### CONTENTS

- Acknowledgements ............................................................................................................................2
- Healthy Marin Partnership Members .................................................................................................3
- CHNA Sub-Committee Members ........................................................................................................3
- Introduction/Background ......................................................................................................................4
  - About MarinHealth Medical Center ................................................................................................4
  - About MarinHealth Community Health .........................................................................................4
- Purpose of the Community Health Needs Assessment (CHNA) .......................................................5
- About Healthy Marin Partnership ......................................................................................................5
- Organizations that Collaborated on the Assessment ........................................................................5
- Consultants .........................................................................................................................................6
- Community Served .............................................................................................................................7
  - Report Availability, Comments and Adoption ................................................................................7
  - Hospital Service Area .......................................................................................................................7
- Process and Methods ..........................................................................................................................8
  - Secondary Data ...............................................................................................................................8
  - Community Input ............................................................................................................................8
  - Written Comments ..........................................................................................................................10
  - Data Limitations and Information Gaps ..........................................................................................10
- Identification and Prioritization of Community Needs .................................................................11
  - Definition of Health Need .............................................................................................................11
  - Methods Used to Identify Community Needs ...............................................................................11
  - Prioritization of Community Needs ..............................................................................................13
  - Description of the Prioritized Significant Community Needs .......................................................15
  - Community Resources Potentially Available to Respond to the Health Needs .........................19
- Demographic Profile of Marin County Residents ............................................................................20
  - Population .......................................................................................................................................20
  - Socioeconomic Data .......................................................................................................................21
- Evaluation of Impact ..........................................................................................................................22
- Appendix A. Secondary Data Sources ..............................................................................................26
- Appendix B. Community Stakeholders .............................................................................................29
- Appendix C. Health Need Profiles ....................................................................................................33
On behalf of Healthy Marin Partnership (HMP) and the Community Health Needs Assessment (CHNA) Sub-Committee, we want to thank all of the individuals who contributed to the development and completion of the 2019 CHNA. Thank you, specifically, to the members of our community, leaders in our community-based organizations, and key representatives from programs across the county who shared their knowledge and feedback during key informant interviews, group interviews, and focus groups. Individuals from a variety of disciplines came together to prioritize our community’s health needs, lending their time and expertise, for which we are extremely grateful. We would also like to thank our consultants, Harder+Company, for leading us through this process with excellent facilitation, data gathering and analysis, and report writing.
ACKNOWLEDGEMENTS

Healthy Marin Partnership Members

Patricia Kendall - HMP Co-Chair
Kaiser Permanente San Rafael Medical Center, Medical Group Administrator

Lisa Santora, MD, MPH - HMP Co-Chair
Marin County Department of Health and Human Services, Deputy Public Health Officer

T. Abraham
Hospital Council of Northern and Central California, Regional Vice President

Mary Jane Burke
Marin County Office of Education (MCOE), Superintendent of Schools

Leigh Burns, RDN CDE
MarnHealth, Manager of PRIME Programs & Supportive Care Center

Jenny Chacon
Marin County Health and Human Services, Chief Strategic Officer

Pamela Eck
Hospital Council of Northern and Central California, Regional Office Coordinator for T. Abraham

Rochelle Eram
Marin County Department of Health and Human Services, Community Epidemiology Program Director

Andrea Garfia
Sutter Novato Community Hospital, Community Health Coordinator

Kathy Koblick
Marin County Health and Human Services, Public Health Division Director

Cally Martin
Kaiser Permanente Northern California, Director of Community Benefit Operations

Reba Meigs
Marin County Health and Human Services, Nutrition Wellness Manager

Tori Murray, RDN
MarnHealth, Director of Integrative Health and Wellness

Alena Ritch-Wall
Kaiser Permanente Northern California, Regional Community Benefit Manager

Theresa Rockas
Kaiser Permanente San Rafael, Project Manager

Kristen Seatavakin, MPH
Marin County Department of Health & Human Services, Sr. Department Analyst

Kathy Sowers
Hospital Council of Northern and Central California, Regional Office Coordinator for Brian Jensen

Laura Trahan
Marin County Office of Education, Director, Education Services

Shirin Vakharia
Marin Community Foundation, Director for Health & Aging

Joanne Webster
San Rafael Chamber of Commerce, President and CEO

Matt Willis
Marin County Department of Health and Human Services, Public Health Officer

CHNA Sub-Committee Members

Lisa Santora, MD, MPH – HMP Co-chair
Marin County Department of Health & Human Services, Deputy Public Health Officer

Leigh Burns, RDN CDE
MarnHealth, Manager of PRIME Programs & Supportive Care Center

Rochelle Eram
Marin County Department of Health & Human Services, Community Epidemiology Program Director

Andrea Garfia
Sutter Novato Community Hospital, Community Health Coordinator

Cally Martin
Kaiser Permanente Northern California, Director of Community Benefit Operations

Reba Meigs
Marin County Health and Human Services, Nutrition Wellness Manager

Tori Murray, RDN
MarnHealth, Director of Integrative Health and Wellness

Alena Ritch-Wall
Kaiser Permanente Northern California, Regional Community Benefit Manager

Theresa Rockas
Kaiser Permanente San Rafael, Project Manager

Shirin Vakharia
Marin Community Foundation, Director Health & Aging
About MarinHealth Medical Center

MarinHealth Medical Center, formerly known as Marin General Hospital, is an independent, not-for-profit organization that has been meeting the community’s healthcare needs since 1952. Owned by the Marin Healthcare District, the 235-bed hospital is the only full-service, acute care hospital in the county. The publicly elected Marin Healthcare District Board of Directors works closely with the MarinHealth Medical Center Board of Directors to oversee operations of the hospital.

MarinHealth Medical Center operates the county’s only Designated Trauma Center, hospital labor and delivery services, and heart surgery programs. In keeping with the values and needs of its community, MarinHealth Medical Center is dedicated to treating the whole patient—mind, body and spirit. Its mission is to provide exceptional healthcare services in a compassionate and healing environment.

MarinHealth Medical Center offers advanced medical expertise, technology, and treatments in a healing environment, and offers patients the opportunity to complement their medical treatment with integrative therapies in both the hospital and outpatient setting through its Integrative Wellness Center. The MarinHealth enterprise includes the main inpatient hospital, outpatient departments, imaging centers, and MarinHealth Medical Network physician offices throughout the North Bay.

Construction is currently underway on an advanced, seismically safe new hospital that will provide an unparalleled healing environment for patients and visitors, staff, and physicians. Plans for the new hospital campus include a four-story, 260,000 square-foot hospital replacement building; a five-story, 100,000 square-foot ambulatory services building; and parking structure. The new hospital will be completed in 2020. Every aspect of the hospital will meet or exceed the latest state-mandated standards for earthquake safety. The hospital continues to operate throughout the construction process.

About MarinHealth Medical Center Community Health

As Marin’s Healing Place, MarinHealth Medical Center is dedicated to caring for all people in Marin throughout the lifespan, including the underserved or uninsured. Our commitment to the community goes beyond the expert medical care we provide during acute illness: we want to help the people we serve to be healthy and live well. To that end, we offer innovative programs such as the Braden Diabetes Center, which helps people manage diabetes effectively and enjoy a better quality of life. Our Integrative Wellness Center offers integrative treatments like massage, nutrition therapy, and acupuncture, to promote healing. We offer community health education programs for a wide range of topics such as childbirth, advance care planning, and falls prevention, through lectures, social media platforms, support groups, and our Health Connection e-newsletter. In addition, with robust care coordination, we provide support during transitions of care, and referrals to community services to enhance access to care and the overall patient experience.

As an independent district hospital, MarinHealth Medical Center is fully committed to serving the healthcare needs of the surrounding community. In addition to being the county’s only full-service acute care facility, it gives extensive charitable resources which support community needs such as access to care, education, and prevention and support for chronic disease management.
Access to health care is a priority community need addressed by MarinHealth Medical Center. As part of our commitment to increase access to care in the community, MarinHealth Medical Center supports primary care and specialty care services for the underserved provided by the MarinHealth Medical Network, a medical foundation with providers throughout the North Bay. We increase access to care through our innovative Supportive Care Center, which provides complex care management and palliative care to at-risk individuals, emphasizing the highest quality, person-centered, culturally appropriate care.

MarinHealth Medical Center partners with community-based organizations to increase access to primary healthcare and other health-related services. We implement programs that help community members manage chronic conditions such as diabetes or hypertension, access ambulatory care services such as dental care and behavioral health care, and transition to stable housing to maintain their health and wellness. Through state-funded initiatives such as the PRIME program, we ensure persons with Medi-Cal receive exceptional healthcare. This is done by nourishing strong communication channels with partner organizations to eliminate barriers to care, and redesigning care to reflect a person-centered, equitable population health focus.

Purpose of the Community Health Needs Assessment (CHNA)

California Senate Bill 697, enacted in 1994, and the Patient Protection and Affordable Care Act (ACA), enacted in 2010, included requirements for nonprofit hospitals to maintain their tax-exempt status. These regulations direct nonprofit hospitals to conduct a Community Health Needs Assessment (CHNA) and develop an Implementation Strategy (IS) every three years.

About Healthy Marin Partnership

MarinHealth Medical Center participated in a collaborative process for the CHNA as a member of the Healthy Marin Partnership (HMP). HMP is a collaborative of local agencies, organizations and individuals that are dedicated to improving the health and well being of all Marin residents. HMP recognizes the importance of taking a comprehensive view toward understanding community health needs, and acknowledges the critical advantage of working collaboratively to address these needs and advance health equity. HMP is a convener of local communities, organizations, agencies, and policymakers to explore strategies that can enable everyone in Marin to live a healthier life.

Healthy Marin Partnership’s Community Health Needs Assessment is a collaborative effort by Kaiser Permanente San Rafael Medical Center, MarinHealth Medical Center, Sutter Health Novato Community Hospital, Marin County Health and Human Services, and other community partners to assess the health status of Marin County residents and to prioritize areas for health improvement. This shared approach avoids duplication and focuses available resources on a community’s most important health needs.
Organizations that Collaborated on the Assessment

Through the HMP, MarinHealth Medical Center worked with local hospitals and other partner organizations with similar service areas in Marin County to support the CHNA. For the CHNA, this group developed a coordinated approach to primary data collection, and determined the list of significant health needs based on primary and secondary data analysis. MarinHealth Medical Center and the HMP partners then engaged a broader group of community stakeholders to prioritize the identified health needs.

Collaborative hospital partners:
- Kaiser Foundation Hospital – San Rafael
- MarinHealth Medical Center
- Sutter Health – Novato Community Hospital

Additional partners:
- Marin County Health and Human Services
- Healthy Marin Partnership
  - Hospital Council of Northern and Central California North Bay Leadership Council
  - Marin County Office of Education
  - Marin Community Foundation
  - San Rafael Chamber of Commerce

For MarinHealth Medical Center, the CHNA process was overseen by:

Leigh Burns, RDN, CDE  
Manager, PRIME Programs & Supportive Care Center

Tori Murray, RDN  
Director, Integrative Health & Wellness

Consultants

Harder+Company Community Research (Harder+Company) is a social research and planning firm with offices in San Francisco, Sacramento, Los Angeles, and San Diego. Harder+Company works with public sector, nonprofit, and philanthropic clients nationwide to reveal new insights about the nature and impact of their work. Through high-quality, culturally responsive evaluation, planning, and consulting services, Harder+Company helps organizations translate data into meaningful action. Since 1986, Harder+Company has worked with health and human service agencies throughout California and the country to plan, evaluate, and improve services for vulnerable populations. The firm’s staff offers deep experience assisting hospitals, health departments, and other health agencies on a variety of efforts including conducting needs assessments, developing and operationalizing strategic plans, engaging and gathering meaningful input from community members, and using data for program development and implementation. Harder+Company offers considerable expertise in broad community participation, which is essential to both health care reform and the CHNA process in particular. Harder+Company is the consultant on several CHNAs throughout the state, including other hospital service areas in Roseville, Sacramento, San Bernardino, Santa Rosa, South Sacramento, Vacaville, and Vallejo.
Report Availability, Comments and Adoption

This report is made available to the public on the hospital’s website, https://www.maringeneral.org/about-us/community-benefit.

To request a printed copy of the documents or to share any feedback/comments please contact Community Benefit at community.benefit@mymarinhealth.org.

This CHNA report was adopted by the MarinHealth Medical Center Board of Directors on September 3, 2019.

Hospital Service Area

MarinHealth Medical Center is located at 250 Bon Air Road, Greenbrae, CA 94904. The hospital service area comprises all of Marin County and includes the cities of: Belvedere, Corte Madera, Fairfax, Larkspur, Mill Valley, Novato, Ross, San Anselmo, San Rafael, Sausalito, Tiburon, and the coastal towns of Stinson Beach, Bolinas, Point Reyes, Inverness, Marshall, and Tomales. The service area was determined from the communities that reflect a majority of patient admissions.

Marin County is north of San Francisco by way of the Golden Gate Bridge. The county includes vast areas of open space, including National Protected areas (such as Muir Woods National Monument), State and Local Protected areas (such as Marin County Department of Parks and Open Space), and State Parks (such as Mount Tamalpais).

Much of Marin’s population lives along the Highway 101 corridor, creating an urban environment in the eastern-central part of the county and a more rural environment along the coast and the Highway 1 corridor in West Marin.

