic Cancer Mortality in Women[9]	2008-2012	8.2	9.3	↓
Prostate Cancer Death Rate[7]	2013-2015	15.3	19.3	↓
Prostate Cancer Incidence Rate[1]	**2010-2014**	**♦119.1**	**109.2**	↓
Uterine Cancer Incidence Rate[9]	**2008-2012**	**♦26.1**	**23.3**	↓
Air Quality - Particulate Matter 2.5[2]	2014	8.2%	10.7%	↓
Alcohol – Binge Drinker[11† & 24]	**2016, 2018**	**16.9%**	**16.3%**	↓
Cancer Screening – FOBT/Sigmoid/Colonoscopy[11 & 24]	2016, 2018	80.4%	71.4%	↑
Cancer Screening – Mammogram[11† & 24]	2016, 2018	86.0%	82.4%	↑
Cancer Screening – Mammogram, Medicare Population[11† & 25]	2016, 2018	67.0%	59.5%	↑
Cancer Screening - Pap Test[1]	2006-2012	82.1%	78.3%	↑
Cancer Screening - Sigmoid/Colonoscopy, Adults 50+[11† & 24]	2016, 2018	77.3%	40.1%	↑
Current Smoker[11† & 24]	2016, 2018	5.7%	11.0%	↓
Liquor Store Access Rate[1†]	2016	6.8	10.7	↓
Low Fruit/Vegetable Consumption (Adult)[1]	2005-2009	67.4%	71.5%	↓
Obesity (Adult)[11† & 24]	**2016, 2018**	**25.4%**	**25.0%**	↓

Indicators	Year(s)	SMC	Benchmark	Desired ↑↓
Overweight (Adult)[1]	2011-2012	31.4%	35.8%	↓
Overweight/Obese Adults[11† & 24]	**2016, 2018**	**63.1%**	**61.0%**	↓
Physical Inactivity (Adult)[1† & 12]	2013	15.5%	17.9%	↓
Smoking in Home[11† & 24]	2016, 2018	7.1%	10.0%	↓

Trends **(†)**

Certain indicators have been measured longitudinally. Below are the trend directions for indicators with trend data available.

- Alcohol – Binge Drinker[11]: Increasing
- Cancer Mortality[11]: Falling since 2010
- Cancer Prevalence (Medicare Population)[21]: No significant change
- Cancer Screening – Mammogram, Medicare Population[11]: Increasing
- Cancer Screening – Mammogram[11]: Decreasing
- Cancer Screening – Fecal Occult Blood Stool Test[11]: Increasing
- Cancer Screening - Sigmoid/Colonoscopy, Adults 50+[11]: Increasing
- Current Smoker[11]: Decreasing
- Engage in Healthy Behaviors[11]: Decreasing
- Liquor Store Access Rate[1]: Falling since 2014
- Regular Vigorous Physical Activity[11]: Decreasing since 2013
- Obesity (Adult)[11]: Increasing
- Overweight/Obese Adults[11]: Increasing
- Physical Inactivity (Adult)[1]: Relatively flat since 2010
- Smoking in Home[11]: Decreasing
- Use Other Tobacco Products[11]: Decreasing

Race & Ethnicity

Certain indicators are available by ethnicity, which shows disparities in certain populations.

Table 30, Statistical Data for Cancer by Ethnicity

Indicators	**Bench-mark**	**White**	**Afr / Afr Anc**	**Asian**	**Pac Isl**	**Native Am**	**Other**	**Multi Race**	**Hisp / Lat (Any Race)**
Breast Cancer Incidence Rate[1]	120.7	**♦139.2**	**♦136.4**	**125.4**					95
Cancer Prevalence[11 & 24]	5.6%	**♦12.1%**	**♦13.4%**						
Cervical Cancer Incidence Rate[1]	[H]7.3	**7.5**		6.2					**♦11.1**
Colon and Rectum Cancer Incidence Rate[1]	37.1	35.4	31.3	30.9					28
Lung Cancer Incidence Rate[1]	44.6	44.4	**♦52.6**	36					31.6
Prostate Cancer Incidence Rate[1]	109.2	**♦125.8**	**♦180.8**	80.5					**♦123.6**
Overweight/ Obese Adults[11 & 24]	61.0%		**♦82.2%**						**♦74.6%**
Cancer Screening – FOBT/Sigmoid/Colonoscopy[11 & 24]	71.4%			74.5%*					
Obesity (Adult)[11 & 24]	25.0%		**♦50.8%**						**♦34.0%**

Blank cells indicate that data were unavailable. * Indicates that survey combined Asian/Pacific Islander.

Other Populations

Certain indicators are available by age, income or education level, or geography, and show disparities in certain populations.

Table 31, Statistical Data for Cancer by Age, Income, Education, or Geography

Indicators	**Bench-mark**	**Male**	**Age 18-39**	**Age 18-64**	**Age 65+**	**≤ High School**	**Some College**	**≥ B.A./B.S. Degree**	**≤ 200% FPL**
Cancer Prevalence[11 & 24]	5.6%			4.9%	**♦19.8%**				
Alcohol – Binge Drinker[11 & 24]	16.3%		**♦28.4%**						
Overweight/Obese Adults[11 & 24]	61.0%	**♦70.1%**							**♦71.6%**
Cancer Screening – FOBT/Sigmoid/Colonoscopy[11 & 24]	71.4%					**68.2%**			**71.0%**

Indicators	Bench-mark	Male	Age 18-39	Age 18-64	Age 65+	≤ High School	Some College	≥ B.A./B.S. Degree	≤ 200% FPL
Obesity (Adult)[11 & 24]	25.0%					♦**35.8%**			♦**39.4%**
Smoking in Home[11† & 24]	10.0%		♦**11.1%**			♦**12.5%**			

Blank cells indicate that data were unavailable.

Data without Benchmarks

Certain indicators were available that had no statewide or national comparison. These data are described below.

- Cancer was the #1 cause of death in the county.[7]
- Regular Vigorous Physical Activity (Adults): More than one third (38%) of Quality of Life survey respondents countywide (N=1,581) indicated that they engage in vigorous physical activity three or more times per week.[11] These proportions were smaller among respondents who earn less than 200% FPL (32%) and among older adults (age 65+) (28%).
- Adequate Fruit/Vegetable Consumption (Adults): Only about 15% of Quality of Life survey respondents countywide (N=1,581) reported that they eat the recommended number of daily servings of fruits and vegetables.[11] These proportions were even smaller among respondents who earned less than 200% FPL (7.4%) and respondents with a high school diploma or less (3.8%).[11]
- Engage in Healthy Behaviors: Less than 4% of Quality of Life survey respondents countywide (N=1,581) engage in "healthy behaviors" (do not smoke cigarettes, are not overweight [based on BMI], exercise at least three times per week for at least 20 minutes each time, eat five or more servings of fruit/vegetables per day).[11] These proportions are even smaller among men (1.4%), respondents who earn less than 200% FPL (0.7%), and respondents with a high school diploma or less (0.3%).[11]

Dementia & Cognitive Decline

Table 32, Statistical Data for Dementia & Cognitive Decline

Indicators	Year(s)	SMC	Benchmark	Desired ↑↓
Alzheimer's Disease Mortality Rate[7†]	2013-2015	29.9	32.1	↓
Median Age[1 & 18†]	**2012-2016**	**♦39.5**	**36.0**	↓

Trends (†)

Certain indicators have been measured longitudinally. Below are the trend directions for indicators with trend data available.

- Alzheimer's Disease (Prevalence)[11]: Generally falling since 2009-11
- Alzheimer's Disease Mortality Rate[7]: Mixed (rose 2005-2011, fluctuated 2012-15)
- Median Age[18]: Rising since at least 2000

Data without Benchmarks

Certain indicators were available that had no statewide or national comparison. These data are described below.

- Alzheimer's Disease was the #3 cause of death in the county.[7]

Heart Disease/Stroke

Table 33, Statistical Data for Heart Disease/Stroke

Indicators	Year(s)	SMC	Benchmark	Desired ↑↓
Coronary Heart Disease Death Rate[7]	2010-2015	59.6	93.2	↓
Heart Disease Death Rate[22†]	2014-2016	55.4	89.1	↓
Heart Disease, Heart Attack – Ever Had/Diagnosed[11† & 24]	2016, 2018	5.3%	[US]8.0%	↓
Heart Disease Hospitalizations Rate (per 1,000 pop.)[2]	2012-2014	6.8	10.5	↓
Heart Disease Prevalence[2]	2014	5.6%	7.0%	↓
Heart Failure (Medicare Population)[21†]	2015	10.9%	12.9%	↓
Heart Failure Emergency Room Visit Rate (per 10,000 pop.)[5]	2013-2015	6.7	9.4	↓
Heart Failure Hospitalizations Rate (per 10,000 pop.)[5]	2013-2015	21.6	29.1	↓
Ischemic Heart Disease (Medicare Population)[21†]	2015	18.7%	23.6%	↓
Stroke Death Rate[22†]	2014-2016	27.1	[H]34.8	↓
Stroke Hospitalizations (per 1,000 Medicare Beneficiaries)[2]	2012-2014	6.4	7.4	↓
Stroke Prevalence[11 & 24]	**2016, 2018**	**♦3.4%**	**2.4%**	↓
Stroke Prevalence (Medicare Population)[21†]	2015	3.0%	3.7%	↓
Alcohol – Binge Drinker[11† & 24]	**2016, 2018**	**16.9%**	**16.3%**	↓
Current Smoker[11† & 24]	2016, 2018	5.7%	11.0%	↓
Diabetes Discharges (% of Total Discharges)[1]	2011	0.6%	0.9%	↓
Diabetes Hospitalizations Rate (per 10,000)[1]	2011	6.1	10.4	↓
Diabetes Management (Medicare Patients with Hemoglobin A1c Test)[1†]	**2014**	**78.8%**	**81.8%**	↑
Diabetes Prevalence, Adults[11† & 24]	**2016, 2018**	**♦12.2%**	**10.2%**	↓
High Blood Pressure - Unmanaged[1]	**2006-2010**	**30.7%**	**30.3%**	↓
High Cholesterol Prevalence, Adults[11† & 24]	2016, 2018	32.2%	[US]36.2%	↓
Hypertension/High Blood Pressure Prevalence, Adults[11† & 24]	**2016, 2018**	**♦31.8%**	**[US]28.7%**	↓
Liquor Store Access Rate[1†]	2016	6.8	10.7	↓
Obesity (Adult)[11† & 24]	**2016, 2018**	**25.4%**	**25.0%**	↓
Obesity (Youth)[2]	2016-2017	14.2%	20.1%	↓
Overweight/Obese Adults[11† & 24]	**2016, 2018**	**63.1%**	**61.0%**	↓
Overweight (Adult)[1]	2011-2012	31.4%	35.8%	↓
Overweight (Youth)[1]	2013-2014	17.7%	19.3%	↓

Indicators	Year(s)	SMC	Benchmark	Desired ↑↓
Park Access[1]	2010	78.6%	58.6%	↑
Physical Inactivity (Adult)[1† & 12]	2013	15.5%	17.9%	↓
Physical Inactivity (Youth)[2]	2016-2017	27.3%	37.8%	↓
Recreation and Fitness Facilities Rate[1†]	2016	14.9	10.8	↑
Walkable Destinations[2]	2012-2015	54.8%	29.0%	↑

Trends (†)

Certain indicators have been measured longitudinally. Below are the trend directions for indicators with trend data available.

- Alcohol – Binge Drinker[11]: Increasing
- Current Smoker[11]: Decreasing
- Diabetes Management (Medicare Patients with Hemoglobin A1c Test)[1]: Mixed.
- Diabetes Prevalence, Adults[11]: Rising overall, and for older adults 65+
- Engage in Healthy Behaviors[11]: Decreasing
- Heart Disease Death Rate[22]: Decreasing
- Heart Disease, Heart Attack – Ever Had/Diagnosed[11]: Decreasing
- Heart Failure (Medicare Population)[21]: Decreasing
- High Cholesterol Prevalence, Adults[11]: Increasing
- Hypertension/High Blood Pressure Prevalence, Adults[11]: Increasing
- Ischemic Heart Disease (Medicare Population)[21]: Decreasing
- Liquor Store Access Rate[1]: Falling from 2014
- Obesity (Adult)[11]: Increasing
- Overweight/Obese Adults[11]: Increasing
- Physical Inactivity (Adult)[1]: Relatively flat since 2010
- Recreation and Fitness Facilities Rate[1]: Mixed.
- Regular Vigorous Physical Activity[11]: Decreasing since 2013
- Stroke Death Rate[22]: No significant change
- Stroke Prevalence (Medicare Population)[21]: Decreasing
- Taking Medication to Control High Blood Pressure[11]: Increasing
- Taking Medication to Control High Cholesterol[11]: Increasing
- Use Other Tobacco Products[11]: Decreasing

Race & Ethnicity

Certain indicators are available by ethnicity, which shows disparities in certain populations.

