2022
SAN DIEGO
CHNA
COMMUNITY HEALTH NEEDS ASSESSMENT

HOSPITAL ASSOCIATION
of San Diego & Imperial Counties

2022 San Diego
Community Health
Needs Assessment

September 19, 2022

To our San Diego Community:

On behalf of HASD&IC and all the participating hospitals and health systems, we want to extend our most sincere thanks to our community partners for their support in compiling the 2022 Community Health Needs Assessment (CHNA). Despite the tremendous challenges and unprecedented struggles during the pandemic, hospitals and health systems, community collaboratives, county public health, community clinics, philanthropic organizations, and community-based organizations created opportunities for us to learn while they continued to serve San Diegans — even in the midst of extreme loss, exhaustion, and uncertainty. To everyone who supported this important work, we extend our heartfelt gratitude.

None of this report would have been possible without collaboration. In fact — for the first time ever — every private hospital, health system, health district, and behavioral health hospital in San Diego County participated in this collective effort to better understand the community's health and social needs. Even as our hospitals were managing multiple surges of COVID-19 hospitalizations, more than 33,000 hospitalized and over 5,400 lives lost since early 2020, they remained committed to engaging and understanding the needs of the communities they serve.

Described in this report are the top needs identified by our community engagement and research, including Access to Health Care, Aging Care & Support, Behavioral Health, Children & Youth Well-Being, Chronic Health Conditions, Community Safety, and Economic Stability. The report also highlights two foundational challenges that are intensifying, growing, and continuing to severely impact those top needs — increasing health disparities and unprecedented workforce shortages and burnout.

The findings attempt to capture the voice of the community as we heard it through focus groups, key informant interviews, interviews regarding access to care, and an online community survey. Both our quantitative research and community engagement confirmed the intersectionality between the seven critical community needs that were identified along with the collective trauma and stigma experienced by many of our community members.

We hope the greater San Diego community can use the report as a resource for further learning, research, grant-writing, grant-making, and to generate discussion around approaches where we can come together and work collaboratively to address the needs of our most vulnerable community members.

Alvarado Hospital Medical Center

Alvarado Parkway Institute Behavioral Health System

Aurora Behavioral Health Care San Diego

Grossmont Healthcare District

Kaiser Permanente – San Diego

Palomar Health

Paradise Valley Hospital/ Bayview Behavioral Health Campus

Rady Children's Hospital - San Diego

San Diego County Psychiatric Hospital

Scripps Health

Sharp HealthCare

Tri-City Medical Center

UC San Diego Health

VA San Diego Healthcare System

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This report is also our invitation to anyone in our community to please reach out and engage with HASD&IC or any of the participating hospitals and health systems. We stand ready to work together to meet the needs of our community through collaborative partnerships and advocacy.

Please contact chna@hasdic.org or visit https://hasdic.org/ to share your thoughts and get engaged. Thank you again for your collective efforts to better understand the needs of San Diegans. We look forward to hearing from you.

Signed by

Tom Gammiere, FACHE
Chair, HASD&IC Board of Directors

Dimitrios Alexiou, FACHE
President & CEO, HASD&IC

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Acknowledgements

2022 CHNA Participating Hospitals and Health Systems

Every private hospital, health system, health district and behavioral health hospital in San Diego participates in the collective effort to better understand the health and social needs of San Diego communities. Participating hospital and health systems supported the Community Health Needs Assessment (CHNA) process through the CHNA Advisory Workgroup, the CHNA Committee, and the HASD&IC Board of Directors.

Community Health Needs Assessment Committee

The CHNA Committee (listed below) designed and implemented HASD&IC 2022 Community Health Needs Assessment process.

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Ari Rojas
Grossmont Healthcare District

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San Diego and Zion

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Jessica Shrader
Tri-City Medical Center

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Thanks to our Community Partners

Thank you to all who participated in this collective effort. HASD&IC acknowledges that our health care and social services sectors have been on high alert through the pandemic and, thus, are exhausted. And yet everyone, without hesitation, answered our requests for data and key informant interviews, organized focus groups, and promoted the CHNA survey. Your collaboration gives the CHNA Committee confidence that this report will be valuable to our partners in San Diego County, including policymakers, health care and social services providers, grant-makers, and other civic leaders.

Thanks | Gracias | Salamat | Shukran

2-1-1 San Diego

Alvarado Hospital Medical Center

Bayview Behavioral Health Hospital and Paradise Valley Hospital

Children's Primary Care Medical Group

Communities Fighting COVID!

Community Resource Center

Community Through Hope

Consumer Center for Health Education and Advocacy (CCHEA)/ Legal Aid Society of San Diego

County of San Diego HHSA

Dreams for Change

El Cajon Collaborative

FACES for the Future Alumni

Full Access and Coordinated Transportation (FACT)

Kaiser Permanente San Diego

Kitchens for Good

MAAC Project

North County LGBTQ Resource Center

North County Lifeline

Palomar Health

PATH San Diego

Pillars of the Community

PsychArmor San Diego

Rady Children's Hospital – San Diego

San Diego American Indian Health Center

San Diego Human Trafficking & CSEC Advisory Council

San Diegans for Healthcare Coverage

San Diego Refugee Communities Coalition

San Ysidro Health Center

Scripps Health

Serving Seniors

Sharp HealthCare

The San Diego LGBT Community Center

Tri-City Medical Center

UC San Diego Health

UC San Diego School of Medicine

Vista Community Clinic/Poder Popular

YMCA San Diego

Special Thanks

Thank you to Price Philanthropies, the San Diego Refugee Communities Coalition, and the Chicano Federation for their invaluable assistance with our research. Their partnership and guidance made it possible for our report to include the voices of 223 community residents representing over 23 different languages spoken by participants, through interviews conducted by community health workers and promotoras.

Thank you to our partners at the County of San Diego Health & Human Services Agency for generously sharing their research and expertise. We are especially grateful to the Community Health Statistics unit which has created numerous incredible research briefs and dashboards which were frequently referenced in this report.

Research Partners

Community Investment Strategies
Patricia Sinay from Community Investment Strategies (CIS) supported the HASD&IC team with qualitative research and report writing. CIS provides strategic visioning and planning, management training, and program implementation services to nonprofits, businesses, governments, and philanthropy. As a Latina immigrant, Patricia specializes in inclusive, cross-sector efforts that strengthen the greater good for individuals, families, and communities.

Institute for Public Health at San Diego State University
For the 2022 CHNA process, HASD&IC contracted with the Institute for Public Health (IPH) at San Diego State University (SDSU). In the last 20 years, the IPH has partnered with over 70 local, state, national and international public and private community-based agencies and organizations representing more than 120 multiple-year contracts with a wide variety of needs and methodologies. The IPH has expertise in qualitative and quantitative community-based research methods. In addition, the IPH has extensive experience in successful community engagement with diverse groups, including non-English speakers. The IPH has been working across cultures and with vulnerable populations for 25 years, including programs with Asian and Pacific Islander communities, African-American communities, East African communities, Latino communities, Native American communities, low-income communities, gay, bisexual, transgender individuals, people living with HIV/AIDS, individuals experiencing homelessness, adolescents who are pregnant or parenting, and survivors of domestic violence and sexual assault, among others. IPH staff have special expertise in conducting culturally competent work and exploring sensitive issues. IPH community engagement efforts have included performing key informant interviews, leading focus groups, facilitating town hall meetings, and conducting patient and provider interviews.

Kaiser Foundation Hospital (KFH)-San Diego and Zion
In addition to the collaborative CHNA process, Kaiser Foundation Hospital (KFH)-San Diego and Zion conducted a separate CHNA. These two processes were intentionally conducted simultaneously with ongoing, continuous feedback between the two groups ; this allowed the groups' efforts to be complementary rather than duplicative. These efforts also enabled HASD&IC and KFH-San Diego and Zion to leverage each other's relationships in the community, resulting in greater community representation and the efficient use of resources. Data were shared between the groups. This innovative and effective partnership resulted in a more robust CHNA for all San Diego County hospitals and health care systems.

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Background

Background

Purpose

The purpose of the CHNA is to identify, understand, and prioritize the health-related needs of San Diego County communities. The results are used to inform and adapt hospital programs and strategies to better meet the health needs of San Diego County communities. In addition, policymakers, civic leaders, nonprofit executives, and community investors are encouraged to use CHNAs in their essential work.

The CHNA responds to IRS regulatory requirements that private not-for-profit (tax-exempt) hospitals conduct a health needs assessment in the community once every three years. Although only not-for-profit 501(c)(3) hospitals and health systems are subject to state and IRS regulatory requirements, the majority of 2022 CHNA collaborative members are hospitals and health systems that are not subject to any CHNA requirements but are deeply engaged in the communities they serve and committed to the goals of a collaborative CHNA.

CHNA Governance

The HASD&IC Board of Directors represents all member sectors and provides policy direction to ensure the interests of member hospitals and health systems are preserved and promoted. The CHNA Advisory Workgroup includes representatives from every participating hospital and health system and provides overarching guidance regarding the research approach and community engagement. The CHNA Committee works closely with the CHNA Advisory Workgroup and reports to the HASD&IC board. The CHNA Committee is responsible for implementing the San Diego CHNA.

Building on the San Diego 2019 CHNA

The 2022 CHNA builds upon the research and findings from Phase 1 and Phase 2 of the San Diego 2019 CHNA.

2019 CHNA: Phase 1

The figure at the right summarizes the 2019 CHNA findings. The highest priority community health needs in San Diego County (in alphabetical order by social determinants of health [SDOH] or health conditions) can be found at the center. The figure illustrates the interactive nature of SDOH and health conditions — each impacts the other. In addition to the top community health needs that were identified, the 2019 CHNA findings describe the underlying theme of stigma and the barriers it created. The full 2019 CHNA report can be found on the HASDIC website.

2019 Findings: Top 10 Community Health Needs

SOCIAL DETERMINANTS OF HEALTH

Access to Health Care
Community & Social Support
Economic Security
Education
Homelessness & Housing Instability
Unintentional Injury & Violence

Aging Concerns
Behavioral Health
Cancer
Chronic Conditions

STIGMA

HEALTH CONDITIONS

2019 Community Health Needs Assessment: Phase 2

Phase 2 was designed to follow up on HASD&IC's 2019 CHNA, which was completed in July 2019.

An online survey was distributed via email to community-based organizations, social service providers, resident-led organizations, federally qualified health centers, governmental agencies, and hospitals and health systems that serve a diverse array of people in San Diego County. The survey was open for approximately five weeks — from February 12 through March 19, 2020. Since survey participants were able to forward the email to their colleagues the total response rate was unable to be calculated. A total of 124 respondents completed the survey.

The purpose of the survey was to determine if HASD&IC's 2019 CHNA findings were accurate, understand how stigma affects health, and explore recurring themes that emerged during our community discussions, including access to health care, immigration, and public charge. Phase 2 included a survey to gather feedback on the 2019 CHNA findings.

NOTE: The 2019 CHNA Phase 2 Survey was developed and disseminated before the COVID-19 pandemic took hold in our region. The CHNA Committee recognizes that communities facing inequities are experiencing unprecedented challenges, and the devastating increase in needs is not captured in our 2019 Phase 2 findings.

Phase 2 Survey Participants and Finding

40%	**16%**	**11%**
Community- based organizations	Hospitals and Health Systems	Community residents

Nearly 92% of respondents (114 out of 124) agreed that the health needs identified in the 2019 CHNA represent the top health needs of communities facing inequities within San Diego County.

Summary of Participant Responses to Key Questions

Access to Health Care

Question: *Please identify changes you have observed in community members' ability to access health care. Please select all that apply.* (n=102)

Unable to access health care	56%
Reluctant or refusing to apply for medical...	45%
Unable to follow care plan	43%
Avoiding or refusing to access health care	42%
Withdrawing from health care coverage	28%
I have not seen any changes	11%
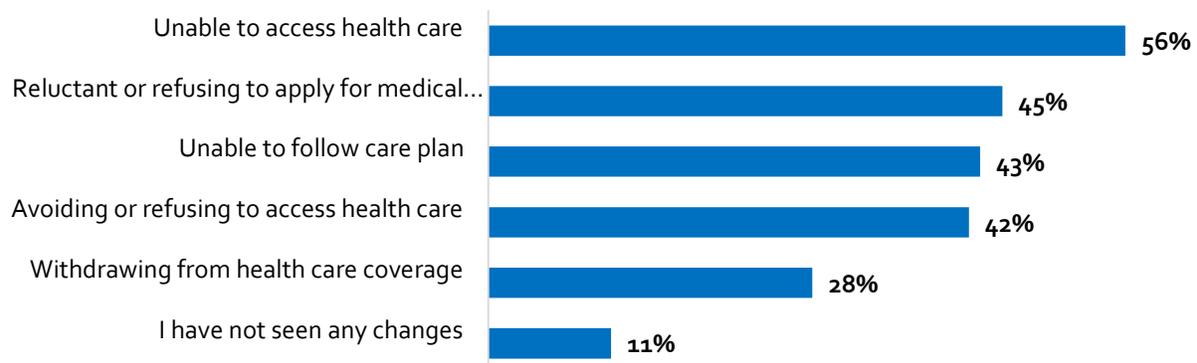
Observation of Stigma in Health Care Settings

Question: *In what ways do you see stigma appear in health care settings?* (n=61)

Respondents' feedback to this open-ended question was evaluated using the Modified Social-Ecological Model of Transgender Stigma & Stigma Interventions to categorize and elucidate the themes of stigma

Individual	• Avoidance, concealment, internalization
Interpersonal	• Health care discrimination, rejection
Structural	• Access to care, lack of provider education and training, language and cultural barriers

Immigration and Access to Health Care Observation

Question: *Are individuals in your community having difficulty accessing health care due to their immigration status?* (n=108)

Yes 58%
No 12%
I do not know 30%
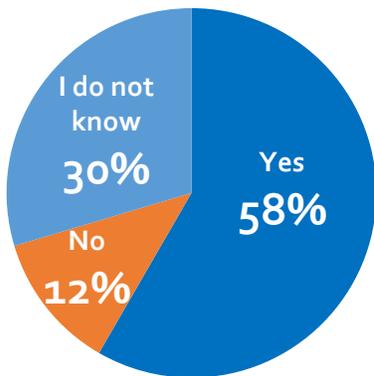
Hospital Patient Financial Service Requirements

Question: *San Diego hospitals offer financial assistance programs and can help answer questions if you or your patients/clients are struggling to pay or understand a hospital bill. Did you know San Diego hospitals offer these services?* (n=106)

No 33%
Yes 67%

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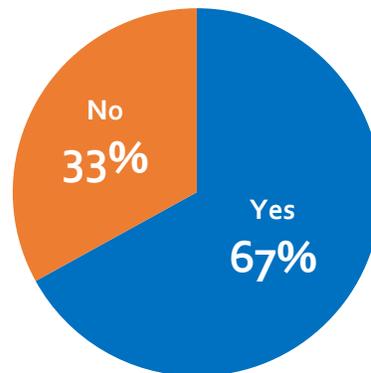
Executive Summary

Executive Summary

Introduction & Background

The CHNA aims to identify, understand, and prioritize the health-related needs of San Diego County communities. The results of the CHNA are used to inform and adapt hospital programs and strategies to better meet the health needs of San Diego County communities. In addition, policymakers, civic leaders, non-profit executives, and community investors are encouraged to use CHNAs in their essential work. Furthermore, the CHNA responds to IRS regulatory requirements that private not-for-profit (tax-exempt) hospitals conduct a health needs assessment in the community once every three years. Although only not-for-profit 501(c)(3) hospitals and health systems are subject to state and IRS regulatory requirements, the majority of 2022 CHNA collaborative members are hospitals and health systems that are not subject to any CHNA requirements but are deeply engaged in the communities they serve and committed to the goals of a collaborative CHNA.

Conducting a CHNA during a pandemic brought challenges to both planning and implementation. We did not see our partners at the usual community meetings and needed new strategies to ensure strong connections with community members and community-based organizations. In addition, the community's needs evolved continuously over the past few years. During the initial shutdown in March 2020, their needs differed from the community's needs as we completed the final interviews in May 2022.

Methodology

The CHNA, conducted every three years, is facilitated by HASD&IC, with the budget and work plan approved by the HASD&IC Board of Directors. In the spring 2021, the HASD&IC Board of Directors approved plans to expand participation in the 2022 CHNA process to include every private hospital, health system, health district, and behavioral health hospital in San Diego in the collective effort to better understand the health and social needs of San Diego communities.

There are social drivers of health and equity at all levels: individual, community, and structural. Historical and systemic inequities disproportionately impact vulnerable populations, including people of color, socially disadvantaged groups, and those living in poverty. The CHNA Committee completed an extensive review of national best practices and evidence-based frameworks to develop a research approach to health equity. The health equity framework below describes the CHNA Advisory Workgroup and CHNA Committee's shared values and commitment to understanding the social drivers of health and equity through our collective research, analysis, and community engagement.

Health Equity Framework

Equity

We commit to research and community engagement strategies that purposefully seek to quantify and describe inequities that disproportionately impact our disadvantaged populations due to structural components.

Inclusion

We commit to meaningful engagement with community organizations, community members, and leaders who serve diverse populations. We understand the importance of sharing a space for listening and honoring perspectives of those with lived experiences.

Empathy

We commit to employing a trauma-informed approach that works to break stigma by creating safe and meaningful opportunities to engage community members and community partners.

Responsibility

We commit to using evidence-informed research methods, analyzing the best available data, and making it available to community members and community partners.

Accountability

We commit to sharing the results of our research as well as our plans to address the findings with everyone who participates.

Research Methods and Approach

To gain a deep and meaningful understanding of the health-related needs of San Diego County communities, two primary methods were employed in the 2022 CHNA:

- Quantitative analyses of existing publicly available data were conducted to provide an overarching view of critical health issues across San Diego County.

- Qualitative information was gathered through a comprehensive community engagement process to understand people's lived experiences and needs in the community.

The CHNA Committee reviewed the feedback and data to prioritize the top health needs in San Diego County. Please see the figure below for more information on the CHNA process.

2022 Community Health Needs Assessment Process Map

2019 CHNA FINDINGS

HEALTH EQUITY FRAMEWORK

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

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

Community Partner Guidance
Conversations with community partners to discuss emergent COVID-19 community needs and identify key areas of focus

Demographics
Age, ethnicity, gender, geography, health coverage status, income, language, race, sex

Online Community Survey
Community members, community-based organizations, community clinics, hospitals and health systems, grantmaking organizations, government employees, and elected officials

Community Data & Assessments
Reports, dashboards, assessments, and analysis compiled or conducted by community-based organizations, coalitions, and researchers in San Diego County

Promotora & Community Health Worker Outreach & Feedback
Focus group participation and interviews of community members

Socioeconomic Data & Indexes
Conditions in the places where people live, learn, work & play affect a wide range of health risks and outcomes

Key Informant Interviews & Focus Groups
Community members, leaders, and health experts representing the community, community-based organizations, and hospitals

Hospital & Health System Utilization
Emergency department discharges and inpatient hospitalizations

Public Health Services Input
Interview & collaboration with County of San Diego Health and Human Services Agency, Public Health Services

County of San Diego Data
Data and analysis from Health and Human Services Agency, Public Health Services including Community Health Statistics, Health Equity Dashboards, Morbidity & Mortality Data

Identification & Prioritization of 2022 Community Needs

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Quantitative Data Collection and Analysis

Quantitative data were used for three primary purposes:

- Describe the San Diego County community
- Plan and design the community engagement process
- Facilitate the "prioritization process" — identifying the most serious community health needs of San Diego County communities facing inequities

Quantitative data include:

- California's Department of Health Care Access and Information limited data sets, 2017-19 SpeedTrack[1]
- [Community Need Index (CNI)[2]](#)
- [Public Health Alliance of Southern California Healthy Places Index](#)
- National and statewide data sets were analyzed, including San Diego mortality and morbidity data, and data related to social determinants of health.

The HPI and the CNI were used to identify the most under-resourced geographic communities. This information helped guide the community engagement process, including selecting communities from which to solicit input and developing relevant and meaningful engagement topics and questions.

Data from the County of San Diego Health and Human Services Agency, including the following reports and dashboards, were also used. A partial list is below. Additional information can be found in **Appendix F**.

Reports	Community Health Statistics Dashboards
County of San Diego Community Health Statistics	LGBTQ Health and Well-Being Dashboard
Health Disparities Executive Summary Report[3]	Health Equity Dashboard Series: Racial Equity Dashboards
Racial Equity: Framework and Outcomes Brief	
San Diego County Self-Sufficiency Standard, Household with Two Adults, One Preschool-Age Child, and One School-Age Child, 2021	San Diego County Self-Sufficiency Standard Dashboard
Overdose Data to Action (OD2A)	COVID-19 in San Diego County

Community Engagement

The goal of the community engagement process was to solicit input from a wide range of stakeholders so that the sample was as representative as possible of those facing inequities in San Diego County. Input from the community was gathered through the following efforts:

- Working with community health workers to conduct interviews with community members
- Conducting focus groups and key informant interviews with community members, community health workers, community-based organizations, service providers, civic leaders, and health care leaders (conducted in collaboration with Kaiser Foundation Hospital (KFH)-San Diego)
- Conducting focus groups and key informant interviews with hospital and health system clinicians, case managers, social workers, and executive leaders
- Distributing an online survey to community members, hospital staff, community-based organizations, federally qualified health centers, and local government staff

Community Engagement Participants

16
Focus Groups

+

26
Key Informant Interviews

+

502
Survey Responses

+

223
CHW & Promotora Interviews

= total of **841** individuals participated in the 2022 Community Health Needs Assessment

2022 Top Community Needs

Findings

Through the prioritization process described in the methodology section, the CHNA Committee identified the most critical community needs within San Diego County, listed below in alphabetical order:

- Access to Health Care
- Aging Care & Support
- Behavioral Health
- Children & Youth Well-Being
- Chronic Health Conditions
- Community Safety
- Economic Stability

HEALTH DISPARITIES

STIGMA

TRAUMA

WORKFORCE

Access to Health Care
Aging Care & Support
Behavioral Health
Children & Youth Well-Being
Chronic Health Conditions
Community Safety
Economic Stability

The graphic above represents the **top identified community needs,** the *foundational challenges,* and the *key underlying themes* revealed through the 2022 CHNA process. The needs identified as the most critical for San Diegans are listed in the center of the circle in alphabetical — not ranked — order. The blue outer arrows of the circle represent the negative impact of two foundational challenges — health disparities and workforce shortages — which greatly exacerbated every identified need at the center of the circle. The orange bars within the outer circle illustrate the underlying themes of stigma and trauma — the quiet yet insidious barriers that became more pervasive during the pandemic.

The graphic demonstrates how each component of the findings — the top identified community needs, the foundational challenges, and the key underlying themes — impacts one another. In particular, the foundational challenges and underlying themes interact with each other to amplify the identified community needs as well as disrupt efforts that advance health equity and improve community well-being.

Foundational Challenges

In addition to identifying the top community needs, the CHNA Committee also recognized two foundational challenges that are intensifying the growing severity of every need — increasing health disparities and unprecedented workforce shortages and burnout.

Health Disparities

The pandemic laid bare the truth that even in ordinary times, some communities fare much worse than others, and their health suffers more as a result. These health disparities are not new; they have been proven by

decades of research[4] and reflect the outcomes of a wide array of variables, including enduring structural and systemic inequities rooted in racism and discrimination. In every conversation, the inequitable outcomes faced by certain communities were consistently emphasized.

At the start of the pandemic, front-line workers had less ability to stay home and faced a disproportionate risk of exposure to COVID-19, and therefore experienced disproportionately higher mortality rates compared to individuals with different occupations. These front-line workers were also disproportionately people of color. In addition, the health of San Diegans who were vulnerable before the pandemic — such as people experiencing homelessness, isolated seniors, LGBTQ+ youth, and children with special needs — deteriorated more acutely as they lost access to critical services and faced new barriers to their safety and economic stability.

Workforce Shortages

Community engagement participants in previous CHNAs often mentioned the need for more health care providers, mostly with a view toward bolstering workforce pipelines. In our 2022 CHNA focus groups and interviews, workforce shortages were consistently top of mind.

Across nearly every sector of the economy, the workforce is facing extraordinary exhaustion, trauma, and burnout. The words "heartbreaking," "frustrating," and "overwhelmed" were frequently repeated by our 2022 CHNA community engagement participants working in the health and social service sectors. Clinical and social work staff at hospitals, community clinics, community-based organizations, and government agencies all shared the same feeling of helplessness — there is no workforce to draw from, and no resources available to meet the intensifying needs they are passionately working to address.

Key Underlying Themes

Stigma

As in our 2019 CHNA findings, the underlying theme of stigma and the barriers it creates arose across our community engagement efforts in 2022. Stigma impacts the way people access needed services (CalFresh, Medi-Cal, other economic support) that address the social determinants of health. This consequentially impacts the ability of people to improve and successfully manage health conditions.

Community engagement participants expressed concerns about the impact of stigma in relation to specific populations, including LGBTQ+ communities, people experiencing homelessness, people of color, seniors, Medi-Cal beneficiaries, and survivors of domestic violence and human trafficking. Stigma was also discussed in relation to specific health conditions such as behavioral health, cancer, diabetes, and obesity. The existing stigma that had prevented community members from accessing needed services led to even more dangerous outcomes amidst the pandemic, as people became more desperate and felt they had fewer options.

Trauma

In addition, an underlying theme of [trauma](#) was shared across community engagement efforts. The impact of trauma has been demonstrated to increase health disparities and inequities. Community engagement participants noted trauma as a nearly universally shared experience that added intensity to the identified community needs.

[Trauma and vicarious trauma](#) were also cited as factors that contributed to compassion fatigue and workforce burnout. Our community has experienced trauma both at work and at home, and consequently, there is often no escape and no downtime from traumatic experiences. This shared trauma interacts with every aspect of the identified community needs. Traumatized community members are seeking assistance from health care providers and community-based organizations who themselves have experienced ongoing trauma since the start of the pandemic.

Community Voice and Experiences

The findings attempt to capture the voice of the community as we heard it through focus groups, key informant interviews, interviews regarding access to care, and an online survey. Both our quantitative research and community engagement confirmed the intersectionality between the seven critical community needs that were identified.

When discussing our findings, we will highlight how they may differ for San Diegans based on their experiences. These experiences may include homelessness, immigration status, gender and sexual orientation, age, poverty, or connections to the military.

Community Recommendations

During the Access to Health Care interviews and in the Online Community Survey, we asked, "What are the most important things that hospitals and health systems could do to improve health and well-being in our community?" Overwhelmingly, respondents agreed that there is a critical need to help patients navigate available services that will improve their health and well-being. In both the interviews and the surveys, options that centered around improved patient care rose to the top.

Most responses fell into four categories: navigation and support, culturally appropriate, workforce development, and community collaboration.

Provide Navigation and Support to Patients	Connect patients to services that will improve their health and well-being
	Help patients understand and use health coverage
	Help patients coordinate their health services
	Help patients apply for health coverage or other benefits
	Help patients pay for their health care bills
Provide Culturally Appropriate Care to Patients	Ensure that a patient's care meets their needs
	Provide culturally appropriate health care in more languages
	Train hospital staff on biases
Workforce Development	Diversify the health care workforce
	Hire more doctors, nurses, and other health care professionals
	Create more health care job opportunities and career pathways
Community Collaboration	Collaborate with community groups and schools
	Provide health education

Next Steps

Hospitals and health systems that participated in the HASD&IC 2022 CHNA process have varying requirements for next steps. Private, not-for-profit (tax exempt) hospitals and health systems are required to develop hospital or health system community health needs assessment reports and implementation strategy plans to address selected identified health needs. The participating health districts and district health systems do not have the same CHNA requirements but work very closely with their patient communities to address health needs by providing programs, resources, and opportunities for collaboration with partners. Every participating hospital and health care system will review the CHNA data and findings in accordance with their own patient communities and principal functions and evaluate opportunities for next steps to address the top identified health needs in their respective patient communities.

The CHNA report will be made available as a resource to the broader community and is intended to serve as a useful resource to both community members and health care providers to further community-wide health improvement efforts. HASD&IC and the CHNA Committee are proud of their collaborative relationships with local organizations and are committed to regularly seeking input from the community to inform community health strategies. The CHNA Committee is in the process of planning Phase 2 of the 2022 CHNA, which will include gathering community feedback on the 2022 CHNA process and strengthening partnerships around the identified community needs.

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Community Description

Community Description

In San Diego County, one can easily see the desert wildflowers, head to the mountains for apple pie, and end the day watching the sunset while touching the Pacific Ocean. And suppose that is not enough, one can hike along the U.S.-Mexico border, stop and eat fish tacos, visit the best zoo in the world at Balboa Park, and complete the day with local microbrews and a toast to the new Marine recruits at Camp Pendleton on the county's northern border.[5]

The San Diego region is known for its 70 miles of beautiful beaches, perfect weather, and innovative economy. Many do not realize how large and diverse the county is demographically and geographically. San Diego is home to 3.4 million people (about the population of Oklahoma), is the second-largest county in California, and is the fifth-most populous in the U.S. The region includes 18 incorporated cities and expansive unincorporated areas.

Most counties in Southern California have fluid borders with their neighbor counties, allowing their residents to work, live, and play seamlessly across county boundaries. San Diego County has concretely defined boundaries, including Marine Corps Base Camp Pendleton's 125,000 acres to the north, the Pacific Ocean to the west, Mexico to the south, and extensive mountains and deserts to the east. Though San Diego County is the size of Connecticut, those who live here promote its small-town vibe due to the diverse networks of tight-knit neighborhoods and communities. These networks have been critical sources of information, support, and resources during the pandemic.

San Diego's economy is an hourglass with a substantial number of highly skilled and high-paying jobs at the top and low-paying service jobs at the bottom with extraordinarily little mobility between the two bubbles. According to the San Diego Economic Development Corporation (SDEDC), "It is projected that 84 percent of new jobs created between now and 2030 will also require post-secondary education. Latinos represent one-third of San Diego's total population but only 15 percent of degree holders." [6]

San Diego County has been home for many and a waypoint for others. It is built on the traditional lands of the Kumeyaay nation and has a history of being a destination for explorers and missionaries. Since the early 1900s, it has been the first home for many immigrants and refugees looking for safe refuge and opportunities for their families in the U.S.

A note on language

We understand that language is fluid and constantly evolving and often means different things to different people. We believe that individuals and communities define themselves for themselves. We intend to be as inclusive as possible in our language and acknowledge that we may falter. Our mistakes should be a starting point for discussion and understanding. We will use person-first language to reinforce the concept that someone is a person first. To be consistent, HASD&IC will use the following terms in this report:

Asian/Pacific Islander, API or AAPI, refers to people from East Asia, Southeast Asia, the Indian Subcontinent, Hawaii, Samoa, Guam, Fiji, and other South Pacific Islands or people of Asian/Pacific Islander descent.

Foreign-born refers to anyone who is not a U.S. citizen at birth, including persons who have become U.S. citizens through naturalization.

Gender is a multidimensional construct that links gender identity, which is a core element of a person's individual identity. Gender expression is how a person signals their gender to others through their behavior and appearance (such as hairstyle and clothing), and cultural expectations about social status, characteristics, and behavior that are associated with sex traits.

Latino includes individuals and communities from Mexico, Central and South America, and the Caribbean. We understand that others may use Latinx, Latino/a, Latine, and Hispanic.

LGBTQ+ is an umbrella term in reference to a broad community that includes lesbians, gay, bisexual, transgender, queer, intersex, and asexual people.

We use **Native American, tribal communities, and indigenous** interchangeably.

People or communities of color refer to individuals or communities who do not identify as white.

Sex is a multidimensional construct based on a cluster of anatomical and physiological traits that include external genitalia, secondary sex characteristics, gonads, chromosomes, and hormones.

What makes San Diego County Unique

The demographics included in this report are just a sampling of the incredible data available through the County of San Diego Community Health Statistics Unit, under the Health and Human Services Agency (HHSA) Public Health Services Division. Much more data are available online. The demographic profiles are a compilation of information relating to the demographic characteristics of specific populations in San Diego County. Each profile contains demographic data for each HHSA region and subregional area, including age, gender, race/ethnicity distributions, school enrollment, educational attainment, income, occupation, housing, and other social/economic data. Many of these factors have been linked to the roots of

2019 Demographic Profiles San Diego County, Community Health Statistics Unit Published May 2021
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https://www.sandiegocounty.gov/hhsa/programs/phs/community_health_statistics/

health disparities. The purpose of the demographic profiles is to provide detailed information about the characteristics of the people living in San Diego County. It is designed to help HHSA staff in each of the agency's regions and other local organizations — including Live Well San Diego-recognized partners — identify and prioritize needs within their communities. These profiles are made available to the public health community and policymakers to better understand and manage the health and well-being of the residents of our county.

Important Tribal Communities: The San Diego region is home to 18 Native American reservations represented by 17 tribal governments — the most in any county in the United States. There are an estimated 20,000 Native Americans in San Diego, with only a small percentage living on reservation land.[7]

Vibrant Immigrant and Refugee Communities: According to the 2020 census, 23% of people living in San Diego County are foreign-born. Nearly 40% of respondents spoke a language other than English at home.[8] The Annie E Casey Foundation's Kids Count Data Center found that California — with 46% — has the largest share of children in immigrant families and only 5% of California children are foreign-born.[9] Of the new refugees who arrived in California between 2009 and 2017, 40% resettled in San Diego County. Currently, 87% of the foreign-born population in San Diego comes from countries in Latin America (44%) and Asia (43%).[10] In the past five years, the immigrant population in San Diego has changed, with the fastest-growing population coming from five Middle Eastern and African countries: Kenya, Iraq, Nigeria, Sudan, and Syria.[11] Fear persists among these foreign-born communities amid xenophobia and anti-immigrant political rhetoric.[12]

Immigrants, refugees, and other communities of color suffered disproportionately from the COVID-19 pandemic in terms of lives lost, hospitalizations, rate of illness, and economics.[13] A study by UCSD found that in the City of San Diego one-third of essential workers in health care and food service were immigrants.[14] Adding to the risk, during the peak of the pandemic, the Partnership for Advancement of New Americans found that
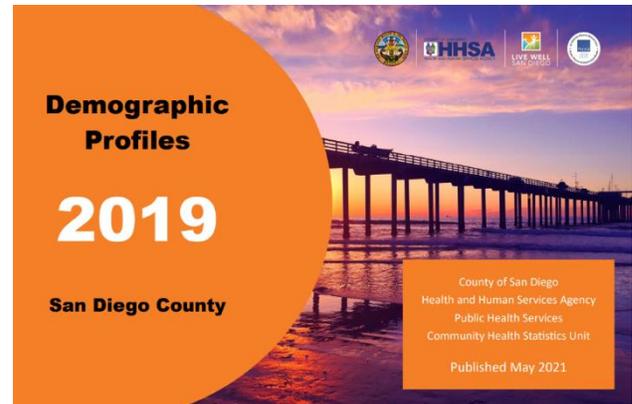
65% of refugees were living in overcrowded homes and experiencing an increase in food insecurity, job loss, and household violence.[15]

Unfortunately, because of how the census data are collected, we do not clearly understand how many San Diegans are Middle Eastern, African, or Southeast Asian. This information is critical to understanding the needs of San Diego's diverse communities.[16]

Language Spoken at Home Among Population 5 Years and Older by HHSA Region, 2019
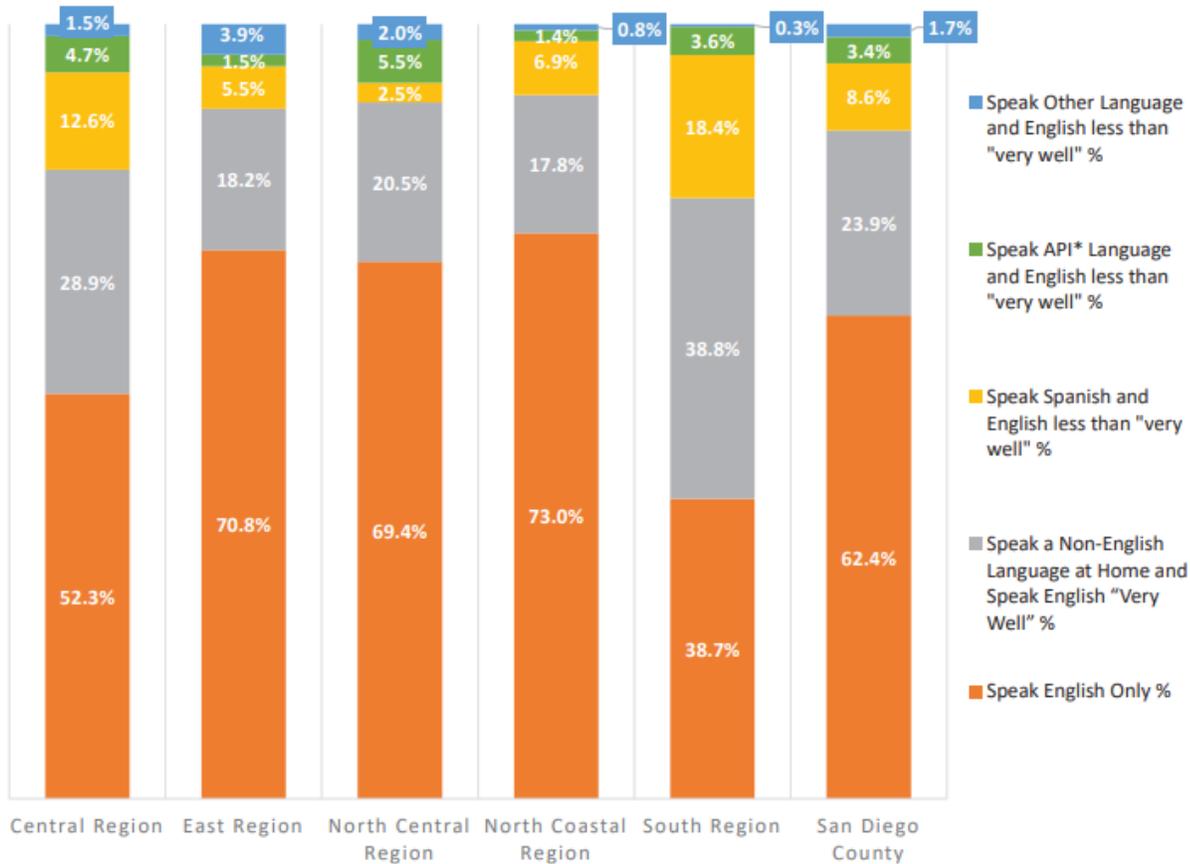
2019 Demographic Profiles San Diego County, Community Health Statistics Unit Published May 2021
County of San Diego Health and Human Services Agency Public Health Services

Percent of Foreign Born in the Population by HHSA Region, 2019
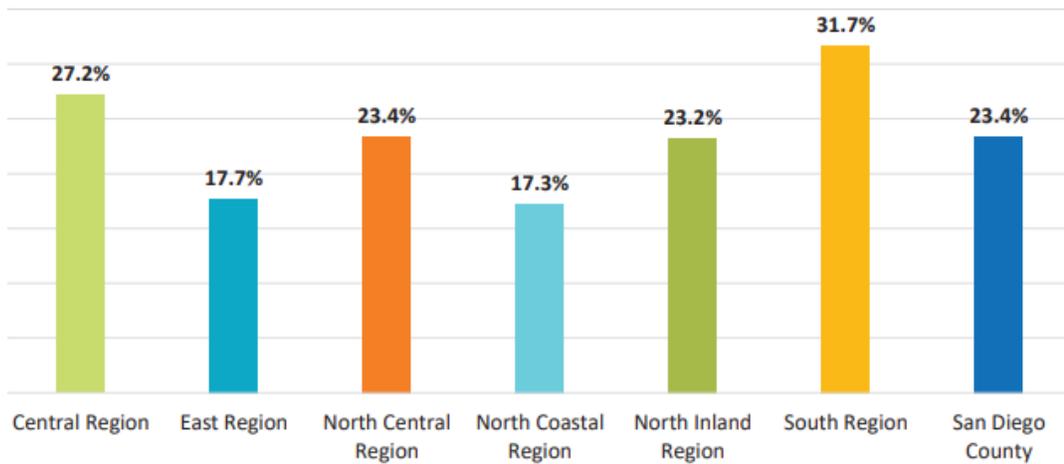
2019 Demographic Profiles San Diego County, Community Health Statistics Unit Published May 2021
County of San Diego Health and Human Services Agency Public Health Services

Military and Veteran-Connected Community: The region has the largest concentration of U.S. military globally, with seven military bases and over 110,000 active-duty service personnel.[17] There are approximately 118,300 military family members, with an estimated 61% who are children.[18] Almost 1 in 10 adults (241,000) in San Diego County is a veteran. Active-duty military and their families live throughout the county, with the highest concentrations in North County. [xv] The highest concentration of veterans in San Diego is in South County.

