



2016 Community Health Needs Assessment



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Acknowledgements

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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 2016 Community Health Needs Assessment process which is described in detail in this report.

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Collaborative Groups:

2-1-1 San Diego

Alpine Special Treatment Center

Family Health Centers

Family Youth Round Table

Hospital Partners Behavioral Health Workgroup

Healthy San Diego Behavioral Health Workgroup

International Rescue Committee

North County Health Services

Resident Leadership Academy

San Diego County of Education School Nurses Resource Group

San Diego Hunger Coalition CalFresh Task Force

San Diego County Health and Human Services Agency

San Ysidro Health Center

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Purpose of the Community Health Needs Assessment Report

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 to build upon efforts to achieve broad community health goals.

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 2016 Scripps Health CHNA is designed to provide a deeper understanding of barriers to health improvement in San Diego County. 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 three 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 (2013) CHNA to address the significant health needs identified in the prior CHNA
3. 2016 Scripps Health 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. This report complies with federal tax law requirements set forth in Internal Revenue Code section 501(r) requiring hospital facilities owned and operated by an organization described in Code section 501 (c)(3) to conduct a community health needs assessment at least once every three years. For more detailed information on the CHNA regulatory requirements and Implementation Strategy see [Appendix M](#).

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

Scripps Introduction



About Scripps

Founded in 1924 by philanthropist Ellen Browning Scripps, Scripps Health is a \$2.8 billion nonprofit 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 14,000 employees among its five acute-care hospital campuses, home health care services, and an ambulatory care network of physician offices and 29 outpatient centers and clinics. In 2013, Scripps Hospice program was established and provides end of life care.

Recognized as a leader in the prevention, diagnosis and treatment of disease, Scripps is also at the forefront of clinical research, genomic medicine, wireless health and graduate medical education. With three highly respected graduate medical education programs, Scripps is a longstanding member of the Association of American Medical Colleges. More information can be found at www.scripps.org.

Today, the health system extends from Chula Vista to Oceanside, with 29 primary and specialty care outpatient centers. A leader in the prevention, diagnosis and treatment of disease, Scripps was named by Truven in 2014 as one of the Top 15 large health systems in the nation for providing high-quality, safe and efficient patient care. On the forefront of genomic medicine and wireless health technology, the organization is dedicated to improving community health while advancing medicine through clinical research and graduate medical education. Scripps has also earned a national reputation as a premier employer, named by Fortune magazine as one of "America's 100 Best Companies to Work For" every year since 2008.

Scripps Facilities/Divisions

Scripps Green Hospital

Scripps Clinic

Scripps Memorial Encinitas

Scripps Coastal Medical Center

Scripps Memorial Hospital La Jolla

Scripps Hospice

Scripps Home Health Care

Scripps Whittier Diabetes Institute

Scripps Clinical Research Services

Scripps Mercy Hospitals

*San Diego Campus

*Chula Vista Campus

Service Offerings

Scripps is an integrated health care delivery system consisting of four acute-care hospitals on five campuses, 29 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 55,000 heart patients annually – more than any other provider in San Diego. With volume comes high quality, as evidenced by the program ranking 20th nationally by U.S. News & World Report in cardiology and heart surgery in 2014-2015. Scripps is the only San Diego heart program on the list that has received the coveted honor eight years in a row (2006-2014).
- In March 2015, Scripps opened the \$456-million Scripps Prebys Cardiovascular Institute, which will bring together expertise from across the system. The institute is the largest heart hospital on the West Coast with 167 inpatient beds and will serve as a center of excellence for research and education.
- For more than 30 years, Scripps has been the exclusive provider of heart services to the more than 500,000 Kaiser Permanente patients in San Diego. A new 10-year contract was signed in 2011.

Cancer Care

- Scripps is committed to fighting cancer and mobilizes the collective resources of its five hospital campuses, outpatient centers, and research division to form the Scripps Cancer Center.
- In 2008, it 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 opened a new state-of-the-art regional radiation therapy center in 2012.
- In February 2014, Scripps opened the region's first proton therapy center, which is only the second in California. It is the first in the U.S. to use pencil-beam technology in all of the treatment rooms.

Diabetes Care and Prevention

- This year, 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. 13 nationally by U.S. News & World Report in its annual “Best Hospitals” rankings. This is a move up from No. 39 last year. Scripps Mercy Hospital ranked No. 42 in the nation in diabetes and endocrinology.

- The Scripps Whittier Diabetes Institute is dedicated to caring for and educating people with diabetes, as well as preventing those at risk from getting diabetes. Scripps provides the best in diabetes care through outpatient education, inpatient glucose management, clinical research, professional education, and community-based programs.

Behavioral Health and Drug and Alcohol Care

- The Scripps behavioral health and drug and alcohol care line offers a variety of services to adults with emotional, behavioral and or addictive 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 and outpatient mental health services.
- Psychiatric liaison services are provided at all five acute care Scripps hospitals and associated urgent care facilities. A supportive employment program is also offered to those seeking volunteer or employment opportunities.
- The Scripps drug and alcohol treatment program is nationally recognized for excellence in treatment of alcohol and drug abuse. The division of mental health is a behavioral health, outpatient treatment facility for geriatric patients of the Scripps Clinic Medical Group.

Women's and Newborn Services

- Scripps delivers 10,000 babies and provides care to thousands of women needing obstetrical, routine and advanced gynecological care on an annual basis.
- Scripps offers a full spectrum of obstetrics and 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” – are ranked among the nation’s top hospitals in gynecology.
- 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 across the inpatient and ambulatory continuum of care. Scripps Health Prioritizes system efforts related to OB, Gynecology and NICU development.

Neurosciences

- Scripps has been recognized for high performance in Neurology & Neurosurgery by U.S. News & World Report (2014-2015)
- Scripps Memorial Hospital La Jolla was one of the first in the nation certified as a Comprehensive Stroke Center by the Joint Commission. Additionally, all four Scripps emergency rooms are certified Primary Stroke Centers.
- Our physicians lead research activities designed to find better treatments for conditions like Parkinson’s, MS, and Alzheimer’s.

Orthopedic/Spine

- 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 Orthopedic Physicians serve as team physicians for the San Diego Padres in collaboration with internal medicine specialists at Scripps.
- Scripps provides musculoskeletal trauma care at Scripps Mercy, 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.

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 to diagnosis and treatment of injuries, illnesses and management of chronic medical conditions.
- Scripps offers more than 2,600 primary care physicians and medical specialists in locations throughout San Diego County.

Hospice Care

- Scripps provides hospice services to the entire San Diego region.
- Hospice provides interventions that focus on comfort and quality of life and help patients to live comfortably as they approach the end of life. The care involves the patient and family and provides supportive services to meet physical, emotional and spiritual needs.
- The interdisciplinary team includes medical doctors board-certified in hospice and palliative care, nurses, social workers and a pastoral or spiritual counselor. Depending on patients' needs, they may also be assigned a home health aide, physical therapist, occupational therapist, nutritionist or volunteers.

Emergency and Trauma Medicine

- Scripps operates two of the region's five adult trauma centers, including a Level 1 trauma center at Scripps Mercy Hospital San Diego.
- Scripps recently redesigned how emergency care is delivered and became the first hospital in California to reduce the average wait time to see a physician to less than 30 minutes.
- All four Scripps Emergency Rooms are accredited 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.

Governance

As a tax exempt health care system, Scripps takes pride in its service to the community. The Scripps system is governed by a 14-member, volunteer Board of Trustees. This single point of authority for organizational policy ensures a unified approach to serving patients across the region.

Organizational 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 and even 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.

Mission, Vision and Values

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 be 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.

Community Benefit

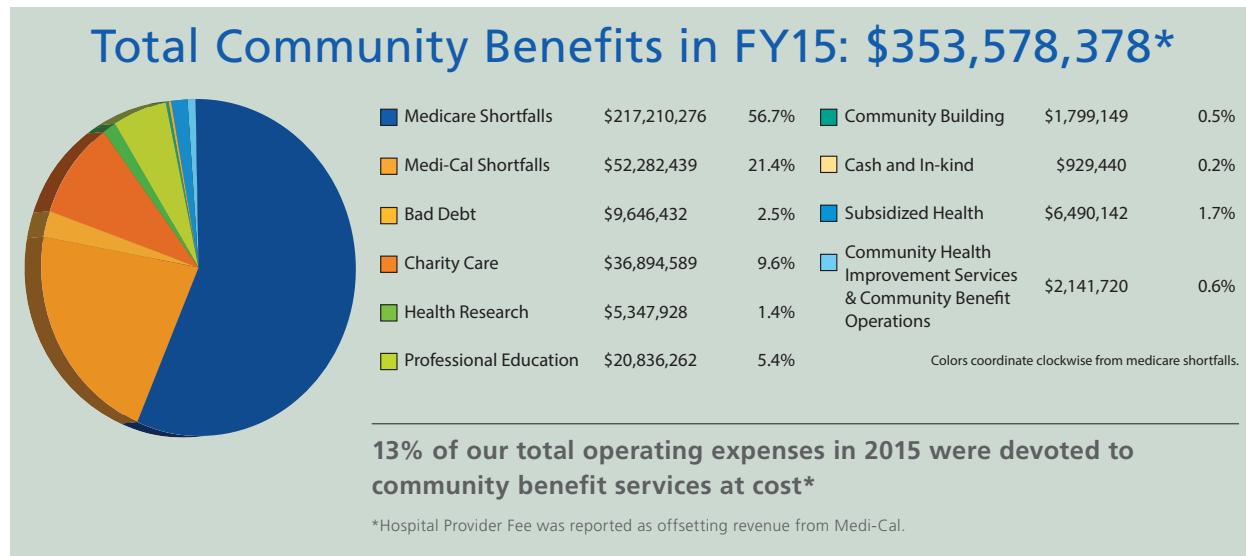
A major element of the Scripps mission is community benefit. The organization works to meet the needs of low-income uninsured and underinsured patients every day. Scripps offers community benefit services through our five acute-care hospitals, home health services, wellness centers and clinics. In addition 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.

Scripps has a long-standing commitment to achieving our mission and values, with more than \$353 million (Figure 1) devoted to local community benefit programs and services during fiscal year 2015. Community benefit is defined as programs or activities that provide treatment or promote health and healing in response to an identified community need.

For more information about the programs and services offered by Scripps Health, visit scripps.org/community benefit or contact the Scripps Health Office of Community Benefit Services at 858-678-7095.

Figure 1. Total Community Benefits in FY15



Uncompensated care represented the largest portion of Scripps community benefit contributions in FY 2015, totaling more than \$316 million. Uncompensated care includes the following elements: under-reimbursed care by government agencies below cost, bad debt or unpaid costs for those not eligible for charity care or other third party coverage, charity care, and care for those who don't qualify for government payer programs and don't have commercial insurance.

Scripps also invested more than \$26 million in professional education and health research in fiscal year 2015, the majority of which went toward Scripps graduate medical education (GME) programs to develop and support graduate medical education. Scripps Mercy Hospital, San Diego, Scripps Green Hospital; and a family medicine program at Scripps Mercy Hospital, Chula Vista serves several hundred thousand San Diegans each year.

Last year, Scripps also supported more than \$3 million in community health services, including prevention, education and wellness programs, as well as screenings and support groups. Key activities included childhood obesity and diabetes prevention programs for underserved communities, reconstructive surgeries for children in need, cancer screenings and imaging services for low-income residents, health services for the homeless at St. Vincent de Paul Village, and a health and wellness program for seniors. In addition, Scripps supported \$1.8 million in community building activities and \$6.5 million in subsidized health.

Implementation Plan Evaluation of Impact Based on the 2013 CHNA



2013 Community Health Needs Assessment

Phase II

The Hospital Association of San Diego and Imperial Counties 2013 Community Health Needs Assessment (HASD&IC 2013 CHNA) used a multi-level, hospital-focused analysis to identify the priority community health needs in San Diego County.

As part of the ongoing efforts to create stronger partnerships within San Diego communities, the participating hospitals designed a collaborative follow-up process (Phase II) after the 2013 CHNA was completed to review methodology and gain a deeper understanding of the 2013 CHNA results. The goal of Phase II was to ensure the results of the 2013 CHNA accurately reflected the health needs of the community. Phase II collected community feedback on both the process and findings of the 2013 CHNA, as well as recommendations for the next CHNA process.

The Institute for Public Health (IPH) at San Diego State University (SDSU) was contracted to provide assistance with the implementation and interpretation of Phase II through two main activities:

1. Conduct community dialogues to share the results of the 2013 CHNA with the community and collect community member feedback on hospital programs that were guided and informed by the results of the 2013 CHNA.
2. Create and analyze an electronic survey for community leaders and health experts to review the methodology and findings from the 2013 CHNA.

Overall there was positive feedback from all community dialogues and a high degree of interest in participating in hospital programs. However, the majority of participants had not heard of the hospital programs that were described. Other barriers to participation most often cited during the community dialogues were location, language, transportation and fear of documentation requirements.

Based on feedback from the health expert and leader survey, it appears that the results of the 2013 CHNA accurately reflected the health needs of San Diego County and provided useful information to help respondents develop programming in their organizations. However, respondents identified several areas that could be improved in future CHNAs, such as including a larger sample size, broadening the number of health needs addressed, increasing diversity in the sample in terms of age, ethnicity, and geographic location, and including more sectors of the community. The majority of respondents agreed that a more focused examination of the priority community health needs identified in the 2013 CHNA would be beneficial in future CHNAs.

2013 Phase 2 Overall Findings & Recommendations*

Common set of barriers make hospital programs inaccessible for residents in high need communities	87% of respondents agreed the 2013 CHNA identified the top health needs of San Diego County Residents	78% of respondents agreed the methodology for the next CHNA should include a deeper dive into the top 4 health needs
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*For a complete description of the HASD&IC 2013 CHNA process and findings, see the full report available at <http://www.hasdic.org/chna.htm>.

Implementation Plan Evaluation of Impact Based on the 2013 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 2013 Community Health Needs Assessment, during FY14-16 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 2014 and 2015. Not reflected in this report is the impact of strategies implemented in 2016 but we will continue to monitor the impact for 2016 and make that report available on Scripps.org.

Based on years 2014 and 2015, below is an overall summary of the strategies, metrics and outcomes to address the 2013 Community Health Needs Assessment prioritized health needs.

2013 CHNA Findings

- Top health needs: Behavioral health, Cardiovascular, Diabetes, and Obesity
- Top categories/recommendations: Access to Care, Care Management, Collaboration, Education, Screening

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.

Cardiovascular Disease

1. Eric Paredes Save A Life Foundation

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 events occur in men. About two-thirds (64 percent) of women who die suddenly of coronary heart disease have no previous symptoms.

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. In 2015, Scripps supported screening events at high schools throughout the county and screened more than 4, 138 teens, identifying 61 with abnormalities and 26 who were at risk.

The goal of the Eric Paredes Save A Life Foundation screenings 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. Unfortunately, heart screenings are not part of a regular, well child exam or pre-participation sports physical. The first symptom of SCA could be death. San Diego alone annually loses three to five teens from SCA. Screenings are non-invasive and include a health history and EKG. Since 2010, nearly 18,500 youth have been screened. Of those, about 375 had heart abnormalities, and 158 were found to be at risk for Sudden Cardiac arrest In addition, half of screened youth represent diverse ethnicities and 40% of youth are from moderate to extremely low-income households. Hundreds are without regular doctors and dozens without health insurance. Thirty-six percent of the schools represented are Title I schools, in which the majority of the students at the schools meet poverty guidelines. The schools qualify for federal government assistance funding such as free or reduced fee lunch programs. 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 physicians.

Policy Implications:

Sudden Cardiac Arrest Prevention legislation has recently been approved by a State Assembly committee. If this proposed legislation becomes law, it could broaden the message of awareness to reach kids throughout California. The bill, which was sponsored by Assemblyman Brian Maienschein, would require a coach or someone in a similar position to remove a student who passes out or faints during athletic activity. The students would need to be cleared by a medical professional before getting back on the field. Additionally, coaches would have to complete SCA prevention training once a year. As written, the proposed law would apply to kindergarteners through 12th-graders at private, public and charter schools. If it passes, California will join nine states that have implemented prevention requirements. Proposals are pending in six more states.

Results: Eric Paredes Save A Life Foundation

Objective(s)	Performance Measures	2014	2015
To prevent sudden cardiac arrest and death in middle high school aged children, including underserved areas in San Diego county through awareness, education and action.	Total Number of Adolescent Screenings 65 out of the 4,188 were uninsured adolescents	4,188	4,138
	Total Number of Adolescents With Positive Findings of Heart Abnormalities	85	61
	Total Number of High Risk Adolescents Identified	38	26

Diabetes

There are 29 million people with diabetes in the United States and 382 million worldwide, and the rates are 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. In fact, it is estimated that one out of every two Hispanic children born in 2000 will develop diabetes in adulthood. 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 pre-diabetes and are at high risk of developing diabetes.

1. Diabetes Community Health Education and Outreach Program

The Scripps Whittier Diabetes Institute collaborates with community clinics and organizations to provide much needed services and solutions. The Diabetes Community Health Education and Outreach Program implements outreach and educational programs that increase knowledge about diabetes and provide access for the community and underserved populations. For those that have positive screenings at

outreach events, a member of the Scripps Whittier Diabetes team follows up with individuals within one week or sooner if the findings are dangerously out of range. The follow-up ensures that the individuals are connected to a provider if they do not have one at the time, and that they schedule an appointment with their existing provider (if they have one) or register to attend a Project Dulce class. At selected Federal Qualified Health Centers (FQHCs) Whittier staff have direct access to scheduling an appointment in real-time for these individuals via an electronic scheduling system called ECIN.

Results: Community Health Fairs

Objective(s)	Community Health Fairs	2014	2015
Implement outreach and educational programs that increase knowledge about diabetes and provide access for the community and underserved populations.	Total Events/Classes	15	17
	Total Patients Participating	858	1,221
	Total Patients Screened	126*	61*
	Positive Screenings	47 (38%)	17 (28%)
	PCP Referrals	45	17

*Individuals who agree to be screened for diabetes management (DM) risk: diabetes risk-paper screen, blood pressure screenings or finger sticks. Blood pressure is a strong indicator of DM risk or pre-DM.

Results: Outreach and Education

Objective(s)	Peer-Led Health Education Classes	2014	2015
Implement outreach and educational programs that increase knowledge about diabetes and provide access for the community and underserved populations.	Total Events/Classes	151	125
	Total Patients Participating	1,111	994

Retinal Screenings

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. 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. After the screenings are interpreted, follow-up care is arranged if needed. More than 100 patients, many suffering from vision complications as a result of their diabetes, receive retinal screenings each month.

Results: Retinal Screenings

Objective(s)	Retinal Screenings	2014	2015
Identify those at high risk for retinal damage because of diabetes and provide access to education, treatment and referrals.	Total Screening Events	11	17
	Total Patients Screened	282	508
	Percentage of Positives	36% (103)	21% (110)
	Retinal Specialist Referrals	12% (38)	9% (50)
	Percentage of PCP Referrals	98% (276)	100%(508)

Benefits:

- Prevention or diagnosis of vision problems, including blindness.
- A reduction in visits to the emergency department for uncontrolled complications of diabetes.
- Cost savings 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.)

2. Project Dulce Care Management

The Project Dulce program has been fighting the diabetes epidemic for more than 19 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 changing eating habits, adopting exercise routines and other ways to help manage this chronic disease.

Results: Project Dulce Care Management

Objective(s)	Project Dulce	2014	2015
Improve Self-Management Education for underserved population living with diabetes.	Total Number of Intake Forms 2014	5,990	6,169
	Total of New Patients Entering the Program	1,049*	1,284*

*The new patients that enter the program each year are newly diagnosed with diabetes and the other are returning patients.

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.

Mental and Behavioral Health

1. National Depression Screening Day

Depression is the most common type of mental illness, affecting more than 26 percent of the U.S. adult population. It has been estimated that by the year 2020, depression will be the second leading cause of disability throughout the world, trailing only ischemic heart disease. Adults with the lowest income or education report more unhealthy days than those with higher income or education.

Mental Health, Inc. (SMH) has partnered with organizations to provide mental health education and screening programs, including National Depression Screening Day, National Alcohol Screening Day®, and the National Eating Disorders Screening Program®. These programs are designed to educate, reduce stigma and screen people for alcohol problems and mood and anxiety disorders. Individuals can locate a mental health screening site or take an online screening by visiting www.HelpYourselfHelpOthers.org.

Scripps participates in the National Depression Screening Day, an annual event in October aimed at helping people identify the signs of depression and providing resources to assist those at risk. Scripps has expanded the availability of free depression screenings by making them available in the community. The screenings are open to adults of all ages on a walk-in basis, and are informational, not diagnostic in nature, simply indicating whether questionnaire responses are consistent with symptoms of depression. Referrals to mental health professionals are provided if screening scores suggest this would be beneficial, and participants are also provided with literature that can be shared with friends and family members.

Results: National Depression Screening Day

Objective(s)	Depression Screenings	2013	2014	2015
Implement mental health screenings and provide resources to raise awareness of mental health disease and its symptoms as well as provide referrals for those at risk for having mental health problems.	Total Number of Visitors	134	151	114
	Total Number of People Screened	22	99	72
	Total Number of People Referred to Emergency Department	0	1	0
	Total Number of People Referred to Outpatient Services (Psychiatric Referrals by Zip Code)	9	0	14
	Total Number of People Tracked as Uninsured	14*	12+**	10 +***
	Total Number of People Tracked as Insured	60	67+**	83 +***

*2013: Scripps Green Hospital and Scripps Mercy Hospital, Chula Vista, did not collect information to record whether or not information was given, and whether or not referrals were given

**2014: Scripps Green did not collect information about insurance; Scripps Mercy Chula Vista insurance information collection was incomplete

***2015 Scripps Memorial Hospital Encinitas' election of demographic information was incomplete on individuals who took information but did not participate in screening.

Challenges:

Scripps initially participated in the National Depression Screening Day by holding the screenings in the lobby of Scripps Mercy Hospital, San Diego. In 2014, Scripps expanded the screenings through its five hospital campuses' lobbies and one emergency department. The hospital lobbies were not an ideal location due to traffic and privacy issues. The emergency department was also not an ideal location to hold screenings as the space does not have privacy and not enough turnovers of patients who were interested in taking the screenings. In 2015, Scripps decided to conduct the depression screenings out in the high-need communities. Originally, Scripps planned to partner with the San Diego Community Clinics to conduct the depression screenings but Scripps was informed that the community clinics — through their primary care visits — screen patients 12 years old and older for depression, using the PHQ-9 for adults and a modified teen version for the 12-17 year olds. In addition, the clinics also already conduct specialized screening/enhanced education events at various clinic sites in October, in recognition of it being the month associated with depression awareness.

Solution:

A beneficial solution came about as the YMCAs had an interest in partnering with Scripps Health. The YMCAs were willing to hold these depression screenings at their sites countywide. Many people visiting the YMCAs were interested in obtaining information for family and friends about depression. Some YMCA visitors were interested in taking the screening for depression. If a person scored in a range that was concerning they were given referrals based on their insurance/ability to pay. Each site had at least one licensed professional employed by Scripps, and if someone scored in a high risk range, a professional would further screen the community member and 911 would have been called if necessary. Scripps also had staff that could answer questions about Covered California and eligibility criteria.

Obesity

1. Dulce Mothers

Between 2007 and 2010, one out of three American adults was considered obese. Obese individuals have a 50–100 percent increased risk of premature death from all causes compared to individuals at a healthy weight. 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. Scripps began a pilot program, Dulce Mothers, with the goal of decreasing the incidence of type 2 diabetes by managing a major risk factor — obesity — in underserved, ethnically diverse populations through testing the effectiveness of a weight management curriculum designed for Latino women with gestational diabetes (GDM). Women with a history of GDM and who meet the criteria for being overweight (BMI above 25) are referred to the Dulce Mothers program.

Challenges:

There was no data captured in FY2014, as Dulce Mothers had some challenges in initiating the pilot program. These included securing community clinic partnerships that would generate participants for the program in a timely manner. As a result, Dulce Mothers added a second arm of the study-program, Nuestra Vida, aimed at 40 middle-aged women who are at high-risk for cardio metabolic conditions. This part of the program is being administered in Chula Vista. See the Identified Community Need Obesity chart breakdown in detailed Implementation Plan under Nuestra Vida for results. The Dulce Mothers' component will be administered in (North County (Escondido) and Dulce Mothers became an active outreach program in FY15.

In FY2015, the Dulce Mothers program continued to be an innovative opportunity for high-risk Latina women with a history of gestational diabetes. The objective of the program is to provide these mothers with tools to empower them to take ownership of their well-being by ultimately preventing the development of type 2 diabetes for them and their children. (Both mother and baby are at great risk of developing this chronic condition in their lifetime.) Some of the lessons learned from this program are that this population is difficult to recruit for the following reasons:

- Many of these women do not have transportation.
- Their health care coverage stops after their baby is born, making it difficult for them to obtain follow-up care or reach them.
- Most do not show up for care until they are pregnant again and at that point do not meet the inclusion criteria to participate in the program.

The Scripps Whittier team was able to recruit 27 women who started late in Quarter Four of this fiscal year. The program is a six-month intervention, therefore most of these women completed the program late in 2015 and early 2016.

Objective(s)	Dulce Mothers	2014*	2015
Decrease the incidence of Type II diabetes by managing a major diabetes risk factor, obesity in underserved, ethnically diverse populations by testing the effectiveness of a weight management curriculum designed for Latino women.	Total # of participants that attended the Dulce Mothers program per cohort	0	27
	Average BMI at Pre-Baseline	0	32.5
	Average BMI at Post-6 Months	0	30.7
	Number of Surveys Completed at Pre-Baseline	0	27
	Number of Surveys Completed at Post-6 Months	0	15

* There was no data captured in FY14, as Dulce Mothers had some challenges in initiating the pilot program. These included securing community clinic partnerships that would generate participants for the program in a timely manner.

Executive Summary



III. 2016 Community Health Needs Assessment Executive Summary

Based on the findings from the 2013 Community Health Needs Assessment (CHNA) and recommendations from the community, the 2016 CHNA was designed to provide a deeper understanding of barriers to health improvement in San Diego County. Participating hospitals will use this information to inform and guide hospital programs and strategies. This report includes an analysis of health outcomes and associated social determinants of health which create health inequities—‘the unfair and avoidable differences in health status seen within and between countries¹ and communities—with the understanding that the burden of illness, premature death, and disability disproportionately affects racial and minority population groups and other underserved populations.² Understanding regional and population-specific differences is an important step to understanding and ultimately strategizing ways to make collective impact. These new insights will allow participating hospitals to identify effective strategies to address the most prevalent and challenging health needs in the community.

Overview and Background

The 2016 CHNA responds to IRS regulatory requirements that private not-for-profit (tax-exempt) hospitals conduct a health needs assessment in the community 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 2016 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.

For the 2016 CHNA, the HASD&IC Board of Directors convened a CHNA Committee to plan and implement the collaborative CHNA process. The CHNA Committee is comprised of representatives from all seven participating hospitals and health care systems:

- Kaiser Foundation Hospital – San Diego
- Palomar Health
- Rady Children’s Hospital–San Diego
- Scripps Health
- Sharp HealthCare
- Tri-City Medical Center
- University of California San Diego Health

1 World Health Organization. Social determinants of health. http://www.who.int/social_determinants/sdh_definition/en/. Accessed March 2016

2 U.S. Department of Health and Human Services, HHS action plan to reduce racial and ethnic health disparities: A nation free of disparities in health and health care (Washington, DC: U.S. Department of Health and Human Services, Office of Minority Health, 2011), http://minorityhealth.hhs.gov/npa/files/plans/hhs/hhs_plan_complete.pdf

In May 2015, HASD&IC contracted with the Institute for Public Health (IPH) at San Diego State University (SDSU) to provide assistance with the collaborative health needs assessment that was officially called the HASD&IC 2016 Community Health Needs Assessment (2016 CHNA). The objective of the 2016 CHNA is to identify and prioritize the most critical health-related needs in San Diego County based on feedback from community residents in high need neighborhoods and quantitative data analysis. The 2016 CHNA involved a mixed methods approach using the most current quantitative data available and more extensive qualitative outreach. Throughout the process, the IPH met bi-weekly with the HASD&IC CHNA committee to analyze, refine, and interpret results as they were being collected. The results of the 2016 CHNA will be used to inform and adapt hospital programs and strategies to better meet the health needs of San Diego County residents.

This Executive Summary provides a high-level summary of the 2016 CHNA methodology and findings. The full CHNA report contains in-depth information and explanations of the data that participating hospitals and healthcare systems will use to evaluate the health needs of their patients and determine, adapt, or create programs at their facilities. Detailed IPH documents regarding the methodology, collected data, and findings are also included. Links and references throughout this summary will allow readers to ascertain the full spectrum of information relative to the development and findings of the 2016 CHNA.

Community Defined

For the purposes of this 2016 CHNA, the service area is defined as the entire County of San Diego due to a broad representation of hospitals in the area. Over three million people live in the socially and ethnically diverse County of San Diego. Select key demographic information is summarized in Figure 2 below. Additional information on socioeconomic factors, access to care, health behaviors, and the physical environment can be found in the full CHNA report.

Figure 2. Selected Community Statistics

Nearly 15% of San Diegans live in households with income below 100% of the Federal Poverty Level*	A greater proportion of Latinos, African Americans, Native Americans, and individuals of other race live in poverty compared to the overall San Diego population	Approximately 1 in 7 San Diegans are food insecure
Almost 15% of San Diegans aged 25 and older have no high school diploma or equivalency	Approximately 46% of households in San Diego have housing costs that exceed 30% of their income	Approximately 16% of San Diegans aged 5 and older have limited English proficiency and 8.5% are linguistically isolated

*Federal Poverty Level (FPL) is a measure of income issued every year by the Department of Health and Human Services. In 2016, the FPL for a family of four was \$24,300.

Because of its large geographic size and population, the San Diego County Health and Human Services Agency (HHSA) organized their service areas into six geographic regions: Central, East, North Central, North Coastal, North Inland, and South. When possible, data is presented at a regional level to provide more detailed understanding of the population. The geographical regions are represented below in Figure 3.

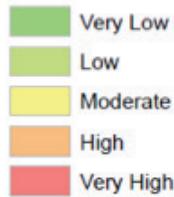
Figure 3. San Diego County with Health and Human Services Regions



Community Need Index

Recognizing that health needs differ across the region and that socio-economic factors impact health outcomes, the IPH used the Dignity Health/Truven Health Community Need Index (CNI) to identify communities with the highest level of health disparities and needs. The CNI score is an average of five different barrier scores that measure various socio-economic indicators of each community using the 2013 source data.

Figure 4. CNI Score and Color Scale

The five barriers used to determine CNI scores are:	CNI Color Scale:
<ul style="list-style-type: none">• Income Barrier• Culture Barrier• Educational Barrier• Insurance Barrier• Housing Barrier	 <p>Very Low Low Moderate High Very High</p>

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 see Figure 5), while a score of 5.0 represents a ZIP code with the most need (bright red in maps see Figure 5). For a detailed description of the CNI please see [Appendix L](#) or visit the interactive website at: <http://cni.chw-interactive.org/>.

When comparing CNI scores across HHSA regions (Table 1), differences in the mean CNI scores were apparent, with the Central region having the highest mean score of 4.2 and North Central having the lowest mean score of 3.1. It is important to note the variation in scores within each region as they highlight geographic differences in need. At a community level, 30 ZIP codes were identified as having high need CNI scores ranging from 4.2 to 5.0 (Table 2). The CHNA committee reviewed the high need ZIP codes to help identify vulnerable communities in which to engage and hold the community partner discussions.

Table 1. 2013 Community Need Index Scores by San Diego HHSA Region

HHSA Region	Min	Max	Mean
San Diego County	1.8	5.0	3.6
Central	3.0	5.0	4.2
East	2.6	4.8	3.8
North Central	2.0	4.4	3.1
North Coastal	1.8	4.6	3.3
North Inland	2.4	4.4	3.5
South	2.2	5.0	3.7

Data Source: Dignity Health Community Need Index. 2013; Zip codes included in each region

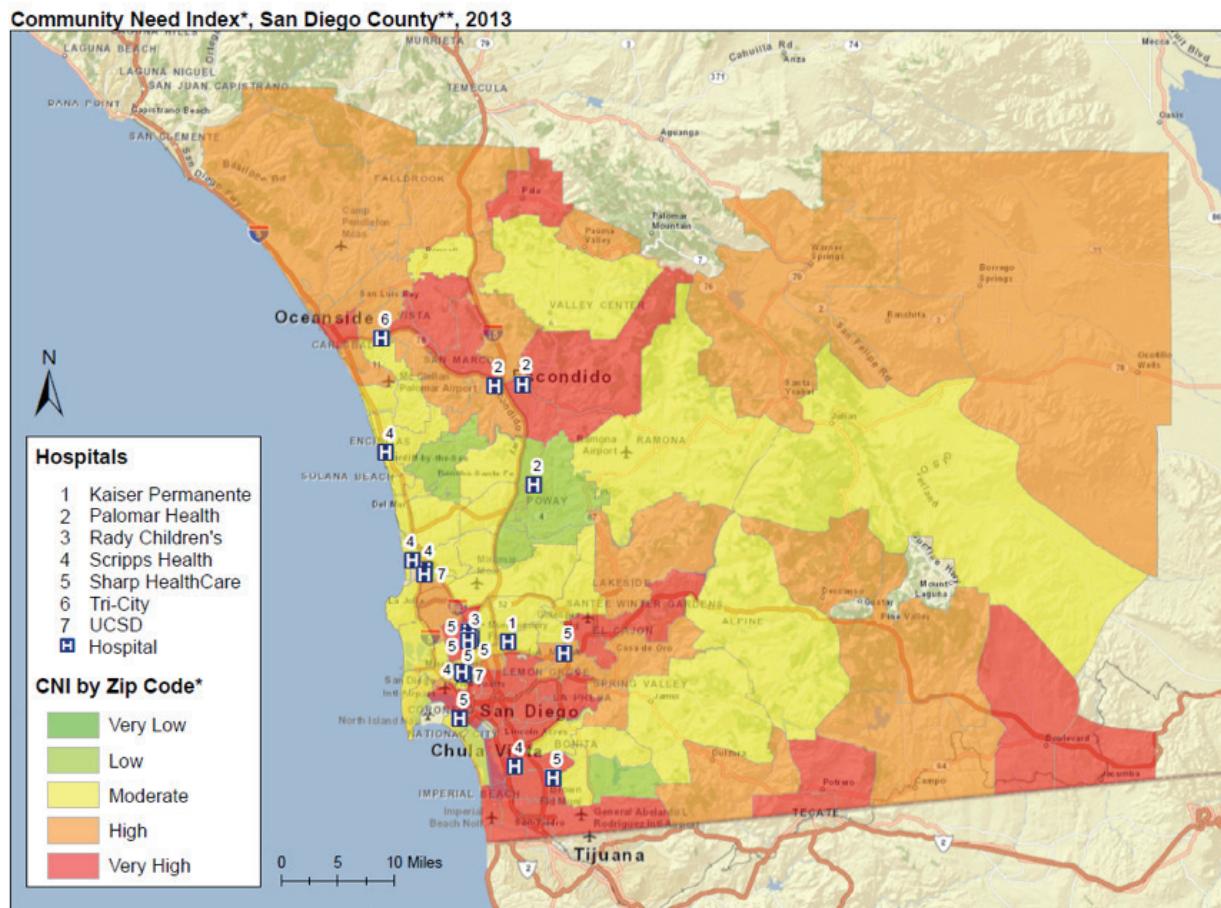
Table 2. Cities with High Need Index Scores (4.2-5.0) by San Diego County HHSA Region

HHSA Region	Zip Codes with a Score of 4.2 or Higher	HHSA Region	Zip Codes with a Score of 4.2 or Higher
Central			
San Diego	92101, 92102, 92104, 92105, 92113, 92114, 92115, 92139	San Diego	92111
East			
Boulevard	91905	Oceanside	92054
El Cajon	92020, 92021	Vista	92083, 92084
Jacumba	91934	South	
Lemon Grove	91945	Chula Vista	91910, 91911
Potrero	91963	Imperial Beach	91932
Spring Valley	91977	National City	91950
Tecate	91980	San Diego	92154
North Inland			
Escondido	92025, 92027	San Ysidro	92173
Paula	92059		
San Marcos	92069		

Source: Dignity Health Community Need Index. 2013; ZIP codes included in each region determined by San Diego HHSA

In addition, Geographic Information System (GIS) maps were created, overlaying CNI data and the hospital discharge rate by primary diagnosis for the health conditions: type 2 diabetes, cardiovascular disease, and behavioral health. GIS maps were not created for obesity due to the fact that obesity is not a common primary diagnosis, but rather a secondary condition that contributes to the primary reason for a hospital visit. A map of the CNI for San Diego County is provided below (Figure 5). To view all CNI maps of San Diego County and the six HHSA regional maps, please see [Appendix L](#).

Figure 5. San Diego Community Need Index, 2013



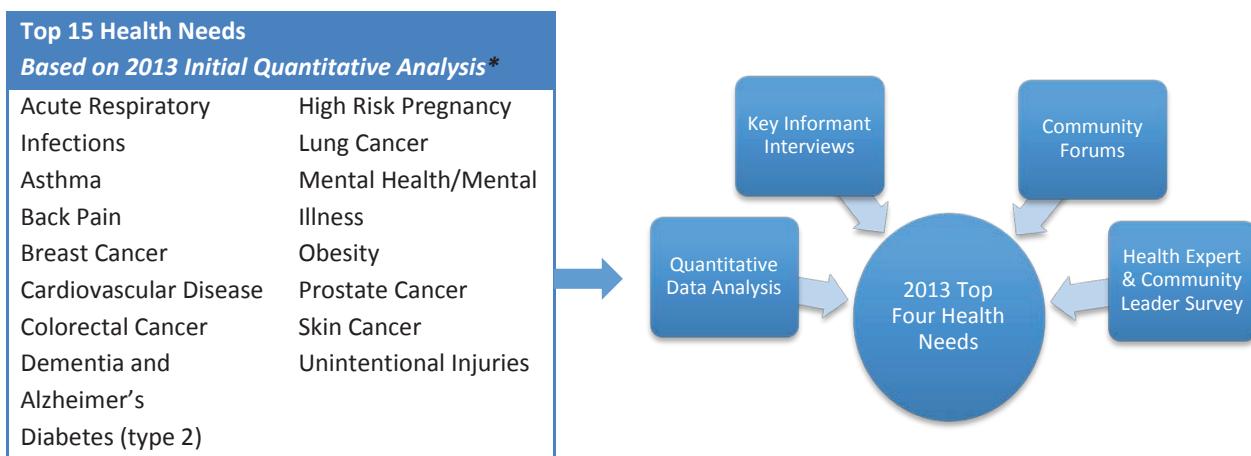
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2016 CHNA Methodology

The CHNA Committee designed the 2016 CHNA process based on the findings and feedback from the 2013 HASD&IC CHNA. The aim of the 2016 CHNA methodology was to provide a more complete understanding of the top four identified health needs and associated social determinants of health in the San Diego community. The 2013 methodology used to identify the top four health needs is described in Figure 6.

Figure 6. HASD&IC 2013 CHNA Methodology



When the results of all of the data and information gathered in 2013 were combined, four conditions emerged clearly as the top community health needs in San Diego County (in alphabetical order):

1. Behavioral/Mental Health
2. Cardiovascular Disease
3. Diabetes (Type 2)
4. Obesity

The CHNA Committee completed a collaborative follow-up process (Phase 2) to ensure the 2013 CHNA findings accurately reflected the health needs of the community. Phase 2 collected community feedback on both the process and findings of the 2013 CHNA, as well as recommendations for the next CHNA process. A summary of the overall findings from Phase 2 of the 2013 CHNA is below.

Figure 7. 2013 CHNA Phase 2 Findings

Phase 2 Overall Findings & Recommendations*		
Common set of barriers make hospital programs inaccessible for residents in high need communities	87% of respondents agreed the 2013 CHNA identified the top health needs of San Diego County Residents	78% of respondents agreed the methodology for the next CHNA should include a deeper dive into the top 4 health needs

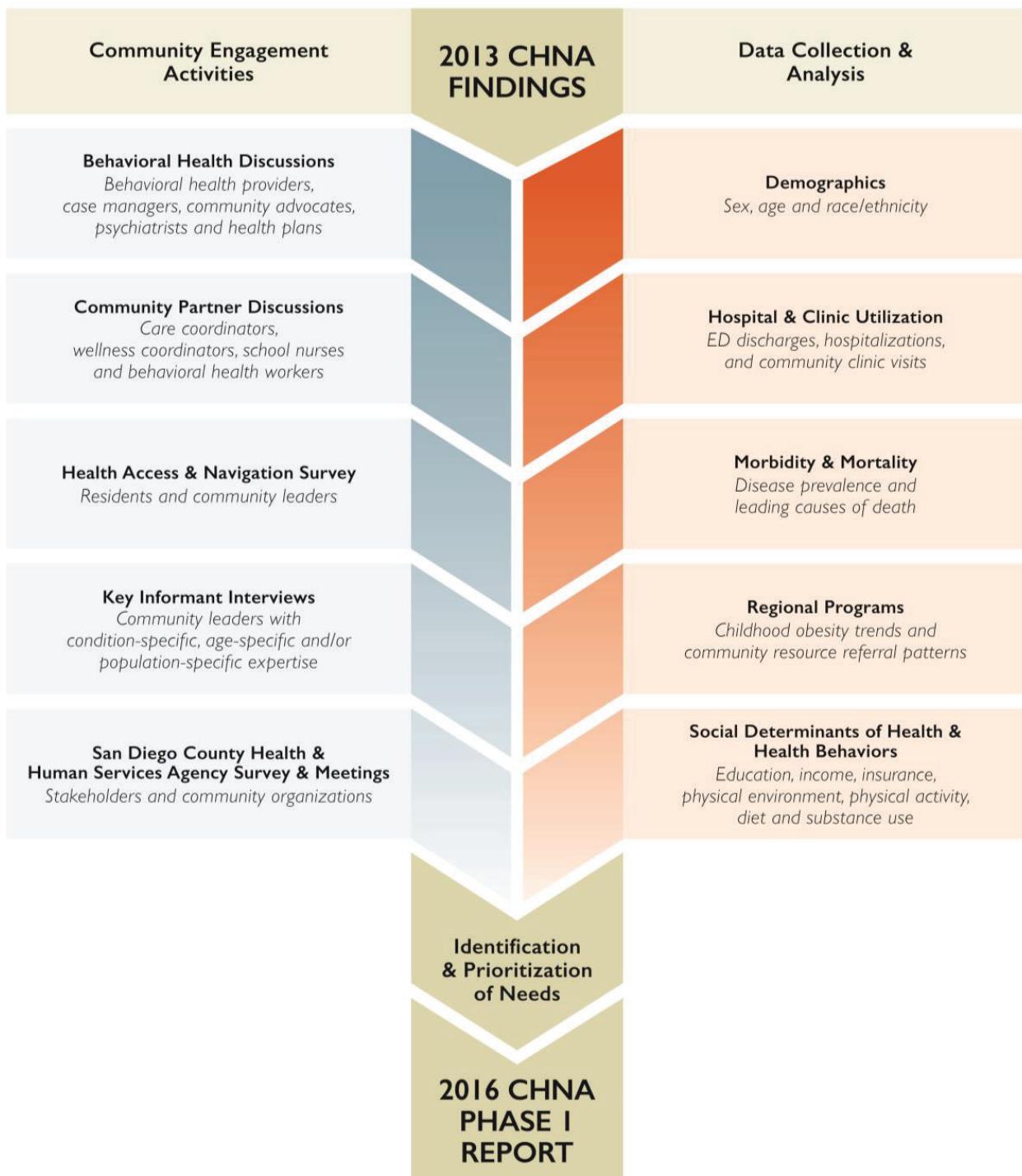
*For a complete description of the HASD&IC 2013 CHNA process and findings, see the full report available at <http://www.hasdic.org/chna.htm>.

Based on the findings and feedback from both phases of the 2013 CHNA, the CHNA Committee made a deeper analysis of the top four identified community health needs (behavioral health, cardiovascular disease, type 2 diabetes and obesity) the goal of the 2016 process. Prior to designing the 2016 methodology, the CHNA Committee met with leaders from community partner organizations who participated in the prior assessment. They advised the committee on ways to engage their staff who work with large numbers of residents in high need and vulnerable communities.

The 2016 process began with a comprehensive scan of recent community health statistics in order to validate the regional significance of the top four health needs identified in the 2013 CHNA.

Based on the results of the scan and feedback from community partners received during the 2016 planning process, a number of community engagement activities were conducted to provide a more comprehensive understanding of the identified health needs, including their associated social determinants of health and potential system and policy changes that may positively impact them. In addition, a detailed analysis of how the top four needs impact the health of San Diego residents was conducted. Figure 8 provides an overview of the process used to identify and prioritize the health needs for the 2016 CHNA. For the purposes of the CHNA, a “health need” is defined as a health outcome and/or the related conditions that contribute to a defined health outcome.

Figure 8. 2016 CHNA Process Map



Methods and Findings

The following sections describe the methods used to gather quantitative data and community input and the summarized findings. For more detail on the methodology and the findings, please see the [complete report](#).

Quantitative Data Collection and Analysis

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 2016 CHNA data collection process, 2013 OSHPD demographic data for hospital inpatient, emergency department, and ambulatory care encounters from all hospitals within San Diego County were analyzed to understand the hospital patient population. Clinic data was also gathered from OSHPD's website and incorporated in order to provide a more holistic view of health care utilization in San Diego, as hospital discharges may not represent all the health conditions in the community.

After comparing results of the quantitative analyses of the San Diego County mortality data, KP Community Benefit Data Analysis Tool, and hospital discharge data, the findings demonstrated that behavioral health, cardiovascular disease, diabetes, and obesity continue to be among the top priority health needs in San Diego County across different quantitative data sources. Information regarding community level programs and social determinants of health associated with the top health needs can be found in the body of the report.

Hospital and Clinic Data

In 2013, there were a total of 1,166,355 patient encounters at all inpatient, emergency department (ED) and ambulatory facilities in San Diego County among San Diego County residents. Approximately 60.8% of those encounters were at ED locations, followed by 25.8% at inpatient facilities and 13.5% at ambulatory centers. Below is a breakdown of the demographic characteristics of all San Diego resident encounters at any point of care location during the year 2013 (Table 3).

Table 3. Demographic Characteristics of All Hospital Encounters in San Diego County by San Diego Residents, 2013

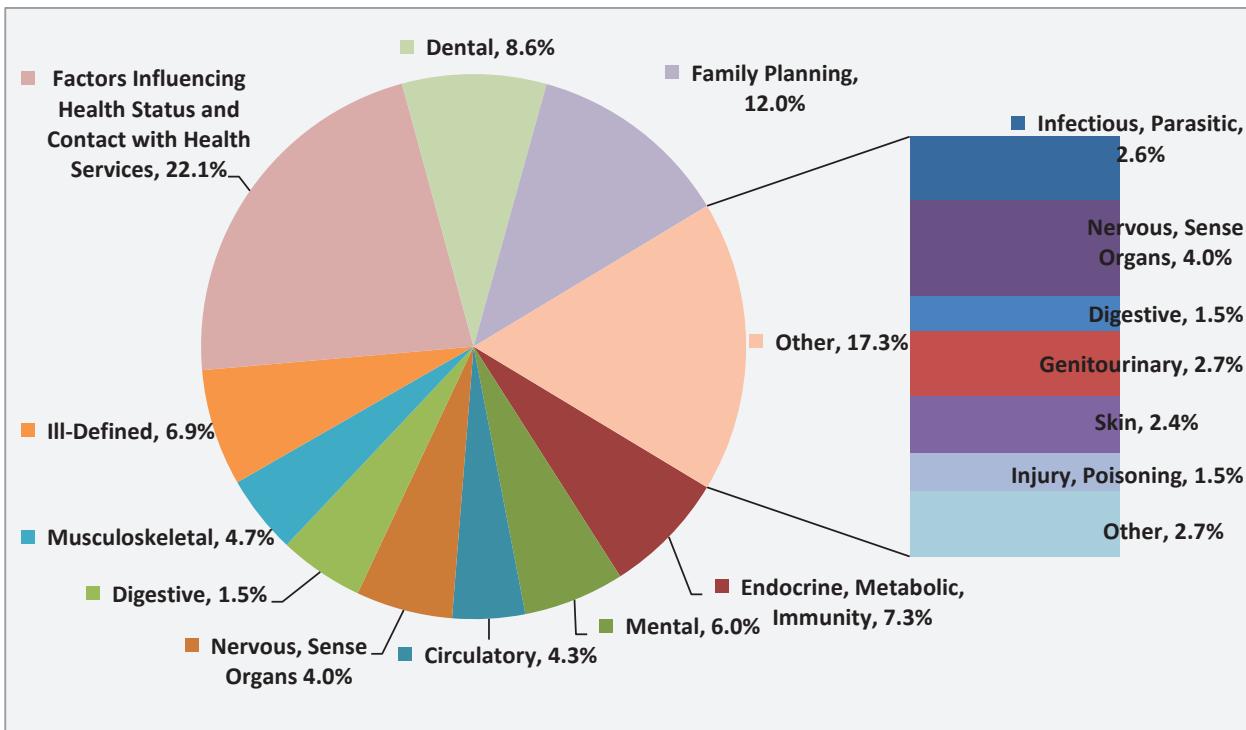
Age	#	%	Race	#	%
0-4 Years	126,677	10.9%	White	710,209	60.9%
5 to 14 Years	77,785	6.7%	Black/African American	90,299	7.7%
15 to 24 Years	129,263	11.1%	Asian/Pacific Islander	65,473	5.6%
25 to 44 Years	279,412	24.0%	Native Hawaiian/Other Pacific Islander	8,390	0.7%
45 to 64 Years	287,162	24.6%	American Indian/Alaskan Native/Eskimo/Aleut	5,026	0.4%
65+ Years	265,974	22.8%	Other Race	274,755	23.6%
			Unknown	12,158	1.0%
Gender	#	%	Ethnicity	#	%
Male	515,795	44.2%	Non-Hispanic/Non-Latino	806,631	69.2%
Female	650,501	55.8%	Hispanic/Latino	344,791	29.6%
			Unknown	14,891	1.3%

* Source: California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2013. SpeedTrack©

Clinic Utilization Data

According to 2013 OSHPD data, there are 103 clinics in operation in San Diego County, of which 77.7% are Federally Qualified Health Centers. There were roughly 2.1 million encounters reported in 2013. The largest majority of clinic patients are low-income, Hispanic, and Medi-Cal or self-pay. More specifically, 68.4% of clinic patients reported having an income below 100% of the poverty level, followed by 15.6% earning between 100-200% of the FPL. The clinic patient population is largely Hispanic (55.7%), and on average (median), approximately 31% of patients are best served in a non-English language. A breakdown of clinic utilization by principal diagnosis is shown below (Figure 9).

Figure 9. Clinic Encounters by Principal Diagnosis, Total Encounters in 2013



Source: California Office of Statewide Health Planning and Development, OSHPD Primary Care and Specialty Clinics Utilization Data. 2013.

Community Engagement Activities

Community engagement activities were conducted with a broad range of people including health experts, community leaders, and San Diego residents, in an effort to gain a more complete understanding of the top identified health needs in the San Diego community. Individuals who were consulted included representatives from state, local, tribal, or other regional governmental public health departments (or equivalent department or agency) as well as leaders, representatives, or members of medically underserved, low-income, and minority populations. For a complete list of individuals who provided input, see [Appendix B](#).

Community input was gathered through the following activities:

- Behavioral Health Discussions
- Community Partner Discussions
- Key Informant Interviews
- Health Access and Navigation Survey
- San Diego County HHSA Survey

Figure 10. Community Engagement Numbers, HASD&IC 2016 CHNA



The overall purpose of collecting community input was to gather information about the health needs and social determinants specific to San Diego County. Specific objectives included:

- Gather in-depth feedback to aid in the understanding of the most significant health needs impacting San Diego County.
- Connect the identified health needs with associated social determinants of health.
- Aid in the process of prioritizing health needs within San Diego County.
- Gain information about the system and policy changes within San Diego County that could potentially impact the health needs and social determinants of health.

Community Partner Discussions

Community partner discussions were conducted in all regions of the county between July and October of 2015, with 87 total participants. Non-traditional stakeholders were recruited through existing community partnerships in order to solicit input from those who work directly with vulnerable populations. These stakeholders (community partners) were comprised of individuals from a variety of backgrounds including: care coordinators, outreach workers, community education specialists, wellness coordinators, school nurses, behavioral health managers and workers, CalFresh Outreach Coordinators, and CalFresh Capacity Coordinators (Capacity Coordinators help to build capacity and community support, implement new projects and provide technical support to better address poverty and hunger). Findings from the community partner discussions are summarized in Table 4.

**Table 4. Summary of Community Partner Discussion Results,
HASD&IC 2016 CHNA**

Community Partner Discussion Questions and Summary of Responses	
1. What are the most common health issues or needs?	
<ul style="list-style-type: none"> Anxiety Depression Drugs/alcohol High blood pressure High cholesterol 	<ul style="list-style-type: none"> Lack of psychiatrists Obesity in youth Problems with compliance/coverage Self-injury/suicidal ideation in youth Unhealthy diet
2. What are the challenges clients face to improving health?	
<ul style="list-style-type: none"> Cost Homeless: often difficult to get proof of appointment; wait times are often longer than the amount of time they are allowed to be gone Lack of access to healthy food Lack of understanding of covered insurance benefits and fear of hidden costs Language barriers Literacy 	<ul style="list-style-type: none"> Stigma Stress Seniors: don't have support at home or forget to take medications, mobility issues and healthy eating Transportation Time Youth: Too few behavioral health practitioners/lack of school counselor, knowledge, getting parents on board/parent follow-up
3. Why do patients not adopt behaviors?	
<ul style="list-style-type: none"> Cost Cultural practices (i.e. unhealthy food, medicine only for the sick) Lack of awareness/recognition/education Not properly motivated/confident 	<ul style="list-style-type: none"> Perceived seriousness Prioritization of other needs The right questions aren't being asked Youth: Lack of role model, lack of control over health behaviors
4. What are top challenges you as case managers, health navigators, etc. face to helping patients?	
<ul style="list-style-type: none"> Compliance and literacy- getting individuals to read/use resources Elderly: may choose medicine over food Getting clients to go is difficult ('I don't need that' or 'I feel fine') Long waiting periods and no follow-up appointments North County: lack of services, only one crisis location Problems confirming appointments/contacting Problems with hospital discharges, continuing care and wrong referrals Patients being signed up for the wrong plans for what they need/want South region: getting documents/verifications Youth: difficulties communicating with parents/ what is told to parents at discharge does not filter down to the nurses, limited school-based interventions, cultural barriers, denial, unaware of problem 	
5. What have you found works best with your clients to help them meet their needs?	
<ul style="list-style-type: none"> Emotional support Finding intrinsic motivation Keeping the phone lines open Multicultural providers 	<ul style="list-style-type: none"> Reducing stigma Strengths-based case management Translators
6. How could hospitals collaborate with your organizations?	
<ul style="list-style-type: none"> Better referrals, streamlined discharge planning, and timely access to medical records (more details) Better ways to ask if people need food or other social services Discharge summary/instructions from hospital/doctor to school sites for kids (what are limitations, needs, modifications), upstream health education curriculum, presentations, and legislation for youth No discharge to streets or without medications, no discharges without making follow-up appointments with clients 	

Key Informant Interviews

In response to feedback from the 2013 CHNA, the number of key informant interviews conducted as part of the 2016 CHNA was expanded to include experts working with a wider variety of patient populations. Participants were selected based on their expertise in a specific condition, age group, and/or population. More specifically, individuals who participated in the 2016 CHNA had knowledge in at least one of the following areas: childhood issues, senior health, Native Americans, Latinos, Asian Americans, refugee and families, homeless, lesbian, gay, bisexual, transgender and queer (LGBTQ) population, veterans, alcohol and drug addiction, cardiovascular health, behavioral health, diabetes, obesity, and food insecurity. In addition there was representation across multiple agencies and organizations including the San Diego County HHSA, local schools, youth programs, community clinics, and community-based organizations.

The development of the key informant Interview tool began with the results from the HASD&IC 2013 CHNA. The interview questions were designed to provide in-depth detail on the top four health needs. Nineteen key informant interviews took place either in-person or via phone interview between July 2015 and February 2016. Each interview lasted no longer than one hour. Six questions were asked during the interviews, with a particular focus on the top four health needs that were identified in the 2013 CHNA. Although there were specific questions asked, the format of the interviews allowed for ample opportunity for open discussion on health needs that the key informants felt were most important in San Diego County, including those not directly related to the top four health needs. Please see [Appendix E](#) for all key informant interview materials.

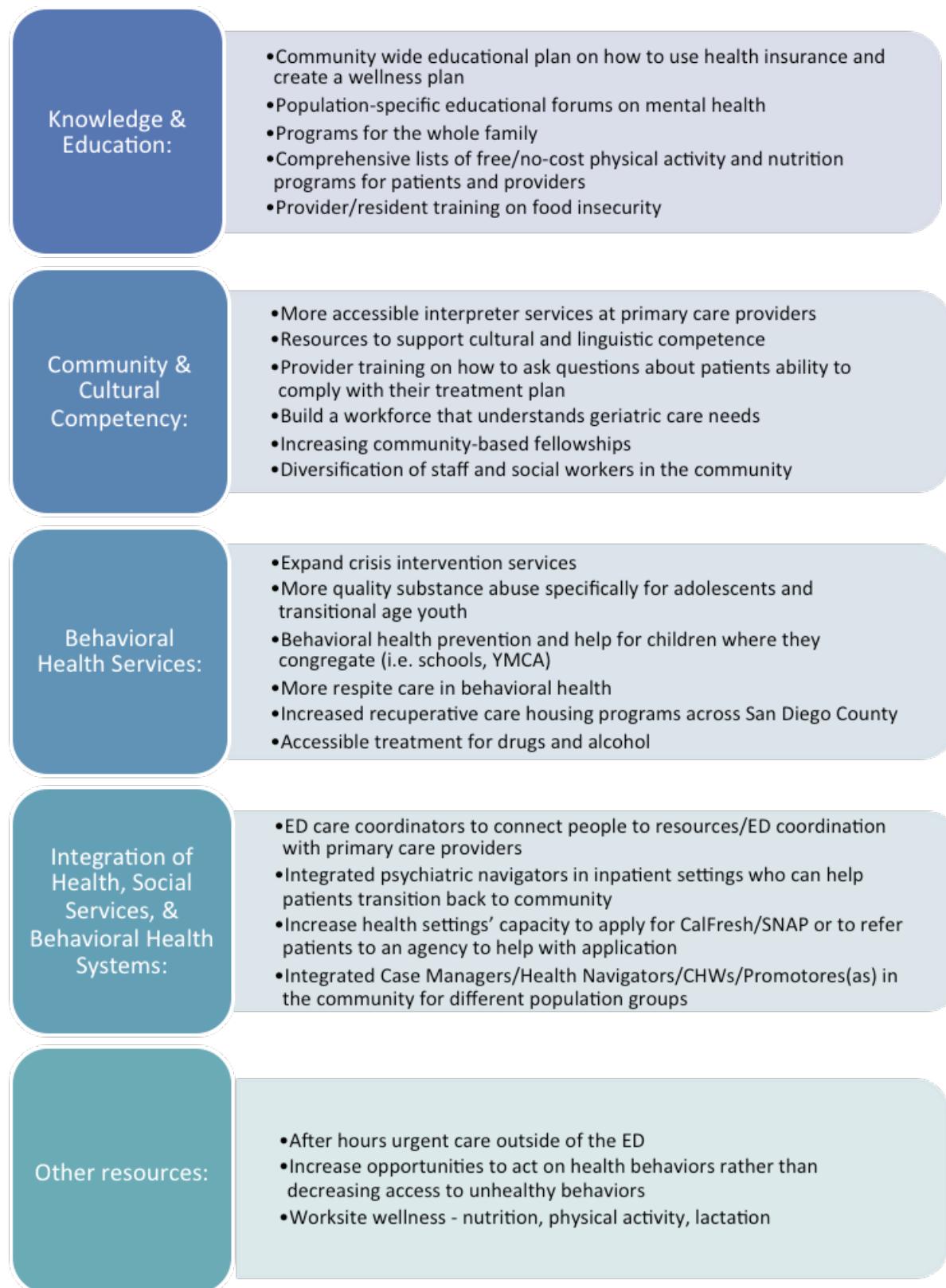
The most common health needs, important modifiable risk factors, effective strategies, and suggestions for collaboration are summarized in Table 5. Some important strategies that key informants suggested included behavioral health prevention and stigma reduction, education on disease management and food insecurity, improving cultural competency and diversity, and integrating physical and mental health, coordinating services across the continuum, and engaging case managers and patient navigators in the community and incorporating them as a routine part of the continuum of care.

In addition, Figure 11 describes key informant recommendations for community resources to address the four identified health needs as well as their associated social determinants of health.

Table 5. Summary of Key Informant Responses, HASD&IC 2016 CHNA

Key Informant Interview Questions and Summary of Responses	
1. What are the most common health issues or needs?	
<ul style="list-style-type: none"> Anxiety Asthma Dental health Depression Dementia and Alzheimer's disease in seniors Depression and diabetes in seniors Diabetes - low-income and food insecure populations, Latinos, Asians 	<ul style="list-style-type: none"> Hypertension –Latinos, African Americans, and Asians Increase in developmental disorders in children Obesity – youth, acculturating refugees, Native Americans, older veterans, low income individuals and families Substance Abuse
2. What do you think are the most important modifiable risk factors related to the health issues you just mentioned?	
<ul style="list-style-type: none"> Access to nutritious food Access to specialty care Childhood and adult traumas Homelessness Lack of access to psychiatrists Lack of physical activity – decreased physical education in youth, decreased mobility in seniors 	<ul style="list-style-type: none"> Lack of resources for care and housing of seriously mentally ill Lack of social support and isolation Lack of substance abuse treatment facilities, especially in North County Limited access to gyms or safe spaces to participate in physical activity
3. What strategies do you think would be most effective for patients, physicians, case managers etc. in addressing the health needs or modifiable risk factors above?	
<ul style="list-style-type: none"> Care integration and coordination Community and cultural competency 	<ul style="list-style-type: none"> Early identification and prevention Knowledge/education
4. What resources need to be developed or increased in order to address the health needs or modifiable risk factors above?	
<ul style="list-style-type: none"> See Figure 10 below for a list of resources 	
5. Are there systems, policy, or environmental changes that, if implemented, could help the hospitals address these health needs or modifiable risk factors?	
<ul style="list-style-type: none"> Increased awareness of available services Increased data sharing Increase psychiatrists and nurse practitioners 	<ul style="list-style-type: none"> Payment model reforms that include reimbursements for social services (i.e. behavioral health case management, wellness/education, community health workers)
6. Can you recommend any partnerships or collaborations between hospitals and specific organizations that would help to address the health needs or modifiable risk factors above?	
<ul style="list-style-type: none"> City leadership and planning departments Community-based organizations External provider support through technology FQHCs Information sharing between physicians/case managers and community-based organizations 	<ul style="list-style-type: none"> Intergenerational partnerships Internship/workforce training programs with local educational institutions San Diego HHSA Managed care plans San Diego County Mental Health Contractors Warm hand-offs

Figure 11. Resources Needed to Meet Needs Identified in Key Informant Interviews



Surveys

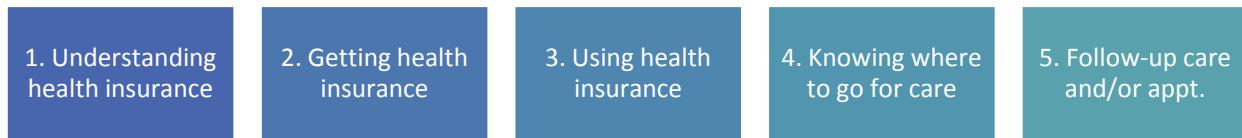
Two different surveys were developed and disseminated through different avenues as part of the 2016 CHNA process – the Health Access and Navigation Survey and the Collaborative San Diego County Health and Human Services Agency Survey.

Health Access and Navigation Survey

The Health Access and Navigation Survey was developed in partnership with the San Diego County Resident Leadership Academy (RLA)^{3,4}. After comparing results of the RLA's 2014 Community Needs Assessment⁵ and with the findings from the HASD&IC 2013 CHNA, access and navigation of health care emerged as a common barrier identified by the San Diego community. The CHNA Committee collaborated with the RLAs to design a survey tool that could identify specific barriers residents face when they try to access health care services. RLA leaders agreed to disseminate the health access and navigation survey to residents in their neighborhoods.

Survey participants were asked to choose the top five barriers the participants or the population they work with experience, and to rank the five barriers from one to five, with one being the most troublesome. Most striking was that the top four barriers cited as most troublesome were all precursors to seeing a health care provider, indicating that community members are often struggling to make it past the first steps of accessing healthcare. Based on the survey responses, the top five barriers to accessing health care were:

Figure 12. Top Five Barriers to Accessing Health Care



As the number of individuals who have health insurance in the nation and within San Diego County has increased, so has the importance of helping people understand how to obtain health insurance, use health insurance, and access care that is appropriate for their health needs. Residents' ability to access health care is a critical first step toward improving the overall health of San Diego community. Table 7 shows the top five barriers countywide.

3 More information about the San Diego Resident Leadership Academy is here <http://www.sdchip.org/initiatives/resident-leadership-academy.aspx>

4 Adapted from San Ysidro Health Center hand out which was adapted from the Centers for Medicare & Medicaid Services, <https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH-Coverage2Care.html>

5 More information about the RLA assessment completed for the San Diego County's Community Action Partnership is available here: http://www.sandiegocounty.gov/hhsa/programs/sd/community_action_partnership/

'Understanding health insurance' was the top cited barrier in all regions with the exception of East region which found 'follow-up care and/or appointments' to be the number one barrier. Within each overarching barrier participants were asked to choose the reasons those barriers were a problem in accessing care. For example, within the overarching barrier 'Understanding health insurance,' the top two reasons this barrier was cited as a problem were 'confusing insurance terms' and 'how does Covered California apply to me?'. Findings by region are also available in [Table 40](#) in the full report.

Eighty-five percent of survey respondents identified themselves as "community member" (Table 6). The majority of the respondents were Hispanic (68.5%) followed by white (26.9%), Asian/Pacific Islander and black (3.7% and 2.3%, respectively). There was representation from all six San Diego County HHSA regions, with the largest proportion of respondents being from South region (46.3%).

**Table 6. Demographic Information, Health Access and Navigation Survey,
HASD&IC 2016 CHNA**

Demographics	n	%
Community Member/Resident	195	85.2%
RLA Leader	17	7.4%
SD County Representative	17	7.4%
Total Individuals	229	100.0%
Race/Ethnicity		
Asian/Pacific Islander	8	3.7%
Black	5	2.3%
Hispanic	150	68.5%
White	59	26.9%
Other (Multi Race/Native American)	2	0.9%
Total Individuals*	219	100.0%
Populations Survey Participant has Knowledge of		
Low Income	135	78.0%
Medically Underserved	64	37.0%
Populations with Chronic Conditions	51	29.5%
Minority Population	44	25.4%
Other	22	12.7%
Total Individuals*	173	100.0%
Region Community Resident Lives in or Works in**		
Central	23	10.0%
East	14	6.1%
North Central	34	14.7%
North Coastal	34	14.7%
North Inland	34	14.7%
South	107	46.3%
Total Individuals*	231	100.0%
Who have you helped navigate thru the health system? (check all that apply)		
Yourself (18+)	124	57.1%
Child	73	33.6%
Another Adult	95	43.8%
Older Adult (65+ yrs.)	37	17.1%
Total Individuals*	217	100.0%

*Note: Total individuals who answered question. Persons could choose more than one category therefore the individual categories do not add up to the total individuals.

