SAN DIEGO

2016

Community Health Needs Assessment

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HOSPITAL ASSOCIATION of San Diego & Imperial Counties

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COMMUNITY HEALTH NEEDS ASSESSMENT COMMITTEE

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

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I. 2016 COMMUNITY HEALTH NEEDS ASSESSMENT EXECUTIVE SUMMARY

Based on the findings from the 2013 Community Health Needs Assessment (CHNA) and recommendations from the community, the 2016 CHNA was designed to provide a deeper understanding of barriers to health improvement in San Diego County. Participating hospitals will use this information to inform and guide hospital programs and strategies. This report includes an analysis of health outcomes and associated social determinants of health which create health inequities – 'the unfair and avoidable differences in health status seen within and between countries[1]' and communities – with the understanding that the burden of illness, premature death, and disability disproportionally affects racial and minority population groups and other underserved populations.[2] Understanding regional and population-specific differences is an important step to understanding and ultimately strategizing ways to make collective impact. These new insights will allow participating hospitals to identify effective strategies to address the most prevalent and challenging health needs in the community.

OVERVIEW AND BACKGROUND

The 2016 CHNA responds to IRS regulatory requirements that private not-for-profit (tax-exempt) hospitals conduct a health needs assessment in the community once every three years. Although only not-for-profit 501(c)(3) hospitals and health systems are subject to state and IRS regulatory requirements, the 2016 CHNA collaborative process also includes hospitals and health systems who are not subject to any CHNA requirements, but are deeply engaged in the communities they serve and committed to the goals of a collaborative CHNA.

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

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

In May 2015, HASD&IC contracted with the Institute for Public Health (IPH) at San Diego State University (SDSU) to provide assistance with the collaborative health needs assessment that was officially called the HASD&IC 2016 Community Health Needs Assessment (2016 CHNA). The objective of the 2016 CHNA is to identify and prioritize the most critical health-related needs in San Diego County based on feedback from community residents in high need neighborhoods and quantitative data analysis. The 2016 CHNA involved a mixed methods

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

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

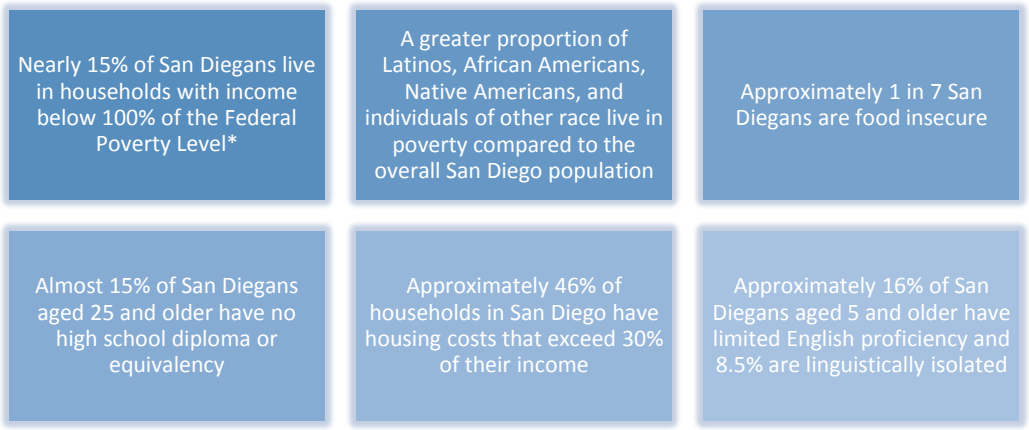
approach using the most current quantitative data available and more extensive qualitative outreach. Throughout the process, the IPH met bi-weekly with the HASD&IC CHNA committee to analyze, refine, and interpret results as they were being collected. The results of the 2016 CHNA will be used to inform and adapt hospital programs and strategies to better meet the health needs of San Diego County residents.

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

COMMUNITY DEFINED

For the purposes of this 2016 CHNA, the service area is defined as the entire County of San Diego due to a broad representation of hospitals in the area. Over three million people live in the socially and ethnically diverse County of San Diego. Select key demographic information is summarized in Figure 1 below. Additional information on socioeconomic factors, access to care, health behaviors, and the physical environment can be found in the full CHNA report.