Table 34, Statistical Data for Heart Disease/Stroke by Ethnicity

Indicators	Bench-mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Heart Disease, Heart Attack – Ever Had/Diagnosed[11 & 24]	[US]8.0%		**♦9.8%**						
Heart Disease Prevalence[1]	6.3%	**♦8.3%**					1.5%		2.6%
Mortality Rate - Stroke[1]	37.4	29.4	**♦46.8**	7.9	**♦47.5**	35.9		7.8	18.6
Diabetes Prevalence, Adults[11 & 24]	**12.2%**		**♦21.2%**						
Hypertension/High Blood Pressure Prevalence, Adults (%)[11 & 24]	[US]28.7		**♦30.3**						
Obesity (Adult)[11 & 24]	25.0%		**♦50.8%**						**♦34.0%**
Overweight/Obese Adults[11 & 24]	61.0%		**♦82.2%**						**♦74.6%**
Overweight (Youth)[1]	19.3%	14.0%	**19.6%**	12.4%				16.4%	**♦22.1%**
Physical Inactivity (Youth)[1]	37.8%	22.4%	**♦45.3%**	18.7%				25.1%	**♦44.5%**

Blank cells indicate that data were unavailable.

Other Populations

Certain indicators are available by age, income or education level, or geography, and show disparities in certain populations.

Table 35, Statistical Data for Heart Disease/Stroke by Age, Income, Education, or Geography

Indicators	Bench-mark	Male	Age 18-39	Age 18-64	Age 65+	≤ High School	Some College	≥ B.A./B.S. Degree	≤ 200% FPL
Heart Disease, Heart Attack – Ever Had/Diagnosed[11 & 24]	[US]8.0%			3.5%	**♦11.8%**				
Stroke Prevalence[11 & 24]	2.4%			2.4%	**♦6.5%**				
Alcohol – Binge Drinker[11 & 24]	16.3%		**♦28.4%**						
Diabetes Prevalence, Adulst[11 & 24]	12.2%			10.5%	**♦18.6%**				**♦23.5%**

High Cholesterol Prevalence, Adults (%)[11 & 24]	[US]36.2			25.8%	♦**54.8%**				
Hypertension/High Blood Pressure Prevalence, Adults (%)[11 & 24]	[US]28.7			24.5%	♦**52.7%**				
Obesity (Adult)[11 & 24]	25.0%					♦**35.8%**			♦**39.4%**
Overweight/Obese Adults[11 & 24]	61.0%	♦**70.1%**							♦**71.6%**

Blank cells indicate that data were unavailable.

Data without Benchmarks

Certain indicators were available that had no statewide or national comparison. These data are described below.

- Ambulance Transports:
  - Cardiac Issues: Of all ambulance transports initiated by a call to 911, cardiac issues were the primary impression (main reason for the call) in 11.5% of cases.[16]
  - Vascular Issues: Of all ambulance transports initiated by a call to 911, vascular issues were the primary impression (main reason for the call) in 9.3% of cases.[16]
- Coronary heart disease was the #2 cause of death in the county.[7]
- Cardiovascular Disease-Related ER Visits:
  - ER Visit Rate, Myocardial Infarction: The average crude Emergency Room visit rate (per 1,000 people) for myocardial infarction, countywide, was 2.43.[11] The rate is highest for people whose ethnicity is “Other/Unknown” (17.8per 100,000).[11]
  - ER Visit Rate, Heart Failure: The average crude Emergency Room visit rate (per 1,000 people) for heart failure, countywide, was 99.07.[11] Rates are highest for people of African ancestry (796.1per 100,000) and Pacific Islanders (741.3per 100,000).[11]
  - ER Visit Rate, Ischemic Heart Disease: The average crude Emergency Room visit rate (per 1,000 people) for ischemic heart disease, countywide, was 166.39.[11] Rates are highest for Pacific Islanders (1,184.8per 100,000) and Whites (982.4per 100,000).[11]
- Engage in Healthy Behaviors: Less than 4% of Quality of Life survey respondents countywide (N=1,581) engage in “healthy behaviors” (do not smoke cigarettes, are not overweight [based on BMI], exercise at least three times per week for at least 20 minutes each time, eat five or more servings of fruit/vegetables per day).[11] These proportions are even smaller among men (1.4%), respondents who earn less than 200% FPL (0.7%), and respondents with a high school diploma or less (0.3%).[11]

- Hypertension and High Cholesterol:
  - Hypertension/High Blood Pressure Prevalence, Adults Native Hawaiians/Pacific Islanders are overrepresented among individuals with high blood pressure.[20]
  - High Blood Pressure Medication Use: Among Quality of Life survey respondents who reported having hypertension, more than three quarters (79%) indicated that they are currently taking medication to control high blood pressure.[11]Older adults (age 65+) were over-represented among those taking such medication (91%), as were women (85%).[11]
  - High Cholesterol Medication Use: Among Quality of Life survey respondents who reported having high cholesterol, 64% indicated that they are currently taking medication to lower their blood cholesterol level.[11]Older adults (age 65+) were over-represented among those taking such medication (85%).[11]
- Stroke-Related ER Visits:
  - ER Visit Rate, Stroke: The average crude Emergency Room visit rate (per 1,000 people) for stroke, countywide, was 13.18.[11] Rates are highest for people of African ancestry (89.4per 100,000) and Whites (80.6per 100,000).[11]
  - ER Visit Rate, Hypertension: The average crude Emergency Room visit rate (per 1,000 people) for hypertension, countywide, was 1,031.87.[11] Rates are highest for Pacific Islanders (8,119.7per 100,000) and people of African ancestry (7,632.8per 100,000).[11]
- Stroke & CVD Related Factors:
  - Regular Vigorous Physical Activity (Adults): More than one third (38%) of Quality of Life survey respondents countywide (N=1,581) indicated that they engage in vigorous physical activity three or more times per week.[11] These proportions were smaller among respondents who earn less than 200% FPL (32%) and among older adults (age 65+) (28%).
  - Adequate Fruit/Vegetable Consumption (Adults): Only 15% of Quality of Life survey respondents countywide (N=1,581) reported that they eat the recommended number of daily servings of fruits and vegetables.[11] These proportions were even smaller among respondents who earned less than 200% FPL (7.4%) and respondents with a high school diploma or less (3.8%).[11]
- Stroke was the #4 cause of death in the county.[7]

Healthy Lifestyles

Diabetes

Table 36, Statistical Data for Diabetes

Indicators	Year(s)	SMC	Benchmark	Desired ↑↓
Diabetes Death Rate[7]	2013-2015	12.9	20.6	↓
Diabetes Discharges (% of Total Discharges)[1]	2011	0.6%	0.9%	↓
Diabetes Discharges, Children/Youth (age 1-19)[1]	2011	1.2%	1.5%	↓
Diabetes Discharges, Older Adults (age 65+)[1]	2011	0.6%	0.8%	↓
Diabetes Hospitalizations Rate (per 10,000)[1]	2011	6.1	10.4	↓
Diabetes Prevalence, Adults[11† & 24]	**2016, 2018**	**♦12.2%**	**10.2%**	↓
Children Walking or Biking to School[2]	**2015-2016**	**38.9%**	**39.3%**	↑
Commute >60 Min.[1]	2012-2016	8.9%	11.3%	↓
Commute to Work - Alone in Car[1]	2012-2016	69.4%	73.5%	↓
Commute to Work – By Public Transit[18†]	2012-2016	10.1%	5.2%	↑
Commute to Work - Walking/Biking[1]	2012-2016	3.8%	3.8%	↑
Current Smoker[11† & 24]	2016, 2018	5.7%	11.0%	↓
Diabetes Management (Medicare Patients with Hemoglobin A1c Test)[1†]	**2014**	**78.8%**	**81.8%**	↑
Drinking Water Violations[2]	**2015**	**♦1.0**	**0.8**	↓
Driving Alone to Work, Long Distances[2]	2012-2016	38.1%	39.3%	↓
Exercise Opportunities[12]	2016	96.2%	89.6%	↑
Fast Food Restaurants Rate[1†]	**2016**	**82.5**	**78.7**	↓
Food Desert Population[1]	2015	9.9%	13.4%	↓
Food Environment Index[12]	2015	8.9	8.8	↑
Food Insecurity Rate[11† & 23]	**2016, 2018**	**♦9.1%**	**[H]6.0%**	↓
Food Insecurity Rate – Children under 18[1]	2014	19.3%	25.3%	↓
Grocery Stores Rate[1†]	2016	25.3	21.8	↑
Lack of Healthy Food Stores[2]	2014	9.9%	13.4%	↑
Low Fruit/Vegetable Consumption (Adult)[1]	2005-2009	67.4%	71.5%	↓
Low Fruit/Vegetable Consumption (Youth)[1]	**2011-2012**	**♦50.0%**	**47.4%**	↓
Physical Inactivity (Adult)[1† & 12]	2013	15.5%	17.9%	↓
Physical Inactivity (Youth)[2]	2016-2017	27.3%	37.8%	↓

Indicators	Year(s)	SMC	Benchmark	Desired ↑↓
Recreation and Fitness Facilities Rate[1†]	2016	14.9	10.2	↑
Soft Drink Consumption[2]	2014	9.2%	18.1%	↓
Walkable Destinations[2]	2012-2015	54.8%	29.0%	↑
WIC-Authorized Food Stores Rate[1]	**2011**	**♦10.5**	**15.8**	↑

Trends (†)

Certain indicators have been measured longitudinally. Below are the trend directions for indicators with trend data available.

- Commute to Work – By Public Transit[18]: Increasing
- Current Smoker[11]: Decreasing
- Diabetes Management (Medicare Patients with Hemoglobin A1c Test)[1]: Mixed.
- Diabetes Prevalence, Adults[11]: Rising overall, and for older adults 65+
- Engage in Healthy Behaviors[11]: Decreasing
- Food Insecurity[11]: More respondents were food-insecure than in any prior survey (1998-2013).[11]
- Fast Food Restaurants Rate[1]: Rising since 2013
- Grocery Stores Rate[1]: Rising since 2013
- Physical Inactivity (Adult)[1]: Relatively flat since 2010
- Received Informal Food Support[11]: Increasing
- Recreation and Fitness Facilities Rate[1]: Mixed.
- Regular Vigorous Physical Activity[11]: Decreasing since 2013

Diet, Fitness & Nutrition

Table 37, Statistical Data for Diet, Fitness & Nutrition

Indicators	Year(s)	SMC	Benchmark	Desired ↑↓
Children Walking or Biking to School[2]	**2015-2016**	**38.9%**	**39.3%**	↑
Commute >60 Min.[1]	2012-2016	8.9%	11.3%	↓
Commute to Work - Alone in Car[1]	2012-2016	69.4%	73.5%	↓
Commute to Work – By Public Transit[18†]	2012-2016	10.1%	5.2%	↑
Commute to Work - Walking/Biking[1]	2012-2016	3.8%	3.8%	↑
Driving Alone to Work, Long Distances[2]	2012-2016	38.1%	39.3%	↓
Low Fruit/Vegetable Consumption (Adult)[1]	2005-2009	67.4%	71.5%	↓

Indicators	Year(s)	SMC	Benchmark	Desired ↑↓
Low Fruit/Vegetable Consumption (Youth)[1]	**2011-2012**	**♦50.0%**	**47.4%**	↓
Physical Inactivity (Adult)[1† & 12]	2013	15.5%	17.9%	↓
Physical Inactivity (Youth)[2]	2016-2017	27.3%	37.8%	↓
Soft Drink Consumption[2]	2014	9.2%	18.1%	↓
Children Eligible for Free/Reduced Price Lunch[1†]	2015-2016	32.9%	58.9%	↓
Exercise Opportunities[12]	2016	96.2%	89.6%	↑
Fast Food Restaurants Rate[1†]	**2016**	**82.5**	**78.7**	↓
Food Desert Population[1]	2015	9.9%	13.4%	↓
Food Environment Index[12]	2015	8.9	8.8	↑
Food Insecurity Rate[11† & 23]	**2016, 2018**	**♦9.1%**	**H6.0%**	↓
Food Insecurity Rate – Children under 18[1]	2014	19.3%	25.3%	↓
Grocery Stores Rate[1†]	2016	25.3	21.8	↑
Lack of Healthy Food Stores[2]	2014	9.9%	13.4%	↑
Public Transit Stops[2]	2013	**♦13.4%**	**16.8%**	↑
Recreation and Fitness Facilities Rate[1†]	2016	14.9	10.2	↑
SNAP Benefits (Households)[1† &2]	2012-2016	3.7%	9.4%	↓
Walkable Destinations[2]	2012-2015	54.8%	29.0%	↑
WIC-Authorized Food Stores Rate[1]	**2011**	**♦10.5**	**15.8**	↑

Trends (†)

Certain indicators have been measured longitudinally. Below are the trend directions for indicators with trend data available.

