Sequoia Healthcare District

FOR YOUR HEALTH

Sequoia Healthcare District Strategic Plan 2022-2025

Adopted June 24, 2022

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I. BACKGROUND

Our last formally adopted strategic plan established 9 key strategic goals that set the policies and priorities for the District for the timeframe of July 1, 2017 to June 30, 2020. Initial steps to develop the next strategic plan, occurred in February 2020, just before the pandemic. The District Board decided to postpone the development and formal adoption of the next consecutive plan that would assume business as usual, and instead develop a Covid-19 response plan that allowed maximum flexibility in our giving, allowing us to respond to needs as they emerged. Staff developed a Covid response and recovery plan through June 2022, and now this new three-year plan will provide direction for District activities and investments between July 2022 and June 2025.

Nearly two years in the making, this Strategic Plan identifies the District's priorities, goals and strategies for supporting the health and well-being of District residents, given consideration to the social determinants of health that are prevalent in the community. It is effectively, the framework to inform and support the Board's future funding, program and policy decisions.

The new strategic plan is a result of Board and staff discussions along with input by community leaders, non-profit directors, school personnel, and residents. Local, current health data was used to determine persistent or emerging health concerns, gaps in access to health services, and opportunities to improve current health outcomes through targeted investments. The investment strategies outlined in the Plan align with health initiatives already underway or propose to launch new collaborative ones. These investments cover a wide array of programs and services for all demographics with varying levels of preventive and treatment services.

II. STRATEGIC PLANNING PROCESS

The New strategic plan included input from 30 community leaders and residents. Local, current health data was also used (*appendix D*) to determine persistent and emerging health concerns, gaps in access to health services and opportunities to improve current health outcomes through targeted investments.

- An ad-hoc strategic planning committee was established in November 2021 consisting of Directors Aaron Nayfack and Kim Griffin.
- The committee met in January 2022 via email to discuss and agree to a format and plan of action.
- The CEO was designated as the planning coordinator and was responsible for managing the process.
- The CEO met with 30 community leaders that either attended a small discussion group or via a one-on-one meeting. These community leaders consisted of representatives from non–profits, school districts, government organizations and a few identified unaffiliated residents of the District.
- The Board and staff held two study sessions, the first one in December 2021 and the second in February 2022. The first study session was facilitated by Redwood City Together Executive Director Rafael Avendano and his staff to help with the development of our new strategic goals, assuring they are explicitly equitable and inclusive. The following set of questions guided our goal setting and investment strategies:

1. What unmet needs does this initiative address?
2. What is our proof that this is a need for the community (rationale plus data)?
3. Why should this initiative be prioritized above others (rationale plus data)?
4. What other services in the community address this need, if any?
5. What is the gap between what is currently offered and what need this would fulfill?
6. Why would we create a new service vs. help fund current services already in place?
7. What community partners could we collaborate with on this or who would support/ collaborate with SHD on this initiative?

- Each Strategic priority was collaboratively developed by the SHD team with Board contributions and input at the planning sessions. Every effort was made to incorporate Specific, Measurable, Attainable, Relevant, Time-bound (SMARTIE), Inclusive, and Equitable goals.
- The draft plan was presented to the Board via email and feedback was received in the same manner. The final draft was presented to the Board at a special public meeting on June 24th and was adopted at that time. CEO Kurtzman will report on the plan's progress on a quarterly basis.

III. FRAMEWORK

This plan aligns with the District's **Mission, Vision and Values.**

Mission statement	Sequoia Healthcare District is committed to improving the health of District residents by enhancing access to care and promoting wellness through responsible stewardship of District taxpayer dollars.
Vision statement	For all District residents to experience optimal physical and mental health at every stage of life
Values (C.A.R.E.S.)	**COMPASSION**- We demonstrate care by the programs we provide and support
	ACTION- We act as catalysts for developing and implementing innovative and impactful programs
	RESPECT- We give due regard for the rights of everyone and uphold the dignity all people deserve
	EQUITY- We are committed to improving access to health and wellness services for all residents
	STEWARDSHIP-We are diligent and ethical in our entrusted role with taxpayer funds

Five new strategic priorities have been established in this plan which were chosen with the mission, vision and values of the organization at the core of each of them. The goals and objectives outlined will directly support the mission and vision of SHD and align with the annual budget projections of the next three years with

periodic updates and course-corrections as appropriate. The priorities are based on both data and educated assumptions that help ensure that our investments are progressively advancing our community toward impactful outcomes as we look to grow, expand, and evolve our efforts in the months and years ahead. Some of our goals require us to remain flexible as needs change and keep our minds open to new approaches and ideas. This has included new kinds of partnerships and new ways of thinking, even funding needs that we have not traditionally funded.

Among significant changes in the plan is an explicit focus on Diversity, Equity, and Inclusion. Although the District has always focused on health equity through targeted investments in our most vulnerable communities, we have not made it an explicit, stated goal. This change re-emphasizes our commitment to advocate for the health and wellness of all District residents going forward. Another significant change is the focus on advocacy as a new priority area. The District has not conventionally prioritized advocacy as a tool to address a range of issues impacting District residents including community health, finance, access to care, and local government.

IV. FIVE NEW STRATEGIC GOALS:

Priority Area	Strategic Goals
Equity and Inclusion	*Engage in population-specific efforts to address the needs of those residents in the district that are historically underserved or particularly impacted by health disparities.*
Innovation	*Support new and innovative strategies that improve the health and well-being of district residents.*
Collaboration	*Use collaboration with community organizations to magnify the positive impact on the health and well-being of district residents*
Communications	*Improve effectiveness and reach of communications to district residents, in a culturally sensitive manner of all resources and activities that enhance their health*
Advocacy	*Be an advocate for change on issues that impact the health of district residents*

1. Priority Area: Equity and Inclusion

Target Area	Objective 1
Health Equity: Focus on increasing equality and decreasing disparities in access to quality health services for impacted populations	**1. Stay informed with up-to-date and relevant community needs assessment data to inform program and investment decisions** *Strategies to include:* • Learn how economic inequality impacts individuals and families across a wide range of issues alongside. (ie. Learn from Covid-19 responses and share what they teach us about effective partnership and funding practices; adjust our practice based on all we learn) • Commit to listening to our residents, especially to those least heard, lifting their voices and experiences to inform our decision-making so we can act on their feedback • Organize or participate in existing workshops, committees, surveys, interviews, and other opportunities to solicit direct community feedback • Develop goals that are aligned with and supported by community members for whom we are working to improve conditions • Use data to evaluate program impact, determine appropriate community health interventions, monitor progress, determine populations to target for an intervention, determine barriers to care, and to influence local public policy • Explore policies that might address these challenges with input from the community
Target Area	**Objective 2**
Health Equity: Focus on increasing equality and decreasing disparities in access to quality health services for impacted populations	**2. Ensure an equity lens is brought to all investment decisions** *Strategies to include:* • Continue internal DEI work (for example, Complete Board DEI survey, offer DEI trainings to community partners, and continue DEI conversations) • Develop a 'habit' of asking whether or not all stakeholders are present at the table to provide input for investment decisions, explore developing a set of DEI criteria • Targeted support to nonprofits that provide emergency health responses and offer services to the many populations that fall through the cracks of standard public services—including elderly people and minorities, those experiencing poverty, unemployment, or homelessness and the undocumented

