Sharp Coronado Hospital and Healthcare Center

Community Health Needs Assessment

Fiscal Year 2022

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

SHARP

Sharp Coronado Hospital and Healthcare Center Community Health Needs Assessment

Fiscal Year 2022

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Preface

Sharp Coronado Hospital and Healthcare Center (SCHHC) prepared this Community Health Needs Assessment (CHNA) for fiscal year 2022 (FY 2022) 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 Coronado Hospital and Healthcare Center 2022 Community Health Needs Assessment (SCHHC 2022 CHNA) and FY 2023 – FY 2026 Implementation Strategy received approval from the SCHHC Board of Directors on Sept. 26, 2022.

Chris Howard
President and Chief Executive Officer
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

The SCHHC 2022 CHNA process included the time, effort, insight and contributions of many members of the San Diego community. The SCHHC 2022 CHNA builds upon the Hospital Association of San Diego and Imperial Counties 2022 Community Health Needs Assessment (HASD&IC 2022 CHNA), described below.

2022 CHNA Participating Hospitals and Health Systems

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

Alvarado Hospital Medical Center
Alvarado Parkway Institute Behavioral Health System
Aurora Behavioral Health Care San Diego
Grossmont Healthcare District
Kaiser Permanente San Diego
Palomar Health
Paradise Valley Hospital/Bayview Behavioral Health Campus
Rady Children's Hospital – San Diego
San Diego County Psychiatric Hospital
Scripps Health
Sharp HealthCare
Tri-City Medical Center
UC San Diego Health
VA San Diego Healthcare System

2022 CHNA Committee

The CHNA Committee (listed below) designed and implemented the HASD&IC 2022 CHNA process.

Hospitals and Health Care Systems

Erica Salcuni (Chair)
Jillian Warriner (Chair 2020-2021)
Sharp HealthCare

Anette Blatt (Vice-Chair)
Scripps Health

Christian Wallis
Amy Abrams
Ari Rojas
Grossmont Healthcare District

Lindsey Wright
Kaiser Foundation Hospital –
San Diego and Zion

Stephanie Gioia-Beckman
Lisa Lomas
Rady Children's Hospital – San Diego

Aaron Byzak
Jessica Shrader
Tri-City Medical Center

David Mier
UC San Diego Health

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 38 hospitals and integrated health systems in San Diego and Imperial counties. Representing all member sectors, HASD&IC's Board of Directors provides policy direction to preserve and promote the interests of member hospitals and health systems.

Dimitrios Alexiou
President and Chief Executive Officer

Alexandrea Clendenin
Research Consultant

Stephanie Phann
Project Manager, Health Equity & Community Engagement

Caryn Sumek
Vice President

Nhat Quang Thai
Epidemiologist

Ivonne Velazquez
Program Manager, Policy & Government Affairs

Lindsey Wade
Senior Vice President

SCHHC 2022 CHNA Planning Team

In addition, team members from Sharp HealthCare (Sharp) and SCHHC either led or provided insight to, support for, or participation in the SCHHC 2022 CHNA process. Sharp also contracted with the Institute for Public Health at San Diego State University (IPH) to develop and implement select community engagement activities. Members of the SCHHC 2022 CHNA Planning Team are listed below.

Sharp HealthCare

Jillian Warriner
Manager, Community Benefit & Health Improvement (through 2/2022)

Erica Salcuni
Manager, Community Benefit & Health Improvement (beginning 4/2022)

Kristine White
Senior Community Benefit Specialist

Diana Romaya
Community Benefit Specialist

Emily McCallum
Senior Planning & Community Benefit Analyst

Steffanie Castaneda
Planning & Community Benefit Analyst

Vivian Kou
Strategic Planning & Community Benefit Intern

Chris Tomac
Director, Clinical Analytics & Data Strategy

Michelle Garcia
Project Implementation Coordinator, Clinical Analytics

Linda Tripp
Clinical Analytics System Analyst I

Pam Sheldon
Clinical Analytics System Analyst I

Elena Cardenas Galindo
Manager, Consumer Insights

Charlotte Harland
Consumer Research Analyst

Aisha Kazmi
Consumer Research Analyst

Holly Miodek
Consumer Research Analyst

Cassie Nordeman
Consumer Research Analyst

Sharp Coronado Hospital and Healthcare Center

Susan Stone
Senior Vice President and Chief Executive Officer

Victoria Risovanny
Manager, Patient Relations

Institute for Public Health at San Diego State University

For 25 years, the IPH has partnered with local, state, national and international organizations to conduct community-based research and program evaluation. The IPH specializes in community engagement with diverse groups utilizing culturally competent methodologies. Engagement efforts have included performing key informant interviews, leading focus groups, facilitating town hall meetings, designing and evaluating electronic surveys, and conducting patient and provider interviews.

Tanya Penn
Senior Research Scientist/Principal Investigator

Martha Crowe
Research Associate

SAN DIEGO STATE UNIVERSITY
Institute for Public Health

Our Local Community

For both the SCHHC 2022 CHNA and HASD&IC 2022 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 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. We are particularly grateful to those patients and community residents who shared their personal insight regarding health care access and challenges to health and well-being, especially amid our community's navigation of the COVID-19 pandemic.

Sharp would like to extend our deepest thanks for the contributions made by all who participated in the 2022 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 partnerships in the years to come.

Section

1 Executive Summary

Sharp HealthCare (Sharp) has been a longtime 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 Coronado Hospital and Healthcare Center (SCHHC), base their community benefit and community health programs on the findings of their CHNAs, expertise in programs and services offered at their hospital, and knowledge of the populations and communities they serve.

The Sharp Coronado Hospital and Healthcare Center 2022 Community Health Needs Assessment (SCHHC 2022 CHNA) examines the health needs of the community members it serves in San Diego County (SDC). SCHHC prepared this CHNA for fiscal year 2022 (FY 2022) 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]

The SCHHC 2022 CHNA process and findings are based on the collaborative Hospital Association of San Diego and Imperial Counties 2022 Community Health Needs Assessment (HASD&IC 2022 CHNA) process and findings for SDC.

HASD&IC CHNA Collaboration and Governance

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

- Kaiser Permanente
- Rady Children's Hospital
- Scripps Health (Vice Chair)
- Sharp HealthCare (Chair)
- Tri City Medical Center

- UC San Diego Health

The process and findings of the collaborative HASD&IC 2022 CHNA significantly informed the SCHHC 2022 CHNA. The SCHHC 2022 CHNA was further supported by additional data analysis and community engagement activities specific to the community served by SCHHC. The findings of the SCHHC 2022 CHNA will be used to help guide current and future community health programs and services at SCHHC, particularly for high-need community members. In addition, SCHHC will develop and make publicly available its three-year implementation strategy — a federally required written strategy to address the needs identified through the SCHHC 2022 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.

2022 CHNA Objectives

Conducting a CHNA during a pandemic brought challenges to both planning and implementation. Both HASD&IC and Sharp developed new strategies to maintain strong connections with community members and community-based organizations (CBOs) throughout the community engagement process. In addition, the community's needs have evolved continuously over the past few years as the pandemic has progressed.

Specific objectives of the 2022 CHNA processes included:

- Identify, understand, and prioritize the health and social needs of SDC residents, especially those community members served by Sharp.
- Provide a greater understanding of barriers to health improvement in SDC and inform and guide local hospitals in the development of programs and strategies that address identified community health needs.
- Build on and strengthen community partnerships established through the 2019 CHNA processes.
- Explore the current impact of COVID-19 on the community health needs identified by the 2019 CHNA.
- Obtain deeper feedback from and about communities in SDC facing inequities.
- Align with national best practices around CHNA development and implementation, including the integration of health conditions with social determinants of health (SDOH).

The HASD&IC and Sharp (including SCHHC) 2022 CHNA community engagement processes used interviews, focus groups and online surveys with a wide range of stakeholders. Input was gathered from community residents and patients, community health workers (CHWs), CBOs, service providers, civic leaders, health care leaders and experts, hospital and health care providers and staff, case managers, social workers,

Federally Qualified Health Centers (FQHCs), and local government staff. The 2022 CHNA also 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 SDOH. The mixed-use approach to data collection and analysis made it possible to view community health needs from multiple perspectives.

Community Defined

For the purposes of the collaborative HASD&IC 2022 CHNA, the study area encompasses all of SDC due to a broad representation of hospitals in the area. More than 3 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 2022 CHNA report at: https://hasdic.org.

The primary communities served by SCHHC include the City of Coronado, Downtown San Diego and Imperial Beach, an incorporated city. **Table 1** presents ZIP codes where the majority of SCHHC patients reside. As many of SCHHC's primary communities span multiple regions in SDC, CHNA demographics are provided at the countywide level for the most accurate reflection of the community served by SCHHC.

Table 1: Primary Communities Served by SCHHC[2]

ZIP Code	Community
91910	Chula Vista
91911	Chula Vista
91913	Chula Vista - Eastlake
91932	Imperial Beach
91950	National City
92021	El Cajon
92101	Downtown San Diego
92102	East San Diego
92113	Southeast San Diego
92114	Encanto
92118	Coronado
92154	Otay Mesa
92173	San Ysidro

Recognizing that health needs differ across SDC regions and that socioeconomic factors impact health outcomes, SCHHC's 2022 CHNA process used the Dignity Health and IBM Watson Health Community Need Index (CNI) to identify communities within its service area that experience greater health inequities. **Table 2** presents ZIP codes of

[2] Sharp HealthCare (Sharp) fiscal year 2021, Centricity HPA via Merlin (internal data warehouse).

the primary communities served by SCHHC that have especially high need based on their CNI score.

Table 2: High-Need Primary Communities Served by SCHHC, CNI Score > 4.0[3]

ZIP Code	Community
91910	Chula Vista
91911	Chula Vista
91932	Imperial Beach
91950	National City
92021	El Cajon
92101	Downtown San Diego
92102	East San Diego
92113	Southeast San Diego
92114	Encanto
92154	Otay Mesa
92173	San Ysidro

Methodology Overview

HASD&IC 2022 CHNA

The CHNA Committee completed an extensive review of national best practices and evidence-based frameworks to develop a research approach to health equity. The purpose of this effort was to address the historical, systemic and social drivers disproportionately impacting vulnerable populations including people of color, socially disadvantaged groups and those living in poverty.

Health Equity Framework

Figure 1 details the health equity framework adopted by the CHNA Committee to help guide collective research, analysis and community engagement. San Diego hospitals, health systems, and health districts are committed to a CHNA process that reflects the shared values outlined in the healthy equity framework.

[3] Dignity Health and IBM Watson Health Community Need Index (2022).

Figure 1: HASD&IC 2022 CHNA Health Equity Framework

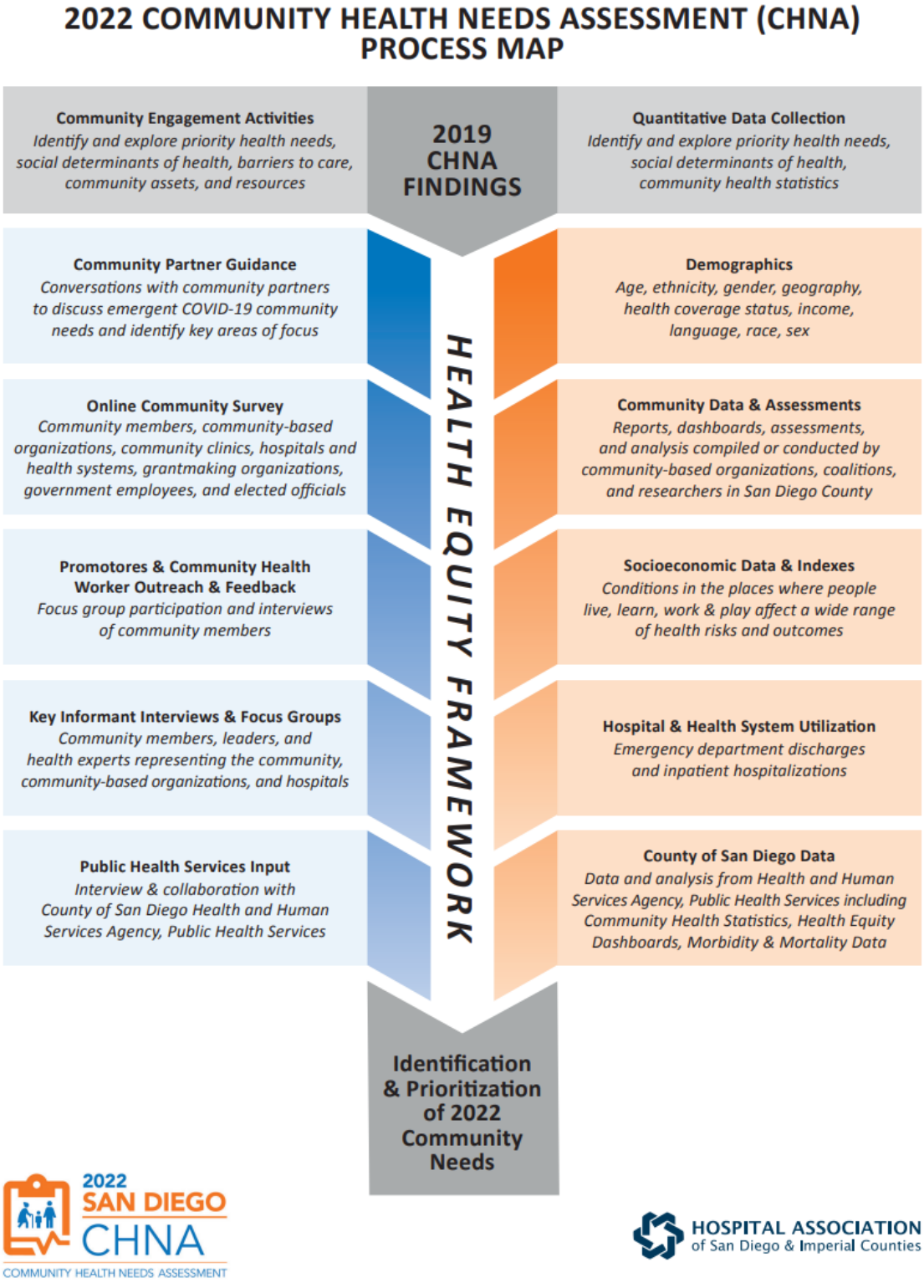
Research Methods and Approach

To gain a deep and meaningful understanding of the health and social needs of SDC residents, two primary methods were employed for the HASD&IC 2022 CHNA:

1. Quantitative analyses of existing publicly available data were conducted to provide an overarching view of critical health issues across SDC.
2. Qualitative information was gathered through a comprehensive community engagement process to understand people's lived experiences and needs in the community.

The CHNA Committee reviewed the feedback and data to prioritize the top needs in SDC. Please see **Figure 2** for more information on the HASD&IC 2022 CHNA process.

Figure 2: HASD&IC 2022 CHNA – Process Map



Quantitative Data

Quantitative data were used for three primary purposes:

1. Describe the SDC community
2. Plan and design the community engagement process
3. Facilitate the "prioritization process" — identifying the most serious community health needs of SDC residents who face inequities

Quantitative data included:

- California's Department of Health Care Access and Information (HCAI) limited data sets, 2017-2019 SpeedTrack©[4]
- CNI[3]
- Public Health Alliance of Southern California Healthy Places Index (HPI)
- National and statewide data sets including SDC mortality and morbidity data and data related to SDOH

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

The following reports and dashboards from the County of San Diego Health and Human Services Agency were also used:

- County of San Diego Community Health Statistics
- Health Disparities Executive Summary Report[5]
- Racial Equity: Framework and Outcomes Brief
- San Diego County Self-Sufficiency Standard, Household with Two Adults, One Preschool-Age Child and One School-Age Child, 2021
- Overdose Data to Action (OD2A)
- Health Equity Dashboard Series: Racial Equity Dashboards
- San Diego County Self-Sufficiency Standard Dashboard
- COVID-19 in San Diego County Dashboard
- LGBTQ+ Health and Well-Being Dashboard

[4] SpeedTrack's Population Health Decision Support Platform, was utilized to export emergency department and inpatient hospital discharge data.
[5] County of San Diego Health and Human Services Agency (HHSA), Public Health Services (PHS), Community Health Statistics Unit (CHSU) (2022), *Exploring Health Disparities in San Diego County: Executive Summary*. www.SDHealthStatistics.com

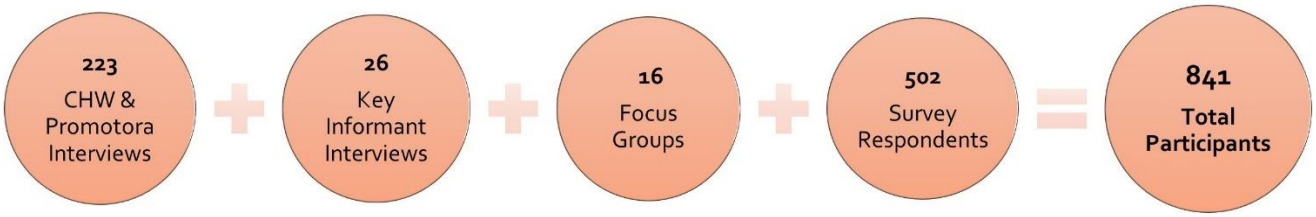
Qualitative Data: Community Engagement Activities

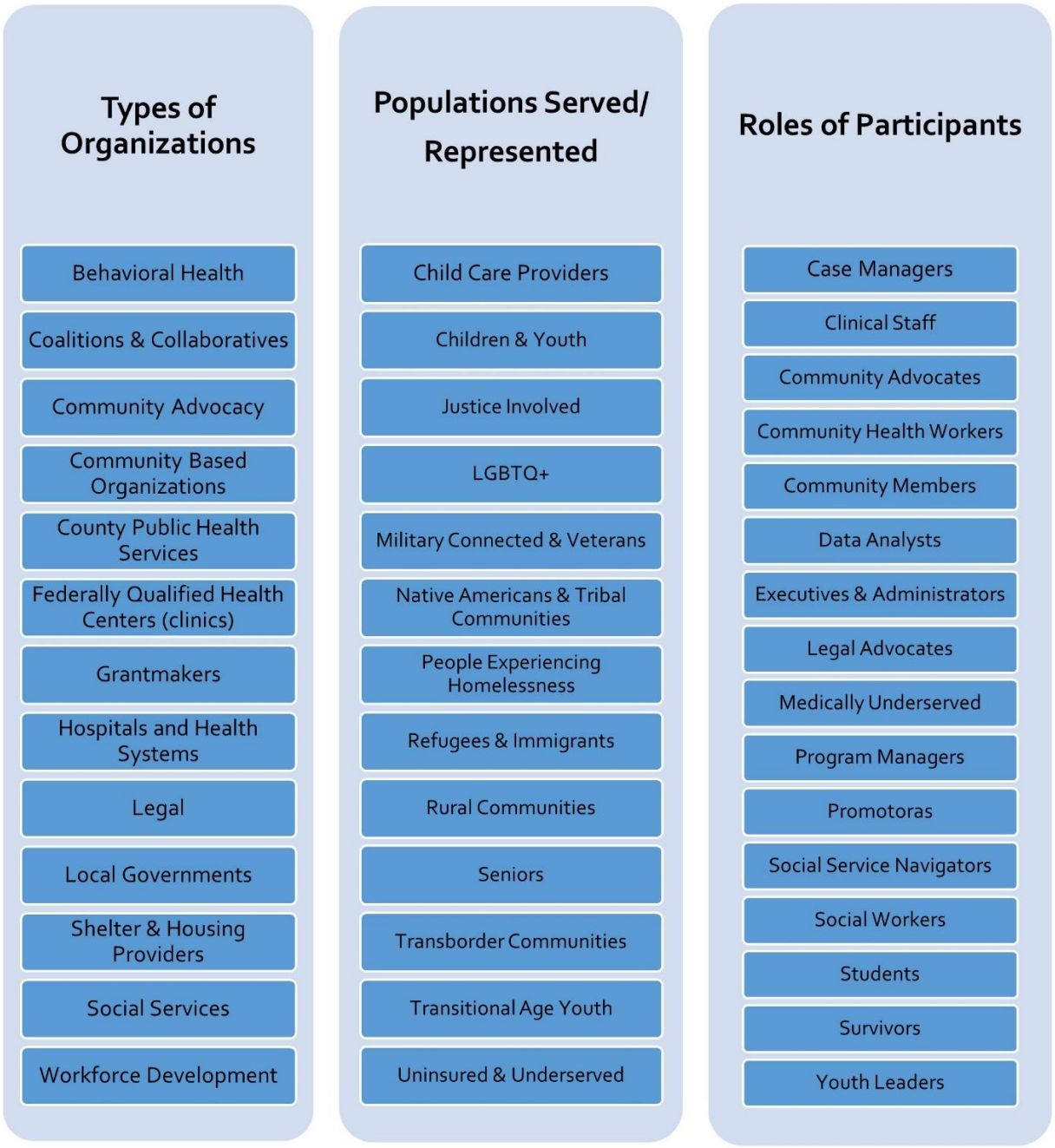
The goal of the HASD&IC 2022 CHNA community engagement process was to solicit input from a wide range of stakeholders so the sample was as representative as possible of those facing inequities in SDC. A total of **841** individuals participated in HASD&IC 2022 CHNA community engagement activities. Input from the community was gathered through the following efforts:

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

Please see **Figure 3** below for a summary of community engagement in the HASD&IC 2022 CHNA.

Figure 3: HASD&IC 2022 CHNA – Summary of Community Engagement Activities





SCHHC 2022 CHNA

The HASD&IC 2022 CHNA process provided the foundation for the development of the SCHHC 2022 CHNA, with additional Sharp-specific quantitative data analysis and community engagement activities completing the SCHHC 2022 CHNA process.

Quantitative Data

The SCHHC 2022 CHNA process included strategic analysis by Sharp's Clinical Analytics team of internal hospital and clinic data to explore observations and trends among Sharp's patient population, particularly related to the impact of the COVID-19 pandemic. Data came from a variety of sources, including the Cerner Millennium electronic medical record, hospital and clinic claims data, managed care enrollment and clinical registries. Key service-line stakeholders in behavioral health and oncology, along with Sharp's Emergency Department Collaborative and Clinical Effectiveness department also participated in the process to ensure the accuracy of data sources and metrics.

SCHHC also used SpeedTrack's California Universal Patient Information Discovery application to analyze HCAI hospital discharge data, which provided insight on top diagnoses, trends and demographic characteristics among both inpatients and individuals who visited the ED at SCHHC during CY 2020. This analysis reinforced key themes identified in the Sharp and HASD&IC 2022 CHNA processes.

In addition, SCHHC used the CNI to identify the communities in its service area experiencing health inequities. This included overlaying hospital discharge data for specific health conditions on top of CNI data in order to analyze the connection between those health conditions and under-resourced communities in SDC.

Qualitative Data: Community Engagement Activities

Sharp conducted community engagement activities specifically for the community members it serves. Sharp collected input through three electronic surveys:

1. A survey for select Sharp health care providers, particularly those professionals who serve patients with health equity challenges.
2. A survey for Sharp human resources (HR) professionals — representing the experiences of Sharp team members impacted by health and equity challenges.
3. A survey for the Sharp Insight Community — representing Sharp current and former patients (or their families and caregivers), some Sharp-affiliated physicians, and community members unaffiliated with Sharp.

The first two surveys were conducted in contract with the Institute for Public Health at San Diego State University (IPH) and included **108** participants. The third survey was implemented in partnership with Sharp's Consumer Research team and included **619**

participants. **Table 3** summarizes the SCHHC 2022 CHNA electronic community engagement surveys.

Table 3: SCHHC 2022 CHNA – Electronic Survey Participant Detail

IPH Sharp Provider Survey, N=92		
Participant	**Hospitals/Facilities Represented**	**Participant Expertise**
Sharp Community Information Exchange (CIE) Workgroup[6]	All	Low-income, medically underserved, populations with chronic diseases, minority populations **Regions**: Central East, North Central, North Coastal, North Inland, South
Sharp Cancer Navigators & Social Workers	SCVMC, SGH, SMH, SRSMG, System Services	Cancer expertise at Sharp; including for low-income, medically underserved, populations with chronic diseases, minority populations **Regions**: Central, East, North Central, South
Sharp Diabetes Health Educators	SCVMC, SGH, SMH, OPP	Low-income, medically underserved, populations with chronic diseases, minority populations **Regions**: Central, East, North Coastal, South
Sharp Patient Access Services Team Members	All	Low-income, medically underserved, populations **Regions**: Central East, North Central, North Coastal, North Inland, South
Sharp Case Manager Leadership	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
IPH Sharp Human Resources Survey, N=16		
Participant	**Hospitals/Facilities Represented**	**Participant Expertise**
Sharp HR Team Members	N/A[7]	Sharp employees – health, social and emotional well-being **Regions**: Central East, North Central, North Coastal, North Inland, South
Sharp Insight Community Survey, N=619		
Participant	**Hospitals/Facilities Represented**	**Participant Expertise**
Sharp patients and caregivers; community members	N/A	Lived experience. **Regions**: Central East, North Central, North Coastal, North Inland, South

Sharp Entity Key: **SCHHC** = Sharp Coronado Hospital and Healthcare Center; **SCVMC** = Sharp Chula Vista Medical Center; **SGH** = Sharp Grossmont Hospital; **SMC**= Sharp McDonald Center; **SMH** = Sharp Memorial Hospital; **SRSMG** = Sharp Rees-Stealy Medical Group; **SCMG** = Sharp Community Medical Group; **OPP** = Sharp Memorial Hospital Outpatient Pavilion; **System Services** = Sharp HealthCare System Services

[6] The Sharp Community Information Exchange (CIE) workgroup is comprised of Sharp staff across entities and departments who help guide the development and expansion of 2-1-1 San Diego's CIE platform utilization at Sharp for case management and care coordination.

[7] Due to small number of participants in the Institute for Public Health at San Diego State University Sharp Human Resources Survey, hospitals/facilities represented are excluded to preserve anonymity.

Prioritization of 2022 Community 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 priority community health needs.

As the HASD&IC 2022 CHNA process included robust representation from the communities served by SCHHC, this prioritization process was replicated for the SCHHC 2022 CHNA.

Findings: Top Community Needs

The CHNA Committee identified the following priority community needs for SDC (listed in alphabetical order):

Figure 4: HASD&IC 2022 CHNA – Top Community Needs for SDC

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

Figure 4 above represents the top identified community needs, the foundational challenges, and the key underlying themes revealed through the HASD&IC 2022 CHNA process. The needs identified as the most critical for San Diegans are listed in the center of the circle in alphabetical — not ranked — order. The blue outer arrows of the circle represent the negative impact of two foundational challenges — health disparities and workforce shortages — which greatly exacerbated every identified need at the center of the circle. The orange bars within the outer circle illustrate the underlying themes of stigma and trauma — the quiet yet insidious barriers that became more pervasive during the COVID-19 pandemic.

The graphic demonstrates how each component of the findings — the top identified community needs, the foundational challenges, and the key underlying themes —

impact one another. In particular, the foundational challenges (health disparities and workforce shortages) and underlying themes (stigma and trauma) interact with each other to amplify the identified community needs as well as disrupt efforts that advance health equity and improve community well-being.

These findings were also supported through both the quantitative analysis and community engagement activities conducted as part of the SCHHC 2022 CHNA.

Community Recommendations

HASD&IC 2022 CHNA

During qualitative data collection, HASD&IC 2022 CHNA community engagement participants were asked, "What are the most important things that hospitals and health systems could do to improve health and well-being in our community?" Overwhelmingly, respondents agreed that there is a critical need to help patients navigate available services that will help improve their health and well-being. In both the interviews and the surveys, suggestions that centered around improved patient care rose to the top.

Most responses fell into four categories: navigation and support, culturally appropriate care, workforce development and community collaboration. See **Table 4** for the types of recommendations identified by HASD&IC's community engagement participants.

Table 4: HASD&IC 2022 CHNA – Community Recommendations for Hospitals and Health Systems to Improve Community Health and Well-Being

HASD&IC 2022 CHNA COMMUNITY ENGAGEMENT RECOMMENDATIONS
Provide Navigation & Support to Patients
• Connect patients to services that will improve their health & well-being • Help patients understand and use health coverage • Help patients coordinate their health services • Help patients apply for health coverage or other benefits • Help patients pay for their health care bills
Provide Culturally Appropriate Care to Patients
• Ensure that a patient's care meets their needs • Provide culturally appropriate health care in more languages • Train hospital staff on biases
Workforce Development
• Diversify the health care workforce • Hire more doctors, nurses, and other health care professionals • Create more health care job opportunities and career pathways
Community Collaboration
• Collaborate with community groups and schools • Provide health education

SCHHC 2022 CHNA

Most IPH Sharp Provider Survey respondents believed Sharp does not have programs or services to address their issues of concern. Recommendations centered around providing increased connection and support, such as: more follow-up calls, home visits, and support for caregivers; enabling safe patient visitation during COVID-19; and raising awareness about and expanding available resources. In addition, the most respondents believed telehealth to be potentially beneficial to patients.

IPH Sharp Human Resources Survey respondents emphasized the importance of addressing employee well-being and reducing turnover. Their recommendations focused on improving communication, work-life balance, compensation, new graduate programs and the hiring process.

Both surveys indicated that efforts must be made to increase the availability of behavioral health care providers and improve access to behavioral health care. It was also recommended to create more community-based behavioral health programs and offer services in patients' primary languages.

Further, respondents from both IPH surveys expressed interest in employee educational opportunities focused on: care for the senior community; defining and applying cultural humility; and implicit/unconscious bias and its impact on decision making.

Overall, IPH survey findings suggest that increased support and human connection in health care — both for patients and staff — is essential to address the most acute needs experienced by Sharp's community.

Similar to the IPH surveys, Sharp Insight Community Survey participants believed telehealth to be beneficial. Participant feedback also revealed that more could be done to promote community awareness about Sharp programs and services among certain populations within SDC.

Next Steps

HASD&IC 2022 CHNA

The CHNA Committee is in the process of planning Phase 2 of the 2022 CHNA, which will include gathering community feedback on the 2022 CHNA process and strengthening partnerships around identified community needs. In addition, the CHNA Committee has identified the following priority areas for future research:

- *Updated hospital discharge data:* Due to the COVID-19 pandemic and its potential to create temporary anomalies, hospital discharge data covering the years 2017-2019 was used for this report. The CHNA Committee plans to seek expert assistance and provide the community with updated hospital discharge data from 2020 and 2021.

- *Substance use:* The 2022 community engagement process revealed concerns around increasing substance use for both children and adults but is not sufficiently documented in the most recent trends. Additional information will be collected from community partners.

- *The impact of future/pending changes to programs critical to the health and well-being of our community:* Following completion of this report, there could be significant changes to many health and social support programs that community members relied on during the pandemic. The CHNA Committee plans to assess the impact of these issues as part of the 2022 CHNA Phase 2 community engagement process.

- *Increasing costs and inflation:* The CHNA Committee plans to follow up with community partners about the impact of increasing costs and inflation as part of the 2022 CHNA Phase 2 community engagement process.

SCHHC 2022 CHNA

SCHHC is committed to the health and well-being of its community, and the findings of the SCHHC 2022 CHNA will help inform the activities and services provided by SCHHC to improve the health of its community members, especially those disproportionately affected by the COVID-19 pandemic. SCHHC developed its FY 2023 – FY 2026 Implementation Strategy to address the needs identified in the 2022 CHNA for the community it serves. Many of the programs included in the implementation strategy have been in place at SCHHC for several years. In addition, SCHHC leadership, Sharp HealthCare Community Benefit and team members across Sharp are committed to an ongoing evaluation of the programs provided to address the needs of SCHHC's community members.

The SCHHC FY 2023 – FY 2026 Implementation Strategy is available online to the community at: http://www.sharp.com/about/community/health-needs-assessments.cfm. It is also 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 SCHHC FY 2023 – FY 2026 Implementation Strategy are summarized in **Table 5** below:

Table 5: SCHHC FY 2023 – FY 2026 Implementation Strategy Summary

SCHHC FY 2023 – FY 2026 IMPLEMENTATION STRATEGY SUMMARY, BY IDENTIFIED NEED
ACCESS TO HEALTH CARE
• Continuation of multiple programs within Sharp that offer financial support and programs for patients needing advanced guidance on available funding options • Continue to facilitate CalFresh (SNAP) applications for patients • Continue to provide Project HELP funds for pharmaceuticals, transportation vouchers and other needs for economically disadvantaged patients

- Led by Sharp Integrated Care Management, including hospital (SCHHC) leaders. enhance access to health and social services for vulnerable patients and community members, particularly San Diego's homeless population; actively pursue new opportunities for community partnership and/or collaboration to improve outcomes for patients experiencing homelessness; continue to refer patients to local community organizations and resources; and continue participation and sponsorship for the Downtown San Diego Partnership's Family Reunification Program
- Continue to partner with 2-1-1 San Diego's CIE to increase assessment for SDOH and connection to community resources addressing SDOH needs

AGING CARE & SUPPORT

- Continued growth of partnerships with community organizations serving vulnerable seniors, including Meals on Wheels San Diego County, Rotary Club of Coronado, Coronado Senior Center Planning Committee and more
- Extensive community education and caregiver support as well as helpful resources for a variety of topics including fall prevention, healthy aging, mental health, senior services, nutrition and exercise and more; education provided on-site, virtually, in collaboration with the Spreckels Center and at community events
- Continued participation in community events for aging care and support as well as the provision of health screenings
- Community health and wellness classes for seniors through SCHHC's Sewall Healthy Living Center
- Participation in the partnership with 2-1-1 CIE to increase assessment for SDOH and connection to community resources addressing those SDOH needs

BEHAVIORAL HEALTH

- Raise awareness and reduce stigma of behavioral health issues as well as provide behavioral health education, screening and resources to community members, with a specific focus on seniors
- Although behavioral health is identified as a priority health need in the primary communities served by SCHHC, the facility is not licensed to comprehensively address this priority. The behavioral health needs of SCHHC's patient community are addressed primarily through the programs and services provided through Sharp Mesa Vista Hospital (SMV) and Sharp McDonald Center. As part of this effort, SMV staff identify patients at SCHHC that should be transferred to SMV

CANCER

- Established a new Cancer Care Clinic for consults and education, as well as follow-up services
- Promote early cancer detection and diagnosis through increased education and screening for patients and community members both on-site and in the community, as well as connection to support services
- Continue to assist newly diagnosed cancer patients by providing support and easily accessible materials
- Participation in the partnership with 2-1-1 CIE to increase assessment for SDOH and connection to community resources addressing those SDOH needs

CARDIOVASCULAR DISEASE

- Continued participation in the San Diego County Stroke Consortium
- Continued community blood pressure screenings for all ages (special focus on seniors)
- Provide community health and wellness classes through SCHHC's Sewall Healthy Living Center
- Provide cardiovascular health education, screenings, and resources to community members through classes, events and health fairs as well as participate in heart-related community events and walks
- Empower patients and community members living with cardiovascular and cerebrovascular disease as well as provide stroke awareness by sharing relevant information through media outlets and community event participation

CHILDREN & YOUTH WELL-BEING

- Continue to support special safety events aimed at reducing drug and alcohol related incidents among Coronado's youth, through collaboration with Safe Harbor Coronado, as well as the Every 15 Minutes program
- Collaborate with local schools to provide opportunities for students to explore and train for a variety of health care professions. This includes career pathway programs for high school-age students
- Through Sharp's ThinkFirst program, continue to partner with Health and Science Pipeline Initiative high school students to increase unintentional injury, violence prevention and associated health career awareness (through talks and various opportunities)
- Participation in the partnership with 2-1-1 CIE to increase assessment for SDOH and connection to community resources addressing those SDOH needs

COMMUNITY & SOCIAL SUPPORT

- Collaborate with local schools to provide opportunities for undergraduate and graduate students to explore and train for a variety of health care professions
- Provide a variety of health and wellness education on-site, virtually and at community events
- Provide education and resources to improve health literacy for patients and community members, with a special focus on seniors
- Continue to administer COVID-19 vaccines on-site for community members
- Participation in the partnership with 2-1-1 CIE to increase assessment for SDOH and connection to community resources addressing those SDOH needs

COMMUNITY SAFETY

- Increase education and awareness of health care professionals and community members in San Diego around violence and trauma, including human trafficking
- Participation in the partnership with 2-1-1 CIE to increase assessment for SDOH and connection to community resources addressing those SDOH needs

DIABETES

- Broadening diabetes education to more vulnerable communities served by SCHHC, including Imperial Beach
- Participate in and host educational forums, health fairs and events throughout San Diego, including Coronado
- Offer community health and wellness classes through SCHHC's Sewall Healthy Living Center
- Utilize findings from the FY 2022 CHNA to assess existing community resources and explore areas where additional diabetes education and resources may be needed
- Participation in the partnership with 2-1-1 CIE to increase assessment for SDOH and connection to community resources addressing those SDOH needs

ECONOMIC STABILITY

- Continued donations of surplus foods to the San Diego Food Bank to support community members facing hunger
- Partner with food delivery services to increase community member access to healthy food due to the COVID-19 pandemic
- Participation in the partnership with 2-1-1 CIE to increase assessment for SDOH and connection to community resources addressing those SDOH needs

OBESITY

- Provide community members with education on nutrition and healthy eating on-site, in collaboration with organizations and virtually
- Offer community health and wellness classes in support of weight loss and healthy lifestyle choices, including fitness opportunities, through SCHHC's Sewall Healthy Living Center
- Utilize SCHHC's on-site organic garden to provide community classes on healthy eating

Sharp will continue to work with HASD&IC and IPH to develop and implement Phase 2 of the 2022 CHNA. Phase 2 will focus on:

- Alignment and innovation of quantitative analyses for future CHNAs
- Continued engagement of community partners to analyze and improve the CHNA process
- Hospital implementation strategies that address the 2022 CHNA findings

Also during Phase 2, Sharp will take a closer look at the findings that emerged during the collaborative 2022 CHNA process but for which the nature of Sharp's community engagement surveys provided limited opportunity for feedback — particularly Child & Youth Well-Being and Community Safety. Sharp will explore strategies to gather feedback on these needs through future community engagement processes.

In addition, as part of Sharp's 2019 CHNA Phase 2 process, the Sharp CHNA Community Guide was developed in response to the 2019 CHNA and is 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 reflecting the 2022 CHNA will be publicly available on Sharp's website in 2023.

Further, Sharp hospitals (including SCHHC), medical groups and health plans will continue advancing data integration and community referral efforts through partnership with 2-1-1 San Diego's CIE. The CIE includes a longitudinal client record with community member history, access to and use 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 115 community partners (organizations) participating in CIE, and more than 90,000 community members enrolled, with approximately 4,500 new enrollments 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 complete SCHHC 2022 CHNA will be available for public download by Sept. 30, 2022 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 2022 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

2 History & Background

Sharp Coronado Hospital and Healthcare Center (SCHHC) is located at 250 Prospect Place in Coronado, ZIP code 92118.

SCHHC History

Coronado Hospital was built in 1926 and began as a 12-bed emergency hospital, which was privately owned by Mrs. Maude Lancaster and subsidized by the city of Coronado for 16 years. Mrs. Lancaster retired in 1938, at which time a group of physicians established the hospital as a not-for-profit, community-owned facility governed by a hospital board. A generous donation in 1942 from John D. Spreckels, then owner of the Hotel Del Coronado, allowed the hospital to expand to a 24-bed general hospital in its current location. In 1970, fundraising efforts and federal dollars funded a new full-service, 64-bed, four-story facility that was one of the most modern hospitals in the region at that time. Coronado Hospital became affiliated with Sharp HealthCare in 1994.

Today, SCHHC is a 181-bed acute care hospital that provides emergency services, medical, surgical, intensive, subacute and long-term care, as well as specialty services including liver care, integrative and rehabilitation therapies, orthopedics and a community fitness center to the island community.

In 2007, SCHHC was the first hospital in California, and the second hospital nationwide, to become a Designated Planetree Patient-Centered Hospital. SCHHC is one of only two hospitals in the world to maintain this designation consecutively since first being recognized. The recognition signifies SCHHC's excellence in providing treatment that extends well beyond caring for a patient's ailment and aims to heal the whole person. SCHHC's patient-centered care includes engaging the patient and family advisors, integrative therapies such as Healing Touch, acupuncture, massage and aromatherapy, as well as art, music and pet therapy.

In 2018, SCHHC reinforced its dedication to patient-centered, holistic care through completion of the Payne Family Outpatient Pavilion, which features all private rooms, outdoor gardens and calm surroundings to facilitate healing. In 2020, the SCHHC emergency department received Bronze Standard Level 3 accreditation as a Senior-Friendly Emergency Department from the American College of Emergency Physicians, in recognition of the high standard of emergency care it provides to older adults.

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

SCHHC 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; 26 medical clinics; five urgent care centers; three skilled nursing facilities; two inpatient rehabilitation centers; home health, hospice and home infusion programs; numerous outpatient facilities and programs; three charitable foundations; and a variety of community health education programs and related services. Sharp also offers individual and group health maintenance organization coverage through Sharp Health Plan.

Sharp serves a population of approximately 3.3 million in San Diego County (SDC) and as of Sept. 30, 2021, is licensed to operate 22,209 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 patients' expectations and are provided in a caring, convenient, cost-effective and accessible manner. More than 2,700 affiliated physicians and 19,000 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 Community Health Needs Assessment (CHNA)

For more than 20 years, Sharp has been actively involved in a triennial 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 Coronado Hospital and Healthcare Center 2022 Community Health Needs Assessment (SCHHC 2022 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 California Department of Health Care Access and Information[8] 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, the program and services expertise of each

[8] Formerly named Office of Statewide Health Planning and Development (OSHPD).

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 in 2010, since 2013 Sharp has participated in a countywide CHNA effort under the auspices of the Hospital Association of San Diego and Imperial Counties (HASD&IC). Through the CHNA Committee, Sharp partners with other San Diego hospitals and health systems on this countywide CHNA, which significantly informs both the process and findings for the CHNAs that are completed for each Sharp hospital.

Although only not-for-profit 501(c)(3) hospitals and health systems are subject to state and IRS regulatory requirements, the 2022 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.

CHNA Governance

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

Hospital Association of San Diego and Imperial Counties 2019 Community Health Needs Assessment (HASD&IC 2019 CHNA)

The HASD&IC 2019 CHNA was completed in July 2019. **Figure 5** below summarizes the findings of the HASD&IC 2019 CHNA. The highest priority community health needs in SDC (in alphabetical order by social determinant of health [SDOH] or health condition) can be found at the center. The figure illustrates the interactive nature of SDOH and health conditions — each impacting the other. In addition to the top community health needs identified, the HASD&IC 2019 CHNA findings described the underlying theme of stigma and the barriers it created. The complete HASD&IC 2019 CHNA can be found at: https://hasdic.org/community-health-needs-assessment-chna/.

Figure 5: HASD&IC 2019 CHNA Findings – Top 10 Community Health Needs

Following the completion of the HASD&IC 2019 CHNA, the CHNA Committee conducted a Phase 2 effort which included a survey for community-based organizations (CBO), hospitals and health systems, and other community stakeholders to gather feedback on the 2019 CHNA findings.[9] Distributed between February and March 2020, the survey was designed to: ensure that the findings of the 2019 CHNA were accurate; understand how stigma affects health; and frequently explore recurring themes that emerged during community discussions, including access to health care, immigration, and public charge. See **Appendix C** for more information about the HASD&IC 2019 CHNA Phase 2 process including a summary of participation and key survey questions and responses.

In addition, the CHNA Committee reviewed all data from the HASD&IC 2019 CHNA in accordance with their own patient communities, determined their capacity to address the identified community 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.

[9] The Hospital Association of San Diego and Imperial Counties 2019 Community Health Needs Assessment (HASD&IC 2019 CHNA) Phase 2 Survey was developed and disseminated before the COVID-19 pandemic took hold in our region. The CHNA Committee recognizes that communities facing inequities are experiencing unprecedented challenges, and the devastating increase in needs is not captured in our 2019 Phase 2 findings.

Notable implementation strategies and program developments for SCHHC since the completion of the SCHHC 2019 CHNA are described in **Table 6** below.

Table 6: Implementation Strategy Summary, SCHHC 2019 CHNA

SCHHC FY 2019 IMPLEMENTATION STRATEGY SUMMARY, BY IDENTIFIED NEED
ACCESS TO HEALTH CARE
• Continuation of multiple programs within Sharp that offer financial support and programs for patients needing advanced guidance on available funding options • Continue to facilitate CalFresh (SNAP) applications for patients • Continue to provide Project HELP funds for pharmaceuticals, transportation vouchers and other needs for economically disadvantaged patients • Creation of a Sharp Homeless Task Force (internal) led by Sharp Integrated Care Management, including hospital (SCHHC) leaders. Sharp developed a robust electronic platform to track the number of current patients experiencing homelessness within Sharp, while actively pursuing new opportunities for community partnership and/or collaboration to improve outcomes for patients experiencing homelessness • Participation in a one-year pilot utilizing 2-1-1 San Diego's Community Information Exchange
AGING CONCERNS (Beginning in 2022, AGING CARE & SUPPORT)
• Continued growth of partnerships with community organizations serving vulnerable seniors, including Meals on Wheels San Diego County, San Diego Food Bank, Coronado Senior Planning Committee, etc. • Extensive community education and caregiver support for fall prevention, healthy aging, mental health, nutrition and exercise, health literacy and more • Community health and wellness classes for seniors through SCHHC's Sewall Healthy Living Center
BEHAVIORAL HEALTH
• Provided community members with behavioral health screenings as well as resources • Improved senior health literacy, including senior wellness, behavioral health and more
CANCER
• Established a new Cancer Care Clinic for consults and education, as well as follow-up services • Increased efforts in cancer screenings to promote early cancer detection and connection to support services
CARDIOVASCULAR DISEASE
• Continued participation in the San Diego County Stroke Consortium • Continued community blood pressure screenings for all ages (special focus on seniors) • Community health and wellness classes through SCHHC's Sewall Healthy Living Center • Continue to host and participate in health fairs, offering cardiovascular health education, resources and screening
COMMUNITY & SOCIAL SUPPORT, ECONOMIC SECURITY, EDUCATION, HOMELESSNESS & HOUSING INSTABILITY, UNINTENTIONAL INJURY & VIOLENCE
• Continued donations of surplus foods to the San Diego Food Bank to support community members facing hunger • Continued educational opportunities and training for high school as well as college students in a variety of health care professions • Participation and sponsorship with the Downtown San Diego Partnership's Family Reunification Program to reduce the number of San Diegans experiencing homelessness

• Support for community safety events aimed at reducing drug and alcohol related incidents among youth in Coronado
DIABETES
• Broadening diabetes education to more vulnerable communities served by SCHHC, including Imperial Beach; in conjunction with and beyond Sharp's City of San Diego community health education partnership • Community health and wellness classes through SCHHC's Sewall Healthy Living Center
OBESITY
• Continued and expanded community screenings for body composition and education on nutrition, functional movement and overall healthy lifestyle • Community health and wellness classes through SCHHC's Sewall Healthy Living Center

For complete details on the progress of programs developed by SCHHC in response to the 2022 CHNA findings, please refer to the SCHHC FY 2023 – FY 2026 Implementation Strategy included in **Appendix D** as well as online at: http://www.sharp.com/about/community/health-needs-assessments.cfm.

Sharp 2019 CHNA

Sharp utilized the results of the collaborative HASD&IC 2019 CHNA along with additional data analysis and community engagement specific to the communities served by SCHHC to complete the SCHHC 2019 CHNA. View the full results of the SCHHC 2019 CHNA on sharp.com at: http://www.sharp.com/about/community/health-needs-assessments.cfm.

Upon completion of the SCHHC 2019 CHNA, Sharp also conducted a Phase 2 effort to collect community member feedback on the 2019 CHNA findings, including a special focus on the impact of COVID-19 at the time of the survey's distribution. Sharp's 2019 CHNA Phase 2 process included two electronic surveys:

1. A survey for Sharp staff and community members who had participated in Sharp's 2019 CHNA process.
2. A survey utilizing the Sharp Insight Community — representing current and former Sharp patients (or their families and caregivers), some Sharp-affiliated physicians, and community members unaffiliated with Sharp.

The first survey was conducted between June and August 2020 in contract with the Institute for Public Health at San Diego State University (IPH), while the second survey was conducted in May 2020 in collaboration with Sharp's Consumer Research team. The purpose of these surveys was to gather feedback on the top community needs identified in Sharp's 2019 CHNAs. Key questions sought input about participants' level of agreement with the identified needs, as well as their perceptions about the impact of COVID-19 on the identified needs, observations of stigma in health care, awareness of patient financial assistance programs, and awareness of community challenges in accessing health care including in relation to immigration status.

Please see **Appendix E** for the IPH 2019 CHNA Phase 2 Survey Report and **Appendix F** for the Sharp Insight Community 2019 CHNA Phase 2 Survey Report.

In addition, in 2020 Sharp incorporated its 2019 CHNA findings into an updated Sharp CHNA Community Guide. The guide provides community members with a user-friendly document describing Sharp's CHNA process and findings, as well as strategies Sharp implements to address identified health and social needs. In addition, the guide includes a direct link for community members to provide feedback on Sharp's CHNA process. Please refer to **Appendix G** for the 2019 Sharp CHNA Community Guide. In early-to mid-2023, an updated Sharp CHNA Community Guide will be publicly available at: https://www.sharp.com/about/community/community-benefits/health-needs-assessments.cfm.

Findings from both the Sharp and HASD&IC 2019 CHNA Phase 2 efforts provided essential guidance for the Sharp (including SCHHC) and HASD&IC 2022 CHNAs, the processes and findings of which are detailed in the following pages.

Section

3 Methodology

The Sharp Coronado Hospital and Healthcare Center 2022 Community Health Needs Assessment (SCHHC 2022 CHNA) draws from and is based on the process and findings of the collaborative Hospital Association of San Diego and Imperial Counties 2022 Community Health Needs Assessment (HASD&IC 2022 CHNA). Sharp HealthCare (Sharp) served as chair of the HASD&IC 2022 CHNA Committee and has actively participated in and collaborated on the HASD&IC-led CHNA process since 2012. The 2022 CHNA community engagement process effectively began upon completion of the 2019 CHNA in Fall 2019. However, the formal HASD&IC 2022 CHNA contract and process began in late Spring 2020 and concluded in Summer 2022. Complete details of the methodology and findings of the HASD&IC 2022 CHNA are available at: https://hasdic.org.

The SCHHC 2022 CHNA process included additional strategic analysis of internal hospital and clinic data to explore observations and trends among Sharp's patient population, particularly related to the impact of the COVID-19 pandemic. Sharp also conducted distinct patient, staff and community member engagement activities in order to further explore the specific health and equity needs of the community served by SCHHC. As such, this section will include details of the SCHHC 2022 CHNA methods and, where applicable, elements of the collaborative HASD&IC 2022 CHNA process.

Based on the findings of the 2019 CHNA and recommendations from the community, the SCHHC and HASD&IC 2022 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 require tax-exempt hospitals to conduct a health needs assessment in the community once every three years. With these goals in mind, the 2022 CHNAs were specifically designed to: build on and strengthen community partnerships established through the 2019 CHNA processes; obtain deeper feedback from and about communities facing inequities in SDC, with a special focus on the impact of the COVID-19 pandemic; and align with national best practices around CHNA development and implementation.

The 2022 CHNA processes included analyses of community-identified health conditions as well as socioeconomic barriers that contribute to health inequity. 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.

Methodology Overview

HASD&IC 2022 CHNA

The CHNA Committee completed an extensive review of national best practices and evidence-based frameworks to develop a research approach to health equity. The purpose of this effort was to address the historical, systemic and social drivers disproportionately impacting vulnerable populations, including people of color, socially disadvantaged groups and those living in poverty.

Figure 6 details the health equity framework adopted by the CHNA Committee to help guide collective research, analysis and community engagement. San Diego hospitals, health systems and health districts are committed to a CHNA process that reflects the shared values outlined in this framework.

Figure 6: HASD&IC 2022 CHNA Health Equity Framework

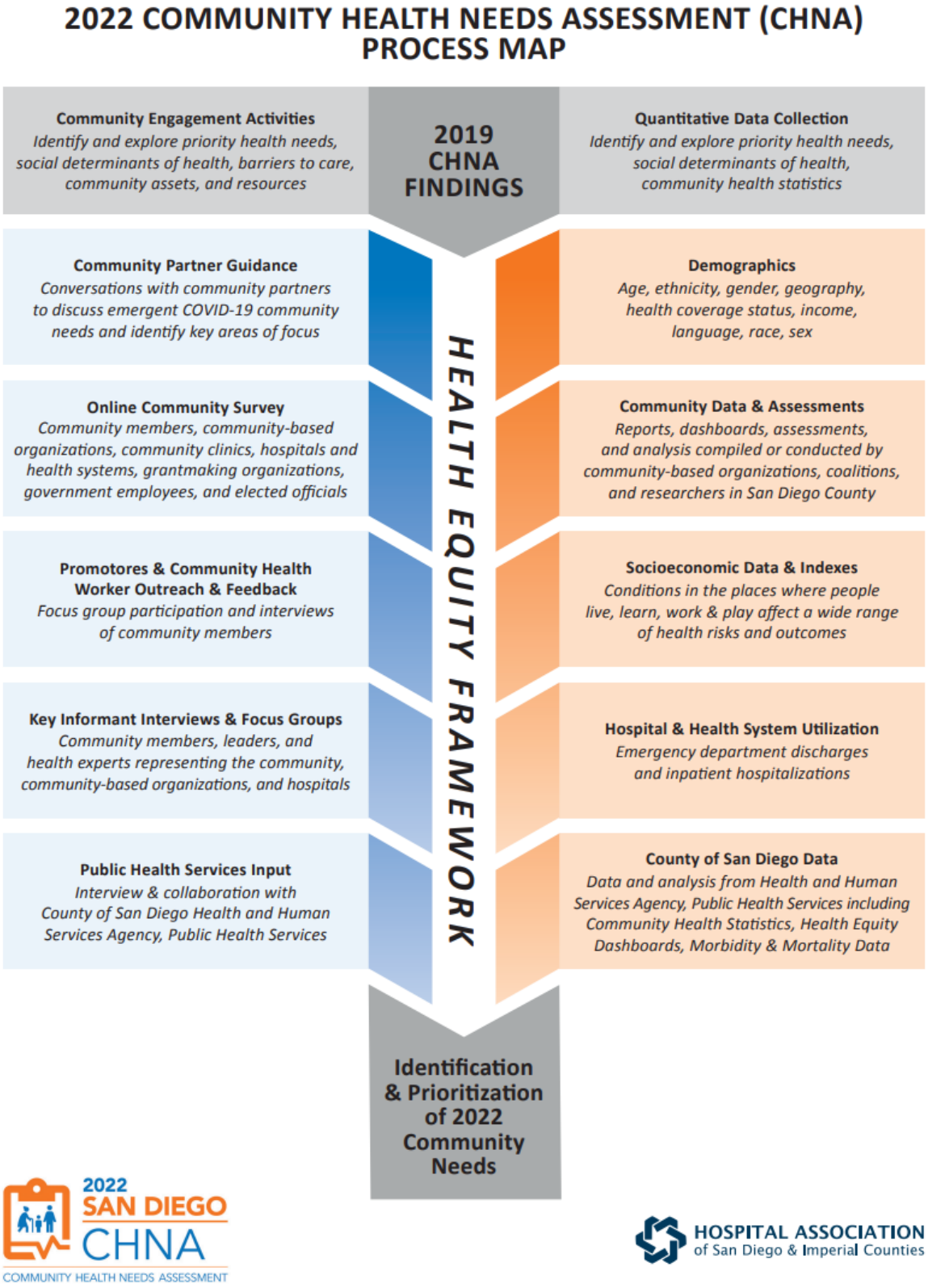
Research Methods and Approach

To gain a deep and meaningful understanding of the health-related needs of SDC residents, two primary methods were employed in the HASD&IC 2022 CHNA:

1. Quantitative analyses were conducted of existing publicly available data to provide an overarching view of critical health issues across SDC.
2. Qualitative information was gathered from community residents, community-based organizations (CBOs), federally qualified health centers (FQHCs), hospitals and health systems, local government agencies, civic leaders, grantmaking organizations and San Diego County Public Health Services through a comprehensive community engagement process to understand the lived experiences and needs of people in the community.

The CHNA Committee reviewed the feedback and data to prioritize the top health needs in SDC. Please see **Figure 7** below for more information on the HASD&IC 2022 CHNA process.

Figure 7: HASD&IC 2022 CHNA – Process Map



SCHHC 2022 CHNA

Guided by the same rationale, the SCHHC 2022 CHNA process also further explored the health and equity issues identified in the SCHHC 2019 CHNA. The HASD&IC 2022 CHNA process provided the foundation for the SCHHC 2022 CHNA, with additional Sharp-specific data analyses and community engagement activities completing the SCHHC 2022 CHNA process. Quantitative and qualitative data methods for both the HASD&IC and SCHHC 2022 CHNAs are described within this section.