- Children Eligible for Free/Reduced Price Lunch[1]: Falling since 2012-13
- Commute to Work – By Public Transit[18]: Increasing
- Engage in Healthy Behaviors[11]: Decreasing
- Fast Food Restaurants Rate[1]: Rising since 2013
- Food Insecurity[11]: More respondents were food-insecure than in any prior survey (1998-2013).
- Grocery Stores Rate[1]: Rising since 2013
- Physical Inactivity (Adult)[1]: Relatively flat since 2010
- Received Informal Food Support[11]: Increasing
- Recreation and Fitness Facilities Rate[1]: Mixed.
- Regular Vigorous Physical Activity[11]: Decreasing since 2013
- SNAP Benefits (Households)[1]: Rising since 2008

Obesity

Table 38, Statistical Data for Obesity

Indicators	Year(s)	SMC	Benchmark	Desired ↑↓
Obesity (Adult)[11† & 24]	**2016, 2018**	**25.4%**	**25.0%**	↓
Obesity (Youth)[2]	2016-2017	14.2%	20.1%	↓
Overweight/Obese Adults[11† & 24]	**2016, 2018**	**63.1%**	**61.0%**	↓
Overweight (Adult)[1]	2011-2012	31.4%	35.8%	↓
Overweight (Youth)[1]	2013-2014	17.7%	19.3%	↓
Breastfeeding (Any)[1]	2012	97.3%	93.0%	↑
Breastfeeding (Exclusive)[1]	2012	80.4%	64.8%	↑
Children Eligible for Free/Reduced Price Lunch[1†]	2015-2016	32.9%	58.9%	↓
Children Walking or Biking to School[2]	**2015-2016**	**38.9%**	**39.3%**	↑
Commute >60 Min.[1]	2012-2016	8.9%	11.3%	↓
Commute to Work - Alone in Car[1]	2012-2016	69.4%	73.5%	↓
Commute to Work – By Public Transit[18†]	2012-2016	10.1%	5.2%	↑
Commute to Work - Walking/Biking[1]	2012-2016	3.8%	3.8%	↑
Diabetes Death Rate[7]	2013-2015	12.9	20.6	↓
Diabetes Discharges (% of Total Discharges)[1]	2011	0.6%	0.9%	↓
Diabetes Discharges, Children/Youth (age 1-19)[1]	2011	1.2%	1.5%	↓
Diabetes Discharges, Older Adults (age 65+)[1]	2011	0.6%	0.8%	↓
Diabetes Hospitalizations Rate (per 10,000)[1]	2011	6.1	10.4	↓
Diabetes Management (Medicare Patients with Hemoglobin A1c Test)[1†]	**2014**	**78.8%**	**81.8%**	↑
Diabetes Prevalence, Adults[11† & 24]	**2016, 2018**	**♦12.2%**	**10.2%**	↓
Driving Alone to Work, Long Distances[2]	2012-2016	38.1%	39.3%	↓
Exercise Opportunities[12]	2016	96.2%	89.6%	↑
Fast Food Restaurants Rate[1†]	**2016**	**82.5**	**78.7**	↓
Food Desert Population[1]	2015	9.9%	13.4%	↓
Food Environment Index[12]	2015	8.9	8.8	↑
Food Insecurity Rate[11† & 23]	**2016, 2018**	**♦9.1%**	**H6.0%**	↓
Food Insecurity Rate – Children under 18[1]	2014	19.3%	25.3%	↓
Grocery Stores Rate[1†]	2016	25.3	21.8	↑

Indicators	Year(s)	SMC	Benchmark	Desired ↑↓
Lack of Healthy Food Stores[2]	2014	9.9%	13.4%	↑
Low Fruit/Vegetable Consumption (Adult)[1]	2005-2009	67.4%	71.5%	↓
Low Fruit/Vegetable Consumption (Youth)[1]	**2011-2012**	**♦50.0%**	**47.4%**	↓
Physical Inactivity (Adult)[1† & 12]	2013	15.5%	17.9%	↓
Physical Inactivity (Youth)[2]	2016-2017	27.3%	37.8%	↓
Public Transit Stops[2]	2013	**♦13.4%**	**16.8%**	↑
Recreation and Fitness Facilities Rate[1†]	2016	14.9	10.2	↑
SNAP Benefits (Households)[1† &2]	2012-2016	3.7%	9.4%	↓
Soft Drink Consumption[2]	2014	9.2%	18.1%	↓
Walkable Destinations[2]	2012-2015	54.8%	29.0%	↑
WIC-Authorized Food Stores Rate[1]	**2011**	**♦10.5**	**15.8**	↑

Trends (†)

Certain indicators have been measured longitudinally. Below are the trend directions for indicators with trend data available.

- Children Eligible for Free/Reduced Price Lunch[1]: Falling since 2012-13
- Commute to Work – By Public Transit[18]: Increasing
- Diabetes Management (Medicare Patients with Hemoglobin A1c Test)[1]: Mixed.
- Diabetes Prevalence, Adults[11]: Rising overall, and for older adults 65+
- Engage in Healthy Behaviors[11]: Decreasing
- Fast Food Restaurants Rate[1]: Rising since 2013
- Grocery Stores Rate[1]: Rising since 2013
- Food Insecurity[11]: More respondents were food-insecure than in any prior survey (1998-2013).
- Obesity (Adult)[11]: Increasing
- Overweight/Obese Adults[11]: Increasing
- Physical Inactivity (Adult)[1]: Relatively flat since 2010
- Received Informal Food Support[11]: Increasing
- Recreation and Fitness Facilities Rate[1]: Mixed.
- Regular Vigorous Physical Activity[11]: Decreasing since 2013
- SNAP Benefits (Households)[1]: Rising since 2008

Race & Ethnicity

Certain indicators are available by ethnicity, which shows disparities in certain populations. Indicators in red are more than 5% worse for that ethnic group than the benchmark.

Table 39, Statistical Data for Healthy Lifestyles by Ethnicity

Indicators	Bench-mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp /Lat (Any Race)
Diabetes Prevalence, Adults[11 & 24]	12.2%		**♦21.2%**						
Low Fruit/Vegetable Consumption (Youth)[1]	47.4%	38.2%					**♦63.5%**		**♦55.9%**
Obesity (Adult)[11 & 24]	25.0%		**♦50.8%**						**♦34.0%**
Overweight (Youth)[1]	19.3%	14.0%	**19.6%**	12.4%				16.4%	**♦22.1%**
Overweight/Obese Adults[11 & 24]	61.0%		**♦82.2%**						**♦74.6%**
Breastfeeding (Any)[1]	93.0%	97.1%	**♦87.2%**	98.3%			92.4%	96.1%	97.5%
Breastfeeding (Exclusive)[1]	64.8%	86.3%	67.4%	79.8%			68.8%	81.4%	77.2%
Food Insecurity Rate[11 & 24]	[H]6.0%		**♦7.5%**	***♦7.2%**					

Blank cells indicate that data were unavailable. * Indicates that survey combined Asian/Pacific Islander.

Other Populations

Certain indicators are available by age, income or education level, or geography, and show disparities in certain populations.

Table 40, Statistical Data for Healthy Lifestyles by Age, Income, Education, or Geography

Indicators	Bench-mark	Male	Female	Age 18-64	Age 65+	≤ 200% FPL	≤ High School
Diabetes Prevalence, Adults[11 & 24]	12.2%			10.5%	**♦18.6%**	**♦23.5%**	
Food Insecurity Rate[11 & 24]	[H]6.0%					**♦10.4%**	
Obesity (Adult)[11 & 24]	25.0%					**♦39.4%**	**♦35.8%**
Overweight/Obese Adults[11 & 24]	61.0%	**♦70.1%**				**♦71.6%**	

Blank cells indicate that data were unavailable.

Data without Benchmarks

Certain indicators were available that had no statewide or national comparison. These data are described below.

- Diabetes:
  - ER Visit Rate, Diabetes: The average crude Emergency Room visit rate (per 1,000 people) for diabetes, countywide, was 471.7.[11] Rates are highest for Pacific Islanders (4,754.5 per 100,000) and people of African ancestry (3,564.8 per 100,000).[11]
  - Cause of Death: Diabetes was tied for the #7 cause of death in the county.[7]
- Engage in Healthy Behaviors: Less than 4% of Quality of Life survey respondents countywide (N=1,581) engage in "healthy behaviors" (do not smoke cigarettes, are not overweight [based on BMI], exercise at least three times per week for at least 20 minutes each time, eat five or more servings of fruit/vegetables per day).[11] These proportions are even smaller among men (1.4%), respondents who earn less than 200% FPL (0.7%), and respondents with a high school diploma or less (0.3%).[11]
- Overweight Adults: Over one third of Quality of Life survey respondents countywide (N=1,581) reported being overweight.[11]
- Obesity/Overweight & Diabetes Related Factors:
  - Regular Vigorous Physical Activity (Adults): More than one third (38%) of Quality of Life survey respondents countywide (N=1,581) indicated that they engage in vigorous physical activity three or more times per week.[11] These proportions were smaller among respondents who earn less than 200% FPL (32%) and among older adults (age 65+) (28%).
  - Diet:
    - Adequate Fruit/Vegetable Consumption (Adults): Only 15% of Quality of Life survey respondents countywide (N=1,581) reported that they eat the recommended number of daily servings of fruits and vegetables.[11] These proportions were even smaller among respondents who earned less than 200% FPL (7.4%) and respondents with a high school diploma or less (3.8%).[11]
    - Sugar-Sweetened Beverages:
      - Sugar-Sweetened Beverage Consumption (Adults): About 18% of Quality of Life survey respondents countywide (N=1,581) reported that they consume sugar-sweetened beverages daily.[11]
        - Over 13% specifically indicated that they consume at least one soda or pop containing sugar per day.[11] The highest proportions of respondents drinking at least one sugar-sweetened soda/pop each day were south county residents (18%), Latinxs (19%), and respondents with a high school education or less (26%).[11]

- About 10% specifically indicated that they consume at least one sugar-sweetened fruit drink per day.[11] The highest proportions of respondents drinking at least one sugar-sweetened fruit drink each day were respondents earning between 200% and 400% of FPL (16%).[11]
- Sugar-Sweetened Beverage Consumption (Youth): "[C]onsumption by adolescents age 12-17 increased to 56% drinking one or more sugar-sweetened beverages per day."[13]
- Teeth Removed Due to Poor Oral Health: Over 20% of Quality of Life survey respondents countywide (N=1,581) reported that three or more of their permanent teeth had been removed due to tooth decay or gum disease.[11] This was the case for greater proportions of respondents with a high school education or less (37%), respondents earning less than 200% FPL (32%), and respondents of African ancestry (31%).[11]
- Food Store Quality/Affordability: "On av[erage,] 20-30% of [food] stores in low income neighborhoods meet the basic quality and affordability standards" in San Mateo County.[14]
- Received Informal Food Support: More than 6% of Quality of Life survey respondents countywide (N=1,581) indicated that they had gone to a food bank or otherwise received free meals in the past year.[11] This figure was higher among low-income respondents (17%) and respondents from the Coastside (12%).[11]

Infectious Diseases

For data on sexually transmitted infections, see separate health need.

