2016 Community Health Needs Assessment

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CHNA REPORT FOR KFH-SAN DIEGO

Authors

Institute for Public Health, San Diego State University
Tanya E. Penn
Epidemiologist

Institute for Public Health, San Diego State University
Nicole Delange
Research Assistant

Acknowledgements

Community Health Needs Assessment Committee

This report is based on the collaboration of representatives from seven local San Diego hospitals called the Community Health Needs Assessment (CHNA) Committee. The CHNA Committee listed below actively participated in completing the HASD&IC 2016 Community Health Needs Assessment which is described in detail in this report.

Jillian Barber
Sharp HealthCare

Anette Blatt
Scripps Health

Aaron Byzak
UC San Diego Health

Elly Garner
Palomar Health

Jamie Johnson
Tri-City Medical Center

Lisa Lomas
Rady Children's Hospital – San Diego

Tana Lorah
Kaiser Foundation Hospital - San Diego

Hospital Association of San Diego and Imperial Counties

Dimitrios Alexiou
President and Chief Executive Officer

Lindsey Wade
Vice President, Public Policy

Institute for Public Health, San Diego State University

Tanya Penn
Epidemiologist

Nicole Delange
Research Assistant

Amy Pan
Senior Research Scientist

Special Thanks

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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
Palomar Health Community Action Council
Resident Leadership Academy
San Diego County of Education School Nurses Resource Group
San Diego County Health and Human Services Agency
San Diego Hunger Coalition CalFresh Task Force
San Ysidro Health Center

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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
HP2020	Healthy People 2020
HPSA	Health professional shortage area
ICD	International Classification of Diseases
IPH	Institute for Public Health
IS	Implementation Strategy
KFH	Kaiser Foundation Hospital
KFHP	Kaiser Foundation Health Plan
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

I.

OSHPD	Office of Statewide Health Planning and Development
PCD	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
TAY	Transitional Age Youth
U.S.	United States

I. EXECUTIVE SUMMARY

San Diego County is home to over three million people making it the fifth most populous county in the United States. It is a socially and ethnically diverse area situated along the southwestern U.S. border with densely populated urban areas found largely along the coast. The Kaiser Foundation Hospital (KFH) -San Diego medical service area is roughly equivalent to the entire San Diego County population. Therefore, the 2016 Community Health Needs Assessment (CHNA) report is comprised of county level data and supplemented with regional data when available.

Based on the findings from the 2013 CHNA, this report was designed to provide a deeper understanding barriers to health improvement in order to better inform and guide hospital implementation strategies. This includes an analysis of health outcomes and associated health drivers which create health inequities – 'the unfair and avoidable differences in health status seen within and between countries[1]' and communities – with the understanding that the burden of illness, premature death, and disability disproportionally affects racial and minority population groups and other underserved populations.[2] Identifying populations with health disparities and the corresponding health driver that create the disparity is an important step to understanding and ultimately strategizing ways to make collective impact. These new insights will allow participating hospitals to identify innovative strategies to address the most prevalent and challenging health needs in the community.

A. Community Health Needs Assessment (CHNA) Background

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, included new requirements for nonprofit hospitals in order to maintain their tax exempt status. The provision was the subject of final regulations providing guidance on the requirements of section 501(r) of the Internal Revenue Code. Included in the new regulations is a requirement that all nonprofit hospitals must conduct a community health needs assessment (CHNA) and develop an implementation strategy (IS) every three years (http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf).

While Kaiser Permanente has conducted CHNAs for many years to identify needs and resources in our communities and to guide our Community Benefit plans, these new requirements have provided an opportunity to revisit our needs assessment and strategic planning processes with an eye toward enhancing compliance and transparency and leveraging emerging technologies. The CHNA process undertaken in 2016 and described in this report was conducted in compliance with current federal requirements.

Representatives from seven local San Diego hospitals formed a committee, convened by the

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[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

Hospital Association of San Diego and Imperial Counties (HASD&IC), called the Community Health Needs Assessment (CHNA) committee. In May 2015, HASD&IC contracted with the Institute for Public Health (IPH) at San Diego State University (SDSU) to provide assistance in the implementation and interpretation of the CHNA. This needs assessment was a collaborative CHNA that was officially called the HASD&IC 2016 Community Health Needs Assessment (2016 CHNA). The purpose of this CHNA was to identify and prioritize health needs in San Diego County using multiple sources of information. This CHNA involved a mixed methods approach including the analysis of existing quantitative data, as well as primary data collection through 1) community partner discussions, 2) key informant interviews, 3) health access and navigation survey, 4) collaborative San Diego County Health and Human Services Agency survey, and 5) behavioral/mental health discussions. Throughout the process, the IPH met bi-weekly with the Hospital Association's CHNA Committee to define, refine, and interpret results as they were being collected. As a part of this process, a list was compiled of assets and resources that are potentially available to address the top health needs in the community. This comprehensive assessment intends to surpass requirements and embody the defining characteristics of community-based participatory research. Through community engagement and data analysis, it is the hope that the 2016 CHNA will help to guide current planning efforts around San Diego County and help organizations to better tailor programs to the needs of vulnerable populations.

B. **Summary of Prioritized Needs**

A broad list of fifteen health needs within San Diego County was prioritized during the collaborative 2013 CHNA effort and utilized in the current 2016 CHNA as a starting point for the data analysis process. All fifteen health needs were validated as having continued relevance within San Diego County due to their significant contribution to morbidity, mortality, and/or disparities. In addition, Kaiser Permanente conducted a supplementary analysis for the 2013 CHNA which identified cervical cancer, chlamydia and HIV as important health needs in San Diego. These three additional health needs were also validated by the current data and one additional emergent health need was added to the list, oral health.

Prioritized health needs:

1. Diabetes (Type 2)
2. Obesity
3. Cardiovascular Disease
4. Behavioral/Mental Health
5. Unintentional Injury
6. High Risk Pregnancy
7. Asthma
8. Dementia & Alzheimer's Disease
9. Breast Cancer
10. Acute Respiratory Infections/Pneumonia
11. Back Pain
12. Colorectal Cancer
13. Lung Cancer
14. Prostate Cancer
15. Skin Cancer

- Cervical Cancer*
- Chlamydia*
- HIV*
- Oral health*

*Kaiser specific outcome, not part of the collaborative process

Based on secondary data and feedback from the community regarding future needs assessments processes, the collaborative CHNA committee chose to conduct an in-depth

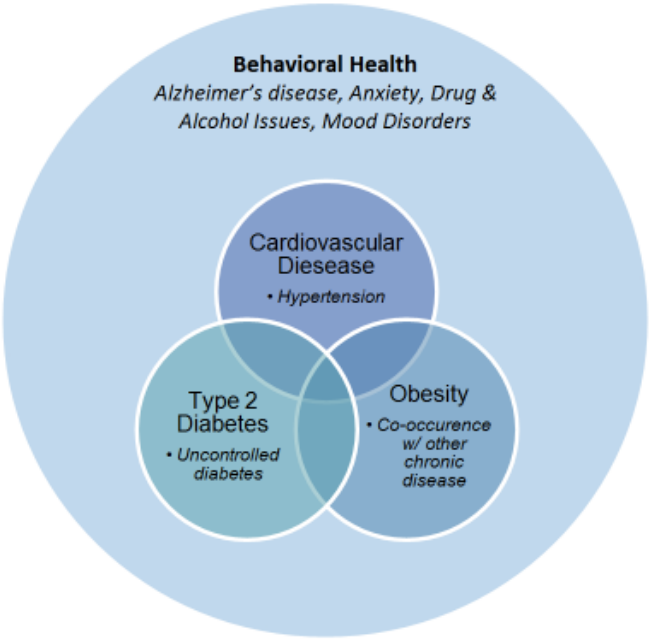
analysis of the top four needs identified: diabetes, obesity, cardiovascular disease, and behavioral/mental health.

In addition, ten health drivers associated with the health needs were identified and prioritized through community input and the secondary data analysis. Below is the list of health drivers in order or priority

1. Food Insecurity & Access to Healthy Food
2. Access to Care or Services
3. Homeless/Housing Issues
4. Physical Activity
5. Education/Knowledge
6. Cultural Competency
7. Transportation
8. Insurance Issues
9. Stigma
10. Poverty

After examination of the combined results, the CHNA Committee identified behavioral/mental health as the number one health issue in San Diego County. In addition, cardiovascular disease, diabetes, and obesity were identified as having equal importance due to the interrelatedness of the three health issues. Sub-categories within each identified health need were identified due to the overwhelming agreement among the data and the community, and in recognition of the important differences within each health issue. Within the category of behavioral/mental health, Alzheimer's, anxiety, mood disorders, and drug and alcohol issues are significant health needs within San Diego County. Among the other chronic health needs, hypertension was consistently found to be a significant health issue related to cardiovascular disease, uncontrolled diabetes was an important factor leading to complications with 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.

2016 CHNA TOP HEALTH NEEDS



The ten prioritized health drivers associated with all four identified health needs were consistently referenced across the various sources of community input and were supported by secondary data as significant issues within San Diego County. Hospital programs and community collaborations have the potential to impact these health drivers, which are outlined below in order of priority.

1. Food Insecurity and Access to Healthy food

Food insecurity and access to healthy food were cited most often as a driver of health across all community input activities. In addition, high levels of food insecurity and the food environment in San Diego County supports this as a high need issue.

Poor 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 California Health Interview survey 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 US (81.9 vs 74.5 and 72.0 respectively) according the US Census Bureau County Business Patterns.

2. Access to healthcare or services

Access to healthcare was cited as an important health driver throughout the community input activities and is supported by secondary 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 health drivers 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 population 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.

Secondary 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.

3. Homeless/housing issues

Housing and homelessness is an important social determinant of health in San Diego County with both community input and secondary data pointing to a continued problem.

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.

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.

4. Physical activity

Lack of physical activity in children and adults was revealed as a major health driver during the community input activities. The high prevalence of physical inactivity was confirmed by secondary 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 PE avoidance among youth also contributes to physical inactivity.

According to the Centers for Disease Control and Prevention’s (CDC) 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.

5. Education/knowledge

Education in some capacity was mentioned during all community input activities and is supported by secondary 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/mental 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 American Community Survey (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%).

6. Cultural Competency

Cultural competency was reiterated as a health driver across all community input activities. In addition, secondary data points to the changing demographics of the population in San Diego County and the need for a culturally competent workforce.

Qualitative feedback was gathered from community partner discussions and key informant interviews which highlighted areas in which different cultural practices and lack of cultural competency in healthcare drives disparities in health outcomes. Among community partners, low motivation and health literacy were cited as behavioral factors that contribute to poorer health outcomes.

Secondary 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.

7. Transportation

Transportation was cited as a health driver 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 heighted 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.

8. 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 across the key informant interviews and community partner discussions.

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.

9. 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".[3]

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 in San Diego County, 89.7% reported experiencing some type of discrimination with relation to their mental health problems.[4]

10. Poverty

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.

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

[4] 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

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.

C. **Summary of Needs Assessment Methodology and Process**

Based on the 2013 CHNA and feedback received as part of the 2013 CHNA Phase II efforts, the participating hospitals developed a methodology for the 2016 CHNA that would:

- Entail a scan of current community health statistics to ensure the continued relevance and influence of the top four health needs identified in the 2013 CHNA on health status, and
- Dive deeper into the four priority health needs identified in the 2013 CHNA through more specific quantitative analyses and broader, more comprehensive qualitative community outreach.

The following are the four significant health needs identified in the 2013 CHNA, listed in alphabetical order:

- Behavioral/Mental Health
- Cardiovascular Disease
- Diabetes (type 2)
- Obesity

Secondary data was collected using various existing data sources in conjunction with the Kaiser Permanente CHNA Data Platform to create a profile of San Diego County demographics and health statistics. The purpose of gathering secondary data was to gain a baseline understanding of San Diego County and the health of its residents, describe the community served, ensure the continued relevance and influence of the top health needs identified in the 2013 CHNA on health status, and gain a better understanding of how the top four identified health needs impact San Diego health systems and hospitals through a detailed analysis of hospital discharge data.

The list of fifteen health needs that were identified during the collaborative 2013 CHNA effort in San Diego County were validated as a broad health need for the 2016 CHNA if they met at least one of the following criteria:

- Mortality: Among the top 10 leading causes of death in San Diego County
- Benchmark analysis: Among the top 10 potential health needs as identified by the Kaiser Permanente's Community Benefit data analysis tool
- Morbidity: Among the top 10 primary or secondary diagnoses as identified in the hospital discharge analysis

Based on secondary data analysis and feedback from Phase II of the 2013 CHNA regarding future needs assessments processes, the collaborative CHNA committee chose to conduct an in-depth analysis of the top four needs identified: diabetes, obesity, cardiovascular disease, and behavioral/mental health. In recognition of the challenges that health providers, community

organizations and other stakeholders face in their efforts to prevent, diagnose and manage significant chronic health needs, input was also gathered from health experts, community leaders, and San Diego residents in an effort to gain a more complete understanding of the top four identified health needs and associated health drivers in the San Diego community. These individuals 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. Additionally, when applicable, other individuals with expertise of local health needs were consulted. Community input was collected 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/Mental Health Discussions

In order to prioritize the four significant health needs in San Diego County, the CHNA Committee used the criteria listed below, taking into account the ability of hospitals to have a significant and meaningful impact given their expertise and available resources. 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 consequence (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. Taking into account both primary and secondary data, a scale of 1 to 4, from most to least significant health need, was applied to each of the four health needs for each criterion. An overall score was given to each health need by averaging the rankings across all categories. Through examination of the combined results, clear divisions emerged and sub-categories within each health need were identified.

In addition, health drivers associated with the health needs were identified and prioritized based on the frequency of times the health drivers were cited during community input activities and if secondary data supported it as a problem within San Diego County.

There are a number of community and countywide initiatives, partnerships, collaborations, and public policies that address the top health needs. Some large scale efforts surrounding the top health needs include:

- Live Well San Diego,
- Be There San Diego, Preventing Heart Attacks and Strokes
- San Diego Childhood Obesity Initiative,

- National Diabetes Prevention Program,
- It's Up to Us Campaign.

Finally, 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 San Diego's Directory of Services (http://www.211sandiego.org/). The number of resources that were identified for each condition were as follows: Behavioral/Mental Health (190), Diabetes (118), Obesity (382), and Cardiovascular Disease (161). Due to the interconnectedness of chronic conditions, many of the organizations and programs included may be designed to treat more than one health need and repeated in these estimates. While this is not a comprehensive list, it provides insight into areas where there may be fewer resources. In particular, behavioral health encompasses many different health issues including mental health and substance abuse. The broadness of this health issue and the dispersion of resources across the behavioral/mental health spectrum signals a potential gap in behavioral/mental health resources despite the current number of available assets.

This comprehensive assessment intends to surpass requirements and embody the defining characteristics of community-based participatory research. Through community engagement and data analysis, it is the hope that the 2016 CHNA will help to guide current planning efforts around San Diego County and help organizations to better tailor programs to the needs of vulnerable populations.

II. INTRODUCTION/BACKGROUND

A. About Kaiser Permanente (KP)

Founded in 1942 to serve employees of Kaiser Industries and opened to the public in 1945, Kaiser Permanente is recognized as one of America's leading health care providers and nonprofit health plans. We were created to meet the challenge of providing American workers with medical care during the Great Depression and World War II, when most people could not afford to go to a doctor. Since our beginnings, we have been committed to helping shape the future of health care. Among the innovations Kaiser Permanente has brought to U.S. health care are:

- Prepaid health plans, which spread the cost to make it more affordable
- A focus on preventing illness and disease as much as on caring for the sick
- An organized coordinated system that puts as many services as possible under one roof—all connected by an electronic medical record

Kaiser Permanente is an integrated health care delivery system comprised of Kaiser Foundation Hospitals (KFH), Kaiser Foundation Health Plan (KFHP), and physicians in the Permanente Medical Groups. Today we serve more than 10 million members in nine states and the District of Columbia. Our mission is to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.

Care for members and patients is focused on their Total Health and guided by their personal physicians, specialists, and team of caregivers. Our expert and caring medical teams are empowered and supported by industry-leading technology advances and tools for health promotion, disease prevention, state-of-the-art care delivery, and world-class chronic disease management. Kaiser Permanente is dedicated to care innovations, clinical research, health education, and the support of community health.

B. About Kaiser Permanente Community Benefit

For more than 70 years, Kaiser Permanente has been dedicated to providing high-quality, affordable health care services and to improving the health of our members and the communities we serve. We believe good health is a fundamental right shared by all and we recognize that good health extends beyond the doctor's office and the hospital. It begins with healthy environments: fresh fruits and vegetables in neighborhood stores, successful schools, clean air, accessible parks, and safe playgrounds. These are the vital signs of healthy communities. Good health for the entire community, which we call Total Community Health, requires equity and social and economic well-being.

Like our approach to medicine, our work in the community takes a prevention-focused, evidence-based approach. We go beyond traditional corporate philanthropy or grantmaking to pair financial resources with medical research, physician expertise, and clinical practices. Historically, we've focused our investments in three areas—Health Access, Healthy Communities, and Health Knowledge—to address critical health issues in our communities.

For many years, we've worked side-by-side with other organizations to address serious public health issues such as obesity, access to care, and violence. And we've conducted Community Health Needs Assessments to better understand each community's unique needs and

resources. The CHNA process informs our community investments and helps us develop strategies aimed at making long-term, sustainable change—and it allows us to deepen the strong relationships we have with other organizations that are working to improve community health.

C. **Purpose of the Community Health Needs Assessment (CHNA) Report**

i. To Advance Community Health

Community Health Needs Assessments (CHNA) have been integral to learning about the health of the communities Kaiser Permanente serves. We are committed to building on the CHNA and relationships in the community to deepen our knowledge of the community specific needs and the resources and leaders in the community. This deeper knowledge will enable us to develop a new approach by engaging differently and activating in a way that addresses specific community needs and in collective action with the community. This new approach will leverage our existing and new community partnerships and harness the power of all Kaiser Permanente assets – economic, relationships, and expertise – to positively impact community health.

ii. To Implement ACA Regulations

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, included new requirements for nonprofit hospitals in order to maintain their tax exempt status. The provision was the subject of final regulations providing guidance on the requirements of section 501(r) of the Internal Revenue Code. Included in the new regulations is a requirement that all nonprofit hospitals must conduct a community health needs assessment (CHNA) and develop an implementation strategy (IS) every three years (http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf). The required written IS plan is set forth in a separate written document. Both the CHNA Report and the IS for each Kaiser Foundation Hospital facility are available publicly at kp.org/chna.

D. **Kaiser Permanente's Approach to CHNA**

Kaiser Permanente has conducted CHNAs for many years, often as part of long standing community collaboratives. The new federal CHNA requirements have provided an opportunity to revisit our needs assessment and strategic planning processes with an eye toward enhanced compliance and transparency and leveraging emerging technologies. Our intention is to develop and implement a transparent, rigorous, and whenever possible, collaborative approach to understanding the needs and assets in our communities. From data collection and analysis to the identification of prioritized needs and the development of an implementation strategy, the intent was to develop a rigorous process that would yield meaningful results.

Kaiser Permanente's innovative approach to CHNAs includes the development of a free, web-based CHNA data platform that is available to the public. The data platform provides access to a core set of approximately 150 publicly available indicators to understand health through a framework that includes social and economic factors; health behaviors; physical environment; clinical care; and health outcomes.

In addition to reviewing the secondary data available through the CHNA data platform, and in some cases other local sources, each KFH facility, individually or with a collaborative, collected primary data through key informant interviews, focus groups, and surveys. Primary data

collection consisted of reaching out to local public health experts, community leaders, and residents to identify issues that most impacted the health of the community. The CHNA process also included an identification of existing community assets and resources to address the health needs.

Each hospital/collaborative developed a set of criteria to determine what constituted a health need in their community. Once all of the community health needs were identified, they were all prioritized, based on identified criteria. This process resulted in a complete list of prioritized community health needs. The process and the outcome of the CHNA are described in this report.

In conjunction with this report, KFH-San Diego will develop an implementation strategy for the priority health needs the hospital will address. These strategies will build on Kaiser Permanente's assets and resources, as well as evidence-based strategies, wherever possible. The Implementation Strategy will be filed with the Internal Revenue Service using Form 990 Schedule H. Both the CHNA and the Implementation Strategy, once they are finalized, will be posted publicly on our website, www.kp.org/chna.

III. COMMUNITY SERVED

A. **Kaiser Permanente's Definition of Community Served**

Kaiser Permanente defines the community served by a hospital as those individuals residing within its hospital service area. A hospital service area includes all residents in a defined geographic area surrounding the hospital and does not exclude low-income or underserved populations.

B. **Map and Description of Community Served**

i. Map

ii. Geographic description of the community served (towns, counties, and/or zip codes)

The Kaiser Foundation Hospital (KFH)-San Diego medical service area includes a large part of San Diego County. The following cities and communities are included: Bonita, Chula Vista, Coronado, Del Mar, Descanso, Dulzura, El Cajon, Encinitas, Leucadia, Olivenhain, Escondido, Fallbrook, Rainbow, Guatay, Imperial Beach, Jamul, La Jolla, La Mesa, Lakeside, Lemon Grove, Lincoln Acres, Mount Laguna, National City, Oceanside, Pala, Palomar Mountain, Pauma Valley, Pine Valley, Potrero, Poway, Ramona, Rancho Santa Fe, San Diego, San Luis Rey, San Marcos, San Ysidro, Santee, Solana Beach, Spring Valley, Tecate, Valley Center, Vista and Warner Springs.

The information for this collaborative CHNA was gathered at a county level due to a broad representation of hospitals from San Diego County. The population that KFH-San Diego medical service area serves is 0.96% smaller than the entire San Diego County population. Because the difference between KFH-San Diego medical service area population and the overall San Diego County population is small (0.96%), statistics and numbers presented at the county level are sufficient for understanding KFH-San Diego's population and demographics. Due to its geographic size and large population, the San Diego County Health and Human Service Agency (HHSA) has organized their service area's 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 1.

FIGURE 1. SAN DIEGO COUNTY WITH HEALTH AND HUMAN SERVICES AGENCY REGIONS

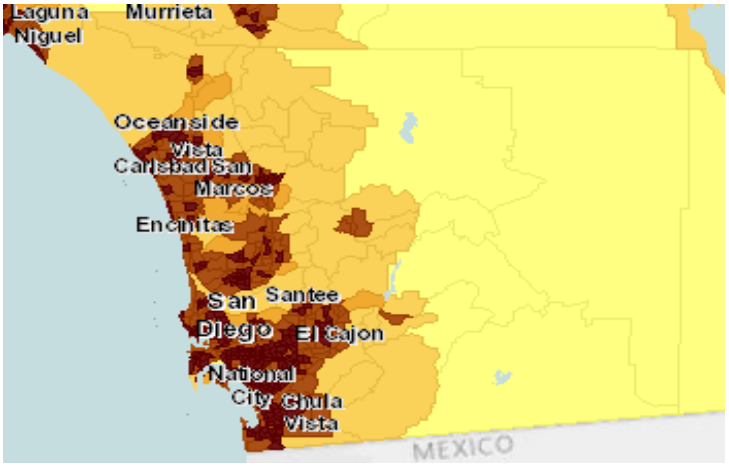
iii. Demographic profile of community served

Socio-Demographic Profile

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, age of a population, and race/ethnicity 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 2009-13, 5-year estimates. The population density for this area, estimated at 746 persons per square mile, is significantly 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.

FIGURE 2. POPULATION, DENSITY (PERSONS PER SQ MILE) BY TRACT, ACS 2009-13

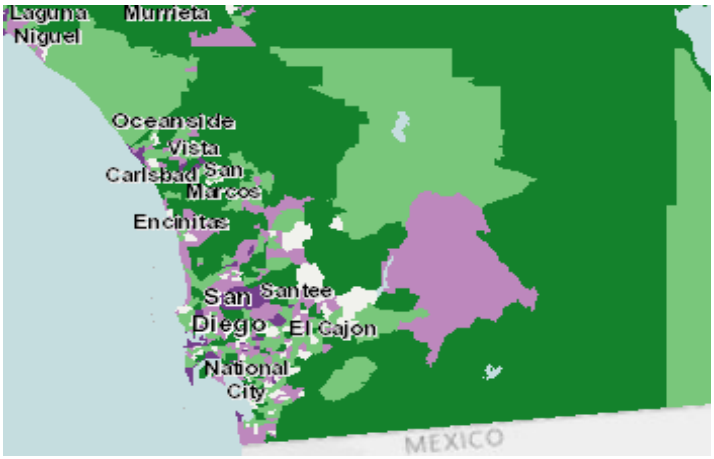


Over 5,000
1,001 - 5,000
501 - 1,000
51 - 500
Under 51
No Data or Data Suppressed
Report Area

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

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.

FIGURE 3. POPULATION CHANGE, PERCENT BY TRACT, US CENSUS 2000-2010

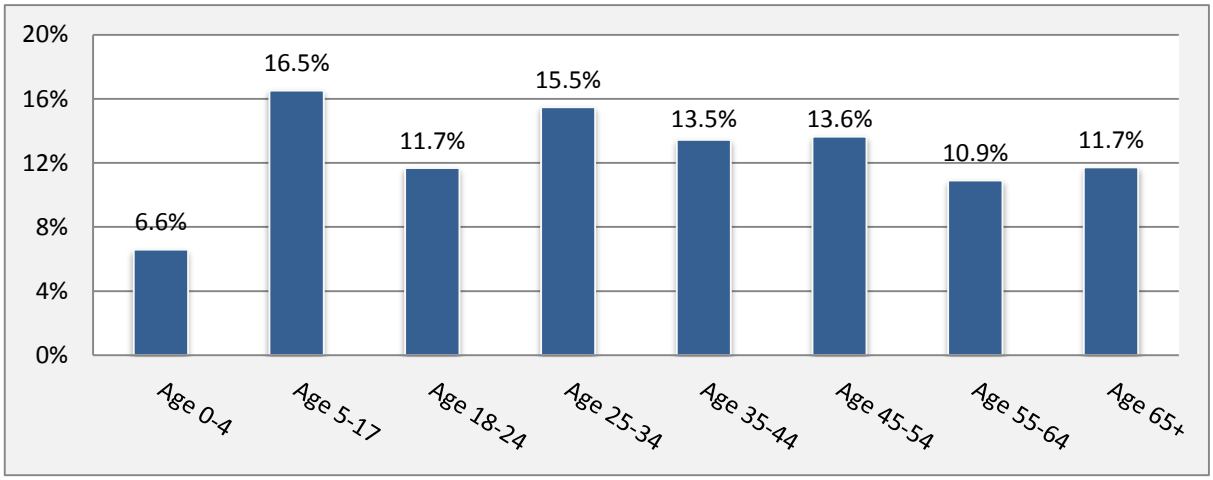


Over 10.0% Increase
1.0 - 10.0% Increase
Less Than 1.0% Change
1.0 - 10.0% Decrease
Over 10.0% Decrease
No Population or No Data
Report Area

Data Source: US Census Bureau, Decennial Census. 2000-2010.

Age: The median age for San Diego County is 34.8 years based on the 2009-2013 5-year ACS estimates. The distribution of the population by age according to the U.S. Census 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.

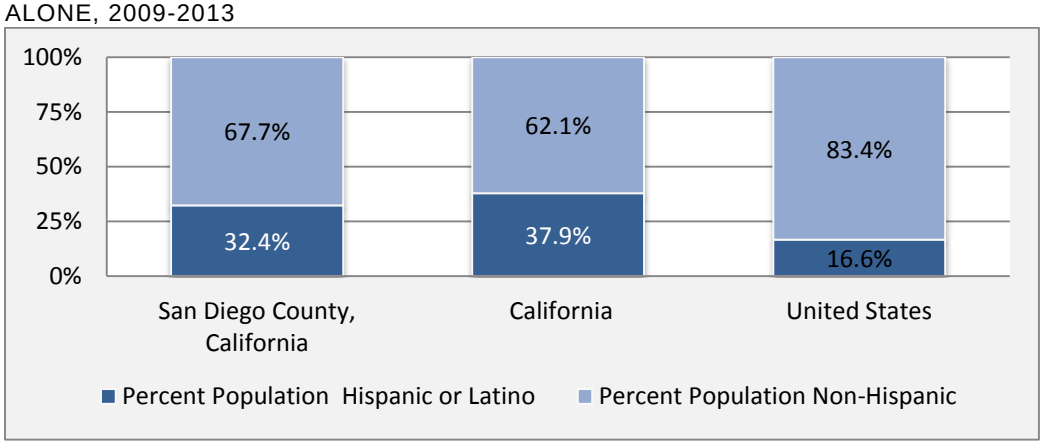
FIGURE 4. PERCENTAGE OF SAN DIEGO POPULATION BY AGE GROUPS, 2009-2013



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

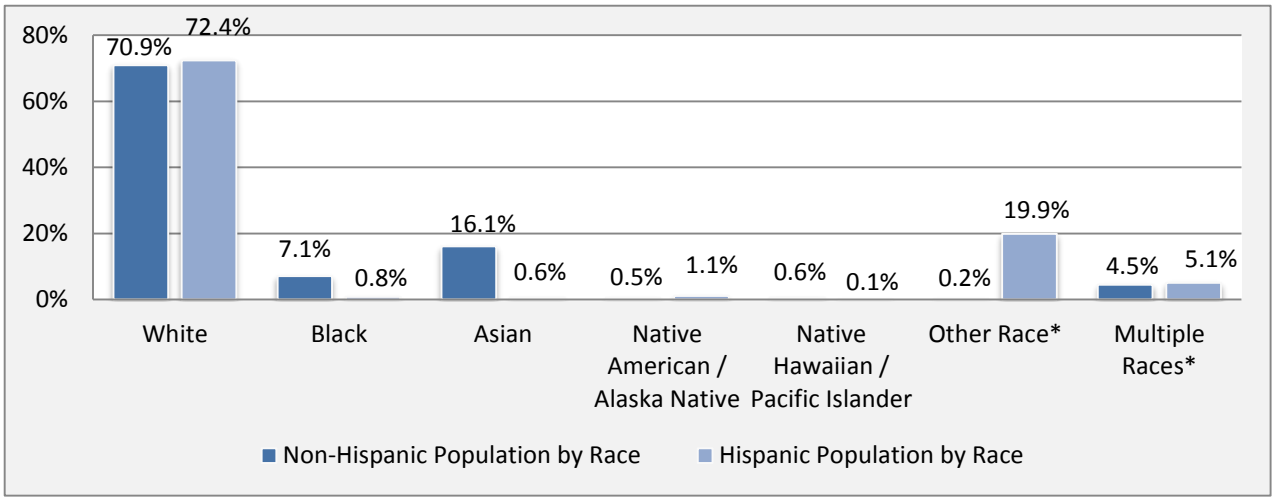
Race/Ethnicity: In the ACS, data for race and ethnicity are collected separately. Of those who identified as non-Hispanic (67.7%) in San Diego County, the majority identified their race as white (70.9%), followed by Asian (16.1%), black (7.1%), multiple races (4.5%), Native Hawaiian/Pacific Islander (0.6%), and American Indian/Alaskan Native (0.5%). Of those who identified as Hispanic or Latino (32.4%) in San Diego County, 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 Figure 5 and 6 as well as Table 1 below for more details.

FIGURE 5. PERCENTAGE OF SAN DIEGO POPULATION BY ETHNICITY ALONE, 2009-2013



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

FIGURE 6. PERCENTAGE OF SAN DIEGO POPULATION BY RACE, 2009-2013



Data Source: US 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

TABLE 1. TOTAL POPULATION, POPULATION CHANGE, AGE, GENDER, AND UNEMPLOYMENT RATE

	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]Data Source: US Census Bureau, American Community Survey. 2009-2013.
[b]Data Source: US Census Bureau, Decennial Census. 2000-2010.
[c]Data Source: US Department of Labor, Bureau of Labor Statistics. July 2015

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, 14.5% or 441,648 individuals were living in households with income below 100% of the Federal Poverty Level (FPL) based on 2009-2013, five-year estimates. 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 increased to 18.8%. For a household size of three the 100% poverty level is $20,090 per year. 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. In 2014, the uninsured rate sharply decreased (See Figure 7). 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 above titled 'The Changing Landscape under the Affordable Care Act.' Lack of insurance is a primary barrier to health care access including regular primary care, specialty care, and other health services and contributes to poor health status.

THE CHANGING LANDSCAPE UNDER THE AFFORDABLE CARE ACT*

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

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

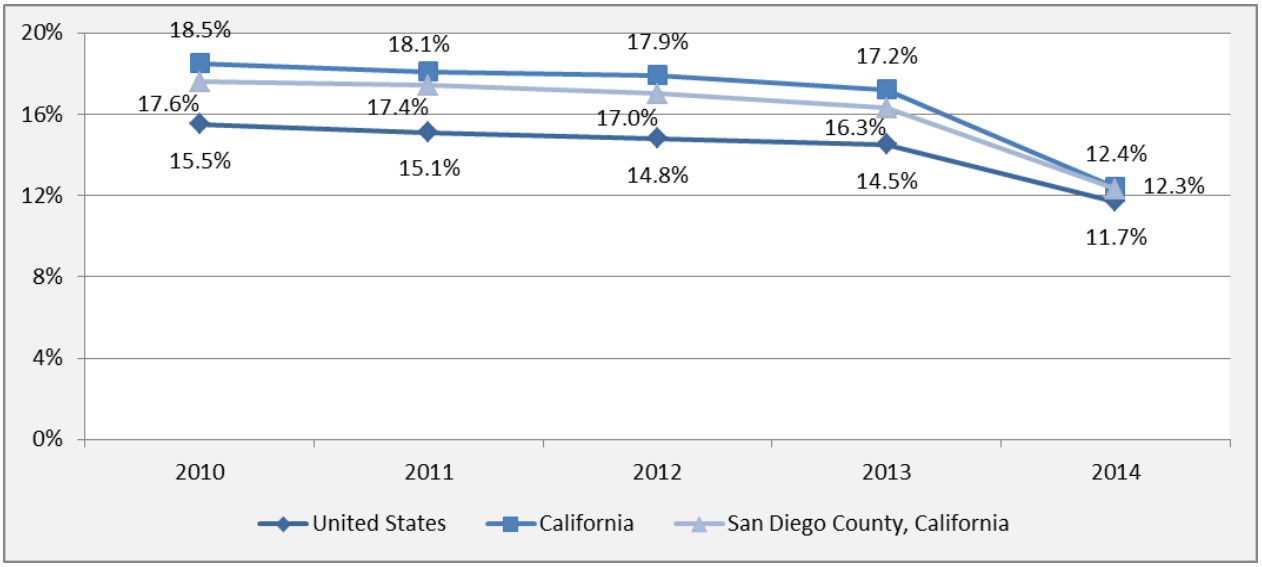
These healthcare reforms have resulted in a large number of newly insured individuals. Recent data from the US Census Bureau demonstrates the following changes in coverage as of 2014:

- Decrease in the percentage of uninsured overall in the US 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.

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.

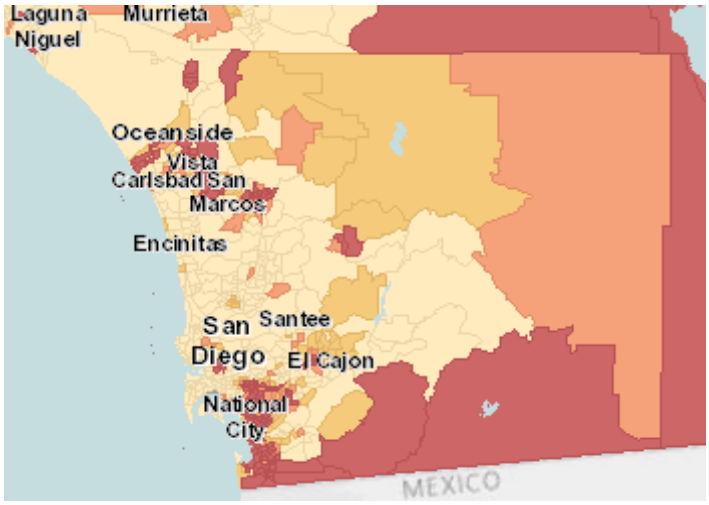
FIGURE 7. PERCENT UNINSURED: UNITED STATES, CALIFORNIA AND SAN DIEGO COUNTY, 2010 - 2014



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 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. 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 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.

FIGURE 8. POPULATION WITH NO HIGH SCHOOL DIPLOMA (AGE 25 AND OLDER), PERCENT BY TRACT, ACS 2009-13



Over 21.0%
16.1 - 21.0%
11.1 - 16.0%
Under 11.1%
No Data or Data Suppressed
Report Area

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

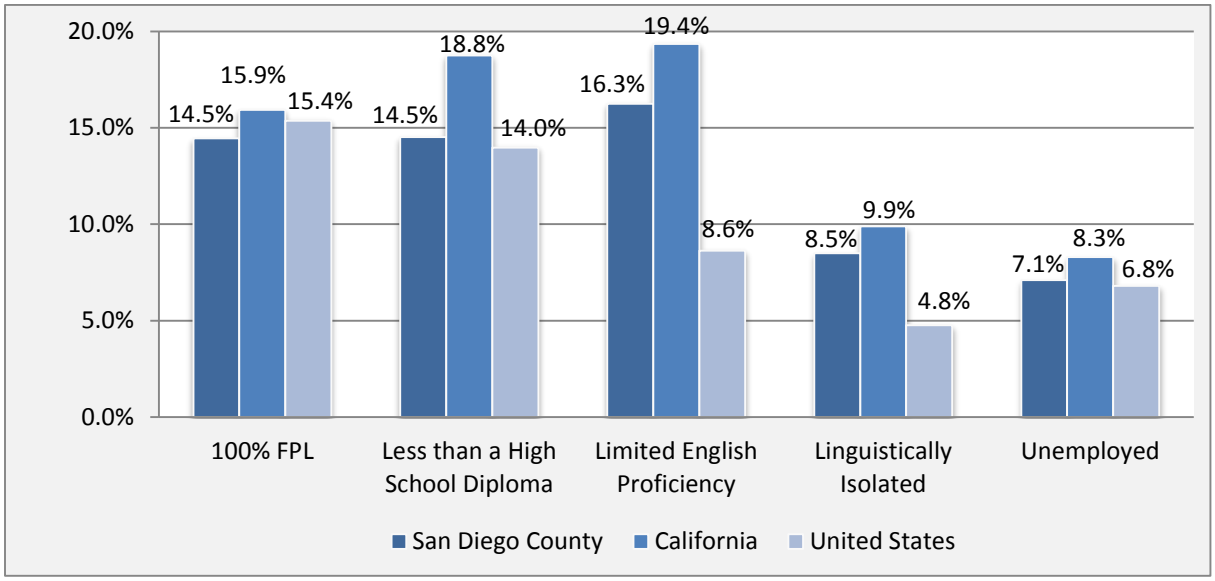
Along with income, education, and insurance status, culture/language and employment status also have profound implications for population health:

Population with Limited English Proficiency: According to 2009-2013 ACS estimates, 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, measuring the impact of linguistic isolation is especially important to understanding health in the community. According to ACS estimates for years 2009-2013, 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 9. POVERTY, EDUCATION, LIMITED ENGLISH PROFICIENCY, LINGUISTICALLY ISOLATED, AND UNEMPLOYED, SAN DIEGO, CALIFORNIA AND UNITED STATES



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

Community Need Index

Recognizing that health needs differ across the county and that socio-economic factors impact health outcomes, the IPH used the Dignity Health/Truven Health Inc. Community Need Index (CNI) to identify communities with the highest level of health disparities and needs. "Based on a wide array of demographic and economic statistics, 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 while a 5.0 represents a Zip code with the highest need."[5] The five factors used to create the index are as follows:

1. Income
2. Culture and language
3. Educational levels
4. Insurance
5. Housing

For detailed description of the CNI please see visit the Dignity Health website at: http://www.dignityhealth.org/cm/content/pages/programs-and-reports.asp

When comparing CNI scores across HHSA regions (Table 2), differences in the mean CNI scores were apparent, with 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 regional 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 3). The

[5] * http://cni.chw-interactive.org/Truven%20Health_2015%20Source%20Notes_Community%20Need%20Index.pdf

CHNA committee utilized the list of cities to identify vulnerable communities in which to engage their community partners and hold the community partner discussions.