Quantitative Data

HASD&IC 2022 CHNA

Quantitative data were used for three primary purposes:

1. Describe the SDC community
2. Plan and design the community engagement process
3. Facilitate the "prioritization process," identifying the most serious community health needs of SDC residents facing inequities

Quantitative data include:

- California's Department of Health Care Access and Information (HCAI) limited data sets, 2017-2019 SpeedTrack©[4]
- Community Need Index (CNI)[3]
- Public Health Alliance of Southern California Healthy Places Index (HPI)
- National and state data sets including SDC mortality and morbidity data and data related to social determinants of health (SDOH)

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

The following reports and dashboards from the County of San Diego Health and Human Services Agency (HHSA) were also used:

- County of San Diego Community Health Statistics
- Health Disparities Executive Summary Report[5]
- Racial Equity: Framework and Outcomes Brief
- Overdose Data to Action (OD2A) Health Equity Dashboard Series: Racial Equity Dashboards
- San Diego County Self-Sufficiency Standard Dashboard
- COVID-19 in San Diego County Dashboard

- San Diego County Self-Sufficiency Standard, Household with Two Adults, One Preschool Age Child and One School-Age Child, 2021
- LGBTQ+ Health and Well-Being Dashboard

SpeedTrack's California Universal Patient Information Discovery, or CUPID application, was used to export emergency department (ED) and inpatient hospital discharge data. These data were analyzed to determine the most common primary diagnosis categories upon discharge. This analysis helped the CHNA Committee understand which health conditions have the greatest impact on hospitals and health systems, providing further insight into priority health needs. For health conditions identified as a high priority for the CHNA, full 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 (2017-2019) were also calculated for each health condition, as well as for each age group and race/ethnicity within each health condition. This stratification shed light on disparities in SDC.

SCHHC 2022 CHNA

To support SCHHC's 2022 CHNA process, Sharp's Clinical Analytics team developed a detailed analysis to investigate key questions and issues related to the health and well-being of Sharp's patient population and the wider SDC community. Data used in this analysis came from a variety of sources, including the Cerner Millennium electronic medical record, hospital and clinic claims data, managed care enrollment and clinical registries. In addition, key service line stakeholders in behavioral health and oncology, along with Sharp's Emergency Department Collaborative and Clinical Effectiveness department, were engaged in the data analytics planning process to ensure the accuracy of various data sources and metrics. Patients included in the analysis had an inpatient discharge or clinic visit at a Sharp facility between calendar year 2016 and 2021 (CY 2016 and 2021). A five-year time period was chosen specifically to analyze trends prior to and during the COVID-19 pandemic. Please refer to **Appendix H** for the complete Sharp-specific data analysis conducted by Sharp's Clinical Analytics team for the SCHHC 2022 CHNA.

SpeedTrack's CUPID application was used to analyze HCAI hospital discharge data, which provided insight on SCHHC's patient population related to specific identified health needs. SCHHC used the most recent year of available data (CY 2020) to identify top diagnoses, trends, and demographic characteristics, such as age, gender, and race/ethnicity, among both inpatients and individuals who visited the ED at SCHHC. The information generated by this analysis reinforced key themes identified in the Sharp and HASD&IC 2022 CHNA processes.

In addition, SCHHC used the CNI to identify the communities in its service area experiencing health inequities. This included overlaying hospital discharge data for behavioral health, cancer, cardiovascular disease, COVID-19 and Type 2 diabetes on

top of CNI data to analyze the connection between these specific health conditions and under-resourced communities in SDC. This information will further assist in the development of SCHHC programs to meet community needs in the areas of greatest disparity and inequity. Please refer to **Section 4: Community Defined** for additional detail on SCHHC's application of CNI data.

Qualitative Data: Community Engagement Activities

HASD&IC 2022 CHNA

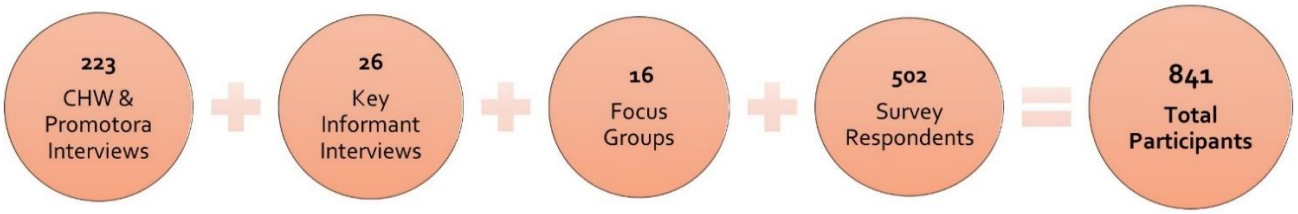
The goal of the community engagement process was to solicit input from a wide range of stakeholders so that the sample was as representative as possible of those facing inequities in SDC. Special efforts were made to include community members from groups that experience health disparities and service providers who work with those vulnerable populations. A total of **841** individuals participated in the HASD&IC 2022 CHNA (See **Figure 8** below). The following steps were taken to ensure community members' experiences were included:

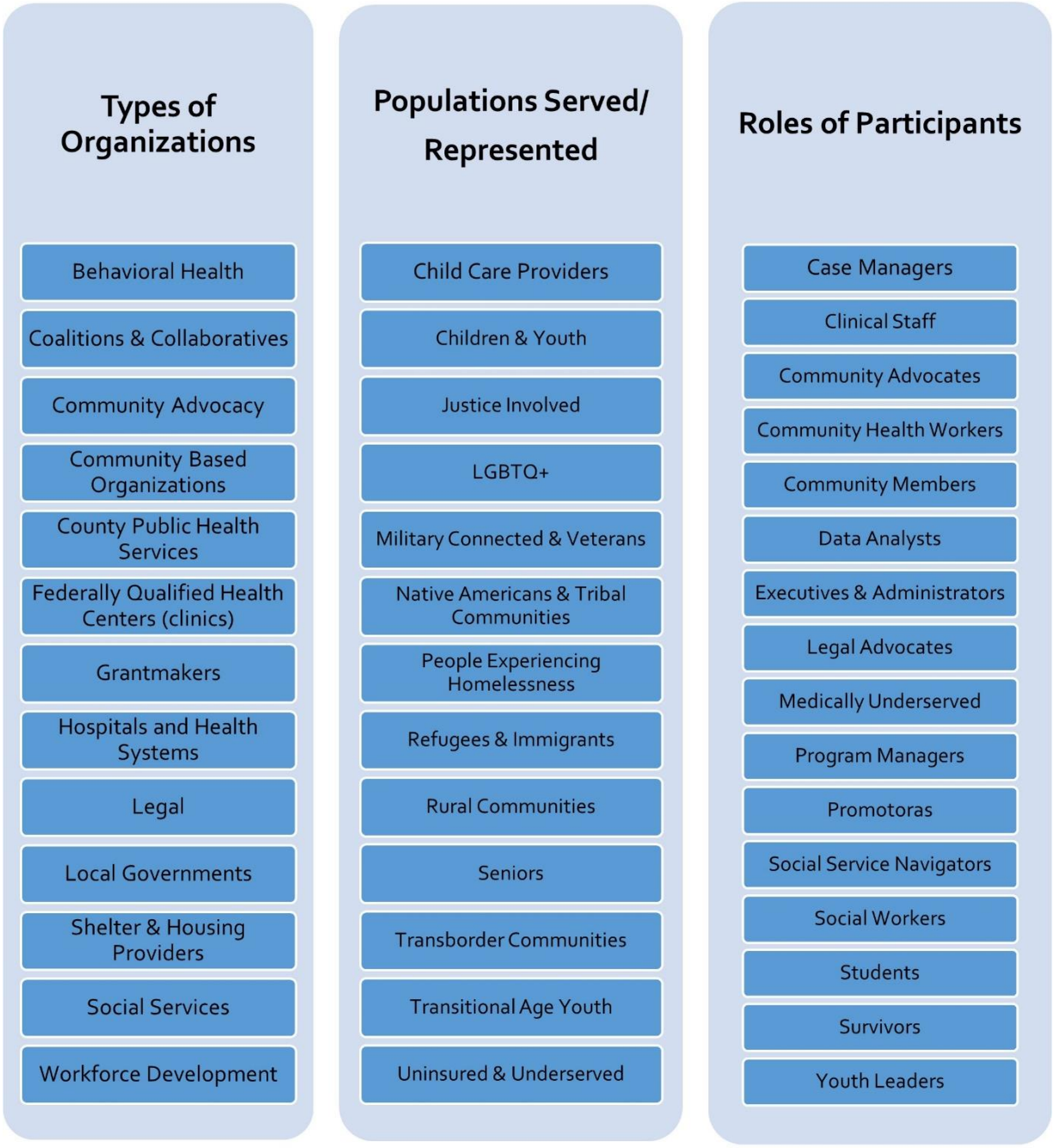
- Working with community health workers (CHWs) to conduct interviews with community members
- Conducting focus groups and key informant interviews with community members, CHWs, CBOs, service providers, civic leaders and health care leaders (conducted in collaboration with Kaiser Foundation Hospital-San Diego)[10]
- Conducting focus groups and key informant interviews with hospital and health system clinicians, case managers, social workers and executive leaders
- Distributing an online survey to community members, hospital staff, CBOs, FQHCs and local government staff

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 a diversity of racial and ethnic groups.

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

Figure 8: HASD&IC 2022 CHNA – Summary of Community Engagement Activities





Key Informant Interviews and Focus Groups

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

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

Online Community Survey

The HASD&IC 2022 CHNA online community survey was used to support prioritization of health conditions and SDOH based on what survey respondents viewed as the most important or most serious challenges.

The survey was distributed by email to targeted CBOs, social service providers, resident-led organizations, FQHCs, government agencies, grantmaking organizations and hospitals and health systems that serve a diverse array of people in SDC. When possible, these organizations shared the link to the survey with the clients they served. Email recipients were also encouraged to share the survey with their colleagues. Open from February 14 to March 30, 2022, the survey was also widely shared through social media and email and reshared by CBOs.

The survey was translated from English into five additional languages: Arabic, Spanish, Somali, Tagalog and Vietnamese. Mid-City CAN, a CBO located in City Heights, was contracted to complete the translations.

Promotoras and CHW Outreach and Feedback

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

Focus group participants were recruited through multiple avenues, including announcements in the County of San Diego HHSA's Community Health Worker Collaborative Newsletter, disseminated by the County of San Diego to provide updates on COVID-19 Communication and Outreach Services to the individuals working on one of the County's COVID-19 contracts. In addition, emails were disseminated directly to all CHWs working on the Communities Fighting COVID! Project[11] at San Diego State University. Emails were sent to the leads on eight different County COVID-19 contracts, requesting that they disseminate the information to their CHWs or outreach workers.

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

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

In addition, to ensure the report included direct community member feedback from racial and ethnic groups experiencing disparate health outcomes, the CHNA Committee employed a new strategy to partner with CBOs that work with promotoras and other CHWs. For this process, the HASD&IC 2022 CHNA online community survey was adapted with a subset of the survey questions for use as a data collection tool. The San Diego Refugee Communities Coalition and the Chicano Federation were selected to recruit interested promotoras and other CHWs to conduct the interviews. HASD&IC staff attended a San Diego Refugee Communities Coalition weekly CHW meeting to provide training on the goals of the CHNA and how to administer the interview. HASD&IC staff also provided training to the Chicano Federation promotoras.

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

Price Philanthropies Foundation generously provided grants to both organizations to compensate the promotoras and other CHWs for completing interviews.

SCHHC 2022 CHNA

In addition to serving on the CHNA Committee in support of the collaborative HASD&IC 2022 CHNA process, Sharp conducted community engagement activities specifically for the community members it serves. The purpose of the Sharp (including SCHHC) 2022

[11] San Diego State University School of Public Health & Institute of Public Health (2021), *Communities Fighting COVID! Project.* https://cfc.sdsu.edu

CHNA community engagement activities was to gather feedback on the health and equity issues that were identified in Sharp's 2019 CHNA, including the impact of COVID-19 on those issues. Sharp solicited community input through three electronic surveys:

1. A survey for select Sharp health care providers, particularly professionals who serve patients with health equity challenges.
2. A survey for Sharp human resources (HR) professionals to capture the interests and experiences of Sharp team members impacted by health and equity challenges.
3. A survey using the Sharp Insight Community to represent current and former Sharp patients (or their families and caregivers), some Sharp-affiliated physicians and community members unaffiliated with Sharp.

The first two surveys were conducted in contract with the IPH to collect feedback related to Sharp patients and employees. Specific objectives of these surveys included:

- Gather feedback to better understand the most significant health and equity issues impacting community members served by Sharp, as well as the impact of the COVID-19 pandemic on those issues.
- Collect insight to improve awareness and knowledge of how the COVID-19 pandemic has also impacted the health and well-being of Sharp health care professionals.
- Identify opportunities for internal and external collaboration to provide new, innovative programs that address the health and equity issues identified by Sharp patients, health care professionals and community members.
- Identify areas for improvement to current patient and community programs in order to better address health and equity issues for San Diegans.

The third survey was implemented in partnership with Sharp's Consumer Research team. The survey was distributed to the Sharp Insight Community — a private, online environment for Sharp patients and their families and caregivers, community members and Sharp-affiliated physicians and staff — to gather input on participants' experiences both at Sharp and within their own communities. Specific objectives of this survey included:

- Obtain feedback from community members on the identified health and equity issues experienced by San Diegans, including the impact of the COVID-19 pandemic on those issues.
- Collect suggestions from community members about how Sharp may improve the health and well-being of the patients and communities it serves.

Table 7 below summarizes the three electronic community engagement surveys implemented for the SCHHC 2022 CHNA.

Table 7: SCHHC 2022 CHNA – Electronic Survey Participant Detail

IPH Sharp Provider Survey, N=92		
Participant	**Hospitals/Facilities Represented**	**Participant Expertise**
Sharp Community Information Exchange (CIE) Workgroup[6]	All	Low-income, medically underserved, populations with chronic diseases, minority populations **Regions**: Central East, North Central, North Coastal, North Inland, South
Sharp Cancer Navigators & Social Workers	SCVMC, SGH, SMH, SRSMG, System Services	Cancer expertise at Sharp; including for low-income, medically underserved, populations with chronic diseases, minority populations **Regions**: Central, East, North Central, South
Sharp Diabetes Health Educators	SCVMC, SGH, SMH, OPP	Low-income, medically underserved, populations with chronic diseases, minority populations **Regions**: Central, East, North Coastal, South
Sharp Patient Access Services Team Members	All	Low-income, medically underserved, populations **Regions**: Central East, North Central, North Coastal, North Inland, South
Sharp Case Manager Leadership	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
IPH Sharp Human Resources Survey, N=16		
Participant	**Hospitals/Facilities Represented**	**Participant Expertise**
Sharp HR Team Members	N/A[7]	Sharp employees – health, social and emotional well-being **Regions**: Central East, North Central, North Coastal, North Inland, South
Sharp Insight Community Survey, N=619		
Participant	**Hospitals/Facilities Represented**	**Participant Expertise**
Sharp patients and caregivers; community members	N/A	Lived experience. **Regions**: Central East, North Central, North Coastal, North Inland, South

Sharp Entity Key: **SCHHC** = Sharp Coronado Hospital and Healthcare Center; **SCVMC** = Sharp Chula Vista Medical Center; **SGH** = Sharp Grossmont Hospital; **SMC**= Sharp McDonald Center; **SMH** = Sharp Memorial Hospital**; SRSMG** = Sharp Rees-Stealy Medical Group; **SCMG** = Sharp Community Medical Group; **OPP** = Sharp Memorial Hospital Outpatient Pavilion; **System Services** = Sharp HealthCare System Services

Please see **Appendix I** for the IPH Sharp Provider/Human Resources 2022 CHNA Survey & Findings and **Appendix J** for the Sharp Insight Community 2022 CHNA Survey & Findings.

2022 CHNA Prioritization Process

HASD&IC 2022 CHNA

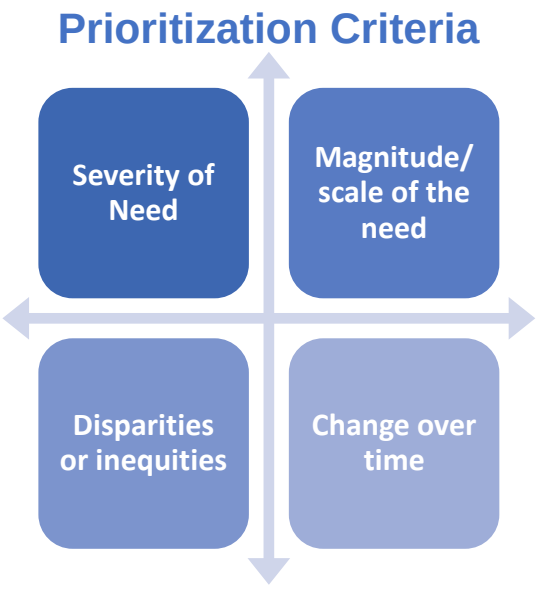
To prioritize the needs, the CHNA Committee analyzed the comprehensive findings from the needs assessment, including quantitative and qualitative data (see **Table 8**).

Table 8: Data Used in HASD&IC 2022 CHNA Prioritization Process

Data Used in Prioritization Process	
Quantitative Data	**Qualitative Data**
• Data and analysis from HHSA, Public Health Services including Community Health Statistics, Health Equity Dashboards, Morbidity & Mortality Data • Analysis of secondary data, health conditions and SDOH • County of San Diego leading causes of death 2019 data • Hospital discharge trend data retrieved from HCAI limited data sets, 2017-2019 SpeedTrack©	• Community guidance from CHNA planning interviews • Community engagement findings from focus groups • Community engagement findings from key informant interviews • Community engagement findings from interviews and focus groups with promotoras and CHWs • 2022 CHNA online community survey

The 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.

SCHHC 2022 CHNA

As the HASD&IC 2022 CHNA process included robust representation from the communities served by SCHHC, this prioritization process was replicated for the SCHHC 2022 CHNA. Findings from the SCHHC 2022 CHNA prioritization process and analysis of identified health and equity needs are summarized in **Section 5: Findings**.

2022 CHNA Data Limitations and Information Gaps

Limitations of the 2022 CHNA processes for both SCHHC and the collaborative HASD&IC CHNA effort are discussed here to potentially benefit future CHNA processes and reports.

Conducting a CHNA during a pandemic brought challenges to both planning and implementation. Community partners no longer met in person and new strategies were needed to maintain connections with residents and CBOs. In addition, the needs of the community evolved from the initial shutdown in March 2020 to when CHNA community engagement activities occurred in late 2021 and early 2022. Every effort was made to capture current sentiment even as the needs of the community changed. Although the intensity of certain needs may have varied over time, the key findings remained clear and consistent throughout the community engagement efforts.

As with any CHNA process, the data available for use are limited. Much of the quantitative data included in both the HASD&IC and SCHHC 2022 CHNA processes were based on several different sources at the state and county level, often over different time periods that were not current to 2022. For example, at the time the report was created, the most recent period available for HCAI hospital discharge data was 2020, while the most recent statistics from the County's Community Health Statistics Unit were from 2019. More current data from these sources (2021 and 2020, respectively) will not be available until later in 2022.

Qualitative data collected for the CHNA also has limitations. The HASD&IC 2022 CHNA process included approximately 840 participants in its community engagement processes, while the SCHHC 2022 CHNA process engaged nearly 730 participants, including over 600 residents/patients. Every effort was made to obtain community input from the 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. Population and disease-specific key informant interviews also presented limitations in that they may not have captured all of the challenges faced by the groups represented. Further, most respondents of the Sharp Insight Community Survey were female, age 55 or older, and white/Caucasian. Panel demographics for this particular survey likely

resulted in responses that were not fully representative of the diverse populations that reside in SDC.

In addition, limitations existed related to the distribution and collection of the HASD&IC 2022 CHNA electronic community engagement surveys. These were distributed through those CBOs who were able to share the survey with their clients, as these partners had access to direct contact information. The response from community residents to the survey was low due to a limited pool of contact information. In addition, while there was representation from all regions and ethnicities based on the participants who completed these surveys, smaller sample sizes among certain groups may limit its generalizability to subsections of the population

Further, the design of the community engagement surveys for Sharp's 2022 CHNA provided limited opportunity for feedback on certain needs that were identified through the collaborative HASD&IC 2022 CHNA. As a result, findings on these needs are only described in this report based on participant feedback from the HASD&IC 2022 CHNA.

Section

4 Community Defined

The primary communities served by Sharp Coronado Hospital and Healthcare Center (SCHHC) include the City of Coronado, Downtown San Diego and Imperial Beach, an incorporated city. See **Table 9** and **Figure 9** for a list and map of where the majority of SCHHC patients reside. For a map of community and region boundaries in San Diego County (SDC) overall, please refer to **Appendix K**.

Table 9: Primary Communities Served by SCHHC[2]

ZIP Code	Community
91910	Chula Vista
91911	Chula Vista
91913	Chula Vista - Eastlake
91932	Imperial Beach
91950	National City
92021	El Cajon
92101	Downtown
92102	East San Diego
92113	Southeast San Diego
92114	Encanto
92118	Coronado
92154	Otay Mesa
92173	San Ysidro

Figure 9: Map of SCHHC's Primary Communities[12]

The primary communities served by SCHHC include ZIP codes that span multiple regions in SDC. Feedback on community health needs was solicited from both community members and service providers living and working throughout SDC to assess priority health issues for the community.

[12] Map created by Sharp HealthCare (Sharp) Strategic Planning Department (Feb. 2022).

Demographics[13]

In this section, SCHHC's community is defined not only by its demographic makeup but also by health equity[14] metrics known to contribute to health care access and health outcomes.

Wherever possible, the following descriptions will focus on primary communities served by SCHHC. However, where secondary data sources are not available at this level of specificity, broader summaries of SDC are provided.

In the next five years, SCHHC's service area population is projected to grow 2.1% while the county is expected to grow 1.8%. The two fastest growing ZIP codes in SCHHC's service area are San Ysidro (92173) and Chula Vista (91911), as shown in **Table 10**.[15]

Table 10: Fastest Growing ZIP Codes in SCHHC's Service Area, 2022-2027[15]

ZIP Code	Community Name	Population		2022-2027 Change
		2022	2027	
92173	San Ysidro	33,606	34,812	3.6%
91911	Chula Vista	94,335	97,602	3.5%
92154	Otay Mesa	89,504	92,286	3.1%
91910	Chula Vista	84,674	87,305	3.1%
91950	National City	66,869	68,855	3.0%

SDC is organized into six regions extending 4,205 square miles from the southern borders of Orange and Riverside counties to the border between Mexico and the U.S. With a population of more than 3 million people, San Diego is the second largest county in California and the fifth-most populous in the U.S. The region includes 18 incorporated cities and expansive unincorporated areas. The population is predominately white (45.6%), Hispanic or Latino[16] (33.7%) and Asian/Pacific Islander (API)[17] (11.6%).[18,19]

In 2022, there were 203,089 residents ages 65 and older in SCHHC's service area, representing 14.8% of its population. Between 2022 and 2027, the service area's senior population is projected to grow 14.7%.[15]

[13] Portions of this section were sourced from the Hospital Association of San Diego and Imperial Counties 2022 Community Health Needs Assessment (HASD&IC 2022 CHNA). Primary sources used by HASD&IC to develop this material are cited throughout.
[14] According to the World Health Organization (WHO), equity is the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other dimensions of inequality (e.g., sex, gender, ethnicity, disability or sexual orientation). Health is a fundamental human right. Health equity is achieved when everyone can attain their full potential for health and well-being (WHO, 2022).
[15] Speedtrack, Inc.; U.S. Census Bureau.
[16] Latino includes individuals and communities from Mexico, Central and South America and the Caribbean.
[17] Asian/Pacific Islander, API or AAPI, refers to people from East Asia, Southeast Asia, the Indian Subcontinent, Hawaii, Samoa, Guam, Fiji and other South Pacific Islands or to describe people of Asian/Pacific Islander descent.
[18] Unfortunately, because of how Census data are collected, we do not clearly understand how many San Diegans are Middle Eastern, African or Southeast Asian. This information is critical to understanding the needs of San Diego's diverse communities.
[19] County of San Diego HHSA, PHS, CHSU (2021), *Demographic Profiles, 2019;* U.S. Census Bureau, *American Community Survey 2015-2019*.

In 2019, the majority of households in SDC (62.4%) reported that the primary language spoken at home was English only. Among households who reported speaking English "less than very well," 8.6% primarily spoke Spanish, 3.4% primarily spoke an API language and 1.7% spoke another language. As of 2019, 12.6% of SDC's population age 25 and older had no high school diploma (or equivalency).[19] Please see **Table 11** and **Figure 10** for more SDC demographic data.

Table 11: SDC Demographics, 2019[19]

Age	#	%
0 to 4 Years	209,680	6.3%
5 to 14 Years	395,673	11.9%
15 to 24 Years	464,149	14.0%
25 to 44 Years	987,139	29.8%
45 to 64 Years	805,343	24.3%
65+ Years	454,089	13.7%

Race/Ethnicity	#	%
White	1,510,756	45.6%
Hispanic	1,117,517	33.7%
Black	156,084	4.7%
API	398,404	12.0%
American Indian/Alaska Native	12,474	0.4%
Other	6,560	0.2%
Two or More Races	114,278	3.4%

Gender	#	%
Male	1,669,515	50.3%
Female	1,646,558	49.7%

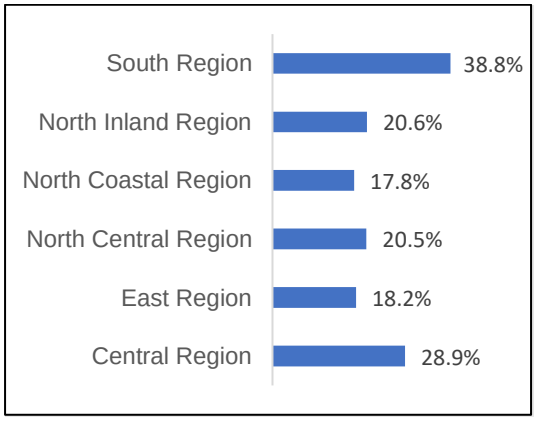
Education	%
< High School Graduate	12.6%
High School Graduate	18.2%
Some College or Associate of Arts Degree	30.4%
Bachelor Degree	23.8%
Graduate Degree	15.0%

Primary Language Spoken at Home	%
English Only	62.4%
Spanish and English "Less Than Very Well"	8.6%
API Language and English "Less Than Very Well"	3.4%
Other Language and English "Less Than Very Well"	1.7%

Percent Below Poverty Level	%
Population	11.6%
Families	7.8%
Families with Children	11.6%

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

Figure 10: Percent of Population Who Speak a Non-English Language at Home – SDC HHSA Region[19]



SDC is home to 18 Native American reservations represented by 17 tribal governments — the most in any U.S. county. An estimated 20,000 Native Americans reside in SDC, with only a small percentage living on reservation land.[20]

According to the 2020 Census, foreign-born individuals make up nearly a quarter (23%) of SDC's population.[21] California has the largest share of children in immigrant families nationwide (46%) and just 5% of California children are foreign-born.[22] Currently, 87% of SDC's foreign-born population comes from countries in Latin America (44%) and Asia (43%).[23] SDC's immigrant population has shifted over the past five years, with the fastest-growing population coming from five Middle Eastern and African countries, including Kenya, Iraq, Nigeria, Sudan and Syria.[24] Fear persists among these foreign-born communities amid xenophobia and anti-immigrant political rhetoric.[25]

For nearly a decade, no county in California has received more refugees than SDC, according to state and federal data. Many refugees are assigned to San Diego because of the presence of four resettlement agencies and the existence of multiple established immigrant communities in the area. Of the new refugees that arrived in California between 2009 and 2017, 40% resettled in SDC. In 2021 alone, more than 3,700 refugees arrived in SDC.[26]

The COVID-19 pandemic has disproportionately impacted immigrants, refugees and other communities of color in terms of lives lost, hospitalizations, rate of illness and economics.[27] A study by University of California, San Diego found that, in the city of San Diego, immigrants accounted for one-third of essential workers in the health care and food/agriculture industries.[24] During the pandemic's peak, the Partnership for the Advancement of New Americans found that 65% of refugees in SDC lived in overcrowded homes and many experienced an increase in food insecurity,[28] job loss, household violence and issues related to school closures.[25]

In February and March 2021, the number of unaccompanied child migrants referred to the federal Office of Refugee Resettlement exceeded the agency's shelter capacity, leading to serious backups and overcrowding at U.S. Customs and Border Protection facilities.[29] For this reason, San Diego provided emergency shelter for more

[20] San Diego Association of Governments (SANDAG), *Tribal Governments*.
[21] Foreign-born refers to anyone who is not a U.S. citizen at birth, including persons who have become U.S. citizens through naturalization.
[22] The Annie E. Casey Foundation (2020), Kids Count Data Center.
[23] San Diego Refugee Communities Coalition (2020), *COVID-19 Refugee Community Impact Report*.
[24] U.S. Immigration Policy Center at University of California San Diego (2020), *Immigration Integration in the City of San Diego*.
[25] Partnership for the Advancement of New Americans (2021), *Refugee Experiences Report*.
[26] California Department of Social Services – Refugee Programs Bureau, *Refugee Arrivals into California Counties, fiscal year 2021*.
[27] San Diego Refugee Communities Coalition (2020), *COVID-19 Refugee Community Impact Report;* SDSU and CommuniVax Coalition (2021)*, Addressing COVID-19 Vaccination Equity and Recovery Among the Hispanic/Latino Population in the Southern California Border Region*.
[28] Food security means access by all people at all times to enough food for an active, healthy life. https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/
[29] Migration Policy Institute (2021), *Hampered by the Pandemic Unaccompanied Child Arrivals Increase*.

than 3,200 unaccompanied children, primarily girls ages 13 to 17.[30, 31]

SDC has seven military bases and the largest global concentration of U.S. military personnel. There are over 143,000 active-duty personnel in SDC — a figure that is expected to increase to over 160,000 by 2025. Veterans account for nearly 1 in 10 adults (240,000) in SDC.[32] Veterans have a unique source of health care available through the U.S. Department of Veterans Affairs; however, it is not universally available to all veterans and their families and many who qualify do not apply. In recent years, the number of uninsured veterans has continued to decline, though a number of veterans remain uninsured.[33] The Department of Defense faces significant challenges ensuring that all members of the military and their families receive proper health care for everything from general health and well-being to specialized clinical care for deployment-related conditions.[34]

There are approximately two dozen post-secondary educational institutions in SDC, which enroll students from throughout San Diego, California, the U.S. and the world. Like non-local college students, most military families live in SDC for a limited time. Military families relocate 10 times more often than civilian families, moving every two to three years on average.[35]

The significant presence of college students and military-connected individuals and families means that a substantial portion of SDC's population resides in the area for less than five years. These populations share challenges similar to other San Diegans, including social isolation, lack of affordable housing, food insecurity and lack of childcare. Nationally, Blue Star Families found that only 23% of active-duty family respondents had access to appropriate childcare, and 14% of enlisted respondents were food insecure.[36] In 2019, more than half of California community college students reported difficulty affording balanced meals or concerns about running out of food, and nearly 1 in 5 were experiencing homelessness or lacked a stable place to live.[37]

Another transitional population in SDC are farmworkers. The National Center for Farmworker Health (NCFH) reports that there are over 14,200 agricultural workers in the county, many of whom are migratory or seasonal.[38,39] Migratory families in SDC include an estimated 4,000 children and youth.[40] NCFH also reports that agricultural workers suffer higher rates of infectious disease, tuberculosis, parasitic infection and diarrhea than the general population. Occupational hazards are also attributed to higher

[30] Unaccompanied children are under 18 years of age, have no legal immigration status and arrive in the U.S. without a parent or legal guardian to provide care and custody. Most of these children come from Central America. These children are especially vulnerable to trafficking and criminal predation.
[31] San Diego Union-Tribune (2021).
[32] San Diego Military Advisory Council (2019), *San Diego Military Economic Impact Study*.
[33] U.S. Census Bureau (2017), *Health Insurance Coverage of Veterans*.
[34] The RAND Corporation, *The Military and Health Care.*
[35] The Soldier Project (2022), *How Often Do Military Families Move?*
[36] Blue Star Families, *2020 Military Family Lifestyle Survey Comprehensive Report*.
[37] California Community Colleges (2019), *#RealCollege Survey*.
[38] Migratory workers and their families use temporary housing as they follow the different crop harvests, while seasonal workers live locally but may experience changes in their tasks, hours or income at work.
[39] National Center for Farmworker Health (NCFH), *Tableau Agricultural Worker Estimates 2017.*
[40] San Diego County Office of Education (2022).

instances of respiratory issues, which are often caused by exposure to fungi, dust and pesticides.[41]

Geography[13]

According to San Diego Association of Governments (SANDAG), over three-quarters (76%) of SDC's land is rural and the remainder is urban. The majority of county residents live in metropolitan San Diego. While urban and rural communities face many of the same challenges — including food insecurity and affordable housing — individuals in rural communities may have fewer resources available or may need to travel greater distances to access them. Access to reliable internet is a unique challenge in rural areas. Less than half of SDC's rural population has fixed internet compared to 97% of residents in urban areas.[42]

The California-Mexico border region includes San Diego and Imperial counties and northern Baja California, Mexico. The transnational region is home to more than 7 million people. The San Diego Workforce Partnership estimates that more than 90 million people cross the border each year, making it the busiest land-border crossing in the world. Over 10,000 students and nearly 50,000 workers live on one side of the border and go to work or school on the other.[43] For many San Diegans, Mexico's border cities provide access to affordable medical and dental care, as well as housing. As a place where many people with varying cultural, economic and political characteristics interact, the border region is particularly vulnerable to the spread of infectious diseases. Controlling infectious diseases in the border region requires international collaboration and communication.[44]

San Diego and Imperial counties are Southern Border Counties (SBC) sharing the U.S.-Mexico border. Although geographically close, their differences present unique challenges and opportunities. For this reason, several independent civic and government entities from each county work closely together, including the workforce development boards and metropolitan planning organizations. In addition, there are nonprofit and philanthropic associations that serve the entire SBC region. Hospitals collaborate daily with patients traveling through the geographically dispersed rural Mountain Empire communities at or near the county line. Cross-county collaboration has been especially critical for coordinating a regional public health response and managing surges throughout the COVID-19 pandemic.

Economic Characteristics[13]

According to the San Diego Regional Economic Development Corporation (SDREDC), small businesses (those with fewer than 100 employees) represent more than 98% of

[41] NCFH (2020), *A Profile of Migrant Health*.
[42] SANDAG (2020), *San Diego Forward: Vision for the 2021 Regional Plan*.
[43] San Diego Workforce Partnership (2022), *Border Relations of the CaliBaja Region & Impacts on our Economy*.
[44] Centers for Disease Control & Prevention (2018), *Workshop Summary: Infectious Disease Prioritization for Multijurisdictional Engagement at the United States Southern Border Region;* Binational Border Health (2019), *Border Health Status Report to the Legislature*.

all firms in SDC and 60% of the region's total employment. Because they are often less financially stable than larger organizations, small business wages are 14% lower than the average.[45] In addition, small businesses often provide fewer benefits and limited career mobility to their employees. The COVID-19 pandemic resulted in the closure of 1 in 3 small businesses across the county. In July 2020, SANDAG reported that the pandemic had negatively impacted 9 in 10 small businesses.[42]

Cost of Living Barriers

SDREDC reports that it is 47% more expensive to live in SDC than the average U.S. metro area, and the area's median home price is the fifth-highest nationwide.[45] Just 39% of San Diegans earn wages that can keep up with the region's rapidly rising cost of living.[46] When housing costs are considered, SDC's overall poverty rate rises from 13% to 20%.[47] Adding to this burden, just 7% of low-income residents have access to fast and frequent transit services. The median transit travel time is 51 minutes — double the average commute time for people who drive to work.[42]

In 2019, 11.6% of the SDC population reported living below 100% of the federal poverty level (FPL). The county's unemployment rate was 5.7% (see **Table 12** for details). In addition, in 2019, 5% of households in SDC received Supplemental Security Income.[19]

Table 12: Unemployment Estimates for SDC, 2019[19]

Eligible Labor Force	
16+ Years	2,671,935
Percent Unemployed	5.7%

According to data from the San Diego Hunger Coalition, the COVID-19 pandemic and economic crisis both increased the strain on existing nutrition insecure populations and increased the number of individuals experiencing nutrition insecurity,[48] many of whom experienced nutrition insecurity for the first time. In 2019, approximately one-quarter of people in SDC were nutrition insecure. Due to the COVID-19 pandemic, the percent of SDC's population experiencing nutrition insecurity increased to a peak of 39% (1.3 million people) in April 2020, then leveled off to 30% (1 million people) in November 2020. As of June 2021, nutrition insecurity continued to affect nearly 1 in 3 SDC residents.[49]

[45] San Diego Regional Economic Development Corporation (2022), *Inclusive Growth Initiative*.
[46] Circulate San Diego (2021), *Community Voices: Community Input to the 2020-2021 Community Action Partnership Needs Assessment*.
[47] California Housing Partnership Corporation (2018), *San Diego County's Housing Emergency & Proposed Solutions*.
[48] Nutrition security means all Americans have consistent access to the safe, healthy, affordable foods essential to optimal health and well-being. Nutrition security builds on food security by focusing on how the quality of our diets can help reduce diet-related diseases. It also emphasizes equity and tackling long-standing health disparities. https://www.usda.gov/nutrition-security.
[49] San Diego Hunger Coalition (2021), *Hunger Free San Diego Issue Brief: The State of Nutrition Security in San Diego County: Before, during and beyond the COVID-19 Crisis*.

Children and youth under the age of 18 make up nearly one-quarter of SDC's population, and nearly 1 in 6 children are living below 100% of the FPL.[50] See **Tables 13** and **14** for additional details about children and poverty in SDC.

Table 13: Number of Children in California and SDC, 2019[50]

Age	Number of Children in California	Number of Children in San Diego
0 to 4 Years	2,370,733	203,638
5 to 17 Years	6,519,517	510,764
Total	8,890,250	714,403

Table 14: Percent of Children & Youth Living Below 100% of FPL in SDC, 2019[19]

Age	Percent
0 to 5 Years	14.7%
6 to 11 Years	14.8%
12 to 17 Years	14.5%
18 to 24 Years	19.9%

In 2019, 7.1% of households in SDC received Supplemental Nutrition Assistance Program (SNAP) benefits, while 16.5% of households were below the eligibility threshold of 130% of the FPL.[19] Please refer to **Table 15** for SNAP participation and eligibility in SDC.

Table 15: Food Stamps/SNAP Benefit Participation and Eligibility Estimates in SDC, 2019[19]

Food Stamps/SNAP Benefits	Percent of Population
Households	7.1%
Families with Children	13.1%
Eligibility by FPL	
Population ≤130% FPL	16.5%
Population ≤138% FPL	17.8%
Population 139% - 350% FPL	31.2%

In 2019, 42.6% of the population in SDC spent 30% or more of their monthly household income on housing costs.[19] Further, in 2018, SDC's lowest-income renters spent almost 70% of their income on rent, leaving little for food, health care, childcare, transportation and other essentials.[51] See **Table 16** for additional details on monthly housing costs in SDC.

[50] U.S. Census Bureau, *2019 American Community Survey one-year estimates.*
[51] California Housing Partnership Corporation (2018), *San Diego County's Housing Emergency & Proposed Solutions*.

Table 16: Monthly Housing Costs in SDC, 2019[19]

Monthly Income Going to Housing Costs	Percent of Population
Less than 20% per Month	31.4%
20% to 29% per Month	23.7%
30% or more per Month	42.6%

Health Insurance/Access Barriers

In SDC in 2019, 96.2% of children ages 18 and under, 87.6% of young adults ages 19 to 25, 87.5% of adults ages 26 to 44, 91.7% of adults ages 45 to 64 and 98.8% of seniors ages 65 and older had health insurance.[19] Health insurance coverage for each age group was lower than the Healthy People 2030 (HP2030) national target of 92.1% health insurance coverage for all individuals under age 65, with the exception of children ages 0 to 18 years.[52] See **Table 17** for health insurance coverage in SDC in 2019.

Table 17: Health Insurance Coverage in SDC, 2019[19]

Description	Rate	HP2030 Target
Current Health Insurance Coverage		
Children 0 to 18 years	96.2%	92.1%
Young adults 19 to 25 years	87.6%	92.1%
Adults 26 to 44 years	87.5%	92.1%
Adults 45 to 64 years	91.7%	92.1%
Seniors 65+ years	98.8%	N/A[53]

According to the California Health Interview Survey (CHIS), in 2020, 17.4% of SDC's population was covered by Medi-Cal.[54] See **Table 18** for details.

Table 18: Medi-Cal (Medicaid) Coverage in SDC, 2020[54]

Description	Rate
Covered by Medi-Cal	17.4%
Not covered by Medi-Cal	82.6%

CHIS data also revealed that 12.9% of individuals in SDC did not have a usual place to go when sick or in need of health advice[54] (see **Table 19**). According to the Medical Board of California, in 2020, there were 62.4 primary care physicians per 100,000 SDC residents, and 15.1% of SDC's population resided in a Health Professional Shortage

[52] The U.S. Department of Health and Human Services' Healthy People 2030 (HP 2030) initiative represents the nation's prevention agenda for the third decade of the 21st century. HP2030 has four overarching goals: to attain healthy, thriving lives and well-being free of preventable disease, disability, injury and premature death; to achieve health equity, eliminate disparities and attain health literacy to improve the health and well-being of all; to create social, physical and economic environments that promote attaining the full potential for health and well-being for all; to promote healthy development, healthy behaviors and well-being across all life stages; and to engage leadership, key constituents and the public across multiple sectors to take action and design policies that improve health and well-being of all.
[53] HP2030 does not include targets for individuals age 65 and older.
[54] University of California Los Angeles Center for Health Policy Research (2022), *2020 California Health Interview Survey*.

Area.[55] In addition, SDC residents are served by 14 federally qualified health centers, which provide critical access to safety net services at more than 100 sites across the region.[56]

Table 19: Regular Source of Medical Care in SDC, 2020[54]

Regular Source of Medical Care	Rate	HP2030 Target
Has a usual source of care	87.1%	84.0%
Has no usual source of care	12.9%	16.0%

Cancer and diseases of the heart were the two leading causes of death in SDC in 2019.[57] See **Table 20** for a summary of leading causes of death in SDC.

Table 20: Leading Causes of Death in SDC, 2019[57]

Cause of Death	Number of Deaths	Percent of Total Deaths
Malignant Neoplasms (Overall Cancer)	5,018	22.9%
Diseases of the Heart	4,689	21.4%
Cerebrovascular Diseases	1,620	7.4%
Alzheimer's Disease	1,546	7.0%
Accidents/Unintentional Injuries	1,273	5.8%
Chronic Lower Respiratory Diseases	1,007	4.6%
Diabetes Mellitus[58]	760	3.5%
Essential Hypertension and Hypertensive Renal Disease	437	2.0%
Intentional Self-Harm (Suicide)	417	1.9%
Parkinson's Disease	381	1.7%
All Other Causes	4,792	21.8%
Total Deaths	**21,940**	**100.0%**

Identifying SCHHC's High-Need Areas

Identifying specific geographic areas with health inequities[59] is critical to understanding community health. SCHHC used a specific metric to determine communities within its service area that experience greater health inequities: the Dignity Health and IBM Watson Health Community Need Index (CNI). The CNI uses demographic and economic statistics to provide a "CNI score" for every populated ZIP code in the U.S.

[55] The Health Resources & Services Administration (HRSA) defines a *shortage designation* as an area, population, or facility experiencing a shortage of health care services. A type of HRSA is a *Health Professional Shortage Area* (*HPSA*). *HPSA* is defined as a geographic area, population group, or health care facility that has been designated by the HRSA as having a shortage of health professionals. HRSA (2021), *What is Shortage Destination?*

[56] California Health Care Foundation (2021), *San Diego: Competing, Collaborating, and Forging Ahead with Population Health*.

[57] County of San Diego HHSA, PHS, CHSU (2021), *Leading Causes of Death Workbook 2011-2019*.

[58] According to Mayo Clinic, diabetes mellitus refers to a group of diseases that affect how the body uses blood sugar (glucose). Chronic diabetes conditions include type 1 diabetes and type 2 diabetes. Type 1 diabetes is thought to be caused by a combination of genetic susceptibility and environmental factors and often appears during childhood or adolescence. Type 2 diabetes, the more common type, can develop at any age, though it's more common in people who are overweight or older than 40 (Mayo Clinic, 2022). Throughout this report, Sharp data relating to diabetes primarily refers to type 2.

[59] According to the WHO, health inequities are differences in health status or in the distribution of health resources between different population groups arising from the social conditions in which people are born, grow, live, work and age. These inequities have significant social and economic costs both to individuals and societies (WHO, 2018).

The CNI score is an average of the following five socio-economic barrier scores for each community:

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

CNI scores range from 1.0 to 5.0, with a score of 1.0 indicating a ZIP code with the least need/low health inequity (light blue in **Figures 11-15** below), and a score of 5.0 for a ZIP code with the most need/high health inequity (dark green in **Figures 11-15** below). For more information about the CNI, please see **Appendix L** or visit the interactive website at: http://cni.dignityhealth.org/.

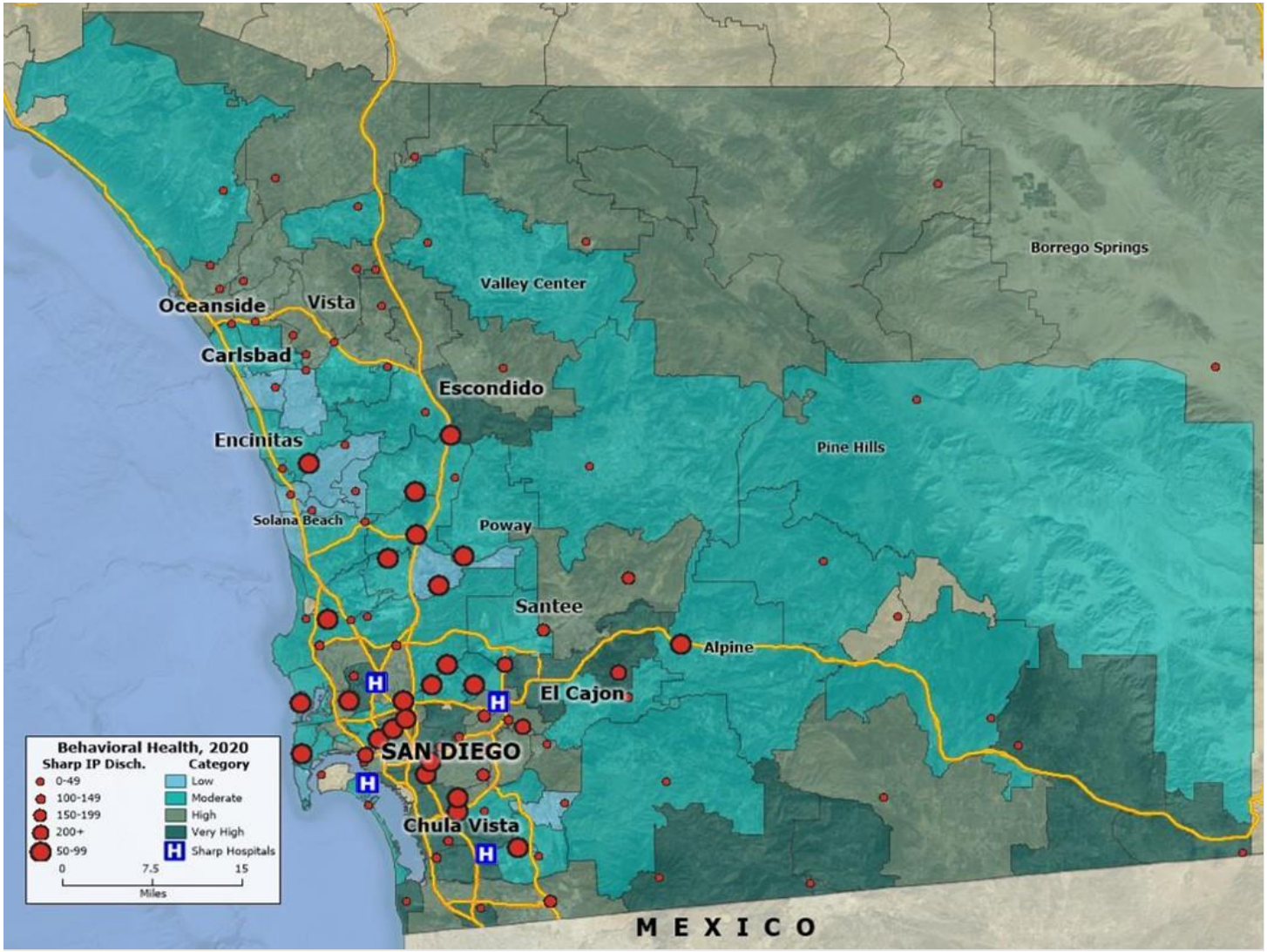
Table 21 presents primary communities (by ZIP code) served by SCHHC that have especially high need/health inequity based on their CNI score.

Table 21: High-Need Primary Communities Served by SCHHC, CNI Score > 4.0[3]

ZIP Code	Community
91910	Chula Vista
91911	Chula Vista
91932	Imperial Beach
91950	National City
92021	El Cajon
92101	Downtown San Diego
92102	East San Diego
92113	Southeast San Diego
92114	Encanto
92154	Otay Mesa
92173	San Ysidro

In addition, **Figures 11-15** present CNI maps for SDC — including many communities served by SCHHC — with Sharp hospital discharge data for behavioral health, cancer, cardiovascular health, COVID-19 and Type 2 diabetes overlaid on the map. The maps demonstrate that while these health conditions affect communities of varying need, those areas with the highest CNI score (i.e., the highest vulnerability) often present higher discharge rates for these health issues. Thus, the maps strongly suggest the connection between rates of illness and disease, health care use, socioeconomic factors and health equity.

Figure 11: Sharp Inpatient Behavioral Health Discharges CNI Map, SDC[60]



[60] Truven Health Analytics, 2021; Insurance Coverage Estimates, 2021; The Nielson Company, 2021; and Community Need Index, 2021; California Department of Health Care Access and Information via SpeedTrack©, Inc., 2020.