Table 41, Statistical Data for Infectious Diseases

Indicators	Year(s)	SMC	Benchmark	Desired ↑↓
Acute Hepatitis B CasesRate[8]	**2015**	**♦0.7**	**0.4**	↓
Influenza/Pneumonia Death Rate[22†]	2014-2016	10.6	14.3	↓
Pertussis CasesRate[8†]	**2016**	**♦13.5**	**4.7**	↓
Pneumonia Vaccine Ever Received (Age 65+)[11 & 24]	2016, 2018	76.0%	72.4%	↑
Tuberculosis Cases Rate[10†]	**2016**	**♦6.8**	**H1.0**	↓
Diphtheria, Tetanus, and Pertussis Vaccine (% of All Kinder)[8]	2016-2017	97.8%	96.9%	↑
Flu Shot in Past Year – Adults 65+[11 & 24]	2016, 2018	73.9%	58.1%	↑
Hepatitis B Vaccine (% of All Kinder)[8]	2016-2017	98.6%	97.8%	↑
Kindergarteners with All Required Immunizations[8]	2016-2017	96.5%	95.6%	↑
Kindergarteners with Overdue Immunizations[8]	2016-2017	**♦1.1%**	**1.0%**	↓
Measles, Mumps, and Rubella Vaccine (% of All Kinder)[8]	2016-2017	98.1%	97.3%	↑
Polio Vaccine (% of All Kinder)[8]	2016-2017	98.3%	97.3%	↑
Varicella Vaccine (% of All Kinder)[8]	2016-2017	99.4%	98.5%	↑

Trends (†)

Certain indicators have been measured longitudinally. Below are the trend directions for indicators with trend data available.

- Influenza/Pneumonia Death Rate[22]: Decreasing
- Pertussis[8]: Trend is mixed
- Tuberculosis Cases Rate[10]: Trending down from 2014 to 2016

Data without Benchmarks

Certain indicators were available that had no statewide or national comparison. These data are described below.

- Influenza/pneumonia was tied for the #7 cause of death in the county.[7]

Mental Health & Well-Being

Mental Health/Emotional Well-Being

Table 42, Statistical Data for Mental Health/Emotional Well-Being

Indicators	Year(s)	SMC	Benchmark	Desired ↑↓
Access to Mental Health Care Providers Rate[1]	2018	300.9	280.6	↑
Adults Needing and Receiving Behavioral Health Care Services[20†]	2015-2016	58.4%	60.5%	↓
Deaths by Suicide, Drug, or Alcohol Poisoning (Rate)[2]	2011-2015	25.2	34.2	↓
Depression Among Medicare Beneficiaries[1†]	2015	10.3%	14.3%	↓
Frequent Mental Distress[12]	2016	8.8%	10.6%	↓
Have Ever Felt Depressed for 2 Years or More[11† & 24]	2016, 2018	26.1%	31.4%	↓
Mental Health Emergency Room Visit Rate (per 10,000 pop.)[5]	2013-2015	61.9	93.4	↓
Needing Mental Health Care[1]	2013-2014	10.7%	15.9%	↓
Poor Mental Health Days (per Month) [11† & 12]	2016, 2018	3.0	3.7	↓
Seriously Considered Suicide[2]	2015-2016	7.6%	10.0%	↓
Suicide Death Rate[2]	2011-2015	7.6	[H]10.2	↓
Youth Intentional Self-Harm-ER Visits (per 10,000 pop.)[5]	2014	7.9	10.9	↓
Disconnected Youth[12]	2010-2014	9.9%	14.4%	↓
Domestic Violence Rate[1]	2013-2014	4.3	4.9	↓
Homicide Rate[12]	2010-2016	2.5	5.0	↓
Insufficient Sleep[11† & 12]	2016, 2018	30.4%	34.5%	↓
Lack of Social or Emotional Support[2]	2006-2012	22.3%	24.7%	↓
Social Associations (per 10,000 pop.)[2]	**2015**	**6.4**	**6.5**	↑

Trends (†)

Certain indicators have been measured longitudinally. Below are the trend directions for indicators with trend data available.

- Adults Age 65+ Living Alone[11]: Flat
- Adults Needing and Receiving Behavioral Health Care Services[20]: No significant change
- Community Connectedness – Feel Not Very or Not at All Connected[11]: No significant change
- Community Tolerance for Racial/Cultural Differences is Fair/Poor[11]: Decreasing

- Depression Among Medicare Beneficiaries[1]: Rising since 2010
- Experienced Depressive Symptoms (Average Days per Month)[11]: Flat
- Experiencing Difficulty in Fear, Anxiety, or Panic[11]: Increasing
- Experiencing Difficulty in Getting Along with People Outside the Family[11]: Increasing
- Experiencing Difficulty in Isolation or Feelings of Loneliness[11]: Increasing
- Experiencing Difficulty in Relationships with Family Members[11]: Increasing
- Fair/Poor Access to Mental Health Services[11]: Increasing
- Felt Healthy and Full of Energy (Average Days/Month)[11]: Decreasing
- Felt Worried/Tense/Anxious (Average Days/Month)[11]: Flat
- Have Ever Felt Depressed for 2 Years or More[11]: Increasing
- Have Ever Sought Professional Help for Mental/Emotional Problem[11]: Increasing
- High Stress on Typical Day[11]: Decreasing
- History of Mental/Emotional Problems[11]: Increasing
- Insufficient Sleep[11]: Increasing
- Lack Support[11]: Increasing since 2008
- Pain Interfered with Usual Activities (Average Days/Month)[11]: Increasing since 2013
- Poor Mental Health (Average Days/Month)[11]: Increasing
- Poor Physical or Mental Health Interfered with Usual Activities (Average Days/Month)[11]: Increasing since 2004
- Spirituality is Very Important[11]: Decreasing

Tobacco/Substance Use

Table 43, Statistical Data for Tobacco//Substance Use

Indicators	Year(s)	SMC	Benchmark	Desired ↑↓
Adults Needing and Receiving Behavioral Health Care Services[20†]	2015-2016	58.4%	60.5%	↓
Alcohol – Binge Drinker[11† & 24]	**2016, 2018**	**16.9%**	**16.3%**	↓
Alcohol – Current Drinker[11† & 24]	**2016, 2018**	**♦60.2%**	**53.7%**	↓
Chronic Liver Disease and Cirrhosis Death Rate[7]	**2013-2015**	**8.5**	**[H]8.2**	↓
Current Smoker[11† & 24]	2016, 2018	5.7%	11.0%	↓
Current User of E-Cigarettes (Vaping)[11 & 24]	2016, 2018	3.0%	3.2%	↓
Deaths by Suicide, Drug or Alcohol Poisoning (Rate)[2]	2011-2015	25.2	34.2	↓
Drug-Related Death Rate[11† & 12]	2014-2016	8.2	[H]11.3	↓
Lung Cancer Death Rate[7]	2013-2015	24.8	30.6	↓
Lung Cancer Incidence Rate[2]	2010-2014	42.7	44.6	↓

Indicators	Year(s)	SMC	Benchmark	Desired ↑↓
Substance-Related Emergency Department Visits Rate[6]	2014	442.5	455.2	↓
Used Marijuana or Hashish Recently[11 & 24]	**2017, 2018**	**♦13.3%**	**8.5%**	↓
Alcohol-Impaired Driving Deaths[12]	2012-2016	26.3%	29.4%	↓
Heart Disease Death Rate[22†]	2014-2016	55.4	89.1	↓
Heart Disease Prevalence[2]	2014	5.6%	7.0%	↓
Liquor Store Access Rate[1†]	2016	6.8	10.7	↓
Low Birth Weight [12]	**2010-2016**	**6.9%**	**6.8%**	↓
Opioid Prescription Drug Claims[2]	2015	4.3%	7.0%	↓

Trends (†)

Certain indicators have been measured longitudinally. Below are the trend directions for indicators with trend data available.

- Adults Needing and Receiving Behavioral Health Care Services[20]: No significant change
- Alcohol – Binge Drinker[11]: Increasing
- Alcohol – Current Drinker[11]: Decreasing
- Current Smoker[11]: Decreasing
- Deaths by Drug Poisoning (Rate)[11]: Increasing
- Ever Sought Professional Help for Drug Related Problem[11]: Flat
- Fair/Poor Access to Help for Substance Abuse[11]: Increasing
- Heart Disease Death Rate[22]: Decreasing
- Know Where to Access Treatment for a Drug-Related Problem if Needed[11]: Increasing
- Liquor Store Access Rate[1]: Falling since 2014
- Substance-related ED Visits[11]: Rising since 2010
- Substance-Related ED Visits (Youth)[11]: Generally falling since 2012-13
- Substance-Related ED Visits (Adults age 20-64)[11]: Generally rising since 2010-11
- Substance-Related ED Visits (Older Adults)[11]: Mixed
- Use Other Tobacco Products[11]: Decreasing

Race & Ethnicity

Certain indicators are available by ethnicity, which shows disparities in certain populations.

Table 44, Statistical Data for Behavioral Health by Ethnicity

Indicators	Bench-mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Alcohol – Current Drinker[11 & 24]	53.7%	**♦68.6%**							
Have Ever Felt Depressed for 2 Years or More (%)[11 & 24]	[US]31.4		**♦37.3**						**♦33.6**
Needing Mental Health Care[1]	15.9%	15.6%					0.5%		14.7%
Used Marijuana or Hashish Recently[11 & 24]	8.5%			**♦18.1%***					
Youth Intentional Self-Harm-ER Visits (per 10,000 pop.)[5]	10.9	9.4	3.3	5.9*		**♦42.6**	**♦12.3**		7.1

Blank cells indicate that data were unavailable. * Indicates that survey combined Asian/Pacific Islander.

Other Populations

Certain indicators are available by age, income or education level, or geography, and show disparities in certain populations.

Table 45, Statistical Data for Behavioral Health by Age, Income, Education, or Geography

Indicators	Bench-mark	Age 0-17	Age 18-39	Age 18-64	Age 65+	≤ 200% FPL	>400% FPL	≤ High School	Coast-side
Alcohol – Binge Drinker[11 & 24]	16.3%		**♦28.4%**						
Alcohol – Current Drinker[11 & 24]	53.7%						**♦70.2%**	**♦63.4%**	**♦69.4%**
Current Smoker[11 & 24]	11.0%		8.1%			6.7%		9.5%	
Current User of E-Cigarettes (Vaping)[11 & 24]	3.2%		**♦7.2%**						
Have Ever Felt Depressed for 2 Years or More (%)[11 & 24]	[US]31.4					**32.2**		**32.1**	**♦33.0**
Used Marijuana or Hashish Recently[11 & 24]	8.5%		**♦26.1%**						**♦18.1%**

Blank cells indicate that data were unavailable.

Data without Benchmarks

Certain indicators were available that had no statewide or national comparison. These data are described below.