Veterans have a unique source of health care available through the Veterans Administration (VA); however, it is not universally available to all veterans and their families. Of those who qualify, many do not apply. In recent years, the number of uninsured veterans has continued to decline, though a number of veterans remain uninsured.[19]

Although a majority of service members return from active duty and combat without physical injuries, some face serious and lasting health effects. According to the Rand Corporation, the Department of Defense faces significant challenges ensuring that all members of the military and their families receive proper health care for everything from general health and well-being to specialized clinical care for deployment-related conditions.[20] In addition, former servicewomen face unique challenges. For instance, one in three female veterans has reported to their VA health care provider that they experienced sexual trauma in the military.[21]

Transitional Communities: San Diego County has at least 24 post-secondary educational institutions with students from throughout San Diego, California, the U.S., and the world. Like out-of-county college students, most military families live in San Diego for a limited time. Military families relocate 10 times more often than civilian families —on average they move every two to three years.[22]

Having a large number of college students and military-connected individuals and families means that a considerable number of San Diego County residents reside here for less than five years. Military families and students share similar challenges to other San Diegans, including social isolation, affordable housing, food insecurity, and childcare. Nationally, Blue Star Families found only 23% of active-duty family respondents could find childcare that works for their situation, and 14% of enlisted active-duty families reported food insecurity.[23] According to a survey released in 2019, more than half the students attending a California community college had trouble affording balanced meals or worried about running out of food, and nearly one in five were either homeless or did not have a stable place to live.[24]

Immigrants and Refugee Populations: For nearly a decade, no California county has received more refugees than San Diego County, according to state and federal data. Many refugees are assigned to San Diego because of the concentration of four resettlement agencies and the existence of several rooted immigrant communities already in the area. It's a trend that dates to the Vietnam War when hundreds of thousands of Southeast Asians landed at Camp Pendleton for U.S. resettlement. Many stayed, helping make the area a beacon for people fleeing from violence, hunger, and instability. In 2021, 3,722 refugees arrived in San Diego County.[25]

Another population that is migratory in San Diego is farmworkers. According to the National Center for Farmworker Health, there are over 14,230 agricultural workers in San Diego County.[26] Agricultural workers may be migratory or seasonal. Migratory workers and their families find new, temporary housing as they follow the different crop harvests, while seasonal workers do not move but may experience a change in their tasks, hours, or income at work. In addition to the agricultural workers in San Diego, there are an estimated 4,000 migratory children and youth.[27]

According to the National Center for Farmworker Health, agricultural workers suffer higher rates of infectious disease, tuberculosis (TB), parasitic infection, and diarrhea than the general population. Occupational hazards are also attributed to higher instances of respiratory issues, which are often caused by exposure to fungi, dust, and pesticides.[28]

In February and March 2021, the number of unaccompanied child migrants referred to the federal Office of Refugee Resettlement exceeded the agency's shelter capacity, leading to serious backups and overcrowding in U.S. Customs and Border Protection facilities.[29] For this reason, San Diego provided emergency shelter for more than 3,200 unaccompanied children; most were girls ages 13 to 17.[30] Unaccompanied children are under age 18, have no legal immigration status, and arrive in the U.S. without a parent or legal guardian to provide care and custody. Most of these children come from Central America. These children are especially vulnerable to trafficking and criminal predation.[31] Most of these children arrived in San Diego with mental health challenges rooted in the trauma they experienced in their home country or along their journey. Many had lice and scabies, TB, and COVID-19, and a few were even pregnant.

Significant Urban and Rural Areas: According to the San Diego Association of Governments (SANDAG), 76% of the county's land is rural, and 24% is urban, while a large majority of San Diegans live in metropolitan San Diego. Urban and rural communities face many of the same challenges, including food insecurity and

affordable housing. However, these issues are worse in rural communities because there are fewer resources, and individuals need to travel greater distances for health care and other services. A unique challenge in rural areas is that less than half of the rural population has fixed internet vs. 97% in urban areas.[32]

Border Region: The California/Baja California or CaliBaja border region spans both sides of the 140-mile border, including San Diego and Imperial counties and northern Baja California (Mexico). It is home to more than 7 million people. The border is a transnational region where two countries' fates are intertwined. According to the San Diego Workforce Partnership, more than 90 million people per year cross the border, making it the busiest land-border crossing in the world. Over 10,000 students and nearly 50,000 workers live in one country and go to school in the other.[33] For many San Diegans, Mexico's border cities provide access to affordable medical and dental care as well as housing.

Because the border region is a space where many people come together with varying cultural, economic, and political characteristics, it is particularly vulnerable to the spread of infectious diseases. For this reason, the work to control infectious diseases in the border region requires international collaboration and communication.[34] California has the highest rates of TB in the U.S., with California's border counties being a substantial contributor to the state's TB burden. A significant number of TB cases in bordering counties are of Mexican origin.[35] The pandemic highlighted the importance of a coordinated U.S. and Mexican response. Since the vaccine rollout began, San Diego's South Bay region located near the border— experienced success in vaccination equity efforts that have contributed to that part of the region having the highest vaccine uptake of all six San Diego County regions.[36]

Close Ties with Imperial County: Imperial and San Diego counties or Southern Border Counties (SBC) are very different counties that share the U.S.-Mexico border, providing unique challenges and opportunities. For this reason, several independent civic and government entities from each county work closely together, including the workforce development boards and metropolitan planning organizations. In addition, there are non-profit and philanthropic associations that serve the entire SBC region.

Hospitals collaborate daily with patients coming over the mountain. Cross-county collaboration has been especially critical for coordinating a regional public health response and managing surges throughout the COVID-19 pandemic. Although this report does not include the needs of Imperial County residents, the Imperial County Community Health Improvement Partnership has developed a [Community Health Assessment and Community Health Improvement Plan](#) that included input from community groups, agencies, health care entities, and residents.

Powered by Small Business: According to the SDEDC, small businesses (those with fewer than 100 employees) represent more than 98% of all firms in San Diego County and 60% of total employment in the region. Because of their financial instability, small-business wages are 14% lower than the average wages.[37] In addition, small businesses provide less career mobility and benefits to their employees. The COVID-19 pandemic resulted in the closure of one-in-three small businesses across San Diego. SANDAG reported in July 2020 that the pandemic had negatively impacted nine in 10 small businesses.[38]

High Cost of Living: According to data reported by the SDEDC, rapidly rising home prices — up more than 30% in the last two years alone — coupled with jobs losses have resulted in almost 11,000 fewer thriving households in 2020 than in 2017.[39] This makes San Diego 47% more expensive to live in than the average U.S. metro area; San Diego has the fifth-highest median home price.[40] Only 39% of San Diegans earn wages that can keep up with the region's rapidly rising costs of living.[41] The California Housing Partnership Corporation reports that San Diego's poverty rate rises from 13% to 20% when housing costs are considered. Moreover, San Diego's lowest-income renters spend almost 70% of their income on rent, leaving little for food, health care, childcare, transportation, and other essentials.[42] Adding to their burden, according to SANDAG, only 7% of low-income residents have access to fast and frequent transit services. The median transit travel time is 51 minutes — double the time for people who drive to work.[43]

Regional Approach to Health Care

Hospitals and health systems define the community served as those individuals who reside within its service area, which includes all residents in a defined geographic area surrounding the hospital. Due to a broad representation of hospitals in the area, the service area is defined as the entire County of San Diego in the 2022 CHNA. Because of its geographic size and large population, the San Diego County HHSA organizes its service areas into six geographic regions: Central, East, North Central, North Coastal, North Inland, and South. See graphic below.

2019 Demographic Profiles San Diego County, Community Health Statistics Unit Published May 2021
County of San Diego Health and Human Services Agency Public Health Services

Demographic Profile of San Diego County

Low-income, uninsured individuals have been found to be most at risk for poor health status. Data from the American Community Survey 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 creates barriers to accessing services that promote well-being including health services, healthy food, housing, childcare, transportation, and other necessities that contribute to improved health status.

San Diego County Demographics

Population	#
Total Population	3,283,665

Socioeconomic	%
Living in Poverty (<100% federal poverty level)	11.6%
Children in Poverty	14.7%
Unemployment	3.1%

Race/Ethnicity	%
Asian	11.6%
Black	4.7%
Hispanic/Latino	33.7%
Native American/Alaska Native	0.4%
Pacific Islander/Native Hawaiian	0.4%
Some Other Race	0.2%
Multiple Races	3.4%

Source: U.S. Census Bureau. American Community Survey, 2015-2019 Five-Year Estimate

Percent Below Poverty Level by HHSA Region, 2019

- Population below 100% federal poverty level (FPL)
- Families below poverty level (out of all families)
- Families with children under 18 years below poverty level (out of families with children)

Region	Population below 100% FPL	Families below poverty level	Families with children under 18
Central Region	18.1%	12.9%	20.7%
East Region	12.5%	9.0%	13.6%
North Central Region	10.0%	5.4%	7.4%
North Coastal Region	8.8%	5.7%	8.9%
North Inland Region	9.2%	6.2%	9.3%
South Region	12.0%	9.9%	12.7%
San Diego County	11.6%	7.8%	11.6%

Source: U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates, Table B17024, B17010.
Prepared by: County of San Diego, Health and Human Services Agency, Public Health Services, Community Health Statistics Unit, 2021.

2019 Demographic Profiles San Diego County, Community Health Statistics Unit
Published May 2021
County of San Diego Health and Human Services Agency Public Health Services

Health Insurance Status by HHSA Region, 2019
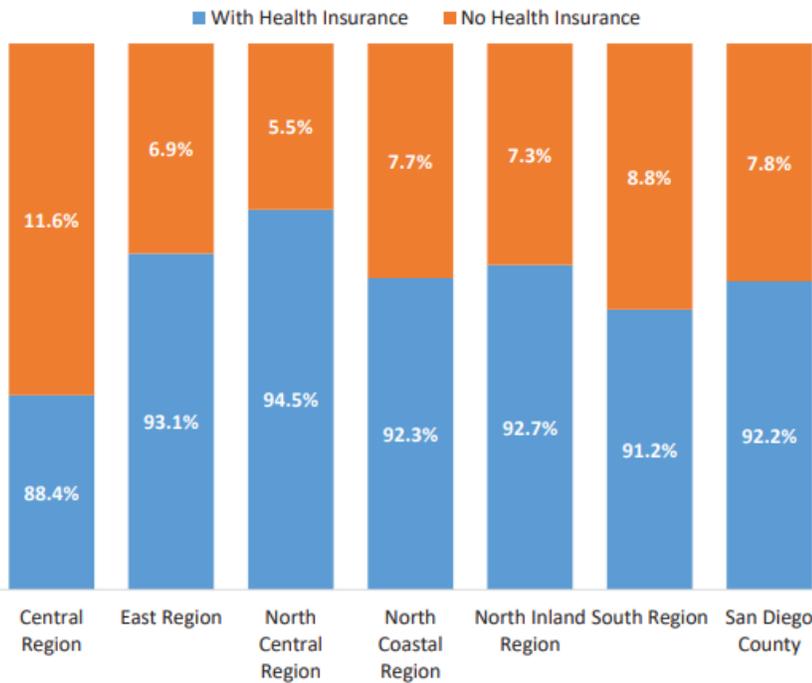
■ With Health Insurance ■ No Health Insurance

Region	No Health Insurance	With Health Insurance
Central Region	11.6%	88.4%
East Region	6.9%	93.1%
North Central Region	5.5%	94.5%
North Coastal Region	7.7%	92.3%
North Inland Region	7.3%	92.7%
South Region	8.8%	91.2%
San Diego County	7.8%	92.2%

2019 Demographic Profiles San Diego County, Community Health Statistics Unit Published May 2021
County of San Diego Health and Human Services Agency Public Health Services

Percent of Population by Age Group and HHSA Region, 2019
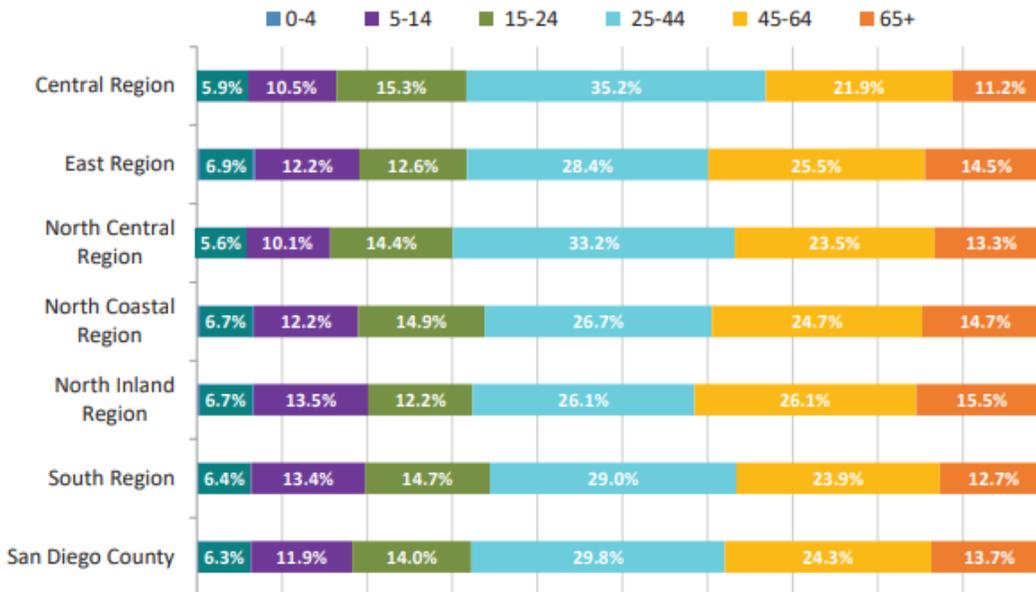
■ 0-4 ■ 5-14 ■ 15-24 ■ 25-44 ■ 45-64 ■ 65+

Region	0-4	5-14	15-24	25-44	45-64	65+
Central Region	5.9%	10.5%	15.3%	35.2%	21.9%	11.2%
East Region	6.9%	12.2%	12.6%	28.4%	25.5%	14.5%
North Central Region	5.6%	10.1%	14.4%	33.2%	23.5%	13.3%
North Coastal Region	6.7%	12.2%	14.9%	26.7%	24.7%	14.7%
North Inland Region	6.7%	13.5%	12.2%	26.1%	26.1%	15.5%
South Region	6.4%	13.4%	14.7%	29.0%	23.9%	12.7%
San Diego County	6.3%	11.9%	14.0%	29.8%	24.3%	13.7%

2019 Demographic Profiles San Diego County, Community Health Statistics Unit Published May 2021
County of San Diego Health and Human Services Agency Public Health Services

Identifying High-Need Areas

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

The California HPI

The California HPI generates a healthy community score for each census tract in California based on data from 25 social determinants of health across eight domains. The eight domains that make up the HPI scores are: Clean Environment, Economic, Education, Housing, Insurance/Health Care Access, Neighborhood, Social Factors, Transportation.

Note: The data used in this report were pulled from Healthy Places Index (HPI 2.0). A complete data update (HPI 3.0) was released in April 2022. Please visit their [website](#) for the most up-to-date information.

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

- Campo
- Boulevard
- Jacumba

- National City
- Potrero

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

- Bostonia
- Chula Vista
- El Cajon
- Escondido
- Imperial Beach
- La Presa

- La Mesa
- Oceanside
- San Diego
- San Marcos
- Vista

Furthermore, within the city of San Diego, healthy community conditions vary significantly from community to community. Examples of **communities within the city of San Diego** with the *lowest levels* of health community conditions include City Heights, Tierrasanta, Otay Mesa, and San Ysidro. This is not a complete list; please visit the [website](#) for more details on communities and neighborhoods.

Community Need Index [44]

The CNI score is an **average of five different barrier scores** that measure various socioeconomic indicators of each community using 2021 source data. The barrier scores are listed below along with the individual 2021 statistics analyzed for each barrier. These barriers, and the statistics that comprise them, were carefully chosen and tested individually by both Dignity Health and IBM Watson Health™.

The *five barriers* used to determine CNI scores are:

- **Income Barrier** — Percentage of households below the poverty line, with head of household age 65 or older; families below the poverty line with children under 18; and single female-headed families below the poverty line with children under 18
- **Cultural Barrier** — Percentage of population that is a minority (including Hispanic ethnicity) and population over age 5 who speaks English poorly or not at all
- **Education Barrier** —Percentage of population over age 25 without a high school diploma
- **Insurance Barrier** — Percentage of population in the labor force, age 16 or older, without employment and population without health insurance
- **Housing Barrier —** Percentage of households renting their home

Every populated ZIP code in the United States is assigned a barrier score of 1, 2, 3, 4, or 5 depending upon the ZIP code's national rank (quintile). A score of 1 represents the lowest rank nationally for the statistics listed, while a score of 5 indicates the highest rank nationally. For all barriers, ZIP codes with scores of 1 or 2 have a smaller percentage of the population facing the barrier than the national average, while ZIP codes with a score of 4 or 5 have a higher percentage.

ZIP Codes with High CNI Scores (4.2-5.0)

5	92105	San Diego	70,530
5	92113	San Diego	51,450
4.6	91917	Dulzura	993
4.6	92102	San Diego	43,902
4.6	92173	San Ysidro	30,351
4.4	91910	Chula Vista	79,689
4.4	91911	Chula Vista	88,985
4.4	91932	Imperial Beach	27,460
4.4	91934	Jacumba	721
4.4	91950	National City	59,293

ZIP Codes with High CNI Scores (4.2-5.0)

4.4	91963	Potrero	1,215
4.4	91980	Tecate	192
4.4	92025	Escondido	52,336
4.4	92115	San Diego	59,565
4.2	91905	Boulevard	1,889
4.2	92020	El Cajon	60,578
4.2	92021	El Cajon	67,739
4.2	92111	San Diego	46,982
4	91945	Lemon Grove	26,540
4	92026	Escondido	54,090

Community Need Index Scores, Zip Code Level, San Diego County
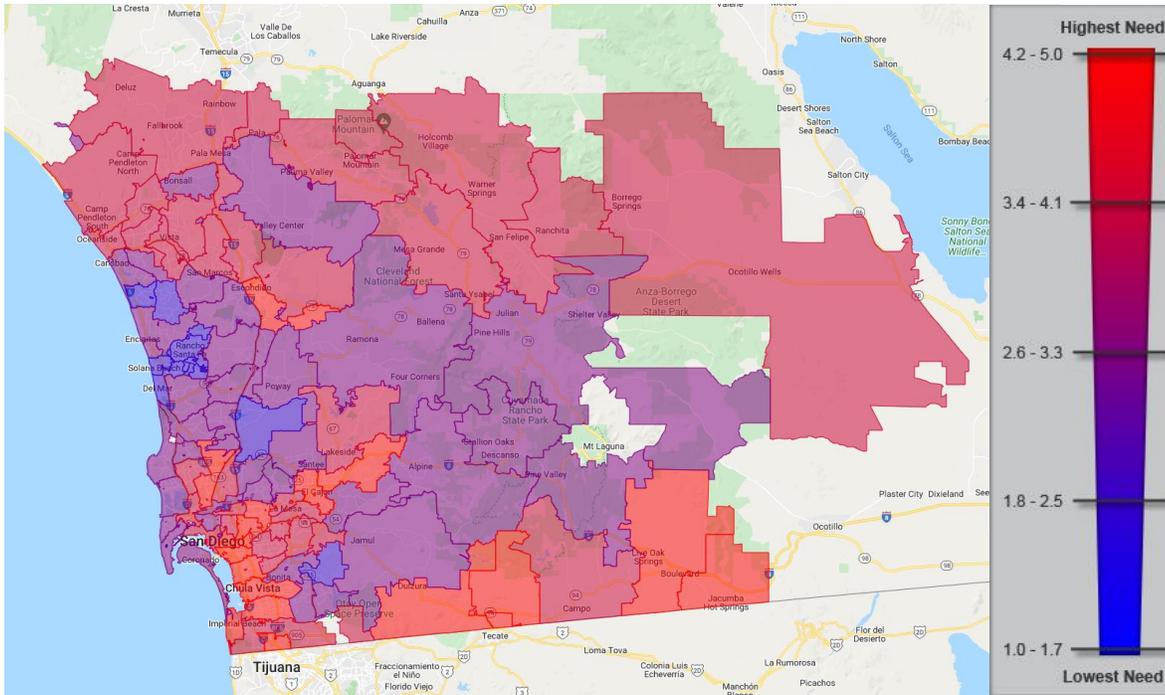
Source: Truven Health Analytics, 2021; Insurance Coverage Estimates, 2021; The Nielson Company, 2021; and Community Need Index, 2021.

Cities with High Need Index Scores (4.2-5.0) by San Diego County HHSA Regions

Central	
San Diego	92102, 92105, 92113, 92115

North Central	
San Diego	92111

East	
Boulevard	91905
Dulzura	91917
El Cajon	92020, 92021
Jacumba	91934
Potrero	91963
Tecate	91980

North Coastal	
Vista	92083

North Inland	
Escondido	92025
San Marcos	92069

South	
Chula Vista	91910, 91911
Imperial Beach	91932
National City	91950
San Diego	92154
San Ysidro	92173

San Diego County Hospital Data

California's Department of Health Care Access (HCAI) and Information, formerly the Office of Statewide Health Planning and Development, is responsible for collecting data and disseminating information about the utilization of health care in California. As part of the 2022 CHNA data collection process, 2019 HCAI demographic data for hospital inpatient and emergency department (ED) discharges from all hospitals within San Diego County were analyzed. Data were exported using SpeedTrack's California Universal Patient Information Discovery or (CUPID) application. SpeedTrack's application contains all hospital discharge data in California for a five-year period (currently 2016-20) in a format that allows for easy queries and comparisons of local and statewide hospital discharge data at the ZIP code level.

Hospital Discharge Data

In 2019, there were a total of 1,274,881 patient encounters at all inpatient, ED, and ambulatory facilities in San Diego County among San Diego County residents. Approximately 62.6% of those encounters were at ED locations, followed by 22.9% at inpatient facilities, and 14.5% at ambulatory centers. Below is a breakdown of demographic characteristics of all San Diego residents' encounters at any point-of-care location during 2019.

Demographic Characteristics of all Hospital ED and Inpatient Discharge Encounters in San Diego County by San Diego County Residents, 2019 [45]

Age	ED	Inpatient
0-10 Years	13.6%	15.9%
11-17 Years	6.3%	2.4%
18-26 Years	12.6%	6.4%
27-44 Years	24.1%	18.7%
45-64 Years	22.9%	20.9%
65+ Years	20.5%	35.6%

Gender	ED	Inpatient
Male	44.6%	43.8%
Female	55.4%	56.2%
Race	ED	Inpatient

Gender	ED	Inpatient
White	54.8%	59.9%
Black/African American	8.7%	6.2%
Asian/Pacific Islander	6.5%	8.6%
American Indian/ Alaskan Native/ Eskimo/ Aleut	0.4%	0.5%
Other Race	29.6%	24.3%

Ethnicity	ED	Inpatient
Hispanic/Latino	36.3%	29.8%

2022 San Diego
Community Health Needs Assessment

Methodology

Methodology

Oversight and Implementation of the 2022 Community Health Needs Assessment

The CHNA, conducted every three years, is facilitated by HASD&IC, with the budget and workplan approved by the HASD&IC Board of Directors. In spring 2021, the HASD&IC Board of Directors approved plans to expand participation in the 2022 CHNA process to include every private hospital, health system, health district, and behavioral health hospital in San Diego in the collective effort to better understand the health and social needs of San Diego communities.

HASD&IC staff support the CHNA work under the guidance of two entities — the CHNA Advisory Workgroup and the CHNA Committee. The CHNA Committee is co-chaired by two participating health systems and consists of a smaller group of hospital and health system staff who provide significant support for the CHNA's design and implementation. The CHNA Committee meets regularly, up to twice a month.

The CHNA Advisory Workgroup is chaired by the HASD&IC President & CEO and includes CHNA Committee members as well as leadership from every participating hospital and health system. The workgroup generally meets on a quarterly basis. Members of the 2022 CHNA Advisory Workgroup are Alvarado Hospital Medical Center, Alvarado Parkway Institute Behavioral Health System, Aurora Behavioral Health Care San Diego, Grossmont Healthcare District, Kaiser Permanente San Diego, Palomar Health, Paradise Valley Hospital/Bayview Behavioral Health Campus, Rady Children's Hospital - San Diego, San Diego County Psychiatric Hospital, Scripps Health, Sharp HealthCare, Tri-City Medical Center, UC San Diego Health, and VA San Diego Healthcare System.

HASD&IC contracted with the Institute for Public Health at the San Diego State University School of Public Health to provide ongoing guidance and review research methods employed in both the quantitative and qualitative research components of the 2022 CHNA process and report.

Health Equity Framework

There are social drivers of health and equity at all levels: individual, community, and structural. Historical and systemic inequities disproportionately impact vulnerable populations including people of color, socially disadvantaged groups, and those living in poverty. The CHNA Committee completed an extensive review of national best practices and evidence-based frameworks to develop a research approach to health equity.

This health equity framework describes the CHNA Advisory Workgroup and CHNA Committee's shared values and commitment to understanding the social drivers of health and equity through our collective research, analysis, and community engagement. San Diego hospitals, health systems, and health districts are committed to a CHNA process that reflects the following shared values:

Health Equity Framework

Equity

We commit to research and community engagement strategies that purposefully seek to quantify and describe inequities that disproportionately impact our disadvantaged populations due to structural components.

Inclusion

We commit to meaningful engagement with community organizations, community members, and leaders who serve diverse populations. We understand the importance of sharing a space for listening and honoring perspectives of those with lived experiences.

Empathy

We commit to employing a trauma-informed approach that works to break stigma by creating safe and meaningful opportunities to engage community members and community partners.

Responsibility

We commit to using evidence-informed research methods, analyzing the best available data, and making it available to community members and community partners.

Accountability

We commit to sharing the results of our research as well as our plans to address the findings with everyone who participates.

Health equity is achieved when every person has the opportunity to 'attain his or her full health potential' and no one is 'disadvantaged from achieving this potential because of social position or other socially determined circumstances.' Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment.

CENTERS FOR DISEASE CONTROL AND PREVENTION

Differences in health status and health outcomes exist between groups. These differences or disparities often result from social determinants of health, including social circumstances, environmental exposures, and behavioral factors, as well as access to adequate health care. Together, these factors impact the health and well-being of San Diegans differently. To achieve health equity, these disparities must be identified, and the root causes determined. It is only through understanding the unique challenges each group faces that solutions can be identified and implemented. When all San Diegans have the opportunity and resources to achieve good health, then we will have health equity.

**COUNTY OF SAN DIEGO, HEALTH AND HUMAN SERVICES AGENCY, PUBLIC HEALTH SERVICES**

Research Methods and Approach

To gain a deep and meaningful understanding of the health-related needs of San Diego County residents, two primary methods were employed in the 2022 CHNA:

1. Quantitative analyses were conducted of existing publicly available data to provide an overarching view of critical health issues across San Diego County.

2. Qualitative information was gathered from community residents, community-based organizations, federally qualified health centers (FQHCs), hospitals and health systems, local government agencies, civic leaders, grant-making organizations, and San Diego County Public Health Services through a comprehensive community engagement process to understand the lived experiences and needs of people in the community.

The CHNA Committee reviewed the feedback and data to prioritize the top health needs in San Diego County. Please see the figure below for more information on the CHNA process.

2022 Community Health Needs Assessment Process Map
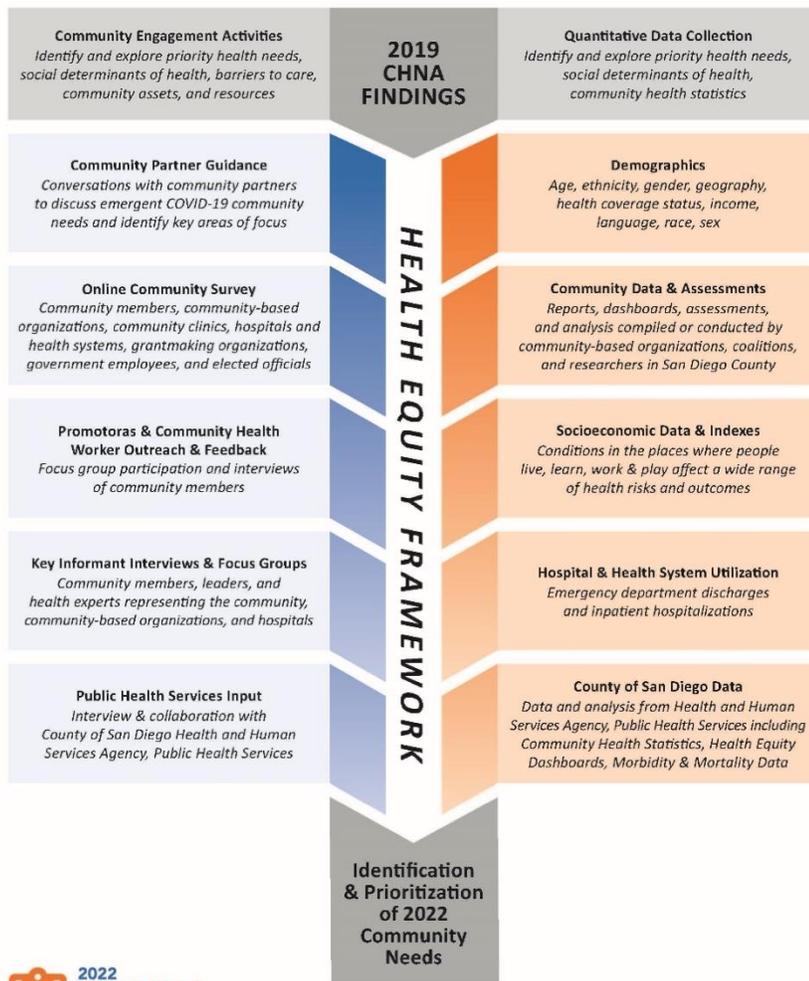
Quantitative Data Collection and Analysis

Quantitative data were used for three primary purposes:

1. Describe the San Diego County community
2. Plan and design the community engagement process
3. Facilitate the "prioritization process" — identify the most serious community health needs of San Diego County residents facing inequities

Quantitative data include:

- California's Department of Health Care Access and Information (HCAI) limited data sets, 2017-19 SpeedTrack[46]
- Community Need Index (CNI)[47]
- Public Health Alliance of Southern California Healthy Places Index (HPI)
- National and statewide data sets were analyzed, including San Diego mortality and morbidity data, and data related to social determinants of health.

The HPI and the CNI were used to identify the most under-resourced geographic communities. This information helped guide the community engagement process, including selecting communities from which to solicit input and developing relevant and meaningful engagement topics and questions.

Data from County of San Diego Health and Human Services Agency (HHSA), including the following reports and dashboards (see **Appendix F**), were also used:

Reports
- County of San Diego Community Health Statistics
- Health Disparities Executive Summary Report[48]
- Racial Equity: Framework and Outcomes Brief
- San Diego County Self-Sufficiency Standard, Household with Two Adults, One Preschool-Age Child, and One School-Age Child, 2021
- Overdose Data to Action (OD2A)

County of San Diego HHSA Community Health Statistics Dashboards
- LGBTQ Health and Well-Being Dashboard
- Health Equity Dashboard Series: Racial Equity Dashboards
- San Diego County Self-Sufficiency Standard Dashboard
- COVID-19 in San Diego County

SpeedTrack's California Universal Patient Information Discovery, or CUPID application, was used to export emergency department (ED) and inpatient hospital discharge data. These data were analyzed to determine the most common primary diagnosis categories upon discharge. This analysis helped the CHNA Committee understand which health conditions have the greatest impact on hospitals and health systems, providing further insight into priority health needs. For health conditions identified as a high priority for the CHNA, full data sets were extracted and stratified by age and race. Rates were calculated for each group and for each condition per 100,000 in the population.

Overall three-year trends (2017-19) were also calculated for each health condition, as well as for each age group and race/ethnicity within each health condition. This stratification shed light on disparities in San Diego County.

Community Engagement Activities

The goal of the community engagement process was to solicit input from a wide range of stakeholders so that the sample was as representative as possible of those facing inequities in San Diego County. Special efforts were made to include community members from groups that experience health disparities and service providers who work with those vulnerable populations. A total of **841** individuals participated in the 2022 CHNA.

Input from the community was gathered through the following efforts:

- Working with community health workers to conduct interviews with community members
- Conducting focus groups and key informant interviews with community members, community health workers, community-based organizations, service providers, civic leaders, and health care leaders (conducted in collaboration with Kaiser Foundation Hospital (KFH)-San Diego)*
- Conducting focus groups and key informant interviews with hospital and health system clinicians, case managers, social workers, and executive leaders
- Distributing an online survey to community members, hospital staff, community-based organizations, federally qualified health centers, and local government staff

16 Focus Groups + **26** Key Informant Interviews + **502** Survey Responses + **223** CHW & Promotora Interviews = *total of* **841** *individuals participated in the 2022 Community Health Needs Assessment*

The CHNA Committee worked with community partners to plan community engagement activities with stakeholders representing every region of San Diego County and all age groups. In addition, the CHNA Committee explicitly sought to engage a wide variety of stakeholders representing numerous, diverse racial and ethnic groups.

*Partnership with Kaiser Foundation Hospital (KFH)-San Diego and Zion
In addition to the collaborative CHNA process, Kaiser Foundation Hospital (KFH)-San Diego and Zion conducted a separate CHNA process consisting of quantitative and qualitative data collection. The qualitative data collection was conducted simultaneously with ongoing, continuous feedback between the two groups about the process; this allowed the groups' efforts to be complementary rather than duplicative. These efforts also enabled HASD&IC and KFH-San Diego and Zion to leverage each other's relationships in the community, resulting in greater community representation and the efficient use of resources. Select data were shared between the groups. This innovative and effective partnership resulted in a more robust CHNA for all San Diego County hospitals and health care systems.

Key Informant Interviews and Focus Groups

Key informant interviews and focus groups were used to identify and explore priority health needs, social determinants of health, barriers to care, and community assets and resources, with interviews and focus groups conducted between October 2021 and April 2022. Interviewers and facilitators employed the questions developed and approved by the CHNA Committee to generate discussion about specific community health needs, as well as open ended questions for broader discussions. Broad questions about health conditions and social determinants of health were asked at the beginning of each discussion, followed by more specific questions targeted for the participants. Questions varied depending on the expertise and/or specific interests of the person or group participating in each interview and focus group.

Focus groups and interviews were conducted via Zoom. Incentives, in the form of gift cards, were also provided when the groups were comprised of community residents. Each interview and focus group began with a discussion about the purpose and process of the CHNA. The interviewer obtained verbal and visual consent to proceed (and, in some cases, record) and assured participants that their participation was voluntary and that their feedback would be anonymous. Interpretative and translation services were arranged for any group that requested them. One focus group was conducted in Spanish by a facilitator through simultaneous English and Spanish interpretation.

Online Community Survey

The CHNA Online Community Survey was used to support prioritization of health conditions and social determinants of health based on community feedback about what survey respondents viewed as the most important or most serious challenges.

The survey was distributed via email to targeted community-based organizations, social services providers, resident-led organizations, federally qualified health centers, government agencies, grant-making organizations, and hospitals and health systems that serve a diverse array of people in San Diego County. When possible, these organizations shared the link to the survey with the clients they served. Email recipients were also encouraged to share the survey with their colleagues. The survey — open from February 14 to March 30, 2022 — was also widely shared through email and reshared by community-based organizations.

The survey was designed to be taken by community members and was translated from English into five additional languages: Arabic, Spanish, Somali, Tagalog, and Vietnamese. Mid-City CAN, a community-based organization located in City Heights, was contracted to complete the translations.

Promotoras and Community Health Worker Outreach and Feedback

Community Health Worker Focus Groups

Research partners at the Institute for Public Health (IPH) at the San Diego State University (SDSU) School of Public Health facilitated two focus groups with community health workers. The IPH conducted both focus groups through Zoom. All focus group participants were community health workers working for a COVID-19 contact tracing program.

Focus group participants were recruited through multiple avenues, including announcements in the County of San Diego HHSA's Community Health Worker Collaborative Newsletter, disseminated by the county to provide updates on COVID-19 Communication and Outreach Services to the individuals working on one of the county COVID-19 contracts. In addition, emails were disseminated directly to all community health workers on the Communities Fighting COVID! Project at SDSU, and emails were sent to the leads on eight different county COVID-19 contracts, requesting that they disseminate the information to their CHWs or outreach workers.

The announcement included an interest form that asked for the person's contact information, day of the week and time of day that worked best for them, type of gift card they would like to receive as a thank you, and a brief description of the type of work they currently do.

Focus group participants were asked open-ended questions about identifying specific health conditions of concern, about inequities in the community, and about the needs of youth and seniors. Gift cards were emailed two days after the focus group as a thank you to all participants.

Promotoras and Community Health Worker Interviews/Access to Health Care Interviews

To ensure the report included direct community member feedback from racial and ethnic groups experiencing disparate health outcomes, the CHNA Committee employed a new strategy to partner with community-based organizations that work with promotoras and community health workers. The Online Community Survey was adapted with a subset of the survey questions for use as a data collection tool. The San Diego Refugee Communities Coalition and the Chicano Federation were selected to recruit interested community health workers and promotoras to conduct the interviews. HASD&IC staff attended a San Diego Refugee Communities Coalition weekly community health worker meeting to provide training on the goals of the CHNA and how to administer the interview. HASD&IC staff also provided training to the Chicano Federation promotoras.

Promotoras and community health workers conducted interviews either in person or over the phone. Interviewers asked open-ended questions about the following: health needs, social needs, access to care challenges, and what hospitals could do to improve the health and well-being of the community. Interviewers then coded responses and input them into an online data collection tool.

Price Philanthropies Foundation generously provided grants to both organizations to compensate promotoras and community health workers for completing interviews.

# 2022 CHNA Prioritization of the Top Community Needs

Process and Criteria for Prioritizing Community Needs: To prioritize the top needs, the CHNA Committee analyzed the comprehensive findings from the needs assessment, including quantitative and qualitative data.

Data Used in Prioritization Process	
Quantitative Data	**Qualitative Data**
• Data and analysis from the Health and Human Services Agency and Public Health Services, including Community Health Statistics, Health Equity Dashboards, Morbidity and Mortality Data • Analysis of secondary data, health conditions, and social determinants of health • County of San Diego leading causes of death 2019 data • Hospital discharge trend data retrieved from • California's Department of Health Care Access and Information limited data sets, 2017-19 SpeedTrack	• Community guidance from CHNA planning interviews • Community engagement findings from focus groups • Community engagement findings from key informant interviews • Community engagement findings from interviews and focus groups with promotoras and community health workers • 2022 CHNA Online Community Survey

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

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

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

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

- **Change over time:** This refers to whether the need has improved, stayed the same, or worsened.

Prioritization Criteria

- Severity of Need
- Magnitude/scale of the need
- Disparities or inequities
- Change over time
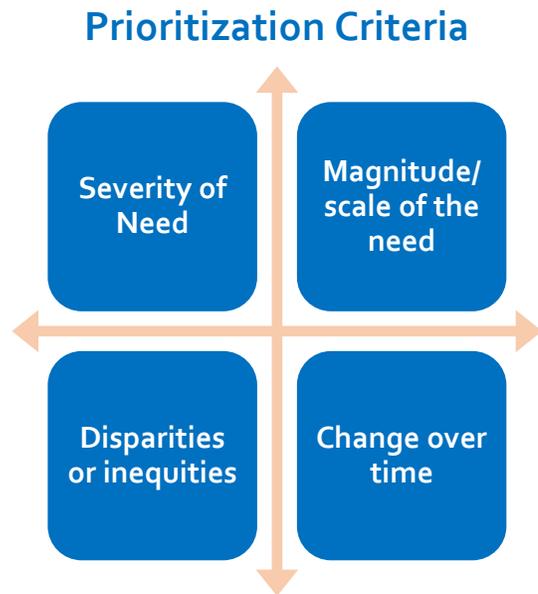
Over the course of several meetings, the HASD&IC staff and CHNA Committee members collectively reviewed the quantitative and qualitative data and findings. Each health condition and social determinant of health for which the committee had data were considered and discussed in terms of these criteria. Those community needs that met the largest number of criteria were chosen as top priorities.

2022 San Diego
Community Health Needs Assessment

2022 SAN DIEGO CHNA
COMMUNITY HEALTH NEEDS ASSESSMENT

HOSPITAL ASSOCIATION
of San Diego & Imperial Counties

2022 CHNA Findings:
Top Community Needs

2022 Top Community Needs

This section shares the results of the CHNA Committee's combined assessment of community engagement and quantitative analysis. Conducting a CHNA during a pandemic brought challenges to both planning and implementation. We did not see our partners at the usual community meetings and needed new strategies to ensure strong connections with community members and community-based organizations. In addition, the needs of the community have evolved continuously over the past few years. Community needs during the initial shutdown in March 2020 were different than community needs as we completed the final interviews in May 2022. The CHNA Committee made every effort to bring in current sentiment even as the needs of the community continued to change. Although the intensity of certain needs may have varied over time, the key findings remained clear and consistent throughout our community engagement efforts.

Findings

Through the prioritization process described in the methodology section, the CHNA Committee identified the most critical community needs within San Diego County, listed below in alphabetical order:

- Access to Health Care
- Aging Care & Support
- Behavioral Health
- Children & Youth Well-Being
- Chronic Health Conditions
- Community Safety
- Economic Stability

2022 Top Community Needs

HEALTH DISPARITIES
STIGMA
TRAUMA
WORKFORCE

Access to Health Care
Aging Care & Support
Behavioral Health
Children & Youth Well-Being
Chronic Health Conditions
Community Safety
Economic Stability

The graphic above represents the *top identified community needs*, the *foundational challenges,* *and the* *key underlying themes* revealed through the 2022 CHNA process. The needs identified as the most critical for San Diegans are listed in the center of the circle in alphabetical — not ranked — order. The blue outer arrows of the circle represent the negative impact of two foundational challenges — health disparities and workforce shortages — which greatly exacerbated every identified need at the center of the circle. The orange bars within the outer circle illustrate the underlying themes of stigma and trauma — the quiet yet insidious barriers that became more pervasive during the pandemic.

The graphic demonstrates how each component of the findings — the top identified community needs, the foundational challenges, and the key underlying themes — impact one another. In particular, the foundational challenges and underlying themes interact with each other to amplify the identified community needs as well as disrupt efforts that advance health equity and improve community well-being.

Foundational Challenges

In addition to identifying the top community needs, the CHNA Committee also recognized two foundational challenges that are intensifying the growing severity of every need — increasing health disparities and unprecedented workforce shortages and burnout.

Health Disparities

The pandemic laid bare the truth that even in ordinary times, some communities fare much worse than others, and their health suffers more as a result. These health disparities are not new[49]; they have been proven by decades of research and reflect the outcomes of a wide array of variables, including enduring structural and systemic inequities rooted in racism and discrimination. In every conversation, the inequitable outcomes faced by certain communities were consistently emphasized.

At the start of the pandemic, front-line workers had less ability to stay home and faced a disproportionate risk of exposure to COVID-19, and therefore experienced disproportionately higher mortality rates compared to individuals with different occupations. These front-line workers were also disproportionately people of color. In addition, the health of San Diegans who were vulnerable before the pandemic — such as people experiencing homelessness, isolated seniors, LGBTQ+ youth, and children with special needs — deteriorated more acutely as they lost access to critical services and faced new barriers to their safety and economic stability.