Marin has consistently been ranked by the Robert Wood Johnson Foundation’s County Health Rankings as one of the healthiest counties in California. For 9 out of the past 10 years, Marin has earned the top spot on this list. There is much to celebrate regarding the positive health outcomes in our county yet clear inequities still exist, illustrating that not all Marin County residents are able to achieve positive health outcomes.
Secondary Data
The MarinHealth Medical Center service area largely overlaps with the Kaiser Permanente-San Rafael service area, so for the purpose of this CHNA collaboration, data were used from the county and the Kaiser Permanente CHNA Data Platform (CHNA Data Platform). Harder+Company used the CHNA Data Platform (http://www.chna.org/kp) to review 130 indicators from publicly available data sources. Harder+Company also used additional data sources, including: California Healthy Kids Survey, Marin County Point in Time Homeless Count and Survey, and Commission on Aging: Housing Report.

The CHNA Data Platform is a web-based resource provided to support community health needs assessments and community collaboration. This platform includes a focused set of community health indicators that allow users to understand what is driving health outcomes in particular neighborhoods. The platform provides the capacity to view, map and analyze these indicators, identify racial/ethnic disparities, and compare local indicators with state and national benchmarks.

CHNA partners provided additional data (e.g., frequency tables, reports, etc.) to inform the identification and prioritization of health needs across the service area. These data provided additional context and, in some cases, more up-to-date statistics than the indicators included in the CHNA Data Platform. From these data, Health Need Profiles were developed that summarize significant community health needs. Each Health Need Profile includes a reference section with a detailed list of secondary data sources used in that profile. See Appendix A for a list of data sources.

Community Input
A broad range of community members provided community input through key informant interviews, group interviews, and focus groups. Individuals with the knowledge, information, and expertise relevant to the health needs of the community were consulted. These individuals included representatives from health departments, school districts, local non-profits, and other regional public and private organizations as well as community leaders, clients of local service providers, and other individuals representing medically underserved, low-income, and sub-populations that face unique barriers to health (e.g., race/ethnic minority populations, individuals experiencing homelessness). Interviews were conducted with 31 key informants and three focus groups, conducted in English and Spanish, engaged 22 community members. For a complete list of stakeholders and organizations that provided input, see Appendix B.

In an effort to include a wide range of diverse community voices including those who work with or represent underserved populations and geographic communities within the MarinHealth Medical Center service area, Harder+Company staff used several methods to identify communities for qualitative data collection activities. First, Harder+Company staff reviewed the participant lists from previous CHNA reports in the same service area. Second, they examined reports published by local organizations and agencies (e.g., county and city plans, community-based organizations) to identify additional high-need communities. Finally, staff researched local news stories to identify emerging health needs and social conditions affecting community health that may not yet be indicated in secondary data. The inclusion of service providers (through key informants and provider group interviews) and community members (through focus groups) allowed us to identify health needs from the perspectives of service delivery groups and beneficiaries.
The consulting team developed interview and focus group protocols, which the CHNA Sub-committee reviewed. Protocols were designed to inquire about health needs in the community, as well as a broad range of social determinants of health (i.e., social, economic, and environmental), behavioral, and clinical care factors. Some of the identified factors represented barriers to care while others identified solutions or resources to improve community health. Participants were also asked to describe any new or emerging health issues and to prioritize the top health concerns in their community.

Harder+Company used a single interviewer to conduct key informant interviews over the phone. A facilitator and note taker conducted the in-person provider group interviews and community focus groups. As long as respondents granted permission, all interviews were recorded and transcribed.

All qualitative data were coded and analyzed using ATLAS.ti software (GmbH, Berlin, version 7.5.18). A codebook with robust definitions was developed to code transcripts for information related to each potential health need, as well as to identify comments related to subpopulations or geographic regions disproportionately affected; barriers to care; existing assets or resources; and community-recommended health care solutions. At the onset of analysis, three interview transcripts (one from each type of data collection) were coded by all of the Harder+Company team members to ensure inter-coder reliability and minimize bias. Following the inter-coder reliability check, the codebook was finalized to eliminate redundancies and capture all emerging health issues and associated factors. All transcripts were analyzed according to the finalized codebook to identify health issues mentioned by interview respondents.

Primary qualitative (i.e., community input) data were essential for identifying needs that have emerged since the previous CHNA. Health need identification used qualitative data based on the number of interviewees or groups who referenced each health need as a concern, regardless of the number of mentions within each transcript.

For the primary data collection activities conducted in Spanish, bilingual staff from the Harder+Company team facilitated and took notes. As long as permission was granted, all recordings were transcribed, but not translated into English. Bilingual staff coded these transcripts and translated any key findings and representative quotes for the health need profiles.
**Written Comments**

In compliance with IRS regulations 501(r) for charitable hospitals, a hospital CHNA and Implementation Strategy must be made widely available to the public and public comment is to be solicited. The previous Community Health Needs Assessment and Implementation Strategy were available to the public on the hospitals website. To date, no comments have been received.

**Data Limitations and Information Gaps**

The CHNA data platform includes 130 secondary indicators that provide timely, comprehensive data to identify a community’s broad health needs. However, there are some limitations with regard to these data, as is true with any secondary data. Some data were only available at a county level, making it a challenge to assess health needs at the neighborhood level. Furthermore, disaggregated data around age, ethnicity, race, and gender are not available for all data indicators, which limited the ability to examine disparities of health within the community. Lastly, data are not always collected on a yearly basis, meaning that some data were several years old.

As is standard, the state average is used as a benchmark when available. Health indicators that perform poorly compared to the state are flagged as potential health needs. However, whether a hospital service area (HSA) indicator is on par with or better than the state average does not necessarily mean that ideal health outcomes or service quality exists.

Harder+Company also gathered extensive qualitative data to complement the quantitative data. Qualitative data is ideal for capturing descriptions of lived experiences, but it cannot be treated as representative of any population or community. Despite efforts to speak to a broad range of service providers and community members, several limitations to the qualitative data remain. First, although experts in their fields, some service providers expressed hesitation about speaking beyond their expertise areas, limiting their contribution to the identification of overall health needs and social determinants. Second, although likely reflective of workforce demographics, people of color were underrepresented in the service providers who engaged in data collection activities, which may limit perspectives captured. Third, in large part, community-based organizations helped to recruit community members for focus groups. This strategy is necessary for making contact with community members and for securing interview spaces that make participants feel safe. However, it inherently excludes individuals who are not engaged in services. To address this, Harder+Company collected data at several community events where individuals gather without directly receiving services. Finally, although, focus groups were conducted in English and Spanish, future CHNA processes should consider strategies to include data collection in additional languages that are prevalent in the service area.
Definition of Health Need
For the purposes of the CHNA, MarinHealth Medical Center defines a “health need” as a health outcome and/or the related conditions that contribute to a defined health need. Health needs are identified by the comprehensive identification, interpretation, and analysis of a robust set of primary and secondary data.

Methods Used to Identify Community Needs
Extensive secondary quantitative data (from the CHNA Data Platform and other publicly available data), as well as primary qualitative data collected from key informant interviews, provider focus groups, and group interviews, were synthesized and analyzed to identify the community health needs.

For the quantitative data, the Harder+Company team identified potential health needs by creating a matrix of health issues and associated secondary data. The CHNA Data Platform groups 130 specific health indicators into 14 health need categories (i.e., composites of individual indicators). The health needs are not mutually exclusive, as indicators can appear in more than one need. Individual indicator values are categorized as relatively better, worse, or similar to established benchmark data, in most cases, the California state average estimate. Indicators identified as on average worse than the benchmark were flagged as potential health needs. In addition, regardless of comparison to the benchmark, any indicator with data reflecting racial or ethnic disparities was also marked as a potential health need.

For the qualitative data, the Harder+Company team read and coded transcripts from all primary data collection activities (i.e., key informant interviews, focus groups, and provider group interviews). The analysis included grouping individual qualitative themes (e.g., green spaces, safe spaces, food security, obesity, diabetes) into health need categories (e.g., healthy eating and active living) similar to those identified in the CHNA Data Platform. Health need categories that were identified in the majority of data collection activities (i.e., the majority of key informant interviews, the majority of group interviews, and the majority of focus groups) were evaluated as potential health needs.
The final process to determine whether each health issue qualified as a health need drew upon both secondary and primary data, as follows:

1. A health need category was identified as a high need based on secondary data from the CHNA Data Platform if it met any of the following conditions:
   • Overall severity: at least one indicator Z-score within the health need was much worse or worse than benchmark.
   • Disparities: at least one indicator Z-score within the health need was much worse or worse than benchmark for any defined racial/ethnic group.
   • External benchmark: indicator value worse than an external goal (e.g., state average, county data, and Healthy People 2020).

2. A health need category was identified as high need based on primary data if it was identified as a theme in a majority of key informant interviews, group interview, and focus groups.

3. Classification of primary and secondary data was combined into the final health need category using the following criteria:
   • Yes: high need indicated in both secondary and across all types of primary data. CHNA partners then confirmed these health needs.
   • Maybe: high need indicated only in secondary data and/or some primary data. These health issues were further discussed with CHNA partners to determine final status.
     - If a health need was mentioned overwhelmingly in primary data but did not meet the high need criteria for secondary data, the Harder+Company team conducted an additional search for secondary data sources that indicated disparities (e.g., geographic, race/ethnicity, and age) to ensure compliance with both primary and secondary criteria.
     - In some cases, multiple indices were merged into one health need if there were cross-cutting secondary indicators or themes from the qualitative data.
   • No: high need indicated in only one or fewer sources.

As a result of these processes, the following significant health needs were identified:
• Access to health care
• Economic security
• Education
• Healthy eating and active living
• Housing and homelessness
• Maternal and infant health
• Mental health/substance use and misuse
• Oral health
• Social connections
• Violence/injury prevention
Prioritization of Community Needs

For each identified community health need, Harder+Company developed a written profile. These health need profiles summarized primary and secondary data, including statistics on sub-indicators, quantitative and qualitative data on regional and demographic disparities, commentary and themes from primary data, contextual information on main drivers and community assets, and suggested solutions. Profiles for all of the identified health needs are included in Appendix C. Health Need Profiles.

Harder+Company then facilitated an in-person prioritization meeting in late 2018 with regional CHNA partners and stakeholders (including service providers, residents, and others) to prioritize the health needs. The meeting began with a brief presentation of each health need profile, highlighting major themes and disparities, followed by small-group discussions of the health needs, including the consideration of the following agreed-upon criteria for prioritization:

- **Severity**: Severity of need demonstrated in data and interviews. Potential to cause death or extreme/lasting harm. Data significantly varies from state benchmarks. Magnitude/scale of the need, where magnitude refers to the number of people affected.

- **Clear Disparities or Inequities**: Health need disproportionately impacts specific subpopulations based on geography, age, gender, race/ethnicity, or sexual orientation.

- **Impact**: The ability to create positive change around this issue, including potential for prevention, addressing existing health problems, mobilizing community resources, and the ability to affect several health issues simultaneously.

Compared to other counties in California, Marin remains a relatively healthy county in which to live, work, play, raise a family, and grow older. However, many individuals and communities in Marin do not have access to resources and good health. During the small-group discussions, meeting participants considered countywide needs as well as ways in which specific health issues may disproportionately impact some populations or communities more than others.

After small-group discussions, meeting participants discussed key insights for each health need with the larger group and then voted to determine the final ranked list of health needs. Participants voted either individually or as a voting bloc if there were multiple stakeholders from the same organization. Participants ranked the health needs three times, once for each prioritization criteria (i.e., severity, disparities, impact), on a scale from 1-10 (1=lowest priority; 10=highest priority). Ranking required that no two health needs were scored the same within each criterion. The following table provides the scores used for ranking and the weighted score across the three criteria.
After small-group discussions, meeting participants discussed key insights for each health need with the larger group and then voted to determine the final ranked list of health needs. Participants voted either individually or as a voting bloc if there were multiple stakeholders from the same organization. Participants ranked the health needs three times, once for each prioritization criteria (i.e., severity, disparities, impact), on a scale from 1-10 (1=lowest priority; 10=highest priority). Ranking required that no two health needs were scored the same within each criterion. The following table provides the scores used for ranking and the weighted score across the three criteria.

<table>
<thead>
<tr>
<th>Health Need</th>
<th>Rank 1 (Highest Priority)</th>
<th>Composite Weighted Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic Security</td>
<td>1</td>
<td>887.5</td>
</tr>
<tr>
<td>Education</td>
<td>2</td>
<td>854.5</td>
</tr>
<tr>
<td>Mental Health/Substance Use</td>
<td>3</td>
<td>842.5</td>
</tr>
<tr>
<td>Access to Care</td>
<td>4</td>
<td>800</td>
</tr>
<tr>
<td>Housing and Homelessness</td>
<td>5</td>
<td>767.5</td>
</tr>
<tr>
<td>Healthy Eating and Active Living</td>
<td>6</td>
<td>682.5</td>
</tr>
<tr>
<td>Maternal and Infant Health</td>
<td>7</td>
<td>546</td>
</tr>
<tr>
<td>Violence/Injury Prevention</td>
<td>8</td>
<td>454</td>
</tr>
<tr>
<td>Oral Health</td>
<td>9</td>
<td>432.5</td>
</tr>
<tr>
<td>Social Connection</td>
<td>10</td>
<td>388.5</td>
</tr>
</tbody>
</table>
Description of the Prioritized Significant Community Needs

Summaries of the health needs for the service area follow. The order of the health needs reflects the final prioritization of needs.

