Sharp Grossmont Hospital

Community Health Needs Assessment

Fiscal Year 2019

Committed to Improving the Health and Well-Being of Our Community

SHARP Grossmont Hospital

Sharp Grossmont Hospital
Community Health
Needs Assessment
Fiscal Year 2019

Table of Contents

List of Appendices

Preface

Sharp Grossmont Hospital (SGH) prepared this Community Health Needs Assessment (CHNA) for Fiscal Year 2019 (FY 2019) in accordance with the requirements of Section 501(r)(3) within Section 9007 of the Patient Protection and Affordable Care Act (Affordable Care Act) and Internal Revenue Service (IRS) Form 990, Schedule H for not-for-profit hospitals.[1]

Under the Affordable Care Act enacted in March 2010, IRS Code Section 501(r)(3) requires not-for-profit hospitals to conduct a triennial assessment of prioritized health needs for the communities served by its hospital facilities, and to adopt an implementation strategy to address health needs identified as a result of the CHNA.

The Sharp Grossmont Hospital 2019 Community Health Needs Assessment (SGH 2019 CHNA) and FY 2020 – FY 2023 Implementation Strategy received approval from the Sharp Grossmont Hospital Board of Directors on August 20, 2019.

Daniel L. Gross
Executive Vice President, Hospital Operations
Sharp HealthCare

[1] See Section 9007(a) of the Patient Protection and Affordable Care Act (Affordable Care Act), Pub. L. No. 111-148, 124 Stat.119, enacted March 23, 2010. Notice 2011-52.

Acknowledgements

SGH's 2019 CHNA process included the time, effort, insight and contributions of many members of the San Diego community. The SGH 2019 CHNA is built off of the Hospital Association of San Diego & Imperial Counties 2019 Community Health Needs Assessment (HASD&IC 2019 CHNA), which was based on the collaboration of representatives from seven local San Diego hospitals called the CHNA Committee. The CHNA Committee (listed below) actively participated in the HASD&IC 2019 CHNA process, elements of which are described within this report.

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For both the SGH 2019 CHNA and HASD&IC 2019 CHNA processes, the time and expertise devoted by hundreds of community members including community residents, physicians, health care professionals, community health leaders, public health officials, and others who are dedicated to the health and well-being of our community, were essential to develop a comprehensive, collaborative assessment of the health and social needs in San Diego. In particular we are grateful to those patients and community residents who shared their personal insight regarding health care access and challenges to health and well-being.

Sharp HealthCare (Sharp) would like to extend our deepest thanks for the contributions made by all who participated in the 2019 CHNA process. Further, Sharp is committed to providing a CHNA that is valuable to all our community partners, and we look forward to strengthening that value and those community partnerships in the years to come.

Section

1 History & Background

Sharp Grossmont Hospital (SGH) is located at 5555 Grossmont Center Drive in La Mesa, ZIP code 91942.

SGH History

When Grossmont Hospital opened its doors in 1955 on a hilltop in La Mesa, the 100-bed hospital provided care to a population of 70,000 in San Diego's East County. Throughout the decades, the publicly-owned hospital has expanded its facilities and services to meet the growing health care needs of the community it serves, which has now topped nearly 700,000.

In 1989, the first women's health center of its kind in San Diego County (SDC) opened on the medical campus with 48 private rooms equipped with the comforts of home. In 1991, Grossmont Hospital affiliated with Sharp HealthCare (Sharp), becoming Sharp Grossmont Hospital. In 1993, the region's first comprehensive, free-standing cancer center made its debut and became known as the David and Donna Long Center for Cancer Treatment. In 2004, SGH dedicated phase one of the state-of-the-art Emergency Room and Critical Care Center, housing a 43-bed emergency department and a 24-bed intensive care unit. The center was completed and expanded in 2009 with 90 intensive care and medical/surgical beds.

Today, SGH is a 524-bed medical center and the largest hospital in East County — recognized for its excellence in cardiac care, oncology services, orthopedics, rehabilitation, stroke care and women's health. The hospital's emergency room and critical care unit is one of San Diego's busiest — treating more than 100,000 patients each year. SGH is nationally recognized as a Magnet hospital by the American Nurses Credentialing Center for its excellence in nursing practices and quality patient care.

As part of its mission to transform patient care in east SDC, in 2018 SGH opened the Burr Heart and Vascular Center — the first and only dedicated heart and vascular center in the region. SGH constructed the facility to address the increasing need for cardiovascular care in East County (the hospital treats a high volume of acute heart attacks and operates one of the busiest cardiac catheterization labs in the county). The new center is part of the hospital's modernization plan that began in 2006 when East County voters approved Proposition G — a $247 million bond measure sponsored by the Grossmont Healthcare District to address the community's growing need for medical services. Along with community support, generous philanthropists donated more than $13 million toward the new facility, including locals Sandy and Ed Burr after whom it is named. The 60,000 square foot facility includes new cardiac catheterization labs, 3-D imaging technology and hybrid operating rooms, enabling the hospital to expand

capacity, increase surgical capabilities in treating complex heart-related diseases and conditions, and continue to provide leading-edge care.

In 2018, the hospital opened the Care Clinic adjacent to the campus to provide quick care for patients with more immediate minor medical needs.

For a complete listing of the programs and services provided at SGH, please refer to **Appendix A**.

SGH is part of Sharp HealthCare — an integrated, regional health care delivery system based in San Diego, California. The Sharp system includes four acute care hospitals; three specialty hospitals; three affiliated medical groups; 29 medical clinics; six urgent care centers; three skilled nursing facilities; two inpatient rehabilitation centers; home health, hospice and home infusion programs; numerous outpatient facilities and programs; and a variety of community health education programs and other related services. Sharp offers a full continuum of care, including but not limited to emergency and urgent care services, home care, hospice and palliative care, inpatient and outpatient care, primary and specialty care, long-term care, mental health services, and rehabilitation. Sharp also offers individual and group Health Maintenance Organization coverage through Sharp Health Plan.

Sharp serves a population of approximately 3.3 million in SDC and as of September 30, 2018, is licensed to operate 2,084 beds. It is Sharp's mission to improve the health of those it serves with a commitment to excellence in all that it does. Sharp's goal is to offer quality care and services that set community standards, exceed patient expectations and are provided in a caring, convenient, cost-effective and accessible manner. More than 2,700 affiliated physicians and 18,000 employees are dedicated to providing the extraordinary level of care that is called The Sharp Experience.

Please refer to **Appendix B** for a detailed overview of the Sharp system.

Background: Sharp HealthCare CHNA

For the past 20 years, Sharp has been actively involved in a triennial community health needs assessment (CHNA) process. This process began in 1995, in accordance with the requirements of Senate Bill 697 (SB 697), community benefit legislation that requires not-for-profit hospitals in California to file a triennial CHNA that identifies community health needs. Further, the Sharp Grossmont Hospital 2019 Community Health Needs Assessment (SGH 2019 CHNA) responds to more recent Internal Revenue Service (IRS) regulatory requirements that private not-for-profit hospitals conduct and make publicly available a triennial CHNA and corresponding implementation strategy. The implementation strategy identifies and details current or planned strategies intended to address the needs identified in the hospital's CHNA.

SB 697 also requires submission of an annual community benefit report to the Office of Statewide Health Planning and Development (OSHPD) that describes programs and

services provided to address those identified community health needs within their mission and financial capacity, as well as the financial value of those programs and services. To view the most recent Sharp HealthCare Community Benefit Plan and Report, please visit: http://www.sharp.com/about/community/community-benefits-health-needs.cfm.

Beginning in 1995, Sharp participated in a countywide collaborative that included a broad range of hospitals, health care organizations, and community agencies to conduct a triennial CHNA. Findings from the CHNA, program and services expertise of each Sharp hospital, and knowledge of the populations and communities served by those hospitals provide a foundation for community benefit programs and implementation strategies.

With the passing of the Patient Protection and Affordable Care Act, since 2013 Sharp has participated in a countywide CHNA effort under the auspices of the Hospital Association of San Diego & Imperial Counties (HASD&IC) and in contract with the Institute for Public Health (IPH) at San Diego State University (SDSU). Sharp partners with other San Diego hospitals and health systems (the CHNA Committee), on this countywide CHNA, which significantly informs both the process and findings for each of the CHNAs completed by Sharp hospitals.

Although only not-for-profit 501(c)(3) hospitals and health systems are subject to state and IRS regulatory requirements, the 2019 CHNA Committee includes hospitals and health systems who are not subject to any CHNA requirements, but who are deeply engaged in the communities they serve and committed to the goals of a collaborative CHNA.

For the 2019 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 (Chair)
- Sharp HealthCare (Vice Chair)
- Tri-City Medical Center
- University of California (UC) San Diego Health

In Spring 2018, HASD&IC contracted with the IPH at SDSU to provide assistance with the collaborative health needs assessment that was officially called the Hospital Association of San Diego & Imperial Counties 2019 Community Health Needs Assessment (HASD&IC 2019 CHNA). The purpose of the collaborative HASD&IC 2019 CHNA was to identify, understand and prioritize the health-related needs of the people of SDC. This was accomplished through two types of data collection: (1) qualitative data

was collected through a community engagement process designed to solicit in-depth feedback from residents in high-need neighborhoods and from local health experts and leaders; and (2) quantitative data was collected by extracting and analyzing data from secondary data sources.[2]

The results of the collaborative HASD&IC 2019 CHNA process significantly informed the SGH 2019 CHNA and was further supported by additional data analysis and community engagement activities specific to the community served by SGH. The findings of the SGH 2019 CHNA will be used to help guide current and future community health programs and services at SGH, particularly for high need community members. In addition, SGH will develop and make publicly available its three-year implementation strategy to address the needs identified through the SGH 2019 CHNA process.

2016 CHNA: Progress Update

Upon completion of the Hospital Association of San Diego & Imperial Counties 2016 Community Health Needs Assessment (HASD&IC 2016 CHNA), the CHNA Committee reviewed all data in accordance with their own patient communities, determined their capacity to address the identified health needs, and evaluated opportunities for next steps. This process guided the development of Sharp's implementation strategies, which detail the programs, services and collaborations designed to address identified community health needs. Sharp hospital implementation strategies are updated annually and are available to the public on Sharp.com at: https://www.sharp.com/about/community/community-benefits/health-needs-assessments.cfm.

Notable implementation strategies and program developments for SGH since the completion of the Sharp Grossmont Hospital 2016 Community Health Needs Assessment (SGH 2016 CHNA) are described in **Table 1** below.

Table 1: Implementation Strategy Updates, SGH 2016 CHNA

SELECT 2016 SGH IMPLEMENTATION STRATEGY UPDATES, BY IDENTIFIED NEED
ACCESS TO CARE
• Continuation of multiple programs within Sharp Patient Access Services to offer financial support and programs for patients needing advanced guidance on available funding options • Continue to facilitate CalFresh (SNAP) applications for patients through Patient Access Services • Continue to provide Project HELP funds for pharmaceuticals, transportation vouchers and other needs for economically disadvantaged patients • Continue to offer the Care Transitions Intervention program, including proactive connection to 2-1-1 San Diego Health Navigation for vulnerable, under- and uninsured patients

[2] The Centers for Disease Control & Prevention (CDC) defines secondary data as data that has been collected by another entity or for another purpose. Common sources for secondary data include the U.S. Census Bureau, California Health Interview Survey (CHIS), and OSHPD.

- Creation of a Sharp Homeless Task Force (internal) led by Sharp Integrated Care Management, including hospital (SGH) leaders. Have since developed a robust electronic platform to track the number of homeless patients currently within Sharp, while actively pursuing new opportunities for community partnership and/or collaboration to improve outcomes for homeless patients

BEHAVIORAL HEALTH

- Continue comprehensive behavioral health inpatient and outpatient programs for East County adults and older adults with acute or persistent psychiatric disorders
- Continue to provide a dedicated psychiatric assessment team in the emergency department and acute care setting

CANCER

- Continued provision of cancer patient navigator programs to assist cancer patients in San Diego's east region; includes facilitation of connection to community resources and special focus on both the clinical and social service needs of community members impacted by cancer
- Continued provision of cancer education, screening and support programs – both onsite as well as out in the community in support of cancer awareness events and community-based organizations

CARDIOVASCULAR DISEASE (includes CEREBROVASCULAR)

- Continued provision of community education classes and support groups for community members impacted by heart disease, stroke and congestive heart failure; includes community education on risk factors and preventive care to maintain cardiovascular health; resources provided both onsite and at community sites throughout San Diego's east region
- Continued participation in the San Diego County Stroke Consortium

DIABETES

- Continue to provide diabetes education through partnerships with community clinics and participation in educational forums, health fairs and events throughout San Diego's east region
- Continue to provide diabetes education to high-risk, underserved pregnant women with diabetes through the California Diabetes and Pregnancy Program's Sweet Success Program
- Continue to provide language-appropriate and culturally sensitive diabetes educational materials

OBESITY

- Continue to provide free education and screenings (body composition, blood pressure) that address risk factors for obesity to community members in San Diego's east region

SENIOR HEALTH (beginning in 2019, AGING CONCERNS)

- Continue to provide seasonal flu vaccinations at community sites for seniors with limited mobility and access to transportation, as well as for high-risk adults (e.g., low income, refugee, chronically ill community members)
- Continue provision of daily telephone reassurance calls with East County individuals (often elderly and home-bound) in rural and suburban settings who are at risk for injury or illness
- Continue to host and collaborate with community organizations to provide a variety of senior health education and screening programs, in order to raise awareness, identify risk factors, and connect seniors to helpful resources
- Maintain active relationships with community organizations serving seniors throughout San Diego
- Increase the availability of education, resources and support to community members with life-limiting illness and their loved ones; also includes bereavement support
- Continue to provide Advance Care Planning education to health care professionals, students, community-based organizations as well as individual consultations to community members and caregivers
- Continue collaboration with community, state and national organizations to develop and implement appropriate services and support for the needs of the aging population and their caregivers

For complete details on the progress of programs developed by SGH in response to the 2019 CHNA findings, please refer to the SGH FY 2020 – FY 2023 Implementation Strategy included in **Appendix C** as well as online at: http://www.sharp.com/about/community/health-needs-assessments.cfm.

HASD&IC 2016 CHNA: Phase 2

In addition, the HASD&IC 2016 CHNA Committee conducted a Phase 2, which included gathering community feedback on the HASD&IC 2016 CHNA process and strengthening partnerships around the identified health needs and social determinants of health (SDOH). Two community surveys were conducted — the first in the fall of 2016 and the second in the summer of 2017. The results of these community surveys helped guide individual hospital programs and greatly informed the design of the 2019 CHNA process.

The survey in fall of 2016 sought to gather feedback on the identified top four health needs and the top 10 SDOH that were identified in the 2016 CHNA. In addition, organizations were asked about their screening methods for behavioral health issues and methods for identifying SDOH.

Of the 132 respondents that completed the survey, 30 worked in hospitals or hospital-based settings, while the remaining 102 respondents self-identified as working for a range of entities including but not limited to community clinics, not-for-profits, community-based organizations, local government, and health insurance plans. Key findings from the survey included:

- Nearly 98% of respondents agreed (33.3%) or strongly agreed (64.4%) that behavioral health, cardiovascular disease, type 2 diabetes, and obesity are the top health needs of communities facing inequities within SDC.

- 99% of respondents agreed (33.0%) or strongly agreed (66.1%) that the top ten SDOH identified by the 2016 CHNA represented the greatest barriers for communities facing inequities within SDC.

- Nearly 72% of respondents are likely (40.0%) or very likely (31.8%) to use the findings and/or data that resulted from the CHNA to help inform their programs in the grant writing process.

A second community feedback survey was conducted in the summer of 2017. Community feedback was gathered in order to understand how the health and social needs of communities facing inequity had changed over the past year. Feedback was collected in several key areas, including:

1. How has access to care changed over the past 12 months.
2. Ways that hospitals can work more effectively with community organizations to ensure that patients are treated in the most appropriate setting.

3. How are patients'/clients' concerns about their immigration status impacting their access to needed health care.
4. Given the federal policies and budget cuts that are under consideration, what are the greatest challenges in the community's ability to address SDOH.

The full results of the HASD&IC 2016 CHNA Phase 2 can be found on the HASD&IC website, https://hasdic.org/.

Lastly, in 2017, the HASD&IC Board of Directors asked the CHNA Committee to conduct a focused analysis of the challenges to treating behavioral health patients in San Diego. The CHNA Committee adopted a methodology similar to 2013 and 2016 CHNAs that used focus groups, key informant interviews, and hospital discharge data. Issues examined included pre-acute, acute, and post-acute services and the impact of SDOH on access and outcomes. Throughout the interviews and focus groups, the most consistent theme was that patients are unable to access or are continuously delayed in accessing needed behavioral health services at every point across the continuum. The analysis found that even when clinical services are available, patients face many challenges to successfully managing their behavioral health conditions on their own. SDOH were identified as the most frequent barriers to creating a safe discharge plan. Please see the full report for the complete list of findings and recommendations — 2018 HASD&IC Behavioral Health Analysis Summary Report: available at https://hasdic.org/key-issues/.

Sharp 2016 CHNA: Phase 2

Sharp also conducted a 2016 CHNA Phase 2 analysis in contract with the IPH similar to but distinct from the HASD&IC 2016 CHNA Phase 2. Sharp's 2016 CHNA Phase 2 process was conducted from December 2016 through December 2017. Sharp's 2016 CHNA Phase 2 consisted of a deeper analysis of the Sharp 2016 CHNA findings through follow-up with community partners and Sharp staff/community members who participated in Sharp's 2016 CHNA process. Please refer to **Appendix D** for detailed findings of the Sharp 2016 CHNA Phase 2 process.

In addition, an analysis of programs in Sharp's implementation strategies (conducted as part of the HASD&IC 2016 CHNA Phase 2) combined with findings from Sharp's 2016 CHNA Phase 2 contributed to the development of a new document for community members — the Sharp CHNA Community Guide. The Sharp CHNA Community Guide was developed to provide community members with a more user-friendly document to learn about Sharp's CHNA process, findings and implementation strategy programs. The Sharp CHNA Community Guide also clearly identifies and connects the health and social needs addressed through Sharp hospital programs included in the implementation strategies. In addition, the Sharp CHNA Community Guide includes a direct link for community members to provide feedback on Sharp's CHNA process.

The most current (2016) Sharp CHNA Community Guide is publicly available on Sharp.com at: https://www.sharp.com/about/community/community-benefits/health-

needs-assessments.cfm. Please refer to **Appendix E** for the Sharp CHNA Community Guide developed in 2016. An updated Sharp CHNA Community Guide will be available in 2020.

Findings from both the Sharp and HASD&IC 2016 CHNA Phase 2 processes provided essential guidance for the Sharp (including SGH) and HASD&IC 2019 CHNAs, the processes and findings of which are detailed in the following pages.

Section

2 Executive Summary

Introduction and Background

Sharp HealthCare (Sharp) has been a long-time partner in the process of identifying and responding to the health needs of the San Diego community. This partnership includes a broad range of hospitals, health care organizations, and community agencies that have worked together to conduct triennial Community Health Needs Assessments (CHNAs) for more than 20 years. Previous collaborations among not-for-profit hospitals and other community partners have resulted in numerous well-regarded CHNA reports. Sharp hospitals, including Sharp Grossmont Hospital (SGH), base their community benefit and community health programs on both the findings of these needs assessments and the combination of expertise in programs and services offered and the knowledge of the populations and communities served by each Sharp hospital.

The Sharp Grossmont Hospital 2019 Community Health Needs Assessment (SGH 2019 CHNA) examines the health needs of the community members it serves in San Diego County (SDC). SGH prepared this CHNA for Fiscal Year 2019 (FY 2019) in accordance with the requirements of Section 501(r)(3) within Section 9007 of the Patient Protection and Affordable Care Act (Affordable Care Act) enacted in March 2010, and Internal Revenue Service (IRS) Form 990, Schedule H for not-for-profit hospitals. SGH's 2019 CHNA process and findings are based on the collaborative Hospital Association of San Diego and Imperial Counties 2019 Community Health Needs Assessment (HASD&IC 2019 CHNA) process and findings for SDC.

The HASD&IC 2019 CHNA is implemented and managed by a standing CHNA Committee comprised of representatives from seven hospitals and health systems. Sharp is an integral hospital partner in the HASD&IC 2019 CHNA. This Committee reports to the HASD&IC Board of Directors who provide policy direction and ensure that the interests of all member hospitals and health systems are met. HASD&IC contracts with the Institute for Public Health (IPH) at San Diego State University (SDSU) to perform the needs assessment. The HASD&IC 2019 CHNA Committee includes representatives from the following San Diego hospitals and health care systems:

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

The process and findings of the collaborative HASD&IC 2019 CHNA significantly informed the SGH 2019 CHNA and was further supported by additional data analysis and community engagement activities specific to the community served by SGH. The findings of the SGH 2019 CHNA will be used to help guide current and future community health programs and services at SGH, particularly for high need community members. In addition, SGH will develop and make publicly available, its three-year implementation strategy — a federally-required written strategy to address the needs identified through the SGH 2019 CHNA process.

The CHNA is considered adopted once it has been made widely available to the public. In addition, the CHNA and the implementation strategy must be approved by an authorized governing body of the hospital facility.

2019 CHNA Objectives

The 2019 CHNA processes (HASD&IC and Sharp) built on the results of the 2016 CHNA and included three types of community engagement efforts: focus groups with residents, patients and their family members, community-based organizations, service providers, and health care leaders; key informant (KI) interviews with health care experts; and online surveys for residents, patients and stakeholders. In addition, the CHNA included extensive quantitative analysis of national and state-wide data sets, SDC emergency department (ED) and inpatient hospital discharge data, community clinic usage data, county mortality and morbidity data, and data related to social determinants of health (SDOH). These different approaches allowed for the capability to view community health needs from multiple perspectives.

Specific objectives of the 2019 CHNA process included:

- To identify, understand and prioritize the health-related needs of the people of SDC, especially those community members served by Sharp.
- Provide a deeper understanding of barriers to health improvement in SDC and to inform and guide local hospitals in the development of their programs and strategies that address identified community health needs.
- Build on and strengthen community partnerships established through the 2016 CHNA processes.
- Obtain deeper feedback from and about specific vulnerable populations in SDC.
- Align with national best practices around CHNA development and implementation, including the integration of health conditions with SDOH.

Community Defined

For the purposes of the collaborative HASD&IC 2019 CHNA, the study area is the entire County of San Diego due to a broad representation of hospitals in the area. More than three million people live in socially and ethnically diverse SDC. Information on key demographics, socioeconomic factors, access to care, health behaviors, and the physical environment can be found in the full HASD&IC 2019 CHNA report at: https://hasdic.org/2019-chna/.

The community served by SGH includes the entire east region of SDC, including the sub-regional areas of Jamul, Spring Valley, Lemon Grove, La Mesa, El Cajon, Santee, Lakeside, Harbison Canyon, Crest, Alpine, Laguna-Pine Valley and Mountain Empire. Approximately 5% of the population lives in remote or rural areas of this region. **Table 2** below presents the ZIP codes where the majority of SGH patients reside. As the majority of SGH's primary communities are in SDC's east region, CHNA demographics provided at the regional level focus on SDC's east region, for the most accurate reflection of the community served by SGH.

Table 2: Primary Communities Served by SGH

ZIP Code	Community
91941	La Mesa
91942	La Mesa
91945	Lemon Grove
91977	Spring Valley
92019	El Cajon
92020	El Cajon
92021	El Cajon
92040	Lakeside
92071	Santee
92114	Encanto

Source: Centricity HPA via Merlin (internal data warehouse), Sharp HealthCare, FY 2018.

Recognizing that health needs differ across the region and that socioeconomic factors impact health outcomes, SGH's 2019 CHNA process utilized the Dignity Health Community Need Index (CNI) to identify communities with the highest level of health disparities and needs. **Table 3** below presents primary communities (by ZIP code) served by SGH that have especially high need based on their CNI score.

Table 3: High-Need Primary Communities Served by SGH, CNI Score > 4.0

ZIP Code	Community
91945	Lemon Grove
91977	Spring Valley
92020	El Cajon
92021	El Cajon
92114	Encanto

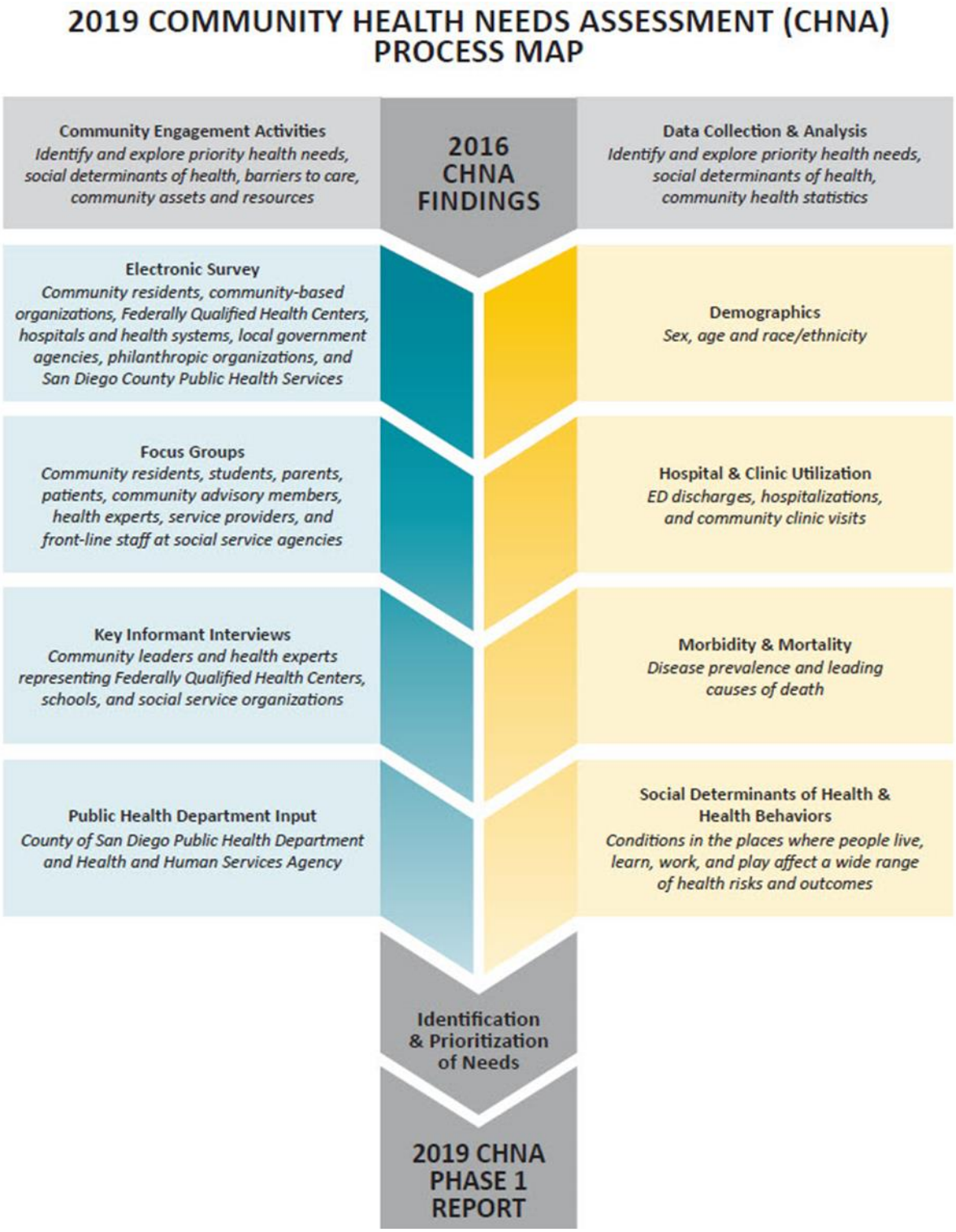
Source: Dignity Health Community Need Index. 2018.

Methodology

The HASD&IC 2019 CHNA process and findings significantly informed the SGH 2019 CHNA process and as such are described as applicable throughout this report. For complete details on the HASD&IC 2019 CHNA process, please visit the HASD&IC website at: https://hasdic.org/2019-chna/ or contact Lindsey Wade at lwade@hasdic.org.

For the HASD&IC 2019 CHNA, quantitative analyses of publicly available data provided an overview of critical health issues across SDC, while qualitative analyses of feedback from the community provided an appreciation for the experiences and needs of San Diegans. The CHNA Committee reviewed these analyses and applied a pre-determined set of criteria to them to prioritize the top health needs in SDC. This process is represented in **Figure 1** below.

Figure 1: HASD&IC 2019 CHNA – Process Map



Quantitative/Secondary Data

Quantitative data were drawn from several public sources to support the HASD&IC and SGH 2019 CHNAs. Data from the Dignity Health CNI and the Public Health Alliance of Southern California's Healthy Places Index were used to identify geographic communities in SDC that were more likely to be experiencing health inequities, which guided the selection of communities/individuals for community engagement activities (described below), as well as the development of community engagement questions.

Hospital discharge data exported from SpeedTrack's California Universal Patient Information Discovery (CUPID) application were used to identify current and three-year trends in primary diagnosis discharge categories and were stratified by age and race. This allowed for the identification of health disparities and the conditions having the greatest impact on hospitals and health systems in SDC.

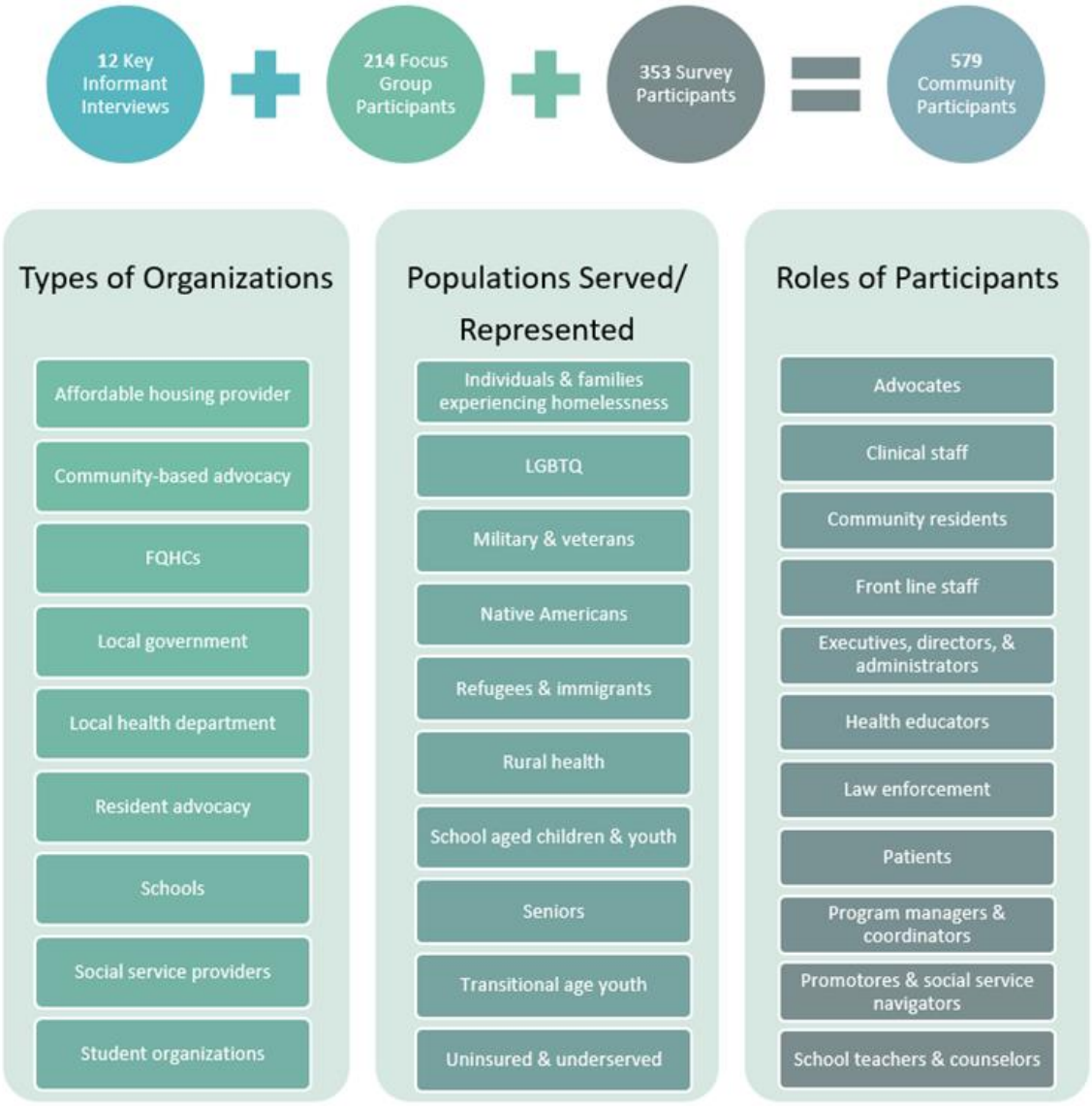
Data from national and statewide data sets were analyzed including SDC mortality and morbidity data, and data related to SDOH. In addition, Kaiser Permanente (KP) consolidated data from several national and statewide data sets related to a variety of health conditions and SDOH in SDC and conducted a comprehensive statistical analysis to identify which SDOH were most predictive of negative health outcomes. KP then created a web-based data platform (chna.org/kp) to post these analyses for use in the CHNA.

Analysis specific to SGH inpatient and ED data was also conducted in addition to the analyses described above. Further, Sharp Cancer Registry Data was also incorporated into the SGH 2019 CHNA quantitative analyses.

Community Engagement

HASD&IC 2019 CHNA community engagement activities included focus groups, KI interviews, and an online survey which targeted stakeholders from every region of SDC, all age groups, and numerous racial and ethnic groups. Collaboration with the County of San Diego Health and Human Services Agency, Public Health Services was vital to this process. A total of 579 individuals participated in the 2019 CHNA: 138 community residents and 441 leaders and experts. Please see **Figure 2** below for details on the types of participants engaged.

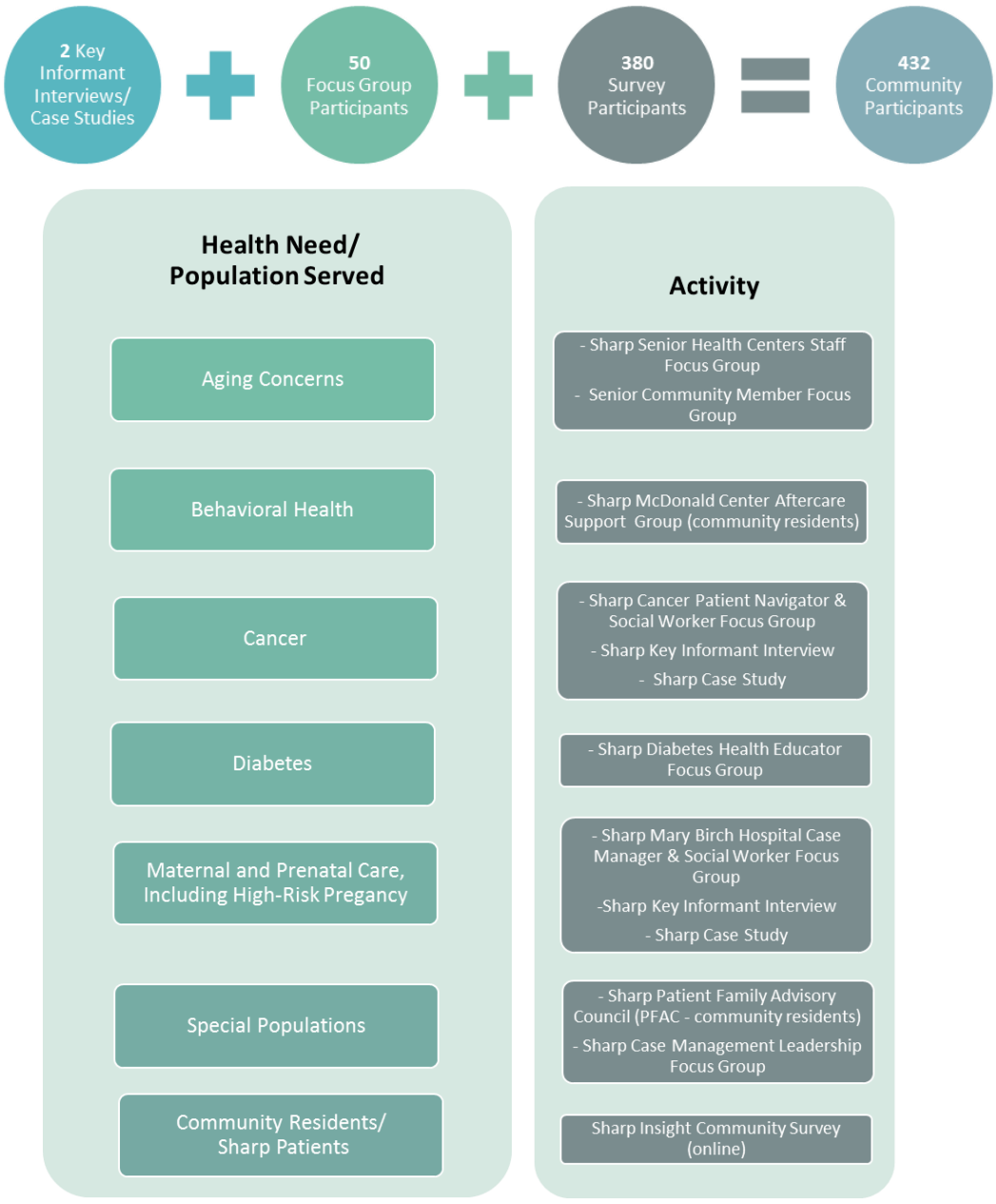
Figure 2: HASD&IC 2019 CHNA – Summary of Community Engagement Activities



In addition to an active role in the collaborative HASD&IC 2019 CHNA process, Sharp contracted separately with the IPH at SDSU to conduct a number of community engagement activities to collect input specifically from Sharp providers as well as from patients and community members served by Sharp hospitals. This input focused on behavioral health, cancer, diabetes, maternal health and prenatal care, senior health (now termed aging concerns), and the needs of highly vulnerable patients and community members. These additional efforts included focus groups and KI interviews involving 50 Sharp providers and 14 patients/community members. Further, IPH created a case study with the intent of representing a “typical” patient experience within Sharp. The case studies focused specifically on breast cancer and high-risk pregnancy. Data collected during the community engagement activities and from literature reviews supported development of the case studies.

Lastly, the SGH 2019 CHNA community engagement process included a robust online survey conducted through the Sharp Insight Community. The Sharp Insight Community is a private online environment for Sharp patients and their families, community members, Sharp employees, and Sharp-affiliated physicians. The 2019 CHNA Sharp Insight Community online survey sought to obtain feedback on the top health and social needs faced by SDC community members, as well as assess their awareness of community outreach programs offered by Sharp. The online survey also provided participants the opportunity to provide specific suggestions for Sharp to improve community health and well-being. A total of 380 community members completed the online survey. **Figure 3** below summarizes SGH 2019 CHNA community engagement:

Figure 3: SGH 2019 CHNA – Summary of Community Engagement Activities



Prioritization of 2019 Health Needs

The CHNA Committee collectively reviewed the quantitative and qualitative data and findings. Several criteria were applied to the data to determine which health conditions were of the highest priority in SDC. These criteria included: the severity of the need; the magnitude/scale of the need; disparities or inequities; and change over time. Those health conditions and SDOH that met the largest number of criteria were then selected as top priority community health needs.

As the HASD&IC 2019 CHNA process included robust representation from the communities served by SGH, this prioritization process was replicated for the SGH 2019 CHNA.

Findings: Top 10 Community Health Needs

The 2019 CHNA Committee identified the following as the highest priority community health needs in SDC, (in alphabetical order by SDOH or health condition).

Figure 4: HASD&IC 2019 CHNA – Top 10 Community Health Needs for San Diego County

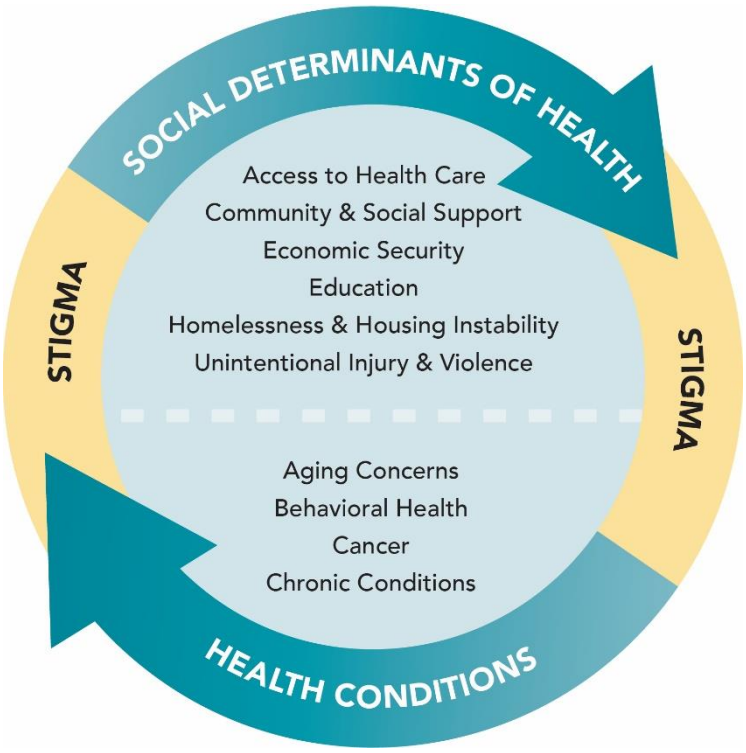


Figure 4 above illustrates the interactive nature of SDOH and health conditions — each impacting the other. In addition, an underlying theme of stigma and the barriers it creates arose across 2019 CHNA community engagement activities. For instance, stigma impacts the way in which people access needed services that address SDOH, which consequentially impacts their ability to maintain and manage health conditions. These same findings were supported through both the quantitative analysis and community engagement activities conducted as part of the SGH 2019 CHNA. In addition, *Maternal and Prenatal Care, including High-Risk Pregnancy*, was also identified as a community health need by the SGH 2019 CHNA.

Description of Identified Needs

Access to health care. Overcoming barriers to health care, such as lack of health insurance and insurance issues, economic insecurity, transportation, the shortage of culturally competent care, fears about immigration status, and the shortage of health care providers emerged as a high priority community need. In addition, specific services were identified as challenging to obtain, including behavioral health care, dental care, primary care, and specialty care.

Aging concerns. Conditions that predominantly affect people who are 65 and older — such as Alzheimer's disease, Parkinson's disease, dementia, falls, and limited mobility — were identified as a high priority health need. Community engagement participants most often described aging concerns in relation to the SDOH, including: transportation, access to fresh food, social isolation and inadequate family support, and economic insecurity.

Behavioral health. Greater access to behavioral health care was cited as a priority health need. Three types of behavioral health care were identified as challenging to access: urgent care services for crisis situations; inpatient psychiatric beds and substance abuse facilities; and transitional programs and services for post-acute care. In addition, several barriers to behavioral health care were named as priorities to address, including a lack of availability of needed services and appointments, insurance issues, logistical issues, such as transportation and time off work, and the inability to pay co-pays and deductibles.

Cancer. Health needs related to cancer were described in relation to the effects on well-being beyond physical health. These include financial, practical, and emotional impacts on individuals and families; these effects are exacerbated by barriers to cancer care.

Chronic conditions. Three chronic conditions were identified as priorities: *cardiovascular disease*, *diabetes*, and *obesity*. Key factors that individuals struggle with to prevent chronic diseases include access to fresh, healthy foods and safe places to exercise and play. In addition, economic issues, transportation to medical care, fears about immigration status, and a lack of knowledge about chronic conditions were named as particular challenges related to the management of chronic conditions.

Community and social support. A high priority for the well-being of San Diego residents is ensuring that individuals have adequate resources and substantial support within their neighborhood. Valuable neighborhood resources include Federally Qualified Health Centers and those that are culturally and linguistically competent. Without adequate support from others, community engagement and community spirit are affected.

Economic security. Economic security was described as a vital social factor impacting every aspect of San Diegans' daily lives. The health of the economically insecure is worsened by food insecurity, chronic stress and anxiety, and reduced capability to manage health needs. Economically insecure community members are at greater risk of poor mental health days, asthma, obesity, diabetes, stroke, cancer, smoking, pedestrian injury and visits to the ED for heart attacks. Low wages and costs associated with housing and childcare were identified as contributors to economic insecurity.

Education. Receiving a high school diploma, having the opportunity to pursue higher or vocational education, being health literate, and having opportunities for non-academic continuing education were identified as important priorities for the health and well-being of San Diego residents. Family stress and a lack of school and community resources were identified as factors underlying low levels of educational attainment.

Homelessness and housing instability. Homelessness and housing instability were identified as critical factors affecting the health of San Diegans. Serious health impacts of these issues were cited, including increased exposure to infectious disease, substantial challenges in chronic disease and wound care management (e.g., asthma), and increased stress and anxiety.

Maternal and prenatal care, including high-risk pregnancy. Maternal and prenatal care were cited as critical components of health and well-being. Maternal health is often complicated by co-existing health conditions including diabetes, preterm pregnancies, substance use, postpartum depression, anxiety, and other mood disorders. In addition, a number of SDOH present obstacles to maternal and prenatal care, such as lack of access to mental health services (even for those patients with insurance), lack of transportation, and economic stress related to childcare and maternity leave.

Unintentional injury and violence. Exposure to violence and neighborhood safety were cited as priority health needs for San Diegans. Neighborhood safety was discussed as influencing residents' ability to maintain good health, while exposure to violence was described as traumatic and impactful on mental health.

Community Assets & Recommendations

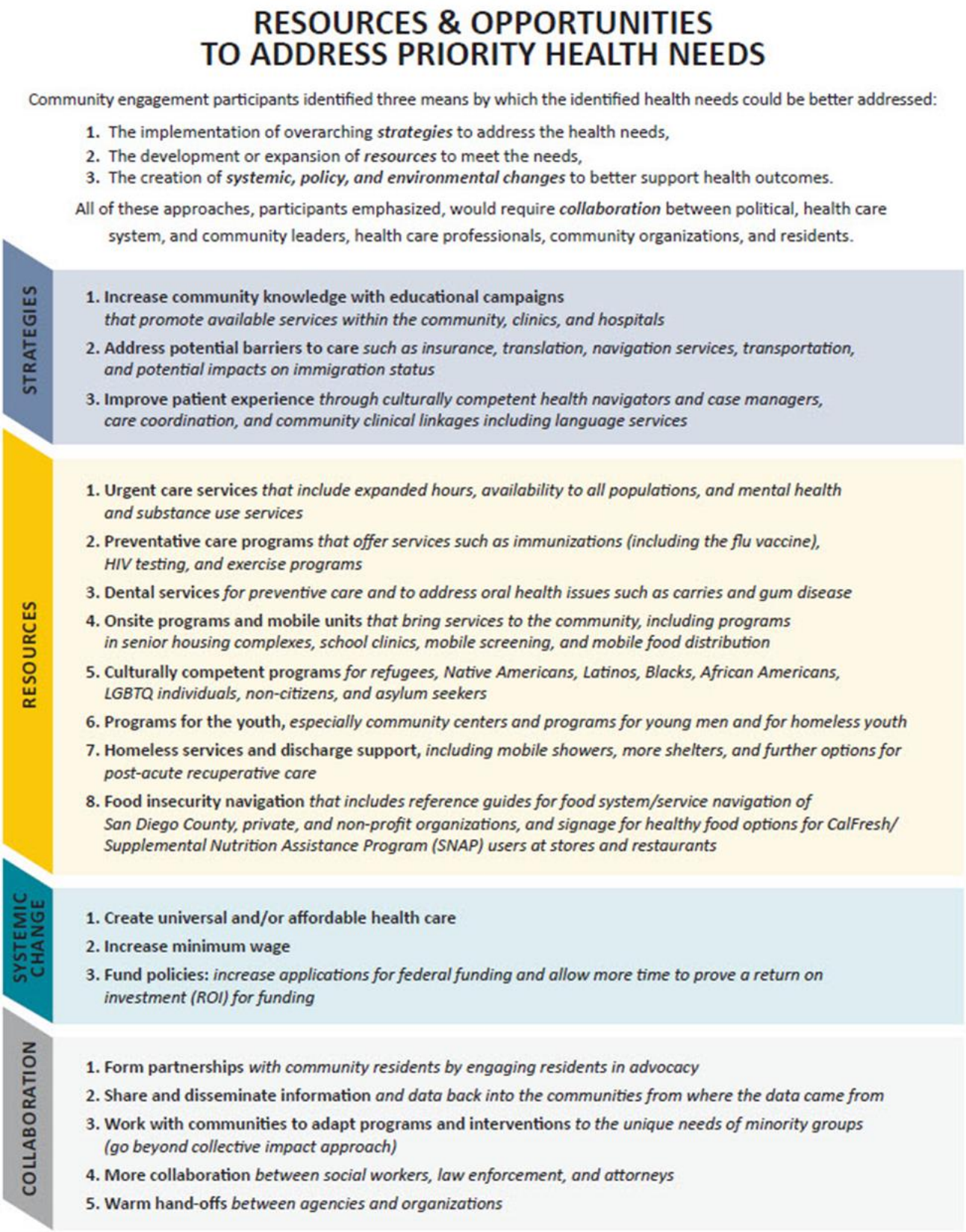
The 2019 CHNA identified many health resources in SDC, including those provided by community-based organizations, government departments and agencies, hospital and clinic partners, and other community members and organizations engaged in addressing many of the health needs identified by this assessment. In addition, 2-1-1 San Diego is an important community resource and information hub that facilitates access to services. Through its 24/7 phone service and online database, 2-1-1 San Diego helps connect individuals with community, health, and disaster services.

2-1-1 San Diego researched their database using relevant search terms for each identified need. The number of resources located for each need are listed below:

- Aging Concerns: 91
- Access to Care: 260
- Behavioral Health: 703
- Cancer: 129
- Cardiovascular Disease: 161
- Diabetes: 144
- Maternal and Prenatal Care, including High-Risk Pregnancy: 251
- Obesity: 298
- Social Determinants of Health: 5,836 (transportation, food access, etc.)

In addition to community input on health conditions and SDOH, a wealth of ideas emerged from community engagement participants about how hospitals and health systems could support additional resources and partner with organizations to help meet San Diego's community health needs. **Figure 5** below outlines types of resources identified by community engagement participants:

Figure 5: HASD&IC 2019 CHNA – Resources & Opportunities



Further, as part of Sharp's 2016 CHNA Phase 2 process, the Sharp CHNA Community Guide was developed in response to the 2016 CHNA and made publicly available on Sharp.com at: https://www.sharp.com/about/community/community-benefits/health-needs-assessments.cfm. The Sharp CHNA Community Guide seeks to provide community members with a user-friendly resource to learn about Sharp's CHNA process and findings, as well as the identified health and social needs addressed through Sharp programs. The Sharp CHNA Community Guide also provides a direct link for community members to provide feedback on Sharp's CHNA. An updated Sharp CHNA Community Guide will be publicly available on Sharp's website during early- to mid- 2020.

Implementation Strategy

SGH developed its FY 2020 – FY 2023 Implementation Strategy to address the needs identified through the 2019 CHNA process for the community it serves. Many of the programs included in the implementation strategy have been in place at SGH for several years. In addition, SGH leadership, Sharp Community Benefit and team members across Sharp are committed to an ongoing evaluation of the programs provided to address the needs of SGH's community members. The SGH FY 2020 – FY 2023 Implementation Strategy is submitted along with the IRS Form 990, Schedule H, and will be publicly available on Guidestar (http://www.guidestar.org/) in the coming months. Categories of programs and activities included in the SGH FY 2020 – FY 2023 Implementation Strategy are summarized in **Table 4** below:

Table 4: SGH FY 2020 – FY 2023 Implementation Strategy Summary

SGH FY 2020 – FY 2023 IMPLEMENTATION STRATEGY SUMMARY, BY IDENTIFIED NEED
ACCESS TO CARE & HEALTH INSURANCE
• Provision of "Public Resource Specialist" position in Sharp Patient Financial Services (PFS) to offer support for underinsured and uninsured patients needing advanced guidance on available funding options • Increase coverage for patients seen in the ED by providing assistance to secure health coverage for all individuals entitled to the benefit; also provide payment options for individuals that chose not to secure coverage or are not currently eligible for health benefits • Provide Project HELP funds for pharmaceuticals, transportation vouchers and other needs for economically disadvantaged patients • Sharp Integrated Care Management (ICM) is working more collaboratively with Sharp PFS to ensure patients are aware of all funding opportunities for which they may be eligible • Collaborate with 2-1-1 San Diego to provide the Care Transitions Intervention (CTI) program which proactively screens high-need patients for SDOH needs, and then proactively refers them to 2-1-1 San Diego's Health Navigation program for connection to community resources • Participation in the one-year pilot/partnership with 2-1-1 San Diego Community Information Exchange (CIE) to increase assessment for social determinant of health needs (SDOH) and connection to community resources addressing those SDOH needs
AGING CONCERNS
• Provide seasonal flu vaccines to seniors with limited mobility and who lack transportation (SGH Senior Resource Center)

- Support the safety net for seniors living alone in SDC's east region through daily telephone reassurance calls (SGH Senior Resource Center)
- Host a variety of community senior health education and screening programs in order to raise health education/awareness, identify risk factors and connect seniors and caregivers to resources (SGH Senior Resource Center); collaborate with Sharp HospiceCare for annual community education events for caregivers
- Maintain active relationships with community organizations serving seniors throughout SDC's east region (board service, financial support, event management, etc.)
- FY 2019 onward: planning community education events for seniors around SDOH (e.g., food insecurity, etc.)

BEHAVIORAL HEALTH

- Provide comprehensive behavioral health programs to adults and older adults in East County with acute or persistent psychiatric disorders. Includes: a dedicated psychiatric assessment team in the ED and acute care; hospital-based outpatient programs that serve adults with a variety of behavioral health issues (e.g., schizophrenia, depression, anxiety, etc.); and specialized inpatient treatment programs designed to address the specific needs and conditions of patients
- Participation in the one-year pilot/partnership with 2-1-1 San Diego Community Information Exchange (CIE) to increase assessment for social determinant of health needs (SDOH) and connection to community resources addressing those SDOH needs

CANCER

- Provide free education and support programs for community members with cancer diagnoses, and their families/loved ones
- Provide ongoing social and psychosocial supports to community member with cancer diagnoses
- Conduct comprehensive community cancer health seminars with health screenings in English and Spanish
- Participation in the one-year pilot/partnership with 2-1-1 San Diego Community Information Exchange (CIE) to increase assessment for social determinant of health needs (SDOH) and connection to community resources addressing those SDOH needs

CARDIOVASCULAR

- Provide free bimonthly cardiac education classes, and monthly congestive heart failure education classes and support groups
- Provide educational sessions on heart disease and cardiovascular health for SDC's east region, as well as blood pressure screenings
- Continued participation in the San Diego County Stroke Consortium
- Through the City of San Diego partnership, provide stroke education and resources to City employees as well as community residents
- Provide weekly support groups for stroke survivors and their families

COMMUNITY & SOCIAL SUPPORT

- Participation in the one-year pilot/partnership with 2-1-1 San Diego Community Information Exchange (CIE) to increase assessment for social determinant of health needs (SDOH) and connection to community resources addressing those SDOH needs

DIABETES

- Increase education of signs and symptoms of diabetes in SDC's east region through participation in community educational forums and health fairs and events
- Provide diabetes education to high-risk pregnant women with diabetes through affiliation with the CA Diabetes and Pregnancy Program's "Sweet Success" Program and in collaboration with community clinics who serve underserved pregnant women with diabetes (in FY 2018, SGH served more than 200 women through this program)
- Collaborate with community clinics (i.e., Family Health Centers of San Diego) to provide diabetes education classes at clinic sites
- Offer and create (as needed) language-appropriate and culturally sensitive diabetes educational materials. To date this has included materials in Arabic, Somali, Tagalog, Vietnamese and Spanish

ECONOMIC SECURITY
• Please see financial support activities listed under Access to Care • Participation in the one-year pilot/partnership with 2-1-1 San Diego Community Information Exchange (CIE) to increase assessment for social determinant of health needs (SDOH) and connection to community resources addressing those SDOH needs • Continue to connect high-risk, underfunded patients and community members to local resources and organizations for low-cost medical equipment and follow-up care. SGH case managers and social workers actively seek durable medical equipment (DME) donations from the community and SGH Volunteer Services, providing nearly 300 DME items in FY 2018
EDUCATION
• Collaborate with local schools to provide opportunities for students to explore and train for a variety of health care professions. Includes: undergraduate and graduate student internships, as well as career pathway programs for high school-age students and younger in SDC's east region (e.g., Health Sciences High and Middle College; Health-Career Summer Institute; Healthcare Towne; I Inspire) • Provide a variety of health and wellness education and services at events and sites throughout the community through the City of San Diego partnership (includes both City employees and residents)
HOMELESSNESS & HOUSING INSTABILITY
• In FY 2019, in conjunction with the passing and signing of SB 1152, Hospital Discharge Processes: Homeless Patients, Sharp HealthCare develop formalized processes, procedures, and protocols to improve care for patients experiencing homelessness. This work includes technology to track and measure care and utilization of individuals experiencing homelessness served within the SHC system. • For FY 2020, Sharp Integrated Care Management (ICM) will use captured data to isolate trends and gaps in care related to homeless populations served. The SB1152 Task Force (formally Homeless Task Force) will use the data to identify plans for future action. • Participation in the one-year pilot/partnership with 2-1-1 San Diego Community Information Exchange (CIE) to increase assessment for social determinant of health needs (SDOH) and connection to community resources addressing those SDOH needs
MATERNAL & PRENATAL CARE, INCLUDING HIGH-RISK PREGNANCY
• Provide education, outreach and support to help meet the unique needs of women, mothers and newborns throughout the community • Collaborate with community organizations to help raise awareness of women's health issues and services, as well as to provide low-income and underserved women in the San Diego community with critical prenatal services • Continue to participate in and partner with several community organizations and advisory boards for maternal and child health
OBESITY
• Provide free education and screenings for community members that address risk factors for obesity; includes screenings for both body mass index and blood pressure
UNINTENTIONAL INJURY & VIOLENCE
• As grant funding allows, offer talks and opportunities within SDC's east region to Health and Science Pipeline Initiative (HASPI) high school students on injury, violence prevention and health care career readiness (ThinkFirst/Sharp on Survival)

Next Steps

SGH is committed to the health and well-being of its community, and the findings of the SGH 2019 CHNA will help inform the activities and services provided by SGH to

improve the health of its community members. These programs are detailed in SGH's FY 2020 – FY 2023 Implementation Strategy, which will be made available online to the community at: http://www.sharp.com/about/community/health-needs-assessments.cfm.

Sharp will continue to work with HASD&IC and IPH as part of the CHNA Committee to develop and implement Phase 2 of the 2019 CHNA. Phase 2 will focus on continued engagement of community partners to analyze and improve the CHNA process, as well as the hospital implementation strategies that address the 2019 CHNA findings. Thus, the CHNA process will evolve to meet the needs of our community members, and support the work of our community partners who also address those identified needs. This will include a deeper dive into the impact of stigma on health, and an exploration of how hospitals may help address this impact.

In addition, in the first year of Sharp's FY 2020 – FY 2023 Implementation Strategy, Sharp hospitals (including SGH), medical groups, and health plans are embarking on a new, innovative partnership with 2-1-1 San Diego's Community Information Exchange (CIE). The CIE includes a longitudinal client record with community member history, access to and utilization of social programs (e.g., housing, food banks, community clinics, etc.), emergency transport data, and much more. The CIE also includes a direct-referral feature, which allows for documented, bi-directional, closed-loop referrals between all CIE partners — including hospitals, clinics, and social service programs. Currently, there are more than 60 community partners (organizations) participating in CIE, and more than 90,000 community members enrolled, with approximately 4,500 new community members enrolled each month. Sharp HealthCare is the first integrated health system — including its hospitals, medical groups and health plan — to wholly participate in the CIE, that is, implementing utilization beyond individual hospitals. By leveraging this technology, and expanding upon this capability for shared data, consistent tracking and robust reporting, the CIE partnership presents an exciting opportunity for Sharp to strengthen and evaluate the impact of clinical-community linkages for its patients and community members in need, particularly regarding SDOH. The data collected in this one-year partnership will inform the value case for continuing with the partnership after the pilot year (Summer 2020).

The complete Sharp Grossmont Hospital 2019 Community Health Needs Assessment will be available for public download by September 30, 2019 at: http://www.sharp.com/about/community/health-needs-assessments.cfm. The report is also available by contacting Sharp HealthCare Community Benefit at: communitybenefits@sharp.com.

Sharp extends our deepest thanks for the contributions made by all who participated in the 2019 CHNA process. Further, Sharp is committed to providing a CHNA that is valuable to all our community partners, and we look forward to strengthening that value and those community partnerships in the years to come.

Section

3 Methodology

The Sharp Grossmont Hospital 2019 Community Health Needs Assessment (SGH 2019 CHNA) draws from and is based on the process and findings of the collaborative Hospital Association of San Diego & Imperial Counties 2019 Community Health Needs Assessment (HASD&IC 2019 CHNA). Sharp HealthCare (Sharp) served as vice-chair of the HASD&IC 2019 CHNA Committee and has actively participated in and collaborated on the HASD&IC-led CHNA process since 2012. The 2019 CHNA process of community engagement effectively began upon completion of the 2016 CHNA in Fall 2016. However, the formal HASD&IC 2019 CHNA contract and process began in late Spring 2017 and concluded in June 2019. Complete details of the methodology and findings of the HASD&IC 2019 CHNA are available at: https://hasdic.org/2019-chna/.

The SGH 2019 CHNA process included additional analyses of SGH discharge data specific to identified health conditions (aging concerns, behavioral health, cancer, cardiovascular disease (CVD), diabetes, unintentional injury, maternal and prenatal care, including high-risk pregnancy, and obesity), as well as patient, staff and community member engagement activities in order to further explore the specific health and social determinants of health (SDOH) needs of the community served by SGH. As such, this section will include details of the SGH 2019 CHNA methods, and, where applicable, elements of the collaborative HASD&IC 2019 CHNA process.

Based on the findings of the 2016 CHNA and recommendations from the community, the SGH and HASD&IC 2019 CHNA processes sought to provide a deeper understanding of barriers to health improvement in San Diego County (SDC) and to inform and guide local hospitals in the development of their programs and strategies that address identified community health needs. These processes also respond to IRS regulatory requirements that tax-exempt hospitals conduct a health needs assessment in the community once every three years. With these goals in mind, the 2019 CHNAs were specifically designed to: build on and strengthen community partnerships established through the 2016 CHNA processes; obtain deeper feedback from and about specific vulnerable populations in San Diego; and align with national best practices around CHNA development and implementation.

The 2019 CHNA processes included analyses of community-identified health conditions as well as SDOH that create health inequities. The latter focus supports the understanding that the burden of illness, premature death, and disability disproportionately affects minority population groups and other underserved community members. Knowledge of regional and population-specific differences is an important factor in understanding and strategizing ways to effectively impact the health of our community.

HASD&IC 2019 CHNA Committee

For the HASD&IC 2019 CHNA, the HASD&IC Board of Directors continued with a CHNA Committee to plan and implement the collaborative CHNA process. The CHNA Committee comprises representatives from seven local participating hospitals and health care systems. Members of the 2019 CHNA Committee are listed below in alphabetical order.

Anette Blatt
Scripps Health
CHNA Committee Chair

Aaron Byzak
Tri-City Medical Center

Lisa Lomas
Rady Children's Hospital – San Diego

David Mier
UC San Diego Health

Joseph Parker
Palomar Health

Jillian Warriner
Sharp HealthCare
CHNA Committee Vice Chair

Lindsey Wright
Kaiser Foundation Hospital – San Diego

In late spring of 2017, 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 (HASD&IC 2019 CHNA). Please see below for the list of individuals from HASD&IC and IPH that led the HASD&IC 2019 CHNA process. Please see **Appendix F** for detailed descriptions of these partnering organizations.

Hospital Association of San Diego & Imperial Counties

Dimitrios Alexiou
President and Chief Executive Officer

Lindsey Wade
Vice President, Public Policy

Ivonne Velazquez
Health Policy Assistant

Institute for Public Health, San Diego State University

Tanya Penn
Senior Research Scientist/Epidemiologist

Martha Crowe
Research Scientist

Lawrence Ayers
Research Assistant

Stephanie Phann
Research Assistant

Nhat Quang Thai
Research Assistant

The HASD&IC 2019 CHNA involved a mixed methods approach using the most current quantitative data available and more extensive qualitative outreach. Throughout the process, the IPH met bi-weekly with the HASD&IC CHNA Committee to analyze, refine, and interpret results as they were being collected.

SGH 2019 CHNA Planning Team

Team members from SGH and Sharp either led or provided insight to, support for, or participation in the 2019 CHNA process for SGH. In addition, Sharp contracted with the IPH in the development and implementation of the SGH 2019 CHNA community engagement activities. Members of the SGH 2019 Planning Team are listed below.

Sharp HealthCare

Jillian Warriner
Manager, Community Benefit and Health Improvement
Sharp HealthCare

Scott Evans
Senior Vice President and Chief Executive Officer
Sharp Grossmont Hospital

Institute for Public Health, San Diego State University

Please see the list above included as part of the HASD&IC 2019 CHNA Committee.

Additional support for the development of the SGH 2019 CHNA was provided by:

Kristine White
Senior Community Benefit Specialist
Sharp HealthCare

Diana Romaya
Community Benefit Specialist
Sharp HealthCare

Emily McCallum
Planning and Community Benefit Analyst
Sharp HealthCare

Sarah Grabe
Strategic Planning and Community Benefit Intern
Sharp HealthCare

Catherine (Cassie) Nordeman
Strategic Planning and Community Benefit Intern
Sharp HealthCare

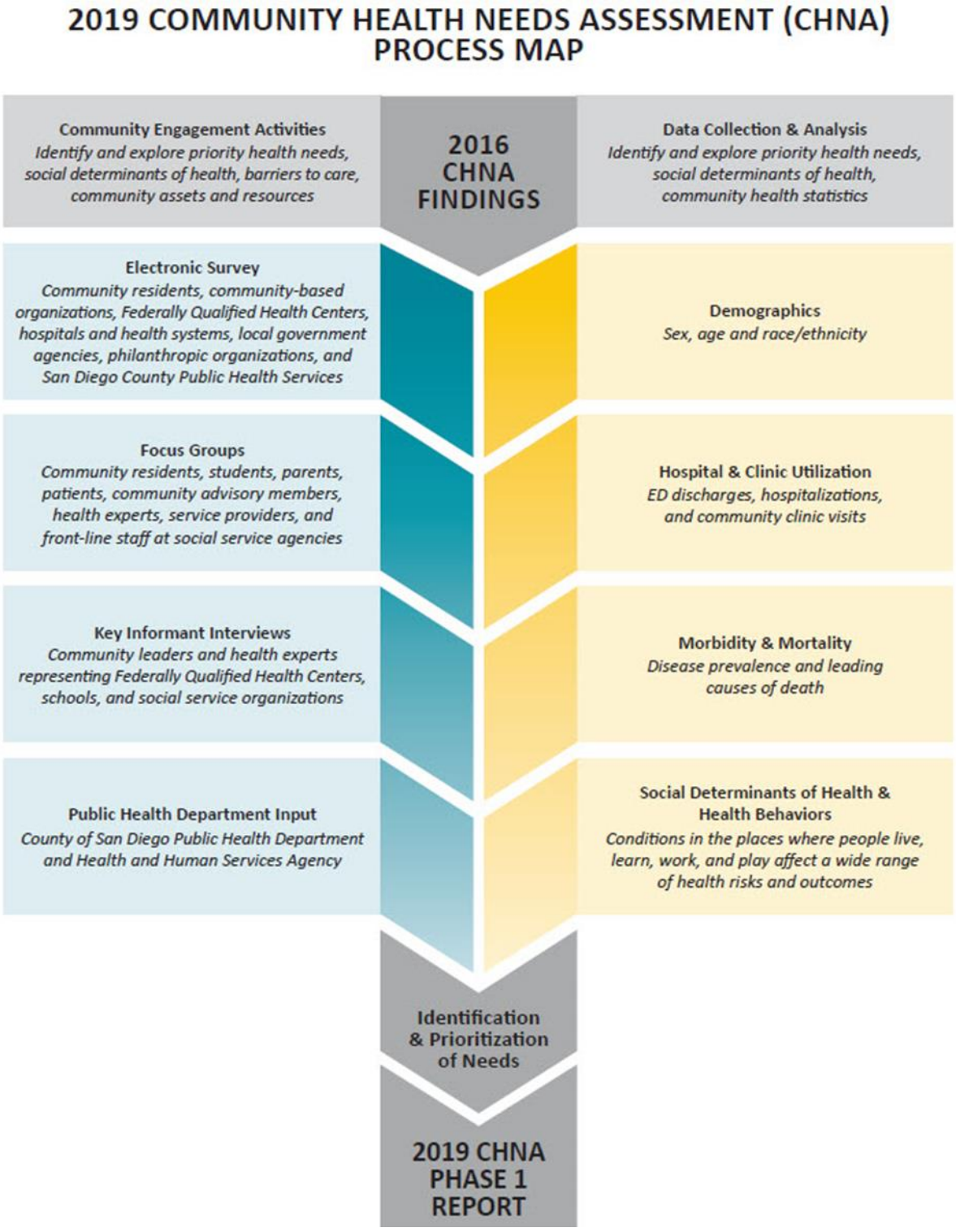
2019 CHNA: Methodology Overview

HASD&IC 2019 CHNA

The HASD&IC 2019 CHNA Committee designed the 2019 CHNA process based on the findings and feedback from the HASD&IC 2016 CHNA. The aim of the HASD&IC 2019 CHNA methodology was to provide a more complete understanding of the identified health needs and associated SDOH in the San Diego community, including barriers connected with those identified needs.

To gain a deep and meaningful understanding of the health-related needs of SDC residents, two primary methods were employed in the HASD&IC 2019 CHNA. First, quantitative analyses were conducted of existing publicly available data to provide an overarching view of critical health issues across SDC. Second, extensive feedback was gathered from community residents, community-based organizations, Federally Qualified Health Centers, hospitals and health systems, local government agencies, philanthropic organizations, and San Diego County Public Health Services through a comprehensive community engagement process to understand the lived experiences and needs of people in the community. Once these analyses were complete, the CHNA Committee reviewed these data and applied an agreed-upon set of criteria to them to prioritize the top health needs in SDC. Please see the process map in **Figure 6** below for an overview of the community engagement activities and quantitative data utilized in the HASD&IC 2019 CHNA. For a summary of the HASD&IC 2019 CHNA community engagement activities, please refer to **Figure 7.**

Figure 6: HASD&IC 2019 CHNA – Process Map



SGH 2019 CHNA

Guided by the same rationale, the SGH 2019 CHNA process also further explored the health needs and SDOH identified in the SGH 2016 CHNA. The HASD&IC 2019 CHNA process provided the foundation for the SGH 2019 CHNA, with additional SGH-specific data analysis and community engagement activities completing the SGH 2019 CHNA process. Quantitative and qualitative data methods for both the HASD&IC and SGH 2019 CHNAs are described within this section.

2019 CHNA Quantitative Data Collection and Analysis

HASD&IC 2019 CHNA

Quantitative data were used for three primary purposes: (1) to describe the SDC community (see **Section 4: Community Defined**); (2) to help plan and design the community engagement process; and (3) to facilitate the "prioritization process" — the identification of the most pressing health needs of SDC residents.

The HASD&IC 2019 CHNA Committee used several sources of data for the quantitative portion of the CHNA, including the:

- Public Health Alliance of Southern California's Healthy Places Index (HPI)
- Community Needs Index (CNI)
- California's Office of Statewide Health Planning and Development (OSHPD) SpeedTrack California Universal Patient Information Discovery (CUPID) application
- Kaiser Permanente (KP) CHNA Data Platform & Analytics (KP CHNA data platform)
- County of San Diego Community Health Statistics

For details on specific sources and dates of the data used, including any data in addition to sources mentioned above, please see the complete HASD&IC 2019 CHNA report at: https://hasdic.org/2019-chna/.

The Public Health Alliance of Southern California's HPI mapping function and the CNI were used to identify the most under-resourced geographic communities in SDC. This information helped guide the 2019 CHNA community engagement process, including selecting communities from which to solicit input and developing relevant and meaningful engagement topics and questions. Please refer to the HASD&IC 2019 CHNA (https://hasdic.org/2019-chna/) for additional details on the HPI tool. Details regarding use of the CNI are included in **Section 4: Community Defined** as well as **Appendix G.**

SpeedTrack's CUPID application, was utilized to export emergency department (ED) and inpatient SDC hospital discharge data. These data were analyzed to determine the most common primary diagnosis categories upon discharge. This analysis provided an

understanding of the specific health conditions that have the greatest impact on hospitals, which helped inform the CHNA Committee about priority health needs. For those health conditions identified as a high priority for the 2019 CHNA, full datasets were extracted and stratified by age and race. Rates were calculated for each group and for each condition per 100,000 in the population. Overall three-year trends from 2014-2016 were also calculated for each health condition as well as for each age group and race within each health condition. This stratification shed light on disparities that potentially impact health in SDC.

In addition, KP consolidated data about a wide variety of health conditions and SDOH. Data were pulled from datasets such as the California Health Interview Survey (CHIS), the Behavioral Risk Factor Surveillance System (BRFSS) Survey, and other national and state-wide data sets. These data included the prevalence of certain health conditions and SDOH in SDC, their relative prevalence to state and national rates and benchmarks, the average resulting reduction of life expectancy (calculated through empirical literature on disability-adjusted life years), disparities across racial and ethnic groups, and alignment with county rankings of top causes of mortality. KP also conducted a comprehensive statistical analysis to identify which SDOH were most predictive of negative health outcomes in SDC census tracts. KP then created a user-friendly, web-based data platform (chna.org/kp) and posted many of their analyses on this platform for use in the HASD&IC 2019 CHNA. These analyses guided the design of survey, interview, and focus group questions and were vital to understanding and prioritizing health needs in SDC. For a complete explanation of resources, please see the HASD&IC 2019 CHNA at: https://hasdic.org/2019-chna/.

SGH 2019 CHNA

Employing similar methodologies, SGH analyzed its own hospital data (OSHPD, 2017) specific to each of the identified health needs from the 2016 CHNA: behavioral health, cancer, CVD, Type 2 diabetes, obesity, and senior health (now termed aging concerns). In addition, hospital data for maternal and prenatal health, including high-risk pregnancy as well as unintentional injury were analyzed. Patients included in the analysis were SDC residents with an ambulatory visit, ED visit, or inpatient discharge at SGH in calendar year (CY) 2017. Please refer to **Appendix H** for the complete SGH data analysis conducted for the 2019 CHNA. Further, SGH cancer registry data were also pulled as part of the quantitative analysis specifically for cancer.

In addition, SGH utilized the CNI to identify the most vulnerable and under-resourced communities within its service area. Further, Sharp overlaid hospital discharge data for CVD, Type 2 diabetes and behavioral health on top of CNI data to analyze the connection between these specific chronic health conditions and under-resourced communities in SDC. This information will further assist in the development of SGH programs to meet community needs in the areas of greatest disparity and inequity. Please refer to **Section 4: Community Defined** for additional detail on SGH's application of CNI data.

2019 CHNA Qualitative Data Collection and Analysis: Community Engagement Activities

HASD&IC 2019 CHNA

For the HASD&IC 2019 CHNA, in collaboration with Kaiser Foundation Hospital – San Diego and Zion, HASD&IC solicited input from the community through three types of efforts:

- Focus groups with community residents, community-based organizations, service providers, and health care leaders
- Key informant interviews with health care experts
- An online survey distributed to community stakeholders and residents

These efforts ensured a rich portrait of community health needs at multiple levels. A key priority of the community engagement process was to solicit input from a wide range of stakeholders so that the sample was as representative of the SDC population as possible. Special efforts were made to include a broad range of community members, including individuals from groups that experience health disparities and service providers who work with those groups. Groups and individuals were invited to participate who had knowledge, information, and expertise relevant to the health needs of the community.

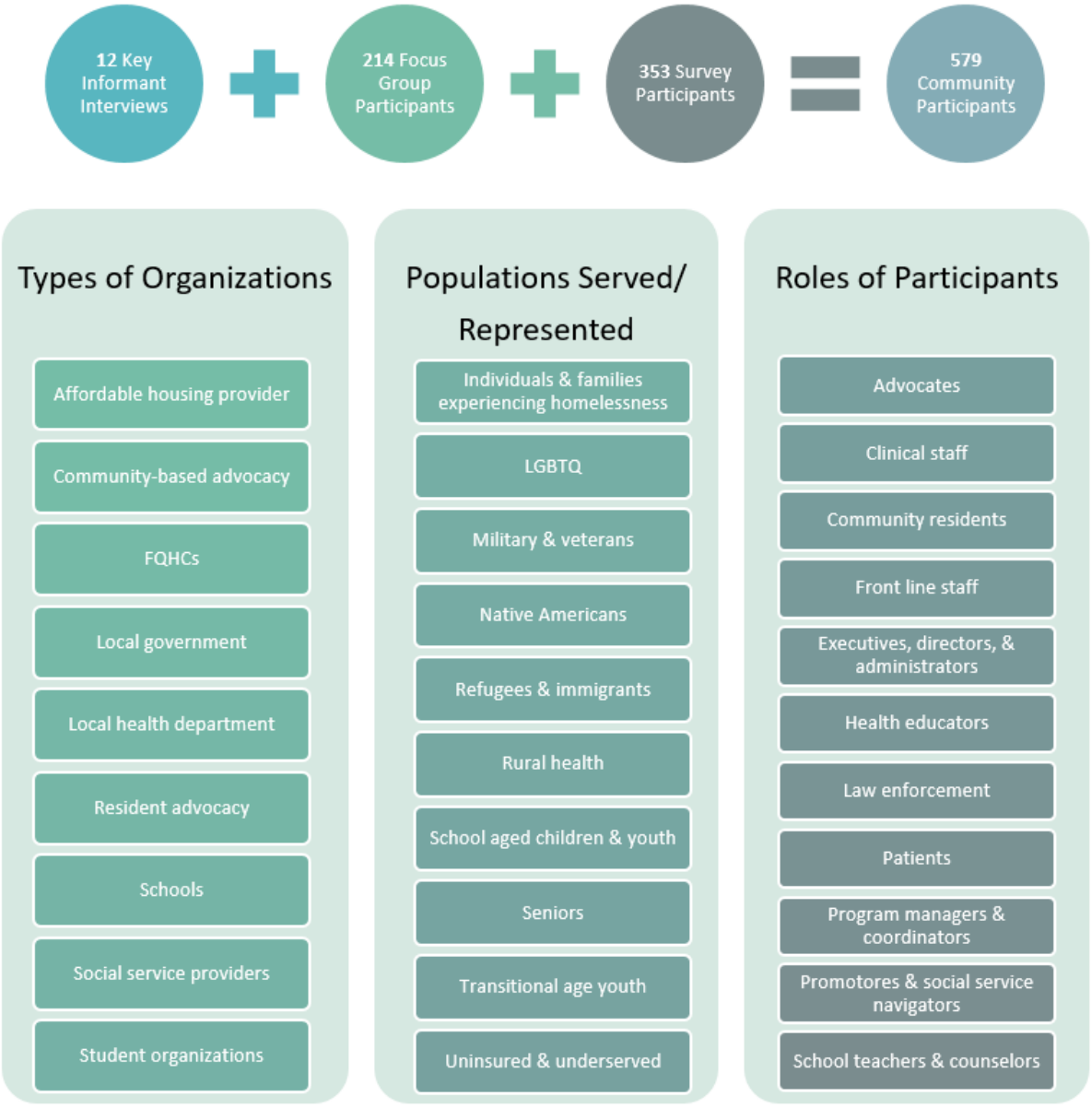
Focus groups and key informant (KI) interviews were utilized to identify and explore priority health needs, SDOH, barriers to care, and community assets and resources. Focus groups and interviews were conducted in a semi-structured manner. Expert facilitators from the IPH employed questions developed and approved by the CHNA Committee to generate discussion about specific community health needs, as well as open-ended questions for broader discussions. Questions varied depending on engagement activity, as well as the expertise and/or specific interests of the person or group participating. The overarching categories explored in these engagement activities included: inequities and disparities; economic security; immigration; housing and homelessness; education; environmental factors; and food insecurity.

The CHNA Committee worked with community partners to plan community engagement activities with stakeholders representing every region of SDC and all age groups. In addition, the CHNA Committee explicitly sought to engage a wide variety of stakeholders representing numerous racial and ethnic groups. Health leaders and a diverse set of advocacy groups and organizations were also recruited for the process. A total of 579 individuals participated in the HASD&IC 2019 CHNA, including: 138 community residents and 441 leaders and experts. Please see **Table 5** and **Figure 7** below for details on the types of participants engaged. A list of individuals who provided input via interview, focus group, or online survey may be found in **Appendix I**.

Table 5: HASD&IC 2019 CHNA – Overview of Community Engagement Participants

Type of Engagement		Participants Engaged		Total Individuals
	# of Engagements	Community Residents	Leaders/Experts	
Focus Groups	18	91	123	214
Key Informant Interviews	12	0	12	12
CHNA Online Survey	-	47	306	353
TOTAL	**30**	**138**	**441**	**579**

Figure 7: HASD&IC 2019 CHNA – Summary of Community Engagement Activities



The HASD&IC 2019 CHNA online survey was used to rank health conditions and SDOH in order of importance within the community. The survey was distributed to a broad range of community-based organizations via email. Organizations were also asked to forward the survey on to the community members they serve if they felt it was appropriate. The survey was designed in and distributed via online survey software (Qualtrics). This allowed for the automatic capture of all survey data, which was subsequently imported into Statistical Analysis Software for analysis. Mean rankings for each health condition and social determinant were calculated, as were the percentage of respondents who thought each condition had improved, stayed the same, or gotten worse.

For a complete description of the HASD&IC 2019 CHNA engagement methodologies — including a list of participating individuals and organizations — as well as a complete description of the HASD&IC 2019 CHNA online survey, please refer to the full HASD&IC 2019 CHNA report at: https://hasdic.org/2019-chna.

SGH 2019 CHNA

In addition to an active role in the collaborative HASD&IC 2019 CHNA process, Sharp contracted separately with the IPH at SDSU to conduct multiple community engagement activities. The overall purpose of the Sharp (including SGH) 2019 CHNA community engagement activities was to gather information about the priority health needs and SDOH impacting Sharp patients in SDC. Specific objectives of this community engagement included:

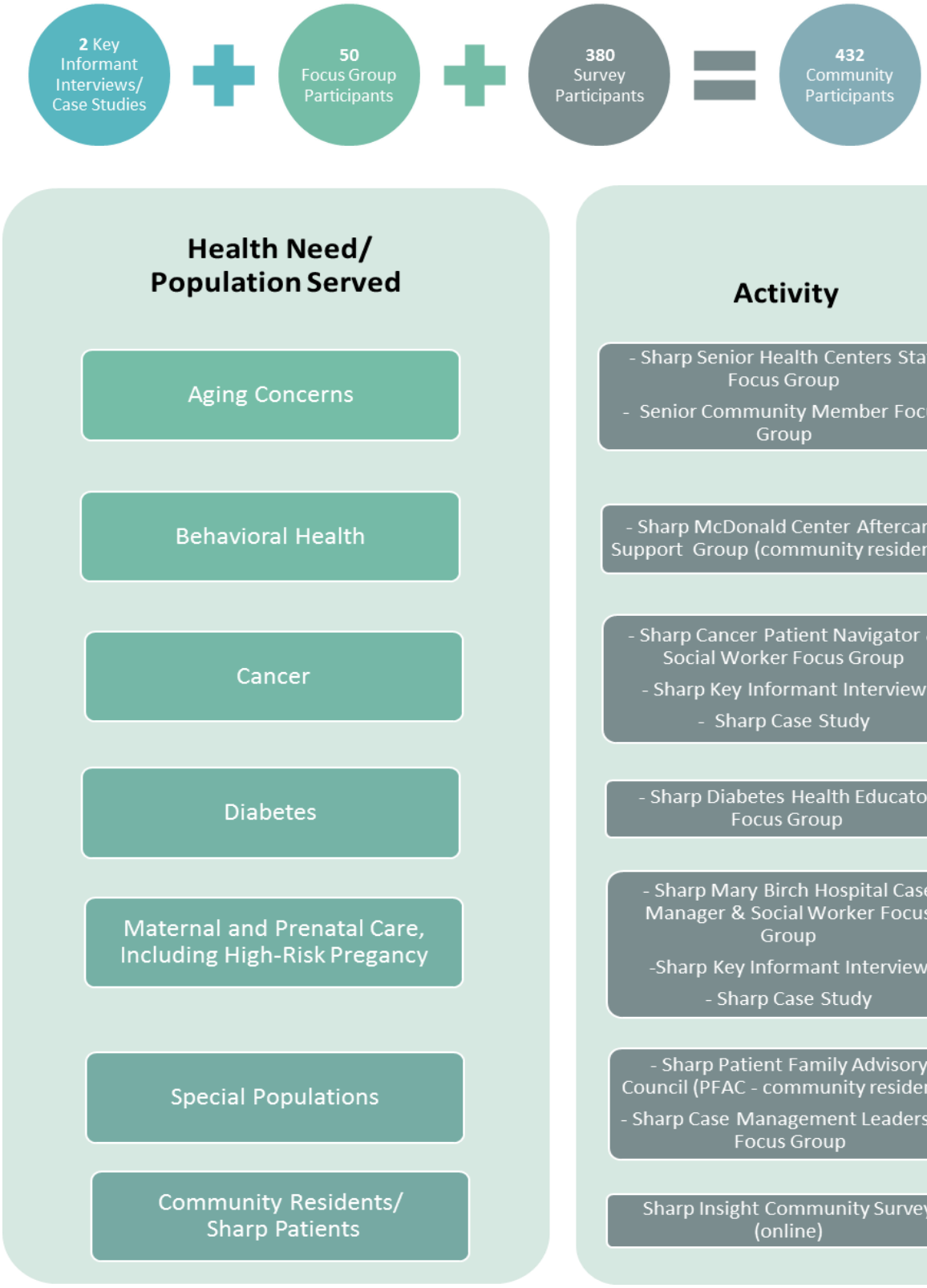
- Gather in-depth feedback to aid in the understanding of the most significant health needs and social determinants impacting community members served by Sharp
- Identify opportunities for collaboration on community programs as well as areas of improvement for current community service offerings
- Align with CHNA best practices across the nation

Sharp solicited input from the community through three types of efforts:

- Focus groups with community residents and Sharp health care providers and leaders
- KI interviews with Sharp health care providers, including development of case studies representing a “typical” patient experience within Sharp
- Online survey utilizing the Sharp Insight Community

Figure 8 outlines the engagement activities for the Sharp 2019 CHNAs, followed by detailed descriptions of each effort.

Figure 8: Sharp 2019 CHNA – Summary of Community Engagement Activities



IPH collected input both from Sharp providers and from patients and community members served by Sharp hospitals. Sharp health care provider focus group members and KIs had knowledge, information, and expertise relevant to the health needs of underserved communities and patients served by Sharp. Community residents had either direct experience with Sharp health care services or experienced these services through the care of a loved one. Input focused on behavioral health, cancer, diabetes, maternal health and prenatal care, senior health (now termed aging concerns), and the needs of highly vulnerable patients and community members.

Focus groups were utilized to identify and explore priority health needs, SDOH, barriers to care, and community assets and resources. IPH conducted focus groups in a semi-structured manner and were facilitated by an expert moderator from the IPH. An additional IPH staff member took notes during the session and summarized these for later analysis. Each group began with a discussion about the purpose and process of the CHNA. The facilitator then received consent to proceed and reassured participants that their participation was voluntary and their feedback would be anonymous. Questions were developed and approved by the IPH and the HASD&IC CHNA Committee, with input from Sharp team members and leaders. Focus groups were allowed to flow in a conversational manner to ensure that participants had the freedom to discuss issues of importance to them. Questions varied by engagement activity, depending on the expertise or specific interests of the group participating. Food was provided for the participants as an incentive and token of appreciation. A total of 62 people participated in eight focus groups, as detailed in **Table 6** below.

Table 6: Sharp 2019 CHNA – Focus Group Participants

Participant	# of Participants	Hospitals/ Facilities Represented	Participant Expertise
Sharp McDonald Center – After Care Support Group Members	6	SMC	Patient-specific challenges related to behavioral health and addiction issues
Sharp HealthCare – Cancer Navigators & Social Workers	18	SCVMC, SGH, SMH, SRSMG, System Services	Cancer expertise at Sharp HealthCare Regions: Central, East, North Central, South
Sharp HealthCare – Diabetes Health Educators	9	SCVMC, SGH, SMH, OPP	Low-income, medically underserved, populations with chronic diseases, minority populations Regions: Central, East, North Coastal, South
Sharp HealthCare – Patient Family Advisory Council – Community Residents	5	SGH	Patient-specific challenges related to health and SDOH
Sharp Mary Birch – Social Workers and Case Managers	10	SMBHWN	Low-income, medically underserved, populations with chronic diseases, minority populations Region: Central
Sharp HealthCare – Case Manager Leadership	8	SCHHC, SCMG, SCVMC, SGH, SMH, SRSMG, System Services	Low-income, medically underserved, populations with chronic diseases, minority populations Regions: Central East, North Central, North Coastal, North Inland, South
Senior Community Members	3	NA	Patient-specific challenges related to senior health issues
Sharp HealthCare – Senior Health Staff	3	SMH, OPP	Low-income, populations with chronic diseases, Medicare primary Region: Central

Sharp Entity Key: **SCHHC** = Sharp Coronado Hospital and HealthCare Center; **SCVMC** = Sharp Chula Vista Medical Center; **SGH** = Sharp Grossmont Hospital; **SMBHWN**=Sharp Mary Birch Hospital for Women & Newborns, **SMC**= Sharp McDonald Center; **SMH** = Sharp Memorial Hospital; **SMVH** = Sharp Mesa Vista Hospital**; SRSMG** = Sharp Rees-Stealy Medical Group; **SCMG** = Sharp Community Medical Group; **OPP** = Sharp Memorial Hospital Outpatient Pavilion; **System Services** = Sharp HealthCare System Services

IPH conducted the KI interviews in an informal, semi-structured manner with Sharp employees who have expertise and practice experience in the content area covered by of the case studies. Questions were developed and shared with the interviewees prior to the interviews (see **Appendix M**). The interviews flowed in a conversational manner, such that some questions were skipped and others were added in an ad-hoc manner. An IPH staff member with expertise in qualitative research conducted the interviews and took notes. Two interviews were performed, as detailed in **Table 7** below.

Table 7: Sharp 2019 CHNA – Key Informant Interview Participants

Participant	Hospital/Facility Represented	Participant expertise
Nurse Educator PSCU/ADC, Perinatal Special Care Unit	SMBHWN	High-risk pregnancy expertise
Clinical Social Worker and Patient Navigator	SCVMC Sharp Barnhart Cancer Center	Cancer expertise

SMBHWN=Sharp Mary Birch Hospital for Women & Newborns; **SCVMC** = Sharp Chula Vista Medical Center

Utilizing data gathered from the focus groups and KI interviews, as well as review of relevant literature, two case studies were developed. Recognizing that each patient presents with unique needs, case studies are intended to represent a "typical" patient experience within Sharp. Two health conditions are presented in the case studies: high-risk pregnancy and breast cancer. The patients in the stories are not real patients; rather, they were created from a compilation of qualitative data collected as part of the CHNA and the literature review. The full case studies are presented in **Appendix J**.

Two focus groups were relevant to the case studies: (1) the cancer-centered group with 18 cancer navigators and social workers from four Sharp entities on January 3, 2019; and (2) the high-risk condition-centered group with 10 case managers and social workers at Sharp Mary Birch Hospital for Women & Newborns (SMBHWN) on January 10, 2019. Sharp entities participating in the cancer focus group included: SGH, Sharp Memorial Hospital (SMH), Sharp Chula Vista Medical Center (SCVMC) and Sharp Rees-Stealy Medical Group (SRSMG).

For the case study related to high-risk pregnancy, Joanna Hunt BSN, RNC-OB, C-EFM, Nurse Educator PSCU/ADC, Perinatal Special Care Unit, SMBHWN was interviewed on December 19, 2018. For the case study related to cancer, Cara Fairfax, MSW, LCSW, CN-BM, Clinical Social Worker and Patient Navigator, SCVMC Barnhart Cancer Center was interviewed on March 1, 2019.

To ensure that the case studies were reflective of current medical knowledge and practice regarding their topics, the IPH researcher consulted a body of literature for each case study. This allowed the case studies to reflect current information and trends regarding risk, symptoms, treatment, management, and morbidities from both health conditions. See **Appendix J** for a list of sources consulted.

For more information on Sharp's focus group and KI interviews (e.g., date and focus), please see **Appendix K**. For additional details about these community engagement participants (e.g., services provided), please refer to **Appendix L**.

Lastly, Sharp conducted an online survey utilizing the Sharp Insight Community, a private online environment for Sharp patients and their families, community members, Sharp employees, and Sharp-affiliated physicians to share insight freely about important information that can help Sharp create a positive health care experience. This survey sought to obtain patient-level feedback on identified health and SDOH needs faced by SDC community members through a broad-reaching online tool. Out of 3,413 survey recipients, a total of 380 participants responded (~ 11%). Participants were asked to choose the top five most important health conditions and top five most important SDOH they felt had the greatest impact on the overall health of their community. Participants were then asked to rank their combined choices in order of importance from 1 to 10, with 1 having the greatest impact on overall community health and well-being. In addition, participants were asked to rate their awareness of five selected patient and community outreach programs offered by Sharp. Lastly, survey participants were provided the opportunity to provide specific suggestions about what Sharp can do to improve the health and well-being of their community. Please see **Appendix N** for a copy of the survey that was distributed, as well as **Appendix R** for the complete Sharp Insight Community survey results.

2019 CHNA Prioritization Process

HASD&IC 2019 CHNA

In order to prioritize the top needs, the CHNA Committee analyzed the comprehensive findings from the needs assessment, including quantitative and qualitative data (see **Table 8**).

Table 8: Data Used in HASD&IC 2019 CHNA Prioritization Process

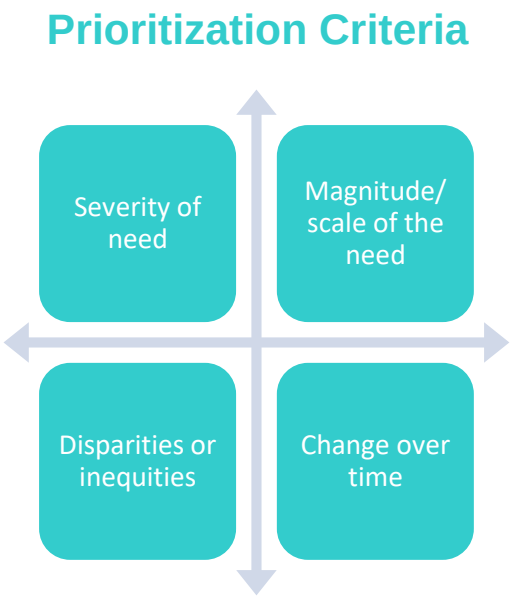
Data Used in Prioritization Process	
Quantitative Data	**Qualitative Data**
▪ Analysis of secondary data, health conditions and SDOH ▪ County of San Diego leading causes of death 2016 data ▪ Hospital discharge trend data retrieved from OSHPD via SpeedTrack	▪ Community engagement findings from focus groups ▪ Community engagement findings from KI interviews ▪ 2019 CHNA survey data

The HASD&IC 2019 CHNA Committee used the following set of criteria in their prioritization process.

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

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

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



- **Change over time:** This refers to whether or not the need has improved, stayed the same, or worsened.

Over the course of several meetings, the CHNA Committee collectively reviewed the quantitative and qualitative data and findings. The CHNA Committee discussed and considered each health condition and SDOH for which data was available. Those health conditions and SDOH that met the largest number of criteria were chosen as top priorities.

SGH 2019 CHNA

As the HASD&IC 2019 CHNA process included robust representation from the communities served by SGH, this prioritization process was replicated for the SGH 2019 CHNA. Findings from the SGH 2019 CHNA prioritization process and analysis of identified health needs and SDOH are summarized in **Section 5: Findings**.

2019 CHNA Data Limitations and Information Gaps

As with any CHNA process, the data available for use are limited. Limitations of the 2019 CHNA processes for both SGH and the collaborative HASD&IC CHNA effort are discussed here to potentially benefit future CHNA processes and reports.

In the KP CHNA data platform, for example, some data were only available at a county level, making an accurate translation to neighborhood-level health needs challenging. In the HPI platform, census tracts with very low populations were represented as missing data (to reduce unreliability of measurement). This caused under-sampling of rural areas. In both platforms, disaggregated data around age, ethnicity, race, and gender were not available for many indicators which limited the ability to examine disparities of health within the community. Additionally, data in both platforms were not often

collected on a yearly basis and therefore may not represent 2018 values. In order to offset these limitations, additional health data were collected and utilized. This data included SDC hospital data, county mortality data, health indicators from the CHIS, clinic data, and other local and national data sources. Please see **Appendix O** for a list of these additional data sources.

Additionally, the age of the data used throughout this CHNA process is worth noting as a limitation. Much of the quantitative data used in both the HASD&IC and SGH 2019 CHNA processes were based on several different sources at the state and county level, often over different time periods that were not current to 2019. For example, the most recent period available for hospital discharge data used in the report was CY 2017, and more current data (2018) will not be available until later in 2019.

Relatedly, lack of obesity data at the ZIP code level demonstrates another limitation. This lack of data presents an obstacle for community programs designed to target the issue of obesity within specific communities below the county level. To help reduce the impact of this limit, data and statistics regarding obesity-related illnesses (e.g., diabetes, CVD) are included in this CHNA.

To conduct a comprehensive CHNA, a mixed method approach was required, including the collection and analysis of quantitative data and community input from a variety of sources, and the primary data also have their own limitations. The HASD&IC 2019 CHNA process included nearly 580 participants in its community engagement processes, while the SGH 2019 CHNA process engaged nearly 445 community participants. For the community engagement processes, every effort was made to target those populations who experience the greatest health inequities. Community participation from these groups was strong; however, participants included only those community members who were interested and able to engage in the process. The first-person voices of certain groups, therefore, were underrepresented, such as those who suffer from severe physical or cognitive impairments and those without access to transportation to the community engagement activities. Another limitation to the 2019 CHNA process was that the population and disease-specific KI interviews may not have captured all of the challenges faced by the groups represented.

Additionally, CHNA surveys were distributed and collected electronically through both the HASD&IC 2019 CHNA survey and the Sharp Insight Community survey. For the HASD&IC 2019 CHNA survey, without access to community members' email addresses, surveys were distributed through those community-based organizations who were willing to share the survey with their clients. As a result, community member response to the survey was low. In addition, while there was representation from all regions and ethnicities based on the participants who completed both surveys, smaller sample sizes among certain groups may limit its generalizability to subsections of the population. Further, the format of the Sharp Insight Community online survey was not conducive to mobile (e.g., cell phone) users, which potentially limited the reach and reduced the response rate of the survey.

Section

4 Community Defined

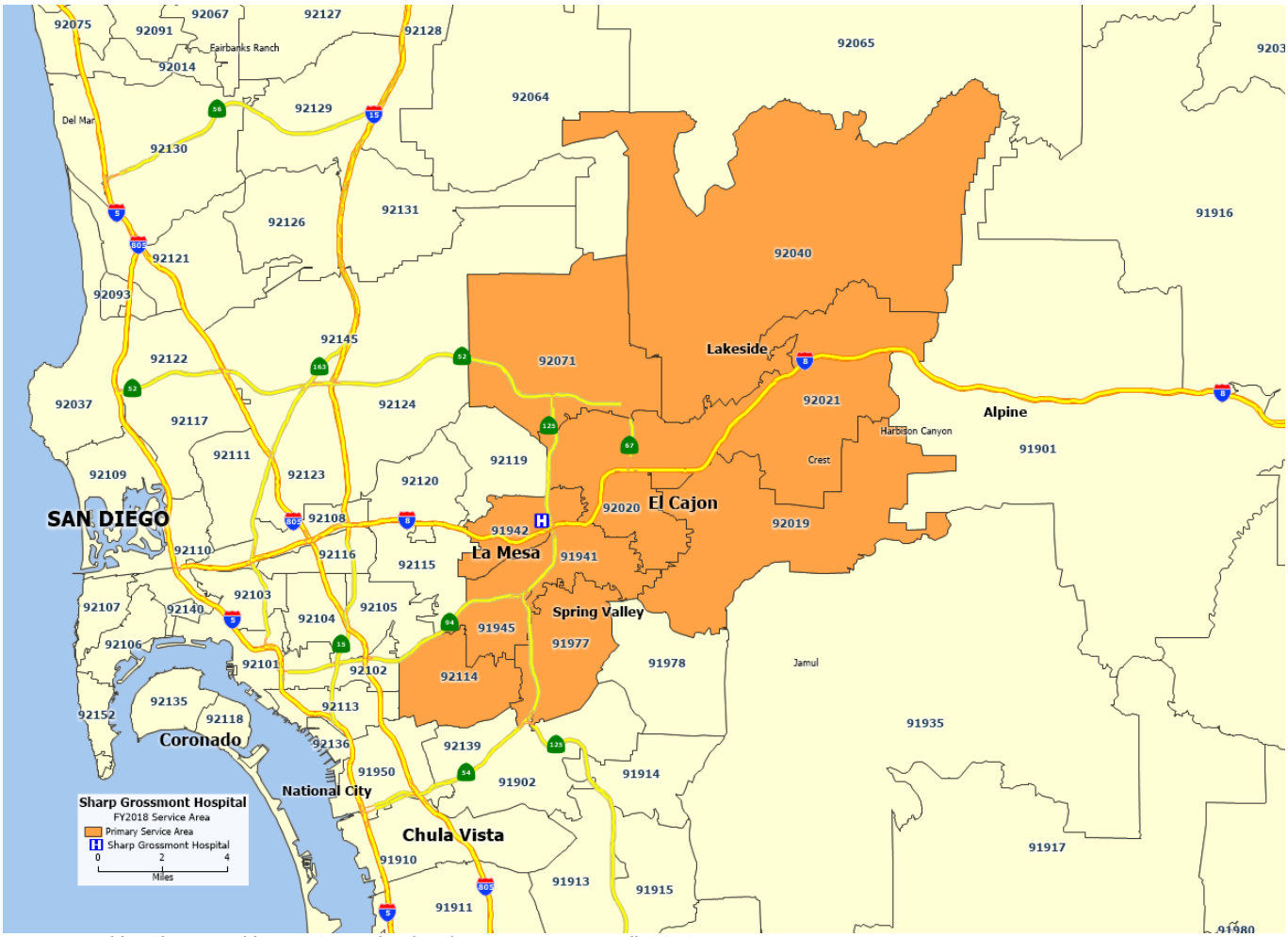
The primary communities served by SGH encompass the entire east region of SDC, including the sub-regional areas of Jamul, Spring Valley, Lemon Grove, La Mesa, El Cajon, Santee, Lakeside, Harbison Canyon, Crest, Alpine, Laguna-Pine Valley and Mountain Empire. See **Table 9** and **Figure 9** below for a listing and map of where the majority of SGH patients reside. For a mapping of community and region boundaries in SDC overall, please refer to **Appendix P**.

Table 9: Primary Communities Served by SGH

ZIP Code	Community
91941	La Mesa
91942	La Mesa
91945	Lemon Grove
91977	Spring Valley
92019	El Cajon
92020	El Cajon
92021	El Cajon
92040	Lakeside
92071	Santee
92114	Encanto

Source: Centricity HPA via Merlin (internal data warehouse), Sharp HealthCare, FY 2018.

Figure 9: Map of SGH's Primary Communities Served



Map created by Sharp HealthCare Strategic Planning Department, April, 2019.

Feedback on community health needs was solicited from both community members and service providers living and working in the east region of SDC, in order to assess priority health issues for the community.

Demographics

In this section, SGH's community is defined not only by its demographic makeup but also by particular socioeconomic barriers known to contribute to health care access and health outcomes.

Wherever possible, the descriptions that follow will focus on primary communities served by SGH; however, certain secondary data sources are not available at this level of specificity and broader summaries of SDC's east region are provided in these instances.

In the next five years, SGH's service area is projected to grow 4.0% which is slightly faster than the county as a whole (3.9%). The service area's two fastest growing ZIP codes are Encanto and Southeast San Diego, as shown in **Table 10** below.[3]

Table 10: Fastest Growing ZIP Codes in SGH's Service Area, 2018-2023

ZIP Code	Community Name	Population		2018-2023 Change
		2018	2023	
92114	Encanto	74,011	78,570	6.2%
92113	Southeast San Diego	62,513	65,735	5.2%
92119	San Carlos	24,564	25,745	4.8%
92102	East San Diego	48,006	50,276	4.7%
91977	Spring Valley	63,348	66,218	4.5%

Source: Speedtrack, Inc.; U.S. Census Bureau

SDC's east region is a large, diverse area including urban, suburban and rural sections. The region is predominantly white (57.3%) and Hispanic (27.3%),[4] and also has a strong refugee presence. According to the California Department of Social Services, more than 13,000 refugees have been admitted to SDC since 2010. From October 2012 to September 2017, SDC had the largest number of admissions among all counties in California.[5] Of these, the majority arrived from Iraq (77%), and most have settled in the county's central and east regions. Within the east region, the majority live in the city of El Cajon (73.0%).[6]

In 2018, there were 119,258 residents ages 65 and older in SGH's service area, representing 14.2% of its total population. Between 2018 and 2023, the service area's senior population is projected to grow by 22.6% — faster than all other age groups.[7]

In 2016, 70.0% of the east region population reported that the primary language spoken at home was English only, while 19.5% identified as bilingual.[6] Please see **Table 11** for more east region demographic data.

[3] Speedtrack, Inc.; US Census Bureau
[4] County of San Diego HHSA, Public Health Service, Community Health Statistics Unit, 2018. Demographic Profiles, 2016, and U.S. Census Bureau, American Community Survey 2012-2016.
[5] California Department of Social Services – Refugee Programs Bureau. Refugee Arrivals into California Counties, FFYs 2013-2017.
[6] County of San Diego HHSA, Refugee Programs Bureau, 2016. County of San Diego Refugee Employment Services Plan 2017-2019.
[7] Sharp Grossmont Hospital Market Assessment, Sharp HealthCare Strategic Planning Department, March 2019.

Table 11: SDC East Region Demographics, 2016

Age	#	%
0-4 Years	30,921	6.4%
5 to 14 Years	61,402	12.7%
15 to 24 Years	65,917	13.6%
25 to 44 Years	130,432	26.9%
45 to 64 Years	129,297	26.7%
65+ Years	66,633	13.8%

Race	#	%
White	277,696	57.3%
Hispanic	132,450	27.3%
Black	27,723	5.7%
Asian/Pacific Islander	24,290	5.0%
Other	22,443	4.6%

Gender	#	%
Male	242,007	49.9%
Female	242,595	50.1%

Note: Table percentages may total more than 100% due to rounding.

Education	%
< High School Graduate	12.6%
High School Graduate	25.6%
Some College or AA	36.6%
Bachelor Degree	16.7%
Graduate Degree	8.6%

Primary Language Spoken at Home	%
English Only	70.0%
Spanish Only	5.4%
Asian/Pacific Islander Only	1.4%
Other Language Only	3.8%
Bilingual	19.5%

Percent Below Poverty Level	%
Population	14.3%
Families	10.8%
Families with Children	16.4%

Source: County of San Diego Health and Human Services Agency (HHSA), Public Health Services, Community Health Statistics Unit, 2018. Demographic Profiles, 2016, and the U.S. Census Bureau, American Community Survey. 2012-2016.

Additional Income Barriers

In 2016, 14.3% of the east region population reported living below 100% of the federal poverty level (FPL). The unemployment rate in SDC's east region was 9.2%, which was higher than the rate of 7.5% for SDC overall (see **Table 12** for details). In addition, 7.1% of households in the east region received Supplemental Security Income, also higher than SDC overall (5.0%).[8]

Table 12: Unemployment Estimates for SDC's East Region, 2016

Eligible Labor Force	
16+ Years	386,262
Percent Unemployed	9.2%

Source: County of San Diego HHSA, Public Health Services, Community Health Statistics Unit, 2018. Demographic Profiles, 2016, and the U.S. Census Bureau, American Community Survey. 2012-2016.

According to data from the San Diego Hunger Coalition, in 2016 one in seven people (15.0% of the population or 486,000 individuals) in SDC experienced food insecurity. An additional 185,000 San Diegans were food secure but relied on supplemental nutrition assistance to support their food budget. Latinos had a disproportionately higher incidence of food insecurity; 42.0% of low-income Latinos (household income below 200% of the FPL) experienced food insecurity and 53.0% of all food insecure adults were Latino.[9]

[8] County of San Diego HHSA, Public Health Service, Community Health Statistics Unit, 2018. Demographic Profiles, 2016, and U.S. Census Bureau, American Community Survey 2012-2016.
[9] San Diego Hunger Coalition. Hunger Free San Diego Issue Brief: 2016 San Diego County Food Insecurity. San Diego, CA; August 2018.

In 2016, 11.0% of households in the east region participated in Supplemental Nutrition Assistance Program (SNAP) benefits, while 21.7% of the population living below 138% of the FPL were eligible for such benefits. These rates were higher than SDC overall (7.0% of households participated in SNAP benefits while 21.0% of those below 138% of the FPL were eligible).[10] Please refer to **Table 13** for SNAP participation and eligibility in the east region.

Table 13: Food Stamps/SNAP Benefit Participation and Eligibility Estimates in SDC's East Region, 2016

Food Stamps/SNAP Benefits	Percent of Population
Households	11.0%
Families with Children	10.5%
Eligibility by Federal Poverty Level (FPL)	
Population ≤130% FPL	20.1%
Population ≤138% FPL	21.7%
Population 139% - 350% FPL	34.1%

Source: County of San Diego HHSA, Public Health Services, Community Health Statistics Unit, 2018. Demographic Profiles, 2016, and the U.S. Census Bureau, American Community Survey. 2012-2016.

In the east region in 2016, 44.0% of the population spent 30% or more of their monthly household income on housing costs, which mirrored SDC overall (also at 44.0%).[10] See **Table 14** below for additional details on monthly housing costs in the east region.

Table 14: Housing Costs in SDC's East Region, 2016

Monthly Income Going to Housing Costs	Percent of Population
Less than 20% per Month	31.7%
20% to 29% per Month	24.3%
30% or more per Month	44.0%

Source: County of San Diego HHSA, Public Health Services, Community Health Statistics Unit, 2018. Demographic Profiles, 2016, and the U.S. Census Bureau, American Community Survey. 2012-2016.

Additional Health Insurance/Access Barriers

In SDC's east region in 2016, 93.5% of children ages 0-17, 81.6% of young adults ages 18-24, 82.2% of adults ages 25-44, 88.5% of adults ages 45-64, and 98.7% of seniors ages 65 and older had health insurance.[10] Health insurance coverage for each age group was lower than the Healthy People 2020 (HP2020) national target of 100% health insurance coverage for all individuals under age 65.[11] **Tables 15** and **16** provide a summary of key indicators of access to care in SDC's east region.

[10] County of San Diego HHSA, Public Health Service, Community Health Statistics Unit, 2018. Demographic Profiles, 2016, and U.S. Census Bureau, American Community Survey 2012-2016.

[11] The U.S. Department of Health and Human Services' HP2020 initiative represents the nation's prevention agenda for the second decade of the 21st century. HP2020 has four overarching goals: to attain high quality, longer lives free of preventable disease, disability, injury, and premature death; to achieve health equity, eliminate disparities, and improve the health of all groups; to create social and physical environments that promote good health for all, and to promote quality of life, healthy development, and healthy behaviors across all life stages.

Table 15: Health Insurance Coverage in SDC's East Region, 2016

Description	Rate	HP2020 Target
Current Health Insurance Coverage		
Children 0 to 17 years	93.5%	100%
Young adults 18 to 24 years	81.6%	100%
Adults 25 to 44 years	82.2%	100%
Adults 45 to 64 years	88.5%	100%
Seniors 65+ years	98.7%	100%

Source: County of San Diego HHSA, Public Health Services, Community Health Statistics Unit, 2018. Demographic Profiles, 2016, and U.S. Census Bureau, American Community Survey 2012-2016.

According to CHIS, 34.4% of the east region population was covered by Medi-Cal.[12] See **Table 16** for details.

Table 16: Medi-Cal (Medicaid) Coverage in SDC's East Region, 2016-2017

Description	Rate
Covered by Medi-Cal	34.4%
Not covered by Medi-Cal	65.6%

Source: 2016-2017 CHIS

CHIS data also revealed that 15.3% of individuals in the east region did not have a usual place to go when sick or in need of health advice (see **Table 17**).[12]

Table 17: Regular Source of Medical Care in SDC's East Region, 2016-2017

Regular Source of Medical Care	Rate[a]	HP2020 Target[b]
Has a usual source of care	84.7%	100%
Has no usual source of care	15.3%	100%

Source[a]: 2016-2017 CHIS.
Source[b]: U.S. Department of Health and Human Services' HP2020.

Cancer and diseases of the heart were the top two leading causes of death in SDC's east region in 2016.[13] See **Table 18** for a summary of leading causes of death in the east region.

[12] 2016-2017 CHIS.
[13] County of San Diego HHSA, Public Health Services, Community Health Statistics Unit, 2018.

Table 18: Leading Causes of Death in SDC's East Region, 2016

Cause of Death	Number of Deaths	Percent of Total Deaths
Malignant Neoplasms (Overall Cancer)	977	24.1%
Diseases of Heart	929	22.9%
Cerebrovascular Diseases	254	6.3%
Chronic Lower Respiratory Diseases	230	5.7%
Accidents/Unintentional Injuries	220	5.4%
Alzheimer's Disease	207	5.1%
Diabetes Mellitus	143	3.5%
Chronic Liver Disease and Cirrhosis	95	2.3%
Essential Hypertension and Hypertensive Renal Disease	83	2.0%
Intentional Self-Harm (Suicide)	74	1.8%
All Other Causes	842	20.9%
Total Deaths	**4,054**	**100.0%**

Source: County of San Diego HHSA, Public Health Services, Community Health Statistics Unit, 2018.