Workforce Shortages

Community engagement participants in previous CHNAs often mentioned the need for more health care providers, mostly with a view toward bolstering workforce pipelines. In our 2022 CHNA focus groups and interviews, workforce shortages were consistently top of mind.

In every single sector of our economy, the workforce is facing extraordinary exhaustion, trauma, and burnout. The words "heartbreaking," "frustrating," and "overwhelmed" were frequently repeated by our 2022 CHNA community engagement participants working in the health and social services sectors. Clinical and social work staff at hospitals, community clinics, community-based organizations, and government agencies all shared the same feeling of helplessness — there is no workforce to draw from, and no resources available to meet the intensifying needs they are passionately working to address.

Key Underlying Themes

Stigma

As in our 2019 CHNA findings, the underlying theme of stigma and the barriers it creates arose across our community engagement efforts in 2022. Stigma impacts the way people access needed services (CalFresh, Medi-Cal, other economic support) that address the social determinants of health. This consequentially impacts the ability of people to improve and successfully manage health conditions.

Community engagement participants expressed concerns about the impact of stigma in relation to specific populations, including LGBTQ+ communities, people experiencing homelessness, people of color, seniors, Medi-Cal beneficiaries, and survivors of domestic violence and human trafficking. Stigma was also discussed in relation to specific health conditions such as behavioral health, cancer, diabetes, and obesity. The existing stigma that had prevented community members from accessing needed services led to even more dangerous outcomes amidst the pandemic, as people became more desperate and felt they had fewer options.

Trauma

In addition, an underlying theme of trauma was shared across community engagement efforts. The impact of trauma has been demonstrated to increase health disparities and inequities. Community engagement participants noted trauma as a nearly universally shared experience that added intensity to the identified community needs.

Trauma and vicarious trauma were also cited as factors contributing to compassion fatigue and workforce burnout. Our community is experiencing trauma both at work and at home, and consequently, there is often no escape and no downtime from traumatic experiences. This shared trauma interacts with every aspect of the identified community needs. Traumatized community members are seeking assistance from health care providers and community-based organizations that have also experienced ongoing trauma since the start of the pandemic.

Community Voice and Experiences

The findings attempt to capture the voice of the community as we heard it through focus groups, key informant interviews, interviews regarding access to care, and an online survey. Both our quantitative research and community engagement confirmed the intersectionality between the seven critical community needs that were identified.

When discussing our findings, we will highlight how they may differ for San Diegans based on their experiences. These experiences may include homelessness, immigration status, gender and sexual orientation, age, poverty, or connections to the military.

2022 San Diego
Community Health Needs Assessment

2022 SAN DIEGO CHNA
COMMUNITY HEALTH NEEDS ASSESSMENT

HOSPITAL ASSOCIATION
of San Diego & Imperial Counties

2022 CHNA Findings:

Access to Health Care

Access to Health Care

Access to care was identified as a high-priority need that continues to negatively impact the overall health of our community. The pandemic further exacerbated existing challenges for both community members and health providers. Both stigma and health literacy were fundamental barriers of access to care. Persistent challenges accessing and navigating care were consistent concerns across all interviews. Our community expressed a strong desire to receive better care and timely access to care. Lastly, there was a universal feeling of intense burnout and exhaustion from health care providers as they continue to work under severe pressures throughout the pandemic.

Access & Navigating Care

Access to care was identified as a priority health need. Community members shared that having good health meant that they have the strength to work and provide for their family.

Across interviews and focus groups, **there was a universal acknowledgment that the pandemic caused a widespread disruption to our local health care system.** Multiple factors were identified as having an impact on the ability to access health care. They include postponed or canceled procedures, long wait times for appointments, and the fear of exposure to COVID-19. That fear caused people to defer routine and medically necessary care.

For those Californians who report skipping or postponing care in the last 12 months, **more than half (57%) cited the COVID-19 pandemic** *as the reason they skipped or postponed care.*

Source: The 2022 CHCF California Health Policy Survey, CHCF [50]

"The number one challenge is access to care; it simply doesn't exist in the community."
FOCUS GROUP PARTICIPANT

"For people who do not speak English and for the elderly, being unable to have a support person with them is a huge barrier. They are scared to go [to health care visits] alone and scared of getting COVID when they go. This extreme fear is then sometimes labeled as people being noncompliant; when really they are just terrified."
FOCUS GROUP PARTICIPANT

"Getting a [health care] appointment that may typically have taken two to three weeks to get now is taking three months because of backlogs… then one layers a fear of going into those spaces, and for a lot of people it's avoid as much as possible and just-try-to-survive mode"
KEY INFORMANT

*In our Online Community Survey, **59% of participants identified Access to Health Care** as a top concern and **long waits for an appointment (31%)** as the top reason for difficulties in accessing health care.*

Access to Quality Patient Care

Community members expressed how important it was for them to spend enough time and have meaningful conversations with their doctor to fully evaluate their health needs and listen to their concerns. Quick and less-thorough doctor visits created challenges to receiving comprehensive care. Our community expressed the importance of building a relationship with their doctor who will listen and help them maintain health.

"Network adequacy, especially for certain specialties, workforce challenges, access to culturally competent (such as LGBTQ+ affirming, and language distinct) providers, pent-up patient demand due to deferred care, and ongoing public health emergency-related concerns and limitations impact access to timely care."

KEY INFORMANT

"I recently had an appointment at the clinic for pain I was having, and the doctor came in quickly to hear why I was there, and he quickly told me to just take this medicine for the pain. I would like the doctor to pay attention to my health instead of just prescribing medication."

FOCUS GROUP PARTICIPANT

"[Clients experiencing homelessness] just assume that they can go to the emergency room or maybe that's really the only place they can get care."

FOCUS GROUP PARTICIPANT

"I think there's a huge need for preventative health care. . . The ability to do regular checkups, so things are caught before they have turned into a larger illness and become more expensive to treat."

FOCUS GROUP PARTICIPANT

Health Literacy

Health literacy was a fundamental barrier in all aspects of accessing care — starting at the point of applying for health coverage to navigating care to health maintenance. There was a need for more health education to help people understand basic health information. For example, more education on preventive health care, healthy lifestyles, and understanding the differences between sources of care (use of urgent clinic vs. emergency room).

Our community and health care providers agreed that health care settings should use simple, plain language forms — preferably at sixth-grade reading level — to help people understand. Health care providers play an important role in assessing and ensuring patients understand the information that is provided to them. Hospital interviews shared that when hospital patients are sick or in pain, it could be even more challenging for them to fully process health information or follow post-discharge instructions, including medication adherence.

*In our Online Community Survey, **67% of respondents said that the most important step hospitals could take to improve community health and well-being is to "connect patients to services that would improve their health and well-being."***

The pandemic further exacerbated existing challenges with health literacy. For example, many of our community members had to navigate the internet to access health information for the first time or had difficulty finding credible online resources to get trusted information about the COVID-19 vaccines.

Navigating the health care system was identified as an increasingly challenging and stressful task. Specific challenges included people not understanding their health insurance benefits, not knowing who to call to access services, and not knowing where to get care. Getting a hold of one's own health care or insurance provider was extremely difficult. Populations who were identified as having significant challenges were people who speak little to no English, people experiencing homelessness, and justice-involved individuals. Community-based organizations shared that there is a significant need for justice-involved individuals to be guided and connected to critically necessary health care services and resources after being released from an institution. English-speaking people and community members who identified as being highly educated also described the health care system as being very difficult to navigate.

"There are times I'm so frustrated I want to cry. I have the education and I speak English, and I still struggle to get my grandmother's basic [health] needs met."
FOCUS GROUP PARTICIPANT

What is Health Literacy, and Why is it Important?

Healthy People 2030 defines both personal health literacy and organizational health literacy as the following:

- Personal health literacy is the degree to which individuals can find, understand, and use information and services to inform health-related decisions and actions for themselves and others.

- Organizational health literacy is the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others. [51]

According to the Centers for Disease Control and Prevention (CDC), individuals who read well and are comfortable using numbers can face health literacy issues when:

- They aren't familiar with medical terms or how their bodies function

- They must interpret statistics and evaluate risks and benefits that affect their health and safety

- They are diagnosed with a serious illness and are scared or confused

- They have health conditions that require complicated self-care [52]

"We need to do a better job as a community of addressing health literacy. [For instance,] if a patient is presenting to the emergency department who is not managing their schizoaffective disorder, has some medical condition, and we're giving them medications … are we adequately assessing whether the patient understands what we're telling them? Are they able to comprehend our instructions and then are they able to act upon?"

KEY INFORMANT

"Everything from talking about things like basic health education around caring for your infant so we're not having parents who are sitting in the [emergency department] for 12 hours because their baby has a fever, so they have the ability to triage themselves and understand what resources are available to them."

FOCUS GROUP PARTICIPANT

Language Diversity in San Diego County

While the majority of our county's population aged 5 and over speaks only English at home (62.4%), many people speak a non-English language at home as well.[53] Language distribution varies by region as shown in the table at right.

A study of refugee communities in San Diego County representing over 1,400 residents of East African, Middle Eastern, Central and South Asian, and Haitian backgrounds noted that during COVID-19 those who spoke little, or no English were negatively affected by access to information. This was reported as an overall sense of confusion due to language barriers and lack of coordinated delivery of information in multiple languages and dialects.[54]

% of Population Who Speak a Non-English Language at Home — San Diego County HHSA Region
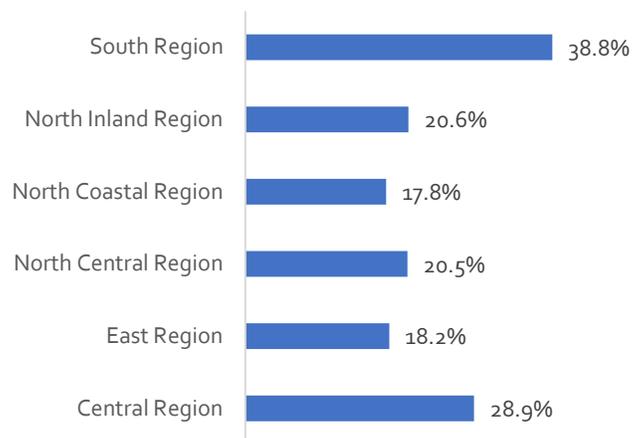
2019 SRA Demographic Profiles

Countywide data are included in the chart below.[55] This highlights the importance of multilingual health educational materials and providers to increase health literacy and more equitable levels of wellness. The California Department of Health Care Services requires all Medi-Cal managed care plans to provide written translated member information in languages that meet a numeric threshold of 3,000 or 5% of the eligible beneficiary population, whichever is lower.[56]

Languages Spoken at Home in San Diego County
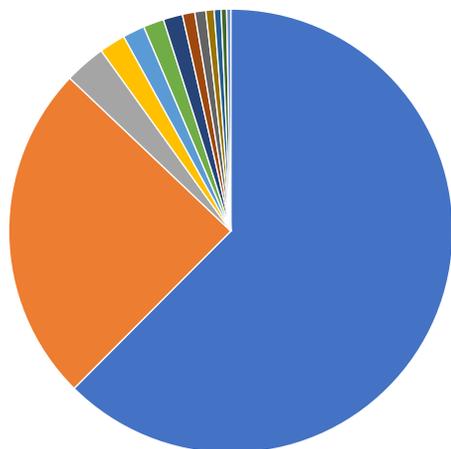
- English (62.4%)
- Spanish (24.6%)
- Tagalog (incl. Filipino) (3%)
- Other Indo-European Languages (1.9%)
- Chinese (incl. Mandarin, Cantonese) (1.6%)
- Other Asian and Pacific Island Languages (1.5%)
- Vietnamese (1.4%)
- Arabic (0.90%)
- Other and Unspecified Languages (0.80%)
- Russian, Polish, or other Slavic Languages (0.6%)
- Korean (0.5%)
- French, Haitian, or Cajun (0.4%)
- German or other West Germanic Languages (0.3%)

2019 SRA Demographic Profiles

Types of Care Most Challenging to Access

Our community shared the underlying challenges they experienced with accessing health care services they needed. Significant challenges related to the logistics and level of care they needed include:

- Making an appointment with primary care or accessing their usual source of care
- Insurance restrictions and confusion – having a certain type of insurance, such as a health maintenance organization and being limited to providers that are only in-network
- Need for referrals as a barrier to accessing the services or treatments they needed
- Finding the right fit with a provider, such as a primary care or mental health care professional
- Timeliness in relation to level of care, such as urgent care for after hours

Community members identified several types of care as being particularly difficult to access, including specialty or referral-based care, oral/dental care, mental/behavioral health care, and follow-up care.

*In our Online Community Survey, respondents identified these services as hardest to access: **Mental/Behavioral Health, Counseling/Therapy, Psychiatry, Dental, and Urgent Care/After-Hours Care.***

Specialty Care/Referral-Based Care: Referrals to see a specialist were commonly cited as a significant challenge. Community members reported long waits for services, treatments, and procedures.

Finding providers who can submit orders or make referrals can be time-consuming. Many patients fall through the cracks, and some do not receive follow-up from their requests.

Some of the specialty care mentioned by community members as being the most challenging to access was either necessary for a certain health concern or care that aligned with cultural or spiritual health-related beliefs: women's health services, dermatology, physical therapy, orthopedics, gender-affirming care, gastroenterology, ear/nose/throat, memory/neurology, alternative/holistic care, or chiropractic services.

Mental and behavioral health care: Timely and appropriate mental/behavioral health care was identified as the most challenging to access. For more information on behavioral and mental health care, please see the **Behavioral Health** finding.

Aging Care/Geriatric Care: In-home services, dental care, and providers trained in geriatric care were cited as a need for aging community members. Please see the **Aging Care & Support** finding for more information.

"Finding an excellent primary care provider who doesn't already have a full panel [is a challenge]."
KEY INFORMANT

"[It] seems like you have to jump through hoops to access a specialist when needed."
**FOCUS GROUP PARTICIPANT**

"[For]mental/behavioral care – [it feels like] you have to fight for your right to access."
FOCUS GROUP PARTICIPANT

Access to Health Care Interviews

Access to Health Care has long been identified as a top community need in San Diego County. Early in the 2022 CHNA process, community partners shared that access to health care challenges had become even more concerning because of the pandemic. With the support of Price Philanthropies, the Chicano Federation and the San Diego Refugee Communities Coalition collaborated with the CHNA Committee to gain a deeper understanding of access to health care challenges experienced by our culturally and linguistically diverse communities. Community health workers and promotoras conducted access to care interviews with community members from their respective neighborhoods and networks. The goals for these interviews were to:

- Increase understanding of the challenges that diverse communities experience accessing and navigating the health care system

- Inform the identification and prioritization of top community needs

Participant Demographics

HHSA Region: A majority (66%) of those interviewed were between 18 and 44. The participants lived in the following regions: 41% were from the east, 32% from the central (mainly City Heights), and 16% from the south.

Age: Interview participants ranged from 12-17 to 65 and older. The majority (44%) of interview participants were 27-44.

- 12 - 17 years old
- 18 - 26 years old
- 27 - 44 years old
- 45 - 64 years old
- 65+ years old
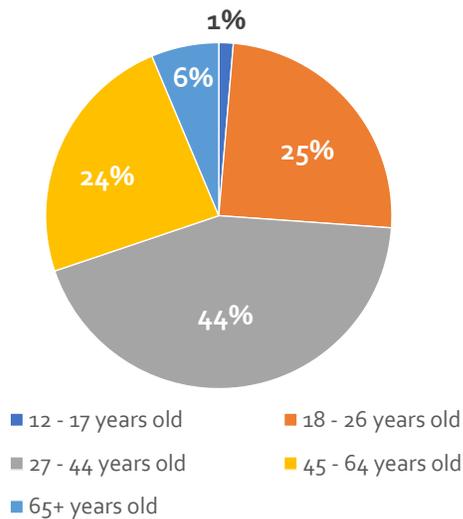
Primary Languages Spoken: Interview participants spoke over 23 languages, including English (45%), Arabic (27%), Spanish (26%), Somali (8%), Amharic (5%), and Dari, Karen, and/or Kurdish (4% each). Other primary languages spoken included Swahili, Pashto, Farsi, Nuer, Oromo, Kizigua, Tigrinya, Haitian Creole, Hmong, Vietnamese, Chaldean/neo-Aramaic, Korean, Tagalog, Guamanian, and French.

Health Coverage: The majority (41%) of interview participants had Medi-Cal health coverage.
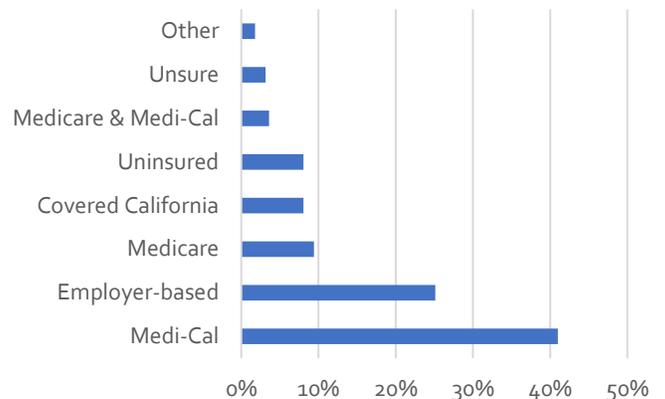
Top Needs Identified by Interview Participants

Top 5 Health Needs

Stress (62%)
Dental Health (44%)
High Blood Pressure (43%)
Diabetes (43%)
Mental/Behavioral Health (43%)

Top 5 Social Needs

Access to Affordable, Quality Housing (69%)
Access to Health Care (47%)
Immigration Status (37%)
Challenges with Education (35%)
Not Having Enough Money (32%)

Challenges with Access to Health Care: 80% of interview participants experienced barriers to accessing health care. The top barrier to accessing health care was long waits for appointments (38%). The overall results are below, sorted by the type of barrier.

Time/Scheduling
- Long waits for appointments (38%)
- Appointment hours are not convienient (33%)

Financial
- Cost of medications (23%)
- Cost of medical appointments or treatments (23%)

Culture, Language & Health Literacy
- Health care providers do not understand me/my culture (20%)
- Limited English or no one to help communicate (17%)
- I do not understand my health condition (14%)

Technology
- Access to the internet or technology (20%)

Lack of Support
- Cannot take time off work (18%)
- Lack of time (15%)
- Family care/elder care needs (11%)
- Lack of childcare (10%)

Health Coverage
- Denial of referral/service (14%)
- Conflicts with health coverage (13%)
- I do not know how/where to find needed care (13%)
- Insurance is not accepted (10%)
- I do not have a doctor (10%)

Distance/ Location
- Provider is too far away (12%)
- Transportation (12%)

Access to Telehealth

Due to the pandemic, telehealth usage rapidly expanded to allow health care providers and patients to connect virtually in a safe manner.

Telehealth Increased Access to Health Care

Telehealth increased access to health care for some community members who had experienced barriers prior to the pandemic. The opportunity to connect virtually with a doctor was a convenient option for those without access to transportation and childcare responsibilities. Some people preferred to receive care in the comfort of their own home.

Telehealth Remained Inaccessible for Some Community Members

Telehealth was not easily accessible for our entire community. The most frequently cited barriers were the lack of access to technology and internet. Some community members were uncomfortable and uncertain about how to navigate the internet (lack of digital literacy) to access their medical records, labs, or paperwork needed for appointments. Community-based organizations and health care providers had to come up with creative ways to ensure that people had access to telehealth.

*More Californians used telehealth as their means of receiving care, whether over the phone or by video. **More than half (55%) reported receiving care by phone and 44% by video in the last 12 months.***

Source: The 2022 CHCF California Health Policy Survey

Our community shared that telehealth during the pandemic was not an optimal choice for:

- People living in crowded households where there was little to no privacy

- People with physical health needs who required in-person care and thorough screenings

- People without a phone or smartphone, including those experiencing homelessness and seniors

"It is important to provide services that are easily accessible to [patients] because transportation is a huge issue ... doing something on Zoom would be really helpful."
FOCUS GROUP PARTICIPANT

"The pandemic has impacted families of individuals with special needs. Home-based services for physical and occupational therapy had to stop so they tried to do via Zoom, which just doesn't work."
FOCUS GROUP PARTICIPANT

"I work with a woman who needed labs for a surgery. But the lab company told her she had to upload things to their website before she could make an appointment. She couldn't do it. She didn't know how."
FOCUS GROUP PARTICIPANT

"Telehealth is preferred for some since they can have someone on the phone with them — but the level of care is not as good because the person is not there for [a] physical exam."
FOCUS GROUP PARTICIPANT

What is Telehealth?

The American Academy of Family Physicians defines *telemedicine* as the practice of medicine using technology to deliver remote clinical services. *Telehealth* refers broadly to electronic and telecommunications technologies and services used to provide care and services at distance. It is different from telemedicine in that it refers to a broader scope of remote health care services than telemedicine.[57] The National Institute on Aging notes that *telehealth* can include non-clinical services. Some examples include health-related education such as diabetes management or nutrition courses and health-related training that may be particularly helpful for older adults with limited mobility and for those living in rural areas.[58]

Preliminary Telehealth Research

Preliminary research on the use of telehealth during the pandemic is beginning to emerge. A few key findings from recent research are below:

- There were 52.7 million Medicare telehealth visits in 2020, a 63-fold increase. This report also found inequities: some people with Medicare, including Black and rural populations, had lower telehealth use compared with white and urban populations.[59]

- When asked, 57% of providers said they viewed telehealth more favorably than before COVID-19, and 64% are now more comfortable using it.[60]

- Remote care reduces the use of resources in health centers, improves access to care while minimizing the risk of direct transmission of (an) infectious agent from person-to-person, and provides wider access to caregivers.[61]

- Implementation and continued access are heavily dependent upon accreditation, payment systems, and insurance coverage.[62]

Barriers to Accessing Health Care

Several factors were identified as being significant barriers to accessing health care in San Diego: transportation, lack of insurance, health care costs and medical debt, and the lack of culturally competent and linguistically appropriate care.

Transportation

Our community shared that transportation to medical appointments is an issue for people without cars, or for anyone without reliable transportation. Public transportation was described as difficult to navigate and time-consuming. Without access to transportation, people are likely to miss or reschedule appointments, postpone care, and unable to pick up medications. Those identified as experiencing significant barriers were people living in rural communities, older adults, people who have limited mobility and are homebound, and people experiencing homelessness.

"Transportation is a need especially for seniors. Some seniors cannot drive, or they are scared of driving, or the health care offices are too far, and it is too dangerous for them to drive."
FOCUS GROUP PARTICIPANT

Lack of Health Insurance

Lack of insurance was identified as a significant barrier to care for San Diegans. Some community members are uninsured due to their inability to pay for health insurance because they have other competing financial priorities (for example, housing costs).

People who are undocumented consistently have more challenges accessing health care because they are more likely to be uninsured or have restricted health coverage benefits that only cover emergency services. There are little to no health care resources that are available in the community for those who are undocumented.

A recurring theme shared by community members and health care providers was the challenges uninsured and underinsured community members face when trying to access follow-up care, treatments, or prescriptions. Uninsured and underinsured are often unable to pay out of pocket for these services.

Our LGBTQ+ community also shared that lack of insurance is a common barrier to health care access. Even with insurance, they have challenges getting the care they need.

High Health Care Costs and Medical Debt

$ *One in four Californians (25%) say they or someone in their family had problems paying at least one medical bill in the past 12 months, an increase from 20% in the 2021 survey. When it comes to paying medical bills, 43% of Californians with lower incomes report having issues paying for them, an increase from 32% from the 2021 survey.*
Source: The 2022 CHCF California Health Policy Survey

Both the high cost of health care and medical debt were frequently identified as causing severe obstacles for our community to access health care. Due to high health care costs, community members would delay seeking care or cross the border to get more affordable health care services (including dental and vision) in Mexico. However, when the

border closed due to the pandemic, people were unable to travel to Mexico for health care.

Our community shared that fear of medical debt was causing people to delay getting treatment because they were already struggling to pay for their bills. Community members shared that if they were not dealing with it personally, they knew a family member or friend who was dealing with medical debt after a hospital stay. As a result, they felt worried about seeking emergency care at a local hospital.

"Even with the language barrier, many Arabic families prefer to get their care over the border, especially their dental and vision care. It's cheaper, and they can get appointments much faster."
FOCUS GROUP PARTICIPANT

Financial Assistance
The need for financial assistance to help pay for medical bills was a frequent and a significant concern shared by many of those we interviewed in our community. There are some programs available at no cost or low cost to help pay for services, but community members are not always informed of those resources. Some people find out about these resources by word of mouth from family or a friend.

Other Barriers That Reduce Access to Health Care
Stigma. Particularly among our LGTBQ+, people experiencing homelessness, older adults, undocumented and refugee communities, stigma was a significant barrier in accessing care. Our community shared feelings of anxiety or fear and/or their likelihood of avoiding or delaying care due to concerns of being treated differently. Community

members insured through the Medi-Cal program also experience stigma while accessing care.

"The majority of LGBTQ+ community members we work with are BIPOC (Black, Indigenous, and people of color). This means there are other barriers on top of their gender or sexual identities. The main barriers for health for our LGBTQ+ community are the lack of insurance, poverty, and long waits for services."
FOCUS GROUP PARTICIPANT

"Medi-Cal and people who have government insurance often feel like they are begging for health care, as opposed to somebody who has a human right and deserves health care."
FOCUS GROUP PARTICIPANT

Childcare. Parents or caregivers with children often face barriers accessing health care and cannot make it to appointments, if they do not have access to childcare.

Fears related to immigration status. Across all interviews, community members, community-based organizations, and hospital leaders, described undocumented immigrants as living in a "constant state of fear" of detention and deportation. This fear prevents them from accessing health care, even in life-threatening or dire situations. Moreover, the multiple changes to public charge rules over the last few years caused many immigrants with a legal status to question or have concerns about their use of health systems and benefits.

"In the Latinx community there is still residual fear of deportation because of the prior administration."
FOCUS GROUP PARTICIPANT

Culturally Competent and Linguistically Appropriate Care

A primary theme across focus groups and interviews was the need for more culturally competent/linguistically appropriate care.

Community members shared their preference for receiving health care from providers who reflect their race and ethnicity. Specific populations, including Latino and Arabic, were concerned that they are not treated fairly because of their cultural differences and thus it was harder for them to trust providers.

"Emotions are tied to language. It's very soothing to have someone speak your language."
FOCUS GROUP PARTICIPANT

Language was identified as a significant access to care barrier for non-English speaking and limited English language proficiency community members. **Having a provider who speaks the patient's language builds trust, understanding, and a comfortable environment to share any health concerns.** Many people who speak little to no English rely on family or friends for translation. Using a loved one was identified as limiting patient-provider privacy, which could result in the patient not fully disclosing their entire medical condition or needs. Language barriers were identified as a reason some community members avoid seeking care.

"The health care workforce does not reflect the community. This is difficult for refugees. If they can navigate the system to see a medical provider, the person most likely will not look like them or know anything about their culture. There is a disconnect."
FOCUS GROUP PARTICIPANT

Translation services have not been an adequate alternative to help with patient-provider communication and building trust. When a patient does not have access to a translator, health care providers utilize translation services via technology or the telephone. Specific challenges using translation services were identified as causing miscommunication:

- Because many of these translators do not have medical training, they may not be able to accurately translate what is being said by a health care provider.

- Translators often speak at a higher reading level or a more formal language than the patient.

- Telephone translators are unable to read facial expressions or body language to identify if people fully understand what they're explaining.

"Medical personnel will say they have a translator … but often it's not a human being doing the translation — they are using an iPad translation which is not always accurate … especially with Arabic dialects. iPad translation uses formal Arabic — and many elderly people don't know formal Arabic."
FOCUS GROUP PARTICIPANT

"Our clients frequently raise concerns about the availability of translation services. They tend to rely on family members and are surprised to learn of the ability to access translation services."
KEY INFORMANT

LGBTQ+ Experience Accessing and Navigating Care

Accessing and navigating care was described as procedurally difficult and complex for our LGBTQ+ community — hitting barrier after barrier after barrier. The traditional approach to health care was described as non-inclusive and inadequately meeting the unique health needs of LGBTQ+ people.

Lack of Safe, Gender-Affirming, and Competent Providers

There is a paramount need for more safe, affirming, and competent providers. Finding a gender-affirming provider is critically important for the LGBTQ+ community to trust their provider and feel comfortable in fully discussing all health needs. **The current network of gender-affirming providers is very limited and providers are hard to find. LGBTQ+ people rely on community-kept records or word of mouth to learn of providers who are safe and gender affirming.**

Clinicians shared that transgender and gender diverse people without insurance (particularly those who are undocumented) or people who are unable to access gender-affirming care are more likely to get risky and dangerous procedures done in non-health care settings.

"Current forms in most health care facilities include binary definition of gender. Thus, many in our community do not feel welcome. Few health care providers are specialized in gender-affirming health care."

KEY INFORMANT

"The lack of data is the number one barrier to accessing health care. We are forced to rely on national surveys to try to make the case for health services that we know are needed. Until our community does a better job collecting sexual orientation or gender identity (SO/GI) data, we won't be able to fully address the unique health care needs of our LGBTQ+ community."

KEY INFORMANT

The Importance of Sexual Orientation and Gender Identity (SOGI) data

Lesbian, gay, bisexual, transgender, queer, intersex, asexual, and all sexual and gender minority (LGBTQ+) people experience health disparities and require care and services tailored to their unique needs.[63] The process of asking all patients about their SOGI empowers health centers to get to know their patients better, and to provide them with the culturally responsive, patient-centered services they need. SOGI data collection also allows health centers to learn about the populations they are serving, and to measure the access to care and quality of care provided to people of all sexual orientations and gender identities.[64]

Source: National LGBTQIA+ Health Education Center - Ready, Set, Go! Guidelines and Tips For Collecting Patient Data on Sexual Orientation and Gender Identity (SOGI) – 2022 Update

"Health plans don't have useful information for LGBTQ+ patients seeking care, so the LGBTQ+ community has become really good at record keeping. They know providers to see."

KEY INFORMANT

Stigmatizing Experiences Accessing Health Care

Interviewees shared that LGBTQ+ people experience stigma and discrimination in all touchpoints of the health care system, especially from health care providers who lack sensitivity. Additionally, current forms and practices were identified as non-inclusive. For example, new patient or intake forms only provide binary options (male or female), which are non-inclusive to our non-binary community members. **People have also struggled with being acknowledged of their new affirmed name and often are deadnamed[65] (called by a name they no longer identify with).** These negative experiences create an unwelcoming and unsafe environment and were identified as reasons for people avoiding or delaying medically necessary care.

Some people who are transgender will experience "gender dysphoria," a mismatch between sex assigned at birth and gender identity, which can cause extreme distress or discomfort. People experiencing gender dysphoria often have feelings of desperation when they do not feel understood or cared for and do not have any other options to obtain care. Advocates shared that in some cases, transgender community members will take extreme measures to avoid the trauma of trying to access the traditional health care system.

"Providers assume a person is cisgender and question certain tests that gay people may request more frequently … Another challenge is reproductive rights for trans people. It is uncomfortable to need to explain when presenting as male that one has female parts."

FOCUS GROUP PARTICIPANT

"With our trans population [experiencing homelessness] there are barriers to being treated due to [one's] gender identity and barriers in changing [an] individual's name legally or even within just the health care system because we know how cumbersome it is overall with any legal matters. And it is often a very triggering factor, especially when individuals are having to call and go by their name given at birth that it turns them away from even seeking care because, again, it just becomes very traumatizing."

FOCUS GROUP PARTICIPANT

"Our LGBTQ+ seniors will never feel comfortable unless it is an affirming health care provider that makes sure to show them their intent in many different ways. It can be a rainbow flag in their office or something that really tells one that it's a safe [LGBTQ+] space."

KEY INFORMANT

"LGBTQ+ people find themselves being their own advocate and/or rely on the community's help to get the care they need."

KEY INFORMANT

"It's important to remember that everyone's experiences are different. An intersex individual will have completely different challenges accessing providers and appropriate health care services than a cisgender gay man. The experiences of the transgender community vary widely across race and generations. Youth living in a strict household considering transition face different challenges than seniors who might be coming out for the first time."

KEY INFORMANT

Pre-Exposure Prophylaxis (PrEP) and PrEP-Related Services

PrEP refers to a medication that lowers a person's risk of contracting HIV and is extremely effective as a preventative.[66] While on PrEP, a regimen that consists of follow-up visits, continuous HIV testing, and obtaining refills must be followed. Interviewees shared that for those who are uninsured, access to PrEP and necessary follow-up care is hindered by extreme cost burden. And for those with insurance, the out-of-pocket cost is even higher as many insurance companies do not cover these treatments. These high costs disproportionately impact BIPOC LGBTQ+ individuals the most as they are more likely to be low-income.[67]

There were also concerns about access to post-exposure prophylaxis (PeP). It is similar to PrEP, except that it is taken when the patient believes they have been exposed to HIV. It must be taken within three days after the exposure, otherwise, it is not effective.

For PeP, the sensitive time frame is extremely hard to meet because some providers will require an in-person appointment before prescribing, that is if you can even talk with a provider directly within three days to have them write the prescription.

KEY INFORMANT

Intersectional Stigma

Black transgender women face many challenges related to their experience with the convergence of race, gender identity, and economic status. They are particularly vulnerable to higher rates of experiencing health disparities, such as higher rates of HIV diagnoses.

In 2019, the majority of new HIV diagnoses among transgender people were among Blacks/African Americans: 45% for transgender women and 41% for transgender men.[68]

LGBTQ+ people and people living with HIV are too often denied the care they need because of their sexual orientation, gender identity and/or HIV status. Almost 8% of LGBTQ+ respondents reported that they had been denied needed health care outright. Over a quarter of all transgender and gender-nonconforming respondents (almost 27%) reported being denied care and 19% of respondents living with HIV also reported being denied care.[69]

Disparities Experienced by Black Transgender and Gender-Nonconforming[70]

- Black transgender people have a 26% unemployment rate. That's twice as high as the unemployment rate for transgender people of all racial and ethnic backgrounds, and four times as high as the unemployment rate in the general population.

- Black transgender people are five times more likely than the general population to experience homelessness.

- When it comes to income, 34% of Black transgender people have household incomes less than $10,000 (more than eight times the general population).

- Nearly half of the Black transgender population has attempted suicide.

The Importance of Trauma-Informed Care

People who have had experienced traumatic events carry that trauma throughout their life. They may seem apprehensive, reluctant to share their needs, or slow to trust providers. This fear and distrust can sometimes lead community members to use traditional remedies or delay care until it becomes an emergency. (Additional information on types of trauma and trauma-informed care is on the following page.)

Recognizing implicit bias and microaggressions are fundamental in understanding what may potentially trigger adverse reactions, especially for patients who are from culturally or linguistically diverse backgrounds. Individuals who have been affected by traumatic events can pass their trauma down through the generations, causing their descendants to experience it as well. Furthermore, due to biological changes in the stress response system, these experiences are linked to a greater risk of health disparities.[71]

Interviewees shared the importance of education, training, and treating those they serve with dignity. Acknowledging the presence of trauma symptoms and the part that trauma may play in a person's health decisions is critical. And because **challenges related to trauma** can trigger adverse feelings and make people feel unsafe, providers should be respectful, gentle, and provide a welcoming, affirming environment. Implementing trauma-informed approaches by recognizing trauma, strengthening resiliency, and avoiding re-traumatization, can lead to more open communication, engaging patients in their care, and serving the broad spectrum of their needs.

"In particular for the transgender, gender variant, and intersex population, being deadnamed,[72] misgendered, or treated in a non-gendering-affirming manner causes trauma and leads to deferred care and exacerbation of symptoms."
KEY INFORMANT

"Regarding historical trauma … some Native Americans in general don't ever want to go to the hospital. I have elders back home who will just use traditional medicines or they just won't go, which is not good, because they're unhealthy. [Therefore] … historical trauma [should be taken] into consideration … that some Native people are very traumatized and do not want to come to a clinic … or the hospital."
FOCUS GROUP PARTICIPANT

"There is a universal need for education and training to get rid of bias, and to teach people to treat others humanely with dignity and respect."
FOCUS GROUP PARTICIPANT

What is Trauma-Informed Care?

The need for a trauma-informed approach to care echoed throughout our research and interview process. Hearing from a multitude of perspectives highlighted the depth and range of traumas many people have experienced in their lifetime. Trauma-informed providers improve access and connection to care and therefore the overall health of our community is positively impacted.

Trauma

While there is no universal definition, the Substance Abuse and Mental Health Services Administration (SAMHSA) defines individual trauma as resulting from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.[73] Trauma refers to what happens inside our bodies during and after the event, not the event itself. SAMHSA notes that trauma can be experienced as a group, community or mass and differentiates between them. It also emphasizes that trauma perceived as intentionally harmful can often make the event more traumatic for people and communities.[74] Please see **Appendix A** for more information on these and the other types listed below.

Types of Trauma

Our research findings included many trauma types and categories. SAMHSA and the National Child Traumatic Stress Network identified the following as examples of the types that people can experience.[75] SAMHSA also noted that there is overlap, as some fit multiple categories:

Types of Trauma

Community	Natural
Complex	Physical
Complex	Political terror and war
Domestic violence	Refugee
Early childhood*	Repeated
Group	Secondary
Historical	Sexual
Human caused	Single
Human trafficking**	Sustained
Individual	System-oriented re-traumatization
Mass	Traumatic grief
Medical	Vicarious
*Please see **ACEs** section for more information.	
Please see **Community Safety finding for more information.	

Sources: Trauma-Informed Care in Behavioral Health Services SAMHSA, Trauma Types the National Child Traumatic Stress Network (nctsn.org)

Trauma and Compassion Fatigue

Researchers have identified two types of compassion fatigue: secondary and vicarious. According to SAMHSA, for some responders, *secondary* traumatic stress refers to the negative effects of this work that can make them feel like the trauma experienced by the people they help is happening to them or someone in their lives. When these feelings are prolonged, they can turn into *vicarious* trauma.[76]

The Impact of Trauma on Health

Traumatic events (for example adverse childhood experiences, domestic violence, elder abuse, and combat trauma) are associated with long-term physical and psychological effects on a person's health. These events may have a negative impact on health care experiences and the likelihood of seeking preventative care. This highlights the importance of trauma-informed care (TIC) for people with this kind of lived experience.

What is TIC?

The Child Welfare Development Services at San Diego State University defines TIC as an organizational practice framework that involves understanding, recognizing, and responding to the effects of all types of trauma a person has experienced. TIC emphasizes physical, psychological, and emotional safety for both patients and providers, and helps rebuild a sense of control and empowerment.[77]

TIC Best Practices

According to SAMHSA, TIC incorporates a set of four "Rs," assumptions that guide the six principles included below. TIC *realizes* the widespread impact of trauma and understands potential paths for recovery; *recognizes* the signs and symptoms of trauma in clients, families, staff, and others

involved with the system; and *responds* by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist *re-traumatization.*[78] TIC can refer to either evidence-based trauma interventions or to a broader systems-level approach that integrates trauma-informed practices throughout a service delivery system (e.g., health care system, educational system, law enforcement).[79]

Source: SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach SAMHSA[80]

Six Key Principles of a Trauma-Informed Care Approach
• Safety • Trustworthiness and Transparency • Peer Support • Collaboration and Mutuality • Empowerment, Voice and Choice • Cultural, Historical, and Gender Issues

Why is TIC Important?

TIC is important because people who have experienced trauma may not seek health care until it is an emergency. By avoiding preventative care and other routine services, negative health outcomes can occur. This is especially a concern for certain populations who often experience a high amount of trauma such as people who are BIPOC, LGBTQ+, and/or have been trafficked. Implementing a TIC approach creates a more comfortable and inclusive environment conducive to a more equitable health care experience and better overall quality of life. As mandated reporters, health care providers play an important role as up to 88% of people who are being trafficked seek care during that period.[81]

Please see **ACEs** section for more information.

Health Care Workforce Challenges

Workforce shortages were identified as the number one priority for our local health care providers. The pandemic severely exacerbated and strained our health care workforce and has severely impacted our ability to meet the growing demand for services in our community.

An overwhelming sense of exhaustion and intense burnout was felt throughout interviews with health care providers who cared for our sickest and most vulnerable throughout the pandemic and beyond. Additional factors identified as contributing to stress among health care workers **include excessive administrative requirements and the lack of available resources in the community.** Without the resources, hospital clinicians and social workers shared that they are unable to fully support patients with follow-up care.

*From the end of 2019 to the second quarter of 2021, **the staff vacancy rate at California hospitals jumped 98%, and 78% of hospitals reported an increase in staff turnover.** California needs to add 500,000 new allied health care professionals by 2024 in order to provide needed care.[82]*

Burnout has led many health care professionals to retire early, relocate to different internal departments, and/or leave the industry entirely. Both clinic and hospital administrators shared that recruiting and retaining health care workers has become increasingly difficult as they compete with other companies that offer higher salaries and/or benefits.

"Our top three priorities— number one, number two, and number three — are all workforce. Staffing limits our ability to deliver care."
FOCUS GROUP PARTICIPANT

*The health care sector has lost **nearly half a million workers since February 2020,**[83] and new data suggest that during the pandemic 18% of health care workers have quit and 12% have been laid off.[84]*

"I've been burnt out, which is why I'm relocating to an outpatient setting. The cycle continues. We need community leadership to let health care workers know that they have our back and to give us hope."
KEY INFORMANT

"The competition is not just other health care providers but with other jobs like In & Out. Employees are exhausted. They would rather deal with someone whose burgers came out wrong than someone who is frustrated because they can't get the service they need."
KEY INFORMANT

Our community recognized that all health care settings — including behavioral health — were understaffed and described how workforce shortages adversely impact the patient experience. Community members shared frustration about long wait times in hospital emergency departments and outpatient care settings.

Health care providers noted that the workforce shortage is also creating a wider equity gap —there are fewer culturally competent and linguistically appropriate providers available to care for our diverse community.