Target Area	Objective 3
Health Equity: Focus on increasing equality and decreasing disparities in access to quality health services for impacted populations	**3. Build systems that support a diverse community through setting and achieving clear goals that are inclusive and racially equitable** *Strategies to include:* • Develop hyperlocal partnerships; Having trusted community members (Promotoras) and leaders support outreach and system navigation to ensure people feel safe to access resources, especially for our undocumented families and households (ie. specific communities of color and LGBTQI+ affinity groups where people can have trusted solidarity to get support and feel like they belong) • Increase access to easily accessible, cultural and linguistically appropriate clinical and educational resources (see Communications Priority Area) • Attempt to recruit representative committees (specifically, increase minority/diversity in CC Grants Committee)

2. Priority Area: Innovate

Target Area	Objective 1
Innovation: Pilot innovative solutions to unmet needs that strengthen the health, safety, and well-being of our community particularly historically underinvested communities	**1. Provide resources to people who would otherwise be unable to access quality health care and/or services due to lack of insurance, transportation, mobility challenges, mental health, language and cultural barriers, immigration status, homelessness, and more** *Strategies to include:* • Explore funding programs that assist low-income residents with paying for medications/co-pays (ie. Santa Clara County's MedAssist program) • Develop new approaches to increase access to oral health services by exploring the development of new dental clinic within district - operated by non-profit partners • Develop creative programming and expand partnerships to address growing concern of food insecurity (ie. DoubleUp Food Bucks) • Expand Lyft Program through innovative approaches to transportation access that are inexpensive and accessible. Transit options that help people access doctor visits, community centers, essential work, goods and services

Target Area	Objective 2
Innovation: Pilot innovative solutions to unmet needs that strengthen the health, safety, and well-being of our community particularly historically underinvested communities	**2. Increase access to mental health services for all residents through creative approaches and partnerships** *Strategies to include:* • Partnering with County to bring thier "Mental Health First Aid" program to community members • Keeping close tabs of the PHD's Alcove model and its viability • Staying informed of opportunities for CARE partnership expansion • Investigating mental health delivery models (ie. mobile Crisis model and Urgent Care delivery) from other healthcare districts • Continue collecting mental health data thru partnerships with local districts, SMCOE, Kognito, Early Alert, and Care Solace

Objective	Objective 3
Innovation: Pilot innovative solutions to unmet needs that strengthen the health, safety, and well-being of our community, particularly historically underinvested communities	**3. Explore innovative partnerships to improve access to health education (S^3 or *Sequoia Safe, Smart & Strong*) and develop a robust in-house programming (S^3) that addresses all resident needs:** *Strategies to include:* • Sequoia Smart: Partner with Parks & Rec across all cities to utilize their health education class offerings - provide stipends/subsidies for district residents • Sequoia Strong: Increase investments in Senior Care programming/services, expand partnerships, develop new models of care if none exist. Focus on fall prevention, strengthen, stretching, balance clinic • Sequoia Safe: Increase District investment in Disaster Preparedness training and supplies thru partnerships with County, City, and Red Cross *(Consider ways to prepare communities for next epidemic/pandemic: Agree on phases and "what if" scenarios and try to anticipate what could happen and develop a plan around those scenarios so we're ready. Establish our emergency response objectives and create a written policy that align emergency response plan with County Plan.)*

3. Priority Area: Collaboration

Target Area	Objective 1
Collaboration and Alignment: Use a collective Impact approach to partner with organizations from different sectors and agree to solve a specific or set of concerns using a common agenda and align our efforts using common measures of success	**1. Encourage partner agency collaborations that will increase impact, improve efficiency of operations, and best leverage limited resources** *Strategies to include:* • Offer incentives for non-profits to partner on a common set of goals and/or objectives • Continue to develop and strengthen existing partnerships. Increase number of collaborative projects. Resources can be monetary or sharing of knowledge or data

Target Area	Objective 2
Collaboration and Alignment: Use a collective Impact approach to partner with organizations from different sectors and agree to solve a specific or set of concerns using a common agenda and align our efforts using common measures of success	**2. Effectively allocate resources - collaborate and align efforts with those already underway.** *Strategies to include:* • Exchange information with county health leaders- align with County health approach • Seek out existing programs/services where collaboration would expand capacity breadth and/or depth of services; ^ impact • Hold roundtable discussions with non-profit leaders to understand challenges, opportunities

Target Area	Objective 3
Collaboration and Alignment: Use a collective Impact approach to partner with organizations from different sectors and agree to solve a specific or set of concerns using a common agenda and align our efforts using common measures of success	**3. Invest with other funders to address a significant health concern in an otherwise fragmented funding landscape - increases impact** *Strategies to include:* • Share information with other funders, align with other funding approaches • Remain vigilant to stay informed and aligned with existing efforts seek partnerships whenever possible • Align strategic plan implementation with county initiatives. Seek out collaboration whenever possible

4. Priority Area: Collaboration

Target Areas	Objective 1
Communications Provide timely and culturally appropriate public information- allow public input, communicate with District residents through a wide approach to communications including website, social media, public presentations and forums, monthly newsletter, and annual report.	**1. Provide intentional targeted outreach to difficult-to-reach populations** *Strategies to include*: • Utilize existing communication channels within communities including radio, social media, places of worship, virtual groups, phone • Use language and messaging that ensures our immigrant families and households without documentations feel like they belong and are essential parts of community • Utilize Digital Media Campaigns for targeted audiences • Ensure outreach and communication is linguistically and culturally appropriate by developing clear language and messaging that enables all to feel essential and not disposable and enables impacted communities to feel seen and not sidelined.

Target Areas	Objective 2
Communications Provide timely and culturally appropriate public information- allow public input, communicate with District residents through a wide approach to communications including website, social media, public presentations and forums, monthly newsletter, and annual report.	**2. Communicate proactively and regularly about our decision-making and response**. *Strategies to include:* • Maintain updated and relevant information/ announcements on website and Sequoia Strong • 2-3 weekly posts on social media venues promoting activities/relevant information • Develop monthly e-newsletter email blasts • Provide monthly town halls in English and Spanish featuring a timely and relevant topics. Allow for public dialogue through Q and A. • Expand language offerings • Brainstorm engaging content for October Annual Report

Target Areas	Objective 3
Communications Provide timely and culturally appropriate public information- allow public input, communicate with District residents through a wide approach to communications including website, social media, public presentations and forums, monthly newsletter, and annual report.	**3. Engage community leaders for their expertise, feedback, and partnership** *Strategies to include:* • Annual or more presentations to City Councils and County Board of Supervisors • Hold roundtable discussions with non-profit leaders to understand challenges/opportunities • Regularly meet with government and community health leaders to discuss current community concerns and potential collaborative solutions

5. Priority Area: Advocacy

Target Areas	Principle Objective
Advocacy Advocate for policies discussions and decisions that go before the legislative and executive branches of the state government on critical issues that affect Healthcare Districts' ability to effectively serve its residents.	**1. Implement District Advocacy Guiding Principles and Strategies that provide leadership and direction on a range of issues impacting District residents including:** *Strategies to include:* • Community Health: Actively engage **community health** support proposals that address social determinants of health, illness prevention, community health and wellness • Finance: Support increased reimbursement **funding** for outpatient, behavioral health, substance abuse, case management, workforce needs and population health • Access to Care: Support proposals to improve **access to care** (ie. increase funding for telehealth services, expand health care workforce trainings, increase workforce diversity and programs geared toward increasing health care workforce, and address gaps in coverage) • Local government: Support **local government** and ensure LAFCOs have adequate resources to accomplish their statutory obligations. Support an update to the Healthcare District Enabling Act to demonstrate Healthcare Districts' commitment to good governance. Support special district's autonomy. *Additional strategies to include:* • Remain vigilant in staying informed and engaged in legislation-related discussions and decisions • Inclusion of legislative updates in Board report from staff

V. Appendices

Appendix A

Definitions:

Health - A state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity' (WHO, 1948). This is consistent with the biopsychosocial model of health, which considers physiological, psychological and social factors in health and illness, and interactions between these factors. It differs from the traditional medical model, which defines health as the absence of illness or disease and emphasizes the role of clinical diagnosis and intervention. The WHO definition links health explicitly with wellbeing, and conceptualizes health as a human right requiring physical and social resources to achieve and maintain.