It is important to note here that for SDC's east region, cancer (malignant neoplasms) is the leading cause of death. This underscores the importance of SGH's commitment to programs that help to educate, screen and prevent the incidence of cancer, as well as to programs that offer support and resources for community members impacted by cancer.

Identifying SGH's High-Need Areas

A critical component of understanding community health is to identify geographic areas of inequities. SGH utilized a specific metric to determine which portions of its service area are likely experience the greatest health disparities: the Dignity Health CNI. The CNI generates a score for each ZIP code based on data about barriers to socioeconomic security.

The five barriers used to determine CNI scores are:

1. Income Barriers
2. Cultural Barriers
3. Educational Barriers
4. Insurance Barriers
5. Housing Barriers

The CNI provides a score for every populated ZIP code in the United States (U.S.) on a scale of 1.0 to 5.0. A score of 1.0 indicates a ZIP code with the least need (light blue in **Figures 10-12** below), while a score of 5.0 represents a ZIP code with the most need (dark green in **Figures 10-12** below). For a detailed description of the CNI please see **Appendix G** or visit the interactive website at: http://cni.chw-interactive.org/.

Table 19 below presents primary communities (by ZIP code) served by SGH that have especially high need based on their CNI score (4-5).

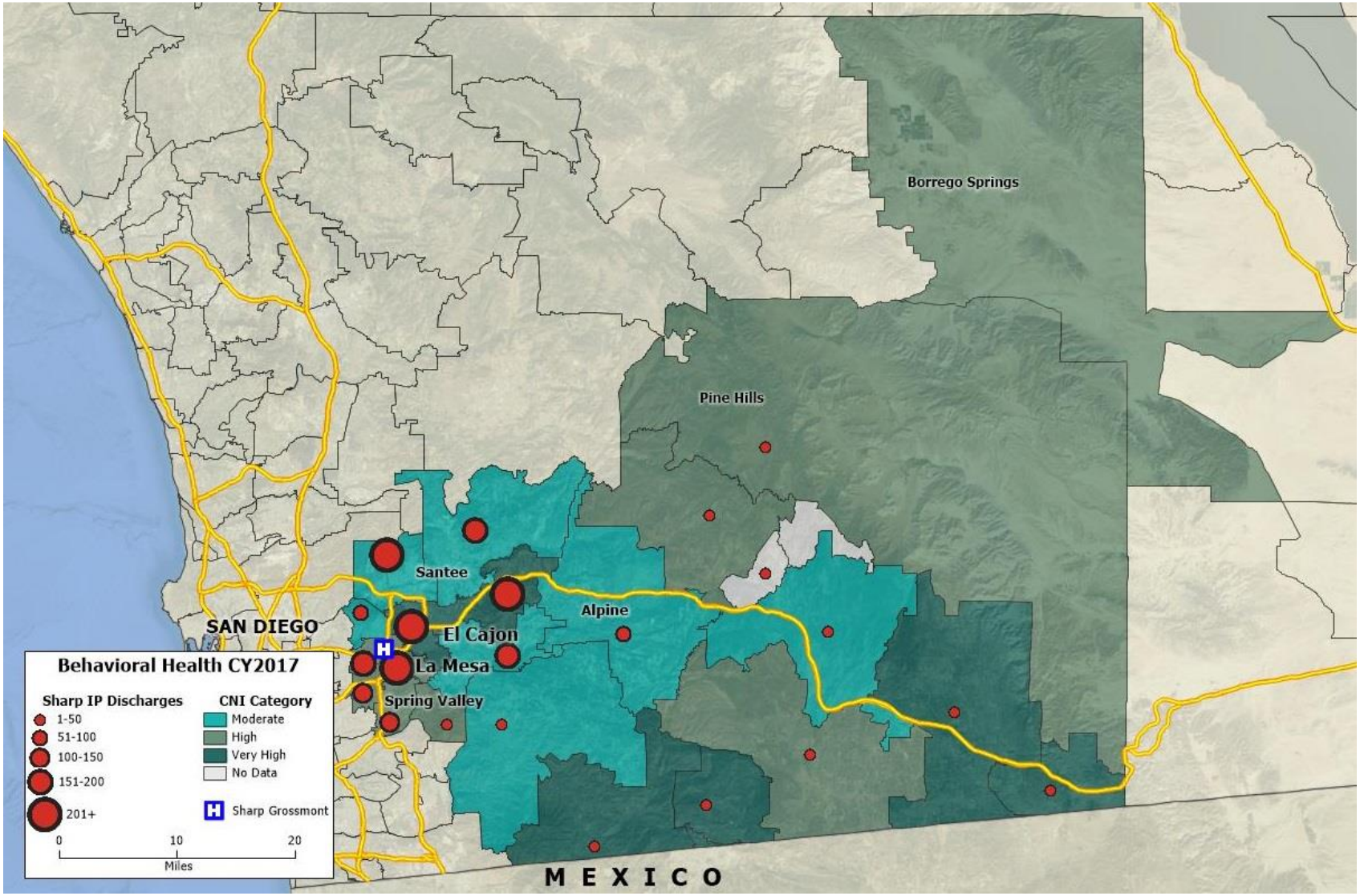
Table 19: High-Need Primary Communities Served by SGH, CNI Score > 4.0

ZIP Code	Community
91945	Lemon Grove
91977	Spring Valley
92020	El Cajon
92021	El Cajon
92114	Encanto

Source: Dignity Health Community Need Index, 2018.

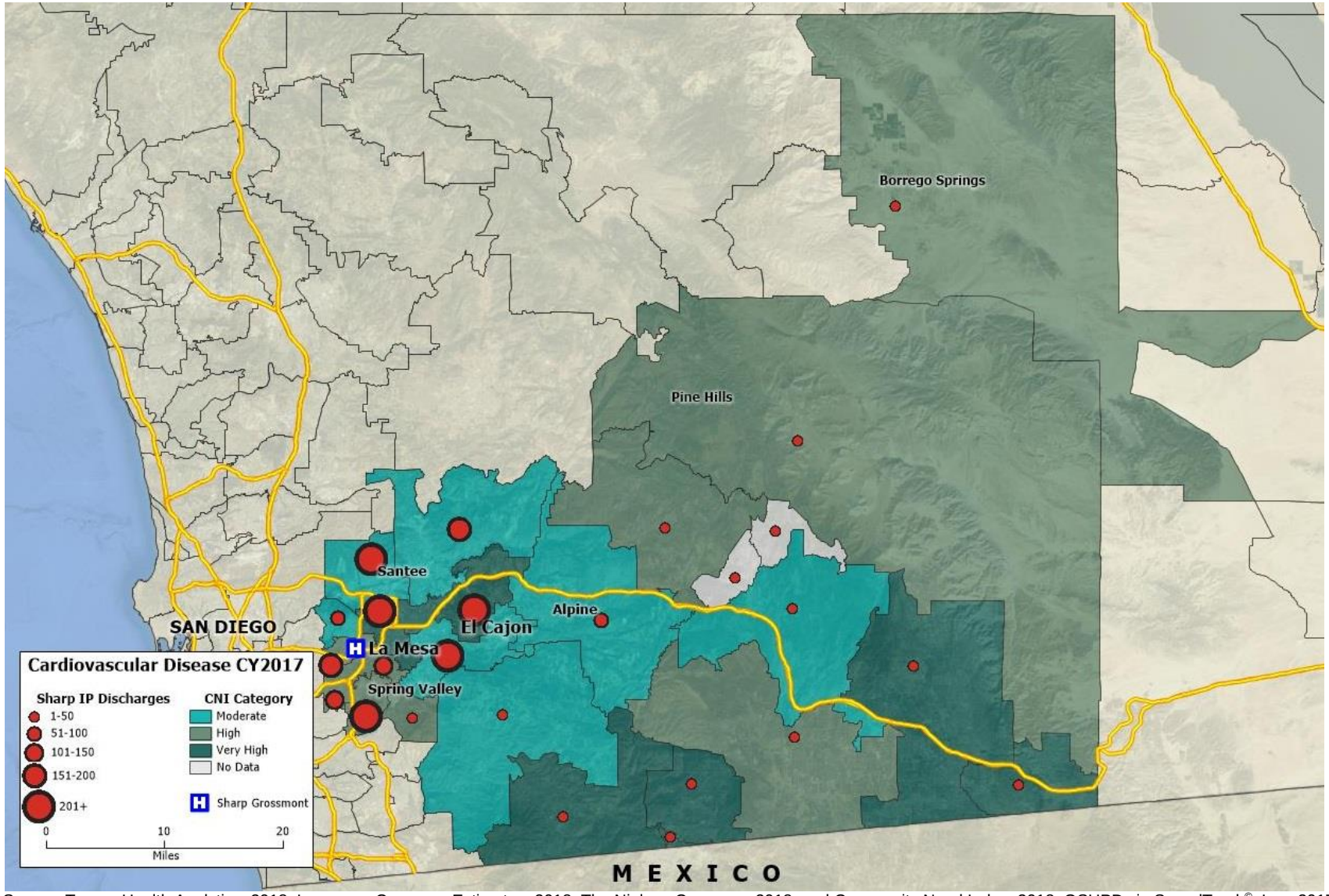
In addition, **Figures 10-12** below present CNI maps for SDC's east region — including many communities served by SGH — with Sharp hospital discharge data for behavioral health, cardiovascular health, and diabetes overlaid on the map. These maps demonstrate that while these chronic diseases affect communities of varying need, those areas with the highest CNI score (and thus highest vulnerability) often present higher discharge rates for these chronic health conditions. Thus, the maps strongly suggest the connection between rates of chronic disease, health care utilization, SDOH/socioeconomic factors and thus, health equity. These maps are also available in **Appendix Q**.

Figure 10: Sharp Inpatient Behavioral Health Discharges CNI Map, East Region (SDC)



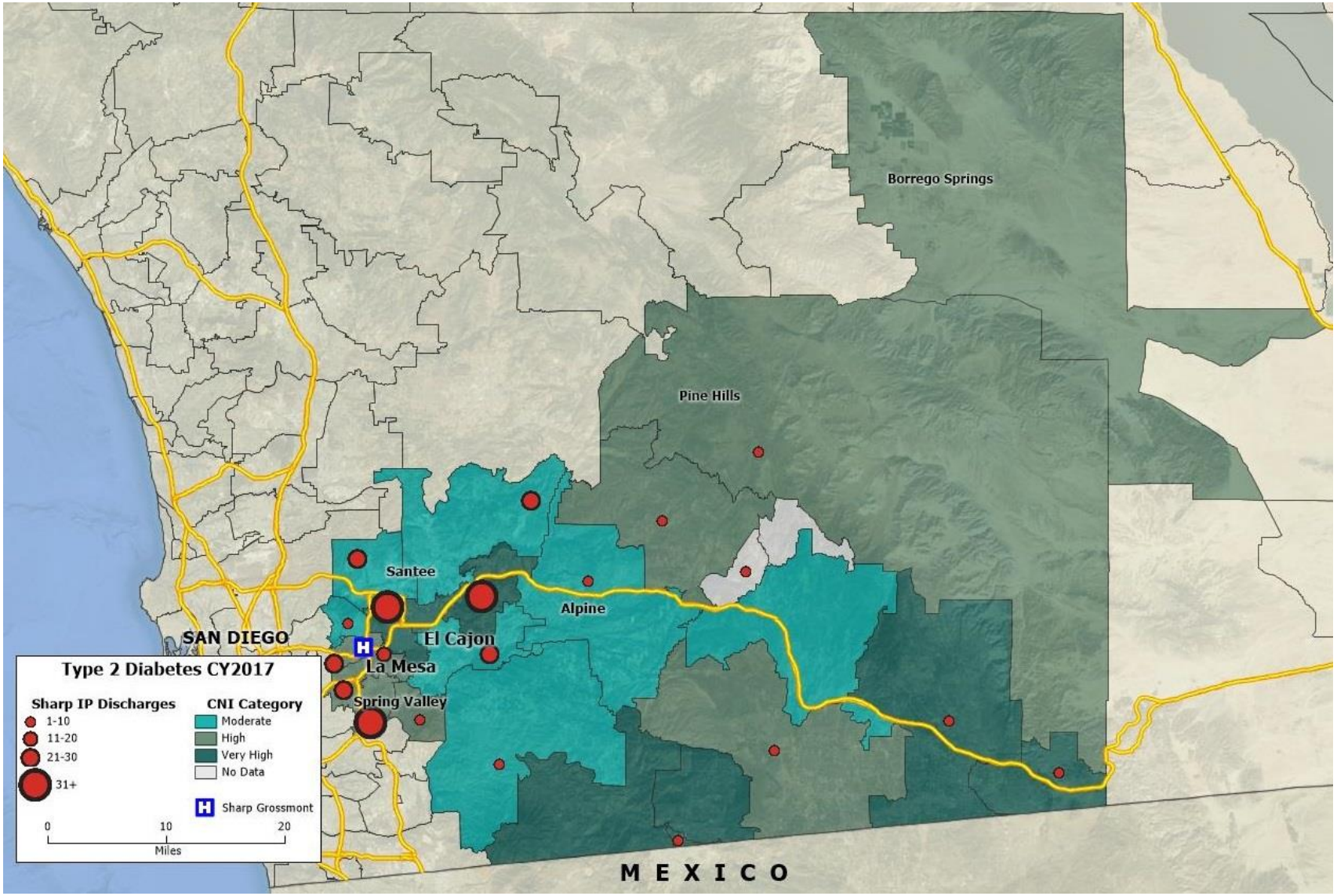
Source: Truven Health Analytics, 2018; Insurance Coverage Estimates, 2018; The Nielson Company, 2018; and Community Need Index, 2018; California Office of Statewide Health Planning and Development (OSHPD) via SpeedTrack©, Inc., 2017.

Figure 11: Sharp Inpatient Cardiovascular Discharges CNI Map, East Region (SDC)



Source: Truven Health Analytics, 2018; Insurance Coverage Estimates, 2018; The Nielson Company, 2018; and Community Need Index, 2018; OSHPD via SpeedTrack©, Inc., 2017.

Figure 12: Sharp Inpatient Type 2 Diabetes Discharges CNI Map, East Region (SDC)



Source: Truven Health Analytics, 2018; Insurance Coverage Estimates, 2018; The Nielson Company, 2018; and Community Need Index, 2018; OSHPD via SpeedTrack©, Inc., 2017.

Section

5 Findings

This section describes findings of the SGH 2019 CHNA process. When applicable, findings from the HASD&IC 2019 CHNA are also described, as the HASD&IC 2019 CHNA process included strong representation of the community served by SGH, and a significant proportion of its findings reflect the same health needs of community members served by SGH.

2019 CHNA Findings: Top Community Health Needs

HASD&IC 2019 CHNA

Through the prioritization process described above in **Section 3: Methodology**, the HASD&IC 2019 CHNA Committee identified the following health conditions and SDOH as the most critical health needs within SDC (listed below in alphabetical order):

1. Access to Health Care
2. Aging Concerns
3. Behavioral Health
4. Cancer
5. Chronic Conditions
6. Community and Social Support
7. Economic Security
8. Education
9. Homelessness and Housing Instability
10. Unintentional Injury and Violence

Figure 13 below describes the interactive nature of SDOH and health conditions — each impacting the other. In addition, an underlying theme of stigma and the barriers it creates arose across both the HASD&IC and SGH 2019 CHNA community engagement efforts. For instance, stigma impacts the way in which people access needed services that address SDOH, which consequentially impacts their ability to maintain and manage health conditions.

Figure 13: HASD&IC 2019 CHNA – Top 10 Community Heath Needs for San Diego County

SGH 2019 CHNA

Also through the prioritization processes described in **Section 3: Methodology**, the SGH 2019 CHNA identified the same health conditions and SDOH as the HASD&IC 2019 CHNA. In addition, SGH identified Maternal and Prenatal Care, including High-Risk Pregnancy as a priority health need for its community members. The priority needs identified for the communities served by SGH are listed below in alphabetical order:

1. **Access to Health Care**
2. **Aging Concerns**
3. **Behavioral Health**
4. **Cancer**
5. **Chronic Health Conditions (CVD, diabetes, obesity)**
6. **Community and Social Support**
7. **Economic Security**
8. **Education**
9. **Homelessness and Housing Instability**
10. **Maternal and Prenatal Care, including High-Risk Pregnancy**
11. **Unintentional Injury and Violence**

Findings related to each of these identified health priorities are described in this section. This includes a definition of the identified health need; a summary of findings from both secondary data analysis and community engagement activities; and a discussion of the findings. Applicable content from the HASD&IC 2019 CHNA process is also included. Please refer to **Section 3: Methodology** for additional details on the secondary data analysis and community engagement processes. In addition, please refer to **Section 7: Health Briefs** for detailed health briefs — providing quantitative and qualitative data — on select community health needs.

SGH 2019 CHNA – Identified Health Conditions and SDOH

Overall Health Conditions and SDOH: Sharp Insight Community Survey

Individually identified health conditions/needs and SDOH are described in the following pages, however, findings from one specific Sharp community engagement strategy — the Sharp Insight Community survey — provide a snapshot of how Sharp 2019 CHNA participants view the connection between those identified health needs and SDOH impacting San Diegans. Please see **Figure 14** below for these overall findings and refer to **Appendix R** for the full findings of the Sharp Insight Community survey. **Section 3: Methodology** provides additional details on the Sharp Insight Community survey process.

Figure 14: Sharp 2019 CHNA – Sharp Insight Community Survey Final Ranked Health Conditions and SDOH

Ranked Health Conditions and Social Determinants

Ranking score is a weighted score that was calculated for each listed item. Items ranked "#1" equate to 10 points, items ranked "#2" equate to 9 points, and so on. The higher the score the more value respondents placed on that particular item. The maximum possible score for an item (if all respondents were to have ranked an item "#1") is 3,800.

No.	Health Condition/ Social Issue	Ranking Score
1	Health insurance (understanding, securing, and using health insurance)	1,941
2	Access to care (primary care, dental care, behavioral health, specialty care)	1,863
3	Aging concerns (e.g., arthritis, falls, Alzheimer's, etc.)	1,808
4	Behavioral/mental health issues (e.g. substance use, suicide, self-inflicted injury, etc.)	1,618
5	Cancer (all types)	1,528
6	Obesity	1,317
7	Economic security (consistent access to healthy food, financial stability, employment)	1,280
8	Heart disease (coronary)	1,188
9	Health behaviors (diet, physical and sexual activity, tobacco and substance use)	1,187
10	Diabetes (types 1 and 2)	951
11	Homelessness (overcrowding, substandard, housing affordability)	831
12	High blood pressure	725
13	Care management (disease management, community social service linkages)	621
14	Education (access, health literacy, workforce development and mobility)	587
15	Screening (BMI, blood pressure, diabetes, cancer, STD, depression)	542

No.	Health Condition/ Social Issue	Ranking Score
16	Social support (social interaction/engagement, cultural and linguistic support)	435
17	Infectious diseases (e.g., hepatitis, tuberculosis, etc.)	300
18	Stigma (immigration status, behavioral health, use of public programs - e.g., food stamps)	296
19	Physical environment (transportation, grocery store/market access, air quality, walkability)	295
20	Safety and violence (community violence, domestic violence, child or elder abuse)	246
21	Stroke	231
22	Respiratory issues (e.g., Asthma, COPD, etc.)	206
23	Maternal/infant health	197
24	Unintentional injury	185
25	Prenatal and maternal care (breastfeeding, post-partum support)	101
26	Other health condition	88
27	Sexually-transmitted disease (e.g., HIV/AIDS)	76
28	Other social issue	62
29	Oral health	56
30	Lung disease	29

Question: Below is a combined list of the health conditions and social issues that you selected in the previous questions. Please rank them in order of importance from 1 to 10, with 1 having the greatest impact on the overall health and well-being of your community.
Survey Responses: n=380
Page 10 Source: Sharp Insight Community – Community Health Needs Assessment 2019 Survey

SHARP

Access to Health Care

Definition

Access to care refers to the ease with which an individual can obtain needed medical services.[14]

Findings

Access to health care includes two components: the specific services that individuals are unable to obtain, and the barriers and SDOH that prevent individuals from obtaining those services.

1. Types of care that are difficult to access:
    - Behavioral health care
    - Dental care
    - Primary care
    - Specialty care
2. Barriers to accessing care and associated SDOH:
    - Culturally competent care
    - Economic security
    - Fear related to immigration status
    - Lack of health insurance and insurance issues
    - Shortage of health care providers
    - Transportation

Access to health care emerged as a high priority health need in both the SGH and HASD&IC 2019 CHNA secondary data analyses and community engagement activities.

Secondary Data Findings

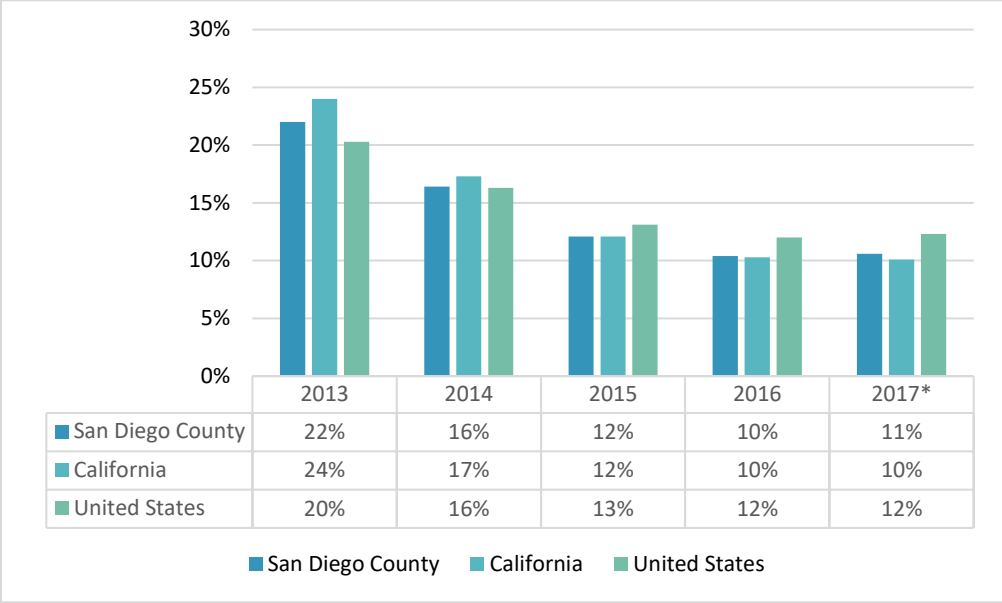
Data are available regarding three components of health care access in SDC: (1) health insurance coverage; (2) preventable hospital events; and (3) receipt of regular care from a primary care physician (PCP).

Health Insurance Coverage

A lack of health insurance coverage represents a major barrier to health care services. In SDC, 11.0% of people are uninsured. Certain groups, including those who identify as "other race," Native American/Alaska Native, Hispanic, Pacific Islander, and Black, have higher rates of being uninsured than others. See **Figures 15**, **16** and **17** below for additional details.

[14] RAND Corporation. https://www.rand.org/topics/health-care-access.html

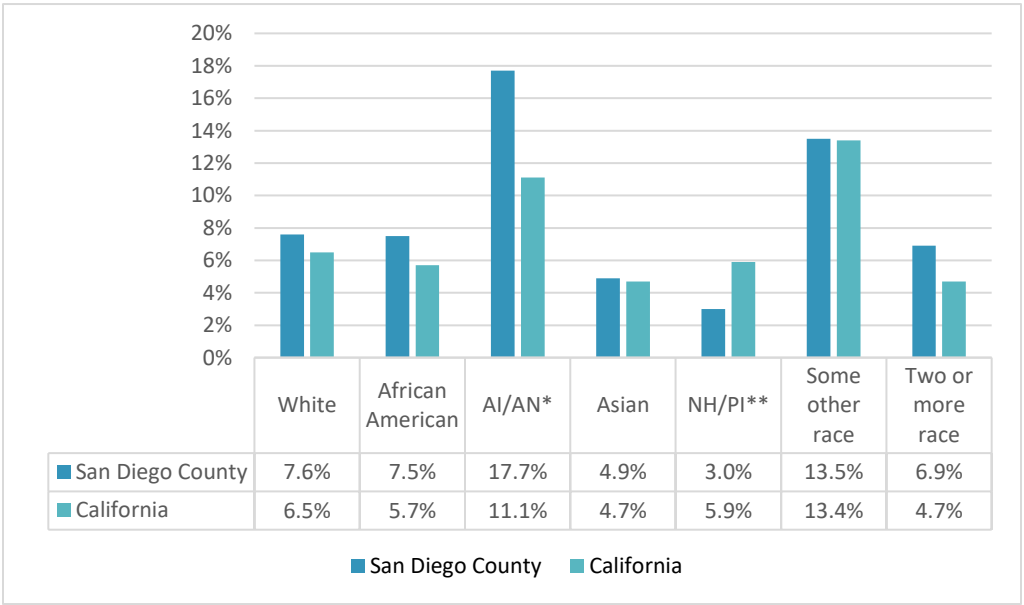
Figure 15: Percentage of Population without Health Insurance in SDC, CA, and the United States. Ages 18-64 Years, 2013-2017



	2013	2014	2015	2016	2017*
San Diego County	22%	16%	12%	10%	11%
California	24%	17%	12%	10%	10%
United States	20%	16%	13%	12%	12%

Source: U.S. Census Bureau. American Community Survey, 2013-2017 1-Year Estimates. Includes civilian non-institutionalized population.
*Ages 19-64 years

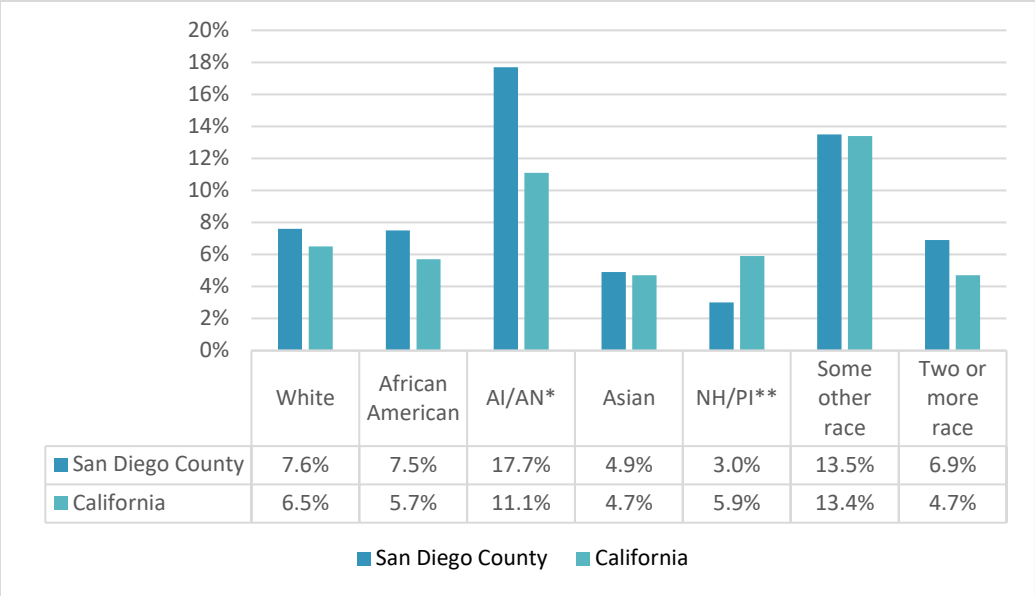
Figure 16: Percentage of Population without Health Insurance in SDC and CA. Ages 19-64 Years by Race, 2017



	White	African American	AI/AN*	Asian	NH/PI**	Some other race	Two or more race
San Diego County	7.6%	7.5%	17.7%	4.9%	3.0%	13.5%	6.9%
California	6.5%	5.7%	11.1%	4.7%	5.9%	13.4%	4.7%

Source: U.S. Census Bureau. American Community Survey, 2017 1-Year Estimates. Includes civilian non-institutionalized population.
*American Indian and Alaska Native
**Native Hawaiian and Other Pacific Islander

Figure 17: Percentage of Population without Health Insurance in SDC and CA. Ages 19-64 Years by Ethnicity, 2017

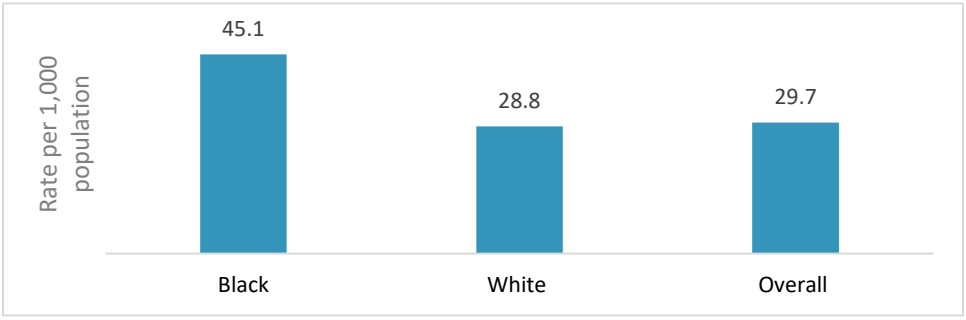


Source: U.S. Census Bureau. American Community Survey, 2017 1-Year Estimates. Includes civilian non-institutionalized population.

Preventable Hospital Events

Another measure of access to care is how often "preventable hospital events" occur. This number is the patient discharge rate for health conditions that are "ambulatory care sensitive" — conditions that could have potentially been prevented or managed with proper preventive care, such as pneumonia, dehydration, asthma and diabetes. In SDC, the rate of preventable hospital events is 29.7 per 1,000 residents. For Black individuals, however, this rate is higher — 45.1 per 1,000 residents — suggesting that Black individuals may have more difficulty accessing primary care resources[3] (see **Figure 18**).

Figure 18: Preventable Hospital Events for Medicare Beneficiaries in SDC by Race, 2015

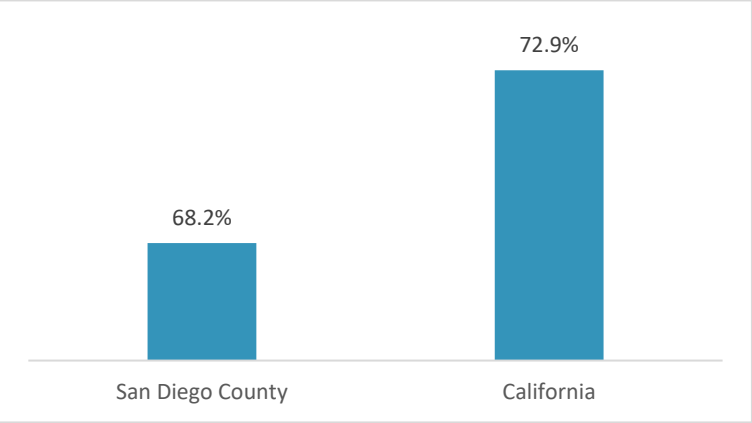


Source: Dartmouth Atlas Data website, which was funded, in part, by the National Institute of Aging, under award number U01 AG046830 and by The Dartmouth Institute for Health Policy and Clinical Practice.

Visits with a Primary Care Physician

Finally, visits to a PCP are a measure of preventive health care service access and utilization, which contribute to health maintenance. While many San Diegans (71.8%) have seen a PCP in the past year, Medicare beneficiaries, a group made up primarily of people ages 65 and older, are less likely to receive regular care from a PCP. Of this group, only 67.4% have seen a PCP in the last year (2015). This is lower than the California state average of 72.9% (see **Figure 19**).

Figure 19: Percentage of Medicare Beneficiaries who have seen a PCP within the Past Year in SDC, 2015



Source: Dartmouth Atlas Data website, which was funded, in part, by the National Institute of Aging, under award number U01 AG046830 and by The Dartmouth Institute for Health Policy and Clinical Practice.

Please see **Appendix O** for Access to Health Care secondary data source information.

Community Engagement Findings

HASD&IC 2019 CHNA

Across all types of *HASD&IC 2019 CHNA* community engagement activities, access to health care was identified by participants as a priority health need in SDC.

Respondents to the *HASD&IC 2019 CHNA* online survey ranked access to care as the health need having the greatest impact on the overall health and well-being of SDC residents out of all listed health conditions and SDOH. See **Appendix S** for a full summary of survey results.

During the *HASDIC 2019 CHNA* focus groups and KI interviews, participants often cited accessing care as the most challenging issue facing their communities. Frequently discussed topics related to access to care included:

- Barriers to care
- The types of care most challenging to access
- People for whom access to care is particularly problematic

Please see **Table 20** or **Appendix T** for a summary of these findings. Further detail is included in the **Discussion of Community Engagement Findings** below.

Sharp 2019 CHNA – Focus Groups

Access to care was identified as having a significant impact on health outcomes and well-being consistently across all of the Sharp/SGH 2019 CHNA focus groups, including: *Sharp Diabetes Health Educators*, *Sharp Case Management Leadership, Sharp Cancer Patient Navigators and Social Workers*, *Sharp Senior Health Center* staff and patients/community members and *Sharp Patient Family Advisory Council (PFAC)* members. Details specific to the *Sharp Case Management Leadership* and *Sharp PFAC* focus groups are included in the **Discussion of Community Engagement Findings** below. **Tables 21** and **22** present summaries of findings from these two focus groups. Please refer to **Appendix U** for a summary of all SGH/Sharp focus groups.

Sharp 2019 CHNA – Sharp Insight Community

Sharp's Insight Community online survey provided greater understanding of access to health care as an identified health need among Sharp patients and community members. Among 14 SDOH, respondents (n=380) ranked access to health care (primary care, dental care, behavioral health, specialty care) as the second most important SDOH impacting their community. Please refer to **Appendix R** for *Sharp Insight Community* participant rankings of SDOH.

When health conditions and SDOH were combined among all respondents, access to health care once again ranked as the second most important health need among a total of 30 choices. Please refer back to **Figure 14** for the final ranking of health conditions and SDOH by *Sharp Insight Community* survey participants.

Discussion of Community Engagement Findings

HASD&IC 2019 CHNA Focus Groups and KI Interviews

HASD&IC 2019 CHNA community engagement participants identified five primary barriers to accessing health care in San Diego: (1) lack of insurance; (2) economic insecurity; (3) transportation; (4) fear related to immigration status; and (5) lack of culturally competent/linguistically appropriate care options.

Lack of insurance was named as an important barrier to care for San Diego residents. The lack of insurance, participants explained, arises from the inability to pay for insurance due to competing financial priorities (particularly housing), the limited

availability of insurance for undocumented residents, and from fears that applying for public insurance, such as Medi-Cal, for their children, will lead to deportation or interfere with a path to citizenship.

Economic insecurity was discussed not only as an underlying reason for not obtaining health insurance but also as a reason for not attempting to receive needed care for acute issues and, particularly, preventive care for health management. Health insurance premiums, co-pays, co-insurance, and out of pocket payments were described as financially prohibitive for many residents. In addition, participants indicated that taking time off work, and losing those paid hours as a result, is not a realistic option for most low-income people.

Transportation was also discussed as a significant obstacle to health care access. Community engagement participants noted that for those without cars, public transportation to health care appointments can be time-consuming, expensive and inconvenient, and some hospitals and clinics are not easily reached by public transportation. Transportation was noted to cause particular challenges for seniors, those in rural areas, and those who are homeless.

Fears related to immigration status came up as an important and pressing topic during nearly all of the community engagement activities. Participants described undocumented immigrants as living in a “constant state of fear” of detention and deportation. This fear, in turn, they said, prevents them from receiving health care, even in acute situations. During focus groups, many stories were told about Immigration and Customs Enforcement raids that resulted in the long-term detention and sometimes deportation of San Diego residents who have lived and worked in the community for decades. Parents talked about being terrified of being separated from their children. Community members also made clear that even immigrants who are in the country legally are worried that the receipt of public benefits or community services will create obstacles in their path to citizenship.

Finally, *HASD&IC 2019 CHNA* community engagement participants noted that the inability to obtain culturally competent/linguistically appropriate care keeps residents from receiving health care. They noted that most individuals prefer to receive health care from people who are from or who understand their cultural background, and that cultural mismatches between health care providers and patients can create mistrust. They also noted that translators are often not available, which makes health care visits frustrating for both the patient and the provider. At times, the participants discussed, children must be utilized as translators, which can create both an undue burden for the children and an uncomfortable situation for the parents when they would rather keep their health information private.

Several other barriers were mentioned but with less frequency:

- Lack of knowledge in the community about available resources and about where to receive specific types of health care

- How to navigate the health care system, particularly in regards to accessing specialists after a diagnosis
- Too few hospitals and clinics in SDC
- Workforce shortages in certain areas of health care (e.g., mental health)

HASD&IC 2019 CHNA community engagement participants emphasized that while all types of health care can be difficult to access, obtaining timely, quality behavioral health services is particularly challenging. Both mental health care and substance abuse treatment were discussed.

Several issues related to mental health care arose during the community engagement activities. For those who are insured, finding a mental health care provider who is available after work or school hours, located reasonably close to home or work, has openings in a short time-frame, and takes their insurance is a time-consuming and frustrating process. For those without insurance, participants felt that it is nearly impossible to find a mental health care provider. A shortage of urgent care mental health options was also discussed. Participants also noted that there are too few inpatient psychiatric beds and that, often, those who have been hospitalized cannot secure appropriate and effective transitional mental health services.

Participants also emphasized a dire shortage of substance use disorder treatment options. For those with addictions, inpatient programs have long waiting lists, and there are too few urgent care options.

Other types of care that *HASD&IC 2019 CHNA* community engagement participants mentioned less frequently included:

- Oral health/dental care
- Specialty appointments after a diagnosis is made
- Primary care
- Urgent care

HASD&IC 2019 CHNA community engagement participants stressed that for certain people, access to care is especially difficult, and that these challenges contribute to and worsen health disparities. Groups cited as particularly vulnerable included:

- Seniors
- Homeless individuals
- Sexual minorities (LGBTQ individuals)
- Immigrants
- Low-income individuals
- Racial/ethnic minorities

Participants explained that all of these groups may be more vulnerable to poor health, so the people who need consistent, quality health care the most may not receive it.

Sharp 2019 CHNA – Focus Groups

In the *Sharp PFAC* focus group, participants identified barriers to accessing care as financial issues, challenges navigating the health care system and insurance issues, lack of health literacy, fears regarding immigration issues, and cultural/language issues. Limited finances were portrayed as a primary barrier to care. Contributors emphasized that the cost of health insurance, co-pays and transportation prevents people from getting necessary health care. People in the community, they explained, are often faced with competing priorities for limited finances, and when the choice is between food or medicine, they choose food.

Sharp PFAC focus group participants highlighted that difficulties with navigation of both the health care system itself and the insurance system also create obstacles to care. One example shared by a focus group member is that some people do not understand that the lower their insurance premium is, the higher their deductible will be. Another contributor talked about how enrolling in public health insurance programs is complicated, and the materials can be difficult to read. Yet another contributor talked about how some people don't understand when they should go to a primary care appointment versus urgent care versus the emergency room. Lack of health literacy about preventive care, illness and disease was also described as a barrier to care.

Sharp PFAC focus group participants explained that all of these issues are exacerbated by language and cultural barriers. New immigrants may be unfamiliar with the U.S. health care system and unaware of available resources. Many are afraid that if they utilize services, their immigration status may be questioned and they may be deported. *Sharp PFAC* focus group contributors also reported that more translation services are needed, and that cultural mismatches between health care provider and patient can cause mistrust.

Sharp PFAC focus group participants also talked about specific challenges for patients who have been discharged from the hospital. Inadequate support at home for people living alone was noted to be a concern, including having enough food, especially among seniors. Transportation to follow-up appointments was also presented as a challenge, particularly for people with limited mobility.

Finally, *Sharp PFAC* focus group contributors highlighted the impact these types of challenges can have. They explained that trying to understand and utilize the health care system and insurance can be physically and mentally exhausting. They also asserted that, for some, depression may develop from the frustration of trying to figure out who will pay for their health care and how they will get there. Please refer to **Table 21** or **Appendix U** for a summary of feedback from the *Sharp PFAC* focus group.

Access to care was discussed extensively during the *Sharp Case Management Leadership* focus group, and contributors cited many factors that serve as obstacles to good care for high-risk populations, including economic and food insecurity, housing,

challenges with insurance for patients and for hospitals, fears related to immigration status, waiting lists for appointments, and issues specific to discharge care.

Sharp Case Management Leadership focus group participants discussed economic insecurity as a barrier to both care access and effective management of chronic conditions. For example, many people cannot afford to take time off work for medical appointments, so they attempt to manage their care around their work schedule. Some medications were identified as being particularly expensive. Related to this, many patients experience food insecurity. One participant shared that patients on a limited income have a hard time choosing between paying their copays and for their medications and eating. This, the participant emphasized, occurs even with those who are insured.

Housing costs and concerns also keep people from getting care, *Sharp Case Management Leadership* focus group members said. “Their main concern,” one participant noted, “is having a home to live in rather than managing their own care….so there is a tendency to delay receiving health care until an emergency situation arises.”

Insurance issues were also described as problematic, both for patients and for hospitals. It is difficult for patients to understand what their insurance will cover. *Sharp Case Management Leadership* focus group members reported that for hospitals, certain case managers spend a lot of time going back and forth with insurance companies — particularly about completed discharges — and the hospital often ends up taking the loss. In addition, many skilled nursing facilities and home health programs do not accept Medi-Cal, making them inaccessible to many people.

Fears related to immigration issues were also brought up as a concern for accessing care. Although eligibility for public insurance has broadened, many people will not sign up, they said, due to fear of being put on a “black list” for utilizing public services. For undocumented women, *Sharp Case Management Leadership* focus group participants explained, follow-up care is extremely difficult because while the mother wants to ensure the well-being of her baby, she is also fearful of immigration officials finding her at medical appointments.

Waiting lists to receive care also create obstacles, *Sharp Case Management Leadership* focus group participants emphasized. It can take a long time to see a PCP, and specialists have even longer waiting lists. Finally, focus group participants discussed issues related to discharge. Transportation support, *Sharp Case Management Leadership* focus group participants said, particularly for those with debilitating conditions, is difficult to access. Recuperative care, they outlined, is also scarce. And for patients who are elderly, it is challenging to find and afford short-term caregivers after hospital discharge. Please refer to **Table 22** or **Appendix U** for a summary of feedback from the *Sharp Case Management Leadership* focus group.

Access to care was mentioned frequently throughout the *Sharp Diabetes Health Educator, Sharp Mary Birch Hospital for Women & Newborns (SMBHWN) Social*

Workers & Case Managers, *Sharp Cancer Navigators and Social Worker,* and *Sharp Senior Health Center* focus groups as well. Please see the findings for **Aging Concerns**, **Diabetes**, **Maternal and Prenatal Care, including High-Risk Pregnancy** and **Cancer** for specific feedback on access to care and its connection to these identified health needs.

Sharp 2019 CHNA Suggestions

Sharp PFAC focus group participants proposed several suggestions to improve community health, all of which address the identified need of access to care:

- Prioritize the hiring and training of social workers. Social workers can coordinate care, create discharge plans, and make follow-up appointments. Patients are in need of a supportive advocate at the time of discharge.
- Offer free post-surgery home visits.
- Make follow-up phone calls to see if patients who have been discharged are doing well and getting proper follow-up care.
- Make in-home care more accessible, particularly for older patients.

Sharp Case Management Leadership focus group participants also offered suggestions to improve the health outcomes of their patients. These suggestions all seek to address the challenge of access to care:

- Ensure 2-1-1 Community Information Exchange (CIE)[15] access for all Sharp facilities.
- Establish more patient-centered initiatives.
- House a program onsite at hospitals that helps place people in housing, gets them referrals/helps with applications to affordable housing.
- Create more home support services and adult day centers to help patients transition back to the community or home after hospital discharge.
- Establish a more streamlined process and a communication system between the hospitals and the County about those who qualify for wraparound services, such as Whole Person Wellness.

Sharp Insight Community survey participants also had the opportunity to provide specific suggestions about what Sharp can do to improve the health and well-being of the community. See **Appendix R** for the most commonly suggested themes, among which 'Improving access to health care' was second most common. Feedback related to access to care included:

[15] 2-1-1 San Diego's Community Information Exchange (CIE) is an ecosystem comprised of multidisciplinary network partners that use a shared language, a resource database, and an integrated technology platform to deliver enhanced community care planning. Care planning tools enable partners to integrate data from multiple sources and make bi-directional referrals to create a shared longitudinal record. *Source*: https://ciesandiego.org/what-is-cie/

- Lower insurance premiums and co-pays; make lower cost health insurance available to Per Diem employees; lower prices and provide a “menu” of services with prices for people with or without insurance.
- Heighten access for low income or limited insurance community members; offer clinics or outreach health care for those without insurance or money to pay; help more people secure insurance to fund programs.
- Advocate for more community-based programs from politicians.
- Offer later appointments or early mornings for working people; shorten wait times for appointments; sometimes obtaining an appointment takes a long time — have more resources so that appointments can be made sooner.
- Provide bus schedules that show routes directly to Sharp facilities.
- Mobile Units — if it is possible to go out to the public, it could help address some of the transportation concerns and even help with some of the stigma concerns by coming to the patient and making it convenient to be seen.
- Create an “app” (for cell phone, etc.) for access to medical records and doctor appointments.

Additional recommendations from the *Sharp Insight Community* survey can be found in **Appendix R**.

Please refer to **Tables 21** and **22** for a summary of responses from the *Sharp PFAC* and *Sharp Case Management Leadership* focus groups.

Table 20: HASD&IC 2019 CHNA – Focus Group and KI Interview Summary of Responses Related to Access to Care

SUMMARY OF RESPONSES RELATED TO ACCESS TO HEALTH CARE		
ASSOCIATED HEALTH CONDITIONS AND NEEDS		
All Age Groups • **Cancer** • **Chronic diseases** (diabetes) • **Mood disorders** (anxiety, depression, stress) • **Substance use disorder** • **Sexually transmitted diseases** • **Suicide & self-harm** • **Trauma** (generational, PTSD, psychological)	**Children/Youth** • **Mood disorders** (anxiety) • **Substance abuse** (alcohol, drugs) • **Suicide & self-harm** • **Trauma** from experiences before coming to America (war, bombing, gas attacks)	**Senior** • **Alzheimer's** • **Dementia** • **Mood disorders** (anxiety, depression, schizophrenia)
ASSOCIATED SOCIAL DETERMINANTS OF HEALTH		
All Age Groups • **Access to dental care:** lack of access to dental care • **Access to mental health services:** lack of services, psychiatrists, PERT, and detox centers for homeless • **Care coordination**: lack of knowledge in navigating the health care system • **Cultural and language barriers** in health care • **Economic insecurity:** insurance costs, services for mental, dental, primary care, surgeries, transgender services, vaccinations, and preventative care • **Education**: Lack of community resident awareness of services • **Follow-up care:** limited follow-up care • **Healthy foods**: lack of access to healthy foods	• **Housing and homelessness** • **Insurance issues** • **Shortage of health care facilities:** shortage of hospitals and clinics, especially in east region • **Shortage of health care providers:** lack of specialists, nurses, medical assistants • **Stigma:** LGBTQ marginalization, doctors refuse to prescribe PrEP, doctors shame patients for getting STD testing • **Transportation**: lack of transportation • **Violence** (fear, homelessness)	**Children/Youth** • **Lack of school-based services** to support emotional and mental health of students • **Education**: lack of education on sexual health (e.g., HIV) • **Stigma** • **Vaccinations** (difficult to access especially among homeless families due to being transient) **Seniors** • **Economic insecurity** • **Services**: limited mental health insurance coverage, senior population increasing, but government is not adjusting to accommodate raising needs • **Social isolation** and loneliness • **Stigma** • **Transportation**
ASSOCIATED BARRIERS AND CHALLENGES		
All Age Groups • **Distrust**: community versus hospital, patient versus doctor and social worker • Lack of **patient autonomy** in making discharge decisions • **Lack of storage** (medications for homeless)	**Children/Youth** • Lack of **follow-up care** post-referral • **Lack of parental involvement** due to cultural differences • **Parental consent** to access services	**Seniors** • **Mobility issues**

• **Long wait times**	• **Vaccinations** and test results across the border are not accepted • Bullying

Table 21: Sharp 2019 CHNA – Sharp HealthCare Patient Family Advisory Council Focus Group Summary of Responses

SHARP HEALTHCARE PATIENT FAMILY ADVISORY COUNCIL - SUMMARY OF RESPONSES	
HEALTH CONDITIONS AND NEEDS	
Adults • **Behavioral/Mental health:** including drug abuse • **Stroke** • **Cardiac/Cardiovascular issues** • **Diabetes** • **Hepatitis** • **Opioid addiction** • **Sciatica**	**Seniors** • **Alzheimer's** • **Aging concerns** such as pain management • **Dementia** **Children and Youth** • **Asthma** • **Food allergies**
SOCIAL DETERMINANTS OF HEALTH	

Adults
• **Access to health care:** difficult to navigate health care system
• **Economic security**
  ○ Unaffordable **housing**
  ○ Substandard **housing** conditions such as mold, asbestos, or lead paint in low-income neighborhoods.
  ○ Lack of **access to healthy food**: junk food is cheaper while healthy food is expensive.
  ○ **Food insecurity:** lack of access to WIC, CalFresh, and other publicly funded food programs. Blackout dates for electronic benefit transfer (EBT) funds due to federal funding.
• **Education** needed on:
  ○ Dementia or Alzheimer's
  ○ How to be a caregiver
  ○ Therapy options & available support groups
  ○ How to navigate the immigration system
• **Fear**: patients delay surgery due to fear.
• **Immunization and Vaccinations:** families are fearful of autism.
  ○ People are uncertain of where to get flu shots and how to pay for them. Misinformation on side effects.
• **Insurance issues**: insurance is expensive especially copays for families.
	Seniors
	• **Food access and food insecurity** which can lead to readmissions.
	• **Economic security**: due to fixed income
	• **Transportation** lack of access to transportation and decreased capacity to drive.
	Children and Youth
	• **Food insecurity and healthy food access**
	  ○ School meals are primary source of food, quality is questionable.
	• **Access to care** is often times delayed.
	• **Behaviors**: access to caffeine energy drinks and coffee is a concern especially in regards to brain development.
	  ○ **Drugs and Smoking**: access to age-restricted substances such as marijuana, E-cigarettes and vaping.
	• **Community and Family Support**: school pressure causes children to be stressed.
	  ○ Pressured by parents to do extracurricular activities, volunteer work, and sports all in an effort to apply for Ivy League schools.
	  ○ Peer pressure
	• **Immunization** against measles and polio.
	• **Sex trafficking** especially in the Parkway Plaza area which affects individuals of all socioeconomic statuses.

- **Transportation** issues cause delays seeing doctors, especially those living in rural areas.
- **Technology**: electronics and social media leads to sleep deprivation, attention problems, and poor sleep quality.

YOUTH ROLES IN FAMILY CARE

- Help with family routines such as helping with taking care of siblings, driving, cooking.

ACCESS TO HEALTH CARE CHALLENGES AND BARRIERS

- **Economic security**
  - High cost of medication is of special concern for seniors impacting their access to health care
  - Food insecurity.
- **Education**: lack of health education and health literacy. Patients do not understand when to use urgent care versus the ED.
- Problems **navigating health insurance** such as understanding health plans.

DAILY LIVES

How do these health and social conditions affect community member's daily lives?

- People can develop depression when trying to figure out how they will pay for their health care or how to secure transportation to appointments.
- People experience mental and physical exhaustion from trying to understand the health care system and insurance.

HOSPITAL DISCHARGE CHALLENGES AND BARRIERS

- **Transportation** is a challenge.
- **Medication** reconciliation of old versus new medications.
- **Language** issues or language barriers.

HOSPITAL DISCHARGE SOLUTIONS

- **Follow-up care and phone calls**
  - Improving social workers role in ensuring follow up care and continuity of care post discharge.
  - Follow up phone calls post discharge especially if patients have rehabilitation scheduled.
- **In-home care and visits**
  - Providing free home visits for post-surgery follow-up.
  - Access to affordable **in-home care** options is needed.
- Patients need a supportive **advocate** at the time of discharge.

IMMIGRATION

Have you observed any changes in the community's health and wellbeing as a result of immigration policies, attitudes and beliefs?

- Some community members believe that new diseases will arrive in the U.S. due to the lack of health care received by immigrants prior to entering the U.S.

Accessing care for undocumented population:

- There is fear of looking for help or accessing care for the undocumented. Often times they have more health issues than the general population

Accessing care for the Middle Eastern (refugee) population:

- **Cultural**: Sometimes there is cultural preference or bias in the language, especially with women because men often make choices for the women, so translation can sometimes be inaccurate
  - They are not accustomed to accessing health care or are unfamiliar with how to access health care in the U.S.
- **Education**: health literacy, knowledge of how to navigate healthcare system. New immigrants are unaware of services available.
- **Fear**: some are afraid of police or authority in general.
- **Language barriers**: there are issues surrounding translations services over the phone versus using someone such as a family member. Some hospital policies are to **not** use family members due to confidentiality and translation issues.

- If there is a workshop or a service refugees are interested in, it is generally not in their language
- **Translations**: for Sharp Grossmont Hospital specifically, many Middle Eastern immigrants need documents translated in their native languages (Farsi, for example)

- **Trauma:** Many come from war zones; have mental trauma, PTSD, and/or depression.

Table 22: Sharp 2019 CHNA – Sharp HealthCare Case Management Leadership Focus Group Summary of Responses

SHARP HEALTHCARE CASE MANAGEMENT LEADERSHIP - SUMMARY OF RESPONSES	
HEALTH CONDITIONS AND NEEDS FOR PATIENT AND FAMILY MEMBERS	
• **Aging concerns** • **Cancer** • **Congestive heart failure** • **COPD**	• **Diabetes** • **Encephalopathy**: specifically liver transplant patients from SGH • **Mental Health**: including alcohol/substance misuse
SOCIAL DETERMINANTS OF HEALTH FOR PATIENT AND FAMILY MEMBERS	

• **Access to health care**
  ○ Lack of SNFs for Medi-Medi patients
  ○ Lack of access to timely care
• **Behaviors** such as smoking, alcohol and substance misuse. Smoking in East County and hookah habits in the Middle Eastern population.
• **Community and social support**
  ○ Lack of family support.
  ○ Lack of caretaker support: no family or spouse to care for when discharged.
	• **Economic security**
	  ○ Food insecurity
	  ○ Lack of childcare due to cost and inability to take time off work to care for newborn.
	• **Housing:** lack of affordable housing.
	• **Insurance issues** and underfunding.
	  ○ Skilled nursing facilities and home health do not accept Medi-Cal.
	• **Health literacy**: not knowing where to get care.
	• Lack of **transportation**

ACCESS TO HEALTH CARE CHALLENGES AND BARRIERS	
• Long wait times to access care leads to readmissions, often times there is a six-month minimum to see a specialist. • Many access issues are insurance driven which creates a backup in hospitals. • Many individuals are unaware that they have a primary care provider which can cause delays in home health referrals.	
HOSPITAL COMMUNICATION Do you or your staff interact with community clinics, social services organizations, or other community resources in any way to support patients/their families?	
• Some case managers use 2-1-1 San Diego as a means to connect patients to needed social services by sending a referral electronically using their electronic health record system.	
HOSPITAL AND COMMUNITY SUPPORT NEEDED	
• **2-1-1 Community Info Exchange Access** is needed for all Sharp facilities to inform next steps for patient discharge (Sharp Grossmont and Sharp Chula Vista currently do not have access, as of 2/21/19). • **Housing** is the number one need for many patients. ○ **Patient-centered initiatives**: there is a need for more patient-centered initiatives, especially with housing.	

○ **Dedicated housing coordinator**: there is a need for an on-site coordinator (non-Sharp staff) whose sole job is to place people in housing or get them referrals/applications to affordable housing.
HOSPITAL DISCHARGE CHALLENGES AND BARRIERS
♦ **Transportation** support is needed, especially for very debilitating health conditions. ○ Need a dedicated person on-site to help patients fill out the metropolitan transit system applications for those who qualify for discounted bus passes due to having a disability. ♦ **Recuperative care** ○ San Diego Rescue Mission's closure means less respite care capacity. ○ The lack of recuperative care forces case managers to discharge patients to Board and Care facilities or Independent Living Facilities, which is very expensive for patients. ♦ **Short term caregivers**: need for additional short-term caregivers to help transport patients and check in on patients. ♦ **Home support services:** need additional in-home support services for hospitals or adult day centers to help patients transition back to the community or home. ♦ **Wraparound service support**: there is a need to streamline the process from the hospital to the County for those who qualify for wraparound services.
IMMIGRATION Have you observed any changes over the past year in patient/community member attitude towards immigration issues?
♦ **Fear** ○ There has been an increase of patients who are eligible for insurance, but will not sign up due to fear of public charge. ○ Patients are fearful of being put on a blacklist if they use public funded services. ○ Immigrants fear that if they use Medi-Cal their property will be taken away.

Aging Concerns

Definition

Aging concerns are defined as those conditions that predominantly affect seniors — people who are 65 and older — such as Alzheimer's disease, Parkinson's disease, dementia, falls and limited mobility.

Findings

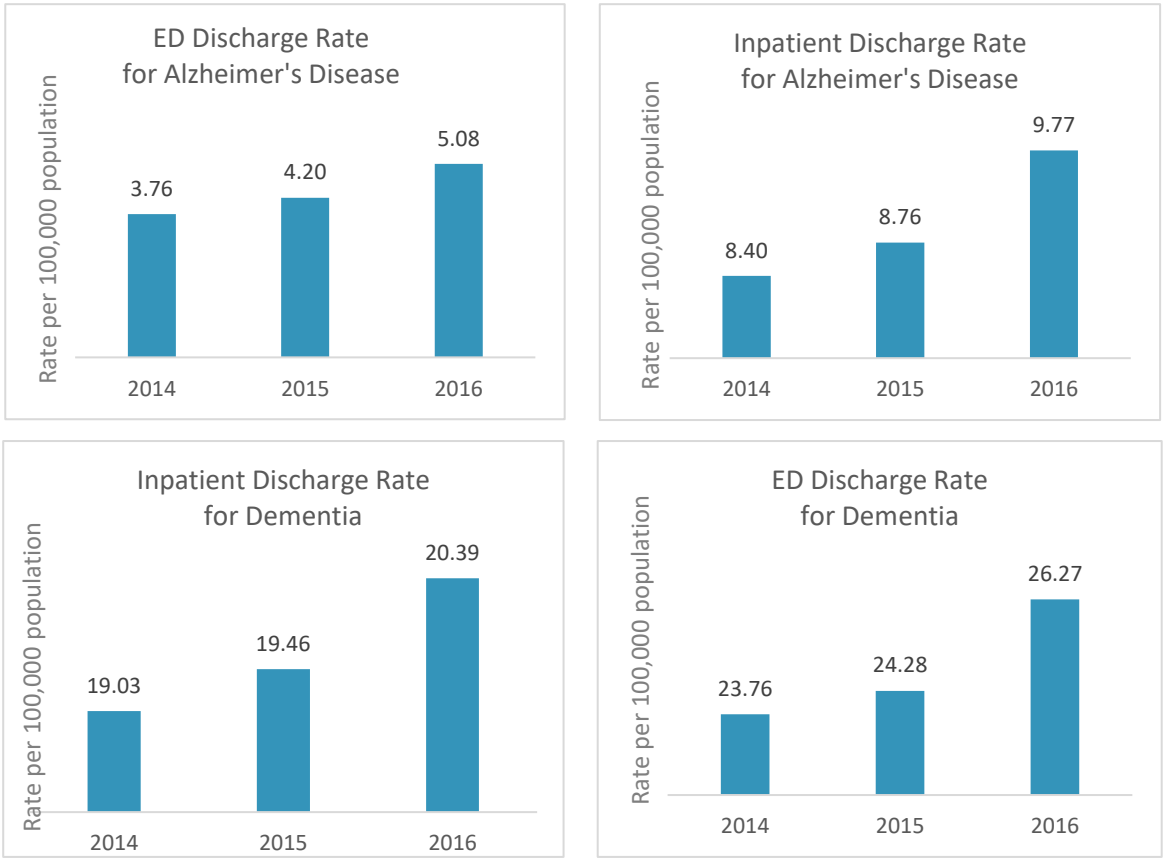
Conditions that disproportionately affect older adults were identified as a high priority health need through both the SGH and HASD&IC 2019 CHNA community engagement activities and secondary data analyses. Community engagement participants most often described aging concerns in relation to the SDOH that affect seniors such as:

- Transportation
- Access to fresh food
- Social isolation and inadequate family support
- Economic insecurity

Secondary Data Findings

According to SDC data, hospital discharges have increased from 2014-2016 for both Alzheimer's disease and dementia (see **Figure 20**). For Alzheimer's disease, the ED discharge rate increased by 35.1%, and the inpatient discharge rate increased by 16.3%. For dementia, the ED discharge rate increased by 10.6%, while the inpatient discharge rate increased by 7.1%.

Figure 20: ED Visit and Inpatient Discharge Rates for Alzheimer's Disease and Dementia in SDC, 2014-2016

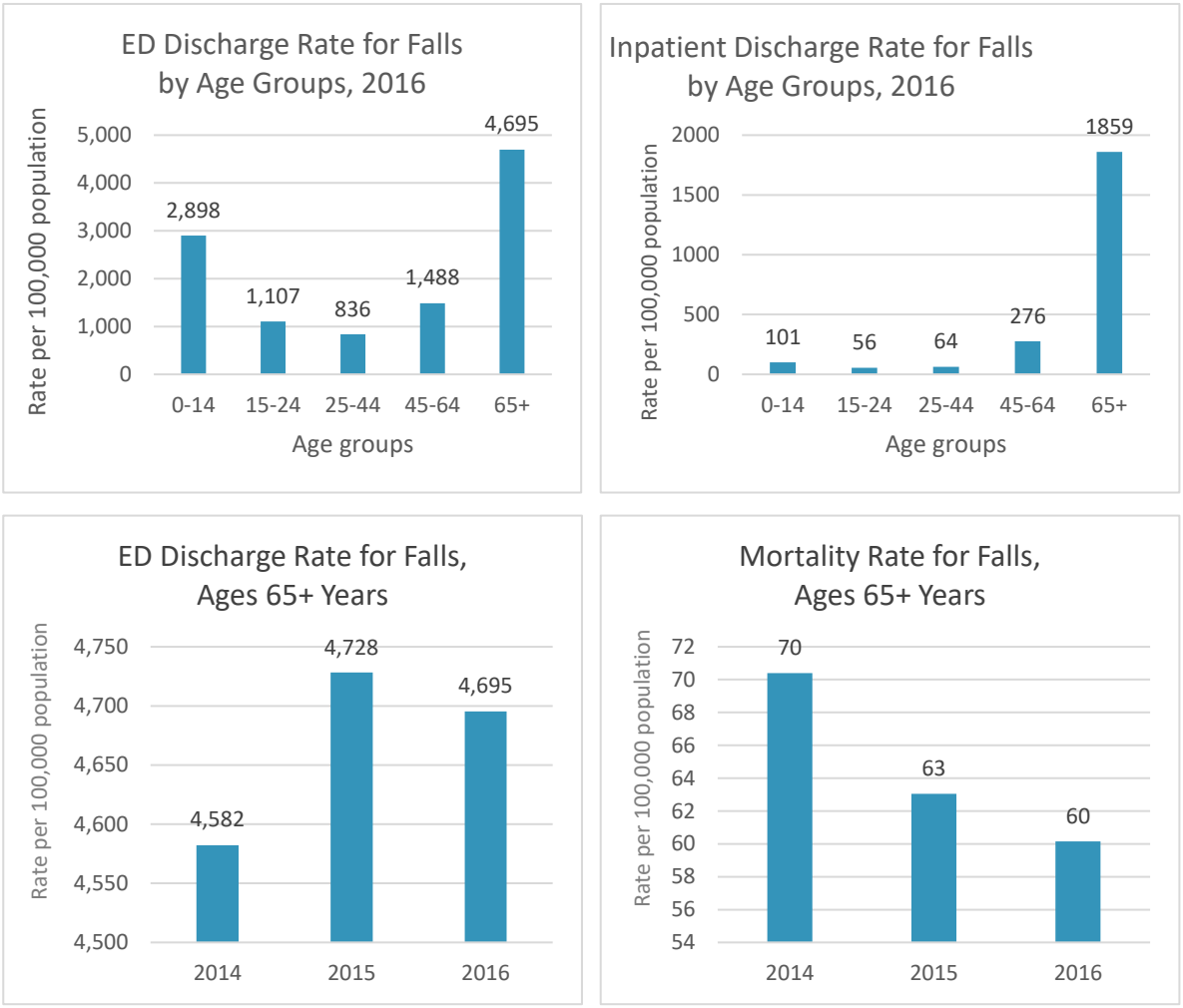


Source: California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2014-2016. SpeedTrack©

In addition, Alzheimer's disease was the third leading cause of death and Parkinson's disease was the 12th leading cause of death in SDC in 2016.

SDC data shows that falls disproportionally affect those over 65 years of age. From 2014 to 2016, ED visits for seniors increased by 2.5%, however, the mortality rate for falls decreased by 14.5% in the same time period. Please see **Figure 21** below for more details.

Figure 21: ED Visit, Inpatient Discharge, and Mortality Rates for Falls in SDC, 2014-2016



Source: Live Well San Diego. Live Well San Diego Data Access Portal. Injury. https://data.livewellsd.org/

Please see **Appendix O** for Aging Concerns secondary data source information.

Notable findings from an analysis of SGH discharge data related to aging concerns included[16]:

Dementia

- Seniors admitted to SGH with a behavioral health diagnosis were more likely to have dementia (42.5%) when compared to all behavioral health inpatient discharges (18.5%).

[16] California Office of Statewide Health Planning and Development (OSHPD) Non-Public Inpatient Discharge and Emergency Department Encounter Data, 2017. Accessed through SpeedTrack Inc.©

- Seniors visiting the ED at SGH with a behavioral health diagnosis were significantly more likely to have dementia (34.6%) when compared to all behavioral health ED visits (6.2%).

Falls

- In 2017, seniors represented 59.4% of inpatient discharges for unintentional injury at SGH, with fall-related injuries occurring in 81.5% of those discharges.

CVD

- In 2017, seniors represented 44.7% of ED visits where a CVD diagnosis was present.

- In 2017, the top three inpatient CVD diagnoses among seniors at SGH were classified as hypertension, Coronary Artery Disease (CAD), and heart failure.

Diabetes

- In 2017, individuals identified as Other Race comprised 26.7% of all senior inpatient discharges and 30.5% of all senior ED visits at SGH, yet comprised 35.9% of senior inpatient discharges and 40.1% of senior ED visits with a Type 2 diabetes diagnosis, respectively.

- In 2017, the top three inpatient and ED Type 2 diabetes diagnoses among seniors at SGH were Type 2 diabetes (uncomplicated), Type 2 diabetes with Chronic Kidney Disease, and Type 2 diabetes with hyperglycemia (high blood sugar).

Obesity

- In 2017, seniors represented 35.0% of inpatient discharges at SGH with a diagnosis related to obesity.

Arthritis

- In 2017, seniors represented 63.4% of inpatient discharges at SGH with a diagnosis related to arthritis.

Community Engagement Findings

HASD&IC 2019 CHNA

Respondents to the *HASD&IC 2019 CHNA* online survey identified Alzheimer's disease as one of the top 10 most impactful behavioral health conditions in SDC. See **Appendix S** for a full summary of survey results.

During the *HASD&IC 2019 CHNA* focus groups and KI interviews, conversations about aging concerns centered around conditions that disproportionately affect older adults and barriers to care for older adults. Please see **Table 23** or **Appendix T** for a summary

of these findings. Further details are covered in the **Discussion of Community Engagement Findings** section below.

Sharp 2019 CHNA – Focus Groups

For SGH's 2019 CHNA, two focus groups were conducted with *Sharp Senior Health Center* staff and patients and community members to better understand the identified health need of aging concerns among Sharp's senior patients and community members. **Table 24** summarizes the findings of these focus groups. Further details are covered in the **Discussion of Community Engagement Findings** section below. For a description of focus group participants, see **Section 3: Methodology**.

In addition, participants in focus groups conducted with the *Sharp PFAC* and *Sharp Case Management Leadership*, also highlighted aging concerns and challenges specific to seniors. However, this section will focus specifically on the focus groups held with *Sharp Senior Health Center* staff and patients and community members. For a summary of feedback from the *Sharp PFAC* and *Sharp Case Management Leadership* focus groups, please refer to **Appendix U.**

Sharp 2019 CHNA – Sharp Insight Community

Sharp's Insight Community online survey provided greater understanding of the identified health need of aging concerns for Sharp patients and community members.

Overall, *Sharp Insight Community* respondents (n=380) ranked aging concerns as the most important health condition impacting their community. Not surprisingly, respondents ages 65 or older (n=163) also ranked aging concerns number one in health conditions impacting their community. Following aging concerns, survey respondents ages 65 or older noted cancer, behavioral/mental health, obesity and heart disease as the next four most important health issues. See **Appendix R** for the ranked health conditions specifically among participants ages 65 or older.

Feedback regarding the most pressing SDOH was also observed specifically among *Sharp Insight Community* survey respondents ages 65 or older. Respondents in this age group ranked health insurance, access to care, health behaviors, economic security and homelessness as the top SDOH impacting their community. See **Appendix R** for details.

When health conditions and SDOH were combined among respondents in all age groups, aging concerns ranked as the third most important health need among a total of 30 choices. Please refer back to **Figure 14** for the final ranking of health conditions and SDOH by *Sharp Insight Community* survey participants.

After ranking various health conditions and SDOH, *Sharp Insight Community* survey participants were asked to rate their awareness of five community outreach programs offered by Sharp. Notably, 55% of respondents ages 65 or older were not at all familiar

with the Sharp Senior Resource Centers, while 58% were not at all familiar with Sharp's transportation services — two programs that especially benefit seniors. Similarly, among all age groups, 59% were not at all familiar with the Sharp Senior Resource Centers, while 59% were not at all familiar with Sharp's transportation services — two programs that could lessen the burden on family members and caregivers of seniors. In addition, 63% of senior survey respondents were not at all aware of Sharp's behavioral health support groups, while 45% were unaware of Sharp's cancer support groups — programs that support two priority health conditions specifically identified by senior respondents. Additional feedback particularly from participants ages 65 or older is presented in **Appendix R**.

Discussion of Community Engagement Findings

HASD&IC 2019 CHNA – Focus Groups

*HASD&IC 2019 CHNA f*ocus group participants discussed several health conditions and SDOH that particularly affect older adults. These included Alzheimer's and Parkinson's diseases, dementia, arthritis, loss of mobility, opioid abuse, diabetes, heart disease, anxiety, depression, lung disease, obesity, and poor oral health. They also detailed SDOH that affect seniors, including lack of accessible or reliable transportation options, challenges accessing fresh food, social isolation and inadequate family support, economic insecurity, and environmental pollutants.

HASD&IC 2019 CHNA focus group participants also emphasized that health maintenance is more difficult for seniors. Medication management, including ordering refills, picking up prescriptions, and taking the right dose of medications at the right time, can be challenging for older adults who do not have adequate support. In addition, the health conditions associated with aging may interfere with an individual's ability to exercise and to access healthy, fresh food.

HASD&IC 2019 CHNA focus group contributors also explained that accessing health care for seniors can be particularly difficult. For instance, when seniors can no longer drive, finding reliable, affordable transportation can be challenging. In addition, seniors living off of social security, or other limited income, are concerned about their economic security. The high cost of medications, co-pays and deductibles may prohibit them from accessing health care. Physical limitations — such as limited mobility, hearing problems and vision issues — may also create difficulties for seniors.

HASD&IC 2019 CHNA focus group contributors highlighted that, for those seniors who do not speak English as a first language, language issues also pose a barrier to care. Please see the **Community and Social Support** section for more details on language issues.

Lastly, *HASD&IC 2019 CHNA* focus group participants noted that after discharge from a hospital, seniors may have inadequate support at home to recover well and follow-up care is difficult for them to locate and secure.

Sharp 2019 CHNA – Focus Groups

Focus groups held with *Sharp Senior Health Center* staff and senior patients and community members identified several health conditions that are especially impactful for seniors. These include opioid abuse, diabetes, heart failure and disease, dementia, depression, lung disease, obesity, and physical aging concerns including loss of mobility and falls. Social conditions that affect seniors were identified as lack of good transportation options, lack of access to fresh food, social isolation and inadequate family support, economic insecurity, housing issues and environmental pollutants (including sound). For seniors, the participants said, these issues lead to a loss of independence, which can contribute to increased stress, isolation, loneliness and poor mental health.

Sharp Senior Health Center staff and senior patients and community members explained that access to health care is especially challenging for several reasons. Since senior patients are often admitted to a hospital in order to receive the treatment they need, health care access becomes even more critical. Regarding transportation, focus group members noted that many seniors can no longer drive themselves and may not have friends or family to drive them. Using public transportation is an intimidating and financially prohibitive prospect for some seniors. Some participants described the difficulty in using public transportation when one is in a wheel chair or uses a cane or walker, and some health care facilities are not easily accessed by public transportation. Further, the cost of transportation can be a barrier.

Participants in both focus groups described isolation and loneliness due to lack of community and family support as barriers to care. This isolation is due to loss of independence and mobility which is exacerbated by the lack of transportation options for seniors. In addition, families are often unable to help their aging parents due to their own financial situations or due to the busy lives they lead with family and work.

Economic security also creates obstacles to care, focus group members said. Seniors generally live on fixed incomes and worry about how to balance high housing costs with high medical costs, especially for medications, as well as with purchasing food.

Physical limitations such as limited mobility, hearing problems and vision issues create substantial obstacles to care for seniors. Participants noted that even calling to schedule medical appointments is inordinately difficult for those who are hard of hearing.

For those who do not speak English as a first language, language issues are also a barrier to care.

After discharge from a hospital, additional barriers exist, the focus group participants said. Follow-up care is difficult for seniors to secure, as is the necessary medical equipment. This can be attributed to the previously described transportation, economic

security and social isolation barriers, as well as a lack of awareness of resources in the community that might be helpful. Sometimes, they said, seniors are hesitant to seek help.

Sharp 2019 CHNA – Sharp Insight Community

The *Sharp Insight Community* survey reinforced the importance of addressing senior health issues, as aging concerns were ranked as the number one health condition affecting community members. In addition, the majority of respondents were not at all familiar with the Sharp Senior Resource Centers. This indicates a missed opportunity for seniors as well as their families and caregivers to receive resources and support for various senior needs such as exercise programs, educational classes, transportation and meal services, and government assistance. Further, although senior respondents ranked cancer and behavioral health as the second and third most important health conditions impacting their community, the majority were not at all familiar with the support groups offered by Sharp to address these issues.

Sharp Insight Community survey participants expressed similar concerns to focus group participants. Survey respondents ages 65 and older identified access to care and economic security as being among the most important issues for the community, in addition to issues related to health insurance (understanding, securing and using), health behaviors (diet, physical activity, etc.), and homelessness (overcrowding, substandard conditions, housing affordability). Further, survey participants of all ages expressed a general lack of awareness of Sharp's community outreach programs, including the Sharp Senior Resource Centers and Sharp's transportation services, which offer resources and support that can address many of the barriers to care expressed above.

Sharp 2019 CHNA Suggestions

During the focus groups, *Sharp Senior Health Center* staff and senior patients and community members provided several suggestions to increase health care access for seniors, including:

- Establish a centralized communication database so that patient information can be shared across health care systems.
- Create and promote more programs to assist seniors with rides to medical appointments and to grocery stores.
- Create and promote more home visitor programs where volunteers visit seniors at home.
- Expand meal delivery services.
- Expand behavioral health care, including psychiatric services, available to Medi-Cal and Medicare patients.
- Increase the availability of translators.

In addition, *Sharp Insight Community* survey participants (43.0% ages 65 and older) had the opportunity to provide specific suggestions about what Sharp can do to improve the health and well-being of the community. See **Appendix R** for the most commonly suggested themes. Feedback related to aging concerns included:

- Continue supporting efforts to address food insecurity.
- Help more people secure health insurance.
- Provide transportation for citizens who cannot drive or afford other means.
- Improve advertising of program and service offerings, ensuring the use of multiple media channels; hold a forum on senior resources.
- Increase investment in post-acute management.
- Promote accessing community centers for physical and social activity.

Additional recommendations from the *Sharp Insight Community* survey can be found in **Appendix R**.

Table 23: HASD&IC 2019 CHNA – Focus Group and KI Interview Summary of Responses Related to Aging Concerns

SUMMARY OF RESPONSES RELATED TO AGING CONCERNS	
ASSOCIATED HEALTH CONDITIONS AND NEEDS	
• **Alzheimer's Disease** • **Arthritis**: joint pain • **Behavioral/Mental Health Issues:** anxiety (fear), depression from hopelessness and discrimination, generational trauma • **Dementia**: including early onset • **Dental/Oral Health**: tooth loss, dentures • **Heart Disease** • **Hypertension** (high blood pressure)	• **Lung disease** • **Obesity** • **Physical limitations**: mobility related to aging, being homebound, disabled, or walker/wheelchair-dependent • **Substance abuse and self-medication** • **Vision and hearing loss**
ASSOCIATED SOCIAL DETERMINANTS OF HEALTH	
• **Behavioral/mental care access**: lack of access to mental health services • **Community and social support**: lack of socialization opportunities, caregiving responsibilities for grandchildren, social isolation leads to loneliness • **Dental care access:** lack of access to dental care, cost, and lack of dental insurance • **Economic security:** limited and fixed incomes, government assistance	• **Environmental issues:** houses close to factories • **Food insecurity**: healthy food access, and malnutrition • **Housing**: affordability, senior housing availability, and evictions • **Homeless issues**: Lack of homeless shelters for seniors • **Language Issues**
ASSOCIATED BARRIERS AND CHALLENGES	
• **Cultural competency**: lack of cultural/linguistically appropriate services • **Fear** of pain or discrimination • **Follow-up**: lack follow-up for referrals, missed appointments • **Health navigation issues** • **Immigration**: Fear of deportation/mistrust of the government	• **Insurance Issues** with benefits and cost of insurance • **Long wait times** for appointments and specialists • **Medication management** • **Transportation**: Lack of transportation

Table 24: Sharp 2019 CHNA – Sharp Senior Health Center Staff, Senior Patients and Community Members Focus Group Summary of Responses

SHARP SENIOR HEALTH CENTER STAFF, PATIENTS & COMMUNITY MEMBERS - SUMMARY OF RESPONSES	
HEALTH NEEDS AND CONDITIONS IMPACTING SENIOR HEALTH	
• **Diabetes** • **Dementia** • **Depression** • **Disability** • **Heart failure/disease**	• **Lung disease** • **Obesity** • **Opioid abuse** • **Physical aging concerns: loss of agility and mobility; falling.**
SOCIAL DETERMINANTS OF HEALTH IMPACTING SENIOR HEALTH	
• **Economic insecurity: housing is too expensive for social security income checks.** • **Environmental issues such as air and sound pollution.** • **Housing issues** • **Lack of access to fresh food**	• **Community and family support**: a lack of support leads to social isolation. • **Transportation:** seniors fear public transportation; do not use Lyft or Uber because of technology.
ACCESS TO HEALTH CARE CHALLENGES AND BARRIERS	
• **Economic insecurity** due to living on a fixed income. • **Fear:** too scared to reach out for help; feel intimidated. • **Hearing and vision problems** • **Community and family support:** being alone leads to difficulties accessing emergency services. • **Language barriers** • **Transportation:** lack of transportation to health appointments; fear of public transportation.	
HOSPITAL DISCHARGE CHALLENGES AND BARRIERS FOR SENIORS	
• **Lack of follow-up care** • **Language barriers**	
HOSPITAL AND COMMUNITY SUPPORT NEEDED	
• **Access to healthy food:** provide meal delivery programs for seniors or transportation so they can access fresh and healthy groceries. • **Access to mental/behavioral health services:** increase/expand psychiatric support for Medi-Cal and Medicare insured; there is a need for subsidized mental health care. • **Community and family support programs:** create programs that help/prevent seniors from isolation and feeling lonely; encourage family members to help seniors. • **Database:** need a centralized communication database that informs Sharp staff on information about patients that use Sharp services but are not Sharp members. • **Home visiting:** have a home visiting program where volunteers visit seniors at least 1 time a month. • **Interpretation** experts are needed. • **Transportation:** provide seniors transportation to health care appointments.	
IMMIGRATION Have you observed any changes over the past year in community members' attitude towards immigration issues?	
• There has been an increased intolerance of those who have immigrated to this country.	

Behavioral Health

Definition

Behavioral health problems include serious psychological distress, suicide, and mental and substance use disorders including alcohol and drug addiction.

Findings

Behavioral health needs will be described within two main categories: barriers and SDOH that prevent individuals from obtaining care, and specific services that are most challenging to access.

1. Barriers to accessing care and associated SDOH:
    - Availability of needed services and appointments
    - Insurance issues
    - Logistical problems getting to the needed appointments (time off work, childcare, transportation)
    - Economic security and inability to pay co-pays and deductibles
2. Types of care that are difficult to access:
    - Urgent care services for crisis situations
    - Inpatient psychiatric beds and substance abuse facilities
    - Transitional programs and services (post-acute care services)

Behavioral health was identified as a high priority health need by both the SGH and HASD&IC 2019 CHNA secondary data analyses and community engagement activities.

Secondary Data Findings

Data were reviewed related to several aspects of behavioral health in SDC: (1) ED and inpatient discharge rates for some behavioral health conditions, including anxiety and mood disorders; (2) the percentage of people who report having thought about committing suicide; (3) the rate of suicide; (4) ED and inpatient discharge rates for acute and chronic substance use; and (5) ED and inpatient discharge rates for opioid misuse.

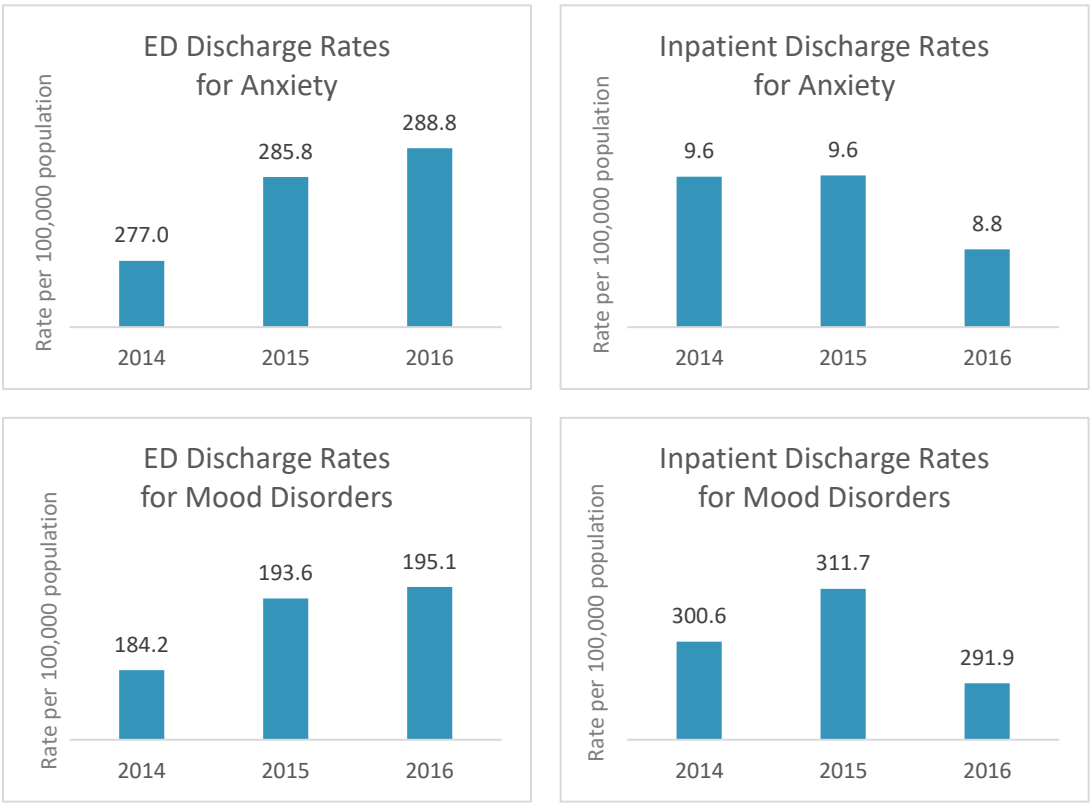
Mental Health Issues

SDC's rates of ED visits for anxiety increased by 4.3% between 2014-2016, while rates of inpatient discharges for anxiety decreased by 7.9% during the same time period (see **Figure 22**). People who identify as "other" race and Black/African American had the highest rates of ED visits and inpatient discharges for anxiety.

ED visits for mood disorders also increased (5.9%) from 2014-2016, while inpatient discharges for mood disorders decreased by 2.9% (see **Figure 22**). Discharge rates for

mood disorders were higher for people who identify their race as Black/African American than for any other race.

Figure 22: ED Visit and Inpatient Discharge Rates for Anxiety and Mood Disorders in SDC, 2014-2016

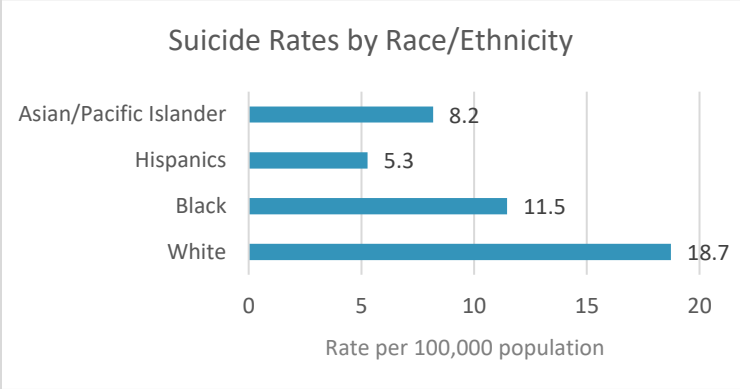


Source: California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2014-2016. SpeedTrack©

Suicidal Ideation and Suicide Attempts

In 2017, 11.8% of adults in SDC seriously considered committing suicide. In 2016, the age-adjusted suicide rate in SDC was 11.9 per 100,000. Rates were highest among Whites (18.7), followed by Blacks (11.5), Asian/Pacific Islanders (8.2) and Hispanics (5.3). While the rate of suicide decreased slightly (1.3%) from 2014-2016 (see **Figure 23**), the rates of suicide for people who identify as Asian/Pacific Islander, Black and "other," increased in those same years by 13.3%, 47.2% and 93.0%, respectively.

Figure 23: Age-Adjusted Suicide Rates in SDC by Race/Ethnicity, 2016

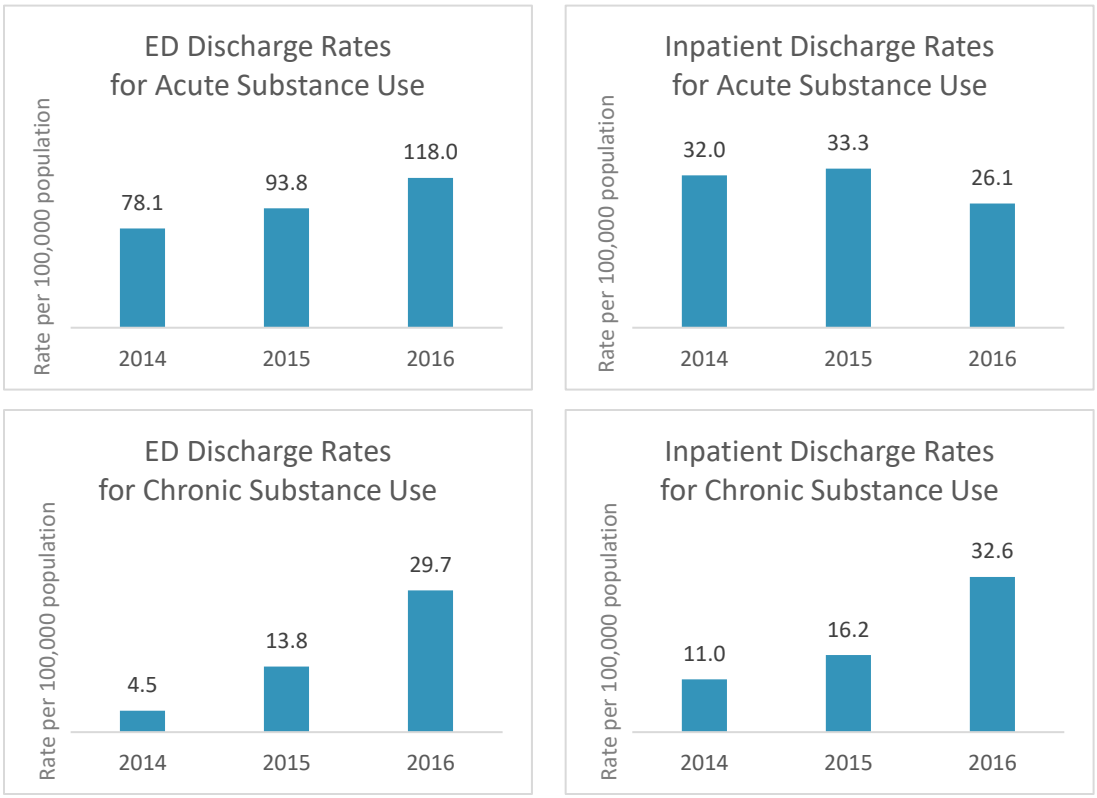


Source: Live Well San Diego. Live Well San Diego Data Access Portal. Injury. https://data.livewellsd.org/

Substance Use

While SDC's rate of ED visits for acute substance use rose by 51.0% from 2014-2016, inpatient discharges dropped by 18.5%. The highest rates for both types of encounter were among Black/African Americans. Steep increases in both types of encounter occurred for chronic substance use; ED visit rates increased by 559.3%, and inpatient discharge rates increased by 195.1% (see **Figure 24**). ED visit rates were highest among Whites (36.7), while inpatient discharge rates were highest among those who identify as "other" race. Across age groups, rates of ED visits for chronic substance abuse increased the most for those ages 65 and older — by 714.0%. In addition, nearly 20% of adults ages 18 and older self-report excessive alcohol use.

Figure 24: ED Visit and Inpatient Discharge Rates for Acute and Chronic Substance Use in SDC, 2014-2016

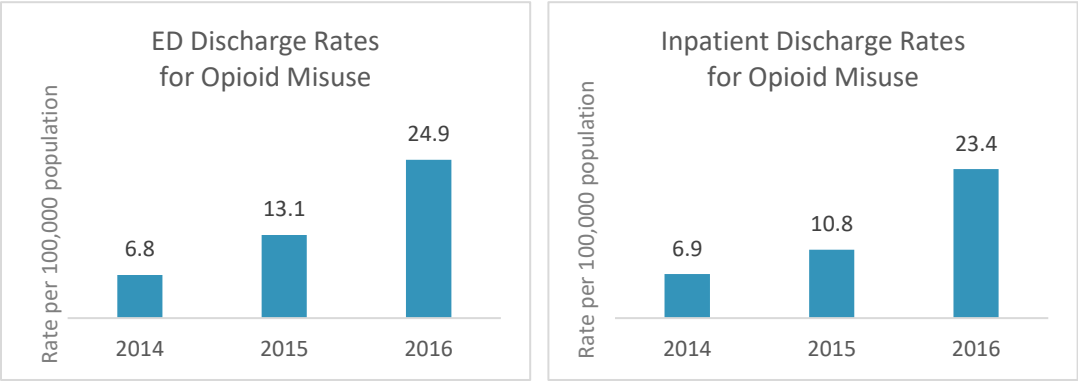


Source: California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2014-2016. SpeedTrack©

Opioid Misuse

In SDC, ED visits for opioid misuse increased by 267.2% from 2014-2016, while inpatient discharges increased by 239.3% (see **Figure 25**). The steepest increases in both rates were among people ages 65 and older, who experienced a 1,734.4% increase in ED visits and an 863.1% increase in inpatient discharges.

Figure 25: ED Visit and Inpatient Discharge Rates for Opioid Misuse in SDC, 2014-2016



Source: California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2014-2016. SpeedTrack©

Please see **Appendix O** for Behavioral Health definition and secondary data source information.

Notable findings from an analysis of SGH behavioral health discharge data included[17]:

- In 2017, 47.8% of individuals admitted to SGH with a behavioral health diagnosis were classified as having a substance-related disorder, while 33.3% were classified as having a mood disorder.
- In 2017, 57.5% of individuals who visited the ED at SGH with a behavioral health diagnosis were classified as having a substance-related disorder, while 28.2% were classified as having an anxiety disorder.
- In 2017, individuals who did not identify as Hispanic or Latino represented 77.9% of all inpatient discharges at SGH, but 85.0% of discharges with a behavioral health diagnosis.
- In 2017, individuals ages 65 and older represented 40.7% and individuals ages 45-64 represented 37.6% of inpatient discharges with a behavioral health diagnosis at SGH.
- In 2017, individuals ages 18-44 represented 47.9% and individuals ages 45-64 represented 32.7% of visits to the ED at SGH where a behavioral health diagnosis was present.

[17] California Office of Statewide Health Planning and Development (OSHPD) Non-Public Inpatient Discharge and Emergency Department Encounter Data, 2017. Accessed through SpeedTrack Inc.©

Community Engagement Findings

HASD&IC 2019 CHNA

Across all community engagement activities conducted in the *HASD&IC 2019 CHNA* — focus groups, interviews and the survey — behavioral health issues were identified as both prevalent and debilitating.

In the online survey, behavioral health was ranked as the health condition having the greatest impact on the health and well-being of San Diego residents and as the second most impactful condition when health conditions and SDOH were combined (only access to care ranked higher). In addition, 63.0% of survey respondents indicated that they believe behavioral health is worsening in SDC. Respondents were also asked to rank which specific behavioral health conditions have the greatest impact in San Diego, and they were ranked as follows:

1. Alcohol use disorder
2. Mood disorders
3. Substance use disorder
4. Anxiety
5. Opioid use
6. Suicide and suicidal thoughts/ideation
7. Self-harm or self-injury

See **Appendix S** for full results of the *HASD&IC 2019 CHNA* online survey.

During focus groups and interviews, frequent topics of discussion related to behavioral health included:

- Barriers to care
- The types of care most challenging to access
- The people who are most impacted by behavioral health issues

Table 25 presents a summary of feedback from the *HASD&IC 2019 CHNA* focus groups and KI interviews, related to behavioral health. Additional detail is included in the **Discussion of Community Engagement Findings** section below.

Sharp 2019 CHNA – Focus Groups

For SGH's 2019 CHNA, a focus group was conducted with members of the *Sharp McDonald Center (SMC) Aftercare Support Group*. Feedback from these individuals provided the unique perspective of people who have either lived through behavioral health or addiction issues themselves or who have helped loved ones through their recovery. Community engagement feedback addressed barriers to behavioral health care as well as the impact of behavioral health issues — particularly substance use and addiction on individuals.

Table 26 summarizes the findings of this focus group. Additional details are covered in the **Discussion of Community Engagement Findings** section. For a description of focus group participants, see **Section 3: Methodology**.

Behavioral health was mentioned frequently in additional focus groups, including the *Sharp Case Management Leadership*, *SMBHWN Social Workers & Case Managers*, *Sharp Cancer Navigators and Social Worker, Sharp Senior Health Center* staff, patients and community members, and *Sharp PFAC* focus groups. Please see the findings for **Aging Concerns**, **Maternal and Prenatal Care, including High-Risk Pregnancy**, and **Cancer** for specific feedback on behavioral health and its connection to these identified health needs. Please refer to **Appendix U** for a summary of Sharp 2019 CHNA focus groups.

Sharp 2019 CHNA – Sharp Insight Community

Sharp's Insight Community online survey provided greater understanding of the identified health need of behavioral health for Sharp patients and community members.

Among 16 health conditions, survey respondents (n=380) ranked behavioral/mental health (including substance use, suicide, self-inflicted injury, etc.) as the second most important health condition impacting their community. Refer to **Appendix R** for the ranking of the most important health conditions by the *Sharp Insight Community* survey.

Worth noting is that respondents in the youngest age group — ages 25-44 years — were significantly more likely than the sample as a whole to select behavioral/mental health as one of the top five most important health conditions impacting their community, when compared to all other survey respondents. In fact, as respondent age group decreased, the identification of behavioral/mental health as a priority health condition increased. See **Appendix R** for age group breakouts for the top most important health conditions.

When health conditions and SDOH were combined among all respondents, behavioral/mental health ranked as the fourth most important health need among 30 choices. Please refer back to **Figure 14** for the final ranking of health conditions and SDOH by *Sharp Insight Community* survey participants.

After ranking various health conditions and SDOH, *Sharp Insight Community* survey participants were asked to rate their awareness of select community outreach programs offered by Sharp, including behavioral health support groups. Notably, only 6% of respondents were very familiar with Sharp's behavioral health support groups, while the majority were either not at all familiar (55%) or somewhat familiar (39%). Further, among the 25-44 year age group, no respondents indicated that they were 'very familiar' with Sharp's behavioral health support groups — the age group that was also significantly more likely than the rest of the sample to select behavioral/mental health as one of the five most important health conditions. See **Appendix R** for details.

Discussion of Community Engagement Findings

HASD&IC 2019 CHNA – Focus Groups and Key Informant Interviews

In the *HASD&IC 2019 CHNA* community engagement process, residents identified several obstacles to the receipt of effective behavioral health services. First, they said, the availability of therapists to address mental health issues and programs to address substance use treatment is extremely limited. Finding providers who accept a patient's insurance creates further obstacles, particularly if the patient is enrolled in a public insurance program like Medi-Cal. In addition, the participants noted, even when therapists or programs can be found, they are often not immediately available, creating challenges to the timely receipt of services. Therapists, it was further discussed, often only have time available during work and school hours and may be located far from where the people who need the services live, work, and go to school, creating logistical problems. Finally, for those who are economically insecure, co-pays and deductibles were cited as prohibitive to the receipt of behavioral health services.

Two types of care for both mental health and substance use disorders were noted to be insufficient in San Diego during the *HASD&IC 2019 CHNA* community engagement events. Urgent care with availability of after-hours services for people in crisis were cited as a critical need for the community. Inpatient psychiatric beds and substance abuse facilities were also identified as being in short supply. Finally, more transitional programs and services (post-acute care services) for those who are being discharged from the inpatient level of care emerged as a priority need.

HASD&IC 2019 CHNA focus group participants emphasized that while accessing behavioral health services is hard for everyone, for people who may be at the highest risk for trauma-related mental illness — like veterans, refugees, and the LGBTQ community — and for those who are uninsured, access to this care can be particularly challenging.

HASD&IC 2019 CHNA participants also discussed the link between mental health and substance misuse, arguing that the failure to provide access to preventive and acute mental health services often leads to self-medicating with drugs and alcohol, which can then exacerbate mental health issues.

Sharp 2019 CHNA – Focus Groups

Focus groups conducted with the *SMC Aftercare Support Group* identified several barriers to behavioral health care. Specific to substance use disorders, participants stressed the need for more low-cost or free, easily and immediately accessible drug treatment programs. In addition, they described health insurance as both expensive and complicated to obtain. Focus group members also talked about challenges related to post-discharge care for all health conditions, including lack of adequate support at home, navigating denied insurance claims, and medication management.

SMC Aftercare Support Group focus group participants discussed specific themes related to the impact of substance use and addiction. First, they noted that certain groups are more vulnerable to addiction and mental health issues. Second, they described the spiral of addiction and the cycle of recovery. Third, they talked about how addiction changes people and can lead to premature mortality. Finally, they described the interlinked nature of substance use disorders and mental health disorders.

Focus group participants described young adults in their early to mid-20s and individuals in the LGBTQ community as being most severely affected by addiction. It was noted that these groups appear to become addicted faster than in the past and move on to more potent drugs sooner. Heroin was cited as a particularly common drug among these groups. Opioid misuse was also cited as a growing issue within the senior population. A common scenario for seniors, focus group members explained, is to be prescribed pain medication for a chronic issue such as back pain, to unwittingly become dependent on that medication, and for this dependence to turn into a full-blown addiction. For youth under 18 years of age, anxiety, depression and suicide were noted as growing problems.

Most people who become addicted, *SMC Aftercare Support Group* participants said, start out by using drugs recreationally. People use drugs while partying — smoking or taking pills — but quickly come to depend on them. Most do not start out injecting drugs and believe they never will. Eventually, participants articulated, addiction takes over, and they become at the mercy of the drug and resort to injecting. Participants emphasized that recovery is a cyclical process. While some achieve long-term recovery, many people relapse, and a certain proportion of people go to detox, discharge 30 days later, and immediately relapse.

Focus group participants described how addiction “makes you do the complete opposite of what is good for you” and “takes away your soul.” They described daily lives being centered around getting high — that drugs are the first thing addicted people think about when they wake up and the last thing they think about before sleep. Once addicted, a person’s character is modified, they said. The addiction causes people to become unproductive and deceptive in service of obtaining drugs. Being addicted, they said, also causes the deterioration of interpersonal relationships and social isolation for the addict.

Of greatest concern, *SMC Aftercare Support Group* contributors emphasized, is the high level of mortality among people with addictions. Every couple of months, they said, someone within their recovery circle passes away. Overdoses are often fatal, and participants explained, people who recover and then relapse are more vulnerable to overdose. This is because, following detox, tolerance for the substance has become much lower. During a relapse, the person often takes the same amount of the drug as they did prior to detoxing, which their bodies can no longer handle.

Focus group participants believe that levels of anxiety and depression are increasing in the community. These mental health issues often lead people to cope by using drugs to

relieve their symptoms, which can lead to dependence and addiction. Social isolation and loneliness may also lead to drug use, they said. Participants asserted that drug use, while temporarily relieving some mental health symptoms, ultimately exacerbates anxiety and depression, leading to deeper loneliness, and at times, suicidal ideation and attempts.

In addition, although the primary emphasis of the focus group was on behavioral health issues, some *SMC Aftercare Support Group* members discussed other health issues of concern in the community. Conditions they listed as negatively affecting all residents include heart disease/cardiovascular issues, diabetes and obesity. Seniors, participants noted, struggle with arthritis, limited mobility, chronic pain, Alzheimer's disease, social isolation and food insecurity. Children, they said, are impacted by obesity, diabetes, racial discrimination, bullying, poor eating habits and exposure to dangerous behaviors on social media. Participants also described discrimination as more prevalent than in the past, and that the current environment is such that people feel emboldened to treat others, particularly immigrants, unkindly. Undocumented workers, they noted, are demonized but used by businesses to generate higher profits. See **Table 26** for a summary of feedback from the *SMC Aftercare Support Group*.

Sharp 2019 CHNA – Sharp Insight Community

The *Sharp Insight Community* survey reinforced the importance of addressing behavioral health issues, as behavioral/mental health was ranked as the second most important health condition affecting community members. In addition, only a minority of survey respondents (6%) were very familiar with Sharp's behavioral health support groups. This indicates a missed opportunity to support community members with behavioral health issues, particularly younger adults ages 25-44 years, who were most likely to select behavioral/mental health as a priority health condition, but who were not at all familiar with Sharp's behavioral health support group offerings. Further, this younger age group was significantly more likely than the other age groups to select stigma as one of the five most important SDOH. Research illustrates that although stigma can exist in a variety of contexts (e.g., immigration status and use of public programs such as food stamps), it is one of the largest barriers for individuals who may seek or engage in treatment for behavioral/mental health conditions.[18]

Sharp 2019 CHNA Suggestions

Focus group participants from the *SMC Aftercare Support Group* proposed three ideas to improve behavioral health in the community:

- Offer more programs like the Sharp McDonald Center.
- Provide more education for health care providers related to addiction, including when and how to intervene when addiction is suspected, how to prevent addiction to pain medications, how alternative or holistic treatments can be used

[18] Ahmedani B. K. (2011). Mental Health Stigma: Society, Individuals, and the Profession. *Journal of social work values and ethics*, *8*(2), 41–416.

to manage pain, and how to act with compassion and empathy towards people with addiction.
- Hold forums for seniors to socially engage with each other and to interact with health advocates who would be available to meet with them, discuss their health issues, and help them navigate the health care system.

Sharp Insight Community survey participants also had the opportunity to provide specific suggestions about what Sharp can do to improve the health and well-being of the community. See **Appendix R** for the most commonly suggested themes. Feedback related to behavioral/mental health included:

- Speed up the delivery of mental health care; referral to a therapist takes too long if in need of hospitalization.
- Advocate for improved access and insurance coverage for the underserved, particularly to stigmatized services including behavioral health.
- Offer more mental health resources, including more classes for mental health issues.

Additional recommendations from the *Sharp Insight Community* survey can be found in **Appendix R**.

Table 25: HASD&IC 2019 CHNA – Focus Group and KI Interview Summary of Responses Related to Behavioral Health

SUMMARY OF RESPONSES RELATED TO BEHAVIORAL HEALTH		
ASSOCIATED HEALTH CONDITIONS AND NEEDS		
All Age Groups • **Mood disorders** including anxiety, depression, and stress • **PTSD and trauma**: including generational trauma • **Substance use disorder** • **Suicide and self-harm**	**Children/Youth** • **Mood disorders**: anxiety • **Substance abuse**: alcohol, drugs • **Suicide and self-harm** • **Trauma**	**Senior** • **Alzheimer's** • **Dementia** • **Mood disorders:** anxiety, depression • **Schizophrenia**
ASSOCIATED SOCIAL DETERMINANTS OF HEALTH		
All Age Groups • **Economic security:** cost of mental health services • **Education**: Lack of community resident awareness of services (unaware of detox requirements) • **Lack of services:** mental health services, psychiatrists, mental health workforce including PERT • **Stigma** • **Violence:** fear, homelessness	**Children/Youth** • **Bullying** • **Lack of school-based services** • **Stigma**	**Senior** • Limited mental health **insurance coverage** • **Social isolation** and loneliness • **Stigma**
ASSOCIATED BARRIERS AND CHALLENGES		
All Age Groups • Long **wait times** for mental health services	**Children/Youth** • Lack of **follow-up care** post-referral • **Parental consent** to access services • Lack of **parental involvement** due to cultural differences	

Table 26: Sharp 2019 CHNA – Sharp McDonald Center Aftercare Support Group Focus Group Summary of Responses

SHARP MCDONALD CENTER AFTERCARE SUPPORT GROUP - SUMMARY OF RESPONSES	
HEALTH CONDITIONS AND NEEDS	
Adults • **Addiction/Substance abuse:** especially young adults, and within the LGBTQ community • **Diabetes** • **Heart disease/Cardiovascular issues** • **Mental health:** anxiety, depression, suicide ideation and suicide	**Seniors** • **Addiction/Substance abuse:** alcohol, opioids • **Alzheimer's** • **Aging concerns:** arthritis, mobility • **Behavioral/Mental health:** anxiety • **Chronic pain:** leads to substance abuse to deal with pain. **Children and Youth** • **Behavioral/Mental health:** depression, anxiety from social media or bullying, and suicide. • **Diabetes** • **Obesity**
SOCIAL DETERMINANTS OF HEALTH	
Adults • **Community and family support:** negative interpersonal relationships with friends or family that encourage substance use/abuse. • **Behaviors:** less perceived danger of marijuana since legalization. **Seniors** • **Access to healthy/nutritious food** • **Economic security:** food insecurity.	**Children and Youth** • **Environment** • **Behaviors:** eating habits and diet, excessive sugar intake. • **Fear/Racial discrimination and bullying:** especially for young black children. • **Parental support:** lack of support. • **Technology:** lack of parental control over social media and internet content exposure.
ACCESS TO HEALTH CARE CHALLENGES AND BARRIERS	
• **Education:** access to information, for example November is prostate cancer month but there is no visible promotion for it. • **Economic security:** high cost of health care, large deductibles create a financial burden on individuals. • **Insurance issues:** the complicated process of health care enrollment. • **Lack of services:** accessibility and availability of health care services for addiction.	
HOSPITAL DISCHARGE CHALLENGES AND BARRIERS	
• **Medications and prescription issues:** pain medication management is challenging and can lead to prescription drug addiction; over-prescription of opioids to treat back surgery. • **Insurance:** insurance claim issues and the stress resulting from denied claims. • **Community and family support:** lack of discharge support at home from friends, family members or caretakers.	
HOSPITAL DISCHARGE IMPROVEMENTS THAT CAN BE MADE	
• **Alternative treatment options:** physician openness to alternative treatments, such as holistic treatments instead of pain medication. • **Education:** increase physician knowledge through training on topics such as proper bedside manner.	
HOSPITAL AND COMMUNITY SUPPORT NEEDED	

- **Community support:** places or forums for the elderly/seniors to talk and socially engage with one another.
- **Education:**
    - **Community members:** A place where health advocates are available for community members to discuss health issues.
    - **Providers:** More education for providers on patient's recovery process; finding alternative treatments to avoid prescription drugs; education on patient struggles and issues and how to empathize.
- **Additional services:** more affordable addiction recovery services like Sharp McDonald Center. More beds in addiction recovery programs.
- **Insurance:** improve insurance process.
- **Stigma:** the system and society treats addiction as shameful.

IMMIGRATION

Have you observed any changes over the past year in patient/community member attitude towards immigration issues?

- The news/media is driving a lot of the negative talk, especially in regards to "The Wall".
- The current administration has caused this change in attitude.
- There is a polarization of extremes in political views. People feel emboldened to treat others unkindly and say hateful things while the people being mistreated feel the need to hide or change behaviors to avoid being bullied.

Cancer

Definition

Cancer is a set of diseases in which abnormal cells grow, spread and crowd out normal cells, which can make it difficult for the body to function. Cancer can start anywhere in the body and can spread to other parts — cancers are named for where they originate in the body.

Findings

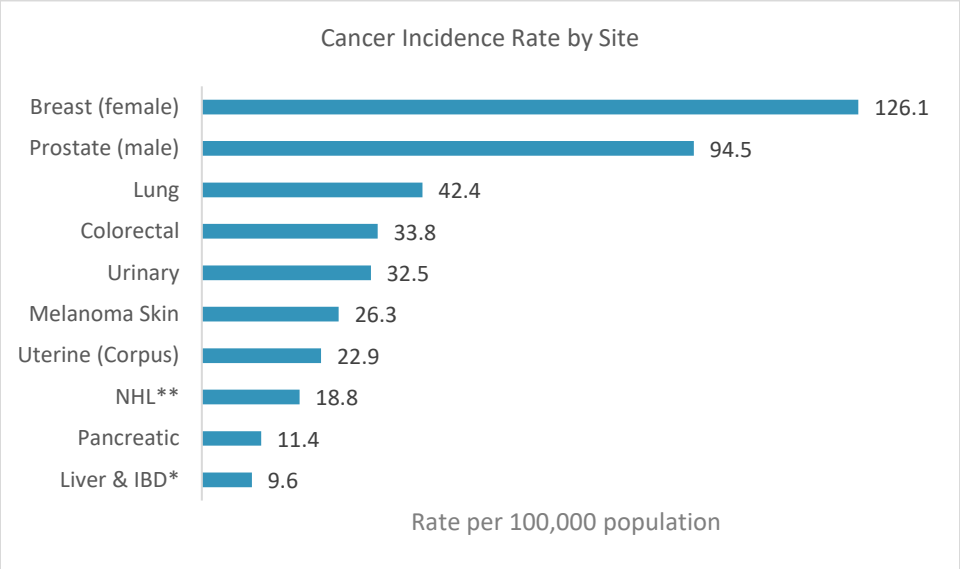
Health needs related to cancer were described in relation to the effects on well-being beyond physical health. These include financial, practical, and emotional impacts on individuals and families; these effects are exacerbated by barriers to cancer care.

Cancer was identified as a priority health need by the SGH and HASD&IC 2019 CHNAs in both the secondary data analyses and in the community engagement process.

Secondary Data Findings

For all cancer sites, the age-adjusted rate from 2011-2015 in San Diego was 402.5 per 100,000; the incidence rates by cancer site are represented in **Figure 26** below.

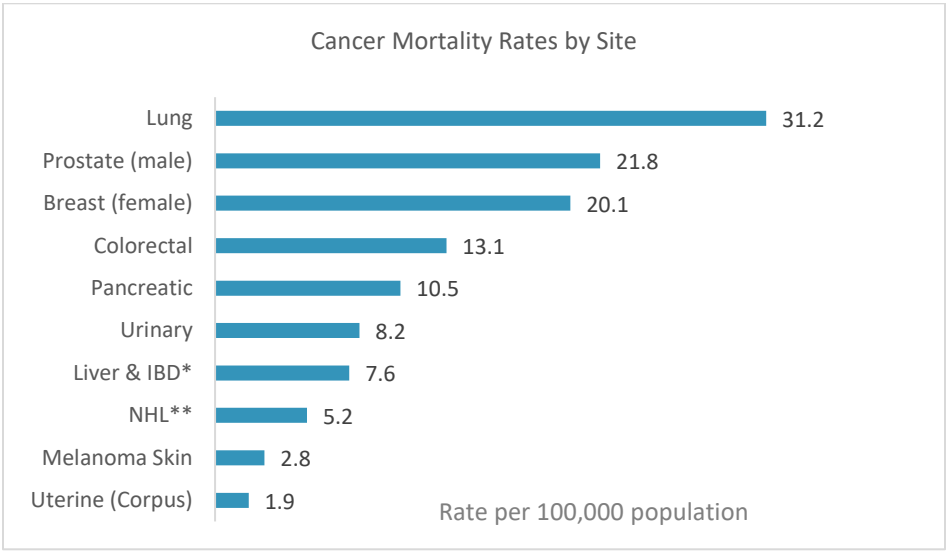
Figure 26: Incidence Rates for Cancer in SDC, 2011-2015



Source: California Cancer Registry. Age-Adjusted Invasive Cancer Incidence Rates in California, 2011- 2015, By County. https://www.cancer-rates.info/ca/. *Non-Hodgkin's Lymphoma (NHL), **Intrahepatic Bile Ducts (IBD)

Cancer is the leading cause of death in SDC. The age-adjusted mortality rate for all cancer sites from 2011-2015 was 150.2 per 100,000. Mortality rates by cancer site are represented in **Figure 27** below. San Diegans who identify as Black/African American have the highest cancer mortality rates (177.3) compared to people of other races.