TABLE 2. 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

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

TABLE 3. HHSA REGION AND CITIES WITH HIGH NEED COMMUNITY NEED INDEX SCORES (4.2-5.0)

HHSA Region	# of ZIP codes in corresponding city with a score of 4.2 or higher
Central	
San Diego	8
East	
Boulevard	1
El Cajon	2
Jacumba	1
Lemon Grove	1
Potrero	1
Spring Valley	1
Tecate	1
North Central	
San Diego	1
North Coastal	
Oceanside	1
Vista	2
North Inland	
Escondido	2
Paula	1

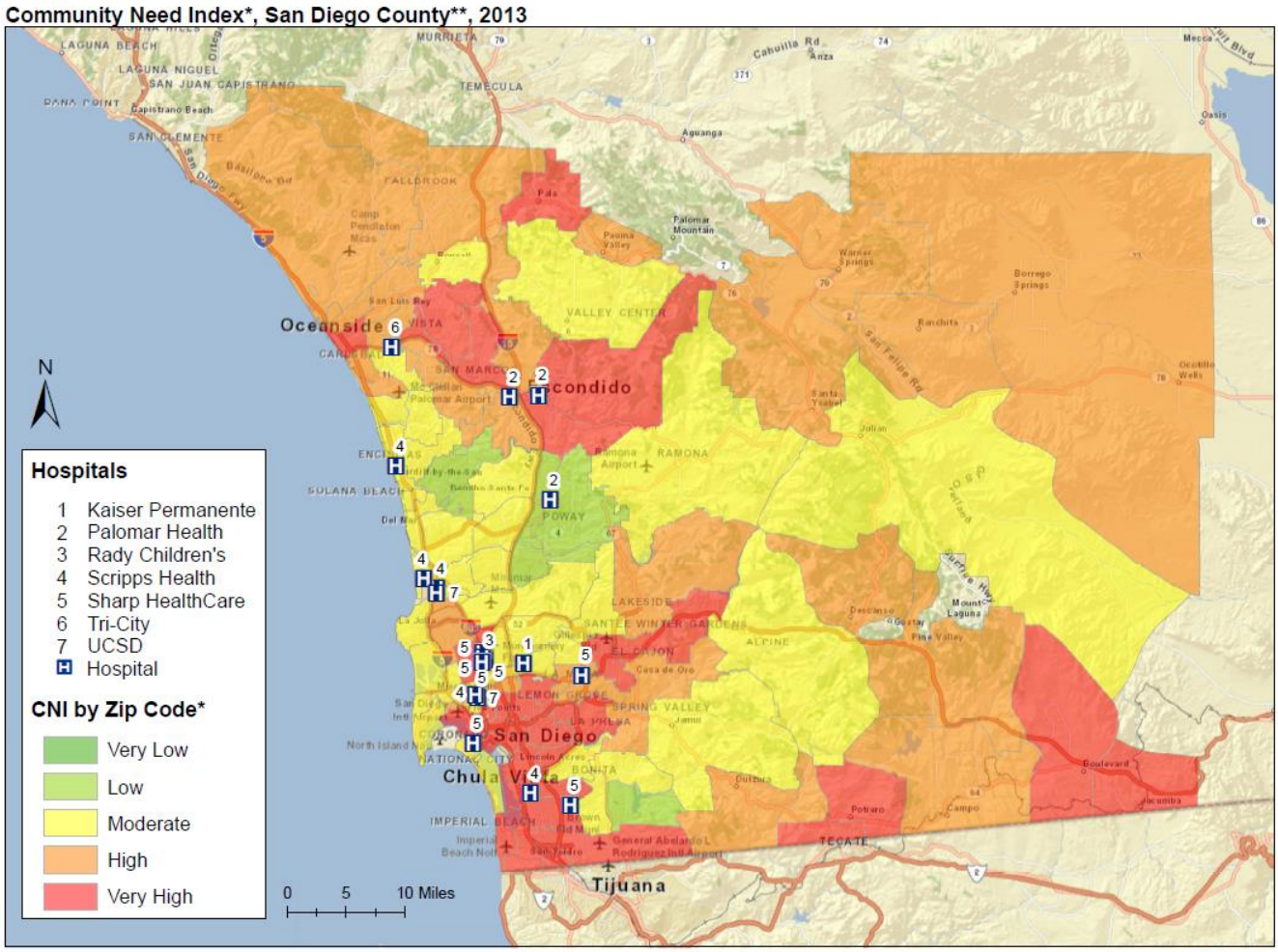
San Marcos	1
South	
Chula Vista	2
Imperial Beach	1
National City	1
San Diego	1
San Ysidro	1

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

A map of the CNI index for San Diego County is provided below (Figure 10). To see all CNI maps of San Diego County and the six HHSA regional maps, please see Appendix K.

- San Diego County
- Central Region
- East Region
- North Central Region
- North Coastal Region
- North Inland Region
- South Region

FIGURE 10. SAN DIEGO COUNTY COMMUNITY NEED INDEX, 2013



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

HOSPITAL ASSOCIATION of San Diego & Imperial Counties

iph

IV. WHO WAS INVOLVED IN THE ASSESSMENT

A. Identity of hospitals that collaborated on the assessment

The Hospital Association of San Diego and Imperial Counties (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. Members range from small, rural hospitals to large, urban medical centers; include not-for-profits (60%), district (16%), investor-owned (9%), and city/county/state/federal facilities (15%); and represent over 8,100 licensed beds.

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 provides strong leadership, representation and advocacy with local governmental entities, business coalitions, the media, community organizations, and the public.

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 HASD&IC 2013 CHNA Advisory Workgroup was reconvened to plan and implement the 2016 CHNA. In recognition of the value of a collaborative needs assessment process, the HASD&IC Board of Directors approved a motion to create a formal CHNA Committee tasked with the implementation and oversight of the 2016 CHNA. The CHNA Committee is comprised of representatives from all seven participating hospitals and health care systems (Table 4):

- 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 4. 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	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
UCSD Medical Center			
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.

B. Other partner organizations that collaborated on the assessment

As part of the needs assessment, a number of community partners were engaged to obtain community level data to aid in the understanding of smaller communities and their potential health needs within San Diego County. These partner organizations include:

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

C. Identity and qualifications of consultants used to conduct the assessment

Institute for Public Health

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.

Partners of the IPH are most frequently in high-risk ethnically diverse neighborhoods that are substantially under-resourced. In this work, the IPH is constantly aware of the significant health disparities between populations and sub-populations, and the tremendous need for community input and involvement in needs assessment, intervention and evaluation efforts in order to create real and sustainable change. Their philosophy also supports a socio-ecological model of health with the belief that human behavior is significantly influenced by the environments people live in, and that for people to be healthy, we need healthy environments. Supportive interpersonal, organizational, community and public policy environments that promote health are essential for individuals to make healthy choices. The methodological strategies of the IPH always include mixed methods (both qualitative and quantitative) and scanning for policy, system, and environmental changes that support or discourage individual behavior change for the improvement of health.

In the last 20 years, the IPH has partnered with over 70 local, state, national and international public and private community-based agencies and organizations representing more than 120 multiple-year contracts with a wide variety of needs and methodologies. The Graduate School of Public Health offers MPH and doctoral level degrees in epidemiology, health behavior, health management and policy and environmental health. The IPH currently employs approximately 20 doctoral and master's level trained employees and students. In the last three years the IPH has provided paid and unpaid student internships to over 50 graduate students. These highly educated professionals initially receive training from the IPH in community engagement including instruction for working within different cultural contexts, with diversity of racial and ethnic groups, and in a wide variety of practice settings. IPH employees are often partnered on community based projects with specific community partners and are responsible for understanding the context of the neighborhoods in which they work. This often includes participation in community collaborative efforts, attendance at community meetings, and knowing and understanding local community needs from a number of different perspectives.

The IPH has been involved in numerous community health needs assessment efforts over the years including California statewide efforts, San Diego County efforts and various local neighborhood assessments. Some notable examples include:

- HASD&IC 2013 Community Health Needs Assessment
- The San Diego County Hunger Free Evaluation
- The First San Diego County Child and Family Health and Well Being Report Card
- Evaluation of Expenditures by California Children Services (CCS) Beneficiaries
- Elder Health Needs Assessment
- Neighborhood Quality of Life Survey

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 was the project lead on the 2013 HASD&IC Community Health Needs Assessment working collaboratively with the Hospital Association of San Diego and Imperial Counties (HASD&IC) and the CHNA Advisory Workgroup. She was also an Epidemiologist on the Communities Putting Prevention to Work (CPPW) project that was funded by the Center for Disease Control and Prevention providing evaluations of population based interventions. 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 Master of Public Health 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.

V. PROCESS AND METHODS USED TO CONDUCT THE CHNA

A. **Secondary data**

i. Sources and dates of secondary data used in the assessment

KFH-San Diego used the Kaiser Permanente CHNA Data Platform (www.chna.org/kp) to review over 150 indicators from publically available data sources. Data by gender, race/ethnicity, and HHSA region were analyzed when available. For details on specific sources and dates of the data used, please see Appendix A.

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

- **Clinic Utilization Data** (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)
- **Health Behavior Data** (Behavioral Risk Factor Surveillance System-BRFSS, California Health Interview Survey-CHIS, ACS
- **Hospital Discharge Data** (OSHPD)
- **Morbidity Data** – (BRFSS, Centers for Disease Control and Prevention-CDC, National Health Interview Survey-NHIS, National Survey on Drug Use and Health-NSDUH, etc.)
- **Mortality Data** (California Department of Public Health)

The secondary data for this report was obtained in May-August of 2015. The CHNA data platform and other supplementary data sources may be undergoing continual enhancements and updates; therefore, certain data indicators may have been updated since the date the data was obtained for this report. As such, the most updated data may not be reflected in the tables, graphs and/or maps provided in this report. For the most recent data and/or additional health data indictors, please visit CHNA.org/kp and the respective data source websites cited in this report.

ii. Methodology for collection, interpretation and analysis of secondary data

Secondary data was compiled using the above sources in conjunction with the Kaiser Permanente CHNA Data Platform to create a profile of San Diego County demographics and health statistics. The purpose of gathering secondary 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 continued relevance and influence of the broad health needs identified in the 2013 CHNA on health status.
- Gain a better understanding of how the broad health needs impact San Diego health systems and hospitals through a detailed analysis of 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 benchmark analysis, an analysis of emergency department and hospitalization discharge data, and an analysis of additional secondary data.

Benchmark Analysis

Secondary data was analyzed using modified versions of the Kaiser Permanente's Community Benefit data analysis tool. The tool utilized organizes the KP common indicators against 14 common health needs[6], using a combination of morbidity/mortality and health driver indicators. For example, the health need of mental health is described by similar indicators such as lack of social or emotional support, depression, and suicide. Each health need topic in this tool is assigned a score based on the difference between the data values at the hospital service area and the CA state benchmark. In this tool, the health need scores provide information about which health need topics may be doing better or worse based on benchmark analyses. In most cases, the service area values represent the aggregate of all data for geographies (ZIP codes, counties, tracts, etc.) which fall within the service area boundary. When one or more geographic boundaries are not entirely encompassed by a service area, the measure is aggregated proportionally. The options for weighting "small area estimations" are based upon:

1. Total Area
2. Total Population
3. Demographic-group Population

In summary, the tool is able to support benchmarking and the assessment of health needs by:

- organizing and mapping indicators to health needs,
- categorizing health needs and indicators by the MATCH model (health need drivers and outcomes),
- ranking health needs based on benchmarking at the county, region, and/or state levels,
- showing ethnic or racial disparities in various health needs, where available, and
- clarifying general demographic information in the hospital service area.

Hospital Emergency Department and Hospitalization Discharge Analysis

California's Office of Statewide Health Planning and Development (OSHPD) are 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. SpeedTrack is a search engine coupled with

[6] 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.

methods of organizing data which contains four years of hospital discharge data from multiple sources (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 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.[7] A principal diagnosis is defined as the condition established after examination to be chiefly responsible for the admission. The 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 Secondary Data

In addition to the Kaiser Permanente's 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 California Health Interview Survey (CHIS), California Reducing Disparities Project reports, and publications by the County of San Diego HHSA. A brief summary of data from CHIS and San Diego County Demographics profiles by region is included in Appendix E. 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 J). These groups were selected based on CDC guidelines and recommendations from the community about specific populations to include in future assessments.

The collaborative also partnered with local community organizations to obtain regional and local neighborhood data. The community partners that were engaged were: North County Health Services, 2-1-1 San Diego, and Palomar Health Community Action Council. The data was summarized and used to aid in understanding geographical and neighborhood level differences. Please see Appendix H for community partner data.

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[7] 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.

B. **Community input**

i. Description of the community input process

In recognition of the challenges that health providers, community organizations and other stakeholders face in their efforts to prevent, diagnose and manage significant chronic health needs, input was gathered from health experts, community leaders, and San Diego residents in order to gain a more complete understanding of the top four identified health needs and associated health drivers in the San Diego community. Community input was provided by a broad range of community members through the use of key informant interviews, discussions/focus groups, and surveys. Individuals with the knowledge, information, and expertise relevant to the health needs within the community were consulted. These individuals 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. Additionally, when applicable, other individuals with expertise of local health needs were consulted. For a complete list of individuals who provided input, see Appendix B.

ii. Methodology for collection, interpretation, and analysis of primary data

Input was gathered through multiple different methods and from a broad range of sources including health experts, community leaders, and San Diego residents. Participants were chosen based on their diverse knowledge of geographic differences, population and age-specific needs, and clinical expertise. The primary data was collected through the following activities:

- Community Partner Discussions (focus groups)
- 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/Mental Health Discussions

The overall purpose of collecting primary data was to gather information about the health needs and health drivers 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 health drivers.
- Aid in the process of prioritizing health needs.
- Gain information about the system and policy changes that could potentially impact the health needs and health drivers.

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/mental health discussions.

Each of the ten discussions and 19 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 (focus groups)

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 and/or group who have not been consistently involved in the CHNA process throughout the past 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 results from the HASD&IC 2013 CHNA. Discussion questions were created with the help of community partner organizations and were designed to provide in-depth detail on the top four health needs. The purpose of the community partner discussions was to:

- Gather in-depth feedback from nontraditional stakeholders/community partners who work directly with community residents,
- Gain a more comprehensive understanding of the most significant health needs impacting San Diego County.
- Connect the identified health needs with associated health drivers.
- Aid in the process of prioritizing 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 Appendix B for general community discussion information. 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 health issues related to the top four 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 issues that the participants felt most important in San Diego County. Please see Appendix F for all community partner discussion materials. The seven discussion questions were:

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 have 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?

Behavioral/Mental Health Discussions

Due to the complexity of behavioral/mental health, additional discussions were held that were specific to this health issue. This was done to ensure the data that was gathered accurately reflected current trends and areas of true need. Existing meetings focused on behavioral/mental health were targeted to provide feedback. Those present at the meetings included hospitals, clinics, County HHSA, smaller behavioral or mental health facilities, health plans and patient advocates. The behavioral/mental health discussion template was developed after the completion of the hospital discharge analysis and incorporated a synthesis of the community partner discussion data. A summary of this data as it related to behavioral/mental needs was provided to the behavioral/mental health experts prior to gaining their feedback. The purpose of the behavioral/mental health discussion were to:

- Gather feedback from behavioral/mental health experts to aid in the understanding of the most significant health needs impacting San Diego County.
- Provide additional context to the secondary data findings and react to community input.
- Gather feedback on health resources available within the community.
- Aid in the process of prioritizing health needs.
- Gain information about the system and policy changes that could potentially impact the health needs and health drivers.

Three behavioral/mental health discussions took place between December 2015 and January 2016. Two of 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. The combined total number of attendees was roughly 50 people between the two meetings. The Alpine Special Treatment Center discussion took place in January 2016 with 8

participants. Please see Appendix F for the handouts provided at the behavioral/mental health discussions.

Due to time constraints during the behavioral/mental health discussions, not all questions were asked at all discussions. The seven behavioral/mental health discussion questions were:

1. When examining hospital discharge data for theICD-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?

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.)

1. How could your facility collaborate with community based organizations to help you meet the needs of your clients?

2. What else should we ask the community about challenges and opportunities to improve behavioral health outcomes?

Key Informant Interview

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, 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, the lesbian, gay, bisexual, transgender and queer (LGBTQ) population, veterans, alcohol and drug addition, cardiovascular health, behavioral/mental 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. The purpose of the key informant interviews was to:

- Gather in-depth population-specific feedback to aid in the understanding of the most significant health needs and the populations that are most impacted in San Diego County.
- Connect the identified health needs with associated health drivers.
- Aid in the process of prioritizing health needs.
- Gain information about the system and policy changes that could potentially impact the health needs and health drivers.

In-person or phone interviews were conducted with 21 key informants 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 issues 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 F for all key informant interview materials. The six key informant interview questions were as follows:

1. Most important health issues or needs:
    a. **For disease-specific expertise:** Within your expertise area what are the most important issues found in your population insert expertise area (e.g. Cardiovascular Disease)? (e.g. hypertension could be a major health issue that affects cardiovascular health or a frequent behavioral health issue could be depression.)
    b. **For population-specific expertise:** What do you think are the most important health issues for insert population expertise (e.g. Latino's) related to behavioral health, cardiovascular disease, diabetes and 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 could be depression.)
2. What do you think are the most important modifiable risk factors related to the health issues you just mentioned?
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?
4. What resources need to be developed or increased in order to address the health needs or modifiable risk factors above?
5. Are there systems, policy, or environmental changes that, if implemented, could help the hospitals address these health needs or modifiable risk factors?
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?

Health Access and Navigation Survey – Roadmap – Where Do You Get Stuck?

The Health Access and Navigation Survey was developed in partnership with the San Diego County Resident Leadership Academy (RLA). Upon review of results from the RLA's 2014 Community Needs Assessment and comparison of the results to the HASD&IC 2013 CHNA, access and navigation of health care emerged as a common barrier identified by the San Diego community. As part of this collaboration, the RLA leaders within the HHSA regions agreed to disseminate the health access and navigation survey to community members and partners within their neighborhoods. The purpose of the health access and navigation survey was to:

- Gather feedback from community residents to increase understanding of the challenges they experience in accessing and navigating the health care system.
- Gather feedback from health leaders on the communities' roadblocks in accessing and navigating health care.
- Aid in the process of identifying and prioritizing the associated health drivers.

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 22nd 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 surveys were completed in Spanish. Seventy paper and 54 online surveys were completed in English. No Arabic surveys were collected or completed.

County of San Diego Health and Human Service Agency (HHSA) Survey

Beginning in 2012, the County of San Diego collaborated with community partners to undertake a comprehensive community health improvement planning process resulting in the Live Well San Diego Community Health Assessment (CHA) and Community Health Improvement Plan[8]. The Health and Human Services Agency (HHSA) engaged community partners at the regional level to best meet the needs of San Diego's large population and diverse communities in all six HHSA regional planning areas. For more information please visit HHSA's website at http://www.sandiegocounty.gov/hhsa/.

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

[8] http://www.livewellsd.org/content/livewell/home/make-an-impact/community-action-for-living-well.html

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, a 16-question assessment was administered via an electronic survey to pre-identified stakeholders and community partners representing all six HHSA regions. HASD&IC and the County HHSA worked collaboratively 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. To assess which health needs had the greatest impact on overall community health, participants were asked to select the top five most important health needs from a list of 15 pre-selected health conditions. There was also an 'Other' category available if there was a health problem not included on the list that the survey participant felt was important. In addition, participants were asked to select which of the top five health conditions had the least amount of resources to address the problem.

C. **Written comments**

KP provided the public an opportunity to submit written comments on the facility's previous CHNA Report through CHNA-communications@kp.org. This website will continue to allow for written community input on the facility's most recently conducted CHNA Report.

As of the time of this CHNA report development, KFH-San Diego had not received written comments about previous CHNA Reports. Kaiser Permanente will continue to track any submitted written comments and ensure that relevant submissions will be considered and addressed by the appropriate Facility staff.

D. **Data limitations and information gaps**

The Kaiser Permanente's 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 secondary 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 California Health Interview Survey, clinic data, and vulnerable population data. In order to gain an in-depth look into smaller aggregate 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 is required, including the collection and analysis of secondary 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, and collecting 235 health access and navigation surveys from community residents which provided a large volume of comprehensive secondary data. The population and disease-specific key informant interviews may not capture all of the challenges faced by these groups. 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.

Community partner discussions were chosen to be as representative as possible of high need communities in San Diego, but due to time constraints only seven dialogues were completed as part of the assessment. High need neighborhoods were identified using the CNI data with dialogues being conducted in communities such as San Ysidro, Escondido, El Cajon, Lemon Grove, and parts of San Diego city. 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.

VI. IDENTIFICATION AND PRIORITIZATION OF COMMUNITY'S HEALTH NEEDS: PROCESS AND KEY FINDINGS

A. Identifying community health needs

i. Definition of "health need"

For the purposes of the CHNA, Kaiser Permanente defines a "health need" as a health outcome and/or the related conditions that contribute to a defined health need. Health needs are identified by the comprehensive identification, interpretation, and analysis of a robust set of primary and secondary data. For the purposes of this report the word health need and health issue are used interchangeably.

ii. Criteria and analytical methods used to identify the community health needs

A broad list of community needs was identified as part of a six-step process for Phase I of the HASD&IC 2013 CHNA. During this phase, an analysis of secondary data (OSHPD, CHIS, County Health Department Mortality Data, etc.) was completed, which evaluated health needs based on their frequency of diagnosis and mortality rate. A full description of the six-step process can be found on HASD&IC's website: http://hasdic.org/.

Building off of the results from the 2013 CHNA, a scan of current community health statistics was completed to confirm the regional significance of the identified health needs and continued influence of those health needs on vulnerable populations. A broad health need was validated as having continued relevance for the 2016 CHNA if they met at least one of the following criteria:

- Mortality: Among the top 10 leading causes of death in San Diego County
- Benchmark analysis: Among the top 10 potential health needs as identified by the Kaiser Permanente's Community Benefit data analysis tool
- Morbidity: Among the top 10 primary or secondary diagnoses as identified in the hospital discharge analysis

The dates and sources of the data utilized to conduct the scan included 2012 San Diego County mortality data from the California Department of Public Health, Kaiser Permanente's Community Benefit data analysis tool – List of potential health needs, and 2013 hospital emergency department and hospitalization discharge data from the Office of Statewide Health Planning and Development (OSHPD).

All fifteen health needs were validated as having continued regional significance within San Diego County within the collaborative process. Utilizing the data sources mentioned above, three distinct lists were created which detailed the top health needs in order of priority for each data source. Table 5 provides a key to aid in identification of the data source and corresponding title used across the different sources for each health issue as it is displayed in Table 6. Each health need in Table 5 is populated in at least one column demonstrating that each of the top fifteen health needs from the 2013 CHNA were ranked among the top 10 by at least one data source.

Table 6 shows the top 10 needs in rank order across the three data sources: the National Center for Health Statistics (NCHS) "rankable" leading causes of death, the Kaiser Permanente Community Benefit Data Analysis Tool[9] 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.

The list of leading causes of death (mortality data) in San Diego identified cancer, cardiovascular, dementia & Alzheimer's, asthma, unintentional injury, diabetes, and behavioral/mental health. Kaiser Permanente's Community Benefit data analysis tool identified cancer, mental health, obesity, diabetes, unintentional injury, and cardiovascular. Hospital emergency department and hospitalization discharge data identified cardiovascular, behavioral/mental health, diabetes, obesity, unintentional injury, asthma, cancers, acute respiratory Infections/pneumonia, back pain, and high risk pregnancy. Each of the fifteen health needs was found among the top 10 health issues of at least one data source.

In addition, Kaiser Permanente conducted a supplementary analysis for the 2013 CHNA which identified cervical cancer, chlamydia and HIV as important health needs in San Diego. These three additional health needs were also validated by the current data and one additional emergent health need was added to the list, oral health.

Broad health needs of community (in alphabetical order):

1. Acute Respiratory Infections/Pneumonia
2. Asthma
3. Back Pain
4. Behavioral/Mental Health
5. Breast Cancer
6. Cardiovascular Disease
7. Cervical Cancer*
8. Chlamydia*
9. Colorectal Cancer
10. Dementia & Alzheimer's Disease
11. Diabetes (Type 2)

[9] 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.

12. High Risk Pregnancy
13. HIV*
14. Lung Cancer
15. Obesity
16. Oral Health*
17. Prostate Cancer
18. Skin Cancer
19. Unintentional Injury

*Kaiser specific identified health needs – not part of the collaborative process

TABLE 5. IDENTIFIED BROAD HEALTH NEEDS BY SAN DIEGO COUNTY DATA SOURCE

Identified Broad Health Needs	San Diego County Mortality Data[a]	Kaiser Permanente Community Benefit Data Analysis Tool [b]	San Diego County Hospital Data[c]
Diabetes (Type 2)	Diabetes mellitus	Obesity/HEAL/ diabetes	Endocrine nutritional and metabolic disease
Obesity		obesity/HEAL/ diabetes	Endocrine nutritional and metabolic disease
Cardiovascular Disease	Disease of the heart Cerebrovascular diseases Essential (primary) hypertension and hypertensive renal disease	CVD/stroke	Symptoms signs and ill-defined condition that includes chest pain, Diseases of the circulatory system
Behavioral/Mental Health	Suicide	Substance abuse/tobacco	Mental disorders
Unintentional Injury	Accidents (unintentional injuries)	Violence/injury prevention	Injury and poisoning
High Risk Pregnancy			Complications of pregnancy and childbirth and the puerperium
Asthma	Chronic lower respiratory disease		Diseases of the respiratory system
Dementia & Alzheimer's Disease	Alzheimer's disease		Mental disorders
Breast Cancer	Malignant neoplasms	Cancers	Neoplasms
Acute Respiratory Infections/ Pneumonia			Diseases of the respiratory system
Back Pain			Disease of the musculoskeletal system
Colorectal Cancer	Malignant neoplasms	Cancers	Neoplasms
Lung Cancer	Malignant neoplasms	Cancers	Neoplasms
Prostate Cancer	Malignant neoplasms	Cancers	Neoplasms
Skin Cancer	Malignant neoplasms	Cancers	Neoplasms
Cervical Cancer*	Malignant neoplasms	Cancers	Neoplasms
Chlamydia*		HIV/AIDS/STD	
HIV*		HIV/AIDS/STD	
Oral Health*		Oral Health	

[a]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) Accessed: http://www.sdcounty.ca.gov/hhsa/programs/phs/community_epidemiology/epi_stats_mortality.html#regional_tables
[b]Source: Kaiser Permanente Data Platform, Potential Health Needs, http://www.communitycommons.org/groups/community-health-needs-assessment-chna/
[c]Source: SpeedTrack© California Universal Patient Information Discovery (CUPID) application. http//www.speedtrack.com

TABLE 6. SUMMARY OF TOP TEN HEALTH NEEDS BY DATA SOURCE

Rank	County Mortality Data-2012[ab]	Kaiser Permanente Benchmark Analysis Tool [c]	Hospital Discharge Data[d] (all ages)			
			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 and 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/. The benchmark scores for each health need are in parenthesis.

[d]Source: SpeedTrack© California Universal Patient Information Discovery (CUPID) application. http://www.speedtrack.com. 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

Note: Those in red represent the top four health needs: behavioral/mental health, cardiovascular, diabetes and obesity.

In addition, the top health drivers associated with the health needs were identified via-community input activities and secondary data analysis (Table 7). For inclusion as a health driver one of the following criteria had to be met:

- **Community Concern**: Stakeholders, community members, and vulnerable populations within the community view the health need as a priority.
- **Magnitude or prevalence**: The health driver affects a large number of people in all regions of San Diego
- **Health Disparities:** The health driver disproportionately impacts one or more vulnerable population groups.

TABLE 7. IDENTIFIED HEALTH DRIVERS

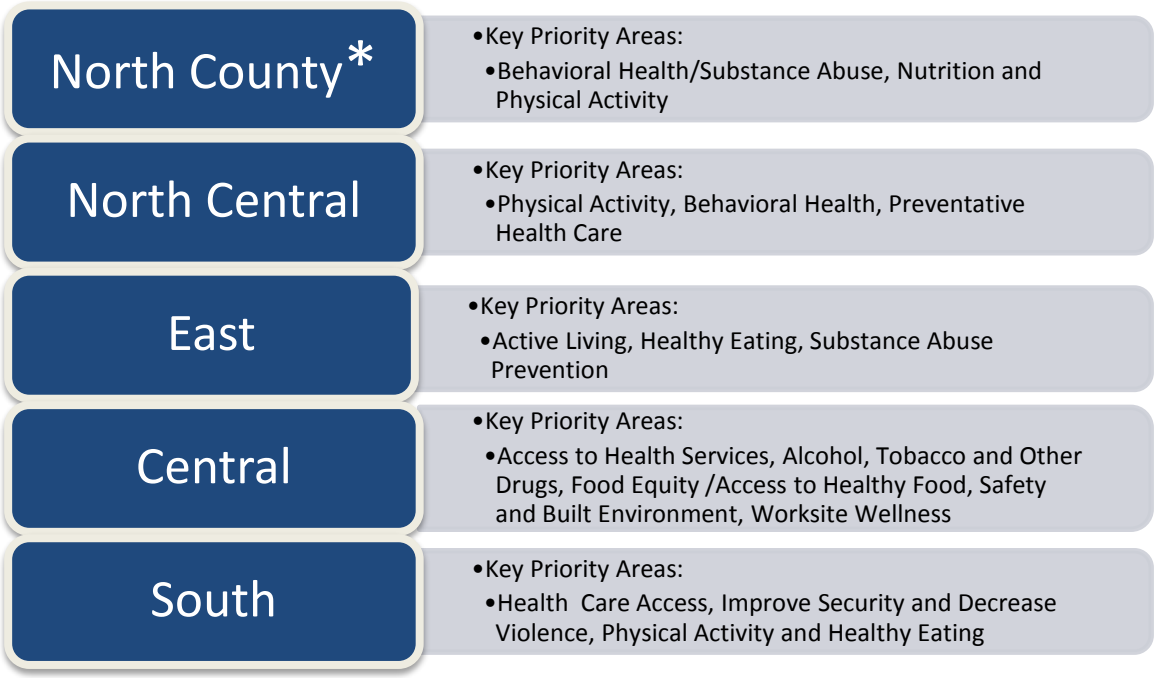
Identified Health Drivers
Access to Care or Services
Cultural Competency
Education/Knowledge
Food Insecurity and Access to Healthy Food
Homeless/Housing Issues
Insurance Issues
Physical Activity
Poverty
Stigma
Transportation

To further support data findings, results from other recent needs assessments were examined. The needs assessments that were reviewed were the County of San Diego Health and Human Service Agency Community Health Assessment and the results from the 2014 Community Action Partnership (CAP) San Diego Community Needs Assessment.

County of San Diego HHSA Community Health Assessment

The *Live Well* San Diego Community Health Assessment 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 below.

FIGURE 11. SUMMARY OF KEY PRIORITY AREAS IDENTIFIED IN THE CHA



*Note: North County includes both North Inland and North Coastal regions.
Data Source: County of San Diego, Health and Human Services Agency. Live Well San Diego Community Health Assessment. 2014

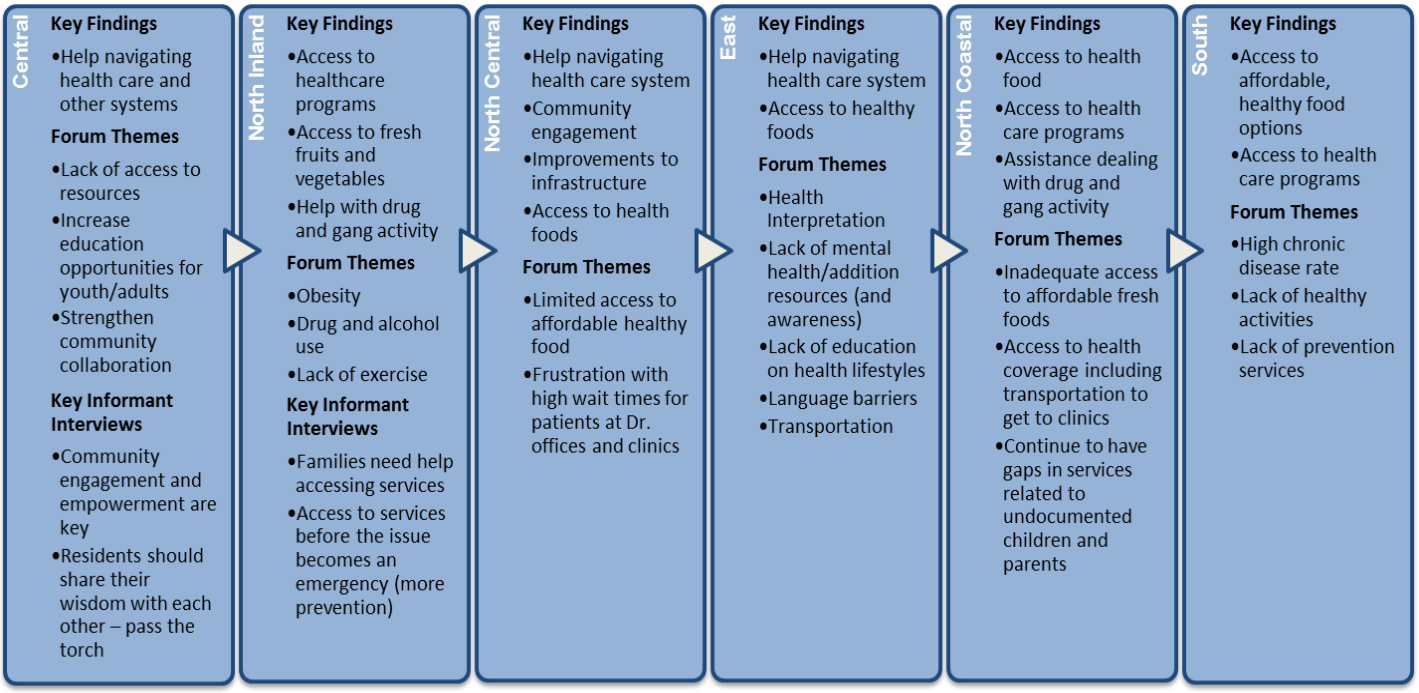
2014 Community Action Partnership San Diego Community Needs Assessment

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 primary and secondary data 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 12. SUMMARY OF THE 2014 CAP COMMUNITY NEEDS ASSESSMENT



Overall the findings from both needs assessment support the top four identified health needs and associated barriers to improved health status. Several areas within behavioral/mental health were identified as well as obesity and chronic diseases. In addition, access to care, navigating the health system, food access and quality of food, education, physical activity,and transportation were identified by at least one of the assessments as a health need within San Diego County.

B. Process and criteria used for prioritization of the health needs

In order to prioritize the four significant health needs in San Diego County, the CHNA Committee used the criteria listed below, taking into account the ability of hospitals to have a significant and meaningful impact given their expertise and available resources. The CHNA Committee applied the following five criteria:

- **Magnitude or prevalence**: The health need affects a large number of people in all regions of San Diego.
- **Severity**: The health need has serious consequence (morbidity, mortality, and/or economic burden).
- **Health Disparities:** The health need disproportionately impacts the health status of one or more vulnerable population groups.
- **Trends**: The health need is either stable or changing over time, e.g., improving or getting worse.
- **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 all forms of data collected, a rank of

1 to 4, with 1 being the most significant, was applied to each of the four health needs for each criterion. An overall score was given to each health need by averaging the rankings across all categories (Table 8). In addition, the health drivers were prioritized based on the frequency of times they were mentioned during community input activities.

TABLE 8. RANKING RESULTS FROM SECONDARY AND COMMUNITY INPUT SOURCES, 2016 CHNA

Data	Behavioral/Mental 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 Survey	1.0	4.0	3.0	2.0
Average Ranking Among 5 Criteria	**1.8**	**2.1**	**2.7**	**2.2**

C. Prioritized description of all the community health needs identified through the CHNA

i. Community Health Landscape and Trends

Behavioral/mental health was identified 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 the interrelatedness of the three health needs. The focused approach to the 2016 CHNA allowed for more in-depth information to be gathered on these specific health needs. Health needs were further broken down into priority areas of need due to the overwhelming agreement among all data sources and in recognition of the important differences and disparities within each health issue.

a. Significant Morbidity and Mortality (Health Outcomes)

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 Kaiser Permanente Data Platform, and other available community data sources. ED discharge and hospitalization data was also assessed in order to understand the downstream impact of these health conditions on the health system. To better understand the important barriers, modifiable risk factors, and potential strategies to address these health needs, please see the ‘Significant Health Drivers’ section.

1. Behavioral/Mental Health

Behavioral/mental health encompasses many different areas including mental health and substance abuse. Because of the broadness of this health issue, it is often difficult to capture the need for behavioral health services with a single measure. Mental Health can be defined as "a state of complete physical, mental and social well-being, and not merely the absence of disease".[10] 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".[11] Behavioral/mental health is an important health need because it impacts an individual's overall health status and is a comorbidity often associated with multiple chronic conditions, such as diabetes, obesity and asthma.

An analysis of mortality data in San Diego County found that in 2012, Alzheimer's was the third leading cause of death and suicide was the eighth. Hospital emergency department encounters, inpatient discharges, and clinic utilization data for patients with a primary diagnosis of a behavioral/mental health-associated ICD-9 code in 2013 was used to provide an overview of main reasons individuals sought care related to behavioral/mental health by age group. A complete analysis of the OSHPD data is available in Appendix G. 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/mental 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/mental 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/mental health primary diagnosis was 'schizophrenia and other psychotic disorders' followed by 'mood disorders.'
- Feedback from the behavioral/mental 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

[10] World Health Organization. Strengthening Mental Health Promotion. Geneva, World Health Organization (Fact sheet no. 220), 2001.
[11] CDC. Mental Health Basics. Retrieved from http://www.cdc.gov/mentalhealth/basics.htm

the importance of emerging data trends. In recent years, discussion participants cited a significant increase in drug-related discharges, particularly meth-amphetamine (~over 100%).

- An analysis of 2013 OSHPD Primary Care and Specialty Clinics Utilization Data for San Diego County also showed that of the estimated 2.06 million encounters, 6.0% had a primary diagnosis related to mental health.

Anxiety: Anxiety is a normal reaction to stress but can become excessive, difficult to control, and ultimately interfere with normal day-to-day living.[12] 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.[13] 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. An analysis of OSHPD trends shows that there has been a significant increase in the rate of ED visits and hospitalizations per 100,000 population in San Diego County attributable to substance and alcohol abuse. 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.[14] According to the 2015 San Diego County Senior Health Report[15], roughly 60,000 individuals in San Diego are living with Alzheimer's disease or other dementia (ADOD) in 2012. It is projected that the

[12] Substance Abuse and Mental Health Services Administration. Mental Disorders. Retrieved from http://www.samhsa.gov/disorders/mental
[13] Substance Abuse and Mental Health Services Administration. Substance Use Disorders. Retrieved from http://www.samhsa.gov/disorders/substance-use
[14] Alzheimer's Association. What is Alzheimer's?. Retrieved from http://www.alz.org/alzheimers_disease_what_is_alzheimers.asp
[15] 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.

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. 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 10) 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 (15.4 and 14.2 per 100,000, respectively). Comparing suicide rates by race, non-Hispanic, black, Asian, Native Hawaiian/Pacific Islander, and those of multiple races were all above state levels.

Needing Mental Health Care: According to the 2014 California Health Interview Survey, approximately 15.0% of San Diego adults compared to 15.9% in California self-reported that there was ever a time during the past 12 months when they felt that they might need to see a professional because of problems with their mental health, emotions, nerves, or use of alcohol or drugs. This indicator is a measure of general poor mental health status and demand for mental and behavioral health services. Please see Table 9 for additional trend data.

TABLE 9. MENTAL HEALTH SAN DIEGO COUNTY TRENDS OVER TIME

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 10. 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

[a]Data Source: University of California Center for Health Policy Research, California Health Interview Survey. 2011-2012.
[b]Data Source: California Department of Public Health, CDPH – Death Public Use Data. University of Missouri, Center for Applied Research and Environmental Systems. 2010-2012.
[c]Data Source: HP 2020

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/mental health are summarized in Table 11.

TABLE 11. QUALITATIVE SUMMARY OF COMMON BEHAVIORAL/MENTAL HEALTH ISSUES

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

The Alpine Special Treatment Center[16], 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

[16] 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.

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 the across the continuum of care.