"I know they are understaffed and that affects us, as patients."
FOCUS GROUP PARTICIPANT

"We're seeing that clients are having a difficult time accessing services because there's literally just less staff than there ever have been before, there's more pressure on them than there ever has been before, and there is built-up demand for appointments."
FOCUS GROUP PARTICIPANT

Access to Health Care Challenges for People Experiencing Homelessness

Those experiencing homelessness face months-long waiting lists for shelter beds. As they wait for a shelter bed opening, many are pushed to utilize the resources available to them to survive until the following day. This may sometimes necessitate a trip to the emergency department (ED) to obtain food, clothing, or a safe place to sleep for the night. For those who have very limited income, their ED visits tend to become more frequent toward the end of the month, as their financial resources dwindle.

The lack of housing and personal resources causes many people experiencing homelessness to access care for episodic, emergency situations when they are on the brink of deterioration. Interviewees frequently cited chronic health conditions, such as chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), chronic pain, and diabetes, as the most common reasons patients experiencing homelessness access health care in the ED. Another reason for accessing care in the ED was related to medication management for example patients who are inconsistently taking or completely discontinuing medications. Please see **Chronic Health Conditions** finding for more information.

There was agreement across interviewees that having a safe place to stay after being discharged from the hospital is crucial to recovery and healing. Without a stable place to stay, community members experiencing homelessness could undo any progress they made during their hospitalization. Recuperative care (also known as

medical respite care) was cited as a specific need for many patients experiencing homelessness who no longer need to be hospitalized but must still have a place to heal and recover from an illness or injury.

In addition to recuperative care, lack of post-acute care with housing and medication management for patients experiencing significant mental health concerns were mentioned as a need. This includes assisted living, board and care homes, and full services partnership programs. Please see **Behavioral Health** finding for more information.

"There is a significant gap in services between skilled-nursing facility level and then being in a shelter and there's not enough recuperative beds. There needs to be an assisted living level [of care]. There's just not enough space and it's very challenging to get our clients into programs like that."
FOCUS GROUP PARTICIPANT

"Unhoused patients need to wait for months for a bed in a shelter."
FOCUS GROUP PARTICIPANT

"Medication management and health education support is what individuals experiencing homeless come to the hospital for when there is a breakdown in their medical or psychiatric care."
FOCUS GROUP

"There is a minimal availability of recuperative beds … and we can't move someone away from the region they believe is their home."
FOCUS GROUP

Stigmatizing Experiences

Interviewees shared that people experiencing homelessness often feel marginalized, socially excluded, and regularly face discrimination from other community members, service, and health care providers. This social exclusion, coupled with daily challenges in building or maintaining social connections with others, makes them fearful of experiencing further discrimination in several settings. Subsequently, many people experiencing homelessness feel discomfort, distressed, or undeserving of help when they seek treatment for health or need help for safety reasons.

Home health devices were identified by interviewees as an existing need for patients experiencing homelessness that had only gotten worse due to the pandemic. Lack of a physical address and lack of mailbox or P.O. box to receive mail is one of the main barriers people experiencing homelessness face in securing home health. Though home health may be an appropriate post-discharge treatment option for certain patients experiencing homelessness, it can be challenging to provide necessary equipment such as (wheelchairs, walkers, canes, portable CPAPs, etc).

In addition, the inability to maintain sanitary conditions could lead to a higher risk of infection and there are challenges with equipment being stolen. Interviewees shared further that even if outpatient services for home health devices can be arranged, transportation is often a barrier to getting access to services.

"[Patients experiencing homelessness] are thinking in terms of the immediate … in the moment how do I just survive the moment and how do I get to the next moment, will it be worth it? [I've] just got to survive out here tonight and worry about tomorrow …Taking medications for a health condition that I don't even see or realize, why would I do it? It's not on my priority list."
KEY INFORMANT

"[Clients experiencing homelessness] are already in distress, in a stressful place mentally, physically. When they do seek services, they may not know how to communicate exactly what their needs are, and even if they do, they often hear 'well we can't be the ones to help you.'"
FOCUS GROUP PARTICIPANT

"A lot of our clients need to see [multiple providers]. That process itself is very irritating for them and requires a lot of planning and scheduling. [Many] times they don't really have that mental capacity; they're worrying, 'How can I survive through the next day?' [This worrying causes clients] to [plan] on these appointments so far in advance that [they end up] missing them."
FOCUS GROUP

Health Equity in End-of-Life Treatment

Despite the increase in the use of hospice and palliative care in recent decades, disparities in access to hospice care and end-of-life treatment remain.[85]

Community members shared it is difficult to find palliative care programs that have culturally diverse services. This was identified as a particularly significant challenge for community members who are LGBTQ+, veterans, and people of color.

The result is an increase in ED visits and hospitalizations in the last six months of life compared to white non-Hispanic individuals, regardless of the cause of death.[86]

"There are cultural nuances that need to be addressed in palliative care and end of life discussions."
KEY INFORMANT

"Some of the worst discriminatory practices, happen to gay seniors. They are still ashamed, afraid of being judged, and can't verbalize that the person they are with is their spouse, even at their partner's end of life."
FOCUS GROUP PARTICIPANT

2022 San Diego
Community Health Needs Assessment

2022 SAN DIEGO CHNA
COMMUNITY HEALTH NEEDS ASSESSMENT

HOSPITAL ASSOCIATION
of San Diego & Imperial Counties

2022 CHNA Findings:

Aging Care & Support

Aging Care & Support

Concern for the mental and behavioral health of seniors in San Diego County was universal in our interviews and focus groups. Of particular concern was the impact of increased isolation as a result of the COVID-19 pandemic. Economic instability was another theme that emerged in every single conversation about seniors.

The Population of Seniors in San Diego County is Growing

Percent of Senior Population by Age Group and HHSA Region, 2019

■ 65-74 ■ 75-84 ■ 85+

Region	65-74	75-84	85+
Central Region	6.6%	3.3%	1.4%
East Region	8.4%	4.1%	2.0%
North Central Region	7.6%	3.9%	1.8%
North Coastal Region	8.5%	4.2%	2.0%
North Inland Region	8.9%	4.5%	2.1%
South Region	7.3%	3.7%	1.7%
San Diego County	7.9%	4.0%	1.8%
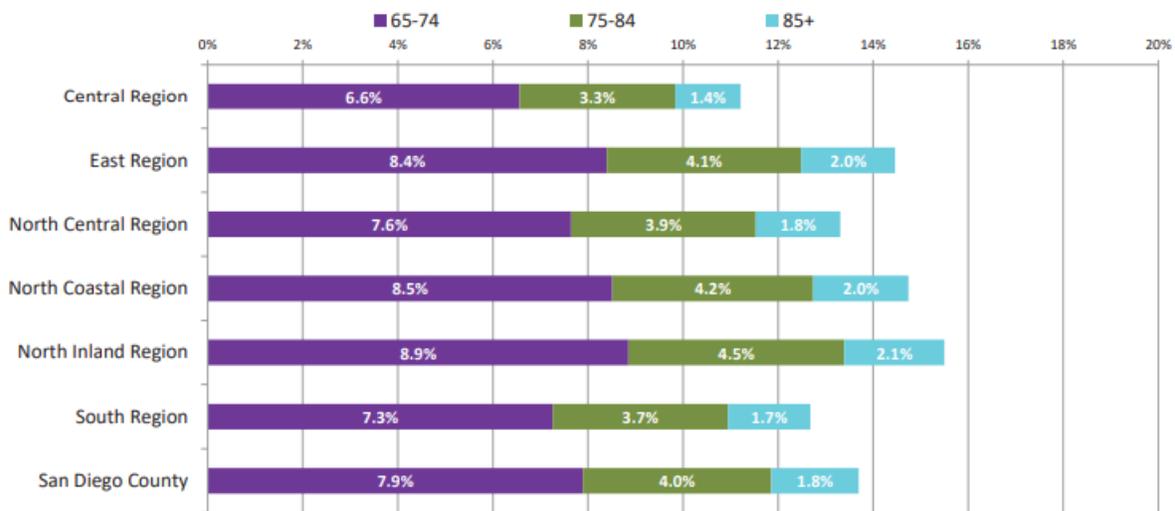
*Percent out of the total population.
Source: U.S. Census Bureau; 2015-2019 American Community Survey 5-Year Estimates, Table B01001.
Prepared by: County of San Diego, Health and Human Services Agency, Public Health Services, Community Health Statistics Unit, 2021.

2022 California Department of Aging Population Demographic Projections – San Diego County[87]

Population 60+	729,001
Non-Minority 60+	333,249
Minority 60+	395,752
Low-Income 60+	80,050
Medi-Cal Eligible 60+	132,030
Geographic Isolation 60+	22,757
Supplemental Security Income/State Supplementary Payment 65+	38,857
Population 75+	234,033
Lives Alone 60+	125,000
Non-English-Speaking 60+	25,990

Economic Stability and Risk of Homelessness

Even before the pandemic, seniors were the fastest-growing age group among the unhoused. Seniors are at a higher risk of poverty for a number of reasons, including limited income. Low-income seniors depend on public programs like Medi-Cal and cash assistance (Supplemental Security Income) to make ends meet. Added risks such as chronic health conditions, disability, and loss of spouse all contribute to an increased risk of poverty.

A significant portion of the region's population that is experiencing homelessness is older adults. In 2020, one out of every four unsheltered San Diego County residents were adults aged 55 and over. Among San Diego's unsheltered seniors, 88% became homeless in San Diego and 43% are experiencing homelessness for the first time in their lives.[88]

There are significant financial barriers to aging at home with dignity. Seniors who are considered higher-resourced individuals may need to sell their homes or possessions to qualify for the help they need. Low-income seniors struggle to afford the home modifications or equipment needed for aging with dignity at home such as grab bars, ramps for wheelchair access, special shower chairs, and so on. This can lead to seniors becoming bed-bound or conditions worsening if they cannot afford to make the necessary modifications to their homes.

The population of elderly individuals who are experiencing homelessness is expected to nearly triple over the next decade. More specifically, the national population of people 65 or older experiencing homelessness is estimated to grow from

40,000 to 106,000 by 2030.[89]

Percent of Seniors, Aged 65+, Living Below 100% of the Federal Poverty Level by HHSA Region, 2019

Central Region 13.4%, East Region 8.9%, North Central Region 6.7%, North Coastal Region 6.6%, North Inland Region 7.5%, South Region 12.6%, San Diego County 8.9%

Source: U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates, Table B17024.
Prepared by: County of San Diego, Health and Human Services Agency, Public Health Services, Community Health Statistics Unit, 2021.

Top 5 Needs for 2-1-1 San Diego Clients Aged 60 & Over

Total Clients 39,699

1. **Housing (22%)**
2. **Utilities (17%)**
3. **Income Support and Employment (12%)**
4. **Consumer Services (12%)**
5. **Health Care (9%)**

"Shallow rental subsidies, tied to rent burden rather than a set amount, are proving to be very effective. Early research suggests that subsidies should be set at 35% of the individual's rent burden." [90]

KEY INFORMANT

Senior Homelessness: A Needs Assessment

In September 2021, Serving Seniors released a report on San Diego's senior homelessness crisis.[91]

Key findings include:

- Many older adults become homeless because they lack an economic safety net. They suffer catastrophic events with dire financial consequences and may take actions that compromise their health and safety to make ends meet.

- More than half (56%) of those interviewed reported an additional $300 or less of monthly income would increase their rent security.

- Some interview participants reported avoiding shelters due to safety concerns, including the risk of theft, physical harm, and potential exposure to substance use.

- The person/environmental fit of shelters may be another area for exploration given functional impairments and health concerns associated with the aging process.

- Older adults who were interviewed reported challenges with identifying and accessing services and resources. They reported struggling with technological barriers, transportation, and mobility limitations.

56% of older adults surveyed report an additional $300 or less per month would prevent them from becoming homeless.

Graph 1.0: Sacrifices Made to Afford Rent

■ Experienced homelessness ■ Has not experienced homelessness

Sacrifice	Experienced homelessness	Has not experienced homelessness
Sold personal items and/or medication	34%	8%
Borrowed money	49%	18%
Allowed others to live with them even if it felt unsafe	21%	16%
Gone without food or medication	45%	11%
Passed on medical care	23%	9%
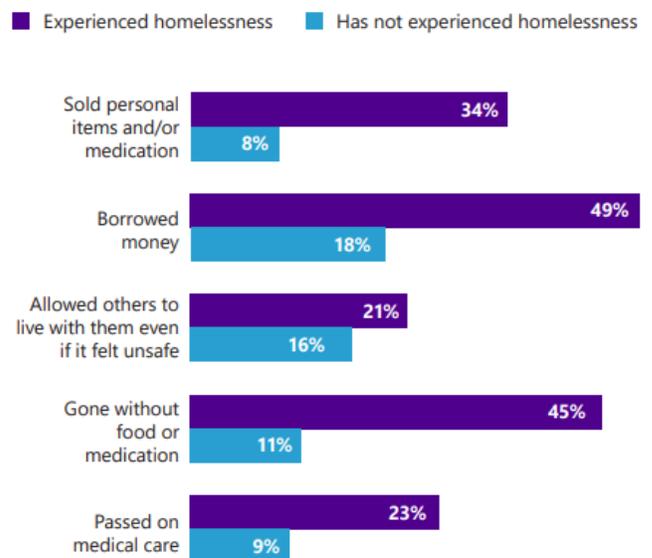
"Navigating systems, such as housing, is a huge issue. When seniors have abrupt changes in circumstances, where do we send them? Where does someone call when their husband dies? Or their wife dies? It feels like there is no right door.

These people need help."

KEY INFORMANT

COVID-19 Exacerbated Challenges for Seniors Experiencing Social and Geographic Isolation

Concerns about social isolation for seniors were a universal theme in focus groups and interviews. Due to safety guidelines and fear, many seniors were isolated, and many remain isolated.

Social isolation affects the health and well-being of seniors. Some seniors did not have access to smart devices and were unable to virtually socialize with family/friends or participate in activities that community-based organizations organized. Increased isolation resulted in many seniors experiencing more depression and anxiety. In some cases, seniors went without medical attention for more than a year during the pandemic and neither their doctor nor their family realized how significantly their cognitive abilities had declined.

Geographic isolation creates additional challenges for seniors. It was evident to service providers we interviewed that geographically isolated seniors need special assistance and consideration, such as food deliveries throughout the county. Some seniors are not just geographically isolated but are also alone, so it is essential to have people who can check in on them.

"I think we are going to see seniors who have been prematurely homebound … and not be able to get them back functioning both physically and mentally. We are going to see lingering mental health impacts from seniors who have been truly isolated."
KEY INFORMANT

Lonely older adults

are nearly twice as likely as seniors not experiencing loneliness to use painkillers and sedatives, which frequently leads to substance use problems, accidents, medical complications, falls, or death. [93]

Social isolation

45%

presents a significant mental health concern among older adults, which affects those experiencing homelessness. Almost half of surveyed older adults (45%) reported experiencing social isolation. They felt lonely, isolated, or cut off from friends and family. [92]

Challenges Accessing Health Care

COVID-19 had a significant impact on older adults' ability to access health care services. This is significant because older adults are at greater risk of having multiple chronic conditions, including dementia.

Due to concerns related to COVID-19, some seniors were not willing to make in-person appointments at their doctors' offices and hospitals. **Mobility related to aging, being homebound, disabled, or walker/wheelchair-dependent is a significant barrier to accessing health care for many seniors.** Physical limitations such as vision loss or hearing loss require extra assistance, consideration, and accommodation that are often not offered or readily available.

Transportation and its costs were consistently cited as a barrier to seniors' ability to manage their health care, including getting to appointments on time or picking up prescriptions on their own. Some seniors rely on family members for their transportation needs due to their age and physical decline, but it can be very overwhelming if there are frequent appointments and seniors may become reluctant to ask for help.

Technology-based health care services and information are often not appropriate for older adults and seniors. Many older adults, especially those with lower incomes, cannot access information or needed forms because they do not own or do not know how to use technology. Lack of access to technology and discomfort using technology also make telehealth appointments problematic for seniors. Vision and hearing challenges add to these difficulties.

Inadequate dental coverage for seniors continues to be a serious issue that negatively impacts overall health. Seniors with Medicare have no dental coverage. Seniors and older adults with Denti-Cal (dental coverage for Medi-Cal beneficiaries) have extreme challenges finding providers.

"Aging can be a great equalizer in some respects, regardless of [the] individual. We all age and at some point…we need to give up keys [both metaphorically and literally]. We all need health care and … accessing this health care is vital for our community."
KEY INFORMANT

San Diego County data show that emergency department (ED) and inpatient discharges have increased from 2017-19 for disorders of the teeth and jaw for those aged 65+.[94] Disorders of the teeth and jaw include dental caries, loss of teeth, and other specified disorders of teeth and supporting structures.[95] ED discharge rates increased by 14.2% from 2017-19 while inpatient discharge rates increased by 26.9% in the same period.[96]

"Technology has been both savior and a barrier these past two years ... Technology allowed government and service providers to share information, register for COVID testing and vaccines, and see patients through telehealth. But for those without broadband or smartphones — those in rural communities and low-income seniors — the focus on technology as the answer has been a barrier."

KEY INFORMANT

During the pandemic, access to appropriate post-acute care became a serious challenge for many seniors who were hospitalized with COVID-19 or other conditions.

In some cases, skilled-nursing facilities (SNFs) closed admissions due to outbreaks, risk of infection, and low staffing. In general, patients with Medi-Cal are the least likely to be admitted by SNFs, especially if the patient is experiencing homelessness. Older adult patients experiencing homelessness have complex health needs that require significant post-acute treatment and healing time, but longer-term post-acute care with housing such as SNFs or recuperative care facilities are very limited.

ED Discharge Rate for Disorders of the Teeth and Jaw, Ages 65+
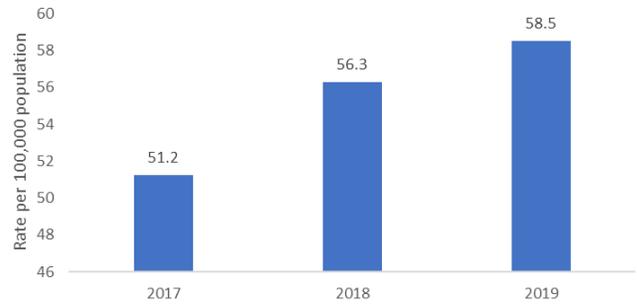
Inpatient Discharge Rate for Disorders of the Teeth and Jaw, Ages 65+
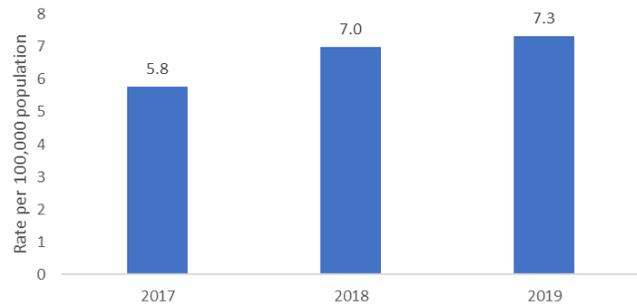
Source: California Department of Health Care Access and Information limited data sets, 2017-2019. SpeedTrack

Oral Health Disparities in Adults Aged 65 or Older

More than nine in 10 older adults *have had cavities, and one in six have untreated cavities. Older non-Hispanic Black or Mexican American adults have two to three times the rate of untreated cavities as older non-Hispanic white adults.[97]*

Seniors With Mental and Behavioral Health Challenges Face Increasingly Difficult Challenges Accessing Services

The most pressing concern identified by hospital **clinicians was the lack of resources for seniors with behavioral health challenges.** Skilled-nursing facilities have limited willingness and capacity to accept patients with behavioral health diagnoses. This challenge is particularly acute for seniors who require psychotropic medications. There are few placement options **for dementia (including Alzheimer's) patients** who have behavioral health issues and show signs of agitation.

There are extremely limited geriatric psychiatry resources, especially for senior patients who need to be discharged from the hospital to a more appropriate level of care. **There is a high need for geropsychiatric care professionals to keep up with the expanding health care needs of the growing senior population, including acute care specialists.**

When older adults struggle to access needed services, they may try to cope through substance use. Clinicians **described recent increases in substance use including alcohol, prescription drugs, and illegal substances such as methamphetamine (meth).**

A study conducted by researchers at a hospital in Central San Diego found that elderly meth patients were more severely injured and required a higher level of care than other elderly patients. Within San Diego County, individuals aged 55-64 have the highest rate of meth-related deaths of any age group (31.8 per 100,000).[98]

"The average senior is not going to be able to readily access a psychiatrist, let alone a geriatric psychiatrist."
KEY INFORMANT

"Finding a therapist or provider they are comfortable with is difficult. There are language and cultural issues, even age becomes a barrier. An 80-year-old senior talking with a 28-year-old therapist could be insensitive to senior-specific issues."
KEY INFORMANT

"When we see seniors that need psychiatric treatment, there is a good chance they are admitted medically because there are no psych beds."
FOCUS GROUP PARTICIPANT

Stigma Prevents Many Seniors from Accessing Critically Needed Programs and Supports

Older adults can be especially reluctant to seek help or admit they are having mental health challenges. From the community, we heard about the role that stigma plays in specific populations of older adults.

Stigma is often associated with mental health conditions due to cultural factors, historical trauma, and mistrust. Some Native American elders will opt to use traditional medicines and healing practices rather than go to a hospital or clinic for their mental health needs.

Many seniors experiencing homelessness fear that they will be judged by their hygiene and turned away from services. They also fear a lack of understanding from those providing needed health care services.

LGBTQ+ seniors will only seek services when they absolutely need to because of fear of judgment and their needs not being understood by health care staff and providers. Some LGBTQ+ seniors feel they may get shamed, which leads them to share less about their health histories with providers.

"Generation-wise, LGBT seniors today have lived through, grown up in, and experienced some of the harshest discriminatory practices to date and do not want to experience more discrimination or frustration when they are in a vulnerable state of health."

KEY INFORMANT

"Some senior behavioral health patients experiencing homelessness are written off as being 'non-compliant' when in reality they may be uncomfortable, have an existing mental health issue they are trying to manage, or cannot understand all the paperwork program requirements."

KEY INFORMANT

2022 San Diego
Community Health Needs Assessment

2022 SAN DIEGO CHNA
COMMUNITY HEALTH NEEDS ASSESSMENT

HOSPITAL ASSOCIATION
of San Diego & Imperial Counties

2022 CHNA Findings:

Behavioral Health

Behavioral Health

The need for a robust, fully coordinated, and integrated continuum of behavioral health care was evident across all interviews. Severe deficits of services are leading to dire consequences in the overall health and well-being of our community, especially for people with existing chronic behavioral health conditions. The pandemic further exacerbated previously existing barriers to accessing services particularly for populations who were already at a disadvantage, creating wider health disparities. Our community expressed desperation in their inability to find help and often felt hopeless as they grappled with the lack of available resources.

Increasing Behavioral Health Needs and the Impact of COVID-19

The pandemic took a substantial toll on our community's mental health. There was universal agreement that mental and behavioral health needs increased dramatically in our community.

The pandemic disrupted daily routines while factors such as economic hardship, uncertainty, social isolation and loneliness, and loss of a loved one contributed to the growing behavioral health disorders and greater treatment needs. These stressors led to unprecedented increases in stress, anxiety, depression, and trauma — especially for people with pre-existing behavioral health conditions.

As the demand for behavioral health services soared, the capacity of behavioral health programs and services fell increasingly short. Community-based service providers and health care providers shared a sense of heartbreak as they worked with community members who were in desperate need of behavioral health care. Providers experienced the community's desperation but were unable to address all their immediate needs — there was almost no availability for timely access to services.

Mental Health Service Utilization Decreased Dramatically Early in the Pandemic
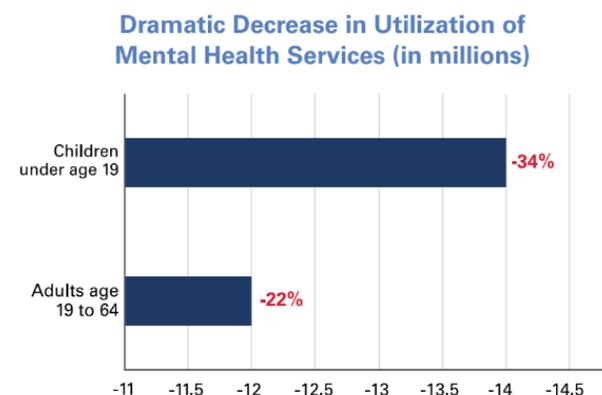
Source: American Hospital Association, Marc to October 2020 data[99]

Some data showed declines in behavioral health service utilization (visits) during the first two years of the pandemic, but providers cautioned that this does not accurately represent the growing needs of our community. Several challenges, including provider capacity and barriers, hindered people from accessing and receiving necessary behavioral health and mental health care.

*In our Online Community Survey, **70% of respondents identified behavioral health as a top health need.** When asked more specifically about behavioral health needs, respondents identified the following as the top 10 most important mental or behavioral health needs in our community.*

The **top 10** most important identified needs were:

1. Depression
2. Access to help
3. Anxiety
4. Stress
5. Drug use
6. Substance use disorder
7. Alcohol use
8. Burnout or fatigue
9. Opioid use (including fentanyl)
10. Suicide and suicidal thoughts

Public health measures and flexibilities to protect the health of our community allowed for the shift in telehealth adoption to increase access to behavioral health services. However, telehealth was identified as an inadequate option for people with a higher acuity level who needed in-person care.

With restrictions on telehealth loosened, providers conducted 75% of behavioral health visits via telehealth in May and June 2020 for patients with commercial insurance.[100]

"It's very, very stressful for people right now and they want that in-person appointment period, and they don't to wait several months for that appointment and they don't want to see someone on Zoom."
FOCUS GROUP PARTICIPANT

"We have seen absolutely a sharp increase in people's mental health needs such as depression because of isolation throughout the pandemic, because of their inability to engage in certain wellness activities that may have been more helpful to them in the past, or coping skills that were more helpful."
FOCUS GROUP PARTICIPANT

"It's really tough and heartbreaking when we go through the database and see all the resources that we have provided them and sometimes we already gave them everything that we have. And there's nothing out there. Even when people reach out to their health insurance, there's nothing they can refer them to."
FOCUS GROUP PARTICIPANT

*A 2021 **American Psychological Association survey of 1,141 psychologists** found a significant increase in the demand for mental health treatment. **84%** reported increases in anxiety, **72%** reported increases in depression, and **62%** reported an increase in trauma and stressor-related disorders for their patients.[101]*

Increase in Substance Use

Our community expressed concern about the increased use of substances to cope with the stress and anxiety caused by the pandemic, such as loss of income or employment, or social isolation. Community members experiencing anxiety and depression turned to self-medication with substances, such as drugs and alcohol, further exacerbating their mental health conditions.

20 million people aged 12 or older attested to having substance use disorders (SUDs), which are characterized by alcohol abuse, illicit drug abuse, or both.[102]

Increasing Fentanyl Use

Fentanyl-related overdose and death were identified by interviewees as being a large area of concern due to its potency and increased, lethal presence in our community. Fentanyl is a synthetic opioid and is 50 times more potent than heroin and one hundred times more potent than morphine.[103] [104] Powdered fentanyl resembles a variety of other substances that are taken recreationally. Recently, there have been reports of substances such as heroin, cocaine, and methamphetamine being mixed ("cut") with it, and the end-product looks like other commonly consumed drugs. Interviewees shared that in many cases, people do not know that their drugs are laced with fentanyl and consume it unknowingly, leading to accidental overdose or death.

Increasing Alcohol Use

Community members noted the increased consumption of alcohol as concerning. For substances such as alcohol, uncertainty combined with disruption of routines, financial instability, and balancing work and sometimes childcare from home may have led some people to progress into heavier drinking habits, or overall increased alcohol consumption.

Substance Use-Related Services

People with SUDs were suddenly isolated due to the pandemic, which increased the risk of solitary drug use and relapse. Social-distancing measures impacted community members who strongly preferred in-person individual or group therapy sessions. Unresolved or unaddressed mental health issues created pressure that led some community members to relapse.

"There are a lot of people that are getting access [and exposure] to in-group settings … maybe it's experimenting with fentanyl … [or] infectious diseases. [Fentanyl is] obviously [an] incredibly potent drug so we're seeing a lot more significant overdoses and deaths."
FOCUS GROUP PARTICIPANT

"Our biggest concern is the increasing use of illicit benzodiazepine (Xanax). Overdoses are on the rise, but there are not many providers with the capacity to provide treatment for benzodiazepine withdrawal syndrome."
KEY INFORMANT

"Some people are at their wit's end. I have people that are saying, 'Well, I've been trying to stay sober, and I've been clean but it's leading me nowhere. Now they understand why I'm so frustrated and why I go back to what I go to because that's all I know.' People are going in circles. We try to help them as much as we can but there's no resources available that will help them right away."
FOCUS GROUP PARTICIPANT

Opioid-Related Overdoses and Encounters[105]

More than 840,000 Americans died of drug overdose between 1999 and 2020, and millions more have been affected by other adverse health and social consequences of SUDs, including injury, infectious diseases, and incarceration.[106]

According to research from Overdose Data to Action (OD2A),[107] the number of unintentional drug overdose deaths in San Diego County has increased since 2015. Research from OD2A identified different demographic profiles for opioid-related events. Higher opioid-related mortality and emergency department (ED) visits were observed in younger populations, and males tended to have higher rates of ED visits and deaths.

Unintentional Prescription-Caused Deaths[108]
According to data from the County of San Diego Medical Examiner's Office that was compiled and visualized by the San Diego Prescription Drug Abuse Task Force, unintentional prescription-cased deaths and fentanyl-caused deaths have been steadily increasing over the years.*

- From 2019 to 2020, **there was a 206% increase in the number of fentanyl-caused deaths**, 151 compared to 462, respectively.

- From 2019 to 2020, **there was a 109% increase in unintentional prescription-caused deaths**, 275 compared to 576, respectively.

It is important to note that not all deaths from fentanyl are captured in these numbers presented; they may actually be an undercount.

In 2020, **62%** of accidental drug overdose deaths **were opioid-related**.

% of Accidental Drug Overdose Deaths Attributable to Opioids, Fentanyl, and Non-Opioids in San Diego County, 2020
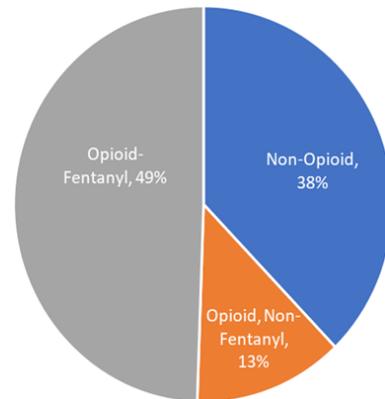
Source: County of San Diego, Health & Human Services Agency, Behavioral Health Services, Population Health Unit

Unintentional Prescription-Caused Deaths
Source: County of San Diego Medical Examiner's Office
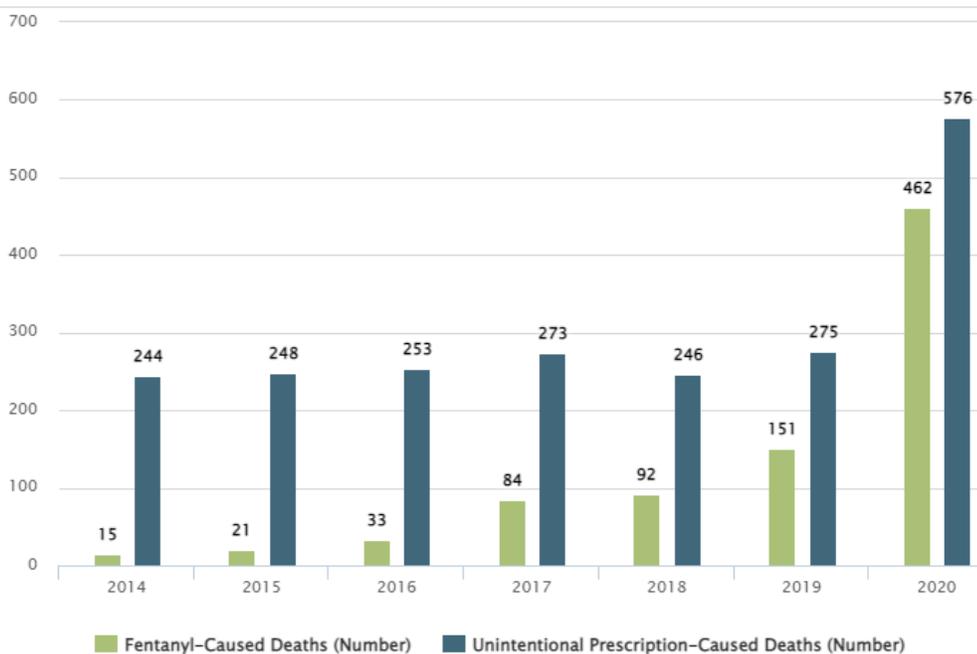
Source: San Diego County Prescription Drug Abuse Task Force Report Card

Note: These deaths are accidental overdose deaths in which a prescription drug alone or with other drugs and/or alcohol was a causative factor in death.[1]

Rates of Accidental Drug Overdose Deaths Among San Diego County Residents

At right are data from the County of San Diego, Health & Human Services Agency Behavioral Health Services Population Health Unit.

The data show that the rates of accidental drug overdose deaths are increasing for every age, region, and race/ethnicity.

Rates of Accidental Drug Overdose Deaths Among San Diego County Residents, 2017-2020

Rates of Accidental Drug Overdose Deaths by Race/Ethnicity Among San Diego County Residents, 2017-2020
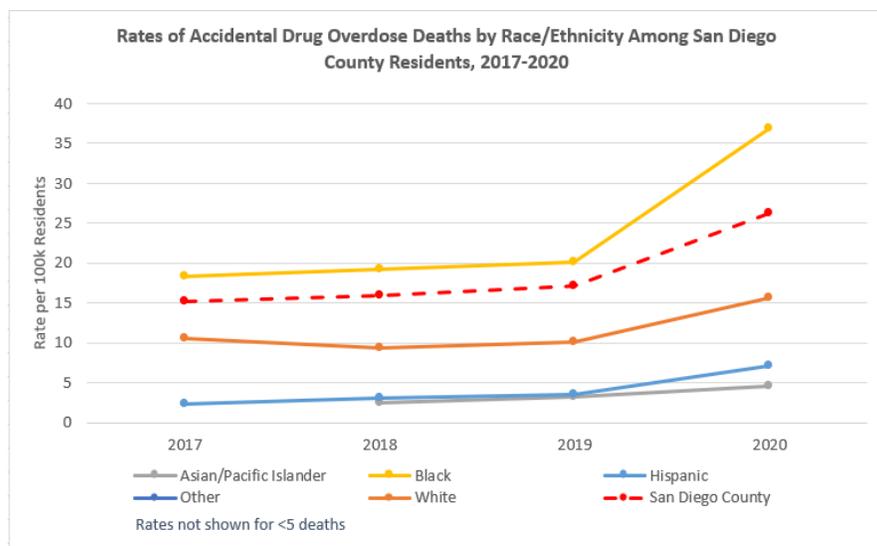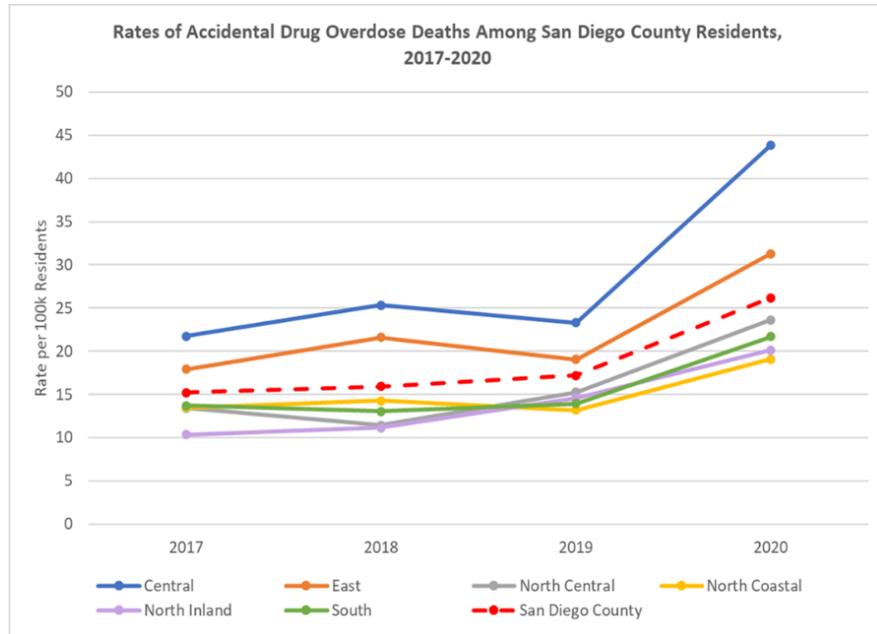
Notes: Counts and rates are suppressed for <5 events. Drug overdose deaths include accidental, acute poisonings due to all drugs excluding natural causes of death. Rates are calculated from deaths occurring among San Diego County residents only, while numbers include total deaths (include out of county residents).

Rates of Accidental Drug Overdose Deaths by Age Groups Among San Diego County Residents, 2017-2020
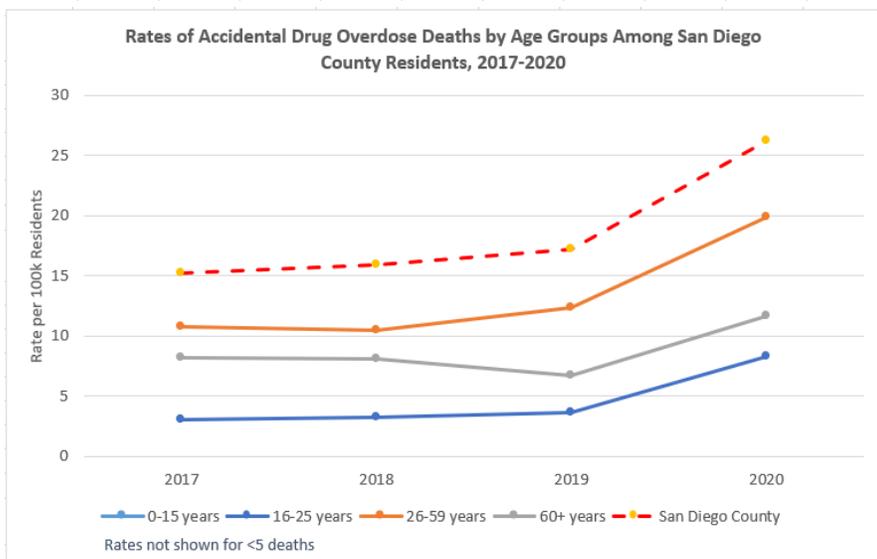
Stigma – A Fundamental Barrier to Accessing Behavioral Health Care

For community members with mental health disorders, stigma was identified as a pervasive issue impacting their overall health, well-being, and quality of life. Stigma can cause people to delay or avoid seeking any help, including treatment and recovery. Several populations — including people of color, LGBTQ+, people experiencing homelessness, undocumented immigrants, refugees, and Native American/Tribal communities — experience stigma more frequently, creating additional challenges when they seek behavioral health care services.

The graphic below includes the several different types of stigmas surrounding people with a mental health condition. Most notably, cultural stigma was identified as a significant barrier to people openly talking about their problems and seeking professional help. People with mental health needs are more likely to internalize their feelings due to negative cultural beliefs around mental health and any experiences with longstanding history of discrimination in the health care system. Particularly for people of color, seeking mental health care is often viewed as shameful, unacceptable, or a sign of weakness.

How does stigma impact people with mental health conditions?

The National Alliance for Mental Illness (NAMI) has identified stigma as a priority concern. The StigmaFree campaign is NAMI's effort to end stigma and create hope for those affected by mental illness.

Fifteen years ago, a U.S. Surgeon General's Report on Mental Health — the first and only one to date — identified stigma as a public health concern that leads peoples to "avoid living, socializing or working with, renting to, or employing" individuals with mental illness. Due to stigma, people living with mental health conditions are:

- *Alienated and seen as "others."*
- *Perceived as dangerous.*
- *Seen as irresponsible or unable to make their own decisions.*
- *Less likely to be hired.*
- *Less likely to get safe housing.*
- *More likely to be criminalized than offered health care services.*
- *Afraid of rejection to the point that they don't always pursue opportunities.*

Source: NAMI StigmaFree Me

Types of Stigma[109]

Individual	• Avoidance, concealment, internalization, language & cultural barriers
Interpersonal	• Health care discrimination, rejection, language & cultural barriers
Structural	• Access to care, lack of provider education & training, language & cultural barriers

Lack of Behavioral Health Services

Barriers to Care

The community identified severe deficits within the behavioral health continuum of care. When people do not have access to comprehensive mental and behavioral health services, they are at an increased risk of crisis. Our community expressed that there is an urgent need to improve access to early intervention services. Key challenges and barriers that cause delays or deter people from accessing necessary care and treatment are discussed below.

Extremely Long Wait Times/Long Waitlists

Long waits for appointments and treatment were a consistent concern. People wait six months or longer for critically necessary mental and behavioral health services. Waiting for treatment has a significant impact on people who are in crisis and need immediate help.

Unaffordable Treatment and Services

Ongoing behavioral health treatment and therapy can be very costly. Affordability was commonly cited as a barrier, especially during the pandemic as people were experiencing more economic hardship.

Health Insurance Provider Limitations

Most health plans have a limited number of in-network providers available for their members. Many community members with health insurance are unable to find someone in their network and seek costly treatment from out-of-network providers. Additionally, provider directories are often inaccurate or list providers who are no longer accepting patients.

Health Insurance/Health Coverage Conflicts

Medi-Cal coverage for beneficiaries with mild to moderate mental illness is separate from Medi-Cal coverage for beneficiaries with serious mental illness. When the health plans disagree about the patient's diagnosis, there can be delays in referrals and access to needed treatment. Patients with private health insurance also face denials for needed treatment.

Access to Technology

Lacking access to internet, computers, and cell phones was frequently cited as a barrier to accessing telehealth appointments.

Transportation

Managing transportation to appointments was an issue for people without cars or for anyone without reliable transportation. Public transportation was described as difficult to navigate and time-consuming. Transportation impacts a person's ability to continue any ongoing treatment or attend therapy.