** Created regions based on ZIP code, when no ZIP code was reported used the region the survey participant chose.

Table 7. Health Access and Navigation Survey Results, HASD&IC 2016 CHNA

Five Most Troublesome Barriers to Accessing Health Care⁶

Resident Responses	Total Respondents* (N=250)	
	n	%
1. Understanding health insurance	194	77.6%
2. Getting health insurance	159	63.6%
3. Using health insurance	149	59.6%
4. Knowing where to go for care	149	59.6%
5. Follow-up care and/or appointment	118	47.2%

*Based on the total number of respondents who selected the barrier as being among the top five barriers they experience

Specific Challenges Identified by San Diego Residents

1. Understanding health insurance	Total Respondents* (N=250)		2. Getting health insurance	Total Respondents* (N=250)	
	n	%		n	%
Confusing insurance terms	104	59.4%	How to pick a plan	92	62.2%
How does Covered California apply to me?	92	52.6%	Eligibility requirements & documentation status	79	53.4%
Total**	175		Total**	148	

3. Using health insurance	Total Respondents* (N=250)	
	n	%
Knowing what services are covered	97	69.3%
Understanding health care costs/bills	70	50.0%
Total**	140	

4. Knowing where to go for care	Total Respondents* (N=250)		5. Follow-up care and/ or appointments	Total Respondents* (N=250)	
	n	%		n	%
When to use the ED vs urgent care vs clinic	80	56.3%	Lack of instructions about necessary follow up care	50	45.9%
No primary care doctor	59	41.5%	Lack of understanding about next steps	47	43.1%
Total**	142		Total**	109	

** Total refers to the number of survey participants who chose to rank specific challenges within a major category. Only the top two challenges are listed and participants were asked to select all that apply so columns should not be added downwards to determine the total.

6 Details and data by region in Table 41.

San Diego County HHSA Survey

In early 2014, HASD&IC and leadership at HHSA began discussing ways to align their efforts to assess community health needs. In recognition of the tremendous opportunity to leverage the work of each entity, HHSA altered their CHA schedule to align it with the triannual CHNA schedule required by federal regulations. The alignment supported several key goals: improved ability to share information from the different assessments; reduced burden on the communities and organizations surveyed by both assessments; and increased opportunities for partnership and collaboration. For this 2016 CHNA process, the HHSA and HASD&IC partnered in regional presentations as well as an electronic survey.

Data presentations were given at five Live Well San Diego Regional Leadership Team meetings across San Diego County in October and November 2015. The Regional Leadership Teams are comprised of community leaders and stakeholders that are active in each of the six HHSA regions. Each meeting included an overview of the HASD&IC 2013 CHNA process and findings followed by a presentation from the County of San Diego Community Health Statistics Unit on current data trends in their region.

Following the data presentations, an electronic survey was sent to pre-identified stakeholders and community partners representing all six HHSA regions. HASD&IC and the County HHSA worked together to create specific questions assessing community perception of the top health needs, and for which health needs resources are lacking.

The results of the survey as it relates to the top health problems and lack of resources are summarized in Table 8. Overall, mental health issues and alcohol and drug abuse were most frequently cited as the most important health problems across all the regions. Additionally, with the exception of East region, Mental Health Issues were found to have the least amount of resources to address the problem across the County. For more information, please visit HHSA's Live Well website at <http://www.livewellsd.org/content/livewell/home/make-an-impact.html>.

Table 8. Collaborative San Diego County Health and Human Services Agency Results, 2016

What do you think are the 5 most important HEALTH PROBLEMS* in your community (those problems that have the greatest impact on overall community health)? (Survey Question)				
Central (15)	East (6)	North Central (14)	North County (44)	South (12)
Mental Health Issues (12)	Alcohol and Drug Abuse (6)	Mental Health Issues (10)	Mental Health Issues (30)	Mental Health Issues (9)
Alcohol and Drug Abuse (9)	Mental Health Issues (5)	Aging concerns& (8) Alcohol/Drug abuse (8)	Alcohol/Drug abuse (30)	Alcohol/Drug Abuse (7)
Diabetes (9)	Obesity (4)	Heart Disease (6)	Aging Concerns& (23)	Obesity (7)
Obesity (7)	Diabetes (3) Cancer (3) Aging Concerns (3)	High Blood Pressure (4) Obesity (4)	Diabetes (20)	Aging Concerns& (7)
Heart Disease (6)			Obesity (18) Cancer (18)	Heart disease (6)
Of the top 5 HEALTH PROBLEMS that you selected above, specify which ONE health problem has the least amount of RESOURCES available to help address the problem. (Survey Question)				
Central (15)	East (6)	North Central (14)	North County (44)	South (12)
Mental Health Issues	Alcohol/Drug Abuse	Mental Health Issues	Mental Health Issues	Mental Health Issues

*Problems were ranked based on total number of respondents identifying the problem as being among the top 5 (shown in parenthesis); health problems with an equal number of responses are listed in the same box.
& e.g., arthritis, falls, Alzheimer's, etc.

Behavioral Health Discussions

Due to the complexity of behavioral health, additional discussions were held specifically to ensure the quantitative data that was gathered accurately reflected current trends and areas of true need. The purpose of the behavioral health discussions was to gather feedback from behavioral health experts to aid in the understanding of the most significant health needs impacting San Diego County and aid in the process of prioritizing health needs within behavioral health.

Meetings focused on behavioral health were targeted to solicit feedback from stakeholders including patient advocates as well as representatives from hospitals, clinics, County HHSA, smaller behavioral or mental health facilities, and health plans. The behavioral health discussion template was developed based on hospital discharge data analysis and incorporated a synthesis of the community partner discussion data. A summary of data as

it relates to behavioral health needs was provided to the behavioral health experts prior to gaining their feedback. Three behavioral health discussions took place between December 2015 and January 2016. The combined total number of attendees was roughly 58 people between the two meetings.

When participants were asked to respond to the hospital data presented, there was general agreement in the findings at both the Hospital Partners and the Healthy San Diego Behavioral Health Workgroup meetings (see [Appendix E](#) for the hospital discharge data presented during meetings). There was consensus that the high rates of psychotic discharges in ages 25 to 44 were likely linked to underlying substance abuse problems. Although participants agreed with the findings, it was pointed out that there were additional important conditions that may not come to the surface because of the way hospital data is coded. Because the data is used for billing purposes, physical conditions may often be coded first and potentially underrepresent the prevalence of underlying behavioral health issues. Most notably missing from the data were developmental disorders. The group also pointed out the importance of data trends. In particular, it was pointed out that in recent years participants have been seeing a significant increase in meth-amphetamine discharges (over 100%).

The Alpine Special Treatment Center⁷, an important provider of care to a particularly vulnerable portion of the San Diego population, referenced a number of additional challenges that should be noted including lack of placements available once patients were ready to leave their facility, overburdened case managers, and difficulty in managing the disability application process. Another frequent challenge cited by the staff at the Alpine Special Treatment Center was the physical health problems of their patients. Discussion participants stated that behavioral health is frequently associated with other chronic conditions and that the majority of their patients fit the diagnosis for all four of the top health needs. Many patients have such serious physical health conditions that they must be sent to facilities that can treat higher acuity patients, though these facilities are generally less appropriate for treatment of their behavioral health conditions. Discussion participants stated that North County in particular lacked available resources to transition their patients. Sufficient step down facilities and improved communication between hospitals, behavioral health facilities, and community based services were some important strategies to success. Understanding the appropriate number and type of facilities needed to rotate this critical population through the health system effectively was said to be key in order to adequately treat patients across the continuum of care.

⁷ Alpine Special Treatment Center is a locked mental health rehabilitation and transitional care facility. They provide care to voluntary and involuntary adults with acute psychiatric symptoms and those suffering from co-occurring disorders. Their primary goal is to quickly and safely stabilize and transition individuals from acute care to community placement.

2016 Prioritization of the Top Four Identified Health Needs

In order to prioritize the four significant health needs in San Diego County, the CHNA Committee applied the following five criteria:

1. **Magnitude or Prevalence:** The health need affects a large number of people in all regions of San Diego.
2. **Severity:** The health need has serious consequences (morbidity, mortality, and/or economic burden).
3. **Health Disparities:** The health need disproportionately impacts the health status of one or more vulnerable population groups.
4. **Trends:** The health need is either stable or changing over time, e.g., improving or getting worse.
5. **Community Concern:** Stakeholders, community members, and vulnerable populations within the community view the health need as a priority.

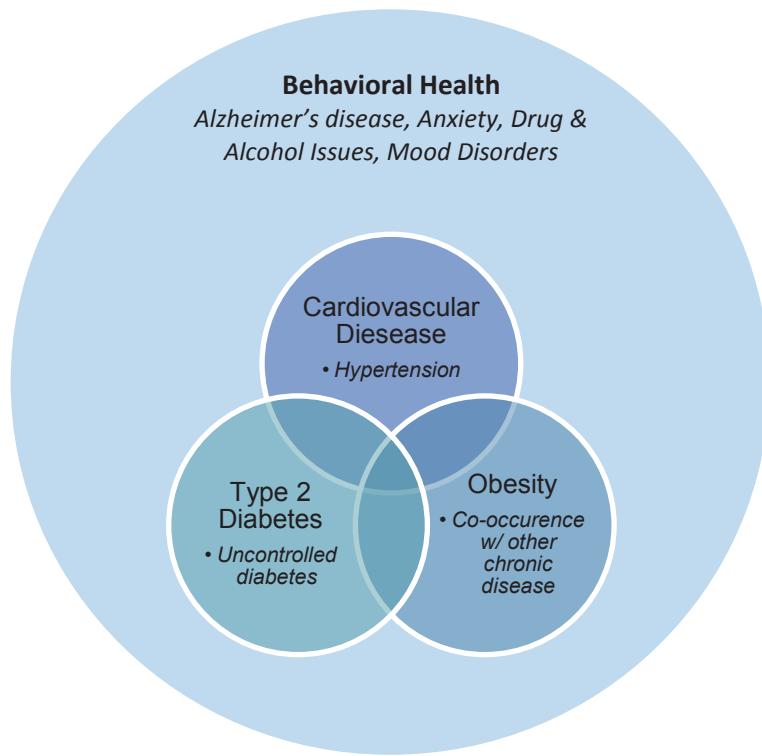
Using these criteria, a summary matrix translating the 2016 CHNA findings was created for review by the CHNA Committee. Taking into account the results of the quantitative data collection and the findings from the community engagement activities, a rank from 1 to 4, with 1 being the most significant, was applied to each criterion. An overall score was given to each health need by averaging the rankings across all five criteria. In addition, the social determinants of health were analyzed and identified across all health needs. Through examination of the combined results and in review of all data, a clear ranking within the top four health needs emerged (Table 9).

Table 9. Ranking Results from Quantitative Data Collection and Community Input, HASD&IC 2016 CHNA

Data	Behavioral Health Rank	Cardiovascular Disease Rank	Diabetes Rank	Obesity Rank
1. Magnitude or Prevalence:	3.0	1.0	4.0	2.0
2. Severity:	2.0	1.0	3.0	4.0
3. Health Disparities:	1.0	1.0	1.0	1.0
4. Trends:	2.0	4.0	3.0	1.0
5. Community Concern:	1.0	3.3	2.7	3.0
Key Informants	1.0	2.0	3.0	4.0
Discussions	1.0	4.0	2.0	3.0
County HHSA	1.0	4.0	3.0	2.0
Average Ranking Among 5 Criteria	1.8	2.1	2.7	2.2

The CHNA Committee identified behavioral health as the number one health need in San Diego County. In addition, cardiovascular disease, diabetes, and obesity were identified as having equal importance due to their interrelatedness. Health needs were further broken down into priority areas due to the overwhelming agreement among all data sources and in recognition of the complexities within each health need. Within the category of behavioral health, Alzheimer's disease, anxiety, drug and alcohol issues, and mood disorders are significant health needs within San Diego County. Among the other chronic health needs, hypertension was consistently found to be a significant priority area related to cardiovascular disease, uncontrolled diabetes was an important factor leading to complications related to diabetes, and obesity was often found to co-occur with other conditions and contribute to worsening health status. The impact of the top health needs differed among age groups; with type 2 diabetes, obesity, and anxiety affecting all age groups, drug and alcohol issues affecting teens and adults, and Alzheimer's disease, cardiovascular disease, and hypertension affecting older adults.

Figure 13. 2016 CHNA Top Health Needs



A description of the impact of the prioritized health needs on the morbidity and mortality of San Diego County residents can be found in the full CHNA report.

A complete analysis of disparities among different population groups with respect to the top four health needs can be found in the Vulnerable Populations Report in [Appendix K](#). In addition, GIS maps were created, overlaying the rate of primary diagnosis for hospital discharge data with CNI data for the health needs: type 2 diabetes, cardiovascular disease, and behavioral health. GIS maps were not created for obesity due to the fact that obesity is not a common primary diagnosis but rather a secondary condition that contributes to the primary reason for a hospital visit. Please see the full report for the GIS maps of hospital discharge rates and CNI data.

To better understand the important barriers, modifiable risk factors, and potential strategies to address these health needs, please see the 'Social Determinants of Health' section below.

Social Determinants of Health

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. Analysis of results from the community partner discussions and key Informant interviews revealed the most commonly associated social determinants of health for each of the top health needs above. Ten social determinants were consistently referenced across the different community engagement activities. The importance of these social determinants was also confirmed by quantitative data. Hospital programs and community collaborations have the potential to impact these social determinants, which are outlined below in order of priority.

Figure 14. Social Determinants of Health, HASD&IC 2016 CHNA

Food Insecurity & Access to Healthy Food	<ul style="list-style-type: none"> • Cited most often as a social determinant of health across all community engagement activities. • Lack of access to healthy food poses a challenge that contributes to diabetes and obesity.
Access to Care or Services	<ul style="list-style-type: none"> • Overarching barriers to access included transportation, language barriers, health literacy, insurance coverage, cost, time, and legal status.
Homeless/Housing issues	<ul style="list-style-type: none"> • Frequently mentioned as barriers to addressing health needs and improving health status, particularly behavioral health.
Physical Activity	<ul style="list-style-type: none"> • For youth, concerns included decreased physical education, limited access to gyms and safe spaces for activities. • For seniors, lack of exercise was attributed to reduced mobility.
Education/Knowledge	<ul style="list-style-type: none"> • Educational efforts on behavioral health & stigma reduction, food insecurity awareness and patient, caregiver, & family empowerment are needed to improve health.
Cultural Competency	<ul style="list-style-type: none"> • The changing demographics of San Diego County require a culturally competent workforce.
Transportation	<ul style="list-style-type: none"> • Transportation problems make it difficult to obtain services. • There are often no providers within a reasonable travel distance.
Insurance Issues	<ul style="list-style-type: none"> • Residents reported challenges understanding, securing and using health insurance, which impede ability to access care.
Stigma	<ul style="list-style-type: none"> • Frequently mentioned as a barrier that hindered individuals from seeking help with behavioral health. • Also mentioned with reference to seeking food assistance.
Poverty	<ul style="list-style-type: none"> • Linkages between low-income levels and diabetes, obesity and cardiovascular disease were cited. • Behavioral health issues were mentioned as barriers to employment and financial stability.

Community Recommendations

Following the completion and of the community engagement activities, all of the different types of feedback were combined and analyzed. Four key categories emerged: overarching strategies to address the top health needs; resources that must be increased or developed to meet the health needs; system, policy and environmental changes that could support better health outcomes; and possible collaborations to improve access and quality of care for vulnerable populations. A compilation of the overarching recommendations is below.

Figure 15. Summary of Community Recommendations, HASD&IC 2016 CHNA

Strategies to address the top health needs fell into four major categories:

Knowledge/education	Community and cultural competency	Early identification and prevention	Care integration and coordination
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Resources that must be developed or increased to address the top health needs are:

Community and cultural competency	Behavioral health services	Integration health/social services/behavioral health systems	After hours urgent care	Worksite wellness
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System, policies and environmental changes required to support better health outcomes

Data sharing	Increased awareness of available services	Increased number of psychiatrists and nurse practitioners	Reimbursement for social and supportive services & care management
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Collaborations that could improve community health outcomes

Warm hand-offs and information sharing between health providers & community based organizations	Increased internship and workforce training programs with local educational institutions	Partnerships with community collaboratives & Intergenerational Partnerships	External support for providers through the use of technology	Collaboration between provider and community
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Although one of the recommendations references the need to add and develop additional services, we want to acknowledge that there are many excellent existing resources available to San Diego County residents. In order to provide an overview of the type and number of resources currently available to address the top health needs, a list of local assets were compiled using on 2-1-1's Directory of Services (Appendix F). 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. Considering that available programs and services continuously change, the community is encouraged to access the most available data through 2-1-1 San Diego.

In addition to citing the resources available through 2-1-1 San Diego, a list of existing health initiatives and public policy efforts was also created. The next phase of this CHNA will likely include an expansion of the current list. (See [Table 55](#) in the report).

Next Steps

Hospitals and healthcare systems that participated in the HASD&IC 2016 CHNA process have varying requirements for next steps. Private, not for profit (tax exempt) hospitals and healthcare systems are required to develop hospital or healthcare system community health needs assessment reports and implementation strategy plans to address selected identified health needs. The participating public hospitals and healthcare systems do not have federal or state 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 healthcare 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 may serve as a useful resource to both residents and healthcare providers to further communitywide health improvement efforts.

The CHNA Committee is in the process of planning Phase 2 of the 2016 CHNA, which will include gathering community feedback on the 2016 CHNA process and strengthening partnerships around the identified health needs and social determinants.

Overview and Background



IV. Overview and Background

In May 2015, seven hospitals and health systems in San Diego County began a Community Health Needs Assessment (CHNA) that was facilitated by the Hospital Association of San Diego and Imperial Counties (HASD&IC) and the Institute for Public Health (IPH) at San Diego State University (SDSU).

HASD&IC was established in 1956 (then the Hospital Council) and is a non-profit organization representing over 35 hospitals and integrated health systems in the two-county area. HASD&IC's mission is to support its members by advancing the organization, management and effective delivery of affordable, medically necessary, quality health care services for the communities of San Diego and Imperial counties. 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. HASD&IC contracted with San Diego State University's Institute for Public Health (IPH) to conduct a hospital-based Community Health Needs Assessment (CHNA) throughout the region.

The Institute for Public Health (IPH) at San Diego State University (SDSU) was founded in 1992 as a unit of SDSU's Graduate School of Public Health (<http://iph.sdsu.edu/>). The mission of the IPH is to bridge academic research and real-world practice by working with public and private community-based agencies, hospitals and health care organizations and the people they serve, assisting them to define their needs, improve their programs, and better serve their communities. The IPH specializes in community-engaged scholarship activities involving applied research and evaluation, teaching and service. Their research and evaluation strategies include community based participatory research, applied research, evaluation, and the integration and dissemination of research in equal partnership with community organizations and their members. Their goal is to translate evidence-based best practice from journal articles in the library to the highest quality public health interventions capable of creating positive health outcomes in a wide variety of community settings and in a diverse number of content areas.

Tanya Penn, MPH, CPH

Tanya Penn is an Epidemiologist for the Institute for Public Health in the Graduate School of Public Health, at San Diego State University. Trained in public health with an emphasis in Epidemiology, Ms. Penn also holds a nationally recognized Certification in Public Health. Ms. Penn has been with the IPH since 2011 and is currently the Principal Investigator on the 2016 HASD&IC Community Health Needs Assessment working collaboratively with the Hospital Association of San Diego and Imperial Counties (HASD&IC) and the CHNA Committee. Her expertise includes: statistical analysis, data management and manipulation, and utilizing large public-use data sets.

Her primary research interests include health disparities in underserved populations, health education and community based participatory research. Before joining the IPH, Ms. Penn was part of a team that helped start one of the first free Diabetic Clinics for indigent patients in Wilmington, North Carolina in which Ms. Penn was ultimately the Clinic Director.

Amy Pan, PhD

Dr. Amy Pan is a research associate at the Institute for Public Health (IPH) at San Diego State University. Dr. Pan provides program evaluation and grant writing support for the IPH. Her primary research interests include violence prevention and other preventative health issues in immigrant and refugee communities. Prior to working at the IPH, Amy worked at the Center for Community Solutions, the Tahirih Justice Center, and the Center for Child Welfare at George Mason University.

Nicole Delange, MPH, CPH

Nicole Delange holds a MPH degree with an emphasis in Epidemiology from San Diego State University. She has served as a research assistant at the IPH since May of 2015, and provided literary and data research support for Phase II of the 2013 HASD&IC Community Health Need Assessment prior to her involvement in this 2016 CHNA. Her research interests include health disparities, community-based participatory research methods and access to care issues.

Background and Objective

The 2016 CHNA responds to IRS regulatory requirements that private not-for-profit (tax-exempt) hospitals conduct a health needs assessment in the community 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 2016 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.

For the 2016 CHNA, the HASD&IC Board of Directors convened a CHNA Committee to plan and implement the collaborative CHNA process. The CHNA Committee is comprised of representatives from all seven participating hospitals and health care systems:

- Kaiser Foundation Hospital – San Diego
- Palomar Health
- Rady Children’s Hospital – San Diego
- Scripps Health
- Sharp HealthCare
- Tri-City Medical Center
- University of California San Diego Health

**Table 10. Participating Hospital Locations for the
2016 Community Health Needs Assessment**

Hospital/Health Care System*	Location		
Kaiser Foundation Hospital			
Kaiser Foundation Hospital – San Diego	4647 Zion Avenue	San Diego	92120
Palomar Health			
Palomar Medical Center	2185 Citracado Parkway	Escondido	92029
Palomar Health Downtown Campus	555 East Valley Parkway	Escondido	92025
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	4077 5th Avenue	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 Street	Chula Vista	91910
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.

The objective of the 2016 CHNA is to identify and prioritize the most critical health-related needs in San Diego County based on feedback from community residents in high need neighborhoods and quantitative data analysis. The 2016 CHNA involved a mixed methods approach using the most current quantitative data available and more extensive qualitative outreach. Throughout the process, the IPH met bi-weekly with the HASD&IC CHNA committee to analyze, refine, and interpret results as they were being collected. The results of the 2016 CHNA will be used to inform and adapt hospital programs and strategies to better meet the health needs of San Diego County residents. See Figure 16 for the HASD&IC 2016 CHNA Process Map which provides an overview of the methods that were employed to gather quantitative data and community input and prioritize the most pressing health needs.

**Figure 16. Hospital Association of San Diego and Imperial Counties
2016 Community Health Needs Assessment Process Map**



Community Defined



V. 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 and does not exclude low income or underserved populations. For the purposes of the 2016 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) organized their service areas into six geographic regions: Central, East, North Central, North Coastal, North Inland, and South. When possible, data is presented at a regional level to provide more detailed understanding of the population. The geographical regions are represented below in Figure 17. Please see [Table 10](#) on page 63 for the list of participating hospital locations.

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



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

 HOSPITAL ASSOCIATION
of San Diego & Imperial Counties

 iph
INSTITUTE FOR POLICY ANALYSIS & PLANNING

Regions 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.

Scripps Health			
Hospital/Health Care System*	Location		
Scripps Memorial Hospital La Jolla	9888 Genesee Avenue	La Jolla	92037
Scripps Mercy Hospital	4077 5th Avenue	San Diego	92103
Scripps Green Hospital	10666 N Torrey Pines Rd.	La Jolla	92037
Scripps Memorial Hospital Encinitas	354 Santa Fe Drive	Encinitas	92024
Scripps Mercy Hospital Chula Vista	435 H Street	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 2012-2014 (Top 70% of inpatient discharges by zip code). Figure 18 is a map of Scripps Health and service areas.

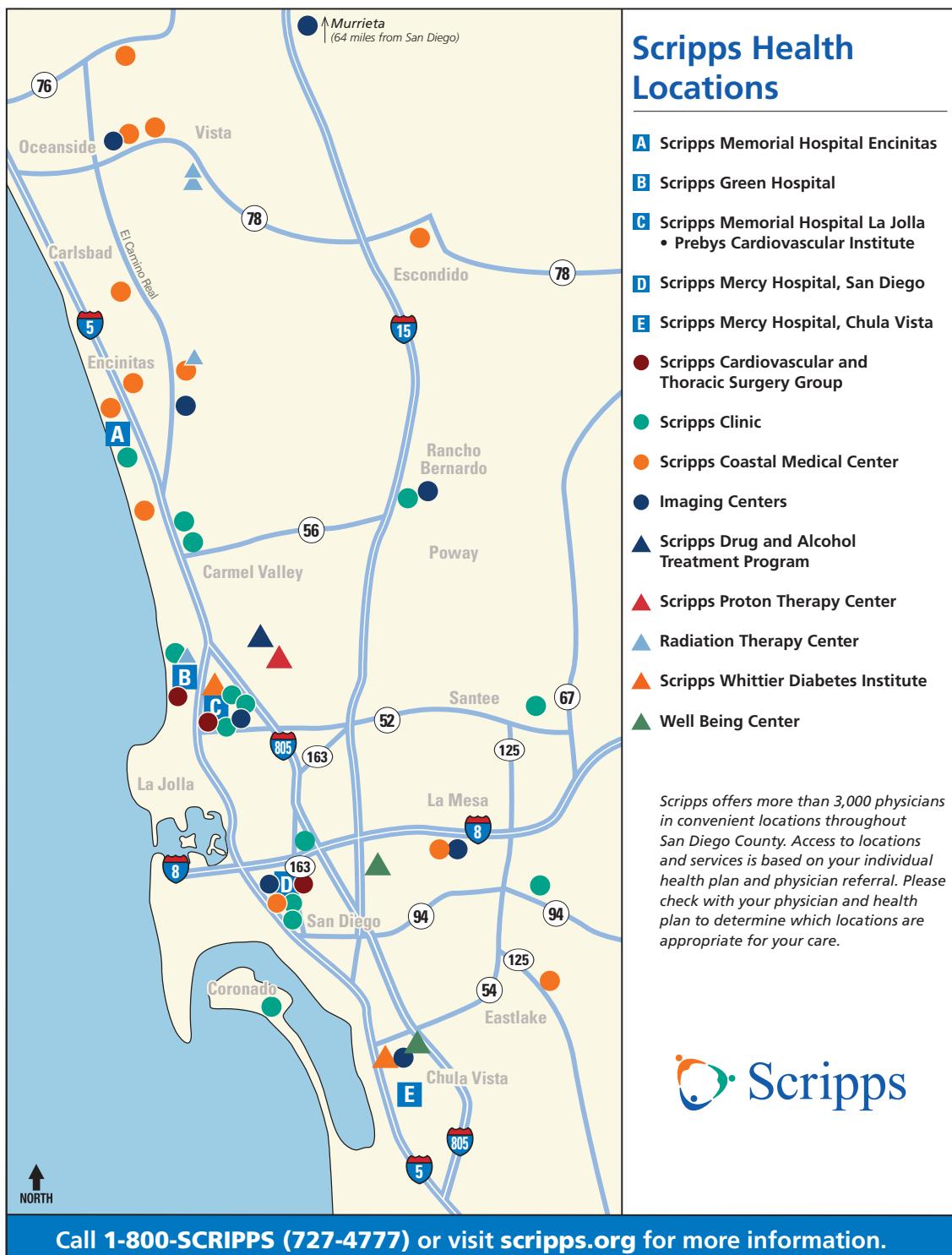
Table 11. Scripps Health Inpatient Discharges for Years 2012-2014 from which the top 70% of Scripps Patients Originate

City	2012	2013	2014
San Diego	38%	38%	37%
Chula Vista	7%	7%	7%
Carlsbad	5%	5%	6%
Oceanside	4%	4%	5%
Encinitas	3%	4%	4%
La Jolla	3%	3%	3%
National City	3%	3%	3%
San Ysidro	2%	2%	2%
San Marcos	2%	2%	2%
Spring Valley	1%	1%	1%
Imperial Beach	1%	1%	1%
Grand Total	70%	70%	70%

Community Served

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.

Figure 18. Scripps Health Service Area



Demographic Profile of San Diego County

The majority of demographic data compiled in this report comes from the Kaiser Permanente (KP) CHNA Data Platform. The KP CHNA data platform includes approximately 150 secondary indicators to ensure a robust and consistent approach to the CHNA and utilizes data from both state and federal agencies including the U.S. Census, Centers for Disease Control and Prevention (CDC), hospital utilization data, and survey data from the California Health Interview Survey (CHIS), the American Community Survey (ACS), and the Behavioral Risk Factor Surveillance System (BRFSS). The indicators are organized into categories that allow the user to better understand who lives in the community, the major health needs, and the drivers of health. For detailed information regarding the source and year of the data provided, please refer to [Appendix A](#)– Quantitative Data Sources and Dates.

In addition to the KP CHNA Data Platform, supplemental demographic and health data was summarized using the following sources:

- **Clinic Utilization Data** - Office of Statewide Health Planning and Development (OSHPD)
- **Community Partner Data** - County of San Diego HHSA, 2-1-1 San Diego, North County Health Services, Palomar Health Advisory Council
- **Community Need Index Data** - Dignity Health/Truven Health Inc.
- **Health Behavior Data** - BRFSS, CHIS, ACS
- **Hospital Discharge Data** - OSHPD
- **Morbidity Data** - BRFSS, CDC, National Health Interview Survey (NHIS), National Survey on Drug Use and Health (NSDUH), etc.
- **Mortality Data** - California Department of Public Health
- **Socio-demographics** - State and Local Population Estimates, U.S. Census Bureau

The quantitative data for this report was obtained in May-August of 2015. The KP CHNA data platform, as well as data obtained from different websites, frequently undergoes enhancements and updates; therefore, certain data indicators may have been updated since the data was obtained for this report. As such, the most updated data may not be reflected in the tables, graphs or maps provided in this report. For the most recent data or additional health-related indicators, please visit CHNA.org/kp or the respective data source website cited in this report.

Socio Demographic Data

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 of a population are all important factors in understanding communities and their residents.

Population: Over three million people (3,138,265) live in the 4,205 square mile area of San Diego County according to the U.S. Census Bureau ACS 2009 to 2013, 5-year estimates. The population density for this area, estimated at 746 persons per square mile, is greater than the national average population density of approximately 88 persons per square mile. Approximately 96.7% of the population lives in an urban area compared to just 3.3% living in rural areas.

Population Change: According to the U.S. Census Bureau Decennial Census, between 2000 and 2010 the population in San Diego County grew by 281,480 persons, a change of 10.0%. This is similar to the percentage population change seen during the same time period in California (10.0%) and the United States (9.7%). San Diego County experienced a 32.0% increase in its Hispanic population compared to a 2.0% increase in the non-Hispanic population. An analysis of the change in composition by race found that the greatest percentage increases were among Asians (34.5%), followed by individuals of multiple races (20.1%). A significant shift in total population or racial/ethnic composition over time increases the demand for culturally competent health care providers and impacts utilization of community resources.

Race/Ethnicity: In the ACS, data for race and ethnicity are collected separately. Of those who identified as non-Hispanic (67.7%) in San Diego County, the majority identified their race as white (70.9%), followed by Asian (16.1%), black (7.1%), multiple races (4.5%), Native Hawaiian/Pacific Islander (0.6%), and American Indian/Alaskan Native (0.5%). Of those who identified as Hispanic or Latino (32.4%), the majority also identified their race as white (72.4%), followed by other (19.9%), multiple races (5.1%), American Indian/Alaskan Native (1.1%), black (0.8%), Asian (0.6%), and Native Hawaiian/Pacific Islander (0.1%). Please see the figures below for more details.

Figure 19. Percentage of San Diego Population by Ethnicity Alone, 2009-2013

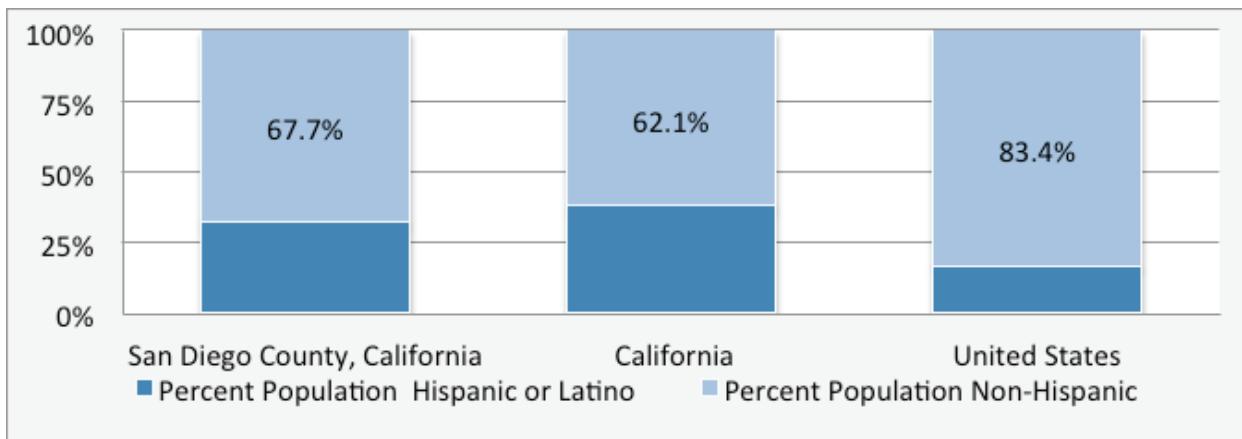
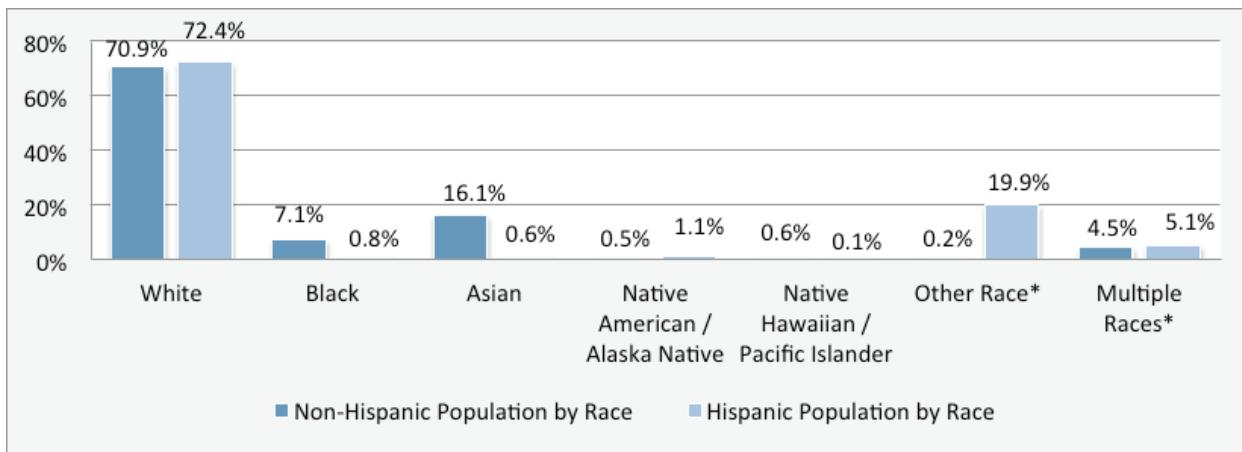


Figure 20. Percentage of San Diego Population by Race, 2009-2013

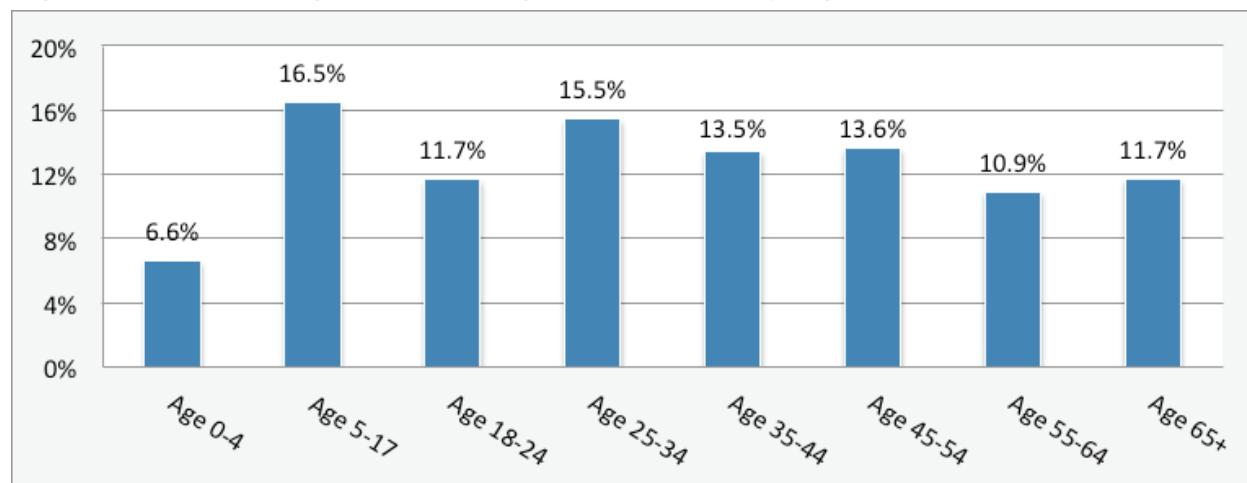


Source: U.S. Census Bureau, American Community Survey. 2009-2013.

*Race and Ethnicity: Race and ethnicity (Hispanic origin) are collected as two separate categories in the American Community Survey (ACS). Using the U.S. Office of Management and Budget (OMB) standard, the race categories reported in the ACS are: white, black, American Indian/Alaskan Native, Asian, and Other. An ACS survey respondent may identify as one race alone, or may choose multiple races. The minimum ethnicity categories reported are: Hispanic or Latino, and Not Hispanic or Latino. Respondents may only choose one ethnicity.

Age: The median age for San Diego County is 34.8 years. The distribution of the population by age shows that 23.1% of the population is under the age of 18, 65.2% is between the ages of 18 and 64, and 11.7% is 65 years old or greater (Figure 21).

Figure 21. Percentage of San Diego Population by Age Group, 2009–2013



Data Source: U.S. Census Bureau, American Community Survey. 2009-2013.

Table 12. Total Population, Population Change, Age, Gender

	San Diego County	California	United States
Total Population ^a	3,138,265	37,659,180	311,536,591
Percent Population Change, 2000-2010 ^b	10%	9.99%	9.74%
Median Age ^a	34.8	35.4	37.3
Percent Male ^a	50.22%	49.73%	49.19%
Percent Female ^a	49.78%	50.27%	50.81%

^a Source: U.S. Census Bureau, American Community Survey. 2009-2013.

^b Source: U.S. Census Bureau, Decennial Census. 2000-2010.

Social Determinants of Health

According to the World Health Organization, “social determinants of health are the circumstances in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.”⁸ Healthy People 2020 highlighted the importance of addressing the social determinants of health by encouraging communities to “create social and physical environments that promote good health for all” as one of the four overarching goals for the decade.⁹ Social determinants of health encompass four predominant categories: 1) Socioeconomic Factors, 2) Access to Care, 3) Health Behaviors 4) Physical Environment.

⁸ World Health Organization. Retrieved from http://www.who.int/social_determinants/en/

⁹ Healthy People 2020. Retrieved from <http://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health>

Socioeconomic Factors

There are three indicators determined to be the most powerful predictors of population health: poverty rate, percent of population uninsured, and educational attainment. 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.

Poverty: Within San Diego County between 2008 and 2013, 14.5% or 441,648 individuals were living in households with income below 100% of the Federal Poverty Level (FPL). An analysis of poverty by race and ethnicity showed that a greater proportion of Latinos, African Americans, Native Americans, and individuals of some other race were in poverty compared to the overall San Diego population. For children 0-17, the percentage living 100% below the FPL (which for a family of three is \$20,090 per year) increases to 18.8%. 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 2010 and 2013, the uninsured rate was relatively stable in the United States, California, and San Diego County, but sharply decreased in 2014.

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.

The Changing Landscape Under the Affordable Care Act*

The Affordable Care Act (ACA) has played a significant role in increasing access to healthcare. 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

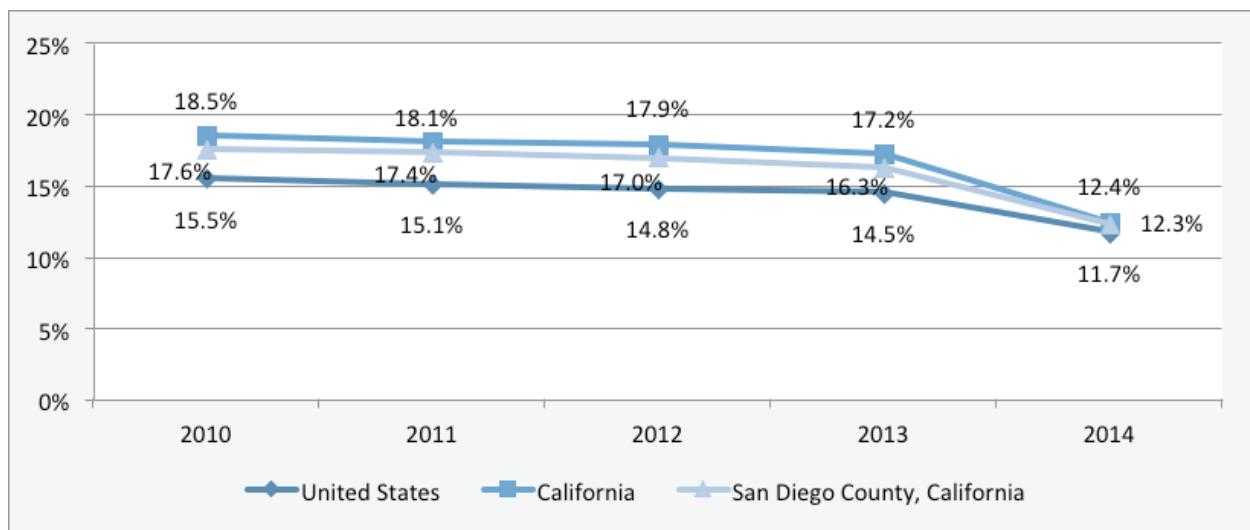
These healthcare reforms have resulted in a large number of newly insured individuals. Recent data from the U.S. Census Bureau demonstrates the following changes in coverage as of 2014:

- Decrease in the percentage of uninsured overall in the U.S. from 13.3% in 2013 to 10.4% in 2014
- Decrease in the percentage of uninsured children under age 19 from 7.5% to 6.2%
- Decrease in the percentage of uninsured across ethnic groups to 19.9%, 11.8%, 9.3% and 7.6% for Hispanics, blacks, Asians, and non-Hispanics whites, respectively. The decrease was approximately 4% for Hispanics, blacks and Asians, and 2% for whites.

Still, discrepancies remain with those aged 19-64 least likely to be insured and roughly 1 in 5 Hispanics still lacking health insurance.

*Smith, Jessica C. and Carla Medalia, U.S. Census Bureau, Current Population Reports, P60-253, Health Insurance Coverage in the United States: 2014, U.S. Government Printing Office, Washington, DC, 2015.

Figure 22. Percent Uninsured: United States, California and San Diego County, 2010-2014

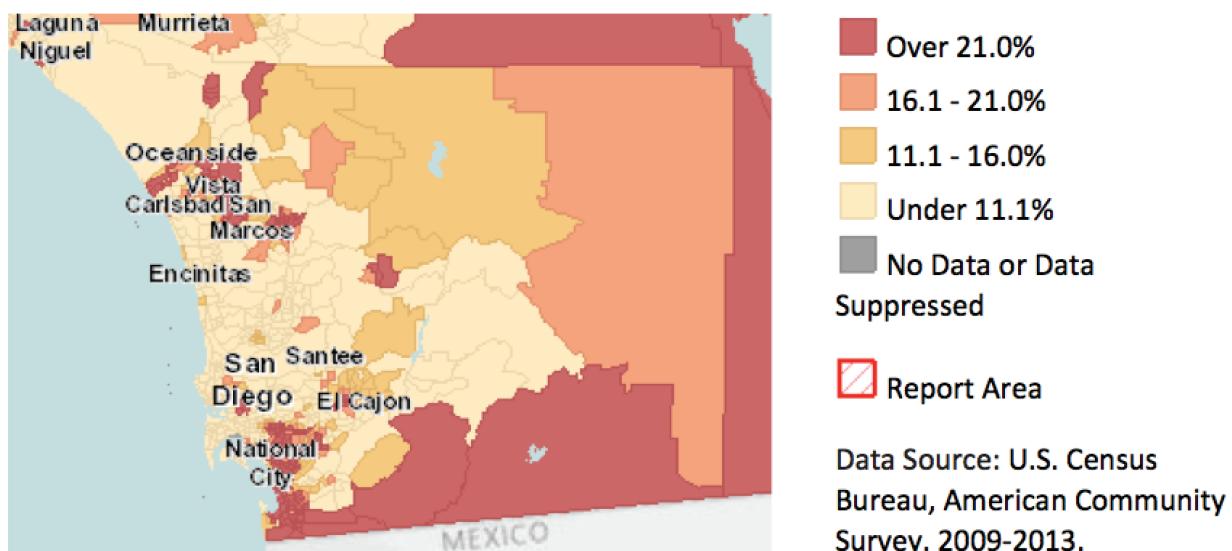


Data Source: U. S. Census Bureau, 2010 to 2014 1-Year American Community Surveys. ACS uninsured rate is based on whether an individual had insurance at the time of the survey. Note: The American Community Survey, estimates are for the civilian noninstitutionalized population. This is different from the percentage uninsured cited in 'The Changing Landscape under the Affordable Care Act' box on the previous page, which used the CPS ASEC. The CPS ASEC uninsured rate represents the percentage of people who had no health insurance coverage at any time during the previous calendar year. For information on confidentiality protection, sampling error, nonsampling error, and definitions in the American Community Survey, see <www2.census.gov/programs-surveys/acs/tech_docs/accuracy/ACS_Accuracy_of_Data_2014.pdf>.

Educational Attainment: Educational attainment is linked to positive health outcomes.¹⁰ Within San Diego County, almost 15% of the total population aged 25 and older (297,188) have no high school diploma (or equivalency) based on 2013 ACS data. 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 (22.4%) and Central (21.1%) and lowest in North Central (5.7%). As of 2013, the San Diego County high school graduation rate (79.8%) was below HP2020 benchmark goal of 82.4%. Graduation rates varied by racial and ethnic groups; non-Hispanic blacks and Hispanic/Latinos had the lowest proportion of graduates compared to non-Hispanic Asians which had the highest. Of children aged 3 to 4, the 2009-2013 ACS found that 48.9% were enrolled in school. As a primary social determinant of health, increasing educational opportunities for young children is important in order to improve future educational attainment and increase economic opportunity.

10 Freudenberg N, Ruglis J. Reframing school dropout as a public health issue. Prev Chronic Dis 2007; 4 (4).http://www.cdc.gov/pcd/issues/2007/oct/07_0063.htm. Accessed March 2016.

**Figure 23. Population with No High School Diploma (Ages 25 and Older),
Percent by Tract, ACS 2009-13**



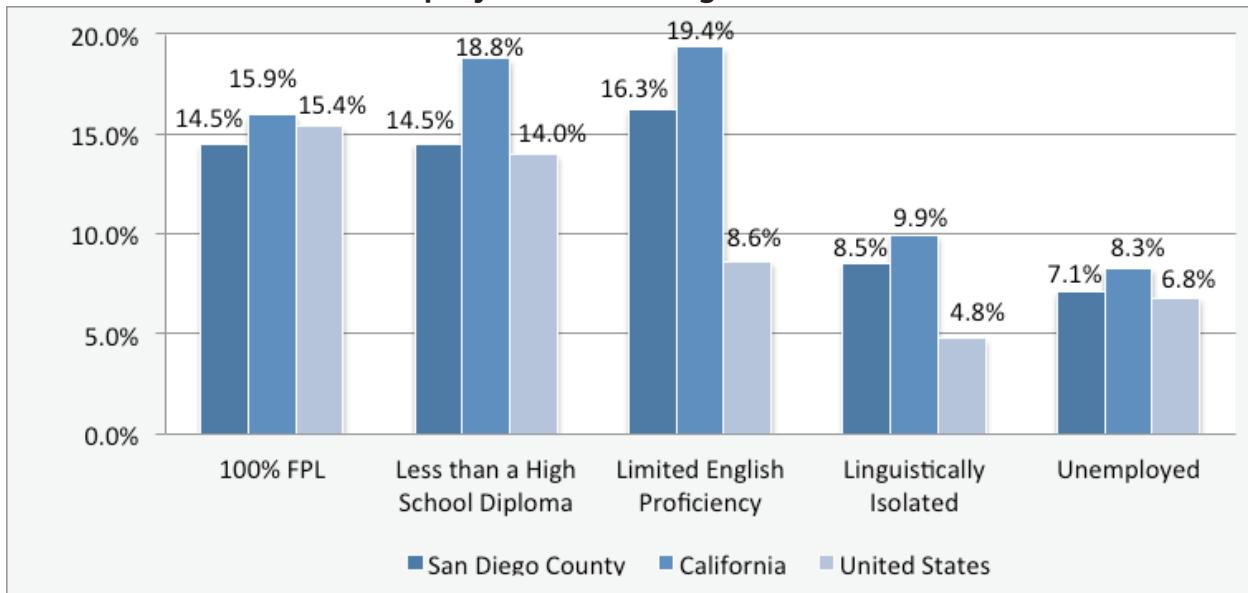
Along with income, education, and insurance status, culture/language and employment status also have profound implications for population health:

Population with Limited English Proficiency: 16.3% of San Diego residents aged 5 and older speak a language other than English at home and speak English less than "very well." The inability to speak English well creates barriers to health care access, provider communications, and health literacy/education.

Linguistically Isolated Population: Given San Diego County's large immigrant and refugee population, the indicator linguistically isolated is especially important to understanding health in the community. According to the ACS, approximately 8.5% 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.

Unemployment: According to the Bureau of Labor Statistics, for the month of February 2016, 7.2%, of the civilian non-institutionalized population age 16 and older (non-seasonally adjusted) was unemployed. The average annual unemployment rate has been steadily decreasing in San Diego following a peak in unemployment in 2010. Unemployment creates financial instability and barriers to accessing necessities such as health services and healthy food that contribute to improved health status.

Figure 24. Poverty, Education, Limited English Proficiency, Linguistically Isolated, and Unemployed in San Diego, California, United States



Source for Poverty, Education, English Proficiency and Linguistic Isolation: U.S. Census Bureau, American Community Survey, 2009-2013; Source for Unemployment: U.S. Department of Labor, Bureau of Labor Statistics. 2016 – February.

Access to Care

A number of factors influence whether individuals in a community have access to care including the number of facilities and providers and the distribution of providers and services across the county. The number of federally qualified health centers in particular is important to consider when determining barriers to care for vulnerable populations. Limited access to primary care providers and residence in a health professional shortage area pose barriers to receiving needed health care as well. Finally, preventable hospital events are important to consider when looking for potential areas of improvement in clinical care and outcomes.

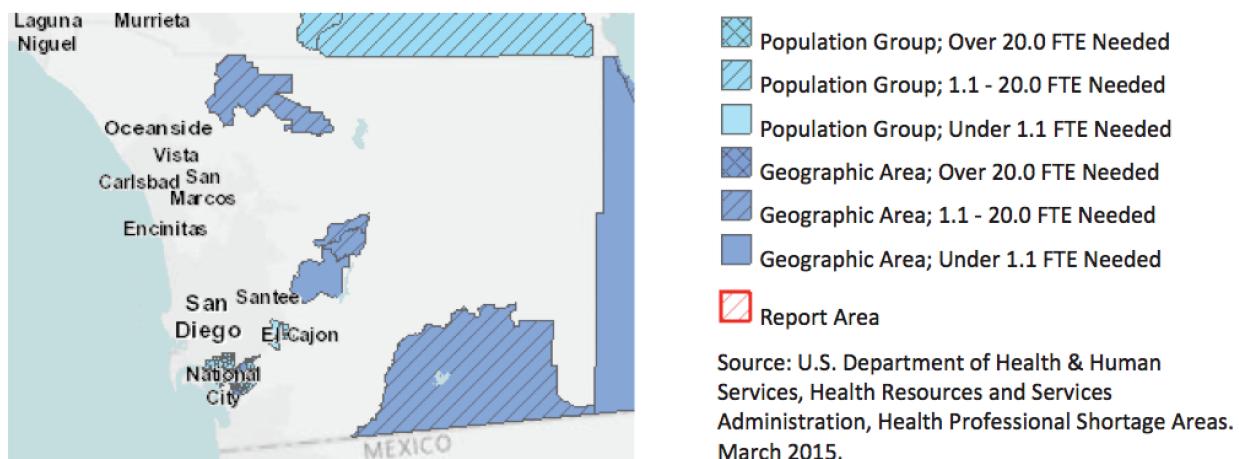
Federally Qualified Health Centers (FQHCs): FQHCs are community assets that provide health care to vulnerable populations. In particular they promote access to ambulatory care in areas designated as medically underserved. There are 2.97 FQHCs per 100,000 persons in San Diego County according to the U.S. Department of Health and Human Services Center for Medicare and Medicaid Services. Although this is higher than the rate for California (2.1) and the U.S. (2.2), individual health centers may not have large enough capacity to deliver the services required for the populations they serve. For a list of FQHCs in San Diego, see [Appendix G](#).

Access to Providers: According the U.S. Department of Health and Human Services Area Health Resource File, there are approximately 77.5 primary care physicians per 100,000 persons in San Diego County. This is similar to the rate in California (77.2). According to 2014 County Health Rankings, San Diego County has 174.4 mental health care providers

per 100,000 total population which is above the state and national levels. 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 as evidenced in Figure 25.

Health Professional Shortage Area (HPSA): Roughly 15.4% of the San Diego County population is living in a geographic area designated as a "Health Professional Shortage Area" (HPSA) by the U.S. Health Resources and Services Administration (HRSA). A HPSA is defined as having a shortage of primary care, dental or mental health professionals. A shortage of health professionals contributes to access and health status issues that may include longer wait times for appointments or the need to travel longer distances in order to access care.

Figure 25. Primary Care HPSA Components, Type and Degree of Shortage by Tract County, 2015



Preventable Hospital Events: According to 2011 OSHPD data, the patient discharge rate for ambulatory care-sensitive conditions (ACSC) was 74.2 per 10,000 total population in San Diego. This is lower than the rate in California (83.2 per 10,000 population). "Chronic health conditions are considered ambulatory care-sensitive conditions (ACSC) when the illness is controllable with effective and timely outpatient care that can potentially prevent the need for hospitalizations."¹¹ ACS conditions include pneumonia, dehydration, asthma, diabetes, and other conditions. ACSC discharge rates indicate possible areas for improvement through better access to primary care, and are a helpful target for interventions that reduce hospital admissions, especially for high risk groups such as the uninsured and Medi-Cal populations.

¹¹ Lui CK, Wallace SP. A common denominator: calculating hospitalization rates for ambulatory care-sensitive conditions in California. [Erratum appears in Prev Chronic Dis 2010;8(6). http://www.cdc.gov/pcd/issues/2011/nov/11_0276.htm.] Prev Chronic Dis 2011;8(5):A102. http://www.cdc.gov/pcd/issues/2011/sep/11_0013.htm. Accessed May 4, 2016.

Table 13. Federally Qualified Health Centers Rate, Primary Care Provider Rate, Percent of Population Living in a Primary Care HPSA, and Preventable ACS Condition Rate

	San Diego County	California	United States
Rate of Federally Qualified Health Centers (per 100,000) ^a	2.97	2.1	2.18
Primary Care Provider Rate (per 100,000) ^b	77.5	77.2	74.5
Percent of Population Living in a Primary Care HPSA ^c	15.37%	25.18%	34.07%
Preventable (ACS) Condition Hospital Discharges, Rate (Per 10,000) ^d	74.18	83.17	NA

^a Source: U.S. Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File. June 2014.

^b Source: U.S. Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2012.

^c Source: U.S. Department of Health & Human Services, Health Resources and Services Administration, Health Professional Shortage Areas. March 2015.

^d Source: California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2011.

Health Behaviors

The risk factors for many chronic diseases are well known. In particular, an unhealthy diet, physical inactivity and substance abuse have been cited by the World Health Organization as important health behaviors that contribute to illnesses such as cardiovascular disease, cancer, chronic respiratory disease, diabetes, and others including mental disorders and oral diseases.¹²

Fruit/Vegetable Consumption: According to 2011-2012 CHIS data, 48.3% of children age 2 to 11 reported consuming less than five servings of fruits and vegetables a day compared to 47.4% in California overall. Adults age 18 and over reported even less fruit and vegetable consumption. Approximately 70.5% of adults reported inadequate consumption of fruits and vegetables. Unhealthy eating habits are a significant contributing factor to future health issues including obesity and diabetes.

Physical Inactivity: According to the CDC's National Center for Chronic Disease Prevention and Health Promotion, 14.9% of adults age 20 and older self-reported that they perform no leisure time physical activity in 2012. Higher rates of limited leisure time activity were reported at the state and national level (16.6% and 22.6% respectively). For youth, results of the FITNESSGRAM¹³ physical fitness test show that 29.4% of children in fifth, seventh and ninth grades ranked within the "High Risk" or "Needs Improvement" zones for aerobic capacity for the 2013-2014 year. The percentage of children that are not in the healthy fitness zone varies among ethnic groups with the most fit being non-Hispanic Asians at 20.6% and the least fit being Hispanic or Latinos at 42.1%. Limited physical activity is a cause for concern and may lead to significant health issues such as obesity, diabetes, and poor cardiovascular health.

12 World Health Organization. Retrieved from <http://www.who.int/chp>

13 FITNESSGRAM is the required physical fitness test that school districts must administer to all California students in Grades 5, 7, and 9.

Alcohol Consumption: The percentage of adults age 18 and older who self-report heavy alcohol consumption (defined as more than two drinks per day on average for men and one drink per day on average for women) is 17.2% in San Diego County according to 2006-2012 BRFSS estimates. Behaviors such as excessive alcohol consumption are detrimental to future health and may illustrate or preclude significant health issues, such as cirrhosis, cancers, and untreated mental and behavioral health needs.

Tobacco Usage: The BRFSS reports that 12.1% of adults age 18 and older self-reported currently smoking cigarettes some days or every day compared to 18.1% in the U.S., adjusted for age. Tobacco use is linked to leading causes of death including cancer and cardiovascular disease.

Physical Environment

A community's health also is affected by the physical environment. A safe, clean environment that provides access to healthy food and recreational opportunities is important to maintaining and improving community health.

Air Quality: According to the National Environmental Public Health Tracking Network, the percentage of days per year with Ozone (O₃) levels above the National Ambient Air Quality Standard of 75 parts per billion (ppb) in San Diego is 0.8%, compared to 2.5% in California and 0.5% nationwide. This percentage varies depending on the region, with coastal areas experiencing a lower percentage of days and inland regions, in particular North Inland experiencing 1.1 to 6.0% of days above the national standard. Poor air quality can contribute to respiratory health issues, including asthma prevalence and asthma hospitalizations, overall poor health, and community vulnerability to climate change.

Food Access and Quality: A safe, clean environment that provides access to quality food is important to maintaining and improving community health. Food access and food insecurity is influenced by a number of factors including the physical food environment and economic security.

Food Insecurity and Food Assistance Enrollment: In 2015, Feeding American San Diego found that 1 in 7 San Diegans were food insecure. This proportion of food insecure residents is higher among those with lower incomes. According to 2014 CHIS data, 38.1% of adults with an income less than 200% of the federal poverty level in San Diego were food insecure, defined as not being able to afford enough food. Conversely, only 17.7% of adults reported currently receiving Cal Fresh benefits.

Food Environment: San Diego County had more fast food restaurants per 100,000 population in 2012 than both California and the U.S. (81.9 vs 74.5 and 72.0 respectively) according to the U.S. Census Bureau County Business Patterns. It also had a lower number of grocery stores per 100,000 at 20.06 than California (21.5)

and the United States (21.1) as well as a higher rate of beer, wine and liquor stores per 100,000 population compared to the state (11.3 vs. 10.0). This is also shown by the percentage of the population living in a food desert. The USDA-Food Access Research Atlas indicated that 15.8% of the San Diego population has low access to a supermarket or large grocery store in 2010. All of these factors influence dietary behaviors and can negatively impact health.

Housing: In San Diego, roughly 45.7% of the households have housing costs that exceed 30% of total household income according to 2010-2014 five-year ACS estimates. Excessive shelter costs may result in an individual's inability to financially meet basic life needs, such as health care, child care, healthy food purchasing, and transportation costs. Data from the U.S. Department of Housing and Urban Development shows that the rate of HUD-Assisted housing eligible to renters in 2013 in San Diego County is slightly less than the state overall (365.0 vs. 368.3 per 10,000 total households). Access to affordable housing can impact economic security, reduce stress, improve mental health, and achieve better overall health outcomes.

Mortality - Pedestrian and Motor Vehicle Accidents: The U.S. Department of Transportation reported the age-adjusted rate of pedestrian deaths due to motor vehicle to be 1.65 per 100,000 population from 2010-2012 which is lower than California (1.97 per 100,000), but still above the Health People (HP) 2020 Benchmark¹⁴ goal of 1.3 per 100,000 persons. According to the San Diego County Medical Examiner 2013 Annual Report, there were 247 traffic related fatalities overall. These are largely deaths of motor vehicle occupants (122), pedestrians (60), and motorcyclists (50). Pedestrian-motor vehicle crash deaths are a preventable cause of premature death.

¹⁴ People 2020 is the federal government's prevention agenda for building a healthier nation. The HP 2020 establishes benchmarks and monitors progress over time. <https://www.healthypeople.gov/2020/About-Healthy-People>

Community Need Index

Recognizing that health needs differ across the region and that socio-economic factors impact health outcomes, the IPH used the Dignity Health/Truven Health Community Need Index (CNI) to identify communities with the highest level of health disparities and needs. The CNI score is an average of five different barrier scores that measure various socio-economic indicators of each community using the 2013 source data.

Figure 26. CNI Score and Color Scale

The five barriers used to determine CNI scores are:	CNI Color Scale:
<ul style="list-style-type: none">• Income Barrier• Culture Barrier• Educational Barrier• Insurance Barrier• Housing Barrier	 <p>Very Low Low Moderate High Very High</p>

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 see Appendix L or visit the interactive website at: <http://cni.chw-interactive.org/>.

When comparing CNI scores across HHSA regions (Table 14), differences in the mean CNI scores were apparent, with the Central region having the highest mean score of 4.2 and North Central having the lowest mean score of 3.1. It is important to note the variation in scores within each region as they highlight geographic differences in need. At a community level, 30 ZIP codes were identified as having high need CNI scores ranging from 4.2 to 5.0 (Table 15). The CHNA committee reviewed the high need ZIP codes to help identify vulnerable communities in which to engage and hold the community partner discussions.

Table 14. 2013 Community Need Index Scores by San Diego County HHSA Region

HHSA Region	Min	Max	Mean
San Diego County	1.8	5.0	3.6
Central	3.0	5.0	4.2
East	2.6	4.8	3.8
North Central	2.0	4.4	3.1
North Coastal	1.8	4.6	3.3
North Inland	2.4	4.4	3.5
South	2.2	5.0	3.7

Source: Dignity Health Community Need Index. 2013; Zip codes included in each region determined by SD HHSA.

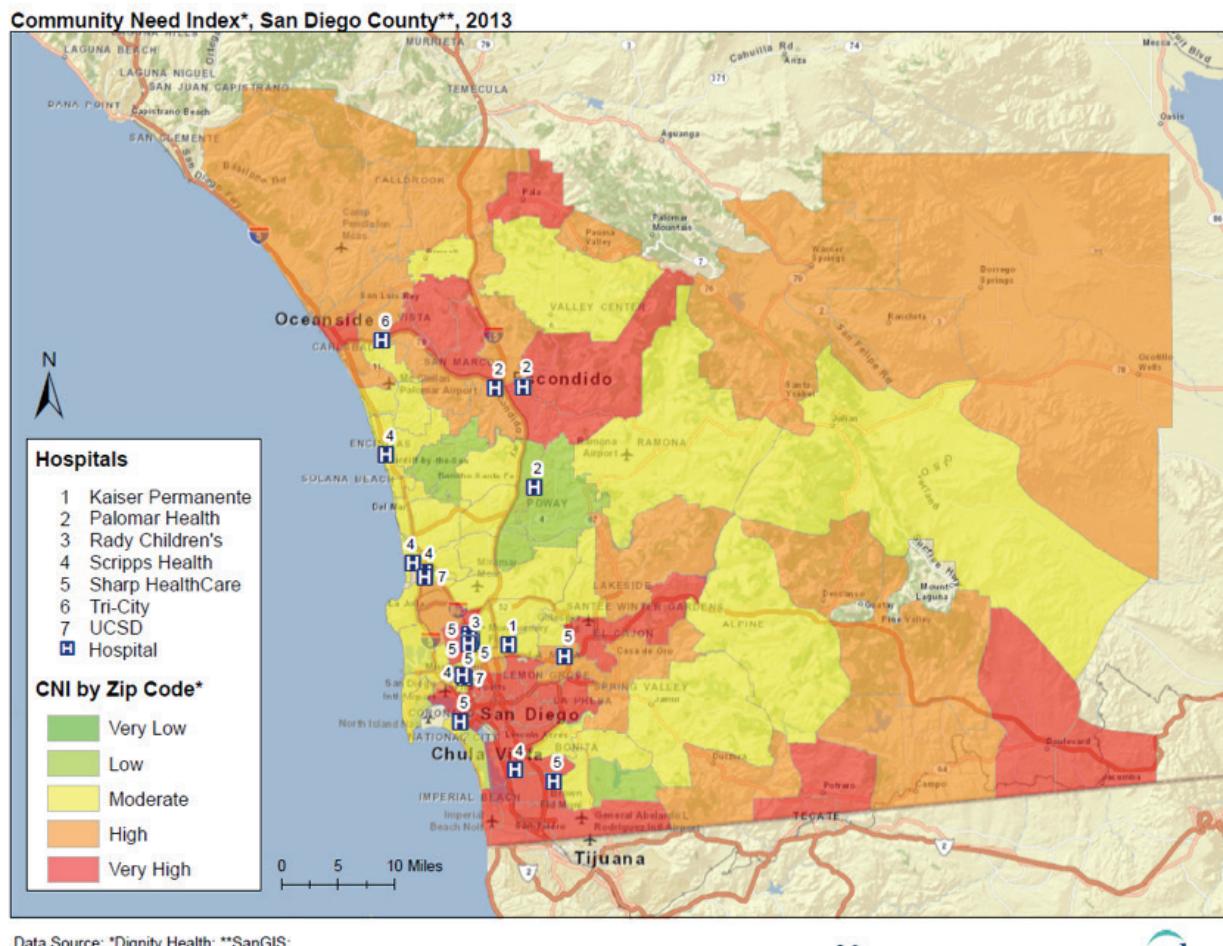
Table 15. Cities with High Need Index Scores (4.2-5.0) by San Diego County HHSA Region

HHSA Region	Zip Codes with a Score of 4.2 or Higher	HHSA Region	Zip Codes with a Score of 4.2 or Higher		
Central			North Central		
San Diego	92101, 92102, 92104, 92105, 92113, 92114, 92115, 92139	San Diego	92111		
East			North Coastal		
Boulevard	91905	Oceanside	92054		
El Cajon	92020, 92021	Vista	92083, 92084		
Jacumba	91934	South			
Lemon Grove	91945	Chula Vista	91910, 91911		
Potrero	91963	Imperial Beach	91932		
Spring Valley	91977	National City	91950		
Tecate	91980	San Diego	92154		
North Inland			San Ysidro	92173	
Escondido	92025, 92027				
Paula	92059				
San Marcos	92069				

Source: Dignity Health Community Need Index. 2013; Zip codes included in each region determined by San Diego HHSA

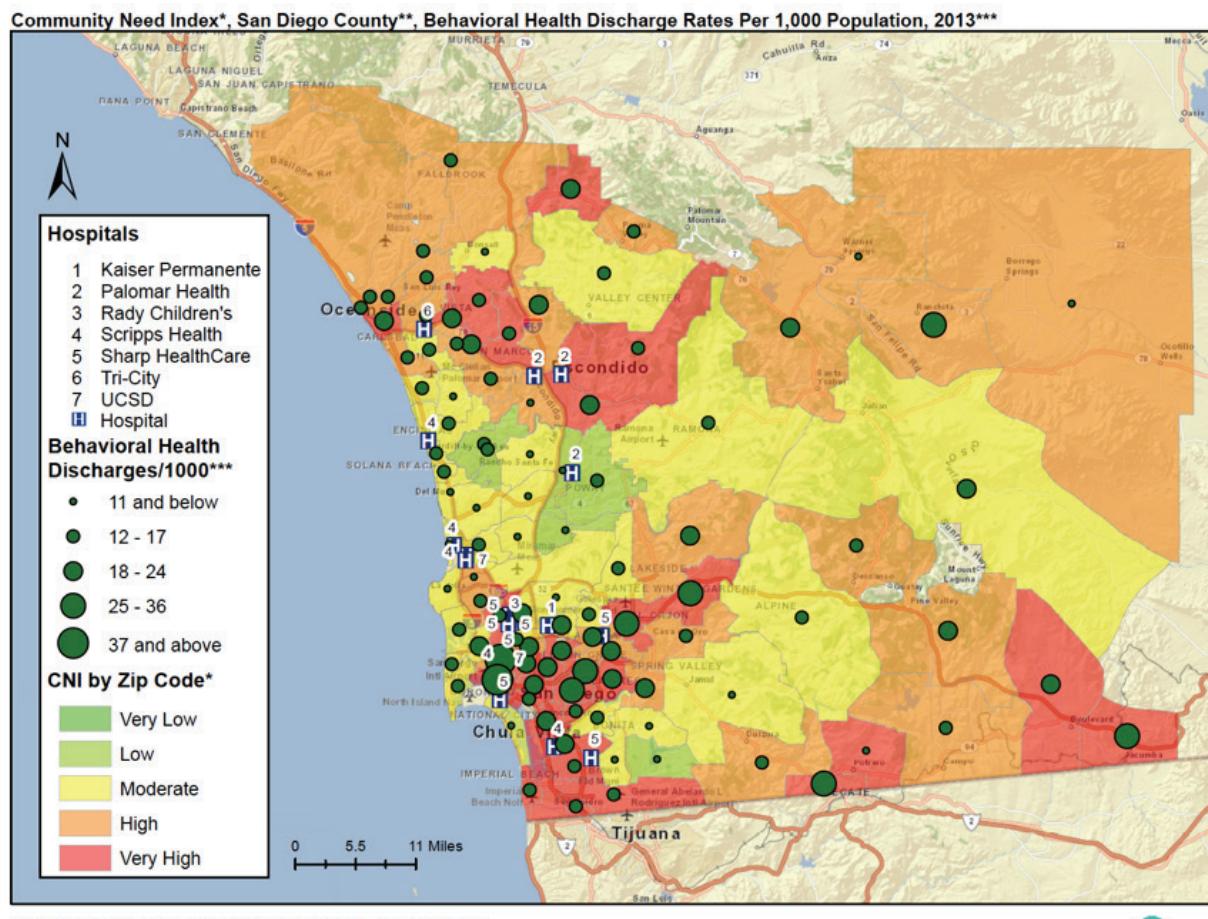
In addition, Geographic Information System (GIS) maps were created, overlaying CNI data and the hospital discharge rate by primary diagnosis for the health conditions: type 2 diabetes, cardiovascular disease, and behavioral health. GIS maps were not created for obesity due to the fact that obesity is not a common primary diagnosis, but rather a secondary condition that contributes to the primary reason for a hospital visit. A map of the CNI for San Diego County is provided below (Figure 27). To view all CNI maps of San Diego County and the six HHSA regional maps, please see [Appendix L](#).

