2022 SAN DIEGO CHNA
COMMUNITY HEALTH NEEDS ASSESSMENT

HOSPITAL ASSOCIATION of San Diego & Imperial Counties

# 2022 San Diego Community Health Needs Assessment

## 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

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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.

## 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.

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# 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."*

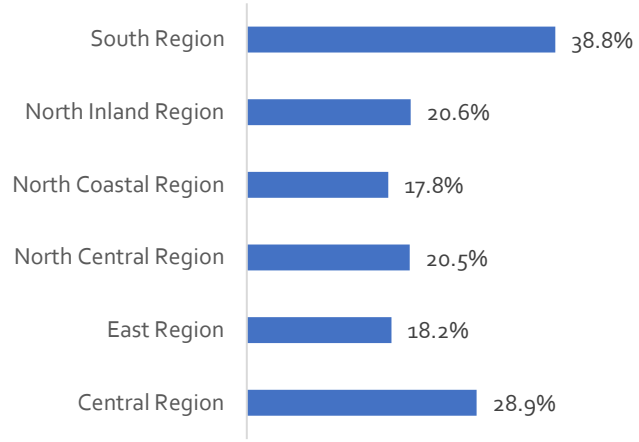
**FOCUS GROUP PARTICIPANT**

## 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]

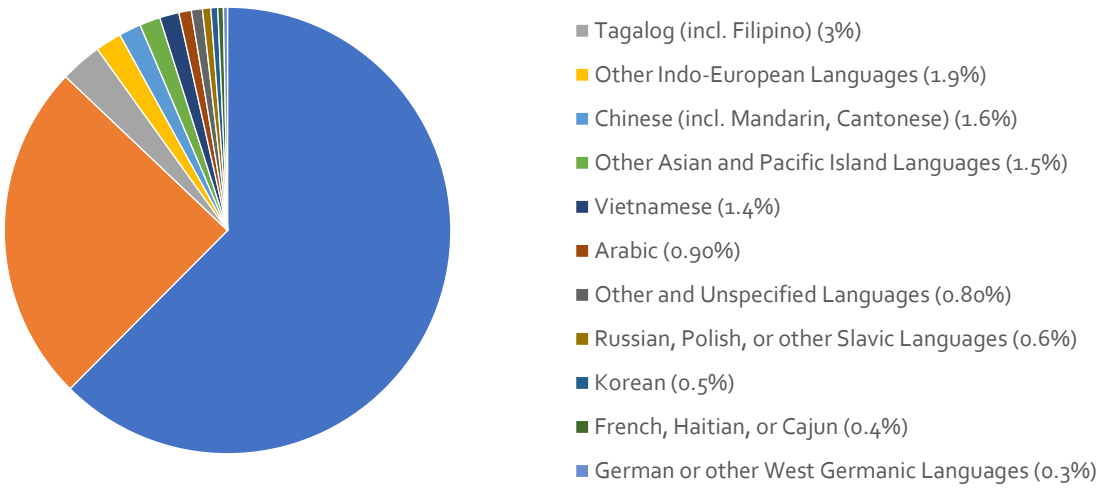
**% of Population Who Speak a Non-English Language at Home — San Diego County HHSA Region**




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**




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

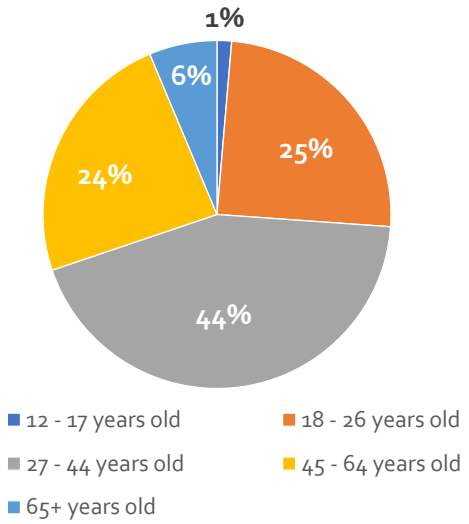
**Access to Health Care** has long been identified as a top community need in San Diego County. Early in the 2022 CHNA process, community partners shared that access to health care challenges had become even more concerning because of the pandemic. With the support of Price Philanthropies, the Chicano 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