- **Economic Security**: Economic security means having the financial resources, public supports, and career and educational opportunities that are necessary to live your fullest life. While Marin County ranks among the top in the country in terms of economic wealth and community resources, 50 percent of residents spend 30 percent or more of household income on rent.\(^1\) Importantly, many residents expressed that the County’s riches are unevenly distributed and not available to all. These divides are particularly stark along lines of race/ethnicity and citizenship status. For example, roughly, 60 percent of Black and Hispanic populations in Marin County are living below the 250 percent federal poverty line compared to 21 percent of the White population. In the state, the average is 35 percent.\(^2\) Further, U.S. born residents in Marin County have an average annual wage of $75,493 compared to $23,742 for undocumented immigrants.\(^3\) Geographically, outcomes related to education, employment, and wage demonstrate a glaringly uneven distribution, with the Canal region and West Marin facing the greatest barriers to economic security. The percentage of businesses owned by minorities is roughly 15 percent in Marin County compared to nearly 46 percent across the state of California.\(^4\) In focus groups, participants connected economics and health by reporting the necessity of working multiple jobs and the long commutes needed to get from where they can afford to live to where jobs are available. These factors can lead to mental and physical health issues.

- **Education**: Educational attainment is a primary factor that influences individual health. It can shape the economic opportunities that impact health outcomes, as well as inform people how to live a healthy lifestyle. While some education outcomes are higher for Marin County when compare to California, disparities—particularly among English language learners, African Americans, and Latino students—indicate that educational equality is a high concern in the county. Among White third graders, 76 percent demonstrate English and language arts proficiency compared to 32 percent of Latino students and 27 percent of African Americans.\(^5\) In mathematics, 73 percent of White third graders are proficient compared to 28 percent of Latino student and 31 percent of African Americans.\(^6\) Disparities in achievement outcomes (e.g., reading/math proficiency) and educational attainment (e.g., college attendance). For example, 85 percent of White 3 and 4 year olds attend preschool compared to 35 percent of Latinos.\(^7\) Among 16-24 year olds, college attendance among Whites is 80 percent compared to 47 percent for Black/African Americans and 37 percent for Hispanic/Latinos.\(^8\) These racial disparities also extend to a sense of belonging at school, with 23 percent of African American 7th graders reporting a high level of school connectedness compared to 75 percent of Whites.\(^9\) Many community members signaled educational equity and increased health awareness as strategies necessary to advancing health goals.

---

\(^1\) American Community Survey. (2012-16).
\(^2\) Ibid.
\(^3\) USC Dornsife, Center for the Study Immigrant Integration. Sanchez et al 2016. https://idornsife.usc.edu/csii/publications/
\(^4\) Healthy People 2020; US Census Bureau – Economic Census 2012
\(^6\) Ibid.
\(^7\) http://www.marinkids.org/wp-content/uploads/2015/02/Education-Data-20141.pdf
\(^8\) American Community Survey. (2012-16).
• **Mental Health/Substance Use:** Marin County residents demonstrate high need in addressing mental health issues, indicated by rates of suicide, medication for mental health issues, and substance abuse treatment. 15 percent of Marin County adults take daily prescriptions for mental health issues, which is higher than the California rate of 11 percent. 10 In Marin County, mental health issues frequently coexist with substance use. In the service area, 21 percent of adults report excessive drinking, higher than the California average of 18 percent. 11 The suicide rate is particularly high among non-Hispanic White and non-Hispanic Black residents, at 13 per 100,000 and 12 per 100,000 respectively; this is roughly twice the rate of suicide among Hispanic/Latinos in the region. 12 In focus groups, community members discussed the stigma around mental illness, a lack of access to mental health providers, and limited treatment options for people who are experiencing homelessness as major concerns.

• **Access to Care:** Access to health care includes insurance coverage, physician access, and availability and affordability of emergency and specialty health services. Access to quality health care is important to overall health, disease prevention, and reducing unnecessary disability and premature death. It is also an important key driver in achieving health equity. While Marin County scores better than the California state average on many indicators measuring health care access, the county has not yet met the Healthy People 2020 benchmark for insurance coverage. In particular, almost half of undocumented immigrants (48 percent) lack insurance coverage compared to 6 percent of U.S. born citizens. 13 Group interview participants were aware of the disparity and reported that the county continues to work toward providing affordable and culturally competent care for all residents, especially community members who are undocumented. Racial minority groups and lower income individuals also face greater challenges in obtaining affordable care. There are also important disparities by income, with fewer women on Medi-Cal receiving prenatal care during their first trimester (89 percent) compared to 94 percent of all pregnant women in Marin County. 14 Additionally, focus group participants expressed that, as Marin’s population ages, innovative options for those who wish to age in place or who are unable to travel to receive health care services will be important. The elderly are less physically mobile, experience more frequent health issues, and often survive on fixed incomes.

• **Housing/Homelessness:** Marin County’s high cost of housing exacerbates issues related to health care access and affordability, which in turn has a negative impact on health outcomes in the area. More than half of renters pay 30 percent or more of their income on rent. 15 Focus group participants shared that, in some neighborhoods, residents fear displacement due to rising housing costs and gentrification. These circumstances are exacerbated by racial inequities since a quarter of Black or Latino residents in Marin own homes compared to two thirds of White residents. 16 Further, housing costs present unique challenges for older adults who wish to age in place but who often live on a fixed income and may require additional services and supports as their needs change. Additionally, homelessness exposes individuals to increased health risks, especially as 63 percent of Marin’s homeless population is unsheltered, 17 and service providers have difficulty linking persons who are experiencing...

---

10 Ibid.
12 CDPH. (2010-12). (Death Master Files, pulled from 2015 Pathways to Progress)
14 Family Health Outcomes Project, California Maternal Child and Adolescent Health 2012.
16 Ibid.
homelessness to supportive housing and health care services. Racial minorities are disproportionately represented among persons experiencing homelessness, and the portion of youth experiencing homelessness has increased in recent years. Twenty-nine percent of those experiencing homelessness are between 18-24 years old, an increase from 6 percent in 2013.

**Healthy Eating and Active Living (HEAL):** Rates of obesity and diabetes are lower in Marin County compared to California. However, there is a high prevalence of youth in the service area who are overweight or obese, especially among Black (18 percent), Hispanic (20 percent), and Native American/Alaska Native populations (24 percent). Disparities also exist in rates of cancer, which is 483 per 100,000 persons among Whites, compared to a rate of 326 per 100,000 persons among Asian and Pacific Islanders. Black residents have the highest rate of cardiovascular disease, at 174 per 100,000 persons, compared to 112 per 100,000 persons among Whites. This is also true for strokes, for which Blacks have a rate of 53 per 100,000 persons compared to 23 per 100,000 persons among Whites. Healthy lifestyle choices greatly affect the rates of chronic conditions like cardiovascular disease, stroke, and cancer. For example, focus group participants noted the lack of resources for education around diabetes management. They also expressed that access to healthy food is a top concern.

**Maternal and Infant Health:** Maternal and infant health describes the health concerns of mothers and their newborn children, and many of the indicators in this category are predictive of health outcomes over the life course. The county has a lower maternal mortality rate, but still struggles with many issues relating to child health and development. For example, of the 750 children on Marin Childcare Council’s waiting list, 288 are infants. In interviews, service providers highlighted the racially concentrated nature of maternal and infant health concerns, 83 percent of African American mothers and 88 percent of Latina mothers receive first trimester prenatal care compared to 94 percent of Whites. Further, African Americans have higher rates of pregnancy-related death and lower rates of prenatal care than other ethnicities. Additionally, the Marin County Hispanic/Latino population has a teen birthrate 20 times higher than their White counterparts. Focus group participants expressed the need for improved childcare and better educational options.

**Violence/Injury Prevention:** Violence and injury prevention covers a broad category of health related indicators, including physical abuse and accidental poisoning. These health-related events are concentrated among certain populations. Marin County has several issues related to violence and injury that present distinct challenges. Due to heavy manual labor, many work-related injuries affect day laborers, particularly community members who are undocumented and 20 percent of day laborers report being injured on the job. Crime rates are unevenly distributed, across racial groups and neighborhoods. For example, juvenile felony arrests

---

18 Ibid.
20 FITNESSGRAM® Physical Fitness Testing (2016-17)
21 CDPH 2010-12 (Death Master Files, pulled from 2015 Pathways to Progress)
22 Ibid.
23 Ibid.
26 Centers for Disease Control and Prevention, Birth Certificate Data 2008-17
28 Family Health Outcomes Project, California Maternal Child and Adolescent Health
occurred at a rate of 43 per 100,000 persons among the Black/African American population compared to 10 per 100,000 persons among Hispanic/Latinos, and 2 per 100,000 persons among Whites.\textsuperscript{30} Conditions that increase the likelihood of involvement with the juvenile justice system include family poverty, separation from family members, including parental incarceration, a history of maltreatment, exposure to violence, and discrimination by law enforcement. The city of San Rafael has a violent crime rate nearly twice as high as Novato.\textsuperscript{31} Community residents expressed concern that crime reporting had decreased as a result of recent Immigration and Customs Enforcement (ICE) raids and that some youth in the Canal Area cities feel pressured to join gangs. Finally, older adults face unique challenges related to physical accidents, as falls are the leading cause of fatal injuries. 20 percent of seniors report a fall each year\textsuperscript{32} and most homes are not designed for aging in place and universal accessibility.

- **Oral Health**: Oral health is a key indicator of overall health. The impact of untreated oral health conditions disproportionately affects the most vulnerable populations and contributes to conditions such as cardiovascular disease, and poor pregnancy and birth outcomes. Although tooth decay and gum disease are preventable, inadequate access to dental insurance and dental providers, and underutilization of dental care, are affecting the oral health of Marin County residents. For example, 43 percent of adults in Marin County do not have dental insurance compared to the state average of 39 percent.\textsuperscript{33} The incidence rate of oral cavity and pharynx cancer is 14 per 100,000 persons, which is higher than the California average of 10 per 100,000 persons.\textsuperscript{34} Marin County has not reached the Healthy People 2020 goal for children’s dental health provision,\textsuperscript{35} and Denti-Cal reimbursement rates are low, indicating an opportunity for improving utilization. Key informant and focus group participants reported that dental insurance is difficult to obtain, and specialty care, like oral surgery, is not affordable.

- **Social Connection**: Social connections can directly impact mental health, and their influence on lifestyle have important consequences for physical health. Only 18 percent of residents feel they have insufficient social and emotional support compared to the California average of 25 percent.\textsuperscript{36} However, economic inequality and the county’s rapidly aging population increase the risk of social isolation. For example, 54 percent of individuals over 65 years of age reported eating alone, and 44 percent reported living alone.\textsuperscript{37} Further, the lack of alternative forms of transportation in rural towns, and racial segregation in parts of Marin County, create barriers to community cohesion. According to the residential segregation dissimilarity index, Whites and Hispanics in the San Rafael area in particular, experience a high degree of census tract separation.\textsuperscript{38} Racial and ethnic minority students report bullying and a lack of connection to their schools; White 7th graders are three times more likely to feel connected to their schools than African Americans, and 50 percent more likely than Latinos.\textsuperscript{39} Key informants reported that language barriers lead to further isolation among immigrant communities.
Populations such as the LGBTQ community and people experiencing homelessness report a lack of safe and welcoming social spaces. Finally, at both ends of the age spectrum, youth and older adults desire social connection; youth want opportunities for positive mentorship and older adults desire more community events.

Community Resources Potentially Available to Respond to the Health Needs
The MarinHealth Medical Center service area includes community-based organizations, government departments and agencies, hospital and clinic partners, and other community members and organizations engaged in addressing many of the health needs identified by this assessment. Examples of community resources potentially available to respond to community-identified health needs are indicated in the Health Need Profiles found in Appendix C. For additional resources, contact 2-1-1 OR 800-273-6222, or reference https://www.211ca.org and enter the topic and/or city of interest.
Population
Marin County is home to 260,814 residents. With a median age of 46.1 and a high percentage of older adults, Marin County is one of the “oldest” counties in the Bay Area. Persons over the age of 60 are estimated to number 72,684, comprising 28% of the County’s total population. By 2030, persons over 60 will account for at least 33% of the population. Statewide, persons over 60 account for 18% of the population.

Youth, 19 and under, make up 22% of Marin’s population. Due to the high cost of living in Marin County, families with young children face significant challenges. Almost one-fourth (23%) of Marin County children are living at or below 199% of the Federal Poverty level ($50,000 for a family of 4). Families must make difficult decisions about paying for housing, paying for food, and paying for quality childcare and education for their children.

In Marin County, 51% of the population is female and 49% is male.

Population by Race
The majority of the population in Marin County is non-Hispanic White (71.9). 15.6% of the population is Hispanic/Latino, 5.6% of the population is Asian, and 2.3% of the population is Black/African American. The remaining 4.6% of the population is multiple races, other races, Native Alaskans, Native Hawaiians and Native Americans.