"The payer for medical needs is different than the payer for behavioral health needs. So, you have two individuals pointing at each other and the patient in the middle. This makes it difficult for service providers and the patient."
FOCUS GROUP PARTICIPANT

"Transportation challenges create significant barriers to access for individuals with mental health needs. When you are struggling to manage a mental health crisis, navigating public transportation, or arranging through insurance is often too overwhelming."
FOCUS GROUP PARTICIPANT

"The demand for services is so much greater than the available resources, patients are faced with long waits for services. It makes it harder to connect them to care."
KEY INFORMANT

Access to Care for Dual Diagnosis Patients

An estimated 500,000 Californians have a dual diagnosis of mental illness and SUD.[110]

Our community shared that there are incredible challenges faced by community members with a dual diagnosis. Managing a dual diagnosis is especially complex because the systems of care for mental illness and substance use are separate.

Common, but Untreated

1 in 3 people (33%) with a substance use disorder has a co-occurring mental health condition

1 in 5 people (20%) with a severe mental health disorder will also develop a substance use disorder

Only 1 in 13 people (7.4%) with dual diagnoses receives treatment for both conditions

Source: How Fragmented Care Harms People with Both Mental Illness and Substance Use Disorder, CHCF 2021 [111]

"There is a huge gap in services for dual diagnosis patients with incomes between 138-200% of [the federal poverty level] — we call it the horrible missing middle. They make too much money to access services through Medi-Cal but not enough to pay for private treatment and services."
KEY INFORMANT

"We need more Assertive Community Treatment (ACT) program slots paired with housing so that people can get services and stay connected to care."
KEY INFORMANT

"Our emergency department is not set up to be a sobering center. We need additional resources for patients seeking treatment, especially if they are ready to seek services. If they are put on a waitlist, they may not be ready when services finally become available."
KEY INFORMANT

"We have seen several folks relapse [on] substances over the last year-and-a-half because of difficulty feeling connected and engaged with recovery-based communities or mental health services not being available. We have actually lost clients to fentanyl in the last year-and-a-half as a result of pressure for relapse coming from unaddressed mental health issues."
FOCUS GROUP PARTICIPANT

Critical Deficits in the Post-Acute Care Continuum

The insufficient availability of post-acute services across the board has created a bottleneck, with people waiting several months to a year to receive the appropriate level of care, especially after a hospital stay. Hospital staff are significantly challenged in finding timely follow-up care or a safe place to discharge people with complex behavioral health needs. These long-standing challenges became even worse because of the pandemic. For patients recently discharged from acute or long-term care, any progress achieved during their stay may be diminished if they have long wait times to access to the appropriate level of care. The most significant deficit in the post-acute care continuum is long-term care beds. The graphic below categorizes the level of need for the different types of post-acute behavioral health services.

Adult Behavioral Health Post-Acute Care Continuum – Needed Services

County Case Management
Crisis Residential Treatment Programs
Intensive Outpatient Programs
Licensed Board & Cares (with augmented support)
Skilled Nursing Facilities (that accept patients with w/psych needs)
Detox Beds
IMD Beds
Long-Term Care Beds
Day Treatment Programs or Partial Hospitalization Programs
Home Health
Structured Independent Living

Critically Urgent Need
Urgent Need
Need

"If patients get to the hospital and get stabilized, the key next step is coordinating outpatient care for a very sick patient. It's essential that they get the right level of care. Having a psychiatric follow-up at the very least within a week, is very essential. We frequently cannot make that happen."

FOCUS GROUP PARTICIPANT

ED cannot say no to patients, but skilled nursing facilities can look at behaviors and all this other stuff to say no. So, we don't have anywhere to discharge aging individuals who are experiencing homelessness and substance abuse. If a person is homeless and does not have a discharge plan from the skilled nursing facility, the skilled nursing facility will not take them.

FOCUS GROUP PARTICIPANT

"Board and cares are a huge need, but reimbursement does not cover costs and 'NIMBYISM' is driving these homes out of communities."

KEY INFORMANT

Populations at Higher Risk

Our community expressed deep concerns for certain populations who have experienced long-standing challenges accessing behavioral health services including youth, the LGBTQ+ community, veteran and military-connected community members, and historically underrepresented groups such as BIPOC, undocumented, refugee, and immigrant communities.

Please see **Access to Health Care, Aging Care & Support,** and **Children & Youth Well-Being** findings for additional information.

Veteran/Military-Connected

Veterans experience mental health disorders, SUDs, post-traumatic stress, and traumatic brain injury at disproportionate rates compared to their civilian counterparts. Daily, 18 to 22 American veterans commit suicide, and young veterans aged 18–44 are most at risk.[112]

Despite reporting better overall health than their civilian counterparts, women who have served are more likely to face mental health challenges. In fact, women who have served have a 42% higher rate of having mental illness in the past year than those who have not served. Further, women who have served are more likely to be diagnosed with depression and have suicidal thoughts than civilian women.[113] Unfortunately, the reluctance of veterans to seek treatment or help makes diagnosing and treating mental illness difficult.[114]

"The greatest need among active-duty military members and their families is behavioral health. Health care providers need cultural training to work with their military-connected patients."
KEY INFORMANT

"We are not seeing as much stigma in regard to behavioral health within the military family community. The military-connected youth are opening up, engaging more on social media, and getting the resources they need. Among the active duty members, yes, there still is stigma."
KEY INFORMANT

Native American/Tribal Communities

Interviewees shared that Native American community members have experienced multiple types of trauma, which may deter some from seeking needed treatment. Our community shared that the most serious behavioral health concerns for Native American community members include SUDs and suicide prevention.

Refugees

Members of our refugee community endured harrowing experiences that can have long-lasting consequences for their mental health. Many have survived traumatic circumstances, witnessed deaths, starvation, or violence in their homelands. Simultaneously attempting to process their experiences while adjusting to a new language and a different everyday life can further impact their mental health. Refugee community members may also face cultural stigma when seeking mental health care.

Receiving mental health treatment can feel traumatizing or invasive to their privacy when translators are used. Community members emphasized that building trust with mental health providers takes time. This is a challenge when most insurance coverage limits the number of appointments per year.

Undocumented Immigrants

Policies in place during the previous presidential administration and pandemic-related stressors have caused our undocumented community to experience stigma, trauma, and severe anxiety. Community-based organizations and providers shared the frustration of not being able to connect undocumented community members without health coverage to behavioral health services and treatments due to the cost. Additionally, language differences and the lack of culturally competent behavioral health providers were barriers for people to feel safe and comfortable in disclosing their personal experiences as an undocumented individual.

"The stigma around [mental health] with Native Americans stemmed from historical trauma and intergenerational trauma … especially for … Native American men. It's really taboo for them to talk about feelings."
FOCUS GROUP PARTICIPANT

"Refugees have an invisible backpack that they carry, and it takes a mental health provider a long time to build the trust needed to unpack the traumas and issues in the backpack. Many times, a person's visits run out before the provider has had that chance to unpack why the refugee is seeking care."
FOCUS GROUP PARTICIPANT

"They [refugees] must go through a lot of questions [to fill out registration paperwork]. Answering the same questions over and over creates more trauma for that person."
FOCUS GROUP PARTICIPANT

"There is no privacy to seeking mental health for non-English speaking refugees because there is an interpreter in the room. A lot gets lost in interpretation."
FOCUS GROUP PARTICIPANT

"Immigration status is a huge barrier, because if they have restricted Medi-Cal, they do not have the finances to access a psychiatric appointment and psychiatric medication."
KEY INFORMANT

LGBTQ+

Our LGBTQ+ community is at higher risk of significant behavioral health disparities due to lack of social support, increased discrimination, stigma, and trauma. LGBTQ+ community members frequently use substances to cope with stress and trauma. Transgender community members face unique challenges, such as gender dysphoria — psychological distress due to mismatch between their biological sex and their gender identity — which can lead to anxiety, depression, and self-harm. Fear of stigmatization and the lack of experienced safe, gender-affirming care providers create additional barriers to accessing behavioral health care.
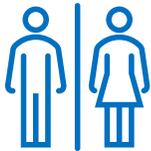
*Rates **of chronic depression among transgender people are more than double** those of cisgender populations, and estimates of the prevalence of depression among **transgender women are as high as 64.2%.**"*[115]

Justice-Involved Community Needs

New data from the San Diego Association of Governments Initial Interim Report on Alternatives to Incarceration[116] clearly demonstrate the disproportionate behavioral health needs of our justice-involved community. Among some of the findings:

- Most individuals booked into jail test positive for at least one substance. In 2020 it was 82% of males and 67% of females.

- Meth is the primary drug used by individuals booked into San Diego County jails.

- At least one in three individuals interviewed in jail reported some type of mental health issue.

- Almost two in five bookings include an alcohol or other drug-related charge, and the majority of individuals booked have recently used a drug.

"I've also gotten calls where people have just come out of prison and/or jail and they're trying to get help. Where are the resources for people who are coming out of prison and jail? It's very limited in what we can provide for them."

FOCUS GROUP PARTICIPANT

Behavioral Health Needs of Community Members Experiencing Homelessness

It can be traumatic and stressful for those who are experiencing homelessness. When unhoused community members live in unsafe conditions, the trauma they endure can further exacerbate their mental health conditions.

For both emergency department and inpatient discharges of patients experiencing homelessness, five of the top 10 primary diagnosis codes were related to behavioral health.

Community members experiencing homelessness frequently avoid seeking medical attention until their situation becomes a crisis, such as a mental breakdown or extreme psychosis. Once someone is in crisis, the only option for care is often the emergency department. There are generally no resources or services available in a timely manner for stabilized patients experiencing homelessness who are ready to be discharged, making post-acute care and treatment nearly impossible.

Health and social service providers emphasized the importance of timeliness in getting appointments and being linked to services in the community. In addition, community members experiencing homelessness face navigation barriers with long waitlists for services like case management.

"Hospitals are open 24/7, 365 days a year. Most community resources are open business hours only."
Focus Group Participant

Top Discharges for Patients Experiencing Homelessness (2019)[117]
Primary Diagnosis, Emergency Department

1. Skin and subcutaneous tissue infections
2. Alcohol-related disorders
3. Schizophrenia spectrum and other psychotic disorders
4. Superficial injury; contusion initial encounter
5. Musculoskeletal pain not low back pain
6. Nonspecific chest pain
7. Suicidal ideation/attempt/intentional self-harm
8. Abdominal pain and other digestive/abdomen signs and symptoms
9. Depressive disorders
10. Stimulant-related disorders

Top Discharges for Patients Experiencing Homelessness (2019)[118]
Primary Diagnosis, Inpatient

1. Schizophrenia spectrum and other psychotic disorders
2. Septicemia
3. Skin and subcutaneous tissue infections
4. Depressive disorders
5. Alcohol-related disorders
6. Bipolar and related disorders
7. Heart failure
8. Diabetes mellitus with complication
9. Poisoning by drugs initial encounter
10. Fracture of the lower limb (except hip)

Health Care Workforce: Behavioral Health Needs and Shortages

Behavioral health providers, social service providers, and community members consistently expressed their feelings of exhaustion and burnout. Every provider was stretched to their absolute limits.

Severe Shortages of Behavioral Health Care Workers

There are severe behavioral health staffing shortages across the continuum, particularly in clinical settings. Outpatient behavioral health clinicians are moving into private practice or moving out of the county. The pre-existing shortage of inpatient behavioral health clinicians was greatly exacerbated by the pandemic. There is no labor force to replace those who have left. Even in situations where new graduates could be brought in, they often lacked the experience or training necessary to prepare them for the intensive and complex care required by patients in severe crisis.

Behavioral Health Needs of Health Care Workers

Due to the nature of the work, health care providers may often experience vicarious trauma, compassion fatigue, and secondary traumatic stress. Health care providers carry many of their patients' stories and are constantly exposed to their traumatic experiences (both physical and psychological).

Some clinicians drew parallels between health care providers working on the front lines of the pandemic and veterans who have served on the front lines in combat. Research has found that health providers providing care on the front lines of the pandemic report similar outcomes of depression, self-reported quality of life, and burnout as those who served on the military front lines. Military conflicts and pandemic health care work have many fundamental differences, but both have presented many people with damaging experiences, which in turn are associated with substantial psychological distress.[119]

Please see **Access to Health Care** finding for more information on vicarious trauma.

"Many folks are exhausted and are burned out from providing mental health services during a global pandemic. It's kind of like having to drink out of a fire hose constantly. So, people are exhausted and they're leaving the mental health field in large numbers, or they're moving to completely different types of models, like online remote services like BetterHelp and Talkspace."
FOCUS GROUP PARTICIPANT

"Mental health care has been considered a stepchild of health care for a really long time. The pipeline for having an adequate number of people working for the system has been really weak for a long time. Now all of a sudden, people want help but there's just not enough people to provide care."
FOCUS GROUP PARTICIPANT

"We have a lot of [behavioral health] staff getting yelled at seemingly on a higher volume currently. I think that's also then adding into that of those who want to help and stay in are getting burnt more and more, even though they're used to this. So, even our experienced people are getting burned out."
FOCUS GROUP PARTICIPANT

Commitment to the Community

Despite these challenges, behavioral health providers in our community remained committed to serving their community, showing up day after day.

"Even though there's been people and staff leaving, there has been an incredible commitment on the part of the teams to try to do right by all of this … those who are standing today and tomorrow and next week are so highly committed."

FOCUS GROUP PARTICIPANT

2022 San Diego
Community Health Needs Assessment

2022 SAN DIEGO CHNA
COMMUNITY HEALTH NEEDS ASSESSMENT

HOSPITAL ASSOCIATION
of San Diego & Imperial Counties

2022 CHNA Findings:

Children & Youth Well-Being

Children & Youth Well-Being

Throughout the interviews and focus groups, there was an overwhelming concern for the well-being of children and youth, an issue made even more distressing by the lack of workforce and resources available to address even the most serious needs. The strongest concerns were consistently related to the behavioral health needs of children and youth. This was also reflected in the online survey results.

Demographics

Almost a quarter of San Diego County's population is children and youth under the age of 18 years old. And nearly 1 of 6 children are living below 100% of the Federal Poverty Level.

Age	# of children in California	# of children in San Diego
Under 5	2,370,733	203,638
5 to 17	6,519,517	510,764
Total	8,890,250	714,403

Children and Youth Living Below 100% of Federal Poverty Level[120]

Under 6	6-11 years	12-17 years	18-24 years
14.7%	14.8%	14.5%	19.9%

Children's Mental Health – A National Emergency

In October 2021, the American Academy of Pediatrics (AAP), American Academy of Child and Adolescent Psychiatry (AACAP), and Children's Hospital Association (CHA) declared a national emergency in children's mental health.

"Children and families across our country have experienced enormous adversity and disruption. The inequities that result from structural racism have contributed to disproportionate impacts on children from communities of color," according to the AAP, AACAP, and CHA.[121]

A few months later, the U.S. surgeon general issued an Advisory on Protecting Youth Mental Health, which outlines the pandemic's unprecedented impacts on the mental health of America's youth and families and the mental health challenges that existed long before the pandemic.

- It is estimated that as of June 2021, more than 140,000 children in the U.S. had lost a parent or grandparent caregiver to COVID-19.
- In 2019, before the pandemic, one in three high school students and half of the female students reported persistent feelings of sadness or hopelessness, an overall increase of 40% from 2009.
- Socioeconomically disadvantaged children and adolescents — for instance, those growing up in poverty — are two to three times more likely to develop mental health conditions than peers with higher socioeconomic status.[122]

Online Community Survey

In our Online Community Survey, we asked the following question: **"What most worries you about the health and well-being of children in our community?"** *Responses are listed in the graphic below, grouped into five major categories. The concerns of the 502 survey respondents echoed much of the feedback gathered during the focus groups and interviews —* **the top concerns were related to children and youth mental well-being. The next highest areas of concern were around community safety.**

Mental Well-being

- Mental/behavioral health (66%)
- Anxiety (61%)
- Depression (60%)
- Isolation (50%)
- Suicide and suicidal ideas (40%)
- Substance use (44%)
- Self-harm (33%)
- Lack of exercise or play (35%)

Community Safety

- Bullying (57%)
- Social media and/or online gaming (56%)
- Being safe from violence or coercion in their home, school, or neighborhood (37%)
- Violence, firearms, and other weapons (27%)
- Injuries/accidents (5%)

Economic Stability

- Access to affordable, quality housing (42%)
- Having enough healthy food (35%)
- Hunger (27%)

Education-Related Concerns

- Lack of school support/services (32%)
- Learning loss/delays (29%)
- Quality childcare or preschool (28%)
- Lack of special education support (26%)
- Lack of after-school activities/care (38%)
- Access to technology/Wi-Fi (24%)

Other Health Concerns

- Chronic health conditions (obesity, asthma) (30%)
- COVID-19 (24%)
- Sexual behavior (16%)

Increasing Behavioral Health Needs

*In the Online Community Survey, **more than 60% of respondents** selected mental/behavioral health, anxiety, and depression as their top concern for children.*

The pandemic had temporary and long-term impacts on children's mental health, leading to an increased need for behavioral health supports and services.

Clinicians and community members agreed that the top behavioral health challenges among children and youth are anxiety and depression. There was also grave concern about children with autism and ADHD.

In 2019, depressive disorders were the most frequent inpatient principal diagnosis for youth 0-17 years old. [123]

Numerous factors have contributed to the increased need include:

- Bullying
- Lack of activities
- Social isolation
- Social media
- Stress due to family and financial circumstances

The factors that lead to increased need translate to an increase in the number of children seeking crisis mental health services at emergency departments (EDs) across the county. Clinicians shared there are additional factors related to the increase in ED volume that include involvement with the justice system and parents seeking respite.

Children with special needs have more serious unmet needs, and their access to care was severely limited by the pandemic. Populations described as being most vulnerable include children with physical and developmental disabilities, children diagnosed as socially emotionally disturbed, children with educational accommodations, and children in special education programs.

Many families had to cancel in-home services during the early part of the pandemic due to exposure risk. Therapy accessed virtually may not always be appropriate for younger children or those who are nonverbal.

"The youth mental health crisis didn't start with the pandemic, but the pandemic has made it much worse."
KEY INFORMANT

"The volume of [pediatric] behavioral health patients coming through the ED overall has gone through the roof. We're seeing winter volumes in summertime, which is very atypical. Obviously, it's been unprecedented."
FOCUS GROUP PARTICIPANT

*Hospital emergency departments have reported an alarming increase in psychiatric crises. For example, Rady Children's Hospital San Diego reported a **1,746% increase** from 2011 to 2019.* [124]

Suicide and Suicidality

*In 2019, as many as **six youth per day were treated for attempted suicide** in San Diego County Emergency Departments.[125]*

Although recent countywide data show an overall decrease in teen suicide deaths, there was an increase for both Asian/Pacific Islander and Black teens in 2020. In addition, there has been a significant number of attempted suicides and increasing concern about suicidality in youth. Clinicians shared their experiences treating youth who are heavily influenced by content they find online and stated that social media has normalized suicide as an option for youth who are struggling with mental and behavioral health challenges. They described an inability for some youth to cope — something as seemingly minor as a parent taking

away a child's cell phone could trigger a mental health crisis.

"In my community a lot of students have felt really upset and lonely and then we've seen like a lot of suicides from young kids. That shouldn't be. It shouldn't be a thing for those kids at that age so young and it's sad seeing so many lives being affected like that, so I think the mental health of the younger generations is something that needs to be looked at a little bit more."

FOCUS GROUP PARTICIPANT

"There are all of these apps and literature that's out there now on how to kill yourself. So, there's access for kids, and there's this normalizing through social media that's happening more and more. We're seeing it more in the outpatient arena where they're bringing in different ways. They're learning ways to die."

FOCUS GROUP PARTICIPANT

Suicide in San Diego County, 2020 [126]

TEEN SUICIDES BY RACE/ETHNICITY, 2010 - 2020

LIVE WELL SAN DIEGO

Legend: Asian/PI, Hispanic, White, Black
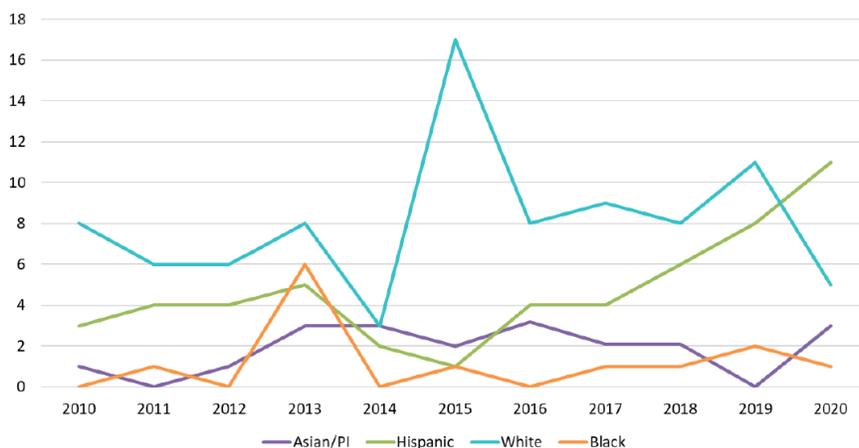
Increased Interest in Seeking Help

One positive result of the pandemic was that some children and youth became more comfortable asking for help. Many in the survey and in interviews mentioned that the stigma of mental health has been reduced. Youth are more open about their mental state and open to seeking help.

Unfortunately, for many other youth, the stigma remains. Aside from the difficulties that behavioral/mental health conditions present for youth, there is also the issue of social or cultural stigma within families. Many youth are discouraged from seeking professional help because of blame, guilt, or shame, combined with a lack of understanding from family. This makes it difficult to have support from family members, which can harm or worsen these conditions over time. Without familial support, early behavioral health intervention and the recovery process may be jeopardized.

"I have seen a big increase in inquiries about mental health services and what that entitles. Usually in the past I've had to bring it up and talk them through it, but youth are actually coming to us and asking, 'Hey, what's the deal with this? How can I find a therapist? What do I do if I don't like my therapist? What does therapy even entail?' I think that that's one thing that I've seen and been very surprised by — just the curiosity of it all."
FOCUS GROUP PARTICIPANT

"I do see that there are more and more of the younger generation students, they pay more attention to their mental health and how to take care of themselves."
FOCUS GROUP PARTICIPANT

"When I started my wellness checks, my mom thought I was mental anyway. So, I just told her, 'It's not that, it's more like I just need someone to talk to instead of pouring everything to you. I need someone who's professional, knows what I'm trying to say, and just listens before trying to help me'."
FOCUS GROUP PARTICIPANT

Critical Deficits Across the Continuum

Frustration and hopelessness about the dire lack of available behavioral health resources and services for children was expressed consistently.

There is a significant gap in both screening and services for school age children (5-12). Schools don't have enough therapists, and even if there were more therapists, some clinicians shared that pulling children out of class isn't always a good solution. There is stigma associated with being pulled from class. Additionally, in-school therapy takes time away from classroom studies.

In San Diego County, approximately 50% of all children (325,747 in April 2022) are enrolled in Medi-Cal[127]. Children enrolled in Medi-Cal often have additional risk factors that increase their need for mental and behavioral health treatments and interventions. Unfortunately, there is a significant gap between the behavioral health services that are needed to treat children and prevent them from reaching a crisis or acute state, and the services that are covered by children's Medi-Cal.

Increased Emergency Department (ED) Volume
One result of the serious deficits within the regional continuum of care is the increase in children and youth in crisis who are presenting to EDs. While for some an inpatient acute care bed is the needed level of care, others would benefit from crisis residential services or partial hospitalization programs where they could remain at home.

Given there are long waitlists for community-based programs, many children and youth who leave the ED often end up back in the ED, even if they do not require hospital-level care. The community-based services do not have the capacity to take on additional clients to provide the ongoing care that is needed.

"We also need more professionals who help students with wellness check in as well, it doesn't have to be anything like formal, this can just be like an informal time for students to talk about like how they feel best for their relationships with everyone in life, I think it's really helpful."
FOCUS GROUP PARTICIPANT

"Clinicians will say, 'I don't want to ask, because if I ask then they're going to say something bad.' The other concern from the pediatrician standpoint, if I screen for something, what do I do about it?"
KEY INFORMANT

"The whole First 5 system, I think, San Diego does that very well…We screen again at 12. Ages 5 to 11, this is what we do not do well. Many issues come up when a child starts school, but for ages 5 to 11 we don't have a good community safety net for the families at all."
KEY INFORMANT

Family Support and Respite Care

There is a lack of specialized programs that are focused on the comprehensive needs of families as they support a child with behavioral/mental health conditions. The lack of family support manifests frequently at EDs. Parents in need of respite sometimes feel like they don't have other options and will drop their children off at the ED to receive treatment and supervision. Some children remain at the ED without parents for a few days at a time.

Emergency Shelter

Over the past few years, there has been an increase in volume at the local emergency shelter for children. Post-shelter placement options are extremely limited. As a result, children who are very chronically ill and need high levels of care often end up in a 10-day treatment or 10-day receiving home. Youth receiving treatment at the local emergency shelter often leave the shelter without permission and then require medical clearance to return. In some instances, clinicians reported seeing the same youth every day for over a week.

"Acute patients have a tough time finding residential homes or other needed treatment or support so many end up in the ED. Referral sources have four-to five month waiting lists. Patients need an Intensive Outpatient Program or a Partial Hospitalization Program. Or they need therapy that can occur more than once every four to six weeks."

FOCUS GROUP PARTICIPANT

*"**We have a cliff.** We provide very acute-level care, and then we push these acute kids out into community-based therapy. The Partial Hospitalization Program and Intensive Outpatient Programs are pretty much nonexistent, and we don't have alternative levels of care to support kids. The outpatient programs right now … more than half of their caseload is seeing kids that need PHP or IOP. The moderate to severe kids are being seen in outpatient or have active suicidality and need more level of care, but the therapists are having to treat them in a traditional model."*

FOCUS GROUP PARTICIPANT

"[Some parents do not want to take their acute child home]. It is sometimes out of real concern for neglect or just fear because they've wrapped through the system multiple places and they're so desperate. It's not because they don't love their child. It's just they're terrified to go back into the same situation, and they know that the resources are very bleak. So it could be a protection issue or it could be just desperation."

FOCUS GROUP PARTICIPANT

"There is that boomerang whereas they go home and then they say, 'It's going to happen as soon as we get home. We know it.' Sometimes even when they get out to the parking lot, they don't even make it home because then the child escalates again, and the families just aren't equipped."

FOCUS GROUP PARTICIPANT

Nearly 50% (325,747) of children in San Diego County rely on Medi-Cal for their health coverage. There are large gaps in coverage for services that are medically necessary. In addition, covered services are severely limited with lengthy wait times.[1]*

Medi-Cal Managed Care
Mental Health Continuum of Care for Children

Continuum of Care

Screening & Assessment

Outpatient Mental Health

In-Home Therapy*

Wrap Around care*

Mobile Crisis*

Intensive Outpatient Program (IOP)

Partial Hospitalization Program (PHP)

Residential (including emergency shelter)

Urgent Care

Inpatient

Crisis Stabilization Unit/ Emergency Stabilzation Unit

Emergency Dept (Physical Assessment Only)

Covered by Medi-Cal

Not Covered by Medi-Cal

[1] *These services are covered (but still difficult to access) for a small percentage of children who have been identified as seriously mentally ill. *Thanks to the San Diego Center for Children for providing information that supported the creation of this graphic.*

Workforce Shortages

The workforce shortage is having a devastating impact on access to mental and behavioral health services for children and youth. There are deficits in the continuum of care for children of all ages, but the need for **early** childhood mental health providers — and in particular, providers who see child-welfare-involved children — is especially acute.

It is important to note that programs created for adults are not appropriate for children and youth. Pediatric providers need to have specialty training to provide effective care for children and youth who need behavioral treatment. Hospital-based and community-based clinicians serving children and youth consistently stated that reducing bureaucratic burdens like reporting requirements would increase clinicians' time and allow them to serve more clients.

"There is a workplace or clinical huge staffing shortage. Our nursing team can speak to that as well. But for the outpatient arena and within the behavioral health system, we are having large turnovers of clinicians leaving the state and/or moving out of traditional therapy and moving to private practice. So, we don't have a stabilizing force, which then, in turn, results in us hiring new grads and very green clinicians. The level of training or the training up that's required for the complexity of care that's needed is a huge burden to the leadership team."
FOCUS GROUP PARTICIPANT

"I think that it's so tough with the staff fatigue and burnout and then losing some really good, strong clinical people who are experienced, then there's less beds because they can't staff them. So, then those people are that much more pushed because then it's a smaller amount of area and longer wait times. It's that cycle."
FOCUS GROUP PARTICIPANT

"Our clinical staff spend as much as 60% of their time on paperwork. This is time that they are not spending serving children."
FOCUS GROUP PARTICIPANT

Physical Health

Vaccinations

Childhood immunizations, including measles, mumps, and rubella and human papillomavirus, are down significantly over pre-pandemic times.[128] Safety from potential COVID-19 exposure and infection may have kept some families from seeking routine pediatric care for their children. Early reports from the pandemic revealed a significant decrease in vaccine administration for children and youth. [129] Furthermore, the shift to online learning from in-person schooling, where immunizations are generally required to attend, may have contributed to this decline.[130] Even catch-up immunizations for children and youth are falling behind, which has serious implications: A decline in routine vaccinations could lead to an increase in death or disability due to the emergence of vaccine-preventable diseases.

According to preliminary data shared by the Epidemiology and Immunization Services Branch of the County of San Diego Health & Human Services Agency, there were drops in the total number of routine childhood immunizations administered in San Diego for most months from March through December when comparing 2020 totals to the same month in 2019. This was true for children aged 0-5 and 6-18, with the greatest decreases in April 2020 during the stay-at-home order (decrease of 26% for those aged 0-5 and 79% for those 6-18). Total vaccinations by month showed some rebounds in 2021 with some months surpassing 2019 totals. February, March, June, and September 2021 showed the greatest gains when compared to the same months from 2019 (possibly catch-up vaccinations).

Obesity

Some community members experienced high levels of inactivity and isolation due to stay at home orders associated with the pandemic, which may have had lasting impacts on children's social and physical health. **A study of over 430,000 children ages 2 to 19 years found that body mass index increased nearly two-fold during the COVID-19 pandemic when compared to a pre-pandemic period.[131]**

"Through COVID, I think childhood obesity came back or obesity overall came back. A lot of kids are gaining weight because they were at home. Some of the families I was talking to were complaining about lack of activity going on and the kids are gaining weight, and they [are] feeling isolated and they don't want to go out."
FOCUS GROUP PARTICIPANT

Childcare and Early Education

The gap between the need and the availability of childcare has been a growing concern, and the pandemic created new challenges for both parents and childcare providers. Our community shared that finding affordable, quality childcare that met the needs of parents was increasingly difficult. Multiple recent studies conducted in San Diego County demonstrate how many families are struggling.

High-quality early education and childcare for young children provides them significant benefits, including physical and cognitive improvements and enhanced school readiness.[132]

San Diego County Childcare Landscape:
An Analysis of the Supply and Demand[133]

- *48% of children ages 0-5 have parents who work and have no available licensed childcare option.*
- *69% of children ages 0-5 need childcare and are income eligible for a subsidy but not enrolled in a subsidized childcare program.*

San Diego Foundation Report on Childcare & the Workforce[134]

- *76% of parents with children 6 and under said finding affordable childcare in their area is an issue.*
- *70% of parents had difficulty finding childcare that meets their expectations.*

Importance of Early Childhood Education

- The positive effects of early childhood interventions are evident even after participants reach adulthood.
- Early childhood education lowered the rate of special education placement by 10%.[136]
- Children participating in high-quality early childhood education had increased college graduation rates and increased rates of employment at age 30.[137]
- Parents with children participating in high-quality childhood education saw sustained parental wage growth.[138]
- Participants in high-quality, early childhood education also showed long-term health benefits, including reduced rates of depression, smoking, and cardiovascular disease.[139]
- Better health outcomes from birth to age 5 and early childhood education led to lower rates of chronic disease and lower health care costs, contributing to a 13% return on investment.[140]
- Adults who participated in high-quality early childhood education[141] as children had a higher rate of four-year high school graduation, college attendance, associate's degree, or higher college degree attainment and postsecondary degree attainment.

Source: First 5 Years Fund

Early Childhood Development

Note: see following page for information on Adverse Childhood Experiences

Our community shared numerous concerns related to infants and young children. Resources to identify and treat developmental challenges were limited prior to the pandemic and are now critically scarce. During the early part of the pandemic, there were significantly fewer screenings available through childcare or regular check-ups. This has led to many children either not receiving or waiting months for diagnosis and treatment.

Clinicians shared that there are specific challenges in diagnosing young children. Under the age of 5, mental health and development for children is often intertwined. Concerns or delays in development (such as speech, hearing, gross motor skills) may often manifest as behavioral challenges, and vice-versa. Successful diagnosis for infants or young children presents unique challenges and requires significant time. Clinicians need to understand whether the challenges they are seeing are development-related (such as autism) or the effects of trauma exposure.

"The field of infant mental health is still burgeoning, but we know from experience that we can see children younger than one with clear trauma responses and symptoms. We know that 90% of a child's brain develops before the age of 5, and when we invest in working with young children, we can also intimately work with the child's caregivers and focus on issues such as the caregiver's mental health, attunement, attachment and prevent larger challenges from occurring later."

KEY INFORMANT

85% *of maltreated children under 3 have a moderate to high risk for developmental delays.[142]*

"Children under the age of 5 who have trauma (such as removal from their home due to Child Welfare Services involvement), behavioral health needs, and/or complex development and behavior challenges, can face significant wait times across the county, often waiting months for services. In a 2-year-old child's life, a six-month wait for services is already a quarter of their life. Given the rapid development and growth in young children, these delays in services mean that we are missing critical opportunities to intervene and support them and their caregivers — increasing their risk for additional challenges in school, with their families, and other systems in the future."

KEY INFORMANT

"We run a county-wide program for complex children with both developmental and behavioral health needs from 0-5 years old. In one out of every three children we care for there is an adverse childhood experiences (ACEs) screening of four or higher (compared to one in 10 nationally). This places these children at high risk for developing future medical and behavioral health challenges. Further, approximately 50% of caregivers in the program also have an ACEs score of four or higher."

KEY INFORMANT

Adverse Childhood Experiences and Their Long-Term Effects

According to the Centers for Disease Control and Prevention (CDC), Adverse Childhood Experiences (ACEs) are potentially traumatic events that occur in childhood (0-17 years). Children who experience ACEs are at increased risk for long-term health problems that span the behavioral, emotional, and physical domains, which also can affect education, employment, and income levels. As the body responds to the toxic stress associated with ACEs, the hormone cortisol is in constant production and has a negative impact on neurological and brain development as well as organs and tissues in the body. As a person's ACEs score increases, their risk of these negative health outcomes increases.[143]

ACEs Aware, California's first-in-the-nation effort to screen patients for ACEs to help improve and save lives, notes that not all stressors are toxic: some are important for growth and development. For example, positive stress can include brief periods of responding to a routine stressor such as a test or competition. Tolerable stress is also a form of positive stress that is limited in time and buffered by connections with adults who help the child adapt and recover from an event like a natural disaster.[144]

Examples of ACEs:

- **Child abuse**: Physical, sexual, and/or emotional
- **Child neglect**: Physical neglect and inadequate supervision, emotional, medical and/or educational neglect
- **Childhood trauma**: Witnessing violence in the home or neighborhood, substance use, mental health challenges in the home, instability from parental separation, or household member incarceration[145]

ACEs are common and the effects can accumulate with time:

- 61% of adults had at least one ACE, and 16% had four or more types of ACEs.
- Females and several racial/ethnic minority groups were at greater risk of experiencing four or more ACEs.
- Children living in under-resourced or racially segregated neighborhoods, who move frequently, and/or experience food insecurity can be exposed to toxic stress and increased ACEs.[146]

The Impact of ACEs

ACEs can create a generational cycle where children from parents with ACEs are more likely to experience ACEs. Traumatic events "rewire" the brain to operate in fight or flight response. This response can hinder executive functions that include attentional control, working memory, inhibition, and problem-solving.[147]

ACEs Associated With Health Conditions By Age

Babies

- Delay in growth and development
- Sleep disruption

School-Age Children

- Increased risk of viral infections
- Asthma or other atopic conditions, including eczema and allergic rhinitis
- Learning and behavior challenges

Adolescents

- Somatic complaints (manifestations of toxic stress) such as headaches or or abdominal pain
- Increased risk of sexually transmitted infections (STIs), teen pregnancy or paternity
- Mental health disorders
- Substance use

Adults

- Chronic conditions, including diabetes, chronic obstructive pulmonary disease (COPD), cardiovascular disease (or an event, like a stroke), cancer
- Mental health challenges such as depression and anxiety, post-traumatic stress disorder (PTSD)
- Substance use
- Chronic pain

Source: ACEs Aware - The Science of ACEs & Toxic Stress

Treating and Preventing ACEs

Being aware of ACEs, their effects, and dedicating resources to early interventions can make a significant impact on the trajectory of a child's life. This is because the brain has the ability to adapt and heal by creating new connections. This can be supported in an environment where a child has healthy, safe, and nurturing relationships with caregivers as well as high-quality childcare, early childhood education, financial and housing stability, and parental employment.

Trauma-informed care is essential in effectively providing care to people affected by ACEs. Instead of asking what is wrong with a person, a trauma-informed approach seeks to learn what happened to them in order to develop a better understanding, sensitivity, and caring awareness.

Please see section on **Trauma-Informed Care** for additional information.

Education Challenges

Children and youth, especially those who were already struggling, faced additional challenges when pandemic safety measures caused schools to move to virtual learning. Even though most schools were open during the time of our focus groups and interviews, youth were still trying to recover from the impact that the pandemic had on their ability to achieve in school.

Early in the pandemic, one of the most serious educational inequities was access to reliable Wi-Fi/internet to support distance learning. School districts and community benefits organizations made tremendous investment, but disparities remain. In addition, as discussed in the whitepaper *Beyond the Hotspot: Supporting Equitable Distance Learning in San Diego County*[148], providing access to Wi-Fi alone was not enough to support successful learning environments at home.

Crowded housing conditions made distance/virtual learning extremely difficult. Youth often struggled to concentrate due to distractions at home. In some households, multiple children were attempting to participate in online classes at the same time. In many cases, older youth supported their younger siblings at the expense of their own education.

"I'm the oldest sibling of six. So sometimes my mom leaves and goes for the groceries or does anything, and then sometimes I'll have to take care of my little siblings while I'm in class. I've been failing with homework sometimes because I take care of my siblings as well. And I don't finish homework. I wasn't finishing homework until like 10 or 12 o'clock in the night."

FOCUS GROUP PARTICIPANT

"I have two little siblings still in elementary and it was hard because my brother would go in a certain time then my older sister, because she's younger and they have different time to go on Zoom. And so, it would distract me because since I would be in class, they will be in class as well and I can hear what they're doing in class. And also, sometimes I would look after them while they're in class while I'm in class and also helping them on their homework because since they can't go to school. I have to be there for them and to check up on them and how they're doing on their homework and if they're doing it correctly."

FOCUS GROUP PARTICIPANT

"We saw so many of our minor clients fall behind on their education because of lack of access to equipment, to reliable internet. And so, there was a lot of learning lost during that time. There was a lot of skill that was lost during that time, and so we were seeing many of our minor clients start the next school year already pretty behind because they didn't get what they needed in the previous year, and in particular, our clients who have special needs, who have IEPs."

FOCUS GROUP PARTICIPANT

"Teachers didn't expect to be teaching remotely. Schools didn't expect any of this. Everyone's been trying to figure it out. But as a result, our kiddos who need more educational support, whether that is because it's a disability, or trauma, or whatever it may be, they fell through the cracks completely. And they lost at minimum, depending on the individual, they've lost at minimum a year of school that they're probably never going to get back."

FOCUS GROUP PARTICIPANT

Housing and Economic Stability for Youth

Our community shared that vulnerable youth are disproportionately impacted by housing challenges, and the pandemic rapidly intensified those challenges. Vulnerable youth subpopulations include LGBTQ+, former foster youth, justice-involved youth, Black and Latino youth, pregnant and parenting youth, youth who did not complete high school, and youth who are survivors of human trafficking, child sexual exploitation, and domestic violence and abuse. These youth often lack the social networks that can serve as supports when there are sudden changes in circumstances.

Young people who experience homelessness are at high risk for adverse outcomes such as physical and mental health challenges, substance abuse, incarceration, violence and abuse, barriers to education and employment, long-term homelessness, and lower life expectancy.

The 2022 San Diego County WeAllCount Point-in-Time Count found the number of families experiencing homelessness was up 56% from 2020. The point-in-time count also found more than 1,800 youth are currently experiencing homelessness in our county.[149]

Often referred to as an "invisible" crisis, youth homelessness impacts one in 10 people ages 18-24 in a year, and one in 30 adolescents (ages 13-17) experience homelessness without a caregiver.[150]

"We (youth housing provider) spent our entire year's budget in the first three months, that's how high the need was for rental assistance."

FOCUS GROUP PARTICIPANT

Risk of Youth Homelessness: National Data[151]

One in 10 young adults ages 18 to 25 and at least one in 30 adolescents ages 13 to 17 experience homelessness over the course of a year.
LGBTQ+ youth are at more than double the risk of homelessness compared to non-LGBTQ+ peers and tend to receive residential treatment at disproportionately high rates.
A significant number of homeless youth report foster care involvement via out-of-home placements, either in foster care or institutional settings.
Youth experiencing behavioral health issues, particularly those receiving inpatient and residential behavioral health treatment, face an increased likelihood of experiencing homelessness.

"[With the pandemic] we saw every single aspect of life flipped for vulnerable young people, those who were sort of unstably housed became immediately homeless and even those who were stably housed became unstably housed …We saw this increased stigma with congregate living. In San Diego, our emergency shelters are our first line of defense against homelessness … But that was just ripped right from us, because now people are fearful of living next to each other."

FOCUS GROUP PARTICIPANT

"We saw a great increase in the mobile services that were provided. We saw more food pantries, we saw pop-up health clinics, there's more information about mental health and hotlines … there are some things that were increased that positively impacted our youth."