Health Disparities – A particular type of health difference that is closely linked with economic, social, or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socioeconomic -status, gender, age, or mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion." (Healthy People 2020)

Health Equity - The principle underlying a commitment to reduce—and, ultimately, eliminate—disparities in health and in its determinants, including social determinants. Pursuing health equity means striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions.

Appendix B

Foundational Principles:

Public Health and Safety: During public health crises, maintain health, safety, and wellbeing of all District residents. Invest robust resources in mental health, medical, and basic needs- address Social Determinants of Health, paying special attention to vulnerable members of our community

Health Equity: Focus on increasing equality and decreasing disparities in access to quality health services for impacted populations

Collaboration and Alignment: Use a collective Impact approach- partner with organizations from different sectors and agree to solve a specific or set of concerns using a common agenda and align our efforts using common measures of success

Fiscal Responsibility: Provide financial support to agencies that facilitate short- and long-term recovery efforts in the most fiscally responsible way possible, leveraging limited public resources while remaining diligent and ethical in our entrusted role over taxpayer funds

Transparency: Remain transparent and informative of District Activities- Communicate regularly and often to stakeholders via print and web- Meetings are open to the public, our budgets may be reviewed by anyone, and our decisions are open to discussion. Develop a well-defined organizational structure that facilitates information sharing and provides transparency in how priorities are identified, and decisions are made.

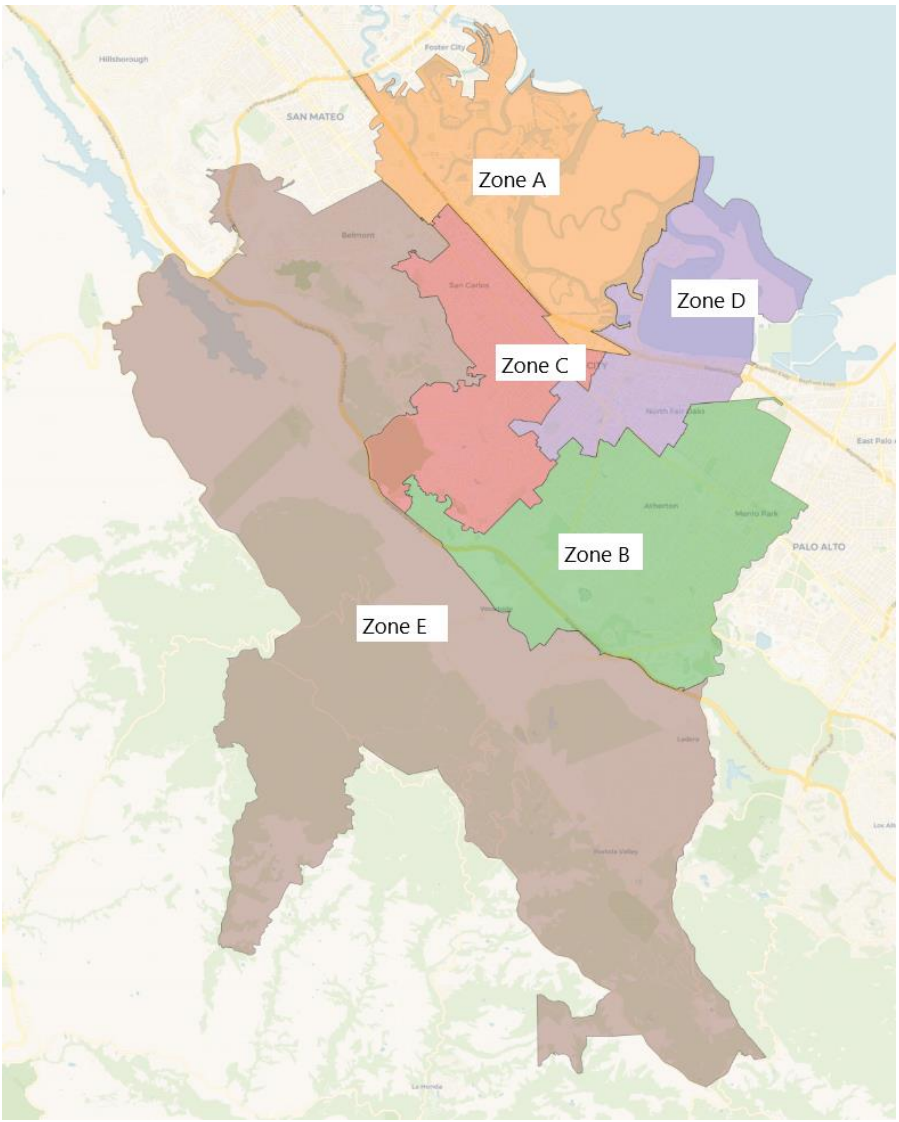
Appendix C

Sequoia Healthcare District Profile

Sequoia Healthcare District is located in San Mateo County (population 764,442 as of the 2020 Census). SHD's boundaries are 100% inclusive of 7 cities located in the southern half of San Mateo County (Belmont, San Carlos, Redwood City, Woodside, Portola Valley, Menlo Park, and Atherton) as well as three census-designated places that are unincorporated communities within San Mateo County (West Menlo Park, North Fair Oaks, and Emerald Hills), and partially inclusive of San Mateo and Foster City.

The District map is divided into 5 separate zones (Image 1). The table (Table 1) and graphic (Image 2) below illustrate the demographic breakdown of each zone. The District has a robust Latinx and Asian population with a slight majority identifying themselves as 'White' or 'Other' on the Census. The District is representative of the Bay Area in that it is multi-culturally diverse compared to other parts of the state.