Finally, mental health issues and alcohol/drug abuse issues were consistently selected by the most number of HHSA survey participants across all of the regions as health problems that have the greatest impact on overall community health. In addition, aging concerns including Alzheimer's was cited among the top five most important health problems in all regions in San Diego except Central. By assessing overlap between community concern and secondary data, a list of the top community health needs which have a significant impact on morbidity and mortality within behavioral and mental health was compiled. The following categories were found to be important health issues within behavioral/mental health in San Diego County:

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

2. 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.[17] Coronary Heart Disease is the most common form of heart disease and the leading cause of death in the U.S.[18] High blood pressure, high cholesterol, and smoking are all risk factors that could lead to CVD and stroke. About half of

[17] World Health Organization. Cardiovascular Diseases. http://www.euro.who.int/en/what-we-do/health-topics/noncommunicable-diseases/cardiovascular-diseases/definition
[18] CDC. Heart Disease Facts. Retrieved from http://www.cdc.gov/heartdisease/facts.htm

Americans (49%) have at least one of these three risk factors.[10]

'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. Twenty-nine percent of discharges were for those with Health Management Organization (HMO) insurance.
- '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.
- An analysis of 2013 OSHPD Primary Care and Specialty Clinics Utilization Data for San Diego County also showed that of the estimated 2.06 million encounters, 4.3% had a primary diagnosis related to circulatory disease. 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.

The 2011-2012 California Health Interview Survey 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. According to the California Department of Public Health, the age-adjusted death rate for ischemic heart disease and stroke was 148.3 and 32.8 per 100,000 population respectively for San Diego in 2010-2012. While the mortality rates were lower for San Diego County than in California, the rate of death due to coronary heart disease is still above the HP2020 benchmark of 100.8 per 100,000 population (Table 13). Additionally, mortality rates for ischemic heart disease and stroke were particularly high for African Americans (211.9 and 60.02 per 100,000 population) and Native Hawaiian/Pacific Islanders (241.4 and 47.0 per 100,000 population) in San Diego County. Unmanaged high blood pressure is also a problem in San Diego. According to the 2006-2010 BRFSS, 31.3% of adults reported that they are not taking medication for their high blood pressure. Please see Table 12 for additional hypertension trend data.

TABLE 12. HYPERTENSION SAN DIEGO COUNTY TRENDS OVER TIME

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

TABLE 13. 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

[a]Data Source: University of California Center for Health Policy Research, California Health Interview Survey. 2011-2012.
[b]Data Source: California Department of Public Health, CDPH – Death Public Use Data. University of Missouri, Center for Applied Research and Environmental Systems. 2010-2012.
[c]Data source: HP2020

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 14.

TABLE 14. QUALITATIVE SUMMARY OF COMMON CARDIOVASCULAR DISEASE ISSUES

Qualitative Summary of Cardiovascular Disease-Related Responses	
1. What are the most common health issues or needs?	
♦ Hypertension ♦ Salt intake/Diet ♦ High cholesterol ♦ Stroke	♦ Adolescent hypertension and cardioconverters ♦ Hypertension and poor CVD outcomes among Latinos, African Americans and Asians ♦ Mobility issues and barriers to healthy food for seniors

Finally, an assessment of health needs by HHSA region found that heart disease was cited as being among the top 5 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.

By assessing overlap between community concern and secondary data, a list of the top community health needs which have a significant impact on morbidity and mortality within cardiovascular disease was compiled. Hypertension was found to

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

3. Diabetes (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 your 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.[19] Diabetes is an important health issue because of its prevalence and 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 16). This percentage is slightly higher for males in San Diego (8.2%) than females (6.9%). It is a relevant target for intervention because hospitalizations due to diabetes-related complications are potentially preventable with proper management and a healthy lifestyle. In San Diego, the discharge rate for diabetes-related complications was approximately 9.0 per 10,000 population overall. As a percentage of total discharges by race, approximately 1.5% of discharges in the black patient population were attributable to diabetes compared to 0.7% of discharges among whites.

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 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.'

An analysis of 2013 OSHPD Primary Care and Specialty Clinics Utilization Data for San Diego County also showed that of the estimated 2.06 million encounters, 7.3% had a primary diagnosis related to endocrine, metabolic or immunity disorders which includes diabetes. Data gathered from North County Health

[19] CDC website: http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf

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 15 for additional trend data.

TABLE 15. DIABETES SAN DIEGO COUNTY TRENDS OVER TIME

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

TABLE 16. 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

[a]Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012.
[b]Data Source: California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2011.

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) are summarized in Table 17.

TABLE 17. QUALITATIVE SUMMARY OF COMMON DIABETES (TYPE 2) ISSUES

Qualitative Summary of Diabetes (Type 2)-Related Responses	
1. What are the most common health issues or needs?	
♦ Treatment compliance issues ♦ Lack of supplies ♦ Diabetes related to low income and food insecure population	♦ Assumption that diabetes only affects older individuals ♦ Chronic kidney disease related to diabetes ♦ Diet and sugar

Finally, an assessment of health needs by HHSA region found that diabetes was cited as being among the top 5 most important health problems in Central, East and North County (comprised of North Coastal and North Inland). By assessing overlap between community concern and secondary data, a list of the top community health needs which have a significant impact on morbidity and mortality within diabetes was compiled. 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.

4. 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.[20] 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.[21] 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 Body Mass Index (BMI) between 25.0 and 30.0 (overweight) in San Diego County according to 2011-2012 BRFSS data (Table 19). An additional 20.1% of adults aged 20 and older self-reported that they have a Body Mass Index (BMI) greater than 30.0 (obese) in San Diego County. The percentage of residents with obesity 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. High levels of body fat are linked to obesity, heart disease, diabetes, and other health issues.

Youth: FITNESSGRAM is the required physical fitness test that school districts must administer to all California students in Grades 5, 7, and 9.The percentage of children in grades 5, 7, and 9 ranking within the "Needs Improvement" 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 ranked within the "Health 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, clinic utilization data from OSHPD and 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:

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[20] CDC. Defining Adult Overweight and Obesity. Retrieved from http://www.cdc.gov/obesity/adult/defining.html
[21] 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.

- 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.

An analysis of 2013 OSHPD Primary Care and Specialty Clinics Utilization Data for San Diego County also showed that of the estimated 2.06 million encounters, 7.3% had a primary diagnosis related to endocrine, metabolic or immunity disorders which includes obesity. 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 screening program screens different youth each year, this decrease could represent a decreasing trend in childhood obesity, particularly in North County. Please see Table 18 for additional adult obesity trend data.

TABLE 18. OBESITY SAN DIEGO COUNTY TRENDS OVER TIME

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

TABLE 19. 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

[a]Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2011-2012.
[b]Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012.
[c]Data 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".

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 20.

TABLE 20. QUALITATIVE SUMMARY OF COMMON OBESITY-RELATED ISSUES

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

Finally, an assessment of health needs by HHSA region found that obesity was consistently cited as being among the top 5 most important health problems across all the regions, though it ranked highest in East and South region.

By assessing overlap between community concern and secondary data, a list of the top community health needs which have a significant impact on morbidity and mortality within obesity was compiled. Obesity and its contribution to other chronic and co-occurring diseases were found to be a significant area of need in San Diego County.

For additional information about the top health needs identified, please see the corresponding Health Profile (Appendix C). A complete analysis of disparities among different population groups with respect to the top four health needs can be found in Appendix J (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/mental 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 K for the GIS maps of hospital discharge rates and CNI data.

b. Significant Health Drivers

After a review of secondary data and community input, ten health drivers were found to significantly contribute towards worsening health status and disparities among the top health needs. The identified health drivers are as follows (in order of priority:

1. Food Insecurity and Access to Healthy Food
2. Access to Care or Services
3. Homeless/Housing Issues
4. Physical Activity
5. Education/Knowledge
6. Cultural Competency
7. Transportation
8. Insurance Issues
9. Stigma

10. Poverty

To better understand how these health drivers affect San Diego County residents, data from the Kaiser Permanente Data Platform and secondary data from the community are summarized below.

i. Access to Care or Services

A number of factors influence whether individuals in a community have access to care including the number of facilities and providers, the distribution of providers and services across the county, and the specific barriers faced by community residents including their ability to navigate the health system.

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 United States (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 Table 26.

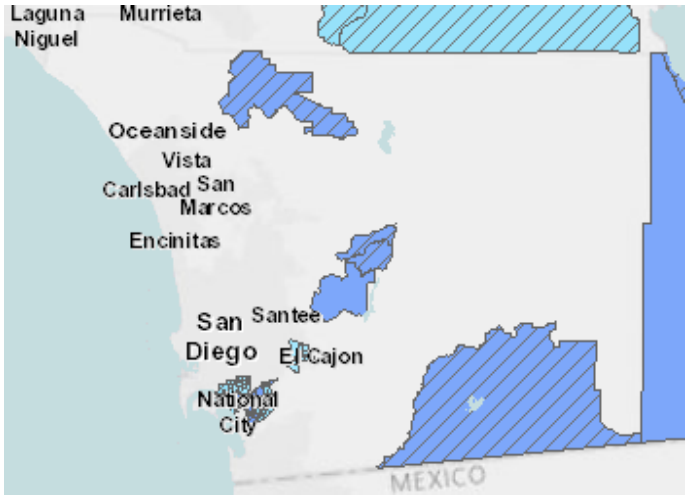
Access to Providers: According the U.S. Department of Health and Human Services Area Health Resource File, there are approximately 77.5 primary care physicians per 100,000 persons in San Diego County. The San Diego County rate is similar to California (77.2). According to 2014 County Health Rankings, 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 health status issues. 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 13.

Health Professional Shortage Areas (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. This is defined as having a shortage of primary medical 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.

Uninsured: Between 2010 and 2013 uninsured rate was relatively stable in San Diego County, California, and the U.S. 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.

FIGURE 13. PRIMARY CARE HPSA COMPONENTS, TYPE AND DEGREE OF SHORTAGE BY TRACT / COUNTY, 2015



Population Group; Over 20.0 FTE Needed
Population Group; 1.1 - 20.0 FTE Needed
Population Group; Under 1.1 FTE Needed
Geographic Area; Over 20.0 FTE Needed
Geographic Area; 1.1 - 20.0 FTE Needed
Geographic Area; Under 1.1 FTE Needed
Report Area

Data Source: US Department of Health & Human Services, Health Resources and Services Administration, Health Professional Shortage Areas. March 2015.

TABLE 21. 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%

[a]Data Source: US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File. June 2014.
[b]Data Source: US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2012.
[c]Data Source: US Department of Health & Human Services, Health Resources and Services Administration, Health Professional Shortage Areas. March 2015.

Qualitative feedback was also gathered to understand the top barriers related to access to care and health system navigation. 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. Key informants also emphasized the need for greater access to specialty care. For behavioral/mental health specifically, limited access to psychiatrists and problems with behavioral and mental health coverage were noted during community partner discussions; lack of access to psychiatrists, lack of substance abuse treatment facilities particularly in North County, and lack of resources for the care and housing of the seriously mentally ill (SMI)/chronically mentally ill population were cited as top concerns across key informant

interviews.

Additionally, a survey administered to community residents through the Resident Leadership Academy asked participants to choose the top five barriers that they themselves, or the population they work with, experience when navigating the health system. In addition, participants then ranked those identified top barriers from one to five, with one being the most troublesome. Approximately half the respondents ranked the top barriers they chose; therefore for reporting purposes, the total number of times respondents selected a barrier as being among the top five was utilized to rank the barriers. Notably, 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 identified barriers were:

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

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. See Table 22 and Table 23 for more details on the survey results.

Of those who responded to the survey, 87% took the survey as a community member. The majority of the respondents were Hispanic (69%) followed by white (27%), Asian/Pacific Islander and black (4% and 2% respectively). There was representation from all San Diego County regions, with the largest proportion of respondents being from South region (46%). East region had the smallest representation with 6% of the overall respondents reporting living or working in East County. Table 23 shows the top five barriers overall in the County and the regional distribution. 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. The top two reasons within the five barriers identified at a County level are shown in addition to the regional distributions (Table 23).

TABLE 22. DEMOGRAPHIC INFORMATION, HEALTH ACCESS AND NAVIGATION SURVEY

Demographic	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 have 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 23. 2016 CHNA SURVEY RESULTS BY SAN DIEGO COUNTY HHSA REGIONS, ROADMAP – WHERE DO YOU GET STUCK? HASD&IC 2016 CHNA

Top Five Health Access & Navigation Categories (barriers cited as most troublesome in accessing health care)	N. Coastal (n=34)		N. Central (n=34)		Central (n=23)		South (n=107)		East (n=14)		N. Inland (n=34)		Total (n=250)	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Understanding health insurance	24	70.6%	22	64.7%	22	95.7%	85	79.4%	10	71.4%	28	82.4%	194	77.60%
Getting health insurance	22	64.7%	19	55.9%	14	60.9%	76	71.0%	7	50.0%	20	58.8%	159	63.60%
Using health insurance	17	50.0%	22	64.7%	15	65.2%	67	62.6%	6	42.9%	20	58.8%	149	59.60%
Knowing where to go for care	19	55.9%	21	61.8%	15	65.2%	62	57.9%	8	57.1%	23	67.6%	149	59.60%
Follow-up care and/or appt.	15	44.1%	16	47.1%	15	65.2%	40	37.4%	11	78.6%	19	55.9%	118	47.20%

Top Five Health Access & Navigation Categories and Responses	N. Coastal		N. Central		Central		South		East		N. Inland		Total	
	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	100.0%	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	46.70%	8	100.00%	13	61.9%	80	56.3%
No primary care doctor	8	44.4%	5	26.3%	7	53.8%	27	45.00%	3	37.50%	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	44.70%	5	50.00%	6	35.3%	50	45.9%
Lack of understanding about next steps	9	64.3%	3	20.0%	6	46.2%	14	36.80%	4	40.00%	11	64.7%	47	43.1%
Total	14		15		13		38		10		17		109	100%

Cultural Competency

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.”[22] 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 the community’s perspective.

Population Change: It is important to understand how ethnic and racial make-up of San Diego is changing in order evaluate how to best meet the county’s cultural competency needs. 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 compared to 2.0% increase in the non-Hispanic population. An analysis of the change in population composition by race found that the greatest percentage increases were among Asians (34.5%), followed by individuals of multiple races (20.1%). From this information, it can be determined that there is a significant need for a diversified healthcare workforce.

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." Additionally, 8.5% are linguistically isolate, defined as 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. It is important to understand the demand to culturally sensitive resources given San Diego County’s geography and large immigrant and refugee populations.

Qualitative feedback was gathered from community partner discussions and key informant interviews which highlighted areas in which different cultural practices and lack of cultural competency in healthcare drives disparities in health outcomes.

Among community partners, low motivation and health literacy were cited as behavioral factors that contribute to poorer health outcomes. For example, patients may only visit the doctor or take their medication when they feel sick. This contributes to problems with treatment compliance and prevention for many chronic conditions such as diabetes and high blood pressure which may not overtly and immediately impact daily quality of life. Cultural practices may also pose a challenge in the form of unhealthy food practices. It is important for providers to understand and consider these differences in order to appropriately communicate health information and engage populations in their care.

[22] 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.

Incorporating translators and multicultural providers as part of the treatment team was also recommended as a strategy to improve cultural competence in the healthcare setting.

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 (i.e. LGBTQ, American Indian/Alaskan Native), 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.

Education/Knowledge

Education is a primary social determinant of health, and is associated with increased economic opportunity, access to social resources (i.e. food access and spaces and facilities for physical activity), and positive health status and outcomes. In addition to level of educational attainment of the population, it is important to understand the impact of low cultural and health literacy on health outcomes.

Educational Attainment: Educational attainment is linked to positive health outcomes. 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 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.

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, educational efforts focused on behavioral/mental 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. Feedback gathered through community partner discussions echoed these suggestions and also highlighted the importance of role models for youth and upstream education of basic health issues as important tools for targeting this health driver. Community partners underscored that that lack of compliance and difficulty with access was being driven in part by poverty, the prioritization of other needs, and lack of education.

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”.[23]

According to a study conducted by Sarkin et al., who examined 2009 data on individuals who had used mental health services in San Diego County, 89.7% reported experiencing some type of discrimination with relation to their mental health problems.[24]

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.

ii. Physical Environment

Food Insecurity and Food Environment

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: According to 2014 California Health Interview survey 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

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

[24] 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

receiving Cal Fresh benefits.

Food Environment: San Diego County has more fast food restaurants per 100,000 population in 2012 than both California and the US (81.9 vs 74.5 and 72.0 respectively) according the US Census Bureau County Business Patterns. It also has 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 indicates that in 2010, 15.8% of the San Diego population has low access to a supermarket or large grocery store. All of these factors influence dietary behaviors and can negatively impact health.

Poor 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, limited mobility (senior population), and transportation also play an important role in diet and food access. Finally, the lack of role models for youth and limited control over health behaviors at home were called out during community discussion as barriers to improving obesity in youth. 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.

Transportation

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.

Transportation was cited as a health driver 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 heighted 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.

iii. Healthy Behaviors

Physical Activity

Current behaviors are determinants of future health. This is particularly true for physical activity which is an important driver of health. Lack of physical fitness in children and adults contributes to weight gain, type 2 diabetes, and poor cardiovascular health.

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. Although higher rates of limited leisure time activity were reported at the state and national level (16.6% and 22.6% respectively), increased physical activity is important to combat weight gain. 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. The percentage of children that are not within the healthy fitness zone varies among racial/ethnic groups with the lowest being Non-Hispanic Asians at 20.6% and the highest being Hispanic or Latinos at 42.1%. Although this is smaller than the state average of 35.9%, it is still cause for concern and may lead to significant health issues, such as obesity, diabetes, and poor cardiovascular health. See Table 24 for additional information.

TABLE 24. PHYSICAL ACTIVITY INDICATORS

	San Diego County	California	United States
Percent Adult Population with no Leisure Time Physical Activity[a]	14.90%	16.60%	22.60%
Percent Physically Inactive (Youth) [b]	29.35%	35.92%	NA

[a]Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012.
[b]Data Source: California Department of Education, FITNESSGRAM®; Physical Fitness Testing. 2013-2014.

Community input further 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.

iv. Socioeconomic Factors

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 how lack of access to health food, including availability and cost, was driven in part by poverty. In addition, lifestyle change and treatment for chronic conditions may not be feasible for individuals and families living in poverty because there are more

pressing needs than health eating or they have a lack of ability to pay for medications.

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.

Homelessness and Housing Issues

Housing and homelessness is an important social determinant of health in San Diego County with both community input and secondary data 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.

ii. Prioritized list of health needs

A broad list of fifteen health needs within San Diego County was prioritized during the collaborative 2013 CHNA effort and utilized in the current 2016 CHNA as a starting point for the data analysis process. All fifteen health needs were validated as having continued relevance within San Diego County due to their significant contribution to morbidity, mortality, and/or disparities. In addition, Kaiser Permanente conducted a supplementary analysis for the 2013 CHNA which identified cervical cancer, chlamydia and HIV as important health needs in San Diego. These three additional health needs

were also validated by the current data and one additional emergent health need was added to the list, oral health. Below is the prioritized list of health needs from 2013:

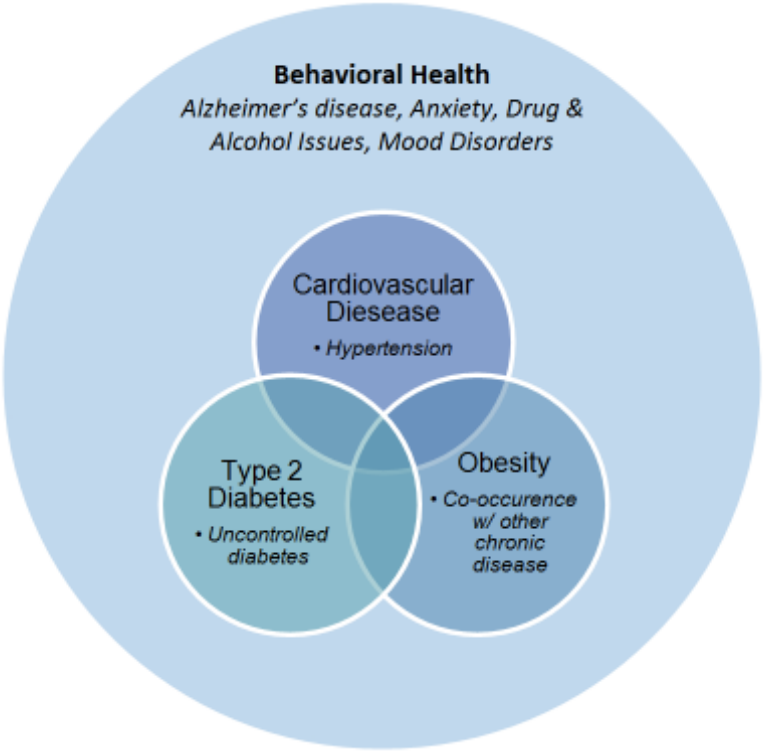
1. Diabetes (Type 2)
2. Obesity
3. Cardiovascular Disease
4. Behavioral/Mental Health
5. Unintentional Injury
6. High Risk Pregnancy
7. Asthma
8. Dementia & Alzheimer's Disease
9. Breast Cancer
10. Acute Respiratory Infections/Pneumonia
11. Back Pain
12. Colorectal Cancer
13. Lung Cancer
14. Prostate Cancer
15. Skin Cancer

- Cervical Cancer*
- Chlamydia*
- HIV*
- Oral Health*

*Kaiser specific identified health needs – not part of the collaborative process

Based on secondary data and feedback from community regarding future needs assessments processes, the collaborative CHNA committee chose to conduct an in-depth analysis of the top four needs identified. The CHNA Committee identified behavioral/mental health as the number one health issue in San Diego County. In addition, cardiovascular disease, diabetes, and obesity were identified as having equal importance due to the interrelation of the three health issues. Health issues were further broken down into priority areas of need due to the overwhelming agreement among all data sources and in recognition of the important differences within each health issue. Within the category of behavioral/mental health, Alzheimer's, anxiety, mood disorders, and drug and alcohol issues are significant health needs within San Diego County. Among the other chronic health needs, hypertension was consistently found to be a significant health issue related to cardiovascular disease, uncontrolled diabetes was an important factor leading to complications with 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.

2016 CHNA TOP HEALTH NEEDS



In addition, ten health drivers associated with all four identified health needs were consistently referenced across the different types of community input. The importance of these drivers was also confirmed by secondary data. Hospital programs and community collaborations have the potential to impact these social determinants, which are outlined below in order of priority.

1. Food Insecurity and Access to Healthy Food
2. Access to Care or Services
3. Homeless/Housing Issues
4. Physical Activity
5. Education/Knowledge
6. Cultural Competency
7. Transportation
8. Insurance Issues
9. Stigma
10. Poverty

1. Food insecurity and access to healthy food

Food insecurity and access to healthy food were cited most often as a driver of health across all community input activities. In addition, high levels of food insecurity and the food environment in San Diego County supports this as a high need issue.

Poor 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 California Health Interview Survey 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 US (81.9 vs 74.5 and 72.0 respectively) according the US Census Bureau County Business Patterns.

2. Access to care or services

Access to care was cited as an important health driver throughout the community input activities and is supported by secondary 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 health drivers 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 population 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.

Secondary 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.

3. Homeless/housing issues

Housing and homelessness is an important social determinant of health in San Diego County with both community input and secondary data pointing to a continued problem.

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.

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.

4. Physical activity

Lack of physical activity in children and adults was revealed as a major health driver during the community input activities. The prevalence of physical inactivity was confirmed by secondary 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 PE 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.

5. Education/knowledge

Education in some capacity was mentioned during all community input activities and is supported by secondary 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/mental 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%).

6. Cultural Competency

Cultural competency was reiterated as a health driver across all community input activities. In addition, secondary data points to the changing demographics of the population in San Diego County and the need for a culturally competent workforce.

Primary data was gathered from community partner discussions and key informant interviews which highlighted areas in which 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.

Secondary 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.

7. Transportation

Transportation was cited as a health driver 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 heighted 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.

8. 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.

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.

9. 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".[25]

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. 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 in San Diego County, 89.7% reported experiencing some type of discrimination with relation to their mental health problems.[26]

10. 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 how lack of access to health food, including availability and cost, was driven in part by poverty. In addition, lifestyle

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

[26] 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

change and treatment for chronic conditions may not be feasible for individuals and families living in poverty because there are more pressing needs than health eating or they have a lack of ability to pay for medications.

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.

D. Community assets, capacities, and resources potentially available to respond to the identified health needs

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 type of programs, initiatives, and organizations that are currently available in the community to address the top health needs are separated based on the following categories:

- Programmatic and/or organizational resources
- Health initiatives and public policy
- Federally qualified health centers

2-1-1 San Diego is an important community resource and information hub. Through its 24/7 phone service and online database, it helps connect individuals with community, health, and disaster services. In recognition that available programs and services are continuously changing, we encourage the community to access the most available data through 2-1-1 San Diego. 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 I.). 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/Mental 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 San Diego 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 25). 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 25. SAN DIEGO COUNTY INITIATIVES, PARTNERSHIPS, COLLABORATIONS AND PUBLIC POLICY THAT ADDRESS BEHAVIORAL/MENTAL HEALTH, CARDIOVASCULAR, DIABETES, AND OBESITY, 2016 CHNA

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

Federally Qualified Health Centers (FQHCs) are community assets that provide health care to vulnerable populations; they receive extra funding from the federal government to promote access to ambulatory care in areas designated as medically underserved. Table 26 below is the list of Federally Qualified Health Centers in KFH-San Diego medical service area.

TABLE 26. FEDERALLY QUALIFIED HEALTH CENTERS IN KFH-SAN DIEGO MEDICAL SERVICE AREA

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
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

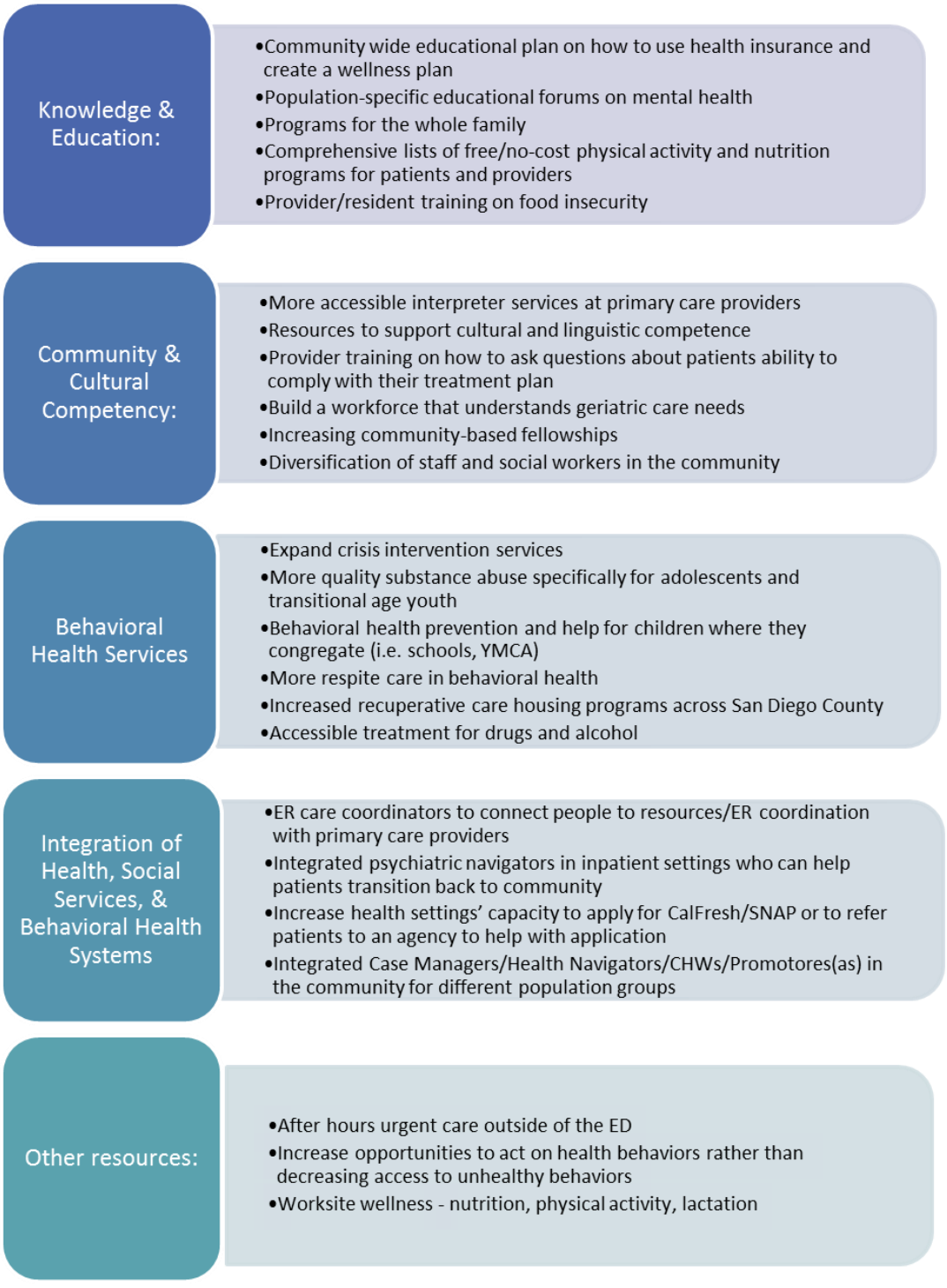
Women's Health & Wellness Center	8851 Center Drive, Suite 210	La Mesa	CA
Neighborhood Healthcare Lakeside	10039 Vine Street Suite 2	Lakeside	CA
Lemon Grove Family Health Center	7592 Broadway	Lemon Grove	CA
La Maestra Community Health Center - Lemon Grove	7967 Broadway	Lemon Grove	CA
National City Family 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
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 I I I (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
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, Suite 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

In addition to the list of potentially available resources currently available in the community, feedback was also gathered directly from the community to assess where additional resources are needed via the key informant interviews, community partner discussion, and the collaborative HHSA survey.

Key Informant Interviews:

Resources that need to be increased or developed to meet these needs are:



Community Partner Discussions:

Suggested resources that need to be developed or increased included:

a. Streamlined discharge planning process including referrals and access to medical records
b. Improved assessments for patient social service needs
c. Increased step-down facilities for SMI patients to transition back into the community
d. Increased behavioral/mental health case managers.

Collaborative HHSA Survey:

The results of the survey provide a better understanding of where significant resources are lacking regionally. This is an important consideration due to the large size and diverse nature of San Diego County. Overall, mental health Issues and alcohol and drug abuse were most frequently cited as the most important health problems across all the regions. With the exception of the East region, mental health Issues were found to have the least amount of available resources to address the problem across the County. The majority of respondents in East region stated that alcohol and drug abuse had the least amount of resources. Together, deficiencies in mental health and alcohol and drug abuse signal a need for more behavioral/mental health resources.

VII. KFH-SAN DIEGO 2013 IMPLEMENTATION STRATEGY EVALUATION OF IMPACT

A. **Purpose of 2013 Implementation Strategy evaluation of impact**

KFH-San Diego's 2013 Implementation Strategy report was developed to identify activities to address health needs identified in the 2013 CHNA. This section of the CHNA Report describes and assesses the impact of these activities. For more information on KFH-San Diego's Implementation Strategy report, including the health needs identified in the facility's 2013 service area, the health needs the facility chose to address, and the process and criteria used for developing Implementation Strategies, please visit https://share.kaiserpermanente.org/wp-content/uploads/2013/10/IS-Report-San-Diego.pdf . For reference, the list below includes the 2013 CHNA health needs that were prioritized to be addressed by KFH-San Diego in the 2013 Implementation strategy report.

1. Access to Health Care
2. Cardiovascular Disease
3. Mental/Behavioral Health
4. Obesity
5. Type 2 Diabetes
6. Broader Health Care System Needs in Our Communities - Research and Workforce

KFH-San Diego is monitoring and evaluating progress to date on their 2013 Implementation Strategies for the purpose of tracking the implementation of those strategies as well as to document the impact of those strategies in addressing selected CHNA health needs. Tracking metrics for each prioritized health need include the number of grants made, the number of dollars spent, the number of people reached/served, collaborations and partnerships, and KFH in-kind resources. In addition, KFH-San Diego tracks outcomes, including behavior and health outcomes, as appropriate and where available.

As of the documentation of this CHNA Report in March 2016, KFH-San Diego had evaluation of impact information on activities from 2014 and 2015. While not reflected in this report, KFH-San Diego will continue to monitor impact for strategies implemented in 2016.

B. **2013 Implementation Strategy Evaluation of Impact Overview**

In the 2013 IS process, all KFH planned for and drew on a broad array of resources and strategies to improve the health of communities and vulnerable populations, such as grantmaking, in-kind resources, collaborations and partnerships, as well as several internal KFH programs including, charitable health coverage programs, future health professional training programs, and research. Based on years 2014 and 2015, an overall summary of these strategies is below, followed by tables highlighting a subset of activities used to address each prioritized health need.

- **KFH Programs:** From 2014-2015, KFH supported several health care and coverage, workforce training, and research programs to increase access to appropriate and effective health care services and address a wide range of specific community health needs, particularly impacting vulnerable populations. These programs included:

- **Medicaid:** Medicaid is a federal and state health coverage program for families and individuals with low incomes and limited financial resources. KFH provided services for Medicaid beneficiaries, both members and non-members.
- **Medical Financial Assistance:** The Medical Financial Assistance (MFA) program provides financial assistance for emergency and medically necessary services, medications, and supplies to patients with a demonstrated financial need. Eligibility is based on prescribed levels of income and expenses.
- **Charitable Health Coverage:** Charitable Health Coverage (CHC) programs provide health care coverage to low-income individuals and families who have no access to public or private health coverage programs.
- **Workforce Training:** Supporting a well-trained, culturally competent, and diverse health care workforce helps ensure access to high-quality care. This activity is also essential to making progress in the reduction of health care disparities that persist in most of our communities.
- **Research:** Deploying a wide range of research methods contributes to building general knowledge for improving health and health care services, including clinical research, health care services research, and epidemiological and translational studies on health care that are generalizable and broadly shared. Conducting high-quality health research and disseminating its findings increases awareness of the changing health needs of diverse communities, addresses health disparities, and improves effective health care delivery and health outcomes.

- **Grant-making:** For 70 years, Kaiser Permanente has shown its commitment to improving Total Community Health through a variety of grants for charitable and community-based organizations. Successful grant applicants fit within funding priorities with work that examines social determinants of health and/or addresses the elimination of health disparities and inequities. From 2014-2015, KFH-San Diego had 95 grant payments amounting to a total of $1,451,480 in service of 2013 health needs. Additionally, KFH-San Diego has funded significant contributions to a donor advised fund (DAF), managed by the California Community Foundation, in the interest of funding effective long-term, strategic community benefit initiatives. During 2014-2015, a portion of money managed by this foundation was used to support 49 grant payments totaling $5,944,289 in service of 2013 health needs. An illustrative list of active grants is provided in each health need section below.
- **In-Kind Resources:** Kaiser Permanente's commitment to Total Community Health means reaching out far beyond our membership to improve the health of our communities. Volunteerism, community service, and providing technical assistance and expertise to community partners are critical components of Kaiser Permanente's approach to improving the health of all of our communities. From 2014-2015, KFH-San Diego donated several in-kind resources in service of 2013 Implementation Strategies and health needs; an illustrative list is provided in each health need section below.
- **Collaborations and Partnerships:** Kaiser Permanente has a long legacy of sharing its most valuable resources: its knowledge and talented professionals. By working together

with partners (including nonprofit organizations, government entities, and academic institutions), these collaborations and partnerships can make a difference in promoting thriving communities that produce healthier, happier, more productive people. From 2014-2015, KFH-San Diego engaged in several partnerships and collaborations in service of 2013 Implementation Strategies and health needs; an illustrative list is provided in each health need section below.

C. **2013 Implementation Strategy Evaluation of Impact by Health Need**

KFH-San Diego Priority Health Need: Access to Health Care

Goals - Improve access to clinical care services.		
Access to Health Care: increasing access to clinical care as this drives poor health outcomes in many health needs **KFH Administered Program Highlights**		
KFH Program Name	**KFH Program Descriptions**	**Results to Date**
Medicaid	Medicaid is a federal and state health coverage program for families and individuals with low incomes and limited financial resources. KFH provided services for Medicaid beneficiaries, both members and non-members.	• In 2014, $13,183,617 was spent on the Medicaid program and 32,578 Medi-Cal managed care members were served • In 2015, $17,339,593 was spent on the Medicaid program and 47,355 Medi-Cal managed care members were served
Medical Financial Assistance	The Medical Financial Assistance (MFA) program provides financial assistance for emergency and medically necessary services, medications, and supplies to patients with a demonstrated financial need. Eligibility is based on prescribed levels of income and expenses.	• In 2014, $4,968,789 was expended for 4,610 MFA recipients • In 2015, $5,215,749 was expended for 4,407 MFA recipients
Charitable Health Coverage	Charitable Health Coverage (CHC) programs provide health care coverage to low-income individuals and families who have no access to public or private health coverage programs.	• In 2014, $2,086,935 was spent on the CHC program and 4,024 individuals received CHC • In 2015, $1,772,681 was spent on the CHC program and 4,304 individuals received CHC
Access to Health Care **Grant-Making Highlights**		
Grant-Making Snapshot During 2014-2015, a portion of the money managed by a donor advised fund (DAF), the California Community Foundation,		

was used to support 20 grant payments, totaling $2,287,500; DAF grants are denoted by asterisks (*). Donor advised fund (DAF) grants may cover multiple KFH service areas and address multiple health needs. All grant amounts reflect the amount paid in 2014 or 2015 and may not be reflective of the total grant amount awarded.

Grantee	Grant Amount	Project Description	Results to Date
Insure the Uninsured Project	$75,000 *	Insure the Uninsured Project (ITUP) received funding to focus on educating consumers and stakeholders on health reform as well as Outreach, Enrollment, Retention and Utilization (OERU) strategies for the uninsured.	ITUP will convene its statewide and regional workgroups to build consensus and engage local leaders to focus on region specific issues that will address the health outcomes of the newly insured and disseminate its non-partisan reports on statewide and local issues. Annually, ITUP will host at least 18 meetings—six statewide issue workgroups, ten regional workgroups, two Los Angeles Health Collaborative meetings, and legislative briefings—as well as produce twenty-five research reports on coverage efforts for the uninsured, health reform implementation strategies, and findings from statewide and regional workgroups, annually.
North County Health Services	$125,000 *	The North County Health Services (NCHS) received funding to construct a new community health center in the City of Carlsbad to improve the health status of their diverse communities by providing quality health care that is comprehensive, affordable and culturally sensitive.	This two-year grant has enabled NCHS to increase services to low-income and medically underserved adults at a new Carlsbad Family Medicine Health Center (CFMHC). In 2015 the Health Center served 3,630 unduplicated patients, more than doubling access compared to the previous facility.
Community Partners	$512,500*	Please see description for the Specialty Care Initiative under Impact of Regional Initiatives.	Please see description for the Specialty Care Initiative under Impact of Regional Initiatives.
Community Clinics Health Network	$175,000*****	Please see description for the ALL HEART program under Impact of Regional Initiatives.	Please see description for the ALL HEART program under Impact of Regional Initiatives.

Access to Health Care
In-Kind Resources Highlights

Recipient	Description of Contribution and Purpose/Goals
211 San Diego and Covered California Collaborative	The goal of the 211 San Diego Collaborative to gather community partners working on Covered California outreach efforts in San Diego County, in order to exchange information and share best practices. The contribution was KFH-San Diego's Senior Community Benefit Manager provided enrollment information on the Kaiser Permanente Child Health so that partners could share this information with potentially eligible children and their families.

Recipient	Description of Contribution and Purpose/Goals
The San Diego County Medical Society Foundation / Project Access San Diego	Surgery days were held on (1) April 26 with 17 gastrointestinal (GI) procedures and 12 outpatient surgeries and (2) October 26, with 20 GI procedures and 16 surgeries or clinical procedures. These procedures were donated by Kaiser Permanente and included employee and physician volunteers, donated OR space and pre and post procedure care.

Impact of Regional Initiatives Addressing Access to Health Care

In addition to the illustrated grants listed above, Kaiser Permanente designs Regional Health Initiatives that are implemented in one or more KFH service areas to address the priority health needs. These initiatives are multi-year investments that support policy, advocacy and/or system changes in communities, including support for clinic systems to enhance capacity, service provision and or coordination. Kaiser Permanente invests in external evaluation for Regional Health Initiatives, and where possible, the results to date will reflect the most recent evaluation findings.