FOCUS GROUP PARTICIPANT

Injury Prevention

The COVID-19 pandemic led to changes in the types of injuries that were most often experienced by children and youth. With stay-at-home orders, families were contained in their homes and unintentional injuries in the home, like window falls, led to hospitalizations in greater numbers than expected. As families began to go outside, hospitals experienced an increase in visits due to ATV crashes and, unexpectedly, due to drownings, primarily in backyard pools.

For more information, please see the Safe Kids Report.

Childhood Unintentional Injuries in San Diego County
A report to the community

SAFE K:DS
SAN DIEGO

February 2022
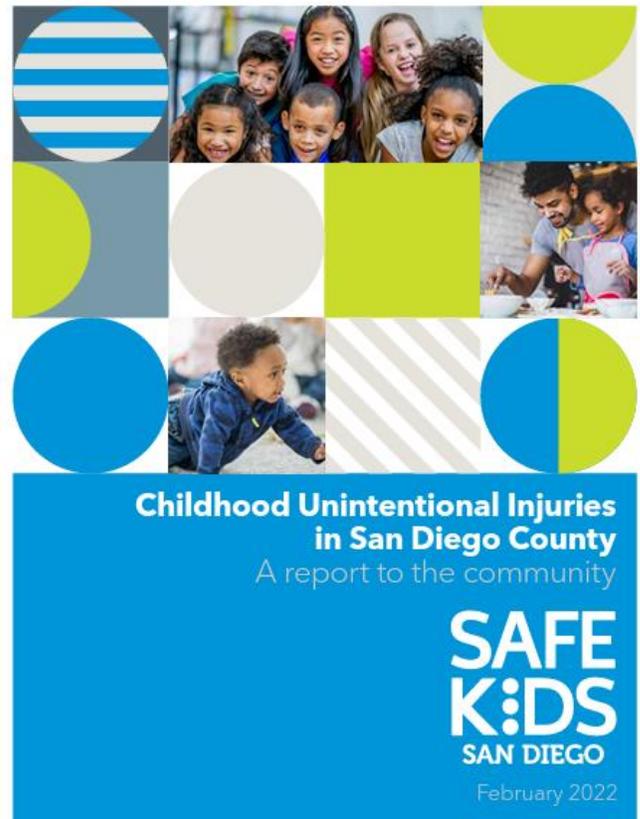
Safety Concerns for Children and Youth

Clinicians and community-based organizations shared concerns about increasing safety risks for children. Many risks were amplified because of the pandemic.

When schools were teaching through virtual learning, there was a reduction in mandated reporters identifying incidents of domestic violence and neglect. Those children who were seen at the hospital seemed to have more serious injuries.
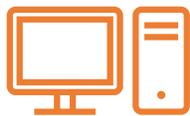
In our Online Community Survey, respondents identified **bullying (57%)** *and* **social media/online gaming (56%)** *as top concerns.*

Although the survey doesn't specify whether the bullying was taking place online or in-person, based on community feedback there is growing concern about bullying and harassment through social media.

In San Diego County, **neglect comprises an average of 75% of all substantiated child maltreatment allegations for children ages 0-5.** *The combination of limited income and high housing costs contribute as risk factors for neglect.* [152]

"I would say not having that support system of people [survivors of domestic violence] that they can go to. A lot of them [home insecure youth] are hiding the fact that they're in a domestic violence situation. … So, I'd say that one challenge is the support system, because they don't have anywhere to go to escape the violence."

FOCUS GROUP PARTICIPANT

"The child abuse concerns … there's definitely, higher incidences of substance use either on the part of the parent or even children … I think the lack of connectivity that the kids have had through COVID and then being back in school and dealing with that adaptation and their parents also trying to make that switch, I think had some impact."

KEY INFORMANT

Commercial Sex Exploitation of Children

Our community also shared serious concerns about the rapid growth of commercial sex exploitation of children (CSEC). Over the past few years, teenagers have spent more time than ever before on their computers and cell phones. A 2016 report found that websites were being used to target youth. Since then, the targeting of youth has become much more sophisticated with social media.

Report on Human Trafficking and Commercial Sex Exploitation of Children in San Diego County Select Findings Related to Children

- Average age of entry into sex trafficking in San Diego County is 16.1 years of age.

- Of the sample of sex trafficking victims among those arrested for prostitution, 55% reported that they were or had been homeless and 28% reported they had been in foster care.

- All 20 high schools that participated in this study confirmed that recruitment was happening with their students.

- 90% (18 schools) reported documented cases of sex trafficking victimization.

Source: The Nature and Extent of Gang Involvement in Sex Trafficking in San Diego County Author(s): Ami Carpenter, Ph.D., Jamie Gates, Ph.D. Document No.: 249857 Date Received: April 2016[153]

"The other (risk factor for trafficking) that's coming to mind is thinking about the LGBTQ+ plus community, but in particular thinking about folks who are gender diverse, so not just trans folks, but non-binary folks, two spirit folks, especially youth, because those are folks who are actually being targeted really frequently from a young age because of their identities for sexually explicit material online or other spaces. We see those folks frequently targeted."
FOCUS GROUP PARTICIPANT

"We did see a huge shift in increase in online exploitation, in seeing youth be reached out to online and recruited into sex trafficking. We did see an increase in minors in particular leaving the home, running away from home or from placements and being recruited by traffickers to engage in sexual exploitation."
FOCUS GROUP PARTICIPANT

"I think there's still a lot of commercial sex exploitation of children, a lot of the sex trafficking and things, especially with social media, because a lot of that kind of goes hand in hand with when they're using social media and then people Snapchat them and it continues to be a big thing that we're seeing."
FOCUS GROUP PARTICIPANT

2022 San Diego
Community Health Needs Assessment

2022 SAN DIEGO CHNA
COMMUNITY HEALTH NEEDS ASSESSMENT

HOSPITAL ASSOCIATION
of San Diego & Imperial Counties

2022 CHNA Findings:

Chronic Health Conditions

Chronic Health Conditions

One of the most pressing community health needs has been identified as chronic health conditions. Several interviews revealed that diabetes and cancer are the biggest concerns for community members. As a result of delayed care from the pandemic, some community members' chronic conditions have worsened over time. Long waitlists and backlogs in accessing care still persisted, even after services were restored. Medication management, deferred care, and increased acuity of conditions (either uncontrolled or undetected) continue to be concern.

Chronic Health Conditions Made Up the Majority of Leading Causes of Death in San Diego County in 2019

Leading Causes of Death

According to the Centers for Disease Control and Prevention (CDC), chronic diseases — referred to in this finding as chronic health conditions — are among the leading causes of death and disability in the U.S. Six in every 10 adults in the U.S. are living with a chronic disease and four in 10 adults are living with at least two chronic diseases.[154]

From 2000 to 2019, San Diego reported an overall decrease in the percentage and rate of deaths due to chronic health conditions.[155] Despite this trend, cancer (malignant neoplasms) was San Diegans' leading cause of death in 2019, followed by diseases of the heart. *Diabetes* was identified as the seventh underlying leading cause of death for San Diegans in that same year.[156]

- **In 2019, 4,689 deaths were due to** *diseases of the heart,* **and 760 deaths were due to** *diabetes mellitus* in San Diego County.

- The age-adjusted death rate due to *diseases of the heart* **was 122.5 per 100,000 population** and **20.6 per 100,000 population due to** *diabetes mellitus* for that same year.[157]

- The vast majority (80%) of the top 10 leading causes of death for San Diegans were due to chronic or non-communicable diseases in 2019.[158]

Top 10 Leading Causes of Death in San Diego County, 2019[159]
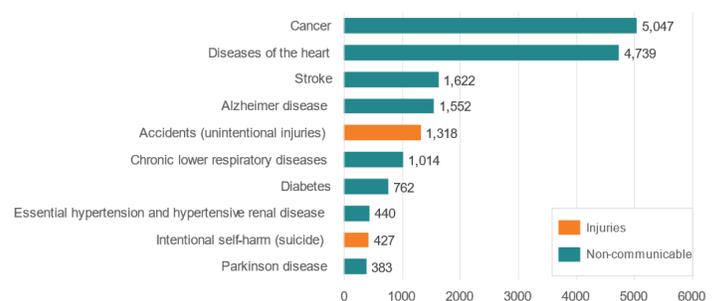
Underlying barriers in the management of chronic health conditions include access to care, economic stability, and stable housing

Access to Health Care

Please see the **Access to Health Care** finding for more information.

Fear of contracting COVID-19 prevented many people from seeking necessary care, delaying care, or receiving routine health care.

As a result, according to interviewees, preventive care screenings and other health-related assessments were delayed, potentially leading to adverse health outcomes or the progression of an undetected or uncontrolled health condition. This is especially concerning for those considered low-income community members.

"There's so much uncertainty and it's not improving. [There's] job and housing instability. Costs of things keep going up … People don't want to engage [in their health] as much."

FOCUS GROUP PARTICIPANT

In 2020, **27.4%** *of San Diego respondents cited COVID-19 as the main reason for delaying or foregoing needed medical care.*[160]

47% *of those who postponed care reported their condition worsened as a result (up 6% from a survey administered in the previous year). When looking at lower income Californians who postponed care, 51% had reported their condition worsening.*[161]

Lingering Concerns

Living with chronic health conditions has always been challenging for community members, but the pandemic made many it much more difficult for many. In addition, new challenges have emerged.

Ongoing unpredictability, social isolation, and the inability to get treatment have all had an effect on people with chronic health conditions. Interviewees shared a deep concern about the possibility of an increase in patients who have delayed care and may now be sicker with more complex or complicated conditions.

The CDC estimated that due to California's stay at home order, screenings may have **decreased by 80%** *for health care facilities.*[162]

Chronic Health Conditions and Economic Stability

Please see the **Economic Stability** finding for more information.

Insurance conflicts, the cost of insurance premiums and co-pays, and eligibility requirements for appropriate programs were cited as barriers to getting the care needed to manage chronic health conditions. Interviewees shared that community members were often confused and did not know what cash assistance programs or services they were eligible for.

Stable Housing and Needs for Utilities and Appliances

Interviewees shared that chronic health conditions are especially difficult to manage for those who are unhoused or facing housing hardship. Lack of access to utilities and household appliances such as refrigerators and stoves were cited as challenges to keeping medication stored at the proper temperature and to cooking nutritious, dietary foods that are necessary for diabetes management.

For cancer patients and survivors, housing is crucial for recovery and healing from treatments.

"They can't pay [their hospital bills], so they don't continue to follow up [on their care]. They don't [schedule] their surgeries because they have no place to [stay] at afterward … and they are dealing with a chronic health condition…"
FOCUS GROUP PARTICIPANT

"It's gotten to the point where sometimes [clients] don't buy their medications and they need to be on their medications. For instance, for a chronic condition, diabetes and anything they need to take on a daily [basis] or have their insulin. It's very heartbreaking … it's just the cost of living here in San Diego."
FOCUS GROUP PARTICIPANT

"There are people that need electricity for medical equipment or to keep their medication in the fridge. Finding a good place to stay when [you] have a health condition or…be hooked up to any sort of a medical equipment at home…is really, really tough."
FOCUS GROUP PARTICIPANT

Cancer in San Diego County

Cancer Incidence

For all cancer sites, the age-adjusted rate from 2013 to 2017 in San Diego County was 406.9 per 100,000. The top 10 incidence rates by cancer site are represented in the figure below. [163]

Incidence Rates for Cancer in San Diego County, 2013-17

Cancer Incidence Rate by Site

Site	Rate
Prostate (male)	96.6
Breast (female)	67.6
Lung & Bronchus	42.4
Colorectal	34
Melanoma Skin	27.7
Uterine (Corpus)	24.1
NHL*	18.5
Urinary Bladder	17.2
Breast (In Situ)	16
Kidney & Renal Pelvis	14.8

Rate per 100,000 population
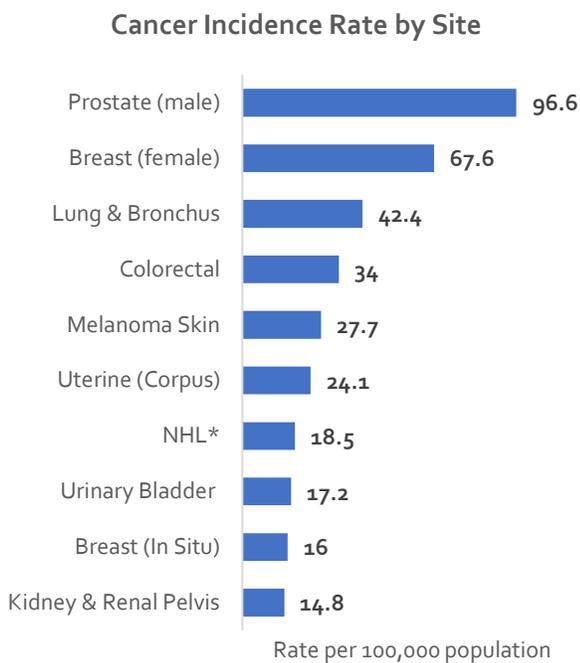
Source: California Cancer Registry. Age-Adjusted Invasive Cancer Incidence Rates in California, 2013-17, by county.
*Non-Hodgkin's lymphoma

Cancer Mortality

Cancer was the leading cause of death in San Diego County in 2019.[164] The age-adjusted mortality rate for all cancer sites from 2013 to 2017 was 145.9 per 100,000. Mortality rates by top 10 cancer sites are represented in the figure below.[165]

Mortality Rates for Cancer in San Diego County, 2013-17
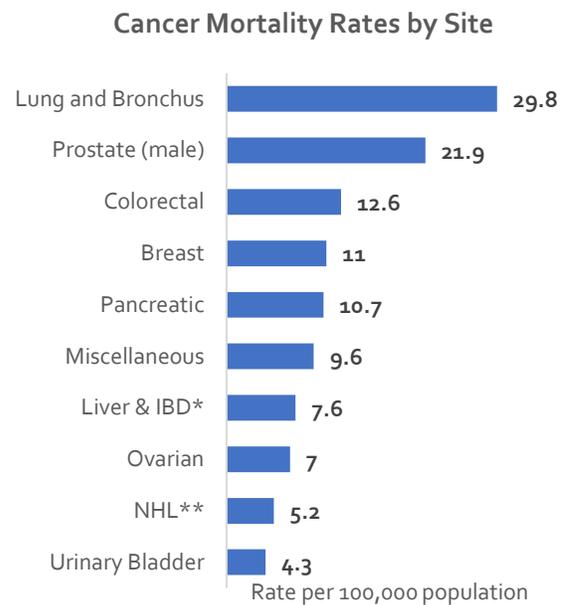
Cancer Mortality Rates by Site

Site	Rate
Lung and Bronchus	29.8
Prostate (male)	21.9
Colorectal	12.6
Breast	11
Pancreatic	10.7
Miscellaneous	9.6
Liver & IBD*	7.6
Ovarian	7
NHL**	5.2
Urinary Bladder	4.3

Rate per 100,000 population

Source: California Cancer Registry. Age-Adjusted Cancer Mortality Rates in California, 2013-17, by county.
*Inflammatory Bowel Disease
**Non-Hodgkin's lymphoma

Challenges for Patients with Cancer

Delayed Access to Cancer Screenings and Early Detection

Access to cancer care was significantly challenging for our community. Delayed access to cancer screening and its long-term consequences was identified as a concern for community members. The pandemic disrupted cancer screening procedures, which has posed a significant challenge to access to cancer care. More advanced cancers and deaths in excess are of particular concern. Interviewees shared that detection of cancer at later stages, where treatment may be more intensive and potentially less effective, was a huge concern.

A National Cancer Institute prediction model [166] estimated that delays in cancer screenings and treatment postponement during the pandemic could result in an additional 10,000 breast and colorectal cancer deaths in the U.S. over the next 10 years.[167]

One study in San Diego found the incidence of late-stage colorectal and breast cancer presentations at their institution corresponded to a decrease in early-stage presentation of these cancers.[168]

Cancer Cost of Care and Treatment Concerns

Cost of care and treatment, along with the looming fear of incurring medical debt, weighs heavy on cancer patients and survivors. Current and future experiences with medical debt, especially with competing financial stressors, can severely hinder cancer patients and survivors from seeking needed care or limit their treatment options altogether.

A survey of over 3,000 cancer patients and survivors through the **American Cancer Society Cancer Action Network Survivor Views** program found: [169]

- **73%** are concerned about their ability to pay current or future costs of care.
- **70%** are worried about incurring medical debt due to cancer care and treatment.
- **51%** reported incurring medical debt due to costs of cancer care.
- **45%** of those who have experienced medical debt have delayed or avoided medical care for serious issues.
- **62%** have delayed or avoided medical care for minor issues.
- About **50%** wanted the least expensive treatment options due to their debt.

Populations at Risk for Chronic Health Conditions

Veterans and Military Connected

Older men and women who have served in the military typically present with co-occurring medical, mental health, and substance use disorders. These complex cases are the most difficult to treat, which can lead to misdiagnosis, inefficient and ineffective treatment plans and care, worsening health, increased system costs, and low patient satisfaction. Fifty-seven percent of older veterans have at least three or more chronic conditions compared to 44% of older civilians.[170] The overall crude prevalence of having multiple chronic conditions was found to be higher among male and female veterans compared to their counterparts who had not served in the military. [171]

Veterans and Cancer

Veterans are at an elevated risk for cancer due to military service exposure to hazardous chemicals, related materials, and environments such as radiation, gas, chemical weapons, and herbicides. Presumptive conditions associated with these exposures include certain cancers, respiratory issues, and central nervous system conditions.[172]

Crude Percentage of Men Ages 25 and Over with Multiple Chronic Conditions, by Veteran Status and Age: U.S., 2015-18

[1]Significantly different from nonveterans (p < 0.05).
NOTES: Multiple chronic conditions include arthritis, cancer, chronic obstructive pulmonary disease, coronary heart disease, current asthma, diabetes, hepatitis, hypertension, stroke, and weak or failing kidneys. Estimates are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: National Center for Health Statistics, National Health Interview Survey, 2015–2018.

Crude Percentage of Women Ages 25 and Over with Multiple Chronic Conditions, by Veteran Status and Age: U.S., 2015-18

[1]Significantly different from nonveterans (p < 0.05).
NOTES: Multiple chronic conditions include arthritis, cancer, chronic obstructive pulmonary disease, coronary heart disease, current asthma, diabetes, hepatitis, hypertension, stroke, and weak or failing kidneys. Estimates are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: National Center for Health Statistics, National Health Interview Survey, 2015–2018.

Seniors and People Experiencing Homelessness

Several interviewees agreed that people experiencing homelessness and senior community members were the most at risk of having an uncontrolled chronic health condition. Most of the time, interviewees shared, these conditions are not detected or addressed until they become an emergency. Further, for community members without a home, it is challenging to adhere to a treatment plan such as taking medications on a regular schedule.

Across several interviews, there was agreement that the most common illnesses or injuries for patients experiencing homelessness were untreated, infected, or open wounds, and uncontrolled chronic health conditions such as diabetes. (spacing is different from paragraph above)

- 2019 hospitalization data show patients identified as experiencing homelessness had a significant number of chronic diseases: **6.1** at the inpatient level of discharge and **2.1** at the emergency department (ED) level of discharge on average.[173]

- The **ED discharge** rate for diabetes in 2019 was 180.6 per 100,000 population for all age groups. For those *ages 65 and over,* the **ED discharge** rate was double: 383.5 per 100,000 population.[174]

"Many people experiencing homelessness are [seen at the ED] due to unmanaged medications or chronic conditions like uncontrolled diabetes."
KEY INFORMANT

"For a diabetic who's experiencing homelessness on the street … that's not a good mix. [There's] no bathroom access, therefore [they] cannot be 'compliant' on a treatment plan."
FOCUS GROUP PARTICIPANT

Undocumented

Undocumented community members, according to interviewees, are on their own in navigating their cancer needs. Many people do not have the necessary insurance coverage to enroll in programs, treatments, and services that may support their financial, logistic, and supportive needs for their cancer diagnosis.

"I get a lot of calls about people who are undocumented and don't have any health insurance … and have cancer. They … can only seek emergency services. They are kind of on their own … when it comes to regular doctor visits or medications, and that makes it really hard for them."
FOCUS GROUP PARTICIPANT

Cancer-Related Stigma

Due to fear, some community members were reluctant to seek preventative care such as cancer screenings, despite recognizing serious physical symptoms or decline in their baseline health. The prospect of receiving a cancer diagnosis made people feel overwhelmed and fearful of potential death and suffering due to having a condition that may never be cured. Therefore, many people avoid seeking these services altogether.

Relying on their support systems too frequently when there were other competing stressors can cause cancer patients and survivors to worry about being an unnecessary burden to others.

"[With] an aging population [there's] an increase…[in]cancer cases as well as chronic conditions on top of what was being [already being] managed prior to [the pandemic]."
FOCUS GROUP PARTICIPANT

Immigrant and Refugee — Cancer-Related Stigma

Immigrants and refugees frequently perceive stigma from other community members because their communities are smaller, closer-knit, and information about others circulates on a regular basis. As a result, they are less likely to seek cancer screening or treatment because they are afraid of being judged by others.

LGBTQ+

Please see the **Access to Health Care** finding for more information.

Interviewees also reported the additional challenges LGBTQ+ people experienced managing their conditions due to insufficient resources that provide holistic care in an inclusive, affirming, supportive environment.

LGBTQ+ persons living with HIV were identified as a group with a disproportionate need for self-management support. In addition to peer support, trauma-informed providers were cited by interviewees as integral to supporting HIV care management.

- Though new cases of HIV infection have decreased over the years, the number of those living with HIV has increased. Over 13,800 people were living with an HIV diagnosis and over 1,300 people were living with an undiagnosed HIV infection at the end of 2018 in San Diego County.[175]

- According to 2016-20 UCLA Community Health Interview Survey (CHIS) data, the LGBQ population had a higher (29%) asthma prevalence rate as compared to its non-LGBQ counterparts.[176]

Chronic Disease Prevalence Among the Adult LGBQ Population in San Diego County
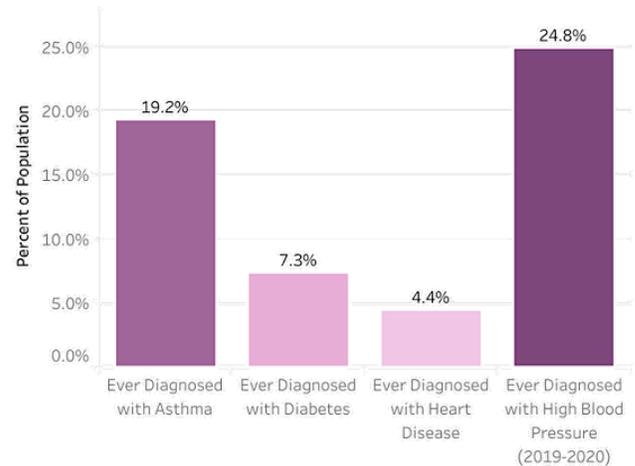
Note that individuals who identify as transgender are not included in the adult LGBQ dashboards due to the instability of the CHIS data for the transgender population in San Diego County.

Source: UCLA Center for Health Policy Research, California Health Interview Survey (CHIS), 2016-2020. Prepared by: County of San Diego, Health and Human Services Agency, Public Health Services, Community Health Statistics Unit, March 2022.

Care Management Needs During the Pandemic

Chronic health condition management (i.e., symptom management such as pain, sleep, stress, and mental health), preventive screenings, and overall self-management have all been impacted as a result of the pandemic. Reduced care management could lead to poorer health outcomes for people with chronic health conditions.[177]

The Pandemic Was Disruptive to Care Management

Some people with chronic health conditions experienced significant disruptions in their care and critical support services, potentially undoing any progress in their care management journey. In addition, delays in getting the care that could have detected uncontrolled or addressed unmanaged conditions could have resulted in more acute and complex cases. Reinforcement of self-management skills such as self-care practices (sleep, diet, physical activity) and medication adherence suffered, potentially jeopardizing the capacity of some people to manage their health and mitigate illness independently.

Through Access to Health Care interviews conducted by community health workers and promotoras, the majority **(six of the top 10) of health conditions** were identified as being the most concerning for community members and were associated with **chronic health conditions:**

- Stress (62%)
- High blood pressure (43%)
- Diabetes (43%)
- Nutrition, physical activity, and weight (35%)
- Heart disease and stroke (27%)
- Cancer (26%)

*According to the CDC, **nearly nine in 10 (87%)** adults ages 18-29 with diabetes reported delayed receipt of medical care.*
*More than **two in five (44%)** reported difficulty accessing diabetes medications between November 2020 and February 2021.[178]*

"People are waiting longer and sicker [and there] are no resources available to treat those patients."
FOCUS GROUP PARTICIPANT

"Having health advocates or support from someone to … follow up with people to see if they followed through on … referrals … someone who holds you accountable really helps."
FOCUS GROUP PARTICIPANT

Care Coordination

The closure of various facilities during the pandemic disrupted access to routine and specialty care, making the receipt of comprehensive care even more challenging for people living with chronic health conditions. Even when in-person services resumed, wait times for appointments were long – sometimes months out. This was especially concerning for patients who require more frequent, timely, coordinated care needs.

Without regular appointments and with long waits for specialty care, patients with chronic health conditions would have to ration treatments or service support they did have access to or risk having their health slowly deteriorate. In turn, much of their care relied on their own ability to stay

engaged in the face of other challenges in their personal lives.

Please see the **Access to Health Care** finding for more general information.

Medication Management, Cost, and Coordination

Please see the **Economic Stability** finding for more information.

During the pandemic, refilling and obtaining prescriptions became more difficult due to financial constraints and increased personal stress. For some patients, medication became a lower priority compared to other competing financial needs. This made sticking to a treatment plan more difficult.

Those with chronic health conditions understand the importance of engaging in self-management activities such as taking medications on a regular basis, but the pandemic made it difficult to stay committed to a routine. As a result, interviewees shared that some people may experience long-term negative consequences such as advanced disease progression.

Emotional Challenges and Mental/Behavioral Health Impact

Adherence to treatment plans is impacted by a variety of factors, including emotional state and mental health conditions such as depression. Anxiety, uncertainty, and other stressful experiences from the pandemic — coping with job loss, changes in income, or health insurance — may have further exacerbated existing emotional and mental health concerns of patients with chronic health conditions.

Emotional and mental anguish can make it difficult for a person to engage in regular, routine activities with family and friends, which can severely impact a person's outlook on life or lead to the development of depression.

- One in 10 Californians say that the stress of the pandemic has worsened chronic conditions.

	All Californians	≥200% FPL	<200% FPL
Trouble falling asleep, or sleeping too much	41%	35%	55%
Poor appetite or overeating	33%	29%	45%
Frequent headaches or stomachaches	25%	20%	36%
Increasing drug or alcohol use	15%	15%	18%
Difficulty controlling temper	22%	19%	32%
Worsening chronic condition (diabetes, high blood...	11%	7%	19%
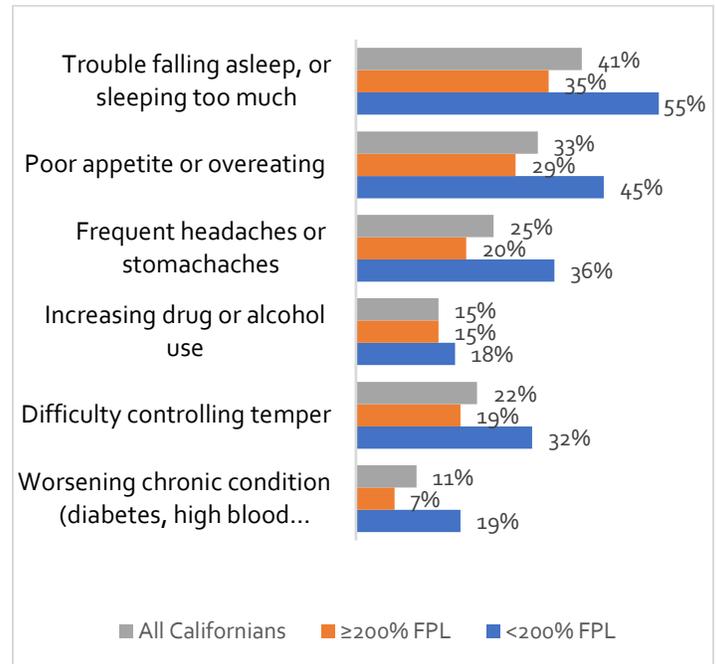
Notes: CHCF/NORC California Health Policy Survey (September 27, 2021–November 17, 2021). *FPL: Federal Policy Level
Source: The 2022 CHCF California Health Policy Survey

Experiencing stress during an infectious disease outbreak can include the following:[179]
Fear and worry about your own health and the health of your loved ones
Changes in sleep or eating patterns
Difficulty sleeping or concentrating
Worsening of chronic health problems
Worsening of mental health conditions
Increased use of alcohol, tobacco, or other drugs

2022 San Diego
Community Health Needs Assessment

2022 SAN DIEGO CHNA
COMMUNITY HEALTH NEEDS ASSESSMENT

HOSPITAL ASSOCIATION
of San Diego & Imperial Counties

2022 CHNA Findings:

Community Safety

Community Safety

There was a noticeable rise in the number of community members concerned about being safe in their homes, communities, schools, and workplaces. In the spring and summer of 2020, the public's awareness of long-standing inequities in their communities was heightened by the social unrest that our country experienced. Those who were already vulnerable to violence or coercion prior to the pandemic were also experiencing new or worsened safety risks in their homes or workplaces as a result of the pandemic.

County of San Diego Declares Racism a Public Health Crisis

In declaring racism a public health crisis, we are acknowledging that racism underpins health inequities throughout the region and has a substantial correlation to poor outcomes in multi-facets of life. As the public health agency for the region, the county has a responsibility to tackle this issue head-on in order to improve the overall health of our residents. The public health and racist implications of county policies extends beyond those decisions in county public health services to all departments.

County of San Diego, Board of Supervisors, Framework for Our Future: Declaring Racism a Public Health Crisis, January 21, 2021[180]

"Specifically thinking about how in particular the last year and three months since George Floyd's passing and his death, how that has ... impacted our clients in particular. Thinking about many of the clients that we work with, for example, who are young Black men and helping them have to navigate complicated feelings and valid feelings around social inequity, but also simultaneously having to find ways to safety plan with them and recognize that, 'Yes, you absolutely want to be involved and also you fit a very specific demographic that's at risk'."

FOCUS GROUP PARTICIPANT

Hate Crimes in San Diego County

The most common motivation for hate crimes was race in both 2020 (76%) and 2021 (64%). In 2020, 6% of the 34 hate crime cases attributed to race involved Asian victims. In 2021, it had increased to 18%.[181]

Impact of Stressors on Community Safety

*In our Online Community Survey, **29%** of respondents identified "Being unsafe from violence and coercion at home, work/school, and in my neighborhood" as a top concern.*

Significant levels of fear and feeling unsafe were reported by members of our community. The COVID-19 pandemic increased stressors that were associated with rises in community violence, such as cases of child abuse, interpersonal violence, and domestic abuse[182]. Pandemic safety measures such as virtual schooling reduced opportunities for government and community agencies to identify potential cases of abuse and intervene. For instance, the amount of mandated reporting declined when schools were closed. Pandemic safety measures further complicated victims' ability to protect themselves from abusers as courts were closed. Therefore, some victims were filing for restraining orders with perpetrators in the same house.

Experiencing Violence and Community Dysfunction

There has been a notable rise in violence against marginalized groups. People who are exposed to violence — those who are victims or witnesses of violence — may experience physical decline or adverse mental health effects such as trauma. Over time, trauma can lead to development of anxiety and depression, or post-traumatic stress disorder.[183] [184]

In addition, **feeling unsafe in one's neighborhood,** due to increased or persistent law enforcement presence, caused community members to worry about being surveilled, which impacted community members' ability to trust their environment and

maintain their health. Interviewees discussed the importance of having a safe environment in which to live, exercise, or play. The combination of feeling unsafe yet being watched may cause individuals to develop feelings of mistrust toward authority, which can lead to withdrawal and a reluctance to seek care or assistance. Please see **ACEs** section for more information.

Safe Neighborhoods and Communities

Community members frequently shared their concerns related to living in unsafe neighborhoods and described their daily precautions (such as always carrying pepper spray). They mentioned the impact on people of all ages, but there were particular concerns about children and their access to safe outdoor spaces. Safety concerns were not limited to those regarding physical harm; our community also cited concerns about exposure to racism and bullying.
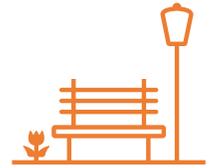
"Public safety and the over-policing of our neighborhoods, whether it's through [Immigration and Customs Enforcement] or through police or overzealous district attorneys [are of concern]."
KEY INFORMANT

"It's basically like being in a constant environment of surveillance where you're worried to drop your kids off at school, where you're worried to get in the car and go someplace because you could be pulled over, detained and made late to your job, made late to different types of things, at best. At worst, beaten up, killed, disrespected, and abused in front of your children."
KEY INFORMANT

Interviewees shared that some populations were identified as more at risk for experiencing violence or abuse and disproportionately suffering from significant health disparities as a result:

- People with a history of involvement in the foster care and child welfare systems
- Youth and adults who are justice-involved
- Seniors who are vulnerable and/or dependent on their caregivers
- People from marginalized race/ethnic groups, such as BIPOC
- LGBTQ+ community members, especially transgender Black women

In California, Adult Protective Services receives more than 15,000 reports of elder and dependent adult abuse per month, and reports are increasing. There are an estimated 202,549 cases of reported elder and dependent adult abuse per year in California, but elder abuse remains significantly underreported. For every case known to programs and agencies, 24 are unknown. For financial abuse, only one in 44 cases is known.[185]

Violence Against Transgender People

Transgender people are more likely than cisgender people to be victims of hate crimes and violence in intimate relationships regardless of sex assigned at birth. At least one lifetime incident of physical or sexual assault is reported by half of transgender adults. Compared to other groups, Black transgender women are more likely than other groups to be poly victimized — subjected to multiple forms of violence, sometimes at the same time, over the course of their lifetime due to the intersectionality of race, gender, and socioeconomic status.[186]

"I think that [domestic violence] is very prevalent in the community and it's making people have a hard time leaving ... All of the [domestic violence] shelters at any given time are most likely full, so there's just not enough resources out there for victims of domestic violence and if they do decide to leave their situation, a lot of them don't have a place to go, they don't have that family member or those friends that they can rely on."

FOCUS GROUP PARTICIPANT

"We've seen a lot of increase in intimate partner violence or family-based violence, and even had clients who have needed to work on getting restraining orders and things like that through the pandemic ... Having to do remote court sessions with clients is not trauma informed. It was just like, 'here's a link, sign on to this link,' and then all of a sudden your perpetrator is on your computer."

FOCUS GROUP PARTICIPANT

Safety Concerns for People Experiencing Homelessness

A frequent theme in conversations was the safety concerns of people experiencing homelessness. Community members who are homeless are more likely to be involved in violent acts and sustain injuries as a result of assaults. Furthermore, they are frequently targeted for theft of their belongings, such as identification documents, medications, or mobility-aiding medical equipment, like wheelchairs, walkers, or canes.

This may often lead to developing an overwhelming sense of fear, a constant sense of being unsafe, and a feeling of deep mistrust of their surroundings. Such experiences can cause re-traumatization.

According to a March 2021 media release from the County of San Diego District Attorney Office, data revealed that individuals experiencing homelessness have higher rates of victimization in the following categories when compared to the general population:[187]

Murder	**19** times
Attempted Murder	**27** times
Robbery	**15** times
Domestic Violence	**15** times
Aggravated Assault	**12** times
Elder Abuse	**10** times
Sexual Assault	**9** times

Human Trafficking

Human trafficking is a public health issue that intersects with all social determinants of health, making anyone vulnerable to it. Some community members are at a higher risk of being a victim of labor and/or sex trafficking due to barriers related to age, socioeconomic status, ethnicity/race, sexual orientation, or gender identity. Misinformation, especially during the pandemic, has made identifying and assisting survivors and potential victims extremely difficult. Another challenge is sensationalism of images, assumptions, and stories shared in the media/publicly.

*While San Diego County is part of an international border, the most recent study from the University of San Diego found that **79.3% of people trafficked for sex are U.S. citizens**. [188] The San Diego Human Trafficking Task Force did note that the border plays a role in labor trafficking.*

"For survivors across the continuum … folks very much see trafficking as a black and white thing. On the continuum of sex work, you're either fully enthusiastically engaged or you're being exploited, end of story. There's no in between of your circumstance of poverty or other things that might occur that might cause you to engage in some form of sex work, whether that is fully consensual or fully exploited."

FOCUS GROUP PARTICIPANT

*At some point in their lives, **more than 90% of people with developmental disabilities will experience sexual abuse;** 49% will experience 10 or more instances of abuse. Other experts have estimated that the percentage is closer to 95%. [189] [190]*

Risk Factors/Populations

In many cases, traffickers identify and exploit the vulnerabilities or unmet needs (emotional, financial, physical, etc.) of their victims to induce dependence. The following community members were identified by interviewees as particularly at risk:

- People living with a developmental disability
- People with children
- People from marginalized race/ethnic groups, such as BIPOC
- People involved with the justice system
- Foster youth
- LGBTQ+
- Undocumented
- People experiencing food, economic, or housing insecurity

"I think what we see a lot is a very specific perspective that trafficking has to be this thing that is extremely violent and is extremely in this underbelly of society and not recognizing that sometimes it happens because a family needs to put food on the table."

FOCUS GROUP PARTICIPANT

Interviewees identified major gaps in critical services for survivors of human trafficking. Needed services include:

- More shelter beds, especially for male survivors and LGBTQ+ survivors. Current beds are inadequate.

- More trauma-informed shelter or short-term housing options. For example, low-barrier options that do not require sobriety.

- A 24/7 hotline for safe shelter collaborative programs staffed by trained mental health professionals

- Text-message accessible hotlines and/or webform intake services that are easily hidden from exploiters

Mislabeling as Non-Compliant

Advocates reported that survivors are frequently misidentified as being difficult or non-compliant in clinical settings because of their inability to follow their care plan. However, it is frequently overlooked that this "non-compliance" may often be a result of trauma responses from what they have endured.

The Need for Trauma-Informed Care and Support for Survivors

Assessments administered by bedside clinicians included in multidisciplinary protocols were identified as needed to prevent moral injury to staff and patient harm. Trauma-informed care is ideal for assisting patients in requesting assistance or ensuring that they feel safe returning to health care facilities if they do not choose assistance. If patients are not ready for support or do not trust the system/authority, a premature hand-off to social work can stigmatize them. [191] [192] [193]

"We know when people are dealing with immense trauma, that they react in a multitude of ways. I've even found that in the work I do with the forensics where we have nurses who are particularly trauma informed, but even they really struggle to see the indicators and the risk factors of patients that come in, in relation to trafficking and exploitation."
FOCUS GROUP PARTICIPANT

"There have been some challenges with the national hotline recently, partly because of increasing calls about conspiracy theories. We need a locally supported, cross-sector, trauma-informed hotline to help human trafficking survivors connect to services and supports."
FOCUS GROUP PARTICIPANT

"A trauma-informed environment uses supportive language conversation with patients, colleagues, and in documentation. Using language that supports the dignity of patients creates an environment where patients feel safe and improves health outcomes."
FOCUS GROUP PARTICIPANT

"Clinicians prefer screening tools, but patients can resist disclosure and screening does not provide the support patients need. A trauma-informed assessment tool like the evidence-based PEARR tool is ideal to facilitate discussions between patients and clinicians about personal safety and how relationships impact our health. When a patient is ready for more support, a hand-off to social work or community support should be done with consent and transparency."
FOCUS GROUP PARTICIPANT

Hospital Workforce Safety

San Diego hospitals and health systems have a long-standing history of being hotspots for violent encounters in all types of settings including the emergency department, inpatient, and outpatient settings. However, workplace violence has worsened during the pandemic and was identified as an alarming concern.

Increased stressors and political tensions (e.g., mask mandates) due to the pandemic may have caused an uptick in aggression and violence towards health care workers.

Examples of violence types that health care workers encounter include:

- Nonphysical/psychological harm such as insults, yelling, threat of physical assault, intimidation
- Physical assault
- Verbal sexual harassment and sexual assault

Violence against health care workers makes it difficult for providers and other health care staff to provide quality care. Additionally, witnessing violence in health care settings creates a stressful environment for other patients seeking care.

Vicarious Trauma

Having a safe, comfortable, and supportive working environment contributes to overall mental, physical, and emotional well-being. **Unfortunately, workplace violence also deeply impacts health care workers emotionally and psychologically.** As a result of witnessing and/or assisting a colleague after a violent encounter with a patient, health care workers are profoundly affected by vicarious trauma. Such experiences could lead to staff

burnout, compassionate fatigue, and secondary traumatic stress. Please see **Trauma-Informed Care** section for more information.

The health care industry experiences the highest rates of injuries caused by workplace violence; workers are five times as likely to suffer a workplace violence injury than workers overall.[194]

Since the onset of the pandemic, violence against hospital employees has markedly increased — and there is no sign it is receding.

Studies indicate that 44% of nurses report experiencing physical violence, and 68% reported experiencing verbal abuse during the pandemic.[195]

"I always get apprehensive when a family starts verbally escalating because I always feel like that translates into possible threat of physical violence. It's not just nursing, not just clinical social work. It's ancillary staffing. It's everyone involved."
FOCUS GROUP PARTICIPANT

"We've been working with hospital leadership [and] nursing leadership on the [emergency department] side to bolster the security presence."
FOCUS GROUP PARTICIPANT

"I feel like there's always these elements there and it spills over into the daily. You experience it at airports, on airplanes. It's that same underlying sense of people are in a different mindset now and on edge a little bit. No one ever voluntarily wants to come to the emergency department. It's never the case that people look forward to coming … into the environment that they don't want to be in."
FOCUS GROUP PARTICIPANT

2022 San Diego
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CHNA
COMMUNITY HEALTH NEEDS ASSESSMENT

HOSPITAL ASSOCIATION
of San Diego & Imperial Counties

2022 CHNA Findings:

Economic Stability

Economic Stability

The profound impact that economic stability has on a person's health and well-being was a universal concern and topic of discussion among all interviews and focus groups. Many people were overwhelmingly stressed and worried about not having enough money to pay for basic essentials. At the same time, we heard from community organizations that they have seen a significant increase in the number of people seeking assistance.