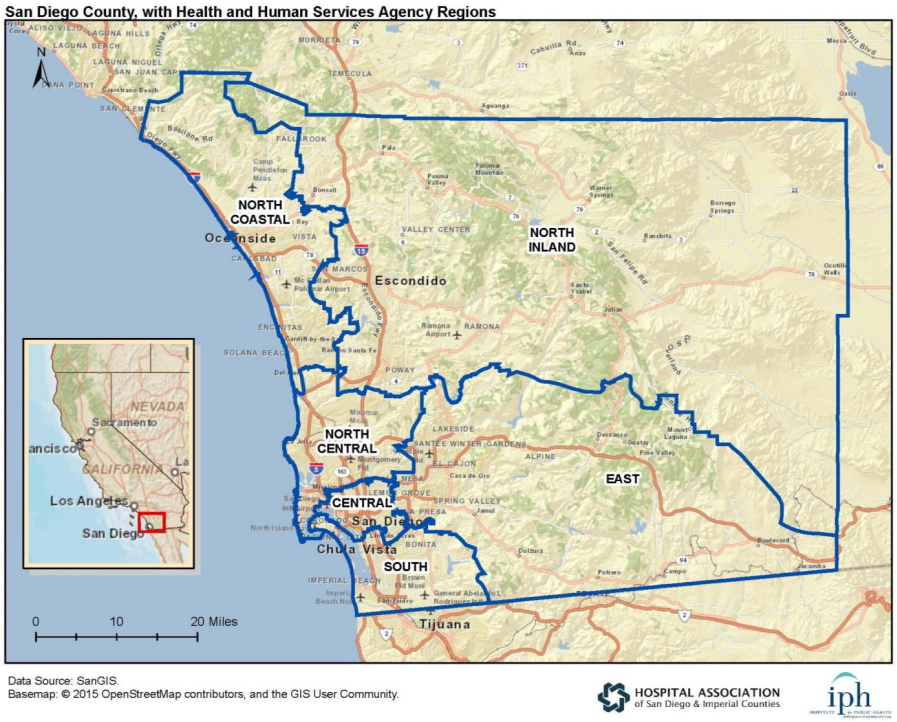
FIGURE 1. SELECTED COMMUNITY STATISTICS



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

Because of its large geographic size and population, the San Diego County Health and Human Services Agency (HHSA) organized their service areas into six geographic regions: Central, East, North Central, North Coastal, North Inland, and South. When possible, data is presented at a regional level to provide more detailed understanding of the population. The geographical regions are represented below in Figure 2.

FIGURE 2. SAN DIEGO COUNTY WITH HEALTH AND HUMAN SERVICES AGENCY REGIONS



COMMUNITY NEED INDEX

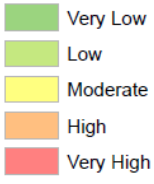
Recognizing that health needs differ across the region and that socio-economic factors impact health outcomes, the IPH used the Dignity Health/Truven Health Community Need Index (CNI) to identify communities with the highest level of health disparities and needs. The CNI score is an average of five different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

FIGURE 3. CNI SCORE AND COLOR SCALE

The five barriers used to determine CNI scores are:

- Income Barrier
- Culture Barrier
- Educational Barrier
- Insurance Barrier
- Housing Barrier

CNI Color Scale:



The CNI provides a score for every populated ZIP code in the United States on a scale of 1.0 to 5.0. A score of 1.0 indicates a ZIP code with the least need (dark green in maps see Figure 4), while a score of 5.0 represents a ZIP code with the most need (bright red in maps see Figure 4). For a detailed description of the CNI please see Appendix L or visit the interactive website at: http://cni.chw-interactive.org/.

When comparing CNI scores across HHSA regions (Table 1), differences in the mean CNI scores were apparent, with the Central region having the highest mean score of 4.2 and North Central having the lowest mean score of

3.1. It is important to note the variation in scores within each region as they highlight geographic differences in need. At a community level, 30 ZIP codes were identified as having high need CNI scores ranging from 4.2 to 5.0 (Table 2). The CHNA committee reviewed the high need ZIP codes to help identify vulnerable communities in which to engage and hold the community partner discussions.

TABLE 1. 2013 COMMUNITY NEED INDEX SCORES BY SAN DIEGO COUNTY HHSA REGION

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

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

TABLE 2. CITIES WITH HIGH NEED INDEX SCORES (4.2-5.0) BY SAN DIEGO COUNTY HHSA REGION

HHSA Region	ZIP codes with a score of 4.2 or higher
Central	
San Diego	92101, 92102, 92104, 92105, 92113, 92114, 92115, 92139
East	
Boulevard	91905
El Cajon	92020, 92021
Jacumba	91934
Lemon Grove	91945
Potrero	91963
Spring Valley	91977
Tecate	91980
North Inland	
Escondido	92025, 92027
Paula	92059
San Marcos	92069