Figure 12: Sharp Inpatient Cancer Discharges CNI Map, SDC[60]

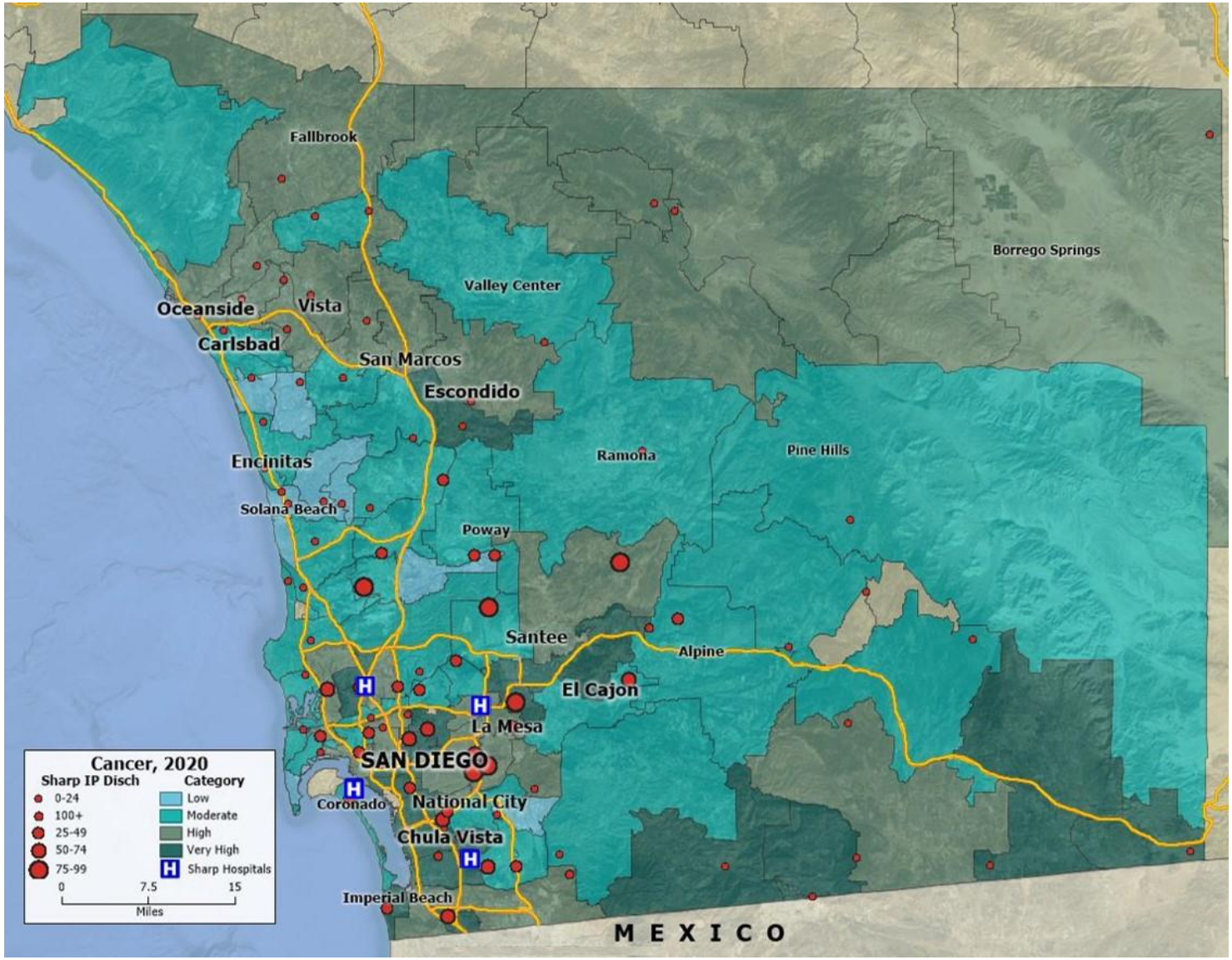


Figure 13: Sharp Inpatient Cardiovascular Discharges CNI Map, SDC[60]

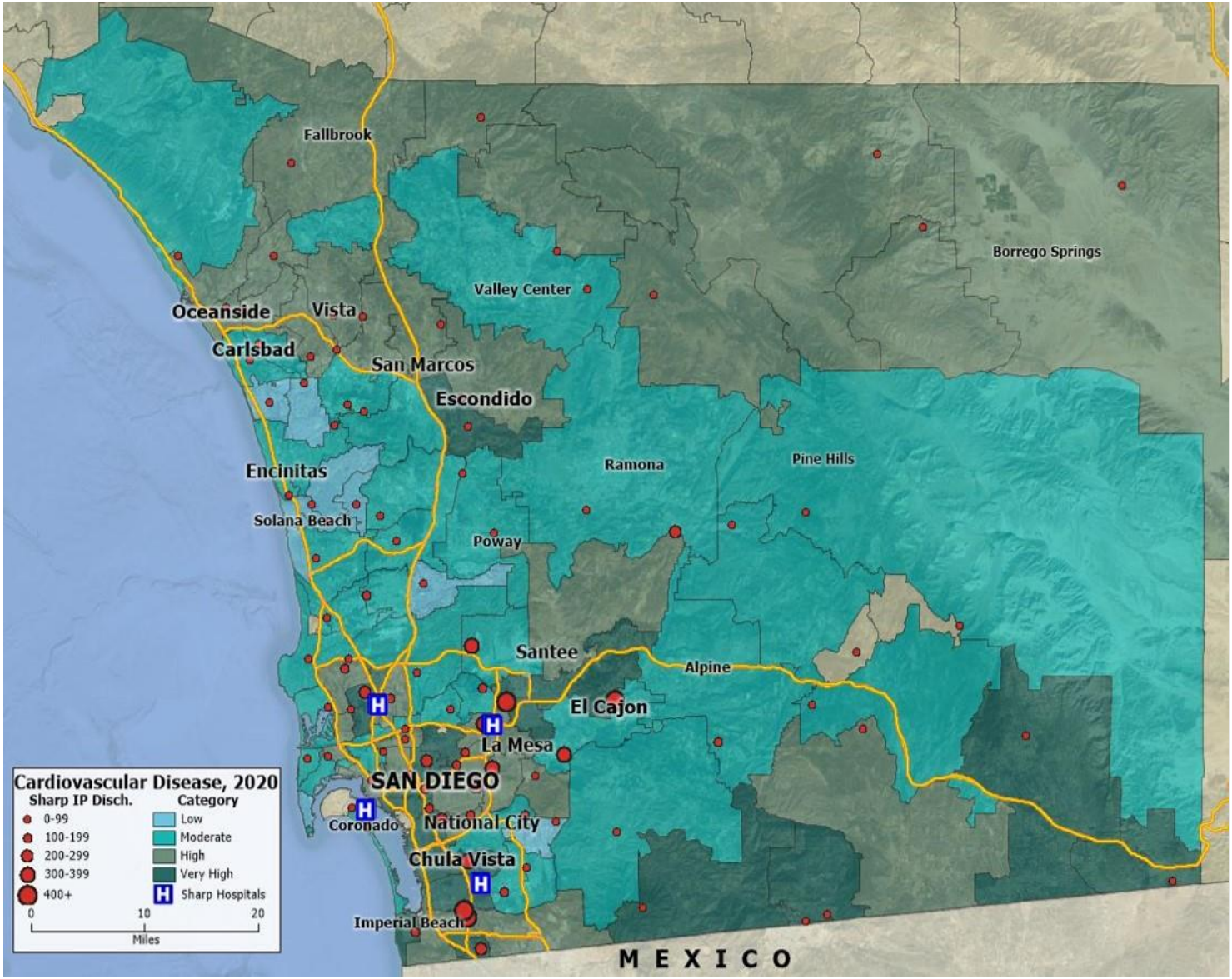


Figure 14: Sharp Inpatient COVID-19 Discharges CNI Map, SDC[60]

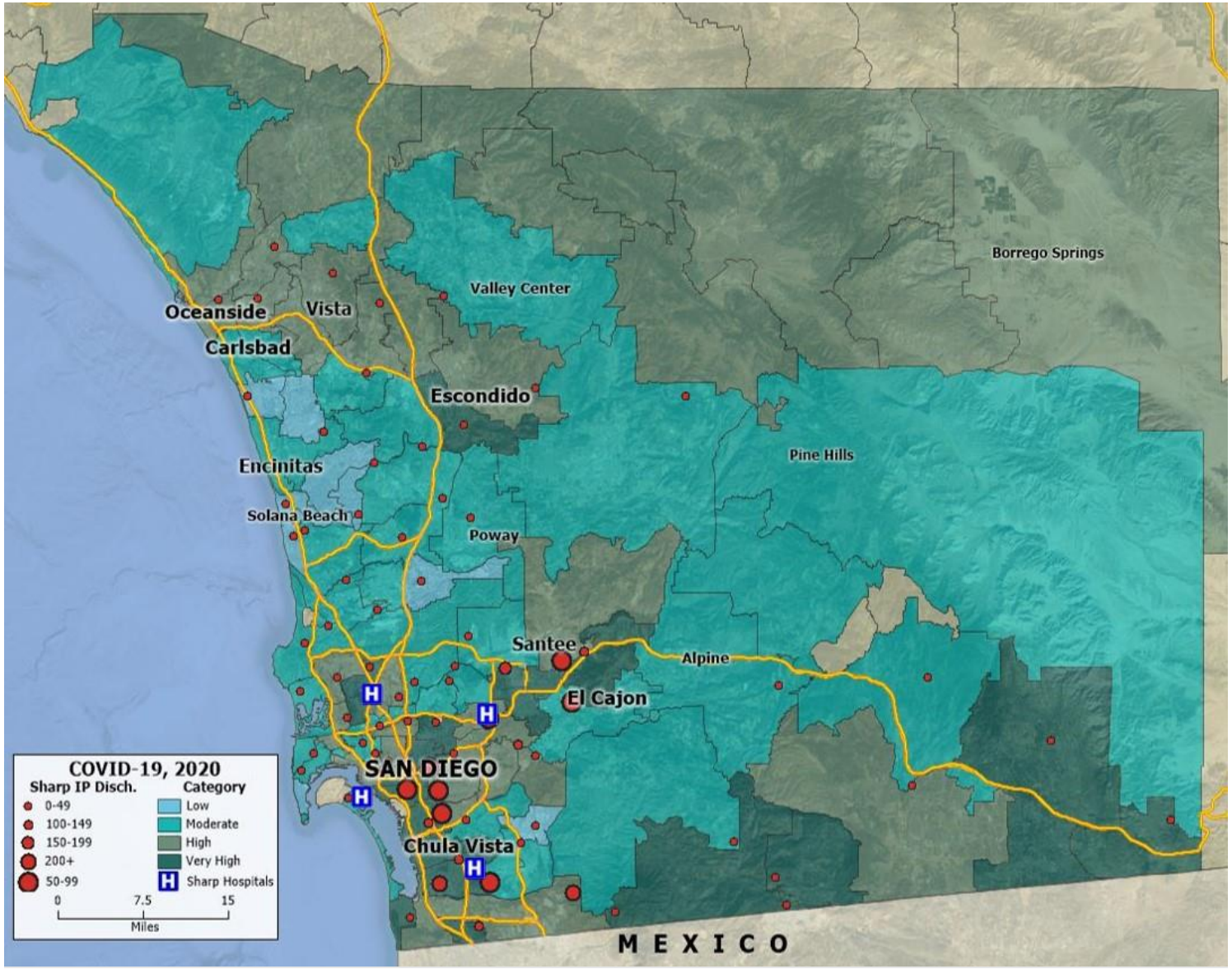
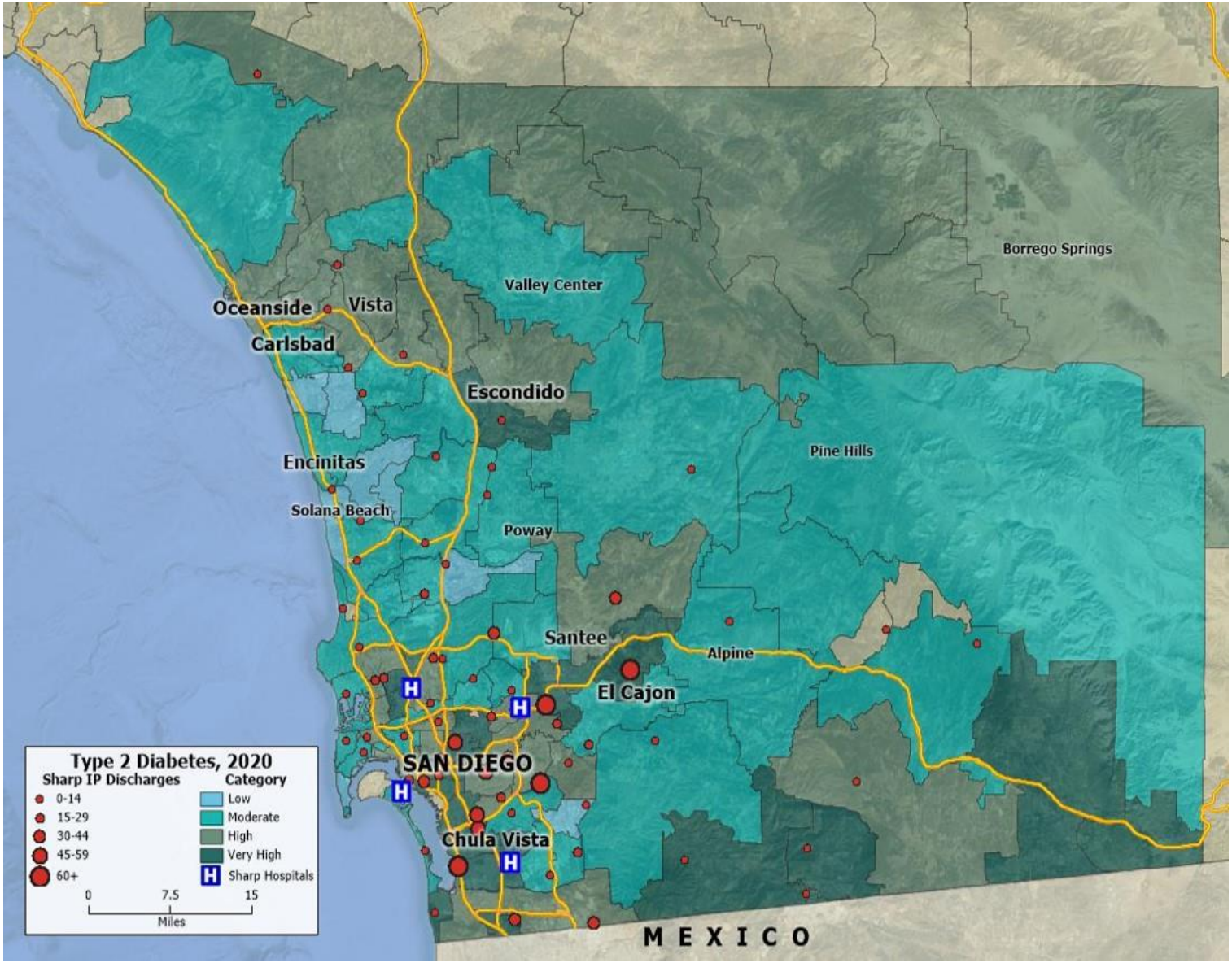


Figure 15: Sharp Inpatient Type 2 Diabetes Discharges CNI Map, SDC[60]



Section

5 Findings

This section presents the top community needs identified in the Sharp Coronado Hospital and Healthcare Center 2022 Community Health Needs Assessment (SCHHC 2022 CHNA) followed by a description of findings for each need. The Hospital Association of San Diego and Imperial Counties 2022 Community Health Needs Assessment (HASD&IC 2022 CHNA) process included strong representation of the community served by SCHHC and a significant portion of its findings reflect the same needs of community members served by the hospital. Therefore, relevant findings from the HASD&IC 2022 CHNA are also included.

2022 Top Community Needs

HASD&IC 2022 CHNA

The HASD&IC 2022 CHNA identified the following priority community needs for San Diego County (SDC) (listed in alphabetical order):

Figure 16: HASD&IC 2022 CHNA – Top Community Needs for SDC

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

Figure 16 above represents the top identified community needs, the foundational challenges, and the key underlying themes revealed through the HASD&IC 2022 CHNA process. The needs identified as the most critical for San Diegans are listed in the center of the circle in alphabetical — not ranked — order. The blue outer arrows of the circle represent the negative impact of two foundational challenges — health disparities and workforce shortages — which greatly exacerbated every identified

need at the center of the circle. The orange bars within the outer circle illustrate the underlying themes of stigma and trauma — the quiet yet insidious barriers that became more pervasive during the COVID-19 pandemic.

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

SCHHC 2022 CHNA

The SCHHC 2022 CHNA identified the same top community needs as the HASD&IC 2022 CHNA. The priority needs for the communities served by SCHHC are listed below in alphabetical order:

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

Description of Findings

The following pages provide a detailed description of the findings for each identified community need above. Please also see **Section 3: Methodology** for a description of the quantitative and qualitative data processes conducted for the HASD&IC and Sharp 2022 CHNAs as well as **Section 7: Recommendations & Next Steps** for additional discussion of the findings.

Access to Health Care

Overall Findings

Access to Health Care emerged as a high priority need in both the SCHHC and HASD&IC 2022 CHNAs. Access to Health Care findings most often relate to the issues listed below, spanning from general barriers to accessing care to disparities and challenges in accessing care for specific populations. The findings also highlight the exacerbation of these access to care issues caused by the COVID-19 pandemic for both community members and health care providers.

- *Overall barriers to care*
- *Telehealth*
- *Health literacy*
- *Transportation*
- *Health insurance and financial concerns*
- *Stigma*
- *LGBTQ+*
- *People experiencing homelessness*
- *Other populations (end-of-life, immigration status, parents/caregivers)*
- *Culturally competent and linguistically appropriate care*
- *Trauma-Informed Care (TIC)*
- *Workforce challenges*

Access to Health Care findings are described below for both the HASD&IC and SCHHC 2022 CHNAs.

HASD&IC 2022 CHNA

Overall Barriers to Care

Across HASD&IC's interviews and focus groups, there was universal acknowledgment that the pandemic caused widespread disruption to local health care systems in SDC. Factors identified as impacting the ability to access health care included postponed or canceled procedures, long wait times for appointments and the fear of COVID-19 exposure. Fear, specifically, caused some people to defer routine and medically necessary care.

Among online survey participants, 59% identified Access to Health Care as a top concern and 31% identified long waits for an appointment as the top challenge in accessing health care. According to HASD&IC's secondary data findings, among Californians who report skipping or postponing care in the prior 12 months, more than half (57%) cited the COVID-19 pandemic as the reason.[61]
In addition, community members expressed the importance of spending enough time and having meaningful conversations with their doctor to fully evaluate their health needs and listen to their concerns. Quick and less thorough doctor visits created challenges to receiving the comprehensive care patients were hoping for. Community members expressed the importance of building a relationship with a doctor who will listen and help them maintain health.

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

[61] California Health Care Foundation (CHCF) (2022), *The 2022 CHCF California Health Policy Survey*.

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

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

In HASD&IC's online community survey, respondents identified these services as hardest to access: behavioral health services, counseling or therapy, psychiatry, dental services and urgent care/after-hours care.

Referrals to see a specialist was commonly cited as a significant challenge. Community members reported long waits for services, treatments and procedures. Finding providers who can submit orders or make referrals can be time consuming. Many patients fall through the cracks, and some do not receive follow-up on their requests.

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

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

In-home services, dental care and providers trained in geriatric care were cited as needs for aging community members. Please see the **Aging Care & Support** findings for more information.

Telehealth[62]

Telehealth usage expanded rapidly during the pandemic to allow health care providers and patients to connect virtually in a safe manner. In 2021, more Californians reported

[62] The American Academy of Family Physicians (AAFP) defines *telemedicine* as the practice of medicine using technology to deliver remote clinical services. *Telehealth* refers broadly to electronic and telecommunications technologies and services used to provide care and services at a distance. It is different from telemedicine in that it refers to a broader scope of remote health care services than telemedicine (AAFP, 2022). The National Institute on Aging (NIA) notes *telehealth* can include non-clinical services, for example health-related education, such as diabetes management or nutrition courses and health-related training and that these types of care may be particularly helpful for older adults with limited mobility and for those living in rural areas (NIA, 2020).

using telehealth as their means of receiving care over the prior 12 months — over half (55%) by phone and 44% by video.[61]

HASD&IC's community engagement findings revealed that telehealth increased access to health care for some community members with existing barriers prior to the pandemic. The opportunity to connect virtually with a doctor was a convenient option for those with childcare responsibilities, or who lacked access to transportation. Some people preferred to receive care in the comfort of their own home.

However, telehealth was not easily accessible for the entire community. The most frequently cited barriers were a lack of access to technology or the internet. Some community members reported being uncomfortable and uncertain about how to navigate the internet (lack of digital literacy) to access their medical records, labs or paperwork needed for appointments. Community-based organizations (CBOs) and health care providers had to come up with creative ways to ensure that people had access to telehealth. Community members shared that telehealth during the pandemic was not an optimal choice for certain groups of people, including those living in crowded households where there was little to no privacy; those with physical health needs that required in-person care and thorough screenings; and those lacking a phone or smart phone, including seniors and individuals experiencing homelessness.

Preliminary research on the use of telehealth during the pandemic is beginning to emerge. Key findings from HASD&IC's quantitative data analysis include:

- There were 52.7 million Medicare telehealth visits in 2020, a 63-fold increase compared to 2019. This report also found inequities: some Medicare beneficiaries, including Black and rural populations, used telehealth less frequently than their white and urban counterparts.[63]
- A majority (57%) of providers viewed telehealth more favorably than before COVID-19, and 64% are now more comfortable using it.[64]
- Remote care reduces the use of resources in health centers, improves access to care while minimizing the risk of direct transmission of an infectious agent from person-to-person, and provides wider access to caregivers.[65]
- Implementation and continued access are heavily dependent upon accreditation, payment systems and insurance coverage.[65]

Health Literacy

HASD&IC's community engagement efforts revealed health literacy[66] as a fundamental barrier in all aspects of accessing care — from the point of applying for health coverage

[63] Seshamani, M. (2022). *Medicare and telehealth: Delivering on innovation's promise for equity, quality, access, and sustainability. Health Affairs, 41*(5). https://doi.org/10.1377/hlthaff.2022.00323
[64] American Hospital Association (AHA) (2022), *A Fresh Perspective on Where Telehealth Growth Will Settle.*
[65] Monaghesh, E., & Hajizadeh, A. (2020). The role of telehealth during COVID-19 outbreak: A systematic review based on current evidence. *BMC Public Health, 20*(1), 1193. https://doi.org/10.1186/s12889-020-09301-4
[66] Healthy People 2030 (HP 2030) provides definitions for both personal health literacy and organizational health literacy. Personal health literacy - the degree to which individuals can find, understand, and use information and services to inform health-related

to navigating care and maintaining health. There was a need for more education to help people understand basic health information. For example, more education on preventive health care, healthy lifestyles, and understanding the differences between sources of care (e.g., when to use urgent care vs. the emergency room).

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

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

Navigating the health care system was identified as an increasingly challenging and stressful task. Specific challenges included people not understanding their health insurance benefits, not knowing whom to call to access services, and identifying where to get care. Getting a hold of one's own health care provider or insurance company was extremely difficult. Populations who were identified as having significant challenges were people who speak little to no English, people experiencing homelessness and justice-involved[67] individuals. Interviewees from CBOs shared that there is a significant need for justice-involved individuals to be guided and connected to critically necessary health care services and resources after being released from an institution. English speaking people and community members who identified as being highly educated also described the health care system as being very difficult to navigate.

SDC is a diverse region, and community members speak a variety of languages. While the majority of the county's population age 5 and older speaks only English at home (62.4%), many people speak a non-English language at home as well.[19] For additional information on languages spoken in SDC, see **Section 4: Community Defined**.

A study of refugee communities in SDC representing over 1,400 residents of East African, Middle Eastern, Central and South Asian, and Haitian backgrounds noted that during the COVID-19 pandemic, having no or limited English proficiency (LEP) negatively affected information access. This was reported as an overall sense of

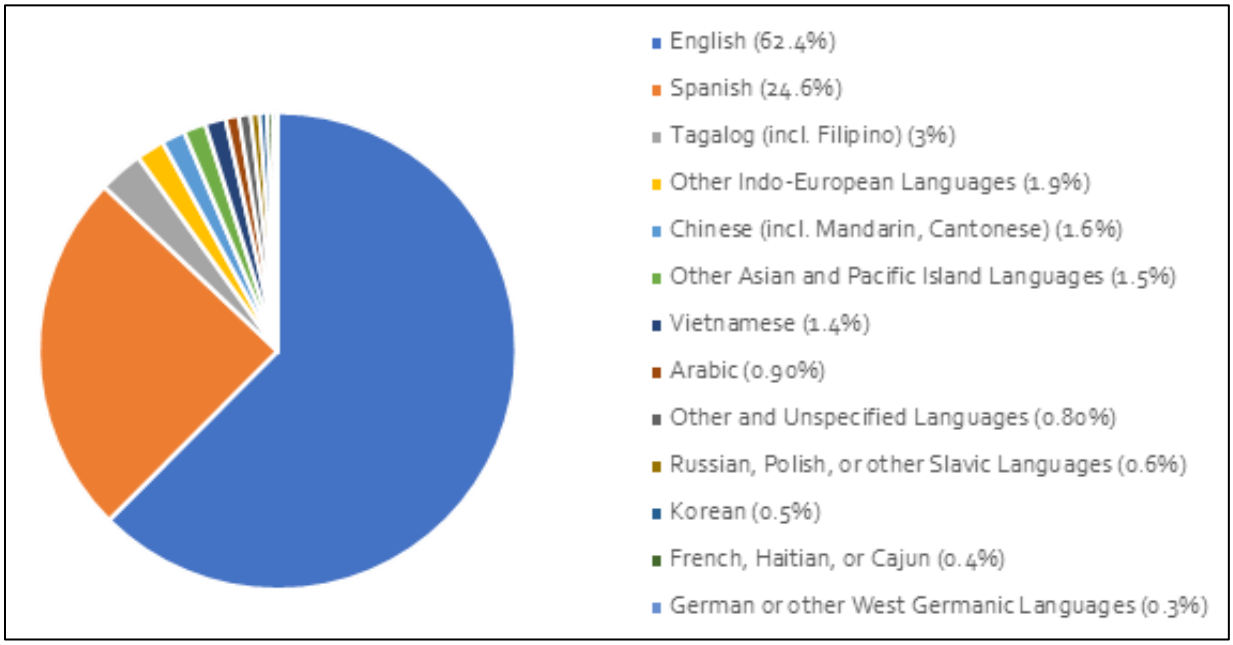
decisions and actions for themselves and others. Organizational health literacy is the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others (HP 2030, 2022) Further, according to Centers for Disease Control and Prevention (CDC), individuals who read well and are comfortable using numbers can face health literacy issues when they aren't familiar with medical terms or how their bodies function; they must interpret statistics and evaluate risks and benefits that affect their health and safety; they are diagnosed with a serious illness and are scared or confused; or they have health conditions that require complicated self-care (CDC, 2020).

[67] This descriptor indicates past or current involvement in the criminal justice system, typically indicating the person has experienced one or more of the following: an arrest, prosecution, incarceration in a jail or prison, and/or community supervision (Substance Abuse and Mental Health Services Administration [SAMHSA], 2019).

confusion due to language barriers and lack of coordinated information delivered in multiple languages and dialects.[23]

Countywide data is included in **Figure 17** below.[19] This highlights the importance of multilingual health educational materials and providers to increase health literacy and equity. The State of California Department of Healthcare Services requires all Medi-Cal managed care plans to provide written member information translated into languages that meet a numeric threshold of 3,000 or 5% of the eligible beneficiary population, whichever is lower.[68]

Figure 17: Languages Spoken at Home in SDC[19]



Transportation

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

[68] State of California Health and Human Services Agency Department of Health Care Services (2022), *Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services*.

Health Insurance and Financial Concerns

Throughout HASD&IC's community engagement activities, lack of insurance was identified as a significant barrier to care for San Diegans. Some uninsured community members described being unable to pay for health insurance because they have other competing financial priorities, such as housing costs.

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

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

LGBTQ+ community members also shared that lack of insurance is a common barrier for health. However, even with insurance, they often face challenges getting the care they need.

According to HASD&IC's secondary data collection, 1 in 4 Californians (25%) say they or someone in their family had problems paying at least one medical bill in the past 12 months, an increase from 20% in the 2021 survey. Forty-three percent of lower income Californians report having issues paying for medical bills, compared to 32% in 2021.[61]

Both the high cost of health care and medical debt were frequently identified by HASD&IC community engagement participants as severe obstacles to health care access. Due to high health care costs, many community members delay seeking care or cross the border to get more affordable health care services (including dental and vision) in Mexico. However, when the border closed due to the pandemic, people were unable to travel to Mexico for health care.

Participants also shared that fear of medical debt was causing people to delay getting treatment because they are already struggling to pay their bills. Community members shared that either they personally, or family or friends, have medical debt following a hospital stay. As a result, they worried about seeking emergency care at local hospitals.

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

Stigma[69]

Stigma was also identified as a significant barrier to accessing care, particularly for LGTBQ+ community members, people experiencing homelessness, older adults and undocumented or refugee communities. Community members shared feelings of anxiety or fear, and a likelihood of avoiding or delaying care due to concerns of being treated differently. Community members insured through the Medi-Cal program also experience stigma while accessing care. Additional findings on stigma as a barrier to accessing health care are included below for select populations.

LGBTQ+

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

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

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

LGBTQ+ people experience health disparities and require care and services tailored to their unique needs.[70] The process of asking all patients about their sexual orientation and gender identity (SOGI) empowers health centers to get to know their patients better and to provide them with the culturally responsive, patient-centered services they need. SOGI data collection also allows health centers to learn about the populations they are serving, and to measure the access to care and quality of care provided to people of all sexual orientations and gender identities.[71]

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[69] Stigma can be generally defined as negative attitudes or beliefs towards another individual or group, which can result in shame, embarrassment or fear. Stigma referenced in this report could either be directly related to a COVID-19 diagnosis or vaccination status or unrelated (e.g., based on age, race/ethnicity, gender, etc.).

[70] Gonzales, G., Przedworski, J., & Henning-Smith, C. (2016) Comparison of health and health risk factors between lesbian, gay, and bisexual adults and heterosexual adults in the United States: Results from the National Health Interview Survey. *JAMA Internal Medicine*,*176*(9):1344-1351.; De Blok, C.J., Wiepjes, C.M., Van Velzen, D.M., et al. (2021). Mortality trends over five decades in adult transgender people receiving hormone treatment: A report from the Amsterdam cohort of gender dysphoria. *Lancet Diabetes Endocrinol*ogy, *9*(10), 663-670.; Branstrom, R., & Pachankis, J.E. (2018). Sexual orientation disparities in the co-occurrence of substance use and psychological distress: A national population-based study (2008-2015). *Social Psychiatry and Psychiatric Epidemiology*, *53*(4), 403-412.; Reisner, S.L., Poteat, T., Keatley, J., et al. (2016). Global health burden and needs of transgender populations: a review. *Lancet*,*388*(10042), 412-436.

[71] Cahill, S., & Makadon, H. (2014). Sexual orientation and gender identity data collection in clinical settings and in electronic health records: A key to ending LGBT health disparities. *LGBT Health*, *1*(1), 34-41.; The Joint Commission (2011), Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community: A Field Guide.

Interviewees shared that LGBTQ+ people experience stigma and discrimination at all touch points of the health care system, especially from health care providers who lack sensitivity. Additionally, current forms and practices were identified as non-inclusive. For example, new patient or intake forms only provide binary options (male or female), which excludes non-binary community members. People have also struggled with being acknowledged by their new affirmed name and are often deadnamed.[72] These negative experiences create an unwelcoming and unsafe environment and were identified by interviewees as reasons for avoiding or delaying medically necessary care.

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

Interviewees also shared that for those who are uninsured, access to medications like PrEP[73] or PeP[74] and necessary follow-up care is hindered by extreme costs. For those with insurance, out-of-pocket costs may be even higher, as many insurance companies do not cover these treatments. These high costs disproportionately impact BIPOC[75] LGBTQ+ individuals, who are more likely to be low-income.[76]

Intersectional stigma[77] also emerged as a barrier to accessing appropriate health care for LGBTQ+ individuals. Black transgender women face many challenges related to the convergence of race, gender identity and economic status in their lived experience. They are particularly vulnerable to health disparities, such as higher rates of HIV diagnoses. In 2019, the majority of new HIV diagnoses among transgender people were among Black or African American people: 45% for transgender women and 41% for transgender men.[78] Black transgender people also experience inequities related to unemployment, homelessness, household income level and attempted suicide.[79]

Further, LGBTQ+ people and people living with HIV are too often denied the care they need because of their sexual orientation, gender identity or HIV status. In a survey of

[72] Deadname refers to the name that a transgender person was given at birth and no longer uses upon transitioning. "Deadname." Merriam-Webster.com Dictionary, Merriam-Webster, https://www.merriam-webster.com/dictionary/deadname. Accessed 8 Jun. 2022.
[73] PrEP, also known as pre-exposure prophylaxis, refers to a medication that lowers a person's risk of contracting HIV and is extremely effective as a preventative. While on PrEP, a regimen must be followed consisting of follow-up visits, continuous HIV testing, and obtaining refills (CDC, 2022).
[74] PeP, also known as post-exposure prophylaxis, is similar to PrEP, except that it is taken when the patient believes they have been exposed to HIV. It must be taken within 3 days after the exposure, otherwise it is not effective.
[75] Black, indigenous and people of color.
[76] The Williams Institute (2019), *LGBT poverty in the United States: A study of differences between sexual orientation and gender identity groups*.
[77] Intersectional stigma occurs when an individual or group experience(s) multiple stigmas that both overlapping and co-constitutive. It denotes the synergistic effect produced by systems of oppression at the intersection of these stigmatized identities, behaviors and/or conditions on well-being and health (Abubakari et al, 2021).
[78] CDC (2021), *HIV Surveillance Report: Diagnoses of HIV Infection in the United States and Dependent Areas, 2019*.
[79] National Lesbian, Gay, Bisexual, Transgender, Queer Task Force (2009), *Injustice at Every Turn: A Look at Black Respondents in the National Transgender Discrimination Survey*.

LGBT people and people living with HIV on discrimination in health care, almost 8% of respondents reported that they had been denied needed health care outright. Over a quarter of transgender or gender-nonconforming respondents and 19% of respondents living with HIV reported being denied care.[80]

People Experiencing Homelessness

Those experiencing homelessness can face months-long wait lists for shelter beds. During these long wait times, many are pushed to use any resources available to them to survive until the following day. In some circumstances, this could mean a trip to the emergency room to obtain food, clothing or a safe place to sleep for the night. For those with a very limited income, emergency department (ED) visits tend to become more frequent toward the end of the month, as their financial resources dwindle.

Lack of housing and personal resources cause many people experiencing homelessness to access care for episodic, emergency situations. Interviewees frequently cited chronic health conditions, such as chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), chronic pain and diabetes as the most common reasons patients experiencing homelessness access health care in the ED. Another reason for accessing care in the ED was related to inconsistently taking or completely discontinuing medications. Please see the **Chronic Health Conditions** findings for more information.

There was agreement among HASD&IC's interviewees that having a safe place to stay after being discharged from the hospital is crucial to recovery and healing; without a stable place to stay, community members experiencing homelessness could undo any progress made during their hospitalization. Recuperative care (also known as medical respite care) was cited as a specific need for many patients experiencing homelessness who no longer need to be hospitalized but must still have a place to heal and recover from an illness or injury.

In addition to recuperative care, lack of post-acute care with housing and medication management for patients experiencing significant behavioral health concerns was mentioned as a need. This includes assisted living, board and care facilities and Full Services Partnership[81] programs. Please see the **Behavioral Health** findings for more information.

Interviewees shared that people experiencing homelessness often feel marginalized, socially excluded, and discriminated against by other community members, services and health care providers. This social exclusion, coupled with daily challenges in building or maintaining social connections with others, makes them fearful of

[80] Lambda Legal (2010*), When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People with HIV*.

[81] Full Service Partnership (FSP) is a comprehensive and intensive mental health program for adults with severe and persistent mental illness. FSP uses a "whatever it takes" field-based approach using innovative interventions to help people reach their recovery goals. FSP programs have a multi-disciplinary team consisting of clinicians, para-professionals, and consumers that provide a wealth of resources and support (Southern California Health and Rehabilitation Program, 2022).

experiencing further discrimination. Subsequently, many people experiencing homelessness feel uncomfortable, distressed or undeserving of help when they seek health care treatment or need help for safety reasons.

Access to home health devices was identified by interviewees as an existing need for patients experiencing homelessness that was worsened by the pandemic. Lack of a physical address and lack of a place to receive mail is one of the main barriers people experiencing homelessness face in securing home health. Though home health may be an appropriate post-discharge treatment option for certain patients experiencing homelessness, it can be challenging to provide necessary equipment, such as wheelchairs, walkers, canes or portable CPAP[82] machines.

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

Other Populations (End-of-Life, Immigration Status, Parents/Caregivers)

Despite the increased use of hospice and palliative care in recent decades, disparities in access to hospice care and end-of-life treatment persist.[83] Community members shared that it's difficult to find palliative care programs offering culturally diverse services. This is a particular challenge for community members who are LGBTQ+, veterans and people of color. The result is an increase in ED visits and hospitalizations in the last six months of life for these populations, compared to non-Hispanic white individuals, regardless of cause of death.[84]

In addition, across all interviews, community members, CBOs and hospital leaders described undocumented immigrants as living in a "constant state of fear" of detention and deportation. This fear prevents them from accessing health care, even in life-threatening or dire situations. Moreover, multiple changes to public charge[85] rules over the last few years have caused many immigrants without a legal status to question or have concerns about their use of health systems and benefits.

Further, HASD&IC's community engagement participants shared that parents or caregivers with children often face challenges accessing health care, such as making it to appointments, if they do not have access to childcare.

Culturally Competent and Linguistically Appropriate Care

A primary theme across focus groups and interviews was the need for more culturally competent and linguistically appropriate care. Community members shared their

[82] Continuous positive airway pressure.
[83] Center to Advance Palliative Care (2020), How to Increase Awareness & Reduce Gaps in Palliative Care for Minorities.
[84] Ornstein, K.A., Roth, D.L., Huang, J., et al. (2020). Evaluation of Racial Disparities in Hospice Use and End-of-Life Treatment Intensity in the REGARDS cohort. *JAMA Network Open*, *3*(8). doi:10.1001/jamanetworkopen.2020.14639
[85] For more information on public charge, please see https://ilrc.org/public-charge

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

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

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

- Because many of these translators do not have medical training, they may not be able to accurately translate what is being said by a health care provider.
- Translators often speak at a higher reading level or use more formal language than the patient.
- Telephone translators are unable to read facial expressions or body language to identify if patients fully understand what they are explaining.

Trauma-Informed Care (TIC)[86]

The need for a trauma-informed approach to care echoed throughout HASD&IC's research and interview process. A multitude of perspectives highlighted the depth and range of traumas[87] many people have experienced in their lifetime. Trauma-informed providers improve access and connection to care, creating a positive impact on the overall health of the community.

Substance Abuse and Mental Health Services Administration (SAMHSA) has noted the items in **Table 22** as examples of the types of trauma people may experience. It should be noted that there can be overlap, as some traumatic experiences fit into multiple categories.[88]

[86] Trauma-Informed Care (TIC) is an organizational practice framework that involves understanding, recognizing and responding to the effects of all types of trauma a person has experienced. TIC emphasizes physical, psychological and emotional safety for both patients and providers, and helps rebuild a sense of control and empowerment (https://theacademy.sdsu.edu/programs/cwds/trauma-informed-care/).
[87] Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening, and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being (SAMHSA, 2016). Trauma refers to what happens inside our bodies during and after the event, not the event itself. Trauma can be experienced as a group, community or mass and differentiates between them. In addition, trauma perceived as intentionally harmful often makes the event more traumatic for people and communities (SAMHSA, 2014).
[88] SAMHSA (2014), TIP 57 *Trauma-Informed Care in Behavioral Health Services;* The National Child Traumatic Stress Network, *Trauma Types.*

Table 22: Types and Categories of Trauma[88]

Trauma Types and Categories	
Community	Natural
Complex	Physical
Domestic violence	Political terror and war
Early childhood	Refugee
Group	Repeated
Historical	Secondary
Human caused	Sexual
Human trafficking	Single
Individual	Sustained
Mass	System-oriented re-traumatization
Medical	Traumatic grief
	Vicarious

Traumatic events such as adverse childhood experiences (ACEs), domestic violence, elder abuse and combat trauma are associated with long-term physical and psychological health effects. Please see the **Children & Youth Well-Being** findings for more information about ACEs. These events may have a negative impact on health care experiences and the likelihood of seeking preventive care. These barriers highlight the importance of TIC for people with this kind of lived experience.

TIC incorporates a set of assumptions called "the four Rs": TIC *realizes* the widespread impact of trauma and understands potential paths for recovery; *recognizes* the signs and symptoms of trauma in clients, families, staff and others involved with the system; *responds* by fully integrating knowledge about trauma into policies, procedures and practices; and seeks to actively *resist* re-traumatization.[89] TIC can refer to either evidence-based trauma interventions or to a broader systems-level approach that integrates trauma-informed practices throughout a service delivery system (e.g., health care system, educational system, law enforcement).[90]

TIC is important because people who have experienced trauma may not seek health care until it is an emergency. Negative health outcomes can occur when individuals avoid preventive care and other routine services. This is of particular concern for certain populations who are more likely to experience trauma, such as people who are BIPOC, LGBTQ+ or have been trafficked. Implementing a TIC approach creates a more comfortable and inclusive environment conducive to a more equitable health care experience and better overall quality of life. As mandated reporters, health care providers play an important role in TIC, as nearly 90% of people who are being trafficked seek care during that period.[91]

People who have experienced traumatic events carry that trauma throughout their life. They may seem apprehensive, reluctant to share their needs or slow to trust providers.

[89] SAMHSA (2014), *Concept of Trauma and Guidance for a Trauma-Informed Approach*.
[90] SAMHSA (2022), *National Strategy for Trauma-Informed Care Operating Plan.*
[91] Polaris Project (2018), *On-Ramps, Intersections, and Exit Routes: A Roadmap for Systems and Industries to Prevent and Disrupt Human Trafficking*.

This fear and distrust can sometimes lead impacted individuals to use traditional remedies or delay care until it becomes an emergency.

Recognizing implicit bias and microaggressions is fundamental to understanding what may potentially trigger adverse reactions, especially for patients from culturally or linguistically diverse backgrounds. Individuals who have been affected by traumatic events can pass their trauma down through generations, causing descendants to experience it as well. Furthermore, due to biological changes in the stress response system, these experiences are linked to a greater risk of health inequities.[92]

HASD&IC's interviewees shared the importance of education, training and treating those they serve with dignity. Acknowledging the presence of trauma symptoms and the role trauma may play in a person's health decisions is critical. Because challenges related to trauma can trigger adverse feelings or make people feel unsafe, providers should be respectful, gentle and provide a welcoming, affirming environment. Implementing trauma-informed approaches to care by recognizing trauma, strengthening resiliency, and avoiding re-traumatization can lead to more open communication, greater patient engagement, and overall better attention to the broad spectrum of patient needs.

Finally, health and service providers can also experience trauma, including compassion fatigue. Researchers have identified two types of compassion fatigue: secondary and vicarious. According to SAMHSA, for some first responders, secondary traumatic stress refers to aspects of their work that can make them feel like the trauma experienced by the people they help is happening to them or someone in their lives. When these feelings are prolonged, they can develop into vicarious trauma.[93]

Workforce Challenges

Workforce shortage was identified by HASD&IC community engagement participants as the number one priority for local health care providers. The pandemic severely strained the existing health care workforce and staffing shortages exacerbated challenges in meeting the growing demand for community services. Community engagement participants recognized that all health care settings, including behavioral health, were understaffed and described how workforce shortages adversely impact the patient experience.

The health care sector has lost nearly half a million workers since February 2020[94] and new data suggests that 18% of health care workers have quit during the pandemic and

[92] Arambula Solomon, T.G., Bobelu Starks, R.R., Attakai, A., Molina, F., Cordova-Marks, F., Kahn-John, M., Antone, C.L., Flores Jr., M., & Garcia, F. (2022). The generational impact of racism on health: Voices From American Indian Communities. *Health Affairs, 41*(2), 281-288. https://doi.org/10.1377/hlthaff.2021.01419

[93] Vicarious trauma is an occupational challenge for people working and volunteering in the fields of victim services, law enforcement, emergency medical services, fire services and other allied professions, due to their continuous exposure to victims of trauma and violence. This work-related trauma exposure can occur from such experiences as listening to individual clients recount their victimization; looking at videos of exploited children; reviewing case files; hearing about or responding to the aftermath of violence and other traumatic events day after day; and responding to mass violence incidents that have resulted in numerous injuries and deaths (U.S. Department of Justice [DOJ] Office for Victims of Crime, 2013).

[94] Bureau of Labor Statistics (2022), *The Employment Situation*.

12% have been laid off.[95] From the end of 2019 to the second quarter of 2021, the staff vacancy rate at California hospitals jumped 98% and 78% of hospitals reported an increase in staff turnover. California needs to add 500,000 new allied health care professionals by 2024 in order to meet the demand for care.[96]

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

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

Further, health care providers noted that the workforce shortage is creating a wider equity gap — fewer culturally competent and linguistically appropriate providers are available to care for SDC's diverse communities.

See **Appendix M** for individual quotes from HASD&IC's community engagement interview and focus group participants regarding the identified community need of Access to Health Care. In addition, the complete results of HASD&IC's online community engagement survey are available within the full HASD&IC 2022 CHNA report at: https://hasdic.org/community-health-needs-assessment-chna/.

SCHHC 2022 CHNA

Overall Barriers to Care

The majority of participants in the Institute for Public Health (IPH) Sharp Provider Survey indicated that the COVID-19 pandemic had a moderate or major impact on limiting patients' access to behavioral health care (91%), specialty care (86%) and primary care (79%). In addition, 85% reported the pandemic either moderately or majorly increased patients' fear about accessing health care.

Employees who participated in the IPH Sharp Human Resources Survey reported Sharp's own workforce faced challenges in accessing health care due to COVID-19. Approximately 80% reported that the pandemic caused at least a minor increase in employees' access to either primary or specialty care and 86% reported increased fear of using health care services.

[95] CHCF (2022), *COVID-19 Is Reshaping California's Health Workforce*.
[96] Hospital Association of San Diego and Imperial Counties (HASD&IC) (2022), *As Budget Season Gets into Full Swing, Workforce Challenges Can't Be Ignored*.

Further, 58% of Sharp Insight Community Survey participants reported the pandemic caused at least a minor decrease in their access to in-person medical care.

Telehealth

Considering the increased use of telehealth during the pandemic, IPH Sharp Provider Survey participants had the opportunity to comment on patients' use of virtual visits for health care, including ease of access to virtual visits, challenges with access, preferences for in-person or virtual visits, and the use of different telehealth modalities. Of those who provided feedback:

- 76% indicated the COVID-19 pandemic had a moderate or major impact on patients' ease of accessing visits.
- Respondents had mixed feedback about how easily patients can access video visits; 42% agreed or strongly agreed that patients could easily access video visits, while 58% disagreed or strongly disagreed.
- Most (91%) noted that lack of access to and knowledge about technology are primary barriers to accessing video visits. Inability to afford technology, insufficient internet access, and unreliable technology were also reported as challenges to access.
- Most (87%) agreed some patients prefer in-person visits for reasons beyond challenges with access to video visits, including to better connect with their provider and for more confidence in their care.
- The primary reason (96%) offered for preferring in-person visits was simply that patients prefer to communicate in person. This was followed by technology challenges (76%), concerns about loss of personal connection between provider and patient (58%), and concerns about medical personnel's ability to perform a virtual physical exam (43%).
- More than half of providers indicated their ability to care for patients, and patients themselves, could benefit from video visits (71%), electronic medication reminders (61%), secure messaging (55%), and electronic health education (54%). Many also believed remote patient monitoring, audio-only visits and digital self-reporting of patient outcomes could be beneficial. Only 5% did not think telehealth has any benefits to their patients.

Sharp Insight Community Survey participants also provided input on their use of telehealth during the past year. Feedback included the following:

- 45% had interacted with a Sharp health care professional (physician, nurse, etc.) through a video visit and 33% had interacted through an audio-only visit.
- Most respondents (77%) who had a video visit reported it being "effective," and most (69%) who had an audio-only telehealth visit reported it being "effective."
- Of those who had a video visit, 82% reported that overall they liked their visit. Of those who had an audio-only visit, 76% reported that overall they liked their visit.

- 33% of respondents who liked their virtual visit (either video or audio) attributed their liking to convenience. Most of those who disliked their virtual visit attributed this to either a physical or general disconnect with their provider.

Health Literacy

Nearly all (99%) respondents to the IPH Sharp Provider Survey reported the pandemic had at least a minor impact on decreased health literacy (i.e., capacity to process or understand basic health information and services in order to make appropriate health decisions).

Transportation

Nearly all (99%) IPH Sharp Provider Survey participants reported the pandemic had at least a minor impact on patients' access to transportation. Ideas provided to address this included increasing community awareness about shuttle access/Sharp Van Services and providing telehealth.

In addition, the pandemic was cited as having at least a minor impact on access to transportation by 15% of Sharp Insight Community Survey participants.

Stigma[69]

The majority (93%) of IPH Sharp Provider Survey participants reported that COVID-19 had at least a minor impact on stigma experienced by patients in the health care setting.

In addition, the majority (88%) of IPH Sharp Human Resources Survey respondents indicated at least a minor increase in stigma in the workplace due to COVID-19.

Further, increased stigma experienced in the health care setting due to COVID-19 was cited by 29% of Sharp Insight Community Survey participants.

Culturally Competent and Linguistically Appropriate Care

Sharp provides a variety of educational opportunities designed to support employees' personal and professional development. Employees who participated in the IPH community engagement surveys had the opportunity to choose among educational topics they would be most interested in learning about. Feedback from those who responded are highlighted below.

<u>IPH Sharp Provider Survey</u>:

Defining cultural humility and applying it to health care was one of the most frequently chosen topics among Sharp providers (50%) in addition to the impact of implicit/unconscious bias on decision-making (40%). Interest in other topics related culturally competent and linguistically appropriate care was as follows

- Maternal and infant health with a focus on the Black community (20%)
- Disparities in the Black community (27%)
- Disparities in Asian communities (24%)
- Disparities in the Latinx community (24%)
- Disparities in immigrant communities (31%)

IPH Sharp Human Resources Survey:

The most frequently chosen topics of interest by Sharp human resources employees included the impact of implicit/unconscious bias on decision-making (80%) and defining cultural humility and applying it to health care (53%). Interest in other topics related culturally competent and linguistically appropriate care was as follows:

- Maternal and infant health with a focus on the Black community (27%)
- Disparities in the Black community (27%)
- Disparities in Asian communities (20%)
- Disparities in the Latinx community (7%)
- Disparities in immigrant communities (7%)

Workforce Challenges

As previously noted in the HASD&IC 2022 CHNA findings on Access to Health Care, the COVID-19 pandemic caused health care workforce shortages which resulted in challenges with meeting the health care needs of community members.

Due to COVID-19, nearly 90% of Sharp professionals who participated in the IPH Sharp Human Resources Survey expressed either a moderate or major increase in employees' desire to change careers or leave the workforce. Of these, the majority (78%) reported that Sharp does not have programs or services available to address this issue.

Nearly 90% also reported that COVID-19 caused at least a moderate increase in employees' frustration or disengagement with their work. Fortunately, most of these respondents (73%) indicated that Sharp has established programs to address these issues.

Please see the following appendices for more information on SCHHC's 2022 CHNA Access to Health Care findings:

- **Appendix I**: IPH Sharp Provider/Human Resources 2022 CHNA Survey & Findings
- **Appendix J**: Sharp Insight Community 2022 CHNA Survey & Findings

Aging Care & Support

Overall Findings

Concerns that disproportionately affect care and support during the aging process were identified as a high priority need in both the SCHHC and HASD&IC 2022 CHNAs. The findings for Aging Care & Support most often relate to the health and social issues listed below, including the impact of the COVID-19 pandemic on older adults in relation to these issues.

- *Economic stability and risk of homelessness*
- *Social isolation*
- *Access to health care*
- *Access to community resources and support*
- *Behavioral health*
- *Stigma*
- *Other health and safety concerns*

Aging Care & Support findings are described below for both the HASD&IC and SCHHC 2022 CHNAs.

HASD&IC 2022 CHNA

Economic Stability and Risk of Homelessness

Throughout HASD&IC's community engagement activities, economic instability emerged as a theme in every conversation that focused on seniors. Interview and focus group participants expressed that there are significant financial barriers to aging at home with dignity. Seniors who are considered higher-resourced may need to sell their homes or possessions to qualify for the assistance they need. Low-income seniors often struggle to afford home modifications or equipment that can allow them to continue living safely and independently in their homes, such as grab bars, wheelchair ramps or shower chairs. If seniors cannot afford to make necessary modifications to their homes, they may experience health-related impacts, such as becoming bed-bound or conditions worsening.

Additional data analysis revealed that seniors are at a higher risk of poverty for many reasons, including limited income. Low-income seniors depend on public programs like Medi-Cal and cash assistance (Supplemental Security Income) to make ends meet. Factors such as chronic health conditions, disability, and loss of a significant other also contribute to an increased risk of poverty. See **Figure 18** for the rates of seniors living in poverty in SDC and **Table 23** for the top needs of older adults served by 2-1-1 San Diego.

Figure 18: Percent of Seniors Ages 65+ Living Below 100% FPL by SDC Region, 2019[19]

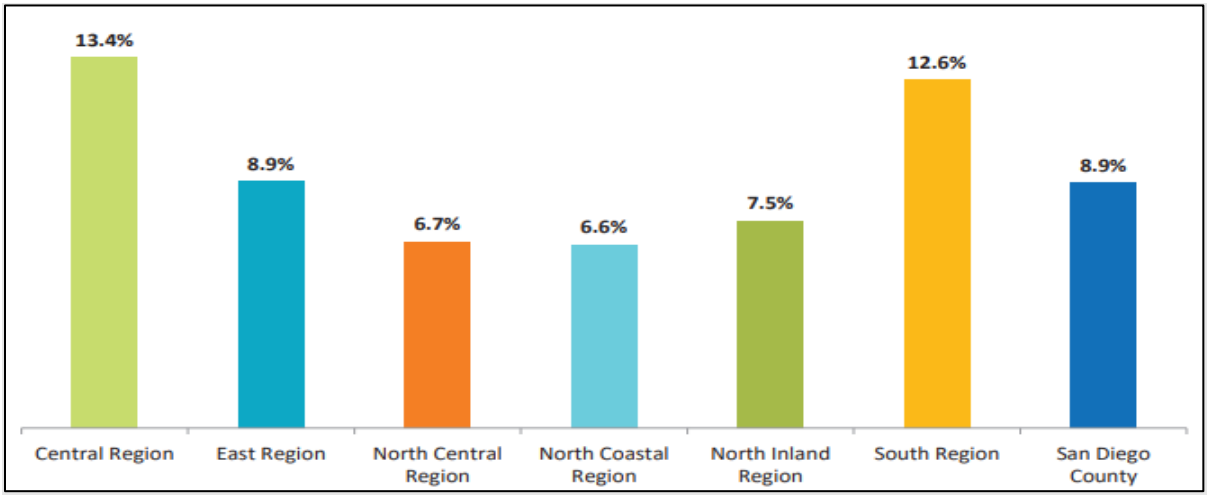


Table 23: Top Five Needs for 2-1-1 San Diego Clients Ages 60+, 2021[97]

Needs	Percent of Total Clients
Total Clients 39,699	
Housing	22%
Utilities	17%
Income Support and Employment	12%
Consumer Services	12%
Health Care	9%

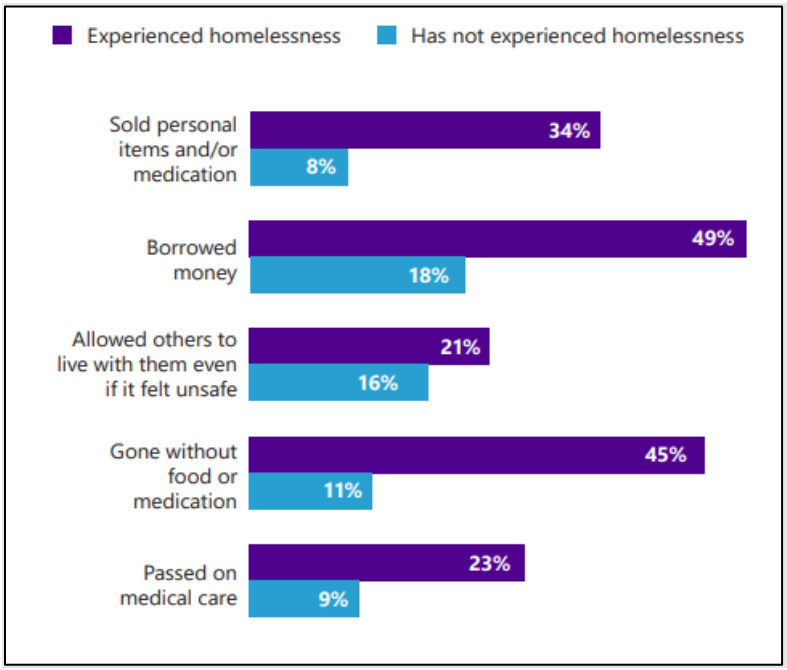
Older adults make up a significant portion of the county's unhoused population. In 2020, 1 in 4 unsheltered SDC residents were adults ages 55 and over. Among the region's unsheltered seniors, 88% became homeless in SDC and 43% reported experiencing homelessness for the first time in their lives.[98] Nationwide, the population of individuals ages 65 and older experiencing homelessness is expected to nearly triple over the next decade — from 40,000 in 2020 to approximately 106,000 by 2030.[99]

In September 2021, Serving Seniors released a study on SDC's senior homelessness crisis. According to the report, many older adults become homeless because they lack an economic safety net. They experience catastrophic events with dire financial consequences and may take actions that compromise their health and safety to make ends meet. More than half (56%) of people interviewed during the study reported that an additional $300 or less of monthly income would increase their rent security. Some interview participants reported avoiding shelters due to safety concerns, including risk of theft, physical harm and potential exposure to substance use. The person or environmental fit of shelters may be another area for exploration, given functional impairments and health concerns associated with the aging process. Further, study

[97] 2-1-1. (2022). *Data Dashboard.* https://211sandiego.org/data-dashboard
[98] Serving Seniors (2021), *Senior Homelessness: A Needs Assessment*.
[99] University of Pennsylvania (2019), *The Emerging Crisis of Aged Homelessness: Could Housing Solutions Be Funded by Avoidance of Excess Shelter, Hospital, and Nursing Home Costs?*

participants reported challenges with identifying and accessing services and resources, as well as struggling with technological barriers, transportation and mobility limitations. **Figure 19** below displays the personal sacrifices that more than half of older adult study participants have made to afford rent.[98]

Figure 19: Sacrifices Made by Older Adults to Afford Rent[98]



Social Isolation

Concerns about the social isolation of seniors were also a universal theme in HASD&IC's focus groups and interviews. Due to COVID-19 safety guidelines and fear, many seniors were isolated during the pandemic, and many remain isolated.

Social isolation impacts the health and well-being of seniors. Throughout the pandemic, some seniors were unable to access smart devices and were unable to virtually socialize with loved ones or participate in community-based activities. Increased isolation resulted in greater depression and anxiety among seniors. In some cases, seniors went without medical attention for more than a year during the pandemic and neither their doctor nor their family realized how significantly their cognitive abilities had declined.

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

In addition, according to Serving Seniors' report on SDC's senior homelessness crisis, social isolation presents a significant behavioral health concern among older adults, which affects those experiencing homelessness. Almost half of surveyed older adults (45%) reported feeling lonely, isolated or cut off from friends and family.[98]

Further, lonely seniors are twice as likely to use painkillers and sedatives, which frequently leads to substance use problems, accidents, medical complications, falls or death.[100]

Access to Health Care

HASD&IC's community engagement participants emphasized that COVID-19 had a significant impact on older adults' ability to access health care services. This is of concern because older adults are at greater risk of having multiple chronic conditions, including dementia.

Due to concerns related to COVID-19, some seniors were unwilling to make in-person appointments at their doctors' offices and hospitals. Mobility issues related to aging, being homebound, disabled, or dependent on a mobility aid are significant barriers to accessing health care for many seniors. Physical limitations, such as vision or hearing loss, require extra assistance, consideration and accommodation that may not be readily available.

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

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

During the pandemic, access to appropriate post-acute care became a serious challenge for many seniors who were hospitalized with COVID-19 or other conditions. In some cases, skilled nursing facilities (SNFs) closed admissions due to COVID-19 outbreaks, risk of infection and low staffing. In general, patients enrolled in Medi-Cal are the least likely to be admitted to SNFs, especially if the patient is experiencing homelessness. Older adult patients experiencing homelessness have complex health needs that may require significant post-acute treatment and healing time, but options for

[100] Kotwal, A.A., Steinman, M.A., Cenzer, I., & Smith, A.K. (2021). Use of High-risk Medications Among Lonely Older Adults: Results From a Nationally Representative Sample. *JAMA Internal Medicine*, *181*(11), 1528-1530. doi: 10.1001/jamainternmed.2021.3775

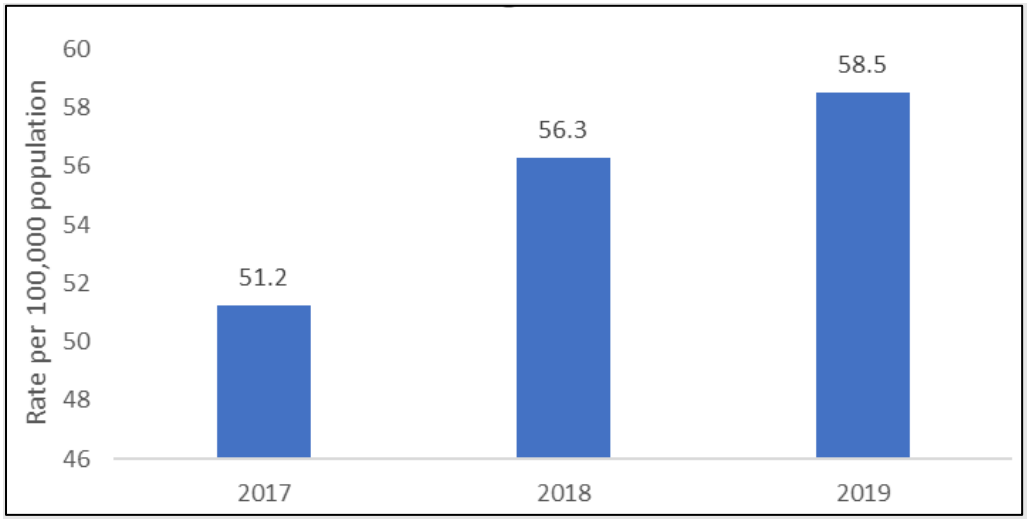
longer-term, post-acute care with housing such as SNFs or recuperative care facilities are very limited.

Further, community engagement participants identified inadequate dental coverage for seniors as a serious, ongoing issue that negatively impacts overall health. Seniors with Medicare do not have dental coverage. Seniors and older adults enrolled in Denti-Cal[101] have extreme challenges finding providers.

According to additional data analysis, oral health disparities are apparent in adults ages 65 and older. More than 9 in 10 older adults have had cavities, and 1 in 6 have untreated cavities. Older non-Hispanic Black or Mexican American adults have two to three times the rate of untreated cavities as non-Hispanic white adults in this age group.[102]

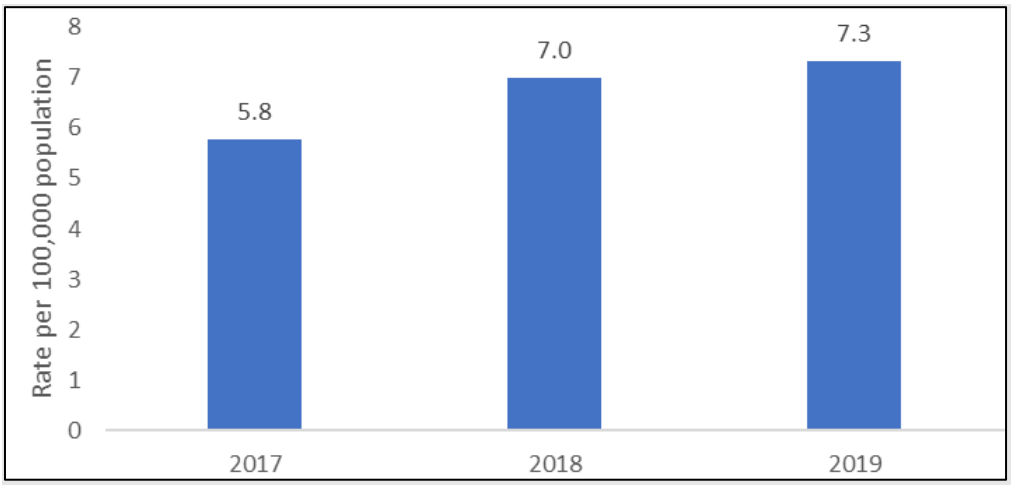
Further, County data indicates that ED and inpatient discharges have increased from 2017 to 2019 for disorders of the teeth and jaw among those ages 65 and older.[4] Disorders of the teeth and jaw include dental caries, loss of teeth, and other specified disorders of teeth and supporting structures.[103] ED discharge rates increased by 14.2% from over the three year period, while inpatient discharge rates increased by 26.9%.[4] See **Figures 20** and **21** for discharge rates among older adults with disorders of the teeth and jaw.[4]

Figure 20: ED Discharge Rate, Ages 65 and Older with Disorders of the Teeth and Jaw – SDC, 2017-2019[4]



[101] Denti-Cal is dental coverage for Medi-Cal beneficiaries.
[102] CDC (2021), *Disparities in Oral Health*.
[103] County of San Diego HHSA, PHS, CHSU (2021), *Public Use Codebook and Metadata File, Data Year: 2019*.