---

40 U.S. Census Bureau, Population Estimates Program (PEP), ACS
41 U.S. Census Bureau, Population Estimates Program (PEP), ACS
42 American Community Survey 2017
43 Area Plan for Aging 2016-2020 FY 2018/2019 Update
Socioeconomic Data
Median income is a helpful indicator of a community’s economic health but does not tell the whole story. A high median income can mask disparities in income levels among residents. These divides are considerable among minority and immigrant populations. Geography, education, employment, and wage outcomes demonstrate an uneven distribution of income with the Canal region and West Marin facing the greatest barriers to economic security. 8.08% of Marin’s population lives below 100% of the Federal Poverty Level (FPL). In the County, 9.89% of children live in poverty. The unemployment rate in the county is 2.2%, 6.89% of the population has no high school diploma, and 6.38% of the population is uninsured.

<table>
<thead>
<tr>
<th>Socioeconomic Data</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living in poverty (&lt;100% federal poverty level)</td>
<td>8.08%</td>
</tr>
<tr>
<td>Children in poverty</td>
<td>9.89%</td>
</tr>
<tr>
<td>Unemployment</td>
<td>2.20%</td>
</tr>
<tr>
<td>Uninsured population</td>
<td>6.38%</td>
</tr>
<tr>
<td>Adults with no high school diploma</td>
<td>6.89%</td>
</tr>
</tbody>
</table>

Homelessness
Marin County conducted the biennial Point-in-Time homeless count in January 2019. The results of the count identified 1,034 homeless individuals. Of the 257 people experiencing chronic homelessness, 86 (33.5%) were in an emergency shelter the night of the count, and 171 (66.5%) were unsheltered chronic homeless individuals. The unsheltered chronic homeless decreased by 41% from the 2017 count.

Population Experiencing Homelessness by Race, 2017

Data drawn from the CHNA data platform. See Appendix A.
MarinHealth Medical Center conducted their previous CHNA in 2016, and significant health needs were identified from primary and secondary data sources. In developing the hospital’s Implementation Strategy associated with the 2016 CHNA, MarinHealth Medical Center chose to address healthcare access, through a commitment of community benefit programs and resources. Access to healthcare focused on the ability to utilize and pay for comprehensive, affordable, quality physical, mental and oral healthcare. This is essential to maximize the prevention, early intervention, and treatment of health conditions such as obesity, cancer, heart disease, asthma, oral health, mental health, substance abuse and diabetes.

To accomplish the Implementation Strategy, goals were established for the expected outcomes and/or desired improvements in health needs resulting from a strong commitment to community programs and activities. Strategies to address the identified health needs were designed, and impact measures tracked. The following section outlines the impact made on the selected significant health needs since the 2016 CHNA.
Community Grants Program

Knowing it could not improve access to care without community partners, the hospital engaged the resources of community groups. In 2017, 11 agencies were funded through the Community Benefit Grants Program. In 2018, 12 agencies were funded and in 2019, 13 agencies were funded.

<table>
<thead>
<tr>
<th>Organizations</th>
<th>Health Needs Addressed</th>
<th>Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buckelew</td>
<td>Access to Care Mental Health</td>
<td>Grant Purpose – Support Casa Rene, a short-term residential program for patients referred from County Psychiatric Emergency Services for further stabilization and treatment.</td>
</tr>
<tr>
<td></td>
<td>Social Supports</td>
<td>Accomplishments – Casa Rene improved its occupancy rate from 72% in FY16, to 80% in FY17. Clients were referred to crisis planning or referred to outpatient services when appropriate. Casa Rene continues to focus on staff training to meet client needs, as well as an agency-wide update to technology infrastructure for better data gathering and usage.</td>
</tr>
<tr>
<td>Coastal Health Alliance</td>
<td>Access to Care</td>
<td>Grant Purpose – Increase access to dental care.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Accomplishments – 2017 saw increase in demand: the number of uninsured patients served rose to 214, up from 112 the prior year. The number of dental visits more than doubled: 659 in 2017, compared to 296 in 2016.</td>
</tr>
<tr>
<td>Community Institute for Psychotherapy</td>
<td>Access to Care Mental Health</td>
<td>Grant Purpose – Provide mental health treatment for low-income families, adults and children.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Accomplishments – provided 758 hours of mental health treatment to almost 40 patients. 2017 saw a 30% increase in “unusual occurrence” reports (i.e. threats or acting out against self or others), and dozens of involuntary psychiatric holds (5150s) – higher than any other single year. By working with private and public agencies, the necessary treatments and referrals were provided.</td>
</tr>
<tr>
<td>Homeward Bound</td>
<td>Access to Care Social Supports</td>
<td>Grant Purpose – Provide respite care and transitional shelter to homeless individuals.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Accomplishments – 53 persons were served and 88% were able to obtain housing or access to a permanent program. All program residents were linked to a medical home, enrolled in health insurance and avoided 565 avoidable hospital days.</td>
</tr>
<tr>
<td>Marin Center for Independent Living</td>
<td>Access to Care Social Supports</td>
<td>Grant Purpose – provide benefits planning, advocacy and access to care as a core service to underserved clients.</td>
</tr>
<tr>
<td></td>
<td>Cancer</td>
<td>Accomplishments – 180 individuals were served by this grant. 50 breast cancer patients received benefits counseling. Eight outreach meetings and community forums were held; 63 clients were referred to other agencies.</td>
</tr>
<tr>
<td>Organizations</td>
<td>Health Needs Addressed</td>
<td>Programs</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Marin Community Clinics</td>
<td>Access to Care Healthy Eating and Active Living</td>
<td>Grant Purpose – Expand pediatric, family primary care, OB/GYN and behavioral health services. Accomplishments – Provided nutrition and health education services to prevent and manage chronic diseases, including hypertension and diabetes. MCC had over 34,021 patients and outreach/health education services were provided to approximately 5,500 individuals. They had a total of 126,850 medical visits. 2,120 patients with diabetes received care and 910 nutrition patient visits were completed. 3,374 patients with hypertension received care.</td>
</tr>
<tr>
<td>Operation Access</td>
<td>Access to Care</td>
<td>Grant Purpose – Free outpatient surgery to persons who would not have access to care. Accomplishments – Provided 311 donated surgical procedures and diagnostic services for 225 Marin County residents. 90% of patients reporting improved health and improved ability to work as a result of the surgery.</td>
</tr>
<tr>
<td>Ritter Center</td>
<td>Access to Care Mental Health Substance Abuse</td>
<td>Grant Purpose – Integrated healthcare services. Accomplishments – Ritter Center provided medical, mental health, and alcohol/drug treatment services to more than 1,600 unduplicated patients in 2017.</td>
</tr>
<tr>
<td>RotaCare San Rafael</td>
<td>Access to Care Healthy Eating and Active Living</td>
<td>Grant Purpose – Free clinic operations support/volunteer recruitment and retention. Accomplishments – RotaCare Clinic of San Rafael provided services to 3,800 patients. RotaCare actively engaged 126 persons as volunteers. The clinic continues to maintain specialty clinics. The clinics are for nutritional support, stress management, dermatology, diabetes podiatry and vaccine. The clinic is leveraging resources to provide a specialty clinic with the focus on asthma and respiratory issues.</td>
</tr>
<tr>
<td>Senior Access</td>
<td>Access to Care Social Supports</td>
<td>Grant Purpose – Adult Day Health Program financial assistance. Accomplishments – Over 15,000 hours of respite care were provided for family caregivers in Marin County. Thirty Senior Access clients were supported throughout 2017.</td>
</tr>
<tr>
<td>Whistle Stop</td>
<td>Access to Care</td>
<td>Grant Purpose – Transportation access to healthcare pilot program. Accomplishments – Through their transportation programs utilizing the Lyft Concierge platform, WhistleStop ensured clients were able to keep their medical appointments. In 2017 they provided 532 client rides for 116 unduplicated riders. 93% of clients stated they would not have been able to attend their appointment without this service.</td>
</tr>
</tbody>
</table>
MarinHealth Medical Center has supported primary care and specialty care services for the uninsured provided by the MarinHealth Medical Network, a medical foundation with providers located throughout the North Bay. In 2017, these clinics served 6,651 low-income patients over 20,741 visits, including Medi-Cal and Charity Care patients.

MarinHealth Medical Center has been collaborating with Operation Access since 2000. Operation Access brings together medical professionals and hospitals to provide donated outpatient surgical and specialty care for the uninsured and underserved. In 2018, MarinHealth Medical Center waived more than $1.025 million in hospital charges.

Access to care also included access to preventive care, chronic disease management resources and maternal/child health resources. In 2017 and 2018, MarinHealth Medical Center accomplished the following:

- Provided financial assistance for uninsured/underinsured and low-income residents. Following our Financial Assistance Policy, the hospital provided discounted and free healthcare to qualified individuals.
- Community education and support groups addressing a variety of health issues were offered to community members free of charge. More than 4,900 persons were reached.
- Mammograms were provided at low cost to 31 underserved women.
- Transportation was provided for low-income persons to access healthcare services.
- Free education, counseling and support were offered to breastfeeding women. More than 2,770 encounters were provided.
- The Supportive Care Center was developed in partnership with MarinHealth Medical Network to enhance care coordination activities and eliminate barriers to care.
## Sources from the CHNA Data Platform

<table>
<thead>
<tr>
<th>Source</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Community Survey</td>
<td>2012-2016</td>
</tr>
<tr>
<td>American Housing Survey</td>
<td>2011-2013</td>
</tr>
<tr>
<td>Area Health Resource File</td>
<td>2006-2016</td>
</tr>
<tr>
<td>California Department of Education</td>
<td>2014-2017</td>
</tr>
<tr>
<td>California EpiCenter</td>
<td>2013-2014</td>
</tr>
<tr>
<td>California Health Interview Survey</td>
<td>2014-2016</td>
</tr>
<tr>
<td>Center for Applied Research and Environmental Systems</td>
<td>2012-2015</td>
</tr>
<tr>
<td>Centers for Medicare and Medicaid Services</td>
<td>2015</td>
</tr>
<tr>
<td>Climate Impact Lab</td>
<td>2016</td>
</tr>
<tr>
<td>County Business Patterns</td>
<td>2015</td>
</tr>
<tr>
<td>County Health Rankings</td>
<td>2012-2014</td>
</tr>
<tr>
<td>Dartmouth Atlas of Health Care</td>
<td>2012-2014</td>
</tr>
<tr>
<td>Decennial Census</td>
<td>2010</td>
</tr>
<tr>
<td>EPA National Air Toxics Assessment</td>
<td>2011</td>
</tr>
<tr>
<td>EPA Smart Location Database</td>
<td>2011-2013</td>
</tr>
<tr>
<td>Fatality Analysis Reporting System</td>
<td>2011-2015</td>
</tr>
<tr>
<td>FBI Uniform Crime Reports</td>
<td>2012-2014</td>
</tr>
<tr>
<td>FCC Fixed Broadband Deployment Data</td>
<td>2016</td>
</tr>
<tr>
<td>Feeding America</td>
<td>2016</td>
</tr>
<tr>
<td>FITNESSGRAM® Physical Fitness Testing</td>
<td>2016-2017</td>
</tr>
<tr>
<td>Food Environment Atlas (USDA) &amp; Map the Meal Gap (Feeding America)</td>
<td>2014</td>
</tr>
<tr>
<td>Health Resources and Services Administration</td>
<td>2016</td>
</tr>
<tr>
<td>Institute for Health Metrics and Evaluation</td>
<td>2014</td>
</tr>
<tr>
<td>Interactive Atlas of Heart Disease and Stroke</td>
<td>2012-2014</td>
</tr>
<tr>
<td>Mapping Medicare Disparities Tool</td>
<td>2015</td>
</tr>
<tr>
<td>National Center for Chronic Disease Prevention and Health Promotion</td>
<td>2015</td>
</tr>
<tr>
<td>National Center for Education Statistics-Common Core of Data</td>
<td>2015-2016</td>
</tr>
<tr>
<td>National Center for Education Statistics-EDFacts</td>
<td>2014-2015</td>
</tr>
<tr>
<td>National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention</td>
<td>2013-2014</td>
</tr>
<tr>
<td>National Environmental Public Health Tracking Network</td>
<td>2014</td>
</tr>
<tr>
<td>National Flood Hazard Layer</td>
<td>2011</td>
</tr>
<tr>
<td>National Land Cover Database 2011</td>
<td>2011</td>
</tr>
</tbody>
</table>
# APPENDIX A.
## SECONDARY DATA SOURCES