Figure 27. San Diego County Community Need Index, 2013



Below are the GIS maps demonstrating the distribution of hospital discharges according to patient ZIP code data per 1,000 population across San Diego County for the top health needs.

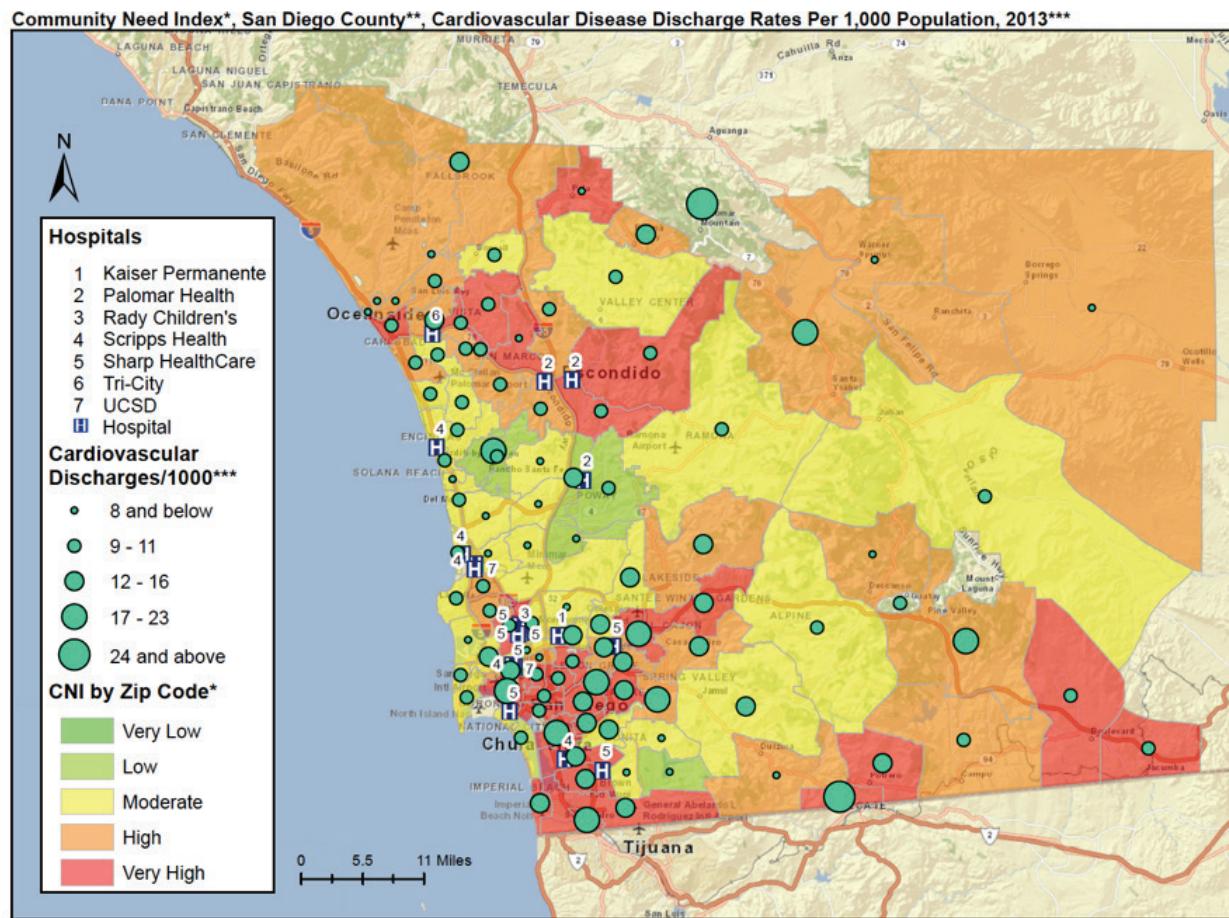
Figure 28. San Diego County Community Need Index, Behavioral Health Hospital Discharge Rate per 1,000 Population, 2013



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Figure 29. San Diego County Community Need Index, Cardiovascular Disease Hospital Discharge Rate per 1,000 Population, 2013

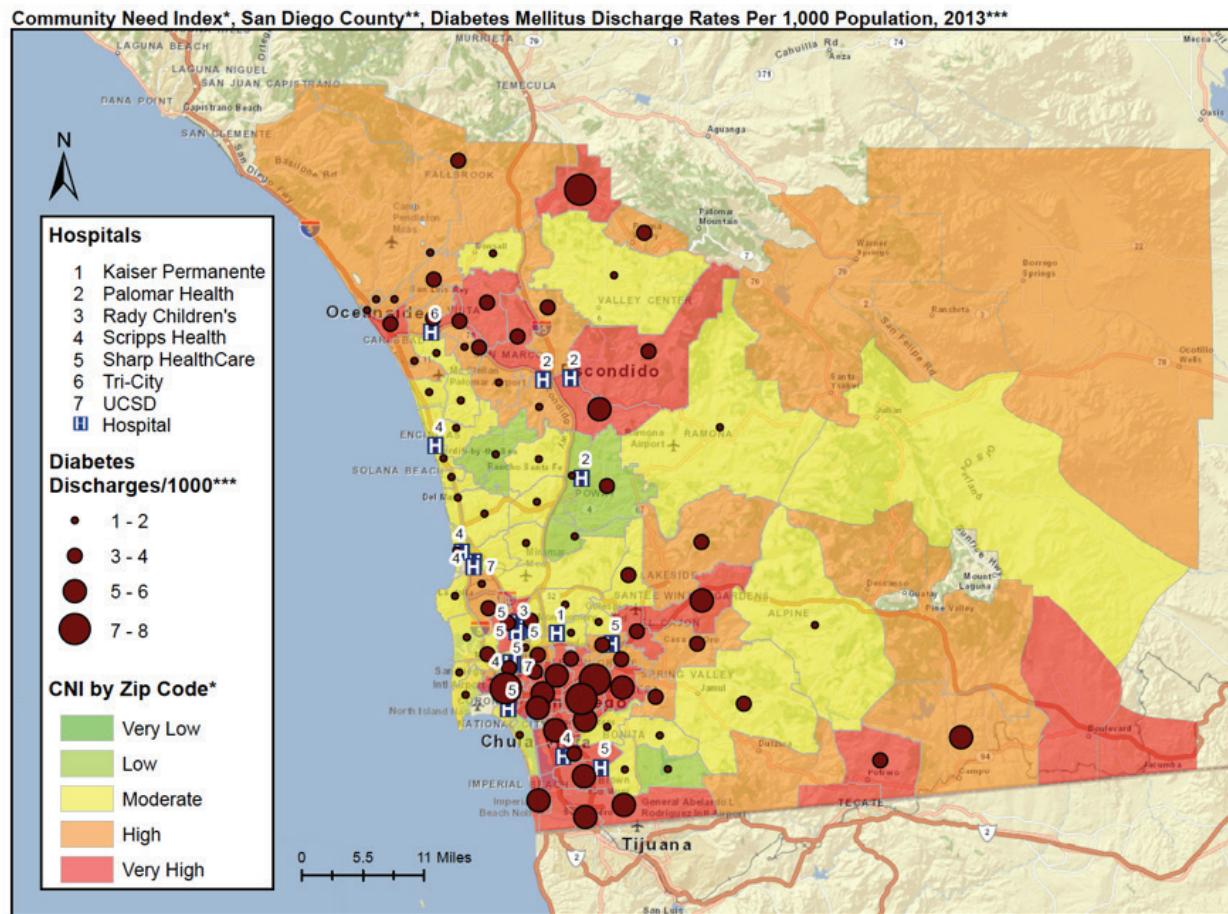


Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
Basemap: © 2015 OpenStreetMap contributors, and the GIS User Community.

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Figure 30. San Diego County Community Need Index, Diabetes Hospital Discharge Rate per 1,000 Population, 2013



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San Diego County Regional Level Data

Due to its geographic size and large population, understanding regional differences in San Diego is critical. Basic demographic information provided for each region is from the San Diego County HHSA Community Health Statistics Unit, based on SANDAG 2012 estimates and 2013 ACS estimates. Please see Figure 31 below for the HHSA regional boundaries. In addition, data from the 2011-2012 California Health Interview Survey (CHIS) is separated by region in order to provide further information on health access, outcomes and behaviors. CHIS is a statewide health survey and an important source of data on the health status of San Diego residents. Please see [Appendix J](#) for a table with all regional CHIS data.

Figure 31. San Diego County with Health and Human Services Agency Regions



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

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Central

The Central region is home to roughly 488,756 residents. This region is predominately Hispanic (43.5%), followed by white (29.0%) and Asian/Pacific Islander (13.4%). While more than half of residents spoke English only, an estimated 16.0% spoke Spanish only and an additional 25.8% were bilingual. Compared to the County as a whole, the Central region had a higher percentage of the population below the poverty level (23.1% compared to 13.9%).

According to 2011-2012 CHIS data, the proportion of residents receiving employer-based health insurance (42.4%) was significantly lower than San Diego County overall (54.5%), with a higher percentage receiving Medi-Cal or Healthy Families (12.0%) and with no usual source of health care (20.9%). Central region also had the higher percentage of residents who reported smoking and binge drinking when compared to other regions. Central region had the highest proportion of food insecurity at 21.9%, followed by South and East with 13.7%, North Coastal (13.1%) and North Inland (10.5%). Please see Tables 16 and 17 for more Central region data.

Table 16. Central Region Demographics

Age	#	%
0-4 Years	33,157	6.8%
5 to 14 Years	59,094	12.1%
15 to 24 Years	78,558	16.1%
25 to 44 Years	163,432	33.4%
45 to 64 Years	109,407	22.4%
65+ Years	45,108	9.2%

Education	%
< High School Graduate	21.9%
High School Graduate	19.9%
Some College or AA	30.1%
Bachelor Degree	18.1%
Graduate Degree	10.0%

Race	#	%
White	141,599	29.0%
Hispanic	212,359	43.5%
Black	53,047	10.9%
Asian/Pacific Islander	65,357	13.4%
Other	16,394	3.4%

Primary Language Spoken at Home	%
English Only	51.3%
Spanish Only	16.0%
Asian/Pacific Islander Only	5.5%
Other Language Only	1.4%
Bilingual	25.8%

Gender	#	%
Male	249,510	51.1%
Female	239,246	49.0%

Percent Below Poverty Level	%
Population	23.1%
Families	18.7%
Families With Children	27.5%

Table 17. California Health Interview Survey Indicators for Central Region, 2011-2012

California Health Interview Survey Indicators	Central HHSA Region
Access and Utilization	
Uninsured all or part year (age 18-64)	33.9%
Employment-based insurance, all year (18-64)	42.4%
Medi-Cal or Healthy Families, all year (18-64)	12.0%
Other coverage, all year (age 18-64)	11.7%
No usual source of health care	20.9%
Delayed getting prescription drugs or medical service	25.0%
Health Outcomes	
Serious psychological distress in the past year	9.2%
Fair or poor health (age-adjusted)	17.7%
Current asthma	8.2%
Ever diagnosed with diabetes	8.7%
Obese	23.7%
Ever diagnosed with high blood pressure	19.8%
Health Behaviors	
Engaged in regular walking in the past week	34.2%
Ate fruits and vegetables 3 or more times yesterday	25.9%
Current Smoker	16.6%
Binge drinking	38.3%
Food insecure	21.9%
Limited English proficiency	29.5%

East

East region is a large, diverse area comprised of urban, suburban and rural sections. The region is largely white (59.2%) and Hispanic (26.1%) but also has a strong refugee presence. The California Department of Social Services reported that San Diego County ranked first among refugee admissions in California from 2010-2014, totaling 13,801, and in 2011, the top cities/communities in which refugees resettled were San Diego (820), El Cajon (677) and Spring Valley (62). Of the 469,985 residents that make up the region, roughly 72.6% spoke English only at home, with another 17.2% who are bilingual. An increased percentage of individuals reported their highest education as 'High School Graduate' in the East region compared to San Diego County overall with a commensurate decrease in the proportion of individuals who reported having a Bachelor's Degree.

According to 2011-2012 CHIS data, East region was second only to Central in the percentage of current smokers and binge drinkers when compared to other regions in the county. Furthermore, 13.7% reported experiencing food insecurity. Please see Tables 18 and 19 for more East region data.

Table 18. East Region Demographics

Age	#	%
0-4 Years	29,982	6.4%
5 to 14 Years	59,945	12.8%
15 to 24 Years	70,002	14.9%
25 to 44 Years	120,597	25.7%
45 to 64 Years	128,184	27.3%
65+ Years	61,275	13.0%

Education	%
< High School Graduate	13.7%
High School Graduate	25.4%
Some College or AA	37.7%
Bachelor Degree	15.2%
Graduate Degree	8.1%

Race	#	%
White	278,179	59.2%
Hispanic	122,712	26.1%
Black	25,470	5.4%
Asian/Pacific Islander	21,639	4.6%
Other	21,985	4.7%

Primary Language Spoken at Home	%
English Only	72.6%
Spanish Only	5.8%
Asian/Pacific Islander Only	1.3%
Other Language Only	3.1%
Bilingual	17.2%

Gender	#	%
Male	231,582	49.3%
Female	238,403	50.7%

Percent Below Poverty Level	%
Population	14.3%
Families	10.5%
Families With Children	16.1%

Table 19. California Health Interview Survey Indicators for East Region, 2011-2012

California Health Interview Survey Indicators	East HHSA Region
Access and Utilization	
Uninsured all or part year (age 18-64)	23.6%
Employment-based insurance, all year (18-64)	60.1%
Medi-Cal or Healthy Families, all year (18-64)	7.7%
Other coverage, all year (age 18-64)	8.7%
No usual source of health care	13.9%
Delayed getting prescription drugs or medical service	22.2%
Health Outcomes	
Serious psychological distress in the past year	8.6%
Fair or poor health (age-adjusted)	14.6%
Current asthma	5.9%
Ever diagnosed with diabetes	8.5%
Obese	26.8%
Ever diagnosed with high blood pressure	28.7%
Health Behaviors	
Engaged in regular walking in the past week	36.8%
Ate fruits and vegetables 3 or more times yesterday	32.0%
Current Smoker	14.6%
Binge drinking	36.0%
Food insecure	13.7%
Limited English proficiency	16.0%

Data on refugees is from the 'United Nations High Commissioner for Refugees. (2014). "UNHCR Global Trends 2014," Retrieved from <http://unhcr.org/556725e69.html>
County of San Diego. (2011). "2011 Refugee Fact Sheet," Retrieved from http://www.sandiegocounty.gov/hhsa/programs/phs/documents/Refugee_FactSheet2011.pdf

North Central

With a population of 615,093, North Central region is the most populous region in San Diego County. North Central is predominantly white (59.3%) but the region also has a significant Asian/Pacific Islander (18.6%) and Hispanic (14.7%) population. When compared to other regions, North Central has the highest educational achievement with roughly 52% of residents having attained a Bachelor's Degree or higher. The majority of residents (71.8%) reported English as their primary language spoken at home followed by bilingual (17.8%).

According to 2011-2012 CHIS data, residents in North Central region were less likely to report being uninsured, obese, in fair or poor health, and food insecure compared to San Diego County overall. Please see Tables 20 and 21 for more North Central data.

Table 20. North Central Region Demographics

Age	#	%
0-4 Years	33,710	5.5%
5 to 14 Years	62,265	10.1%
15 to 24 Years	103,420	16.8%
25 to 44 Years	194,557	31.6%
45 to 64 Years	145,078	23.6%
65+ Years	76,063	12.4%

Education	%
< High School Graduate	6.0%
High School Graduate	13.4%
Some College or AA	28.3%
Bachelor Degree	30.3%
Graduate Degree	22.0%

Race	#	%
White	364,966	59.3%
Hispanic	90,162	14.7%
Black	18,575	3.0%
Asian/Pacific Islander	114,106	18.6%
Other	27,284	4.4%

Primary Language Spoken at Home	%
English Only	71.8%
Spanish Only	2.9%
Asian/Pacific Islander Only	5.6%
Other Language Only	1.9%
Bilingual	17.8%

Gender	#	%
Male	310,962	50.6%
Female	304,131	49.4%

Percent Below Poverty Level	%
Population	10.9%
Families	5.6%
Families With Children	8.4%

Table 21. California Health Interview Survey Indicators for North Central Region, 2011-2012

California Health Interview Survey Indicators	North Central HHSA Region
Access and Utilization	
Uninsured all or part year (age 18-64)	16.1%
Employment-based insurance, all year (18-64)	61.2%
Medi-Cal or Healthy Families, all year (18-64)	5.3%
Other coverage, all year (age 18-64)	17.4%
No usual source of health care	12.1%
Delayed getting prescription drugs or medical service	22.6%
Health Outcomes	
Serious psychological distress in the past year	7.9%
Fair or poor health (age-adjusted)	9.7%
Current asthma	5.0%
Ever diagnosed with diabetes	7.2%
Obese	16.6%
Ever diagnosed with high blood pressure	23.0%
Health Behaviors	
Engaged in regular walking in the past week	32.7%
Ate fruits and vegetables 3 or more times yesterday	31.2%
Current Smoker	10.3%
Binge drinking	34.8%
Food insecure	8.2%
Limited English proficiency	11.7%

North Coastal

North Coastal region is home to 514,402 residents and has a population density of 1,384 persons per square mile. This region is predominately white (58.2%), Hispanic (29.2%) and Asian/Pacific Islander (6.2%). While the majority of residents report speaking English only or being bilingual, there remains a significant percentage (11.8%) of the population that reported speaking Spanish only at home.

According to 2011-2012 CHIS data, North Coastal region residents were less likely to report being obese or having ever been diagnosed with high blood pressure when compared to San Diego County overall. Please see Tables 22 and 23 for more North Coastal data.

Table 22. North Coastal Region Demographics

Age	#	%
0-4 Years	35,869	7.0%
5 to 14 Years	66,452	12.9%
15 to 24 Years	85,302	16.6%
25 to 44 Years	136,157	26.5%
45 to 64 Years	126,877	24.7%
65+ Years	63,745	12.4%

Education	%
< High School Graduate	13.0%
High School Graduate	17.8%
Some College or AA	33.3%
Bachelor Degree	22.4%
Graduate Degree	13.5%

Race	#	%
White	299,147	58.2%
Hispanic	150,322	29.2%
Black	14,054	2.7%
Asian/Pacific Islander	31,654	6.2%
Other	19,225	3.7%

Primary Language Spoken at Home	%
English Only	71.2%
Spanish Only	11.8%
Asian/Pacific Islander Only	1.9%
Other Language Only	1.0%
Bilingual	14.2%

Gender	#	%
Male	262,046	50.9%
Female	252,356	49.1%

Percent Below Poverty Level	%
Population	11.5%
Families	8.9%
Families With Children	16.5%

Table 23. California Health Interview Survey Indicators for North Coastal Region, 2011-2012

California Health Interview Survey Indicators	North Coastal HHSA Region
Access and Utilization	
Uninsured all or part year (age 18-64)	28.8%
Employment-based insurance, all year (18-64)	54.6%
Medi-Cal or Healthy Families, all year (18-64)	5.2%
Other coverage, all year (age 18-64)	11.4%
No usual source of health care	15.9%
Delayed getting prescription drugs or medical service	21.7%
Health Outcomes	
Serious psychological distress in the past year	6.4%
Fair or poor health (age-adjusted)	14.9%
Current asthma	5.2%
Ever diagnosed with diabetes	6.3%
Obese	17.5%
Ever diagnosed with high blood pressure	21.7%
Health Behaviors	
Engaged in regular walking in the past week	37.3%
Ate fruits and vegetables 3 or more times yesterday	36.1%
Current Smoker	12.4%
Binge drinking	31.7%
Food insecure	13.1%
Limited English proficiency	20.3%

North Inland

North Inland region is the largest geographically and home to 581,849 residents. This is a diverse region with urban, suburban and rural areas. North Inland is predominately white (53.89%), Hispanic (29.85%) and Asian/Pacific Islander (10.74%). While the majority of residents report speaking English only or being bilingual, there remains a significant percentage (12.08%) of the population that reported speaking Spanish only at home. According to 2011-2012 CHIS data, a smaller percentage of North Inland region residents reported having fair or poor health or experiencing psychological distress in the past year compared to all other regions in the County. Please see Tables 24 and 25 for more North Inland data.

Table 24. North Inland Region Demographics

Age	#	%
0-4 Years	37,540	6.5%
5 to 14 Years	82,111	14.1%
15 to 24 Years	82,935	14.3%
25 to 44 Years	146,096	25.1%
45 to 64 Years	155,314	26.7%
65+ Years	77,853	13.4%

Education	%
< High School Graduate	14.1%
High School Graduate	18.2%
Some College or AA	31.6%
Bachelor Degree	22.8%
Graduate Degree	13.3%

Race	#	%
White	313,555	53.9%
Hispanic	173,681	29.9%
Black	10,062	1.7%
Asian/Pacific Islander	62,503	10.7%
Other	22,048	3.8%

Primary Language Spoken at Home	%
English Only	66.5%
Spanish Only	12.1%
Asian/Pacific Islander Only	3.3%
Other Language Only	1.7%
Bilingual	16.5%

Gender	#	%
Male	286,529	49.2%
Female	295,320	50.8%

Percent Below Poverty Level	%
Population	11.1%
Families	7.7%
Families With Children	10.2%

Table 25. California Health Interview Survey Indicators for North Inland Region, 2011-2012

California Health Interview Survey Indicators	North Inland HHSA Region
Access and Utilization	
Uninsured all or part year (age 18-64)	27.5%
Employment-based insurance, all year (18-64)	56.5%
Medi-Cal or Healthy Families, all year (18-64)	5.8%
Other coverage, all year (age 18-64)	10.2%
No usual source of health care	13.1%
Delayed getting prescription drugs or medical service	21.8%
Health Outcomes	
Serious psychological distress in the past year	5.8%
Fair or poor health (age-adjusted)	13.6%
Current asthma	7.4%
Ever diagnosed with diabetes	6.4%
Obese	22.9%
Ever diagnosed with high blood pressure	30.1%
Health Behaviors	
Engaged in regular walking in the past week	32.9%
Ate fruits and vegetables 3 or more times yesterday	28.3%
Current Smoker	14.1%
Binge drinking	35.8%
Food insecure	10.5%
Limited English proficiency	18.0%

South

The South region borders the Pacific Ocean to the West and Mexico to the South. This region is predominately Hispanic (60.4%), white (20.0%) and Asian/Pacific Islander (12.8%). The majority of households reported that the primary language spoken at home was a language other than English only. Thirty-seven percent reported they were bilingual and an additional 19.1% cited their primary language as Spanish only. Over half of residents in the South region reported spending 30% or more of their household income a month on housing.

According to 2011-2012 CHIS data, residents of the South region were more likely to report limited English proficiency and being in fair or poor health compared to San Diego County overall. Furthermore, approximately 13.7% reported experiencing food insecurity. Please see Tables 26 and 27 for more South region data.

Table 26. South Region Demographics

Age	#	%
0-4 Years	33,571	7.1%
5 to 14 Years	68,549	14.5%
15 to 24 Years	82,499	17.4%
25 to 44 Years	129,212	27.3%
45 to 64 Years	109,022	23.0%
65+ Years	50,491	10.7%

Education	%
< High School Graduate	22.6%
High School Graduate	21.8%
Some College or AA	32.4%
Bachelor Degree	15.8%
Graduate Degree	7.6%

Race	#	%
White	94,874	20.0%
Hispanic	285,990	60.4%
Black	18,175	3.8%
Asian/Pacific Islander	60,676	12.8%
Other	13,629	2.9%

Primary Language Spoken at Home	%
English Only	39.9%
Spanish Only	19.1%
Asian/Pacific Islander Only	3.8%
Other Language Only	0.3%
Bilingual	37.0%

Gender	#	%
Male	235,314	49.2%
Female	238,030	50.3%

Percent Below Poverty Level	%
Population	13.7%
Families	11.6%
Families With Children	16.3%

Table 27. California Health Interview Survey Indicators for South Region, 2011-2012

California Health Interview Survey Indicators	South HHSA Region
Access and Utilization	
Uninsured all or part year (age 18-64)	34.1%
Employment-based insurance, all year (18-64)	50.1%
Medi-Cal or Healthy Families, all year (18-64)	8.5%
Other coverage, all year (age 18-64)	7.3%
No usual source of health care	15.7%
Delayed getting prescription drugs or medical service	25.2%
Health Outcomes	
Serious psychological distress in the past year	9.0%
Fair or poor health (age-adjusted)	21.8%
Current asthma	5.7%
Ever diagnosed with diabetes	11.0%
Obese	26.6%
Ever diagnosed with high blood pressure	31.5%
Health Behaviors	
Engaged in regular walking in the past week	33.9%
Ate fruits and vegetables 3 or more times yesterday	30.5%
Current Smoker	11.0%
Binge drinking	32.7%
Food insecure	13.7%
Limited English proficiency	37.7%

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 2016 CHNA data collection process, 2013 OSHPD demographic data for hospital inpatient, emergency department, and ambulatory care encounters from all hospitals within San Diego County were analyzed to understand the hospital patient population. Clinic data was also gathered from OSHPD's website and incorporated in order to provide a more holistic view of health care utilization in San Diego, as hospital discharges may not represent all the health conditions in the community.

Hospital Discharge Data

In 2013, there were a total of 1,166,355 patient encounters at all inpatient, emergency department (ED) and ambulatory facilities in San Diego County among San Diego County residents. Approximately 60.8% of those encounters were at ED locations, followed by 25.8% at inpatient facilities and 13.5% at ambulatory centers. Below is a breakdown of the demographic characteristics of all San Diego resident encounters at any point of care location during the year 2013 (Table 28).

**Table 28. Demographic Characteristics of All Hospital Encounters
in San Diego County by San Diego Residents, 2013**

Age	#	%
0-4 Years	126,677	10.9%
5 to 14 Years	77,785	6.7%
15 to 24 Years	129,263	11.1%
25 to 44 Years	279,412	24.0%
45 to 64 Years	287,162	24.6%
65+ Years	265,974	22.8%

Race	#	%
White	710,209	60.9%
Black/African American	90,299	7.7%
Asian/Pacific Islander	65,473	5.6%
Native Hawaiian/Other Pacific Islander	8,390	0.7%
American Indian/Alaskan Native/Eskimo/Aleut	5,026	0.4%
Other Race	274,755	23.6%
Unknown	12,158	1.0%

Gender	#	%
Male	515,795	44.2%
Female	650,501	55.8%

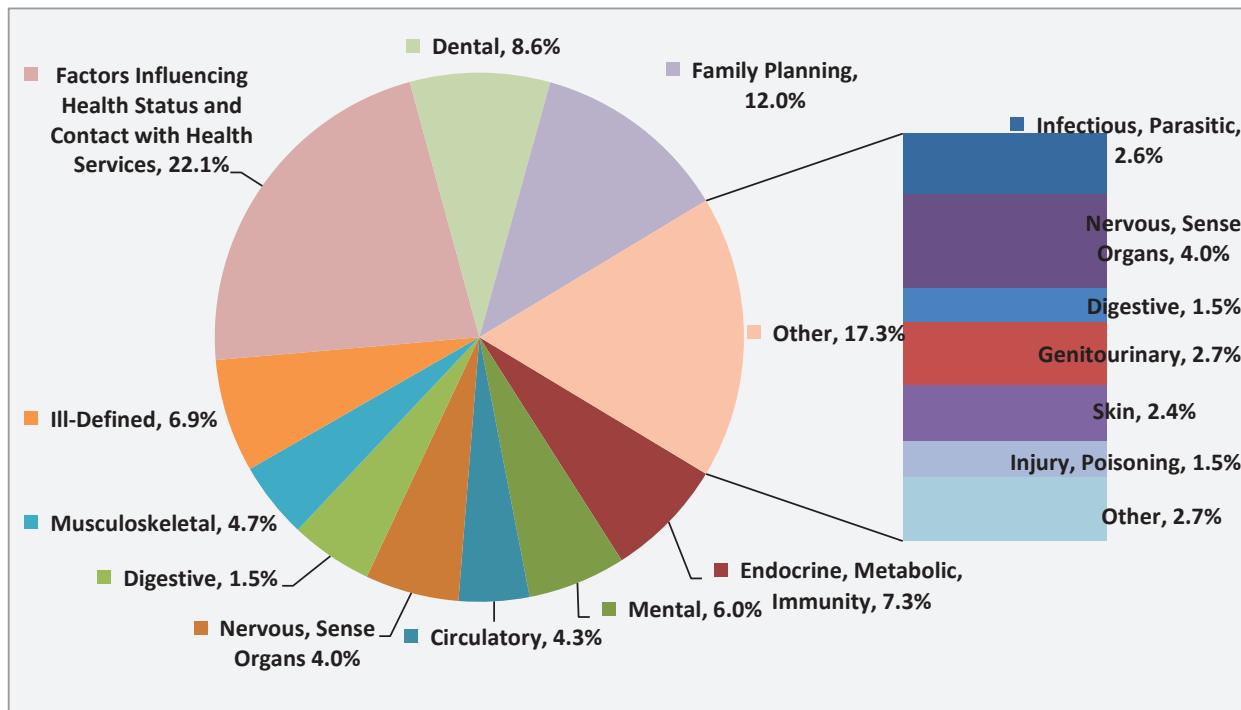
Ethnicity	#	%
Non-Hispanic/Non-Latino	806,631	69.2%
Hispanic/Latino	344,791	29.6%
Unknown	14,891	1.3%

* Source: California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2013. SpeedTrack©

Clinic Utilization Data

According to 2013 OSHPD data, there are 103 clinics in operation in San Diego County, of which 77.7% are Federally Qualified Health Centers. There were roughly 2.1 million encounters reported in 2013. The largest majority of clinic patients are low-income, Hispanic, and Medi-Cal or self-pay. More specifically, 68.4% of clinic patients reported having an income below 100% of the poverty level, followed by 15.6% earning between 100-200% of the FPL. The clinic patient population is largely Hispanic (55.7%), and on average (median), approximately 31% of patients are best served in a non-English language. A breakdown of clinic utilization by principal diagnosis is shown below (Figure 32).

Figure 32. Clinic Encounters by Principal Diagnosis, Total Encounters in 2013



Source: California Office of Statewide Health Planning and Development, OSHPD Primary Care and Specialty Clinics Utilization Data. 2013.

Community Partner Data

To further support data findings from the KP Data Platform, the collaborative partnered with local community organizations to obtain more local level data. The data was summarized and used to aid in understanding geographical and neighborhood level differences. The community partners that were engaged were:

- 2-1-1 San Diego
- North County Health Services
- Palomar Health Community Action Council – TODAY Program
- Resident Leadership Academy
- County of San Diego Health and Human Services Agency

2-1-1 San Diego Data

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. The most common callers with health-related needs were female, between the ages of 50 and 59, and Hispanic or Latino. North County and North Inland had largely white callers aged 50-59 whereas South and Central callers tended to be younger, between the ages of 20-29, and Hispanic or Latino. Additionally, the largest majority of clients overall lived in a one-person household and had an income that hovers just above the Federal Poverty Line (FPL). Below is data capturing the top health-related needs based on the frequency of requests by callers (Table 29).

Table 29. 2-1-1 San Diego Top Needs and Referrals

Health-Related Needs by Taxonomy Category		Needs for Clients with Referrals to Hospitals		Top Five Referrals to Clients with Health-Related Needs	
Need	Count of Needs	Need	Count of Needs	Referral	Number of Referrals
Health Insurance Marketplaces	2,594	General Acute Care Hospitals	461	Covered California	3,693
Community Clinics	2,493	Emergency Room Care	449	Benefits and Enrollment for CALFresh, Medi-Cal, 2-1-1 San Diego	977
State Health Insurance Marketplace Call Centers/Websites	1,498	Adult Psychiatric Inpatient Units	186	Breast Health Specialist	841
General Dentistry	977	Urgent Care Centers	185	Access and Crisis Line, Optum Health (formerly United Behavioral Health)	410
Dental Care	690	Speech and Language Evaluations	162	Physician Referral Services	367

Source: 2-1-1 San Diego. FY 2014-15.

With the exception of North Inland, the health-related needs in the table above were consistently cited as the top five across the regions. North Inland, in particular, noted a need for managed care health information as its fifth highest need. Nearly 10% of referrals for health-related needs were for Covered California. This is also reflected in the high count of needs related to health insurance marketplaces, call centers, and websites. Behavioral health service requests are also among the top five shown by the number of referrals to the Access and Crisis Line. When looking at the needs for clients with referrals to hospitals, it is important to note that, along with general acute care hospitals and emergency room care, adult psychiatric inpatient unit referrals ranks among the top five needs.

North County Health Services

As a federally qualified health center, North County Health Services (NCHS) is a community asset that provides health care to vulnerable populations and promotes access to ambulatory care in areas designated as medically underserved. Trend data provided by North County Health Services provide insight into changing demographics, access to care issues, and utilization of services by residents in North Coastal and North Inland FQHC areas. The patient population served is largely low-income with 97.6% of those who reported income citing they were below 200% FPL. From 2013 to 2014 there has been a significant decrease in the number of uninsured patients and a subsequent increase in the number of Medi-Cal for both adults and children. Thirty-nine percent of patients reported being best served in a language other than English, highlighting the demand for a multi-cultural health care workforce. While the number of patients increased among all service types (medical, dental, mental) in 2014, the largest was seen among mental health, with an increase of approximately 50% from 2013. Below is a chart describing the top eight diagnoses for 2014 (Table 30). Among them are issues relating to pregnancy, dental care, diabetes and abnormal glucose, and hypertension. More specifically, it can be seen that Diabetes Mellitus, Abnormal Glucose Tolerance of Mother Antepartum, and Hypertension Unspecified Essential are the fourth, fifth and sixth most common primary diagnoses.

**Table 30. North County Health Services Top 8 Primary Diagnoses in 2004
(Among Adults and Seniors)**

Diagnosis	Number
1. Supervision of Other Normal Pregnancy (V22.1)	18,167
2. Supervision of Normal First Pregnancy (V22.0)	6,547
3. Dental Examination (V72.2)	6,180
4. Diabetes Mellitus (250)	5,809
5. Abnormal Glucose Tolerance of Mother Antepartum (401.9)	3,723
6. Hypertension Unspecified Essential (V24.2)	3,581
7. Routine Postpartum Follow-Up (521.02)	3,150
8. Dental Carries Extending Into Dentine (521.02)	2,558

Source: North County Health Services. 2014.

Below is a breakdown of visits among the top four health needs.

Table 31. Selected Diagnosis and Services Rendered Among Top 4 Needs at North County Health Services

	# of Visits by Diagnosis Regardless of Primacy	# of Patients with Diagnosis Regardless of Primacy
Behavioral Health		
Alcohol Related Disorders	742	308
Other Substance Related Disorders (Excluding Tobacco Use Disorders)	612	350
Tobacco Use disorder	1,369	1,038
Depression and Other Mood Disorders	8,752	3,275
Anxiety Disorders Including PTSD	5,757	2,179
Attention Deficit and Disruptive Behavior Disorders	2,871	1,033
Other Mental Disorders, Excluding Drug or Alcohol Dependence (includes mental retardation)	4,926	2,638
Cardiovascular Disease		
Heart Disease (selected)	1,631	768
Hypertension	10,883	5,288
Diabetes Mellitus	9,214	3,526
Overweight and Obesity	8,658	6,159

Source: North County Health Services. 2014.

Palomar Health Community Action Council – Today Program

Palomar Health's Community Action Council (CAC) model is to identify, address and advocate for the health care needs of Palomar Health's communities. There are five CACs throughout the Palomar Health service area that use collaboration and partnership to actively work to promote healthy environments and wellness, build relationships with key leaders and educate residents about health-related community services. The CACs have implemented the Transforming Obesity & Diabetes Awareness in Youth (TODAY) project which has administered body mass index (BMI) percentile screening to thousands of youth since 2008 to identify and provide resources to families of youth at-risk for obesity and diabetes.

The TODAY program sheds light on the burden of obesity in San Diego youth. A decrease in the proportion of both overweight and obese children from 45.2% in 2008 to 40.28% in 2014 can be seen among those who were screened. That decrease appears to be largely attributable to a decrease in the percentage of obese children from 27.7% to 21.6%. There is also an increase in the percentage of healthy weight children from 52.5% in 2008 to 57.1% in 2014. Please note that the same children are not being screened from year to year therefore it is difficult to make assumptions of decreasing obesity in the youth population.

**Table 32. Body Mass Index and Glucose Test Results
from the Today Program, 2008–2014**

	2008	2009	2010	2011	2012	2013	2014
Number of Schools Screened	8	8	10	12	13	14	13
Total Students Screened	661	640	821	1,022	1,096	1,165	1,147
BMI Results							
Underweight (< 5th percentile)	2.3%	2.0%	2.1%	3.4%	2.6%	2.92%	2.61%
Healthy Weight (5th to <84th percentile)	52.5%	56.7%	55.8%	57.8%	56.1%	57.60%	57.06%
Overweight (85th–94th percentile)	17.5%	19.8%	18.5%	17.5%	19.3%	17.85%	18.64%
Obese (95th percentile or >)	27.7%	21.4%	23.6%	21.2%	22.1%	21.63%	21.60%
Both Overweight & Obese	45.2%	41.3%	42.1%	38.7%	41.3%	39.48%	40.28%
Glucose Results							
Total Students Screened for Glucose Levels	502 (75.9%)	536 (83.8%)	660 (80.4%)	737 (72.1%)	794 (72.4%)	743 (63.8%)	NA
% with Normal Glucose Levels	65.1%	78.2%	79.5%	87.8%	85.0%	85.1%	NA
High Glucose Levels	34.9%	21.8%	20.5%	4.7%	8.9%	13.9%	NA

Source: Palomar Health CAC TODAY Program. 2008-2014.

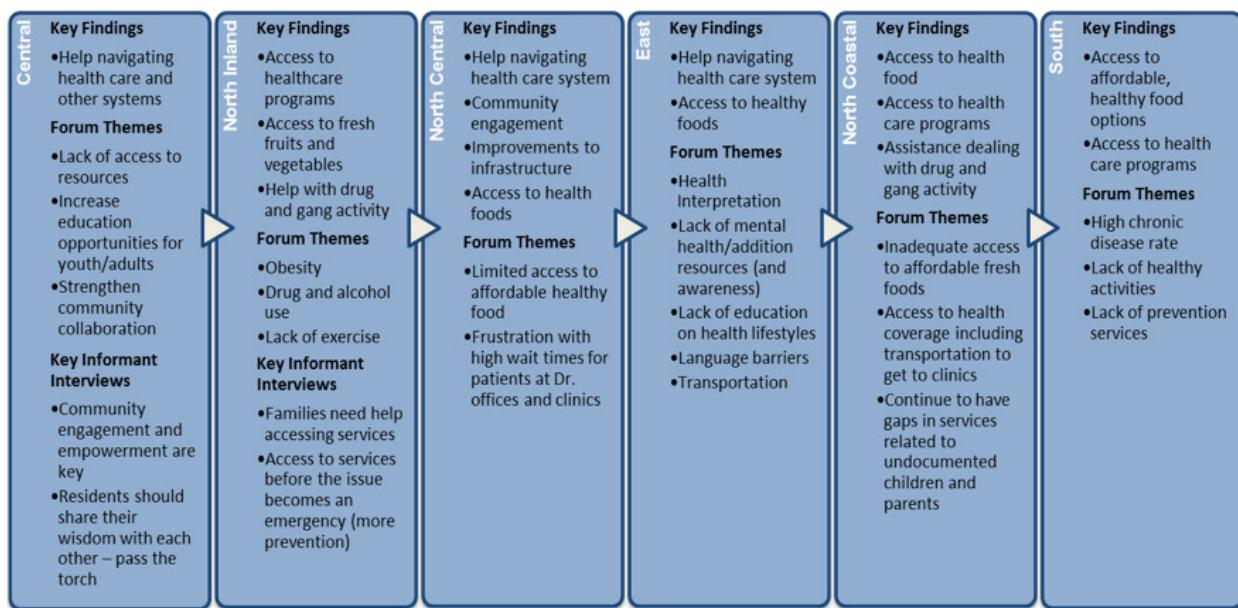
2014 Community Action Partnership San Diego

Community Needs Assessment

San Diego's Community Action Partnership (CAP) is a public community action agency, within the County's Health and Human Services Agency (HHSA). In 2014, CAP San Diego conducted a Community Needs Assessment as part of the development of their Community Action Plan for 2016-17. The assessment included the identification and analysis of key community indicators, solicitation of direct community input regarding the needs and priorities of low-income communities by local residents, and analysis of quantitative data and community input collected by CAP San Diego staff and the Community Action Board.

To gather community input, CAP San Diego leveraged a model called Resident Leadership Academy (RLA). The RLAs provide local leaders in low-income neighborhoods with training and tools to take action in their neighborhoods to increase healthy behavior, improve safety, and create vital neighborhoods. In July 2014, CAP commissioned six regional RLAs (one in each HHSA designated service region) to train 10-15 residents using the RLA curriculum and complete a needs assessment for their designated region. Below is a summary of the 2014 CAP Community Needs Assessment findings (Figure 33).

Figure 33. Summary of the 2014 Cap Community Needs Assessment Findings



San Diego HHSA Community Health Assessment

The Live Well San Diego Community Health Assessment (CHA) process began in 2012. During this process, regional leadership teams were formed and each region conducted the following three assessments: 1) Community Health Status Assessment, 2) Forces of Change Assessment, and 3) Community Themes and Strengths Assessment. This process allowed each region to assess the health status of its community by determining the root causes of health including health behaviors, social factors, and health services. The results of these assessments were combined and key priority areas were identified. These priority areas are summarized in Figure 34.

Figure 34. Summary of Key Priority Areas Identified in the San Diego County HHSA CHA

North County*	<ul style="list-style-type: none">•Key Priority Areas:•Behavioral Health/Substance Abuse, Nutrition and Physical Activity
North Central	<ul style="list-style-type: none">•Key Priority Areas:•Physical Activity, Behavioral Health, Preventative Health Care
East	<ul style="list-style-type: none">•Key Priority Areas:•Active Living, Healthy Eating, Substance Abuse Prevention
Central	<ul style="list-style-type: none">•Key Priority Areas:•Access to Health Services, Alcohol, Tobacco and Other Drugs, Food Equity /Access to Healthy Food, Safety and Built Environment, Worksite Wellness
South	<ul style="list-style-type: none">•Key Priority Areas:•Health Care Access, Improve Security and Decrease Violence, Physical Activity and Healthy Eating

*Note: North County includes both North Inland and North Coastal regions.

Source: County of San Diego, Health and Human Services Agency. Live Well San Diego Community Health Assessment. 2014

2016 CHNA Methodology

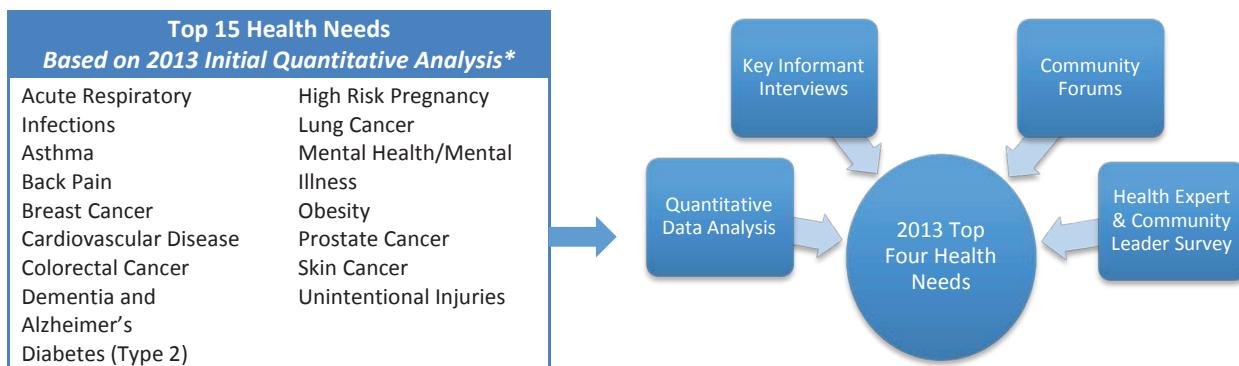


VI. 2016 CHNA Methodology

The CHNA Committee designed the 2016 CHNA process based on the findings and feedback from the 2013 HASD&IC CHNA. The aim of the 2016 CHNA methodology was to provide a more complete understanding of the top four identified health needs and associated social determinants of health in the San Diego community.

The methodology that was used to identify the top four health needs is described in Figure 35 (below).

Figure 35. HASD&IC 2013 CHNA Methodology



When the results of all of the data and information gathered in 2013 were combined, four conditions emerged clearly as the top community health needs in San Diego County (in alphabetical order):

1. Behavioral/Mental Health
2. Cardiovascular Disease
3. Diabetes (Type 2)
4. Obesity

The CHNA Committee completed a collaborative follow-up process (Phase 2) to ensure the 2013 CHNA findings accurately reflected the health needs of the community. Phase 2 collected community feedback on both the process and findings of the 2013 CHNA, as well as recommendations for the next CHNA process. A summary of the overall findings from Phase 2 of the 2013 CHNA is below. For a complete description of the HASD&IC 2013 CHNA process and findings, see the full report available at <http://www.hasdic.org/chna.htm>.

Phase 2 Overall Findings & Recommendations*

Common set of barriers make hospital programs inaccessible for residents in high need communities	87% of respondents agreed the 2013 CHNA identified the top health needs of San Diego County Residents	78% of respondents agreed the methodology for the next CHNA should include a deeper dive into the top 4 health needs
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*For a complete description of the HASD&IC 2013 CHNA process and findings, see the full report available at <http://www.hasdic.org/chna.htm>.

Based on the findings and feedback from the two phases of the 2013 CHNA, the goal of the 2016 methodology was to do a deeper analysis of the top four identified community health needs: behavioral health, cardiovascular disease, diabetes (type 2) and obesity.

Prior to the beginning of this focused analysis, the CHNA Committee completed a scan of recent community health statistics which validated the regional significance of the top four health needs identified in the 2013 CHNA. In addition, the CHNA Committee met with community partners who participated in the 2013 CHNA process to discuss how best to move forward with a deeper analysis and identify how to engage the community.

Based on the results of the scan and input received from the community during the 2016 planning process, a number of community engagement activities were conducted to further understanding of the identified health needs, including their associated social determinants of health as well as potential system and policy changes to impact them. In addition, a detailed analysis of how the top four needs impact the health of San Diego residents was conducted.

Figure 36 provides an overview of the community engagement activities and the quantitative data that were used to identify and prioritize the health needs for the 2016 CHNA. For the purposes of the CHNA, a “health need” is defined as a health outcome and/or the related conditions that contribute to a defined health outcome.

Figure 36. 2016 CHNA Process Map



Quantitative Data Collection and Analysis

The CHNA Committee used the KP CHNA Data Platform¹⁵ to review over 150 indicators from publically available data sources. Data on gender and race/ethnicity breakdowns were analyzed when available. In addition to the KP CHNA Data Platform, supplemental demographic and health data were summarized. For details on specific sources and dates of the data used, please see [Appendix A](#).

The purpose of gathering quantitative data was to:

- Gain a baseline understanding of San Diego County and the health of its residents.
- Describe the community served through existing demographic and health related data sources.
- Provide a scan of current community health statistics to ensure the regional significance and influence of the top four health needs identified in the 2013 CHNA on health status.
- Gain a better understanding of how the top identified health needs impact San Diego health systems and hospitals through a detailed analysis of hospital discharge data.

For the 2016 CHNA process, consideration was given to newly available data as well as the 2013 CHNA findings and recommendations. Current San Diego County data was assessed through a scan of recent community health statistics including an analysis of emergency department and hospitalization discharge data, indicators in Kaiser Permanente's Community Benefit Tool¹⁶ and an analysis of additional quantitative data.

Hospital Emergency Department and Hospitalization Discharge Analysis

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 our data collection process, 2013 OSHPD discharge data for hospital inpatient, emergency department, and ambulatory care encounters from all hospitals within San Diego County were analyzed through the SpeedTrack® California Universal Patient Information Discovery (CUPID) application (<http://www.speedtrack.com>). Patients included in the analysis were those who were discharged from a San Diego County hospital and reported a San Diego County ZIP code of residence, or were discharged and described as a homeless patient. Those patients who entered through the Emergency Department (ED) and then were admitted into the hospital were counted as an inpatient discharge. ICD-9 codes for each health need were chosen based on ICD-9 codes used by the San Diego County

¹⁵ The KP Data Platform is a web-based resource designed to support community health needs assessments and community collaboration. This platform includes a focused set of community health indicators that allow users to understand what is driving health outcomes in particular neighborhoods. The platform provides the capacity to view, map and analyze these indicators as well as access additional public data and assess community assets available to meet the needs identified.

¹⁶ Kaiser Permanente Community Benefit Data Analysis Tool organizes the Kaiser Permanente common indicators against 14 common health needs, using a combination of morbidity/mortality and health driver indicators. The common health needs are Access to Care, Asthma, Cancers, Climate and Health, CVD/Stroke, Economic Security, HIV/AIDS/STDs, Maternal and Infant Health, Mental Health, Obesity/HEAL/ Diabetes, Oral Health, Overall health, Substance Abuse/Tobacco, and Violence/Injury Prevention.

Community Health Statistics Unit and hospital service line recommendations. ICD-9 codes are a standardized classification of disease, injuries and cause of death which allow clinicians and others to speak a common language and bill insurance.

The top 10 discharges by principal and secondary diagnosis were pulled for both ED and inpatient hospitalization discharge data at the body system level.¹⁷ A principal diagnosis is defined as the condition established after examination to be chiefly responsible for the admission. A secondary diagnosis can be defined as other diagnoses that coexisted in addition to the diagnosis reported as the principal diagnosis. It is important to assess principal diagnoses using ED discharge and hospitalization data in order to understand the downstream impact of different health conditions on the health system. Evaluating secondary diagnoses helps to describe existing co-morbidities which may be exacerbating poor health outcomes, including chronic conditions such as hypertension and diabetes.

Additional Quantitative Data

To supplement the Kaiser Permanente's CHNA Data Platform and the analysis described above, additional health data was collected to capture a holistic picture of the health of San Diego County. This included 2012 mortality data from California Department of Public Health and health indicator data from local, state, and national agencies including the CHIS, California Reducing Disparities Project reports, and publications by the County of San Diego HHSA. A vulnerable populations report was created to provide a more in-depth understanding of the following populations: Children, Seniors, Asian American/Native Hawaiian and Other Pacific Islander, American Indians/Alaskan Natives, Latinos, African Americans, Homeless, LGBTQ, and Refugees (Appendix K). These groups were selected based on CDC guidelines and recommendations from the community about specific populations to include in future assessments.

¹⁷ Developed at the Agency for Healthcare Research and Quality (AHRQ), the Clinical Classifications Software (CCS) is a tool for clustering patient diagnoses and procedures into a manageable number of clinically meaningful categories. The multi-level CCS groups single-level CCS categories (specific diagnoses and procedures) into broader body systems or condition categories (e.g., "Diseases of the Circulatory System," "Mental Disorders," and "Injury").which can be used to explore data on types of conditions.

*Note: North County includes both North Inland and North Coastal regions.

Source: County of San Diego, Health and Human Services Agency. Live Well San Diego Community Health Assessment. 2014

Community Engagement Activities

Community engagement activities were conducted with a broad range of community members, including health experts, community leaders, and San Diego residents, in an effort to gain a more complete understanding of the top identified health needs in the San Diego community. Individuals who were consulted included representatives from state, local, tribal, or other regional governmental public health departments (or equivalent department or agency) as well as leaders, representatives, or members of medically underserved, low-income, and minority populations. For a complete list of individuals who provided input, see [Appendix B](#).

Community input was gathered through the following activities:

- Community Partner Discussions
- Key Informant Interviews
- Health Access and Navigation Survey: Roadmap – Where Do You Get Stuck?
- Collaborative San Diego County Health and Human Services Agency Survey
- Behavioral Health Discussions

The overall purpose of collecting community input was to gather information about the health needs and social determinants specific to San Diego County. Specific objectives included:

- Gather in-depth feedback to aid in the understanding of the most significant health needs impacting San Diego County.
- Connect the identified health needs with associated social determinants of health.
- Aid in the process of prioritizing health needs within San Diego County.
- Gain information about the system and policy changes within San Diego County that could potentially impact the health needs and social determinants of health.

Each of the discussions and key informant interviews was summarized and themes were extracted. A full list of themes was then aggregated and tallied by the frequency of times they were mentioned across all community input activities for use in the prioritization process. In addition, the results from the HHSA survey were used in the above tally for the prioritization of health needs. The health access and navigation survey was utilized to further support the findings.

Community Partner Discussions

Non-traditional stakeholders were recruited through existing community partnerships in order to solicit input from those who work directly with more vulnerable populations. A non-traditional stakeholder is defined as an individual or group who has not been consistently involved in the CHNA process throughout previous cycles of the CHNA. These stakeholders (community partners) were comprised of individuals from a variety of backgrounds including: care coordinators, outreach workers, community education

specialists, wellness coordinators, school nurses, behavioral health managers and workers, CalFresh Outreach Coordinators, and CalFresh Capacity Coordinators (Capacity Coordinators help to build capacity and community support, implement new projects and provide technical support to better address poverty and hunger).

The development of the community partner discussion tool began with the top health needs identified in the HASD&IC 2013 CHNA. Discussion questions were created with the help of community partner organizations and designed to provide in-depth detail on the top four health needs. Community partner discussions were conducted in all regions of the county between July and October of 2015, with 87 total participants. Please see Table 33 for more details on the discussions.

Table 33. Community Partner Discussion Information, HASD&IC 2016 CHNA

Who Participated		Title/Organization	Number of Participants	Description of public health knowledge/expertise
1	Behavioral Health Case Managers	Case Managers Network	7	Low income, medically underserved, minority population, population with chronic diseases
2	CalFresh Coordinator Project Coordinator Community Health Access Department - Cal-Fresh (food stamps) Case Management	San Diego Hunger Coalition CalFresh Task Force	7	Low income, medically underserved, minority population, population with chronic diseases
3	Outreach workers, Community Education Specialist	San Ysidro Health Center	23	Low income, medically underserved, minority population, population with chronic diseases
4	Care coordinator, Special populations health enrollment specialist, specialist/care coordinator	Family Health Centers	4	Low income, medically underserved, minority population, population with chronic diseases
5	Community health workers Health interpreter Family support worker senior, Health program coordinator Wellness coordinator	International Rescue Committee	7	Refugees, Low income, medically underserved, minority population, population with chronic diseases
6	Parent and Youth Partners, Program Managers and Directors	Family Youth Round Table	9	Youth and children, medically underserved, minority population
7	School Nurses	SD County of Education School Nurses Resource Group	30	Low income, medically underserved, minority population, population with chronic diseases, youth and children

Each participant at the discussion was asked to fill out a voluntary sign-in sheet in order to gather general information about the population they serve. During the community dialogue, the facilitator provided brief explanations of the 2016 CHNA process and the top four health needs that were identified in the 2013 CHNA. Participants were then asked to provide feedback on the most common issues related to the top four health needs and the barriers that their clients face in improving their health. Although there were specific questions asked, the format of the discussions allowed for ample opportunity for open dialogue about health needs that the participants felt most important in San Diego County. Please see Appendix E for all community partner discussion materials. The findings from the community partner discussions are summarized in [Table 37](#).

Behavioral Health Discussions

Due to the complexity of behavioral health, additional discussions were held specifically to ensure the quantitative data that was gathered accurately reflected current trends and areas of true need. The purpose of the behavioral health discussions was to gather feedback from behavioral health experts to aid in the understanding of the most significant health needs impacting San Diego County and aid in the process of prioritizing health needs within behavioral health.

Meetings focused on behavioral health were targeted to solicit feedback from stakeholders including patient advocates as well as representatives from hospitals, clinics, County HHSA, smaller behavioral or mental health facilities, and health plans. The behavioral health discussion template was developed based on hospital discharge data analysis and incorporated a synthesis of the community partner discussion data. A summary of data as it relates to behavioral health needs was provided to the behavioral health experts prior to gaining their feedback.

Two behavioral health presentations took place between December 2015 and January 2016. The combined total number of attendees was roughly 50 people between the two meetings. The presentations were conducted during existing meetings so a sign-in sheet was not provided and a specific count of the number of participants is not available. In recognition of unique challenges faced by individuals at different points along the continuum of behavioral health care, an additional discussion at the Alpine Special Treatment Center discussion took place in January 2016 with eight participants. Please see [Appendix E](#) for the handouts provided at the behavioral health discussions and Table 34 below for additional details. The findings for the behavioral health discussions are summarized in the Results section.

Table 34. Behavioral Health Discussion Information, HASD&IC 2016 CHNA

Who Participated		Title/ Organization	Number of Participants	Description of public health knowledge/expertise
1	Physicians, social workers, case workers	Hospital Partners Behavioral Health Workgroup	30	Low income, medically underserved, minority population, population with chronic diseases
2	Physicians, social workers, case workers	Healthy San Diego Behavioral Health Workgroup	~20	Low income, medically underserved, minority population, population with chronic diseases
3	Physicians, social workers, case workers	Alpine Special Treatment Center	8	Low income, medically underserved, minority population, population with chronic diseases

Key Informant Interviews

Health experts and leaders were asked to participate in the key informant interviews based on their diverse knowledge of the health and well-being of vulnerable populations within San Diego County. In response to feedback from the 2013 CHNA, the number of key informant interviews conducted as part of the 2016 CHNA was expanded to include experts working with a wider variety of patient populations. Participants were selected based on their expertise in a specific condition, age group, or population. More specifically, individuals who participated in the 2016 CHNA had knowledge in at least one of the following areas: childhood issues, senior health, Native Americans, Latinos, Asian Americans, refugee and families, homeless, lesbian, gay, bisexual, transgender and queer (LGBTQ) population, veterans, alcohol and drug addiction, cardiovascular health, behavioral health, diabetes, obesity, and food insecurity. In addition there was representation across multiple agencies and organizations including the San Diego County HHSA, local schools, youth programs, community clinics, and community-based organizations.

The development of the key informant Interview tool began with the results from the HASD&IC 2013 CHNA. The interview questions were designed to provide in-depth detail on the top four health needs. Nineteen key informant interviews took place either in-person or via phone interview between July 2015 and February 2016. Each interview lasted no longer than one hour. Six questions were asked during the interviews, with a particular focus on the top four health needs that were identified in the 2013 CHNA. Although there were specific questions asked, the format of the interviews allowed for ample opportunity for open discussion on health needs that the key informants felt were most important in San Diego County, including those not directly related to the top four health needs. Please see [Appendix E](#) for all key informant interview materials and Table 35 below for additional information. The findings from the key informant interviews are summarized in [Table 38](#).

Table 35. Key Informant Interview Information, HASD&IC 2016 CHNA

Who Participated		Title/Organization	Number of Participants	Description of public health knowledge/expertise
1	Martha Bajet	School Nurse, Rosa Parks Elementary School	1	Children, Youth and Families, low income, medically underserved
2	Ellen Schmeding, M.S., MFT; Brenda Schmittener, MPA	Healthy San Diego Behavioral Health Workgroup	~20	Low income, medically underserved, minority population, population with chronic diseases
3	Steven Jella, MA, MFT, PsyD	Associate Executive Director, San Diego Youth Services	1	Children, Youth and Families, Refugees
4	Naomi Billups	Nutrition Manager, Public Health Services, County of San Diego Health and Human Services Agency	1	Obesity, Diabetes, Food issues
5	Cheryl Moder	VP, Collective Impact, Community Health Improvement Partners	1	Low income, medically underserved, minority population, population with chronic diseases, obesity
6	Don Stump	Executive Director, North County Lifeline	1	Homeless, Behavioral Health, low income
7	Kim Bond, MFT	CEO & President, Mental Health Systems	1	Behavioral Health
8	Greg Angela	Executive Director, Interfaith Community Services	1	Homeless, Veteran population, Housing
9	Maria Carriedo-Ceniceros, MD	Vice President & Chief Medical Officer, San Ysidro Health Center	1	Low income, medically underserved, Latino population
10	Fe Seligman	Director of Program & Fund Development, Operation Samahan Health Centers	1	Low income, medically underserved, minority population, Breast Cancer, Cardiovascular Disease, Diabetes (Type 2)
11	Irma Cota	President and CEO, North County Health Services	1	Low income, medically underserved, minority population, Latinos
12	Laura Vleugels, MD	Supervising Child and Adolescent Psychiatrist, Behavioral Health Services, County of San Diego Health and Human Services Agency	1	Children, Youth and Families, Behavioral Health
13	Erica Bouris	Deputy Director, Programs, International Rescue Committee	1	Refugees, medically underserved

Who Participated		Title/Organization	Number of Participants	Description of public health knowledge/expertise
14	Delores Jacobs, Ph.D.	CEO, The San Diego LGBT Community Center	1	LGBTQ population
15	Douglas Flaker Perse Hooper	Program Development Director, San Diego American Indian Health Center Community Engagement Specialist	2	Native American population
16	Margaret Iwanaga-Penrose	President & CEO, Union of Pan Asian Communities	1	Asian American population
17	Anahid Brakke	Executive Director, San Diego Hunger Coalition	1	Food systems issues/food insecurity, low income
18	Rodney G. Hood, M.D.	President and Chairman, MultiCultural Health Foundation	1	Low income, medically underserved, population with chronic diseases, African Americans
19	Wilma Wooten, M.D., M.P.H.	Deputy Health Officer, County of San Diego Health and Human Services Agency	1	Low income, medically underserved, minority population, population with chronic diseases

Health Access and Navigation Survey

The Health Access and Navigation Survey was developed in partnership with the San Diego County Resident Leadership Academy (RLA).^{18, 19} After comparing results of the RLA's 2014 Community Needs Assessment²⁰ and with the findings from the HASD&IC 2013 CHNA, access and navigation of health care emerged as a common barrier identified by the San Diego community. The CHNA Committee collaborated with the RLAs to design a survey tool that could identify specific barriers residents face when they try to access health care services. RLA leaders generously agreed to disseminate the health access and navigation survey to residents in their neighborhoods.

The roadmap survey was designed to identify particular areas in which residents struggle when they are using the health system. The surveys were fielded on September 22, 2015 and closed November 2, 2015. Survey responses were collected both electronically and via paper and pencil format from community residents. Paper and electronic copies of the survey were made available to the RLA leaders in Spanish, English, and Arabic. An online survey link was also emailed out in both Spanish and English. A total of 235 surveys were completed with the majority being completed on paper (181) and 54 completed via the online survey. One hundred and eleven paper surveys and zero online

18 More information about the San Diego Resident Leadership Academy is here <http://www.sdchip.org/initiatives/resident-leadership-academy.aspx>

19 Adapted from San Ysidro Health Center hand out which was adapted from the Centers for Medicare & Medicaid Services, <https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH-Coverage2Care.html>

20 More information about the RLA assessment completed for the San Diego County's Community Action Partnership is available here: http://www.sandiegocounty.gov/hhsa/programs/sd/community_action_partnership/

surveys were completed in Spanish. Seventy paper and 54 online surveys were completed in English. No Arabic surveys were collected or completed. The findings from the Health Access and Navigation Survey are summarized in [Table 40](#).

Survey participants were asked to choose the top five barriers the participants or the population they work with experience, and to rank the five barriers from one to five, with one being the most troublesome.

Collaboration with County of San Diego Health and Human Services Agency

In early 2014, HASD&IC and leadership at HHSA began discussing ways to align their efforts to assess community health needs. In recognition of the tremendous opportunity to leverage the work of each entity, HHSA altered their CHA schedule to align it with the triannual CHNA schedule required by federal regulations. The alignment supported several key goals: improved ability to share information from the different assessments; reduced burden on the communities and organizations surveyed by both assessments; and increased opportunities for partnership and collaboration. For this 2016 CHNA process, the HHSA and HASD&IC partnered in regional presentations as well as an electronic survey.

Data presentations were given at five Live Well San Diego Regional Leadership Team meetings across San Diego County in October and November 2015. The Regional Leadership Teams are comprised of community leaders and stakeholders that are active in each of the six HHSA regions. Each meeting included an overview of the HASD&IC 2013 CHNA process and findings followed by a presentation from the County of San Diego Community Health Statistics Unit on current data trends in their region.

Following the data presentations, an electronic survey was sent to pre-identified stakeholders and community partners representing all six HHSA regions. HASD&IC and the County HHSA worked together to create specific questions assessing community perception of the top health needs, and for which health needs resources are lacking.

The survey was made available to the Regional Leadership Team members and community partners for a two week period of time. A total of 91 respondents completed the assessment. Survey participants represented a wide range of disciplines, with the most frequently cited sectors being Community Organizations, Health/Long-Term Care, Government, Education and Social Services. Detailed results and analysis of the survey are summarized in [Table 41](#) of the results section of this report.