Figure 27: Mortality Rates for Cancer in SDC, 2011-2015



Source: California Cancer Registry. Age-Adjusted Cancer Mortality Rates in California, 2011-2015, By County. *Intrahepatic Bile Ducts (IBD), **Non-Hodgkin's Lymphoma (NHL)

Please see **Appendix O** for Cancer definition and secondary data source information

Notable findings from an analysis of SGH discharge data for cancer included:

- In 2018, the top sites for cancer diagnoses observed at SGH were: breast, lung, colon, lymphoma, prostate, and bladder.[19]

- Among individuals who visited the ED at SGH in 2017, the top three cancer diagnoses were classified as uterine cancer, bone cancer, and breast cancer. [20]

- In 2017, individuals ages 65 and older represented 57.2% and individuals ages 45-64 represented 32.0% of inpatient discharges with a cancer diagnosis at SGH.[20]

- In 2017, individuals ages 65 and older represented 37.3% and individuals ages 45-64 represented 37.0% of ED visits with a cancer diagnosis at SGH.[20]

- In 2017, females represented 56.3% of inpatient discharges with a cancer diagnosis at SGH, and 65.4% of ED visits where a cancer diagnosis was present.[20]

- Individuals identified as White represented 44.3% of all ED visits at SGH in 2017, but 51.5% of ED visits with a cancer diagnosis.[20]

Community Engagement Findings

HASD&IC 2019 CHNA

Findings from the *HASD&IC 2019 CHNA* community engagement process show that San Diegans believe cancer is one of the top health priorities in the county.

In the *HASD&IC 2019 CHNA* online survey, cancer was ranked as the fourth most impactful health condition for the San Diego community. See **Appendix S** for a full summary of survey results.

In the *HASD&IC 2019 CHNA* focus groups and KI interviews, participants described barriers to receiving cancer screenings, diagnosis, and treatment along with the severe, negative impact a cancer diagnosis can have on individuals and their loved ones. See **Table 27** for a summary of findings from the *HASD&IC 2019 CHNA* community engagement activities related to cancer.

[19] 2018 Sharp HealthCare Cancer Registry Data
[20] California Office of Statewide Health Planning and Development (OSHPD) Non-Public Inpatient Discharge and Emergency Department Encounter Data, 2017. Accessed through SpeedTrack Inc.©

Sharp 2019 CHNA – Focus Group and KI Interview

A focus group with *Sharp Cancer Patient Navigators and Social Workers* and a KI interview with one *Sharp Cancer Patient Navigator/Clinical Social Worker*, were conducted to better understand the unique needs of Sharp cancer patients. Both the focus group and KI interview also informed the development of a *case study*.

Interview and focus group contributors described: barriers to care for cancer patients; the impact of a cancer diagnosis on family dynamics; the services provided by navigators and social workers and the ways in which they coordinate care with other community organizations; and suggestions for ways in which their work could be better supported. See **Table 28** or **Appendix U** for a summary of the focus group and interview findings.

Finally, please refer to **Appendix J** for the case study of "Camila" developed with insight collected from both the *Sharp Cancer Patient Navigators and Social Workers* focus group and the *Sharp Cancer Patient Navigator/Clinical Social Worker* KI interview.

Sharp 2019 CHNA – Sharp Insight Community Survey

Sharp's Insight Community online survey also provided greater understanding of cancer as a concern among Sharp patients and community members. Out of 16 health conditions, respondents (n=380) ranked cancer as the second most important health condition impacting their community (see **Appendix R** for details).

When health conditions and SDOH were combined among all respondents, cancer ranked as the fifth most important health need among a total of 30 choices. Please refer back to **Figure 14** for the final ranking of health conditions and SDOH by *Sharp Insight Community* survey participants.

Further, after ranking various health conditions and SDOH, *Sharp Insight Community* survey participants were asked to rate their awareness of select community outreach programs offered by Sharp, including Sharp's cancer support groups. Notably, only 13% of respondents were very familiar with this offering, while the majority were either not at all familiar (43%) or somewhat familiar (44%). See **Appendix R** for details.

Discussion of Community Engagement Findings

HASD&IC 2019 CHNA – Focus Groups

HASD&IC 2019 CHNA community engagement participants described cancer as a health condition that community residents find extremely scary. They discussed how fear about the impact of the cancer and about the stigma of cancer keeps people from accepting their diagnosis and pursuing cancer treatment. Brain, colon and breast cancer were specifically mentioned as diseases people find particularly intimidating. In addition,

HASD&IC 2019 CHNA participants noted that people who have cancer are sometimes judged in the community, and worry that others will avoid them once they know of their diagnosis.

Fears about immigration status, *HASD&IC 2019 CHNA* focus group members asserted, have also become a deterrent to receiving cancer screening, diagnosis and treatment. Asylum seekers, in particular, are hesitant to access cancer care because they believe they will be deported if they do not have insurance.

HASD&IC 2019 CHNA community engagement participants highlighted how finances related to cancer care are also burdensome for community members. Even for those with insurance, co-pays and deductibles can be prohibitive. People who have cancer also worry about losing their jobs and about who will take care of their children while they are undergoing treatment. Finally, *HASD&IC 2019 CHNA* community engagement participants named practical issues, such as transportation to medical appointments, as barriers to receiving cancer screenings and treatment.

Sharp 2019 CHNA – Focus Group and KI Interview

In both the *Sharp Cancer Patient Navigators and Social Worker* focus group and the *Sharp Cancer Patient Navigator/Clinical Social Worker* KI interview, barriers to effective cancer care were summarized as: fear, finances, frustration, and logistics. Community engagement participants detailed the myriad ways that a patient's fear can interfere with the receipt of and compliance with cancer treatment. Denying their illness serves as a coping mechanism for this fear; by starting and complying with treatment patients must acknowledge the reality of their disease, and so, they sometimes delay treatment.

Sharp Cancer Patient Navigators and Social Workers focus group participants also described how patients will, out of fear, try "alternative" treatments instead — like eliminating sugar, taking high doses of vitamin C, and using herbs and marijuana. They explained that patients are also often afraid of the side effects of cancer treatment, such as losing their hair and becoming ill.

Fears about immigration status, *Sharp Cancer Patient Navigators and Social Worker* focus group members asserted, have become much more pronounced. Navigators and social workers described situations in which families have disenrolled from their health insurance out of fear of being placed on a "list" for deportation. In addition, sometimes undocumented residents choose not to receive cancer care rather than face the perceived risk of coming to the attention of immigration officials.

Sharp Cancer Patient Navigators and Social Worker focus group members and KI both emphasized that financial impacts create significant barriers to care. Patients worry about whether they can cover co-pays and co-insurance and how they will cope with any loss of income resulting from taking time off work during treatment. Relatedly, frustration related to negotiating insurance claims, *Sharp Cancer Patient Navigators and*

Social Workers reported, is common for patients. Interactions with insurance companies can cause delays, which can cause patients to want to give up on their care. Delays caused by the unavailability of surgeons and other specialists or related to the commencement of chemotherapy also create patient frustration.

In addition, *Sharp Cancer Patient Navigators and Social Workers* identified logistical issues, like securing affordable, convenient transportation and covering responsibilities at home, as obstacles to the receipt of cancer care. Practical issues related to post-discharge care were described as particularly challenging, such as when the patient lives alone and has no one to assist with his or her recovery, when the patient is homeless, or when the patient is unable to arrange follow-up medical appointments.

Sharp Cancer Patient Navigators and Social Workers expressed great concern about the impact that a cancer diagnosis and subsequent treatment may have on families. Communication about diagnosis, treatment, and the types of assistance needed can be challenging for the patient. Engagement participants described how children can be traumatized not only by the prospect of a sick or dying parent but also by additional responsibilities they may have to take on that are beyond their maturity level. Children may provide translation services, transportation, and health care assistance. One 10-year-old child, for example, had the responsibility for draining her mother's mastectomy bags.

Sharp 2019 CHNA Suggestions

The *Sharp Cancer Patient Navigators and Social Worker* focus group members and KI had several suggestions for how either Sharp or community organizations could support the work of navigators and improve the outcomes of San Diego's community members facing cancer:

- Assign cancer patients to financial case managers or navigators to help them deal specifically and exclusively with health insurance issues.
- Create a one-stop shop for cancer patients that offers legal and financial services, pain clinics, and wig disbursements — and house that within the cancer center.
- Have more staff dedicated to breast cancer patients.
- Offer more post-surgery or post-chemotherapy follow-up to patients.

Sharp Insight Community survey participants also had the opportunity to provide specific suggestions about what Sharp can do to improve the health and well-being of the community. See **Appendix R** for the most commonly suggested themes. Feedback related to cancer included:

- Be more proactive in terms of getting patients in for cancer screening; provide free screenings and online educational webinars.
- Provide more educational programs, including for cancer.

- Increase access to primary health care services; shorten waiting times for primary and specialty care appointments.
- Invest more in post-acute care management.
- Provide opportunities for technical education on many areas of medicine; develop decision-making tools for complex patient decisions (e.g., prostate cancer treatment).

Additional recommendations from the *Sharp Insight Community* survey can be found in **Appendix R**.

Table 27: HASD&IC 2019 CHNA – Focus Group and KI Interview Summary of Responses Related to Cancer

SUMMARY OF RESPONSES RELATED TO CANCER
ASSOCIATED HEALTH CONDITIONS AND NEEDS
♦ **Brain cancer** ♦ **Breast cancer** ♦ **Cancer** (all types, especially in older populations) ♦ **Chronic diseases**: stress leads to increased cortisol levels which over time is linked to increases in chronic diseases such as asthma, heart disease, and cancer
ASSOCIATED SOCIAL DETERMINANTS OF HEALTH
♦ **Healthy behaviors:** poor diet, and lack of physical activity ♦ **Physical environment:** chemical exposures from industrial sites, and from being in war zones prior to arriving in the U.S. ♦ **Substance use**: tobacco, alcohol misuse ♦ **Stigma**: fear of community stigmatization due to cancer diagnosis
ACCESS TO SERVICES BARRIERS AND CHALLENGES
♦ **Cost** ♦ **Delays** to see specialists, like surgeons ♦ **Fear** of a diagnosis therefore people delay addressing serious health issue until it progresses too far ♦ **Fear** related to immigration status ♦ **Frustration** with navigating insurance issues ♦ **Logistical issues** such as transportation, childcare and home responsibilities ♦ **Preventative care**: people believe they are healthy due to not having any physical symptoms, therefore do not receive preventative care ♦ **Screenings**: avoidance of screenings, specifically breast cancer

Table 28: Sharp 2019 CHNA – Sharp HealthCare Cancer Patient Navigators and Social Worker Focus Group and KI Interview Summary of Responses

SHARP HEALTHCARE CANCER PATIENT NAVIGATORS AND SOCIAL WORKER - SUMMARY OF RESPONSES
SOCIAL DETERMINANTS OF HEALTH – PATIENT AND FAMILY
♦ **Access to health care** specifically for recovery issues, post-surgery or post-treatment. ♦ **Community and family support** ○ Patients sometimes hide cancer status from their children. Sometimes it is due to the young age of their children. ○ Patients do not want to ask for help, they want to manage their health condition on their own. ○ Lack of caregivers ○ Lack of effective communication between patient and family members, especially senior patients. ♦ **Transportation** problems getting to health services ♦ **Financial issues** and needs related to their care plans ♦ **Insurance Issues** (i.e. having Medi-Cal, but no supplemental income) ♦ **Homelessness:** some patients live in cars ♦ **Language barrier** becomes a problem when trying to accurately translate cancer status to patient and family
YOUTH ROLES IN FAMILY CARE
♦ Children will often take on a role reversal when their parent is sick. ♦ Children provide **transportation** ♦ Children provide **translation**
ACCESS TO HEALTH CARE CHALLENGES AND BARRIERS FOR PATIENTS AND FAMILY MEMBERS
♦ **Economic security** ♦ **Fear** ○ Fear and pain management are challenges for head and neck cancer patients. ○ Patients do not want chemotherapy because they do not want to lose their hair. ○ Patients fear the impact of treatment and are scared of the future and its uncertainty. ○ Sometimes other people will instill fear in the patients and tell them to partake in certain activities such as not eating sugar or going to Mexico to get their cancer treatments. ♦ **Mental health issues and substance misuse** can create challenges in care. ♦ **Untimely access** to providers and treatment, due to insurance issues or lack of providers to render services. ♦ **Provider shortage** ♦ **Treatment compliance:** providers may be unaware of a patient's psychiatric history which may complicate treatment compliance. ♦ **Conflicting treatments**: some patients use holistic methods such as herbs and vitamin C therapy that may interact with treatments.
HOSPITAL COMMUNICATION Do you or your staff interact with community clinics, social services organizations, or other community resources in any way to support patients/their families?

- **Referrals** are made to resources such as financial services, In-Home Care, transportation, and housing.
    - Based on identified needs they refer to Komen Foundation or Cancer society.
    - Jewish Family Services and Mama's Kitchen are organizations that social workers and navigators rely on.
    - For patients with mental health issues or suicide ideation, social workers and navigators will call Sharp Mesa Vista to refer patients to a psychiatrist.

HOSPITAL DISCHARGE CHALLENGES AND BARRIERS

- **Lack of family support**: issues when there is no one at home for the patient to be discharged to.
- **Homeless**: when the patient does not have a home.
- **Medications**: when the patient has no access to their medications.
- **Follow-up care**: lack of follow-up care.
- **Insurance issues**, especially when patients have no outpatient care coverage.
- **Education**: some caregivers lack health education or are not capable of effectively being a caregiver.

HOSPITAL AND COMMUNITY SUPPORT NEEDED

Financial navigators: there is a need for financial navigators to help oncology patients navigate their health insurance policy.

One stop shop for patients that includes all the services they may need during this time, such as pain management clinics, wig disbursement, and help with legal issues.

Additional staff: there is a need for more staff for breast cancer patients.

Follow-up care: after surgery and chemotherapy follow up care.

Education: patients need more education and support during this process such as education around why going back to work is not advisable.

Legal Services: there is a need for more assistance with legal services and lawyers. Legal issues arise for some patients on immigration, custody of children, divorce, or work-related issues on discrimination.

IMMIGRATION

Have you observed any changes over the past year in patient/community member attitude towards immigration issues?

- Patients are afraid to talk when it comes to their citizenship status.
- Many patients disenrolled from their health insurance out of fear of being on a “list”.
- There has been an increase in inpatient care due to placing patients on restricted Medi-Cal and then admitting them to obtain treatment and needed tests and scans such as MRI’s. These services would otherwise not occur if the patient were an outpatient due to insurance.
- Many immigrants debate stopping treatment or just leaving the country all together.
- In terms of access to health care, there are a lot of legal and family issues involved.

Chronic Health Conditions (Cardiovascular disease, Diabetes, Obesity)

Definition

The Centers for Disease Control and Prevention (CDC) defines chronic health conditions as those that last at least one year and require ongoing medical care and/or limit activities of daily living.

Three chronic health conditions were identified as being of primary concern during the 2019 CHNA: CVD, diabetes and obesity.

CVD refers to a set of conditions related to the heart and blood vessels, including: heart disease, heart attack, stroke, heart failure, arrhythmia, and heart valve problems. The most common form of CVD is heart disease, and the most common heart disease is coronary artery disease (CAD – also referred to as coronary heart disease).

Diabetes is a set of diseases that affect the way the body metabolizes sugar (glucose). The three primary types of diabetes are: Type 2 (the most common type), Type 1, and gestational (occurring during pregnancy).

Overweight or obese people weigh more than is considered healthy for a given height. Body Mass Index (BMI) is a screening tool for overweight and obesity that divides people's weight by the square of their height. Obesity is defined in adults as having a BMI of 30.0 or higher. For children, obesity is defined as having a BMI at or above the 95th percentile for children of the same age and sex.

Findings

The chronic health conditions of CVD, diabetes and obesity were identified as priority health needs by both the SGH and HASD&IC 2019 CHNA secondary data analyses and community engagement efforts.

The community engagement activities identified key factors that community members struggle with to prevent chronic diseases, including access to fresh, healthy foods and safe places to exercise and play. In addition, barriers to care, SDOH, and disease management were identified as particularly difficult for those with chronic health conditions. This included:

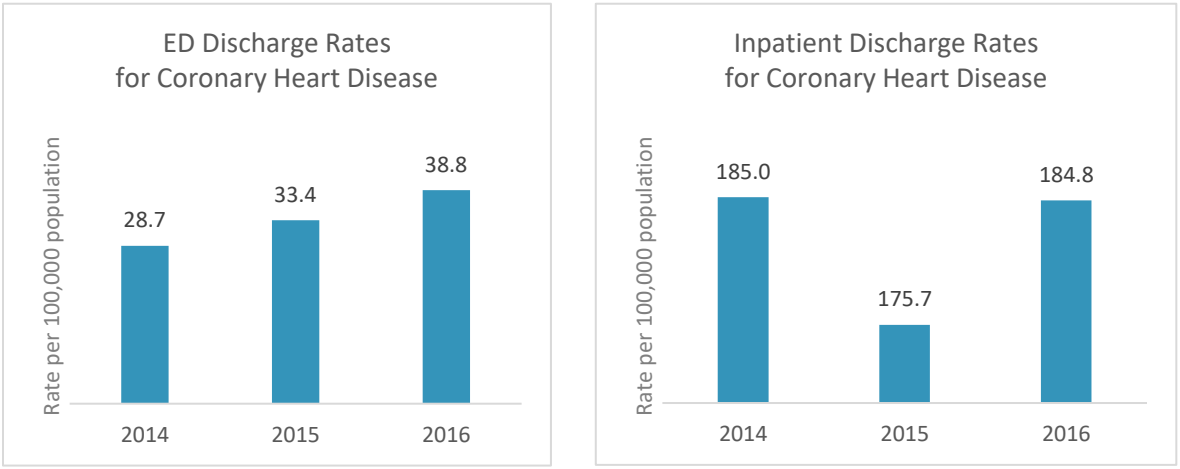
- Economic security
- Transportation
- Immigration fears
- Lack of knowledge on health condition

Secondary Data Findings

Cardiovascular Disease

The rate of ED visits for coronary heart disease increased by 35.3% from 2014-2016. The steepest increases were for those ages 45-64 (41.9%) and Asian/Pacific Islanders (55.1%). Inpatient discharge rates decreased slightly (by 0.1%). See **Figure 28** below for details.

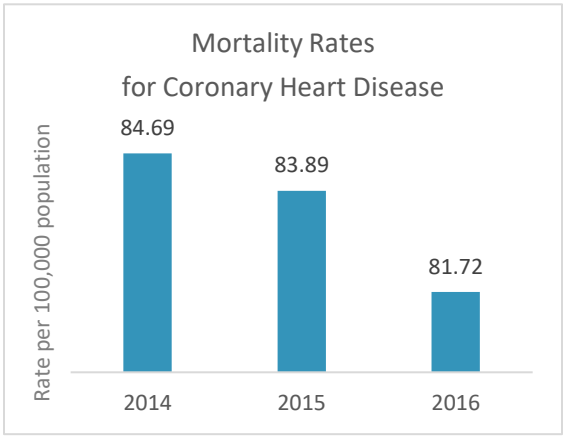
Figure 28: ED Visit and Inpatient Discharge Rates for Coronary Heart Disease in SDC, 2014-2016



Source: California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2014-2016. SpeedTrack©

Heart disease was the second leading cause of death in SDC in 2016. The overall death rate from coronary heart disease decreased by 3.5% from 2014-2016 but increased among Black (8.7%) and American Indian/Alaska Native (29.4%) individuals. See **Figure 29** below for details.

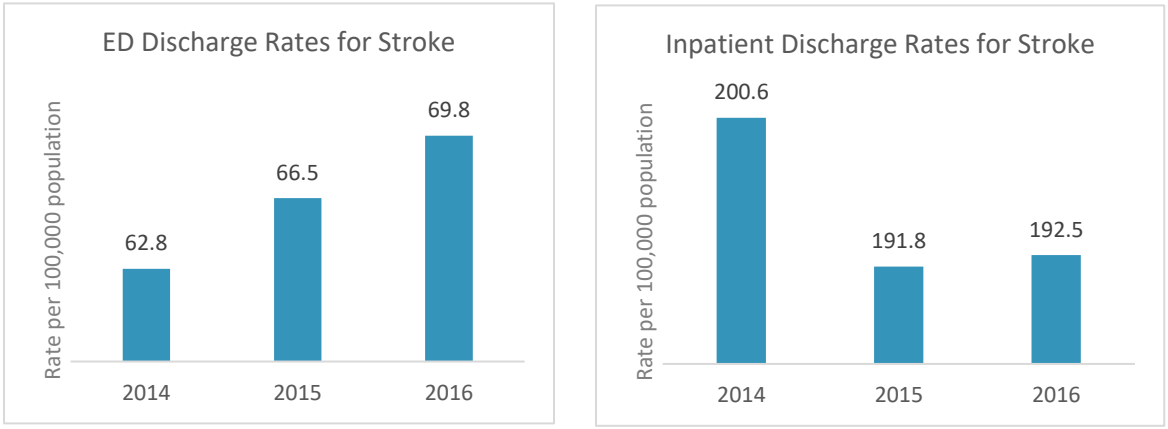
Figure 29: Mortality Rates for Coronary Heart Disease in SDC, 2014-2016



Source: County of San Diego Health and Human Services Agency Public Health Services, Regional & Community Data.

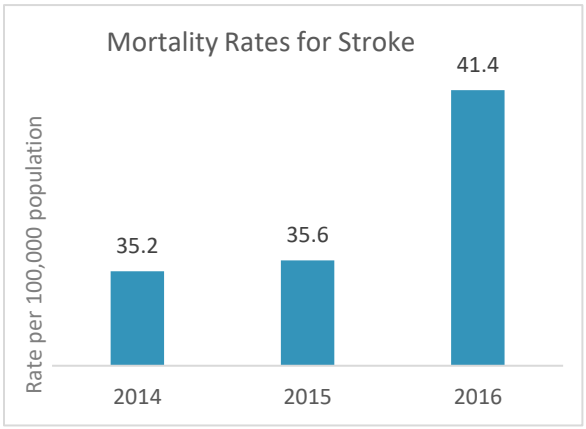
The rate of ED visits for stroke increased by 11.0% from 2014-2016. The steepest increases were for those ages 27-44 (20%) and for people who identify their race as "other" (28.9%). Rates of inpatient discharge for stroke decreased by 4.1%. Stroke was the fourth leading cause of death in SDC in 2016. Death rates for stroke increased by 17.6% from 2014-2016. The increase was steepest for Hispanics (28.5%). See **Figures 30** and **31** below for details.

Figure 30: ED Visit and Inpatient Discharge Rates for Stroke in SDC, 2014-2016



Source: California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2014-2016. SpeedTrack©

Figure 31: Mortality Rates for Stroke in SDC, 2014-2016

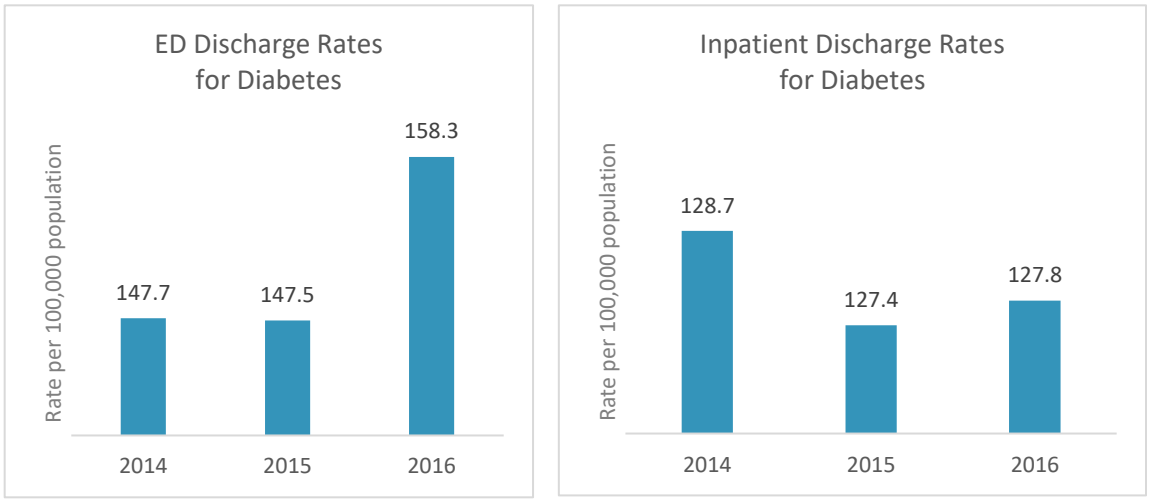


Source: County of San Diego Health and Human Services Agency Public Health Services, Regional & Community Data.

Diabetes

In SDC in 2017, 9.4% of adults had diabetes. ED visits for diabetes increased 7.2% from 2014-2016; increases in rates were highest (13.9%) for those ages 27-44 years and for Asian/Pacific Islander (16.3%) and Black individuals (15.1%). Inpatient discharge rates for diabetes decreased slightly (0.7%) from 2014-2016 but increased for Asian/Pacific Islanders (28.6%), for people ages 11-17 (15.7%) and for people 18-26 years old (28.8%). See **Figure 32** below for details.

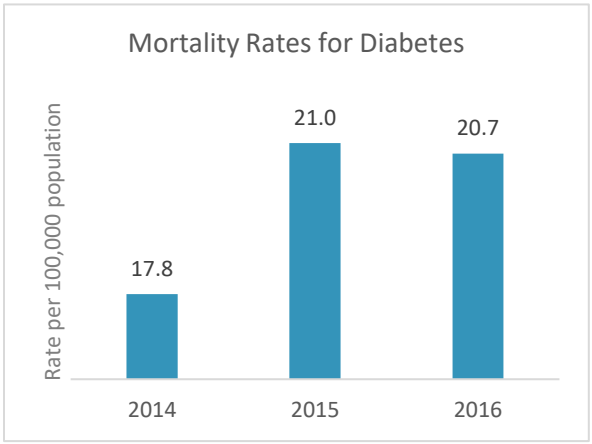
Figure 32: ED Visit and Inpatient Discharge Rates for Diabetes in SDC, 2014-2016



Source: California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2014-2016. SpeedTrack©

Diabetes was the seventh leading cause of death in SDC in 2016. The age-adjusted death rate for diabetes increased 16.3% from 2014-2016. Increases were steepest for Hispanics (53.0%) and those who identify their race as "other" (35.0%). See **Figure 33** below for details.

Figure 33: Mortality Rates for Diabetes in SDC, 2014-2016

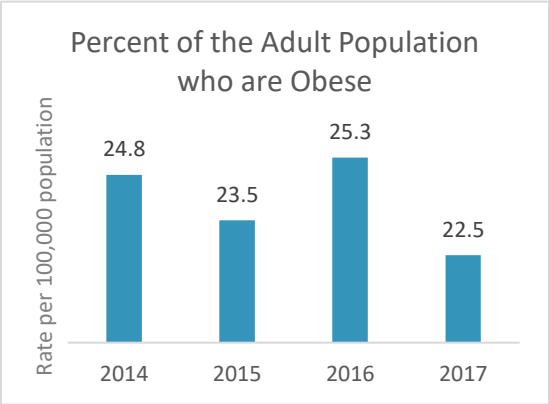


Source: County of San Diego Health and Human Services Agency Public Health Services, Regional & Community Data.

Obesity

In 2016, 25.3% of adults in SDC were obese, a 2.0% increase from 2014. See **Figure 34** below for details.

Figure 34: Percent of the Adult Population who are Obese in SDC, 2014-2017



Source: California Health Interview Survey, 2014-2017

Please see **Appendix O** for Chronic Health Conditions definition and secondary data source information.

Notable findings from an analysis of SGH discharge data for chronic health conditions — specifically CVD, Type 2 diabetes, and obesity — included[21]:

CVD

- In 2017, the top three inpatient CVD diagnoses at SGH were classified as hypertension, CAD, and heart failure.

- Among individuals who visited SGH's ED in 2017, the top three CVD diagnoses were classified as hypertension, CAD, and undiagnosed prior heart attack.

- In 2017, males represented 41.8% of all inpatient discharges at SGH but 47.9% of inpatient discharges with a CVD diagnosis. In addition, males accounted for 54.6% of inpatient discharges where CVD was the principal diagnosis.

- Among individuals who visited the ED at SGH with a CVD diagnosis in 2017, 44.7% were ages 65 and older, and 42.0% were ages 45-64.

Type 2 Diabetes

- In 2017, the top three ED and inpatient Type 2 diabetes diagnoses at SGH included Type 2 diabetes (uncomplicated), Type 2 diabetes with Chronic Kidney Disease, and Type 2 diabetes with hyperglycemia (high blood sugar).

- In 2017, males represented 41.8% of all inpatient discharges at SGH, but 50.2% of inpatient discharges with a Type 2 diabetes diagnosis. In addition, males

[21] California Office of Statewide Health Planning and Development (OSHPD) Non-Public Inpatient Discharge and Emergency Department Encounter Data, 2017. Accessed through SpeedTrack Inc.©

accounted for 64.3% of inpatient discharges where Type 2 diabetes was the principal diagnosis.

- Among individuals admitted to SGH with a Type 2 diabetes diagnosis in 2017, 56.0% were ages 65 and older, and 38.7% were ages 45-64.

- In 2017, seniors represented 41.1% of ED visits related to Type 2 Diabetes at SGH.

- Among individuals who visited the ED at SGH with a Type 2 diabetes diagnosis in 2017, 45.5% were ages 45-64 and 41.1% were ages 65 and older.

Obesity

- Females represented 60.5% of individuals admitted to SGH in 2017 with an obesity diagnosis, and 66.2% of ED visits where an obesity diagnosis was present.

- Among individuals admitted to SGH with an obesity diagnosis in 2017, 40.8% were ages 45-64, and 35.0% were ages 65 and older.

- Among individuals who visited the ED at SGH with an obesity diagnosis in 2017, 39.4% were ages 18-44, and 38.0% were ages 45-64.

Community Engagement Findings

HASD&IC 2019 CHNA

CVD, diabetes and cancer were the chronic health conditions most frequently discussed by community members as priority health needs in SDC.

In the *HASD&IC 2019 CHNA* online survey, these conditions were ranked as three of the five most impactful health conditions on the overall well-being of San Diegans. In addition, of those who chose obesity as the greatest influence on poor health outcomes, 51.0% identified obesity as growing worse within SDC.

Conversations about chronic health conditions in the *HASD&IC 2019 CHNA* focus groups centered on barriers to care, particularly related to prevention and disease management, and on specific challenges faced by vulnerable populations. See **Table 29** for a summary of findings from the *HASD&IC 2019 CHNA* community engagement activities related to chronic health conditions.

Sharp 2019 CHNA – Focus Groups

A focus group conducted with the *Sharp PFAC* highlighted both CVD — including stroke — and diabetes as chronic health conditions of particular concern. In addition, a focus

group conducted with *Sharp Case Management Leadership* specifically cited diabetes, chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF) as chronic health conditions that severely impact Sharp's more vulnerable patient populations; that is, the populations experiencing greater health disparities than others.

Please refer to **Tables 21** and **22** or **Appendix U** for a summary of these findings. The **Discussion of Community Engagement Findings** below highlights those focus group findings that specifically connect to chronic health conditions.

Lastly, a focus group conducted with *Sharp Diabetes Health Educators* facilitated a better understanding of the unique health needs of Sharp's diabetes patients. Please refer to **Table 30** or **Appendix U** for a summary of *Sharp Diabetes Health Educator* focus group findings.

For a description of all Sharp focus group participants, see **Appendix K** and **Appendix L**.

Sharp 2019 CHNA – Sharp Insight Community

Sharp's Insight Community online survey provided greater understanding of chronic health conditions of concern among Sharp patients and community members. Out of 16 health conditions, respondents (n=380) ranked obesity as the third most important health condition impacting their community, while ranking heart disease (coronary) and diabetes (types 1 and 2) fourth and fifth, respectively (see **Appendix R** for details).

When health conditions and SDOH were combined among all respondents, obesity, heart disease, diabetes and health behaviors all ranked within the top 10 most important health needs among 30 choices. Please refer back to **Figure 14** for the final ranking of health conditions and SDOH by *Sharp Insight Community* survey participants.

Further, after ranking various health conditions and SDOH, *Sharp Insight Community* survey participants were asked to rate their awareness of select community outreach programs offered by Sharp. This included the education programs Sharp offers in partnership with the City of San Diego on various health and healthy lifestyle topics, including chronic health conditions such as diabetes, as well as heart health and nutrition. Notably, only 9% of respondents were very familiar with these education programs, while the majority were either not at all familiar (46%) or 'somewhat familiar' (45%). See **Appendix R** for details.

Discussion of Community Engagement Findings

HASD&IC 2019 CHNA – Focus Groups

HASD&IC 2019 CHNA focus group participants repeatedly asserted that in order to prevent CVD, diabetes and obesity, community members must have economic and

geographic access to fresh, healthy foods and to safe places to exercise and play. Focus group participants felt that some San Diego neighborhoods have an overabundance of fast food restaurants and convenience stores and far fewer grocery stores featuring affordable fresh produce, which makes healthy eating economically and logistically challenging. In addition, some neighborhoods lack safe, open places to play and exercise. In addition, in some families, they said, the adults work long hours to earn enough to cover their necessities, leaving little time for healthy cooking and exercise.

HASD&IC 2019 CHNA focus group participants noted that concerns about finances create obstacles to the effective management of chronic conditions like CVD and diabetes. Co-pays for doctor's visits and medications, loss of income due to time off work, and the cost of transportation to medical appointments are prohibitive. Focus group participants described instances in which people had to choose between feeding their families and getting their medications.

Immigration fears, *HASD&IC 2019 CHNA f*ocus group participants said, keep some of them from getting the health care they need to manage their conditions. Many undocumented residents fear being placed on an "alert list" for immigration officials when receiving health care. Residents who are attempting to become U.S. citizens fear that the receipt of services will interfere with their ability to become naturalized. Lack of knowledge, one participant asserted, is another primary obstacle to disease management. Individuals may be unaware of how to manage their diseases and unsure about how to secure resources to assist them.

Further, *HASD&IC 2019 CHNA* focus group participants emphasized that managing chronic health conditions is particularly troublesome for two groups: (1) homeless and insecurely housed individuals and (2) seniors. For homeless and insecurely housed individuals, managing medical appointments and the storage of insulin were frequently mentioned as barriers to diabetes management. For seniors, transportation to care and the management of medication were discussed as especially challenging. For additional details on the *HASD&IC 2019 CHNA* community engagement findings, please refer to the full *HASD&IC 2019 CHNA* at: https://hasdic.org/2019-chna/.

Sharp 2019 CHNA – Focus Groups

Participants in the *Sharp PFAC* and *Sharp Case Management Leadership* focus groups discussed the conditions most negatively impacting the community, barriers to accessing care, and suggestions for ways in which patient/community health outcomes could be improved. Please refer to **Tables 21** and **22** at the end of this section for a summary of these findings. The discussion below highlights those focus group findings that specifically connect to chronic health conditions.

In the *Sharp Diabetes Health Educator* focus group, the discussion focused on diabetes. Topics covered were those barriers to disease management for diabetic patients; the impact of diabetes on an individual and his/her family; the services provided by Sharp diabetes health educators and the ways in which they coordinate

care with other community organizations; and suggestions for ways in which their work could be better supported. Please refer to **Table 30** at the end of this section, as well as **Appendix U**, for a summary of *Sharp Diabetes Health Educator* focus group findings.

In the *Sharp PFAC* focus group, barriers to care connected to chronic disease management included economic insecurity (including food insecurity), housing and insurance issues, challenges with navigating the health care system, lack of health literacy, fears regarding immigration issues, and cultural and language barriers. Essentially, the very same barriers that have a critical impact on access to care. For a deeper discussion of these barriers, please refer to the **Access to Health Care** section.

During the focus group conducted with *Sharp Case Management Leadership*, barriers to accessing care were discussed extensively. Participants cited many factors that serve as obstacles to quality care for vulnerable populations, including economic and food insecurity, housing, challenges with insurance for patients and for hospitals, fears related to immigration status, waiting lists for appointments, and issues specific to discharge care. Regarding chronic disease management, the barriers of economic security, housing, waiting lists and discharge challenges were noted in particular. For a deeper discussion of these barriers, please refer to the **Access to Health Care** section.

In the *Sharp Diabetes Health Educator* focus group several barriers to effective diabetes management were described, including challenges with finances, pharmacies, insurance policies, fear, and lack of knowledge/cultural beliefs about food and illness. Focus group participants noted that concerns about finances create obstacles to effective diabetes management for their patients: co-pays for doctor's visits and medications, loss of income due to time off work, and the cost of transportation to medical appointments are prohibitive. Health educators described instances in which patients had to choose between feeding their families and getting their medications — and the inability to purchase healthy foods further exacerbates their diabetes.

The *Sharp Diabetes Health Educator* focus group also described challenges patients face with pharmacies — prescription renewals are sometimes denied because a physician fails to use the right language on a prescription and the pharmacists are unwilling or unable reach out to the doctor to resolve the issue. In addition, many pharmacies do not offer discount programs, creating further financial stress, and while some pharmacies will ensure that patients have testing strips and supplies, others will not. Relatedly, focus group participants also noted that insurance issues, such as a "donut hole[22]" that creates challenges for some patients to receive medications between August and January, are also problematic.

In addition, *Sharp Diabetes Health Educator* focus group participants identified fears related to two subjects that prevent people from getting the care they need. First, for

[22] Most plans with Medicare prescription drug coverage (Part D) have a coverage gap (called a "donut hole"). This means that after the individual and their insurance plan have spent a certain amount of money for covered prescriptions, the individual must pay all costs out-of-pocket for their prescriptions up to a yearly limit. Once the individual has spent up to the yearly limit, their coverage gap ends and their insurance plan helps pay for covered prescriptions again. *Source: https://www.healthcare.gov/glossary/donut-hole-medicare-prescription-drug/*

undocumented immigrants, concerns about revealing their immigration status may keep them from getting health care. Second, for people in certain professions, such as pilots and truck drivers, the use of insulin can result in job loss, leading them to avoid using this medication.

Further, focus group participants asserted that lack of knowledge is another primary obstacle to disease management for their patients. In particular, patients are often unaware of their rights as employees to, for example, take breaks to check their blood sugar. In addition, participants said, cultural beliefs about food and illness at times do not align with effective diabetes care. For example, among some groups, it is common to eat very late at night and to only eat twice a day — both of which make controlling blood sugar difficult. For other groups, eating high carbohydrate foods, like rice, with most meals is routine, and it can be difficult to change these behaviors.

In addition, the *Sharp Diabetes Health Educators* cited several impacts of diabetes management that can also create barriers. “Diabetes,” one focus group participant explained, “is a never-ending disease that includes a long journey of self-management. This takes a toll on the patient’s psyche as well as their work and family life.” *Sharp Diabetes Health Educators* described diabetes patients as, at times, feeling isolated and lonely. They experience, health educators said, a great deal of stigma — they are blamed for their disease and feel guilt and shame as a result. At times, this stigma is reinforced by physicians. Families, participants said, may not be supportive of dietary changes. The associated co-morbidities, including cardiovascular issues, kidney issues, neuropathy, and vision issues are also impactful. Attempting to manage their health, focus group participants emphasized, can therefore cause diabetes patients to feel overwhelmed and depressed.

Sharp 2019 CHNA – Sharp Insight Community

Feedback regarding the most important SDOH was also obtained from *Sharp Insight Community* survey participants (see **Appendix R**), and this feedback had profound implications for chronic health conditions. Notably, among 14 choices, health behaviors (diet, physical and sexual activity, tobacco and substance use) were ranked as the third most important SDOH impacting the community. According to the County of San Diego Health and Human Services Agency (HHSA), lack of physical activity and poor nutrition are risk factors for obesity[23], while poor diet, physical inactivity and tobacco use contribute to heart disease and diabetes.[24] All three of these health conditions — obesity, heart disease and diabetes — were identified as priority health conditions in the SGH and HASD&IC 2019 CHNAs.

[23] County of San Diego HHSA. Public Health Services, Community Health Statistics. Obesity https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/documents/CHS-Obesity_SlideSet.pdf
[24] County of San Diego HHSA. https://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/community_health_statistics/3-4-50.html

Sharp 2019 CHNA Suggestions

Sharp 2019 CHNA focus group participants provided several suggestions to improve the health and well-being of patients and community members, particularly related to the chronic health conditions they experience.

In the *Sharp PFAC* focus group, suggestions focused around access to care and care coordination, which would have a significant impact on chronic disease management. Specific suggestions included:

- Prioritize the hiring and training of social workers. Social workers can coordinate care, create discharge plans, and make follow-up appointments. Patients are in need of a supportive advocate at the time of discharge.
- Offer free post-surgery home visits.
- Make follow-up phone calls to see if patients who have been discharged are doing well and getting proper follow-up care.
- Make in-home care more accessible, particularly for older patients.

In the *Sharp Case Management Leadership* focus group, suggestions centered around improved care coordination and programming that would also help address SDOH that challenge patient health. It was repeatedly emphasized that health outcomes could not be improved until SDOH were included as part of patient care plans. Specific suggestions included:

- Ensure 2-1-1 CIE[25] access for all Sharp facilities.
- Establish more patient-centered initiatives.
- House a program onsite at hospitals that helps place people in housing, and gets them referrals/helps with applications to affordable housing.
- Create more home-based support services and adult day centers to help patients transition back to the community or home after hospital discharge.
- Establish a more streamlined process and a communication system between the hospitals and the County about those who qualify for wraparound services, such as Whole Person Wellness.

Sharp Diabetes Health Educators had several suggestions for ways in which their work could be better supported and their patients' health improved:

- Provide a 24-hour pharmacy in the Outpatient Pavilion, at Sharp Memorial Hospital.
- Build partnerships with organizations that provide transportation and food/meal services.

[25] 2-1-1 San Diego's Community Information Exchange (CIE) is an ecosystem comprised of multidisciplinary network partners that use a shared language, a resource database, and an integrated technology platform to deliver enhanced community care planning. Care planning tools enable partners to integrate data from multiple sources and make bi-directional referrals to create a shared longitudinal record. *Source*: https://ciesandiego.org/what-is-cie/

- Make sure health care providers are aware that the diabetes education department exists and allow them to refer out from Sharp Rees-Stealy.
- Improve technology: they need telehealth capability, the ability to download a patient's glucose device, Wi-Fi, and access to the Cloud.
- Providers on their team need to sign off on prescriptions — otherwise it is "time lost" in terms of disease progression.
- Add psychologists to their team who can vet patients for organ transplants.
- Give the Diabetes Educators more office space.
- Add social workers to their team.

Sharp Insight Community survey participants also had the opportunity to provide specific suggestions about what Sharp can do to improve the health and well-being of the community. See **Appendix R** for the most commonly suggested themes. Feedback related to chronic health conditions included:

- Make nutrition/weight loss assistance free and continue to encourage diet and nutrition education.
- Implement healthy living strategies in schools to avoid some of the issues that affect communities as adults (prevention).
- Network with other health care providers to provide a seamless approach to community health.
- Change the role or image of the role of being a health care provider as the place to go for emergency solutions to being looked to as an ongoing part of one's overall health, and as a reminder to maintain a healthy weight, diet and exercise plan.

Additional recommendations from the *Sharp Insight Community* survey can be found in **Appendix R**.

Please refer to **Tables 21** and **22** for a summary of responses from the *Sharp PFAC* and *Sharp Case Management Leadership* focus groups. **Table 30** presents a summary of feedback from the *Sharp Diabetes Health Educator* focus group.

Table 29: HASD&IC 2019 CHNA – Focus Group and KI Interview Summary of Responses Related to Chronic Health Conditions

SUMMARY OF RESPONSES RELATED TO CHRONIC HEALTH CONDITION
ASSOCIATED HEALTH CONDITIONS AND NEEDS
All Age Groups • Cardiovascular disease (heart attack, stroke) • Cholesterol • COPD • Diabetes (Type I, II, and pre-diabetic) • Hypertension (high blood pressure) • Obesity/overweight
ASSOCIATED BARRIERS AND CHALLENGES
All Age Groups • **Lack of access to healthy food** (living in a 'food desert', lack of grocery stores with healthy or fresh food) • **Lack of transportation:** difficulty in traveling to purchase groceries for rural areas and seniors • **Limited physical mobility:** difficult to purchase groceries due to physical limitations or being homebound (seniors) • **Healthcare cost:** high cost of insurance, medical bills, or medications • **Economic insecurity:** cost of living (rent, utilities), cost of healthy food • **Lack of health education and/or knowledge:** prevention, disease management, nutrition/diet modification • **Poor health behaviors:** unhealthy diets, lack of exercise or physical activity • **Medication management:** timing, frequency, and how to take medications • **Unsafe or poorly kept neighborhoods or public spaces** for physical activity • **Housing:** Unstable or complete lack of housing **Children and youth** • **Refusing to eat healthy foods** • **Lack of safe places to exercise or play** **Individuals Experiencing Homelessness** • **Lack of kitchen** to cook healthy meals • **Lack of refrigeration** to store temperature-specific medications such as insulin • **Lack of safe storage of medications:** can get lost or stolen

Table 30: Sharp 2019 CHNA – Sharp HealthCare Diabetes Health Educators Focus Group Summary of Responses

SHARP HEALTHCARE DIABETES HEALTH EDUCATORS - SUMMARY OF RESPONSES
HEALTH CONDITIONS AND NEEDS FOR PATIENTS AND FAMILY MEMBERS
♦ **Cardiovascular issues** ♦ **Behavioral health issues:** depression associated with diabetes, bipolar ♦ **Diabetes** ♦ **Eating disorders** ♦ **Gastric bypass issues** ♦ **Kidney issues** ♦ **Neuropathy:** weakness, numbness, and pain from nerve damage, usually in the hands and feet ♦ **Post kidney transplant issues** ♦ **Vision issues**
SOCIAL DETERMINANTS OF HEALTH FOR PATIENTS AND FAMILIES
♦ **Community and family support:** families can be unsupportive of the "diet" they must adhere to. There are misconceptions about the health conditions by family members**.** ♦ **Education for patients:** general lack of patient empowerment and knowledge on diabetes ♦ **Education for providers**: patients are referred to general practitioners and medical doctors who are not knowledgeable in diabetes care ♦ **Food insecurity** ♦ **Medication Issues:** prescription issues such as medications not being covered under the patients insurance. This can be an issue when the doctor does not write "or" on the prescription renewal so that it can be replaced with different type of drug. ♦ **Stigma**: the burden is reinforced by medical providers who scare the patients.
ACCESS TO HEALTH CARE CHALLENGES AND BARRIERS FOR PATIENTS AND FAMILY MEMBERS
♦ **Community and family support**: lack of family support due to economic reasons. ♦ **Cultural differences** o Middle Eastern patient population cultural/belief differences: ▪ Tendency to eat very late and only two times a day which make it harder to control blood glucose levels. ▪ Arab population –has difficulty trusting and believing the diabetes education content, which creates challenges when trying to change eating and life style habits. ▪ Husbands are dominant in the household and due to work status cannot support their wife during appointments. o Asian culture –eating two bowls of rice is the norm; lack health literacy in nutrition. o Some cultures believe big babies are healthier. ♦ **Economic insecurity** o If husband misses work, family does not eat; same goes for taking time off for sick leave or medical emergencies. o Food insecurity ♦ **Education**: lack of knowledge of disability and employment rights (i.e. employees are unaware that by law they must be allowed to check their blood sugar levels at work). o Some patients believe insulin causes blindness (not diabetes condition itself) or think that death or amputation is inevitable when diagnosed with diabetes. o Providers forget to remind patients to bring their blood glucose meters. o Even well-educated patients with gestational diabetes may not care for themselves properly. ♦ **Health insurance issues** ♦ **Stigma**: some patients have preconceived ideas of what a person living with diabetes looks like. There is stigma around the use of the word diabetic, and some people believe people with diabetes are lazy. ♦ **Violence**: instances of domestic/familial abuse.

HOSPITAL COMMUNICATION Do you or your staff interact with community clinics, social services organizations, or other community resources in any way to support patients/their families?
♦ **Referrals**: refer patients with newborns who need resources to the Salvation Army and other organizations. ♦ **Partner with community organizations such as:** ○ Family Health Center (FHC) to help patients set goals, follow-up, and check in on patient progress. ○ 2-1-1 San Diego to work on food insecurity resources. ○ Sharp Mesa Vista Outpatient Center ○ Senior centers ○ Feeding America and Senior Meal Programs ♦ **Additional partnerships include** ○ WIC interns conduct projects with Sharp HealthCare to implement changes. WIC is a federally funded food supplement nutrition program for Women, Infants, and Children (WIC). ○ Help uninsured patients enroll into the Care Transitions Intervention (CTI) Program
HOSPITAL DISCHARGE CHALLENGES AND BARRIERS
♦ At discharge, there is no continuity of care. Patients are only provided with papers on resources. ♦ Language barrier when trying to understand discharge papers.
IMMIGRATION Have you observed any changes over the past year in patient/community member attitude towards immigration issues?
♦ The group has observed changes in attitudes toward immigrant issues and stated that it is most noticeable in the Chula Vista location. ♦ There is fear of crossing the border from the South Bay.

Community and Social Support

Definition

Community support refers to the resources available within an individual's neighborhood to promote the well-being of the residents. Social support is defined as the types of help that people receive from other individuals including emotional, practical and informational assistance.

Findings

Community and social support were identified as a priority health need by both the SGH and HASD&IC 2019 CHNAs in the community engagement process. For health care in particular, community-clinical linkages that provide social support are critical. Per the CDC, community-clinical linkages are defined as connections between community and clinical sectors to improve population health.

Secondary Data Findings

SDC data related to the number of Federally Qualified Health Centers (FQHCs), the percent of the population with limited English proficiency, and the percent of the population who are linguistically isolated were studied as proxies for the level of available community and social support in the county.

FQHCs are community assets that provide health care to vulnerable populations. In particular, they promote access to ambulatory care in areas designated as medically underserved. There are 3.17 FQHCs per 100,000 persons in SDC according to the U.S. Department of Health and Human Services Center for Medicare and Medicaid Services. Although this is higher than the rate for California (2.5) and the U.S. (2.5), individual health centers may not have large enough capacity to deliver the services required for the populations they serve.

In recent years, the role of FQHCs has evolved beyond providing access to health care services. FQHCs are medical homes and health homes that not only provide case management for health care needs, they also coordinate their patients' access to social services. FQHCs often screen and assess for a wide-range of SDOH and connect patients to internal resources or community-based services.

Regarding linguistic and cultural barriers, with SDC's large immigrant and refugee population, the indicators of limited English proficiency and linguistic isolation are especially important to understanding who might lack social support as a result of these factors. According to the American Community Survey (ACS), approximately 14.5% of San Diego residents ages 5 and older speak a language other than English at home and speak English less than "very well." In addition, 6.8% of the population ages 5 and older live in a home in which no person age 14 or older speaks only English, or speaks a non-English language but does not speak English "very well." Similar to those with limited English proficiency, linguistically isolated populations may struggle with accessing health services, communicating with health care providers, and understanding health information. Please see **Table 31** below for more information on how SDC compares to the state and nation.

Table 31: Federally Qualified Health Centers Rate, Primary Care Provider Rate, Percent of Population Living with Limited English Proficiency, and Linguistically Isolated

	San Diego County	California	United States
Rate of Federally Qualified Health Centers (per 100,000)[a]	3.17	2.51	2.45
Primary Care Provider Rate (per 100,000)[b]	78.3	72.4	72.4
Percent Limited English Proficiency	14.6%	18.4%	8.5%
Percent Linguistically Isolated[c]	6.8%	9.2%	4.5%

[a]Source: U.S. Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File. December 2016.
[b]Source: U.S. Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2014
[c]Source: U.S. Census Bureau, American Community Survey. 2013-2017.

Please see **Appendix O** for Community and Social Support definition and secondary data source information.

Community Engagement Findings

HASD&IC 2019 CHNA

Community members in the *HASD&IC 2019 CHNA* identified community and social support as extremely important to the health of SDC residents.

In the *HASD&IC 2019 CHNA* community online survey, community and social support was ranked as one of the five most influential SDOH in SDC.

During *HASD&IC 2019 CHNA* focus group and KI interviews, participants emphasized three topics related to community and social support:

- Well-being is enhanced when people have adequate community and social support.
- When communities are disproportionately affected by economic stress and/or a poor physical environment, community engagement and the community spirit are affected.
- For certain populations, the receipt of services within their community is an important strategy to overcome barriers to care.

Sharp 2019 CHNA – Focus Groups

Community and social support was identified as having a significant impact on health outcomes and well-being across all of the Sharp/SGH 2019 CHNA focus groups, including: *Sharp Diabetes Health Educators*, *SMBHWN Case Managers & Social Workers, Sharp Case Management Leadership*, *Sharp Cancer Patient Navigators and*

Social Worker, *Sharp Senior Health Center* staff and patients/community members, *SMC Aftercare Support Group* members and *Sharp PFAC* members. Focus group participants also discussed community and social support specifically in connection to access to care challenges. Further details are included in the **Discussion of Community Engagement Findings** below.

Please refer to **Appendix U** for a summary of all SGH/Sharp 2019 CHNA focus groups.

Sharp 2019 CHNA – Sharp Insight Community

Sharp's Insight Community online survey provided greater understanding of community and social support as an identified health need among Sharp patients and community members. Among 14 SDOH, respondents (n=380) ranked community and social support (including social interaction/engagement, cultural and linguistic support) as the ninth most important SDOH impacting their community. See **Appendix R**.

When health conditions and SDOH were combined among all respondents, community and social support ranked as the 16th most important health need among 30 choices. Please refer back to **Figure 14** for the final ranking of health conditions and SDOH by *Sharp Insight Community* survey participants.

Discussion of Community Engagement Findings

HASD&IC 2019 CHNA – Focus Groups

HASD&IC 2019 CHNA focus group contributors frequently identified the support of family, friends and community as necessary to good health. People who are lonely or isolated, they said, are impacted physically and emotionally, whereas people who are connected to others feel better and are more motivated to stay healthy. In addition, contributors emphasized, people may be more likely to seek and receive both health and social services if they are able to do so within their own communities. The receipt of community-based services reduces logistical barriers to care, such as obtaining transportation. In addition, focus group participants explained, individuals are less hesitant to accept care from organizations that feel like part of their community.

In addition, *HASD&IC 2019 CHNA* focus group participants emphasized that the ability of people within a community to be civically engaged and supportive of other residents is impacted by economic stress and environmental conditions. When residents are focused on economic survival — paying rent and securing food for their families — they are less likely to be involved in their communities. In addition, residents are less likely to be active in their communities that suffer from air pollution, poor housing conditions, and lack of pleasant recreational areas like parks. Further, the essential "spirit" of communities that lack healthy conditions is affected, and this in turn negatively impacts residents' ability to support one another.

HASD&IC 2019 CHNA focus group members also stressed that particular populations are deeply in need of services within their communities. This is especially true, they emphasized, for immigrants who are fearful about their legal status; these individuals are far more likely to trust information they receive from people within their communities and to believe that they will not be reported to authorities when they receive services. Community-based support and services are also important, focus group participants said, for people from other cultures. Trust is built, they explained, when services are offered by people within the community who are either from similar cultural backgrounds or who make the effort to immerse themselves in a community. Seniors would also benefit from having services that are offered closer to home and within a familiar neighborhood. Finally, those who are homeless are more likely to receive and be compliant with health care services, focus group members said, if clinics are available in the communities in which they reside.

Sharp 2019 CHNA – Focus Groups

Sharp PFAC focus group participants described community and social support specifically in connection to its impact on vulnerable populations navigating the health care system, particularly seniors. For seniors and other individuals living alone, inadequate support at home was noted to be a concern, including: having enough food; transportation to follow-up appointments; and support in understanding new prescriptions and reconciling previous medications with a new medication regimen. *Sharp PFAC* focus group participants also explained that trying to understand and utilize the health care system and insurance can be physically and mentally exhausting; which is only exacerbated for those who lack community and social support. Please refer to **Table 21** or **Appendix U** for a summary of feedback from the *Sharp PFAC* focus group.

Sharp Case Management Leadership focus group participants highlighted lack of family support, lack of a caregiver upon discharge and lack of childcare assistance as elements of community and social support that have devastating impacts on the health and well-being of their patients. In addition, for patients who are elderly, it is a significant challenge to locate affordable short-term caregivers upon discharge from the hospital. Please refer to **Table 22** or **Appendix U** for a summary of feedback from the *Sharp Case Management Leadership* focus group.

Community and social support was mentioned frequently throughout the *Sharp Diabetes Health Educator, SMBHWN Social Workers & Case Managers, Sharp Cancer Navigators and Social Worker, and Sharp Senior Health Center staff*, patients and community member focus groups as well. Please see the findings for **Aging Concerns**, **Diabetes**, **Maternal and Prenatal Care, including High-Risk Pregnancy** and **Cancer** for specific feedback on community and social support and its connection to these identified health needs.

Sharp 2019 CHNA Suggestions

Sharp PFAC suggestions that specifically address community and social support included:

- Prioritize the hiring and training of social workers. Patients are in need of a supportive advocate at the time of discharge.
- Offer free post-surgery home visits.
- Make follow-up phone calls to see if patients who have been discharged are doing well and getting proper follow-up care.
- Make in-home care more accessible, particularly for older patients.

Sharp Case Management Leadership suggestions that specifically address community and social support included:

- Ensure 2-1-1 CIE[26] access for all Sharp facilities.
- Create more home support services and adult day centers to help patients transition back to the community or home after hospital discharge.
- Establish a more streamlined process and a communication system between the hospitals and the County about those who qualify for wraparound services, such as Whole Person Wellness.

Sharp Insight Community survey participants also had the opportunity to provide specific suggestions about what Sharp can do to improve the health and well-being of the community. See **Appendix R** for the most commonly suggested themes. Feedback related to community and social support included:

- Mobile Units — if it is possible to go out to the public, it could help address some of the transportation concerns and even help with some of the stigma concerns by coming to the patient and making it convenient to be seen.
- Partner with schools to start health education early.
- Network with other health care providers to provide a seamless approach to community health.
- Actively advocate for health care reform to ensure fair, equitable health care for everyone.

Additional recommendations from the *Sharp Insight Community* survey can be found in **Appendix R**.

[26] 2-1-1 San Diego's Community Information Exchange (CIE) is an ecosystem comprised of multidisciplinary network partners that use a shared language, a resource database, and an integrated technology platform to deliver enhanced community care planning. Care planning tools enable partners to integrate data from multiple sources and make bi-directional referrals to create a shared longitudinal record. *Source*: https://ciesandiego.org/what-is-cie/

Economic Security

Definition

Economic security refers to the ability to meet essential financial needs sustainably, including those for food, shelter, clothing, hygiene, health care and education.

Economic insecurity is associated with:

- Poor mental health days
- Visits to the ED for heart attacks
- Asthma
- Obesity
- Diabetes
- Stroke
- Cancer
- Smoking
- Pedestrian injury

Economic insecurity may also lead to food insecurity, which is linked to:

- Fair or poor health, anemia and asthma in children
- Mental health problems, diabetes, hypertension, hyperlipidemia and oral health problems in adults
- Fair or poor health, depression and limitations in activities of daily living in seniors

Findings

For the purposes of this report, chief areas of economic security include poverty, wages and food insecurity.

Economic security was identified as a priority health need by the SGH and HASD&IC 2019 CHNAs in the secondary data analyses and in the community engagement process.

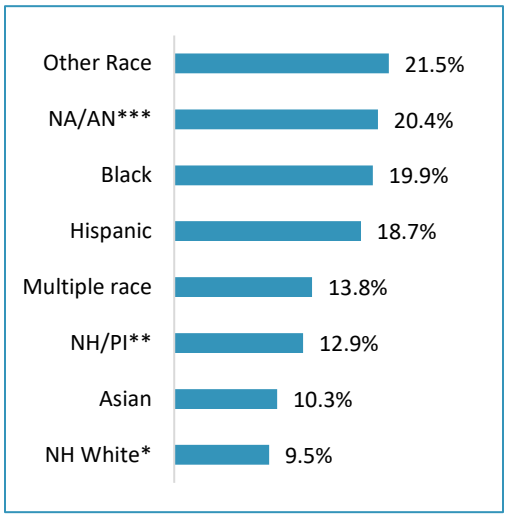
Secondary Data Findings

Data are available related to three indicators of economic security in SDC: the percent of the population living in poverty; the unemployment rate; and the percent of the population who are food insecure.

Poverty

For 2019, the federal poverty guidelines range from $12,490 for a 1-person household, to $25,750 for a 4-person household, to $43,430 for an 8-person household. In SDC, 13.3% of residents live below the federal poverty guidelines, and 17.1% of children live in poverty. Poverty rates vary by race (see **Figure 35** below):

Figure 35: Percent of the Population below 100% Poverty Level in SDC, 2013-2017

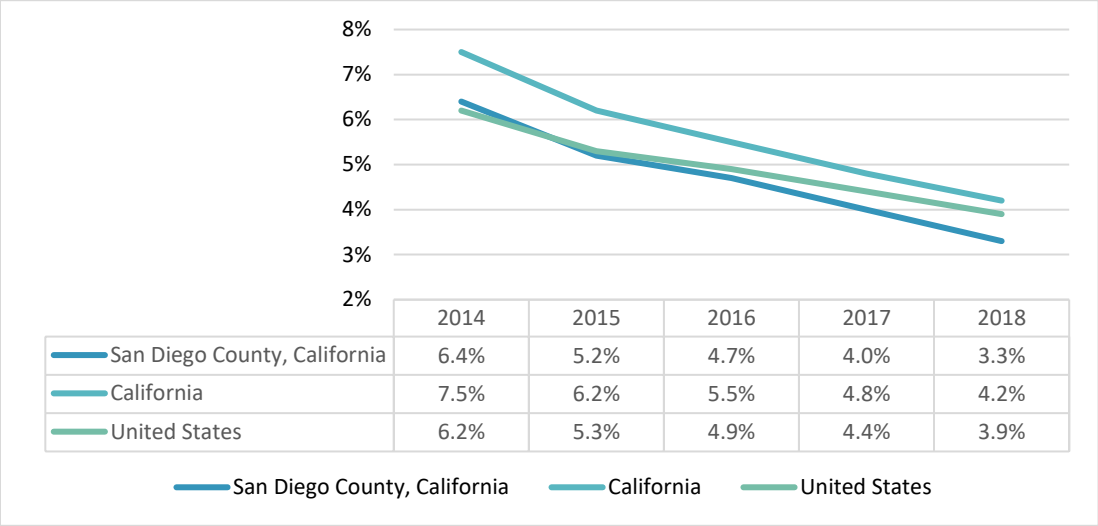


Source: U.S. Census Bureau, American Community Survey, 2013-2017 5-Year Estimates.
*Non-Hispanic White
**Native Hawaiian and Other Pacific Islander
***American Indian and Alaska Native

Unemployment

In 2018, the average unemployment rate in SDC was 3.3%. This rate has decreased by 48.0% since 2014. See **Figure 36** below for more details on unemployment.

Figure 36: Unemployment Rate in SDC, CA and the United States, 2014-2018



Source: Local Area Unemployment Statistics, 2018 annual averages. United States Department of Labor. Bureau of Labor Statistics.

Food insecurity

Food insecurity is defined as not always having enough food for everyone in the household to lead an active, healthy life. In San Diego:

- 14.0% of people experience food insecurity (1 in 7 people)
- 9.0% of seniors experience food insecurity (1 in 11 seniors)
- 22.0% of children live in food insecure households (more than 1 in 5 children)

Please see **Appendix O** for Economic Security definition and secondary data source information.

Community Engagement Findings

HASD&IC 2019 CHNA

Economic insecurity was identified as a priority health need in each of the *HASD&IC 2019 CHNA* community engagement activities and was described as impacting "every aspect" of residents' daily lives.

HASD&IC 2019 CHNA online survey results indicate that San Diegans believe that economic insecurity is profoundly impactful on the on the overall health and well-being of the community. Economic insecurity was ranked as the third most influential condition on well-being, after access to care and behavioral health. In addition, 55.0% of survey

respondents reported that they believe that the economic situation in San Diego has gotten worse over time. See **Appendix S** for a full summary of survey results. During the *HASDIC 2019 CHNA* focus groups and KI interviews, participants focused on two issues related to economic insecurity: (1) factors that contribute to economic insecurity; and (2) the impact of economic insecurity on well-being. See **Table 32** for a summary of findings from these community engagement activities. Additional details are included in the **Discussion of Community Engagement Findings** below.

Sharp 2019 CHNA – Focus Groups

Economic security was identified as having a significant impact on health outcomes and well-being consistently across all of the Sharp/SGH 2019 CHNA focus groups, including: *Sharp Diabetes Health Educators*, *SMBHWN Case Managers & Social Workers, Sharp Case Management Leadership*, *Sharp Cancer Patient Navigators and Social Worker*, *Sharp Senior Health Center* staff and senior patients/community members and *Sharp PFAC* members.

Additional details are included in the **Discussion of Community Engagement Findings** below. Please refer to **Appendix U** for a summary of all SGH/Sharp focus groups.

Sharp 2019 CHNA – Sharp Insight Community Survey

Sharp's Insight Community online survey provided greater understanding of economic security as an SDOH impacting Sharp patients and community members. Among 14 SDOH, survey respondents (n=380) ranked economic security (including consistent access to healthy food, financial stability, employment) as the fourth most important SDOH impacting their community (see **Appendix R**).

When health conditions and SDOH were combined among all respondents, economic security ranked as the seventh most important health need among 30 choices. Please refer back to **Figure 14** for the final ranking of health conditions and SDOH by *Sharp Insight Community* survey participants.

Discussion of Community Engagement Findings

HASD&IC 2019 CHNA – Focus Groups

HASD&IC 2019 CHNA community engagement participants identified housing and childcare costs as the two primary contributors to economic insecurity in SDC. Low wages were also cited as an underlying cause but were discussed but with less frequency.

Housing costs were repeatedly named as a cause of economic stress. *HASD&IC 2019 CHNA* community engagement participants asserted that rent is disproportionate to

income in San Diego, and that for many people, a very high percentage of their wages must be used to cover this cost, leaving them with too little money to cover other basic expenses. Although community members are aware of affordable housing programs, they indicated that these programs have long waiting lists and are inaccessible to most people. Community engagement participants described multiple ways that San Diegans try to cope with housing costs, including living in small spaces with multiple families or roommates or in substandard housing without adequate facilities.

HASD&IC 2019 CHNA community engagement participants also cited childcare costs as a financial concern for San Diego families. Participants asserted that for those residents who participate in a welfare-to-work program, subsidized childcare is available, but for others it is either unavailable or inaccessible due to waiting lists.

In terms of its impact, *HASD&IC 2019 CHNA* community engagement participants focused on three main concerns about economic hardship. First, they talked about the association between economic insecurity and food insecurity. Second, they described how health maintenance necessarily becomes a low priority when incomes are not secure. Third, they explained that people who are financially unstable experience chronic stress and anxiety, which undermines their health and daily functioning.

Community members told many stories about friends, relatives, colleagues, and neighbors who struggle with food insecurity on a regular basis. Further, the community asserted, people who are food insecure must find cheap meals, which results in frequent dining at fast food restaurants and the purchase of lower cost, processed foods rather than fresh foods. The community is aware of available benefits, such as the Supplemental Nutrition Assistance Program (SNAP) and local food pantries, but these programs are, at times, inconvenient and challenging to obtain, and are often inadequate to cover a family's nutritional needs.

When making difficult financial decisions about which essential needs to cover, the community voiced that investing in health maintenance becomes a low priority. Purchasing health insurance, they explained, is expensive, and when people are worried about having enough to eat, spending money on something that they may not need does not make sense to them. Because of co-pays, co-insurance and lost wages due to time off work, visits to the doctor for preventive care or for an acute illness can be financially prohibitive even for those who have health insurance. In addition, participants explained that when people are working long hours and are excessively worried about finances, taking the time for activities that promote good health, like home cooking and exercise, simply isn't feasible.

Finally, the *HASD&IC 2019 CHNA* community engagement participants were clear that the chronic stress and anxiety of being financially insecure takes a toll on health. Emotional well-being and mental health are threatened, they explained, by constant worry and anxiety. Physical health is also compromised by being unable to care for oneself adequately. Community engagement participants stressed that for certain people, economic insecurity is especially impactful. This included:

- Children
- Seniors
- People living in rural areas, due to lack of access to social support
- Homeless individuals

Sharp 2019 CHNA – Focus Groups

Sharp PFAC focus group participants specifically cited economic security and financial issues as barriers to care, health and well-being. Economic insecurity was discussed as a primary contributor to poor health. *Sharp PFAC* focus group participants indicated food insecurity also worsens health, and leads to the purchase of cheap, unhealthy food, which is easier for families to access than nutritious food. Seniors, participants said, are particularly vulnerable to food insecurity.

Generally, *Sharp PFAC* focus group participants viewed limited finances as a primary barrier to care. The cost of health insurance, co-pays, and transportation, contributors emphasized, prevents people from getting necessary health care. *Sharp PFAC* focus group participants explained that people in the community are often faced with competing priorities for limited finances, and when the choice is between food or medicine, they choose food. Participants highlighted that these circumstances are especially severe for seniors, particularly those who live alone. Please refer to **Table 21** or **Appendix U** for a summary of feedback from the *Sharp PFAC* focus group.

In the *Sharp Case Management Leadership* focus group, economic security came up repeatedly as a significant barrier to care, specifically calling out housing and economic stress. Focus group participants discussed economic insecurity as a barrier to effective management of health care, particularly chronic health conditions. For example, participants noted that many people cannot afford to take time off work for medical appointments, so they attempt to manage their care around their work schedule. *Sharp Case Management Leadership* focus group participants also cited that certain medications are particularly expensive, and, related to this, many patients also experience food insecurity. Consequently, one focus group participant shared that patients on a limited income have a hard time choosing between paying their copays and for their medications and eating. This, the participant emphasized, occurs even among those who are insured.

In addition, *Sharp Case Management Leadership* focus group participants highlighted that housing costs and concerns also keep people from getting care. “Their main concern,” one participant noted, “is having a home to live in rather than managing their own care….so there is a tendency to delay receiving health care until an emergency situation arises.” Please refer to **Table 22** or **Appendix U** for a summary of feedback from the *Sharp Case Management Leadership* focus group.

Economic security was mentioned consistently throughout the *Sharp Diabetes Health Educator, SMBHWN Social Workers & Case Managers, Sharp Cancer Navigators and*

Social Worker, and Sharp Senior Health Center focus groups as well. Please see the findings for **Aging Concerns**, **Diabetes**, **Maternal and Prenatal Care, including High-Risk Pregnancy**, and **Cancer** for specific feedback on economic security and its connection to these identified health needs.

Sharp 2019 CHNA Suggestions

Sharp PFAC suggestions that specifically addressed economic security for more vulnerable patients included:

- Prioritize the hiring and training of social workers. Patients are in need of a supportive advocate at the time of discharge.
- Offer free post-surgery home visits.
- Make follow-up phone calls to see if patients who have been discharged are doing well and getting proper follow-up care.
- Make in-home care more accessible, particularly for older patients.

Sharp Case Management Leadership suggestions that specifically address economic security included:

- Ensure 2-1-1 CIE[27] access for all Sharp facilities.
- Establish more patient-centered initiatives.
- House a program onsite at hospitals that helps place people in housing, gets them referrals/helps with applications to affordable housing.

Sharp Insight Community survey participants also had the opportunity to provide specific suggestions about what Sharp can do to improve the health and well-being of the community. See **Appendix R** for the most commonly suggested themes. Feedback related to economic security included:

- Provide transportation for citizens who cannot drive and cannot afford other means.
- Make sure patients are aware of the rides available to Sharp facilities if they don't have their own transportation.
- Continue support for food insecurity.
- Heighten access for low-income or limited insurance community members; offer clinics or outreach health care for those without insurance or money to pay;
- Lower insurance premiums and co-pays; make lower cost health insurance available to per diem employees; lower prices and provide a "menu" of services with prices for people with or without insurance.

[27] 2-1-1 San Diego's Community Information Exchange (CIE) is an ecosystem comprised of multidisciplinary network partners that use a shared language, a resource database, and an integrated technology platform to deliver enhanced community care planning. Care planning tools enable partners to integrate data from multiple sources and make bi-directional referrals to create a shared longitudinal record. *Source*: https://ciesandiego.org/what-is-cie/

Additional recommendations from the *Sharp Insight Community* survey can be found in **Appendix R**.

Table 32: HASD&IC 2019 CHNA – Focus Group and KI Interview Summary of Responses Related to Economic Security

SUMMARY OF RESPONSES RELATED TO ECONOMIC SECURITY		
ASSOCIATED HEALTH CONDITIONS AND NEEDS		
All Age Groups • Malnutrition • Overweight and obesity • Stress • Behavioral health: anxiety, depression, suicide • Hypertension	**Children/Youth** • Growth and development • Ability to focus and learn • Trauma	**Seniors** • Behavioral/mental health issues and connection with not eating healthy foods
ASSOCIATED SOCIAL DETERMINANTS OF HEALTH		

All Age Groups
• **Access to care**: afraid of losing benefits to Medi-Cal
• **Economic security:** cost of medical bills and services. Childcare cost is high.
• **Employment**: unemployment, low wages
• **Food insecurity:** organic, healthy, and fresh foods are expensive
• **Homeless**: criminalization of the homeless, no kitchen for cooking food, difficulty accessing the types of food needed due to special diet needs
	• **Housing**: cost of housing
	• **Language barrier**
	• **Physical environment**: lack of groceries stores with fresh and healthy food Transportation: lack of transportation especially for rural areas
	Children/Youth
	• **Safety**: walking to school alone
	• **Stigma** of being economically disadvantaged
		Seniors
		• **Economic security**
		  • Gas prices are high and increasing
		  • Lack of affordable home food delivery options
		  • Wheelchairs need repair
		  • Social Security Income : wait time is long, ineligible when staying in the hospital
		  • Lack of fresh items in food pantries
		• **Food insecurity:** hunger and nutrition
		• **Lower education, less economic empowerment** and less family ties were described in specific locations such as City Heights

ASSOCIATED BARRIERS AND CHALLENGES		
All Age Groups • **Benefits**: afraid of losing benefits to Medi-Cal, CalFresh, and WIC, wait time is too long • **Budget**: ability to budget is difficult • **Childcare**: lack of childcare programs • **Hygiene** (homeless) • **Lack of time** for adults between work and family to get additional training or education to help increase income level • **Legal status** • **Sleep deprivation** • **Special diet needs**: culturally appropriate foods, allergies, and dietary restrictions due to chronic conditions make it difficult to eat healthy	**Children/Youth** • Refuse to eat **healthy food** • Lack of healthy food **education** for youth • Families have **limited time** and money to cook healthy meals. Eating fast food becomes an easier way to manage time and money. • **School lunches** have a lot of unappetizing processed foods	**Seniors** • **Cooking** can be a challenge

Education

Definition:

Community engagement participants define educational attainment in a number of ways, including the receipt of a high school diploma, the opportunity to pursue vocational or higher education, being health literate, and having opportunities for non-academic continuing education.

Findings

Education was identified as a priority health need in both the SGH and HASD&IC 2019 CHNA secondary data analyses and community engagement processes.

Secondary Data Findings

Educational attainment, limited English proficiency, linguistic isolation, and poverty have profound implications for population health. These data elements were analyzed as indicators of the level of education within SDC.

Educational Attainment

Within SDC, almost 13.3% of the total population ages 25 and older (292,200) have no high school diploma (or equivalency) based on 2013-2017 ACS data. An assessment of educational attainment by San Diego regions showed that the percentage of adults who had less than a high school diploma was highest in the south (21.9%) and central regions (19.9%) and lowest in the north inland region (13.0%). As of 2013-2017, the SDC high school graduation rate (86.7%) was below the Healthy People 2020 (HP2020) benchmark goal of 87.0%. Graduation rates varied by racial and ethnic groups; non-Hispanic, “other” race (64.0%) and Hispanic/Latinos (67.6%) had the lowest proportion of graduates compared to non-Hispanic Whites (95.8%) which had the highest. Of children ages 3-4, the 2013-2017 ACS found that 51.0% were enrolled in school.

Limited English Proficiency and Linguistically Isolated Populations

Given SDC’s large immigrant and refugee population, the indicators of limited English proficiency and linguistic isolation are especially important to understanding health in the community. According to the ACS, approximately 14.5% of San Diego residents ages 5 and older speak a language other than English at home and speak English less than “very well.” In addition, 6.8% of the population ages 5 and older live in a home in which no person age 14 or older speaks only English, or speaks a non-English language but does not speak English “very well.” Similar to those with limited English proficiency, linguistically isolated populations may struggle with accessing health services, communicating with health care providers, and understanding health information.

Poverty

Please see the information on **Economic Security** within this Findings section for details on poverty in SDC.

Table 33: Poverty, Education, Limited English Proficiency, Linguistically Isolated and Unemployed in SDC, CA and United States, 2013-2017

	San Diego County	California	United States
Percent Population in Poverty	13.3%	15.1%	14.6%
Percent Population with Less than a High School Diploma	13.3%	17.5%	12.7%
Percent Limited English Proficiency	14.6%	18.4%	8.5%
Percent Linguistically Isolated	6.8%	9.2%	4.5%

Source: U.S. Census Bureau, American Community Survey, 2013-2017 5-Year Estimates.

Please see **Appendix O** for Education secondary data source information.

Community Engagement Findings

HASD&IC 2019 CHNA

HASD&IC 2019 CHNA community engagement participants discussed four topics related to education and its impact on health and well-being:

- The underlying reasons that some youth in San Diego do not attain educational success
- The impact that low levels of educational achievement have on the health and well-being of San Diegans
- The barriers to care created by a lack of health literacy
- The need for continuing education beyond traditional academics

Sharp 2019 CHNA – Focus Groups

Education was identified as having a significant impact on health outcomes and well-being consistently across all Sharp/SGH 2019 CHNA focus groups, including: *Sharp Diabetes Health Educators*, *SMBHWN Case Managers & Social Workers, Sharp Case Management Leadership*, *Sharp Cancer Patient Navigators and Social Worker*, *Sharp Senior Health Center* staff and senior patients/community members, and *Sharp PFAC* members.

Additional details are included in the **Discussion of Community Engagement Findings** below. Please refer to **Appendix U** for a summary of all Sharp/SGH focus groups.

Sharp 2019 CHNA – Sharp Insight Community Survey

Sharp's Insight Community online survey provided greater understanding of education as an SDOH impacting Sharp patients and community members. Among 14 SDOH, survey respondents (n=380) ranked education (access, health literacy, workforce development and mobility) as the seventh most important SDOH impacting their community (see **Appendix R**).

When health conditions and SDOH were combined among all respondents, education ranked as the 14th most important health need among 30 choices. Please refer back to **Figure 14** for the final ranking of health conditions and SDOH by *Sharp Insight Communit*y survey participants.

Discussion of Community Engagement Findings

HASD&IC 2019 CHNA – Focus Groups

*HASD&IC 2019 CHNA c*ommunity engagement contributors cited two primary causes of low educational attainment: family stress and a lack of resources. Participants explained, first, that family support for youth education is sometimes unavailable. Parents may not know high school graduation requirements, for example, and language and cultural differences may create communication challenges with school personnel. Some parents, they said, may be unable to read their child's report card. Another issue focus group members pointed out is that some economically strained families may wish for their children to begin working as soon as possible — preferring for them to find a job after high school rather than attend college. Participants also mentioned that low-income families may have to be more transient, needing to move when rent increases. These moves, they said, can cause instability in children's educational placements, which negatively affects their potential to succeed in school.

HASD&IC 2019 CHNA community engagement participants mentioned that insufficient resources at home and in schools also hinder educational success. These include:

- Spotty Wi-Fi in neighborhoods
- Lack of computers in the home
- Crowded, noisy housing
- Lack of transportation to school
- Too few school counselors
- Large class sizes
- Lack of school-based family support systems

For students who are homeless or insecurely housed, focus group participants stressed that thriving in school is even more challenging. This is in part, they said, because education becomes a lower priority than simply surviving day to day. Focus group contributors believe, however, that their success is also impeded by socioemotional

issues. The stigma attached to being poor and, in particular, to poor hygiene and dirty clothing can make these students feel ashamed, they explained. They may experience bullying, have low social status, and have difficulty forming lasting friendships, which in turn can impact the students' mental health and undermine their motivation to attend and succeed in school.

HASD&IC 2019 CHNA focus group members relayed that both individual and community health are profoundly impacted when residents are not able to achieve high levels of educational attainment. First, participants explained, employment opportunities for those without college degrees and especially without high school diplomas are in short supply, and wages for available jobs tend to be low. Educational attainment, they pointed out, is directly related to economic security. Participants emphasized that families who are not secure live under the constant stress of worrying about paying rent and having enough food to eat, which then negatively impacts their health. Furthermore, contributors stated, without education, career mobility is "horizontal," and there is little potential for promotions and higher wages. Focus groups described scenarios for these San Diegans in which work seems endless and when the possibility of a better life seems impossible, they lose hope.

HASD&IC 2019 CHNA focus group participants also pointed out that a lack of health literacy is a significant barrier to care for some San Diegans. Community members, they said, need further education about preventive health care — including immunizations and health screenings — that is conducted in a manner that is sensitive to the individual's culture. They also need, they emphasized, more information about lifestyle choices that promote health, like smoking cessation, nutrition and exercise. Many people, focus group contributors said, need assistance understanding and navigating the health care and insurance systems. They emphasized that, for people who have received a serious health diagnosis, like cancer, having a health advocate who can explain the diagnosis and potential treatment options is beneficial and enhances patient compliance with care.

HASD&IC 2019 CHNA participants also noted community members are seeking educational opportunities beyond traditional academics. They want and need health education and parenting classes. For their children, they indicated a need for programs about sexual health, self-esteem, and transitional life skills. They are also seeking enrichment classes — for themselves and their children — in the arts and in athletics. Focus group participants emphasized that education needs to be viewed from a broader perspective than traditional academics.

Sharp 2019 CHNA – Focus Groups

Sharp PFAC focus group participants cited lack of health education and health literacy as posing a significant barrier to health and well-being. Specifically, lack of health literacy about preventive care, illness, and disease, were described as barriers to health care. One particular topic emphasized by this group was parent's hesitancy to have their children immunized because of fears about debunked myths such as the

relationship between vaccines and autism. In addition, *Sharp PFAC* focus group participants highlighted that many community members and patients do not understand how to navigate the health care system, particularly in identifying the appropriate sites of care to meet their health needs. That is, when it is appropriate to seek care from the ED versus an urgent care site. *Sharp PFAC* focus group participants emphasized that this lack of education poses especially significant challenges for newly immigrated community members. Please refer to **Table 21** or **Appendix U** for a summary of feedback from the *Sharp PFAC* focus group.

In the *Sharp Case Management Leadership* focus group, education was also brought up specifically as a lack of health literacy, and the negative impact this has on maintaining health and well-being. Health literacy is of particular importance for the patients that *Sharp Case Management Leadership* focus group participants work with, as the majority of these community members are managing chronic health conditions such as diabetes, COPD, congestive heart failure, and cancer. Please refer to **Table 22** or **Appendix U** for a summary of feedback from the *Sharp Case Management Leadership* focus group.

Education was mentioned throughout the *Sharp Diabetes Health Educator, SMBHWN Social Workers & Case Managers, Sharp Cancer Navigators and Social Worker, and Sharp Senior Health Center* focus groups as well. Please see the findings for **Aging Concerns**, **Diabetes**, **Maternal and Prenatal Care, including High-Risk Pregnancy**, and **Cancer** for specific feedback and recommendations on education and its connection to these identified health needs.

Sharp 2019 CHNA Suggestions

To address education, *Sharp Case Management Leadership* suggested the establishment of more patient-centered initiatives, in which health literacy could be a component. The addition of more social workers, proposed by *Sharp PFAC* focus group participants, could also assist in this area.

Sharp Insight Community survey participants also had the opportunity to provide specific suggestions about what Sharp can do to improve the health and well-being of the community. See **Appendix R** for the most commonly suggested themes. Feedback related to education included:

- Partner with schools to start health education early.
- Increase educational/informational awareness by partnering with public school systems' adults programs.
- Put education facilities in the impoverished communities.
- Provide a mobile bus for education and screenings.
- Offer classes for how to file for Medicare, Medicaid and how to choose what plans are right for your family.

- Remind patients of programs during routine visits if relevant; provide fliers in doctors' offices; make a video about health and well-being and play it in waiting rooms.
- Provide opportunities for technical education on many areas of medicine.

Additional recommendations from the *Sharp Insight Community* survey can be found in **Appendix R**.

Homelessness and Housing Instability

Definition

Homelessness is when a person does not have a fixed, regular, and adequate nighttime residence. Housing problems include a lack of full kitchen or plumbing facilities, a household comprised of more than one person per room, or a housing cost burden of more than 30% of the household income. Severe housing problems include a lack of full kitchen or plumbing facilities, severe overcrowding, or a housing cost burden of more than 50% of the household income.

According to the American Hospital Association, housing instability is an umbrella term for the continuum between homelessness and a completely stable, secure housing situation. Housing instability takes many forms: physical conditions like poor sanitation, heating and cooling; compromised structural integrity; exposure to allergens or pests; homelessness; and unstable access to housing or severe rent burden.

Findings

Homelessness and housing instability includes the impact of homelessness and housing on community health:

- Homelessness seriously impacts health in both direct and indirect ways, such as exposure to infectious disease, difficulty managing chronic diseases, and maintaining wound care.
- Poor housing conditions have a direct, negative impact on physical and mental health.
- The cost of housing affects health because it is the primary driver of economic insecurity in San Diego.
- Several subsets of the San Diego population are particularly vulnerable to homelessness and housing problems.

Homelessness and housing instability was identified as a priority health need by the SGH and HASD&IC 2019 CHNAs in the secondary data analyses and in the community engagement process.

Secondary Data Findings

On a given night in San Diego in 2018, 8,576 individuals were homeless; the number of homeless decreased by 6.0% between 2017-2018 and 3.4% since 2013. Among the homeless, 3,586 (41.8%) were sheltered, and 4,990 (58.2%) were unsheltered. Of those who were unsheltered, 50.0% slept on the street/sidewalk; 18.0% slept in a vehicle; 14.0% slept in a park; 5.0% slept in a hand-built structure or tent. Nearly half (43.0%) of homeless people had a chronic health condition.

From 2011-2015, in San Diego, 42.7% of households were cost burdened, spending more than 30% of their income on housing, while 20.0% were severely cost burdened, spending more than half of their income on housing. The lowest-income families had the highest rates of severely cost burdened housing — 47.4% of families with incomes 30.0% or less of the median family income in the county were severely cost burdened. Approximately 46.0% of San Diegans had housing problems, and 25.2% of San Diegans had severe housing problems.

Please see **Appendix O** for Homelessness and Housing Instability definition and secondary data source information.

Community Engagement Findings

HASDIC 2019 CHNA

In the *HASDIC 2019 CHNA* online community engagement survey, homelessness was identified as the fifth most impactful condition on the health and well-being of San Diego residents, and housing was ranked the sixth most impactful condition.

*HASDIC 2019 CHNA c*ommunity engagement participants made four main points about the impact of homelessness and housing on community health:

- Homelessness seriously impacts health in both direct and indirect ways.
- Poor housing conditions have a direct, negative impact on physical and mental health.
- The cost of housing affects health because it is the primary driver of economic insecurity in San Diego.
- Several subsets of the San Diego population are particularly vulnerable to homelessness and housing problems.

For a summary of community engagement findings related to homelessness and housing instability, see **Table 34**. Additional details are included in the **Discussion of Community Engagement Findings** section below.

Sharp 2019 CHNA – Focus Groups

Homelessness and housing instability was identified as having a significant impact on health outcomes and well-being consistently across all Sharp/SGH 2019 CHNA focus groups, including: *Sharp Case Management Leadership, Sharp Cancer Patient Navigators and Social Worker, Sharp Senior Health Center* staff and senior patients/community members and *Sharp PFAC members*. Please refer to **Appendix U** for a summary of all Sharp/SGH focus groups. Additional details are included in the **Discussion of Community Engagement Findings** below.

Sharp 2019 CHNA – Sharp Insight Community

Sharp's Insight Community online survey provided greater understanding of homelessness and housing instability as an SDOH impacting Sharp patients and community members. Among 14 SDOH, survey respondents (n=380) ranked homelessness (overcrowding, substandard conditions, housing affordability) as the fifth most important SDOH impacting their community (see **Appendix R**).

When health conditions and SDOH were combined among all respondents, homelessness ranked as the 11th most important health need among 30 choices. Please refer back to **Figure 14** for the final ranking of health conditions and SDOH by *Sharp Insight Community* survey participants.

Discussion of Community Engagement Findings

HASDIC 2019 CHNA – Focus Groups and KI Interviews

*HASDIC 2019 CHNA c*ommunity engagement participants argued that being homeless directly impacts health by increasing exposure to infectious disease, particularly hepatitis A, and to contagious illnesses. In addition, homeless individuals are exposed to extreme weather conditions, which contributes to poor health. Participants also explained that managing chronic diseases, like diabetes, without a place to store medications is impossible, and without the ability to maintain hygiene, so is effective wound care. In addition, they suggested that those homeless individuals who have prescription medications become targets of street violence. Care after discharge from the hospital is particularly challenging for the homeless, they argued, since they have no safe place to recover. Homelessness also indirectly affects health through its influence on access to care, since homeless individuals face challenges in transportation and in making and keeping medical appointments. In addition, homeless people face stigma in the health care community, participants said, which can make them hesitant to seek care when they need it.

HASDIC 2019 CHNA community engagement participants also noted that health is negatively impacted for those who worry about maintaining their housing. This is in part, they explained, because paying rent becomes their primary focus; attending to their own

health, and the health of their families, is a lower priority than keeping a roof over their heads. Participants also argued that stress and anxiety about housing contribute to both physical and mental health issues. Housing conditions, they claimed, also affect health. Crowded housing, for instance, was presented as contributing to the spread of illness, and environmental hazards, such as the presence of lead paint, cockroaches and other pests, are believed to exacerbate conditions like asthma.

*HASDIC 2019 CHNA c*ommunity engagement participants contended that housing costs are the primary driver of economic insecurity in SDC and described lower-income residents as a population that lives "on the edge of homelessness." Increases in rent outpace increases in pay, they explained, creating a scenario in which many people cannot achieve stability, no matter how hard they work. In addition, community residents suggested that affordable housing is scare, and housing assistance programs like Section 8 have long waiting lists. These costs, then, render people economically insecure, which impacts their heath in numerous ways.

Community residents participating in the *HASDIC 2019 CHNA* focus groups expressed particular concern related to housing and homelessness for three groups: transitional age youth, seniors and immigrants.

Focus group participants highlighted how transitional age youth (youth who have recently reached legal adulthood of 18 years old), are not allowed in "family" homeless shelters; parents, then, must decide whether to let their young adult children fend for themselves on the street or risk the entire family's safety by leaving the shelter. Focus group contributors also asserted that young adults who are desperate for places to stay may make poor decisions that jeopardize their safety and well-being — trading their bodies, for instance, for a place to sleep, or using drugs to stay warm. Former foster youth were described as being particularly vulnerable. In addition, community engagement contributors said that homeless youth who are younger than 18 years old and living apart from their parents often do not know how to obtain needed health care. When they try to get health care services parental consent is usually needed, so they are turned away.

Regarding seniors, focus group participants suggested that older community members are in particular need of assistance with locating and utilizing housing resources, with applications for senior housing, and with managing landlord-tenant relationships. Lastly, community engagement participants argued that immigrants, particularly those who do not have documentation, are at the mercy of their landlords; fear of deportation keeps them from complaining about substandard housing conditions and rent increases.

Sharp 2019 CHNA – Focus Groups

Sharp PFAC focus group participants cited housing specifically as an SDOH that poses a significant barrier to health and health care. The cost of housing was identified as a primary factor underlying economic stress, and cheaper, substandard housing was

noted to contribute to poor health. Please refer to **Table 21** or **Appendix U** for a summary of feedback from the *Sharp PFAC* focus group.

In addition, *Sharp Case Management Leadership* focus group participants identified housing instability as a primary factor impacting community health, particularly the lack of housing available in the community. *Sharp Case Management Leadership* focus group participants also highlighted that housing costs and concerns keep people from getting care. "Their main concern," one focus group participant noted, "is having a home to live in rather than managing their own care….so there is a tendency to delay receiving health care until an emergency situation arises." Please refer to **Table 22** or **Appendix U** for a summary of feedback from the *Sharp Case Management Leadership* focus group.

Housing was mentioned frequently throughout the *Sharp Cancer Navigators and Social Worker and Sharp Senior Health Center* focus groups as well. Please see the findings for **Aging Concerns** and **Cancer** for specific feedback on homelessness and housing instability and its connection to these identified health needs.

Sharp 2019 CHNA Suggestions

Sharp Case Management Leadership suggestions that could potentially help address challenges with homelessness and housing instability include:

- Ensure 2-1-1 CIE[28] access for all Sharp facilities.
- Establish more patient-centered initiatives.
- House a program onsite at hospitals that helps place people in housing and gets them referrals/helps with applications to affordable housing.
- Establish a more streamlined process and a communication system between the hospitals and the County about those who qualify for wraparound services, such as Whole Person Wellness.

The addition of more social workers, proposed by *Sharp PFAC* focus group participants, could also assist in this area.

Sharp Insight Community survey participants also had the opportunity to provide specific suggestions about what Sharp can do to improve the health and well-being of the community. See **Appendix R** for the most commonly suggested themes. Feedback related to homelessness and housing instability included:

- Offer clinics that serve homeless and uninsured individuals.
- Put education facilities in the impoverished communities.

[28] 2-1-1 San Diego's Community Information Exchange (CIE) is an ecosystem comprised of multidisciplinary network partners that use a shared language, a resource database, and an integrated technology platform to deliver enhanced community care planning. Care planning tools enable partners to integrate data from multiple sources and make bi-directional referrals to create a shared longitudinal record. *Source*: https://ciesandiego.org/what-is-cie/

- Create discounted programs for immigrants, the poor or underemployed, and the homeless.
- Provide more community events in high-risk areas.

Additional recommendations from the *Sharp Insight Community* survey can be found in **Appendix R**.

Table 34: HASD&IC 2019 CHNA – Focus Group and KI Interview Summary of Responses Related to Homelessness and Housing Instability

SUMMARY OF RESPONSES RELATED TO HOMELESSNESS AND HOUSING INSTABILITY		
ASSOCIATED HEALTH CONDITIONS AND NEEDS		
All Age Groups ♦ **Behavioral health:** depression, schizophrenia, PTSD ♦ **Hygiene and cleanliness** ♦ **Infectious diseases:** hepatitis, HIV/AIDS ♦ **Stress and anxiety** ♦ **Substance abuse:** opioids, meth, crack, Xanax, Percocet, heroin	**Children/Youth** ♦ Flu ♦ Hepatitis A ♦ Pregnancy	**Senior** ♦ Disabilities ♦ Chronic conditions ♦ Behavioral health issues
ASSOCIATED SOCIAL DETERMINANTS OF HEALTH, BARRIERS AND CHALLENGES		
All Age Groups ♦ **Employment difficulty** ♦ **Health insurance** ♦ **Housing:** lack of affordable housing ♦ **Access to health care**: poor quality health care ♦ **Vaccinations and immunizations** are difficult to get because homeless move locations depending on shelters and availability. To get immunization must go to the primary provider they signed up with which could be too far once they move. ♦ **Stigma**	**Children/Youth** ♦ **Community and social support:** Foster children are not prepared to move out once they turn 18. They have no family support and have not been taught how to survive on their own ♦ **Safety**: Youth (18 years old) who turn 18 while in shelters with their family are kicked out and have no safe place to stay ♦ **Safety & violence:** gang violence, neighborhood safety, rape and sex trafficking ♦ **Vaccinations** can be difficult to get due to moving (see adult section)	**Seniors** ♦ **Physical limitations:** mobility issues make it difficult to access services ♦ **Housing**: Lack of senior housing
ASSOCIATED BARRIERS AND CHALLENGES		
All Age Groups ♦ **Lack of resources:** limited short-term & emergency resources, lack of affordable services ♦ **Food:** lack of ability to store and cook food, eating unhealthy foods to fill stomach ♦ **Shelters:** lack of women emergency shelters ♦ **Storage** for personal belongings and medical supplies	**Children/Youth** ♦ Endless cycle of homelessness ♦ Lack of **transitional housing** ♦ **Low paying jobs**	**Seniors** ♦ **Food**: Special dietary needs due to chronic health conditions

Maternal and Prenatal Care, including High-Risk Pregnancy

Definition

Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period.[29] Early and regular prenatal care helps many women have healthy pregnancies and deliveries without complications. This care can begin even before pregnancy with a preconception care visit to a health care provider.[30]

A high-risk pregnancy is one that threatens the health or life of the mother or her fetus. High-risk pregnancy may result from a medical condition present before pregnancy or a medical condition that develops during pregnancy for either mom or baby and causes the pregnancy to become high risk. A high-risk pregnancy can pose problems before, during or after delivery and may require special monitoring throughout the pregnancy.[31]

Risk factors for high-risk pregnancy include: advanced maternal age — there is an increased risk for mothers age 35 years and older; lifestyle choices such as smoking, alcohol consumption or the use of illegal drugs; medical history including prior high-risk pregnancies or deliveries, fetal genetic conditions or family history of genetic conditions; underlying conditions such as diabetes, high blood pressure, obesity and epilepsy; and multiple pregnancies.[32]

Findings

Maternal and prenatal care, including high-risk pregnancy, was identified as a priority health need in both the SGH 2019 CHNA community engagement activities and secondary data analysis.

Secondary Data Findings

According to the CDC, in the U.S., the number of births decreased 2.0% (to 3.85 million) from 2016-2017, continuing the downward trend that is now at the lowest number of births in 30 years. This trend held true across all major racial/ethnic groups. The 2017 national general fertility rate and total fertility rate are both down 3.0% from 2016 — the largest single-year drop since 2000.[33]

The teenage birth rate reached a record low in 2017, dropping to 18.8 births per 1,000 women. The teen birth rate has declined 70.0% since its most recent peak in 1991.The birth rate of women in their 20s and 30s declined while the birth rate rose for women in

[29] 2019 World Health Organization. https://www.who.int/maternal-health/en/

[30] National Institutes of Health (NIH). What is prenatal care and why is it important? https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/prenatal-care

[31] NIH. What is a high-risk pregnancy? https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/high-risk

[32] 1998-2019 Mayo Foundation for Medical Education and Research. High-risk pregnancy: Know what to expect. https://www.mayoclinic.org/healthy-lifestyle/pregnancy-week-by-week/in-depth/high-risk-pregnancy/art-20047012

[33] CDC. Infant Mortality. 2016

their early 40s. **Table 35** below presents age-adjusted infant mortality rates in SDC. The central and east regions of SDC present the highest rates of infant mortality when compared to other regions of the county, although all SDC regions meet the HP2020 target rate of 6.0 infant deaths per 100,000 population.

Table 35: Age-Adjusted Infant Mortality Rates*, 2016

Geographic Area	Death Rate (per 1,000 live births)
United States[a]	5.9
California	4.2
SDC[b]	3.7
San Diego Regions[b]	
Central	3.8
North Central	3.9
North Coastal	3.4
North Inland	3.2
East	3.7
South	4.3
HP 2020 Target[c]	**6.0**

[a]Source: CDC. Infant Mortality. 2016.
[b]Source: SDC HHS, Public Health Service. Community Health Statistics Unit. Maternal and Child Health Data: Infant Mortality VRBIS, 2016. 2018
*Note: Infant mortality rates are deaths under 1 year per 1,000 live births in specified group.

There were 42,741 live births in SDC overall in 2016, and the infant mortality rate in SDC was 3.7 per 1,000 live births. These statistics meet the HP2020 national targets for all maternal and infant health indicators including the target of less than 6.0 infant deaths per 1,000 live births. **Table 36** below presents a summary of maternal and infant health indicators.

Table 36: Maternal and Infant Health Indicators in SDC, 2016

Maternal and Infant Health Indicator	Rate	Year 2020 Target
First Trimester Prenatal Care	84.2%	77.9%
Preterm Births	8.5%	9.4%
Very Low Birth Weight (VLBW) Infants	1.2%	1.4%
Low Birth Weight (LBW) Infants	6.7%	7.8%
Infant Mortality	3.7%	6.0%

Source: County of San Diego, HHSA, Public Health Services, Community Health Statistics Unit. Maternal and Child Health, 2016. 2018.
Notes:
Preterm births are births with less than 37 weeks gestation.
Very low birth weight infants weigh less than 1,500 grams, approximately 3.5 pounds.
Low birth weight infants weigh less than 2,500 grams, approximately 5.5 pounds.
Infant mortality refers to the death of infants less than one year of age.
Infant mortality rates are per 1,000 live births. Fetal mortality rates are per 1,000 live births and fetal deaths.

SDC regions met all HP2020 national targets in 2016. Infant mortality has continued to decrease. SDC has continued to see a trend over the last few years of a decreasing

birth rate, which is in line with state and national trends as well. However, despite the decreasing birth rate, unhealthy births such as infants born VLBW, LBW, preterm, and with other health issues are on the rise, while first trimester prenatal care has seen a decrease. See **Table 37** for a summary of maternal and infant health indicators by region.

Table 37: Maternal and Infant Health Indicators by SDC Region, 2016

Indicator	North Coastal	North Central	Central	South	East	North Inland
Prenatal Care	85.6%	89.1%	80.3%	85.5%	81.5%	82.9%
Preterm Births	8.1%	8.1%	8.8%	8.6%	8.7%	8.5%
VLBW Infants	1.0%	1.1%	1.2%	1.3%	1.2%	1.2%
LBW Infants	6.3%	7.1%	6.8%	6.4%	6.6%	6.7%
Infant Mortality	3.4%	3.9%	3.8%	4.3%	3.7%	3.2%

Source: County of San Diego, HHSA, Public Health Services, Community Health Statistics Unit, Maternal and Child Health. 2016. 2018.
Note: Infant mortality rates are per 1,000 live births.

Notable findings from an analysis of SGH discharge data include[34]:

- In 2017, women identified as Hispanic or Latino represented 22.8% of all inpatient discharges at SGH, but 40.4% of inpatient discharges with a gestational diabetes diagnosis.

- Among women admitted to SGH in 2017 with a high-risk pregnancy, the top three diagnoses were classified as pregnancy in a mother over the age of 35 (40.9%), pregnancy with insufficient prenatal care (26.0%), and pregnancy with a history of preterm labor (12.3%).

- In 2017, women identified as Other Race represented 35.4% of all inpatient discharges at SGH, but 50.0% of inpatient discharges related to high-risk pregnancy.

- In 2017, women identified as Black or African American represented 7.8% of all inpatient discharges at SGH, but 14.6% of inpatient discharges related to preterm labor. Women identified as Other Race represented 35.4% of all inpatient discharges, but 48.2% of preterm labor discharges.

- In 2017, women identified as Hispanic or Latino represented 22.8% of all inpatient discharges at SGH, but 35.7% of inpatient discharges related to preterm labor.[35]

[34] California Office of Statewide Health Planning and Development (OSHPD) Non-Public Inpatient Discharge and Emergency Department Encounter Data, 2017. Accessed through SpeedTrack Inc.©
[35] In OSHPD's inpatient hospital discharge and ED datasets, patient race and ethnicity are two distinct characteristics. Patients self-identify their race as one of the following: American Indian or Alaska Native; Asian; Black or African American; Native Hawaiian or

- Babies identified as Black or African American represented 8.1% of all inpatient discharges for infants (under one year) at SGH in 2017, but 19.6% of LBW discharges.

- In 2017, babies identified as not Hispanic or Latino represented 58.2% of all inpatient discharges for infants (under one year) at SGH, but 65.6% of discharges related to prematurity.

- In 2017, 39.0% of inpatient discharges at SGH related to a premature birth were financially covered by Medi-Cal.

Community Engagement Findings

Sharp 2019 CHNA – Focus Group and KI Interview

For SGH's 2019 CHNA, a focus group was conducted with case managers and social workers from Sharp Mary Birch Hospital for Women and Newborns (SMBHWN) — Sharp's freestanding women's hospital specializing in labor and delivery services, high-risk pregnancy, obstetrics, gynecology, gynecologic oncology and neonatal intensive care. This *SMBHWN Case Manager and Social Worker* focus group was held to better understand the identified health need of maternal and prenatal care, including high-risk pregnancy, for Sharp patients and community members. **Table 28** summarizes the findings of this focus group. Further details are covered in the **Discussion of Community Engagement Findings** section below. For a description of focus group participants, see **Section 3: Methodology**.

In addition, a KI interview was conducted with a Nurse Educator from SMBHWN's Perinatal Special Care Unit (PSCU) to dive deeper into this identified need, as well as to develop a case study around maternal and prenatal care. Further details are covered in the **Discussion of Community Engagement Findings** section below. Please refer to **Appendix J** for the case study.

Sharp 2019 CHNA – Sharp Insight Community

In addition, the online survey that was sent to participants in *Sharp's Insight Community* provided greater understanding of prenatal and maternal care (including high-risk pregnancy) as identified health needs among Sharp patients and community members. Among 16 health conditions, respondents (n=380) ranked maternal/infant health as the 10th most important health condition impacting their community. Among 14 SDOH, respondents ranked prenatal and maternal care (breastfeeding, post-partum support) as the 13th most important SDOH impacting their community. See **Appendix R**. Further, respondents in the $100,000 to $149,000 income range were significantly less likely

Other Pacific Islander; White; or Other Race. The ethnicity category is used to determine whether a patient is of Hispanic origin, and an individual identified as Hispanic may be of any race (OSHPD 2019; U.S. Census Bureau, 2018).

than the sample as a whole to select prenatal and maternal care as one of the five most important SDOH.

When health conditions and SDOH were combined among all respondents, maternal/infant health ranked as the 23rd most important health need, and prenatal and maternal care ranked as the 25th most important health need, among a total of 30 choices. Please refer back to **Figure 14** for the final ranking of health conditions and SDOH by *Sharp Insight Community* survey participants.

Discussion of Community Engagement Findings

Sharp 2019 CHNA – Focus Group and KI Interview

The *SMBHWN Case Manager and Social Worker* focus group, and *PSCU Nurse Educator KI* interview focused on the conditions affecting Sharp maternal and prenatal care patients, the obstacles they face to receiving care, the services provided at Sharp, and suggestions for ways in which patient health and access to care could be improved.

Several health conditions were listed as negatively impacting Sharp maternal and prenatal care patients, including: diabetes; preterm pregnancies; short interval pregnancies; substance use; and postpartum depression, anxiety, and other mood disorders. SDOH impacting patients were noted to be: lack of access to mental health services, even for those patients with insurance; lack of access to transportation; and economic stress related to childcare and maternity leave.

In addition, *SMBHWN Case Manager and Social Worker* focus group participants and the *PSCU Nurse Educator KI* interviewee outlined a number of obstacles to care for maternal and prenatal care patients. Finances were discussed as a primary barrier to care, particularly related to receiving appropriate follow-up care after hospital discharge. Parents have difficulty obtaining and paying for childcare and transportation, and they worry about losing their jobs if they prioritize their newborn's needs over work. In addition, focus group participants said, women often do not understand the nuances of health care leave and disability rights.

SMBHWN Case Manager and Social Worker focus group participants also cited fears related to immigration as obstacles keeping people from applying for Medi-Cal; some patients believe that their contact information will be registered somewhere and are afraid that they will be turned in to authorities. Focus group participants reported that some immigrants are, in fact, afraid to give any contact information. Participants shared that, sometimes, asylum seekers from Africa will not seek services because they feel they cannot talk about their faith or about the country they come from because of discrimination against Muslims.

Further, *SMBHWN Case Manager and Social Worker* focus group participants noted that an inadequate supply of health care providers, particularly mental health providers, posed a significant obstacle to care, as does the unavailability of home health services.

Sharp 2019 CHNA Suggestions for Maternal and Prenatal Care, including High-Risk Pregnancy

Both the *SMBHWN Case Manager and Social Worker* focus group participants, and the *PSCU Nurse Educator KI* interviewee suggested several strategies to improve women's health, including:

- Build awareness about the importance of preconception and prenatal care.
- Establish more options for home health care, particularly for postpartum women.
- Increase lactation consulting and services.
- Increase availability of translation services.
- Hire more providers who are linguistically and culturally compatible with patients.
- Have nurses, lactation consultants, dietitians, social workers and interpreters engage with patients as one team so that all needs can be discussed at once.
- Provide inpatient and outpatient mental health services including freestanding women's hospital support groups.
- Improve communication between physicians and pharmacists so that, for instance, a generic medication can be given in place of a brand name.

Sharp Insight Community survey participants also had the opportunity to provide specific suggestions about what Sharp can do to improve the health and well-being of the community. See **Appendix R** for the most commonly suggested themes. Feedback related to maternal/infant health and prenatal and maternal care included:

- Offer fun preventative care opportunities (i.e., outdoor activities with information on diet and its effect on health, or mother/mother-to-be informational events with a socializing component).
- Provide prenatal care and delivery to mothers who cannot afford it.
- Advocate for improved access for the underserved, such as insurance coverage, particularly to stigmatized services like behavioral health and sexual health.

Additional recommendations from the *Sharp Insight Community* survey can be found in **Appendix R**.

Table 38: Sharp 2019 CHNA – SMBHWN Case Manager and Social Worker Focus Group Summary of Responses

SMBHWN CASE MANAGER AND SOCIAL WORKER - SUMMARY OF RESPONSES	
HEALTH CONDITIONS AND NEEDS FOR PATIENT AND FAMILY MEMBERS	
♦ **Diabetes** ♦ **Preterm pregnancies** ♦ **Short interval pregnancy**	♦ **Substance use and abuse**: including alcohol use. Use of marijuana during pregnancy
SOCIAL DETERMINANTS OF HEALTH FOR PATIENT AND FAMILY MEMBERS	
♦ **Lack of access to mental health services outside of the Sharp Mary Birch facility, even for patients with good insurance coverage** o Difficult for patients with Medi-Cal coverage. o UC San Diego mental health program is overcrowded most of the time. ♦ **Economic security:** lack of affordable postpartum child care.	**Economic security (continued):** o New mothers may sign out of hospital against medical advice because they cannot afford childcare and need to return to work to pay bills. o Many mothers spend their entire maternity leave in the hospital with their premature baby. ♦ **Education** needed on postpartum anxiety and mood disorders. ♦ **Transportation**: lack of access to transportation.
YOUTH ROLES IN FAMILY CARE	
♦ High school aged siblings typically take over a babysitting role, which can cause them to miss school. ♦ Children translate for parents.	
ACCESS TO HEALTH CARE CHALLENGES AND BARRIERS	
♦ **Education:** lack of health education such as patients and their families not being aware of preventive medicine. ♦ **Services:** not enough health-related programs and not enough providers. o Access to home care programs is difficult. ♦ **Providers:** lack of mental health providers across all payer sources.	
HOSPITAL DISCHARGE CHALLENGES AND BARRIERS	
♦ **Transportation issues:** hard to keep appointments if you do not have reliable transportation. ♦ **Access to health care** ♦ **Financial issues** ♦ **Medication availability:** once a patient is discharged with special medications, they often have difficulty getting the same medication in outpatient pharmacies due to insurance issues. ♦ **Health literacy & education, patients do not understand:** o the nuances of health care leave and disability rights. o the difference between inpatient and home services or what is covered by their insurance.	
HOSPITAL AND COMMUNITY SUPPORT NEEDED	
♦ More home health, especially for postpartum ♦ Lactation consulting and services to increase breastfeeding rates and potentially divert readmissions. ♦ Interpretation and translations: access to language compatible providers and services – Muslim patients most notably. In-person translators needed. ♦ Have nursing, lactation consultants, dieticians, social workers, and interpreters come in as one team for each patient so that all needs are met. ♦ Maternal mental health services - inpatient and outpatient. ♦ Support groups: freestanding women hospital support groups.	

• Improving communication between doctors and pharmacists - making sure that for certain medications, doctors indicate a substitute can be given in place of a brand name.
IMMIGRATION **Have you observed any changes over the past year in patient/community member attitude towards immigration issues?**
Fear and Stigma have increased: • Immigrant's fear of applying for Medi-Cal has multiplied; some fear their contact information will be registered. • Fearful of public charge rule and of being turned into the authorities. • Asylum seekers from Africa who are Muslim are scared to seek services because of the stigma to their faith and country of origin. • People feel emboldened by the current administration to act out.   ○ Providers often make assumptions and racist remarks before looking at the patient's fact sheet.

Unintentional Injury and Violence

Definition

Per HP2020, "unintentional injuries and violence-related injuries can be caused by a number of events, such as motor vehicle crashes and physical assault, and can occur virtually anywhere."

Unintentional injuries include motor vehicle accidents, falls, firearms, fire/flame, drowning, poisoning, machinery and suffocation.

Findings

Unintentional injury and violence are described as three issues:

- Exposure to violence is traumatic and impacts mental health.
- Neighborhood safety impacts residents' ability to maintain health.
- Certain groups have increased risk of being exposed to or victims of violence.

Unintentional injury and violence was identified as a priority health need by the SGH and HASD&IC 2019 CHNAs in both the secondary data analysis and the community engagement process.