Mental Health/Emotional Well-Being

- Felt Worried/Tense/ Anxious (Average Days/Month): On average, Quality of Life survey respondents countywide (N=1,581) indicated that they felt worried, tense, or anxious on four out of the past 30 days.[11]
- Bullying:
  - Cyberbullying: Nearly one in five (19%) “of [teen] females reported being bullied or harassed via the internet compared to 11% of [teen] males” (N=3,284).[13]
  - Absenteeism Due to Cyberbullying: A total of “11% of [teen] respondents who reported being bullied or harassed via the internet missed one or more days of school in the past month” (N=3,284).[13]
- Community Connectedness:
  - Community Connectedness – Feel Not Very or Not at All Connected: About one third of Quality of Life survey respondents countywide (N=1,581) reported that they felt not very or not at all connected to their community.[11] Higher proportions of men (41%) and Asian/Pacific Islander (40.5%) respondents felt this way.[11]
  - Adults Age 65+ Living Alone: Nearly 36% of Quality of Life survey respondents countywide (N=1,581) who were adults age 65+ indicated they were living alone.[11] This was indicated by greater proportions of older adult women and middle income (200-400% FPL) respondents than others.[11]
  - Lack of Meaningful Connections to Community (Youth): “Students attending non-traditional schools reported lower rates of meaningful connections in their community” than students attending traditional schools.[13]
- Experienced Depressive Symptoms (Average Days/Month): On average, Quality of Life survey respondents countywide (N=1,581) indicated that they felt sad, blue, or depressed on 2.5 out of the past 30 days.[11] Respondents earning less than 200% FPL reported feeling that way on 4.3 out of the past 30 days.[11]
- Discrimination Due to Mental Health Problems, Youth: “Youth who have mental health problems… are more likely to have felt discriminated against than youth who have no mental health problems” (N=3,284).[13]
- History of Mental Health Issues: About 10% of Quality of Life survey respondents countywide (N=1,581) reported a history of problems with mental/emotional illness.[11] The proportions who reported such a history were higher among adult respondents age 18-39 (over 17%) and Latinx respondents (15%).[11]
- Lack Support: About 14% of Quality of Life survey respondents countywide (N=1,581) reported that they had someone they could turn to if they needed or wanted help “little/none of the time.”[11] These proportions were higher (i.e., worse) for respondents

earning less than 200% FPL (32%) and respondents with a high school diploma or less (31%).[11]

- Pain:
  - Ambulance Transport, Pain: Of all ambulance transports initiated by a call to 911, pain was the primary impression (main reason for the call) in 12.1% of cases.[16]
  - Pain Interfered with Usual Activities (Average Days/Month): On average, Quality of Life survey respondents countywide (N=1,581) indicated that pain made it hard to do their usual activities on 3.5 out of the past 30 days.[11] Respondents of African ancestry experienced this interference more often (4.2 of the past 30 days), as did respondents earning less than 200% FPL (5.2 of the past 30 days).[11]
- Perception of Safety, Youth: "Only 53% of all [teen] respondents reported feeling safe in their community" (N=3,284).[13]
- Poor Physical or Mental Health Interfered with Usual Activities (Average Days/Month): On average, Quality of Life survey respondents countywide (N=1,581) indicated that their physical/mental health had prevented their usual activities three out of the past 30 days.[11] The average for respondents earning less than 200% FPL was 4.3 days, and for African ancestry respondents was 3.5 days.[11]
- Poor Mental Health:
  - Poor Mental Health (Average Days/Month): On average, Quality of Life survey respondents countywide (N=1,581) indicated that their mental health was not good on two out of the past 30 days.[11]
  - ER Visit Rate: Mental Health Issues: Young adults (age 18-24 and 25-34) and adults age 85+ are the most likely among the population of all ages to visit the emergency room for mental health issues.[5]
- Poor Sleep (Average Days/Month): On average, Quality of Life survey respondents countywide (N=1,581) said that they felt they didn't get enough sleep on 7.6 out of the past 30 days.[11] Among the populations of respondents who reported more days of poor sleep were African ancestry respondents (9 days), respondents earning less than 200% FPL (8.6 days), and adults age 18-39 (8.6 days).[11]
- Have Ever Sought Professional Help for Mental/Emotional Problem: Nearly one third of Quality of Life survey respondents countywide (N=1,581) reported that they had ever sought help from a professional for a mental/emotional problem.[11] Among the populations of respondents less likely to report they had ever sought professional help were men (26%), older adults (age 65+) (24%), Asian/Pacific Islanders (20.5%), and respondents with a high school diploma or less (18%).[11]
- High Stress on Typical Day: More than half of the Quality of Life survey respondents countywide (N=1,581) reported that their typical day contained a low level of stress, while 39% reported a moderate level of stress and six percent reported a high level of

stress.[11] A greater proportion of respondents from the Coastside (11%) reported a high level of stress.[11]

- Suicidal Ideation: A total of "38% of [teen] female and 23% of [teen] male respondents reported having suicidal thoughts" (N=3,284).[13]
- Suicide:
    - The age-adjusted, countywide suicide mortality rate was 9.5 per 100,000 people.[11]
    - Nearly three quarters of the suicides in San Mateo County between 2010 and 2015 were male.[11]
    - The crude countywide suicide rate per 100,000 was highest for middle-aged adults (ages 45-64, 7.2 per 100,000).[11] Note, there were no suicide deaths in individuals under the age of 20 in year 2016 in San Mateo County.[11]
    - Suicide mortality rates for Latinxs and Asian/Pacific Islanders rose from 2014 to 2015, as did suicide mortality rates for age groups 20-24 and 25-44.[11]Whites had the highest crude rate of suicide in the county between 2010 and 2015 (13.7 per 100,000), followed by people of African ancestry (10.5 per 100,000).[11]
    - The crude rate of suicide deaths between 2010 and 2015 was highest in the mid-county area (54.3 per 100,000); this was followed by the coast (52.9 per 100,000), the south county area (46.3 per 100,000), and the north county area (43.9 per 100,000).[11]
    - Suicide was the #11 cause of death in the county.[7]
- Witnessing Violence at School: "28% of [teen] respondents reported seeing violence at their schools and 30% reported seeing violence in their community" (N=3,284).[13]
- Witnessing Violence in Community: "28% of [teen] respondents reported seeing violence at their schools and 30% reported seeing violence in their community" (N=3,284).[13]

Tobacco/Substance Use

- Chronic liver disease/cirrhosis was the #9 cause of death in the county.[7]
- Marijuana:
    - Recent Marijuana Use: Fully 20% of San Mateo County Behavioral Health and Recovery Services survey respondents countywide (N=3,981) reported that they had used marijuana in the past month.[17]
    - Used Marijuana or Hashish Recently: In contrast, about 13% of Quality of Life survey respondents countywide (N=1,581) indicated they had used marijuana or hashish at least once in the past 30 days.[11]
        - Form of Marijuana Use: The most popular form of marijuana use among Quality of Life survey respondents (N=179) was smoking (62%); approximately one third had also used it in vaporized form (35%) or in edible form (32%).[11]

        - Used Marijuana or Hashish Recently: Among Quality of Life survey respondents who had used marijuana or hashish in the past 30 days (N=179), most (57%) had only used it once in a day, and most of the rest (20%) had used it twice in a day.[11]
- Other Drugs: About 4% of Quality of Life survey respondents countywide (N=1,581) reported having used any illicit drugs.[11]
- Coping and Drug Use, Youth: Youth who reported using drugs engaged in positive coping strategies (e.g., talking to a friend, having an artistic outlet) in much lower proportions (13-26%) than youth who reported not using drugs (74-87%) (N=3,284).[13]
- Drug/Alcohol Education:
    - Effective Drug/Alcohol Prevention, Youth: "Only 55% of [teen] respondents reported that their schools provided effective drug and alcohol prevention services" (N=3,284).[13]
    - Know Where to Access Treatment for a Drug-Related Problem if Needed: Nearly half (47%) of Quality of Life survey respondents countywide (N=1,581) indicated they knew where to access treatment for a drug-related problem if they or someone in their family needed it.[11] Only about 40% of respondents on the Coastside knew where to access such treatment if needed.[11]
- Drug-Related Deaths:
    - The age-adjusted, countywide drug overdose mortality rate (from all drugs) was 6.78 per 100,000 people.[11] This rate includes both ICD 10 codes and coroner case review. The rate when counting only ICD 10 codes was 4.57 per 100,000.[11]
    - The crude rates per 100,000 are highest for adults in late middle-age (ages 55-64, 25.5 per 100,000 ICD 10 and coroner, 14.7 per 100,000 ICD 10 only).[11]
    - Drug-induced death was the #10 cause of death in the county.[7]
- Emergencies:
    - Ambulance Transport, Behavioral Health: Of all ambulance transports initiated by a call to 911, behavioral health was the primary impression (main reason for the call) in 4.4% of cases.[16]
    - Ambulance Transport, Toxicological Issues: Of all ambulance transports initiated by a call to 911, toxicological issues (accidental or intentional poisoning by alcohol, drugs, or other toxins) were the primary impression (main reason for the call) in 5% of cases.[16]

Oral/Dental Health

Table 46, Statistical Data for Oral/Dental Health

Indicators	Year(s)	SMC	Benchmark	Desired ↑↓
Access to Dentists Rate[1† &12]	2016	101.2	82.3	↑
Health Professional Shortage Area – Dental[2]	2016	0.0%	13.2%	↓
Lack of Dental Insurance Coverage[2]	2015-2016	26.0%	38.5%	↓
No Recent Dental Exam (Youth)[1]	2013-2014	1.2%	18.5%	↓
Poor Dental Health[1]	2006-2010	11.2%	11.3%	↓
Recent Dental Exam[11 & 24]	2016, 2018	78.9%	66.8%	↑
Current Smoker[11† & 24]	2016, 2018	5.7%	11.0%	↓
Drinking Water Violations[2]	**2015**	♦**1.0**	**0.8**	↓
Soft Drink Consumption[2]	2014	9.2%	18.1%	↓

Trends (†)

Certain indicators have been measured longitudinally. Below are the trend directions for indicators with trend data available.

- Access to Dentists Rate[1]: Rising since 2010
- Child Had Recent Dental Exam[11]: Increasing
- Current Smoker[11]: Decreasing
- Lack of Insurance Prevented Dental Care[11]: No clear trend
- Have No Dental Insurance Coverage that Pays for Some or All of Routine Dental Care[11]: Increasing since 2008
- Use Other Tobacco Products[11]: Decreasing

Other Populations

Certain indicators are available by age, income or education level, or geography, and show disparities in certain populations.

Table 47, Statistical Data for Oral/Dental Health by Age, Income, Education, or Geography

Indicators	Bench-mark	Age 0-5	Age 6-17	Age 18-64	Age 65+	≤ High School	Some College	≥ B.A./B.S. Degree	≤ 200% FPL
Recent Dental Exam[11 & 24]	66.8%								♦**51.1%**

Blank cells indicate that data were unavailable.

Data without Benchmarks

Certain indicators were available that had no statewide or national comparison. These data are described below.

- Usual Source of Dental Care: Almost 82% of Quality of Life survey respondents countywide (N=1,581) reported having a usual source of dental care.[11] This was the case for a smaller proportion of respondents earning less than 200% FPL (57%).[11]
- Insurance:
  - Dental Insurance: About two thirds of Quality of Life survey respondents countywide (N=1,581) reported having dental insurance.[11] This was the case for smaller proportions of respondents earning less than 200% FPL (42%) and older adult (65+) respondents (44%).[11]
  - Lack of Insurance Prevented Dental Care: About 30% of Quality of Life survey respondents countywide (N=1,581) indicated that they or a family member(s) have dental problems they cannot take care of because of a lack of insurance.[11] This affected greater proportions of Latinx respondents (44%) and adults age 18-39 (45%).[11]
- Sugar-Sweetened Beverages:
  - Sugar-Sweetened Beverage Consumption (Adults): About 18% of Quality of Life survey respondents countywide (N=1,581) reported that they consume sugar-sweetened beverages daily.[11]
    - Over 13% specifically indicated that they consume at least one soda or pop containing sugar per day.[11] The highest proportions of respondents drinking at least one sugar-sweetened soda/pop each day were south county residents (18%), Latinxs (19%), and respondents with a high school education or less (26%).[11]
    - About 10% specifically indicated that they consume at least one sugar-sweetened fruit drink per day.[11] The highest proportions of respondents drinking at least one sugar-sweetened fruit drink each day were respondents earning between 200% and 400% of FPL (16%).[11]
  - Sugar-Sweetened Beverage Consumption (Youth): "[C]onsumption by adolescents age 12-17 increased to 56% drinking one or more sugar-sweetened beverages per day."[13]
- Teeth Removed Due to Poor Oral Health: Over 20% of Quality of Life survey respondents countywide (N=1,581) reported that three or more of their permanent teeth had been removed due to tooth decay or gum disease.[11] This was the case for greater proportions of respondents with a high school education or less (37%), respondents earning less than 200% FPL (32%), and respondents of African ancestry (31%).[11]

Sexually Transmitted Infections

Table 48, Statistical Data for Sexually Transmitted Infections

Indicators	Year(s)	SMC	Benchmark	Desired ↑↓
Chlamydia Cases (Incidence) Rate[26]	2016	336.1	504.4	↓
Early Latent Syphilis Cases (Incidence) Rate[26]	2016	6.9	13.5	↓
Gonorrhea Cases (Incidence) Rate[26]	2016	80.2	164.3	↓
HIV Hospitalizations Rate[1]	2011	1.3	2.0	↓
HIV Prevalence[12]	2015	228.6	376.4	↓
HIV/AIDS Deaths Rate[2]	2008-2014	74.0	323.9	↓
Primary & Secondary Syphilis Cases (Incidence) Rate[26]	2016	7.8	15.0	↓
No HIV Screening[1]	**2011-2012**	**62.5%**	**60.8%**	↓

Trends (†)

Certain indicators have been measured longitudinally. Below are the trend directions for indicators with trend data available.