2016 CHNA Prioritization of the Top Four Health Needs

The purpose of the prioritization process was to identify the most significant health needs in the community. The prioritization process was performed by the CHNA Committee during regularly scheduled meetings convened at HASD&IC offices. Conference call lines were available, giving all members the opportunity to meet either in person or via a conference call. A comprehensive collection of the quantitative data and community engagement results gathered by the IPH was presented to the CHNA Committee for review. Decisions regarding prioritization were made by consensus of the CHNA Committee. Those not in attendance were kept informed to ensure consensus was maintained. A minimum of one representative from each of the seven hospitals was consulted on the final prioritization list.

In order to prioritize the four significant health needs in San Diego County, the CHNA Committee applied the following five criteria:

1. **Magnitude or Prevalence:** The health need affects a large number of people in all regions of San Diego.
2. **Severity:** The health need has serious consequences (morbidity, mortality, and/or economic burden).
3. **Health Disparities:** The health need disproportionately impacts the health status of one or more vulnerable population groups.
4. **Trends:** The health need is either stable or changing over time, e.g., improving or getting worse.
5. **Community Concern:** Stakeholders, community members, and vulnerable populations within the community view the health need as a priority.

Using the criteria above, a summary matrix translating the 2016 CHNA findings was created for review by the CHNA Committee. Taking into account the results of the quantitative data collection and the findings from the community engagement activities, a rank from 1 to 4, with 1 being the most significant, was applied for each criterion. An overall score was given to each health need by averaging the rankings across all five criteria. In addition, associated social determinants of health were identified and prioritized based on the frequency of times the social determinants were cited during community input activities and if secondary data supported it as a problem within San Diego County.

2016 CHNA Results



VII. Results

Quantitative Data Collection and Analysis

After comparing results of the quantitative analyses of the San Diego County mortality data, KP Community Benefit Data Analysis Tool, and hospital discharge data, the findings demonstrated that behavioral health, cardiovascular disease, diabetes, and obesity continue to be among the top priority health needs in San Diego County across different quantitative data sources.

Table 36 shows the top 10 health needs in rank order across three quantitative data sources: the National Center for Health Statistics (NCHS) “rankable” leading causes of death, the KP Community Benefit Data Analysis Tool²¹ top identified health needs, and the OSHPD top 10 primary and secondary diagnoses by body system for both ED and inpatient San Diego County hospital discharges listed in order of frequency.

The health needs highlighted in red correspond to the top four health needs identified in 2013, underscoring their significance in comparison to the additional identified health needs. While it is critical to recognize the impact of other issues on the health of the community, the top four needs identified in the 2013 CHNA were chosen as the focus of the 2016 CHNA due to their regional significance and influence on health status, as well as the recommendations of participants (including community residents and community health leaders) from Phase 2 of the 2013 CHNA. Thus, improvements that address the top four health needs will likely decrease the impact of other health conditions on the health of the community as well.

Quantitative data was compiled on each of the four health needs and can be found in the '[Description of Identified Needs](#)' section.

²¹ Kaiser Permanente Community Benefit Data Analysis Tool organizes the Kaiser Permanente common indicators against 14 common health needs, using a combination of morbidity/mortality and health driver indicators. The common health needs are Access to Care, Asthma, Cancers, Climate and Health, CVD/Stroke, Economic Security, HIV/AIDS/STDs, Maternal and Infant Health, Mental Health, Obesity/HEAL/ Diabetes, Oral Health, Overall health, Substance Abuse/Tobacco, and Violence/Injury Prevention.

Table 36. Summary of Top Ten Health Needs by Data Source, HASD&IC 2016 CHNA

Rank #	County Mortality Data-2012 ^{a,b}	Kaiser Data Platform ^c	ED Discharges-Principal Diagnosis - Body Systems	ED Discharges-Secondary Diagnosis -Body System-duplicates	Inpatient Discharges-Principal Diagnosis - Body Systems	Inpatient Discharge-Secondary Diagnosis -Body Systems - duplicates
1	Malignant neoplasms	HIV/AIDS/STDs (1.0)	Symptoms Signs and Ill-Defined Conditions (25%) *Includes chest pain, and abdominal	Factors Influencing Health Status and Contact with Health Services (41%)	Complications of Pregnancy and Childbirth and the Puerperium (15%)	Factors Influencing Health Status and Contact with Health Services (73%)
2	Disease of heart	Cancers (0.56)	Injury and Poisoning (22%)	Diseases of the Circulatory System (32%)	Diseases of the Circulatory System (19%)	Endocrine Nutritional and Metabolic Diseases and Immunity Disorders (55%)
3	Alzheimer's disease	Mental Health (0.33)	Diseases of the Respiratory System (9%)	Endocrine Nutritional and Metabolic Diseases and Immunity Disorders (30%)	Diseases of the Digestive System (9%)	Diseases of the Circulatory System (52%)
4	Chronic lower respiratory disease	Substance Abuse/ Tobacco (0.33)	Diseases of the Musculoskeletal System (6%)	Symptoms Signs and Ill-Defined Conditions (29%)	Injury and Poisoning (9%)	Mental Disorders (36%)
5	Cerebrovascular diseases	Obesity/HEAL/ Diabetes (0.32)	Diseases of the Nervous System and Sense Organs (6%)	Mental Disorders (29%)	Mental Disorders (9%)	Symptoms Signs and Ill-Defined Conditions (34%)
6	Accidents (unintentional injuries)	Climate and Health (0.28)	Diseases of the Genitourinary System (6%)	Diseases of the Nervous System and Sense Organs (16%)	Factors Influencing Health Status and Contact With Health Services (7%)	Diseases of the Genitourinary System (28%)
7	Diabetes mellitus	Access to Care (0.23)	Diseases of the Digestive System (5%)	Diseases of the Musculoskeletal System (14%)	Diseases of the Respiratory System (7%)	Diseases of the Nervous System and Sense Organs (28%)
8	Intentional self-harm (suicide)	Oral Health (0.14)	Mental Disorders (5%)	Diseases of the Respiratory System (13%)	Diseases of the Musculoskeletal System (6%)	Diseases of the Digestive System (27%)
9	Chronic liver diseases and cirrhosis	Violence/Injury Prevention (0.13)	Diseases of the Skin and Subcutaneous Tissue (4%)	Diseases of the Genitourinary System (11%)	Infectious and Parasitic Disease (6%)	Diseases of the Respiratory System (25%)
10	Essential (primary) hypertension & hypertensive renal disease	CVD/Stroke (0.11)	Complications of Pregnancy and Childbirth and the Puerperium (3%)	Injury and Poisoning (11%)	Neoplasms (4%)	Diseases of Blood and Blood-Forming Organs (25%)

a Rank is based on total number of deaths in each of the National Center for Health Statistics (NCHS) "rankable" categories. The top 10 leading causes of death presented here are based on the county-wide rank among San Diego County residents in 2012.

b Source: California Department of Public Health, Center for Health Statistics, Office of Health Information and Research, Death Statistical Master Files; SANDAG January 1 population estimates (2001-2013 estimate released January 2014)

c Source: Kaiser Permanente Data Platform, Potential Health Needs, <http://www.communitycommons.org/groups/community-health-needs-assessment-chna/>. Note: The benchmark scores for each health need are in parenthesis.

dSource: SpeedTrack© California Universal Patient Information Discovery (CUPID) application. <http://www.speedtrack.com>. Note: The top 10 primary and secondary diagnoses by body system for both ED and inpatient hospital discharges are listed in order of frequency, with the total percentage of encounters being displayed in parenthesis.

Community Engagement Activities

In total, there were 87 participants in seven community partner discussions, 19 key informant interviews, 235 completed Health Access and Navigation surveys, 91 completed collaborative HHSA surveys, and three behavioral health discussions.

Community Partner Discussions

Community partner discussions were conducted in all regions of the county between July and October of 2015, with 87 total participants. A summary of the discussion results are presented below (Table 37).

**Table 37. Summary of Community Partner Discussion Results,
HASD&IC 2016 CHNA**

Community Partner Discussion Questions and Summary of Responses	
1. What are the most common health issues or needs?	
• Anxiety • Depression • Drugs/alcohol • High blood pressure • High cholesterol	• Lack of psychiatrists • Obesity in youth • Problems with compliance/coverage • Self-injury/suicidal ideation in youth • Unhealthy diet
2. What are the challenges clients face to improving health?	
• Cost • Homeless: often difficult to get proof of appointment; wait times are often longer than the amount of time they are allowed to be gone • Lack of access to healthy food • Lack of understanding of covered insurance benefits and fear of hidden costs • Language barriers • Literacy	• Stigma • Stress • Seniors: don't have support at home or forget to take medications, mobility issues and healthy eating • Transportation • Time • Youth: Too few behavioral health practitioners/lack of school counselor, knowledge, getting parents on board/parent follow-up
3. Why do patients not adopt behaviors?	
• Cost • Cultural practices (i.e. unhealthy food, medicine only for the sick) • Lack of awareness/recognition/education • Not properly motivated/confident	• Perceived seriousness • Prioritization of other needs • The right questions aren't being asked • Youth: Lack of role model, lack of control over health behaviors
4. What are top challenges you as case managers, health navigators, etc. face to helping patients?	
• Compliance and literacy- getting individuals to read/use resources • Elderly: may choose medicine over food • Getting clients to go is difficult ('I don't need that' or 'I feel fine') • Long waiting periods and no follow-up appointments • North County: lack of services, only one crisis location • Problems confirming appointments/contacting • Problems with hospital discharges, continuing care and wrong referrals • Patients being signed up for the wrong plans for what they need/want • South region: getting documents/verifications • Youth: difficulties communicating with parents/ what is told to parents at discharge does not filter down to the nurses, limited school-based interventions, cultural barriers, denial, unaware of problem	

Community Partner Discussion Questions and Summary of Responses

5. What have you found works best with your clients to help them meet their needs?

- | | |
|---|---|
| <ul style="list-style-type: none">• Emotional support• Finding intrinsic motivation• Keeping the phone lines open• Multicultural providers | <ul style="list-style-type: none">• Reducing stigma• Strengths-based case management• Translators |
|---|---|

6. How could hospitals collaborate with your organizations?

- | |
|--|
| <ul style="list-style-type: none">• Better referrals, streamlined discharge planning, and timely access to medical records (more details)• Better ways to ask if people need food or other social services• Discharge summary/instructions from hospital/doctor to school sites for kids (what are limitations, needs, modifications), upstream health education curriculum, presentations, and legislation for youth• No discharge to streets or without medications, no discharges without making follow-up appointments with clients |
|--|

Key Informant Interviews

In response to feedback from the 2013 CHNA, the number of key informant interviews conducted as part of the 2016 CHNA was expanded to include experts working with a wider variety of patient populations. Participants were selected based on their expertise in a specific condition, age group, and/or population.

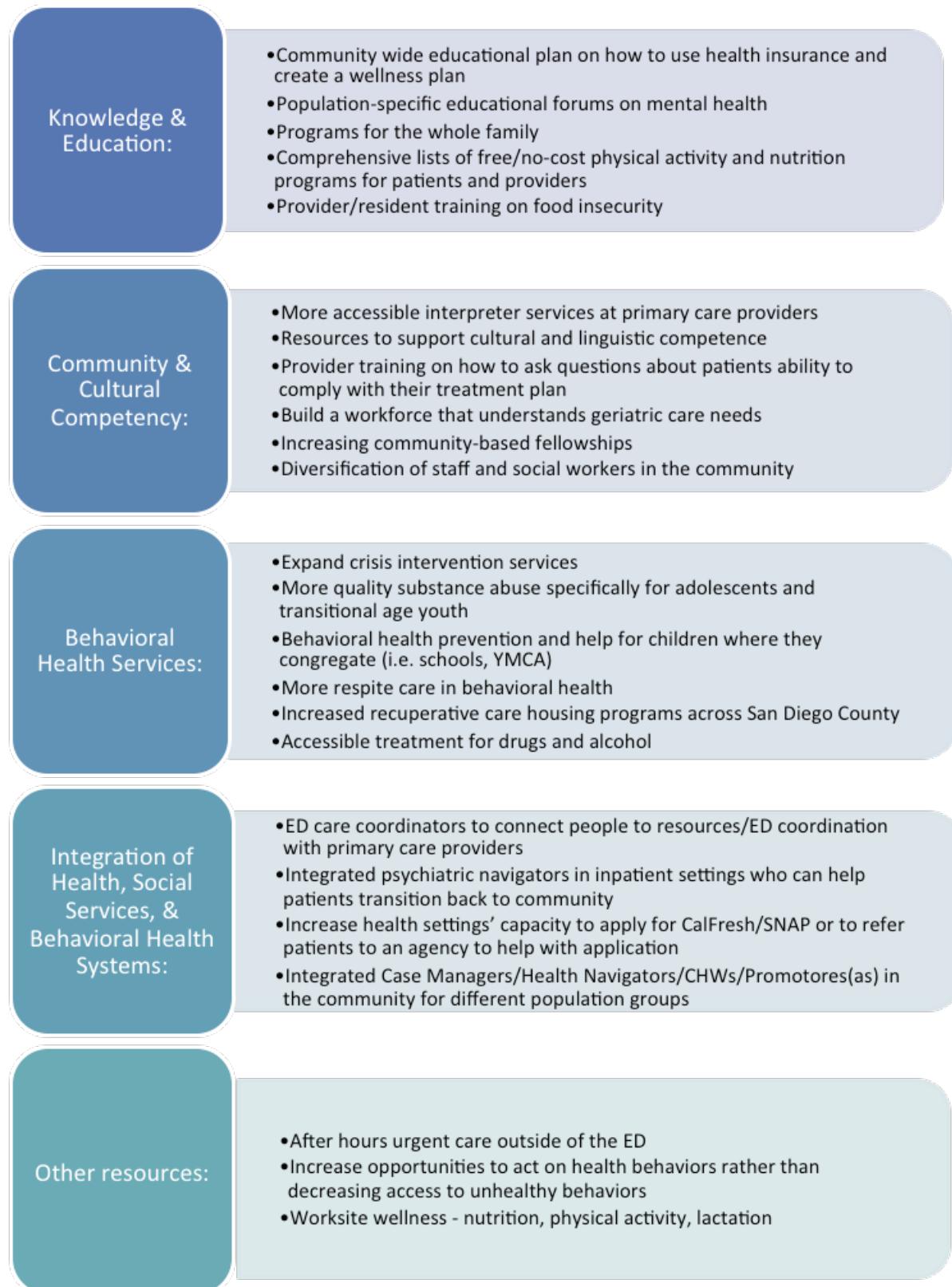
The most common health needs, important modifiable risk factors, effective strategies, and suggestions for collaboration are summarized in Table 38. Some important strategies that key informants suggested included behavioral health prevention and stigma reduction, education on disease management and food insecurity, improving cultural competency and diversity, and integrating physical and mental health, coordinating services across the continuum, and engaging case managers and patient navigators in the community and incorporating them as a routine part of the continuum of care.

In addition, Figure 37 describes key informant recommendations for community resources to address the four identified health needs as well as their associated social determinants of health.

Table 38. Summary of Key Informant Responses, HASD&IC 2016 CHNA

Key Informant Interview Questions and Summary of Responses	
1. What are the most common health issues or needs?	
<ul style="list-style-type: none">• Anxiety• Asthma• Dental health• Depression• Dementia and Alzheimer's disease in seniors• Depression and diabetes in seniors• Diabetes - low-income and food insecure populations, Latinos, Asians	<ul style="list-style-type: none">• Hypertension –Latinos, African Americans, and Asians• Increase in developmental disorders in children• Obesity – youth, acculturating refugees, Native Americans, older veterans, low income individuals and families• Substance Abuse
2. What do you think are the most important modifiable risk factors related to the health issues you just mentioned?	
<ul style="list-style-type: none">• Access to nutritious food• Access to specialty care• Childhood and adult traumas• Homelessness• Lack of access to psychiatrists• Lack of physical activity – decreased physical education in youth, decreased mobility in seniors	<ul style="list-style-type: none">• Lack of resources for care and housing of seriously mentally ill• Lack of social support and isolation• Lack of substance abuse treatment facilities, especially in North County• Limited access to gyms or safe spaces to participate in physical activity
3. What strategies do you think would be most effective for patients, physicians, case managers etc. in addressing the health needs or modifiable risk factors above?	
<ul style="list-style-type: none">• Care integration and coordination• Community and cultural competency	<ul style="list-style-type: none">• Early identification and prevention• Knowledge/education
4. What resources need to be developed or increased in order to address the health needs or modifiable risk factors above?	
<ul style="list-style-type: none">• See Figure 35 for a list of resources	
5. Are there systems, policy, or environmental changes that, if implemented, could help the hospitals address these health needs or modifiable risk factors?	
<ul style="list-style-type: none">• Increased awareness of available services• Increased data sharing• Increase psychiatrists and nurse practitioners	<ul style="list-style-type: none">• Payment model reforms that include reimbursements for social services (i.e. behavioral health case management, wellness/education, community health workers)
6. Can you recommend any partnerships or collaborations between hospitals and specific organizations that would help to address the health needs or modifiable risk factors above?	
<ul style="list-style-type: none">• City leadership and planning departments• Community-based organizations• External provider support through technology• FQHCs• Information sharing between physicians/case managers and community-based organizations	<ul style="list-style-type: none">• Intergenerational partnerships• Internship/workforce training programs with local educational institutions San Diego HHSA• Managed care plans• San Diego County Mental Health Contractors• Warm hand-offs

Figure 37. Resources Needed to Meet Needs Identified in Key Informant Interviews, HASD&IC 2016 CHNA



Surveys

Two different surveys were developed and disseminated through different avenues as part of the 2016 CHNA process – the Health Access and Navigation Survey and the Collaborative San Diego County HHSA Survey.

Health Access and Navigation Survey

Of those who responded to the Health Access and Navigation survey, 85.2% identified themselves as a “community member” (Table 39). The majority of the respondents were Hispanic (68.5%) followed by white (26.9%), Asian/Pacific Islander and black (3.7% and 2.3%, respectively). There was representation from all San Diego County HHSA regions, with the largest proportion of respondents being from South region (46.3%). East region had the smallest representation with 6.1% of the overall respondents reporting living or working in East County.

Survey participants were asked to choose the top five barriers the participants or the population they work with experience. Most striking was the top four barriers cited as most troublesome were all precursors to seeing a health care provider, indicating that community members are often struggling to make it past the first steps of accessing healthcare. The top five barriers for accessing health care were:

- Understanding health insurance
- Getting health insurance
- Using health insurance
- Knowing where to go for care
- Follow-up care and/or appointment

As the number of individuals who have health insurance in the nation and within San Diego County increases, it is important to address the issue of helping residents understand how to attain and use their health insurance and access care that is appropriate for their health needs. Accessing health care is a first step to improving the overall health of San Diego community residents. Table 40 shows the top five barriers overall in the County and a breakdown of the findings by HHSA region. ‘Understanding health insurance’ was the top cited barrier in all regions with the exception of East region which found ‘follow-up care and/or appointments’ to be the number one barrier. Within each overarching barrier participants were asked to choose the reasons those barriers were a problem in accessing care. More specific reasons residents struggle with these issues were also ascertained (Table 40). For example, within the overarching barrier ‘Understanding health insurance,’ the top two reasons this barrier was cited as a problem were ‘confusing insurance terms’ and ‘how does Covered California apply to me?’.

**Table 39. Demographic Information, Health Access and Navigation Survey,
HASD&IC 2016 CHNA**

Demographics	n	%
Community Member/Resident	195	85.2%
RLA Leader	17	7.4%
SD County Representative	17	7.4%
Total Individuals	229	100.0%
Race/Ethnicity		
Asian/Pacific Islander	8	3.7%
Black	5	2.3%
Hispanic	150	68.5%
White	59	26.9%
Other (Multi Race/Native American)	2	0.9%
Total Individuals*	219	100.0%
Populations Survey Participant has Knowledge of		
Low Income	135	78.0%
Medically Underserved	64	37.0%
Populations with Chronic Conditions	51	29.5%
Minority Population	44	25.4%
Other	22	12.7%
Total Individuals*	173	100.0%
Region Community Resident Lives in or Works in**		
Central	23	10.0%
East	14	6.1%
North Centralw	34	14.7%
North Coastal	34	14.7%
North Inland	34	14.7%
South	107	46.3%
Total Individuals*	231	100.0%
Who have you helped navigate thru the health system? (check all that apply)		
Yourself (18+)	124	57.1%
Child	73	33.6%
Another Adult	95	43.8%
Older Adult (65+ yrs.)	37	17.1%
Total Individuals*	217	100.0%

*Note: Total individuals who answered question. Persons could choose more than one category therefore the individual categories do not add up to the total individuals.

** Created regions based on ZIP code, when no ZIP code was reported used the region the survey participant chose.

Table 40. Health Access and Navigation Survey Results by San Diego County & HHSA Regions, HASD&IC 2016 CHNA

Top Five Health Access & Navigation Categories (barriers cited as most troublesome in accessing health care)	N.Coastal (n=34)		N.Coastal (n=34)		N.Coastal (n=23)		N.Coastal (n=107)		N.Coastal (n=14)		N.Coastal (n=34)		N.Coastal (n=250)	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Understanding health insurance	24	70.6%	22	64.70%	22	95.70%	85	79.40%	10	71.40%	28	82.40%	194	77.60%
Getting health insurance	22	64.7%	19	55.90%	14	60.90%	76	71.00%	7	50.00%	20	58.80%	159	63.60%
Using health insurance	17	50.0%	22	64.70%	15	65.20%	67	62.60%	6	42.90%	20	58.80%	149	59.60%
Knowing where to go for care	19	55.9%	21	61.80%	15	65.20%	62	57.90%	8	57.10%	23	67.60%	149	59.60%
Follow-up care and/or appt.	15	44.1%	16	47.10%	15	65.20%	40	37.40%	11	78.60%	19	55.90%	118	47.20%
Top Five Health Access & Navigation Categories and Responses	N.Coastal		N.Coastal		N.Coastal		N.Coastal		N.Coastal		N.Coastal		N.Coastal	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Understanding health insurance														
Confusing insurance terms	15	68.2%	8	44.4%	14	73.7%	41	51.9%	8	100%	16	61.5%	104	59.4%
How does Covered California apply to me?	10	45.5%	9	50.0%	12	63.2%	40	50.6%	3	37.5%	18	69.2%	92	52.6%
Total	22		18		19		79		8		26		175	
Getting health insurance														
How to pick a plan	13	65.0%	8	50.0%	9	69.2%	43	62.3%	5	71.4%	14	70.0%	92	62.2%
Eligibility requirements & documentation status	14	70.0%	9	56.3%	10	76.9%	29	42.0%	3	42.9%	14	70.0%	79	53.4%
Total	20		16		13		69		7		20		148	
Using health insurance														
Knowing what services are covered	12	75.0%	11	55.0%	12	85.7%	42	67.7%	4	66.7%	15	75.0%	97	69.3%
Understanding health care costs/bills	8	50.0%	8	40.0%	6	42.9%	31	50.0%	4	66.7%	12	60.0%	70	50.0%
Total	16		20		14		62		6		20		140	
Knowing where to go for care														
When to use the ED vs urgent care vs clinic	11	61.1%	12	63.2%	8	61.5%	28	46.7%	8	100%	13	61.9%	80	56.3%
No primary care doctor	8	44.4%	5	26.3%	7	53.8%	27	45.0%	3	37.5%	8	38.1%	59	41.5%
Total	18		19		13		60		8		21		142	
Follow-up care and/or appt.														
Lack of instructions about necessary follow up care	7	50.0%	10	66.7%	5	38.5%	17	44.7%	5	50.0%	6	35.3%	50	45.9%
Lack of understanding about next steps	9	64.3%	3	20.0%	6	46.2%	14	36.8%	4	40.0%	11	64.7%	47	43.1%
Total	14		15		13		38		10		17		109	100%

*Note: The total number of surveys completed was 235; however, since participants could identify multiple regions that they work in, duplications were made for those regional responses.

Collaborative San Diego County Health and Human Services Agency

The results of the survey as it relates to the top health problems and lack of resources are summarized in Table 41. Overall, mental health issues and alcohol and drug abuse were most frequently cited as the most important health problems across all the regions. Additionally, with the exception of East region, mental health issues were found to have the least amount of resources to address the problem across the County. For more information, please visit HHSA's Live Well website at <http://www.livewellsd.org/content/livewell/home/make-an-impact.html>.

Table 41. Collaborative San Diego County Health and Human Services Agency Results, 2016

What do you think are the 5 most important HEALTH PROBLEMS* in your community (those problems that have the greatest impact on overall community health)? (Survey Question)				
Central (15)	East (6)	North Central (14)	North County (44)	South (12)
Mental Health Issues (12)	Alcohol and Drug Abuse (6)	Mental Health Issues (10)	Mental Health Issues (30)	Mental Health Issues (9)
Alcohol and Drug Abuse (9)	Mental Health Issues (5)	Aging concerns& (8) Alcohol/Drug abuse (8)	Alcohol/Drug abuse (30)	Alcohol/Drug Abuse (7)
Diabetes (9)	Obesity (4)	Heart Disease (6)	Aging Concerns& (23)	Obesity (7)
Obesity (7)	Diabetes (3) Cancer (3) Aging Concerns (3)	High Blood Pressure (4) Obesity (4)	Diabetes (20)	Aging Concerns& (7)
Heart Disease (6)			Obesity (18) Cancer (18)	Heart disease (6)
Of the top 5 HEALTH PROBLEMS that you selected above, specify which ONE health problem has the least amount of RESOURCES available to help address the problem. (Survey Question)				
Central (15)	East (6)	North Central (14)	North County (44)	South (12)
Mental Health Issues	Alcohol/Drug Abuse	Mental Health Issues	Mental Health Issues	Mental Health Issues

*Problems were ranked based on total number of respondents identifying the problem as being among the top 5 (shown in parenthesis); health problems with an equal number of responses are listed in the same box.

& e.g., arthritis, falls, Alzheimer's, etc.

Behavioral Health Discussions

When participants were asked to respond to the hospital data presented, there was general agreement in the findings at both the Hospital Partners and the Healthy San Diego Behavioral Health Workgroup meetings (see [Appendix E](#) for the hospital discharge data presented during meetings). There was consensus that the high rates of psychotic discharges in ages 25 to 44 were likely linked to underlying substance abuse problems. Although participants agreed with the findings, it was pointed out that there were additional important conditions that may not come to the surface because of the way hospital data is coded. Because the data is used for billing purposes, physical conditions may often be coded first and potentially underrepresent the prevalence of underlying behavioral health issues. Most notably missing from the data were developmental disorders. The group also pointed out the importance of data trends. In particular, it was pointed out that in recent years participants have been seeing a significant increase in meth-amphetamine discharges (over 100%).

The Alpine Special Treatment Center²², an important provider of care to a particularly vulnerable portion of the San Diego population, referenced a number of additional challenges that should be noted including lack of placements available once patients were ready to leave their facility, overburdened case managers, and difficulty in managing the disability application process. Another frequent challenge cited by the staff at the Alpine Special Treatment Center was the physical health problems of their patients. Discussion participants stated that behavioral health is frequently associated with other chronic conditions and that the majority of their patients fit the diagnosis for all four of the top health needs. Many patients have such serious physical health conditions that they must be sent to facilities that can treat higher acuity patients, though these facilities are generally less appropriate for treatment of their behavioral health conditions. Discussion participants stated that North County in particular lacked available resources to transition their patients. Sufficient step down facilities and improved communication between hospitals, behavioral health facilities, and community based services were some important strategies to success. Understanding the appropriate number and type of facilities needed to rotate this critical population through the health system effectively was said to be key in order to adequately treat patients across the continuum of care.

²² Alpine Special Treatment Center is a locked mental health rehabilitation and transitional care facility. They provide care to voluntary and involuntary adults with acute psychiatric symptoms and those suffering from co-occurring disorders. Their primary goal is to quickly and safely stabilize and transition individuals from acute care to community placement.

2016 CHNA Prioritized Community Health Needs

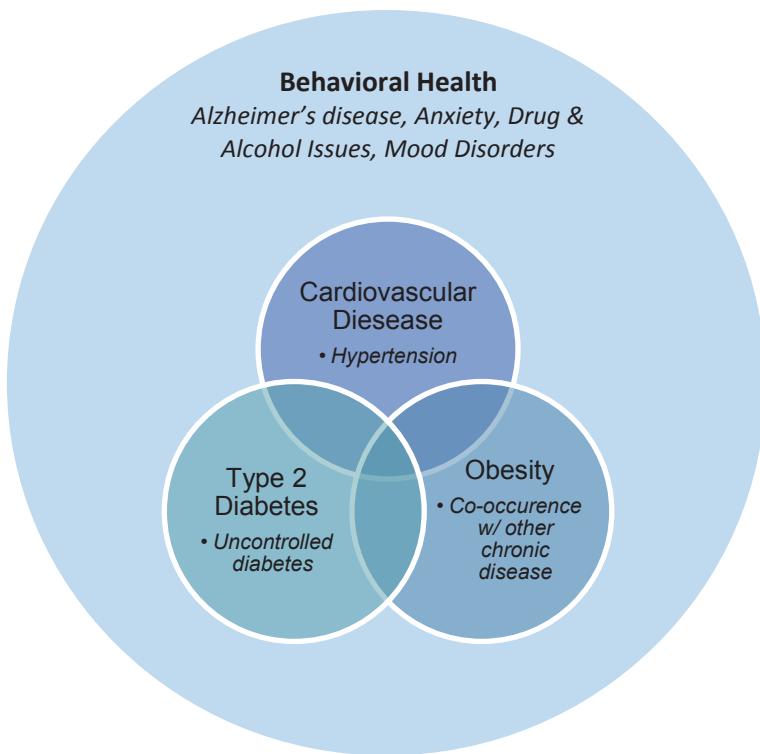
In order to prioritize the four significant health needs in San Diego County, the CHNA Committee applied the following five criteria: magnitude or prevalence, severity, health disparities, trends, and community concern. Using these criteria, a summary matrix translating the 2016 CHNA findings was created for review by the CHNA Committee. Taking into account the results of the quantitative data collection and the findings from the community engagement activities, a rank from 1 to 4, with 1 being the most significant, was applied to each criterion. An overall score was given to each health need by averaging the rankings across all five criteria. In addition, the social determinants of health were analyzed and identified across all health needs. Through examination of the combined results and in review of all data, a clear ranking within the top four health needs emerged (Table 42).

Table 42. Ranking Results from Quantitative Data Collection and Community Input, HASD&IC 2016 CHNA

Data	Behavioral Health Rank	Cardiovascular Disease Rank	Diabetes Rank	Obesity Rank
1. Magnitude or Prevalence:	3.0	1.0	4.0	2.0
2. Severity:	2.0	1.0	3.0	4.0
3. Health Disparities:	1.0	1.0	1.0	1.0
4. Trends:	2.0	4.0	3.0	1.0
5. Community Concern:	1.0	3.3	2.7	3.0
Key Informants	1.0	2.0	3.0	4.0
Discussions	1.0	4.0	2.0	3.0
County HHSA	1.0	4.0	3.0	2.0
Average Ranking Among 5 Criteria	1.8	2.1	2.7	2.2

The CHNA Committee identified behavioral health as the number one health need in San Diego County. In addition, cardiovascular disease, diabetes (type 2), and obesity were identified as having equal importance due to their interrelatedness. Health needs were further broken down into priority areas due to the overwhelming agreement among all data sources and in recognition of the complexities within each health need. Within the category of behavioral health, Alzheimer's disease, anxiety, drug and alcohol issues, and mood disorders are significant health needs within San Diego County. Among the other chronic health needs, hypertension was consistently found to be a significant priority area related to cardiovascular disease, uncontrolled diabetes was an important factor leading to complications related to diabetes, and obesity was often found to co-occur with other conditions and contribute to worsening health status. The impact of the top health needs differed among age groups; with type 2 diabetes, obesity, and anxiety affecting all age groups, drug and alcohol issues affecting teens and adults, and Alzheimer's disease, cardiovascular disease, and hypertension affecting older adults.

Figure 38. 2016 CHNA Top Health Needs



Description of Identified Community Health Needs

A description of the impact of the prioritized health needs on the morbidity and mortality of San Diego County residents is provided below. Mortality data was gathered by the San Diego County HHSA using the California Department of Public Health Death Statistical Master files for the year 2012. Morbidity was assessed using 2013 OSHPD hospital discharge data, the KP Data Platform, and other available community data sources. To better understand the important barriers, modifiable risk factors, and potential strategies to address these health needs, please see the 'Social Determinants of Health' section.

For additional information about the top health needs identified, please see the corresponding Health Profiles ([Appendix C](#)). A complete analysis of disparities among different population groups with respect to the top four health needs can be found in Appendix K (Vulnerable Populations Report). In addition, GIS maps were created, overlaying the rate of primary diagnosis for hospital discharge data with CNI data for the health conditions: type 2 diabetes, cardiovascular disease, and behavioral health. GIS maps were not created for obesity due to the fact that obesity is not a common primary diagnosis but rather a secondary condition that contributes to the primary reason for a hospital visit. Please see [Appendix L](#) for the GIS maps of hospital discharge rates and CNI data.

Behavioral Health

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. Behavioral health encompasses many different areas including mental health, mental illness and substance abuse. Because of its broadness, it is often difficult to capture the need for behavioral health services with a single measure.

An analysis of mortality data in San Diego County found that in 2012, Alzheimer's was the third leading cause of death

and intentional self-harm (suicide) was the eighth. Hospital emergency department encounters and inpatient discharge data for patients with a primary diagnosis of a behavioral health-associated ICD-9 code in 2013 was used to provide an overview of main reasons individuals sought care related to behavioral health by age group. A complete analysis of the behavioral health OSHPD data is available in [Appendix E](#). A summary of the trends found were as follows:

- OSHPD ED discharge data: Anxiety disorders were the top primary diagnosis for ED discharge among those age 5 through 44 and those 65 and older. For those aged 45-64, the top ED discharge for behavioral health was alcohol-related disorders followed by anxiety and mood disorders. Alcohol related disorders was the number two primary diagnosis for discharge for those aged 15 through 44 and those 65 years and older.
- OSHPD inpatient discharge data revealed that when examining the ICD-9 codes related to behavioral health, 'mood disorders' was the top primary diagnosis for inpatient discharge for ages 5 through 24 and 45 and over. For those aged 25 through 44, the top behavioral health primary diagnosis was 'schizophrenia and other psychotic disorders' followed by 'mood disorders.'
- Feedback from the behavioral health discussions found that high rates of psychotic discharges in ages 25 to 44 were likely linked to underlying substance abuse problems. Although participants agreed with the findings, it was found that hospital coding may potentially underrepresent the prevalence of underlying issues and miss certain conditions. Most notably missing from the OSHPD data was developmental disorders. The groups also pointed out the importance of emerging data trends. In recent years, discussion participants cited a significant increase in drug-related discharges, particularly methamphetamine (~over 100%).

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".*

*See the Health Need Profile in Appendix C for more details

Anxiety: Anxiety is a normal reaction to stress but can become excessive, difficult to control, and ultimately interfere with normal day-to-day living.²³ There are a wide variety of anxiety disorders including post-traumatic stress disorder, generalized anxiety disorder, panic disorder, and social anxiety disorder. National prevalence data estimates that 18% of the population has an anxiety disorder, with phobias and generalized anxiety being the most common. In San Diego County, there has been a steady increase in the rate of ED discharges with a primary diagnosis of anxiety. In particular, there has been a 64.2% increase in children up to age 14 from 25.0 per 100,000 in 2010 to 41.0 per 100,000 in 2013.

Substance Abuse: The Substance Abuse and Mental Health Services Administration (SAMHSA) defines substance use disorders as the recurrent use of alcohol and/or drugs which causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.²⁴ The percentage of adults age 18 and older in San Diego County who self-report heavy alcohol consumption (defined as more than two drinks per day on average for men and one drink per day on average for women) is 17.2%; additionally, 12.1% reported currently smoking cigarettes some days or every day according to the BRFSS. Acute substance abuse hospitalization rates increased 37.4% from 2010 to 2013 and increased most among 15-24 year olds (58.0%). Acute alcohol hospitalization rates grew most among 25-44 year olds with a 45.9% increase between 2010 and 2013. Finally, chronic alcohol ED visits among seniors age 65 and older increased 89.7% during the same time period.

Alzheimer's disease: Alzheimer's is the most common form of dementia although all dementias are characterized by a decline in memory, thinking skills, and ability to perform everyday activities.²⁵ According to the 2015 San Diego County Senior Health Report²⁶, roughly 60,000 individuals in San Diego are living with Alzheimer's disease or other dementia (ADOD) in 2012. It is projected that the number of San Diego adults age 55 and older with ADOD will increase by 55.9% between 2012 and 2030. The largest majority of individuals live in East region though the largest percentage increase is projected in North Central. ADOD also affects caregivers physically and emotionally so significant increases in the number of people living with ADOD will have an impact that extends beyond those affected.

Mood Disorders: Mood disorders are particularly prevalent in the community and increasing. Data from the Centers for Medicare and Medicaid show that among the fee-for-service population, 14.5% suffer from depression compared to 13.4% in California in 2012.

23 Substance Abuse and Mental Health Services Administration. Substance Use Disorders. Retrieved from <http://www.samhsa.gov/disorders/substance-use>

24 Substance Abuse and Mental Health Services Administration. Substance Use Disorders. Retrieved from <http://www.samhsa.gov/disorders/substance-use>

25 Alzheimer's Association. What is Alzheimer's? Retrieved from http://www.alz.org/alzheimers_disease_what_is_alzheimers.asp

26 County of San Diego, Health and Human Services Agency, Public Health Services, Community Health Statistics Unit. (2015). San Diego County Senior Health Report. Retrieved from www.SDHealthStatistics.com.

In addition, an analysis of OSHPD data shows that the rate of ED discharges per 100,000 individuals with a primary diagnosis of mood disorders increased by 38.7% from 2010 to 2013 for children up to age 14; hospitalizations also went up by 26.8% in this age group. Mood disorders are often associated with comorbidities including diabetes, obesity and asthma. Suicide is also an indicator of poor mental health and is one of the major complications of depression. In San Diego County, the suicide rate according to the California Department of Public Health is 11.3 per 100,000 population which is above the state suicide rate of 9.8 per 100,000 (Table 44) and above the HP2020 benchmark of 10.2 per 100,000 population. It is also the eighth leading cause of death in San Diego County. When adjusting for race/ethnicity, Non-Hispanic whites are more likely to commit suicide followed by Native Hawaiian/Pacific Islander. Comparing suicide rates by race, non-Hispanic, black, Asian, Native Hawaiian/Pacific Islander, and those of multiple races were all above state levels. Please see Table 43 for additional trend data.

Table 43. Mental Health San Diego County Trends Over Time, 2009-2013

California Health Interview Survey Trends	2009	2011-2012	2012-2013
Serious psychological distress in the past year (Adults 18-64 years old) % based on 6 questions, known as the "Kessler 6", to assess symptoms of distress during a 30-day period in the past year. Often used as a proxy measure for severe mental illness.	5.3%	7.7%	7.6%

*Source: California Health Interview Survey, 2009, 2011-2012, and 2012-2013

Table 44. Suicide Mortality and Poor Mental Health Indicators

	San Diego County	California	United States
Poor Mental Health^a	12.75%	14.3%	NA
Suicide Mortality, Age-Adjusted Rate (per 100,000)^b	11.29	9.8	NA
HP 2020 Target for Suicide^c	<=10.2	<=10.2	<=10.2

^aSource: University of California Center for Health Policy Research, California Health Interview Survey. 2011-2012.

^bSource: California Department of Public Health, CDPH – Death Public Use Data. University of Missouri, Center for Applied Research and Environmental Systems. 2010-2012.

^cSource: Healthy People 2020 . <https://www.healthypeople.gov>

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 behavioral health are summarized in Table 45.

**Table 45. 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?	
<ul style="list-style-type: none">• Anxiety• Behavioral health affects all other diseases• Depression• Dementia and Alzheimer's in seniors• Homelessness• Increase in developmental disorders in children• Lack of psychiatrists	<ul style="list-style-type: none">• 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

Finally, mental 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 disease was cited among the top five most important health needs in all regions in San Diego except Central. 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)

Cardiovascular Disease

'Diseases of the heart' were the second leading cause of death in San Diego County in 2012. In addition, 'Cerebrovascular Diseases' were the fifth leading cause of death, and 'Essential (primary) hypertension and hypertensive renal disease' was the tenth.

Hospital emergency department encounters, inpatient discharges, and clinic utilization data for patients with a primary diagnosis of a cardiovascular disease-related ICD-9 code in 2013 was analyzed in order to provide an overview of the main reasons individuals sought care related to cardiovascular disease by age group. A summary of the trends found were as follows:

- 'Essential hypertension' was the top primary diagnosis from the ED for ages 25 and up related to cardiovascular disease.
- 'Congestive heart failure; non-hypertension' was the top primary diagnosis for inpatients ages 25 and older. Sixty-seven percent of inpatients discharged for a cardiovascular primary diagnosis had Medicare insurance.

The 2011-2012 CHIS estimates that 135,000 adults, or 5.8% of the adult population, in San Diego County have ever been told by a doctor that they have coronary heart disease or angina. Data gathered from North County Health Services, a local FQHC, found that 'Hypertension Unspecified Essential' ranked 6th out of the top 8 primary diagnosis in 2014 among seniors and adults who visited their clinic.

Table 46 provides a summary of the quantitative data relevant to cardiovascular disease. While the mortality rates due to ischemic heart disease and stroke were lower for San Diego County than in California, the rate of death is still above the HP2020 benchmark (Table 46). Additionally, mortality rates for ischemic heart disease and stroke were particularly high for African Americans and Native Hawaiian/Pacific Islanders. Unmanaged high blood pressure is also a problem in San Diego. According to the 2006-2010 BRFSS, roughly a third of adults reported that they are not taking medication for their high blood pressure. Please see Table 47 for additional hypertension trend data.

The World Health Organization defines cardiovascular disease (CVD) as a group of disorders of the heart and blood vessels that include coronary heart disease, cerebrovascular disease, peripheral arterial disease, rheumatic heart disease, congenital heart disease, deep vein thrombosis and pulmonary embolism.*

Coronary Heart Disease is the most common form of heart disease and the leading cause of death in the U.S. High blood pressure, high cholesterol, and smoking are all risk factors that could lead to CVD and stroke.*

*See the Health Need Profile in Appendix C for more details

Table 46. Cardiovascular Disease Indicators

	San Diego County	California	United States
Percentage with Heart Disease^a	5.80%	6.30%	NA
Stroke Age-Adjusted Death Rate (per 100,000)^b	32.8	37.38	NA
Ischemic Heart Disease Age-Adjusted Death Rate (per 100,000)^b	148.27	163.18	NA
HP 2020 Target for Ischemic Heart Disease Death Rate^c	<=100.8	<=100.8	<=100.8

^aSource: University of California Center for Health Policy Research, California Health Interview Survey. 2011-2012.

^bSource: California Department of Public Health, CDPH – Death Public Use Data. University of Missouri, Center for Applied Research and Environmental Systems. 2010-2012.

^cSource: Healthy People 2020 . <https://www.healthypeople.gov>

Table 47. Hypertension San Diego County Trends Over Time, 2009-2013

California Health Interview Survey Trends	2009	2011-2012	2012-2013
Ever diagnosed with hypertension (Adults 18-64 years old) % Diagnosed	26.3%	25.8%	26.4%

*Source: California Health Interview Survey, 2009, 2011-2012, and 2012-2013

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 cardiovascular disease are summarized in Table 48.

Table 48. Summary of Community Input on Common Cardiovascular Disease Issues, HASD&IC 2016 CHNA

Summary of Cardiovascular Disease-Related Responses*	
1. What are the most common health issues or needs?	
<ul style="list-style-type: none">• Adolescent hypertension & cardioconverters• Hypertension• High cholesterol	<ul style="list-style-type: none">• Hypertension and poor cardiovascular disease outcomes among Latinos, African Americans and Asians• Mobility issues and barriers to healthy food for seniors• Salt intake/Diet• Stroke

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

Finally, an assessment of health needs by HHSA region found that heart disease was cited as being among the top five most important health problems in Central, North Central, and South. Additionally, high blood pressure was selected as a problem that has a substantial impact on overall community health in North Central region.

Hypertension was found to be a major contributor to poor cardiovascular disease-related outcomes and a significant area of need in San Diego County.

Diabetes (Type 2)

Diabetes is an important health need because of its prevalence, its impact on morbidity and mortality, and its preventability. An analysis of mortality data for San Diego County found that in 2012 'Diabetes mellitus' was the seventh leading cause of death. The percentage of adults aged 20 and older who have ever been diagnosed with diabetes was 7.2% in 2012 in San Diego County and has been steadily rising since 2005 according to the National Center for Chronic Disease Prevention and Health Promotion (Table 49). Type 2 diabetes is an important target for intervention because hospitalizations due to diabetes-related complications are potentially preventable with proper management and a healthy lifestyle. In San Diego, approximately 1.5% of discharges in the black patient population were attributable to diabetes compared to 0.7% of discharges among whites.

Type 2 diabetes, once known as adult-onset or noninsulin-dependent diabetes, is a chronic condition that affects the way the body metabolizes sugar (glucose), which is the body's main source of fuel. With type 2 diabetes, the body either resists the effects of insulin — a hormone that regulates the movement of sugar into the cells — or doesn't produce enough insulin to maintain a normal glucose level. If left untreated, type 2 diabetes can be life-threatening.*

*See the Health Need Profile in Appendix C for more details

Hospital emergency department encounters, inpatient discharges, and clinic utilization data for patients with a primary diagnosis of a diabetes-related ICD-9 code in 2013 was used to provide an overview of the main reasons individuals sought care related to diabetes by age group. A summary of the trends found were as follows:

- 'Diabetes ... Uncontrolled' was the top inpatient primary diagnosis related to diabetes (type 2) for those age 15-24 and 45 and older. For individuals age 25-44, the top inpatient primary diagnosis was 'Abnormal Glucose Tolerance of Mother with Delivery' followed by 'Diabetes...Uncontrolled.'

Data gathered from North County Health Services, a local FQHC, found that 'Diabetes mellitus' and 'Abnormal glucose of mother antepartum' ranked 4th and 5th respectively out of the top 8 primary diagnosis in 2014 among seniors and adults who visited their clinic. Please see Table 50 for additional trend data.

Table 49. Diabetes Indicators

	San Diego County	California	United States
Population with Diagnosed Diabetes Age-Adjusted Rate^a	7.20%	8.05%	9.11%
Diabetes Age-Adjusted Discharge Rate (per 10,000)^b	8.96	10.4	NA

^aSource: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012.

^bSource: California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2011.

Table 50. Diabetes San Diego County Trends Over Time, 2009-2013

California Health Interview Survey Trends	2009	2011-2012	2012-2013
Ever diagnosed with diabetes (Adults 18-64 years old) % Diagnosed. Excludes ever been diagnosed with gestational diabetes.	7.8%	7.9%	8.0%

*Source: California Health Interview Survey, 2009, 2011-2012, and 2012-2013

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 diabetes (Type 2) disease are summarized in Table 51.

Table 51. 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?	<ul style="list-style-type: none"> • Assumption that diabetes only affects older individuals • Chronic kidney disease related to diabetes • Diabetes related to low income and food insecure population <ul style="list-style-type: none"> • Diet and sugar • Lack of supplies • Treatment compliance issues

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

Finally, an assessment of health needs by HHSA region 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.

Obesity

Obesity is an important health need due to its high prevalence in the U.S. and San Diego and although it is not a leading cause of death, it is a significant contributor to the development of other chronic conditions.

Adults: 36.3% of adults aged 18 and older self-reported that they have a BMI between 25.0 and 30.0 (overweight) in San Diego County according to 2011-2012 BRFSS data (Table 51). An additional 20.1% of adults aged 20 and older self-reported that they have a BMI greater than 30.0 (obese) in San Diego County. The percentage of residents who are obese was higher slightly among men (21.3%) than women (18.8%). Excess weight may indicate an unhealthy lifestyle and puts individuals at risk for further health issues including 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 (overweight) for body composition on the FITNESSGRAM physical fitness test was 17.7% in San Diego County for the years 2013-2014. Furthermore, approximately 15.9% of children in grades 5, 7, and 9 were ranked within the "high risk" category (obese). Rates of overweight and obese youth were highest among Hispanic/Latino and African American youth.

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 the 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 were nonspecific chest pain in ages 25-64, abdominal pain for those age 15-24, and for those over 65 years their primary diagnosis was osteoarthritis, septicemia followed by congestive heart failure.

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). *

For adults:

- BMI between 25 and 29.9 is considered overweight.
- BMI of 30 or higher is considered obese.

For children and adolescents (ages 2-19):

- BMI at or above the 85th percentile and lower than the 95th percentile for children of the same age and sex is considered overweight
- BMI at or above the 95th percentile for children of the same age and sex is considered obese.

*See the Health Need Profile in Appendix C for more details

Local data from Palomar Health's TODAY program demonstrated a decrease in the percentage of children screened who were obese from in 2014 compared to 2008. While the program screens different youth each year, this decrease may represent a decreasing trend in childhood obesity, particularly in North County. Please see Table 53 for additional adult obesity trend data.

Table 52. Adult and Youth Overweight and Obese Indicators

	San Diego County	California	United States
Percent Adults Overweight^a	36.28%	35.85%	35.78%
Percent Adults with BMI > 30.0 (Obese)^b	20.10%	22.32%	27.14%
Percent Youth Overweight^{c**}	17.74%	19.30%	NA
Percent Youth Obese^{c**}	15.89%	18.99%	NA

^aSource: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2011-2012.

^bSource: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012.

^cData Source: California Department of Education, FITNESSGRAM®; Physical Fitness Testing. 2013-2014.

** The thresholds for youth overweight and obese are based on the CDC's BMI-for-age growth charts, which define an individual as overweight when his or her weight is between the "85th to less than the 95th percentile".

Table 53. Obesity San Diego County Trends Over Time, 2009-2013

California Health Interview Survey Trends	2009	2011-2012	2012-2013
Obese (Adults 18-64 years old) Defined as body mass index (weight [kg]/height [m ²]) greater than or equal to 30.0	21.9%	22.1%	23.1%

*Source: California Health Interview Survey, 2009, 2011-2012, and 2012-2013

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 54.

Table 54. 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?	
<ul style="list-style-type: none"> • High obesity prevalence • Issue for acculturating refugees, Native Americans, older veterans and low-income individuals • Lack of physical activity • Nutrition and diet 	<ul style="list-style-type: none"> • 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

Finally, 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 the 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.

Social Determinants of Health

Analysis of results from the community partner discussions and key Informant interviews revealed the most commonly associated social determinants of health for each of the top health needs above. Ten social determinants were consistently referenced across the different community engagement activities and were confirmed by quantitative data as important issues. Hospital programs and community collaborations have the potential to impact these social determinants, which are outlined below in order of priority.

Figure 39. Social Determinants of Health HASD&IC 2016 CHNA



Food Insecurity and Access to Healthy Food

Food insecurity and access to healthy food were cited most often as a social determinant of health across all community engagement activities. In addition, high levels of food insecurity and the food environment in San Diego County supports this as an important social determinant of health. An unhealthy diet was among the most commonly cited modifiable risk factors for the top identified health needs. Community discussion participants stated that lack of access to healthy food, including availability and cost, continue to pose a challenge that contributes to diabetes and obesity. Education, cultural practices, and transportation also play an important role in diet and food access. Key informant interview participants stated that inexpensive 'junk food,' food access/food insecurity issues, and food assistance stigma were perpetuating forces that increased the onset of chronic diseases such as diabetes, obesity and cardiovascular disease. According to 2014 CHIS data, 38.1% of adults with an income less than 200% of the federal poverty level in San Diego were food insecure, defined as not being able to afford enough food. Conversely, only 17.7% of adults reported currently receiving Cal Fresh benefits. In addition, San Diego County has more fast food restaurants per 100,000 population in 2012 than both California and the U.S. (81.9 vs 74.5 and 72.0 respectively) according the U.S. Census Bureau County Business Patterns.

Access to Care or Services

Access to care was cited as an important social determinant of health throughout the community engagement activities and is supported by quantitative data which demonstrates shortages of health care services in and around San Diego County. Overarching access to care barriers that were highlighted during community partner discussions included issues with transportation, language barriers, health literacy, insurance coverage, cost, time, and legal status. Transportation and insurance issues were specifically called out separately as important social determinants of health and are described further below. Both discussion and survey participants stated that knowing where to go for care was also a factor that impacted access to care. Key informants highlighted that certain populations are struggling to access services as they need them, and that access to 'good' services, defined as a provider where the patient feels comfortable and understood, were important for increased compliance. Overburdened case managers and lack of access to clinics, primary care providers, and specialists including psychiatrists were also areas of concern. Fragmentation of care and lack of available placements for behavioral health patients are additional problems that were described during key informant interviews. Qualitative data shows that roughly 15.4% of the San Diego County population is living in a geographic area designated as a "Health Professional Shortage Area" (HPSA) by the U.S. Health Resources and Services Administration. This is defined as having a shortage of primary medical care, dental or mental health professionals.

Homeless/Housing Issues

Housing and homelessness is an important social determinant of health in San Diego County with both quantitative and community input pointing to a continued problem. According to 2015 Point-in-Time counts, the homeless population in San Diego County is the fourth highest in the U.S at 8,742 individuals. Key informants highlighted that homelessness and housing issues are barriers to the successful treatment of health needs, and that this is particularly true of behavioral health. Key Informants pointed out that individuals often do not have the resources to get off the street and treat mental illness. Of the unsheltered homeless in San Diego, the 2015 WeALLCount report estimates that 17% have problems with substance/alcohol abuse and 19% self-reported having severe mental illness, defined as a mental illness that is severe, long term, and inhibits their ability to live independently. The homeless population also has unique challenges that may prevent them from accessing care; discussion participants found that individuals who are involved with programs often struggle to get proof of their appointment and stated that long wait times that can negatively impact their status in the program. Finally, discussion participants emphasized the importance of meeting basic needs first including housing, a safe environment, sleep and food.

Physical Activity

Lack of physical activity in children and adults was revealed as a major social determinant of health during the community engagement activities. The prevalence of physical inactivity was confirmed by quantitative data, supporting a need to increase adult and youth physical activity. Community input elaborated on the specific challenges faced in the San Diego area related to physical activity. Based on key informant interviews, lack of exercise was attributed to decreased mobility in seniors, decreased physical education for youth, and limited access to gyms, resources, and safe spaces to participate in physical activity. Discussions with community partners highlighted that physical education avoidance among youth also contributes to physical inactivity. According to the CDC's National Center for Chronic Disease Prevention and Health Promotion, 14.9% of adults in San Diego County age 20 and older self-reported that they perform no leisure time physical activity in 2012. For youth, results of the FITNESSGRAM physical fitness test show that 29.4% of children in grades 5, 7, and 9 ranked within the "High Risk" or "Needs Improvement" zones for aerobic capacity for the 2013-2014 year.

Education/Knowledge

Education in some capacity was mentioned during all community engagement activities and is supported by quantitative data which shows disparities in educational attainment across the San Diego regions. Community input provided insight into important areas related to education that drive poor health outcomes and could be targeted in future health programs. Based on information gathered from key informant interviews and community partner discussions, educational efforts focused on

behavioral health and stigma reduction, food insecurity awareness (for both providers and residents), and patient, caregiver, and family empowerment would have a positive impact on health. In addition, modified messaging based on culture and literacy level is important. Within the County of San Diego, almost 15% of the total population aged 25 and older have no high school diploma (or equivalency) or higher based on 2013 ACS data. An assessment of educational attainment by region of San Diego found that the percentage of adults who had less than a high school diploma were highest in South (22.4%) and Central (21.1%) and lowest in North Central (5.7%).

Cultural Competency

Cultural competency was reiterated as a social determinant of health across all community engagement activities. In addition, quantitative data highlights the changing demographics of the population in San Diego County and the need for a culturally competent workforce. Cultural competence in health care can be described as “the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients’ social, cultural, and linguistic needs.²⁷” In order to understand the cultural needs of the community, it is important to consider the changing demographics of the population, potential language barriers, and how different cultural practices and lack of cultural competency in health care drives disparities in health outcomes.

Among community partners, low motivation and health literacy were cited as behavioral factors that contribute to poorer health outcomes. Key informant interviews also illuminated strategies for improvement that would help eliminate disparities. These strategies included: understanding the environment patients are coming from and their ability to comply with treatment plans, increasing provider comfort and knowledge working with different populations and their needs, providing culturally and linguistically appropriate services, including accessible interpreter services, developing trusting relationships between providers and patients, and diversifying of staff and social workers in the community.

Quantitative data shows a dramatic change in demographics in the San Diego population. According to the U.S. Census Bureau Decennial Census, between 2000 and 2010, San Diego County has experienced a 32.0% increase in the Hispanic population and a change in composition by race where the greatest percentage increases were among Asians (34.5%), followed by individuals of multiple races (20.1%). Changes in racial and ethnic composition also points to potential language barriers. From this information, it can be determined that there is a significant need for a diversified healthcare workforce.

²⁷ Betancourt, J. R., Green, A. R., & Carrillo, J. E. 2002. Cultural competence in health care: Emerging frameworks and practical approaches. New York: The Commonwealth Fund.

Transportation

Transportation was cited as a social determinant of health across different community engagement activities. More specifically, transportation was mentioned as a problem that made it difficult to obtain services and that too few practitioners and distance to services heightened the problem. Transportation issues also impacted access to healthy foods. Discussion participants highlighted the need for better Medi-Cal education on which plans have available services to better meet their transportation needs. According to 2010-2014 ACS estimates, roughly 6.1%, or 66,596, of households in San Diego have no motor vehicle. Households without access to a vehicle may lack access to health care or other services that may improve health.

Insurance Issues

The percentage of the population without insurance is a powerful predictor of health that was cited as a continued problem within San Diego County during the community input activities. Insurance issues were found to be the cause of three out of five of the top barriers to accessing care according to the 2016 CHNA Access and Navigation survey. Residents reported challenges understanding insurance, getting insurance, and using health insurance which impeded their ability to access care. Within these categories, survey participants stated that confusing insurance terms, knowing how to pick a plan, and knowing what services are covered were the top problems they faced. These sentiments were echoed in across the key informant Interviews and community partner discussions. Key Informants stated that many individuals don't understand their benefits, including what's available or how to access it. Others stated that lack of insurance and affordability remain problems in certain groups in San Diego and that it resulted in the delay of medication. Discussion participants cited that a lack of understanding of covered benefits and fear of hidden costs plays a key role in the decision to seek care. In addition, current coverage may not be sufficient to meet specific needs, including behavioral health treatment.

According to the ACS, the uninsured rate in San Diego decreased from 16.3% in 2013 to 12.3% in 2014 following the implementation of the Affordable Care Act. While it is important to recognize the proportion of uninsured individuals that remain, as more people become insured, it will become increasingly more important to address challenges individuals face with their insurance.

Stigma

The CDC defines stigma as "the prejudice, avoidance, rejection and discrimination directed at people believed to have an illness, disorder or other trait perceived to be undesirable." The CDC describes that negative consequences of stigma as the "needless suffering, potentially causing a person to deny symptoms, delay treatment and refrain from daily activities. Stigma can exclude people from access to housing,

employment, insurance, and appropriate medical care".²⁸ Stigma was mentioned in two contexts during the community engagement activities- behavioral health stigma and food assistance stigma. Strong stigma associated with behavior health was a frequently mention barrier that hindered individuals from seeking help. Discussion participants stated that fear of that disclosure will result in repercussions such as job loss also creates a barrier to accessing needed care for behavioral health issues. Reducing stigma related to mental health, building relationships with patients, and teaching families about the signs and symptoms of mental health issues were important concepts expressed during community partner discussions. Community residents may also experience stigma that prevents them from accessing needed food assistance. Discussion participants found that some individuals may not give the correct answer when asked if they need food. Working on different ways to ask or refer individuals to food assistance programs that avoids confusion or embarrassment was suggested by participants as a way to decrease the stigma barrier. According to a study conducted by Sarkin et al., who examined 2009 data on individuals who had used mental health services San Diego County, 89.7% reported experiencing some type of discrimination with relation to their mental health problems.²⁹

Poverty

Poverty is one of the most powerful predictors of population health. Community input activities cited poverty as a continued problem within San Diego County as well as data from the ACS showing disparities by race and ethnicity. Key informants highlighted the link between diabetes, obesity and cardiovascular disease as it related to low-income individuals and families. Behavioral health issues were also mentioned as a barrier to employment and financial stability. In addition, key informants emphasized that prevention is hard for those living in poverty. During community partner discussions, participants described the impact of poverty on their clients' ability to manage their chronic conditions. Lifestyle change and treatment for chronic conditions can be unaffordable for individuals and families living in poverty. For example, for many low income families healthy food options are not readily available or are unaffordable. In addition, low income families often struggle to purchase medications even when utilizing insurance. Data from the ACS found that within San Diego County between 2009 and 2013, 14.5% or 441,648 individuals were living in households with income below 100% of the Federal Poverty Level (FPL). An analysis of poverty by race and ethnicity showed that a greater proportion of Latinos, African Americans, Native Americans, and individuals of some other race were in poverty compared to the overall San Diego population. For children 0-17, the percentage living 100% below the FPL (which for a family of three is \$20,090 per year) increases to 18.8%. Poverty creates barriers to accessing services that promote well-being including health services, healthy food, and other necessities that contribute to improved health status.

28 Centers for Disease Control and Prevention, Mental Health. Stigma and Mental Illness. <http://www.cdc.gov/mentalhealth/basics/stigma-illness.htm>. Accessed May 2016.

29 Sarkin, A. , Lale, R. , Sklar, M. , Center, K. , Gilmer, T. , et al. (2015). Stigma experienced by people using mental health services in San Diego County. *Social Psychiatry and Psychiatric Epidemiology*, 50(5), 747-756. DOI 10.1007/s00127-014-0979-9

Community Assets

Assets, capacities and resources within a community are integral to addressing the full spectrum of health needs that exist in the population. In recognition of the various levels of intervention and health improvement, the community assets (i.e., programs, initiatives and organizations) that are currently available to address the top health needs are separated based on the following categories:

- Programmatic and/or organizational resources
- Health initiatives and public policy

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. Considering that available programs and services continuously change, the community is encouraged to access the most available data through 2-1-1 San Diego. In order to provide an overview of the type and number of resources currently available to address the top health needs, a list of local assets were compiled using on 2-1-1's Directory of Services ([Appendix F](#)).

Data was pulled by searching the 2-1-1 taxonomy using relevant search terms for each condition. The number of resources that were located for each condition were as follows:

- Behavioral Health (190),
- Diabetes (118),
- Obesity (382), and
- Cardiovascular Disease (161).

Please note, this is an assessment of the type and number of services available as of February 2016 but it is not an exhaustive list of resources available in San Diego County. Due to the interconnectedness of chronic conditions, organizations and programs may be repeated if they provide more than one service and if they are located in more than one location. For more specific information about the programs within each category, please contact 2-1-1 or visit their website (<http://www.211sandiego.org/>).

In addition to the resources available at 2-1-1 San Diego there are community and county wide initiatives, partnerships, collaborations, and public policy that address the top health needs (Table 55). Please note this is a survey of local assets and is not an exhaustive list of the initiatives, partnerships, collaborations, or public policy available in San Diego County.

Table 55. San Diego County Initiatives, Partnerships, Collaborations and Public Policy that Address Behavioral Health, Cardiovascular, Diabetes, and Obesity, HASD&IC 2016 CHNA

Health Initiatives		Website
1	Be There San Diego, Preventing Heart Attacks and Strokes	http://betheresandiego.org
2	California's Health Care Coverage Initiative	http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20C/PDF%20CountyIndigentCareInitiative.pdf
3	CHIP Suicide Prevention Council	http://www.sdchip.org/initiatives/suicide-prevention-council.aspx
4	Chula Vista Community Collaborative	http://chulavistacc.org
5	Farm to School Taskforce	https://healthykidshealthyfuture.org/links/san-diego-county-school-taskforce/
6	HASD&IC Behavioral Health Continuum of Care	http://hasdic.org/
7	Healthy Chula Vista Initiative	http://www.chulavistaca.gov
8	Healthy Weight Collaborative	http://www.ncbi.nlm.nih.gov
9	It's Up to Us Campaign	http://www.up2sd.org/
10	Live Well Food System Initiative	http://www.livewellsd.org/
11	Live Well San Diego	http://www.livewellsd.org/
12	National Diabetes Prevention Program (National DPP)	http://www.cdc.gov/diabetes/prevention/index.html
13	Regional Continuum of Care Collaborative	http://www.sandiegococ.org/
14	Re-Think Your Drink	https://www.cdph.ca.gov/programs/cpns/Pages/RethinkYourDrink-Resources.aspx
15	Safe Routes to School	http://www.sandag.org/index.asp?projectid=404&fuseaction=projects.detail
16	San Diego County Childhood Obesity Initiative (COI)	http://ourcommunityourkids.org
17	San Diego County Stroke Consortium (HHSA and San Diego County hospitals)	http://search.usa.gov/search?utf8=%E2%9C%93&affiliate=cosd&query=stroke+consortium
18	San Diego Family Military Collaborative	http://sdmilitaryfamily.org/
19	San Diego Food System Alliance	http://www.sdfsa.org/
20	The Alzheimer's Project (HHSA)	http://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/community_health_statistics/Alzheimers.html

Data Limitations and Information Gaps

The KP CHNA data platform includes approximately 150 secondary indicators that provide timely, comprehensive data to identify the broad health needs faced by a community. However, there are some limitations with regard to these data, as is true with any quantitative data. Some data were only available at a county level, making an assessment of health needs at a neighborhood level challenging. Furthermore, disaggregated data around age, ethnicity, race, and gender are not available for all data indicators, which limited the ability to examine disparities of health within the community. Lastly, data are not always collected on a yearly basis, meaning that some data are several years old.

In order to offset these limitations, additional health data was collected and utilized. This data included San Diego County hospital data, county mortality data, health indicators from the CHIS, clinic data, and vulnerable population data. In order to gain an in-depth look into smaller communities, the collaborative partnered with local community organizations to obtain regional and local neighborhood data.

To conduct a comprehensive community health needs assessment, a mixed method approach was required, including the collection and analysis of quantitative data and community input from a variety of sources. The collaborative 2016 CHNA process involved conducting 19 key informant interviews, conducting seven community partner discussions, three behavioral health discussions, and collecting 235 health access and navigation surveys from community residents which provided a large volume of comprehensive community input. One limitation to the 2016 CHNA process was that the population and disease-specific key informant interviews may not have captured all of the challenges faced by the groups represented. Additionally, while there was representation from all regions and ethnicities based on the participants who completed the survey, smaller sample sizes among certain groups may limit its generalizability to subsections of the population.

Similarly, while community partner discussions were chosen to be as representative as possible of high need communities in San Diego, due to time constraints only seven dialogues were completed as part of the assessment. These included high need neighborhoods identified in the CNI data. While these dialogues were only held in seven locations, there was representation from many additional cities due to the recruitment of participants from different San Diego communities. Given the existence of regional differences and population-specific challenges, these seven discussions may not be completely representative of San Diego County or of high-need neighborhoods as a whole.

Community Recommendations

Following the completion and of the community engagement activities, all of the different types of feedback were combined and analyzed. Four key categories emerged: overarching strategies to address the top health needs; resources that must be increased or developed to meet the health needs; system, policy and environmental changes that could support better health outcomes; and possible collaborations to improve access and quality of care for vulnerable populations. A compilation of the overarching recommendations is below.

Figure 40. Summary of Community Recommendations

Strategies to address the top health needs fell into four major categories:

Knowledge/education	Community and cultural competency	Early identification and prevention	Care integration and coordination
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Resources that must be developed or increased to address the top health needs are:

Community and cultural competency	Behavioral health services	Integration health/social services/behavioral health systems	After hours urgent care	Worksite wellness
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System, policies and environmental changes required to support better health outcomes

Data sharing	Increased awareness of available services	Increased number of psychiatrists and nurse practitioners	Reimbursement for social and supportive services & care management
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Collaborations that could improve community health outcomes

Warm hand-offs and information sharing between health providers & community based organizations	Increased internship and workforce training programs with local educational institutions	Partnerships with community collaboratives & Intergenerational Partnerships	External support for providers through the use of technology	Collaboration between provider and community
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Next Steps

Hospitals and healthcare systems that participated in the HASD&IC 2016 CHNA process have varying requirements for next steps. Private, not for profit (tax exempt) hospitals and healthcare systems are required to develop hospital or healthcare system community health needs assessment reports and implementation strategy plans to address selected identified health needs. The participating public hospitals and healthcare systems do not have federal or state 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 healthcare 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 to solicit additional feedback on findings and may serve as a useful resource to both residents and healthcare providers to further communitywide health improvement efforts.