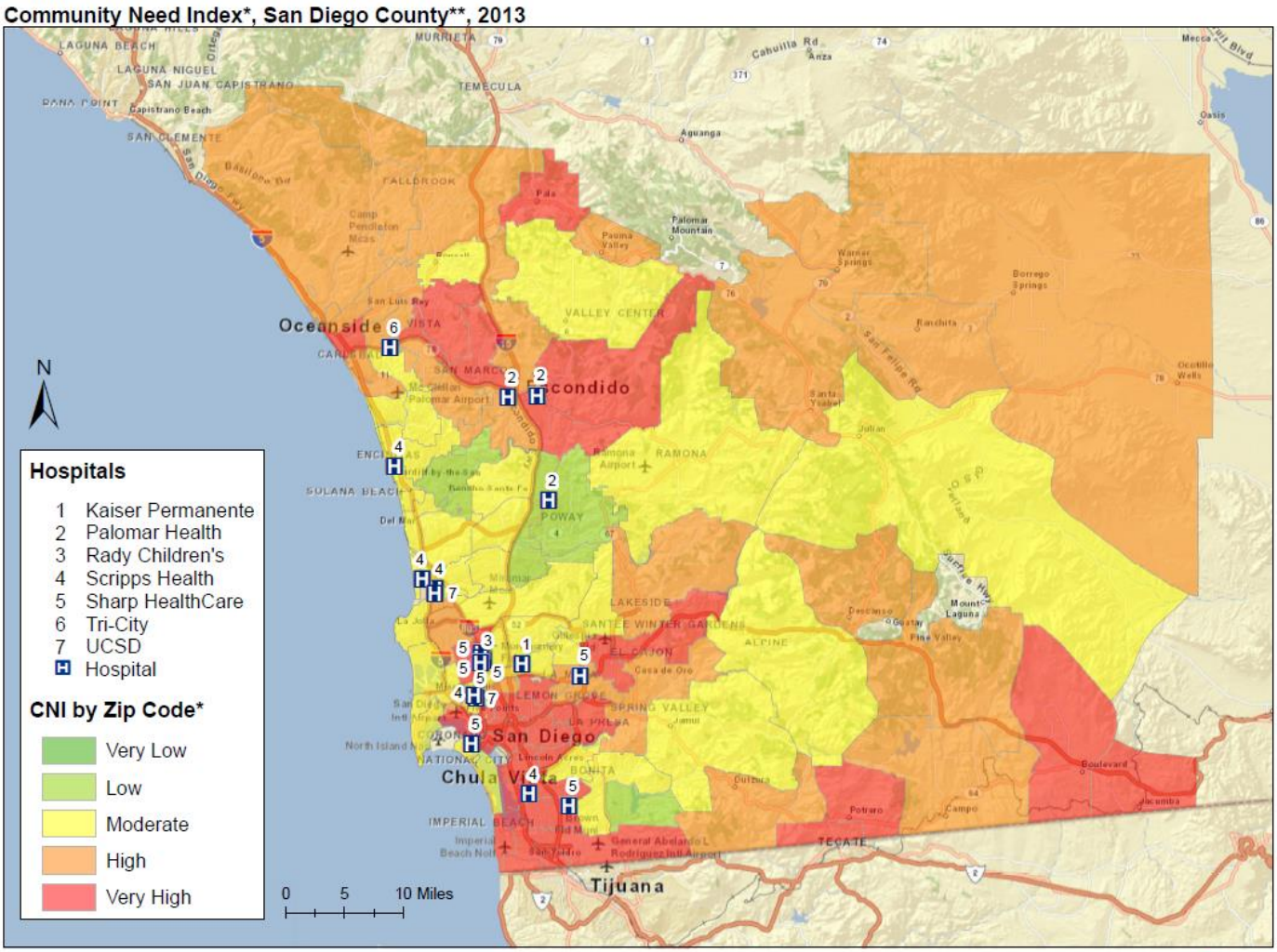
HHSA Region	ZIP codes with a score of 4.2 or higher
North Central	
San Diego	92111
North Coastal	
Oceanside	92054
Vista	92083, 92084
South	
Chula Vista	91910, 91911
Imperial Beach	91932
National City	91950
San Diego	92154
San Ysidro	92173

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

In addition, Geographic Information System (GIS) maps were created, overlaying CNI data and the hospital discharge rate by primary diagnosis for the health conditions: type 2 diabetes, cardiovascular disease, and behavioral health. GIS maps were not created for obesity due to the fact that obesity is not a common primary diagnosis, but rather a secondary condition that contributes to the primary reason for a hospital visit. A map of

the CNI for San Diego County is provided below (Figure 4). To view all CNI maps of San Diego County and the six HHSA regional maps, please see Appendix L.

FIGURE 4. SAN DIEGO COUNTY COMMUNITY NEED INDEX, 2013



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

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2016 CHNA METHODOLOGY

The CHNA Committee designed the 2016 CHNA process based on the findings and feedback from the 2013 HASD&IC CHNA. The aim of the 2016 CHNA methodology was to provide a more complete understanding of the top four identified health needs and associated social determinants of health in the San Diego community. The 2013 methodology used to identify the top four health needs is described in Figure 5.

FIGURE 5. HASD&IC 2013 CHNA METHODOLOGY

Top 15 Health Needs *Based on 2013 Initial Quantitative Analysis**	
Acute Respiratory Infections	High Risk Pregnancy
Asthma	Lung Cancer
Back Pain	Mental Health/Mental Illness
Breast Cancer	Obesity
Cardiovascular Disease	Prostate Cancer
Colorectal Cancer	Skin Cancer
Dementia and Alzheimer's	Unintentional Injuries
Diabetes (type 2)	

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

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

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

FIGURE 6. 2013 CHNA PHASE 2 FINDINGS

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

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

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

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

Based on the results of the scan and feedback from community partners received during the 2016 planning process, a number of community engagement activities were conducted to provide a more comprehensive understanding of the identified health needs, including their associated social determinants of health and potential system and policy changes that may positively impact them. In addition, a detailed analysis of how the top four needs impact the health of San Diego residents was conducted. Figure 7 provides an overview of the process used to identify and prioritize the health needs for the 2016 CHNA. For the purposes of the CHNA, a "health need" is defined as a health outcome and/or the related conditions that contribute to a defined health outcome.