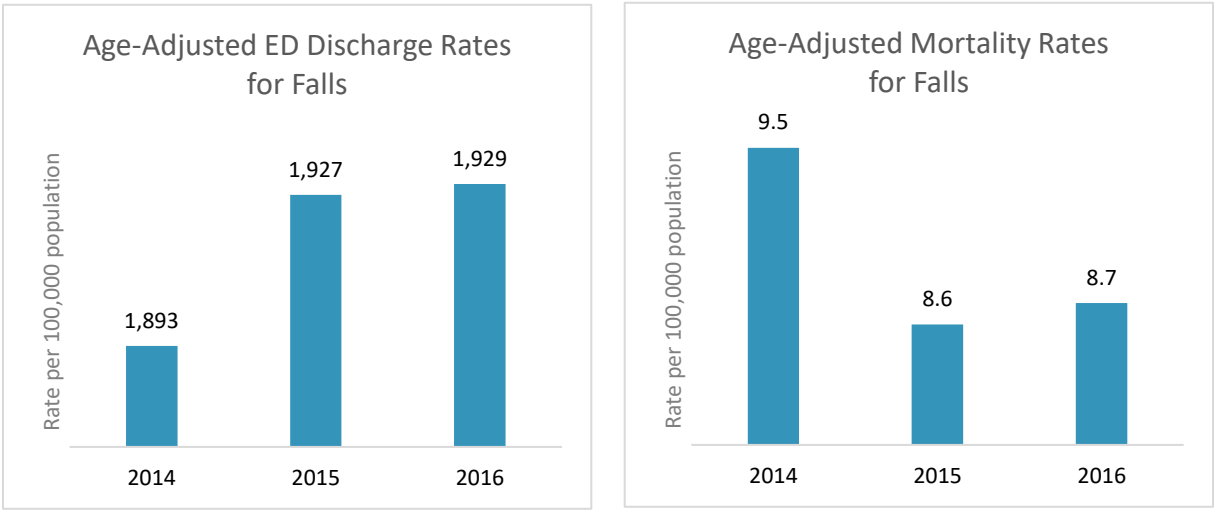
Secondary Data Findings

Data were reviewed related to several aspects of unintentional injury and violence in SDC: falls; motor vehicle injuries; and overall crime rate.

Falls

The rate of ED visits caused by falls increased by 1.9% from 2014-2016. In that same time period, death rates decreased by 8.4% (see **Figure 37**). Falls disproportionally affect those over 65 years of age; please see the **Aging Concerns** section for a breakdown of falls by age groups.

Figure 37: Age-Adjusted ED Visit and Mortality Rates for Falls in SDC, 2014-2016

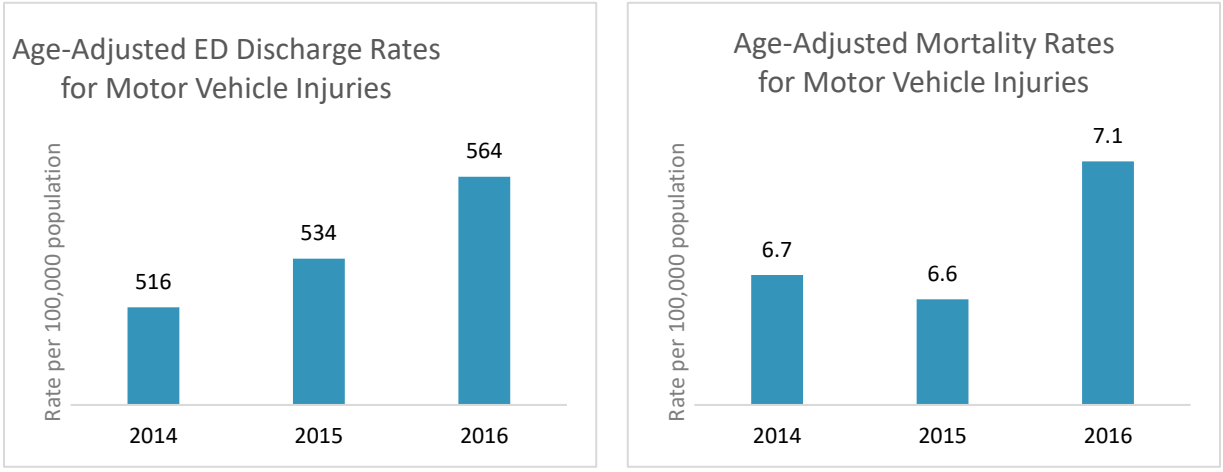


Source: County of San Diego Health and Human Services Agency Public Health Services, Regional & Community Data

Motor Vehicle Injuries

SDC data shows that from 2014-2016, age-adjusted ED visit rates for motor vehicle injuries increase by 9.3%, while deaths due to motor vehicle injuries increased 1.08%. Please see **Figure 38** below for more details.

Figure 38: Age-Adjusted ED Visit and Mortality Rates for Motor Vehicle Injuries in SDC, 2014-2016

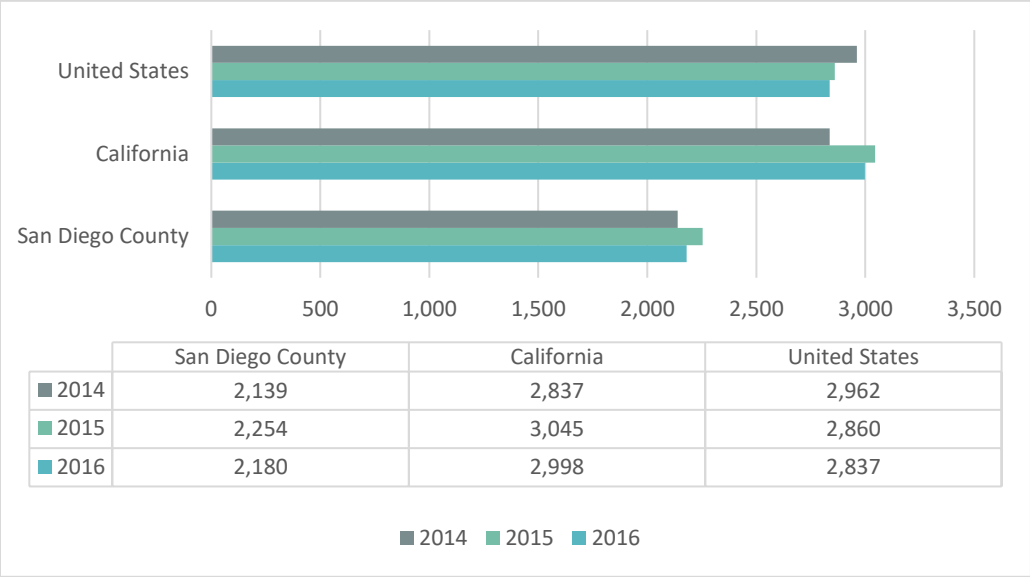


Source: County of San Diego Health and Human Services Agency Public Health Services, Regional & Community Data

Overall Crime Rate

The overall crime rate has increased in both SDC and California (1.9% and 5.7 % respectively) from 2014-2016. Please see **Figure 39** below for more details.

Figure 39: Overall Crime Rate in SDC, CA and the United States, 2014-2016



	San Diego County	California	United States
2014	2,139	2,837	2,962
2015	2,254	3,045	2,860
2016	2,180	2,998	2,837

Source: Live Well San Diego. Live Well San Diego Data Access Portal. Injury. https://data.livewellsd.org/

Please see **Appendix O** for Unintentional Injury and Violence definition and secondary data source information.

Notable findings related to unintentional injury in SGH's discharge data include[36]:

- In 2017, 66.2% of inpatient injury discharges at SGH were due to a fall, 21.2% were due to natural/environmental causes[37], and 5.4% were due to motor vehicle traffic (MVT).

- In 2017, 37.0% of injury-related visits to the ED at SGH were due to falls, while 22.1% were due to natural/environmental causes and 14.5% were due to being struck by/against an object.

- Among individuals admitted to SGH with an unintentional injury in 2017, 59.4% were ages 65 and older, and 28.9% were ages 45-64.

[36] California Office of Statewide Health Planning and Development (OSHPD) Non-Public Inpatient Discharge and Emergency Department Encounter Data, 2017. Accessed through SpeedTrack Inc.©
[37] The ICD-10 External Causes of Injury classification of "injury due to natural/environmental causes" includes injuries related to overexertion, repetitive motion, exposure to heat or cold, exposure to toxic plants, and contact with animals or insects.

- Among individuals who visited the ED at SGH with an unintentional injury in 2017, 41.3% were ages 18-44, and 23.8% were ages 45-64.

- In 2017, 32.6% of inpatient discharges for injury among individuals ages 18-44 were due to a fall, while 32.1% were due to natural/environmental causes and 14.7% were due to MVT.

- In 2017, 26.1% of injury-related visits to SGH's ED by individuals ages 18-44 were due to natural/environmental causes, while 20.1% were due to a fall and 20.7% were due to MVT.

- Among individuals ages 65 and older who visited the ED at SGH with an injury in 2017, 70.9% of injuries were due to a fall, and 13.4% of injuries were due to natural/environmental causes.

Community Engagement Findings

HASD&IC 2019 CHNA

Within the *HASD&IC 2019 CHNA* online survey, of those who chose safety and violence as the greatest influence on poor health outcomes, 55.0% believed that safety and violence is getting worse in SDC.

Additional feedback from the *HASD&IC 2019 CHNA* focus groups is included in the **Discussion of Community Engagement Findings** section below.

Sharp 2019 CHNA – Focus Groups

Safety and violence was identified as having a significant impact on health and well-being specifically within the *Sharp Diabetes Health Educators* and *Sharp PFAC* focus groups. Please refer to **Appendix U** for a summary of findings from both of these focus groups. Further detail is included in the **Discussion of Community Engagement Findings** below.

Sharp 2019 CHNA – Sharp Insight Community

Sharp's Insight Community online survey provided greater understanding of unintentional injury and violence as an SDOH impacting Sharp patients and community members. Among 14 SDOH, survey respondents (n=380) ranked safety and violence (including community violence, domestic violence, child or elder abuse) as the 12th most important SDOH impacting their community (see **Appendix R**).

When health conditions and SDOH were combined among all respondents, safety and violence ranked as the 20th most important health need among 30 choices. Please refer back to **Figure 14** for the final ranking of health conditions and SDOH by *Sharp Insight Community* survey participants.

Discussion of Community Engagement Findings

HASD&IC 2019 CHNA – Focus Groups

HASD&IC 2019 CHNA community engagement participants emphasized that people who are a victim of or witness to violence may experience trauma as a result. This trauma can lead to PTSD and to other mental health conditions like anxiety and depression. These conditions, in turn, they said, may make people less able to seek out and receive the care they need. They asserted furthermore that mental health care is extremely difficult to access even when a person is not struggling with the aftereffects of trauma.

HASD&IC 2019 CHNA focus group members also discussed the importance of a safe environment for good health. Residents need to feel safe outside in order to play and exercise, and when they do not, contributors said, they are far more likely to be sedentary. Physical inactivity, they asserted, lends to poor health and is a risk factor for obesity, which is then a risk factor for chronic conditions like diabetes and CVD. They explained that a safe and pleasant neighborhood also contributes to reducing anxiety and stress.

In addition, *HASD&IC 2019 CHNA* focus group participants talked about two groups who have increased risk of exposure to violence. Homeless individuals were discussed as frequent targets of violence. Health care providers identified injuries from violence as one of the conditions for which they often treat homeless individuals. In addition, the constant stress or worrying about staying safe, contributors stressed, creates severe anxiety among some homeless individuals. Refugees were also noted to be a group who are more likely to have been exposed to violence and to suffer from that exposure. As a result of witnessing violence, participants said, refugees may be hyper vigilant to perceived threats and mistrustful of those who try to help them.

Sharp 2019 CHNA – Focus Groups

In the *Sharp PFAC* focus group, safety and violence was brought up specifically in connection to sex trafficking and its serious impact on youth. *Sharp PFAC* focus group participants highlighted how in certain areas, especially in the east region of SDC, sex trafficking affects individuals of all socioeconomic status. Please refer to **Table 21** or **Appendix U** for a summary of feedback from the *Sharp PFAC* focus group.

The *Sharp Diabetes Health Educator* focus group also stated that instances of domestic violence and familial abuse pose a challenge to accessing care and a barrier for both patients and their family members.

Section

6 Community Assets, Recommendations and Next Steps

The findings of this CHNA revealed significant priority health needs impacting communities served by SGH, particularly those communities facing inequities. In addition, the findings provided insight and recommendations from direct conversations with the community. This insight will assist in the design and implementation of SGH programs and services to help improve the health and well-being of the community it serves.

To support cross-sector information-sharing about the CHNA-identified health needs for San Diegans, the HASD&IC 2019 CHNA Committee worked with IPH to develop health briefs for selected identified health needs. **Section 7: Health Briefs** provides both quantitative and qualitative data on selected identified health needs and SDOH. These health briefs are intended to both provide educational resources for the community, as well as to support community-based organizations who may utilize this data to pursue funding opportunities. Through these health briefs, the CHNA Committee seeks to aid and champion the work of the community-based organizations and social support networks that are critical community assets in San Diego.

Community Assets to Respond to Identified Needs

Community assets and resources are integral to addressing the full spectrum of health needs that exist in the population. For purposes of this report, available community assets and resources to address the top health needs are separated into two categories:

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

The County of San Diego has many assets and resources addressing the health needs identified in this assessment including: community-based organizations; government departments and agencies; hospital and clinic partners; and community members.

The HASD&IC and Sharp 2019 CHNAs relied on and utilized the 2-1-1 San Diego database as its comprehensive resource for community assets in San Diego. Details are provided below.

2-1-1 San Diego

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. Recognizing that available programs and services are

continuously changing, we encourage the community to access the most available data through 2-1-1 San Diego. For more specific information about the programs within each category, please contact 2-1-1 San Diego or visit their website (http://www.211sandiego.org/).

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

- Aging Concerns: 91
- Access to Care: 260
- Behavioral Health: 703
- Cancer: 129
- Cardiovascular Disease: 161
- Diabetes: 144
- Maternal and Prenatal Care: 251
- Obesity: 298
- Social Determinants of Health: 5,836

Please note, this is an assessment of the type and number of services available as of June 17, 2019, but it is not an exhaustive list of resources available in SDC. Due to the interconnectedness of chronic conditions, organizations, programs and services may be repeated if they provide more than one service and if they are located in more than one location. For more specific information about the programs within each category, please contact 2-1-1 San Diego or visit their website at: http://www.211sandiego.org.

Sharp CHNA Community Guide

As part of Sharp's 2016 CHNA Phase 2 process, a Sharp CHNA Community Guide was developed and made publicly available on Sharp.com at: https://www.sharp.com/about/community/community-benefits/health-needs-assessments.cfm. The Sharp CHNA Community Guide was developed to provide community members with a more user-friendly resource to learn about Sharp's CHNA process and findings, as well as the identified health and social needs addressed in Sharp's programs. In addition, the Sharp CHNA Community Guide provides a direct link for community members to provide feedback on Sharp's CHNA process. Please refer to **Appendix E** for the Sharp CHNA Community Guide. An updated Sharp CHNA Community Guide will be publicly available on sharp.com during early- to mid- 2020.

HASD&IC 2019 CHNA: Community Recommendations

HASDIC 2019 CHNA community engagement participants identified three means by which the identified health needs could be better addressed:

1. The implementation of overarching strategies to address the health needs
2. The development or expansion of resources to meet the needs
3. The creation of systemic, policy and environmental changes to better support health outcomes

All of these approaches, participants emphasized, would require collaboration between political, health care system, and community leaders, health care professionals, community organizations, and residents. Please refer to **Figure 40**, the Resource & Opportunities to Address Priority Health Needs graphic below for a summary of these approaches.

Strategies to improve / enhance knowledge, patient experience, and collaboration

Community knowledge

Community residents of all ages and backgrounds need a better understanding of how to maintain good health and prevent illness and disease. Culturally competent and linguistically appropriate educational campaigns should be developed that target groups experiencing health disparities.

Educational campaigns should:

- Promote available services in the community, clinics, and hospitals
- Address potential barriers to care, including:
    - how to apply for health insurance and/or public benefits
    - how to access transportation
    - whether translation and navigation services are available
    - any potential impact on immigration status
- Market services to address SDOH, such as:
    - affordable housing
    - resources targeted to food insecurity

Patient experience

The patient experience would be improved by a more diverse hospital workforce with knowledge of the specific needs of racial/ethnic and sexual minorities. Navigating the health care system for people whose first language is not English or who have recently immigrated, for example, presents overwhelming challenges. In addition, coordinating care between health care providers and with social service organizations is crucial to improving the patient experience. Efforts should be made to:

- Provide more health navigators and case managers who speak the patient's language and understand the patient's culture
- Coordinate care between health care providers and across clinics
- Provide continuity of care with warm hand-offs between health care systems and social service organizations

Collaboration

Enhanced collaboration was named as essential to improving health. This includes collaboration between health care professionals — such as primary care providers and specialists — and between health care systems and social service organizations. Improved collaboration between social workers, law enforcement, and attorneys would also be beneficial. Partnerships with community residents and organizations would improve the efficacy of health care services and develop trust between health care providers and the people they serve. These partnerships should include collaborative advocacy efforts, efforts to adapt programs and interventions to the unique needs of specific groups, and the dissemination of information back to communities collected from research projects in those communities.

The development and expansion of specific types of resources

Community engagement participants identified several specific types of resources that are necessary to address the priority health needs of the community:

- Urgent Care services that include expanded hours, availability to all populations, and mental health and substance use services
- Preventive care programs that offer services such as immunizations (including the flu vaccine), HIV testing, and exercise programs
- Dental services for preventive care and to address oral health issues such as carries and gum disease
- Onsite programs and mobile units that bring services to the community, including programs in senior housing complexes, school clinics, mobile screening, and mobile food distribution
- Culturally competent programs for refugees, Native Americans, Latinos, Black/African Americans, LGBTQ individuals, non-citizens, and asylum seekers
- Programs for the youth, especially community centers and programs for young men and for homeless youth
- Homeless services and discharge support, including mobile showers, more shelters, and further options for post-acute recuperative care
- Food insecurity navigation that includes reference guides for food system/service navigation of San Diego County, private, and non-profit organizations, and signage for healthy food options for CalFresh/SNAP users at stores and restaurants

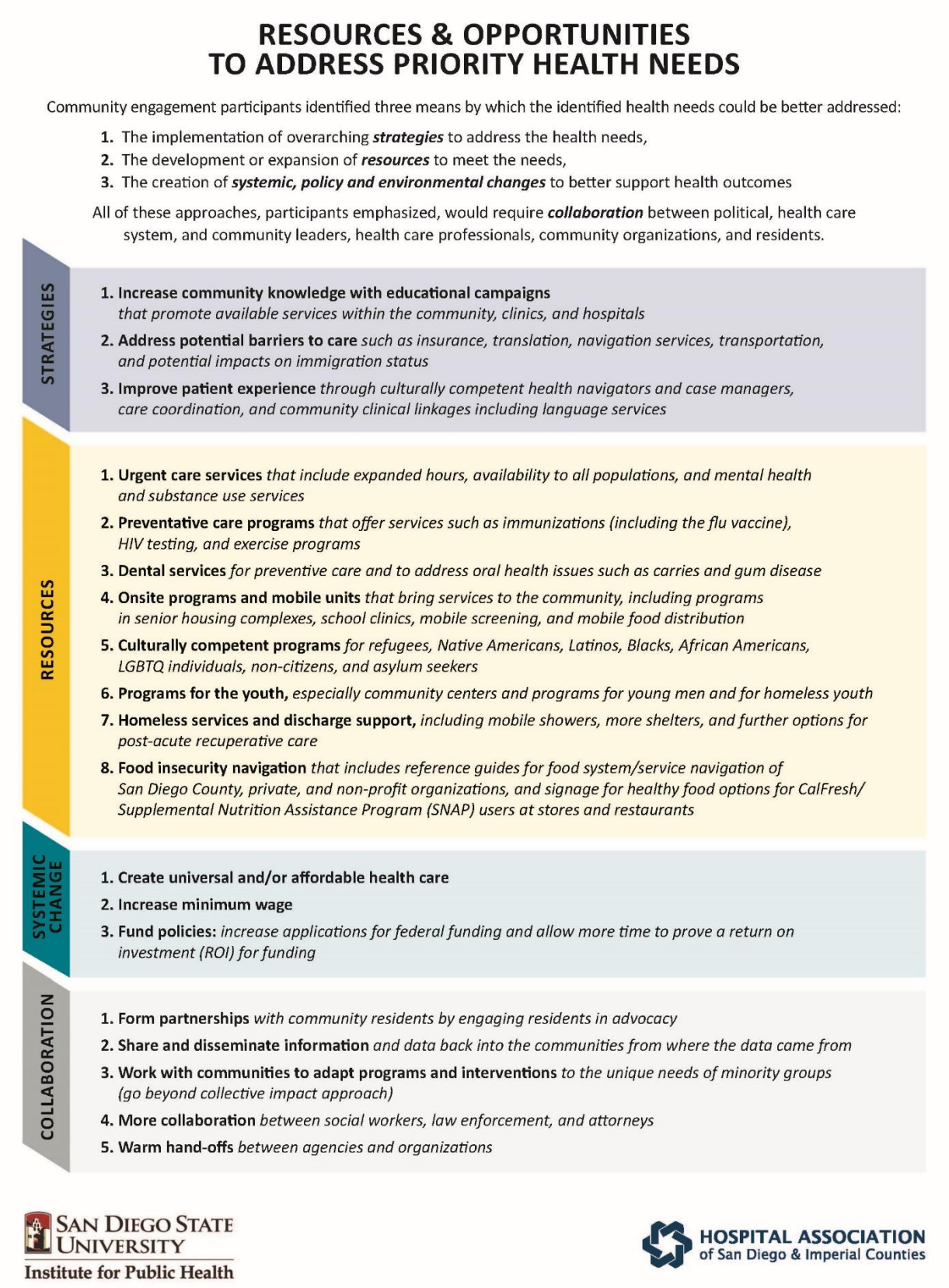
Systemic change

Finally, it was evident from the community engagement findings that San Diegans think that large-scale system, policy, and environmental changes are necessary to make true progress toward good health for all residents. These changes include:

- Creating universal and/or affordable health care
- Increasing the minimum wage
- Increasing applications for federal funding and allowing more time to prove a return on investment for this funding
- Enabling easy sharing of information about patients between organizations and hospitals

Figure 40 below presents a summary of approaches recommended by HASD&IC 2019 CHNA community engagement participants.

Figure 40: HASD&IC 2019 CHNA – Resources & Opportunities



SGH 2019 CHNA: Community Recommendations

Community engagement participants throughout the SGH 2019 CHNA process provided specific suggestions to help address the identified health needs and SDOH in the CHNA. These recommendations were highly aligned with the suggestions outlined in the narrative above and summarized in **Figure 40**. For specific recommendations from each SGH 2019 CHNA community engagement group, please refer to **Section 5: Findings** of this report.

HASD&IC 2019 CHNA: Hospital Next Steps

Hospitals and health systems that participated in the HASD&IC 2019 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 district hospitals and 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 to solicit additional feedback on findings and may serve as a useful resource to both residents and health care providers to further community-wide health improvement efforts.

The CHNA Committee is in the process of planning Phase 2 of the 2019 CHNA, which will include gathering community feedback on the 2019 CHNA process and strengthening partnerships around the identified health needs and SDOH. This will include an exploration to deepen the understanding of stigma's impact on SDOH and health needs, as well as how hospitals and health systems could better address stigma in patient care.

The complete summary of the HASD&IC 2019 CHNA is available online at: https://hasdic.org/2019-chna/. Paper copies or electronic files are also available upon request, as well as items provided in the HASD&IC 2019 CHNA developed by the Institute for Public Health (IPH) at San Diego State University. Please contact Lindsey Wade at the HASD&IC with any questions.

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SGH 2019 CHNA: Next Steps

SGH has developed its FY 2020 – FY 2023 Implementation Strategy to address the needs identified through the 2019 CHNA process for the primary communities it serves. In addition, the SGH 2019 CHNA Planning Team, in addition to Sharp leadership, Sharp Community Benefit, service line leaders, and other team members are committed to an ongoing exploration of partnerships and collaborations that help address the needs of SGH's community members.

Tools such as the asset map of currently existing resources within SDC, as well as the CNI data, will be utilized to help continue to identify gaps in community resources and provide insight into further program development.

The SGH FY 2020 – FY 2023 Implementation Strategy is available on sharp.com at: http://www.sharp.com/about/community/health-needs-assessments.cfm. In addition, the implementation strategy is submitted along with the Internal Revenue Service (IRS) Form 990, Schedule H. The IRS Form 990, Schedule H will also be publicly available on Guidestar (http://www.guidestar.org/) in the coming months.

Sharp will continue to work with HASD&IC and IPH as part of the CHNA Committee to develop and implement Phase 2 of the 2019 CHNA. In addition, the Grossmont Healthcare District will also join the CHNA Committee beginning with Phase 2 of the 2019 CHNA. Phase 2 will focus on continued engagement of community partners to analyze and improve the CHNA process, as well as the hospital implementation strategies that address the 2019 CHNA findings. Thus, the CHNA process will evolve to meet the needs of our community members and support the work of our community partners who also address those identified needs.

In addition, in the first year of Sharp's FY 2020 – FY 2023 Implementation Strategy, Sharp hospitals (including SGH), medical groups, and health plans are embarking on a new, innovative partnership with 2-1-1 San Diego's Community Information Exchange (CIE). The CIE includes a longitudinal client record with community member history, access to and utilization of social programs (e.g., housing, food banks, community clinics, etc.), emergency transport data, and much more. The CIE also includes a direct-referral feature, which allows for documented, bi-directional, closed-loop referrals between all CIE partners — including hospitals, clinics, and social service programs. Currently, there are more than 60 community partners (organizations) participating in CIE, and more than 90,000 community members enrolled, with approximately 4,500 new community members enrolled each month. Sharp is the first integrated health system — including its hospitals, medical groups and health plan — to participate in the CIE. By leveraging this technology, and expanding upon this capability for shared data, consistent tracking and robust reporting, the CIE partnership presents an exciting opportunity for Sharp to strengthen and evaluate the impact of clinical-community linkages for its patients and community members in need, particularly regarding SDOH. The data collected in this one-year partnership will inform the value case for continuing with the partnership after the pilot year (Summer 2020).

Overall, there is broad recognition that all regions of SDC will continue to experience changes that directly affect the health of the communities served by SGH. This uncertainty in the general environment — including changes at the local, state and federal levels of government, as well as transformation of the health care market landscape — continues to be a serious issue and key consideration for the health care community. While this CHNA provides a high-level view of health in the communities served by SGH, hospital leaders are mindful of the need to be responsive to those emerging trends and needs in health care that shape the health and well-being of our community.

Section

7 Health Briefs: Select Identified Community Health Needs and SDOH

To support cross-sector information-sharing about the CHNA-identified health needs for San Diegans, the HASD&IC 2019 CHNA Committee worked with IPH to develop health briefs for selected identified health needs. This section includes those health briefs, which provide both quantitative and qualitative data on the selected identified health needs and SDOH. The health briefs are intended to both provide educational resources for the community, as well as to support community-based organizations who may utilize this data to pursue funding opportunities. Through these health briefs, the CHNA Committee seeks to aid and champion the work of the community-based organizations and social support networks that are critical community assets in San Diego.

HOSPITAL ASSOCIATION
of San Diego & Imperial Counties

Access to Health Care

28.5 million people are without health insurance in the U.S.[1]

Access to high quality, comprehensive care is vital for preserving good health, preventing and managing disease, decreasing disability, averting premature death, and achieving health equity for all.[2]

To access care, people need health insurance coverage and a consistent source of care that provides evidence-based, culturally competent preventive and emergency medical services in a timely manner.[2]

Uninsured in the U.S.[1] (2017)

8.8% of people are without health insurance.

By Age

Seniors and children are the least likely to be uninsured, while a large percentage of working adults have no coverage:

- People age 65+ have the highest rates of coverage, with only 1.3% uninsured.
- 5.4% of children under the age of 19 are uninsured (7.8% for children living in poverty).
- Working adults ages 26-34 are more likely to be uninsured than the overall working population (15.6% vs 12.2%).

By Race

- Uninsured rates are highest for people who identify as Hispanic (16.1%), followed by Black (10.6%), and Asian (7.3%).

By Educational Attainment

The uninsured rate decreases as education level increases. While only 4.3% of people with a graduate or professional degree are uninsured, 26.3% of people without a high school diploma are uninsured.

By Income

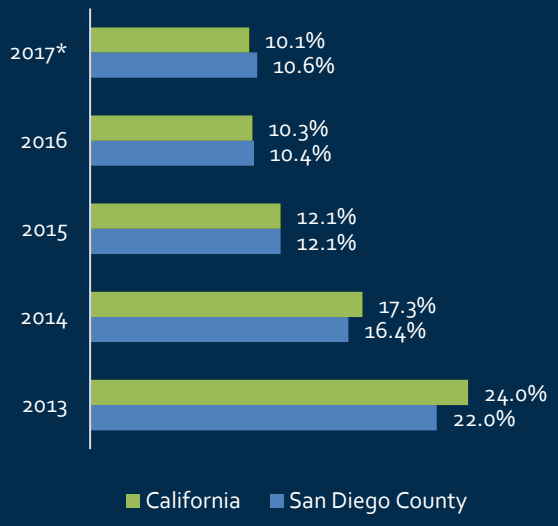
Uninsured rates increase as level of income decreases. The highest uninsured rates are among those who make less than $25,000 annually (13.9%), and the lowest are among those who make more than $125,000 (4.3%).

UNINSURED IN SAN DIEGO COUNTY

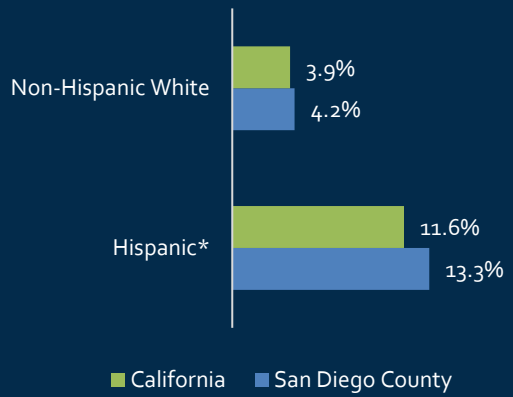
In 2017, 10.6% of adults aged 19-64 years were uninsured[3] in San Diego County.

- Uninsured rates have decreased across all racial/ethnic groups. Those who identify as Hispanic, however, are disproportionately without health insurance, 13.3% (Hispanic) compared to 4.2% (non-Hispanic White).

Percent Uninsured (Ages 18-64)*, 2013-2017



Percent Uninsured (Ages 19-64) by Ethnicity*, 2017



*Note: Includes civilian noninstitutionalized population. 2017 data includes 19-64 years olds.

Ongoing Care with a Primary Care Provider in the U.S.[4] (2015)

76.4% of people in the U.S. have a primary care provider (PCP).

By Age

The youngest and oldest age groups have the highest percentages of people with a PCP: 93.2% of those under the age of 5 and 92.4% of those 85 years old and older. More broadly, people less than 18 years old have the highest proportion with a usual PCP (90.0%), followed by those 65 and older (89.4%), and those 45-64 (79.2%). The lowest percentage was among those 18-44 (60.1%).

By Race

The percentage of people with a PCP is highest among Native Hawaiian or Other Pacific Islander individuals (82.3%), followed by people of two or more races (80%), non-Hispanic Whites (79.1%), American Indian or Alaska Natives (74.3%), Asians (74.2%), and Black individuals (72.6%). The percentage was lowest (70.1%) among Hispanics.

By Educational Attainment

The highest proportion of people with a usual PCP is among those with an advanced degree (77.8%), followed by those with a college degree (74.2%). The lowest rate is among those with less than a high school diploma (68.9%).

By Income

The percentage of people with a PCP increases in proportion to income. Among those with income levels 600% or more over the federal poverty level (FPL), 81.7% have a usual PCP, whereas among those with incomes of less than 100% of the FPL, 71.8% have a usual PCP.

The Affordable Care Act (ACA)[9]

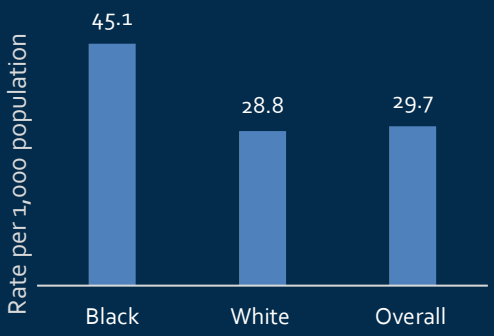
The **ACA** increased access to healthcare. In 2014, a number of changes took effect in California:

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

PREVENTIVE & PRIMARY CARE IN SAN DIEGO COUNTY

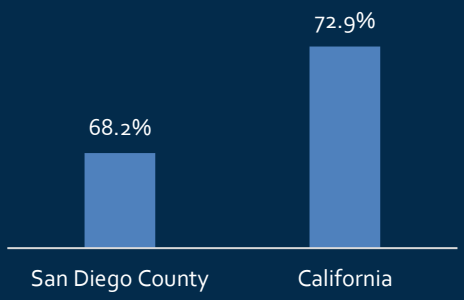
In 2015, San Diego had fewer hospital discharges for preventable conditions (29.7 per 1,000) than the state average (36.2 per 1,000); however, Black individuals have a far greater number of these events.[6]

Preventable Hospital Events for Medicare Beneficiaries, 2015 [6]



In 2015, 71.3% of adults in San Diego County had seen a PCP in the past year,[8] however Medicare beneficiaries have

Medicare Beneficiaries who Have Seen a PCP Within Past Year, 2015[6]



lower rates (68.2%).[6]

HEALTH IMPACTS

Being uninsured is associated with:[7]

- Poor mental health days
- More heart attack ED visits
- Asthma
- Obesity
- Low birth weight

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HOSPITAL ASSOCIATION
of San Diego & Imperial Counties

Aging Concerns

By 2030, 1 in 5 Americans will be 65 years or older[1]

Older adults are at greater risk of having multiple chronic conditions, including dementia, and of suffering injury and death from falls.[2,3]

Dementia in the U.S. (2017)

Dementia is a general term used to describe symptoms indicative of cognitive decline, like memory loss or confusion. The most common cause of dementia is Alzheimer's disease.[4,5]

- Approximately 5.7 million people are living with dementia
  - Alzheimer's disease accounts for about 60-70% of these cases.[6]
- Dementia is the 3rd leading cause of death in the U.S. when combining all four causes of dementia.*[,7]
- About 262,000 people will die from dementia each year
  - 46.4% of these deaths result from Alzheimer's disease[7]
- Age-adjusted death rate due to dementia is 66.7 per 100,000.[7]
- Alzheimer's disease is the 5th leading cause of death among those over 65 years in the U.S.[8]

By Sex

More women than men have Alzheimer's disease or other dementias:

- Among people 65 years and older (65+), 62.5% of people with Alzheimer's disease are women[5]

By Race and Ethnicity

Blacks and Hispanic individuals are more likely to have Alzheimer's disease or other dementias than Whites.[5]

Leading causes of death among persons aged 65 and over[8]

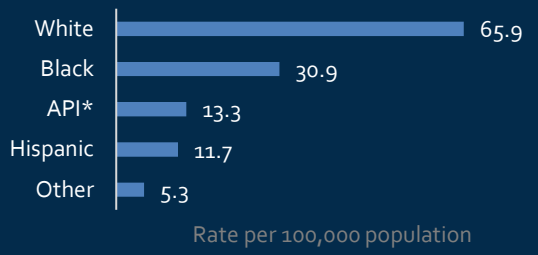
1. Heart disease (25.1%)
2. Cancer (20.7%)
3. Chronic lower respiratory disease (6.6%)
4. Stroke (6.1%)
5. Alzheimer's disease(5.8%)

*Includes: unspecified dementia, Alzheimer disease, Vascular dementia, other degenerative disease of nervous system

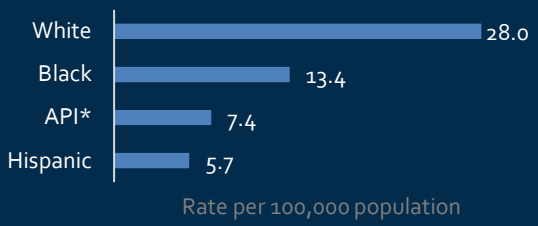
DEMENTIA AND ALZHEIMER'S IN SAN DIEGO COUNTY[9] (2016)

In San Diego, White residents, followed by Black residents are disproportionately affected by dementia and Alzheimer's disease.

Alzheimer's Disease Death Rate by Race/Ethnicity, 2016



Dementia Death Rate by Race/Ethnicity, 2016



*Asian & Pacific Islander

The percentage of San Diego population who have seen a primary care physician in the last year, 71.8%, is slightly lower than the state average of 72.7% (2015).[14]

For Medicare beneficiaries, this gap is larger: only 68.2% of Medicare beneficiaries in San Diego have seen a PCP in the past year, compared to the state average of 72.9% (2015).[15]

Falls in the U.S.

More than 31,000 people 65 years and older died from falls in 2017[10]

In 2017, for every individual 65 years and older who died from falls, 28 were hospitalized, and 62 were treated for fall-related injuries.[10,11] In 2015, the total cost for falls for those 65 years and older was more than $50 billion. Since the U.S. population is aging, both the number of falls and the cost to treat fall injuries are likely to rise.[12]

Among people 65 years and older (65+) (2017)

- Falls are the leading cause of injury-related *mortality*, accounting for 55.7% of unintentional fatal injuries in 2017.[13]
- The *death* rate due to falls was 61.3 per 100,000.[10]
- The *nonfatal* rate due to falls is 5,841.1 per 100,000 (about 3 million nonfatal fall injuries).[11]

By Sex

- For *fatal* falls, males who are 65+ are more likely to die than females who are 76+ (75.3 vs 54.8 per 100,000).[10]
- For *nonfatal* fall-related injuries, females who are 65+ accounted for 64.6%.[11]

By Race and Ethnicity

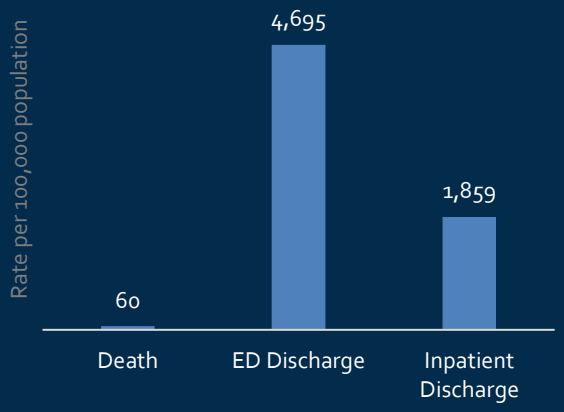
Non-Hispanic Whites are more impacted by falls:

- Non-Hispanic Whites have the highest *death* rate (70.6 per 100,000), followed by non-Hispanic Native American (49.3 per 100,000)[10]
- Non-Hispanic Whites have the highest number of *nonfatal* fall injuries (1,648,923)[11]

FALLS IN SAN DIEGO COUNTY[9](2016)

In San Diego, thousands of residents 65 years and older visit an emergency department (ED) for fall-related injuries.

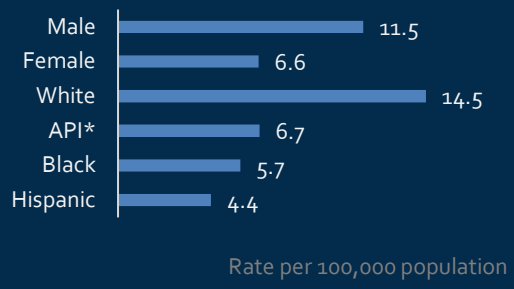
Hospital Discharge and Death Rates for Falls, Age 65+, 2016



In San Diego, male residents and White residents are more likely to die from a fall than any other groups.

- **Males** are 1.7 times more likely to die than females.
- **Whites** are at least 2.2 times more likely to die than API, Black, and Hispanic.

Falls Death Rate by Sex and Race/Ethnicity, 2016



*Asian & Pacific Islander

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HOSPITAL ASSOCIATION
of San Diego & Imperial Counties

Asthma

26.5 million Americans suffer from this chronic disease[1]

Asthma is a chronic lung disease that causes inflammation and narrowing of the airways. Symptoms of asthma attacks include wheezing, tightness or pain in the chest, shortness of breath, and coughing. The severity of attacks range from mild to life threatening.[2]

Asthma has significant impact on the daily lives of the people who suffer,[2] and in California alone, the 2020 projected medical costs are estimated to be $4.9 billion.[3]

Asthma in the U.S. (2016)

In 2016, 8.3% of Americans currently had asthma[4], and 13.6% will be diagnosed with asthma at some point in their lifetime.[5]

By Sex

- Among children, asthma is more common among boys (9.2%) than girls (7.4%), but among adults asthma is more common among women (10.4%) than men (6.2%).[4]

By Age

- 8.3% of children younger than 18 years old have asthma, a decrease from 9.4% in 2010. Rates are higher among those 5-11 years old (9.6%) and 12-17 years old (10.5%) than among children 0-4 years old (3.8%).[4,6]
- The rate is the same among adults 18+ (8.3%).[4]

By Race/Ethnicity

- Puerto Ricans have the highest rates of asthma (14.3%), followed by Non-Hispanic Black (11.6%), Non-Hispanic Whites (8.3%), Other Non-Hispanic (8.0%), and Hispanics (6.6%).[4]

By Income & Housing Quality

- Asthma is most prevalent among the lowest economic groups: 11.8% of those whose income is below 100% of the federal poverty level (FPL) have asthma, compared to 8.9% with incomes 100% to less than 250% of the FPL and 7.4% of those with incomes 250% to less than 450% of the FPL.[4]
- Poor housing quality is independently associated with asthma diagnoses and higher rates of *emergency department* (ED) *discharges* for asthma.[7]

ASTHMA IN SAN DIEGO COUNTY[8]

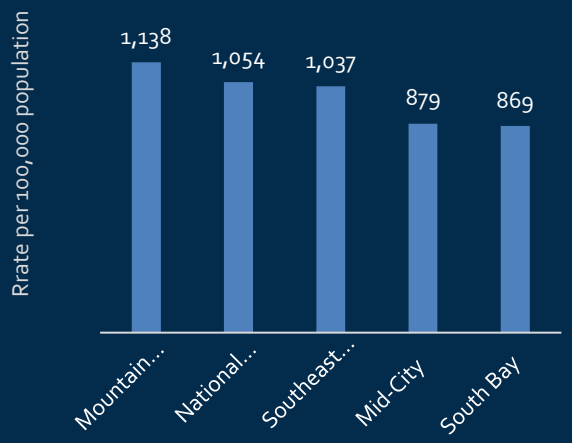
Inpatient Discharge Rates

In 2016, 264.4 people per 100,000 were discharged from an ED for asthma and 38.6 per 100,000 people were discharged from inpatient hospitalizations.

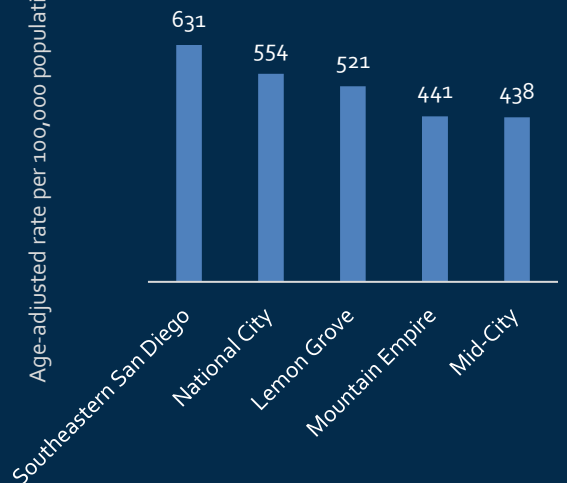
ED Discharge Rates by Region

Asthma disproportionately affects San Diegans living in certain areas. ED discharge rates are highest (per 100,000) for children (0-14 yrs.) in the Mountain Empire region and for all age groups in Southeast San Diego.

ED Discharge Rates for Asthma by Top 5 Regions (Ages 0-14), 2016



ED Discharge Rates for Asthma by Top 5 Regions, 2016



Impact of Asthma in the U.S.

Children: School achievement

- Asthma is associated with cognitive deficits, particularly among low-income, minority youth with severe asthma.[9]
- 49.0% of children with asthma miss one or more days of school annually and 13.8 million school days are missed altogether.[10] (2013).

Adults: Reports of poor and fair health[11] (2015)

- Among adults with asthma, 33.1% report fair or poor health compared to those without asthma (15.9%). In California 29.1% of adults with asthma report fair or poor health compared to 17.0% without asthma.

Mortality[12] (2016)

- Approximately 3,500 people die annually from asthma (10 per 1 million).
- Adults are more likely to die from asthma than children – the *death rate* is highest (29.2 per million) among those 65 years and older.
- Non-Hispanic Blacks are two to three times more likely (22.3 per million) to die from asthma than people from other races/ethnicities.
- *Deaths* from asthma are largely preventable.

Risk Factors and Triggers for Asthma

Factors that **increase the risk** of an asthma diagnosis include:[13]

- Parental asthma
- Prenatal environmental tobacco smoke
- Premature birth
- Maternal weight gain or obesity during pregnancy
- Maternal stress
- Maternal use of antibiotics or paracetamol
- Birth by caesarean delivery
- Severe respiratory syncytial virus (RSV) in infancy
- Overweight or obesity
- Indoor exposure to mold or fungi
- Outdoor air pollution

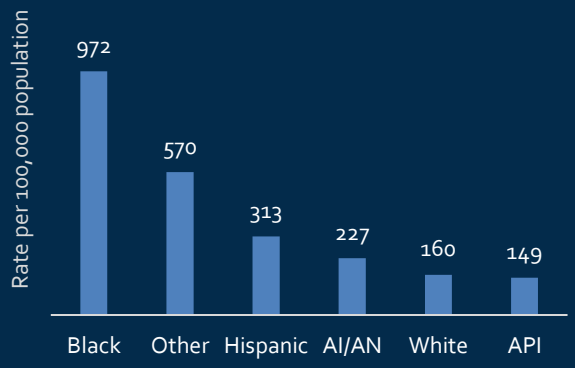
Triggers that **exacerbate asthma** and/or cause attacks include:[14]

- Tobacco smoke
- Dust mites
- Outdoor air pollution
- Cockroaches and their droppings
- Pets
- Mold
- Smoke from burning wood or grass
- Certain Illnesses
- Bad weather

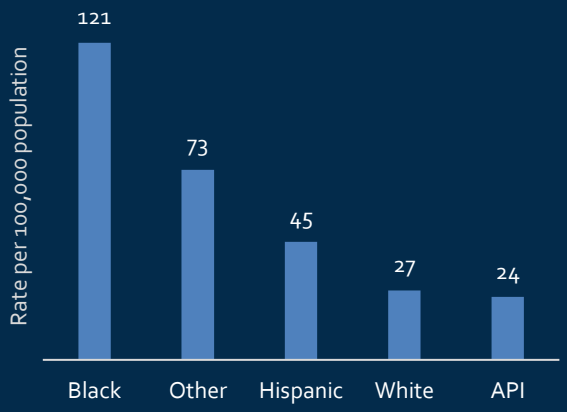
HOSPITAL DISCHARGES IN SAN DIEGO COUNTY[8]

Inpatient discharge rates (per 100,000) in San Diego County are highest among Black and Hispanic individuals as well as those who identify as "Other".

ED Discharge Rates for Asthma by Race/Ethnicity, 2016



Inpatient Discharge Rates for Asthma by Race/Ethnicity, 2016



Hospital Discharge Rates by Age (2016)

- Children 0-14 years old have the highest rate of ED discharges for asthma – 530.9 per 100,000, while people ages 65+ have the lowest rates – 128.7 per 100,000.
- Children also have the highest rates of discharge for asthma from inpatient hospitalizations – 104.0 per 100,000, while people ages 15-24 have the lowest – 12.5 per 100,000.

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HOSPITAL ASSOCIATION
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Behavioral Health

Nearly 1 in 5 U.S. adults live with a mental illness

Behavioral health problems include serious psychological distress, mental and substance use disorders, suicide, and alcohol and drug addiction.[1] If left untreated, these issues can have a devastating impact. They are a leading cause of disability, are associated with chronic disease, and may lead to premature mortality.[2,3,4]

Mental Illness in the U.S.

Among Adults, 18 years old and older (2017):

- 18.9% of adults 18 and older have a **mental illness** in this past year[5]
- 7.1% of adults experienced a **major depressive episode** (**MDE**) in the past year; 66.8% received treatment[5]

Among Youth and Young Adults (2017):

- 31.5% of high school students are so sad or hopeless every day for 2 or more weeks in a row that they stop doing some usual activities. Rates are particularly high (63.0%) among gay, lesbian, and bisexual students and are higher among females (41.1%) than males (21.4%).[6]
- 13.3% of youth aged 12 to 17 had an **MDE** in the past year; only 41.5% received treatment for depression.[5]
- 13.1% of young adults aged 18-25 had an **MDE** in the past year; only 50.7% received treatment.[5]

Mood Disorder and Anxiety in San Diego County[8]

Mood Disorders

- From 2014-2016, *inpatient discharge* rates for **mood disorders** *decreased* by 2.9%.
- From 2014-2016, rates of emergency department (*ED) discharge* for **mood disorders** *increased* by 5.9%.

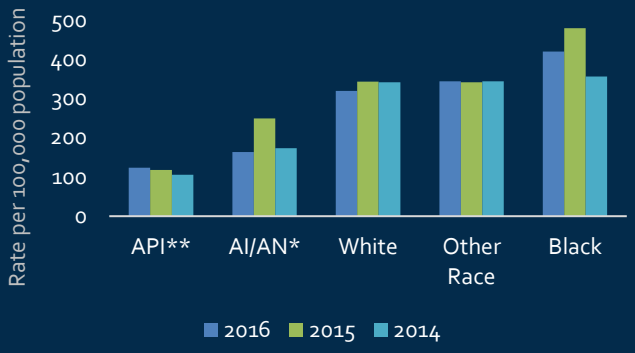
Anxiety

- From 2014-2016, *inpatient discharge* rates for **anxiety** *decreased* by 7.9%.
- From 2014-2016, rates of *ED discharge* for **anxiety** *increased* by 4.3%.

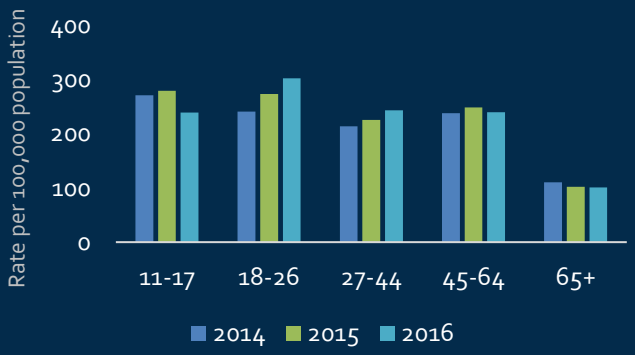
MOOD DISORDER & ANXIETY IN SAN DIEGO COUNTY

The most common mood disorders include depression, bipolar disorder, and seasonal affective disorder[7]

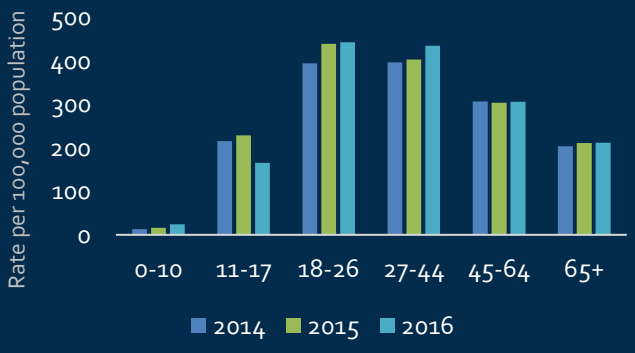
Inpatient Discharge Rates for Mood Disorder by Race[8]



ED Discharge Rates for Mood Disorder by Age[8]



ED Discharge Rates for Anxiety by Age[8]



*American Indian / Alaskan Native / Eskimo / Aleut
**Asian Pacific Islander

Suicide in the U.S.

Among Adults, 18 years and older (2017):

- **Suicide** is the 2nd leading cause of death among 10-34 year olds and the 4th among 35-54 year olds[9]
- 1.4 million people have nonfatal **suicide** attempts each year[5]
- 10.6 million people (4.3%) think seriously about trying to kill themselves each year[5]

Among Youth and Young Adults (2017):

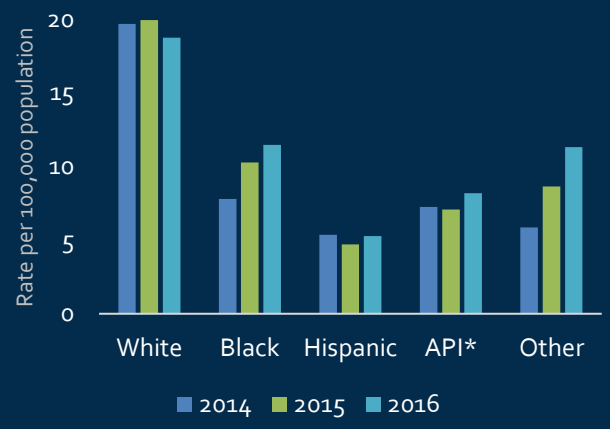
- Rates of **suicide attempts** in high school students are higher among females (9.3%) than males (5.1%) and much higher among gay, lesbian, and bisexual students (23.9%) than among heterosexual students (5.4%)[6]
- 17.2% of high school students[6] and 10.5% of young adults seriously considered suicide in the past year[5]

Suicide and Self Inflicted Injury in San Diego County[7]

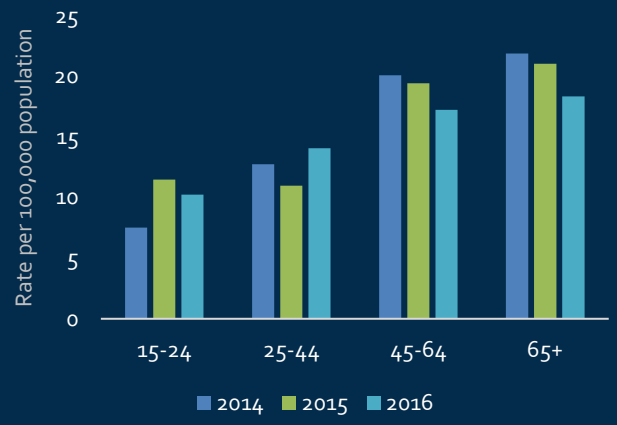
- In 2016, **suicide** was the 9th leading cause of death in San Diego County.[15]
- 11.8% of adults in San Diego have seriously considered suicide.[10] (2017)
- Rates of **suicide** *decreased* 1.3% from 2014-2016 among all San Diegans.[16]
  - Rates *increased* during these same years among those who identified as Asian/Pacific Islander, Black, and "Other," by 13.3%, 47.2%, and 93% respectively.
  - Rates also *increased* for two age groups during this period: for those 15-24 years old (by 36.4%) and 25-44 years old (by 10.4%).
- *ED discharge rates* for **self-inflicted injury** have *decreased* slightly (0.1%) from 2014-2016.[16]
  - Rates are highest among those 15-24 years old and among people who identify their race/ethnicity as "Other," American Indian/Alaska Native, and Black.

SUICIDE & SELF INFLICTED INJURY IN SAN DIEGO COUNTY[7]

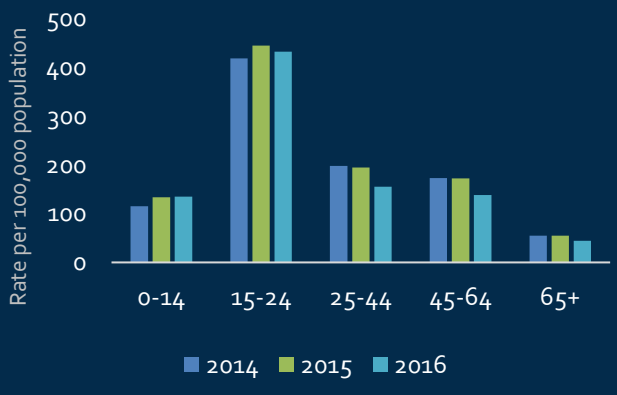
Suicide Rates by Race/Ethnicity



Suicide Rates by Age



ED Discharge Rates for Self-Inflicted Injury by Age



*Asian Pacific Islander

Substance Misuse in the U.S.[5] (2017)

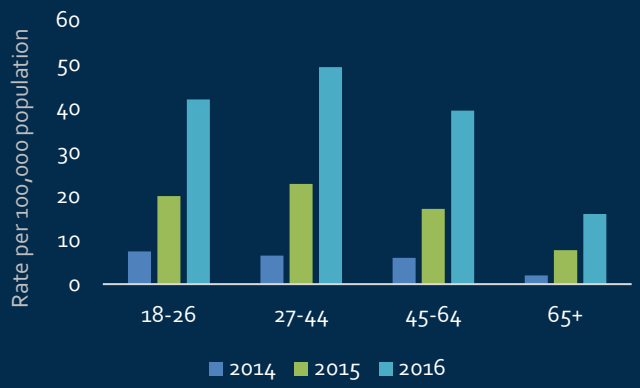
- 30.5 million people 12 and older have used an illicit drug in the past 30 days – this is equal to 1 in 9 people (11.2%).
- Approximately 19.7 million people ages 12 and older have a **substance use disorder**:
  - 14.5 million have an alcohol use disorder
  - 7.5 million have an illicit drug use disorder
- Only 4 million people 12 and older received substance use treatment in the past year.
- About 1 in 3 people 12 and older who perceive a need for treatment do not receive it because they do not have health insurance and cannot afford it.
- 8.5 million adults 18 or older (3.4%) have both a **mental illness and a substance use disorder.**
  - 1 in 3 of these people did not receive care for either condition.

Substance Misuse in San Diego County[8]

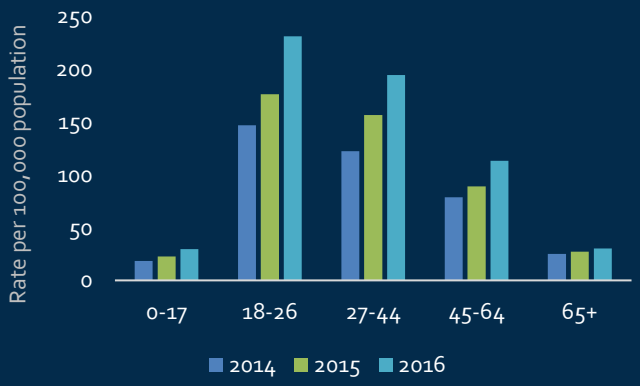
- Nearly 20% of adults ages 18 and older self-report excessive alcohol use, exceeding the state and national averages of approximately 18%.[11] (2015)
- *ED discharge* rates for **chronic substance abuse** grew substantially (by 559%) from 2014-2016.[8]
  - The steepest *increase* (714%) was for those 65 years old and older, followed by those 27-44 years old (657%).
- *ED discharge rates* for **acute substance abuse** *increased* by 51% from 2014-2016.[8]
  - These rates rose the most for 0-17 year olds (61%), followed by 27-44 year olds (59%), and 18-26 olds (57%).
  - Rates *increased* for all races, but the most substantial increase (177%) was among Black individuals.

SUBSTANCE MISUSE IN SAN DIEGO COUNTY[8]

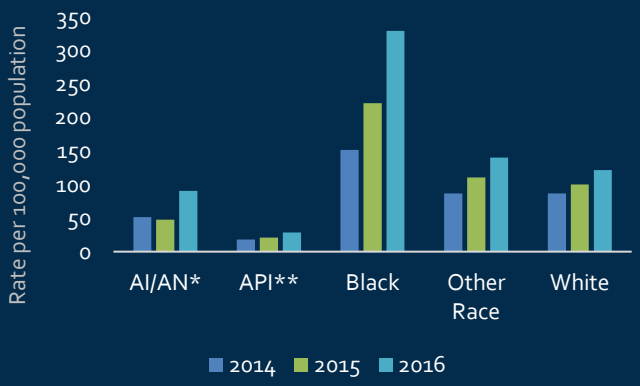
ED Discharge Rates for Chronic Substance Use by Age



ED Discharge Rates for Acute Substance Use by Age



ED Discharge Rates for Acute Substance Use by Race



*American Indian / Alaskan Native / Eskimo / Aleut
** Asian Pacific Islander

Opioid Misuse in the U.S.

Opioid misuse is defined as the use of opioids without a prescription or in a manner other than as directed by a doctor, which can result in an overdose.[12]

Opioid Deaths in the U.S.[13] (2017)

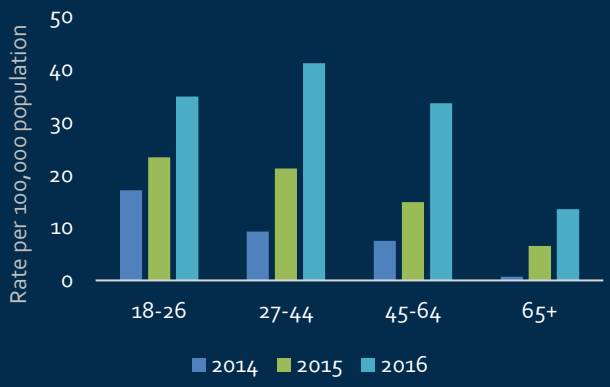
- The rate of **opioid overdose** deaths rose by 12.0% from 2016-2017.
- Males are twice as likely to die from an opioid overdose than females (20.4 per 100,000 vs 9.4 per 100,000).
- Non-Hispanic White individuals have the highest opioid overdose death rate (19.4 per 100,000), followed by non-Hispanic American Indian/Alaska Native (15.7 per 100,000).
- The highest opioid overdose death rate is among those 25-34 years old (29.1 per 100,000).

Opioids in San Diego County

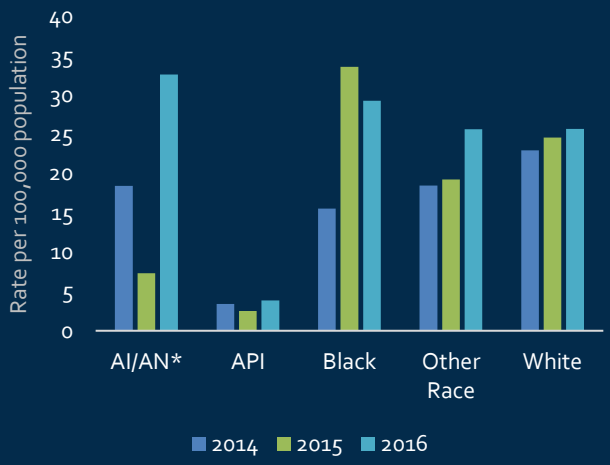
- **Opioids were prescribed** 1,701,077 times in San Diego in 2017, an annual age-adjusted rate of 475.5 times per 1,000 residents.[14]
  - This represents a 17% decrease from 2015.
- Death rates from **opioid overdose** are highest for individuals who are Native American, followed by White, Black, Latino, and Asian individuals.[14] (2017)
- *ED discharges* for **opioid misuse** rose 267.2% from 2014-2016.[8]
  - Rates are highest for those 27 -44 years old, but the largest *increase* (1,734%) was for those 65 years and older.
- *ED discharge rates* for **opioid overdose** rose by 18.1% from 2014-2016.[8]
  - Rates increased for all racial groups, but the largest increase was seen among Black individuals (88.2%).
- Rates of *inpatient discharge* for **opioid overdose** decreased overall by 6.3% from 2014-2016.[8]
  - Rates of those 65 years and older decreased by 11.6%.

OPIOID MISUSE & OVERDOSE IN SAN DIEGO COUNTY[8]

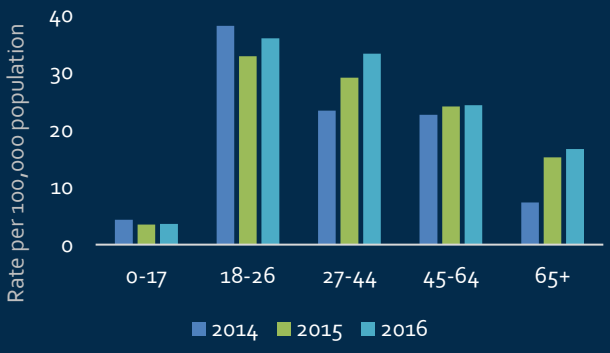
ED Discharge Rates for Opioid Misuse by Age



ED Discharge Rates for Opioid Overdose by Race



ED Discharge Rates for Opioid Overdose by Age



*Asian Pacific Islander

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Cancer

15.5 million Americans have a history of cancer, and in 2019, 606,880 Americans will die from cancer and 1.7 million new cases will be diagnosed. [1]

Cancer is a set of diseases in which abnormal cells grow and spread.[1] In 2017, it was the second leading cause of death in the U.S.[2] The annual direct medical costs for cancer are over $80 billion in the U.S. (2015).[3]

Cancer in the U.S.

The Most Common Cancers: Prevalence and Mortality Estimates for 2019[1]

The most common types of cancer among women are breast, lung, colorectal, and uterine. Among men, they are prostate, lung, colorectal, and urinary. Mortality rates for women are highest for lung, breast, colorectal, and pancreatic, and for men are highest for lung, prostate, colorectal, and pancreatic cancer.

Breast (invasive)

- 271,270 cases will be diagnosed
- 42,260 people will die

Lung

- 228,150 cases will be diagnosed
- 142,670 people will die

Prostate

- 174,650 cases will be diagnosed
- 78,500 men will die

Colorectal

- 145,600 cases will be diagnosed
- 51,020 people will die

Urinary

- 80,470 cases will be diagnosed
- 17,670 people will die

Uterine/Endometrial

- 61,880 cases will be diagnosed
- 12,160 people will die

Pancreatic

- 56,770 cases will be diagnosed
- 45,750 people will die

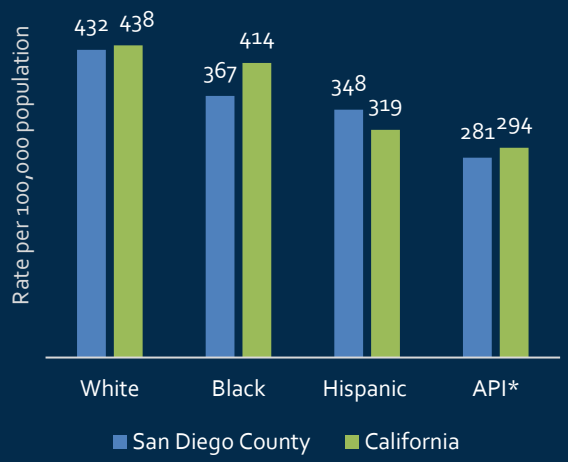
CANCER RATES IN SAN DIEGO COUNTY

Incidence Rates (2012-2016)[5]

The age-adjusted cancer (all-sites)incidence rates per 100,000:

San Diego County	399.9
California	393.6

Cancer Incidence Rates by Race/Ethnicity

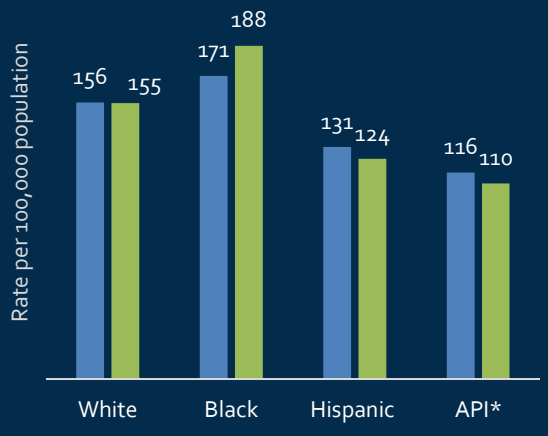


Mortality Rates (2012-2016)[6]

The age adjusted cancer (all-sites)mortality rates per 100,000:

San Diego County	148.3
California	144.6

Cancer Mortality Rates by Race/Ethnicity



*Asian/Pacific Islander

Disparities in the U.S.*

By Socioeconomic Status[1] (SES)

- Individuals with lower SES have higher cancer *mortality* rates than people with higher SES, regardless of factors such as race/ethnicity.

By Race/Ethnicity[1]

The overall cancer *incidence* (2011-2015) and *mortality* rates (2012-2016) for all race/ethnicities per 100,000 is 449.8 and 161.0 respectively.

- 465.3/165.4 for Non-Hispanic Whites
- 463.9/190.6 for Non-Hispanic Blacks
- 291.7/100.4 for Asian/Pacific Islanders
- 398.5/148.8 per American Indian/Alaska Natives
- 346.6/113.6 for Hispanic/Latinos

Non-Hispanic Blacks[4]

- Collectively, Black people have the highest *death* rates (2016)
- Black women have 21.5% higher cancer *mortality* rates than White women (2012-2016).
- *Mortality rates* from uterine/endometrial cancer for Black women is nearly double that of White women and is 40% higher for breast cancer (2012-2016).
- *Mortality rates* from prostate cancer for Black men are more than double those of every other group (2012-2016).
- Black men have the highest cancer *incidence* rates compared to all other racial/ethnic groups (2011-2015).
- Black people have the highest *incidence* rates of colorectal cancers of any racial/ethnic groups (2011-2015).

Hispanic/Latinos[1]

- Collectively, Hispanics have lower overall cancer *incidence* (2011-2015) and *mortality* rates (2012-2016)
- Hispanics have the highest *incidence* rates for cancers linked to infectious agents, like cervical, liver, and stomach cancer (2011-2015)

Asian/Pacific Islanders (API)[1]

- APIs have the lowest overall cancer *incidence* (2011-2015) and *mortality* rates (2012-2016)
- APIs have the highest rate of stomach cancer (2011-2015)

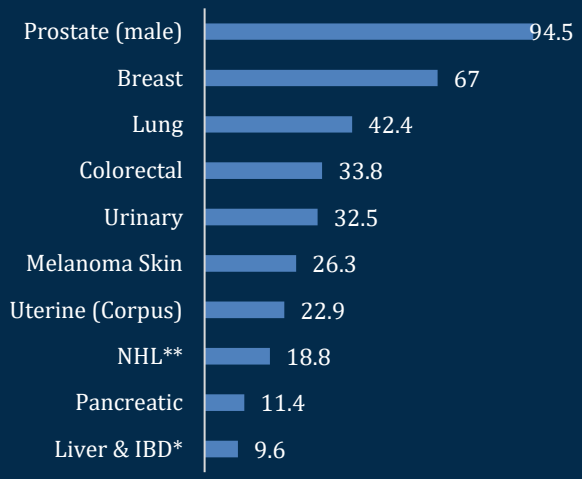
American Indian/Alaska Natives (AI/ANs)[1]

- AI/ANs have lower than average overall cancer *incidence* (2011-2015) and *mortality* rates (2012-2016)
- AI/ANs have the highest kidney cancer *incidence* (2011-2015) and *mortality* (2012-2016) rate of any population – nearly 3 times the rates among APIs.

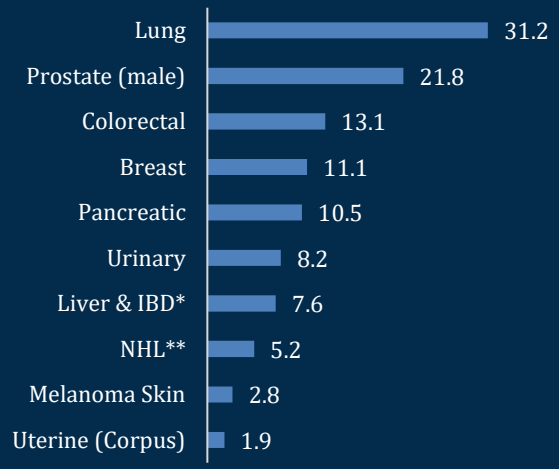
*Cancer **mortality (death) rates** are from years 2012-2016 unless otherwise specified.
Cancer **incidence rates** are from years 2011-2015

TOP CANCERS IN SAN DIEGO COUNTY

Cancer Incidence Rate by Site[5]



Cancer Mortality Rates by Site[6]



*Inflammatory Bowel Disease
**Non-Hodgkin Lymphoma

San Diego County Disparities

Incidence[5] (2012-2016)

The following table shows age-adjusted *incidence* rates per 100,000 for the top cancers in San Diego County, by race. Of note:

- Blacks have the highest rates of prostate, and colorectal cancer (followed closely by Whites).
- Hispanics have the highest rates of liver and intrahepatic bile duct cancer (followed closely by APIs) and pancreatic cancer (followed closely by Whites).

Site-Specific Cancer Age-Adjusted Incidence Rates in San Diego County by Race/Ethnicity (per 100,000)

	White	Black	Hispanic	API
Prostate	95.5	123.1	94.7	49.2
Breast	72.3	57.5	56.3	55.8
Lung	47.2	46.8	27.5	35.9
Colorectal	34.1	36.9	33.2	28.2
Urinary	35.3	31.3	29.5	16.8
Melanoma Skin	37.9	**	5.1	1.5
Uterine	23.6	15.1	19.9	21.4
Non-Hodgkin Lymphoma	19.8	13.4	19.3	12.8
Pancreatic	11.7	10.1	12.2	8.9
Liver & IBD*	6.8	11.4	15.8	12.2

Mortality[6] (2012-2016)

The following table shows age adjusted *mortality* rates per 100,000 for the top cancers in San Diego County by race. Of note:

- Black individuals have the highest *mortality* rates from breast, lung, and colorectal cancer.
- Hispanics have the highest *mortality* rates from liver and intrahepatic bile duct cancers, followed by Asian Pacific Islanders.

Site-Specific Cancer Mortality Age-Adjusted Rates in San Diego County by Race/Ethnicity (per 100,000)

	White	Black	Hispanic	API
Lung	34.6	39.3	18.6	26.7
Prostate	22.2	34.6	20.9	13.2
Colorectal	13.1	17.6	13.4	10.8
Breast	11.7	13.7	9.3	7.5
Pancreatic	10.8	10.1	10.4	8.5
Urinary	9.1	7.7	6.6	5.0
Liver & IBD*	5.6	8.3	12.0	10.9
Non-Hodgkin Lymphoma	5.3	4.9	4.9	4.6
Melanoma Skin	4	**	1.1	**
Uterine	1.8	**	2.0	**

*Inflammatory Bowel Disease
**Rates are too low to be statistically stable

CANCER MORTALITY BY REGION IN SAN DIEGO COUNTY

(per 100,000 population)

Cancer is the leading cause of death in San Diego County representing 24% of all underlying causes of death.[8]

Breast[7] (2016)

Female *mortality* rates were *highest* in La Mesa (62.9), Spring Valley (35.1), Santee (33.8) National City (33.3), and Elliott-Navajo (33.2) and *lowest* Vista (13.1), Sweetwater (16.3), Central San Diego (16.9), Southeastern San Diego (18.4), Chula Vista (18.5)

Lung[7] (2016)

Age-adjusted *mortality* rates were *highest* for Coronado (48.6), Lakeside (47.6), Pauma (46.8), Fallbrook (46.7), and Harbison Crest (42.9) and *lowest* for National City (11.5), San Dieguito (15.6), University (15.8), Coastal (19.5), and North San Diego (21.9)

Colorectal[7] (2016)

Age-adjusted *morality* rates were *highest* in Spring Valley (20.5), La Mesa (20.2), El Cajon (20.0), Vista (19.6), and Chula Vista (18.7) and *lowest* in San Dieguito (7.8), Poway (8.4), North San Diego (8.5), Peninsula (9.6), and Oceanside (10.1)

Liver[7] (2015)

Age-adjusted *mortality* rates were *highest* for National City (13.8), South Bay (13.7), Lemon Grove (13.6), Southeastern San Diego (12.0), and Oceanside (11.9) and *lowest* for Del Mar-Mira Mesa (3.2), North San Diego (4.7), Carlsbad (5.0), Coastal (5.2), Harvison Crest-El Cajon (5.4)

Prostate[7] (2016)

Male *mortality* rates were *highest* for Jamul (57.7), Valley Center (41.0), Spring Valley (39.9), Fallbrook (34.2), and Santee (32.6) and *lowest* for South Bay (9.9), Mid-City (10.5), Central San Diego (12.9), North San Diego (14.0), and Chula Vista (14.1)

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HOSPITAL ASSOCIATION
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Cardiovascular Disease

More than one-third of the U.S. adult population has cardiovascular disease (CVD)[1]

Cardiovascular disease refers to a set of conditions related to the heart and blood vessels, including: heart disease, heart attack, stroke, heart failure, arrhythmia, and heart valve problems.[2]

Cardiovascular Disease in the U.S.

- 836,000 people die from CVD annually while the annual financial burden from direct and indirect costs was $329.7 billion annually.[1] (2015)
- By 2035, more than 130 million adults, or 45.1%, are projected to have CVD with total costs expected to reach $1.1 trillion.[5]
- 36.6% of adults have been diagnosed with a CVD.[1] (2011-2014)

Heart Disease

- The most common CVD is **heart disease**, which occurs in 10.6% of adults and is the leading cause of death accounting for more than 647,000 deaths annually.[3,4] (2017)
  - **Coronary artery or coronary heart disease (CHD)** is the most common type of heart disease.[6]

Stroke

- **Stroke** affects 2.9% of the population and is the 5th leading cause of death, accounting for more than 146,000 deaths annually.[3,4] (2017)

Reducing the Risk of CVD

Seven health factors and behaviors can reduce the risk of developing and dying from CVD:[7]

1. Not smoking
2. Being physically active
3. Having normal blood pressure
4. Maintaining normal blood glucose levels
5. Having low total cholesterol levels
6. Maintaining a healthy weight
7. Eating a healthy diet

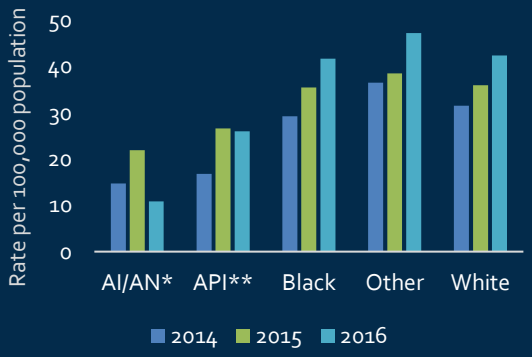
- Adults who meet at least six of these criteria reduce their risk of death from CVD by 76% compared to those who meet none.[8]
- Only 8.8% of Americans meet at least six of these criteria.[8]

CORONARY HEART DISEASE & STROKE IN SAN DIEGO COUNTY[9]

Coronary Heart Disease (CHD)

Emergency department (ED) discharge rates for CHD increased by 35.3% from 2014-2016. The steepest increases were for those ages 45-64 (41.9%) and Asian/Pacific Islanders (55.1%).

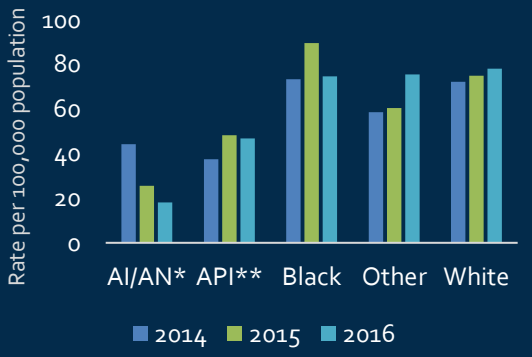
ED Discharge Rates for Coronary Heart Disease by Race



Stroke

ED discharge rates for stroke increased by 11% between 2014-2016. The steepest increases were for those ages 27-44 (20.1%) and for people who identify their races "Other" (28.9%).

ED Discharge Rates for Stroke by Race



*American Indian / Alaskan Native / Eskimo / Aleut
**Asian Pacific Islander

CVD Disparities in the U.S.[4] (2017)

CVD is more common among males, older adults, some minorities, people with lower educational and income levels, and people living in the Midwest and the South.

By Sex

- Males are more likely to have heart disease (11.8%), coronary heart disease (7.2%), hypertension (26.0%), and stroke (3.3%) compared to females (9.5%, 4.2%, and 2.5% respectively).

By Age

- **CVD** is more common with age. The prevalence among those 75 and older is highest (35% for heart disease; 23.8% for CHD; 59.8% for hypertension, and 12.0% for stroke), followed by those 65-74 (23.1% for heart disease; 14.0% for CHD; 53.7% for hypertension; and 6.4% for stroke).

By Race

Compared to **stroke** and **heart disease**, racial disparities are largest for **hypertension** among adults:

- 32.1% of Black/African Americans
- 30.6% of American Indians or Alaska Natives
- 28.2% of individuals of 2 or more races
- 23.5% of Whites
- 22.1% of Asians
- 21.1% of Hispanics

By Educational Levels

- **CVD** rate is lower among people with a bachelor's degree or higher compared to people with some college, a high school diploma or GED, or less than a high school diploma. Hypertension rates again offer the largest comparative difference with 22.7% of people with a bachelor's degree or more having hypertension compared to 32.3% of people with less than a high school diploma.

By Income

- People who are living below the federal poverty level (FPL) guidelines have higher rates of **heart disease** (12.6%), **CHD** (8.0%), **hypertension** (29.4), and **stroke** (5.8%) compared to those with an income above the FPL (10.3%, 5.0%, 22.9%, and 2.2% respectively).

By Region

- The largest regional disparities are for **hypertension**: 26.8% of people living in the South and 25.9% of people living in the Midwest have hypertension, compared to 22.1% of people living in the West, and 21.3% of people living in the Northeast.

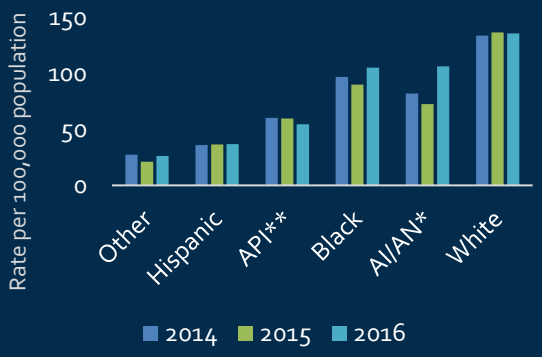
CHD & STROKE MORTALITY IN SAN DIEGO COUNTY[10]

Mortality Rates for CHD (2016)

Mortality **(death)** rates for CHD were higher for males (102.5) compared to females (75.0), and for people 65+ (559.3) compared to those ages 45-64 (59.5).

The overall mortality rate attributed to **CHD** decreased by 3.5% from 2014-2016. However, Black (8.7%) and American Indian/Alaska Native (29.4%) individuals experienced an increase in rates.

Mortality Rates for Coronary Heart Disease by Race/Ethnicity

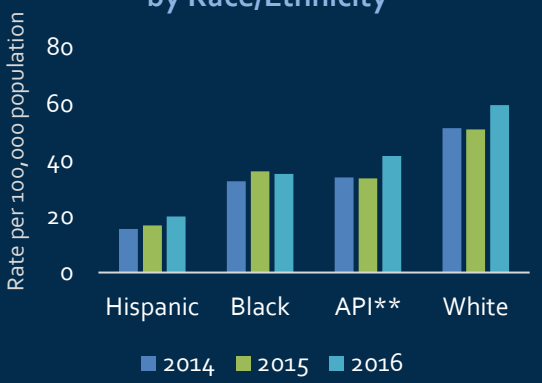


Mortality Rates for Stroke (2016)

Mortality rates for **stroke** are higher for females (47.9) compared to males (35.0) and for people 65 years and older (276.4) compared to those ages 45-64 (144.0).

Deaths attributed to stroke increased by 17.6% from 2014-2016 -- most substantially for Hispanics (28.5%).

Mortality Rates for Stroke by Race/Ethnicity



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**Asian Pacific Islander

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Diabetes Mellitus

More than 30 million Americans suffer from this chronic disease[1]

Diabetes is a set of diseases that affect the way the body metabolizes sugar (glucose). The three primary types of diabetes are: ***Type 2*** (the most common type), ***Type 1***, and ***gestational*** (occurring during pregnancy).

Diabetes has a significant impact on morbidity and mortality[1] and has an economic burden of approximately $245 billion in the United States.[2]

Diabetes in the U.S.

- Approximately 9.7% of adults have a diabetes diagnosis.[3] (2016-2017)
- Among those with diabetes, 91.2% have ***type 2*** diabetes and 5.6% have **type 1**.[3] (2016-2017)
- 132,000 youth younger than 18 years old have diabetes.[1] (2013-2015)
- **Type 2** diabetes is more common among adults 65+, males, those with higher body mass index, Asian-Americans, those with lower family incomes, and lower educational levels.[3] (2016-2017)
- The age adjusted *death rate* for diabetes in the U.S. is 21.5 per 100, 000.[5] (2016)
- Diabetes is the 7th leading cause of *mortality* in the U.S., and the 5th leading cause of death for those 55-64 years old.[4] (2017)
- The number of adults diagnosed with diabetes in the U.S. has more than tripled in the last 20 years.[6] (2017)

Risk Factors

According to the CDC, the following are risk factors for developing diabetes:[1]

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

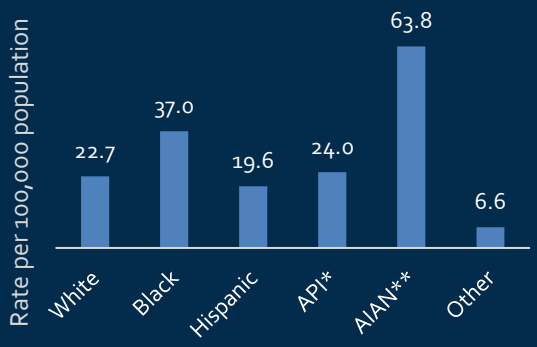
DIABETES IN SAN DIEGO COUNTY

9.4% of adults have diabetes; lower than the state rate of 10.7%[7] (2017)

Mortality

- In 2017, diabetes was the 7th leading cause of death in San Diego County.[8]
- The age-adjusted *death rate* for diabetes was 20.7 per 100,000 population.[9] (2016)
- American Indian and Alaska Natives have the highest diabetes *death rate*, 63.8 compared to the unadjusted county rate of 22.3 per 100,000.[9] (2016)

Mortality Rate for Diabetes by Race/Ethnicity, 2016



Opportunities for Prevention:[11]

- 97% of the population lives in close proximity to a park or recreational facility, an indicator of strong "exercise opportunities".
- San Diego receives an 8.3/10 on the "Food Environment Index (2015/2016)," a measure of affordable, close, and nutritious food retailers. This exceeds the national benchmark of 7.4.

*Asian Pacific Islander
**American Indian / Alaskan Native / Eskimo / Aleut

Diabetes in San Diego: Disparities and Risk

Disparities in Diabetes

Emergency department (ED) discharge rates for **diabetes** remained fairly stable from 2014-2016, but disparities are apparent:[10]

- *ED discharge* rates are highest for those 65 and older and for Black individuals
- Increases in discharge rates occurred for those 27-44 years old and for Asian/Pacific Islander and Blacks

Inpatient discharges for **gestational diabetes** are decreasing, but disparities are evident here as well:[10]

- Asian/Pacific Islanders and those who identify their race as "Other" are disproportionally impacted by gestational diabetes

Most San Diegans manage their diabetes well, but disparities are also seen in these data:[12] (2015)

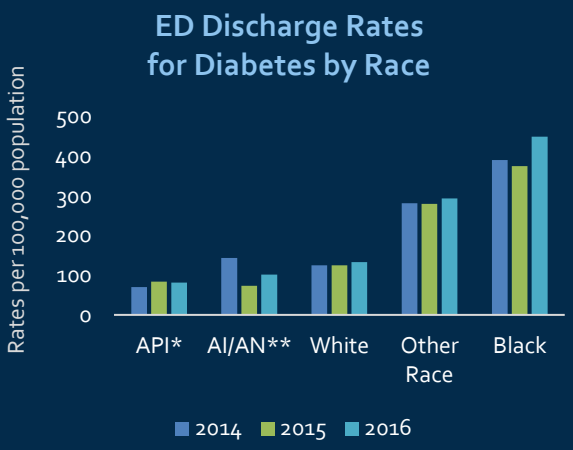
- 81.2% of Medicare patients with diabetes have had a hemoglobin A1c blood sugar test by a health care professional in the past year
- This rate is 5.2% lower for Black individuals than for White individuals

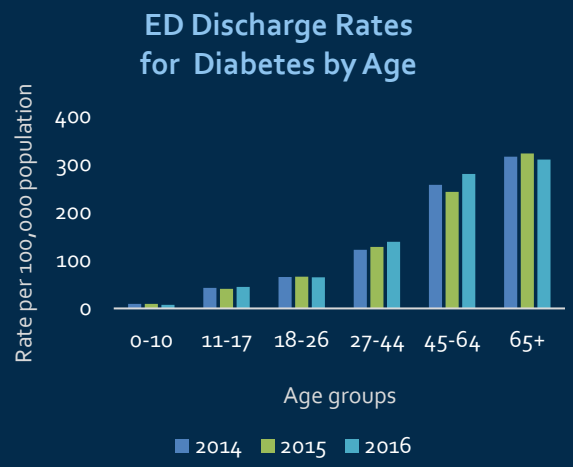
Risk Factors for Diabetes in San Diego County

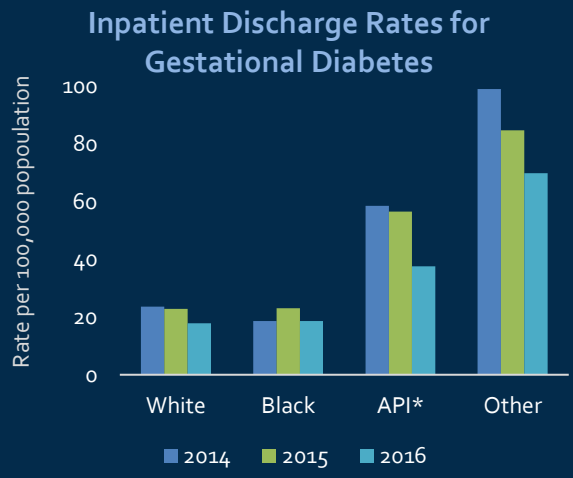
Relative to state averages, San Diego has a lower proportion of people with risk factors for diabetes.[7] (2017)

- While 22.5% of adults in San Diego are **obese**, this is lower than the California rate of 26.4%.
- San Diego children (5-11 years old) have higher rates of at least one hour a day of **physical activity**, each day of the week (33.6%) than the California average (31.2%).
- Among adults in San Diego, 20.4% have at least 20 minutes of **physical activity** each day of the week, similar to the state average of 20.%.
- Rates of **smoking** (10.2%) are the same in San Diego and across California.

HOSPITAL DISCHARGES FOR DIABETES IN SAN DIEGO COUNTY[10]







*Asian Pacific Islander
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Economic Security[1]

39.7 million people in the U.S. live in poverty (2017)

Federal poverty level (FPL) is a measure of income that varies according to the size of a family and are updated each year. For 2019, the poverty guidelines range up to $12, 490 for a 1-person household, to $25, 750 for a 4-person household, and up to $43, 430 for an 8-person household.[2]

Poverty in the U.S.[1] (2017)

- The U.S. poverty rate in 2017 was 12.3%.

By Age

Poverty rates are highest for the youngest individuals:

- 17.5% for those under 18
- 11.2% for those 18-64
- 9.2% for those 65 and older

By Race

Poverty rates are highest for Black and Hispanic individuals:

- 21.2% for Black individuals
- 18.3% for Hispanic individuals
- 10.7% for White individuals
- 10.0% for Asian individuals

By Region

People in the Southern U.S. have the highest poverty rates:

- 13.6% in the South
- 11.8% in the West
- 11.4% in the Midwest
- 11.4% in the Northeast

By Educational Attainment

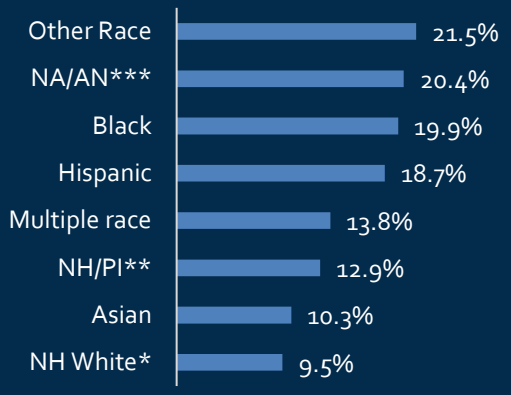
Among people 25 years old and older, less education is associated with higher poverty rates:

- 24.5% for those with no high school diploma
- 12.7% for those with a high school diploma, but no college
- 8.8% for those with some college, but no degree
- 4.8% for those with a Bachelor's degree or higher

POVERTY IN SAN DIEGO COUNTY

In San Diego, residents belonging to minority ethnic groups are disproportionately affected by poverty.[3]

Population Below Poverty Level in San Diego County[3], 2013-2017



*non-Hispanic White, **Native Hawaiian & Pacific Islander, ***Native American & Alaskan Native

San Diegans are struggling:

- In 2017, 13.3% lived below the federal poverty guidelines, which is a decrease since 2013.[3] (5 year estimates compared)
- The per capita income is $34,350.[3] (2013-2017)
- 17.1% of all children live below the federal poverty level.[3] (2013-2017)
- 33% of working age families can not cover their basic expenses.[4] (2015)

Unemployment in San Diego County

In 2018, the overall unemployment rate in San Diego is 3.3%, which is a 48% decrease since 2014 (6.4%).[5]

Food insecurity in the U.S.[6]

40 million Americans do not have enough to eat

Food-insecure households face challenges providing enough food for all members of the household to have an active, healthy life. Households with **very low food *security*** are those in which the food intake of at least one member is reduced and normal eating patterns are disrupted due to limited resources.

Food Insecure Households in the U.S. (2017)

- 11.8% of households – nearly 1 in 8 - are *food insecure*
- 4.5% of households have *very low food security*

By Household Composition

Food insecurity is highest for households with young children:

- 15.7% of households with children
- 16.4% of household with children less than six years old
- 13.9% of adult women who live alone
- 13.4% of men who live alone
- 8.6% of seniors who live alone
- 7.7% of households with no children and more than one adult

By Race/Ethnicity

Minority households have higher rates of food insecurity:

- 21.8% of Black households
- 18% of Hispanic households
- 9.9% of households who identify as "other"
- 8.8% of White households

By Region

People living in the Southern regions of the US have the highest rates of food insecurity:

- 13.4% of households in the South
- 11.7% of households in the Midwest
- 10.7% of households in the West
- 9.9% of households in the Northeast

ECONOMIC INSECURITY IN SAN DIEGO COUNTY

Housing (2013-2017)

- The median gross rent was $1, 467 per month[3]
- 46.7% of San Diegans who rent their homes spend 35% or more of their household income on rent[3]

Childcare (2016)

- The average monthly cost of childcare in San Diego in 2016 was between $620 and $1,293[8]

Food insecurity

- 14% of people experience food insecurity, more than 1 in 7[7] (2016)
- 22% of children are in food insecure households, more than 1 in 5[7](2016)
- 7.2% of San Diegans receive Supplemental Nutrition Assistance Program (SNAP) Benefits[3] (2013-2017)

Health impacts of food insecurity

Lower incomes are associated with:[9]

- Poor mental health days
- Visits to the ED for heart attacks
- Asthma
- Obesity
- Diabetes
- Stroke
- Cancer
- Smoking
- Pedestrian Injury

Food insecurity is linked to:[10]

- Fair or poor health, anemia, and asthma in *children*
- Mental health problems, diabetes, hypertension, hyperlipidemia, and oral health problems in *adults*
- Fair or poor health, depression, and limitations in activities of daily living in *seniors*

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Homelessness & Housing Instability

553,000 people in the U.S. are homeless[1], 1.3 million people live in severely inadequate housing[2], and 8.3 million households have "worst case housing needs"[4]

Homelessness is when a person does not have a fixed, regular, and adequate nighttime residence.[1] **Housing problems** include a lack of full kitchen or plumbing facilities, a household comprised of more than one person per room, or a housing cost burden of more than 30% of the household income. **Severe housing problems** include a lack of full kitchen or plumbing facilities, severe overcrowding, or a housing cost burden of [4] Health outcomes are strongly influenced by the stability, quality, safety and affordability of housing.[5]

Homelessness in the U.S.[1,*] (2018)

From 2010-2018, rates of homelessness fell by 13.2% nationwide.

By Sex

- 60.2% of the nation's homeless population are male; 39.1% are female; 0.5% are transgender, and 0.2% are gender non-conforming

By Age

- A fifth (20.2%) of the homeless population is comprised of children, while 8.7% are 18-24, and 71.1% are over 24

By Race/Ethnicity

Race	%
White	48.9%
Black	39.8%
Multiple races	5.9%
Native American	2.8%
Pacific Islander	1.5%
Asian	1.2%

Ethnicity	%
Hispanic/Latino	22.2%

By Sheltered Status

- 65% of people who experience homelessness stay in sheltered locations, while 35% are unsheltered

In California (2018)

- California has the highest rates of unsheltered homeless (68.9% of the homeless population) and the largest number of homeless unaccompanied youth (12,396)

*Data is from the Point-in-Time Count that takes place one morning in late January where volunteers and outreach workers engage and survey those experiencing homelessness.

HOMELESSNESS IN SAN DIEGO COUNTY, POINT-IN-TIME COUNT[6]

8,576 individuals are homeless in San Diego on any given night (2018)

- The number of homeless decreased by 6% between 2017-2018 and 3.4% since 2013

Sheltered and unsheltered (2018)

- 3,586 (41.8%) are sheltered, and 4,990 (58.2%) are unsheltered
- 54.3% of **sheltered** homeless individuals are sheltered in an emergency shelter; 43.9% are in transitional housing; 1.8% are in a safe haven
- 50% of **unsheltered** homeless sleep on the street/sidewalk; 18% sleep in a vehicle; 14% sleep in a park; 5% sleep in a hand-built structure or tent

Health conditions among unsheltered

- 43% report having a chronic health condition
- 43% report instances of mental health issues
- 43% report having a physical disability

Length of time among unsheltered

- More than half of those who become homeless remain homeless for longer than one year

Demographics among unsheltered respondents

- 70% have been in jail, prison, or juvenile hall
- 13.3% are veterans
- 13.2% are youth under the age of 24

The American Hospital Association describes housing instability as an umbrella term for the continuum between homelessness and completely stable, secure housing.

***Housing instability** takes on many forms: physical conditions like poor sanitation, heating and cooling; compromised structural integrity; exposure to allergens or pests; homelessness; and unstable access to housing or severe rent burden.[8]*

Severely Inadequate Housing in the U.S.[2] (2017)

1,348,000 households have ***severely inadequate housing*** conditions; an additional 4,648,000 households have ***moderately inadequate*** conditions

- 3,267,000 have exposed wiring
- 938,000 have inadequate heating capacity
- 3,602,000 have had water stoppages in the last three months
- 1,391,000 have had sewage disposal breakdowns in the last three months
- 3,775,000 have mold

Worst Case Housing Needs[4] (2015)

The number of households that have ***worst case needs*** has increased by 41% since 2007

- 98.2% of ***worst case needs*** renters have severe rent burdens, paying one half or more of their income for rent.

By Race/Ethnicity

Among all renters, the percent who have ***worse case housing*** needs:

- 45.5% of non-Hispanic Whites
- 25.3% of Hispanics
- 21.7% of non-Hispanic Blacks
- 7.5% of renters of other races and ethnicities

By Household Composition

Among the households with ***worst case needs***:

- 34.8% are families with children
- 33.2% are single adults with roommates
- 22.3% are elderly households
- 9.7% are "other family" households

Health Impacts[5]

- People who are ***chronically homeless*** have higher rates of physical and mental health problems, higher health care expenditures, and higher rates of premature mortality
- People who are ***unstably housed*** (who move frequently, fall behind on rent and/or "couch surf") are more likely to experience poor health. Among youth, ***housing instability*** is associated with a higher risk of teen pregnancy, substance abuse, and depression
- ***Homelessness and residential instability*** make the proper storage of medications challenging or impossible, impacting the management of illness and chronic disease
- ***Substandard housing conditions*** are linked to poor health outcomes, including asthma and cardiovascular events
- ***Crowded housing*** is associated with infections disease and psychological distress
- ***Cost burdened households*** are less likely to have a primary care provider and to postpone needed medical treatment
- ***Cost burdened households*** are also more likely to face food insecurity

HOUSING INSTABILITY IN SAN DIEGO COUNTY

Rental and owner-occupied units

- The median gross rent is $1, 467 per month[7] (2013-2017)
- The median value of owner-occupied housing units is $484,900[7] (2013-2017)
- 52.9% of households are owned, while 47.1% are rented[3] (2011-2015)
- 8.3% of households that are owned have an income of less than 30% of the average median family income, while 33.7% of households that are rented have incomes of that level[3] (2011-2015)

Cost burden[3] (2011-2015)

- 42.7% of San Diegans have *cost **burdened housing***—spending more than 30% of their income on housing
- 20.0% of San Diegans have ***severely cost burdened*** housing—spending more than 50% of their income on housing
- The lowest-income families have the highest rates of severely cost burdened housing—47.4% of families with incomes 30% or less of the median family income in the County are severely cost burdened

Housing problems[3] (2011-2015)

- 46.0% of San Diegans have housing problems: their household lacks full kitchen or plumbing facilities, has more than 1 person per room, or is cost burdened
- 25.2% of San Diegans have severe housing problems: their household lacks full kitchen or plumbing facilities, is severely overcrowded (more than 2 people per room), or is severely cost burdened

Sources: Homelessness & Housing Instability

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HOSPITAL ASSOCIATION
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Unintentional Injury and Violence

More than 243,000 people died from injury and violence in 2017[4]

In the first half of life (44 years), more Americans die from violence and injuries than from any other cause. In addition, for every person who dies from injury or violence, another 13 are hospitalized and 129 are treated in an emergency room. Those who survive may be faced with life-long mental, physical, and financial problems.[1]

Unintentional Injuries in the U.S. (2017)

- Unintentional injury is the third leading cause of death in the U.S. overall and is the first leading cause of death among persons 1-44.[2,3]
- Unintentional Injury accounts for 93.2% nonfatal injuries and 69.9% fatal injuries.[4]

By Sex:

Unintentional injuries are more common among males:

- Males are 2.1 times more likely die from an unintentional injury than females (67.7 vs 31.9 per 100,000)[4]
- Males are 1.2 times more likely to be involved in a non-fatal unintentional injury than female[5]

By Age:

Older people (65+ years) have the highest mortality rate from unintentional injury:[4]

- 374.9 per 100,000 among people 85+
- 152.4 per 100,000 among people 80-84
- 86.6 per 100,000 among people 75-79

Older people also have the highest nonfatal unintentional injury rate:[5]

- 19,833.3 per 100,000 among people 85+
- 12,656.8 per 100,000 among people 80-84
- 10,883.7 per 100,000 among people 20-24

By Race and Ethnicity:

Native Americans have the highest fatality from unintentional injury:[4]

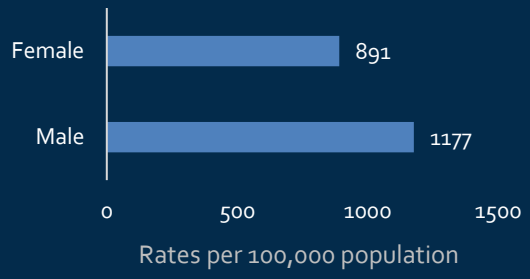
- 86.4 per 100,000 for Non-Hispanic Native American
- 56.1 per 100,000 for Non-Hispanic White
- 47.4 per 100,000 for Non-Hispanic Black

UNINTENTIONAL INJURY IN SAN DIEGO COUNTY[6] (2016)

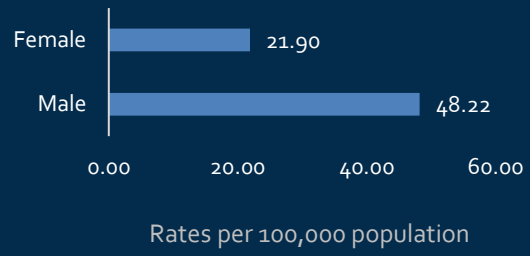
San Diegan males are:

- 2.2 times more likely to die from an unintentional injury than female (48.2 vs 21.9 per 100,000).
- 1.3 times more likely to be hospitalized from an unintentional injury than female (1177 vs 891 per 100,000).

Inpatient Discharge Rates by Sex, 2016



Emergency Department Discharge Rates by Sex, 2016



*Per the Healthy People 2020, "**unintentional injuries and violence-related injuries** can be caused by a number of events, such as motor vehicle crashes and physical assault, and can occur virtually anywhere."*[7]

***Unintentional injuries** include motor vehicle accidents, falls, firearms, fire/flame, drowning, poisoning, machinery, suffocation, etc.*[4]

Unintentional Injury in Youth (under 18 years) in the U.S.[4] (2017)

More than 5,700 youth died from an unintentional injury in 2017 (7.7 per 100,000)

By Type of Injury:

- 39.7% are due to motor vehicle
- 22.9% due to suffocation
- 14.2% due to drowning

By Race/Ethnicity

- 16.8 per 100,000 for Non-Hispanic Native American
- 12.5 per 100,000 for Non-Hispanic Blacks
- 7.7 per 100,000 for Non-Hispanic White

Unintentional Injury in San Diego County

By Age:

- **Older San Diegans** 65 years and older have the highest death and emergency department (ED) discharge rate from unintentional injury (97.1 and 7,698 respectively).[6]
- **Youth aged 0-14** are impacted by ED discharges for unintentional injury with a rate of 6,781 per 100,000.[6]
- The leading causes of ED discharge for an unintentional injury in 2018 (**1-14 years**):[8]
    1. 18,072 falls
    2. 8,029 struck by object
    3. 1,999 natural/environmental
    4. 2,452 motor vehicle
    5. 1,318 cut/pierce

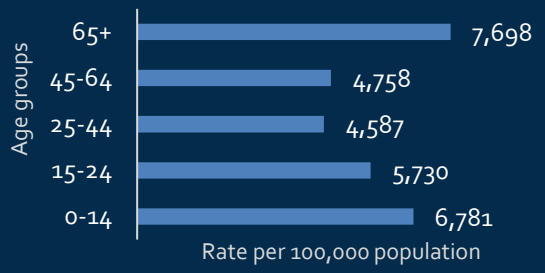
By Race and Ethnicity:[6]

In San Diego, residents belonging to minority groups are disproportionately affected by unintentional injury.

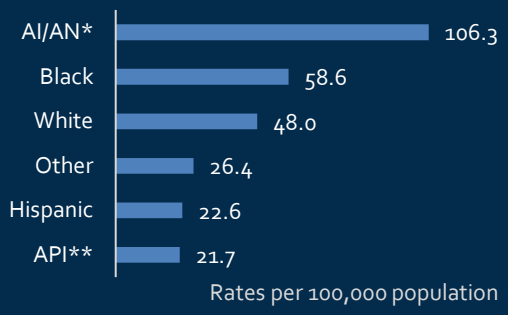
- Those who identify as "Other" have the highest ED discharge rate (12,151 per 100,000) followed by Blacks (8,792 per 100,000) and Whites (5,583 per 100,000).
- Black individuals have the second highest mortality and ED discharge rate compared to all other race/ethnicities (58.6 and. 8,792 per 100,000).
- American Indian and Alaska Natives have the highest mortality rates for unintentional injury, however they have the second lowest ED discharge rate (106.3 and 3,705 per 100,000 respectively)

UNINTENTIONAL INJURY IN SAN DIEGO COUNTY[6] (2016)

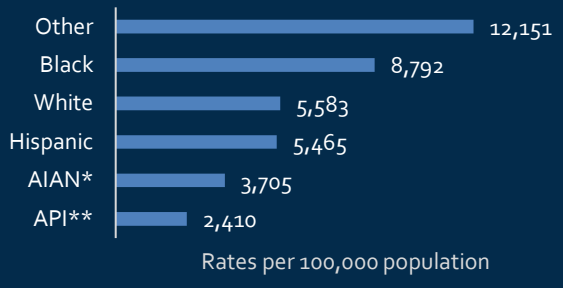
ED Discharge Rates for Unintentional Injury by Age Groups, 2016



Mortality Rates for Unintentional Injury by Race/Ethnicity, 2016



ED Discharge Rates for Unintentional Injury by Race/Ethnicity, 2016



*American Indian & Alaska Native
**Asian & Pacific Islander

Motor Vehicle Injuries

More than 37,000 people died from motor vehicle injuries in 2017 in the U.S.[9]

The total estimated lifetime medical and work-loss cost associated with motor vehicle injuries in the U.S.is more than $63 billion.[12]

Motor Vehicle Injuries in the U.S.[9] (2017)

- More than 2.7 million people were seen in the ED due to motor vehicle-related injuries in 2017.
- In 2017, the fatality rate was 11.4 per 100,000, while the injury rate was 843 per 100,000 population.
- Among all fatalities, 29.3% were due to drunk driving (Blood alcohol concentration (BAC) of 0.08 g/dL or higher) while 26.2% were due to speeding.
- More than two-thirds (70.2%) of the pedestrians killed in traffic crashes were males.
- Pedestrians 75 and older have the highest fatality rate (2.7 per 100,000) while pedestrians ages 16-20 have the highest injury rate (37.6 per 100,000).

By Sex

- Males account for 71.1% of all fatalities due to motor vehicle injuries.

By Age

Drivers 15-20 (younger) and 65+ (older) are mostly impacted:

- Although *younger drivers* account for 5.4% of total licensed drivers, they are involved in 8.4% of fatal crashes.
- Among *younger drivers*, the rate of fatal crashes for males was 2.3 times greater than that of female drivers.
- *Younger drivers* were speeding or driving drunk at the time of fatal crashes more than all other age groups.
- Among *older drivers*, the rate of fatal crashes with male drivers was 2.6 times greater than that of female drivers.
- Among *older drivers*, the rate of involvement in fatal crashes increases as age increases.

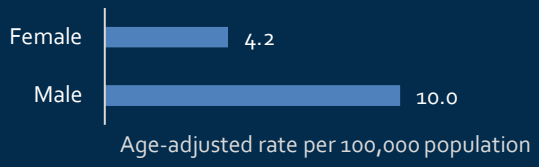
By Race/Ethnicity

- American Indian/Alaska native (AI/AN) adults are 1.5 times more likely to die in a crash than White or Black adults.

MOTOR VEHICLE INJURIES IN SAN DIEGO COUNTY[6] (2016)

In San Diego, males experience more injuries related to motor vehicles than females:

Mortality Rates for Motor Vehicle Injury by Sex, 2016



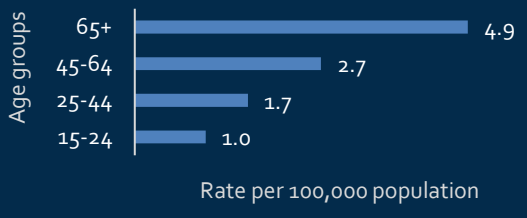
Motor vehicle injury mortality (death) rate per 100,000 among San Diego residents:

- Individuals who identify as **AI/AN** have the highest death rate (35.4), followed by **Black** individuals (11.5).
- Those **65+** have the highest death rate (12.3), followed by those 15-24 (8.8).

Motor vehicle injury inpatient discharge rate per 100,000 among San Diego residents:

- **Blacks** have the highest inpatient discharge rate (132.5), followed by American Indian & Alaska Native (92.1).
- Those **15-24** have the highest inpatient discharge rate (105.1), followed by those 65+ (99.2)

Mortality Rates for Pedestrian Death Due to Motor Vehicle Injuries by Age, 2016



Crime in the U.S.

Property crime is currently the biggest criminal issue

In 2017, the estimated number of violent crime offenses was 1,247,321, a decrease of 0.2 percent from the 2016 estimate. [10]

Violent Crimes in the U.S.[11] (2017)

- Aggravated assault accounted for 65% of reported violent crimes, followed by robbery (25.6%), rape (8.0%), and murder (1.4%).
- Firearms were used in 72.6% of the nation's murders, 40.6% robberies, and 26.3% of aggravated assaults.

Homicide:

Both murder victims and offenders were more likely to be:

- Black (victims: 53.7%) (offenders: 54.2%)
- Male (victims: 78.6%) (offenders: 88.1%)
- 20-29 years old (victims: 32.6%) (offenders: 39.9%)

Property Crimes in the U.S.[11] (2017)

- In 2017, the rate of property crime was 2362.2 per 100,000, a 3.6% decrease from 2016.
- Losses were estimated at $15.3 billion in 2017 with only 29.2% of stolen properties recovered.
- Larceny-theft accounted for 71.7% of all property crimes, followed by burglary (18.2%), and motor vehicle theft (10.0%).

VIOLENT CRIMES IN SAN DIEGO COUNTY[6] (2016)

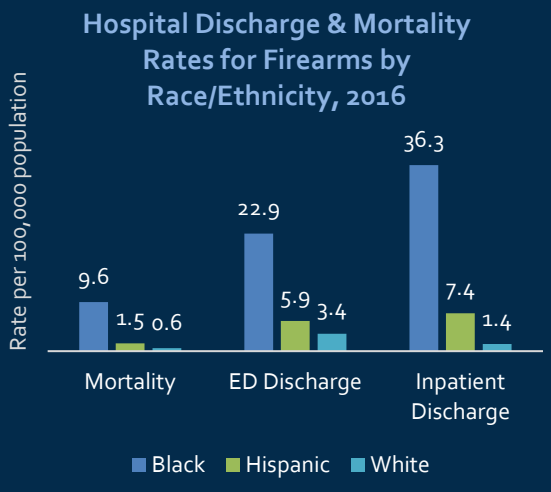
In San Diego, crime rates have increased slightly since 2014:[13]

For crimes involving assault:[6]

- **Males** are 3.2 times more likely to die and 4.9 more likely to be hospitalized than females.
- **Blacks** have the highest death (17.2 per 100,000), ED discharge (700.3 per 100,000), and inpatient discharge rates (109.0 per 100,000)..
- Those **15-24** have the highest death (4.6 per 100,000), and hospital discharge rates (**ED**: 416.8 per 100,000, **inpatient**: 47.2 per 100,000).

For crimes involving a firearm:[6]

- **Males** are 3.5 times more likely to die and 9.3 times more likely to be hospitalized than females.
- **Blacks** are 16.2 times more likely to die and 26.3 times more likely to be hospitalized than Whites.
- Those **15-24** have the highest death (2.9 per 100,000) and hospital discharge rates (**ED**: 13.4 per 100,000, **inpatient**: 10.2 per 100,000).