The CHNA Committee is in the process of planning Phase 2 of the 2016 CHNA, which will include gathering community feedback on the 2016 CHNA process and strengthening partnerships around the identified health needs and social determinants.

Appendices



VIII. APPENDICES

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APPENDIX A: QUANTITATIVE DATA SOURCES AND DATES

Quantitative Data Sources and Dates

1. 2-1-1 San Diego. FY 2014-15.
2. California Department of Education. 2012-2013.
3. California Department of Education. 2013.
4. California Department of Education, FITNESSGRAM®; Physical Fitness Testing. 2013-2014.
5. California Department of Public Health, CDPH – Birth Profiles by ZIP Code. 2011.
6. California Department of Public Health, CDPH – Breastfeeding Statistics. 2012.
7. California Department of Public Health, CDPH – Death Public Use Data. University of Missouri, Center for Applied Research and Environmental Systems. 2010-2012.
8. California Department of Public Health, CDPH – Tracking. 2005-2012.
9. California Department of Social Services - Refugee Programs Bureau, 2010-2014.
10. California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2011.
11. California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2013.
12. California Office of Statewide Health Planning and Development, OSHPD Primary Care and Specialty Clinics Utilization Data. 2013.
13. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2006-2010.
14. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2006-2012.
15. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2011-2012.
16. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. U.S. Department of Health & Human Services, Health Indicators Warehouse. 2005-2009.
17. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. U.S. Department of Health & Human Services, Health Indicators Warehouse. 2006-2012.
18. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012.
19. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. U.S. Department of Health & Human Services, Health Indicators Warehouse. 2010.
20. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. U.S. Department of Health & Human Services, Health Indicators Warehouse. 2012.
21. Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network. 2008.
22. Centers for Disease Control and Prevention, National Vital Statistics System. Centers for Disease Control and Prevention, Wide Ranging Online Data for Epidemiologic Research. 2006-2010.
23. Centers for Disease Control and Prevention, National Vital Statistics System. Centers for Disease Control and Prevention, Wide Ranging Online Data for Epidemiologic Research. 2007-2010.
24. Centers for Disease Control and Prevention, National Vital Statistics System. Centers for Disease Control and Prevention, Wide Ranging Online Data for Epidemiologic Research. 2007-2011.
25. Centers for Disease Control and Prevention, National Vital Statistics System. University of Wisconsin Population Health Institute, County Health Rankings. 2008-2010.
26. Centers for Disease Control and Prevention, National Vital Statistics System. U.S. Department of Health & Human Services, Health Indicators Warehouse. 2006-2012.
27. Centers for Medicare and Medicaid Services. 2012.
28. Child and Adolescent Health Measurement Initiative, National Survey of Children's Health. 2011-2012.
29. County of San Diego, Community Action Plan, 2016-2017, Community Needs Assessment. 2014.
30. County of San Diego, Health and Human Services Agency. Live Well San Diego Community Health Assessment. 2014.
31. County of San Diego Refugee Fact Sheet. 2011.
32. Dartmouth College Institute for Health Policy & Clinical Practice. Dartmouth Atlas of Health Care. 2012.

33. Dignity Health Community Need Index. 2013.
34. Environmental Protection Agency, EPA Smart Location Database. 2011.
35. Federal Bureau of Investigation, FBI Uniform Crime Reports. 2010-2012.
36. Feeding America. 2012.
37. Multi-Resolution Land Characteristics Consortium, National Land Cover Database. 2011.
38. National Center for Education Statistics, NCES – Common Core of Data. 2012-2013.
39. National Oceanic and Atmospheric Administration, North America Land Data Assimilation System (NLDAS). 2014.
40. New America Foundation, Federal Education Budget Project. 2011.
41. Nielsen, Nielsen Site Reports. 2014.
42. North County Health Services. 2014.
43. Palomar Health CAC TODAY Program. 2008-2014.
44. San Diego County Community Health Statistics Unit based on 2012 SANDAG population estimates and 2013 ACS estimates.
45. Sarkin, A., Lale, R., Sklar, M., Center, K., Gilmer, T., et al. (2015). Stigma experienced by people using mental health services in San Diego County. *Social Psychiatry and Psychiatric Epidemiology*, 50(5), 747-756. DOI 10.1007/s00127-014-0979-9
46. State Cancer Profiles. National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. 2008-2011.
47. University of California Center for Health Policy Research, California Health Interview Survey. 2009.
48. University of California Center for Health Policy Research, California Health Interview Survey. 2011-2012.
49. University of California Center for Health Policy Research, California Health Interview Survey. 2012.
50. University of Wisconsin Population Health Institute, County Health Rankings. 2012-2013.
51. University of Wisconsin Population Health Institute, County Health Rankings. 2014.
52. U.S. Census Bureau, American Community Survey. 2009-2013.
53. U.S. Census Bureau, American Community Surveys, 2014.
54. U.S. Census Bureau, American Housing Survey. 2011, 2013.
55. U.S. Census Bureau, County Business Patterns. 2011.
56. U.S. Census Bureau, County Business Patterns. 2012.
57. U.S. Census Bureau, County Business Patterns. 2013.
58. U.S. Census Bureau, Decennial Census. 2000-2010.
59. U.S. Census Bureau, Decennial Census, ESRI Map Gallery. 2010.
60. U.S. Census Bureau, Small Area Income & Poverty Estimates. 2010.
61. U.S. Department of Agriculture, Economic Research Service, USDA – Food Access Research Atlas. 2010.
62. U.S. Department of Agriculture, Economic Research Service, USDA – Food Environment Atlas. 2011.
63. U.S. Department of Agriculture, Economic Research Service, USDA – Child Nutrition Program. 2013.
64. U.S. Department of Education, ED Facts. 2011-2012.
65. U.S. Department of Health & Human Services, Administration for Children and Families. 2014.
66. U.S. Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File. June 2014.
67. U.S. Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2012.
68. U.S. Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2013.
69. U.S. Department of Health & Human Services, Health Resources and Services Administration, Health Professional Shortage Areas. March 2015.
70. U.S. Department of Health & Human Services, Healthy People 2020, Social Determinants of Health.
71. U.S. Department of Housing and Urban Development. 2013.

72. U.S. Department of Labor, Bureau of Labor Statistics. June 2015.
73. U.S. Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System. 2011-2013.
74. U.S. Drought Monitor. 2012-2014
75. World Health Organization, Chronic Diseases and Health Promotion.

APPENDIX B: COMMUNITY INPUT TRACKING TABLE

	Data Collection Method	Title/Name	Number of Participants	Target Group(s) Represented	Role in Target Group	Date Input was Gathered
1	Discussion	Case Managers Network	7	<i>Low income, medically underserved, minority population, population with chronic diseases</i>	Members	7/17/15
2	Discussion	San Diego Hunger Coalition CalFresh Task Force	7	<i>Low income, medically underserved, minority population, population with chronic diseases</i>	Members	7/30/15
3	Discussion	San Ysidro Health Center	23	<i>Low income, medically underserved, minority population, population with chronic diseases</i>	Members	8/21/15
4	Discussion	Family Health Centers	4	<i>Low income, medically underserved, minority population, population with chronic diseases</i>	Members	9/8/2015
5	Discussion	International Rescue Committee	7	<i>Low income, medically underserved, minority population, population with chronic diseases</i>	Members	9/15/15
6	Discussion	Family Youth Round Table	9	<i>Youth and children, medically underserved, minority population</i>	Members	10/19/15
7	Discussion	SD County of Education School Nurses Resource Group	30	<i>Low income, medically underserved, minority population, population with chronic diseases, youth and children</i>	Members	10/20/15
8	Behavioral Health Discussion	Hospital Partners Behavioral Health Workgroup	30	<i>Low income, medically underserved, minority population, population with chronic diseases</i>	Representative Health Experts	11/20/15
9	Behavioral Health Discussion	Healthy San Diego Behavioral Health Workgroup	Approx. 20	<i>Low income, medically underserved, minority population, population with chronic diseases</i>	Representative Health Experts	12/10/15
10	Behavioral Health Discussion	Physicians, social workers, case workers	8	<i>Low income, medically underserved, minority population, population with chronic diseases</i>	Representative Health Experts	1/7/16

	Data Collection Method	Title/Name	Number of Participants	Target Group(s) Represented	Role in Target Group	Date Input was Gathered
11	Key Informant Interview	School Nurse, Rosa Parks Elementary School	1	Low income, medically underserved, minority population	Community Leader	7/31/15
12	Key Informant Interview	Director, Aging & Independence Services, County of San Diego, HHSA Aging Program Administrator; County of San Diego, HHSA	2	Health department representative, Low income, medically underserved, population with chronic diseases	Community Leader	8/7/15
13	Key Informant Interview	Program Development Director, San Diego American Indian Health Center Community Engagement Specialist, San Diego American Indian Health Center	2	Medically underserved, minority population	Community Leader	12/15/15
14	Key Informant Interview	Associate Executive Director, San Diego Youth Services	1	Low income, medically underserved, minority population	Community Leader	8/13/15
15	Key Informant Interview	Nutrition Manager, Public Health Services, County of San Diego Health and Human Services Agency	1	Health department representative, Low income, medically underserved, minority population, population with chronic diseases	Community Leader	8/19/15
16	Key Informant Interview	VP, Collective Impact, Community Health Improvement Partners	1	Low income, medically underserved, minority population	Community Leader	8/24/15
17	Key Informant Interview	Executive Director, North County Lifeline	1	Low income, medically underserved, population with chronic diseases	Community Leader	8/24/15
18	Key Informant Interview	CEO & President, Mental Health Systems	1	Low income, medically underserved	Community Leader	8/31/15

	Data Collection Method	Title/Name	Number of Participants	Target Group(s) Represented	Role in Target Group	Date Input was Gathered
19	Key Informant Interview	Executive Director, Interfaith Community Services	1	Low income, medically underserved, population with chronic diseases	Community Leader	9/2/15
20	Key Informant Interview	Vice President & Chief Medical Officer, San Ysidro Health Center	1	Low income, medically underserved, minority population, population with chronic diseases	Community Leader	9/24/15
21	Key Informant Interview	Director of Program & Fund Development, Operation Samahan Health Centers	1	Low income, medically underserved, minority population, population with chronic diseases	Community Leader	10/1/15
22	Key Informant Interview	President and CEO, North County Health Services	1	Low income, medically underserved, minority population	Community Leader	10/26/15
23	Key Informant Interview	Supervising Child and Adolescent Psychiatrist, Behavioral Health Services, County of San Diego Health and Human Services Agency	1	Health department representative, Low income, medically underserved, minority population	Community Leader	11/12/15
24	Key Informant Interview	Deputy Director, Programs, International Rescue Committee	1	Medically underserved, minority population	Community Leader	11/16/15
25	Key Informant Interview	CEO, The San Diego LGBT Community Center	1	Medically underserved, minority population	Community Leader	11/17/15
26	Key Informant Interview	President & CEO, Union of Pan Asian Communities	1	Medically underserved, minority population	Community Leader	1/6/16
27	Key Informant Interview	Executive Director, San Diego Hunger Coalition	1	Low income, medically underserved, population with chronic diseases	Community Leader	1/12/16
28	Key Informant Interview	Presidents and Chairman, MultiCultural Health Foundation	1	Low income, medically underserved, minority population, population with chronic diseases	Community Leader	1/22/16

Data Collection Method	Title/Name	Number of Participants	Target Group(s) Represented	Role in Target Group	Date Input was Gathered	
29	<i>Key Informant Interview</i>	<i>Deputy Health Officer, County of San Diego Health and Human Services Agency</i>	1	<i>Health department representative, Low income, medically underserved, minority population, population with chronic diseases</i>	<i>Community Leader</i>	2/3/16
30	<i>Survey</i>	<i>Health Access and Navigation online and paper surveys</i>	235	<i>Low income, medically underserved, minority population, population with chronic diseases</i>	<i>Members</i>	9/22/15-11/2/15
31	<i>Survey</i>	<i>San Diego Health and Human Services Agency online survey</i>	91	<i>Population with chronic diseases</i>	<i>Representative</i>	11/20/15-12/4/15

APPENDIX C: HEALTH NEED PROFILES

Cardiovascular Disease

The World Health Organization defines cardiovascular disease (CVD) as a group of disorders of the heart and blood vessels that include coronary heart disease, cerebrovascular disease, peripheral arterial disease, rheumatic heart disease, congenital heart disease, deep vein thrombosis and pulmonary embolism.¹ Coronary Heart Disease is the most common form of heart disease.² High blood pressure, high cholesterol, and smoking are all risk factors that could lead to CVD and stroke. About half of Americans (49%) have at least one of these three risk factors.²

Risk Factors for Cardiovascular Disease:²

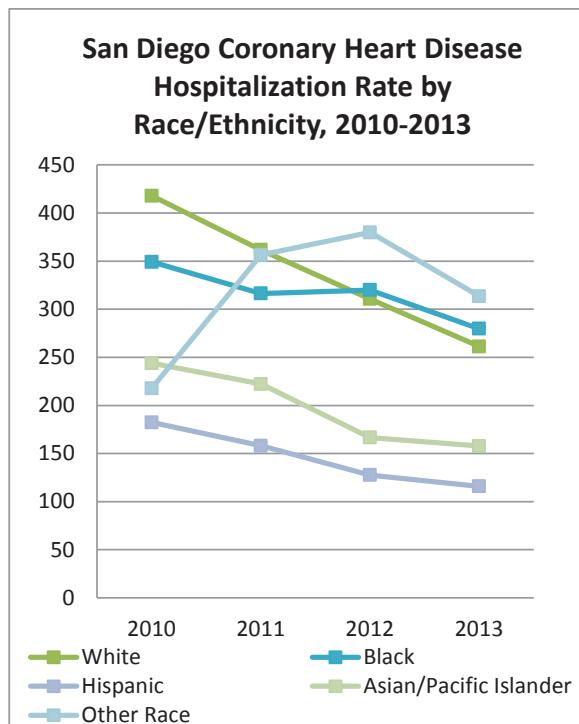
- Behaviors: Tobacco use, obesity, physical inactivity, poor diet that is high in saturated fats, and excessive alcohol use.*
- Conditions: High cholesterol levels, high blood pressure and diabetes.*
- Heredity: Genetic factors likely play a role in heart disease and can increase risk.*

Heart disease is the leading cause of death in the U.S.³

- Heart disease is the leading cause of death for people of most racial/ethnic groups in the United States, including African Americans, Hispanics and whites.*

Prevalence Data:⁴

- In 2012, 11% of U.S. adults aged 18 and over had ever been told by a doctor or other health professional that they had heart disease.*
- In 2012, 24% of U.S. adults 18 and over had been told on two or more visits that they had hypertension.*



County age-adjusted rates per 100,000 2000 U.S. standard population. Coronary Heart Disease hospitalization refers to (principal diagnosis) ICD-9 codes 402, 410-414, 429.2. Source: OSHPD, County of San Diego, Health & Human Services Agency, Public Health Services, Epidemiology & Immunization Services Branch; SANDAG, Current Population Estimates, 10/2013.

DISPARITIES & CVD^{4,8}

Cardiovascular Disease & Race

➤ In 2012, thirty-five percent of non-Hispanic black women had hypertension compared with 22% of non-Hispanic white women and 22% of Hispanic women. Thirty percent of non-Hispanic black men had hypertension compared with 25% of non-Hispanic white men and 19% of Hispanic men.

Cardiovascular Disease & Gender

➤ Men are more likely than women to have ever been told they have coronary heart disease or hypertension.

Cardiovascular Disease & Income

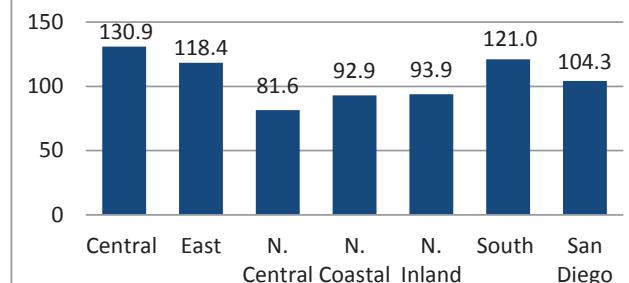
➤ Individuals with low incomes are much more likely to suffer from high blood pressure, heart attack, and stroke.

➤ Among adults aged 65 and over, those covered by Medicare and Medicaid were more likely to have been told they had hypertension than those with either Medicare alone or private insurance.

Cardiovascular Disease & Behavioral Health

➤ Depression occurs in up to 20% of people with heart disease and has also been found to be a risk factor for subsequent heart attack.

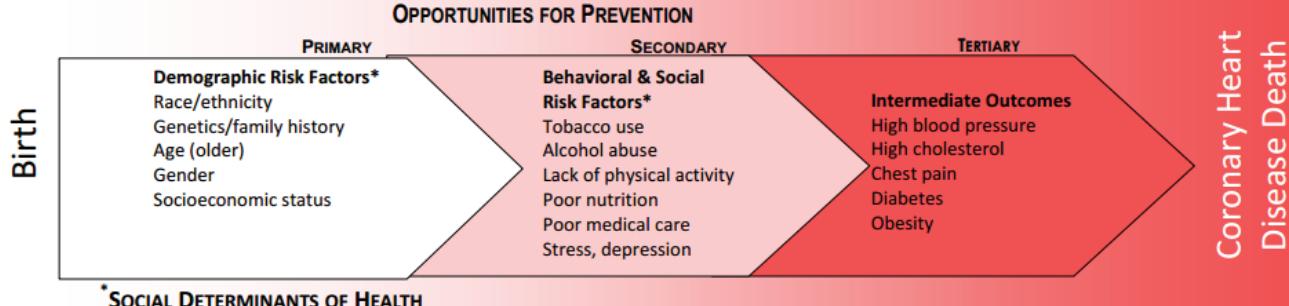
Coronary Heart Disease Mortality Rate in San Diego County, 2013



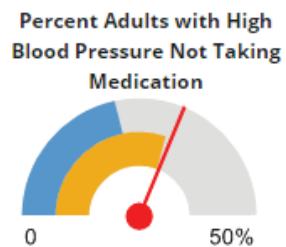
Age Adjusted Death Rate per 100,000 Population.

Source: Death Statistical Master Files (CDPH), County of San Diego, Health & Human Services Agency, Public Health Services, Epidemiology & Immunization Services Branch; SANDAG, Current Population Estimates, 10/2013.

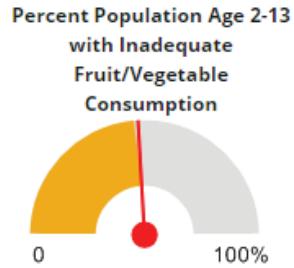
Coronary Heart Disease



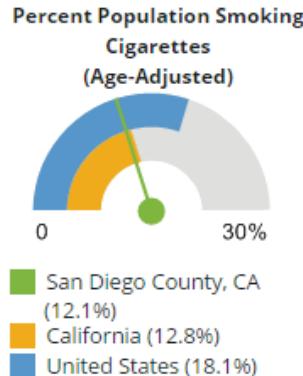
Characteristics of Residents, San Diego County Selected Elements from Cardiovascular Disease Pathway:⁹



Data Source: Centers for Disease Control and Prevention, BRFSS 2006-2010.



Data Source: University of California Center for Health Policy Research, California Health Interview Survey 2011-2012.



Data Source: Centers for Disease Control and Prevention, BRFSS 2006-2012.

Possible Intervention Opportunities

- Clinical Decisions Support Systems: computer-based information systems designed to assist healthcare providers in implementing clinical guidelines at the point of care¹⁰
- Behavioral Counseling for Overweight and Obese Individuals with other CVD Risk Factors: intensive counseling to promote a healthful diet and physical activity for CVD prevention¹¹
- Screening: Lipid disorder screenings are recommended for men 35 and over and women 45 and older; blood pressure screenings are recommended for individuals 18 and over¹¹

For More Information, Visit the American Heart Association's Website: <http://www.heart.org/>

- WHO. Cardiovascular Diseases. <http://www.euro.who.int/en/what-we-do/health-topics/noncommunicable-diseases/cardiovascular-diseases/definition>
- CDC. <http://www.cdc.gov/heartdisease/facts.htm>
- CDC. <http://www.cdc.gov/nchs/data/databriefs/db103.htm>
- Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2012. http://www.cdc.gov/nchs/data/series/sr_10/sr10_260.pdf
- Division for Heart Disease and Stroke Prevention: Data Trends & Maps Web site. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion, Atlanta, GA, 2010. Available at <http://www.cdc.gov/dhdsp/>
- County of San Diego. 3-4-50: Chronic Disease Deaths in San Diego County. http://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/documents/CHS-3-4-50DataReport_2013.pdf
- County of San Diego Health and Human Services Agency, Public Health Services. Community Health Statistics Unit. (2009). Critical Pathways: the Disease Continuum, Coronary Heart Disease. January, 2012. Retrieved from http://www.sdcounty.ca.gov/hhsa/programs/phs/documents/CHS-Critical_Pathways_2012.pdf.
- CDC. Million Hearts Initiative. <http://millionhearts.hhs.gov/abouthds/risk-factors.html#>
- Kaiser Permanente CHNA Data Platform.
- The Community Guide. Cardiovascular Disease Prevention and Control. <http://www.thecommunityguide.org/cvd/index.html>
- U.S. Preventative Services Task Force. <http://www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations>

Diabetes Mellitus (Type 2)

Type 2 diabetes, once known as adult-onset or noninsulin-dependent diabetes, is a chronic condition that affects the way the body metabolizes sugar (glucose), which is the body's main source of fuel. With type 2 diabetes, the body either resists the effects of insulin — a hormone that regulates the movement of sugar into the cells — or doesn't produce enough insulin to maintain a normal glucose level. If left untreated, type 2 diabetes can be life-threatening. Clinical symptoms can include: frequent urination, excessive thirst, extreme hunger, sudden vision changes, unexplained weight loss, extreme fatigue, sores that are slow to heal, and increased number of infections.¹

Some alarming facts about Type 2 Diabetes:^{2,3}

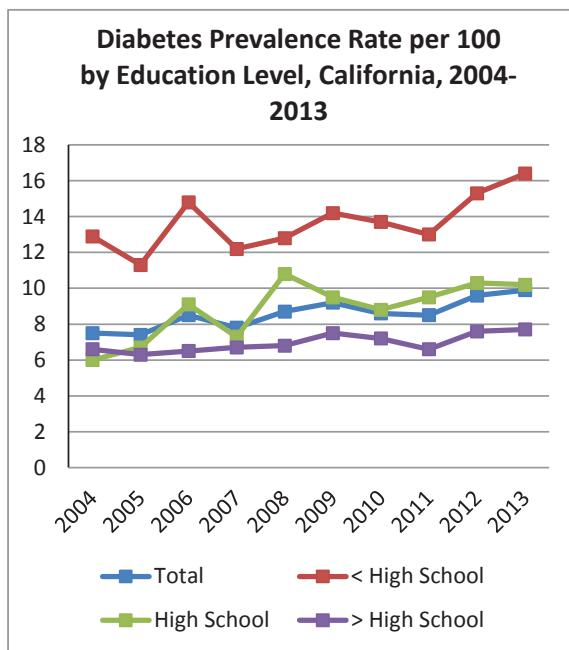
- About 1.7 million people aged 20 years or older were newly diagnosed with diabetes in 2012 in the U.S.
- Diabetes is a major cause of heart disease and stroke, and is the 7th leading cause of death in the United States and California.
- More than 1 out of 3 adults have prediabetes and 15-30% of those with prediabetes will develop type 2 diabetes within 5 years.

Some risk factors for developing Diabetes include:

- Being overweight or obese.
- Smoking
- Having a parent, brother, or sister with diabetes.
- Having high blood pressure measuring 140/90 or higher.
- Being physically inactive—exercising fewer than three times a week.

Diabetes Prevalence:³

- U.S. Age-adjusted prevalence rate for adult diagnosed diabetes for the year of 2012 was 9.3%, with 90-95% of cases being type 2 diabetes. In 2011-2012, the state of California reported a rate of 6.9% of adults with diabetes and this rate was the same for San Diego County.⁷



*Source: CDC National Health Interview Survey; National Center for Health Statistics; Division of Health Interview Statistics

DISPARITIES & DIABETES^{6,7}

Diabetes & Race

- Hispanics and African Americans have two times higher prevalence: 1 in 20 non-Hispanic whites have type 2 diabetes, compared with 1 in 10 Hispanics and 1 in 11 African Americans in 2011-2012.
- In San Diego, whites and blacks had the highest death rates due to diabetes in 2012.

Diabetes & Gender

- The prevalence of type 2 diabetes is 13 percent higher in men than women in California.
- In San Diego, males had a higher death rate than females (22.5 per 100,000 versus 19.0 per 100,000 in 2012).

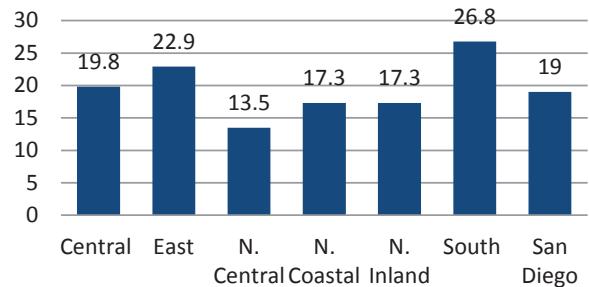
Diabetes & Income

- The percent of adults in Californians with diabetes is almost two times higher in those with family incomes below 200 percent of the federal poverty level compared to those whose income is 300 percent above.

Diabetes & Co-Morbidities

- Adults with diabetes are more likely to have arthritis, hypertension and cardiovascular disease than adults without diabetes.
- Diabetes is a leading cause of lower limb amputation and kidney failure in the U.S.

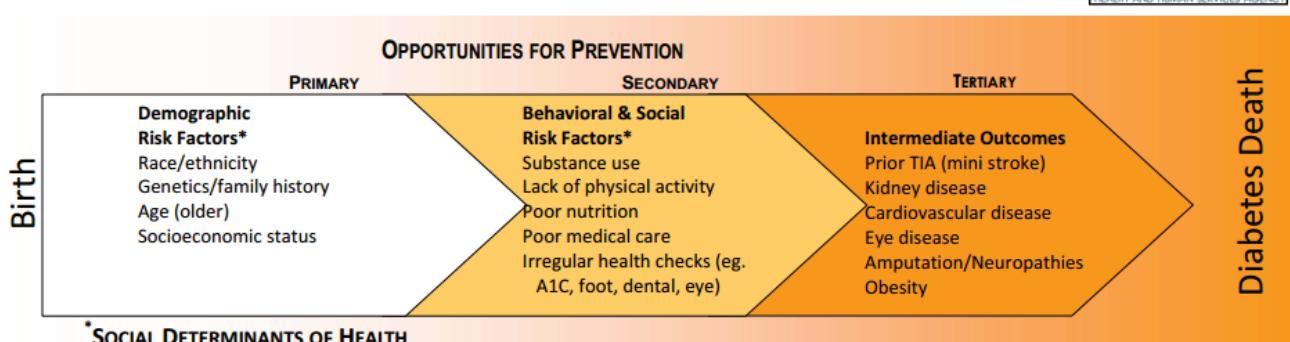
Diabetes Mortality Rate in San Diego County, 2013



Age Adjusted Death Rate per 100,000 Population.

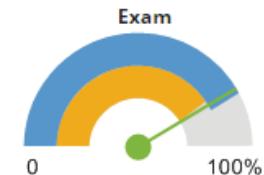
Source: Death Statistical Master Files (CDPH), County of San Diego, Health & Human Services Agency, Public Health Services, Epidemiology & Immunization Services Branch; SANDAG, Current Population Estimates, 10/2013.

Diabetes



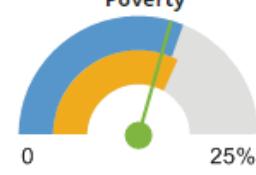
Characteristics of Residents, San Diego County Selected Elements from Diabetes Pathway:¹⁰

Percent Medicare Enrollees with Diabetes with Annual Exam



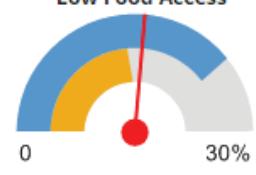
Data Source: Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care 2012.

Percent Population in Poverty



Data Source: U.S. Census Bureau, American Community Survey 2010-2014.

Percent Population with Low Food Access



Data Source: U.S. Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas 2010.

Possible Intervention Opportunities⁹

- Combined Diet and Physical Activity Promotion Programs: trained providers in clinical or community settings who work directly with program participants for at least 3 months and include some combination of counseling, coaching, and extended support
- Case Management Interventions to Improve Glycemic Control: appointing a professional case manager who oversees and coordinates all of the services received by someone with the disease
- Disease Management Programs and Screening in High Risk Patients: integrating services to improve glycemic control and monitoring retinopathy and lower extremity neuropathy

For More Information, Visit the American Diabetes Association's Website: <http://www.diabetes.org/>

1. CDC website: http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf
2. CDC website: National Diabetes Statistics report: <http://www.cdc.gov/diabetes/pdfs/data/2014-report-estimates-of-diabetes-and-its-burden-in-the-united-states.pdf>
3. CDC website: <http://www.cdc.gov/diabetes/data/statistics/2014StatisticsReport.html>
4. State Health Facts Website: <http://kff.org/other/state-indicator/diabetes-death-rate-per-100000/>
5. County of San Diego. Mortality Data. http://www.sdcounty.ca.gov/hhsa/programs/phs/community_epidemiology/epi_stats_mortality.html#regional_tables
6. County of San Diego: Non-Communicable (Chronic Disease) Profile. http://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/CHS/CHS_NonCommunicable_Disease_Profiles.pdf
7. California Department of Public Health: Burden of Disease Brief. http://www.cdph.ca.gov/programs/cdcb/Documents/FINAL%20Rpt%20%281877%29%20DM%20burden%202014_9-04-14MNR3.pdf
8. County of San Diego Health and Human Services Agency, Public Health Services. Community Health Statistics Unit. (2012). Critical Pathways: the Disease Continuum, Stroke. January 2012. http://www.sdcounty.ca.gov/hhsa/programs/phs/documents/CHS-Critical_Pathways_2012.pdf.
9. The Community Guide. Diabetes Prevention and Control. <http://www.thecommunityguide.org/diabetes/index.html>.
10. Kaiser Permanente CHNA Data Platform.
11. Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2012. http://www.cdc.gov/nchs/data/series/sr_10/sr10_260.pdf

Behavioral Health

Mental Health is defined as “a state of complete physical, mental and social well-being, and not merely the absence of disease”.¹ 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”.²

Mental and Behavior Health covers a broad range of topics:

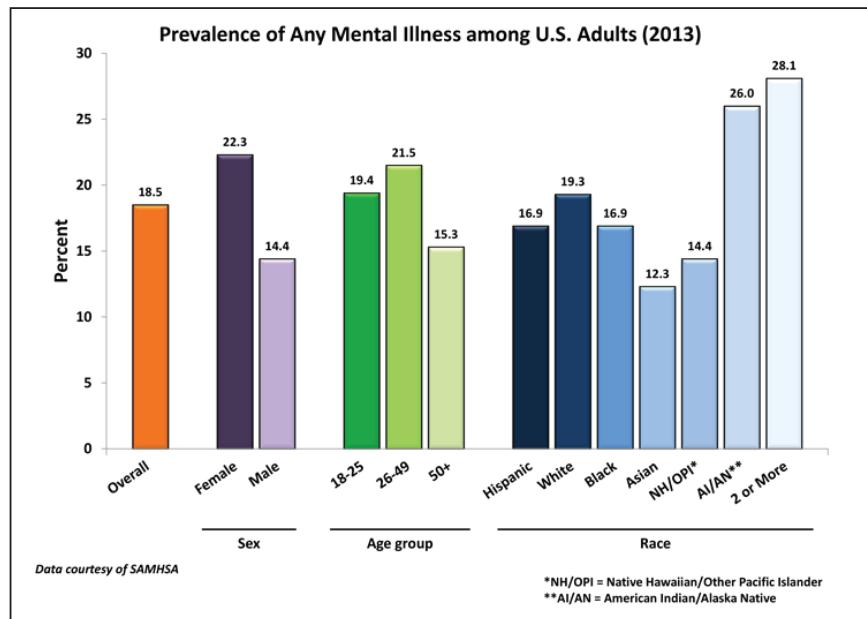
- Substance abuse and misuse are one set of behavioral health problems. Others include (but are not limited to) serious psychological distress, suicide, and mental illness.⁷
- Barriers can exist for patients across the lifespan. The National Survey for Children’s Health (HRSA, 2010) showed that among children with emotional, developmental, or behavioral conditions, 45.6% were receiving needed mental health services.¹⁰
- In 2014, among the 20.2 million adults with a past year substance use disorder, 7.9 million (39.1 percent) had any mental illness in the past year.⁷

Depression:

- Depression is the leading cause of disability worldwide and is a major contributor to the global burden of disease.⁴
- In 2014, 11.4% percentage of adolescents aged 12 to 17 had a major depressive episode. The percentage who used illicit drugs in the past year was higher among those with a past year major depressive episode (MDE) than it was among those without a past year MDE (33.0 vs. 15.2%).⁷

Prevalence:

- In 2014, an estimated 43.6 million (roughly 18%) adults aged 18 or older had any mental illness in the United States.⁷
- One-half of all chronic mental illness begins by the age of 14; three-quarters by the age of 24.⁴



*Data from National Survey on Drug Use and Health (NSDUH)³
Any Mental Illness: A mental, behavioral, or emotional disorder (excluding developmental and substance use disorders); diagnosable currently or in the past year

DISPARITIES & BEHAVIORAL HEALTH^{4, 5, 10}

Behavioral Health & Race

- Compared with whites, African Americans and Hispanic Americans used mental health services at about one-half the rate in 2010.
- Black adults and adolescents were less likely than their white counterparts to receive treatment for depression.
- American Indian/Alaskan Native adults and those of 2 or more races had the highest prevalence of mental illness with 26% and 28% living with a mental health condition, respectively.

Behavioral Health & Housing

- An estimated 26% of homeless adults staying in shelters live with serious mental illness and an estimated 46% live with severe mental illness and/or substance use disorders.

Behavioral Health & Gender

- Males commit suicide four times more than females.
- Adult males were less likely than adult females to receive treatment for depression.

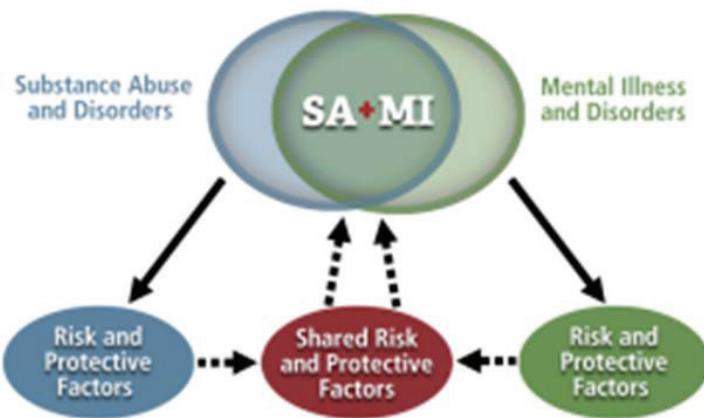
Behavioral Health & Sexuality

- LGBTQ individuals are 2 or more times more likely as straight individuals to have a mental health condition.

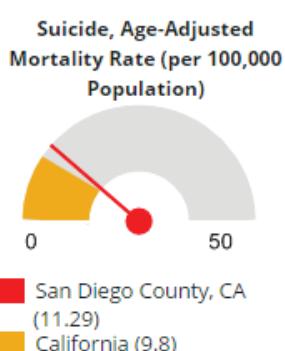
Behavioral Health & Chronic Disease

- Mental Illness is associated with chronic diseases such as cardiovascular disease, diabetes, and obesity.

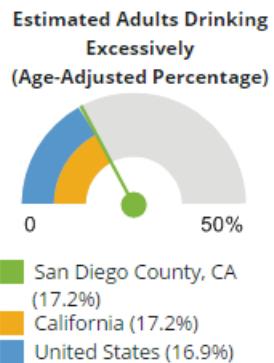
Interaction of Substance Abuse and Mental Illness



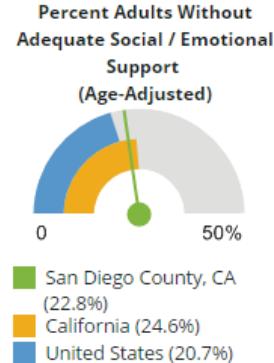
Characteristics of Residents, San Diego County Selected Elements Contributing to Behavioral Health:⁹



Data Source: University of Missouri, Center for Applied Research and Environmental Systems. CDPH-Death Public Use Data. 2010-12.



Data Source: Centers for Disease Control and Prevention, BRFSS 2006-2012.



Data Source: Centers for Disease Control and Prevention, BRFSS 2006-2012.

Possible Intervention Opportunities⁸

- Collaborative Care for the Management of Depressive Disorders: using case managers to link primary care providers, patients, and mental health specialists with the goal of improved screening and diagnosis and increased use of evidence-based best practices and patient engagement
- Electronic Screening and Brief Intervention for Excessive Alcohol Consumption: screening individuals and delivering a brief intervention, which provides personalized feedback about the risks and consequences of excessive drinking with at least one part delivered on an electronic device

For More Information, Visit the Substance Abuse and Mental Health Services Website:
<http://www.samhsa.gov/>

1. World Health Organization. *Strengthening Mental Health Promotion*. Geneva, World Health Organization (Fact sheet no. 220), 2001.
2. CDC. Mental Health Basics. <http://www.cdc.gov/mentalhealth/basics.htm>
3. National Institute of Mental Health. Any Mental Illness (AMI) Among Adults. <http://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-adults.shtml>
4. National Alliance on Mental Illness. Mental Health by the Numbers. <http://www.nami.org/Learn-More/Mental-Health-By-the-Numbers>
5. Suicide. http://www.cdc.gov/ViolencePrevention/pdf/Suicide_DataSheet-a.pdf
6. CDC. BRFSS Trend Data. <http://apps.nccd.cdc.gov/HRQOL/>
7. SAMHSA. Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health. <http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.htm>
8. The Community Guide. Alcohol Consumption and Mental Health. <http://www.thecommunityguide.org/>
9. Kaiser Permanente CHNA Data Platform.
10. National Health Care Disparities Report, 2013. <http://www.ahrq.gov/research/findings/nhqrdr/nhdr13/chap2b.html>

Obesity

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.¹ 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.²

Some facts about Obesity in the United States:³

- According to the 2013 BRFSS and YRBSS, 28.3% of U.S. adults were obese, 35.5% of adults were overweight, 13.7% of adolescents were considered obese and 16.6% of adolescents were overweight.
- In 2013, 21.4% of adults reported in engaging in no leisure time activity and the number of adults who report eating less than 1 vegetable or fruit daily is 17.3% and 30.4% respectively.

Health Consequences due to Overweight and Obesity:⁴

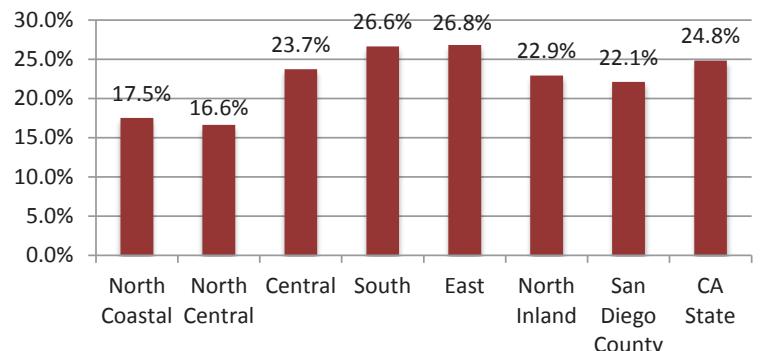
Research has shown that as weight increases to reach the levels of "overweight" and "obesity," the risks for the following conditions also increases:

- Coronary heart disease
- Type 2 diabetes
- Cancers (endometrial, breast, and colon)
- Hypertension (high blood pressure)
- Stroke
- Liver and Gallbladder disease
- Sleep apnea and respiratory problems
- Osteoarthritis

Overweight and Obesity Associated Costs:¹

- In 2008, medical costs associated with obesity were estimated at \$147 billion; the medical costs for people who are obese were \$1,429 higher than those of normal weight.

Obese Weight Status Among San Diego County Adults by Region, 2011-2012



* Based on the 2011-2012 California Health Interview Survey

DISPARITIES & OBESITY^{10,11}

Obesity & Race

- According to the BRFSS, from 2012 through 2014, non-Hispanic blacks had the highest prevalence of self-reported obesity (38.1%), followed by Hispanics (31.3%) and non-Hispanic whites (27.1%).
- In 2011-2012, the prevalence among children and adolescents was higher among Hispanics (22.4%) and non-Hispanic blacks (20.2%) than among non-Hispanic whites (14.1%).

Obesity & Gender

- Among men, 42% were considered to be overweight compared to 29% of women. The median percentage of obesity was similar among men (28%) and women (27%) in the U.S.

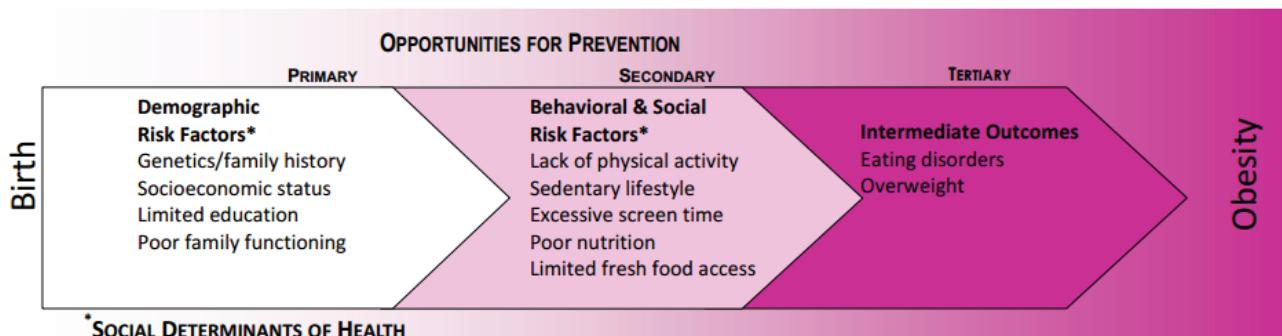
Obesity & Income

- Among non-Hispanic black and Mexican-American men, those with higher incomes are more likely to have obesity than those with low income.
- Higher income women and women with higher educational attainment are less likely to be obese than low-income women.
- Obesity prevalence was the highest among children in families with an income-to-poverty ratio of 100% or less.

Obesity & Quality of Life

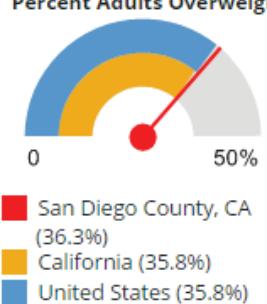
- Obesity can affect the quality of life through limited mobility and decreased physical endurance, in addition to social, academic, and job discrimination.

Obesity



Characteristics of Residents, San Diego County Selected Elements from Obesity Pathway:⁸

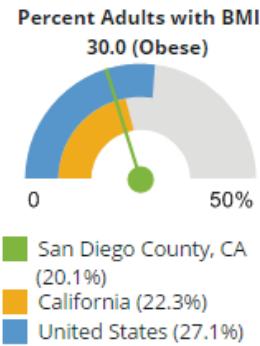
Percent Adults Overweight



Data Source: Centers for Disease Control and Prevention, BRFSS 2011-2012.

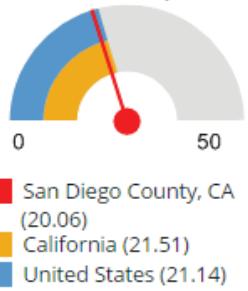
Percent Adults with BMI >

30.0 (Obese)



Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion 2012.

Grocery Stores, Rate
(Per 100,000 Population)



Data Source: U.S. Census Bureau, County Business Patterns 2011.

Possible Intervention Opportunities⁹

- Behavioral Interventions that Aim to Reduce Recreational Sedentary Screen Time Among Children:* teaching behavioral self-management skills to initiate or maintain behavior change including the use of an electronic monitoring device to limit screen time; TV Turnoff Challenge; screen time contingent on physical activity; or small media.
- Worksite Programs:* using one or more approaches to support behavioral change at employee worksites including informational and educational, behavioral and social, and policy and environmental strategies

For More Information, Visit Medline's Obesity Page: <http://www.nlm.nih.gov/medlineplus/obesity.html>

1. CDC Website: Centers for Disease Control and Prevention. Def. Obesity and Overweight: <http://www.cdc.gov/obesity/adult/defining.html>
2. 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.
3. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition, Physical Activity and Obesity. Nutrition, Physical Activity and Obesity Data, Trends and Maps. <http://www.cdc.gov/ncdpdp/DNPAO/index.html>
4. NIH, NHLBI Obesity Education Initiative. Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: http://www.nhlbi.nih.gov/guidelines/obesity/ob_gdlns.pdf
5. CDC Website: NCHS Factsheet: http://www.cdc.gov/nchs/data/factsheets/factsheet_disparities.htm
6. CDC Website: Centers for Disease Control and Prevention. Adult Obesity facts: <http://www.cdc.gov/obesity/data/adult.html>.
7. County of San Diego HHSAA, Community Health Statistics Unit, Obesity Brief, http://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/documents/CHS-Obesity_Brief.pdf
8. Kaiser Permanente CHNA Data Platform.
9. The Community Guide. Obesity Prevention and Control. <http://www.thecommunityguide.org/obesity/index.html>
10. CDC Website: Centers for Disease Control and Prevention. Childhood Obesity facts: <http://www.cdc.gov/obesity/data/childhood.html>
11. CDC Website: Centers for Disease Control and Prevention. Adult Obesity facts: <http://www.cdc.gov/obesity/data/adult.html>

APPENDIX D: GLOSSARY OF TERMS

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 driver. Health drivers are behavioral, environmental, social, economic and clinical care factors that positively or negatively impact health. For example, smoking (behavior) is a health driver for lung cancer, and access to safe parks (environmental) is a health driver for obesity/overweight. Some health drivers, such as poverty or lack of insurance, impact multiple health issues.

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.

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. See also **Health Driver**.

APPENDIX E: COMMUNITY ENGAGEMENT ACTIVITY DATA COLLECTION TOOLS

Community Partner Discussion Template

Note: Questions to aid in discussion. Remind participants to keep in mind the top four health needs. All four needs do not need to be addressed for every question.

1. What are the most common health issues or needs of your clients related to behavioral health, cardiovascular disease, diabetes or obesity? (Please explore within the health needs that you feel are most important; for example hypertension could be a major health issue that affects cardiovascular health, or a frequent behavioral health issue with your clients could be depression.)
2. For the health issues and needs identified above, what are the challenges your clients face to improving their health? This could refer to any aspect of health (i.e. behavior change, access, etc.)
3. When your patients are unable to adopt healthy behaviors, what are their reasons for not adopting changes?

Follow up Questions if needed:

- a. *What barriers or lack of resources contribute to this challenge?*
- b. *What knowledge/education would be beneficial to help your patient adopt behavior change?*
4. What are the top challenges that you, as case managers, face to successfully helping your clients meet their health needs?
5. What have you found works best with your clients to help them meet their health needs? (For example health navigators, mobile devices and apps, translators, etc.)
6. How could the hospitals collaborate with your organizations to help you meet the needs of your clients?
7. What do you want the hospitals to know that we haven't already asked?

Sign-in Sheet for Community Partner Discussion

Name	Contact Information	Organization	Organization Type	Region	Population Served (Mark all that apply)
			<input type="checkbox"/> Clinic <input type="checkbox"/> Government <input type="checkbox"/> Non-profit <input type="checkbox"/> Other: _____	<input type="checkbox"/> Central <input type="checkbox"/> East <input type="checkbox"/> North Central <input type="checkbox"/> North Coastal <input type="checkbox"/> North Inland <input type="checkbox"/> South	<input type="checkbox"/> Low-income <input type="checkbox"/> Medically Underserved <input type="checkbox"/> Population with chronic diseases <input type="checkbox"/> Minority Population <input type="checkbox"/> Other
			<input type="checkbox"/> Clinic <input type="checkbox"/> Government <input type="checkbox"/> Non-profit <input type="checkbox"/> Other: _____	<input type="checkbox"/> Central <input type="checkbox"/> East <input type="checkbox"/> North Central <input type="checkbox"/> North Coastal <input type="checkbox"/> North Inland <input type="checkbox"/> South	<input type="checkbox"/> Low-income <input type="checkbox"/> Medically Underserved <input type="checkbox"/> Population with chronic diseases <input type="checkbox"/> Minority Population <input type="checkbox"/> Other
			<input type="checkbox"/> Clinic <input type="checkbox"/> Government <input type="checkbox"/> Non-profit <input type="checkbox"/> Other: _____	<input type="checkbox"/> Central <input type="checkbox"/> East <input type="checkbox"/> North Central <input type="checkbox"/> North Coastal <input type="checkbox"/> North Inland <input type="checkbox"/> South	<input type="checkbox"/> Low-income <input type="checkbox"/> Medically Underserved <input type="checkbox"/> Population with chronic diseases <input type="checkbox"/> Minority Population <input type="checkbox"/> Other
			<input type="checkbox"/> Clinic <input type="checkbox"/> Government <input type="checkbox"/> Non-profit <input type="checkbox"/> Other: _____	<input type="checkbox"/> Central <input type="checkbox"/> East <input type="checkbox"/> North Central <input type="checkbox"/> North Coastal <input type="checkbox"/> North Inland <input type="checkbox"/> South	<input type="checkbox"/> Low-income <input type="checkbox"/> Medically Underserved <input type="checkbox"/> Population with chronic diseases <input type="checkbox"/> Minority Population <input type="checkbox"/> Other
			<input type="checkbox"/> Clinic <input type="checkbox"/> Government <input type="checkbox"/> Non-profit <input type="checkbox"/> Other: _____	<input type="checkbox"/> Central <input type="checkbox"/> East <input type="checkbox"/> North Central <input type="checkbox"/> North Coastal <input type="checkbox"/> North Inland <input type="checkbox"/> South	<input type="checkbox"/> Low-income <input type="checkbox"/> Medically Underserved <input type="checkbox"/> Population with chronic diseases <input type="checkbox"/> Minority Population <input type="checkbox"/> Other

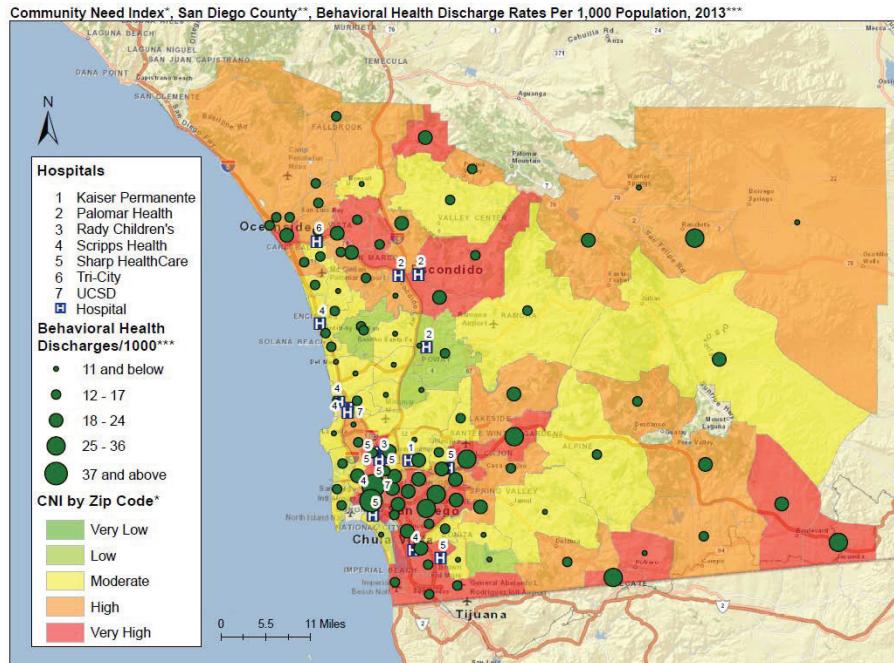
BEHAVIORAL HEALTH DISCUSSION TEMPLATE

Welcome/Introduction: Seven hospitals and health care systems have come together under the auspices of the Hospital Association of San Diego and Imperial Counties (HASD&IC) and the Institute for Public Health (IPH) to conduct a triennial Community Health Needs Assessment (CHNA) that identifies and prioritizes the most critical health-related needs of San Diego County residents. A longitudinal review of CHNAs conducted over the past 15 years reveals that overarching health needs in the region have remained relatively stable over time. Based on 2013 CHNA findings and the consistency of these findings over time, it is likely that going forward, behavioral health , cardiovascular disease, diabetes (type 2), and obesity will continue to be top community health concerns in our region, particularly in high need communities.

In recognition of the challenges that health providers, community organizations and residents face in their efforts to prevent, diagnose and manage these chronic conditions, the 2016 CHNA process will focus on gaining deeper insight into the top health needs identified in the HASD&IC 2013 CHNA . Accordingly, participating hospitals are seeking input from local clinicians, nurses, therapists and other health care professionals in order to better understand the challenges and opportunities that arise from the top four community health needs. This input will then be used to inform hospital programs.

Top four community health needs identified (listed alphabetically, not ranked):

- Behavioral Health
- Cardiovascular Disease
- Diabetes (Type 2)
- Obesity



HOSPITAL ASSOCIATION
of San Diego & Imperial Counties

iph
INSTITUTE OF PUBLIC HEALTH

Hospital Discharge Data from OSHPD

Behavioral Health discharge data for patients with a primary diagnosis of a behavioral health ICD-9 code:

- OSHPD Inpatient discharge data revealed that when examining the ICD-9 codes related to behavioral health, 'mood disorders' was the top primary diagnosis for inpatient discharge for ages 5 through 24 and 45 and over. For those aged 25 through 44, the top behavioral health primary diagnosis was 'schizophrenia and other psychotic disorders' followed by 'mood disorders.'
- OSHPD ED discharge data: Anxiety disorders were the top primary diagnosis for ED discharge among those age 5 through 44 and those 65 and older. For those aged 45-64, the top ED discharge for behavioral health was alcohol-related disorders followed by anxiety and mood disorders. Alcohol related disorders was the number two primary diagnosis for discharge for those aged 15 through 44 and those 65 years and older.

Hospital Discharge Data (2013 OSHPD via SpeedTrack)

Age	Inpatient				Emergency Department			
	Group	Diagnosis Classification	#	%	Diagnosis Classification	#	%	
5-14	Mood Disorders	927	78.83%		Anxiety Disorders	236	27.96%	
	Impulse Control Disorders Nec	85	7.23%		Mood Disorders	218	25.83%	
					Attention-Deficit Conduct and Disruptive Behavior Disorders	111	13.15%	
15-24	Mood Disorders	2647	57.79%		Anxiety Disorders	1583	28.17%	
	Schizophrenia and Other Psychotic Disorders	1083	23.65%		Alcohol-Related Disorders	1379	24.54%	
					Mood Disorders	1168	20.78%	
25-44	Schizophrenia and Other Psychotic Disorders	2877	39.00%		Anxiety Disorders	3259	29.19%	
	Mood Disorders	2754	37.34%		Alcohol-Related Disorders	3037	27.20%	
	Alcohol-Related Disorders	982	13.31%		Schizophrenia and Other Psychotic Disorders	1721	15.42%	
					Mood Disorders	1700	15.23%	
45-64	Mood Disorders	3078	38.15%		Alcohol-Related Disorders	4283	42.54%	
	Schizophrenia and Other Psychotic Disorders	2909	36.05%		Anxiety Disorders	2046	20.32%	
	Alcohol-Related Disorders	1495	18.53%		Mood Disorders	1539	15.29%	
					Schizophrenia and Other Psychotic Disorders	1310	13.01%	
65+	Mood Disorders	903	36.40%		Anxiety Disorders	761	30.38%	
	Schizophrenia and Other Psychotic Disorders	659	26.56%		Alcohol-Related Disorders	507	20.24%	
	Delirium Dementia and Amnestic and Other Cognitive Disorders	404	16.28%		Schizophrenia and Other Psychotic Disorders	399	15.93%	
					Mood Disorders	351	14.01%	

Behavioral Health: V40.0-V41.0, 290-292, 293.81-293.84, 295-301, 303-305.0, 305.2-305.9, 307.0, 307.2, 307.3, 307.6, 307.7, 307.9, 308, 309.21, 309.81, 311, 312.00-312.23, 312.3, 312.4, 312.8, 312.9, 313.00-313.23, 313.3, 313.81, 313.83-313.84, 313.89, 313.9-315, 317-319, 331, 980.0.

Community Partner Discussion Questions and Summary of Behavioral Health Responses	
1. What are the most common health issues or needs?	
<ul style="list-style-type: none"> ♦ Depression (depression in seniors mentioned most often) ♦ Anxiety ♦ Lack of psychiatrists ♦ Lack of training in schools ♦ Homelessness/drug-induced issues ♦ Smoking 	<ul style="list-style-type: none"> ♦ Stress ♦ Drugs/alcohol ♦ Self-injury/suicidal ideation in youth ♦ Problems with compliance/coverage ♦ Social media/bullying ♦ Behavioral Health affects all other diseases
2. What are the challenges clients face to improving health?	
<ul style="list-style-type: none"> ♦ Strong stigma ♦ Specific Vulnerable Populations: <ul style="list-style-type: none"> Youth: too few behavioral health practitioners/lack of school counselor, knowledge, getting parents on board/parent follow-up Seniors: don't have support at home or forget to take medications, mobility issues and healthy eating Homeless: often difficult to get proof of appointment; wait times are often longer than the amount of time they are allowed to be gone 	
3. Why do patients not adopt behaviors?	
<ul style="list-style-type: none"> ♦ Lack of awareness/recognition ♦ Self-medication ♦ Not properly motivated/confident ♦ The right questions aren't being asked 	
4. What are top challenges you as case managers face to helping?	
<ul style="list-style-type: none"> ♦ Getting clients to go is difficult ('I don't need that'); also problems confirming appointments/contacting ♦ Problems with hospital discharges, continuing care and wrong referrals ♦ Patients being signed up for the wrong plans for what they need/want ♦ Long waiting periods and no follow-up appointments ♦ Compliance and literacy- getting individuals to read/use resources ♦ For healthy eating, may want to but don't want to run out of money by the end of the month ♦ South- getting documents/verifications ♦ North County – lack of services, only one crisis location ♦ Specific Vulnerable Populations: <ul style="list-style-type: none"> Youth: difficulties communicating with parents/ what is told to parents at discharge does not filter down to the nurses, limited school-based interventions, cultural barriers, denial, unaware of problem Elderly: may choose medicine over food 	
5. What have you found works best with your clients to help them meet their needs?	
<ul style="list-style-type: none"> ♦ Reducing stigma ♦ Emotional support ♦ Strengths-based case management ♦ Finding intrinsic motivation ♦ Keeping the phone lines open 	
6. How could hospitals collaborate with your organizations?	
<ul style="list-style-type: none"> ♦ Would like to see better referrals, discharge plans, and access to medical records (more details) ♦ No discharge to streets or without medications, , no discharges without making follow-up appointments with clients ♦ Discharge to crisis houses ♦ Follow ups with clinics when patients visit the ED ♦ Better ways to ask if people need food or other social services ♦ Youth: discharge summary/instructions from hospital/doctor to school sites for kids (What are limitations, needs, modifications) <ul style="list-style-type: none"> ♦ Create curriculum/legislation for schools (One set of curriculum in elementary, middle, and high schools) teaching BASIC health issues; have Children's Hospital present health issues, educational presentations, and available resources/services to nurses and school personnel 	

Questions to aid in discussion. Please respond as it pertains to your area of expertise:

1. When examining hospital discharge data for the ICD-9 codes associated with behavioral health, the top health issues were:

- a. Mood disorder
- b. Anxiety disorder
- c. Alcohol-related disorder

Do you believe these are the top concerns within the population you work with? What are additional health issues that are of high concern for the populations you work with?

2. For the health issues and needs identified above, what are the challenges your clients face to improving their health? This could refer to any aspect of health (i.e. behavior change, access, understanding of health issue, etc.)
3. When your patients are unable to adopt healthy behaviors, what are their reasons for not adopting changes?

Follow up Questions if needed:

- a. *What barriers or lack of resources contribute to this challenge?*
 - b. *What knowledge/education would be beneficial to help your patient adopt behavior change?*
4. What are the top challenges that you and your colleagues/teams face to successfully help your clients meet their health needs?
 5. What have you found works best with your clients to help them meet their health needs? (For example health navigators, mobile devices and apps, translators, etc.)
 6. How could your facility collaborate with community based organizations to help you meet the needs of your clients?
 7. What else should we ask the community about challenges and opportunities to improve behavioral health outcomes

Roadmap - WHERE DO YOU GET STUCK?



Why this was created:

Seven hospitals and health care systems have come together under the guidance of the Hospital Association of San Diego and Imperial Counties (HASD&IC) and the Institute for Public Health (IPH) to conduct a triennial Community Health Needs Assessment (CHNA) that identifies and prioritizes the most critical health-related needs of San Diego County residents. Based on 2013 Community Health Needs Assessment findings, the following conditions were found to be the top health needs in San Diego: (in alphabetical order)

- Behavioral health
- Cardiovascular disease
- Diabetes (type 2)
- Obesity

Management of chronic conditions such as these depends on an individual's ability to **flow through the health care system**. When community members are unable to complete the necessary steps to maintain and improve their health, these conditions worsen and pose a serious health risk. The results of the 2014 Community Needs Assessment completed as part of the 2016-2017 County of San Diego Community Action Plan showed that access and health navigation were common problems throughout all six regions in San Diego. In order to further understand the issue of access to health care and how to help individuals navigate the health care system, we have created this document to ask individuals: 'Where do you get stuck?' Survey results will be used to inform and adapt hospital programs to better meet resident needs.

How this was created:

This roadmap was created based on:

- 2014 Community Needs Assessment within the 2016-2017 County of San Diego Community Action Plan (CAP)
- 2013 Hospital Association of San Diego and Imperial Counties Community Health Needs Assessment (CHNA) final report
- Conversation with community partners (e.g. Resident Leadership Academy Council and community groups)

Commonalities between the CAP report and CHNA report results were summarized. Access and health navigation were the two major overlapping themes that were found. This roadmap was created to better understand these barriers in relation to the health care system as a whole.

Tell us about yourself (please fill out questions below that you feel comfortable in answering)

How are you answering the survey?

- Community member/resident (18+)
- RLA Leader
- SD County Representative

San Diego Region

- South
- North Coastal
- Central
- North Inland
- North Central
- East

Race/Ethnicity

- Asian/Pacific Islander
- Black
- Hispanic
- White
- Other

Populations you have knowledge of:

(Mark all that apply):

- Low Income
- Minority Population
- Medically Underserved
- Population w/ chronic condition
- Other

Who have you helped navigate thru the health system?

- Yourself (18+) Another Adult
- Child Older Adult (65+)

ZIP CODE

*Adapted from San Ysidro Health Center handout which was adapted from the Centers for Medicare & Medicaid Services, <https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH-Coverage2Care.html>

Objective: Survey results will be used to inform and adapt hospital programs to better meet resident needs.

Instructions:

Step One: Please rank the top 5 obstacles to accessing health care, 1 being the most troublesome.

Step Two: Within the top 5 obstacles that you ranked, check the smaller boxes below which are most applicable to you and your community in terms of obstacles to health care. If you feel there are other obstacles that should be included please mark 'Other' and write them in.