FIGURE 7. 2016 CHNA PROCESS MAP

METHODS AND FINDINGS

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

QUANTITATIVE DATA COLLECTION AND ANALYSIS

California's Office of Statewide Health Planning and Development (OSHPD) is responsible for collecting data and disseminating information about the utilization of health care in California. As part of the 2016 CHNA data collection process, 2013 OSHPD demographic data for hospital inpatient, emergency department, and ambulatory care encounters from all hospitals within San Diego County were analyzed to understand the hospital patient population. Clinic data was also gathered from OSHPD's website and incorporated in order to provide a more holistic view of health care utilization in San Diego, as hospital discharges may not represent all the health conditions in the community.

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

HOSPITAL AND CLINIC DATA

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

TABLE 3. DEMOGRAPHIC CHARACTERISTICS OF ALL HOSPITAL ENCOUNTERS IN SAN DIEGO COUNTY BY SAN DIEGO RESIDENTS, 2013

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

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

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

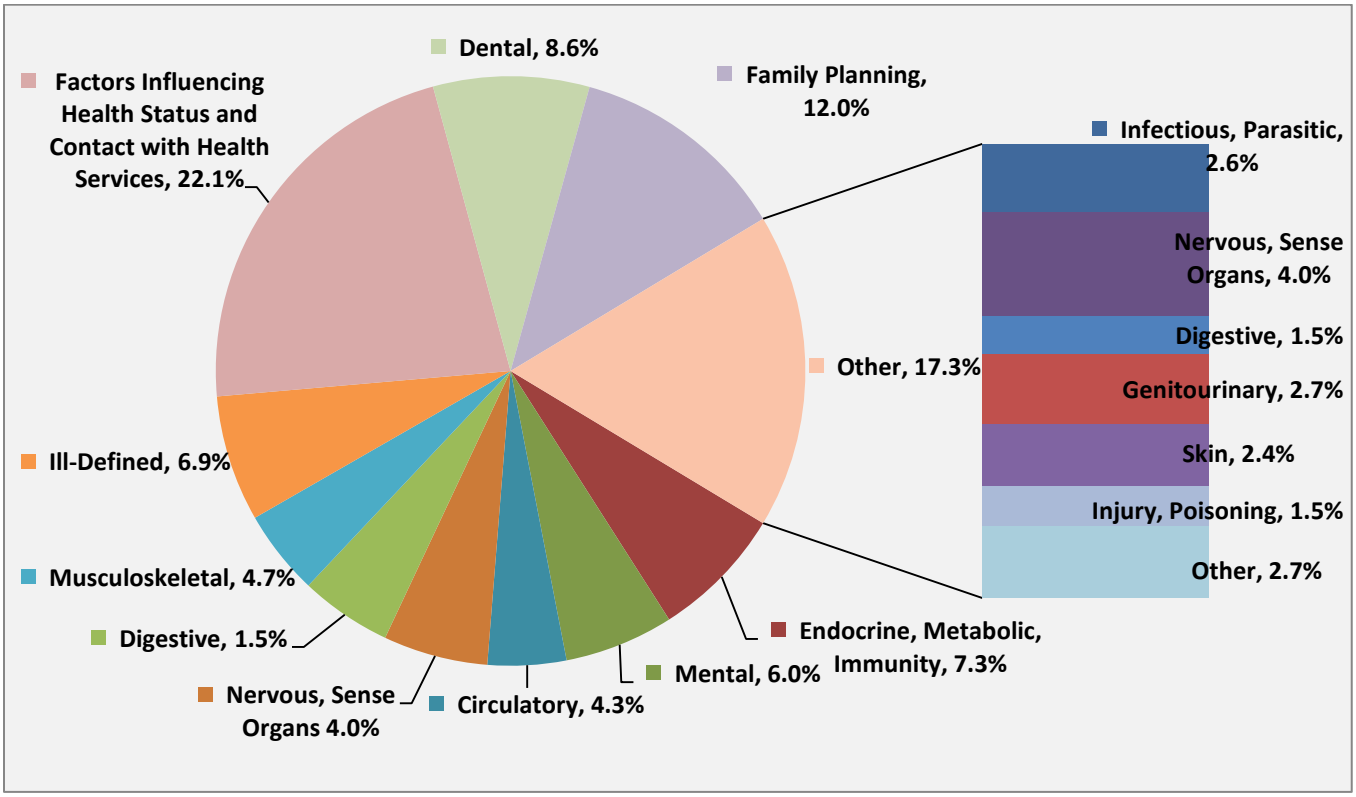
Ethnicity	#	%
Non-Hispanic/Non-Latino	806,631	69.2%
Hispanic/Latino	344,791	29.6%
Unknown	14,891	1.3%

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

CLINIC UTILIZATION DATA

According to 2013 OSHPD data, there are 103 clinics in operation in San Diego County, of which 77.7% are Federally Qualified Health Centers. There were roughly 2.1 million encounters reported in 2013. The largest majority of clinic patients are low-income, Hispanic, and Medi-Cal or self-pay. More specifically, 68.4% of clinic patients reported having an income below 100% of the poverty level, followed by 15.6% earning between 100-200% of the FPL. The clinic patient population is largely Hispanic (55.7%), and on average (median), approximately 31% of patients are best served in a non-English language. A breakdown of clinic utilization by principal diagnosis is shown below (Figure 8).