Image 1: District map by Zones

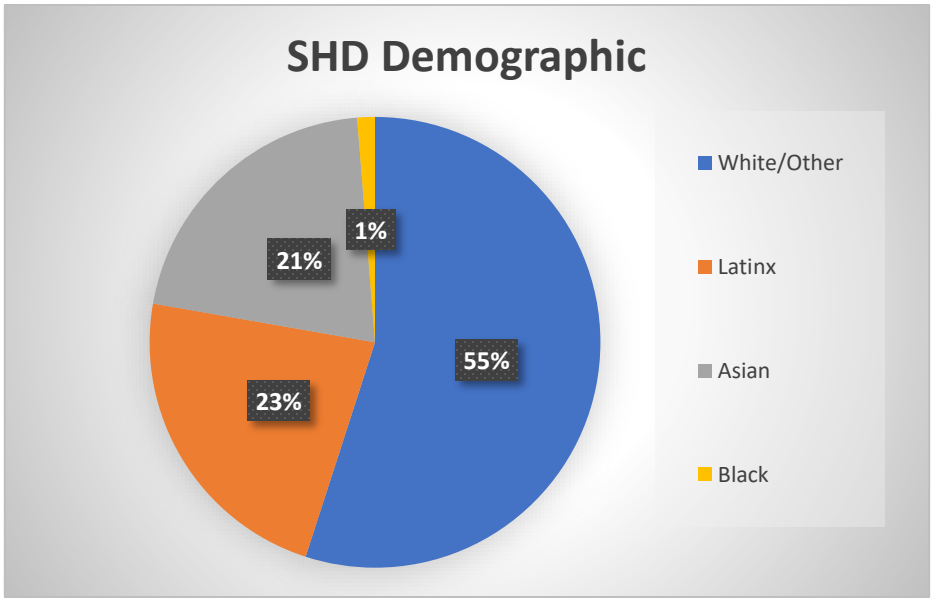


Per 2020 Census, SHD's population totaled 248,559. The table below shows population breakdown by Zone along race and ethnic identifiers. The largest racial or ethnic group by District is white/other (non-Hispanic) group, followed by Latinx and closely behind by the Asian population. It is worthy to note that county-wide, the Asian population was the fastest growing population in the past decade and is projected to continue growing while the white population experienced the largest decrease drop (Source: usa.facts.org.)

Table 1: District population by demographic (Source: Census 2020)

	Total	Other	Latino	Asian	Black
Zone A	50803	21799	6340	21875	789
Zone B	49558	34846	6352	7891	469
Zone C	49178	33350	8105	7188	535
Zone D	47548	12763	30535	3387	863
Zone E	51472	33906	5267	11802	497
	248559	**136664**	**56599**	**52143**	**3153**

Image 2: District demographic by percentage (Source: Census 2020)

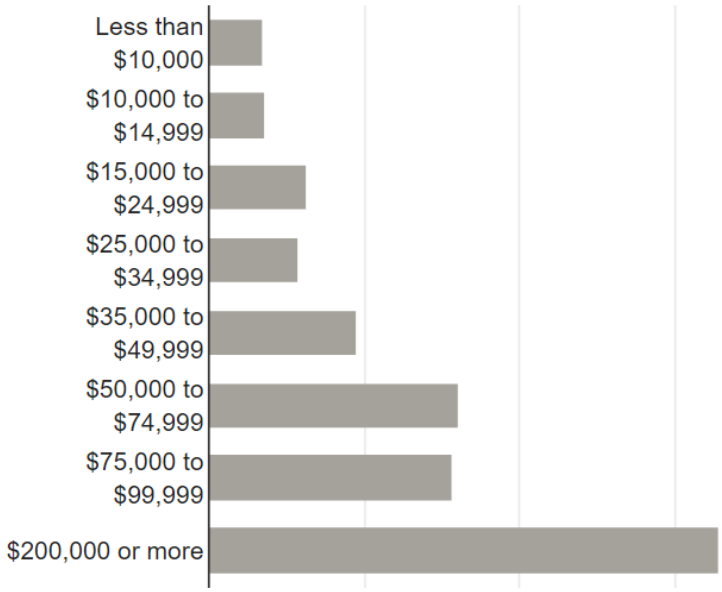


Economic Diversity

The District encompasses an area of socio-economic diversity as reflected by some of the wealthiest zip codes in the state of California on one end spectrum to low-income neighborhoods at the other end. SHD's tax base continues to grow due to the strength of the real estate market as the Peninsula continues to be a desirable place to live. Even in the wealthier school districts with high property values such as Woodside Elementary and Portola Valley School District with their per pupil spending of $25k still see 10.2% and 8.9% students receiving free and reduced lunch respectively (data from 2017-18 school year, Source: smcoe.org).

This table shows the distribution of household income in the County, with a quarter of the population's income annual earning at $200,000. The median household income is $108,627 which is almost twice the national average.

Household Income	Number	Percent	National Avg
Less than $10,000	7,067	2.7%	6.7
$10,000 to $14,999	7,117	2.7%	4.8
$15,000 to $24,999	12,691	4.8%	9.7
$25,000 to $34,999	11,564	4.4%	9.5
$35,000 to $49,999	19,051	7.2%	13.0
$50,000 to $74,999	32,146	12.2%	17.7
$75,000 to $99,999	31,386	11.9%	12.3
$100,000 to $149,000	45,950	17.4%	14.0
$150,000 to $199,999	30,689	11.6%	5.8
$200,000 or more	65,784	25.0%	6.4
Median household income	108,627		57,617
Per capita income	55,257		31,128



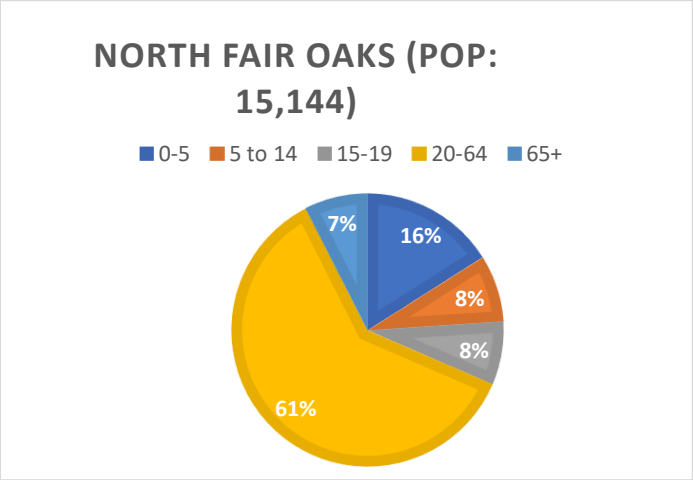
(Source: Homefacts.com)

Age of Population

The latest Census arrived at broad conclusions about how the distribution of ages in San Mateo County has changed over the decade:

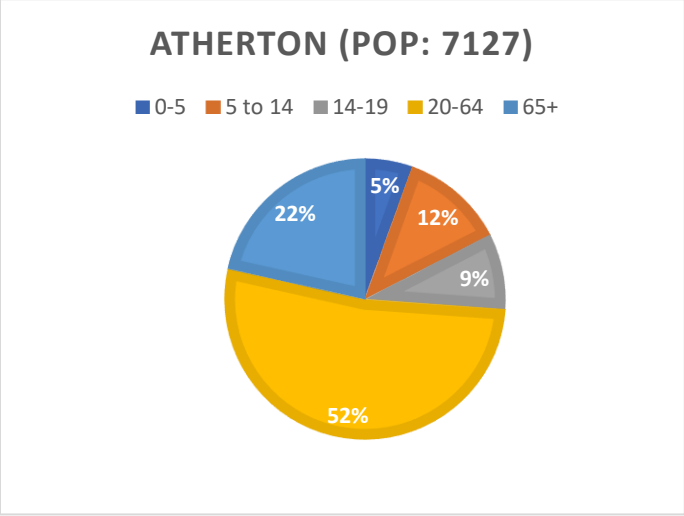
1) The share of the population that is 0 to 4 years old decreased from 6.4% in 2010 to 5.4% in 2020; and
2) The share of the population that is 65 and older increased from 13.4% in 2010 to 17.1% in 2020.

It is worthy to note that while the majority of the cities' population data reflects these County-wide trends, there are some pockets of anomalies. If we were to call out North Fair Oaks, which is a census-designated place and an unincorporated area of the County, which lies adjacent to Redwood City and borders both Menlo Park and Atherton, the 0-4 population age group is among the highest in the County at 16%.