<table>
<thead>
<tr>
<th>Source</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Survey of Children’s Health</td>
<td>2016</td>
</tr>
<tr>
<td>Nielsen Demographic Data (PopFacts)</td>
<td>2014</td>
</tr>
<tr>
<td>North America Land Data Assimilation System</td>
<td>2006-2013</td>
</tr>
<tr>
<td>Opportunity Nation</td>
<td>2017</td>
</tr>
<tr>
<td>Safe Drinking Water Information System</td>
<td>2015</td>
</tr>
<tr>
<td>State Cancer Profiles</td>
<td>2010-2014</td>
</tr>
<tr>
<td>US Drought Monitor</td>
<td>2012-2014</td>
</tr>
<tr>
<td>USDA - Food Access Research Atlas</td>
<td>2014</td>
</tr>
<tr>
<td>Additional sources</td>
<td></td>
</tr>
<tr>
<td>American Association of Retired Persons</td>
<td>2012</td>
</tr>
<tr>
<td>Area Agency on Aging Marin County Plan</td>
<td>2016-2020</td>
</tr>
<tr>
<td>Behavioral Risk Surveillance Task Force</td>
<td>2017</td>
</tr>
<tr>
<td>Brown University, Diversity and Disparities Project</td>
<td>2010</td>
</tr>
<tr>
<td>California Department of Education, School Level Data Files</td>
<td>2014-2015</td>
</tr>
<tr>
<td>California Department of Public Health</td>
<td>2010-2012</td>
</tr>
<tr>
<td>California Department of Public Health, Kindergarten Assessment Results</td>
<td>2013-15</td>
</tr>
<tr>
<td>California Health Interview Survey</td>
<td>2014-2015</td>
</tr>
<tr>
<td>California Healthy Kids Survey</td>
<td>2017-2018</td>
</tr>
<tr>
<td>California Office of Traffic Safety (OTS)</td>
<td>2016</td>
</tr>
<tr>
<td>California Oral Health Reporting</td>
<td>2008-2010</td>
</tr>
<tr>
<td>Centers for Disease Control</td>
<td>2013</td>
</tr>
<tr>
<td>Centers for Disease Control and Prevention</td>
<td>2008-2017</td>
</tr>
<tr>
<td>Commission on Aging, Housing Report</td>
<td>2018</td>
</tr>
<tr>
<td>County Business Patterns</td>
<td>2015</td>
</tr>
<tr>
<td>Insight Center</td>
<td>2012</td>
</tr>
<tr>
<td>Kidsdata.org, California Dept. of Justice, Criminal Justice Statistics Center</td>
<td>2016</td>
</tr>
<tr>
<td>Marin Community Clinic</td>
<td>2013-2015</td>
</tr>
<tr>
<td>Marin County Human Development Report</td>
<td>2012</td>
</tr>
<tr>
<td>Marin County Oral Health Report</td>
<td>2014</td>
</tr>
<tr>
<td>Marin County Point in Time Homeless Count and Survey</td>
<td>2015</td>
</tr>
<tr>
<td>Marin Independent Journal</td>
<td>2015</td>
</tr>
<tr>
<td>MarinKids</td>
<td>2015</td>
</tr>
</tbody>
</table>
APPENDIX A.
SECONDARY DATA SOURCES

Maternal and Infant Health Assessments, California Department of Public Health ...........2013-2015
National Cancer Institute ...........................................................................................................2011-2015
National Survey of Children’s Exposure to Violence .................................................................2015
Same as above ............................................................................................................................2016
The California Pregnancy-Associated Mortality Review, California Department 
of Public Health ......................................................................................................................2002-2007
U.S. Census Bureau (Economic Census) .................................................................................2012
UCLA Newsroom .......................................................................................................................2006
Uniform Crime Reporting Statistics, U.S. Department of Justice ..........................................2012
USC Dornsife, Center for the Study Immigrant Integration ......................................................2016
<table>
<thead>
<tr>
<th>#</th>
<th>Data collection method</th>
<th>Title/name</th>
<th>Number</th>
<th>Target group(s) represented</th>
<th>Role in target group</th>
<th>Date input was gathered</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Key Informant Interview</td>
<td>Marin Food Policy Council (Program Manager)</td>
<td>1</td>
<td>health department representative minority medically underserved low-income</td>
<td>Service provider</td>
<td>10/3/18</td>
</tr>
<tr>
<td>2</td>
<td>Key Informant Interview</td>
<td>Canal Alliance (Family Resource Manager)</td>
<td>1</td>
<td>minority medically underserved low-income</td>
<td>Service provider</td>
<td>8/30/18</td>
</tr>
<tr>
<td>3</td>
<td>Key Informant Interview</td>
<td>City of San Rafael (Chief of Police)</td>
<td>1</td>
<td>minority medically underserved low-income</td>
<td>Service provider</td>
<td>9/5/18</td>
</tr>
<tr>
<td>4</td>
<td>Key Informant Interview</td>
<td>Marin Transit (Director of Policy and Legislative Programs)</td>
<td>1</td>
<td>minority medically underserved low-income</td>
<td>Service provider</td>
<td>9/18/18</td>
</tr>
<tr>
<td>5</td>
<td>Key Informant Interview</td>
<td>Marin County Dept. of Health &amp; Human Services, Behavioral Health and Recovery Services (Director)</td>
<td>1</td>
<td>health department representative minority medically underserved low-income</td>
<td>Service provider</td>
<td>8/28/18</td>
</tr>
<tr>
<td>6</td>
<td>Group Interview</td>
<td>Substance Use/Behavioral Health: RxSafe Marin (Coordinator), National Alliance of Mental Illness Marin (executive Director), North Marin Community Services (Director of Mental Health Programs)</td>
<td>3</td>
<td>health department representative minority medically underserved low-income</td>
<td>Service providers</td>
<td>10/8/18</td>
</tr>
</tbody>
</table>
## APPENDIX B.
### COMMUNITY STAKEHOLDERS

<table>
<thead>
<tr>
<th>Data collection method</th>
<th>Title/name</th>
<th>Number</th>
<th>Target group(s) represented</th>
<th>Role in target group</th>
<th>Date input was gathered</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 Group Interview</td>
<td>Healthcare Delivery/Access: Coastal Health Alliance (CEO), Marin City Health and Wellness Center (CEO), Marin Community Clinics (CEO), RotaCare Clinic of San Rafael (Medical Director)</td>
<td>4</td>
<td>health department representative minority medically underserved low-income</td>
<td>Service providers</td>
<td>10/11/18</td>
</tr>
<tr>
<td>8 Group Interview</td>
<td>Economic Development: Marin Economic Forum (Board member), San Rafael Chamber of Commerce (President and CEO), Novato Chamber of Commerce (CEO), Latino Council of Marin (Executive Director), North Bay Leadership Council (President and CEO)</td>
<td>5</td>
<td>health department representative minority low-income</td>
<td>Service providers</td>
<td>10/15/19</td>
</tr>
<tr>
<td>9 Group Interview</td>
<td>Disabilities: Marin Center for Independent Living (Executive Director), Buckelew Programs (CEO), Whistlestop (Healthcare Market Strategist), Casa Allegra (Executive Director), Marin Ventures (Executive Director), Marin IHSS Public Authority (Executive Director)</td>
<td>6</td>
<td>health department representative minority medically underserved low-income</td>
<td>Service providers</td>
<td>9/21/18</td>
</tr>
</tbody>
</table>
## APPENDIX B. COMMUNITY STAKEHOLDERS

<table>
<thead>
<tr>
<th>Data collection method</th>
<th>Title/name</th>
<th>Number</th>
<th>Target group(s) represented</th>
<th>Role in target group</th>
<th>Date input was gathered</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organizations</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Group Interview</td>
<td>Housing/Safety Net: Ritter Center (Executive Director), Homeward Bound (Executive Director and Chief Provider of Homeless Services), St. Vincent de Paul Society (Executive Director), Marin Housing Authority (Executive Director), Whole Person Care Marin County (Director), Downtown Streets Team (Program Director)</td>
<td>8</td>
<td>health department representative minority medically underserved low-income</td>
<td>Service providers</td>
<td>9/19/18</td>
</tr>
<tr>
<td><strong>Community residents</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focus Group</td>
<td>Youth: Youth served by the Marin County Youth Court program located in San Rafael</td>
<td>6</td>
<td>minority low-income</td>
<td>Community members</td>
<td>9/5/18</td>
</tr>
<tr>
<td>Focus Group</td>
<td>LGBT: LGBT community members served by the Spahr Center located in San Rafael</td>
<td>7</td>
<td>low-income</td>
<td>Community members</td>
<td>9/21/18</td>
</tr>
<tr>
<td>Focus Group</td>
<td>ESL: Parent members of the District English Language Learners Advisory Council of San Rafael City Schools</td>
<td>9</td>
<td>minority medically underserved low-income</td>
<td>Community members</td>
<td>10/2/18</td>
</tr>
</tbody>
</table>
Focus Group and Group Interview participants completed an optional survey. These data were used to inform representation of the four target groups during data collection events.

- **Medically underserved**  
  *Focus Groups:* One or more participant indicated they have “No Insurance”  
  *Group Interviews:* One or more participant indicated they identify as a leader, representative, or member of the medically underserved community.

- **Low-income**  
  *Focus Groups:* One or more participant indicated they are a recipient of government programs; and/or their family earns less than $20,000/year.  
  *Group Interviews:* One or more participant indicated they identify as a leader, representative, or member of any of the low-income community.

- **Minority**  
  *Focus Groups:* One or more participant indicated their race/ethnicity as non-White.  
  *Group Interviews:* One or more participant indicated they identify as a leader, representative, or member of any of the minority community.

- **Health department representative**  
  *Focus Groups:* N/A  
  *Group Interviews:* One or more participant indicated they identify as a leader, representative, or member of any of a health department or the health care sector.
Health need profiles focus on the identified significant health needs and include primary data (i.e. qualitative findings from focus groups, key informant interviews, and group interviews) and secondary data (regional statistics).

Access to quality health care is important to overall health, disease prevention, and reducing unnecessary disability and premature death. Importantly, it is also one of the key drivers in achieving health equity. While Marin County scores better than the California state average on many indicators measuring health care access, the county has not yet met the Healthy People 2020 benchmark for insurance coverage. Further, the county continues to work towards providing affordable and culturally competent care for all residents, especially community members who are undocumented. Racial minority groups and lower income individuals also face great challenges in obtaining affordable care. Additionally, as Marin’s population ages, innovative options for those who wish to age in place or are unable to travel will be key.

## Key Data

### Indicators

**Adults with Health Insurance: 18-64 (89.8%) compared to Healthy People 2020 target (100%)**

- 89.8%
- 100%

**Children with Health Insurance: 0-17 (99.2%) compared to Healthy People 2020 target (100%)**

- 99.2%
- 100%

**Federally Qualified Health Centers (rate per 100,000)**

- California: 2.51
- San Rafael service area: 5.61

### Qualitative Themes

#### Availability of Services
- Appointment wait times and distances traveled with few public transit options
- Food and shelter are prioritized when money is tight

#### System Navigation
- Language/cultural barriers (e.g., fear of deportation for accessing services)
- Siloed organization making care coordination difficult

---

"They told me I don’t qualify for Medi-Cal, that I earn too much ... They don’t understand that with every additional dollar you’re earning, the rent goes up by that much, too. [Original in Spanish]
- Focus Group Participant"

---


---
APPENDIX C.
HEALTH NEED PROFILES

Access to Care

Populations Disproportionately Affected

**Populations with Greatest Risk**

Percentage of the population without health insurance

<table>
<thead>
<tr>
<th>Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>26.15%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>21.34%</td>
</tr>
<tr>
<td>NH PI</td>
<td>18.84%</td>
</tr>
<tr>
<td>NAAN</td>
<td>12.44%</td>
</tr>
<tr>
<td>Black</td>
<td>8.53%</td>
</tr>
<tr>
<td>Multi</td>
<td>5.98%</td>
</tr>
<tr>
<td>Asian</td>
<td>5.92%</td>
</tr>
<tr>
<td>NH White</td>
<td>3.88%</td>
</tr>
</tbody>
</table>

**CA (12.59%)**
San Rafael service area (7.25%)

88.5% of Marin kindergartners start school with all required immunizations

Compared to 92.8% of kindergartners statewide *

93.6% of pregnant women in Marin initiated prenatal care during their first trimester in 2012

Compared to 88.5% of women covered by Medi-Cal.  6

*Marin rates were 80% in 2013-14 and 84% in 2014-15. Coverage varies widely (29%-100%) from school to school, creating communities more prone to outbreaks. Schools serving higher income communities have worse rates of immunization.  5

**Percent uninsured by legal immigration status**

- Unauthorized residents (48%)
- Authorized immigrants (22%)
- Lawful permanent residents (22%)
- Naturalized residents (8%)
- U.S. born citizens (6%)

"We are in a difficult time here right now with some of our immigrant population not being comfortable signing up for healthcare or other things through a government agency because they’re not sure of what will happen to them because of immigration or ICE."

- Key Informant
**APPENDIX C. HEALTH NEED PROFILES**

**Access to Care**

**Populations Disproportionately Affected**

**Geographic Areas with Demographic Change**

Areas with the greatest change in elderly population by 2030:

- **Highest**
  - Fairfax (54% increase)
  - Corte Madera (53%)
  - Novato (41%)

- **Lowest**
  - Belvedere (-12%)
  - Tiburon (16%)
  - Sausalito (21%)

**Emerging Needs**

For the “very old” (over 85) in California,

- **7.5%** Require full-time Nursing care
- **6.8%** Require full-time Assisted Living
- **11%** Receive Home Care
- **1.4%** Receive Adult Day Services

---

"For seniors, especially homeless seniors that don’t have an adequate healthcare system that can really deal with issues like dementia, there just is no place for them to go."
- **Key Informant**

There’s a long waiting list, and meanwhile you have somebody in crisis, who you have to say to: ‘Hold onto that depression. Three months from now we’ll be able to see you.’
- **Key Informant**
APPENDIX C. HEALTH NEED PROFILES

Access to Care

Assets and Ideas

**Examples of Existing Community Assets**

- Low cost or free community clinics
- Public assistance programs (such as Medi-Cal)
- Coordinated entry database/communications among social and medical service agencies
- Community organizations, committees, and support groups

**Ideas from Focus Groups and Interview Participants**

- Increase number of bilingual and bicultural service providers
- Confront stigma around accessing mental health care services
- Increase place-based health delivery, such as mobile health clinics and home-based care
- Integrate currently fragmented channels of care (primary, dental, mental health, substance abuse, social services)

2. Same as above.
3. Provider of Services File - Number of Federally Qualified Health Centers (FQHCs)
4. American Community Survey (2012-16)
6. Family Health Outcomes Project, California Maternal Child and Adolescent Health
8. American Community Survey (2012-16)
9. CDC's “Long Term Care Services in the US: 2013.”
Economic security means having the financial resources, public supports, career and educational opportunities necessary to be able to live your fullest life. As such, this health need touches upon every other health-related issue in the Marin community from mental health to housing. While Marin County ranks among the top in the country in terms of economic wealth and community resources, many residents expressed that these riches are unevenly distributed and not available to all. These divides are particularly stark along lines of race/ethnicity and citizenship status. Geographically, education, employment, and wage outcomes demonstrate a starkly uneven distribution with the Canal region and West Marin facing the greatest barriers to economic security.

