Scripps

2019 Community Health Needs Assessment

Scripps Health
10140 Campus Point Drive
San Diego, CA 92121

scripps.org

Scripps Health 2019 Community Health Needs Assessment

GENERAL INFORMATION

Contact Person:

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www.Scripps.org/communitybenefit

Authorized governing body that adopted the community Health Needs Assessment (CHNA):

Strategic Planning Committee of the Scripps Board of Trustees

Tax Year in which CHNA was made available to the public:

Tax Year 2019 (available on http://www.scrippshealth.org/)

Name and state license number of Hospital Organization Operating Hospital Facility: Address of Hospital Organization:

Scripps Mercy Hospital 4077 5th Avenue San Diego, CA 92103
090000074

*Scripps Mercy Hospital has a second campus in Chula Vista, and they share the same license.

Scripps Memorial Hospital La Jolla
9888 Genesee Avenue
La Jolla, CA 92037
080000050

Scripps Green Hospital
10666 Torrey Pines Road
San Diego, CA 92037
080000139

Scripps Memorial Hospital Encinitas
354 Santa Fe Drive
La Jolla, CA 92037
080000148

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I. ACKNOWLEDGEMENTS

COMMUNITY HEALTH NEEDS ASSESSMENT COMMITTEE

This report is based on the collaboration of representatives from seven local San Diego hospitals called the Community Health Needs Assessment (CHNA) Committee. The CHNA Committee (listed below) actively participated in the HASD&IC 2019 Community Health Needs Assessment process which is described in detail in this report.

Anette Blatt (Chair)

Scripps Health

Aaron Byzak

Tri-City Medical Center

Lisa Lomas

Rady Children's Hospital – San Diego

David Mier

UC San Diego Health

Joseph Parker

Palomar Health

Jillian Warriner (Vice Chair)

Sharp HealthCare

Lindsey Wright

Kaiser Foundation Hospital – San Diego and Zion

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Research Assistant

Stephanie Phann
Research Assistant

Nhat Quang Thai
Research Assistant

A heartfelt appreciation goes out to everyone involved in this collaborative process. The expertise and time were essential for accomplishing a comprehensive, collaborative assessment of the health and social needs of San Diego County. The CHNA Committee wishes to thank those who made contributions and were involved in the focus group participants, key informant interviews, and the San Diego County Health and Human Services Agency for their collaboration in the community survey. It is important to our committee that our Assessment report is valuable to our partners.

Alliance for Regional Solutions	California State University of San Marcos, School of Nursing, Student Healthcare Project	Casa Familiar	Chaldean & Middle-Eastern Social Services
Community Housing Works	Dreams for Change	Education Without Borders, San Diego State University	ElderHelp
Environmental Health Coalition	Family Health Centers of San Diego	Health Center Partners	International Rescue Committee
Jewish Family Services	Monarch School	Mountain Health	O'Farrell Charter School
Otay Elementary/Chula Vista School District	Partnership for the Advancement of New Americans	Pillars of the Community	Regional Task Force on the Homeless
San Diego American Indian Health Center	San Diego County Health and Human Services Agency	San Diego Hunger Coalition	San Diego Youth Services, Youth Action Board
San Ysidro Health Center	South Bay Community Center	Southwest High School – School Based Health Center	Think Dignity
United Women of East Africa	University of California San Diego School of Medicine Center for Community Health	Vista Community Clinic	

INTRODUCTION AND PURPOSE OF THE COMMUNITY HEALTH NEEDS ASSESSMENT REPORT

Introduction

The Scripps Health 2019 CHNA responds to federal tax law requirements set forth in Internal Revenue Code section 501(r) requiring private not-for-profit (tax-exempt) hospitals as described in Code section 501 (c)(3) to conduct a community health needs assessment at least once every three years.

Although only not-for-profit 501(c)(3) hospitals and health systems are subject to state and IRS regulatory requirements, the 2019 CHNA collaborative process also includes hospitals and health systems who are not subject to any CHNA requirements but are deeply engaged in the communities they serve and committed to the goals of a collaborative CHNA. Scripps participates in the collaborative CHNA process led by the Hospital Association of San Diego and Imperial Counties (HASD&IC).

The HASD&IC Board of Directors oversees a standing CHNA Committee that is responsible for the implementation and oversight of the collaborative 2019 CHNA. HASD&IC's board of directors represents all member sectors and provides policy direction to ensure the interests of member hospitals and health systems are preserved and promoted. The CHNA Committee is comprised of representatives from all seven participating hospitals and health care systems. The CHNA Committee includes representatives from the following:

- Kaiser Foundation Hospital – San Diego and Zion
- Palomar Health
- Rady Children's Hospital – San Diego
- Scripps Health (Chair)
- Sharp HealthCare (Vice Chair)
- Tri-City Medical Center
- UC San Diego Health

Scripps Health actively participates in the collaborative CHNA process led by the Hospital Association of San Diego & Imperial Counties (HASDIC) and develops a Scripps consolidated CHNA report in accordance with federal regulatory requirements. Please see Appendix K for further details.

CHNA Research Partner

For the 2019 Community Health Needs Assessment process, HASD&IC contracted with the Institute for Public Health (IPH) at San Diego State University (SDSU). In the last 20 years, the IPH has partnered with over 70 local, state, national and international public and private community-based agencies and organizations representing more than 120 multiple-year contracts with a wide variety of needs and methodologies. The IPH has expertise in qualitative and quantitative community-based research methods. In addition, the IPH has extensive experience in successful community engagement with diverse groups, including non-English speakers. The IPH has been working across cultures and with

vulnerable populations for 25 years, including programs with Asian and Pacific Islander communities, African-American communities, East African communities, Latino communities, Native American communities, low-income communities, gay, bisexual, transgender individuals, people living with HIV/AIDS, individuals experiencing homelessness, adolescents who are pregnant or parenting, and survivors of domestic violence and sexual assault, among others. IPH staff have special expertise in conducting culturally competent work and exploring sensitive issues. IPH Community engagement efforts have included performing key informant interviews, leading focus groups, facilitating town hall meetings, and conducting patient and provider interviews.

Purpose of the Community Health Needs Assessment Report

The purpose of the 2019 CHNA was to identify, understand, and prioritize the health-related needs of San Diego County residents facing inequities. This was accomplished through two types of data collection: (1) qualitative data was collected through a community engagement process designed to solicit in-depth feedback from residents in high-need neighborhoods and from local health experts and leaders; and (2) quantitative data was obtained by extracting and analyzing data from secondary data sources.[1] Special efforts were made to include community residents from groups that experience health disparities and service providers who work with those groups. Community engagement efforts included:

- ❖ Focus groups with community residents, community-based organizations, service providers, and health care leaders
- ❖ Key informant interviews with health care experts
- ❖ Online survey distributed to community stakeholders and residents

The 2019 CHNA also included extensive quantitative analysis of San Diego County emergency department and in-patient hospital discharge data and other secondary sources. Taken together, these qualitative and quantitative approaches allowed the CHNA Committee to view community health needs from multiple perspectives. The results of the 2019 CHNA will be used to inform and adapt hospital programs and strategies to better meet the health needs of San Diego County residents.

As part of the federal reporting requirement for private, not-for-profit (tax exempt) hospitals, Scripps conducts a consolidated Community Health Needs Assessment (CHNA) and corresponding joint Implementation Strategy for its licensed hospital facilities. As a nonprofit hospital, Scripps Health is fulfilling its requirement through the development and distribution of this Assessment.

The 2019 Scripps Health CHNA is designed to provide a deeper understanding of barriers to health improvement in San Diego County. Scripps strives to improve community health through collaboration with a wide range of partners and like-minded organizations. Working with other health systems, community groups, government agencies, businesses and grassroots movements, Scripps is better able

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[1] The CDC defines secondary data as data that has been collected by another entity or for another purpose. Common sources for secondary data include the U.S. Census Bureau, California Health Interview Survey (CHIS), and the Office of Statewide Planning and Development (OSHPD).

to build upon efforts to achieve broad community health goals. Therefore, the report will help us better understand our community's health needs and inform community benefit planning and the Implementation Strategy for Scripps Health.

The Assessment is broken down into four main components:

1. Introduction to Scripps Health
2. An evaluation of the impact of any actions that were taken since the hospital finished conducting its immediately preceding (2016) CHNA to address the significant health needs identified in the prior CHNA
3. Building on previous Community Health Needs Assessments
4. Scripps Health 2019 Community Health Needs Assessment

While this is a federally mandated exercise, Scripps Health hopes to leverage the information collected for this report to benefit the community at-large in other future planning initiatives.

 For more information about Scripps Health, please visit www.scrippshealth.org.

ABOUT SCRIPPS HEALTH

III. ABOUT SCRIPPS HEALTH

Founded in 1924 by philanthropist Ellen Browning Scripps, Scripps Health is a $3.2 billion not-for-profit integrated health system based in San Diego, California. Scripps treats more than 700,000 patients annually through the dedication of 3,000 affiliated physicians and more than 15,000 employees among its five acute-care hospital campuses, home health care services, and an ambulatory care network of physician offices and 30 outpatient centers and clinic. Scripps also offers payer products and population health services through Scripps Accountable Care Organization, Scripps Health Plan and customized narrow network plans in collaboration with third-party payers

Today, the health system extends from Chula Vista to Oceanside and is dedicated to improving community health while advancing medicine. Recognized as a leader in disease and injury prevention, diagnosis and treatment, Scripps is also at the forefront of clinical research, and wireless health care. With three highly respected graduate medical education programs, Scripps is a longstanding member of the Association of American Medical Colleges. Scripps has been ranked five times as one of the nation's best health care systems by Truven Health Analytics division of IBM Watson Health. Its hospitals are consistently ranked by U.S. News & World Report among the nation's best and Scripps is regularly recognized by Fortune magazine, Working Mother magazine and AARP as one of the best places in the nation to work. More information can be found at www.scripps.org

SCRIPPS FACILITIES/DIVISIONS

Scripps Memorial Hospital Encinitas
Scripps Green Hospital
Scripps Memorial Hospital La Jolla
Scripps Clinic
Scripps Mercy Hospital
*San Diego & Chula Vista Campuses

Scripps Clinical Research Services
Scripps Coastal Medical Center
Scripps Home Health Care
Scripps Whittier Diabetes Institute

Scripps is an integrated health care delivery system consisting of four acute-care hospitals on five campuses, 30 outpatient centers and clinics, home health care, hospice care, clinical research, and ancillary services for the San Diego region and beyond. Scripps primary services include:

CARDIOVASCULAR CARE

- Scripps treats 100,000 heart patients annually – more than any other provider in San Diego. With volume comes high quality, as evidenced by the program being consistently ranked as the best in San Diego for cardiology and heart surgery by U.S. News & World Report. Scripps is the only San Diego heart program on the list that has received the coveted honor for more than a decade (2006-2018).

- In March 2015, Scripps opened the $456 million Prebys Cardiovascular Institute, which brought together expertise from across the system. The institute is the largest heart hospital on the West Coast with 167 inpatient beds and serves as the center of excellence for research and education.

- For more than 30 years, Kaiser Permanente has chosen Scripps Health to be its partner in cardiac care. Scripps is the exclusive provider of heart surgery to Kaiser Permanente members throughout the San Diego County.

DIABETES CARE AND PREVENTION

The combined diabetes and endocrinology programs of Scripps Green Hospital and Scripps Memorial Hospital La Jolla – listed as "Scripps La Jolla Hospitals and Clinics" – were ranked No. 1 in San Diego, and No. 14 nationally by U.S. News & World Report in its annual 2017–18 "Best Hospitals" rankings.

Scripps Whittier Diabetes Institute is Southern California's leading diabetes center of excellence, committed to providing the best evidence-based diabetes screening, education and patient care in San Diego, including outpatient education, inpatient glucose management, clinical research, professional education, and community-based programs.

CANCER CARE

- In 2016, Scripps Health and MD Anderson Cancer Center announced a partnership agreement to create a comprehensive and clinically integrated cancer center in San Diego, to be known as Scripps MD Anderson Cancer Center.

- Scripps MD Anderson is committed to fighting cancer through a collaborative, team approach that put the patient at the center of care.

- Scripps MD Anderson is part of MD Anderson Cancer Network, a global collaborative network of hospitals and health care systems dedicated to MD Anderson's mission to eliminate cancer.

- MD Anderson has been ranked the nation's top hospital for cancer care by U.S. News & World Report for 14 of the past 17 years. Scripps has been the leading hospital system in San Diego for nearly 95 years and cares for around a third of all cancer patients in the region.
- Scripps MD Anderson also has an expert team of oncology nurse navigators who give personalized assistance to help guide patients through their treatment journey.
- In 2008, Scripps became the first multihospital system in California to earn accreditation from the American College of Surgeons Commission on Cancer as an integrated network cancer program.
- Scripps Radiation Therapy Center on Torrey Pines Mesa, Scripps Clinic Radiation Therapy Center Vista and Scripps Clinic Radiation Therapy Center Encinitas have each been awarded a four-year accreditation by ASTRO's Accreditation Program for Excellence, or APEx. These are the first three cancer care centers in San Diego County to earn APEx distinction.
- Scripps opened a new state-of-the-art regional radiation therapy center in 2012 at Scripps Green Hospital.
- In 2015, three radiation therapy centers located in north San Diego County joined Scripps Clinic Medical Group. The centers continue to practice at their same locations under new names: Scripps Clinic Radiation Therapy Center Encinitas; Scripps Clinic Radiation Therapy Center Vista, and Scripps Clinic Radiation Therapy Center Vista CyberKnife®.
- In August of 2019, Scripps broke ground on a comprehensive regional radiation treatment center on the Scripps Mercy Hospital Campus.

ORTHOPEDICS

- Scripps Health orthopedic and spine care is committed to helping the greater San Diego community stay healthy and active. In addition to providing advanced diagnostic services, surgical and non-surgical treatments and rehabilitation care, Scripps physicians are also well-known leaders in the field of orthopedic surgery – locally and nationally.
- Dedicated to improving patient care and quality of life, Shiley Center for Orthopedic Research and Education (SCORE) at Scripps Clinic investigates the safety and efficacy of new technologies and therapies designed for the treatment of musculoskeletal diseases and disorders.
- Scripps provides musculoskeletal trauma care at Scripps Mercy Hospital, San Diego, a Level I trauma center, and Scripps La Jolla, a Level II trauma center.
- The combined programs of Scripps Green Hospital and Scripps Memorial Hospital La Jolla – listed as "Scripps La Jolla Hospitals and Clinics" – are ranked among the nation's top hospitals in orthopedics.

NEUROSCIENCES

- Scripps has been recognized for high performance in Neurology & Neurosurgery by U.S. News & World Report (2018–2019)
- Scripps is San Diego's leader in stroke prevention, life-saving stroke treatment and stroke rehabilitation. All five Scripps Health hospital campuses have earned the Stroke Gold Plus Quality Achievement Award by the American Heart Association/American Stroke Association for delivering high-quality, life-saving stroke care. The awards, which are part of the AHA/ASA's Get With The Guidelines stroke program, recognize hospitals across the United States that consistently comply with patient management quality measures.
- The Joint Commission has certified all four Scripps hospital campuses with emergency rooms as Primary Stroke Centers. The certification recognizes organizations that make exceptional efforts to foster better outcomes for stroke care. It signifies that our hospitals have all the critical elements in place to achieve long-term success in improving outcomes after stroke.
- Our physicians lead research activities designed to find better treatments for conditions like Parkinson's, MS, and Alzheimer's.

WOMEN'S AND NEWBORN SERVICES

- Scripps delivers almost 9,000 babies annually and provides care to thousands of women needing routine and advanced obstetrical care.
- Scripps offers a full spectrum of gynecology services throughout San Diego. The combined programs of Scripps Green Hospital and Scripps Memorial Hospital La Jolla – listed as "Scripps La Jolla Hospitals and Clinics" – were ranked No.1 in San Diego, and No.8 nationally by U.S. News & World Report in its annual 2017–2018 "Best Hospitals" rankings.
- The women and newborn services care line creates a forum to foster development of an integrated women's clinical care line operated at multiple Scripps Health sites bridging together the inpatient and ambulatory continuum of care. Scripps Health prioritizes system efforts related to OB, gynecology and NICU development.
- Scripps has a perinatology program, also known as Maternal Fetal Medicine Specialists offering comprehensive care for patients delivering at Scripps throughout their pregnancy episode.

BEHAVIORAL HEALTH

- The Scripps behavioral health care line offers a variety of services to adults with emotional and behavioral disorders. Our goal is to assist patients in regaining control of their lives and reconnecting with their families and community. The Scripps behavioral health services program provides inpatient treatment and access to outpatient mental health services. The psychiatric liaison services are provided at all five acute care Scripps hospital campuses and associated urgent care facilities. A supportive employment program is also offered to those seeking volunteer or employment opportunities.

PRIMARY CARE

- Scripps Health offers a county-wide network of primary care physicians with expertise in family medicine, internal medicine and pediatrics to care for individuals at every stage of their lives.
- Full range of services includes prevention, wellness and early detection services for diagnosis and treatment of injuries, illnesses and management of chronic medical conditions.

HOME HEALTH CARE

- Scripps Home Health Care Services provides a range of health care services in people's homes. Scripps Home Health has a 28-year service history in the San Diego community.
- More than 160 nurses, therapists and support staff work closely with patients' physicians and family to offer a variety of services, including nursing care, physical, occupational and speech therapy, wound management, diabetic care and cardiovascular care.

EMERGENCY AND TRAUMA MEDICINE

- Scripps operates four emergency departments and three urgent care centers and is home to two of the region's five adult trauma centers. A Level I trauma center at Scripps Mercy Hospital, San Diego and Level II Trauma center at Scripps Memorial Hospital La Jolla.
- Scripps La Jolla opened a new emergency department with three times more capacity to better serve the community. Scripps Encinitas and Scripps Mercy San Diego also opened new, larger Emergency Departments (EDs) within the past five years.
- All four Scripps emergency rooms are certified as Primary Stroke Centers by The Joint Commission, and are certified by the American Heart Association as STEMI (ST) Elevation Myocardial Infarction – a severe heart attack caused by clotting of one or more arteries) receiving centers.
- Scripps Emergency Departments (EDs)serve as major training sites for interns, residents, nurse practitioners, and physician assistants from multiple training programs around the region, including Naval Medical Center San Diego. These intensive, hands-on clinical rotations help train future providers not only for our local community but also for our troops overseas.
- Scripps EDs treats tens of thousands of disadvantaged and underserved patients each year, often for free or at steeply discounted rates through Medi-Cal and similar programs. Scripps EDs are part of the safety net for patients who often have nowhere else to turn for timely primary care or specialty care that is not available in the local community clinics.
- Scripps doctors have led the way for emergency care in San Diego County by leading the annual county-wide Emergency Care Summit, creating safe prescribing guidelines for controlled substances, promoting guidelines for the use of CT scan in pediatric head injuries, creating a system to reduce ambulance bypass hours, and educating providers about the appropriate use of anti-psychotic medications for psychiatric emergencies.

B. GOVERNANCE

As a tax-exempt health care system, Scripps takes pride in its service to the community. The Scripps system is governed by an 18-member, volunteer Board of Trustees. This single point of authority for organizational policy ensures a unified approach to serving patients across the region.

C. ORGINIZATIONAL FOUNDATION

Scripps provides a comprehensive range of inpatient and ambulatory services through our system of hospitals and clinics. In addition, Scripps participates in dozens of partnerships with government and Not-for-profit agencies across our region to improve our community's health. And our partnerships don't stop at our local borders. Our participation at the state, national and international levels includes work with government and private disaster preparedness and relief agencies, the State Commission on Emergency Medical Services, national health advocacy organizations; as well as international partnerships for physician education and training, and direct patient care. In all that we do, we are committed to quality patient outcomes, service excellence, operating efficiency, caring for those who need us today and planning for those who may need us in the future.

OUR MISSION

Scripps strives to provide superior health services in a caring environment and to make a positive, measurable difference in the health of individuals in the communities we serve.

We devote our resources to delivering quality, safe, cost-effective, socially responsible health care services. We advance clinical research, community health education, education of physicians and health care professionals and sponsor graduate medical education. We collaborate with others to deliver the continuum of care that improves the health of our community.

OUR VALUES

WE PROVIDE THE HIGHEST QUALITY OF SERVICE

Scripps is committed to putting the patient first, and quality is our passion. In the new world of health care, we want to anticipate the cause of illness and encourage healthy behavior for all that rely on us for service. We teach and encourage patients to participate in their care and to make well-informed decisions. We will be their advocates when they are most vulnerable. We measure our success by our patients' satisfaction, their return to health and well-being, and our compassionate care for dying patients, their families and friends.

WE DEMONSTRATE COMPLETE RESPECT FOR THE RIGHTS OF EVERY INDIVIDUAL

Scripps honors the dignity of all persons. We show this by our actions toward one another and those we serve. We embrace the diversity that allows us to draw on the talents of one another. We respect and honor the cultural, ethnic and religious beliefs and practices of our patients in a manner consistent with the highest standard of care. All this is done in a compassionate setting. Our goal is to create a healing environment in partnership with all caregivers committed to serving our patients.

WE CARE FOR OUR PATIENTS EVERY DAY IN A RESPONSIBLE AND EFFICIENT MANNER

Scripps serves as a major community health care resource for San Diego County and, as such, we are accountable for the human, financial and ecological resources entrusted to our care as we promote healing and wholeness. We begin from a base of excellence and collaborate with co-workers, physicians, patients, and other providers to find new and creative ways to improve the delivery of health care services. All members of our community will have access to timely, affordable and appropriate care.

OUR VISION

Scripps strives to be the health care leader in San Diego and nationally by becoming:

- The provider of choice for patients
- The employer of choice for the community
- The practice environment of choice for physicians, nurses and all health care professionals.

A major element of the Scripps mission is community benefit. The organization works to meet the needs of low-income uninsured and underinsured patients every day. Scripps offers community benefit services through our five acute-care hospitals, home health services, wellness centers and clinics. In addition to the CHNA and Implementation Plan, Scripps Health continues to meet community needs by providing charity care and uncompensated care, professional education and an array of community benefit programs.

Scripps Health documents and tracks its community benefit programs and activities on an annual basis and reports these benefits through an annual report submitted to the State of California under the requirements of SB697. Scripps Health community benefit programs are commitments Scripps makes to improve the health of both patients and the diverse San Diego communities. As a longstanding member of these communities, and as a not-for-profit community resource, Scripps' goal and responsibility is to assist all who come to us for care, and to reach out especially to those who find themselves vulnerable and without support. Through our continued actions and community partnerships, we strive to raise the quality of life in the community as a whole.

In FY 2018 Scripps documented more than $395 million in local community benefit programs and services. For more information about the programs and services offered by Scripps Health, visit www.scripps.org/communitybenefit or contact the Scripps Health Office of Community Benefit Services at 858.678.7095.

Total Community Benefits in FY18: $395,361,567

Medicare Shortfalls	$284,008,306	63.0%
Medi-Cal and other means tested government programs*	$47,735,604	22.9%
Professional Education	$24,984,374	5.5%
Charity Care	$20,245,366	4.5%
Bad Debt	$6,328,976	1.4%
Subsidized Health Services	$3,817,785	0.8%

Cash and In-Kind Contributions	$3,064,897	0.7%
Community Health Improvement Services & Community Benefit Operations	$2,269,786	0.5%
Health Research	$1,773,452	0.4%
Community Building Activities	$1,133,020	0.3%

Colors coordinate clockwise from medicare shortfalls.

12% of our total operating expenses in 2018 were devoted to community benefit services at cost.

Hospital Provider Fee was reported as offsetting revenue from Medi-Cal.

SCRIPPS IMPLEMENTATION PLAN - EVALUATION OF IMPACT BASED ON THE 2016 CHNA

Scripps Health anticipates the implementation strategies may evolve due to the fast pace at which the community and health care industry changes. Therefore, a flexible approach is best suited for the development of its response to the Scripps Health Community Health Needs Assessment (CHNA). On an annual basis Scripps Health evaluates the implementation strategy and its resources and interventions; and makes adjustments as needed to achieve its stated goals and outcome measures as well as to adapt to the changes and resources available. Scripps describes any challenges encountered to achieve the outcomes described and makes modifications as needed. In addition, Scripps Health Implementation Plan is filed with the Internal Revenue Service using Form 990 Schedule H on annual basis.

In response to identified unmet health needs in the 2016 Community Health Needs Assessment, during FY17-19 Scripps Health is focusing on the strategies and initiatives, their measures of implementation and the metrics used to evaluate their effectiveness. Scripps Health has evaluation of impact information on activities from 2017 and 2018. Not reflected in this report is the impact of strategies implemented in 2019 but we will continue to monitor the impact for 2019 and make that report available on Scripps.org.

Based on fiscal years 2017 and 2018, below is an overall summary of the strategies, metrics and outcomes to address the 2016 Community Health Needs Assessment prioritized health needs.

2016 CHNA FINDINGS

• Top health needs: Behavioral health, Cardiovascular, Diabetes, and Obesity

• In addition to the health outcome needs that were identified, social determinants of health were a key theme in all of the community engagement activities. Ten social determinants were consistently referenced across the different community engagement activities.

An in depth report with individual metrics and outcomes by individual Scripps hospital sites can be found at https://www.scripps.org/about-us__scripps-in-the-community__assessing-community-needs.

A. CARDIOVASCULAR DISEASE

Heart disease is the leading cause of death for people of most racial/ethnic groups in the United States, including African Americans, Hispanics and Caucasians. Between 70 percent and 89 percent of sudden cardiac event occur in men. About two-thirds (64 percent) of women who die suddenly of coronary heart disease have no previous symptoms. Individuals with low incomes are much more likely to suffer from high blood pressure, heart attack, and stroke.

Heart disease prevalence reports the percentage of adults who have ever been told by a doctor that they have any kind of heart disease. In San Diego County (SDC), the reported prevalence is 5.8%. It is also a significant cause of death in San Diego with 'Diseases of the Heart' ranked second, 'Cerebrovascular Disease' ranked fourth, and 'Essential (primary) Hypertension and Hypertensive Renal Disease' ranked tenth. The overall death rate from coronary heart disease decreased by 3.5% from 2014-2016 but increased among Black (8.7%) and American Indian/Alaska Native (29.4%) individuals.[2]

Figure 1. Mortality Rates for Coronary Heart Disease
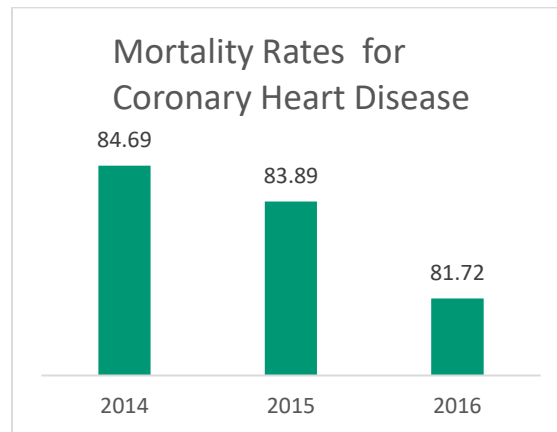
According to data presented in the Scripps 2016 CHNA, high blood pressure, high cholesterol and smoking are all risk factors that could lead to cardiovascular disease and stroke. About half of all Americans (47 percent) have at least one of these three risk factors. Additional risk factors include alcohol use, obesity, physical inactivity, poor diet, diabetes and genetic factors (CDC, 2015).

Rates of ED discharge for *Coronary Heart Disease* increased by 35.3% from 2014–2016. The steepest increases were for those 45–64 years old (41.9%) and Asian/Pacific Islanders (55.1%). Inpatient discharge rates decreased slightly (by 0.1%). [3]

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[2] County of San Diego Health and Human Services Agency Public Health Services, Regional & Community Data. https://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/community_health_statistics/regional-community-data.html
[3] California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2014-2016. SpeedTrack©

Figure 2. Hospital Discharge Rates for Coronary Heart Disease, 2014—2017

ED Dishcarge Rates for Coronary Heart Disease	Inpatient Discharge Rates for Coronary Heart Disease

ED Dishcarge Rates for Coronary Heart Disease

2014	2015	2016
28.7	33.4	38.8

Inpatient Discharge Rates for Coronary Heart Disease

2014	2015	2016
185.0	175.7	184.8
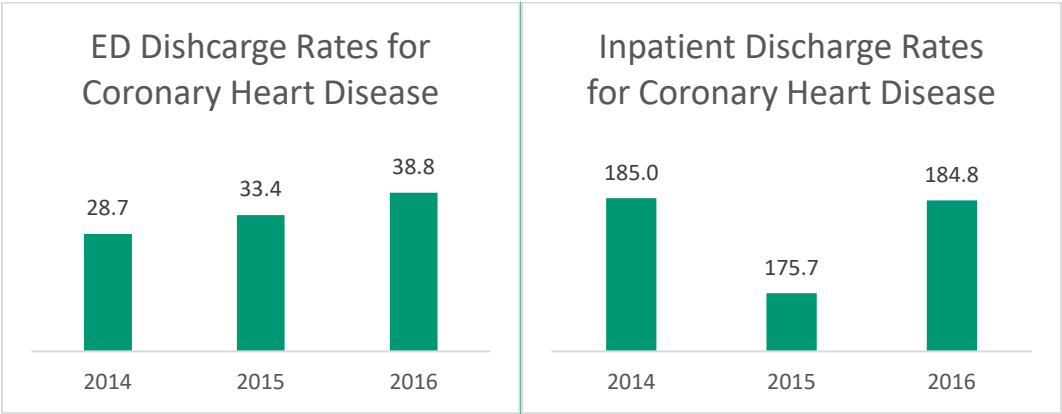
Scripps Health is addressing cardiovascular disease through the following programs and interventions:

1. ERIC PAREDES SAVE A LIFE FOUNDATION

Scripps Health is addressing cardiovascular disease in our partnership with the Eric Paredes Save A Live Foundation. Eric was a healthy Steel Canyon High School sophomore athlete who died suddenly and unexpectedly from Sudden Cardiac Arrest (SCA) in 2009. His parents established the EP Save A Life Foundation which provides free screenings to youth identify cardiac anomalies that may lead to SCA, with the ultimate goal of standardizing cardiac screenings among the youth. The goal is to prevent sudden cardiac arrest and death in middle and high school aged children, including underserved areas in San Diego County, through awareness, education and action. It's most common in student athletes. Each year 7,000 teens in the United States lose their lives due to sudden cardiac arrest (SCA). SCA is not a heart attack, it is caused by an abnormality in the heart's electrical system that can be easily detected with a simple EKG. If abnormalities are detected, a second test called an echo cardiogram, an ultrasound for the heart, is administered.

Sudden cardiac arrest is the leading cause of death on school campuses and the number one killer of student athletes. While studies show that 1 in 300 youth has an undetected heart condition, heart screenings are not part of regular well-child exams or pre-participations sports physicals, even though the first symptom of sudden cardiac arrest could be death. Free youth heart screenings provided by the Eric Paredes Save A Life Foundation are non-invasive and include a cardiac risk assessment, and EKG, a consultation with a cardiologist and if indicated, an echocardiogram. Since 2010, the foundation has screened 29,610 youth, finding 476 with cardiac abnormalities requiring follow-up serious enough to put the youth at risk for sudden cardiac arrest. In 2018, 81 percent of youth screened participated in school or community sports programs. More than half of youth screened represent diverse ethnicities, while 39% were from extremely low to moderate income households. Nearly 250 youth indicated they did not have a regular pediatrician, while four percent were uninsured. Of parents surveyed, 61 percent indicated they were not aware of the need to actively prevent SCA in youth, while unaware of warning signs and risk factors.

When findings are positive, Scripps takes the following steps:

- Checks for an abnormal heartbeat that could signal an underlying heart condition using an echocardiogram.
- Notifies parents of the results for follow-up with their family physician.

STRATEGIES

Scripps partners with local San Diego schools to administer and read electrocardiograms and if warranted an echocardiogram screening by Scripps physicians (cardiologist) before high school students participate in organized sport and activities. As a sponsor of the Eric Paredes Save A Life Foundation, Scripps has held more than 10,000 free cardiac screenings for local teens, including the homeless and the underinsured. Scripps provides financial contribution annually to help pay for the screenings.

EVALUATION METHODS AND MEASURABLE TARGETS

Table 1. Results: Eric Paredes Save A Life Foundation

Objective(s): To prevent sudden cardiac arrest and death in middle and high school aged children, including underserved areas in San Diego county through awareness, education and action.		
Performance Measures	2017	2018
In the total number of adolescent Screenings, 6% of the 4,915 were uninsured adolescents.	3,533	4,915
Total number of adolescents with positive finding of heart abnormalities.	35	32
Total number of high-risk adolescents identified.	13	23

2. ADULTS SCREENING IN CONJUNCTION WITH THE EP SAVE A LIFE "SCREEN YOUR TEEN" EVENTS

STRATEGIES

Scripps Health empowers community members with cardiovascular screenings, education and support. Scripps promotes accountability and behavior change through education on chronic disease self-management by providing Lipid panel/glucose screenings, body analysis screenings and heart care information for adults in conjunction with the EP Save A Life "Screen Your Teen" events.

EVALUATION METHODS AND MEASURABLE TARGETS

Table 2. Results: Adult Screenings: Eric Paredes Save A Life Foundation

Objective(s): Empower community members with cardiovascular screenings, education and support. Promote accountability and behavior change through education on chronic disease self-management.		
Performance Measures	2017	2018
Track number of cardio check tests for adults screened	20	36
Track number of adults found at risk	0	8
Track number of referrals	0	8

CHALLENGES

In FY18, the program manager was the only staff person conducting the screening program and his main role was market outreach. We were not able to provide the full lipid panel/glucose screening, but blood pressure screenings were conducted.

3. SWEETWATER UNION HIGH SCHOOL DISTRICT PRE-PARTICIPATION SPORTS SCREENING ASSESSMENTS

Scripps Health prevents sudden cardiac arrest and death primarily in the South Bay, for high school aged students by increasing education and awareness related to cardiovascular screenings and healthy lifestyles.

STRATEGIES

Scripps partners with local Sweetwater High School District yearly to implement cardiac screenings and sports physicals before students participate in organized sports. Scripps Community Benefits, Chula Vista Scripps Family Medicine Residents assist with the screenings. Metrics are collected via surveys bi-annually and insurance information is collected via surveys at injury clinics. Two injury clinics were held on 8/18/18 and 9/15/18. The sports physicals are conducted once a year before students participate in organized sports.

Table 3. Sweetwater Union High School District Pre-Participation Sports Screening Assessment

Objective(s): To prevent Sudden Cardiac Arrest (SAC) and death in South Bay/Chula Vista high school students by increasing education and awareness related to cardiovascular screenings and healthy lifestyles.		
Performance Measures	2017	2018
Total number of youths screened	814	1,025
Number of youths with heart abnormalities	1	2
Percentage of individuals that are underserved *(based on enrollment in school lunch program)*	51.9%	51.9%
Number of injury clinics held during football season. Dates: 8/18/18 and 9/15/18	2	2

4. SU CORAZON, SU VIDA / YOUR HEART, YOUR LIFE – SCRIPPS MERCY HOSPITAL, CHULA VISTA

Scripps Health supports individuals to manage their heart health through a community intervention program which decreases the readmission rates for heart failure patients, reduces medical costs for patients and improves their quality of life in underserved population in the South Bay San Diego, and underserved community along the US/Mexico border region.

STRATEGIES

Scripps implements a five-week educational based community intervention program to support improved quality of life for patients diagnosed with heart disease. Patients in the intervention group are followed up weekly via phone for five consecutive weeks. These calls are focused on motivational support and encouragement. An educational packet is given to support the initial educational seminar that includes information from the *Your Heart, Your Life* curriculum.

EVALUATION METHODS AND MEASURABLE TARGETS

- Participants receive an initial heart health educational session that includes review of daily-self assessment, salt avoidance, and exercise and medication adherence.
- Outcomes explored include decreased hospitalizations and improved biometric measures including weight and blood pressure pre and post.
- Readmissions related to heart failure are tracked in each participant. (The number of times a patient is admitted to the hospital for a condition related to heart disease is tracked over the course of the intervention).
- Each participant is given a "Health Habits" pre-test and post-test to measure behavior change.

Table 4. Su Corazon, Su Vida – Your Heart, Your Life

Objective(s): Empower Latina women to manage their heart health through a community intervention program which decreases the readmission rates for heart failure patients and improves their quality of life in the underserved population in South Bay, San Diego, and underserved communities along the U.S./Mexico border region.				
Performance Measures	**2017**		**2018**	
Number of initial Heart Health Education participants	66		33	
Overall Unhealthy Behavior	Pre	Post	Pre	Post
	21%	11%	81%	19%
Overall Healthy Behavior	Pre	Post	Pre	Post
	79%	98%	69%	31%
Pre	Post	178.5	177.3	171.3	170.3
Pre	Post	134/75	132/75	126/77	125/76
Number of Heart Failure Readmissions	2		9	

5. STROKE RISK PROGRAM

Stroke was the fourth leading cause of death in San Diego County in 2016. Death rates for stroke increased by 17.6% from 2014–2016. The increase was steepest for Hispanics (28.5%).[4]

Figure 3. Mortality Rates for Stroke, 2014–2016
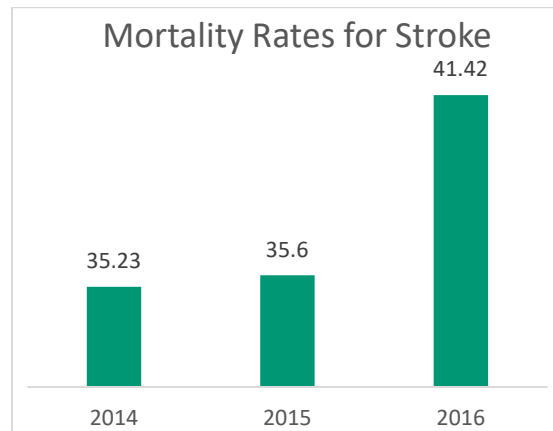
Rates of ED discharge for *stroke* increased by 11.0% from 2014–2016. The steepest increases were for those 27–44 (20%) and for people who identify their race as "Other" (28.9%). Rates of Inpatient discharge for stroke decreased by 4.1%.[5]

Figure 4. Hospital Discharge Rates for Strokes
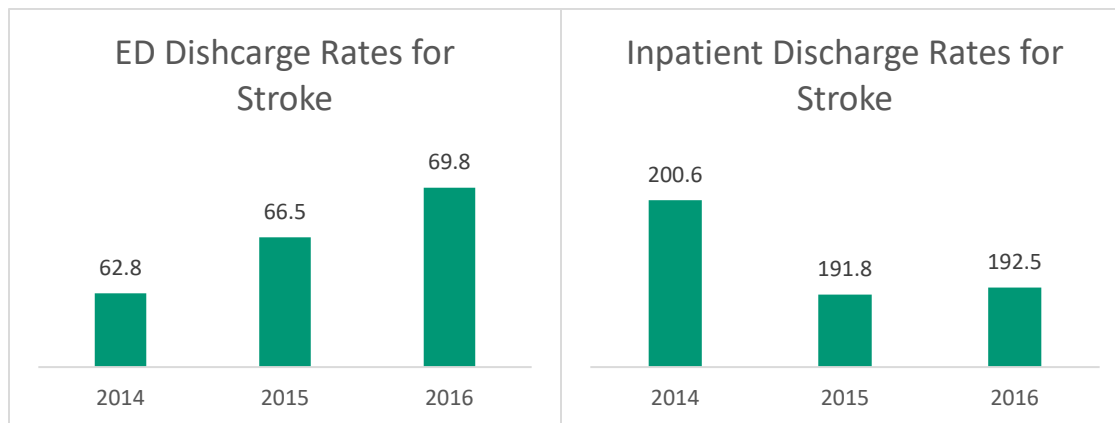
Seventy to seventy-five percent of strokes and heart attacks can be reduced by eliminating risk factors. Scripps and its partners will work to make San Diego a heart attack and stroke free zone by educating

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[4] County of San Diego Health and Human Services Agency Public Health Services, Regional & Community Data. https://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/community_health_statistics/regional-community-data.html

[5] California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2014-2016. SpeedTrack©

and engaging individuals and communities in understanding and taking action to address the risk factors that cause heart attack and strokes.

STRATEGIES

Scripps Health educates and engages the San Diego community for stroke by attending at least one community event and screening for stroke via a stroke risk factor score card and educating individuals on the FAST test. The FAST test was developed in the UK in 1998 by a group of stroke physicians, ambulance personnel, and emergency room physician and was designed to be an integral part of training package for ambulance staff. The FAST test is an easy way to recognize and remember the most common signs of stroke. Using the FAST test involves asking three simple questions. The acronym stands for **F**acial drooping, **A**rm weakness, **S**peech difficulties and **T**ime.

- **F**acial drooping: A section of the face, usually only on one side, that is drooping and hard to move. This can be recognized by a crooked smile.
- **A**rm weakness: The inability to raise one's arm fully.
- **S**peech difficulties: An inability or difficulty to understand or produce speech.
- **T**ime: If any of the symptoms above are showing, time is of the essence, call the emergency services or go to the hospital.

In FY18, The Scripps Stroke Team and their community partners worked on the vision to make San Diego a heart attack stroke free zone by educating and engaging individuals and communities in understanding and taking action to address the risk factors that cause heart attack and stroke. The following are the events the Stroke Team participated in:

ANNUAL CORONADO FIRE DEPARTMENT OPEN HOUSE

The Scripps Health Stoke Team participated in the Coronado Fire and Police Departments annual open house. Stroke Team members provided community outreach through stroke risk screenings as well as education on stroke to the public. Informational provided to the community included education on stroke signs and symptoms, risk factors, healthy life style promotions, and calling 911 for someone with symptoms of stroke. This event was held at the Coronado Fire Department. The event is open for all San Diego County residents to attend but primarily serves residents of Central San Diego City and those on Coronado Island.

ANNUAL IMPERIAL BEACH FIRE DEPARTMENT OPEN HOUSE

The Scripps Health Stoke Team participated in the Imperial Beach Fire Department's annual open house. Stroke Team members provided community outreach through stroke risk screenings as well as education on stroke to the public. Informational provided to the community included education on stroke signs and symptoms, risk factors, healthy life style promotions, and calling 911 for someone with symptoms of stroke.

This event was held at the Imperial Beach Fire Department. The event is open for all San Diego County residents to attend but primarily serves residents of Southern and South Bay San Diego City.

<u>STRIKE OUT STROKE</u>

Strike Out Stoke is a national fundraising and community awareness campaign to educate the public about the urgency as well as the signs and symptoms of stroke. The simple mission of Strike Out Stroke is to spread the **F.A.S.T** message across the country and greatly increase the number of stroke survivors who get to the hospital in time to get life-saving treatment. The San Diego event was held on April 18th, 2018 in collaboration with the San Diego County Stroke Consortium in which donors attend a game at PETCO Park to see the Padres play. The Stoke Team had an informational booth that provided community outreach through stroke risk screenings and education on stroke. Education included signs and symptoms of stroke, risk factors, healthy life style promotions, and calling 911 for someone with symptoms of stroke.

This event was held at PETCO Park in Downtown San Diego. The event is open for all San Diego County residents that buy a ticket and attend the baseball game. Although the event is in downtown San Diego given the nature of the event the population served is generalized county wide.

EVALUATION METHODS AND MEASURABLE TARGETS

Table 5. Stroke Risk Factor Program

Objective(s): Scripps and its partners will work to make San Diego a heart attack and stroke *free zone* by educating and engaging individuals and communities in understanding and taking action to address the risk factors that cause heart attacks and strokes.		
Performance Measures	2017	2018
Total number of community events	5	3
Total number of completed risk factor score cards	118	117
Number of high-risk individuals identified	31	11
Number of referrals made	15	11
Number of individuals that are uninsured/underserved	13	0

Throughout the three events 11 individuals were identified as high risk for stroke. This is a decrease from 31 total from FY17. The largest difference between the two fiscal years occurred at the Imperial Beach Fire Department event where, although a similar number of individuals were screened for risks there was a significant decrease in the number identified as high risk. The reason for the decrease is unknown but may be related to the population attending the event or increased awareness regarding stroke throughout the county.

For FY18, 11 referrals were made throughout the three events, which is a few less than FY17. This may be because there were two fewer events in FY18 than in FY17 when the additional referrals occurred.

There is also a noticeable difference in the number of identified uninsured individuals between FY17 and FY18. FY18 had zero reported uninsured individuals screened, including at the event where the majority of high-risk individuals are identified, whereas FY17 had 13 uninsured individuals identified. The reason for the difference is unknown. The response by the individual to the question of insurance at the time of screening is voluntary and so the number of uninsured individuals screened may be inaccurate. The difference may also be related to the population of attendees or stroke awareness throughout the county.

B. DIABETES (TYPE 2)

There are 29 million people with diabetes in the United States and 382 million worldwide, and the rates are the highest in diverse racial and ethnic communities and low-income populations. Type 2 diabetes has reached epidemic proportions, and people of Hispanic origin have dramatically higher rates of the disease and the complications that go along with its poor management, including cardiovascular disease, eye disease and limb amputation. Diabetes is a major cause of heart disease and stroke and is the 7th leading cause of death in the United States and California. More than 1 out of 3 adults have prediabetes and 15-30% of those with prediabetes will develop Type 2 diabetes within 5 years. This is especially true in the South Bay communities in San Diego. Specifically, the city of Chula Vista is home to 26,000 Latinos with diagnosed diabetes and tens of thousands more who are undiagnosed, have prediabetes and at high risk of developing diabetes. A summary of the magnitude and prevalence of diabetes is described below.

Diabetes is an important health need because of its prevalence and its potential to have a devastating impact on morbidity and mortality. Diabetes is also largely preventable; rates of diabetes are, therefore, potentially amenable to health promotion efforts. Diabetes was the seventh leading cause of death in San Diego County in 2016. The age-adjusted death rate for diabetes increased 16.3% from 2014-2016. Increases were steepest for Hispanics (53.0%) and those who identify as "Other" (35.0%).[6]

Figure 5. Mortality Rate for Diabetes in San Diego County
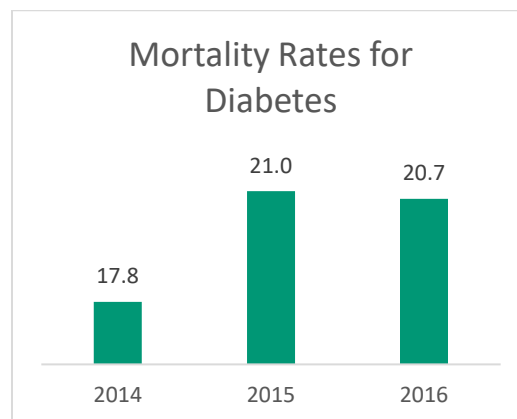
Mortality Rates for Diabetes

2014	2015	2016
17.8	21.0	20.7

[6] County of San Diego Health and Human Services Agency Public Health Services, Regional & Community Data. https://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/community_health_statistics/regional-community-data.html

In San Diego County, in 2017, 9.4% of adults had diabetes.[7] ED discharges for diabetes increased 7.2% stable from 2014–2016; increases in discharge rates were highest (13.9%) or those 27–44 years old and for Asian/Pacific Islander (16.3%) and Black individuals (15.1%). Inpatient discharge rates for diabetes decreased slightly (0.7%) from 2014–2016 but increased for Asian/Pacific Islanders (28.6%) and for people 11–17 years old (15.7%) and for people 18–26 years old (28.8%).[8]

Figure 6. Discharge Rates for Diabetes
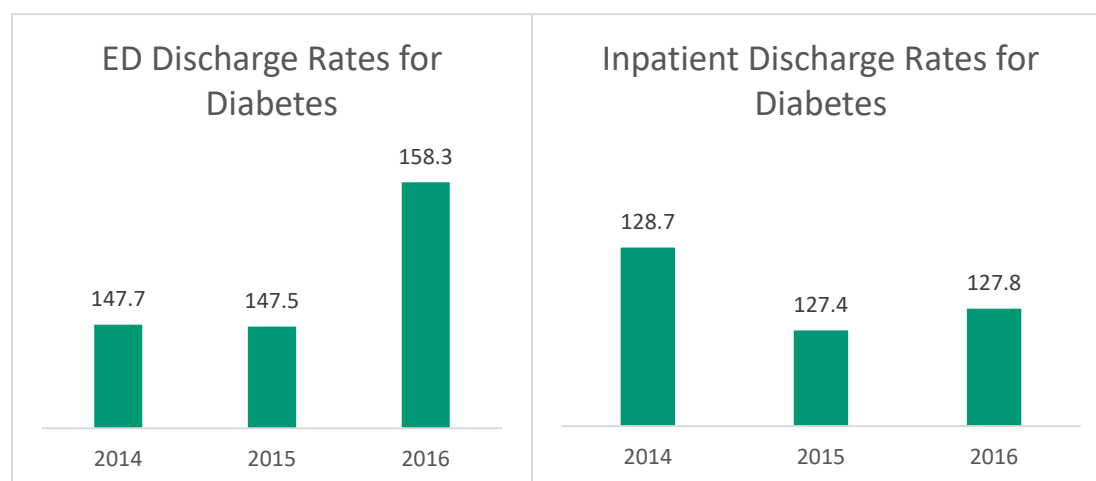
During focus groups, health care personnel working in clinics and hospital settings discussed diabetes and its management as one of the "biggest health issues" they face; they also indicated that the public seems unaware about how to prevent the onset of diabetes. Community residents also identified diabetes management as a significant health problem for San Diego County. In particular, the cost of insulin was cited as a significant barrier to care for diabetes management, and because insulin needs to be refrigerated, diabetes management was noted as especially challenging for those without a refrigerator, such as those who are homeless.

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[7] California Health Interview Survey, 2013 to 2017, UCLA Center for Health Policy Research. California Health Interview Survey, 2013 to 2017, UCLA Center for Health Policy Research. Rates indicate the percentage of people who had a diagnosis of diabetes in 2017.

[8] California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2014-2016. SpeedTrack©

Community input was also collected through the CHNA on the most common health issues that contribute significantly to overall morbidity through key informant interviews and community partner discussions. The results for diabetes (Type 2) are summarized in Table 6.

Table 6. Summary of Community Input on Common Diabetes (Type 2) Issues, HASD&IC 2016 CHNA

SUMMARY OF DIABETES (TYPE 2)-RELATED RESPONSES*
1. WHAT ARE THE MOST COMMON HEALTH ISSUES OR NEEDS?
• Assumption that diabetes only affects older individuals   • Diet and sugar • Chronic kidney disease related to diabetes   • Lack of supplies • Diabetes related to low income and food insecure population   • Treatment compliance issues

Based on feedback during Key Informant Interviews and Community Partner Discussions

An assessment of health needs by HHSA regions found that diabetes was cited as being among the top five most important health problems in Central, East and North County (comprised of North Coastal and North Inland). Uncontrolled Type 2 diabetes was found to be a major contributor to poor diabetes related outcomes and a significant area of need in San Diego County.

Scripps Health is addressing diabetes through the following programs and interventions:

1. THE SCRIPPS DIABETES CARE RETINAL SCREENING PROGRAM

It is estimated that every 24 hours, 55 people will lose their vision as a direct result of diabetic retinopathy. With early diagnosis and appropriate treatment, 95 percent of diabetic blindness could be prevented. The Scripps Whittier Diabetes Institute collaborates with community clinics and organizations to provide much needed services and solutions. For the past decade, the Scripps Diabetes Care Retinal Screening Program has provided low-cost or free screenings to the community. Retinal screenings are important for the prevention and early treatment of diabetic retinopathy.

STRATEGIES

Scripps improved identification of diabetic retinopathy (vision complications because of diabetes) through preventions, early diagnosis and appropriate treatment in the underserved population. With early diagnosis and appropriate treatment, 95% of blindness can be prevented. The Scripps Diabetes Care Retinal Screening Program provides low-cost and/or free screenings to the community. Patients are screened and retinal photographs are taken. After the screenings are interpreted, follow-up care is arranged as needed. The impacts of such a community retinal program create the following benefits:

- Prevention or diagnosis of vision problems, including blindness.
- A reduction in visits to the emergency department for uncontrolled complications of diabetes
- Cost saving to patients and health care systems. The cost to screen each patient is about $30 versus emergency department fees, possible laser treatment and office visits that could potentially cost up to $23,000 per year per patient).