- Early Syphilis Rates (Men)[11]: Generally rising since 2000

Race & Ethnicity

Certain indicators are available by ethnicity, which shows disparities in certain populations.

Table 49, Statistical Data for Sexually Transmitted Infections by Ethnicity

Indicators	Bench-mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
HIV Prevalence[1+]	376.2	248.3	♦**1046.6**						266.6
No HIV Screening[1]	60.8%	47.9%		58.1%					47.7%

Blank cells indicate that data were unavailable. +Using older data from 2012-2014 to highlight health disparities by race/ethnicity.

Data without Benchmarks

Certain indicators were available that had no statewide or national comparison. These data are described below.

- Effective Sex Education: About “74% of [teen] respondents reported that they feel they are making informed decisions about sex and their sexuality” (N=3,284).[13]

Unintended Injuries/Accidents

Table 50, Statistical Data for Unintended Injuries/Accidents

Indicators	Year(s)	SMC	Benchmark	Desired ↑↓
Accidents (Unintentional Injuries) Death Rate[7]	2013-2015	20.8	29.1	↓
Drug-Related Death Rate[12]	2014-2016	8.2	ᴴ11.3	↓
Firearm-Related Death Rate[12]	2012-2016	4.3	7.9	↓
Injury Deaths Rate[12]	2012-2016	35.1	47.6	↓
Motor Vehicle Crash Death Rate[12]	2010-2016	5.3	8.5	↓
Pedestrian Accident Death Rate[1]	**2010-2012**	**♦1.4**	**ᴴ1.3**	↓
Unintentional Drowning/Submersion Death Rate[6]	**2013**	**♦1.1**	**1.0**	↓
Unintentional Poisoning Death Rate[6]	2013	7.7	10.1	↓
Alcohol – Binge Drinker[11† & 24]	**2016, 2018**	**16.9%**	**16.3%**	↓
Alcohol-Impaired Driving Deaths[12]	2012-2016	26.3%	29.4%	↓
Firearm Kept in or around Home[11† & 24]	2016, 2018	16.8%	32.7%	↓
Liquor Store Access Rate[1†]	2016	6.8	10.7	↓

Trends (†)

Certain indicators have been measured longitudinally. Below are the trend directions for indicators with trend data available.

- Alcohol – Binge Drinker[11]: Increasing
- Drowning Deaths[11]: Mixed
- Falls Among Older Adults:
  - Deaths: The rate of deaths due to unintentional falls among older adults (age 65+) rose between 2008 and 2012, and is now back to the 2006-2008 level. However, it was lower in 2013-2015 (3.73 per 100,000) than it is now.[11]
  - ED Visits: The rate of ED visits due to non-fatal unintentional falls among older adults (age 65+) rose between 2008 and 2012, and has remained relatively stable since then.[11]
  - Hospitalizations: The rate of hospitalizations due to non-fatal unintentional falls among older adults (age 65+) has been declining since 2008.[11]
- Firearm Kept in or around Home[11]: Flat
- Liquor Store Access Rate[1]: Falling since 2014
- Poisoning Deaths Rate[11]: Mixed

Race & Ethnicity

Certain indicators are available by ethnicity, which shows disparities in certain populations.

Table 51, Statistical Data for Unintended Injuries/Accidents by Ethnicity

Indicators	Bench-mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Pedestrian Accident Death Rate[1]	H1.3	1.2	0.0	0.0	0.0	1.0		0.0	♦**1.9**

Blank cells indicate that data were unavailable.

Data without Benchmarks

Certain indicators were available that had no statewide or national comparison. These data are described below.

- Accidents/unintended injuries were the #6 cause of death in the county.[7]
- Falls Among Older Adults:
  - The age-adjusted rate of hospitalizations due to non-fatal unintentional falls among older adults (age 65+) was 164.6 per 100,000.[11]
  - The age-adjusted rate of ED visits due to non-fatal unintentional falls among older adults (age 65+) was 497.4 per 100,000.[11]
  - The age-adjusted rate of deaths due to unintentional falls among older adults (age 65+) was 4.2 per 100,000.[11]
- Ambulance Transport, Trauma (Injury): Of all ambulance transports initiated by a call to 911, trauma (injury) was the primary impression (main reason for the call) in 7.6% of cases.[16]
- Motor Vehicle Accidents: The leading mechanism of injury for adults 18-65 is motor vehicle collisions.[16]
- Ambulance Transport, Toxicological Issues: Of all ambulance transports initiated by a call to 911, toxicological issues (accidental or intentional poisoning by alcohol, drugs, or other toxins) were the primary impression (main reason for the call) in 5% of cases.[16]

General Health

Table 52, Statistical Data Related General Health

Indicators	Year(s)	SMC	Benchmark	Desired ↑↓
All Causes of Death Rate[7]	2013-2015	493.2	616.2	↓
Child Mortality Rate[12]	2013-2016	26.1	38.5	↓
Frequent Physical Distress[12]	2016	8.0%	10.9%	↓
Life Expectancy at Birth (in Years)[2]	2014	83.1	80.8	↑
Mortality – Premature Deaths (Years of Potential Life Lost)[1]	2014-2016	3,552	5,862	↓
Poor or Fair Health[11† & 24]	2016, 2018	13.3%	17.8%	↓
Poor Physical Health (Average Days/Month)[11† & 12]	2016, 2018	2.7	3.5	↓
Population with Any Disability[1]	2012-2016	8.3%	10.6%	↓

Trends (†)

Certain indicators have been measured longitudinally. Below are the trend directions for indicators with trend data available.

- Felt Healthy and Full of Energy (Average Days/Month)[11]: Decreasing
- Older Dependents in Home who Cannot Live Alone[11]: Increasing
- Pain Interfered with Usual Activities (Average Days/Month)[11]: Increasing since 2013
- Poor or Fair Health[11]: Increasing since 2008
- Poor Physical Health (Average Days/Month)[11]: Increasing since 2004
- Poor Physical or Mental Health Interfered with Usual Activities (Average Days/Month)[11]: Increasing since 2004

Race & Ethnicity

Certain indicators are available by ethnicity, which shows disparities in certain populations.

Table 53, Statistical Data for General Health by Ethnicity

Indicators	Bench-mark	White	Afr / Afr Anc	Asian	Pac Isl	Native Am	Other	Multi Race	Hisp / Lat (Any Race)
Poor or Fair Health[11 & 24]	17.8%		**♦19.5%**						**♦21.3%**
Population with Any Disability[1]	10.6%	9.7%	**♦18.1%**	6.2%	6.8%	10.5%	5.1%	5.9%	6.6%

Blank cells indicate that data were unavailable.

Other Populations

Certain indicators are available by age, income or education level, or geography, and show disparities in certain populations.

Table 54, Statistical Data for General Health by Age, Income, Education, or Geography

Indicators	Bench-mark	Age 0-5	Age 6-17	Age 18-64	Age 65+
Poor or Fair Health[11 & 24]	17.8%				♦**22.2%**

Blank cells indicate that data were unavailable.

Data without Benchmarks

Certain indicators were available that had no statewide or national comparison. These data are described below.

- Discrimination Due to Physical Disabilities, Youth: "Youth who have …physical disabilities are more likely to have felt discriminated against than youth who have no …physical disabilities" (N=3,284).[13]
- General Health:
  - Felt Healthy and Full of Energy (Average Days/Month): On average, Quality of Life survey respondents countywide (N=1,581) reported that they felt healthy and full of energy on 18 out of the past 30 days.[11]
  - Poor Physical Health (Average Days/Month): On average, Quality of Life survey respondents countywide (N=1,581) indicated that their physical health was not good on four out of the past 30 days.[11] The average for respondents earning less than 200% FPL was 6.7 days, and for African ancestry respondents was 5.9 days.[11]
  - Poor Physical or Mental Health Interfered with Usual Activities (Average Days/Month): On average, Quality of Life survey respondents countywide (N=1,581) indicated that their physical/mental health had prevented their usual activities three out of the past 30 days.[11] The average for respondents earning less than 200% FPL was 4.3 days, and for African ancestry respondents was 3.5 days.[11]
- Ambulance Transport, Neurological Issues: Of all ambulance transports initiated by a call to 911, neurological issues were the primary impression (main reason for the call) in 10.1% of cases.[16]
- Older Dependents in Home who Cannot Live Alone: Nearly 12% of Quality of Life survey respondents countywide (N=1,581) reported that they had older dependents living in their household because these older individuals were unable to live alone.[11] This was reported in higher proportions by adults age 18-39 (21%), and Asian/Pacific Islanders (23%).[11]

Summary List of Sources

Health needs data found in this document were collected primarily from the publicly available Community Commons data platform (https://www.communitycommons.org/maps-data/) and a related data platform (http://www.CHNA.org). Other data were reviewed and provided by San Mateo County Health's Division of Public Health, Policy, and Planning and are noted in the report. Pertinent data points on health needs from these sources are included in data tables with superscript notation:

[1] Community Commons Data Platform
[2] CHNA.org Data Platform
[3] Centers for Disease Control and Prevention State Profiles
[4] California Department of Education
[5] Office of Statewide Health Planning and Development
[6] California Department of Public Health, EpiCenter California Injury Data
[7] California Department of Public Health, County Health Status Profiles
[8] California Department of Public Health, Immunization Branch
[9] California Department of Public Health, California Cancer Registry (CCR) Fact Sheet
[10] California Department of Public Health, Tuberculosis Branch
[11] San Mateo County Health
[12] County Health Rankings & Roadmaps, Robert Wood Johnson Foundation
[13] County of San Mateo, Board of Supervisors, Adolescent Report
[14] Get Healthy San Mateo County
[15] Insight Center for Community Economic Development
[16] County of San Mateo Emergency Medical Services
[17] San Mateo County Behavioral Health and Recovery Services
[18] U.S. Census Bureau
[19] Zilpy.com Rental Estimates
[20] California Health Interview Survey
[21] U.S. Department of Health & Human Services, Centers for Medicare and Medicaid Services
[22] California Department of Public Health
[23] Feeding America
[24] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System
[25] The Dartmouth Atlas of Health Care
[26] California Department of Public Health, Sexually Transmitted Diseases Control Branch

For an index that lists full original sources and years as well as indicator descriptions, see Attachment 3: Secondary Data Indicators List.

Attachment 5. Community Assets and Resources

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

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ACCESS TO HEALTH CARE RESOURCES

HEALTH CARE FACILITIES AND AGENCIES

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

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

Clinics*	City/Region
Arbor Free Clinic, Cardinal Free Clinics	Menlo Park
Belle Air School Health Clinic	San Bruno
Clinic by the Bay	San Francisco
Daly City Youth Health Center	Daly City
Lucile Packard Children's Hospital Stanford	Mobile Health Services
Planned Parenthood	Multiple locations[1]
Ravenswood Family Health Center EPA	
RotaCare Bay Area	Half Moon Bay and Daly City
Samaritan House Free Clinic	San Mateo and Redwood City
San Mateo Medical Center Clinics	Multiple locations[2]
Sequoia Teen Health Center/Sequoia High School	Redwood City
Student Health Clinic/Belle Air School	San Bruno Park School District

*Does not include private health care services. Please use 2-1-1 for lists of those clinics.