NFO	Population	Percentage
0-5	2428	**16%**
5 to 14	1202	8%
15-19	1137	8%
20-64	9248	61%
65+	1129	7%

And while the trend of an increasing aging population was already forecasted in our last Strategic Plan report, the latest data show the cities of Atherton, Portola Valley, and Woodside with senior population of over 20%, trending above the County average.



Atherton	Population	Percentage
0-5	390	5%
5 to 14	856	12%
14-19	617	9%
20-64	3732	52%
65+	1532	**22%**

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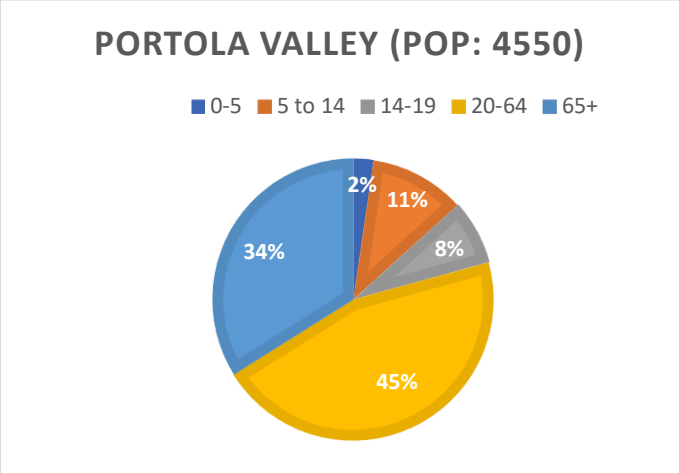
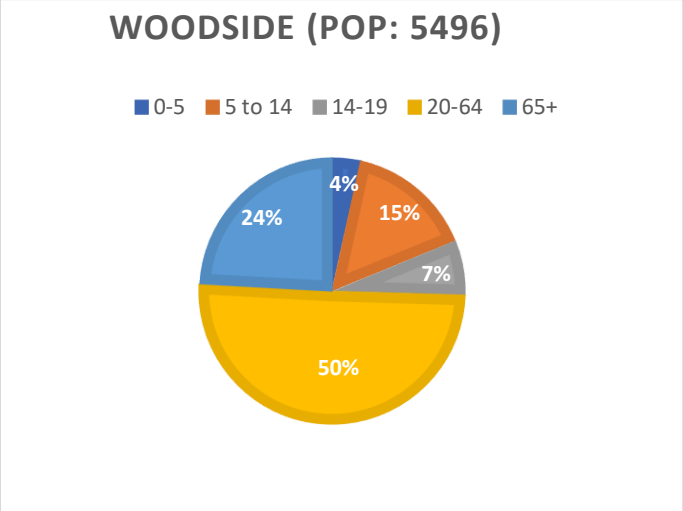


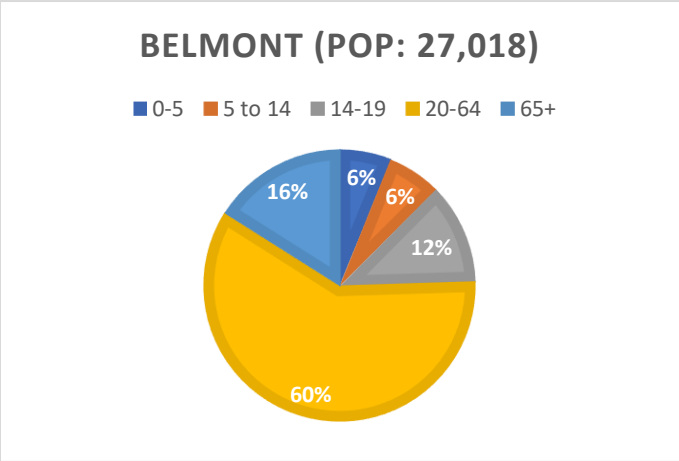
Portola Valley	Population	Percentage
0-5	105	2%
5 to 14	501	11%
14-19	338	8%
20-64	2063	45%
65+	1543	**34%**

Not surprisingly, one-third of Portola Valley's population belong to the 65+ demographic, the highest in the County. Woodside, in contrast, the senior population is 10% lower, at 24%.

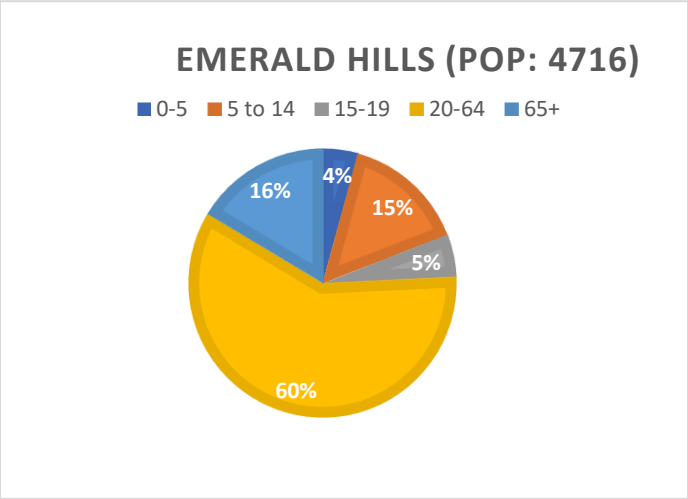


Woodside	Population	Percentage
0-5	190	4.00%
5 to 14	845	15%
14-19	365	7%
20-64	2770	50%
65+	1326	**24%**

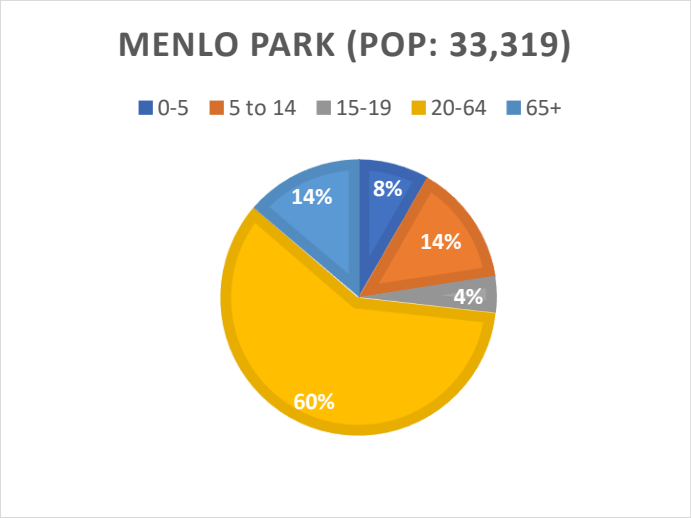
The remaining cities of Belmont, Redwood City, San Carlos, and Menlo Park and communities of West Menlo Park and Emerald Hills all have age populations aligned with current County data and trends.