Table 7. The Scripps Diabetes Care Retinal Screening Program

Objective(s): Improve identification of diabetic retinopathy (vision complications because of diabetes) through preventions, early diagnosis and appropriate treatment in the underserved population.		
Program Measures	2017	2018
Total Screening Events	24	25
Total Patients Screened	542	534
Percentage of Positive Screens	28%	33.5%
Percentage of individuals referred to Primary Care Physician	100%	100%
Percentage of individuals referred to Retinal Specialist	6%	5.8%

CHALLENGES

One of the successes of the retinal screening program is having a solid relationship with a clinical partner for follow up and referrals for individuals found at risk. Without this link to a clinical home we risk patients not having navigation to treatment. In FY18, the program manager was the only staff person conducting the screening program. His main role was market outreach and currently he is only allocated 16 hours a month to the retinal program. Therefore, screenings were only held at Encinitas, La Jolla and Mercy hospitals for FY18.

2. PROJECT DULCE CARE MANAGEMENT

The Project Dulce program has been fighting the diabetes epidemic for more than 20 years by providing diabetes care, self-management education and continuous support to low-income and uninsured populations throughout San Diego County. Recognized for its impact, the comprehensive program serves as an international model of patient care and advocacy, helping individuals with the disease learn to improve their health. One of the primary components of the program is recruiting peer educators from the community to work directly with patients. These educators reflect the diverse population affected by diabetes and help teach others about the changing eating habits, adopting exercise routines and other ways to help manage this chronic disease. The impacts of such a community diabetes care management program create the following benefits:

- Higher quality of care.
- Reduced hospital and emergency department care costs.
- Decreased incidence of diabetes-related complications and hospitalizations.
- Improvements in health status and quality of life.

STRATEGIES

Scripps improves self-management education for underserved population living with diabetes. It offers a comprehensive, culturally sensitive diabetes self-management program for underserved and uninsured populations. These educators, "Promotoras", reflect the diverse population affected by diabetes and will help teach others about changing eating habits, adopting exercise routines and other ways to help manage this chronic disease. Refer to Table 8 for program measures.

EVALUATION METHODS AND MEASURABLE TARGETS

Table 8. Project Dulce Care Management Program

Objective(s): Improve self-management education for underserved population living with diabetes.		
Program Measures	2017	2018
*Total number of new patients cared for by clinical team.	1,258	5,165

*Individuals with more chronic needs will be referred for the Project Dulce Clinical component and will not be traced through the Implementation Plan.

While there was a larger increase in people served in FY18 at Mercy Hospital there was a significant decline at the other hospital sites. In FY18 there was an overall reduction of Diabetes Health Educators (DHE's). An internal strategic decision was made at Scripps Whittier Diabetes Institute to shift resources to Scripps Whittier Diabetes DSME program and as a result the Project Dulce community classes were reduced significantly. To that, in FY18, Scripps adopted the role of Diabetes Health Educator (DHE - community health workers) to deliver T2 DSME programs with its payor population. This resulted in less available staff to continue efforts in the community with Project Dulce classes. In the summer of 2018, two new Diabetes Health Educators were hired. They were officially signed off to teach Project Dulce classes in December 2018. These new staffing resources will allow the Whittier Diabetes Institute to re-initiate the Project Dulce Community classes. For FY19, an additional 1.0 FTE DHE will be hired, and the Whittier is committed to offering a minimum of 10 Project Dulce class series in the FY19.

Pre/Post Survey metrics

- Track knowledge of diabetes recommendations
- Track diabetes distress
- Track support for diabetes management
- Track diabetes self-care behaviors (fruit/vegetable consumption, exercise, blood glucose monitoring, medication adherence, foot checks).

3. MEDICAL ASSISTANT HEALTH COACHING (MAC) FOR DIABETES IN DIVERSE PRIMARY CARE SETTINGS – SCRIPPS HOSPITAL ENCINITAS

Diabetes affects nearly 29 million individuals in the U.S, and if current trends continue, 1 of 3 adults will have diabetes by 2050. Diabetes self-management education and support (DSME) is a cornerstone of effective care that improves clinical control and health outcomes, however, DSME participation is low, particularly among underserved populations, and ongoing support is often needed to maintain DSME gains.

In 2015, the National Institute of Diabetes and Digestive and Kidney Diseases (NIH/NIDDK) granted Scripps Whittier Diabetes Institute $2.1 million to fund the MAC Trial, which is studying an innovative team care approach that trains medical assistants (MAs) to provide health coaching in the primary care setting to patients with poorly controlled Type 2 diabetes, help them problem solve, and improve their diabetes-related health outcomes. The goals include improving diabetes self-management and clinical outcomes, such as blood glucose levels, cholesterol and blood pressure. The study is being conducted in two diverse settings: a Scripps Health primary care practice, and a community health center, Neighborhood Healthcare. The MAC program offers a potential solution to the burgeoning primary care demand capacity imbalance that can be applied in diverse healthcare setting to better address the needs of the growing number of individuals with Type 2 diabetes management.

STRATEGIES

The program takes place within the primary care clinics of two health systems that serve large, ethnically/racially, and socioeconomically diverse populations in San Diego County. Neighborhood Healthcare (a FQHC) and Scripps. One clinic within each system is designated to MAC (Scripps Clinic Encinitas, n=150, Neighborhood Healthcare Temecula, n=150), and one Usual Care (UC) (Scripps Coastal Carlsbad, n-150, Neighborhood Healthcare Escondido, n=150). In addition to usual care, MAC clinic patients receive brief, targeted self-management support from the MA Health Coach. The MA incorporates health behavior assessment, medication reconciliation, motivational interviewing, goal-setting, problem-solving, and "closing the loop" techniques – all tailored to patient-specific needs and priorities. As needed, Medical Assistants coordinate brief phone follow-up to review progress and problem-solve barriers. Refer to Table 9 for program measures.

EVALUATION METHODS AND MEASURABLE TARGETS

Electronic health records are used to identify eligible patients and to examine change in clinical outcomes over 12 months. Phone surveys are used to assess changes in behavioral (diabetes self-care) and psychosocial (quality of life, patient activation) outcomes in 50% of participants at baseline, and 6 and 12.

Table 9. Medical Assistant Health Coaching (MAC)

Objective(s): The complex needs of individuals with diabetes cannot be adequately addressed in the typical 15-minute primary care visit. By adopting a "team based" approach, other primary care personnel (e.g., medical assistant (MA)) can be trained as health coaches to work in tandem with primary care providers to deliver self-management support.

Program Measures	2017	2018
Number of eligible patients	482	489
Number of enrolled patients	59*	34*
Number patients declined	4	7

*Maximum class size is 390. Classes start on different cycles throughout the 12-month period. New patients enroll as openings occur.

C. BEHAVIORAL HEALTH

Behavioral health encompasses many different areas including mental health and substance abuse. Because of the broadness of this health issue, it is often difficult to capture the need for behavioral health services with a single measure. Mental health can be defined as "a state of complete physical, mental and social well-being, and not merely the absence of disease". Mental illness is defined as "collectively all diagnosable mental disorders" or "health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning". Behavioral health is an important health need because it impacts an individual's overall health status and is a comorbidity often associated with multiple chronic conditions, such as diabetes, obesity and asthma.

An analysis of mortality data in San Diego County found that in 2016, intentional self-harm (suicide) was the ninth leading cause of death. In 2016, the age-adjusted suicide rate in San Diego was 11.9 per 100,000. Rates were highest among Whites (18.7), followed by Blacks (11.5), Asian Pacific Islanders (8.2) and Hispanics (5.3). While the rate of suicide decreased slightly (1.3%) from 2014-2016, the rates of suicide for people who identify as Asian/Pacific Islander, Black, and "other," increased in those same years by 13.3%, 47.2%, and 93.0% respectively.[9]

Figure 7. Age Adjusted Suicide Rates in San Diego County

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[9] Live Well San Diego. Live Well San Diego Data Access Portal. Injury. https://data.livewellsd.org/
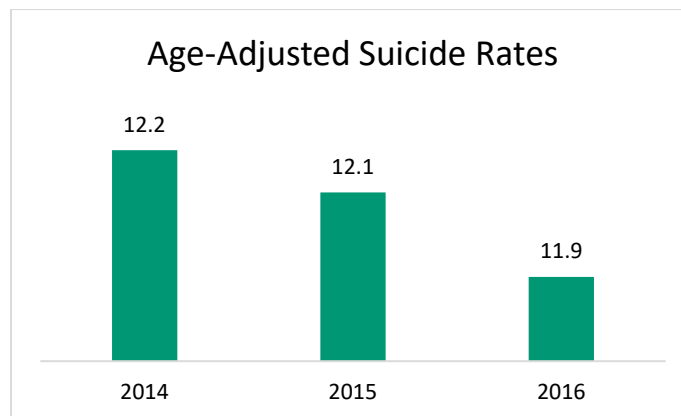
Mental health issues affect nearly 1 in 5 people, and when left untreated, are a leading cause of disability, are associated with chronic disease, and may lead to premature mortality. In San Diego County, 12.4 people per every 100,000 die from suicide annually, and approximately 10% of all adults seriously consider committing suicide. While the rate of suicide decreased slightly (1.3%) from 2014–2016, the rates of suicide for people who identify as Asian/Pacific Islander, Black, and "other," increased in those same years (13.3%, 47.2%, 93.0%). In addition, more people are being discharged emergency departments for anxiety than in the past – rates increased by 4.3% between 2014–2016, while rates of inpatient discharges for anxiety decreased by 7.9% during the same time period. People who identify as "other race" and Black/African American had the highest rates of ED and hospital discharge for anxiety.[10]

Figure 8. Hospital Discharge Rates for Anxiety
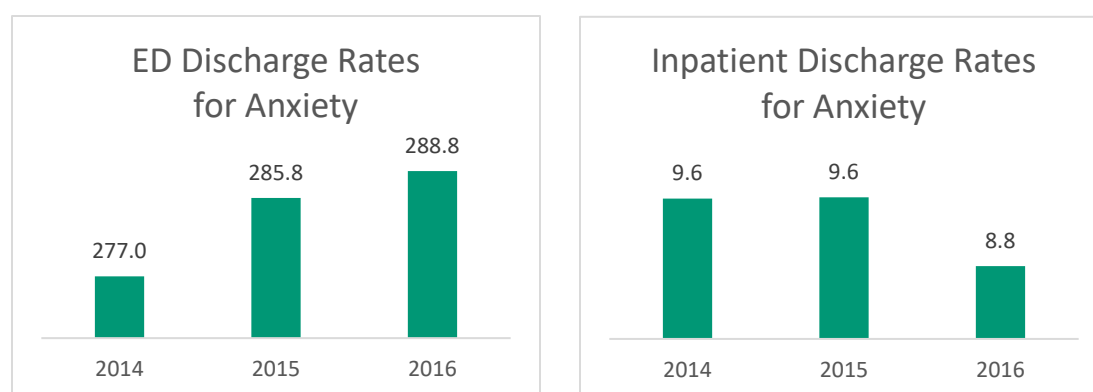
ED Discharge Rates for Anxiety — 2014: 277.0, 2015: 285.8, 2016: 288.8

Inpatient Discharge Rates for Anxiety — 2014: 9.6, 2015: 9.6, 2016: 8.8

ED discharges for mood disorders also increased (5.9%) from 2014-2016, while inpatient discharges for mood disorders decreased by 2.9%. Discharge rates for mood disorders were higher for people who identify their race as Black/African American than for any other race.[11]

Figure 9. Hospital Discharge Rates for Mood Disorders
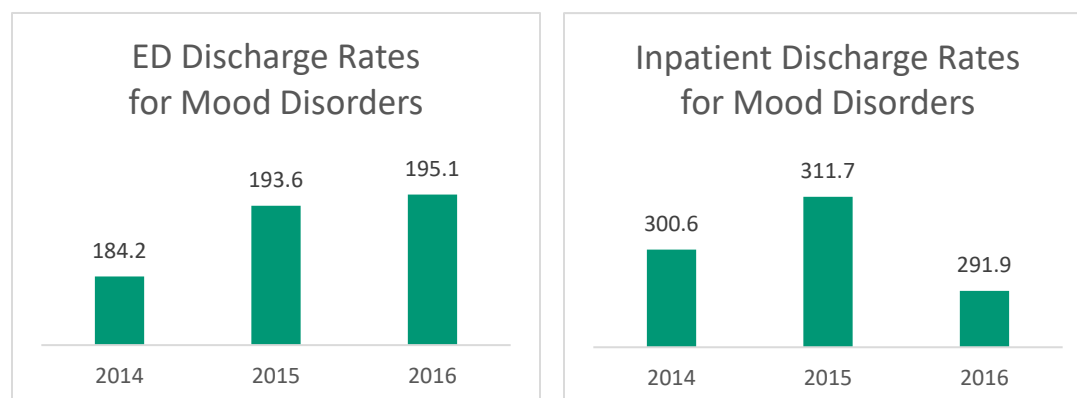
ED Discharge Rates for Mood Disorders — 2014: 184.2, 2015: 193.6, 2016: 195.1

Inpatient Discharge Rates for Mood Disorders — 2014: 300.6, 2015: 311.7, 2016: 291.9

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[10] California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2014-2016. SpeedTrack©
[11] California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2014-2016. SpeedTrack©

In the community engagement process, residents described the desperation of people who need but cannot get quality, timely mental health services; they emphasized that while accessing services is hard for everyone, for people who may be at the highest risk for trauma related mental illness – like veterans, refugees, and the LGBTQ community, and for those who are uninsured, access to this care seems nearly impossible.

Substance and opioid misuse. Substance use, particularly opioid misuse, is a health crisis that has reached epidemic proportions both nationally and locally. In San Diego County, ED discharges for opioid misuse increased by 267.2% from 2014-2016, while inpatient discharges increased by 239.3%. The steepest increases in both discharge rates were among people 65+, who experienced a 1,734.4% increase in ED discharges and an 863.1% increase in hospital discharges.[12]

Heavy alcohol consumption is also problem in San Diego County. Nearly 20% of adults ages 18 and older self-report excessive alcohol use. Participants in the community engagement process discussed the link between mental health and substance misuse, arguing that the failure to provide preventive and acute mental health services often leads to self-medicating with drugs and alcohol. They also an insufficient supply of substance use disorder outpatient and in-patient drug treatment programs as a critical need in San Diego County.

Community input was also collected on the most common health issues that contribute significantly to overall morbidity through key informant interview and community partner discussion. The results for behavioral health are summarized in Table 10.

Table 10. Summary of Community Input on Common Behavioral Health Issues, HASD&IC 2016 CHNA

Summary of Behavioral Health-Related Responses*	
1. What are the most common health issues or needs?	
- Anxiety - Behavioral health affects all other diseases - Depression - Dementia and Alzheimer's in seniors - Homelessness - Increase in developmental disorders in children - Lack of psychiatrists	- Lack of training in schools - Problems with compliance/coverage - Self-injury/suicidal ideation in youth - Smoking - Social media/bullying - Stress - Substance Abuse — Drugs/alcohol

Based on feedback during Key Informant Interviews and Community Partner Discussions

Behavioral health issues and alcohol/drug abuse issues were consistently selected by the highest number of HHSA survey participants in all regions as health problems that have the greatest impact on overall community health. In addition, aging concerns including Alzheimer's was cited among the top five most important health needs in all regions in San Diego except Central.

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[12] California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2014-2016. SpeedTrack©

The following categories were found to be important health needs within behavioral health in San Diego County:

- Alzheimer's disease (seniors)
- Anxiety (all age groups)
- Drug and alcohol issues (teens and adults)
- Mood disorders (all age groups)

Scripps Health is addressing behavioral health disease through the following programs and interventions:

1. PSYCHIATRIC LIAISON TEAM (PLT)

The Psychiatric Liaison Team is a mobile psychiatric assessment team with clinicians providing mental health evaluation and triage services. Although based at Scripps Mercy Hospitals, the team travels countywide serving all Scripps Hospitals.

STRATEGIES

The Psychiatric Liaison Team (PLT) helps to accurately access patients and provide them with the best and safest community resources in order to enhance the continuity of care for every patient. The goal is to reduce rates of readmission to the hospital, help people adhere to treatment plans, bring about the relief of symptoms and ensure the long-term stabilization of the individual's health. Scripps will continue to provide a dedicated Psychiatric Liaison Team at all Scripps Hospitals Emergency Departments and urgent care settings (Ranch Bernardo and Torrey Pines).

EVALUATION METHODS AND MEASURABLE TARGETS

The PLT clinicians are a resource to the acute care and urgent care settings with a primary responsibility to; perform a psychosocial evaluation upon receipt of a physician order, serve as liaisons between the system-wide patients care settings, Scripps Mercy Hospital's Behavioral Health Unit and provide community behavioral health resources. Information is retrieved from the Midas Data Base, for all patients seen by the Psychiatric Liaison Team. Refer to Table 11 for program measures

Table 11. Psychiatric Liaison Team (PLT)

Objective(s): The Psychiatric Liaison Team will help to accurately assess patients and provide them with the best and safest community resources in order to enhance the continuity of care for every patient.		
Programs Measures	2017	2018
Number of encounters (visits) referred to inpatient **setting**		
a. Discharge/ Transfer from ED to Mercy Behavioral Health Unit	1,227	1,233
b. Other Non-Scripps Inpatient Facilities	101	51
c. Crisis Residential Placement	37	1
	2017	2018
Number of encounters (visits) referred to an outpatient **setting**		
a. Patient given outpatient referrals	678	486
b. Family Health Centers	11	17
c. Outpatient Psychiatrist	74	43
d. Detox	17	14
e. Shelter	16	20

2. SCRIPPS DRUG AND ALCOHOL RESOURCES NURSES

Through a contract with Volunteers of America (VOA), Scripps provides safe detox up to five patients per week with Case Management from the Scripps Drug and Alcohol Resource Nurses to help them into community-based programs. Note: Scripps will not be contracting with Volunteers of America in 2019 and will be looking to partner with other organizations. The role of the resource Nurse is to work directly with the nursing staff at each of the hospitals in search of patients who may be at risk for alcohol/drug withdrawal. The proactive approach involves daily discussions with the Charge Nurse on characteristics of an addicted patient as well as specific diagnosis common to those with substance abuse.

STRATEGIES

Patients presenting with mental health, drug and alcohol complications are identified to the appropriate level of care including community clinics. Providers have an increased ability to provide treatment to those who are unfunded or underfunded.

EVALUATION METHODS AND MEASURABLE TARGETS

The VOA uses intensive wrap-around approaches to provide clients with tip-quality clinical services, as well as the support the need to best manage their behavioral health. An enhanced case management approach is used, promoting intensive coordination and communication with Scripps staff. Refer to Table 12 for program measures.

Table 12. Scripps Drug and Alcohol Resource Nurse

Objective(s): Patients presenting with mental health, drug and alcohol abuse will be identified to the appropriate level of care including community clinics. Providers will have an increased ability to provide treatment to those who are uninsured or underinsured.		
Program Measures	2017	2018
Number of referrals sent to Volunteers of America (VOA)	110	73

3. MI PUENTE: "MY BRIDGE" TO BETTER CARDIOMETABOLIC HEALTH AND WELL BEING SCRIPPS MERCY HOSPITAL, CHULA VISTA

Scripps Whittier Diabetes Institute received a $2.4 million study grant from the NIH's National Institute of Nursing Research in 2015 to evaluate Mi Puente, a program at Scripps Mercy Chula Vista hospital that uses a "nurse + volunteer" team approach to help hospitalized Hispanic patients with multiple chronic diseases reduce their hospitalizations and improve their day-to-day health and quality of life.

Individuals of low socioeconomic (SES) and ethnic minority status, including Hispanics, the largest U.S. ethnic minority group are disproportionately burdened by chronic cardiovascular and metabolic conditions ("cardiometabolic" e.g. obesity, diabetes, hypertension, heart disease). High levels of unmet behavioral health in this population contribute to striking disparities in disease prevalence and outcomes.

A behavioral health nurse provides in-hospital coaching to patients, who are then followed after discharge by a volunteer community peer mentor to assist them in overcoming barriers that may interfere with achieving and maintaining good health.

Mi Puente aims to improve continuity of care and address the (physical and behavioral) health needs of the at-risk Hispanic population. This program holds promise for impactful expansion to other conditions and underserved populations.

STRATEGIES

Mi Puente includes in-hospital coaching visit(s) from a Behavioral Health RN, and post-discharge supportive telephone calls from the RN (week 1) and a specially-trained Volunteer Peer Mentor (weeks 1–4).

EVALUATION METHODS AND MEASURABLE TARGETS

This program compares Mi Puente ("My Bridge", n=260) in a total of 560 Hispanic adults, hospitalized with multiple cardiometabolic conditions and 1+ behavioral health concern(s) at Scripps Mercy Chula Vista. A thorough evaluation of this program will not be evaluated until the end of the study which will in 2020 when the program will be completed. The evaluation is being conducted by San Diego State University.

Table 13. Mi Puente/My Bridge

Objective(s): Mi Puente applies RN plus volunteer approach and builds upon a strong collaborative partnership between inpatient ("referring") and outpatient ("receiving") care settings. Mi Puente aims to improve continuity of care and address the (physical and behavioral) health needs of the at-risk Hispanic population.		
Program Measures	2017	2018
Number of eligible patients	214	202
Number of enrolled patients	153	147
Number of patients who declined	45	16

4. SCRIPPS MERCY AND FAMILY HEALTH CENTERS BEHAVIORAL HEALTH PARTNERSHIP

Community clinics have become better prepared to treat the traditional pre-expansion Medi-Cal population. Thanks to a longstanding focus on integrating behavioral health into primary, community clinics have developed considerable in-house resources and expertise to deal with mild to moderate behavioral health issues. For example, since the late 2000s, Family Health Centers of San Diego (FHCSD) has embedded mental health services into most of its primary care clinic sites. Every primary care visit includes mental health screening, and FHCSD clinics handle between 125 to 200 mental health visits a day in-house.[13]

STRATEGIES

Scripps partners with FHCSD to help ensure behavioral health patient's transition into appropriate outpatient care when discharged from Scripps Mercy. Scripps Mercy and Family Health Centers work on a seamless transition post discharge with mental health intake centers. The two organizations have formed a Joint Operating Committee between both parties to study, address and improve patient flow (including establishing baseline metrics for reporting outcomes). Refer to Table 14 for program measures.

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[13] California Health Care Foundation, "San Diego: Major Providers Pursue Countywide Networks and New Patient Care Models", Mathematica Policy Research, July 2016.

Table 14. Scripps Mercy and Family Health Centers Behavioral Health Partnership

Objective(s): With the expansion of Medi-Cal and Covered California, a large number of individuals with coverage are looking to access behavioral health care.

The goal is to strengthen behavioral health services in the community and ensure patients are seen in a timely access to medically necessary care at community clinics and through hospital outpatients' services before their behavioral health issues become acute and they do not return to the Emergency Department.

Program Measures	2017	2018
Number of referrals to FHCSD	213	378
Number of referrals for medical follow up. (Referrals are made to the transition clinic for medical follow up when patients leave the ED)	470	398
Track number of patients referred using ER Connect and expect a 10% increase from prior year. Number of patients referred in FY18 using ER Connect*.	173	536

*ER Connect is a software program that tracks appointments and no-show rates and other useful data.

5. BEHAVIORAL HEALTH INTEGRATION PROGRAM (BHIP) IN DIABETES

Many people find that the day-to-day tasks associated with having diabetes –testing one's blood sugar, planning meals, getting enough physical activity and remembering to take medications can be stressful. A common condition known as "diabetes distress" can be the result of feeling like it's all too much. Scripps Diabetes Care and Prevention has a Diabetes Behavioral Specialist on staff to help people manage their diabetes without being overwhelmed or unduly distressed. The Behavioral Health Integration Program (BHIP) in Diabetes is an integrated, interdisciplinary approach to managing the emotional and behavioral needs of individuals with Type 1 and Type 2 diabetes. The collocation of medical and behavioral health services in the same facility allow for convenient, warm hand-off from physician to behavioral health specialist. It also affords opportunities for physicians, diabetes educators and others to receive consultation on behavioral health concerns, and in turn, more comprehensively address the multi-faceted needs of their patients with diabetes.

STRATEGIES

The BHIP service is delivered by a Scripps Whittier Diabetes Institute licensed clinical health psychologist and supervised, AIU pre-doctoral clinical psychology trainees at the Scripps Clinic Anderson Medical Pavilion (AMP) facility. The clinical staff does not currently bill for these services as this is supported through philanthropy. The BHIP team receives referrals and warm hand-offs from physicians, diabetes educators, and other providers in order to support patients who are facing challenges related to health behaviors, adjustment, coping and/or emotional well-being in the context of diabetes. Patient-facing services include intake assessment, and 1:1 and group treatment sessions.

EVALUATION METHODS AND MEASURABLE TARGETS

Table 15. Behavioral Health Program in Diabetes (BHIP)

Objective(s): Behavioral Health Integration Program (BHIP) is an integrated, interdisciplinary approach to managing the emotional and behavioral needs of individuals with Type 1 and Type 2 diabetes. The co-location of medical and behavioral health services in the same facility allows for convenient, warm hand-off from physician to behavioral health specialist. It also affords opportunities for physicians, diabetes educators, and others to receive consultation on behavioral health concerns, and in turn, more comprehensibly address the multi-faceted needs of their patients with diabetes.

Program Measures	2017	2018	
Process/Utilization Measures			
Number of referrals received	153	221	
Number of intakes completed	131	100	
Number of 1:1 and group sessions provided per patient	67	251	
	2017	**2018**	
Self-Report			
Diabetes Distress Scale (Pre/Post) *	0	Pre	Post
		3	2.25

*The Diabetes Distress Scale was not provided as BHIP was temporarily closed during Q2 & Q3 (due to transition in Interventionist)

Obesity is a medical condition in which excess body fat has accumulated to the extent that it may have an adverse effect on health. Overweight and obesity ranges are determined using weight and height to calculate a number known as "body mass index" (BMI). An adult with a BMI between 25 and 29.9 is considered overweight, while an adult who has a BMI of 30 or higher is considered obese.[14] For children and adolescents aged 2–19, overweight is defined as a BMI at or above the 85th percentile and lower than the 95th percentile for children of the same age and sex, while obese is defined as a BMI at or above the 95th percentile for children of the same age and sex.[15] Obesity is an important health needs due to its high prevalence in the U.S. and San Diego and its contribution to the development of other chronic conditions. Obesity-related conditions include heart disease, stroke, Type 2 diabetes and certain types of cancer, which are some of the leading causes of preventable death. In 2016, 25.3% of adults were obese, a 2% increase from 2014.

Figure 10. Percent of the Adult Population who are Obese in San Diego County, 2014–2016
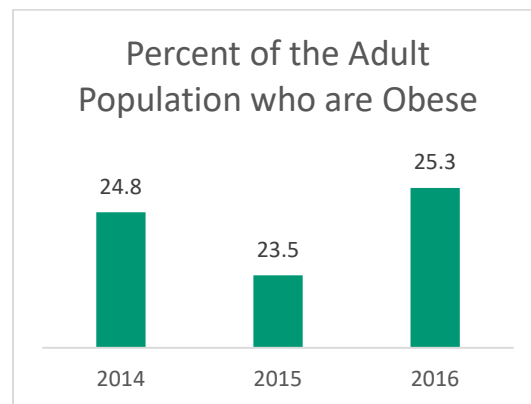
Source: California Health Interview Survey, 2014 to 2016, UCLA Center for Health Policy Research.

Adults: 36.3% of adults aged 18 and older self-report that they have a Body Mass Index (BMI) between 25 and 30 (overweight) in SDC. An additional 20.1% of adults aged 20 and older self-report that they have a Body Mass Index (BMI) greater than 30 (obese) in SDC. Excess weight may indicate an unhealthy lifestyle and puts individuals at risk for further health issues. High levels of body fat are linked to obesity, heart disease, diabetes, and other health issues.

Youth: FITNESSGRAM® is the required physical fitness test that school districts must administer to all California students in grades (5, 7, and 9). The percentage of children in grades 5, 7, and 9 ranking within the "health risk" category (obese). Rates of overweight and obese youth were highest among Hispanic/Latino and African American youth.

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[14] CDC. Defining Adult Overweight and Obesity. Retrieved from CDC.gov.
[15] Barlow SE and the Expert Committee. Expert Committee recommendations regarding the prevention, assessment, and treatment of child and adolescent overweight and obesity: summary report. Pediatrics 2007, 120 Supplement December 2007:S164 –S192.

Obesity is largely categorized as a secondary diagnosis in hospital discharge data. An analysis of the primary diagnoses associated with a secondary diagnosis of an obesity-related ICD-9 code in 2013 was used to provide an overview of the main reasons individuals with abnormal weight seek care by age group. In addition, local program data were summarized to provide additional perspective on the impact of obesity on morbidity in San Diego. A summary of trends found were as follows:

> When examining inpatient hospital discharge data with obesity as a secondary diagnosis, it was found that the most common primary diagnosis of those patients was nonspecific chest pain in ages 25–64, abnormal pain for those age 15–24, and for those over 65 years their primary diagnosis was osteoarthritis, septicemia followed by congestive heart failure.

Community input was also collected on the most common health issues that contribute significantly to overall morbidity through key informant interviews and community partner discussions. The results for obesity are summarized in Table 16.

Table 16. Summary of Community Input on Common Obesity-Related Issues, HASD&IC 2016 CHNA

Summary of Obesity-Related Responses*	
1. What are the most common health issues or needs?	
High obesity prevalence Issue for acculturating refugees, Native Americans, older veterans and low-income individuals Lack of physical activity Nutrition and diet	• Orthopedic issues • Physical education avoidance due to body image and anxiety • Starts in youth

*Based on feedback during Key Informant Interviews and Community Partner Discussions.

An assessment of health needs by HHSA region found that obesity was consistently cited as being among the top five most important health problems across all regions, though it ranked highest in East and South region. Obesity and its contribution to other chronic and co-occurring diseases was found to be a significant area of need in San Diego County.

Scripps Health is addressing obesity through the following programs and interventions:

1. DIABETES PREVENTION PROGRAM (DPP)

Congress authorized the Center for Disease to establish the **National Diabetes Prevention Program** (National DPP) www.cdc.gov/diabetes/prevention - a public-private initiative to offer evidence-based, cost effective interventions in communities across the United States to prevent Type 2 diabetes. The National DPP, a CDC-led lifestyle change program, has more than 1,300 sites nationwide, including county public health departments, YMCAs, community health centers, health care facilities, academic institutions, and community centers. There are 86 million people with diabetes and this lifestyle change program has been shown to be cost effective and a cost saving initiative for the organization.

The Diabetes Prevention Program is a scientifically validated lifestyle intervention-based model. The Center for Disease Control and the National Institute of Health promote widespread adoption of the DPP due to its demonstrated effectiveness. Without weight loss and moderate physical activity 15-30% of people with prediabetes will develop Type 2 diabetes within five years. Research shows structured lifestyle interventions can cut the risk of Type 2 diabetes in half.

While the Scripps Whittier Diabetes Institute has been providing the best care for people with diabetes for decades, the Institute continued with the Scripps Diabetes Prevention Program (DPP), which is a yearlong intervention where people with prediabetes meet weekly for 16 weeks, then monthly thereafter. The Diabetes Prevention Program (DPP) is an intensive lifestyle intervention program that has been proven to prevent diabetes in large-scale national studies. The primary objective is to lose 5 to 7% of body weight through healthy eating and physical activity. The Diabetes Prevention Program has been thoroughly evaluated in NIH sponsored randomized controlled trials and has been found to decrease the number of new cases of diabetes among those with prediabetes by 58%.

STRATEGIES

Scripps offers an intensive lifestyle intervention program that has been validated by the NIH and CDC. The program empowers patients with pre-diabetes to take charge of their health and well-being. The individuals meet in groups with a community health promoter/lifestyle coach for 16 weeks, 1-hour sessions and 6-8 monthly follow up sessions for a total of 12 months.

Scripps aims to decrease the incidence of Type 2 diabetes by managing a major diabetes risk factor, obesity in underserved, ethnically diverse populations by testing the effectiveness of a lifestyle curriculum. Scripps aims to examine the effectiveness of the DPP program in reducing BMI and weight. Scripps also aims to examine the effectiveness of the DPP Program in improving behavioral and psychological risk profiles.

EVALUATION METHODS AND MEASURABLE TARGETS

It takes an entire year to collect the surveys at baseline, month 6, and month 12. In FY17, there was only one cohort that had completed the full 12 months. Of the 14 participants who started in October 2016 for *Cohort #1, only 5 completed through month 12 classes and survey data points at the end of year one. For this reason, the baseline sample size (used for the "pre" analysis) was 14 participants, while month 12 sample size (used for the "post" analysis) was only 5 participants. This makes for an extremely small sample size which in turn skews the results of the post analyses. At the end of FY18, nearly 18 cohorts have completed the program which produces a much larger sample size and data that is interpretable. In addition, in FY18 an additional 9 cohorts were started and are aimed to complete various time points over the year in FY19. Now that the program is running to scale, the sample sizes will be significantly larger and therefore produce statistically significant outcomes and yield the pre and post analysis. In FY19, Scripps plans to start a minimum of 10 cohorts throughout San Diego County.

Cohort definition: A cohort is a group of participants who attend DPP classes at the same time, on the same day of the week, at the same location, and with the same instructor over the course of the 1-year program. By utilizing the cohort format, the program aims to develop a group dynamic among participants which has been shown to increase motivation, participation, and feelings of support.

2. HEALTHY LIVING PROGRAM

In 2015, Scripps began Healthy Living classes which are open to anyone interested in learning about the benefits of good nutrition, physical activity, and avoiding tobacco. These behaviors can help to prevent the four chronic diseases (lung disease, cancer, type 2 diabetes and, cardiovascular disease) that contribute to 50 percent of all the deaths in the US. The three-class series is held at locations throughout the community. Two hundred and eight people attended Healthy Living classes that were provided throughout the County, again with special attention to the Latino community of the South Bay.

STRATEGIES

Scripps encourages participants to adopt three health behaviors (nutritious diet, physical activity and not smoking) to prevent cancer, Type 2 diabetes, cardiovascular disease and respiratory disease that causes 50% of all deaths in San Diego and the underserved population. Participants learn how to make health food choices using low cost options, make physical activity part of their daily life and learn how to stay motivated and maintain health habits. Scripps implements a series of three free sessions that encourage participants to identify and adopt practical ways to improve their health habits. Sessions are offered throughout San Diego County in English and Spanish, with special emphasis on Latino and underserved communities. Sessions include health screenings, health cooking tips and mindful eating and practice sessions.

EVALUATION METHODS AND MEASURABLE TARGETS

Pre/Post measures

Objective(s): Encourage participants to adopt three health behaviors (nutritious diet, physical activity and not smoking) to prevent cancer, Type 2 diabetes, cardiovascular disease and respiratory disease that causes 50% of all deaths in San Diego and the underserved population. Participants will learn how to make healthy food choices using low cost options, make physical activity part of their daily life and learn how to stay motivated and maintain healthy habits.		
Program Measures	2017	2018
Number of individuals that attend/complete program		
Attended 1 class	89	29
Attended 2 classes	60	22
Attended 3 classes	47	22

Track Healthful Change Rulers (participants' rate importance of readiness, and confidence in making healthful changes – completed prior to first class, and at the end of every class). Numbers of individuals were lower in FY18 due to less resources, but this program will be revamped to increase outcomes for FY19.

Table 17. Healthy Living Program

Objective(s): Encourage participants to adopt three health behaviors (nutritious diet, physical activity and not smoking) to prevent cancer, Type 2 diabetes, cardiovascular disease and respiratory disease that causes 50% of all deaths in San Diego and the underserved population. Participants will learn how to make healthy food choices using low cost options, make physical activity part of their daily life and learn how to stay motivated and maintain healthy habits.				
Program Measures	**2017**		**2018**	
Track participants evaluation (participants' rate satisfaction/acceptability) completed at the end of each class.	Number of classes included in average	*Mean	Number of classes included in average	*Mean
Overall Quality of Session 1	17	3.75	15	3.81
Overall Quality of Session 2	13	3.25	15	3.85
Overall Quality of Session 3	12	3.83	12	3.83

*Mean number is based on a scale of 1 (Needs a lot of improvement) to 4 (Excellent)

3. PROMISE NEIGHBORHOOD (REDUCING CHILDHOOD OBESITY IN SOUTH BAY)

Scripps is a partner with the Promise Neighborhood Initiative and the goals are to implement and coordinate activities specific to 5210 (**5** fruits or more a day, **2** hours or less of screen time, **1** hour of physical activity a day and **0** surgery beverages). These messages are tailored to school staff, parents and the students. Promise Neighborhood has also developed a wellness committee composed of the school principal, teachers, parents and Scripps staff that will sustain strategies campus wide that support healthy eating and active living. The program provides a series of five wellness classes (10 sessions each) to 120 youth participants in the 4th and 5th grade classes at Castle Park Elementary. Sessions begin in the second quarter of the school year. Since 2013, over 400 children and over 100 parents have participated in wellness activities on campus. As a result of implementing wellness activities, lesson plans and advocacy in health living at the school and surrounding community, the amount of physical activity and consumption of fruits and vegetable has increased by over 50% of the children, school staff and parents.

STRATEGIES

1. Scripps partners with local elementary schools to implement and coordinate activities specific to 5210 and healthy lifestyles. 5-2-1-0 message (**5** fruits or more a day, **2** hours or less of screen time, **1** hour of physical activity a day and **0** surgery beverages).

2. Scripps helps to administer the 5210 Health Assessment Survey and Health Plan to the 4th and 5th grade classes before the 10 sessions are introduced to evaluate knowledge on the 5210 message. In addition, support physical activities for students to pass the yearly State fitness exam. Pre-survey is administered in the second quarter of the school year.

3. Scripps helps to administer the 5210 Pre and Post goal setting plan to 4th and 5th grade classes on the last day of the 10 sessions in an effort to have students set long term goals. Goal setting survey is administered in the third quarter of the school year.

4. After the 10 sessions, a summary report on the Health Assessment Survey and goal plan is developed. The report compares responses from the previous school year 4th grade classes to the current 5th grade classes to evaluate changes in behavior. The summary report is completed at the end of the school year.

5. Scripps organizes school-wide wellness fairs for parents and students and invite local service organizations to provide additional resources for parents and facilitated activities promoting the 5210 message.

6. Scripps implements wellness activities/classes with community partners, Scripps Family Medicine Residents and Resident Leadership Academy.

SUMMARY REPORT

Background: Castle Park Elementary students from the 4th and 5th grade classes were introduced to the 5210 Health Assessment Survey in October 2016. The survey was administered prior to starting the 5210 nutritional education classes to learn about their knowledge of the 5210 message. Four sessions were offered to the 4th and 5th grade classes. Topics and activities included: reading nutrition labels, essential vitamins, screen time presentations, physical activity bingo, role playing, circuit training and measuring sugar in drinks. Their responses would give a better idea on the type of 5210 activities to include in each session. The nutritional education classes initiated the week after the survey was conducted in each class. Data was compared from the 4th grade classes' school year 2016–2017 to the 5th grade classes' school year 2017–2018.

Methodology: The pre surveys were conducted face-to-face in the classroom with the support of the teachers and tutors at the beginning of the session. Scripps Mercy Hospital Chula Vista staff along with residents from the Scripps Family Residency Program assisted a total of students, 56 4th grade students and 53 5th grade students from academic year 2017–2018. The surveys consisted of nine questions focused on the 5210 message and were distributed at the first session and revisited at the conclusion. Towards the end of the school year, Scripps will administer the Post survey with the same questions to compare responses and changes in behavior

Results: Student responses (154) showed that there was an increase in improvement from one grade level to the next in knowledge of the 5210 message related to the importance of nutrition and physical activity.

- Improvement rate for knowledge after participating in 5210 sessions – Pre 60% Post 79%.
- Improvement rate for behavior after participating in 5210 sessions – Pre 60.9% Post 62.5%.

Overall, the course conveys a positive message to get students interested in healthy behaviors and to be proactive with them while at a young age. According to the data, the kids are learning and remembering the different components of 5210, but they are having trouble executing the knowledge into their everyday life.

EVALUATION METHODS AND MEASURABLE TARGETS

Table 18. Promise Neighborhood (Reducing Childhood Obesity in South Bay)

Objective(s): Increase education and awareness related to health lifestyles for elementary aged children, parents and school staff. Improve behaviors related to nutrition and physical activity.				
Program Measures	2017*		2018*	
Total number of youth participants	100		159	
Improvement rate for *knowledge* after participating in 5210 sessions	Pre	Post	Pre	Post
	58%	80%	59.8%	79.2%
Improvement rate for *behavior* after participating in 5210 sessions	Pre	Post	Pre	Post
	20%	37.5%	60.9%	62.5%
Number of students who completed post goal setting plan and 5210 educational sessions	95		154	
Number of Wellness Meetings documented	9		9	

*The metrics are reported at the end of the school year (May).

EVALUATION PLANS

Scripps monitors and evaluates the strategies listed in this document for the purpose of tracking the implementation of those strategies as well as to document the anticipated impact. Plans to monitor are tailored to each strategy and include the collection and documentation of tracking measures as listed in this report and more detailed in its corresponding table metric tool documents. As stated earlier, Scripps Health anticipates the implementation strategies may evolve due to the fast pace at which the community and health care industry change. Therefore, a flexible approach is best suited for the development of its response to the Scripps Health Community Health Needs Assessment (CHNA).

BUILDING ON PREVIOUS COMMUNITY HEALTH NEEDS ASSESSMENTS

2016 COMMUNITY HEALTH NEEDS ASSESSMENT – PHASE 2

Upon completion of the 2016 CHNA, the CHNA Committee conducted a Phase 2, which included gathering community feedback on the 2016 CHNA process and strengthening partnerships around the identified health needs and social determinants of health. Two community surveys were conducted – the first in the fall of 2016 and the second in the summer of 2017. The results of these community surveys helped guide individual hospital programs and greatly informed the design of the 2019 CHNA process.

The survey in fall of 2016 sought to gather feedback on the top four health needs and the top ten social determinants of health that were identified in the 2016 CHNA. In addition, organizations were asked about their screening methods for behavioral health issues and methods for identifying social determinants of health for the clients or patients they served.

Of the 132 respondents that completed the survey, 30 worked in hospitals or hospital-based settings, while the remaining 102 respondents self-identified as working for a range of entities including but not limited to community clinics, not-for-profits, community-based organizations, local government, and health insurance plans.

2016 CHNA Phase 2 Community Survey	Nearly **98%** of respondents *agreed* (33.3%) or *strongly agreed* (64.4%) that behavioral health, cardiovascular disease, type 2 diabetes, and obesity are the top health needs of communties facing inequities within San Diego County.
	99% of respondents *agreed* (33.0%) or *strongly agreed* (66.1%) that the top ten social determinants of health identified by the 2016 CHNA represented the greatest barriers for communities facing inequities within San Diego County.
	Nearly **72%** of respondents are *likely* (40.0%) or *very likely* (31.8%) to use the findings and/or data that resulted from the CHNA to help inform their programs in the grant writing process.

A second community feedback survey was conducted in the summer of 2017. Community feedback was gathered in order to understand how the health and social needs of communities facing inequities had changed over the past year. Feedback was collected in several key topics, including:

1. *How has access to care changed over the past 12 months?*
2. *In what ways can hospitals work more effectively with community organizations to ensure that patients are treated in the most appropriate setting?*
3. *How are patients'/clients' concerns about their immigration status impacting their access to needed health care?*
4. *Given the federal policies and budget cuts that are under consideration, what are the greatest challenges in the community's ability to address social determinants of health?*

The full results of Phase 2 of the 2016 Community Health Needs Assessment can be found on the HASD&IC website, https://hasdic.org/.

2018 BEHAVIORAL HEALTH ANALYSIS

In 2017, the HASD&IC Board of Directors asked the CHNA Committee to conduct a focused analysis of the challenges to treating behavioral health care patients in San Diego[16]. The CHNA Committee adopted a methodology similar to 2013 and 2016 CHNAs that used focus groups, key informant interviews, and hospital discharge data. Issues examined included pre-acute, acute, and post-acute services and the impact of social determinants of health on access and outcomes. Throughout the interviews and focus groups, the most consistent theme was that patients are unable to access or are continuously delayed in accessing needed behavioral health services at every point across the continuum. The analysis found that even when clinical services are available, patients face many challenges to successfully managing their behavioral health conditions on their own. Social determinants of health (SDOH) were identified as the most frequent barriers to creating a safe discharge plan. Figure 11 below lists the most frequently cited SDOH identified by interviewees.

Figure 11. 2018 Behavioral Health Analysis, Social Determinants of Health Limit Patient's Ability to Manage Their Care

Housing
- Lack of housing is a primary challenge for many patients
- Finding shelter for SMI homeless patient is an immense challenge
- Some people do not feel safe in shelters or do not want to go shelters
- SSI income impacts housing options

Access to Care
- Insurance coverage determines patient access to the appropriate level of care
- Patients without financial resources have fewer options
- Needed services do not exist in communities

Family Support/Conservatorship
- Family support is key, especially for safe discharge
- Conservatorship slows discharge process - conservator is generally difficult to get in contact with, and often disagree with discharge plans or other pertinent decisions.

Medication
- Adherence - patients need assistance to take their medications correctly
- Costs - patients are often unable to afford their medications.
- Preauthorization - some medications require preauthorization from insurance companies while others do not. Physicians do not readily have information on which medications fall into either category, but any authorization or delay is significant for a recently discharged patient.
- Lengthy approval process - there is a risk that the approval process between the insurance company and the doctor's prescription request can take up to 72 hours, during which time patients return to the ED due to lack of critical medications.

Transportation
- Patients have serious cognitive and resource challenges getting to and from appointments, and getting to a pharmacy to pick-up medication.

Income
- Patients may be unable to miss work to attend appointments or therapy

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[16] November 2018 HASD&IC Behavioral Health Analysis Summary Report: available at https://hasdic.org/key-issues/

The analysis also found that services across the continuum for behavioral health patients are deficient. Interviewees overwhelmingly cited finding appropriate behavioral health services in the community for Medi-Cal patients as their most critical challenge.

Figure 12 below shows the post-acute care services and resources most frequently cited by interviewees. Interviewers did not offer examples or provide a list of options to choose from; this list is based on open-ended questions regarding the post-acute treatment needs of behavioral health patients.

Figure 12. Post-Acute-Care Service Needs Identified by Interviewees

Adolescent rehabilitation services

County case management

Crisis Residential Treatment Programs

Intensive Outpatient Program

Licensed board and cares (with augmented support)

Skilled nursing facilities (that accept patients w/ psych needs)

Detox beds

IMD beds

Long Term Care beds

County Inpatient psych hospital beds

Day Treatment Programs or Partial Hospitalization Programs

Home Health

Structured independent living

KEY

Most Urgent Need

Urgent Need

Need

As described in the full analysis, workforce shortages create severe deficits across the behavioral health continuum of care, limiting access to critical services. Recruiting and retaining qualified behavioral health providers is a growing challenge. The shortage of qualified behavioral health professionals narrows the range and availability of behavioral health services. Inadequate reimbursement has resulted in a shortage of psychiatrists who accept Medi-Cal in San Diego County. The situation is particularly dire for children in need of psychiatric inpatient services, with the extremely small number of child and adolescent psychiatrists and psychologists who are willing to accept Medi-Cal and work in acute care settings continuing to decline.

Please see the full report for the complete list of findings and recommendations. *2018 HASD&IC Behavioral Health Analysis Summary Report: available at https://hasdic.org/key-issues/*

EXECUTIVE SUMMARY

VII. EXECUTIVE SUMMARY

INTRODUCTION AND BACKGROUND

Every three years, the Hospital Association of San Diego and Imperial Counties (HASD&IC) conducts a collaborative community health needs assessment (CHNA) to meet IRS regulatory requirements and to identify and prioritize the health needs of San Diego County residents, particularly those who experience health inequities. The CHNA is implemented and managed by a standing CHNA Committee comprised of representatives from seven hospitals and health systems. This committee reports to the HASD&IC Board of Directors who provide policy direction and ensure that the interests of all member hospitals and health systems are met. HASD&IC contracts with the Institute for Public Health (IPH) at San Diego State University (SDSU) to perform the needs assessment. Scripps Health actively participates in the collaborative CHNA process led by the Hospital Association of San Diego and Imperial Counties and develops a Scripps consolidated CHNA report.

The 2019 CHNA built on the results of the 2016 CHNA and included three types of community engagement efforts: focus groups with residents, community-based organizations, service providers, and health care leaders; key informant interviews with health care experts; and an online survey for residents and stakeholders. In addition, the CHNA included extensive quantitative analysis of national and state-wide data sets, San Diego County emergency department and inpatient hospital discharge data, community clinic usage data, county mortality and morbidity data, and data related to social determinants of health. These two different approaches allowed the CHNA Committee to view community health needs from multiple perspectives.
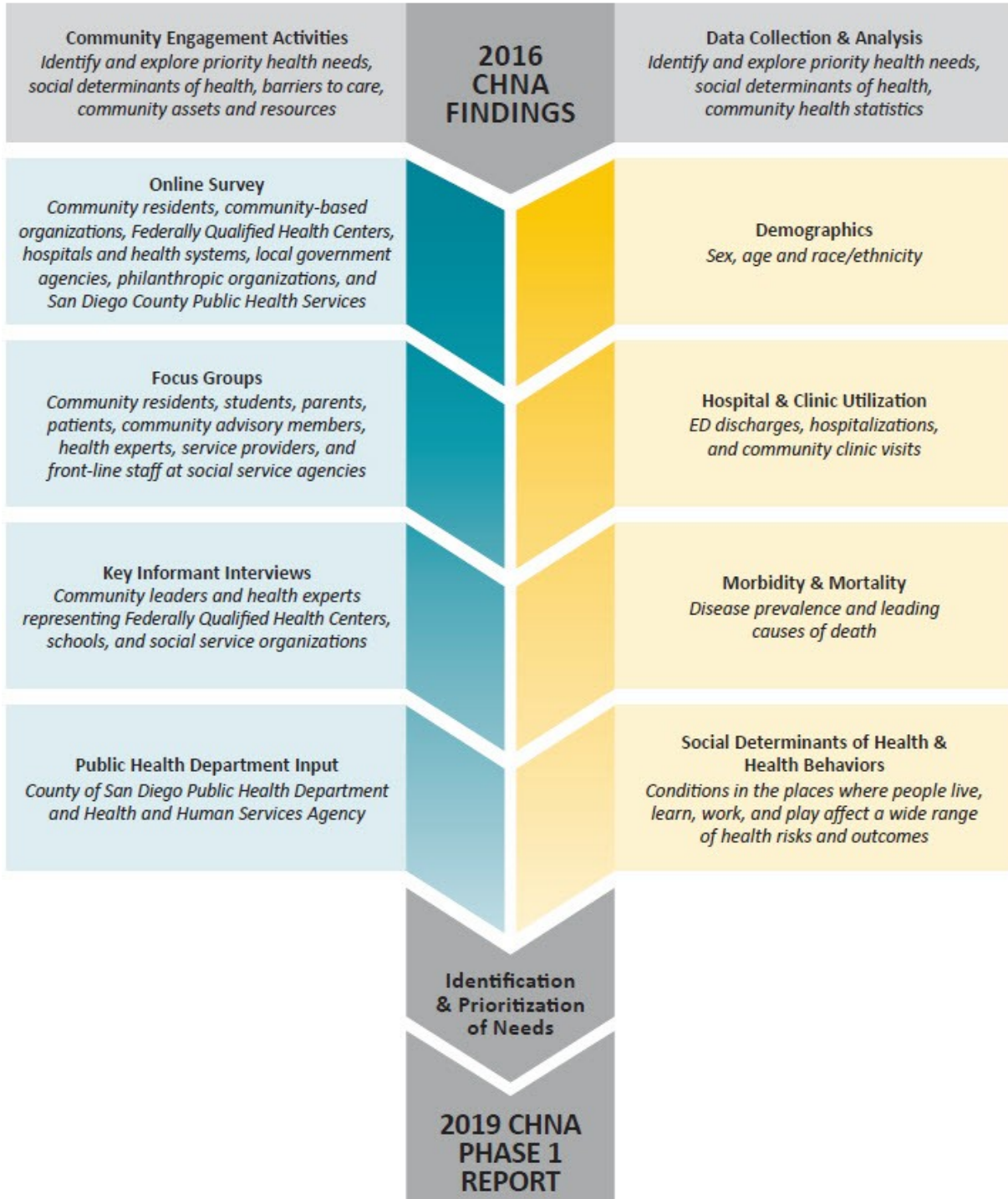
In addition to this collaborative CHNA process, Kaiser Foundation Hospital (KFH)-San Diego and Zion conducted a separate CHNA process; data were shared between the two groups. These simultaneous processes allowed for a more robust, comprehensive CHNA for all San Diego County hospitals and health care systems.