When a person loses their job or has unstable income, and/or is living in poverty, they are likely to experience economic instability and are unable to afford necessities including food, utilities, housing, childcare, and health care. Alternatively, households or individuals with steady employment may still not earn enough (low-wage earnings) to meet their health needs.[196] Economic instability has a domino effect and often results in people experiencing multiple challenges at once — for instance housing instability, food insecurity, and a lack of reliable transportation. The high cost of living in San Diego County, coupled with the pressure of inflation has resulted in many people expressing difficulty affording and accessing services that meet their health and social needs. Economic instability places a burden on people by forcing them to make difficult decisions. For instance, does one spend money on rent or pay for that life-saving medication, or pay for groceries instead of the utility bill? Having to make these trade-offs can have a dire impact on our community's overall health and well-being.

Note: Community engagement was conducted in the middle of a pandemic and at a time when many protections were in place for Californians. Hardship would have been far worse without extraordinary steps taken by the federal government, states, and local counties to respond to the pandemic and its economic fallout. To protect the health and well-being of Californians, COVID-19 temporary flexibilities and waivers were approved to modify requirements and ease enrollment that has allowed thousands of San Diegans to maintain or access new health care coverage and receive maximum CalFresh benefits. Other temporary provisions such as emergency childcare subsidies, rental assistance, and eviction moratoriums also provided financial relief while many were experiencing financial hardship during an economic crisis. Such protective measures have been the safety net and it's important to note that needs will likely increase as these provisions expire when the public health emergency ends.

The following are key findings provided by the **County of San Diego's Self-Sufficiency Standard Dashboard** (an economic stability measure that considers essential household expenses), to provide a more accurate picture of the income needed to live comfortably in San Diego County. [197]

San Diego County Self-Sufficiency Standard Dashboard

A household of two adults and two children would **need an annual income of $81,98 to be economically self-sufficient** without the use of public or private insurance.	Two full-time working adults **making minimum wage of $14 would fall short of the minimum income needed to survive in San Diego County, by about $23,800 a year.** Even in the most affordable region of San Diego County, families would still fall short by almost $10,000 a year.	A single-parent household with two children **would need an annual salary of $97,466.07, or $8,130.51** a month, to make ends meet in the North Central Region. Housing accounts for the largest portion of the total budget (29%), followed by child care (19%), and transportation (14%).	A single adult living below the Federal Poverty Level ($12,880 annual income) would not be able to afford rent in San Diego County, **where rent accounts for 41% of the total income needed for an individual to make ends meet.**

Monthly Expenses for a Household with 2 Adults, 2 Children (1 Preschool-Age, 1 School-Age), 2021
The average amount spent per month by expense type to meet basic necessities without public or private assistance.

San Diego County

Housing	$1,866.23
Transportation	$1,187.50
Childcare	$1,351.80
Food	$926.00
Healthcare	$587.90
Taxes	$727.11
Miscellaneous	$591.94
Child Care Tax Credit	($48.31)
Child Tax Credit	($176.00)
Earned Income Tax Credit	($181.81)
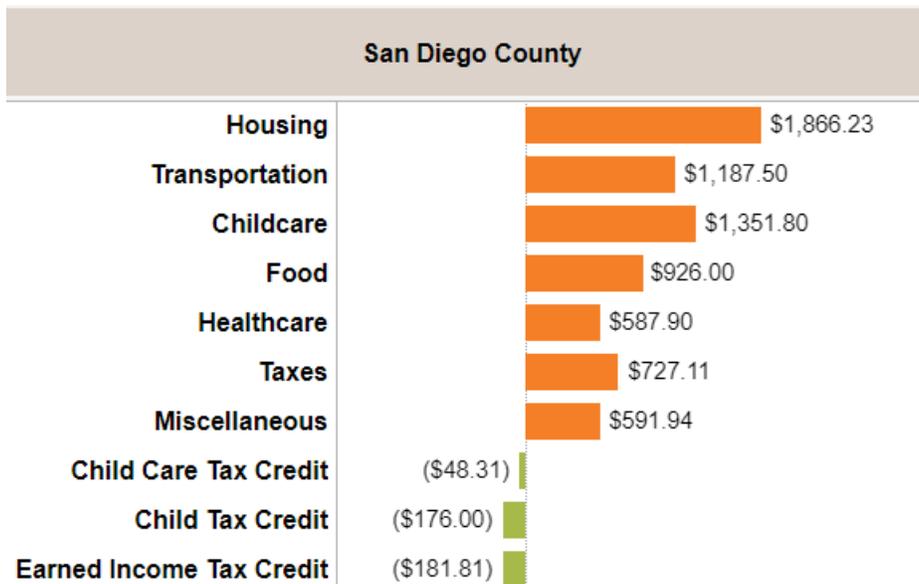
Source: San Diego County Self-Sufficiency Standard Dashboard by Community Health Statistics Unit

COVID-19 Economic Hardship

As businesses were shutting down, an unprecedented number of people in our community were losing their jobs. A frequent theme heard from interviewees was the profound stress and constant worry that come with not having enough money to provide for themselves or their families. Interviewees shared that front-line workers in particular were heavily impacted and faced economic hardship as well as exposure to COVID-19.

Communities of color, especially Blacks and Latinos, were also most at risk for economic instability due to work disruption. Families of affected workers also had to face the consequences of lost jobs or wages — causing a ripple effect on their ability to access essential needs.

COVID-19's Impact on the San Diego Regional Economy [198]

- By March 28, 2020, the estimated number of unemployed residents reached about 20 times pre-COVID-19 rates.

- [May 30, 2020], the unemployment rate in the region remain[ed] high and [was] estimated to be at 28.5%.

- On June 7, 2020, more than two-thirds of Black (67%) and Hispanic (70%) San Diego County residents lived in ZIP codes with higher than average unemployment rates.

*In interviews conducted with refugees in 2021, **86% of participants shared that financial stress was their biggest source of emotional distress.**[199]*

Source: 2021 COVID-19 Refugee Health Impact Assessment the UCSD Center for Community Health-Refugee Health Unit

"In the population we serve and in a variety of places, people did lose their jobs, they lost income. We did try to connect them as much when we could, or they qualified for unemployment..."
FOCUS GROUP PARTICIPANT

"And our families [that are] at [the] federal poverty level...they're struggling even more now on their economic security."
FOCUS GROUP PARTICIPANT

"Front-line workers, those individuals that work in restaurants or in the transportation business, maintenance...in many cases, the lower-paying jobs.... place them at greatest risk to exposure because they are in contact with the general public. And then people of color have most of those jobs. And...in many cases, a greater risk of complications because of their comorbid conditions. So, all of those factors place these populations at greater risk for developing the disease if they're exposed, and further for being hospitalized or dying from the illness."
KEY INFORMANT

The Role of Safety-Net Programs in Economic Stability

More than 1.35 million San Diegans are enrolled in safety-net programs such as Medi-Cal, CalFresh, CalWORKs. That is more than one of three people in San Diego County.[200] COVID-19 heightened the importance and need for safety-net programs during an economic crisis. Interviewees shared there was an increase in calls from community organizations encouraging them to enroll in these programs designed to help them access and afford food and health care.

In San Diego County, the average monthly income of CalFresh recipients was $997 while the average monthly income for Medi-Cal was $1,082 in January 2022.[201]

Fear of Accessing Services: Community organizations and community members both expressed the "deep fear" our immigrant community had in sharing their information with other entities and/or having their "undocumented" status being revealed.

Although many immigrant families qualified for safety-net programs and other resources that became available during the pandemic, our community shared that that fear prevented people from seeking help. Multiple interviewees stated that the previous presidential administration's public charge rule caused immigrants and their family members (including U.S.-born children) to disenroll or avoid enrollment in public benefit programs.

Nearly half (46%) of families who needed assistance during the pandemic did not apply for it due to concerns over immigration status. [202]

Source: BSP Research and Protecting Immigrant Families Coalition

"While the temporary expansion of federal nutrition assistance programs during COVID has played a pivotal role in helping many households meet their food needs each month, we know that looming expirations of these flexibilities will result in potentially devastating benefits cliffs for hundreds of thousands of San Diegans. In addition to navigating broader long-term economic impacts of COVID, recipients will once again need to think about how to meet their food needs after CalFresh/SNAP runs out two-thirds of the way through the month and face ensuing intersectional health implications of episodic hunger."

KEY INFORMANT

"I'm not talking about a concern. I'm talking about a deep fear. I never knew the rawness of it, how afraid they are."

FOCUS GROUP PARTICIPANT

"Our undocumented folks have really, really struggled in particular... The last administration being in place during the beginning of the pandemic...created this space where undocumented folks felt like they couldn't come forward for any type of help whatsoever to any government agency."

FOCUS GROUP PARTICIPANT

Housing Instability

Affordable housing has become unattainable for San Diegans and was identified as a top need for our community. With the soaring cost of housing, community members consistently and overwhelmingly expressed difficulty paying for rent and/or finding an affordable place to live. Community members stressed that paying to maintain their housing was their top priority and left little budget for other costs.

81% of extremely low-income households in San Diego County are paying more than half of their income toward housing costs compared to just 1% of moderate-income households.[203]

Our community shared that rent increases create an even bigger challenge for people who are already living month-to-month. Some community members have experienced rent increases twice in one year and faced the risk of being evicted from their homes or have had to move in with others to offset housing expenses. Not being able to afford rent can eventually push people into homelessness.

Special Populations at Risk of Housing Instability. Interviewees shared that strict requirements such as established rental history, and income that is at least two times the amount of rent. create additional challenges for certain community members and increase their risk for housing instability.

Individuals on fixed incomes, like seniors and people with disabilities, were identified as struggling to pay housing costs. Young people without extensive rental history struggle to get approved for housing even with initial assistance provided by organizations.

Refugee communities face significant challenges in managing the costs of housing. A recent assessment of refugee health concerns during the pandemic found that the pandemic made it harder for 75% of those interviewed to cover housing costs. Although 83% of the households included in the assessment received Section 8 housing vouchers**, they still reported spending more than 30% of their income on housing costs.**[204]

Community organizations shared that undocumented workers in particular have a hard time finding employment because some of them do not have a visa (work permit). Without sufficient or stable income, finding affordable housing is difficult.

In California, **nearly 38% of undocumented workers and more than 61% of children** living with undocumented workers live in households earning less than a living wage and face chronic and severe housing instability. [205]

"While there have been a lot of really fantastic resources that have come out [during the pandemic] like rental assistance and stuff like that, our folks who are undocumented don't qualify for that."
KEY INFORMANT

Focus group participants and key informants identified that people who are house insecure are also at high risk for human trafficking – especially labor trafficking – working in high-risk, dangerous conditions in exchange for housing or income to pay for housing costs.

"We've seen a lot of folks experience labor trafficking through spaces where maybe they were told, 'Hey, we'll give you free room and board and we'll pay you if you do this in-home health care service for us.' Then ended end up being labor trafficking, a process as a result where literally there's that coercion of, they care about the person that they're caring for, and so they don't want to leave that person."
KEY INFORMANT

"Housing insecurity, period, and the threat of that has become a really big driver in the pandemic in particular for both sex and labor trafficking."
FOCUS GROUP PARTICIPANT

Rental Assistance During the Pandemic
Community organizations shared that they experienced an increase in call volumes pleading for cash assistance to pay for rent, mortgage, and utilities. Despite eviction moratoriums, many households still found themselves at risk for eviction and some received eviction notices. The worry about losing their home resulted in turmoil, fear, and anxiety. Rental assistance programs were available and provided relief to some families.

However, not everyone received assistance right away or qualified to receive any aid. Our community shared that it was particularly stressful trying to assist undocumented residents because there were no housing resources available.

Participants who were selected from the Section 8 waitlist in 2020 had **waited an average of 12 years before being selected.**[206]

Long Waits for Housing Subsidies. Our community shared that although housing assistance exists for our low-income community, these resources fall short. People who are eligible for housing programs such as Section 8 and public housing encounter long waits due to high demand throughout the county. Interviewees shared that being on the waitlist causes stress, anxiety, and hopelessness as they try to advocate for themselves and support their families.

"Thinking about housing insecurity in particular and the struggle for many of our clients to find places that they could live that are affordable, especially because the pandemic has actually made housing costs skyrocket throughout San Diego County. And so it's made it that much more difficult for folks with unstable income."
KEY INFORMANT

"People are desperate for housing. Our calls are housing, housing, housing. Getting a vaccine becomes low on the list when you need housing."
FOCUS GROUP PARTICIPANT

2-1-1 San Diego: 2021 Client Needs for Housing and Economic Assistance

Top client needs were housing (23%), utilities (14%), and income support and employment (12%).

Of the clients assessed for housing:

- **54%** of clients had an immediate need for housing.
- **21%** of clients needed housing starting in less than a month.
- **28%** of clients were identified as homeless (sheltered, unsheltered, unspecified homeless).

Source: 211 San Diego | Community Information Exchange All Clients Profile Report 2021[207]

"When the moratorium on evictions is lifted, I believe that there are going to be many families losing their homes, where they rent. I think it's really difficult for some families to catch up. I mean, if you're living month to month, and then you're [trying to] catch up [on] payments and [do] not have access to rental assistance, even though it's out there…
There will be a wave of families losing their homes."
KEY INFORMANT

Housing Quality Conditions

Living in poor housing conditions can lead to an increased exposure to mold and allergens that can result in negative health outcomes over time. Additionally, indoor conditions where cold and extreme temperature fluctuations can occur have been found to put people, such as seniors, at a higher risk of cardiovascular disease or mortality.[208]

Adequate housing conditions and safety were identified as being a high need for community members throughout the interviews. Some of the concerns about housing quality raised by interviewees included contaminants, pests, and lack of accessibility for those who are aging, those with disabilities, or those with a health condition.

Food Insecurity

Food insecurity was identified as being a persistent issue in our community. Economic instability and competing priorities were commonly mentioned as having an impact on a household's access to food. Households forced to choose between competing priorities due to limited resources are often left without enough money for food. Financial strain, especially during the pandemic, caused an alarming number of people to experience food insecurity, many for the first time.

In 2021, **83% of 2-1-1 San Diego clients had to meet other basic needs before they could pay for nutrition needs.**

About 43% of clients reported "sometimes" running out of food, and 29% of clients reported running out of food during the previous month of that time.

Source: 211 San Diego Client Profile Report [209]

A few barriers to accessing food were identified. They included not having enough money to purchase food, lack of reliable transportation to buy groceries or to drive to a local food bank (especially among people with physical limitations), and fear of applying or seeking help (as previously mentioned). Some community members also expressed the need for food pantries to extend their normal business hours.

Food insecurity is linked to negative health outcomes including poor nutrition, health, and disease management. [210] Food insecure children are more likely to have poor school performance, higher levels of behavioral and emotional problems (anxiety and depression), asthma and iron deficiency anemia, and increased emergency department visits. [211] [212] Food insecure adults are likely to have chronic conditions such as hypertension, diabetes, and coronary heart disease [213], while older adults are likely to have limitations in activities of daily living, lower cognitive function, and congestive heart failure. [214]

"When a household's budget is already limited due to expenses or when an unexpected surgery occurs and now, a person or family does not have enough savings to count on, less money becomes available to spend on food."

FOCUS GROUP PARTICIPANT

State of Hunger in San Diego County

In October 2021, the San Diego Hunger Coalition released the State of Nutrition Security in San Diego County. Key findings include:
- Total nutrition insecure population: 1 in 3 people or 30% of the total population
- Nutrition insecure adults: 1 in 3 (this is up from an estimated 1 in 4 in 2019)
- Nutrition insecure children: 2 in 5
- Nutrition insecure seniors: 146,000 or 30% of the senior population

In 2019, 25% of the population in San Diego County was nutrition insecure. However, 44% of the Black population and 37% of the Indigenous population were nutrition insecure. 44% of Hispanic or Latinx people across nationalities were nutrition insecure.

**Source: San Diego Hunger Coalition Issue Brief, October 2021**

Childcare

In California, the annual cost of infant care is $16,945.[215]Like housing, childcare costs were referred to as consuming a significant portion of a household's budget and causing financial hardship among parents, especially single parents.

The average price of childcare for two young children in the San Diego region consumes 40% of the budget for a typical family of four. [216]

Childcare providers shared that childcare is expensive — especially infant and toddler care — because there are far fewer providers available. Interviewees shared that without access to affordable childcare, some parents lean on family members or relatives to care for their children. Other working parents are forced to decide whether to leave their job to care for their children at home.

According to research by the San Diego Workforce Partnership, the childcare crisis hits middle income working families hardest. They created the graphic below to illustrate the "chasm" – where families fall if they don't have enough income to afford childcare and don't qualify for childcare support.

San Diego's Child Care Affordability Chasm
Annual Income Ranges for a Family of 4

25-30% of families receive child care support*

30-40% of families fall into the chasm

35-40% of families can afford to pay out of pocket

$0

$25,750
Qualifying income for Head Start

$80,628
Qualifying income for state subsidies

$107,358
Income needed to afford basic needs, including child care

*Funding for subsidized child care is insufficient. Many families that qualify for and request support never get it. In addition, families that access subsidies may still struggle because they only have access to part-time or part-year programs.

Source: San Diego Workforce Partnership

Childcare subsidies are available for low-to-moderate-income families, but interviewees expressed that there are long waiting lists to get financial assistance. We also learned that some middle-income working families are stuck between not qualifying for financial assistance and not being able to afford the out-of-pocket expenses. Community leaders shared that due to the pandemic and increased need for childcare assistance, the waiting list was severely impacted. Interviewees expressed how much parents were under financial stress and desperate to find affordable childcare. Although emergency subsidies provided financial relief for some families, childcare slots were hard to find due to business closures.

"Even if parents can find an infant toddler slot, it's going to cost them … it's [said to be] more than college tuition a year."
KEY INFORMANT

"The desperation that families feel to get that childcare subsidy is fierce and it leads to just this …level of stress and anger that we hear from parents rightfully so that they cannot access this thing that would change their lives, this one resource right that could open the door to a completely different future."
KEY INFORMANT

Fear of Health Care Costs

A common theme raised during all interviews and focus groups was the fear of health care costs. Even people with existing health insurance shared that the out-of-pocket costs are expensive and unaffordable, especially among our low-income community. Concerns about not being able to afford copayments or medical bills often cause people to delay necessary health care, maintain their health or a chronic condition, take less medication as prescribed to extend their supply (particularly among seniors), and in some cases, avoid going to the emergency department in the event of an emergency.

"I get a lot of clients…that are afraid to go back to get their needs met because they can't afford their copayments, or they have huge astronomical bills from the hospital they can't pay."
FOCUS GROUP PARTICIPANT

"I took a [community member] that was having severe pain to the ER and guided them via text on what to do or ask for. He was worried to go in because of lack of insurance and the fear of receiving a large hospital bill."
FOCUS GROUP PARTICIPANT

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Resilience

Resilience

*Psychologists define **resilience** as the process of adapting well in the face of **adversity, trauma, tragedy, threats, or significant sources of stress.** Our community's resilience was evident during our focus groups, interviews, and in the online survey open response. The following is a snapshot of what gives our community hope as we continue to move forward.*

Participants who completed the online survey were asked, "What gives you hope?" About 10% of the respondents said they were not hopeful, were unsure what gave them hope, or shared their disappointment. A few examples are below.

"It started pretty well, but the last 18 months have been kind of a dog-eat-dog world. I haven't had a lot of hope in the community if people are not even willing to wear masks to help others."
SURVEY RESPONDENT

"My husband died of COVID, and I now only have my income for my home, bills/car/phone, and I have four others living in my home, and no one has a job but me."
SURVEY RESPONDENT

"In the beginning, everyone seemed to come together and support each other. That sentiment has faded away. It would be nice to feel like 'we are all in this together again'."
SURVEY RESPONDENT

Most respondents (more than 80%) who took the time to share their thoughts were optimistic and shared their hope as we move forward. These responses generally fell under three categories: **generosity, leadership, and collaboration.**

Generosity

San Diegans are generous with their time, money, and talents. The pandemic has allowed us to dig deeper and show we care about the greater good in new and innovative ways. For example, neighbors were helping neighbors with childcare so parents could work from home, creating food pantries, or running errands for the more vulnerable. The pandemic allowed individuals to expand their circle of caring from their immediate family or neighborhood to the larger community. Health care workers risked their lives day after day, putting the health of the community above their own safety. For front-line workers, their generous choice to prioritize service to the community often came at a cost to their health, their families, and loved ones.

"Many people now understand how people could suddenly fall upon hard times and face economic challenges that result in hunger, lack of health care, or housing. I think there is a greater understanding and empathy toward those struggling to meet their basic needs."
SURVEY RESPONDENT

I didn't always have the answers, but I was able to provide people who stopped by a cup of tea and compassion, respect, and a few minutes of peace during a difficult time.

FOCUS GROUP PARTICIPANT

We had an employee who chose to move out of her parents' home to continue to serve the community and not expose her parents.

KEY INFORMANT

What gives me hope is just the overall kindness of some people in our community. Despite a narrative that COVID has divided us in many ways, it has also brought people together, increased empathy, and promoted tolerance and understanding.

SURVEY RESPONDENT

People who agreed to wear masks even when their personal risk was low … People thinking about others rather than being selfish.

SURVEY RESPONDENT

Leadership

Respondents were impressed with San Diego County's civic efforts to keep the community informed, provide cash assistance to individuals and businesses, and ensure that all had basic needs, including food. Many applauded the government for implementing mandates to keep us safe (vaccines and free testing) and providing the resources needed to contain the virus such as personal protective equipment and treatments. Most respondents viewed health care workers as community heroes during the pandemic.

"Access to vaccinations has been excellent. Initially, financial support for businesses to keep folks employed and unemployment assistance was good."

SURVEY RESPONDENT

"Some community and academic leaders have consistently been beacons of knowledge and compassion, explaining the science in clear and digestible ways."

SURVEY RESPONDENT

"There have been a lot of programs from the federal, state, and local governments to help [federally qualified health centers] during COVID. There also seems to be more collaboration focused on a single goal of getting past COVID."

SURVEY RESPONDENT

"What gives me hope: Funding for housing support and rental assistance, extended unemployment, additional CalFresh benefits, Medi-Cal, peer

counseling, homeless services, collaboration of providers, food pantry expansion, faith-based organizations providing programs, outreach and case management services, community health clinics and pharmacies providing testing and vaccinations."

SURVEY RESPONDENT

During the pandemic, we knew we had to go back to work and serve the community. It was the start of the pandemic, we had to be careful and not get infected or bring it home to our families. In terms of success, being open allowed us to gain a lot of trust in the community.

FOCUS GROUP PARTICIPANT

Collaboration

Traditional silos were torn down and replaced with unique, innovative collaborations. For instance, schools, libraries, faith institutions, and health clinics became one-stop locations for neighbors to obtain information, food, COVID-19 tests, vaccines, educational materials, and so much more. The private sector worked with government and service providers to ensure that all had the resources needed during the crisis. Health systems, community clinics, county public health, and others pulled together complex and costly operations to provide the community with access to vaccines and essential treatment. Organizations shared resources, staff, and space whenever possible. These collaborations gave the community hope and a sense of security.

"I have seen a tremendous amount of coordination and collaboration throughout the pandemic. This shows that when times are difficult, our community does rally to support those in need."
SURVEY RESPONDENT

"Seeing community health workers from different groups reaching out, providing information, and hosting events has been great."
SURVEY RESPONDENT

*"El estar en constante comunicación y mutuo ayuda por talleres en Zoom, te das cuenta de muchos recursos que hay en la comunidad, y gracias a lugares que trabajan sin fines de lucro."***Translation:** *"Being in constant contact and informed via Zoom workshops, one realizes that there are many community resources thanks to nonprofits."*
SURVEY RESPONDENT

"Organizations and agencies worked together on new ideas to fill the voids the community did not know were there until the pandemic hit."
SURVEY RESPONDENT

"During the early days of the pandemic, I was busy and not taking care of myself. We came together as a coalition. We saw that all [the community leaders] were in the same situation. We helped and coached each other. Collectively we were able to serve the community. We received a grant that helped us provide financial assistance to families; we received food and diapers from the food bank; the courts were open, so we were able to help domestic violence survivors; and some provided us with cash, which we used to create food baskets for families."
FOCUS GROUP PARTICIPANT

Looking Ahead

Finally, it is also important to hear the community's hopes and fears for the future as we move forward. For example, there is genuine concern that the public support available during the pandemic, like the rental eviction moratorium and other subsidies, is ending. Not having these supports will leave individuals and families who were struggling before the pandemic in a more precarious situation.

"My family currently has health care, CalFresh benefits, and has been receiving some rental assistance, but I continually worry [about] when it ends because we live on my husband's small income and my SSDI and cannot get by on it without the assistance. I worry that our rent will be raised etc. ..."
SURVEY RESPONDENT

"Not much [gives me hope]. Access to health care, childcare, food, and housing is just as hard as pre-pandemic. All the little things that were waived (i.e., CalFresh interviews) are not enough. There shouldn't even be an application process to get access to food ... it should be a given."
SURVEY RESPONDENT

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Community Recommendations, Resources, & Next Steps

Community Resources & Recommendations

A Note to Community Investors

During the early days of the pandemic, community investors — those who invest or fund in the well-being of our region, be it government, foundation, business, philanthropist, or other grantmaking entities — were generous, creative, and flexible. Unfortunately, the crisis is not over, and our service providers are strained financially and emotionally. The pandemic shined a spotlight on the inequities that have been entrenched and normalized within our society. The communities affected the hardest by inequity tend to be low-income communities of color. The community-based organizations (CBOs) that lead and serve our communities of color often face unique challenges.

Businesses in our region, including service providers, are having difficulties finding qualified employees, and the cost of doing business continues to increase. For service providers, this reality is compounded with an increase in demand for their services and an exhausted workforce that has been in crisis mode for over two years. A study published in January 2020 found that over 70% of health care workers are struggling with symptoms of depression and anxiety, 40% with symptoms of post-traumatic stress disorder.[217]

> "'Broken crayons still color' and that is who we are, we are all broken crayons. We realize that we all have stories that have led us to this building, but we also realize that we all still color just the same, maybe even better — so I'm here. This is the team that's doing the work."
>
> **KEY INFORMANT**

For these reasons, we encourage all community investors to be flexible supporters and collaborators with service providers. Lead your work with equity, trust, and respect by:

Educating Yourself on the Issues

Our community is in crisis, and those in the trenches are busy and tired. Instead of requesting meetings and briefings, please listen to what community leaders tell us they need. These needs are highlighted in reports like this one and those that can be found in this report's resource section.

Also, connect with those who have been supporting front-line CBOs. These community investors have built trust through long-term relationships and can give you an accurate assessment of the current reality.

Ensuring that Investments are Inclusive

Move beyond "safe bets" and support smaller entities led by local community leaders who understand their community's needs. These CBOs are traditionally under-resourced. Fund these community-trusted entities and efforts directly and not through an intermediary. Directly supporting CBOs will build their capacity as an organization and their ability to serve their clients effectively. Also, we need to examine our regulations and practices to eliminate unnecessary barriers for small entities.[218]

"People tend to want to fund big and shiny things, and at times, big and shiny means big and bureaucratic. Many small and mid-size nonprofits are at a (loss) on how to even begin to access that type of funding."
KEY INFORMANT

Decreasing Bureaucratic Barriers

Simplify and streamline paperwork. Nonprofits spend excessive time on funder-driven applications and reports, distracting them from their mission-critical work.[219] This includes doing away with cumbersome "proof" of service systems like sign-in sheets, multiple bid requirements, and submitting receipts. Prohibiting grantees or contractors from applying for new funding opportunities until they have spent a prior grant ignores the reality that organizations implement multiple programs. Also, if we design our investment programs centered on those in need, it is more efficient and effective to receive as many services as possible in one location close to one's home or work.

Increasing Foundation Payout Rates

Private foundations must meet or exceed an annual payout requirement of 5% of the average market value of their net investment assets to avoid paying taxes. The minimum payout requirement aims to prevent foundations from receiving gifts, investing the assets, and never spending any funds on charitable purposes. The current practice of only meeting the minimum payout requirement keeps us from making the significant investments needed to solve our current community challenges. By making small incremental investments in the community, we are kicking the can down the road, where those challenges will worsen exponentially.[220]

Being Transparent and Responsive

It is essential to be clear upfront about what we fund or do not fund, allowing potential community partners to assess if applying may be a waste of their time. As you change funding guidelines or priorities, give your community partners ample notice. Be open about your organizational challenges and invite nonprofits to share theirs. Be responsive to calls and emails from the community. Provide the community with opportunities to learn about your process and give them feedback if they ask for it.[221]

Covering the Entire Cost of Doing Business

Nonprofits are the only contractors that are not paid the total cost of doing business. It is not fair to contract with an entity and ask the organization to find additional funding to cover the cost of services or require that they raise matching funds. In addition, due to the pandemic and inflation, all prices have gone up. For this reason, community investors should dig a little deeper to ensure that those entities they support can provide their staff with a competitive salary and stay in the black while delivering the services that are much needed in our community. Ideally, all grants and contracts

would be for three to five years, with an annual increase in financing for the cost of living and doing business. This practice would go a long way to help nonprofits' sustainability and community impact.

Providing Funding Upfront

When funders and government contractors do not front the cost of providing services, they ask nonprofits to take on an incredible risk. Moreover, it is cost-effective and efficient to support those CBOs that are already doing the work versus funding more established organizations to create a similar program.

Collaborating with Other Community Investors

As an opportunity to learn and leverage your investments, join local communities of grant makers, like Catalyst San Diego & Imperial Counties. Catalyst has several issue-based collaboratives that align with the issues in this report, including people experiencing homelessness, food insecurity, early childhood, military, binational migration, and social equity.[222]

Community Recommendations

During the Access to Health Care interviews and in the Online Community Survey, we asked "What are the most important things that hospitals and health systems could do to improve health and well-being in our community?" Overwhelmingly, respondents agreed that there is a critical need to help patients navigate available services that will help improve their health and well-being. In both the interviews and the surveys, options that centered around improved patient care rose to the top.

Most responses fell into four categories: navigation and support, culturally appropriate care, workforce development, and community collaboration.

Provide Navigation & Support to Patients	Connect patients to services that will improve their health and well-being
	Help patients understand and use health coverage
	Help patients coordinate their health services
	Help patients apply for health coverage or other benefits
	Help patients pay for their health care bills
Provide Culturally Appropriate Care to Patients	Ensure that a patient's care meets their needs
	Provide culturally appropriate health care in more languages
	Train hospital staff on biases
Workforce Development	Diversify the health care workforce
	Hire more doctors, nurses, and other health care professionals
	Create more health care job opportunities and career pathways
Community Collaboration	Collaborate with community groups and schools
	Provide health education

Resources and Assets to Meet Community Needs

San Diego's rich service ecosystem includes community-based organizations, government agencies, hospitals and health systems, federally qualified health centers (FQHCs), and other community members and organizations that seek opportunities to collaborate to improve the health of San Diegans. This service ecosystem is engaged in addressing all of the health needs identified by this assessment.

Community Resources in San Diego County

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 community members to access the most available, current data through 2-1-1 San Diego. In addition to connecting individuals to community services over the phone, 2-1-1 San Diego also manages the Community Information Exchange (CIE). The CIE is a network comprised of more than 115 health, social, and government organizations coordinating care through a shared technology platform and data integration. As of March 2021, there are more than 250,000 San Diegans who have consented to share their information with CIE members.

The following graphic lists the top 20 needs organized by specific category and percentage of 2-1-1 clients in 2021[223]. Needs represent the reasons or descriptions of the type of help that was provided and are documented when clients receive referrals to community services. There were 551,727 total needs for this client population. For more specific information about the needs within each service category, please contact 2-1-1 San Diego or visit their website.

Top 20 Needs by Most Specific Category-Percent of Total Needs
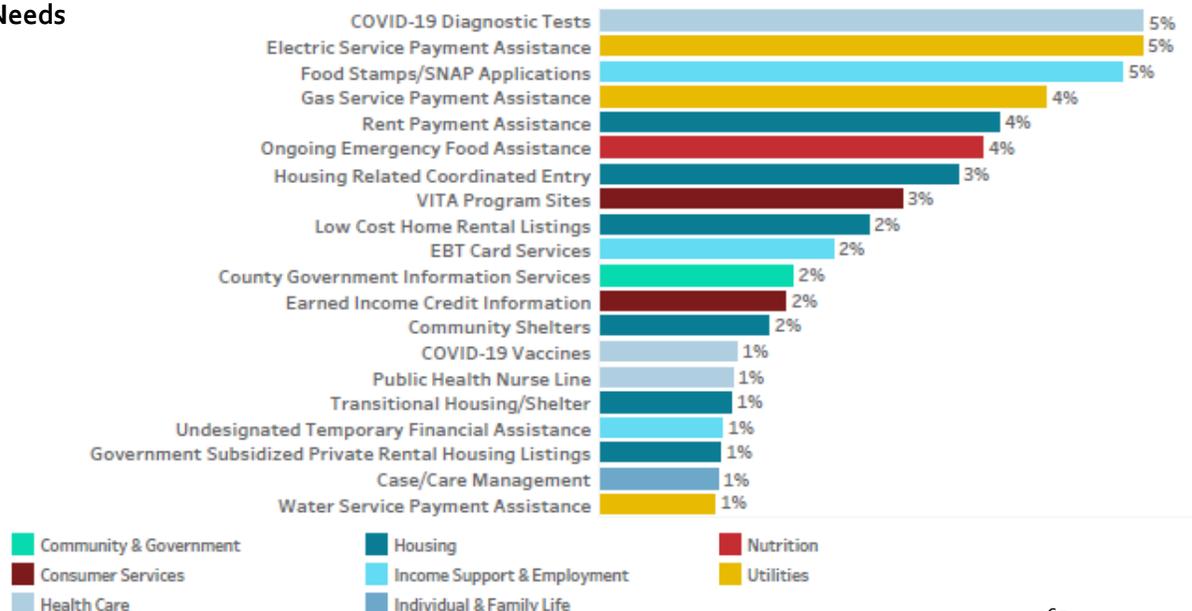
Health Care Facilities in San Diego County

The California Department of Health Care Access and Information (HCAI) is an excellent resource to find more detailed information on every health care facility licensed in California. The following data are available on their Healthcare Facility Attributes web page

Facility Profiles – Interactive map to find a summary profile of facility information, including license, service level, revenue, payer mix, length of stay, and building safety information. Use the map or search functions to find hospital, long-term care, clinical, home health, and hospice facilities.

Licensed Facility Information System (LFIS) – View facility license information of California hospitals, long-term care facilities, primary care and specialty clinics, home health agencies, and hospices.

Licensed Health Care Facility Listing – A list of California health care facilities licensed by California Department of Public Health (CDPH) Licensing and Certification.

Licensed Facility Crosswalk – This dataset provides a simple crosswalk using HCAI-assigned licensed facility identification numbers linked with matched CDPH, Licensing and Certification facility lists based on license number. This is not a comprehensive matched list. Facility identification numbers that did not match are also included from both the HCAI and CDPH lists. Facility status or facility level designations may explain some HCAI non-matches; for additional information contact HCAI directly. Please contact CDPH directly for more information regarding un-matched facility identifiers that do not have corresponding HCAI identifiers.

Next Steps & Future Research

Hospitals and health systems that participated in the HASD&IC 2022 CHNA process have varying requirements for next steps. Private, not-for-profit (tax-exempt) hospitals and health systems are required to develop hospital or health system community health needs assessment reports and implementation strategy plans to address selected identified health needs. The participating health districts and district health systems do not have the same CHNA requirements but work very closely with their patient communities to address health needs by providing programs, resources, and opportunities for collaboration with partners. Every participating hospital and health care system will review the CHNA data and findings in accordance with their own patient communities and principal functions and evaluate opportunities for next steps to address the top identified health needs in their respective patient communities.

The CHNA report will be made available as a resource to the broader community and is intended to serve as a useful resource to help both residents and health care providers further communitywide health improvement efforts. HASD&IC, the CHNA Advisory Workgroup, and the CHNA Committee are proud of their collaborative relationships with local community organizations and are committed to regularly seeking input from the community to inform community health strategies. The CHNA Committee is in the process of planning Phase 2 of the 2022 CHNA, which will include gathering community feedback on the 2022 CHNA process and strengthening partnerships around the identified community needs.

The CHNA Committee & CHNA Advisory Workgroup have already identified a few priority areas for future research:

- **Updated hospital discharge data.** For this report, we generally used hospital discharge data covering the years 2017-2019. This decision was made to not include 2020 hospital discharge data, as there were potentially many temporary anomalies due to the COVID-19 pandemic. We plan to seek expert assistance and provide the community updated hospital discharge reports with data from 2020 and 2021.

- **Prevention and early intervention.** Our community expressed significant concerns regarding access to care, including difficulties with scheduling routine health screenings and obtaining assistance with managing chronic health conditions. We plan to work closely with community partners to gain a deeper understanding of the barriers community members face when seeking preventative health care services.

- **Substance use.** We heard from the community about concerns around increasing substance use for both children and adults but were not able to sufficiently document the most recent trends. We plan to seek additional information from community partners.

- **The impact of future/pending changes to programs critical to the health and well-being of our community.** Within weeks or months after this report is drafted, there could be significant changes to housing eviction protections, Covered California premium subsidies, Medi-Cal requirements to maintain coverage, CalFresh benefits, free school lunches, and other programs and supports that communities relied on during the pandemic. We plan to check in with community partners about the impact of these issues as part of Phase 2 community engagement.

- **Increasing costs and inflation**. Within the last few weeks of our community engagement, the issue of inflation and the rising cost of essential items were of increasing concern. Community organizations and food banks were reporting increasing need and struggling with the increased costs to meet the need. High gas prices were preventing community members from accessing needed services such as health care appointments and food distributions. We plan to check in with community partners about the impact of these issues as part of Phase 2 community engagement.

The CHNA Advisory Workgroup & CHNA Committee welcome feedback on the report and planning for Phase 2 of the 2022 Community Health Needs Assessment. Please visit www.hasdic.org or email CHNA@hasdic.org.

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Appendices

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Appendix A: 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.

Adverse Childhood Experiences. According to the Centers for Disease Control and Prevention (CDC), adverse childhood experiences (ACEs) are potentially traumatic events that occur in childhood (0-17 years). Children who experience ACEs are at increased risk for long-term health conditions that span the behavioral, emotional, and physical domains. Please see **ACEs** section for more information.

Age-adjusted rate. The incidence or mortality rate of a condition can depend on the age distribution of a community. Because chronic conditions 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 conditions than another community that may have a higher number of younger people. An incidence or mortality rate that is **age-adjusted** takes into consideration the proportions of persons in corresponding age groups, which allows for more meaningful comparison between communities with different age distributions.

Body Mass Index. The CDC defines Body Mass Index (BMI) as a person's weight in kilograms (or pounds) divided by the square of height in meters (or feet). A high BMI can indicate high body fatness. BMI screens for weight categories that may lead to health conditions, but it does not diagnose the body fatness or health of an individual.

CalFresh. The CalFresh Program, federally known as the Supplemental Nutrition Assistance Program (SNAP), issues monthly electronic benefits that can be used to buy most foods at many markets and food stores. It is for people with low-income who meet federal income eligibility rules and want to add to their budget to put healthy and nutritious food on the table.

CalWORKs. CalWORKs is a public assistance program that provides cash aid and services to eligible families who have a child(ren) in the home. If a family has little or no cash and needs housing, food, utilities, clothing, or medical care, they may be eligible to receive immediate short-term help. Families who apply and meet specific eligibility requirements for ongoing assistance receive money each month to help pay for housing, food, and other necessary expenses.

Cisgender. According to the American Psychological Association, the term cisgender is used to describe a person whose gender identity and gender expression align with sex assigned at birth; a person who is not transgender.

Community Health Worker (CHW). *Also see Promotora.* The CDC defines a community health worker (CHW) as a front line public health worker who is a trusted member or has a particularly good understanding of the community served. A CHW serves as a liaison between health and social services and the community to facilitate access to services and to improve the quality and cultural competence of service delivery.

Deadnamed. [The Cleveland Clinic notes that deadnaming](#) is referring to someone by a name they didn't ask you to use. A new name can represent a more affirming life for some transgender or gender nonconforming (someone who doesn't follow gender stereotypes) people. But when people refuse to acknowledge a person's new name or continue to use their old name, it can be quite invalidating or traumatic.

Death rate. See *Mortality rate*.

Dual diagnosis. A diagnosis of both mental illness and Substance-Use Disorder (SUD).

Gender affirming. The [World Health Organization notes](#) that gender-affirmative health care can include any single or combination of a number of social, psychological, behavioral, or medical (including hormonal treatment or surgery) interventions designed to support and affirm an individual's gender identity.

Gender dysphoria. Psychological distress due to mismatch between a person's biological sex and gender identity.

Health condition. A disease, impairment, or other state of physical or mental ill health that contributes to a poor health outcome.

Health disparity. Health conditions do not affect all populations in the same way. Health disparity refers to the disproportionate impact of a health condition on specific populations. Much of the research literature on health disparity focuses on racial and ethnic differences in how these communities experience the conditions, but health disparity can be correlated with gender, age, and other factors, such as veteran, disability, and housing status.

Health indicator. A characteristic of an individual, population, or environment that 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 inequity. See *Health disparity.*

Health literacy. [Healthy People 2030](#) defines *personal* health literacy as the degree to which individuals can find, understand, and use information and services to inform health-related decisions and actions for themselves and others and *organizational* health literacy as the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.

Health outcome. A snapshot of a health condition in a community that can be described in terms of both morbidity and mortality (e.g., breast cancer prevalence, lung cancer mortality, HIV rate, etc.).

Health need. A health need arises from a current state of deficit in one or more aspects of a person's health. It is associated with poor health outcome(s) and can be improved through an appropriate intervention.