Figure 21: Inpatient Discharge Rate, Ages 65 and Older with Disorders of the Teeth and Jaw – SDC, 2017-2019[4]



Behavioral Health

Participants in the HASD&IC 2022 CHNA community engagement process expressed that seniors with behavioral health challenges face increasing difficulty accessing services.

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

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

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

In addition to these findings, a study conducted by researchers at a hospital in central San Diego found that elderly meth patients were more severely injured and required a higher level of care than other elderly patients. The study also found that within SDC, individuals ages 55 to 64 have the highest rate of meth-related deaths of any age group (31.8 per 100,000).[104]

[104] Benham, D.A., Rooney, A.S., Calvo, R.Y., Carr, M.J., Diaz, J.A., Sise, C.B., Bansal, V., Sise, M.J., & Martin, M.J. (2021). The rising tide of methamphetamine use in elderly trauma patients. *The American Journal of Surgery*, *221*(6), 1246-1251. https://doi.org/10.1016/j.amjsurg.2021.02.030

Stigma[69]

HASD&IC's community engagement participants described the role that stigma plays in preventing many seniors from accessing critical programs and support. Older adults can be especially reluctant to seek help or admit they are experiencing behavioral health challenges, especially those in specific demographic groups.

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

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

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

See **Appendix M** for individual quotes from HASD&IC's community engagement interview and focus group participants regarding the identified community need of Aging Care & Support. In addition, the complete results of HASD&IC's online community engagement survey are available within the full HASD&IC 2022 CHNA report at: https://hasdic.org/community-health-needs-assessment-chna/.

SCHHC 2022 CHNA

Economic Stability

Sharp health care providers who participated in the IPH Sharp Provider Survey noted that caregivers of adults or older adults were especially impacted by COVID-19 in relation to increased financial insecurity.

In addition, Sharp Insight Community Survey participants ages 65 and older expressed COVID-19 had at least minorly impacted them in the following ways: increased financial uncertainty (33%), increased housing instability or risk of homelessness (10%) and increased unemployment (9%).

Please see Sharp's **Economic Stability** findings for more information on this topic.

Social Isolation

Through the IPH Sharp Provider Survey, increased isolation among seniors was identified as one of the top needs most seriously impacted by the COVID-19 pandemic

in the past year. Respondents were nearly unanimous (98%) that COVID-19 had a moderate or major impact on the isolation of seniors/older adults. Respondents also noted that COVID-19 made it more difficult to have contact with family and to have family at the bedside, which is especially important for highly vulnerable patients, such as those with dementia.

Survey participants had the opportunity to choose among specific populations that were most impacted by COVID-19 in relation to increased isolation among seniors; caregivers of adults or older adults were the most frequently selected population. The racial or ethnic groups most frequently identified as being most impacted in relation to isolation of seniors/older adults included Black/African American, Hispanic and Multiracial.

Survey respondents were divided about whether Sharp has programs that help address increased isolation among seniors; 44% indicated yes and 56% indicated no. Examples provided by respondents of Sharp's existing efforts to address increased isolation among seniors/older adults included educational efforts, outreach and referrals for resources and support, the Sharp Senior Resource Center, and increased use of telehealth.

Further, 70% of Sharp Insight Community Survey respondents ages 65 and older reported experiencing at least a minor increase in isolation or decrease in access to social support due to COVID-19.

Access to Health Care

Sharp Insight Community Survey participants ages 65 and older reported that COVID-19 had caused at least a minor decrease in their access to the following types of care: in-person medical care (52%); in-person behavioral health care (17%); and medications or medical supplies (12%). Half of participants ages 65 and older reported increased fear of using health care services, and approximately one-quarter (22%) felt they experienced increased stigma in the health care setting due to COVID-19.

In addition, Sharp Insight Community Survey participants were asked about their use of telehealth services in the past year. Findings from those ages 65 and older included the following:

- 41% reported they had interacted with a Sharp professional (physician, nurse, etc.) through a video visit and 36% reported they had interacted through an audio-only visit.
- Of those who had virtual visits, 81% reported their video visit as "effective" in addressing their health needs while 71% reported their audio visit as "effective" in addressing their health needs.
- Overall, 70% reported they "liked" their telehealth visit (either video or audio) while 30% "disliked" their visit.

- Compared to other age groups, the survey found an association between being ages 65 and older and liking one's telehealth visit.

Access to Community Resources and Support

IPH Sharp Provider Survey participants had the opportunity to choose among specific populations who have been particularly impacted by COVID-19 in relation to limited access to emotional or social support; Caregivers of adults or older adults were the most frequently selected population. Hispanic, Multiracial, Black/African American and Asian patients were the racial and ethnic groups noted to be especially impacted by COVID-19 in relation to limited access to emotional or social support.

In addition, 70% of Sharp Insight Community Survey respondents ages 65 and older reported at least a minor increase in isolation or decrease in access to social support due to COVID-19. Respondents in this age group also reported decreased access to healthy food (15%), transportation (20%) and community resources (10%) as a result of COVID-19.

Among all age groups, the majority of Sharp Insight Community Survey respondents (96%) did not participate in Sharp's programs designed to support older adults, their caregivers and loved ones with aging concerns. Those who did participate named caregiver or family support programs, senior health education, and the Sharp Senior Resource Center as the most used programs.

Behavioral Health

IPH Sharp Provider Survey participants noted caregivers of adults or older adults as being especially impacted by COVID-19 in relation to increased anxiety and depression and decreased access to behavioral health care.

In addition, due to COVID-19, more than half (53%) of Sharp Insight Community Survey participants ages 65 and older reported at least a minor increase in their anxiety or depression, and 17% experienced at least a minor decrease in their access to in-person behavioral health care. It is also worth noting that Sharp Insight Community Survey respondents ages 65 and older were more likely to participate in behavioral health programs compared to respondents from other age groups.

Analysis of hospital discharge data for SCHHC showed that nearly a third (31.3%) of seniors admitted to SCHHC in 2020 had a mental, behavioral or neurodevelopmental disorder. Among this group, over half (51.8%) were diagnosed with a depressive disorder, while 27.7% were diagnosed with an anxiety and fear-related disorder.[4]

Please see Sharp's **Behavioral Health** findings for more information.

Other Health and Safety Concerns[4]

- According to hospital discharge data for SCHHC, seniors ages 65 and older accounted for nearly half (49.5%) of all inpatient discharges, and 18.4% of ED encounters at the hospital in 2020.
- The top three principal diagnoses among senior inpatients were classified as osteoarthritis (14.5%), septicemia (10.8%) and COVID-19 (5.9%).
- The top three principal diagnoses among seniors who visited the ED were classified as nonspecific chest pain (4.3%), urinary tract infections (4.3%) and exposure to infectious diseases (4.2%).
- Seniors represented 68.9% of inpatient discharges for unintentional injury, with fall-related injuries occurring in 75.2% of those discharges.
- The majority (59.2%) of seniors admitted had a disease of the circulatory system. Among this group, over half (53.2%) were diagnosed with essential hypertension, while 23.7% were diagnosed with a cardiac dysrhythmia.
- More than half (52.8%) of inpatients with a diabetes diagnosis were seniors.
- Seniors represented 60.1% of inpatient discharges with an osteoarthritis diagnosis.

Please see the following appendices for more information on SCHHC's 2022 CHNA Aging Care & Support findings:

- **Appendix I**: IPH Sharp Provider/Human Resources 2022 CHNA Survey & Findings
- **Appendix J**: Sharp Insight Community 2022 CHNA Survey & Findings

Behavioral Health

Overall Findings

Behavioral Health was identified as a high priority need in both the SCHHC and HASD&IC 2022 CHNAs. Behavioral Health findings are most notably described in relation to the health, social and population-specific challenges listed below. In addition, the CHNA findings highlight the profound impact of the COVID-19 pandemic on community members' mental well-being and their ability to access needed behavioral health care.

- *Increasing behavioral health needs*
- *Increasing substance use*
- *Access to behavioral health care*
- *Stigma*
- *Post-acute care concerns*
- *Dual diagnosis patients*
- *LGBTQ+*

- *People experiencing homelessness*
- *Veterans and military*
- *Other populations (Native American/Tribal, refugees*, *undocumented)*
- *Workforce challenges*

Behavioral Health findings are described below for both the HASD&IC and SCHHC 2022 CHNAs. Please see the **Access to Health Care**, **Aging Care & Support**, and **Children & Youth Well-Being** findings for additional data related to behavioral health.

HASD&IC 2022 CHNA

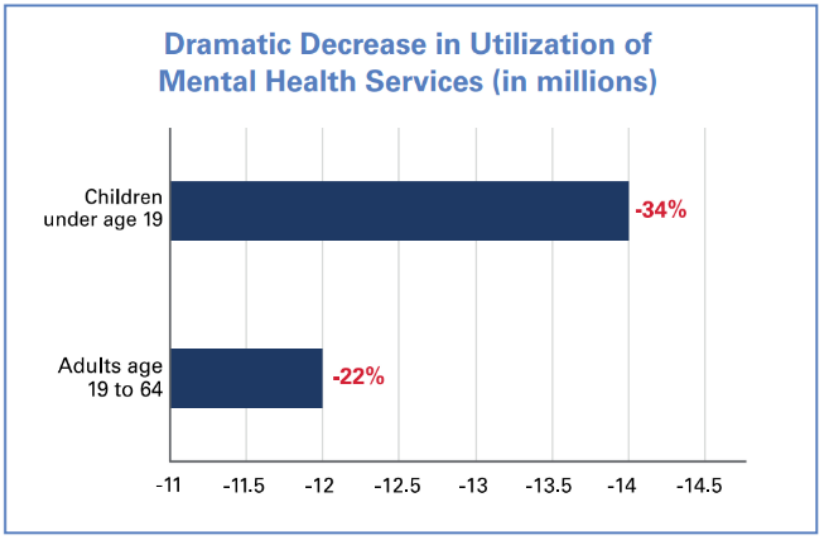
Increasing Behavioral Health Needs

The pandemic took a substantial toll on the community's mental health. There was universal agreement among community engagement participants that mental and behavioral health needs in the community increased dramatically during this time.

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

As the demand for behavioral health services soared, the capacity of behavioral health programs and services fell increasingly short. Community-based service providers and health care providers expressed a feeling of heartbreak as they worked with community members who were in desperate need of behavioral health care. Providers experienced the community's desperation but were unable to address all their immediate needs — there was almost no availability for timely access to services. See **Figure 22** below for a representation of the decline in mental health service utilization during the onset of the pandemic.

Figure 22: Dramatically Decreased Mental Health Service Utilization Early in Pandemic[105]



Some data showed a decline in behavioral health service utilization (visits) during the first two years of the pandemic, but providers cautioned that this does not accurately represent the growing needs of the community. Challenges such as provider capacity and barriers hindered people from accessing and receiving necessary behavioral health care.

In HASD&IC's online community survey, 70% of respondents identified behavioral health as a top health need. When asked more specifically about behavioral health needs, respondents identified the following as the 10 most important mental or behavioral health needs in the community (in ranked order): depression; access to help; anxiety; stress; drug use; substance use disorders (SUDs); alcohol use; burnout or fatigue; opioid use (including Fentanyl); and suicide or suicidal thoughts.

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

With reimbursement-related restrictions on telehealth loosened, providers conducted 75% of behavioral health visits for commercially insured patients via telehealth in May and June 2020.[105]

A 2021 American Psychological Association survey of more than 1,100 psychologists found a significant increase in the demand for behavioral health treatment. Among their patients, 84% of providers reported increases in anxiety, 72% reported increases in depression, and 62% reported increases in trauma and stress-related disorders.[106]

[105] AHA (2022), *TrendWatch: The impacts of the COVID-19 pandemic on behavioral health.*
[106] American Psychological Association (2021), *2021 COVID-19 Practitioner Survey.*

Increasing Substance Use

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

SAMHSA data indicates that, in 2019, 20 million Americans ages 12 or older attested to having SUDs, which are characterized by alcohol use, illicit drug use, or both.[105]

Fentanyl-related overdose and death were identified by interviewees as a large area of concern due to its potency, lethality and increased presence in the community. Fentanyl is a synthetic opioid that is 50 times more potent than heroin and 100 times more potent than morphine.[107,108] Powdered fentanyl resembles a variety of other substances that are taken recreationally. There have been recent reports of substances such as heroin, cocaine and meth being mixed ("cut") with it, and the end-product looks like other commonly consumed drugs. Interviewees shared that, in many cases, people do not know that their drugs are laced with fentanyl and consume it unknowingly, leading to accidental overdose or death.

An area of concern expressed by community members was the increased consumption of alcohol. During the pandemic, uncertainty combined with disruption of routines, financial instability, and balancing work and sometimes childcare from home may have led some people to progress into heavier drinking habits or increase their overall alcohol consumption.

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

According to research from Overdose Data to Action (OD2A),[109] the number of unintentional drug overdose deaths in SDC has increased since 2015. Most unintentional overdose deaths were opioid-related, and those numbers increased from 2015 to 2019.

Research from OD2A also identified different demographic profiles for opioid-related events. Higher opioid-related mortality and ED visits were observed in younger populations, and males tended to have higher rates of ED visits and deaths.

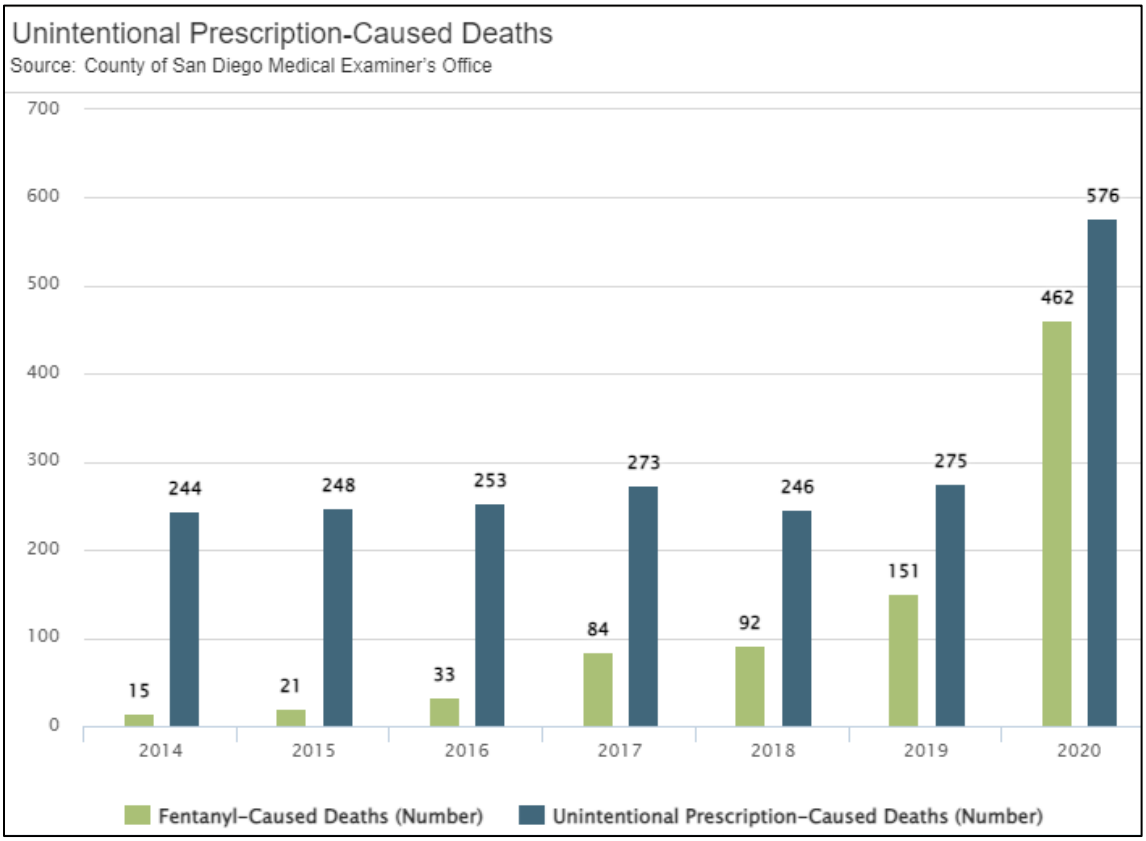
[107] Wilson, N., Kariisa, M., Seth, P., Smith IV, H., & Davis, N.L. (2020). Drug and opioid-involved overdose deaths — United States, 2017–2018. *MMWR Morbidity and Mortality Weekly Report*, *69*(11), 290–297. DOI: http://dx.doi.org/10.15585/mmwr.mm6911a4
[108] CDC (2022), *Fentanyl Facts*.
[109] County of San Diego HHSA (2021), *Opioid-Related Overdoses & Encounters In San Diego County 2015-2019.*

More than 840,000 Americans died of a drug overdose between 1999 and 2020, and millions more have been affected by other adverse health and social consequences of SUDs, including injury, infectious diseases and incarceration.[110]

According to data from the County of San Diego Medical Examiner's Office that was compiled and visualized by the San Diego Prescription Drug Abuse Task Force, unintentional prescription-caused deaths and Fentanyl-caused deaths have been steadily increasing over the years (see **Figure 23**).[111] However, it is important to note that not all deaths from Fentanyl are captured in these numbers — they may actually be undercounted.

- From 2019 to 2020, there was a 206% increase in the number of Fentanyl-caused deaths — 151 compared to 462, respectively.
- From 2019 to 2020, there was a 109% increase in unintentional prescription-caused deaths — 275 compared to 576, respectively.

Figure 23: Unintentional Prescription-Caused Deaths in SDC, 2014-2020[111]



[110] Saloner, B., Li, W., Bandara, S.N., McGinty, E.E., & Barry, C.L. (2022). Trends in the use of treatment for substance use disorders, 2010-19. *Health Affairs*, *41*(5), 696-702. doi:10.1377/hlthaff.2021.01767

[111] San Diego Prescription Drug Abuse Task Force (2022), *San Diego County Prescription Drug Abuse Task Force Report Card.* Note: Figure includes accidental overdose deaths in which a prescription drug alone or with other drugs and/or alcohol was a causative factor in death.

Access to Care Challenges

HASD&IC 2022 CHNA findings revealed the need for a robust, fully coordinated and integrated continuum of behavioral health care. Service deficits are causing severe consequences to the overall health and well-being of the community, especially for people with existing chronic behavioral health conditions. The pandemic further exacerbated existing barriers to accessing services, particularly for populations who were already experiencing inequities. Community members expressed desperation in their inability to find help and often felt hopeless as they grappled with the lack of available resources.

Community engagement participants identified severe deficits within the behavioral health continuum of care. People who do not have access to comprehensive mental and behavioral health services are at an increased risk of crisis. Community members expressed that there is an urgent need to improve access to early intervention services. Participants cited several key challenges and barriers that cause delays or deter people from accessing necessary care and treatment including: extremely long wait times or waitlists; unaffordable treatment and services; health insurance provider limitations and coverage conflicts; access to technology; and transportation.

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

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

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

Medi-Cal coverage for beneficiaries diagnosed with Mild to Moderate Mental Illness is separate from Medi-Cal coverage for beneficiaries diagnosed with Serious Mental Illness. When the health plans disagree about the patient's diagnosis, there can be delays in referrals and access to needed treatment. Patients with private health insurance also face denials for needed treatment.

Lack of access to internet, computers and cellphones were frequently cited as barriers to accessing telehealth appointments.

Transportation to appointments was an issue for people without cars, or for anyone without reliable transportation. Public transportation was described as time-consuming

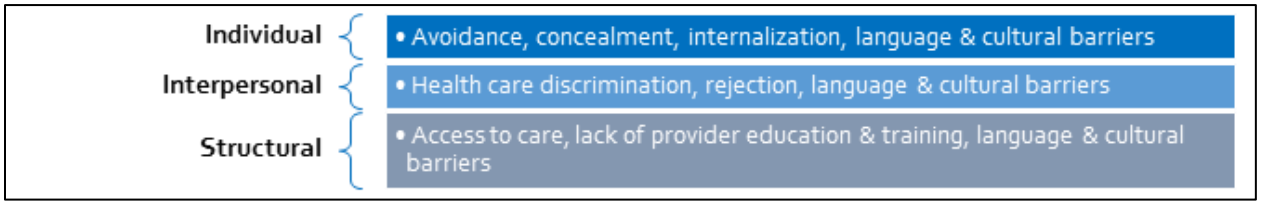
and difficult to navigate. Transportation impacts a person's ability to continue any ongoing treatment or attend therapy.

Stigma[69]

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

Figure 24 includes several different types of stigma surrounding people with a behavioral health condition. Most notably, cultural stigma was identified as a significant barrier to people openly talking about their problems and seeking professional help. People with behavioral health needs are more likely to internalize their feelings due to negative cultural beliefs around behavioral health and any experiences with longstanding history of discrimination in the health care system. Particularly for people of color, seeking behavioral health care is often viewed as shameful, unacceptable or a sign of weakness.

Figure 24: Types of Stigma[112]



The National Alliance for Mental Illness (NAMI) has identified stigma as a priority concern. The StigmaFree campaign is NAMI's effort to end stigma and create hope for those affected by mental illness.[113]

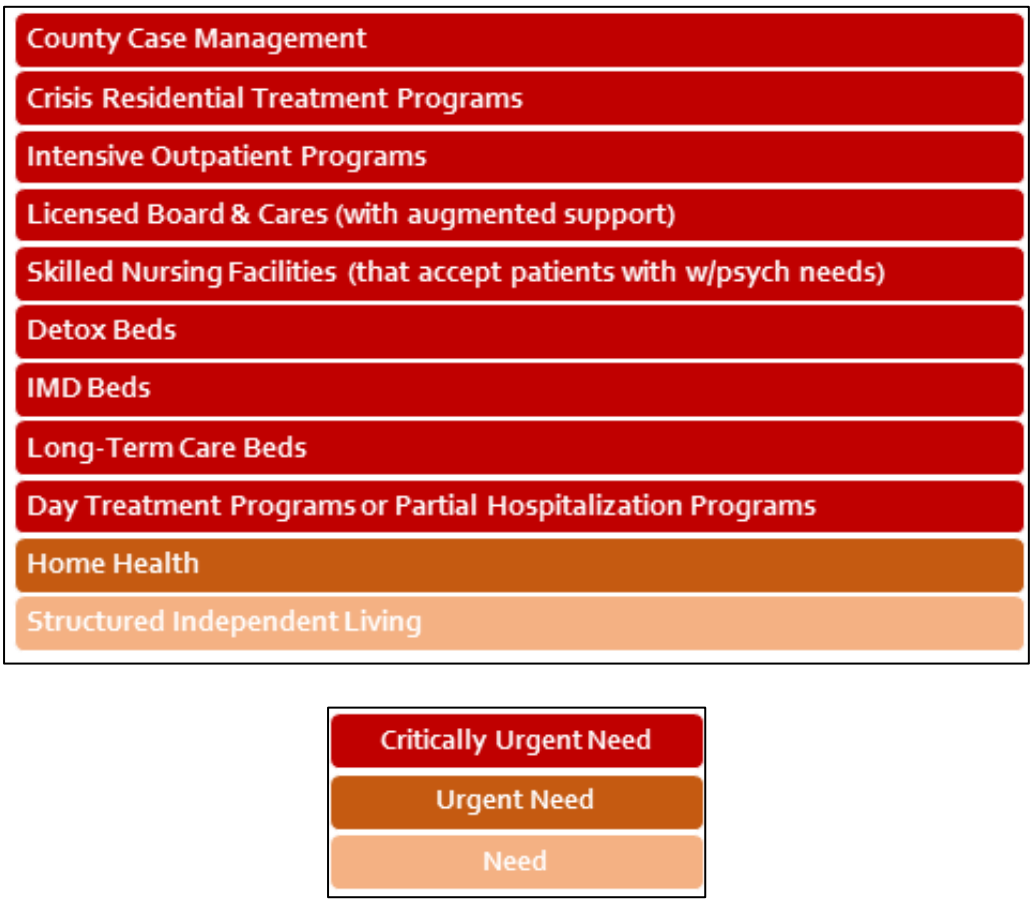
Fifteen years ago, a U.S. Surgeon General's Report on Mental Health — the first and only one to date — identified stigma as a public health concern that leads people to "avoid living, socializing or working with, renting to or employing" individuals with mental illness. Due to stigma, people living with mental health conditions are often: alienated and seen as "others;" perceived as dangerous; seen as irresponsible or unable to make their own decisions; less likely to be hired or obtain safe housing; more likely to be criminalized than offered health care services; and afraid of rejection to the point that they don't always pursue opportunities.

[112] White Hughto, J. M., Reisner, S. L., & Pachankis, J. E. (2015). Transgender stigma and health: A critical review of stigma determinants, mechanisms, and interventions. *Social Science & Medicine*, 147, 222–231. https://doi.org/10.1016/j.socscimed.2015.11.010
[113] National Alliance on Mental Illness (2022), *Pledge to Be StigmaFree.*

Post-Acute Care Concerns

The insufficient availability of post-acute services across the board has created a bottleneck, with people waiting several months to a year to receive the appropriate level of care, especially after a hospital stay. Hospital staff are significantly challenged in finding timely follow-up care or a safe place to discharge people with complex behavioral health needs. These longstanding challenges became even worse during the pandemic. For patients recently discharged from acute or long-term care, any progress achieved during their stay may be diminished if they have long wait times to access the appropriate level of care. The most significant deficit in the post-acute care continuum is long-term care beds. **Figure 25** below categorizes the level of need for the different types of post-acute behavioral health services.

Figure 25: Adult Behavioral Health Post-Acute Care Continuum – Needed Services



Dual Diagnosis Patients

An estimated 500,000 Californians have a dual diagnosis of mental illness and a SUD.[114]

[114] CHCF (2021), *In Their Own Words: How Fragmented Care Harms People with Both Mental Illness and Substance Use Disorder.*

- One in three people (33%) with a SUD has a co-occurring mental health condition.
- One in five people (20%) with a severe mental health disorder will also develop a SUD.
- Only 1 in 13 people (7.4%) with dual diagnoses receives treatment for both conditions.

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

LGBTQ+

The LGBTQ+ community is at a higher risk of significant behavioral health inequities due to lack of social support, increased discrimination, stigma and trauma. LGBTQ+ community members frequently use substances to cope with stress and trauma. Transgender community members face unique challenges, such as gender dysphoria, which could lead to anxiety, depression and self-harm. Fear of stigmatization and the lack of experienced, safe, gender-affirming care providers create additional barriers to accessing behavioral health care.

Rates of chronic depression among transgender people are more than double those of cisgender populations and estimates of the prevalence of depression among transgender women are as high as 64.2%.[115]

People Experiencing Homelessness

The experience of being homeless is traumatic and stressful. When unhoused community members live in unsafe conditions, the trauma they endure can further exacerbate their behavioral health conditions.

For both ED and inpatient discharges of patients experiencing homelessness in SDC in 2019, half of the top 10 primary diagnosis codes were related to behavioral health. See **Figures 26** and **27**.

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

Health and social service providers emphasized the importance of timeliness in getting appointments and being linked to services in the community. In addition, community

[115] National Institutes of Health (2022), *Women's Health in Focus at NIH: Transgender Women's Health.*

members experiencing homelessness face navigation barriers with long waitlists for services like case management.

Figure 26: Top Discharges for Patients Experiencing Homelessness in SDC, 2019[4]

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

Figure 27: Top Discharges for Patients Experiencing Homelessness in SDC, 2019[4]

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

Veterans and Military

Compared to their civilian counterparts, veterans experience behavioral health disorders, SUDs, post-traumatic stress and traumatic brain injury at disproportionate rates. It is estimated that 18 to 22 American veterans die by suicide each day and young veterans ages 18 to 44 are at highest risk.[116]

[116] Olenick, M., Flowers, M., & Diaz, V. J. (2015). US veterans and their unique issues: Enhancing health care professional awareness. *Advances in Medical Education and Practice*, *6*, 635–639. https://doi.org/10.2147/AMEP.S89479

Despite reporting better overall health than their civilian counterparts, women who have served are more likely to face behavioral health challenges. In fact, women who have served have a 42% higher rate of having experienced a mental illness in the past year than those who have not served. Further, women who have served are more likely to be diagnosed with depression and have suicidal thoughts than civilian women.[117] Unfortunately, the reluctance of veterans to seek treatment or help makes diagnosing and treating mental illness difficult.[116]

Other Populations (Native American/Tribal, Refugees, *Undocumented)*

HASD&IC community engagement participants shared that Native American community members have experienced multiple types of trauma which may deter some from seeking needed treatment. They also shared that the most serious behavioral health concerns for Native American community members include SUDs and suicide prevention.

Members of SDC's refugee community may have endured harrowing experiences that can cause long-lasting behavioral health consequences. Many have survived traumatic circumstances, such as witnessing deaths, starvation or violence in their homeland. Simultaneously attempting to process their experiences while adjusting to a new language and a different everyday life can further impact their behavioral health. Refugee community members may also face cultural stigma when seeking behavioral health care.

Receiving behavioral health treatment with the assistance of a translator can feel traumatizing or invasive to an individual's privacy. Community members emphasized that building trust with behavioral health providers takes time. This is a challenge when most insurance coverage limits the number of appointments per year.

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

Workforce Challenges

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

[117] Military Officers Association of America (2017), *Health of Women Who have Served.*

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

Due to the nature of the work, health care providers experienced vicarious trauma,[93] compassion fatigue and secondary traumatic stress. Health care providers carry many of their patients' stories and are constantly exposed to their traumatic experiences (both physical and psychological).

Some clinicians drew parallels between health care providers working at the frontline of the pandemic and veterans who have served on the frontlines in combat. Research has found that frontline health providers during the pandemic report similar outcomes of depression, self-reported quality of life and burnout as combat veterans. Military conflicts and pandemic health care work have fundamental differences, but both have presented many people with morally damaging experiences, which in turn are associated with substantial psychological distress.[118]

See **Appendix M** for individual quotes from HASD&IC's community engagement interview and focus group participants regarding the identified community need of Behavioral Health. In addition, the complete results of HASD&IC's online community engagement survey are available within the full HASD&IC 2022 CHNA report at: https://hasdic.org/community-health-needs-assessment-chna/.

SCHHC 2022 CHNA

Increasing Behavioral Health Needs

Participants in the IPH Sharp Provider Survey identified increased anxiety and depression as being among the top community needs most seriously impacted by the COVID-19 pandemic in the past year. Nearly all respondents agreed that COVID-19 had either a moderate or major impact on rates of anxiety (98%) and depression (96%).

Those noted as being most impacted by COVID-19 in relation to increased depression included caregivers of adults or older adults, patients using Medi-Cal or Medicare, and those with LEP. Hispanic individuals were identified as being especially affected by increased depression due to COVID-19, as well as Black/African American, Multiracial and Asian individuals. Further, two-thirds of survey respondents suggested that Sharp has not implemented programs or services to help address increased depression.

[118] Nieuwsma, J.A., O'Brien, E.C., Xu, H., Smigelsky, M.A., VISN 6 MIRECC Workgroup, HERO Research Program, & Meador, K.G. (2022). Patterns of potential moral injury in post-9/11 combat veterans and COVID-19 healthcare workers. *Journal of General Internal Medicine, 37*, 2033–2040. DOI: 10.1007/s11606-022-07487-4

Respondents to the Sharp Insight Community Survey indicated that increased anxiety or depression had a minor impact on the community due to COVID-19.

According to internal data analysis conducted for Sharp's 2022 CHNA, in fiscal year 2021 (FY 2021), Sharp's acute care hospitals admitted over 38,000 individuals as inpatients with a behavioral health diagnosis. This is a steady increase year-over-year from FY 2016. This increase is likely the result of both improved documentation and actual disease prevalence in the community. See **Figures 28** and **29** below.

Figure 28: Behavioral Health Disorders among Sharp's Acute Inpatients, FY 2016-2021

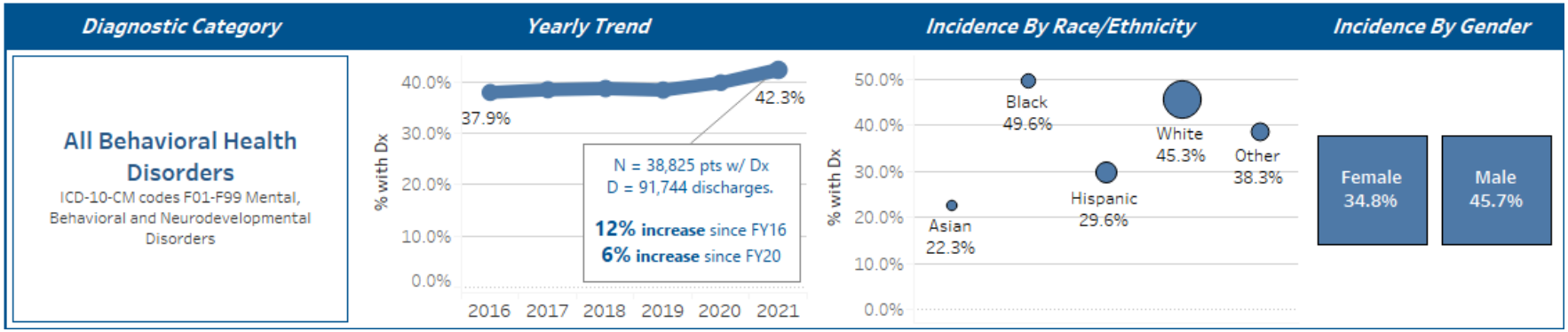
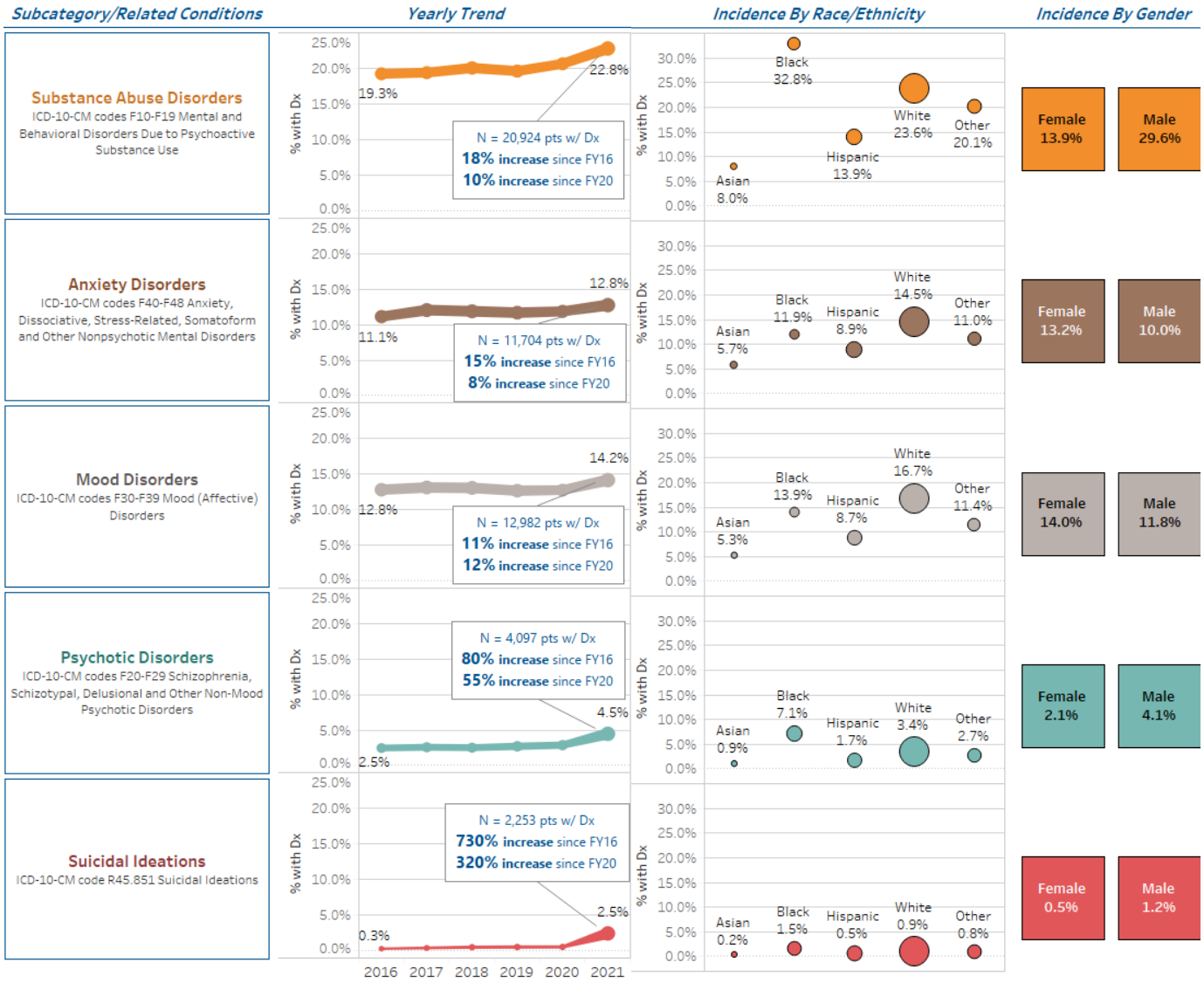


Figure 29: Behavioral Health Disorders among Sharp's Acute Inpatients, Specific Conditions, FY 2016-2021



Access to Behavioral Health Care

According to the IPH Sharp Provider Survey, limited access to behavioral health services and limited access to emotional and social support were among the top clinical and social needs most seriously impacted by COVID-19 in the past year. The vast majority of survey respondents indicated that COVID-19 had a moderate or major impact on limiting access to behavioral health care (91%) and access to emotional or social support (e.g., support groups) (95%).

Survey respondents indicated that the populations who have been especially affected by COVID-19 in relation to limited access to behavioral health care include patients utilizing Medi-Cal and Medicare and patients with LEP, as well as Hispanic, Black/African American, and Multiracial individuals.

More than half (57%) of survey respondents believed Sharp has not implemented programs or services to address limited access to behavioral health care. Further, most respondents (71%) indicated that Sharp has not implemented services to address limited access to emotional or social support. Virtual support groups were the only example offered about Sharp's efforts taken to address access to emotional or social support.

Respondents to the Sharp Insight Community Survey reported that decreased access to in-person behavioral health care due to COVID-19 had a minor impact on the community. The majority of respondents (95%) did not participate in Sharp's behavioral health program offerings. Those who did participate were more likely to be age 65 or older.

Workforce Challenges

IPH Sharp Human Resources Survey participants identified increased anxiety or stress as the most significant issue impacting Sharp team members during the past year (93%). Respondents were unanimous (100%) that Sharp has implemented programs and services to help employees with increased anxiety or stress.

Please see the following appendices for more information on SCHHC's 2022 CHNA Behavioral Health findings:

- **Appendix H**: Sharp 2022 Clinical Data Analytics
- **Appendix I**: IPH Sharp Provider/Human Resources 2022 CHNA Survey & Findings
- **Appendix J**: Sharp Insight Community 2022 CHNA Survey & Findings

Children & Youth Well-Being

Overall Findings

Concern for the well-being of children and youth was identified as a high priority for the community in both the SCHHC and HASD&IC 2022 CHNAs. The findings for Children & Youth Well-Being are most often described in relation to the health and social issues below. Overwhelming, the findings also emphasize the behavioral health needs of children and youth, and the impact of the COVID-19 pandemic on their overall health and well-being.

- *Increasing behavioral health needs*
- *Resource and service deficits in behavioral health*
- *Behavioral health workforce shortages*
- *Physical health*
- *Childcare and early education*
- *Early childhood development*
- *Education challenges*
- *Housing and economic stability for youth*
- *Safety concerns*
- *Sexual exploitation*

Children & Youth Well-Being findings are described below for both the HASD&IC and SCHHC 2022 CHNAs.

HASD&IC 2022 CHNA

Increasing Behavioral Health Needs

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

"Children and families across our country have experienced enormous adversity and disruption. The inequities that result from structural racism have contributed to disproportionate impacts on children from communities of color," according to the AAP, AACAP and CHA.[119]

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

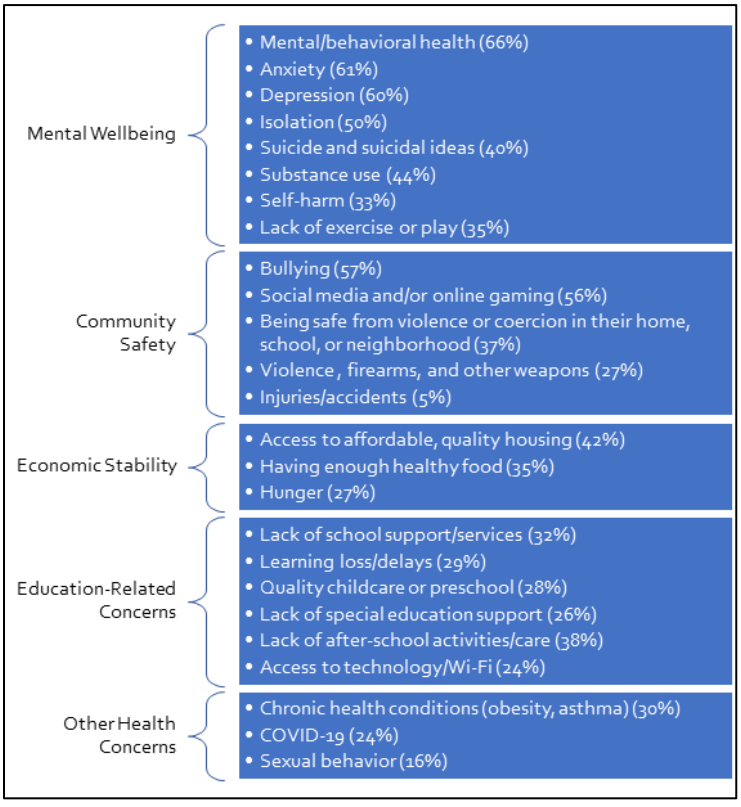
[119] American Academy of Pediatrics (2021), *AAP-AACAP-CHA Declaration of a National Emergency in Child and Adolescent Mental Health.*

- It is estimated that as of June 2021, more than 140,000 children in the U.S. had lost a parent or grandparent caregiver to COVID-19.
- In 2019, before the pandemic, 1 in 3 high school students and half of female students reported persistent feelings of sadness or hopelessness, an overall increase of 40% from 2009.
- Socioeconomically disadvantaged children and adolescents are two to three times more likely to develop behavioral health conditions than peers with higher socioeconomic status.[120]

HASD&IC's online community survey included the following question: "What most worries you about the health and well-being of children in our community?"

Responses are listed in **Figure 30** below, grouped into five major categories. The concerns of the 502 survey respondents echoed much of the feedback gathered during the focus groups and interviews — the top concerns were related to the mental well-being of children and youth. The next highest areas of concern were around community safety.

Figure 30: HASD&IC Online Community Survey Response – Top Concerns for Children's Health & Well-Being



[120] U.S. Department of Health & Human Services (2021), *U.S. Surgeon General Issues Advisory on Youth Mental Health Crisis Further Exposed by COVID-19 Pandemic.*

Mental/behavioral health, anxiety and depression were each selected as top concerns for children by more than 60% of online survey respondents.

The pandemic has had both temporary and long-term impacts on children's behavioral health, leading to an increased need for behavioral health services and support. Clinicians and community members agreed that the top behavioral health challenges among children and youth are anxiety and depression. There was also grave concern about children with autism and ADHD. Factors that have contributed to increased demand for behavioral health services and support include: bullying, lack of activities, social isolation, social media, and stress due to family and financial circumstances

These factors have translated to a greater number of children seeking crisis mental health services at EDs across the county. Clinicians shared additional factors related to the increase in ED access, including involvement with the justice system and parents seeking respite.

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

Early in the pandemic, many families were forced to cancel in-home services due to the risk of exposure. Therapy accessed virtually may not always be appropriate for younger children or those who are nonverbal.

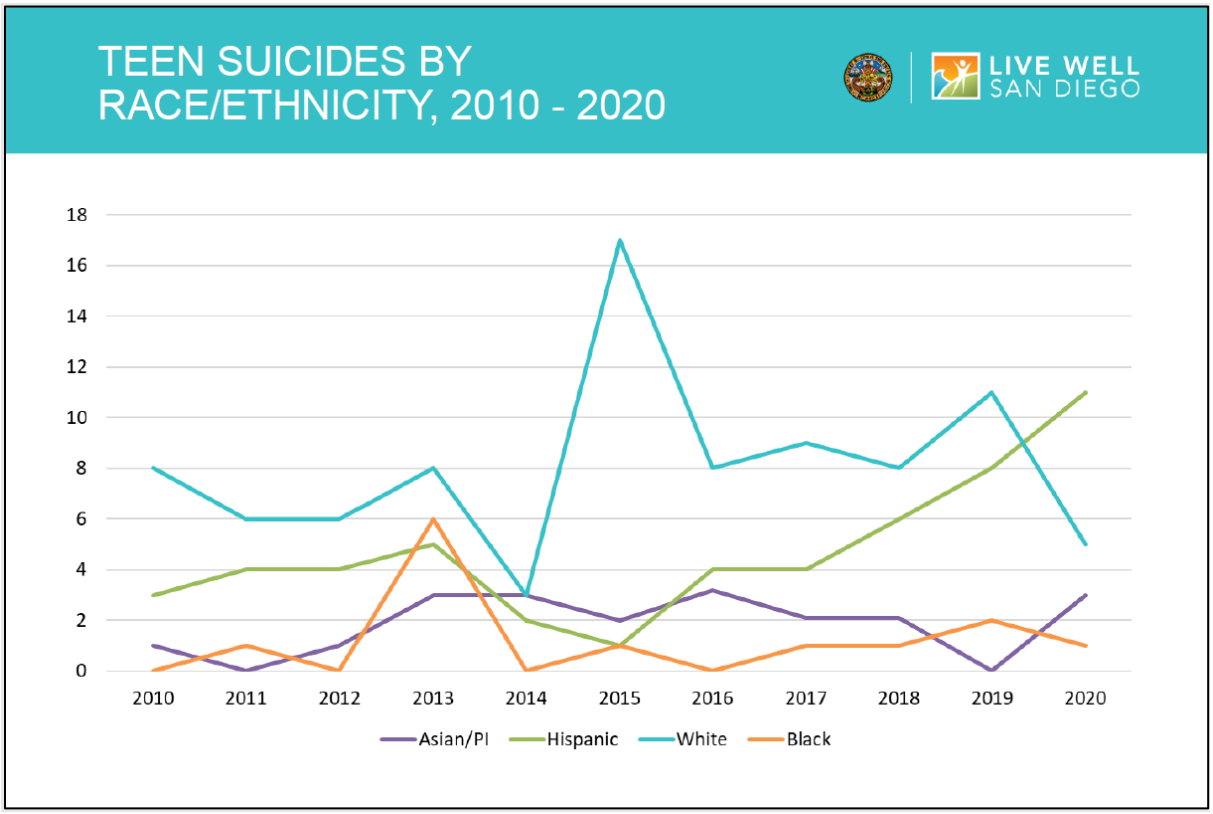
Hospital EDs have reported an alarming increase in psychiatric crises among children and youth. For example, Rady Children's Hospital San Diego reported a 1,746% increase from 2011 to 2019.[121] In 2019, as many as six youth per day were treated for attempted suicide in local EDs. Also in 2019, depressive disorders were the most frequent principal diagnosis among hospital inpatients 17 years or younger.[122]

Although recent countywide data show an overall decrease in teen suicide deaths, there was an increase in 2020 among both Asian/Pacific Islander and Hispanic teens (see **Figure 31**). In addition, there has been a significant number of attempted suicides and increasing concern about suicidality in youth. Clinicians shared their experiences treating youth who are heavily influenced by content they find online and stated that social media has normalized suicide as an option for youth who are struggling with mental and behavioral health challenges. They described an inability for some youth to cope — something as seemingly minor as a parent taking away a child's cellphone could trigger a mental health crisis.

[121] Rady Children's Transforming Mental Health Initiative, Rady Children's Hospital – San Diego and San Diego Center for Children (2021). Teaming Up for Healthy Kids [PowerPoint slides]. Presented virtually at The California Alliance of Child and Family Services and California Association of Health Plans *Teaming Up for Healthy Kids* Webinar, January 2021. https://cacfs.memberclicks.net/assets/website/SanDiego%26Rady.pdf

[122] California's Department of Health Care Access and Information limited data sets, 2016-2020. SpeedTrack© – In 2019, 2,379 San Diego youth seen in San Diego County emergency departments were coded with a primary diagnosis of Suicidal Ideation/Attempt/Intentional Self-Harm.

Figure 31: Teen Suicides in SDC, 2020[123]



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

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

Resource and Service Deficits in Behavioral Health

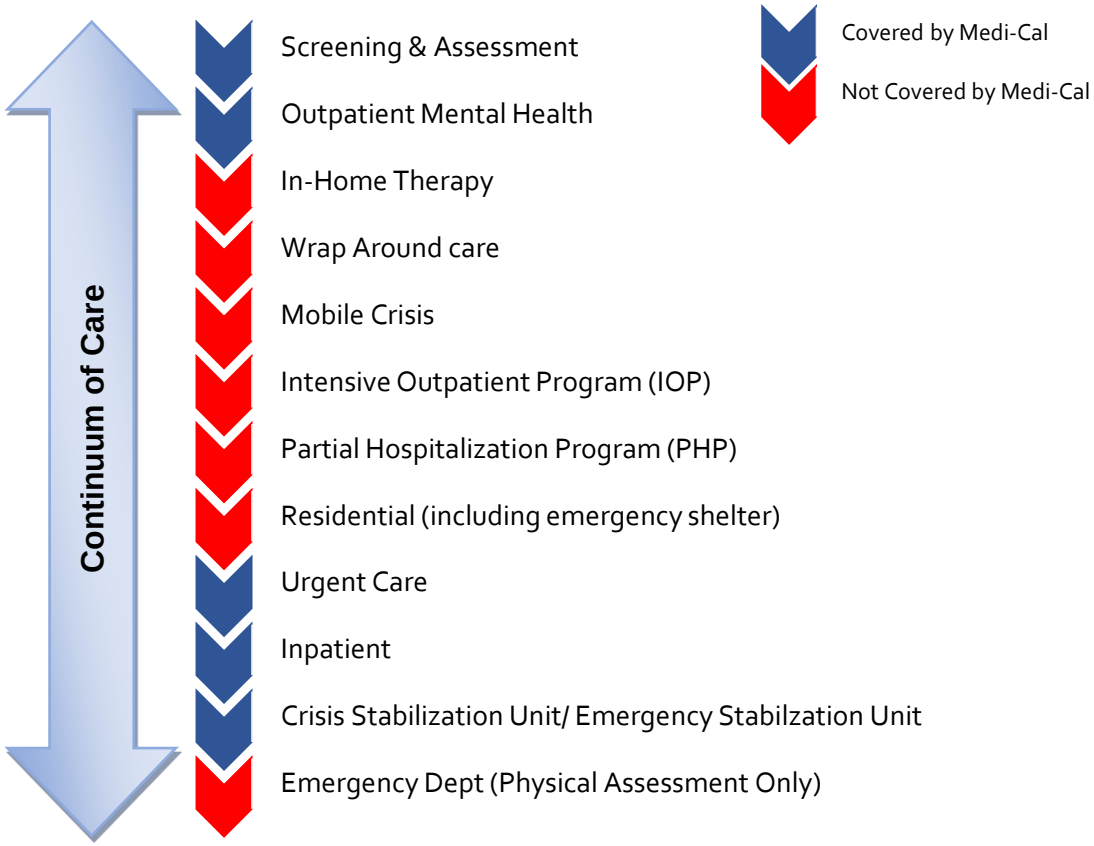
Frustration and hopelessness about the dire lack of available behavioral health resources and services for children was expressed consistently in HASD&IC's community engagement process.

[123] County of San Diego HHSA (2021), *Suicide in San Diego County, 2020: Suicide Prevention Council Annual Stakeholders Meeting.*

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

In SDC, approximately half of all children (325,747 as of April 2022) are enrolled in Medi-Cal.[124] Children enrolled in Medi-Cal often have additional risk factors that increase their need for mental and behavioral health treatments and interventions. Unfortunately, there is a significant gap between the behavioral health services that are needed to treat children and prevent them from reaching a crisis or acute state and the services that are covered by children's Medi-Cal. **Figure 32** below describes Medi-Cal's mental health continuum of care for children.[125]

Figure 32: Medi-Cal Managed Care Mental Health Continuum of Care for Children[125]



One result of the serious deficits within the regional continuum of care is the increase in children and youth in crisis who are presenting at local EDs. While an inpatient acute care bed may be the needed level of care for some, others would benefit from crisis residential services or partial hospitalization programs where they could remain at

[124] County of San Diego HHSA (2022), *Eligibility Services by the Numbers Report: April 2022.*
[125] Graphic created by HASD&IC (2022) using data from the San Diego Center for Children.

home. With long waitlists for community-based programs, many children and youth end up making repeated visits to the ED, even if they do not require hospital-level care. Community-based services often lack the capacity to take on additional clients to provide the ongoing care that is needed.

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

In recent years, there has been an increase in volume at SDC's only emergency shelter for children. Post-shelter placement options are extremely limited. As a result, children who need high levels of care often end up in a 10-day treatment or another short-term placement. Youth receiving treatment at the emergency shelter often leave without permission and then require medical clearance to return. In some instances, clinicians reported seeing the same youths leaving and returning to the shelter each day for over a week.

Behavioral Health Workforce Shortages

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

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

Physical Health

Rates of childhood immunizations, including MMR (measles, mumps and rubella) and human papillomavirus, are down significantly compared to pre-pandemic times. The risk of COVID-19 exposure and infection may have kept some families from seeking routine pediatric care for their children. Reports from early in the pandemic revealed a significant decrease in vaccine administration for children and youth.[126] This decline may have been worsened by the shift to online learning from in-person schooling, where

[126] Patel Murthy, B., Zell, E., et al. (2021). Impact of the COVID-19 pandemic on administration of selected routine childhood and adolescent vaccinations — 10 U.S. jurisdictions, March–September 2020. *MMWR Morbidity and Mortality Weekly Report*, *7,* 840–845. DOI: http://dx.doi.org/10.15585/mmwr.mm7023a2

immunizations are generally required to attend.[127] Even catch-up immunizations for children and youth are falling behind, which has serious implications. A decline in routine vaccinations could lead to an increase in death or disability due to the emergence of vaccine-preventable diseases.

According to preliminary data shared by the County of San Diego HHSA's Epidemiology and Immunization Services Branch, there was a decline in the total number of routine childhood immunizations administered in SDC for most months from March through December 2020, compared to the same months in 2019. The greatest impact was seen during the stay-at-home order in April 2020, with a 26% decline in vaccinations among children ages 0 to 5, and a 79% decline among those ages 6 to 18. Total vaccinations by month showed some rebounds in 2021 with some months surpassing 2019 totals, which may be attributed to catch-up vaccinations.

In addition, some community members experienced high levels of inactivity and isolation due to stay-at-home orders associated with the pandemic, which may have lasting impacts on children's social and physical health. A study of over 430,000 children ages 2 to 19 years found that body mass index increased nearly two-fold during the COVID-19 pandemic when compared to a pre-pandemic period.[128]

Childcare and Early Education

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

High-quality early education and childcare for young children provides significant benefits, including physical and cognitive improvements and enhanced school readiness.[129] An analysis of childcare supply and demand found that nearly half (48%) of children ages 5 and under have parents who work and have no available licensed childcare option, while 69% of children in that age group need childcare and are income eligible for a subsidy but not enrolled in a subsidized childcare program. In addition, over three-quarters (76%) of parents with children under 6 said finding affordable childcare in their area is an issue and 70% had difficulty finding childcare that meets their expectations.