METHODOLOGY

For the 2019 CHNA quantitative analyses of publicly available data provided an overview of critical health issues across San Diego County, while qualitative analyses of feedback from the community provided an appreciation for the experiences and needs of San Diegans. The CHNA Committee reviewed these analyses and applied a pre-determined set of criteria to them to prioritize the top health needs in San Diego County. This process is represented in Figure 13.

Figure 13. 2019 Community Health Needs Assessment Process Map

2019 COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) PROCESS MAP

2016 CHNA FINDINGS

Community Engagement Activities
Identify and explore priority health needs, social determinants of health, barriers to care, community assets and resources

Data Collection & Analysis
Identify and explore priority health needs, social determinants of health, community health statistics

Online Survey
Community residents, community-based organizations, Federally Qualified Health Centers, hospitals and health systems, local government agencies, philanthropic organizations, and San Diego County Public Health Services

Demographics
Sex, age and race/ethnicity

Focus Groups
Community residents, students, parents, patients, community advisory members, health experts, service providers, and front-line staff at social service agencies

Hospital & Clinic Utilization
ED discharges, hospitalizations, and community clinic visits

Key Informant Interviews
Community leaders and health experts representing Federally Qualified Health Centers, schools, and social service organizations

Morbidity & Mortality
Disease prevalence and leading causes of death

Public Health Department Input
County of San Diego Public Health Department and Health and Human Services Agency

Social Determinants of Health & Health Behaviors
Conditions in the places where people live, learn, work, and play affect a wide range of health risks and outcomes

Identification & Prioritization of Needs

2019 CHNA PHASE 1 REPORT

QUANTITATIVE

Quantitative data were drawn from several public sources. Data from Dignity Health/Truven Health **Community Needs Index (CNI)** and the Public Health Alliance of Southern California's **Healthy Places Index (HPI)** were used to identify geographic communities in San Diego County that were more likely to be experiencing health inequities, which guided the selection of communities for the engagement and the development of engagement questions.

Hospital discharge data exported from **SpeedTrack's California Universal Patient Information Discovery, or CUPID application** were used to identify current and three-year trends in primary diagnosis discharge categories and were stratified by age and race. This allowed for the identification of health disparities and the conditions having the greatest impact on hospitals and health systems in San Diego County.

Data from **national and state-wide data sets** were analyzed including San Diego County mortality and morbidity data, and data related to social determinants of health. In addition, Kaiser Permanente consolidated data from several national and state-wide data sets related to a variety of health conditions and social determinants of health in San Diego County and conducted a comprehensive statistical analysis to identify which social determinants of health were most predictive of negative health outcomes. Kaiser Permanente then created a, web-based data platform (chna.org/kp) to post these analyses for use in the CHNA. These analyses guided the design of the online survey, interview, and focus group questions.

COMMUNITY ENGAGEMENT

Community engagement activities included focus groups, key informant interviews, and an online survey which targeted stakeholders from every region of San Diego County, all age groups, and numerous racial and ethnic groups. Collaboration with the County of San Diego Health & Human Services Agency, Public Health Services was vital to this process. A total of **579** individuals participated in the 2019 Community Health Needs Assessment: **138** community residents and **441** leaders and experts. Please see Figure 14 below for details on the types of participants engaged.

Figure 14. 2019 CHNA Community Engagement Participants

12 Key Informant Interviews + **214 Focus Group Participants** + **353 Survey Participants** = **579 Community Participants**

Types of Organizations

- Affordable housing provider
- Community-based advocacy
- FQHCs
- Local government
- Local health department
- Resident advocacy
- Schools
- Social service providers
- Student organizations

Populations Served/ Represented

- Individuals & families experiencing homelessness
- LGBTQ
- Military & veterans
- Native Americans
- Refugees & immigrants
- Rural health
- School aged children & youth
- Seniors
- Transitional age youth
- Uninsured & underserved

Roles of Participants

- Advocates
- Clinical staff
- Community residents
- Front line staff
- Executives, directors, & administrators
- Health educators
- Law enforcement
- Patients
- Program managers & coordinators
- Promotores & social service navigators
- School teachers & counselors

2019 CHNA PRIORITIZATION OF THE TOP HEALTH NEEDS

The CHNA Committee collectively reviewed the quantitative and qualitative data and findings. Several criteria were applied to the data to determine which health conditions were of the highest priority in San Diego County. These criteria included: the severity of the need, the magnitude/scale of the need; disparities or inequities and change over time. Those health conditions and social determinants of health that met the largest number of criteria were then selected as top priority community health needs.

2019 FINDINGS: TOP 10 COMMUNITY HEALTH NEEDS

The CHNA Committee identified the following as the highest priority community health needs in San Diego County (in alphabetical order by SDOH or health condition).

Figure 15. 2019 Top 10 Community Health Needs
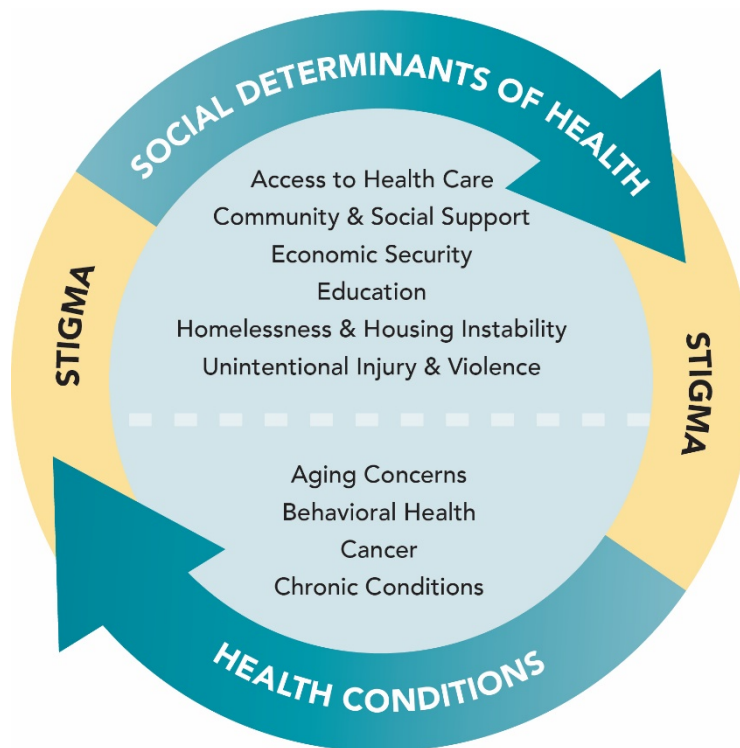
Figure 15 above illustrates the interactive nature of SDOH and health conditions - each impacting the other. In addition, an underlying theme of stigma and the barriers it creates arose across community engagement. For instance, stigma impacts the way in which people access needed services that address SDOH, which consequentially impacts their ability to maintain and manage health conditions. Due to the complexity of this underlying theme, the CHNA Committee plans to explore and understand ways in which hospitals and health systems could better address stigma in patient care during Phase 2 of the CHNA process.

Access to health care. Overcoming barriers to health care, such as lack of health insurance and insurance issues, economic insecurity, transportation, the shortage of culturally competent care, fears about immigration status, and the shortage of health care providers emerged as a high priority community need. In addition, specific services were identified as challenging to obtain, including behavioral health care, dental care, primary care, and specialty care.

Aging concerns. Conditions that predominantly affect people who are 65 and older -- such as Alzheimer's disease, Parkinson's, dementia, falls, and limited mobility - were identified as a high priority health need. Community engagement participants most often described aging concerns in relation to the social determinants of health, including: transportation, access to fresh food, social isolation and inadequate family support, and economic insecurity.

Behavioral health. Greater access to behavioral health care was cited as a priority health need. Three types of behavioral health care were identified as challenging to access: urgent care services for crisis situations; inpatient psychiatric beds and substance abuse facilities; and transitional programs and services for post-acute care. In addition, several barriers to behavioral health care were named as priorities to address, including a lack of availability of needed services and appointments, insurance issues, logistical issues, such as transportation and time off work, and the inability to pay co-pays and deductibles.

Cancer. Health needs related to cancer were described in relation to the effects on well-being beyond physical health. These include financial, practical, and emotional impacts on individuals and families; these effects are exacerbated by barriers to cancer care.

Chronic conditions. Three chronic conditions were identified as priorities: cardiovascular disease, diabetes, and obesity. Key factors that individuals struggle with to prevent chronic diseases include access to fresh, health foods and safe places to exercise and play. In addition, economic issues, transportation to medical care, fears about immigration status, and a lack of knowledge about chronic conditions were named as particular challenges related to the management of chronic conditions.

Community and social support. A high priority for the well-being of San Diego residents is ensuring that individuals have adequate resources and substantial support within their neighborhood. Valuable neighborhood resources include federally qualified health centers (FQHCs) and those that are culturally and linguistically competent. Without adequate support from others, community engagement and community spirit are affected.

Economic security. Economic security was named as vitally important to the well-being of San Diego residents and was described as impacting every aspect of residents' daily life. The health of those who are economically insecure is negatively affected by food insecurity, chronic stress and anxiety, and the lack of time and money to take care of health needs. In San Diego County, 13.3% of residents have incomes below the federal poverty level and 15% experience food insecurity. Those who are economically insecure are at greater risk of poor mental health days, as well as, asthma, obesity, diabetes, stroke, cancer, smoking, pedestrian injury and visits to the emergency department for heart

attacks. Factors identified as contributing to economic insecurity include housing and child care costs as well as low wages.

Education. Receiving a high school diploma, having the opportunity to pursue higher or vocational education, being health literate, and having opportunities for non-academic continuing education were identified as important priorities for the health and well-being of San Diego residents. Family stress and a lack of school and community resources were identified as factors underlying low levels of educational attainment.

Homelessness and housing instability. Homelessness and housing instability were named as important factors affecting the health of San Diego County residents. They were described as having serious health impacts, such as increasing exposure to infectious disease, creating substantial challenges in the management of chronic diseases and wound care, and increasing stress and anxiety. Poor housing conditions were also cited as impactful of physical and mental health; crowded housing leads to the spread of illness, and environmental hazards can exacerbate conditions like asthma.

Unintentional injury and violence. Exposure to violence and neighborhood safety were cited as priority health needs for San Diegans. Neighborhood safety was discussed as influencing residents' ability to maintain good health, while exposure to violence was described as traumatic and impactful on mental health.

COMMUNITY RESOURCES

The 2019 CHNA identified many health resources in San Diego County, including those provided by 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. In addition, 2-1-1 San Diego is an important community resource and information hub that facilitates access to services. Through its 24/7 phone service and online database, 2-1-1 San Diego helps connect individuals with community, health, and disaster services.

In addition to community input on health conditions and social determinants of health, a wealth of ideas emerged from community engagement participants about how hospitals and health systems could support, expand, or create additional resources and partner with organizations to better meet San Diego's community health needs. Please see Figure 16 below for the types of resources that were identified by community engagement participants:

Figure 16. Resources & Opportunities to Address Priority Health Needs

RESOURCES & OPPORTUNITIES TO ADDRESS PRIORITY HEALTH NEEDS

Community engagement participants identified three means by which the identified health needs could be better addressed:

1. The implementation of overarching *strategies* to address the health needs,
2. The development or expansion of *resources* to meet the needs,
3. The creation of *systemic, policy, and environmental changes* to better support health outcomes.

All of these approaches, participants emphasized, would require *collaboration* between political, health care system, and community leaders, health care professionals, community organizations, and residents.

STRATEGIES

1. **Increase community knowledge with educational campaigns** *that promote available services within the community, clinics, and hospitals*
2. **Address potential barriers to care** *such as insurance, translation, navigation services, transportation, and potential impacts on immigration status*
3. **Improve patient experience** *through culturally competent health navigators and case managers, care coordination, and community clinical linkages including language services*

RESOURCES

1. **Urgent care services** *that include expanded hours, availability to all populations, and mental health and substance use services*
2. **Preventative care programs** *that offer services such as immunizations (including the flu vaccine), HIV testing, and exercise programs*
3. **Dental services** *for preventive care and to address oral health issues such as carries and gum disease*
4. **Onsite programs and mobile units** *that bring services to the community, including programs in senior housing complexes, school clinics, mobile screening, and mobile food distribution*
5. **Culturally competent programs** *for refugees, Native Americans, Latinos, Blacks, African Americans, LGBTQ individuals, non-citizens, and asylum seekers*
6. **Programs for the youth,** *especially community centers and programs for young men and for homeless youth*
7. **Homeless services and discharge support,** *including mobile showers, more shelters, and further options for post-acute recuperative care*
8. **Food insecurity navigation** *that includes reference guides for food system/service navigation of San Diego County, private, and non-profit organizations, and signage for healthy food options for CalFresh/ Supplemental Nutrition Assistance Program (SNAP) users at stores and restaurants*

SYSTEMIC CHANGE

1. **Create universal and/or affordable health care**
2. **Increase minimum wage**
3. **Fund policies:** *increase applications for federal funding and allow more time to prove a return on investment (ROI) for funding*

COLLABORATION

1. **Form partnerships** *with community residents by engaging residents in advocacy*
2. **Share and disseminate information** *and data back into the communities from where the data came from*
3. **Work with communities to adapt programs and interventions** *to the unique needs of minority groups (go beyond collective impact approach)*
4. **More collaboration** *between social workers, law enforcement, and attorneys*
5. **Warm hand-offs** *between agencies and organizations*

CONCLUSIONS AND NEXT STEPS

HASD&IC and the CHNA Committee are proud of their collaborative relationships with local community organizations and are committed to regularly seeking input from the community to inform community health strategies. The 2019 CHNA will be utilized by participating hospitals and health systems to evaluate opportunities for next steps to address the top identified health needs in their respective patient communities.

In addition, the CHNA report will be made available to the broader community and is intended to be a useful resource to both residents and health care providers to further communitywide health access and health improvement efforts.

The CHNA Committee is in the process of planning Phase 2 of the 2019 CHNA, which will include gathering community feedback on the 2019 CHNA process and strengthening partnerships around the identified priority health needs and social determinants of health.

COMMUNITY DEFINED

Hospitals and health care systems define the community served as those individuals residing within its service area. A hospital or health care system service area includes all residents in a defined geographic area surrounding the hospital. For the purposes of the 2019 CHNA, the service area is defined as the entire County of San Diego due to a broad representation of hospitals in the area. Because of its geographic size and large population, the San Diego County Health and Human Services Agency (HHSA) organizes their service areas into six geographic regions: Central, East, North Central, North Coastal, North Inland, and South. The geographical regions are represented below in Figure 17. Please see Appendix K on page 182 for the list of participating hospital locations.

Figure 17. San Diego County Health and Human Services Agency Regions

Data Source: SanGIS.
Basemap: © 2015 OpenStreetMap contributors, and the GIS User Community.

A. SCRIPPS HEALTH COMMUNITY SERVED

Hospitals and health care systems define the community served as those individuals residing within its service area. A hospital or health care system service area includes all residents in a defined geographic area surrounding the hospital and does not exclude low income or underserved populations.

Scripps serves the entire San Diego county region with services concentrated in North Coastal, North Central, Central and Southern region of San Diego. Community outreach efforts are focused in those areas with proximity to a Scripps facility. Scripps hosts, sponsors and participates in many community-building events throughout the year. Per calendar year 2017, OSHPD annual financial data there are 19 other hospital facilities serving the San Diego community.

Scripps Mercy Hospital (including San Diego and Chula Vista campuses) provides 64 percent of the charity care within the Scripps system. Scripps Mercy's service area has a more economically disadvantaged population compared to the county as a whole, with the lowest numbers of insured adults in the county and a much higher percentage of ethnic minorities, primarily Hispanic and Asian.

As a disproportionate-share hospital, Scripps Mercy San Diego and Chula Vista campuses play important health care service roles in the Central/Southern San Diego County service area (ranging from interstate 8 to the United States-Mexico border). More than half of Scripps Mercy San Diego and Chula Vista patients are government insured-Medicare and Medi-Cal.

Scripps hospitals housed 24.5% percent of the county's general acute-care licensed beds. Scripps provides significant and growing volumes of emergency, outpatient and primary care. In FY17, Scripps provided 2,513,440 outpatient visits. Nearly half (38.8%) of San Diego County's 60,325 (see table 19 & 20) safety net discharges are from central and south suburban regions. Safety net discharges include county indigent programs, Medi-Cal and self-pay. Source: OSHPD 2017 CY Hospital Annual Selected File (Pivot Table).

Scripps has a total of 1,387 acute care licensed beds. San Diego has a total of 5,652 general acute care licensed beds. Percentage of Scripps beds is 1,387/5,652 = 24.5%

Table 19. San Diego County Safety Net Discharges CY17: Safety Net Discharges Include Payer Categories: County Indigent Programs, Medi-Cal and Self-Pay

San Diego Reporting Area	Number of Discharges
Central	12,199
East County	442
East Suburban	11,186
North City East	2,904
North City West	2,503
North County East	7,505
North County West	3,613
Outside San Diego	8,790
South Suburban	6,297
South Suburban East	3,038
South Suburban West	1,848
Total	**60,325**

OSHPD 2017 CY Hospital Annual Selected File

Table 20. Scripps OSHPD Safety Net Discharges CY17: Safety Net Discharges Include Payer Categories: County Indigent Programs, Medi-Cal and Self-Pay

San Diego Reporting Area	Number of Discharges
Central	3,759
East County	16
East Suburban	804
North City East	393
North City West	602
North County East	406
North County West	1,040
Outside San Diego	2,274
South Suburban	1,770
South Suburban East	701
South Suburban West	606
Total	12,371

OSHPD 2017 CY Hospital Annual Selected File

Table 21. Scripps Health Locations

Scripps Health			
Hospital/Health Care System*	**Location**		
Scripps Memorial Hospital La Jolla	9888 Genesee Ave.	La Jolla	92037
Scripps Mercy Hospital	4077 5th Ave.	San Diego	92103
Scripps Green Hospital	10666 N. Torrey Pines Road	La Jolla	92037
Scripps Memorial Hospital Encinitas	354 Santa Fe Drive	Encinitas	92024
Scripps Mercy Hospital Chula Vista	435 H St.	Chula Vista	91910

*Locations represent the major hospital or health care/system locations and do not represent all types of hospital or health care locations.

The trended table below shows the primary service area as defined by those zip codes from which 70% of Scripps patients originate for discharge years 2013-2016 (Top 70% of inpatient discharges by zip code). Figure 18 is a map of Scripps Health and service areas.

Table 22. Scripps Health Inpatient Discharges for Years 2013-2016 from which the Top 70% of Scripps Patients Originate

CITY	2013	2014	2015	2016
San Diego	37%	37%	36%	36%
Chula Vista	8%	8%	8%	7%
Carlsbad	5%	6%	6%	6%
Oceanside	5%	5%	5%	6%
Encinitas	3%	3%	3%	3%
National City	3%	2%	2%	2%
La Jolla	3%	2%	2%	2%
San Marcos	2%	2%	2%	2%
Vista	2%	2%	2%	3%
El Cajon	2%	2%	2%	2%
Grand Total	**70%**	**70%**	**70%**	**70%**

B. COMMUNITY SERVED

Scripps serves the entire San Diego county region with services concentrated in North Costal, North Central, Central and Southern. Community outreach efforts are focused in those areas with proximity to a Scripps facility. Scripps hosts, sponsors and participates in many community-building events throughout the year.

Figure 18. Scripps Health Service Area

C. DEMOGRAPHIC PROFILE OF SAN DIEGO COUNTY

Current population demographics and changes in demographic composition over time play a defining role in the types of health and social services needed by communities. Population size change in population, race and ethnicity, and age distribution of a population are all important factors in understanding communities and their residents.

Population: Over three million people (3,283,665) live in the 4206.64 square mile area of San Diego County according to the U.S. Census Bureau ACS 2013 to 2017, 5-year estimates[17]. The population density for this area, estimated at 781 persons per square mile, is greater than the national average population density of approximately 91 persons per square mile.

Age: The median age for San Diego County is 35.4 years. The distribution of the population by age shows that 22.2% of the population is under the age of 18, 64.9% is between the ages of 18 and 64, and 12.9% is 65 years old or greater (Figure 19).

Table 23. San Diego County Demographics, 2013-2017

Population	#	Race/Ethnicity	%
Total Population	3,283,665	Asian	11.5%
Socioeconomic	%	Black	4.7%
Living in Poverty (<100% federal poverty level)	13.3%	Hispanic/Latino	33.4%
Children in Poverty	17.1%	Native American/Alaska Native	0.4%
Unemployment	3.2%	Pacific Islander/Native Hawaiian	0.4%
Adults with No High School Diploma	13.3%	Some Other Race	0.2%
		Multiple Races	3.3%
		White	46.2%

Source: U.S. Census Bureau. American Community Survey, 2013-2017 5-Year Estimate.

Figure 19. Percentage of San Diego Population by Age Group, 2013 - 2017
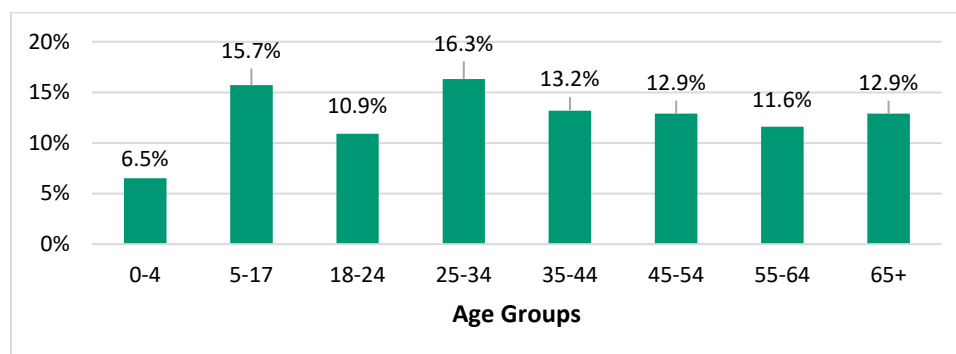
Source: U.S. Census Bureau. American Community Survey, 2013-2017 5-Year Estimate.

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[17] U.S. Census Bureau. American Community Survey, 2013-2017 5-Year Estimates.

SOCIOECONOMIC FACTORS

Low-income, uninsured, and undereducated individuals have been found to be most at risk for poor health status. Data from the ACS show how these indicators impact the San Diego community. Evaluating these risk factors is important for identifying communities with the most significant health needs and health disparities.

Within San Diego County between 2013 and 2017, 13.3% or 427,031 individuals were living in households with income below 100% of the Federal Poverty Level (FPL). For children 0-17, the percentage living 100% below the FPL (which for a family of three is $20,420 per year) decreased slightly from 18.8% to 17.1%. Poverty creates barriers to accessing services that promote well-being including health services, healthy food, and other necessities that contribute to improved health status.

Uninsured: Between 2013 and 2017, the percent uninsured decreased by 40% in California, and 50% in San Diego County. This decrease can be attributed in large part to the Affordable Care Act (ACA). For more information on the impact of the ACA, please see the box titled 'The Changing Landscape under the Affordable Care Act.' Lack of insurance is a primary barrier to accessing health care services, including primary care, specialty care and other health services. Please see Figure 20 below for more details on the uninsured in San Diego, California, and the United States.

THE CHANGING LANDSCAPE UNDER THE AFFORDABLE CARE ACT*

The Affordable Care Act (ACA) has played a significant role in increasing access to health care. In 2014, a number of changes took effect in California including:

➢ The expansion of Medi-Cal to individuals making less than 138% of the poverty level
➢ The establishment of Covered California for individuals who make up to 400% of the poverty level to purchase subsidized health insurance
➢ The elimination of health coverage discrimination due to pre-existing conditions
➢ The requirement to obtain health insurance coverage
➢ No annual or lifetime dollar limits on benefits

These health care reforms have significantly increased the number of insured individuals. A recent report from Insure the Uninsured Project demonstrates the following changes in coverage as of 2017:

➢ The number of uninsured Californians under age 65 has been reduced to approximately three million
➢ On average, 1.3 million Californians are enrolled in Covered California
➢ 90% of Covered California consumers receive federal subsidies

Despite the increased coverage, health care affordability is still a major concern; 2 in 5 Covered California enrollees report difficulty paying monthly premiums.

*Source: Insure the Uninsured Project, Mapping the Future Individual Health Insurance, http://www.itup.org/wp-content/uploads/2019/03/ITUP_Mapping_Health_Insurance.pdf

Figure 20. Percentage of Population without Health Insurance among Civilian Non-institutionalized Population Ages 18–64 Years in San Diego County, California and the United States, 2013—2017

	2013	2014	2015	2016	2017*
■ San Diego County	22%	16%	12%	10%	11%
■ California	24%	17%	12%	10%	10%
■ United States	20%	16%	13%	12%	12%

■ San Diego County   ■ California   ■ United States
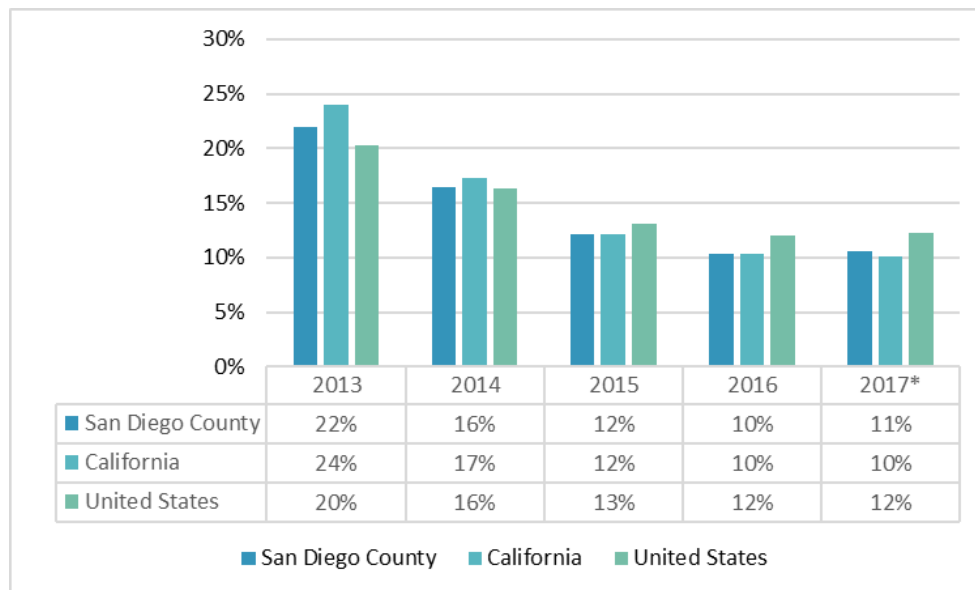
Source: U.S. Census Bureau. American Community Survey, 2013-2017 1-Year Estimates
*Ages 19-64 years

D. IDENTIFYING HIGH-NEED AREAS

A critical component of understanding community health is to identify geographic areas of inequities. The CHNA Committee utilized two metrics to determine which areas of San Diego County likely experience the greatest health disparities: (1) the Healthy People Index (HPI) which analyzes health opportunities by census tract; and (2) the Dignity Health/Truven Health Community Need Index (CNI), which measures barriers to socio-economic security by ZIP code. Data from these two sources provided key information about resources and disparities in different regions of San Diego County and guided the selection process for the community engagement.

THE CALIFORNIA HEALTHY PLACES INDEX (HPI)[18]

The California HPI generates a healthy community score, or HPI score, for each census tract in California based on data from 25 social determinants of health across eight domains. The eight domains that make up the HPI scores are:

1. Clean Environment
2. Economic
3. Education
4. Housing

5. Insurance/Health Care Access
6. Neighborhood
7. Social Factors
8. Transportation

---

[18] The California Healthy Places Index, © 2018 Public Health Alliance of Southern California, http://healthyplacesindex.org/

The map below displays the differences in healthy community scores for residents in San Diego County.[19] Areas in dark red represent census tracts in the lowest quartile of healthy communities across San Diego County. Please see HPI map below (Figure 21).

Figure 21. Health Places Index (HPI), San Diego County
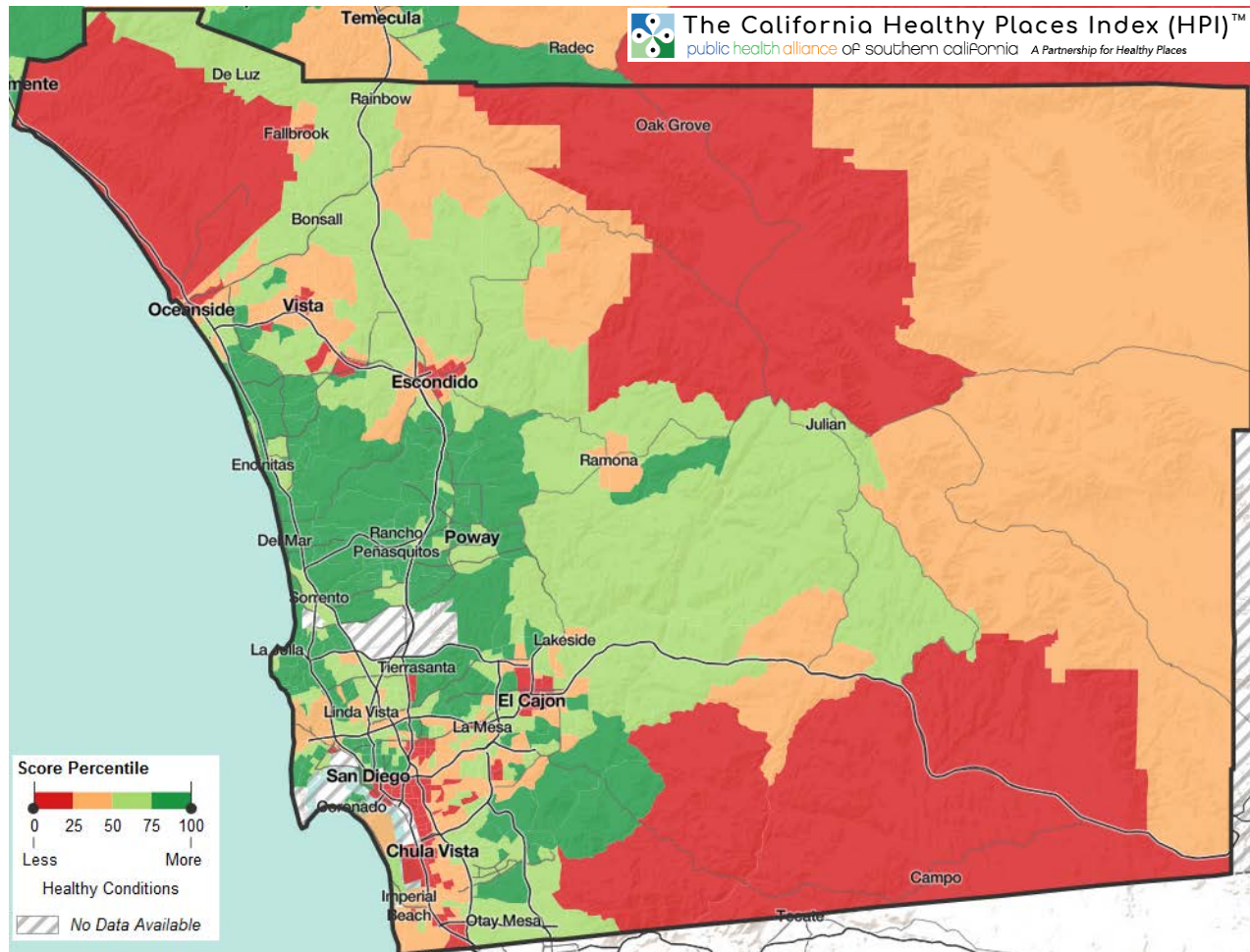
Source: *The California Healthy Places Index, © 2018 Public Health Alliance of Southern California, http://healthyplacesindex.org/.*
Note: this map displays an area slightly larger than San Diego County boundaries

The HPI identifies the following **cities** in San Diego County that have *lower levels* of healthy community conditions:

1. Campo
2. Boulevard
3. Jacumba
4. National City
5. Potrero

---

[19] For more detailed maps and additional information about HPI methodology, please visit http://healthyplacesindex.org.

In addition, the HPI identifies the following **census tracts within San Diego County cities** that have *lower levels* of healthy community conditions:

1. Bostonia
2. Chula Vista
3. El Cajon
4. Escondido
5. Imperial Beach
6. La Presa
7. La Mesa
8. Oceanside
9. San Diego
10. San Marcos
11. Vista

Furthermore, within the City of San Diego healthy community conditions vary greatly from community to community. Examples of **communities within the City of San Diego** that have the *lowest levels* of health community conditions include: City Heights, Tierrasanta, Otay Mesa, and San Ysidro. This is not a complete list; please visit the website *http://healthyplacesindex.org/* for more details on communities and neighborhoods.

COMMUNITY NEED INDEX (CNI)

The Dignity Health/Truven Health Community Need Index (CNI) generates a score for each ZIP code based on data about barriers to socioeconomic security.

The five barriers used to determine CNI scores are:

1. Income Barriers
2. Cultural Barriers
3. Educational Barriers
4. Insurance Barriers
5. Housing Barriers

The CNI provides a score for every populated ZIP code in the United States on a scale of 1.0 to 5.0. A score of 1.0 indicates a ZIP code with the least need (dark blue in maps, see Figure 22), while a score of 5.0 represents a ZIP code with the most need (bright red in maps, see Figure 22). For a detailed description of the CNI please see Appendix H or visit the interactive website at: http://cni.chw-interactive.org/.

Figure 22. Community Need Index (CNI), San Diego County
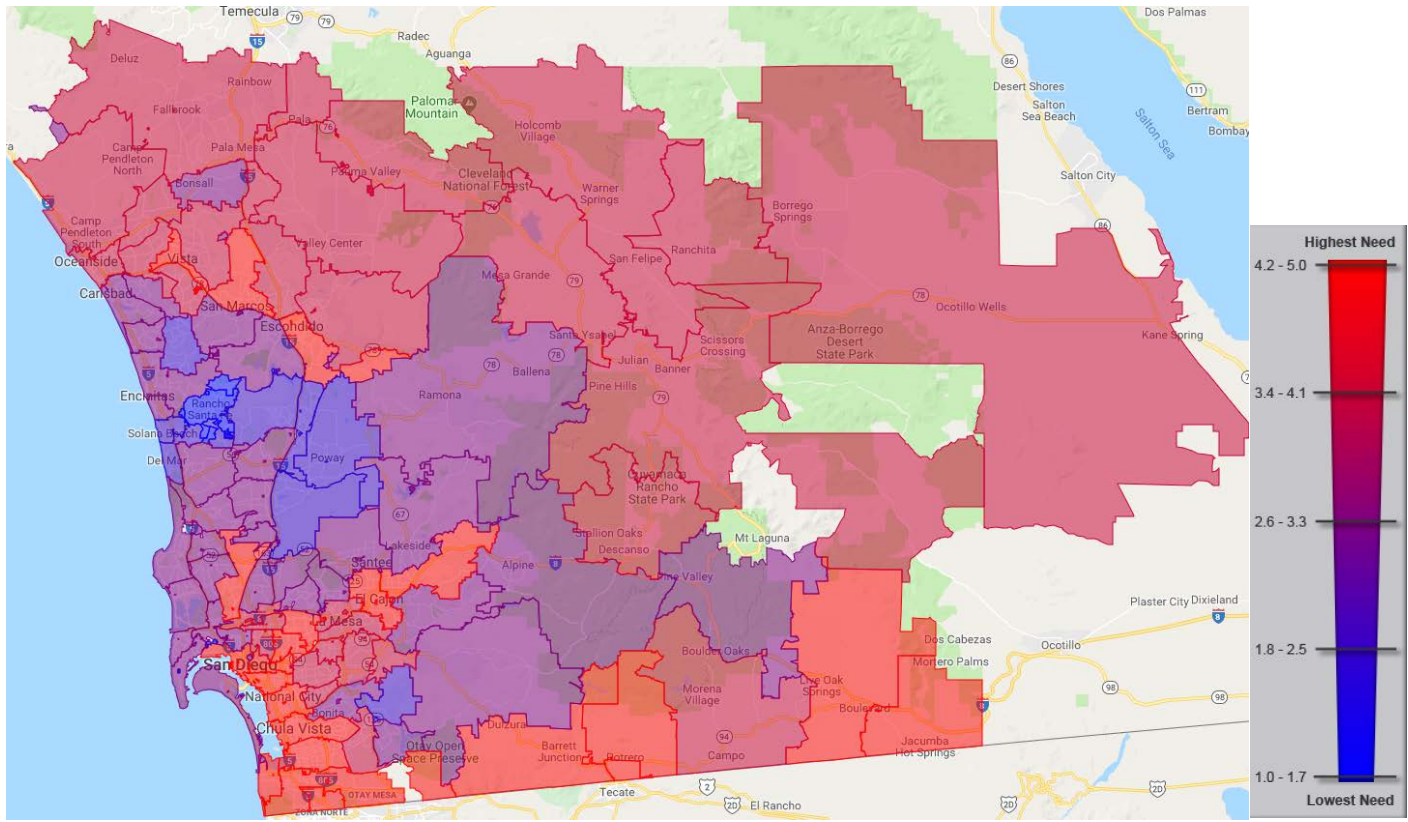
Source: Truven Health Analytics, 2018; Insurance Coverage Estimates, 2018; The Nielson Company, 2018; and Community Need Index, 2018

When comparing CNI scores across HHSA regions (Table 24), differences in mean CNI scores were apparent, with the Central region having the highest mean score of 3.9 and North Central having the lowest mean score of 2.9. It is important to note the variation in scores within each region, as this variation highlights geographic differences in need within the region. At a community level, 22 ZIP codes were identified as having high need CNI scores ranging from 4.2 to 5.0 (Table 25).

Table 24. Community Need Index Scores by San Diego County HHSA Regions, 2015

HHSA Region	Min	Max	Mean
San Diego County	1.6	5.0	3.3
Central	2.4	5.0	3.9
East	2.8	4.8	3.7
North Central	2.0	4.2	2.9
North Coastal	1.6	4.2	3.0
North Inland	2.4	4.4	3.3
South	2.2	4.6	3.6

Table 25. Cities with High Need Index Scores (4.2-5.0) by San Diego County HHSA Regions, 2015

HHSA Region	ZIP codes with a score of 4.2 or higher
Central	
San Diego	92101, 92102, 92105, 92113, 92115
East	
Boulevard	91905
Dulzura	91917
El Cajon	92020, 92021
Jacumba	91934
Potrero	91963
Tecate	91980
North Central	
San Diego	92111

HHSA Region	ZIP codes with a score of 4.2 or higher
North Coastal	
Vista	92083
North Inland	
Escondido	92025
San Marcos	92069
South	
Chula Vista	91910, 91911
Imperial Beach	91932
National City	91950
San Diego	92154
San Ysidro	92173

E. SAN DIEGO COUNTY HOSPITAL AND CLINIC DATA

California's Office of Statewide Health Planning and Development (OSHPD) is responsible for collecting data and disseminating information about the utilization of health care in California. As part of the 2019 CHNA data collection process, 2016 OSHPD demographic data for hospital inpatient and emergency department discharges from all hospitals within San Diego County were analyzed. Data were exported using SpeedTrack's California Universal Patient Information Discovery, or CUPID application. SpeedTrack's application contains all hospital discharge data in California for a 4-year time period (currently 2014–2017) in a format that allows for easy queries and comparisons of local and statewide hospital discharge data at the ZIP code level.

Clinic data were also gathered from OSHPD's website to provide a more holistic view of health care utilization in San Diego, as hospital discharges may not represent all health conditions in the community.

HOSPITAL DISCHARGE DATA

In 2016, there were a total of 1,270,630 patient encounters at all inpatient, emergency department (ED) and ambulatory facilities in San Diego County among San Diego County residents. Approximately 62.8% of those encounters were at ED locations, followed by 22.3% at inpatient facilities and 13.9% at ambulatory centers. Below is a breakdown of demographic characteristics of all San Diego resident encounters at any point of care location during the year 2016 (Table 26).

Table 26. Demographic Characteristics of all Hospital Emergency Department and Inpatient Discharge Encounters in San Diego County by San Diego Residents, 2016

	ED	Inpatient
Age	%	%
0-10 Years	14.2%	16.8%
11 to 17 Years	6.3%	2.4%
18 to 26 Years	13.6%	7.6%
27 to 44 Years	24.0%	18.9%
45 to 64 Years	24.2%	22.5%
65+ Years	17.8%	31.9%
Gender		
Male	45.1%	43.5%
Female	54.9%	56.5%

	ED	Inpatient
Race	%	%
White	57.2%	63.0%
Black/African American	9.1%	6.3%
Asian/Pacific Islander	5.8%	8.0%
American Indian/Alaskan Native/Eskimo/Aleut	0.4%	0.4%
Some Other Race	27.5%	22.3%
Ethnicity		
Hispanic/Latino	34.6%	28.7%

Source: California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2016. SpeedTrack©

CLINIC UTILIZATION DATA

According to 2016 OSHPD data, there are 114 primary care clinics in operation in San Diego County, of which 78.1% are Federally Qualified Health Centers. There were roughly 2.6 million encounters reported in 2016. The largest majority of clinic patients were low-income, Hispanic, and Medi-Cal or self-pay. More specifically, 67.3% of clinic patients reported having an income below 100% of the poverty level, followed by 17.0% between 100-200% of the FPL. The clinic patient population is largely Hispanic (54.8%). A breakdown of clinic utilization by principal diagnosis is shown below (Table 27).

Table 27. Clinic Encounters by Principal Diagnosis, Total Encounters in San Diego County, 2016

Principal Diagnosis	%
Factors Influencing Health Status and Contact with Health Services	29.5%
Dental	12.4%
Other	9.4%
Mental	8.4%
Endocrine, Metabolic, Immunity	6.7%
Musculoskeletal	6.2%
Ill-Defined	4.8%
Respiratory	4.3%
Nervous, Sense Organs	3.6%

Principal Diagnosis	%
Circulatory	3.4%
Genitourinary	2.1%
Infectious, Parasitic	2.1%
Pregnancy, Childbirth	2.0%
Skin	2.0%
Injury, Poisoning	1.5%
Digestive	1.3%
Neoplasms	0.3%

Source: California Office of Statewide Health Planning and Development, OSHPD Primary Care Clinics Utilization Data. 2016.

2019 CHNA METHODOLOGY

IX. METHODOLOGY

To gain a deep and meaningful understanding of the health-related needs of San Diego County residents, two primary methods were employed in the 2019 CHNA. First, quantitative analyses were conducted of existing publicly available data to provide an overarching view of critical health issues across San Diego County. Second, extensive feedback was gathered from community residents, community-based organizations, Federally Qualified Health Centers (FQHCs), hospitals and health systems, local government agencies, philanthropic organizations and San Diego County Public Health Services through a comprehensive community engagement process to understand the lived experiences and needs of people in the community. Once these analyses were complete, the CHNA Committee reviewed these data, along with other criteria, to prioritize the top health needs in San Diego County (see section "C" below). Please see Figure 23 on the next page for more information on the CHNA process.

Figure 23. Community Health Needs Assessment Process Map

2019 COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) PROCESS MAP

2016 CHNA FINDINGS

Community Engagement Activities
Identify and explore priority health needs, social determinants of health, barriers to care, community assets and resources

Data Collection & Analysis
Identify and explore priority health needs, social determinants of health, community health statistics

Online Survey
Community residents, community-based organizations, Federally Qualified Health Centers, hospitals and health systems, local government agencies, philanthropic organizations, and San Diego County Public Health Services

Demographics
Sex, age and race/ethnicity

Focus Groups
Community residents, students, parents, patients, community advisory members, health experts, service providers, and front-line staff at social service agencies

Hospital & Clinic Utilization
ED discharges, hospitalizations, and community clinic visits

Key Informant Interviews
Community leaders and health experts representing Federally Qualified Health Centers, schools, and social service organizations

Morbidity & Mortality
Disease prevalence and leading causes of death

Public Health Department Input
County of San Diego Public Health Department and Health and Human Services Agency

Social Determinants of Health & Health Behaviors
Conditions in the places where people live, learn, work, and play affect a wide range of health risks and outcomes

Identification & Prioritization of Needs

2019 CHNA PHASE 1 REPORT

A. QUANTITATIVE DATA COLLECTION AND ANALYSIS

Quantitative data were used for three primary purposes: (1) to describe the San Diego County community (see "Community Defined" section); (2) to help plan and design the community engagement process; and (3) to facilitate the "prioritization process" – the identification of the most pressing health needs of San Diego County residents.

The CHNA Committee used several sources of data for the quantitative portion of the needs assessment, including the:

1. Public Health Alliance of Southern California Healthy Places Index (HPI)
2. Community Needs Index (CNI)
3. California Office of Statewide Health Planning and Development (OSHPD) SpeedTrack CUPID application
4. Kaiser Permanente CHNA Data Platform & Analytics
5. County of San Diego Community Health Statistics

For details on specific sources and dates of the data used, including any data in addition to sources mentioned above, please see Appendix C.

The Public Health Alliance of Southern California's Healthy Places Index (HPI) mapping function (see Figure 21) and the Community Needs Index (see Figure 22) were used to identify the most under-resourced geographic communities. This information helped guide the community engagement process, including selecting communities from which to solicit input and developing relevant and meaningful engagement topics and questions.

SpeedTrack's California Universal Patient Information Discovery, or CUPID application, was utilized to export emergency department and inpatient hospital discharge data. These data were analyzed to determine the most common primary diagnosis categories upon discharge. This analysis helped the CHNA Committee understand which health conditions that have the greatest impact on hospitals and health systems, which helped inform the CHNA Committee about priority health needs. For those health conditions identified as a high priority for the CHNA, full datasets were extracted and stratified by age and race/ethnicity. Rates were calculated for each group and for each condition per 100,000 in the population. Overall three-year trends from (2014–2016) were also calculated for each health condition as well as for each age group and race/ethnicity within each health condition. This stratification shed light on disparities in San Diego County.

In addition, Kaiser Permanente consolidated data about a wide variety of health conditions and social determinants of health, including data from the California Health Interview Survey (CHIS), the Behavioral Health Risk Factor Survey, and other national and state—wide data sets. These data included the prevalence of certain health conditions and social determinants of health in San Diego County, their relative prevalence to state and national rates and benchmarks, the average resulting reduction of life expectancy (calculated through empirical literature on disability-adjusted life years), disparities across racial and ethnic groups, and alignment with county rankings of top causes of mortality. (Please refer to Appendix J to see results). Kaiser Permanente also conducted a comprehensive statistical analysis to

identify which social determinants of health were most predictive of negative health outcomes in San Diego County census tracts. (Please refer to Appendix J to see results). Kaiser Permanente then created a user-friendly, web-based data platform (chna.org/kp) and posted many of their analyses on this platform for use in the CHNA. These analyses guided the design of survey, interview, and focus group questions and was vital to understanding and prioritizing health needs in San Diego County.

B. COMMUNITY ENGAGEMENT ACTIVITIES

HASD&IC is proud of its strong relationships with local community organizations and is committed to regularly seeking input from the community to inform its community health strategies. The community engagement process described in this report is one component of HASD&IC's triennial Community Health Needs Assessment (CHNA). In collaboration with KFH-San Diego and Zion, HASD&IC solicited input from the community through four types of efforts:

- ❖ Focus groups with community residents, community-based organizations, service providers, and health care leaders
- ❖ Key informant interviews with health care experts
- ❖ Online survey distributed to community stakeholders and residents
- ❖ Collaboration with the County of San Diego Health & Human Services Agency, Public Health Services

These efforts ensured a rich portrait of community health needs at multiple levels.

METHODOLOGY FOR THE COMMUNITY ENGAGEMENT PROCESS

A key priority of the community engagement process was to solicit input from a wide range of stakeholders so that the sample was as representative as possible of those facing inequities in San Diego County. Special efforts were made to include community residents from groups that experience health disparities and service providers who work with those groups.

The CHNA Committee worked with community partners to plan community engagement activities with stakeholders representing every region of San Diego County and all age groups. In addition, the CHNA Committee explicitly sought to engage a wide variety of stakeholders representing diverse numerous racial and ethnic groups. Health leaders and a diverse set of advocacy groups and organizations were also recruited for the process. A total of **579** individuals participated in the 2019 Community Health Needs Assessment: **138** community residents and **441** leaders and experts. Please see Table 28 and Figure 24 below for details on the types of participants engaged. A list of individuals who provided input via interview, focus group, or online survey may be found in Appendix D.

Table 28. 2019 HASD&IC Community Health Needs Assessment - Overview of Community Engagement Participants

Type of Engagement	# of Engagements	# of Participants Engaged		Total Individuals
		Community Residents	Leaders/Experts	
Focus Groups	18	91	123	214
Key Informant Interviews	12	0	12	12
CHNA Online Survey	-	47	306	353
TOTAL	**30**	**138**	**441**	**579**

Figure 24. 2019 CHNA Community Engagement Participants

12 Key Informant Interviews ➕ 214 Focus Group Participants ➕ 353 Survey Participants ➖ 579 Community Participants

Types of Organizations

- Affordable housing provider
- Community-based advocacy
- FQHCs
- Local government
- Local health department
- Resident advocacy
- Schools
- Social service providers
- Student organizations

Populations Served/ Represented

- Individuals & families experiencing homelessness
- LGBTQ
- Military & veterans
- Native Americans
- Refugees & immigrants
- Rural health
- School aged children & youth
- Seniors
- Transitional age youth
- Uninsured & underserved

Roles of Participants

- Advocates
- Clinical staff
- Community residents
- Front line staff
- Executives, directors, & administrators
- Health educators
- Law enforcement
- Patients
- Program managers & coordinators
- Promotores & social service navigators
- School teachers & counselors

KEY INFORMANT INTERVIEWS AND FOCUS GROUPS

Key informant interviews and focus groups were utilized to identify and explore priority health needs, social determinants of health, barriers to care, and community assets and resources. Focus groups and interviews were conducted in a semi-structured manner. Expert interviewers and facilitators from the IPH employed the questions developed and approved by the CHNA Committee to generate discussion about specific community health needs as well as open ended questions for broader discussions. Broad questions about health conditions and social determinants of health were asked at the beginning of each discussion and were followed by more specific questions targeted for the participants. Questions varied depending for each interview and focus group, depending on the expertise and/or specific interests of the person or group participating. Please see Appendix E for sample questions asked during focus groups and key informant interviews.

In addition, when appropriate given the composition of the focus group, discussions were allowed to flow in a conversational manner to ensure that community residents had the opportunity to discuss issues of importance to them. One focus group was conducted via a video conference call; all others were conducted in-person. For in-person group events, food was provided for the participants. Incentives, in the form of gift cards, were also provided when the groups were comprised of community residents. The contact person for that community resident focus groups provided suggestions on the type of incentives to provide. Each interview and focus group began with a discussion about the purpose and process of the CHNA. The IPH facilitator then received consent to proceed and reassured participants that their participation was voluntary, and their feedback would be anonymous. Interpretative and translation services were arranged for any group that requested them. Two focus groups were conducted in Spanish, and one had simultaneous English and Spanish interpretations via headsets for all participants.

For each focus group and key informant interview, IPH staff in addition to the facilitator or interviewer took detailed notes and then shared summaries with full IPH research team. These summaries were then entered into the qualitative research software (NVivo) as stand-alone sets of data. After all the focus groups and interview summaries were completed, the team used software tools to analyze the qualitative data. All health needs and social determinants of health that were mentioned were tabulated. The IPH then made a complete list of all the conditions mentioned in focus groups or interviews, counted how many groups or informants listed those conditions, and noted how many times they had been prioritized by a focus group. This qualitative data analysis was designed to identify emergent themes.

ONLINE SURVEY

The CHNA online survey was used to rank health conditions and social determinants of health in order of importance within the community. The survey was distributed via email to targeted community- based organizations, social service providers, resident led organizations, federally qualified health centers, governmental agencies, and hospitals and health systems who serve a diverse array of people in San Diego County. When possible, these organizations shared the link to the survey with their clientele. Email recipients were also encouraged to share the survey with their colleagues.