FIGURE 8. CLINIC ENCOUNTERS BY PRINCIPAL DIAGNOSIS, TOTAL ENCOUNTERS IN 2013



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

COMMUNITY ENGAGEMENT ACTIVITIES

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

Community input was gathered through the following activities:

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

FIGURE 9.COMMUNITY ENGAGEMENT NUMBERS, HASD&IC 2016 CHNA

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

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

COMMUNITY PARTNER DISCUSSIONS

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

TABLE 4. SUMMARY OF COMMUNITY PARTNER DISCUSSION RESULTS, HASD&IC 2016 CHNA

Community Partner Discussion Questions and Summary of Responses	
1. What are the most common health issues or needs?	
• Anxiety • Depression • Drugs/alcohol • High blood pressure • High cholesterol	• Lack of psychiatrists • Obesity in youth • Problems with compliance/coverage • Self-injury/suicidal ideation in youth • Unhealthy diet
2. What are the challenges clients face to improving health?	
• Cost • Homeless: often difficult to get proof of appointment; wait times are often longer than the amount of time they are allowed to be gone • Lack of access to healthy food • Lack of understanding of covered insurance benefits and fear of hidden costs • Language barriers • Literacy	• Stigma • Stress • Seniors: don't have support at home or forget to take medications, mobility issues and healthy eating • Transportation • Time • Youth: Too few behavioral health practitioners/lack of school counselor, knowledge, getting parents on board/parent follow-up
3. Why do patients not adopt behaviors?	
• Cost • Cultural practices (i.e. unhealthy food, medicine only for the sick) • Lack of awareness/recognition/education • Not properly motivated/confident	• Perceived seriousness • Prioritization of other needs • The right questions aren't being asked • Youth: Lack of role model, lack of control over health behaviors
4. What are top challenges you as case managers, health navigators, etc. face to helping patients?	
• Compliance and literacy- getting individuals to read/use resources • Elderly: may choose medicine over food • Getting clients to go is difficult ('I don't need that' or 'I feel fine') • Long waiting periods and no follow-up appointments • North County: lack of services, only one crisis location • Problems confirming appointments/contacting • Problems with hospital discharges, continuing care and wrong referrals • Patients being signed up for the wrong plans for what they need/want • South region: getting documents/verifications • Youth: difficulties communicating with parents/ what is told to parents at discharge does not filter down to the nurses, limited school-based interventions, cultural barriers, denial, unaware of problem	
5. What have you found works best with your clients to help them meet their needs?	
• Emotional support • Finding intrinsic motivation • Keeping the phone lines open • Multicultural providers	• Reducing stigma • Strengths-based case management • Translators
6. How could hospitals collaborate with your organizations?	
• Better referrals, streamlined discharge planning, and timely access to medical records (more details) • Better ways to ask if people need food or other social services • Discharge summary/instructions from hospital/doctor to school sites for kids (what are limitations, needs, modifications), upstream health education curriculum, presentations, and legislation for youth • No discharge to streets or without medications, no discharges without making follow-up appointments with clients	

KEY INFORMANT INTERVIEWS

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

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

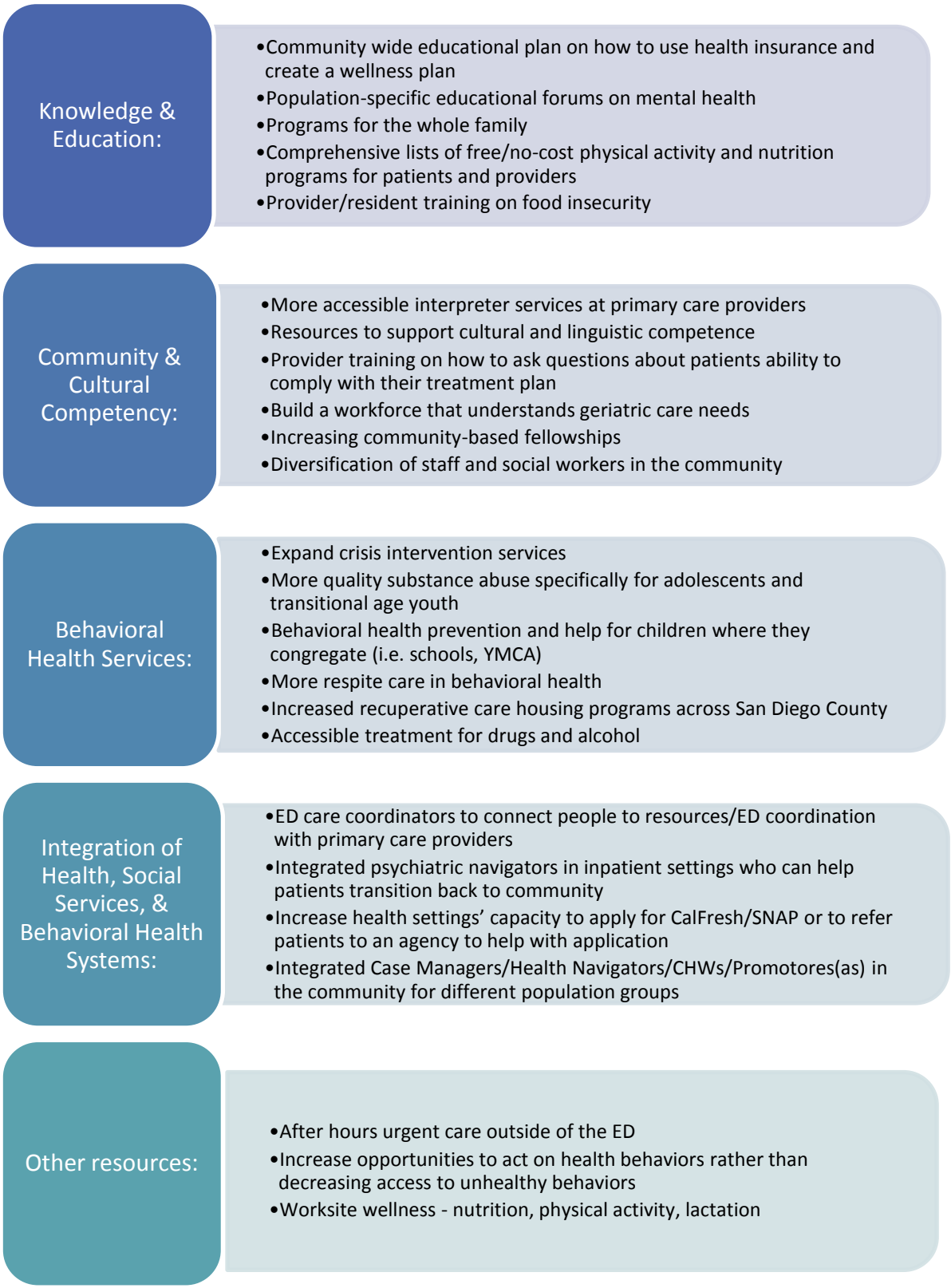
The most common health needs, important modifiable risk factors, effective strategies, and suggestions for collaboration are summarized in Table 5. Some important strategies that key informants suggested included behavioral health prevention and stigma reduction, education on disease management and food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