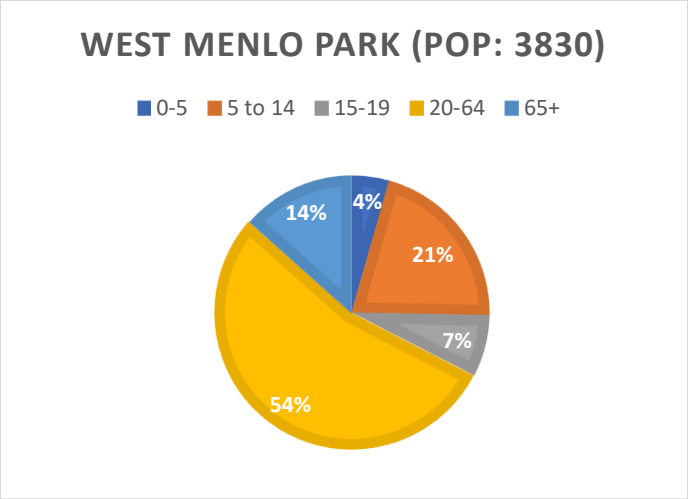
Belmont	Population	Percentage
0-5	1646	5%
5 to 14	1745	6%
14-19	3230	12%
20-64	16072	60%
65+	4325	16%



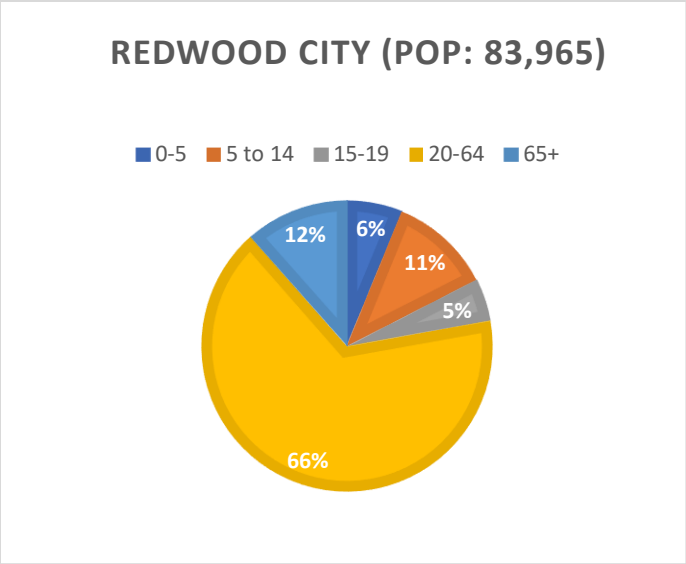
Emerald Hills	Population	Percentage
0-5	200	4%
5 to 14	704	15%
15-19	239	5%
20-64	2801	60%
65+	772	16%



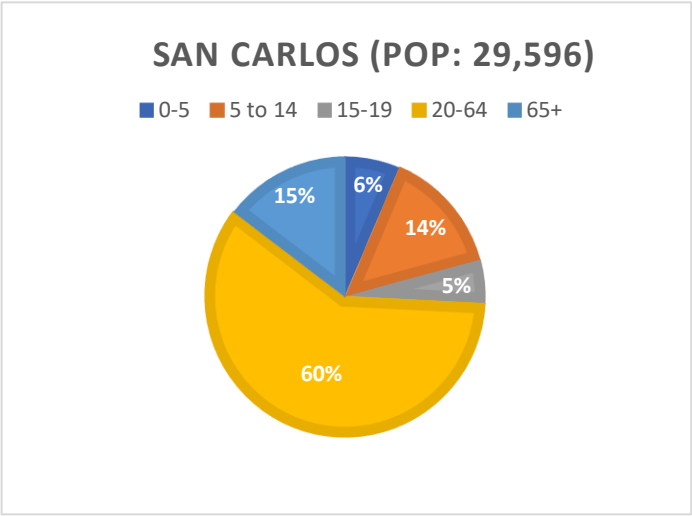
Menlo Park	Population	Percentage
0-5	2745	8%
5 to 14	4782	14%
15-19	1383	4%
20-64	19838	60%
65+	4571	14%



West MP	Population	Percentage
0-5	168	4%
5 to 14	801	21%
15-19	279	7%
20-64	2065	54%
65+	517	14%



RWC	Population	Percentage
0-5	5185	6%
5 to 14	9511	14%
15-19	3938	5%
20-64	55680	60%
65+	9651	15%



San Carlos	Population	Percentage
0-5	1893	6%
5 to 14	4264	14%
15-19	1478	5%
20-64	17631	60%
65+	4330	15%

Disclaimer: *All the population sizes referred in these charts were sourced from homefacts.com and have a standard deviation of 10%. Furthermore, the total populations of all the SHD in-boundary cities and census-designated places in the County amount to 214,761, which is 33,798 short of the official count by Census 2020 of SHD residents. This can easily be reconciled when we take into account that the boundary includes a portion of San Mateo (population 99,653) and Foster City (population 31,247). A quarter of the two combined populations amounts to approximately 33,000. This data corroborates with the demographic data provided by our demographer Paul Mitchell in November, 2021 which may still be further amended as future data comes to light.*

Cities & Unincorporated Areas	Population
Atherton	7127
Portola Valley	4550
Belmont	27018
Woodside	5496
San Carlos	29596
RWC	83965
NFO	15144
MP	33319
WMP	3830
Emerald Hills	4716
Total Population	**214,761**

Appendix D

Health Needs Assessment Data

The SHD Board and staff review health data from various local sources to inform the strategic planning process, including:

1. County Data from Community Health Data Platform
2. San Mateo CHNA 2019
3. RWC & NFO Needs Assessment Data from Gardner Center
4. Kaiser CHNA preliminary data
5. Dignity Health CHNA preliminary data
6. California Healthy Kids Survey

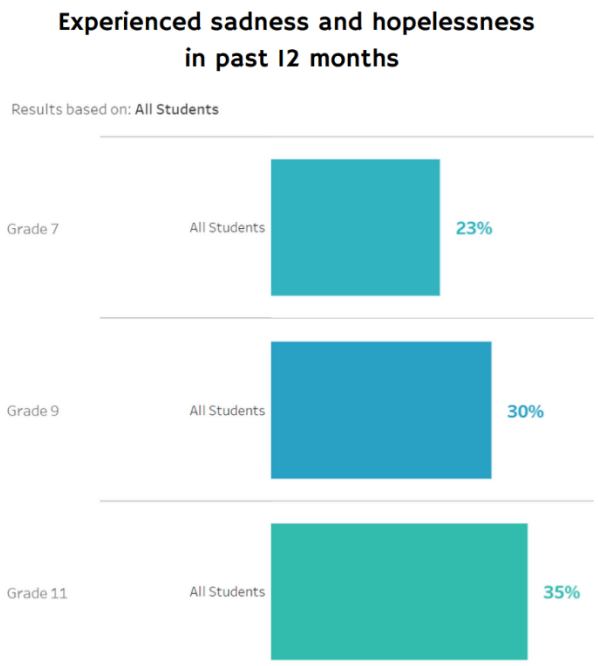
Some key (positive) take-aways from the **San Mateo Community Health Platform** are:

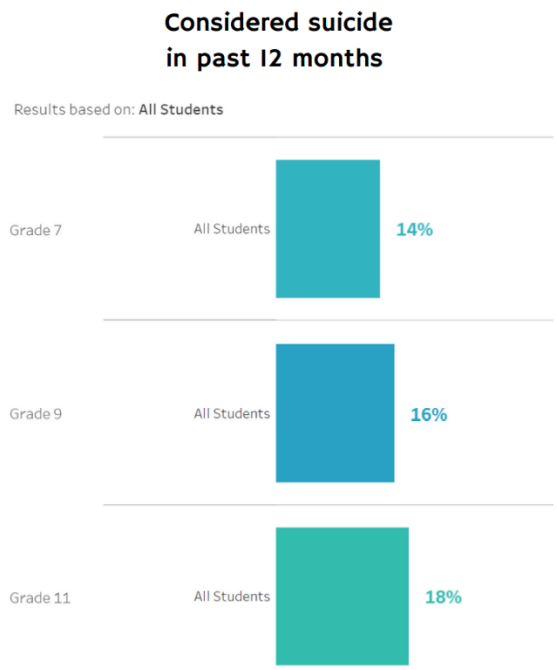
1. San Mateo County (SMC)ranked among the healthiest counties in California, receiving a ranking of 2 behind Marin County.
2. The rate of uninsured in SMC is at 5% and below falls the national and state percentage.
3. The County ratio of population to primary care physicians and dentists is 960:1 which is also better than state and national ratios.
4. The County's unemployment rate stands at 2% which is getting better for this measure.
5. The County's children poverty rate stands at 6% which is also an improvement.
6. The Inactivity Rate is measured at 16% which indicates an improvement from past measures.