Through the leadership of the County Public Health Officer, Dr. Wilma Wooten, there was a coordinated effort to distribute the survey to the County of San Diego Public Health staff (California Children Services, Epidemiology and Immunization Services, HIV, STD, & Hepatitis, Maternal, Child & Family Health Services, Public Health Preparedness & Response, Public Health Services Administration, Tuberculosis Control and Refugee Health)

An introductory email with a link to the survey provided both an explanation of the purpose and instructions for completing the survey. Questions were tailored slightly depending on how survey respondents self-identified. For example, if a survey respondent identified as a community resident, they were asked about conditions in their community. If a survey respondent identified as working for a social services organization, they were asked about the challenges facing their clients. The survey asked respondents to identify where he/she or his/her clients live in San Diego County. Respondents were then provided lists of health conditions and social determinants of health and asked to do the following:

Organizations:

❖ "Please rank the **HEALTH CONDITIONS** in order from 1 to 13, with 1 having the greatest impact on the overall health and well-being *for your clients and the communities in which they live."*
❖ "Please rank the following **SOCIAL DETERMINANTS OF HEALTH** from 1 to 15, with 1 having the greatest influence on poor health outcomes for *your clients and the communities in which they live*. Some examples of challenges associated with each social determinant of health are provided in parenthesis. This is not intended to be a comprehensive list."

Community Residents:

❖ "Please rank the **HEALTH CONDITIONS** in order from 1 to 13, with 1 having the greatest impact on the overall health and well-being *of you, your family or your community.*"
❖ "Sometimes our health is influenced by the conditions of the places where we work, live, and spend time. For example, it is harder to be healthy if you do not have a safe place to sleep, clean water to drink, access to healthy food, or if the air in your neighborhood is poor quality. We call these "social determinants" of health.

   o Please review the following list of **SOCIAL DETERMINANTS OF HEALTH** that relate to health and well-being. Please rank them from 1 to 15, with 1 being the greatest challenge to health and well-being for *you, your family, or your community*. Some examples of challenges related to each social determinant of health are provided in parenthesis. This is not a complete list."

They were also asked to comment on whether these conditions had improved, stayed the same, or gotten worse over the past three years. The surveys were designed in and distributed via an online survey software (Qualtrics). This allowed for the automatic capture of all survey data, which was subsequently imported into Statistical Analysis Software (SAS) for analysis. Mean rankings for each health condition and social determinant were calculated, as were the percentage of respondents who thought each condition had improved, stayed the same, or gotten worse.

PROCESS AND CRITERIA USED FOR PRIORITIZATION OF HEALTH NEEDS

In order to prioritize the top needs, the CHNA Committee analyzed the comprehensive findings from the needs assessment, including quantitative and qualitative data.

Data Used in Prioritization Process	
Quantitative Data	**Qualitative Data**
▪ Analysis of secondary data, health conditions and SDOH.	▪ Community engagement findings from focus groups
▪ County of San Diego leading causes of death 2016 data.	▪ Community engagement findings from key informant interviews
▪ Hospital discharge trend data retrieved from California's Office of Statewide Health Planning and Development (OSHPD) via SpeedTrack.	▪ 2019 CHNA survey data

The CHNA Committee used the following set of criteria in their prioritization process.

- ❖ **Severity of need:** This refers to how severe the health need is (such as its potential to cause death or disability) and its degree of poor performance against the relevant benchmark.

- ❖ **Magnitude/scale of the need:** The magnitude refers to the number of people affected by the health need.

- ❖ **Disparities or inequities:** This refers to differences in health outcomes by subgroups. Subgroups may be based on geography, languages, ethnicity, culture, citizenship status, economic status, sexual orientation, age, gender, or others.

- ❖ **Change over time:** This refers to whether or not the need has improved, stayed the same, or worsened.

Prioritization Criteria

Severity of need

Magnitude/ scale of the need

Disparities or inequities

Change over time

Over the course of several meetings, the CHNA Committee collectively reviewed the quantitative and qualitative data and findings. Each health condition and social determinant of health for which the committee had data was considered and discussed in terms of these criteria. Those health conditions and social determinants of health that met the largest number of criteria were chosen as top priorities.

D. DATA LIMITATIONS AND INFORMATION GAPS

As with any community needs assessment process, the data available for use is limited. In the KP CHNA data platform, for example, some data were only available at a county level, making an accurate translation to neighborhood-level health needs challenging. In the Healthy Places Index platform, census tracts with very low populations were represented as missing data (to reduce unreliability of measurement). This caused under-sampling of rural areas. In both platforms, disaggregated data around age, ethnicity, race, and gender were not available for many indicators which limited the ability to examine disparities of health within the community. Additionally, data in both platforms were not often collected on a yearly basis and therefore may not represent 2018 values.

The primary data also have limitations. For the community engagement process, every effort was made to target those populations who experience the greatest health inequities. Community participation from these groups was strong; however, participants included only those community members who were interested and able to engage in the process. The first-person voices of certain groups, therefore, were underrepresented, such as those who suffer from severe physical or cognitive impairments and those without access to transportation to the community engagement events.

CHNA surveys were distributed and collected electronically. Without access to community members' email addresses, surveys were distributed through those community-based organizations who were willing to share the survey with their clients. As a result, community member response to the survey was low.

2019 CHNA FINDINGS

X. FINDINGS

A. 2019 FINDINGS: TOP 10 COMMUNITY HEALTH NEEDS

Through the prioritization process described above in Section IX C. the CHNA Committee identified the following health conditions and social determinants of health as the most critical health needs within San Diego County (listed below in alphabetical order):

1. Access to Health Care
2. Aging Concerns
3. Behavioral Health
4. Cancer
5. Chronic Conditions

6. Community and Social Support
7. Economic Security
8. Education
9. Homelessness and Housing Instability
10. Unintentional Injury and Violence

Figure 25. 2019 CHNA Top Health Needs
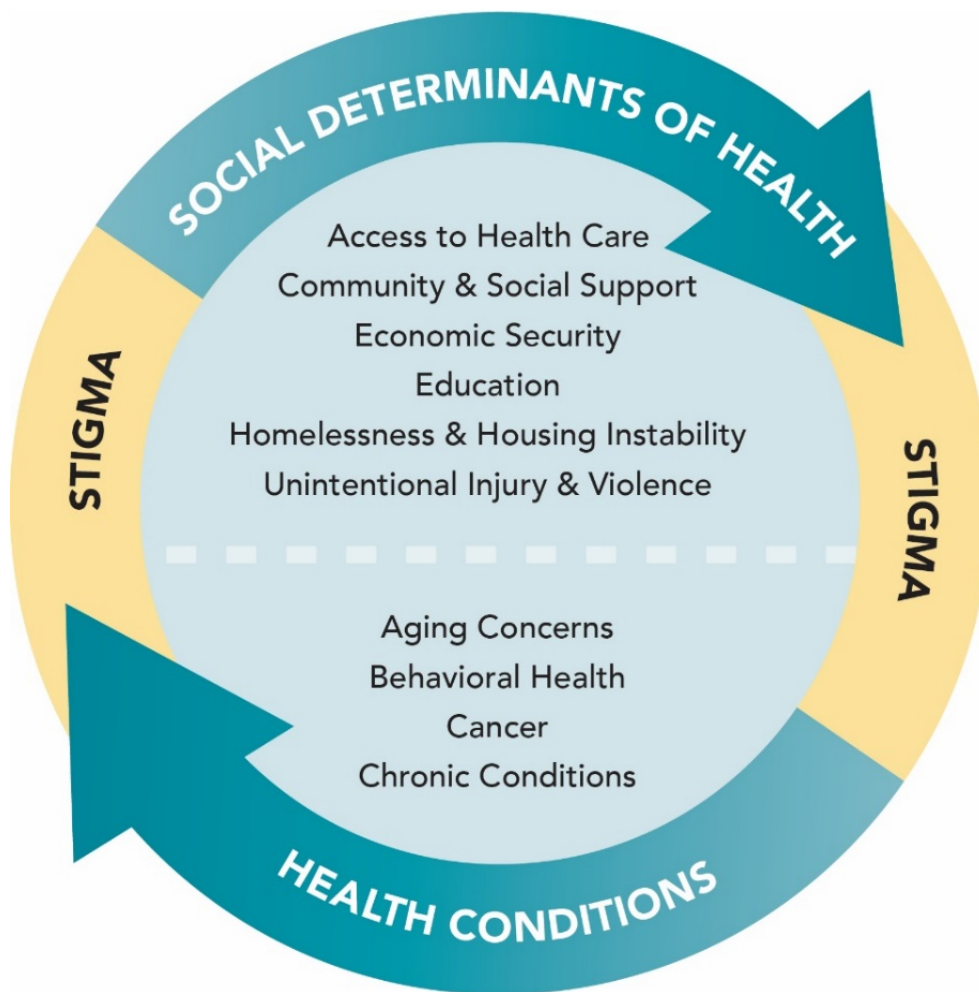
Figure 25 on the previous page illustrates the interactive nature of SDOH and health conditions – each impacting the other. In addition, an underlying theme of stigma and the barriers it creates arose across community engagement. For instance, stigma impacts the way in which people access needed services that SDHO, which consequentially impacts their ability to maintain and manage health conditions. Due to the complexity of this underlying theme, the CHNA Committee plans to explore and understand ways in which hospitals and health systems could better address stigma in patient care during Phase 2 of the CHNA process. Please see Health Briefs section for individual **health briefs** on select community health needs.

ACCESS TO HEALTH CARE

Access to health care includes two components – the specific services that individuals are unable to obtain and the barriers and SDOH that prevent individuals from obtaining those services.

1. *Types of care that are difficult to access*
   - ❖ Behavioral Health Care
   - ❖ Dental Care
   - ❖ Primary Care
   - ❖ Specialty Care

2. *Barriers to accessing care & associated SDOH*
   - ❖ Culturally competent care
   - ❖ Economic security
   - ❖ Fear related to immigration status
   - ❖ Lack of health insurance & insurance issues
   - ❖ Shortage of health care providers
   - ❖ Transportation

Access to health care emerged as a high priority health need in both the secondary data analyses and the community engagement events.

SECONDARY DATA ANALYSIS

Data are available regarding three components of health care access in San Diego County: (1) health insurance coverage; (2) preventable hospital events; and (3) receipt of regular care from a primary care physician.

HEALTH INSURANCE COVERAGE

A lack of health insurance coverage represents a major barrier to health care services. In San Diego County, 11% of people are uninsured. Certain groups, including those who identify as "Other," Native American/Alaska Natives, Hispanics, Pacific Islanders, and Blacks, have higher rates of being uninsured than others.[1] See Figures 26, 27, and 28 below for additional details.

Figure 26. Percentage of Population without Health Insurance in San Diego County, California, and the United States Ages 18-64 Years, 2013–2017
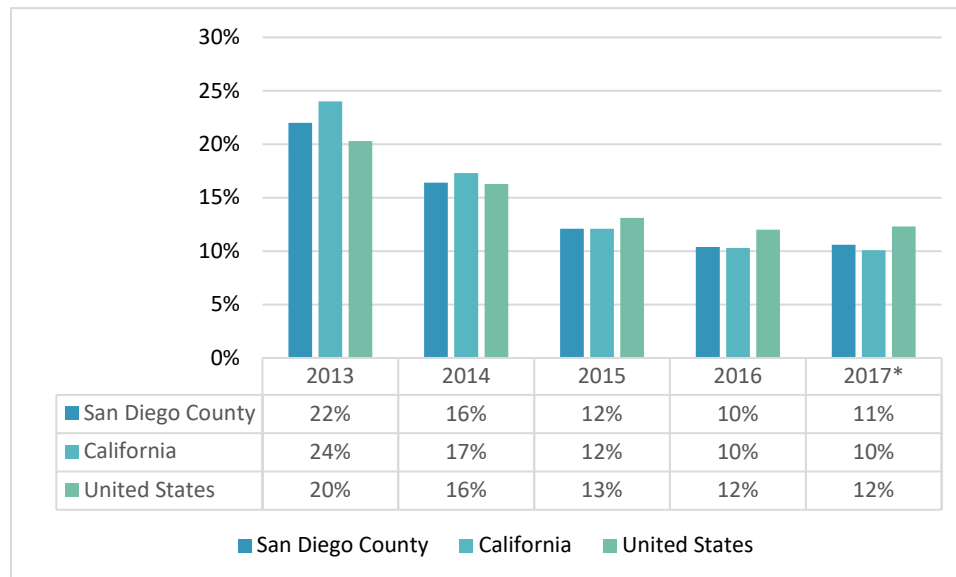
	2013	2014	2015	2016	2017*
San Diego County	22%	16%	12%	10%	11%
California	24%	17%	12%	10%	10%
United States	20%	16%	13%	12%	12%

Source: U.S. Census Bureau. American Community Survey, 2013–2017 1-Year Estimates. Includes civilian non-institutionalized population.
*Ages 19–64 years

Figure 27. Percentage of Population without Health Insurance in San Diego County and California Ages 19–64 Years by Race, 2017
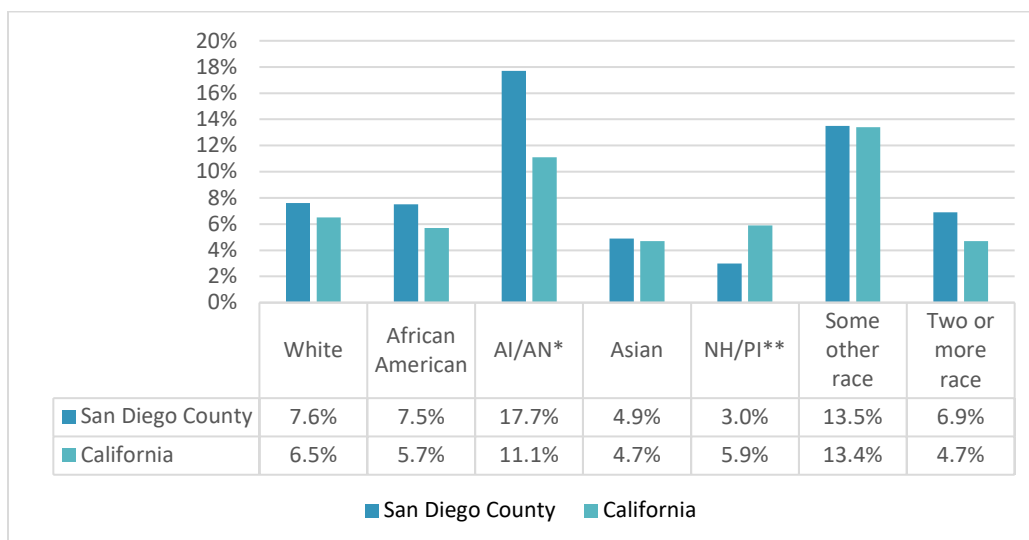
	White	African American	AI/AN*	Asian	NH/PI**	Some other race	Two or more race
San Diego County	7.6%	7.5%	17.7%	4.9%	3.0%	13.5%	6.9%
California	6.5%	5.7%	11.1%	4.7%	5.9%	13.4%	4.7%

Source: U.S. Census Bureau. American Community Survey, 2017 1-Year Estimates. Includes civilian non-institutionalized population.
*American Indian and Alaska Native
**Native Hawaiian and other Pacific Islanders

Figure 28. Percentage of Population without Health Insurance in San Diego County and California Ages 19–64 by Ethnicity, 2017
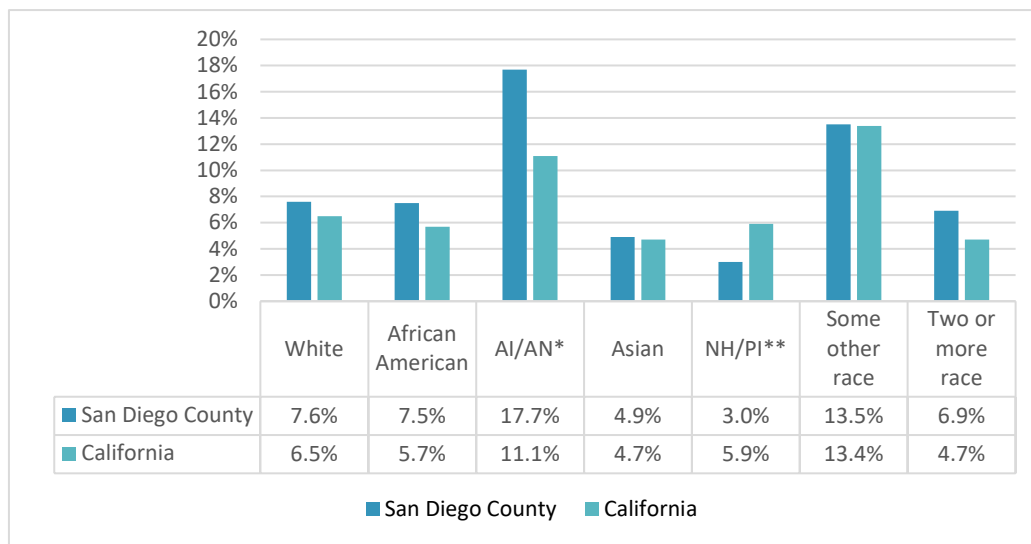
	White	African American	AI/AN*	Asian	NH/PI**	Some other race	Two or more race
San Diego County	7.6%	7.5%	17.7%	4.9%	3.0%	13.5%	6.9%
California	6.5%	5.7%	11.1%	4.7%	5.9%	13.4%	4.7%

Source: U.S. Census Bureau. American Community Survey, 2017 1-Year Estimates. Includes civilian non-institutionalized population.

PREVENTABLE HOSPITAL EVENTS

Another measure of access to care is how many "preventable hospital events" occur. This number is the patient discharge rate for health conditions that are "ambulatory care sensitive" – conditions that could have been potentially prevented or managed with proper preventive care, such as pneumonia, dehydration, asthma, and diabetes. In San Diego County, the rate of preventable hospital events is 29.7 per 1,000 residents. For Black individuals, however, this rate is higher – 45.1 per 1,000, suggesting that Black individuals may have more difficulty accessing primary care resources.[2] (Figure 29).

Figure 29. Preventable Hospital Events for Medicare Beneficiaries in San Diego County, 2015
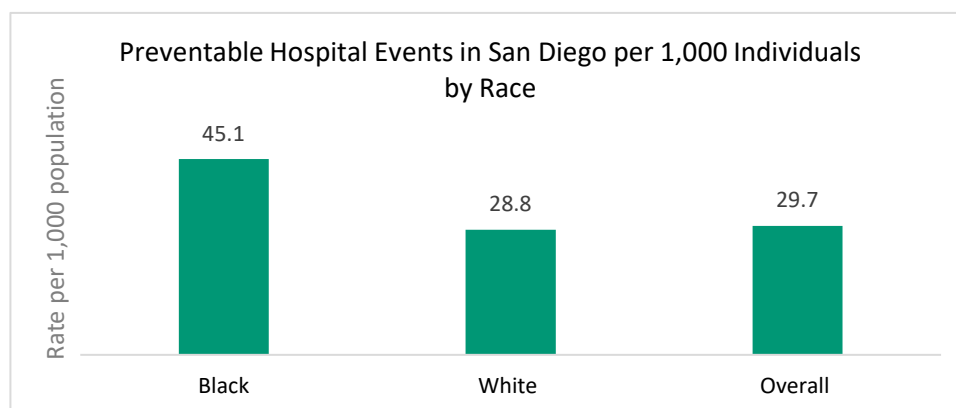
Source: Dartmouth Atlas Data website, which was funded, in part, by the National Institute of Aging, under award number U01 AG046830 and by The Dartmouth Institute for Health Policy and Clinical Practice. 2015.

ACCESS TO PROVIDERS

According to the U.S. Department of Health and Human Services Area Health Resource File, there are approximately 78.3 primary care physicians per 100,000 persons in San Diego County.[3] This is similar to the rate in California (78.1). According to 2018 County Health Rankings, San Diego County has 295.6 mental health care providers per 100,000 total population which is above the state and national levels.[4] These indicators are important because a shortage of health professionals creates barriers to accessing regular primary care and mental health care and contributes to poor health status. While the number of health care professionals per 100,000 persons is similar for California and San Diego County, these providers may not be evenly distributed across the county.

VISITS WITH A PRIMARY CARE PHYSICIAN

Finally, visits to a primary care physician are a measure of preventive health care service access and utilization, which contribute to health maintenance. While many San Diegans (71.8%) have seen a primary care physician in the past year,[5] Medicare beneficiaries, a group made up primarily of people 65 years old and older, are less likely to receive regular care from a primary care physician (PCP). Of this group, only 68.2% have seen a PCP in the last year (2015).[2] This is lower than the California state average of 72.9%.[2] (Figure 30).

Figure 30. Percentage of Medicare Beneficiaries who have seen a PCP within Past Year in San Diego County, 2015
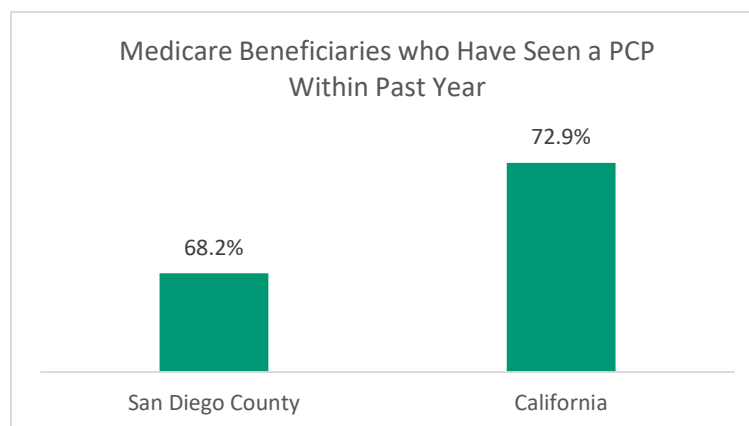
Source: Dartmouth Atlas Data website, which was funded, in part, by the National Institute of Aging, under award number U01 AG046830 and by The Dartmouth Institute for Health Policy and Clinical Practice. 2015

Please see Appendix C for Access to Health Care secondary source information

COMMUNITY ENGAGEMENT FINDINGS

Across all types of community engagement events, access to health care was identified by participants as a priority health need in San Diego County.

On the online survey, for example, respondents ranked *Access to Care* as the health need having the greatest impact on the overall health and well-being of San Diego County residents out of all listed health conditions and social determinants of health (see Appendix F for full results).

During focus groups and key informant interviews, participants often cited accessing care as the most challenging issue facing their communities. Frequently discussed topics related to access to care included:

- ❖ Barriers to care
- ❖ The types of care most challenging to access
- ❖ The individuals for whom access to care is particularly problematic

A summary of findings from the focus groups can be found in Table 29 below.

BARRIERS TO CARE

Community engagement participants identified five primary barriers to accessing health care in San Diego: (1) lack of insurance; (2) economic insecurity; (3) transportation (4) fear related to immigration status; and (5) lack of culturally competent/linguistically appropriate care options.

Lack of insurance was identified as an important barrier to care for San Diego residents. The lack of insurance, participants explained, arises from the inability to pay for insurance due to competing financial priorities (particularly housing), the limited availability of insurance for undocumented residents, and from fears that applying for public insurance, such as Medi-Cal, for their children, will lead to deportation or interfere with a path to citizenship.

Economic insecurity was discussed as not only an underlying reason for not obtaining health insurance but also as a reason for not attempting to receive needed care for acute issues and, particularly, preventive care for health management. Health insurance premiums, co-pays, co-insurance, and out of pocket payments were described as financially prohibitive for many residents. In addition, participants indicated that taking time off work, and losing those paid hours as a result, is not a realistic option for most low-income people.

Transportation was also discussed as a significant obstacle to health care access. Community engagement participants noted that for those without cars, public transportation to health care appointments can be time-consuming, expensive, and inconvenient, and some hospitals and clinics are not easily reached by public transportation. Transportation was noted to cause particular challenges for seniors, those in rural areas, and those who are homeless.

Fears related to immigration status came up as an important and pressing topic during nearly all of the community engagement events. Participants described undocumented immigrants as living in a "constant state of fear" of detention and deportation. This fear, they said, prevents them from accessing health care, even in acute situations. During focus groups, many stories were shared about Immigration and Customs Enforcement (ICE) raids that resulted in the long-term detention and sometimes deportation of San Diego residents who have lived and worked in the community for decades. Parents

talked about being terrified of being separated from their children. Community residents also made clear that even immigrants who are in the country legally are worried that the use of public benefits or community services will create obstacles in their path to citizenship.

Finally, community engagement participants noted that the inability to obtain *culturally competent/linguistically appropriate* care keeps residents from receiving health care. They noted that most individuals prefer to receive health care from people who are from or who understand their cultural background, and that those cultural mismatches between health care providers and patients can create mistrust. They also noted that translators are often not available, which makes health care visits frustrating for both the patient and the provider. Participants spoke about how children are often utilized as translators, at times creating both an undue burden for the child and an uncomfortable situation for the parents who would rather keep their health information private.

Several other barriers were mentioned but with less frequency:

- ❖ Lack of knowledge in the community about available resources and about where to receive specific types of health care
- ❖ Questions about how to navigate the health care system
- ❖ Too few hospitals and clinics in San Diego County
- ❖ Workforce shortages in certain areas of health care, e.g. mental health

TYPES OF CARE

Community engagement participants emphasized that while all types of health care can be difficult to access, obtaining timely, quality behavioral health services are particularly challenging. Both mental health care and substance abuse treatment were discussed.

Several issues related to *mental health care* arose during the community engagement. For those who are insured, finding a mental health care provider who is available after work or school hours, is located reasonably close to home or work, has openings in a short time-frame, and who takes their insurance is a time-consuming and frustrating process. For those without insurance, participants felt that it is nearly impossible to find a mental health care provider. A shortage of urgent care mental health options was also discussed. Participants also noted that there are too few inpatient psychiatric beds and that, often, those who have been hospitalized cannot secure appropriate and effective transitional mental health services.

Participants also emphasized a dire shortage of s*ubstance use disorder* treatment options. For those with addictions, inpatient programs have long waiting lists, and there are too few urgent care options.

Other types of care that were mentioned, although less frequently include:

- ❖ Oral health/dental care
- ❖ Specialty appointments after a diagnosis is made
- ❖ Primary care
- ❖ Urgent care

VULNERABLE POPULATIONS

Community engagement participants stressed that for certain people, access to care is especially difficult, and that these challenges contribute to and worsen health disparities. Groups cited as particularly vulnerable included:

- ❖ Homeless individuals
- ❖ Immigrants
- ❖ Low income individuals
- ❖ Racial/ethnic minorities
- ❖ Seniors
- ❖ Sexual minorities (LGBTQ individuals)

Participants explained that all of these groups may be more vulnerable to poor health, so that the very people who need consistent, quality health care the most may not receive it.

Table 29. Summary of Focus Group and Key Informant Interview Input Related to Access to Care

SUMMARY OF RESPONSES RELATED TO ACCESS TO HEALTH CARE

ASSOCIATED HEALTH CONDITIONS AND NEEDS

All Age Groups
- **Cancer**
- **Chronic diseases** (diabetes)
- **Mood disorders** (anxiety, depression, stress)
- **Substance use disorder**
- **Sexually transmitted diseases**
- **Suicide & self-harm**
- **Trauma** (generational, PTSD, psychological)

Children/Youth
- **Mood disorders** (anxiety)
- **Substance abuse** (alcohol, drugs)
- **Suicide & self-harm**
- **Trauma** from experiences before coming to America (war, bombing, gas attacks)

Senior
- **Alzheimer's**
- **Dementia**
- **Mood disorders** (anxiety, depression, schizophrenia)

ASSOCIATED SOCIAL DETERMINANTS OF HEALTH

All Age Groups
- **Access to dental care:** lack of access to dental care
- **Access to mental health services:** lack of services, psychiatrists, PERT, and detox centers for homeless
- **Care coordination**: lack of knowledge in navigating the health care system
- **Cultural and language barriers** in health care
- **Economic insecurity:** insurance costs, services for mental, dental, primary care, surgeries, transgender services, vaccinations, and preventative care
- **Education**: Lack of community resident awareness of services
- **Follow-up care:** limited follow-up care
- **Healthy foods**: lack of access to healthy foods

- **Housing and homelessness**
- **Insurance issues**
- **Shortage of health care facilities:** shortage of hospitals and clinics, especially in East Region
- **Shortage of health care providers:** lack of specialists, nurses, medical assistants
- **Stigma:** LGBTQ marginalization, doctors refuse to prescribe PrEP, doctors shame patients for getting STD testing
- **Transportation**: lack of transportation
- **Violence** (fear, homelessness)

Children/Youth
- **Lack of school-based services** to support emotional and mental health of students
- **Education**: lack of education on sexual health (HIV)
- **Stigma**
- **Vaccinations** (difficult to access especially among homeless families due to being transient)

Seniors
- **Economic insecurity**
- **Services**: limited mental health insurance coverage, senior population increasing, however the government is not adjusting to accommodate raising needs
- **Social isolation** and loneliness
- **Stigma**
- **Transportation**

ASSOCIATED BARRIERS AND CHALLENGES

All Age Groups
- **Distrust**: community versus hospital, patient versus doctor and social worker
- Lack of **patient autonomy** in making discharge decisions
- **Lack of storage** (medications for homeless)
- **Long wait times**

Children/Youth
- Lack of **follow-up care** post-referral
- **Lack of parental involvement** due to cultural differences
- **Parental consent** to access services
- **Vaccinations** and test results across the border are not accepted
- Bullying

Seniors
- **Mobility issues**

Aging concerns are defined as those conditions that predominantly affect seniors --- people who are 65 and older -- such as Alzheimer's disease, Parkinson's, dementia, falls, and limited mobility.

Conditions that disproportionately affect older adults were identified as a high priority health need through both the community engagement events and the secondary data analyses. Community engagement participants most often described aging concerns in relation to the SDOH that affect seniors such as:

- ❖ Access to fresh food
- ❖ Economic insecurity
- ❖ Social isolation and inadequate family support
- ❖ Transportation

SECONDARY DATA ANALYSIS

San Diego County data shows that inpatient discharges have increased from 2014–2016 for both Alzheimer's and dementia. For Alzheimer's disease, the ED discharge rate increased by 35.1%, and the inpatient discharge rate increased by 16.3%. For dementia, the ED discharge rate increased by 10.6%,

Figure 31. Hospital Discharge Rates for Alzheimer's and Dementia in San Diego County, 2014–2016
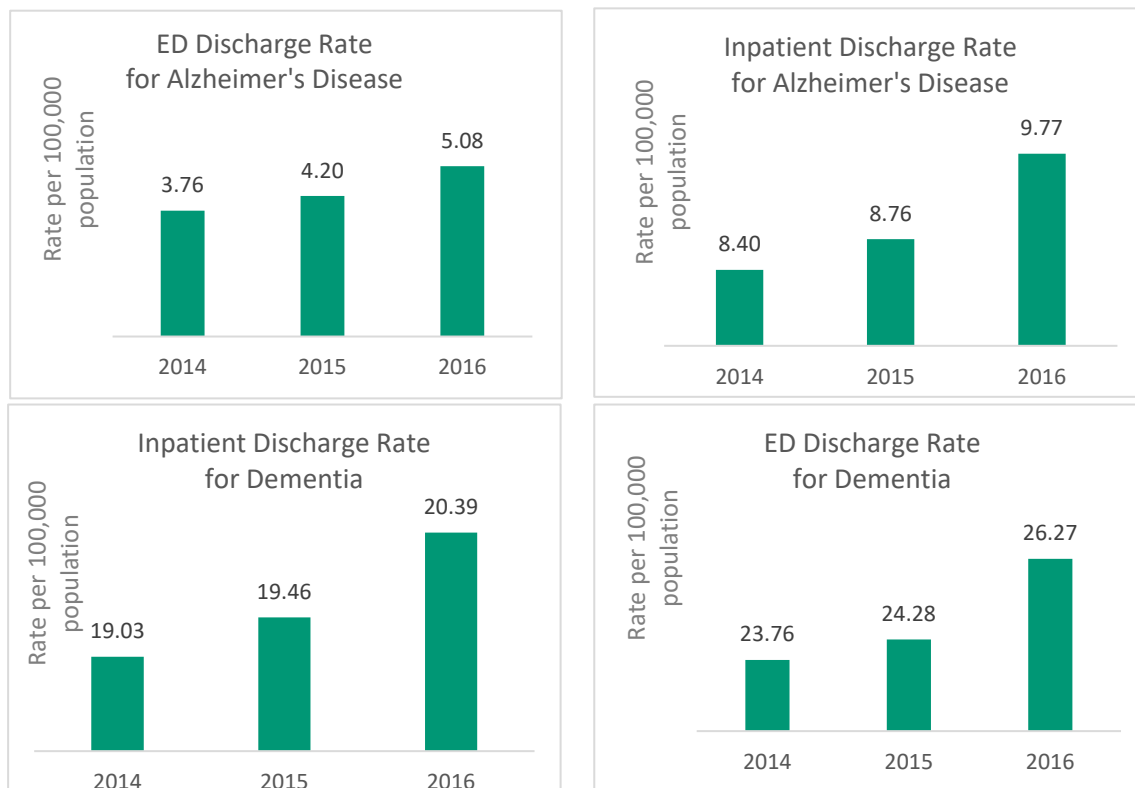
Source: California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2014-2016. SpeedTrack©

while the inpatient discharge rate increased by 7.1%.[1] Please see Figure 31 above for more details on Alzheimer's and dementia.

In addition, Alzheimer's disease was the third leading cause of death and Parkinson's disease was the 12th leading cause of death in San Diego County in 2016.[2]

San Diego County data shows that falls disproportionally affect those over 65 years of age. From 2014 to 2016 ED discharges for seniors increased by 2.5%, however the mortality rate for falls decreased by 14.5% in the same time period.[3] Please see Figure 32 below for more details.

Figure 32. Hospital Discharge and Mortality Rates for Falls in San Diego County, 2014–2016
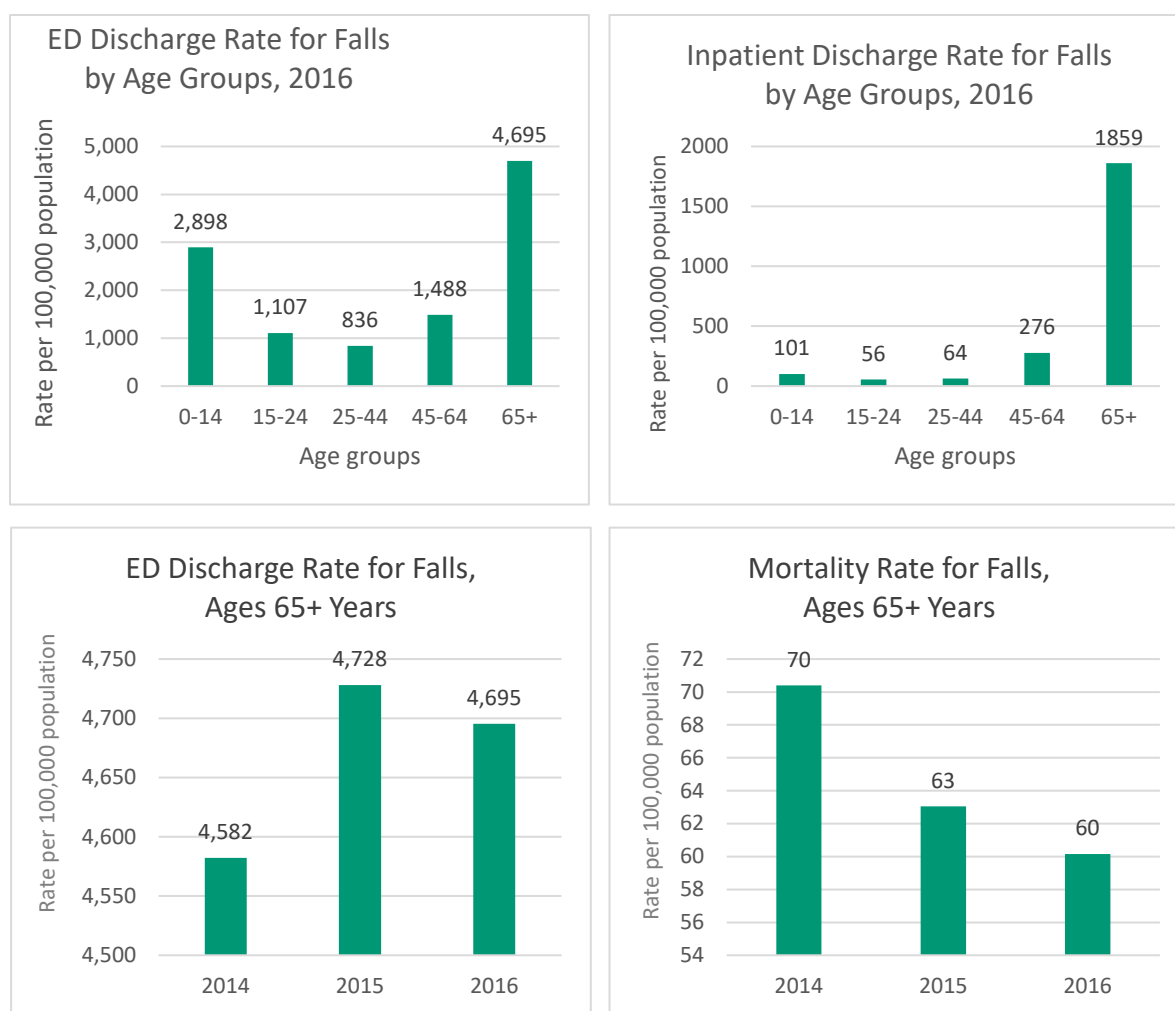
Source: Live Well San Diego. Live Well San Diego Data Access Portal. Injury. https://data.livewellsd.org/

Please see Appendix C for Aging Concerns secondary source information.

COMMUNITY ENGAGEMENT ANALYSIS

Respondents to the community engagement online survey identified Aging Concerns as one of the top 10 most impactful health conditions in San Diego County. See Appendix F for a full summary of survey results.

During community engagement events, conversations about aging concerns centered on conditions that disproportionately affect older adults and barriers to care for older adults. See Table 30 below for a summary of findings from the focus groups.

CONDITIONS AFFECTING SENIORS

Focus group participants discussed several health conditions and social determinants of health that particularly affect older adults. These included Alzheimer's and Parkinson's diseases, dementia, arthritis, loss of mobility, opioid abuse, diabetes, heart disease, anxiety, depression, lung disease, obesity, and poor oral health. They also detailed social determinants of health that affect seniors, including lack of accessible or reliable transportation options, challenges accessing fresh food, social isolation and inadequate family support, economic insecurity, and environmental pollutants.

Focus group participants also emphasized that health maintenance is more difficult for seniors. Medication management, including ordering refills, picking up prescriptions, and taking the right dose of medications at the right time, can be challenging for older adults who do not have adequate support. In addition, the health conditions associated with aging may interfere with an individual's ability to exercise and to access healthy, fresh food.

BARRIERS TO CARE

For seniors, focus group contributors explained, accessing health care can be particularly difficult. When seniors can no longer drive, finding reliable, affordable *transportation* can be challenging.

Seniors living off social security, or other limited income, are concerned about their *Economic security.* The high cost of medications and of co-pays and deductibles may prohibit them from accessing health care.

Physical limitations may also create difficulties for seniors. These include limited mobility, hearing problems, and vision issues.

For those who do not speak English as a first language, *language issues* are also a barrier to care. Please see Community and Social Support section of the report for more details on language issues.

After *discharge* from a hospital, seniors may have inadequate support at home to recover well and follow-up care is hard for seniors to locate and secure.

Table 30. Summary of Focus Group and Key Informant Interview Input Related to Aging Concerns

SUMMARY OF RESPONSES RELATED TO AGING CONCERNS	
ASSOCIATED HEALTH CONDITIONS AND NEEDS	
Alzheimer's Disease **Arthritis**: joint pain **Behavioral/Mental Health Issues:** anxiety (fear), depression from hopelessness and discrimination, generational trauma **Dementia**: including early onset **Dental/Oral Health**: tooth loss, dentures **Heart Disease** **Hypertension** (high blood pressure)	**Lung disease** **Obesity** **Physical limitations**: mobility related to aging, being homebound, disabled, or walker/wheelchair-dependent **Substance abuse and self-medication** **Vision and hearing loss**
ASSOCIATED SOCIAL DETERMINANTS OF HEALTH	
Behavioral/mental care access: lack of access to mental health services **Community and social support**: lack of socialization opportunities, caregiving responsibilities for grandchildren, social isolation leads to loneliness **Dental care access:** lack of access to dental care, cost, and lack of dental insurance **Economic security:** limited and fixed incomes, government assistance	**Environmental issues:** houses close to factories **Food insecurity**: healthy food access, and malnutrition **Housing**: affordability, senior housing availability, and evictions **Homeless issues**: Lack of homeless shelters for seniors **Language Issues**
ASSOCIATED BARRIERS AND CHALLENGES	
Cultural competency: lack of cultural/linguistically appropriate services **Fear** of pain or discrimination **Follow-up**: lack follow-up for referrals, missed appointments **Health navigation issues** **Immigration**: Fear of deportation/mistrust of the government	**Insurance Issues** with benefits and cost of insurance **Long wait times** for appointments and specialists **Medication management** **Transportation**: Lack of transportation

Behavioral health will be described within two main components – barriers and SDOH that prevent individuals from obtaining care and specific services that are most challenging to access.

1. *Barriers to accessing care & associated SDOH*
   - Availability of needed services and appointments
   - Economic security and inability to pay co-pays and deductibles
   - Insurance issues
   - Logistical problems getting to the needed appointments (time off work, childcare, transportation)
2. *Types of care that are difficult to access*
   - Inpatient psychiatric beds and substance abuse facilities
   - Urgent care services for crisis situations
   - Transitional programs and services (post-acute care services)

Behavioral health was identified as a high priority health need by the CHNA both in the secondary data analyses and in the community engagement events.

> ## BEHAVIORAL HEALTH
>
> *Behavioral health problems include serious psychological distress, mental and substance use disorders, suicide, and alcohol and drug addiction.[1]*
>
> [1] Substance Abuse and Mental Health Services Administration, Leading Change: A Plan for SAMHSA's Roles and Actions 2011-2014. HHS Publication No. (SMA) 11-4629. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2011.

SECONDARY DATA ANALYSIS

Data were reviewed related to several aspects of behavioral health in San Diego County: (1) ED and inpatient discharge rates for some mental health conditions, including anxiety and mood disorders; (2) the percent of people who report having thought about committing suicide; (3) the rate of suicide; (4) the ED and inpatient discharge rates for acute and chronic substance use; and (5) the ED and inpatient discharge rates for opioid misuse.

MENTAL HEALTH ISSUES

Rates of discharge from emergency departments due to a*nxiety* increased by 4.3% between 2014–2016, while rates of inpatient discharges for anxiety decreased by 7.9% during the same time period. People who identify as "other race" and Black/African American had the highest rates of ED and inpatient discharge for anxiety.[2]

ED discharges for *mood disorders* also increased (5.9%) from 2014–2016, while inpatient discharges for mood disorders decreased by 2.9%. Discharge rates for mood disorders were higher for people who identify their race as Black/African American than for any other race. [2] Please see Figure 33 below for more details.

Figure 33. Hospital Discharge Rates for Anxiety and Mood Disorders In San Diego County, 2014–2016
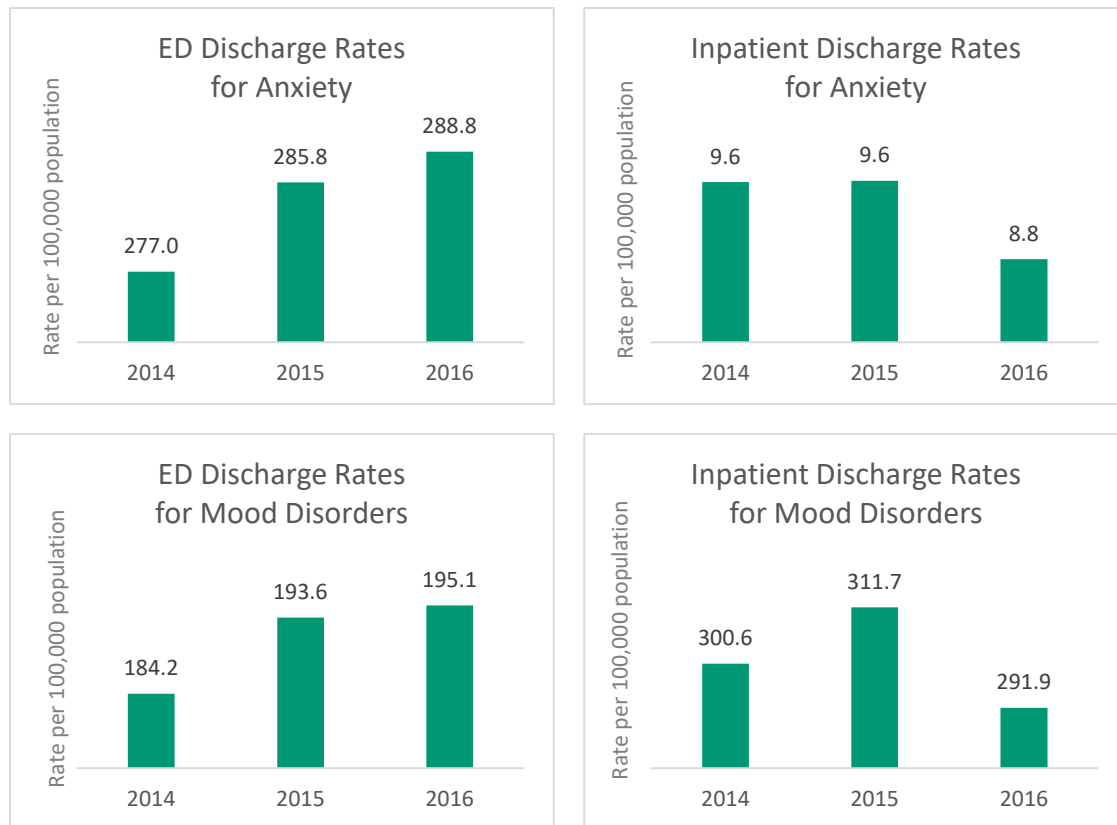
Source: California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2014-2016. SpeedTrack©

SUICIDAL IDEATION AND SUICIDE ATTEMPTS

11.8% of adults in San Diego seriously considered committing suicide in 2017.[3] In 2016, the age-adjusted suicide rate in San Diego was 11.9 per 100,000. Rates were highest among Whites (18.7), followed by Blacks (11.5), Asian Pacific Islanders (8.2) and Hispanics (5.3). While the rate of suicide decreased slightly (1.3%) from 2014–2016, the rates of suicide for people who identify as Asian/Pacific Islander, Black, and "other," increased in those same years by 13.3%, 47.2%, and 93.0% respectively[4]. Please see Figure 34 below for more details.

Figure 34. Suicide Rates in San Diego County by Race/Ethnicity, 2016

Source: Live Well San Diego. Live Well San Diego Data Access Portal.
Injury. https://data.livewellsd.org/

SUBSTANCE USE

While ED discharges for *acute substance use* rose by 51.0% from 2014–2016, inpatient discharges dropped by 18.5%. The highest discharge rates of both types were among Black/African Americans. Steep increases in both types of discharge occurred for chronic substance use; ED discharge rates increased by 559.3%, and inpatient discharge rates increased by 195.1%. ED discharge rates were highest among Whites (36.7, per 100,000), while inpatient discharges were highest among those who identify as "other" race. Across age groups, rates of ED discharge for chronic substance abuse increased the most for those over 65 years - by 714%.[2] In addition, nearly 20% of adults ages 18 and older self-report excessive alcohol use.[5] Please see Figure 35 below for more details.

Figure 35. Hospital Discharge Acute and Chronic Substance Use Rates, 2014—2016
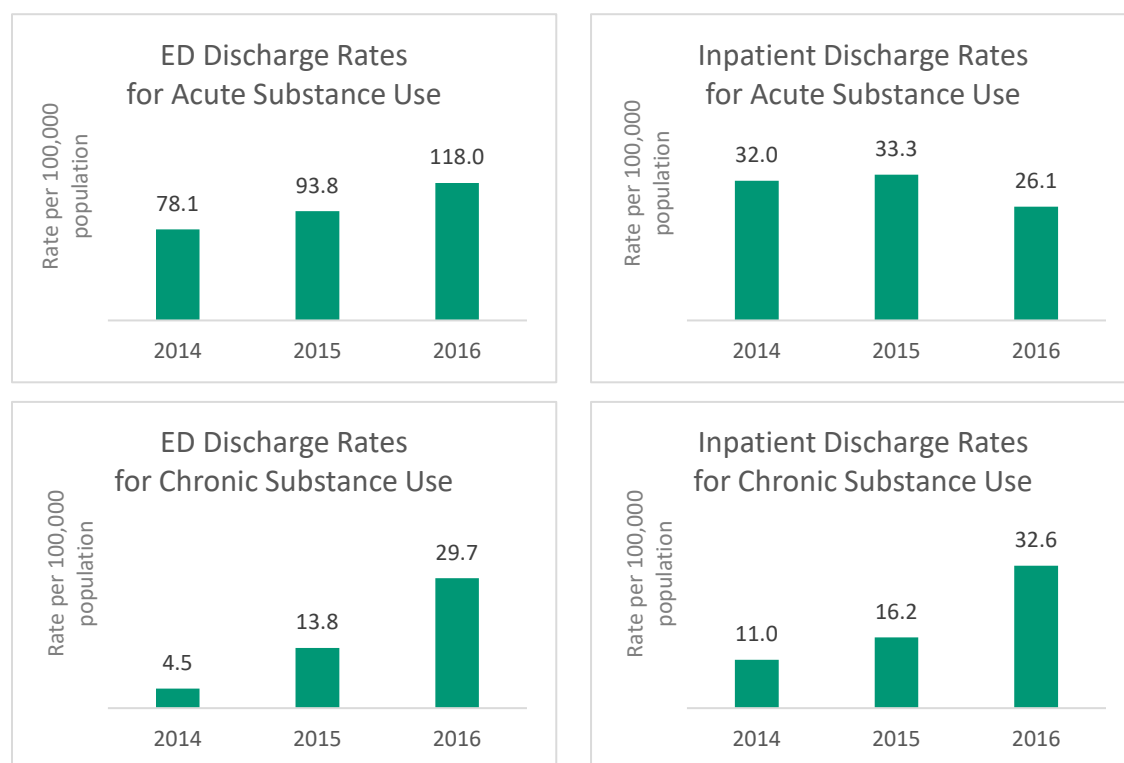
ED Discharge Rates for Acute Substance Use
Rate per 100,000 population
2014: 78.1
2015: 93.8
2016: 118.0

Inpatient Discharge Rates for Acute Substance Use
Rate per 100,000 population
2014: 32.0
2015: 33.3
2016: 26.1

ED Discharge Rates for Chronic Substance Use
Rate per 100,000 population
2014: 4.5
2015: 13.8
2016: 29.7

Inpatient Discharge Rates for Chronic Substance Use
Rate per 100,000 population
2014: 11.0
2015: 16.2
2016: 32.6

Source: California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2014-2016. SpeedTrack©

OPIOID MISUSE

ED discharges for opioid misuse increased by 267.2% from 2014–2016, while inpatient discharges increased by 239.3%. The steepest increases in both discharge rates were among people 65+, who experienced a 1,734.4% increase in ED discharges and an 863.1% increase in hospital discharges.[2] See Figure 36 below for more details.

Figure 36. Hospital Discharge Rates for Opioid Misuse, 2014—2016
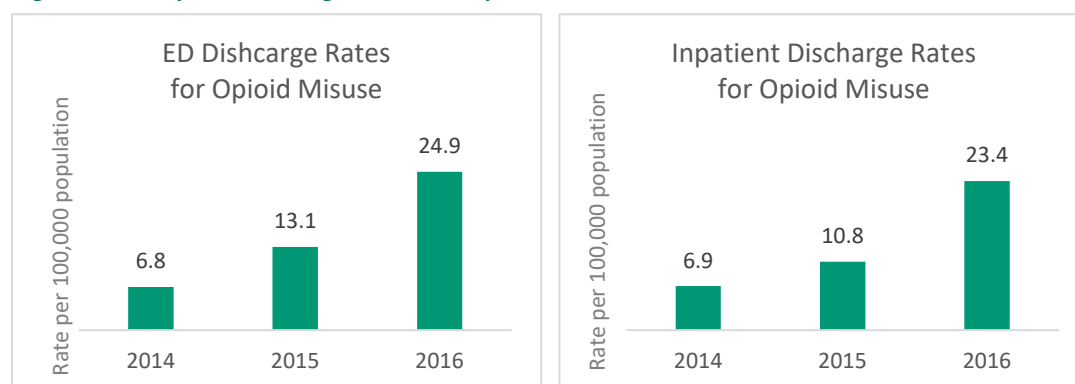
ED Dishcarge Rates for Opioid Misuse
Rate per 100,000 population
2014: 6.8
2015: 13.1
2016: 24.9

Inpatient Discharge Rates for Opioid Misuse
Rate per 100,000 population
2014: 6.9
2015: 10.8
2016: 23.4
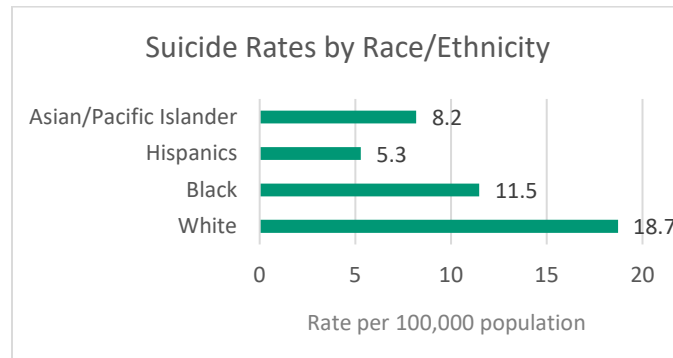
Source: California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2014-2016. SpeedTrack©

Please see Appendix C for [Behavioral Health](#) secondary source information.