In addition, Figure 10 describes key informant recommendations for community resources to address the four identified health needs as well as their associated social determinants of health.

TABLE 5. SUMMARY OF KEY INFORMANT RESPONSES, HASD&IC 2016 CHNA

Key Informant Interview Questions and Summary of Responses	
1. What are the most common health issues or needs?	
• Anxiety • Asthma • Dental health • Depression • Dementia and Alzheimer's disease in seniors • Depression and diabetes in seniors • Diabetes - low-income and food insecure populations, Latinos, Asians	• Hypertension –Latinos, African Americans, and Asians • Increase in developmental disorders in children • Obesity – youth, acculturating refugees, Native Americans, older veterans, low income individuals and families • Substance Abuse
2. What do you think are the most important modifiable risk factors related to the health issues you just mentioned?	
• Access to nutritious food • Access to specialty care • Childhood and adult traumas • Homelessness • Lack of access to psychiatrists • Lack of physical activity – decreased physical education in youth, decreased mobility in seniors	• Lack of resources for care and housing of seriously mentally ill • Lack of social support and isolation • Lack of substance abuse treatment facilities, especially in North County • Limited access to gyms or safe spaces to participate in physical activity
3. What strategies do you think would be most effective for patients, physicians, case managers etc. in addressing the health needs or modifiable risk factors above?	
• Care integration and coordination • Community and cultural competency	• Early identification and prevention • Knowledge/education
4. What resources need to be developed or increased in order to address the health needs or modifiable risk factors above?	
• **See Figure 10 below for a list of resources**	
5. Are there systems, policy, or environmental changes that, if implemented, could help the hospitals address these health needs or modifiable risk factors?	
• Increased awareness of available services • Increased data sharing • Increase psychiatrists and nurse practitioners	• Payment model reforms that include reimbursements for social services (i.e. behavioral health case management, wellness/education, community health workers)
6. Can you recommend any partnerships or collaborations between hospitals and specific organizations that would help to address the health needs or modifiable risk factors above?	
• City leadership and planning departments • Community-based organizations • External provider support through technology • FQHCs • Information sharing between physicians/case managers and community-based organizations	• Intergenerational partnerships • Internship/workforce training programs with local educational institutions San Diego HHSA • Managed care plans • San Diego County Mental Health Contractors • Warm hand-offs

FIGURE 10. RESOURCES NEEDED TO MEET NEEDS IDENTIFIED IN KEY INFORMANT INTERVIEWS



SURVEYS

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

HEALTH ACCESS AND NAVIGATION SURVEY

The Health Access and Navigation Survey was developed in partnership with the San Diego County Resident Leadership Academy (RLA)[3, 4]. After comparing results of the RLA's 2014 Community Needs Assessment[5] and with the findings from the HASD&IC 2013 CHNA, access and navigation of health care emerged as a common barrier identified by the San Diego community. The CHNA Committee collaborated with the RLAs to design a survey tool that could identify specific barriers residents face when they try to access health care services. RLA leaders agreed to disseminate the health access and navigation survey to residents in their neighborhoods

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

FIGURE 11. TOP FIVE BARRIERS TO ACCESSING HEALTH CARE

As the number of individuals who have health insurance in the nation and within San Diego County has increased, so has the importance of helping people understand how to obtain health insurance, use health insurance, and access care that is appropriate for their health needs. Residents' ability to access health care is a critical first step toward improving the overall health of San Diego community. Table 7 shows the top five barriers countywide. 'Understanding health insurance' was the top cited barrier in all regions with the exception of East region which found 'follow-up care and/or appointments' to be the number one barrier. Within each overarching barrier participants were asked to choose the reasons those barriers were a problem in accessing care. For example, within the overarching barrier 'Understanding health insurance,' the top two reasons this barrier was cited as a problem were 'confusing insurance terms' and 'how does Covered California apply to me?'. Findings by region are also available in Table 39 in the full report.