[127] Czeisler, M.É., Marynak, K., Clarke K.E., et al. Delay or Avoidance of Medical Care Because of COVID-19–Related Concerns — United States, June 2020. (2020). *Morbidity and Mortality Weekly Report*, *69*:1250–1257. DOI: http://dx.doi.org/10.15585/mmwr.mm6936a4

[128] Lange, S.J., Kompaniyets, L., Freedman, D.S., et al. (2021). Longitudinal trends in body mass index before and during the COVID-19 pandemic among persons aged 2–19 Years — United States, 2018–2020. *Morbidity and Mortality Weekly Report*, *70*:1278–1283. DOI: http://dx.doi.org/10.15585/mmwr.mm7037a3

[129] Donoghue, E.A., Council on Early Childhood, Lieser, D., DelConte, B., Donoghue, E., Earls, M., Glassy, D., Mendelsohn, A., McFadden, T., Scholer, S., Takagishi, J., Vanderbilt, D., & Williams, P.G. (2017). Quality early education and child care from birth to kindergarten. *Pediatrics*, *140*(2). https://doi.org/10.1542/peds.2017-1488

Research suggests that early childhood education is important for a variety of reasons, and positive interventions are evident even after participants reach adulthood.[130] For example:

- Early childhood education has been shown to lower the rate of special education placement by 10%.[131]
- Children who participated in high-quality early childhood education had increased rates of four-year high school graduation, college attendance, associate's or higher college degree attainment and postsecondary degree attainment[132] and higher employment rates at age 30.[133]
- Participants also showed long-term health benefits, including reduced rates of depression, smoking and cardiovascular disease,[134] which can lead to lower health care costs — resulting in a 13% return on investment for these programs.[133]
- Parents with children who participated in high-quality early childhood education saw sustained parental wage growth.[135]

Early Childhood Development

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

Clinicians shared that there are specific challenges in diagnosing young children. Under the age of 5, behavioral health and development for children are often intertwined. Developmental concerns or delays (such as speech, hearing or gross motor skills) may often manifest as behavioral challenges, and vice-versa. Successful diagnosis for infants or young children requires significant time. Clinicians need to understand whether the challenges they are seeing are development-related (such as autism) or effects of trauma exposure. Research shows that 85% of maltreated children under 3 have a moderate to high risk for developmental delays.[136]

In addition, ACEs can have long-term effects on children's health and well-being. The CDC describes ACEs as potentially traumatic events that occur during childhood (ages 0 to 17 years). Examples include child abuse (physical, sexual or emotional); child

[130] Cannon, J. S., Kilburn, M. R., Karoly, L. A., Mattox, T., Muchow, A. N., & Buenaventura, M. (2018). Investing early: Taking stock of outcomes and economic returns from early childhood programs. *RAND Health Quarterly*, *7*(4). 6.
[131] Learning Policy Institute (2019), *Untangling the Evidence on Preschool Effectiveness*.
[132] Reynolds, A.J., Ou, S., & Temple, J.A. (2018). A multicomponent, preschool to third grade preventive intervention and educational attainment at 35 years of age. *JAMA Pediatrics*, *172*(3), 247–256. doi:10.1001/jamapediatrics.2017.4673
[133] García, J.L., Heckman, J.J., Leaf, D.E, & Prados, M.J. (2020). Quantifying the life-cycle benefits of an influential early-childhood program. *Journal of Political Economy*, *128*(7). https://doi.org/10.1086/705718
[134] Health Affairs (2019), *The Effects of Early Care and Education on Children's Health*.
[135] Strong Nation (2018), *The Economic Impacts of Insufficient Child Care on Working Families*.
[136] UC Davis Continuing and Professional Education Human Services (2020), *About Child Welfare Developmental Screening and the Child Abuse Prevention and Treatment Act.*

neglect (physical neglect and inadequate supervision, or emotional, medical or educational neglect); and childhood trauma (witnessing violence in the home or neighborhood, substance use, mental health challenges in the home, instability from parental separation or household member incarceration).[137]

Children who experience ACEs are at increased risk for long-term health problems that span behavioral, emotional and physical wellness, which also can affect education, employment and income levels. As the body responds to the toxic stress associated with ACEs, the hormone cortisol is in constant production and has a negative impact on neurological development as well as organs and tissues in the body. As a person's ACE score increases, their risk of these negative health outcomes increases.[138]

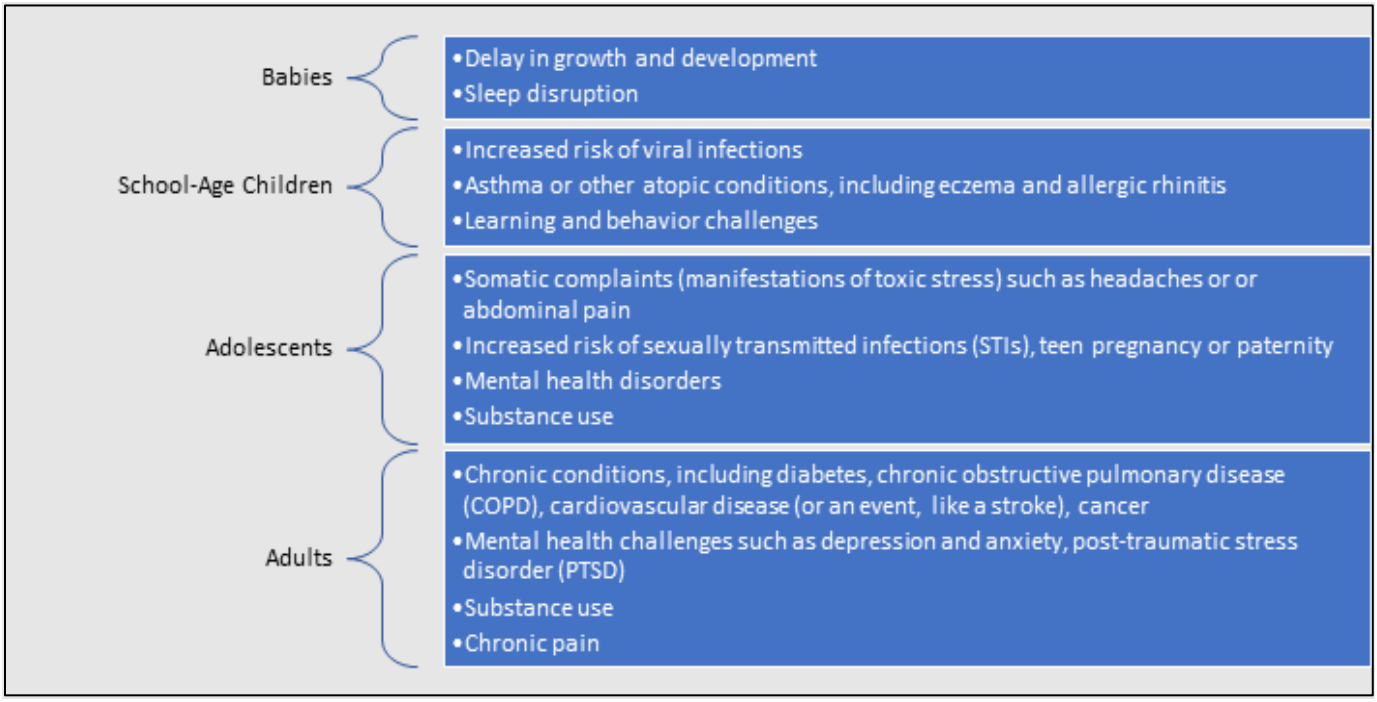
ACEs Aware, California's first-in-the-nation effort to screen patients for ACEs to help improve and save lives notes that not all stressors are toxic — some are important for growth and development. For example, positive stress can include brief periods of responding to a routine stressor such as a test or competition. Tolerable stress is also a form of positive stress that is limited in time and buffered by connections with adults who help the child adapt and recover from an event, such as a natural disaster.[139]

ACEs are common and the effects can accumulate over time. CDC research suggests that 61% of adults have had at least one ACE and 16% have experienced four or more types of ACEs. Females and several racial/ethnic minority groups are at greater risk of experiencing four or more ACEs. Further, children living in under-resourced or racially segregated neighborhoods, who move frequently, or who experience food insecurity can be exposed to toxic stress and increased ACEs.[140]

ACEs can create a generational cycle in which the children of parents with ACEs are more likely to experience ACEs. Traumatic events "rewire" the brain to operate in fight or flight response. This response can hinder executive functions that include attentional control, working memory, inhibition and problem-solving.[141] **Figure 33** below lists health conditions by age that are associated with ACEs.

[137] Childhelp. (2022), *What is Child Abuse?*
[138] ACEs Aware (2020), *Adverse Childhood Experiences Questionnaire for Adults.*
[139] ACEs Aware (2022), *The Science of ACEs & Toxic Stress.*
[140] CDC (2022), *Preventing Adverse Childhood Experiences*.
[141] CDC (2018), *We All Have a Role in Preventing ACEs*.

Figure 33: ACEs Associated with Health Conditions by Age[139]



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

TIC is essential to effectively provide care to people affected by ACEs. Instead of asking what is "wrong" with a person, a trauma-informed approach seeks to learn what happened to them in order to develop a better understanding, sensitivity and caring awareness. Please see the **Access to Health Care** findings for more information about TIC.

Education Challenges

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

Early in the pandemic, one of the most serious educational inequities was access to reliable Wi-Fi or internet to support distance learning. School districts and CBOs made tremendous investment, but disparities remain. In addition, research suggests that

providing access to Wi-Fi alone was not enough to support successful learning environments at home.[142]

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

Housing and Economic Stability for Youth

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

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

The San Diego Regional Task Force on Homelessness' 2022 WeAllCount Point-in-Time Count found that the number of families experiencing homelessness was up 56% from 2020. The count also found that more than 1,800 youth are currently experiencing homelessness countywide.[143]

Often referred to as an "invisible" crisis, youth homelessness impacts 1 in 10 young adults ages 18 to 24 each year, and 1 in 30 adolescents (ages 13 to 17) experience homelessness without a caregiver.[144] LGBTQ+ youth are twice as likely to become homeless compared to their non-LGBTQ+ peers and tend to receive residential treatment at disproportionately high rates. Youth experiencing behavioral health issues, particularly those receiving inpatient and residential behavioral health treatment, face an increased likelihood of experiencing homelessness. A significant number of homeless youth report foster care involvement via out-of-home placements, either in foster care or institutional settings.[145]

Safety Concerns

Clinicians and CBOs shared concerns about increasing safety risks for children. Many risks were amplified because of the pandemic.

[142] San Diego for Every Child (2020), *Beyond the Hotspot: Supporting Equitable Distance Learning in San Diego County.*
[143] San Diego Regional Taskforce on Homelessness (2022), *San Diego County WeAllCount Point-in-Time Count.*
[144] Voices of Youth Count (2017), *Missed opportunities: Youth homelessness in America.*
[145] Manatt Health (2022), *Leveraging Medicaid to Reduce Youth Homelessness.*

The COVID-19 pandemic led to changes in the types of injuries that were most often experienced by children and youth. With stay-at-home orders, families were contained in their homes and unintentional injuries in the home, like window falls, led to hospitalizations in greater numbers than expected. As families spent more time outside, hospitals experienced an increase in ATV crashes and an unexpected increase in drownings — primarily in backyard pools.[146]

When schools were teaching through virtual learning, there was a reduction in mandated reporters identifying incidents of domestic violence and neglect. Children who were seen at hospitals seemed to have more serious injuries.

In HASD&IC's online community survey, respondents identified bullying (57%) and social media/online gaming (56%) as top concerns. Although the survey doesn't specify whether the bullying was taking place online or in-person, based on community feedback there is growing concern about bullying and harassment through social media.

In SDC, neglect comprises an average of 75% of all substantiated child maltreatment allegations for children ages 0 to 5. The combination of limited income and high housing costs are risk factors for neglect.[147]

Sexual Exploitation

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

A study of human trafficking and CSEC in SDC found that the average age of entry into sex trafficking is 16.1 years of age. Among sex trafficking victims included in the study who had been arrested for prostitution, 55% reported that they were homeless and 28% had been in foster care. Twenty high schools were involved in the study, and all participating schools affirmed that recruitment was happening among their students. Further, 90% of participating schools had documented cases of sex trafficking victimization.[148]

See **Appendix M** for individual quotes from HASD&IC's community engagement interview and focus group participants regarding the identified community need of Children & Youth Well-Being. In addition, the complete results of HASD&IC's online community engagement survey are available within the full HASD&IC 2022 CHNA report at: https://hasdic.org/community-health-needs-assessment-chna/.

[146] Rady Children's Hospital San Diego (2022), *Childhood Unintentional Injuries in San Diego County: A report to the community.*
[147] Partners in Prevention (2020), *Children, Family & Community Wellness: Prevention Landscape Scan.*
[148] Carpenter, A. C. and Gates, J. (2016). *The Nature and Extent of Gang Involvement in Sex Trafficking in San Diego County.* San Diego, CA: University of San Diego and Point Loma Nazarene University.

Childcare and Early Education

The majority (82%) of IPH Sharp Human Resources Survey respondents expressed that the COVID-19 pandemic had at least a minor impact on access to dependent care (childcare or eldercare). When asked how this need would impact Sharp team members over the next year, 43% believed the issue would remain the same while 21% thought it would get worse.

Please see the IPH Sharp Provider/Human Resources 2022 CHNA Survey & Findings in **Appendix I** for more information on SCHHC's 2022 CHNA Children & Youth Well-Being findings.

Chronic Health Conditions

Overall Findings

Chronic Health Conditions were identified as a high priority need through both the SCHHC and HASD&IC 2022 CHNAs. Chronic Health Conditions findings are described in terms of specific health conditions (e.g., cancer, cardiovascular disease, diabetes) as well as relative to the affected populations and care challenges listed below. The findings also illustrate how the COVID-19 pandemic has exacerbated these issues.

- *Incidence and mortality*
- *Access to care*
- *Economic stability, housing and the cost of care*
- *Veterans and military*
- *LGBTQ+*
- *Other vulnerable populations*
- *Stigma*
- *Care management and coordination*
- *Medication management, cost and coordination*
- *Emotional and behavioral health*

Chronic Health Conditions findings are described below for both the HASD&IC and SCHHC 2022 CHNAs.

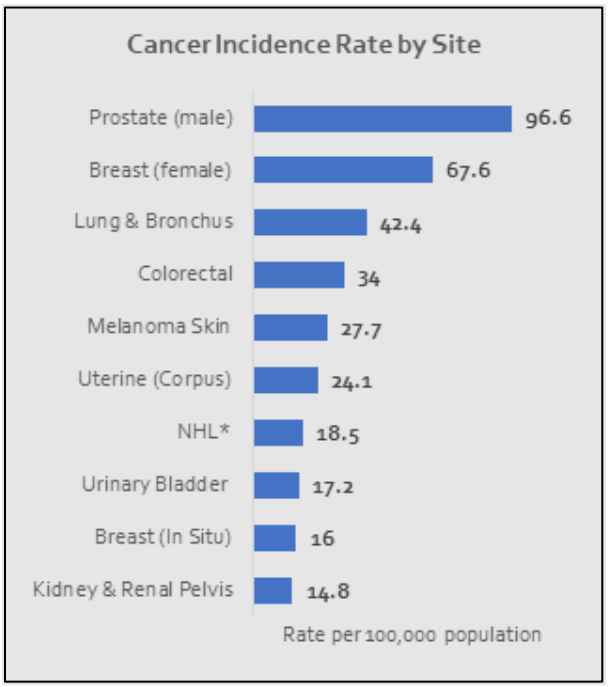
Incidence and Mortality

In 2019, chronic health conditions accounted for the majority of SDC's leading causes of death.[57] According to the CDC, chronic diseases — referred to in this finding as chronic health conditions — are among the leading causes of death and disability in the U.S. Six in ten U.S. adults live with a chronic disease and 4 in 10 adults live with at least two chronic diseases.[149]

From 2000 to 2019, SDC reported an overall decrease in the percentage and rate of deaths due to chronic health conditions.[150] Despite this trend, cancer (malignant neoplasms) was San Diegans' leading cause of death in 2019, followed by diseases of the heart. Diabetes was identified as the seventh leading underlying cause of death for San Diegans in that same year.[57] For additional data on SDC's leading causes of death, see **Section 4: Community Defined**.

For all cancer sites, the age-adjusted rate in SDC from 2013 to 2017 was 406.9 per 100,000 population. The top 10 incidence[151] rates by cancer site are represented in **Figure 34**.[152]

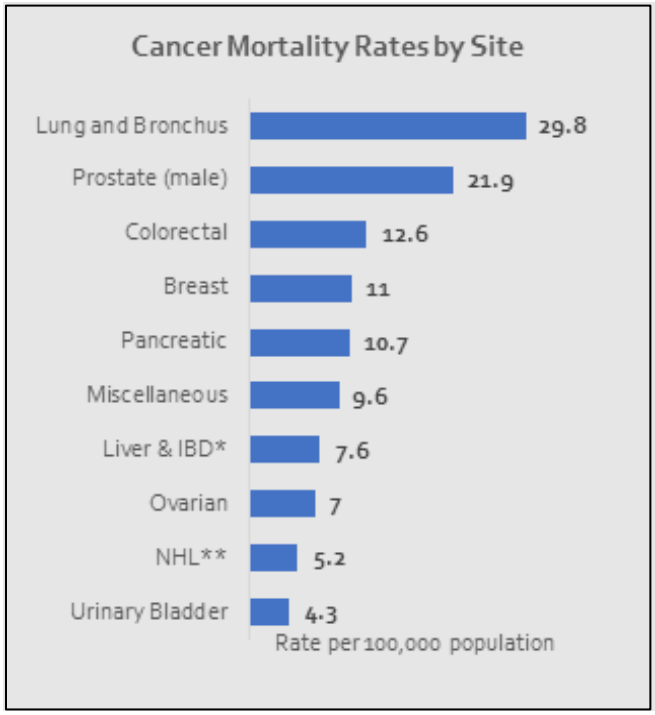
Figure 34: Incidence Rates for Cancer in SDC, 2013-2017[152]



[149] CDC (2022), *About Chronic Diseases.*
[150] San Diego County HHSA, PHS, CHSU (2021), *Chronic Disease Deaths in San Diego County – County Overview, 2000-2019.*
[151] Incidence is the rate of new cases or events over a specified period for the population at risk for the event. In medicine, the incidence is commonly the newly identified cases of a disease or condition per population at risk over a specified timeframe (National Library of Medicine, 2022).
[152] California Cancer Registry (2019), *Age-Adjusted Invasive Cancer Incidence Rates in California, 2013-2017, By County.*

The age-adjusted mortality rate for all cancer sites from 2013 to 2017 was 145.9 per 100,000 population. Mortality rates by top 10 cancer sites are represented in **Figure 35**.[153]

Figure 35. Mortality Rates for Cancer in SDC, 2013-17[153]



*Inflammatory Bowel Disease
**non-Hodgkin's lymphoma

Access to Care

Fear of contracting COVID-19 caused many people to delay or forgo necessary or routine health care.

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

In 2020, 27.4% of California Health Interview Survey (CHIS) respondents from SDC cited COVID-19 as the main reason for delaying or foregoing needed medical care.[54]

Research from California Health Care Foundation shows that nearly half (47%) of those who postponed care reported their condition worsened as a result (up 6% from a survey administered in the previous year). When looking at lower-income Californians who postponed care, 51% reported their condition worsening.[61]

[153] California Cancer Registry (2019), *Age-Adjusted Cancer Mortality Rates in California, 2013-2017, By County.*

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

Ongoing unpredictability, social isolation and the inability to get treatment have all had an impact on people with chronic health conditions. Interviewees shared a deep concern about the possibility of an increase in patients who have delayed care and may now be sicker with more complex or complicated conditions. The CDC estimated that due to California's stay-at-home order, screenings at health care facilities may have decreased by 80% from 2019 to 2020.[154]

Access to cancer care was identified as a significant challenge for the community. Delayed or disrupted access to cancer screening and its long-term consequences was identified as a need for community members. More advanced cancers and excess deaths are of particular concern. Interviewees shared that cancer detection at later stages, when treatment may be more intensive and potentially less effective, was a significant concern.

A National Cancer Institute prediction model[155] estimated that delays in cancer screenings and postponed treatment during the pandemic could result in additional breast and colorectal cancer deaths in the U.S. over the next decade.[156] One study in SDC found that the incidence of late-stage colorectal and breast cancers presenting at that institution corresponded to a decrease in early-stage presentation of these cancers.[157]

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

Economic Stability, Housing and the Cost of Care

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

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

[154] Miller, M.J., Xu, L., Qin, J., et al. (2021). Impact of COVID-19 on cervical cancer screening rates among women aged 21–65 years in a large integrated health care system — Southern California, January 1–September 30, 2019, and January 1–September 30, 2020. *MMWR Morbidity and Mortality Weekly Report*, *70*(4),109–113. DOI: http://dx.doi.org/10.15585/mmwr.mm7004a1external
[155] It is important to note that the model does not include other cancers and assumes no disruption in care for 6 months.
[156] Sharpless, N.E. (2020). COVID-19 and cancer. *Science, 368*(6497), 1290. https://doi.org/10.1126/science.abd3377
[157] Zhou, J.Z., Kane, S., Ramsey, C., et al. (2022). Comparison of early- and late-stage breast and colorectal cancer diagnoses during vs before the COVID-19 pandemic. *JAMA Network Open*, *5*(2), e2148581. doi:10.1001/jamanetworkopen.2021.48581

A survey of over 3,000 cancer patients and survivors by the American Cancer Society Cancer Action Network Survivor Views program found that nearly three-quarters (73%) were concerned about their ability to pay current or future costs of care, and 7 in 10 worried about incurring medical debt due to cancer care and treatment. In addition, half of respondents (51%) reported incurring medical debt due to costs related to cancer care. Nearly half of respondents (45%) with medical debt delayed or avoided medical care for serious issues, and 62% reported delaying or avoiding medical care for minor issues. Further, about half of respondents described wanting the least expensive treatment options due to their debt. Among the 71% of respondents who made major changes to pay for their care, 36% reported cutting back spending on food, clothing and basic household items, while 28% used all of their savings and 20% borrowed money from family or friends.[158]

In addition, interviewees shared that chronic health conditions are especially difficult to manage for those who are unhoused or facing housing hardship. Lack of access to utilities and household appliances, such as refrigerators and stoves, was cited as a challenge to keeping medication stored at the proper temperature and to cooking nutritious meals that are necessary for diabetes management. For cancer patients and survivors, housing is crucial for recovery and healing from treatments.

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

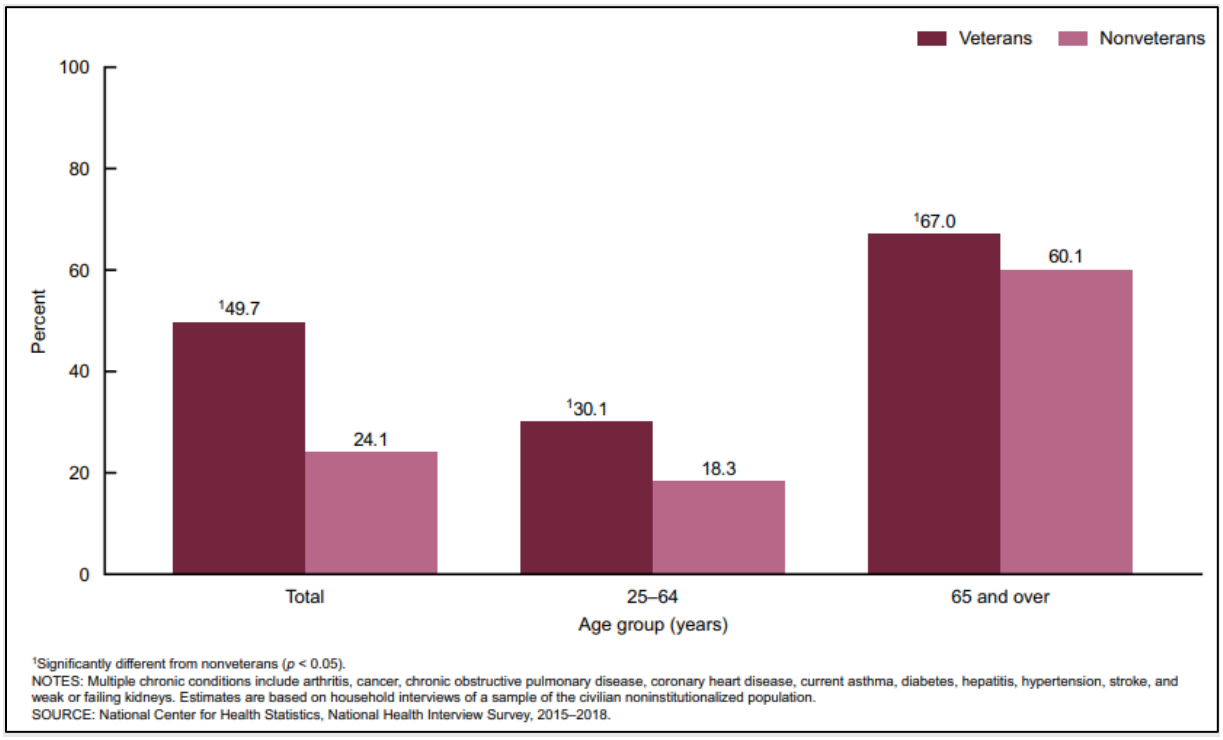
Veterans and Military

Older adults who have served in the military often present with co-occurring medical, behavioral health and SUDs. These complex cases are the most difficult to treat, which can lead to misdiagnosis, inefficient and ineffective treatment plans and care, worsening health, increased system costs and low patient satisfaction. Fifty-seven percent of older veterans have at least three or more chronic conditions, compared to 44% of older civilians.[159] The overall crude prevalence of having multiple chronic conditions was found to be higher among male and female veterans compared to their counterparts who had not served in the military.[160]

Veterans are at an elevated risk for cancer due to military service exposure to hazardous chemicals, related materials, and environmental hazards such as radiation, gas, chemical weapons and herbicides. Presumptive conditions associated with these exposures include certain cancers, respiratory issues and central nervous system conditions.[161] Please see **Figures 36** and **37** for 2015 to 2018 data showing the crude percentage of men and women, respectively, with multiple chronic conditions by veteran status and age.

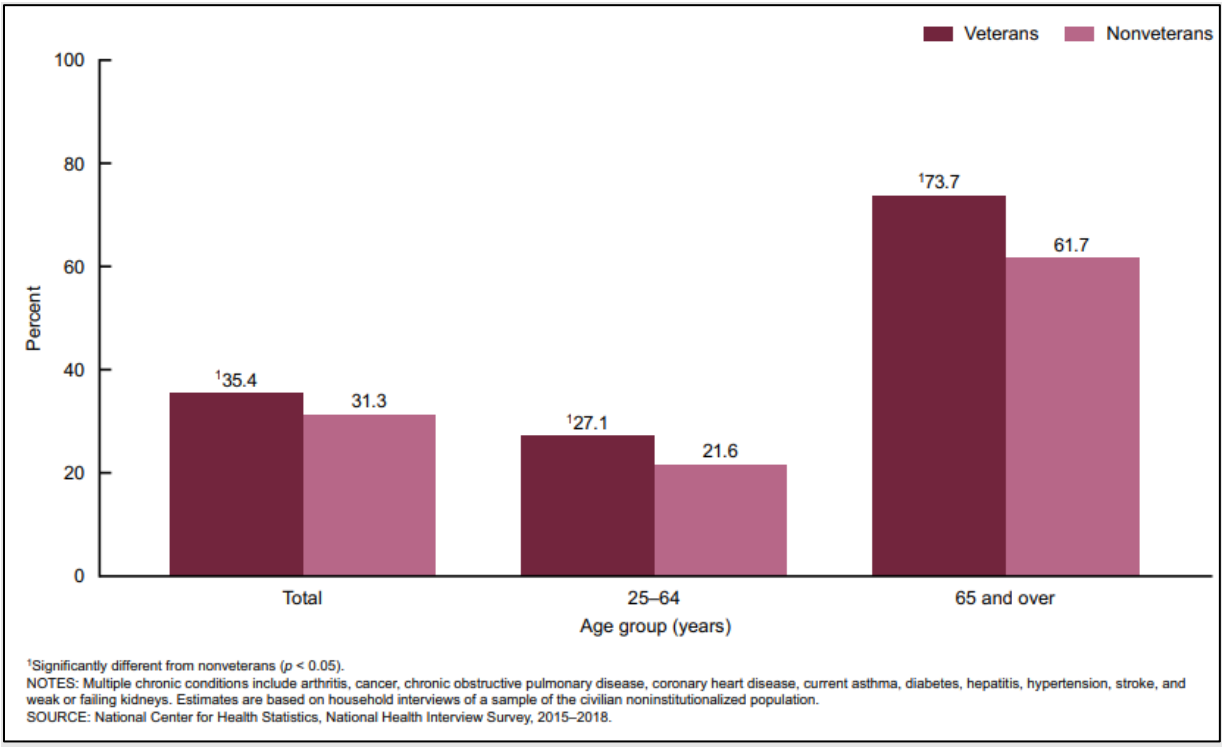
[158] American Cancer Society Cancer Action Network (2022), *Survivor Views: Cancer & Medical Debt.*
[159] National Council on Aging (2019), *A Profile of Older US Veterans*.
[160] CDC (2021), *Multiple Chronic Conditions Among Veterans and Nonveterans: United States, 2015–2018*.
[161] Veterans Affairs Office of Research & Development (2021), *Cancer*.

Figure 36: Crude Percentage of Men Ages 25 and Over with Multiple Chronic Conditions, by Veteran Status and Age: U.S., 2015-18[160]



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

Figure 37: Crude Percentage of Women Ages 25 and Over with Multiple Chronic Conditions, by Veteran Status and Age: U.S., 2015-18[160]



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

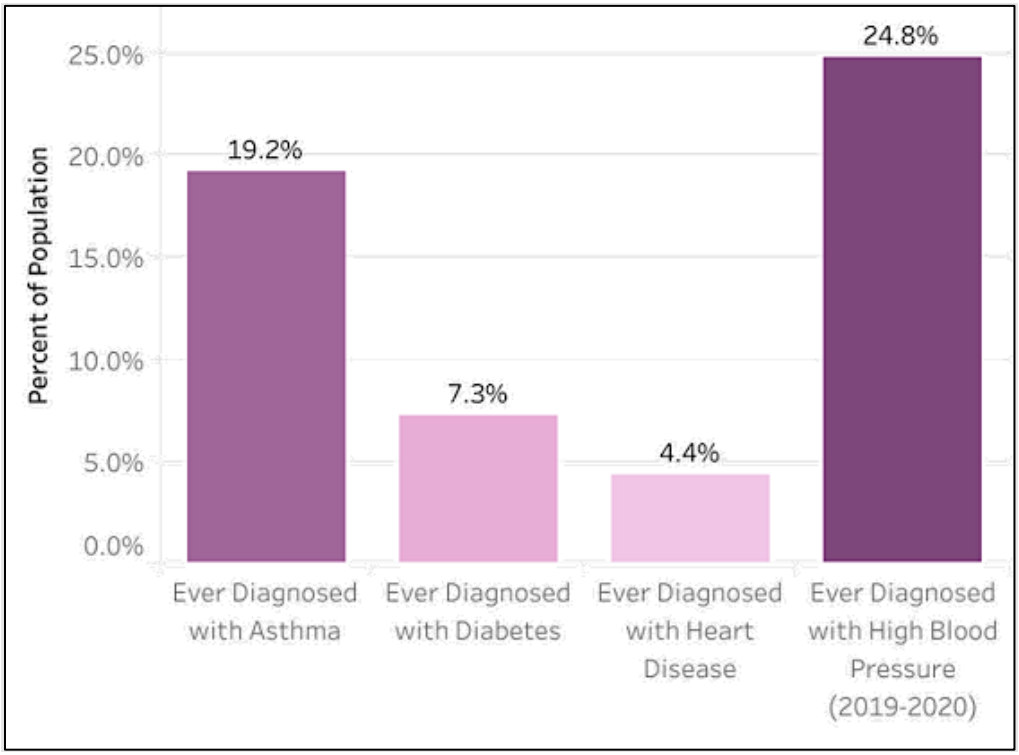
LGBTQ+

Interviewees also reported that members of the LGBTQ+ community experience significant challenges while trying to manage health conditions due to a lack of services that provide care in an inclusive, affirming and supportive environment.

LGBTQ+ persons living with HIV were identified as a group with a disproportionate need for care management support. Peer support and trauma-informed providers were also cited by interviewees as integral for successful disease management.

Though new cases of HIV have decreased over the years, the number of individuals living with HIV has increased. In 2018, over 13,800 people in SDC were living with HIV. Researchers estimate that another 1,300 SDC residents are living with undiagnosed HIV.[162] And, according to 2016 to 2020 CHIS data, the LGBQ[163] population in SDC had a higher (29%) asthma rate compared to people who don't identify as LGBQ.[164] Please refer to **Figure 38** below for additional data on chronic disease prevalence among SDC's LGBQ community.

Figure 38: Chronic Disease Prevalence Among the Adult LGBQ Population in SDC[164]



[162] San Diego County HHSA (2019), *Monthly Communicable Disease Report.*
[163] Data from California Health Interview Survey (CHIS) describes the adult LGBQ population and their health and wellbeing outcomes in San Diego County. Note that individuals who identify as transgender are not included in the adult LGBQ dashboards due to the instability of the CHIS data for the transgender population in San Diego County.
[164] County of San Diego HHSA (2022), *The Adult Lesbian, Gay, Bisexual, and Queer (LGBQ) Population in San Diego County, 2016-2020.*

Other Vulnerable Populations

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

Across multiple interviews, there was agreement that the most common illnesses or injuries for patients experiencing homelessness were untreated, infected or open wounds, and uncontrolled chronic health conditions such as diabetes. The California Department of Health Care Access and Information 2019 hospitalization data showed a significant number of chronic diseases among patients identified as experiencing homelessness — an average of 6.1 chronic conditions for inpatient discharges and 2.1 for ED discharges.[4] In 2019, the ED discharge rate for diabetes was 180.6 per 100,000 population for all age groups; however, the rate was double for those age 65 and older (383.5 per 100,000 population).[4]

Interviewees also described undocumented community members with cancer as being at a severe disadvantage. Many do not have the necessary insurance coverage to enroll in programs and services that could provide financial, logistical and other supportive needs related to their cancer diagnosis.

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

Stigma[69]

Some community members said they are reluctant to seek preventive care such as cancer screenings, despite experiencing physical symptoms or a decline in their baseline health. The prospect of receiving a cancer diagnosis made people feel overwhelmed and fearful of potential suffering and death.

Immigrants and refugees, whose communities may be smaller and closer-knit, reported being less likely to seek cancer screening or treatment because they are afraid of being judged by others.

Care Management and Coordination

Chronic health condition management (i.e., symptom management), preventive screenings, and overall self-management have all been impacted by the pandemic.

Some people with chronic health conditions experienced significant disruptions in their care and critical support services, potentially undoing progress in their care management journey. In addition, delays in getting the care that could have detected disease early or addressed unmanaged conditions have potentially resulted in more

acute and complex cases. For example, CDC research shows that, between November 2020 and February 2021, nearly 9 in 10 adults (87%) ages 18 to 29 with diabetes reported delayed receipt of medical care, and 44% reported difficulty accessing diabetes medications.[165]

Reinforcement of self-management skills such as self-care practices (sleep, diet, physical activity) and medication adherence suffered, potentially jeopardizing the capacity of some people to independently manage their health and mitigate illness.

Through interviews conducted by community health workers and promotoras, the majority of health conditions (six of the top 10) identified as being the most concerning for community members were associated with chronic health conditions, including: stress (62%); high blood pressure (43%); diabetes (43%); nutrition, physical activity and weight (35%); heart disease and stroke (27%) and cancer (26%).

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

Without regular appointments and with long waits for specialty care, patients with chronic health conditions may have had to ration treatment and support services, in turn relying on their own ability to stay engaged. According to the CDC's best practices in self-management, increased knowledge, education, support and resources can lead to positive chronic health condition outcomes.[166]

Due to the intersectionality of findings, please see the **Access to Health Care** findings for more general information.

Medication Management, Cost and Coordination

HASD&IC's community engagement participants expressed that financial constraints related to the pandemic made it more difficult to refill and obtain prescriptions. For some patients, medication became a lower priority than other competing financial needs. This made sticking to a treatment plan more difficult.

Participants also shared that although those with chronic health conditions understand the importance of engaging in self-management activities such as taking medications on a regular basis, the pandemic made it difficult to stay committed to a routine. This may lead to long-term negative consequences such as advanced disease progression for some people.

[165] Czeisler, M., Barrett, C.E., Siegel, K.R., et al. (2021), Health care access and use among adults with diabetes during the COVID-19 pandemic — U.S., February–March 2021. *MMWR Morbidity and Mortality Weekly Report*, *70*(46),1597–1602. DOI: http://dx.doi.org/10.15585/mmwr.mm7046a2

[166] CDC (2018), *Self-Management Support and Education*.

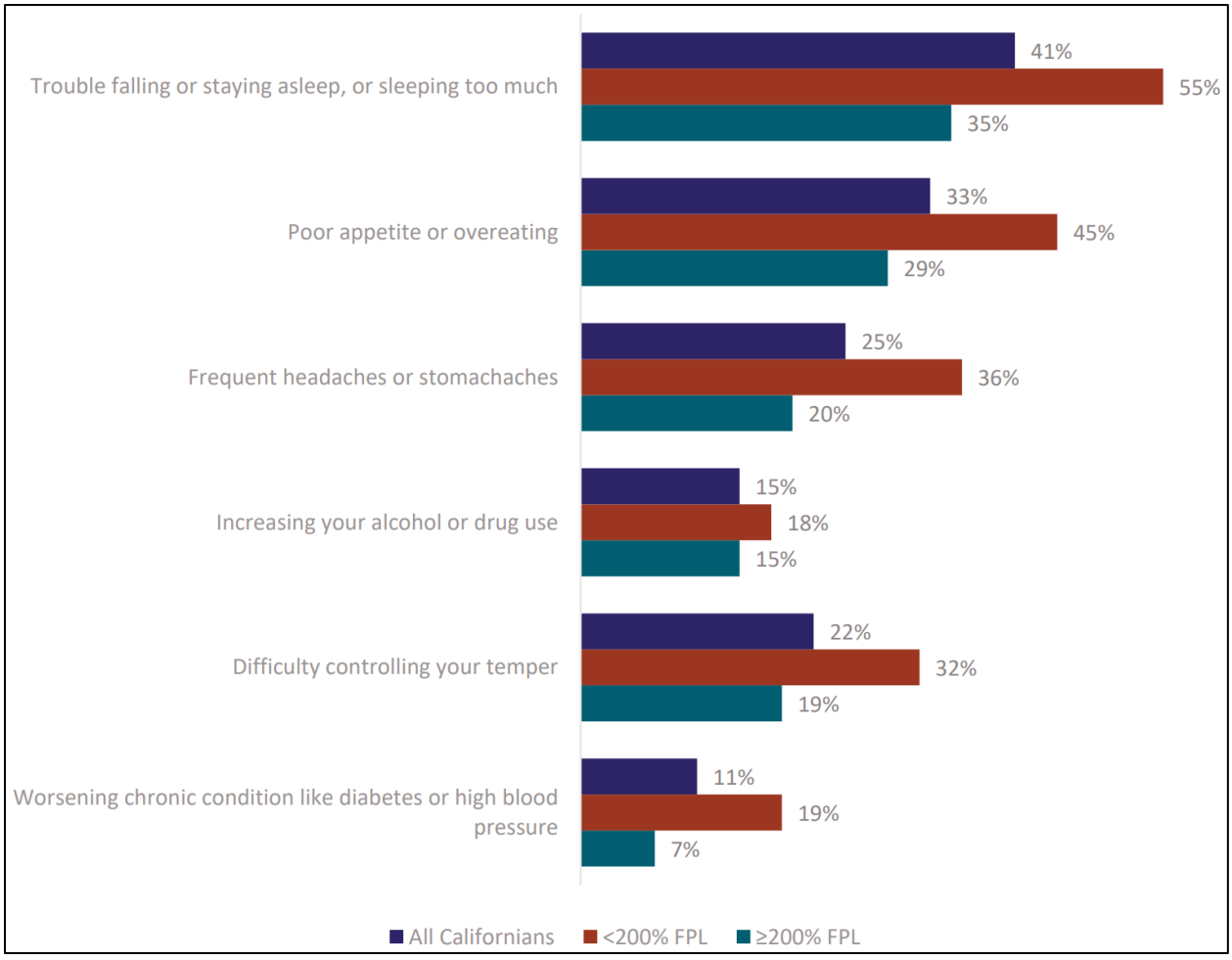
Please see the **Economic Stability** findings for more information.

Emotional and Behavioral Health

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

As shown in **Figure 39** below, 1 in 10 Californians reported that the stress of the pandemic worsened chronic health conditions.[61] Others reported changes in eating patterns, difficulty sleeping and increased use of alcohol, tobacco or other substances. Income played a role in the extent to which the pandemic interrupted a person's life.[167]

Figure 39: Effects of Worry or Stress Among Californians Related to the COVID-19 Pandemic, 2021[61]



[167] U.S. Department of Health & Human Services (2022), *Mental Health and Coping during the Coronavirus (COVID-19) Pandemic.*

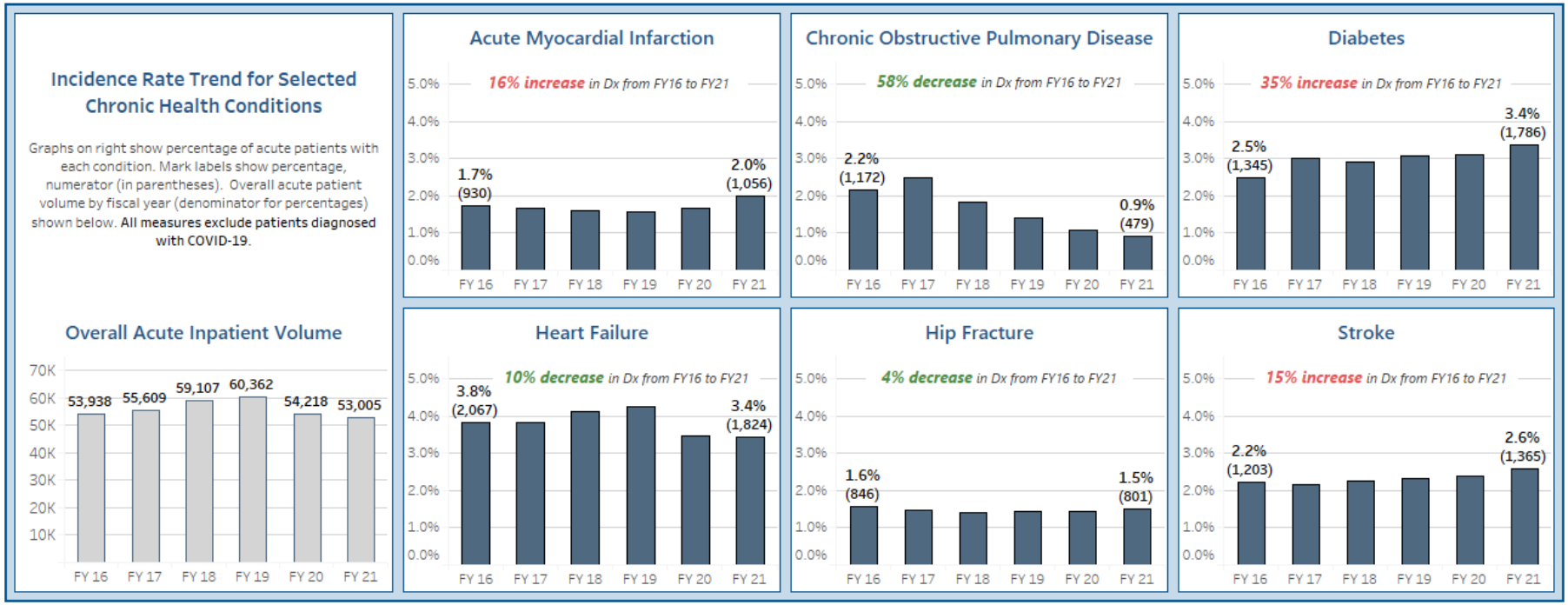
In addition, HASD&IC's community engagement feedback indicated that cancer patients and survivors often worry about being an unnecessary burden to their support systems when there were other competing stressors.

See **Appendix M** for individual quotes from HASD&IC's community engagement interview and focus group participants regarding the identified community need of Chronic Health Conditions. In addition, the complete results of HASD&IC's online community engagement survey are available within the full HASD&IC 2022 CHNA report at: https://hasdic.org/community-health-needs-assessment-chna/.

Incidence and Mortality

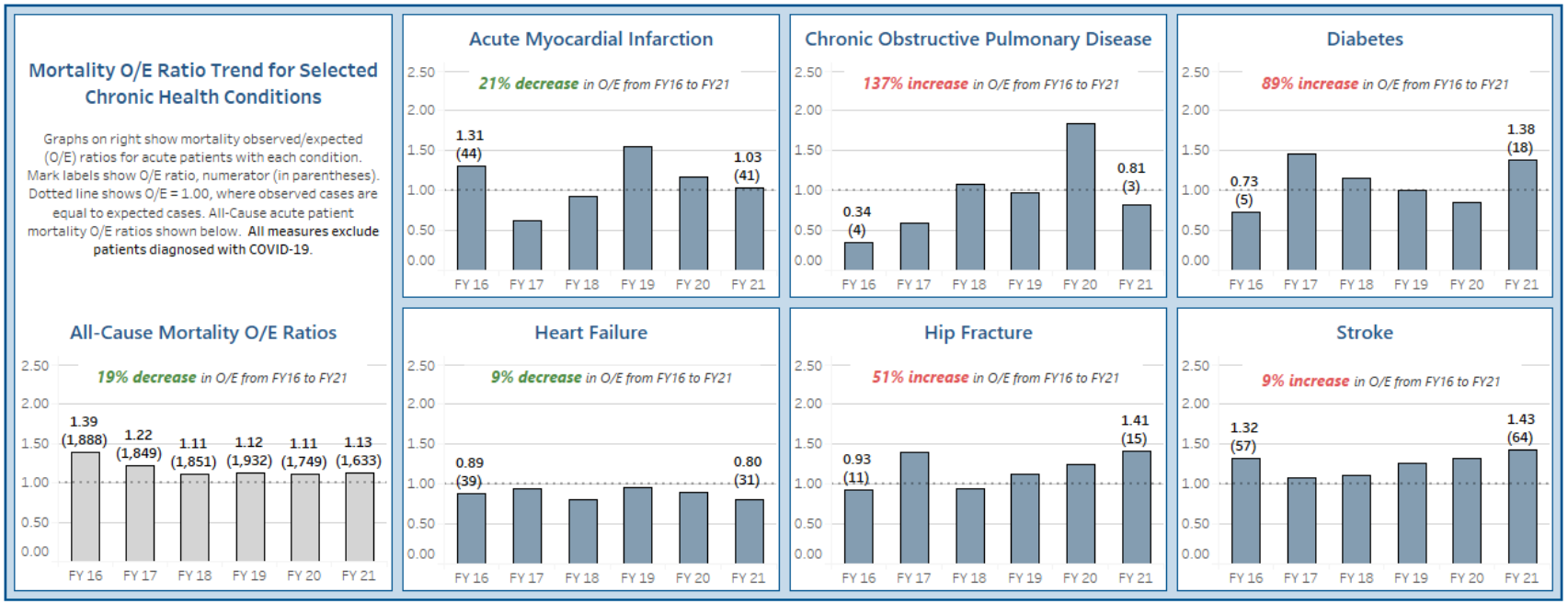
Analysis of Sharp clinical data shows the impact of the COVID-19 pandemic on the incidence of chronic diseases among hospital inpatients. From FY 2016 to FY 2021, there was a 16% increase in the incidence of acute myocardial infarction, a 35% increase in diabetes diagnoses and a 15% increase in stroke. Please refer to **Figure 40** below for additional detail on the incidence of chronic health conditions at Sharp hospitals.

Figure 40: Incidence Rate Trend for Selected Chronic Health Conditions, FY 2016-FY 2021



Examining observed to expected mortality (O/E) ratios[168] at Sharp hospitals from FY 2016 to FY 2021, there was an increase in deaths due to COPD, diabetes, acute myocardial infarction and hip fracture. There was a slight increase in deaths due to stroke and a slight decrease in deaths due to heart failure. However, further analysis is needed to determine if this variation is statistically significant. See **Figure 41** below for additional detail.

Figure 41: Mortality O/E Ratio Trend for Selected Chronic Health Conditions, FY 2016-FY 2021



[168] To compare performance across all institutions in terms of mortality, the observed vs expected mortality ratio (O:E) is utilized. The expected mortality is based on the patient's clinical acuity and severity of comorbidities. Therefore, institutions with a higher case mix index have a higher expected mortality. However, when the observed mortality is lower than the expected, the ratio becomes less than 1 (Cleveland Clinic, 2022).

Analysis of Sharp hospital data shows that, among COVID-19 patients admitted to the hospital, 62% presented with hypertension, 40% presented with diabetes and 43% presented with obesity. Patients presenting to the ED with COVID-19 and hypertension were 2.5 times more likely to be admitted to the hospital compared to COVID-19 patients without hypertension. There was a varying risk breakdown by race and ethnicity for hypertension, diabetes and obesity. Patients with diabetes were much more likely to require a stay in the intensive care unit (ICU). COVID-19 patients with hypertension and diabetes had higher mortality rates than those without those conditions. Further analysis is required to fully understand these trends. See **Figures 42-45** below for additional information.

Figure 42: Comorbid Conditions in Sharp COVID-19 Inpatients, March 2020-March 2022

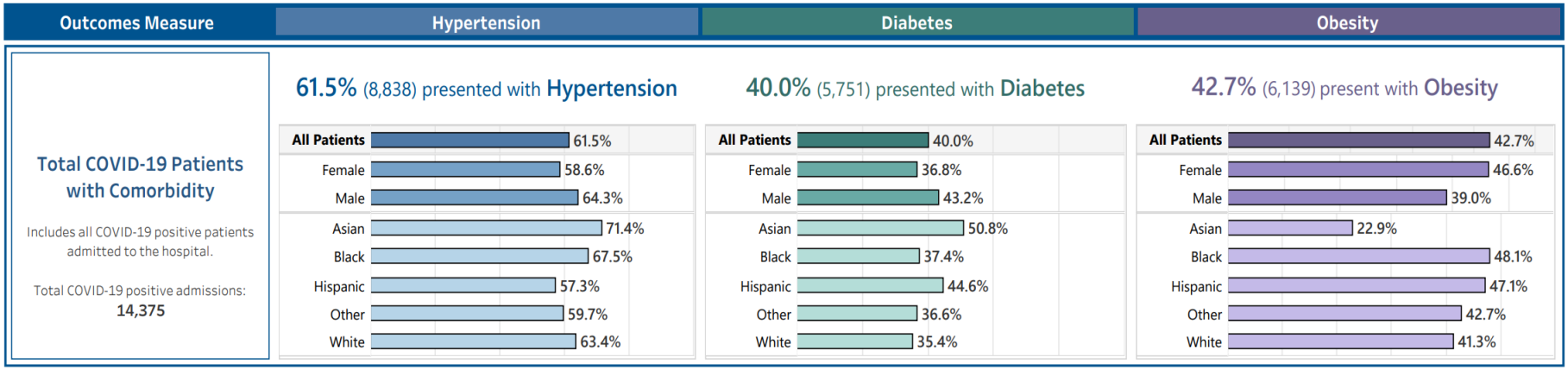


Figure 43: Effect of Comorbidities on COVID-19 Hospital Admission Rate, Sharp Hospitals, March 2020-March 2022

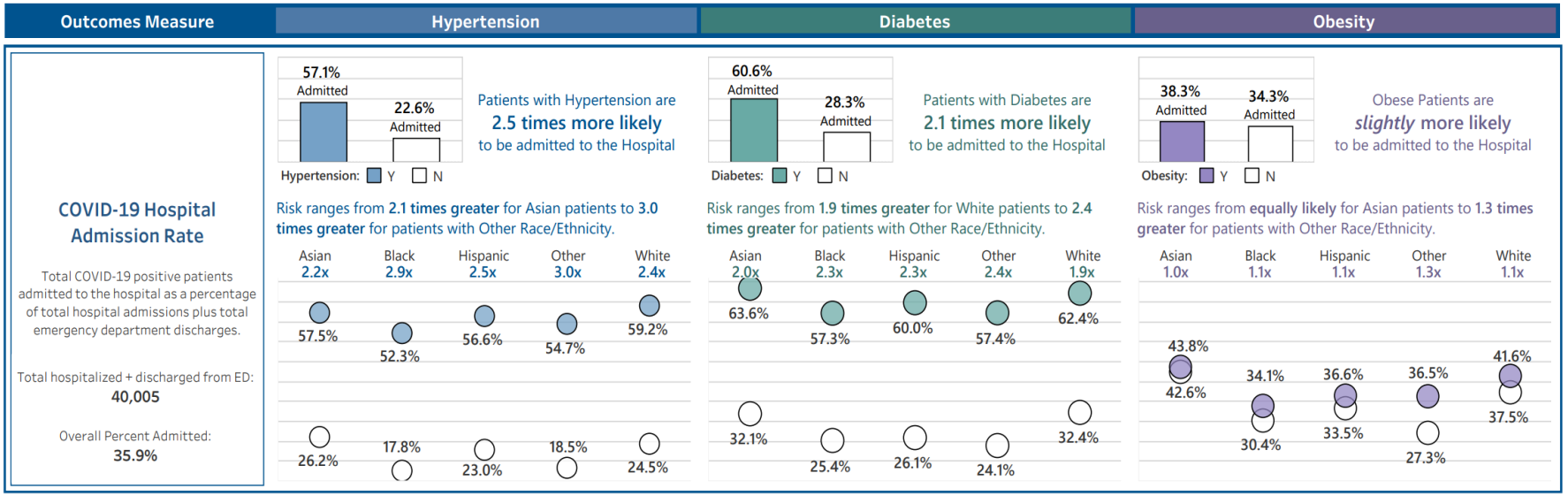


Figure 44: Effect of Comorbidities on COVID-19 ICU Utilization, Sharp Hospitals, March 2020-March 2022

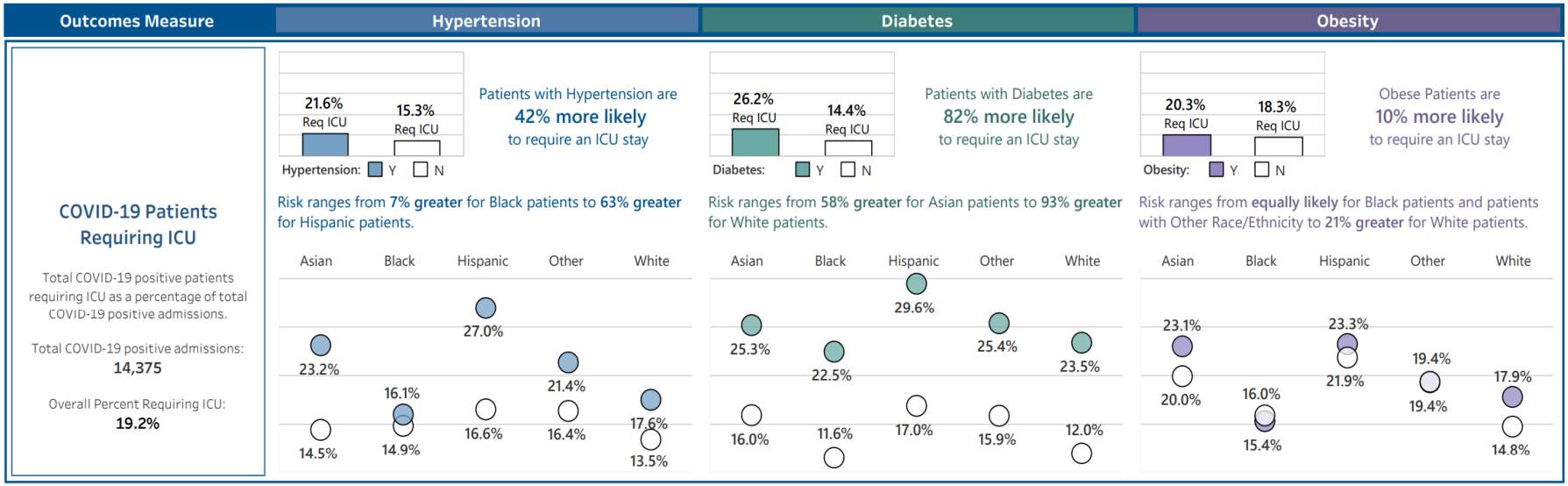
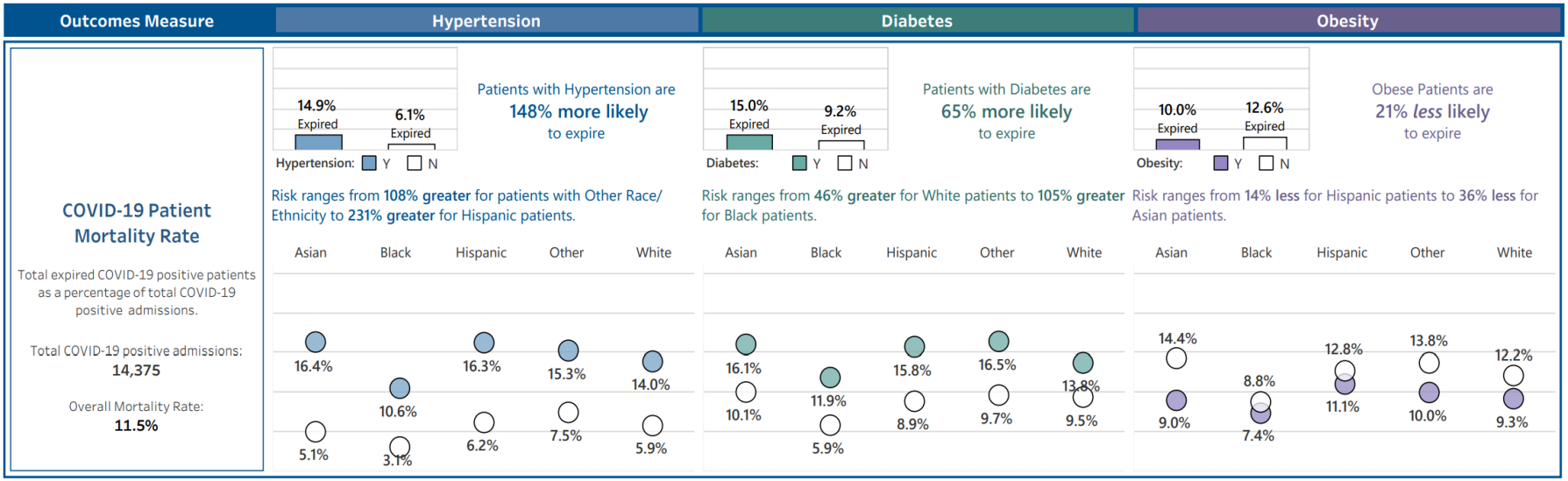


Figure 45: Effect of Comorbidities on COVID-19 Mortality, Sharp Hospitals, March 2020-March 2022



Care Management and Coordination

The majority (96%) of Sharp Insight Community Survey respondents reported they did not participate in Sharp's programs designed to connect patients and community members to support services or resources. Of those who did participate, 63% named "other" Sharp programs. This included: diabetes care and education programs (12%); nutrition programs (6%), and weight management programs (6%).