COMMUNITY ENGAGEMENT ANALYSIS

Across all types of community engagement – focus groups, key informant interviews, and the online survey -- behavioral health issues were identified as both prevalent and debilitating in the community.

In the online survey, behavioral health was ranked as the health condition having the greatest impact on the health and well-being of San Diego County residents and as the second most impactful condition when health conditions and social determinants of health were combined (only access to care ranked higher). In addition, 63% of survey respondents indicated that they believe behavioral health is worsening in San Diego County. Respondents were also asked to rank specific behavioral health conditions having the greatest impact in San Diego. The top seven conditions identified were as follows:

1. Alcohol Use Disorder
2. Mood Disorders
3. Substance Use Disorder
4. Anxiety
5. Opioid Use
6. Suicide and Suicidal Thoughts/Ideation
7. Self-Harm or Self-Injury

See Appendix F for full results.

During focus groups and interviews, frequent topics of discussion related to behavioral health included:

❖ Barriers to care
❖ The types of care most challenging to access
❖ The people who are most impacted by behavioral health issues

For a summary of focus group findings, please see Table 31 below.

BARRIERS TO CARE

In the community engagement process, residents identified several obstacles to the receipt of effective behavioral health services. First, they said, the *availability* of therapists to address mental health issues and programs to address substance use treatment is extremely limited. Finding providers who accept a patient's *insurance* creates further obstacles, particularly if the patient is enrolled in a public insurance program like Medi-Cal. In addition, the participants noted, even when therapists or programs can be found, they are often not immediately available, creating challenges to the *timely receipt of services*. Therapists, it was further discussed, often only have time available during work and school hours and may be located far from where the people who need the services live, work, and go to school, creating *logistical* problems. Finally, for those who are economically insecure, *co-pays and deductibles* were cited as prohibitive to the receipt of behavioral health services.

TYPES OF CARE

Two types of care for both mental health and substance use disorders were noted to be insufficient in San Diego during the community engagement events. *Urgent care* with availability for after-hours services for people in crisis were cited as a critical need for the community. *Inpatient* psychiatric beds and substance abuse facilities were also identified as being in short supply. Finally, more *transitional* programs and services (post-acute care services) for those who are being discharged from the inpatient level of care emerged as a priority need.

VULNERABLE POPULATIONS

Focus group participants emphasized that while accessing behavioral health services is hard for everyone, for people who may be at the highest risk for trauma-related mental illness – like veterans, refugees, and the LGBTQ community -- and for those who are uninsured, access to this care can be particularly challenging.

Participants also discussed the link between mental health and substance misuse, arguing that the failure to provide access to preventive and acute mental health services often leads to self-medicating with drugs and alcohol, which can then exacerbate mental health issues.

Table 31. Summary of Focus Group and Key Informant Input Related to Behavioral Health

SUMMARY OF RESPONSES RELATED TO BEHAVIORAL HEALTH		
ASSOCIATED HEALTH CONDITIONS AND NEEDS		
All Age Groups • **Mood disorders** including anxiety, depression, and stress • **PTSD and trauma**: including generational trauma • **Substance use disorder** • **Suicide and self-harm**	**Children/Youth** • **Mood disorders**: anxiety • **Substance abuse**: alcohol, drugs • **Suicide and self-harm** • **Trauma**	**Senior** • **Alzheimer's** • **Dementia** • **Mood disorders**: anxiety, depression • **Schizophrenia**
ASSOCIATED SOCIAL DETERMINANTS OF HEALTH		
All Age Groups • **Economic security**: cost of mental health services • **Education**: Lack of community resident awareness of services (unaware of detox requirements) • **Lack of services:** mental health services, psychiatrists, mental health workforce including PERT • **Stigma** • **Violence**: fear, homelessness	**Children/Youth** • **Bullying** • **Lack of school-based services** • **Stigma**	**Senior** • Limited mental health **insurance coverage** • **Social isolation** and loneliness • **Stigma**
ASSOCIATED BARRIERS AND CHALLENGES		
All Age Groups • Long **wait times** for mental health services	**Children/Youth** • Lack of **follow-up care** post-referral • **Parental consent** to access services • Lack of **parental involvement** due to cultural differences	

Health needs related to **cancer** were described in relation to the effects on well-being beyond physical health. These include financial, practical, and emotional impacts on individuals and families; these effects are exacerbated by barriers to cancer care.

Cancer was identified as a priority health need in the secondary data analyses and in the community engagement process.

SECONDARY DATA ANALYSIS

For all cancer sites, the age-adjusted rate from 2011–2015 in San Diego was 402.5 per 100,000; the incidence rates by cancer site are represented in Figure 37 below.[2]

> ## CANCER
>
> *Cancer is a set of diseases in which abnormal cells grow and spread and crowd out normal cells, which can make it difficult for the body to function. Cancer can start anywhere in the body and can spread to other parts – cancers are named for where they originate in the body.[1]*
>
> [1] American Cancer Society. Cancer Facts & Figures 2019. Atlanta: American Cancer Society; 2019.

Figure 37. Incidence Rates for Cancer in San Diego County, 2011–2015
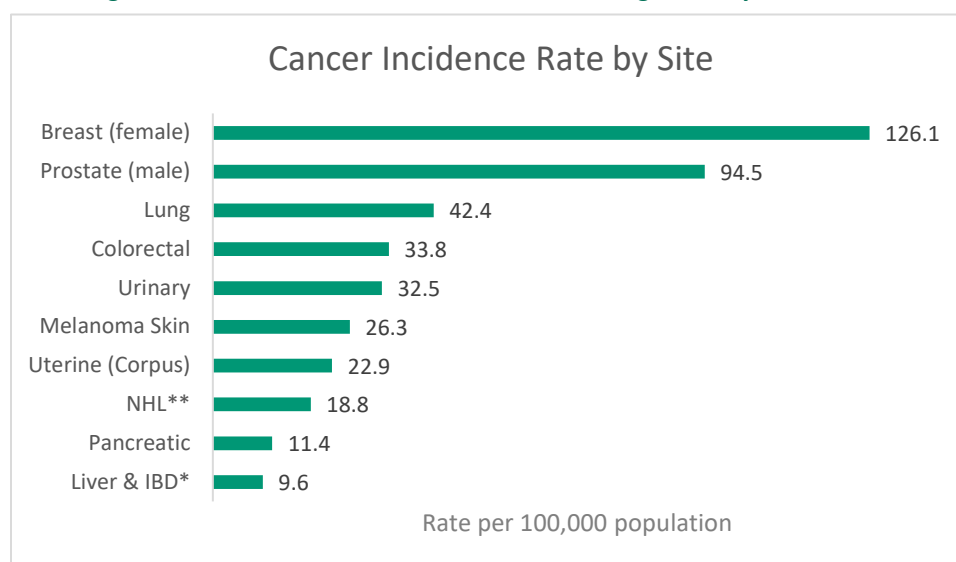
Cancer Incidence Rate by Site

Site	Rate per 100,000 population
Breast (female)	126.1
Prostate (male)	94.5
Lung	42.4
Colorectal	33.8
Urinary	32.5
Melanoma Skin	26.3
Uterine (Corpus)	22.9
NHL**	18.8
Pancreatic	11.4
Liver & IBD*	9.6

Source: California Cancer Registry. Age-Adjusted Invasive Cancer Incidence Rates in California, 2011- 2015, By County. https://www.cancer-rates.info/ca/.
*Non-Hodgkin's Lymphoma (NHL), **Intrahepatic Bile Ducts (IBD)

Cancer is the leading cause of death in San Diego County.[3] The age-adjusted mortality rate for all cancer sites from 2011–2015 was 150.2 per 100,000. Morality rates by cancer site are represented in Figure 38 below.[4] San Diegans who identify as Black/African American have the highest cancer mortality rates (177.3) compared to people of other races.

Figure 38. Mortality Rates for Cancer in San Diego County, 2011–2015
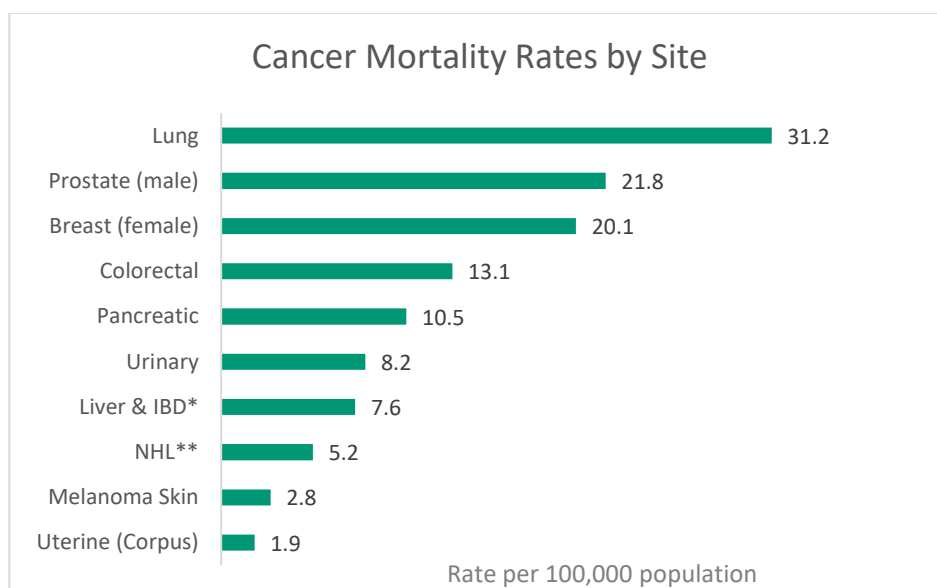
Cancer Mortality Rates by Site

Site	Rate
Lung	31.2
Prostate (male)	21.8
Breast (female)	20.1
Colorectal	13.1
Pancreatic	10.5
Urinary	8.2
Liver & IBD*	7.6
NHL**	5.2
Melanoma Skin	2.8
Uterine (Corpus)	1.9

Rate per 100,000 population

Source: California Cancer Registry. Age-Adjusted Cancer Mortality Rates in California, 2011-2015, By County. https://www.cancer-rates.info/ca/.
*Intrahepatic Bile Ducts (IBD), **Non-Hodgkin's Lymphoma (NHL)

Please see Appendix C for Cancer secondary source information.

COMMUNITY ENGAGEMENT FINDINGS

Findings from the community engagement process show that San Diegans believe cancer is one of the top health priorities in the County.

In the community engagement survey, cancer was ranked as the fourth most impactful health condition for the San Diego community. See Appendix F for a full summary of survey results.

In focus groups and key informant interviews, contributors described barriers to receiving cancer screenings, diagnosis, and treatment along with the severe, negative impact a cancer diagnosis can have on individuals and their loved ones. See Table 32 below for a summary of focus group findings.

BARRIERS TO CARE

Community engagement participants described cancer as a health condition that community residents find extremely scary. They discussed how *fear* about the impact of the cancer and about the stigma of cancer keeps people from accepting their diagnosis and pursuing cancer treatment. Brain, colon and breast cancer were specifically mentioned as diseases people find particularly intimidating. People who

have cancer are sometimes judged in the community, and people with cancer worry that others will avoid them once they know of their diagnosis.

Fears about *immigration status*, focus group members asserted, have also become a deterrent to receiving cancer screening, diagnosis, and treatment. Asylum seekers, in particular, are hesitant to access cancer care because they believe they will be deported if they do not have insurance.

Finances related to cancer care are also burdensome for community members. Even for those with insurance, co-pays and deductibles can be prohibitive. People who have cancer also worry about losing their jobs and about who will take care of their children while they are undergoing treatment.

Finally, *practical issues*, like transportation to medical appointments were also named as barriers to receiving cancer screenings and treatment.

IMPACT

Community residents stressed that a cancer diagnosis and the subsequent treatment are substantially impactful on individuals and their families. The cost of treatment, even with insurance, contributors emphasized, can devastate a family's finances – co-pays, co-insurance, transportation, the cost of extra childcare, and time off work create economic burdens. In addition to caring for a sick family member, that member's household and family responsibilities, participants explained, must be redistributed, causing further stress on the family. Finally, in some communities a cancer diagnosis creates stigma, so that the person with cancer becomes socially isolated.

Table 32. Summary of Focus Group and Key Informant Interview Input Related to Cancer

SUMMARY OF RESPONSES RELATED TO CANCER (all age groups)
ASSOCIATED HEALTH CONDITIONS AND NEEDS
Brain cancer   **Breast cancer**   **Cancer** (all types, especially in older populations)   **Chronic diseases**: stress leads to increased cortisol levels which over time is linked to increases in chronic diseases such as asthma, heart disease, and cancer
ASSOCIATED SOCIAL DETERMINANTS OF HEALTH
Economic security: cost of treatment   **Healthy behaviors:** poor diet, and lack of physical activity   **Physical environment:** chemical exposures from industrial sites, and from being in war zones prior to arriving in the United States.   **Substance use**: tobacco, alcohol misuse   **Stigma**: fear of community stigmatization due to cancer diagnosis
ASSOCIATED BARRIERS AND CHALLENGES
Delays to see specialists, like surgeons   **Fear** of a diagnosis therefore people delay addressing serious health issue until it progresses too far   **Fear** related to immigration status   **Frustration** with navigating insurance issues   **Logistical issues** such as transportation, childcare and home responsibilities   **Preventative care**: people believe they are healthy due to not having any physical symptoms, therefore do not receive preventative care   **Screenings**: avoidance of screenings, specifically breast cancer

Three chronic conditions were identified as of primary concern during the community health needs assessment: cardiovascular disease, diabetes, and obesity[20]. Key factors that individuals struggle with to prevent chronic diseases include access to fresh, health foods and safe places to exercise and play. In addition, barriers to care, SDOH, and disease management were identified as particularly difficult for those with chronic diseases:

- ❖ Economic security
- ❖ Immigration fears
- ❖ Lack of knowledge on health condition
- ❖ Transportation

Chronic conditions were identified as a priority health need in the secondary data analyses and in the community engagement process.

CHRONIC CONDITIONS

The CDC defines chronic health conditions as those that last at least one year and require ongoing medical care and/or limit activities of daily living.[1]

Cardiovascular disease (CVD) refers to a set of conditions related to the heart and blood vessels, including: heart disease, heart attack, stroke, heart failure, arrhythmia, and heart valve problems. The most common CVD is heart disease, and the most common heart disease is coronary artery disease (also referred to as coronary heart disease).[2]

Diabetes is a set of diseases that affect the way the body metabolizes sugar (glucose). The three primary types of diabetes are: Type 2 (the most common type), Type 1 (previously called insulin-dependent or juvenile diabetes), and gestational (occurring during pregnancy).[3]

Overweight or obese people weigh more than is considered healthy for a given height. Body Mass Index (BMI) is a screening tool for overweight and obesity that divides people's weight by the square of their height. Obesity is defined in adults as having a BMI of 30.0 or higher. For children, obesity is defined as having a BMI at or above the 95th percentile for children of the same age and sex.[4]

[1]Centers for Disease Control and Prevention. National Center for Chronic Disease Prevention and Health Promotion. About chronic diseases.

[2]What is cardiovascular disease? American Heart Association Web site.

[3]Centers for Disease Control and Prevention. Diabetes. CDC website.

[4]Centers for Disease Control and Prevention. Overweight & obesity. CDC website.

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[20] According to the CDC "Chronic diseases such as heart disease, cancer, and diabetes are the leading causes of death and disability in the United States." CDC website. https://www.cdc.gov/chronicdisease/about/index.htm

CARDIOVASCULAR DISEASE

Rates of ED discharge for *Coronary Heart Disease* increased by 35.3% from 2014-2016. The steepest increases were for those 45–64 years old (41.9%) and Asian/Pacific Islanders (55.1%). Inpatient discharge rates decreased slightly (by 0.1%).[5] See Figure 39 for more details.

Figure 39. Hospital Discharge Rates for Coronary Heart Disease in San Diego County, 2014–2016
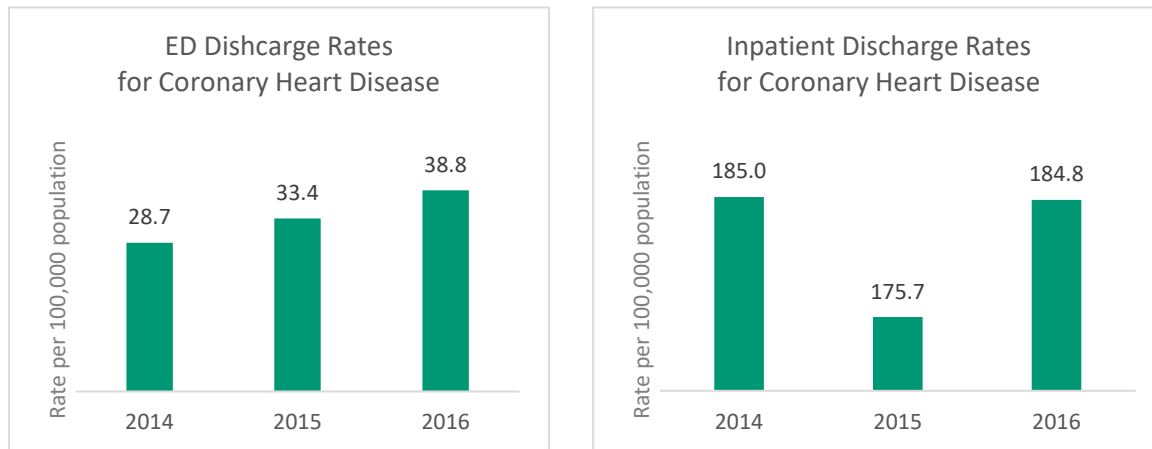
ED Dishcarge Rates
for Coronary Heart Disease

Rate per 100,000 population

28.7	33.4	38.8
2014	2015	2016

Inpatient Discharge Rates
for Coronary Heart Disease

Rate per 100,000 population

185.0	175.7	184.8
2014	2015	2016

Source: California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2014-2016. SpeedTrack©

Heart disease was the second leading cause of death in San Diego County in 2016[6]. The overall death rate from coronary heart disease decreased by 3.5% from 2014–2016 but increased among Black (8.7%) and American Indian/Alaska Native (29.4%) individuals.[7] See Figure 40 below for more details.

Figure 40. Mortality Rates for Coronary Heart Disease in San Diego County, 2014–2016

Mortality Rates
for Coronary Heart Disease

Rate per 100,000 population

84.69	83.89	81.72
2014	2015	2016

Source: County of San Diego Health and Human Services Agency Public Health Services, Regional & Community Data.

For the purposes of this report cancer was pulled out separately from chronic diseases.

Rates of ED discharge for *stroke* increased by 11.0% from 2014–2016. The steepest increases were for those 27–44 (20%) and for people who identify their race as "Other" (28.9%). Rates of Inpatient discharge for stroke decreased by 4.1%.[5] Stroke was the fourth leading cause of death in San Diego County in 2016.[6] Death rates for stroke increased by 17.6% from 2014–2016.[7] The increase was steepest for Hispanics (28.5%).[7] See Figures 41 and 42 below for more details.

Figure 41. Hospital Discharge Rates for Stroke in San Diego County, 2014–2016

Source: California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2014-2016. SpeedTrack©

Figure 42. Mortality Rates for Stroke in San Diego County, 2014–2016
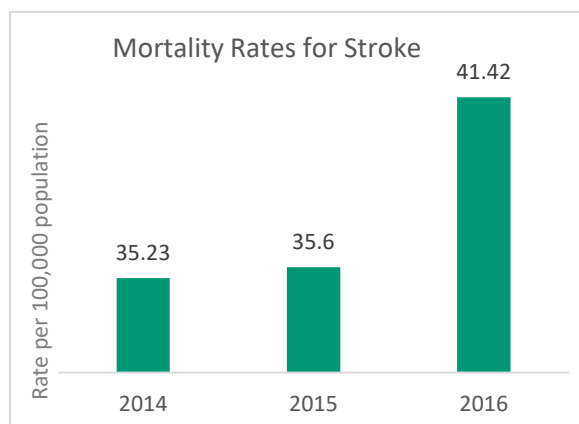
Source: County of San Diego Health and Human Services Agency Public Health Services, Regional & Community Data.

In San Diego County, in 2017, 9.4% of adults had diabetes.[8] ED discharges for diabetes increased 7.2% from 2014–2016; increases in discharge rates were highest (13.9%) for those 27–44 years old and for Asian/Pacific Islander (16.3%) and Black individuals (15.1%).[5] Inpatient discharge rates for diabetes decreased slightly (0.7%) from 2014-2016 but increased for Asian/Pacific Islanders (28.6%) and for people 11-17 years old (15.7%) and for people 18-26 years old (28.8%).[5] See Figure 43 below for more details.

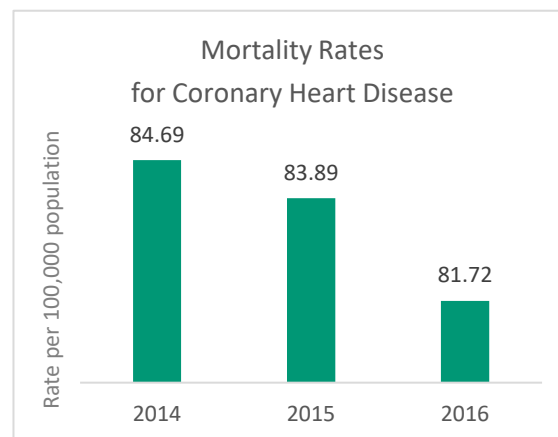**Figure 43. Hospital Discharge Rates for Diabetes in San Diego County 2014–2016**
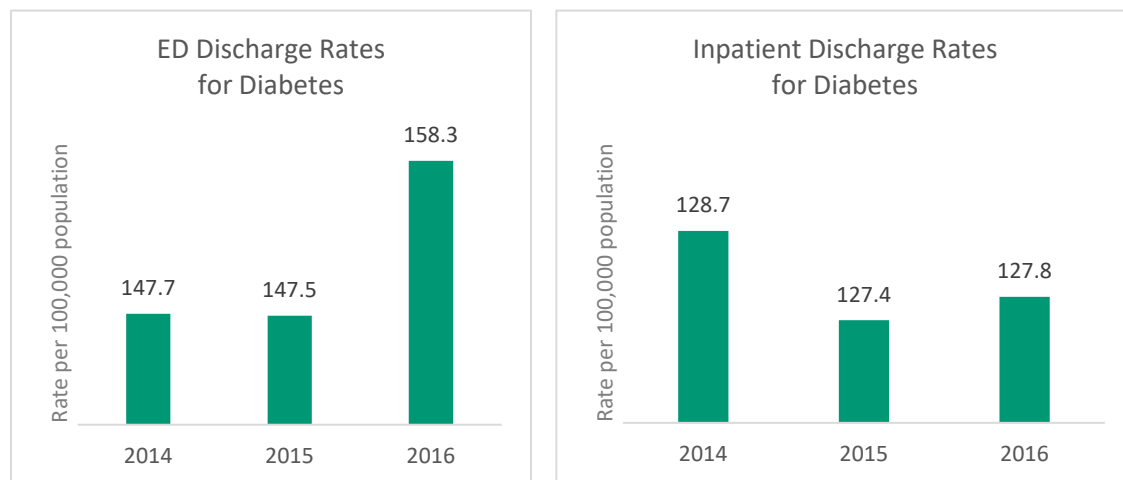
Source: California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2014-2016. SpeedTrack©

Diabetes was the seventh leading cause of death in San Diego County in 2016.[6] The age-adjusted death rate for diabetes increased 16.3% from 2014-2016. Increases were steepest for Hispanics (53.0%) and those who identify as "Other" (35.0%).[7] See Figure 44 below for more details on diabetes mortality in San Diego County
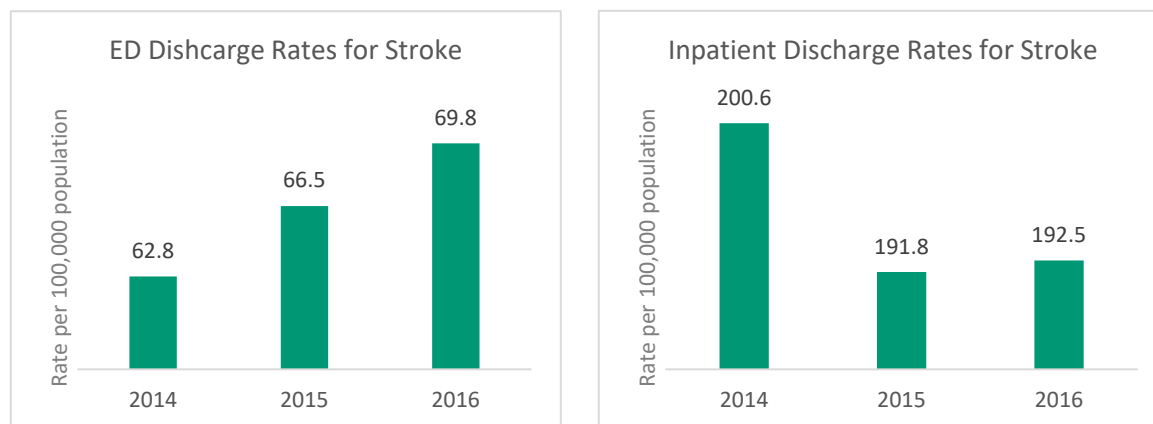
Figure 44. Mortality Rates for Diabetes in San Diego County 2014–2016
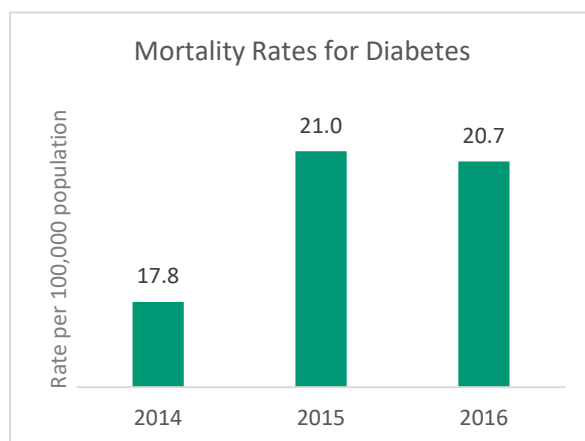
Source: County of San Diego Health and Human Services Agency Public Health Services, Regional & Community Data.

OBESITY

In 2017, 22.5% of adults in San Diego were obese, a 9% decrease from 2014.[9] Please see Figure 45 below for more details.

Figure 45. Percent of the Adult Population who are Obese in San Diego County, 2014–2017

Percent of the Adult Population who are Obese

24.8 — 2014
23.5 — 2015
25.3 — 2016
22.5 — 2017

(Rate per 100,000 population)
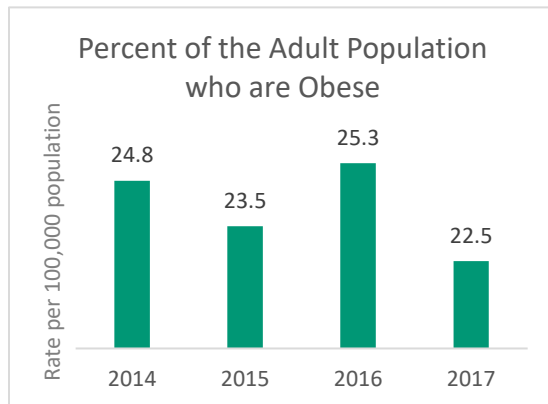
Source: California Health Interview Survey, 2014 to 2017

Please see Appendix C for Chronic Condition secondary source information.

## COMMUNITY ENGAGEMENT ANALYSIS

Cardiovascular disease, diabetes, and cancer were the chronic conditions most frequently discussed by community residents as priority health needs in San Diego County.

In the online survey, these three conditions were ranked as three of the five most impactful health conditions on the overall well-being of San Diegans. In addition, of those who chose obesity as the greatest influence on poor health outcomes, 51% of participants identified obesity as growing worse within San Diego County.

Conversations in focus groups about chronic conditions centered on barriers to care, particularly related to prevention and to disease management, and on particular challenges faced by vulnerable populations. See Table 33, below, for a summary of focus group findings.

BARRIERS TO CARE

Prevention

In order to prevent CVD, diabetes, and obesity, focus group participants asserted, people must have economic and geographic access to fresh, healthy foods and to safe places to exercise and play. Contributors felt that some San Diego neighborhoods have an overabundance of fast food restaurants and convenience stores and far fewer grocery stores featuring affordable fresh produce, which makes healthy eating economically and logistically challenging. In addition, some neighborhoods lack safe,

open places to play and exercise. In some families, they said, the adults work long hours in order to earn just enough to cover necessities, leaving little time for healthy cooking and exercise.

Disease management

Focus group participants noted that *financial issues* create barriers to the effective management of chronic conditions like CVD and diabetes. These issues include paying for medical care and medication for those who do not have insurance and co-pays for appointments and prescriptions for those who are insured. The cost of transportation to appointments and the loss of income from time off work also create obstacles to care.

Immigration fears, focus group participants said*,* keep some residents from getting the health care they need to manage their chronic conditions. For undocumented residents, the fear is that they will be placed on an "alert list" for immigration officials when receiving health care. Likewise, for residents who are attempting to become citizens, they fear that the receipt of services will interfere with their ability to become citizens.

Lack of knowledge, community engagement participants asserted, also prevents people from managing their chronic conditions. Individuals may not have the information they need to manage their disease and may be unsure about how to secure resources to assist them with chronic disease management.

VULNERABLE POPULATIONS

Focus group contributors emphasized that managing chronic conditions is particularly troublesome for two groups: (1) homeless and insecurely housed individuals; and (2) seniors. For those who are experiencing homelessness and insecurely housed individuals, making and getting to medical appointments and the storage of insulin were frequently mentioned as barriers to diabetes management. For seniors, transportation to care and the management of medication were discussed as especially challenging.

Table 33. Summary of Focus Group and Key Informant Interview Input Related to Chronic Conditions

SUMMARY OF RESPONSES RELATED TO CHRONIC CONDITIONS
ASSOCIATED HEALTH CONDITIONS AND NEEDS

All Age Groups
- **Cardiovascular disease** (heart attack, stroke)
- **Cholesterol**
- **Chronic obstructive pulmonary disease** (COPD)
- **Diabetes** (Type I, II, and pre-diabetic)
- **Hypertension** (high blood pressure)
- **Obesity/overweight**

ASSOCIATED SOCIAL DETERMINANTS OF HEALTH

All Age Groups
- **Economic insecurity:** cost of living (rent, utilities), cost of healthy food
- **Healthcare cost:** high cost of insurance, medical bills, or medications
- **Housing:** Unstable or complete lack of housing
- **Lack of access to healthy food** (living in a 'food desert', lack of grocery stores with healthy or fresh food)
- **Lack of health education and/or knowledge:** prevention, disease management, nutrition/diet modification
- **Lack of transportation:** difficulty in traveling to purchase groceries for rural areas and seniors
- **Limited physical mobility:** difficult to purchase groceries due to physical limitations or being homebound (seniors)
- **Medication management:** timing, frequency, and how to take medications

- Poor health behaviors: unhealthy diets, lack of exercise or physical activity
- Unsafe or poorly kept neighborhoods or public spaces for physical activity

Children/Youth
- Lack of safe places to exercise or play
- Refusing to eat healthy foods

Individuals Experiencing Homelessness
- Lack of kitchen to cook healthy meals
- Lack of refrigeration to store temperature-specific medications such as insulin
- Lack of safe storage of medications: can get lost or stolen

Community support refers to the resources available within an individual's neighborhood to promote the well-being of residents. *Social support* is defined as the types of help that people receive from other individuals including emotional, practical, and informational assistance.[1]

Community and social support were identified as a priority health need in the community engagement process.

SECONDARY DATA ANALYSIS

Data are available related to three indicators associated with *community and social support* in San Diego County: the rate of FQHCs; the percent with limited English proficiency; and the percent who are linguistically isolated.

FEDERALLY QUALIFIED HEALTH CENTERS (FQHCS)

FQHCs are community assets that provide health care to vulnerable populations. In particularly they promote access to ambulatory care in areas designated as medically underserved. There are 3.17 FQHCs per 100,000 persons in San Diego County according to the U.S. Department of Health and Human Services Center for Medicare and Medicaid Services.[2] Although this is higher than the rate for California (2.5) and the U.S. (2.5), individual health centers may not have large enough capacity to deliver the services required for the populations they serve.

In recent years, the role of FQHCs has evolved beyond providing access to health care services. FQHCs are medical homes and health homes that not only provide case management for health care needs, they also coordinate their patients' access to social services. FQHCs often screen and assess for a wide-range of social determinants of health and connect patients to internal resources or community-based services.

LIMITED ENGLISH PROFICIENCY AND LINGUISTICALLY ISOLATED

Given San Diego County's large immigrant and refugee population, limited English proficiency and linguistically isolated indicators are especially important to understanding who might lack social support due to cultural and linguistic barriers. According to the ACS, approximately 14.5% of San Diego residents aged 5 and older speak a language other than English at home and speak English less than "very well."[3] In addition, 6.8% of the population aged 5 and older live in a home in which no person 14 years old and over speaks only English, or speaks a non-English language but does not speak English "very well."[3] Similar to those with limited English proficiency, linguistically isolated populations may struggle with accessing health services, communicating with health care providers, and understanding health information. Please see Table 34 below for more information on how San Diego compares to the state and nation.

Table 34. Federally Qualified Health Centers Rate, Primary Care Provider Rate, Percent of Population Living with Limited English Proficiency, and Linguistically Isolated in San Diego County, California, and the United States, 2013–2017

	San Diego County	California	United States
Rate of Federally Qualified Health Centers (per 100,000)[a]	3.17	2.51	2.45
Primary Care Provider Rate (per 100,000)[b]	78.3	78.1	75.9
Percent Limited English Proficiency	14.6%	18.4%	8.5%
Percent Linguistically Isolated[c]	6.8%	9.2%	4.5%

[a]Source: U.S. Department of Health & Human Services, Center for Medicare & Medicaid Services. Provider of Services File, December 2016.
[b]Source: U.S. Department of Health & Human Services, Health Resources and Services Administration. Area Health Resource File, 2014.
[c]Source: U.S. Census Bureau, American Community Survey, 2013–2017 5-Year Estimates.

Please see Appendix C for Community and Social Support secondary source information.

COMMUNITY ENGAGEMENT ANALYSIS

Community residents identified community and social support as extremely important to the good health of San Diego County residents.

In the community engagement survey, community and social support was ranked as one of the five most influential social determinants of health in San Diego County.

During focus group and interviews, participants emphasized three topics related to community and social support:

- Well-being is enhanced when people have adequate community and social support;
- When communities are disproportionately affected by economic stress and/or a poor physical environment, community engagement and the community spirit are affected;
- For certain populations of people, the receipt of services within their community is an important strategy to overcome barriers to care.

WELL-BEING AND SUPPORT

Focus group contributors frequently identified the support of family, friends, and community as necessary to good health. People who are lonely or isolated, they said, are impacted physically and emotionally, whereas people who are connected to others feel better and are more motivated to stay healthy. In addition, contributors emphasized, people may be more likely to seek and receive both health and social services if they are able to do so within their own communities. The receipt of community-based services reduces logistical barriers to care, such as obtaining transportation. In addition, focus group participants explained, individuals are less hesitant to accept care from organizations that feel like part of their community.

THE IMPACT OF COMMUNITY STRESS

The ability of people within a community to be civically engaged and supportive of other residents, focus group participants further explained, is impacted by economic stress and environmental conditions. When residents are focused on economic survival – paying the rent and securing food for their families – they are less likely to be involved in their communities. In addition, when communities suffer from air pollution, poor housing conditions, and lack of pleasant recreational areas like parks, residents are less likely to be active in their communities and to offer or take advantage of support. The essential "spirit" of the communities that lack healthy conditions is affected, and this affects residents' ability to support one another.

VULNERABLE POPULATIONS

Certain populations, focus group members stressed, are deeply in need of services within their communities. This is particularly true, they emphasized, for immigrants who are fearful about their legal status – immigrants are far more likely to trust information they receive from people within their communities and to feel confident that they will not be reported to authorities when they receive services. Community-based support and services are also important, focus group participants said, for people from other cultures. Trust is built, they explained, when services are offered by people within the community who are either from similar cultural backgrounds or who make the effort to immerse themselves in a community. Seniors would also benefit from having services that are offered closer to home and within a familiar neighborhood, due to mobility and transportation issues. Finally, those who are homeless are more likely to receive and be compliant with health care services, focus group members said, if clinics are available in the communities in which they reside.

For the purposes of this report, chief areas of **economic security** include poverty, wages and food insecurity.

Economic security was identified as a priority health need in the secondary data analyses and in the community engagement process.

SECONDARY DATA ANALYSIS

Data are available related to three indicators of economic security in San Diego County: the percent of the population living in poverty; the unemployment rate; and the percent of the population who are food insecure.

Poverty

For 2019, the federal poverty guidelines range from $12, 490 for a 1-person household, to $25,750 for a 4- person household, to $43,430 for an 8-person household.[4] In San Diego County, 13.3% of residents live below the federal poverty guidelines, and 17.1% of children live in poverty.[5] Poverty rates vary by race (Figure 46):

Figure 46. Percent of the Population below 100% Poverty Level in San Diego County, 2013–2017

Percent of Population Below Poverty Level

Race	Percent
Other Race	21.5%
NA/AN***	20.4%
Black	19.9%
Hispanic	18.7%
Multiple race	13.8%
NH/PI**	12.9%
Asian	10.3%
NH White*	9.5%
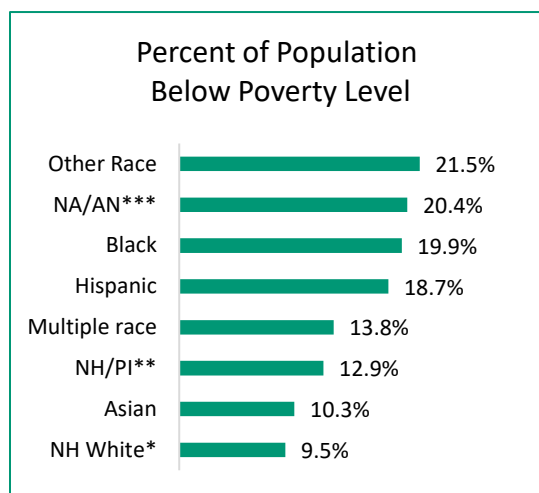
Source: U.S. Census Bureau, American Community Survey, 2013-2017 5-Year Estimates. *Non-Hispanic White, **Native Hawaiian and Other Pacific Islander, ***American Indian and Alaska Native

ECONOMIC SECURITY

Economic security refers to the ability to meet essential financial needs sustainably, including those for food, shelter, clothing, hygiene, health care, and education.[1] Economic insecurity is associated with[2]:

- Poor mental health days
- Visits to the ED for heart attacks
- Asthma
- Obesity
- Diabetes
- Stroke
- Cancer
- Smoking
- Pedestrian Injury

Economic insecurity may also lead to food insecurity, which is linked to[3]:

- Fair or poor health, anemia, and asthma in children
- Mental health problems, diabetes, hypertension, hyperlipidemia, and oral health problems in adults
- Fair or poor health, depression, and limitations in activities of daily living in seniors

[1] What is economic security? The International Committee of the Red Cross. 18 June 2015.
[2] Kaiser Permanente of Southern California Community Health Department, Secondary Data Analysis. Data Source 2018
[3] Gundersen C, Ziliak JP (2015). Food insecurity and health outcomes. *Health Affairs.* 2015. *34*(11): 1830-1839

UNEMPLOYMENT

In 2018, the average unemployment rate in San Diego County was 3.3% in San Diego County[6]. This rate has decreased by 48% since 2014. See Figure 47, below, for more details on unemployment.

Figure 47. Unemploment Rate in San Diego County, California, and the United States, 2014-2018

	2014	2015	2016	2017	2018
San Diego County, California	6.4%	5.2%	4.7%	4.0%	3.3%
California	7.5%	6.2%	5.5%	4.8%	4.2%
United States	6.2%	5.3%	4.9%	4.4%	3.9%
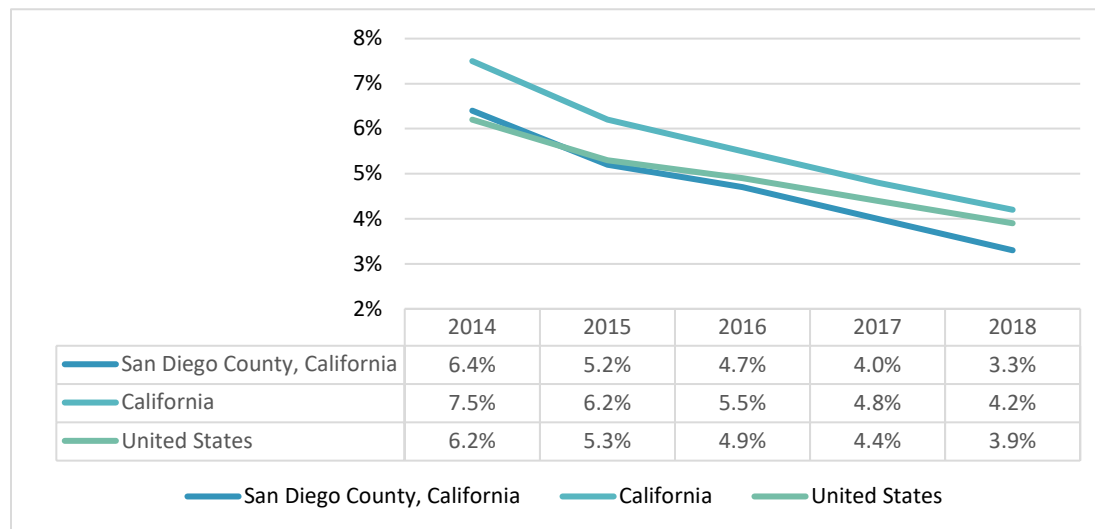
Source: Local Area Unemployment Statistics, 2018 annual averages. United States Department of Labor.
Bureau of Labor Statistics

FOOD INSECURITY

Food insecurity is defined as not always having enough food for everyone in the household to lead an active, healthy life[7] in San Diego[8]:

In San Diego County:

- ❖ 14% of people experience food insecurity, 1 in 7 people
- ❖ 22% of children are in food insecure households, more than 1 in 5 children
- ❖ 9% of seniors experience food insecurity, 1 in 11 seniors

Please see Appendix C for Economic Security secondary source information.

COMMUNITY ENGAGEMENT FINDINGS

Economic insecurity was identified as a priority health need in each of the community engagement events and was described as impacting "every aspect" of residents' daily lives.

Survey results indicate that San Diegans believe that economic insecurity is profoundly impactful on the overall health and well-being of the community. Economic insecurity was ranked as the third most influential condition on well-being, after access to care and behavioral health. In addition, 55% of survey respondents reported that they believe that the economic situation in San Diego has gotten worse over time (See Appendix F).

During focus groups and key informant interviews, participants focused on two issues related to economic insecurity: (1) factors that contribute to economic insecurity; and (2) the impact of economic insecurity on well-being. See Table 35 below for a summary of focus group findings.

CONTRIBUTING FACTORS

Community engagement participants identified housing and childcare costs as the two primary contributors to economic insecurity in the region. Low wages were also cited as an underlying cause but were discussed with less frequency.

Housing costs were repeatedly named as a cause of economic stress. Community engagement participants asserted that rent is disproportionate to income in San Diego, and that for many people, a very high percentage of their wages must be used to cover this cost, leaving them with too little money to cover other basic expenses. Although community residents are aware of affordable housing programs, they indicated that these programs have long waiting lists and are inaccessible to most people. Engagement participants described a number of ways that San Diegans try to cope with high housing costs, including living in small spaces with multiple families or roommates, or in substandard housing without adequate facilities.

Childcare costs were also named as financial concern for San Diego families. Participants asserted that for those residents who participate in a welfare-to-work program, subsidized childcare is available, but for others it is either unavailable or inaccessible due to waiting lists.

IMPACTS OF ECONOMIC INSECURITY

Community residents focused on three main concerns about economic hardship. First, they talked about the association between economic insecurity and food insecurity. Second, they described how health maintenance necessarily becomes a low priority when incomes are not secure. Third, they explained that people who are financially unstable experience chronic stress and anxiety, which undermines their health and daily functioning.

Community residents told many stories about friends, relatives, colleagues, and neighbors who struggle with *food insecurity* on a regular basis. Further, the community asserted, people who are food insecure must find cheap meals – which results in frequent dining at fast food restaurants and the purchase of lower cost, processed foods rather than fresh foods. The community is aware of available benefits, such as the Supplemental Nutrition Assistance Program (SNAP) and local food pantries, but these programs, they emphasized are, at times, inconvenient and challenging to obtain, and are often inadequate to cover a family's nutritional needs.

When making difficult financial decisions about which essential needs to cover, the community voiced that investing in *health maintenance becomes a low priority.* Purchasing health insurance, they explained, is expensive, and when people are worried about having enough to eat, spending money on something that they may not need does not make sense to them. Because of co-pays, co-insurance and lost wages due to time off work, visits to the doctor for preventive care or for an acute illness can be financially prohibitive, even for those who have health insurance. In addition, when people are working

long hours and excessively worried about finances, participants explained, taking the time for activities that promote good health, like home cooking and exercise, simply is not feasible.

Finally, the community was clear that the *chronic stress and anxiety* of being financially insecure takes a toll on health. Emotional well-being and mental health are threatened, they explained, by constant worry and anxiety. Physical health, too, is compromised by being unable to care for oneself adequately.

VULNERABLE POPULATIONS

Community engagement participants stressed that for certain people, economic insecurity is especially impactful. This includes:

- ❖ Children
- ❖ Homeless individuals
- ❖ People living in rural areas, due to lack of access to social support
- ❖ Seniors

Table 35. Summary of Focus Group and Key Informant Interview Input Related to Economic Security

SUMMARY OF RESPONSES RELATED TO ECONOMIC SECURITY		
ASSOCIATED HEALTH CONDITIONS AND NEEDS		
All Age Groups • Malnutrition • Overweight and obesity • Stress • Behavioral health: anxiety, depression, suicide • Hypertension	**Children/Youth** • Growth and development • Ability to focus and learn • Trauma	**Seniors** • Behavioral/mental health issues and connection with not eating healthy foods
ASSOCIATED SOCIAL DETERMINANTS OF HEALTH		

All Age Groups
• **Access to care**: afraid of losing benefits to Medi-Cal
• **Economic security:** cost of medical bills and services. Child care cost is high.
• **Employment**: unemployment, low wages
• **Food insecurity:** organic, healthy, and fresh foods are expensive
• **Homeless**: criminalization of the homeless, no kitchen for cooking food, difficulty accessing the types of food needed due to special diet needs
	• **Housing**: cost of housing
	• **Language barrier**
	• **Physical environment**: lack of groceries stores with fresh and healthy food Transportation: lack of transportation especially for rural areas
	
	Children/Youth
	• **Safety**: walking to school alone
	• **Stigma** of being economically disadvantaged
		Seniors
		• **Economic security**
		  • Gas prices are high and increasing
		  • Lack of affordable home food delivery options
		  • Wheelchairs need repair
		  • Social Security Income (SSI): wait time is long, ineligible when staying in the hospital
		  • Lack of fresh items in food pantries
		• **Food insecurity:** hunger and nutrition
		• **Lower education, less economic empowerment** and less family ties were described in specific locations such as City Heights

ASSOCIATED BARRIERS AND CHALLENGES		
All Age Groups • **Benefits**: afraid of losing benefits to Medi-Cal, CalFresh, and WIC, wait time is too long • **Budget**: ability to budget is difficult • **Childcare**: lack of childcare programs • **Hygiene** (homeless) • **Lack of time** for adults between work and family to get additional training or education to help increase income level • **Legal status** • **Sleep deprivation** • **Special diet needs**: culturally appropriate foods, allergies, and dietary restrictions due to chronic conditions make it difficult to eat healthy	**Children/Youth** • Refuse to eat **healthy food** • Lack of healthy food **education** for youth • Families have **limited time** and money to cook healthy meals. Eating fast food becomes an easier way to manage time and money. • **School lunches** have a lot of unappetizing processed foods	**Seniors** • **Cooking** can be a challenge

EDUCATION

Community engagement participants define educational attainment in a number of ways, including the receipt of a high school diploma, the opportunity to pursue vocational or higher education, being health literate, and having opportunities for non-academic continuing education.

Education was identified as a priority health need in the community engagement process.

SECONDARY DATA ANALYSIS

Educational attainment limited English proficiency, linguistically isolated population, and poverty have profound implications for population health.

EDUCATIONAL ATTAINMENT

Within San Diego County, almost 13.3% of the total population aged 25 and older (292,200) have no high school diploma (or equivalency) based on 2013–2017 ACS data.[1] An assessment of educational attainment by region of San Diego showed that the percentage of adults who had less than a high school diploma was highest in South (21.9%) and Central (19.9%) and lowest in North Inland (13.0%). As of 2013–2017, the San Diego County high school graduation rate (86.7%) was below HP2020 benchmark goal of 87.0%.[2] Graduation rates varied by racial and ethnic groups; non-Hispanic some Other Race (64.0%) and Hispanic/Latinos (67.6%) had the lowest proportion of graduates compared to non-Hispanic Whites (95.8%) which had the highest. Of children aged 3 to 4, the 2013-2017 ACS found that 51.0% were enrolled in school. Please see Table 36 for more information.

LIMITED ENGLISH PROFICIENCY AND LINGUISTICALLY ISOLATED POPULATIONS

Given San Diego County's large immigrant and refugee population, the indicators limited English proficiency and linguistically isolated are especially important to understanding health in the community. According to the ACS, approximately 14.5% of San Diego residents aged 5 and older speak a language other than English at home and speak English less than "very well." In addition, 6.8% of the population aged 5 and older live in a home in which no person 14 years old and over speaks only English or speaks a non-English language but does not speak English "very well." Similar to those with limited English proficiency, linguistically isolated populations may struggle with accessing health services, communicating with health care providers, and understanding health information. Please see Table 36 for more information.

POVERTY

Please see Economic Security Section for details on poverty in San Diego County.

Table 36. Poverty, Education, Limited English Proficiency, Linguistically Isolated and Unemployed in San Diego, California and United States, 2013-2017

	San Diego County	California	United States
Percent Population in Poverty[a]	13.3%	15.1%	14.6%
Percent Population with Less than a High School Diploma[a]	13.3%	17.5%	12.7%
Percent Limited English Proficiency[a]	14.6%	18.4%	8.5%
Percent Linguistically Isolated[a]	6.8%	9.2%	4.5%

[a]Source: U.S. Census Bureau, American Community Survey, 2013-2017 5-Year Estimates.

Please see Appendix C for Education secondary source information.

COMMUNITY ENGAGEMENT FINDINGS

Community engagement participants discussed four topics related to education and its impact on health and well-being:

- ❖ The underlying reasons that some youth in San Diego do not attain educational success
- ❖ The impact low levels of educational achievement have on the health and well-being of San Diegans
- ❖ The barriers to care created by a lack of health literacy
- ❖ The need for continuing education beyond traditional academics

BARRIERS TO EDUCATIONAL ATTAINMENT

Community engagement contributors cited two primary causes of low educational attainment: family stress and a lack of resources.

Participants explained, first, that family support for youth education is sometimes unavailable. Parents may not know high school graduation requirements, for example, and language and cultural differences, they said, create communication challenges with school personnel. Some parents, they said, may be unable to read their child's report card. Another issue focus group members pointed out, is that some economically strained families may wish for their children to begin working as soon as possible – preferring for them to find a job after high school rather than attend college. Participants also mentioned that low-income families may have to be more transient, needing to move when rent increases. These moves, then, they said can cause instability in children's educational placements, which negatively affects their potential to succeed in school.