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Appendix

A SGH Programs and Services

- 24-hour emergency room and critical care center, with heliport and paramedic base station — designated STEMI Center
- Acute care
- Ambulatory Care Center
- Behavioral health services, including inpatient and hospital-based outpatient programs
- Brier Patch Outpatient Nutrition Counseling Program
- Burr Heart & Vascular Center with bi-plane, electrophysiology and standard cardiac catheterization labs, as well as hybrid operating rooms and endovascular and cardiothoracic surgery suites
- Cardiac Training Center
- Care Clinic, for minor medical needs
- Care Partner Program
- Care Transitions Intervention program
- Clinical trials in oncology, heart and vascular, neurology and orthopedics
- David and Donna Long Center for Cancer Treatment, including genetic counseling, radiation therapy, chemotherapy and medical oncology
- Endoscopy
- Grossmont Medical Plaza Outpatient Surgery Center
- Home health, including home infusion services[38]
- Hospice[39], including BonitaView, LakeView and ParkView hospice homes
- Intensive Care Unit
- Level III Neonatal Intensive Care Unit
- Minimally invasive surgery, including the da Vinci robotic surgical system and the Mako robotic-arm assisted surgery system
- Orthopedics, including total joint replacement surgery
- Outpatient diabetes services, recognized by the ADA
- Outpatient Infusion Center
- Palliative care services
- Pathology services
- Pediatric services[40]
- Pharmacy services
- Post-Anesthesia Care Unit
- Pre-Anesthesia Evaluation Services
- Pulmonary services
- Radiology and diagnostic imaging, including biopsies, fluoroscopy/digital and interventional radiology, computed tomography scan, positron emission

[38] Provided through Sharp Memorial Hospital Home Health Agency
[39] Provided through Sharp HospiceCare
[40] Inpatient services are provided through an affiliation with Rady Children's Hospital

tomography scan, digital mammography, magnetic resonance imaging, ultrasound and DEXA bone density scan
- Rehabilitation services (inpatient and outpatient)
- Senior Resource Center
- Skilled nursing facility/Transitional Care Unit
- Sleep Disorders Center
- Spiritual care services
- Stroke Center — nationally recognized by the American Heart Association/American Stroke Association
- Surgical Intensive Care Unit
- Surgical services
- Therapy Pet Program
- Van transportation services
- Women's Health Center, offering a full range of pregnancy, delivery, gynecologic and women's reproductive services
- Wound Healing Center, including hyperbaric medicine

Appendix

B An Overview of Sharp HealthCare

FOUR ACUTE CARE HOSPITALS:

Sharp Chula Vista Medical Center (343 licensed beds)

The largest provider of health care services in SDC's fast-growing South Bay, Sharp Chula Vista Medical Center (SCVMC) operates the region's busiest emergency department (ED) and is the closest hospital to the busiest international border in the world. SCVMC is home to the region's most comprehensive heart program, services for orthopedic care, cancer treatment, women's and infant's services, and the only bloodless medicine and surgery center in SDC.

Sharp Coronado Hospital and Healthcare Center (181 licensed beds)

Sharp Coronado Hospital and Healthcare Center (SCHHC) provides services that include acute, subacute and long-term care, liver care, rehabilitation therapies, orthopedics, and hospice and emergency services.

Sharp Grossmont Hospital (524 licensed beds)

Sharp Grossmont Hospital (SGH) is the largest provider of health care services in San Diego's East County and has one of the busiest EDs in SDC. SGH is known for outstanding programs in heart care, oncology, orthopedics, rehabilitation, stroke care and women's health.

Sharp Memorial Hospital (656 licensed beds)

A regional tertiary care leader, Sharp Memorial Hospital (SMH) provides specialized care in cancer treatment, orthopedics, organ transplantation, bariatric surgery, heart care and rehabilitation. SMH also houses the county's largest emergency and trauma center.

THREE SPECIALTY CARE HOSPITALS:

Sharp Mary Birch Hospital for Women & Newborns (206 licensed beds)

A freestanding women's hospital specializing in labor and delivery services, high-risk pregnancy, obstetrics, gynecology, gynecologic oncology and neonatal intensive care, Sharp Mary Birch Hospital for Women & Newborns (SMBHWN) delivers more babies than any other hospital in California.

Sharp Mesa Vista Hospital (158 licensed beds)

As the most comprehensive mental health hospital in San Diego, Sharp Mesa Vista Hospital (SMV) provides behavioral health services to treat anxiety,

depression, substance abuse, eating disorders, bipolar disorder and more for patients of all ages.

Sharp McDonald Center (16 licensed beds)[41]

Sharp McDonald Center (SMC) is the only medically supervised substance abuse recovery center in SDC. Offering the most comprehensive hospital-based treatment program in San Diego, SMC provides services such as addiction treatment, medically supervised detoxification and rehabilitation, day treatment, outpatient and inpatient programs, and aftercare.

Collectively, the operations of SMH, SMBHWN, SMV and SMC are reported under the not-for-profit public benefit corporation of SMH and are referred to as the Sharp Metropolitan Medical Campus. The operations of Sharp Rees-Stealy Medical Centers (SRSMC) are included under the not-for-profit public benefit corporation of Sharp, the parent organization. The operations of SGH are reported under the not-for-profit public benefit corporation of Grossmont Hospital Corporation. The operations of Sharp HospiceCare are reported under SGH.

Please refer to **Appendix V** for a map of Sharp HealthCare locations in SDC.

Mission Statement

It is Sharp's mission to improve the health of those it serves with a commitment to excellence in all that it does. Sharp's goal is to offer quality care and services that set community standards, exceed patients' expectations and are provided in a caring, convenient, cost-effective and accessible manner.

Vision

Sharp's vision is to become the best health system in the universe. Sharp will attain this position by transforming the health care experience through a culture of caring, quality, safety, service, innovation and excellence. Sharp will be recognized by employees, physicians, patients and families, volunteers and the community as the best place to work, the best place to practice medicine and the best place to receive care. Sharp will be known as an excellent community citizen embodying an organization of people working together to do the right thing every day to improve the health of those it serves.

Values

- Integrity
    - Trustworthy, Respectful, Sincere, Authentic, Committed to Organizational Mission and Values
- Caring

[41] As a licensed chemical dependency recovery hospital, SMC is not required to file a community benefit plan. However, SMC is committed to community programs and services and has presented community benefit information in Section 11: SMV and SMC.

    - Compassionate, Communicative, Service-Oriented, Dedicated to Teamwork and Collaboration, Serves Others Above Self, Celebrates Wins, Embraces Diversity
- Safety
    - Reliable, Competent, Inquiring, Unwavering, Resilient, Transparent, Sound Decision Maker
- Innovation
    - Creative, Drives for Continuous Improvement, Initiates Breakthroughs, Develops Self, Willing to Accept New Ideas and Change
- Excellence
    - Quality-Focused, Compelled by Operational and Service Excellence, Cost Effective, Accountable

Culture: The Sharp Experience

For more than 19 years, Sharp has been on a journey to transform the health care experience for patients and their families, physicians and staff. Through a sweeping organization-wide performance-and-experience-improvement initiative called The Sharp Experience*,* the entire Sharp team has recommitted to purposeful, worthwhile work and creating the kind of health care people want and deserve. This work has added discipline and focus to every part of the organization, helping to make Sharp one of the nation's top-ranked health care systems. Sharp is San Diego's health care leader because it remains focused on the most important element of the health care equation: the people.

Supported by its extraordinary culture, Sharp is transforming the health care experience in San Diego by striving to be:

- *The best place to work*: Attracting and retaining highly skilled and passionate staff members who are focused on providing quality health care and building a culture of teamwork, recognition, celebration, and professional and personal growth. This commitment to serving patients and supporting one another will make Sharp "the best health system in the universe."

- *The best place to practice medicine*: Creating an environment in which physicians enjoy positive, collaborative relationships with nurses and other caregivers; experience unsurpassed service as valued customers; have access to state-of-the-art equipment and cutting-edge technology; and enjoy the camaraderie of the highest-caliber medical staff at San Diego's health care leader.

- *The best place to receive care*: Providing a new standard of service in the health care industry, much like that of a five-star hotel; employing service-oriented individuals who see it as their privilege to exceed the expectations of every patient—treating them with the utmost care, compassion and respect; and creating healing environments that are pleasant, soothing, safe, immaculate, and easy to access and navigate.

Through this transformation, Sharp continues to live its mission to care for all people, with special concern for the underserved and San Diego's diverse population. This is something Sharp has been doing for more than 60 years.

Pillars of Excellence

In support of Sharp's organizational commitment to transform the health care experience, Sharp's Pillars of Excellence serve as a guide for its team members, providing framework and alignment for everything Sharp does. In 2014, Sharp made an important decision regarding these pillars as part of its continued journey toward excellence.

Each year, Sharp incorporates cycles of learning into its strategic planning process. In 2014, Sharp's Executive Steering and Board of Directors enhanced Sharp's safety focus, further driving the organization's emphasis on its culture of safety and incorporating the commitment to become a High Reliability Organization (HRO) in all aspects of the organization. At the core of HROs are five key concepts:

- Sensitivity to operations
- A reluctance to simplify
- Preoccupation with failure
- Deference to expertise
- Resilience

Applying high-reliability concepts in an organization begins when leaders at all levels start thinking about how the care they provide could improve. It begins with a culture of safety.

With this learning, Sharp is a seven-pillar organization — Quality, Safety, Service, People, Finance, Growth and Community. The foundational elements of Sharp's strategic plan have been enhanced to emphasize Sharp's desire to do no harm. This strategic plan continues Sharp's transformation of the health care experience, focusing on safe, high-quality and efficient care provided in a caring, convenient, cost-effective and accessible manner.

The seven pillars listed below are a visible testament to Sharp's commitment to become the best health care system in the universe by achieving excellence in these areas:

Demonstrate and improve clinical excellence and exceed customer expectations.

Keep patients, employees and physicians safe and free from harm.

Create exceptional experiences at every touch point for patients and families, enrollees, physicians, partners and team members.

Create a values-driven culture that attracts, retains and promotes the best people who are committed to Sharp's mission and vision.

Achieve financial results to ensure Sharp's ability to deliver on its mission and vision.

Achieve net revenue growth to enhance market position, sustain infrastructure improvements and support innovative development.

Be an exemplary public citizen by improving the health of our community and environment.

Awards

Below please find a selection of recognitions Sharp has received in recent years:

In 2013, 2014, 2016 and 2017, Sharp was recognized as one of the "World's Most Ethical (WME) Companies" by the Ethisphere Institute, the leading business ethics think tank. WME companies are those that truly embrace ethical business practices and demonstrate industry leadership, forcing peers to follow suit or fall behind.

Sharp was ranked No. 45 out of 500 large employers on *Forbes*' 2017 America's Best Employers listing. In 2016, Sharp ranked No. 16 and received the No. 2 spot on the newcomer's list. In 2018, *Forbes* ranked Sharp No. 25 on its first-ever list of Best Employers for Women and No. 52 on its list of Best Employers for Diversity.

Becker's Hospital Review recognized Sharp as one of "150 Top Places to Work in Healthcare" in 2017 and 2018. The list recognizes hospitals, health systems and organizations committed to fulfilling missions, creating outstanding cultures and offering competitive benefits to their employees.

From 2013 to 2018, Sharp ranked in the top 10 of the large employers category as one of the "Best Places to Work" for information technology professionals by the International Data Group's *Computerworld* survey. The list is compiled by evaluating a company's benefits, training, retention, career development, average salary increases, employee surveys, workplace morale and more.

In 2015, 2017 and 2018, Sharp ranked first for "San Diego's Best Hospital Group" in the annual *San Diego Union-Tribune* Readers Poll. In 2017, SMH was ranked "San Diego's Best Hospital" and, in 2018, Sharp's Weight Management Programs ranked first for "Best Weight Loss Clinic/Counseling." Sharp Community Medical Group (SCMG) was ranked "San Diego's Best Medical Group" from 2015 to 2018. Sharp Rees-Stealy Medical Group (SRSMG) was ranked "Best Hearing Aid Store" in 2018 for the second year in a row, as well as first for "Best Audiologist," second for "Best Laser Eye Center" and third for "Best Pharmacy."

In 2016 and 2017, SMBHWN was named to The Leapfrog Group's Top Hospitals list, which recognizes facilities that meet the highest standards of patient safety, care quality and efficiency. In 2016, SMH was also recognized as a Top Hospital.

SGH, SMH and SMBHWN received MAGNET® recognition by the American Nurses Credentialing Center (ANCC). The MAGNET Recognition Program® is the highest level of honor bestowed by the ANCC and is recognized nationally as the gold standard in nursing excellence. SGH first received the designation in 2006, and was most recently re-designated in 2017. SMBHWN received its current designation in 2015. SMH was first designated in 2008, and received its most recent re-designation in 2018.

Sharp was named one of the nation's "Most Wired" health care systems from 2012 to 2018 by *Hospitals & Health Networks* magazine's annual Most Wired Survey and Benchmark Study. "Most Wired" hospitals are committed to using technology to enhance quality of care for both patients and staff.


Planetree is a coalition of more than 80 hospitals worldwide that are committed to improving medical care from the patient's perspective. SCHHC became a Designated Planetree Person-Centered Hospital in 2007, and was re-designated in 2017 for the fourth consecutive time. Additionally, in 2014, SCHHC achieved Planetree Designation with Distinction for its leadership and innovation in patient-centered care. SMH became a Planetree Person-Centered Hospital in 2012 and achieved Planetree Designation with Distinction in 2014. In 2015, SMH was re-designated as a Planetree Person-Centered Hospital. SCVMC joined SCHHC and SMH as a Designated Planetree Person-Centered Hospital in 2014, and was re-designated in 2018. In addition, Planetree awarded SGH the Gold Certification for Excellence in Person-Centered Care in 2018.

SCHHC and SCVMC received Energy Star (ES) designation from the U.S. Environmental Protection Agency (EPA) for outstanding energy efficiency. Buildings that receive ES certification use an average of 40% less energy than other buildings and

release 35% less carbon dioxide into the atmosphere. SCHHC first earned ES certification in 2007, and SCVMC was first certified in 2009. Both entities were most recently re-certified in 2018.

San Diego Gas & Electric (SDG&E) named Sharp the 2017 Grand Energy Champion at its annual Energy Showcase Awards. Sharp was recognized for making tremendous strides in reducing its consumption of electricity and natural gas, and in promoting energy-saving techniques to the community.

Sharp received the Environmental Stewardship Award in the large business category from the Better Business Bureau (BBB), serving San Diego, Orange and Imperial counties, as part of BBB's 2017 Torch Awards. The award recognizes businesses that increase efforts toward a more sustainable footprint and green initiatives.

Sharp was named the 2017 Outstanding Recycling Program by California Resource Recovery Association (CRRA) — California's statewide recycling association — for its innovative waste-minimization initiatives. As the oldest and one of the largest nonprofit recycling organizations in the country, CRRA is dedicated to achieving environmental sustainability in and beyond California through zero waste strategies, including product stewardship, waste prevention, reuse, recycling and composting.

Sharp was one of nine awardees in San Diego to receive a 2018 EMIES *UnWasted Food* Award by the San Diego Food System Alliance for its collaboration as an innovator and early adopter with upstream "unusual but usable" procurement, soup stock program, organic gardens, animal feed and composting. Sharp was also recognized in 2016, for developing best practices in waste prevention, composting, recycling, food donation and source reduction efforts in partnership with the Sodexo Food and Nutrition team.

In 2016, Sharp ranked third on *San Diego Business Journal's* list of Healthiest Companies. The Healthiest Companies list honors those organizations that have created a supportive environment for their employees and fostered a work/life balance for their families.

In 2016, Sharp Best Health received the American Heart Association® (AHA) Fit-Friendly Worksites Honor Roll award (Gold Category) for the fourth consecutive year, which recognizes employers that promote a culture of health and physical activity in the workplace or community.

SRSMG was recognized by the Centers for Disease Control and Prevention (CDC) as a 2017 Million Hearts Hypertension Control Champion for achieving blood pressure control for at least 70% of its adult patients with hypertension.

From 2013 to 2018, the Press Ganey organization recognized multiple Sharp entities with Guardian of Excellence Awards®. Based on one year of data, this designation recognizes recipients that reach the 95th percentile for patient satisfaction, employee engagement, physician engagement surveys or clinical quality. Awarded Sharp entities in the employee engagement category included SCVMC, SCHHC, SGH, SMBHWN, SMH, SMH Outpatient Pavilion (OPP), SMV, Sharp HospiceCare, SRSMG, SCMG and Sharp Home Health, while SMH, SMH OPP and SMBHWN have been awarded for Patient Experience and SCHHC, SMBHWN and SMV have received awards for Physician Engagement.

Press Ganey also recognized multiple Sharp entities with the Pinnacle of Excellence Award® (formerly named the Beacon of Excellence Award). This award recognizes the top three performing health care organizations that have maintained consistently high levels of excellence over three years in the categories of Patient Experience, Employee Engagement, Physician Engagement and Clinical Quality Performance. In 2013 as well as 2015 through 2017, Press Ganey recognized SMH for patient experience. From 2013 to 2015, Sharp was recognized for Employee Engagement. In 2013, SCHHC and SMV were recognized for Physician Engagement.

SHP has maintained a National Committee for Quality Assurance's (NCQA) Private Health Insurance Plan Rating of 4.5 out of 5 each year since 2016, making it one of the highest-rated health plans in the nation. SHP has also maintained the NCQA's highest level "Excellent" Accreditation status for service and clinical quality each year from 2013 to 2018. The NCQA awards accreditation status based on compliance with rigorous requirements and performance on Healthcare Effectiveness Data and Information Set and Consumer Assessment of Healthcare Providers and Systems measures.

Covered California is California's official health insurance marketplace, offering individuals and small businesses the ability to purchase health coverage at federally subsidized rates. SHP earned a five-star rating — the highest possible — in Covered California's 2018 Coverage Year Quality Ratings in the categories of "Summary Quality Rating," "Getting the Right Care" and "Plan Services for Members."

America's Physician Groups (APG) is a professional association, representing over 300 medical groups, independent practice associations, and integrated health care systems across the nation. APG has awarded its highest level of distinction — "Elite Status" — to SCMG and SRSMG each year from 2010 to 2018.

The Women's Choice Award® is a symbol of excellence in customer experience awarded by the collective voice of women. In 2018, SGH received the Women's Choice Award® as one of America's Best Breast Centers, Best Stroke Centers and Best Hospitals for Heart Care. The Women's Choice Award® also recognized SMH and SMBHWN in 2018 among America's Best Hospitals for Bariatric Surgery, Cancer Care, Obstetrics and Patient Experience, as well as among America's Best Breast and Stroke Centers. SCVMC was also recognized as one of America's Best Breast Centers in 2018. In addition, SCHHC has maintained its ranking as one of America's Best 100 Hospitals for Patient Experience from 2012 to 2018.

Powered by the San Diego Association of Governments (SANDAG) in cooperation with the 511 transportation information service, iCommute is the Transportation Demand Management program for the San Diego region and encourages use of transportation alternatives to help reduce traffic congestion and greenhouse gas emissions. Sharp received iCommute Diamond Awards — which recognize employers in the San Diego region who have made strides to promote alternative commute choices — in the platinum tier in 2016 and the gold tier in 2017 and 2018.

For the fourth year in a row, and the fifth time in six years, Sharp won the top spot in the Mega Employer category in SANDAG's 2016 iCommute Rideshare Corporate Challenge. The annual monthlong challenge encourages the replacement of solo drivers with sustainable carpool, vanpool, bike, walk or transit commutes.

Global Healthcare Exchange (GHX) recognized Sharp as one of the 2016 GHX "Best 50" Supply Chains in North America. Organizations receiving this distinction are recognized for their work in improving operational performance and driving down costs through supply chain automation.

Appendix

C SGH FY 2020 – FY 2023 Implementation Strategy

Identified Health Need: Health Conditions

Aging Concerns

Behavioral Health

Cancer

Cardiovascular Disease

Diabetes

Maternal and Prenatal Care, including High-Risk Pregnancy

Obesity

Identified Health Need: Social Determinants of Health

Access to Care and Health Insurance

Community and Social Support

Economic Security

Education

Homelessness and Housing Instability

Unintentional Injury and Violence

Identified Community Health Need – Aging Concerns					
Objectives/ Anticipated Impact	**Strategy/ Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
1. Increase access for seniors and other high-risk populations to flu vaccines.	a. Continue to provide seasonal flu vaccinations at community sites for seniors with limited mobility and access to transportation, as well as for high-risk adults, including low-income, minority, chronically ill and refugee populations.	Ongoing (evaluated annually)	Program Coordinator, SGH Senior Resource Center	Senior Health Access to Care Transportation	For FY 2020: provide flu vaccinations to community members facing barriers to accessing care, including homeless persons at eight community sites. Track and evaluate trends in flu clinic attendance. In FY 2019, the SGH Senior Resource Center provided nearly 400 flu shots to seniors and high-risk adults at 10 clinics, nine different sites, including senior centers, community centers, the Salvation Army and faith centers. Because of increased availability of the flu vaccine at grocery stores and pharmacies, numbers served by the SGH Senior Resource Center have continued to decrease. However, the SGH Senior Resource Center is investing additional effort to reach the uninsured and high-risk adults.
	b. Continue to coordinate the notification of seniors regarding the availability of seasonal flu vaccines and the provision of flu vaccines to high-risk individuals in selected community settings. Publicize flu clinics through media and community partners.	Ongoing (evaluated annually)	Program Coordinator, SGH Senior Resource Center	Senior Health Access to Care	Seniors were notified of flu clinics through activity calendars, collaborative outreach conducted by the flu clinic site, sharp.com and both paper and electronic newspaper notices. The flu clinic sites assisted in distributing flu clinic information and encouraged their clients to get vaccinated.

Identified Community Health Need – Aging Concerns					
Objectives/ Anticipated Impact	**Strategy/ Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
	c. Continue to direct seniors and other chronically ill adults to available seasonal flu clinics, including physicians' offices, pharmacies and public health centers.	Ongoing (evaluated annually)	Program Coordinator, SGH Senior Resource Center	Senior Health Access to Care	Provided reminders to seniors who attend the Senior Resource Center programs that flu vaccination is important for themselves and their families. Encouraged community partners who work with seniors to remind staff and clients of the importance of vaccinations.
2. Support the safety net for seniors living alone in East County.	a. Maintain daily contact through phone calls with East County individuals (often elderly and home-bound) in rural and suburban settings who are at risk for injury or illness, and continue supporting telephone reassurance call services for East County residents.	Ongoing (evaluated annually)	Program Coordinator, Sharp Senior Resource Center	Senior Health Care Management Access to Care	In FY 2020, the SGH Senior Resource Center will explore ways to update the telephone reassurance call program and potentially increase the number of telephone calls. For FY 2018, 4,900 calls were made through the daily telephone reassurance call program with 18 alerts. Telephone reassurance call data are tracked internally by the Program Coordinator for the Sharp Senior Resource Center.
3. Continue to host a variety of senior health education and screening programs, in order to raise	a. Provide information on various senior issues such as senior mental health, memory loss, hospice, senior	Ongoing (evaluated annually)	Program Coordinator, SGH Senior Resource Center	Senior Health Education Screenings Collaboration	In FY 2020, the SGH Senior Resource Center will hold two additional classes focusing on homelessness and food insecurity to help raise awareness around both of these issues. YTD FY 2019, the SGH Senior Resource Center has provided more than 30 free health education programs and presentations to nearly 1,000

Identified Community Health Need – Aging Concerns					
Objectives/ Anticipated Impact	**Strategy/ Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
awareness, identify risk factors, and connect seniors to helpful resources.	services, nutrition, healthy aging and balance and fall prevention.				community members. In FY 2018, the SGH Senior Resource Center provided nearly 60 free health education programs to more than 1,400 community members. In FY 2018, the SGH Senior Resource Center collaborated with San Diego Oasis — an organization that promotes healthy aging through lifelong learning, active lifestyles and volunteer engagement to provide education on topics including mindful eating, preventing fractures and ACP. Eleven screening events were provided in FY 2018 to 190 seniors and as a result 12 attendees were referred to physicians for follow-up on their screening results. The SGH Senior Resource Center continued to sponsor the Grossmont Mall Walkers, a free fitness program to increase physical activity, improve balance and strength, and encourage a healthy lifestyle among community adults and seniors. Every Saturday, participants gathered at Grossmont Center to walk around the mall and perform gentle exercises led by an instructor from the SGH Senior Resource Center. More than 130 community members participated each month in the program in FY 2018. Each education program provided by or in collaboration with the Sharp Senior Resource Center is evaluated by participants. Evaluations include point scores and average evaluation scores, as well as open-ended questions such as: what was the most important thing participants learned, what other programs seniors (participants) would like. This feedback is provided to speakers so that they may refine future educational offerings. In addition, Sharp's Senior Resource Centers track attendance and for each educational event, flu vaccination event and screening held throughout the year. Metrics on community members referred for follow-up are also

Identified Community Health Need – Aging Concerns					
Objectives/ Anticipated Impact	**Strategy/ Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					tracked, and often participants' names and phone numbers are collected in order to facilitate follow-up. Often the community member talks to the department directly, or their provider (if a Sharp provider) is forwarded the information directly. In addition, community members receive their results and feedback to take to their doctor on their own time.
	b. Continue to participate in community health fairs for seniors.	Ongoing (evaluated annually)	Program Coordinator, SGH Senior Resource Center	Senior Health Education Collaboration	In FY 2019, the SGH Senior Resource Center participated in more than 10 health fairs throughout SDC, including El Cajon, Lakeside, Santee, La Mesa, the College Area, Point Loma and San Diego, reaching more than 3,600 community members. Populations served at these fairs included seniors and caregivers; Parkinson's patients and caregivers, Dementia patients and caregivers, veterans and those caring for veterans, and Lesbian, Gay, Bisexual and Transgender (LGBT) seniors. In addition, the SGH Senior Resource Center provided more than 500 free blood pressure screenings as well as educational resources on senior and caregiver services. Through participation in these events, the SGH Senior Resource Center provided education and resources to nearly 800 east region community members in FY 2019. Throughout FY 2019, the SGH Senior Resource Center also provided six health screening events at various sites in SDC's east region, reaching nearly 105 members of the senior community. Screenings included balance and fall prevention, hand, carotid artery, peripheral artery disease, stroke, and behavioral health.
	c. Coordinate two conferences – one dedicated to family caregiver issues in collaboration with the Caregiver	Ongoing (evaluated annually)	Program Coordinator, SGH Senior Resource Center	Senior Health Education Collaboration	In FY 2020, the SGH Senior Resource Center will again collaborate with the Caregiver Coalition to provide education and support for their annual conference for family caregivers. In April of 2018, the SGH Senior Resource Center partnered with Sharp HospiceCare and the City of La Mesa to provide a conference titled Healthy

Identified Community Health Need – Aging Concerns					
Objectives/ Anticipated Impact	**Strategy/ Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
	Coalition of San Diego and one focused on chronic care and palliative care in collaboration with Sharp HospiceCare.				and Wellness in Aging for community seniors and their families. Held at the La Mesa Community Center, the free conference provided approximately 110 attendees with educational presentations from a marriage and family therapist, attorney, nurse practitioner, ACP specialist, and other experts on how to plan for a healthy, safe and mindful future.
4. Engage and partner with local community organizations that address senior health issues in order to foster future opportunities for collaboration in provision of education, screening, and other resources to seniors and high-risk populations.	a. Maintain active relationships with community organizations serving seniors throughout San Diego. Organizations include: East County Senior Service Providers, Meals on Wheels, Caregiver Coalition, and the Caregiver Education Committee.	Ongoing (evaluated annually)	Program Coordinator, SGH Senior Resource Center	Senior Health Collaboration	In FY 2020, the SGH Senior Resource Center plans to partner with the City of La Mesa Adult Enrichment Center as part of their Livable La Mesa project. The SGH Senior Resource Center plans to hold health-related programming for seniors at the center, as well as assist with their annual transportation expo. Livable La Mesa is a project through AARP's Livable Communities Initiative, with support from The San Diego Foundation Age-Friendly Communities Program and an affiliate of the World Health Organization's Global Network of Age-Friendly Cities and Communities. This initiative is a national effort to help cities prepare for their own and the world's growing population of older adults. With input from La Mesa residents, the project will prepare a plan to help make La Mesa a community for all ages, and will focus on outdoor spaces and buildings, transportation, social and civic participation, housing, community information and support, health and wellness, and respect and social inclusion. In FY 2019, the SGH Senior Resource Center maintained active relationships with organizations that enhance professional networking and provide quality programming for seniors in SDC's east region, including the Caregiver Coalition of San Diego (the Caregiver Education Committee), East County Senior Service Providers, East County Action Network, AIS Health Promotion Committee and Meals on Wheels Greater San Diego East County

Identified Community Health Need – Aging Concerns					
Objectives/ Anticipated Impact	**Strategy/ Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					Advisory Board. In addition, the Program Coordinator participates in the Sharp Equality Alliance, an internal committee that provides outreach to various community organizations. Further, in order to avoid unnecessary visits to the emergency room and the potential risks of hospitalization, SGH is a part of the Alzheimer's Response Team in East County, which links medical first-responders, social workers, Sheriff's deputies and other professionals to individuals living with dementia, to ensure proper assistance as well as the most appropriate services during an emergency. Launched in 2018, by the County of San Diego, SGH works alongside the Grossmont Healthcare District, Alzheimer's San Diego and Live Well San Diego. The team also collaborates to provide ongoing support to families and help prevent future crises. The Alzheimer's Response Team is an outgrowth of The Alzheimer's Project, the county-led initiative to find a cure for Alzheimer's and help families struggling with the disease. As the Senior Resource Center increases the number of community partners it collaborates with, it is expected that additional opportunities will arise.
5. Increase the availability of education, resources and support to community members with life-limiting illness and their loved ones.	a. Provide 13 mailings of bereavement support newsletters.	9/30/2019 Ongoing (evaluated annually)	Bereavement Dept., Sharp HospiceCare;	Senior Health Education	In FY 2019, approximately, 1,400 community members received bereavement support newsletters. The amount of bereavement mailings is growing each year. Track number of mailings annually through internal Access/Excel database.

Identified Community Health Need – Aging Concerns					
Objectives/ Anticipated Impact	**Strategy/ Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
	b. Support the unique advanced illness management and end-of-life care needs of military veterans and their families through participation in veteran-oriented community events and services.	9/30/2019 Ongoing (evaluated annually)	Bereavement Dept., Sharp HospiceCare;	Senior Health Veterans Education	At a variety of community events throughout 2019, Sharp HospiceCare provided resources and information on veteran programs. FY 2018 veteran-specific community work included: • In honor of Veterans Day, Sharp HospiceCare celebrated patients who served in the U.S. military by holding 21 flag ceremonies throughout the month of November. • Sharp HospiceCare provided veteran-specific community education and outreach, including a presentation on the WHV program to approximately 150 attendees of the CSU Institute for Palliative Care at California State University San Marcos (CSUSM) and SDCCC's High Tech High Touch palliative care conference in June. The annual conference strives to educate community members as well as current and future health care professionals about palliative care options and ACP. • In October, Sharp HospiceCare, the San Diego County Hospice-Veteran Partnership and the Caregiver Coalition of San Diego hosted the Veterans Resource Fair at the Silverado Encinitas Memory Care Community. The free event provided veterans, family members and caregivers with community resources, presentations on available health care services. • Sharp HospiceCare also honored the nation's veterans at various community ceremonies and events in FY 2018. • Since 2010, member of the San Diego County Hospice-Veteran Partnership. • Participation on the advisory board for the Southern Caregiver Resource Center's Operation Family Caregiver. • Currently a Level 3 Partner, working towards Level 4 (4 levels available) in WHV, a national program developed by the NHPCO in collaboration with the VA to empower hospice professionals to

Identified Community Health Need – Aging Concerns					
Objectives/ Anticipated Impact	**Strategy/ Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					meet the unique end-of-life needs of veterans and their families. As WHV partners, hospice organizations can achieve up to four levels of commitment in serving veterans. Level 3 Partners have developed and strengthened relationships with VA medical centers and other veteran organizations.
	c. Continue to provide the community end-of-life and advanced illness management education and resource services throughout San Diego.	9/30/2019 Ongoing (evaluated annually)	Business Development, Sharp HospiceCare	Senior Health Education Collaboration	YTD in FY 2019, Sharp HospiceCare collaborated with community organizations to provide more than 2,300 community members with end-of-life and advanced illness management education and outreach at a variety of churches, senior living centers, and community health agencies and organizations throughout SDC, as well as through participation in community health fairs and events. In FY 2019, Sharp HospiceCare will continue to host two aging conferences with the Sharp Senior Resource Centers and a Health and Wellness in Aging Conference in August with Sharp Chula Vista Medical Center at the Elks Lodge in Chula Vista. In FY 2018, Sharp HospiceCare helped plan and facilitate the San Diego Community Action Network (SanDi-CAN) 11th annual community conference at the Balboa Park Club titled Planning Ahead: Ensuring Your Decisions Will Be Honored for approximately 100 seniors. Sharp HospiceCare partnered with the Sharp Senior Resource Centers to provide two aging conferences for more than 200 community seniors, family members and caregivers, titled Healthy and Safe Aging. Sharp HospiceCare partnered with the Caregiver Coalition of San Diego to offer free conferences to approximately 200 community members who provide care for a friend or family member. Track number of community education events through internal database.

Identified Community Health Need – Aging Concerns					
Objectives/ Anticipated Impact	**Strategy/ Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
	d. Continue to offer individual and family bereavement counseling and support groups.	9/30/2019 Ongoing (evaluated annually)	Bereavement Dept., Sharp HospiceCare	Senior Health Care Management	In FY 2018, the Healing After Loss and the Widow's and Widower's ongoing bereavement support groups served approximately 400 community members. In May, Sharp HospiceCare hosted classes and support groups for 60 adults who have lost a parent. Held at the Peninsula Family YMCA and the Grossmont Healthcare District, two Remembering Our Parents classes highlighted the unique aspects of parent loss, coping strategies and how to discover a sense of hope. In addition, in July and August, Sharp HospiceCare provided community members with education on coping skills during bereavement support groups hosted by the John D. Spreckels Center in Coronado. Track number of individual and group counseling sessions through internal database.
	e. Provide Advance Care Planning (ACP) for community groups as well as individual consultations.	9/30/2019 Ongoing (evaluated annually)	Advance Care Planning Dept., Sharp HospiceCare	Senior Health Education Care Management	In FY 2018, the program engaged more than 1,100 community members and caregivers in free ACP and POLST (Physician Orders for Life-Sustaining Treatment) education at a variety of community sites, including health fairs, senior centers, homecare agencies, senior living communities and seminars. This number continues to grow, and FY 2019 data is forthcoming; anticipate a higher figure. Throughout FY 2018, the Sharp ACP team provided approximately 80 phone and in-person consultations to community members seeking guidance with identifying their personal goals of care and health care preferences, appointing an appropriate health care agent, and completing an advance directive. In FY 2018, Sharp HospiceCare was one of 50 sites across the country selected to receive grant funding from the Hospice Foundation of America

Identified Community Health Need – Aging Concerns					
Objectives/ Anticipated Impact	**Strategy/ Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					(HFA) to provide community outreach aimed at understanding the ACP needs of underserved populations. Using an interactive, end-of-life game called Hello, Sharp HospiceCare engaged individuals who face barriers to health care due to socioeconomic, geographic, linguistic, cultural or educational circumstances. This included 12 transgender and heterosexual women at Christie's Place as well as five community members at the Valencia Park/Malcolm X Library. As a Hello game community outreach site, Sharp HospiceCare helped the HFA assess the game's effectiveness and the readiness of underserved groups to engage in further ACP. The "Hello" initiative concluded in FY 2018. In addition, in FY 2018, Sharp's ACP team partnered with the CSU Institute for Palliative Care at CSUSM to discuss potential outreach strategies for bringing information about advance health care directives to the county's homeless community. Sharp HospiceCare honored National Healthcare Decisions Day by providing ACP presentations to more than 600 community members. Sharp's ACP team reached an additional 30 community members through free ACP workshops in FY 2018, including a monthly workshop at the David and Donna Long Center for Cancer Treatment at SGH. Track number of sessions and individual consultations through Allscripts Business Unit, Excel spreadsheet and participant evaluations. Quarterly community presentations offered throughout SDC.

Identified Community Health Need – Aging Concerns					
Objectives/ Anticipated Impact	**Strategy/ Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
	f. Continue to conduct outreach activities and provide professional education on hospice-related topics to community agencies, health care facilities, colleges and universities on hospice and palliative care.	Ongoing (evaluated annually)	Medical Director, Sharp HospiceCare Business Development, Sharp HospiceCare Program Coordinator, Sharp Senior Resource Center	Senior Health Education Collaboration	In FY 2018, the team provided classroom-based lectures on hospice and palliative care to approximately 225 nursing students from Azusa Pacific University, University of San Diego and CSUSM, as well as to more than 50 social work students from SDSU. Topics included ACP, POLST, goals of care, hospice, palliative care, bioethics and bereavement Sharp HospiceCare leadership provided education, training and outreach to more than 1,500 local, state and national health professionals at various national conferences and community centers throughout the year. These efforts sought to guide industry professionals in achieving person-centered, coordinated care through the advancement of innovative hospice and palliative care initiatives. Audiences included the National Association of ACOs Conference; Baptist MD Anderson Cancer Center; Center to Advance Palliative Care National Seminar; Coalition to Transform Advanced Care National Summit; St. Joseph Home Health; Dignity Health and many others. Presentations provided to the health care community are evaluated through survey and tracked through an internal Excel database. Survey and data tracking serve to evaluate effectiveness and to document activities for Sharp's annual Community Benefit Plan and Report.
6. Provide education and outreach to the San Diego health care community concerning hospice and palliative services within the care continuum, in order to raise awareness of the	a. Provide hospice, palliative care and ACP training to physicians, case managers and other health care professionals.	Ongoing (evaluated annually)	Advance Care Planning Coordinator	Senior Health Education	Throughout the year, Sharp's ACP team educated nearly 600 local, state and national health care professionals on ACP and POLST. In addition, in January, the ACP team served as a speaker and facilitator of a workshop titled The Road Ahead for Serious Illness Care, which engaged more than 50 community providers from nonprofit organizations and health care agencies in planning for better community engagement in ACP and palliative care. In addition, the ACP team provided classroom-based lectures designed to enhance students' understanding of hospice and palliative care to

Identified Community Health Need – Aging Concerns					
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choices available towards the end of life and empower community members so that they and their family members may take an active role in their treatment.					approximately 225 nursing students from various local universities, as well as to more than 50 social work students from San Diego State University. The Sharp HospiceCare Resource and Educational Expo in February 2019 included approximately 50 exhibitors and provided tools for nearly 100 community health care professionals – including nurses, social workers, spiritual care providers and physicians – on how to best balance modern issues of technology while providing compassionate care to patients Sharp HospiceCare plans to hold the Resource and Educational Expo again in 2020.
	b. Continue active involvement with and participation on state and national hospice organizations (CHAPCA, NHPCO, etc.) included presentations on understanding late-stage illness, changing our culture of Care to one of partnership and a continuum of Care perspective, advance Care planning, etc.	Ongoing (evaluated annually)	Vice President, Sharp HospiceCare Medical Director, Sharp HospiceCare	Senior Health Education Collaboration	Sharp HospiceCare provides approximately six presentations provided each year in collaboration with state and national organizations. Sharp HospiceCare leadership continues to serve as the board, and as a state hospice representative, for NHPCO and CHAPCA. Community presentations provided through Sharp HospiceCare – including those to professional organizations – are evaluated through survey to evaluate effectiveness and revise program content.

Identified Community Health Need – Aging Concerns					
Objectives/ Anticipated Impact	**Strategy/ Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
7. Collaborate with community, state and national organizations to develop and implement appropriate services for the needs of the aging population.	a. Explore partnership with community organizations designed specifically to meet the needs of caregivers.	9/30/2019 Ongoing (evaluated annually)	Business Development Dept., Sharp HospiceCare	Senior Health Collaboration	In March 2018, Sharp became the first health care system in SDC to begin electronic uploads of patient POLST forms to the POLST eRegistry. As of late 2018, nearly 23,000 POLST forms faxed by Sharp hospitals, Sharp Rees-Stealy Medical Group, Sharp HospiceCare and other patient care departments have been uploaded to the POLST eRegistry. More current data forthcoming. **Background**: Since FY 2016, Sharp's ACP team has partnered with San Diego Health Connect, Health and Human Services Agency's Aging and Independence Services, Health Services Advisory Group, County of San Diego Emergency Medical Services, and various health care providers in SDC to ensure that community providers have access to POLST forms through the San Diego Healthcare Information Exchange, a countywide program that securely connects health care providers and patients to private health information exchanges. The Sharp HospiceCare ACP team participates in this initiative — funded by the California Health Care Foundation and supported by the CCCC and California Emergency Medical Services Authority — to create an electronic POLST registry (POLST eRegistry).
	b. Continue to collaborate with a variety of local networking groups and community-oriented agencies to provide caregiver classes, end-of-life programs, ACP seminars and web	Ongoing (evaluated annually)	Business Development, Sharp HospiceCare	Senior Health Education Collaboration	No new updates; efforts ongoing.

Identified Community Health Need – Aging Concerns					
Objectives/ Anticipated Impact	**Strategy/ Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
	presentations for consumers and health care professionals.				
	c. Sharp HospiceCare (along with other Sharp HealthCare entities) will participate in a one-year pilot utilizing 2-1-1 San Diego's Community Information Exchange (CIE).	July, 2020 To be evaluated in May 2020, for continued participation after the one-year pilot.	Manager, Sharp HealthCare Community Benefit and Health Improvement Director, SGH Case Management & Social Work VP Sharp HospiceCare	Clinical Community Linkages Data Sharing Community Collaboration All SDOH, e.g., housing, nutrition, transportation, etc.	Beginning in July, 2019 Sharp HospiceCare will participate along with multiple Sharp entities (hospitals, medical groups, and health plan) in a one-year pilot with the CIE stewarded by 2-1-1 San Diego. CIE training for Sharp HospiceCare staff was completed in July, 2019. Sharp teams are working closely with 2-1-1 San Diego on the implementation plan for CIE, which includes ongoing metrics, such as CIE utilization across the system, referral tracking, impact on case management efficacy and successful connection to needed social services, health care utilization (e.g., inpatient readmissions, unnecessary ED visits, LOS, etc.) and others. This data will be used to re-evaluate the value and sustainability of CIE for Sharp HealthCare after the one-year pilot.

Identified Community Health Need – Behavioral Health					
Objectives/ Anticipated Impact	**Strategy/ Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
1. Provide comprehensive behavioral health programs to adults and older adults in East County with acute or persistent psychiatric disorders. Programs will help individuals in crisis regain their optimal level of functioning and achieve a renewed sense of emotional stability and wellness.	a. Continue to provide a dedicated psychiatric assessment team in the ED and acute care.	Ongoing	Director, SGH Behavioral Health Services Manager, SGH Behavioral Health Services Chief Medical Officer, Sharp Behavioral Health	Behavioral Health Screening Access to Care Co-occurring disorders	SGH is the only hospital in East County to provide this assessment to patients in the ED. Average daily census of psychiatric consults in the ED is 20 patients per day. This is 7% of the total patient population seen in the ED. 95% of psychiatric admissions are from the ED. Psychiatric consultations in the ED have increased approximately 70% from 2012 (5008 consults) to 2018 (7219 consults). Although Behavioral Health is identified as a health need in the communities served by SGH, beyond clinical services, the facility does not have the resources to comprehensively address the elements of community education and support around this health need. Consequently, the community education and support elements of behavioral health care are addressed through collaboration with the programs/services provided through Sharp Mesa Vista Hospital and Sharp McDonald Center, which are the major providers of behavioral health and chemical dependency services in San Diego County (SDC).
	b. Continue to provide hospital-based outpatient programs that serve individuals dealing with a variety of behavioral health issues, including schizophrenia, depression and bipolar or anxiety	Ongoing	Director, SGH Behavioral Health Services Manager, SGH Behavioral Health Services	Behavioral Health Screening Access to Care Co-occurring disorders Depression Bipolar	Current outpatient programs include: Adult Mental Health Program for adults with acute and chronic disorders such as schizophrenia and bipolar disease; Bridges Program, based on the Recovery Model for adults diagnosed with schizophrenia and bipolar disorder; Dual Recovery Program, for adults with co-existing mental illness and chemical-use/addictive behavior disorder; Outpatient Electroconvulsive Therapy (ECT) Program; and Medication Clinic for adults that benefit from Long Acting Injectable medications.

Identified Community Health Need – Behavioral Health					
Objectives/ Anticipated Impact	**Strategy/ Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
	disorders, as well as psychiatric diagnosis for patients 18 or older.			Anxiety Substance Use	
	c. Continue to offer specialized inpatient treatment programs designed to address the specific needs and conditions of patients.	Ongoing	Director, SGH Behavioral Health Services Manager, SGH Behavioral Health Services Chief Medical Officer, Sharp Behavioral Health	Behavioral Health Screening Access to Care Co-occurring disorders	Current inpatient programs include: comprehensive program for adults suffering from psychiatric illness such as psychosis, delusions, depression, grief, anxiety, panic, obsessive-compulsive disorder, and traumatic stress syndromes; Intensive treatment programs for short-term crisis intervention, rapid recovery and return home; and a Medical Psychiatric Program.
2. Improve care management and clinical-community linkages that address social determinants of health (SDOH) through implementation of a new technology platform that shares health and social services data across health care and social service sectors.	a. SGH (along with other Sharp HealthCare entities) will participate in a one-year pilot utilizing 2-1-1 San Diego's Community Information Exchange (CIE).	July, 2020 To be evaluated in May 2020, for continued participation after the one-year pilot.	Director, SGH Case Management & Social Work SGH Lead Medical Social Worker Manager, Sharp HealthCare Community Benefit and Health Improvement	Clinical Community Linkages Data Sharing Collaboration All SDOH, e.g., housing, nutrition, transportation, etc.	Beginning in July, 2019 SGH will participate along with multiple Sharp entities (hospitals, medical groups, and health plan) in a one-year pilot with the CIE stewarded by 2-1-1 San Diego. Sharp teams are working closely with 2-1-1 San Diego on the implementation plan for CIE, which includes ongoing metrics, such as CIE utilization across the system, referral tracking, impact on case management efficacy and successful connection to needed social services, health care utilization (e.g., inpatient readmissions, unnecessary ED visits, LOS, etc.) and others. This data will be used to re-evaluate the value and sustainability of CIE for Sharp HealthCare after the one-year pilot.

Identified Community Health Need – Cancer					
Objectives/ Anticipated Impact	**Strategy/ Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
1. Improve navigation of the health care system for cancer patients in San Diego's east region through patient navigation services.	a. Continue to offer the cancer patient navigator program to SGH cancer patients.	Ongoing	SGH Cancer Patient Navigator Coordinator	Access to Care Care Management	In FY 2018, the SGH breast health navigator facilitated access to care for nearly 200 breast cancer patients in need — many with late-stage cancer diagnoses — through the provision of referrals to various community and national organizations. See below for details. Sharp's 2019 CHNA process included a facilitated discussion with Sharp Cancer Patient Navigators. In this discussion – and through other tools discussed below – financial distress was identified as a critical need to address for cancer patients and their families. Includes concerns in both inpatient and outpatient settings. As such, there is work in progress to bring Sharp teams together for system-wide strategies and resource utilization to address patient financial needs. This includes exploration of software (Vivor) and financial navigation resource implementation. To better assist the community, the Sharp Cancer Centers share direct links to community resources and agencies by service needed as well as information on advance care planning on sharp.com. Patient record is easy to access and also downloadable for documenting mediations, allergies, screenings and treatments. The Sharp Cancer Centers also include a new online assessment on sharp.com for individuals to assess if at risk and qualify for a lung screening. **Cancer Navigation Background:** SGH offers a cancer patient navigator program through which trained and certified navigators provide personalized education, support and guidance to patients At SGH, a licensed clinical social worker, nurses and nurse navigators work in unison to provide the patient with the necessary services based upon their needs.

Identified Community Health Need – Cancer					
Objectives/ Anticipated Impact	**Strategy/ Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					The breast health navigator is a registered nurse certified in breast health who personally assists breast cancer patients and their families with navigating the health care system. The breast health navigator offers support, guidance, education, financial assistance referrals and recommendations to community resources. Through collaboration with community clinics — including Family Health Centers of San Diego (FHCSD), Neighborhood Healthcare and Borrego Health — the breast health navigator identifies patients who may financially benefit from the Breast and Cervical Cancer Treatment Program. Offered through the California Department of Health Care Services, the program provides urgently needed cancer treatment coverage for unfunded or underfunded low-income patients, while local clinics help facilitate the enrollment process. Sharp patients are tracked internally, and patients meet with a navigator on their initial visit to Radiation Oncology. Navigation services provided to patients are closely tracked through internal databases. Systemwide Patient Navigation documentation in Cerner was rolled out in 2018, which allows for all Cerner users to view the Patient Navigation notes.
	b. Provide and refine SGH Cancer Patient Navigator Distress Screening technology to screen, track and respond to psychological, spiritual, practical and other social	Ongoing (evaluated annually)	VP Oncology Service Line SGH Cancer Patient Navigator Coordinator Oncology Social Workers	Cancer Fear Care Management Data Management/ Technology	**New**: Beginning in June, 2019, an electronic distress screening (available in both English and Spanish), using a validated tool distributed by the Cancer Support Community, was implemented. New tool provides easier methods for completion, timely results sharing, report tabulation and provides chronologic comparison of results for each patient for monitoring. Algorithms established for each question to identify information resources for concern and staff member to provide support if desired. Goals for 2019 and future include expanded use of tool to increase number of patients screened at least one time, as well as

Identified Community Health Need – Cancer					
Objectives/ Anticipated Impact	**Strategy/ Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
	needs experienced by cancer patients and their families.		Sharp Nurses	Logistical support services Social Determinants of Health (especially financial)	number of patients screened more than one time, especially at times of care transitions. Financial concerns were a key source of distress for cancer patients. Will compare financial distress data form Distress Screening Reports in FY2019 to FY2020 and/or FY 2021 According to 2018 Sharp oncology data, nearly half (46%) of the 518 SGH cancer patients who received the cancer psychosocial distress screening scored at a range of high to very high distress. In addition, 3% (17) of these patients reported some level of suicidal ideation. All of these identified patients were referred to internal or external resources, such as social workers or community cancer resources. From 2017-2018, anxiety levels increased across all Sharp cancer centers. **Distress Screening Background** Distress Screening to assess psychological, social, spiritual and practical issues contributing to cancer patient distress has been conducted at SGH over the past several years. This tool identifies patient needs in greater detail in order to make them actionable and rate them by intensity so that they may be prioritized and addressed appropriately. Routine reports including number of patients screened, information on the issues that are most challenging for patients and the percentage of patients rated in high distress are reported to the Integrated Network Cancer Program and to hospital entities annually. The information will drive efforts to target and provide additional support and resources to better meet our patient needs. Data collected via the distress screening has shown financial issues are a main area of concern for patients served (per above, there is work in progress to secure a part-time financial navigator).

Identified Community Health Need – Cancer					
Objectives/ Anticipated Impact	**Strategy/ Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
	c. Provide and refine SGH Cancer Patient Navigator PowerForm technology to screen, track and respond to psychological, spiritual, practical and other social needs experienced by cancer patients and their families.		VP Oncology Service Line	Cancer Fear Care Management Data Management/ Technology Logistical Support Services Social Determinants of Health (especially financial)	In April 2019, Sharp Cancer Centers implemented a revised Powerform for better capture and reporting on logistical support services needed and referrals provided. **Cancer Patient Navigator PowerForm Background**: Cancer patient navigators across Sharp collaborated to define, develop and propose a new Cerner Oncology Navigator PowerForm. The PowerForm was designed to standardize the cancer patient navigator's documentation, increase efficiency in patient care coordination, and improve overall patient care. By utilizing the PowerForm, navigators can document their assessment of patient needs and barriers to care, in addition to how they addressed patient unmet needs with appropriate internal and external support services and referrals. The need of financial assistance was selected as the Integrated Network Cancer Program annual goal, and now navigators document interventions specifically for financial barriers. The data from the documentation will be analyzed to optimize Sharp cancer care continuum.
	d. SGH Cancer Patient Navigators (along with other Sharp HealthCare entities) will participate in a one-year pilot utilizing 2-1-1 San Diego's Community Information Exchange (CIE).	July, 2020 To be evaluated in May 2020, for continued participation after the one-year pilot.	Manager, Sharp HealthCare Community Benefit and Health Improvement VP Oncology Service Line SGH Cancer Patient Navigator Coordinator	Clinical Community Linkages Data Sharing Collaboration All Social Determinants of Health (SDOH), e.g., finances,	Beginning in July, 2019 SGH will participate along with multiple Sharp entities (hospitals, medical groups, and health plan) in a one-year pilot with the Community Information Exchange stewarded by 2-1-1 San Diego. SGH Cancer Patient Navigators at all three Cancer Centers will be trained on CIE in order to better support challenges with social determinant of health identified in cancer patients and their families. Specific metrics to be tracked for Oncology: • # of oncology patients served via CIE linkages; FY 2019 baseline compared to FY2020/FY2021 utilization

Identified Community Health Need – Cancer					
Objectives/ Anticipated Impact	**Strategy/ Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
			Oncology Social Workers	nutrition, transportation, etc.	• # of services accessed by cancer patients via CIE; FY 2019 baseline compared to FY2020/FY2021 utilization Sharp teams are working closely with 2-1-1 San Diego on the implementation plan for CIE, which includes ongoing metrics, such as CIE utilization across the system, referral tracking, impact on case management efficacy and successful connection to needed social services, health care utilization (e.g., inpatient readmissions, unnecessary ED visits, LOS, etc.) and others. This data will be used to re-evaluate the value and sustainability of CIE for Sharp HealthCare after the one-year pilot. CIE is a multi-sector data-sharing collaboration in San Diego County, stewarded by 2-1-1 San Diego to proactively, efficiently address the social determinants of health needs in the community. CIE provides a longitudinal client record with patient history, access to social programs (e.g., housing/ HMIS, Food Banks, community clinics, etc.), emergency transport data, and care team data. CIE provides the capability to generate direct referrals to community resource, track referrals and outcomes and share reports among care team members.
	e. Seek funding for the cancer patient navigator program and expand navigator services to all cancers.	Ongoing	SGH Cancer Patient Navigator	Access to Care Care Management	Navigator Program grant funding at SHC Cancer Centers (SGH, Sharp Chula Vista Medical Center and Sharp Memorial Hospital) will be sought in collaboration with Sharp Foundation efforts. External funding sources are also being explored to further enhance/expand navigator services.

Identified Community Health Need – Cancer					
Objectives/ Anticipated Impact	**Strategy/ Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
2. Increase cancer education and support for community members in the east region with cancer diagnoses.	a. Continue to provide free support programs for community members with cancer diagnoses.	Ongoing	SGH Cancer Patient Navigator Coordinator	Cancer Education Care Management	In FY 2018, the SGH Cancer Center provided a variety of free support groups for approximately 100 community members impacted by cancer. Offered twice monthly, the breast cancer support group allowed women in all stages of breast cancer — from recent diagnosis, to treatment and survivorship — to share experiences and discover coping strategies. The weekly Art and Chat support group offered cancer patients, survivors and their loved ones support to increase focus, creativity, self-confidence and personal well-being. Monthly Lunch and Learn education series were available as well as a monthly Man Cave support group for men with cancer. Expansion of Sharp partnership with the American Cancer Society (ACS) to provide education and support materials and community support connections to ACS Patient Organizers. This will be in conjunction with Sharp information for patient education, services offered, information specific to care at SGH and additional connections to community and national organizations that provide assistance to cancer patients. *Metrics:* Number of Patient Organizers delivered for SGH (YTD FY 2019 = 23 and FY 2018 = 88). Initiation of patient information website section.
	b. Continue to provide Look Good Feel Better classes to community members with cancer diagnoses.	Ongoing	SGH Cancer Patient Navigator Coordinator	Cancer Education Care Management Collaboration	The SGH Cancer Center also provided meeting space for ACS' Look Good Feel Better classes, which teach women techniques to manage the appearance-related side effects of cancer treatment (e.g., hair loss, etc.) and boost self-confidence. Classes included a complimentary makeup kit and instruction from a licensed beauty professional on makeup application, skin care, and wearing wigs and headwear. Four classes were offered at the SGH Cancer Center in FY 2018, reaching more than 30 women.

Identified Community Health Need – Cancer					
Objectives/ Anticipated Impact	**Strategy/ Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
	c. Continue to provide ongoing social and psychosocial supports to community member with cancer diagnoses.	Ongoing	SGH Cancer Licensed Clinical Social Worker	Cancer Education Care Management	The LCSW served more than 300 patients and family members in FY 2018, as well as approximately 100 community members that contacted the LCSW for consultation regarding support groups and other SGH Cancer Center services and community resources. This included improving patient and family connections to community resources, such as the ACS, San Diego Brain Tumor Foundation, Leukemia and Lymphoma Society, Lung Cancer Alliance, Mama's Kitchen, 2-1-1 San Diego, JFS, Feeding San Diego, and the Food Bank's Breast Cancer Case Management program, as well as other food and financial assistance programs. SGH created a Moving Ahead Clinic that provides support for patients after radiation therapy that have feeding tubes to ensure they stay nourished, hydrated, and continue utilizing muscles for swallowing. More than 30 patients meet monthly with a nurse, social worker, dietitian, and speech pathologist. **Background**: The LCSW offers psychosocial services (assessments, crisis intervention, counseling, bereavement, cognitive behavioral therapy and stress management), support group leadership, and advocacy and resources for transportation, palliative care and hospice, food and financial assistance.
3. Increase community education on the signs and symptoms of cancer through education and screening events.	a. Continue to conduct comprehensive community cancer health seminars with health	Ongoing (evaluated annually)	Manager, SGH Radiation Oncology HBO/WHC	Cancer Education Collaboration Screening	In FY 2018, the SGH Cancer Center provided education on cancer, breast self-examination demonstrations, breast cancer awareness, and resources to approximately 200 individuals at community events throughout SDC's east region. At Sharp's annual Women's Health Conference in April, the SGH Cancer Center offered cancer education,

Identified Community Health Need – Cancer					
Objectives/ Anticipated Impact	**Strategy/ Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
	screenings in SDC's east region.		SGH Cancer Patient Navigator Coordinator		screenings, recommendations and literature to 1,000 community members. Throughout the year, the SGH Cancer Center continued to collaborate with Chaldean and Middle-Eastern community leaders in El Cajon to determine the most common barriers to obtaining breast health care among the Middle-Eastern community as well as how to provide appropriate, culturally sensitive educational materials and trainings for this population. The SGH Cancer Center continued to host educational classes at no cost for patients and community members facing cancer. Through the monthly Survivorship Lunch and Learn series, community members, patients and families hear local experts speak about a unique cancer-related topic and participate in a question-and-answer session alongside a complimentary lunch. The series reached an average of 8 to 14 individuals per session in FY 2018. Throughout the year, the SGH Cancer Center offered free workshops for patients and community members, including monthly ACP workshops provided in collaboration with Sharp's ACP program. The SGH Cancer Center also offered a workshop to help cancer patients and their loved ones manage the stress, anxiety and difficult emotions that accompany a cancer diagnosis. A Managing Sleep and Fatigue Workshop was also offered to patients and family members, as well as a quarterly Chemo Brain Workshop: Improving Memory and Concentration. In FY 2019, the SHC Cancer Centers plan to coordinate at least one prevention event and one screening event (see line item "b" below).

Identified Community Health Need – Cancer					
Objectives/ Anticipated Impact	**Strategy/ Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
	b. Continue with annual, systemwide INCP community event for prevention, including provision of education and screenings.	Ongoing (Annual Calendar Year Event) In planning stages for CY 2019 – 2023 events	VP Oncology Service Line	Cancer Education Screening Prevention	Sharp's systemwide Integrated Network Cancer Program (INCP) in FY2019 provided its annual community event, focused on cancer prevention. FY 2019 was an online event on HPV vaccination for prevention of various cancers including head and neck cancers. Event was conducted over ten days and 665 adults (72% female) participated. **Collected metrics included**: • Awareness of HPV health complications (somewhat or extremely familiar): Baseline=75.8% of participants. Post-education = 91.6%. • Awareness of HPV risk factors (somewhat/extremely familiar): females baseline: 75.3%; post-ed: 92.6%. Males baseline: 58%; post-ed: 87.2%. • Awareness of HPV vax benefits: Baseline: 76.5%; post-ed: 92.6%. • Post-ed, 41.3% were somewhat or very likely to discuss HPV risk and prevention with their PCP (w/28% of men having already done so). • Post ed, more than half of respondents who are adults or share a household with adults 27+ y/o were very likely to recommend HPV vax to those they thought could benefit from it. Sharp's INCP annual community screening events included breast screening events in SDC's south region and skin cancer screenings. While the latter screening event produced minimal impactful metrics (Results were not readily available due to non-reportability of basal cell carcinomas), the breast cancer screening event was more successful, through collaboration with La Maestra Health Clinic and Las Damas de San Diego. Outcome data from this event is unavailable.

Identified Community Health Need – Cancer					
Objectives/ Anticipated Impact	**Strategy/ Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
	c. Increase access to appropriate cancer screenings for high-risk community members through expansion of cancer genetics program.	Ongoing Evaluated annually	VP Oncology Service Line	Cancer Screening Prevention Access to Care	Systemwide initiative to improve access to cancer screenings and other preventive measures (e.g., surgeries) for individuals with genetic predispositions to cancer. In 2019, an increase in recommended annual breast MRIs, clinical breast exams, and colonoscopy screenings was observed (compared to 2018) due to this effort.

Identified Community Health Need – Cardiovascular Disease					
Objectives/ Anticipated Impact	**Strategy/ Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
1. Empower community members with cardiovascular and cerebrovascular disease through education, screening and support; promote accountability and	a. Continue to provide free bimonthly cardiac education classes.	Ongoing (evaluated annually)	Lead, SGH Cardiac Rehabilitation Manager, Noninvasive Director, SGH Cardiac/ Vascular Services	Cardiovascular Disease Education	A free Heart and Vascular Risk Factors Education class was offered twice a month to individuals who were hospitalized within the last six months due to select heart conditions, reaching more than 270 individuals in FY 2018. SGH educational programs are evaluated by participants through survey.

Identified Community Health Need – Cardiovascular Disease					
Objectives/ Anticipated Impact	**Strategy/ Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
behavioral change through education on chronic disease self-management.			Director, SGH Marketing and Communication		
	b. Continue to provide free congestive heart failure (CHF) education classes and support groups.	Ongoing	Lead, SGH Cardiac Rehabilitation SGH Heart Failure Senior Specialist Manager, Noninvasive Director, SGH Cardiac/ Vascular Services Director, SGH Marketing and Communication	Cardiovascular Disease Education	In FY 2019, a free, monthly CHF class and support group provided nearly 65 individuals with a supportive environment to discuss various topics about living well with CHF, covering topics such as exercise, nutrition, treatment plans and symptoms. SGH educational programs are evaluated by participants through survey.
	c. Provide free support groups to stroke survivors and their family members.	Ongoing (Evaluated annually)		Cardiovascular Disease Support Education Collaboration	In FY 2018, the SGH Outpatient Rehabilitation Department offered a weekly Stroke Communication Support Group for stroke survivors and their family members with a focus on stroke and brain injury survivors with aphasia or other speech or language difficulties. Topics included games to improve visual skills, language stimulation, listening activities and social interaction. The support group is sponsored by Young Enthusiastic Stroke Survivors, a community network that offers social, recreational and support group activities to stoke survivors and their families and caregivers. An average of six community members attended each session.

Identified Community Health Need – Cardiovascular Disease					
Objectives/ Anticipated Impact	**Strategy/ Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
	d. Educational sessions focused on heart disease and cardiovascular health for the east region communities.	Ongoing (evaluated annually)	Manager, SGH 5 West, Cardiac Rehabilitation Director, SGH Cardiac/ Vascular Services Director, SGH Marketing and Communication	Cardiovascular Disease Education	SGH's Cardiac Training Center and Cardiac Rehabilitation Departments participated in a variety of community events throughout San Diego in FY 2019. Together, they offered community members free blood pressure screenings, cardiopulmonary resuscitation (CPR) demonstrations, and cardiac health education and resources, including prevention, symptom recognition, evaluation and treatment. Events included the Sharp Disaster Preparedness Expo, Celebrando Latinas, Live Well San Diego's (LWSD's) Love Your Heart event, SGH's Burr Heart & Vascular Community Open House, AHA Heart & Stroke Walk and annual Sharp Women's Health Conference. The Cardiac Rehabilitation team also collaborated with the SGH Senior Resource Center in February to educate seniors at a local library about the importance of exercise and nutrition to maintain a healthy heart. Further, the Cardiac Rehabilitation team provided free flu shots to community seniors during a flu clinic held at the hospital in October. Throughout FY 2019, SGH-affiliated cardiologists shared heart-related information with various media outlets on topics including aspirin and heart health, cannabis and heart heath, and sex after a heart attack. Throughout the year, SGH provided its Peripheral Vascular Disease Rehabilitation Program to provide education and coaching on exercise, diet and medication to keep patients — particularly low-income patients — at the highest functional level. The program is partially funded by donations to the Grossmont Hospital Foundation to help defray the cost for patients with limited resources. Annual target is at least one to two community events per year – including health fairs and lectures. SGH educational programs are

Identified Community Health Need – Cardiovascular Disease					
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					evaluated by participants through survey.
	e. Continue to provide educational resources on cardiac health at community events throughout San Diego.	Ongoing (evaluated annually)	Director, SGH Cardiac/ Vascular Services	Cardiovascular Disease Education	In FY 2018, SGH's Cardiac Training and Cardiac Rehabilitation Departments provided education and free cardiovascular screenings at various community events throughout San Diego (see item 1c above).
	f. Continue to provide preventative cardiovascular screenings to community members in San Diego's east region.	Ongoing (evaluated annually)	Director, SGH Cardiac/ Vascular Services Manager, Noninvasive Director, SGH Marketing and Communications	Cardiovascular Disease Screenings	Preventive cardiovascular screenings (fee-based) are comprehensive, include ultrasound, lab tests, and calcium scoring as well as assessing and educating the patient on his or her risk of a heart attack or stroke. Preventive cardiovascular screenings (fee-based) are comprehensive, include ultrasound, lab tests, and offer a calcium scoring option as well as assessing and educating the patient on his or her risk of a heart attack or stroke. SGH has screened more than 1,200 individuals since 2008.
	g. Continue to provide stroke education and screening for SDC's east region; education events to including events	Ongoing	Vice President, Sharp Ortho/Neuro Service Line Director, Sharp Neuroscience Service Line	Stroke Education Screening Collaboration	In FY 2019, SGH will participate in Sharp's partnership with the City of San Diego to provide stroke education and resources to employees and residents in the City's nine districts. In FY 2018, the SGH Stroke Center provided stroke education and screenings at 11 community events in SDC's east region. At these events, the team provided more than 600 community members with information about stroke risk factors, warning signs, and appropriate interventions, including arrival at the hospital within early onset of

Identified Community Health Need – Cardiovascular Disease					
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	targeting seniors & high-risk adults as well as individuals with identified risk factors.		Director, SGH Acute Care Nursing Administration Program Coordinator, Sharp Senior Resource Center		symptoms. In addition, more than 80 community members received blood pressure checks or stroke screenings. During the screenings, the SGH Stroke Center identified risk factors as well as provided education and advised behavior modification. The SGH Stroke Center also provided stroke education to nearly 20 members of the Grossmont Mall Walkers group at Grossmont Center and nearly 30 members of a local weight loss support group at Renette Recreation Center in El Cajon. Further, the SGH Stroke Center provided education and tours at the SGH's Burr Heart & Vascular Community Open House, AHA Heart & Stroke Walk and annual Sharp Women's Health Conference. The Sharp HealthCare Stroke service line team also once again participated in Stroke Awareness Day at Petco Park in May 2019, with nearly 30,000 attendees. Sharp offered stroke and blood pressure screenings, education about stroke prevention, recovery, the warning signs of stroke and how to respond using FAST (Face, Arms, Speech, Time). In collaboration with the SGH Senior Resource Center, the SGH Stroke Center and a Sharp interventional neuroradiologist presented on the recent advances in the treatment of stroke and provided resources to nearly 50 community members at San Diego Oasis in May. The SGH Stroke Center also conducted personal health interviews, blood pressure and pulse checks, and provided education on emergency treatment for stroke, prevention and warning signs, and how to respond. Also in partnership with the SGH Senior Resource Center, the SGH Stroke Center provided stroke screenings to approximately 10 community seniors at a community library.

Identified Community Health Need – Cardiovascular Disease					
Objectives/ Anticipated Impact	**Strategy/ Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					Educational events conducted in collaboration with the Sharp Senior Resource Center collect evaluation forms to assess the quality of education/screening events. Feedback from these evaluations is incorporated for future planning. In addition, Sharp's Senior Resource Centers track attendance for each educational event and screening. Metrics on community members referred for follow-up are also tracked, and often participant's name and phone number are collected in order to facilitate follow-up. Often the community member talks to the department directly, or their provider (if a Sharp provider) is forwarded the information directly. Community members receive their results and feedback to take to their doctor on their own time.
	h. Continue to collaborate with community organizations to provide support for community members impacted by stroke.	Ongoing	Director, Sharp Neuroscience Service Line Director, SGH Acute Care Nursing Administration	Stroke Collaboration Support	In FY 2018, the SGH Outpatient Rehabilitation Department offered a weekly Stroke Communication Support Group for stroke survivors and their family members with a focus on stroke and brain injury survivors with aphasia or other speech or language difficulties. The support group is sponsored by Young Enthusiastic Stroke Survivors. An average of six community members attended each session.
2. Collaborate with other health care organizations in San Diego to provide cardiovascular and stroke data in order to support prevention and	a. Continue participation in the San Diego County Stroke Consortium.	Ongoing	Vice President, Sharp Ortho/Neuro Service Line Director, Sharp Neuroscience Service Line	Stroke Collaboration Data Sharing	SGH continues to actively participate in the quarterly San Diego County Stroke Consortium, a collaborative effort to improve stroke care and discuss issues impacting stroke care in SDC. Additionally, SGH continues to collaborate with the County of San Diego Emergency Medical Services to provide data for the SDC stroke registry.

Identified Community Health Need – Cardiovascular Disease					
Objectives/ Anticipated Impact	**Strategy/ Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
successful treatment of San Diegans with cardiovascular and stroke issues.			Director, SGH Acute Care Nursing Administration		

Identified Community Health Need – Diabetes					
Objectives/ Anticipated Impact	**Strategy/ Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
1. Increase education of signs and symptoms of diabetes in East County.	a. Participate in educational forums, health fairs and events in San Diego's east region.	Ongoing (evaluated annually)	SHC Diabetes Leadership Team	Diabetes Education Collaboration	As of YTD FY 2019, the SGH Diabetes Education Program provided 11 lectures to nearly 150 community members at the Family Health Centers of San Diego (FHCSD) Lemon Grove, El Cajon and Grossmont Spring Valley sites. In FY 2018, the SGH Diabetes Education Program provided eight diabetes lectures to more than 50 community members at the FHCSD Lemon Grove site. Topics included creating an active lifestyle, nutrition, diabetes self-management, goal setting, and diabetes risk factors, symptoms and treatment. In FY 2019, the Sharp Diabetes Education Program provided a presentation on diabetes including the different types of diabetes, medicine, technology and diagnosis, as well as resources and career information to more than 20 students at San Diego State University. Also in FY 2019, the SGH Diabetes Education Program educated

Identified Community Health Need – Diabetes					
Objectives/ Anticipated Impact	**Strategy/ Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					approximately 15 community members on heart healthy cooking at the Temple Emanu-El in Del Cerro. In addition, at the Grossmont Healthcare District Conference Center, the SGH Diabetes Education Program provided a community lecture on lifestyle change. In FY 2019, the Sharp Diabetes Education Program offered diabetes education, support and risk assessments to approximately 1,000 attendees at the Sharp Women's Health Conference. In addition, in October 2018, the Sharp Diabetes Education Program provided fundraising and team participation for the ADA's Step Out Walk to Stop Diabetes. **Evaluation Methods:** Collect feedback from community members on educational courses provided, in order to improve and refine educational resources tailored to community member needs. In addition, the Sharp Diabetes Leadership Team meets annually to evaluate the programs over the previous year.
	b. Explore opportunities with new venues/ community groups to provide additional resources. E.g. churches, YMCA's and schools.	9/30/2019 (Currently evaluated annually)	SHC Diabetes Leadership Team SHC Manager, Community Benefit and Health Improvement	Diabetes Education Access to Care Collaboration	In FY 2019, the educational collaboration with the City of San Diego included the SHC Diabetes Educators, leaving little staffing capacity for additional community collaborations (beyond the activities listed in item 1.a. above, and 2.a. below). SHC Manager, Community Benefit and Health Improvement meets with SHC Diabetes Leadership Team regularly to assess, grow and support additional opportunities for outreach and education.
	c. Utilize findings in the FY 2019 CHNA to	9/30/2019	SHC Manager, Community Benefit	Diabetes Food Insecurity	In FY 2019, the Sharp Diabetes Education Program plans to explore additional collaborations to assist and educate food insecure

Identified Community Health Need – Diabetes					
Objectives/ Anticipated Impact	**Strategy/ Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
	assess existing community resources and explore areas where additional diabetes education and resources may be needed in SDC's east region.	(Ongoing, evaluated annually)	and Health Improvement SHC Diabetes Leadership Team	Education Access to Care	community members and participate in Sharp's partnership with the City of San Diego to provide diabetes education and resources to employees and residents in the city's nine districts. In FY 2020, the Sharp Diabetes Education Program will train one of its team members on 2-1-1 San Diego's Community Information Exchange (CIE) in order to assess the value of this technology as a support for their patients. Please see Identified Community Health Need: Behavioral Health 2a for details on the CIE. Sharp Manager, Community Benefit and Health Improvement meets with Sharp Diabetes Leadership Team regularly to assess, grow and support additional opportunities for outreach and education. Continued efforts focus on: • *Clinic collaborations* (FHCSD Partnership continuance) • Exploring *partnerships to address food insecurity as part of nutrition education, and incorporating food insecurity screening* into patient diabetes education and counseling. • *CDC's National Diabetes Prevention Program* – a partnership of public and private organizations working to prevent or delay Type 2 diabetes. Partners work to make it easier for people with prediabetes to participate in evidence-based, affordable, and high-quality lifestyle change programs to reduce their risk of Type 2 diabetes and improve their overall health. The Sharp Manager of Community Benefit and Health Improvement also spoke on the food insecurity-health connection at Sharp's annual Obesity Conference in May, 2018 (FY 2019) at the invitation of the SHC Diabetes Education Team.

Identified Community Health Need – Diabetes					
Objectives/ Anticipated Impact	**Strategy/ Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
	d. Provide diabetes education to high-risk women with gestational diabetes, through collaboration with community clinics.	Ongoing - evaluated Annually	SHC Diabetes Leadership Team SHC Manager, Community Benefit and Health Improvement	Gestational Diabetes Community Clinics Education Access to Care Collaboration	In FY 2019, the Sharp Diabetes Education Program plans to continue to provide gestational services and resources to underserved pregnant women, both at the hospital and in collaboration with community clinics. **Findings**: At SGH, the Sharp Diabetes Education Program provided services and education to nearly 420 underserved pregnant women with diabetes in FY 2018. **Background**: The Sharp Diabetes Education Program is an affiliate of the California Diabetes and Pregnancy Program's Sweet Success Program, which provides comprehensive technical support and education to medical personnel and community liaisons to promote improved outcomes for high-risk pregnant women with diabetes. As an affiliate, the Sharp Diabetes Education Program educates underserved pregnant women and breastfeeding mothers with Type 1, Type 2 or gestational diabetes (diabetes developed during pregnancy) on how to manage their blood sugar levels. In collaboration with community clinics, in FY 2018 the team provided these patients with a variety of education and resources. Clinic patients also received logbooks to track and manage their blood sugar levels. In addition, the Sharp Diabetes Education Program evaluated patients' management of their blood sugar levels and collaborated with community clinics' obstetrician/gynecologists to prevent complications.
2. Improve access to diabetes educational resources for underserved	a. Explore potential partnerships with the community clinics in order to offer diabetes	9/30/2019 (Ongoing, evaluate annually)	SHC Diabetes Leadership Team SHC Manager, Community Benefit	Access to Care Collaboration Community Clinics	As of YTD FY 2019, the SGH Diabetes Education Program provided 11 lectures to nearly 150 community members at the Family Health Centers (FHCSD) Lemon Grove, El Cajon and Grossmont Spring Valley sites. In FY 2018, the SGH Diabetes Education Program provided eight diabetes lectures to more than 50 community members at the FHCSD

Identified Community Health Need – Diabetes					
Objectives/ Anticipated Impact	**Strategy/ Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
populations in SDC's east region.	classes at their clinic locations.		and Health Improvement		Lemon Grove site. Topics included creating an active lifestyle, nutrition, diabetes self-management, goal setting, and diabetes risk factors, symptoms and treatment. Moving forward, the Sharp Diabetes Education Program plans to continue to foster relationships and collaborate with FHCSD to provide education and resources to their diabetic patients. **Background**: The Sharp Diabetes Education Program continues to collaborate with FHCSD to conduct outreach and education to vulnerable community members in SDC's east region at multiple FHCSD sites, through the organization's Diabetes Management Care Coordination Project (DMCCP). DMCCP provides FHCSD patients with group diabetes education and encourages peer support and education from project "graduates" to current patients/project enrollees. The project monitors enrollees' physical activity, as well as their A1C and blood glucose levels, which it has proven to successfully maintain and lower. In FY 2018, participants with more severe cases of diabetes (i.e., higher blood glucose levels) compared to the overall group experienced a decrease of 30 percent in blood glucose levels. Sharp Manager, Community Benefit and Health Improvement continues to work with the Diabetes Education Team to support and facilitate the FHCSD partnership. In addition, the SHC Diabetes Leadership team meets annually to evaluate the programs over the previous year.

Identified Community Health Need – Diabetes					
Objectives/ Anticipated Impact	**Strategy/ Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
	b. Create language-appropriate and culturally sensitive diabetes educational materials.	9/30/2019 Ongoing (evaluate annually)	SHC Diabetes Leadership Team	Diabetes Education Care Management Collaboration Cultural Competency Language/ Translation Services	In FY 2019, the Sharp Diabetes Education Program continued to provide services and resources to meet the needs of San Diego's newly immigrated Iraqi Chaldean population. The program facilitated translation as well as provided resources to better assist Chaldean cultural needs. Educational resources included: How to Live Healthy With Diabetes; What You Need to Know About Diabetes; All About Blood Glucose for People With Type 2 Diabetes; All About Carbohydrate Counting; Getting the Very Best Care for Your Diabetes; All About Insulin Resistance; All About Physical Activity With Diabetes; Gestational Diabetes Mellitus Seven-Day Menu Plan; Food Groups; and Arabic language materials about pregnancy. Handouts were provided in Arabic, Somali, Tagalog, Vietnamese and Spanish, and food diaries and logbooks were distributed for community members to track blood sugar levels. Live interpreter services were available in more than 200 languages via the Stratus Video Interpreting iPad application, and the program facilitated translation and other resources to specifically assist Chaldean cultural needs. Further, Sharp team members received education regarding the different cultural needs of these diverse communities. Also exploring new opportunities for more effective methods and resources for properly translated educational materials (e.g. multi-lingual interns, etc.).

Identified Community Health Need – Maternal and Prenatal Care, including High-Risk Pregnancy					
Objectives/ Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
1. Provide support and education for women on a variety of health topics, including prenatal care and parenting skills.	a. Provide education, outreach and support to help meet the unique needs of women, mothers and newborns in SDC's east region.	Ongoing	Manager, SGH Obstetrics and Gynecology Manager, SGH Labor and Delivery Lead Clinical Nurse, SGH Neonatal Intensive Care Unit (NICU)	Maternal and Prenatal Care High-Risk Pregnancy Education Support	The SGH Women's Health Center provided free support groups to assist women and families with the challenges and adaptations of having a newborn in FY 2018. A breastfeeding support group was offered twice a week and served nearly 20 attendees per session, including fathers. A weekly postpartum support group supported more than 30 mothers per session. In FY 2018, educational classes covered a variety of parenting and newborn care topics, including breastfeeding, Baby Care Basics, caesarean delivery preparation, childbirth preparation, infant and child CPR, and preparing new siblings and grandparents. The SGH Women's Health Center also supported the community through participation in the Sharp Women's Health Conference in April 2018. Team members offered information on women's health including labor and delivery, prenatal care, obstetrics/gynecology care, neonatal intensive care options and more to 1,000 attendees.
2. Demonstrate best practices in breastfeeding and maternity care, and provide education and support to new mothers on the importance of breastfeeding.	a. Implement process improvements to increase breastfeeding rates among new mothers. Explore and participate in opportunities to share these best practices with the broader health care community.	Ongoing (evaluated annually)	Manager, SGH Obstetrics and Gynecology Lead Clinical Nurse, SGH Lactation	Maternal and Prenatal Care High-Risk Pregnancy Education Support	Following the implementation of the 10 Steps to Successful Breastfeeding initiative in 2012, the SGH Women's Health Center has pursued various quality strategies to promote exclusive breastfeeding and exclusive breast milk in the NICU. In addition, educational resources provided at community clinics and in the hospital's childbirth education classes have been updated to reflect best practices in breastfeeding for mothers and their families. NICU nurses also continued to encourage mothers to use a pump log to document and increase accountability of their 24-hour breastmilk volumes. Early intervention strategies were incorporated to promote the establishment of breastmilk in the first couple of weeks. The SGH

Identified Community Health Need – Maternal and Prenatal Care, including High-Risk Pregnancy					
Objectives/ Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					Women's Health Center also continued to track mothers of premature infants 28 to 34 weeks who had established breastmilk supply at two weeks. As a result of these comprehensive efforts, the SGH Women's Health Center increased the exclusive newborn breastfeeding rate at discharge from 49 percent in 2011 to 59 percent in 2018. **Background**: In 2015, the SGH Prenatal Clinic joined the Breastfeeding-Friendly Community Health Centers project (BFCHC) — an initiative of Live Well San Diego and funded through a grant from the First 5 Commission of San Diego. Through the BFCHC collaboration, the SGH Prenatal Clinic was selected out of six participating clinics as the pilot clinic to help establish Baby-Friendly USA guidelines around breastfeeding during the prenatal period and after discharge, and support other prenatal clinics in achieving Baby-Friendly USA standards. Though the pilot program ended in 2016, SGH continues its collaboration in the BFCHC to ensure sustainability of the model.
3. Collaborate with community organizations to: raise awareness of women's health issues and services; provide low-income and underserved women in SDC's east region with critical prenatal services.	a. Support low-income and underserved women in the community through collaboration with community organizations.	Ongoing (evaluated annually)	Perinatal Advanced Practitioner, SGH Perinatal Services Manager, SGH Obstetrics and Gynecology	Maternal and Prenatal Care High-Risk Pregnancy Collaboration Support Economic Security	New in FY 2019, SGH began a collaboration with San Diego Food Bank's Diaper Bank Program, designed to help solve a critical challenge (namely, the expense of diapers, often required to enroll/keep a child in daycare) for young parents living in poverty. Through this program, SGH will serve as a diaper distributor for high-need mothers/patients in need of this economic support. Implementation is planned for Aug/Sept 2019. Throughout FY 2018, SGH Prenatal Clinic midwives provided in-kind help at Neighborhood Health Centers in El Cajon to support the underserved

Identified Community Health Need – Maternal and Prenatal Care, including High-Risk Pregnancy					
Objectives/ Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
				Behavioral Health	population in SDC's east region. This included nearly 1,000 hours of care for pregnant women, with midwife coverage five days per week. The SGH Prenatal Clinic also continued to participate in the CDPH Comprehensive Perinatal Services Program to offer comprehensive prenatal clinical and social services to low-income, low-literacy women with Medi-Cal benefits. Services included health education, nutritional guidance, and psychological and social issue support as well as translation services for non-English-speaking women. Nutrition classes were offered to help reduce the number of women who meet the criteria for gestational diabetes. Women with a current diabetes diagnosis were referred to the SGH Diabetes Education Program, while those with nutrition issues were referred to an SGH registered dietitian (RD) or the SGH Diabetes Education Program. At-risk women with elevated BMIs received education and glucometers in order to measure their blood sugar and prevent the development of gestational diabetes. In addition, the SGH Prenatal Clinic provided education on gestational diabetes to pregnant community members. The SGH Women's Health Center continued its partnership with Vista Hill ParentCare to assist chemically dependent (addicted) women with psychological and social issues during pregnancy. These approaches have been shown to reduce both LBW rates and health care costs for women and infants. The SGH Women's Health Center also provided women with referrals to a variety of community resources, including, but not limited to California Teratogen Information Service, WIC, and the County of San Diego Public Health Nursing.

Identified Community Health Need – Maternal and Prenatal Care, including High-Risk Pregnancy					
Objectives/ Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
	b. Continue to participate in and partner with several community organizations and advisory boards for maternal and child health.	Ongoing	Manager, SGH Obstetrics and Gynecology Manager, SGH Labor and Delivery Lead Clinical Nurse, SGH Neonatal Intensive Care Unit (NICU)	Maternal and Prenatal Care High-Risk Pregnancy Collaboration	Community organizations include: WIC; California Teratogen Information Service; Partnership for Smoke-Free Families; San Diego County Breastfeeding Coalition Advisory Board; Beacon Council's Patient Safety Collaborative; ACNL; the regional Perinatal Care Network; the local chapter of AWHONN; California Maternal Quality Care Collaborative; California Perinatal Quality Care Collaborative; American Association of Critical-Care Nurses — Clinical Scene Investigator Academy; and the County of San Diego Public Health Nursing Advisory Board.

Identified Community Health Need – Obesity					
Objectives/ Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
1. Provide free education and screenings for community members that address risk factors for obesity.	a. Coordinate and provide various health screenings, including body mass index and blood pressure screenings at community events.	Ongoing	Manager, SGH Community Relations	Screenings Collaboration	In FY 2018 SGH participated in a variety of community events and provided education and health screenings for diabetes, stroke and heart health; many of which address risk factors and interventions for obesity as well. Education and screenings include nutrition, and exercise education, as well as emphasis on maintaining a healthy weight and lifestyle. SGH also provides educational resources on risk factors for obesity and resulting chronic diseases. In April, staff from a range of hospital departments participated in Sharp's annual Women's Health Conference, where they offered wellness education and services to approximately 1,000 attendees. This included the provision of nutrition education, handouts, recipes and healthy food samples as well as answering nutrition-related questions. In FY 2018, SGH RDs offered more than 100 community members nutrition handouts and healthy food samples, as well as answered nutrition-related questions at multiple community events, including Sempra/San Diego Gas & Electric's employee health fair, SGH's Burr Heart & Vascular Center Community Open House and a National Nutrition Month table located at the SGH cafeteria. In January, an SGH RD presented on eating well in the new year to nearly 20 seniors at the Dr. William C. Herrick Community Health Care Library. In addition, an SGH RD presented on mindful eating to nearly 50 community members at the SGH Cancer Center and San Diego Oasis. Education and programs provided by SGH are evaluated by participants through survey.
2. Provide care management in	Not Applicable (NA)	NA	NA	Obesity Cardiovascular	In general, resource limitations restrict growth beyond current programs and services provided at SGH that specifically address obesity at this time.

Identified Community Health Need – Obesity					
Objectives/ Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
support of weight loss and healthy life style choices for San Diego community members.				Hypertension Diabetes Chronic Disease Care Management	However, free, New Weigh Program classes are provided to community members through Sharp HealthCare's medical group, Sharp Rees-Stealy, including sites in SDC's east region. The free ten-week class emphasizes nutrition education and healthy lifestyle development. Classes offer access to a skilled health coach or registered dietitian for continued support and accountability and are offered at various locations around San Diego County, including the east region. To create a semi-structured food plan, participants will have the choice of using either their own foods or meal replacements. A free online program is also available for those unable to attend the in-person class.

Identified Community Health Need – Access to Care and Health Insurance					
Objectives/ Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
1. Increase coverage for patients seen in the Emergency Department (ED) by providing assistance to secure health coverage for all individuals entitled to the benefit; also provide payment options for individuals that chose not to secure coverage or are not currently eligible for health benefits. Secure benefit concurrent with stay when Medi-Cal Presumptive Eligibility rules apply.	a. Continue to provide services to help every unfunded patient received in the ED find coverage options.	Ongoing (evaluated annually)	Supervisor, Patient Assistance Navigators	Access to Care Education	The PointCare program continues to collect metrics on a number of individuals served and cost savings. From October 2015 to June 2019, Sharp helped nearly 47,934 self-pay patients through PointCare, while maintaining each patient's dignity throughout the process. PointCare has expanded its website to also provide linkage to Covered California as appropriate. The tool interfaces patient screening information in the GE record. Thus far in FY 2019, Sharp's Patient Access Services department has assisted 1,840 recipients in maintaining Medi-Cal eligibility after the HPE period lapse via advanced advocacy efforts. Continued unknowns in understanding the efficacy of efforts include: the increase in the patient out- of-pocket responsibility resulting from health plan coverage purchased off the insurance exchange; and the transition of qualified unfunded patients directly to Medi-Cal. Sharp has initiated a process of trending straight self-pay collections separate from balance after insurance collections in an effort to closely monitor these two distinct populations. **Background**: PointCare is a quick, web-based screening, enrollment and reporting technology designed by a team of health coverage experts to provide community members with health coverage and financial assistance options. At Sharp HealthCare (Sharp), patients use PointCare's simple online questionnaire to generate personalized coverage options that are filed in their account for future reference and accessibility. The results of the questionnaire enable Sharp staff to have an informed and supportive discussion with the patient about health

Identified Community Health Need – Access to Care and Health Insurance					
Objectives/ Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					care coverage, and empower them with options. PointCare also directs patients to the Covered California website for health coverage or Medi-Cal enrollment as Presumptively Eligible and/or full scope benefits.
2. Provide payment options, education and support to high-risk, uninsured, underinsured, and patients admitted to hospital facilities with an inability to pay their financial responsibility after health insurance.	a. Provide the Maximum Out of Pocket Program to patients who express an inability to pay their financial responsibility after health insurance.	Ongoing	All Revenue Cycle Staff	Access to care Financial assistance Provide education on patient financial services	In FY 2019 YTD, the Maximum Out of Pocket Program made a total of more than $384,500 in adjustments to patient bills. **Background**: The Maximum Out of Pocket Program was launched in October 2014. Sharp provides one-on-one interviews during the hospital stay focusing on educating the patient regarding their health insurance benefits, accessing care, and payments options with a compassionate approach while promoting healing.
	b. Provide a Public Resource Specialist for uninsured and underinsured patients, to offer support to patients needing advanced guidance on available funding options.	Ongoing	Patient Access Services (system- level) Public Resource Specialists	Access to care Financial assistance Provide education on patient financial services	In 2015, positions were created within Sharp's Patient Access Services department (system level) entitled Public Resource Specialists – to support patients at all Sharp hospitals needing extra guidance on available funding options. Public Resource Specialists also perform what is traditionally called "field calls" (home visits) to patients who required assistance with completing the coverage application process after leaving the hospital.
	c. Provide specialized financial assistance and support program to families with children in a Sharp Neonatal Intensive Care Unit (NICU).	Ongoing	Patient Access Services Public Resource Specialist	Access to care Financial assistance	This program was expanded to SGH in 2017 – outcomes/case data forthcoming. This is a benefit to the family in that they not only get support for their hospital stay, but many other services outside of the hospital to assist with the cost of care for their newborn. It is assistance not only for unfunded patients, but for insured families.

Identified Community Health Need – Access to Care and Health Insurance					
Objectives/ Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
			Patient Access Service Self-Pay Team Manager		**Background**: In summer 2015, a pilot program was launched at SMBHWN to evaluate both insured and unfunded families with Neonatal Intensive Care Unit (NICU) babies for financial assistance. This process included helping families whose newborn had been diagnosed with a devastating medical condition or extremely low birth weight apply for Supplemental Security Income (SSI) to help with the cost of care for their newborn both within and outside of the hospital. Public Resource Specialists have assisted more than 260 families through the SSI application process.
	d. The Patient Assistance Team will continue to assist patients in need of assistance gain access to free or low-cost medications.	Ongoing	Supervisor, Patient Assistance Navigators Manager Patient Access Services, Self-Pay Patients	Access to care Provide education on patient financial services	Cost savings for replacement drugs are monitored through pharmacy and supply chain. The patient accounting staff remove the charges from the patient's statement. Patients are identified through usage reports, or referred through case management, nursing, physicians or even other patients. If eligible, uninsured patients are offered assistance, which can help decrease readmissions due to lack of medication access. The team members research all options available, including programs offered by drug manufacturers, grant-based programs offered by foundations, copay assistance, low-cost alternatives, or research where the patient might find their medication at a lower cost. Sharp also tracks each individual that has applied for financial assistance. The patient account is noted with the findings, and a specific adjustment code is used to track the dollars associated with these reviews.
	e. Continue to offer ClearBalance – a specialized loan program	Ongoing	Supervisor, Patient	Access to Care	YTD FY 2019, nearly 4, 079 Sharp hospital encounters have been assisted through the ClearBalance zero-interest loan program since its inception.

Identified Community Health Need – Access to Care and Health Insurance					
Objectives/ Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
	for patients facing high medical bills. Through this collaboration with San Diego-based CSI Financial Services, both insured and uninsured patients have the opportunity to secure small bank loans in order to pay off their medical bills in low monthly payments.		Assistance Navigators Manager Patient Access Services, Self-Pay Patients		
	f. Continue to provide Project HELP and other funds as available for pharmaceuticals, transportation vouchers and other needs for economically disadvantaged patients.	Ongoing	SGH Chief Financial Officer	Access to Care	Project HELP funds are tracked though an internal database. From FY 2010 – FY 2018, Project HELP funds totaled more than $371K. In addition, SGH pharmacists assisted more than 400 economically disadvantaged patients with outpatient prescriptions valued at more than $228,000 in FY 2018.
3. Improve access and health outcomes for high-risk community members, particularly San Diego's homeless population.	a. Expand Sharp HealthCare integrated delivery system access to post acute recuperative care services offered in collaboration with the San Diego Rescue Mission (SDRM), to include: • All Sharp HealthCare acute hospitals	Ongoing	Sharp VP Integrated Care Management	Access to Care Care Management Collaboration	In January 2019, SDRM unexpectedly and with very short notice, closed their recuperative care unit. This created a critical void for SHC. Moreover, one that comes at a time when we were seeking to expand our relationship with the SDRM allowing for increased volumes for individuals experiencing homelessness that likewise are in need of recuperative care services. With regard to this need, our focus is two-fold. Firstly, we are seeking to identify short-term solutions for immediate needs as they occur. Each patient is independently considered for exact care need, likely

Identified Community Health Need – Access to Care and Health Insurance					
Objectives/ Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
	• Sharp Rees-Stealy Medical Group • Sharp Community Medical Group Here, individuals experiencing homelessness find a safe environment to support respite and recovery. In addition, the SDRM offers counseling and education services, access to continued ambulatory care through Federally Qualified Health Center clinics, and information and referral resources for supportive housing.				term for the need, and various care setting options immediately available.
4. Seek to provide health care funding options, education, and/or support to the high-risk, uninsured/underinsured patients admitted to hospitals of the Sharp HealthCare system.	a. Integrated Care Management and Patient Access Services (PFS) support education and access to: • Medi-Cal for CalFresh (Food Stamps) • Hospital Outstation Program (collaboration with the County of San Diego)	Ongoing with Annual Evaluation	Manager, Patient Access Services Sharp VP Integrated Care Management	Access to Care Health Insurance Access to Healthy Food (Food Insecurity) Collaboration	Integrated Care Management (ICM) has expanded efforts for patient education related to funding options/access to care, as well as San Diego community resources. In regard to funding opportunities, ICM now works more aggressively and closely with Sharp Patient Access Services (PFS) to ensure patients are aware of all funding opportunities for which they may be eligible. Also, patients may receive education related to structure and access for managed Medi-Cal products within San Diego County. This year, ICM has expanded their relationship and utilization of 2-1-1. For FY 2020, in collaboration with 2-1-1 ICM will identify metrics to gage

Identified Community Health Need – Access to Care and Health Insurance					
Objectives/ Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
	• Enrollment of qualified patients in CalFresh			Clinical-Community Linkages	successes, benefits, and value to SHC patients as a result of improved community engagement. SGH's Patient Access Services team worked closely with the hospital's Care Transitions Intervention program to evaluate patients for CalFresh — California's Supplemental Nutrition Assistance Program — prior to hospital discharge, which dramatically increased the likelihood that patients will complete CalFresh applications and receive benefits. In February 2017, Sharp's Patient Access Services team expanded CalFresh consults to the remainder of Sharp's acute care hospitals. From FY 2016 through June 2019, more than 650 Sharp patients have been granted CalFresh benefits.

	b. Continued partnership and collaboration with Father Joe's Villages in support of Project SOAR:
	
	• A program through the County of San Diego's Aging and Independence Services (AIS)
	
	• Provides care management services to frail and disabled adults – aged 60 years or older
	
	• Adults are at risk for nursing home placement
		Ongoing with Annual Evaluation	Sharp Clinical Social Workers
			
			Sharp VP Integrated Care Management
				Access to Care
				Collaboration
				Care Management
				Food Security
					Eligibility for Project SOAR's programming is incorporated into Sharp HealthCare's current eligibility review process for all patients.
					
					• Patient files are assessed for possible eligibility
					• Referrals are conducted for qualified patients
					• Currently there are no mechanisms in place to track cost or volume for this program
					  ○ The nature of the program is cooperative collaboration, referral, and/or sharing of information as appropriate
					  ○ There are no direct costs for Sharp HealthCare. Thus, it is difficult to measure any savings that Sharp might experience

Identified Community Health Need – Access to Care and Health Insurance					
Objectives/ Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
	• Adults who do not have access or qualify for supportive services through other programs and/or in-home-care service programs				
5. Continue to explore opportunities for collaboration with community organizations to enhance access as appropriate for individuals experiencing homelessness to: • Medical care • Financial assistance • Psychiatric and social services	a. Creation of a Homeless Task Force within Sharp HealthCare, led by Integrated Care Management, and including leaders across the Sharp continuum (Sharp, Sharp Mesa Vista Hospital, Sharp Rees-Stealy Medical Group, and Sharp Community Medical Group) for the purposes of: Identifying alternative solutions for hard to place patients requiring long-term supportive care, assisted living, and/or custodial care • To guide assessment and planning for:	Ongoing (annual evaluation)	Sharp VP Integrated Care Management	Access to Care Homelessness Housing Instability Collaboration Care Management	Integrated Care Management (ICM): In FY2019, in conjunction with the passing and signing of SB 1152, Hospital Discharge Processes: Homeless Patients, SHC develop formalized processes, procedures, and protocols to improve care for patients experiencing homelessness. This work includes technology to track and measure care and utilization of individuals experiencing homelessness served within the SHC system. For FY2020, ICM will use captured data to isolate trends and gaps in care related to homeless populations served. The SB1152 Task Force (formally Homeless Task Force) will use the data to identify action planning for go-forward.

Identified Community Health Need – Access to Care and Health Insurance					
Objectives/ Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
	○ Allocation of internal resources ○ Possible expansion of existing external relationships ○ Identification of new opportunities for partnership and/or collaboration				
	b. Continue to offer high-risk, vulnerable SGH patients (Self-Pay, Medi-Cal, Medi-Cal Presumptive, with complex chronic health conditions and limited social support) health coaching and resources (through multiple community partnerships) upon discharge to help ensure safe transition from hospital to home, and improve their quality of life; a Care Transitions Intervention (CTI) model pilot.	Ongoing with Annual Evaluation	Sharp VP Case Management Service Line Director, SGH Case Management & Social Work Manager, Community Benefit and Health Improvement	Access to Care Care Management Collaboration	As of March, 2019 nearly 2,200 patients were enrolled in the CTI program. The readmission rate for CTI patients since partnership with 2-1-1 San Diego dropped from nearly 30% to below 9%. For the third project year, all CTI patients referred to 2-1-1's Health Navigation (about 70): reduced social determinant of health (SDOH) vulnerability; 96% of referred patients reported improved ability to manage their health; and 91% reported improved care coordination. In particular, marked improvements regarding vulnerability related to housing and nutrition were observed over the past three years. Further, the CTI program data revealed significant reduction in cost between average LOS for high-risk vulnerable patients, as well as average direct costs (per day) and average hospital day direct cost. In FY 2019, the CTI team in conjunction with ICM and 2-1-1 leadership held a retreat to identify gaps and priorities for advancing value through measurable data from CTI services.

Identified Community Health Need – Access to Care and Health Insurance					
Objectives/ Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					For FY 2020, ICM leadership will continue isolation of metrics to benchmark CTI value and successes. ICM will use information to assess opportunities for CTI across the SHC system. This will be accompanied with evaluation of the new CIE pilot partnership (see Identified Community Health Need: Behavioral Health 2a). Currently, the SGH CTI team are active participants in the CIE pilot. **Background**: The CTI© program focuses on transitioning patient home safely by reviewing Medications, early recognition of symptoms, establishing a Medical Home, providing Advance Care Planning (ACP) choices and ensuring the patient has a plan for managing their care across the care continuum. Part of this is accomplished by connecting to patients to community resources (e.g., the San Diego Food Bank, 2-1-1 San Diego, Feeding San Diego) that help them maintain their health and safety, including: food (directly), hunger relief organizations, transportation resources, access to a primary care physician for follow up care, medical equipment, and other social supports. With generous support from the Grossmont Hospital Foundation, the program has been able to support CTI patients with post-discharge social service navigation, food, blood pressure cuffs, diabetes kits, pulse oximeters and pill boxes. The program is also able to assist with co-pays for medications should the need arise.
6. Improve care management and clinical-community linkages that address social determinants of health (SDOH) through implementation of a new technology platform that	a. SGH (along with other Sharp HealthCare entities) will participate in a one-year pilot utilizing 2-1-1 San Diego's Community Information Exchange (CIE).	July, 2020 To be evaluated in May 2020, for continued participation after the one-year pilot.	Director, SGH Case Management & Social Work SGH Lead Medical Social Worker	Clinical Community Linkages Data Sharing Community Collaboration	This strategy also addresses Identified Community Health Need: Behavioral Health 2a. Please refer to that section for details.

Identified Community Health Need – Access to Care and Health Insurance					
Objectives/ Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
shares health and social services data across health care and social service sectors.			Manager, Sharp HealthCare Community Benefit and Health Improvement	All SDOH, e.g., housing, nutrition, transportation, etc.	

Identified Community Health Need – Community and Social Support					
Objectives/ Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
1. Collaborate with community organizations to help raise awareness of women's health issues and services, as well as provide low-income and underserved	a. Support low-income and underserved women in the community through collaboration with community organizations.	Ongoing			This strategy also addresses Identified Community Health Need: Maternal and Prenatal Health, Including High-Risk Pregnancy 3a. Please refer to that section for details.

Identified Community Health Need – Community and Social Support					
Objectives/ Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
women in the San Diego community with critical prenatal services.					
2. Improve care management and clinical-community linkages that address social determinants of health (SDOH) through implementation of a new technology platform that shares health and social services data across health care and social service sectors.	a. SGH (along with other Sharp HealthCare entities) will participate in a one-year pilot utilizing 2-1-1 San Diego's Community Information Exchange (CIE).	July, 2020 To be evaluated in May 2020, for continued participation after the one-year pilot.	Director, SGH Case Management & Social Work SGH Lead Medical Social Worker Manager, Sharp HealthCare Community Benefit and Health Improvement	Clinical Community Linkages Data Sharing Community Collaboration All SDOH, e.g., housing, nutrition, transportation, etc.	This strategy also addresses Identified Community Health Need: Behavioral Health 2a. Please refer to that section for details.
3. Offer various support groups to community members.	a. Continue to support community members by offering various support groups.	Ongoing			For details on SGH community support and patient support groups, please refer to the following line items: • Identified Community Health Need: Aging Concerns 5d • Identified Community Health Need: Cancer 2a • Identified Community Health Need: Cardiovascular Disease 1b • Identified Community Health Need: Cardiovascular Disease 1c • Identified Community Health Need: Maternal and Prenatal Health, Including High-Risk Pregnancy 1a

Identified Community Health Need – Economic Security					
Objectives/ Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2016 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
1. Improve outcomes for high-risk underfunded patients and community members through facilitated referral and connection to social, practical and other services in the community.	a. Connect high-risk, underfunded patients and community members to local resources and organizations for low-cost medical equipment, housing options and follow-up care.			Access to Care Care Management Collaboration Social Determinants of Health	In FY 2018, SGH continued to provide post-acute care facilitation for high-risk patients, including individuals who were homeless or without a safe home environment. Individuals received referrals to and assistance from a variety of local resources and organizations. These groups provided support with transportation, placement, medical equipment, medications, outpatient dialysis and nursing home stays. SGH referred high-risk patients, families and community members to churches, shelters and other community resources for food, safe shelter and other resources. For unemployed, uninsured and underinsured patients, or for those who simply cannot afford the expense of durable medical equipment, including a wheelchair, walker or cane due to a fixed income, SGH has committed to providing medically necessary equipment for high-risk patients upon discharge. SGH case managers and social workers actively seek DME donations from the community and SGH Volunteer Services, providing nearly 300 DME items in 2018. In addition, SGH paid nearly $46,000 for uninsured patients to receive continued short-term rehabilitative care in a skilled nursing facility to improve patient mobility and stability.
	b. Continue to offer high-risk, vulnerable SGH patients (Self-Pay, Medi-Cal, Medi-Cal Presumptive, with complex chronic health conditions and limited social support) health	Ongoing with Annual Evaluation	Sharp VP Case Management Service Line Director, SGH Case Management & Social Work	Access to Care Care Management Collaboration	This strategy also addresses Access to Care/Health Insurance 5b. Please refer to that section for details.

Identified Community Health Need – Economic Security					
Objectives/ Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2016 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
	coaching and resources (through multiple community partnerships) upon discharge to help ensure safe transition from hospital to home, and improve their quality of life; a Care Transitions Intervention (CTI) model pilot.		Manager, Community Benefit and Health Improvement	Social Determinants of Health	
2. Improve care management and clinical-community linkages that address social determinants of health (SDOH) through implementation of a new technology platform that shares health and social services data across health care and social service sectors.	a. SGH (along with other Sharp HealthCare entities) will participate in a one-year pilot utilizing 2-1-1 San Diego's Community Information Exchange (CIE).	July, 2020 To be evaluated in May 2020, for continued participation after the one-year pilot.	Director, SGH Case Management & Social Work SGH Lead Medical Social Worker Manager, Sharp HealthCare Community Benefit and Health Improvement	Clinical Community Linkages Data Sharing Community Collaboration All SDOH, e.g., housing, nutrition, transportation, etc.	This strategy also addresses Identified Community Health Need: Behavioral Health 2a. Please refer to that section for details.

Identified Community Health Need – Education					
Objectives/ Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
1. Collaborate with local colleges and universities to provide professional development lectures to students from local colleges and universities	a. Continue to provide elementary, middle and high school students with opportunities to explore health care professions.	Ongoing	Varies – Preceptors throughout SGH	Education Career Pipeline Economic Security	Throughout the academic year, SGH provided more than 840 students from colleges and universities throughout San Diego with various placement and professional development opportunities. Approximately 580 nursing students spent nearly 56,000 hours at SGH, including time spent both in clinical rotations and individual preceptor training, while more than 260 ancillary students spent more than 65,300 hours on the SGH campus.
2. Collaborate with local middle and high schools to provide opportunities for students to explore health care professions.	a. Continue to provide elementary, middle and high school students with opportunities to explore health care professions.	Ongoing	Varies – Preceptors throughout SGH Manager, SGH Community Relations	Education Career Pipeline Economic Security	For FY 2019: SGH plans to continue to participate in HESI, Healthcare Towne, In Inspire and Health Sciences High and Middle College (HSHMC) programs. See background information below for details on these programs. *I Inspire*: New in FY 2018 SGH created the I Inspire program, a weeklong program that encourages high school students from underrepresented backgrounds to consider careers in health care and learn about nursing directly from those in the field. SGH partnered with License to Freedom, a local nonprofit that advocates for and empowers immigrants and refugees in SDC, to recruit participants. Students shadowed nurses in outpatient, acute and critical care; women's health and surgical services; and administrative settings. In addition, daily meet-and-greet luncheons with representatives from local colleges and universities including PLNU, National University, USD were held and lastly, students created community-based education projects on topics chosen from the SGH CHNA. In small groups, the students performed research and created poster presentations and handouts on obesity, mental health, diabetes and heart health and shared these projects at both SGH and a community health fair in El Cajon.

Identified Community Health Need – Education					
Objectives/ Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					In FY 2018, SGH continued to collaborate with the Grossmont Union High School District (GUHSD) in the Healthcare Exploration Summer Institute (HESI), providing 23 high school students with opportunities for classroom instruction, job shadowing, observations and limited hands-on experiences. SGH continued to provide HealthCare Towne in FY 2018, an early outreach program for middle and junior high school students designed to build the health care workforce of tomorrow through a field trip to the SGH campus. SGH also continued its participation in the HSHMC program in FY 2018, providing early professional development for approximately 160 students in ninth through 12th grades. Students spent more than 28,440 hours shadowing staff in various areas throughout the hospital. **Background**: *Health Sciences High and Middle College (HSHMC)*: Sixty-seven percent of HSHMC students are economically disadvantaged, and the school's free and reduced-price meal eligibility rate is higher than the average for both SDC and California. Despite these challenges, HSHMC maintains a 95 percent attendance rate and excels in preparing students for high school graduation, college entrance and a future career. In 2018, 91 percent of the HSHMC graduating class went on to attend two- or four-year colleges, while 83 percent of students said they wanted to pursue a career in health care. In addition, HSHMC has a 98.7 percent graduation rate, which is higher than the state of California's average of 82.7 percent.

Identified Community Health Need – Education					
Objectives/ Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					HealthCare Towne: This unique event encouraged students to connect what they learn in the classroom to real-life career opportunities in health care. Healthcare Towne has four major components that include: World of Work, the Puzzle Room, Scenario Tour and In-the-Round Activity. The first component, World of Work, empowered students to develop self-awareness by exploring their strengths, interests and values. Students were divided into three groups to solve three different scenarios. In the Puzzle Room, students collaborated to diagnose a hypothetical patient before they arrived at the hospital by interpreting clues to find the answer and reveal the next piece. In the Scenario Room, students learned about and walked through clinical areas where the patient would receive care, including the ambulance bay, ED, operating room, catheterization laboratory, imaging and intensive care unit. During the final component, In-the-Round Activity, students applied clues, lab results and what they learned throughout the day to help fully diagnose the patient with several conditions. In April and September 2018, approximately 70 local middle school students participated in HealthCare Towne. SGH plans to continue to offer HealthCare Towne to middle and junior high school students in FY 2019.
3. Provide a variety of health and wellness education and services at events and sites throughout the community.	a. Continue participation in City of San Diego Partnership to provide community health education for City of San Diego employees and community residents.	Ongoing	Varies – Educators throughout SGH	Education Chronic Health Conditions Aging Concerns	In FY 2018, this education included classes focused on: diabetes, behavioral health, cardiovascular disease, and aging concerns. Participate in Sharp's partnership with the City of San Diego to provide a variety of education topics and resources to employees and residents in the City's nine districts. Please see the following line items for additional details on SGH community health education addressing identified health needs:

Identified Community Health Need – Education					
Objectives/ Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					• Identified Community Health Need: Aging Concerns 3 • Identified Community Health Need: Aging Concerns 5c • Identified Community Health Need: Aging Concerns 6 • Identified Community Health Need: Cancer 3 • Identified Community Health Need: Cardiovascular Disease 1a and 1b • Identified Community Health Need: Cardiovascular Disease 1d and 1e • Identified Community Health Need: Cardiovascular Disease 1g • Identified Community Health Need: Diabetes • Identified Community Health Need: Maternal and Prenatal Health, Including High-Risk Pregnancy 1a • Identified Community Health Need: Maternal and Prenatal Health, Including High-Risk Pregnancy 3a • Identified Community Health Need: Obesity • Identified Community Health Need: Unintentional Injury & Violence 1a • Identified Community Health Need: Unintentional Injury & Violence 1b

Identified Community Health Need – Homelessness and Housing Instability					
Objectives/ Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
1. Collaborate with organizations in San Diego to serve homeless individuals.	a. Sponsor and participate in the Downtown San Diego Partnership Family Reunification Program.	Ongoing	Sharp Executive Vice President Hospital Operations	Homelessness Housing Instability Transportation Collaboration	With Sharp's help, the Family Reunification Program has reunited nearly 2,200 homeless individuals in Downtown San Diego with friends and family across the nation. In FY 2019, Sharp provided financial assistance for two additional vans to support the program. **Background**: Since 2011, Sharp has sponsored the Downtown San Diego Partnership's Family Reunification Program, which serves to reduce the number of homeless individuals on the streets of downtown San Diego. Through the program, homeless outreach coordinators from the Downtown San Diego Partnership's Clean & Safe Program identify homeless individuals who will be best served by traveling back home to loved ones. Family and friends are contacted to ensure that the individuals have a place to stay and the support they need to get back on their feet. Once confirmed, the outreach team provides the transportation needed to reconnect with their support system.
	b. Assist high-risk and homeless patients, and refer them to local community organizations and resources.	Ongoing	Director, SGH Case Management and Social Work	Homelessness Housing Instability Collaboration Economic Security Transportation	In FY 2018, SGH continued to provide post-acute care facilitation for high-risk patients, including individuals who were homeless or without a safe home environment. Individuals received referrals to and assistance from a variety of local resources and organizations. These groups provided support with transportation, placement, medical equipment, medications, outpatient dialysis and nursing home stays. SGH referred high-risk patients, families and community members to churches, shelters and other community resources for food, safe shelter and other resources. Further, in FY 2018, collaboration with Sharp Global Patient Services, SGH transferred three homeless hospice patients to their native countries and reunited them with family and friends.

Identified Community Health Need – Homelessness and Housing Instability					
Objectives/ Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
	c. Expand Sharp HealthCare integrated delivery system access to post acute recuperative care services offered in collaboration with the San Diego Rescue Mission (SDRM), to include: • All Sharp HealthCare acute hospitals • Sharp Rees-Stealy Medical Group • Sharp Community Medical Group Here, individuals experiencing homelessness find a safe environment to support respite and recovery. In addition, the SDRM offers counseling and education services, access to continued ambulatory care through Federally Qualified Health Center clinics, and information and referral resources for supportive housing.	Ongoing	Sharp VP Integrated Care Management	Homelessness Housing Instability Care Management Collaboration	This strategy also addresses Identified Community Health Need: Access to Care and Health Insurance. Line 3a. Please refer to that section for details.
	d. Creation of a Homeless Task Force within Sharp HealthCare, led by	Ongoing	Sharp VP Integrated Care Management	Access to Care Homelessness	This strategy also addresses Identified Community Health Need: Access to Care and Health Insurance. Line 5a. Please refer to that section for details.