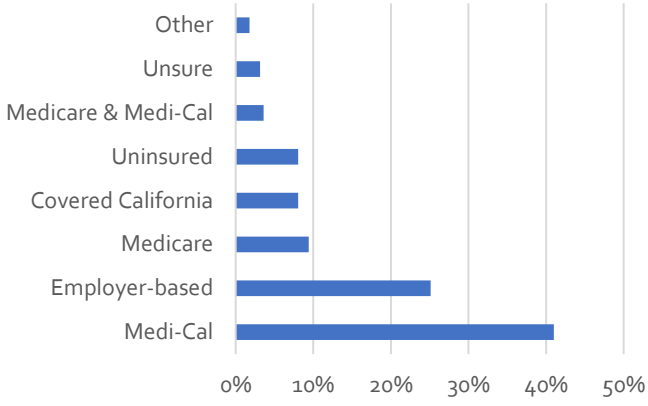
**HHSA Region:** A majority (66%) of those interviewed were between 18 and 44. The participants lived in the following regions: 41% were from the east, 32% from the central (mainly City Heights), and 16% from the south.

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




**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%)<br>• Appointment hours are not convienient (33%) |
| **Financial** | • Cost of medications (23%)<br>• Cost of medical appointments or treatments (23%) |
| **Culture, Language & Health Literacy** | • Health care providers do not understand me/my culture (20%)<br>• Limited English or no one to help communicate (17%)<br>• 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%)<br>• Lack of time (15%)<br>• Family care/elder care needs (11%)<br>• Lack of childcare (10%) |
| **Health Coverage** | • Denial of referral/service (14%)<br>• Conflicts with health coverage (13%)<br>• I do not know how/where to find needed care (13%)<br>• Insurance is not accepted (10%)<br>• I do not have a doctor (10%) |
| **Distance/ Location** | • Provider is too far away (12%)<br>• 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.<br>**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

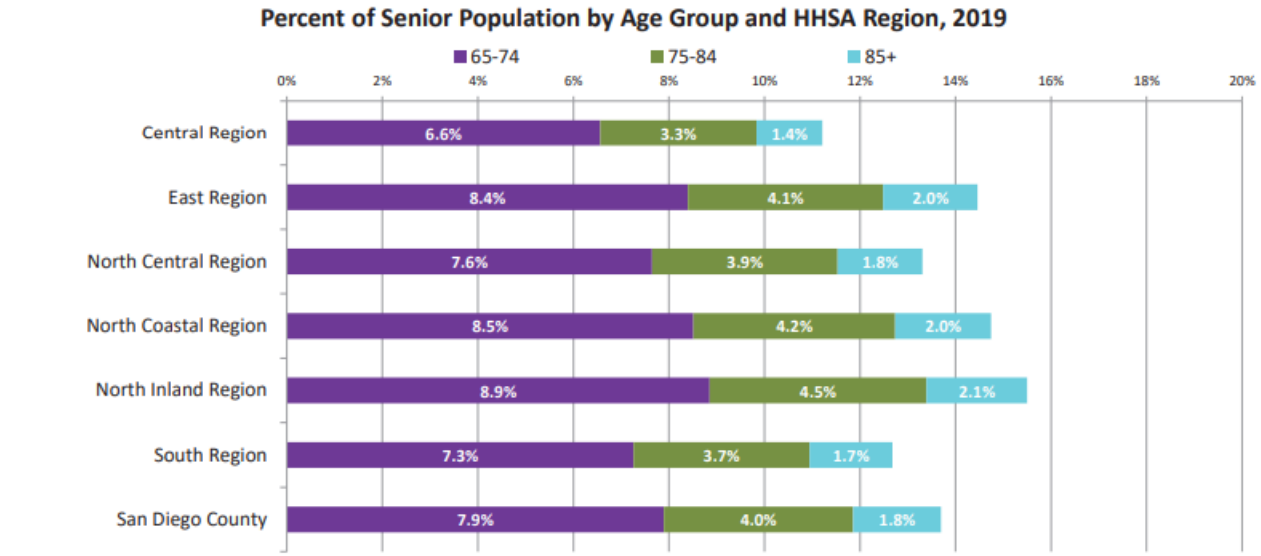
# 2022 CHNA Findings:

# 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 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

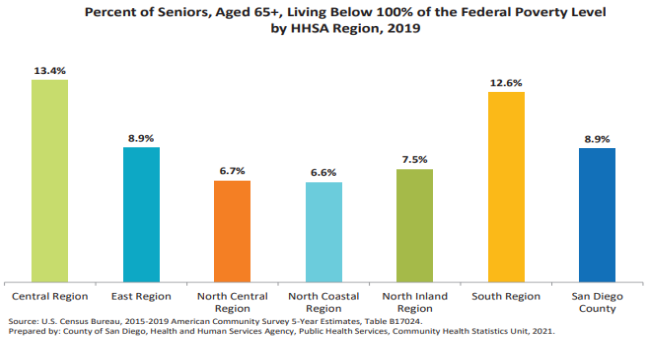
**Even before the pandemic, seniors were the fastest-growing age group among the unhoused.** Seniors are at a higher risk of poverty for a number of reasons, including limited income. Low-income seniors depend on public programs like Medi-Cal and cash assistance (Supplemental Security Income) to make 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]




**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]

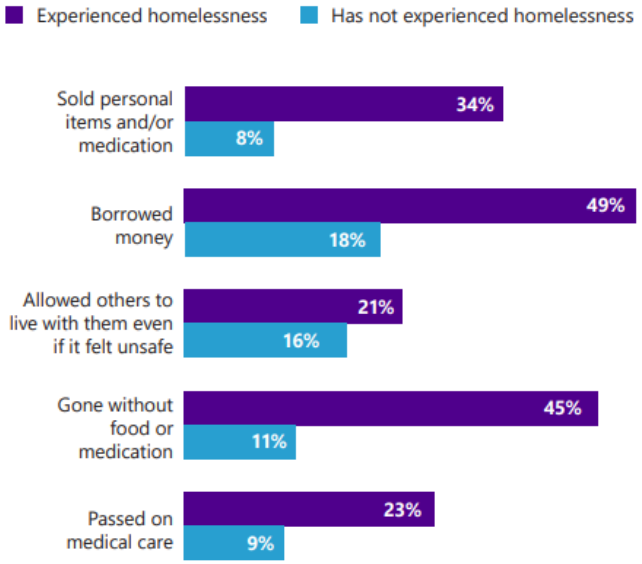
**Key findings include:**

- 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**




*"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**

# 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.

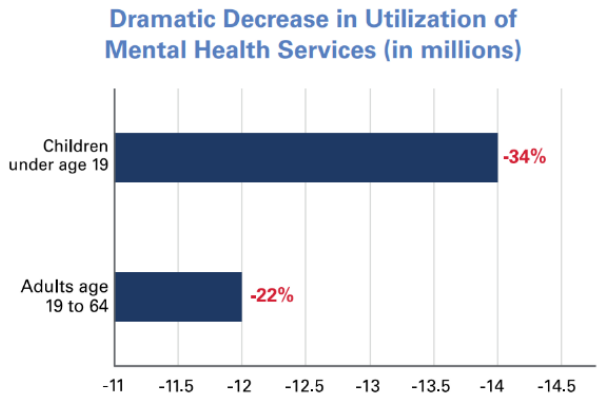
## Increasing Behavioral Health Needs and the Impact of COVID-19

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.

# 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]

# 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

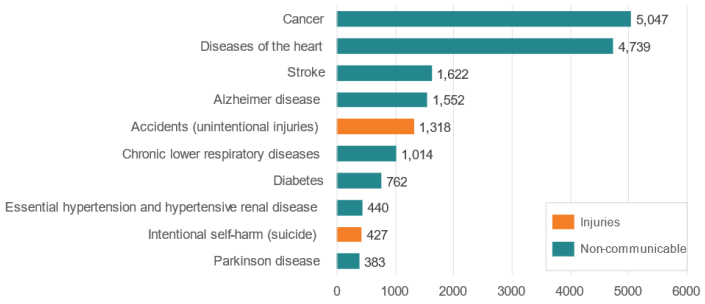
### Leading Causes of Death

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]**



# 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]

# 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.

# 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% |

# 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**<br><br>**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**<br><br>**Methodology** |
| **Health Equity in San Diego** | https://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/community_health_statistics/healthequity.html | **Executive Summary**<br><br>**Methodology** |
| **Health Equity Dashboard Series: Racial Equity Dashboards, San Diego County** | https://public.tableau.com/app/profile/chsu/viz/HealthEquityDashboardSeriesRacialEquityDashboardsSanDiegoCounty/HomePage | **Executive Summary**<br><br>**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**<br><br>**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*<br><br>**Access to Health Care Finding:** *Language Diversity in San Diego County*<br><br>**Aging Care & Support Finding:** *The Population of Seniors in San Diego County is Growing; Economic Stability & Risk of Homelessness*<br><br>**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%20220104.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*<br><br>**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<br><br>**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<br><br>**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<br><br>**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

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**Community Description**

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**Methodology**

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