Insufficient resources at home and in schools also hinder educational success. These include:

- ❖ Spotty Wi-Fi in neighborhoods
- ❖ Lack of computers in the home
- ❖ Crowded, noisy housing
- ❖ Lack of transportation to school
- ❖ Too few school counselors
- ❖ Large class sizes
- ❖ Lack of school-based family support systems

For students who are homeless, focus group participants stressed that thriving in school is even more challenging. This is in part, they said because education becomes a lower priority than simply surviving day to day. Focus group contributors believe, however, that their success is also impeded by socioemotional issues. The stigma attached to being poor and, in particular, to poor hygiene and dirty clothing can make these students feel ashamed, they explained. They may experience bullying, have low social status, and have difficulty forming lasting friendships, which in turn can impact the students' mental health and undermine their motivation to attend and succeed in school.

IMPACT

Focus group members relayed that both individual and community health are profoundly impacted when their residents are not able to achieve high levels of educational attainment. First, participants explained, employment opportunities for those without college degrees and especially without high school diplomas are in short supply, and wages for the available jobs tend to be low. Educational attainment, they pointed out, is directly related, then, to economic security. And families who are not secure, participants emphasized, live under the constant stress of worry about paying rent and having enough food to eat, which then negatively impacts their health. Furthermore, contributors stated, without education, career mobility is "horizontal," and there is little potential for promotions and higher wages. Focus groups described scenarios for these San Diegans in which work seems endless and when the possibility of a better life seems impossible, and they lose hope for a better life.

HEALTH LITERACY AS A BARRIER TO CARE

Focus group participants pointed out that a lack of health literacy is a significant barrier to care for some San Diegans. Community residents were said to need preventive health care information including information about health screenings and immunizations, conducted in a manner sensitive to the individual's culture. It was also emphasized they needed more information about lifestyle choices that promote health, for example, smoking cessation, nutrition and exercise. Many individuals, focus group contributors said, need assistance understanding and navigating the health care and insurance systems. For people who have received a serious health diagnosis, like cancer, having a health advocate who could explain the diagnosis and potential treatment options was strongly suggested to be beneficial by enhancing patient compliance with care.

CONTINUING EDUCATION

Participants also noted community residents are seeking educational opportunities beyond traditional academics. They want and need health education and parenting classes. For their children, they indicated a need for programs about sexual health, self-esteem, and transitional life skills. They are also

seeking enrichment classes – for themselves and their children – in the arts and in athletics. Focus group participants emphasized that education needs to be viewed from a broader perspective than traditional academics.

HOMELESSNESS AND HOUSING INSTABILITY

Homelessness and housing instability include the impact of homelessness and housing on community health:

- ❖ ***Homelessness*** seriously impacts health in both direct and indirect ways, such as exposure to infectious disease, difficulty managing chronic diseases, and maintaining wound care.
- ❖ ***Poor housing conditions*** have a direct, negative impact on physical and mental health.
- ❖ The ***cost of housing*** affects health because it is the primary driver of economic insecurity in San Diego
- ❖ Several subsets of the San Diego population are particularly ***vulnerable*** to homelessness and housing problems

Homelessness and housing instability were identified as a priority health need in the secondary data analyses and in the community engagement process.

SECONDARY DATA ANALYSIS

HOMELESSNESS[3]

On a given night in San Diego in 2018, 8,576 individuals were homeless; the number of homeless decreased by 6% between 2017–2018 and 3.4% since 2013. Among the homeless, 3,586 (41.8%) were sheltered, and 4,990 (58.2%) were unsheltered. Of those who were unsheltered, 50% slept on the street/sidewalk; 18% slept in a vehicle; 14% slept in a park; 5% slept in a hand-built structure or tent. Nearly a half (43%) of homeless people had a chronic health condition.

HOMELESSNESS AND HOUSING INSTABILITY

Homelessness is when a person does not have a fixed, regular, and adequate nighttime residence.[1] Housing problems include a lack of full kitchen or plumbing facilities, a household comprised of more than one person per room, or a housing cost burden of more than 30% of the household income. Severe housing problems include a lack of full kitchen or plumbing facilities, severe overcrowding, or a housing cost burden of more than 50% of the household income.[2]

Per the American Hospital Association, ***housing instability*** is an umbrella term for the continuum between **homelessness** and a completely stable, secure housing situation. Housing instability takes many forms: physical conditions like poor sanitation, heating and cooling; compromised structural integrity; exposure to allergens or pests; homelessness; and unstable access to housing or severe rent burden.

[1]The U.S. Department of Housing and Urban Development. The 2018 Annual Homeless Assessment Report (AHAR) to Congress.
[2]Consolidated Planning/CHAS data. San Diego County 2011-2015 from the American Community Survey. U.S. Department of Housing and Urban Development. Office of Policy Development and Research.

HOUSING[2]

From 2011-2015, in San Diego County, 42.7% of households were cost burdened, spending more than 30% of their income on housing, while 20.0% were severely cost burdened, spending more than half their income on housing. The lowest-income families had the highest rates of severely cost burdened housing – 47.4% of families with incomes 30% or less of the median family income in San Diego County were severely cost burdened. Approximately 46.0% of San Diegans had housing problems, and 25.2% of San Diegans had severe housing problems.

Please see Appendix C for Homelessness and Housing Instability secondary source information.

COMMUNITY ENGAGEMENT FINDINGS

In the online community engagement survey, homelessness was identified as the fifth most impactful condition on the health and well-being of San Diego residents, and housing was ranked the sixth most impactful condition.

Community engagement participants made four main points about the impact of homelessness and housing on community health:

❖ Homelessness seriously impacts health in both direct and indirect ways
❖ Poor housing conditions have a direct, negative impact on physical and mental health
❖ The cost of housing affects health because it is the primary driver of economic insecurity in San Diego
❖ Several subsets of the San Diego population are particularly vulnerable to homelessness and housing problems

For a summary of community engagement findings related to homelessness and housing instability, see Table 37 below.

IMPACT OF HOMELESSNESS

Community engagement participants argued that being homeless directly impacts health by increasing exposure to infectious disease, particularly Hepatitis A, and to contagious illnesses. In addition, homeless individuals are exposed to extreme weather conditions, which, they said contributes to poor health. In addition, participants explained that managing chronic diseases, like diabetes, without a place to store medications is impossible, and without the ability to maintain hygiene, so is effective wound care. In addition, they suggested that those homeless individuals who have prescription medications become targets of street violence. Care after discharge from the hospital is particularly challenging for the homeless, they argued, since they have no safe place to recover. Homelessness, it was argued, also indirectly affects health through its influence on access to care. Homeless individuals face challenges in transportation and in making and keeping medical appointments. In addition, homeless people face stigma in the health care community, participants said, which can make them hesitant to seek care when they need it.

IMPACT OF HOUSING PROBLEMS

According to engagement contributors, for those who worry about maintaining their housing, health is negatively impacted. This is in part, they explained, because paying rent becomes their primary focus; attending to their own health, and the health of their families, is a lower priority than keeping a roof over their heads. Participants also argued that stress and anxiety about housing contribute to both physical and mental health issues. Housing conditions, they claimed, also affect health. Crowded housing, for instance, was presented as leading to the spread of illness, and environmental hazards, such as the presence of lead paint, cockroaches and other pests, are believed to exacerbate conditions like asthma.

IMPACT OF HOUSING COSTS

Community engagement participants contended that housing costs are the primary driver of economic insecurity in San Diego County and described lower-income residents as a population that lives "on the edge of homelessness." Increases in rent outpace increases in pay, they explained, creating a scenario in which many people cannot achieve stability, no matter how hard they work. In addition, community residents suggested that affordable housing is scarce, and housing assistance programs like Section 8 have long waiting lists. These costs, then, render people economically insecure, which impacts their heath in numerous ways (see section on Economic Insecurity).

VULNERABLE POPULATIONS

Community residents expressed particular concern related to housing and homelessness about three groups:

- ❖ Transitional age youth
- ❖ Seniors
- ❖ Immigrants

Transitional age youth

Participants explained that youth who have recently reached legal adulthood (18 years old) are not allowed in "family" homeless shelters; parents, then, must decide whether to let their young adult children fend for themselves on the street or risk the entire family's safety by leaving the shelter. Focus group contributors also asserted that young adults who are desperate for places to stay may make poor decisions that jeopardize their safety and well-being – trading their bodies, for instance, for a place to sleep, or using drugs to stay warm. Former foster youth were described as being particularly vulnerable. In addition, community engagement contributors said that homeless youth who are younger than 18 years old and living apart from their parents often do not know how to obtain needed health care. When they try to get health care services parental consent is usually needed, so they are turned away.

Seniors

Contributors suggested that seniors are in particular need of assistance with locating and utilizing housing resources, with applications for senior housing, and with managing landlord-tenant relationships.

Immigrants

Community engagement participants argued that immigrants, particularly those who do not have documentation, are at the mercy of their landlords; fear of deportation keeps them from complaining about substandard housing conditions and rent increases.

Table 37. Summary of Focus Group and Key Informant Interview Input Related to Homelessness and Housing Instability

SUMMARY OF RESPONSES RELATED TO HOMELESSNESS AND HOUSING INSTABILITY		
ASSOCIATED HEALTH CONDITIONS AND NEEDS		
All Age Groups • **Behavioral health**: depression, schizophrenia, PTSD • **Hygiene** and cleanliness • **Infectious diseases:** hepatitis, HIV/AIDS • **Stress and anxiety** • **Substance abuse**: opioids, meth, crack, Xanax, Percocet, heroin	**Children/Youth** • Flu • Hepatitis A • Pregnancy	**Senior** • **Disabilities** • **Chronic conditions** • **Behavioral health** issues
ASSOCIATED SOCIAL DETERMINANTS OF HEALTH		
All Age Groups • **Employment** difficulty • **Health insurance** • **Housing:** lack of affordable housing • **Access to health care**: poor quality health care • **Vaccinations and immunizations** are difficult to get because homeless move locations depending on shelters and availability. To get immunization must go to the primary provider they signed up with which could be too far once they move. • **Stigma**	**Children/Youth** • **Community and social support:** Foster children are not prepared to move out once they turn 18. They have no family support and have not been taught how to survive on their own • **Safety**: Youth (18 years old) who turn 18 while in shelters with their family are kicked out and have no safe place to stay • **Safety & violence:** gang violence, neighborhood safety, rape and sex trafficking • **Vaccinations** can be difficult to get due to moving (see adult section)	**Seniors** • **Housing**: Lack of senior housing • **Physical limitations:** mobility issues make it difficult to access services
ASSOCIATED BARRIERS AND CHALLENGES		
All Age Groups • **Lack of resources**: limited short-term & emergency resources, lack of affordable services • **Food**: lack of ability to store and cook food, eating unhealthy foods to fill stomach • **Shelters**: lack of women emergency shelters • **Storage** for personal belongings and medical supplies	**Children/Youth** • Endless cycle of **homelessness** • Lack of **transitional housing** • **Low paying jobs**	**Seniors** • **Food**: Special dietary needs due to chronic health conditions

UNINTENTIONAL INJURY AND VIOLENCE

Unintentional injury and violence are described as three issues:

- ❖ Exposure to violence is traumatic and impacts mental health
- ❖ Neighborhood safety impacts residents' ability to maintain health
- ❖ Certain groups have increased risk of being exposed to or victims of violence

Unintentional injury and violence were identified as a priority health need in the community engagement process.

SECONDARY DATA ANALYSIS

Data were reviewed related to several aspects of unintentional injury and violence in San Diego County: (1) falls, (2) motor vehicle injuries, and (3) overall crime rate.

UNINTENTIONAL INJURIES[3]

Falls. Rates of discharge from emergency departments caused by falls increased by 1.9% from 2014–2016. In that same time period, death rates decreased by 8.4% (Figure 48). Falls disproportionally affect those over 65 years of age; please see *Aging Concerns* section for a breakdown of falls by age groups.

UNINTENTIONAL INJURY AND VIOLENCE

*Per the Healthy People 2020, "**unintentional injuries and violence-related injuries** can be caused by a number of events, such as motor vehicle crashes and physical assault, and can occur virtually anywhere."[1]*

Unintentional injuries *include motor vehicle accidents, falls, firearms, fire/flame, drowning, poisoning, machinery, suffocation, etc.[2]*

[1]Source: Office of Disease Prevention and Health Promotion. Healthy People2020. Injury and violence. Health Impact of Injury and Violence. https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Injury-and-Violence

[2]Source: Center for Disease Control and Prevention. WISQARS. https://wisqars-viz.cdc.gov:8006/

Figure 48. Age-Adjusted ED Discharge and Mortality Rates for Falls in San Diego County, 2014–2016
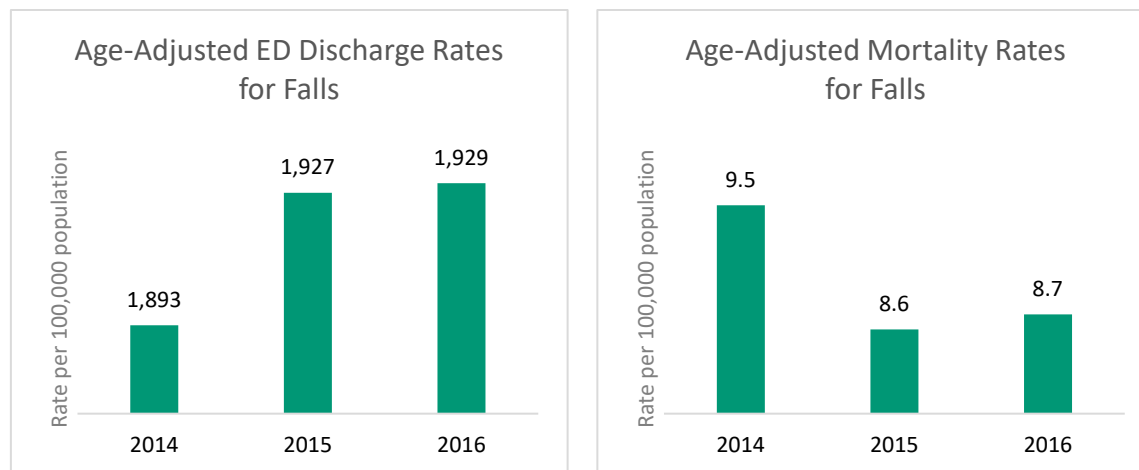
Source: County of San Diego Health and Human Services Agency Public Health Services, Regional & Community

Motor Vehicle Injuries. San Diego County data shows that age adjusted ED discharge rates for motor vehicle injuries increased (9.3%) from 2014–2016 as well as deaths due to motor vehicle injuries (1.08%).[3] Please see Figure 49 below for more details.

Figure 49. Age-Adjusted ED Discharge and mortality Rates for Motor Vehicle Injuries in San Diego County, 2014–2016
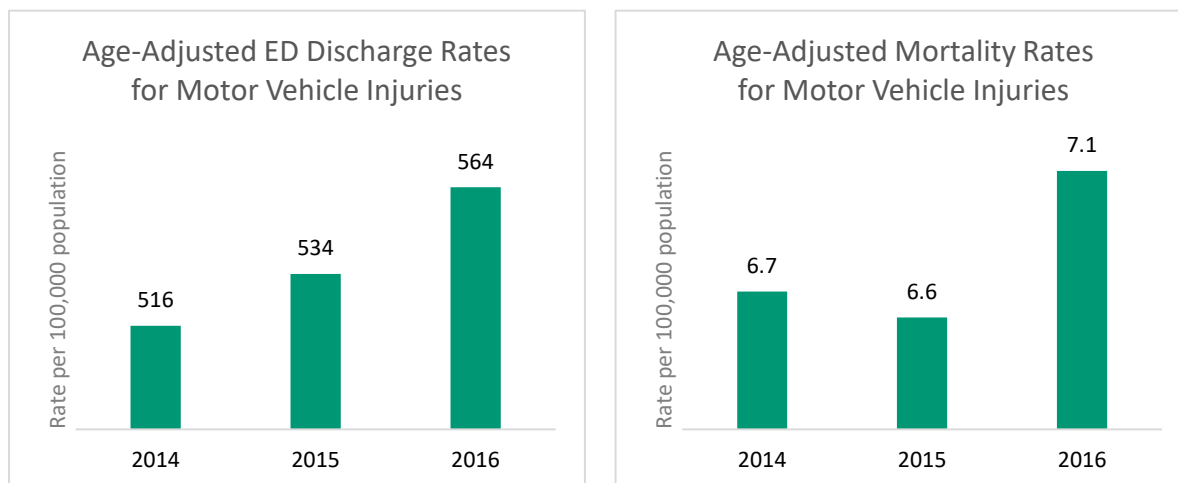
Source: County of San Diego Health and Human Services Agency Public Health Services, Regional & Community Data

Overall Crime Rate. Overall crime rate has increased in both San Diego County and California (1.9% and 5.7 % respectively) from 2014–2016.[4] Please see Figure 50 below for more details.

Figure 50. Overall Crime Rate in San Diego County, California, and the United States, 2014–2016

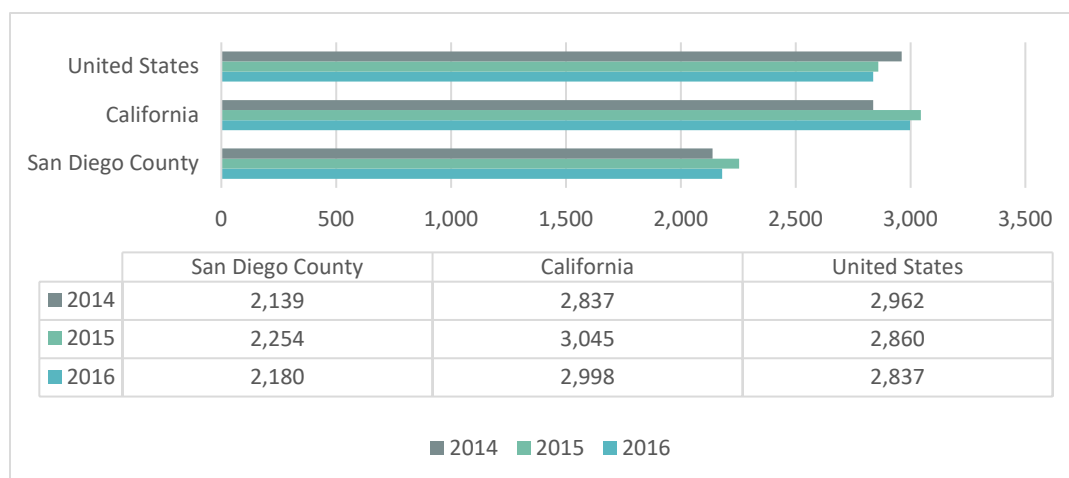|	San Diego County	California	United States
■2014	2,139	2,837	2,962
■2015	2,254	3,045	2,860
■2016	2,180	2,998	2,837

■2014 ■2015 ■2016

Source: Live Well San Diego. Live Well San Diego Data Access Portal. Injury. https://data.livewellsd.org/

Please see Appendix C for Unintentional Injury and Violence secondary source information.

COMMUNITY ENGAGEMENT ANALYSIS

Community engagement participants emphasized three issues related to safety and violence:

- ❖ Exposure to violence is traumatic and impacts mental health
- ❖ Neighborhood safety impacts residents' ability to maintain health
- ❖ Certain groups have increased risk of being exposed to or victims of violence

Within the 2019 CHNA survey, of those who chose safety and violence as the greatest influence on poor health outcomes, 55% believed that safety and violence is getting worse in San Diego County.

EXPOSURE TO VIOLENCE

People who are the victims of or witness to violence, community engagement participants emphasized, may experience trauma as a result. This trauma can lead to Post Traumatic Stress Disorder (PTSD) and to other mental health conditions like anxiety and depression. These conditions, in turn, they said, may make people less able to seek out and receive the care they need. Furthermore, mental health care, they asserted, is extremely difficult to access even when a person is not struggling with the after effects of trauma.

THE IMPACT OF NEIGHBORHOOD SAFETY

Focus group members also discussed the importance of a safe environment for good health. Residents need to feel safe outside in order to play and exercise, and when they do not, contributors said, they are far more likely to be sedentary. Physical inactivity, they asserted, lends to poor health and is a risk factor for obesity, which is then a risk factor for chronic conditions like diabetes and cardiovascular disease. A safe and pleasant neighborhood also, they explained, contributes to reducing anxiety and stress.

VULNERABLE POPULATIONS

Focus group participants talked about two groups who have increased risk of exposure to violence. Homeless individuals were discussed as frequent targets of violence. Health care providers identified injuries from violence as one of the conditions for which they often treat homeless individuals. In addition, the constant stress or worrying about staying safe, contributors stressed, creates severe anxiety among some homeless individuals. Refugees were also noted to be a group who are more likely to have been exposed to violence and to suffer from that exposure. As a result of witnessing violence, participants said, refugees may be hyper vigilant to perceived threats and mistrustful of those who try to help them.

B. COMMUNITY RESOURCES AND ASSETS AVAILABLE TO RESPOND TO THE IDENTIFIED HEALTH NEEDS

The County of San Diego contains 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. In addition, 2-1-1 San Diego is an important community resource and information hub. Through its 24/7 phone service and online database, it helps connect individuals with community, health, and disaster services. In recognition that available programs and services are continuously changing, we encourage the community to access the most available data through 2-1-1 San Diego. For more specific information about the programs within each category, please contact 2-1-1 San Diego or visit their website (http://www.211sandiego.org/).

COMMUNITY RECOMMENDATIONS

Community engagement participants identified three means by which the identified health needs could be better addressed:

1. The implementation of overarching **strategies** to address the health needs
2. The development or expansion of **resources** to meet the needs
3. The creation of **systemic, policy, and environmental changes** to better support health outcomes

All of these approaches, they emphasized, would require **collaboration** between political, health care systems, and community leaders, health care professionals, community organizations, and residents. Please see Figure 51 below, Resource & Opportunities to Address Priority Health Needs, page 155.

STRATEGIES TO INCREASE KNOWLEDGE, IMPROVE THE PATIENT EXPERIENCE, AND ENHANCE COLLABORATION

COMMUNITY KNOWLEDGE

Community residents of all ages and backgrounds need a better understanding of how to maintain good health and prevent illness and disease. Culturally competent and linguistically appropriate educational campaigns should be developed that target groups experiencing health disparities.

Educational campaigns should:

- Promote available services in the community, clinics, and hospitals
- Address potential barriers to care, including:
  - how to apply for health insurance and/or public benefits
  - how to access transportation
  - whether translation and navigations services are available
  - and any potential impact on immigration status
- Market services to address social determinants of health, such as:
  - affordable housing
  - food insecurity

THE PATIENT EXPERIENCE

The patient experience would be improved by a more diverse hospital workforce with knowledge of the specific needs of racial/ethnic and sexual minorities. Navigating the health care system for people whose first language is not English or who have recently immigrated, for example, presents overwhelming challenges. In addition, coordinating care between health care providers and with social service organizations is crucial to improving the patient experience. Efforts should be made to:

- Provide more health navigators and case managers who speak the patient's language and understand the patient's culture
- Coordinate care between health care providers and across clinics
- Provide continuity of care with warm hand-offs between health care systems and social service organizations

COLLABORATION

Enhanced collaboration was named as essential to improving health. This includes collaboration between health care professionals – such as primary care providers and specialists – and between health care systems and social service organizations. Improved collaboration between social workers, law enforcement, and attorneys would also be beneficial. Partnerships with community residents and organizations would improve the efficacy of health care services and develop trust between health care providers and the people they serve. These partnerships should include collaborative advocacy efforts, efforts to adapt programs and interventions to the unique needs of specific groups, and the dissemination of information back to communities collected from research projects in those communities.

THE DEVELOPMENT AND EXPANSION OF SPECIFIC TYPES OF RESOURCES

Community engagement participants identified several specific types of resources that are necessary to address the priority health needs of the community:

- ❖ Urgent Care services that include expanded hours, availability to all populations, and mental health and substance use services
- ❖ Preventative care programs that offer services such as immunizations (including the flu vaccine), HIV testing, and exercise programs
- ❖ Dental services for preventive care and to address oral health issues such as carries and gum disease
- ❖ Onsite programs and mobile units that bring services to the community, including programs in senior housing complexes, school clinics, mobile screening, and mobile food distribution
- ❖ Culturally competent programs for refugees, Native Americans, Latinos, Blacks, African Americans, LGBTQ individuals, non-citizens, and asylum seekers
- ❖ Programs for the youth, especially community centers and programs for young men and for homeless youth
- ❖ Homeless services and discharge support, including mobile showers, more shelters, and further options for post-acute recuperative care
- ❖ Food insecurity navigation that includes reference guides for food system/service navigation of San Diego County, private, and non-profit organizations, and signage for healthy food options for CalFresh/Supplemental Nutrition Assistance Program (SNAP) users at stores and restaurants

SYSTEMIC CHANGE

Finally, it was evident from the community engagement findings that San Diegans think that large-scale system, policy, and environmental changes are necessary to make true progress toward good health for all residents. These changes include:

- ❖ Creating universal and/or affordable health care
- ❖ Increasing the minimum wage
- ❖ Increasing applications for federal funding and allowing more time to prove a return on investment (ROI) for this funding
- ❖ Enabling easy sharing of information about patients between organizations and hospitals

Figure 51. Resources and Opportunities to Address Priority Health Needs

RESOURCES & OPPORTUNITIES TO ADDRESS PRIORITY HEALTH NEEDS

Community engagement participants identified three means by which the identified health needs could be better addressed:

1. The implementation of overarching *strategies* to address the health needs,
2. The development or expansion of *resources* to meet the needs,
3. The creation of *systemic, policy, and environmental changes* to better support health outcomes.

All of these approaches, participants emphasized, would require *collaboration* between political, health care system, and community leaders, health care professionals, community organizations, and residents.

STRATEGIES

1. **Increase community knowledge with educational campaigns** *that promote available services within the community, clinics, and hospitals*
2. **Address potential barriers to care** *such as insurance, translation, navigation services, transportation, and potential impacts on immigration status*
3. **Improve patient experience** *through culturally competent health navigators and case managers, care coordination, and community clinical linkages including language services*

RESOURCES

1. **Urgent care services** *that include expanded hours, availability to all populations, and mental health and substance use services*
2. **Preventative care programs** *that offer services such as immunizations (including the flu vaccine), HIV testing, and exercise programs*
3. **Dental services** *for preventive care and to address oral health issues such as carries and gum disease*
4. **Onsite programs and mobile units** *that bring services to the community, including programs in senior housing complexes, school clinics, mobile screening, and mobile food distribution*
5. **Culturally competent programs** *for refugees, Native Americans, Latinos, Blacks, African Americans, LGBTQ individuals, non-citizens, and asylum seekers*
6. **Programs for the youth,** *especially community centers and programs for young men and for homeless youth*
7. **Homeless services and discharge support,** *including mobile showers, more shelters, and further options for post-acute recuperative care*
8. **Food insecurity navigation** *that includes reference guides for food system/service navigation of San Diego County, private, and non-profit organizations, and signage for healthy food options for CalFresh/ Supplemental Nutrition Assistance Program (SNAP) users at stores and restaurants*

SYSTEMIC CHANGE

1. **Create universal and/or affordable health care**
2. **Increase minimum wage**
3. **Fund policies:** *increase applications for federal funding and allow more time to prove a return on investment (ROI) for funding*

COLLABORATION

1. **Form partnerships** *with community residents by engaging residents in advocacy*
2. **Share and disseminate information** *and data back into the communities from where the data came from*
3. **Work with communities to adapt programs and interventions** *to the unique needs of minority groups (go beyond collective impact approach)*
4. **More collaboration** *between social workers, law enforcement, and attorneys*
5. **Warm hand-offs** *between agencies and organizations*

C. NEXT STEPS

Hospitals and health systems that participated in the HASD&IC 2016 CHNA process have varying requirements for next steps. Private, not for profit (tax exempt) hospitals and health systems are required to develop hospital or health system community health needs assessment reports and implementation strategy plans to address selected identified health needs. The participating district hospitals and health systems do not have the same CHNA requirements but work very closely with their patient communities to address health needs by providing programs, resources, and opportunities for collaboration with partners. Every participating hospital and health care system will review the CHNA data and findings in accordance with their own patient communities and principal functions and evaluate opportunities for next steps to address the top identified health needs in their respective patient communities.

The CHNA report will be made available as a resource to the broader community and is intended to serve as a useful resource to both residents and health care providers to further communitywide health improvement efforts.

The CHNA Committee is in the process of planning Phase 2 of the 2019 CHNA, which will include gathering community feedback on the 2019 CHNA process and strengthening partnerships around the identified health needs and social determinants of health.

HEALTH BRIEFS

HEALTH BRIEFS

ACCESS TO HEALTH CARE

AGING CONCERNS

ASTHMA

BEHAVIORAL HEALTH

CANCER

CARDIOVASCULAR DISEASE

DIABETES

ECONOMIC SECURITY

HOMELESSNESS AND HOUSING INSTABILITY

UNINTENTIONAL INJURY AND VIOLENCE

Access to Health Care

28.5 million people are without health insurance in the U.S.[1]

Access to high quality, comprehensive care is vital for preserving good health, preventing and managing disease, decreasing disability, averting premature death, and achieving health equity for all.[2]

To access care, people need health insurance coverage and a consistent source of care that provides evidence-based, culturally competent preventive and emergency medical services in a timely manner.[2]

Uninsured in the U.S.[1] (2017)

8.8% of people are without health insurance.

By Age

Seniors and children are the least likely to be uninsured, while a large percentage of working adults have no coverage:

- People age 65+ have the highest rates of coverage, with only 1.3% uninsured.
- 5.4% of children under the age of 19 are uninsured (7.8% for children living in poverty).
- Working adults ages 26-34 are more likely to be uninsured than the overall working population (15.6% vs 12.2%).

By Race

- Uninsured rates are highest for people who identify as Hispanic (16.1%), followed by Black (10.6%), and Asian (7.3%).

By Educational Attainment

The uninsured rate decreases as education level increases. While only 4.3% of people with a graduate or professional degree are uninsured, 26.3% of people without a high school diploma are uninsured.

By Income

Uninsured rates increase as level of income decreases. The highest uninsured rates are among those who make less than $25,000 annually (13.9%), and the lowest are among those who make more than $125,000 (4.3%).

UNINSURED IN SAN DIEGO COUNTY

In 2017, 10.6% of adults aged 19-64 years were uninsured[3] in San Diego County.

- Uninsured rates have decreased across all racial/ethnic groups. Those who identify as Hispanic, however, are disproportionately without health insurance, 13.3% (Hispanic) compared to 4.2% (non-Hispanic White).

Percent Uninsured (Ages 18-64)*, 2013-2017

Year	California	San Diego County
2017*	10.1%	10.6%
2016	10.3%	10.4%
2015	12.1%	12.1%
2014	17.3%	16.4%
2013	24.0%	22.0%

■ California ■ San Diego County
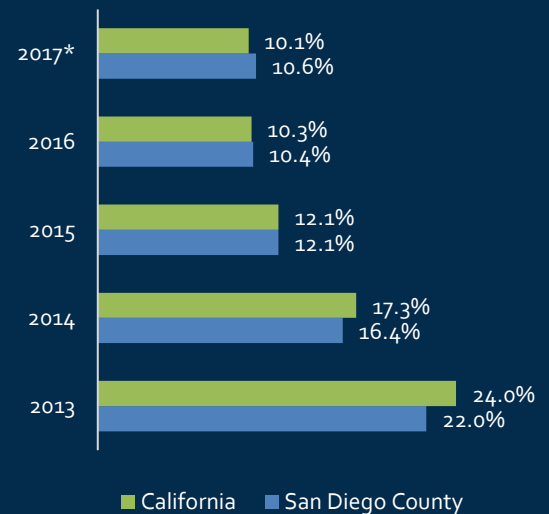
Percent Uninsured (Ages 19-64) by Ethnicity*, 2017

Ethnicity	California	San Diego County
Non-Hispanic White	3.9%	4.2%
Hispanic*	11.6%	13.3%

■ California ■ San Diego County
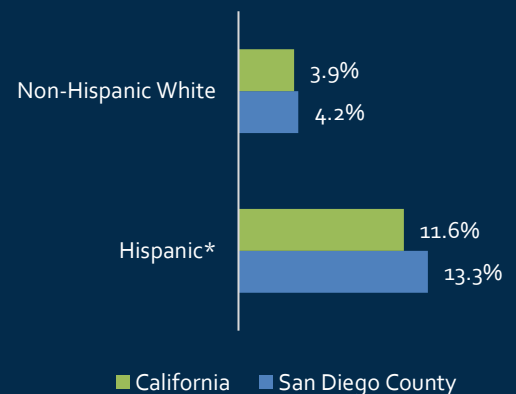
*Note: Includes civilian noninstitutionalized population. 2017 data includes 19-64 years olds.

Ongoing Care with a Primary Care Provider in the U.S.[4] (2015)

76.4% of people in the U.S. have a primary care provider (PCP).

By Age

The youngest and oldest age groups have the highest percentages of people with a PCP: 93.2% of those under the age of 5 and 92.4% of those 85 years old and older. More broadly, people less than 18 years old have the highest proportion with a usual PCP (90.0%), followed by those 65 and older (89.4%), and those 45-64 (79.2%). The lowest percentage was among those 18-44 (60.1%).

By Race

The percentage of people with a PCP is highest among Native Hawaiian or Other Pacific Islander individuals (82.3%), followed by people of two or more races (80%), non-Hispanic Whites (79.1%), American Indian or Alaska Natives (74.3%), Asians (74.2%), and Black individuals (72.6%). The percentage was lowest (70.1%) among Hispanics.

By Educational Attainment

The highest proportion of people with a usual PCP is among those with an advanced degree (77.8%), followed by those with a college degree (74.2%). The lowest rate is among those with less than a high school diploma (68.9%).

By Income

The percentage of people with a PCP increases in proportion to income. Among those with income levels 600% or more over the federal poverty level (FPL), 81.7% have a usual PCP, whereas among those with incomes of less than 100% of the FPL, 71.8% have a usual PCP.

The Affordable Care Act (ACA)[9]

The **ACA** increased access to healthcare. In 2014, a number of changes took effect in California:

- The expansion of Medi-Cal to individuals making less than 138% of the poverty level.
- The establishment of Covered California for individuals who make up to 400% of the poverty level to purchase subsidized health insurance.
- The elimination of the health coverage discrimination due to pre-existing conditions.

PREVENTIVE & PRIMARY CARE IN SAN DIEGO COUNTY

In 2015, San Diego had fewer hospital discharges for preventable conditions (29.7 per 1,000) than the state average (36.2 per 1,000); however, Black individuals have a far greater number of these events.[6]

Preventable Hospital Events for Medicare Beneficiaries, 2015 [6]
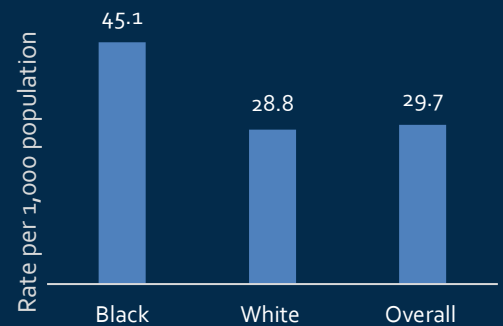
In 2015, 82.5% of adults in San Diego County had seen a PCP in the past year,[8] however Medicare beneficiaries have lower rates (68.2%).[6]

Medicare Beneficiaries who Have Seen a PCP Within Past Year, 2015[6]
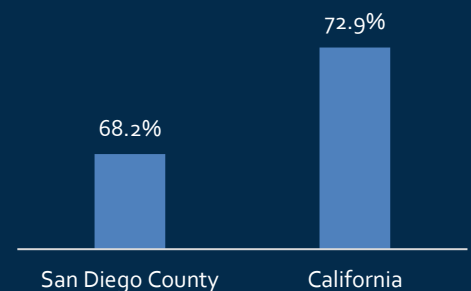
HEALTH IMPACTS

Being uninsured is associated with:[7]

- Poor mental health days
- More heart attack ED visits
- Asthma
- Obesity
- Low birth weight
- Smoking

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Aging Concerns

By 2030, 1 in 5 Americans will be 65 years or older[1]

Older adults are at greater risk of having multiple chronic conditions, including dementia, and of suffering injury and death from falls.[2,3]

Dementia in the U.S. (2017)

Dementia is a general term used to describe symptoms indicative of cognitive decline, like memory loss or confusion. The most common cause of dementia is Alzheimer's disease.[4,5]

- Approximately 5.7 million people are living with dementia
  - Alzheimer's disease accounts for about 60-70% of these cases.[6]
- Dementia is the 3rd leading cause of death in the U.S. when combining all four causes of dementia.[*,7]
- About 262,000 people will die from dementia each year
  - 46.4% of these deaths result from Alzheimer's disease[7]
- Age-adjusted death rate due to dementia is 66.7 per 100,000.[7]
- Alzheimer's disease is the 5th leading cause of death among those over 65 years in the U.S.[8]

By Sex

More women than men have Alzheimer's disease or other dementias:

- Among people 65 years and older (65+), 62.5% of people with Alzheimer's disease are women[5]

By Race and Ethnicity

Blacks and Hispanic individuals are more likely to have Alzheimer's disease or other dementias than Whites.[5]

Leading causes of death among persons aged 65 and over[8]

1. Heart disease (25.1%)
2. Cancer (20.7%)
3. Chronic lower respiratory disease (6.6%)
4. Stroke (6.1%)
5. Alzheimer's disease (5.8%)

*Includes: unspecified dementia, Alzheimer disease, Vascular dementia, other degenerative disease of nervous system

DEMENTIA AND ALZHEIMER'S IN SAN DIEGO COUNTY[9] (2016)

In San Diego, White residents, followed by Black residents are disproportionately affected by dementia and Alzheimer's disease.

Alzheimer's Disease Death Rate by Race/Ethnicity, 2016

Race/Ethnicity	Rate
White	65.9
Black	30.9
API*	13.3
Hispanic	11.7
Other	5.3

Rate per 100,000 population
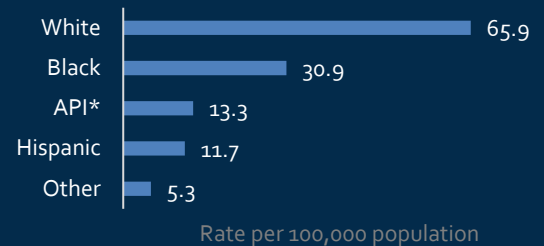
Dementia Death Rate by Race/Ethnicity, 2016

Race/Ethnicity	Rate
White	28.0
Black	13.4
API*	7.4
Hispanic	5.7

Rate per 100,000 population
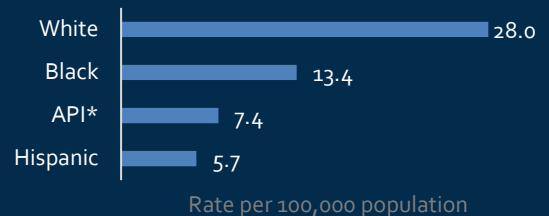
*Asian & Pacific Islander

The percentage of San Diego population who have seen a primary care physician in the last year, 71.8%, is slightly lower than the state average of 72.7% (2015).[14]

For Medicare beneficiaries, this gap is larger: only 68.2% of Medicare beneficiaries in San Diego have seen a PCP in the past year, compared to the state average of 72.9% (2015).[15]

Falls in the U.S.

More than 31,000 people 65 years and older died from falls in 2017[10]

In 2017, for every individual 65 years and older who died from falls, 28 were hospitalized, and 62 were treated for fall-related injuries.[10,11] In 2015, the total cost for falls for those 65 years and older was more than $50 billion. Since the U.S. population is aging, both the number of falls and the cost to treat fall injuries are likely to rise.[12]

Among people 65 years and older (65+) (2017)

- Falls are the leading cause of injury-related *mortality*, accounting for 55.7% of unintentional fatal injuries in 2017.[13]
- The *death* rate due to falls was 61.3 per 100,000.[10]
- The *nonfatal* rate due to falls is 5,841.1 per 100,000 (about 3 million nonfatal fall injuries).[11]

By Sex

- For *fatal* falls, males who are 65+ are more likely to die than females who are 76+ (75.3 vs 54.8 per 100,000).[10]
- For *nonfatal* fall-related injuries, females who are 65+ accounted for 64.6%.[11]

By Race and Ethnicity

Non-Hispanic Whites are more impacted by falls:
- Non-Hispanic Whites have the highest *death* rate (70.6 per 100,000), followed by non-Hispanic Native American (49.3 per 100,000)[10]
- Non-Hispanic Whites have the highest number of *nonfatal* fall injuries (1,648,923)[11]

FALLS IN SAN DIEGO COUNTY[9] (2016)

In San Diego, thousands of residents 65 years and older visit an emergency department (ED) for fall-related injuries.

Hospital Discharge and Death Rates for Falls, Age 65+, 2016

Rate per 100,000 population

Death	60
ED Discharge	4,695
Inpatient Discharge	1,859
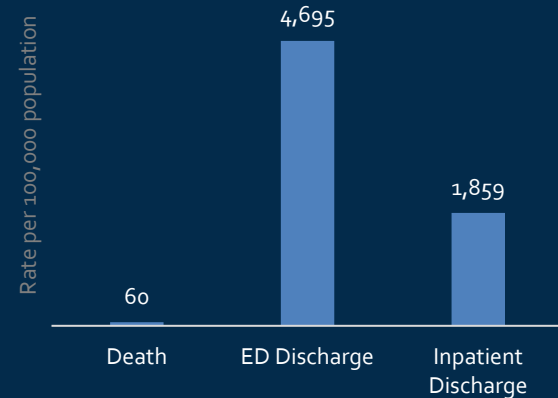
In San Diego, male residents and White residents are more likely to die from a fall than any other groups.

- **Males** are 1.7 times more likely to die than females.
- **Whites** are at least 2.2 times more likely to die than API, Black, and Hispanic.

Falls Death Rate by Sex and Race/Ethnicity, 2016

Male	11.5
Female	6.6
White	14.5
API*	6.7
Black	5.7
Hispanic	4.4
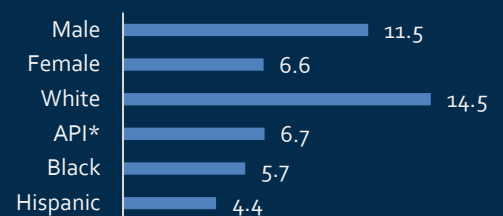
Rate per 100,000 population

*Asian & Pacific Islander

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Asthma

26.5 million Americans suffer from this chronic disease[1]

Asthma is a chronic lung disease that causes inflammation and narrowing of the airways. Symptoms of asthma attacks include wheezing, tightness or pain in the chest, shortness of breath, and coughing. The severity of attacks range from mild to life threatening.[2]

Asthma has significant impact on the daily lives of the people who suffer,[2] and in California alone, the 2020 projected medical costs are estimated to be $4.9 billion.[3]

Asthma in the U.S. (2016)

In 2016, 8.3% of Americans currently had asthma[4], and 13.6% will be diagnosed with asthma at some point in their lifetime.[5]

By Sex

- Among children, asthma is more common among boys (9.2%) than girls (7.4%), but among adults asthma is more common among women (10.4%) than men (6.2%).[4]

By Age

- 8.3% of children younger than 18 years old have asthma, a decrease from 9.4% in 2010. Rates are higher among those 5-11 years old (9.6%) and 12-17 years old (10.5%) than among children 0-4 years old (3.8%).[4,6]
- The rate is the same among adults 18+ (8.3%).[4]

By Race/Ethnicity

- Puerto Ricans have the highest rates of asthma (14.3%), followed by Non-Hispanic Black (11.6%), Non-Hispanic Whites (8.3%), Other Non-Hispanic (8.0%), and Hispanics (6.6%).[4]

By Income & Housing Quality

- Asthma is most prevalent among the lowest economic groups: 11.8% of those whose income is below 100% of the federal poverty level (FPL) have asthma, compared to 8.9% with incomes 100% to less than 250% of the FPL and 7.4% of those with incomes 250% to less than 450% of the FPL.[4]
- Poor housing quality is independently associated with asthma diagnoses and higher rates of *emergency department* (ED) *discharges* for asthma.[7]

ASTHMA IN SAN DIEGO COUNTY[8]

Inpatient Discharge Rates

In 2016, 264.4 people per 100,000 were discharged from an ED for asthma and 38.6 per 100,000 people were discharged from inpatient hospitalizations.

ED Discharge Rates by Region

Asthma disproportionately affects San Diegans living in certain areas. ED discharge rates are highest (per 100,000) for children (0-14 yrs.) in the Mountain Empire region and for all age groups in Southeast San Diego.

ED Discharge Rates for Asthma by Top 5 Regions (Ages 0-14), 2016

Rrate per 100,000 population

1,138	1,054	1,037	879	869
Mountain...	National...	Southeast...	Mid-City	South Bay

ED Discharge Rates for Asthma by Top 5 Regions, 2016

Age-adjusted rate per 100,000 population

631	554	521	441	438
Southeastern San Diego	National City	Lemon Grove	Mountain Empire	Mid-City
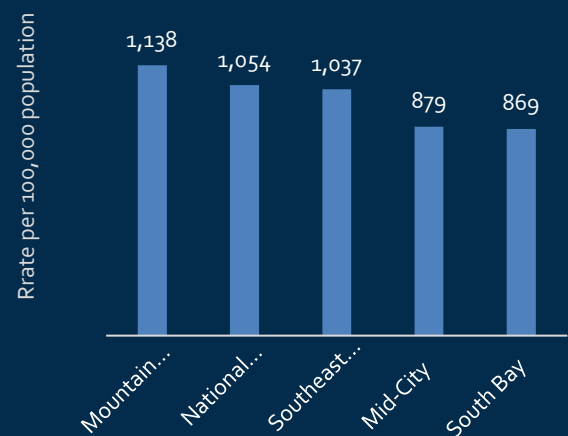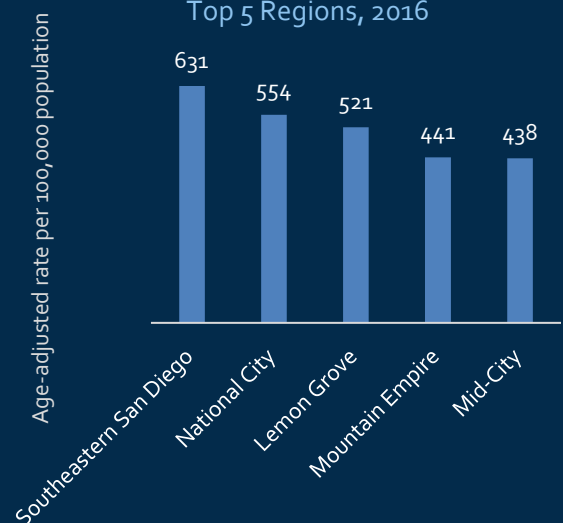
Impact of Asthma in the U.S.

Children: School achievement

- Asthma is associated with cognitive deficits, particularly among low-income, minority youth with severe asthma.[9]
- 49.0% of children with asthma miss one or more days of school annually and 13.8 million school days are missed altogether.[10] (2013).

Adults: Reports of poor and fair health[11] (2015)

- Among adults with asthma, 33.1% report fair or poor health compared to those without asthma (15.9%). In California 29.1% of adults with asthma report fair or poor health compared to 17.0% without asthma.

Mortality[12] (2016)

- Approximately 3,500 people die annually from asthma (10 per 1 million).
- Adults are more likely to die from asthma than children – the *death rate* is highest (29.2 per million) among those 65 years and older.
- Non-Hispanic Blacks are two to three times more likely (22.3 per million) to die from asthma than people from other races/ethnicities.
- *Deaths* from asthma are largely preventable.

Risk Factors and Triggers for Asthma

Factors that **increase the risk** of an asthma diagnosis include:[13]

- Parental asthma
- Prenatal environmental tobacco smoke
- Premature birth
- Maternal weight gain or obesity during pregnancy
- Maternal stress
- Maternal use of antibiotics or paracetamol
- Birth by caesarean delivery
- Severe respiratory syncytial virus (RSV) in infancy
- Overweight or obesity
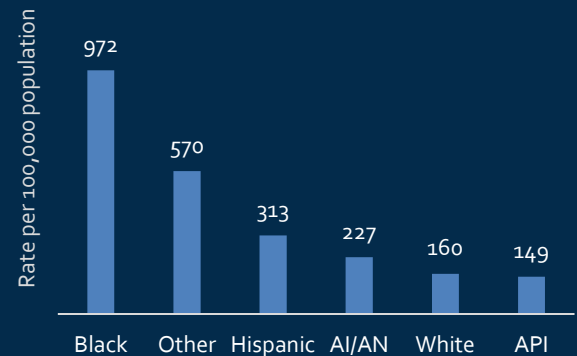- Indoor exposure to mold or fungi
- Outdoor air pollution

Triggers that **exacerbate asthma** and/or cause attacks include:[14]

- Tobacco smoke
- Dust mites
- Outdoor air pollution
- Cockroaches and their droppings
- Pets
- Mold
- Smoke from burning wood or grass
- Certain Illnesses
- Bad weather

HOSPITAL DISCHARGES IN SAN DIEGO COUNTY[8]

Inpatient discharge rates (per 100,000) in San Diego County are highest among Black and Hispanic individuals as well as those who identify as "Other".

ED Discharge Rates for Asthma by Race/Ethnicity, 2016

Race/Ethnicity	Rate per 100,000 population
Black	972
Other	570
Hispanic	313
AI/AN	227
White	160
API	149

Inpatient Discharge Rates for Asthma by Race/Ethnicity, 2016

Race/Ethnicity	Rate per 100,000 population
Black	121
Other	73
Hispanic	45
White	27
API	24
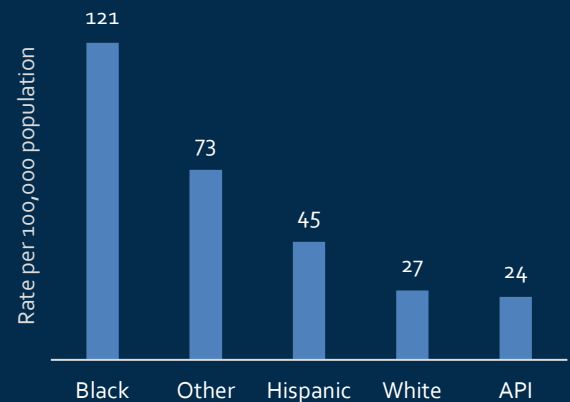
Hospital Discharge Rates by Age (2016)

- Children 0-14 years old have the highest rate of ED discharges for asthma – 530.9 per 100,000, while people ages 65+ have the lowest rates – 128.7 per 100,000.
- Children also have the highest rates of discharge for asthma from inpatient hospitalizations – 104.0 per 100,000, while people ages 15-24 have the lowest – 12.5 per 100,000.

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Behavioral Health

Nearly 1 in 5 U.S. adults live with a mental illness

Behavioral health problems include serious psychological distress, mental and substance use disorders, suicide, and alcohol and drug addiction.[1] If left untreated, these issues can have a devastating impact. They are a leading cause of disability, are associated with chronic disease, and may lead to premature mortality.[2,3,4]

Mental Illness in the U.S.

Among Adults, 18 years old and older (2017):

- 18.9% of adults 18 and older have a **mental illness** in this past year[5]
- 7.1% of adults experienced a **major depressive episode** (**MDE**) in the past year; 66.8% received treatment[5]

Among Youth and Young Adults (2017):

- 31.5% of high school students are so sad or hopeless every day for 2 or more weeks in a row that they stop doing some usual activities. Rates are particularly high (63.0%) among gay, lesbian, and bisexual students and are higher among females (41.1%) than males (21.4%).[6]
- 13.3% of youth aged 12 to 17 had an **MDE** in the past year; only 41.5% received treatment for depression.[5]
- 13.1% of young adults aged 18-25 had an **MDE** in the past year; only 50.7% received treatment.[5]

Mood Disorder and Anxiety in San Diego County[8]

Mood Disorders

- From 2014-2016, *inpatient discharge* rates for **mood disorders** *decreased* by 2.9%.
- From 2014-2016, rates of emergency department (*ED*) *discharge* for **mood disorders** *increased* by 5.9%.

Anxiety

- From 2014-2016, *inpatient discharge* rates for **anxiety** *decreased* by 7.9%.
- From 2014-2016, rates of *ED discharge* for **anxiety** *increased* by 4.3%.