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[1] See https://www.plannedparenthood.org/health-center?
[2] See https://www.smchealth.org/smmc-guide-clinics

OTHER GENERAL HEALTH CARE RESOURCES

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

RESOURCES BY IDENTIFIED HEALTH NEED (LIST A)

AGENCY OR ORGANIZATION	ARTHRITIS	ASTHMA	CANCER	MATERNAL & INFANT HEALTH	UNINTEN-TIONAL INJURIES	ORAL HEALTH	INFECTIOUS DISEASES
Northern California Arthritis Foundation	●						
American Lung Association		●					
Breathe California Smoking Cessation Classes		●					
American Cancer Society			●				
Bay Area Cancer Connections			●				
Breast Cancer Connections, Gabriella Pastor Program			●				
Colon Cancer Community Awareness campaign			●				

AGENCY OR ORGANIZATION	ARTHRITIS	ASTHMA	CANCER	MATERNAL & INFANT HEALTH	UNINTEN-TIONAL INJURIES	ORAL HEALTH	INFECTIOUS DISEASES
Joy Luck Club			●				
Relay For Life			●				
Samaritan House			●				
"Look Good, Feel Better"			●				
March of Dimes				●			
Mid-Coastal California Prenatal Outreach Program				●			
Preeclampsia Foundation				●			
San Mateo County Health Department Nurse-Family Partnership program				●			
San Mateo County Health Department Pre-to-3 Program				●			

AGENCY OR ORGANIZATION	ARTHRITIS	ASTHMA	CANCER	MATERNAL & INFANT HEALTH	UNINTEN-TIONAL INJURIES	ORAL HEALTH	INFECTIOUS DISEASES
Sequoia Hospital Lactation Center				●			
San Mateo County Fall Prevention Coalition					●		
Sonrisas Dental Health Half Moon Bay and San Mateo						●	
San Mateo County Oral Health Coalition						●	
Health Connected							●
SF HepB Free – Bay Area							●

RESOURCES THAT ADDRESS MULTIPLE HEALTH NEEDS (LIST B)

AGENCY OR ORGANIZATION	BEHAVIORAL HEALTH	COMMUNITY & FAMILY SAFETY	EMPLOYMENT/ FOOD INSECURITY	HOUSING/ HOMELESSNESS	HEALTHY LIFESTYLES	HEART DISEASE/ STROKE
70 Strong	●				●	
12-step recovery programs	●				●	
Acknowledge Alliance	●					
African American Community Health Advisory Committee					●	●
ALICE: Filipino organization		●				
American Board for Child Diabetics					●	
Asian American Recovery Services	●	●				
Boys & Girls Clubs of North San Mateo County	●					
Caminar	●					
Catholic Charities	●					

AGENCY OR ORGANIZATION	BEHAVIORAL HEALTH	COMMUNITY & FAMILY SAFETY	EMPLOYMENT/ FOOD INSECURITY	HOUSING/ HOMELESSNESS	HEALTHY LIFESTYLES	HEART DISEASE/ STROKE
Cleo Eulau Center	●					
Coastside Adult Day Health Center	●					
Coastside Hope			●	●		
Community Overcoming Relationship Abuse (CORA)	●	●				
Daly City Community Services Center			●	●		
Daly City Peninsula Partnership Collaborative	●					
Daly City Youth Health Center	●	●			●	
Edgewood Center for Children & Families	●	●	●			
El Centro de Libertad	●	●				
Elder Abuse		●				

AGENCY OR ORGANIZATION	BEHAVIORAL HEALTH	COMMUNITY & FAMILY SAFETY	EMPLOYMENT/ FOOD INSECURITY	HOUSING/ HOMELESSNESS	HEALTHY LIFESTYLES	HEART DISEASE/ STROKE
Prevention Task Force						
Freedom House	●					
Friends for Youth	●					
Health Right 360 San Mateo	●					
HIP Housing				●		
Home & Hope				●		
Latino Commission	●					
LifeMoves	●	●	●	●		
Mental Health Association of San Mateo County	●					
National Alliance on Mental Illness/San Mateo County	●					
Niroga Institute	●					
North Fair Oaks Community Center			●	●		

AGENCY OR ORGANIZATION	BEHAVIORAL HEALTH	COMMUNITY & FAMILY SAFETY	EMPLOYMENT/ FOOD INSECURITY	HOUSING/ HOMELESSNESS	HEALTHY LIFESTYLES	HEART DISEASE/ STROKE
North Peninsula Food Pantry & Dining Center of Daly City			●			
Pacific Stroke Association					●	●
Pacifica Resource Center			●	●		
Peace Development Fund		●				
Peninsula Conflict Resolution Center		●			●	
Peninsula Family Service	●					
Peninsula Kidpower, Teenpower, Fullpower		●				
Pre-to-3 Program					●	
Puente de la Costa Sur			●	●		

AGENCY OR ORGANIZATION	BEHAVIORAL HEALTH	COMMUNITY & FAMILY SAFETY	EMPLOYMENT/ FOOD INSECURITY	HOUSING/ HOMELESSNESS	HEALTHY LIFESTYLES	HEART DISEASE/ STROKE
Pyramid Alternatives	●					
Rape Trauma Services	●	●				
Rebuilding Together Peninsula				●		
SafeKids Coalition of Santa Clara and San Mateo Counties		●			●	
Samaritan House	●		●	●	●	
Second Careers Employment Program			●			
Streets Alive! Parks Alive!					●	
Youth Mental Health First Aid Training	●					
San Mateo County Human Trafficking Initiative		●				

AGENCY OR ORGANIZATION	BEHAVIORAL HEALTH	COMMUNITY & FAMILY SAFETY	EMPLOYMENT/ FOOD INSECURITY	HOUSING/ HOMELESSNESS	HEALTHY LIFESTYLES	HEART DISEASE/ STROKE
San Mateo Police Activities League					●	
Second Harvest Food Bank			●			
Sitike Counseling Center	●					
Strong for Life					●	
StarVista	●					
Via Heart Project						●
Women's Recovery Association	●					
YMCA	●		●	●	●	
Community/ Senior Centers						
Adaptive Physical Education Center (Redwood City)					●	●
Fair Oaks Adult Activity Center (Redwood City)					●	●

AGENCY OR ORGANIZATION	BEHAVIORAL HEALTH	COMMUNITY & FAMILY SAFETY	EMPLOYMENT/ FOOD INSECURITY	HOUSING/ HOMELESSNESS	HEALTHY LIFESTYLES	HEART DISEASE/ STROKE
Little House Activity Center (Menlo Park)					●	●
San Carlos Adult Community Center					●	●
Twin Pines Senior & Community Center (Belmont)					●	●
Veterans Memorial Senior Center (Redwood City)					●	●

Attachment 6. Qualitative Research Protocols

Prior to key informant interviews in San Mateo County, participants were provided with the 2016 CHNA health needs list to consider.

Table 1, 2016 Health Needs List

2016 Priority Health Need	Examples
Alzheimer's Disease & Dementia	
Arthritis	
Behavioral Health	Depression, suicide, drug/alcohol addiction
Birth Outcomes	Premature births, infant mortality
Cancer	Breast cancer, leukemia
Childhood Obesity	
Climate Change	Global warming, drought
Communicable Diseases	TB, flu, salmonella (separate from STIs)
Diabetes	
Emotional Well-Being	Stress, worry, sub-clinical anxiety
Fitness/Diet/Nutrition	Nutritious food, safe places to exercise
Healthcare Access & Delivery	Health insurance, costs of medicine, availability of providers, getting appointments, patients being treated with respect
Heart Disease & Stroke	
Housing & Homelessness	
Income & Employment	
Oral/Dental Health	
Respiratory Conditions	Asthma, COPD
Sexually Transmitted Infections	
Transportation & Traffic	Public transportation, safe roads
Unintended Injuries	Car accidents, falls, drownings
Violence & Abuse	Child abuse, violent crime, human trafficking

Key Informant Protocol – Professionals

Introduction – 5 mins

- Welcome and thanks
- What the project is about:
    - Identifying health needs in our community (called the Community Health Needs Assessment or CHNA)
    - Required of all non-profit hospitals in the U.S. every three years
    - The hospitals (Seton, Kaiser SSF and Redwood City, Peninsula, Sequoia, Stanford, and LPCH) who serve San Mateo County residents are working together to meet this requirement
    - Will inform the investments that hospitals make to address community needs
- Scheduled for one hour - does that still work for you?
- Today's questions:
    - Most pressing health needs in San Mateo County
    - Your perspective on [expertise area]
    - How access to care and mental health play a part in those needs
    - Which populations may have different or worse needs or experiences
    - Your suggestions for improvement
- What we'll do with the information you tell us today
    - Notes will go to hospitals
    - Would like to record so that we can get the most accurate record possible
    - Will not share the audio itself
    - Can keep anything confidential – even the whole interview. Let me know at any time.
    - Permission to record?
- Any questions before I begin? *[If interviewer does not have the answer, commit to finding it and sending later via email.]*

Health Needs Prioritization – 6-10 min.

Part of our task today is to find out which health needs you think are most important. You may want to take a look at the list we sent you of the most common needs from the 2016 CHNA. You can see that some of them are health conditions, and others reflect the social determinants of health (housing, education, cost of living, environment, etc.).

Thinking specifically about San Mateo County …

1. Are there any needs that should be added to the list?

Expertise Area – 20 mins

You are here to share your expertise/experience about [e.g., senior health].

2. **Which three needs (2016 and others added) do you believe are the most *important* to address here in the next few years for the population you serve?** [See table above.]

I am going to take you through a few questions about each of these needs.

3. **When you think about [health need 1]…**
    - What are people struggling with?
    - What barriers exist to seeing better health in this area?
4. **Are some people better or worse off?**
   Prompts: Differences by age, education level, disability status, income (affecting housing and transportation), etc.

[Repeat 3-4 for each health need they prioritized.]

5. **Lastly, are you seeing any trends related to these needs in the last three years?**

Access to Care – 5 mins

We know that access to care impacts all aspects of health. (Access includes not only having insurance and being able to afford co-pays/premiums, but also having a primary care physician versus using urgent care or the ER, and being able to get timely appointments with various providers.)

6. **Would you say that health access [related to your specific expertise] is sufficient or not?**
7. **Do you see differences among any particular groups in your work?**
   Prompts: Differences by age, education level, disability status, language, those experiencing homelessness

Mental health – 5 mins

In recent assessments, mental health arose as a top health need. (By mental health, we mean everything ranging from sub-clinical issues like stress, substance use disorder through issues like anxiety or depression, all the way up to severe mental illness.)

8. **Do you agree? In your opinion, what are the specific mental health needs in our community?**
   Prompt: Conditions like stress or depression, outcomes like suicide, concerns about stigma

9. **a. In what ways might people who are struggling with mental health issues be doing worse than others when it comes to health?**
   Prompt: Mental health issues driving other health needs?

   b. In particular, how might stress be contributing to people's specific health issues?

Suggestions/Improvements/Solutions – 5-10 mins

In addition to what we have already talked about…

10. **What opinions, if any, do you have on what should be in place in our community to address these needs?**
    a. **What types of services would you like to see in the community, that aren't already in place?**
       Prompt: Preventative care? Deep-end services? Workforce changes? Are there any quick wins or low-hanging fruit?
    b. **What new/revised policies or other public health approaches are needed, if any?**
       Prompt: Program models?

[Time permitting] Additional comments

We thank you so much for answering our questions. In the few minutes we have left, is there anything else you would like us to add regarding community health needs?

Closing

OK, if anything occurs to you later that you would like to add to this interview, please just let us know. Thank you for contributing your expertise and experience to the CHNA. You can look for the hospital CHNAs to be made publicly available in 2019.

Focus Group Protocols

During focus groups, facilitators presented the 2016 CHNA List (**Table 1** of this attachment). Questions found in these protocols refer to that list.

Focus Groups with Professional or Community Representatives

Introduction – 6 mins

- Welcome and thanks
- What the project is about:
  - San Mateo County Community Health Needs Assessment
  - Identifying unmet health needs in our community
  - Ultimately, to plan on how to address health needs now and in future
- Today's questions (refer to agenda flipchart page)
- Introductions (name and organization)
- Confidentiality:
  - When we are finished with all of the focus groups, we will look at all of the transcripts and summarize the things we learn.
  - Would like to record so that we can be sure to get your words right.
  - Now that we have introduced ourselves, we will only use first names here to preserve your anonymity. However, if you want to keep a comment anonymous, you may not want to name your organization.
  - We also will pull out some quotes so that the hospitals can hear your own words. We will not use your name when we give them those quotes.
  - Transcripts will go to hospitals if that is OK with you.
  - Permission to record?
- What we'll do with the information you tell us today
  - Hospitals will report the assessment to the IRS
  - Hospitals will use information for planning future investments
- Logistics
  - We will end at ___:___.
  - It is my job to move us along to stay on time. I may interrupt you; I don't mean any disrespect, but it is important to get to all of the questions and get you out in time.
  - Cell phones: On vibrate; please take calls outside.
  - Bathroom location.
- Guidelines: It's OK to disagree, but be respectful. We want to hear from everyone.

Health Needs Prioritization – 10 min.

You are here to share your experience as a professional serving [e.g., seniors, persons experiencing homelessness, young adults, etc.].