Identified Community Health Need – Homelessness and Housing Instability					
Objectives/ Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
	Integrated Care Management, and including leaders across the Sharp continuum (Sharp, Sharp Mesa Vista Hospital, Sharp Rees-Stealy Medical Group, and Sharp Community Medical Group) for the purposes of: Identifying alternative solutions for hard to place patients requiring long-term supportive care, assisted living, and/or custodial care • To guide assessment and planning for: o Allocation of internal resources o Possible expansion of existing external relationships e. Identification of new opportunities for partnership and/or collaboration			Housing Instability Collaboration Care Management	
3. Improve care management and clinical-community linkages that	a. SGH (along with other Sharp HealthCare entities) will participate in a one-year pilot	July, 2020 To be evaluated in May 2020, for	Director, SGH Case	Clinical Community Linkages	This strategy also addresses Identified Community Health Need: Behavioral Health 2a. Please refer to that section for details.

Identified Community Health Need – Homelessness and Housing Instability					
Objectives/ Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
address social determinants of health (SDOH) through implementation of a new technology platform that shares health and social services data across health care and social service sectors.	utilizing 2-1-1 San Diego's Community Information Exchange (CIE).	continued participation after the one-year pilot.	Management & Social Work SGH Lead Medical Social Worker Manager, Sharp HealthCare Community Benefit and Health Improvement	Data Sharing Community Collaboration All SDOH, e.g., housing, nutrition, transportation, etc.	

Identified Community Health Need – Unintentional Injury & Violence					
Objectives/ Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
1. Increase education and awareness of high school students in SDC's east region around injury and violence prevention, and health care career readiness in these areas (e.g., rehabilitation).	a. Through the ThinkFirst/Sharp on Survival program, continue to partner with Health and Science Pipeline Initiative (HASPI) to increase unintentional injury, violence prevention and associated health career awareness.	Ongoing	Sharp Community Health Educator	Unintentional Injury Violence Prevention Education Collaboration Career Pipleline	FY 2019 plan: • With grant funding, continue linking injury prevention with career readiness and career paths • As part of the HASPI partnership, continue to evolve program curricula to meet the needs of health career pathway classes. • Grow partnership with HASPI through participation in conferences, round table events and collaboration on letters of support for various funding opportunities • Explore further opportunities to provide education to health care professionals and college students interested in health care careers In FY 2018, ThinkFirst/Sharp on Survival provided injury prevention education in a variety of settings to approximately 3,000 East County residents. More than 1,400 of these residents were students in grades nine through 12 who are part of the HASPI program. In FY 2018, ThinkFirst/Sharp on Survival expanded its delivery of HASPI education within East County through presentations to 65 students at Mountain Empire High School, located in the rural backcountry of southeastern SDC. Through the partnership and financial support from HASPI, the ThinkFirst/Sharp on Survival program offered schools in SDC's east region: classroom presentations, small assemblies and offsite learning expos. HASPI school-site programs consisted of classes on the modes of injury, disability awareness, the anatomy and physiology of the brain and spinal cord and other topics. Programs included

Identified Community Health Need – Unintentional Injury & Violence					
Objectives/ Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					personal testimonies from individuals with traumatic brain injury or SCI. **Background**: Sharp's ThinkFirst/Sharp on Survival program is a chapter of the ThinkFirst National Injury Prevention Foundation, a nonprofit organization dedicated to preventing brain, spinal cord, and other traumatic injuries through education, research and advocacy. HASPI is a collaborative network of educators, community organizations and health care industry representatives all working together to increase health and medical career awareness, improve science proficiency in schools and prepare students for future health care careers.
	b. Through the ThinkFirst/Sharp on Survival program, continue to provide education on safety and injury prevention to East County schools, from elementary students to college/university students.	Ongoing	Community Health Educator	Unintentional Injury Violence Prevention Education Collaboration Career Pipeline	FY 2019 plan: • With grant funding, provide educational programming and presentations for local schools and organizations • With grant funding, increase community awareness of ThinkFirst/Sharp on Survival through participation in community events • Continue to provide booster seat education to elementary school children and their parents with funding support from grants • With grant funding, continue to expand program to reach new populations, including throughout SDC's east region and Imperial County • Explore further opportunities to provide education to health care professionals and college students interested in health care careers

Identified Community Health Need – Unintentional Injury & Violence					
Objectives/ Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					With grant funding from the Grossmont Healthcare District (GHD), ThinkFirst/Sharp on Survival provided further outreach to East County schools through presentations reaching more than 70 students at Avocado Elementary School. Presentations were provided to students during three assemblies that focused on TBI, SCI and disabilities. In addition, a group of fourth graders received education on booster seat safety. Students engaged in hands-on learning and disability education through exploration of wheelchair accessible vans. In October, ThinkFirst/Sharp on Survival provided injury prevention education to approximately 550 youth and their parents at the annual GHD-sponsored Kids Care Fest at the Lakeside Rodeo Grounds. Education included proper helmet fitting and booster and car seat use; TBI and SCI; and state safety laws. ThinkFirst/Sharp on Survival also presented on injury prevention, TBI, SCI and disability awareness to approximately 900 college students in SDSU's Disability in Society course. In July, ThinkFirst/Sharp on Survival presented to 20 members of the Casa De Oro, El Cajon and Sunrise Optimist Clubs **Background**: Sharp's ThinkFirst/Sharp on Survival program is a chapter of the ThinkFirst National Injury Prevention Foundation, a nonprofit organization dedicated to preventing brain, spinal cord, and other traumatic injuries through education, research and advocacy.

Identified Community Health Need – Unintentional Injury & Violence					
Objectives/ Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
2. Improve care management and clinical-community linkages that address social determinants of health (SDOH) through implementation of a new technology platform that shares health and social services data across health care and social service sectors.	a. SGH (along with other Sharp HealthCare entities) will participate in a one-year pilot utilizing 2-1-1 San Diego's Community Information Exchange (CIE).	July, 2020 To be evaluated in May 2020, for continued participation after the one-year pilot.	Manager, Sharp HealthCare Community Benefit and Health Improvement Director, Case Management & Social Work	Clinical Community Linkages Data Sharing Community Collaboration All SDOH, e.g., housing, nutrition, transportation, etc.	This strategy also addresses Identified Community Health Need: Behavioral Health 2a. Please refer to that section for details.

Appendix

D Sharp HealthCare 2016 CHNA Phase 2 Findings

SHARP HEALTHCARE 2016 CHNA PHASE 2 FOLLOW-UP SURVEY RESULTS

Abstract

This document includes the results of the Phase 2 Sharp specific survey.

Institute for Public Health| Graduate School of Public Health | San Diego State University

Table of Contents

Introduction

Sharp conducted hospital-specific analyses and contracted separately with IPH to conduct community engagement activities expressly for the communities served by each of its hospitals in the follow-up to the needs assessment. The following are Sharp HealthCare's identified health needs and social determinants of health (SDOH) from the 2016 Community Health Needs Assessment (CHNA).

FIGURE 1. TOP IDENTIFIED HEALTH NEEDS ACROSS ALL SHARP HEALTHCARE HOSPITALS, SHARP HEALTHCARE 2016 CHNA

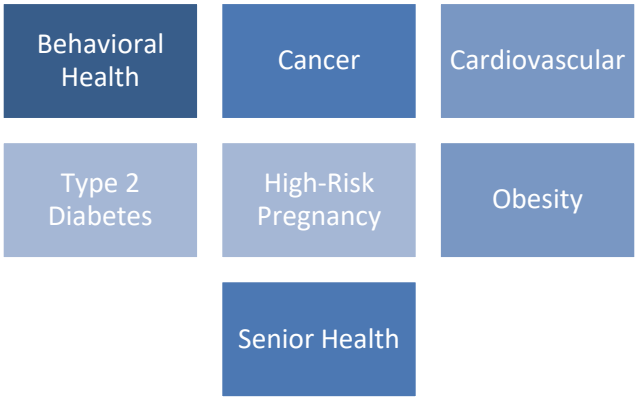


FIGURE 2. SOCIAL DETERMINANTS OF HEALTH, SHARP HEALTHCARE 2016 CHNA

As a follow up to the 2016 CHNA process a community and health care provider survey was conducted in order to gain feedback on the top four health needs and top 10 SDOH that were identified in the 2016 CHNA. Electronic and paper surveys were created in both English and Spanish for the following Sharp community engagement groups: behavioral health, cancer, senior health, and Promotores.

Health Care Provider Survey

Health care provider surveys were collected from different provider groups within Sharp HealthCare. All surveys were given to the IPH for analysis. A total of 11 surveys were completed, six were completed online and five were completed via pencil/paper format.

TABLE 2. HEALTH CARE PROVIDER SURVEY, 2016 CHNA FOLLOW-UP SURVEY (N=11)

Survey Question and Response Choices	n	%
1. Who/what group did you represent in Sharp's 2016 CHNA process? (n=11)		
Sharp cancer patient navigator	3	27%
Sharp care coordinator	0	0%
Sharp nurse* (including nurse practitioner)	4	36%
Promotora	0	0%
Sharp social worker	3	27%
Other, please specify	1	9%
Senior center manager		
Total	**11**	**100%**
2. Do you agree that the health needs listed above are the top health needs of communities facing inequities within San Diego County? (n=11)		
Strongly Agree	7	64%
Agree	4	36%
Neutral	0	0%
Disagree	0	0%
Strongly Disagree	0	0%
Total	**11**	**100%**
3. Please add any additional comments about the top health needs of communities facing inequities within San Diego County (n=5)		
Total Comments	5	
Behavioral Health		
Narcotic addiction		
Does behavioral health include drug abuse?		
Substance abuse - alcohol and heavy recreational drugs (i.e. meth) and pain medication (narcotics), mental health, and pain management.		
Senior Health Issues		
Seniors on Medi-Cal are particularly vulnerable population for a variety of reasons.		
Access to transportation for seniors is also a high priority		

4.	**Do you/does your organization or department screen for behavioral health issues when treating patients for a physical health condition? (n=11)**		
	Yes	11	100%
	No	0	0%
	I Don't Know	0	0%
	Total	**11**	**100%**
5.	**Please choose the different screening methods you utilize to identify and/or document behavioral health issues. Check all that apply. (n=10)**		
	Casually talk with patients to gather information on possible behavioral health issues.	5	50%
	Ask standardized screening questions on specific behavioral health issues.	8	80%
	Document identified behavioral health issues within the patients' chart or records.	6	60%
	Refer patients to behavioral health resources.	6	60%
	Conduct trend analysis on the behavioral health issues for your patients and clients.	0	0%
	Follow-up with patients' behavioral health care provider (if they have one).	2	20%
	Follow-up with patients on their behavioral health screening and referrals.	3	30%
	Other, please specify	2	20%
	Distress screening tool (for radiation patients)		
	Total Respondents	**10**	
6.	**Please explain your organization's/department's screening process. (n=6)**		
	Total comments	**6**	
7.	**Have you tried to gain access to patient medical records outside of your organization for patients' physical conditions? (n=5)**		
	Yes	7	70%
	No	3	30%
	Total	**10**	**100%**
8.	**What has been your experience when trying to obtain patient medical records? (n=7)**		
	Very Easy	1	14%
	Easy	2	29%
	Neutral	2	29%
	Difficult	2	29%
	Very Difficult	0	0%
	Total	**7**	**100%**
9.	**Please explain your experience with obtaining patient medical records. (n=6)**		
	Total comments	**6**	
10.	**Do you agree that the ten factors listed above represent the greatest barriers for communities with poor health outcomes in San Diego County? (n=9)**		
	Strongly Agree	7	78%
	Agree	1	11%
	Neutral	1	11%
	Disagree	0	0%
	Strongly Disagree	0	0%

Total	**9**	**100%**
11. Please add any additional comments about factors representing the greatest barriers for communities with poor health outcomes in San Diego County. (n=2)		
Total comments	**2**	
I do not have an adequate vision across the broad needs because I deal only with a subset (geriatrics) of the whole (population). View complete survey for this response		
I agree with all of the above list!		
12. Do you/does your organization identify factors that contribute to a person's health within the populations that you serve? (n=9)		
Yes	8	89%
No	0	0%
I Don't Know	1	11%
Total	**9**	**100%**
13. What factors that contribute to a person's health does your organization screen for? Check all that apply. (n=8)		
Food Insecurity & Access to Healthy Food	5	63%
Access to Care or Services	7	88%
Homeless/Housing issues	6	75%
Physical Activity	6	75%
Education/Knowledge	8	100%
Cultural Competency	4	50%
Transportation	8	100%
Insurance Issues	6	75%
Stigma	4	50%
Poverty	5	63%
Other	0	0%
Total Respondents	**8**	
14. Please choose the different screening methods you utilize in your organization to identify and/or document the factors that contribute to a patients' health. Check all that apply. (n=8)		
Casually talk with patients to gather information on possible factors that contribute to a person's health	8	100%
Ask standardized screening questions on these specific factors.	1	13%
Document any identified factors within the patients' chart or records.	8	100%
Refer patients to resources that address these factors.	8	100%
Conduct trend analysis on the factors that contribute to a person's health identified for your patients and clients.	1	13%
Follow-up with patients who were identified with high risk factors.	3	38%
Other	2	25%
Distress screening in radiation identifies social issues. Radiation oncology nurses do an assessment as well as navigators.		
Distress screening tool, radiology oncology (RadOnc) RN assessment, and patient navigator interactions.		
Total Respondents	**8**	

15. How likely are you to use these findings and/or data that resulted from the CHNA to help inform your programs or help in the grant writing process? (n=9)		
Very Likely	3	33%
Likely	1	11%
Neutral	4	44%
Unlikely	1	11%
Very Unlikely	0	0%
Total	**9**	**100%**
16. Sharp HealthCare is trying to learn about the work already being done to address factors that contribute to a person's health and reduce health inequity. Please take a moment to identify organizations who are leading in the areas identified below. (n=8)		
Food Insecurity & Access to Healthy Food	7	88%
Access to Care or Services	5	63%
Homeless/Housing issues	3	38%
Physical Activity	5	63%
Education/Knowledge	2	25%
Cultural Competency	2	25%
Transportation	7	88%
Insurance Issues	5	63%
Stigma	0	0%
Poverty	3	38%
Total Respondents	**8**	
17. Please provide any additional comments about the results of the CHNA: (n=1)		
Total comments	**1**	
Often times we can identify a need, but there may be a lack of resources to help meet those needs.		
18. For reporting purposes for the hospitals, please provide the type of organization you work for. (n=9)		
Sharp Coronado Hospital and Healthcare Center	0	0%
Sharp Chula Vista Medical Center	0	0%
Sharp Grossmont Hospital	2	22%
Sharp McDonald Center	0	0%
Sharp Memorial Hospital	3	33%
Sharp Mary Birch Hospital for Women & Newborns	1	11%
Sharp Mesa Vista Hospital	0	0%
Community Based Organization	0	0%
Other (non Sharp) Health Care Provider	0	0%
Community Clinic (Federally Qualified Health Center)	0	0%
Other, please specify	3	33%
Sharp Senior Health Centers (Downtown)		
Total	**9**	**100%**

Health Care Provider - Open Ended Responses

Question 6. Please explain your organization's/department's screening process. (N=6)

Depression Screening (including dementia and functional status) **(n=2)**

1. All new patients get screened for depression and again if an annual wellness visit is done. Patient may be screened again for interval symptom development. Patients are treated in this office/or referred to as appropriate.
2. When we do their annual wellness visit, we do a dementia, functional status, and depression screening.

Distress Screening for radiation patients (n=2)

1. Distress screening is done with radiation patients to identify barriers and needs incorporating psycho-social assessment. Radiation nurses ask about social situation when doing their consults.
2. The distress screening tool is given prior to the start of radiation treatment and reviewed by the Radiation Oncology nurses and social workers. Asks questions about: thoughts about death and dying, personal safety, suicidal thoughts, substance use, and other emotions.

Standardized Screening (including social worker follow-up) **(n=2)**

1. Alcohol, Depression, Tobacco, Falls, Immunizations, Preventative health measures, Obesity, Diabetes
2. There are standardized questions asked of all pts [patients] upon admission and if they screen positive to any of the, a social worker f/u with them for further assessment and to provide referrals as appropriate.

Question 9. Please explain your experience with obtaining patient medical records. (N=6)

1. If the doctor office is Sharp affiliated or has good referral relations, it is typically easy to get information on shared patients. Typically, there are time delays for patients outside of Sharp affiliates i.e. UCSD.
2. Usually straightforward process. Once the proper papers are signed, sometimes can take several days to receive copies.
3. Difficult at times; sometimes I need to request 2-3 times.
4. Takes extra time. Most, but not all requested records arrive in a timely manner.
5. Sometimes can present a challenge with the efficiency of the office that we are dealing with.
6. We rarely get notes automatically sent to us from referral clinics and have to request them, often taking extended periods of time to obtain.

Question 16. Sharp HealthCare is trying to learn about the work already being done to address factors that contribute to a person's health and reduce health inequity. Please take a moment to identify organizations who are leading in the areas identified below. (N=8)

Food Insecurity & Access to Healthy Food

1. Mama's Kitchen
2. Jewish Family Services Food Pantry
3. Serving Seniors (2)

4. San Diego Food Bank (3)
5. General comments: (food bank, nutrition classes, nutrition services)

Access to Care or Services

1. PACE (Programs of All-Inclusive Care for the Elderly)
2. Insurance companies (some provide translation and transportation)
3. San Diego County Aging and Independence Services
4. General comment: provide resources for home care services, in-home care services information

Homeless/Housing Issues

1. 2-1-1 San Diego, but they do not have too much to offer
2. Serving Seniors
3. General comment: need more resources for outpatients such as actual housing and/or funding for housing

Physical Activity

1. Feeling Fit
2. Sharp HealthCare
3. Silver Sneakers, for Medicare patients (2)
4. YMCA (2)
5. General comment: will order physical therapy (PT) when necessary

Education Knowledge

1. General comment: community education classes on senior topics

Cultural Competency

1. Jewish Family Service - Refugee Program

Transportation

1. American Cancer Society Road to Recovery
2. Jewish Family Services Sharp
3. Sharp HealthCare Van Services (2)
4. Sharp Senior Center
5. General comments: our clinic offers limited transportation; there is a need for more free transportation for patients who have appointments/ treatment. (3)

Insurance Issues

1. HiCAP (Health Insurance Counseling & Advocacy Program)
2. Sharp HealthCare
    a. Referrals to local clinics for the Breast and Cervical Cancer Treatment Program
    b. Vital support fund for breast cancer patients who cannot afford out of pocket for services at Sharp Grossmont
    c. Financial Counselors
3. Sharp Senior Center
4. Social services

Poverty

1. Breast Cancer Angels
2. Cancer care grants for breast cancer patients

3. Jewish Family Community Service
4. Patient Advocate Foundation
5. Shades of Pink
6. St. Vincent De Paul
7. General comments: Referrals are needed and some are income-based, need for more financial assistance resources and for all types of cancer patients (disease sites)

Behavioral Health Community Survey

As part of Sharp HealthCare's specific needs assessment process, attendees of an aftercare support group were asked to fill out the follow-up survey during an existing meeting. The purpose was to follow-up with the same aftercare group that was targeted during the 2016 CHNA Phase 1 process, but generally speaking, respondents to this survey were not the original participants in Phase 1 of the 2016 CHNA process/survey. This is due to turnover in this particular patient population.

TABLE 3. COMMUNITY SURVEY, AFTERCARE SUPPORT GROUP, 2016 CHNA FOLLOW-UP SURVEY (N=65)

Survey Question and Response Choices	n	%
1. Who/what group did you represent in Sharp's 2016 CHNA process? (n=65)		
Aftercare support group	56	86%
Cancer support group	0	0%
Patient Family Advisory Council (PFAC)	0	0%
Senior	0	0%
I was not involved in the 2016 CHNA process	9	14%
Other	0	0%
Total	**65**	**100%**
2. Do you agree that the health needs listed above are the top health needs for you or others in your community? (n=65)		
Strongly Agree	27	42%
Agree	29	45%
Neutral	8	12%
Disagree	1	2%
Strongly Disagree	0	0%
Total	**65**	**100%**
3. Please add any additional comments about the top health needs for you or others in your community (n=14)		
Total Comments	**14**	
4. Do you agree that the ten factors listed above represent the greatest barriers to health for you or others within your community? (n=65)		
Strongly Agree	22	34%
Agree	22	34%
Neutral	19	29%
Disagree	1	2%
Strongly Disagree	1	2%
Total	**65**	**100%**
5. Please add any additional comments about factors that contribute to a person's health. (n=15)		
Total Comments	**15**	

6. Please provide any additional comments about the results of the CHNA (n=6)	
Total Comments	6

Behavioral Health Community - Open Ended Responses

Question 3. Please add any additional comments about the top health needs for you or others in your community. (N=14)

Access to services (n=1)

1. Need additional attention and aftercare services.

Behavioral Health (addiction, inquiry regarding inclusiveness of definition) **(n=4)**

1. I think addiction is in behavioral health category. But I somewhat feel that for some of us, once you take the drugs and alcohol away, there are no other present mental health issues.
2. Addiction should be its own category.
3. Addiction.
4. Substance abuse (if that is considered behavioral health).

Cancer (n=1)

1. Cancer should be [the] #1 [health need] in my opinion.

Compliment (n=2)

1. Sharp is great.
2. Aftercare has been instrumental in my continued sobriety.

Education/Knowledge (n=1)

1. Ignorant of big picture.

Health Insurance/Access to Care (Socio-Economic) **(n=1)**

1. More health care for the poor.

Miscellaneous (including critiques) **(n=3)**

1. Med-nurse at McDonald Center "Chester" is highly inappropriate and oversteps boundaries with patients during their inpatient treatment.
2. Not sure about it.
3. Monte Morbach here - I have two degrees in college. This survey is ridiculous (sorry for the poor wording). I'm doing this in a meeting (as requested). Regarding this aftercare program - it is a very important program to those of us that went through the IOP programs. Please call me or email me and I will be happy to help you put together a useful and realistic survey for all of us in this Sharp program. (left contact info) What do you really want to know?

Sexual Health Education/Awareness (n=1)

1. HIV/AIDS awareness/ Sexual health

Question 5. Please add any additional comments about factors that contribute to a person's health. (N=15)

Access to care (time to see provider, behavioral health, insurance issues, stigma) **(n=4)**

1. One factor is also the time it takes to get to see a doctor.
2. We need more residential treatment centers in San Diego County. Jail is not recovery!
3. Access to affordable healthcare - affordable healthcare that provides coverage to preexisting conditions. Stress related to insurance complexities.
4. More focus needed on stigma and access to care or services

Behavior (Health Habits) **(n=1)**

1. Lazy is a bigger cause of poor eating.

Compliment (n=1)

1. Sharp is doing a great job in identifying needs and acting on them.

Education/Knowledge (financial competence, prevention) **(n=2)**

1. Financial competence and its relationship to cooking competence.
2. Not enough attention paid to preventative health care.

Miscellaneous (including critiques) **(n=3)**

1. Not sure about it.
2. Ignorant of big picture.
3. More food options for diabetics, less sweets!

Supportive Services (n=4)

1. Individual support services.
2. Support system.
3. Spiritual.
4. Spirituality and a strong support group.

Question 6. Please provide any additional comments about the results of the CHNA. (N=6)

Compliment (aftercare program, McDonald Center) **(n=4)**

1. Thank you.
2. McDonald aftercare has been instrumental in my sobriety. This group has changed my life by the friendships I have developed as a result of this amazing group pf people.
3. Aftercare has given me a sense of community. Staying connected to those I went through treatment with is an important part of my sobriety.
4. Aftercare is incredibly successful.

Miscellaneous (n=1)

1. Was not a part of [the CHNA].

Stigma/Access to Care/Access to Services (n=1)

1. More focus needed on stigma and access to care or services

Cancer Community Survey

As part of Sharp HealthCare's specific follow-up process, cancer support group participants were asked to fill out a follow-up survey. The cancer surveys were slightly modified compared to the community surveys after receiving feedback from the Cancer Patient Navigators. The survey was facilitated by a Cancer Patient Navigator with the purpose of gathering feedback from community residents within San Diego County whose lives are impacted by cancer. All surveys were given to the IPH for analysis. A total of 60 surveys were completed by cancer support group participants.

TABLE 4. CANCER SURVEY, 2016 CHNA FOLLOW-UP SURVEY (N=60)

Survey Question and Response Choices	n	%
1. Please mark the category that best describes your connection to Sharp. (n=57)		
Cancer Patient	57	100%
Family member of a cancer patient	0	0%
Other, please specify	0	0%
Total	**57**	**100%**
2. Did you participate in Sharp's 2016 community health needs assessment survey last year? (n=57)		
Yes	2	4%
No	42	74%
I Don't Know	13	23%
Total	**57**	**100%**
3. Do you agree that health needs listed below are the top health needs for you or others in your community? (n=60)		
Strongly Agree	31	49%
Agree	24	42%
Neutral	4	7%
Disagree	0	0%
Strongly Disagree	1	2%
Total	**60**	**100%**
4. Are there any other health needs for you or others in your community? (n=22)		
Total Comments	**22**	
5. Do you agree that the ten factors listed below are the greatest health concerns for you and others within your community? (n=60)*		
Strongly Agree	19	32%
Agree	24	39%
Neutral	15	26%
Disagree	1	2%
Strongly Disagree	1	2%
Total	60	100%
6. Please let us know of any other issues that you feel affects a person's health. (n=13)		
Total Comments	**13**	

*Question 5 on the community survey had slightly different wording compared to the cancer survey, three responses were completed with the community survey. Q5: Do you agree that the ten factors listed above represent the greatest barriers to health for you or others within your community?

Question 4. Are there any other health needs for you or others in your community? (N=22)

Access to care (providers, specialists, services) **(n=2)**

1. Better access to second opinions. Better access to fast emergency room care.
2. Lungs primary care doctor

Behavioral Health (Mental Health) **(n=3)**
Chronic Disease (Parkinson's Disease) **(n=1)**
Compliment (n=2)

1. Good
2. Note: All your workers are very kind and professional and caring people

Critique (Transportation services, appointments, related costs) **(n=2)**

1. Better coordination for appointments, perhaps 2 or 3 in one day saves time, cost of time, and travel. We spend a minimum of $9.00 a day for an appointment.
2. The transport of all times and having to call every day before is a true mess. I get so flustered. I want to be nice, but the person doing the day to day does not make it easy!

No additional comment (n=9)

- **Written response of "no", don't know, "not at this time/to my knowledge"**

Nutrition (Proper nutrition) (**n=1)**
Prevention/Early Screening (for Children and Teens) **(n=1)**

- Physicals for healthy kids that are at risk for heart attacks and food options that are healthy for growing teens (the risk of so much caffeine, sodas, etc.).

Senior Health Supportive Care/Services (n=1)

- Alzheimer's/elderly care for those that live a full life. We need to take care of our elderly by providing better care of us when we get old.

Question 6. Please let us know of any other issues that you feel affects a person's health. (N=13)

Access to care and services (n=1)

- Service from all of branches of healthcare are number one.

Behavioral Health (n=2)

1. Mental health/depression.
2. Mental attitude. Teeth care.

Health (General) Risk Factors (genetics, stress) **(n=2)**

1. Genetic - family history of disease
2. Work environment - stress

Compliment (n=2)

1. Satisfied.
2. You've covered the bases quite well in our opinion. We have always been very pleased with our care here. You are stellar at what you do for patients and their families. Thank you!

Food and Nutrition Habits (n=1)

- Daily food preparation for self and family

Housing Issues (n=1)

- Affordable rent

Physical Health (n=1)

- Chronic Pain

Senior Health Issues (n=1)

- Aging issues

No additional comments (n=2)

- Written response of "no" and "none".

Promotores Community Survey

A survey was conducted during a bi-monthly Sharp HealthCare Share and Learn Breakfast in order to follow-up with the community health workers and Promotores who were involved in the Phase 1 process, but generally speaking, respondents to this survey were not the original participants in Phase 1 of the 2016 CHNA process/survey. This is due to turnover in this particular community group. The Conviva y Aprenda (Share and Learn) Breakfast is an educational breakfast seminar that Sharp HealthCare Multicultural Services offers to community health workers and Promotores. During this event attendees were asked to complete a survey after a brief presentation about Sharp HealthCare's CHNA results. The presentation was conducted in Spanish; and Spanish surveys were distributed. The surveys were completed in pencil/ paper format and were collected by a Sharp HealthCare representative. All surveys were given to the IPH for analysis. A total of 38 surveys were completed.

TABLE 5. PROMOTORA SURVEY, 2016 CHNA FOLLOW-UP SURVEY (N=38)

Survey Question and Response Choices		n	%
1.	**Who/what group did you represent in Sharp's 2016 CHNA process? (n=38)**		
	Sharp cancer patient navigator	2	5%
	Sharp care coordinator	0	0%
	Sharp Nurse	0	0%
	Promotora	18	47%
	Sharp social worker	1	3%
	Other: *not specified (5)*, volunteer (2), patient (1), community health worker (2), community outreach/health promotion/health education (7)***	17	45%
	Total	**38**	**100%**
2.	**Do you agree that the health needs listed above are the top health needs of communities with poor health outcomes within San Diego County? (n=37)**		
	Strongly Agree	22	59%
	Agree	13	35%
	Neutral	2	5%
	Disagree	0	0%
	Strongly Disagree	0	0%
	Total	**37**	**100%**
3.	**Please add any additional comments about the top health needs of communities with poor health outcomes within San Diego County. (n=28)**		
	Total Comments	**28**	

4.	**Do you/does your organization or department screen for behavioral health issues when treating patients for a physical health condition? (n=38)**		
	Yes	16	42%
	No	15	39%
	I Don't Know	7	18%
	Total	**38**	**100%**
5.	**Please choose the different screening methods you utilize to identify and/or document behavioral health issues. Check all that apply. (n=16)**		
	Casually talk with patients to gather information on possible behavioral health issues.	12	75%
	Ask standardized screening questions on specific behavioral health issues.	8	50%
	Write down any identified behavioral health issues within the patients' chart or records.	7	44%
	Refer patients to behavioral health resources.	9	56%
	Look at trends on the behavioral health issues for your patients and clients.	6	38%
	Follow-up with patients' behavioral health care provider (if they have one).	5	31%
	Follow-up with patients on their behavioral health screening and referrals.	7	44%
	Other, please specify *(Request further study on the problem at hand, Recommend books, etc., Do a follow-up with the patient about their needs, appointments and help provided.)*	3	19%
	Total	**16**	
6.	**Please explain your organizations/departments screening process. (n=9)**		
	Total comments	**9**	
7.	**Have you tried to gain access to patient medical records outside of your organization for patients' physical conditions? (n=34)**		
	Yes	10	29%
	No	24	71%
	Total	**34**	**100%**
8.	**What has been your experience when trying to obtain patient medical records? (n=8)**		
	Very Easy	2	25%
	Easy	1	13%
	Neutral	3	38%
	Difficult	1	13%
	Very Difficult	1	13%
	Total	**8**	**100%**
9.	**Please explain your experience with obtaining patient medical records. (n=5)**		
	Total comments	**5**	
10.	**Do you agree that the ten factors listed above represent the greatest barriers for communities with poor health outcomes in San Diego County? (n=35)**		
	Strongly Agree	21	60%
	Agree	11	31%
	Neutral	3	9%
	Disagree	0	0%
	Strongly Disagree	0	0%
	Total	**35**	**100%**
11.	**Please add any additional comments about factors representing the greatest barriers for communities with poor health outcomes in San Diego County.(n=16)**		
	Total comments	**16**	

12. Do you/does your organization identify factors that contribute to a person's health within the populations that you serve? (n=32)		
Yes	21	66%
No	6	19%
I Don't Know	5	16%
Total	**32**	**100%**
13. What factors that contribute to a person's health does your organization screen for? Check all that apply. (n=21)		
Food Insecurity & Access to Healthy Food	9	43%
Access to Care or Services	14	67%
Homeless/Housing issues	8	38%
Physical Activity	9	43%
Education/Knowledge	10	48%
Cultural Competency	7	33%
Transportation	10	48%
Insurance Issues	10	48%
Stigma	5	24%
Poverty	7	33%
Other	0	0%
Total	**21**	
14. Please choose the different screening methods you utilize in your organization to identify and/or document the factors that contribute to a patients' health. Check all that apply. (n=21)		
Casually talk with patients to gather information on possible factors that contribute to a person's health	12	57%
Ask standardized screening questions on these specific factors.	11	52%
Write down any identified factors within the patients' chart or records.	7	33%
Refer patients to resources that address these factors.	13	62%
Look at trends on the factors that contribute to a person's health identified for your patients and clients.	7	33%
Follow-up with patients who were identified with high risk factors.	10	48%
Other *(Workshops, Go to shelters to help women and men who have been abused physically and mentally, Give patients/clients written information on health/resources and references and a phone number where people can contact me in a secure way with no compromise.)*	3	14%
Total	**21**	
15. How likely are you to use these findings and/or data that resulted from the CHNA to help inform your programs or help in the grant writing process? (n=32)		
Very Likely	15	47%
Likely	10	31 %
Neutral	4	13%
Unlikely	3	9%
Very Unlikely	0	0%
Total	**32**	**100%**

16. Sharp HealthCare is trying to learn about the work already being done to address factors that contribute to a person's health and reduce health inequity. Please take a moment to identify organizations who are leading in the areas identified below. (n=14)		
Food Insecurity & Access to Healthy Food	12	86 %
Access to Care or Services	10	71 %
Homeless/Housing issues	6	43 %
Physical Activity	6	43 %
Education/Knowledge	5	36 %
Cultural Competency	2	14 %
Transportation	7	50 %
Insurance Issues	7	50 %
Stigma	1	7%
Poverty	1	7%
Total	**14**	
17. Please provide any additional comments about the results of the CHNA: (n=12)		
Total comments	**12**	
18. For reporting purposes for the hospitals, please provide the type of organization you work for. (n=25)		
Community Based Organization	12	48 %
Other (non-Sharp) Health Care Provider	1	4%
Community Clinic (Federally Qualified Health Center)	5	20 %
Other, please specify	7	28 %
Vision y Compromiso		
Invited Guest		
PAC (Amigaspunto)		
Casa Familiar of San Ysidro		
CASA/ San Ysidro Health Center		
American Diabetes Association Volunteer		
Other, not specified		
Total	**25**	**10 0%**

Health Care Provider Survey, Promotores - Open Ended Responses

Question 3. Please add any additional comments about the top health needs of communities with poor health outcomes within San Diego County. (N=28)

Access to care (Doctors/medical staff, Appointment availability and length of scheduling time) **(n=16)**

1. When I request an appointment, there is no availability for when I need it when I am sick.
2. Appointments are too far out. Doctors do not treat you as needed.
3. Appointments are too hard.
4. Follow-up appointments are too far out and very little listening to the patient's symptoms.
5. Maybe more medical staff and offer appropriate amount of attention as necessary.
6. Medical appointments are (scheduled) too far away.
7. Need for health coverage.
8. Promote community clinics that can serve and primary doctors who can help in that area.
9. Sometimes appointments are given too far out (in time).
10. The appointment process is slow due to the high volume of patients.
11. The appointments are too far out. The invoice sometimes does not correspond to the care being provided, the time of care is very little, and they do not treat you properly. They do not treat all of your health problems.
12. The appointments given are too far out.
13. The doctors have a slow process. Doctors are in a hurry.
14. The process of appointments is very prolonged (2 to 3 months). The main (primary) doctor does not send you to see a specialist until your situation is critical.
15. There are no basic services being done like annual physicals and annual dental exams.
16. Very short time for the appointments.

Behavioral Health (n=1)

1. In behavioral health, the topic of "depression" should be more exposed continually and how to identify it in kids, adolescents, adults, and the elderly. Also, oral health.

Cultural Competency/Knowledge/Education (n=6)

1. There is a need for more health education in the community in general...the consequences of not going to an appointment. There needs to be education on prevention.
2. Language - they do not reach out because it is embarrassing. They do not have trust in giving their personal information and other people do not have the information of where to go for help. They take forever to treat and the appointments are given too far out.
3. Give them the information in their primary language and socially-cultural competency according to each generation being treated.
4. Offer classes or conferences to people, especially house wives and thousands of women that do not work.
5. Both the community group and the group of people who provide a service must be well informed about the service as well as providing a collaborative service.
6. Health fairs with education information and disease prevention information.

Insurance Issues (n=3)

1. I would like for the process to not be so difficult. And for there to be an Obamacare that is truly a good health coverage...and for everyone to be treated without excuses.
2. Very little information on how to obtain health coverage. Opportunity to express ourselves with the doctor without having to worry about another patient coming in.

3. Currently it is unknown on whether Obamacare is in effect or not.

Oral/dental health* (mentioned with behavioral health comment) **(n=1)**

Senior Issues (n=1)

1. More information to the population of 65+ in the process of Medicare and Medi-Cal to be able to evaluate the health services for the older adult.

Sexually transmitted diseases and teen pregnancy (n=1)

Question 6. Please explain your organization's screening process.

1. Talk with the patient and accompany them
2. When a behavioral health issue is observed, a referral is made to a specialty provider. We keep in contact with the patient.
3. We start off with a questionnaire. Based on this we start a conversation. And based on the reaction and response, we give an orientation.
4. At the beginning there is a questionnaire to be filled out to be able to detect behavioral health issues.
5. Follow the patient's requirements for their health.
6. Workshops on identification in their personality and emotions.
7. I do not have the information or details, but I know it is a process that happens with every patient.
8. After determining that the client needs our services, a process of demographic exploration starts with a worker that links them to medical services.
9. Used internal referrals and self-referrals information as referral number for behavioral health!

Question 9. Please explain your experience (with obtaining patient medical records).

1. As a patient, sometimes with clinics, it is a long process. One has to be calling and they do not pay attention or they charge.
2. They do not give access to the medical records quickly.
3. It is a bit of a slow process and it is confidential information. We ask for information from the patient of where to ask for their information. Then the patient signs a form to release their information.
4. Having the authorization from your health insurance makes it faster to schedule an appointment.
5. One requests that the patient request their own medical records and then send it to us via mail.

Question 11. Please add any additional comments about factors representing the greatest barriers for communities with poor health outcomes in San Diego County. (N=16)

Education (n=5)

1. Knowledge - lack of knowing what is good for your health.
2. Provide the patient with more clear information about their health care plan.
3. Ignorance, but that depends on each person. They can go to a library to learn and know more about a topic, specifically about health.

4. Culture - it is hard for people to be preventative. They wait until they are ill to see a doctor.
5. I'm new to the country. I do not know who to go to or where.

Immigration (n=1)

1. Migration problems

Lack of quality care (n=1)

1. The fast lifestyle that one lives obstructs a service of excellence. Everything is with very little amount of time for both the provider and the patient. There needs to be more time to create quality service and to create a link between providers and patients. In doing so, there will be more medical follow-ups.

Language (n=2)

1. Language, socially cultural, generational (baby boomers, generation x, millennials, etc.).

Miscellaneous (n=2)

1. Medical personnel only devote themselves to prescribe without guiding the patients about their diagnosis.
2. "Barriers: fear, education, socio-economic level, language, immigration status, transportation, child care, civil status, attitude/conduct, information, social environment. Necessities: healthy foods, basic necessities (clothes, shoes, food), health services that are accessible, recreational areas, public security/safety, education (access) information and support, community support."

Oral Health (n=1)

1. One other topic that is almost never considered is oral health in kids, adults, and the elderly (taking care of dentures).

Socio-economic (n=1)

1. Missing: abuse of every class (socio-economic?)

Transportation (n=1)

Trust (n=1)

1. There needs to be trust in the community workers, promotores, and clinics from the community members.

Question 16. Sharp HealthCare is trying to learn about the work already being done to address factors that contribute to a person's health and reduce health inequity. Please take a moment to identify organizations who are leading in the areas identified below. (N=14)

Social Determinant of Health	Organization
Access to Care or Services (n=10)	Casa Familiar of San Ysidro (n=2)
	Family Health Centers of San Diego
	Live Well San Diego
	PAC
	San Ysidro Health Center (n=5)
Homeless/Housing Issues (n=7)	CASA Familiar

	Chula Vista Police Department Homeless Outreach Team (CVPD HOT)
	Family Health Centers of San Diego
	Homeless grant
	HOPWA (Housing Opportunities for Persons with AIDS) (n=2)
	SBCS (Southbay Community Services)
Physical Activity (n=8)	CASA (n=2)
	Casa Familiar of San Ysidro (n=4)
	Public Library Yoga Classes at Chula Vista and Otay
	YMCA
Education Knowledge (n=6)	CASA
	Casa Familiar of San Ysidro
	Instituto Cisotifico San Luis
	San Ysidro Health Center (SYHC) (n=2)
	Vision y Compromiso (Vision and Commitment) - Education/training for health promoters and community workers
Cultural Competency (n=2)	Depending on a patient's health care plan.
	Employee training at Family Health Centers of San Diego
Transportation (n=7)	Depending on age/health insurance
	Medical insurance plans
	MTS (San Diego Metropolitan Transit System) (n=3)
	PACE (San Diego Program of All-Inclusive Care for the Elderly) as offered through SYHC
	San Ysidro Health Center (SYHC)
Insurance Issues (n=10)	2-1-1 San Diego
	Chula Vista Community Collaborative * (n=2)
	Family Health Centers of San Diego (n=2)
	HICAP (the Health Insurance Counseling & Advocacy Program)
	San Ysidro Health Center (n=3)
	Sharp HealthCare
Stigma (n=1)	HIV, HEP C, STD Programs
Food Insecurity & Access to Healthy Food (n=16)	2-1-1 San Diego
	Alma Sandoval
	Family Health Centers of San Diego
	Farmers Markets
	Food Bank
	Heart and Hands Working Together - San Ysidro
	Homestart Program
	Mama's Kitchen (n=4)
	PAC
	SNAP

	WIC (n=3)
Poverty (n=2)	Family Health Centers of San Diego - homeless program
	Food lines

*Respondents did not define acronym for org. This was our best guess in identifying the organization.

Question 17. Please provide any additional comments about the results of the CHNA (N=12)

1. "everything is fine"
2. It is good to have these statistics. But there should be a priority on people rather than number resulting from a study. Let's take care of issues, not be worried by them.
3. Promotores/community workers should have the opportunity to learn strategies to reach our communities.
4. I do not know many people in these situations.
5. Compliment (**n=**4):
    a. Excellent information. Inform the leaders and new generations for them to see and understand.
    b. Good job. Thank you for your valuable assistance to our community's well-being
    c. They have been very beneficial and helpful for everyone. Thank you very much.
    d. Very good.
6. Take into account that these results change with every major event in society. Please continue studying the results to be able to update community needs.
7. Dental health - access to dentists and health coverage.
8. In reference to health fairs, it would be good to implement a new concept that is not for people who are already ill, but to prevent it. And try to implement something new that attracts attention from patients like Zumba, informative loteria (Mexican bingo card game), vaccines, dental revision.
9. Nowadays because of our new government, we have the problem of fear in communities to seek and receive medical attention or services offered to the community.

Senior Health Community Survey

As part of Sharp HealthCare's specific needs assessment process, community members accessing services from Sharp Senior Health Centers were asked to fill out the follow-up survey with assistance from their health care practitioner; most often a nurse. The purpose was to follow-up with the same senior groups that were targeted during the 2016 CHNA Phase 1 process; however generally speaking, respondents to this survey were not the original participants in Phase 1 of the 2016 CHNA process/survey. This is due to turnover in this particular patient population

TABLE 6. COMMUNITY SURVEY, SENIOR CENTER, 2016 CHNA FOLLOW-UP SURVEY (N=5)

Survey Question and Response Choices	n	%
1. Who/what group did you represent in Sharp's 2016 CHNA process? (n=5)		
Aftercare support group	0	0%
Cancer support group	0	0%
Patient Family Advisory Council (PFAC)	0	0%
Senior	1	20%
I was not involved in the 2016 CHNA process	4	80%
Other	0	0%
Total	**5**	**100%**
2. Do you agree that the health needs listed above are the top health needs for you or others in your community? (n=5)		
Strongly Agree	2	40%
Agree	2	40%
Neutral	1	20%
Disagree	0	0%
Strongly Disagree	0	0%
Total	**5**	**100%**
3. Please add any additional comments about the top health needs for you or others in your community (n=1)		
Total Comments (Senior mobility is very important to me.)	**1**	
4. Do you agree that the ten factors listed above represent the greatest barriers to health for you or others within your community? (n=5)		
Strongly Agree	3	60%
Agree	1	20%
Neutral	1	20%
Disagree	0	0%
Strongly Disagree	0	0%
Total	**5**	**100%**
5. Please add any additional comments about factors that contribute to a person's health. (n=1)		
Total Comments (I feel that teen pregnancy is another issue that should be talked about more.)	**1**	
6. Please provide any additional comments about the results of the CHNA (n=0)*		
Total Comments	**0**	

*excluded one comment due to individual not understanding question

Appendix

E Sharp CHNA Community Guide

Sharp HealthCare
Community Health Needs Assessment Guide

As a not-for-profit organization, Sharp HealthCare places great value on the health and wellness of the San Diego community. This value is reflected in Sharp's mission to improve the health of those it serves with a commitment to excellence in all that it does.

Since 1995, Sharp has participated in a countywide collaborative to conduct a triennial Community Health Needs Assessment (CHNA) in an effort to identify the priority health needs facing the San Diego community. In 2013, the Patient Protection and Affordable Care Act presented a new requirement for not-for-profit hospitals and health care systems to develop a separate CHNA for each individually licensed hospital.

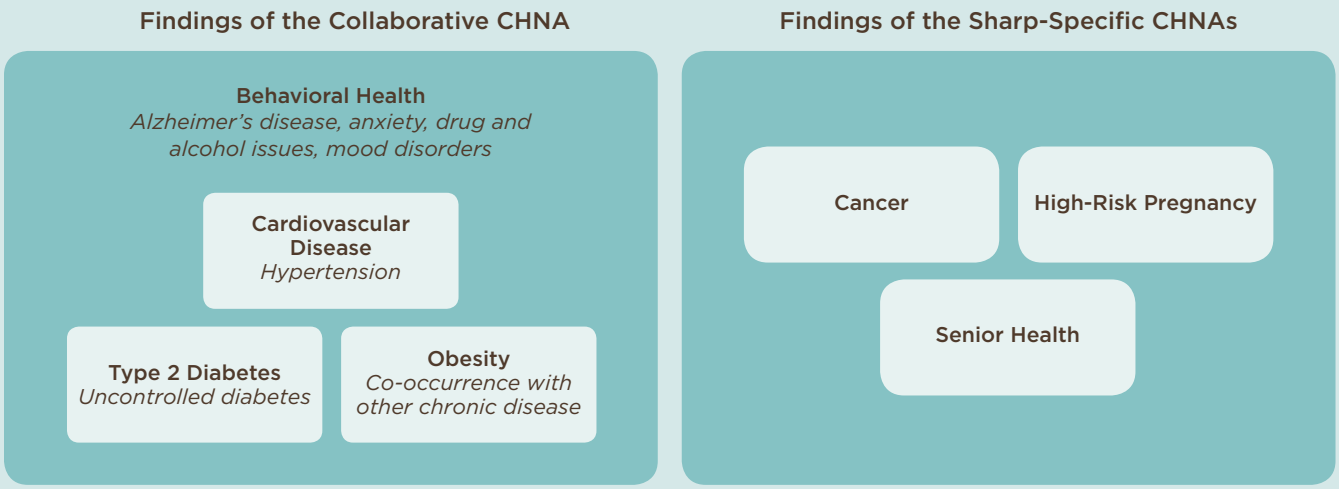
To address these new requirements, in 2013 and 2016, Sharp began its CHNA process by collaborating with other hospitals and health care systems in San Diego County to create a collaborative CHNA — an effort led by the Hospital Association of San Diego and Imperial Counties (HASD&IC) and in contract with the Institute for Public Health (IPH) at San Diego State University. The collaborative CHNA process and findings provided the foundation for the development of CHNAs for each Sharp hospital.

In 2016, Sharp contracted separately with IPH to develop tailored CHNAs through two phases:

Phase 1

Sharp conducted discussions, interviews and surveys to collect feedback from Sharp clinicians and staff, as well as patients and community members served specifically by each of its hospitals. This allowed Sharp to understand the unique needs of those who live throughout its hospitals' communities. Phase 1 findings identified the priority health needs and social determinants of health (factors that contribute to challenges faced by community members in their attempts to maintain health and well-being) highlighted in the figures below.

2016 CHNA Priority Health Needs



2016 CHNA Social Determinants of Health (in Rank Order)

1. FOOD INSECURITY AND ACCESS TO HEALTHY FOOD	6. CULTURAL COMPETENCY
2. ACCESS TO CARE OR SERVICES	7. TRANSPORTATION
3. HOMELESS/HOUSING ISSUES	8. INSURANCE ISSUES
4. PHYSICAL ACTIVITY	9. STIGMA
5. EDUCATION/KNOWLEDGE	10. POVERTY

Phase 2

Upon the completion of Phase 1, Sharp distributed follow-up surveys to Sharp patients, community members and health care providers to collect feedback on the CHNA findings and process, including input on the priority health needs and related social determinants of health identified in Phase 1. This feedback helps guide planning for future CHNAs.

Annual Implementation Strategy

In response to the 2016 CHNA findings, each Sharp hospital created an implementation strategy that highlights the programs, services and resources provided by the hospital to address the identified health needs in its community. A general list of these programs, services and resources is provided in the table below. To view the full implementation strategy for each Sharp hospital, please visit sharp.com/about/community/health-needs-assessments.cfm.

	PRIORITY HEALTH NEED						
Implementation Strategy	**Behavioral Health**	**Cancer**	**Cardio-vascular Disease**	**Type 2 Diabetes**	**High-Risk Pregnancy**	**Obesity**	**Senior Health**
Community education and resources (includes advance care planning) through health fairs, seminars, lectures, educational classes, conferences and events	✔	✔	✔	✔	✔	✔	✔
Collaboration with community organizations	✔	✔	✔	✔			✔
Education/training for staff and community health professionals	✔	✔	✔	✔	✔	✔	✔
Flu shots			✔				✔
Screening programs	✔	✔	✔		✔	✔	✔
Support groups/programs	✔	✔	✔		✔		✔
Research (actively exploring or participating in research activities)	✔	✔			✔		✔

SOCIAL DETERMINANTS OF HEALTH (SDOH)							
SDOH Strategy	Behavioral Health	Cancer	Cardio-vascular Disease	Type 2 Diabetes	High-Risk Pregnancy	Obesity	Senior Health
Food Insecurity and Access to Healthy Food (includes screenings, referrals, community collaboration, education or provision of medically tailored meals, fruits and vegetables)		✔		✔		✔	✔
Access to Care/Insurance Issues (includes financial assistance programs and assistance with public program enrollment such as Medi-Cal and CalFresh)	✔	✔	✔	✔	✔	✔	✔
Homeless/Housing Issues: Sharp HealthCare works with various community entities — including the state and local government — to coordinate appropriate post-discharge support for those who are homeless or at risk of homelessness; Sharp also sponsors the Family Reunification Program, which has connected 1,700 formerly homeless with families and loved ones	✔	✔	✔	✔	✔	✔	✔
Physical Activity	✔	✔	✔	✔	✔	✔	✔
Education/Knowledge (includes health literacy programs and resources as well as community education events, lectures, etc.)	✔	✔	✔	✔	✔	✔	✔
Cultural Competency (includes educational materials designed for different cultures, staff education on cultural competency, etc.)	✔	✔		✔			✔
Transportation (available to all patients who meet criteria: sharp.com/hospitals/transportation-services.cfm)	✔	✔	✔	✔	✔	✔	✔
Stigma (includes education around stigma, support for community organizations addressing stigma, and community integration programs to reduce stigma)	✔	✔					

Insight from the San Diego community is critical to Sharp's CHNA process and the programs provided to meet the needs of its community members. For questions or additional information on Sharp's CHNAs or implementation strategies, please contact Jillian Barber, Manager, Community Benefit and Health Improvement, at jillian.barber@sharp.com.

Appendix

F Description of Partnering Organizations – HASD&IC and IPH

The Hospital Association of San Diego and Imperial Counties

The Hospital Association of San Diego and Imperial Counties (HASD&IC) was established in 1956 (then the Hospital Council) and is a nonprofit organization representing over 35 hospitals and integrated health systems in the two-county area. HASD&IC's mission is to support its members by advancing the organization, management and effective delivery of affordable, medically necessary, quality health care services for the communities of San Diego and Imperial counties. HASD&IC's board of directors represents all member sectors and provides policy direction to ensure the interests of member hospitals and health systems are preserved and promoted. HASD&IC contracted with San Diego State University's Institute for Public Health (IPH) to conduct a hospital-based Community Health Needs Assessment (CHNA) throughout the region.

The Institute for Public Health at San Diego State University

For the 2019 Community Health Needs Assessment process, HASD&IC contracted with the Institute for Public Health (IPH) at San Diego State University (SDSU). In the last 20 years, the IPH has partnered with over 70 local, state, national and international public and private community-based agencies and organizations representing more than 120 multiple-year contracts with a wide variety of needs and methodologies. The IPH has expertise in qualitative and quantitative community-based research methods. In addition, the IPH has extensive experience in successful community engagement with diverse groups, including non-English speakers. The IPH has been working across cultures and with vulnerable populations for 25 years, including programs with Asian and Pacific Islander communities, African-American communities, East African communities, Latino communities, Native American communities, low-income communities, gay, bisexual, transgender individuals, people living with HIV/AIDS, individuals experiencing homelessness, adolescents who are pregnant or parenting, and survivors of domestic violence and sexual assault, among others. IPH staff have special expertise in conducting culturally competent work and exploring sensitive issues. IPH community engagement efforts have included performing key informant interviews, leading focus groups, facilitating town hall meetings, and conducting patient and provider interviews.

Appendix

G Community Need Index Description

The Community Need Index

Dignity Health and Truven Health jointly developed the nation's first standardized Community Need Index (CNI).[42] The CNI identifies the severity of health vulnerability for every ZIP code in the U.S. based on specific barriers to health care access.

The CNI provides a score for every populated ZIP code in the U.S. on a scale of 1.0 to 5.0. A score of 1.0 indicates a ZIP code with the least need (dark green in maps), while a score of 5.0 represents a ZIP code with the most need (bright red in maps). For a detailed description of the CNI please visit the interactive website at: http://cni.chw-interactive.org/. The five barriers are listed below along with the individual statistics that were analyzed for each barrier.

1. **Income Barrier**
    - Percentage of households below poverty line, with head of household age 65 or more
    - Percentage of families with children under 18 below poverty line
    - Percentage of single female-headed families with children under 18 below poverty line
2. **Cultural Barrier**
    - Percentage of the population that is minority (including Hispanic ethnicity)
    - Percentage of the population over age 5 that speaks English poorly or not at all
3. **Educational Barrier**
4.
    - Percentage of the population over 25 without a high school diploma
5. **Insurance Barrier**
    - Percentage of the population in the labor force, aged 16 or more, without employment
    - Percentage of the population without health insurance
6. **Housing Barrier**
    - Percentage of the population renting their home

Based on these 5 categories and 9 total criteria, every ZIP code in the U.S. was assigned an index number:

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

[42] Dignity Health, Community Need Index. http://cni.chw-interactive.org/Truven%20Health_2015%20Source%20Notes_Community%20Need%20Index.pdf

Appendix

H SGH Hospital Data

Aging Concerns

Behavioral Health

Cancer

Cardiovascular

Diabetes

Obesity

Maternal and Prenatal Care, including High-Risk Pregnancy

Unintentional Injury

SGH Hospital Data – Aging Concerns

Table 1: SGH Aging Concerns – Top 10 Behavioral Health Inpatient ICD-10 Codes, CY 2017

Top 10 ICD-10 Diagnosis Codes	ICD-10 Code	Frequency	Percentage	Male Freq.*	% Male	Female Freq.*	% Female
Unspecified Dementia Without Behavioral Disturbance	F03.90	1,362	16.41%	487	5.87%	875	10.54%
Major Depressive Disorder Single Episode Unspecified	F32.9	1,249	15.04%	389	4.69%	860	10.36%
Anxiety Disorder Unspecified	F41.9	1,039	12.52%	262	3.16%	777	9.36%
Nicotine Dependence Cigarettes Uncomplicated	F17.210	742	8.94%	358	4.31%	384	4.63%
Delirium Due to Known Physiological Condition	F05	608	7.32%	256	3.08%	352	4.24%
Dementia in Other Diseases Classified Elsewhere Without Behavioral Disturbance	F02.80	511	6.16%	197	2.37%	314	3.78%
Nicotine Dependence Unspecified Uncomplicated	F17.200	215	2.59%	111	1.34%	104	1.25%
Opioid Dependence Uncomplicated	F11.20	208	2.51%	91	1.10%	117	1.41%
Schizophrenia Unspecified	F20.9	151	1.82%	63	0.76%	88	1.06%
Bipolar Disorder Unspecified	F31.9	145	1.75%	55	0.66%	90	1.08%
Other Diagnoses In This Identified Health Area	--	*2,072*	*24.96%*	*1,001*	*12.06%*	*1,071*	*12.90%*
Total ICD-10 Code Count		**8,302**	--	**3,270**	**39.4%**	**5,032**	**60.6%**

Data Source: SpeedTrack CUPID; OSHPD Inpatient Hospital Discharge Data. Pulled for patients ages 65 years and older.
*Male Frequency and Female Frequency are out of the combined Frequency total.

Table 2: SGH Aging Concerns – Top 10 Behavioral Health Emergency Department ICD-10 Codes, CY 2017

Top 10 ICD-10 Diagnosis Codes	ICD-10 Code	Frequency	Percentage	Male Freq.*	% Male	Female Freq.*	% Female
Unspecified Dementia Without Behavioral Disturbance	F03.90	1,124	18.78%	363	6.07%	761	12.72%
Anxiety Disorder Unspecified	F41.9	1,050	17.55%	253	4.23%	797	13.32%
Major Depressive Disorder Single Episode Unspecified	F32.9	782	13.07%	230	3.84%	552	9.22%
Nicotine Dependence Cigarettes Uncomplicated	F17.210	621	10.38%	290	4.85%	331	5.53%
Nicotine Dependence Unspecified Uncomplicated	F17.200	380	6.35%	193	3.23%	187	3.13%
Bipolar Disorder Unspecified	F31.9	305	5.10%	105	1.75%	200	3.34%
Dementia in Other Diseases Classified Elsewhere Without Behavioral Disturbance	F02.80	305	5.10%	117	1.96%	188	3.14%
Schizophrenia Unspecified	F20.9	163	2.72%	67	1.12%	96	1.60%
Opioid Dependence Uncomplicated	F11.20	82	1.37%	32	0.53%	50	0.84%
Alcohol Abuse With Intoxication Unspecified	F10.129	82	1.37%	57	0.95%	25	0.42%
Other Diagnoses In This Identified Health Area	--	*1,090*	*18.22%*	*508*	*8.49%*	*582*	*9.73%*
Total ICD-10 Code Count		**5,984**	--	**2,215**	**37.0%**	**3,769**	**63.0%**

Data Source: SpeedTrack CUPID; OSHPD Emergency Department Discharge Data. Pulled for patients ages 65 years and older.
*Male Frequency and Female Frequency are out of the combined Frequency total.

Table 3: SGH Aging Concerns – Top 10 Cardiovascular Inpatient ICD-10 Codes, CY 2017

Top 10 ICD-10 Diagnosis Codes	ICD-10 Code	Frequency	Percentage	Male Freq.*	% Male	Female Freq.*	% Female
Essential (Primary) Hypertension	10	4,590	29.87%	1,788	11.63%	2,802	18.23%
Atherosclerotic Heart Disease of Native Coronary Artery Without Angina Pectoris	25.10	2,928	19.05%	1,575	10.25%	1,353	8.80%
Hypertensive Heart Disease With Heart Failure	11.0	1,349	8.78%	522	3.40%	827	5.38%
Hypertensive Heart and Chronic Kidney Disease With Heart Failure and Stage 1 Through Stage 4 Chronic Kidney Disease or Unspecified Chronic Kidney Disease	13.0	1,127	7.33%	561	3.65%	566	3.68%
Hypertensive Chronic Kidney Disease With Stage 1 Through Stage 4 Chronic Kidney Disease or Unspecified Chronic Kidney Disease	12.9	1,044	6.79%	503	3.27%	541	3.52%
Old Myocardial Infarction	25.2	741	4.82%	399	2.60%	342	2.23%
Ischemic Cardiomyopathy	25.5	550	3.58%	363	2.36%	187	1.22%
Other Forms of Acute Ischemic Heart Disease	24.8	428	2.78%	214	1.39%	214	1.39%
Hypertensive Heart and Chronic Kidney Disease With Heart Failure and With Stage 5 Chronic Kidney Disease or End Stage Renal Disease	13.2	228	1.48%	132	0.86%	96	0.62%
Non-St Elevation (Nstemi) Myocardial Infarction	21.4	196	1.28%	111	0.72%	85	0.55%
Other Diagnoses In This Identified Health Area	--	*2,188*	*14.24%*	*1,057*	*6.88%*	*1,131*	*7.36%*
Total ICD-10 Code Count		**15,369**	--	**7,225**	**47.0%**	**8,144**	**53.0%**

Data Source: SpeedTrack CUPID; OSHPD Inpatient Hospital Discharge Data. Pulled for patients ages 65 years and older.
*Male Frequency and Female Frequency are out of the combined Frequency total.

Table 4: SGH Aging Concerns – Top 10 Cardiovascular Health Emergency Department ICD-10 Codes, CY 2017

Top 10 ICD-10 Diagnosis Codes	ICD-10 Code	Frequency	Percentage	Male Freq.*	% Male	Female Freq.*	% Female
Essential (Primary) Hypertension	I10	7,181	61.72%	2,573	22.11%	4,608	39.60%
Atherosclerotic Heart Disease of Native Coronary Artery Without Angina Pectoris	I25.10	1,506	12.94%	810	6.96%	696	5.98%
Old Myocardial Infarction	I25.2	710	6.10%	362	3.11%	348	2.99%
Hypertensive Chronic Kidney Disease With Stage 1 Through Stage 4 Chronic Kidney Disease or Unspecified Chronic Kidney Disease	I12.9	678	5.83%	302	2.60%	376	3.23%
Hypertensive Heart Disease With Heart Failure	I11.0	464	3.99%	170	1.46%	294	2.53%
Hypertensive Heart and Chronic Kidney Disease With Heart Failure and Stage 1 Through Stage 4 Chronic Kidney Disease or Unspecified Chronic Kidney Disease	I13.0	223	1.92%	117	1.01%	106	0.91%
Hypertensive Chronic Kidney Disease With Stage 5 Chronic Kidney Disease or End Stage Renal Disease	I12.0	136	1.17%	61	0.52%	75	0.64%
Ischemic Cardiomyopathy	I25.5	119	1.02%	76	0.65%	43	0.37%
Hypertensive Heart Disease Without Heart Failure	I11.9	108	0.93%	41	0.35%	67	0.58%
Hypertensive Heart and Chronic Kidney Disease With Heart Failure and With Stage 5 Chronic Kidney Disease or End Stage Renal Disease	I13.2	60	0.52%	26	0.22%	34	0.29%
Other Diagnoses In This Identified Health Area	--	*450*	*3.87%*	*215*	*1.85%*	*235*	*2.02%*
Total ICD-10 Code Count		**11,635**	--	**4,753**	**40.9%**	**6,882**	**59.1%**

Data Source: SpeedTrack CUPID; OSHPD Emergency Department Discharge Data. Pulled for patients ages 65 years and older.
*Male Frequency and Female Frequency are out of the combined Frequency total.

Table 5: SGH Aging Concerns – Top 10 Diabetes Inpatient ICD-10 Codes, CY 2017

Top 10 ICD-10 Diagnosis Codes	ICD-10 Code	Frequency	Percentage	Male Freq.*	% Male	Female Freq.*	% Female
Type 2 Diabetes Mellitus Without Complications	E11.9	1,466	25.21%	632	10.87%	834	14.34%
Type 2 Diabetes Mellitus With Diabetic Chronic Kidney Disease	E11.22	1,289	22.17%	661	11.37%	628	10.80%
Type 2 Diabetes Mellitus With Hyperglycemia	E11.65	774	13.31%	383	6.59%	391	6.73%
Type 2 Diabetes Mellitus With Diabetic Nephropathy	E11.21	511	8.79%	266	4.58%	245	4.21%
Type 2 Diabetes Mellitus With Diabetic Neuropathy Unspecified	E11.40	429	7.38%	210	3.61%	219	3.77%
Type 2 Diabetes Mellitus With Diabetic Polyneuropathy	E11.42	261	4.49%	133	2.29%	128	2.20%
Type 2 Diabetes Mellitus With Diabetic Peripheral Angiopathy Without Gangrene	E11.51	235	4.04%	145	2.49%	90	1.55%
Type 2 Diabetes Mellitus With Hypoglycemia Without Coma	E11.649	195	3.35%	91	1.57%	104	1.79%
Type 2 Diabetes Mellitus With Unspecified Diabetic Retinopathy Without Macular Edema	E11.319	165	2.84%	85	1.46%	80	1.38%
Type 2 Diabetes Mellitus With Foot Ulcer	E11.621	106	1.82%	72	1.24%	34	0.58%
Other Diagnoses In This Identified Health Area	--	*383*	*6.59%*	*217*	*3.73%*	*166*	*2.86%*
Total ICD-10 Code Count		**5,814**	--	**2,895**	**49.8%**	**2,919**	**50.2%**

Data Source: SpeedTrack CUPID; OSHPD Inpatient Hospital Discharge Data. Pulled for patients ages 65 years and older.
*Male Frequency and Female Frequency are out of the combined Frequency total.

Table 6: SGH Aging Concerns – Top 10 Diabetes Emergency Department ICD-10 Codes, CY2017

Top 10 ICD-10 Diagnosis Codes	ICD-10 Code	Frequency	Percentage	Male Freq.*	% Male	Female Freq.*	% Female
Type 2 Diabetes Mellitus Without Complications	E11.9	2,532	64.62%	1,058	27.00%	1,474	37.62%
Type 2 Diabetes Mellitus With Diabetic Chronic Kidney Disease	E11.22	472	12.05%	225	5.74%	247	6.30%
Type 2 Diabetes Mellitus With Hyperglycemia	E11.65	410	10.46%	176	4.49%	234	5.97%
Type 2 Diabetes Mellitus With Diabetic Neuropathy Unspecified	E11.40	140	3.57%	83	2.12%	57	1.45%
Type 2 Diabetes Mellitus With Hypoglycemia Without Coma	E11.649	97	2.48%	44	1.12%	53	1.35%
Type 2 Diabetes Mellitus With Diabetic Nephropathy	E11.21	75	1.91%	34	0.87%	41	1.05%
Type 2 Diabetes Mellitus With Diabetic Polyneuropathy	E11.42	43	1.10%	12	0.31%	31	0.79%
Type 2 Diabetes Mellitus With Unspecified Diabetic Retinopathy Without Macular Edema	E11.319	43	1.10%	18	0.46%	25	0.64%
Type 2 Diabetes Mellitus With Diabetic Peripheral Angiopathy Without Gangrene	E11.51	31	0.79%	21	0.54%	10	0.26%
Type 1 Diabetes Mellitus Without Complications	E10.9	13	0.33%	3	0.08%	10	0.26%
Other Diagnoses In This Identified Health Area	--	*62*	*1.58%*	*36*	*0.92%*	*26*	*0.66%*
Total ICD-10 Code Count		**3,918**	--	**1,710**	**43.6%**	**2,208**	**56.4%**

Data Source: SpeedTrack CUPID; OSHPD Emergency Department Discharge Data. Pulled for patients ages 65 years and older.
*Male Frequency and Female Frequency are out of the combined Frequency total.

Table 7: SGH Aging Concerns – Top 10 Obesity Inpatient ICD-10 Codes, CY 2017

Top 10 ICD-10 Diagnosis Codes	ICD-10 Code	Frequency	Percentage	Male Freq.*	% Male	Female Freq.*	% Female
Obesity Unspecified	E66.9	795	27.09%	338	11.52%	457	15.57%
Morbid (Severe) Obesity Due to Excess Calories	E66.01	526	17.92%	203	6.92%	323	11.01%
Body Mass Index (BMI) 40.0-44.9 Adult	Z68.41	246	8.38%	72	2.45%	174	5.93%
Morbid (Severe) Obesity With Alveolar Hypoventilation	E66.2	165	5.62%	75	2.56%	90	3.07%
Body Mass Index (BMI) 45.0-49.9 Adult	Z68.42	104	3.54%	39	1.33%	65	2.21%
Body Mass Index (BMI) 35.0-35.9 Adult	Z68.35	102	3.48%	40	1.36%	62	2.11%
Body Mass Index (BMI) 30.0-30.9 Adult	Z68.30	97	3.30%	51	1.74%	46	1.57%
Body Mass Index (BMI) 31.0-31.9 Adult	Z68.31	90	3.07%	38	1.29%	52	1.77%
Body Mass Index (BMI) 33.0-33.9 Adult	Z68.33	88	3.00%	41	1.40%	47	1.60%
Body Mass Index (BMI) 34.0-34.9 Adult	Z68.34	85	2.90%	30	1.02%	55	1.87%
Other Diagnoses In This Identified Health Area	--	*637*	*21.70%*	*280*	*9.54%*	*357*	*12.16%*
Total ICD-10 Code Count		**2,935**	--	**1,207**	**41.1%**	**1,728**	**58.9%**

Data Source: SpeedTrack CUPID; OSHPD Inpatient Hospital Discharge Data. Pulled for patients ages 65 years and older.
*Male Frequency and Female Frequency are out of the combined Frequency total.

Table 8: SGH Aging Concerns – Top 10 Obesity Emergency Department ICD-10 Codes, CY 2017

Top 10 ICD-10 Diagnosis Codes	ICD-10 Code	Frequency	Percentage	Male Freq.*	% Male	Female Freq.*	% Female
Obesity Unspecified	E66.9	375	39.35%	137	14.38%	238	24.97%
Morbid (Severe) Obesity Due to Excess Calories	E66.01	218	22.88%	59	6.19%	159	16.68%
Body Mass Index (BMI) 40.0-44.9 Adult	Z68.41	44	4.62%	17	1.78%	27	2.83%
Body Mass Index (BMI) 30.0-30.9 Adult	Z68.30	40	4.20%	16	1.68%	24	2.52%
Body Mass Index (BMI) 31.0-31.9 Adult	Z68.31	27	2.83%	14	1.47%	13	1.36%
Body Mass Index (BMI) 35.0-35.9 Adult	Z68.35	25	2.62%	16	1.68%	9	0.94%
Body Mass Index (BMI) 32.0-32.9 Adult	Z68.32	25	2.62%	11	1.15%	14	1.47%
Body Mass Index (BMI) 45.0-49.9 Adult	Z68.42	23	2.41%	6	0.63%	17	1.78%
Body Mass Index (BMI) 33.0-33.9 Adult	Z68.33	20	2.10%	8	0.84%	12	1.26%
Body Mass Index (BMI) 37.0-37.9 Adult	Z68.37	18	1.89%	4	0.42%	14	1.47%
Other Diagnoses In This Identified Health Area	--	*138*	*14.48%*	*49*	*5.14%*	*89*	*9.34%*
Total ICD-10 Code Count		**953**	--	**337**	**35.4%**	**616**	**64.6%**

Data Source: SpeedTrack CUPID; OSHPD Inpatient Hospital Discharge Data. Pulled for patients ages 65 years and older.
*Male Frequency and Female Frequency are out of the combined Frequency total.

SGH Hospital Data – Behavioral Health

Table 1: SGH Behavioral Health – Top 10 Inpatient ICD-10 Codes, CY 2017

Top 10 ICD-10 Diagnosis Codes	ICD-10 Code	Frequency	Percentage	Male Freq.*	% Male	Female Freq.*	% Female
Nicotine Dependence Cigarettes Uncomplicated	F17.210	3,399	13.90%	1,767	7.22%	1,632	6.67%
Major Depressive Disorder Single Episode Unspecified	F32.9	2,666	10.90%	920	3.76%	1,746	7.14%
Anxiety Disorder Unspecified	F41.9	2,629	10.75%	834	3.41%	1,795	7.34%
Unspecified Dementia Without Behavioral Disturbance	F03.90	1,438	5.88%	524	2.14%	914	3.74%
Nicotine Dependence Unspecified Uncomplicated	F17.200	958	3.92%	504	2.06%	454	1.86%
Cannabis Use Unspecified Uncomplicated	F12.90	834	3.41%	508	2.08%	326	1.33%
Delirium Due to Known Physiological Condition	F05	828	3.39%	380	1.55%	448	1.83%
Other Stimulant Abuse Uncomplicated	F15.10	711	2.91%	413	1.69%	298	1.22%
Schizophrenia Unspecified	F20.9	663	2.71%	356	1.46%	307	1.26%
Opioid Dependence Uncomplicated	F11.20	627	2.56%	266	1.09%	361	1.48%
Other Diagnoses In This Identified Health Area	--	*9,707*	*39.69%*	*4,934*	*20.17%*	*4,773*	*19.51%*
Total ICD-10 Code Count		**24,460**	--	**11,406**	**46.6%**	**13,054**	**53.4%**

Data Source: SpeedTrack CUPID; OSHPD Inpatient Hospital Discharge Data
*Male Frequency and Female Frequency are out of the combined Frequency total.

Table 2: SGH Behavioral Health – Encounters by Age, CY 2017

Age Range	Frequency	%
Under 1 Year	0	0.00%
1 - 17 Years	5	0.05%
18 - 34 Years	1,362	13.23%
35 - 64 Years	4,753	46.18%
65 Years or Greater	4,173	40.54%
Total Encounters	**10,293**	--

Data Source: SpeedTrack CUPID; OSHPD Inpatient Hospital Discharge Data

Table 3: SGH Behavioral Health – Top 10 Ambulatory ICD-10 Codes, CY 2017

Top 10 ICD-10 Diagnosis Codes	ICD-10 Code	Frequency	Percentage	Male Freq.*	% Male	Female Freq.*	% Female
Nicotine Dependence Unspecified Uncomplicated	F17.200	511	19.66%	287	11.04%	224	8.62%
Nicotine Dependence Cigarettes Uncomplicated	F17.210	483	18.58%	257	9.89%	226	8.70%
Major Depressive Disorder Single Episode Unspecified	F32.9	475	18.28%	137	5.27%	338	13.01%
Anxiety Disorder Unspecified	F41.9	463	17.81%	131	5.04%	332	12.77%
Bipolar Disorder Unspecified	F31.9	74	2.85%	19	0.73%	55	2.12%
Cannabis Abuse Uncomplicated	F12.10	56	2.15%	36	1.39%	20	0.77%
Unspecified Dementia Without Behavioral Disturbance	F03.90	43	1.65%	22	0.85%	21	0.81%
Other Stimulant Use Unspecified Uncomplicated	F15.90	34	1.31%	13	0.50%	21	0.81%
Alcohol Abuse Uncomplicated	F10.10	32	1.23%	27	1.04%	5	0.19%
Alcohol Dependence in Remission	F10.21	27	1.04%	16	0.62%	11	0.42%
Other Diagnoses In This Identified Health Area	--	*401*	*15.43%*	*191*	*7.35%*	*210*	*8.08%*
Total ICD-10 Code Count		**2,599**	--	**1,136**	**43.7%**	**1,463**	**56.3%**

Data Source: SpeedTrack CUPID; OSHPD Ambulatory Surgery Hospital Discharge Data
*Male Frequency and Female Frequency are out of the combined Frequency total.

Table 4: SGH Behavioral Health – Ambulatory Encounters by Age, CY 2017

Age Range	Frequency	%
Under 1 Year	0	0.00%
1 - 17 Years	6	0.34%
18 - 34 Years	225	12.62%
35 - 64 Years	1,086	60.91%
65 Years or Greater	466	26.14%
Total Encounters	**1,783**	--

Data Source: SpeedTrack CUPID; OSHPD Ambulatory Surgery Hospital Discharge Data

Table 5: SGH Behavioral Health – Top 10 Emergency Department ICD-10 Codes, CY 2017

Top 10 ICD-10 Diagnosis Codes	ICD-10 Code	Frequency	Percentage	Male Freq.*	% Male	Female Freq.*	% Female
Nicotine Dependence Cigarettes Uncomplicated	F17.210	6,528	15.83%	3,571	8.66%	2,957	7.17%
Anxiety Disorder Unspecified	F41.9	5,782	14.02%	1,976	4.79%	3,806	9.23%
Nicotine Dependence Unspecified Uncomplicated	F17.200	4,833	11.72%	2,507	6.08%	2,326	5.64%
Major Depressive Disorder Single Episode Unspecified	F32.9	3,832	9.29%	1,322	3.21%	2,510	6.09%
Bipolar Disorder Unspecified	F31.9	2,345	5.69%	968	2.35%	1,377	3.34%
Schizophrenia Unspecified	F20.9	1,572	3.81%	925	2.24%	647	1.57%
Unspecified Dementia Without Behavioral Disturbance	F03.90	1,186	2.88%	394	0.96%	792	1.92%
Alcohol Abuse With Intoxication Unspecified	F10.129	1,111	2.69%	658	1.60%	453	1.10%
Other Stimulant Abuse Uncomplicated	F15.10	1,106	2.68%	644	1.56%	462	1.12%
Nicotine Dependence Other Tobacco Product Uncomplicated	F17.290	1,084	2.63%	586	1.42%	498	1.21%
Other Diagnoses In This Identified Health Area	--	*11,854*	*28.75%*	*6,331*	*15.35%*	*5,523*	*13.39%*
Total ICD-10 Code Count		**41,233**	--	**19,882**	**48.2%**	**21,351**	**51.8%**

Data Source: SpeedTrack CUPID; OSHPD Emergency Department Hospital Discharge Data
*Male Frequency and Female Frequency are out of the combined Frequency total.

Table 6: SGH Behavioral Health – Emergency Department Encounters by Age, CY 2017

Age Range	Frequency	%
Under 1 Year	1	0.00%
1 - 17 Years	333	1.53%
18 - 34 Years	6,963	32.09%
35 - 64 Years	10,757	49.58%
65 Years or Greater	3,644	16.79%
Total Encounters	**21,698**	--

Data Source: SpeedTrack CUPID; OSHPD Emergency Department Hospital Discharge Data

SGH Hospital Data – Cancer

Table 1: SGH Cancer – Top 10 Inpatient ICD-10 Codes, CY 2017

Top 10 ICD-10 Diagnosis Codes	ICD-10 Code	Frequency	Percentage	Male Freq.*	% Male	Female Freq.*	% Female
Secondary Malignant Neoplasm of Bone	C79.51	210	6.25%	114	3.39%	96	2.86%
Secondary Malignant Neoplasm of Liver and Intrahepatic Bile Duct	C78.7	153	4.55%	64	1.90%	89	2.65%
Malignant Neoplasm of Prostate	C61	102	3.03%	102	3.03%	0	0.00%
Leiomyoma of Uterus Unspecified	D25.9	92	2.74%	0	0.00%	92	2.74%
Malignant Neoplasm of Unspecified Part of Unspecified Bronchus or Lung	C34.90	90	2.68%	39	1.16%	51	1.52%
Intramural Leiomyoma of Uterus	D25.1	76	2.26%	0	0.00%	76	2.26%
Myelodysplastic Syndrome Unspecified	D46.9	70	2.08%	37	1.10%	33	0.98%
Secondary Malignant Neoplasm of Brain	C79.31	70	2.08%	28	0.83%	42	1.25%
Multiple Myeloma not Having Achieved Remission	C90.00	61	1.81%	23	0.68%	38	1.13%
Secondary Malignant Neoplasm of Retroperitoneum and Peritoneum	C78.6	61	1.81%	29	0.86%	32	0.95%
Other Diagnoses In This Identified Health Area	--	*2,377*	*70.70%*	*1,078*	*32.06%*	*1,299*	*38.64%*
Total ICD-10 Code Count		**3,362**	--	**1,514**	**45.0%**	**1,848**	**55.0%**

Data Source: SpeedTrack CUPID; OSHPD Inpatient Hospital Discharge Data
*Male Frequency and Female Frequency are out of the combined Frequency total.

Table 2: SGH Cancer – Inpatient Encounters by Age, CY 2017

Age Range	Frequency	%
Under 1 Year	0	0.00%
1 - 17 Years	0	0.00%
18 - 34 Years	27	3.68%
35 - 64 Years	315	42.92%
65 Years or Greater	392	53.41%
Total Encounters	**734**	--

Data Source: SpeedTrack CUPID; Inpatient Hospital Discharge Data

Table 3: SGH Cancer – Top 10 Ambulatory Surgery ICD-10 Codes, CY 2017

Top 10 ICD-10 Diagnosis Codes	ICD-10 Code	Frequency	Percentage	Male Freq.*	% Male	Female Freq.*	% Female
Benign Neoplasm of Ascending Colon	D12.2	346	13.98%	198	8.00%	148	5.98%
Benign Neoplasm of Transverse Colon	D12.3	274	11.07%	159	6.42%	115	4.65%
Benign Neoplasm of Sigmoid Colon	D12.5	237	9.58%	129	5.21%	108	4.36%
Benign Neoplasm of Cecum	D12.0	190	7.68%	110	4.44%	80	3.23%
Benign Neoplasm of Descending Colon	D12.4	177	7.15%	97	3.92%	80	3.23%
Benign Neoplasm of Rectum	D12.8	74	2.99%	43	1.74%	31	1.25%
Benign Neoplasm of Bone and Articular Cartilage Unspecified	D16.9	73	2.95%	38	1.54%	35	1.41%
Benign Lipomatous Neoplasm of Spermatic Cord	D17.6	50	2.02%	50	2.02%	0	0.00%
Leiomyoma of Uterus Unspecified	D25.9	38	1.54%	0	0.00%	38	1.54%
Malignant Neoplasm of Unspecified Site of Right Female Breast	C50.911	37	1.49%	0	0.00%	37	1.49%
Other Diagnoses In This Identified Health Area	--	*979*	*39.56%*	*405*	*16.36%*	*574*	*23.19%*
Total ICD-10 Code Count		**2,475**	--	**1,229**	**49.7%**	**1,246**	**50.3%**

Data Source: SpeedTrack CUPID; OSHPD Ambulatory Surgery Hospital Discharge Data
*Male Frequency and Female Frequency are out of the combined Frequency total.

Table 4: SGH Cancer – Ambulatory Surgery by Age, CY 2017

Age Range	Frequency	%
Under 1 Year	0	0.00%
1 - 17 Years	0	0.00%
18 - 34 Years	54	4.95%
35 - 64 Years	588	53.85%
65 Years or Greater	450	41.21%
Total Encounters	**1,092**	--

Data Source: SpeedTrack CUPID; Ambulatory Surgery Discharge Data

Table 5: SGH Cancer – Top 10 Emergency Department ICD-10 Codes, CY 2017

Top 10 ICD-10 Diagnosis Codes	ICD-10 Code	Frequency	Percentage	Male Freq.*	% Male	Female Freq.*	% Female
Leiomyoma of Uterus Unspecified	D25.9	277	17.51%	0	0.00%	277	17.51%
Secondary Malignant Neoplasm of Bone	C79.51	75	4.74%	42	2.65%	33	2.09%
Malignant Neoplasm of Unspecified Part of Unspecified Bronchus or Lung	C34.90	71	4.49%	36	2.28%	35	2.21%
Malignant Neoplasm of Prostate	C61	61	3.86%	61	3.86%	0	0.00%
Secondary Malignant Neoplasm of Liver and Intrahepatic Bile Duct	C78.7	59	3.73%	22	1.39%	37	2.34%
Malignant Neoplasm of Unspecified Site of Unspecified Female Breast	C50.919	55	3.48%	0	0.00%	55	3.48%
Malignant Neoplasm of Colon Unspecified	C18.9	30	1.90%	9	0.57%	21	1.33%
Secondary Malignant Neoplasm of Unspecified Lung	C78.00	29	1.83%	10	0.63%	19	1.20%
Hemangioma of Intra-Abdominal Structures	D18.03	28	1.77%	7	0.44%	21	1.33%
Multiple Myeloma not Having Achieved Remission	C90.00	27	1.71%	14	0.88%	13	0.82%
Other Diagnoses In This Identified Health Area	--	*870*	*54.99%*	*380*	*24.02%*	*490*	*30.97%*
Total ICD-10 Code Count		**1,582**	--	**581**	**36.7%**	**1,001**	**63.3%**

Data Source: SpeedTrack CUPID; OSHPD Emergency Department Hospital Discharge Data
*Male Frequency and Female Frequency are out of the combined Frequency total

Table 6: SGH Cancer – Emergency Department by Age, CY 2017

Age Range	Frequency	%
Under 1 Year	0	0.00%
1 - 17 Years	1	0.16%
18 - 34 Years	60	9.54%
35 - 64 Years	360	57.23%
65 Years or Greater	208	33.07%
Total Encounters	**629**	--

Data Source: SpeedTrack CUPID; Emergency Department Discharge Data

SGH Hospital Data – Cardiovascular

Table 1: SGH Cardiovascular – Top 10 Inpatient ICD-10 Codes, CY 2017

Top 10 ICD-10 Diagnosis Codes	ICD-10 Code	Frequency	Percentage	Male Freq.*	% Male	Female Freq.*	% Female
Essential (Primary) Hypertension	I10	8,609	35.23%	3,904	15.98%	4,705	19.25%
Atherosclerotic Heart Disease of Native Coronary Artery Without Angina Pectoris	I25.10	4,086	16.72%	2,355	9.64%	1,731	7.08%
Hypertensive Heart Disease With Heart Failure	I11.0	2,004	8.20%	918	3.76%	1,086	4.44%
Hypertensive Heart and Chronic Kidney Disease With Heart Failure and Stage 1 Through Stage 4 Chronic Kidney Disease or Unspecified Chronic Kidney Disease	I13.0	1,462	5.98%	793	3.25%	669	2.74%
Hypertensive Chronic Kidney Disease With Stage 1 Through Stage 4 Chronic Kidney Disease or Unspecified Chronic Kidney Disease	I12.9	1,439	5.89%	761	3.11%	678	2.77%
Old Myocardial Infarction	I25.2	1,155	4.73%	675	2.76%	480	1.96%
Ischemic Cardiomyopathy	I25.5	813	3.33%	562	2.30%	251	1.03%
Other Forms of Acute Ischemic Heart Disease	I24.8	611	2.50%	320	1.31%	291	1.19%
Hypertensive Heart and Chronic Kidney Disease With Heart Failure and With Stage 5 Chronic Kidney Disease or End Stage Renal Disease	I13.2	449	1.84%	251	1.03%	198	0.81%
Hypertensive Chronic Kidney Disease With Stage 5 Chronic Kidney Disease or End Stage Renal Disease	I12.0	418	1.71%	194	0.79%	224	0.92%
Other Diagnoses In This Identified Health Area	--	*3,390*	*13.87%*	*1,810*	*7.41%*	*1,580*	*6.47%*
Total ICD-10 Code Count		**24,436**	--	**12,543**	**51.3%**	**11,893**	**48.7%**

Data Source: SpeedTrack CUPID; OSHPD Inpatient Hospital Discharge Data
*Male Frequency and Female Frequency are out of the combined Frequency total.

Table 2: SGH Cardiovascular – Encounters by Age, CY 2017

Age Range	Frequency	%
Under 1 Year	0	0.00%
1 - 17 Years	0	0.00%
18 - 34 Years	323	2.16%
35 - 64 Years	5,778	38.66%
65 Years or Greater	8,845	59.18%
Total Encounters	**14,946**	--

Data Source: SpeedTrack CUPID; Inpatient Hospital Discharge Data

Table 3: SGH Cardiovascular – Top 10 Ambulatory Surgery ICD-10 Codes, CY 2017

Top 10 ICD-10 Diagnosis Codes	ICD-10 Code	Frequency	Percentage	Male Freq.*	% Male	Female Freq.*	% Female
Essential (Primary) Hypertension	I10	3,083	65.89%	1,513	32.34%	1,570	33.55%
Atherosclerotic Heart Disease of Native Coronary Artery Without Angina Pectoris	I25.10	487	10.41%	320	6.84%	167	3.57%
Hypertensive Heart Disease Without Heart Failure	I11.9	279	5.96%	158	3.38%	121	2.59%
Old Myocardial Infarction	I25.2	151	3.23%	110	2.35%	41	0.88%
Hypertensive Heart Disease With Heart Failure	I11.0	129	2.76%	76	1.62%	53	1.13%
Hypertensive Chronic Kidney Disease With Stage 1 Through Stage 4 Chronic Kidney Disease or Unspecified Chronic Kidney Disease	I12.9	72	1.54%	41	0.88%	31	0.66%
Ischemic Cardiomyopathy	I25.5	60	1.28%	46	0.98%	14	0.30%
Atherosclerotic Heart Disease of Native Coronary Artery With Unspecified Angina Pectoris	I25.119	52	1.11%	31	0.66%	21	0.45%
Atherosclerotic Heart Disease of Native Coronary Artery With Unstable Angina Pectoris	I25.110	51	1.09%	34	0.73%	17	0.36%
Chronic Total Occlusion of Coronary Artery	I25.82	50	1.07%	39	0.83%	11	0.24%
Other Diagnoses In This Identified Health Area	--	*265*	*5.66%*	*162*	*3.46%*	*103*	*2.20%*
Total ICD-10 Code Count		**4,679**	--	**2,530**	**54.1%**	**2,149**	**45.9%**

Data Source: SpeedTrack CUPID; OSHPD Ambulatory Surgery Hospital Discharge Data
*Male Frequency and Female Frequency are out of the combined Frequency total.

Table 4: SGH Cardiovascular – Ambulatory Surgery Encounters by Age, CY 2017

Age Range	Frequency	%
Under 1 Year	0	0.00%
1 - 17 Years	0	0.00%
18 - 34 Years	38	1.01%
35 - 64 Years	1,624	43.17%
65 Years or Greater	2,100	55.82%
Total Encounters	**3,762**	--

Data Source: SpeedTrack CUPID; Ambulatory Surgery Hospital Discharge Data

Table 5: SGH Cardiovascular – Top 10 Emergency Department ICD-10 Codes, CY 2017

Top 10 ICD-10 Diagnosis Codes	ICD-10 Code	Frequency	Percentage	Male Freq.*	% Male	Female Freq.*	% Female
Essential (Primary) Hypertension	I10	17,174	70.29%	7,411	30.33%	9,763	39.96%
Atherosclerotic Heart Disease of Native Coronary Artery Without Angina Pectoris	I25.10	2,258	9.24%	1,301	5.32%	957	3.92%
Old Myocardial Infarction	I25.2	1,404	5.75%	830	3.40%	574	2.35%
Hypertensive Chronic Kidney Disease With Stage 1 Through Stage 4 Chronic Kidney Disease or Unspecified Chronic Kidney Disease	I12.9	908	3.72%	447	1.83%	461	1.89%
Hypertensive Heart Disease With Heart Failure	I11.0	757	3.10%	352	1.44%	405	1.66%
Hypertensive Chronic Kidney Disease With Stage 5 Chronic Kidney Disease or End Stage Renal Disease	I12.0	379	1.55%	176	0.72%	203	0.83%
Hypertensive Heart and Chronic Kidney Disease With Heart Failure and Stage 1 Through Stage 4 Chronic Kidney Disease or Unspecified Chronic Kidney Disease	I13.0	309	1.26%	179	0.73%	130	0.53%
Ischemic Cardiomyopathy	I25.5	191	0.78%	127	0.52%	64	0.26%
Hypertensive Heart Disease Without Heart Failure	I11.9	167	0.68%	74	0.30%	93	0.38%
Hypertensive Heart and Chronic Kidney Disease With Heart Failure and With Stage 5 Chronic Kidney Disease or End Stage Renal Disease	I13.2	148	0.61%	85	0.35%	63	0.26%
Other Diagnoses In This Identified Health Area	--	*737*	*3.02%*	*399*	*1.63%*	*338*	*1.38%*
Total ICD-10 Code Count		**24,432**	--	**11,381**	**46.6%**	**13,051**	**53.4%**

Data Source: SpeedTrack CUPID; OSHPD Emergency Department Hospital Discharge Data
*Male Frequency and Female Frequency are out of the combined Frequency total.

Table 6: SGH Cardiovascular – Emergency Department Encounters by Age, CY 2017

Age Range	Frequency	%
Under 1 Year	0	0.00%
1 - 17 Years	16	0.08%
18 - 34 Years	1,044	5.10%
35 - 64 Years	10,262	50.13%
65 Years or Greater	9,149	44.69%
Total Encounters	**20,471**	--

Data Source: SpeedTrack CUPID; Emergency Department Hospital Discharge Data

SGH Hospital Data – Diabetes

Table 1: SGH Diabetes – Top 10 Inpatient ICD-10 Codes, CY 2017

Top 10 ICD-10Diagnosis Codes	ICD-10 Code	Frequency	Percentage	Male Freq.*	% Male	Female Freq.*	% Female
Type 2 Diabetes Mellitus Without Complications	E11.9	2,566	21.81%	1,156	9.82%	1,410	11.98%
Type 2 Diabetes Mellitus With Diabetic Chronic Kidney Disease	E11.22	1,978	16.81%	1,082	9.20%	896	7.62%
Type 2 Diabetes Mellitus With Hyperglycemia	E11.65	1,771	15.05%	933	7.93%	838	7.12%
Type 2 Diabetes Mellitus With Diabetic Nephropathy	E11.21	883	7.50%	494	4.20%	389	3.31%
Type 2 Diabetes Mellitus With Diabetic Neuropathy Unspecified	E11.40	840	7.14%	467	3.97%	373	3.17%
Type 2 Diabetes Mellitus With Diabetic Polyneuropathy	E11.42	483	4.11%	260	2.21%	223	1.90%
Type 2 Diabetes Mellitus With Unspecified Diabetic Retinopathy Without Macular Edema	E11.319	376	3.20%	214	1.82%	162	1.38%
Type 2 Diabetes Mellitus With Diabetic Peripheral Angiopathy Without Gangrene	E11.51	356	3.03%	219	1.86%	137	1.16%
Type 2 Diabetes Mellitus With Hypoglycemia Without Coma	E11.649	313	2.66%	165	1.40%	148	1.26%
Type 2 Diabetes Mellitus With Foot Ulcer	E11.621	270	2.29%	197	1.67%	73	0.62%
Other Diagnoses In This Identified Health Area	--	*1,930*	*16.40%*	*1,119*	*9.51%*	*811*	*6.89%*
Total ICD-10 Code Count		**11,766**	--	**6,306**	**53.6%**	**5,460**	**46.4%**

Data Source: SpeedTrack CUPID; OSHPD Inpatient Hospital Discharge Data
*Male Frequency and Female Frequency are out of the combined Frequency total.

Table 2: SGH Diabetes – Encounters by Age, CY 2017

Age Range	Frequency	%
Under 1 Year	0	0.00%
1 - 17 Years	0	0.00%
18 - 34 Years	111	1.70%
35 - 64 Years	2,759	42.19%
65 Years or Greater	3,670	56.12%
Total Encounters	**6,540**	--

Data Source: SpeedTrack CUPID; OSHPD Inpatient Hospital Discharge Data

Table 3: SGH Diabetes – Top 10 Ambulatory Surgery ICD-10 Codes, CY 2017

Top 10 ICD-10 Diagnosis Codes	ICD-10 Code	Frequency	Percentage	Male Freq.*	% Male	Female Freq.*	% Female
Type 2 Diabetes Mellitus Without Complications	E11.9	1,300	83.17%	685	43.83%	615	39.35%
Type 2 Diabetes Mellitus With Diabetic Chronic Kidney Disease	E11.22	52	3.33%	32	2.05%	20	1.28%
Type 2 Diabetes Mellitus With Diabetic Neuropathy Unspecified	E11.40	38	2.43%	29	1.86%	9	0.58%
Type 2 Diabetes Mellitus With Foot Ulcer	E11.621	31	1.98%	26	1.66%	5	0.32%
Type 2 Diabetes Mellitus With Hyperglycemia	E11.65	24	1.54%	18	1.15%	6	0.38%
Type 2 Diabetes Mellitus With Diabetic Polyneuropathy	E11.42	17	1.09%	13	0.83%	4	0.26%
Type 2 Diabetes Mellitus With Diabetic Nephropathy	E11.21	14	0.90%	9	0.58%	5	0.32%
Type 2 Diabetes Mellitus With Unspecified Complications	E11.8	13	0.83%	7	0.45%	6	0.38%
Type 1 Diabetes Mellitus Without Complications	E10.9	13	0.83%	6	0.38%	7	0.45%
Type 2 Diabetes Mellitus With Diabetic Peripheral Angiopathy Without Gangrene	E11.51	11	0.70%	9	0.58%	2	0.13%
Other Diagnoses In This Identified Health Area	--	*50*	*3.20%*	*35*	*2.24%*	*15*	*0.96%*
Total ICD-10 Code Count		**1,563**	--	**869**	**55.6%**	**694**	**44.4%**

Data Source: SpeedTrack CUPID; OSHPD Ambulatory Surgery Hospital Discharge Data
*Male Frequency and Female Frequency are out of the combined Frequency total.

Table 4: SGH Diabetes – Ambulatory Surgery Encounters by Age, CY 2017

Age Range	Frequency	%
Under 1 Year	0	0.00%
1 - 17 Years	0	0.00%
18 - 34 Years	13	0.89%
35 - 64 Years	685	46.95%
65 Years or Greater	761	52.16%
Total Encounters	**1,459**	--

Data Source: SpeedTrack CUPID; OSHPD Ambulatory Surgery Hospital Discharge Data

Table 5: SGH Diabetes – Top 10 Emergency Department ICD-10 Codes, CY 2017

Top 10 ICD-10 Diagnosis Codes	ICD-10 Code	Frequency	Percentage	Male Freq.*	% Male	Female Freq.*	% Female
Type 2 Diabetes Mellitus Without Complications	E11.9	6,013	61.77%	2,606	26.77%	3,407	35.00%
Type 2 Diabetes Mellitus With Hyperglycemia	E11.65	1,543	15.85%	696	7.15%	847	8.70%
Type 2 Diabetes Mellitus With Diabetic Chronic Kidney Disease	E11.22	771	7.92%	398	4.09%	373	3.83%
Type 2 Diabetes Mellitus With Diabetic Neuropathy Unspecified	E11.40	327	3.36%	187	1.92%	140	1.44%
Type 2 Diabetes Mellitus With Hypoglycemia Without Coma	E11.649	213	2.19%	115	1.18%	98	1.01%
Type 2 Diabetes Mellitus With Diabetic Nephropathy	E11.21	141	1.45%	70	0.72%	71	0.73%
Type 2 Diabetes Mellitus With Diabetic Polyneuropathy	E11.42	98	1.01%	42	0.43%	56	0.58%
Type 2 Diabetes Mellitus With Unspecified Diabetic Retinopathy Without Macular Edema	E11.319	89	0.91%	46	0.47%	43	0.44%
Type 1 Diabetes Mellitus With Hyperglycemia	E10.65	89	0.91%	50	0.51%	39	0.40%
Type 1 Diabetes Mellitus Without Complications	E10.9	83	0.85%	37	0.38%	46	0.47%
Other Diagnoses In This Identified Health Area	--	*367*	*3.77%*	*194*	*1.99%*	*173*	*1.78%*
Total ICD-10 Code Count		**9,734**	--	**4,441**	**45.6%**	**5,293**	**54.4%**

Data Source: SpeedTrack CUPID; OSHPD Emergency Department Hospital Discharge Data
*Male Frequency and Female Frequency are out of the combined Frequency total.

Table 6: SGH Diabetes – Emergency Department Encounters by Age, CY 2017

Age Range	Frequency	%
Under 1 Year	0	0.00%
1 - 17 Years	16	0.18%
18 - 34 Years	539	6.10%
35 - 64 Years	4,695	53.12%
65 Years or Greater	3,588	40.60%
Total Encounters	**8,838**	--

Data Source: SpeedTrack CUPID; OSHPD Emergency Department Hospital Discharge Data

SGH Hospital Data – Obesity

Table 1: SGH Obesity – Top 10 Inpatient ICD-10 Codes, CY 2017

Top 10 ICD-10 Diagnosis Codes	ICD-10 Code	Frequency	Percentage	Male Freq.*	% Male	Female Freq.*	% Female
Obesity Unspecified	E66.9	2,421	26.42%	931	10.16%	1,490	16.26%
Morbid (Severe) Obesity Due to Excess Calories	E66.01	1,666	18.18%	629	6.86%	1,037	11.31%
Body Mass Index (BMI) 40.0-44.9 Adult	Z68.41	835	9.11%	241	2.63%	594	6.48%
Body Mass Index (BMI) 45.0-49.9 Adult	Z68.42	426	4.65%	133	1.45%	293	3.20%
Obesity Complicating Childbirth	O99.214	400	4.36%	0	0.00%	400	4.36%
Morbid (Severe) Obesity With Alveolar Hypoventilation	E66.2	358	3.91%	171	1.87%	187	2.04%
Body Mass Index (BMI) 50-59.9 Adult	Z68.43	301	3.28%	108	1.18%	193	2.11%
Body Mass Index (BMI) 35.0-35.9 Adult	Z68.35	289	3.15%	114	1.24%	175	1.91%
Body Mass Index (BMI) 31.0-31.9 Adult	Z68.31	234	2.55%	105	1.15%	129	1.41%
Body Mass Index (BMI) 36.0-36.9 Adult	Z68.36	226	2.47%	86	0.94%	140	1.53%
Other Diagnoses In This Identified Health Area	--	*2,009*	*21.92%*	*844*	*9.21%*	*1,165*	*12.71%*
Total ICD-10 Code Count		**9,165**	--	**3,362**	**36.7%**	**5,803**	**63.3%**

Data Source: SpeedTrack CUPID; OSHPD Inpatient Hospital Discharge Data
*Male Frequency and Female Frequency are out of the combined Frequency total.

Table 2: SGH Obesity – Inpatient Encounters by Age, CY 2017

Age Range	Frequency	%
Under 1 Year	0	0.00%
1 - 17 Years	3	0.07%
18 - 34 Years	675	14.91%
35 - 64 Years	2,331	51.50%
65 Years or Greater	1,517	33.52%
Total Encounters	**4,526**	--

Data Source: SpeedTrack CUPID; OSHPD Inpatient Hospital Discharge Data

Table 3: SGH Obesity – Top 10 Ambulatory Surgery ICD-10 Codes, CY 2017

Top 10 ICD-10 Diagnosis Codes	ICD-10 Code	Frequency	Percentage	Male Freq.*	% Male	Female Freq.*	% Female
Obesity Unspecified	E66.9	521	16.00%	207	6.36%	314	9.64%
Morbid (Severe) Obesity Due to Excess Calories	E66.01	249	7.65%	103	3.16%	146	4.48%
Body Mass Index (BMI) 26.0-26.9 Adult	Z68.26	226	6.94%	106	3.25%	120	3.68%
Body Mass Index (BMI) 30.0-30.9 Adult	Z68.30	221	6.79%	109	3.35%	112	3.44%
Body Mass Index (BMI) 29.0-29.9 Adult	Z68.29	206	6.32%	116	3.56%	90	2.76%
Body Mass Index (BMI) 25.0-25.9 Adult	Z68.25	198	6.08%	85	2.61%	113	3.47%
Body Mass Index (BMI) 27.0-27.9 Adult	Z68.27	197	6.05%	90	2.76%	107	3.29%
Body Mass Index (BMI) 28.0-28.9 Adult	Z68.28	178	5.47%	83	2.55%	95	2.92%
Body Mass Index (BMI) 40.0-44.9 Adult	Z68.41	153	4.70%	56	1.72%	97	2.98%
Body Mass Index (BMI) 32.0-32.9 Adult	Z68.32	153	4.70%	70	2.15%	83	2.55%
Other Diagnoses In This Identified Health Area	--	*955*	*29.32%*	*408*	*12.53%*	*547*	*16.79%*
Total ICD-10 Code Count		**3,257**	--	**1,433**	**44.0%**	**1,824**	**56.0%**

Data Source: SpeedTrack CUPID; OSHPD Ambulatory Surgery Hospital Discharge Data
*Male Frequency and Female Frequency are out of the combined Frequency total.

Table 4: SGH Obesity – Ambulatory Surgery Encounters by Age, CY 2017

Age Range	Frequency	%
Under 1 Year	0	0.00%
1 - 17 Years	0	0.00%
18 - 34 Years	241	11.89%
35 - 64 Years	1,158	57.13%
65 Years or Greater	628	30.98%
Total Encounters	**2,027**	--

Data Source: SpeedTrack CUPID; OSHPD Ambulatory Surgery Hospital Discharge Data

Table 5: SGH Obesity – Top 10 Emergency Department ICD-10 Codes, CY 2017

Top 10 ICD-10 Diagnosis Codes	ICD-10 Code	Frequency	Percentage	Male Freq.*	% Male	Female Freq.*	% Female
Obesity Unspecified	E66.9	1,692	39.25%	555	12.87%	1,137	26.37%
Morbid (Severe) Obesity Due to Excess Calories	E66.01	1,031	23.92%	354	8.21%	677	15.70%
Body Mass Index (BMI) 40.0-44.9 Adult	Z68.41	248	5.75%	76	1.76%	172	3.99%
Body Mass Index (BMI) 30.0-30.9 Adult	Z68.30	235	5.45%	55	1.28%	180	4.18%
Body Mass Index (BMI) 45.0-49.9 Adult	Z68.42	118	2.74%	43	1.00%	75	1.74%
Body Mass Index (BMI) 50-59.9 Adult	Z68.43	98	2.27%	24	0.56%	74	1.72%
Body Mass Index (BMI) 35.0-35.9 Adult	Z68.35	91	2.11%	42	0.97%	49	1.14%
Body Mass Index (BMI) 31.0-31.9 Adult	Z68.31	75	1.74%	29	0.67%	46	1.07%
Body Mass Index (BMI) 33.0-33.9 Adult	Z68.33	72	1.67%	35	0.81%	37	0.86%
Body Mass Index (BMI) 37.0-37.9 Adult	Z68.37	67	1.55%	25	0.58%	42	0.97%
Other Diagnoses In This Identified Health Area	--	*584*	*13.55%*	*214*	*4.96%*	*370*	*8.58%*
Total ICD-10 Code Count		**4,311**	--	**1,452**	**33.7%**	**2,859**	**66.3%**

Data Source: SpeedTrack CUPID; OSHPD Emergency Department Hospital Discharge Data
*Male Frequency and Female Frequency are out of the combined Frequency total.

Table 6: SGH Obesity – Emergency Department Encounters by Age, CY 2017

Age Range	Frequency	%
Under 1 Year	0	0.00%
1 - 17 Years	19	0.68%
18 - 34 Years	650	23.28%
35 - 64 Years	1,519	54.41%
65 Years or Greater	604	21.63%
Total Encounters	**2,792**	--

Data Source: SpeedTrack CUPID; OSHPD Emergency Department Hospital Discharge Data

SGH Hospital Data – Maternal and Prenatal Care, including High-Risk Pregnancy

Table 1: SGH Maternal Health/High-Risk Pregnancy – Top 10 Inpatient ICD-10 Codes, CY 2017

Top 10 ICD-10 Diagnosis Codes	ICD-10 Code	Frequency	Percentage	Male Freq.*	% Male	Female Freq.*	% Female
Gestational Diabetes Mellitus in Childbirth Diet Controlled	O24.420	135	11.26%	0	0.00%	135	11.26%
Preterm Labor Third Trimester With Preterm Delivery Third Trimester not Applicable or Unspecified	O60.14x0	129	10.76%	0	0.00%	129	10.76%
Newborn Small for Gestational Age Other	P05.19	124	10.34%	53	4.42%	71	5.92%
Preterm Newborn Gestational Age 36 Completed Weeks	P07.39	97	8.09%	51	4.25%	46	3.84%
Gestational Diabetes Mellitus in Childbirth Controlled by Oral Hypoglycemic Drugs	O24.425	70	5.84%	0	0.00%	70	5.84%
Other Low Birth Weight Newborn 2000-2499 Grams	P07.18	68	5.67%	38	3.17%	30	2.50%
Supervision of Elderly Multigravida Third Trimester	O09.523	63	5.25%	0	0.00%	63	5.25%
Newborn Small for Gestational Age 2000-2499 Grams	P05.18	48	4.00%	22	1.83%	26	2.17%
Gestational Diabetes Mellitus in Childbirth Insulin Controlled	O24.424	45	3.75%	0	0.00%	45	3.75%
Preterm Labor Without Delivery Third Trimester	O60.03	44	3.67%	0	0.00%	44	3.67%
Other Diagnoses In This Identified Health Area	--	*376*	*31.36%*	*103*	*8.59%*	*273*	*22.77%*
Total ICD-10 Code Count		**1,199**	--	**267**	**22.3%**	**932**	**77.7%**

Data Source: SpeedTrack CUPID; OSHPD Inpatient Hospital Discharge Data
*Male Frequency and Female Frequency are out of the combined Frequency total.

Table 2: SGH Maternal Health/High-Risk Pregnancy – Inpatient Encounters by Age, CY 2017

Age Range	Frequency	%
Under 1 Year	309	40.50%
1 - 17 Years	4	0.52%
18 - 34 Years	304	39.84%
35 - 64 Years	146	19.13%
65 Years or Greater	0	0.00%
Total Encounters	**763**	--

Data Source: SpeedTrack CUPID; OSHPD Inpatient Hospital Discharge Data

SGH Hospital Data – Unintentional Injury

Table 1: SGH Unintentional Injury – Top 10 Inpatient ICD-10 Codes, CY 2017

Top 10 ICD-10 Diagnosis Codes	ICD-10 Code	Frequency	Percentage	Male Freq.*	% Male	Female Freq.*	% Female
Fall on Same Level From Slipping Tripping and Stumbling Without Subsequent Striking Against Object Initial Encounter	W01.0xxa	1,505	10.06%	503	3.36%	1,002	6.70%
Exposure to Other Specified Factors Initial Encounter	X58.Xxxa	1,246	8.33%	591	3.95%	655	4.38%
Car Driver Injured in Collision With Other Type Car in Traffic Accident Initial Encounter	V43.52xa	754	5.04%	295	1.97%	459	3.07%
Striking Against or Struck by Other Objects Initial Encounter	W22.8xxa	672	4.49%	397	2.65%	275	1.84%
Other Fall on Same Level Initial Encounter	W18.39xa	544	3.64%	225	1.50%	319	2.13%
Overexertion From Prolonged Static or Awkward Postures Initial Encounter	X50.1xxa	502	3.35%	236	1.58%	266	1.78%
Unspecified Fall Initial Encounter	W19.Xxxa	496	3.31%	201	1.34%	295	1.97%
Overexertion From Strenuous Movement or Load Initial Encounter	X50.0xxa	438	2.93%	234	1.56%	204	1.36%
Striking Against Other Stationary Object Initial Encounter	W22.09xa	329	2.20%	186	1.24%	143	0.96%
Fall on Same Level Unspecified Initial Encounter	W18.30xa	279	1.86%	113	0.76%	166	1.11%
Other Diagnoses In This Identified Health Area	--	*8,198*	*54.79%*	*4,349*	*29.07%*	*3,849*	*25.72%*
Total ICD-10 Code Count		**14,963**	--	**7,330**	**49.0%**	**7,633**	**51.0%**

Data Source: SpeedTrack CUPID; OSHPD Inpatient Hospital Discharge Data
*Male Frequency and Female Frequency are out of the combined Frequency total.

Table 2: SGH Unintentional Injury – Inpatient Encounters by Age, CY 2017

Age Range	Frequency	Percentage
Under 1 Year	0	0.00%
1 - 17 Years	1	0.07%
18 - 34 Years	38	2.76%
35 - 64 Years	436	31.71%
65 Years or Greater	900	65.45%
Total Encounters	**763**	**--**

Data Source: SpeedTrack CUPID; OSHPD Inpatient Hospital Discharge Data

Table 3: SGH Unintentional Injury – Top 10 Ambulatory ICD-10 Codes, CY 2017

Top 10 ICD-10 Diagnosis Codes	ICD-10 Code	Frequency	Percentage	Male Freq.*	% Male	Female Freq.*	% Female
Exposure to Other Specified Factors Initial Encounter	X58.Xxxa	209	51.73%	100	24.75%	109	26.98%
Overexertion From Strenuous Movement or Load Initial Encounter	X50.0xxa	30	7.43%	24	5.94%	6	1.49%
Fall on Same Level From Slipping Tripping and Stumbling Without Subsequent Striking Against Object Initial Encounter	W01.0xxa	29	7.18%	11	2.72%	18	4.46%
Exposure to Other Specified Factors Subsequent Encounter	X58.Xxxd	13	3.22%	6	1.49%	7	1.73%
Other Fall From One Level to Another Initial Encounter	W17.89xa	10	2.48%	7	1.73%	3	0.74%
Exposure to X-Rays Initial Encounter	W88.0xxa	8	1.98%	6	1.49%	2	0.50%
Unspecified Fall Initial Encounter	W19.Xxxa	8	1.98%	3	0.74%	5	1.24%
Exposure to X-Rays Subsequent Encounter	W88.0xxd	6	1.49%	5	1.24%	1	0.25%
Other Fall on Same Level Initial Encounter	W18.39xa	6	1.49%	3	0.74%	3	0.74%
Fall on Same Level Unspecified Initial Encounter	W18.30xa	6	1.49%	4	0.99%	2	0.50%
Other Diagnoses In This Identified Health Area	--	*79*	*19.55%*	*48*	*11.88%*	*31*	*7.67%*
Total ICD-10 Code Count		**404**	--	**217**	**53.7%**	**187**	**46.3%**

Data Source: SpeedTrack CUPID; OSHPD Ambulatory Surgery Hospital Discharge Data
*Male Frequency and Female Frequency are out of the combined Frequency total.