MOOD DISORDER & ANXIETY IN SAN DIEGO COUNTY

The most common mood disorders include depression, bipolar disorder, and seasonal affective disorder.[7]

Inpatient Discharge Rates for Mood Disorder by Race[8]

Rate per 100,000 population — API**, AI/AN*, White, Other Race, Black
■ 2016 ■ 2015 ■ 2014

ED Discharge Rates for Mood Disorder by Age[8]

Rate per 100,000 population — 11-17, 18-26, 27-44, 45-64, 65+
■ 2014 ■ 2015 ■ 2016
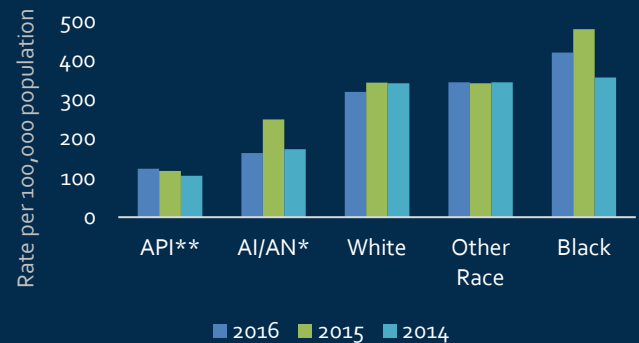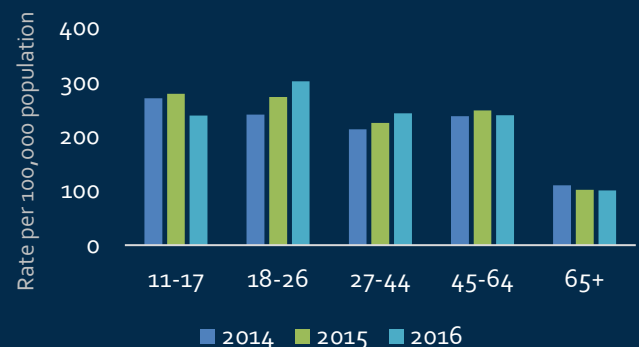
ED Discharge Rates for Anxiety by Age[8]

Rate per 100,000 population — 0-10, 11-17, 18-26, 27-44, 45-64, 65+
■ 2014 ■ 2015 ■ 2016
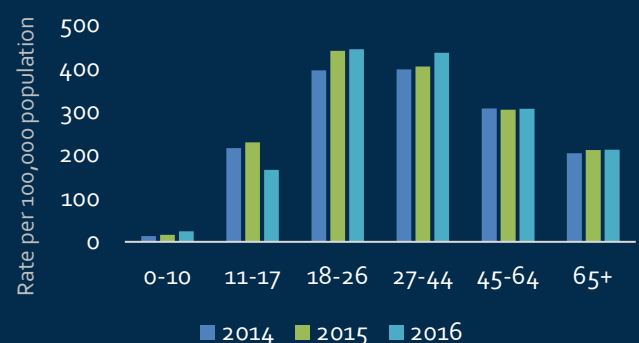
*American Indian / Alaskan Native / Eskimo / Aleut
**Asian Pacific Islander

Suicide in the U.S.

Among Adults, 18 years and older (2017):

- **Suicide** is the 2nd leading cause of death among 10-34 year olds and the 4th among 35-54 year olds[9]
- 1.4 million people have nonfatal **suicide** attempts each year[5]
- 10.6 million people (4.3%) think seriously about trying to kill themselves each year[5]

Among Youth and Young Adults (2017):

- Rates of **suicide attempts** in high school students are higher among females (9.3%) than males (5.1%) and much higher among gay, lesbian, and bisexual students (23.9%) than among heterosexual students (5.4%)[6]
- 17.2% of high school students[6] and 10.5% of young adults seriously considered suicide in the past year[5]

Suicide and Self Inflicted Injury in San Diego County[7]

- In 2016, **suicide** was the 9th leading cause of death in San Diego County.[15]
- 11.8% of adults in San Diego have seriously considered suicide.[10] (2017)
- Rates of **suicide** *decreased* 1.3% from 2014-2016 among all San Diegans.[16]
  - ➢ Rates *increased* during these same years among those who identified as Asian/Pacific Islander, Black, and "Other," by 13.3%, 47.2%, and 93% respectively.
  - ➢ Rates also *increased* for two age groups during this period: for those 15-24 years old (by 36.4%) and 25-44 years old (by 10.4%).
- *ED discharge rates* for **self-inflicted injury** have *decreased* slightly (0.1%) from 2014-2016.[16]
  - ➢ Rates are highest among those 15-24 years old and among people who identify their race/ethnicity as "Other," American Indian/Alaska Native, and Black.

SUICIDE & SELF INFLICTED INJURY IN SAN DIEGO COUNTY[7]

Suicide Rates by Race/Ethnicity
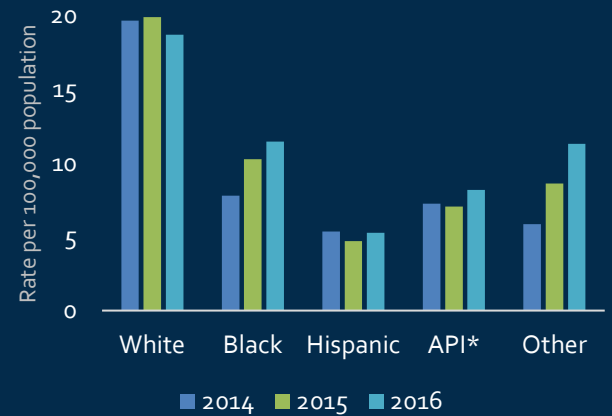
Suicide Rates by Age
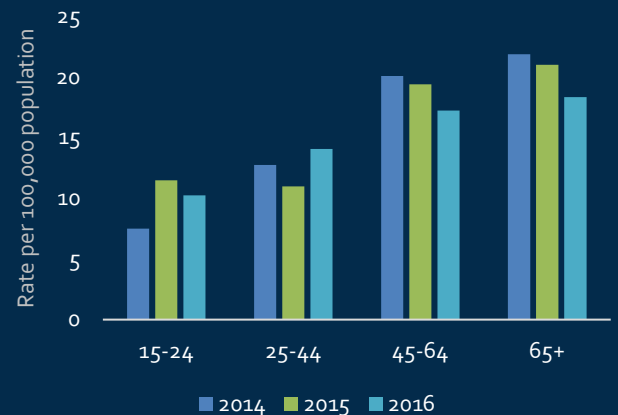
ED Discharge Rates for Self-Inflicted Injury by Age

*Asian Pacific Islander

Substance Misuse in the U.S.[5] (2017)

- 30.5 million people 12 and older have used an illicit drug in the past 30 days – this is equal to 1 in 9 people (11.2%).
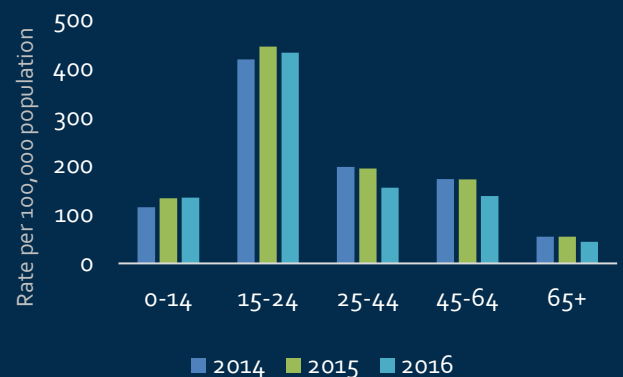- Approximately 19.7 million people ages 12 and older have a **substance use disorder**:
  - 14.5 million have an alcohol use disorder
  - 7.5 million have an illicit drug use disorder
- Only 4 million people 12 and older received substance use treatment in the past year.
- About 1 in 3 people 12 and older who perceive a need for treatment do not receive it because they do not have health insurance and cannot afford it.
- 8.5 million adults 18 or older (3.4%) have both a **mental illness and a substance use disorder.**
  - 1 in 3 of these people did not receive care for either condition.

Substance Misuse in San Diego County[8]

- Nearly 20% of adults ages 18 and older self-report excessive alcohol use, exceeding the state and national averages of approximately 18%.[11] (2015)
- *ED discharge* rates for **chronic substance abuse** grew substantially (by 559%) from 2014-2016.[8]
  - The steepest *increase* (714%) was for those 65 years old and older, followed by those 27-44 years old (657%).
- *ED discharge rates* for **acute substance abuse** *increased* by 51% from 2014-2016.[8]
  - These rates rose the most for 0-17 year olds (61%), followed by 27-44 year olds (59%), and 18-26 olds (57%).
  - Rates *increased* for all races, but the most substantial increase (177%) was among Black individuals.

SUBSTANCE MISUSE IN SAN DIEGO COUNTY[8]

ED Discharge Rates for Chronic Substance Use by Age
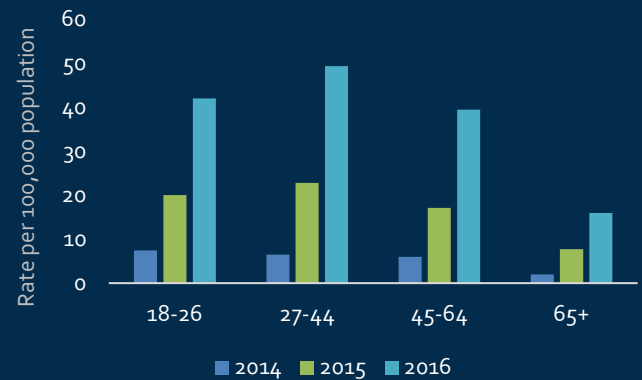
ED Discharge Rates for Acute Substance Use by Age
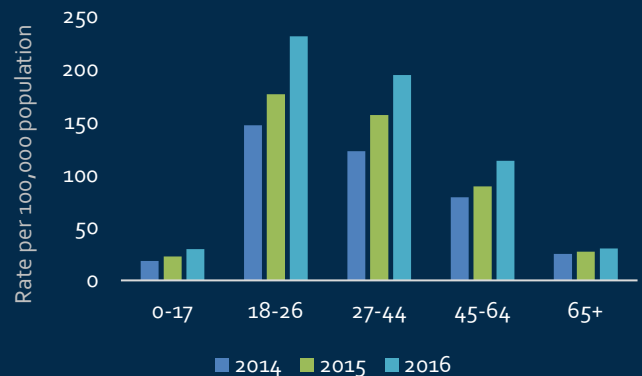
ED Discharge Rates for Acute Substance Use by Race
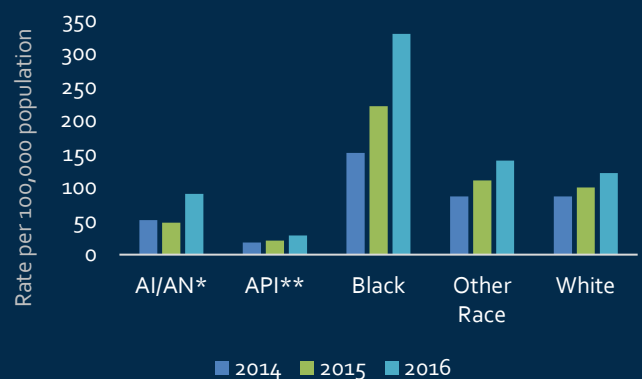
*American Indian / Alaskan Native / Eskimo / Aleut
** Asian Pacific Islander

Opioid Misuse in the U.S.

Opioid misuse is defined as the use of opioids without a prescription or in a manner other than as directed by a doctor, which can result in an overdose.[12]

Opioid Deaths in the U.S.[13] (2017)

- The rate of **opioid overdose** deaths rose by 12.0% from 2016-2017.
- Males are twice as likely to die from an opioid overdose than females (20.4 per 100,000 vs 9.4 per 100,000).
- Non-Hispanic White individuals have the highest opioid overdose death rate (19.4 per 100,000), followed by non-Hispanic American Indian/Alaska Native (15.7 per 100,000).
- The highest opioid overdose death rate is among those 25-34 years old (29.1 per 100,000).

Opioids in San Diego County

- **Opioids were prescribed** 1,701,077 times in San Diego in 2017, an annual age-adjusted rate of 475.5 times per 1,000 residents.[14]
  - ➢ This represents a 17% decrease from 2015.
- Death rates from **opioid overdose** are highest for individuals who are Native American, followed by White, Black, Latino, and Asian individuals.[14] (2017)
- *ED discharges* for **opioid misuse** rose 267.2% from 2014-2016.[8]
  - ➢ Rates are highest for those 27 -44 years old, but the largest *increase* (1,734%) was for those 65 years and older.
- *ED discharge rates* for **opioid overdose** rose by 18.1% from 2014-2016.[8]
  - ➢ Rates increased for all racial groups, but the largest increase was seen among Black individuals (88.2%).
- Rates of *inpatient discharge* for **opioid overdose** decreased overall by 6.3% from 2014-2016.[8]
  - ➢ Rates of those 65 years and older decreased by 11.6%.

OPIOID MISUSE & OVERDOSE IN SAN DIEGO COUNTY[8]

ED Discharge Rates for Opioid Misuse by Age
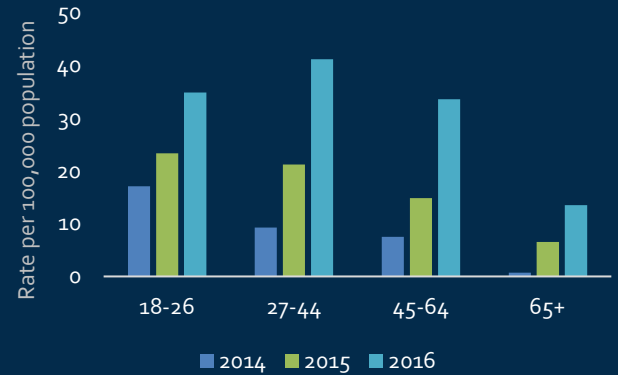
Rate per 100,000 population — 2014 ■ 2015 ■ 2016

ED Discharge Rates for Opioid Overdose by Race

Rate per 100,000 population — 2014 ■ 2015 ■ 2016

ED Discharge Rates for Opioid Overdose by Age

Rate per 100,000 population — 2014 ■ 2015 ■ 2016
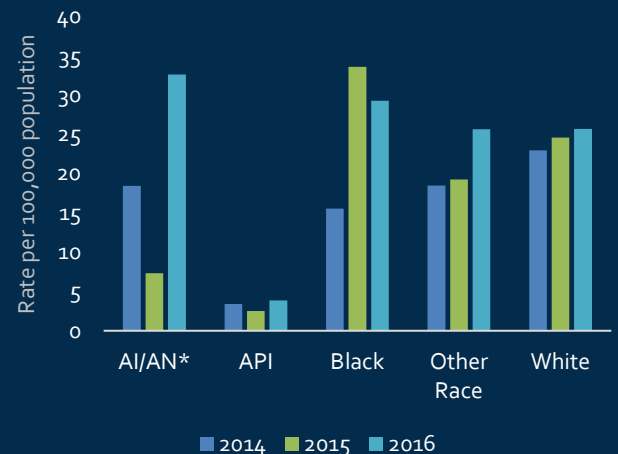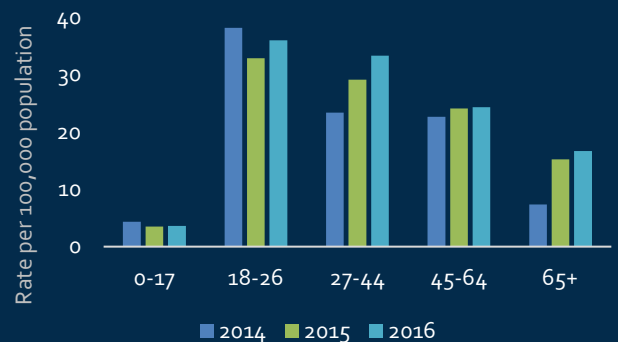
*Asian Pacific Islander

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Cancer

15.5 million Americans have a history of cancer, and in 2019, 606,880 Americans will die from cancer and 1.7 million new cases will be diagnosed. [1]

Cancer is a set of diseases in which abnormal cells grow and spread.[1] In 2017, it was the second leading cause of death in the U.S.[2] The annual direct medical costs for cancer are over $80 billion in the U.S. (2015).[3]

Cancer in the U.S.
The Most Common Cancers: Prevalence and Mortality Estimates for 2019[1]

The most common types of cancer among women are breast, lung, colorectal, and uterine. Among men, they are prostate, lung, colorectal, and urinary. Mortality rates for women are highest for lung, breast, colorectal, and pancreatic, and for men are highest for lung, prostate, colorectal, and pancreatic cancer.

Breast (invasive)
- 271,270 cases will be diagnosed
- 42,260 people will die

Lung
- 228,150 cases will be diagnosed
- 142,670 people will die

Prostate
- 174,650 cases will be diagnosed
- 78,500 men will die

Colorectal
- 145,600 cases will be diagnosed
- 51,020 people will die

Urinary
- 80,470 cases will be diagnosed
- 17,670 people will die

Uterine/Endometrial
- 61,880 cases will be diagnosed
- 12,160 people will die

Pancreatic
- 56,770 cases will be diagnosed
- 45,750 people will die

CANCER RATES IN SAN DIEGO COUNTY

Incidence Rates (2012-2016)[5]
The age-adjusted cancer (all-sites)incidence rates per 100,000:

San Diego County	399.9
California	393.6

Cancer Incidence Rates by Race/Ethnicity

Rate per 100,000 population

	White	Black	Hispanic	API*
San Diego County	432	367	348	281
California	438	414	319	294

■ San Diego County ■ California
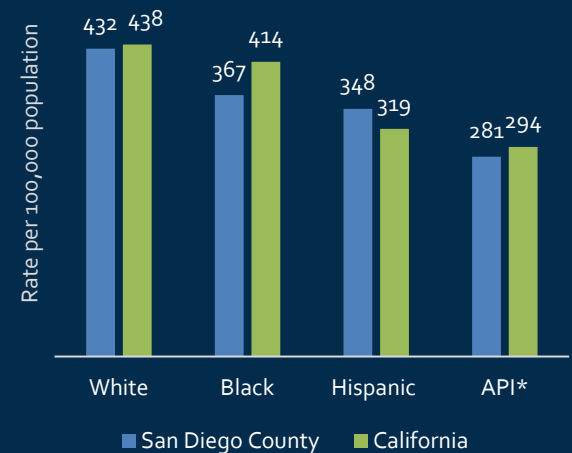
Mortality Rates (2012-2016)[6]
The age adjusted cancer (all-sites)mortality rates per 100,000:

San Diego County	148.3
California	144.6

Cancer Mortality Rates by Race/Ethnicity

Rate per 100,000 population

	White	Black	Hispanic	API*
San Diego County	156	171	131	116
California	155	188	124	110

*Asian/Pacific Islander

Disparities in the U.S.*

By Socioeconomic Status[1] (SES)

- Individuals with lower SES have higher cancer *mortality* rates than people with higher SES, regardless of factors such as race/ethnicity.

By Race/Ethnicity[1]

The overall cancer *incidence* (2011-2015) and *mortality* rates (2012-2016) for all race/ethnicities per 100,000 is 44[9].8 and 161.0 respectively.

- 465.3/165.4 for Non-Hispanic Whites
- 463.9/190.6 for Non-Hispanic Blacks
- 291.7/100.4 for Asian/Pacific Islanders
- 398.5/148.8 per American Indian/Alaska Natives
- 346.6/113.6 for Hispanic/Latinos

Non-Hispanic Blacks[4]

- Collectively, Black people have the highest *death* rates (2016)
- Black women have 21.5% higher cancer *mortality* rates than White women (2012-2016).
- *Mortality rates* from uterine/endometrial cancer for Black women is nearly double that of White women and is 40% higher for breast cancer (2012-2016).
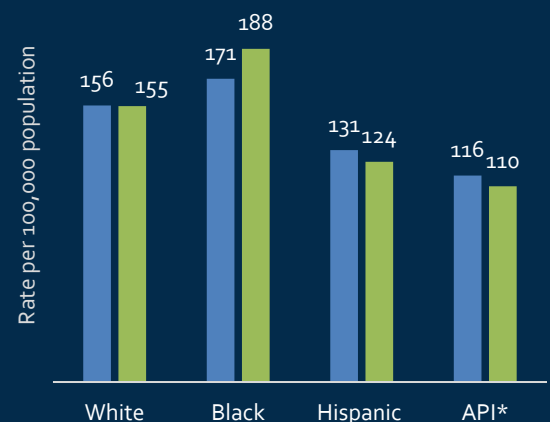- *Mortality rates* from prostate cancer for Black men are more than double those of every other group (2012-2016).
- Black men have the highest cancer *incidence* rates compared to all other racial/ethnic groups (2011-2015).
- Black people have the highest *incidence* rates of colorectal cancers of any racial/ethnic groups (2011-2015).

Hispanic/Latinos[1]

- Collectively, Hispanics have lower overall cancer *incidence* (2011-2015) and *mortality* rates (2012-2016)
- Hispanics have the highest *incidence* rates for cancers linked to infectious agents, like cervical, liver, and stomach cancer (2011-2015)

Asian/Pacific Islanders (API)[1]

- APIs have the lowest overall cancer *incidence* (2011-2015) and *mortality* rates (2012-2016)
- APIs have the highest rate of stomach cancer (2011-2015)

American Indian/Alaska Natives (AI/ANs)[1]

- AI/ANs have lower than average overall cancer *incidence* (2011-2015) and *mortality* rates (2012-2016)
- AI/ANs have the highest kidney cancer *incidence* (2011-2015) and *mortality* (2012-2016) rate of any population – nearly 3 times the rates among APIs.

*Cancer **mortality (death) rates** are from years 2012-2016 unless otherwise specified. Cancer **incidence rates** are from years 2011-2015 .

TOP CANCERS IN SAN DIEGO COUNTY

Cancer Incidence Rate by Site[5]

Site	Rate
Prostate (male)	94.5
Breast	67
Lung	42.4
Colorectal	33.8
Urinary	32.5
Melanoma Skin	26.3
Uterine (Corpus)	22.9
NHL**	18.8
Pancreatic	11.4
Liver & IBD*	9.6

Cancer Mortality Rates by Site[6]

Site	Rate
Lung	31.2
Prostate (male)	21.8
Colorectal	13.1
Breast	11.1
Pancreatic	10.5
Urinary	8.2
Liver & IBD*	7.6
NHL**	5.2
Melanoma Skin	2.8
Uterine (Corpus)	1.9
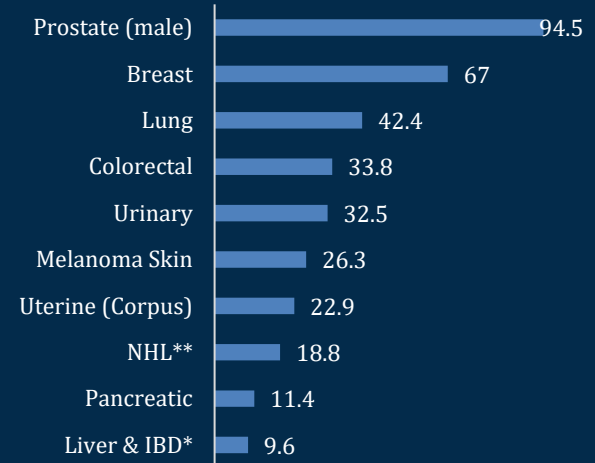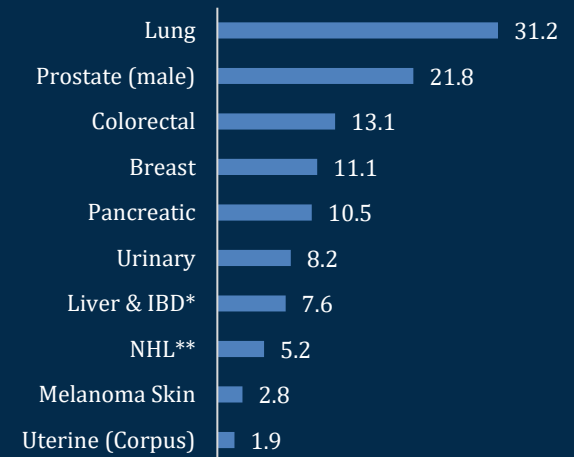
*Inflammatory Bowel Disease
**Non-Hodgkin Lymphoma

San Diego County Disparities

Incidence[5] (2012-2016)

The following table shows age-adjusted *incidence* rates per 100,000 for the top cancers in San Diego County, by race. Of note:

- Blacks have the highest rates of prostate, and colorectal cancer (followed closely by Whites).
- Hispanics have the highest rates of liver and intrahepatic bile duct cancer (followed closely by APIs) and pancreatic cancer (followed closely by Whites).

Site-Specific Cancer Age-Adjusted Incidence Rates in San Diego County by Race/Ethnicity (per 100,000)				
	White	Black	Hispanic	API
Prostate	95.5	123.1	94.7	49.2
Breast	72.3	57.5	56.3	55.8
Lung	47.2	46.8	27.5	35.9
Colorectal	34.1	36.9	33.2	28.2
Urinary	35.3	31.3	29.5	16.8
Melanoma Skin	37.9	**	5.1	1.5
Uterine	23.6	15.1	19.9	21.4
Non-Hodgkin Lymphoma	19.8	13.4	19.3	12.8
Pancreatic	11.7	10.1	12.2	8.9
Liver & IBD*	6.8	11.4	15.8	12.2

Mortality[6] (2012-2016)

The following table shows age adjusted *mortality* rates per 100,000 for the top cancers in San Diego County by race. Of note:

- Black individuals have the highest *mortality* rates from breast, lung, and colorectal cancer.
- Hispanics have the highest *mortality* rates from liver and intrahepatic bile duct cancers, followed by Asian Pacific Islanders.

Site-Specific Cancer Mortality Age-Adjusted Rates in San Diego County by Race/Ethnicity (per 100,000)				
	White	Black	Hispanic	API
Lung	34.6	39.3	18.6	26.7
Prostate	22.2	34.6	20.9	13.2
Colorectal	13.1	17.6	13.4	10.8
Breast	11.7	13.7	9.3	7.5
Pancreatic	10.8	10.1	10.4	8.5
Urinary	9.1	7.7	6.6	5.0
Liver & IBD*	5.6	8.3	12.0	10.9
Non-Hodgkin Lymphoma	5.3	4.9	4.9	4.6
Melanoma Skin	4	**	1.1	**
Uterine	1.8	**	2.0	**

*Inflammatory Bowel Disease
**Rates are too low to be statistically stable

CANCER MORTALITY BY REGION IN SAN DIEGO COUNTY
(per 100,000 population)

Cancer is the leading cause of death in San Diego County representing 24% of all underlying causes of death.[8]

Breast[7] (2016)

Female *mortality* rates were *highest* in La Mesa (62.9), Spring Valley (35.1), Santee (33.8) National City (33.3), and Elliott-Navajo (33.2) and *lowest* Vista (13.1), Sweetwater (16.3), Central San Diego (16.9), Southeastern San Diego (18.4), Chula Vista (18.5)

Lung[7] (2016)

Age-adjusted *mortality* rates were *highest* for Coronado (48.6), Lakeside (47.6), Pauma (46.8), Fallbrook (46.7), and Harbison Crest (42.9) and *lowest* for National City (11.5), San Dieguito (15.6), University (15.8), Coastal (19.5), and North San Diego (21.9)

Colorectal[7] (2016)

Age-adjusted *morality* rates were *highest* in Spring Valley (20.5), La Mesa (20.2), El Cajon (20.0), Vista (19.6), and Chula Vista (18.7) and *lowest* in San Dieguito (7.8), Poway (8.4), North San Diego (8.5), Peninsula (9.6), and Oceanside (10.1)

Liver[7] (2015)

Age-adjusted *mortality* rates were *highest* for National City (13.8), South Bay (13.7), Lemon Grove (13.6), Southeastern San Diego (12.0), and Oceanside (11.9) and *lowest* for Del Mar-Mira Mesa (3.2), North San Diego (4.7), Carlsbad (5.0), Coastal (5.2), Harvison Crest-El Cajon (5.4)

Prostate[7] (2016)

Male *mortality* rates were *highest* for Jamul (57.7), Valley Center (41.0), Spring Valley (39.9), Fallbrook (34.2), and Santee (32.6) and *lowest* for South Bay (9.9), Mid-City (10.5), Central San Diego (12.9), North San Diego (14.0), and Chula Vista (14.1)

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Cardiovascular Disease

More than one-third of the U.S. adult population has cardiovascular disease (CVD)[1]

Cardiovascular disease refers to a set of conditions related to the heart and blood vessels, including: heart disease, heart attack, stroke, heart failure, arrhythmia, and heart valve problems.[2]

Cardiovascular Disease in the U.S.

- 836,000 people die from CVD annually while the annual financial burden from direct and indirect costs was $329.7 billion annually.[1] (2015)
- By 2035, more than 130 million adults, or 45.1%, are projected to have CVD with total costs expected to reach $1.1 trillion.[5]
- 36.6% of adults have been diagnosed with a CVD.[1] (2011-2014)

Heart Disease

- The most common CVD is **heart disease**, which occurs in 10.6% of adults and is the leading cause of death accounting for more than 647,000 deaths annually.[3, 4] (2017)
    - **Coronary artery or coronary heart disease (CHD)** is the most common type of heart disease.[6]

Stroke

- **Stroke** affects 2.9% of the population and is the 5th leading cause of death, accounting for more than 146,000 deaths annually.[3, 4] (2017)

Reducing the Risk of CVD

Seven health factors and behaviors can reduce the risk of developing and dying from CVD:[7]
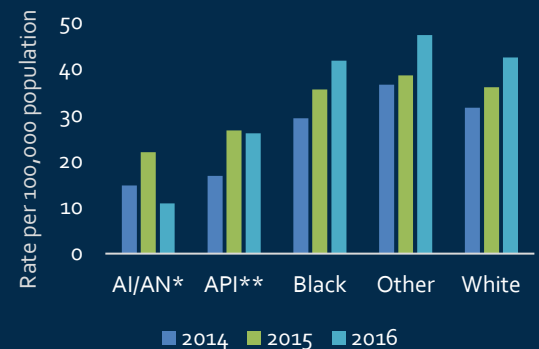
1. Not smoking
2. Being physically active
3. Having normal blood pressure
4. Maintaining normal blood glucose levels
5. Having low total cholesterol levels
6. Maintaining a healthy weight
7. Eating a healthy diet

- Adults who meet at least six of these criteria reduce their risk of death from CVD by 76% compared to those who meet none.[8]
- Only 8.8% of Americans meet at least six of these criteria.[8]

CORONARY HEART DISEASE & STROKE IN SAN DIEGO COUNTY[9]

Coronary Heart Disease (CHD)

Emergency department (ED) discharge rates for CHD increased by 35.3% from 2014-2016. The steepest increases were for those ages 45-64 (41.9%) and Asian/Pacific Islanders (55.1%).

ED Discharge Rates for Coronary Heart Disease by Race

Rate per 100,000 population

Categories: AI/AN*, API**, Black, Other, White
Legend: 2014, 2015, 2016

Stroke

ED discharge rates for stroke increased by 11% between 2014-2016. The steepest increases were for those ages 27-44 (20.1%) and for people who identify their races "Other" (28.9%).

ED Discharge Rates for Stroke by Race

Rate per 100,000 population

Categories: AI/AN*, API**, Black, Other, White
Legend: 2014, 2015, 2016
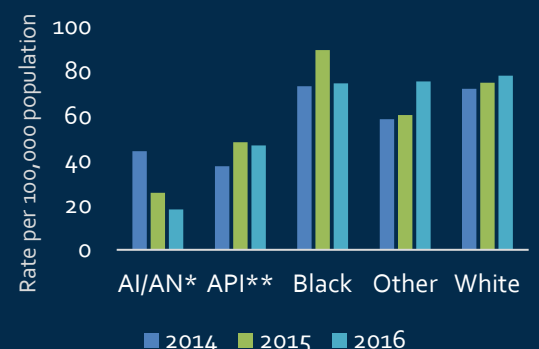
*American Indian / Alaskan Native / Eskimo / Aleut
**Asian Pacific Islander

CVD Disparities in the U.S.[4] (2017)

CVD is more common among males, older adults, some minorities, people with lower educational and income levels, and people living in the Midwest and the South.

By Sex

- Males are more likely to have heart disease (11.8%), coronary heart disease (7.2%), hypertension (26.0%), and stroke (3.3%) compared to females (9.5%, 4.2%, and 2.5% respectively).

By Age

- **CVD** is more common with age. The prevalence among those 75 and older is highest (35% for heart disease; 23.8% for CHD; 59.8% for hypertension, and 12.0% for stroke), followed by those 65-74 (23.1% for heart disease; 14.0% for CHD; 53.7% for hypertension; and 6.4% for stroke).

By Race

Compared to **stroke** and **heart disease**, racial disparities are largest for **hypertension** among adults:

- 32.1% of Black/African Americans
- 30.6% of American Indians or Alaska Natives
- 28.2% of individuals of 2 or more races
- 23.5% of Whites
- 22.1% of Asians
- 21.1% of Hispanics

By Educational Levels

- **CVD** rate is lower among people with a bachelor's degree or higher compared to people with some college, a high school diploma or GED, or less than a high school diploma. Hypertension rates again offer the largest comparative difference with 22.7% of people with a bachelor's degree or more having hypertension compared to 32.3% of people with less than a high school diploma.

By Income

- People who are living below the federal poverty level (FPL) guidelines have higher rates of **heart disease** (12.6%), **CHD** (8.0%), **hypertension** (29.4), and **stroke** (5.8%) compared to those with an income above the FPL (10.3%, 5.0%, 22.9%, and 2.2% respectively).

By Region

- The largest regional disparities are for **hypertension**: 26.8% of people living in the South and 25.9% of people living in the Midwest have hypertension, compared to 22.1% of people living in the West, and 21.3% of people living in the Northeast.

CHD & STROKE MORTALITY IN SAN DIEGO COUNTY[10]

Mortality Rates for CHD (2016)

Mortality **(death)** rates for CHD were higher for males (102.5 per 100,000) compared to females (75.0), and for people 65+ (559.3) compared to those ages 45-64 (59.5).

The overall mortality rate attributed to **CHD** decreased by 3.5% from 2014-2016. However, Black (8.7%) and American Indian/Alaska Native (29.4%) individuals experienced an increase in rates.

Mortality Rates for Coronary Heart Disease by Race/Ethnicity
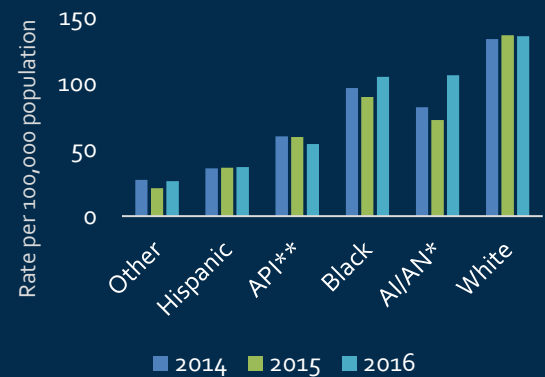
Mortality Rates for Stroke (2016)

Mortality rates for **stroke** are higher for females (47.9 per 100,000) compared to males (35.0) and for people 65 years and

Mortality Rates for Stroke by Race/Ethnicity

*American Indian / Alaskan Native / Eskimo / Aleut
**Asian Pacific Islander

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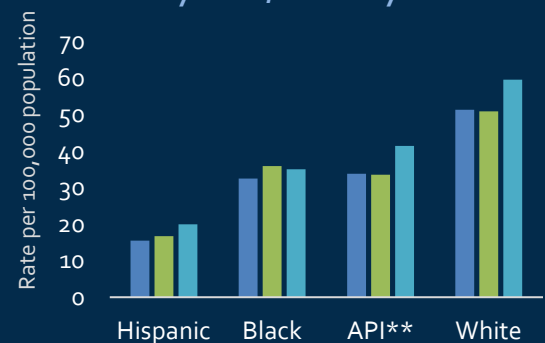3. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Leading Causes of Death, WISQARS Fatal Injury Data. https://webappa.cdc.gov/sasweb/ncipc/leadcause.html. Updated January 18, 2019. Accessed on March 28, 2019.
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Diabetes Mellitus

More than 30 million Americans suffer from this chronic disease[1]

Diabetes is a set of diseases that affect the way the body metabolizes sugar (glucose). The three primary types of diabetes are: **Type 2** (the most common type), **Type 1**, and **gestational** (occurring during pregnancy).

Diabetes has a significant impact on morbidity and mortality[1] and has an economic burden of approximately $245 billion in the United States. [2]

Diabetes in the U.S.
- Approximately 9.7% of adults have a diabetes diagnosis.[3] (2016-2017)
- Among those with diabetes, 91.2% have **type 2** diabetes and 5.6% have **type 1**.[3] (2016-2017)
- 132,000 youth younger than 18 years old have diabetes.[1] (2013-2015)
- **Type 2** diabetes is more common among adults 65+, males, those with higher body mass index, Asian-Americans, those with lower family incomes, and lower educational levels.[3] (2016-2017)
- The age adjusted *death rate* for diabetes in the U.S. is 21.5 per 100, 000.[5] (2016)
- Diabetes is the 7th leading cause of *mortality* in the U.S., and the 5th leading cause of death for those 55-64 years old.[4] (2017)
- The number of adults diagnosed with diabetes in the U.S. has more than tripled in the last 20 years.[6] (2017)

Risk Factors
According to the CDC, the following are risk factors for developing diabetes:[1]
- Being overweight or obese
- Smoking
- Having a parent, brother, or sister with diabetes
- Having high blood pressure measuring 140/90 or higher, high cholesterol, and high blood glucose
- Being physically inactive-exercising fewer than three times a week

DIABETES IN SAN DIEGO COUNTY

9.4% of adults have diabetes; lower than the state rate of 10.7%[7] (2017)

Mortality
- In 2017, diabetes was the 7th leading cause of death in San Diego County.[8]
- The age-adjusted *death rate* for diabetes was 20.7 per 100,000 population.[9] (2016)
- American Indian and Alaska Natives have the highest diabetes *death rate*, 63.8 compared to the unadjusted county rate of 22.3 per 100,000.[9] (2016)

Mortality Rate for Diabetes by Race/Ethnicity, 2016

Rate per 100,000 population

White	Black	Hispanic	API*	AIAN**	Other
22.7	37.0	19.6	24.0	63.8	6.6
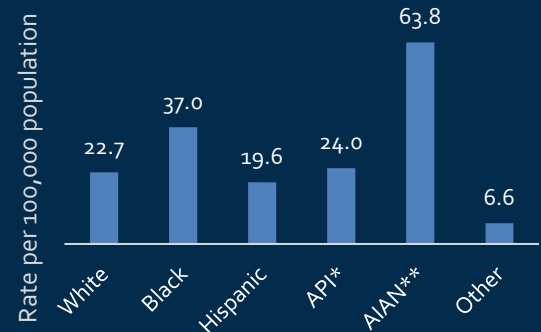
Opportunities for Prevention:[11]
- 97% of the population lives in close proximity to a park or recreational facility, an indicator of strong "exercise opportunities".
- San Diego receives an 8.3/10 on the "Food Environment Index (2015/2016)," a measure of affordable, close, and nutritious food retailers. This exceeds the national benchmark of 7.4.

*Asian Pacific Islander
**American Indian / Alaskan Native / Eskimo / Aleut

Diabetes in San Diego: Disparities and Risk

Disparities in Diabetes

Emergency department (ED) discharge rates for **diabetes** remained fairly stable from 2014-2016, but disparities are apparent:[10]

- *ED discharge* rates are highest for those 65 and older and for Black individuals
- Increases in discharge rates occurred for those 27-44 years old and for Asian/Pacific Islander and Blacks

Inpatient discharges for **gestational diabetes** are decreasing, but disparities are evident here as well:[10]

- Asian/Pacific Islanders and those who identify their race as "Other" are disproportionally impacted by gestational diabetes

Most San Diegans manage their diabetes well, but disparities are also seen in these data:[12] (2015)

- 81.2% of Medicare patients with diabetes have had a hemoglobin A1c blood sugar test by a health care professional in the past year
- This rate is 5.2% lower for Black individuals than for White individuals

Risk Factors for Diabetes in San Diego County

Relative to state averages, San Diego has a lower proportion of people with risk factors for diabetes.[7] (2017)

- While 22.5% of adults in San Diego are **obese,** this is lower than the California rate of 26.4%.
- San Diego children (5-11 years old) have higher rates of at least one hour a day of **physical activity,** each day of the week (33.6%) than the California average (31.2%).
- Among adults in San Diego, 20.4% have at least 20 minutes of **physical activity** each day of the week, similar to the state average of 20.%.
- Rates of **smoking** (10.2%) are the same in San Diego and across California.

HOSPITAL DISCHARGES FOR DIABETES IN SAN DIEGO COUNTY[10]

ED Discharge Rates for Diabetes by Race

Rates per 100,000 population

API* · AI/AN** · White · Other Race · Black

2014 · 2015 · 2016

ED Discharge Rates for Diabetes by Age

Rate per 100,000 population

0-10 · 11-17 · 18-26 · 27-44 · 45-64 · 65+

Age groups

2014 · 2015 · 2016
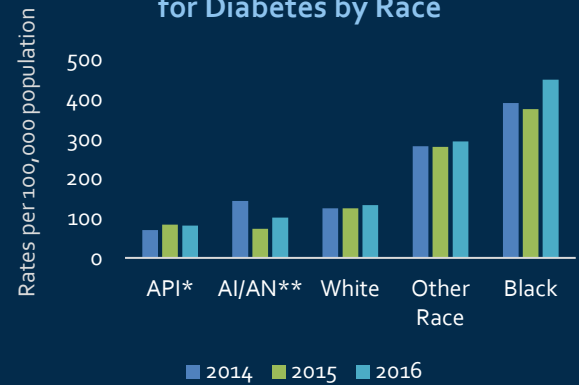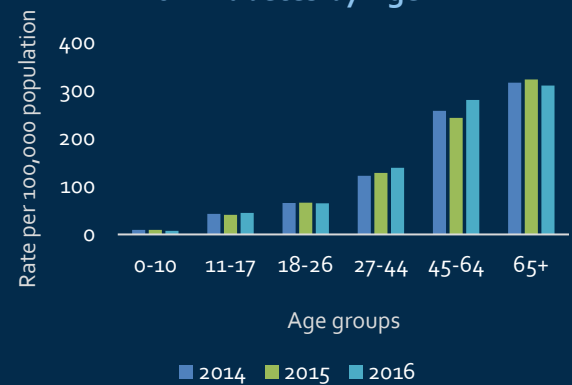
Inpatient Discharge Rates for Gestational Diabetes

Rate per 100,000 popoulation

White · Black · API* · Other

2014 · 2015 · 2016
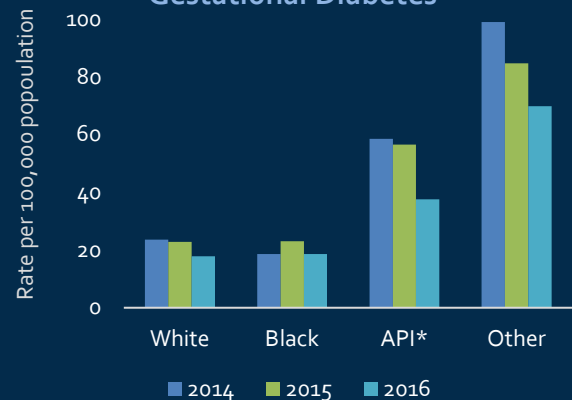
*Asian Pacific Islander
**American Indian / Alaskan Native / Eskimo / Aleut

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Economic Security[1]

39.7 million people in the U.S. live in poverty (2017)

Federal poverty level (FPL) is a measure of income that varies according to the size of a family and are updated each year. For 2019, the poverty guidelines range up to $12, 490 for a 1-person household, to $25, 750 for a 4-person household, and up to $43, 430 for an 8-person household.[2]

Poverty in the U.S.[1] (2017)

- The U.S. poverty rate in 2017 was 12.3%.

By Age

Poverty rates are highest for the youngest individuals:

- 17.5% for those under 18
- 11.2% for those 18-64
- 9.2% for those 65 and older

By Race

Poverty rates are highest for Black and Hispanic individuals:

- 21.2% for Black individuals
- 18.3% for Hispanic individuals
- 10.7% for White individuals
- 10.0% for Asian individuals

By Region

People in the Southern U.S. have the highest poverty rates:

- 13.6% in the South
- 11.8% in the West
- 11.4% in the Midwest
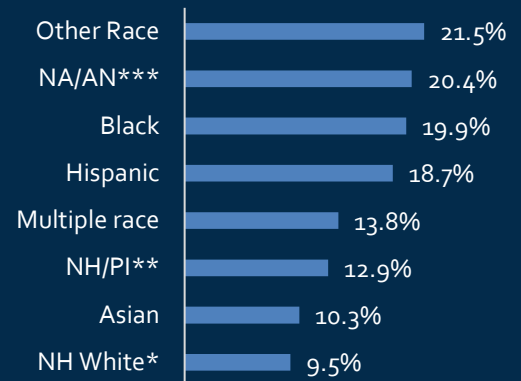- 11.4% in the Northeast

By Educational Attainment

Among people 25 years old and older, less education is associated with higher poverty rates:

- 24.5% for those with no high school diploma
- 12.7% for those with a high school diploma, but no college
- 8.8% for those with some college, but no degree
- 4.8% for those with a Bachelor's degree or higher

POVERTY
IN SAN DIEGO COUNTY

In San Diego, residents belonging to minority ethnic groups are disproportionately affected by poverty.[3]

Population Below Poverty Level in San Diego County[3], 2013-2017

Race	%
Other Race	21.5%
NA/AN***	20.4%
Black	19.9%
Hispanic	18.7%
Multiple race	13.8%
NH/PI**	12.9%
Asian	10.3%
NH White*	9.5%

*non-Hispanic White, **Native Hawaiian & Pacific Islander, ***Native American & Alaskan Native

San Diegans are struggling:

- In 2017, 13.3% lived below the federal poverty guidelines, which is a decrease since 2013. [3] (5 year estimates compared)

- The per capita income is $34,350.[3] (2013-2017)

- 17.1% of all children live below the federal poverty level.[3] (2013-2017)

- 33% of working age families can not cover their basic expenses.[4] (2015)

Unemployment in San Diego County

In 2018, the overall unemployment rate in San Diego is 3.3%, which is a 48% decrease since 2014 (6.4%).[5]

Food insecurity in the U.S.[6]

40 million Americans do not have enough to eat

Food-insecure households face challenges providing enough food for all members of the household to have an active, healthy life. Households with **very low food security** are those in which the food intake of at least one member is reduced and normal eating patterns are disrupted due to limited resources.

Food Insecure Households in the U.S. (2017)

- 11.8% of households – nearly 1 in 8 - are *food insecure*
- 4.5% of households have *very low food security*

By Household Composition

Food insecurity is highest for households with young children:

- 15.7% of households with children
- 16.4% of household with children less than six years old
- 13.9% of adult women who live alone
- 13.4% of men who live alone
- 8.6% of seniors who live alone
- 7.7% of households with no children and more than one adult

By Race/Ethnicity

Minority households have higher rates of food insecurity:

- 21.8% of Black households
- 18% of Hispanic households
- 9.9% of households who identify as "other"
- 8.8% of White households

By Region

People living in the Southern regions of the US have the highest rates of food insecurity:

- 13.4% of households in the South
- 11.7% of households in the Midwest
- 10.7% of households in the West
- 9.9% of households in the Northeast

ECONOMIC INSECURITY IN SAN DIEGO COUNTY

Housing (2013-2017)

- The median gross rent was $1, 467 per month[3]
- 46.7% of San Diegans who rent their homes spend 35% or more of their household income on rent[3]

Childcare (2016)

- The average monthly cost of childcare in San Diego in 2016 was between $620 and $1,293[8]

Food insecurity

- 14% of people experience food insecurity, more than 1 in 7[7] (2016)
- 22% of children are in food insecure households, more than 1 in 5[7] (2016)
- 7.2% of San Diegans receive Supplemental Nutrition Assistance Program (SNAP) Benefits[3] (2013-2017)

Health impacts of food insecurity

Lower incomes are associated with:[9]

- Poor mental health days
- Visits to the ED for heart attacks
- Asthma
- Obesity
- Diabetes
- Stroke
- Cancer
- Smoking
- Pedestrian Injury

Food insecurity is linked to:[10]

- Fair or poor health, anemia, and asthma in *children*
- Mental health problems, diabetes, hypertension, hyperlipidemia, and oral health problems in *adults*
- Fair or poor health, depression, and limitations in activities of daily living in *seniors*

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Homelessness & Housing Instability

553,000 people in the U.S. are homeless[1], 1.3 million people live in severely inadequate housing[2], and 8.3 million households have "worst case housing needs"[4]

Homelessness is when a person does not have a fixed, regular, and adequate nighttime residence.[1] **Housing problems** include a lack of full kitchen or plumbing facilities, a household comprised of more than one person per room, or a housing cost burden of more than 30% of the household income. **Severe housing problems** include a lack of full kitchen or plumbing facilities, severe overcrowding, or a housing cost burden of [4] Health outcomes are strongly influenced by the stability, quality, safety and affordability of housing.[5]

Homelessness in the U.S.[1,*] (2018)
From 2010-2018, rates of homelessness fell by 13.2% nationwide.

By Sex
- 60.2% of the nation's homeless population are male; 39.1% are female; 0.5% are transgender, and 0.2% are gender non-conforming

By Age
- A fifth (20.2%) of the homeless population is comprised of children, while 8.7% are 18-24, and 71.1% are over 24

By Race/Ethnicity

Race	%
White	48.9%
Black	39.8%
Multiple races	5.9%
Native American	2.8%
Pacific Islander	1.5%
Asian	1.2%

Ethnicity	%
Hispanic/Latino	22.2%

By Sheltered Status
- 65% of people who experience homelessness stay in sheltered locations, while 35% are unsheltered

In California (2018)
- California has the highest rates of unsheltered homeless (68.9% of the homeless population) and the largest number of homeless unaccompanied youth (12,396)

*Data is from the Point-in-Time Count that takes place one morning in late January where volunteers and outreach workers engage and survey those experiencing homelessness.

HOMELESSNESS IN SAN DIEGO COUNTY, POINT-IN-TIME COUNT[6]

8,576 individuals are homeless in San Diego on any given night (2018)
- The number of homeless decreased by 6% between 2017-2018 and 3.4% since 2013

Sheltered and unsheltered (2018)
- 3,586 (41.8%) are sheltered, and 4,990 (58.2%) are unsheltered
- 54.3% of **sheltered** homeless individuals are sheltered in an emergency shelter; 43.9% are in transitional housing; 1.8% are in a safe haven
- 50% of **unsheltered** homeless sleep on the street/sidewalk; 18% sleep in a vehicle; 14% sleep in a park; 5% sleep in a hand-built structure or tent

Health conditions among unsheltered
- 43% report having a chronic health condition
- 43% report instances of mental health issues
- 43% report having a physical disability

Length of time among unsheltered
- More than half of those who become homeless remain homeless for longer than one year

Demographics among unsheltered respondents
- 70% have been in jail, prison, or juvenile hall
- 13.3% are veterans
- 13.2% are youth under the age of 24

The American Hospital Association describes housing instability as an umbrella term for the continuum between homelessness and completely stable, secure housing.

Housing instability takes on many forms: physical conditions like poor sanitation, heating and cooling; compromised structural integrity; exposure to allergens or pests; homelessness; and unstable access to housing or severe rent burden.[8]

Severely Inadequate Housing In the U.S.[2] (2017)

1,348,000 households have *severely inadequate housing* conditions; an additional 4,648,000 households have *moderately inadequate* conditions

- 3,267,000 have exposed wiring
- 938,000 have inadequate heating capacity
- 3,602,000 have had water stoppages in the last three months
- 1,391,000 have had sewage disposal breakdowns in the last three months
- 3,775,000 have mold

Worst Case Housing Needs[4] (2015)

The number of households that have *worst case needs* has increased by 41% since 2007

- 98.2% of *worst case needs* renters have severe rent burdens, paying one half or more of their income for rent.