Analysis of Sharp patient data found that cancer screening volumes dipped significantly during the COVID-19 pandemic. While there was an increase in stage 1 cancer diagnoses, this is a continued trend from previous years and may or may not be related to the reduction in screenings from the previous year. More time and analysis are needed to assess the impact of the pandemic on screening and oncology patient volumes. See **Figures 46** and **47** below for additional details.

Figure 46: Impact of COVID-19 Pandemic on Oncology Screening Volumes, FY 2016-2021

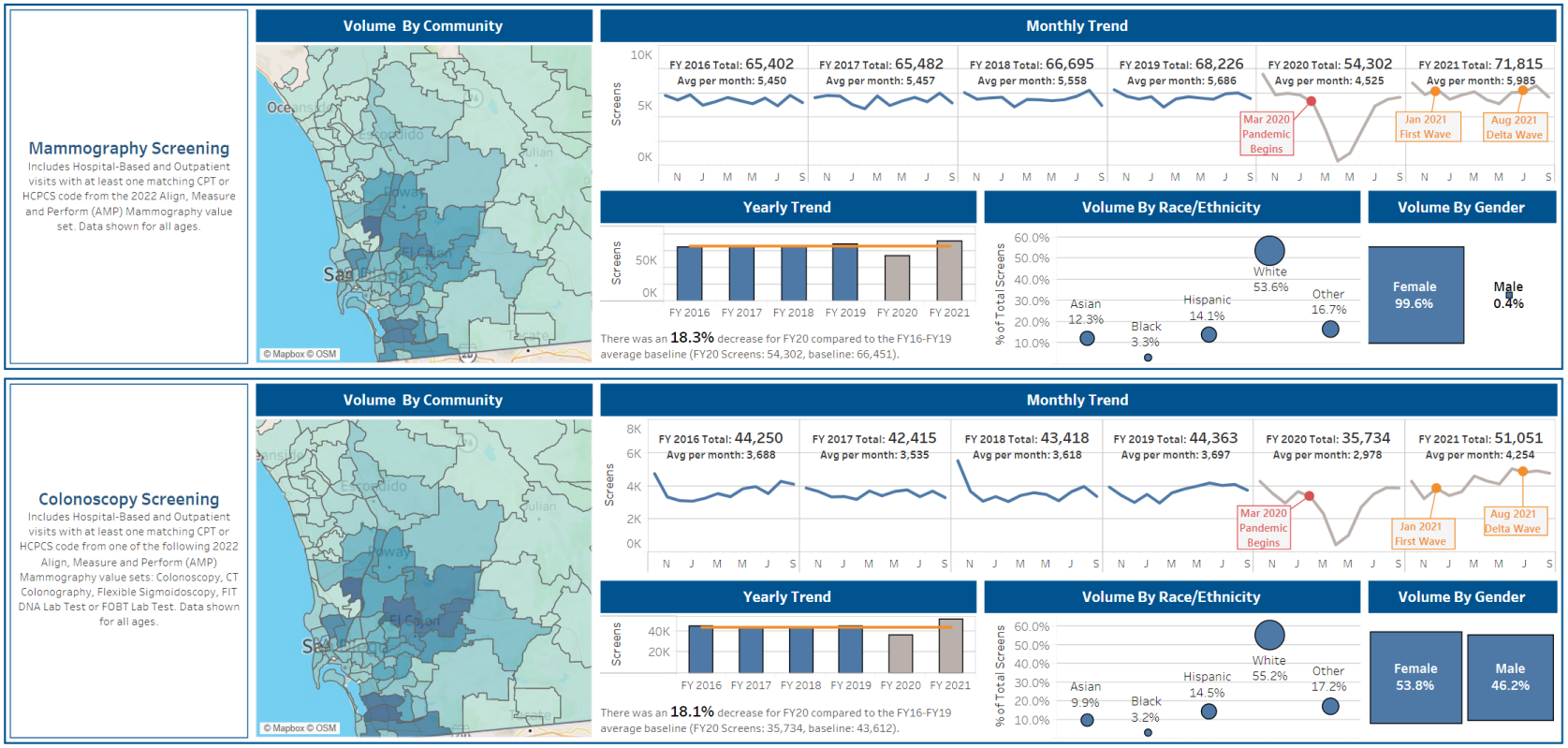
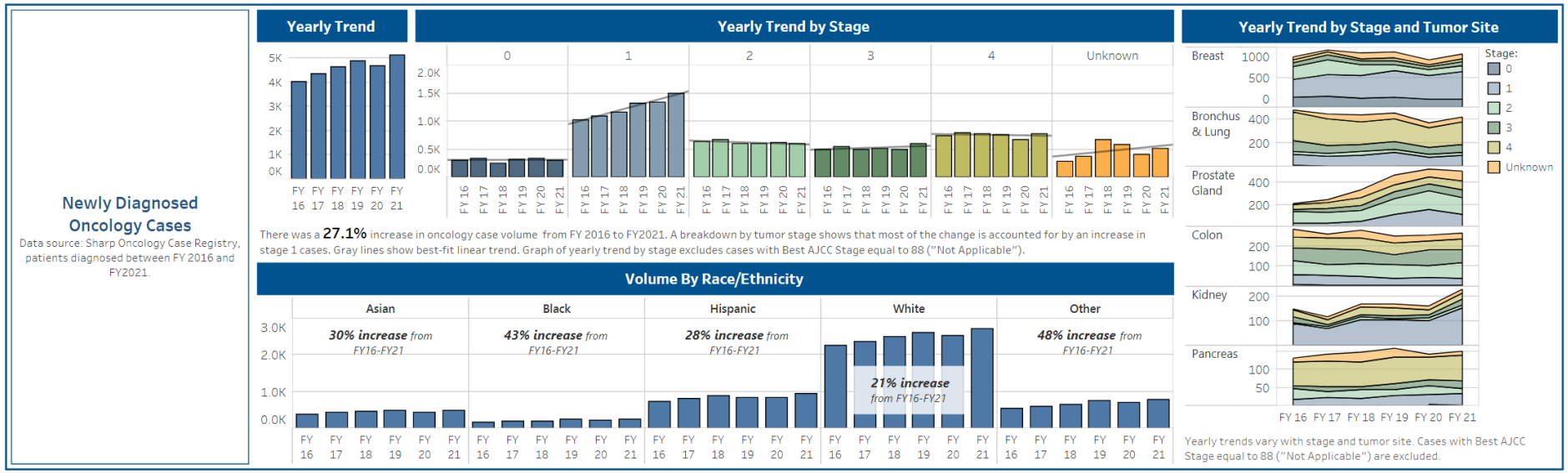


Figure 47: Impact of COVID-19 Pandemic on New Cancer Diagnoses, FY 2016-2021



Please see the following appendices for more information on SCHHC's 2022 CHNA Chronic Health Conditions findings:

- **Appendix H**: Sharp 2022 Clinical Data Analytics
- **Appendix I**: IPH Sharp Provider/Human Resources 2022 CHNA Survey & Findings
- **Appendix J**: Sharp Insight Community 2022 CHNA Survey & Findings

Community Safety

Overall Findings

Community Safety was identified as a high priority need through both the SCHHC and HASD&IC 2022 CHNAs. However, due to the nature of Sharp's community engagement survey questions, opportunities for participant feedback on this topic were limited. Therefore, only findings from the HASD&IC 2022 CHNA process are described in this section. Community Safety findings are most often described in relation to the concerns listed below, including the significant impact of the COVID-19 pandemic on these issues.

- *Racism*
- *Violence and coercion*
- *High-risk populations*
- *Human trafficking*
- *Hospital workforce safety*

Community Safety findings are described below for the HASD&IC 2022 CHNA.

HASD&IC 2022 CHNA

Racism

In January 2021, the County of San Diego declared racism a public health crisis. In doing so, the County acknowledged that racism underpins health inequities throughout the region and has a substantial correlation to poor outcomes in many facets of life. As the public health agency for the region, the County has a responsibility to tackle this issue head on in order to improve the overall health of residents.[169]

Race was the most common motivation for hate crimes in both 2020 (76%) and 2021 (64%). In 2020, 6% of the 34 hate crime cases reported in SDC attributed to race involved Asian victims. In 2021, this percentage increased to 18%.[170]

Violence and Coercion

In HASD&IC's online community survey, 29% of respondents identified "being unsafe from violence and coercion at home, work/school, and in my neighborhood" as a top concern.

Community members reported significant levels of fear and feeling unsafe. The COVID-19 pandemic increased stressors that were associated with community violence, such as cases of child abuse, interpersonal violence and domestic abuse.[171] Pandemic safety measures, such as virtual schooling, reduced opportunities for government and community agencies to identify

[169] County of San Diego Board of Supervisors (2021), *Framework for Our Future: Declaring Racism a Public Health Crisis*.
[170] While these numbers are relatively small and should be considered when comparing percentage change, they are consistent with national statistics and other anecdotal feedback from the community regarding increases in these types of hate crimes since the pandemic began. SANDAG (2021), *Crime in the San Diego Region Mid-Year 2021 Statistics*.
[171] Cannon, C. E. B., Ferreira, R., Buttell, F., & First, J. (2021). COVID-19, intimate partner violence, and communication ecologies. *American Behavioral Scientist*, *65*(7), 992–1013. https://doi.org/10.1177/0002764221992826

and intervene in potential cases of abuse. For instance, there was less mandated reporting while schools were closed. Pandemic safety measures further complicated victims' ability to protect themselves from abusers as courts were closed. In some cases, victims were filing restraining orders while continuing to live with the abuse perpetrator.

There has been a notable rise in violence against marginalized groups. People who are exposed to violence, such as being victims of or witnesses to violent acts may experience physical decline or adverse mental health effects, including trauma. Over time, trauma can lead to development of anxiety and depression, or post-traumatic stress disorder.[172, 173]

In addition**,** feeling unsafe in one's own neighborhood due to increased or persistent law enforcement presence caused community members to worry about being surveilled. This impacted individuals' ability to trust their environment and maintain their health. Interviewees discussed the importance of having a safe environment in which to live, exercise, or play. The combination of feeling unsafe yet being watched may cause individuals to develop feelings of mistrust toward authority, which can lead to withdrawal and a reluctance to seek care or assistance.

High-Risk Populations

Community members frequently shared concerns related to living in unsafe neighborhoods and described their daily precautions (such as always carrying pepper spray). They mentioned the impact on people of all ages, but there were particular concerns about children and their access to safe outdoor spaces. Safety concerns were not limited to concerns regarding physical harm — the community also cited concerns about exposure to racism and bullying.

Interviewees identified some populations as higher risk for experiencing violence or abuse and disproportionately suffering from significant health inequities as a result. This included:

- People with a history of involvement in the foster care and child welfare systems
- Justice-involved youth and adults
- Seniors who are vulnerable or caregiver-dependent
- People from marginalized racial/ethnic groups, such as those who are BIPOC
- LGBTQ+ community members, especially transgender Black women

In California, Adult Protective Services receives more than 15,000 reports of elder and dependent adult abuse per month, and reports are increasing. There are over 200,000 cases of elder and dependent adult abuse reported each year in California. Elder abuse is significantly underreported — for every case known to programs and agencies, an estimated 24 are unknown. For financial abuse, just 1 in 44 cases is known.[174]

In addition, transgender people are more likely than cisgender people to be victims of hate crimes and intimate partner violence, regardless of sex assigned at birth. Half of transgender adults report at least one lifetime incident of physical or sexual assault. Compared to other

[172] CDC (2022), *Community Violence Prevention*.
[173] Karatekin, C., & Hill, M. (2018). Expanding the original definition of Adverse Childhood Experiences (ACEs). *Journal of Child and Adolescent Trauma*, *12*(3), 289-306. doi: 10.1007/s40653-018-0237-5
[174] California Association of Area Agencies of Aging (2019), *Elder and Dependent Adult Abuse Awareness*.

groups, Black transgender women are more likely than other groups to be polyvictimized — subjected to multiple forms of violence, sometimes at the same time, over the course of their lifetime due to the intersectionality of race, gender and socioeconomic status.[175]

A frequent theme in conversations was the safety concerns of people experiencing homelessness. Community members who are homeless are more likely to be involved in violent acts and sustain injuries as a result of assaults. Furthermore, they are frequently targeted for theft of their belongings, such as identification documents, medications or mobility aids like wheelchairs, walkers or canes. This may lead individuals to develop an overwhelming sense of fear, a constant sense of being unsafe, and a feeling of deep mistrust of their surroundings. Such experiences can cause re-traumatization.

According to County data, individuals experiencing homelessness have higher rates of victimization in the following categories when compared to the general population: murder (19 times higher), attempted murder (27 times), robbery (15 times), domestic violence (15 times), aggravated assault (12 times), elder abuse (10 times) and sexual assault (9 times).[176]

Human Trafficking

Human trafficking is a public health issue that intersects with all social determinants of health. Some community members are at a higher risk of being a victim of labor or sex trafficking due to age, socioeconomic status, ethnicity/race, sexual orientation or gender identity. Misinformation, especially during the pandemic, made identifying and assisting survivors and potential victims extremely difficult. Another challenge is sensationalism of images, assumptions, and stories shared publicly or in the media.

While SDC is located along an international border, the most recent study from the University of San Diego found that 79.3% of people trafficked for sex are U.S. citizens.[177] The San Diego Human Trafficking Task Force did note that the border plays a role in labor trafficking.

At some point in their lives, more than 90% of people with developmental disabilities will experience sexual abuse, and nearly half (49%) will experience 10 or more instances of abuse. Other experts have estimated that the percentage is closer to 95%.[178,179]

In many cases, traffickers identify and exploit the vulnerabilities or unmet needs (emotional, financial, physical, etc.) of their victims to induce dependence. The following community members were identified by interviewees as particularly at risk:

- People living with a developmental disability
- People with children
- People from marginalized racial/ethnic groups, such as BIPOC

[175] Sherman, A. D. F., Allgood, S., Alexander, K. A., Klepper, M., Balthazar, M. S., Hill, M., Cannon, C. M., Dunn, D., Poteat, T., & Campbell, J. (2022). Transgender and gender diverse community connection, help-seeking, and mental health among Black transgender women who have survived violence: A mixed-methods analysis. *Violence Against Women*, *28*(3–4), 890–921. https://doi.org/10.1177/10778012211013892
[176] Office of the District Attorney County of San Diego (2022), *DA Shares First-of-Its Kind Crime Data, Proposes Three-Point Plan to Address Intersection of Crime and Homelessness.*
[177] University of San Diego (2022), *How Kroc School Professor Ami Carpenter's Human Trafficking Report Findings Are Fueling Prevention Efforts.*
[178] U.S. DOJ Office of Justice Programs (1995), *The sexual abuse interview for those with developmental disabilities.*
[179] The Journal of Adult Protection (2020), *People with an intellectual disability: under-reporting sexual violence.*

- Foster youth
- LGBTQ+ populations
- Undocumented individuals
- People experiencing food, economic or housing insecurity

Interviewees identified major gaps in critical services for survivors of human trafficking. Needed services include: more shelter beds, especially for male or LGBTQ+ survivors; more trauma-informed shelter or short-term housing options, such as low barrier options that do not require sobriety; a 24/7 hotline for safe shelter collaborative programs, staffed by trained mental health professionals; and text-message accessible hotlines or web-based intake services that are easily hidden from exploiters.

Advocates reported that survivors are frequently misidentified as being difficult or non-compliant in clinical settings because of their inability to follow their care plan. However, this "non-compliance" may often be the result of trauma responses.

To help prevent patient harm and moral injury to staff, bedside clinicians should administer assessments as part of multidisciplinary protocols. TIC is ideal for assisting patients in requesting assistance or ensuring that they feel safe returning to health care facilities if they choose to decline assistance. If patients are not ready for support or do not trust the system or authorities, a premature hand-off to social work can stigmatize them.[180] [181] [182]

Hospital Workforce Safety

San Diego hospitals and health systems have historically been hotspots for violent encounters. However, workplace violence has worsened during the pandemic and was identified as an alarming concern.

Increased stressors and political tensions (e.g., mask mandates) due to the pandemic may have caused an uptick in aggression and violence towards health care workers. Types of violence that health care workers may encounter include: nonphysical or psychological harm, such as insults, yelling, threat of physical assault or intimidation; physical assault; and verbal sexual harassment or sexual assault.

Violence against health care workers makes it difficult for providers and other health care staff to provide quality care. Additionally, witnessing violence in health care settings creates a stressful environment for other patients seeking care.

Having a safe, comfortable and supportive working environment contributes to overall mental, physical and emotional well-being. Unfortunately, workplace violence also deeply impacts health care workers emotionally and psychologically. After witnessing or assisting a colleague after a violent encounter with a patient, health care workers are profoundly affected by vicarious trauma.[93] Such experiences could lead to staff burnout, compassion fatigue and

[180] National Human Trafficking Training and Technical Assistance Center (2021), *Core competencies for human trafficking response in health care and behavioral health systems.*
[181] Stoklosa, H., & Ash, C. (2021). It has to be their choice. We need to give them options. *Journal of Health Services Research & Policy*, *26*(4), 221-223. https://doi.org/10.1177/13558196211034898
[182] Carroll, S. M. (2019). Respecting and empowering vulnerable populations: contemporary terminology. *The Journal for Nurse Practitioners*, *15*(3), 228-231. https://doi.org/10.1177/13558196211034898

secondary traumatic stress. Please see the **Access to Health Care** findings for more information.

The health care industry experiences the highest rate of injuries caused by workplace violence and employees are five times as likely to suffer an injury from workplace violence compared to the overall workforce.[183]

Since the onset of the pandemic, violence against hospital employees has markedly increased — and there is no sign it is receding. Studies indicate that 44% of U.S. nurses reported experiencing physical violence and 68% reported verbal abuse during the pandemic.[184]

See **Appendix M** for individual quotes from HASD&IC's community engagement interview and focus group participants regarding the identified community need of Community Safety. In addition, the complete results of HASD&IC's online community engagement survey are available within the full HASD&IC 2022 CHNA report at: https://hasdic.org/community-health-needs-assessment-chna/.

Economic Stability

Overall Findings

Economic Stability was identified as a high priority need in both the SCHHC and HASD&IC 2022 CHNAs. Economic Stability findings primarily highlight the concerns listed below, including the profound impact of the COVID-19 pandemic on community members' ability to thrive economically.

- *Economic self-sufficiency in SDC*
- *COVID-19 economic hardship*
- *Safety net/support programs*
- *Housing concerns*
- *Food insecurity*
- *Childcare*
- *Fear of health care costs*

Economic Stability findings are described below for both the HASD&IC and SCHHC 2022 CHNAs.

HASD&IC 2022 CHNA

Economic Self-Sufficiency in SDC

The profound impact that economic stability has on a person's health and well-being was a universal concern and topic of discussion among all interviews and focus groups. Many people

[183] U.S. Bureau of Labor Statistics (2020), *Workplace Violence in Healthcare, 2018.*
[184] Byon, H.D., Sagherian, K., Kim, Y., Lipscomb, J., Crandall, M., & Steege, L. (2021). Nurses' experience with Type II workplace violence and underreporting during the COVID-19 pandemic. *Workplace Health and Safety*, 1-9. doi: 10.1177/21650799211031233

were overwhelmingly stressed and worried about not having enough money to pay for essential necessities. At the same time, HASD&IC heard from community organizations that have seen a significant increase in the number of people seeking assistance.

When a person loses their job, has unstable income or lives in poverty, they may struggle to afford essential necessities including food, utilities, housing, childcare and health care. Alternatively, households or individuals with steady employment may still not earn enough (low-wage earnings) to meet their health needs.[185] Economic instability has a domino effect, and people often experience multiple challenges at once — for instance housing instability, food insecurity and a lack of reliable transportation.

The high cost of living in SDC, coupled with the pressure of inflation has resulted in many people expressing difficulty affording and accessing services that meet their health and social needs. Economic instability places a burden on people by forcing them to make difficult decisions. For instance, does one spend money on rent or pay for a life-saving medication, or pay for groceries instead of the utility bill? Having to make these trade-offs can have a dire impact on the overall health and well-being of the community.

Figures 48 and **49** below contain key findings from the County of San Diego's Self-Sufficiency Standard Dashboard (an economic stability measure that considers essential household expenses), to provide a more accurate picture of the income needed to live comfortably in SDC.[186]

[185] HP 2030 (2022), *Economic Stability*.
[186] County of San Diego HHSA (2022); *San Diego County Self-Sufficiency Standard Brief, Single-Adult Household, 2021.*

Figure 48: 2021 Self-Sufficiency Standard Dashboard, Key Findings[186]

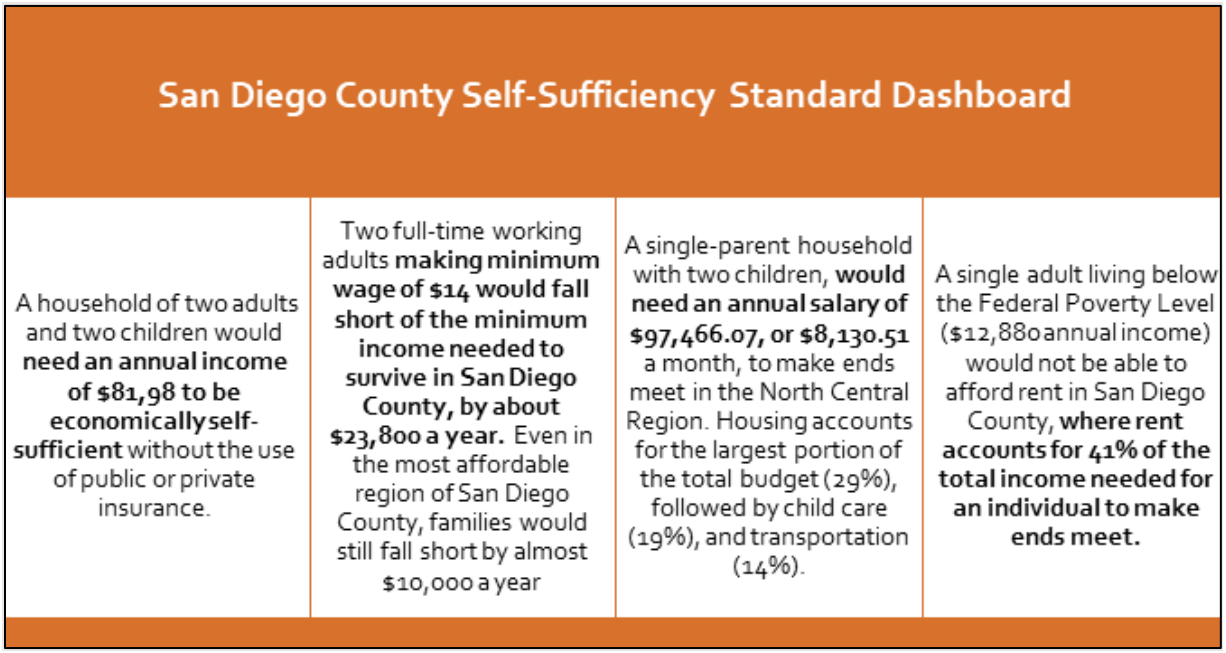
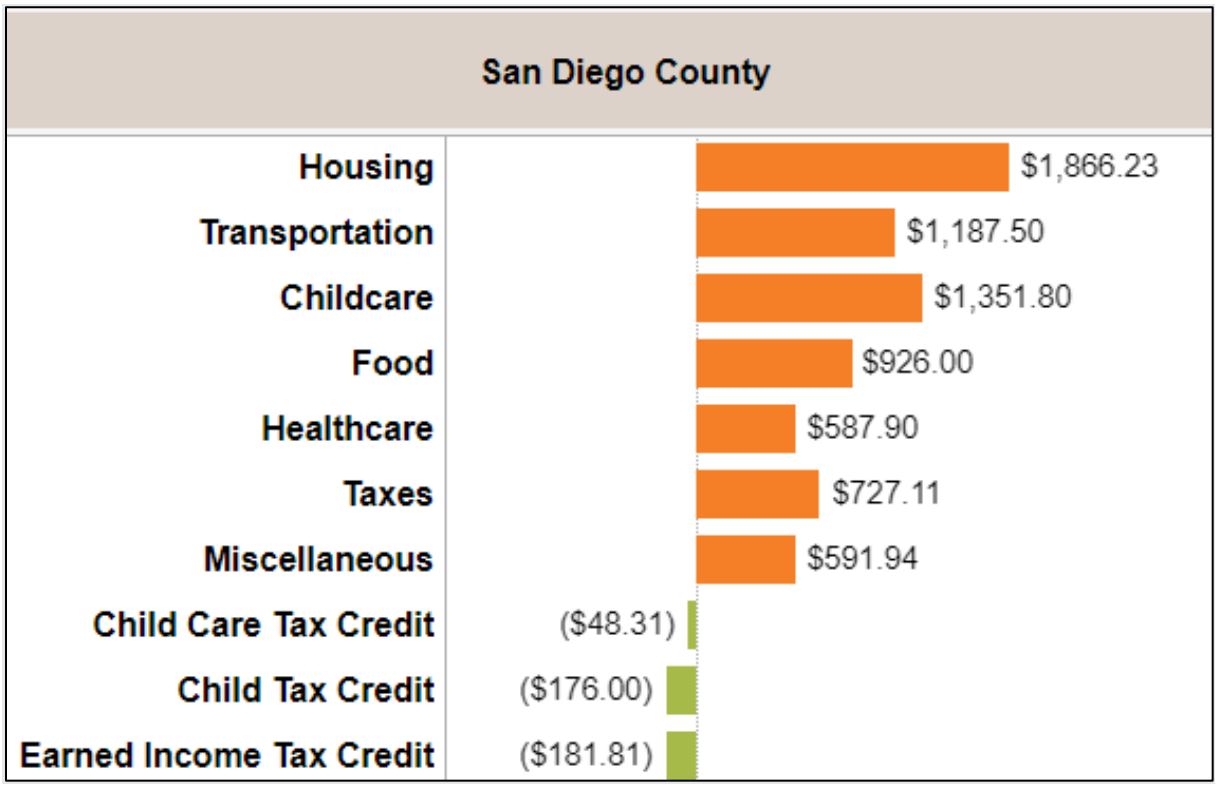


Figure 49: Monthly Costs for a Single-Adult Household, SDC, 2021[186]



COVID-19 Economic Hardship

Communities of color, especially Black and Latino communities, were also at highest risk for economic instability due to work disruption. Families of affected workers also faced the consequences of lost jobs or wages, causing a ripple effect on their ability to access essential needs. The immediate impact of COVID-19 on SDC's regional economy included:[187]

- As of March 28, 2020, estimated unemployment among SDC residents was approximately 20 times the pre-pandemic rate.
- The unemployment rate in the region remained high, and at the end of May 2020, was estimated to be at 28.5%.
- As of June 7, 2020, more than two-thirds of Black (67%) and Hispanic (70%) SDC residents lived in ZIP codes with higher-than-average unemployment rates.

In interviews conducted with refugees in 2021, 86% of participants shared that financial concerns were their biggest source of emotional distress.[188]

Safety-Net/Support Programs

Over 1.35 million San Diegans — more than 1 in 3 SDC residents — are enrolled in safety-net programs such as Medi-Cal, CalFresh and CalWORKs.[189] COVID-19 heightened the importance of and need for safety-net programs during an economic crisis. Interviewees shared that there was an increase in outreach from community organizations during the pandemic, encouraging them to enroll in programs designed to help them access and afford food and health care.

In January 2022, the average monthly income of CalFresh recipients in SDC was $997, while the average monthly income for Medi-Cal enrollees was $1,082.[190]

In addition, community organizations and community members expressed the "deep fear" the undocumented community had in having their immigration status revealed. Although many immigrant families qualified for safety-net programs and other resources that became available during the pandemic, community members shared that fear prevented people from seeking help. Multiple interviewees stated that the previous presidential administration's public charge[85] rule caused immigrants and their family members (including U.S.-born children) to disenroll or avoid enrollment in public benefit programs.

Nearly half (46%) of families who needed assistance during the pandemic did not apply for it due to concerns over immigration status.[191]

[187] SANDAG (2020), *COVID-19 Impact on the San Diego Region: Black and Hispanic Communities Hardest Hit.*
[188] University of California San DIego Center for Community Health-Refugee Health Unit (2021), *2021 COVID-19 Refugee Health Impact Assessment.*
[189] County of San Diego HHSA (2022), *Eligibility of Services by the Numbers.*
[190] County of San Diego Office of Business Intelligence (2022), *CalFresh and Medi-Cal Dashboards.*
[191] No Kid Hungry (2021), *Public Charge was Reversed— But Not Enough Immigrant Families Know.*

Housing

Affordable housing has become unattainable for many San Diegans and was identified as a top need by community engagement participants. With the soaring cost of housing, community members consistently described difficulty paying rent or finding an affordable place to live. Community members stressed that paying to maintain their housing was their top priority and left little money for other costs.

Community members shared that rent increases create an even bigger challenge for people who are already living month-to-month. Some community members said they experienced rent increases twice in one year and faced the risk of being evicted from their homes. Others said they have had to move in with others to offset housing expenses. Unaffordable rent can eventually push people into homelessness.

In addition, certain populations are at increased risk of housing instability. Interviewees shared that strict requirements, such as established rental history and income that is at least double the amount of rent, create additional challenges for certain community members and increase the risk of housing instability.

Individuals on fixed incomes, like seniors and people with disabilities, were identified as struggling to pay housing costs. Young people without an extensive rental history struggle to get approved for housing even with assistance from organizations.

Refugee communities also face significant challenges in managing housing costs. A recent assessment of refugee health concerns during COVID-19 found that the pandemic made it harder for 75% of those interviewed to cover housing costs. Although 83% of the households included in the assessment received Section 8 housing vouchers, they still reported spending more than 30% of their income on housing.[188]

Without sufficient or stable income, finding affordable housing is difficult. Community organizations shared that undocumented workers in particular have a hard time finding employment because some of them do not have a visa (work permit). In California, nearly 38% of undocumented workers and more than 61% of children living with undocumented workers live in households earning less than a living wage and face chronic and severe housing instability.[192]

Focus group participants and key informants said that people who are housing insecure are also at high risk for human trafficking — especially labor trafficking, which involves working in high-risk, dangerous conditions in exchange for housing or income to pay for housing costs.

Community organizations shared that, during the pandemic, there was an increase in calls pleading for cash assistance to pay for rent, mortgage and utilities. Despite eviction moratoriums, many households still found themselves at risk for eviction and some received eviction notices. Concern over losing their home caused turmoil, fear and anxiety. Rental assistance programs were available and provided relief to some families; however, not

[192] University of California Merced Community and Labor Center (2022), *Essential Fairness: The Case for Unemployment Benefits for California's Undocumented Immigrant Workers.*

everyone qualified for assistance or received it in a timely fashion. Community engagement participants shared that it was particularly stressful trying to assist undocumented residents because there were no housing resources available.

The community shared that although housing assistance exists for low-income residents, these resources fall short. People who are eligible for housing programs such as Section 8 and public housing encounter long waits due to high demand throughout SDC. Interviewees shared that being on the waitlist causes stress, anxiety and hopelessness as they try to advocate for themselves and support their families. According to 2-1-1 San Diego, the top client needs were housing (23%), utilities (14%), and income support and employment (12%). Of the clients assessed for housing, 54% had an immediate need; 21% needed housing in less than a month; and 28% were identified as homeless (sheltered, unsheltered or unspecified homeless).[193] In 2020, people on the Section 8 waitlist who were selected to receive a housing voucher had waited an average of 12 years before being chosen.[194]

In addition, adequate housing conditions and safety were identified throughout the interviews as being a high need for community members. Some of the concerns about housing quality raised by interviewees included contaminants, pests and lack of accessibility for those who are aging, those with disabilities or those with a health condition.

Living in poor housing conditions can lead to an increased exposure to mold and allergens that can result in negative health outcomes over time. Additionally, housing that lacks reliable heating or cooling mechanisms has been found to put some people, such as seniors, at a higher risk of cardiovascular disease or death.[195]

Food Insecurity

Food insecurity was identified as a persistent issue in the community. Economic instability and competing priorities were commonly mentioned as impacting a household's access to food. Households forced to choose between competing priorities due to limited resources are often left without enough money for food. Financial strain, especially during the pandemic, caused an alarming number of people to experience food insecurity — many for the first time.

In 2021, 83% of 2-1-1 San Diego clients said they struggled to meet other basic needs before they could pay for nutritional needs. About 43% of clients reported "sometimes" running out of food and 29% of clients reported running out of food during the previous month.[193]

Barriers to accessing food were identified. These included not having enough money to purchase food, lack of reliable transportation to buy groceries or get to a local food bank (especially among people with physical limitations), and fear of applying or seeking help. Some community members also expressed the need for food pantries to extend their normal business hours.

[193] 2-1-1 San Diego (2021), *Community Information Exchange All Clients Profile Report 2021.*
[194] County of San Diego HHSA (2021), *Public Housing Agency Plans.*
[195] Robert Wood Johnson Foundation (2011), *How Does Housing Affect Health?*

Food insecurity is linked to negative health outcomes including poor nutrition and disease management.[196] Food insecure children are more likely to have poor school performance, higher levels of behavioral and emotional problems such as anxiety and depression, asthma, iron-deficiency anemia and increased ED visits.[196,197] Food insecure adults are likely to have chronic conditions such as hypertension, diabetes or coronary heart disease,[198] while older adults are likely to have limitations in activities of daily living,[199] lower cognitive function, and CHF.[200] For additional information on food and nutrition insecurity in SDC, see **Section 4: Community Defined**.

Childcare

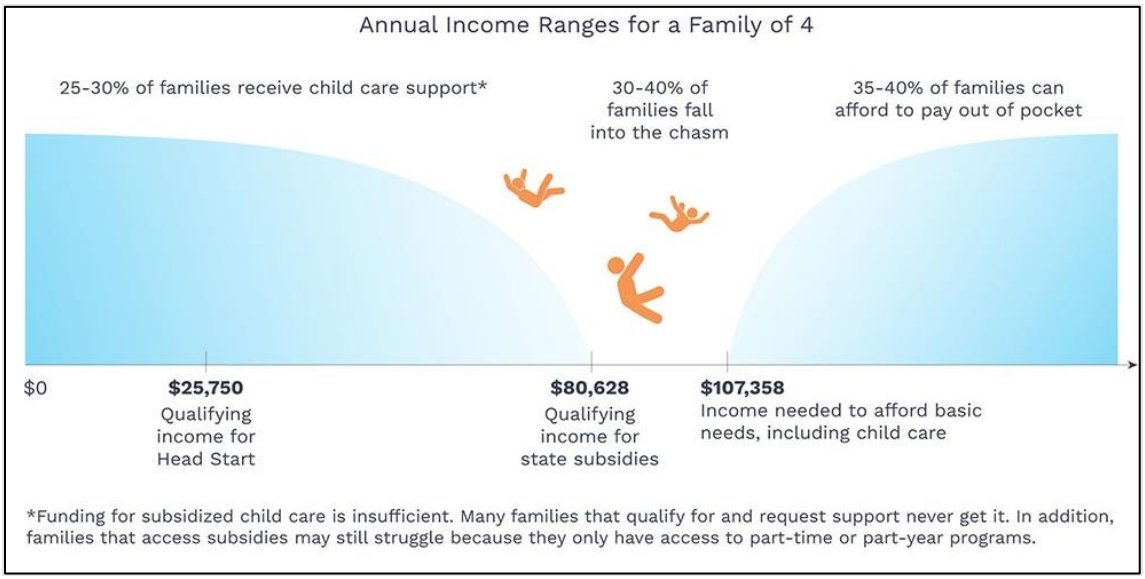
In California, the annual cost of infant care is $16,945.[201] Like housing, childcare costs were referred to as consuming a significant portion of a household's budget and causing financial hardship among parents, especially single parents. The average price of childcare for two young children in the San Diego region consumes 40% of the budget for a typical family of four.[202]

Childcare providers shared that childcare is expensive — especially infant and toddler care — because there are far fewer providers available than prior to the pandemic. Interviewees shared that without access to affordable childcare, some parents lean on family members or relatives to care for their children. Other working parents are forced to decide whether to leave their job to care for their children at home.

According to research by the San Diego Workforce Partnership, the childcare crisis hits middle income working families hardest. **Figure 50** below illustrates the "chasm" families fall into if they do not have enough income to afford childcare and don't qualify for childcare subsidies.[203]

[196] Food Research and Action Center (2017), *The Impact of Poverty, Food Insecurity, and Poor Nutrition on Health and Well-Being.*
[197] Margaret M.C., Thomas, Miller, D.P., & Morrissey, T.W. (2019). Food Insecurity and Child Health. *Pediatrics*, *144*(4): e20190397. 10.1542/peds.2019-0397
[198] U.S. Department of Agriculture Economic Research Service (2017), *Food Insecurity, Chronic Disease, and Health Among Working-Age Adults.*
[199] The activities of daily living (ADLs) is a term used to collectively describe fundamental skills required to independently care for oneself, such as eating, bathing, and mobility (NIH, 2022).
[200] Food Research and Action Center (2017), *The Impact of Poverty, Food Insecurity, and Poor Nutrition on Health and Well-Being.*
[201] Economic Policy Institute (2020), *Childcare costs in the United States.*
[202] San Diego Workforce Partnership (SDWP) (2020), *Workforce + Childcare: Two Vital Components of a Thriving San Diego Region.*
[203] SDWP (2020), *Workforce + Childcare: The Struggle to Find Good Child Care.*

Figure 50: San Diego's Childcare Affordability Chasm[203]



Childcare subsidies are available for low-to-moderate-income families, but interviewees expressed that there are long waitlists for financial assistance. In addition, some middle-income working families are stuck between not qualifying for financial assistance and not being able to afford the expenses out-of-pocket. Community leaders shared that due to the pandemic and increased need for childcare assistance, the waitlist was severely impacted. Interviewees shared that parents were under financial stress and desperate to find affordable childcare. Although emergency subsidies provided financial relief for some families, childcare slots were hard to find due to business closures.

Fear of Health Care Costs

A common theme raised during all interviews and focus groups was the fear of health care costs. Even people with existing health insurance shared that the out-of-pocket costs are expensive and unaffordable, especially among low-income communities. Concerns about not being able to afford copayments or medical bills often cause people to delay the care necessary to maintain their health or a chronic condition, take less medication than prescribed to extend their supply (particularly among seniors), and in some cases, avoid going to the ED in an event of an emergency.

See **Appendix M** for individual quotes from HASD&IC's community engagement interview and focus group participants regarding the identified community need of Economic Stability. In addition, the complete results of HASD&IC's online community engagement survey are available within the full HASD&IC 2022 CHNA report at: https://hasdic.org/community-health-needs-assessment-chna/.

COVID-19 Economic Hardship

Sharp health care providers who participated in the IPH Sharp Provider Survey identified increased financial insecurity as one of the top needs most seriously impacted by the COVID-19 pandemic in the past year. More than 90% of respondents reported that COVID-19 had either or a moderate or major impact on patients' financial security and 96% reported it had either a moderate or major impact on patients' employment stability.

Patients noted to be especially impacted by COVID-19 in relation to increased financial insecurity included patients who use Medi-Cal; refugee or newly immigrated patients; individuals with LEP; caregivers of adults or older adults; Hispanic patients; and Black/African American patients.

In addition, the majority (88%) of IPH Sharp Human Resources Survey participants noted that COVID-19 had at least a minor impact on Sharp team members' financial security.

Further, 43% of Sharp Insight Community Survey respondents reported experiencing at least a minor increase in financial uncertainty due to COVID-19.

Safety-Net/Support Programs

Approximately 90% of IPH Sharp Provider Survey respondents reported that COVID-19 had either a moderate or major impact on patients' access to community resources (e.g., housing, financial assistance, in-home support) and 83% reported that COVID-19 had a moderate or major impact on access to transportation. In addition, the majority (78%) of IPH Sharp Human Resources Survey participants noted that COVID-19 had at least a minor impact on Sharp team members' access to community resources.

Most IPH Sharp Provider Survey respondents (70%) indicated that Sharp has not implemented programs to address increased financial insecurity. Examples given about how Sharp has addressed increased financial insecurity included: financial assistance, including pharmaceutical assistance and grocery gift cards; community resources, including referrals to CalFresh and local food pantries as well as Lyft rides to appointments; and clinical programs, such as telehealth and case management outreach.

Among Sharp Insight Community Survey respondents, 15% reported that COVID-19 had at least minorly decreased their access to transportation, and 13% reported it had at least minorly decreased their access to community resources (e.g., housing, utilities, financial support).

The majority (96%) of Sharp Insight Community Survey respondents reported that they did not participate in Sharp's programs designed to connect patients and community members to support services or resources. Of those who did participate, 26% utilized Sharp's referrals to 2-1-1 San Diego, 11% utilized Sharp's referrals to 2-1-1 San Diego's Community Information Exchange, 11% utilized Sharp's patient transportation services, and 22% utilized other Sharp community resource referrals for concerns such as food, housing and transportation.

Housing Concerns

Among Sharp Insight Community Survey respondents, 12% reported COVID-19 had at least minorly increased their housing instability/homelessness.

Food Insecurity

Nearly all (98%) IPH Sharp Provider Survey respondents reported that COVID-19 had at least a minor impact on patients' food security, and the majority (75%) of IPH Sharp Human Resources Survey participants noted that COVID-19 had at least a minor impact on Sharp team members' food security.

Further, 20% of Sharp Insight Community Survey participants indicated that COVID-19 had at least minorly decreased their access to healthy food.

Childcare

The majority (82%) of IPH Sharp Human Resources Survey respondents expressed that COVID-19 had at least a minor impact on access to dependent care (childcare or eldercare).

Please see the following appendices for more information on SCHHC's 2022 CHNA Economic Security findings:

- **Appendix I**: IPH Sharp Provider/Human Resources 2022 CHNA Survey & Findings
- **Appendix J**: Sharp Insight Community 2022 CHNA Survey & Findings

Section

6 Community Assets

Community Assets to Respond to Identified Needs

San Diego's rich service ecosystem includes community-based organizations, government agencies, hospital and health systems, federally qualified health centers and other community members and organizations that seek opportunities to collaborate to improve the health of San Diegans. This service ecosystem is engaged in addressing all health needs identified by this assessment.

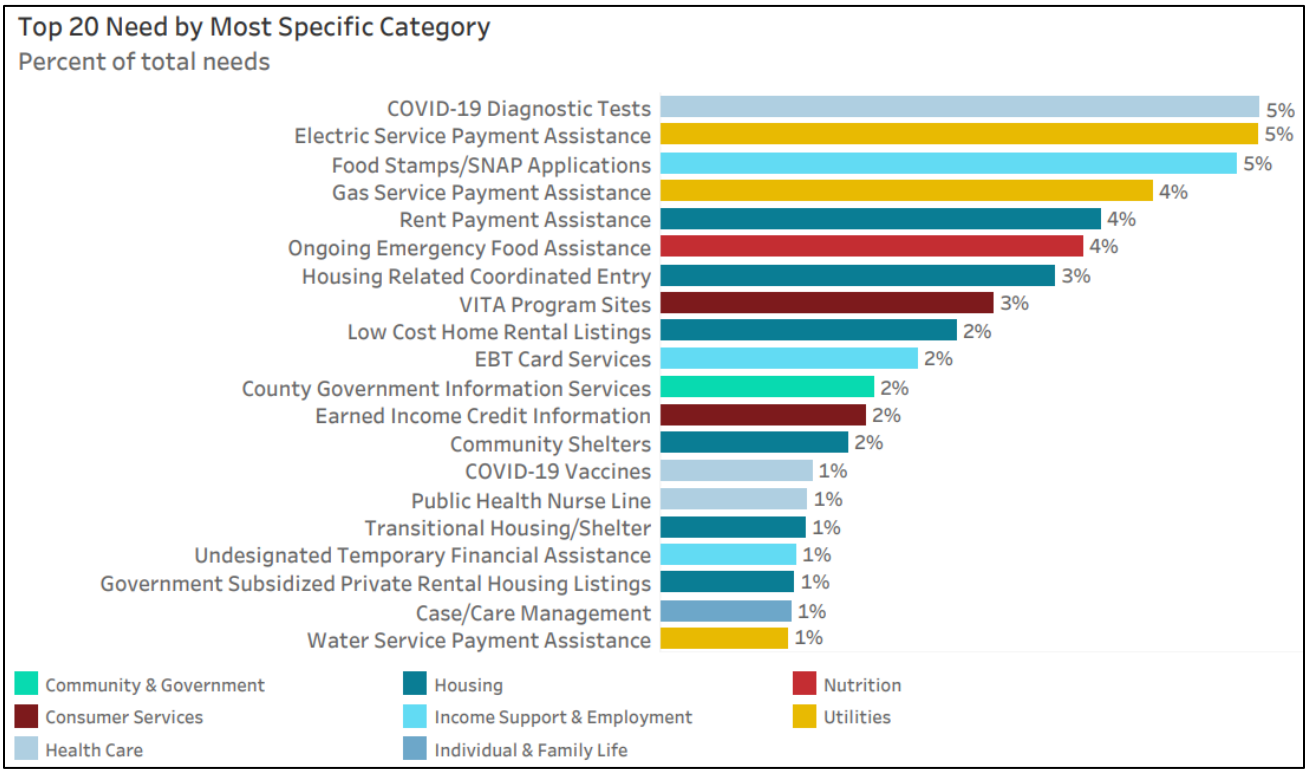
Community Resources in San Diego County

2-1-1 San Diego is an important community resource and information hub. Through its 24/7 phone service and online database, it helps connect individuals with community, health and disaster services. Recognizing that available programs and services are continuously changing, we encourage community members to access the most available, current data through 2-1-1 San Diego. In addition to connecting individuals to community services over the phone, 2-1-1 San Diego also manages the Community Information Exchange (CIE). The CIE is a network composed of more than 115 health, social and government organizations coordinating care through a shared technology platform and data integration. As of March 2021, there are more than 250,000 San Diegans who have consented to share their information with CIE members.

Figure 51 lists the top 20 needs organized by specific category and percentage of 2-1-1 San Diego clients in 2021.[204] Needs represent the reasons or descriptions of the type of help that was provided and are documented when clients receive referrals to community services. There were 551,727 total needs documented for this client population. For more specific information about the needs within each service category, or programs that address these needs, please contact 2-1-1 San Diego or visit their website (http://www.211sandiego.org/).

[204] 2-1-1 San Diego Client Profile Report. Data Source: 2-1-1 San Diego/Community Information Exchange Information Systems Reporting Period: January 1, 2021 to December 31, 2021.

Figure 51: 2-1-1 San Diego Top 20 Client Needs, 2021[204]



Health Care Facilities in San Diego County

The California Department of Health Care Access and Information (HCAI) is an excellent resource to find more detailed information on every health care facility licensed in California. The following data is available on their Healthcare Facility Attributes website: https://hcai.ca.gov/data-and-reports/healthcare-facility-attributes/.

- *Facility Profiles:* Interactive map to find a summary profile of facility information, including license, service level, revenue, payer mix, length of stay and building safety information. Use the map or search functions to find hospital, long-term care, clinical, home health and hospice facilities.

- *Licensed Facility Information System:* View facility license information for California hospitals, long-term care facilities, primary care and specialty clinics, home health agencies and hospices.

- *Licensed Healthcare Facility Listing:* A list of California health care facilities licensed by the California Department of Public Health (CDPH), Licensing and Certification.

- *Licensed Facility Crosswalk:* This dataset provides a simple crosswalk using HCAI assigned licensed facility identification numbers linked with matched CDPH, Licensing and Certification facility lists based on license number. This is not a comprehensive matched list; facility identification numbers that did not match are also included from

both the HCAI and CDPH lists. Facility Status or Facility Level designations may explain some HCAI non-matches. For additional information, contact HCAI directly. Please contact CDPH directly for more information regarding un-matched facility identifiers that do not have corresponding HCAI identifiers.

Sharp HealthCare (Sharp) Community Health Needs Assessment (CHNA) Community Guide

As part of its 2019 CHNA Phase 2 process, Sharp updated the Sharp CHNA Community Guide. The guide is available to the public on sharp.com and provides a user-friendly document describing Sharp's CHNA process and findings, as well as strategies employed by Sharp to address identified health and social needs. 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 G** for the 2019 Sharp CHNA Community Guide. In early- to mid-2023, an updated Sharp CHNA Community Guide will be available at: https://www.sharp.com/about/community/community-benefits/health-needs-assessments.cfm.

Section

7 Recommendations & Next Steps

The findings of this Community Health Needs Assessment (CHNA) revealed significant priority health needs impacting communities served by Sharp Coronado Hospital and Healthcare Center (SCHHC), particularly those facing inequities. In addition, the findings provided insight and recommendations from patients and community members and the Sharp HealthCare (Sharp) team members who serve them. This insight will assist SCHHC in the design and implementation of programs and services to help improve community health and well-being.

Hospital Association of San Diego and Imperial Counties 2022 Community Health Needs Assessment (HASD&IC 2022 CHNA): Community Recommendations

HASD&IC 2022 CHNA community engagement participants were asked, "What are the most important things that hospitals and health systems could do to improve health and well-being in our community?" Overwhelmingly, respondents expressed a critical need to help patients connect to and navigate available services that will help improve their health and well-being. In both the interviews and surveys, options that centered around improved patient care rose to the top. Most responses fell into four categories: navigation and support, culturally appropriate care, workforce development, and community collaboration. See **Table 24** for the types of recommendations identified by HASD&IC's community engagement participants. For the complete results of HASD&IC's online community engagement survey, see the full HASD&IC 2022 CHNA report at: https://hasdic.org/community-health-needs-assessment-chna/.

Table 24: HASD&IC 2022 CHNA – Community Recommendations for Hospitals and Health Systems to Improve Community Health and Well-being

HASD&IC 2022 CHNA COMMUNITY ENGAGEMENT RECOMMENDATIONS
Provide Navigation & Support to Patients
• Connect patients to services that will improve their health & well-being • Help patients understand and use health coverage • Help patients coordinate their health services • Help patients apply for health coverage or other benefits • Help patients pay for their health care bills
Provide Culturally Appropriate Care to Patients
• Ensure that a patient's care meets their needs • Provide culturally appropriate health care in more languages • Train hospital staff on biases
• **Workforce Development**
• Diversify the health care workforce • Hire more doctors, nurses, and other health care professionals • Create more health care job opportunities and career pathways
• **Community Collaboration**
• Collaborate with community groups and schools

- Provide health education

Sharp Coronado Hospital and Healthcare Center 2022 Community Health Needs Assessment (SCHHC 2022 CHNA): Community Recommendations

The SCHHC 2022 CHNA community engagement process collected input through a series of surveys with a special focus on the impact of the COVID-19 pandemic. Specifically, this included the pandemic's impact on: the needs previously identified in the 2019 CHNA; the use of Sharp's programs and services designed to address those needs; participation in telehealth; and engagement in Sharp's employee educational opportunities. Through these surveys, participants provided valuable feedback and suggestions to help SCHHC address the community's top health and social needs.

Institute for Public Health at San Diego State University (IPH) Sharp Provider and Human Resources Surveys

In partnership with the IPH, two surveys were distributed to Sharp team members; the IPH Sharp Provider Survey assessed impacts on Sharp patients and the IPH Sharp Human Resources Survey assessed impacts on Sharp employees. A total of 108 employees representing different Sharp entities and occupations completed the two surveys.

IPH Sharp Provider Survey results made it clear that the COVID-19 pandemic has had serious effects on Sharp's patients including: the isolation of seniors; mental health; access to health care; fear of utilizing health care; economic and food security; and access to social and emotional support and community resources. Most respondents believed Sharp does not have programs or services to address these issues. Recommendations included providing more follow-up calls with patients, home visits, caregiver support, and enabling safe visitation even during COVID-19. Respondents also suggested raising awareness about existing resources and expanding resources that are already in place.

When asked about telehealth, the majority of survey participants indicated that virtual video visits were not easy for patients due to challenges with accessing and using technology. Although most agreed that many patients prefer in-patient visits for a better connection with providers and confidence in their care, 95% of respondents still agreed that many telehealth modalities are potentially beneficial to patients.

IPH Sharp Human Resources Survey results revealed that COVID-19 was negatively impacting Sharp employees, most notably their levels of anxiety, stress, depression and frustration. Fortunately, most respondents believed Sharp has implemented programs to address these concerns. In addition, respondents indicated that employees are more likely to wish to change careers or leave the workforce and that they are more isolated. Most respondents believed Sharp does not have programs in place to alleviate these issues. Respondents emphasized the importance of addressing employee well-being and reducing turnover. Their recommendations centered around improving communication, work-life balance, compensation, new graduate programs and the hiring process.

Most critically, both surveys indicated that the community is facing a behavioral health crisis. And while the behavioral health of patients and employees is worsening, the availability of

behavioral health providers has decreased and access to timely behavioral health care services has become even more difficult. Respondents emphasized that efforts must be made to increase the availability of behavioral health care providers and to ensure easy access to them for both patients and employees. Also emphasized was the creation of more community-based programs as well as the importance of offering behavioral health services in patients' primary languages.

Further, of the more than half of respondents from both surveys who participated in Sharp's employee educational opportunities, most felt these programs better prepared them to meet patient needs, relate to patients and fellow team members, and protect their own mental health and well-being. The topics of greatest interest for future educational sessions included: care in the senior community; defining and applying cultural humility; and implicit/unconscious bias and its impact on decision making.

Overall, the results of the two surveys indicate that the negative impact of the COVID-19 pandemic has been significant on both patients and employees. Findings suggest that increased support and human connection in health care — both for patients and staff — is essential to address the most acute needs experienced by Sharp's community. These findings will help guide Sharp's (including SCHHC) internal discussions and program planning to address these complex issues with engagement, care and empathy.

Please see the IPH Sharp Provider/Human Resources 2022 CHNA Survey & Findings in **Appendix I** for a complete discussion of these findings and recommendations.

Sharp Insight Community Survey

The Sharp Insight Community Survey was distributed to 3,156 Sharp Insight Community members including Sharp patients and their families, community residents, Sharp employees, and Sharp-affiliated physicians. A total of 619 recipients completed the survey.

Although the majority of respondents did not participate in Sharp programs designed to connect patients and community members to support services or community resources that might help address the identified community needs, those who did reported them as effectively connecting them to the programs or services they were looking for. Due to the low number of participants reporting interaction with support services or community resources, recommendations for Sharp programs was limited.

In addition, although the majority of survey participants indicated that the pandemic had a limited impact on their access to care, most still emphasized the convenience of telehealth in accessing care during the pandemic.

This data suggests that the pandemic impacted different demographic groups in different ways, further demonstrating health inequities faced in our region. The feedback also suggests that more can be done to promote community awareness about Sharp programs and services among certain populations within San Diego County (SDC).

Please see the Sharp Insight Community 2022 CHNA Survey & Findings in **Appendix J** for additional feedback from this community engagement group.

HASD&IC 2022 CHNA: Hospital Next Steps

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

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

The CHNA Committee has already identified a few priority areas for future research:

- *Updated hospital discharge data:* This report generally cites hospital discharge data covering the years 2017-2019. Due to the COVID-19 pandemic and its potential to create temporary anomalies, 2020 hospital discharge data was not used. The CHNA Committee plans to seek expert assistance and provide the community with updated hospital discharge reports with data from 2020 and 2021.

- *Substance use:* The 2022 community engagement process revealed concerns around increasing substance use for both children and adults but is not sufficiently documented in the most recent trends. Additional information will be collected from community partners.

- *The impact of future/pending changes to programs critical to the health and well-being of our community:* Within weeks or months after this report is drafted, there could be significant changes to housing eviction protections, Covered California premium subsidies, Medi-Cal requirements to maintain coverage, CalFresh benefits, free school lunches and other programs and supports that communities relied on during the pandemic. The CHNA Committee plans to check in with community partners about the impact of these issues as part of the 2022 CHNA Phase 2 community engagement process.