On the other hand, there are several main areas of concern prioritized by County residents in the **San Mateo County CHNA 2019.** These ongoing needs can be addressed by ongoing health education and increasing access to treatment:

1. **Mental Health:**
   a. Mental health persists as a growing public health issue. One in ten report a history of mental health or emotional problems while one in four experience symptoms of chronic depression.
   b. Mental health treatment gaps still persist: While almost one-third have sought professional help, those less likely to utilize mental health services include those with less education (18%), Asians (20%), older adults 65+ (24%), and men (26%).

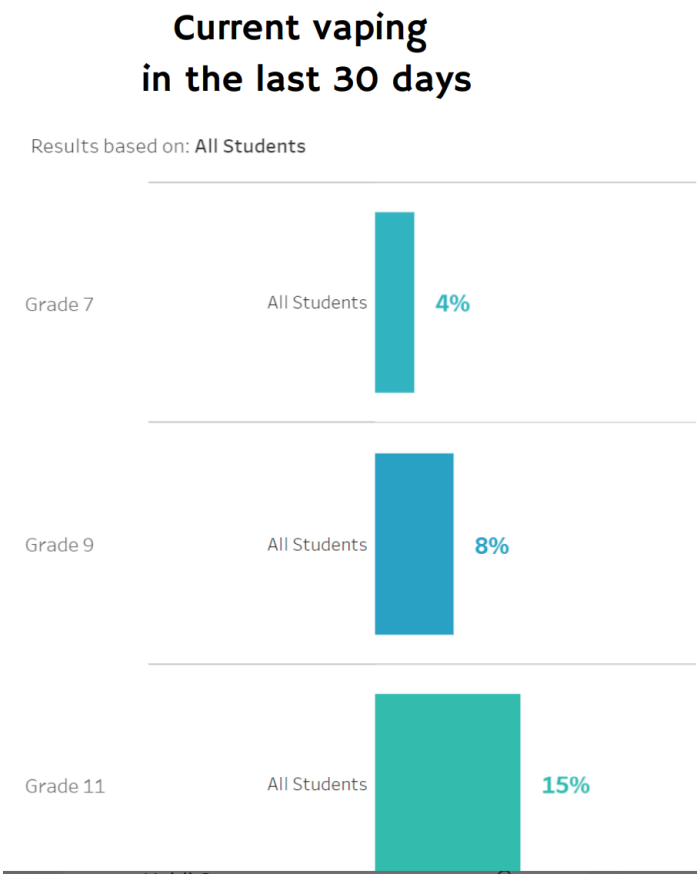
The mental health needs is further supported by data from the **California Healthy Kids Survey** (CHKS). The portion of the survey dedicated to children's emotional health asked whether or not the student had experienced sadness and hopeless in the past 12 months and whether or not they considered suicide in the past 12 months. The table below reflects the recent CHKS data from the County.





2. **<u>Substance Abuse:</u>**
    a. Substance abuse is another area of concern. Four in ten adults admit they would not know where to access treatment for a drug-related problem, which has been increasing.
    b. Vaping rate is double for younger adults (7% vs. 3% for general population), and vaping is high among those with chronic depression (38%).

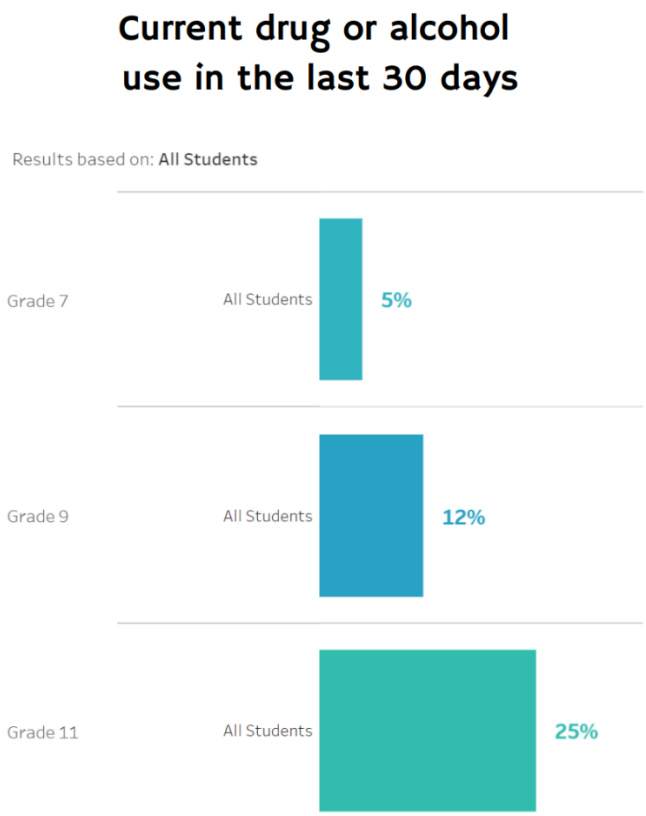
The CHKS data for vaping rate (15% by 11th grade students) is twice the rate of the general population shown in the County's data:

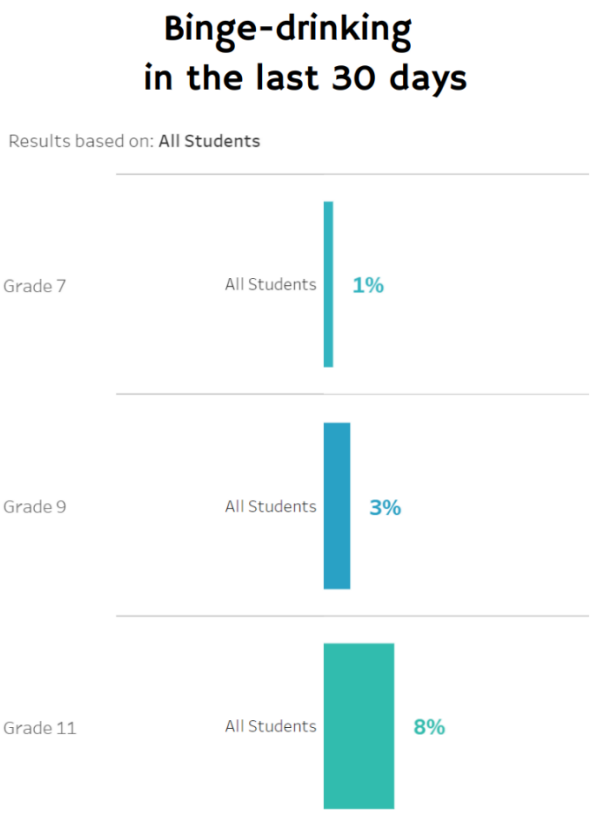


As more students are vaping, the cigarette usage has plummeted. Only 3% of 11th graders said they had smoked a cigarette in the last 30 days.