### Key Data

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Marin County</th>
<th>California</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income inequality (Gini Coefficient): Where 0 is full equality</strong>¹</td>
<td>0.488</td>
<td>0.525</td>
</tr>
<tr>
<td><strong>Renters spending 30% or more of household income on rent</strong>²</td>
<td>49.8%</td>
<td>56.5%</td>
</tr>
<tr>
<td><strong>Firms owned by minorities</strong>³</td>
<td>14.6%</td>
<td>45.6%</td>
</tr>
</tbody>
</table>

**Qualitative Themes**

**Income Inequality**
- Community is split into "two different worlds" based on income disparity
- Worker exploitation / intimidation common among undocumented community members; people are forced into accepting lower wages

**High Cost of Living**
- Reduced budget for healthy food, enrichment opportunities for children, and medical treatment
- Economic necessity of working many jobs and long commutes lead to stressors on mental and physical health

"From an outsider's point of view, you could say Marin county is a very wealthy place. I know there's been some surveys that say it's one of the most healthy, but it does come down to the haves and the have-nots."
- **Key Informant**

"There's affordable on the Federal level and there's affordable for Marin. They are not the same."
- **Key Informant**
**APPENDIX C. HEALTH NEED PROFILES**

**Economic Security**

**Populations Disproportionately Affected**

### Populations with Greatest Risk

Individuals living below 250% of the federal poverty level

- **Black:** 66.00%
- **Hispanic:** 62.00%
- **White:** 21.00%

- **CA (35%)**
- **Marin (28%)**

---

**Unemployment rates across Marin County**

- **6%** of 18-64 year olds in Marin County are unemployed
- **18%** of Black 18-64 year olds in Marin County are unemployed
- **7%** of Hispanic 18-64 year olds in Marin County are unemployed
- **5%** of White 18-64 year olds in Marin County are unemployed

---

“In Marin County, we have the largest income gap between rich and poor—and White and people of color—in the entire state.

- *Focus Group Participant*
APPENDIX C.
HEALTH NEED PROFILES

Economic Security

Populations Disproportionately Affected

Geographic Areas with Greatest Risk

San Rafael, Sausalito/Marin City, and Shoreline School Districts have the highest percent of children eligible for free or reduced priced meals (over 60% of children).

Average Income

Downtown, Tiburon ($81,000)

5% Latino, 87% White

Canal Neighborhood, San Rafael ($21,000)

76% Latino, 13% White

There is a fourfold difference in income between Tiburon and San Rafael.

Emerging Needs

Median Annual Wages of Residents in Marin County

- U.S. born residents: $75,493
- Naturalized residents: $58,000
- Lawful permanent residents: $43,815
- Authorized immigrants: $37,600
- Un-authorized immigrants: $23,742

Residents living below 100% Federal Poverty Level

- Undocumented: 38%
- U.S. Born: 11%

Many people that live here, their children can't afford to live here, so even the natural supports that would typically be there ... are missing in our community. That will feed the epidemic as people age.

- Key Informant
APPENDIX C.
HEALTH NEED PROFILES

Assets and Ideas

Examples of Existing Community Assets

- Low cost or free community clinics
- Public assistance programs (such as Medi-Cal)
- Community organizations, committees, and support groups
- Community food pantries

Ideas from Focus Groups and Interview Participants

- Reduce cost of transportation by making more of the community accessible for walking and biking
- Find ways for higher and lower income community members to relate to one another and create cohesive community
- Increase awareness of availability of in-home medical care
- Include community perspective in the development of strategic plans

2. Same as above
3. Healthy People 2020; US Census Bureau - Economic Census 2012
4. American Community Survey (2012-16)
5. Same as above
8. Same as above
Educational attainment is linked to health throughout the lifespan. While some education outcomes are higher for Marin County than the rest of California, disparities—particularly among English language learners, African Americans, and Latino students—indicate that educational equality is a high concern in the county. These disparities are present both among educational attainment (e.g., college attendance) and achievement (e.g., reading/math proficiency) outcomes. Many community members signaled educational equity and increased health awareness as important strategies to advance health goals.

### Key Data

#### Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Marin County</th>
<th>California</th>
<th>San Rafael service area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults with some post-secondary education&lt;sup&gt;1&lt;/sup&gt;</td>
<td>63.6%</td>
<td>72.9%</td>
<td></td>
</tr>
<tr>
<td>Preschool enrollment&lt;sup&gt;2&lt;/sup&gt;</td>
<td>48.6%</td>
<td>67.8%</td>
<td></td>
</tr>
</tbody>
</table>

<sup>1</sup> Marin’s adult education rate is below the state average and below the county average.

<sup>2</sup> Marin’s preschool enrollment rate is lower than Marin County and California averages.

"It really starts with the younger kids where they started not having access to preschool, or to quality daycare. And then they kind of start at a lower level once they start school."
- **Key Informant**

"Education level is one of the biggest social determinates of health... Because if they don’t have that, they won’t be able to get a decent job, or live in a decent place, or be probably civically engaged to keep the community strong."
- **Key Informant**

#### Qualitative Themes

- **Quality of preK-12 education and school environment**
  - Strive to provide universal access to preschool/early childcare
  - Difficulty with retaining quality workforce due to high cost of living for educators

- **Access to community-level and higher education**
  - Desire for greater education around preventive healthcare, such as nutrition, diabetes prevention, and identifying symptoms of poor mental health
  - Foreign-born parents wish to improve their English, but lack time

81% of Marin households with less than a high school diploma live below the self-sufficiency standard

20% of Marin households with a bachelor degree or higher live below the self-sufficiency standard<sup>3</sup>
APPENDIX C.
HEALTH NEED PROFILES

Education

Populations Disproportionately Affected

Populations with Greatest Risk

High school dropout rates, 4-year cohort starting in 2013\textsuperscript{4}

- Hispanic: 14%
- Black: 12%
- Multiracial: 11%
- Asian: 3%
- White: 3%

Preschool attendance in 3 and 4 year-olds\textsuperscript{5}
- 85% of Whites
- 35% of Hispanic/Latinos

College attendance in 16-24 year-olds\textsuperscript{6}
- 80% of Whites
- 47% of Black/African Americans
- 37% of Hispanic/Latinos

Standardized testing proficiency

**White, Hispanic/Latino/a, and Black/African American students**\textsuperscript{7}

### English Language Arts/Literacy

- 3rd Grade: 76%, 32%, 27%
- 8th Grade: 66%, 24%, 18%
- 11th Grade: 48%, 24%, 9%

### Mathematics

- 3rd Grade: 73%, 28%, 31%
- 8th Grade: 77%, 38%, 34%
- 11th Grade: 81%, 46%, 49%
Emerging Needs

Percent who did not graduate from high school

- Unauthorized residents (50%)
- Authorized immigrants (22%)
- Lawful permanent residents (18%)
- Naturalized residents (11%)
- U.S. born citizens (3%)

Non-English speakers by residency

- 8% (1,704 Naturalized Residents)
- 42% (5,530 [Undocumented] Immigrants)
- 21% (594 Authorized Immigrants)
- 16% (1,901 Lawful Permanent Residents)

I have to improve my English. Why? Because if you see the school meetings, the first time, everyone comes. The second meeting no one comes anymore because they already know it will just be in English.

- Focus Group Participant
APPENDIX C.
HEALTH NEED PROFILES

Education

Assets and Ideas

Examples of Existing Community Assets

- Community organizations and resources that support first generation college students
- Multiple options for university attendance
- High degree of parent involvement
- Strong public school system

Ideas from Focus Groups and Interview Participants

- Increase community-based, culturally appropriate education initiatives around identifying and treating chronic diseases and mental health problems
- Advocate for alternatives to incarceration for youth in the criminal justice system
- Increase opportunities for professional development/training
- Increase support (i.e., counselors, therapists) in schools

1. American Community Survey (2012-16)
2. Same as above.
5. MarinKids.org
6. American Community Survey (2012-16)
9. Same as above.
Healthy Eating and Active Living (HEAL) relates to Marin residents’ ability to shape health outcomes through a focus on nutrition and physical activity. While rates of obesity and diabetes are lower in Marin County compared to California as a whole, there is still a high prevalence of adults and youth in Marin County who are overweight or obese, especially among Black and Hispanic populations. Further, healthy lifestyle choices greatly impact the rates of chronic conditions like cardiovascular disease, stroke, and cancer. Access to healthy food is a top concern, particularly in specific geographically isolated areas of the county.

### Key Data

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Qualitative Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adults who are obese¹</strong></td>
<td><strong>Inequities in treatment and prevention of chronic disease</strong></td>
</tr>
<tr>
<td>15.7 per 100,000 population in Marin County compared to</td>
<td>• Economic barriers and under-insurance impede preventative care</td>
</tr>
<tr>
<td>30.5 the Healthy People 2020 target</td>
<td>• Lack of educational resources for management and prevention of chronic disease</td>
</tr>
<tr>
<td><strong>Age-adjusted death rate due cancer²</strong></td>
<td><strong>Barriers to physical activity/healthy food</strong></td>
</tr>
<tr>
<td>116 per 100,000 population in Marin County compared to</td>
<td>• High concentration of fast food and liquor stores</td>
</tr>
<tr>
<td>161.4 the Healthy People 2020 target</td>
<td>• Childcare providers have limited policies and systems to support healthy eating an active living</td>
</tr>
<tr>
<td><strong>Age-adjusted death rate due to coronary heart disease³</strong></td>
<td></td>
</tr>
<tr>
<td>52.1 per 100,000 population in Marin County compared to</td>
<td></td>
</tr>
<tr>
<td>103.4 the Healthy People 2020 target</td>
<td></td>
</tr>
</tbody>
</table>

“It’s cheaper to go to McDonald’s than it is to go to Whole Foods. And if you’re working for 12 to 14 hours a day, how are you gonna go out and take an hour and a half walk?
- Key Informant

Someone recently said finding a diabetes doctor is like winning the lottery. That’s a whole other thing because when I tried to find a diabetes doctor, two out of the three doctors had a nine-month waiting list in Marin.
- Focus Group Participant
### Populations with Greatest Risk

**Obesity percentage among youth in the San Rafael service area**

- Native American/Alaska Native: 24%
- Hispanic: 22%
- Black: 18%
- Multiracial: 13%
- White: 9%
- Asian: 6%

**Percentage of 6th graders taking California Department of Education physical fitness test who meet fitness standards**

- 34% of those economically disadvantaged
- 52% of those not economically disadvantaged

**Incidence rates for Cancer, Heart Disease, and Stroke per 100,000 population by race/ethnicity from 2010-2012**

- **Cancer**
  - Asian Pacific Islander: 326
  - Black/African American: 457
  - Hispanic/Latino/a: 365
  - White: 483

- **Heart Disease**
  - Asian Pacific Islander: 86
  - Black/African American: 174
  - Hispanic/Latino/a: 24
  - White: 112

- **Stroke**
  - Asian Pacific Islander: 17
  - Black/African American: 53
  - Hispanic/Latino/a: 20
  - White: 28
Populations Disproportionately Affected

Populations with Greatest Risk

Prevalence of diabetes among patients at the Marin Community Clinic

- Asian Pacific Islander (15%)
- White (10%)
- African American (7%)

Prevalence of food insecurity

- 1 in 7 Caucasians
- 1 in 3 Asians and Pacific Islanders
- 1 in 2 African Americans and Latinos

"[The uninsured] are buying food, they're paying rent, instead of coming and utilizing the healthcare system. What does that result in? Inequities in cancer screenings, inequities in chronic disease control rates... We know that the life expectancy gap in Marin County, half of it's attributed to chronic disease, heart attack, strokes.
- Key Informant"

Geographic Areas with the Greatest Risk

Lynwood, and Hamilton Novato
Canal Area, San Rafael

Three of Marin's census tracts—Hamilton, the Canal area of San Rafael and the Lynwood section of Novato—have been deemed “food deserts” by the USDA. Food deserts are low-income neighborhoods without ready access to healthy and affordable food.