Kaiser Permanente's Specialty Care Initiative aims to increase access to healthcare services for the underserved through the development and enhancement of specialty care access. In order to achieve this goal, Kaiser Permanente funded technical assistance through Community Partners to implement a coalition approach, where various partners collaborated to develop and implement strategies tailored to their communities in Southern California. These strategies focused on instituting and enhancing referral processes, building and expanding specialty care networks, increasing primary care physicians' capacity, and utilizing care coordination in the safety net. This multi-year initiative was launched in 2007 and to date a total of over $4,953,000 were awarded and paid to community based agencies across Southern California to support specialty care access

The San Diego Countywide Specialty Care Initiative Coalition aimed to embed guidelines, build networks, increase primary care physician (PCP) capacity, and enhance care coordination. They were able to (a) develop and implement an eConsult system where volunteer specialists provide case review and consultation in various specialties; (b) implement a number of programs to improve PCP knowledge including physician roundtables, didactic lectures and webinars, and in-person training on performing two procedures: orthopedic joint injections and punch and shave biopsies; and (c) create over 90 guidelines that are posted online so that PCPs and referral coordinators can easily access it and train the users.

ALL HEART - In 2006, Kaiser Permanente's Southern California Community Benefit (KPSC CB) began the translation of KP's evidence-based cardiovascular disease (CVD) risk-reduction program across the safety net organizations in Southern California through a program called *ALL* (*A*spirin, *L*isinopril, and *L*ipid lowering medications). As a result of receiving the James A. Vohs Award for Quality in 2011, Kaiser Permanente Southern California selected the Community Clinic Health Network (CCHN) to serve as a Project Office to further translate the ALL protocol across the Southern California Region. The program was renamed to *ALL HEART* (Heart Smart Diet, Exercise, Alcohol limits, Rx Medicine compliance, and Tobacco cessation) to include lifestyle measures that were also included in this program. CCHN continues to enroll community health centers across Southern California into the ALL HEART Program. To date, KPSC CB has invested a total of six (6) grants, amounting to $1,220,000 to support this initiative. This current two year grant began in 2015 and the focus will be on the diabetic and/or hypertension population. The ALL HEART program will also continue its pilot projects around behavioral health integration and clinic to community linkages.

CCHN has exceeded reach targets for ALL HEART, reaching over 35,000 patients served by 14 health centers and 75 clinic sites in Southern California. Based on the results of an evaluation of a cohort of 11 health centers in San Diego County, ALL HEART has built health center capacity to successfully implement and institutionalize the ALL medication protocol and most participating health centers improved blood pressure control among their patients, potentially reducing the risks associated with cardiovascular disease. Furthermore, Health Centers built their capacity to

engage in population health management and to align with other national initiatives, such as Patient Centered Medical Home (PCMH) and Meaningful Use. Successful implementation of ALL HEART was driven by several HEAL Center characteristics, including data & IT systems, dedicated staffing, leadership buy-in, quality improvement infrastructure, and adequate time and space.

KFH-San Diego Priority Health Need: Cardiovascular Disease

Goals

- Increase healthy eating among vulnerable populations residing in the high need areas of San Diego County.
- Increase access to active living among vulnerable populations residing in the high need areas of San Diego County.
- Improve access to cardiovascular disease care management among vulnerable populations residing in the high need areas of San Diego County.

Cardiovascular Disease
Grant-Making Highlights

Grant-Making Snapshot During 2014-2015, there were 13 active KFH grants, totaling $256,500, addressing the priority health need in the KFH-San Diego service area. In addition, a portion of the money managed by a donor advised fund (DAF), The California Community Foundation, was used to support grants that support access to care addressing this health need (see Access to Care for examples). Donor advised fund (DAF) grants may cover multiple KFH service areas and address multiple health needs. All grant amounts reflect the amount paid in 2014 or 2015 and may not be reflective of the total grant amount awarded.

Grantee	Grant Amount	Project Description	Results to Date
Senior Community Centers of San Diego	$12,000	The Heart Disease Prevention for Low Incomes Project will increase awareness of heart disease and its predictors, while promoting heart healthy living for low-income seniors who suffer from hypertension, high cholesterol and low medication adherence.	This grant aims to increase seniors' knowledge of cardiovascular disease, which will be measured by pre and posttests/surveys and attendance. Seniors' knowledge of healthy eating and healthy food choices is hope to increase as well. Finally, increased empowerment over healthcare maintenance is hope to be achieved and will be measured through self-reports of receiving follow-up screenings for hypertension, cardiovascular disease, and cholesterol.
Neighborhood Healthcare	$40,000	The CMHBP project will assist patients in reaching a blood pressure goal of 140/90 through a standardized treatment protocol (PAL) and receive medication management by a pharmacist.	This grant aims to prescribe a blood pressure lowering medication regimen (PAL) to adults with high blood pressure and help achieve blood pressure control as defined by current evidence-based guidelines (goal 140/90). This grant seeks to help decrease the risk of cardiovascular disease for members of the community.
Vista Community Clinic	$30,000	Vista Community Clinic is proposing to provide primary care, as well as education and case management services for at least 225 hypertensive adult patients in Vista and Oceanside, California.	By August 31, 2015, it is estimated that at least 20% of targeted patients will have blood pressure measurements within normal range.

Cardiovascular Disease
Collaboration/Partnership Highlights

Organization/Collaborative Name	Collaborative/Partnership Goal	Results to Date
San Diego County Childhood Obesity Initiative (COI)	The goal of the San Diego Childhood Obesity Initiative is preventing or reducing childhood obesity.	KFH-San Diego community benefit staff provided information and education on Thriving Schools and Fire Up Your Feet resources. One school (JCS Innovation Center) from San Diego County earned first place in the Fall Activity Challenge for Fire Up Your Feet and two schools (La Mesa Middle School and Sunset Hills Elementary School) from San Diego County earned second place. Additionally, KFH-San Diego's Senior Community Benefit Manager was a member of the COI leadership council. On March 6, 2015 Kaiser Permanente's Senior Community Benefit Manager and Food and Nutrition Services Director attended the all-day strategic planning retreat for the COI. They provided guidance on matters related to policy and environmental change strategies to be incorporated into the COI's strategic plan, to prevent and reduce childhood obesity in San Diego County.
San Diego County Childhood Obesity Initiative Leadership Council and Lemon Grove HEAL Zone Steering Committee	This partnership can help provide guidance and oversight of two different obesity prevention and reduction efforts based on the collective impact model.	On September 19, the San Diego County Childhood Obesity Initiative's Government Domain hosted an educational and interactive forum that brought together community members, planners, government officials, and school board members to discuss safe routes to school. On October 24, the San Diego County Childhood Obesity Initiative's Farm to School Taskforce celebrated Food Day by hosting the second annual Let's Go Local! Produce Showcase for local institutional buyers, growers and distributors of fruits and vegetables. The event drew nearly 40 local growers and eight distributors, as well as a number of critical partner agencies like the San Diego County Farm Bureau, UC San Diego Center for Community Health, County of San Diego, and hundreds of institutional produce buyers. For Lemon Grove, partnership efforts include: planning for park infrastructure improvements; exploring a joint use agreement among the City of Lemon Grove and Lemon Grove Elementary School District so that fields can be used for physical activity; promotion of 5210 messaging; increased choices

Organization/Collaborative Name	Collaborative/Partnership Goal	Results to Date
		of healthy foods at 10 restaurants in Lemon Grove; enhanced retail space at Don's Farmer's market; hydration stations installed in three schools; city council adopted health element; and preschool providers implemented farm-to-preschool curriculum, started gardens, and developed wellness policies.

Cardiovascular Disease
In-Kind Resources Highlights

Recipient	Description of Contribution and Purpose/Goals
San Diego County high school students.	A total of 779 high school students from all over San Diego County were provided with free sports physicals in 2015.

KFH-San Diego Priority Health Need: Mental/Behavioral Health

- Improve screening of mental health symptoms.
- Reduce suicide risk by strengthening protective factors.
- Prevent the onset of suicidal behaviors among specific high-risk subpopulations

Mental/Behavioral Health Grant-Making Highlights

Grant-Making Snapshot During 2014-2015, there were 44 active KFH grants, totaling $619,880, addressing the priority health need in the KFH-San Diego service area. All grant amounts reflect the amount paid in 2014 or 2015 and may not be reflective of the total grant amount awarded.

Grantee	Grant Amount	Project Description	Results to Date
San Diego Unified School District	$20,000	The San Diego Unified School District Coordination on Mental Health Care Services project intent is to increase student access to mental/behavioral health care by increasing collaboration and improving coordination of mental health services within the school district and with community partners.	This grant aims to increase communication and collaboration within the San Diego Unified School District's Student Services Division, which can help expand the services provided and make them more accessible to students. It is estimated that the number of community mental health partners providing services to students will increase and SDUSD will find new and innovative ways to bring these much needed services to students. It is also projected that site nurses will be better informed on mental health topics and better able to navigate the mental health system with this new level of mental/behavioral health expertise available. Site nurses will also be trained in trauma-informed and restorative justice practices, and will be able to provide leadership and guidance to others at their school sites.
Info Line of San Diego County	$10,000	2-1-1 San Diego provides 24/7 mental health service information online and through one-on-one assistance, guiding clients to mental health prevention and treatment options and publicly sharing trends of community needs.	This grant will have a 24/7 phone line where calls are aimed at being responded within an average wait time of 2 minutes or less. It is hoped that the grant will assist 18,000 uninsured/underinsured clients, clients with income at/below 250% FPL, and military and veteran households with accessing services not typically covered by health insurance. This grant is aimed at helping improve access to mental health information, services for prevention, early intervention of depression or other serious mental health illnesses that could lead to suicide or other physical or emotional harm for the person in need or the people around them.
Community	$15,000	The Community Health Improvement Partners	This grant aims to provide The two Applied Suicide

Grantee	Grant Amount	Project Description	Results to Date
Health Improvement Partners		project will engage, educate and empower community providers, lay persons, school administrators, and healthcare stakeholder groups in advancing the progressive, collaborative action strategies of the San Diego County Suicide Prevention Council.	Intervention Skills Training (ASIST) sessions that will each serve 30 providers and community lay persons (volunteers) over a 2 day period. Additionally, the SPC Medical Provider Roundtable conference event will serve 200 participants representing a diverse range of stakeholder groups such as hospitals, clinics, medical providers, mental health organizations and others. Finally, The Gay, Lesbian Straight Education Network training workshop aimed to serve 40 school district administrators from around the San Diego County.
La Maestra Family Clinic, Inc.	$40,000	La Maestra Family Health Clinic will integrate behavioral health screenings into all primary care visits. LMFC will do this by using proven, evidenced-based tools and by hiring a full-time MFT therapist.	Within 90 days of grant award, it is estimated that depression screenings and SBIRT screenings will be fully integrated into the organization primary care practice. Within six months of grant award, each MFT will be assigned to a primary care team and patients will become more comfortable with the screening questionnaires, clinical work flows, and patient feedback will be captured in a semi-annual survey, and adjustments will be made as deemed appropriate. Within one year of grant award, it is expected that approximately 60% more patients will have improved access to needed behavioral health care due to integrated screenings. The MFT and other behavioral health staff will measure patient screenings and treatment by documenting care in NextGen EHR and i2i Tracks for all patients served.
Family Health Centers of San Diego Inc.	$40,000	FHCSD's Postpartum Distress Screening and Treatment Project (PDSTP) will screen mothers for postpartum distress (which includes postpartum depression (PPD) and anxiety), when they bring their infants in for well-baby check-ups.	This grants aims to screen about 150 new moms for PPD by the pediatrician, as documented by Electronic Health Records (EHR). About 75 moms identified as experiencing PPD are estimated to complete a counseling session with the project MFT. Approximately 20 new moms will be assessed by the project psychiatrist, and clients in need of medication will be referred to one of our Certified Enrollment Counselors so they can complete a Patient Assistance Application.

Mental/Behavioral Health
In-Kind Resources Highlights

Recipient	Description of Contribution and Purpose/Goals

Recipient	Description of Contribution and Purpose/Goals
Community Health Improvement Partners Suicide Prevention Council	On February 15, 2015 Kaiser Permanente's Ralph Johnson, MD lent his talent and time by participating on a panel at the Suicide Prevention Council (SPC) Medical Provider Roundtable event serving 197 participants, to advance discussions related to universal suicide risk assessment in San Diego County. During the panel, Dr. Johnson talked about Kaiser Permanente's approach to screening for suicide risk in the primary care setting and how care is provided to patients.

KFH-San Diego Priority Health Need: Obesity

- Improve healthy eating and active living among vulnerable populations residing in the high need areas of San Diego County.

Obesity
Grant-Making Highlights

Grant-Making Snapshot During 2014-2015, there were 20 active KFH grants, totaling $293,600, addressing the priority health need in the KFH-San Diego service area. In addition, a portion of the money managed by a donor advised fund (DAF), The California Community Foundation, was used to support 125 grant payments, totaling $2,456,789[27]; DAF grants are denoted by asterisks (*). Donor advised fund (DAF) grants may cover multiple KFH service areas and address multiple health needs. Grants supporting obesity may include grants that address diabetes (see section below under Healthcare Needs). All grant amounts reflect the amount paid in 2014 or 2015 and may not be reflective of the total grant amount awarded.

Grantee	Grant Amount	Project Description	Results to Date
California Food Policy Advocates	$212,500*	The Improving Nutrition Program Participation and Quality in Southern California project works to ensure that eligible people in need of nutritional support programs have access to CalFresh and Child Nutrition Programs such as federally subsidized school breakfast and lunch programs and child care nutrition.	To date, the California Food Policy Advocates has increased school breakfast participation, increased the number of public school students in Medi-Cal households who are enrolled in free school meal programs, and increased CalFresh enrollment. The grant has built awareness, evidence, and support for child care nutrition policies.
Community Health Improvement Partners	$125,000*	The San Diego Childhood Obesity Initiative (COI) aims to reduce and prevent childhood obesity in San Diego County through policy, systems, and environmental change by bringing together partners from various sectors and regions to collaborate and work together to find innovative solutions and build healthier communities.	To date, Community Health Improvement Partners (CHIP) has enhanced the capacity of the Childhood Obesity Initiative to create healthy environments by engaging, convening, and supporting new and existing partners to implement obesity prevention strategies across seven domains including government, healthcare, schools/after-school, early childhood, community, media and business sectors.
Friends of Chula Vista Parks and Recreation (FCVPR)	$55,000*	This Operation Splash program provides swim lessons, recreation programming, and healthy beverage education to low-income youth.	FCVPR has partnered in the Operation Splash program since 2012. In 2014 and 2015, it provided approximately 1,200 swim lessons on an annual basis. The Rethink your Drink Campaign has been implemented every year and is designed to reach both participants and employees to avoid flavored beverages.

[27] These grants support obesity and overweight prevention, including diabetes.

Grantee	Grant Amount	Project Description	Results to Date
Chula Vista Elementary School District	$55,810*	This Thriving School project aims to a) implement a new standard-based Physical Education (PE) curriculum, b) develop a school-wide master schedule that identifies physical education (PE) and physical activity (PA) requirements for each grade-level or teacher, and c) provide training, ongoing technical assistance, resources and materials to support implementation.	To date, the school district has succeeded in enabling teachers to track the minutes of PE provided to students. Teachers do this by completing a monthly reporting template, logging the number of physical education minutes they provide (must be a minimum of 200 minutes every 10 days). The district implemented additional physical activity opportunities such as “Brain Breaks” in the classroom and active recess. All school sites have been trained by the PE Resource Teachers and were provided with a PE/PA curriculum and support materials. This project is being implemented in four (4) Middle Schools and potentially reaches 2,885 students.
Community Partners	$350,000*	Community Partners provides technical assistance and strategic support for coalition building, resident engagement, and leadership through peer-to-peer learnings, webinars, teleconferences for the HEAL Zone and HEAL Partnership grant communities.	Community Partners provided technical assistance and strategic support to ten HEAL grantees, their partners, and resident/youth leaders to apply the knowledge, skills, and competencies to successfully implement their HEAL Community Action Plan strategies in 2015.
Community Health Improvement Partners	$150,000*	This HEAL Zone site focuses on school and community strategies, such as: a) strengthening existing school district wellness policies, b) providing three Lemon Grove schools with water stations, c) implementing a worksite wellness program for LGSD employees and encouraging role modeling for students, d) improving nutrition and physical activity within childcare settings, e) creating joint use agreements with schools to enable access to physical activity equipment, f) advocating for city policies promoting physical activity and healthy eating (Health Element), g) building the capacity of community residents and youth to advocate for school and community change, h) implementing a clinic approach to supporting patients with healthy eating and physical activity behaviors, i) working with small grocers/convenience store to provide healthy food for residents, j) working with restaurants to provide healthy food for residents, and k) improving the	To date, the following key accomplishments were documented: a) installation and promotion of three hydration stations, b) implementation of Smarter Lunchroom strategies, c) 24 out of 68 childcare providers (13 family childcare homes, 5 centers, and 6 school districts) have implemented the NAPSACC assessment, setting goals around healthy eating, and adopting a wellness policy; additionally 14 have implemented the Farm-to-Preschool curriculum and 21 created garden, d) a joint use agreement resolution was passed by the City allowing the piloting of opening of the school fields every Saturday and Sunday, e) installation of a walking trail at a park, and e) a Health Element was adopted by the City Council. These efforts have the potential to reach approximately 26,000 individuals.

Grantee	Grant Amount	Project Description	Results to Date
		infrastructure to create more physical activities opportunities.	
Jacobs & Cushman San Diego Food Bank	$25,000	The Jacobs & Cushman San Diego Food Bank project will provide low-income people with nutritious foods (monthly) and nutrition education that will improve nutritional choices and knowledge, which can lead to healthier eating and reduction of obesity.	This grant aims to provide 4,800 low-income people with 20 pounds of nutritious foods (monthly) and nutrition education.
California Food Policy Advocates, Inc.	$15,000	The California Food Policy Advocates project will increase participation in school meals by automatically and paperless enrolling students living in CalFresh and/or Medi-Cal households in free school meals.	This grant aims to have at least 95% of the students in the Medi-Cal households to be certified into school meals in SDUSD, and that participation in school meals increases by at least 6% in the targeted area. It is hoped that MOUs or other data sharing agreements between Department of Health Care Services and Department of Education are produced as milestones toward the establishment of the state-level match.
Circulate San Diego	$12,000	Circulate San Diego's Healthy Safe Streets will engage members of San Diego's Community Budget Alliance in a targeted pedestrian safety campaign to increase funding for projects in disadvantaged neighborhoods and increase walking rates.	Circulate San Diego proposed a plan called Vision Zero. It uses a strategy to improve safety in a few key corridors that the group found to be the most dangerous for drivers, pedestrians and bicyclists. On June 25, 2015 the Mayor of San Diego Kevin Faluconer announced his official support for this initiative, along with the Police Department.
Centro de Salud La Comunidad De San Ysidro Inc.	$20,000	Salsita is a childhood obesity prevention and intervention program, which includes a 4-week class series, for Latino children (5-12 years old) and parents living San Diego County's South Region.	This program is aimed at increasing families' knowledge of healthy lifestyles as a result of their participation in Salsita's class series. Families are also estimated to demonstrate an increase in knowledge of risk factors for cardiovascular disease and diabetes and increase their daily consumption of fruits and vegetables and physical activity.

Obesity
Collaboration/Partnership Highlights

Organization/Collaborative Name	Collaborative/Partnership Goal	Results to Date
New Roots Fresh Farm Community	The collaboration between Kaiser Permanente and	There are 49 active growing spaces in the

Organization/Collaborative Name	Collaborative/Partnership Goal	Results to Date
Garden, a partnership project among International Rescue Committee (IRC) and Kaiser Permanente	the International Rescue Committee will transform vacant Kaiser Permanente property into a thriving garden that provides opportunities for healthy eating and active living.	garden including 34 plots for families; 3 Kaiser Permanente employee and physician plots; 10 raised beds, and; 2 community partner plots. The estimated total pounds of produce grown in 2015 were 22,000 pounds which is estimated to be worth $33,000.

Obesity
In-Kind Resources Highlights

Recipient	Description of Contribution and Purpose/Goals
New Roots Fresh Farm Community Garden, a partnership project among International Rescue Committee (IRC) and Kaiser Permanente	On November 21, 2015, our service area's Property Manager and Minor Work Order team had 21 volunteers complete needed garden improvements, landscape and infrastructure repairs, and beautification work to enhance the space. These team members lent their day to day job expertise to the community garden.
Students from various high schools in San Diego County.	This contribution is aimed at increasing physical activity, specifically in school related sports, by improving access to sports physicals. Kaiser Permanente San Diego staff and physicians use their talent and lend their time to provide the physicals.
San Diego County community.	Joe Libertucci, Department Administrator for KFH-San Diego's Food and Nutrition Services Department, provides his expertise in the area of healthy eating and shares Kaiser Permanente's protocols related to healthy vending, healthy catering and healthy cafeteria policies to San Diego County's Childhood Obesity Initiative's Nutrition in Healthcare Leadership Team (NHLT).
Refugee families.	The contribution was volunteer time to enhance and update the garden and to promote continued growing of fresh produce for the purpose of healthy eating.
Community based organizations that work with school aged children.	The purpose of this activity is to share Kaiser Permanente developed resources with the broader community. Thriving Schools and Weight of the Nation Kids resources were provided to 200 nonprofit leaders during the KFH-San Diego Community Benefit workshop, to increase awareness of healthy eating and active living. Additionally, KFH-San Diego community benefit staff provided information and education for the Schools Domain members of the San Diego County Childhood Obesity Initiative on Thriving Schools and Fire Up Your Feet resources.

Impact of Regional Initiatives Addressing Obesity

In addition to the illustrated grants listed above, Kaiser Permanente designs Regional Health Initiatives that are implemented in one or more KFH service areas to address the priority health needs. These initiatives are multi-year investments that support policy, advocacy and/or system changes in communities, including support for clinic systems to enhance capacity, service provision and or coordination. Kaiser Permanente invests in external evaluation for Regional Health Initiatives, and where possible, the results to date will reflect the most recent evaluation findings.

Kaiser Permanente's Thriving Schools initiative expands Kaiser Permanente's commitment to the total health of members and the communities it serves through work with local schools and school districts. It is an effort to improve healthy eating, physical activity and school climate in K-12 schools in Kaiser Permanente's service areas, primarily through a focus on policy, systems and environmental changes that support healthy choices and a positive school climate. For the specific project implemented in KFH-San Diego and the results to date, please see the Thriving Schools listing above under Chula Vista Elementary School District.

Kaiser Permanente's HEAL (Healthy Eating, Active Living) Zone initiative is a place-based approach that aims to lower the prevalence of obesity and overweight by increasing access to fresh fruit, vegetables and healthy beverages, as well as increasing safe places to be play and be physically active. HEAL Zones work through a collaboration of local organizations and agencies to implement policies, programs and environmental system changes to impact healthy eating and active living behavior. To date, Kaiser Permanente has awarded over $7,000,000 to community based organizations across Southern California to support this initiative. For the specific project implemented in KFH-San Diego and the results to date, please see the listing above for Lemon Grove HEAL Zone coordinated by the Community Health Improvements Partners.

KFH-San Diego Priority Health Need: Type 2 Diabetes

- Improve healthy eating and active living among vulnerable populations residing in the high need areas of San Diego County.
- Improve access to diabetes care management among vulnerable populations residing in the high need areas of San Diego County.

Type 2 Diabetes
Grant-Making Highlights

Grant-Making Snapshot During 2014-2015, there were 21 KFH grant payments, totaling $333,500, addressing the priority health need in the KFH-San Diego service area. In addition, a portion of the money managed by a donor advised fund (DAF), The California Community Foundation, was used to support 25 grant payments, totaling $2,456,789[28]; DAF grants are denoted by asterisks (*). Donor advised fund (DAF) grants may cover multiple KFH service areas and address multiple health needs. Grants supporting diabetes may include grants that address obesity (see section above under Healthcare Needs). All grant amounts reflect the amount paid in 2014 or 2015 and may not be reflective of the total grant amount awarded.

Grantee	Grant Amount	Project Description	Results to Date
Neighborhood Healthcare	$40,000	The Diabetes Prevention Program will make available the Omada Health, Inc. PREVENT program for weight loss to NHcare diabetic patients. This pilot will determine the feasibility of full-scale implementation.	This program hopes to increase the efficacy of Prevent with NHcare's population of patients at-risk for developing diabetes by helping them lose weight. It is also aimed at increasing patients' ability to access technology to participate in programs and interventions. Additionally, NHcare's Finance Department aims to share program data results with contracted health plans and negotiate pay-for-performance rates, as appropriate.
San Diego MANA	$10,000	MANA de San Diego and the American Diabetes Association SD office will partner to provide diabetes awareness, prevention and management services to Latinas who participate in the Hermanitas Platicas.	This program is aimed at reaching 50-75 program participants at each of the quarterly "Platicas." It is aimed at assisting 80% of participants to take the pre- and post-tests during the classes by June 31, 2015. The organization hopes to have 100% of the participants complete pre- and post tests during each of the 3 Hermanitas Platicas and one at the 2015 Family Health Fair. Additionally, a Diabetes 101 discussion will be provided for the 2015 Health Fair participants with the focus on the importance of nutrition, exercise and/or diabetes and related complications.
Special Delivery San Diego	$10,000	The Diabetes Nutrition Program includes weekly diabetes education classes and onsite diabetic food pantry. After diagnosis, many diabetics are not given adequate training and education to	This program aims to assist attendees in achieving weight loss, increased blood sugar readings, and increased physical and mental outlook after attending at least three months of attending education classes.

[28] These grants support obesity and overweight prevention, including diabetes.

Grantee	Grant Amount	Project Description	Results to Date
		manage their diagnoses.	

Type 2 Diabetes		
Organization/Collaborative Name	**Collaborative/Partnership Goal**	**Results to Date**
Lemon Grove HEAL Zone	Collaboration among Kaiser Permanente community benefit staff and staff at Community Health Improvement Partners will reduce calorie consumption and increase physical activity in the City of Lemon Grove. .	In 2015, the following accomplishments were achieved: sidewalk improvements to increase connectivity and walking near a school; walking path installation at Berry Street park; a joint use agreement among the City of Lemon Grove and Lemon Grove School District to allow for public use of athletic fields on Saturdays (KFH-San Diego's Senior Community Benefit Manager provided guidance on the advocacy process), and; installation of physical activity equipment at Lemon Grove Park.

PRIORITY HEALTH NEED V: BROADER HEALTH CARE SYSTEM NEEDS IN OUR COMMUNITIES – WORKFORCE

KFH Workforce Development Highlights
Long Term Goal: • To address health care workforce shortages and cultural and linguistic disparities in the health care workforce
Intermediate Goal: • Increase the number of skilled, culturally competent, diverse professionals working in and entering the health care workforce to provide access to quality, culturally relevant care
Summary of Impact: During 2014-2015, a portion of money managed by a donor advised fund at California Community Foundation was used to pay two grants, totaling $150,000, that address this need. An illustrative sample of grants is provided below; DAF grants are denoted by asterisks (*). **All grant amounts reflect the amount paid in 2014 or 2015 and may not be reflective of the total grant amount awarded.** KFH-San Diego also provided trainings and education for 417 residents in its Graduate Medical Education program, 43 nurse practitioner or other nursing beneficiaries, and 73 other health (non-MD) beneficiaries as well as internships for 47 high school and college students (Summer Youth, INROADS, etc.).

Grant Highlights			
Grantee	Grant Amount	Project Description	Results to Date
California Institute for Nursing and Health Care (CINHC)	$100,000*	To provide expert technical assistance to registered nursing programs at California state universities (CSUs) and their identified California community	CINHC will facilitate engagement and partnership to develop, implement, and sustain the CCMNE across all 10 CSU's and respective CCC's. CINHC will engage

		college (CCC) partners in Southern California. It will also help schools implement an associate degree to a bachelor of science in nursing pathway, facilitating fast tracking and efficient implementation of the California Collaborative Model of Nursing Education (CCMNE).	interested private universities and colleges within the region, including deans, directors, and faculty. Lastly, CINHC will conduct a curriculum review, mapping process, and development of integrated pathways based on prior success strategies that are consistent with evidence based models.
Campaign for College Opportunity (CCO)	$50,000*	This grant supports an in-depth research report to analyze trends in California science, technology, engineering, and math (STEM)/health workforce needs. The STEM/Health Workforce Report will focus on factors affecting demand and supply; public higher education funding policies; and programs to help meet workforce demands. This grant supports an in-depth research report to analyze trends in California science, technology, engineering, and math (STEM)/health workforce needs. The STEM/Health Workforce Report will focus on factors affecting demand and supply; public higher education funding policies; and programs to help meet workforce demands.	The Campaign for College Opportunity will develop and disseminate the STEM/Health Workforce Report to increase awareness among the public and policymakers of the growing need for STEM health workers in California and the role California community colleges play in filing the demand. CCO has completed the report and the general release will occur in June 2016. The report's release will be accompanied by a media and communications strategy including a webinar, briefings with key stakeholders (in education, business, community and civic organizations) along with policymakers in Sacramento.
In-Kind Resources Highlights			
Recipient	Description of Contribution and Purpose/Goals		
Individuals and organizations in the health care and medical workforce.	Kaiser Permanente Southern California Region's Department of Professional Education offered Advanced Practice and Allied Health Care Educational Programs for allied health care providers throughout Southern California. In 2015, across Kaiser Permanente Southern California Region, 644 community-based nurses, nurse practitioners, physician assistants, imaging professionals, clinical laboratory scientists, community audiologists and speech pathologists, and other health care professionals participated in symposia at no cost.		

PRIORITY HEALTH NEED VI: BROADER HEALTH CARE SYSTEM NEEDS IN OUR COMMUNITIES – RESEARCH

KFH Research Highlights			
Long Term Goal: • To increase awareness of the changing health needs of diverse communities			
Intermediate Goal: • **I**ncrease access to, and the availability of, relevant public health and clinical care data and research			
Summary of Impact: Kaiser Permanente conducts, publishes, and disseminates research to improve the health and medical care of members and the communities served. The Southern California Region Department of Research and Evaluation (DRE) conducted a total of 988 studies in 2014 and 1,404 studies in 2015 across all regional hospitals, totaling $16,385,832. Research focuses on clinical trials, building scientific expertise in health services and policy, and implementation science to bridge the gap between research and practice. In addition, a portion of money managed by a donor advised fund (DAF) at California Community Foundation was used to pay two grants, totaling $1,050,000 that address this need. **All grant amounts reflect the amount paid in 2014 or 2015 and may not be reflective of the total grant amount awarded.**			
Grant Highlights			
Grantee	Grant Amount	Project Description	Results to Date
UCLA Center for Health Policy Research	$500,000*	The California Health Interview Survey (CHIS) investigates key public health and health care policy issues, including health insurance coverage and access to health services, chronic health conditions and their prevention and management, the health of children, working age adults, and the elderly, health care reform, and cost effectiveness of health services delivery models.	At the end of the grant period, UCLA Center for Health Policy Research interviewed approximately 41,500 households and completed 78,127 screenings along with 40,125 adult, 2,255 adolescent and 5,514 child interviews. In addition, 12 AskCHIS online trainings were completed.
In-Kind Resources Highlights			
Recipient	Description of Contribution and Purpose/Goals		
Individuals and organizations in the health care and medical community.	Kaiser Permanente Southern California Region's Department of Research and Evaluation works closely with national and regional research institutions and universities to provide high-quality health research. In the KFH-San Diego service area, 216 research projects were active in 2014 and 218 research projects were active as of year-end 2015.		
Individuals and organizations in the health care and medical community.	Kaiser Permanente Southern California Region's Nursing Research Program provides administrative and technical support for nurses to conduct, publish and disseminate research studies and evidence based practice projects. In the KFH-San Diego service area, three research projects were active as of year-end 2014 and five research projects were active as of year-end 2015.		

D. **Implementation Strategy Evaluation of Impact**

In the 2013 Implementation Strategy (IS) process, all KFH planned for and drew on a broad array of resources and strategies to improve the health of communities and vulnerable populations, such as grantmaking, in-kind resources, collaborations and partnerships, as well as several internal KFH programs including, charitable health coverage programs, future health professional training programs, and research. KFH-San Diego is monitoring and evaluating progress to date on their 2013 Implementation Strategies for the purpose of tracking the implementation of those strategies as well as to document the impact of those strategies in addressing selected CHNA health needs. Tracking metrics for each prioritized health need include the number of grants made, the number of dollars spent, the number of people reached/served, collaborations and partnerships, and KFH in-kind resources. In addition, KFH-San Diego tracks outcomes, including behavior and health outcomes, as appropriate and where available. As of the documentation of this CHNA Report in March 2016, KFH-San Diego had evaluation of impact information on activities from 2014 and 2015. While not reflected in this report, KFH-San Diego will continue to monitor impact for strategies implemented in 2016.

APPENDIX

Appendix A: Secondary Data Sources and Dates

Secondary 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. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2006-2010.
11. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2006-2012.
12. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2011-2012.
13. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. US Department of Health & Human Services, Health Indicators Warehouse. 2005-2009.
14. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. US Department of Health & Human Services, Health Indicators Warehouse. 2006-2012.
15. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012.
16. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. US Department of Health & Human Services, Health Indicators Warehouse. 2010.
17. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. US Department of Health & Human Services, Health Indicators Warehouse. 2012.
18. Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network. 2008.
19. 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.
20. 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.
21. 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.
22. Centers for Disease Control and Prevention, National Vital Statistics System. University of Wisconsin Population Health Institute, County Health Rankings. 2008-2010.
23. Centers for Disease Control and Prevention, National Vital Statistics System. US Department of Health & Human Services, Health Indicators Warehouse. 2006-2012.
24. Centers for Medicare and Medicaid Services. 2012.
25. Child and Adolescent Health Measurement Initiative, National Survey of Children's Health. 2011-2012.
26. County of San Diego, Community Action Plan, 2016-2017, Community Needs Assessment. 2014.
27. County of San Diego, Health and Human Services Agency. Live Well San Diego Community Health Assessment. 2014.

28. County of San Diego Refugee Fact Sheet. 2011.
29. Dartmouth College Institute for Health Policy & Clinical Practice. Dartmouth Atlas of Health Care. 2012.
30. Dignity Health Community Need Index. 2013.
31. Environmental Protection Agency, EPA Smart Location Database. 2011.
32. Federal Bureau of Investigation, FBI Uniform Crime Reports. 2010-2012.
33. Feeding America. 2012.
34. Multi-Resolution Land Characteristics Consortium, National Land Cover Database. 2011.
35. National Center for Education Statistics, NCES – Common Core of Data. 2012-2013.
36. National Oceanic and Atmospheric Administration, North America Land Data Assimilation System (NLDAS). 2014.
37. New America Foundation, Federal Education Budget Project. 2011.
38. Nielsen, Nielsen Site Reports. 2014.
39. North County Health Services. 2014.
40. Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2011.
41. Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2013.
42. Office of Statewide Health Planning and Development, OSHPD Primary Care and Specialty Clinics Utilization Data. 2013.
43. Palomar Health CAC TODAY Program. 2008-2014.
44. 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
45. San Diego County Community Health Statistics Unit based on 2012 SANDAG population estimates and 2013 ACS estimates.
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. US Census Bureau, American Community Survey. 2009-2013.
53. US Census Bureau, American Community Surveys, 2014.
54. US Census Bureau, American Housing Survey. 2011, 2013.
55. US Census Bureau, County Business Patterns. 2011.
56. US Census Bureau, County Business Patterns. 2012.
57. US Census Bureau, County Business Patterns. 2013.
58. US Census Bureau, Decennial Census. 2000-2010.
59. US Census Bureau, Decennial Census, ESRI Map Gallery. 2010.
60. US Census Bureau, Small Area Income & Poverty Estimates. 2010.
61. US Department of Agriculture, Economic Research Service, USDA – Food Access Research Atlas. 2010.
62. US Department of Agriculture, Economic Research Service, USDA – Food Environment Atlas. 2011.
63. US Department of Agriculture, Economic Research Service, USDA – Child Nutrition Program. 2013.
64. US Department of Education, EDFacts. 2011-2012.
65. US Department of Health & Human Services, Administration for Children and Families. 2014.

66. US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File. June 2014.
67. US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2012.
68. US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2013.
69. US Department of Health & Human Services, Health Resources and Services Administration, Health Professional Shortage Areas. March 2015.
70. US Department of Health & Human Services, Healthy People 2020, Social Determinants of Health.
71. US Department of Housing and Urban Development. 2013.
72. US Department of Labor, Bureau of Labor Statistics. June 2015.
73. US Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System. 2011-2013.
74. US Drought Monitor. 2012-2014
74. World Health Organization, Chronic Diseases and Health Promotion.