Table 4: SGH Unintentional Injury – Ambulatory Encounters by Age, CY 2017

Age Range	Frequency	Percentage
Under 1 Year	0	0.00%
1 - 17 Years	5	1.54%
18 - 34 Years	97	29.94%
35 - 64 Years	160	49.38%
65 Years or Greater	62	19.14%
Total Encounters	**324**	--

Data Source: SpeedTrack CUPID; OSHPD Ambulatory Surgery Hospital Discharge Data

Table 5: SGH Unintentional Injury – Top 10 Emergency ICD-10 Codes, CY 2017

Top 10 ICD-10 Diagnosis Codes	ICD-10 Code	Frequency	Percentage	Male Freq.*	% Male	Female Freq.*	% Female
Fall on Same Level From Slipping Tripping and Stumbling Without Subsequent Striking Against Object Initial Encounter	W01.0xxa	1,505	10.06%	503	3.36%	1,002	6.70%
Exposure to Other Specified Factors Initial Encounter	X58.Xxxa	1,246	8.33%	591	3.95%	655	4.38%
Car Driver Injured in Collision With Other Type Car in Traffic Accident Initial Encounter	V43.52xa	754	5.04%	295	1.97%	459	3.07%
Striking Against or Struck by Other Objects Initial Encounter	W22.8xxa	672	4.49%	397	2.65%	275	1.84%
Other Fall on Same Level Initial Encounter	W18.39xa	544	3.64%	225	1.50%	319	2.13%
Overexertion From Prolonged Static or Awkward Postures Initial Encounter	X50.1xxa	502	3.35%	236	1.58%	266	1.78%
Unspecified Fall Initial Encounter	W19.Xxxa	496	3.31%	201	1.34%	295	1.97%
Overexertion From Strenuous Movement or Load Initial Encounter	X50.0xxa	438	2.93%	234	1.56%	204	1.36%
Striking Against Other Stationary Object Initial Encounter	W22.09xa	329	2.20%	186	1.24%	143	0.96%
Fall on Same Level Unspecified Initial Encounter	W18.30xa	279	1.86%	113	0.76%	166	1.11%
Other Diagnoses In This Identified Health Area	--	*8,198*	*54.79%*	*4,349*	*29.07%*	*3,849*	*25.72%*
Total ICD-10 Code Count		**14,963**	--	**7,330**	**49.0%**	**7,633**	**51.0%**

Data Source: SpeedTrack CUPID; OSHPD Emergency Department Hospital Discharge Data
*Male Frequency and Female Frequency are out of the combined Frequency total.

Table 6: SGH Unintentional Injury – Emergency Encounters by Age, CY 2017

Age Range	Frequency	Percentage
Under 1 Year	22	0.33%
1 - 17 Years	898	13.33%
18 - 34 Years	1,864	27.68%
35 - 64 Years	2,461	36.54%
65 Years or Greater	1,490	22.12%
Total Encounters	**6,735**	--

Data Source: SpeedTrack CUPID; OSHPD Ambulatory Surgery Hospital Discharge Data

Appendix

I HASD&IC 2019 CHNA Community Engagement Tracking Form

Focus Groups							
#	**Organization/Participants**	**Number of participants**	**Minority, medically underserved, & low-income group**	**Expertise**	**Role in target group**	**Region**	**Date input was gathered**
1	**Health Center Partners,** Promotors	3	Yes	Minority, underserved communities, behavioral health, social service navigation, stigma	Community Leader	South	10/9/18
2	**Alliance for Regional Solution,** Homeless providers, healthcare providers, government, law enforcement, non-profits	40	Yes	Homeless, housing and health, stigma	Community Leader	North Coastal, North Inland	10/24/18
3	**School Based Health Center – Southwest High School,** Clinic staff including providers, school staff, parents, interns	17	Yes	Children/youth, students, stigma	Representative Health Expert	South	11/28/18
4	**San Diego Hunger Coalition**, Task Force Meeting Members	11	Yes	Food Insecurity, healthy food access, hunger and health	Community Leader	All Regions	11/29/18
5	**California State University of San Marcos, School of Nursing, Student Healthcare Project,** Director and Student Nurses	10	Yes	Underserved communities, undocumented, stigma	Representative Health Expert	North Coastal, North Inland	1/29/19
6	**Casa Familiar, South Bay Community Center, and San Ysidro Health,** Promotoras	14	Yes	Minority communities	Community Leader	South	1/31/19

Focus Groups							
#	**Organization/Participants**	**Number of participants**	**Minority, medically underserved, & low-income group**	**Expertise**	**Role in target group**	**Region**	**Date input was gathered**
7	**Regional Task Force on the Homeless**, General Membership Meeting Members	12	Yes	Homeless, homeless TAY population, housing and health	Community Leader	North Central	1/31/19
8	**Family Health Centers of San Diego,** Special populations health educators and program coordinators	13	Yes	LGBTQ, stigma	Representative Health Expert	Central	2/4/19
9	**University of California San Diego School of Medicine Center for Community Health, Partnership for the Advancement of New Americans, United Women of East Africa**	3	Yes	Underserved communities, refugee, new immigrant	Community Leader	Central	2/7/19
10	**Community Housing Works,** Residents	20	Yes	Minority, medically underserved, and low income, aging concerns	Community Resident	Central	1/16/18
11	**Environmental Health Coalition,** Community Advisory Members	9	Yes	Minority, environmental issues	Community Resident	Central	11/14/18
12	**Monarch School,** Parents of homeless youth	8	Yes	Homeless Youth, students, stigma	Community Resident	Central	12/4/18
13	**Chaldean & Middle-Eastern Social Services,** Community Advisory Board Members	10	Yes	Refugee, new immigrant	Community Resident	East	12/4/18
14	**Vista Community Clinic,** Youth Patient Advisory Board Members	7	Yes	Minority youth, underserved communities, stigma	Community Resident	North Coastal, North Inland	12/5/18

Focus Groups							
#	**Organization/Participants**	**Number of participants**	**Minority, medically underserved, & low-income group**	**Expertise**	**Role in target group**	**Region**	**Date input was gathered**
15	**Vista Community Clinic,** Patient Advisory Board Members	10	Yes	Minority, underserved communities, stigma	Community Resident	North Coastal, North Inland	12/5/18
16	**Education Without Borders, San Diego State University,** Students	8	Yes	College students, minority, undocumented, stigma	Community Resident	Central	1/22/19
17	**Family Health Centers of San Diego,** Patients, community members	12	Yes	LGBTQ, stigma	Community Resident	Central	2/6/19
18	**San Diego Youth Services,** Youth Action Board Members	7	Yes	Homeless Youth	Community Resident	Central, East	2/7/19

Online Survey				
#	**Participants**	**Number**	**Expertise**	**Date input was gathered**
1	**Community Based Organizations, Federally Qualified Health Centers, Hospital/Health System, Local Government Agency, Philanthropic Organizations, San Diego County Public Health Services**	306	Minority, medically underserved, and low income, population with chronic diseases	1/29/19 – 2/12/19
2	**Community Residents**	47	Minority, medically underserved, and low income, population with chronic diseases	1/29/19 – 2/12/19

Key Informant Interviews					
#	**Organization/Participants**	**Expertise**	**Role in target group**	**Region**	**Date input was gathered**
1	**University of California San Diego School of Medicine Center for**	Underserved communities	Community Leader	Central	11/5/18

Key Informant Interviews					
#	**Organization/Participants**	**Expertise**	**Role in target group**	**Region**	**Date input was gathered**
	Community Health, Executive Director				
2	**Mountain Health,** CEO	Rural Health	Community Leader	North Inland, East	11/30/18
3	**O'Farrell Charter School,** Teacher	Children/youth, students	Community Leader	Central	12/4/18
4	**Jewish Family Service,** Director of Nutrition	Military hunger	Community Leader	All Regions	12/4/18
5	**Think Dignity,** Executive Director	Homeless	Community Leader	Central	12/5/18
6	**ElderHelp,** Advocate	Senior Health	Community Leader	All Regions	12/12/18
7	**San Diego American Indian Health Center,** Substance Abuse Treatment Provider	Native American Health	Community Leader	Central	1/18/19
8	**Dreams for Change**, CEO	Homeless	Community Leader	Central	1/22/19
9	**International Rescue Committee**, Senior Food and Farming Program Manager	Refugees	Community Leader	Central	1/29/19
10	**Pillars of the Community**, Program Coordinator	Minority, underserved communities	Community Leader	Central	1/31/19
11	**Otay Elementary, Chula Vista School District,** School Counselor	Children/youth, students	Community Leader	South	2/4/19
12	**San Diego County Health and Human Services Agency,** Director and Deputy Chief Administrative Officer	Health Department Representative, Low-income, medically underserved, minority population, population with chronic disease	Community Leader	All Regions	2/19/19

Appendix

J Sharp HealthCare 2019 CHNA Case Studies

Sharp 2019 CHNA Case Study: Breast Cancer

Sharp 2019 CHNA Case Study: High-Risk Pregnancy

Sharp 2019 CHNA: Case Study – "Camila"

Breast Cancer: A Crisis One in Eight Women Will Face

Camila is a 55-year-old, single Latina woman who works as an LVN at a skilled nursing facility. Camila loves her job, and she known for the nurturing and intelligent way she cares for her patients. At home, Camila has a 15-year-old son, and she also cares for her 75-year-old mother. They are a close and loving family. Camila is a legal resident of the United States, and her son is a citizen. Her mother, however, is in the country without proper documentation.

After a recent mammogram at the Sharp Memorial Outpatient Pavilion, an abnormality is found in Camila's right breast. After further imaging, Camila is sent for a biopsy, and she is diagnosed with invasive ductal carcinoma — the most common type of breast cancer. Camila is referred to a medical oncologist and a breast surgeon.

Meeting Camila's Medical Needs

Camila's care team is housed at Sharp Memorial Hospital. They formulate a treatment plan for her, which will include:

- Four months of chemotherapy
- Surgery (breast conserving, if possible)
- Radiation therapy five days a week for six weeks
- Five years of hormone targeted therapy drugs
- Five years of close surveillance once treatment has ended

Breast Cancer

As of 2016, 3.5 million women in the United States had a history of breast cancer.[1]

American women have a 1 in 8 (12.4%) chance of developing breast cancer.[2]

In San Diego from 2011-2015, 127 women per 100,000 had breast cancer diagnosis.[2]

In the same time period, 20.3 per 100,000 women died from breast cancer. Death rates from breast cancer in San Diego vary by race[3]:

- 25.7 for Black women
- 22.1 for White women
- 18.1 for Hispanic women
- 12.6 for Asian/Pacific Islander women

> *"You are never again the person you were before the cancer diagnosis"*
> — Clinical Social Worker and Patient Navigator Sharp Barnhart Cancer Center

Clinical staging assessed Camila's breast cancer as Stage IIb. The tumor is initially too large for Camila to be a candidate for breast conserving surgery. Therefore, Camila undergoes neoadjuvant chemotherapy — systemic therapy that occurs *before* surgery. Camila receives the chemotherapy every three weeks for four months. As expected, Camila loses her hair, and while she is able to continue working after the first round of

Community Engagement Findings: Gaps in Services

Financial concerns are a primary source of stress for cancer patients. Financial navigators to deal specifically and exclusively with health insurance and other financial issues are needed.

Social and support services for cancer patients are fragmented. They would benefit from an in-house "one-stop" shop that provide services to meet a variety of needs.

Too few therapists who specialize in oncology accept insurance; this leaves those who cannot self-pay without vital long-term mental health care.

More resources are needed to provide adequate post-surgery or post-chemotherapy follow-up to cancer patients.

chemotherapy, after the second, she becomes too sick to work. She also feels as if her brain is foggy — she can't concentrate well, and she is especially forgetful. Once the chemotherapy has concluded, new imaging scans show that the tumor has adequately shrunk to allow for breast conserving surgery. Camila has the surgery and returns home the same day. Three weeks later, she begins radiation therapy, attending five days a week for six weeks. She is also taking Tamoxifen, a hormone-targeted drug, to lower her risk of recurrence. She will take this medication for at least five years. After her treatment concludes, Camila will have physical examinations every six months for the next three years and a mammogram every six months for the next five years, at which time she will return to annual mammograms.

Meeting Camila's Social, Emotional, and Practical Needs

Camila is surprised at how deeply this diagnosis has shaken her given her experience in the health care field. She is scared and overwhelmed with worry about her health and about how she will manage her family while she is undergoing treatment.

Camila knows that her chances of survival are excellent. Nevertheless, she is scared of dying and can't help but wonder what will happen to her son and to her mother if she dies. Camila knows it isn't the most important thing, but she is also deeply upset about losing her hair.

Camila also has a long list of practical concerns. She isn't sure how the family will make it financially — the co-pays for her treatment are high, and her disability check will be smaller than her regular income. Her car is old, and the hospital is 15 miles from her home, and she is concerned that her car will break down. She also isn't sure what she will do about getting home from surgery or about driving herself to chemotherapy and radiation if she is sick — she's the only person in the house who drives. At home, her mom tries to help, but her mother is not in the best of health and her mobility is limited. Camila does not want her to son to have to take care of her during her chemotherapy and after surgery. She worries about how his needs will be met while she is sick — how will he get to school and to sports and to his friends' houses? And, although she doesn't like to discuss this openly, Camila is worried

that all of this contact with the health care community might result in her residency status being revoked — or worse — her mother's deportation.

Fortunately, Camila is referred to a Sharp Memorial Hospital cancer patient navigator. The navigator calls her before she begins chemotherapy and:

- Administers a distress scale which helps the navigator assess Camila's physical, social, emotional, and practical needs
- Helps Camila schedule her appointments for surgery
- Talks to Camila about what to expect during treatment and what side effects might occur
- Offers Camila tips and tools to manage treatment side effects
- Refers Camila to community resources that can help with transportation
- Helps Camila apply for a grant that will provide her with financial assistance
- Refers her to a Sharp social worker who provides Camila with several counseling sessions during her cancer treatment
- Comes to her bedside before her surgery to reassure her
- Refers her to twice-monthly support group for women with breast cancer at Sharp Memorial Outpatient Pavilion
- Encourages her to attend a "Lunch and Learn" education program at Sharp Memorial Outpatient Pavilion to cope with the emotional aspects of cancer
- Discusses some of the integrative care options available at Sharp Memorial Hospital and whether they would be beneficial to Camila

Potential Long-term Side Effects of Breast Cancer Treatment[9,10]

Anxiety
Depression
Suicide
Neurocognitive dysfunction
Sexual dysfunction
PTSD
Fear of recurrence
Poor body image
Cardiovascular toxicities
Lymphedema
Fatigue
Pain
Bone loss
Premature menopause
Infertility
Skin changes

Survivorship: Meeting Camila's Needs After Treatment Ends

Mood disorders, including depression, are common among cancer patients. Depression, in turn, is associated with higher levels of cancer mortality.[4-8]

Seven months after her diagnosis, Camila's cancer treatment comes to a successful end. The cancer has been treated, and Camila recovers quickly. The cancer navigator helps Camila complete a survivorship care plan, which will ensure that Camila is aware of symptoms of recurrence and of potential long-term effects from her treatment. The plan also gives details about the kind of follow-up care Camila should receive.

Physically, Camila is doing fairly well. Fortunately, she did not develop lymphedema, cardiovascular issues, or neuropathy as some breast cancer patients do. Camila is, however, exhausted and continues to be forgetful and less organized than she was before she had cancer. She also struggles emotionally. She doesn't understand why she isn't happier and is extremely anxious that the cancer will recur. Her son, too, struggles. He worries about leaving his mom home alone and has taken over some of the care for his grandmother.

Camila isn't sure where to turn for help. Her relationship with the cancer patient navigator ended when her treatment ended, as did her counseling with the social worker. She knows that support groups are available for breast cancer survivors, but she doesn't have the energy to find one. She is trying to find a therapist, both for her and for her son, but the therapists she locates who have experience in cancer survivorship don't take her insurance. Camila's experience is not uncommon. A key finding of the 2019 CHNA was that cancer survivors need easily accessible, long-term support and services after their treatment has concluded.

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Sharp 2019 CHNA: Case Study – "Ashley"

Ashley's High-Risk Pregnancy: A Physical and Emotional Journey

Ashley is a 42-year-old, African American woman who has taught elementary school for nearly two decades; she is beloved for her intelligence, genuine love of children, infectious laugh, and strong work ethic.

Ashley is pregnant with her second child. She has a 7-year-old girl, Natasha, at home, who was born at 35 weeks, 1 day gestation, two and a half hours after Ashley's membranes ruptured. Natasha spent 4 days in the Neonatal Intensive Care Unit (NICU) and was discharged. Natasha suffered no long-term effects from her early delivery, but Ashley remembers the time her daughter spent in the NICU as extremely stressful and anxiety-provoking — unlike anything she and her husband had ever experienced before.

Premature Birth and PROM

Premature delivery occurs in approximately 10% of all births in the United States[1] Preterm Premature Rupture of the Membranes (PROM) complicates an estimated 3% of all pregnancies.[2]

About 1/3 of premature births are caused by PROM.[3]

Ashley and her husband waited four years before trying to conceive again, in part because of the traumatic nature of Natasha's birth. Unfortunately, Ashley had two miscarriages, one at 7 weeks' gestation and the other at 15 weeks' gestation, before this pregnancy. As a result, Ashley and her husband are both thrilled and very nervous about this pregnancy.

Thirty weeks into her pregnancy, Ashley comes into the triage unit at Sharp Mary Birch Hospital for Women and Newborns (SMBHWN). After a physical examination, a physician confirms that Ashley's membranes have ruptured. As in her first pregnancy, Ashley is once again experiencing what is known as *Preterm Premature Rupture of the Membranes* or PROM, one of the most common causes of premature birth, and one of the most common reasons women are admitted to the Perinatal Special Care Unit (PSCU) at SMBHWN.

Meeting Ashley's Medical Needs

Ashley is admitted to the PSCU at SMBHWN, where she will remain until she delivers. Ashley's obstetrician consults with a perinatologist and neonatologist, and they agree on the following plan:

- Administer intravenous antibiotics for 48 hours followed by 5 days of oral antibiotics to minimize risk of infection, two doses of corticosteroid to enhance fetal lung development, and one dose of magnesium sulphate for fetal neural protection
- Check Ashley's vital signs every four hours, monitor for signs of infection
- Check fetal heart rate and for uterine contractions every four hours

- Perform weekly ultrasounds to check amniotic fluid levels
- Arrange physical therapy (PT) consult within 48 hours of admission, offer PT as necessary

The hope is that Ashley's labor will not begin for at least another three weeks, but no attempts will be made to stop her labor once it begins. If the baby is born, as expected, before full-term, he will be transferred immediately to the NICU at SMBHWN for assessment, monitoring, and any necessary interventions.

Women with high-risk pregnancies are at risk of anxiety and depression.[4-7]

Meeting Ashley's Social, Emotional, and Practical Needs

Ashley knew that her pregnancy was considered higher risk than usual since she was older and had a history of PROM, and she is grateful for the care she is receiving. Nevertheless, the practical and emotional realities of Ashley's situation are overwhelming to her. She feels as if she has no control over her life and is worried about being a burden.

Ashley finds herself crying a lot and is worried about her baby: *Will her baby be ok? Will he live? How long will he have to be in the hospital after he is born? Are there long-term effects of being born so early? Will he be able to nurse? Will his breathing be labored? Will she be able to hold him? Will he be lonely in the NICU if she isn't there all the time? Will he bond with her if she can't bring him home?*

Ashley remembers the NICU and all its beeping machines and long tubes. She also remembers the tiny, fragile-looking babies housed within its walls. And she is scared. On top of that, she is uncomfortable lying in bed all the time. And she is lonely. And bored.

Ashley is also worried about a host of practical issues*: Who will find a substitute teacher for her and how will she get the lesson plans to the substitute? How long will her maternity leave be now that she is out of work so much earlier than expected? How will they afford the co-pays for her hospitalization? When will her disability payments start? How will her husband cope with caring for their home, their child, and their pets by himself?*

And is she worried about her daughter at home: *How will Natasha cope with being without her mom until the baby is born? Will she be scared? Who will pick her up from school, help her with her homework, and get her to playdates and birthday parties? How will they take care of the baby in the NICU and take care of Natasha at the same time? Will Natasha's relationship with the baby be affected by his time in the NICU?*

Fortunately, the caregivers on the SMBHWN PSCU have extensive experience in caring for women like Ashley with high-risk pregnancies. They answer her questions, reassure her about her baby's health, monitor her health and the health of her baby closely, and

ensure that she receives a wide range of services to meet her psychosocial needs. During her stay, Ashley:

- Works with a SMBHWN social worker, who assesses Ashley's needs and helps her arrange her disability payments, navigate her insurance plan, and formulate a plan for after the baby is born; teaches her about resources for premature babies, like the Early Start program; and provides her with much-needed emotional support. The social worker is also actively monitoring Ashley for signs of serious depression. Equally important, the social worker arranges for a tour of the NICU, where Ashley meets other moms of premature babies and is able to see babies who were born at the same gestation her baby is at now.
- Attends the Baby Chat group with other mothers on the PSCU. The prenatal educator who facilitates the group answers the moms' questions about caring for babies, both premature and full-term, and talks about resources in the community. She also goes to an Arts for Healing group in the lobby of the unit. Both of these groups help Ashley battle the loneliness and isolation of being hospitalized.
- Receives bedside pet therapy, music therapy, and art therapy. Ashley treasures her time with the therapy dog who visits her and she enjoys her time in music and art therapy. She also loves it when the volunteer violinist comes to her room — they love to chat, and the music cheers her up.

Community Engagement Findings: Gaps in Services

High-risk pregnancies take an emotional toll on women and their families.

Financial concerns are a primary source of stress for women with high-risk pregnancies.

Women need help navigating the insurance and disability systems.

The lack of available transitional services once the mother and her baby are home is a major gap in care.

The Baby

Fifteen days after Ashley's admission to SMBHWN, contractions begin. She delivers her little boy just three hours later. He is 33 weeks, 1 day gestation. The delivery goes smoothly, and Ashley and her husband welcome Baby Neal who weighs 4 pounds, 6 ounces and is 17 inches long. Ashley is officially discharged 48 hours later. She decides, however, to take advantage of the SMBHWN "hotel" program where she is allowed to stay in a hospital room, without hospital services, to be near her baby. She is concerned about the additional expense but cannot bear the thought of being away from Neal.

Ashley returns home after a week and makes twice daily visits to see Neal in the NICU. The transition home is challenging for Ashley and her family on many levels. They are faced with renegotiating their

Women who are hospitalized with high- risk pregnancies benefit from services such as support groups and music, art, and recreational therapy.[8-11]

roles and responsibilities within the family and with rebuilding the structure of their daily lives. In addition, now that the major crisis has passed, Ashley and her husband must contend with paying the accumulating bills, determining when Ashley will need to return to work, and getting a nursery and supplies ready for Neal. Physically, Ashley is still recovering from childbirth, and she is pumping breast milk every four hours. She is exhausted and overwhelmed.

Overall, Neal does well. He can breathe on his own but does have difficulty with feeding and develops a severe case of jaundice. He spends three weeks in the hospital. When he is discharged, the family joyfully welcomes him home but also faces new challenges to the family schedule and routines. Ashley, especially, struggles. She wants to breastfeed her baby, but Neal does not latch well, and Ashley cannot find the time or the energy to return to the hospital to receive lactation consulting, so she continues to pump milk every four hours. She finds this both depressing and exhausting. Ashley is also anxious about finding appropriate childcare for her tiny baby as she must return to work in six short weeks. Ashley desperately needs more support but simply does not know how to find it.

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2. American College of Obstetricians and Gynecologists Committee on Practice Bulletins. Practice Bulletin No. 172: Premature Rupture of Membranes. *Obstet Gynecol.* 2016;128(4):e165-177.
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Appendix

K Sharp HealthCare 2019 CHNA Community Engagement Tracking Form

#	Type of Engagement	Who Participated	# of Participants	Date	Hospital/Facility Represented	Description of public health knowledge/expertise
1.	**Focus Group**	Sharp McDonald Center – After Care Support Group Members	6	2/27/2019	SMC	Patient specific challenges related to behavioral health and addiction issues
2.	**Focus Group**	Sharp HealthCare – Cancer Navigators & Social Workers	18	1/03/2019	SCVMC, SGH, SMH, SRSMG, System Services	Cancer expertise at Sharp HealthCare Regions: Central East, North Central, South
3.	**Focus Group**	Sharp HealthCare – Diabetes Health Educators	9	11/20/2018	SCVMC, SGH, SMH, OPP	Low income, medically underserved, population with chronic diseases, minority population Regions: Central East, North Coastal, South
4.	**Focus Group**	Sharp HealthCare – Patient and Family Advisory Council – Community Residents	5	1/21/2019	SGH	Patient specific challenges related to health and social determinants of health
5.	**Focus Group**	Sharp Mary Birch – Social Workers and Case Managers	10	1/10/2019	SMBHWN	Low income, medically underserved, population with chronic diseases, minority population Region: Central
6.	**Focus Group**	Sharp HealthCare – Case Manager Leadership	8	2/21/2019	SCHHC, SCMG, SCVMC, SGH, SMH, SRSMG, System Services	Low income, medically underserved, population with chronic diseases, minority population Regions: Central East, North Central, North Coastal, North Inland, South

7.	**Focus Group**	Senior Community Members	3	2/20/2019	NA	Patient specific challenges related to senior health issues
8.	**Focus Group**	Sharp HealthCare – Senior Health Staff	3	2/12/2019	SMH, OPP	Low income, population with chronic diseases, Medicare primary Region: Central
9.	**Key Informant Interview**	Nurse Educator PSCU/ADC, Perinatal Special Care Unit	1	12/19/2018	SMBHWN	High risk pregnancy expertise
10	**Key Informant Interview**	Clinical Social Worker and Patient Navigator	1	1/03/2019	SCVMC Sharp Barnhart Cancer Center	Cancer expertise

Sharp Entity Key: **SCHHC** = Sharp Coronado Hospital and HealthCare Center; **SCVMC** = Sharp Chula Vista Medical Center; **SGH** = Sharp Grossmont Hospital; **SMBHWN**=Sharp Mary Birch Hospital for Women & Newborns, **SMC**= Sharp McDonald Center; **SMH** = Sharp Memorial Hospital; **SMVH** = Sharp Mesa Vista Hospital**; SRSMG** = Sharp Rees-Stealy Medical Group; **SCMG** = Sharp Community Medical Group; **OPP** = Sharp Memorial Hospital Outpatient Pavilion; **System Services** = Sharp HealthCare System Services

Appendix

L Sharp HealthCare 2019 CHNA Community Engagement Participant Descriptions

Cancer Navigation Services and Care Coordination

Community engagement participants described their work as helping patients and loved ones navigate the treatment process and secure additional needed support and resources. Navigators and social workers may set up family meetings to initiate conversations and provide clear communication about the treatment trajectory. They help structure family roles and responsibilities during treatment. They talk to physicians about recommending home health when needed. They may help parents figure out how to talk about the cancer in an age-appropriate way with their children, and they help patients and their families find local resources. Social workers and navigators continually reevaluate patients' needs and serve as a source of reassurance and support. All of this is done in the context of a trusting relationship that is built over time. In addition, the navigators and social workers:

- Provide ongoing reinforcement of treatment plan and goals
- Provide education on what to expect during treatment, anticipated side effects, and ways to manage them
- Support patient compliance and best outcomes
- Provide ongoing assessment of patient barriers to care, nutrition, and psychosocial support needs
- Assist with resources/referrals for transportation, financial grants, and other services as appropriate
- Provide and review survivorship care plans
- Provide patients with education information
- Inform patients about programs and services at Sharp

Navigators and social workers also coordinate care with organizations such as Jewish Family Service and Mama's Kitchen for meal delivery and transportation options. They also refer patients to Sharp Mesa Vista Hospital during psychiatric emergencies and to psychiatrists for psychotropic medications when mental health issues are of concern.

Diabetes Navigation Services and Care Coordination

Community engagement participants described the purpose of the diabetes health educator's job as to empower the patients to "own their health" and provide education to all family members who are willing to participate. Health educators work with adults and seniors (over 65 years) who have type 1, type 2, or gestational diabetes mellitus. Focus group participants emphasized the importance of treating patients as a community and not just as an individual — changes made in the family, they stressed, can have lasting

positive effects on the children and their future health trajectories. Sharp Diabetes Health Educators also:

- Perform assessments of patient knowledge and ability to perform self-care
- Work with organ transplant patients about nutrition and eating
- Teach patients how to use insulin and navigate the system to get diabetes supplies
- Provide case management for patients with multiple comorbidities
- Offer workshops at Family Health Centers of San Diego and senior centers about nutrition, exercise, and self-management
- Support physicians in helping manage their patients
- Explain side effects of medications
- Provide emotional support and help lessen anxiety
- Make referrals to Feeding America, Salvation Army, WIC, and other organizations
- Help patients secure resources through 2-1-1 San Diego
- Partner with the Sharp Mesa Vista Outpatient Center

Services Provided by Patient Family Advisory Council (PFAC)

Community engagement participants described PFAC members as advocates for patients and family members at Sharp Grossmont Hospital to make the patient experience more welcoming and to help address their needs. They give input to the hospital from the patient perspective about how to serve patients and their families better and help patients be more informed. They are also engaged in various improvement projects within the hospital.

Sharp HealthCare has PFAC members at each of its hospital entities.

Services Provided by SMBHWN Case Managers, Social Workers, and the Perinatal Special Care Unit

Community engagement participants who serve as case managers and social workers at SMBHWN and the Perinatal Special Care Unit provide a variety of services for maternal-child health issues and work directly with the Neonatal Intensive Care Unit. They explained that their work helps women heal faster and enhances mother-newborn bonding. They provide:

- Advocacy for families
- Assessments of family needs
- Emotional support and crisis intervention to mothers and families
- Support and resources for mothers with a high-risk pregnancy, including vulnerable groups such as those who are drug users, teens, or homeless
- Crisis intervention in different hospital units
- Referrals to child protective services when necessary
- Discharge planning
- Referrals for home health services for the mother and baby
- Referrals for durable medical equipment
- Referrals for skilled nursing facilities
- Referrals to Early Start for premature babies

- Set up for *gastrostomy* tube supplies (feeding tube to help deliver nutrition)
- Group, art, music, and pet therapy for women in the hospital
- Set up for lactation services

Appendix

M Sharp HealthCare 2019 CHNA Key Informant Interview Questions

SAN DIEGO STATE UNIVERSITY
Institute for Public Health

Sharp 2019 CHNA Case Study Questions – High-Risk Pregnancy

Joanna Hunt BSN, RNC-OB, C-EFM
Nurse Educator PSCU/ADC
Perinatal Special Care Unit
Sharp Mary Birch Hospital for Women & Newborns
December 3, 2018

1. What kind of high-risk pregnancies do you see most often at Mary Birch?
2. What kinds of services do these women receive in your unit? Inpatient, outpatient?
3. Do you notice any disparities in: (1) who is most likely to have a high-risk pregnancy (e.g., we know that Black women, in particular, have much higher rates of maternal mortality — do you see this at Mary Birch?); and (2) who receives services at Mary Birch?
4. What do you think the barriers are, at an individual, community, hospital, or cultural level for women to: (1) receive the kind of care that might prevent a high-risk pregnancy; and (2) receive the care they need after it is known that they have a high-risk pregnancy?
5. How do women get referred to you? Can any MD, nurse practitioner/midwife refer a woman to your unit or does the health care provider have to be Sharp-affiliated? Are your services covered by most insurance? Medi-Cal?
6. Are there women you wish you were serving that you think you are not serving?
7. Do you see immigration/documentation as a factor that is impacting women's willingness/ability to receive the care they need for a high-risk pregnancy?
8. How do you work through some of the barriers to care with women, such as: transportation; work hours/appointments; child care; mistrust of health care system; cultural beliefs?
9. Can you tell me about one (or more!) of the cases that has stayed with you in terms of a really positive outcome for a woman and her child who received care from your unit?
10. Can you think of a patient for whom the outcome might have been very different if she had not received the special services of your unit?
11. Can you tell me about one (or more) of the cases that has stayed with you in terms of sad/negative outcomes for a woman who received care from your unit? Was there any way this could have turned out differently?

SAN DIEGO STATE UNIVERSITY
Institute for Public Health

Sharp CHNA 2019 Case Study Questions – Cancer

Cara Fairfax, MSW, LCSW, CN-BM
Clinical Social Worker and Patient Navigator
Sharp Chula Vista Barnhart Cancer Center
March 1, 2019

1. Tell me about the work you do at the Cancer Center.
    a. What is a typical day like for you?
2. Tell me about the Cancer Center. What medical, social, or other services are available for patients?
3. Tell me about the patients you work with — who are they? What kind of cancer do they have? Is there a "typical" patient for you?
4. What are some of the most significant challenges your patients face?
    a. Physically
    b. Practically — managing care, appointments, transportation
    c. Socially
    d. Emotionally
5. How does your work impact these challenges?
6. Can you think of and describe to me a "case" on which you felt that you were able to be especially helpful?
7. Can you think of and describe to me a "case" that you felt was not as successful as you would have liked?
8. What is the most important thing you do for your patients?
9. If you had all the money in the world, how would you change the care that your patients receive — in terms of medical care, the services your team offers, and services in the community? What could be done to make their lives better?
10. I'm a 67-year-old woman, recently widowed, who lives alone. I've recently been diagnosed with stage 3 breast cancer and am referred to your program. What will that experience be like for me?

Appendix

N Sharp HealthCare 2019 CHNA – Sharp Insight Community Survey Distributed

EMAIL INVITATION:

Email subject line:

Help us positively impact the health of your community

Email body:

Hi [Panelist Name],
We have a new survey activity for you. Sharp HealthCare is seeking your input to identify and prioritize the most critical health-related needs in San Diego County, as part of its Community Health Needs Assessment (CHNA) process. The findings from this survey will be used in combination with other CHNA findings to provide a foundation for community benefit program planning and implementation. This activity should take about 10 minutes to complete, and must be completed on a computer. Thank you for your time and for your valuable opinion!

EMAIL REMINDER:

Email subject line:

Reminder: Help us positively impact the health of your community.

Email body:

Hi [Panelist Name],

As a reminder, you have a survey activity waiting for your input.

We can't wait to hear your thoughts on your community's most critical health-related needs. With your help, we will have the insight we need to make a positive impact on health in your community. This activity must be completed on a computer.

The activity will close on [Closing Date] at 11:59 PM.

SURVEY DRAFT:

MOBILE USERS:

Page 1 –

On behalf of the Sharp Insight Community, thank you for taking time to complete this activity.

Your honest feedback will help improve the health needs within the communities where you live, work, play, and receive services.

This activity cannot be completed on a mobile device or tablet. Please access the activity from a computer.

[Next button redirects to Sharp Insight Community website]

DESKTOP USERS:

Page 1 – Welcome

On behalf of the Sharp Insight Community, thank you for taking time to complete this activity. Your honest feedback will help improve the health needs within the communities where you live, work, play, and receive services.

This activity should take about 10 minutes of your time.

Page 2 –

1. In the following list, what do you think are the **five** most important **health conditions** in your community (those health conditions that have the greatest impact on overall community health)?

   Please select five options.

   - Aging concerns (e.g., arthritis, falls, Alzheimer's, etc.)
   - Behavioral/mental health issues (e.g., substance use, suicide, self-inflicted injury, etc.)
   - Cancer (all types)
   - Diabetes (types 1 and 2)
   - Heart disease (coronary)
   - High blood pressure
   - Infectious diseases (e.g., hepatitis, tuberculosis, etc.)
   - Lung disease
   - Obesity
   - Oral health
   - Respiratory issues (e.g., asthma, COPD, etc.)
   - Sexually-transmitted disease (e.g., HIV/AIDS)
   - Stroke
   - Unintentional injury
   - Maternal/infant health
   - Other health condition [please specify box]

Page 3 –

2. In the following list, what do you think are the **five** most important **social determinants** of health in your community (those social issues that have the greatest impact on overall community health)?

   Please select five options.

- Access to care (primary care, dental care, behavioral health, specialty care)
- Health insurance (understanding, securing, and using health insurance)
- Care management (disease management, community social service linkages)
- Social support (social interaction/engagement, cultural and linguistic support)
- Economic security (consistent access to healthy food, financial stability, employment)
- Education (access, health literacy, workforce development and mobility)
- Health behaviors (diet, physical and sexual activity, tobacco and substance use)
- Homelessness (overcrowding, substandard, housing affordability)
- Physical environment (transportation, grocery store/market access, air quality, walkability)
- Prenatal and maternal care (breastfeeding, post-partum support)
- Safety and violence (community violence, domestic violence, child or elder abuse)
- Screening (BMI, blood pressure, diabetes, cancer, STD, depression)
- Stigma (immigration status, behavioral health, use of public programs - e.g., food stamps)
- Other social issue

Page 4 –

3. Below is a combined list of the health conditions and social issues that you selected in the previous questions. Please rank them in order of importance from 1 to 10, with 1 having the greatest impact on the overall health and well-being of your community.

Page 5 –

4. Please rate your awareness of the following patient and community outreach programs implemented by Sharp HealthCare:

   Not at all familiar/ somewhat familiar/ very familiar

   - Transportation
   - Education programs through the City of San Diego Partnership (diabetes, heart health, nutrition and healthy lifestyle, new moms)
   - Sharp Senior Resource Centers
   - Sharp cancer support groups
   - Behavioral health support groups (mood disorders, aftercare, etc.)

5. What would you suggest Sharp do to improve the health and well-being of your community?
   [open response]

Page 6 –

Thank you for taking the time to complete this activity. Your feedback provides valuable insight on the health needs in your community. We look forward to sharing the survey findings and continuing this conversation with you in the near future.

Please click Finish below to submit your answers.

END OF SURVEY:

Redirect to Community Benefit page on Sharp.com.

Appendix

O Secondary Data Sources From Findings Section

	Access to Health Care Sources
1.	U.S. Census Bureau. American Community Survey, 2013-2017 1-Year Estimates. Includes civilian non-institutionalized population ages 18-64. Note: year 2017 includes ages 19-64 years
2.	The Dartmouth Institute for Health Policy and Clinical Practice. Primary care access and quality measures, 2015. https://atlasdata.dartmouth.edu/static/general_atlas_rates.
3.	U.S. Department of Health & Human Services, Health Resources and Services Administration. Area Health Resource File, 2014.
4.	County Health Rankings and Roadmaps. California, San Diego County, 2018. https://www.countyhealthrankings.org/app/california/2019/rankings/san-diego/county/outcomes/overall/snapshot. Generated interactively March 29, 2019.
5.	UCLA Center for Health Policy Research. California Health Interview Survey, 2015-2016.
	Aging Concerns Sources
1.	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2013-2016. SpeedTrack©
2.	County of San Diego Health and Human Services Agency. Measures of Mortality. Leading Causes of Death, 2016. HHSA website: https://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/community_health_statistics/CHSU_Mortality.html.
3.	Live Well San Diego. Live Well San Diego Data Access Portal. Injury. https://data.livewellsd.org/
	Behavioral Health Sources
1.	Substance Abuse and Mental Health Services Administration (SAMHSA). Leading Change: A Plan for SAMHSA's Roles and Actions 2011-2014. https://www.ncceh.org/media/files/article/SAMHSA_Plan_2011-14.pdf. Published 2011. Accessed March 28, 2019.
2.	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2013-2016. SpeedTrack©
3.	UCLA Center for Health Policy Research. California Health Interview Survey, 2017.
4.	Live Well San Diego. Live Well San Diego Data Access Portal. Injury. https://data.livewellsd.org/
5.	CDC. BRFSS Survey Data, 2015.
	Cancer Sources
1.	American Cancer Society. Cancer Facts & Figures 2019. https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2019/cancer-facts-and-figures-2019.pdf. Accessed April 16, 2019.
2.	California Cancer Registry. Age-Adjusted Invasive Cancer Incidence Rates in California, 2012- 2016, By County. https://www.cancer-rates.info/ca/. Accessed June 20. 2019
3.	County of San Diego Health and Human Services Agency. Measures of Mortality. Leading Causes of Death, 2016. HHSA website: https://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/community_health_statistics/CHSU_Mortality.html.
4.	California Cancer Registry. Age-Adjusted Cancer Mortality Rates in California, 2012-2016, By County. https://www.cancer-rates.info/ca/. Accessed June 20. 2019.

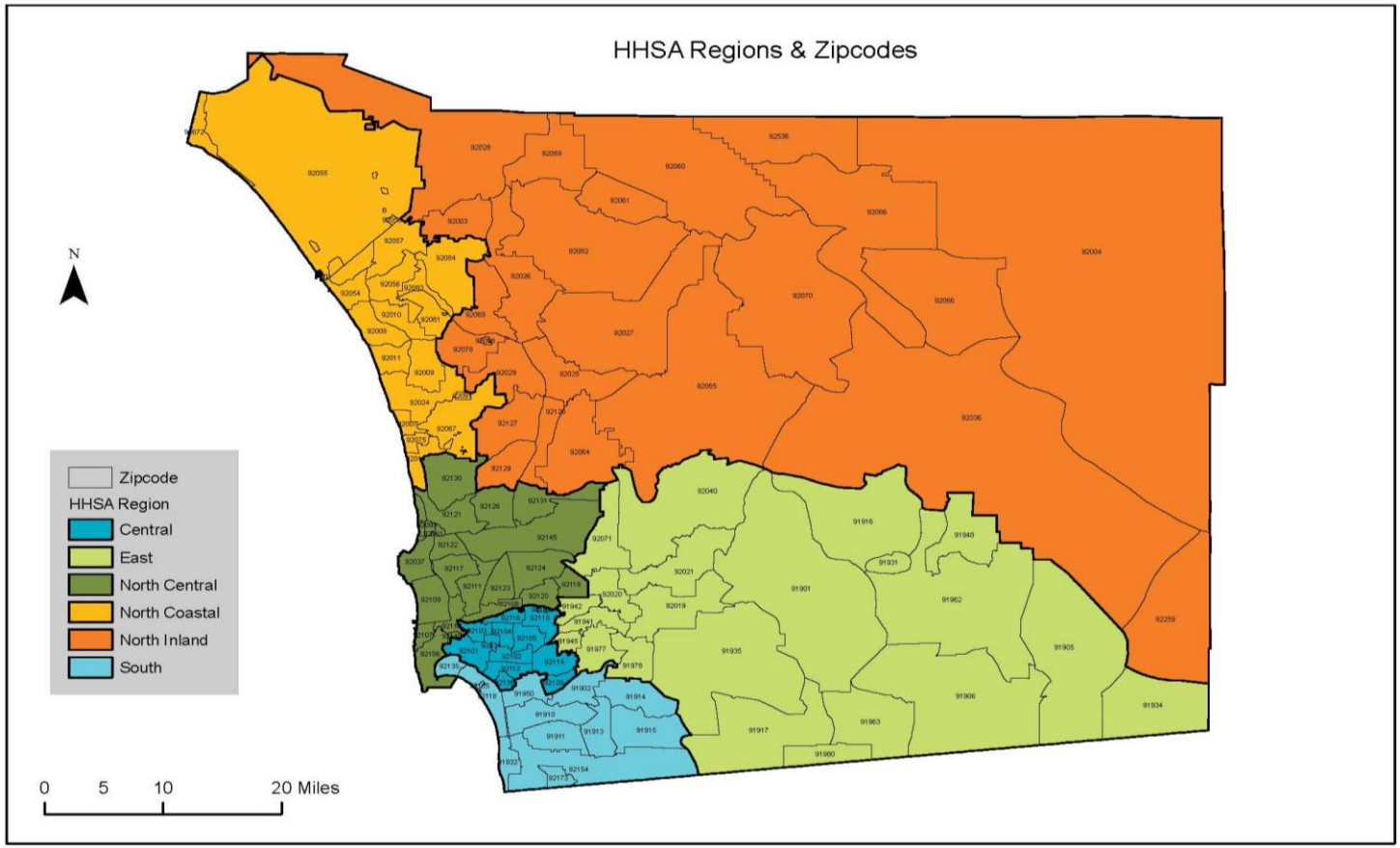
	Chronic Conditions Sources

1.	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. About chronic diseases. CDC Web site: https://www.cdc.gov/chronicdisease/about/index.htm. Updated March 8, 2019. Accessed May 16, 2019.
2.	American Heart Association. What is cardiovascular disease? American Heart Association Web site. https://www.heart.org/en/health-topics/consumer-healthcare/what-is-cardiovascular-disease. Updated May 31, 2017. Accessed on March 30, 2019.
3.	Centers for Disease Control and Prevention. Diabetes. CDC Web site: https://www.cdc.gov/diabetes/basics/diabetes.html. Updated June 1, 2017. Accessed May 16, 2019.
4.	Centers for Disease Control and Prevention. Overweight & obesity. CDC Web site: https://www.cdc.gov/obesity/adult/defining.html. Updated July 3, 2018. Accessed May 16. 2019.
5.	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2013-2016. SpeedTrack©
6.	County of San Diego Health and Human Services Agency. Measures of Mortality. Leading Causes of Death, 2016. HHSA website: https://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/community_health_statistics/CHSU_Mortality.html.
7.	County of San Diego Health and Human Services Agency Public Health Services, Regional & Community Data. https://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/community_health_statistics/regional-community-data.html.
8.	UCLA Center for Health Policy Research. California Health Interview Survey, 2013-2017. Rates indicate the percentage of people who had a diagnosis of diabetes in 2017.
9.	UCLA Center for Health Policy Research. California Health Interview Survey, 2014-2017.
	Community and Social Support Sources
1.	MacArthur Research Network on SES & Health. Research, psychosocial notebook. https://macses.ucsf.edu/research/psychosocial/socsupp.php. Updated April 2008. Accessed May 17, 2019.
2.	U.S. Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File. December 2016.
3.	U.S. Census Bureau. American Community Survey, 2013-2017 5-Year Estimates.
	Economic Security Sources
1.	What is economic security? The International Committee of the Red Cross. 18 June 2015. Accessed from: https://www.icrc.org/en/document/introduction-economic-security on May 8, 2019.
2.	Kaiser Permanente of Southern California Community Health Department. Secondary Data Analysis, 2018.
3.	Gundersen C, Ziliak JP (2015). Food insecurity and health outcomes. *Health Affairs.* 2015. *34*(11): 1830-1839.
4.	U.S. Department of Health & Human Services. 2019 Poverty Guidelines. Office of the Assistant Secretary for Planning and Evaluation Web site. https://aspe.hhs.gov/2019-poverty-guidelines. Accessed March 28, 2019.
5.	U.S. Census Bureau. American Community Survey, 2013-2017 5-Year Estimates.
6.	U.S. Bureau of Labor Statistics. Local Area Unemployment Statistics, 2018 annual averages.
7.	Coleman-Jensen A, Rabbitt MP, Gregory CA, Singh A. Household Food Security in the United States in 2017. https://www.ers.usda.gov/webdocs/publications/90023/err-256.pdf?v=0. Published September 2018. Accessed March 28, 2019.
8.	San Diego Hunger Coalition. Current Research on Hunger in San Diego County. https://www.sandiegohungercoalition.org/research. Accessed April 10, 2019. Original source: California Health Interview Survey, 2014-2016.
	Education Sources
1.	U.S. Census Bureau. American Community Survey, 2013-2017 5-Year Estimates.
2.	U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Social Determinants: Latest Data. HealthyPeople Web site. https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Social-Determinants/data. Accessed June 5, 2019.
	Homelessness and Housing Sources

1.	U.S. Department of Housing and Urban Development, Office of Community Planning and Development. The 2018 Annual Homeless Assessment Report (AHAR) to Congress. https://www.hudexchange.info/resources/documents/2018-AHAR-Part-1.pdf. Published December 2018. Accessed April 1, 2019.
2.	U.S. Department of Housing and Urban Development, Office of Policy Development and Research. Consolidated Planning/CHAS data, San Diego County 2011-2015. https://www.huduser.gov/portal/datasets/cp.html. Original Source: American Community Survey, 2011-2015.
3.	San Diego Regional Task Force on the Homeless. 2018 WEALLCOUNT Annual Report: San Diego County. https://www.rtfhsd.org/wp-content/uploads/2017/06/2018-WPoint-in-Time-Count-Annual-Report.pdf. Accessed April 1, 2019.
	Unintentional Injury and Violence Sources
1.	U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Injury and Violence. HealthyPeople Web site. https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Injury-and-Violence. Accessed June 5, 2019.
2.	Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) Fatal Injury Data, 2017. https://wisqars-viz.cdc.gov:8006/
3.	County of San Diego Health and Human Services Agency Public Health Services, Regional & Community Data. https://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/community_health_statistics/regional-community-data.html.
4.	Live Well San Diego. Live Well San Diego Data Access Portal. Injury. https://data.livewellsd.org/

Appendix

P Map of Community and Region Boundaries in San Diego County

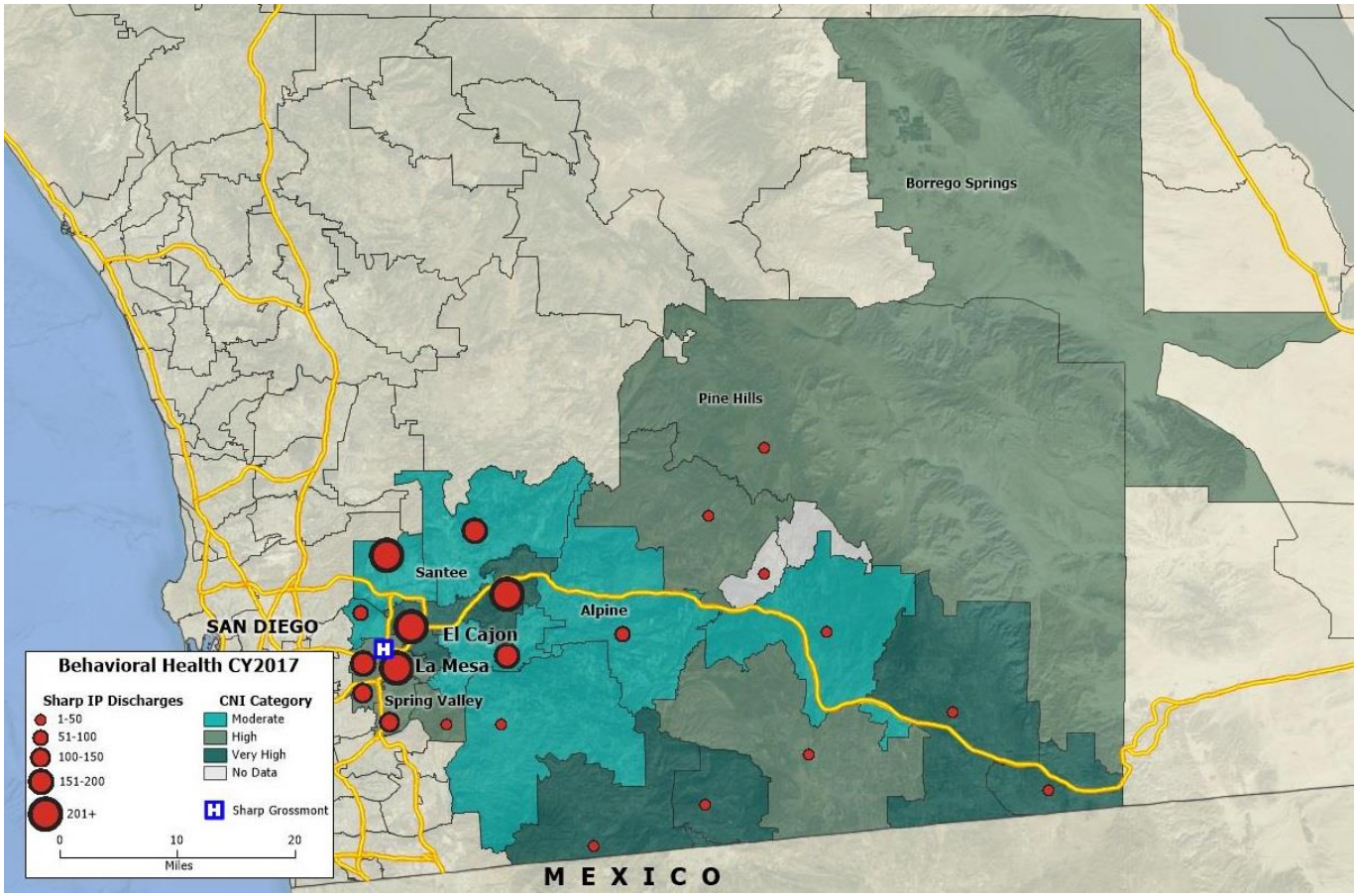


Map by County of San Diego, Emergency Medical Services. Contact: Isabel Corcos or Leslie Ray, 619.285.6429
Map Date: January, 2015

Appendix

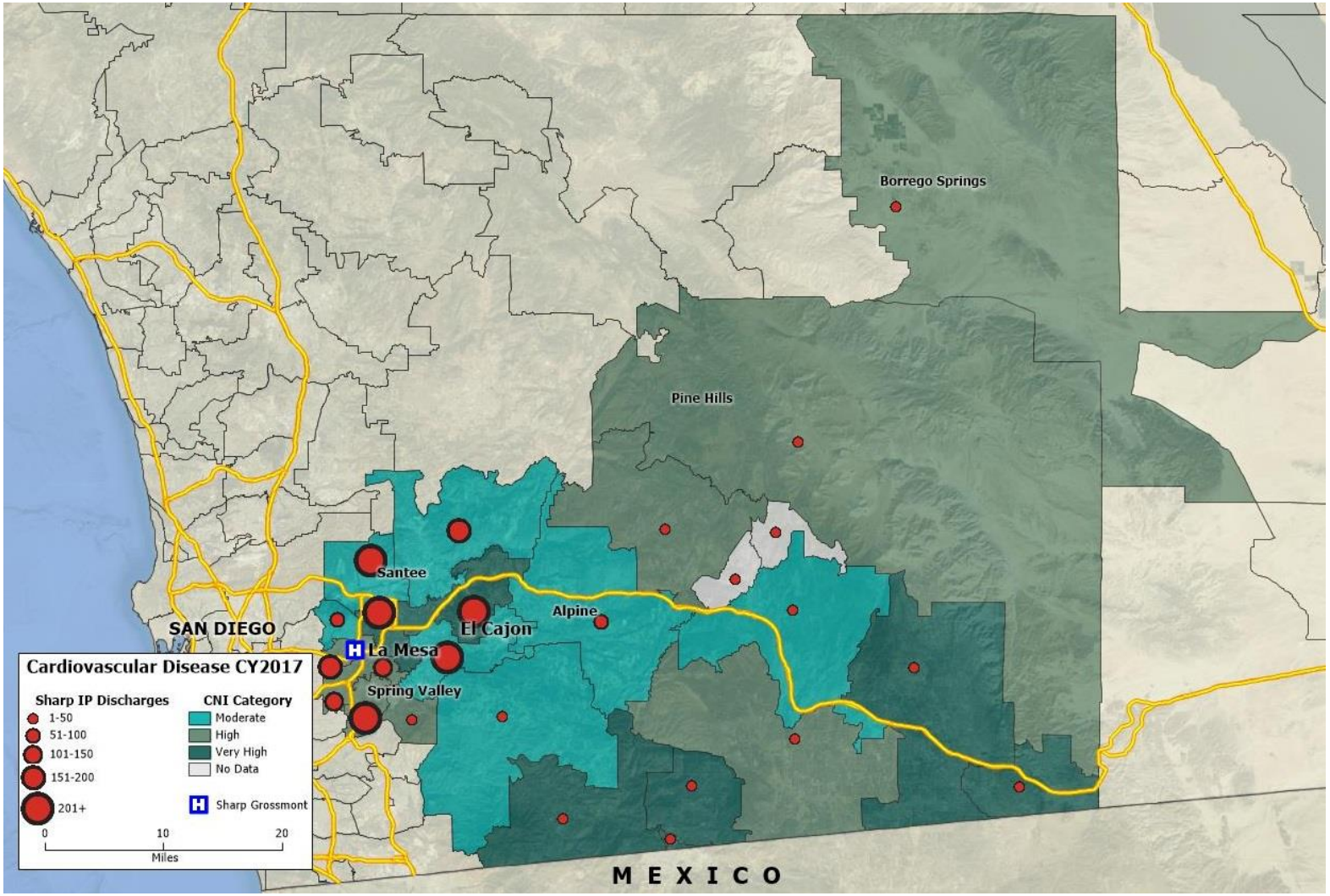
Q Community Need Index Maps San Diego County East Region

Sharp Inpatient Behavioral Health Discharges CNI Map, East Region (SDC)



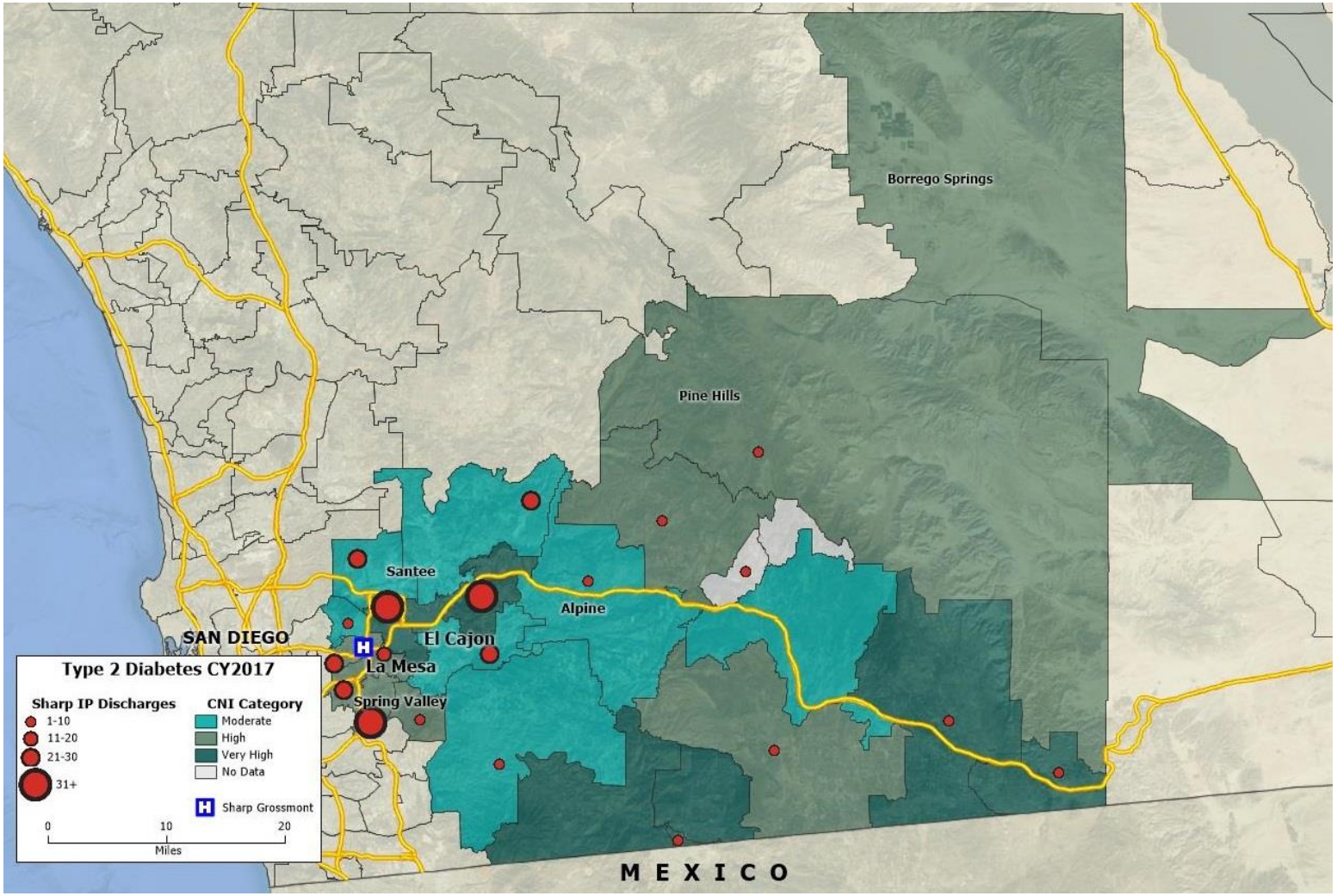
Source: Truven Health Analytics, 2018; Insurance Coverage Estimates, 2018; The Nielson Company, 2018; and Community Need Index, 2018; California Office of Statewide Health Planning and Development (OSHPD) via SpeedTrack©, Inc., 2017.

Sharp Inpatient Cardiovascular Discharges CNI Map, East Region (SDC)



Source: Truven Health Analytics, 2018; Insurance Coverage Estimates, 2018; The Nielson Company, 2018; and Community Need Index, 2018; OSHPD via SpeedTrack©, Inc., 2017.

Sharp Inpatient Type 2 Diabetes Discharges CNI Map, East Region (SDC)



Source: Truven Health Analytics, 2018; Insurance Coverage Estimates, 2018; The Nielson Company, 2018; and Community Need Index, 2018; OSHPD via SpeedTrack©, Inc., 2017.

Appendix

R Sharp HealthCare 2019 CHNA – Sharp Insight Community Survey Results

Sharp Insight Community:
Community Health Needs Assessment

Consumer Research Report

February 2019

SHARP

Survey Methodology and Background

- **Survey was sent to:** 3413 active participants of the Sharp Insight Community
- **Total respondents:** 380 (**11.1%** response rate)
- **Data collected from:** February 1, 2019 – February 11, 2019
- **Median survey completion time:** 6 minutes 4 seconds
- **Survey goals:**
  - To obtain feedback from San Diego County community residents and Sharp HealthCare health professionals about what they believe are the most important health problems and social determinants of health faced by their communities
  - To identify the top health and social needs of community members served by Sharp HealthCare
- **Note:** Participants using a mobile phone or tablet to complete the study were excluded due to the incompatibility of study question types with those devices.

Executive Summary

- Respondents most often selected **aging concerns**, **behavioral/mental health issues**, **cancer**, **obesity**, or **coronary heart disease** as those **health conditions** that had the greatest impact on overall community health.
- Respondents most often selected **health insurance**, **access to care**, **health behaviors**, **economic security**, or **homelessness** as those **social determinants** of health that had the greatest impact on overall community health.
- When respondents ranked the top ten health conditions and social determinants of health in order of impact, the **highest ranked** items were **health insurance**, **access to care**, and **aging concerns**.
- Though most respondents were **unfamiliar** with Sharp HealthCare's **community outreach programs**, respondents were **most familiar** with **Sharp cancer support groups**.

Source: Sharp Insight Community – Community Health Needs Assessment 2019 Survey

Panel Demographics

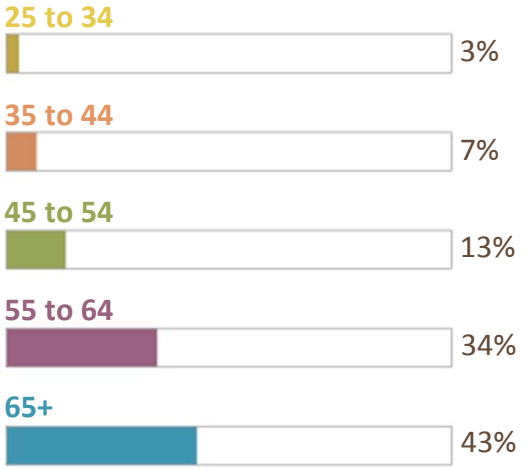
Gender

n= 380

Female: 68% **Male:** 32%

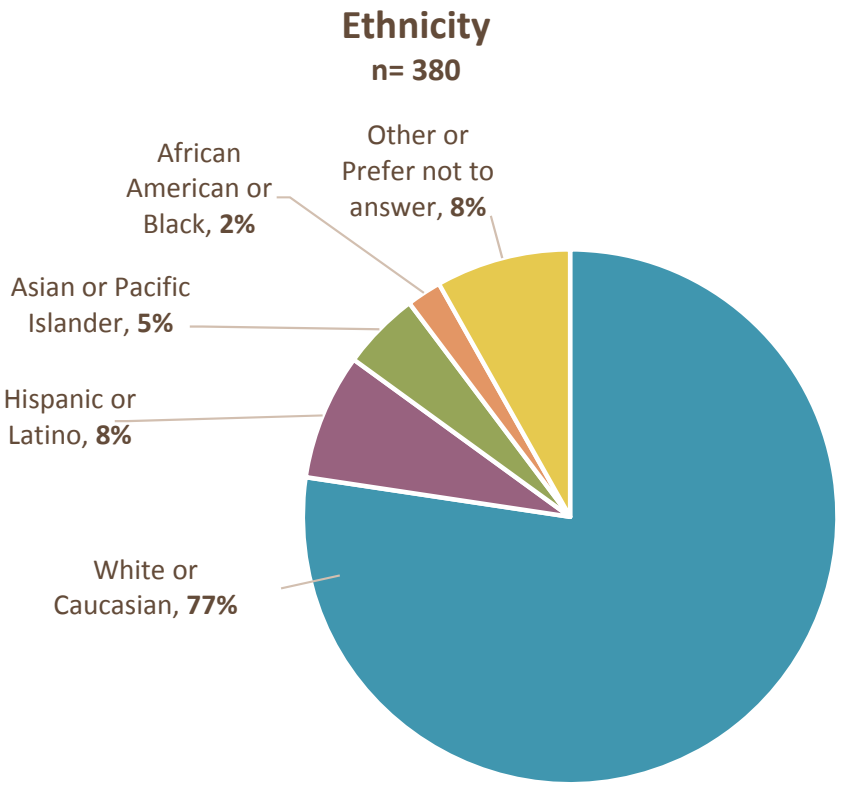
Age

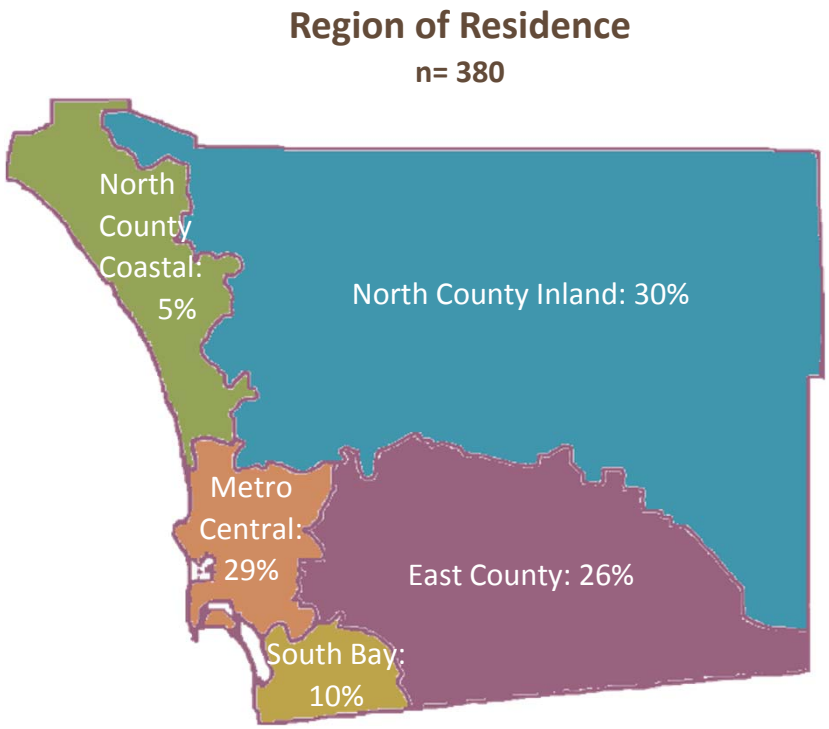
n= 380



Source: Sharp Insight Community Invitation Survey
Survey Responses: n=380

Panel Demographics



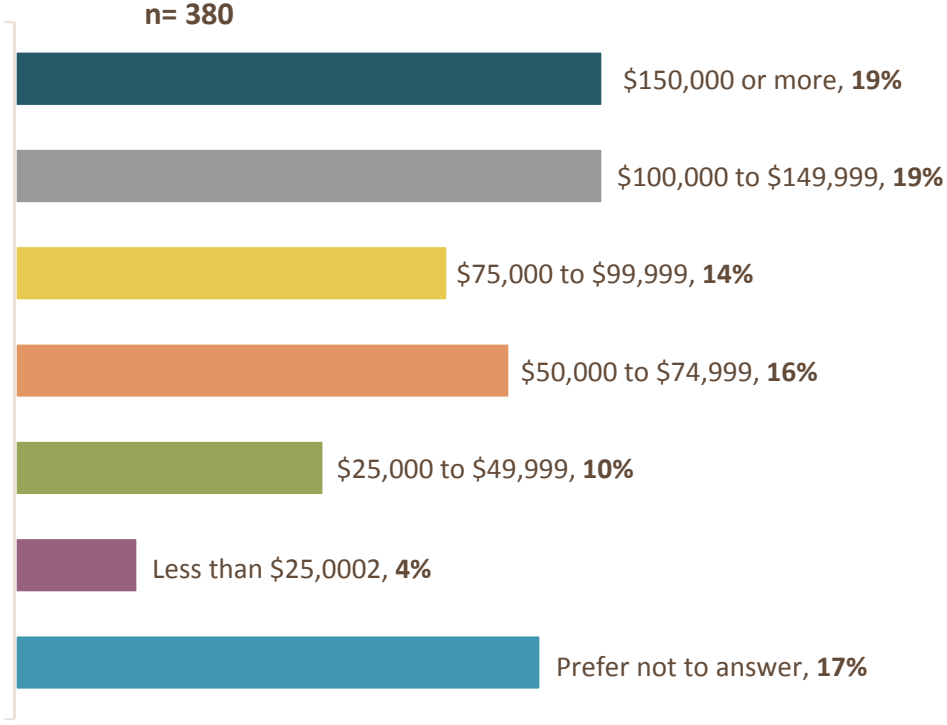


Source: Sharp Insight Community Invitation Survey
Survey Responses: n=380

Panel Demographics

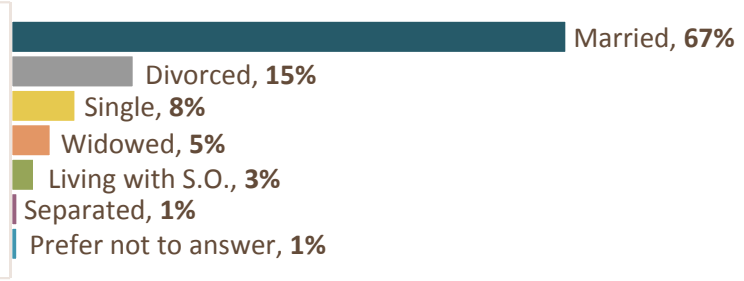
Household Income

n= 380



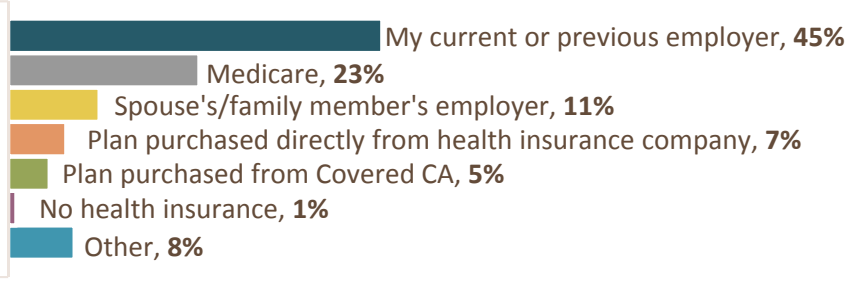
Marital Status

n= 380



Source of Health Insurance

n= 380



Source: Sharp Insight Community Invitation Survey
Survey Responses: n=380

Sharp Insight Community: CHNA 2019 Survey

Survey Results

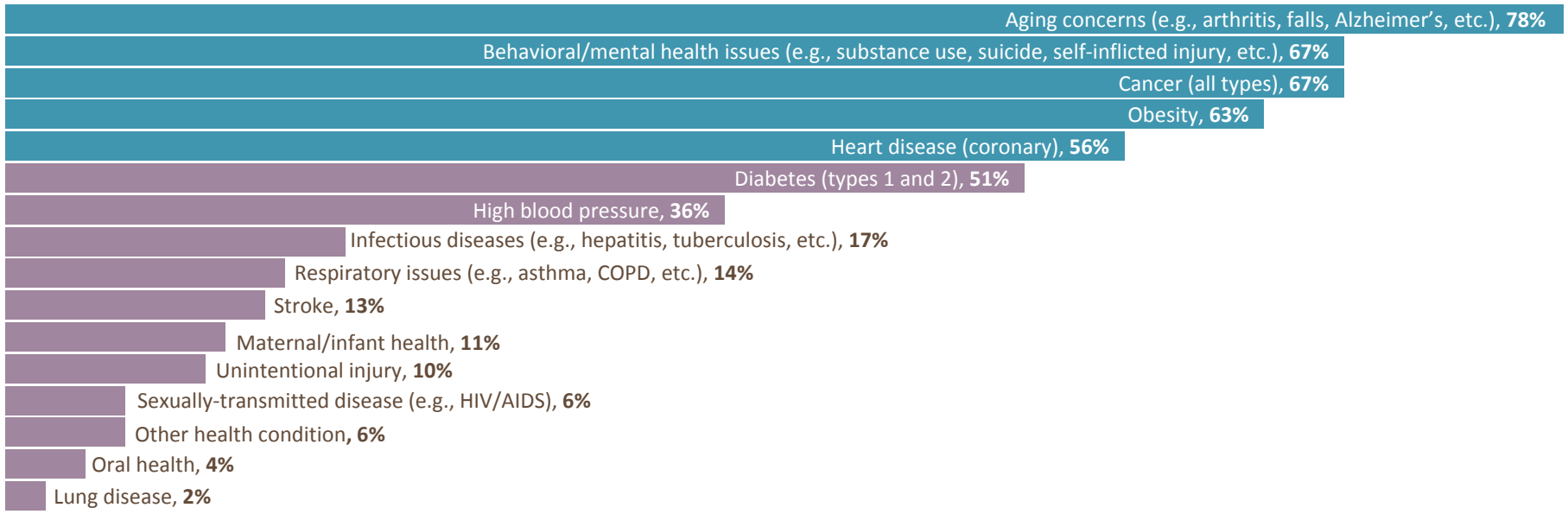
SHARP

Health Conditions with the Greatest Impact on Overall Community Health

Most respondents view aging concerns (78%), behavioral/mental health issues (67%), and cancer, obesity, and coronary heart disease (67%) among the top five health conditions with the greatest impact on their community.

Top Five Most Important Health Conditions

Respondents were able to select up to 5 options from a list of health conditions. These selections are not ordinal. Percentages reflect the proportion of respondents who selected a specific listed item.



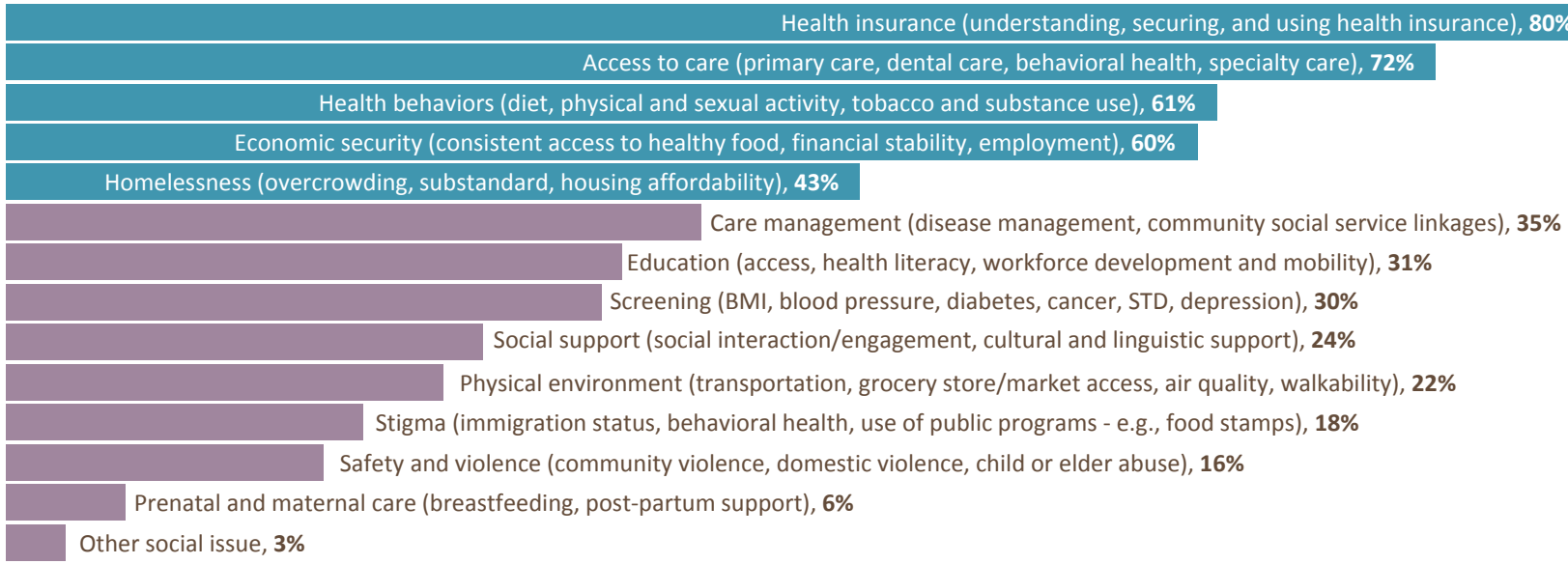
Question: In the following list, what do you think are the five most important health conditions in your community (those health conditions that have the greatest impact on overall community health)?
Survey Responses: n=380
Source: Sharp Insight Community – Community Health Needs Assessment 2019 Survey

Social Determinants with the Greatest Impact on Overall Community Health

Most respondents view health insurance (80%), access to care (72%), and health behaviors (61%) among the top five social issues with the greatest impact on their community.

Top Five Most Important Social Determinants of Health

Respondents were able to select up to 5 options from a list of social issues. These selections are not ordinal. Percentages reflect the proportion of respondents who selected a specific listed item.



Question: In the following list, what do you think are the five most important social determinants of health in your community (those social issues that have the greatest impact on overall community health)?
Survey Responses: n=380
Source: Sharp Insight Community – Community Health Needs Assessment 2019 Survey

Ranked Health Conditions and Social Determinants

Ranking score is a weighted score that was calculated for each listed item. Items ranked “#1” equate to 10 points, items ranked “#2” equate to 9 points, and so on. The higher the score the more value respondents placed on that particular item. The maximum possible score for an item (if all respondents were to have ranked an item “#1”) is 3,800.

No.	Health Condition/ Social Issue	Ranking Score
1	Health insurance (understanding, securing, and using health insurance)	1,941
2	Access to care (primary care, dental care, behavioral health, specialty care)	1,863
3	Aging concerns (e.g., arthritis, falls, Alzheimer's, etc.)	1,808
4	Behavioral/mental health issues (e.g. substance use, suicide, self-inflicted injury, etc.)	1,618
5	Cancer (all types)	1,528
6	Obesity	1,317
7	Economic security (consistent access to healthy food, financial stability, employment)	1,280
8	Heart disease (coronary)	1,188
9	Health behaviors (diet, physical and sexual activity, tobacco and substance use)	1,187
10	Diabetes (types 1 and 2)	951
11	Homelessness (overcrowding, substandard, housing affordability)	831
12	High blood pressure	725
13	Care management (disease management, community social service linkages)	621
14	Education (access, health literacy, workforce development and mobility)	587
15	Screening (BMI, blood pressure, diabetes, cancer, STD, depression)	542

No.	Health Condition/ Social Issue	Ranking Score
16	Social support (social interaction/engagement, cultural and linguistic support)	435
17	Infectious diseases (e.g., hepatitis, tuberculosis, etc.)	300
18	Stigma (immigration status, behavioral health, use of public programs - e.g., food stamps)	296
19	Physical environment (transportation, grocery store/market access, air quality, walkability)	295
20	Safety and violence (community violence, domestic violence, child or elder abuse)	246
21	Stroke	231
22	Respiratory issues (e.g., Asthma, COPD, etc.)	206
23	Maternal/infant health	197
24	Unintentional injury	185
25	Prenatal and maternal care (breastfeeding, post-partum support)	101
26	Other health condition	88
27	Sexually-transmitted disease (e.g., HIV/AIDS)	76
28	Other social issue	62
29	Oral health	56
30	Lung disease	29

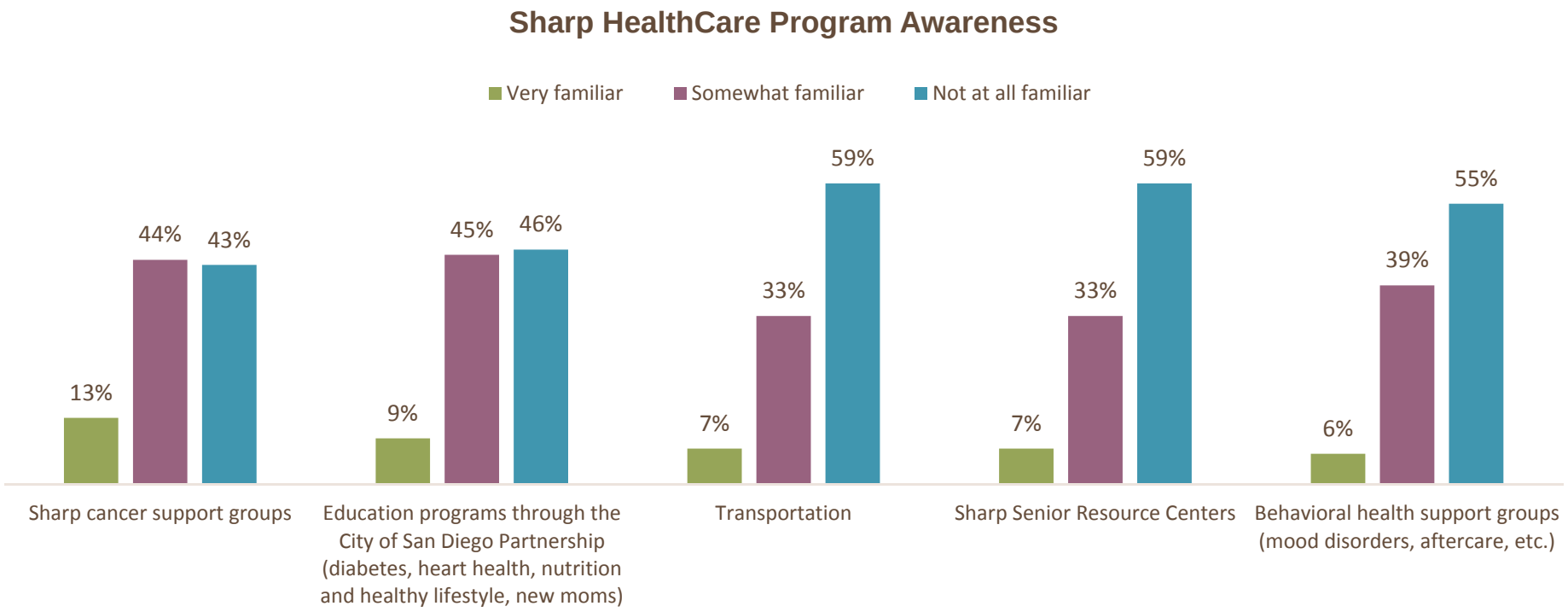
Question: Below is a combined list of the health conditions and social issues that you selected in the previous questions. Please rank them in order of importance from 1 to 10, with 1 having the greatest impact on the overall health and well-being of your community.
Survey Responses: n=380

Source: Sharp Insight Community – Community Health Needs Assessment 2019 Survey

SHARP

Awareness of Sharp HealthCare Community Outreach Programs

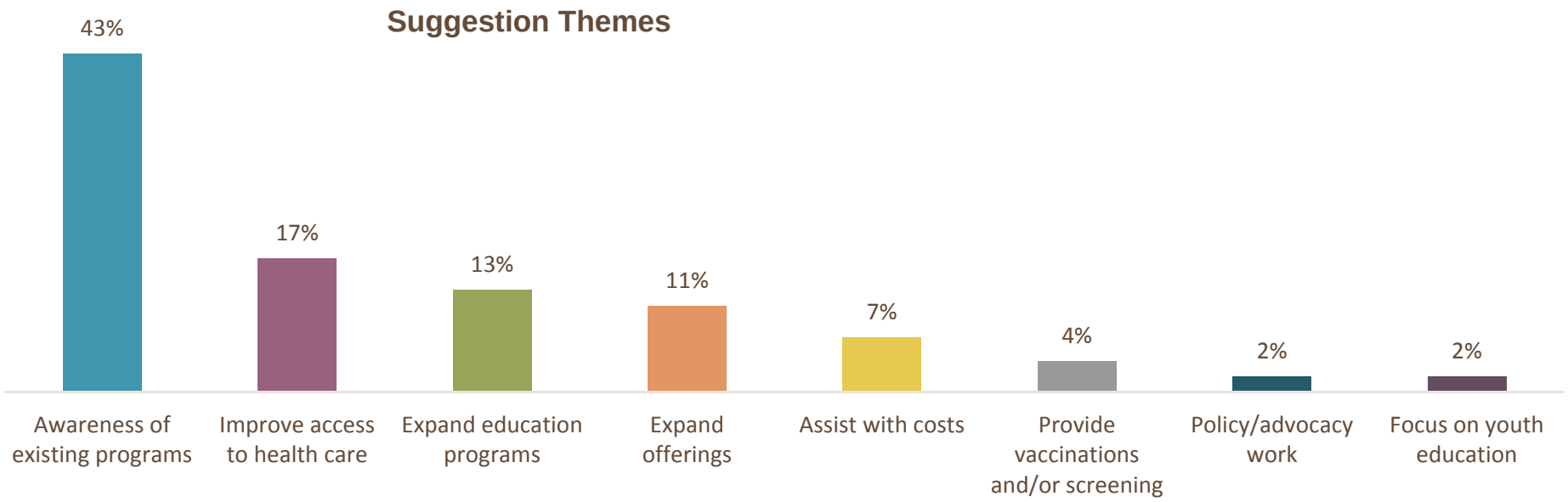
Respondents are most familiar with Sharp cancer support groups (13%) and least familiar with transportation programs (59%) and Sharp Senior Resource Centers (59%).



Question: Please rate your awareness of the following patient and community programs implemented by Sharp HealthCare:
Survey Responses: n=380
Source: Sharp Insight Community – Community Health Needs Assessment 2019 Survey

Suggestions to Improve Community Health and Well-being

Several respondents (43%) suggested that existing Sharp HealthCare community outreach programs be more broadly advertised. Respondents also suggested improvements to access (17%), and expansion of educational programs (13%).



Note: Percentages may not equal 100% because respondents may have offered more than one suggestion.

Question: What would you suggest Sharp do to improve the health and well-being of your community? (open-ended)
Survey Responses: n=380
Source: Sharp Insight Community – Community Health Needs Assessment 2019 Survey

Suggestions to Improve Awareness of Existing Community Health and Well-being Programs

43% of respondents mention a need for awareness of existing programs

"For those that regularly visit their doctor, have the staff (doctor, nurses, technicians) be **familiar with the various options available to patients** and recommend them. I've been to many Sharp-sponsored programs and my awareness of them always came from my doctor, the nurses or my dietitian. People today prefer to receive their information through **various channels**. Some like it presented in person, some like to read, some prefer videos. Making information available through all these channels would help."

"Better **promotion** in the community. Open Houses of the facilities and resources that are available. Looking at the demographics of a community - I live next to a university which has different needs based on the very young population of the students and thus my neighbors."

"Improve community awareness for patient and community education programs. Include **publicizing to employees** for better communication and follow up."

"Continue with your support for food insecurity and the support groups you provide. Continue to work with other health organizations and coordinating your efforts. I think there is **a lot of support out there but the public isn't aware**."

"Who knew? Where are these secrets kept, and **how do you communicate** to your patients?"

"**Advertise** these programs to Sharp patients through a **variety of methods** (e.g. mail, electronic/ computer, literature available at SHR facilities.)"

Question: What would you suggest Sharp do to improve the health and well-being of your community? (open-ended)
Survey Responses: n=380
Source: Sharp Insight Community – Community Health Needs Assessment 2019 Survey

Suggestions to Improve Access to Health Care Through Existing Community Health and Well-being Programs

17% of respondents mention a need for improved access to health care

"Greatly increase **access to primary health care services**, shorten **waiting times** for primary and specialty care appointments, free preventive health screenings, become politically active and advocate for public policies that address **access to health care/food insecurity/etc.**, increase number of physicians in the South Bay, get SRS to work with the hospital entities to promote screenings, i.e., lung cancer (because right now they refuse to work with the hospital entities), invest more in post-acute care management."

"Speed up the delivery of mental health care in the community. It **takes too long to get a referral and finally see a therapist** if you are at the level of needing hospitalization."

"Mobile units - If it is possible to go out to the public, it could help us address some of the transportation concern and even help with some of the stigma concerns... by coming to the patient and **making it convenient to be seen**."

"Community screenings, **ride share**, **bus schedules** that show routes directly to Sharp facilities."

"Offer clinics or outreach healthcare for **those without insurance** or money to pay."

"Help more people **secure insurance** to fund programs. Advocate for more community-based programs from politicians."

"Sometimes obtaining an appointment takes a long time-perhaps having **more resources so that appointments can be made** sooner."

Question: What would you suggest Sharp do to improve the health and well-being of your community? (open-ended)
Survey Responses: n=380
Source: Sharp Insight Community – Community Health Needs Assessment 2019 Survey

Suggestions to Expand Education of Community Health and Well-being Programs

13% of respondents mention expanding education programs

"First you need to change the role or image of the role of being a health care provider as the place to go for emergency solutions vs. being looked to as **an ongoing part of my overall health**. I see you as only being valued when I break an arm or have an obstructed bowel, not as a **reminder to maintain healthy weight and diet and exercise plan**. BIG CHANGE to see you that way."

"**Educate regarding expectations** for age-related degeneration and develop program to help."

"Provide opportunities for technical education on many areas of medicine; **develop decision-making tools for complex patient decisions** e.g., prostate cancer treatment."

"How to file for **Medicare, Medicaid** and how to choose what plans are right for your family."

"Educational/ informational awareness by **partnership with public school systems' adult programs**."

Question: What would you suggest Sharp do to improve the health and well-being of your community? (open-ended)
Survey Responses: n=380
Source: Sharp Insight Community – Community Health Needs Assessment 2019 Survey

Other Suggestions to Improve Community Health and Well-being

- 11% of respondents mentioned ways to **expand offerings**

"Recognize and include **oral care/ dentistry** in health system. It's critically important, undervalued and extremely difficult to get insurance for this as well as very expensive to maintain."

"Promote accessing community center for **physical and social activity**."

- 7% of respondents mentioned ways to **assist with costs**

"Create **discounted programs** for immigrants, the poor or underemployed, and the homeless."

"**Lower prices** and a **'menu' of services** with prices for people with or without insurance."

- 4% of respondents mentioned ways to **provide vaccinations/ screenings**

"More proactive in terms of **getting patients in for screening** (cancer etc.)"

"Possibly offer **free vaccines** to children."

- 2% of respondents mentioned **policy/ advocacy work**

"Actively advocate for **health care reform**, to ensure fair, equitable health care for everyone."

"**Advocate** for improved access for underserved: insurance coverage, access (particularly to stigmatized services like behavioral health and sexual health.)"

- 2% of respondents mentioned **focus on youth education**

"Try to **implement healthy living strategies in schools** to avoid some of the issues that affect communities as adults."

"**Partner with schools** to start health education **early**."

Question: What would you suggest Sharp do to improve the health and well-being of your community? (open-ended)
Survey Responses: n=380
Source: Sharp Insight Community – Community Health Needs Assessment 2019 Survey

Sharp Insight Community: CHNA 2019 Survey

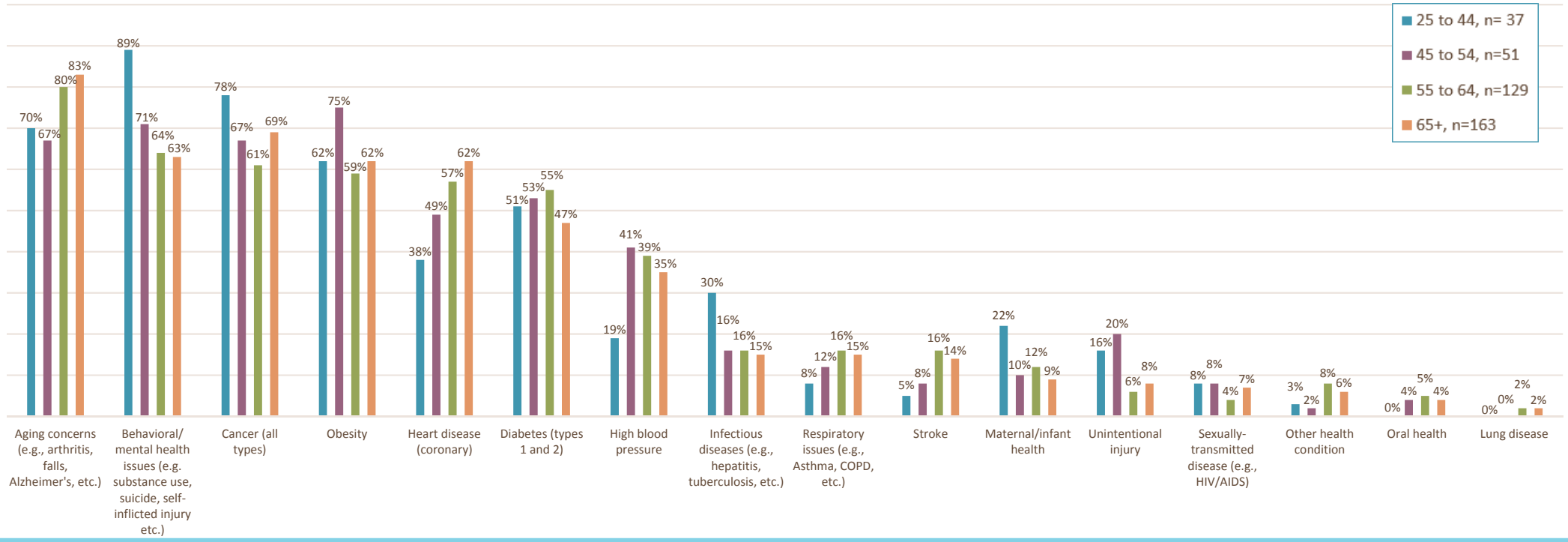
Additional Survey Findings

SHARP

Age Group Breakouts – Health Conditions

Top Five Most Important Health Conditions

Respondents were able to select up to 5 options from a list of health conditions. These selections are not ordinal. Percentages reflect the proportion of respondents who selected a specific listed item.
Due to low response rates, age groups 25 to 34 and 35 to 44 were combined to form the 25 to 44 age group.

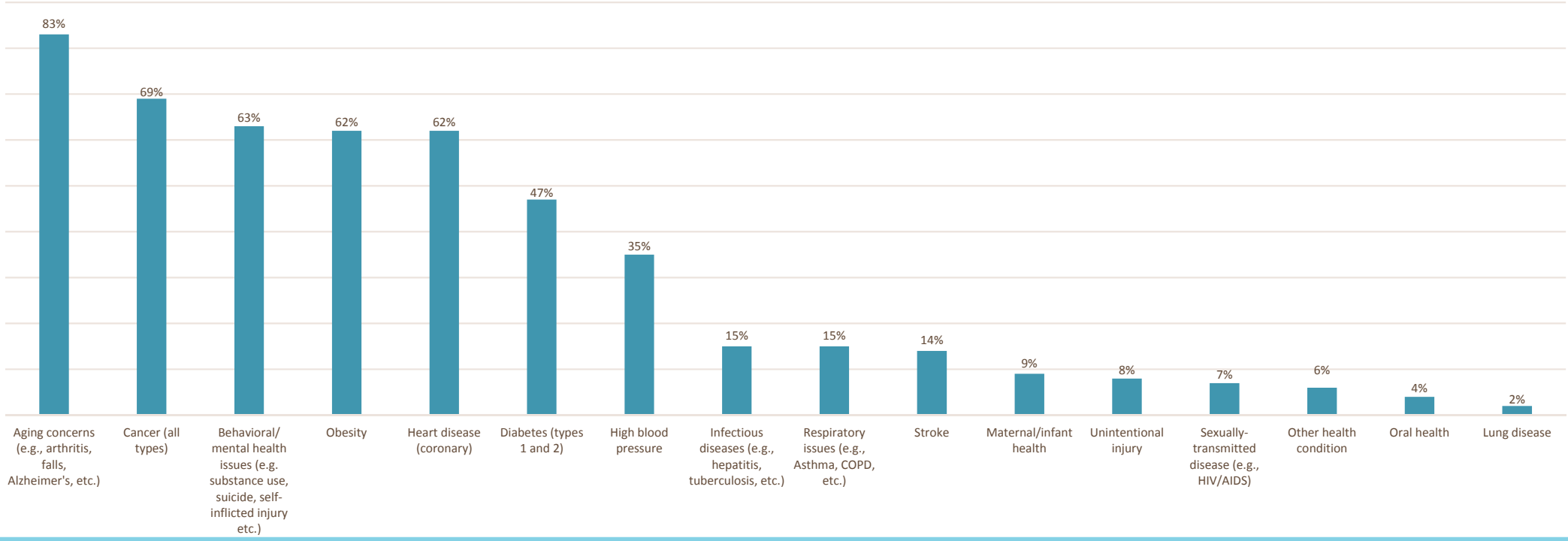


Question: In the following list, what do you think are the five most important health conditions in your community (those health conditions that have the greatest impact on overall community health)?
Survey Responses: n=380
Source: Sharp Insight Community – Community Health Needs Assessment 2019 Survey

65+ Age Group Breakout – Health Conditions

Top Five Most Important Health Conditions

Respondents were able to select up to 5 options from a list of health conditions. These selections are not ordinal. Percentages reflect the proportion of respondents who selected a specific listed item.

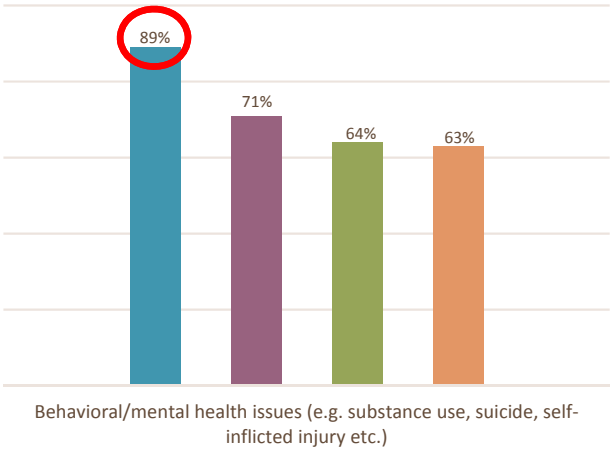


Question: In the following list, what do you think are the five most important health conditions in your community (those health conditions that have the greatest impact on overall community health)?
Survey Responses: n=163
Source: Sharp Insight Community – Community Health Needs Assessment 2019 Survey

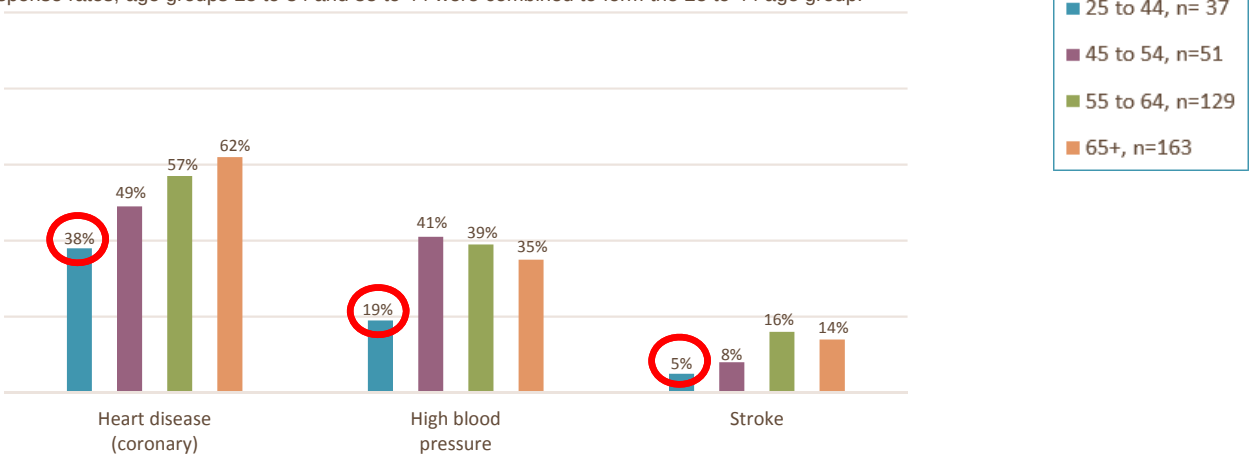
Age Group Breakouts – Health Conditions

Statistically Significant Differences

The frequency with which each group selected a particular health issue was compared with the frequency with which the sample as a whole selected that issue. The charts below represent these frequencies and do not reflect group size or significance of the difference between the group frequency and the sample frequency. The statistical significance of these differences was determined using a two-tailed Student's t-test with a 95% confidence interval. Due to low response rates, age groups 25 to 34 and 35 to 44 were combined to form the 25 to 44 age group.



Respondents in the **25 to 44** age group were significantly **more** likely than the sample as a whole to select **behavioral/mental health issues** as one of the five most important health issues.



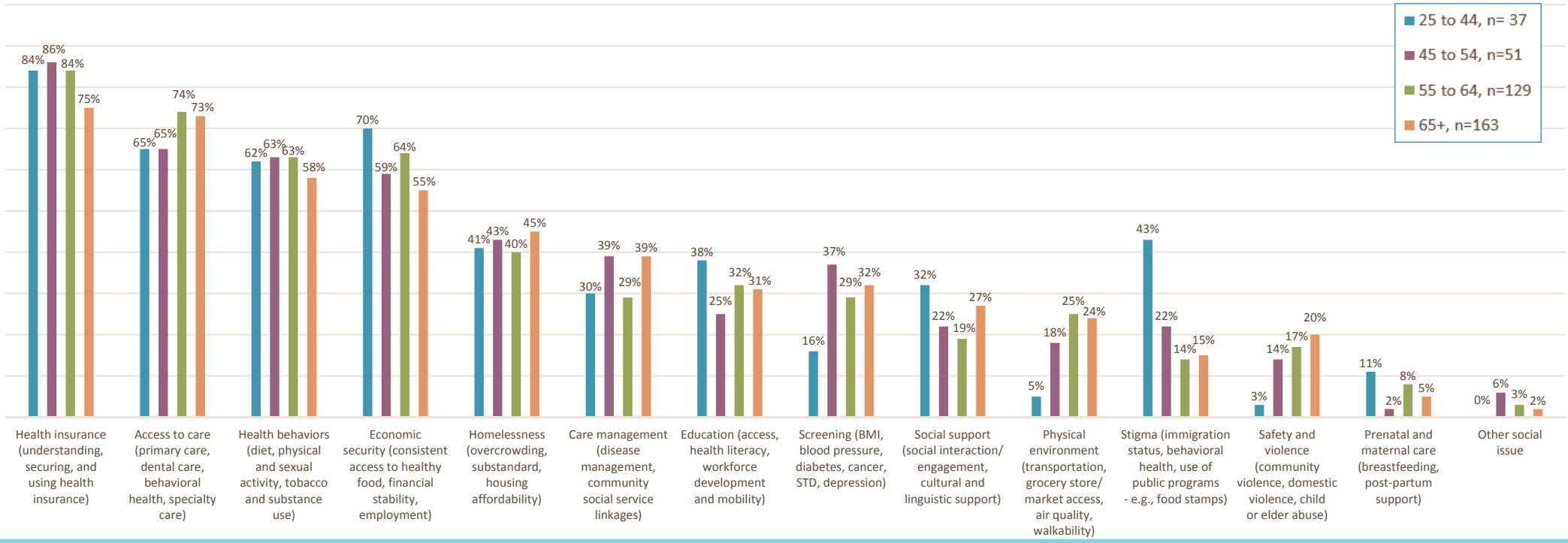
Respondents in the **25 to 44** age group were significantly **less** likely than the sample as a whole to select **heart disease**, **high blood pressure**, or **stroke** as one of the five most important health issues.

Question: In the following list, what do you think are the five most important health conditions in your community (those health conditions that have the greatest impact on overall community health)?
Survey Responses: n=380
Source: Sharp Insight Community – Community Health Needs Assessment 2019 Survey

Age Group Breakouts – Social Determinants

Top Five Most Important Social Determinants of Health

Respondents were able to select up to 5 options from a list of social issues. These selections are not ordinal. Percentages reflect the proportion of respondents who selected a specific listed item. Due to low response rates, age groups 25 to 34 and 35 to 44 were combined to form the 25 to 44 age group.

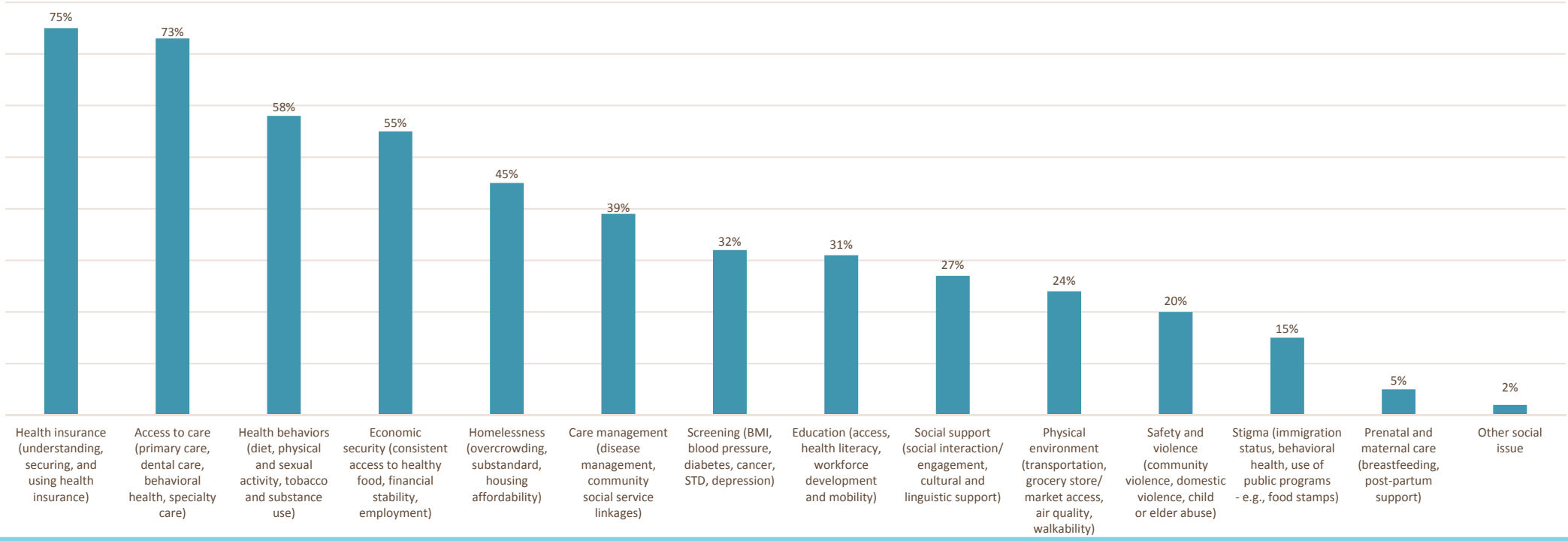


Question: In the following list, what do you think are the five most important social determinants of health in your community (those social issues that have the greatest impact on overall community health)?
Survey Responses: n=380
Source: Sharp Insight Community – Community Health Needs Assessment 2019 Survey

65+ Age Group Breakout – Social Determinants

Top Five Most Important Social Determinants of Health

Respondents were able to select up to 5 options from a list of social issues. These selections are not ordinal. Percentages reflect the proportion of respondents who selected a specific listed item.

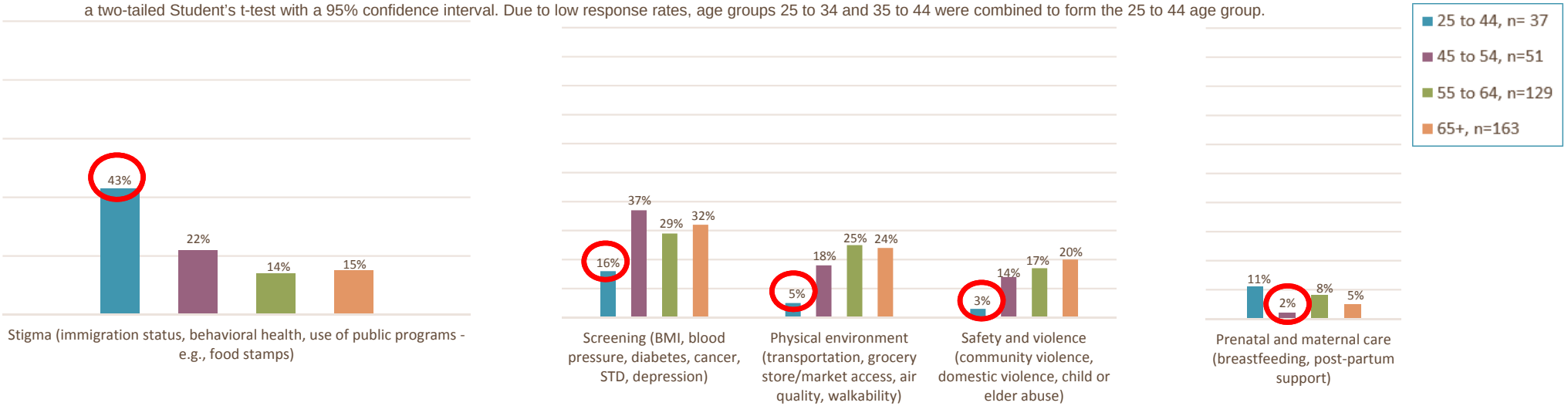


Question: In the following list, what do you think are the five most important social determinants of health in your community (those social issues that have the greatest impact on overall community health)?
Survey Responses: n=163
Source: Sharp Insight Community – Community Health Needs Assessment 2019 Survey

Age Group Breakouts – Social Determinants

Statistically Significant Differences

The frequency with which each group selected a particular social determinant was compared with the frequency with which the sample as a whole selected that item. The charts below represent these frequencies and do not reflect group size or significance of the difference between the group frequency and the sample frequency. The statistical significance of these differences was determined using a two-tailed Student's t-test with a 95% confidence interval. Due to low response rates, age groups 25 to 34 and 35 to 44 were combined to form the 25 to 44 age group.



Respondents in the **25 to 44** age group were significantly **more** likely than the sample as a whole to select **stigma** as one of the five most important social determinants of health.

Respondents in the **25 to 44** age group were significantly **less** likely than the sample as a whole to select **screening**, **physical environment**, or **safety and violence** as one of the five most important social determinants of health.

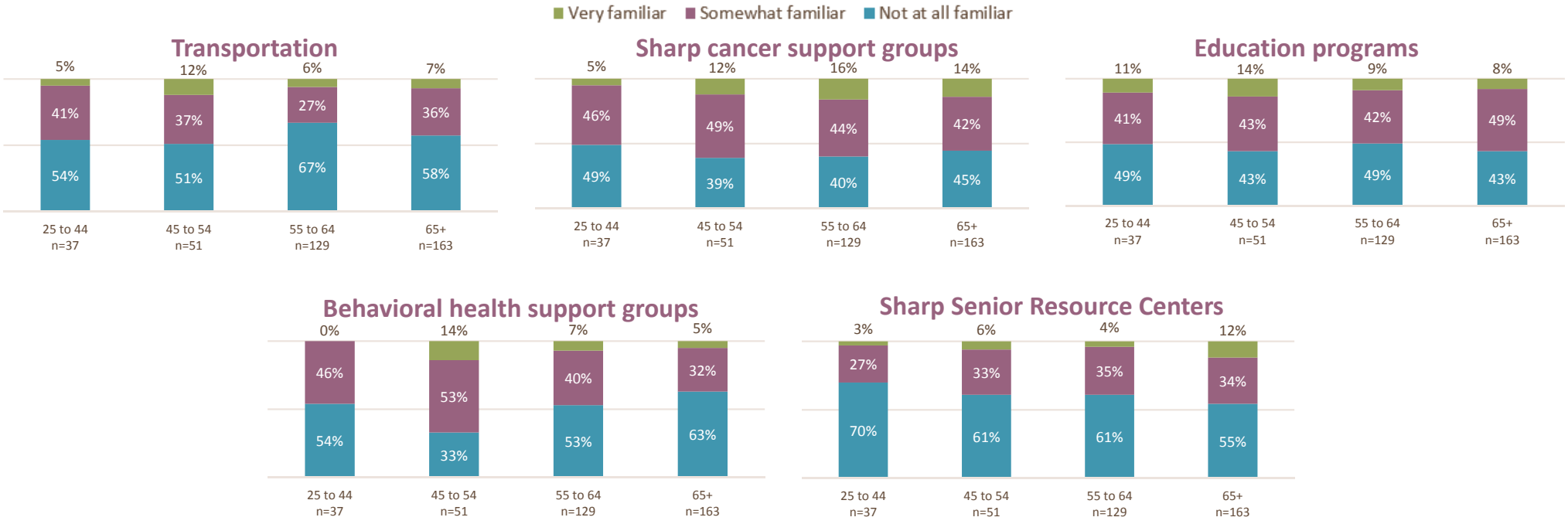
Respondents in the **45 to 54** age group were significantly **less** likely than the sample as a whole to select **prenatal and maternal care** as one of the five most important social determinants of health.

Question: In the following list, what do you think are the five most important social determinants of health in your community (those social issues that have the greatest impact on overall community health)?
Survey Responses: n=380
Source: Sharp Insight Community – Community Health Needs Assessment 2019 Survey

Age Group Breakouts – Community Outreach Awareness

Awareness of Sharp HealthCare Community Outreach Programs

Percentages reflect the proportion of respondents in each age group who selected the indicated level of familiarity. Due to low response rates, age groups 25 to 34 and 35 to 44 were combined to form the 25 to 44 age group.