"If you're familiar with the Canal, it's only like one street and then you have all these others shops, mechanics, and fumes, and all that stuff. There is a community center and a park here that is owned by the city, but the park really has minimal things for the kids.
- Key Informant"
APPENDIX C.
HEALTH NEED PROFILES
Healthy Eating, Active Living (HEAL)

Assets and Ideas

Examples of Existing Community Assets

- Existing bike lanes and safe sidewalks (e.g., Safe Routes to School network)
- Uptake of Food Pharmacies and Parks Prescription programs
- Community centers with sports programs and social gatherings over healthy meals
- Meals on Wheels; food pantries and “food trucks” that accept CalFresh

Ideas from Focus Groups and Interview Participants

- Increase peer to peer and group-oriented services for disease management to help people learn about nutrition and make healthy lifestyle changes
- Increase access to general preventative care resources, and education around chronic disease management
- Increase number of bilingual and bicultural service providers, across medical and social services
- Improve zoning regulations to separate commercial/industrial and residential areas

2. Same as above.
3. Same as above.
4. FITNESSGRAM® Physical Fitness Testing (2016-17)
6. CDPH 2010-12 (Death Master Files, pulled from 2015 Pathways to Progress)
Marin County’s high cost of living exacerbates issues related to healthcare access and affordability. More than half of renters pay 30 percent or more of their income on rent; and in some neighborhoods, residents fear displacement due to rising housing costs and gentrification. Further, housing costs present unique challenges for older adults who wish to age in place but who may require additional services and supports as their needs change.

Additionally, homelessness exposes individuals to increased health risks. Service providers have difficulty linking persons who are experiencing homelessness to supportive housing and healthcare services. Racial minorities are disproportionately represented among persons experiencing homelessness and the portion of youth experiencing homelessness has increased in recent years.

**Key Data**

**Indicators**

Households with at least one of four housing problems: overcrowding, high housing costs, lack of kitchen, or lack of plumbing facilities\(^1\)

- Marin County: 24.3%
- California: 27.9%

Renters spending 30% or more of household income on rent\(^2\)

- Marin County: 49.8%
- California: 56.5%

Proportion of sheltered and unsheltered homeless individuals\(^3\)

- Sheltered: 37%
- Unsheltered: 63%

**Qualitative Themes**

**Increasing population experiencing homelessness**
- Different issues for those experiencing chronic versus temporary homelessness
- Housing is the first step in improving health for individuals experiencing homelessness

**Unsustainably rising rent**
- Money spent on rent takes away from preventive and urgent medical care
- Service providers cannot afford to live in Marin; long commute times are unhealthy
- Precarious housing a reality for many; overcrowded, poor living conditions

"There are no starter homes, there's no place for families to be reformed on one income or just one spouse. One spouse income? Forget about it.
- *Key Informant*

"The fact is that Marin as a whole, sees homelessness as a failing of the person experiencing homelessness and not a failing of the society that allowed them to become homeless. I think that really creates barriers.
- *Key Informant*
Populations with Greatest Risk

Race/ethnicity demographics of those experiencing homelessness

- White: 62%
- Black: 20%
- Hispanic/Latino: 15%

**Characteristics of those who are homeless**

- 44% Have psychiatric or emotional conditions
- 27% Have chronic health problems (2% have HIV/AIDS)
- 28% Have Post Traumatic Stress Disorder (PTSD)
- 7% Have a traumatic brain injury
- 26% Have a physical disability

*Getting a 30-hour-a-week job at minimum wage somewhere is huge victory. Guess what? They’re still homeless. That doesn’t feel right.*  
- Key Informant
APPENDIX C. HEALTH NEED PROFILES

Housing and Homelessness

Populations Disproportionately Affected

**Population with Greatest Risk**

- **Home Ownership**
  - 2/3 of those who are White own their home
  - 1/4 of those who are Black or Latino own their home

- **Overcrowding** is experienced by...  
  - 50% of those undocumented
  - 11% Authorized immigrants
  - 12% Lawful permanent residents
  - 1% U.S. born and naturalized citizens

“...The people we serve in the Canal have 8 to 10 people in a 2 bedroom apartment paying 200 bucks a month for 10x10 square feet on the floor to put their sleeping bag down with access to a bathroom and no access to the kitchen in place that is moldy with cockroaches.

- **Key Informant**

**Emerging Needs**

**Older Adults in Marin**

- The older adult population will increase 37% by 2030 in Marin County

- 90% of older adults intend to stay in their own homes for the next 5-10 years

- 70% of older adult homeowners have not created a "second unit," to provide space for caregivers.

“We have folks who have lived in the community for many years. They have a fall. They have a medical episode. They go into the hospital. And now the home that they lived in for 20-plus years is no longer accessible to them.

- **Key Informant**
### Assets and Ideas

#### Examples of Existing Community Assets

- **Coordinated entry database/communications among social and medical service agencies**
- **Nonprofits and community organizations working to address housing crisis**
- **Programs that connect residents in affordable housing to other social/medical services**
- **Available shelters and affordable housing units**

#### Ideas from Focus Groups and Interview Participants

- Fund service providers/increase services that help older adults age in place
- Increase cooperative/shared housing options, specifically for younger generations
- Build more affordable housing units at all income levels
- Multi-pronged approach that gives persons experiencing homelessness jobs/purpose while providing them housing

---

4. Same as above.
5. Same as above.
10. Same as above.
The San Rafael service area has a lower infant mortality rate than California, and the county has a lower maternal mortality rate, but still struggles with many issues relating to child health and development. Focus group participants expressed the need for childcare and improved educational options. Further, service providers highlighted the racially concentrated nature of maternal and infant health concerns: African Americans have higher rates of pregnancy-related death and lower rates of pre-natal care than other ethnicities. Hispanic/Latino populations have higher teen birthrates and lower pre-school attendance than White counterparts.

### Key Data

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Qualitative Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Infant mortality rate per 1,000 live births</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
<td><strong>Lack of affordable options for young families with children</strong></td>
</tr>
<tr>
<td>San Rafael service area: 3.6</td>
<td>• Many families share houses with several other families</td>
</tr>
<tr>
<td>California: 5.0</td>
<td>• Lack of childcare options within families’ budgets</td>
</tr>
<tr>
<td><strong>Percent of first trimester initiation of prenatal care</strong>&lt;sup&gt;2&lt;/sup&gt;</td>
<td><strong>Youth focused issues</strong></td>
</tr>
<tr>
<td>Medi-Cal Recipients: 88.5%</td>
<td>• Need for universal pre-k and early education</td>
</tr>
<tr>
<td>Marin County: 93.6%</td>
<td>• Pressure on children from a young age to succeed socially and academically</td>
</tr>
</tbody>
</table>

There are currently **750** children on the Marin Childcare Council’s waiting list for subsidized childcare, **288** of these are infants.<sup>4</sup>

> I think with the high cost of living, it also affects the lack of childcare, not having qualified people that can take care of your children while you work two jobs.
> - Key Informant
## APPENDIX C. HEALTH NEED PROFILES

## Maternal and Infant Health

### Populations Disproportionately Affected

#### Populations with Greatest Risk

<table>
<thead>
<tr>
<th>Group</th>
<th>Pregnancy-related mortality rate per 1,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>39.9</td>
</tr>
<tr>
<td>Hispanic</td>
<td>8.9</td>
</tr>
<tr>
<td>White</td>
<td>8.5</td>
</tr>
</tbody>
</table>

#### Percent receiving 1st trimester pre-natal care

- **White**: 94%
- **Asian**: 91%
- **Hispanic/Latino/a**: 88%
- **Black/African American**: 83%

### Emerging Needs

#### Pre-school attendance among 3 and 4 year-olds

- **85%** of Whites
- **35%** of Hispanic/Latino/as

---

A lot of the cases that I hear, in talking with my staff, it’s families who have immigrated here from Mexico, Central America, South America primarily, and the trauma that they’ve brought with them ... Even young children have experienced it.

- *Key Informant*

Latinas have a teen birth rate more than **20** times higher than their White counterparts.

---
APPENDIX C.
HEALTH NEED PROFILES

Maternal and Infant Health

Assets and Ideas

Examples of Existing Community Assets

- Parenting classes
- Parks (i.e., places to play)
- Services for mothers with post-partum depression

Ideas from Focus Groups and Interview Participants

- Increase support (i.e., counselors, therapists) in schools
- Implement universal pre-school program
- Improve access to midwives, doulas and alternative care

1. Area Health Resource File (Health Resources & Services Administration)
2. California Dept. of Public Health, Immunization Branch, Kindergarten Assessment Results
6. Centers for Disease Control and Prevention, Birth Certificate Data 2008-17
8. Family Health Outcomes Project, California Maternal Child and Adolescent Health
Marin County residents demonstrate high need in mental health issues, including suicide rate, medication for mental health issues or substance abuse treatment. Mental health issues frequently co-exist with substance abuse. The San Rafael service area ranks above the California averages for alcohol abuse and opioid deaths. The suicide rate is particularly high among non-Hispanic Whites. Access to mental health providers and treatment was also raised as a key concern by community members.

**Key Data**

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Qualitative Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of adults who report excessive drinking¹</td>
<td>Lack of culturally appropriate care and resources</td>
</tr>
<tr>
<td>18%</td>
<td>• Language and cultural barriers prevent patients from feeling comfortable or understood by providers</td>
</tr>
<tr>
<td>21%</td>
<td>• Feeling of isolation within LGBTQ community</td>
</tr>
<tr>
<td>California</td>
<td>Availability of mental health services</td>
</tr>
<tr>
<td>San Rafael service area</td>
<td>• Mental health care is inaccessible and unaffordable for many people</td>
</tr>
<tr>
<td>Adults needing help with mental, emotional, or substance use problems²</td>
<td>• Lack of specialized services for senior population with mental health needs</td>
</tr>
<tr>
<td>15.1%</td>
<td></td>
</tr>
<tr>
<td>HealthyPeople 2020 Goal</td>
<td></td>
</tr>
<tr>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Marin County</td>
<td></td>
</tr>
<tr>
<td>Percentage of adults taking daily prescriptions for mental health issues³</td>
<td></td>
</tr>
<tr>
<td>11%</td>
<td></td>
</tr>
<tr>
<td>14.8%</td>
<td></td>
</tr>
<tr>
<td>California</td>
<td></td>
</tr>
<tr>
<td>Marin County</td>
<td></td>
</tr>
</tbody>
</table>

"Young people are so desperate to talk about their mental health needs - it's just a suicide conversation. We're not teaching them to talk about this from point A, it just becomes point C, "I'm suicidal."
- Key Informant

There is still the stigma of mental health and substance abuse. In many communities, the concept of mental health is so foreign or not even part of their culture.
- Key Informant
### Populations with Greatest Risk

<table>
<thead>
<tr>
<th>Suicide Rate per 100,000 population</th>
<th>Student-reported use of alcohol or any illegal drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic/Latinos</td>
<td>Hispanic/Latinos</td>
</tr>
<tr>
<td>6</td>
<td>33</td>
</tr>
<tr>
<td>Whites</td>
<td>Whites</td>
</tr>
<tr>
<td>13</td>
<td>29</td>
</tr>
<tr>
<td>Blacks</td>
<td>Blacks</td>
</tr>
<tr>
<td>12</td>
<td>32</td>
</tr>
<tr>
<td>Asian</td>
<td>Asian</td>
</tr>
<tr>
<td></td>
<td>21</td>
</tr>
</tbody>
</table>

In 2010-2012, the **suicide rate** in Marin was lowest among Hispanic/Latinos (6/100,000) and highest among non-Hispanic Whites (13/100,000) and non-Hispanic Blacks (12/100,000).

Among Marin County 7th, 9th and 11th graders between 2011-2013, nearly a third of Hispanic/Latino students and African American/Black students reported using alcohol or any illegal drugs in the past 30 days, with slightly lower figures for White students, and Asian students reporting lowest use.

Percent of adults who reported there ever being a time in the past 12 months when they felt that they **might need to see a professional because of problems with their mental health, emotions, nerves, or use of alcohol or drugs.**

- **22%** of whites
- **25%** of Hispanic/Latinos
- **40%** of Blacks

### Emerging Needs

Late life depression is associated with increased risk of morbidity, suicide; decreased physical, cognitive, social functioning; and greater self-neglect (increases mortality).

- **25%** of those with comorbidities suffer from clinically significant depression.
- **17%** of Marin seniors reported binge drinking in the past year.

Are you drinking at your kid’s sporting event? Are you drinking in preparation for homecoming, while you’re taking photos? Yeah, that’s an issue.

- **Key Informant**
**Examples of Existing Community Assets**

- School-based therapists
- Community organizations, committees, and support groups; groups that raise awareness and educate general population
- Coordinated entry database/communications among social and medical service agencies
- Services geared toward Medi-Cal patients

**Ideas from Focus Groups and Interview Participants**

- Implement “community health navigator” programs through faith-based, neighborhood, or community organizations
- Integrate currently fragmented channels of care (primary, dental, mental health, substance abuse, social services)
- Confront stigma around accessing mental health care services; educate community about the many manifestations of mental health
- Bring mental health services directly to hard-to-reach populations such as the homeless population

---

1. Behavioral Risk Surveillance Task Force. (2017). Excessive Drinking is the percentage of adults that report either binge drinking, defined as consuming more than 4 (women) or 5 (men) alcoholic beverages on a single occasion in the past 30 days, or heavy drinking, defined as drinking more than one (women) or 2 (men) drinks per day on average.
3. Same as above.
4. CDPH 2010-12 (Death Master Files, pulled from 2015 Pathways to Progress).
7. Same as above.
Oral health is a key indicator of overall health, however, it is often treated as separate. Oral health has been linked to cardiovascular disease, and poor pregnancy and birth outcomes. A lack of access to dental insurance and inadequate utilization of dental care are identified as important issues affecting oral health in Marin County. Key informant and focus group participants report that dental insurance is limited, and specialty care, like oral surgery, is not affordable. Marin has not yet reached its Healthy People 2020 goal for children’s dental health provision, and Denti-Cal reimbursement rates are low, indicating an opportunity for improving dental care utilization.