Appendix B: Community Input Tracking Form

KP SCAL CHNA Community Input Tracking Form

#	Data Collection Method Employed	Who Participated / Title of event//Type of Input	Number of Participants	Who Participant(s) Represent(s)	Position with respect to the group	Date	Comments / Notes
1	Discussion	Behavioral health case managers/Case Mangers Network Meeting/prioritize health needs	7	Low income, medically underserved, minority population, population with chronic diseases	Members	7/17/15	Representation from North Inland/ North Coastal
2	Discussion	*CalFresh Coordinator, Project Coordinator, Community Health Access Department - Cal-Fresh (food stamps), Case Management/* San Diego Hunger Coalition CalFresh Task Force/prioritize health needs	7	Low income, medically underserved, minority population, population with chronic diseases	Members	7/30/15	Representation from all regions
3	Discussion	Outreach workers, Community Education Specialist/San Ysidro Health Center/ prioritize health needs	23	Low income, medically underserved, minority population, population with chronic diseases	Members	8/21/15	Representation from South region
4	Discussion	Care coordinator, Special populations health enrollment specialist, Care coordinator/Family Health Centers/prioritize health needs	4	Low income, medically underserved, minority population, population with chronic diseases	Members	9/8/2015	Representation from Central
5	Discussion	Community health workers, health interpreter, Family support worker senior, health program coordinator/International	7	Low income, medically underserved, minority population, population with chronic diseases	Members	9/15/15	Representation from East

		Rescue Committee/prioritize health needs					
6	Discussion	Parent & Youth partners, Program managers, Director/Family Youth Round Table/prioritize health needs	9	Youth and children, medically underserved, minority population	Members	10/19/15	Representation from Central, East, North Central, South
7	Discussion	School nurses/San Diego County Office of Education School Nurses Resource Group/prioritize health needs	30	Low income, medically underserved, minority population, population with chronic diseases, youth and children	Members	10/20/15	Representation from all regions
8	Behavioral/Mental Health Discussion	*Physicians, social workers, case workers* /Hospital Partners Behavioral Health Workgroup meeting/prioritize health needs	30	Low income, medically underserved, minority population, population with chronic diseases	Representative Health Experts	11/20/15	Representation from all regions
9	Behavioral/Mental Health Discussion	*Physicians, social workers, case workers* /Healthy San Diego Behavioral Health Workgroup meeting/prioritize health needs	Approx. 20	Low income, medically underserved, minority population, population with chronic diseases	Representative Health Experts	12/10/15	Representation from all regions
10	Behavioral/Mental Health Discussion	*Physicians, social workers, case workers* /Physicians, social workers, case workers/prioritize health needs	8	Low income, medically underserved, minority population, population with chronic diseases	Representative Health Experts	1/7/16	Representation from all regions
11	Key Informant Interview	School Nurse, Rosa Parks Elementary School, prioritize health needs	1	Low income, medically underserved, minority population	Community Leader	7/31/15	Children - School representative

12	Key Informant Interview	Director, Aging & Independence Services, County of San Diego, HHSA Aging Program Administrator; County of San Diego, HHSA Prioritize health needs	2	Health department representative, Low income, medically underserved, population with chronic diseases	Community Leader	8/7/15	Mental health/homeless, senior health
13	Key Informant Interview	Program Development Director, San Diego American Indian Health Center Community Engagement Specialist, San Diego American Indian Health Center Prioritize health needs	2	Medically underserved, minority population	Community Leader	12/15/15	Native Americans
14	Key Informant Interview	Associate Executive Director, San Diego Youth Services, prioritize health needs	1	Low income, medically underserved, minority population	Community Leader	8/13/15	Youth and refugee families
15	Key Informant Interview	Nutrition Manager, Public Health Services, County of San Diego Health and Human Services Agency, prioritize health needs	1	Health department representative, Low income, medically underserved, minority population, population with chronic diseases	Community Leader	8/19/15	Diabetes/Obesity/Food Adults
16	Key Informant Interview	Vice President, Collective Impact, Community Health Improvement Partners, prioritize health needs	1	Low income, medically underserved, minority population	Community Leader	8/24/15	Children - Diabetes/Obesity
17	Key Informant Interview	Executive Director, North County Lifeline, prioritize	1	Low income, medically underserved, population	Community Leader	8/24/15	Behavioral/Mental Health

		health needs		with chronic diseases			
18	Key Informant Interview	CEO & President, Mental Health Systems, prioritize health needs	1	Low income, medically underserved	Community Leader	8/31/15	Mental Health (community voice)
19	Key Informant Interview	Executive Director, Interfaith Community Services, prioritize health needs	1	Low income, medically underserved, population with chronic diseases	Community Leader	9/2/15	Homelessness/Housing/ Veterans
20	Key Informant Interview	Vice President & Chief Medical Officer, San Ysidro Health Center, prioritize health needs	1	Low income, medically underserved, minority population, population with chronic diseases	Community Leader	9/24/15	Cardiovascular Health in South region/Latinos
21	Key Informant Interview	Director of Program & Fund Development, Operation Samahan Health Centers, prioritize health needs	1	Low income, medically underserved, minority population, population with chronic diseases	Community Leader	10/1/15	Asian Pacific Islanders, refugee & families
22	Key Informant Interview	President and CEO, North County Health Services, prioritize health needs	1	Low income, medically underserved, minority population	Community Leader	10/26/15	Latino
23	Key Informant Interview	Supervising Child and Adolescent Psychiatrist, Behavioral Health Services, County of San Diego Health and Human Services Agency, prioritize health needs	1	Health department representative, Low income, medically underserved, minority population	Community Leader	11/12/15	Children – Behavioral/Mental Health
24	Key Informant Interview	Deputy Director, Programs, International Rescue Committee, prioritize health needs	1	Medically underserved, minority population	Community Leader	11/16/15	Refugee Population
25	Key Informant Interview	CEO, The San Diego LGBT Community Center, prioritize health needs	1	Medically underserved, minority population	Community Leader	11/17/15	LGBTQ
26	Key Informant Interview	President & CEO, Union of Pan Asian Communities, prioritize health needs	1	Medically underserved, minority population	Community Leader	1/6/16	Asian Pacific Islanders

27	Key Informant Interview	Executive Director, San Diego Hunger Coalition, prioritize health needs	1	Low income, medically underserved, population with chronic diseases	Community Leader	1/12/16	Hunger/Food Insecurity
28	Key Informant Interview	Presidents and Chairman, MultiCultural Health Foundation, prioritize health needs	1	Low income, medically underserved, minority population, population with chronic diseases	Community Leader	1/22/16	African American & Cardiovascular
29	Key Informant Interview	Deputy Health Officer, County of San Diego Health and Human Services Agency, prioritize health needs	1	Health department representative, Low income, medically underserved, minority population, population with chronic diseases	Community Leader	2/3/16	County Health Department
30	Survey	Health Access and Navigation online and paper surveys, support findings	235	Low income, medically underserved, minority population, population with chronic diseases	Resident Members	9/22/15-11/2/15	Representation from all regions
31	Survey	San Diego Health and Human Services Agency online survey, prioritize health needs	91	Population with chronic diseases	Representative	11/20/15-12/4/15	Representation from all regions

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]

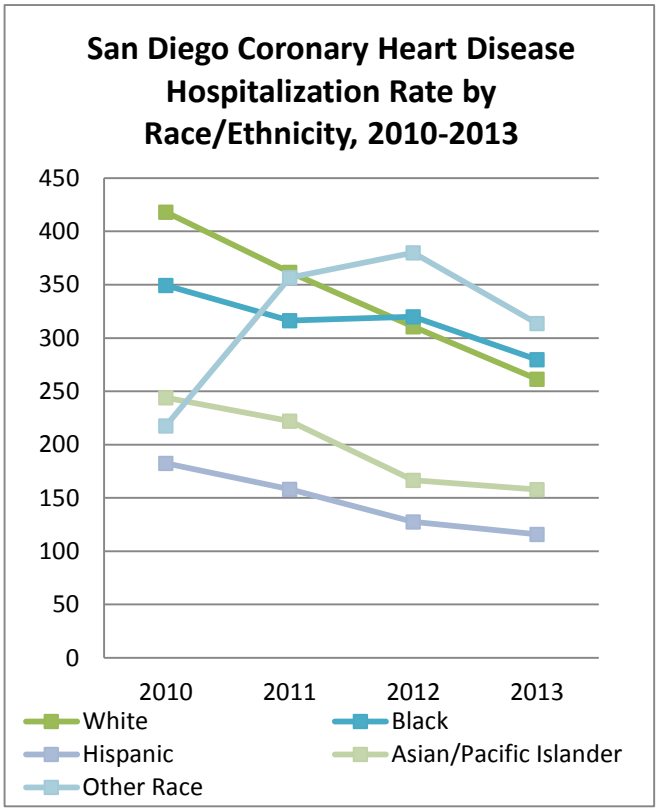
- Behaviors: Tobacco use, obesity, physical inactivity, poor diet that is high in saturated fats, and excessive alcohol use.
- Conditions: High cholesterol levels, high blood pressure and diabetes.
- Heredity: Genetic factors likely play a role in heart disease and can increase risk.

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 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 adults 18 and over had been told on two or more visits that they had hypertension.



County age-adjusted rates per 100,000 2000 US 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, Community Health Statistics Unit, 2015.

Disparities & CVD[4,8,9]

Cardiovascular Disease & Race

➢In 2013-2014, a higher percentage of American Indian/Alaskan Natives, African Americans, and individuals of 2 or more races had ever been diagnosed with high blood pressure compared to whites, Latinos, and Asians in San Diego County.

Cardiovascular Disease & Gender

➢In San Diego, there has been a decreasing trend in heart disease prevalence among women (6.8% in 2011 to 4.2% in 2014) but increasing prevalence among men (5.0% in 2011 to 7.1% in 2014).

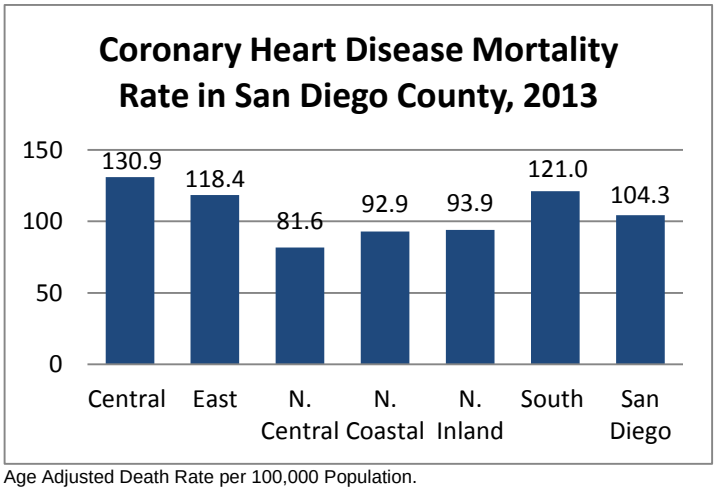
Cardiovascular Disease & Income

➢Individuals with low incomes in the U.S. 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 in the U.S.

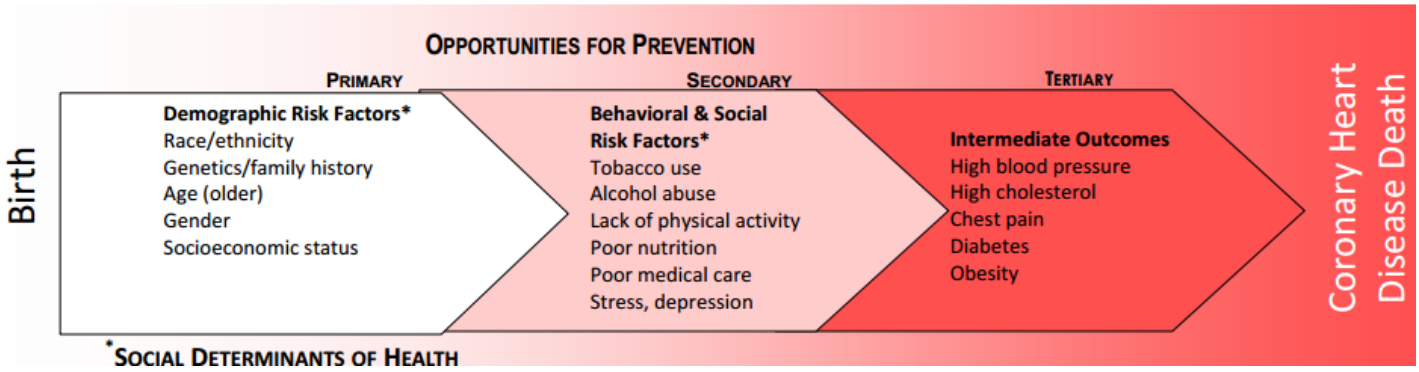
Cardiovascular Disease & Co-Morbidities

➢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.



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



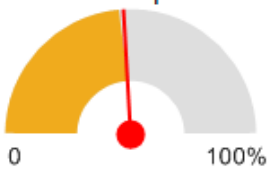
Characteristics of Residents, San Diego County
Selected Elements from Cardiovascular Pathway:

Percent Adults with High Blood Pressure Not Taking Medication

San Diego County, CA (31.3%)
California (30.3%)
United States (21.7%)

Data Source: Centers for Disease Control and Prevention, BRFSS 2006-2010. Accessed via Kaiser Permanente CHNA Data Platform.

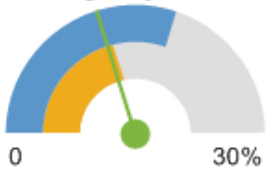
Percent Population Age 2-13 with Inadequate Fruit/Vegetable Consumption



San Diego County, CA (48.3%)
California (47.4%)

Data Source: University of California Center for Health Policy Research, California Health Interview Survey 2011-2012. Accessed via Kaiser Permanente CHNA Data Platform.

Percent Population Smoking Cigarettes (Age-Adjusted)



San Diego County, CA (12.1%)
California (12.8%)
United States (18.1%)

Data Source: Centers for Disease Control and Prevention, BRFSS 2006-2012. Accessed via Kaiser Permanente CHNA Data Platform.

Possible Intervention Opportunities

- Clinical Decisions Support Systems: computer-based information systems designed to assist healthcare providers in implementing clinical guidelines at the point of care[10]
- Behavioral Counseling for Overweight and Obese Individuals with other CVD Risk Factors: intensive counseling to promote a healthful diet and physical activity for CVD prevention[11]
- 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 over[11]

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

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11. The Community Guide. Cardiovascular Disease Prevention and Control. http://www.thecommunityguide.org/cvd/index.html
12. 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 your body metabolizes sugar (glucose), which is your body's main source of fuel. With type II diabetes, your body either resists the effects of insulin — a hormone that regulates the movement of sugar into your 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]

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 California in 2011-2012.
- In San Diego, whites and blacks had the highest death rates due to diabetes in 2013.

Diabetes & Gender

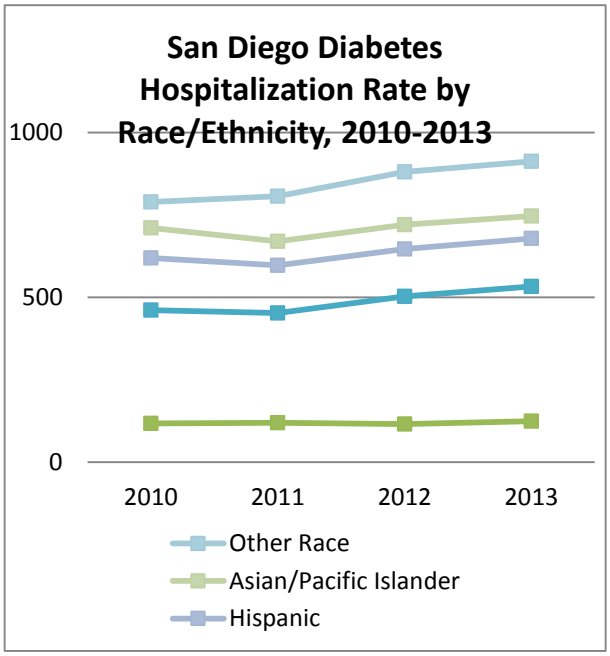
- In 2014, the prevalence of type 2 diabetes was higher in men than women in San Diego (8.3% for men and 5.5% for women).
- In San Diego, males had a higher diabetes death rate than females (20.3 per 100,000 versus 18.7 per 100,000 in 2013).

Diabetes & Income

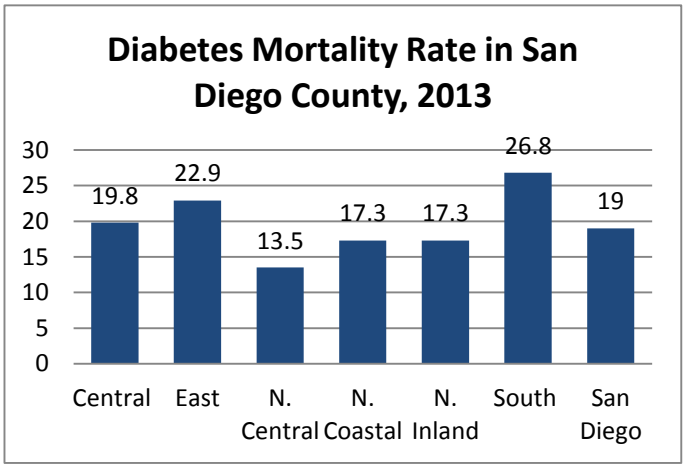
- The percent of adults in California with diabetes is almost two times higher in those with family incomes below 200 percent of the federal poverty level compared to those whose income is 300 percent above.

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.

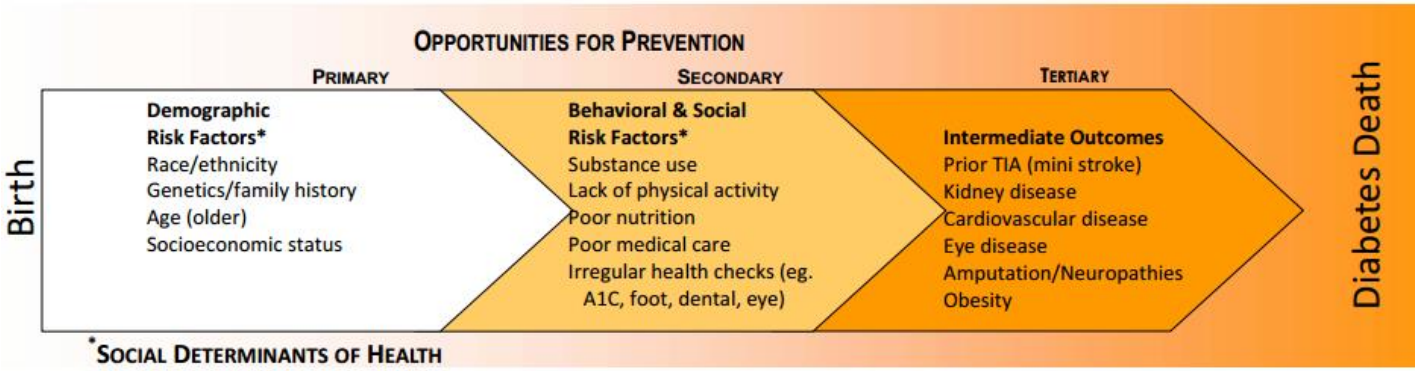


County age-adjusted rates per 100,000 2000 US standard population.
Diabetes hospitalization refers to (principal diagnosis) ICD-9 code 250.
Source: OSHPD, County of San Diego, Health & Human Services Agency, Public Health Services, Community Health Statistics Unit, 2015.



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



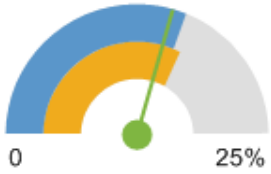
Characteristics of Residents, San Diego County
Selected Elements from Diabetes Pathway:[9]

Percent Medicare Enrollees with Diabetes with Annual Exam

San Diego County, CA (82.7%)
California (81.5%)
United States (84.6%)

Data Source: Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care 2012. Accessed via Kaiser Permanente CHNA Data Platform.

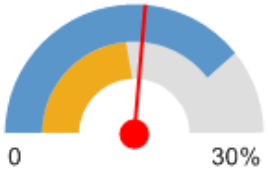
Percent Population in Poverty



San Diego County, CA (14.69%)
California (16.38%)
United States (15.59%)

Data Source: US Census Bureau, American Community Survey 2010-2014. Accessed via Kaiser Permanente CHNA Data Platform.

Percent Population with Low Food Access



San Diego County, CA (15.76%)
California (14.31%)
United States (23.61%)

Data Source: US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas 2010. Accessed via Kaiser Permanente CHNA Data Platform.

Possible Intervention Opportunities[9]

- 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. Kaiser Permanente CHNA Data Platform.
10. The Community Guide. Diabetes Prevention and Control. http://www.thecommunityguide.org/diabetes/index.html.

Behavioral/Mental 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:

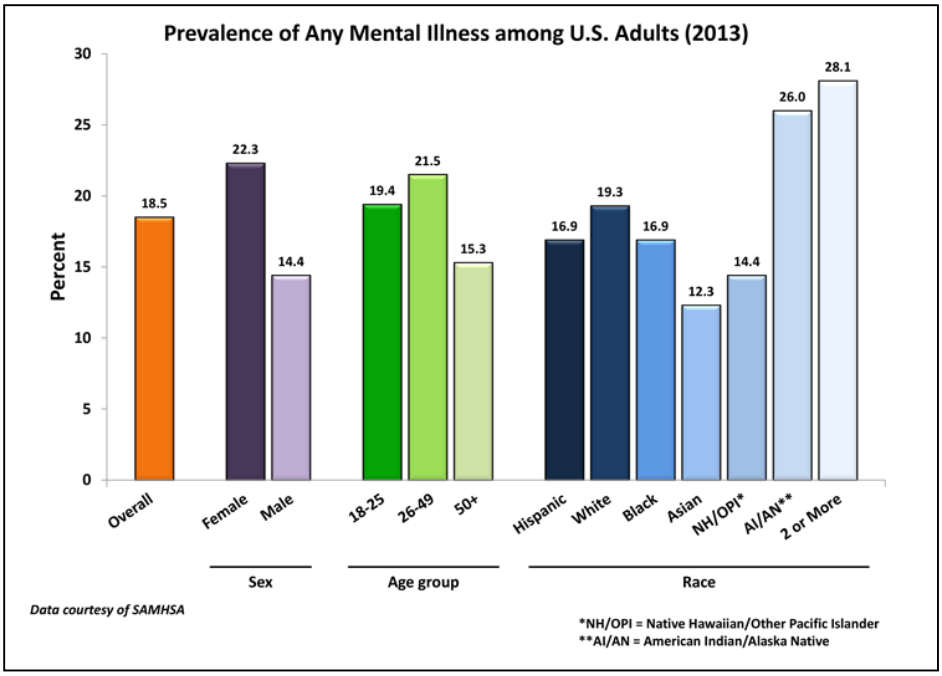
- Substance abuse and misuse are one set of behavioral health problems. Others include (but are not limited to) serious psychological distress, suicide, and mental illness.[7]
- Barriers can exist for patients across the lifespan. The National Survey for Children’s Health (HRSA, 2010) showed that among 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 in San Diego[4-6,9,10]

Behavioral Health & Race

➢Based on 2013-2014 CHIS data, the percentage of adults who self-reported there was ever a time during the past 12 months when they felt that they might need to see a professional because of problems with their mental health, emotions, nerves, or use of alcohol or drugs differed by race/ethnicity: Black (31.1%), non-Hispanic Other Race (18.7%), non-Hispanic white (13.4%), Hispanic or Latino (13.3%).

Behavioral Health & Housing

➢In 2015, it is estimated at one-fifth of San Diego’s homeless population had a serious mental illness and 17% reported substance or alcohol abuse disabilities.

Behavioral Health & Gender

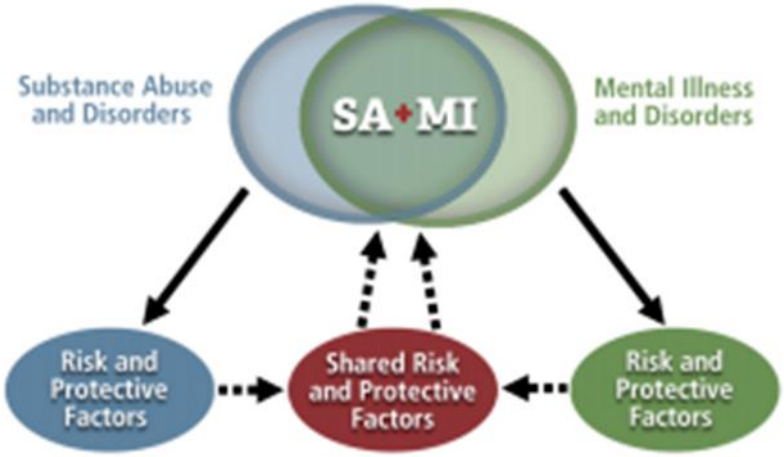
➢Among San Diego adults, an estimated 10.1% of females and 8.5% of males had ever seriously thought about committing suicide in 2014. However, in 2013, the rate of suicide death was 20.3 per 100,000 for males and 6.9 for females.

➢Roughly 47% of males who reported needing help for behavioral health issues did not receive treatment compared to 27% of women in San Diego in 2013-2014.

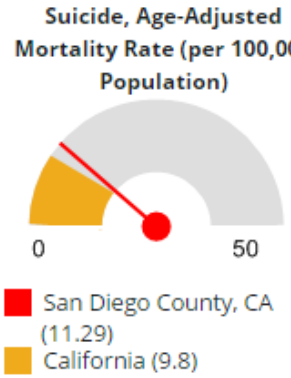
Behavioral Health & Chronic Disease

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

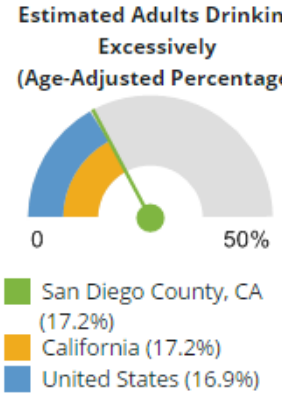
Interaction of Substance Abuse and Mental Illness



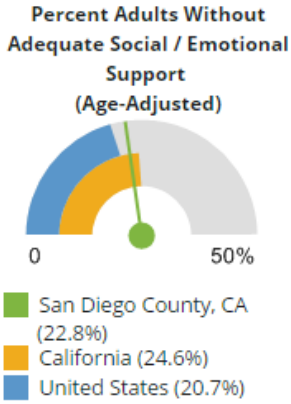
Characteristics of Residents, San Diego County
Selected Elements Contributing to Behavioral/Mental Health: [9]



Data Source: University of Missouri, Center for Applied Research and Environmental Systems. CDPH-Death Public Use Data. 2010-12.Accessed via Kaiser Permanente CHNA Data Platform.



Data Source: Centers for Disease Control and Prevention, BRFSS 2006-2012. Accessed via Kaiser Permanente CHNA Data Platform.



Data Source: Centers for Disease Control and Prevention, BRFSS 2006-2012. Accessed via Kaiser Permanente CHNA Data Platform.

Possible Intervention Opportunities[8]

- 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. Death Statistical Master Files (CDPH), County of San Diego, Health & Human Services Agency, Public Health Services, Epidemiology & Immunization Services Branch
6. California Health Interview Survey. 2014. AskCHIS.
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. Regional Taskforce on the Homeless. 2015 We ALL Count Results. http://www.rtfhsd.org/wp/wp-content/uploads/2011/08/2015-WeAllCount-Results-Final.pdf

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.

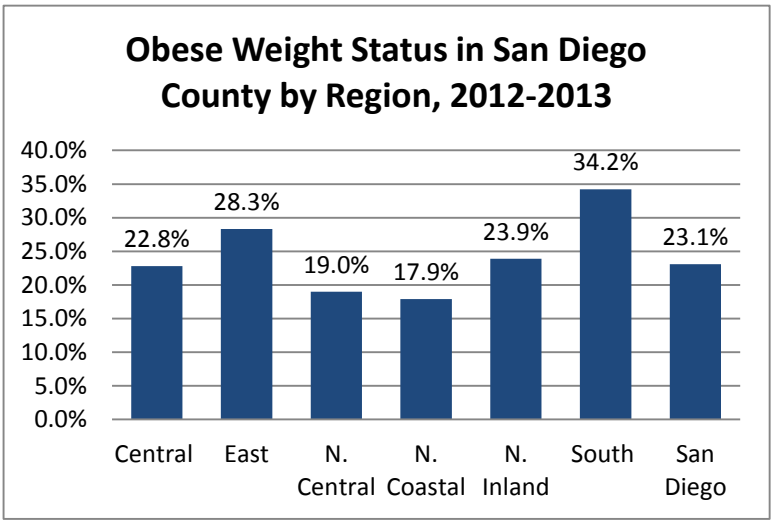
Health Consequences due to Overweight and Obesity: [4]

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.



Disparities & Obesity in San Diego[5,6,8]

Obesity & Race/Ethnicity

➢According to the 2013-2014 California Health Interview Survey, 43.3% of African Americans, 30.7% of Latinos, 20.4% of whites, and 11.1% of Asians reported a BMI of 30.0 or greater in San Diego.

➢According to 2013-2014 Fitnessgram testing in San Diego, the proportion of total 5th, 7th, and 9th grade students in the "high risk" fitness level differed by ethnicity: Hispanic children comprised the highest proportion (66.7%) followed by non-Hispanic whites (18.4%) and African Americans (6.0%).

Obesity & Gender

➢Among men in San Diego County, 25.2% were considered to be obese compared to 24.4% of women in 2014. The percentage who reported being overweight was also higher among men (40.8%) than women (28.8%).

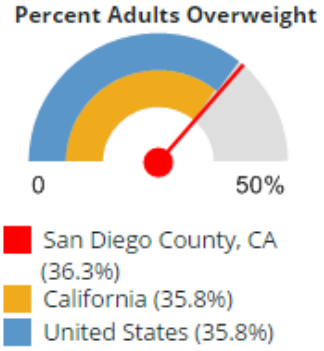
Obesity & Income

➢A smaller percentage of women in San Diego with incomes greater than 100% of the federal poverty level were obese compared to lower-income women (23.4% vs. 29.6). Conversely, 24.3% of men with an income greater than 100% of the federal poverty level compared to 22.2% of those with a lower income.

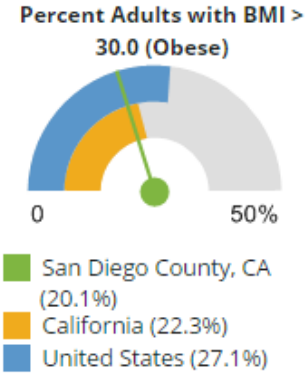
Obesity & Quality of Life

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

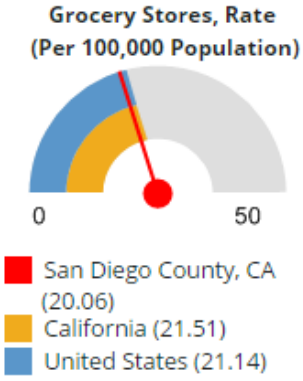
Characteristics of Residents, San Diego County
Selected Elements from Obesity Pathway:[8]



Data Source: Centers for Disease Control and Prevention, BRFSS 2011-2012. Accessed via Kaiser Permanente CHNA Data Platform.



Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion 2012. Accessed via Kaiser Permanente CHNA Data Platform.



Data Source: US Census Bureau, County Business Patterns 2011. Accessed via Kaiser Permanente CHNA Data Platform.

Possible Intervention Opportunities[9]

- 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/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/nccdphp/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. California Health Interview Survey. AskCHIS. http://ask.chis.ucla.edu/AskCHIS/tools/_layouts/AskChisTool/home.aspx#/geography
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 HHSA, 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
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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 health driver, or a health driver 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.

Primary data. Primary data are new data collected or observed directly from first-hand experience. They are typically primary (not numerical) in nature. For this community health needs assessment, primary data were collected through focus groups and interviews with key stakeholders. These primary data describe what is important to the people who provide the information and are useful in interpreting secondary data.

Secondary data. Secondary data are data that have been collected and published by another entity. They are typically secondary (numerical) in nature. Secondary data are useful in highlighting in an objective manner health outcomes that significantly impact a community.

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: San Diego County HHSA Regional Data

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 a further 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 data from the CHIS, 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 smoking and binge drinking when compared to other regions. Central region has 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%).

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%

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%

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

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%

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%

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

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

California Health Interview Survey (CHIS) 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%

FOOTNOTE
Regional Demographic Data is from the San Diego County Community Health Statistics Unit, based on SANDAG 2012 estimates and 2013 American Community Survey estimates
Data on Health and Health Behaviors is from the 2011-2012 California Health Interview Survey (CHIS)

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 a 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 data from the California Health Interview Survey, 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.

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%

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%

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

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%

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%

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

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

California Health Interview Survey (CHIS) 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%

FOOTNOTE
Regional Demographic Data is from the San Diego County Community Health Statistics Unit, based on SANDAG 2012 estimates and 2013 American Community Survey estimates
Data on Health and Health Behaviors is from the 2011-2012 California Health Interview Survey (CHIS); Data on refugees is from the ‘

North Central

At 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 the 2011-2012 CHIS, 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.

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%

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%

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

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%

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 %

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

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

California Health Interview Survey (CHIS) 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%

FOOTNOTE
Regional Demographic Data is from the San Diego County Community Health Statistics Unit, based on SANDAG 2012 estimates and 2013 American Community Survey estimates
Data on Health and Health Behaviors is from the 2011-2012 California Health Interview Survey (CHIS)

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 the 2011-2012 CHIS, 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.

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%

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%

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

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%

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%

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

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

California Health Interview Survey (CHIS) 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%

FOOTNOTE
Regional Demographic Data is from the San Diego County Community Health Statistics Unit, based on SANDAG 2012 estimates and 2013 American Community Survey estimates
Data on Health and Health Behaviors is from the 2011-2012 California Health Interview Survey (CHIS)

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 the 2011-2012 California Health Interview Survey, 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.

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%

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%

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

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%

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%

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

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

California Health Interview Survey (CHIS) 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%

FOOTNOTE
Regional Demographic Data is from the San Diego County Community Health Statistics Unit, based on SANDAG 2012 estimates and 2013 American Community Survey estimates
Data on Health and Health Behaviors is from the 2011-2012 California Health Interview Survey (CHIS)

South

The South region of San Diego 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 with another 19.1% citing the primary language as Spanish only. Over half of residents in the South region report spending 30% or more of their household income a month on housing.

According to the 2011-2012 CHIS, 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.

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%

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%

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

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%

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%

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

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

California Health Interview Survey (CHIS) 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%

FOOTNOTE
Regional Demographic Data is from the San Diego County Community Health Statistics Unit, based on SANDAG 2012 estimates and 2013 American Community Survey estimates
Data on Health and Health Behaviors is from the 2011-2012 California Health Interview Survey (CHIS)

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	North Coastal	North Central	Central	South	East	North Inland	Overall	CA State
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 F: Primary Data Collection Materials

Sign-in Sheet for Community Partner Discussion

Name	Contact Information	Organization	Organization Type	Region	Population Served (Mark all that apply)
			☐ Clinic ☐ Government ☐ Non-profit ☐ Other:_____________	☐ Central ☐ East ☐ North Central ☐ North Coastal ☐ North Inland ☐ South	☐ Low-income ☐ Medically Underserved ☐ Population with chronic diseases ☐ Minority Population ☐ Other
			☐ Clinic ☐ Government ☐ Non-profit ☐ Other:_____________	☐ Central ☐ East ☐ North Central ☐ North Coastal ☐ North Inland ☐ South	☐ Low-income ☐ Medically Underserved ☐ Population with chronic diseases ☐ Minority Population ☐ Other
			☐ Clinic ☐ Government ☐ Non-profit ☐ Other:_____________	☐ Central ☐ East ☐ North Central ☐ North Coastal ☐ North Inland ☐ South	☐ Low-income ☐ Medically Underserved ☐ Population with chronic diseases ☐ Minority Population ☐ Other
			☐ Clinic ☐ Government ☐ Non-profit ☐ Other:_____________	☐ Central ☐ East ☐ North Central ☐ North Coastal ☐ North Inland ☐ South	☐ Low-income ☐ Medically Underserved ☐ Population with chronic diseases ☐ Minority Population ☐ Other
			☐ Clinic ☐ Government ☐ Non-profit ☐ Other:_____________	☐ Central ☐ East ☐ North Central ☐ North Coastal ☐ North Inland ☐ South	☐ Low-income ☐ Medically Underserved ☐ Population with chronic diseases ☐ Minority Population ☐ Other

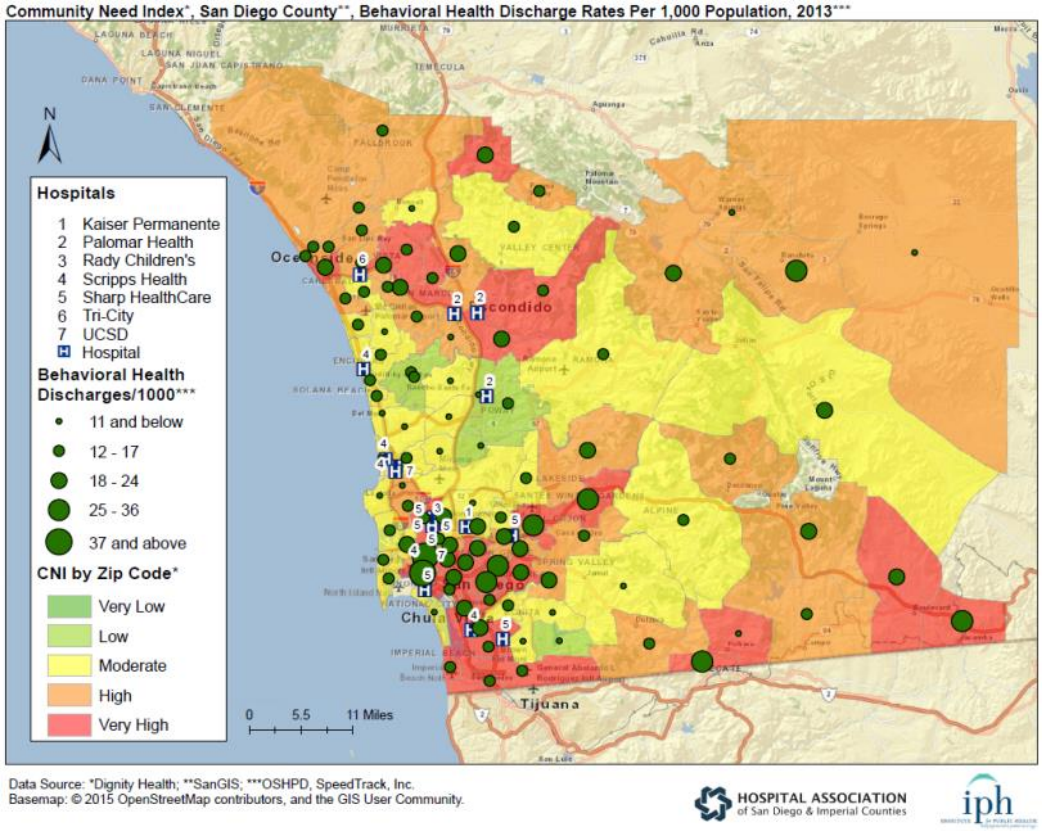
BEHAVIORAL/MENTAL HEALTH DISCUSSION TEMPLATE

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/mental 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):

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



Hospital Discharge Data from OSHPD

Behavioral/Mental Health discharge data for patients with a primary diagnosis of a behavioral/mental 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 Group	Inpatient			Emergency Department		
	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/Mental Health Responses
1. What are the most common health issues or needs?
• Depression (depression in seniors mentioned most often) • Anxiety • Lack of psychiatrists • Lack of training in schools • Homelessness/drug-induced issues • Smoking • Stress • Drugs/alcohol • Self-injury/suicidal ideation in youth • Problems with compliance/coverage • Social media/bullying • Behavioral/mental health affects all other diseases
2. What are the challenges clients face to improving health?
• Strong stigma • Specific Vulnerable Populations: **Youth**: too few behavioral/mental 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?
• Lack of awareness/recognition • Self-medicating • Not properly motivated/confident • The right questions aren't being asked
4. What are top challenges you as case managers face to helping?
• 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: **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?
• Reducing stigma • Emotional support • Strengths-based case management • Finding intrinsic motivation • Keeping the phone lines open
6. How could hospitals collaborate with your organizations?
• 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 ER • 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)   • 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

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

Who have you helped navigate thru the health system?

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

San Diego Region

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

ZIP CODE ☐

Race/Ethnicity

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

Populations you have knowledge of:

(Mark all that apply):

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

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 G: Hospital and Clinic Data

Hospital and Clinic Data

California's Office of Statewide Health Planning and Development (OSHPD) are 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 from all hospitals within San Diego County were analyzed through the SpeedTrack© California Universal Patient Information Discovery (CUPID) application. SpeedTrack is a search engine coupled with revolutionary methods of organizing data which contains four years of hospital discharge data from multiple sources (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 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 Community Health Statistics Unit and hospital service line recommendations. In addition, clinic data was 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.

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

Age	#	%
0-4 Years	126,677	7.1%
5 to 14 Years	77,785	14.5%
15 to 24 Years	129,263	17.4%
25 to 44 Years	279,412	27.3%
45 to 64 Years	287,162	23.0%
65+ Years	265,974	10.7%

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%

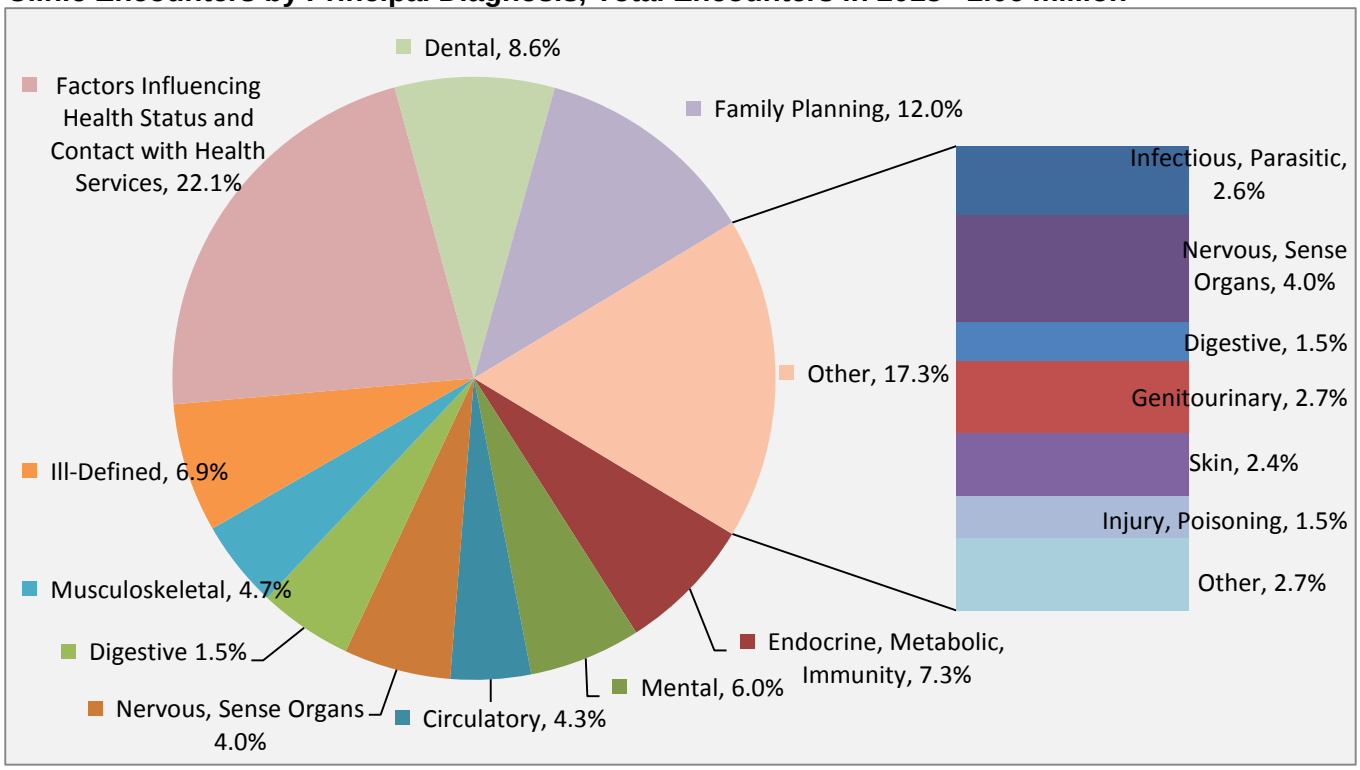
Ethnicity	#	%
Non-Hispanic/Non-Latino	806,631	69.2%
Hispanic/Latino	344,791	29.6%
Unknown	14,891	1.3%

*Data 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 approximately 78% are Federally Qualified Health Centers. The largest majority of clinic patients are low-income, Hispanic and Medi-Cal or Self Pay. More specifically, 68% of clinic patients reported having an income below 100% of the poverty level, followed by 16% earning between 100-200% of the FPL. The clinic patient population is largely Hispanic (56%), and on average (median), 31% of patients are best served in a non-English language. A breakdown of clinic utilization by principal diagnosis is shown below.