- *Increasing costs and inflation:* Within the last few weeks of the community engagement process, there was increasing concern surrounding the issue of inflation and the rising cost of essential items. Community organizations and food banks were reporting

increasing need and struggling with the increased costs to meet the need. High gas prices were preventing community members from accessing needed services, such as health care appointments and food distributions. The CHNA Committee plans to check in with community partners about the impact of these issues as part of the 2022 CHNA Phase 2 community engagement process.

SCHHC 2022 CHNA: Next Steps

SCHHC has developed its fiscal year 2023-2026 (FY 2023 – FY 2026) Implementation Strategy to address the needs identified through the 2022 CHNA process for the primary communities it serves. The SCHHC 2022 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 will help address the needs of SCHHC's community members.

The SCHHC FY 2023 – FY 2026 Implementation Strategy is available 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.

In addition, tools such as the Dignity Health and IBM Watson Health Community Need Index (CNI), will be used to continue to identify gaps in community resources and provide insight into further program development.

Sharp will continue to work with HASD&IC and IPH to develop and implement Phase 2 of the 2022 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 2022 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. Also during Phase 2, Sharp will take a closer look at the findings that emerged during the collaborative 2022 CHNA process but for which the nature of Sharp's community engagement surveys provided limited opportunity for feedback — particularly Child & Youth Well-Being and Community Safety. Sharp will explore strategies to gather feedback on these needs through future community engagement processes.

In addition, Sharp hospitals (including SCHHC), medical groups and health plans will continue advancing data integration and community referral efforts through 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 use of social programs (e.g., housing, food banks, community clinics, etc.), emergency transport data and 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 115 community partners (organizations) participating in CIE, and more than 300,000 community members enrolled, with approximately 5,000 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 social determinants of health.

Appendix

A SCHHC Programs and Services

SCHHC Program and Service Highlights

- 24-hour emergency services with non-urgent online reservations available
- Acute care
- Advanced liver care and hepatology, including clinical trials, MARS® treatment for liver dialysis, and joint liver transplantation program with University of California San Diego Health
- Advanced robotic-assisted procedures
- Care Partner Program
- Classes, events and physician referral through 1-800-82-SHARP
- Electroencephalograms
- FollowMyHealth®, a secure online patient website that gives patients convenient, 24-hour access to their personal health information
- Heart and lung services, including electrocardiogram
- Home health, including home infusion services[205]
- Hospice[206]
- Image-guided sinus surgeries using state-of-the-art 3D endoscopic visualization and modeling
- Imaging services, including multipurpose fluoroscopy room, X-ray, computed tomography scan with magnetic resonance imaging, cardiovascular, mammography, dual-energy x-ray absorptiometry (DEXA) scanning, ultrasound, and electrocardiography (EKG).
- Inpatient hospice unit
- Integrative therapies, including acupuncture, clinical aromatherapy and massage
- Intensive Care Unit
- Laboratory services, including drive-thru phlebotomy, COVID-19 polymerase chain reaction testing and 10 patient service centers throughout San Diego County
- Long-term care at Villa Coronado Skilled Nursing Facility, accredited by The Joint Commission
- Mindful Café, offering healthy and nutritious food options for patients, families, staff and community members
- Nutrition counseling
- Orthopedics, including Radiostereometric Analysis, and robotic and total joint replacement surgeries — certified by The Joint Commission
- Online appointment scheduling for emergency care, mammograms, physical therapy, laboratory services, integrative spa therapies and fitness services

[205] Provided through Sharp Memorial Hospital Home Health Agency.
[206] Provided through Sharp HospiceCare.

- Payne Family Outpatient Pavilion, including robotic surgery, an endoscopy suite with endoscopic ultrasound and a dedicated imaging and women's services suite providing 3D mammography, DEXA scanning and ultrasound
- Pathology services
- Pharmacy, including a prescription medication disposal kiosk, immunizations, Community Pharmacy Travel Clinic, bedside prescription payment options, curbside delivery and free delivery throughout Coronado and the Cays and Imperial Beach
- Rehabilitation services, including sports medicine, and occupational, physical and speech therapies
- Respiratory care, providing 24-hour services that include ventilator and high flow oxygen management, obstructive sleep apnea screening, oximetry and capnography monitoring, EKG, arterial blood gas testing and pulmonary function testing
- Sharp Coronado Hospital Auxiliary and Meals on Wheels Adopt-a-Route
- Senior community wellness and educational services
- Sewall Healthy Living Center, providing integrative spa therapies, rehabilitation and fitness programs
- Stroke care, nationally certified as Acute Stroke Ready by The Joint Commission
- Subacute services
- Surgical services
- Vision-saving laser treatment for glaucoma using endoscopic cyclophotocoagulation
- Women's services and surgeries

Appendix

B An Overview of Sharp HealthCare

FOUR ACUTE CARE HOSPITALS:

Sharp Chula Vista Medical Center (SCVMC) (449 licensed beds)

The largest provider of health care services in San Diego County's (SDC) fast-growing south region, 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, services for women and infants, and the only bloodless medicine and surgery center in SDC.

Sharp Coronado Hospital and Healthcare Center (SCHHC) (181 licensed beds)

SCHHC provides services that include acute, subacute and long-term care, liver care, integrative and rehabilitative therapies, orthopedics, a community fitness center and emergency services.

Sharp Grossmont Hospital (SGH) (542 licensed beds)

SGH is the largest provider of health care services in San Diego's east region 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 (SMH) (656 licensed beds)

A regional tertiary care leader, 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 (SMBHWN) (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, SMBHWN delivers more babies than nearly any other hospital in California.

Sharp Mesa Vista Hospital (SMV) (159 licensed beds)

As the most comprehensive behavioral health hospital in San Diego, SMV provides services to treat anxiety, depression, substance use, eating disorders, bipolar disorder and more for patients of all ages.

Sharp McDonald Center (SMC) (16 licensed beds)

SMC is the only medically supervised substance use 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 herein 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 N** for a map of Sharp locations in SDC.

Mission Statement

It is Sharp's mission to improve the health of those it we serve with a commitment to excellence in all that it we do. Our 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 transform the health care experience and be recognized 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 and well-being of those we serve.

Values

- Integrity
  - Trustworthy, Respectful, Sincere, Authentic, Committed to Organizational Mission and Values

- Caring
  - Compassionate, Communicative, Service-Oriented, Dedicated to Teamwork and Collaboration, Serves Others Above Self, Celebrates Wins, Embraces Diversity, Equity and Inclusion

- Safety
  - Reliable, Competent, Inquiring, Unwavering, Resilient, Transparent, Sound Decision Maker

- Innovation
  - Continuous, Creative, 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 over two decades, 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 by 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 65 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 Committee 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:

Be the leader in clinical excellence across the care continuum.

Keep patients, employees, physicians and volunteers safe and free from harm.

Create exceptional experiences at every touch point for consumers, patients and families, enrollees, physicians, partners and team members.

Create an inclusive, values-driven culture that attracts, retains and promotes the best people, representative of the community.

Achieve financial results to ensure Sharp's ability to deliver on its mission and vision as a high-quality, affordable health system.

Be the integrated delivery system of choice by enhancing market position, innovation, physician collaboration, systemness and our value proposition.

Be an exemplary public citizen by improving the health equity and wellness 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. 19 on Forbes' 2020 Best Employers in California list. Forbes previously recognized Sharp in 2019 as No. 31 on this list, as well as No. 58 on its list of Best Employers for Women and No. 201 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.

In 2021, Sharp ranked No. 30 in the large employer category as one of the "Best Places to Work" for information technology (IT) professionals by the International Data Group's Computerworld survey. Sharp was also ranked No. 5 among the top 10 employers for diversity and inclusion. The list is compiled by evaluating a company's benefits, training, retention, career development, average salary increases, employee surveys, workplace morale and more. Sharp has been recognized as one of the "Best Places to Work" in IT each year since 2013.

Sharp was named one of the nation's "Most Wired" health care systems from 2012 to 2021 by the College of Healthcare Information Management Executives' 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. In 2021, Sharp met the criteria to be designated a Level 8 Acute health system, meaning it has deployed various technologies and

strategies to help analyze data and is starting to achieve meaningful clinical and efficiency outcomes.

In 2021, SMH was recognized on *Newsweek*'s third annual list of the top 1,000 hospitals worldwide. SMH was ranked No. 78 among all U.S. hospitals included in the ranking and No. 11 in California. SCVMC was also ranked at No. 141 in the U.S. for 2021, while SGH was ranked among *Newsweek*'s Best Maternity Hospitals. SMH was previously ranked No. 78 in 2020 and No. 89 in 2019, while SCVMC was ranked No. 137 in 2019.

In 2015, and from 2017 to 2021, Sharp was ranked "San Diego's Best Hospital Group" in the annual *San Diego Union-Tribune* Readers Poll. In 2017, and from 2019 to 2021, SMH was ranked "San Diego's Best Hospital." Sharp Rees-Stealy Medical Group (SRSMG) was ranked "Best Hearing Aid Store" in 2021 for the fifth year in a row, as well as "San Diego's Best Medical Group," "Best Audiologist," "Best Weight Loss Clinic/Counseling," "Best Laser Eye Center" and "Best Pharmacy." Sharp Home Care was ranked "Best In-Home Care (Medical)." Sharp Community Medical Group (SCMG) was previously ranked "San Diego's Best Medical Group" in 2020 as well as from 2015 to 2018.

In 2021, SCHHC 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. SMBHWN was previously recognized as a Top Hospital in 2016, 2017 and 2019, and SMH was recognized in 2016.

SCVMC, SGH, SMH and SMBHWN have received MAGNET® recognition by the American Nurses Credentialing Center (ANCC). The MAGNET Recognition Program® is the highest 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 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. SCVMC received its first designation in 2021.

The American Nurses Credentialing Center (ANCC) Practice Transition Accreditation validates hospital residency programs that meet rigorous, evidence-based

standards for quality and excellence. In 2020, the Sharp HealthCare Nurse Residency Program achieved accreditation with distinction from ANCC, becoming the second organization nationwide and the first in California to be accredited under the new 2020 standards.

In 2021, SGH received Gold Standard Level 1 accreditation as “Accredited Senior-Friendly Emergency Departments” by the American College of Emergency Physicians. The Geriatric Emergency Department Accreditation program was created to recognize EDs that prioritize the highest standards of care for older adults. SGH is the second hospital in California to receive this status. Previously, in 2020, SGH and SCHHC were recognized with Bronze Standard Level 3 accreditation.

In 2021, SCVMC, SGH and SMH received four-year accreditation by the American Society for Radiation Oncology Accreditation Program for Excellence. This accreditation recognizes the excellence of the hospitals' radiation oncology programs.


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. SMH became a Planetree Person-Centered Hospital in 2012 and was re-designated in 2015. SCVMC joined SCHHC and SMH as a Designated Planetree Person-Centered Hospital in 2014 and was re-designated in 2018. Also, in 2014, SCHHC and SMH each achieved Planetree Designation with Distinction for demonstrating leadership and innovation in patient-centered care. In addition, Planetree awarded the Gold Certification for Excellence in Person-Centered Care to SGH in 2018, SMH in 2019 and SCHHC in 2020.

In 2019, SMBHWN became one of only 40 institutions in North America to receive a Center of Excellence designation from the Society for Obstetric Anesthesia and Perinatology. The designation honors hospitals that demonstrate excellence and safety in obstetric anesthesiology and achieve a high level of clinical care.

In fiscal year 2021, Sharp Specialty Pharmacy earned full accreditation from two of the country's leading health care accrediting agencies, the Utilization Review Accreditation Commission and the Accreditation Commission for Health Care. This dual accreditation recognizes Sharp's commitment to providing quality care and services to patients who are on complex, high-cost medication to treat serious and specialized disease states.

San *Diego Business Journal*'s Corporate & Social Responsibility Diversity, Equity & Inclusion Awards recognize the significant accomplishments of local organizations who embrace these values and incorporate them into company culture. In 2020, Sharp was recognized with this award for its commitment to equity and inclusion, as demonstrated by the ongoing work of the Sharp Equality Alliance.

SCHHC and SCVMC received Energy Star (ES) designation from the U.S. Environmental Protection Agency for outstanding energy efficiency. Buildings that receive ES certification use an average of 35% less energy than other buildings and achieve a 35% reduction in greenhouse gas emissions. SCHHC first earned ES certification in 2007 and was re-certified for the ninth time in 2020. SCVMC was first certified in 2009 and was re-certified in 2020.

The San Diego Green Building Council (SDGBC) is a group of building industry professionals and sustainability advocates who work to promote sustainable building and community practices to help the San Diego region achieve its climate, water, waste and energy goals. In 2020, SDGBC selected the new SRSMC Santee facility as a Zero Net Energy awardee in its third annual Sustainability Awards.

Engineering News-Record (ENR) California's annual Regional Best Projects competition evaluates construction projects statewide on a variety of safety and sustainability metrics. In 2021, ENR California awarded SRSMC Santee the Sustainability Award of Merit in the Southern California region.

San Diego Gas & Electric 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 strategies 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 their environmental sustainability efforts and green initiatives.

In 2020, Sharp was named a "Recycler of the Year" by the City of San Diego Environmental Services Department's annual Business Waste Reduction and Recycling Awards Program for its outstanding waste reduction and recycling efforts. Sharp was previously recognized with this award in 2013, 2015 and 2016.

Sharp was named the 2017 Outstanding Recycling Program by California Resource Recovery Association (CRRA) — a 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 organizations in San Diego to receive a 2018 EMIES Unwasted Food award from the San Diego Food System Alliance for its collaboration as an innovator and early adopter with its 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.

SRSMG was recognized by the Centers for Disease Control and Prevention 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 2021, 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 or clinical quality. Sharp entities awarded in the Employee Engagement category include SCVMC, SCHHC, SGH, SMBHWN, SMH, Sharp Memorial Outpatient Pavilion (OPP), SMV, Sharp HospiceCare, SRSMG, SCMG and Sharp Home Health, while SCHHC, 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 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 2021, Sharp was recognized for Physician Engagement. Between 2013 and 2020, Press Ganey recognized SMH six times for Patient Experience.

Sharp Health Plan (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. In 2021, SHP was recognized with distinction in the Electronic Clinical Data category, which recognizes organizations that collect and report structured electronic clinical data for quality measurement and improvement. SHP previously maintained the NCQA's highest level "Excellent" accreditation status for service and clinical quality annually from 2013 to 2018. Accreditation status is based on compliance with rigorous requirements and performance on the Healthcare Effectiveness Data and Information Set, and Consumer Assessment of Healthcare Providers and Systems measures. In addition, in 2020, SHP earned a three-year Wellness & Health Promotion Accreditation from NCQA. SHP was the only organization to earn a longer accreditation status than the standard one-year period.

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 out of five-star overall rating in Covered California's 2021 Coverage Year Quality Ratings, which included five-star ratings in the categories of "Plan Services for Members" and "Members' Care Experience," and a four-star rating in "Getting the Right Care."

The Foundations of Sharp HealthCare achieved High Performer: Overall status among respondents for the 2020 Association for Healthcare Philanthropy (AHP) Report on Giving. AHP recognizes high performance based on organizations that fall within the 75th percentile in net production returns, calculated by subtracting total fundraising expenses from total production returns. This is the seventh consecutive year that Sharp has been recognized as an AHP High Performer.

America's Physician Groups (APG) is a professional association representing more than 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 2020. In consideration of the ongoing impact of the COVID-19 pandemic, APG canceled its awards survey for 2021.

The Integrated Healthcare Association recognized SCMG in 2020 with its annual Excellence in Healthcare Award, California's top honor for provider organizations. The award recognizes provider organizations that earn strong results in clinical quality and patient experience while effectively managing costs. SCMG was one of only 20 provider organizations across California to earn this recognition in 2020. In addition, SCMG was one of eight winners honored with the Ronald P. Bangasser, M.D., Memorial Award for Quality Improvement for demonstrating the highest year-to-year relative quality improvement in the San Diego region.

The Women's Choice Award® is a symbol of excellence in customer experience awarded by the collective voice of women. In 2021, multiple Sharp entities were recognized in a variety of categories, including: Best Mammogram Imaging Center, Comprehensive Breast Centers, Heart Care, Minimally-Invasive Surgery, Obstetrics, Orthopedics, Patient Experience and Patient Safety. Awarded Sharp entities included SCHHC, SCVMC, SGH, SMH (including SMBHWN and OPP), and several SRSMC locations, including Sorrento Mesa, Downtown, Rancho Bernardo, El Cajon and Sharp Rees-Stealy Breast Imaging Center in Mira Mesa. Previously, in 2019, Birch Patrick Convalescent Center was recognized among America's Best Extended Care and Nursing Homes.

Powered by the San Diego Association of Governments, 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 recognizes employers who have made strides to promote alternative commute choices — in the platinum tier in 2016, 2020 and 2021, and in the gold tier from 2017 to 2019.

Global Healthcare Exchange (GHX) recognized Sharp as one of the 2016 GHX "Best 50" Healthcare Providers in Supply Chain Excellence 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 HASD&IC 2019 CHNA Phase 2 Survey Summary

HASD&IC 2019 CHNA: Phase 2

Phase 2 was designed to follow up on Hospital Association of San Diego and Imperial Counties' 2019 Community Health Needs Assessment (HASD&IC 2019 CHNA), which was completed in July 2019.

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

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

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

Phase 2 Survey Participants and Findings

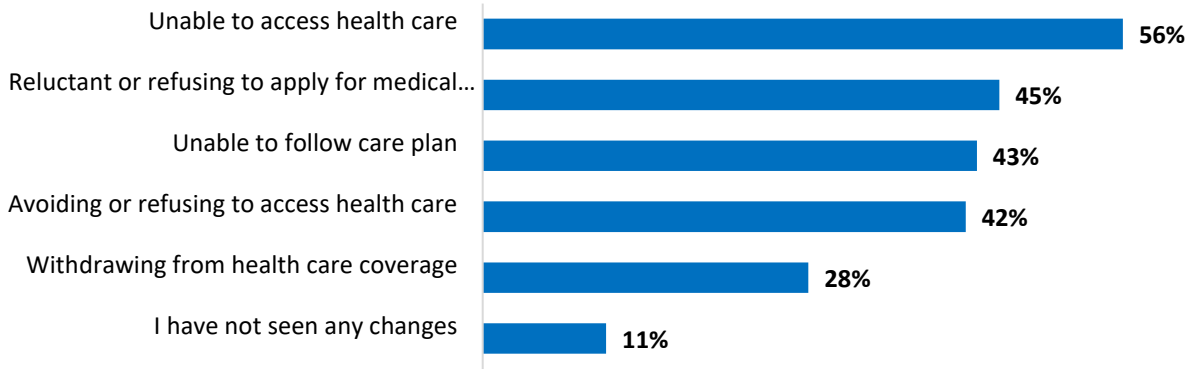
40%	16%	11%
Community-based organizations	Hospitals & health systems	Community residents

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

Summary of Participant Responses to Key Questions

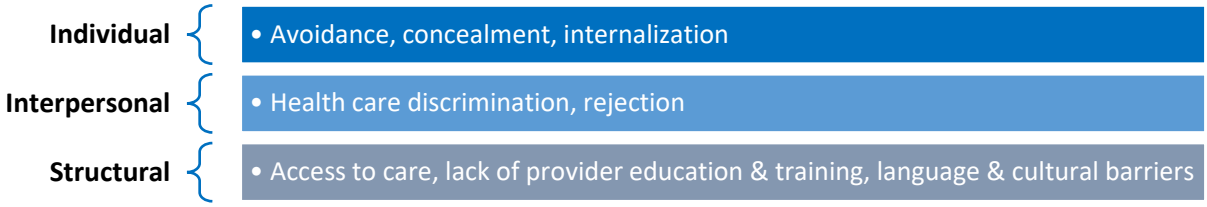
Access to Health Care

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



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

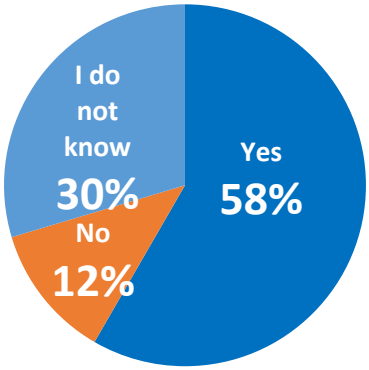
Respondents' feedback to this open-ended question was evaluated using the Modified Social-Ecological Model of Transgender Stigma & Stigma[207] to categorize and elucidate the themes of stigma



[207] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4689648/

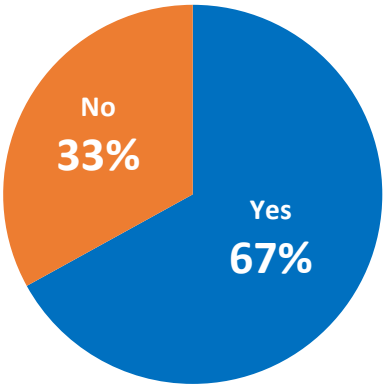
Immigration and Access to Health Care Observation

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



Hospital Patient Financial Service Requirements

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



Appendix

D SCHHC FY 2023 – FY 2026 Implementation Strategy

Sharp Coronado Hospital and Healthcare Center
Implementation Strategy
Fiscal Years 2023 – 2026

As a not-for-profit organization, Sharp HealthCare (Sharp) 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 we serve with a commitment to excellence in all that we do.

Sharp participates in a countywide collaborative to conduct a triennial Community Health Needs Assessment (CHNA) to identify the priority health needs facing the San Diego community, and also develops a separate CHNA for each individually licensed hospital. To learn more about Sharp's CHNA process and findings please view Sharp's 2022 CHNAs (including the Sharp Coronado Hospital and Healthcare Center (SCHHC) CHNA) at: https://www.sharp.com/about/community/community-benefits/health-needs-assessments.cfm.

In response to the 2022 CHNA findings, each Sharp hospital, including SCHHC, created an implementation strategy that highlights programs, services and resources provided by the hospital to address the identified health needs in its community (view the graphic below).

2022 CHNA Top Community Needs

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

underlying themes of stigma and trauma — barriers that became more pervasive during the pandemic.

Sharp has numerous support programs for patients and employees to help address the foundational challenges and underlying themes contributing to these needs and will continue to examine them with a goal to expand and improve offerings.

The following pages detail the strategies designed to address the community needs identified through SCHHC's CHNA process. In addition, the Sharp HealthCare Community Health Needs Assessment Guide (CHNA Guide) provides a general overview of Sharp's CHNA process as well as the programs that address the identified community needs. Please view Sharp's most current CHNA Guide at: https://www.sharp.com/about/community/community-benefits/health-needs-assessments.cfm.

For questions regarding SCHHC's implementation strategy or CHNA, please contact Erica Salcuni, Manager, Community Benefit and Health Improvement at Erica.Salcuni@sharp.com.

SCHHC FY 2023 – 2026 Implementation Strategy

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Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
1. Continue to host a variety of senior health education and screening programs, in order to raise awareness, identify risk factors, and connect seniors to helpful resources.	a. Provide information on various senior issues such as senior mental health, memory loss, hospice, senior services, nutrition, healthy aging and balance and fall prevention.	Ongoing (evaluated annually)	Manager, Sharp Coronado Hospital and Healthcare Center (SCHHC) Patient and Administrative Relations	Education Collaboration	Sharp Coronado Hospital and Healthcare Center (SCHHC) plans to collaborate with the John D. Spreckels Center and Bowling Green (Spreckels Center) in fiscal year (FY) 2022. In FY 2022, this collaboration will continue with education on a variety of health topics, including diabetes, mental health, brain health, stroke awareness, pelvic floor disorders, healthy habits and exercise for weight loss, obstructive sleep apnea, mindful eating, muscular-skeletal conditions, as well as fall prevention. In FY 2021, SCHHC continued to collaborate with the Spreckels Center to provide free health education to community seniors. Education was provided on a variety of topics, including stretching and stress relief; plantar fasciitis and foot pain; mindful eating and diabetes; vertigo, dizziness, and balance; healthy barbecue recipes; living with diabetes and heart disease; and traveling safely. From October to June, education was shared in video format with over 1,200 recipients of the Spreckels Center's monthly digital newsletter, as well as approximately 30 community members through live virtual presentations. From July to September, an additional 30 community members attended presentations, as well as blood glucose and blood pressure screenings, on-site at the Spreckels Center. In FY 2021, SCHHC planned to provide education on a variety of community health needs both on-site at the hospital and at community health fairs and events however many events did not occur due to the coronavirus disease 2019 (COVID-19) pandemic. Pending COVID-19 guidelines, SCHHC will continue to evaluate its offered services/events.

Identified Community Health Need – Aging Care & Support					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					In FY 2021, SCHHC partnered with the City of Coronado, Coronado police and fire departments and several community organizations to provide a community COVID-19 vaccination clinic at the Coronado Community Center, where more than 50,000 vaccines were administered between January to June. From June to December 2021, SCHHC continued to provide COVID-19 vaccines every weekday, on campus. SCHHC plans to provide vaccines in FY 2022 as well. FY 2021 education and screening programs provided by SCHHC in partnership with Spreckels Center were evaluated by participants. Evaluations include point scores and average evaluation scores, as well as open-ended questions such as the most important concept participants learned, and what other programs seniors (participants) would like. This strategy also addresses Identified Community Health Need – Obesity 3a. Please refer to that section for details.
	b. Continue to participate in community health fairs for seniors.	Ongoing (evaluated annually)	Manager, SCHHC Patient and Administrative Relations	Education Screenings Collaboration Behavioral Health	SCHHC continues to explore opportunities to provide education and resources to community seniors. SCHHC is currently exploring opportunities for community event participation — especially those serving older adults.
	c. Continue to offer health screenings tailored for seniors, annually.	Ongoing (evaluated annually)	Manager, SCHHC Patient and Administrative Relations	Education Screenings Collaboration	Due to COVID-19 social distancing guidelines, health screenings were not offered or were limited during FY 2021. Pending guidelines, SCHHC will continue to evaluate its offered services/events.

Sharp Coronado Hospital and Healthcare Center
Community Health Needs Assessment – Implementation Strategy
Fiscal Years 2023 – 2026

Identified Community Health Need – Aging Care & Support					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					SCHHC plans to provide behavioral health education, screenings and resources in FY 2022 as well. Education and screening programs provided by SCHHC in partnership with Spreckels Center are 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, and what other programs seniors (participants) would like.
2. Engage and collaborate with local community organizations that address senior health issues in order to foster future opportunities for collaboration in provision of education, screening, food and other resources to seniors.	a. Maintain active relationships with community organizations serving seniors throughout San Diego.	Ongoing (evaluated annually)	Manager, SCHHC Patient and Administrative Relations	Education Screenings Collaboration	SCHHC continues its presence on the Rotary Club of Coronado, Coronado Chamber of Commerce and the Coronado Senior Center Planning Committee. In FY 2021, SCHHC partnered with the City of Coronado, Coronado police and fire departments and several community organizations to provide a community COVID-19 vaccination clinic at the Coronado Community Center, where more than 50,000 vaccines were administered between January to June. For the rest of the FY and into FY 2022, SCHHC continued to administer vaccines on-site.
	b. Continue and strengthen partnership with Meals on Wheels San Diego County to serve homebound seniors and other vulnerable community members.	Ongoing	Manager, SCHHC Patient and Administrative Relations	Food Insecurity Social Isolation Collaboration Access to Health Care	For more than 30 years, SCHHC has partnered with Meals on Wheels San Diego County. Despite the COVID-19 pandemic, SCHHC volunteers continued delivering meals, and ensured that meals were not disrupted. In FY 2021, SCHHC auxiliary members and volunteers provided nearly 5,300 meals to approximately 37 community members. In addition to meal service delivery seven days a week, SCHHC's partnership with Meals on Wheels San Diego provides extensive community services, including meals with enhanced nutritional quality, free pet food, in-home

Identified Community Health Need – Aging Care & Support					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					safety assessments and sliding-scale payment options for those in need. Meals on Wheels volunteers also observe the client's environment for potential health and safety issues and are trained to obtain emergency response if needed. This partnership helps promote independence, reduce social isolation and improve the quality of life and health of participating community members.
3. Improve access to quality hospice, palliative and end-of-life care.	a. Maintain active relationships with or participate on local, state and national community boards and committees to expand access to quality hospice, palliative and end-of-life care.	Ongoing	Various, Sharp HospiceCare	Collaboration	Sharp HospiceCare participated on several local, state and national community boards and committees dedicated to hospice, palliative and end-of-life care, and the needs of seniors. This included, but was not limited to, the Caregiver Coalition, Coalition for Compassionate Care of California (CCCC), National Hospice and Palliative Care Organization's (NHPCO), ECSSP, National Alliance for Caregiving (NAC), San Diego County Hospice Veteran Partnership (HVP), San Diego Coalition for Compassionate Care (SDCCC), San Diego County Coalition for Improving End-of-Life Care (SDCCEOLC), San Diego Regional Home Care Council, California Health Care Foundation's (CHCF) California Physician Orders for Life-Sustaining Treatment (POLST) eRegistry Evaluation Team, San Diego Health Connect POLST e-registry workgroup and San Diego County Medical Society (SDCMS) Bioethics Commission. In addition, Sharp HospiceCare continued to participate in the Health Services Advisory Group/Sharp Grossmont Care Coordination Collaborative. Sharp HospiceCare leadership also continued to serve on the board of directors for California Hospice and Palliative Care Association (CHAPCA).
	b. Collaborate with a variety of experts throughout San Diego County (SDC) to provide ethical and equitable crisis care	9/30/2022 (evaluated annually)	Vice President (VP), Sharp HospiceCare	Collaboration Access to Health Care	As part of the SDCMS Bioethics Commission, in March and April, Sharp HospiceCare served on the bioethics workgroup for the development of a new framework called the San Diego County Allocation of Scarce Resources During Crisis Care – The Community Standard of Care Consensus. This countywide framework was rapidly developed as a collaborative effort

Identified Community Health Need – Aging Care & Support					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
	throughout the county in response to the COVID-19 pandemic.		Advance Care Planning (ACP) Coordinator, Sharp HospiceCare		between San Diego County's (SDC) hospital, medical, nursing, bioethics and legal experts to provide ethical and equitable crisis care throughout SDC during the COVID-19 pandemic.
4. 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.	9/30/2022 Ongoing (evaluated annually)	Bereavement Department, Sharp HospiceCare	Education Community & Social Support	In FY 2021, more than 1,800 community members received bereavement support newsletters. Sharp HospiceCare tracks the number of mailings annually through an internal database.
	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.	9/30/2022 Ongoing (evaluated annually)	Bereavement Department, Sharp HospiceCare	Veterans Education Collaboration	At a variety of community events throughout 2021, Sharp HospiceCare provided resources and information on veteran programs. FY 2021 veteran-specific community work included: • In FY 2021, more than 70 veteran patients and their families were recognized by volunteers, who dropped off a pin, certificate, flag and yard sign. • In March, Sharp HospiceCare presented on the We Honor Veterans (WHV) program to 75 staff members at the County of San Diego's Office of Military & Veterans Affairs, as well as participated in San Diego County HVP's virtual Vietnam veterans' recognition event, which reached an additional 75 veteran community members. • In December, Sharp HospiceCare honored veterans through the annual Wreaths Across America wreath-laying ceremony at Fort Rosecrans National Cemetery.

Identified Community Health Need – Aging Care & Support					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					• In June, Sharp HospiceCare honored veteran residents at Westmont of La Mesa senior living facility on Flag Day. • In November, Sharp HospiceCare supported Honor Flight San Diego through the Parade of Honor, a drive-by Veterans Day celebration at National University (NU), serving more than 600 community veterans. Since 2010, Sharp HospiceCare has been a member of the San Diego County HVP. Currently a Level 4 Partner, working towards Level 5 in WHV, a national program developed by the NHPCO in collaboration with the U.S. Department of Veterans Affairs to empower hospice professionals to meet the unique end-of-life needs of veterans and their families. At Level 4 the organization has achieved improved access to and quality of care for community veterans.
	c. Continue to provide community education and resource services throughout San Diego.	9/30/2022 Ongoing effort (programs planned on an annual basis)	Business Development Department, Sharp HospiceCare	Education Collaboration	Sharp HospiceCare supports the San Diego community in the areas of end-of-life care and Advanced Illness Management through the provision of education and resources at community health fairs and events, as well as educational presentations to community groups. Due to the COVID-19 pandemic, Sharp HospiceCare conducted its community outreach virtually in FY 2021, reaching more than 1,700 community members. In May, Sharp HospiceCare partnered with the Sharp Grossmont Hospital (SGH) Senior Resource Center to provide the Sharp HealthCare Virtual Aging Conference. In April, Sharp HospiceCare participated in the virtual Sharp Women's Health Conference, reaching more than 900 community members at both events.

Identified Community Health Need – Aging Care & Support					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					Sharp HospiceCare also engaged approximately 70 community members in education on understanding hospice and palliative care. In November, this included a virtual presentation to 20 members of the East County San Diego Bar Association. Sharp HospiceCare also presented virtually in May to 10 staff members at San Diego PACE, a geriatric-focused health plan that serves the needs of older adults who require coordinated care and support. In addition, Sharp HospiceCare staff provided education by telephone to approximately 40 community members seeking general information about hospice and palliative care. Sharp HospiceCare tracks the number of community education events through an internal database.
	d. Continue to offer individual and family bereavement counseling and support groups.	9/30/2022 Ongoing (evaluated annually)	Bereavement Department, Sharp HospiceCare	Care Management Community & Social Support	In FY 2021, Sharp HospiceCare's licensed clinical therapists with specific training in grief and loss devoted nearly 2,400 hours to home-, office-, and phone-based as well as virtual bereavement counseling with people who have lost loved ones. Referrals to community counselors, mental health services, bereavement support services and other community resources — including those related to COVID-19 — were provided as needed. Sharp HospiceCare provided a three-session Healing After Loss support group in November and December, which focused on practical concerns of adults grieving the loss of a loved one during the holidays. Another three-session Healing After Loss support group was offered in the spring, followed by an eight-session support group in summer. In FY 2021, Sharp HospiceCare's Healing After Loss support group served 135 members of the community.

Identified Community Health Need – Aging Care & Support					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					Sharp HospiceCare supported approximately 55 community members grieving the loss of a loved one during the 2020 holiday season through its Coping With Grief During the Holiday Season event in November. In FY 2021, Sharp HospiceCare offered an eight-week Widow's and Widower's support group in spring and summer, which addressed the concerns of more than 80 men and women who have lost their spouses, including emotional challenges and coping skills. Sharp HospiceCare tracks the number of individual and group counseling sessions through an internal database.
	e. Provide advance care planning (ACP) for community groups as well as individual consultations.	9/30/2022 Ongoing (evaluated annually)	ACP Department, Sharp HospiceCare	Education Care Management	Sharp's advance care planning (ACP) team engaged more than 930 community members in virtual ACP education throughout FY 2021. ACP presentations were provided to participants at the virtual Sharp Women's Health Conference, Live Well San Diego's 2021 Vital Aging Conference, a CCCC meeting, a meeting of the East County San Diego Bar Association and for a group of Sharp HospiceCare volunteers. To ensure ongoing community member access to ACP information during the pandemic, Sharp HospiceCare's ACP website offered a variety of resources to the community through PREPARE for Your Care — a free online ACP platform — which includes educational videos and a guided, step-by-step advance directive template. In FY 2021, Sharp's ACP team hosted free, monthly ACP webinars to help more than 90 community members identify their personal health care choices, communicate their wishes to loved ones and document their goals of care. This included specialized webinars to address the ACP needs of individuals with cancer and their loved ones, the needs of family caregivers

Identified Community Health Need – Aging Care & Support					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					and the needs of veterans and their families. In honor of National Healthcare Decisions Day — a nationwide initiative celebrated every April to educate adults of all ages about the importance of ACP — Sharp HospiceCare provided a webinar titled Spirituality and the Five Precepts in Advance Care Planning. In addition, Sharp HospiceCare partnered with Sharp Chula Vista Medical Center (SCVMC) in October to provide a virtual seminar about the importance of completing an advance directive and available ACP resources in the community, serving more than 20 community members. Throughout FY 2021, the Sharp ACP team conducted nearly 130 free consultations with 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. Consultations took place in-person and by phone, as well as virtually to support COVID-19 social distancing efforts. In FY 2021, Sharp's ACP team collaborated with Beautiful Dying by providing a presentation on ACP at the virtual 2020 Beautiful Dying Expo to 30 community members.
5. Provide education and outreach to the San Diego community concerning hospice and palliative services within the care continuum, in order to raise awareness of the choices available toward the end of	a. Provide hospice, palliative care and ACP education and training to physicians, case managers, other health care professionals and health care students.	Ongoing (evaluated annually)	Medical Director, Sharp HospiceCare Business Development Department,	Education Collaboration	Sharp HospiceCare participated on several local, state and national community boards and committees dedicated to hospice, palliative and end-of-life care, and the needs of seniors. This included, but was not limited to, the Caregiver Coalition, ECSSP, NAC, San Diego County HVP, South County Action Network, SDCCC and SDCCEOLC. Presentations provided to the health care community are evaluated through survey and tracked through an internal Excel database. Survey and data

Identified Community Health Need – Aging Care & Support					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
life and empower community members so that they and their family members may take an active role in their treatment.			Sharp HospiceCare ACP Coordinator, Sharp HospiceCare		tracking serve to evaluate effectiveness and to document activities for Sharp's annual Community Benefit Plan and Report. On a quarterly basis in FY 2021, Sharp HospiceCare provided virtual education on ACP, POLST, End of Life Option Act and goals of care to 140 nursing students at Azusa Pacific University (APU). APU students also received training on the role of bioethics in end-of-life care. In addition, in May, Sharp HospiceCare provided 30 Master of Social Work students from San Diego State University (SDSU) with a virtual lecture on hospice, ACP, bioethics and bereavement. In FY 2021, Sharp HospiceCare partnered with SDCCC to provide monthly education and training on POLST to 75 community health professionals and students. This included clinicians from local skilled nursing facilities (SNF), including Sharp facilities, as well as students from California State University San Marcos and SDSU. These web-based seminars helped develop and enhance participants' skills for facilitating meaningful conversations with patients and families about their care goals. Sharp HospiceCare also worked directly with community facilities to provide opportunities for students to shadow clinicians during telehealth ACP and POLST conversations with patients and families. Sharp HospiceCare also participated in SDCCC, CCCC and Children's Hospice & Palliative Care Coalition's telehealth and ACP pilot project in 2021, serving 30 Sharp HospiceCare patients. Recognizing the increased need for ACP during the COVID-19 pandemic, this project used video conferencing technology to provide counseling and support to patients, clients, and families across a

Identified Community Health Need – Aging Care & Support					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					variety of institutional settings, including SNFs, residential care facilities for the elderly, community clinics, housing shelters and correctional facilities.
	b. Continue active involvement with and participation on state and national hospice organizations (California Hospice and Palliative Care Association), including 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)	VP, Sharp HospiceCare Medical Director, Sharp HospiceCare	Education Collaboration	Sharp HospiceCare provides approximately six presentations each year in collaboration with state and national organizations. Sharp HospiceCare leadership continues to serve on the board for CHAPCA. Community presentations provided through Sharp HospiceCare — including those to professional organizations — are evaluated through surveys to evaluate effectiveness and revise program content.
6. 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.	9/30/2022 Ongoing (evaluated annually)	Business Development Department, Sharp HospiceCare	Collaboration	In March 2017, Sharp became the first health care system in SDC to begin electronic uploads of patient POLST forms to the POLST eRegistry. As of September 2021, more than 60,000 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 (EMS), 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

Identified Community Health Need – Aging Care & Support					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					connects health care providers and patients to private health information exchanges. The Sharp HospiceCare ACP team participates in this initiative — funded by CHCF 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, web presentations and community-related information for consumers and health care professionals.	Ongoing (evaluated annually)	Business Development Department, Sharp HospiceCare	Education Collaboration	Sharp HospiceCare also coordinated with 2-1-1 San Diego (2-1-1) to identify, register and vaccinate homebound individuals in the community, reaching over 1,100 of SDC's most vulnerable residents. This collaboration was completed in May 2022. Sharp HospiceCare will continue to explore collaborations — see line items below. Please refer to line items 4b-4c, 4e and 5b for additional information on current efforts.
7. 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. Sharp HospiceCare and SCHHC (along with other Sharp HealthCare (Sharp) entities) will participate in a one-year pilot utilizing 2-1-1 San Diego's (2-1-1) Community Information Exchange (CIE).	June 2023	Manager, Sharp HealthCare Community Benefit and Health Improvement VP, Sharp HospiceCare	Clinical Community Linkages Data Sharing Collaboration	Sharp entities — including SCHHC and Sharp HospiceCare — will continue participation in year 4 of the Community Information Exchange (CIE) pilot partnership, July 1, 2022 through June 30, 2023. Utilization remained consistent between Years 2 and 3 among Sharp staff, with an increase in the number of CIE clients identified as Sharp patients. Utilization metrics through April 2022 included: • 202 Sharp Users • 646 Referrals Received within CIE • 65 Sharp Services listed • >8,400 CIE enrollees identified as Sharp patients

Identified Community Health Need – Aging Care & Support					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					• >3,330 CIE enrollees identified as having Sharp Health Plan • Communities served through CIE: Downtown, Mission Valley, Southeast San Diego, Encanto, El Cajon, Lakeside, La Mesa, Otay Mesa, National City, Chula Vista, Carlsbad, Escondido, Oceanside • Top services/referrals provided through CIE: utilities, nutrition (food), housing, economic support Sharp's systemwide pilot partnership with 2-1-1's CIE is approaching completion of Year 3, with an ongoing commitment to better understand and address the health equity barriers that influence the health and well-being of patients. Research continues to underscore that social determinants of health (SDOH) have a significant impact on a person's ability to access care and maintain health. Sharp's participation in the CIE pilot partnership promotes opportunities for case managers and social workers across the system to provide more informed, holistic care to patients facing barriers, and make direct referrals to critical community-based resources to meet their needs. In addition, at the start of Year 3 of the partnership, Sharp leadership approved moving forward with data integration of select CIE data with Sharp's Electronic Health Record system, in order to further increase and support utilization, and strengthen the community piece of Sharp's efforts to identify and address SDOH and health equity in the communities it serves. Exploratory work is well underway to design the implementation strategy for this data integration over the next several months/year. Sharp teams continue to work closely with 2-1-1 on the implementation and data integration plans for CIE, which includes ongoing metrics, such as CIE

Identified Community Health Need – Aging Care & Support					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					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 emergency department (ED) visits, length of stay, etc.) and others. This data will be used to re-evaluate the value and sustainability of CIE for Sharp after the fourth year of the pilot. **Background**: Beginning in July 2019, Sharp HospiceCare participated along with multiple Sharp entities (hospitals, medical groups, and health plan) in a one-year pilot with the CIE stewarded by 2-1-1. CIE training for Sharp HospiceCare staff was completed in July 2019.

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Identified Community Health Need – Behavioral Health					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
1. Raise awareness and reduce stigma of behavioral health issues, with a specific focus on seniors.	a. Provide behavioral health education, screening and resources to community members, specifically seniors.	Ongoing (evaluated annually)	Manager, SCHHC Patient and Administrative Relations	Aging Care & Support Collaboration Education Stigma	In FY 2022, SCHHC will explore opportunities to provide virtual behavioral health screenings and resources to community members in collaboration with Sharp Mesa Vista Hospital (SMV). Between May and August, SCHHC & SMV specialists will conduct a series of in person presentations on mental and brain health at the Spreckels Center. Topics include stress relief with music therapy, care for the caregiver, understanding mental health and maintaining brain health. Additionally, the Sewall Healthy Living Center will continue to provide weekly in-person guided labyrinth walks, as well as virtual meditation and yoga classes to support mental well-being and promote relaxation. In May 2021, SCHHC participated in Mental Health Awareness Month by sharing tips on how to take care of emotional well-being as well as resources. In addition, nine staff members from the hospital's Sewall Healthy Living Center hosted a Zoom presentation on senior behavioral health. Topics included decreasing stress and anxiety as well as breathing techniques to calm the body and mind. Although behavioral health is identified as a priority health need in the primary communities served by SCHHC, the facility is not licensed to comprehensively address this priority. The behavioral health needs of SCHHC's patient community are addressed primarily through the programs and services provided through SMV and Sharp McDonald Center – the major providers of behavioral health and chemical dependency services in SDC. As part of this effort, SMV dispatches PET (Psychiatric Evaluation Team) staff to SCHHC's ED in order to identify patients that should be transferred to SMV.

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Identified Community Health Need – Behavioral Health					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
2. Improve care management and clinical-community linkages that address SDOH through implementation of a new technology platform that shares health and social services data across health care and social service sectors.	a. SCHHC (along with other Sharp entities) will participate in a pilot partnership with 2-1-1's CIE.	June 2023	Manager, SCHHC Case Management & Social Work Manager, Sharp HealthCare Community Benefit and Health Improvement	Clinical Community Linkages Data Sharing Collaboration	This strategy also addresses Identified Community Health Need – Aging Care & Support 7a. Please refer to that section for details.

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Identified Community Health Need – Cancer					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
1. Promote early cancer detection and diagnosis through increased education and screening for patients and community members.	a. Conduct cancer health screenings — on-site and in the community.	Ongoing	VP, Sharp HealthCare Oncology Service Line	Screening	In March 2021, SCHHC's endoscopy team provided colon cancer outreach at the Coronado Community Center COVID-19 vaccination clinic. Education and resources included colon cancer signs and symptoms, screening tips and guidelines, and frequently asked questions about colon cancer. In further support of cancer awareness and prevention, in September, a SCHHC dermatologist provided visual skin exams, information on skin cancer and safe skin practices, when to obtain follow-up care and resources to 140 attendees of the annual Sharp Coronado Hospital Foundation Golf Tournament. SCHHC currently provides cancer screening for breast cancer through digital mammography and 3D Tomosynthesis; screening for colon cancer through colonoscopy; and CT lung screening for lung cancer. SCHHC has recently invested in additional cancer screening services, including breast and lung. SCHHC has also established a new Cancer Care Clinic for consults/education, and follow-up services. SCHHC has limited cancer resources and staff compared to other Sharp entities, which reflects the lower volume of cancer patients seen at SCHHC. Given the lower patient volume, as well as the cost, expertise and sophistication requirements needed to expand cancer services, increasing investment in cancer screening to promote early cancer detection and connection to services will best support patients and community members served by SCHHC.
2. Improve navigation of the health care system for newly diagnosed cancer patients.	a. Continue to assist newly diagnosed cancer patients by providing support and easily accessible materials.	Ongoing	VP Oncology Service Line	Access to Health Care	Representatives throughout the Sharp system are exploring ways to further assist newly diagnosed cancer patients who are particularly anxious at this vulnerable time. A new educational resource published in late FY 2021 — both printed and on sharp.com — provides a wealth of information for newly

Sharp Coronado Hospital and Healthcare Center
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Identified Community Health Need – Cancer					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
				Care Management	diagnosed patients including how to prepare for upcoming visits to cancer specialists; what they can do personally and with family and friends to prepare for the days ahead with treatment; and how to access information about cancer services and support provided by Sharp. While developing the brochure, access gaps were identified, and so special efforts are underway to ensure the brochure is easily accessible and that patients have reliable methods for questions to be answered in a timely manner.
3. Improve care management and clinical-community linkages that address SDOH through implementation of a new technology platform that shares health and social services data across health care and social service sectors.	a. SCHHC (along with other Sharp entities) will participate in a pilot partnership with 2-1-1's CIE.	June 2023	VP Oncology Service Line Manager, Sharp HealthCare Community Benefit and Health Improvement	Clinical Community Linkages Data Sharing Collaboration	This strategy also addresses Identified Community Health Need – Aging Care & Support 7a. Please refer to that section for details.

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Community Health Needs Assessment – Implementation Strategy
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Identified Community Health Need – Cardiovascular Disease					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
1. Increase access to cardiovascular health screenings, education, support and resources for community members; promote accountability and behavioral change through education on chronic disease self-management.	a. Provide cardiovascular health education, screenings, and resources to community members through classes, events and fairs as well as participate in heart-related community events.	9/30/2022 (evaluated annually)	Manager, SCHHC Patient Relations	Education Screenings Access to Health Care	Sharp's systemwide stroke program plans to resume community classes at SCHHC, focusing on stroke recognition, treatment and rehabilitation in the fall of 2021. Also, in FY 2022, SCHHC-affiliated physicians plan to provide stroke education. In FY 2021, SCHHC continued to collaborate with the Spreckels Center to provide community seniors with education on living with diabetes and heart disease. An educational video was shared with over 1,200 recipients of the Spreckels Center's monthly digital newsletter, as well as 30 community members through live virtual presentations. From July to September, an additional 30 community members attended presentations, as well as blood glucose and blood pressure screenings, on-site at the Spreckels Center. Also in FY 2021, SCHHC partnered with the SunCoast Market Co-op to provide an educational video on exercise and nutrition to prevent heart disease and diabetes to more than 1,000 Imperial Beach community members. During American Heart Month in February, SCHHC shared a heart-healthy recipe created by the hospital's executive chef, as well as mindfulness breathing exercises to promote relaxation and lower blood pressure. In April, SCHHC hosted an online community seminar titled The Golden Hour: How to Respond Quickly to a Stroke and Other Emergencies for 30 community members. Led by the hospital's board-certified emergency medicine doctor, the free event discussed the different types of strokes, common warning signs and when to seek emergency care and included a question-and-answer session.

Identified Community Health Need – Cardiovascular Disease					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					In May, the hospital honored Stroke Awareness Month by sharing how to recognize and respond to signs of stroke and invited the community to participate in a free webinar about stroke awareness. Throughout FY 2021, SCHHC shared articles in the local Coronado Eagle & Journal newspaper, covering various topics, including stroke awareness. To promote the value of physical health during the pandemic, articles offered heart-healthy recipes from the executive chef at SCHHC's Mindful Café as well as safe exercises at home. SCHHC participated in year-round fundraising activities in support of the 2021 San Diego Heart & Stroke Walk in September. In addition, this need is addressed by currently existing support groups across Sharp, including Heart Failure, Heart Transplant Support Group and YESS (Young Enthusiastic Stroke Survivors).
2. Collaborate with other health care organizations in San Diego on stroke education and prevention efforts.	a. Continue participation in San Diego County Stroke Consortium — a collaborative effort to improve stroke care and discuss issues impacting stroke care in SDC.	Ongoing	Director, Sharp Neuroscience Service Line Program Manager – Ortho/Neuro Service Line.	Stroke Collaboration Data Sharing	Sharp team members actively participated in the quarterly San Diego County Stroke Consortium, a collaborative effort with other SDC hospitals to improve stroke care and discuss issues impacting stroke care in SDC. In FY 2021, meetings continued to be held virtually. Sharp team members also continued collaboration with the County of San Diego EMS to provide data for the SDC stroke registry. In FY 2022, consortium education goals include recognizing strokes more quickly in the field and pushing BEFAST (balance, eyes, face, arm, speech, time) as a SDC recognition of stroke symptoms.

Identified Community Health Need – Cardiovascular Disease					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
			Sharp Medical Directors, Stroke SCHHC Manager, Emergency Department		In FY 2021, all 17 hospitals that collaborate in the San Diego Stroke Consortium collectively released two messages to the community via social media to encourage San Diegans not to delay seeking care during the COVID-19 pandemic. Each message sent from Sharp reached 16,000 subscribers to Facebook, Instagram and other social media outlets with a Sharp following. Sharp's systemwide stroke program participated in submitting data on stroke codes to SDC on a monthly basis. As a result, data is tracked to determine trends and gap identification in the County of San Diego EMS/hospital arena.
3. Provide heart health education to health care professionals in the community.	a. Provide expert speakers on heart disease, heart failure and stroke at professional conferences and events.	Ongoing	Various	Education Collaboration	In FY 2021, SCHHC anticipated providing health education at conferences and events throughout the year. However, many opportunities were canceled or postponed due to the ongoing COVID-19 pandemic. In partnership with the San Diego County Stroke Consortium, in November 2020 Sharp's systemwide stroke program participated in an EMS training video to provide stroke education to AMR San Diego, a medical transportation company that assists with emergency and non-emergency transportation. The video covered new stroke procedures and guidelines and how to assess a stroke patient at the scene. Sharp's systemwide stroke program submitted three poster presentations to the International Stroke Conference 2021 in February: Should I Stay Or Go: Seeking Stroke Care During COVID-19, COVID-19 Geographic Distribution and Stroke Code Activation Within San Diego County, and Coming Together in a Time of Distancing: Creating Community Messaging for Emergency Care During COVID. The International Stroke Conference was dedicated to the science and

Identified Community Health Need – Cardiovascular Disease					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					treatment of cerebrovascular disease, and stroke experts shared the latest clinical trial results with attendees from all over the world.

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Community Health Needs Assessment – Implementation Strategy
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Identified Community Health Need – Diabetes					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
1. Increase education of signs and symptoms of diabetes throughout San Diego, particularly underserved and minority populations in the community.	a. Participate in educational forums, health fairs and events throughout San Diego, including Coronado.	9/30/2022 (evaluated annually)	Manager, SCHHC Patient and Administrative Relations Sharp Diabetes Service Line Leadership Team Sharp Manager, Community Benefit and Health Improvement	Education Collaboration Food Insecurity Access to Health Care	In FY 2022, SCHHC will provide a series of virtual presentations in collaboration with SunCoast Market Co-op in Imperial Beach. The partnership programming has been delayed due to staffing changes, lack of resources and COVID-19 public health and safety guidelines. Topics will include healthy food and a healthy heart diet. In April 2022, SCHHC provided mindful eating and diabetes education through the Spreckels Center. Initially, SCHHC intended to provide several classes in FY 2021, however due to COVID-19, many activities may not have occurred as planned, and may have been prevented entirely or severely limited. In FY 2021, SCHHC partnered with the SunCoast Market Co-op to provide education to the Imperial Beach community on health and wellness topics requested directly by residents. The SunCoast Market Co-op is a grassroots effort to open a community-owned, full-service cooperative grocery store with a goal of strengthening the local food system, increasing residents' access to healthy food, and providing a needed retail outlet for small local farms and producers. In July, SCHHC shared a video on exercise and nutrition to prevent heart disease and diabetes in the SunCoast Market Co-op's digital newsletter, which reached more than 1,000 community members. SCHHC continued to collaborate with the Spreckels Center to provide free health education to community seniors. Education was provided on a variety of topics, including mindful eating and diabetes; healthy barbecue recipes; and living with diabetes and heart disease. From October to June,

Identified Community Health Need – Diabetes					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					education was shared in video format with over 1,200 recipients of the Spreckels Center's monthly digital newsletter, as well as approximately 30 community members through live virtual presentations. From July to September, an additional 30 community members attended presentations, as well as blood glucose and blood pressure screenings, on-site at the Spreckels Center. In FY 2022 and 2021, SCHHC hosted a free, online webinar titled Mindful Eating During the Holidays. Led by a hospital registered dietitian, the class introduced the concept of mindful eating — a way to develop awareness from one's experiences, physical cues and feelings about food that can support weight loss, behavior change and stress reduction — and how it can help individuals make healthy food choices during the holidays. In FY 2022, nearly 10 community members participated in the webinar. Although the Sharp Diabetes Education Program (Sharp's systemwide diabetes education program) had anticipated participating in additional community events, conferences and educational presentations throughout FY 2021, most in-person activities were canceled or postponed due to COVID-19. The Sharp Diabetes Education Program provided fundraising and team participation for the 2021 San Diego Heart & Stroke Walk in September and plans to participate in FY 2022. The Sharp Diabetes Leadership Team meets annually with the Sharp Manager of Community Benefit and Health Improvement to evaluate

Identified Community Health Need – Diabetes					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					community programs over the previous year and identify opportunities for community outreach and collaboration. The Sharp Manager of Community Benefit and Health Improvement will continue to work with the Sharp Diabetes Education Team as staffing and resources become available.
	b. Utilize findings from the FY 2022 Community Health Needs Assessment to assess existing community resources and explore areas where additional diabetes education and resources may be needed.	9/30/2022	Sharp Diabetes Service Line Leadership Manager, SCHHC Patient Administrative Relations Sharp Manager, Community Benefit and Health Improvement	Education Collaboration Access to Health Care	The Sharp Diabetes Education Program intended to explore additional collaborations to assist and educate food insecure community members in FY 2021, however due to COVID-19, many activities were canceled or severely limited. Continued efforts focus on: • Clinic collaborations — Exploring the possibility of a clinic collaboration is in process. • Exploring partnerships to address food insecurity as part of nutrition education and incorporating food insecurity screening into patient diabetes education and counseling. • Centers for Disease Control and Prevention'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. 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.

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Identified Community Health Need – Diabetes					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
2. Improve care management and clinical-community linkages that address SDOH through implementation of a new technology platform that shares health and social services data across health care and social service sectors.	a. SCHHC (along with other Sharp entities) will participate in a pilot partnership with 2-1-1's CIE.	June 2023	Manager, Sharp HealthCare Community Benefit and Health Improvement Sharp Diabetes Health Educator	Clinical Community Linkages Data Sharing Collaboration	The Sharp Diabetes Education Program trained team members on 2-1-1's CIE in order to assess the value of this technology as a support for their patients. This strategy also addresses Identified Community Health Need – Aging Care & Support 7a. Please refer to that section for additional details.