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

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

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

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

TABLE 6. DEMOGRAPHIC INFORMATION, HEALTH ACCESS AND NAVIGATION SURVEY, HASD&IC 2016 CHNA

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

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

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

TABLE 7. HEALTH ACCESS AND NAVIGATION SURVEY RESULTS, HASD&IC 2016 CHNA

Five Most Troublesome Barriers to Accessing Health Care[6]

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

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

Specific Challenges Identified by San Diego Residents

1. Understanding health insurance	Total Respondents	
	n	%
Confusing insurance terms	104	59.4%
How does Covered California apply to me?	92	52.6%
Total**	**175**	

2. Getting health insurance	Total Respondents	
	n	%
How to pick a plan	92	62.2%
Eligibility requirements & documentation status	79	53.4%
Total**	**148**	

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

4. Knowing where to go for care	Total Respondents	
	n	%
When to use the ED vs urgent care vs clinic	80	56.3%
No primary care doctor	59	41.5%
Total**	**142**	

5. Follow-up care and/ or appointments	Total Respondents	
	n	%
Lack of instructions about necessary follow up care	50	45.9%
Lack of understanding about next steps	47	43.1%
Total**	**109**	

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

[6] Details and data by region in Table 39.

SAN DIEGO COUNTY HHSA SURVEY

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

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

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

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

TABLE 8. COLLABORATIVE SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY SURVEY RESULTS, 2016

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

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

BEHAVIORAL HEALTH DISCUSSIONS

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

Meetings focused on behavioral health were targeted to solicit feedback from stakeholders including patient advocates as well as representatives from hospitals, clinics, County HHSA, smaller behavioral or mental health facilities, and health plans. The behavioral health discussion template was developed based on hospital discharge data analysis and incorporated a synthesis of the community partner discussion data. A summary of data as it relates to behavioral health needs was provided to the behavioral health experts prior to gaining their feedback. Three behavioral health discussions took place between December 2015 and January 2016. The combined total number of attendees was roughly 58 people between the two meetings.

When participants were asked to respond to the hospital data presented, there was general agreement in the findings at both the Hospital Partners and the Healthy San Diego Behavioral Health Workgroup meetings (see Appendix E for the hospital discharge data presented during meetings). There was consensus that the high rates of psychotic discharges in ages 25 to 44 were likely linked to underlying substance abuse problems. Although

participants agreed with the findings, it was pointed out that there were additional important conditions that may not come to the surface because of the way hospital data is coded. Because the data is used for billing purposes, physical conditions may often be coded first and potentially underrepresent the prevalence of underlying behavioral health issues. Most notably missing from the data were developmental disorders. The group also pointed out the importance of data trends. In particular, it was pointed out that in recent years participants have been seeing a significant increase in meth-amphetamine discharges (over 100%).

The Alpine Special Treatment Center[7], an important provider of care to a particularly vulnerable portion of the San Diego population, referenced a number of additional challenges that should be noted including lack of placements available once patients were ready to leave their facility, overburdened case managers, and difficulty in managing the disability application process. Another frequent challenge cited by the staff at the Alpine Special Treatment Center was the physical health problems of their patients. Discussion participants stated that behavioral health is frequently associated with other chronic conditions and that the majority of their patients fit the diagnosis for all four of the top health needs. Many patients have such serious physical health conditions that they must be sent to facilities that can treat higher acuity patients, though these facilities are generally less appropriate for treatment of their behavioral health conditions. Discussion participants stated that North County in particular lacked available resources to transition their patients. Sufficient step down facilities and improved communication between hospitals, behavioral health facilities, and community based services were some important strategies to success. Understanding the appropriate number and type of facilities needed to rotate this critical population through the health system effectively was said to be key in order to adequately treat patients across the continuum of care.