Step One: Rank Your Top 5 Obstacles to accessing health care (1-5)

- A. Understanding health insurance _____
- B. Getting health insurance _____
- C. Using health insurance _____
- D. Knowing where to go for care _____
- E. Making an appointment for care _____
- F. Getting to the appointment _____
- G. Problems at the appointment _____
- H. Follow-up care and/or apt _____
- I. Picking up prescriptions _____
- J. Managing medications _____

Step Two: Only within the top 5 obstacles you ranked, check the smaller boxes that apply to you

A. Understanding health insurance 

- Confusing insurance terms
- Insurance information not in my preferred language
- How does Covered California apply to me?
- Other: _____

B. Getting health insurance 

- Where to sign up
- Time required to sign up
- How to pick a plan
- Hearing back after signing up
- Eligibility requirements and documentation status
- Other: _____

C. Using health insurance 

- Finding a doctor
- Understanding health care costs/bills
- Knowing what services are covered
- Language translation availability
- Confusing insurance terms
- Other: _____

D. Knowing where to go for care 

- No primary care doctor
- When to use the emergency department vs urgent care vs clinic
- Lack of health insurance
- Language translation availability
- Other: _____

E. Making an appointment for care 

- Where to call
- No available appointments
- Wait time issues
- Hours of operation
- Language translation availability
- Other: _____

F. Getting to the appointment 

- Lack of transportation
- Lack of childcare
- Time off work
- Lack of caregiver assistance
- Other: _____

G. Problems at the appointment 

- Lack of clear communication with doctor and/or staff
- Payments at the appointment
- Language translation availability
- Cultural sensitivity
- Fair treatment
- Other: _____

H. Follow-up care and/or appointment 

- Lack of instructions about necessary follow-up care
- Lack of understanding about next steps
- No available follow-up appointments
- Lack of transportation
- Time off work
- Lack of caregiver assistance
- Other: _____

I. Picking up prescriptions 

- What pharmacy to use
- Understanding costs
- Prioritizing food/rent/utilities/other over prescriptions
- Lack of time
- Lack of transportation
- Language translation availability
- Other: _____

J. Managing medications 

- Understanding how and when to take medications
- Prescription information not in my preferred language
- Refilling prescriptions
- Lack of caregiver assistance
- Other: _____

APPENDIX F: 2-1-1 SAN DIEGO COMMUNITY ASSET LIST BY CONDITION

2-1-1 Taxonomy of Services Available in San Diego Related to the Top 4 Health Needs

Mental Health and Substance Abuse Services	# Services
Behavioral Learning Therapy	4
Behavior Modification	38
Cognitive Behavioral Therapy	8
Dialectical Behavior Therapy	1
Psychosocial Therapy	3
Multimodal Therapy	1
Pastoral Counseling	3
Psychodynamic Therapy	1
Psychotherapy/Psychoanalysis	6
Conjoint Counseling	5
Family Counseling	43
Group Counseling	27
Individual Counseling	38
Internet Counseling	3
Peer Counseling	14
Talklines/Warmlines	7
Counseling Services	10
General Counseling Services	64
Specialized Counseling Services	13
Abuse Counseling	20
Child Abuse Counseling	10
Counseling for Children Affected by Domestic Violence	2
Elder Abuse Counseling	2
Parent Abuse Counseling	2
Spouse/Intimate Partner Abuse Counseling	8
Adolescent/Youth Counseling	43
Anger Management	39
Bereavement Counseling	8
Caregiver Counseling	3
Child Guidance	3
Crime Victim/Witness Counseling	6
Cultural Transition Counseling	1
Divorce Counseling	1
Employment Transition Counseling	6
Ex-Offender Counseling	2
Gambling Counseling/Treatment	2
Gender Identity Counseling	1
Geriatric Counseling	3
Health/Disability Related Counseling	34
Juvenile Delinquency Diversion Counseling	18

Marriage Counseling	5
Parent Child Interactive Therapy	1
Parent Counseling	4
Perinatal/Postpartum Depression Counseling	5
Post abortion Counseling	6
Psychiatric Disorder Counseling	3
Sex Offender Counseling	2
Sexual Assault Counseling	17
Sexual Orientation Counseling	2
Terminal Illness Counseling	2
Veteran Reintegration Counseling	9
Crisis Intervention	22
Crisis Intervention Hotlines/Helplines	24
Child Abuse Hotlines	11
Domestic Violence Hotlines	8
General Crisis Intervention Hotlines	5
Human Trafficking Hotlines	3
Mental Health Hotlines	4
Runaway/Homeless Youth Helplines	4
Sexual Assault Hotlines	8
Suicide Prevention Hotlines	5
Suicide Prevention Hotlines For Veterans	1
Crisis Residential Treatment	6
In Person Crisis Intervention	40
Internet Based Crisis Intervention	1
Involuntary Psychiatric Intervention	1
Psychiatric Mobile Response Teams	1
Psychiatric Emergency Room Care	1
Mental Health Evaluation	54
Central Intake/Assessment for Mental Health Services	8
Clinical Psychiatric Evaluation	7
Mental Health Screening	13
Anxiety Disorders Screening	6
Depression Screening	3
Psychological Assessment	13
Psychological Testing	3
Psychosocial Evaluation	19
Psychiatric Services	5
Adult Psychiatry	2
Eating Disorders Treatment	4
Geriatric Psychiatry	1
Special Psychiatric Programs	5
Assertive Community Treatment	4

Home Based Mental Health Services	2
Integrated Dual Diagnosis Treatment	1
Psychiatric Case Management	26
Psychiatric Day Treatment	21
Psychiatric Medication Services	17
Psychiatric Medication Monitoring	9
Psychiatric Rehabilitation	23
Clubhouse Model Psychiatric Rehabilitation	13
Supportive Therapies	1
Art Therapy	5
Equestrian Therapy	2
Music Therapy	2
Pet Assisted Therapy	3
Play Therapy	5
Recreational Therapy	10
Inpatient Mental Health Facilities	1
Psychiatric Hospitals	1
Adult Psychiatric Hospitals	14
Children's/Adolescent Psychiatric Hospitals	2
Psychiatric Inpatient Units	1
Adolescent Psychiatric Inpatient Units	2
Adult Psychiatric Inpatient Units	10
Children's Psychiatric Inpatient Units	6
Outpatient Mental Health Facilities	11
Community Mental Health Agencies	57
Family Counseling Agencies	8
Mental Health Drop In Centers	6
Private Therapy Practices	1
Residential Treatment Facilities	1
Adult Residential Treatment Facilities	6
Children's/Adolescent Residential Treatment Facilities	5
Early Intervention for Mental Illness	6
Mental Health Information/Education	3
Family Psychoeducation	1
General Mental Health Information/Education	37
Mental Health Related Prevention Programs	6
Body Image Education	1
Gambling Addiction Prevention Programs	1
Runaway Prevention Programs	1
Suicide Prevention Programs	3
Licensed Clinical Social Worker Referrals	1
Psychiatrist Referrals	1
Psychologist Referrals	3

Mental Health Halfway Houses	3
Psychiatric Aftercare Services	5
Psychiatric Resocialization	2
Central Intake/Assessment for Alcohol Abuse	7
Central Intake/Assessment for Drug Abuse	7
Drug/Alcohol Testing	22
General Assessment for Substance Abuse	8
Substance Abuse Screening	6
Substance Abuse Treatment Orders	1
Detoxification	1
Alcohol Detoxification	2
Inpatient Medically Assisted Alcohol Detoxification	4
Non-Medically Assisted Alcohol Detoxification	6
Outpatient Medically Assisted Alcohol Detoxification	2
Drug Detoxification	3
Inpatient Drug Detoxification	7
Opioid Detoxification	5
Outpatient Drug Detoxification	6
Social Model Drug Detoxification	6
DUI Offender Programs	2
First Offender DUI Programs	2
Multiple Offender DUI Programs	2
Alcohol Abuse Education/Prevention	17
Alcohol/Drug Impaired Driving Prevention	4
Drug Abuse Education/Prevention	19
Smoking Education/Prevention	8
Substance Abuse Treatment Programs	6
Comprehensive Outpatient Substance Abuse Treatment	13
Comprehensive Outpatient Alcoholism Treatment	24
Comprehensive Outpatient Drug Abuse Treatment	25
Inpatient Substance Abuse Treatment Facilities	1
Inpatient Alcoholism Treatment Facilities	6
Inpatient Drug Abuse Treatment Facilities	6
Medication Assisted Maintenance Treatment for Opioid Addiction	7
Perinatal Substance Abuse Treatment	1
Perinatal Alcoholism Treatment	7
Perinatal Drug Abuse Treatment	4
Residential Alcoholism Treatment Facilities	36
Residential Drug Abuse Treatment Facilities	37
Smoking Cessation	7
Substance Abuse Counseling	7
Alcoholism Counseling	15
Drug Abuse Counseling	17

Substance Abuse Day Treatment	1
Alcoholism Day Treatment	8
Drug Day Treatment	8
Supportive Substance Abuse Services	2
Relapse Prevention Programs	3
Smoking Cessation Support	9
Alcohol Related Crisis Intervention	12
Drug Related Crisis Intervention	13
Alcoholism Drop In Services	6
Drug Drop In Services	6
Alcoholism Hotlines	3
Drug Abuse Hotlines	5
Substance Abuse Intervention Programs	1
Substance Abuse Referrals	4
Transitional Residential Substance Abuse Services	4
Recovery Homes/Halfway Houses	1
Alcoholism Related Recovery Homes/Halfway Houses	3
Drug Related Recovery Homes/Halfway Houses	1
Sober Living Homes	7
Sober Living Homes for Recovering Alcoholics	6
Sober Living Homes for Recovering Drug Abusers	4
Number of Services Available for Mental Health and Substance Abuse Services	190

*Pathway: 2-1-1 Resources and Services Tab > Directory of Services > Outline of Categories > Mental Health and Substance Abuse Services > Removed those with '0' programs determined by [0/#]

**Locations/programs providing more than one service/in more than one category may be duplicated in the count of services

Diabetes-Related Health Care Services	# Services
Disease/Disability Specific Screening/Diagnosis	
Diabetes Screening	80
Condition Specific Treatment	8
Diabetes Management Clinics	19
Adult Diabetes Management Clinics	8
Pediatric Diabetes Management Clinics	2
Wound Clinics	1
Number of Services Available for Diabetes Services	118

*Pathway: 2-1-1 Resources and Services Tab > Directory of Services > Outline of Categories > Health Care > Keywords "Diabetes" "Wound Clinics" "Insulin" "Insulin Injection Supplies" "Home Glucose Monitoring Systems" "Foot Screening" & "Diabetes Screening" used to locate diabetes specific programs > Removed those with '0' programs determined by [0/#]

**Locations/programs providing more than one service/in more than one category may be duplicated in the count of services

Obesity-Related Health Care Services	# Services
Weight Management	38
Weight Loss Assistance	12
Clinical Weight Loss Programs	3
Diet and Exercise Resorts	6
Non-Clinical Weight Loss Programs	2
Nutrition Education	147
Dietary Services	1
Healthy Eating Programs	3
Nutrition Assessment Services	36
Physical Activity and Fitness Education/Promotion	134
Number of Services Available for Services for Weight Management	382

*Pathway: 2-1-1 Resources and Services Tab > Directory of Services > Outline of Categories > Health Care > Keywords "Weight Management" "Eating Disorders Screening" "Eating Disorders Treatment" "Nutrition Education" "Body Image Education" "BMI/Body Composition Screening" "Weight Related Support Groups" "Fitness Equipment and Accessories" "Physical Fitness Referrals" "Healthy Eating Programs" "Physical Activity and Fitness Education/Promotion" "Nutrition Assessment Services" "Dietician/Nutritionist Referrals" "Physical Fitness" used to locate programs > Removed those with '0' programs determined by [0/#]

**Locations/programs providing more than one service/in more than one category may be duplicated in the count of services

Cardiovascular-Related Health Care Services	# Services
Disease/Disability Specific Screening/Diagnosis	
Blood Pressure Screening	133
Cholesterol/Triglycerides Tests	10
Clinical Cholesterol/Triglycerides Tests	1
Health Education	
Chronic Disease Self-Management Programs	17
Number of Services Available for Cardiovascular Related Needs	161

*Pathway: 2-1-1 Resources and Services Tab > Directory of Services > Outline of Categories > Health Care > Keywords "Blood Pressure" "Cholesterol" "Chronic Disease" "Cardiovascular" "Heart Disease" used to locate programs > Removed those with '0' programs determined by [0/#]

**Locations/programs providing more than one service/in more than one category may be duplicated in the count of services

APPENDIX G: FEDERALLY QUALIFIED HEALTH CENTERS IN SAN DIEGO COUNTY

Federally Qualified Health Centers (FQHCs) in the community are community assets that provide health care to vulnerable populations; they receive funding from the federal government to promote access to ambulatory care in areas designated as medically underserved.

Facility Name	Address	City	State
Alpine Family Medicine	1620 Alpine Blvd, Suite 119	Alpine	CA
Southern Indian Health Council Inc.	4058 Willows Road	Alpine	CA
Borrego Medical Clinic	4343 Yaqui Pass Road	Borrego Springs	CA
Borrego CHF Clinica Familiar De Woolcott	655 Palm Canyon Drive Suite C Box 2369	Borrego Springs	CA
Southern Indian Health Council	36350 Church Road	Campo	CA
Mountain Empire Family Medicine	31115 Hwy 94	Campo	CA
Carlsbad Family Medicine	3050 Madison Street	Carlsbad	CA
Rice Family Health Center	352 L Street	Chula Vista	CA
Otay Family Health Clinic	1637 Third Avenue, Suite B	Chula Vista	CA
Chula Vista Family Health Center	251 Landis Avenue	Chula Vista	CA
Chula Vista Medical Plaza	678 3rd Avenue	Chula Vista	CA
Mi Clinica	1058 3rd Avenue	Chula Vista	CA
Teen Clinic	1637 3rd Avenue	Chula Vista	CA
Chase Avenue Family Health Center	1111 West Chase Avenue	El Cajon	CA
Neighborhood Healthcare El Cajon	855 East Madison Avenue	El Cajon	CA
Centro Medico, El Cajon	133 West Main Street	El Cajon	CA
La Maestra Community Health Center - El Cajon	165 S First Street	El Cajon	CA
North County Health Services Inc.	629 Second Street	Encinitas	CA
NCHS - Encinitas Women & Children's Health Center	332 Santa Fe Drive, Suite 150	Encinitas	CA
North County Health Services San Dieguito	629 Second St	Encinitas	CA
Neighborhood Healthcare - Pediatrics & Prenatal	426 N Date Street	Escondido	CA
Neighborhood Healthcare-Valley Parkway	728 East Valley Parkway	Escondido	CA
Escondido Family Medicine	255 North Ash Street, Suite 101	Escondido	CA
Escondido Community Clinic	460 North Elm	Escondido	CA
Ray M Dickinson Wellness Center	425 N Date Street	Escondido	CA

Facility Name	Address	City	State
Escondido Community Clinic	1001 East Grand Avenue	Escondido	CA
Centro Medico, Escondido	1121 East Washington Avenue	Escondido	CA
Fallbrook Family Health Center	1328 South Mission Road	Fallbrook	CA
Imperial Beach Health Center	949 Palm Avenue	Imperial Beach	CA
High Desert Family Medicine	44460 Old Hwy 80	Jacumba	CA
Julian Medical Clinic	2721 Washington Street	Julian	CA
Women's Health & Wellness Center	8851 Center Drive, Suite 210	La Mesa	CA
Neighborhood Healthcare Lakeside	10039 Vine Street Suite 2	Lakeside	CA
Lemon Grove Family Health Center	7592 Broadway	Lemon Grove	CA
La Maestra Community Health Center - Lemon Grove	7967 Broadway	Lemon Grove	CA
National City Family Clinic	1136 D Avenue	National City	CA
Paradise Hills Family Clinic	2400 East 8th St, Suite A	National City	CA
Granger School Based Health Center	2101 Granger Avenue, Suite 101a	National City	CA
Operation Samahan Health Clinic	2743 Highland Avenue	National City	CA
La Maestra Community Health Center - National City	217 Highland Ave	National City	CA
Operation Samahan Community Health Center	2835 Highland Avenue, Suite A	National City	CA
Oceanside - Carlsbad Community Clinic	605 Crouch Street, Bldg C	Oceanside	CA
Vista Community Clinic	4700 North River Road	Oceanside	CA
Vista Community Clinic - Horne Street	517 North Horne Street	Oceanside	CA
NCHS- Mission Mesa Pediatrics	2210 Mesa Drive, Suite 300	Oceanside	CA
North County Health Services - La Mision	3220 Mission Avenue #1	Oceanside	CA
NCHS Oceanside Carlsbad Health Center	605 Crouch Street, Bldg C	Oceanside	CA
NCHS Women's Health Services	2210 Mesa Drive, Suite 5 & 7 & 8	Oceanside	CA
Neighborhood Healthcare - Pauma Valley	166650 Highway 76	Pauma Valley	CA
Mountain Empire School Clinic	3291 Buckman Springs Road	Pine Valley	CA
NCHS Ramona Health Center	217 Earlham Street	Ramona	CA
Ramona Health Center	217 East Earlham	Ramona	CA

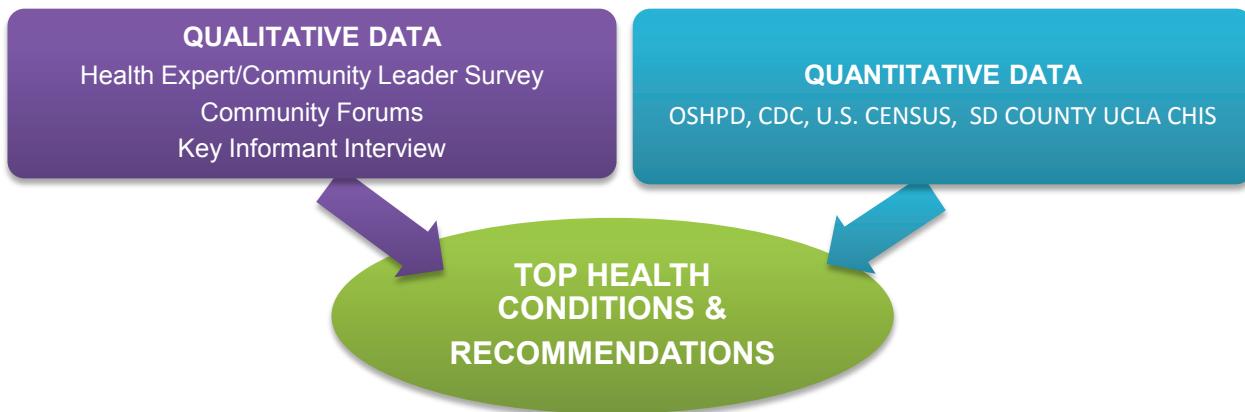
Facility Name	Address	City	State
Rancho Penasquitos Community Health Center	9955 Carmel Mountain Road, Suite F2	San Diego	CA
Comprehensive Health Center - Metro	3177 Oceanview Boulevard	San Diego	CA
Comprehensive Health Center - Euclid	286 Euclid Ave Suite 302	San Diego	CA
Mid-City Community Clinic-Pediatrics	4305 University Ave, Suite 150	San Diego	CA
Sherman Heights Family Health Center	2391 Island Avenue	San Diego	CA
La Maestra Community Health Center - City Heights	4060 Fairmount Avenue	San Diego	CA
Elm Street Family Health Center	140 Elm Street	San Diego	CA
King-Chavez Health Center	950 South Euclid Ave	San Diego	CA
Hillcrest Family Health Center	4094 4th Avenue	San Diego	CA
Kidcare Express II	823 Gateway Center Way	San Diego	CA
St Vincent De Paul Village Family Health Center	1501 Imperial Avenue	San Diego	CA
City Heights Family Health Center	5454 El Cajon Blvd	San Diego	CA
The Comprehensive Health Centers	446 26th Street, Suite 101	San Diego	CA
Beach Area Family Health Center	3705 Mission Blvd	San Diego	CA
Kidcare Express	823 Gateway Center Way	San Diego	CA
Pa'a School Based Health Center	4260 54th Street	San Diego	CA
Kidcare Express III (Mobile Medical Unit)	823 Gateway Center Way	San Diego	CA
Nestor Community Health Center	1016 Outer Road	San Diego	CA
Family Health Center on Commercial	2325 Commercial Street, Suite 1400	San Diego	CA
Operation Samahan Mira Mesa Outreach Clinic	10737 Camino Ruiz, Suite 235	San Diego	CA
Linda Vista Health Care Center	6973 Linda Vista Road	San Diego	CA
Beach Area Family Health Center-Annex	3690 Mission Blvd	San Diego	CA
San Diego American Indian Health Center	2630 First Avenue	San Diego	CA
Mid-City Community Clinic	4290 Polk Ave	San Diego	CA
North Park Family Health Center	3544 30th St	San Diego	CA
Downtown Family Health Centers At Connections	1250 6th Ave, Suite 100	San Diego	CA
25th Street Family Medicine	316 25th Street	San Diego	CA
Ibarra Family Health Center	4875 Polk Avenue	San Diego	CA

Facility Name	Address	City	State
Logan Heights Family Counseling Center	2204 National Avenue	San Diego	CA
San Ysidro Health Center	4004 Beyer Blvd	San Diego	CA
Diamond Neighborhoods Family Health Center	4725 Market Street	San Diego	CA
San Diego Children's Dental Clinic	8110 Birmingham Way	San Diego	CA
Logan Heights Family Health Center	1809 National Ave	San Diego	CA
North County Health Services	348 Rancheros Drive, #118	San Marcos	CA
North County Health Services	150 Valpreda Road	San Marcos	CA
North County Health Services - Grand Avenue Family	727 West San Marcos Blvd, Suite 112	San Marcos	CA
San Ysidro Senior Health Center	3364 Beyer Blvd, Ste 102 & 103	San Ysidro	CA
Maternal and Child Health Center	4050 Beyer Boulevard	San Ysidro	CA
Grossmont Spring Valley Family Health Center	8788 Jamacha Road	Spring Valley	CA
Indian Health Council, Inc.	50100 Golsh	Valley Center	CA
Vista Community Clinic - Grapevine	134 Grapevine Road	Vista	CA
Vista Community Clinic	981 Vale Terrace	Vista	CA

APPENDIX H: HASD&IC 2013 CHNA PROCESS AND FINDINGS

HASD&IC Community Health Needs Assessment Process Map

Phase 1 (August 2012 – May 2013)



When the results of all of the data and information gathered were combined, four conditions emerged clearly as the top community health needs in San Diego County:

Cardiovascular Disease

Diabetes (Type 2)

Mental/Behavioral Health

Obesity

Five broad categories of recommendations for hospitals to improve community health included:

Access to Care or Insurance

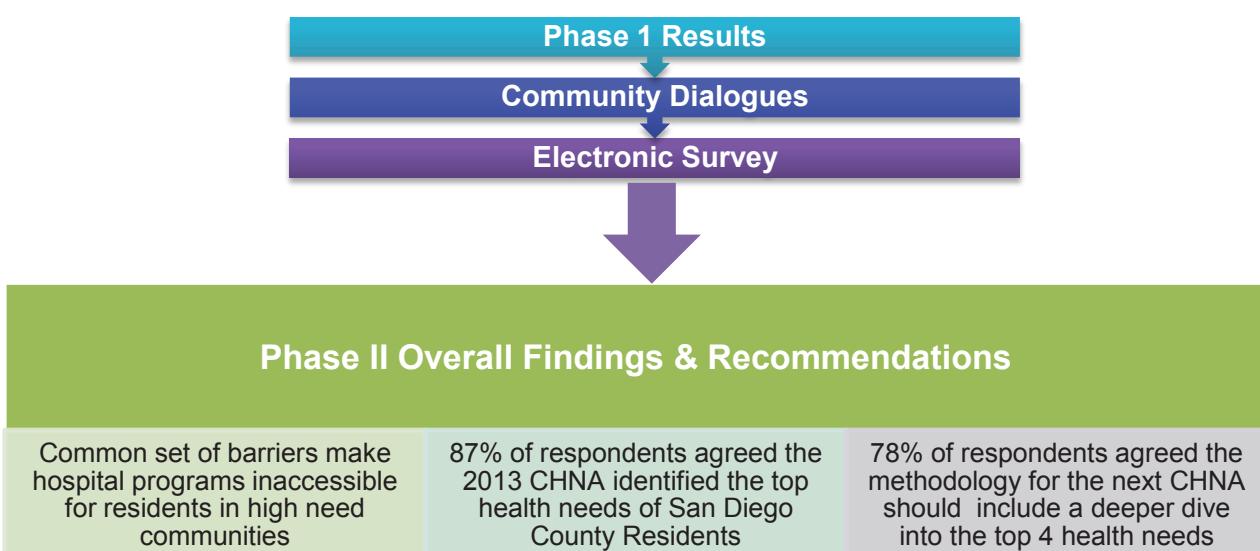
Care Management

Collaboration

Education

Screening Services

Phase 2 (January 2014 - September 2014)



APPENDIX I: OVERVIEW OF THE TOP 15 HEALTH NEEDS

Top 15 Health Conditions

Below are brief descriptions of the top 15 health conditions that were evaluated as part of the 2013 CHNA. After synthesizing information from various sources, the results demonstrated that cardiovascular disease, diabetes, obesity, and behavioral health were the top 4 priority health needs in San Diego County. During Phase 2 of the 2013 CHNA process, 87% of survey respondents agreed that these results reflected the top health needs of San Diego County residents, and 78% of respondents agreed there would be greater value in a 2016 CHNA that dove deeper into these conditions. For the 2016 CHNA process, consideration was given to both new, available data as well as the 2013 CHNA findings. Death, hospitalization, and emergency department data for San Diego County were assessed for the top 15 conditions to provide insight into recent trends.

Acute Respiratory Infections/Pneumonia¹ Influenza, also known as the “flu”, is a contagious respiratory illness caused by influenza viruses that infect the nose, throat, and lungs. It can cause mild to severe illness, and at times can lead to death. Complications of flu can include bacterial pneumonia (particularly for older and immunocompromised individuals), ear infections, sinus infections, dehydration, and worsening of chronic medical conditions, such as congestive heart failure, asthma, or diabetes. Clinical symptoms include fever, cough, sore throat, chills, muscle and body aches, and congestion.	Asthma² Asthma is a chronic breathing condition due to inflammation of the air passages in the lungs. Asthma affects the sensitivity of the nerve endings in the airways causing them to become easily irritated. During an asthma attack, the lining of these passages swell causing the airways to narrow thereby reducing the flow of air in and out of the lungs. Asthma attacks can range in severity from mild to life-threatening. Clinical symptoms include coughing, shortness of breath, wheezing, and tightness or pain in the chest.
Breast Cancer³ Breast Cancer is defined as any cancerous growth that inhabits the tissues in the breast. In this type of cancer, the cells in the breast region grow abnormally and in an uncontrolled way. Though Breast Cancer is mostly found in women, in rare cases it is also found in men. Except for skin cancer, breast cancer is the most common cancer in American women. Risk factors include being a woman, getting older, having a family history of breast cancer, having first menstrual period at a younger age, and starting menopause later.	Colorectal Cancer^{4,5} National Cancer Institute (NCI) defines Colorectal Cancer as any cancer “that forms in the tissues of the colon or rectum.” Most Colon Cancers are adenocarcinomas (cancers that begin in cells that make and release mucus and other fluids). Of cancers that affect both men and women, Colorectal Cancer is the second leading cause of cancer-related deaths in the United States. Colorectal Cancer also is one of the most commonly diagnosed cancers in the United States; among all men and women it is the third most common cancer in the U.S. today. Clinical symptoms include blood in/on the stool, persistent cramping, pains, and aching in the stomach, and unexplained weight-loss.
Dementia and Alzheimer’s Disease⁶ Dementia is a clinical syndrome of decline in memory and other thinking abilities. It is caused by various diseases and conditions that result in damage to brain cells and lead to distinct symptom patterns and distinguishing brain abnormalities. Alzheimer’s Disease (AD) is a progressive brain disorder that gradually destroys a person’s memory and ability to learn, reason, make judgments, communicate and carry out daily activities such as bathing and eating.	High Risk Pregnancy⁷ High Risk Pregnancy can be the result of a medical condition present before pregnancy or a medical condition that develops during pregnancy for either mom or baby and causes the pregnancy to become high risk. A high risk pregnancy can pose problems before, during or after delivery and might require special monitoring throughout the pregnancy.
Lung Cancer^{8,9} Lung Cancer is the leading cause of cancer death and the second most diagnosed cancer in both men and women in the United States. Lung Cancers usually are grouped into two main types called small cell and non-small cell. These types of Lung Cancer progress in different manners, and therefore require different courses of treatment. Non-small cell lung cancer is more common than small cell lung cancer. Clinical symptoms can include chest pain, shortness of breath, wheezing, coughing up blood, constant	Prostate Cancer^{10,11} National Cancer Institute (NCI) defines Prostate Cancer as a cancer that forms in tissues of the prostate, a gland in the male reproductive system found below the bladder and in front of the rectum. While cancerous cells within the prostate itself are generally not deadly on their own, as a cancerous tumor grows some of the cells can break off and spread to other parts of the body through the lymph or the blood. Prostate Cancer usually occurs in older men. Clinical symptoms include difficulty starting

<p>fatigue, unexplained weight loss, and coughing that progressively worsens and does not subside.</p>	<p>urination, weak/interrupted flow of urine, pain/burning during urination, frequent urination, blood in urine or semen, and unspecified pain in the back, hips or pelvis.</p>
<p>Skin Cancer¹²</p> <p>Skin Cancer is a cancer that forms in the various tissues of the skin, and is the most common form of cancer in the United States. The two most prevalent types of Skin Cancer—basal cell (forms in the lower part of the epidermis) and squamous cell (forms in the flat cells that form the surface of the skin) carcinomas—are highly curable. However, the third most common Skin Cancer, melanoma, forms in the cells that make the pigment melanin and are considered more dangerous. About 65%–90% of melanomas are caused by exposure to ultraviolet (UV) light. Clinical symptoms include moles that are asymmetrical, have irregular borders, uneven coloration, experience increases in diameter, or have evolved or changed in recent weeks or months.</p>	<p>Unintentional Injury¹³</p> <p>An injury is defined as “a body lesion at the organic level, resulting from an acute exposure to energy mechanical, thermal, electrical, chemical or radiant) in amounts that exceed the threshold of physiological tolerance. In some cases (e.g. drowning, strangulation, freezing), the injury results from an insufficiency of a vital element.” The most basic classification of injury is whether the injury was intentional or unintentional. Unintentional injury can be characterized by unintended events that cause injury.</p>
<p>Mental/Behavioral Health^{14,15}</p> <p>Mental Health is 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.”</p>	<p>Overweight/Obesity^{16,17}</p> <p>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. 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.</p>
<p>Cardiovascular Disease^{18,19}</p> <p>The World Health Organization defines cardiovascular disease (CVD) as a group of disorders of the heart and blood vessels that include coronary heart disease, cerebrovascular disease, peripheral arterial disease, rheumatic heart disease, congenital heart disease, deep vein thrombosis and pulmonary embolism. Coronary Heart Disease is the most common form of Heart Disease. High blood pressure, high cholesterol, and smoking are all risk factors that could lead to CVD and stroke. About half of Americans (49%) have at least one of these three risk factors.</p>	<p>Type 2 Diabetes²⁰</p> <p>Type 2 diabetes, once known as adult-onset or noninsulin-dependent diabetes, is a chronic condition that affects the way your body metabolizes sugar (glucose), which is your body's main source of fuel. With type 2 diabetes, the body either resists the effects of insulin — a hormone that regulates the movement of sugar into your cells — or does not produce enough insulin to maintain a normal glucose level. If left untreated, type 2 diabetes can be life-threatening. Clinical symptoms can include: frequent urination, excessive thirst, extreme hunger, sudden vision changes, unexplained weight loss, extreme fatigue, sores that are slow to heal, and increased number of infections.</p>
<p>Back Pain²¹</p> <p>Most people in the United States will experience lower back pain at least once during their lives. Back pain is one of the most common reasons people go to the doctor or miss work. Some causes of back pain include muscle or ligament strain, bulging or ruptured disks, arthritis, skeletal irregularities and osteoporosis.</p>	

Selected San Diego County Health Measures for the Top 15 Health Conditions Identified in the 2013 CHNA^{1,2,3,22}

		Deaths		Hospitalizations		Emergency Department	
		No.	Rate	No.	Rate	No.	Rate
1 Acute Respiratory Infections/ Pneumonia							
	Influenza	303*	8.9*	199	6.4	1,233	38.8
	Pneumonia	303*	8.9*	5,423	172.6	5,630	173.2
2 Asthma							
3 Breast Cancer							
4 Colorectal Cancer							
5 Dementia and Alzheimer's Disease							
	Alzheimer's Disease	1,163	33.9	535	17.3	206	6.6
	Dementia	820	23.5	131	4.2	23	0.7
6 High Risk Pregnancy							
	Maternal Complications	-	-	5,014	319.9	2,399	153
7 Lung Cancer							
8 Prostate Cancer							
9 Skin Cancer							
10 Unintentional Injury							
11 Mental/Behavioral Health							
	Anxiety Disorders	-	-	550	17.1	8,117	252.7
	Mood Disorders	-	-	10,755	334.7	5,380	166.8
	Acute Substance-Related Disorders	-	-	1,124	34.3	2,417	73.5
12 Obesity ^							
13 Cardiovascular Disease							
	Coronary Heart Disease	3,248	99.3	7,555	238.3	1,125	35.4
	Stroke	1,003	30.3	6,725	212.3	1,789	56.9
14 Diabetes							
15 Back Pain							
^San Diego County age-adjusted rates per 100,000 U.S. Standard Population							
^Based on 2012 data from the County of San Diego HHSA Community Profile Reports							
^Data unavailable for certain categories, denoted by "-".							
* Includes deaths from Pneumonia and Influenza combined							
^ No ICD-9 codes were reviewed for this condition on the County's Community Profile Report							

Deaths are categorized only by the disease or injury that initiated the chain of events leading to death and not by the immediate cause or any other contributing causes. Hospital Discharge and Emergency Department Discharge data is reported by the primary diagnosis at time of discharge for which the medical encounter occurred.

Influenza: ICD-9 codes 487-488; ICD-10 codes J10-J11. Death, Hospital, Emergency Department.

Pneumonia: ICD-9 codes 480-486; ICD-10 codes J12-J18. Death, Hospital, Emergency Department.

Asthma: ICD-9 code 493; ICD-10 codes J45-J46. Death, Hospital, Emergency Department.

Female Breast Cancer: ICD-10 code C50. Death.

Colorectal Cancer: cancer of the colon, rectum or anus, ICD-10 codes C18-C21. Death.

Alzheimer's Disease: ICD-9 code 331; ICD-10 code G30. Death, Hospital, Emergency Department.

Dementia: ICD-9 code 290; ICD-10 codes F10, F03. Death, Hospital, Emergency Department.

Maternal Complications: ICD-9 codes 641, 642.0-642.7, 642.9, 643.2, 646.2, 646.6, 646.7, 648.0, 648.5, 648.6, 648.8, 658.4, 659.2, 659.3, 664.2, 664.3, 664.5, 665.0-665.9, 666, 668, 669.0-669.4, 670, 671.3-671.5, 672, 673, 674.0-674.54, 674.8-674.9. Hospital, Emergency Department.

Lung Cancer: cancer of the trachea, bronchus or lung, ICD-10 codes C33-C34. Death.

Prostate Cancer: ICD-10 code C61. Death.

Unintentional Injury: ICD-9 Ecodes E800-E869, E880-E929; ICD-10 codes V01-X59, Y85-Y86. This generalized unintentional injury may overlap with specific indicators below, such as drowning, smoke/fire, suffocation, falls, motor vehicle or pedestrian deaths, as well as the unintentional portion of overdose/poisoning and firearm injuries. Death, Hospital, Emergency Department.

Anxiety Disorders: ICD-9 codes 293.84, 300, 308, 309.81, 313.00-313.22, 313.3, 313.83-313.84. Hospital, Emergency Department.

Mood Disorders: ICD-9 codes 293.83, 296, 300.4, 311. Hospital, Emergency Department.

Acute Substance-Related Disorders: ICD-9 codes 292, 305.2-305.9. Hospital, Emergency Department.

Coronary Heart Disease: ischemic and hypertensive heart disease, ICD-9 codes 402, 410-414, 429.2; ICD-10 codes I11, I20-I25. Death, Hospital, Emergency Department.
Diabetes: diabetes mellitus, includes insulin-dependent and non-insulin dependent diabetes, ICD-9 code 250; ICD-10 codes E10-E14. Death, Hospital, Emergency Department.
Dorsopathy: ICD-9 codes 720-724. Hospital, Emergency Department.

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APPENDIX J: DATA SUMMARY TABLES

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

	San Diego County, California	California	United States
Total Population^a	3,138,265	37,659,180	311,536,591
Percent Population Change, 2000-2010^b	10%	9.99%	9.74%
Median Age^a	34.8	35.4	37.3
Percent Male^a	50.22%	49.73%	49.19%
Percent Female^a	49.78%	50.27%	50.81%
Percent Population in Poverty^a	14.45%	15.94%	15.37%
Percent Uninsured^c	12.3%	12.4%	11.7%
Percent Population with Less than a High School Diploma^a	14.52%	18.76%	13.98%
Percent Limited English Proficiency^a	16.25%	19.35%	8.63%
Percent Linguistically Isolated^a	8.50%	9.90%	4.76%
Unemployment Rate^d	7.1	8.3	6.8
Percent Occupied Housing Units with One or More Substandard Conditions^a	48.10%	48.37%	36.11%

^aData Source: U.S. Census Bureau, American Community Survey. 2009-2013.

^bData Source: U.S. Census Bureau, Decennial Census. 2000-2010.

^cData Source: U.S. Census Bureau, American Community Surveys, 2014.

^dData Source: U.S. Department of Labor, Bureau of Labor Statistics. July 2015.

Access to Health Care Summary

	San Diego County, California	California	United States
Rate of Federally Qualified Health Centers (per 100,000)^a	2.97	2.1	2.18
Primary Care Provider Rate (per 100,000)^b	77.5	77.2	74.5
Percent of Population Living in a Primary Care HPSA^c	15.37%	25.18%	34.07%
Preventable (ACS) Condition Hospital Discharges, Rate (Per 10,000)^d	74.18	83.17	NA

^aData Source: U.S. Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File. June 2014.

^bData Source: U.S. Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2012.

^cData Source: U.S. Department of Health & Human Services, Health Resources and Services Administration, Health Professional Shortage Areas. March 2015.

^dData Source: California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2011.

Health Behaviors Summary

	San Diego County, California	California	United States
Percent Adults with Inadequate Fruit / Vegetable Consumption^a	70.50%	71.50%	75.70%
Percentage of Youth Reporting Inadequate Fruit/Vegetable Consumption^b	48.30%	47.40%	NA
Percent Adult Population with no Leisure Time Physical Activity^c	14.90%	16.60%	22.60%
Percent Physically Inactive (Youth)^d	29.35%	35.92%	NA
Estimated Adults Drinking Excessively (Age-Adjusted)^e	17.20%	17.20%	16.90%
Percent Population Smoking Cigarettes (Age-Adjusted)^e	12.10%	12.80%	18.10%

^aData Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. U.S. Department of Health & Human Services, Health Indicators Warehouse. 2005-2009.

^bData Source: University of California Center for Health Policy Research, California Health Interview Survey. 2011-2012.

^cData Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012.

^dData Source: California Department of Education, FITNESSGRAM®; Physical Fitness Testing. 2013-2014.

^eData Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. U.S. Department of Health & Human Services, Health Indicators Warehouse. 2006-2012.

Physical Environment Summary

	San Diego County, California	California	United States
Percentage of Days Exceeding Ozone Standards, Pop. Adjusted Average^a	0.77%	2.47%	0.47%
Fast Food Establishment Rate per 100,000 Population^b	81.93	74.51	71.97
Grocery Store Establishment Rate per 100,000 Population^b	20.06	21.51	21.14
Percent Population with Low Food Access^c	15.76%	14.31%	23.61%
Liquor Store Establishment Rate per 100,000 Population^d	11.34	10.02	10.35
HUD-Assisted Units, Rate per 10,000 housing units^e	365.01	1,399.04	1,468.19
% of Cost Burdened Households (over 30% income)^f	46.98%	45.89%	35.47%
% Occupied Housing Units with One or More Substandard Conditions^f	48.10%	48.37%	36.11%
Age-Adjusted Pedestrian Death Rate (per 100,000 Pop.)^g	1.65	1.97	NA

^aData Source: Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network. 2008.

^bData Source: U.S. Census Bureau, County Business Patterns. 2011.

^cData Source: U.S. Department of Agriculture, Economic Research Service, USDA – Food Access Research Atlas. 2010.

^dData Source: U.S. Census Bureau, County Business Patterns. 2012.

^eData Source: U.S. Department of Housing and Urban Development. 2013.

^fData Source: U.S. Census Bureau, American Community Survey. 2009-2013.

^gData Source: California Department of Public Health, CDPH – Death Public Use Data. University of Missouri, Center for Applied Research and Environmental Systems. 2010-2012.

Health Indicators for Top Four Health Needs

	San Diego County, California	California	United States
Population with Diagnosed Diabetes Age-Adjusted Rate^a	7.20%	8.05%	9.11%
Diabetes Age-Adjusted Discharge Rate (per 10,000)^b	8.96	10.4	NA
Percentage with Heart Disease^c	5.80%	6.30%	NA
Ischemic Heart Disease Age-Adjusted Death Rate (per 100,000)^d	148.27	163.18	NA
Stroke Age-Adjusted Death Rate (per 100,000)^d	32.8	37.38	NA
Suicide Mortality, Age-Adjusted Rate (per 100,000)^d	11.79	10.24	11.82
Poor Mental Health^c	12.75%	14.3%	NA
Percent Adults Overweight^e	36.28%	35.85%	35.78%
Percent Adults with BMI > 30.0 (Obese)^a	20.10%	22.32%	27.14%
Percent Youth Overweight^{f**}	17.74%	19.30%	NA
Percent Youth Obese^{f**}	15.89%	18.99%	NA

^aData Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012.

^bData Source: California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2011.

^cData Source: University of California Center for Health Policy Research, California Health Interview Survey. 2011-2012.

^dData Source: California Department of Public Health, CDPH – Death Public Use Data. University of Missouri, Center for Applied Research and Environmental Systems. 2010-2012.

^eData Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2011-2012.

^fData Source: California Department of Education, FITNESSGRAM®; Physical Fitness Testing. 2013-2014.

** The thresholds for youth overweight and obese are based on the CDC's BMI-for-age growth charts, which define an individual as overweight when his or her weight is between the "85th to less than the 95th percentile".

San Diego Indicators Not Reaching HP2020 Targets

	Annual Breast Cancer Incidence Rate ^{a*}	Annual Cervical Cancer Incidence Rate ^{a*}	Annual Colon and Rectum Cancer Incidence Rate ^{b*}	Cancer Mortality Rate ^{c*}	Ischemic Heart Disease Mortality Rate ^{c*}	Pedestrian Accident Death Rate ^{c*}	Suicide Mortality Rate ^{c*}
San Diego County, CA	129.7	7.5	38.2	161.64	148.27	1.65	11.29
California	122.4	7.8	40.0	157.1	163.18	1.97	9.8
United States	122.7	7.8	41.9	NA	NA	NA	NA
HP 2020 Target	<= 40.9	<= 7.1	<= 38.7	<= 160.6	<=100.8	<= 1.3	<= 10.2

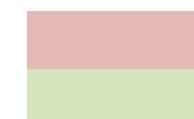
^aAge-Adjusted to 2000 Standard U.S. Population, Rate per 100,000 Population

^bData Source: State Cancer Profiles. National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. 2008-2011.

^cData Source: State Cancer Profiles. National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. 2008-2011.

^cData Source: California Department of Public Health, CDPH – Death Public Use Data. University of Missouri, Center for Applied Research and Environmental Systems. 2010-2012.

California Health Interview Survey (CHIS) Questions and Key Health Topics Based on 2011-2012 Data								
Health Profiles	North Coastal	North Central	Central	South	East	North Inland	Overall	CA State
Demographics								
Age 18-64	84.6%	83.4%	89.6%	86.6%	85.3%	80.2%	84.7%	84.2%
Age 65 and over	15.4%	16.6%	10.4%	13.4%	14.7%	19.8%	15.3%	15.8%
White	60.4%	58.2%	29.2%	21.3%	62.7%	67.1%	51.4%	43.5%
Latino	27.2%	16.6%	35.8%	61.0%	23.7%	21.2%	29.4%	34.2%
Asian	8.0%	16.7%	16.9%	11.4%	7.4%	6.1%	11.1%	13.9%
Black	2.5%	6.2%	13.3%	3.8%	3.3%	1.6%	5.0%	5.6%
Other race	2.0%	2.3%	4.8%	2.5%	2.9%	4.1%	3.1%	2.8%
Adults with income <200% FPL	30.5%	23.2%	46.0%	39.9%	31.6%	27.6%	32.4%	35.9%
Access and Utilization								
Uninsured all or part year (age 18-64)	28.8%	16.1%	33.9%	34.1%	23.6%	27.5%	26.9%	26.6%
Employment-based insurance, all year (18-64)	54.6%	61.2%	42.4%	50.1%	60.1%	56.5%	54.5%	50.6%*
Medi-Cal or Healthy Families, all year (18-64)	5.2%	5.3%	12.0%	8.5%	7.7%	5.8%	7.3%	11.6%*
Other coverage, all year (age 18-64)	11.4%	17.4%	11.7%	7.3%	8.7%	10.2%	11.4%	11.3%
No usual source of health care	15.9%	12.1%	20.9%	15.7%	13.9%	13.1%	15.1%*	17.6%*
Delayed getting prescription drugs or medical service	21.7%	22.6%	25.0%	25.2%	22.2%	21.8%	22.9%	21.5%
Health Outcomes								
Serious psychological distress in the past year	6.4%	7.9%	9.2%	9.0%	8.6%	5.8%	7.7%	7.9%
Fair or poor health (age-adjusted)	14.9%	9.7%	17.7%	21.8%	14.6%	13.6%	14.9%*	19.4%*
Current asthma	5.2%	5.0%	8.2%	5.7%	5.9%	7.4%	6.2%	7.7%*
Ever diagnosed with diabetes	6.3%	7.2%	8.7%	11.0%	8.5%	6.4%	7.9%	8.4%
Obese	17.5%	16.6%	23.7%	26.6%	26.8%	22.9%	22.1%	24.8%*
Ever diagnosed with high blood pressure	21.7%	23.0%	19.8%	31.5%	28.7%	30.1%	25.8%	27.3%

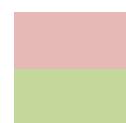


statistically significant difference between HHSA region and SD County



statistically significant difference between SD County and State

Health Profiles	<i>North Coastal</i>	<i>North Central</i>	<i>Central</i>	<i>South</i>	<i>East</i>	<i>North Inland</i>	<i>Overall</i>	<i>CA State</i>
Health Behaviors								
Engaged in regular walking in the past week	37.3%	32.7%	34.2%	33.9%	36.8%	32.9%	34.5%	33.3%
Ate fruits and vegetables 3 or more times yesterday	36.1%	31.2%	25.9%	30.5%	32.0%	28.3%	30.6%	27.2%*
Current Smoker	12.4%	10.3%	16.6%	11.0%	14.6%	14.1%	13.1%	13.8%
Binge drinking	31.7%	34.8%	38.3%	32.7%	36.0%	35.8%	34.9%	31.1%*
Other Factors								
Food insecure	13.1%	8.2%	21.9%	13.7%	13.7%	10.5%	13.2%	14.9%
Limited English proficiency	20.3%	11.7%	29.5%	37.7%	16.0%	18.0%	21.3%*	26.9%*



statistically significant difference between HHSA region and SD County

statistically significant difference between SD County and State

APPENDIX K: VULNERABLE POPULATIONS REPORT

Vulnerable Populations

Institute for Public Health, SDSU
Hospital Association of San Diego & Imperial Counties

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Vulnerable Populations

According to the 2013 CDC Health Disparities and Inequities Report, “health disparities and inequalities are gaps in health or health determinants between segments of the population.” In particular the CDC’s Office of Minority Health & Health Equity highlights ‘Racial and Ethnic Minorities’ and ‘Other At-Risk/Vulnerable Populations’ including those defined by age and risk status related to sex and gender as potentially vulnerable populations. Using these guidelines and recommendations from the community about specific populations to include, reports were compiled to provide a more in-depth understanding of the following populations: Children, Seniors, Asian American/Native Hawaiian and Other Pacific Islander, American Indians/Alaskan Natives, Latinos, African Americans, Homeless, LGBTQ, and Refugees.

Children

The Life Course Perspective emphasizes the importance of looking at health across the lifespan rather than as distinct, disconnected stages. This is due to the complex interplay of biological, behavioral, psychological, social, and environmental factors that contribute to health outcomes across the course of a person’s life. Evidence of the connection between childhood and adulthood as it relates to health status has become increasingly clear. In a large San Diego study of Adverse Childhood Events (ACE), greater exposure to abuse or household dysfunction during childhood was linked to an increase in risk factors for several leading causes of illness such as heart disease, substance abuse, obesity and depression.

Chronic Conditions

Many trends in childhood predict future health status in adulthood. For example, reports show that 80% of children who are overweight at ages 10-15 were obese by the age of 25 and at an increased risk of high blood pressure, high cholesterol, and type 2 diabetes. In San Diego, a lower proportion of school age students 5th, 7th, and 9th grade were at high risk/obese compared to California. Childhood poverty is also associated with adverse conditions in adulthood including chronic stress and mental health conditions, obesity, heart disease, and increases in hospitalizations. Poor children are disproportionately exposed to inadequate nutrition, child abuse and neglect, trauma, parental depression or substance abuse, and violence. Furthermore, teens in poor families are more likely to engage in risky behaviors such as smoking and alcohol and drug abuse. In a recent issue brief released by the California Budget & Policy Center, researchers found that while children only make up about a quarter of the Californian population, roughly 32.7% are in deep poverty. Furthermore, studies have found that being born into poverty more than doubles a child’s chance of having a lower income as an adult. According to the 2013 San Diego Report Card on Children and Families, there is a worsening trend for the percentage of children 0-17 living in poverty. Recognizing disparities such as these and how they contribute to poor health is an important first step to addressing the needs of vulnerable populations in the San Diego community.

Mental/Behavioral Health

The life course of unmet mental health needs from childhood to adulthood has a significant impact on the individual, family and society as a whole. Focusing on mental and behavioral health issues in children and youth is particularly important because it is estimated that half of all lifetime cases of mental disorders begin by age 14 and three-quarters by age 24. Early identification and intervention has the potential to improve both short and long term health outcomes.

Table 1. Selected Indicators from 2013 San Diego County Report Card on Children & Families

	Trend	San Diego	California
% of mothers who initiate breast feeding		95.2	92.3
Ages 6-12 (School Age)			
% of children ages 2-11 who have never visited a dentist		6.5	10.3
% of students not in the Healthy Fitness Zone (at high risk/obese)			
Grade 5		30.7	33.7
Grade 7		27.2	30.1
Grade 9		23.1	26.2
Ages 13-18 (Adolescents)			
% of students who report using cigarettes in the past 30 days			
Grade 7		4.5	NA
Grade 9		7.6	NA
Grade 11		9.8	NA
% of students who report using alcohol in the past 30 days			
Grade 7		10.8	NA
Grade 9		18.8	NA
Grade 11		27.5	NA
% of students who report using marijuana in the past 30 days			
Grade 7		7.1	NA
Grade 9		14.3	NA
Grade 11		19.3	NA
% of male students (grades 9-12) who report they attempted suicide in the previous 12 months	NA	6.5	NA
% of female students (grades 9-12) who report they attempted suicide in the previous 12 months	NA	10.1	NA
Community and Family (Cross Age)			
% of children ages 0-17 living in poverty		19.8	23.8
# of eligible children receiving Food Stamps		135,487	NA
% of children ages 0-17 without health coverage		6.3	4.2
Rate of domestic violence reports per 1,000 households		15	12.5
Rate of substantiated cases of child abuse and neglect per 1,000 children ages 0-17		7.6	8.9
Adult Indicators			
% of adults 18 or older that are obese		22.1	24.8
% of adults 18 or older that reported smoking		12.8	13.6
% of adults 18 -64 living in poverty		14.3	15.6

*The Children's Initiative San Diego County Report Card on Children and Families 2013 Edition. www.thechildrensinitiative.org

*NA refers to Not Available

FOOTNOTE

Fine, Amy, Kotelchuck, Milton, Adess, Nancy, & Pies, Cheri. (2009). A New Agenda for MCH Policy and Programs: Integrating a Life Course Perspective. http://cchealth.org/lifecourse/pdf/2009_10_policy_brief.pdf

Felitti, Vincent J et al. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults, American Journal of Preventive Medicine, 14 (4), 245 – 258.

Alissa Anderson. (2015). Five Facts Everyone Should Know About Deep Poverty. California Budget & Policy Center. http://calbudgetcenter.org/wp-content/uploads/Five-Facts-Everyone-Should-Know-About-Deep-Poverty_Issue-Brief_06.05.2015.pdf

The Children's Initiative. (2013). San Diego County Report Card on Children & Families. www.thechildrensinitiative.org

Seniors

The following data is from the 2015 San Diego County Senior Health Report and provides information on the senior population in San Diego County. As significant users of the health system, it is important to understand the demographic composition of the senior population and forecast potential changes in utilization.

Seniors age 65 and older (65+) represented approximately 12% (374,535) of the San Diego population in 2012 according to SANDAG population estimates. This percent is expected to almost double by 2030 to 23%. The racial and ethnic composition of this group is also anticipated to change. Currently 69.4% of seniors are white followed by Hispanic (16.0%), Asian/Pacific Islander (10.3%), black (2.8%) and Other/2+ (1.6%). By 2030, the demographic composition of seniors is projected to be 55.7% white, 22.9% Hispanic, 13.5% Asian/Pacific Islander, 4.3% black, and 3.7% Other/2+ races. Of those aged 65 and older, a significant percentage (23.8%) are Veterans.

It is also important to understand the current burden of disease. Overall, a greater percentage of San Diego seniors compared to California overall reported their health status as good or better for all age groups 55 and older. More specifically, 79.4% of San Diego residents 65 years or older reported being in good to excellent health compared to just 72.6% in California. Similarly, a smaller percentage (48.0%) reported having a physical, mental or emotional disability compared to the state overall (51.9%). To better understand morbidity and mortality, Table 2. describes the leading causes of death by age in San Diego County, followed by a more detailed description of how the top four health needs affect seniors.

Table 2. Top Five Leading Causes of Death by Number of Death Due to Disease, San Diego County, 2012*

Rank	55-64 Years	65-75 Years	75-84 Years	85+ Years
1	Cancer	Cancer	Cancer	Diseases of the Heart
2	Diseases of the Heart	Diseases of the Heart	Diseases of the Heart	Cancer
3	Unintentional Injury	Chronic Lower Respiratory Diseases	Chronic Lower Respiratory Diseases	Alzheimer's
4	Chronic Liver Disease & Cirrhosis	Diabetes	Alzheimer's Disease	Stroke
5	Diabetes	Stroke	Stroke	Chronic Lower Respiratory Diseases

*Adapted from the 2015 San Diego County Senior Health Report; Source: Death Statistical Master Files (CDPH), County of San Diego, Health & Human Services Agency, Epidemiology & Immunization Services Branch; SANDAG, Current Population Estimates, 2012.

Behavioral Health

According to 2012 CHIS data, 15.0% of individuals age 55-64 and 8.1% of individuals age 65 and older reported needing help for an emotional/mental health problem or for use of alcohol/drugs in San Diego County.

Approximately a third of seniors 65 and older who reported needing help sought support from a professional for their problems.

Mental Health

Rates of anxiety disorder, mood disorders, schizophrenia and other psychotic disorders, and self-inflicted injury were consistently highest among those age 55-64 compared to those 65+ in both ED and Inpatient settings in 2012. Among those 65+, rates of anxiety-related discharges were highest living in South in 2012. Mood disorder discharge rates were highest among those 65+ in Central, for both ED and Inpatient hospitalization. Central and East region had the highest ED and hospitalization rates for Schizophrenia and other psychotic disorders and North Inland experienced the highest rates of suicide and self-inflicted injury.

Substance Abuse

A higher percentage of San Diego seniors reported binge drinking (defined as 5 or more drinks for men or 4 or more drinks for women) in the past year compared to California overall (12.8% vs 9.3%). Similarly, a slightly higher percentage of San Diego seniors reported smoking than in California (8.6% vs. 6.5%) but this is still under the HP2020 goal of less than 12%. In San Diego County, a higher rate of acute alcohol-related discharges were found among those 55-64 compared to those 65+. Of those 65 years or older, the highest rate of hospitalization and ED discharges was seen in Central. ED discharges for acute substance-related disorder were highest among 55-64 year olds, but hospitalization was highest among those 85 years or older.

Diabetes

In 2012, approximately 14.3% of seniors reported having ever been told they have pre-diabetes or borderline diabetes. It is estimated that roughly 15-30% of individuals with pre-diabetes will progress to type 2 diabetes within 5 years. A further 16.0% reported that they have diabetes according to 2012 CHIS data. Deaths due to diabetes were highest among those 85+, whereas hospitalization and ED discharge rates were highest for those 75-84 years old in 2012. In particular, Central and South region demonstrated a greater burden of diabetes-related deaths and discharges.

Overweight/Obesity

Among those 65 and older in 2012, roughly 37% were overweight and 19% were obese.

Cardiovascular Disease

Diseases of the heart have been shown to be the leading cause of death among those 65 and older and put a significant burden on the health system. Rates of hospitalization and death due to Coronary Heart Disease were found to increase with age. Regionally, rates of hospitalization for CHD were found to be highest in South. Similarly, rates of stroke, another form of cardiovascular disease, were also found to increase with age, particularly among those 85+, and also had higher hospitalization rates in South. According to 2012 CHIS data, 60.7% of adults 65 years or older reported having ever been told they had high blood pressure, a significant risk factor for health outcomes such as heart attack and stroke.

Additional Barriers to Care

Poverty is a significant barrier to care. In 2012, roughly 18.9% of seniors estimated to be living at 149% or below the federal poverty level. In 2012, the ACS found that 19.2% of seniors spoke English less than “very well” and the anticipated demographic shift has implications for future demand for a diverse, culturally competent workforce. Seniors also face increased social isolation and physical limitations that may contribute to poorer health outcomes.

FOOTNOTE

County of San Diego HHSA. (2015). San Diego County Senior Health Report. Retrieved from
http://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/CHS/COSD_SeniorHealthReport_2015.pdf

Asian American and Native Hawaiian and Other Pacific Islander

According to the 2010 Census, approximately 5.6% (17.3 million) of the U.S. population identified as “Asian alone” or “Asian in combination.” An overwhelming thirty-two percent of this population reported living in California. The Native Hawaiian and other Pacific Islander (NHPI) population accounted for an additional 0.4% (1.2 million) of the U.S. population. San Diego ranked 5th among U.S. counties with the highest number of Asian individuals and also had the 5th highest number of NHPIs. As a percentage of San Diego County’s population, Asians represented roughly 13% and NHPI represented 1% in 2010. Furthermore, Asian Americans were the fastest growing racial group and NHPI were the third fastest from 2000 to 2010 in the county. Finally, within the Asian American population, Filipino Americans made up the largest ethnic group, followed by Chinese and Vietnamese, and the Bangladeshi ethnic group was the fastest growing from 2000 to 2010. There exists a significant amount of variation within these groups, including language, culture, immigration patterns, spirituality, acculturation, education level, and socioeconomic status. To better understand morbidity and mortality, Table 3. describes the leading causes of death by ethnic group in San Diego County, followed by a more detailed description of how the top four health needs affect the AANHPI population.

Table 3. Leading Causes of Death by Race and Ethnic Group, San Diego County 2005-2010

Race and Ethnic Group	Leading Causes of Death		
	No. 1 Cause % of Total for Group	No. 2 Cause % of Total for Group	No. 3 Cause % of Total for Group
Asian American	Cancer 30%	Heart Disease 23%	Stroke 9%
Cambodian	Heart Disease 29%	Cancer 21%	Stroke 12%
Chinese	Cancer 31%	Heart Disease 21%	Stroke 9%
Filipino	Cancer 27%	Heart Disease 25%	Stroke 8%
Indian	Heart Disease 32%	Cancer 22%	Diabetes 7%
Japanese	Cancer 30%	Heart Disease 20%	Stroke 9%
Korean	Cancer 34%	Heart Disease 14%	Stroke 9%
Laotian	Cancer 31%	Heart Disease 17%	Stroke 9%
Vietnamese	Cancer 36%	Heart Disease 17%	Stroke 9%
NHPI	Heart Disease 28%	Cancer 21%	Diabetes 8%
Guamanian or Chamorro	Heart Disease 28%	Cancer 20%	Diabetes 8%
Native Hawaiian	Heart Disease 29%	Cancer 25%	Accidents 7%
Samoan	Heart Disease 25%	Cancer 19%	Diabetes 8%
Total Population	Heart Disease 25%	Cancer 25%	Stroke 6%

*Adapted from the ‘A Community of Contrasts: Asian Americans, Native Hawaiians and Pacific Islanders in San Diego County,’ 2015 Report; Source: California Department of Public Health Death Public Use Files 2005–2010. Note: Chinese figures include Taiwanese

Behavioral Health

According to the Asian Pacific Islander California Reducing Disparities (CRD) Population Report, there exists a significant amount of variation in the rates of behavioral health needs among different ethnic groups. While data finds that typically prevalence of mental illness and service utilization are low among Asians, literature cited

in the CRP report found that suicidal Asian Americans perceived less need for help and sought less services compared to Latinos, Asian and Pacific Islander youth had similar rates of emotional disturbance to the total population, Asian and Pacific Islander women over 65 years of age consistently had the highest suicide rates, and NHPI adults had the highest rate of depressive disorders and second highest rate of anxiety disorders among all racial groups. In San Diego, the 2012 County of San Diego 'Progress towards Reducing Disparities: A Report for San Diego County Mental Health' report found that the most common mental health disorders diagnosed among Asian American and NHPI adults were major depression disorders and schizophrenia/schizoaffective disorders.

Aggregated data, stigma, language barriers, lack of access to care, complexity of healthcare systems, unfamiliarity with Western treatment models, and lack of culturally competent services may contribute to deceptively low rates of mental illness and utilization of services. In particular, low demand for pre-crisis services and conversely, increased use of hospital-based crisis services could signify delayed help-seeking due to stigma, mistrust, or language barriers. Among strategies cited to decrease barriers to accessing mental health, the report suggested creating programs for a specific culture, issue, topic, or age group, using social/recreational activities, providing services in their primary language, increasing the availability and affordability of services, outreach to counteract stigma, disaggregating data, including the family, and creating a culturally sensitive/competent staff. For a more detailed list of community-defined recommendations and strategies, please refer to the report found here: <http://crdp.pacificclinics.org/files/resource/2013/04/Report.pdf>

Diabetes

According to the 2011-2012 California Health Interview Survey (CHIS), approximately 7.1% of Asian Americans have diabetes compared to 8.4% in California overall.

Overweight/Obesity

According to 2011-2012 CHIS data, Asians reported the lowest proportion of obesity compared to other racial groups (9.7% vs 24.8% in CA overall). Diet and exercise play an important role in maintaining a healthy weight. Roughly 27.9% ate fruits and vegetables 3 or more times a day and 35.4% reported regular walking.

Cardiovascular Disease

Heart disease was the leading cause of death among NHPIs and the second among Asian Americans according to 2005-2010 data from the California Department of Public Health. Smoking and hypertension rates, both significant risk factors for cardiovascular disease, were lowest among Asians compared to other racial groups according to 2011-2012 CHIS data.

Additional Barriers to Care

Roughly 56% of Asian Americans were foreign-born in San Diego according to five-year 2006-2010 ACS estimates. This was higher than all other racial groups. They were also second behind Latinos in the percentage of the population with limited English proficiency (36% of Latinos vs. 29% of AA). This rate increases to 58% among Asian American seniors according to a 2015 UPAC report. By contrast, only 9% NHPIs were foreign-born and 11% had limited English proficiency.

FOOTNOTE

California Reducing Disparities Project (CRDP) Asian and Pacific Islander Population Report. (2013). 'In Our Own Words.' Retrieved from <http://crdp.pacificclinics.org/files/resource/2013/04/Report.pdf>

Union Pan Asian Communities (UPAC). (2015). A Community of Contrasts: Asian Americans, Native Hawaiians and Pacific Islanders in San Diego County. Retrieved from <http://www.upacsdc.com/wp-content/uploads/2015/05/Community-of-Contrasts-Report-6-1-15.pdf>

American Indians/Alaskan Natives

According to the 2010 U.S. Census, 1.7% (5.2 million) of the U.S. population reported being American Indian/ Alaskan Native (AI/AN) alone or in combination and they were found to largely reside in urban settings. The San Diego American Indian Health Center (SDAIHC) identified 0.9% of their service area population as AI/AN alone and 1.7% (52,749) reported they were AI/AN alone or in combination with other races. This culturally diverse group experiences significant challenges due to misclassification, particularly into the categories of Latino, Asian Pacific Islander and Other. Although typically undercounted in sampling efforts, in 2011 an oversample was done of the AI/AN population for the California Health Interview Survey providing a more accurate estimate of the health status of the population. In California, the AI/AN population was found to have the highest percentage of individuals' age 65 and older (28.4%) compared to other racial and ethnic groups. Additionally, a higher percentage reported being in fair or poor health compared to the state (25.6% vs. 19.4%) and 29.0% of AI/AN individuals in California reported delaying getting prescriptions or medical services in the past year, a proportion higher than all other racial or ethnic groups. They were, however, more likely to report they had a usual source of care with only 9.7% of AI/ANs compared to 17.6% in the state citing they had no usual source of care. To better understand morbidity and mortality, Table 4. describes the leading causes of death among Native Americans in San Diego County, followed by a more detailed description of how the top four health needs affect the AI/AN population. While not mentioned below, asthma is also of particular concern in this population (23% vs. 7.7% in CA).

Table 4. Top Causes of Mortality, 2003-2007, SDAIHC Service Area

Rank	AI/AN		All Race	
	Cause of Death	Rate per 100,000	Cause of Death	Rate per 100,000
1	Heart Disease	124.5	Heart Disease	179.5
2	Cancer	116.4	Cancer	172.2
3	Diabetes	47.0	Stroke	46.1
4	Stroke	42.6	Chronic Lower Respiratory Disease	38.9
5	Unintentional Injury	34.5	Alzheimer's Disease	36.3

*Adapted from 'San Diego American Indian Health Center: Community Health Profile, 2011'; Source: U.S. Center for Health Statistics

Behavioral Health

According to the AI/AN focused California Reducing Disparities Population (CRD) Report focusing on behavioral health, there are a number of challenges, needs and opportunities to improving mental health wellness. Historical trauma, cultural and language differences, barriers to accessing services including tribal enrollment, data limitations, and mental health care billing contributed to mental health disparities in this population. Reports found that AI/ANs in California had elevated rates of poverty, violence, substance abuse, and depression

compared to non-Hispanic whites (CTEC, 2009; CRIHB, 2010). The CRD report suggested that to improve Native American wellness, more collective, holistic approaches with integrated family and community support were needed as opposed to the more Western individualist interventions. It emphasized healing through increased participation in traditional activities, improved cultural connectivity, use traditional healers and practices and integration of mental health and substance abuse prevention and treatment. Finally given the diversity of the AI/AN population, a number of successful programs were cited based on practice and community-based evidence. For more information the report can be viewed at <http://www.nativehealth.org/content/publications>.

Diabetes

According to the 2011-2012 CHIS, approximately 13.9% of AI/AN population reported having ever been diagnosed diabetes, which is significantly higher percentage than California overall (8.4%), and higher than any other racial or ethnic group. According to the 2011 SDAIHC Community Profile, diabetes-associated deaths were the third highest cause of mortality among AI/ANs in the San Diego service area and an estimated 16.0% of AI/ANs reported being told they have diabetes.

Overweight/Obesity

According to 2011-2012 CHIS data, AI/AN adults reported the highest proportion of obesity compared to other racial groups (36.2% vs 24.8% in CA overall). Estimates from the 2005-2010 BRFSS found that in the SDAIHC service area 41.1% of the AI/AN population were obese compared to just 23.6% of the general population. Diet and exercise play an important role in maintaining a healthy weight. Roughly 27.2% reported eating fruits and vegetables 3 or more times a day and 35.0% reported regular walking (2011-2012 CHIS).

Cardiovascular Disease

Heart disease and stroke were the first and fourth leading cause of death respectively among AI/ANs in the service area of the San Diego Indian Health according to 2003-2007 data from the U.S. Center for Health Statistics. Smoking and hypertension rates, both significant risk factors for cardiovascular disease, were highest among AI/ANs compared to other racial groups (2011-2012 CHIS).

FOOTNOTE

California Reducing Disparities Project (CRDP) Native American Strategic Planning Workgroup Report. ‘Native Vision: A Focus on Improving Behavioral Health Wellness for California Native Americans.’

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Latinos

According to the 2010 U.S. Census, Latinos constitute 16.3% (50.5 million) of the U.S. population. They are also the largest racial or ethnic group in California and estimates from the California Department of Finance suggest that Latinos will comprise 52% of the state population by 2050. Furthermore, roughly 53% of California's elementary school children are now of Latino origin (Department of Education, 2012). In particular, Grieco (2010) found that roughly 82% of Latinos in California were of Mexican descent. Estimates from the 2011 ACS showed that roughly 32.5% of the San Diego County population identified as Hispanic or Latino, ranking 10th among U.S. counties with the largest Hispanic population. Data from the 2011-2012 CHIS found that Latinos had the highest proportion of adults (58.2%) living below 200% of the federal poverty level among all racial and ethnic groups. Latinos in California also had the highest percentage of adults (27.5%) who reported being in fair or poor health compared to other racial and ethnic groups. Finally, 25.5% of Latinos reported having no usual source of care when sick or in need of health advice; this proportion was the highest among all racial groups. 'The Hispanic Community Health Study/Study of Latinos (HCHS/SOL)', a longitudinal study of over 16,000 Latinos in four locations including San Diego, and the California Reducing Disparities Report were used to gain further insight into how the top four health conditions impact the Latino population.

Behavioral Health

According to the California Reducing Disparities Population (CRD) Report focusing on behavioral health in Latinos, the Hispanic population face many life stressors and experiences, including poor housing, abuse, trauma, stigma and discrimination, which contribute to mental health problems. In particular, depression is a major concern and a leading cause of disability, especially for Latino youth (McKenna, Michaud, Murray, and Marks, 2005). The Hispanic Community Health Study/Study of Latinos (HCHS/SOL)' found that roughly 1 in 3 women compared to 1 in 5 men reported high depressive symptoms. These differences were less pronounced for anxiety, which ranged from 13.4% to 16.4% among breakouts by age and sex. The CRD report also cites literature emphasizing that utilization differs by nativity status. For example, Grant et al. (2011) found that approximately one quarter (24.2%) of U.S.-born Latinos received minimally adequate treatment (MAT) for their mental health needs, similar to the California rate of 23.4%, but only 10% of Latinos born abroad received MAT. Higher social acculturation, including changes in lifestyle, cultural practices, increased stress, and adoption of new social norms were found to be associated with a decline in health status (Alegria, Chatterji, Wells, Cao, Chen, Takeuchi et al., 2008).

While the lack of health insurance coverage, immigration status, poverty, masculinity, inadequate transportation, and lack of information/awareness of existing mental health services are significant barriers to mental health care, stigma continues to be a main contributing factor. The report found that cultural beliefs may be used to explain mental illness as fate, and decrease help-seeking. Other barriers included a shortage of culturally and linguistically appropriate services, qualified mental health professionals and academic and school-based mental health programs, structural barriers to care (no touching protocols, hours, no privacy), and social exclusion. Strategies to improve these disparities included: (1) school-based and academic mental health programs; (2) community-based organizations and co-location of services; (3) community media; (4) culturally and linguistically appropriate treatment; (5) workforce development to sustain a culturally and linguistically competent mental health workforce; and (6) community outreach and engagement. Finally, three Latino cultural values were cited to have the greatest potential to influence the delivery of mental health services to Latinos: familismo, respeto and personalismo (incorporating a person-centered approach that emphasizes empathy, warmth, and attentiveness and that uses titles of respect and physical proximity) (Añez, Paris, Bedregal, Davidson, and Grilo, 2005; Garza and Watts, 2010).