(As an aside, while it was not part of the data collection phase of the strategic planning as no definitive County data exists yet, SHD will maintain a proactive interest in looking at community data around cannabis and marijuana usage. SHD has been involved in city discussions around the opening of cannabis dispensaries and will play a key role in promoting education to all community stakeholders about the health issues around cannabis.)

The CHKS data also shows that by 11th grade, 25% of the students have used drugs or alcohol in the past 30 days while 8% have binged on alcohol, as shown in this table:





3. **<u>Obesity:</u>**
   a. Additional findings point to an on-going need for health education to promote healthy lifestyles to combat obesity rates (25%) and the diabetes rate (12%).
   b. An emphasis on healthy nutrition such as increasing the consumption fruits and vegetables may be part of the solution given that only 15% of the County's populace eat 5 or more servings a day.
4. **<u>Chronic Diseases:</u>**
   a. Heart disease: At a steady rate at 5%, is still the leading cause of death with 1 in 3 reporting high blood pressure and 32% with high blood cholesterol.
   b. Cancer: 8% have been diagnosed with a form of cancer.
   c. Arthritis: affects 22% of SMC residents and 47% of 65+ age group
   d. Chronic Obstructive Pulmonary Disease (COPD): 9% double that of state level
   e. Asthma: affects 19% of SMC residents

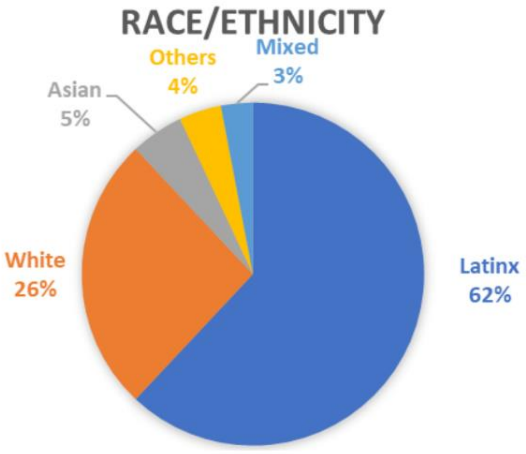
While infectious disease such as tuberculosis, STDs, and influenza/pneumonia are still rising, they were not prioritized by the community members in this needs assessment.

Both **Kaiser** and **Dignity Health** released preliminary needs assessment findings in January, 2022. These needs were based on community surveys and focus groups/interviews with key informants. The list contains the areas of concern or identified community needs that were distilled down from a longer list:

Kaiser	Dignity Health
Housing	**Mental Health**
Income & Employment	**Covid-19**
Mental/Behavioral health	**Access to care**
Structural racism	**Chronic Diseases**
Access to Care	**Substance use**
Education	**Preventive practices**
Family and Social Support	**Senior health**
Food Security	**Overweight & Obesity**
Substance Abuse	**Housing and Homelessness**
	Food Insecurity
	Tuberculosis

There are several themes that were echoed in both assessments: Housing, Mental Health, Access to Care, Food (In)security, and Substance Abuse made both lists.

The Redwood City & North Fair Oaks CHNA findings from Spring 2021 by the Gardner Center, partially funded by SHD and several community partners, provided key data for the District as it was localized and timely. The survey was designed to look into how Covid, in particular, had impacted this community, which has been historically primarily a Latino neighborhood with more acute health needs.

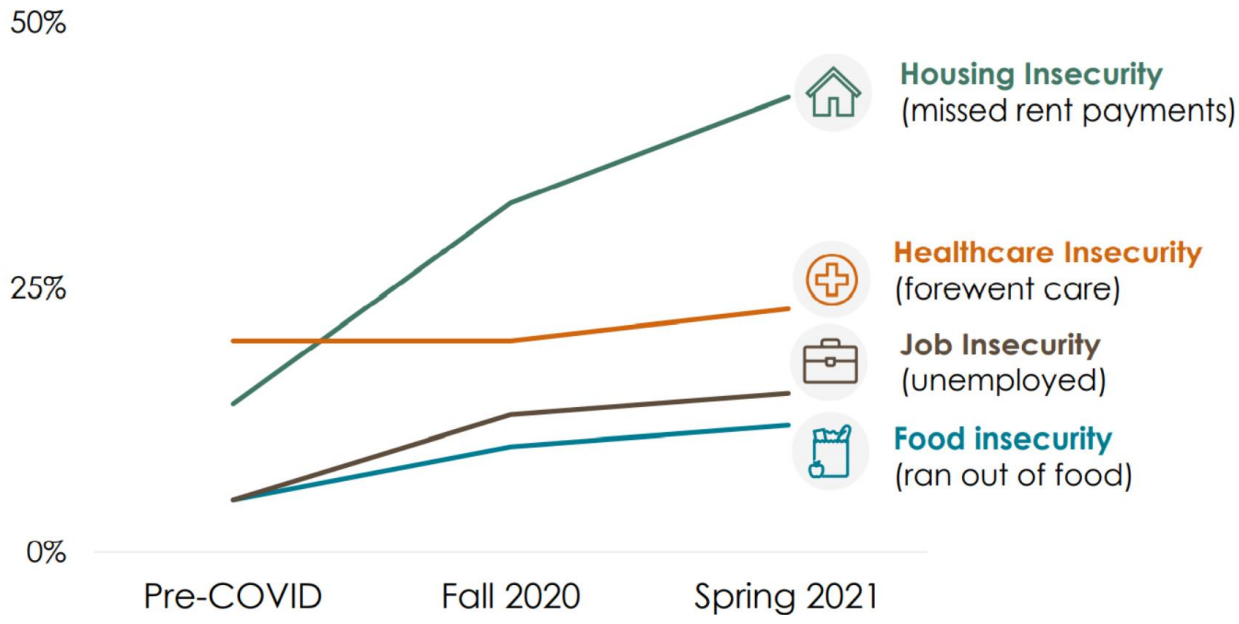


Sample size: 751 responses (441 households)

Here are among the key findings of the survey:

Housing Insecurity	▪ Has increased far more than other unmet needs ▪ Highest for parents and Spanish language respondents ▪ A large minority of renters are vulnerable to the moratorium expiration
Food Insecurity	▪ Has the largest demographic disparities overall ▪ Food insecure respondents had lowest awareness of resources ▪ High rates of hunger and worry about food persist
Digital Divide	▪ Technology interventions appear to be working, as access has increased across all types
Vaccination Status	▪ 86% of respondents were vaccinated ▪ Over 60% of unvaccinated respondents were willing to get the vaccine

Key takeaways



The Gardner Center findings of community needs point out housing insecurity, healthcare insecurity, job insecurity, and food insecurity as the top concerns for its community members. This also corroborates with Kaiser and Dignity Health CHNAs which prioritizes housing, access to care, and food insecurity. In summary, the findings show that upstream socio-economic determinants of health play a vital and crucial role in the health of the community. These findings were reflected in the recent conversations at the Board and staff level: Moving forward, a deep and complete understanding of these complex issues that plague our community will play a large importance in our efforts to create long-lasting systemic change in the SHD community.