Clinic Encounters by Principal Diagnosis, Total Encounters in 2013 ~2.06 million



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

Appendix H: Community Partner Data

Community Partner Data

To further support data findings from the Kaiser Permanente Data Platform, additional existing secondary data were gathered and consolidated for San Diego County and broken down regionally when possible. This includes data from:

- 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 Service 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.

2-1-1 San Diego Top Needs and Referrals

Health-Related Needs by Taxonomy Category	
Need	**Count of Needs**
Health Insurance Marketplaces	2,594
Community Clinics	2,493
State Health Insurance Marketplace Call Centers/Websites	1,498
General Dentistry	977
Dental Care	690

Needs for Clients with Referrals to Hospitals	
Need	**Count of Needs**
General Acute Care Hospitals	461
Emergency Room Care	449
Adult Psychiatric Inpatient Units	186
Urgent Care Centers	185
Speech and Language Evaluations	162

Top 5 Referrals to Clients with Health-Related Needs	
Referral	**Number of Referrals**
Covered California	3,693
Enrollment Center for CalFresh, Medi-Cal, 2-1-1 San Diego	977
Breast Health Specialist	841
Access and Crisis Line, Optum Health (formerly United Behavioral Health)	410
Physician Referral Service	367

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

With the exception of North Inland, the same health-related needs in the table above were consistently cited as the top 5 across the regions. North Inland, in particular, noted a need for managed ca e health information as its 5th 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/mental 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 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, and enabling) 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. 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 4th, 5th and 6th most common primary diagnoses.

North County Health Services Top 8 Primary Diagnoses in 2014 (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

Data Source: North County Health Services. 2014.

Below is data regarding the top North County Health Services diagnosis as well a breakdown of visits among the top four health needs.

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

Health Need	# 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	1038
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

Data 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.

Body Mass Index and Glucose Test Results from the TODAY Program, 2008 – 2014

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

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

Appendix I: Community Asset List by Condition

2-1-1 San Diego 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
Postabortion 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 San Diego 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 San Diego 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 San Diego 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 San Diego 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 J: 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.thechildrensinitiatve.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
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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.thechildrensinitiatve.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 deceivingly 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, outreaching 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, 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% or 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 of Pan Asian Communities (UPAC). (2015). A Community of Contrasts: Asian Americans, Native Hawaiians and Pacific Islanders in San Diego County. Retrieved from http://www.upacsd.com/wp-content/uploads/2015/05/Community-of-Contrasts-Report-6-1-15.pdf

UCLA California Health Interview Survey. A Health Profile of California's Diverse Population, 2011-2012 Race/Ethnicity Health Profiles.

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 need as opposed to the more Western individualist interventions. It emphasized healing though 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 California Health Interview Survey (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.'

UCLA California Health Interview Survey. A Health Profile of California's Diverse Population, 2011-2012 Race/Ethnicity Health Profiles.

San Diego American Indian Health Center. (2011). Community Health Profile. Retrieved from http://www.uihi.org/download/CHP_San-Diego_Final.pdf

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 California Health Interview Survey 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 California Health Interview Survey, 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

U.S. Census Bureau. (2011). Overview of Race and Hispanic Origin: 2010. Retrieved from https://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf

Pew Research Center. (2013). Mapping the Latino Population, By State, County and City. Retrieved from http://www.pewhispanic.org/files/2013/08/latino_populations_in_the_states_counties_and_cities_FINAL.pdf

California Reducing Disparities Project (CRDP) Latino Strategic Planning Workgroup Report. (2012) 'Community-Defined Solutions for Latino Mental Health Care Disparities.'

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: 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_CRDP_Pop_Rept_FINAL2012.pdf

Diabetes

According to the 2011-2012 California Health Interview Survey, 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

CDC/National Center for Health Statistics, National Vital Statistics System. Mortality, 2013. Retrieved from http://www.cdc.gov/nchs/data/dvs/LCWK1_2013.pdf

California Reducing Disparities Project (CRDP) African American Strategic Planning Workgroup Report. (2012) 'WE AIN'T CRAZY! Just Coping With a Crazy System:' Pathways into the Black Population for Eliminating Mental Health Disparities.' Retrieved from http://www.cdph.ca.gov/programs/Documents/African_Am_CRDP_Pop_Rept_FINAL2012.pdf

UCLA California Health Interview Survey. A Health Profile of California's Diverse Population, 2011-2012 Race/Ethnicity Health Profiles.

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

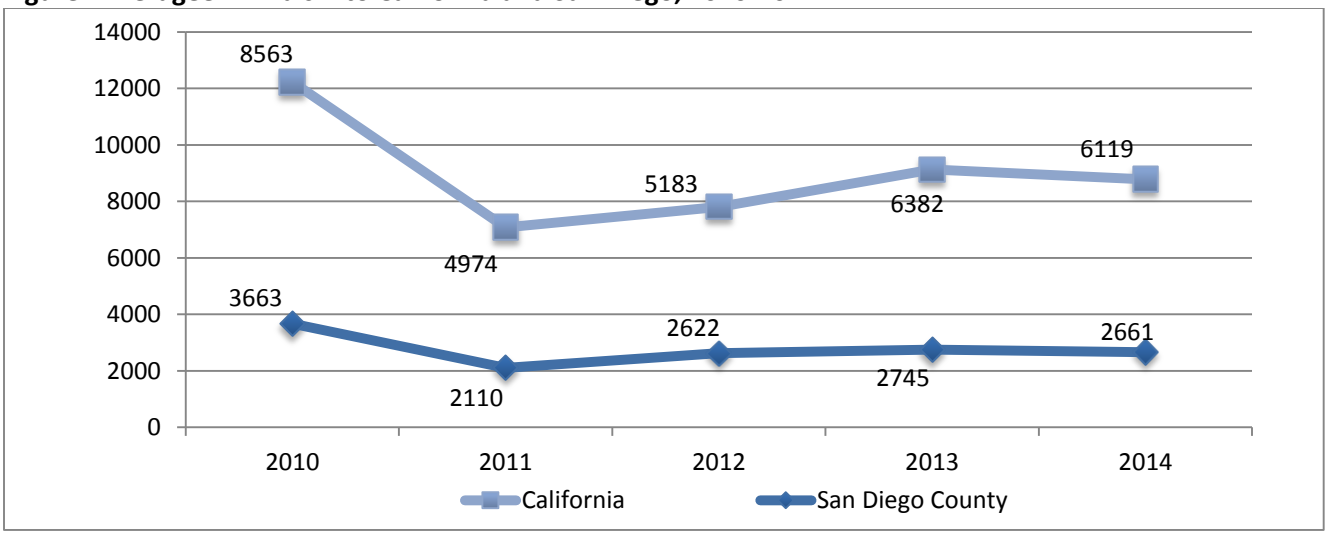
National Health Statistics Reports. (2014). Sexual Orientation and Health Among U.S. Adults: National Health Interview Survey, 2013. Retrieved from http://www.cdc.gov/nchs/data/nhsr/nhsr077.pdf

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

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
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 K: Community Need Index Explanation & Regional Maps

CNI Maps:

- Community Need Index Summary
- 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, formerly Catholic Healthcare West, developed the nation's first standardized Community Need Index (CNI) in partnership with Solucient, LLC. The CNI identifies the severity of health vulnerability for every zip code in the United States based on specific barriers to healthcare access. In doing so Dignity Health has demonstrated the link between community need, access to care and preventable hospitalization for conditions that, if effectively diagnosed and managed, should be treatable in an outpatient setting. For more information about the CNI, visit Dignity Health's website (http://www.dignityhealth.org/cm/content/pages/programs-and-reports.asp)

The CNI identifies the severity of health disparity for every zip code in the United States and demonstrates the link between community need, access to care, and preventable hospitalizations. The CNI Index is comprised of five defined barriers to care which contribute to health vulnerability:

1. **Income Barriers**
    - What percentage of the population is elderly and in poverty?
    - What percentage of the population is composed of children in poverty?
    - What percentage of the population is composed of single-parent households in poverty?
2. **Cultural/Language Barriers**
    - What percentage of the population is of minority status?
    - What percentage of the population is monolingual (not including English) or has limited English-speaking proficiency?
3. **Educational Barriers**
    - What percentage of the population lacks a high school diploma?
4. **Insurance Barriers**
    - What percentage of the population lacks health insurance?
    - What percentage of the population is unemployed?
5. **Housing Barriers**
    - What percentage of the population rents its shelter? (house, apt, condo…etc.)

Based on these 5 categories and 9 total criteria, every zip code in the US was assigned an index number:

- Scale of 1 – 5
- 5 represents the most vulnerable communities; 1 the least vulnerable

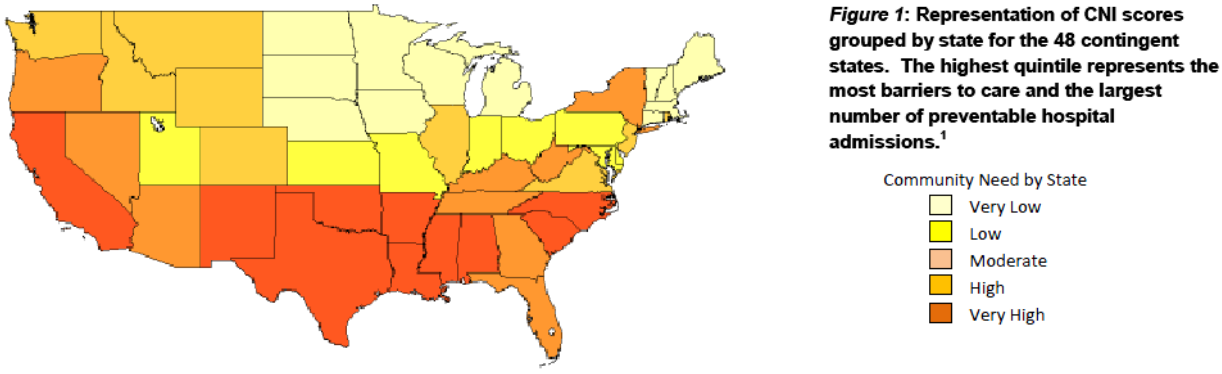


***Figure 1*: Representation of CNI scores grouped by state for the 48 contingent states. The highest quintile represents the most barriers to care and the largest number of preventable hospital admissions.[1]**

Reference:

[1] Roth R, Presken P, Pickens G. "A standardized national community needs index for the objective high-level assessment of community health care" CHW Community Needs Index. Accessed on Sept 2, 2012 at: http://www.dignityhealth.org/stellent/groups/public/@xinternet_con_sys/documents/webcontent/084757.pdf

CNI Data: San Diego County & Regional Maps

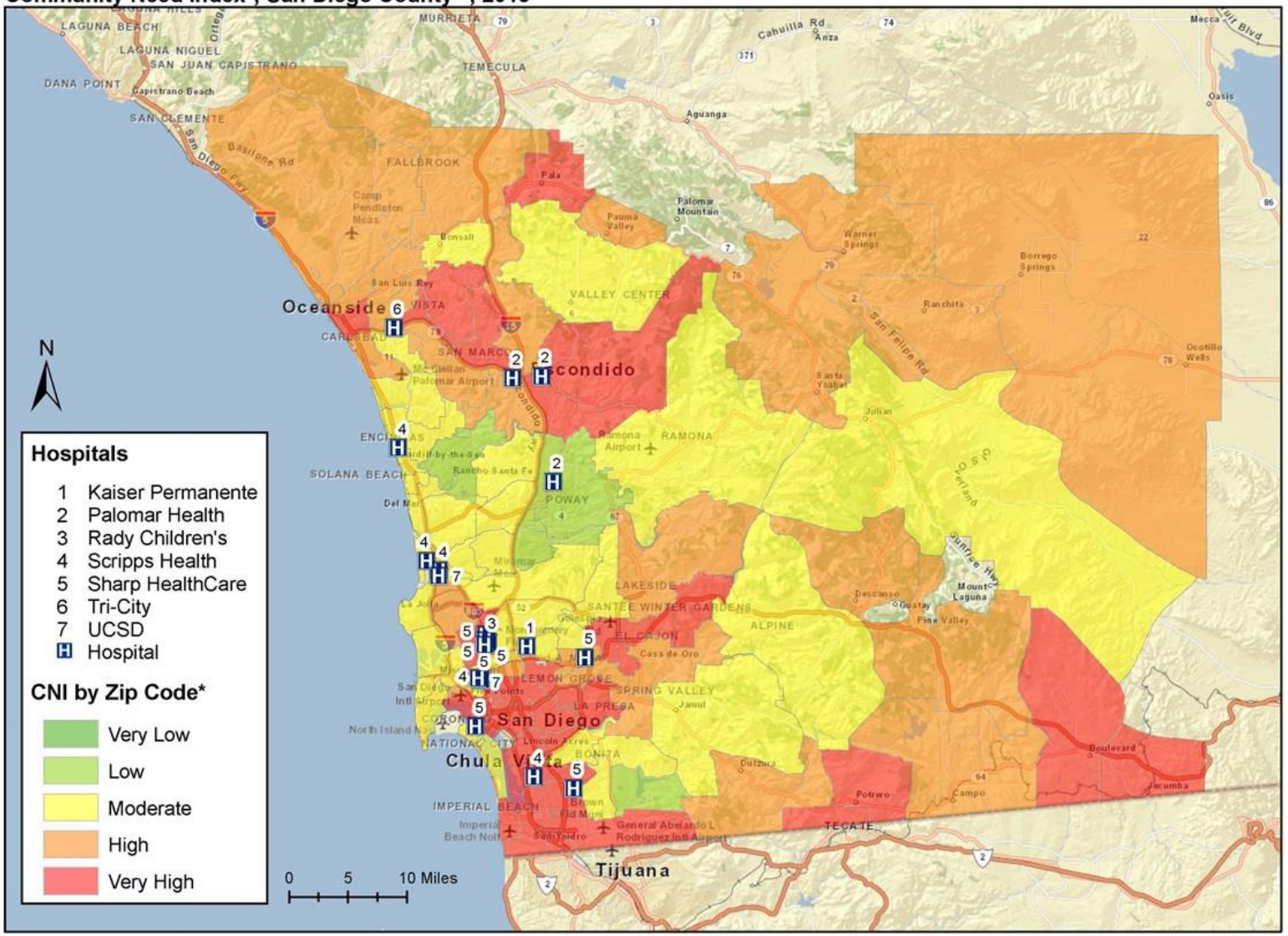
COMMUNITY NEED INDEX DATA SOURCE EXPLANATION

***Community Need Index**
Universe: Total Population of San Diego County
Data Source: Dignity Health
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 factors:

1. Income
2. Culture and language
3. Educational levels
4. Insurance
5. Housing

Community Need Index*, San Diego County, 2013**



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

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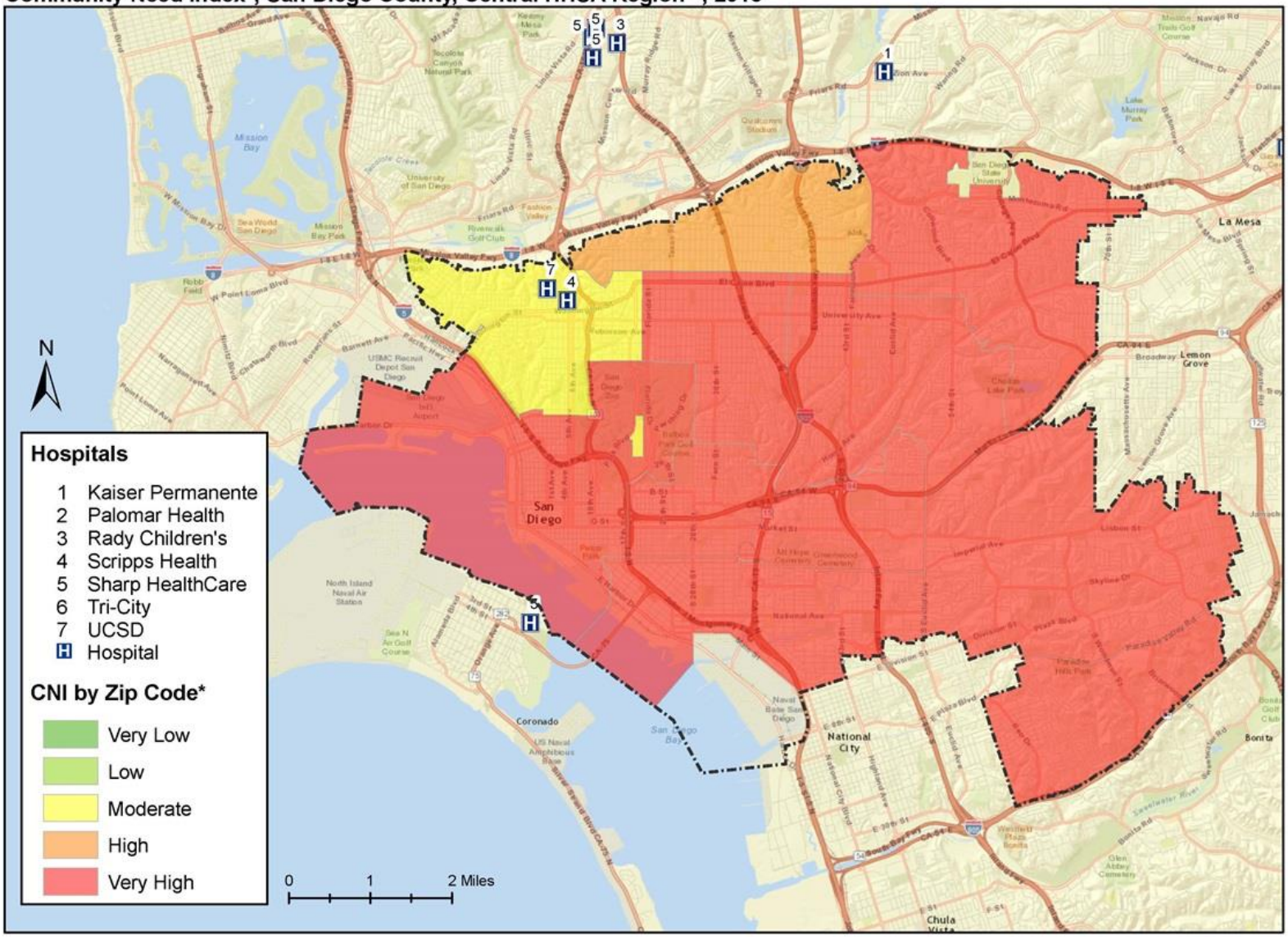
Community Need Index*, San Diego County, Central HHSA Region, 2013**



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

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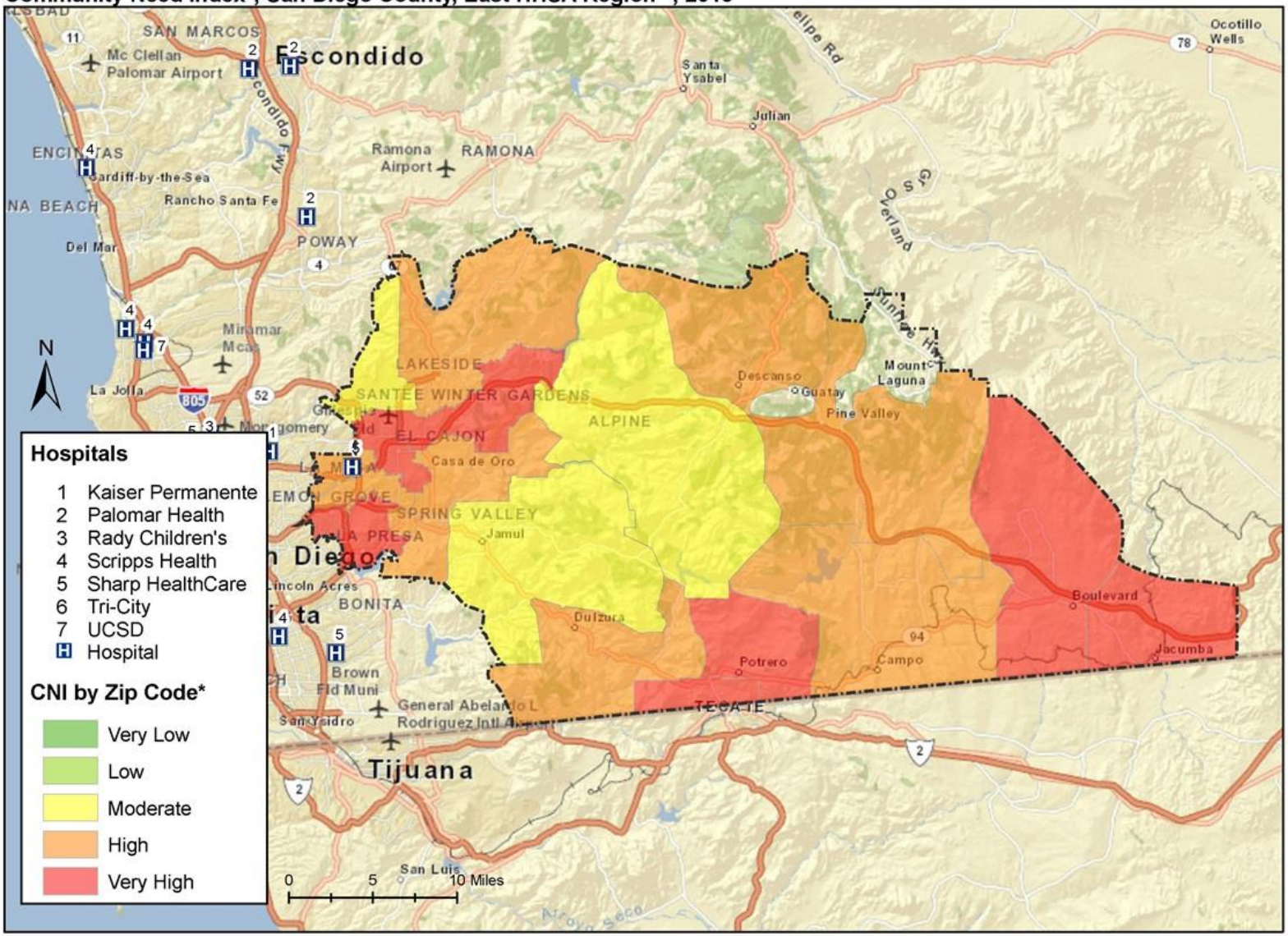
Community Need Index*, San Diego County, East HHSA Region, 2013**



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

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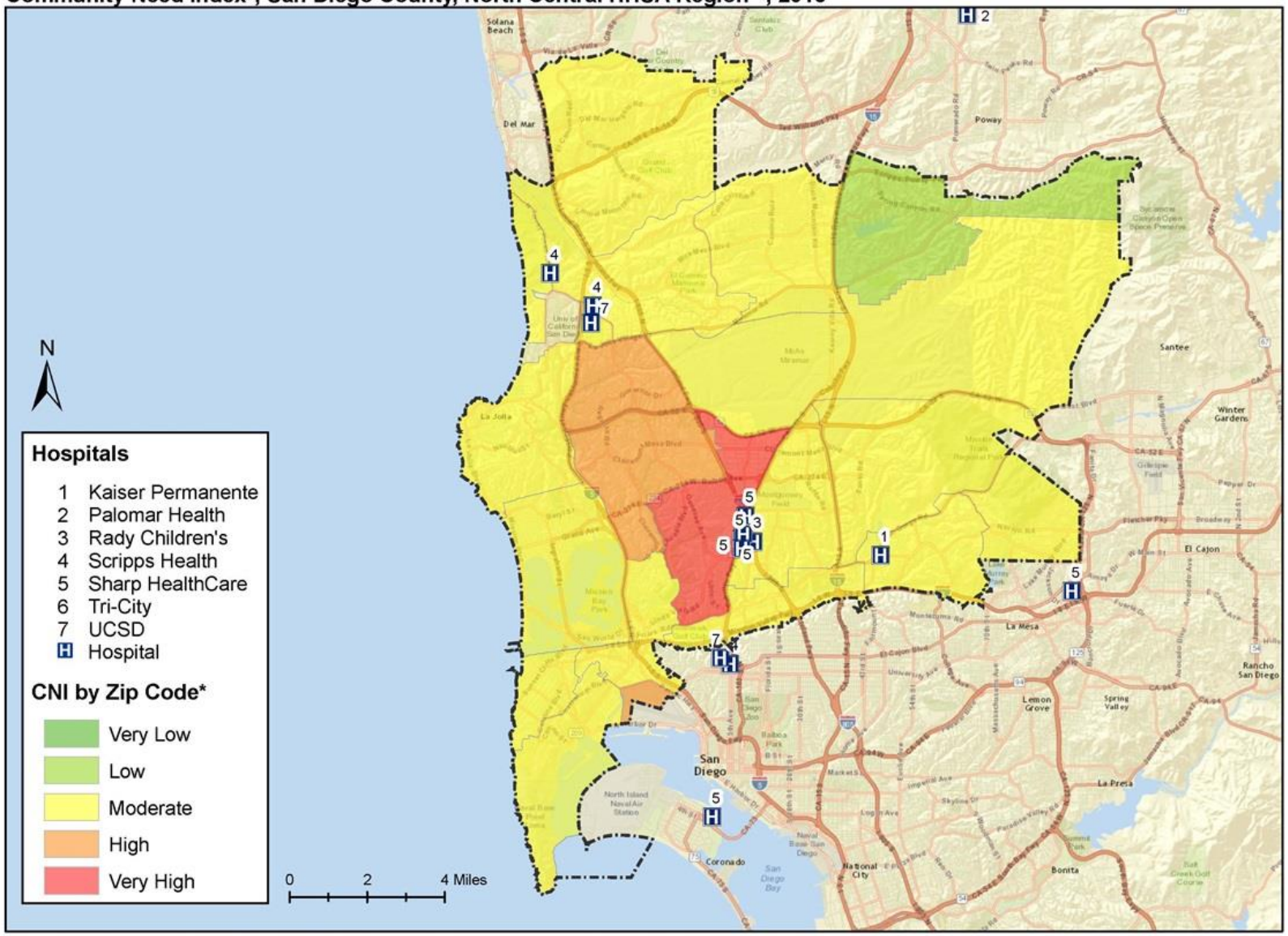
Community Need Index*, San Diego County, North Central HHSA Region, 2013**



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

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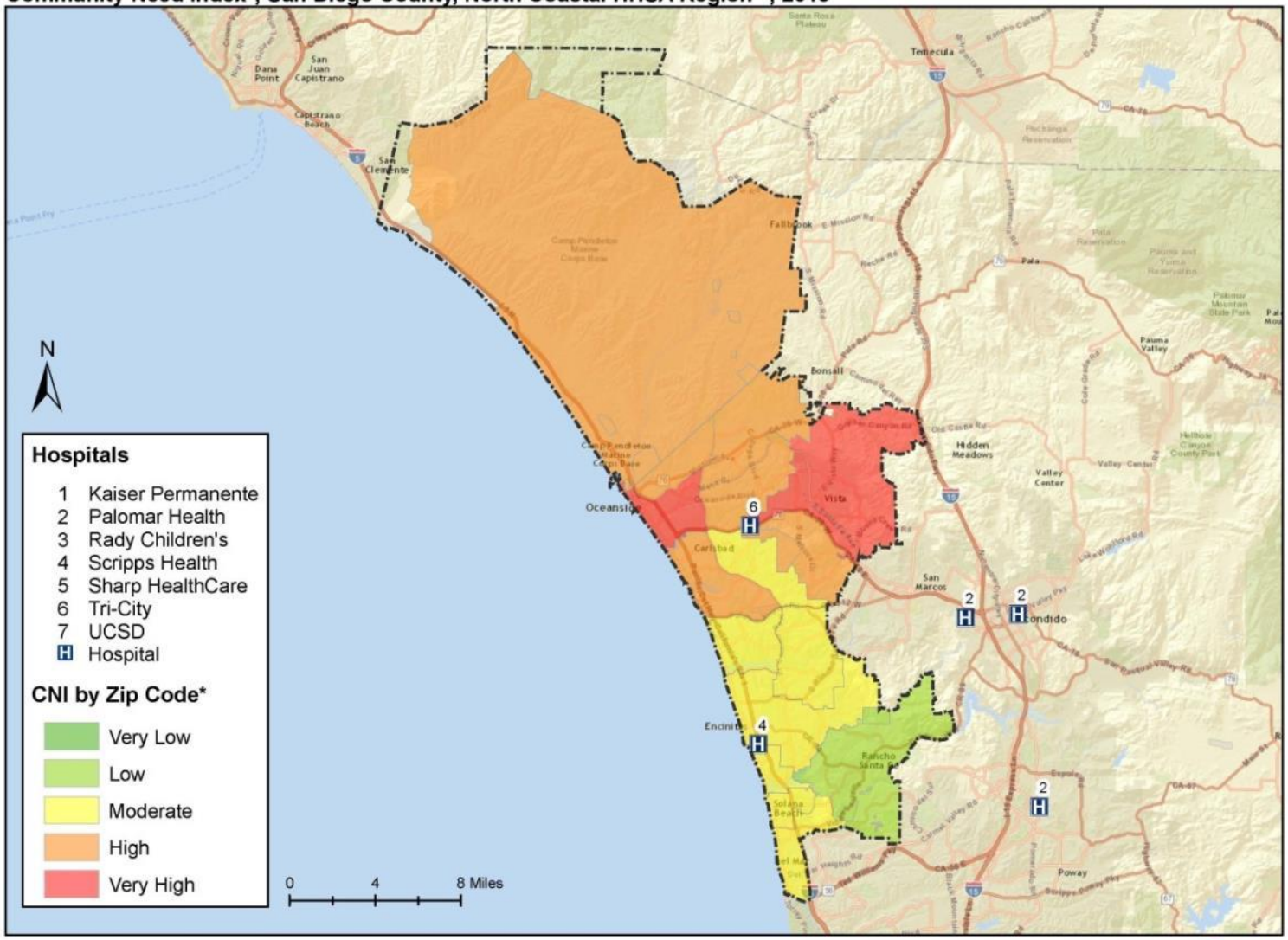
Community Need Index*, San Diego County, North Coastal HHSA Region, 2013**



Data Source: *Dignity Health; **SanGIS;
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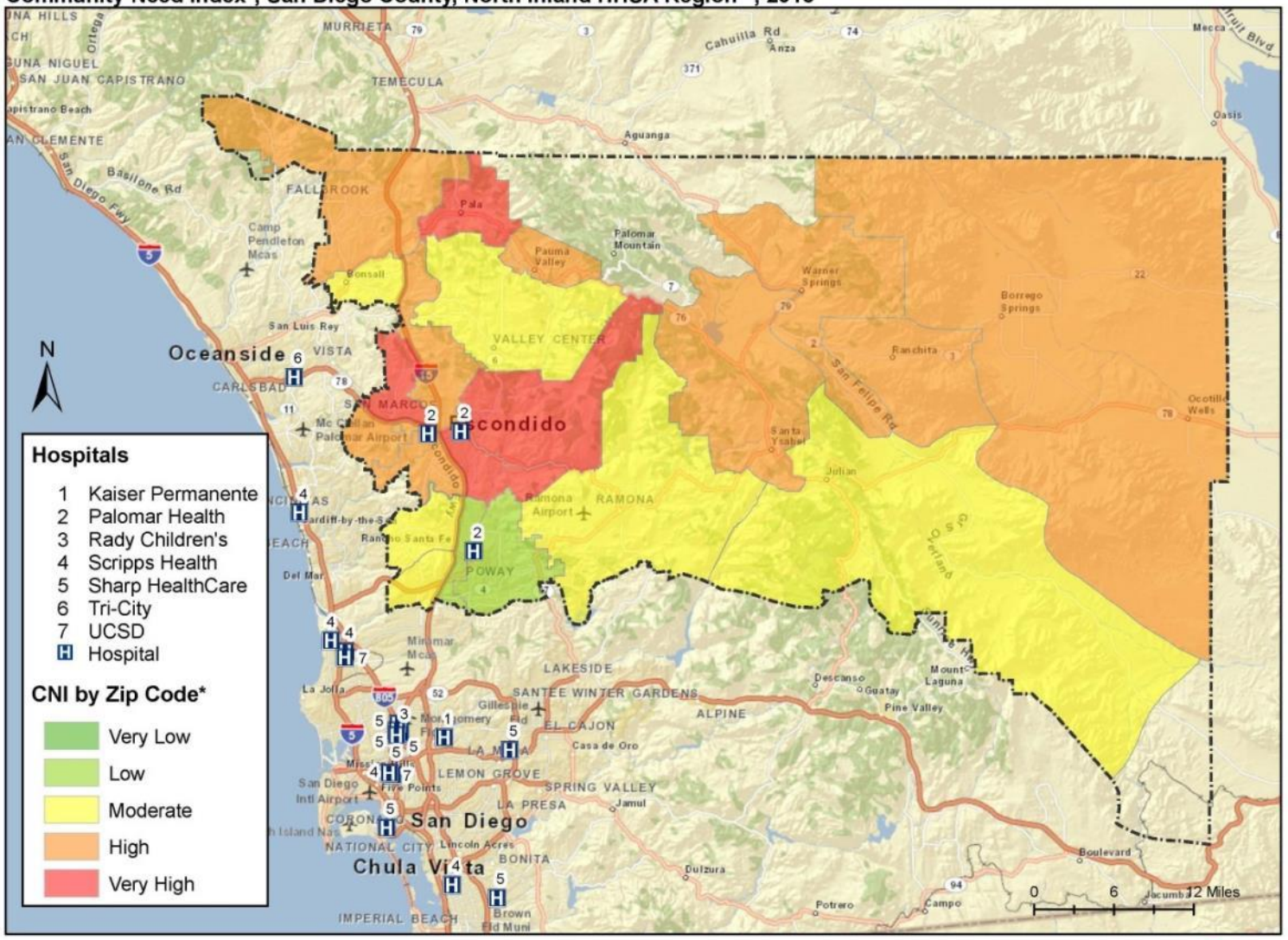
Community Need Index*, San Diego County, North Inland HHSA Region, 2013**



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

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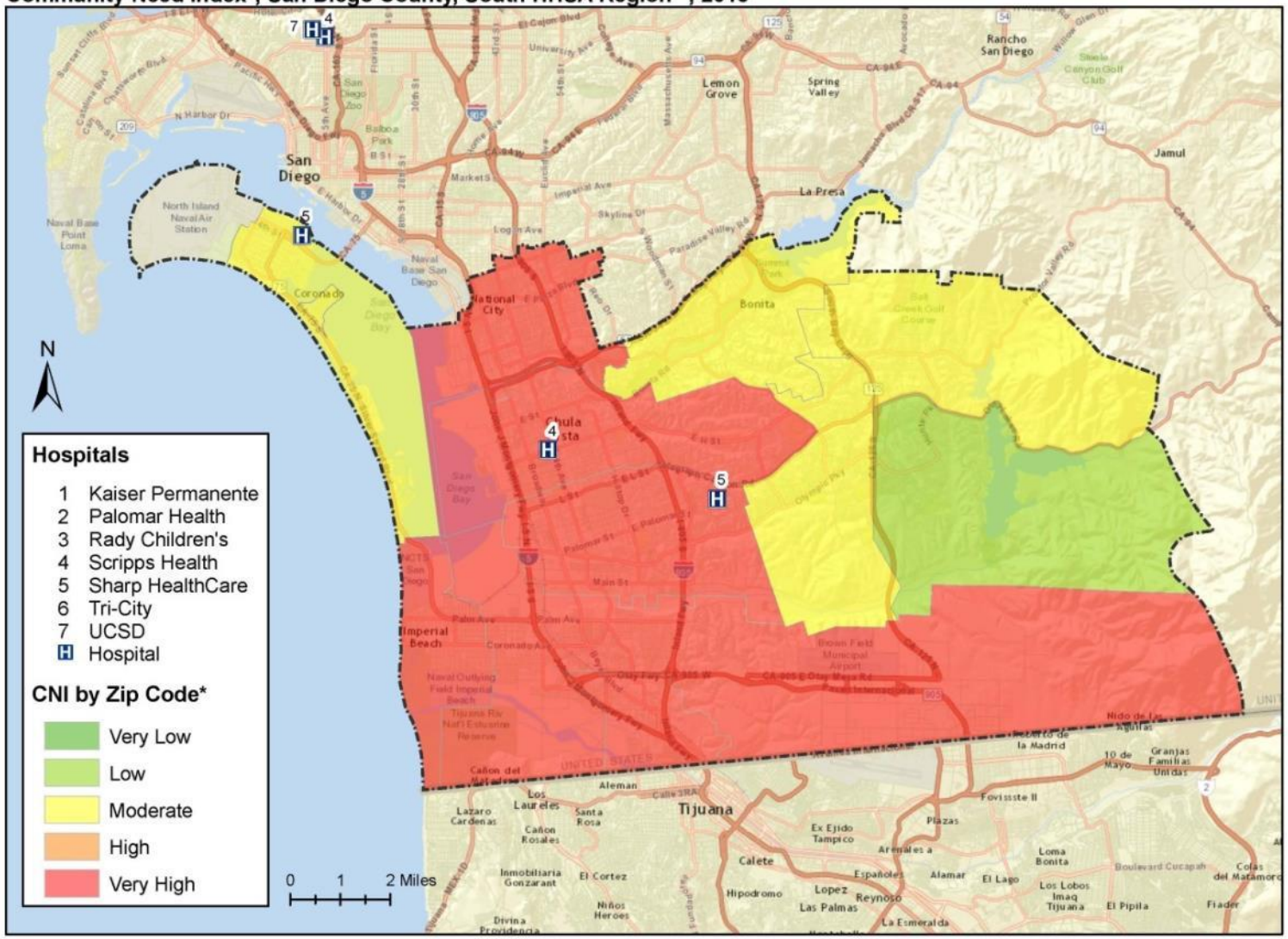
Community Need Index*, San Diego County, South HHSA Region, 2013**



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

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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: Dignity Health
Data Year: 2013
Data Level: ZIP code

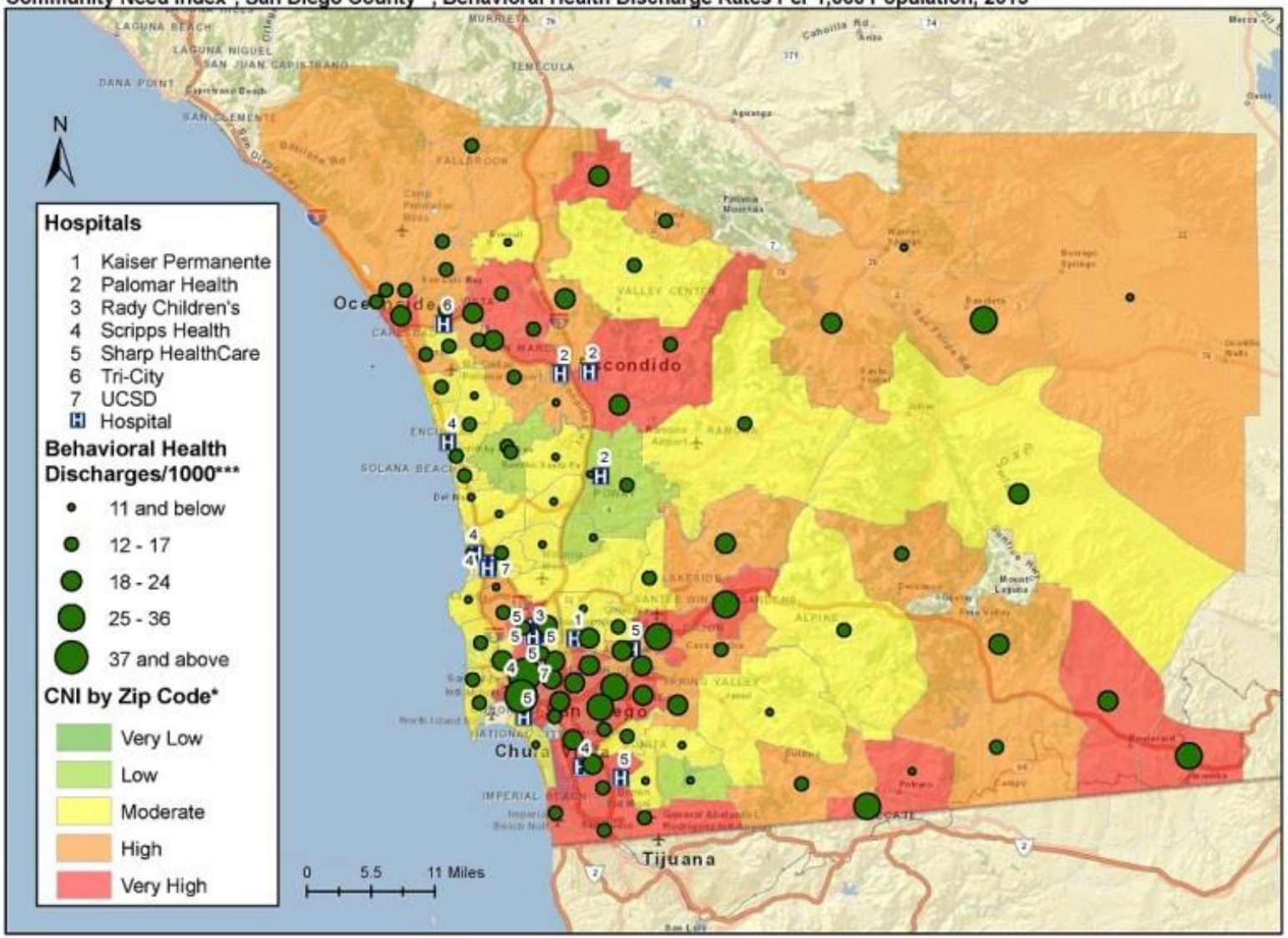
*****Behavioral Health Discharge Rate**
Description: 2013 hospital discharge rate (Inpatient/ED) was determined where *Behavioral Health* was the condition established to be the principal diagnosis, per 1,000 people (population stats: United States Census 2010 population). The following ICD-9 codes were 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 factors:

1. Income
2. Culture and language
3. Educational levels
4. Insurance
5. Housing

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.