By Race/Ethnicity

Among all renters, the percent who have *worse case housing* needs:

- 45.5% of non-Hispanic Whites
- 25.3% of Hispanics
- 21.7% of non-Hispanic Blacks
- 7.5% of renters of other races and ethnicities

By Household Composition

Among the households with *worst case needs*:

- 34.8% are families with children
- 33.2% are single adults with roommates
- 22.3% are elderly households
- 9.7% are "other family" households

Health Impacts[5]

- People who are *chronically homeless* have higher rates of physical and mental health problems, higher health care expenditures, and higher rates of premature mortality
- People who are *unstably housed* (who move frequently, fall behind on rent and/or "couch surf") are more likely to experience poor health. Among youth, *housing instability* is associated with a higher risk of teen pregnancy, substance abuse, and depression
- *Homelessness and residential instability* make the proper storage of medications challenging or impossible, impacting the management of illness and chronic disease
- *Substandard housing conditions* are linked to poor health outcomes, including asthma and cardiovascular events
- *Crowded housing* is associated with infections disease and psychological distress
- *Cost burdened households* are less likely to have a primary care provider and to postpone needed medical treatment
- *Cost burdened households* are also more likely to face food insecurity

HOUSING INSTABILITY IN SAN DIEGO COUNTY

Rental and owner-occupied units

- The median gross rent is $1, 467 per month[7] (2013-2017)
- The median value of owner-occupied housing units is $484,900[7] (2013-2017)
- 52.9% of households are owned, while 47.1% are rented[3] (2011-2015)
- 8.3% of households that are owned have an income of less than 30% of the average median family income, while 33.7% of households that are rented have incomes of that level[3] (2011-2015)

Cost burden[3] (2011-2015)

- 42.7% of San Diegans have *cost burdened housing*—spending more than 30% of their income on housing
- 20.0% of San Diegans have *severely cost burdened* housing—spending more than 50% of their income on housing
- The lowest-income families have the highest rates of severely cost burdened housing—47.4% of families with incomes 30% or less of the median family income in the County are severely cost burdened

Housing problems[3] (2011-2015)

- 46.0% of San Diegans have housing problems: their household lacks full kitchen or plumbing facilities, has more than 1 person per room, or is cost burdened
- 25.2% of San Diegans have severe housing problems: their household lacks full kitchen or plumbing facilities, is severely overcrowded (more than 2 people per room), or is severely cost burdened

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Unintentional Injury and Violence in the U.S.:

More than 243,000 people died from injury and violence in 2017[4]

In the first half of life (44 years), more Americans die from violence and injuries than from any other cause. In addition, for every person who dies from injury or violence, another 13 are hospitalized and 129 are treated in an emergency room. Those who survive may be faced with life-long mental, physical, and financial problems.[1]

Unintentional Injuries in the U.S. (2017)

- Unintentional injury is the third leading cause of death in the U.S. overall and is the first leading cause of death among persons 1-44.[2,3]
- Unintentional Injury accounts for 93.2% nonfatal injuries and 69.9% fatal injuries.[4]

By Sex:

Unintentional injuries are more common among males:
- Males are 2.1 times more likely die from an unintentional injury than females (67.7 vs 31.9 per 100,000)[4]
- Males are 1.2 times more likely to be involved in a non-fatal unintentional injury than female[5]

By Age:

Older people (65+ years) have the highest mortality rate from unintentional injury:[4]
- 374.9 per 100,000 among people 85+
- 152.4 per 100,000 among people 80-84
- 86.6 per 100,000 among people 75-79

Older people also have the highest nonfatal unintentional injury rate:[5]
- 19,833.3 per 100,000 among people 85+
- 12,656.8 per 100,000 among people 80-84
- 10,883.7 per 100,000 among people 20-24

By Race and Ethnicity:

Native Americans have the highest fatality from unintentional injury:[4]
- 86.4 per 100,000 for Non-Hispanic Native American
- 56.1 per 100,000 for Non-Hispanic White
- 47.4 per 100,000 for Non-Hispanic Black

UNINTENTIONAL INJURY IN SAN DIEGO COUNTY[6] (2016)

San Diegan males are:
- 2.2 times more likely to die from an unintentional injury than female (48.2 vs 21.9 per 100,000).
- 1.3 times more likely to be hospitalized from an unintentional injury than female (1177 vs 891 per 100,000).

Inpatient Discharge Rates by Sex, 2016
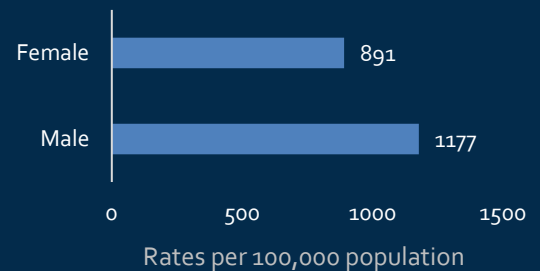
Rates per 100,000 population

Emergency Department Discharge Rates by Sex, 2016

Rates per 100,000 population

*Per the Healthy People 2020, "**unintentional injuries and violence-related injuries** can be caused by a number of events, such as motor vehicle crashes and physical assault, and can occur virtually anywhere."[7]*

***Unintentional injuries** include motor vehicle accidents, falls, firearms, fire/flame, drowning, poisoning, machinery, suffocation, etc.[4]*

Unintentional Injury in Youth (under 18 years) in the U.S.[4] (2017)

More than 5,700 youth died from an unintentional injury in 2017 (7.7 per 100,000)

By Type of Injury:

- 39.7% are due to motor vehicle
- 22.9% due to suffocation
- 14.2% due to drowning

By Race/Ethnicity

- 16.8 per 100,000 for Non-Hispanic Native American
- 12.5 per 100,000 for Non-Hispanic Blacks
- 7.7 per 100,000 for Non-Hispanic White
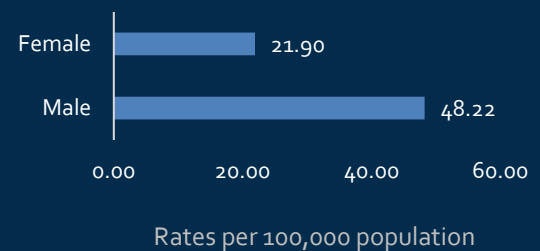
Unintentional Injury in San Diego County

By Age:

- **Older San Diegans** 65 years and older have the highest death and emergency department (ED) discharge rate from unintentional injury. (97.1 and 7,698 respectively).[6]
- **Youth aged 0-14** are impacted by ED discharges for unintentional injury with a rate of 6,781 per 100,000.[6]
- The leading causes of ED discharge for an unintentional injury in 2018 (**1-14 years**):[8]
  1. 18,072 falls
  2. 8,029 struck by object
  3. 1,999 natural/environmental
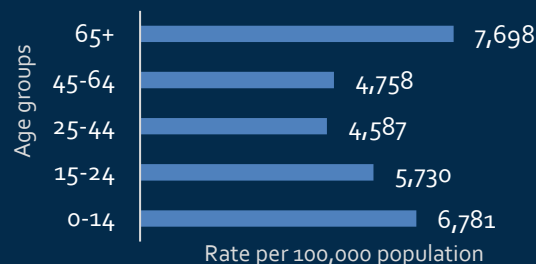 4. 2,452 motor vehicle
  5. 1,318 cut/pierce

By Race and Ethnicity:[6]

In San Diego, residents belonging to minority groups are disproportionately affected by unintentional injury.
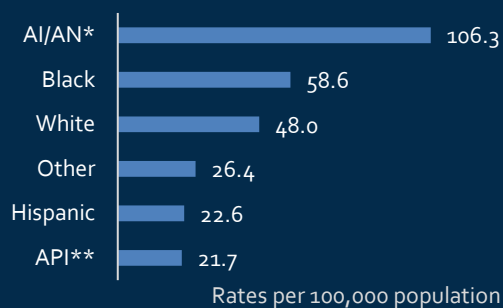
- Those who identify as "Other" have the highest ED discharge rate (12,151 per 100,000) followed by Blacks (8,792 per 100,000) and Whites (5,583 per 100,000).
- Black individuals have the second highest mortality and ED discharge rate compared to all other race/ethnicities (58.6 and. 8,792 per 100,000).
- American Indian and Alaska Natives have the highest mortality rates for unintentional injury, however they have the second lowest ED discharge rate (106.3 and 3,705 per 100,000 respectively)

UNINTENTIONAL INJURY IN SAN DIEGO COUNTY[6] (2016)

ED Discharge Rates for Unintentional Injury by Age Groups, 2016

Age groups	Rate per 100,000 population
65+	7,698
45-64	4,758
25-44	4,587
15-24	5,730
0-14	6,781

Mortality Rates for Unintentional Injury by Race/Ethnicity, 2016

	Rates per 100,000 population
AI/AN*	106.3
Black	58.6
White	48.0
Other	26.4
Hispanic	22.6
API**	21.7

ED Discharge Rates for Unintentional Injury by Race/Ethnicity, 2016

	Rates per 100,000 population
Other	12,151
Black	8,792
White	5,583
Hispanic	5,465
AIAN*	3,705
API**	2,410
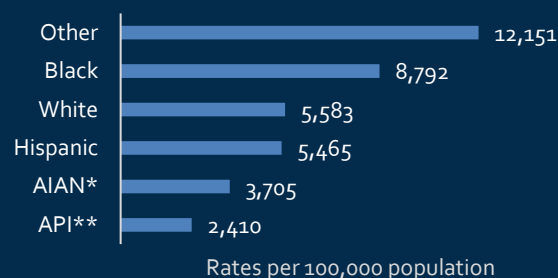
*American Indian & Alaska Native
**Asian & Pacific Islander

Motor Vehicle Injuries

More than 37,000 people died from motor vehicle injuries in 2017 in the U.S.[9]

The total estimated lifetime medical and work-loss cost associated with motor vehicle injuries in the U.S.is more than $63 billion.[12]

Motor Vehicle Injuries in the U.S.[9] (2017)

- More than 2.7 million people were seen in the ED due to motor vehicle-related injuries in 2017.
- In 2017, the fatality rate was 11.4 per 100,000, while the injury rate was 843 per 100,000 population.
- Among all fatalities, 29.3% were due to drunk driving (Blood alcohol concentration (BAC) of 0.08 g/dL or higher) while 26.2% were due to speeding.
- More than two-thirds (70.2%) of the pedestrians killed in traffic crashes were males.
- Pedestrians 75 and older have the highest fatality rate (2.7 per 100,000) while pedestrians ages 16-20 have the highest injury rate (37.6 per 100,000).

By Sex
- Males account for 71.1% of all fatalities due to motor vehicle injuries.

By Age
Drivers 15-20 (younger) and 65+ (older) are mostly impacted:
- Although *younger drivers* account for 5.4% of total licensed drivers, they are involved in 8.4% of fatal crashes.
- Among *younger drivers*, the rate of fatal crashes for males was 2.3 times greater than that of female drivers.
- *Younger drivers* were speeding or driving drunk at the time of fatal crashes more than all other age groups.
- Among *older drivers*, the rate of fatal crashes with male drivers was 2.6 times greater than that of female drivers.
- Among *older drivers*, the rate of involvement in fatal crashes increases as age increases.

By Race/Ethnicity
- American Indian/Alaska native (AI/AN) adults are 1.5 times more likely to die in a crash than White or Black adults.

MOTOR VEHICLE INJURIES IN SAN DIEGO COUNTY[6] (2016)

In San Diego, males experience more injuries related to motor vehicles than females:

Mortality Rates for Motor Vehicle Injury by Sex, 2016

Female	4.2
Male	10.0

Age-adjusted rate per 100,000 population
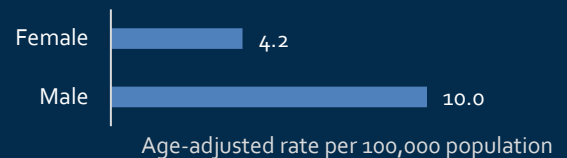
Motor vehicle injury mortality (death) rate per 100,000 among San Diego residents:

- Individuals who identify as **AI/AN** have the highest death rate (35.4), followed by **Black** individuals (11.5).
- Those **65+** have the highest death rate (12.3), followed by those 15-24 (8.8).

Motor vehicle injury inpatient discharge rate per 100,000 among San Diego residents:

- **Blacks** have the highest inpatient discharge rate (132.5), followed by American Indian & Alaska Native (92.1).
- Those **15-24** have the highest inpatient discharge rate (105.1), followed by those 65+ (99.2).

Mortality Rates for Pedestrian Death Due to Motor Vehicle Injuries by Age, 2016

Age groups	
65+	4.9
45-64	2.7
25-44	1.7
15-24	1.0

Rate per 100,000 population
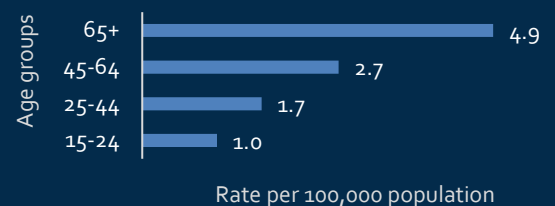
Crime in the U.S.

Property crime is currently the biggest criminal issue

In 2017, the estimated number of violent crime offenses was 1,247,321, a decrease of 0.2 percent from the 2016 estimate. [10]

Violent Crimes in the U.S.[11] (2017)

- Aggravated assault accounted for 65% of reported violent crimes, followed by robbery (25.6%), rape (8.0%), and murder (1.4%).

- Firearms were used in 72.6% of the nation's murders, 40.6% robberies, and 26.3% of aggravated assaults.

Homicide:

Both murder victims and offenders were more likely to be:
- Black (victims: 53.7%) (offenders: 54.2%)
- Male (victims: 78.6%) (offenders: 88.1%)
- 20-29 years old (victims: 32.6%) (offenders: 39.9%)

Property Crimes in the U.S.[11] (2017)

- In 2017, the rate of property crime was 2362.2 per 100,000, a 3.6% decrease from 2016.

- Losses were estimated at $15.3 billion in 2017 with only 29.2% of stolen properties recovered.

- Larceny-theft accounted for 71.7% of all property crimes, followed by burglary (18.2%), and motor vehicle theft (10.0%).
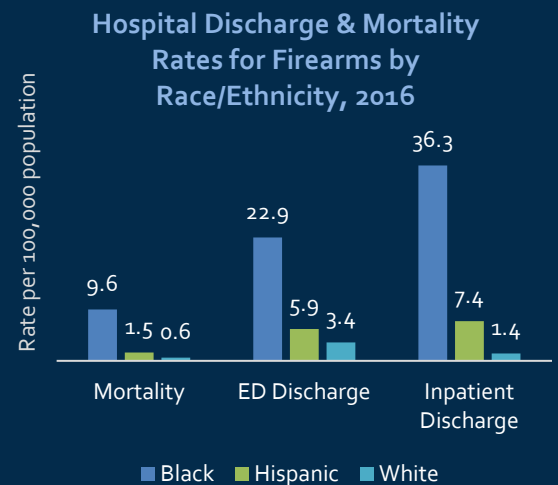
VIOLENT CRIMES IN SAN DIEGO COUNTY[6] (2016)

In San Diego, crime rates have increased slightly since 2014:[13]

For crimes involving assault:[6]

- **Males** are 3.2 times more likely to die and 4.9 more likely to be hospitalized than females.
- **Blacks** have the highest death (17.2 per 100,000), ED discharge (700.3 per 100,000), and inpatient discharge rates (109.0 per 100,000)..
- Those **15-24** have the highest death (4.6 per 100,000), and hospital discharge rates (**ED**: 416.8 per 100,000, **inpatient**: 47.2 per 100,000).

For crimes involving a firearm:[6]

- **Males** are 3.5 times more likely to die and 9.3 times more likely to be hospitalized than females.
- **Blacks** are 16.2 times more likely to die and 26.3 times more likely to be hospitalized than Whites.
- Those **15-24** have the highest death (2.9 per 100,000) and hospital discharge rates (**ED**: 13.4 per 100,000, **inpatient**: 10.2 per 100,000).

Hospital Discharge & Mortality Rates for Firearms by Race/Ethnicity, 2016

Rate per 100,000 population

	Mortality	ED Discharge	Inpatient Discharge
Black	9.6	22.9	36.3
Hispanic	1.5	5.9	7.4
White	0.6	3.4	1.4

■ Black ■ Hispanic ■ White

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APPENDICES

APPENDICES

The following terms are used throughout the Community Health Needs Assessment report. They represent concepts that are important to understanding the findings and analysis in this report.

Age-adjusted rate. The incidence or mortality rate of a disease can depend on the age distribution of a community. Because chronic diseases and some cancers affect older adults disproportionately, a community with a higher number of older adults might have a higher mortality or incidence rate of some diseases than another community that may have a higher number of younger people. An incidence or mortality rate that is **age-adjusted** takes into the consideration of the proportions of persons in corresponding age groups, which allows for more meaningful comparison between communities with different age distributions.

Benchmarks. A benchmark serves as a standard by which a community can determine how well or not well it is doing in comparison for specific health outcomes. For the purpose of this report, one of two benchmarks is used to make comparison with the medical center area. They are Healthy People 2020 objectives and state (California) averages.

Death rate. See *Mortality rate.*

Disease burden. Disease burden refers to the impact of a health issue not only on the health of the individuals affected by it, but also the financial cost in addressing this health issue, such as public expenditures in addressing a health issue. The burden of disease can also refer to the disproportionate impact of a disease on certain populations, which may negatively affect their quality of life and socioeconomic status.

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

Health disparity. Diseases and health problems do not affect all populations in the same way. Health disparity refers to the disproportionate impact of a disease or a health problem on specific populations. Much of research literature on health disparity focuses on racial and ethnic differences in how these communities experience the diseases, but health disparity can be correlated with gender, age, and other factors, such as veteran, disability, and housing status.

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

Health outcome. A health outcome is a snapshot of a disease in a community that can be described in terms of both morbidity and mortality (e.g. breast cancer prevalence, lung cancer mortality, homicide rate, etc.).

Health need. A health need is a poor health outcome and its associated social determinant of health or a social determinant of health associated with a poor health outcome where the outcome itself has not yet arisen as a need.

Hospitalization rate. Hospitalization rate refers to the number of patients being admitted to a hospital and discharged for a disease, as a proportion of total population.

Incidence rate. Incidence rate is the number of *new* cases for a specific disease or health problem within a given time period. It is expressed either as a fraction (e.g. percentage) or a density rate (e.g., *x*

number of cases per 10,000 people), in order to allow for comparison between different communities. It should not be confused with *prevalence rate*, which measures the proportion of people found to have a specific disease or health problem.

Morbidity rate. Morbidity rate refers to the frequency with which a disease appears within a population. It is often expressed as a *prevalence rate* or *incidence rate.*

Mortality rate. Mortality rate refers to the number of deaths in a population due to a disease. It is usually expressed as a density rate (e.g. *x* number of cases per 10,000 people). It is also referred to as "death rate."

Prevalence rate. Prevalence rate is the proportion of total population that currently has a given disease or health problem. It is expressed either as a fraction (e.g. percentage) or a density rate (e.g., *x* number of cases per 10,000 people), in order to allow for comparison between different communities. It should not be confused with incidence rate, which focuses only on *new* cases. For instance, a community may experience a decrease in new cases of a certain disease (incidence) but an increase in the total of number suffering that disease (prevalence) because people are living longer due to better screening or treatment for that disease.

Qualitative data. Qualitative data is descriptive information (it describes something).

Quantitative data. Quantitative data is numerical information.

Sexual and gender minorities. According to the National Institutes of Health, " 'Sexual and gender minority' is an umbrella term that encompasses lesbian, gay, two-spirit, bisexual, and transgender populations as well as those whose sexual orientation, gender identity and expressions, or reproductive development varies from traditional, societal, cultural, or physiological norms. This includes individuals with disorders or differences of sex development (DSD), sometimes known as intersex." [21]

Social Determinants of Health. Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

TAY. "TAY typically refers to the span from older adolescence (e.g., 15–16 years of age) to young adulthood (24–26 years). TAY are navigating the potentially perilous developmental years of growing out of childhood and into adulthood— a time of facing more adult-like challenges without having yet mastered the tools and cognitive maturity of adulthood. Some critical developmental steps occur during the transitional years, reflecting changing neurobiology, the tasks of separation and individuation, and the influences of pre-existing and concurrent mental health and substance use issues.[22]

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[22] Journal of the American Academy of Child and Adolescent Psychiatry. Accessed June 7, 2019.
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ACA	Affordable Care Act
ACS	American Community Survey
ADOD	Alzheimer's Disease or Other Dementia
AIDS	Acquired Immune Deficiency Syndrome
BMI	Body Mass Index
BRFSS	Behavioral Risk Factor Surveillance System
CA	California
CAC	Community Action Council
CAP	Community Action Partnership
CDC	Centers For Disease Control and Prevention
CHC	Charitable Health Coverage
CHIS	California Health Interview Survey
CHNA	Community Health Needs Assessment
CNI	Community Need Index
COI	Childhood Obesity Initiative
CUPID	California Universal Patient Information Discovery
CVD	Cardiovascular Disease
ED	Emergency Department
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
GIS	Geographic Information System
HASD&IC	Hospital Association of San Diego and Imperial Counties
HEAL	Healthy Eating Active Living
HHSA	Health & Human Services Agency
HIV	Human Immunodeficiency Virus
HP 2020	Healthy People 2020
HPSA	Health Professional Shortage Area

ICD	International Classification of Diseases
IPH	Institute for Public Health
IS	Implementation Strategy
KI	Key Informant
KP	Kaiser Permanente
LGBTQ	Lesbian, Gay, Bisexual, Transgender, Queer
MFA	Medical Financial Assistance
NCHS	National Center for Health Statistics
NHIS	National Health Interview Survey
NIH	National Institutes of Health
NSDUH	National Survey on Drug Use and Health
OSHPD	Office of Statewide Health Planning and Development
PCP	Primary Care Provider
PE	Physical Education
RLA	Resident Leadership Academy
SAMHSA	Substance Abuse and Mental Health Services Administration
SDSU	San Diego State University
SNAP	Supplemental Nutrition Assistance Program
SMI	Serious Mental Illness
STD	Sexually Transmitted Disease
TAY	Transitional Age Youth
U.S.	United States

SECONDARY SOURCES FROM THE KP CHNA DATA PLATFORM

	Source	Dates
1.	American Community Survey	2012-2016
2.	American Housing Survey	2011-2013
3.	Area Health Resource File	2006-2016
4.	Behavioral Risk Factor Surveillance System	2006-2015
5.	Bureau of Labor Statistics	2016
6.	California Department of Education	2014-2017
7.	California EpiCenter	2013-2014
8.	California Health Interview Survey	2014-2016
9.	Center for Applied Research and Environmental Systems	2012-2015
10.	Centers for Medicare and Medicaid Services	2015
11.	Climate Impact Lab	2016
12.	County Business Patterns	2015
13.	County Health Rankings	2012-2014
14.	Dartmouth Atlas of Healthcare	2012-2014
15.	Decennial Census	2010
16.	EPA National Air Toxics Assessment	2011
17.	EPA Smart Location Database	2011-2013
18.	Fatality Analysis Reporting System	2011-2015
19.	FBI Uniform Crime Reports	2012-14
20.	FCC Fixed Broadband Deployment Data	2016
21.	Feeding America	2014
22.	FITNESSGRAM® Physical Fitness Testing	2016-2017
23.	Food Environment Atlas (USDA) & Map the Meal Gap (Feeding America)	2014
24.	Health Resources and Services Administration	2016
25.	Institute for Health Metrics and Evaluation	2014
26.	Interactive Atlas of Heart Disease and Stroke	2012-2014
27.	Mapping Medicare Disparities Tool	2015
28.	National Center for Chronic Disease Prevention and Health Promotion	2013
29.	National Center for Education Statistics-Common Core of Data	2015-2016
30.	National Center for Education Statistics-EDFacts	2014-2015
31.	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2013-2014
32.	National Environmental Public Health Tracking Network	2014
33.	National Flood Hazard Layer	2011

34.	National Land Cover Database 2011	2011
35.	National Survey of Children's Health	2016
36.	National Vital Statistics System	2004-2015
37.	Nielsen Demographic Data (PopFacts)	2014
38.	North America Land Data Assimilation System	2006-2013
39.	Opportunity Nation	2017
40.	Safe Drinking Water Information System	2015
41.	State Cancer Profiles	2010-2014
42.	US Drought Monitor	2012-2014
43.	USDA - Food Access Research Atlas	2014

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FOCUS GROUPS

#	Organization/Participants	NUMBER OF PARTICIPANTS	Minority, medically underserved, & low-income group	Expertise	Role in target group	Region	Date input was gathered
1	**Health Center Partners,** *Promotoras*	*3*	Yes	*Minority, underserved communities, behavioral health, social service navigation, stigma*	*Community Leader*	*South*	*10/9/18*
2	**Alliance for Regional Solution,** *Homeless providers, healthcare providers, government, law enforcement, non-profits*	*40*	Yes	*Homeless, housing and health, stigma*	*Community Leader*	*North Coastal, North Inland*	*10/24/18*
3	**School Based Health Center – Southwest High School,** *Clinic staff including providers, school staff, parents, interns*	*17*	Yes	*Children/youth, students, stigma*	*Representative Health Expert*	*South*	*11/28/18*
4	**San Diego Hunger Coalition***, Task Force Meeting Members*	*11*	Yes	*Food Insecurity, healthy food access, hunger and health*	*Community Leader*	*All Regions*	*11/29/18*
5	**California State University of San Marcos, School of Nursing, Student Healthcare Project,** *Director and Student Nurses*	*10*	Yes	*Underserved communities, undocumented, stigma*	*Representative Health Expert*	*North Coastal, North Inland*	*1/29/19*
6	**Casa Familiar, South Bay Community Center, and San Ysidro Health,** *Promotoras*	*14*	Yes	*Minority communities*	*Community Leader*	*South*	*1/31/19*
7	**Regional Task Force on the Homeless***, General Membership Meeting Members*	*12*	Yes	*Homeless, homeless TAY population, housing and health*	*Community Leader*	*North Central*	*1/31/19*
8	**Family Health Centers of San Diego,** *Special populations health educators and program coordinators*	*13*	Yes	*LGBTQ, stigma*	*Representative Health Expert*	*Central*	*2/4/19*
9	**University of California San Diego School of Medicine Center for Community Health, Partnership for the Advancement of New**	*3*	Yes	*Underserved communities, refugee, new immigrant*	*Community Leader*	*Central*	*2/7/19*

#	Organization/Participants	NUMBER OF PARTICIPANTS	Minority, medically underserved, & low-income group	Expertise	Role in target group	Region	Date input was gathered
	Americans, United Women of East Africa						
10	*Community Housing Works,* Residents	20	Yes	Minority, medically underserved, and low income, aging concerns	Community Resident	Central	1/16/18
11	*Environmental Health Coalition,* Community Advisory Members	9	Yes	Minority, environmental issues	Community Resident	Central	11/14/18
12	*Monarch School,* Parents of homeless youth	8	Yes	Homeless Youth, students, stigma	Community Resident	Central	12/4/18
13	*Chaldean & Middle-Eastern Social Services,* Community Advisory Board Members	10	Yes	Refugee, new immigrant	Community Resident	East	12/4/18
14	*Vista Community Clinic,* Youth Patient Advisory Board Members	7	Yes	Minority youth, underserved communities, stigma	Community Resident	North Coastal, North Inland	12/5/18
15	*Vista Community Clinic,* Patient Advisory Board Members	10	Yes	Minority, underserved communities, stigma	Community Resident	North Coastal, North Inland	12/5/18
16	*Education Without Borders, San Diego State University,* Students	8	Yes	College students, minority, undocumented, stigma	Community Resident	Central	1/22/19
17	*Family Health Centers of San Diego,* Patients, community members	12	Yes	LGBTQ, stigma	Community Resident	Central	2/6/19

ONLINE SURVEY

#	Participants	Number	Expertise	Date input was gathered
1	*Community Based Organizations, Federally Qualified Health Centers, Hospital/Health System, Local Government Agency, Philanthropic Organizations, San Diego County Public Health Services*	*306*	*Minority, medically underserved, and low income, population with chronic diseases*	*1/29/19 – 2/12/19*
2	*Community Residents*	*47*	*Minority, medically underserved, and low income, population with chronic diseases*	*1/29/19 – 2/12/19*

FOCUS GROUPS

#	Organization/Participants	NUMBER OF PARTICIPANTS	Minority, medically underserved, & low-income group	Expertise	Role in target group	Region	Date input was gathered
18	*San Diego Youth Services,* Youth Action Board Members	*7*	*Yes*	*Homeless Youth*	*Community Resident*	*Central, East*	*2/7/19*

KEY INFORMANT INTERVIEWS

#	Organization/Participants	Expertise	Role in target group	Region	Date input was gathered
1	*University of California San Diego School of Medicine Center for Community Health*, Executive Director	*Underserved communities*	*Community Leader*	Central	*11/5/18*
2	*Mountain Health,* CEO	*Rural Health*	*Community Leader*	North Inland, East	*11/30/18*
3	*O'Farrell Charter School,* Teacher	*Children/youth, students*	*Community Leader*	Central	*12/4/18*
4	*Jewish Family Service,* Director of Nutrition	*Military hunger*	*Community Leader*	All Regions	*12/4/18*
5	*Think Dignity,* Executive Director	*Homeless*	*Community Leader*	Central	*12/5/18*
6	*ElderHelp,* Advocate	*Senior Health*	*Community Leader*	All Regions	*12/12/18*

KEY INFORMANT INTERVIEWS

#	Organization/Participants	Expertise	Role in target group	Region	Date input was gathered
7	**San Diego American Indian Health Center,** *Substance Abuse Treatment Provider*	*Native American Health*	*Community Leader*	Central	*1/18/19*
8	**Dreams for Change**, *CEO*	*Homeless*	*Community Leader*	Central	*1/22/19*
9	**International Rescue Committee,** *Senior Food and Farming Program Manager*	*Refugees*	*Community Leader*	Central	*1/29/19*
10	**Pillars of the Community**, *Program Coordinator*	*Minority, underserved communities*	*Community Leader*	Central	*1/31/19*
11	**Otay Elementary, Chula Vista School District,** *School Counselor*	*Children/youth, students*	*Community Leader*	South	*2/4/19*
12	**San Diego County Health and Human Services Agency,** *Director and Deputy Chief Administrative Officer*	*Health Department Representative, Low-income, medically underserved, minority population, population with chronic disease*	*Community Leader*	All Regions	*2/19/19*

SAMPLE FOCUS GROUP AND KEY INFORMANT QUESTIONS

NOTE: NOT ALL QUESTIONS WILL BE USED IN A SINGLE FOCUS GROUP

1. Can you please describe the type of work that you do as position or title?

    a. What strengths does the position or title program bring to the community?

2. How do you think your role is helping both adults and children in the community?

ADULT HEALTH & SOCIAL ISSUES

3. **Adult Health Issue** What are the priority <u>health</u> issues faced by the adult population you work with?

4. **Adult Social Issue** What are the priority <u>social issues</u> faced by the adult population you work with? *Prompt if needed, social issues are conditions in the places where people live, work, and play that affect a wide range of health risks and outcomes. For example, access to healthy food.*

5. How has your work as a position or title helped address these health and social issues?

CHILD HEALTH & SOCIAL ISSUES

6. **Child/Youth Health Issue** What are the priority <u>health</u> issues faced by the children of families that you work with?

7. **Child/Youth Social Issue** What are the <u>social issues</u> faced by the children of families that you work with?

ORGANIZATIONS: WORK AND GAPS

8. How has your work as a position or title helped address these health and social issues?

9. (core e) What solutions are potentially available to address these health needs? Where are the gaps?

YOUTH QUESTION FOR SCHOOLS OR YOUTH PROGRAMS

10. **Child/Youth Roles** What roles do the youth take in the healthcare of other family members? (*examples if needed: babysitting, translators, driving, healthcare providers*)

DAILY LIVES

11. **Daily Lives**: How do these health and social issues affect your clients' daily lives?

ACCESS TO HEALTH CARE

12. **Access**: What are the challenges and barriers in accessing health care for family members?

HOSPITAL SPECIFIC QUESTIONS

13. **Hospital communication:** Do you or your staff interact with hospitals in any way?

    a. If yes, how?

14. **Discharge**: Are you aware of any challenge's patients face following being discharged from a hospital?

    a. What can be done to help improve these challenges?

15. **Hospital:** What do you or your staff need from hospitals to better support your work and improve health outcomes of your clients?

IMMIGRATION

16. **Immigration**: Have you observed any changes over the past year in the community's attitude towards immigration issues?

    a. If yes, what has changed? What do you think has caused this change?

## 2019 COMMUNITY HEALTH NEEDS ASSESSMENT SURVEY FINDINGS

The online community needs assessment survey was distributed to targeted community- based organizations, federally qualified health centers, governmental agencies, and public health systems who serve a diverse array of people in San Diego County. When possible, these organizations shared the link to the survey with their clientele. Table 38 (below) describes the online 2019 CHNA survey respondents. Survey questions were primarily centered around the prioritization of health needs and the identification of social predictors of health.

Table 38. 2019 Community Health Needs Assessment - Overview of Online Survey Participants

Organization	n	Percent
Community Resident	47	13.3%
Community-Based Organization	69	19.5%
Community Clinic (Federally Qualified Health Center)	33	9.3%
Hospital/Health System	47	13.3%
Local Government Agency	32	9.1%
Philanthropic Organization	3	0.8%
San Diego County Public Health Services	104	29.5%
Other	18	5.1%
Total	**353**	**100%**

RANKING QUESTIONS

Three separate ranking questions were asked in the 2019 survey on 1) health conditions, 2) SDOH, and 3) health conditions and SDOH together. The first question asked survey participants to rank 13 health conditions in ranked order, with 1 having the greatest impact on the overall health and well-being within San Diego communities. The following were identified as the top five health conditions in San Diego County.

Behavioral Health	Diabetes	Cardiovascular Disease	Cancer	Obesity
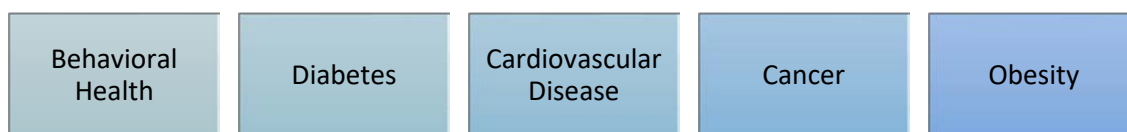
In addition to behavioral health being identified as the number one health condition, 63% of survey respondents believe that behavioral health is worsening for San Diego County residents.

From a list of 15, the following were identified as the social determinants of health that have the greatest influence on poor health outcomes in San Diego County communities.

Access To Care	Economic Security	Health Insurance	Health Behaviors	Community Social Support

In addition, the majority of survey respondents thought economic security (55%), has gotten worse over the past three years.

The final ranking question took the top five health conditions and top five SDOH that participants previously ranked and put them into one list of ten. Participants were asked to rank this combined list in order of importance, 1 through 10. Below are the top ten ranked list of health conditions and SDOH together, with 1 having the greatest impact on the overall health and well-being of San Diego County residents.

1. Access to Care
2. Behavioral Health
3. Economic Security
4. Health Insurance
5. Homelessness
6. Housing
7. Diabetes
8. Care Management
9. Health Behaviors
10. Cardiovascular Disease

A total of three health conditions and seven social determinants of health are represented in this list. This demonstrates that survey respondents consider social determinants to be more significant than health conditions in terms of their overall well-being.

TRENDS OVER TIME

Survey participants were asked whether the top five health conditions they identified were improving, staying the same, or getting worse over the past 3 years. Behavioral health, economic security, homelessness, and housing were identified by the majority of survey participants as getting worse in San Diego County. Please see the Table 39 below for more information.

Table 39. 2019 HASD&IC CHNA Survey, Trends over Time Question

Health Conditions & Social Determinants of Health	Improved		Stay the Same		Worse	
	n	%	n	%	n	%
Behavioral/Mental Health	21	7.92%	77	29.06%	167	63.02%
Cardiovascular Disease	24	12.83%	125	66.84%	38	20.32%
Diabetes	25	12.89%	110	56.70%	59	30.41%
Access to Care	96	39.34%	96	39.34%	52	21.31%
Health Insurance	64	32.00%	71	35.50%	65	32.50%
Care Management	31	25.41%	72	59.02%	19	15.57%
Economic Security	21	9.29%	80	35.40%	125	55.31%
Health Behaviors	11	9.57%	56	48.70%	48	41.74%
Homelessness	3	2.31%	18	13.85%	109	83.85%
Housing	1	0.88%	10	8.85%	102	90.27%

BEHAVIORAL HEALTH CONDITIONS

Due to continued identification of behavioral health as an important health issue in San Diego County a follow-up question asked participants to rank behavioral health conditions in order of greatest impact on the overall health and well-being of San Diego County residents. The following is the ranked order identified by survey participants, with number one having the greatest impact.

1. Alcohol Use Disorder
2. Mood Disorders
3. Substance Use Disorder
4. Anxiety
5. Opioid Use
6. Suicide and Suicidal thoughts/Ideation
7. Self-Harm or Self-Injury
8. Alzheimer's

The tables below are summary tables for the data cited in the demographic summary report, including data for California and the United States when available.

Demographic Summary

Indicator	San Diego County	California	United States
Total Population[a]	3,283,665	38,982,847	321,004,407
Median Age[a]	35.4	36.1	37.8
Percent Male[a]	50.3%	49.7%	49.2%
Percent Female[a]	49.7%	50.3%	50.8%
Percent Population in Poverty[a]	13.3%	15.1%	14.6%
Percent Population with Less than a High School Diploma[a]	13.3%	17.5%	12.7%
Percent Limited English Proficiency[a]	14.6%	18.4%	8.5%
Percent Linguistically Isolated[a]	6.8%	9.2%	4.5%
Percent Uninsured[b]	10.6%	10.1%	12.3%
Unemployment Rate[c]	3.2	4.1	3.9

[a]Source: U.S. Census Bureau. American Community Survey, 2013-2017 5-Year Estimates.
[b]Source: U.S. Census Bureau. American Community Survey, 2017 1-Year Estimates.
[c]Source: Bureau of Labor Statistics. United States Department of Labor, July 2015.

Access to Health Care Summary

Indicator	San Diego County	California	United States
Rate of Federally Qualified Health Centers (per 100,000)[a]	3.17	2.51	2.45
Primary Care Provider Rate (per 100,000)[b]	78.3	78.1	75.9
Preventable (ACS) Condition Hospitalization, Rate (Per 1,000)[c]	29.7	36.2	49.4

[a]Source: U.S. Department of Health & Human Services, Center for Medicare & Medicaid Services. Provider of Services File, December 2016.

[b]Source: U.S. Department of Health & Human Services, Health Resources and Services Administration. Area Health Resource File, 2014.

[c]Source: Dartmouth Atlas of Health website, which was funded, in part, by the National Institute of Aging, under award number U01 AG046830 and by Dartmouth Institute for Health Policy and Clinical Practice. 2015.

Education Summary

HHSA Regions	Percent less than High School Diploma in San Diego County
Central	19.9%
East	12.1%
North Central	5.3%
North Coastal	10.6%
North Inland	13.0%
South	21.9%
Source: U.S. Census Bureau. American Community Survey, 2013-2017 5-Year Estimates.	

Health Behaviors Summary

Indicator	San Diego County	California	United States
Percent Adults with Inadequate Fruit Consumption [a]	%	32.5%	36.0%
Percent Adult Population with no Leisure Time Physical Activity[b]	15.6%	17.3%	21.7%
Percent Physically Inactive (Youth) [c]	31.1%	37.8%	NA
Estimated Adults Drinking Excessively (Age-Adjusted)[d]	19.7%	18.3%	17.8%
Percent Population Smoking Cigarettes (Age-Adjusted)[d]	10.8%	11.7%	15.7%

[a]Source: Centers for Disease Control and Prevention, *Behavioral Risk Factor Surveillance System.* National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition, Physical Activity, and Obesity. 2017.
[b]Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2013.
[c]Source: California Department of Education, FITNESSGRAM®; Physical Fitness Testing. 2016-2017.
[d]Source: Centers for Disease Control and Prevention, *Behavioral Risk Factor Surveillance System*. Atlanta, Georgia. U.S. Department of Health & Human Services, Center for Disease Control and Prevention, Health Indicators Warehouse. 2015.

Physical Environment Summary

Indicator	San Diego County	California	United States
Percentage of Days Exceeding Ozone Standards, Pop. Adjusted Average[a]	41.7%	42.0%	38.0%
Grocery Store Establishment Rate per 100,000 Population[b]	21.9	23.5	24.2
Percent Population with Low Food Access[c]	14.7%	13.4%	22.4%
Liquor Store Establishment Rate per 100,000 Population[d]	12.4	10.6	10.9

[a]Source: Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network. 2014.
[b]Source: U.S. Census Bureau, County Business Patterns. 2015.
[c]Source: U.S. Department of Agriculture, Economic Research Service, USDA – Food Access Research Atlas. 2014.
[d]Source: U.S. Census Bureau, County Business Patterns. 2012.

THE COMMUNITY NEED INDEX

Dignity Health and Truven Health jointly developed the nation's first standardized Community Need Index (CNI).[23] The CNI identifies the severity of health vulnerability for every ZIP code in the United States based on specific barriers to health care access.

The CNI provides a score for every populated ZIP code in the United States on a scale of 1.0 to 5.0. A score of 1.0 indicates a ZIP code with the least need (dark green in maps), while a score of 5.0 represents a ZIP code with the most need (bright red in maps). For a detailed description of the CNI please visit the interactive website at: http://cni.chw-interactive.org/. The five barriers are listed below along with the individual 2013 statistics that were analyzed for each barrier.

1. **Income Barrier**
   - Percentage of households below poverty line, with head of household age 65 or more
   - Percentage of families with children under 18 below poverty line
   - Percentage of single female-headed families with children under 18 below poverty line
2. **Cultural Barrier**
   - Percentage of the population that is minority (including Hispanic ethnicity)
   - Percentage of the population over age 5 that speaks English poorly or not at all
3. **Educational Barrier**
   - Percentage of the population over 25 without a high school diploma
4. **Insurance Barrier**
   - Percentage of the population in the labor force, aged 16 or more, without employment
   - Percentage of the population without health insurance
5. **Housing Barrier**
   - Percentage of the population renting their home

Based on these 5 categories and 9 total criteria, every ZIP code in the U.S. was assigned an index number:
   - Scale of 1 – 5
   - 5 represents the most vulnerable communities; 1 the least vulnerable

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[23] Source: Dignity Health, Community Need Index. http://cni.chw-interactive.org/Truven%20Health_2015%20Source%20Notes_Community%20Need%20Index.pdf

KFH-SAN DIEGO AND ZION - RANKED HEALTH OUTCOME COMPARISON TABLE

Health Outcome Category Name	Prevalence in Service Area	Difference From State Average	Reduction in Life Expectancy	Worst Performing Race/Ethnicity vs. Average	Listed in San Diego County Top 5 Causes of Death
Mental Health*	11.3%	-0.83% (Better than CA)	61.3% Reduction	40% Worse than Average	No
HIV/AIDS/STD	0.5%	0.09% (Worse than CA)	58.2% Reduction	211% Worse than Average	No
Asthma	13.8%	-1% (Better than CA)	13.3% Reduction	156% Worse than Average	Yes
Cancer*	4.0%	0.67% (Worse than CA)	51% Reduction	11% Worse than Average	Yes
Stroke*	3.4%	-0.3% (Better than CA)	57% Reduction	30% Worse than Average	Yes
Obesity	24.1%	-5.5% (Better than CA)	37% Reduction	52% Worse than Average	No
Substance/Tobacco Use	5.2%	-1.79% (Better than CA)	69.7% Reduction	48% Worse than Average	No
Maternal/Infant Health	6.5%	-0.3% (Better than CA)	17.9% Reduction	28% Worse than Average	No
CVD*	5.2%	-1.75% (Better than CA)	30% Reduction	38% Worse than Average	Yes
Oral Health	10.5%	-0.8% (Better than CA)	2.8% Reduction	17% Worse than Average	No
Diabetes*	7.4%	-1% (Better than CA)	24.1% Reduction	6% Worse than Average	No
Violence/Injury	0.0%	-0.001% (Better than CA)	13.2% Reduction	7% Worse than Average	No

Indicators for prevalence and racial disparities are publicly available. Technical documentation and data dictionary for this table available upon request. Health need category names provided by Kaiser Permanente Program Office. Reduction in life expectancy estimated based on disability-adjusted life years research. "Mental Health" indicators refer to "poor mental health". "Violence/Injury" prevalence is rounded down but not technically zero. "Yes" indicates health outcome is listed in the top five causes of death for the county covering the majority of this service area. If asthma is listed as "Yes", then chronic lower respiratory disease was listed in the county rankings. Asterisks are outcomes measured by Kaiser Permanente's Program Office.

Multiple linear regression models used nearly one dozen social indicators to predict each of the negative health outcomes below. An "X" indicates a statistically significant (*p*<.05) predictive relationship across all census tracts in the service area between a given social factor and a health outcome (e.g. "*service area census tracts reporting less health insurance also tended to report more heart attack ER visits, even when holding many other social factors constant*").

	More Poor Mental Health Days	More Heart Attack ER Visits	Higher Asthma Prevalence	Higher Obesity Prevalence	Higher Diabetes Prevalence	Higher Stroke Prevalence	Higher Cancer Prevalence	Higher Percentage of Babies Born with Low Birth Weight	Higher Smoking Prevalence	More Pedestrian Injury	Number of Outcomes Affected
Lower Income	X	X	X	X	X	X	X		X	X	9
Less Health Insurance	X	X	X	X				X	X		6
Fewer Bachelor's Degrees	X	X		X	X			X	X		6
More Crowded Housing	X	X		X	X						4
More Racial Segregation			X			X		X		X	4
Less Access to Parks/Beaches	X		X		X				X		4
More Homeownership					X	X	X				3
Less Employment			X			X					2
More Bachelor's Degrees							X				1
Less Crowded Housing							X				1
Less Homeownership									X		1

Hospital/Health Care System*	Location		
Kaiser Foundation Hospital			
Kaiser Permanente San Diego Medical Center	9455 Clairemont Mesa Blvd	San Diego	92123
Kaiser Foundation Hospital – San Diego	4647 Zion Avenue	San Diego	92120
Palomar Health			
Palomar Medical Center	2185 Citracado Parkway	Escondido	92029
Pomerado Hospital	15615 Pomerado Road	Poway	92064
Rady Children's Hospital			
Rady Children's Hospital – San Diego	3020 Children's Way	San Diego County	92123
Scripps Health			
Scripps Memorial Hospital La Jolla	9888 Genesee Avenue	La Jolla	92037
Scripps Mercy Hospital San Diego	4077 5th Avenue	San Diego	92103
Scripps Mercy Hospital Chula Vista	435 H Street	Chula Vista	91910
Scripps Green Hospital	10666 N Torrey Pines Road	La Jolla	92037
Scripps Memorial Hospital Encinitas	354 Santa Fe Drive	Encinitas	92024
Sharp HealthCare			
Sharp Chula Vista Medical Center	751 Medical Center Court	Chula Vista	91911
Sharp Coronado Hospital	250 Prospect Place	Coronado	92118
Sharp Grossmont Hospital	5555 Grossmont Center Drive	La Mesa	91942
Sharp Mary Birch Hospital	3003 Health Center Drive	San Diego	92123
Sharp McDonald Center	7989 Linda Vista Road	San Diego	92111
Sharp Memorial Hospital	7901 Frost Street	San Diego	92123
Sharp Mesa Vista Hospital	7850 Vista Hill Avenue	San Diego	92123
Tri-City Medical Center			
Tri-City Medical Center	4002 Vista Way	Oceanside	92056
UC San Diego Health			
UCSD Thornton Hospital	9300 Campus Point Drive	La Jolla	92037
UCSD Hillcrest	200 West Arbor Drive	San Diego	92103

*Locations represent the major hospital or health care/system locations and do not represent all types of hospital or health care locations.

SB 697 and Scripps history with past assessments

Scripps Health has a long history of responding to the health needs of the communities it serves, extending beyond traditional hospital care to address the health care needs of the region's most vulnerable populations. In 1994, California legislators passed Senate Bill 697 (SB 697), which requires all private nonprofit hospitals in the state to conduct a CHNA every three years. Since 1994, these programs have been created based on an assessment of needs identified through hospital data, community input, and major trends. Previous collaborations among non-profit hospitals, healthcare systems, and other community partners have resulted in numerous well-regarded Community Health Needs Assessments (CHNA) reports. Information is gathered through the CHNA for the purposes of reporting community benefit, developing strategic plans, creating annual reports, providing input on legislative decisions, and informing the general community of health issues and trends.

Federal Requirements

In 2010, Congress added several new requirements for hospital organizations to maintain federal income tax exempt status under Section 501(r) of the Internal Revenue Code (the "Code") as part of the Affordable Care Act. One of the requirements set forth in Section 501(r) of the Code is for each hospital organization to conduct a Community Health Needs Assessment (CHNA) at least once every three tax years. The requirement to conduct a CHNA applies to Scripps Health, which is a health system that operates four hospital facilities. In addition, Scripps Health must adopt a triennial Implementation Plan which is a separate written document to address certain community health needs identified in the CHNA by September 30, 2019.

Scripps Health Consolidated Community Health Needs Assessment Report

Scripps Health actively participates in the collaborative CHNA process led by the Hospital Association of San Diego and Imperial Counties and develops a Scripps consolidated CHNA report. Scripps issues a consolidated CHNA report based on the following regulatory requirements. The final rules on what constitutes compliance with community health needs assessment and implementation strategy provisions in the Affordable Care Act can be viewed at (https://federalregister.gov/a/2014-30525).

- A consolidated CHNA centers on the commonality of the community and adoption of the CHNA by each of the hospital facilities. Specifically, the regulations note that a joint (i.e., consolidated) CHNA can be issued if: (i) an authorized body of the hospital facility adopts for the hospital facility a joint CHNA; (ii) all the collaborating hospital facilities define their community to be the same; (iii) all the collaborating hospital facilities conduct a joint CHNA process; and (iv) the joint CHNA report is clearly identified as applying to the hospital facility.   Treas. Reg. § 1.501(r)-3(b)(6)(v)(A).

- The consolidated CHNA report must include: (i) a definition of the community served by the hospital facilities and a description of how the community was determined; (ii) a description of the process and methods used to conduct the CHNA; (iii) a description of how the hospital facilities solicited and took into account input received from persons who represent the broad interest of the community it serves; (iv) a prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs; (v) a description of the resources potentially available to address the significant health needs identified through the CHNA; and (vi) an evaluation of the impact of any actions that were taken, since the hospital facilities finished conducting their immediately preceding CHNA, to address the significant health needs identified in the hospital facilities prior CHNA. Treas. Reg. § 1.501(r)-3(b)(6)(i).

- The regulations also permit a hospital facility that adopts a joint CHNA report to also adopt a joint implementation strategy which, with respect to each significant health need identified through the joint CHNA, either describes how one or more of the collaborating facilities plan to address the health need or identifies the health need as one the collaborating facilities do not intend to address (and provides an explanation as to why such need will not be addressed). The joint implementation strategy adopted for the hospital facility must: (i) be clearly identified as applying to the hospital facility; (ii) clearly identify the hospital facility's particular roles and responsibilities in taking the actions described in the implementation strategy, and the programs and resources the hospital facility plans to commit to such actions; and (iii) include a summary or other tool that helps the reader easily locate those portions of the joint implementation strategy that relate to the hospital facility. Treas. Reg. § 1.501(r)-3(c)(4).

Required Components of the Community Health Needs Assessment

Per IRS requirements, (Treas. Reg. § 1.501(r)-3(b)(6)(i)) the following are components the CHNA must include:

- A description of the community served by the health system and how it was determined
- A description of the processes and methods used to conduct the assessment
- A description of how the hospital organization took into account input from persons who represent the broad interests of the community served by the hospital facility
- A prioritized description of all of the community health needs identified through the CHNA, as well as a description of the process and criteria used in prioritizing such health needs.
- A description of the existing health care facilities and other resources within the community available to meet the community health needs identified the CHNA.
- An evaluation of the impact of any actions that were taken since the hospital finished conducting its immediately preceding CHNA to address the significant health needs identified in the prior CHNA.
- Make the CHNA widely available to the public via the hospital's website

Required Components of the Implementation Strategy

Provisions in the Affordable Care Act permit a hospital facility that adopts a joint CHNA report to also adopt a joint implementation strategy which, with respect to each significant health need identified through the joint CHNA, either describes how one or more collaborating facilities plan to address the health need or identifies the health need as one the collaborating facilities do not intend to address. The joint implementation strategy adopted for the hospital facility must: (Treas. Reg. § 1.501(r)-3(c)(4).

- Meet community health needs identified in the CHNA. Describe any needs identified in the CHNA that are not being addressed and the reasons for not addressing them
- Be clearly identified as applying to the hospital facility
- Clearly identify the hospital facility's particular roles and responsibilities in taking the actions described in the implementation strategy, and the programs and resources the hospital facility plans to commit to such actions
- Include a summary or other tool that helps the reader easily locate those portions of the joint implementation strategy that relates to the hospital facility.