Diabetes

According to the 2011-2012 CHIS, approximately 9.9% of the adult Latino population reported having ever been diagnosed diabetes. Results from 'The Hispanic Community Health Study/Study of Latinos found that the percentage of adults with pre-diabetes was lowest in the 18-44 age group and highest among middle age Latinos (45-64). Furthermore, one in three participants had pre-diabetes regardless of background, although Mexicans had a marginally higher at 37.7%. The percentage of Latinos with diabetes in the study increased substantially with age: roughly 6% among 18-44 year olds, 26% among 45-64 year olds, and 46% among 65-74 year olds. The study also determined that about two-thirds of participants who had diabetes were aware of it but this increased with age, and similarly, only half of those with diabetes had their condition under control.

Overweight/Obesity

According to 2011-2012 CHIS data, 32.6% of Latino adults were estimated to be obese compared to 24.8% in CA overall. Diet and exercise play an important role in maintaining a healthy weight. Roughly 21.4% reported eating fruits and vegetables 3 or more times a day and 34.8% reported regular walking in the past week (2011-2012 CHIS). Also of interest, Latino adults had a higher proportion of food insecurity (26.8%) than other racial and ethnic groups, and this was significantly higher than the state (14.9%). The Hispanic Community Health Study/Study of Latinos found that the percentage of obese Latinos (ranging from 30.3-46.8%) was roughly the same across age groups and backgrounds.

Cardiovascular Disease (CVD)

Results from 'The Hispanic Community Health Study/Study of Latinos (HCHS/SOL)' found that more men than women reported having coronary heart disease (CHD) and the percentage increased with age, peaking at 13.6% of men aged 65-74. This trend was similar for participants' self-reported history of stroke. Major risk factors for CVD including hypertension, high cholesterol, obesity, diabetes, and smoking. The Hispanic Community Health Study/Study of Latinos (HCHS/SOL) also found that the number of CVD risk factors experienced by Latinos increased by age for both men and women. In particular, the percentage of Latinos with hypertension in the study increased substantially with age: roughly 7-9% among 18-44 year olds, 40-41% among 45-64 year olds, and 72-77% among 65-74 year olds.

FOOTNOTE

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National Institutes of Health. (2013). Hispanic Community Health Study/Study of Latinos Data Book: A Report to the Communities. UCLA California Health Interview Survey. A Health Profile of California's Diverse Population, 2011-2012 Race/Ethnicity Health Profiles.

African Americans

According to the 2010 Census, approximately 12.6% (38.9 million) of the U.S. population identified as “black or African American.” In California, they made up 6.2% of the total state population (2010 Census). Compared to the percentage of the U.S. and California populations that identify as African American, there are a number of risk factors that disproportionately affect this group and may contribute to poorer health outcomes (Table 5). Additionally, 2011-2012 CHIS data shows that roughly 23.3% reported being in fair or poor health compared to 19.4% in the state.

Table 5. Percentage of African Americans with At-Risk Factors for Health Disparities*

Risk Factor	U.S. Population	California Population
Homeless	40%	45% (est.)
Juveniles in Legal Custody	40%	28%
Incarceration (All Prisoners)	50%	35%
Foster Care	31%	45%
Below Poverty Level	25%	20%

*Adapted from the CRDP African American Strategic Planning Workgroup Report; Source: U.S. Census Bureau, 2009; Poverty data: U.S. Census Bureau, American Community Survey, 2005-2009 U.S. Data; Homeless data: Interagency Council on the Homeless Report, 2011; Homeless data: HUD Annual Homeless Assessment Report (AHAR), 2009; Juvenile data: Office of Juvenile Justice & Delinquency Prevention, 2011; Incarceration data: California Department of Corrections and U.S. Department of Justice

Behavioral Health

According to the California Reducing Disparities Population (CRD) Report focusing on behavioral health, in 2007-2008, African Americans represented 5.8% of California’s population but accounted for 16.59% of clients served in the California Department of Mental Health system. During the same year, the top three mental health diagnoses among this population were depressive disorders (12.6%), schizophrenia (8.4%), and bipolar disorder (6.2%). In a survey done for the CRD report, the top four mental health conditions that received the highest responses were bipolar, schizophrenia, drug addiction and depression. However, the report finds that in relationship to the black population, the mental health system has offered “inaccurate diagnoses, disproportionate findings of severe illness, greater usage of involuntary commitments, and inadequacy of service integration.” In particular, African Americans tended to be over diagnosed for poorer treatment outcomes, such as schizophrenia, while anxiety and mood disorders often go untreated, and were more likely to have their first contact of mental health in an emergency room as opposed to in an outpatient care setting. Similarly, the report also states that black youth tend to be over diagnosed with conduct disorder and under diagnosed for depression. This has contributed to increased stigma in the black community that defines mental illness as “crazy,” personally caused, and difficult to resolve.

The CRD report found that current barriers to care include stress, perceived discrimination and racism, personal crises, insurance coverage, financial resources, communication, stigma and lack of African American providers. African Americans may over-rely on more informal approaches to help with behavioral disorders and thus

underutilize behavioral health services. In particular, the help seeking behavior of African Americans tends to be delayed and rely on the black church. Delayed help seeking for behavioral health problems among blacks has been found to last for years or even decades and is likely contribute to increased emergency room use. A number of suggestions for prevention and early intervention were found as a result of community input and quantitative data collection including working with the faith-based community, working with the criminal justice system, training first responders to work in partnership with African Americans, working with hospital staff in emergency rooms, targeting the whole person, creating more opportunities for feedback on care received and providing more jobs for survivors of mental issues. Furthermore, the report states that there is a missed prevention and early intervention opportunity in our public school system including health screening and low academic scores as possible indicators of mental illness, learning disability, developmentally delayed or medical problems. For a more complete list of suggestions and statistics, please refer to the CRD report:
https://www.cdph.ca.gov/programs/Documents/African_Am_CRPD_Pop_Rept_FINAL2012.pdf

Diabetes

According to the 2011-2012 CHIS, approximately 11.4% of the black adult population reported having ever been diagnosed diabetes, which is significantly higher percentage than California overall (8.4%)

Overweight/Obesity

According to 2011-2012 CHIS data, African American adults had the second the highest proportion of obesity, behind AI/ANs, compared to other racial groups in California (36.1% vs 24.8% in CA overall). Diet and exercise play an important role in maintaining a healthy weight. Black adults had the lowest proportion of engagement in regular walking in the past week and consumption of fruits and vegetables 3 or more times a day compared to other racial and ethnic groups (2011-2012 CHIS).

Cardiovascular Disease

According to 2013 U.S. Census data, diseases of the heart were the leading cause of death for African Americans at 23.8%. Behind Native Americans, blacks also had the highest percentage of individuals with high blood pressure when compared to other racial and ethnic groups (2011-2012 CHIS).

FOOTNOTE

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Homeless

The Regional Taskforce for the Homeless conducted a count of San Diego homeless on January 23rd, 2015. The data collected from this 2015 Point-in-Time count provides an important snapshot of the demographic and vital statistics of the San Diego homeless population. According to the WeALLCount report, there is estimated to be 8,742 homeless individuals in San Diego County, roughly half of which were unsheltered at the time of the survey. Compared to 2014 there was a 4.3% increase in the number of unsheltered homeless and a 1.4% increase in the number of homeless persons staying in the shelter system. A sample of unsheltered homeless individuals was interviewed to estimate the characteristics of this population.

The majority of unsheltered homeless were male (70%) and between the ages of 25 and 54 (58%). The majority of those surveyed were white (64%), followed by black or African American (22%), multiple races (7%), AI/AN (4%), Native Hawaiian or Other Pacific Islander (2%) and Asian (1%). Roughly 35% reported having a physical disability, 63% have spent time in jail, prison, or both, and 70% have been homeless for a year or longer. Loss of a job was the most common cause of homelessness (27%), followed by disability (9%), loss of a spouse (5%), and abuse (5%). In terms of accessing healthcare, unsheltered homeless cited clinic/urgent care (42%) and the emergency room, no appointment (35%) as their leading place of health care service. The majority of unsheltered homeless had health insurance (63%) with 75% insured through Medicaid and 15% covered by Medicare. Approximately a third (39%) reported not seeing a doctor despite needing to largely because of cost (39%), distance (31%), and fear (20%).

Additionally 16% were veterans, almost half of which entered into service between 1976-1990. While there has been a decline in the number of homeless over the last five years, there was a 22% increased in the number of unsheltered veterans from 2014 to 2015. The full report can be found at <http://www.rtfhsd.org/publications/>

Behavioral Health

Of the unsheltered homeless, 17% self-reported problems with substance/alcohol abuse and 19% self-reported having severe mental illness, defined as a mental illness that is severe, long term, and inhibits their ability to live independently.

Diabetes

Approximately 9.1% of unsheltered homeless in San Diego had diabetes, a similar rate to the general population but it is estimated that only 19% of unsheltered diabetics use insulin.

Cardiovascular Disease

According to the 2015 WeALLCount report, approximately 28.9% were estimated to have a heart condition. Additionally, a large majority (71%) reported smoking at least 100 cigarettes in their lifetime.

FOOTNOTE

Regional Taskforce on the Homeless. (2015). 2015 WeALLCount Results. Retrieved from <http://www.rtfhsd.org/wp/wp-content/uploads/2011/08/2015-WeAllCount-Results-Final.pdf>

LGBTQ

According to the 2013 National Health Interview Survey (NHIS), roughly 97.7% of the U.S. population over the age of 18 identified as straight, 1.6% identified as gay or lesbian, and 0.7% identified as bisexual. Overall health status was largely the same among all groups, although among women age 18-64, a higher proportion of those who identified as straight (63.3%) were in excellent or very good health compared to those who identified as gay or lesbian (54.0%). When evaluating access to health care by sexual orientation, the report found that among women, a higher percentage of those age 18-64 who identified as straight (85.5%) had a usual place to go for medical care compared to those who identified as gay or lesbian (75.6%) or bisexual (71.6%). Roughly 15.2% of gay or lesbian women age 18-64 also failed to obtain needed medical care in the past year due to cost compared to 9.6% of straight women. While this provides baseline data regarding the health of this group, it is important to note that there are significant limitations to data on sexual orientation, including the lack of data on gender identity and potentially biased estimates due to increased risk and stigma or lack of identification as LGBTQ. The LGBTQ group is a very heterogeneous entity, found within all races, religions and socioeconomic backgrounds.

Behavioral Health

According to the California Reduction Disparities (CRD) report focusing on behavioral health in the LGBTQ population, lack of cultural competency in the health care system, reduced access to employer-provided health insurance and/or lack of domestic partner benefits, and social stigma against LGBTQ persons were cited as major contributing factors to negative health outcomes in the LGBTQ community and these factors were amplified among LGBTQ persons of color. The report's community survey found that over 75% of respondents somewhat or strongly agreed they had experienced emotional difficulties which were directly related to their sexual identity or gender identity/expression. This was highest percentages were found among the Trans Spectrum group, queer-identified individuals, Native Americans and youth.

Of those services the population wanted but did not receive were individual counseling/therapy, couples or family counseling, peer support groups and non-Western medical intervention. In particular, those on Medi-Cal had more difficulty accessing services than those who reported having private insurance. Among the recommendations to improve mental and behavioral health for the LGBTQ community, the CRD report emphasizes the need for demographic information to be collected, workforce training on cultural competency and the distinctness of each sector of the LGBTQ community, development of effective anti-bullying and anti-harassment campaigns, and the creation of a safe and welcoming space for LGBTQ individuals seeking services and LGBTQ employees.

Overweight/Obesity

According to the 2013 NHIS, a higher percentage of straight men aged 20–64 (30.7%) were obese compared to men who identified as gay (23.2%) and similarly, among women aged 20–64, a higher percentage of those who identified as bisexual (40.4%) were obese compared to women who identified as straight (28.8%). No differences were found among levels of aerobic exercise among the groups.

FOOTNOTE

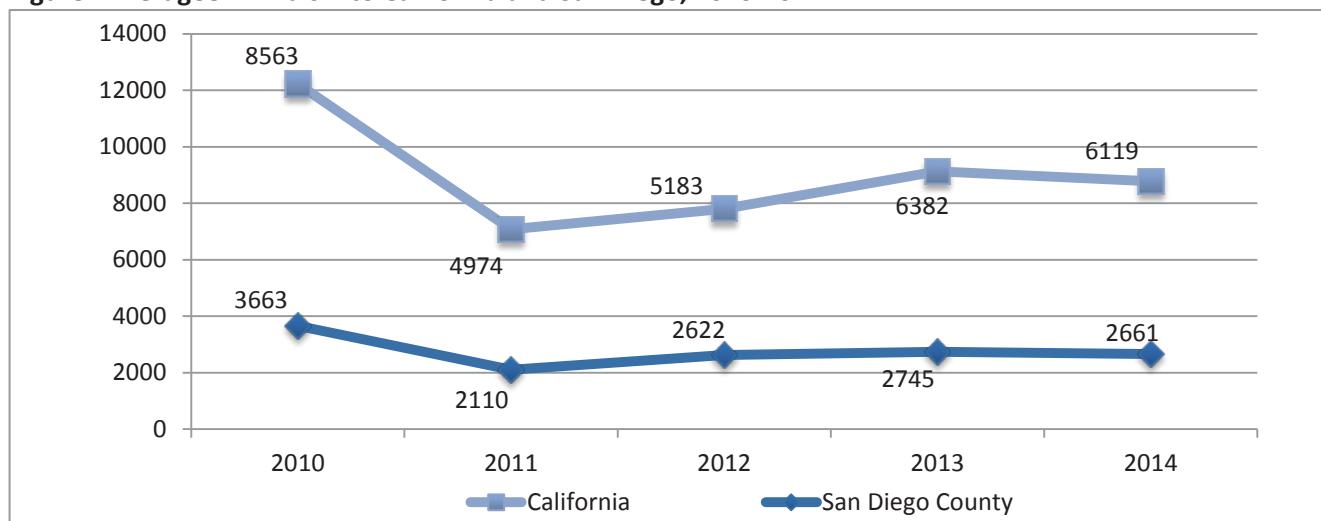
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California Reducing Disparities Project (CRDP) LGBTQ Strategic Planning Workgroup Report. 'First, Do No Harm: Reducing Disparities for Lesbian, Gay, Bisexual, Transgender, Queer and Questioning Populations in California.' Retrieved from https://www.cdph.ca.gov/programs/Documents/LGBTQ_Population_Report.pdf

Refugee Population

According to a 2014 report by the United Nations High Commissioner for Refugees, there was marked growth in forced displacement globally with a total of 59.5 million individuals who have been forcibly displaced as a result of persecution, conflict, generalized violence, or human rights violations. In 2014, 13.9 million individuals were newly displaced, including 11.0 million internally displaced individuals and 2.9 million new refugees. Of 1.7 million submitted applications for asylum and refugee status, 121,200 were to the United States and 73,000 were admitted in 2014. During the 2010-2014 federal fiscal year, 31,221 refugees arrived in California. Of those, 13,801 refugees arrived in San Diego County, ranking highest among all California counties in every year in the number of refugee admissions. The largest group arriving to California was from Iraq (15,736), followed by Iran (7,361), Southeast Asia (2,785). A slightly different trend was seen in San Diego with 10,363 refugees arriving from Iraq, 1,281 from Africa, and 1,118 from Southeast Asia over the course of four years. According to the County of San Diego '2011 Refugee Fact Sheet,' the top cities/communities in which refugees resettled were San Diego (820), El Cajon (677) and Spring Valley (62) in 2011.

Figure 1. Refugee Arrivals into California and San Diego, 2010-2014



Source: California Department of Social Services-Refugee Programs Bureau, Refugee Arrivals Into California Counties, Federal Fiscal Years 2010 – 2014 (October 1, 2009 through September 30, 2014)

A 2007 Assessment of Community Member Attitudes Towards the Health Needs of Refugees in San Diego found the following to be major perceived health concerns (Table 6.). Rankings should be taken with caution due to the qualitative nature of the data.

Table 6. Major Perceived Refugee Health Concerns by Demographic Group

Rank	Children	Women	Elderly
1	Nutritional Issues: Obesity/Malnourishment	Reproductive Health Issues	Hypertension
2	Mental Health	Domestic Violence	Diabetes
3	--	Mental Health	Mental Health
Other Important Health Conditions	Alcohol/Drugs, Asthma, STIs, Immunizations	Nutritional Issues, Obesity, STIs	Arthritis, Cardiovascular Conditions, Hearing, Vision

Source: UCSD Assessment of Community Member Attitudes towards the Health Needs of Refugees in San Diego, 2007

Behavioral Health

The 2007 assessment found that mental health was among the most commonly mentioned health concerns for the San Diego refugee community. In particular, depression and PTSD or “traumatized living” were cited as problems. Factors contributing to depression were feelings of loneliness, lack of control over their environment, and hopelessness. Stigma, cultural issues, fear of appearing ‘crazy,’ and a lack of knowledge of symptoms were obstacles to acknowledging mental illness and accessing treatment. The report found that mental health issues were found to play a role in physical health problems of refugees. Those who did seek treatment struggled to find culturally appropriate services specific to their unique stressors and language needs. This is particularly true for the elderly who have greater barriers to care, such as transportation, and may experience increased isolation.

Diabetes

Diabetes and management of the disease was identified as an emerging health issue for refugees. The prevalence of diabetes and its causes were thought to vary depending on the country of origin and acculturation levels according to San Diego interviewees.

Obesity

According to the 2007 assessment regarding the health of refugees, those interviewed had concerns over the changing eating habits of their children, including the lack of nutritious foods and potential weight gain. Reasons for this were higher cost of nutritious food, desire for children to ‘fit in,’ and increased sedentary lifestyle. In general, obesity was found to be more prevalent among those who had lived in the U.S. longer thanks to poor diet choices, lack of knowledge of healthy practices, acculturation problems shopping and preparing food with new ingredients, and overall lifestyle changes.

Cardiovascular Disease

While cardiovascular disease specifically was not a major concern mentioned by San Diego refugees and providers in the 2007 assessment, several contributing risk factors were frequently mentioned. Hypertension was cited as a perceived health concern by more subjects in the assessment than any other health concern, with the exception of mental health, and was found to increase with age. Research into potential causes identified stress, psychosocial issues, and diet as potentially exacerbating forces. High cholesterol was also mentioned by providers for refugees as a condition that emerged upon resettlement, due to changes in diet and lifestyle.

Barriers to Care

The report also found the top five perceived barriers to accessing healthcare were lack of transportation, language barriers, gaps in insurance and unfamiliarity with the health system. Language barriers including interpretation and translated health information were found to be barriers to accessing preventative services. Cultural barriers were also cited including the role of the physician, stigma, and the gender of the physician.

FOOTNOTE

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County of San Diego. (2011). “2011 Refugee Fact Sheet,” Retrieved from

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University of California- San Diego. (2007). Assessment of Community Member Attitudes Towards the Health Needs of Refugees in San Diego.

California Department of Social Services - Refugee Programs Bureau. Refugee Arrivals into California Counties, FY 2010 – 2014.

APPENDIX L: COMMUNITY NEED INDEX DESCRIPTION & REGIONAL MAPS

Community Need Index Summary

CNI Maps:

- CNI Data Source Explanation
- San Diego County
- Central Region
- East Region
- North Central Region
- North Coastal Region
- North Inland Region
- South Region

CNI & Hospital Discharge Maps by Condition

Behavioral Health

- CNI & Hospital Discharge Data: Behavioral Health Data Source Explanation
- San Diego County
- Central Region
- East Region
- North Central Region
- North Coastal Region
- North Inland Region
- South Region

Cardiovascular Disease

- CNI & Hospital Discharge Data: Cardiovascular Disease Data Source Explanation
- San Diego County
- Central Region
- East Region
- North Central Region
- North Coastal Region
- North Inland Region
- South Region

Type 2 Diabetes

- CNI & Hospital Discharge Data: Type 2 Diabetes Data Source Explanation
- San Diego County
- Central Region
- East Region
- North Central Region
- North Coastal Region
- North Inland Region
- South Region

THE COMMUNITY NEED INDEX SUMMARY

Dignity Health and Truven Health jointly developed the nation's first standardized Community Need Index (CNI).³⁰ The CNI identifies the severity of health vulnerability for every ZIP code in the United States based on specific barriers to healthcare 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

³⁰ Source: Dignity Health, Community Need Index. http://cni.chw-interactive.org/Truven%20Health_2015%20Source%20Notes_Community%20Need%20Index.pdf

COMMUNITY NEED INDEX DATA SOURCE EXPLANATION

*Community Need Index

Universe: Total Population of San Diego County

Data Source: Truven Health Analytics³¹

Data Year: 2013

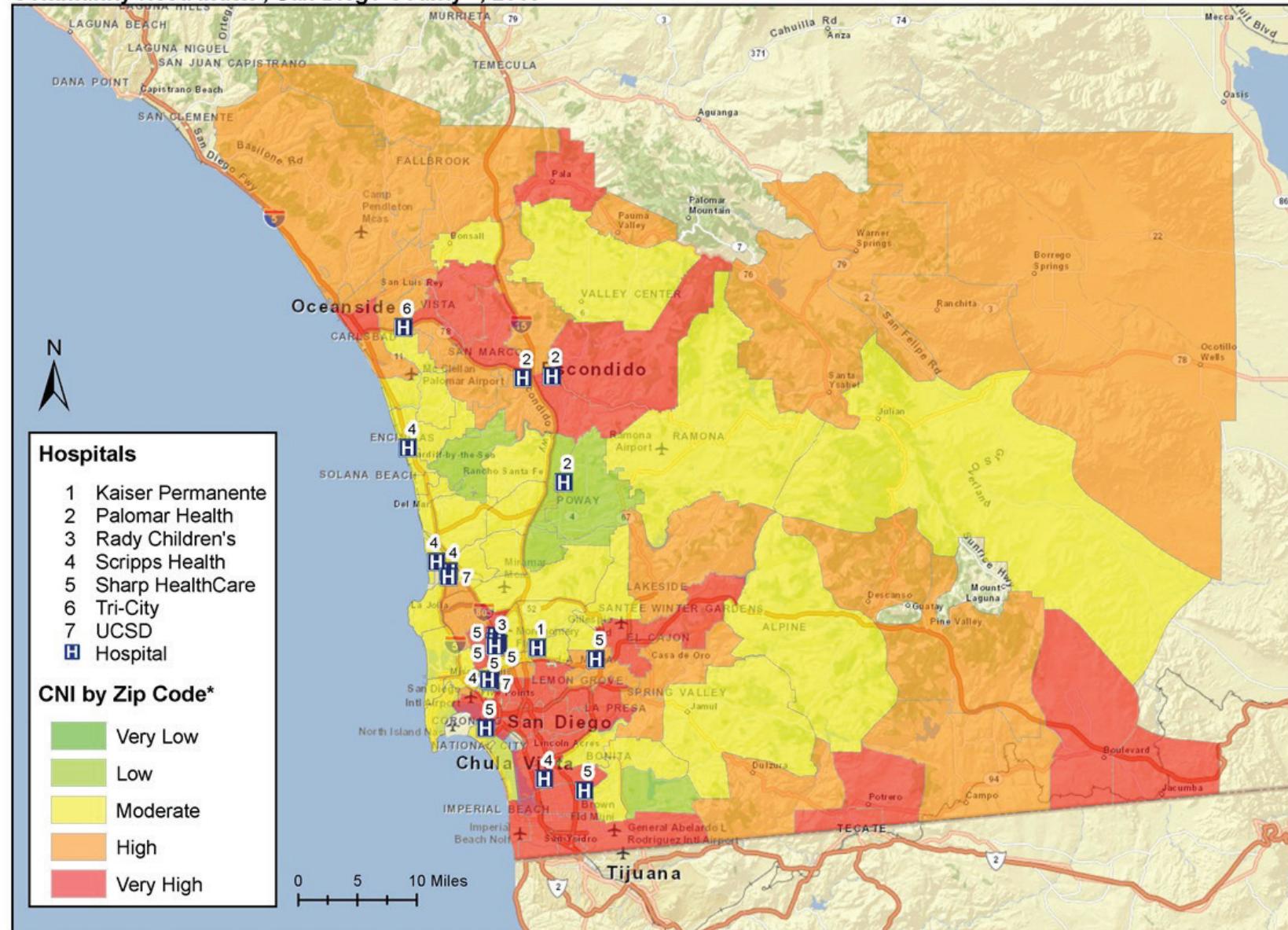
Data Level: ZIP code

Description of Community Need Index (CNI): Identifies and compares community need across every ZIP code in the United States based on the following five barriers:

1. Income Barrier
2. Culture Barrier
3. Educational Barrier
4. Insurance Barrier
5. Housing Barrier

³¹e: Truven Health Analytics, 2015; Insurance Coverage Estimates, 2015; The Nielson Company, 2015; and Community Need Index, 2015.

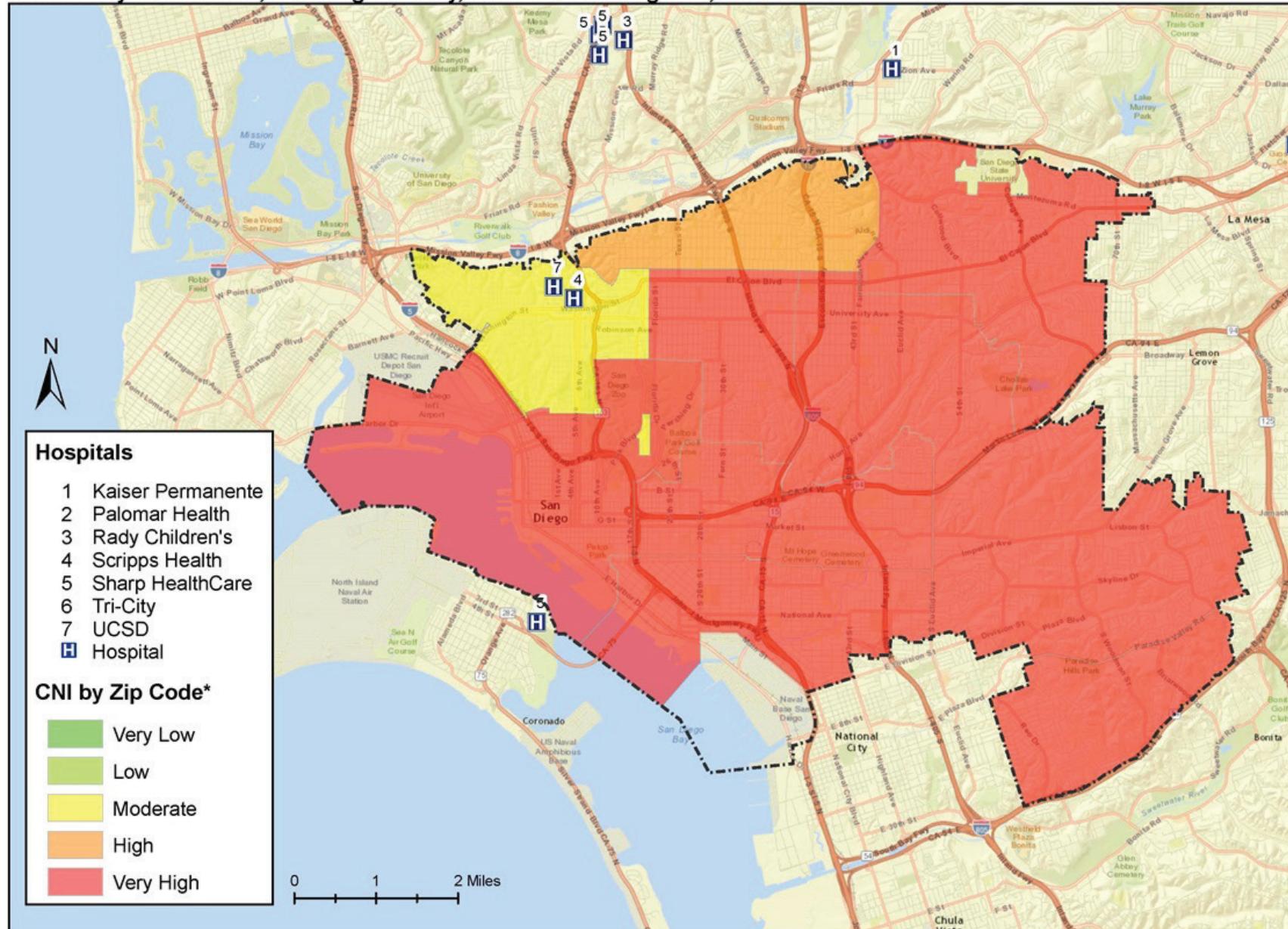
Community Need Index*, San Diego County**, 2013



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

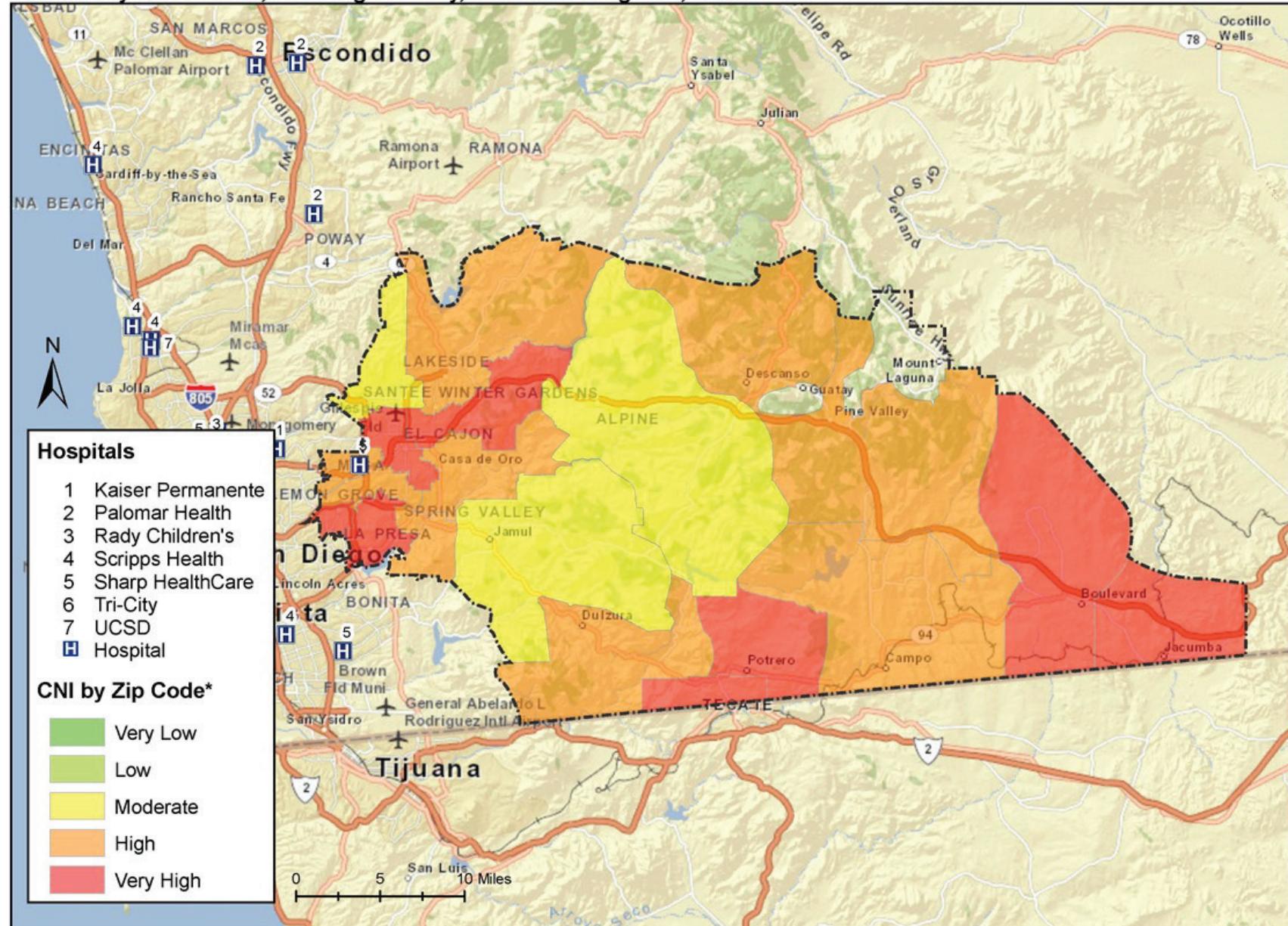


Community Need Index*, San Diego County, Central HHSA Region**, 2013



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

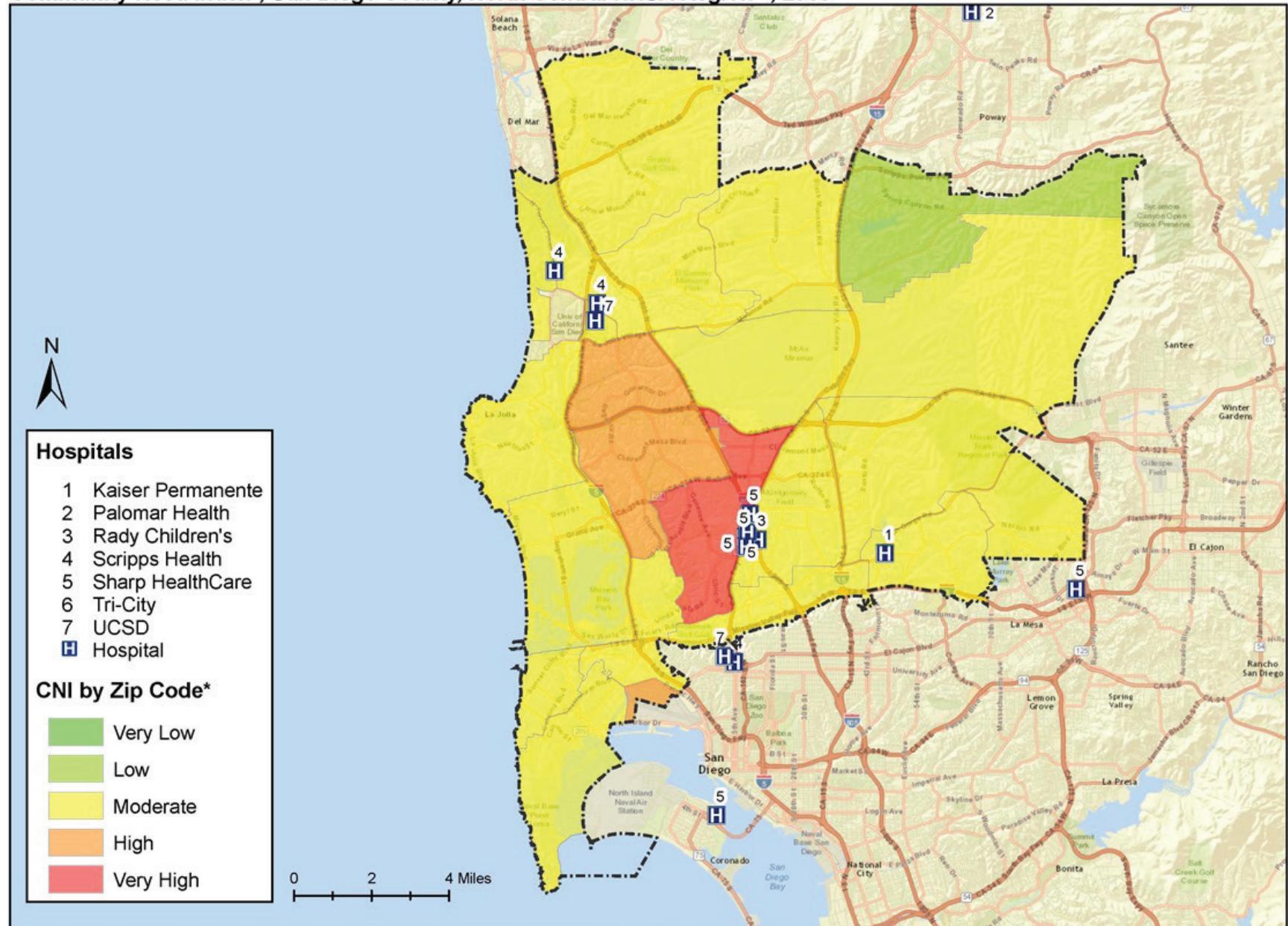
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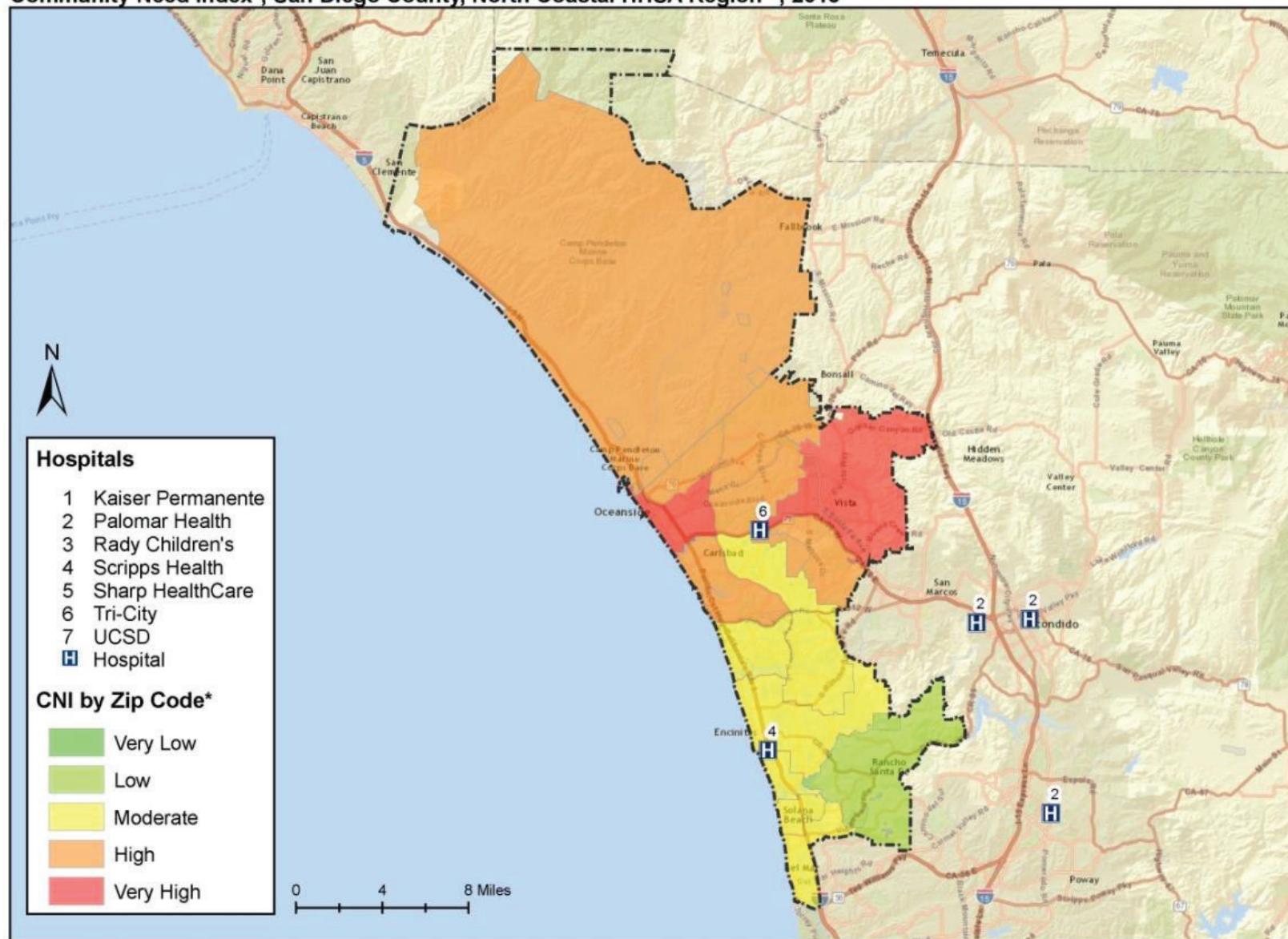
Community Need Index*, San Diego County, North Central HHSA Region**, 2013



Data Source: *Dignity Health; **SanGIS;

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

Community Need Index*, San Diego County, North Coastal HHSA Region**, 2013

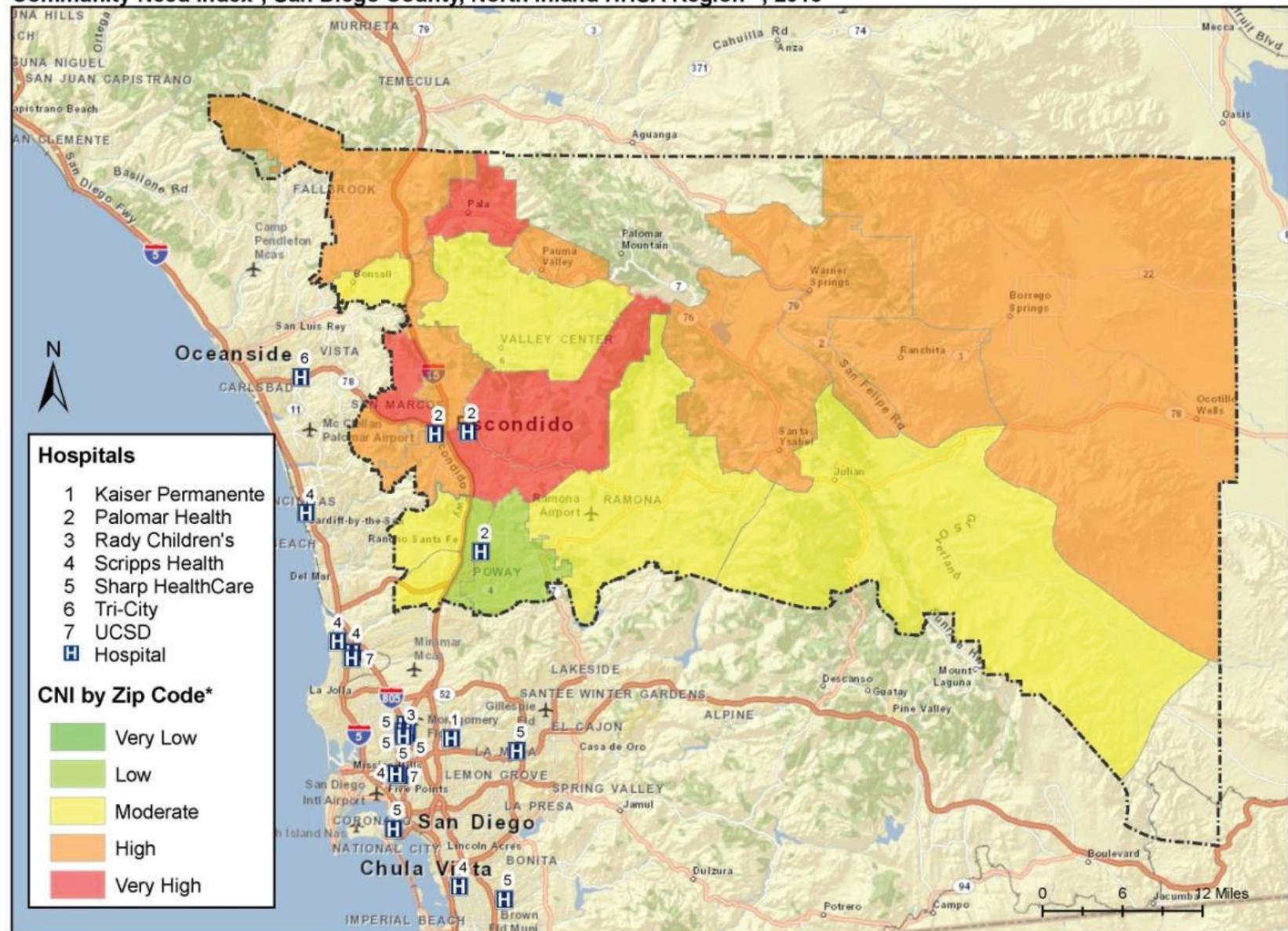


Data Source: *Dignity Health; **SanGIS;
Basemap: © 2015 OpenStreetMap contributors, and the GIS User Community.

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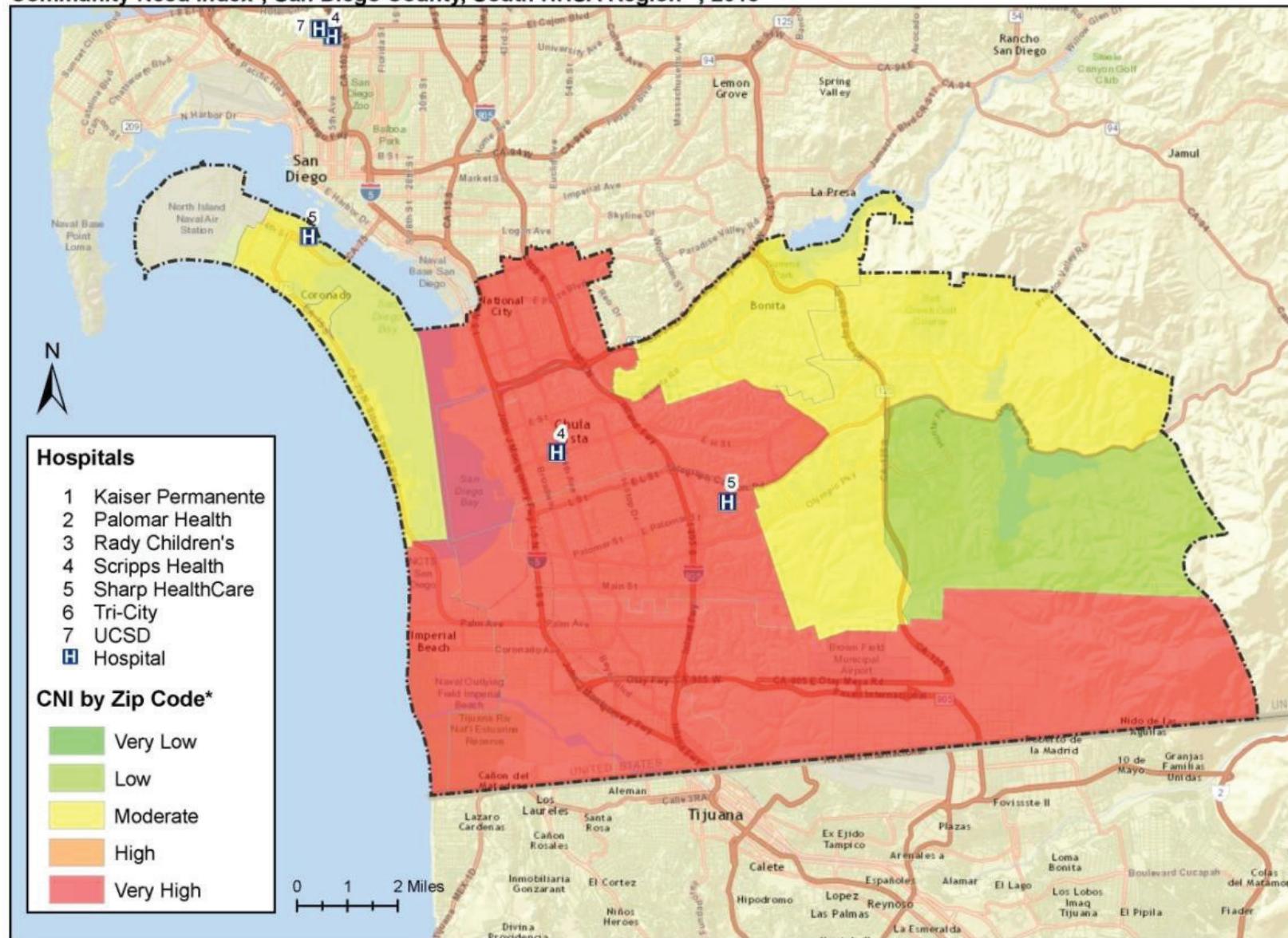

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Community Need Index*, San Diego County, North Inland HHSA Region**, 2013



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

Community Need Index*, San Diego County, South HHSA Region**, 2013



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CNI & HOSPITAL DISCHARGE DATA: BEHAVIORAL HEALTH SAN DIEGO COUNTY & REGIONAL MAPS

CNI & HOSPITAL DISCHARGE DATA: BEHAVIORAL HEALTH DATA SOURCE EXPLANATION

*Community Need Index

Universe: Total Population of San Diego County

Data Source: Truven Health Analytics³²

Data Year: 2013

Data Level: ZIP code

***Behavioral Health Discharge Rate

Description: 2013 hospital discharge rate (Inpatient/ED) was determined where *Behavioral Health* was the condition established to be the principal diagnosis, per 1,000 people (population stats: United States Census 2010 population). The following ICD-9 codes were used to identify a discharge as Behavioral Health: V40.0-V41.0, 290-292,293.81-293.84, 295-301, 303-305.0,305.2-305.9, 307.0, 307.2, 307.3, 307.6, 307.7,307.9, 308, 309.21, 309.81,311,312.00-312.23,312.3,312.4, 312.8,312.9, 313.00-313.23, 313.3, 313.81, 313.83-313.84,313.89, 313.9-315, 317-319,331, 980.0.

Universe: Total Population of San Diego County

Data Source: California Office of Statewide Health Planning and Development, accessed through SpeedTrack[©], Inc.

Data Year: 2013

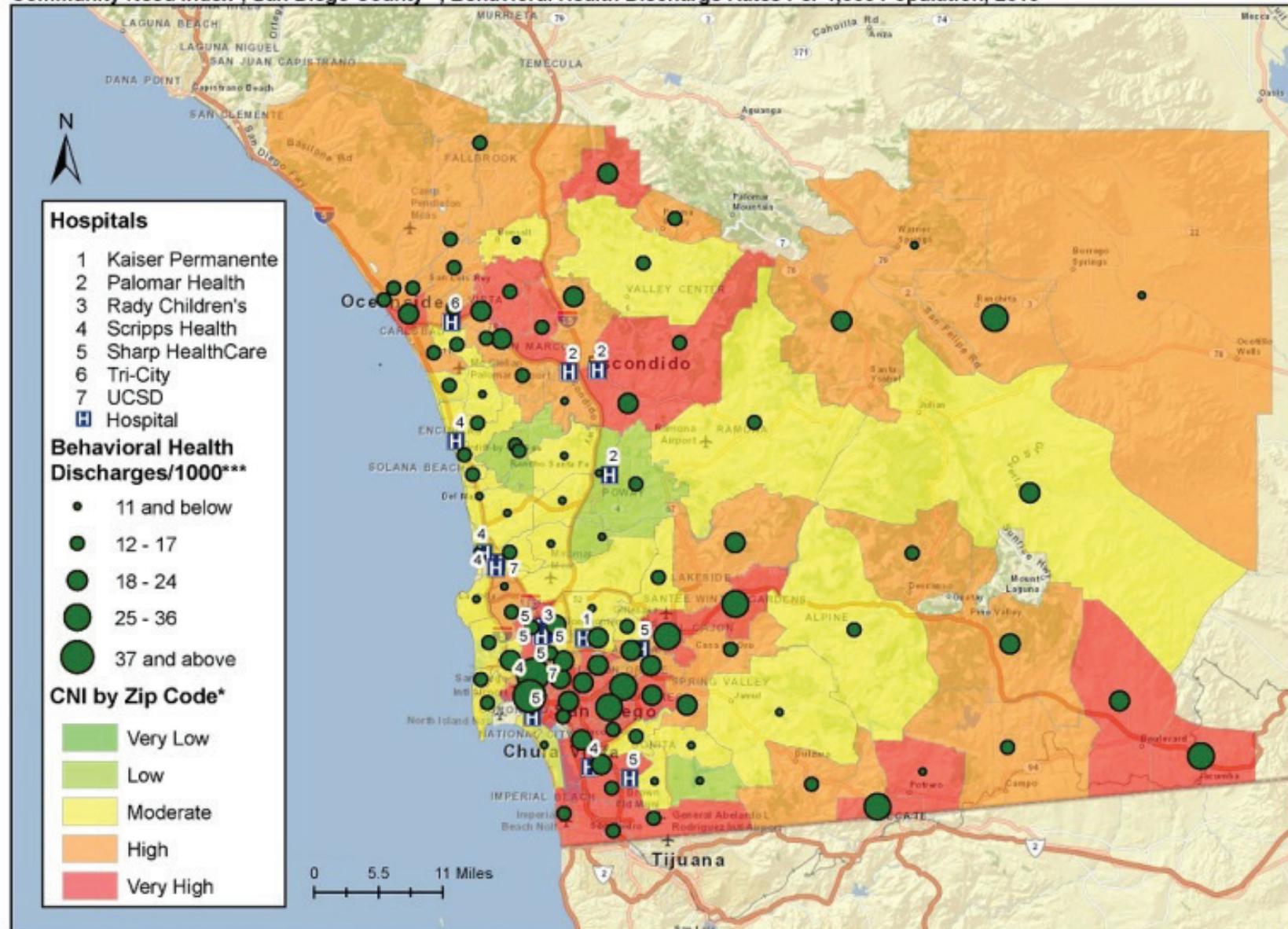
Data Level: ZIP code

Description of Community Need Index (CNI): Identifies and compares community need across every ZIP code in the United States based on the following five barriers:

1. Income Barrier
2. Culture Barrier
3. Educational Barrier
4. Insurance Barrier
5. Housing Barrier

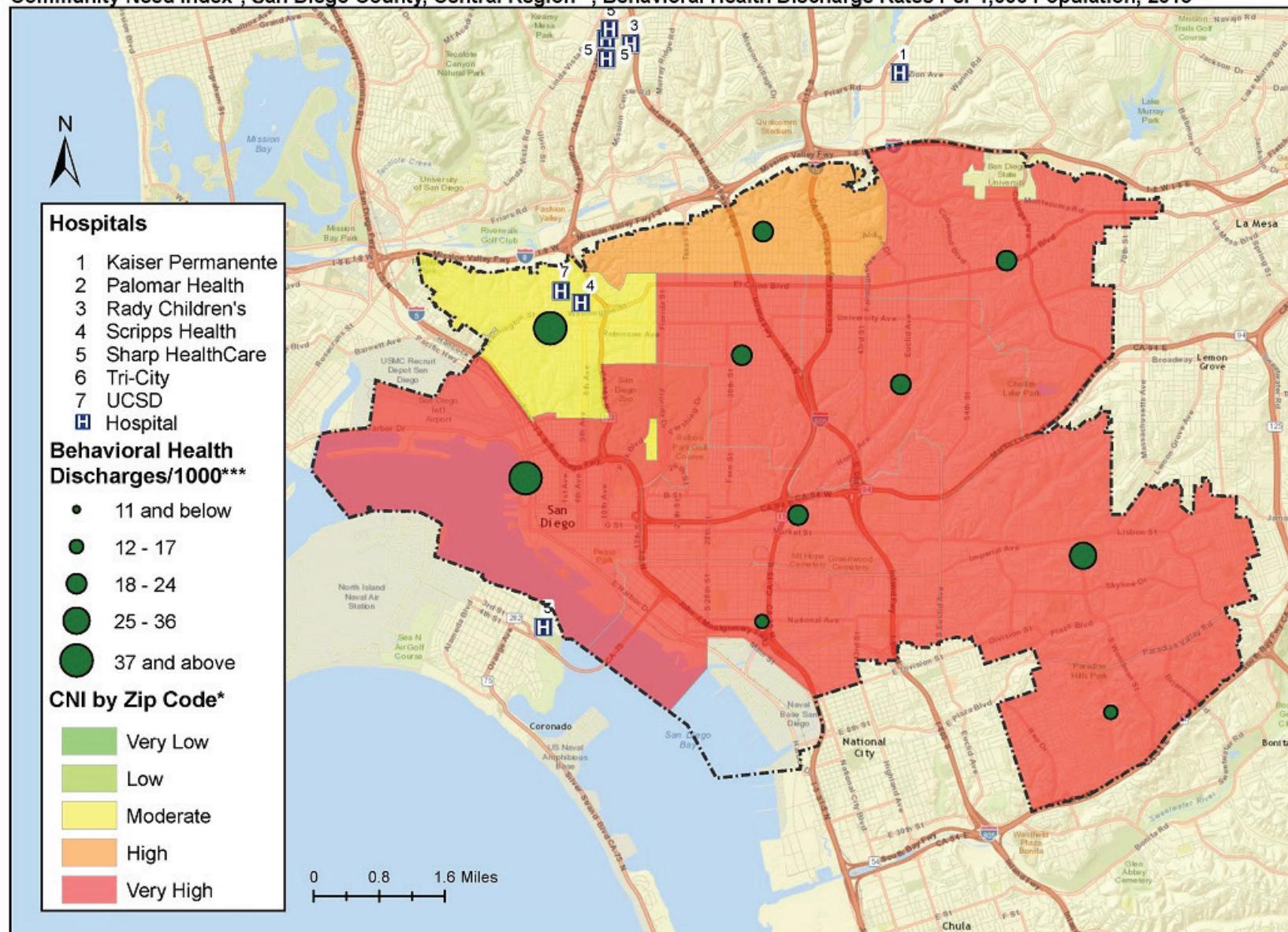
³² Source: Truven Health Analytics, 2015; Insurance Coverage Estimates, 2015; The Nielson Company, 2015; and Community Need Index, 2015.

Community Need Index*, San Diego County**, Behavioral Health Discharge Rates Per 1,000 Population, 2013***



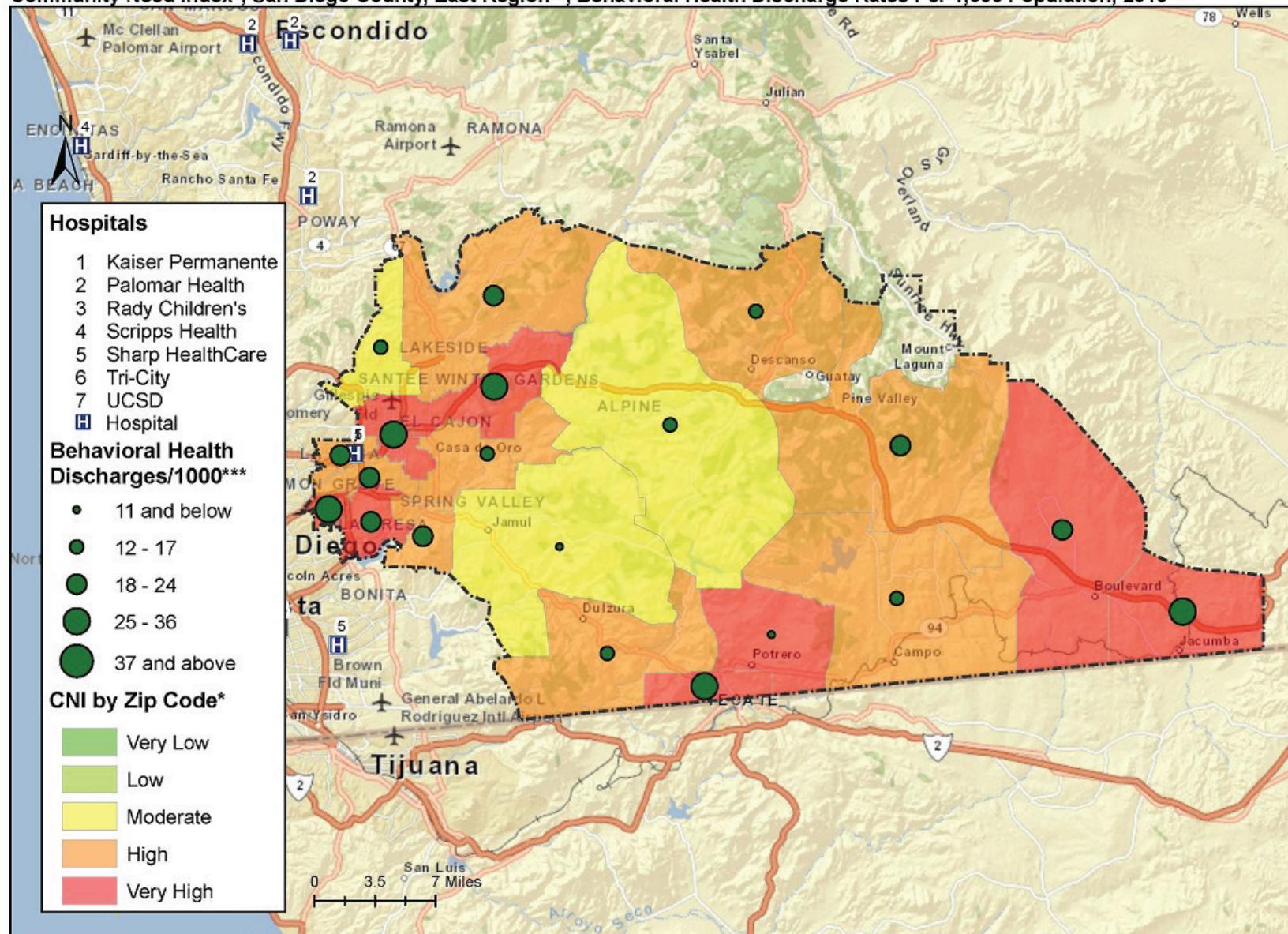
Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
Basemap: © 2015 OpenStreetMap contributors, and the GIS User Community.

Community Need Index*, San Diego County, Central Region**, Behavioral Health Discharge Rates Per 1,000 Population, 2013***



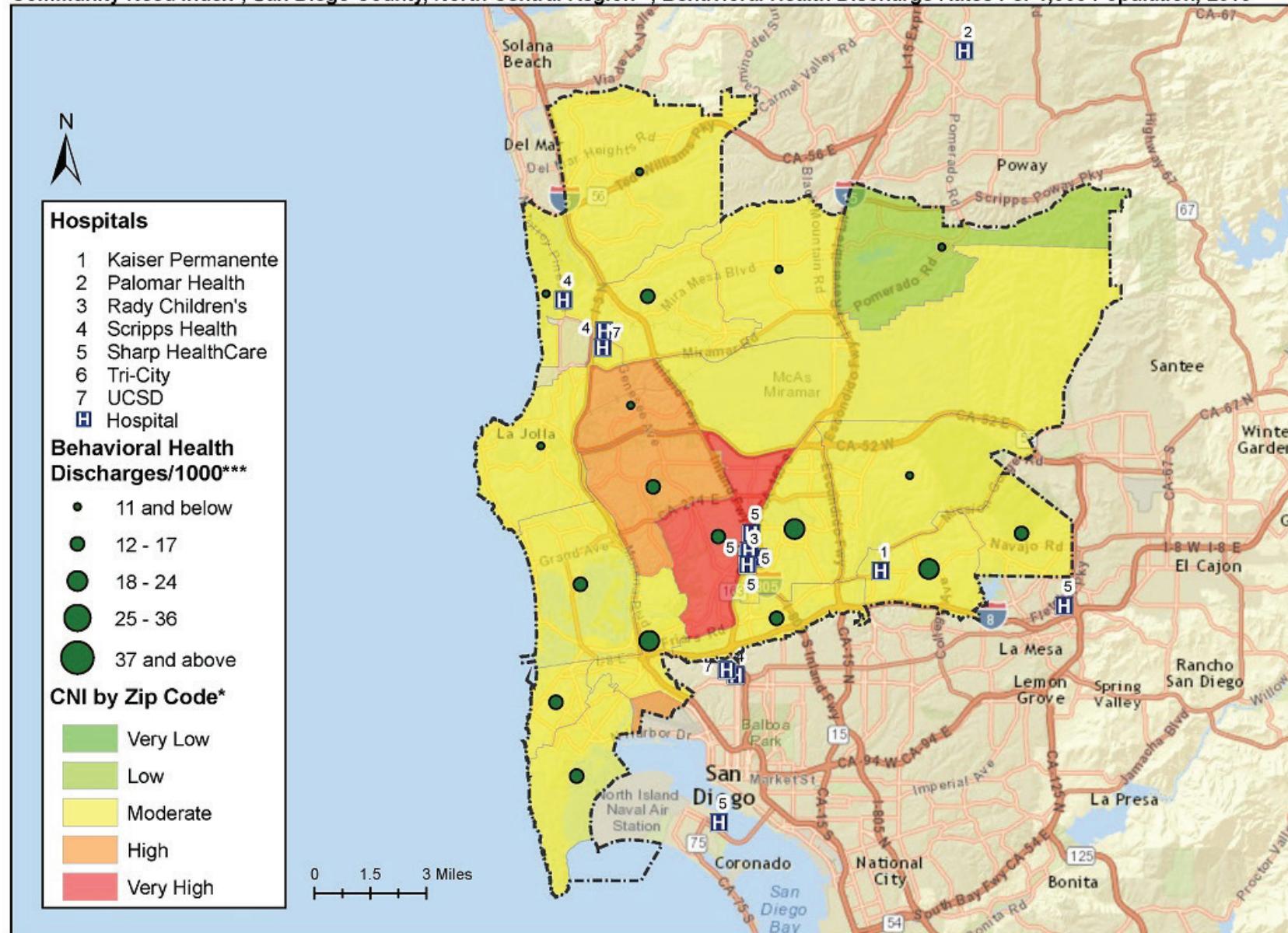
Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
Basemap: © 2015 OpenStreetMap contributors, and the GIS User Community.

Community Need Index*, San Diego County, East Region**, Behavioral Health Discharge Rates Per 1,000 Population, 2013***



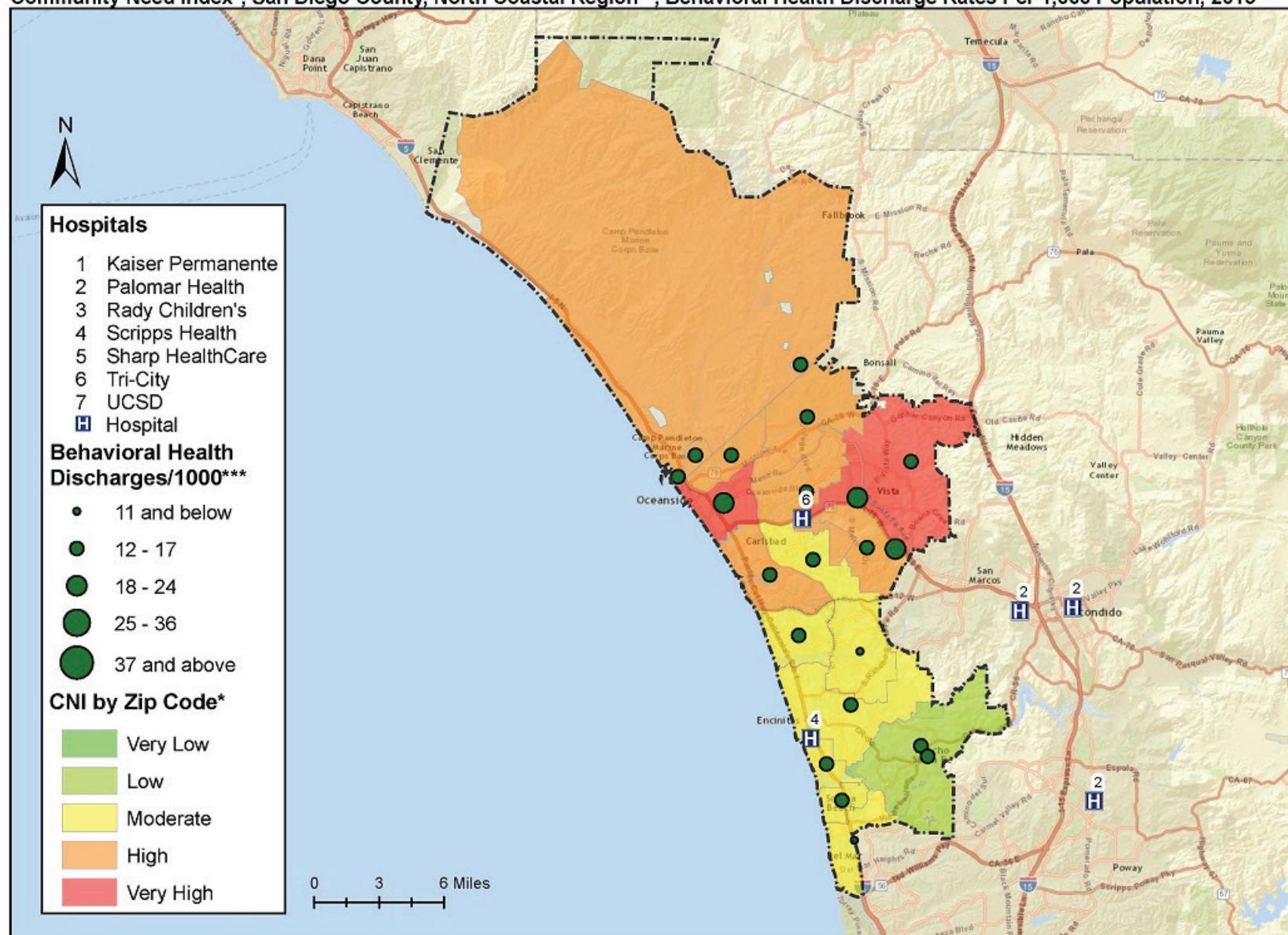
Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
Basemap: © 2015 OpenStreetMap contributors, and the GIS User Community.