### Key Data

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Qualitative Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adults (18+) without dental health insurance (self-reported)</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
<td><strong>Limited access to oral health care</strong></td>
</tr>
<tr>
<td>38.5%</td>
<td>• High cost of care if underinsured, and/or undocumented</td>
</tr>
<tr>
<td>42.6%</td>
<td>• Preventive services underutilized, increasing need for emergency treatment</td>
</tr>
<tr>
<td>California</td>
<td>• Specialized dental care not accessible through low-cost/free clinics</td>
</tr>
<tr>
<td>Marin County</td>
<td><strong>Better integrate oral and general care</strong></td>
</tr>
<tr>
<td><strong>Ratio of the Population to the Total Number of Dentists Available</strong>&lt;sup&gt;2&lt;/sup&gt;</td>
<td>• Oral health tied to self-esteem, physical and mental health, and wellbeing</td>
</tr>
<tr>
<td>943:1</td>
<td>Marin County</td>
</tr>
<tr>
<td>1,291:1</td>
<td>California</td>
</tr>
</tbody>
</table>

Between 2005 and 2012, a total of 4,183 people were seen at emergency departments in Marin County for ambulatory care-sensitive dental conditions (otherwise known as preventable dental conditions).<sup>3</sup>

I know it's a long history of more than 100 years of why dental services are separate from medical health, so it's very political, but we need to see it as one thing. When people don't have good dental hygiene, it can affect their other health needs.  
- Key Informant
## Oral Health

### Populations with Greatest Risk

Age-adjusted incidence rate for **oral cavity and pharynx cancer** (in cases per 100,000 population)⁴

<table>
<thead>
<tr>
<th></th>
<th>Marin County</th>
<th>California</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age-adjusted incidence rate</strong></td>
<td>14.4</td>
<td>10.3</td>
</tr>
</tbody>
</table>

According to the American Cancer Society, individuals who both smoke and drink excessively are 30 times more likely to develop oral cancer than those who do not.

### Reported dental cleanings in the past year⁶

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian</td>
<td>77%</td>
</tr>
<tr>
<td>White</td>
<td>76%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>62%</td>
</tr>
<tr>
<td>Am. Indian/AK Native</td>
<td>62%</td>
</tr>
<tr>
<td>Black</td>
<td>57%</td>
</tr>
</tbody>
</table>

Asians and Whites had the highest proportion of dental cleanings in 2008, followed by Hispanics and American Indians/Alaska Natives, while only about half of Blacks reported a dental cleaning in the past year.

### The percent of children with untreated dental decay⁷

- **10%**: Current percentage of children with dental decay
- **5%**: Healthy People 2020 target

2 school districts did not meet the Healthy People 2020 goal of no more than 25.9 percent of children aged 6 to 9 years with untreated tooth decay in at least one primary or permanent tooth.⁸

For people who don’t have legal status here, they can’t get full scope Medi-Cal, same for dental coverage. It’s really expensive...most of the medical care that they have access to is only emergency medical. - Key Informant

Oral surgery for low-income individuals, especially for impacted wisdom teeth, is a dental care gap in Marin. There is 1 private oral surgeon who accepts Medi-Cal insurance.⁵
**Examples of Existing Community Assets**

- Community clinics with basic oral health services
- Public Assistance Programs (e.g., Medi-Cal Dental)
- System coordination among social and medical service providers

**Ideas from Focus Groups and Interview Participants**

- Integrate disparate channels of care (primary, oral/dental, mental/behavioral, substance use, social services)
- Make specialized care such as oral surgery available in low cost or free clinics

---

3. OSHPD Data analyzed by Marin County Department of Health and Human Services, Epidemiology Department.
6. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3866511/(Note: National study, trends consistent with Marin focus group reports).
8. Same as above.
APPENDIX C.
HEALTH NEED PROFILES

Social Connection

The San Rafael service area boasts many social associations, and residents generally feel they know where to go for emotional and social support. However, economic inequality and the County’s rapidly aging population increase the risk of social isolation. The high cost of living results in extended work hours and long commutes, leaving people with less time to spend engaging with their community. Further, the lack of alternative forms of transportation in rural towns, and racial segregation in parts of Marin, create barriers to community cohesion. Racial and ethnic minorities report bullying and a lack of connection to their schools; language barriers lead to further isolation among immigrant communities. Populations such as the LGBTQ community and people experiencing homelessness report a lack of safe and welcoming social spaces. Finally, at both ends of the age spectrum, youth and older adults desire social connection; youth want opportunities for positive mentorship and older adults desire more community events.

Key Data

<table>
<thead>
<tr>
<th>Indicators</th>
<th>San Rafael service area</th>
<th>California</th>
<th>Marin County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insufficient Social &amp; Emotional Support (%)(^1)</td>
<td>18%  (\leq 25%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Associations per 10,000 people (rate)(^2)</td>
<td>6.51</td>
<td>9.16</td>
<td></td>
</tr>
<tr>
<td>Income Inequality (Gini Coefficient): where 0 is full equality(^3)</td>
<td>.488</td>
<td>.525</td>
<td></td>
</tr>
<tr>
<td>Long Commute – Driving Alone (%)(^4)</td>
<td>37%</td>
<td>40%</td>
<td></td>
</tr>
</tbody>
</table>

Qualitative Themes

Desire for social inclusion and connection

- Social isolation leads to substance use, and mental and physical health issues
- People struggle to change unhealthy behaviors without social support
- Economic inequality and a competitive social environment lead to loneliness, anxiety, and depression

Need for mentors and safe social spaces for youth

- Youth need positive alternatives to unhealthy behaviors and restorative, rather than punitive, discipline
- Youth do not always feel comfortable sharing personal concerns with their families

We tend to provide healthcare and housing, and those fall short of a full life. I hear a lot from clients, ‘Can you help us organize an event? Can we go on a picnic together?‘
- Key Informant

They’re self-medicating because, in Marin County, there is an epidemic of loneliness. I know it’s a huge problem in the senior community and I see it in our kids too.
- Key Informant
**Populations Disproportionately Affected**

### Populations with Greatest Risk

<table>
<thead>
<tr>
<th>Race/ethnicity</th>
<th>Proportion of 7th graders reported high levels of school connectedness, by race/ethnicity.</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>23%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>55%</td>
</tr>
<tr>
<td>Asian</td>
<td>70%</td>
</tr>
<tr>
<td>White</td>
<td>75%</td>
</tr>
</tbody>
</table>

31% reported being harassed or bullied at school for any bias related reason (i.e., gender, race/ethnicity, sexual orientation).

We need access to mentors, please... Just not looking anyone up, definitely, a role model, and I don’t know what else. Just a group of people you can talk to I guess. Just someone on your side.
- Youth Focus Group Participant

### Geographic Areas of Interest

**Residential segregation:** The dissimilarity index measures whether one particular group resides across census tracts in the metropolitan area in the same way as another group. A high value indicates that the two groups tend to live in different tracts. A value of 60 or above is considered very high.

**San Rafael**
- Black-White/White-Black = 25
- White-Hispanic/Hispanic-White = 52

**Novato**
- Black-White/White-Black = 26
- White-Hispanic/Hispanic-White = 20

### Emerging Needs

- **32%** Proportion of undocumented [community members] who report they don’t speak English well.
- **20%** Proportion of Hispanic households that are linguistically isolated.

For people who don’t speak English well, that’s a challenge for them in terms of their social, cultural, and political participation.
- Key Informant

- **28,600 (44%)** individuals 65+ reported living alone.
- **35,100 (54%)** individuals 65+ reported eating alone.
- **40%** of individuals 65+ reported feeling isolated and/or depressed as one of their top six health concerns.
APPENDIX C.
HEALTH NEED PROFILES

Social Connection

Assets and Ideas

Examples of Existing Community Assets

- **Community organizations, committees, and support groups**
- **Collaborative partnerships between social agencies that connect individuals to the support they need and organize events**
- **Financial and political capital that can be channeled to promote equity**

Ideas from Focus Groups and Interview Participants

- Create safe spaces for diverse communities to interact, take part in meaningful activities, and learn from each other’s experiences
- Address financial and transportation barriers to attending social events by subsidizing cost to participate
- Design community programs and events to be accessible by considering the location, time, language needs, and cultures of participants
- Offer more free, youth-centered extra-curricular community programming, whether social, recreational, or skills-based. Provide youth with opportunities to interact with positive role models
- Offer support groups through local clinics, hospitals, and community-based organizations to help individuals with chronic disease management, mental health, and physical health
- Promote programs and events using strategic messaging and channels, such as social media

4. Same as above.
6. Same as above.
10. Same as above.
The San Rafael service area has a much lower rate of violent crime than California overall. However, Marin does have several issues related to violence and injury that present unique challenges. Due to heavy manual labor, many work-related injuries affect day laborers, particularly community members who are undocumented. Crime rates are unevenly distributed, both across racial groups and regions. Finally, older adults face unique challenges related to physical accidents, as falls are the leading cause of fatal injuries, and most homes are not designed for aging in place and universal accessibility.

Key Data

**Indicators**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>California</th>
<th>San Rafael service area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injury deaths (rate per 100,000)</td>
<td>46.7</td>
<td>49.9</td>
</tr>
</tbody>
</table>

**Qualitative Themes**

**Police Relationships**
- Need for law enforcement and health providers to coordinate services
- Police slow to respond to calls in Canal areas
- Decrease in crime reporting due to fear of ICE

**Violence (Youth & Family)**
- Domestic violence number one violent crime in Marin County
- Easy for youth to become involved with the wrong crowd and fall into gangs

*Suicide is happening across the county at significant levels, at higher rates here than in other counties in this state. For young people, and also across the age span as well.*

- Key Informant

*The biggest crime in Marin County is domestic violence. And VOWA, the Violence Against Women Act, they actually say that, if you could cure poverty, you could have many things cured, including things like domestic violence.*

- Key Informant
APPENDIX C.
HEALTH NEED PROFILES

Violence and Injury Prevention

Populations Disproportionately Affected

**Populations with Greatest Risk**

Youth who have contact with the juvenile justice system are at increased risk for a number of negative long-term outcomes, such as injury, substance use and dependency, dropping out of school, and early pregnancy.

Conditions that increase the likelihood of involvement with the juvenile justice system include family poverty, separation from family members including parental incarceration, a history of maltreatment, and exposure to violence.

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Juvenile Felony Arrests, rate per 1,000 pop.</th>
</tr>
</thead>
<tbody>
<tr>
<td>White/Caucasian</td>
<td>2.7</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>10.4</td>
</tr>
<tr>
<td>Black/African American</td>
<td>43.4</td>
</tr>
</tbody>
</table>

Homicides, rate per 100,000 pop.:
- Non-Hispanic White: 0.9
- Non-Hispanic Black/African American: 5

Out of 58 counties in California, Marin ranks 3rd worst for vehicle collisions, and 2nd worst for vehicle collisions with bicycles.

**Geographic Areas with Greatest Risk**

- San Rafael
  - Violent Crime Rate: 325/100,000 pop.
  - Property Crime Rate: 1,923/100,000 pop.

- Novato
  - Violent Crime Rate: 181/100,000 pop.
  - Property Crime Rate: 1,806/100,000 pop.

Exposure to neighborhood violence can have lasting effects on health and well-being, especially among children. Whether a victim or witness, children who experience violence are more likely to suffer from a variety of physical, emotional, and behavioral health problems, as well as struggle academically.

“Local law enforcement should work closely with behavioral health services because there’s often a behavioral health issue there... What’s the best service for this person to rehabilitate them and get the services they need so they can thrive?”
- Key Informant

**Emerging Needs**

- 20% of day laborers were injured on the job. Among those, 2/3 missed work as a result. Of those,
  - more than 50% did not receive the medical care they needed for the injury, either because the worker could not afford healthcare or the employer refused to cover the worker under the company’s workers’ compensation insurance.

- 20% of seniors 65+ reported falling in the past year.

- Falls are a leading cause of fatal and nonfatal injuries in older adults.
  - 1 out of 5 falls causes a serious injury.
  - Falls cause > 95% of hip fractures.
  - Up to 33% of older hip fracture patients die within 1 year.
APPENDIX C. HEALTH NEED PROFILES

Violence and Injury Prevention

Assets and Ideas

Examples of Existing Community Assets

- Community groups and initiatives against violence (e.g., legal advocacy resources)
- Law enforcement; especially bilingual/bicultural officers
- Community members who have experienced adversity and can teach others how to cope with feelings of suicide

Ideas from Focus Groups and Interview Participants

- Protections for manual laborers
- Alternative programs for incarceration
- Improve response time of police (especially in the Canal area)
- Increase bilingual/bicultural law enforcement officers

2. Healthy People 2020; County Health Rankings (2012-16).
11. Same as above.