Hospitalization rate. The number of patients being admitted to a hospital and discharged for a condition, as a proportion of a total population.

Incidence rate. The number of *new* cases for a specific health condition within a given time period, 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 health condition.

Intersex. The [American Psychological Association](#) defines intersex as a person having atypical combinations of features that usually distinguish male from female.

LGBTQ+. Also referred to as LGBTQIA+, [this term is defined](#) by the American Psychological Association as the abbreviation for lesbian, gay, bisexual, transgender, and questioning or queer: an inclusive term used to refer to the homosexual population in all of its diverse forms, to those with both homosexual and heterosexual preferences, and to those whose gender identity differs from the culturally determined gender roles for their birth sex.

Morbidity rate. The frequency with which a health condition appears within a population. It is often expressed as a *prevalence rate* or *incidence rate.*

Mortality rate. The number of deaths in a population due to a health condition, usually expressed as a density rate (e.g., *x* number of cases per 10,000 people). Also referred to as "death rate."

Non-binary. The CDC defines [gender non-binary](#) people as individuals who do not identify their gender as man or woman. Other terms to describe this identity include genderqueer, agender, bigender, and gender creative.

Palliative care. The National Institute on Aging defines palliative care as specialized medical care for people living with a serious illness, such as cancer or heart failure. Patients in palliative care may receive medical care for their symptoms, or palliative care, along with treatment intended to cure their serious illness. Palliative care is meant to enhance a person's current care by focusing on quality of life for them and their family. [What Are Palliative Care and Hospice Care? | National Institute on Aging (nih.gov)](#)

Polyvictimization. According to the [U.S. Department of Justice, Office of Juvenile Justice and Delinquency Programs](#), polyvictimization refers to having experienced multiple victimizations such as sexual abuse, physical abuse, bullying, and exposure to family violence. The definition emphasizes experiencing different kinds of victimization, rather than multiple episodes of the same kind of victimization.

Post-acute care. Health care services provided after inpatient hospitalization, including but not limited to: skilled nursing, home health, recuperative care (medical respite), and step-down services for patients with behavioral health needs.

Prevalence rate. The proportion of a total population that currently has a given health condition, 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 condition (incidence) but an increase in the total of number suffering of that condition (prevalence) because people are living longer due to better screening or treatment for that condition.

Promotora. Also see Community Health Worker. According to the CDC, Promotores de salud, also known as promotoras, is the Spanish term for "community health workers." It also notes that the Hispanic community recognizes promotores de salud as lay health workers who work in Spanish-speaking communities.

Qualitative data. Information that describes something.

Quantitative data. Numerical information.

Recuperative care. Also known as medical respite care, a lower level of medical care is provided where a patient can heal and recover from an illness or injury. Medical Respite Care - National Health Care for the Homeless Council (nhchc.org)

Refugee. According to USA for the United Nations High Commissioner for Refugees, a refugee is someone who has been forced to flee his or her country because of persecution, war, or violence. A refugee has a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group. Most likely, they cannot return home or are afraid to do so. War and ethnic, tribal, and religious violence are leading causes of refugees fleeing their countries.

Secondary traumatic stress. The Substance Abuse and Mental Health Services Administration (SAMHSA) notes that secondary traumatic stress refers to the negative effects of health care work that can make workers feel like the trauma experienced by the people they help is happening to them or someone in their lives. When these feelings are prolonged, they can turn into vicarious trauma. Tips for Healthcare Professionals: Coping with Stress and Compassion Fatigue (samhsa.gov)

Sexual exploitation. USA for the United Nations High Commissioner for Refugees defines sexual exploitation as an actual or attempted abuse of someone's position of vulnerability (such as a person dependent on another for survival, food rations, school, books, transport, or other services), differential power, or trust to obtain sexual favors, including but not only by offering money or other social, economic, or political advantages. It includes trafficking and prostitution. A related term includes commercial sexual exploitation of children (CSEC).

Stigma. The CDC defines stigma as discrimination against an identifiable group of people, a place, or a nation. Stigma can negatively affect the emotional, mental, and physical health of stigmatized groups and the communities they live in. Stigmatized individuals may experience isolation, depression, anxiety, or public embarrassment. Reducing Stigma (cdc.gov)

Social Determinants of Health. 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. Some examples include health care and educational access and quality, economic stability, and neighborhood.

TAY. Transitional-age youth. Typically refers to the span from older adolescence (e.g., 15–16 years of age) to young adulthood (24–26 years). TAY are navigating the potentially perilous developmental years of growing out of childhood and into adulthood — a time of facing more adult-like challenges without having yet mastered the tools and cognitive maturity of adulthood. Some critical developmental steps occur during the transitional

years, reflecting changing neurobiology, the tasks of separation and individuation, and the influences of pre-existing and concurrent mental health and substance use issues.[2]

Telehealth. Refers broadly to electronic and telecommunications technologies and services used to provide care and services at distance. It is different from telemedicine in that it refers to a broader scope of remote health care services than telemedicine. The National Institute on Aging notes that telehealth can include non-clinical services.

Telemedicine. The American Academy of Family Physicians defines telemedicine as the practice of medicine using technology to deliver remote clinical services.

Transgender. The American Psychological Association notes that transgender is an umbrella term used to describe the full range of people whose gender identity and/or gender role do not conform to what is typically associated with their sex assigned at birth. While the term "transgender" is commonly accepted, not all transgender and on-conforming people self-identify as transgender.

Trauma. While there is no universal definition, SAMHSA defines individual trauma as resulting from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. Trauma can also be experienced as a group, community, or mass.

Trauma-Informed Care (TIC). The Child Welfare Development Services at San Diego State University defines TIC as an organizational practice framework that involves understanding, recognizing, and responding to the effects of all types of trauma a person has experienced. TIC emphasizes physical, psychological, and emotional safety for both patients and providers, and helps rebuild a sense of control and empowerment.

Undocumented. People who are undocumented do not have a valid visa or other immigration documentation, because they entered the U.S. without inspection, stayed longer than their temporary visa permitted, or otherwise are not meeting the terms under which they were admitted.

Vicarious Trauma. According to SAMHSA, vicarious trauma can be thought of as the negative changes that happen to humanitarian workers over time as they witness and engage with other people's suffering and need.

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[2] Journal of the American Academy of Child and Adolescent Psychiatry. Accessed June 7, 2019. https://www.jaacap.org/article/S0890-8567(13)00331-6/pdf

Appendix B: List of Acronyms and Abbreviations

AACAP   American Academy of Child and Adolescent Psychiatry

AAP   American Academy of Pediatrics

ACEs   Adverse Childhood Experiences

ACS   American Community Survey

ADHD   Attention Deficit Hyperactivity Disorder

ADOD   Alzheimer's Disease or Other Dementia

AI/AN   American Indian/Alaska Native

AIDS   Acquired Immune Deficiency Syndrome

API   Asian/Pacific Islander (also referred to as AAPI)

BIPOC   Black, Indigenous, and People of Color

BMI   Body Mass Index

CA   California

CAP   Community Action Partnership

CBO   Community-Based Organization

CDC   Centers For Disease Control and Prevention

CDPH   California Department of Public Health

CHA   Children's Hospital Association, California Hospital Association

CHF   Congestive Heart Failure

CHIS   California Health Interview Survey

CHNA   Community Health Needs Assessment

CHW   Community Health Worker

CIE   Community Information Exchange

CNI   Community Need Index

COPD	Chronic Obstructive Pulmonary Disease
CSEC	Commercial Sex Exploitation of Children
CUPID	California Universal Patient Information Discovery
CVD	Cardiovascular Disease
ECE	Early Childhood Education
ED	Emergency Department
FG	Focus Group
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
GIS	Geographic Information System
HASD&IC	Hospital Association of San Diego and Imperial Counties
HCAI	California Department of Health Care Access and Information (formerly OSHPD)
HHSA	Health & Human Services Agency
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
HP 2030	Healthy People 2030
HPI	Healthy Places Index
IOP	Intensive Outpatient Program
IPH	Institute for Public Health
IS	Implementation Strategy
KI	Key Informant
KP	Kaiser Permanente
LFIS	Licensed Facility Information System
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer
NAMI	National Alliance for Mental Illness
NCHS	National Center for Health Statistics
NHIS	National Health Interview Survey
NIH	National Institutes of Health

PeP	Post-(HIV) exposure Prophylaxis
PHP	Partial Hospitalization Program
PrEP	Pre-(HIV) Exposure Prophylaxis
SAMHSA	Substance Abuse and Mental Health Services Administration
SANDAG	San Diego Association of Governments
SBC	Southern Border Counties
SDEDC	San Diego Economic Development Corporation
SDOH	Social Determinants of Health
SDSU	San Diego State University
SNAP	Supplemental Nutrition Assistance Program
SMI	Serious Mental Illness
SNF	Skilled-Nursing Facility
SOGI	Sexual Orientation and Gender Identity
SSI	Supplemental Security Income
SUD	Substance Use Disorder
TIC	Trauma Informed Care
TAY	Transitional Age Youth
TGD	Transgender and Gender Diverse
U.S.	United States
VA	Veterans Administration

Appendix C: Online Survey Summary Results

2022 Online Community Survey

The CHNA Online Community Survey was used to support prioritization of health conditions and social determinants of health based on community feedback about what survey respondents viewed as the most important or most serious challenges.

The survey was distributed via email to targeted community- based organizations, social service providers, resident-led organizations, federally qualified health centers, government agencies, grantmaking organizations, and hospitals and health systems that serve a diverse array of people in San Diego County. When possible, these organizations shared the link to the survey with the clients they served. Email recipients were also encouraged to share the survey with their colleagues. The survey — open from February 14 to March 30, 2022 — was also widely shared through social media, email, and reshared by community-based organizations.

The survey was designed to be taken by community members and was translated from English into five additional languages: *Arabic*, *Spanish*, *Somali*, *Tagalog*, and *Vietnamese*.

There were 502 total respondents to the Online Community Survey.

NOTE ON SUMMARY DATA PRESENTED: Please note that overall survey responses presented are rounded to the nearest tenth percentage. Regional survey responses are rounded to the nearest whole number percentage. Some responses presented may exceed five or 10 total due to having equal percentages.

Survey Participant Demographics

Participants by Zip Code Top 10 Zip Codes	
92103	5.7%
92105	3.6%
92115	3.4%
92020	3.2%
92101	2.4%
92056	2.2%
92154	2.2%
91910	2.2%
91911	2.2%
91941	2.2%

Participants by HHSA Region	
Central	26.7%
North Coastal	23.3%
East	18.6%
South	17.8%
North Central	16.2%
All San Diego County	15.6%
North Inland	13.0%

Participants by Language(s) Spoken at Home

Language	%
English	89.0%
Spanish	22.7%
Other	4.4%
Tagalog/Filipino	3.2%
Burmese, Karen, Kachin, Karenni	2.2%
Arabic, Farsi, Hindi, Japanese, Somali, or Vietnamese	0.4%
Armenian, Assyrian/Neo-Aramaic, Chaldean/Neo-Aramaic, Chinese, Korean, Kurdish, Oromo, Persian, or Russian	0.2%

Participants by Age Group

Age Group	%
45 – 64 years old	39.8%
27 - 44 years old	32.6%
65+ years old	18.2%
18 - 26 years old	9.0%
12 - 17 years old	0.4%

Participants by Health Coverage Type or Insurance

Coverage Type	%
Employer-based private insurance	63.0%
Medicare	11.4%
Medi-Cal	10.6%
Other	4.8%
Covered California health insurance	4.4%
Tri-Care/CHAMPUS	2.0%
VA benefits	0.8%
Unsure	0.8%
Both Medicare and Medi-Cal	0.6%

Participants by Self-Description

Parent	46.3%
Advocate	34.6%
Person of color	25.9%
Person with ongoing health condition	25.3%
Caregiver	19.6%
Volunteer	17.3%
Grandparent	13.0%
Retired	10.3%
Immigrant	9.1%
LGBTQIA+	8.2%
Person with disability	6.6%
Self-employed	5.8%
Veteran	5.4%
Small business owner	4.7%
Military spouse/family member	3.7%
Youth	2.7%
Refugee	1.9%
Unemployed	1.9%
Native American/Tribal member	1.2%
Unhoused individual/homeless	0.4%
Active military	0.2%

Survey Participant Responses: Community Needs

Top Community Needs

- **Top 5 health conditions**: Mental/behavioral health (70.3%), followed by Alcohol and Drug Use (58.5%) and COVID & Long-COVID (50.1%), Stress (49.1%), Diabetes (40.7%)

- **Top 5 behavioral health needs:** Depression (67.9%), Access to help (61.3%), Anxiety (56.7%), Stress (55.9%), Drug Use (48.5%)

- **Top 5 problems negatively impacting the overall health of our community:** Access to affordable, quality housing (75.3%), Access to health care (58.9%), Being homeless (58.9%), Not having enough money to pay my bills (50.1%), Isolation (being alone, feeling lonely) (40.7%)

- **Top 5 concerns about the health and well-being of children:** Mental/behavioral health (65.7%), Anxiety (60.5%), Depression (60.1%), Bullying (56.7%), Social media and/or online gaming (56.3%)

Most Important Things Hospitals and Health Systems Can Do to Improve the Health and Well-Being of Our Community

- Connect patients to services that will improve their health and well-being (66.9%)

- Ensure that a patient's care meets their needs (52.4%)

- Help patients understand and use health coverage (49.2%)

- Help patients coordinate their health services (47.6%)

- Help patients apply for health coverage or other benefits (43.8%)

- Collaborate with community groups and schools (43.0%)

Survey Participant Responses: Access to Health Care

Top 5 Difficulties Accessing Health Care

- Long waits for an appointment (30.6%)
- Appointment hours are not convenient (24.4%)
- Limited time with health care providers (16.5%)
- Lack of time (16.3%)
- Cost of medical appointments or treatments (15.5%)

Top 5 Health Care Services that are Difficult to Access

- Mental/behavioral health services (33.8%)
- Counseling, therapy (27.3%)
- Psychiatry (19.9%)
- Dental services (13.9%)
- Urgent care/ after hours care (9.8%)

Top 5 Expenses that Result in Delayed Health Care

- Health Insurance (premium, co-pays, deductibles, and out-of-pocket costs) (21.3%)
- Rent/mortgage (18.3%)
- Current, or fear of, future medical debt (16.0%)
- Prescription medications (co-pays, deductibles, and out-of-pocket costs) (15.2%)
- Loss of or less work/income (13.5%)

Appendix D: Regional Survey Results

Most Important Health Conditions

Survey Responses: Top 5 Overall

1. Mental/Behavioral Health (70%)
2. Alcohol and Drug Use (58%)
3. COVID and Long-COVID (50%)
4. Stress (49%)
5. Diabetes (41%)

Survey Responses: Top 5 by Region

South
- Mental/Behavioral Health (69%)
- Alcohol/Drug Use (61%)
- Stress (57%)
- Diabetes (52%)
- COVID and Long-COVID (51%)
- Nutrition, Physical Activity, Weight (51%)

Central
- Mental/Behavioral Health (80%)
- Alcohol/Drug Use (65%)
- COVID and Long COVID (54%)
- Stress (52%)
- Nutrition, Physical Activity, Weight (47%)

East
- Mental/Behavioral Health (71%)
- COVID and Long COVID (58%)
- Stress (55%)
- Alcohol and Drug Use (54%)
- Diabetes (44%)

North Central
- Mental/Behavioral Health (73%)
- Alcohol and Drug Use (65%)
- COVID and Long COVID (49%)
- Stress (46%)
- Senior Health (41%)

North Coastal
- Mental/Behavioral Health (73%)
- Alcohol and Drug Use (53%)
- COVID and Long-COVID (47%)
- Stress (47%)
- Senior Health (40%)

North Inland
- Mental/Behavioral Health (80%)
- Alcohol and Drug Use (57%)
- Stress (57%)
- COVID and Long-COVID (51%)
- Diabetes (35%)
- Nutrition, Physical Activity, Weight (35%)

Survey Results: Most Important Mental & Behavioral Health Needs/Conditions

Survey Responses: Top 5 Overall

1. Depression (68%)
2. Access to help (61%)
3. Anxiety (57%)
4. Stress (56%)
5. Drug Use (49%)

Survey Responses: Top 5 by Region

South
- Depression (74%)
- Access to help (67%)
- Stress (65%)
- Anxiety (63%)
- Drug Use (53%)

Central
- Depression (73%)
- Stress (62%)
- Access to help (61%)
- Anxiety (59%)
- Alcohol Use (56%)
- Drug Use (56%)

East
- Depression (71%)
- Access to help (66%)
- Anxiety (63%)
- Stress (60%)
- Burnout or Fatigue (47%)

North Central
- Access to help (73%)
- Depression (60%)
- Stress (53%)
- Substance Use Disorder (52%)
- Opioid Use including Fentanyl (49%)

North Coastal
- Depression (67%)
- Access to help (57%)
- Stress (54%)
- Anxiety (51%)
- Substance Use Disorder (48%)

North Inland
- Access to help (68%)
- Depression (63%)
- Stress (58%)
- Anxiety (57%)
- Substance Use Disorder (51%)

Survey Results: Most Important Social Needs

Survey Responses: Top 5 Overall

1. Access to affordable, quality housing (75%)
2. Access to health care (59%)
3. Being homeless (59%)
4. Not having enough money to pay my bills (50%)
5. Isolation (being alone, feeling alone) (41%)

Survey Responses: Top 5 by Region

South

- Access to affordable, quality housing (79%)
- Access to health care (65%)
- Being homeless (61%)
- Not having enough money to pay my bills (60%)
- Not having enough healthy food (46%)

Central

- Access to affordable, quality housing (83%)
- Access to health care (69%)
- Being homeless (69%)
- Not having enough money to pay my bills (56%)
- Isolation (being alone, feeling alone) (44%)

East

- Access to affordable, quality housing (79%)
- Access to health care (69%)
- Being homeless (57%)
- Not having enough money to pay my bills (54%)
- Not having enough healthy food (45%)

North Central

- Access to affordable, quality housing (78%)
- Access to health care (67%)
- Being homeless (62%)
- Not having enough money to pay my bills (46%)
- Lack of childcare (38%)

North Coastal

- Access to affordable, quality housing (77%)
- Being homeless (64%)
- Access to health care (52%)
- Not having enough money to pay my bills (43%)
- Isolation (being alone, feeling alone) (37%)

North Inland

- Access to affordable, quality housing (71%)
- Access to health care (60%)
- Being homeless (52%)
- Not having enough money to pay my bills (43%)
- Not having enough healthy food (42%)

Survey Results: Concerns About Health and Well-Being of Children

Survey Responses: Top 5 Overall

1. Mental/behavioral health (66%)
2. Anxiety (61%)
3. Depression (60%)
4. Bullying (57%)
5. Social media and/or online gaming (56%)

Survey Responses: Top 5 by Region

South
- Depression (74%)
- Anxiety (71%)
- Mental/behavioral health (71%)
- Isolation (being alone or lonely) (61%)
- Social media and/or online gaming (60)%)

Central
- Mental/behavioral health (72%)
- Depression (64%)
- Anxiety (61%)
- Social media and/or online gaming (58%)
- Bullying (56%)

East
- Depression (66%)
- Anxiety (65%)
- Mental/behavioral health (63%)
- Bullying (59%)
- Isolation (being alone or lonely) (58%)

North Central
- Mental/behavioral health (60%)
- Anxiety (59%)
- Social media and/or online gaming (56%)
- Bullying (53%)
- Depression (51%)

North Coastal
- Mental/behavioral health (65%)
- Bullying (64%)
- Anxiety (61%)
- Depression (60%)
- Social media and/or online gaming (60%)

North Inland
- Anxiety (73%)
- Mental/behavioral health (73%)
- Depression (70%)
- Social media and/or online gaming (50%)
- Substance use (alcohol, tobacco, drugs) (50%)

Survey Results: Challenges Accessing Health Care

Survey Results: Top 5 Overall

1. Long waits for an appointment (31%)
2. Appointment hours are not convenient (24%)
3. Limited time with health care providers (17%)
4. Lack of time (16%)
5. Cost of medical appointments or treatments (15%)

Survey Results: Top 5 by Region

South
- Appointment hours are not convenient (37%)
- Long waits for an appointment (27%)
- Cost of medical appointments or treatments (25%)
- Cannot take time off from work (20%)
- Limited time with health care providers (19%)

Central
- Long waits for an appointment (35%)
- Appointment hours are not convenient (20%)
- Limited time with health care providers (20%)
- Lack of time (18%)
- Cost of medical appointments or treatments (17%)

East
- Long waits for an appointment (29%)
- Appointment hours are not convenient (28%)
- Lack of time (23%)
- Limited time with health care providers (16%)
- Cannot take time off from work (14%)

North Central
- Appointment hours are not convenient (33%)
- Long waits for an appointment (33%)
- Cost of medical appointments or treatments (23%)
- Limited time with health care providers (21%)
- Cannot take time off from work (15%)
- Lack of time (15%)

North Coastal
- Long waits for an appointment (31%)
- Appointment hours are not convenient (21%)
- Lack of time (16%)
- Cannot take time off from work (15%)
- Cost of medical appointments or treatments (14%)

North Inland
- Long waits for an appointment (30%)
- Appointment hours are not convenient (19%)
- Lack of time (19%)
- Cannot take time off from work (16%)
- Cost of medications (11%)
- Provider is too far away (11%)
- Limited time with health care providers (11%)

Survey Results: Health Care Services That are Most Difficult to Access

Survey Responses: Top 5 Overall

- Mental/Behavioral health services (34%)
- Counseling, therapy (27%)
- Psychiatry (20%)
- Dental services (14%)
- Urgent care/ after-hours care (10%)

Survey Responses: Top 5 by Region

South
- Mental/behavioral health services (38%)
- Counseling, therapy (30%)
- Psychiatry (24%)
- Dental services (18%)
- Substance use treatment (12%)

Central
- Mental/behavioral health services (38%)
- Counseling, therapy (32%)
- Psychiatry (25%)
- Dental services (18%)
- Substance use treatment (12%)
- Urgent care/ after hours care (12%)

East
- Mental/behavioral health services (36%)
- Counseling, therapy (35%)
- Psychiatry (16%)
- Dental services (16%)
- Eye care services (11%)

North Central
- Mental/behavioral health services (31%)
- Counseling, therapy (27%)
- Psychiatry (19%)
- Other (18%)
- Substance use treatment (9%)
- Urgent care/ after-hours care (9%)

North Coastal
- Mental/behavioral health services (27%)
- Counseling, therapy (26%)
- Psychiatry (15%)
- Urgent care/ after-hours care (14%)
- Dental services (10%)

North Inland
- Mental/behavioral health services (40%)
- Counseling, therapy (27%)
- Psychiatry (19%)
- Dental services (13%)
- Case management/care coordination (10%)
- Substance use treatment (10%)

Survey Results: Expenses That Result in Delayed Health Care

Survey Responses: Top 5 Overall

1. Health insurance (premium, co-pays, deductibles, and out-of-pocket costs) (21%)
2. Rent/mortgage (18%)
3. Current, or fear of, future medical debt (16%)
4. Prescription medications (co-pays, deductibles, and out-of-pocket costs) (15%)
5. Loss or less work/income (14%)

Survey Responses: Top 5 by Region

South

- Health insurance (premium, co-pays, deductibles, and out-of-pocket costs) (24%)
- Prescription medications (co-pays, deductibles, and out-of-pocket costs) (20%)
- Utilities (water, gas, electric, internet) (20%)
- Rent/mortgage (19%)
- Current, or fear of, future medical debt (18%)

Central

- Health insurance (premium, co-pays, deductibles, and out-of-pocket costs) (27%)
- Prescription medications (co-pays, deductibles, and out of pocket costs) (20%)
- Rent/mortgage (19%)
- Current, or fear of, future medical debt (18%)
- Loss or less work/income (17%)

East

- Health Insurance (premium, co-pays, deductibles, and out-of-pocket costs) (21%)
- Rent/mortgage (18%)
- Prescription medications (co-pays, deductibles, and out-of-pocket costs) (16%)
- Transportation/car costs (16%)
- Utilities (water, gas, electric, internet) (14%)

North Central

- Prescription medications (co-pays, deductibles, and out-of-pocket costs) (16%)
- Health Insurance (premium, co-pays, deductibles, and out-of-pocket costs) (15%)
- Current, or fear of, future medical debt (14%)
- Loss or less work/income (10%)
- Rent/mortgage (10%)
- Utilities (water, gas, electric, internet) (10%)

North Coastal

- Health Insurance (premium, co-pays, deductibles, and out-of-pocket costs) (20%)
- Rent/mortgage (20%)
- Current, or fear of, future medical debt (17%)
- Loss or less work/income (16%)
- Prescription medications (co-pays, deductibles, and out-of-pocket costs) (13%)

North Inland

- Health Insurance (premium, co-pays, deductibles, and out-of-pocket costs) (22%)
- Current, or fear of, future medical debt (17%)
- Rent/mortgage (17%)
- Prescription medications (co-pays, deductibles, and out-of-pocket costs) (12%)
- Education (9%)
- Loss or less work/income (9%)

Appendix E:
Summary of Community Engagement

Online Community Survey

Participants	Number of Participants
Community Members	276
Community-Based Organizations	91
Hospital/Health System	81
Community Clinic (federally qualified health center)	20
Government Employee/Elected Official	10
Grantmaking Organization	1
Other	23
Total	**502**

Expertise: Minority, medically underserved, and low-income population living with chronic health conditions

Survey Dates: 2/14/2022-3/30/2022

Access to Health Care Interviews, Conducted by Promotoras & Community Health Workers

Participants	Number of Participants	Expertise	Date Input was Gathered
Community Members	223	Minority, medically underserved, and low-income population living with chronic health conditions	3/10/2022-4/4/2022

Focus Groups

#	Organization/Participants	Number of Participants	Expertise	Role in Target Group	Region	Date Input Was Gathered
1	San Diego American Indian Health Center/ *CEO, Director of Clinic Operations, Director of Behavioral Health, Wellness Manager for Youth, Family, and Elders*	4	Native American/Tribal Communities, access to care, behavioral health, children & youth well-being, stigma, trauma	Representative Health Expert	Central	9/23/2021
2	Scripps Health/*Administrator, Manager, Clinician, Supervisor, Director*	5	Access to care, behavioral health, chronic health conditions	Representative Health Expert	Central, North Central, South	10/26/2021
3	2-1-1 San Diego/*community connectors, health agents*	9	Access to services, care connection	Representative Health Expert	All Regions	10/28/2021
4	Scripps Health/*Case Managers, Social Workers*	3	Access to care, behavioral health, chronic health conditions	Representative Health Expert	Central, North Central, South	11/4/2021
5	El Cajon Collaborative/*Service Providers, Advocates, Community Members*	5	Access to care, behavioral health, chronic health conditions	Community Member and Leader	East	11/16/2021
6	PATH San Diego/*Associate Director, Program Managers, Case Managers*	6	Experiencing homelessness, access to care and services, behavioral health, chronic health conditions, stigma, trauma-informed care	Representative Health Expert	Central	11/18/2021
7	San Diego Refugee Communities Coalition/*Advocates, Directors*	4	Access to care, behavioral health, chronic health conditions, economic stability	Community Leader	Central	11/19/2021
8	Communities Fighting COVID!/ *Community Health Workers*	8	Access to care, behavioral health, chronic health conditions	Community Leader	All Regions	11/29/2021

#	Organization/Participants	Number of Participants	Expertise	Role in Target Group	Region	Date Input Was Gathered
9	Vista Community Clinic, Poder Popular/ *Lideres/Advocates*	10	Access to care, behavioral health, chronic health conditions	Community Member and Leader	North Coastal, North Inland	12/1/2021
10	Communities Fighting COVID!/ , *Community Health Workers*	4	Access to care, behavioral health, chronic health conditions	Community Leader	All Regions	12/7/2021
11	Tri-City Medical Center/ *Executive Team*	5	Access to care, behavioral health, chronic health conditions	Representative Health Expert	North Coastal	12/8/2021
12	Rady Children's Hospital/ *Interim Chief Of The Division Of Emergency Medicine And Medical Director, Senior Director Of Behavioral Health Services, ED Supervisor, ED Physician, Supervisor, Medical Social Work, Director Of Inpatient Behavioral Health Programs*	6	Children & youth well-being, access to care, behavioral health, chronic health conditions	Representative Health Expert	All Regions	12/9/2021
13	FACES for the Future Alumni/ *Youth program alumni*	3	Youth well-being, access to care, behavioral health, chronic health conditions	Youth Community Member	Central	12/20/2021
14	San Diego Human Trafficking & CSEC Advisory Council/ *Advocates*	4	Human trafficking, stigma, trauma, community safety, trauma-informed care	Representative Health Expert	All Regions	1/24/2022
15	North County Lifeline Youth RLA/ *Youth Advocates*	4	Youth well-being, behavioral health, family and community safety, economic stability, housing	Youth Community Member and Leader	All Regions	Fall 2021

#	Organization/Participants	Number of Participants	Expertise	Role in Target Group	Region	Date Input Was Gathered
16	YMCA Youth & Family Services/ *Youth Advocates, Service Providers*	3	Housing, behavioral health, LGBTQ experiencing homelessness, houth experiencing homelessness	Youth Community Member and Leader	All Regions	Fall 2021

Key Informant Interviews

#	Organization/ Participants	Expertise	Role in Target Group	Region(s) Represented	Date Input Was Gathered
1	**Full Access and Coordinated Transportation (FACT)/***Director, Operations*	Transportation, access to care and services, economic stability	Community Leader	North Coastal, East	9/16/2021
2	**Bayview Behavioral Health Hospital and Paradise Valley Hospital**/*medical social work, inpatient social work team leaders*	Access to care, behavioral health, chronic health conditions, community safety	Representative Health Expert	South	10/28/2021
3	**Serving Seniors/** *President & CEO*	Aging care and support, seniors experiencing homelessness, economic stability	Community Leader	Central	11/11/2021
4	**Alvarado Hospital Medical Center/***ER Director*	Access to care, behavioral health, chronic health conditions, community safety	Representative Health Expert	Central	12/3/2021
5	**Sharp HealthCare/***VP, Integrated Care Management, System Director, Integrated Care Management*	Access to care, behavioral health, chronic health conditions	Representative Health Expert	North Central, Central, South	12/7/2021
6	**Community Through Hope/***CEO & Founder*	Access to care, experiencing homelessness, food insecurity, stigma	Community Leader	South	12/8/2021
7	**UC San Diego Health and UC San Diego School of Medicine,/***Clinical Director, Chair Department of Psychiatry*	Access to care, behavioral health, chronic health conditions	Representative Health Expert	North Central, Central	12/20/2021
8	**UC San Diego Health/** *Executives and Officers of Population Health Services*	Access to care, behavioral health, chronic health conditions, population health	Representative Health Expert	North Central, Central	1/7/2022

#	Organization/ Participants	Expertise	Role in Target Group	Region(s) Represented	Date Input Was Gathered
9	**Rady Children's Hospital**/*Director of Developmental Services*	Children and youth well-being, child development	Representative Health Expert	All Regions	1/13/2022
10	**Children's Primary Care Medical Group** (**CPCMG**)/*Director of Behavioral and Mental Health Services*	Access to care, children and youth well-being	Representative Health Expert	All Regions	1/21/2022
11	**Kaiser Permanente, San Diego**/*ER Physician*	Access to care, aging care and support, behavioral health, chronic health conditions, community safety, economic stability	Representative Health Expert	North Central, Central	1/25/2022
12	**Community Resource Center**/*CEO*	Food insecurity, housing, economic stability	Community Leader	North Coastal, North Inland	2/2/2022
13	**San Ysidro Health Center**/*VP of External Affairs, VP & Chief Strategy Officer*	Access to care, workforce	Representative Health Expert	South	2/3/2022
14	**PsychArmor San Diego**/*CEO*	Veterans and military-connected, behavioral health	Community Leader	All Regions	2/8/2022
15	**North County LGBTQ Resource Center/** *Executive Director*	LGBTQ+ care and support, aging care and support, behavioral health, stigma, access to care	Community Leader	North Coastal	2/25/2022
16	**The San Diego LGBT Community Center/** *Director of Behavioral Health Services*	LGBTQ+ care and support, behavioral health, stigma, access to care	Community Leader	Central	3/9/2022

#	Organization/ Participants	Expertise	Role in Target Group	Region(s) Represented	Date Input Was Gathered
17	**YMCA San Diego/** *Youth Providers, Advocates, Program Director*	Access to care, children and youth well-being, child development, economic stability	Representative Health Expert	All Regions	3/21/2022
18	**Palomar Health/***VP Continuum of Care*	Access to care, behavioral health, chronic health conditions	Representative Health Expert	North Inland	3/28/2022
19	**Palomar Health/***Chief Operations Officer*	Access to care, behavioral health, chronic health conditions	Representative Health Expert	North Inland	4/5/2022
20	**Consumer Center for Health Education and Advocacy (CCHEA), Legal Aid Society of San Diego/***Director of Policy and Training/HCA Coordinator, Staff Attorney*	LGBTQ+ care and support, access to care, legal assistance, trauma-informed care	Community Leader	All Regions	6/2/2022
21	**County of San Diego HHSA/***Public Health Director*	Public health, population health, access to care, chronic health conditions	Community Leader	All Regions	Fall 2021
22	**Dreams for Change/** CEO	Housing, behavioral health, economic stability, experiencing homelessness	Community Leader	Central	Fall 2021
23	**Kitchens for Good/** *CEO*	Hood insecurity, economic stability/ career readiness, education	Community Leader	Central, North Coastal	Fall 2021
24	**MAAC Project/***CEO*	Access to care, housing, food insecurity, economic stability, education, child development	Community Leader	South	Fall 2021

#	Organization/ Participants	Expertise	Role in Target Group	Region(s) Represented	Date Input Was Gathered
25	**North County Lifeline/** *Clinicians*	Youth well-being, behavioral health, family and community safety, economic stability, housing	Community Leader	All Regions	Fall 2021
26	**Pillars of the Community/***CEO*	Community safety, stigma, economic stability, education	Community Leader	Central	Fall 2021

Appendix F: Summary Table of County of San Diego Data & Resources

Source (In Order of Report Appearance)	Link Location	Location in CHNA Report
Exploring Health Disparities in San Diego County: Executive Summary – *Report Series to Identify Opportunities to Achieve Health Equity*	https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/CHS/Health%20Equity%20Report%20Series_Executive%20Summary_2022.pdf	**Executive Summary** **Methodology**
Racial Equity: Framework & Outcomes Brief	https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/CHS/Racial%20Equity%20Framework%20and%20Outcomes%20Brief%2c%20Data%20Guide.pdf	**Executive Summary** **Methodology**
Health Equity in San Diego	https://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/community_health_statistics/healthequity.html	**Executive Summary** **Methodology**
Health Equity Dashboard Series: Racial Equity Dashboards, San Diego County	https://public.tableau.com/app/profile/chsu/viz/HealthEquityDashboardSeriesRacialEquityDashboardsSanDiegoCounty/HomePage	**Executive Summary** **Methodology**
COVID-19 in San Diego County Dashboards	https://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/community_epidemiology/dc/2019-nCoV/status.html	**Executive Summary** **Methodology**

Source (In Order of Report Appearance)	Link Location	Location in CHNA Report
2019 Demographic Profiles San Diego County	https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/CHS/demographics/2019%20SRA%20Demographic%20Profiles.pdf	**Community Description:** *What Makes San Diego County Unique* **Access to Health Care Finding:** *Language Diversity in San Diego County* **Aging Care & Support Finding:** *The Population of Seniors in San Diego County is Growing; Economic Stability & Risk of Homelessness* **Children & Youth Well-Being Finding:** *Children andYouth Living Below 100% of Federal Poverty Level table*
San Diego County Resettlement Agencies: Monthly Refugee Arrival Reports	https://www.sandiegocounty.gov/content/sdc/hhsa/programs/sd/community_action_partnership/OfficeofRefugeeCoord2.html	**Community Description:** *Immigrants and Refugee Populations*
County of SD HHSA Public Health Services Public Use Codebook and Metadata File, Data Year: 2019 *Health Data – Community Profiles: Public Health Services Data Guide and Codebook* [automatic download]	https://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/community_health_statistics/regional-community-data.html	**Aging Care & Support Finding:** *Challenges Accessing Health Care*
Harm Reduction/Overdose Data to Action (OD2A): *Opioid-Related Overdoses and Encounters in San Diego County Retrospective Analysis*	https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/CHS/OD2A%20-%202015-2019%20Retrospective%20Analysis%2020220104.pdf	**Behavioral Health Finding:** *Opioid-Related Overdoses and Encounters*

Source (In Order of Report Appearance)	Link Location	Location in CHNA Report
San Diego County Prescription Drug Abuse Task Force Report Card: *Key Measures of Prescription Drug and Opioid Problems*	https://www.sdpdatf.org/livestories-template	**Behavioral Health Finding:** *Unintentional Prescription-Caused Deaths*
Data Request: Drug Overdose Deaths in San Diego County, 2017-2020, County of San Diego, *Department of the Medical Examiner, Data as of 6/2022, Prepared by: County of San Diego, Health & Human Services Agency Behavioral Health Services, Population Health Unit*	n/a	**Behavioral Health Finding:** *Unintentional Prescription-Caused Deaths; Rates of Accidental Drug Overdose Deaths Among San Diego County Residents*
County of San Diego HHSA April 2022 Eligibility Services by the Numbers Report	https://acrobat.adobe.com/link/track?uri=urn:aaid:scds:US:df3df425-c98b-3add-8188-395122277b07#pageNum=3	**Children & Youth Well-Being Finding:** *Critical Deficits Across the Continuum* **Economic Stability Finding:** *The Role of Safety-Net Programs in Economic Stability*
Suicide in San Diego County, 2020 Suicide Prevention Council Annual Stakeholders Meeting June 22, 2021, *Prepared and Presented by: County of San Diego, Health and Human Services Agency, Medical Care Services Division, Emergency Medical Services*	https://www.sdchip.org/wp-content/uploads/2021/09/2020-San-Diego-County-Suicide.pdf	**Children & Youth Well-Being:** *Suicide and Suicidality*
3-4-50: Chronic Disease Deaths in San Diego County – County Overview, 2000-2019	https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/CHS/3-4-50/3-4-50_County_Detailed_Brief_2021.pdf	**Chronic Health Conditions Finding:** *Leading Causes of Death*
Leading Causes of Death Among San Diego County Residents by Year, 2016-2020	https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/CHS/Mortality/2011-2020%20Leading%20Causes%20of%20Death_8.6.20.pdf	**Chronic Health Conditions Finding:** *Leading Causes of Death; Cancer Mortality*

Source (In Order of Report Appearance)	Link Location	Location in CHNA Report
2019 Leading Causes of Death Workbook *[automatic download]*	https://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/community_health_statistics/CHSU_Mortality.html#:~:text=Leading%20Causes%20of%20Death&text=While%20diseases%20of%20the%20heart,death%20in%20San%20Diego%20County.	**Chronic Health Conditions Finding:** *Leading Causes of Death*
Epidemiology And Immunization Services Branch: Monthly Communicable Disease Report September 2019	https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/documents/Monthly_CD_Report_September2019.pdf	**Chronic Health Conditions Finding:** *LGBTQ+*
LGBTQ Health and Well-Being Dashboard	https://public.tableau.com/app/profile/chsu/viz/LGBTQHealthandWell-Being_16473833366900/LGBTQPopulationinSanDiego	**Chronic Health Conditions Finding:** *LGBTQ+*
County of San Diego, Board of Supervisors, Framework for Our Future: Declaring Racism a Public Health Crisis, January 12, 2021	https://www.sandiegocounty.gov/content/dam/sdc/lwhrc/011921/Jan%2019%202020%20Agenda%20Supporting%20Materials%20-%20Racism%20as%20a%20Public%20Health%20Crisis.pdf	**Community Safety Finding:** *County of San Diego Declares Racism a Public Health Crisis*

Source (In Order of Report Appearance)	Link Location	Location in CHNA Report
San Diego County Self-Sufficiency Standard Briefs	**Household with Two Adults and Two Children, 2021:** https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/CHS/San%20Diego%20County%20Self-Sufficiency%20Standard%20Brief%20Household%20with%20Two%20Adults%20and%20Two%20Children%2C%202021%20FINAL.pdf **Household with Two Adults, 2021:** https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/CHS/San%20Diego%20County%20Self-Sufficiency%20Standard%20Brief%20Household%20with%20Two%20Adults%2c%202021.pdf **Single-Adult Household, 2021:** https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/CHS/San%20Diego%20County%20Self-Sufficiency%20Standard%20Brief%20Single-Adult%20Household%2c%202021%20FINAL.pdf **Single-Parent Household with Two Children, 2021** https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/CHS/San%20Diego%20County%20Self%20Sufficiency%20Standard%20Brief%20Single%20Parent%20Household%20with%20Two%20Children%2c%202021.pdf	**Economic Security Finding:** *Key Findings Provided by the County of San Diego's Self-Sufficiency Standard Dashboard*
San Diego County Self-Sufficiency Standard Dashboard	https://public.tableau.com/app/profile/chsu/viz/SanDiegoCountySelf-SufficiencyStandardDashboard/Self-SufficiencyStandardDashboard	**Economic Security Finding:** *Key Findings Provided by the County of San Diego's Self-Sufficiency Standard Dashboard*
County of San Diego Office of Business Intelligence CalFresh and Medi-Cal Dashboards	n/a	**Economic Security Finding:** *The Role of Safety-Net Programs in Economic Stability*

Source (In Order of Report Appearance)	Link Location	Location in CHNA Report
Housing Authority of the County of San Diego Public Housing Agency Plans Five Year Plan: For Fiscal Years 2020-2024, Annual Plan for Fiscal Year 2021-2022	https://www.sandiegocounty.gov/content/dam/sdc/sdhcd/new-docs/2021-Board-Approved-Agency-Plan-HUD-Submission.pdf	**Economic Stability:** *Rental Assistance During the Pandemic*

Appendix G: Endnotes

[1] SpeedTrack's Population Health Decision Support (PHDS) Platform, was utilized to export emergency department and inpatient hospital discharge data. http://speedtrack.com/healthcare.php

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Community Description

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Methodology
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