Community Need Index*, San Diego County, North Central Region**, Behavioral Health Discharge Rates Per 1,000 Population, 2013***



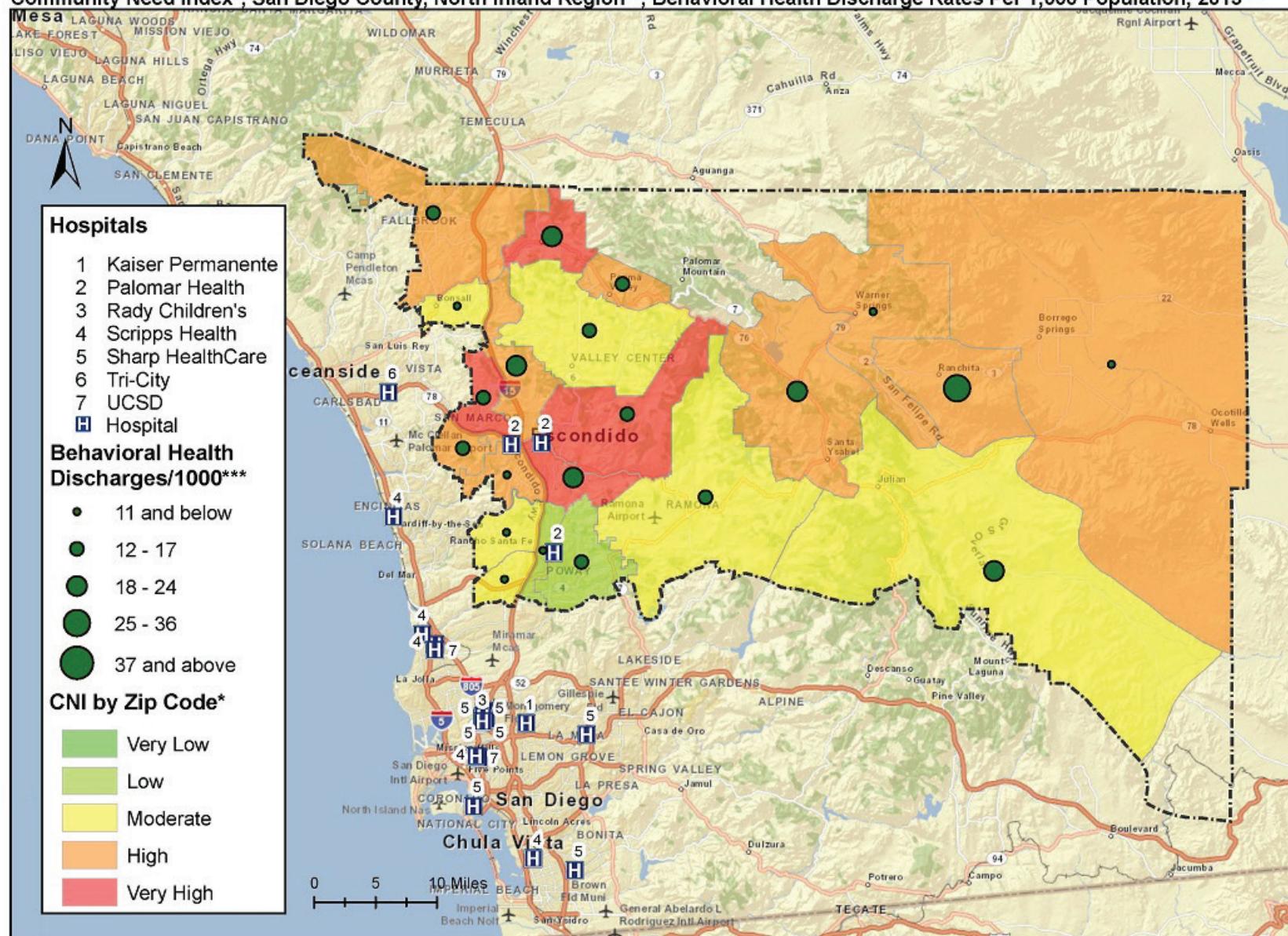
Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
Basemap: © 2015 OpenStreetMap contributors, and the GIS User Community.

Community Need Index*, San Diego County, North Coastal Region**, Behavioral Health Discharge Rates Per 1,000 Population, 2013***



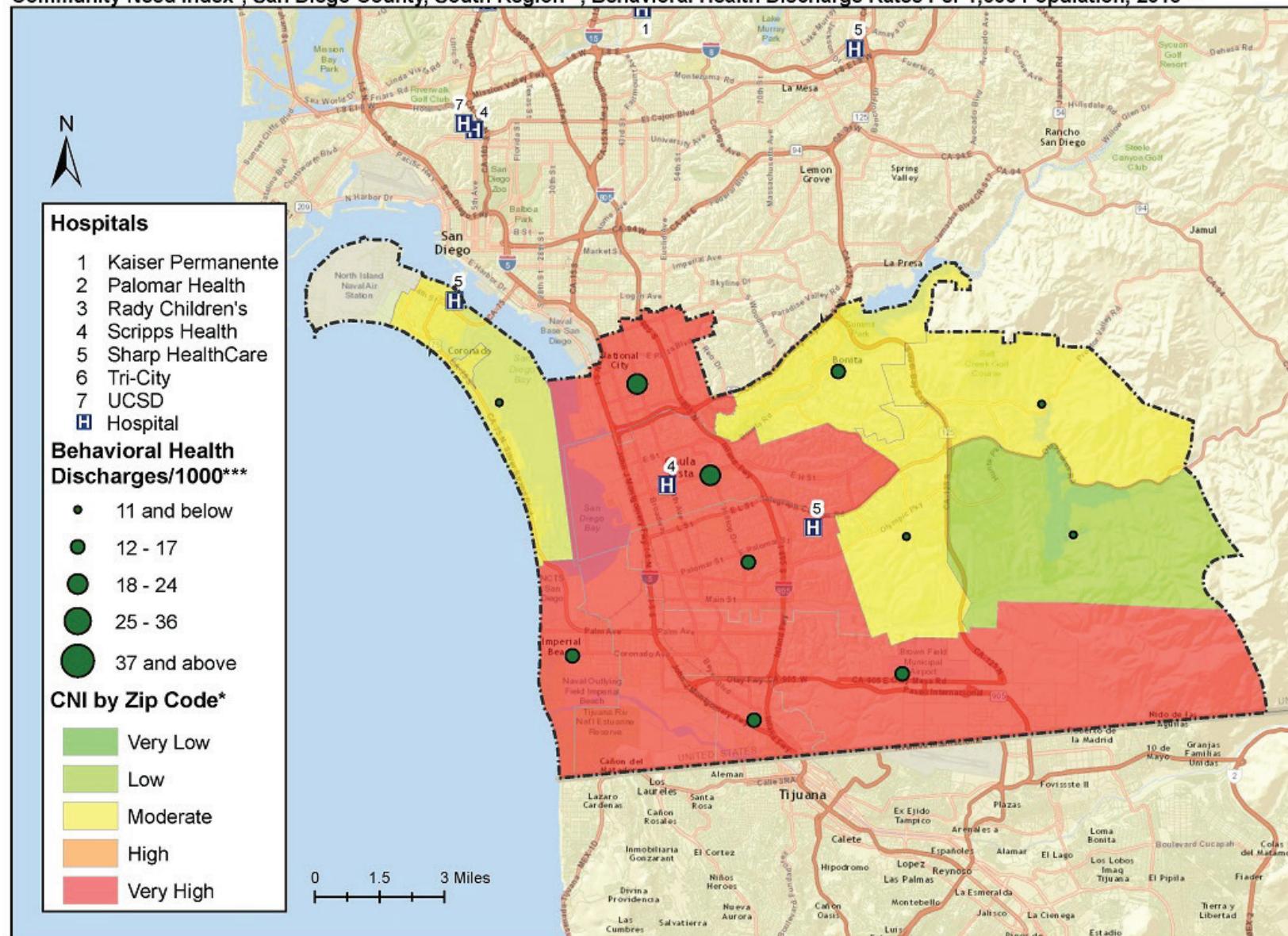
Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
Basemap: © 2015 OpenStreetMap contributors, and the GIS User Community.

Community Need Index*, San Diego County, North Inland Region**, Behavioral Health Discharge Rates Per 1,000 Population, 2013***



Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
Basemap: © 2015 OpenStreetMap contributors, and the GIS User Community.

Community Need Index*, San Diego County, South Region**, Behavioral Health Discharge Rates Per 1,000 Population, 2013***



Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
Basemap: © 2015 OpenStreetMap contributors, and the GIS User Community.

CNI & HOSPITAL DISCHARGE DATA: CARDIOVASCULAR DISEASE, SAN DIEGO COUNTY & REGIONAL MAPS

CNI & HOSPITAL DISCHARGE DATA: CARDIOVASCULAR DISEASE, DATA SOURCE EXPLANATION

*Community Need Index

Universe: Total Population of San Diego County

Data Source: Truven Health Analytics³³

Data Year: 2013

Data Level: ZIP code

***Cardiovascular Disease Discharge Rate

Description: 2013 hospital discharge rate (Inpatient/ED) was determined where *Cardiovascular Disease* was the condition established to be the principal diagnosis, per 1,000 people (population stats: United States Census 2010 population). The following ICD-9 codes were used to identify a discharge as Cardiovascular Disease: 401-405, 410-414, 427.31, 428, 429.2, 430-438, 440.

Universe: Total Population of San Diego County

Data Source: California Office of Statewide Health Planning and Development, accessed through SpeedTrack[®], Inc.

Data Year: 2013

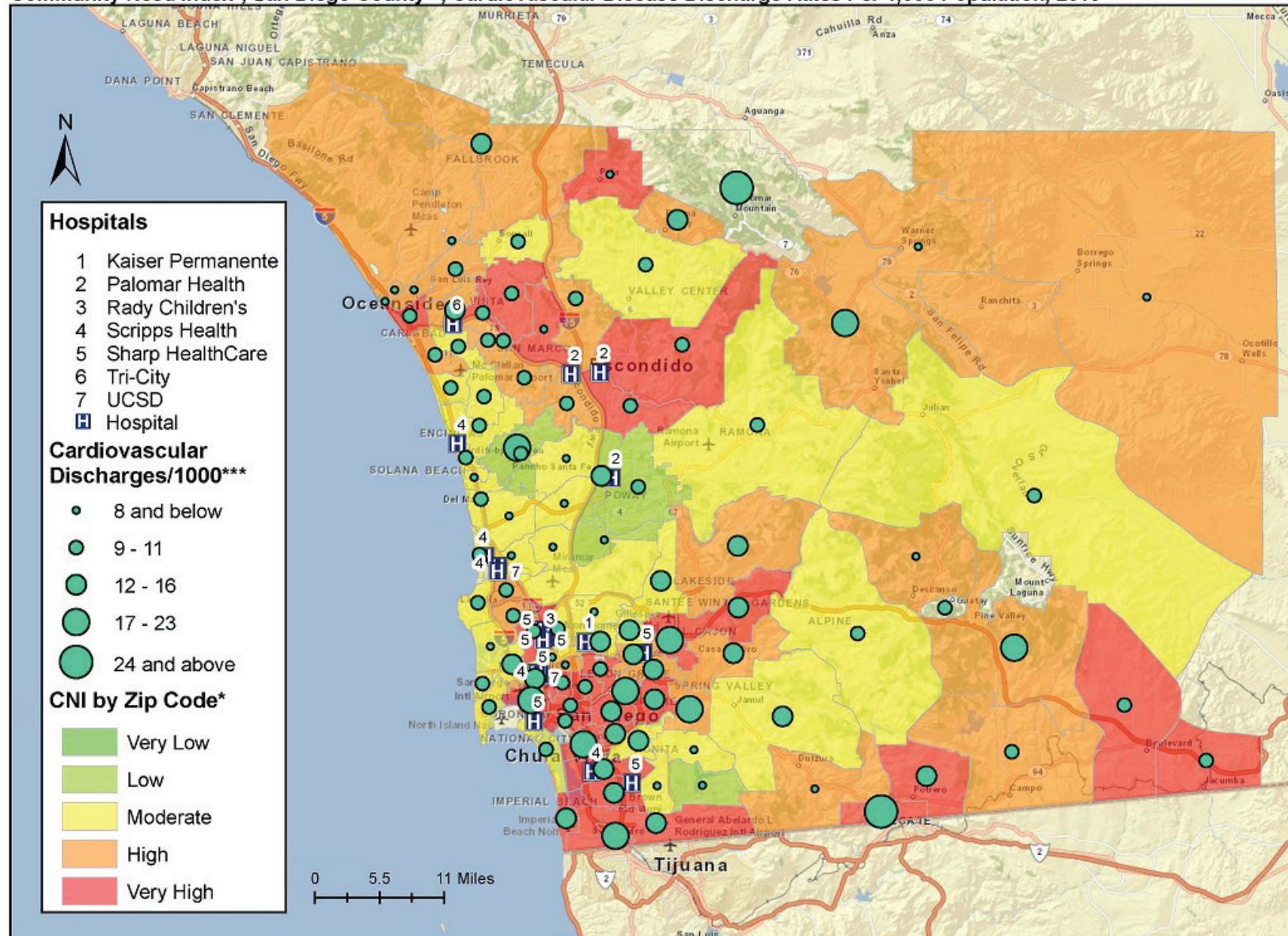
Data Level: ZIP code

Description of Community Need Index (CNI): Identifies and compares community need across every ZIP code in the United States based on the following five barriers:

1. Income Barrier
2. Culture Barrier
3. Educational Barrier
4. Insurance Barrier
5. Housing Barrier

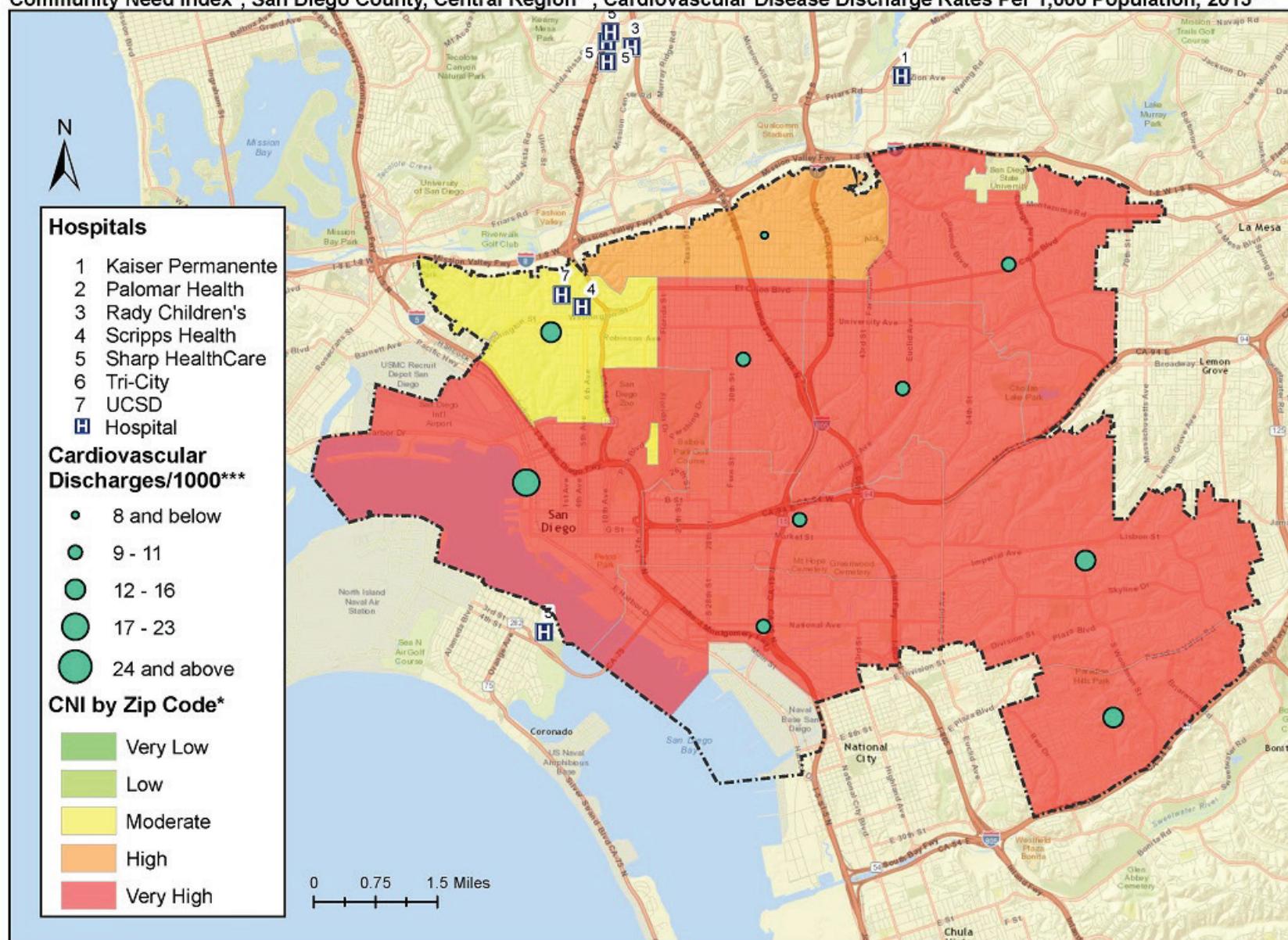
³³ Source: Truven Health Analytics, 2015; Insurance Coverage Estimates, 2015; The Nielson Company, 2015; and Community Need Index, 2015.

Community Need Index*, San Diego County**, Cardiovascular Disease Discharge Rates Per 1,000 Population, 2013***



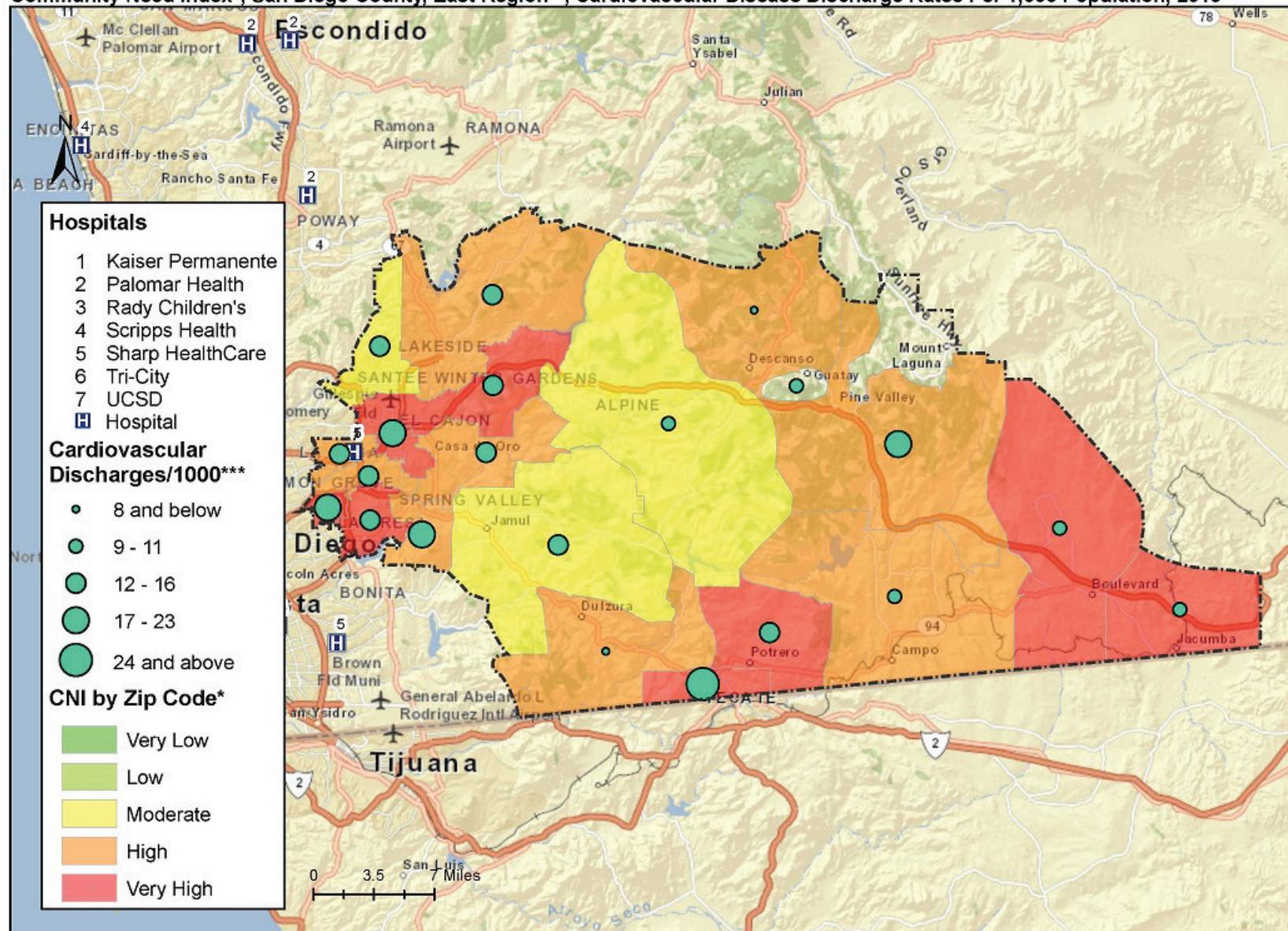
Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
Basemap: © 2015 OpenStreetMap contributors, and the GIS User Community.

Community Need Index*, San Diego County, Central Region**, Cardiovascular Disease Discharge Rates Per 1,000 Population, 2013***



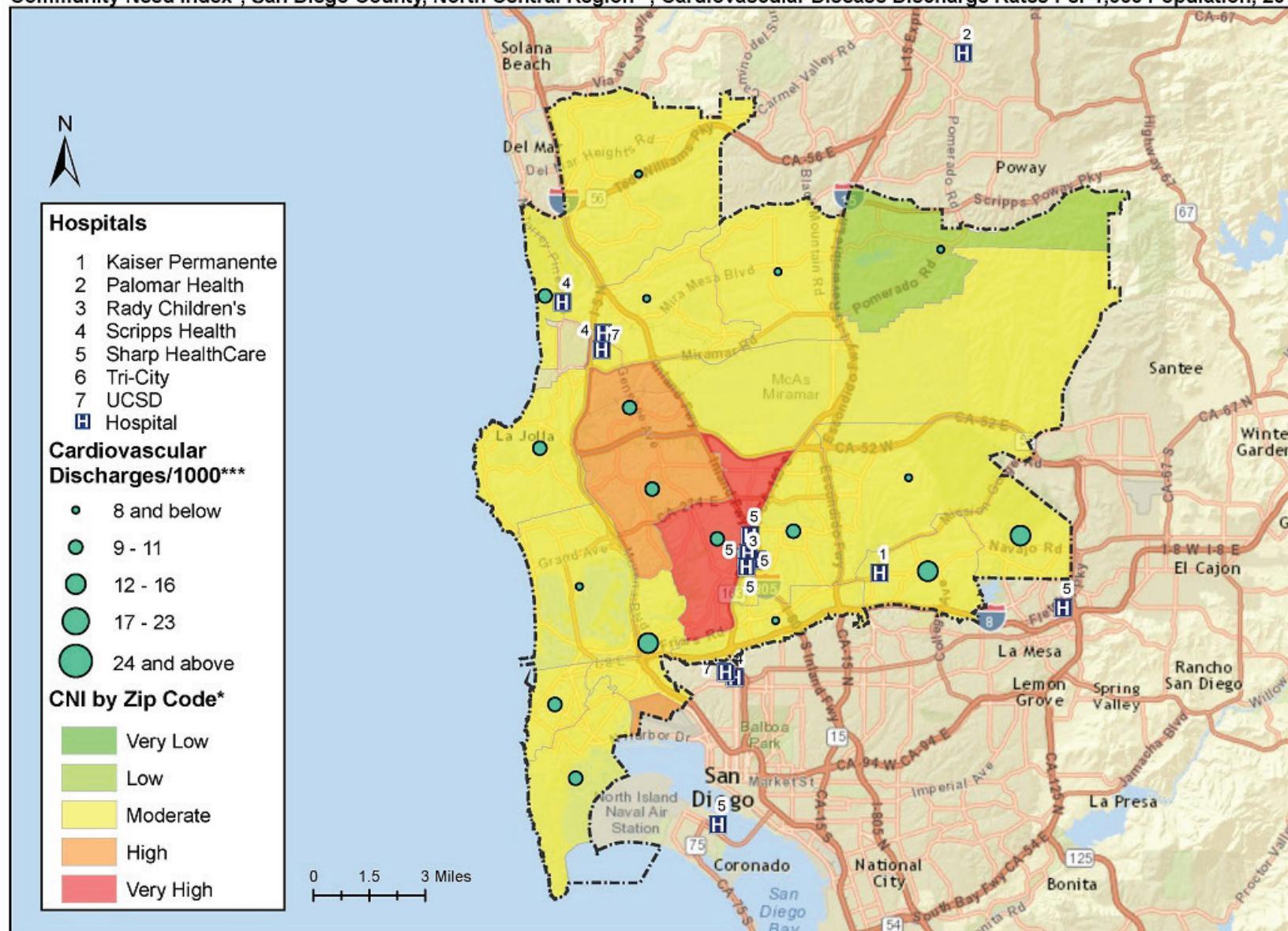
Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
Basemap: © 2015 OpenStreetMap contributors, and the GIS User Community.

Community Need Index*, San Diego County, East Region**, Cardiovascular Disease Discharge Rates Per 1,000 Population, 2013***



Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
Basemap: © 2015 OpenStreetMap contributors, and the GIS User Community.

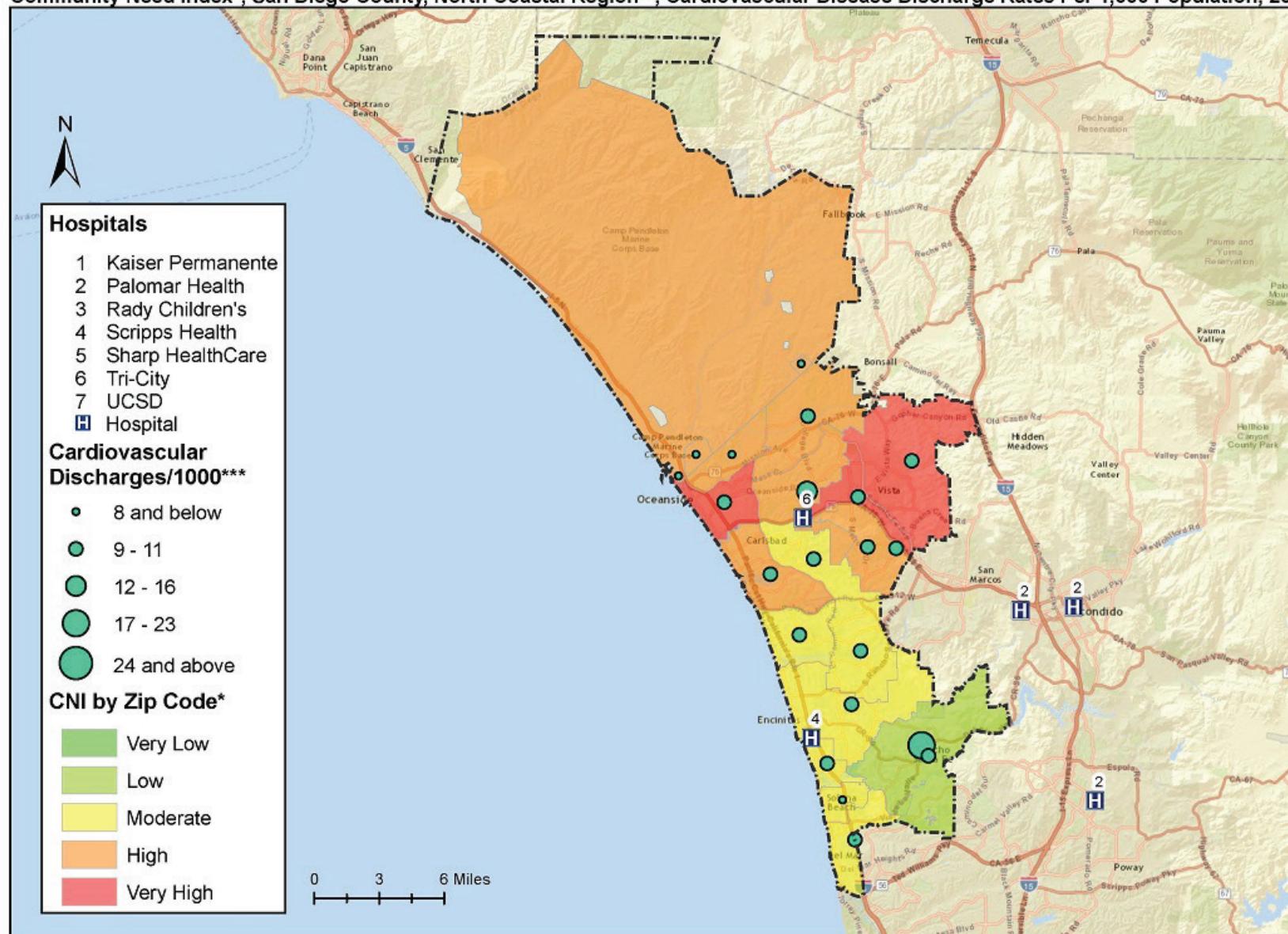
Community Need Index*, San Diego County, North Central Region**, Cardiovascular Disease Discharge Rates Per 1,000 Population, 2013***



Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
Basemap: © 2015 OpenStreetMap contributors, and the GIS User Community.



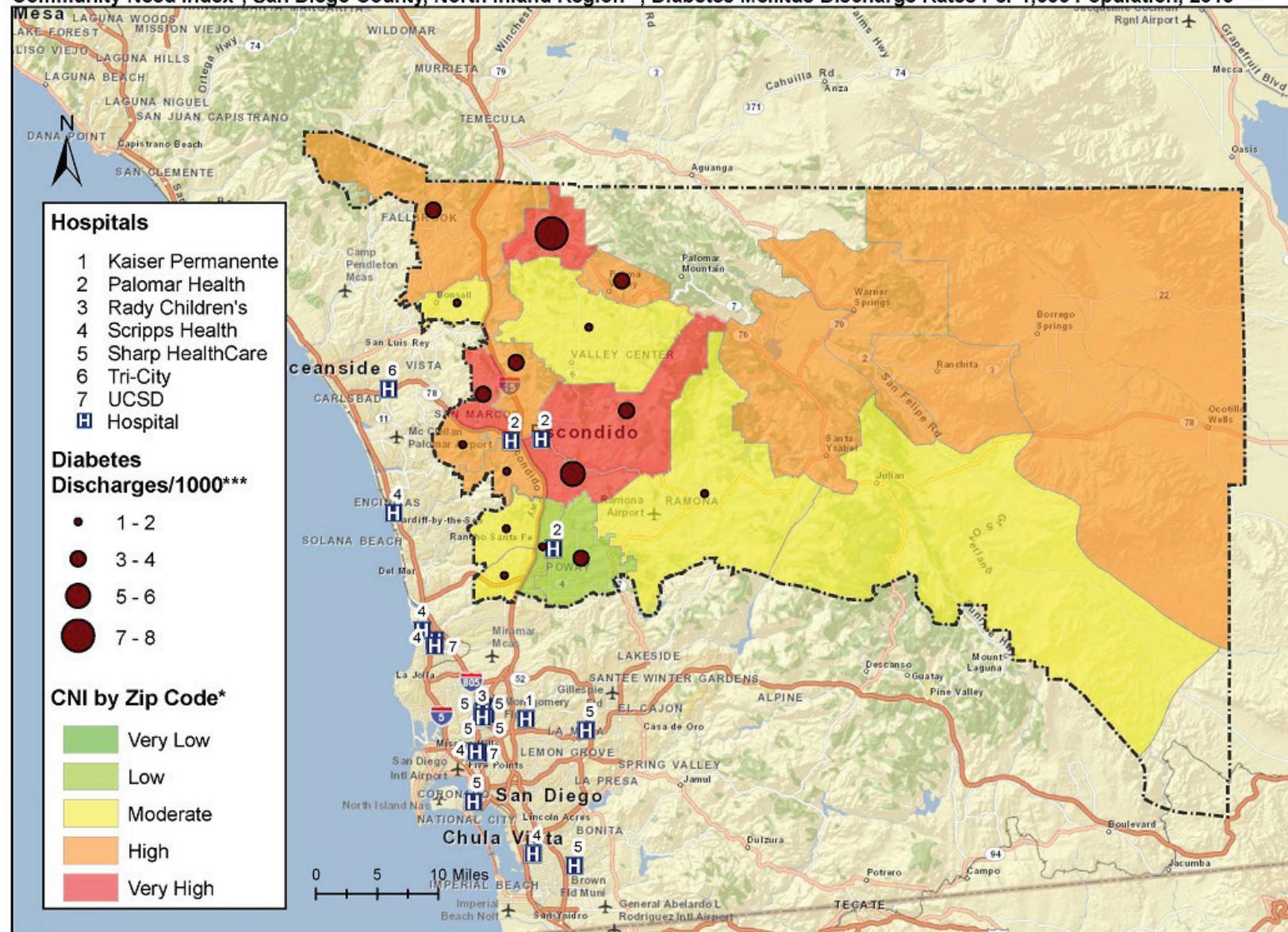
Community Need Index*, San Diego County, North Coastal Region**, Cardiovascular Disease Discharge Rates Per 1,000 Population, 2013***



Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
Basemap: © 2015 OpenStreetMap contributors, and the GIS User Community.



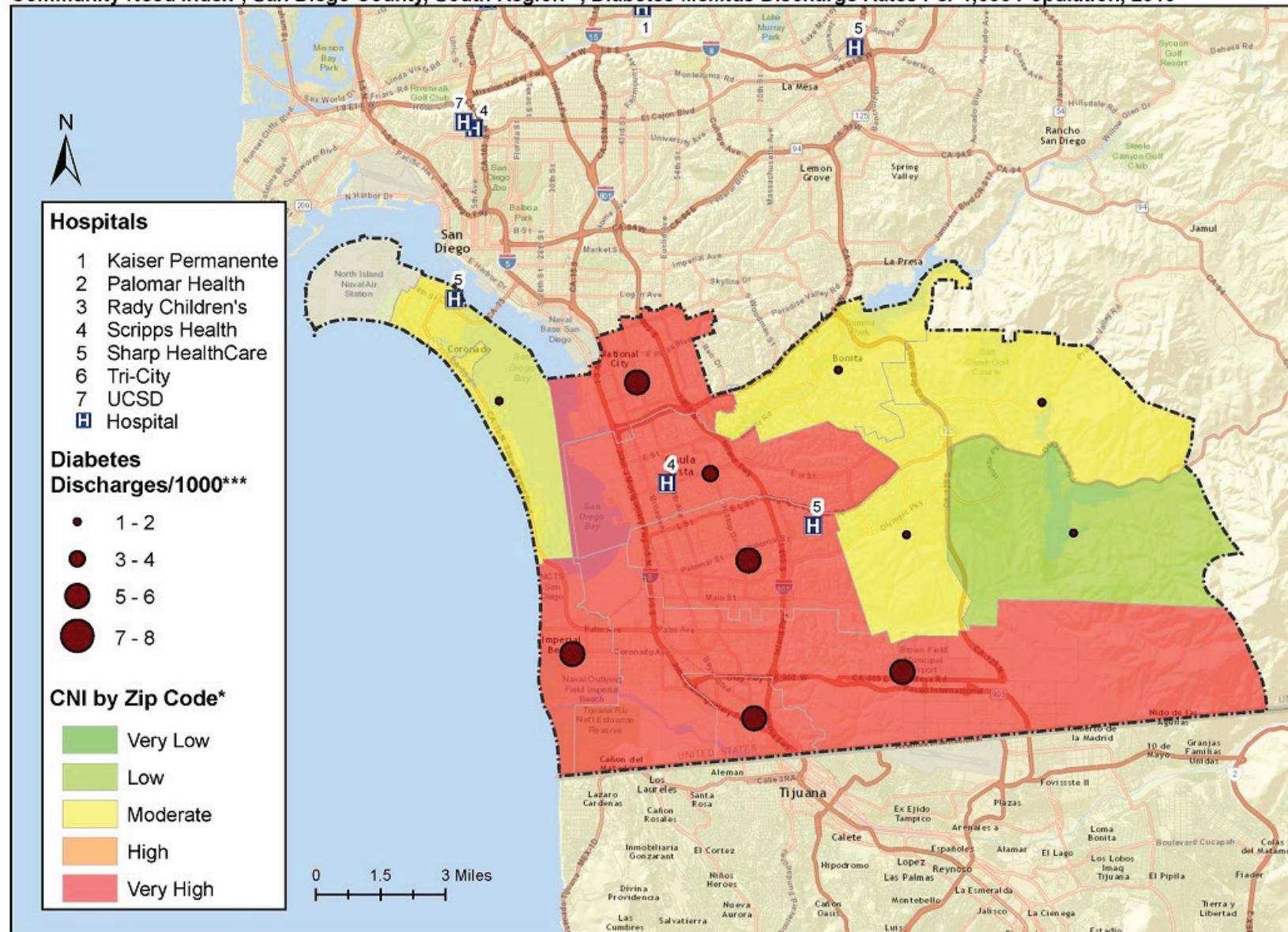
Community Need Index*, San Diego County, North Inland Region**, Diabetes Mellitus Discharge Rates Per 1,000 Population, 2013***



Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
Basemap: © 2015 OpenStreetMap contributors, and the GIS User Community.



Community Need Index*, San Diego County, South Region**, Diabetes Mellitus Discharge Rates Per 1,000 Population, 2013***



Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
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CNI & HOSPITAL DISCHARGE DATA: TYPE 2 DIABETES, SAN DIEGO COUNTY & REGIONAL MAPS

CNI & HOSPITAL DISCHARGE DATA: TYPE 2 DIABETES DATA SOURCE EXPLANATION

*Community Need Index

Universe: Total Population of San Diego County

Data Source: Truven Health Analytics³⁴

Data Year: 2013

Data Level: ZIP code

***Type 2 Diabetes Discharge Rate

Description: 2013 hospital discharge rate (Inpatient/ED) was determined where *Type 2 Diabetes* was the condition established to be the principal diagnosis, per 1,000 people (population stats: United States Census 2010 population). The following ICD-9 codes were used to identify a discharge as Type 2 Diabetes: 249-250, 648.00-648.04, 648.80-648.84.

Universe: Total Population of San Diego County

Data Source: California Office of Statewide Health Planning and Development, accessed through SpeedTrack[®], Inc.

Data Year: 2013

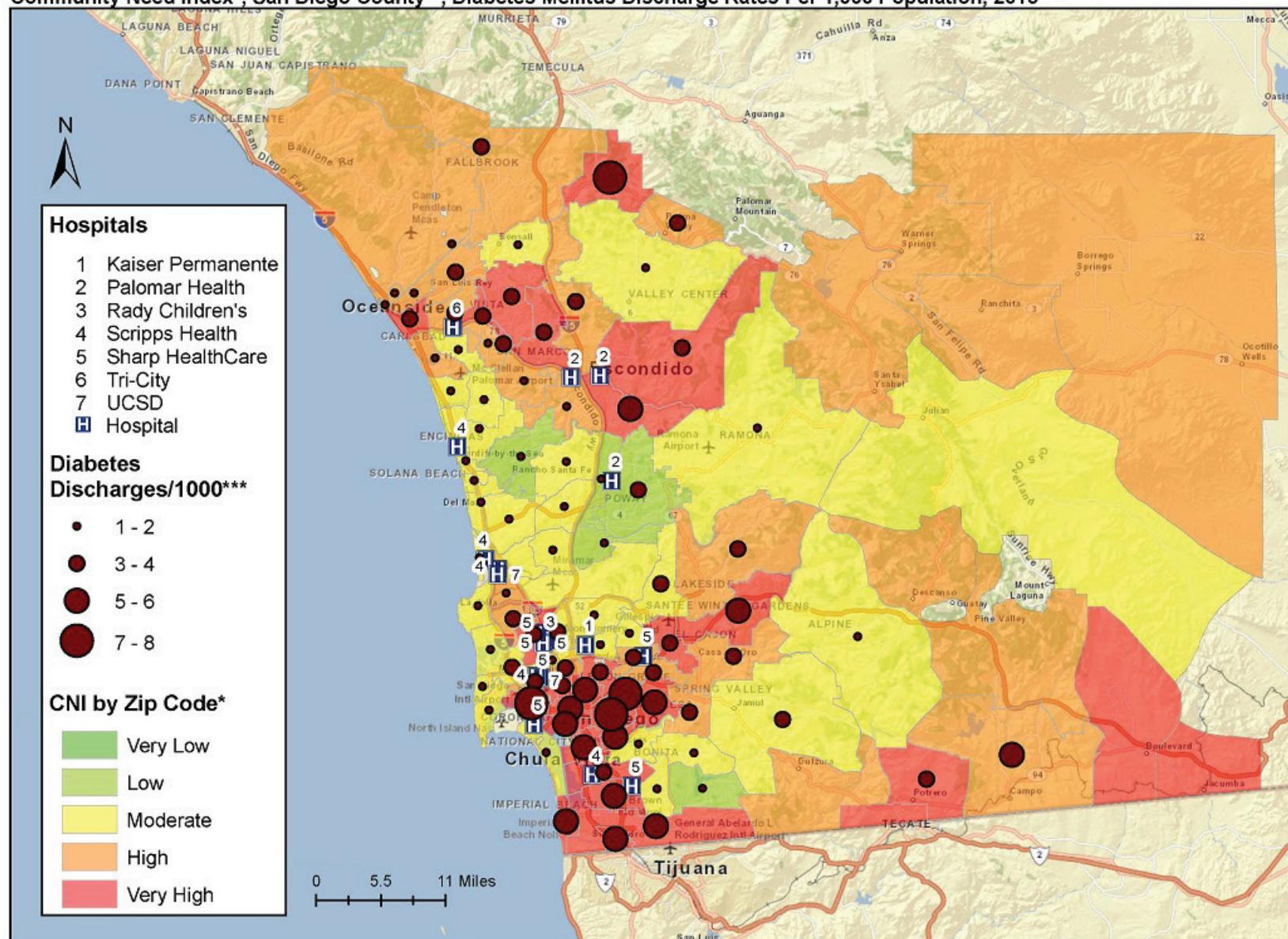
Data Level: ZIP code

Description of Community Need Index (CNI): Identifies and compares community need across every ZIP code in the United States based on the following five barriers:

1. Income Barrier
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3. Educational Barrier
4. Insurance Barrier
5. Housing Barrier

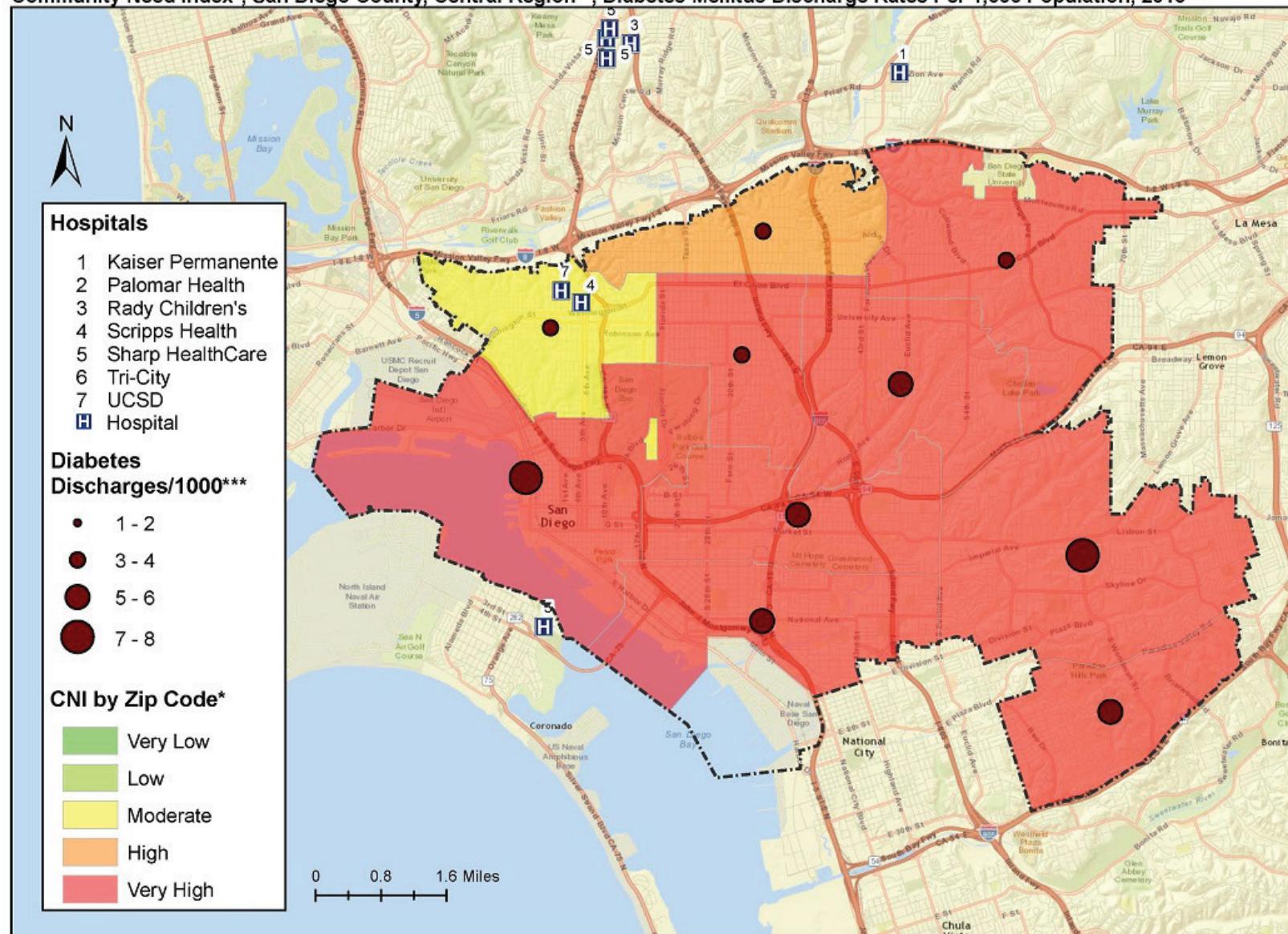
³⁴e: Truven Health Analytics, 2015; Insurance Coverage Estimates, 2015; The Nielson Company, 2015; and Community Need Index, 2015.

Community Need Index*, San Diego County**, Diabetes Mellitus Discharge Rates Per 1,000 Population, 2013***



Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
Basemap: © 2015 OpenStreetMap contributors, and the GIS User Community.

Community Need Index*, San Diego County, Central Region**, Diabetes Mellitus Discharge Rates Per 1,000 Population, 2013***

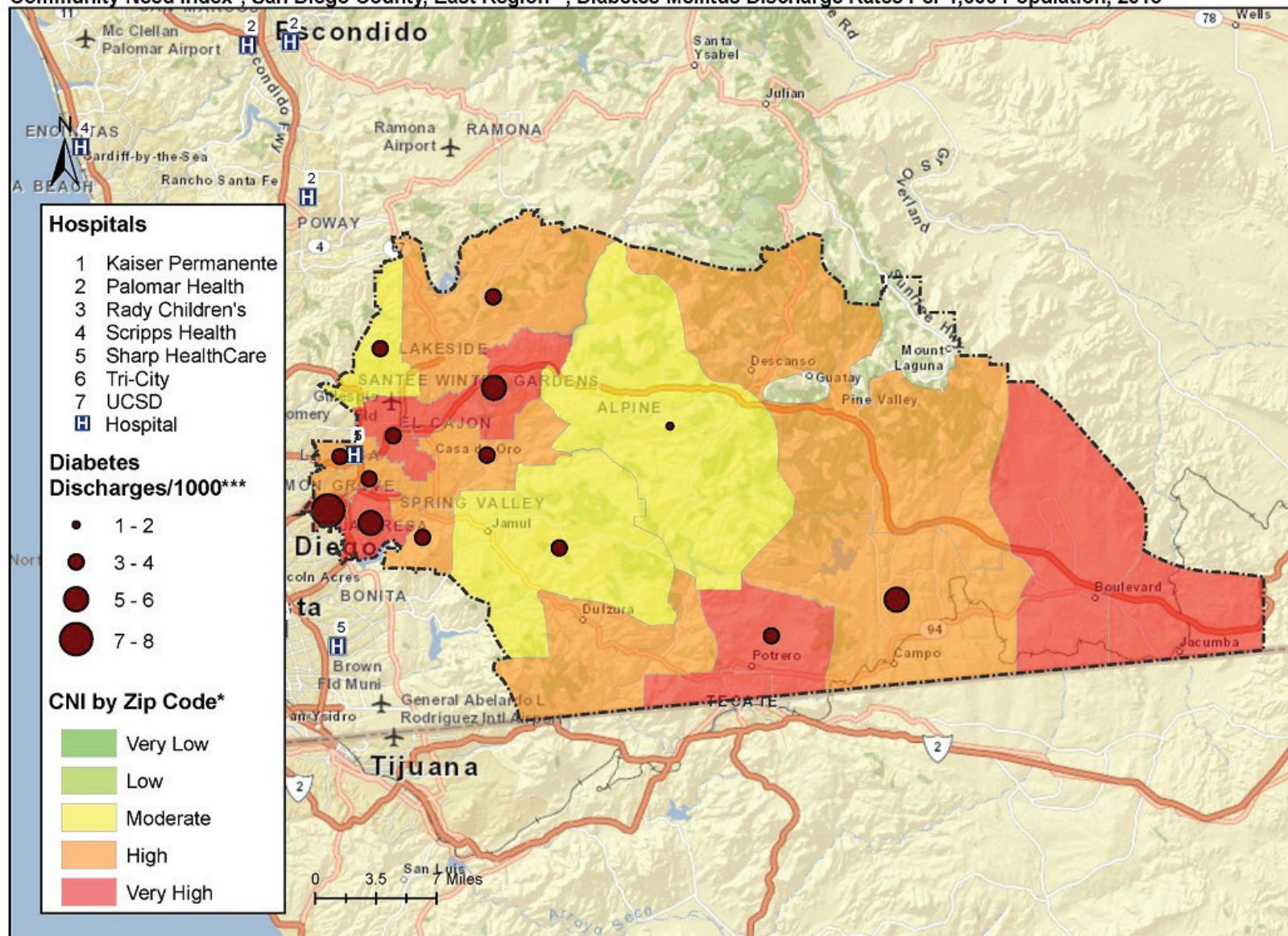


Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
Basemap: © 2015 OpenStreetMap contributors, and the GIS User Community.

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Community Need Index*, San Diego County, East Region**, Diabetes Mellitus Discharge Rates Per 1,000 Population, 2013***

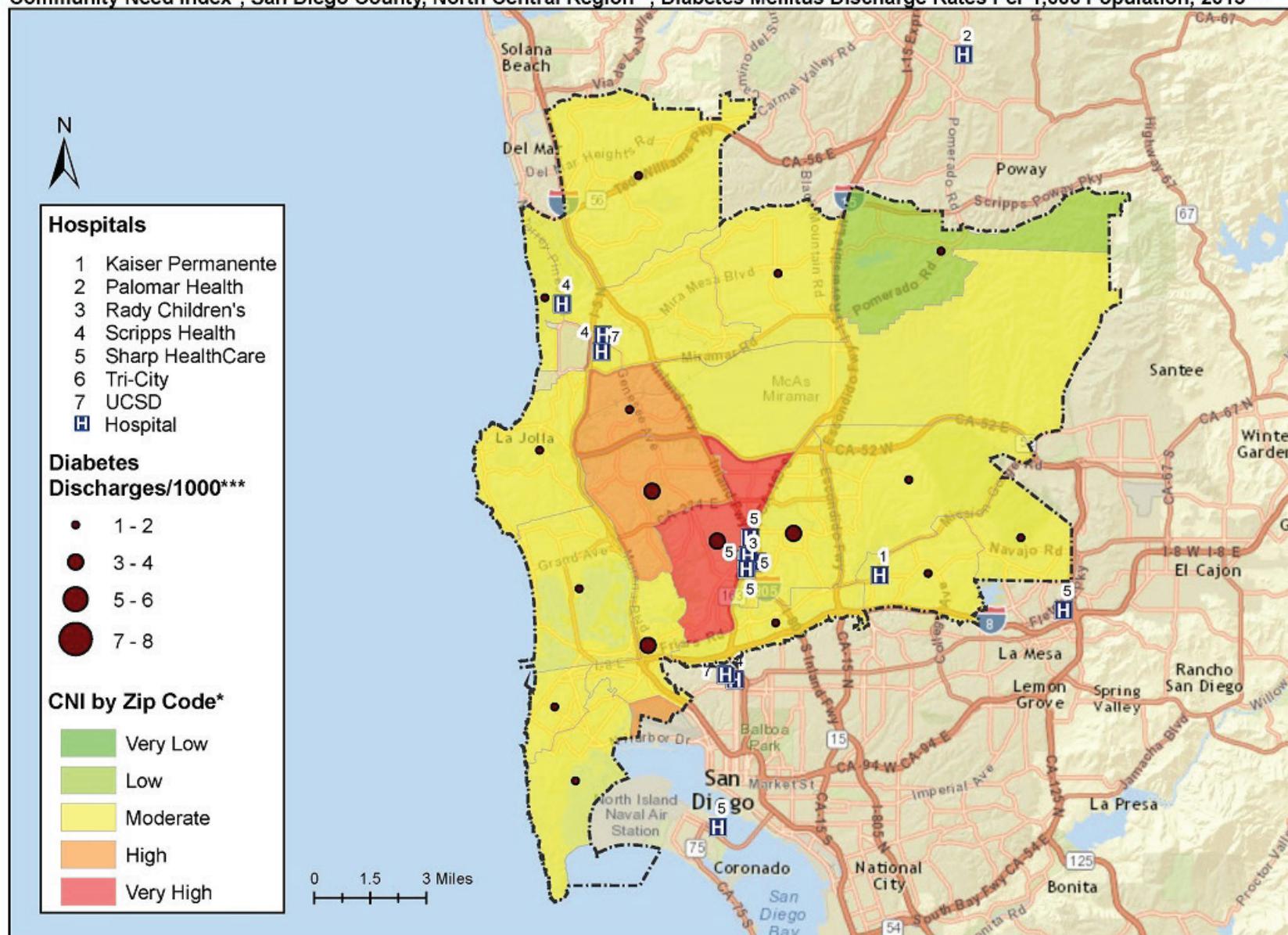


Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
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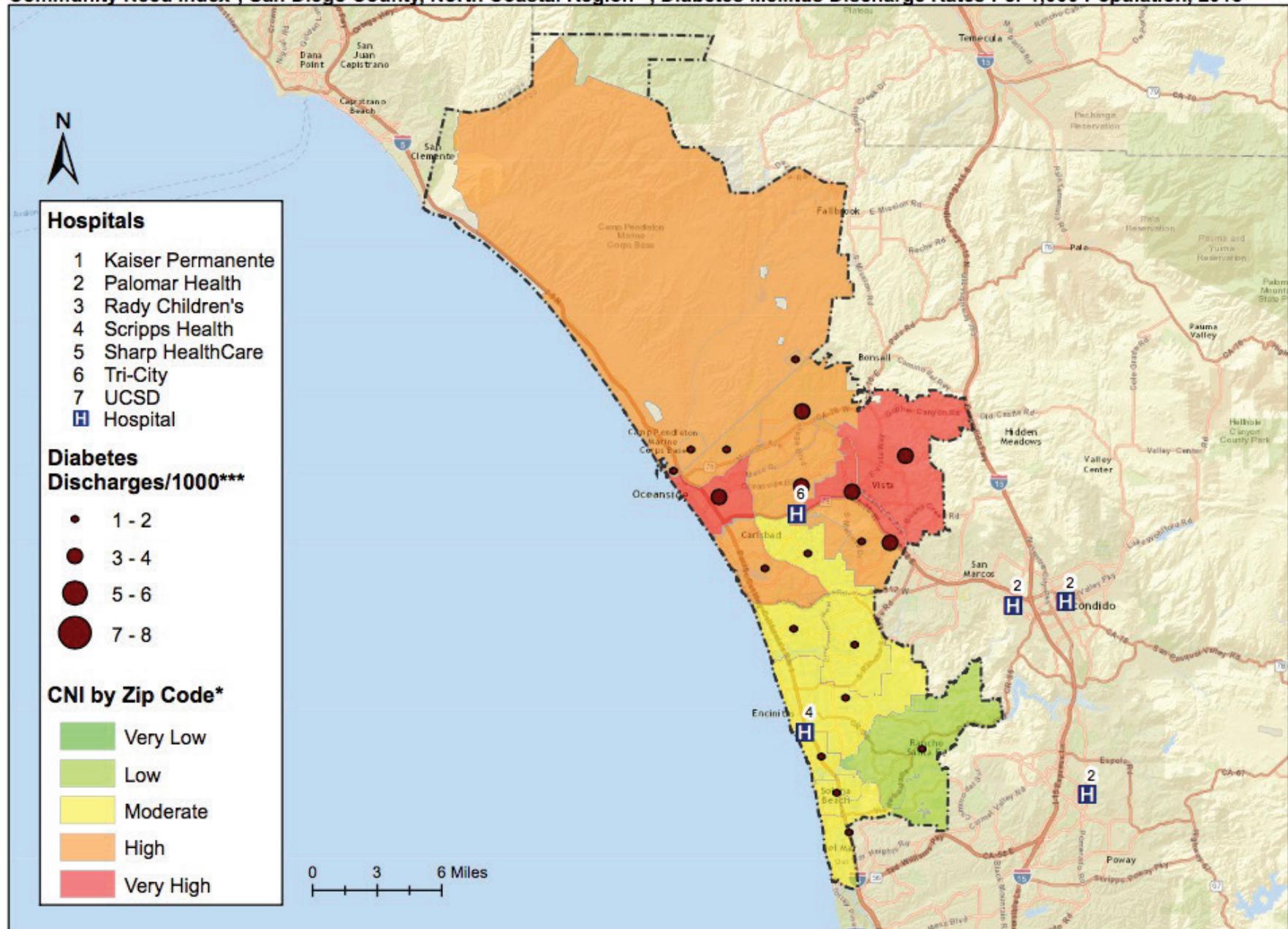
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Community Need Index*, San Diego County, North Central Region**, Diabetes Mellitus Discharge Rates Per 1,000 Population, 2013***



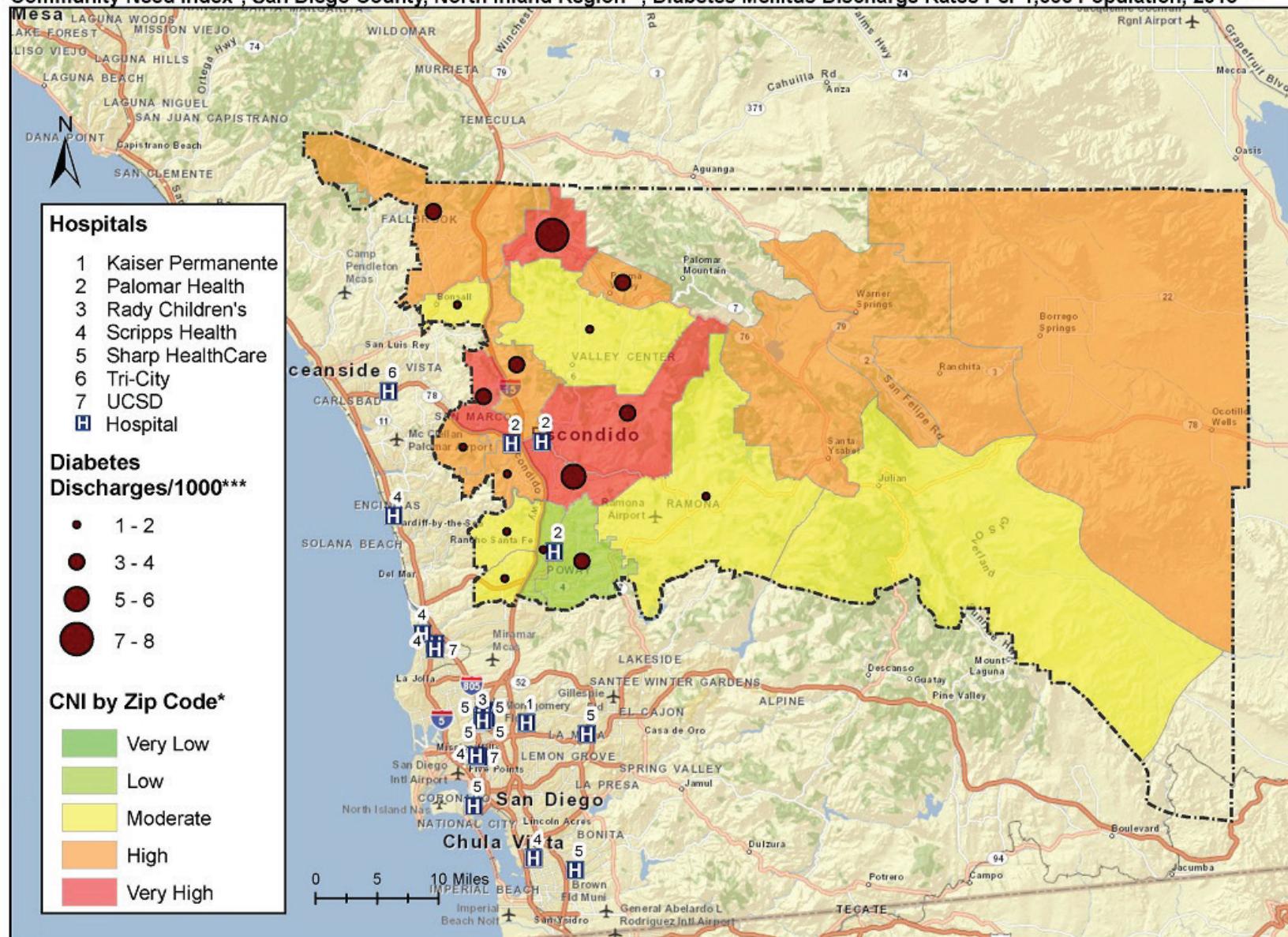
Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
Basemap: © 2015 OpenStreetMap contributors, and the GIS User Community.

Community Need Index*, San Diego County, North Coastal Region, Diabetes Mellitus Discharge Rates Per 1,000 Population, 2013*****



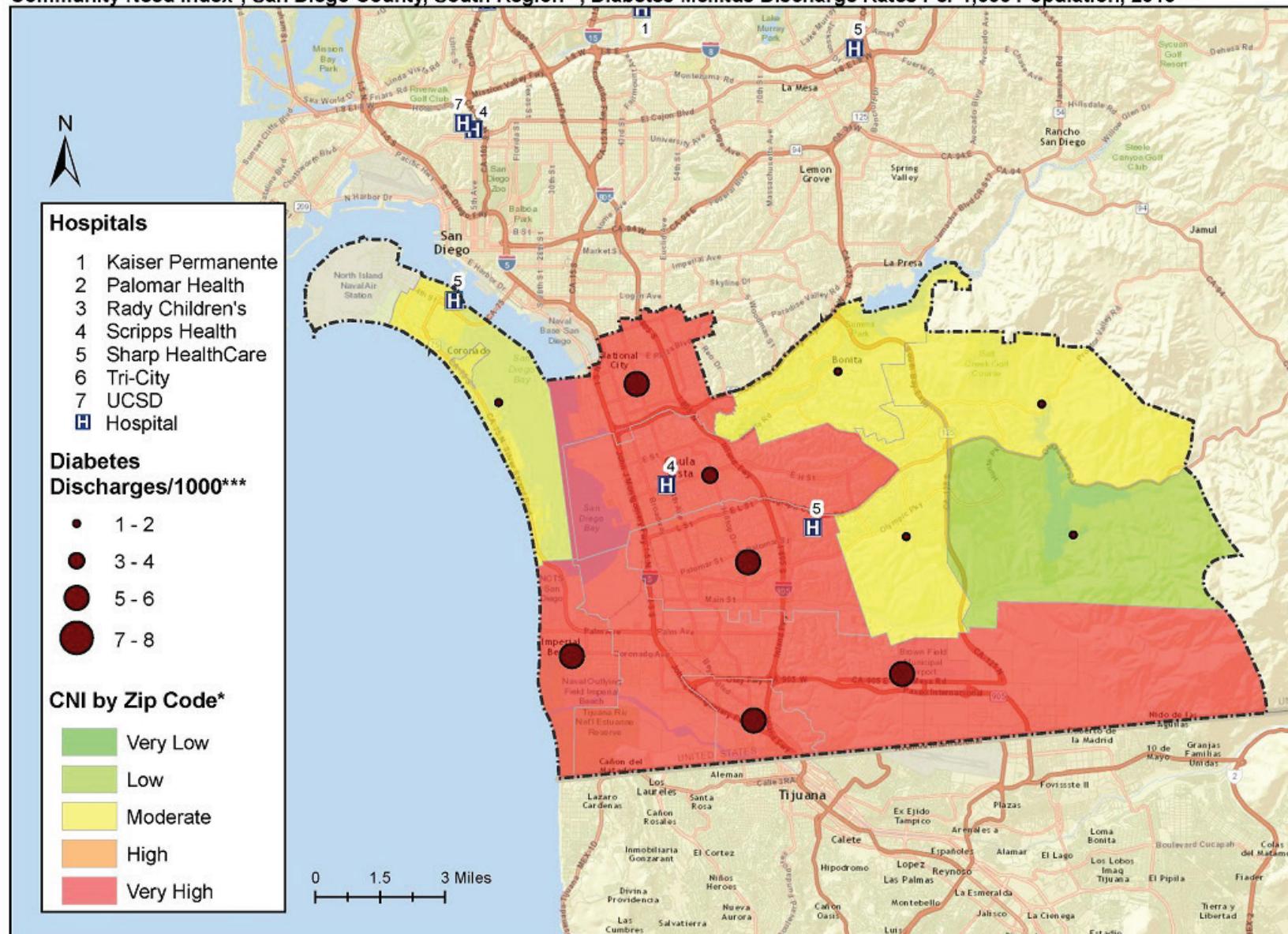
Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
Basemap: © 2015 OpenStreetMap contributors, and the GIS User Community.

Community Need Index*, San Diego County, North Inland Region**, Diabetes Mellitus Discharge Rates Per 1,000 Population, 2013***



Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
Basemap: © 2015 OpenStreetMap contributors, and the GIS User Community.

Community Need Index*, San Diego County, South Region**, Diabetes Mellitus Discharge Rates Per 1,000 Population, 2013***



Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
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APPENDIX M: REGULATORY REQUIREMENTS

Appendix M: Regulatory Requirements

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, 2016. Additional information on the ACA requirements for nonprofit hospitals can be found at www.irs.gov, keyword: "Charitable Organizations".

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.

APPENDIX N: ACRONYMS AND ABBREVIATIONS

Acronyms and Abbreviations

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
SAMSHA	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
U.S.	United States

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
SAMSHA	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
U.S.	United States