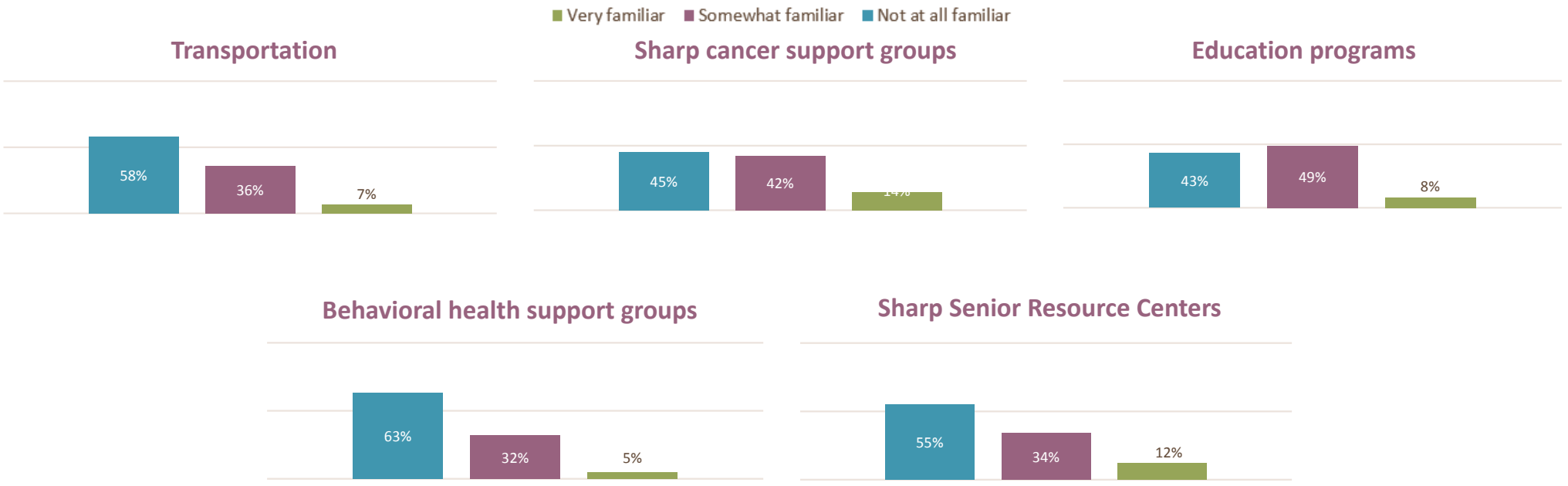


Question: Please rate your awareness of the following patient and community programs implemented by Sharp HealthCare:
Survey Responses: n=380
Source: Sharp Insight Community – Community Health Needs Assessment 2019 Survey

65+ Age Group Breakout – Community Outreach Awareness

Awareness of Sharp HealthCare Community Outreach Programs

Percentages reflect the proportion of respondents in each age group who selected the indicated level of familiarity.

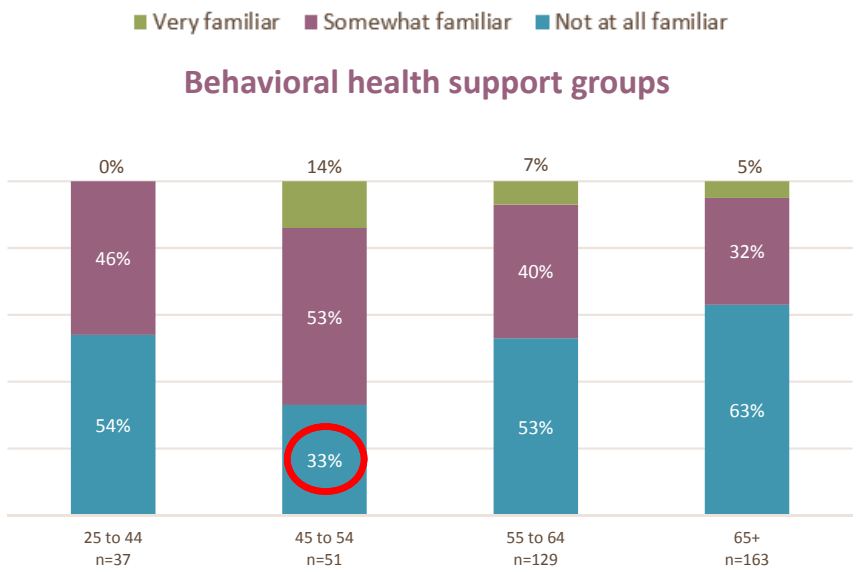


Question: Please rate your awareness of the following patient and community programs implemented by Sharp HealthCare:
Survey Responses: n=163
Source: Sharp Insight Community – Community Health Needs Assessment 2019 Survey

Age Group Breakouts – Community Outreach Awareness

Statistically Significant Differences

The frequency with which each group selected a particular level of familiarity was compared with the frequency with which the sample as a whole selected that level. The chart below represents these frequencies and does not reflect group size or significance of the difference between the group frequency and the sample frequency. The statistical significance of these differences was determined using a two-tailed z-test with a 95% confidence interval. Due to low response rates, age groups 25 to 34 and 35 to 44 were combined to form the 25 to 44 age group.



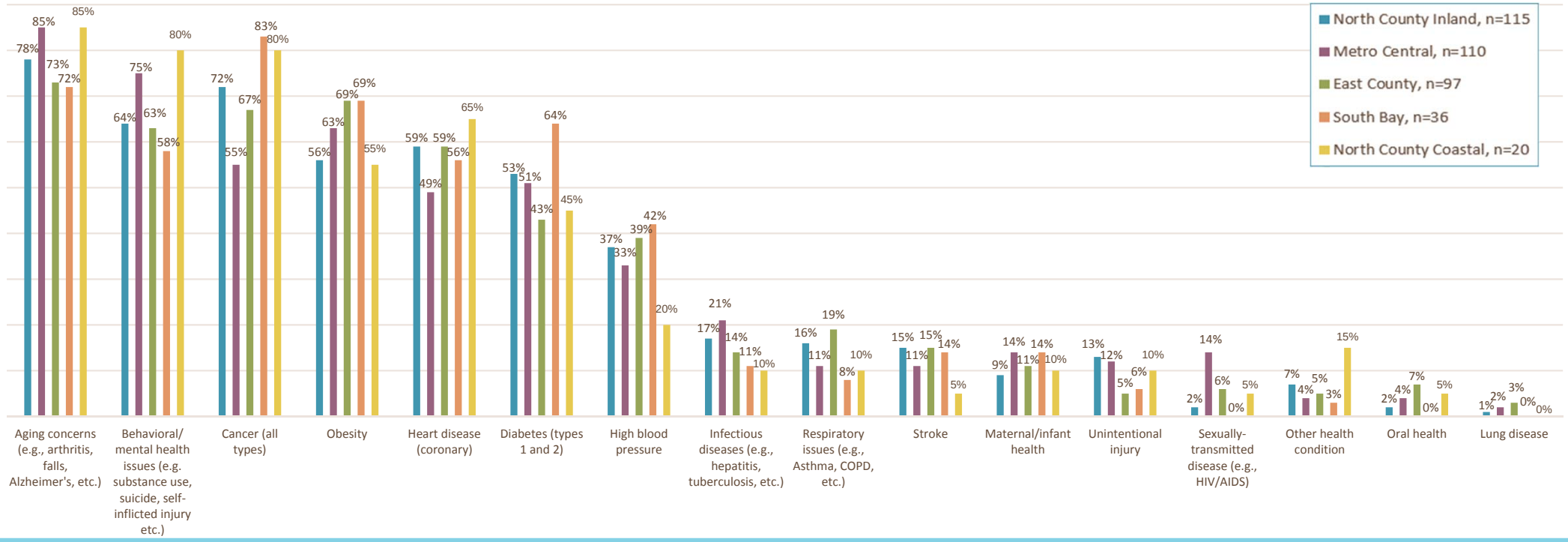
Respondents in the **45 to 54** age group were significantly **less** likely than the sample as a whole to indicate that they were **not at all familiar** with Sharp HealthCare's **behavioral health support groups**.

Question: Please rate your awareness of the following patient and community programs implemented by Sharp HealthCare:
Survey Responses: n=380
Source: Sharp Insight Community – Community Health Needs Assessment 2019 Survey

Region Breakouts – Health Conditions

Top Five Most Important Health Conditions

Respondents were able to select up to 5 options from a list of health conditions. These selections are not ordinal. Percentages reflect the proportion of respondents who selected a specific listed item.

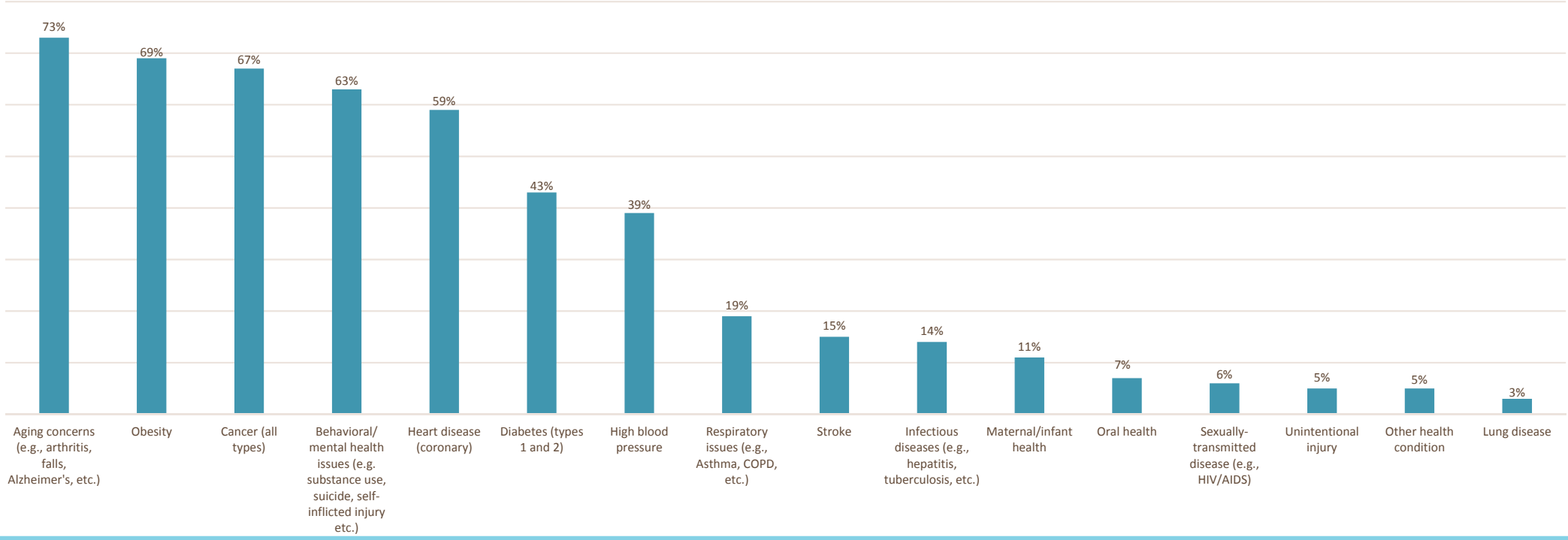


Question: In the following list, what do you think are the five most important health conditions in your community (those health conditions that have the greatest impact on overall community health)?
Survey Responses: n=380
Source: Sharp Insight Community – Community Health Needs Assessment 2019 Survey

East County Breakout – Health Conditions

Top Five Most Important Health Conditions

Respondents were able to select up to 5 options from a list of health conditions. These selections are not ordinal. Percentages reflect the proportion of respondents who selected a specific listed item.

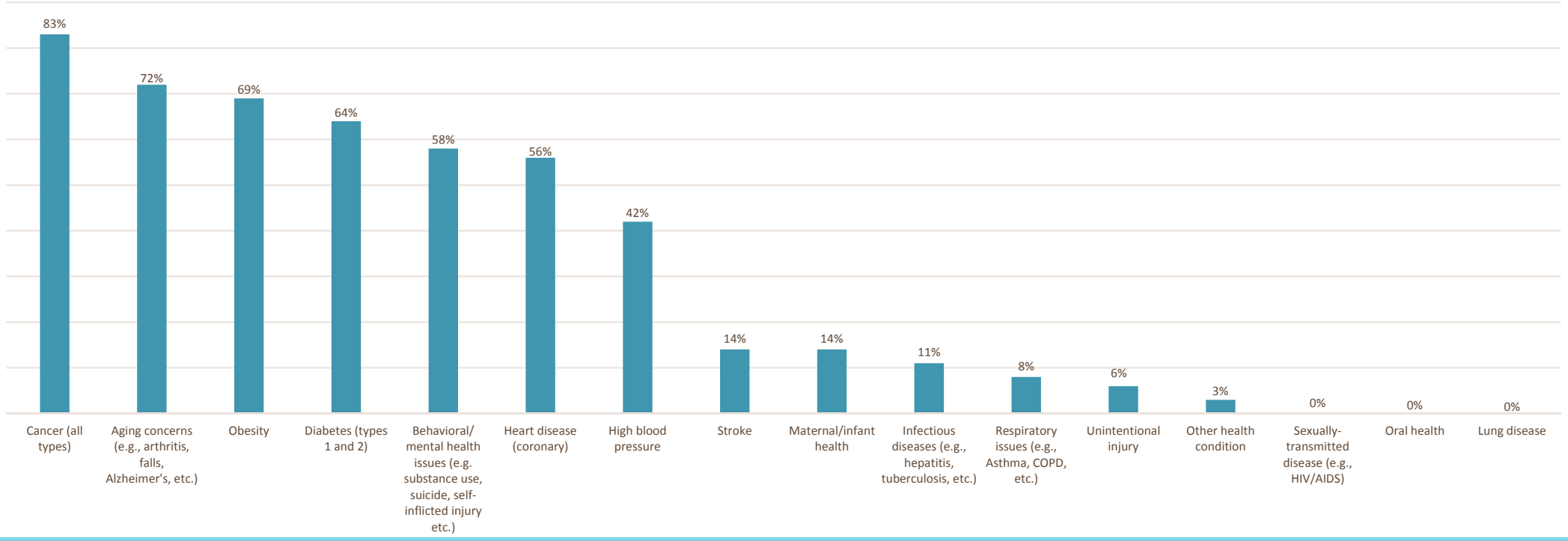


Question: In the following list, what do you think are the five most important health conditions in your community (those health conditions that have the greatest impact on overall community health)?
Survey Responses: n=97
Source: Sharp Insight Community – Community Health Needs Assessment 2019 Survey

South Bay Breakout – Health Conditions

Top Five Most Important Health Conditions

Respondents were able to select up to 5 options from a list of health conditions. These selections are not ordinal. Percentages reflect the proportion of respondents who selected a specific listed item.

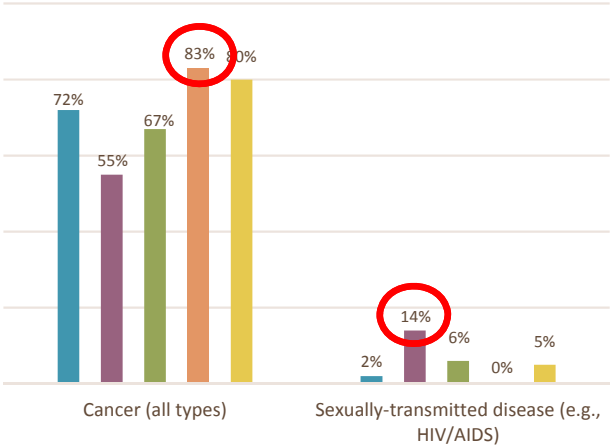


Question: In the following list, what do you think are the five most important health conditions in your community (those health conditions that have the greatest impact on overall community health)?
Survey Responses: n=36
Source: Sharp Insight Community – Community Health Needs Assessment 2019 Survey

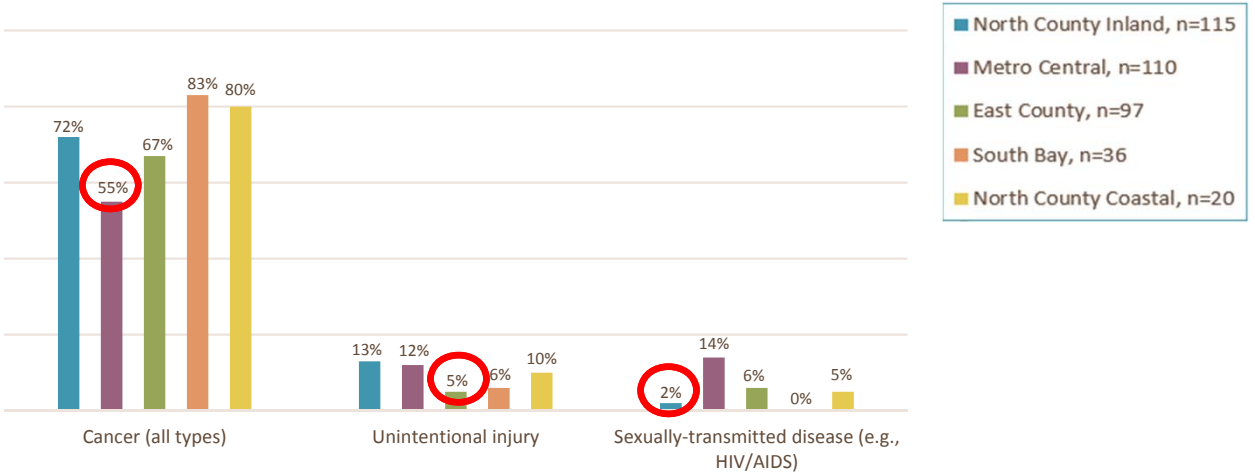
Region Breakouts – Health Conditions

Statistically Significant Differences

The frequency with which each group selected a particular health issue was compared with the frequency with which the sample as a whole selected that issue. The charts below represent these frequencies and do not reflect group size or significance of the difference between the group frequency and the sample frequency. The statistical significance of these differences was determined using a two-tailed Student's t-test with a 95% confidence interval.



Respondents in **South Bay** were significantly **more** likely than the sample as a whole to select **cancer(all types)** as one of the five most important health issues. Respondents in **Metro Central** were significantly **more** likely than the sample as a whole to select **sexually-transmitted disease** as one of the five most important health issues.



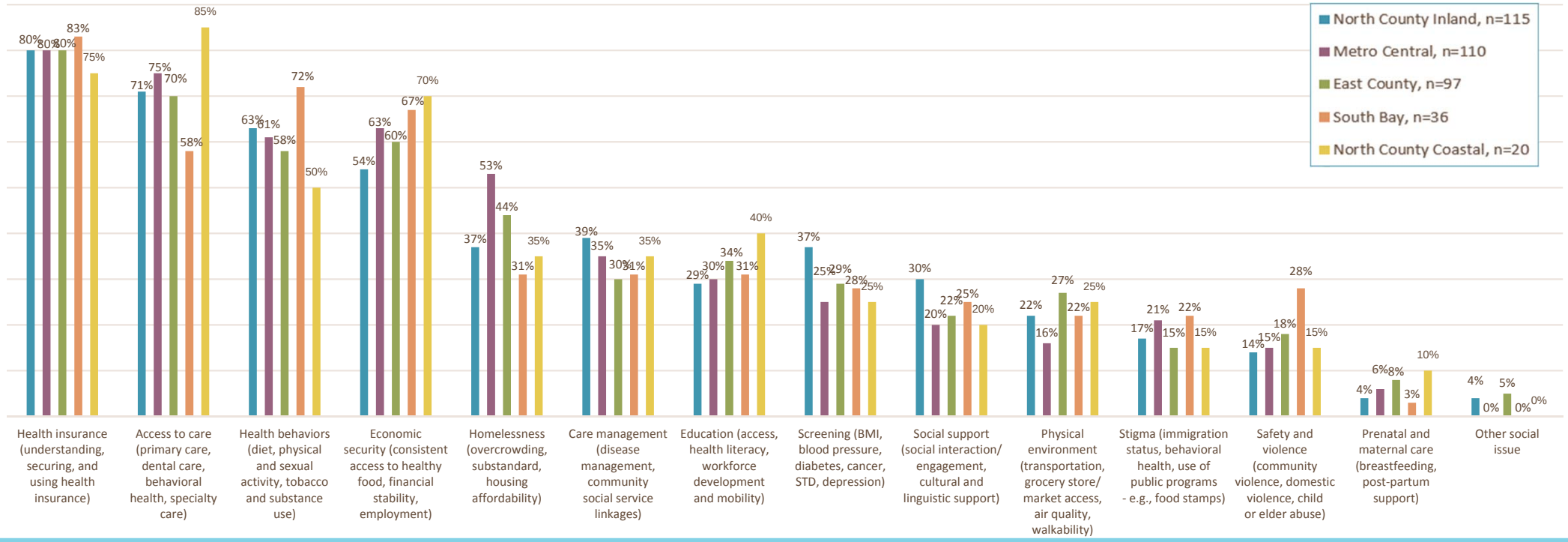
Respondents in **Metro Central** were significantly **less** likely than the sample as a whole to select **cancer (all types)** as one of the five most important health issues. Respondents in **East County** were significantly **less** likely than the sample as a whole to select **unintentional injury** as one of the five most important health issues. Respondents in **North County** Inland were significantly **less** likely than the sample as a whole to select **sexually-transmitted disease** as one of the five most important health issues.

Question: In the following list, what do you think are the five most important health conditions in your community (those health conditions that have the greatest impact on overall community health)?
Survey Responses: n=380
Source: Sharp Insight Community – Community Health Needs Assessment 2019 Survey

Region Breakouts – Social Determinants

Top Five Most Important Social Determinants of Health

Respondents were able to select up to 5 options from a list of social issues. These selections are not ordinal. Percentages reflect the proportion of respondents who selected a specific listed item.

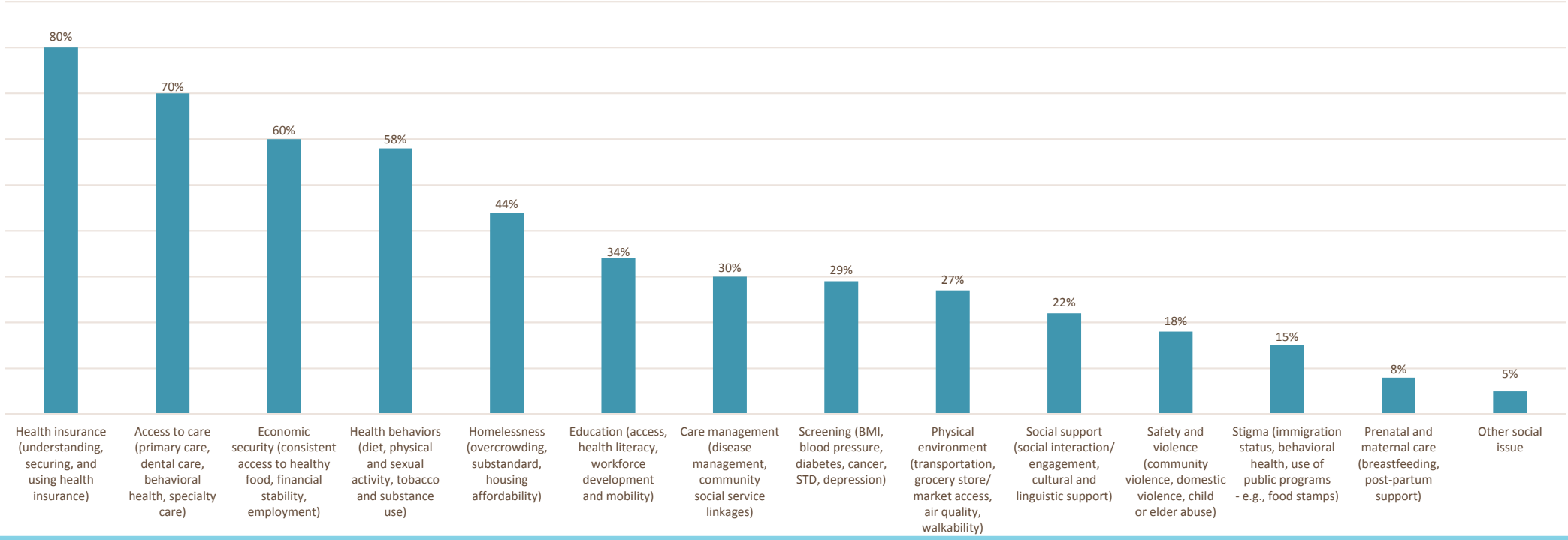


Question: In the following list, what do you think are the five most important social determinants of health in your community (those social issues that have the greatest impact on overall community health)?
Survey Responses: n=380
Source: Sharp Insight Community – Community Health Needs Assessment 2019 Survey

East County Breakout – Social Determinants

Top Five Most Important Social Determinants of Health

Respondents were able to select up to 5 options from a list of social issues. These selections are not ordinal. Percentages reflect the proportion of respondents who selected a specific listed item.

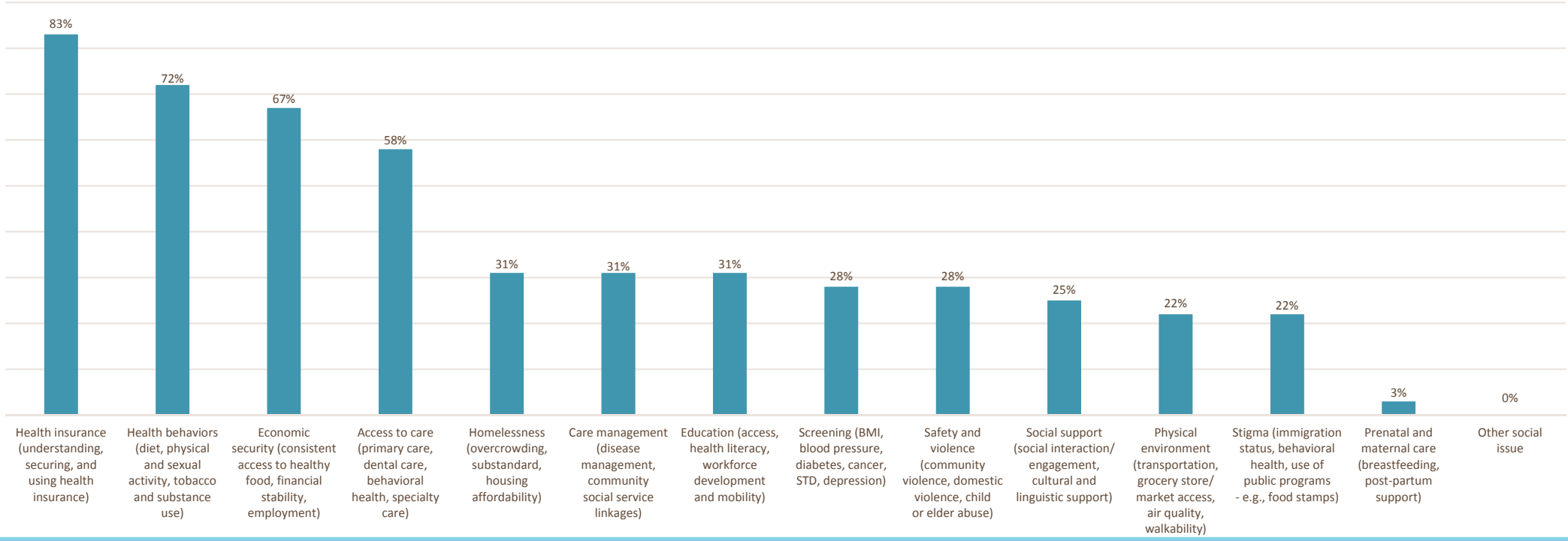


Question: In the following list, what do you think are the five most important social determinants of health in your community (those social issues that have the greatest impact on overall community health)?
Survey Responses: n=97
Source: Sharp Insight Community – Community Health Needs Assessment 2019 Survey

South Bay Breakout – Social Determinants

Top Five Most Important Social Determinants of Health

Respondents were able to select up to 5 options from a list of social issues. These selections are not ordinal. Percentages reflect the proportion of respondents who selected a specific listed item.

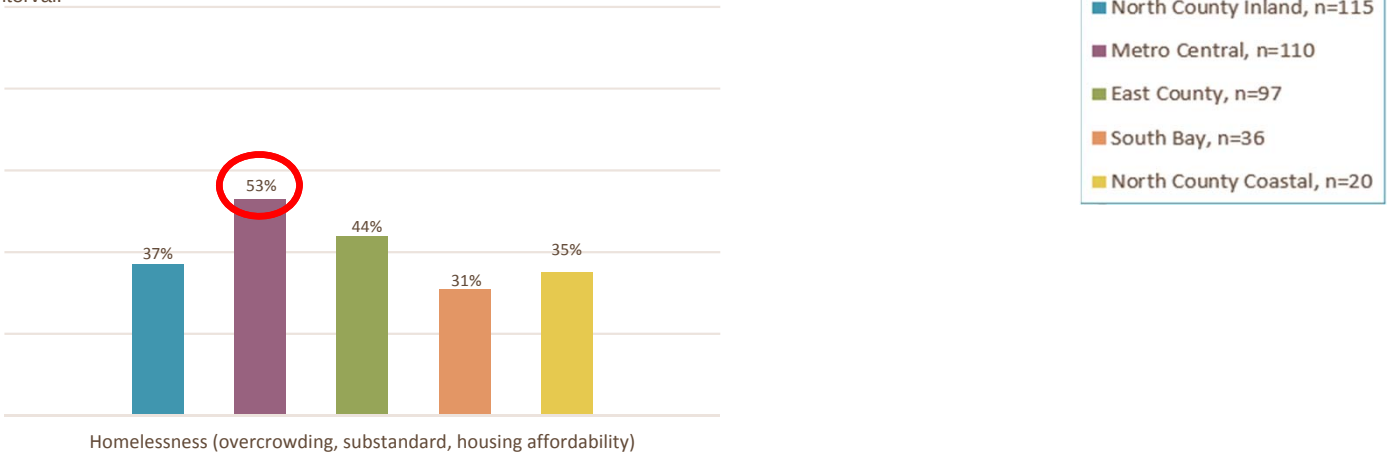


Question: In the following list, what do you think are the five most important social determinants of health in your community (those social issues that have the greatest impact on overall community health)?
Survey Responses: n=36
Source: Sharp Insight Community – Community Health Needs Assessment 2019 Survey

Region Breakouts – Social Determinants

Statistically Significant Differences

The frequency with which each group selected a particular social determinant was compared with the frequency with which the sample as a whole selected that item. The chart below represents these frequencies and does not reflect group size or significance of the difference between the group frequency and the sample frequency. The statistical significance of these differences was determined using a two-tailed Student's t-test with a 95% confidence interval.



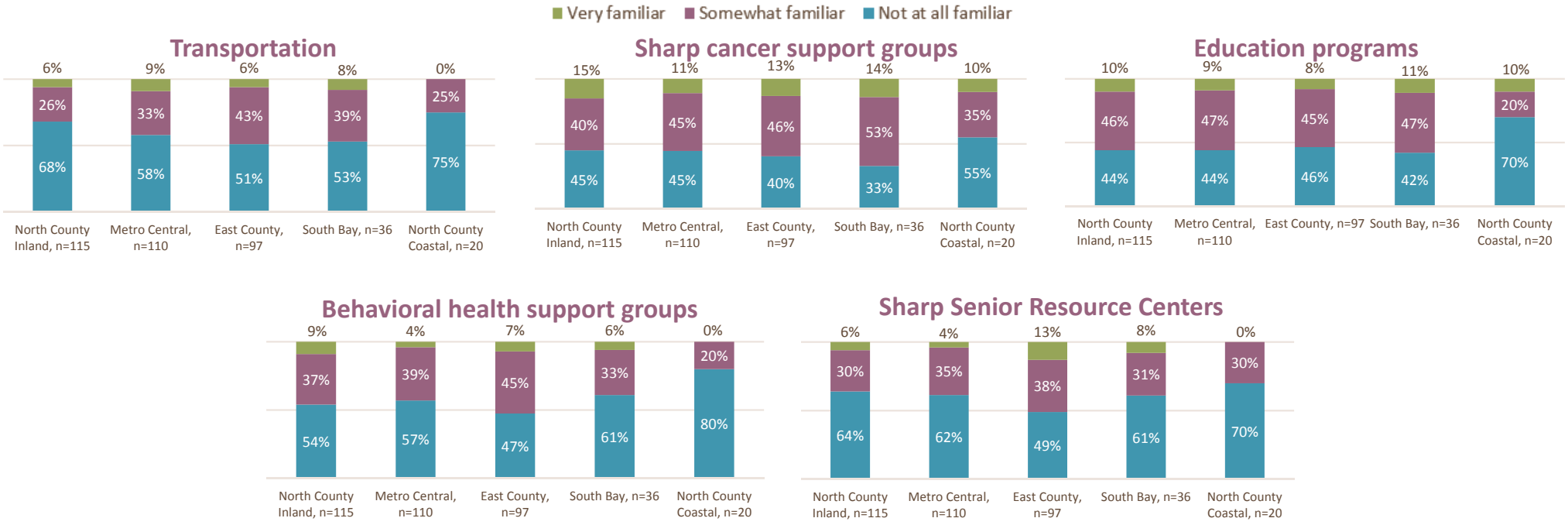
Respondents in **Metro Central** were significantly **more** likely than the sample as a whole to select **homelessness** as one of the five most important social determinants of health.

Question: In the following list, what do you think are the five most important social determinants of health in your community (those social issues that have the greatest impact on overall community health)?
Survey Responses: n=380
Source: Sharp Insight Community – Community Health Needs Assessment 2019 Survey

Region Breakouts – Community Outreach Awareness

Awareness of Sharp HealthCare Community Outreach Programs

Percentages reflect the proportion of respondents in each regional group who selected the indicated level of familiarity.

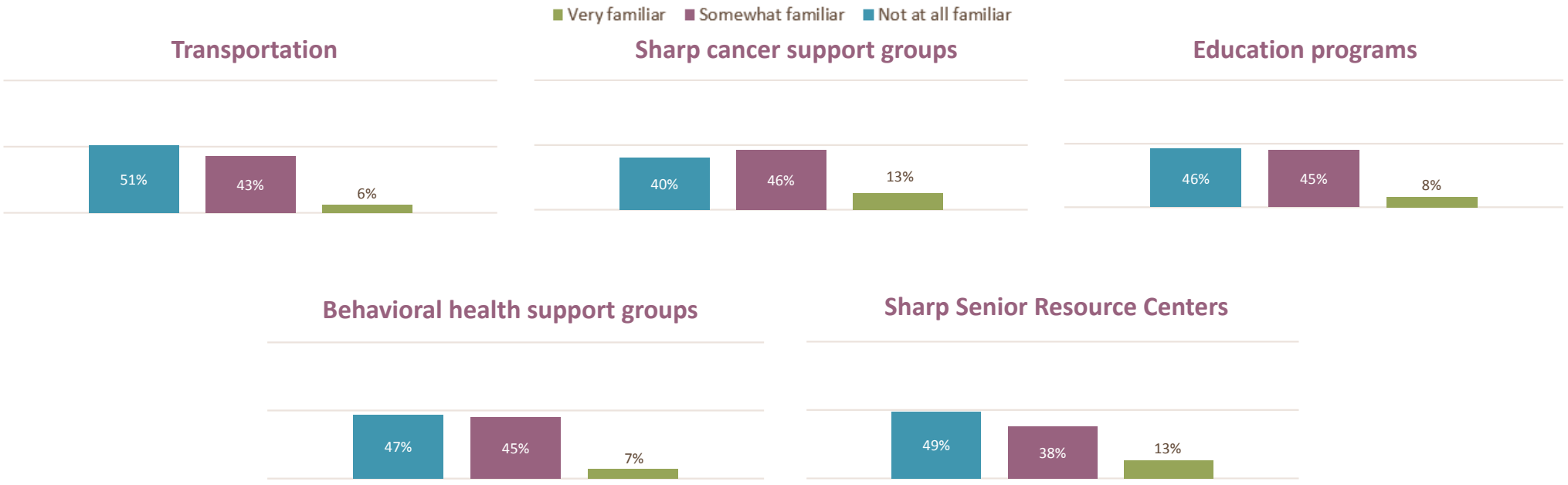


Question: Please rate your awareness of the following patient and community programs implemented by Sharp HealthCare:
Survey Responses: n=380
Source: Sharp Insight Community – Community Health Needs Assessment 2019 Survey

East County Breakout – Community Outreach Awareness

Awareness of Sharp HealthCare Community Outreach Programs

Percentages reflect the proportion of respondents in each regional group who selected the indicated level of familiarity.

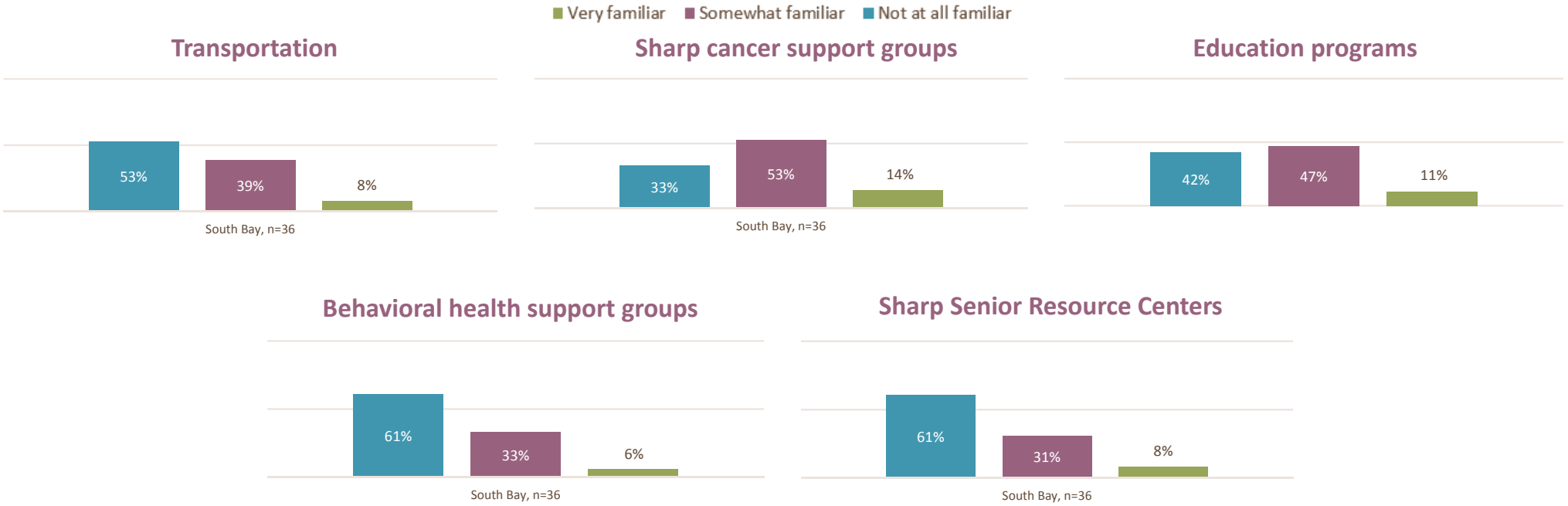


Question: Please rate your awareness of the following patient and community programs implemented by Sharp HealthCare:
Survey Responses: n=97
Source: Sharp Insight Community – Community Health Needs Assessment 2019 Survey

South Bay Breakout – Community Outreach Awareness

Awareness of Sharp HealthCare Community Outreach Programs

Percentages reflect the proportion of respondents in each regional group who selected the indicated level of familiarity.

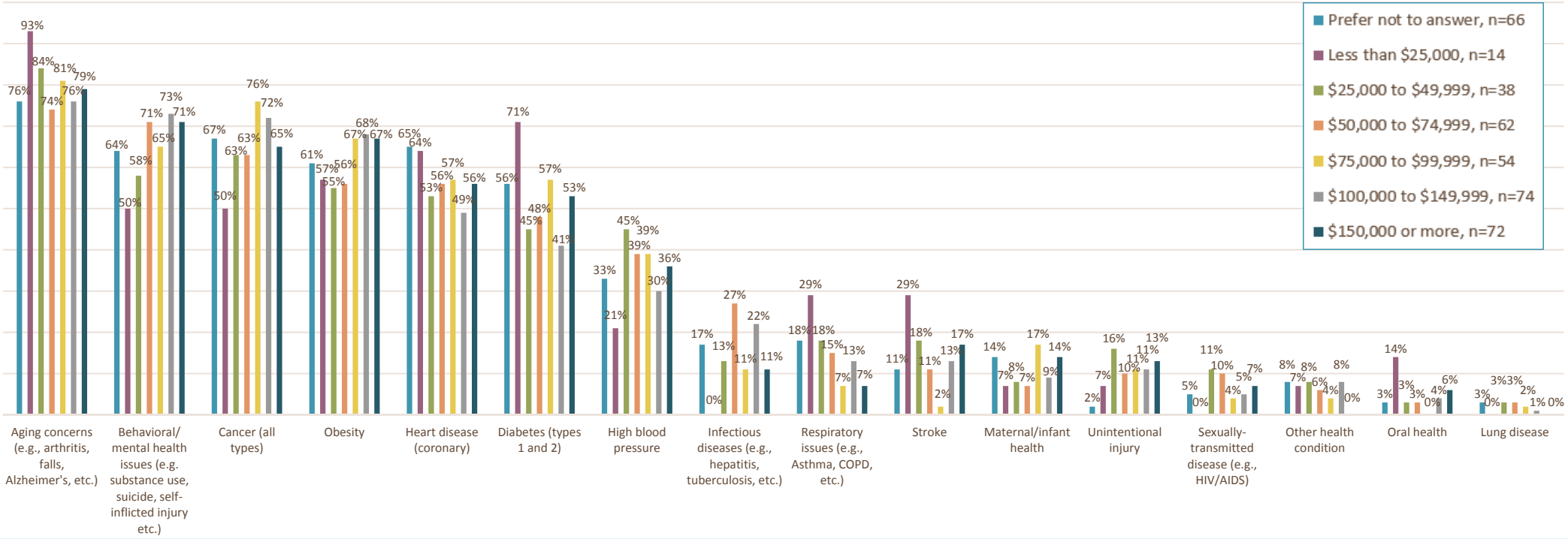


Question: Please rate your awareness of the following patient and community programs implemented by Sharp HealthCare:
Survey Responses: n=36
Source: Sharp Insight Community – Community Health Needs Assessment 2019 Survey

Household Income Breakouts – Health Conditions

Top Five Most Important Health Conditions

Respondents were able to select up to 5 options from a list of health conditions. These selections are not ordinal. Percentages reflect the proportion of respondents who selected a specific listed item.

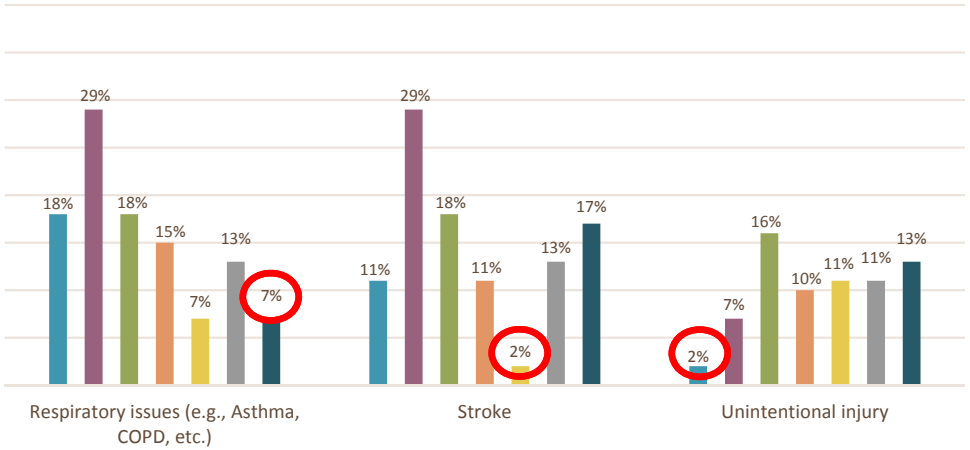


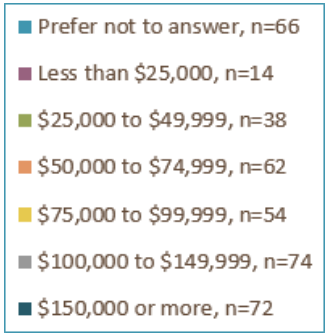
Question: In the following list, what do you think are the five most important health conditions in your community (those health conditions that have the greatest impact on overall community health)?
Survey Responses: n=380
Source: Sharp Insight Community – Community Health Needs Assessment 2019 Survey

Household Income Breakouts – Health Conditions

Statistically Significant Differences

The frequency with which each group selected a particular health issue was compared with the frequency with which the sample as a whole selected that issue. The charts below represent these frequencies and do not reflect group size or significance of the difference between the group frequency and the sample frequency. The statistical significance of these differences was determined using a two-tailed Student's t-test with a 95% confidence interval.





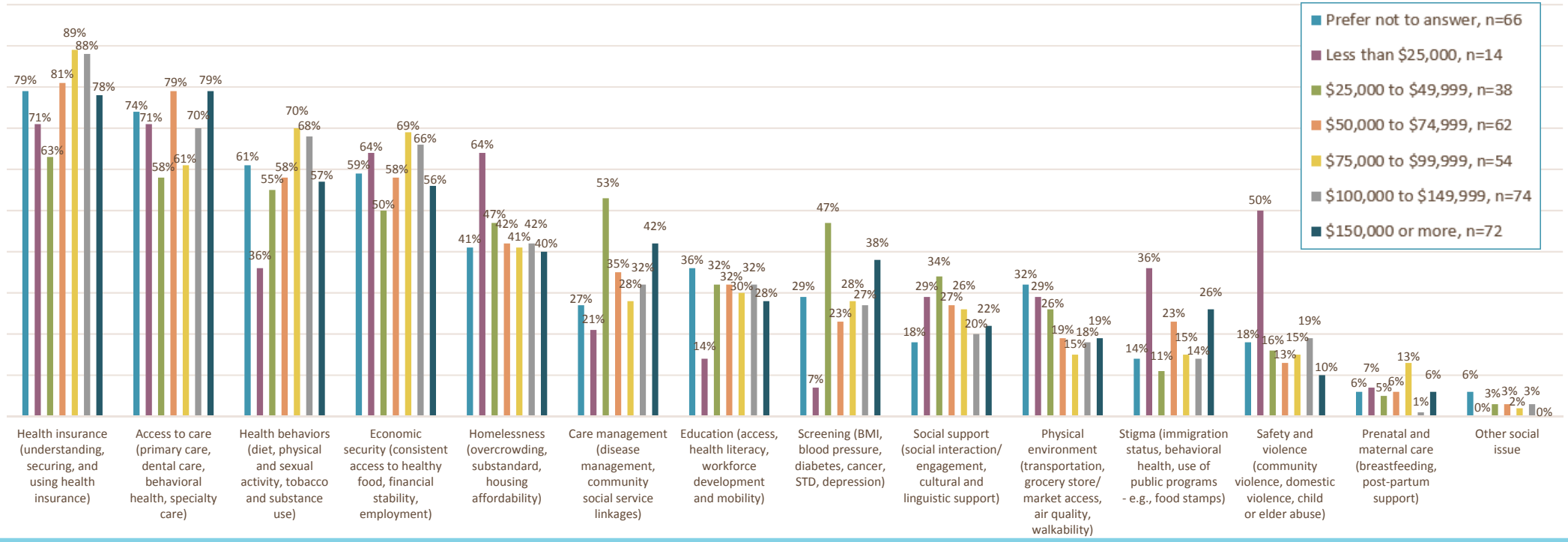
Respondents in the **$150,000 or more** income range were significantly **less** likely than the sample as a whole to select **respiratory issues** as one of the five most important health issues. Respondents in the **$75,000 to $99,999** income range were significantly **less** likely than the sample as a whole to select **stroke** as one of the five most important health issues. Respondents who **preferred not to indicate** their income were significantly **less** likely than the sample as a whole to select **unintentional injury** as one of the five most important health issues.

Question: In the following list, what do you think are the five most important health conditions in your community (those health conditions that have the greatest impact on overall community health)?
Survey Responses: n=380
Source: Sharp Insight Community – Community Health Needs Assessment 2019 Survey

Household Income Breakouts – Social Determinants

Top Five Most Important Social Determinants of Health

Respondents were able to select up to 5 options from a list of social issues. These selections are not ordinal. Percentages reflect the proportion of respondents who selected a specific listed item.

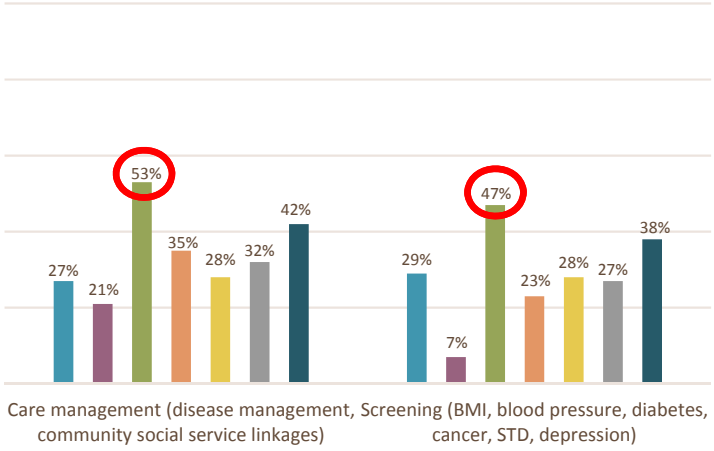


Question: In the following list, what do you think are the five most important social determinants of health in your community (those social issues that have the greatest impact on overall community health)?
Survey Responses: n=380
Source: Sharp Insight Community – Community Health Needs Assessment 2019 Survey

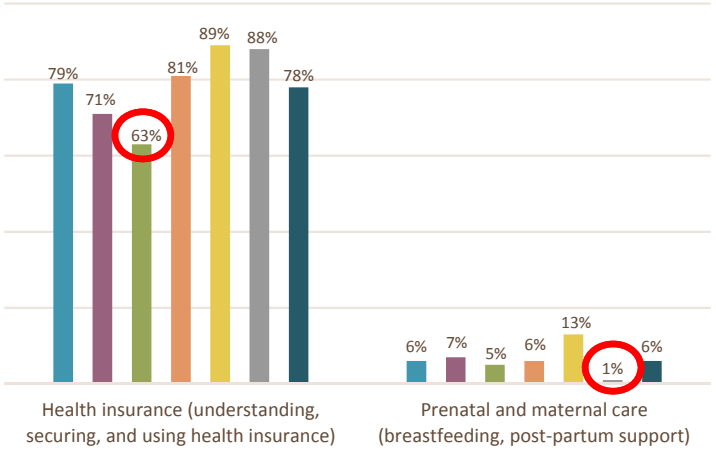
Household Income Breakouts – Social Determinants

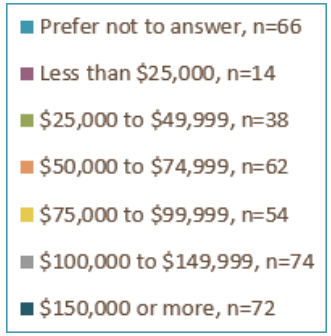
Statistically Significant Differences

The frequency with which each group selected a particular social determinant was compared with the frequency with which the sample as a whole selected that item. The charts below represent these frequencies and do not reflect group size or significance of the difference between the group frequency and the sample frequency. The statistical significance of these differences was determined using a two-tailed Student's t-test with a 95% confidence interval.



Respondents in the **$25,000 to $49,999** income range were significantly **more** likely than the sample as a whole to select **care management** or **screening** as one of the five most important social determinants of health.





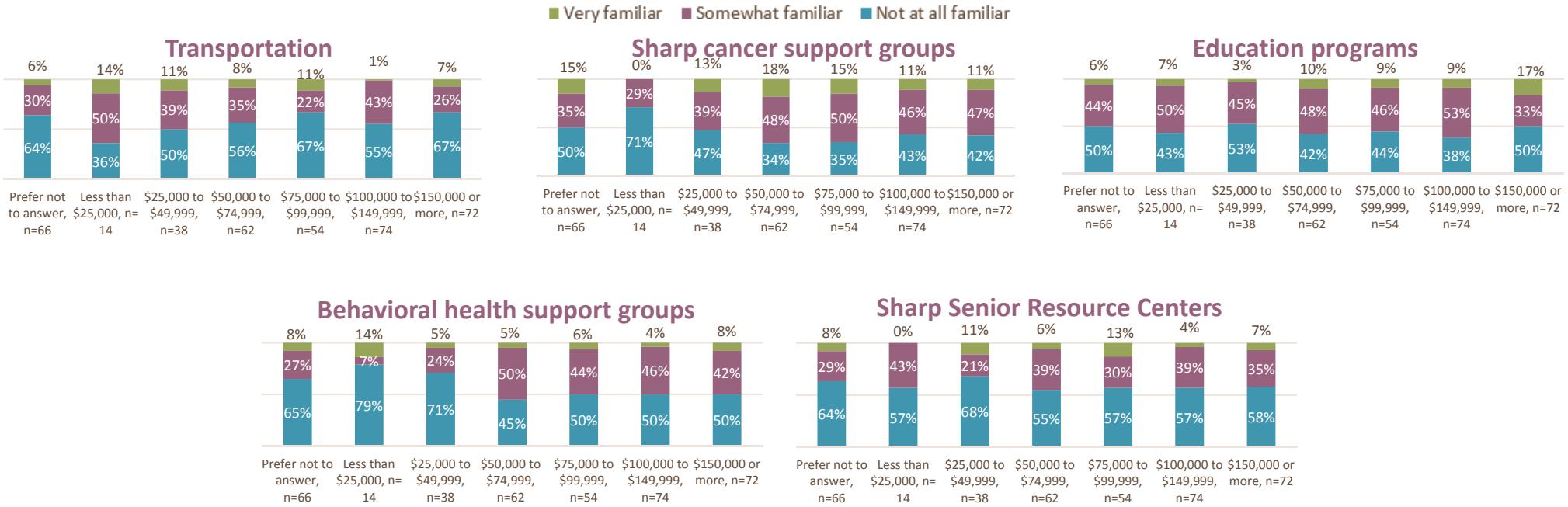
Respondents in the **$25,000 to $49,999** income range were significantly **less** likely than the sample as a whole to select **health insurance** as one of the five most important social determinants of health. Respondents in the **$100,000 to $149,999** income range were significantly **less** likely than the sample as a whole to select **prenatal and maternal care** as one of the five most important social determinants of health.

Question: In the following list, what do you think are the five most important social determinants of health in your community (those social issues that have the greatest impact on overall community health)?
Survey Responses: n=380
Source: Sharp Insight Community – Community Health Needs Assessment 2019 Survey

Household Income Breakouts – Community Outreach Awareness

Awareness of Sharp HealthCare Community Outreach Programs

Percentages reflect the proportion of respondents in each household income group who selected the indicated level of familiarity.



Question: Please rate your awareness of the following patient and community programs implemented by Sharp HealthCare:
Survey Responses: n=380
Source: Sharp Insight Community – Community Health Needs Assessment 2019 Survey

Appendix

S HASD&IC 2019 CHNA Summary of Online Survey Results

2019 Community Health Needs Assessment Survey Findings

The online community health needs assessment survey was distributed to targeted community-based organizations, Federally Qualified Health Centers, governmental agencies, and public health systems who serve a diverse array of people in San Diego County. When possible, these organizations shared the link to the survey with their clientele. Table 1 (below) describes the online 2019 CHNA survey respondents. Survey questions were primarily centered around the prioritization of health needs and the identification of social predictors of health.

TABLE 1. 2019 COMMUNITY HEALTH NEEDS ASSESSMENT - OVERVIEW OF ONLINE SURVEY PARTICIPANTS

Organization	n	Percent
Community Resident	47	13.3%
Community-Based Organization	69	19.5%
Community Clinic (Federally Qualified Health Center)	33	9.3%
Hospital/Health System	47	13.3%
Local Government Agency	32	9.1%
Philanthropic Organization	3	0.8%
San Diego County Public Health Services	104	29.5%
Other	18	5.1%
Total	**353**	**100%**

Ranking Questions

Three separate ranking questions were asked in the 2019 survey on 1) health conditions, 2) social determinants of health (SDOH), and 3) health conditions and SDOH together. The first question asked survey participants to rank 13 health conditions, with 1 having the greatest impact on the overall health and well-being within San Diego communities. The following were identified as the top five health conditions in San Diego County.

In addition to behavioral health being identified as the number one health condition, 63% of survey respondents believe that behavioral health is worsening for San Diego County residents.

From a list of 15, the following were identified as the SDOH that have the greatest influence on poor health outcomes in San Diego County communities.

In addition, the majority of survey respondents thought economic security (55%), has gotten worse over the past three years.

The final ranking question took the top five health conditions and top five SDOH that participants previously ranked and put them into one list of ten. Participants were asked to rank this combined list in order of importance, 1 through 10. Below are the top ten ranked list of health conditions and SDOH together, with 1 having the greatest impact on the overall health and well-being of San Diego County residents.

1. Access to Care
2. Behavioral Health
3. Economic Security
4. Health Insurance
5. Homelessness
6. Housing
7. Diabetes
8. Care Management
9. Health Behaviors
10. Cardiovascular Disease

A total of three health conditions and seven SDOH are represented in this list. This demonstrates that survey respondents consider social determinants to be more significant than health conditions in terms of their overall well-being.

Trends over Time

Survey participants were asked whether the top five health conditions they identified were improving, staying the same, or getting worse over the past 3 years. Behavioral health, economic security, homelessness, and housing were identified by the majority of survey participants as getting worse in San Diego County. Please see the Table 2 below for more information.

TABLE 2. 2019 HASD&IC CHNA SURVEY, TRENDS OVER TIME QUESTION

Health Conditions & Social Determinants of Health	Improved		Stay the Same		Worse	
	n	%	n	%	n	%
Behavioral/Mental Health	21	7.92%	77	29.06%	167	63.02%
Cardiovascular Disease	24	12.83%	125	66.84%	38	20.32%
Diabetes	25	12.89%	110	56.70%	59	30.41%
Access to Care	96	39.34%	96	39.34%	52	21.31%
Health Insurance	64	32.00%	71	35.50%	65	32.50%
Care Management	31	25.41%	72	59.02%	19	15.57%
Economic Security	21	9.29%	80	35.40%	125	55.31%
Health Behaviors	11	9.57%	56	48.70%	48	41.74%
Homelessness	3	2.31%	18	13.85%	109	83.85%
Housing	1	0.88%	10	8.85%	102	90.27%

Behavioral Health Conditions

Due to continued identification of behavioral health as an important health issue in San Diego County, a follow-up question asked participants to rank behavioral health conditions in order of greatest impact on the overall health and well-being of San Diego County residents. The following is the ranked order identified by survey participants, with number one having the greatest impact.

1. Alcohol Use Disorder
2. Mood Disorders
3. Substance Use Disorder
4. Anxiety
5. Opioid Use
6. Suicide and Suicidal thoughts/Ideation
7. Self-Harm or Self-Injury
8. Alzheimer's Disease

Appendix

T HASD&IC 2019 CHNA Focus Group and Key Informant Summary Tables

Access to Care

Aging Concerns

Behavioral Health

Cancer

Chronic Health Conditions

Economic Security

Homelessness and Housing Instability

Table 1: HASD&IC 2019 CHNA – Focus Group and KI Interview Summary of Responses Related to Access to Care

SUMMARY OF RESPONSES RELATED TO ACCESS TO HEALTH CARE

ASSOCIATED HEALTH CONDITIONS AND NEEDS

All Age Groups

- **Cancer**
- **Chronic diseases** (diabetes)
- **Mood disorders** (anxiety, depression, stress)
- **Substance use disorder**
- **Sexually transmitted diseases**
- **Suicide & self-harm**
- **Trauma** (generational, PTSD, psychological)

Children/Youth

- **Mood disorders** (anxiety)
- **Substance abuse** (alcohol, drugs)
- **Suicide & self-harm**
- **Trauma** from experiences before coming to America (war, bombing, gas attacks)

Senior

- **Alzheimer's**
- **Dementia**
- **Mood disorders** (anxiety, depression, schizophrenia)

ASSOCIATED SOCIAL DETERMINANTS OF HEALTH

All Age Groups

- **Access to dental care:** lack of access to dental care
- **Access to mental health services:** lack of services, psychiatrists, PERT, and detox centers for homeless
- **Care coordination**: lack of knowledge in navigating the health care system
- **Cultural and language barriers** in health care
- **Economic insecurity:** insurance costs, services for mental, dental, primary care, surgeries, transgender services, vaccinations, and preventative care
- **Education**: Lack of community resident awareness of services
- **Follow-up care:** limited follow-up care
- **Healthy foods**: lack of access to healthy foods
- **Housing and homelessness**
- **Insurance issues**
- **Shortage of health care facilities:** shortage of hospitals and clinics, especially in East Region
- **Shortage of health care providers:** lack of specialists, nurses, medical assistants
- **Stigma:** LGBTQ marginalization, doctors refuse to prescribe PrEP, doctors shame patients for getting STD testing
- **Transportation**: lack of transportation
- **Violence** (fear, homelessness)

Children/Youth

- **Lack of school-based services** to support emotional and mental health of students
- **Education**: lack of education on sexual health (e.g., HIV)
- **Stigma**
- **Vaccinations** (difficult to access especially among homeless families due to being transient)

Seniors

- **Economic insecurity**
- **Services**: limited mental health insurance coverage, senior population increasing, but government is not adjusting to accommodate raising needs
- **Social isolation** and loneliness
- **Stigma**
- **Transportation**

ASSOCIATED BARRIERS AND CHALLENGES

All Age Groups

- **Distrust**: community versus hospital, patient versus doctor and social worker
- Lack of **patient autonomy** in making discharge decisions
- **Lack of storage** (medications for homeless)
- **Long wait times**

Children/Youth

- Lack of **follow-up care** post-referral
- **Lack of parental involvement** due to cultural differences
- **Parental consent** to access services
- **Vaccinations** and test results across the border are not accepted
- Bullying

Seniors

- **Mobility issues**

Table 2: HASD&IC 2019 CHNA – Focus Group and KI Interview Summary of Responses Related to Aging Concerns

SUMMARY OF RESPONSES RELATED TO AGING CONCERNS	
ASSOCIATED HEALTH CONDITIONS AND NEEDS	
• **Alzheimer's Disease** • **Arthritis**: joint pain • **Behavioral/Mental Health Issues:** anxiety (fear), depression from hopelessness and discrimination, generational trauma • **Dementia**: including early onset • **Dental/Oral Health**: tooth loss, dentures • **Heart Disease** • **Hypertension** (high blood pressure)	• **Lung disease** • **Obesity** • **Physical limitations**: mobility related to aging, being homebound, disabled, or walker/wheelchair-dependent • **Substance abuse and self-medication** • **Vision and hearing loss**
ASSOCIATED SOCIAL DETERMINANTS OF HEALTH	
• **Behavioral/mental care access**: lack of access to mental health services • **Community and social support**: lack of socialization opportunities, caregiving responsibilities for grandchildren, social isolation leads to loneliness • **Dental care access:** lack of access to dental care, cost, and lack of dental insurance • **Economic security:** limited and fixed incomes, government assistance	• **Environmental issues:** houses close to factories • **Food insecurity**: healthy food access, and malnutrition • **Housing**: affordability, senior housing availability, and evictions • **Homeless issues**: Lack of homeless shelters for seniors • **Language Issues**
ASSOCIATED BARRIERS AND CHALLENGES	
• **Cultural competency**: lack of cultural/linguistically appropriate services • **Fear** of pain or discrimination • **Follow-up**: lack follow-up for referrals, missed appointments • **Health navigation issues** • **Immigration**: Fear of deportation/mistrust of the government	• **Insurance Issues** with benefits and cost of insurance • **Long wait times** for appointments and specialists • **Medication management** • **Transportation**: Lack of transportation

Table 3: HASD&IC 2019 CHNA – Focus Group and KI Interview Summary of Responses Related to Behavioral Health

SUMMARY OF RESPONSES RELATED TO BEHAVIORAL HEALTH		
ASSOCIATED HEALTH CONDITIONS AND NEEDS		
All Age Groups • **Mood disorders** including anxiety, depression, and stress • **PTSD and trauma**: including generational trauma • **Substance use disorder** • **Suicide and self-harm**	**Children/Youth** • **Mood disorders**: anxiety • **Substance abuse**: alcohol, drugs • **Suicide and self-harm** • **Trauma**	**Senior** • **Alzheimer's** • **Dementia** • **Mood disorders:** anxiety, depression • **Schizophrenia**
ASSOCIATED SOCIAL DETERMINANTS OF HEALTH		
All Age Groups • **Economic security:** cost of mental health services • **Education**: Lack of community resident awareness of services (unaware of detox requirements) • **Lack of services:** mental health services, psychiatrists, mental health workforce including PERT • **Stigma** • **Violence:** fear, homelessness	**Children/Youth** • **Bullying** • **Lack of school-based services** • **Stigma**	**Senior** • Limited mental health **insurance coverage** • **Social isolation** and loneliness • **Stigma**
ASSOCIATED BARRIERS AND CHALLENGES		
All Age Groups • Long **wait times** for mental health services	**Children/Youth** • Lack of **follow-up care** post-referral • **Parental consent** to access services • Lack of **parental involvement** due to cultural differences	

Table 4: HASD&IC 2019 CHNA – Focus Group and KI Interview Summary of Responses Related to Cancer

SUMMARY OF RESPONSES RELATED TO CANCER
ASSOCIATED HEALTH CONDITIONS AND NEEDS
• **Brain cancer** • **Breast cancer** • **Cancer** (all types, especially in older populations) • **Chronic diseases**: stress leads to increased cortisol levels which over time is linked to increases in chronic diseases such as asthma, heart disease, and cancer
ASSOCIATED SOCIAL DETERMINANTS OF HEALTH
• **Healthy behaviors:** poor diet, and lack of physical activity • **Physical environment:** chemical exposures from industrial sites, and from being in war zones prior to arriving in the United States. • **Substance use**: tobacco, alcohol misuse • **Stigma**: fear of community stigmatization due to cancer diagnosis
ACCESS TO SERVICES BARRIERS AND CHALLENGES
• **Cost** • **Delays** to see specialists, like surgeons • **Fear** of a diagnosis therefore people delay addressing serious health issue until it progresses too far • **Fear** related to immigration status • **Frustration** with navigating insurance issues • **Logistical issues** such as transportation, childcare and home responsibilities • **Preventative care**: people believe they are healthy due to not having any physical symptoms, therefore do not receive preventative care • **Screenings**: avoidance of screenings, specifically breast cancer

Table 5: HASD&IC 2019 CHNA – Focus Group and KI Interview Summary of Responses Related to Chronic Health Conditions

SUMMARY OF RESPONSES RELATED TO CHRONIC HEALTH CONDITION
ASSOCIATED HEALTH CONDITIONS AND NEEDS
All Age Groups • Cardiovascular disease (heart attack, stroke) • Cholesterol • COPD • Diabetes (Type I, II, and pre-diabetic) • Hypertension (high blood pressure) • Obesity/overweight
ASSOCIATED BARRIERS AND CHALLENGES
All Age Groups • **Lack of access to healthy food** (living in a 'food desert', lack of grocery stores with healthy or fresh food) • **Lack of transportation:** difficulty in traveling to purchase groceries for rural areas and seniors • **Limited physical mobility:** difficult to purchase groceries due to physical limitations or being homebound (seniors) • **Healthcare cost:** high cost of insurance, medical bills, or medications • **Economic insecurity:** cost of living (rent, utilities), cost of healthy food • **Lack of health education and/or knowledge:** prevention, disease management, nutrition/diet modification • **Poor health behaviors:** unhealthy diets, lack of exercise or physical activity • **Medication management:** timing, frequency, and how to take medications • **Unsafe or poorly kept neighborhoods or public spaces** for physical activity • **Housing:** Unstable or complete lack of housing **Children and youth** • **Refusing to eat healthy foods** • **Lack of safe places to exercise or play** **Individuals Experiencing Homelessness** • **Lack of kitchen** to cook healthy meals • **Lack of refrigeration** to store temperature-specific medications such as insulin • **Lack of safe storage of medications:** can get lost or stolen

Table 6: HASD&IC 2019 CHNA – Focus Group and KI Interview Summary of Responses Related to Economic Security

SUMMARY OF RESPONSES RELATED TO ECONOMIC SECURITY		
ASSOCIATED HEALTH CONDITIONS AND NEEDS		
All Age Groups • Malnutrition • Overweight and obesity • Stress • Behavioral health: anxiety, depression, suicide • Hypertension	**Children/Youth** • Growth and development • Ability to focus and learn • Trauma	**Seniors** • Behavioral/mental health issues and connection with not eating healthy foods
ASSOCIATED SOCIAL DETERMINANTS OF HEALTH		

All Age Groups
• **Access to care**: afraid of losing benefits to Medi-Cal
• **Economic security:** cost of medical bills and services. Childcare cost is high.
• **Employment**: unemployment, low wages
• **Food insecurity:** organic, healthy, and fresh foods are expensive
• **Homeless**: criminalization of the homeless, no kitchen for cooking food, difficulty accessing the types of food needed due to special diet needs
	• **Housing**: cost of housing
	• **Language barrier**
	• **Physical environment**: lack of groceries stores with fresh and healthy food Transportation: lack of transportation especially for rural areas
	Children/Youth
	• **Safety**: walking to school alone
	• **Stigma** of being economically disadvantaged
		Seniors
		• **Economic security**
		  • Gas prices are high and increasing
		  • Lack of affordable home food delivery options
		  • Wheelchairs need repair
		  • Social Security Income: wait time is long, ineligible when staying in the hospital
		  • Lack of fresh items in food pantries
		• **Food insecurity:** hunger and nutrition
		• **Lower education, less economic empowerment** and less family ties were described in specific locations such as City Heights

ASSOCIATED BARRIERS AND CHALLENGES		
All Age Groups • **Benefits**: afraid of losing benefits to Medi-Cal, CalFresh, and WIC, wait time is too long • **Budget**: ability to budget is difficult • **Childcare**: lack of childcare programs • **Hygiene** (homeless) • **Lack of time** for adults between work and family to get additional training or education to help increase income level • **Legal status** • **Sleep deprivation** • **Special diet needs**: culturally appropriate foods, allergies, and dietary restrictions due to chronic conditions make it difficult to eat healthy	**Children/Youth** • Refuse to eat **healthy food** • Lack of healthy food **education** for youth • Families have **limited time** and money to cook healthy meals. Eating fast food becomes an easier way to manage time and money. • **School lunches** have a lot of unappetizing processed foods	**Seniors** • **Cooking** can be a challenge

Table 7: HASD&IC 2019 CHNA – Focus Group and KI Interview Summary of Responses Related to Homelessness and Housing Instability

SUMMARY OF RESPONSES RELATED TO HOMELESSNESS AND HOUSING INSTABILITY		
ASSOCIATED HEALTH CONDITIONS AND NEEDS		
All Age Groups • **Behavioral health:** depression, schizophrenia, PTSD • **Hygiene and cleanliness** • **Infectious diseases:** hepatitis, HIV/AIDS • **Stress and anxiety** • **Substance abuse:** opioids, meth, crack, Xanax, Percocet, heroin	**Children/Youth** • Flu • Hepatitis A • Pregnancy	**Senior** • Disabilities • Chronic conditions • Behavioral health issues
ASSOCIATED SOCIAL DETERMINANTS OF HEALTH, BARRIERS AND CHALLENGES		
All Age Groups • **Employment difficulty** • **Health insurance** • **Housing:** lack of affordable housing • **Access to health care**: poor quality health care • **Vaccinations and immunizations** are difficult to get because homeless move locations depending on shelters and availability. To get immunization must go to the primary provider they signed up with which could be too far once they move. • **Stigma**	**Children/Youth** • **Community and social support:** Foster children are not prepared to move out once they turn 18. They have no family support and have not been taught how to survive on their own • **Safety**: Youth (18 years old) who turn 18 while in shelters with their family are kicked out and have no safe place to stay • **Safety & violence:** gang violence, neighborhood safety, rape and sex trafficking • **Vaccinations** can be difficult to get due to moving (see adult section)	**Seniors** • **Physical limitations:** mobility issues make it difficult to access services • **Housing**: Lack of senior housing
ASSOCIATED BARRIERS AND CHALLENGES		
All Age Groups • **Lack of resources:** limited short-term & emergency resources, lack of affordable services • **Food:** lack of ability to store and cook food, eating unhealthy foods to fill stomach • **Shelters:** lack of women emergency shelters • **Storage** for personal belongings and medical supplies	**Children/Youth** • Endless cycle of homelessness • Lack of **transitional housing** • **Low paying jobs**	**Seniors** • **Food**: Special dietary needs due to chronic health conditions

Appendix

U Sharp HealthCare 2019 CHNA Focus Group Summary Tables

Sharp Patient Family Advisory Council

Sharp Case Management Leadership

Sharp Senior Health Center Staff/ Senior Patients/ Community Members

SMC Aftercare Support Group

Sharp Cancer Patient Navigators & Social Worker

Sharp Diabetes Health Educators

SMBHWN Case Manager & Social Worker

Table 1: Sharp 2019 CHNA – Sharp HealthCare Patient Family Advisory Council Focus Group Summary of Responses

SHARP HEALTHCARE PATIENT FAMILY ADVISORY COUNCIL - SUMMARY OF RESPONSES	
HEALTH CONDITIONS AND NEEDS	
Adults • **Behavioral/Mental health:** including drug abuse • **Stroke** • **Cardiac/Cardiovascular issues** • **Diabetes** • **Hepatitis** • **Opioid addiction** • **Sciatica**	**Seniors** • **Alzheimer's** • **Aging concerns** such as pain management • **Dementia** **Children and Youth** • **Asthma** • **Food allergies**
SOCIAL DETERMINANTS OF HEALTH	
Adults • **Access to health care:** difficult to navigate health care system • **Economic security** ○ Unaffordable **housing** ○ Substandard **housing** conditions such as mold, asbestos, or lead paint in low-income neighborhoods. ○ Lack of **access to healthy food**: junk food is cheaper while healthy food is expensive. ○ **Food insecurity:** lack of access to WIC, CalFresh, and other publicly funded food programs. Blackout dates for electronic benefit transfer (EBT) funds due to federal funding. • **Education** needed on: ○ Dementia or Alzheimer's ○ How to be a caregiver ○ Therapy options & available support groups ○ How to navigate the immigration system • **Fear**: patients delay surgery due to fear. • **Immunization and Vaccinations:** families are fearful of autism. ○ People are uncertain of where to get flu shots and how to pay for them. Misinformation on side effects. • **Insurance issues**: insurance is expensive especially copays for families. • **Transportation** issues cause delays seeing doctors, especially those living in rural areas.	**Seniors** • **Food access and food insecurity** which can lead to readmissions. • **Economic security**: due to fixed income • **Transportation** lack of access to transportation and decreased capacity to drive. **Children and Youth** • **Food insecurity and healthy food access** ○ School meals are primary source of food, quality is questionable. • **Access to care** is often times delayed. • **Behaviors**: access to caffeine energy drinks and coffee is a concern especially in regards to brain development. ○ **Drugs and Smoking**: access to age-restricted substances such as marijuana, E-cigarettes and vaping. • **Community and Family Support**: school pressure causes children to be stressed. ○ Pressured by parents to do extracurricular activities, volunteer work, and sports all in an effort to apply for Ivy League schools. ○ Peer pressure • **Immunization** against measles and polio. • **Sex trafficking** especially in the Parkway Plaza area which affects individuals of all socioeconomic statuses. • **Technology**: electronics and social media leads to sleep deprivation, attention problems, and poor sleep quality.
YOUTH ROLES IN FAMILY CARE	

- Help with family routines such as helping with taking care of siblings, driving, cooking.

ACCESS TO HEALTH CARE CHALLENGES AND BARRIERS

- **Economic security**
  - High cost of medication is of special concern for seniors impacting their access to health care
  - Food insecurity.
- **Education**: lack of health education and health literacy. Patients do not understand when to use urgent care versus the emergency department.
- Problems **navigating health insurance** such as understanding health plans.

DAILY LIVES

How do these health and social conditions affect community member's daily lives?

- People can develop depression when trying to figure out how they will pay for their health care or how to secure transportation to appointments.
- People experience mental and physical exhaustion from trying to understand the health care system and insurance.

HOSPITAL DISCHARGE CHALLENGES AND BARRIERS

- **Transportation** is a challenge.
- **Medication** reconciliation of old versus new medications.
- **Language** issues or language barriers.

HOSPITAL DISCHARGE SOLUTIONS

- **Follow-up care and phone calls**
  - Improving social workers role in ensuring follow up care and continuity of care post discharge.
  - Follow up phone calls post discharge especially if patients have rehabilitation scheduled.
- **In-home care and visits**
  - Providing free home visits for post-surgery follow-up.
  - Access to affordable **in-home care** options is needed.
- Patients need a supportive **advocate** at the time of discharge.

IMMIGRATION

Have you observed any changes in the community's health and wellbeing as a result of immigration policies, attitudes and beliefs?

- Some community members believe that new diseases will arrive in the United States due to the lack of health care received from immigrants prior to entering the U.S.

Accessing care for undocumented population:

- There is fear of looking for help or accessing care for the undocumented. Often times they have more health issues than the general population

Accessing care for the Middle Eastern (refugee) population:

- **Cultural**: Sometimes there is cultural preference or bias in the language especially with women because men make the choices for the women, so translation can sometimes be inaccurate
  - They are not accustomed to accessing health care or are unfamiliar with how to access health care in the U.S.
- **Education**: health literacy, knowledge of how to navigate healthcare system. New immigrants are unaware of services available.
- **Fear**: some are afraid of police or authority in general.
- **Language barriers**: there are issues surrounding translations services over the phone versus using someone such as a family member. Some hospital policies are to **not** use family members due to confidentiality and translation issues.
  - If there is a workshop or a service refugees are interested in, it is generally not in their language
  - **Translations**: for Sharp Grossmont Hospital specifically, many Middle Eastern immigrants need documents translated in their native languages (Farsi, for example)
- **Trauma:** Many come from war zones; have mental trauma, PTSD, and/or depression.

Table 2: Sharp 2019 CHNA – Sharp HealthCare Case Management Leadership Focus Group Summary of Responses

SHARP HEALTHCARE CASE MANAGEMENT LEADERSHIP - SUMMARY OF RESPONSES	
HEALTH CONDITIONS AND NEEDS FOR PATIENT AND FAMILY MEMBERS	
♦ **Aging concerns** ♦ **Cancer** ♦ **Congestive heart failure** (CHF) ♦ **COPD**	♦ **Diabetes** ♦ **Encephalopathy**: specifically liver transplant patients from SGH ♦ **Mental Health**: including alcohol/substance misuse
SOCIAL DETERMINANTS OF HEALTH FOR PATIENT AND FAMILY MEMBERS	
♦ **Access to health care** ○ Lack of SNFs for Medi-Medi patients ○ Lack of access to timely care ♦ **Behaviors** such as smoking, alcohol and substance misuse. Smoking in East County and hookah habits in the Middle Eastern population. ♦ **Community and social support** ○ Lack of family support. ○ Lack of caretaker support: no family or spouse to care for when discharged.	♦ **Economic security** ○ Food insecurity ○ Lack of childcare due to cost and inability to take time off work to care for newborn. ♦ **Housing:** lack of affordable housing. ♦ **Insurance issues** and underfunding. ○ Skilled nursing facilities and home health do not accept Medi-Cal. ♦ **Health literacy**: not knowing where to get care. ♦ Lack of **transportation**
ACCESS TO HEALTH CARE CHALLENGES AND BARRIERS	
♦ Long wait times to access care leads to readmissions, often times there is a six month minimum to see a specialist. ♦ Many access issues are insurance driven which creates a backup in hospitals. ♦ Many individuals are unaware that they have a primary care provider which can cause delays in home health referrals.	
HOSPITAL COMMUNICATION Do you or your staff interact with community clinics, social services organizations, or other community resources in any way to support patients/their families?	
♦ Some case managers use 2-1-1 San Diego as a means to connect patients to needed social services by sending a referral electronically using their electronic health record system.	
HOSPITAL AND COMMUNITY SUPPORT NEEDED	
♦ **2-1-1 Community Info Exchange Access** is needed for all Sharp facilities to inform next steps for patient discharge (Sharp Grossmont and Sharp Chula Vista currently do not have access, as of 2/21/19). ♦ **Housing** is the number one need for many patients. ○ **Patient-centered initiatives**: there is a need for more patient-centered initiatives, especially with housing. ○ **Dedicated housing coordinator**: there is a need for an on-site coordinator (non-Sharp staff) whose sole job is to place people in housing or get them referrals/applications to affordable housing.	
HOSPITAL DISCHARGE CHALLENGES AND BARRIERS	
♦ **Transportation** support is needed, especially for very debilitating health conditions.	

- Need a dedicated person on-site to help patients fill out the metropolitan transit system) applications for those who qualify for discounted bus passes due to having a disability.

- **Recuperative care**
  - San Diego Rescue Mission's closure means less respite care capacity.
  - The lack of recuperative care forces case managers to discharge patients to Board and Care facilities or Independent Living Facilities, which is very expensive for patients.
- **Short term caregivers**: need for additional short term caregivers to help transport patients and check in on patients.
- **Home support services:** need additional in-home support services for hospitals or adult day centers to help patients transition back to the community or home.
- **Wraparound service support**: there is a need to streamline the process from the hospital to the County for those who qualify for wraparound services.

IMMIGRATION

Have you observed any changes over the past year in patient/community member attitude towards immigration issues?

- **Fear**
  - There has been an increase of patients who are eligible for insurance, but will not sign up due to fear of public charge.
  - Patients are fearful of being put on a blacklist if they use public funded services.
  - Immigrants fear that if they use Medi-Cal their property will be taken away.

Table 3: Sharp 2019 CHNA – Sharp Senior Health Center Staff, Senior Patients and Community Members Focus Group Summary of Responses

SHARP SENIOR HEALTH CENTER STAFF, PATIENTS & COMMUNITY MEMBERS - SUMMARY OF RESPONSES	
HEALTH NEEDS AND CONDITIONS IMPACTING SENIOR HEALTH	
• **Diabetes** • **Dementia** • **Depression** • **Disability** • **Heart failure/disease**	• **Lung disease** • **Obesity** • **Opioid abuse** • **Physical aging concerns: loss of agility and mobility; falling.**
SOCIAL DETERMINANTS OF HEALTH IMPACTING SENIOR HEALTH	
• **Economic insecurity: housing is too expensive for social security income checks.** • **Environmental issues such as air and sound pollution.** • **Housing issues** • **Lack of access to fresh food**	• **Community and family support: a lack of support leads to social isolation.** • **Transportation: seniors fear public transportation; do not use Lyft or Uber because of technology.**
ACCESS TO HEALTH CARE CHALLENGES AND BARRIERS	
• **Economic insecurity** due to living on a fixed income (i.e. Cannot afford to buy the "life button"). • **Fear:** too scared to reach out for help; feel intimidated. • **Hearing and vision problems** • **Community and family support:** being alone leads to difficulties accessing emergency services. • **Language barriers** • **Transportation:** lack of transportation to health appointments; fear of public transportation.	
HOSPITAL DISCHARGE CHALLENGES AND BARRIERS FOR SENIORS	
• **Lack of follow-up care** • **Language barriers**	
HOSPITAL AND COMMUNITY SUPPORT NEEDED	
• **Access to healthy food:** provide meal delivery programs for seniors or transportation so they can access fresh and healthy groceries. • **Access to mental/behavioral health services:** increase/expand psychiatric support for Medi-Cal and Medicare insured; there is a need for subsidized mental health care. • **Community and family support programs:** create programs that help/prevent seniors from isolation and feeling lonely; encourage family members to help seniors. • **Database:** need a centralized communication database that informs Sharp staff on information about patients that use Sharp services but are not Sharp members. • **Home visiting:** have a home visiting program where volunteers visit seniors at least 1 time a month. • **Interpretation** experts are needed. • **Transportation:** provide seniors transportation to health care appointments.	
IMMIGRATION Have you observed any changes over the past year in community members' attitude towards immigration issues?	
• There has been an increased intolerance for those who have immigrated to this country.	

Table 4: Sharp 2019 CHNA – Sharp McDonald Center Aftercare Support Group Focus Group Summary of Responses

SHARP MCDONALD CENTER AFTERCARE SUPPORT GROUP - SUMMARY OF RESPONSES	
HEALTH CONDITIONS AND NEEDS	
Adults • Addiction/Substance abuse: **especially young adults, and within the LGBTQ community** • Diabetes • Heart disease/Cardiovascular issues • Mental health: **anxiety, depression, suicide ideation and suicide**	**Seniors** • **Addiction/Substance abuse:** alcohol, opioids • **Alzheimer's** • **Aging concerns: a**rthritis, mobility • **Behavioral/Mental health:** anxiety • **Chronic pain:** leads to substance abuse to deal with pain. **Children and Youth** • **Behavioral/Mental health:** depression, anxiety from social media or bullying, and suicide. • **Diabetes** • **Obesity**
SOCIAL DETERMINANTS OF HEALTH	
Adults • **Community and family support:** negative interpersonal relationships with friends or family that encourage substance use/abuse. • **Behaviors:** less perceived danger of marijuana since legalization. **Seniors** • **Access to healthy/nutritious food** • **Economic security:** food insecurity.	**Children and Youth** • **Environment** • **Behaviors:** eating habits and diet, excessive sugar intake. • **Fear/Racial discrimination and bullying:** especially for young black children. • **Parental support:** lack of support. • **Technology:** lack of parental control over social media and internet content exposure.
ACCESS TO HEALTH CARE CHALLENGES AND BARRIERS	
• **Education:** access to information, for example November is prostate cancer month but there is no visible promotion for it. • **Economic security:** high cost of health care, large deductibles create a financial burden on individuals. • **Insurance issues:** the complicated process of health care enrollment. • **Lack of services:** accessibility and availability of health care services for addiction.	
HOSPITAL DISCHARGE CHALLENGES AND BARRIERS	
• **Medications and prescription issues:** pain medication management is challenging and can lead to prescription drug addiction; over-prescription of opioids to treat back surgery. • **Insurance:** insurance claim issues and the stress resulting from denied claims. • **Community and family support:** lack of discharge support at home from friends, family members or caretakers.	
HOSPITAL DISCHARGE IMPROVEMENTS THAT CAN BE MADE	
• **Alternative treatment options:** physician openness to alternative treatments, such as holistic treatments instead of pain medication. • **Education:** increase physician knowledge through training on topics such as proper bedside manner.	
HOSPITAL AND COMMUNITY SUPPORT NEEDED	

- **Community support:** places or forums for the elderly/seniors to talk and socially engage with one another.
- **Education:**
    - **Community members:** A place where health advocates are available for community members to discuss health issues.
    - **Providers:** More education for providers on patient's recovery process; finding alternative treatments to avoid prescription drugs; education on patient struggles and issues and how to empathize.
- **Additional services:** more affordable addiction recovery services like Sharp McDonald Center. More beds in addiction recovery programs.
- **Insurance:** improve insurance process.
- **Stigma:** the system and society treats addiction as shameful.

IMMIGRATION

Have you observed any changes over the past year in patient/community member attitude towards immigration issues?

- The news/media is driving a lot of the negative talk, especially in regards to "The Wall".
- The current administration has caused this change in attitude.
- There is a polarization of extremes in political views. People feel emboldened to treat others unkindly and say hateful things while the people being mistreated feel the need to hide or change behaviors to avoid being bullied.

Table 5: Sharp 2019 CHNA – Sharp HealthCare Cancer Patient Navigators and Social Worker Focus Group and KI Interview Summary of Responses

SHARP HEALTHCARE CANCER PATIENT NAVIGATORS AND SOCIAL WORKER - SUMMARY OF RESPONSES
SOCIAL DETERMINANTS OF HEALTH – PATIENT AND FAMILY
♦ **Access to health care** specifically for recovery issues, post-surgery or post-treatment. ♦ **Community and family support** ○ Patients sometimes hide cancer status from their children. Sometimes it is due to the young age of their children. ○ Patients do not want to ask for help, they want to manage their health condition on their own. ○ Lack of caregivers ○ Lack of effective communication between patient and family members, especially senior patients. ♦ **Transportation** problems getting to health services ♦ **Financial issues** and needs related to their care plans ♦ **Insurance Issues** (i.e. having Medi-Cal, but no supplemental income) ♦ **Homelessness:** some patients live in cars ♦ **Language barrier** becomes a problem when trying to accurately translate cancer status to patient and family
YOUTH ROLES IN FAMILY CARE
♦ Children will often take on a role reversal when their parent is sick. ♦ Children provide **transportation** ♦ Children provide **translation**
ACCESS TO HEALTH CARE CHALLENGES AND BARRIERS FOR PATIENTS AND FAMILY MEMBERS
♦ **Economic security** ♦ **Fear** ○ Fear and pain management are challenges for head and neck cancer patients. ○ Patients do not want chemotherapy because they do not want to lose their hair. ○ Patients fear the impact of treatment and are scared of the future and its uncertainty. ○ Sometimes other people will instill fear in the patients and tell them to partake in certain activities such as not eating sugar or going to Mexico to get their cancer treatments. ♦ **Mental health issues and substance misuse** can create challenges in care. ♦ **Untimely access** to providers and treatment, due to insurance issues or lack of providers to render services. ♦ **Provider shortage** ♦ **Treatment compliance:** providers may be unaware of a patient's psychiatric history which may complicate treatment compliance. ♦ **Conflicting treatments**: some patients use holistic methods such as herbs and vitamin C therapy that may interact with treatments.
HOSPITAL COMMUNICATION Do you or your staff interact with community clinics, social services organizations, or other community resources in any way to support patients/their families?

- **Referrals** are made to resources such as financial services, In-Home Care, transportation, and housing.
    - Based on identified needs they refer to Komen Foundation or Cancer society.
    - Jewish Family Services and Mama's Kitchen are organizations that social workers and navigators rely on.
    - For patients with mental health issues or suicide ideation, social workers and navigators will call Sharp Mesa Vista to refer patients to a psychiatrist.

HOSPITAL DISCHARGE CHALLENGES AND BARRIERS

- **Lack of family support**: issues when there is no one at home for the patient to be discharged to.
- **Homeless**: when the patient does not have a home.
- **Medications**: when the patient has no access to their medications.
- **Follow-up care**: lack of follow-up care.
- **Insurance issues**, especially when patients have no outpatient care coverage.
- **Education**: some caregivers lack health education or are not capable of effectively being a caregiver.

HOSPITAL AND COMMUNITY SUPPORT NEEDED

Financial navigators: there is a need for financial navigators to help oncology patients navigate their health insurance policy.

One stop shop for patients that includes all the services they may need during this time, such as pain management clinics, wig disbursement, and help with legal issues.

Additional staff: there is a need for more staff for breast cancer patients.

Follow-up care: after surgery and chemotherapy follow up care.

Education: patients need more education and support during this process such as education around why going back to work is not advisable.

Legal Services: there is a need for more assistance with legal services and lawyers. Legal issues arise for some patients on immigration, custody of children, divorce, or work-related issues on discrimination.

IMMIGRATION

Have you observed any changes over the past year in patient/community member attitude towards immigration issues?

- Patients are afraid to talk when it comes to their citizenship status.
- Many patients unenrolled from their health insurance out of fear of being on a “list”.
- There has been an increase in inpatient care due to placing patients on restricted Medi-Cal and then admitting them to obtain treatment and needed tests and scans such as MRI’s. These services would otherwise not occur if the patient were an outpatient due to insurance.
- Many immigrants debate stopping treatment or just leaving the country all together.
- In terms of access to health care, there are a lot of legal and family issues involved.

Table 6: Sharp 2019 CHNA – Sharp HealthCare Diabetes Health Educators Focus Group Summary of Responses

SHARP HEALTHCARE DIABETES HEALTH EDUCATORS - SUMMARY OF RESPONSES
HEALTH CONDITIONS AND NEEDS FOR PATIENTS AND FAMILY MEMBERS
♦ **Cardiovascular issues** ♦ **Behavioral health issues:** depression associated with diabetes, bipolar ♦ **Diabetes** ♦ **Eating disorders** ♦ **Gastric bypass issues** ♦ **Kidney issues** ♦ **Neuropathy:** weakness, numbness, and pain from nerve damage, usually in the hands and feet ♦ **Post kidney transplant issues** ♦ **Vision issues**
SOCIAL DETERMINANTS OF HEALTH FOR PATIENTS AND FAMILIES
♦ **Community and family support:** families can be unsupportive of the "diet" they must adhere to. There are misconceptions about the health conditions by family members**.** ♦ **Education for patients:** general lack of patient empowerment and knowledge on diabetes ♦ **Education for providers**: patients are referred to general practitioners and medical doctors who are not knowledgeable in diabetes care ♦ **Food insecurity** ♦ **Medication Issues:** prescription issues such as medications not being covered under the patients insurance. This can be an issue when the doctor does not write "or" on the prescription renewal so that it can be replaced with different type of drug. ♦ **Stigma**: the burden is reinforced by medical providers who scare the patients.
ACCESS TO HEALTH CARE CHALLENGES AND BARRIERS FOR PATIENTS AND FAMILY MEMBERS
♦ **Community and family support**: lack of family support due to economic reasons. ♦ **Cultural differences** o Middle Eastern patient population cultural/belief differences: ▪ Tendency to eat very late and only two times a day which make it harder to control blood glucose levels. ▪ Arab population –has difficulty trusting and believing the diabetes education content, which creates challenges when trying to change eating and life style habits. ▪ Husbands are dominant in the household and due to work status cannot support their wife during appointments. o Asian culture –eating two bowls of rice is the norm; lack health literacy in nutrition. o Some cultures believe big babies are healthier. ♦ **Economic insecurity** o If husband misses work, family does not eat; same goes for taking time off for sick leave or medical emergencies. o Food insecurity ♦ **Education**: lack of knowledge of disability and employment rights (i.e. employees are unaware that by law they must be allowed to check their blood sugar levels at work). o Some patients believe insulin causes blindness (not diabetes condition itself) or think that death or amputation is inevitable when diagnosed with diabetes. o Providers forget to remind patients to bring their blood glucose meters. o Even well-educated patients with gestational diabetes may not care for themselves properly. ♦ **Health insurance issues** ♦ **Stigma**: some patients have preconceived ideas of what a person living with diabetes looks like. There is stigma around the use of the word diabetic, and some people believe people with diabetes are lazy. ♦ **Violence**: instances of domestic/familial abuse.

HOSPITAL COMMUNICATION

Do you or your staff interact with community clinics, social services organizations, or other community resources in any way to support patients/their families?

- **Referrals**: refer patients with newborns who need resources to the Salvation Army and other organizations.
- **Partner with community organizations such as:**
  - Family Health Center to help patients set goals, follow-up, and check in on patient progress.
  - 2-1-1 San Diego to work on food insecurity resources.
  - Sharp Mesa Vista Outpatient Center
  - Senior centers
  - Feeding America and Senior Meal Programs
- **Additional partnerships include**
  - WIC Interns conduct projects with Sharp HealthCare to implement changes. WIC is a federally funded food supplement nutrition program for Women, Infants, and Children (WIC).
  - Help uninsured patients enroll into the Care Transitions Intervention Program

HOSPITAL DISCHARGE CHALLENGES AND BARRIERS

- At discharge, there is no continuity of care. Patients are only provided with papers on resources.
- Language barrier when trying to understand discharge papers.

IMMIGRATION

Have you observed any changes over the past year in patient/community member attitude towards immigration issues?

- The group has observed changes in attitudes toward immigrant issues and stated that it is most noticeable in the Chula Vista location.
- There is fear of crossing the border from the South Bay.

Table 7: Sharp 2019 CHNA – SMBHWN Case Manager and Social Worker Focus Group Summary of Responses

SMBHWN CASE MANAGER AND SOCIAL WORKER - SUMMARY OF RESPONSES	
HEALTH CONDITIONS AND NEEDS FOR PATIENT AND FAMILY MEMBERS	
♦ **Diabetes** ♦ **Preterm pregnancies** ♦ **Short interval pregnancy**	♦ **Substance use and abuse**: including alcohol use. Use of marijuana during pregnancy
SOCIAL DETERMINANTS OF HEALTH FOR PATIENT AND FAMILY MEMBERS	
♦ **Lack of access to mental health services outside of the Sharp Mary Birch facility. even if you have good insurance coverage** ○ Difficult for patients with Medi-Cal coverage. ○ UC San Diego mental health program is overcrowded most of the time. ♦ **Economic security:** lack of affordable postpartum child care.	**Economic security continued** ○ New mothers may sign out of hospital against medical advice because they cannot afford childcare and need to return to work to pay bills. ○ Many mothers spend their entire maternity leave in the hospital with their premature baby. ♦ **Education** needed on postpartum anxiety and mood disorders. ♦ **Transportation**: lack of access to transportation.
YOUTH ROLES IN FAMILY CARE	
♦ High school aged siblings typically take over a babysitting role, which can cause them to miss school. ♦ Children translate for parents.	
ACCESS TO HEALTH CARE CHALLENGES AND BARRIERS	
♦ **Education:** lack of health education such as patients and their families not being aware of preventive medicine. ♦ **Services:** not enough health-related programs and not enough providers. ○ Access to home care programs is difficult. ♦ **Providers:** lack of mental health providers across all payer sources.	
HOSPITAL DISCHARGE CHALLENGES AND BARRIERS	
♦ **Transportation issues:** hard to keep appointments if you do not have reliable transportation. ♦ **Access to health care** ♦ **Financial issues** ♦ **Medication availability:** once a patient is discharged with special medications, they often have difficulty getting the same medication in outpatient pharmacies due to insurance issues. ♦ **Health literacy & education, patients do not understand:** ○ the nuances of *health care leave and disability* rights. ○ the difference between *inpatient and home services* or what is covered by their insurance.	
HOSPITAL AND COMMUNITY SUPPORT NEEDED	
♦ More home health, especially for postpartum ♦ Lactation consulting and services to increase breastfeeding rates and potentially divert readmissions. ♦ Interpretation and translations: access to language compatible providers and services – Muslim patients most notably. In-person translators needed. ♦ Have nursing, lactation consultants, dieticians, social workers, and interpreters come in as one team for each patient so that all needs are met. ♦ Maternal mental health services - inpatient and outpatient. ♦ Support groups: freestanding women hospital support groups.	

- Improving communication between doctors and pharmacists - making sure that for certain medications, doctors indicate a substitute can be given in place of a brand name.

IMMIGRATION

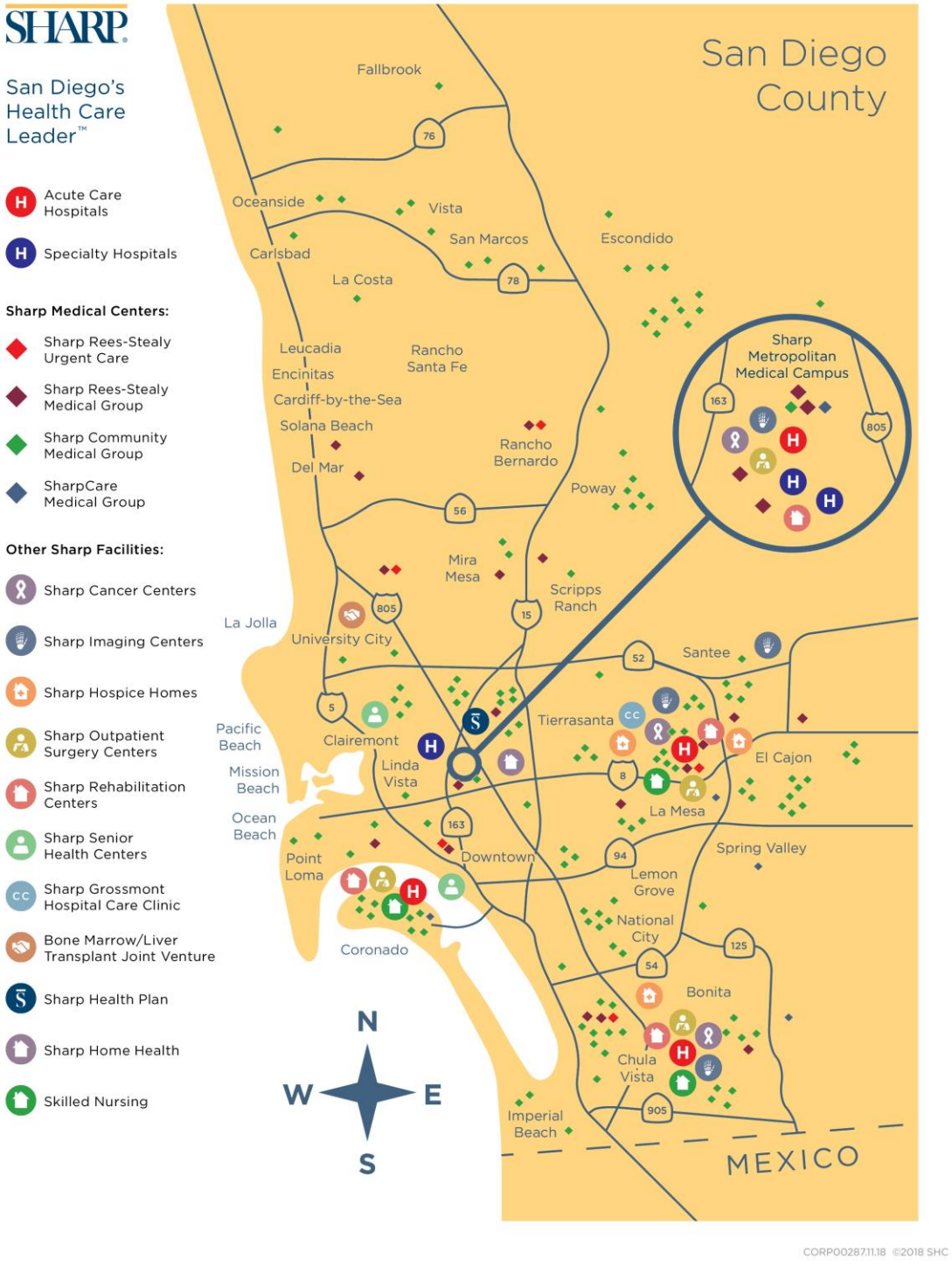
Have you observed any changes over the past year in patient/community member attitude towards immigration issues?

Fear and Stigma have increased:

- Immigrant's fear of applying for Medi-Cal has multiplied; some fear their contact information will be registered.
- Fearful of public charge rule and of being turned into the authorities.
- Asylum Seekers from Africa who are Muslim are scared to seek services because of the stigma to their faith and country of origin.
- People feel emboldened by the current administration to act out.
    - Providers often make assumptions and racist remarks before looking at the patient's fact sheet.

Appendix

V Map of Sharp HealthCare Locations



Appendix

W Sharp HealthCare Involvement in Community Organizations

The list below shows the involvement of Sharp executive leadership and other staff in community organizations and coalitions in Fiscal Year 2018. Community organizations are listed alphabetically.

- 2-1-1 San Diego Board
- A New PATH (Parents for Addiction, Treatment and Healing)
- Adult Protective Services
- Alliance for African Assistance
- Altrusa International Club of San Diego
- Alzheimer's Project Safety Workgroup
- Alzheimer's San Diego
- Alzheimer's San Diego Client Advisory Board
- American Academy of Nursing
- American Association of Colleges of Nursing
- American Association of Critical-Care Nurses
- American Cancer Society
- American College of Healthcare Executives
- American Congress of Obstetricians and Gynecologists
- American Diabetes Association
- American Foundation for Suicide Prevention
- American Heart Association
- American Hospital Association
- American Hospital Association Regional Policy Board
- American Lung Association
- American Nurses Association
- American Psychiatric Nurses Association
- American Red Cross of San Diego
- Angels Foster Family Network
- The Arc of San Diego
- Asian Business Association of San Diego
- Association for Ambulatory Behavioral Healthcare
- Association for Clinical Pastoral Education
- Association for Community Health Improvement
- Association for Contextual Behavioral Science – Aging Special Interest Group
- Association of California Nurse Leaders
- Association of Fundraising Professionals – San Diego Chapter
- Association of Women's Health, Obstetric and Neonatal Nurses
- Azusa Pacific University
- Balboa Institute of Transplantation
- BAME Renaissance, Inc. (BAME CDC)

- Bayside Community Center
- Beacon Council's Patient Safety Collaborative
- Behavioral Health Recognition Dinner Planning Team
- Borrego Health
- Boys and Girls Club of South County
- Cabrillo Credit Union Sharp Division Board
- Cabrillo Credit Union Supervisory Committee
- California Academy of Nutrition and Dietetics – San Diego District
- California Association of Health Plans
- California Association of Hospitals and Health Systems Committee on Volunteer Services and Directors' Coordinating Council
- California Association of Marriage and Family Therapists San Diego Chapter
- California Association of Physician Groups
- California Board of Behavioral Health Sciences
- California College San Diego
- California Department of Public Health (CDPH)
- CDPH Healthcare Acquired Infections/Antimicrobial Stewardship Program subcommittee
- CDPH Healthcare Associated Infection Advisory Committee
- CDPH Joint Advisory Committee
- California Dietetic Association
- California Emergency Medical Services Authority
- California Health Care Foundation
- California Health Information Association
- California Hospice and Palliative Care Association
- California Hospital Association (CHA)
- CHA Board of Trustees
- CHA Center for Behavioral Health
- CHA Emergency Management Advisory Committee
- CHA Hospital Quality Institute Regional Quality Leaders Network
- CHA San Diego Association of Directors of Volunteer Services
- CHA Workforce Committee
- California Immunization Coalition
- California Library Association
- California Maternal Quality Care Collaborative
- California Perinatal Quality Care Collaborative
- California Society for Clinical Social Work Professionals
- California State University San Marcos
- California Teratogen Information Service
- Cameron Family YMCA
- Community Health Improvement Partners Behavioral Health Work Team
- Chula Vista Chamber of Commerce
- Chula Vista Community Collaborative
- Chula Vista Police Foundation
- City of Chula Vista
- City of San Diego

- City of San Diego Park & Recreation
- Clairemont Lutheran Church
- Community Center for the Blind and Visually Impaired
- Consortium for Nursing Excellence, San Diego
- Coronado Chamber of Commerce
- Coronado Public Library
- Coronado SAFE (Student and Family Enrichment)
- Coronado Senior Center Planning Committee
- Council of Women's and Infants' Specialty Hospitals
- County Service Area – 69 Advisory Board
- Doors of Change
- Downtown San Diego Partnership
- East County Action Network
- East County Senior Service Providers
- Emergency Nurses Association – San Diego Chapter
- Employee Assistance Professionals Association
- EMSTA College
- Family Health Centers of San Diego
- Father Joe's Villages
- Feeding San Diego
- Friends of Scott Foundation
- Gary and Mary West Senior Wellness Center
- George G. Glenner Alzheimer's Family Centers, Inc.
- Girl Scouts San Diego
- Grossmont College Occupational Therapy Assistant Advisory Board
- Grossmont College Respiratory Advisory Committee
- Grossmont Healthcare District Community Grants and Sponsorships Committee
- Grossmont Healthcare District Independent Citizens' Bond Oversight Committee
- Grossmont Imaging LLC Board
- Grossmont Union High School District
- Hands United for Children
- Health and Science Pipeline Initiative
- Health Care Communicators Board
- Health Industry Collaboration Effort, Inc.
- Health Insurance Counseling and Advocacy Program
- Health Sciences High and Middle College (HSHMC)
- Healthy Chula Vista Advisory Commission
- Helix Charter High School
- Hidden Heroes campaign
- Home Start, Inc.
- Hospice and Palliative Nurses Association — San Diego Chapter
- Hospital Association of San Diego and Imperial Counties (HASD&IC)
- HASD&IC Community Health Needs Assessment Advisory Group
- HSHMC Board
- Hunger Advocacy Network

- I Love a Clean San Diego
- Inner City Action Network
- Institute for Public Health, San Diego State University (IPH)
- Integrative Therapies Collaborative
- International Association of Eating Disorders Professionals
- The Jacobs & Cushman San Diego Food Bank
- Jewish Family Service of San Diego (JFS)
- JFS Behavioral Health Committee
- JFS Public Affairs Committee
- Kiwanis Club of Bonita
- La Maestra Community Health Centers
- La Mesa Lion's Club
- La Mesa Parks and Recreation
- Lantern Crest Senior Living Advisory Board
- Las Damas de San Diego International Nonprofit Organization
- Las Patronas
- Las Primeras
- Life Rolls On
- Live Well San Diego Check Your Mood Committee
- Live Well San Diego – South Region
- Lightbridge Hospice
- Mama's Kitchen
- March of Dimes
- Meals on Wheels San Diego County
- Meals on Wheels Greater San Diego East County Advisory Board
- Mental Health America
- Miracle Babies
- MRI Joint Venture Board
- National Active and Retired Federal Employees Association
- National Alliance on Mental Illness
- National Association of Hispanic Nurses, San Diego Chapter
- National Association of Perinatal Social Workers
- National Association of Neonatal Nurses
- National Association of Orthopedic Nurses
- National Hospice and Palliative Care Organization
- National Institute for Children's Health Quality
- National University
- Neighborhood Healthcare
- Neighborhood House Association
- North San Diego Business Chamber
- Pacific Arts Movement
- Palomar Community College
- Paradise Village
- Partnership for Smoke-Free Families
- Partnerships with Industry
- Peninsula Family YMCA

- Peninsula Shepherd Senior Center
- Perinatal Safety Collaborative
- Perinatal Social Work Cluster
- Planetree Board of Directors
- Point Loma/Hervey Library
- Point Loma Nazarene University
- Postpartum Health Alliance
- Practice Greenhealth
- Promises2Kids
- Psychiatric Emergency Response Team
- Public Health Emergency Hospital Preparedness Program
- Regional Perinatal System
- Residential Care Committee
- Ronald McDonald House Operations Committee
- Rotary Club of Chula Vista
- Rotary Club of Coronado
- San Diego Association of Diabetes Educators
- San Diego Association of Governments
- San Diego Blood Bank
- San Diego Community Action Network
- San Diego Community College District
- San Diego County
- San Diego County Aging and Independence Services
- San Diego Dietetic Association
- San Diego East County Chamber of Commerce
- San Diego Eye Bank Nurses' Advisory Board
- San Diego Fire-Rescue Department
- San Diego Food System Alliance
- San Diego Freedom Ranch
- San Diego Habitat for Humanity
- San Diego Health Information Association
- San Diego Housing Commission
- San Diego Human Dignity Foundation
- San Diego Humane Society
- San Diego Hunger Coalition
- San Diego Imaging – Chula Vista
- San Diego Immunization Coalition
- San Diego-Imperial County Council of Hospital Volunteers
- San Diego North Chamber of Commerce
- San Diego Organization of Healthcare Leaders
- San Diego Physician Orders for Life-Sustaining Treatment Coalition/San Diego Coalition for Compassionate Care
- San Diego Psych-Law Society
- San Diego Psychological Association Supervision Committee
- San Diego Regional Chamber of Commerce
- San Diego Regional Healthcare Sustainability Collaborative

- San Diego Regional Home Care Council
- San Diego Rescue Mission
- San Diego River Park Foundation
- San Diego Square
- San Diego State University
- San Diego Unified School District
- San Diego Workforce Partnership (SDWP)
- Santee-Lakeside Rotary Club
- SAY San Diego
- Serving Seniors
- Sharp and Children's MRI Board
- Sharp and UC San Diego Health's Joint Venture
- Smart Kitchens San Diego
- South Bay Community Services
- South Bay Senior Providers
- South County Action Network
- South County Economic Development Council
- Southern Caregiver Resource Center
- Southwestern College
- Special Needs Trust Foundation
- Special Olympics
- Ssubi is Hope
- St. Paul's PACE
- St. Paul's Retirement Home Foundation
- Statewide Medical Health Exercise Program
- SuperFood Drive
- The Meeting Place
- Transitional Age Youth Behavioral Health Services Council
- Trauma Center Association of America
- Union of Pan Asian Communities
- University of California, San Diego
- University of San Diego
- University of Southern California
- USS Midway Museum
- VA San Diego Healthcare System
- VA San Diego Mental Health Council
- Veterans Village of San Diego
- Vista Hill ParentCare
- We Honor Veterans
- Westminster Tower
- Women, Infants and Children Program
- Wreaths Across America — San Diego
- YMCA
- YWCA Becky's House®
- YWCA Board of Directors
- YWCA In the Company of Women Event

Appendix

X Glossary of Terms

ACS	American Community Survey
Affordable Care Act	Patient Protection and Affordable Care Act
BMI	Body Mass Index
BRFSS	Behavioral Risk Factor Surveillance System
CAD	Coronary Artery Disease
CDC	Centers for Disease Control and Prevention
CDPH	California Department of Public Health
CHIS	California Health Interview Survey
CHNA	Community Health Needs Assessment
CIE	Community Information Exchange
CNI	Community Need Index
COPD	Chronic Obstructive Pulmonary Disease
CTI	Care Transitions Intervention
CUPID	California Universal Patient Information Discovery
CVD	Cardiovascular Disease
CY	Calendar Year
ED	Emergency Department
FPL	Federal Poverty Level
FQHCs	Federally Qualified Health Centers
FY 2019	Fiscal Year 2019
HASD&IC	Hospital Association of San Diego and Imperial Counties
HASD&IC 2016 CHNA	Hospital Association of San Diego and Imperial Counties 2016 Community Health Needs Assessment
HASD&IC 2019 CHNA	Hospital Association of San Diego and Imperial Counties 2019 Community Health Needs Assessment
HHSA	County of San Diego Health and Human Services Agency
HP2020	Healthy People 2020
HPI	The Public Health Alliance of Southern California's Healthy Places Index
HRO	High Reliability Organization
ICU	Intensive Care Unit
IPH	Institute for Public Health
IRS	Internal Revenue Service
KI	Key Informant
KP	Kaiser Permanente
LGBTQ	Lesbian, Gay, Bisexual, Transgender and Queer (or Questioning)
LBW	Low Birth Weight

MVT	Motor Vehicle Traffic
NCQA	National Committee for Quality Assurance
NICU	Neonatal Intensive Care Unit
OSHPD	Office of Statewide Health Planning and Development
PCP	Primary Care Physician
PFAC	Sharp Patient Family Advisory Council
PTSD	Post-Traumatic Stress Disorder
SAMHSA	Substance Abuse and Mental Health Services Administration
SANDAG	San Diego Association of Governments
SCHHC	Sharp Coronado Hospital and Healthcare Center
SCVMC	Sharp Chula Vista Medical Center
SDC	San Diego County
SDSU	San Diego State University
SGH	Sharp Grossmont Hospital
SGH 2016 CHNA	Sharp Grossmont Hospital 2016 Community Health Needs Assessment
SGH 2019 CHNA	Sharp Grossmont Hospital 2019 Community Health Needs Assessment
Sharp	Sharp HealthCare
SHP	Sharp Health Plan
SMBHWN	Sharp Mary Birch Hospital for Women & Newborns
SMC	Sharp McDonald Center
SMH	Sharp Memorial Hospital
SMV	Sharp Mesa Vista Hospital
SNAP	Supplemental Nutrition Assistance Program
UC	University of California
U.S.	United States
VLBW	Very Low Birth Weight

SHARP Grossmont Hospital