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

2016 CHNA PRIORITIZATION OF THE TOP FOUR IDENTIFIED HEALTH NEEDS

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

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

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

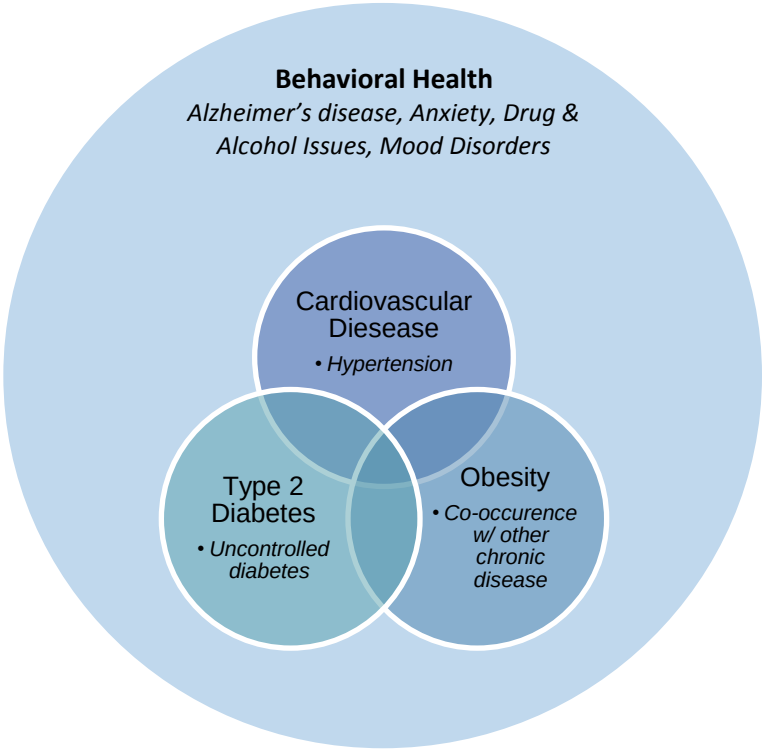
TABLE 9. RANKING RESULTS FROM QUANTITATIVE DATA COLLECTION AND COMMUNITY INPUT, HASD&IC 2016 CHNA

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

The CHNA Committee identified behavioral health as the number one health need in San Diego County. In addition, cardiovascular disease, diabetes, and obesity were identified as having equal importance due to their interrelatedness. Health needs were further broken down into priority areas due to the overwhelming

agreement among all data sources and in recognition of the complexities within each health need. Within the category of behavioral health, Alzheimer's disease, anxiety, drug and alcohol issues, and mood disorders are significant health needs within San Diego County. Among the other chronic health needs, hypertension was consistently found to be a significant priority area related to cardiovascular disease, uncontrolled diabetes was an important factor leading to complications related to diabetes, and obesity was often found to co-occur with other conditions and contribute to worsening health status. The impact of the top health needs differed among age groups; with type 2 diabetes, obesity, and anxiety affecting all age groups, drug and alcohol issues affecting teens and adults, and Alzheimer's disease, cardiovascular disease, and hypertension affecting older adults.

FIGURE 12. 2016 CHNA TOP HEALTH NEEDS



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

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

SOCIAL DETERMINANTS OF HEALTH

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

FIGURE 13. SOCIAL DETERMINANTS OF HEALTH, HASD&IC 2016 CHNA

Food Insecurity & Access to Healthy Food	• Cited most often as a social determinant of health across all community engagement activities. • Lack of access to healthy food poses a challenge that contributes to diabetes and obesity.
Access to Care or Services	• Overarching barriers to access included transportation, language barriers, health literacy, insurance coverage, cost, time, and legal status.
Homeless/Housing issues	• Frequently mentioned as barriers to addressing health needs and improving health status, particularly behavioral health.
Physical Activity	• For youth, concerns included decreased physical education, limited access to gyms and safe spaces for actitivities. • For seniors, lack of excercise was attributed to reduced mobility.
Education/Knowledge	• Educational efforts on behavioral health & stigma reduction, food insecurity awareness and patient, caregiver, & family empowerment are needed to improve health.
Cultural Compentency	• The changing demographics of San Diego County require a culturally competent workforce.
Transportation	• Transportation problems make it difficult to obtain services. • There are often no providers within a reasonable travel distance.
Insurance Issues	• Residents reported challenges understanding, securing and using health insurance, which impede ability to access care.
Stigma	• Frequently mentioned as a barrier that hindered individuals from seeking help with behavioral health. • Also mentioned with reference to seeking food assistance.
Poverty	• Linkages between low-income levels and diabetes, obesity and cardiovascular disease were cited. • Behavioral health issues were mentioned as barriers to employment and financial stability.

COMMUNITY RECOMMENDATIONS

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

FIGURE 14. SUMMARY OF COMMUNITY RECOMMENDATIONS, HASD&IC 2016 CHNA

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

Knowledge/education	Community and cultural competency	Early identification and prevention	Care integration and coordination

Resources that must be developed or increased to address the top health needs are:

Community and cultural competency	Behavioral health services	Integration health/social services/behavioral health systems	After hours urgent care	Worksite wellness

System, policies and environmental changes required to support better health outcomes

Data sharing	Increased awareness of available services	Increased number of psychiatrists and nurse practitioners	Reimbursement for social and supportive services & care management

Collaborations that could improve community health outcomes

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

Although one of the recommendations references the need to add and develop additional services, we want to acknowledge that there are many excellent existing resources available to San Diego County residents. In order to provide an overview of the type and number of resources currently available to address the top health needs, a list of local assets were compiled using on 2-1-1's Directory of Services (Appendix F). 2-1-1 San Diego is an important community resource and information hub. Through its 24/7 phone service and online database, it

helps connect individuals with community, health, and disaster services. Considering that available programs and services continuously change, the community is encouraged to access the most available data through 2-1-1 San Diego.

In addition to citing the resources available through 2-1-1 San Diego, a list of existing health initiatives and public policy efforts was also created. The next phase of this CHNA will likely include an expansion of the current list. (See Table 54 in the report).

NEXT STEPS

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

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

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