Part of our task today is to find out which health needs you think are most important for the population you serve. This poster has a list of the health needs that the community came up with when we did the Community Health Needs Assessment for San Mateo County in 2016. Many of these we have already talked about.

[Read aloud from flipchart and define (e.g. “Access and Delivery” means insurance, having a primary care physician, preventive care instead of ED, being treated with dignity and respect, wait times, etc.).]

1. **Are there any that should be added to the list?**
2. **Please think about the three from the list you believe are the most *important* to address here in the next 3-4 years.**
    a. What we would like you to do is to take the three sticky dots you have there and use them to vote for three health needs that you think are the most important to address in the next few years. There may be some needs that are very dire – like ones that cause death. But you are voting on the things that you think may not be well-addressed now. In other words, some health needs may have a lot of people working on them, and plenty of treatments or medicines to address them. Others we may not understand as well, or there may not be enough doctors or facilities out there to help people. Then we will discuss the results of your votes.
3. **Summarize voting results.** Explain that we will spend the rest of our time reflecting on these top priorities.

Health Needs Discussion, Including Expertise Area – 20 mins

4. **When you think about this health need…**
    - What are people struggling with?
    - What barriers exist to seeing better health in this area?
5. **Which groups, if any, are better or worse off than others?**
   Prompts: Differences by age, education level, disability status, income (affecting housing and transportation), etc.
6. **What trends, if any, have you seen in the last three years?**

Repeat questions 4-6 for each of the top health needs prioritized by the group.

7. **[If their expertise was not related to one or more of the needs chosen:] You are here to share your expertise/experience about [e.g., senior health]. Let's talk a little about that; how does it relate to the community's health needs?**

Access to Care – 5 mins

We know that access to care impacts all aspects of health. (Access includes not only having insurance and being able to afford co-pays/premiums, but also having a primary care physician versus using urgent care or the ER, and being able to get timely appointments with various providers.)

8. **Would you say that healthcare access [related to the specific population you serve] is sufficient? Why or why not?**
9. **What differences do you see, if any, among various groups in your work?**
   Prompts: Differences by age, education level, disability status, language, those experiencing homelessness, immigration status, sexual orientation (i.e., LGBTQ).

Mental health – 5 mins

In recent assessments, mental health arose as a top health need. (By mental health, we mean everything ranging from stress to mental illness.)

10. **Do you agree? In your opinion, what are the specific mental health needs in our community?**
    Prompt: Conditions like stress or depression, outcomes like suicide, concerns about stigma

    a. **In what ways might people who are struggling with mental health issues be doing worse than others when it comes to health?**
    Prompt: Mental health issues driving other health needs?

    b. **In particular, how might stress be contributing to people's specific health issues?**

Suggestions/Improvements/Solutions – 5-10 mins

In addition to what we have already talked about…

11. **What opinions, if any, do you have on what should be in place in our community to address these needs?**
    a. **What types of services would you like to see in the community, that aren't already in place?**
       Prompts:

- Preventative care? Deep-end services?
- Workforce changes?
- Are there any quick wins or low-hanging fruit?

b. What new/revised policies or other public health approaches are needed, if any?

Closing – 5 mins

- Thank you
- Repeat - What we will do with the information
- Look for CHNA reports to be publicly available in 2019

Focus Groups with San Mateo County Residents

Introduction – 6 mins

- Welcome and thanks
- What the project is about:
  - San Mateo County Community Health Needs Assessment
  - Identifying unmet health needs in our community
  - Ultimately, to plan on how to address health needs now and in future
- Today's questions (refer to agenda flipchart page)
- Confidentiality:
  - Would like to record so that we can be sure to get your words right.
  - We will only use first names here to preserve your anonymity.
  - Transcripts will go to hospitals if that is OK with you.
  - When we are finished with all of the focus groups, we will look at all of the transcripts and summarize the things we learn. We also will pull out some quotes so that the hospitals can hear your own words. We will not use your name when we give them those quotes.
- What we'll do with the information you tell us today:
  - Hospitals will report the assessment to the IRS
  - Hospitals will use information for planning future investments
- Logistics
  - We will end at ___:___.
  - It is my job to move us along to stay on time. I may interrupt you; I don't mean any disrespect, but it is important to get to all of the questions and get you out in time.
  - Cell phones: On vibrate; please take calls outside.
  - Bathroom location

   - Incentives – please sign the sheet
- Guidelines: It's OK to disagree, but be respectful. We want to hear from everyone.

Health Needs Prioritization – 10 min.

You are here to share your experience as a [e.g., young adult].

Part of our task today is to find out which health needs you think are most important. This poster has a list of the health needs that the community came up with when we did the Community Health Needs Assessment for San Mateo County in 2016. Many of these we have already talked about.

[Read aloud from flipchart and define (e.g. "Access and Delivery" means insurance, having a primary care physician, preventive care instead of ED, being treated with dignity and respect, wait times, etc.).]

1. **Are there any that should be added to the list?**
2. **Please think about the three from the list you believe are the most *important* to address here in the next few years.**
   a. What we would like you to do is to take the three sticky dots you have there and use them to vote for three health needs that you think are the most important to address in the next 3-4 years. There may be some needs that are very dire – like ones that cause death. But you are voting on the things that you think may not be well-addressed now. In other words, some health needs may have a lot of people working on them, and plenty of treatments and medicines to address them. Others we may not understand as well, or there may not be enough doctors or facilities out there to help people. Then we will discuss the results of your votes.
3. **Summarize voting results.** Explain that we will spend the rest of our time reflecting on these top priorities.

Understanding the Needs – 15 mins

4. **When you think about [health need1]…**
   - What are people struggling with?
   - What barriers exist to people getting healthy or staying healthy?

   [Repeat question 4 for each top health need.]

5. **What about healthcare access?**
   - Is everyone able to get health insurance for their needs?
   - Is everyone able to afford to pay for health services and medication?
   - Is everyone able to get to the doctors they need when they need to?

- Do people mostly have a primary care doctor, or do they mostly use urgent care or the ER instead? [If the latter: Why?]

6. **What about mental health?** Mental health was one of the top health needs last time.

   (By mental health, we mean everything ranging from stress, substance use disorder to mental illness.)

   a. **In your opinion, what are the specific mental health needs in our community?** Prompt: Conditions like stress or depression, outcomes like suicide, concerns about stigma

   b. **Do you think that people who are struggling with mental health issues are doing worse than others when it comes to these other health issues we have listed? If so, how?** (Drivers)

7. **Do you think that things have been getting better, stayed the same, or gotten worse, in the last three years or so?** [If things have changed: How?]

Equity & Cultural Competency – 15 mins

8. **Do you think that everyone in our community is getting the same health care, and has the same access to care? If not, what are the barriers for them?** Prompt: Think about all of the people in our community… some have different ethnicities, languages, sexual orientations, and religions. They may be disabled or be low-income or be experiencing homelessness.

Suggestions/Improvements/Solutions – 5-10 mins

In addition to what we have already talked about…

9. **What types of services, if any, does the community need more of?** Prompt: Preventative care? Deep-end services? Workforce changes?

10. **What kinds of changes could those in charge here in San Mateo County make to help all of us stay healthy?**

Closing – 5 mins

- Thank you
- Repeat - What we will do with the information
- Incentives – **after you turn in the demographic survey**

Attachment 7. IRS Checklist

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

Federal Requirements Checklist	Regulation Section Number	Report Reference
A. Activities Since Previous CHNA(s)		
Describes the written comments received on the hospital's most recently conducted CHNA and most recently adopted implementation strategy.	(b)(5)(C)	Final draft Section #2
Describes an evaluation of the impact of any actions that were taken, since the hospital facility finished conducting its immediately preceding CHNA, to address the significant health needs identified in the hospital facility's prior CHNA(s).	(b)(6)(F)	Section #8
B. Process and Methods		
Background Information		
Identifies any parties with whom the facility collaborated in preparing the CHNA(s).	(b)(6)(F)(ii)	Section #4
Identifies any third parties contracted to assist in conducting a CHNA.	(b)(6)(F)(ii)	Section #4
Defines the community it serves, which: • Must take into account all patients without regard to whether (or how much) they or their insurers pay for care or whether they are eligible for assistance. • May take into account all relevant circumstances including the geographic area served by the hospital, target population(s), and principal functions. • May *not* exclude medically underserved, low-income, or minority populations who live in the geographic areas from which the hospital draws its patients.	(b)(i) (b)(3) (b)(6)(i)(A)	Section #3
Describes how the community was determined.	(b)(6)(i)(A)	Section #3
Describes demographics and other descriptors of the hospital service area.		Section #3
Health Needs Data Collection		
Describes **data and other information** used in the assessment:	(b)(6)(ii)	
a. Cites external source material (rather than describe the method of collecting the data).	(b)(6)(F)(ii)	Attachments 2, 3, & 4
b. Describes methods of collecting and analyzing the data and information.	(b)(6)(ii)	Section #5

Federal Requirements Checklist			Regulation Section Number	Report Reference
		CHNA describes how it took into account input from people who represent the broad interests of the community it serves in order to identify and prioritize health needs and identify resources potentially available to address those health needs.	(b)(1)(iii) (b)(5)(i) (b)(6)(F)(iii)	Section #5
		Describes the medically underserved, low-income, or minority populations being represented by organizations or individuals that provide input.	(b)(6)(F)(iii)	Section #5
		a. At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) or a State Office of Rural Health.	(b)(5)(i)(A)	Section #5 & Attachment 1
		b. Members of the following populations, or individuals serving or representing the interests of populations listed below. (Report includes the names of any organizations - names or other identifiers not required.)	(b)(5)(i)(B)	Section #5 & Attachment 1
		I. Medically underserved populations	(b)(5)(i)(B)	Section #5 & Attachment 1
		II. Low-income populations	(b)(5)(i)(B)	Section #5 & Attachment 1
		III. Minority populations	(b)(5)(i)(B)	Section #5 & Attachment 1
		c. Additional sources (optional) – (e.g. health care consumers, advocates, nonprofit and community-based organizations, elected officials, school districts, health care providers and community health centers).	(b)(5)(ii)	Section #5 & Attachment 1
		Describes how such input was provided (e.g., through focus groups, interviews or surveys).	(b)(6)(F)(iii)	Section #5 & Attachment 1
		Describes over what time period such input was provided and between what approximate dates.	(b)(6)(F)(iii)	Section #5 & Attachment 1
		Summarizes the nature and extent of the organizations' input.	(b)(6)(F)(iii)	Section #5
C. CHNA Needs Description and Prioritization				
	Health needs of a community include requisites for the improvement or maintenance of health status both in the community at large and in particular parts of the community (such as particular neighborhoods or populations experiencing health disparities).		(b)(4)	Section #6
	Prioritized description of significant health needs identified.		(b)(6)(i)(D)	Section #6
	Description of process and criteria used to identify certain health needs as significant and prioritizing those significant health needs.		(b)(6)(i)(D)	Section #6
	Description of the resources potentially available to address the significant health needs (such as organizations, facilities,		(b)(4) (b)(6)(E)	Section #7 & Attachment 5

Federal Requirements Checklist			Regulation Section Number	Report Reference
	and programs in the community, including those of the hospital facility.			
D. Finalizing the CHNA				
	CHNA is conducted in such taxable year or in either of the two taxable years immediately preceding such taxable year.		(a)1	Section #2
	CHNA is a written report that is adopted for the hospital facility by an authorized body of the hospital facility (authorized body defined in §1.501(r)-1(b)(4)).		(b)(iv)	Section #9
	Final, complete, and current CHNA report has been made widely available to the public until the subsequent two CHNAs are made widely available to the public. “Widely available on a website” is defined in §1.501(r)-1(b)(29).		(b)(7)(i)(A)	Date(s) on which a-f below were done:
		a. May not be a copy marked “Draft.”	(b)(7)(ii)	
		b. Posted conspicuously on website (either the hospital facility’s website or a conspicuously located link to a website established by another entity).	(b)(7)(i)(A)	
		c. Instructions for accessing CHNA report are clear.	(b)(7)(i)(A)	
		d. Individuals with Internet access can access and print reports without special software, without payment of a fee, and without creating an account.	(b)(7)(i)(A)	
		e. Individuals requesting a copy of the report(s) are provided the URL.	(b)(7)(i)(A)	
		f. Makes a paper copy available for public inspection upon request and without charge at the hospital facility.	(b)(7)(i)(B)	

Further IRS requirements available:

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