HOSPITAL ASSOCIATION of San Diego & Imperial Counties

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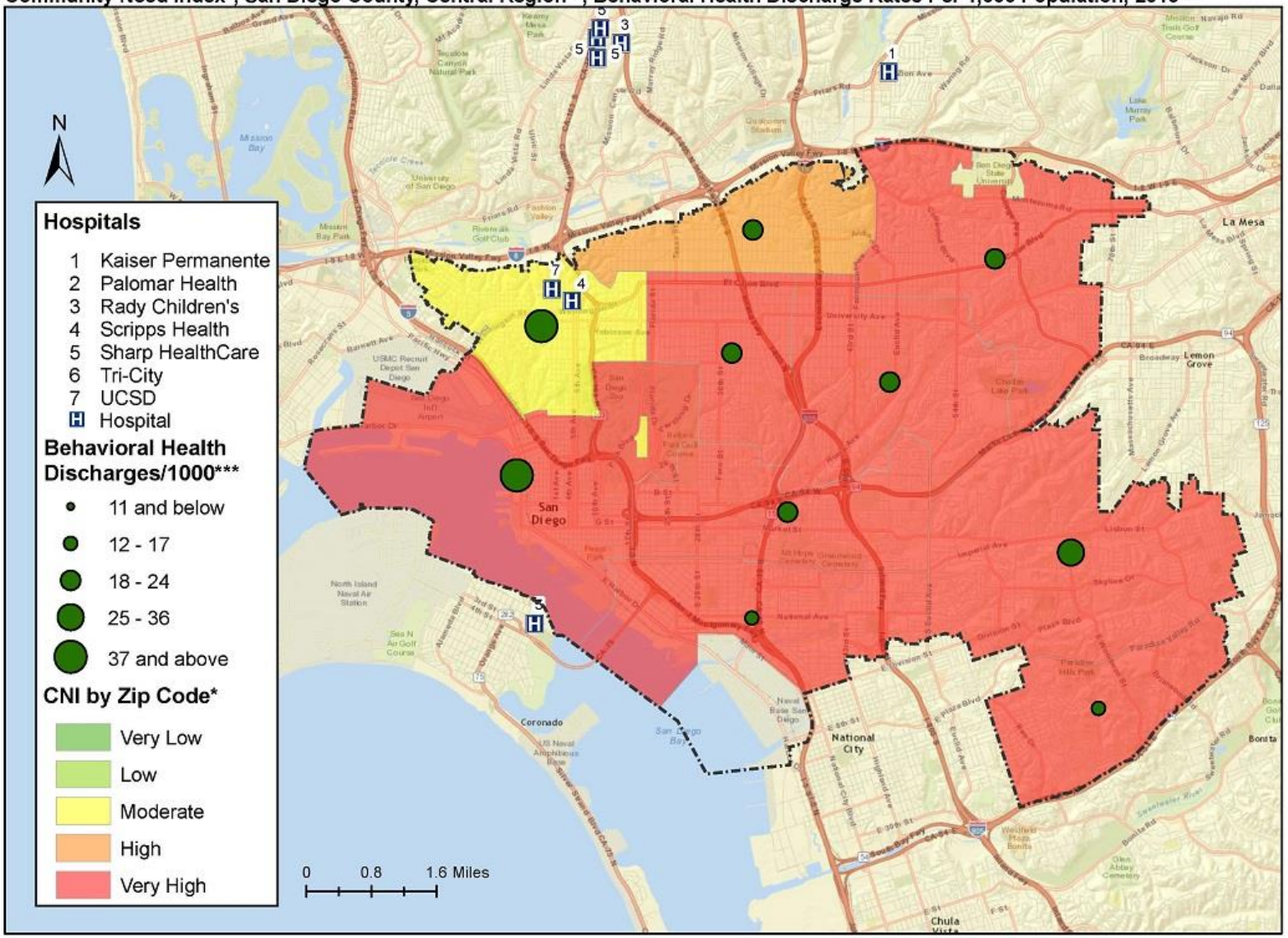
Community Need Index*, San Diego County, Central Region**, Behavioral Health Discharge Rates Per 1,000 Population, 2013***



Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
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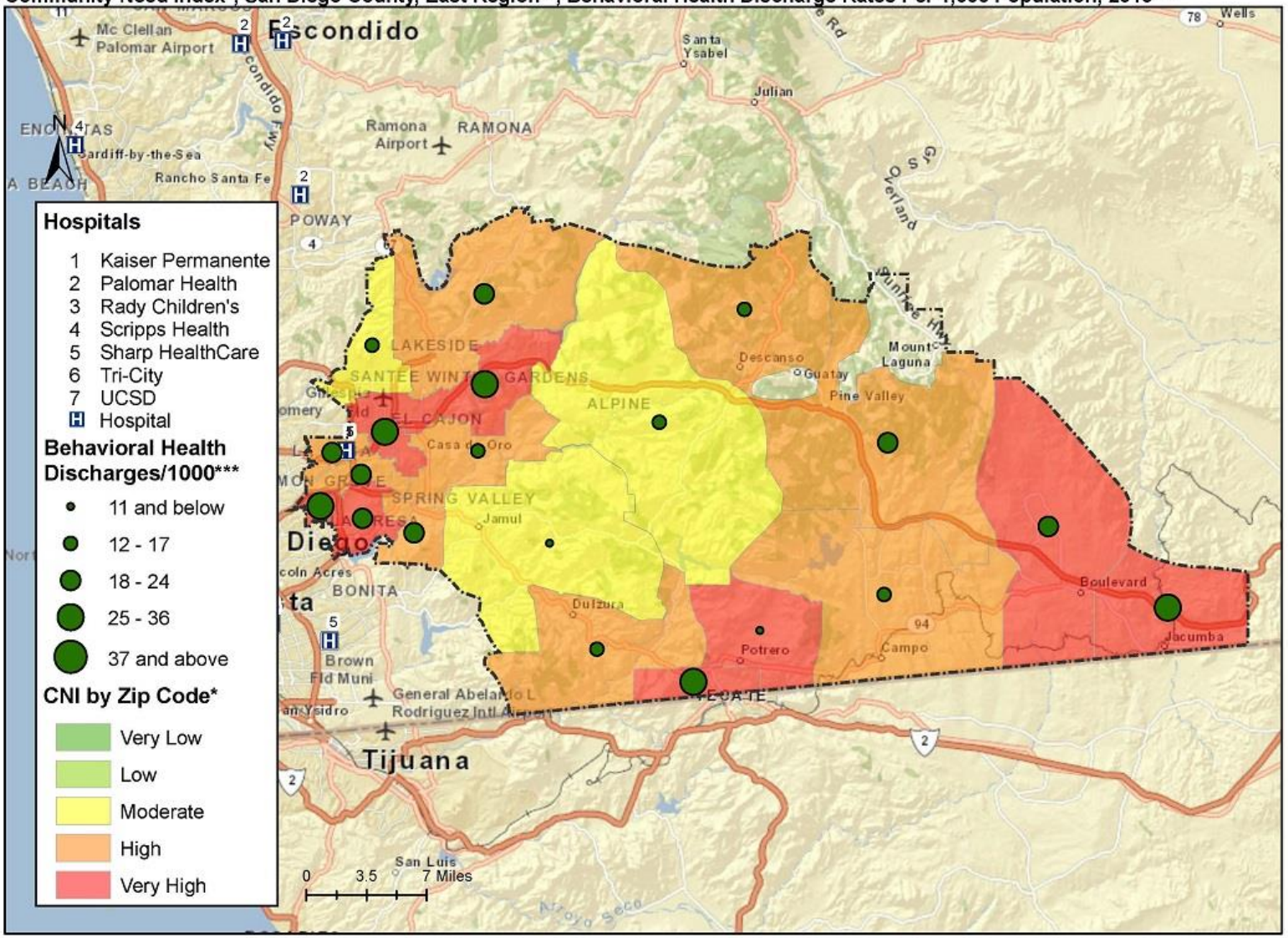
Community Need Index*, San Diego County, East Region**, Behavioral Health Discharge Rates Per 1,000 Population, 2013***



Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
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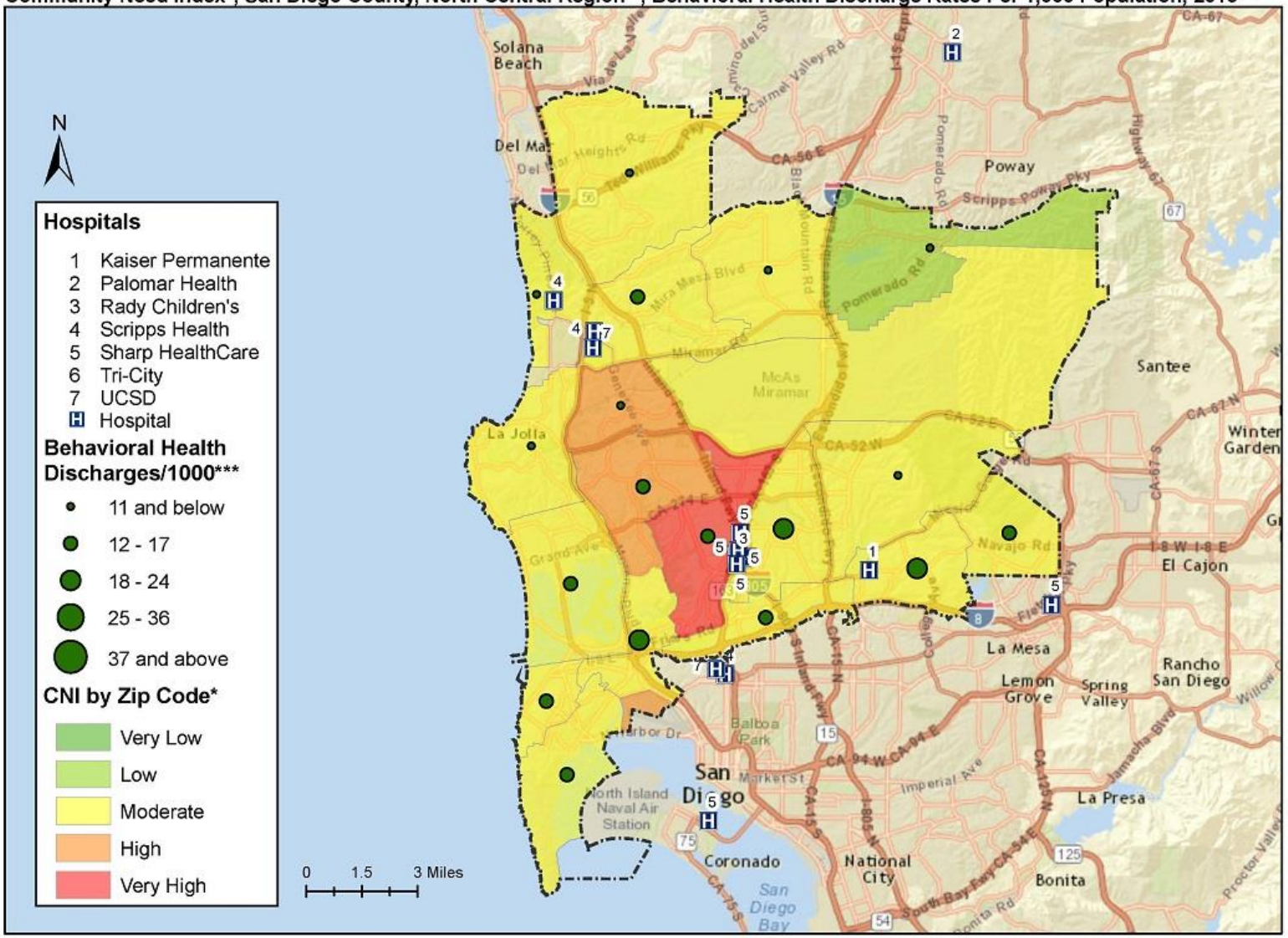
Community Need Index*, San Diego County, North Central Region, Behavioral Health Discharge Rates Per 1,000 Population, 2013*****



Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
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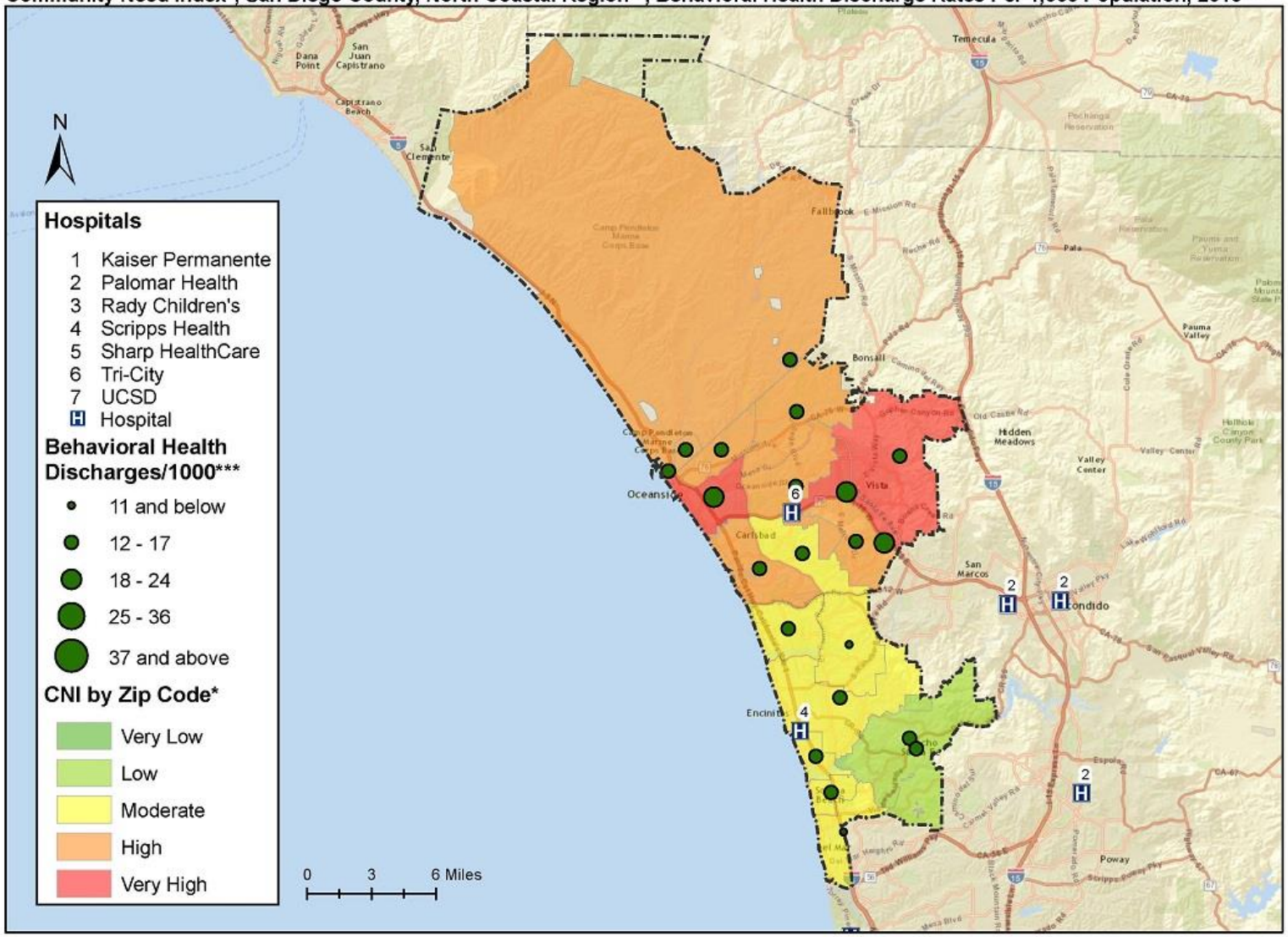
Community Need Index*, San Diego County, North Coastal Region**, Behavioral Health Discharge Rates Per 1,000 Population, 2013***



Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
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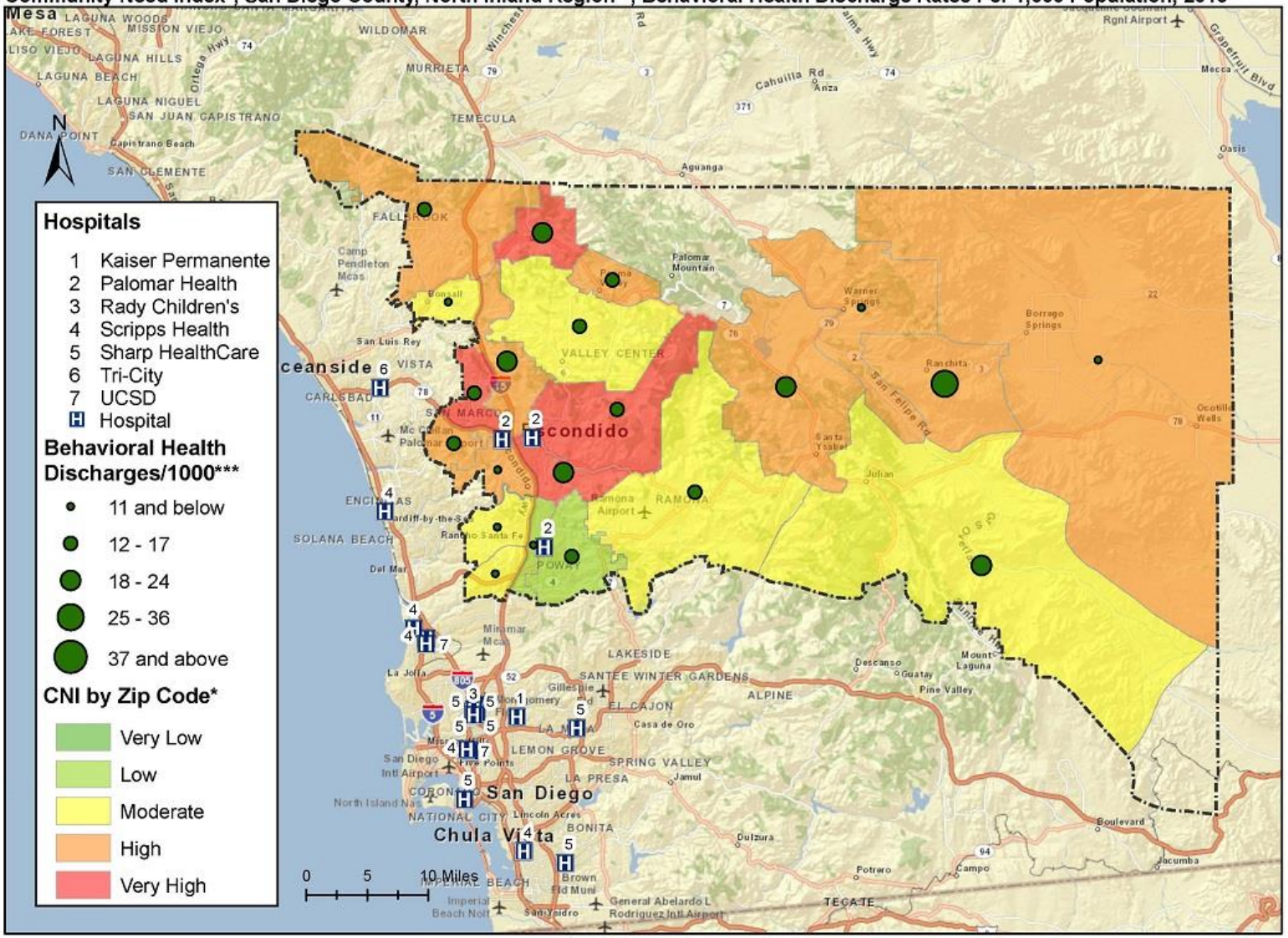
Community Need Index*, San Diego County, North Inland Region, Behavioral Health Discharge Rates Per 1,000 Population, 2013*****



Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
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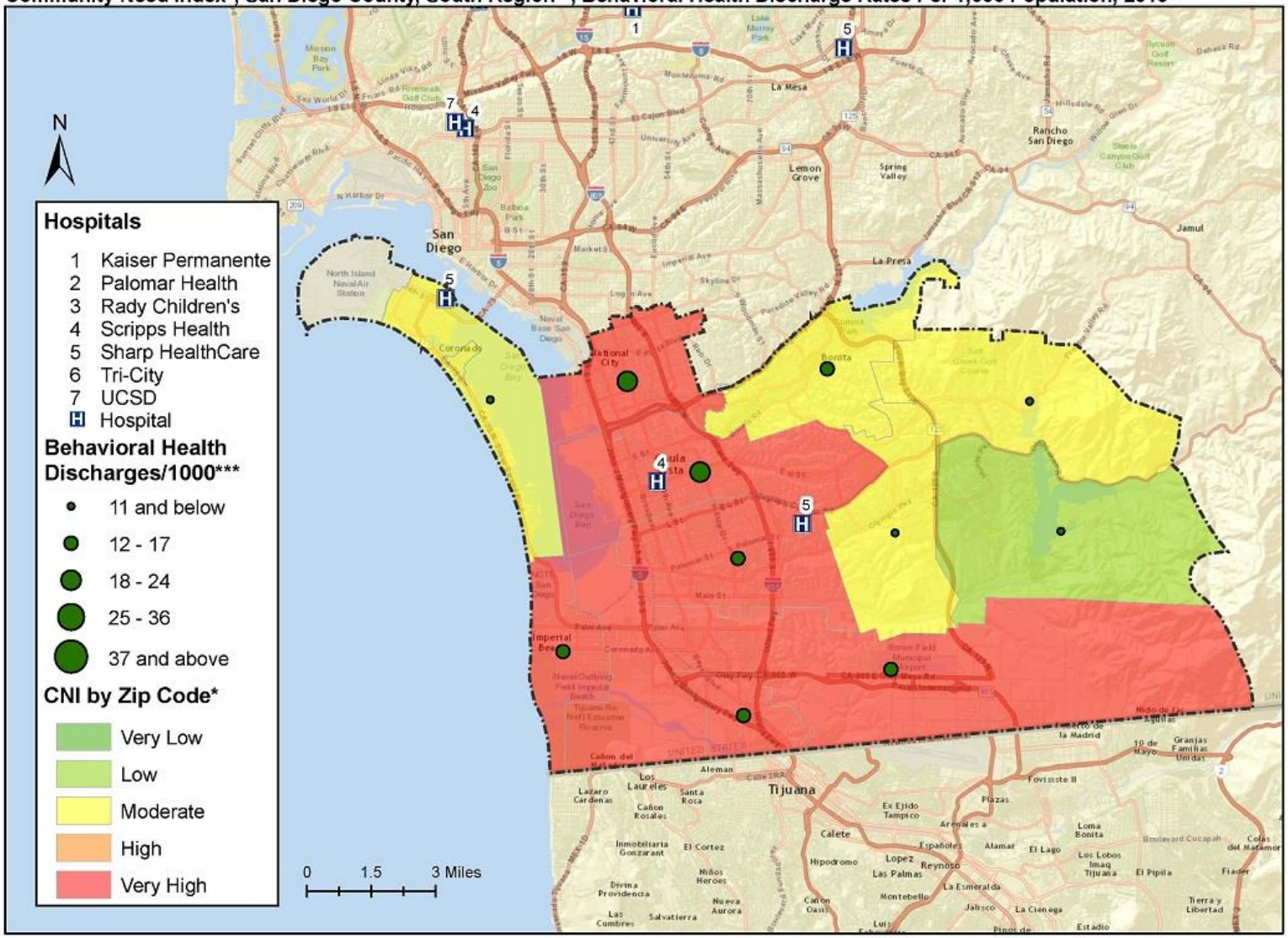
Community Need Index*, San Diego County, South Region**, Behavioral Health Discharge Rates Per 1,000 Population, 2013***



Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
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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: Dignity Health
Data Year: 2013
Data Level: ZIP code

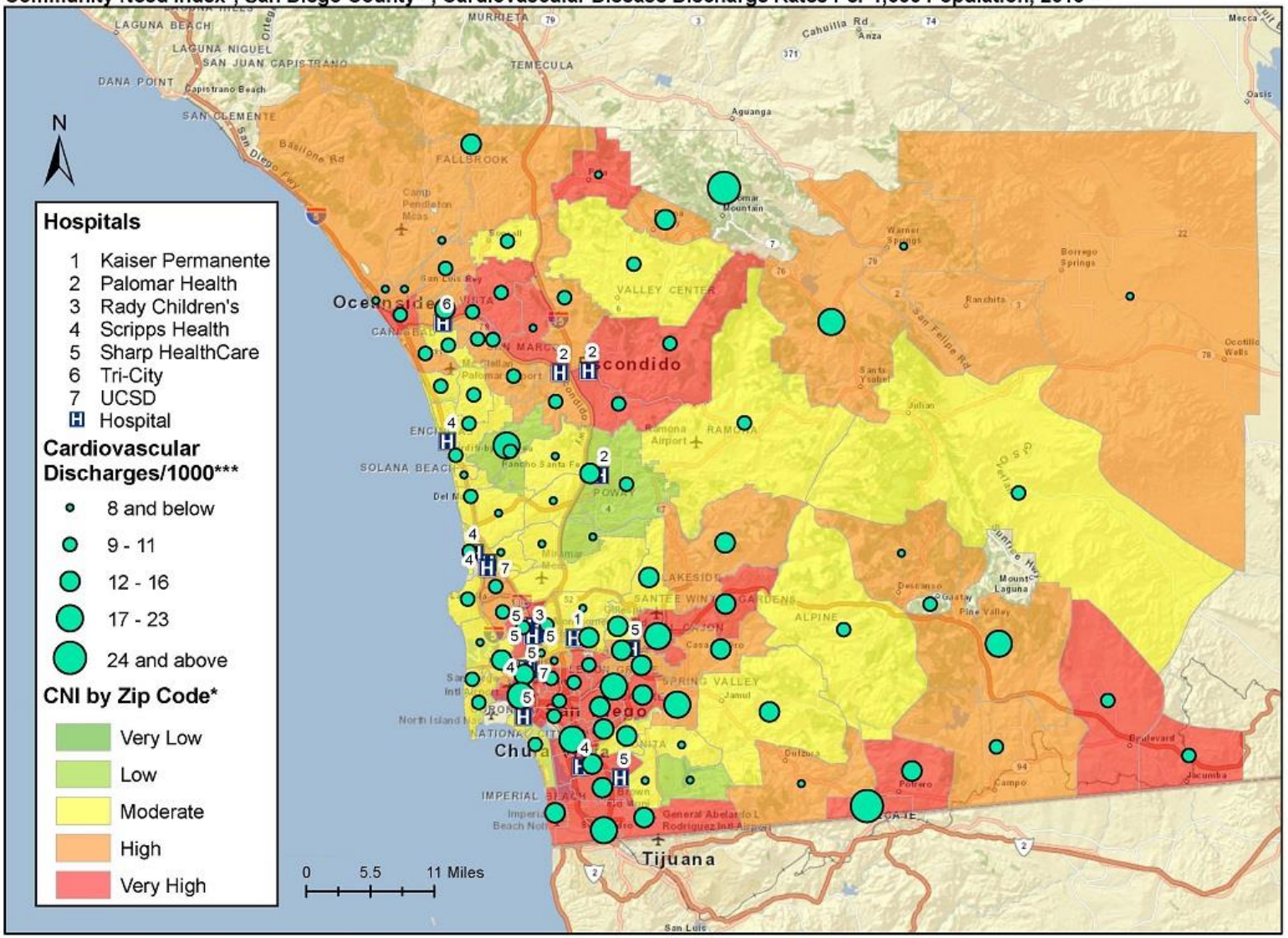
*****Cardiovascular Disease Discharge Rate**
Description: 2013 hospital discharge rate (Inpatient/ED) was determined where *Cardiovascular Disease* was the condition established to be the principal diagnosis, per 1,000 people (population stats: United States Census 2010 population). The following ICD-9 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 factors:

1. Income
2. Culture and language
3. Educational levels
4. Insurance
5. Housing

Community Need Index*, San Diego County**, Cardiovascular Disease Discharge Rates Per 1,000 Population, 2013***



Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
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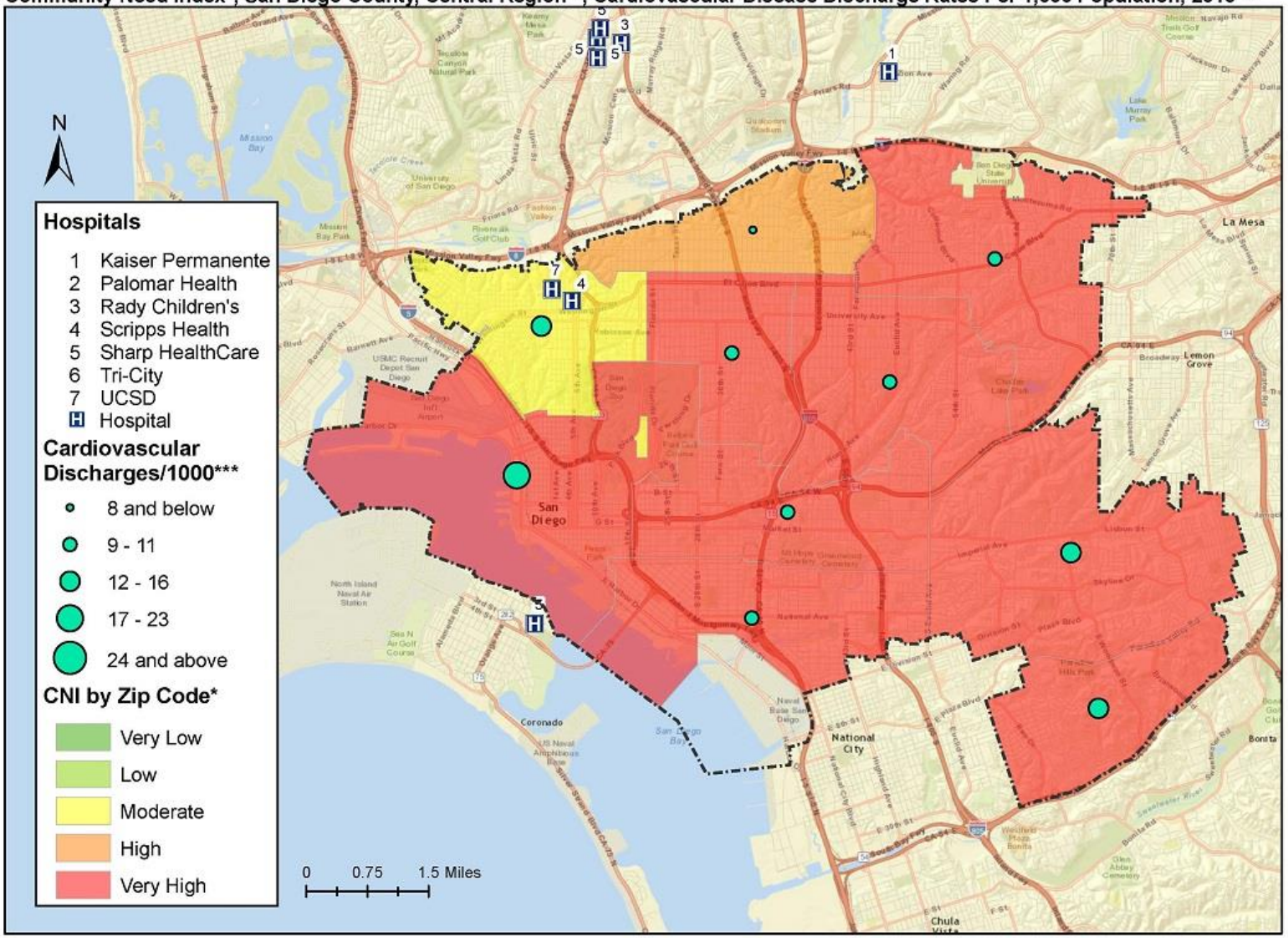
Community Need Index*, San Diego County, Central Region**, Cardiovascular Disease Discharge Rates Per 1,000 Population, 2013***



Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
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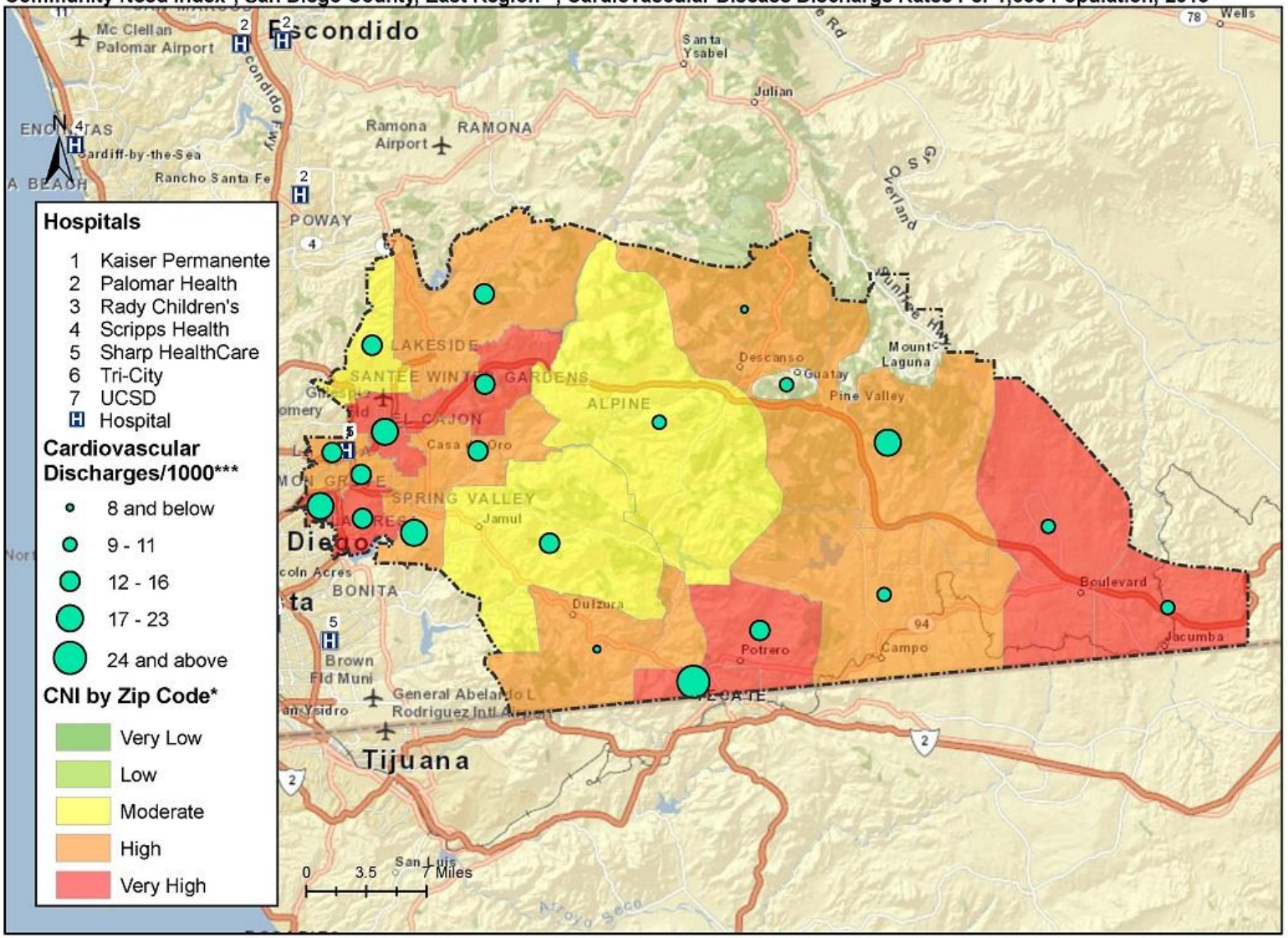
Community Need Index*, San Diego County, East Region, Cardiovascular Disease Discharge Rates Per 1,000 Population, 2013*****



Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
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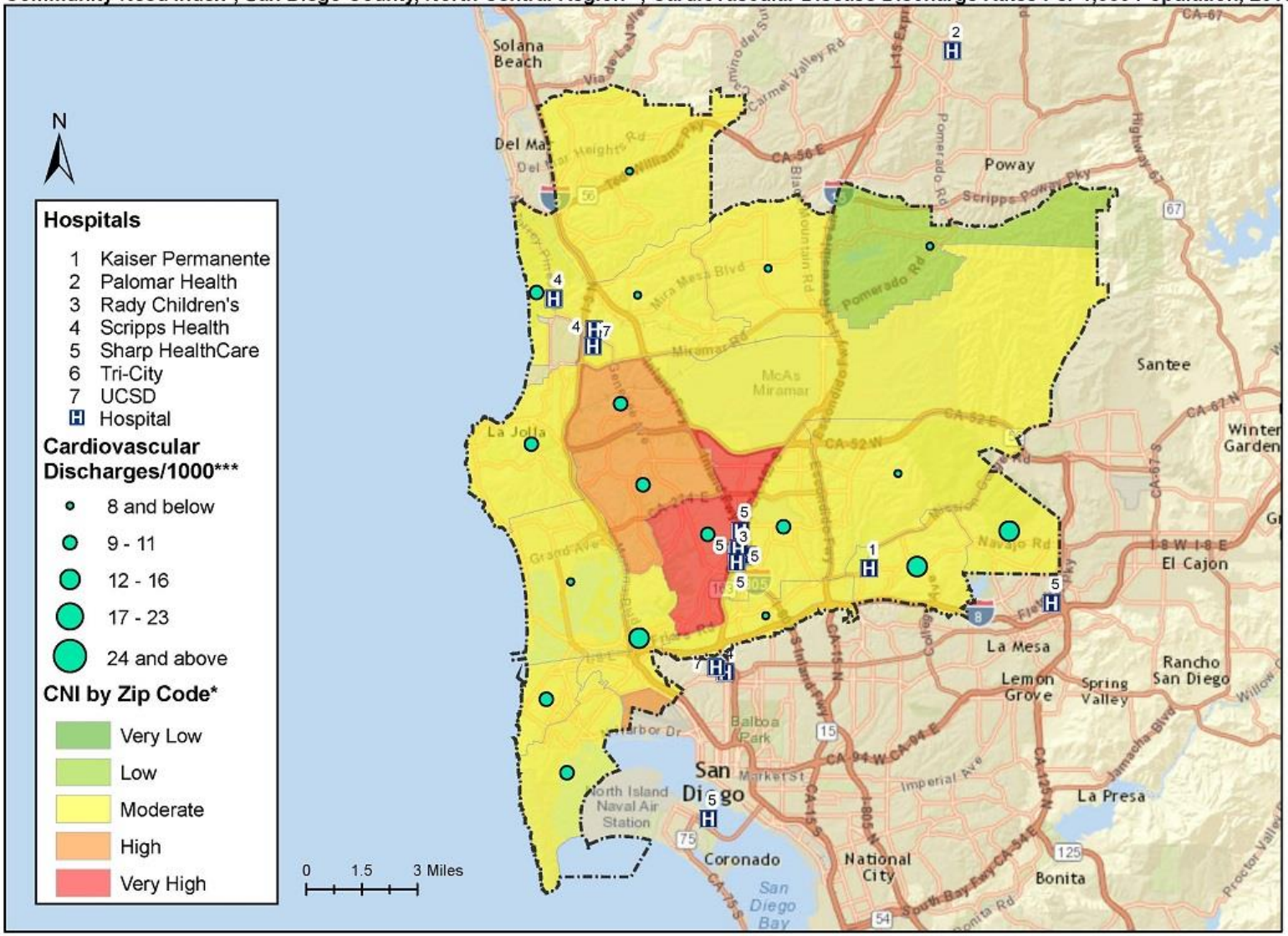
Community Need Index*, San Diego County, North Central Region**, Cardiovascular Disease Discharge Rates Per 1,000 Population, 2013***



Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
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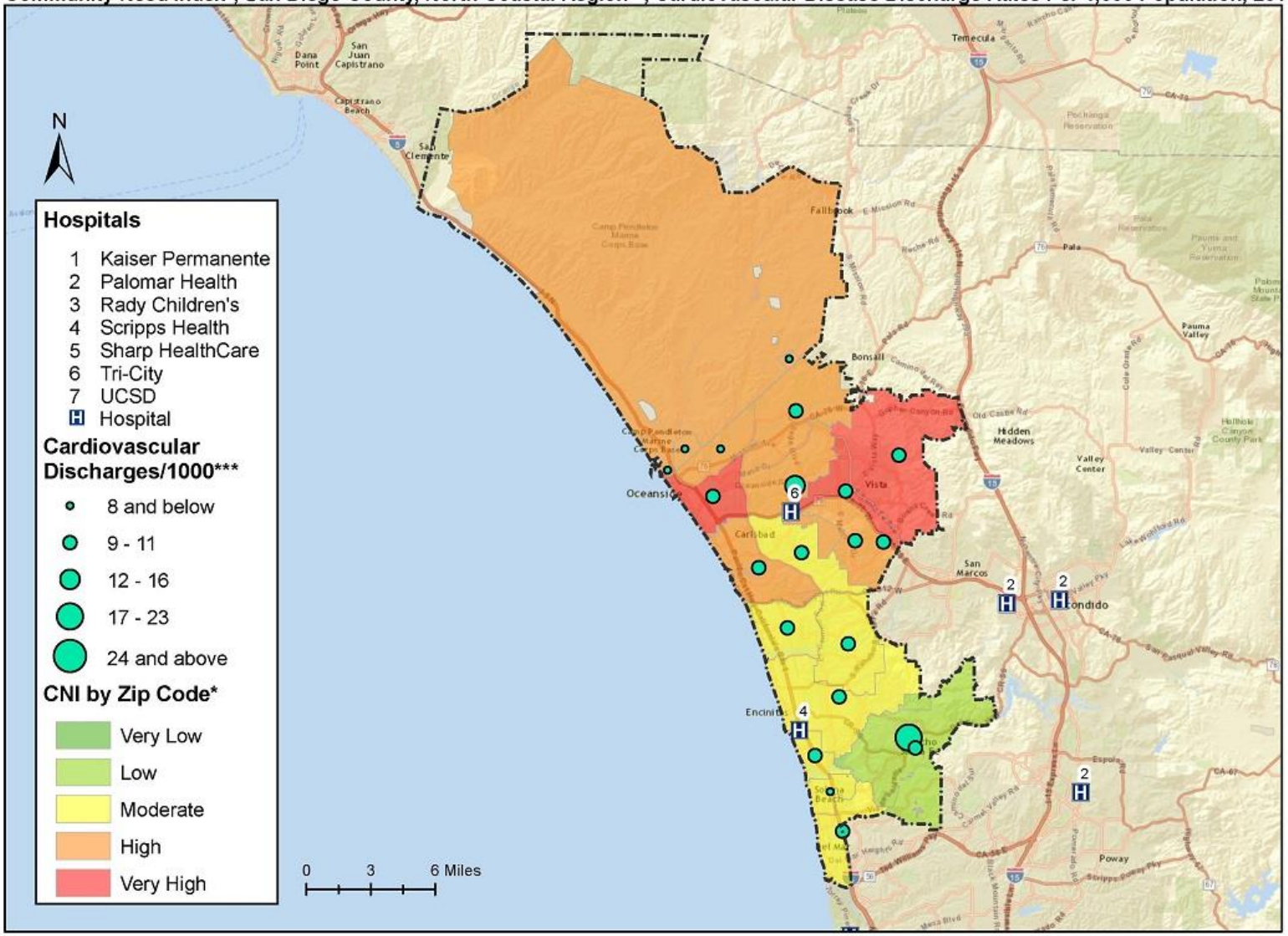
Community Need Index*, San Diego County, North Coastal Region**, Cardiovascular Disease Discharge Rates Per 1,000 Population, 2013***



Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
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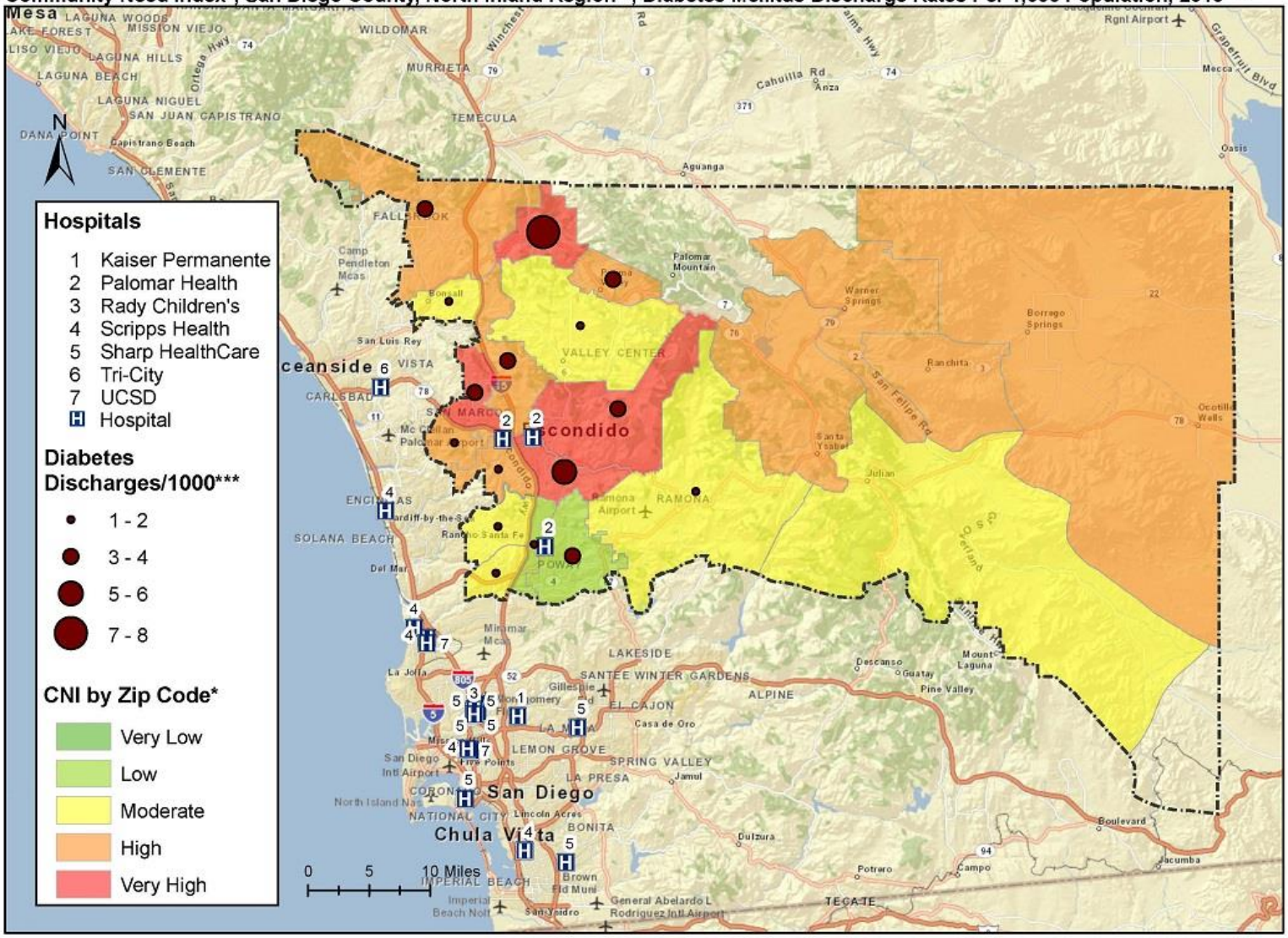
Community Need Index*, San Diego County, North Inland Region**, Diabetes Mellitus Discharge Rates Per 1,000 Population, 2013***



Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
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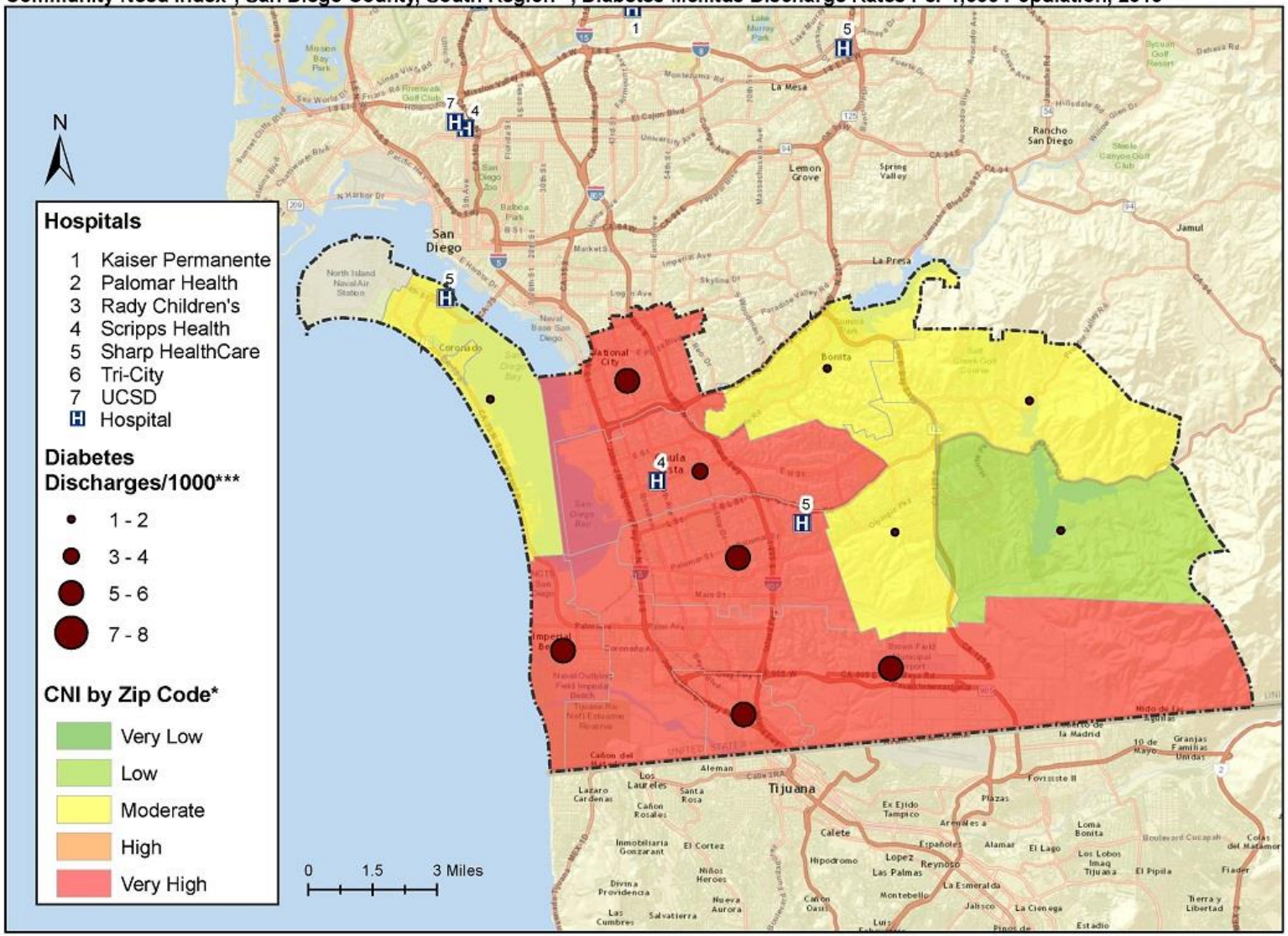
Community Need Index*, San Diego County, South Region**, Diabetes Mellitus Discharge Rates Per 1,000 Population, 2013***



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: Dignity Health
Data Year: 2013
Data Level: ZIP code

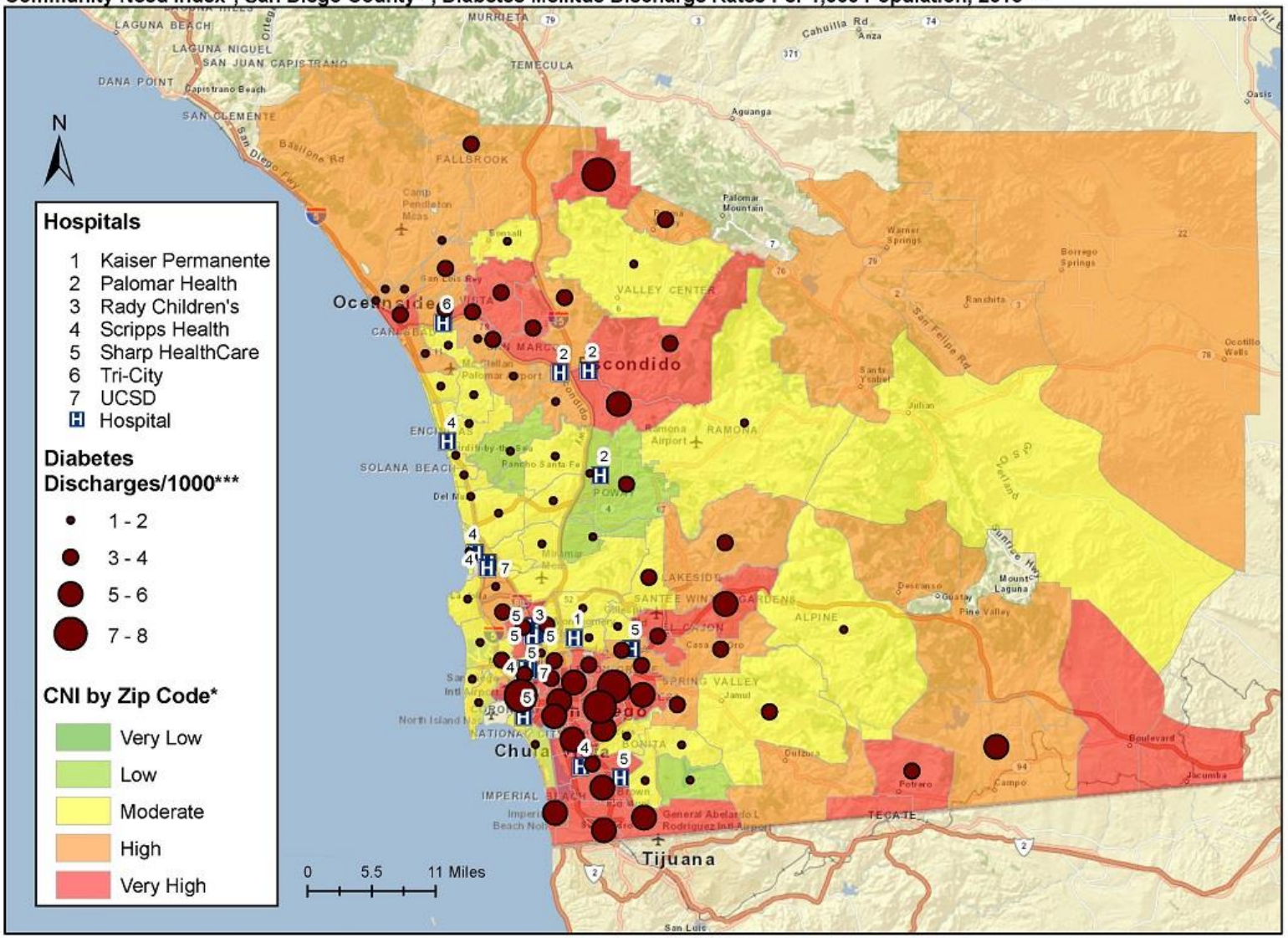
*****Type 2 Diabetes Discharge Rate**
Description: 2013 hospital discharge rate (Inpatient/ED) was determined where *Type 2 Diabetes* was the condition established to be the principal diagnosis, per 1,000 people (population stats: United States Census 2010 population). The following ICD-9 codes were 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 factors:

1. Income
2. Culture and language
3. Educational levels
4. Insurance
5. Housing

Community Need Index*, San Diego County, Diabetes Mellitus Discharge Rates Per 1,000 Population, 2013*****



Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
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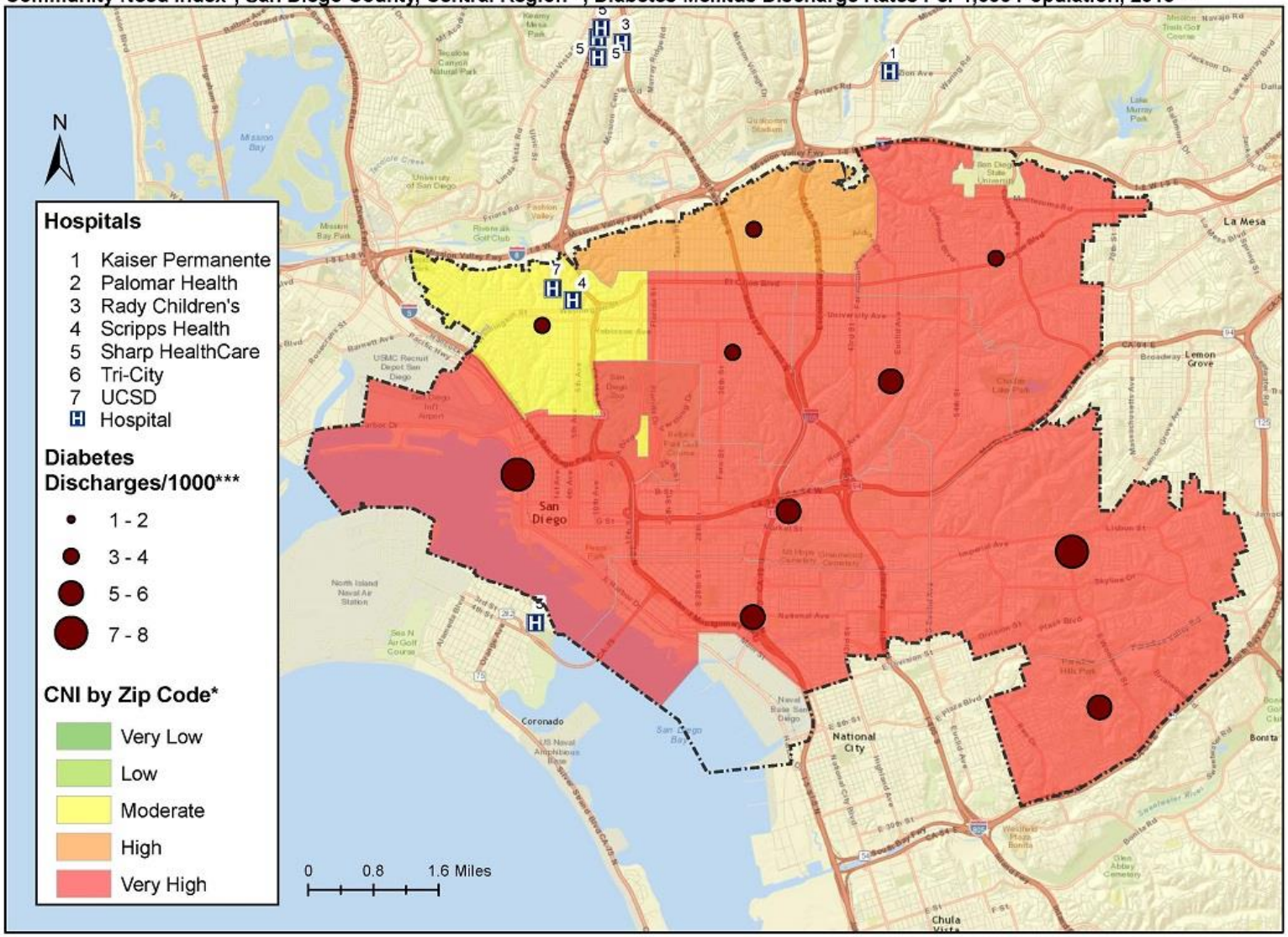
Community Need Index*, San Diego County, Central Region**, Diabetes Mellitus Discharge Rates Per 1,000 Population, 2013***



Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
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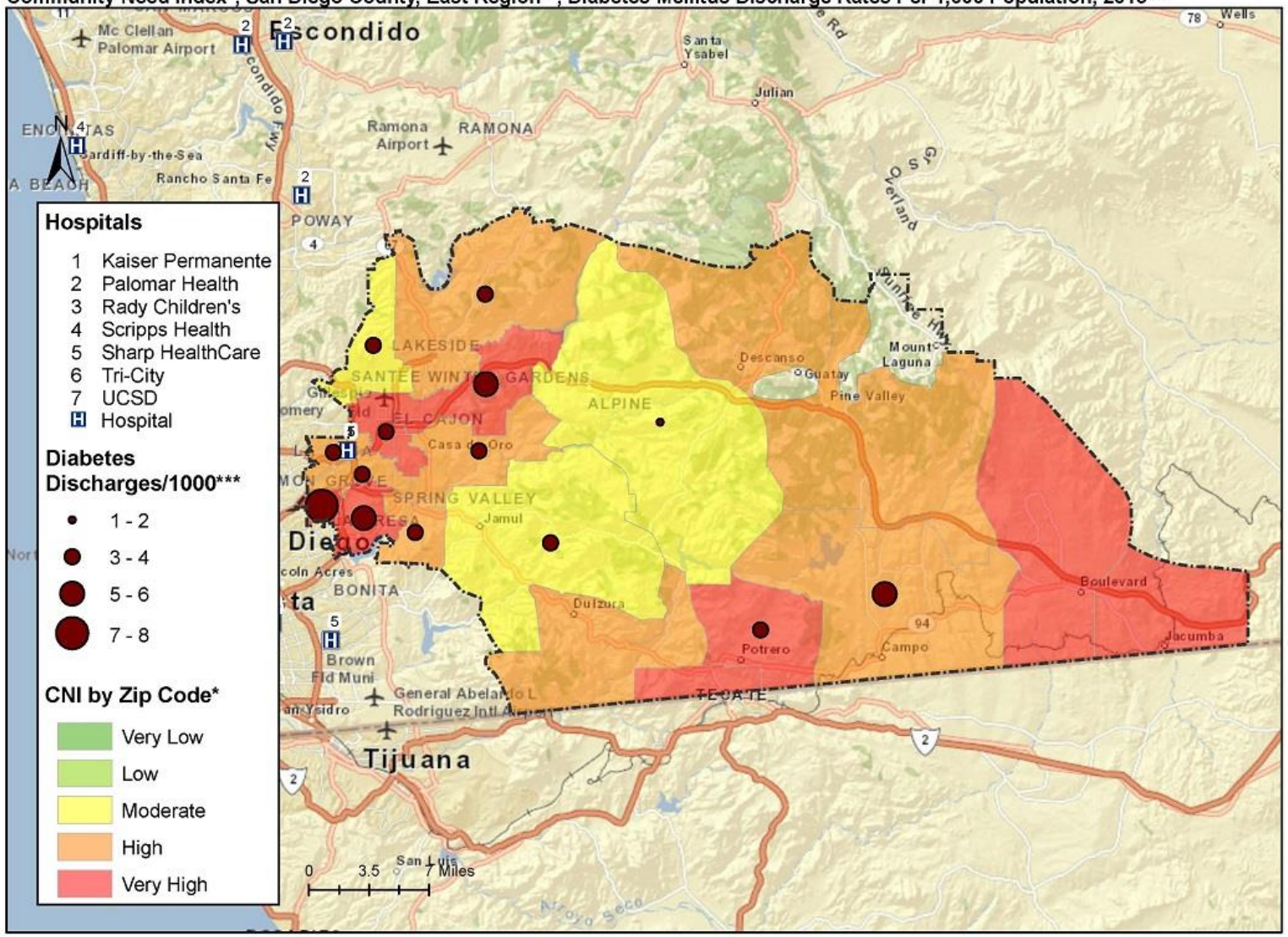
Community Need Index*, San Diego County, East Region**, Diabetes Mellitus Discharge Rates Per 1,000 Population, 2013***



Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
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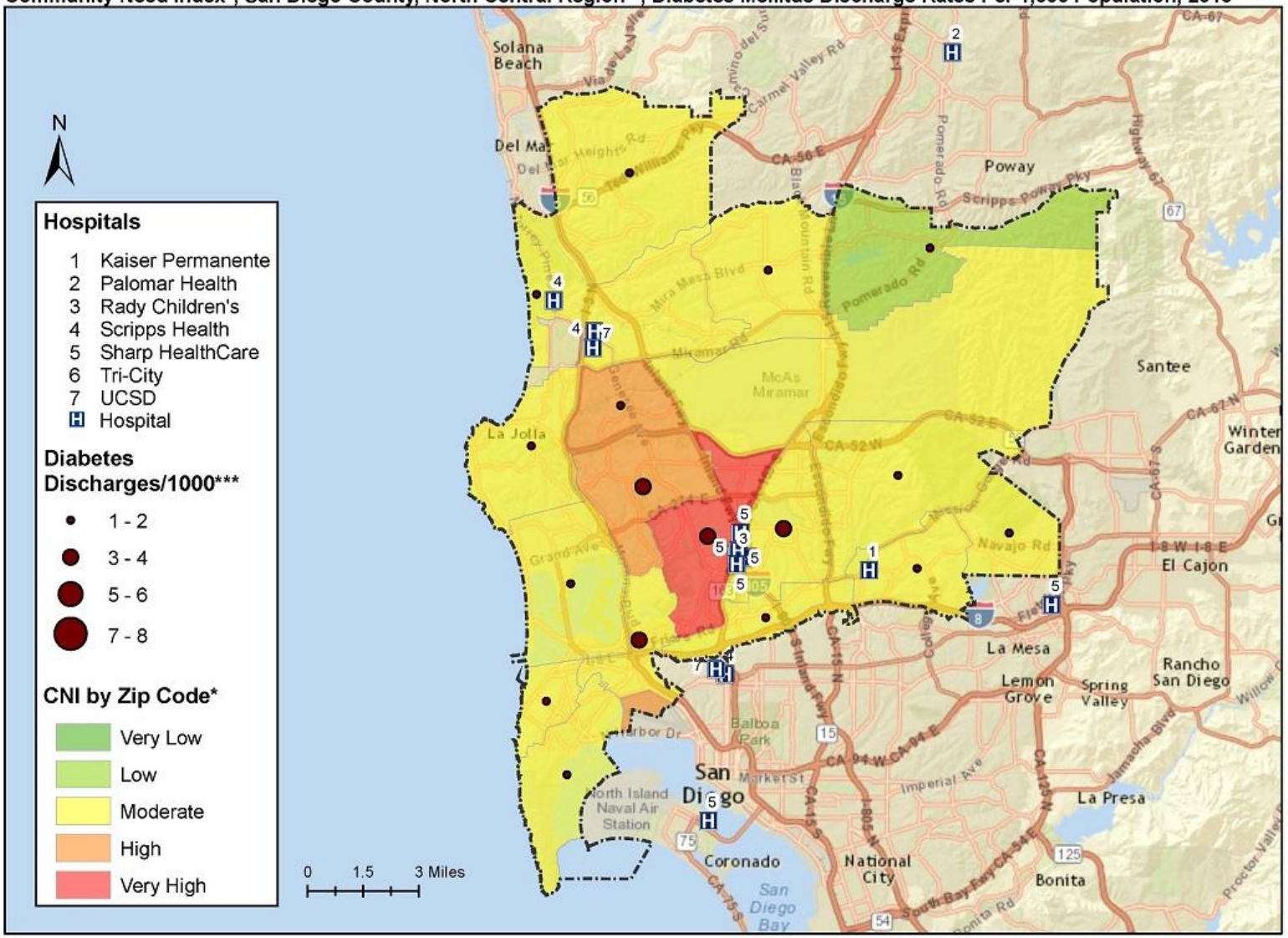
Community Need Index*, San Diego County, North Central Region, Diabetes Mellitus Discharge Rates Per 1,000 Population, 2013*****



Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
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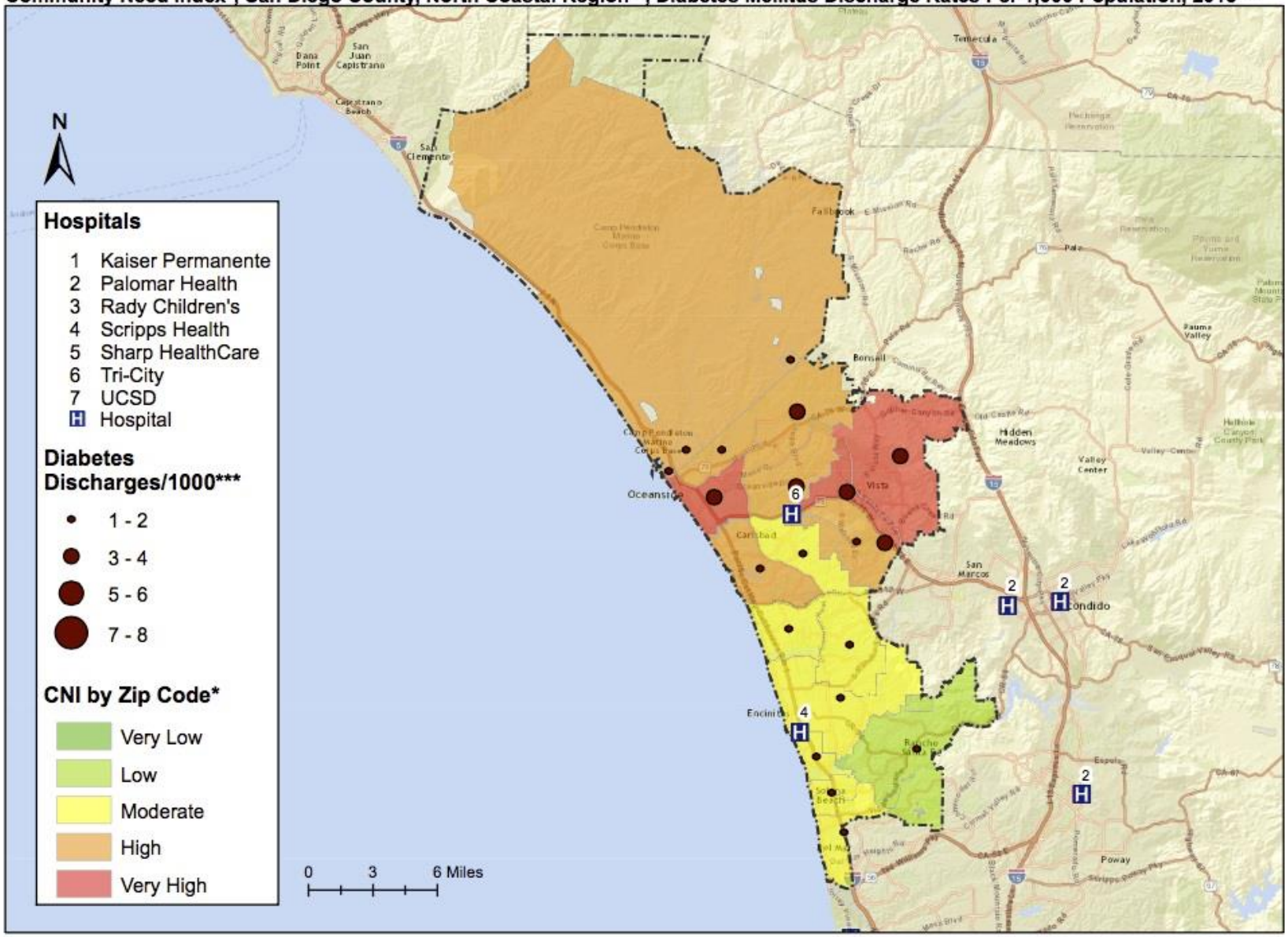
Community Need Index*, San Diego County, North Coastal Region, Diabetes Mellitus Discharge Rates Per 1,000 Population, 2013*****



Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
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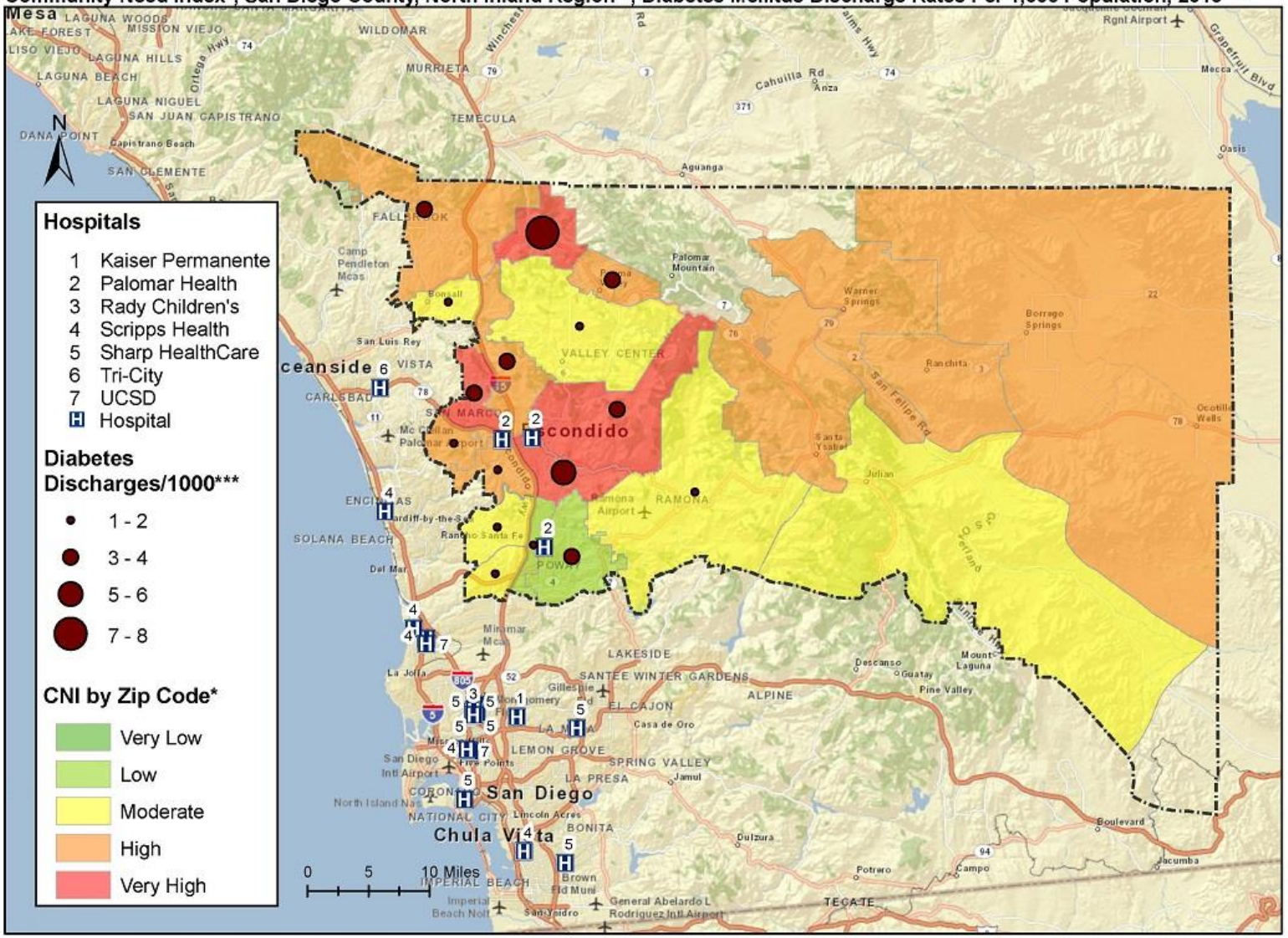
Community Need Index*, San Diego County, North Inland Region**, Diabetes Mellitus Discharge Rates Per 1,000 Population, 2013***



Data Source: *Dignity Health; **SanGIS; ***OSHPD, SpeedTrack, Inc.
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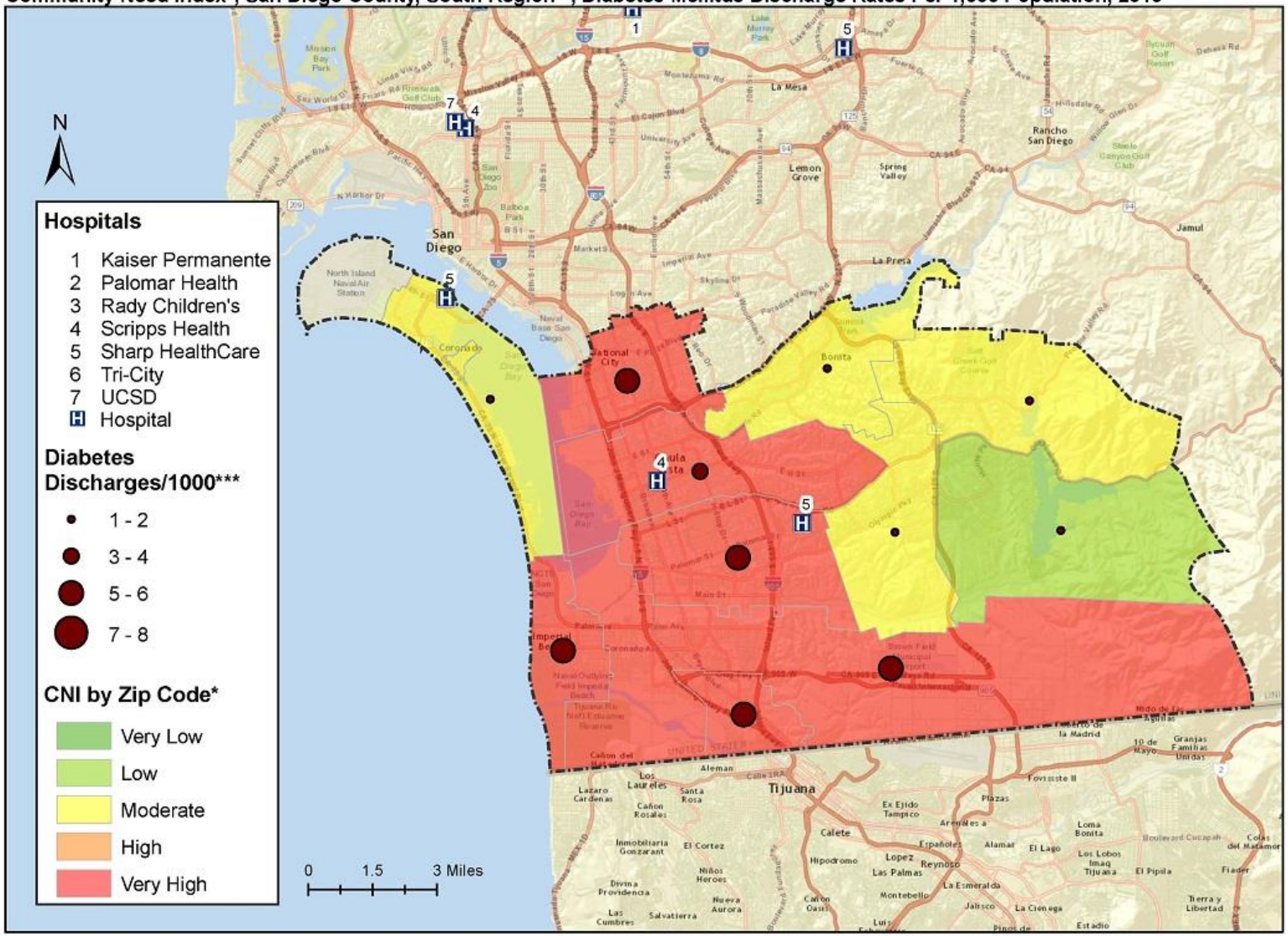
Community Need Index*, San Diego County, South Region**, Diabetes Mellitus Discharge Rates Per 1,000 Population, 2013***



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