Sharp Coronado Hospital and Healthcare Center
Community Health Needs Assessment – Implementation Strategy
Fiscal Years 2023 – 2026

Identified Community Health Need – Obesity					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
1. Provide free biometric screenings for community members that address risk factors for obesity; includes education on reducing those risks.	a. Coordinate and provide health education as well as body mass index and blood pressure screenings for indicators of risk of obesity in community members.	Ongoing (evaluated annually)	Manager, SCHHC Rehabilitation Services	Screening Education Collaboration	In November, SCHHC hosted a free, online webinar titled Mindful Eating During the Holidays that was led by a hospital registered dietitian. The class introduced the concept of mindful eating — a way to develop awareness from one's experiences, physical cues and feelings about food that can support weight loss, behavior change and stress reduction — and how it can help individuals make healthy food choices during the holidays. Nearly 10 community members participated in the webinar.
2. Provide community education on nutrition, healthy eating and access to healthy food.	a. Utilize SCHHC's on-site organic garden to provide community classes on healthy eating.	Ongoing (evaluated annually)	Manager, SCHHC Patient and Administrative Relations	Healthy eating Food Insecurity	In FY 2022, SCHHC plans to offer free, in person education for community members on a range of health and wellness topics at the Spreckels Center. SCHHC plans to re-open the garden as COVID-19 public health and safety guidelines allow. SCHHC plans to provide presentations at the garden as well. Initially, SCHHC intended to provide several classes in FY 2021, however due to COVID-19 and visitor restrictions, this activity was canceled. The hospital's on-site, certified organic fruit, vegetable and herb garden provides nutritious ingredients for the hospital's Mindful Café, as well as serves as an educational tool to teach community members how to start an organic garden through free monthly gardening classes. On average, six community members attended the classes each month prior to the COVID-19 pandemic.
	b. Provide community members with education on nutrition and healthy eating on-site, in collaboration with organizations and virtually.	Ongoing (evaluated annually)	Manager, SCHHC Rehabilitation Services	Screening Education Collaboration	In FY 2022, SCHHC will provide a series of virtual wellness presentations in collaboration with SunCoast Market Co-op in Imperial Beach, which has been delayed for some time due to staffing changes and lack of resources. Topics include healthy food and healthy eating habits, nutrition, diabetes and diabetes and heart health.

Identified Community Health Need – Obesity					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					In July 2021, SCHHC shared a video on exercise and nutrition to prevent heart disease and diabetes in the SunCoast Market Co-op's digital newsletter, which reached more than 1,000 community members. In FY 2021, SCHHC hosted a free, online webinar titled Mindful Eating During the Holidays for more than 10 community members. Led by a hospital registered dietitian, the class introduced the concept of mindful eating and how it can help individuals make healthy food choices during the holidays. In FY 2021, the Spreckels Center provided free health education to community seniors on several topics, including mindful eating and diabetes; healthy barbecue recipes; and living with diabetes and heart disease. Please see line item 3a below for additional information on current efforts.
3. Provide care management in support of weight loss and healthy lifestyle choices for San Diego community members.	a. Continue to offer health and wellness services in the Sewall Healthy Living Center.	Ongoing (evaluated annually)	Manager, SCHHC Rehabilitation Services SCHHC Director of Ancillary Services SCHHC Chief Financial	Screening Education Physical activity Healthy eating	In FY 2022, SCHHC's Dietary and Nutrition department offered in-person presentations at the Spreckels Center. In FY 2022, SCHHC plans to develop virtual community education and fitness opportunities, including pre-recorded classes and workshops for anytime viewing. Initially, SCHHC intended to provide several in-person classes in FY 2021, however due to COVID-19, many classes transitioned to virtual sessions, expanding their reach throughout and beyond SDC. Services available through the Sewall Healthy Living Center include:

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Identified Community Health Need – Obesity					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
			Officer, VP of Clinical Services		• Memberships for general fitness center access • Personal training sessions for individualized fitness services • Fitness classes for all levels of mobility • Personalized nutrition counseling services • A menu of diagnostic health screenings In general, resource limitations restrict growth beyond current programs and services that specifically address obesity at this time. SCHHC continues to offer weekly exercise and wellness classes for individuals of all ages including a variety of yoga, fitness, and mindfulness classes each week. Classes took place at the hospital's Sewall Healthy Living Center, Sandermann Education Center.

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Identified Community Health Need – Access to Health Care					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
1. Increase coverage for patients seen in the emergency department 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	Education Financial Assistance	In FY 2021, Sharp secured Presumptive Eligibility for 7,068 unfunded patients in the ED. From October 2021 through May 2022, Sharp has secured Presumptive Eligibility for 4,179 unfunded patients in the ED. 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 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. Sharp will continue to monitor results. **Background**: In 2014, Sharp hospitals implemented an on-site process for real-time Medi-Cal eligibility determinations (Presumptive Eligibility), making Sharp the first hospital system in SDC to provide this service. The PointCare program continues to collect metrics on a number of individuals served and cost savings. From October 2015 to September 2021, Sharp helped more than 97,700 self-pay patients through PointCare, while maintaining each patient's dignity throughout the process. In year-to-date (YTD) FY 2022, the number of individuals served increased by more than 1,300. **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

Identified Community Health Need – Access to Health Care					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					assistance options. At 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 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. The tool interfaces patient screening information in the GE record.
2. Provide payment options, education and support to vulnerable, 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	Financial Assistance Provide education on patient access services	In YTD FY 2022, the Maximum Out of Pocket Program made a total of $325,000 in adjustments to patient bills. In FY 2021, this figure totaled more than $640,000. The significant change in volume is a result of the COVID-19 pandemic and a decline in scheduled services. **Background**: The Maximum Out of Pocket Program was launched in October 2014. Sharp assists underinsured and vulnerable individuals unable to meet their financial responsibility after health insurance. Through the program, team members meet with patients at all Sharp hospitals to help them better understand their health insurance benefits and how to access care during their hospital stay, as well as provide payment options.
	b. Provide a Public Resource Specialist for uninsured and underinsured patients, to offer support patients needing advanced guidance on available funding options.	Ongoing	Patient Access Services (system-level) Public Resource Specialists	Financial assistance Provide education on	Prior to the COVID-19 pandemic, Public Resource Specialists performed field calls (home visits) to patients who require assistance with completing the coverage application process after leaving the hospital. Field calls were paused due to COVID-19 public health and safety restrictions, and have recently been transformed to telehealth (virtual) calls.

Identified Community Health Need – Access to Health Care					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
				patient access services	**Background**: 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 in need of extra guidance on available funding options.
	c. The Patient Assistance Team will continue to assist patients in need of assistance gain access to free or low-cost medications.	Ongoing	Manager of Pharmacy Finance & Regulatory Compliance Supervisor, Patient Assistance Navigators	Provide education on patient access services	In FY 2021, the Patient Assistance Program helped under- and uninsured patients access more than $9.1 million savings in medications. Cost savings for replacement drugs is monitored through the pharmacy. The patient accounting staff remove the charges from the patient's statement. Patients are referred by population health teams, physicians, pharmacists, case managers, social workers, nurses and at times, other patients. Team members research all available options for these patients, including programs offered by drug manufacturers, grant-based programs offered by foundations, co-pay assistance and other low-cost alternatives. Eligible patients receive assistance that may help reduce readmissions and the need for frequent medical services resulting from the lack of access to medications. 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.
	d. Continue to offer ClearBalance — a specialized loan program for patients facing high medical bills. Through this collaboration with	Ongoing	Supervisor, Patient Assistance Navigators	Access to Health Care	As of September 30, 2020 more than 5,100 Sharp patients have received assistance through the ClearBalance zero-interest loan program.

Identified Community Health Need – Access to Health Care					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
	San Diego-based CSI Financial Services, both insured and uninsured patients have the opportunity to secure small bank loans to help pay off their medical bills in low monthly payments and prevent unpaid accounts from going to collections.		Manager Patient Access Services, Self-Pay Patients		
	e. Continue to provide Project HELP funds for pharmaceuticals, transportation vouchers and other needs for economically disadvantaged patients.	Ongoing	SCHHC Chief Financial Officer	Access to Health Care	From FY 2010 – FY 2020, funds for SCHHC Project HELP were more than $60,000. In FY 2021, funds for SCHHC Project HELP were approximately $27,000. Project HELP funds are tracked though an internal database. In FY 2021, SCHHC also provided nearly $115,000 in free valet services to improve patient, family and community member access to the hospital.
3. Collaborate with organizations in San Diego to serve individuals experiencing homelessness.	a. Sponsor and participate in the Downtown San Diego Partnership Family Reunification Program.	Ongoing	Sharp Executive VP Hospital Operations	Homelessness Housing Instability Transportation Collaboration	With Sharp's contributions, the Family Reunification Program has reunited more than 3,800 homeless individuals in Downtown San Diego with friends and family across the nation. **Background**: Since 2012, 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

Identified Community Health Need – Access to Health Care					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					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.
4. Improve access to health and social services for vulnerable community members, particularly San Diego's homeless population.	a. Explore and expand Sharp integrated delivery system access to post acute recuperative care services.	FY 2023	VP Integrated Care Management (ICM)	Access to/ Longitudinal Coordinated Care	With regard to this need, Sharp is seeking to identify short-term solutions for immediate needs as they occur, in addition to long-term, sustainable solutions. Each patient is independently considered for exact care need, likely term for the need, and various care setting options immediately available. Sharp continues to coordinate care efforts in partnership such as Whole Person Wellness, PATH (People Assisting the Homeless) and 2-1-1 CIE. Likewise in support of California Senate Bill (SB) 1152, patient's experiencing homelessness are screened for insurance and provided weather appropriate clothing, meal prior to discharge, prescriptions and community resources when needed. During FY 2023, Integrated Care Management (ICM) seeks to resolve gaps in care through community outreach efforts to identify opportunities as they become available.
5. Seek to provide health care funding options, education, and/or support to the vulnerable, uninsured/underinsured patients admitted to hospitals of the Sharp system.	a. Sharp Integrated Care Management and Patient Access Services support education and access to: • Medi-Cal for CalFresh (Food Stamps) • Hospital Outstation Program (collaboration with the County of San Diego)	Ongoing (evaluated annually)	Manager, Patient Access Services Sharp VP ICM	Access to Healthy Food (Food Insecurity) Collaboration and Connectivity with Available Community Resources	ICM has expanded efforts for patient education related to funding options/access to health care, as well as San Diego community resources. This largely occurred in concert with California SB 1152. ICM continues to finetune and improve identification of individual's experiencing homelessness, especially for treat and release patients seen through Sharp EDs. ICM has renewed efforts with their relationship and utilization of 2-1-1. In conjunction with the initial patient assessment, individuals are considered

Identified Community Health Need – Access to Health Care					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
	• Enrollment of qualified patients in CalFresh				for benefit of a 2-1-1 referral (please refer to Identified Community Health Need – Aging Care & Support 7a for details). ICM case managers make referrals as needed across all Sharp sites. Sharp seeks to identify opportunities to engage payers through the CalAIM (California Advancing and Innovating Medi-Cal) program.
	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 • Provides care management services to frail and disabled adults – age 60 years or older • Adults are at risk for nursing home placement • Adults who do not have access or qualify for supportive services through other programs and/or in-home-care service programs	Ongoing (evaluated annually)	Sharp Clinical Social Workers Sharp VP ICM	Collaboration Care Management Food Insecurity	Secondary to the global pandemic, the formal Project SOAR's programming offered through Father Joe's Villages was suspended. Sharp partners with Father Joe's Villages to provide assistance for its patients experiencing homelessness. Sharp and ICM will continue to seek and optimize opportunities with Father Joe's Villages to serve the needs of patient's experiencing homelessness. Given the ongoing state of the pandemic, we continue to assess for the opportunity to establish timelines and priorities.
6. Continue to explore opportunities for collaboration with community organizations	a. Ongoing assessment of homeless data to identify interventions though analysis of trends and key	Ongoing	Sharp VP ICM	Collaboration	Sharp ICM will continue to progress data collection to concurrently advance care opportunities. To that end, and in addition to current efforts, Sharp ICM anticipates:

Identified Community Health Need – Access to Health Care					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
to enhance access as appropriate for individuals experiencing homelessness to: • Medical care • Financial assistance • Psychiatric and social services	indicators. To guide assessment and planning for: • Allocation of internal resources • Possible expansion of existing external relationships • Identification of new opportunities for partnership and/or collaboration			Care Management	• Exploring opportunities for introduction of a risk index that will include consideration of individuals experiencing homelessness to more quickly pair assessment with appropriate intervention (FY 2023) • Introduce methods for considering/distinguishing homelessness as a comorbidity versus SDOH (FY 2023) • Explore data integration with CIE to improve the provision of person-centered care for patients experiencing homelessness as well as success of community referrals for housing and other social needs (FY 2022)
7. Collaborate with organizations in San Diego to serve individuals experiencing homelessness.	a. Sponsor and participate in the Downtown San Diego Partnership Family Reunification Program.	Ongoing	Sharp Executive VP, Hospital Operations	Homelessness Housing Instability Transportation Collaboration	In FY 2021, with Sharp's help, the Family Reunification Program has reunited more than 3,800 homeless individuals in Downtown San Diego with friends and family across the nation. **Background**: Since 2011, Sharp has sponsored the Downtown San Diego Partnership's Family Reunification Program, which serves to reduce the number of individuals experiencing homelessness on the streets of downtown San Diego. Through the program, homeless outreach coordinators from the Downtown San Diego Partnership's Clean & Safe Program identify individuals experiencing homelessness 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.

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Identified Community Health Need – Access to Health Care					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
8. Improve care management and clinical-community linkages that address SDOH through implementation of a new technology platform that shares health and social services data across health care and social service sectors.	a. SCHHC (along with other Sharp entities) will participate in a one-year pilot utilizing 2-1-1's CIE.	June 2023	Manager, SCHHC Case Management & Social Work Manager, Sharp HealthCare Community Benefit and Health Improvement	Clinical Community Linkages Data Sharing Collaboration	Sharp is engaged with 2-1-1 leadership to explore opportunities to leverage data captured as a part of the CIE. This data exploration includes consideration for integration of data as well as extraction of data identified as pertinent for activities managed through the ICM team. This strategy also addresses Identified Community Health Need – Aging Care & Support 7a. Please refer to that section for additional details.

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Identified Community Health Need – Children & Youth Well-Being					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
1. Collaborate with local schools to provide opportunities for students to explore and train for a variety of health care professions.	a. Provide career pipeline programs and early professional development for high school students.	Ongoing	Various	Education Collaboration Economic Stability	In FY 2021, Health Sciences High and Middle College students were not on campus due to COVID-19 pandemic guidelines, but SCHHC plans to host ninth and 10th grade students in FY 2022. In FY 2022, SCHHC plans to continue collaborating with Coronado High School to provide learning experiences for students in grades 10 through 12. In FY 2021, the collaboration was paused due to COVID-19 public health and safety regulations. In FY 2022, SCHHC plans to collaborate with Safe Harbor Coronado and offer ways to help reduce stress and anxiety, including walks in SCHHC's outdoor labyrinth.
2. Collaborate with local schools and first responders to promote community safety.	a. Support special safety events aimed at reducing drug and alcohol related incidents among Coronado's youth.	Ongoing	SCHHC Manager of Patient Relations	Safety Collaboration Education	At Coronado Middle School in FY 2022, team members participated in Safe Harbor Coronado's Drug Store event which used lifelike scenarios to educate sixth-grade students about the dangers of drugs and alcohol. Due to COVID-19 restrictions, SCHHC staff recorded and presented a film to sixth graders at a virtual event. In partnership with California Highway Patrol, Coronado Fire Department, local agencies and Coronado High School, the SCHHC ED participated in the "Every 15 Minutes" demonstration in FY 2022. The event simulates a drunk driving accident to help raise awareness about the dangers of driving under the influence of drugs and alcohol. As part of the simulation, students were taken to the ED to see how first responders and emergency room staff would respond to a real-life accident.

Identified Community Health Need – Children & Youth Well-Being					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
3. Increase education for Health and Science Pipeline Initiative high school students around injury and violence prevention and health care career readiness.	a. Through the ThinkFirst program, continue to partner with Health and Science Pipeline Initiative to increase unintentional injury, violence prevention and associated health career awareness.	Ongoing	Sharp Community Health Educator	Community Collaboration Education Career Pathway Programs	Sharp's ThinkFirst program intended to offer numerous educational opportunities for community students and residents in FY 2021, however, due to COVID-19, many activities were canceled or severely limited. In total, ThinkFirst injury prevention education reached 225 community members throughout SDC in FY 2021. The Health and Science Pipeline Initiative (HASPI) programs consisted of one- to two-hour virtual classes on topics including the modes of injury; disability awareness; the anatomy and physiology of the brain and spinal cord; and career opportunities in physical rehabilitation. These programs were enhanced by powerful testimonies from Sharp's VIPs (Voices for Injury Prevention). Virtual presentations included lengthy question-and-answer segments to enhance the feeling of connectedness between the students and the VIP speakers. Despite the virtual format, students showed greater engagement and participation compared to previous in-person presentations. **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. Increase knowledge and awareness of the causes and risk factors of brain and spinal cord	Ongoing	Sharp Community Health Educator	Community Collaboration Education	In FY 2022, Sharp's ThinkFirst program plans to expand beyond the scope of HASPI with the SDCOE's College and Career Readiness Department to provide educational presentations to schools in Coronado. In FY 2022, the program also

Identified Community Health Need – Children & Youth Well-Being					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
	injury and injury prevention measures.			Career Pathway Programs	plans to partner with the SDCOE's College and Career Readiness Department through participation in conferences, round table events and collaborative projects. Opportunities may be limited due to the continued impact of COVID-19 on school closures and other regulatory requirements.
4. Improve care management and clinical-community linkages that address implementation of a new technology platform that shares health and social services data across health care and social service sectors.	a. Sharp entities (including hospital entities, select medical groups, Sharp Health Plan and Sharp HospiceCare) will participate in a one-year pilot utilizing 2-1-1's CIE.	June 2023	Manager, Sharp HealthCare Community Benefit and Health Improvement	Clinical Community Linkages Data Sharing Collaboration	This strategy also addresses Identified Community Health Need – Aging Care & Support 7a. Please refer to that section for details.

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Identified Community Health Need – Community & Social Support					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
1. Provide COVID-19 vaccines to community members in collaboration with community organizations.	a. Partner with the City of Coronado, Coronado Community Center and other organizations to provide a community-based COVID-19 vaccination clinic.	Ongoing	SCHHC Pharmacy Manager	Collaboration	Beginning in January, SCHHC partnered with the City of Coronado, Coronado police and fire departments, Coronado Chamber of Commerce, Rotary Club of Coronado, Soroptimist International of Coronado, Optimist Club of Coronado and NU Nursing Department — as well as more than 475 community volunteers — to provide a community-based COVID-19 vaccination clinic at the Coronado Community Center. In March, SCHHC and the Coronado Fire Department expanded vaccination efforts to Coronado's homebound seniors. The free program helped ensure that seniors with limited mobility, fear of leaving their home, or other barriers to accessing the clinic received the vaccine, as well as human interaction and fire safety checks. Between January and June, SCHHC and its community partners dedicated nearly 20,000 hours to providing more than 49,000 COVID-19 vaccinations to members of the community. Between April and October, SCHHC provided over 4,400 COVID-19 vaccinations to community members through its Sharp Coronado Community Pharmacy.
2. Collaborate with local schools to provide opportunities for students to explore and train for a variety of health care professions.	a. Provide career pipeline programs and early professional development for high school students.	Ongoing	Various	Education Collaboration	This strategy also addresses Identified Community Health Need - Children & Youth Well-Being 3a. Please refer to that section for additional details.
	b. Provide education and training for college students and health professionals.	Ongoing	Various	Education Collaboration	In FY 2021, SCHHC collaborated with local, state and national schools, colleges and universities to provide hospital-based opportunities for students to explore and train for a variety of careers in health care. Although still significant, in FY 2021, student participation in these programs declined because of temporary interruptions to on-site learning caused by COVID-19.

Identified Community Health Need – Community & Social Support					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					SCHHC provided training opportunities for approximately 80 nursing students and nearly 30 ancillary (non-nursing) students. Together, these students dedicated more than 10,000 hours on the SCHHC campus. Internships were completed by students from a variety of schools, including APU, Pima Medical Institute, Point Loma Nazarene University, SDSU, San Joaquin Valley College and Southwestern College. In addition, SCHHC continued to partner with Midwestern University in Glendale, Arizona to provide physician-led mentorship opportunities for medical students, serving 14 students in FY 2021. **Background**: The Planetree philosophy of care holds that care should be organized around the needs of the patient. In 2007, SCHHC became California's first Planetree designated hospital and is one of only three hospitals worldwide to have maintained this designation for each of the past 13 years. In 2017, NU's School of Health and Human Services achieved Planetree Silver Recognition, making it the first academic institution in the world to be recognized by Planetree. Since September 2018, SCHHC has supported NU's efforts to integrate the Planetree model of patient-centered care into its student training curriculum by providing internship opportunities for the school's nursing students. As two Planetree recognized organizations, SCHHC and NU serve as a global model for other academic-practice partnerships, while exposure to a Planetree designated hospital in action helps give NU students a competitive advantage for entering the health care profession.
3. Raise awareness of chronic health conditions and community health needs	a. Provide health education to community members through conferences, fairs and collaborations.	Ongoing	Various (see "Other Comments")	Aging Care & Support	SCHHC keeps the community regularly informed of upcoming health classes and events through the internet, radio broadcast, local journals and newspapers, posters in the hospital lobby, and fliers within physician offices and other community organizations. SCHHC also supports patients, family and

Identified Community Health Need – Community & Social Support					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
through community education.				Chronic Health Conditions Education	community members with locating reliable health information to support their diagnosis. Individuals can search relevant literature from high-quality websites using the hospital's computer stations. Please see line items for additional detail on community health education: • Identified Community Health Need – Aging Care & Support 1a • Identified Community Health Need – Aging Care & Support 4c • Identified Community Health Need – Cardiovascular Disease 1-2 • Identified Community Health Need – Obesity 2-3 In FY 2023 and FY 2022, SCHHC plans to provide presentations on the following topics: healthy eating and exercise for those who have diabetes and heart disease, mindful living, self-care, sleep improvement, stress reduction, fall prevention, mental health, activity/exercise and various chronic diseases. In FY 2022, SCHHC plans to expand education and outreach to the Logan Heights community. Although several public events, including those for health education, did not occur due to COVID-19 guidelines, SCHHC continued to provide educational events In FY 2021 and 2022, both virtually and in person.
4. Increase health literacy in community members, particularly seniors.	a. Provide education and resources to improve health literacy for patients and community members, with a special focus on seniors.	Ongoing	Manager, SCHHC Patient Relations	Education Health Literacy Collaboration Aging Care & Support	In FY 2021, SCHHC provided education and screenings at community events as well as on-site to support identified community health needs including obesity, cardiovascular health, aging care & support and unintentional injury. SCHHC also plans to support health literacy among seniors and their caregivers through the distribution of easy-to-read materials from the Institute for Healthcare Advancement at community health fairs and events.

Identified Community Health Need – Community & Social Support					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					This strategy also addresses Identified Community Health Need – Aging Care & Support 1a. Please refer to that section for additional details.
5. Improve care management and clinical-community linkages that address SDOH through implementation of a new technology platform that shares health and social services data across health care and social service sectors.	a. SCHHC (along with other Sharp entities) will participate in a pilot partnership with 2-1-1's CIE.	June 2023	Manager, SCHHC Case Management & Social Work Manager, Sharp HealthCare Community Benefit and Health Improvement	Clinical Community Linkages Data Sharing Collaboration	This strategy also addresses Identified Community Health Need – Aging Care & Support 7a. Please refer to that section for additional details.

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Identified Community Health Need – Community Safety					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
1. Collaborate with local schools to provide opportunities for students to explore and train for a variety of health care professions.	a. Provide career pipeline programs and early professional development for high school students.	Ongoing	Various	Education Collaboration Economic Stability	This strategy also addresses Identified Community Health Need – Children & Youth Well-Being 1a. Please refer to that section for details.
2. Increase education and awareness of health care professionals and community members in San Diego around violence and trauma, including human trafficking.	a. Collaborate with community organizations and health care professionals to share best practices and provide education around human trafficking.	Ongoing	Sharp Memorial Hospital (SMH) Assistant Librarian Trauma-Informed Care Team at SMV	Collaboration Education Trauma	Sharp FY 2022 – FY 2023 plans: ▪ Collaborate with the Hospital Association of San Diego and Imperial Counties (HASD&IC) to address human trafficking by improving and implementing protocols in regional health care systems to identify and support patients who have been trafficked ▪ Collaborate with HASD&IC on additional continuing education addressing human trafficking in health care settings ▪ Explore training human trafficking survivors to teach best practices to health care systems ▪ Share the trauma-informed care (TIC) series with other stakeholders and organizations Sharp's Continuing Medical Education (CME) Department has provided numerous CME activities targeted to Sharp and non-Sharp community physicians and providers related to human trafficking. The Health Subcommittee for the San Diego Regional Human Trafficking and Commercial Sexual Exploitation of Children Advisory Council (Health Subcommittee) is collaborating with local stakeholders and HASD&IC to include human trafficking in HASD&IC's Community Health Needs Assessment (CHNA) and promote TIC in all clinical settings.

Identified Community Health Need – Community Safety					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					In an effort to equip Sharp and community health systems with TIC skills, Sharp collaborated with the Health Subcommittee, Palomar Health and the Institute on Violence, Abuse and Trauma to create a TIC continuing education series for physicians, physician assistants, nurse practitioners, nurses, licensed marriage and family therapists, licensed clinical social workers (LCSW), and other interested individuals within and outside the medical profession. Topics include ACE (Adverse Childhood Experience) score — a metric that represents the amount of toxic stress endured during childhood; PEARR (provide privacy, education, ask, respect and respond) Tool — an effective, evidence-based and trauma-informed assessment for human trafficking, domestic violence and related violence; Neurobiology of Trauma; Vicarious Trauma; and Trauma-Informed Principles. The series addresses TIC, a gap in addressing human trafficking, which is vital to supporting patients who have been trafficked as well as the SDOH that contribute to human trafficking and similar exploitation, including poor health outcomes. An evidence-based and trauma-informed assessment like the PEARR Tool is more effective than screening. A trauma-informed assessment using the PEARR Tool facilitates discussions between patients and clinicians about personal safety, and hand offs to social workers should be done with consent and transparency to avoid stigmatizing patients. TIC is a best practice to help patients feel safe requesting help, even if they do not request help to exit their situation. Since disclosure is not the goal, patients do not feel manipulated and are more likely to seek medical attention as needed. As part of the Health Subcommittee in FY 2021, the Sharp Memorial Hospital (SMH) assistant librarian presented A Trauma-Informed Approach to Human

Identified Community Health Need – Community Safety					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					Trafficking at three continuing education events to nearly 90 clinical staff, which included nurse practitioners, social workers and registered nurses. The SMH team member was a facilitator at the Health, Education, Advocacy, Linkage Trafficking Train the Trainer Academy, along with a cohort of 42 individuals. The SMH team member contributed to trainings and other events that helped equip community health care professionals with best practices to identify and support patients who have experienced human trafficking. Monthly meeting topics for the Health Subcommittee included: the prevalence of pelvic floor dysfunction misdiagnosis in victims of sexual abuse/trauma as well as treatment techniques; Sharp's CHNA and community benefit process and how nonprofit health care systems can address public health concerns like human trafficking; the Safe Shelter Collaborative; the PEARR Tool; suspicious injury and mandated reporting for health care providers; 2-1-1's CIE as a tool to help prevent client/survivor re-traumatization; Free to Thrive legal clinic and its holistic legal services; SDOH and human trafficking; internet conspiracy theories; and informal open forums. More than 150 community members attended the live meetings, which were recorded, when appropriate, and shared on YouTube. Nearly 500 community members received meeting details, best practices and topic resources throughout the year. In addition, the Health Subcommittee, including Sharp team members, as well as other community stakeholders, responded to and provided feedback for the County Board of Supervisors request titled: County Actions to Enhance Human Trafficking Prevention and Coordination. The group identified a need for a local hotline staffed by mental health professionals to triage for acute mental health and/or addiction needs before placement. The group also addressed

Identified Community Health Need – Community Safety					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					challenges faced by clinicians with safety planning and referring patients for support. Other identified items included openings in recovery programs, connecting to survivors for peer support, utilizing 2-1-1's CIE, ongoing mental health support, ensuring all processes are trauma-informed and much more. **Background**: In 2018, the SMH assistant librarian created the Health Subcommittee. This multidisciplinary group — including physicians, nurses, mental health professionals, social workers, executives and community stakeholders — was established to support health care systems in addressing human trafficking through best practice sharing, protocol development and education. Sharp representations include the CME Department, Sharp clinicians, two Sharp Chief Medical Officers (CMO) and more.
	b. Collaborate with community organizations to improve data collection and assessments for non-fatal strangulation.	Ongoing	SMH Assistant Librarian	Collaboration	In FY 2022, Sharp collaborated with and connected the Training Institute on Strangulation Prevention, a San Diego-based program of Alliance for HOPE International, with the Safe Shelter Collaborative to improve patient outcomes and facilitate the collection of local and national data to support assessments and interventions to prevent stroke and death. The goal is to prevent stroke and death by identifying and treating non-fatal strangulation with sex trafficking and domestic violence survivors. Sharp plans to appropriately assess and address non-fatal strangulation to prevent stroke and homicide. This is prevalent with patients who have experienced domestic violence, sex trafficking and prostitution. Sharp also plans to train clinicians in this area to prioritize safety planning for these patients.

Sharp Coronado Hospital and Healthcare Center
Community Health Needs Assessment – Implementation Strategy
Fiscal Years 2023 – 2026

Identified Community Health Need – Community Safety					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
	c. Collaborate with community organizations to support, empower and protect vulnerable San Diego youth.	Ongoing	SMH Assistant Librarian	Collaboration Trauma	FY 2022 plans: Initiate and support plans to safer spaces for LGBTQ+ (lesbian, gay, bisexual, transgender and queer (or questioning) and others) and other at-risk youth to learn about safe relationships and healthy boundaries with local stakeholders and organizations. In FY 2022, Sharp plans to expand the Sharp Like Me program and collaborate with Clairemont High School, while continuing its partnership with Lincoln High School. The Sharp Equality Alliance partnered with San Diego Unified School Districts' College Career and Technical Education Department to mentor at-risk youth by providing health care career pathways with its Sharp Like Me program. Through a goals-based curriculum, Sharp mentors assisted students in navigating next steps to their desired health care career, including pay range and education level requirements. The curriculum also included a checklist of one- and five-year plans for attainable goals, life hacks such as maintaining a credit score and reading through contracts before signing, and a mock interview. Presentations included An Introduction to Sharp Healthcare, Culture and Expectations, Turning Points and Pathways and Workplace Skills. The students were encouraged to share their perspective, enhancing their communication skills. This program was piloted in summer 2021 at La Jolla High School and Lincoln High School, serving a total of 13 students.
	d. Implement human trafficking and trauma-informed care (TIC) trainings and protocols at Sharp.	Ongoing	SMH Assistant Librarian SMH ED Leadership	Collaboration Trauma	FY 2023 – FY 2024 plans: • Complete SMH ED protocol: ○ Replace previously used screening tools with the PEARR Tool ○ Obtain survivor input for any gaps

Identified Community Health Need – Community Safety					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
			Sharp's Continuing Medical Education Department		• Expand human trafficking and TIC protocols to Sharp EDs, urgent care centers, progressive care units, and clinics • Integrate best practices on human trafficking and TIC into new nurse orientations • Transition the PEARR Tool and other best practices to Sharp's electronic health record system The Health Subcommittee Chair has given TIC trainings for Sharp Mary Birch Hospital for Women & Newborns (SMBHWN) and SGH nurses and social workers. The SMH ED currently has a protocol in place for clinicians identifying patients who have been trafficked. Sharp plans to expand implementation of TIC protocols for SMV, SMBHWN, SGH and SCVMC clinicians to support patients who have been trafficked or have experienced similar exploitation/abuse. In 2021, the SMV CMO and a LCSW presented on trauma and post-traumatic stress disorder as a part of Sharp's Current Conversations – What's in a Name? series to Sharp employees. A SMH LCSW and a Health Subcommittee member gave a TIC introduction to Sharp leadership, as well as created a TIC training for new SMH nurses that was also shared with the Health Subcommittee.
	e. Support patients by providing personal items for safety planning.	Ongoing	SMH Assistant Librarian	Collaboration Trauma	In August 2021, Sharp established a personal safety item group to distribute ChapStick and other benign personal items to patients who are not ready to exit domestic violence or human trafficking. This project identified needs that were shared with the San Diego County Board of Supervisors. Once these gaps are addressed, contact information for support services will be included on the personal items for safety planning.

Sharp Coronado Hospital and Healthcare Center
Community Health Needs Assessment – Implementation Strategy
Fiscal Years 2023 – 2026

Identified Community Health Need – Community Safety					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
3. Improve care management and clinical-community linkages that address SDOH through implementation of a new technology platform that shares health and social services data across health care and social service sectors.	a. SCHHC (along with other Sharp entities) will participate in a pilot partnership with 2-1-1's CIE.	June 2023	Manager, Sharp Community Benefit and Health Improvement	Clinical Community Linkages Data Sharing Collaboration	This strategy also addresses Identified Community Health Need – Aging Care & Support 7a. Please refer to that section for details.

Sharp Coronado Hospital and Healthcare Center
Community Health Needs Assessment – Implementation Strategy
Fiscal Years 2023 – 2026

Identified Community Health Need – Economic Stability					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
1. Support community members affected by food insecurity.	a. Donate surplus foods to organizations that provide this food to community members in need.	Ongoing (evaluated annually)	SCHHC Cafeteria Staff	Collaboration Food Insecurity	In FY 2022, SCHHC plans to host a holiday food drive to support the Food Bank. Through its virtual Sharp SuperFood Drive, the hospital collected approximately 3.5 large bins of food valued at $120. In FY 2022, SCHHC plans to continue donating surplus food from its kitchen to the San Diego Food Bank. SCHHC donates surplus food from its kitchen to the San Diego Food Bank to support community members facing hunger. In FY 2020, the hospital donated surplus food from its kitchen, as well as collected more than 430 pounds of food (360 meals) during the 2019 Sharp SuperFood Drive, for the San Diego Food Bank to distribute to San Diegans in need. Since August 2021, SCHHC began making weekly donations to the San Diego Rescue Mission and has donated 950 pounds of unused canned and dry goods.
	b. Partner with food delivery services to increase community member access to healthy food due to the COVID-19 pandemic.	Ongoing (evaluated annually)	SCHHC Cafeteria Staff	Collaboration Food Insecurity Community	In FY 2022, SCHHC plans to expand the GrubHub/Mindful Café partnership. SCHHC's Mindful Café continued to partner with Grubhub food delivery service in FY 2022. Community members can place orders through the Grubhub application or call the café directly. Since March 2020, SCHHC's Mindful Café has fulfilled approximately 70 Grubhub orders.
	c. Continue and strengthen partnership with Meals on Wheels San Diego County to serve homebound seniors and other vulnerable community members.	Ongoing	Manager, SCHHC Patient and Administrative Relations	Aging Care & Support Food Insecurity Social Isolation Collaboration	This strategy also addresses Identified Community Health Need – Aging Care & Support 2b. Please refer to that section for additional details.

Sharp Coronado Hospital and Healthcare Center
Community Health Needs Assessment – Implementation Strategy
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Identified Community Health Need – Economic Stability					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2022 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
				Access to Health Care	
2. Collaborate with local schools to provide opportunities for students to explore and train for a variety of health care professions.	a. Provide career pipeline programs and early professional development for high school students.	Ongoing	Various	Education Collaboration Children & Youth Well-Being	This strategy also addresses Identified Community Health Need - Children & Youth Well-Being 1a. Please refer to that section for additional details.
3. Collaborate with local schools and first responders to promote community safety.	a. Support special safety events aimed at reducing drug and alcohol related incidents among Coronado's youth.	Ongoing	SCHHC Manager of Patient Relations	Children & Youth Well-Being Safety Collaboration Education	This strategy also addresses Identified Community Health Need - Children & Youth Well-Being 2a. Please refer to that section for additional details.
4. Improve care management and clinical-community linkages that address SDOH through implementation of a new technology platform that shares health and social services data across health care and social service sectors.	a. SCHHC (along with other Sharp entities) will participate in a pilot partnership with 2-1-1's CIE.	June 2023	Manager, SCHHC Case Management & Social Work Manager, Sharp HealthCare Community Benefit and Health Improvement	Clinical Community Linkages Data Sharing Collaboration	This strategy also addresses Identified Community Health Need – Aging Care & Support 7a. Please refer to that section for additional details.

Appendix

E IPH 2019 CHNA Phase 2 Survey Report

Sharp HealthCare

Sharp HealthCare 2019 CHNA Phase 2 Survey Report

Table of Contents

Introduction

Sharp conducted hospital-specific analyses and contracted separately with the Institute for Public Health (IPH) to conduct a follow-up survey in the Summer of 2020. The purpose was to gather feedback on the top health needs (Figure 1) that were identified in the 2019 Sharp HealthCare Community Health Needs Assessment (CHNA). In addition, the survey sought to collect further input on issues such as the impact of COVID-19, access to health care, stigma, public charge, and immigration.

Figure 1. Identified Top Health Needs from CHNA Phase 1 Findings

Methodology

An electronic survey was created through Qualtrics and distributed to the following Sharp teams that were engaged in the phase 1 process: case management leadership, cancer navigators/social workers, diabetes educators, patient and family advisory council (PFAC) members, Mary Birch social workers and case managers, senior health center staff. The survey was open for approximately 7 weeks from June 16, 2020 through August 7, 2020 with a total of 18 respondents completing the survey.

An introductory email with a link to the survey provided both an explanation of the purpose and instructions for completing the survey. The survey asked respondents to identify their participation in CHNA Phase 1, the group they represent at Sharp HealthCare, and the Sharp entity they are affiliated with. Based on the top health needs identified from the 2019 Sharp HealthCare CHNA, survey participants were asked to provide their agreement and additional

comments on the findings, and to discuss on the impact of the top health needs due to COVID-19. The survey also collected participants' inputs on several topics related to the top health needs including the community's member's ability to access health care, stigma in health care settings, ways to address stigma, public charge, immigration, patient financial assistance program, and future communication.

Survey data was automatically captured through Qualtrics and analyzed through Statistical Analysis Software (SAS) and NVIVO. All percentages were calculated based on the total number of survey participants responding to the question.

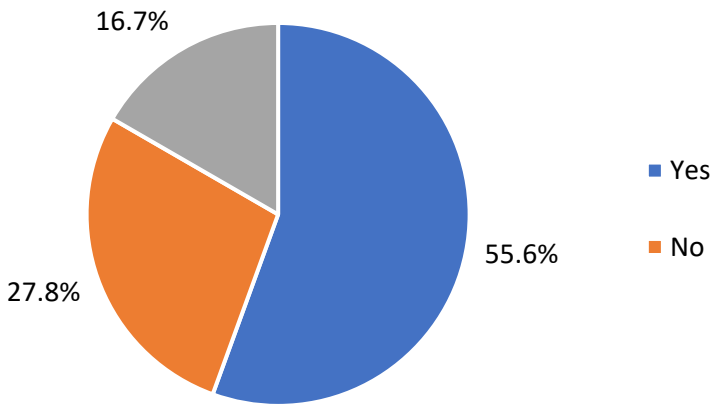
Participation in CHNA Phase 1

Question 1. Participation in CHNA Phase 1

Did you participate in a Community Health Needs Assessment (CHNA) Phase 1 facilitated discussion conducted in the Winter of 2019?

A total of 18 survey participants responded to the question regarding their participation in CHNA Phase 1. The majority of respondents participated in the CHNA Phase 1 conducted in the Winter of 2019 (55.6%). About 27.8% respondents did not participate in the CHNA Phase 1 process while 16.7% did not know about the CHNA Phase 1 process. Please see Figure 2 below for more information.

Figure 2. Participants of Survey Participants in CHNA Phase 1 (n=18)



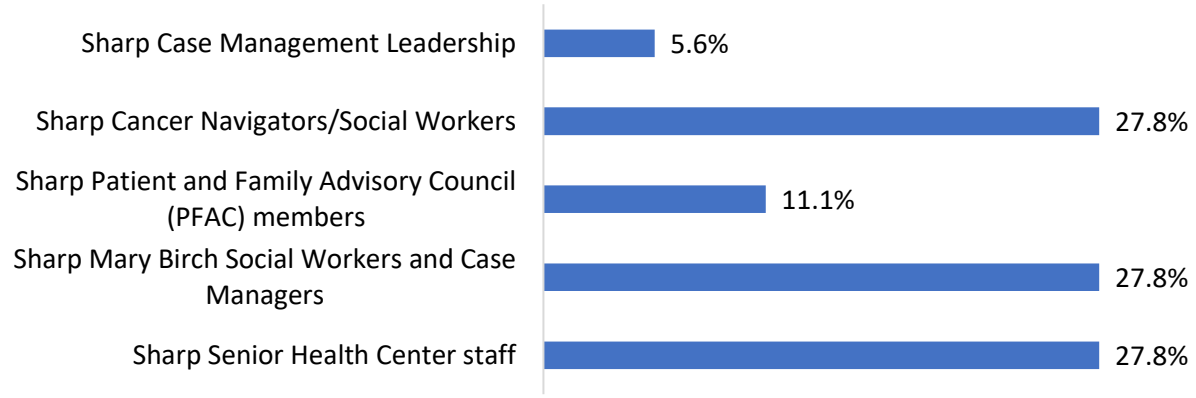
Sharp HealthCare Representation and Entity Affiliation

Question 2. Sharp HealthCare Representation

Who/what group do you currently represent at Sharp HealthCare?

Among the 18 survey participants who responded to the question regarding Sharp HealthCare representation, 27.8% were Sharp cancer navigators/social workers, 27.8% were Sharp Mary Birch social workers and case managers, 27.8% were Sharp Senior Health Center staff, 11.1% were Sharp Patient and Family Advisory Council (PFAC) members, and 5.6% were Sharp case management leadership. Please see Figure 3 below.

Figure 3. Sharp HealthCare Representation (n=18)

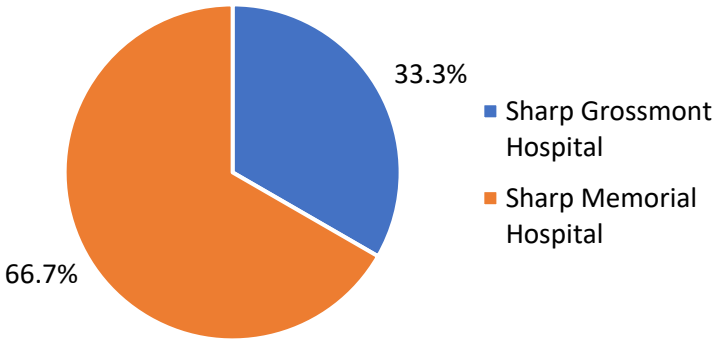


Question 3. Sharp Entity Affiliation

What Sharp entity are you affiliated with?

Among Sharp cancer navigators/social workers that responded to the survey,66.7% were affiliated with Sharp Memorial Hospital and 33.3% were affiliated with Sharp Grossmont Hospital. Please see Figure 4 below.

Figure 4. Sharp Entity Affiliation (n=6)



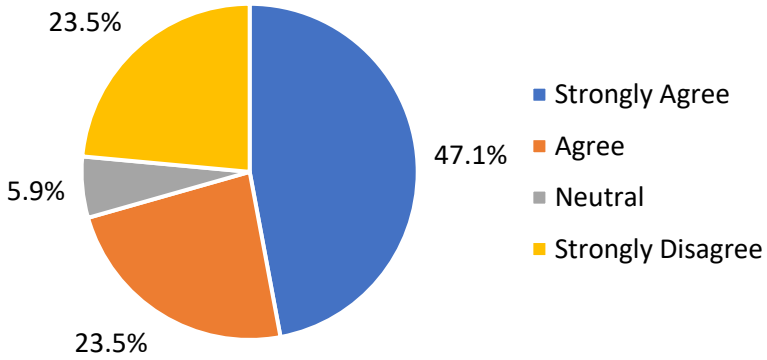
Top Health Needs

Question 4. Level of Agreement with the Findings from 2019 CHNA Phase 1

Please indicate your level of agreement with the following statement: The identified needs listed above represent the top needs that you observe in your patients or community members of San Diego County?

A total of 17 survey participants responded to the level of agreement with the top identified health needs. The majority of survey participants (70.6%) strongly agreed or agreed (47.1% strongly agree and 23.5% agree) the identified needs in the 2019 CHNA represented the top health needs of patients or community members of San Diego County. Please see Figure 5 below for more information.

Figure 5. Level of Agreement with the Findings from CHNA Phase 1 (n=17)

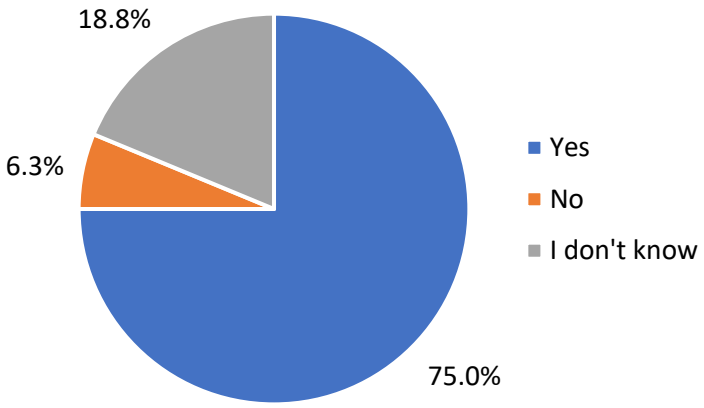


Question 5. COVID-19 Impact on Top Health Needs

As the San Diego community continues to navigate the COVID-19 pandemic, have you observed any impact on the identified community health needs specifically because of COVID-19?

A total of 16 survey participants responded to the impact of COVID-19 on the top identified health needs. The majority of survey participants (75.0%) indicated that they observed some impact on the identified community health needs due to COVID-19. Please see Figure 6 below for more information.

Figure 6. Impact on Community Health Needs due to COVID-19 (n=16)



Survey participants who selected "Yes" to Question 5 discussed how COVID-19 impacted the following health needs: access to health care, aging concerns, behavioral health, cancer, community and social support, economic security, education, housing instability and homelessness, maternal health, and stigma. One major theme that survey participants spoke of was that COVID-19 had exposed and exacerbated the existing disparities in health outcomes.

Access to health care. Respondents commented on how COVID-19 instilled fear on the utilization of health facilities, temporary closed health offices, changed the level of care to virtual, and created problems on finding transportation and resources. Furthermore, one participant provided a scenario where a patient who had a premature birth could not access prenatal care because the health offices were not accepting new patients during the pandemic, which illustrated a burden on maternal health.

Aging concerns: Participants commented on seniors experiencing isolation and fear due to COVID-19 and having difficulty accessing telehealth because they did not have latest communication technology or unable to afford the necessary tools.

Health Conditions: For *behavioral health*, respondents mentioned that isolation, anxiety, and depression were major issues people are experiencing through the COVID-19 pandemic. For *cancer*, a participant stated that COVID-19 pandemic had impacted cancer care due to patients having difficulty obtaining essential supplies and their social and emotional support were limited.

Community and social support: Survey participants discussed the limited assistance and resources due to challenges in funding and accessing community programs. Lastly, respondents mentioned *unemployment* caused by the COVID-19 pandemic had incurred financial hardships, considerably affecting food and housing security in many households.

Please see Table 1 below for more information.

Table 1. Examples of COVID-19 Impacts on Top Health Needs (n=12)

Overarching Categories and Responses	Frequency*
Access to Health Care	5
"Access to Healthcare" *"Fear of utilization of health facilities"* *"Patients have lost access to their mental health providers as a result of COVID-19. Some patients do not find tele-health to be adequate for them."* *"Temporary closure of dental offices, clinics, etc."* *"Services are not offered in person and virtual or video care is not the same level of care. Transportation and other resources are much harder to find. "*	
Aging Concerns	3
"Senior Isolation" *"Some of our elderly population are fearful of leaving their homes d/t fear of Covid-19, and many of them do not have the technology (telephone, smart phone, or computers) to do telehealth visits. "* *"Some seniors are unable to afford technology related items to be able to utilize online telemedicine or education and supports"*	
Behavioral Health	3
"Behavioral health; isolation and anxiety seems to be an issue" *"Patients are more isolated than usual. "* *"The patients are filled with mixed emotions some bored and ready to leave the house and others depressed, some becoming angry or anxious"*	
Cancer	1
"Patient isolation is always a concern in cancer care, but the COVID-19 pandemic has intensified this dynamic greatly causing difficulty in obtaining essential goods like groceries and greatly limiting social and emotional support for patients"	
Community and Social Support	3
"Access to community programs (ie, home visits, PHN, etc.), access to resources donations for clothing. " *"Community and Social Support"* *"Also, community resources previously available for families including the Ronald McDonald House have severely limited their resources to the families we serve. Other foundations normally accessed for assistance with funds or supports are also providing less assistance due to impact of their funding during this time. "*	
Economic Security	3
"Economic Security" *"Financial/food insecurity due to job loss"* *"Some seniors are unable to afford technology related items to be able to utilize online telemedicine or education and supports"*	
Education	1
"Access to updated information"	
Housing Instability and Homelessness	1
"Housing insecurity due to job loss"	
Maternal Health	1

"I have seen a patient who delivered pre-term who was not able to access prenatal care d/t offices not accepting new patients during the pandemic. "	
Stigma	1
"Disparities in health outcomes by race, racial discrimination/stigma associated with COVID-19"	
Total	**22**

*A total of 12 individuals submitted a response. Some individuals identified several categories of community health needs that have been impacted by COVID-19 in their singular responses.

Question 6. Additional Comments on Top Health Needs

Please add any additional comments about community health needs that greatly affect overall health and well-being of communities facing inequities within San Diego County.

A total of three survey participants provided additional comments on community health needs that greatly affect overall health and well-being of communities facing inequities within San Diego. Overall, they discussed how COVID-19 changed community members' daily life, surrounding environment, employment status, and access to services and health care.

Please see Table 2 below for more information.

Table 2. Additional Comments on Identified Health Needs (n=3)

Overarching Categories and Responses	Frequency*
Changes in daily life – perceived personal health environment	1
"For sure COVID-19, while I have not seen its effects directly, the virus permeates every corner of our health environments be they our prioritized listed above as well as our home settings. Just making sure that we have our 'masks' as we leave to carry out our daily tasks makes the point about our dangerous health environments, we now encounter every day stretching where we work and live. "	
Access to Health Care	2
"Patients are afraid to come in for MD visits due to fear of COVID-19"	
"Patients don't always have access to telehealth tools to communicate with their care providers"	
Limited community resources/services	1
"Community resources are limited or services have been placed on hold"	
Economic security - unemployment	1
"Financial hardship due to unemployment issues"	
Changes to service modality – virtual delivery	1
"Support groups have gone to virtual meetings vs in-person support"	
Behavioral Health	1
"Loneliness and Isolation"	
Total	**7**

*A total of 3 individuals submitted a response. Some individuals identified several categories of community health needs that greatly affect overall health and well-being of communities facing inequities within San Diego in their singular responses.

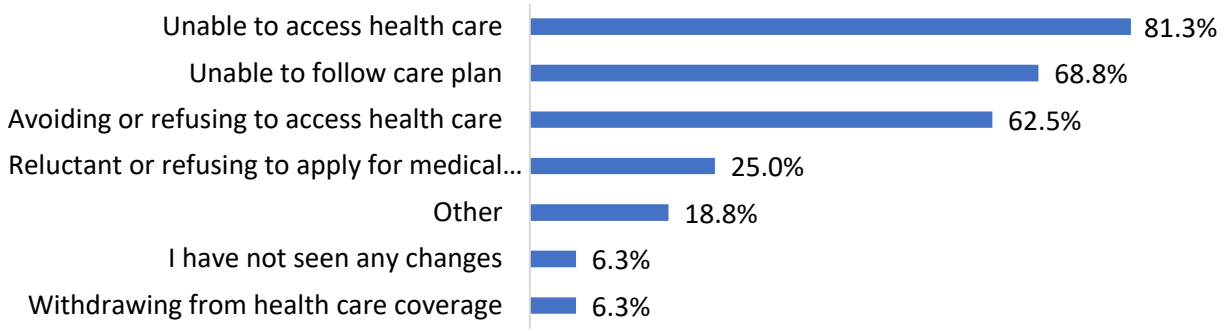
Top Health Needs

Question 7. Access to Health Care

Please identify challenges you have observed in the patient or community member's ability to access health care.

Among the 16 participants who responded to question seven, 81.3% identified “Unable to access health care” as a challenge they observed in patient or community member’s ability to access health care. Other identified challenges included “Unable to follow care plan” (68.8%), “Avoiding or refusing to access health care” (62.5%), and “Reluctant or refusing to apply for medical coverage” (25.0%). Please see Figure 7 below for more information.

Figure 7. Challenges in Ability to Access Health Care (n=16)



A total of three survey respondents chose “Other” from question 7 and provided examples of other challenges. They discussed how patients were generally ignored if they did not have symptoms related to COVID-19 and how navigating the health insurance system could be difficult and confusing.

Please see Table 3 below for more information.

Table 3. Examples of Other Challenges (n=3)

Overarching Categories and Responses	Frequency
Health Service Utilization	1
”Not being seen if it is not related to Covid-19”	
Health Insurance Navigation	1
”Changing health plans and confused about the services that were promised to them”	
Other Comment	1
”As a volunteer on the Sharp Grossmont PFAC I seek to bring "culture" awareness along with "literacy" concerns as my contribution to Grossmont’s mission as well as the patient’s and their caregivers (and families) coming to and using the hospital’s services. ”	
Total	**3**

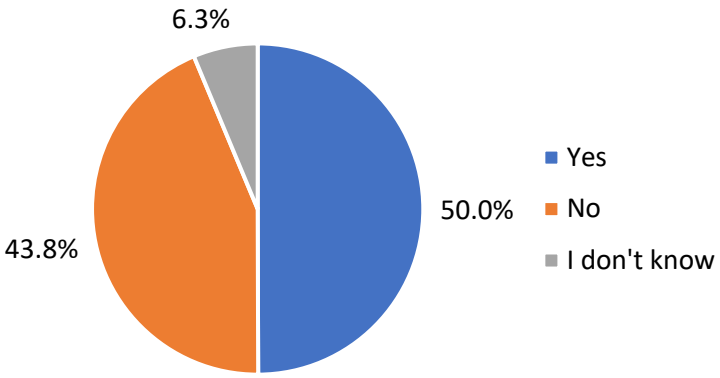
Stigma

Question 8. Stigma in Health Care

Have you observed stigma in health care setting?

Among 16 survey participants who responded to observation of stigma in health care settings, 50.0% had observed stigma in health care settings while 43.8% did not observe stigma in health care settings. Please see Figure 8 below for more information.

Figure 8. Observation of Stigma in Health Care (n=16)



There were eight participants who provided an example of stigma observed in a health care setting. Responses were categorized based on the Modified Social-Ecological Model of Transgender Stigma & Stigma Interventions[1] (Appendix B), which included three main themes:

- Individual Stigma
- Interpersonal Stigma
- Structural Stigma

For *individual stigma*, respondents provided two examples of avoidance of stigma: being shameful for having to apply for Medi-Cal or not having insurance and worried about leaving their home for anything due to the fear of COVID-19. Survey participants spoke about *interpersonal stigma* and how it related to lower socioeconomic status, weight, smoking, alcohol, drug abuse, and mental health issues can manifest through provider-patient communication and interaction. Lastly, *structural stigma* could exist in a discriminatory healthcare system. Racial discrimination, including experienced by the Asian communities, was identified in the care provided and in the lack of diversity in Sharp materials.

Please see Table 4 below for more information.

[1] Hughto, Jaclyn & Reisner, Sari & Pachankis, John. (2015). Transgender Stigma and Health: A Critical Review of Stigma Determinants, Mechanisms, and Interventions. Social Science & Medicine. 147. 222–231. 10.1016/j.socscimed.2015.11.010.

Table 4. Examples of Stigma in Health Care (n=8)

Overarching Categories and Responses	Frequency
Individual	2
Avoidance of Stigma *"They were shamed about not having insurance and/or requesting to apply for Medi-Cal"* *"Patients call in worried about the dangers of covid thinking they'll get infected if they even leave the home"*	
Interpersonal	3
Healthcare Discrimination *"I see nurses and doctors treat the patients from lower socioeconomic standing with less respect and less willingness to communicate fully with them"* *"Stigma associated with weight, smoking/alcohol/drug abuse, and financial limitations"* *"Around mental health issues"* *"Mental health"*	
Structural	2
Racial Discrimination *"Discrimination faced by Asian communities"* *"Yes, patients not feeling welcome due to their race. Sometimes in the care they are given, sometimes in the lack of diversity in the Sharp materials"*	
Total	**8**

Question 9. Community Efforts to Reduce Stigma

Are you aware of community efforts to help reduce stigma?

A total of 16 survey participants responded to the awareness of community efforts to help reduce stigma. The majority of survey participants (68.8%) were not aware of community efforts to help reduce stigma while 31.3% were aware. Please see Figure 9 below. Responses were categorized based on the Resources and Opportunities to Address Priority Health Needs graphic in the 2019 HASD&IC CHNA report (Appendix A), which included four main themes:

- Collaboration
- Systemic Change
- Strategies
- Resources

For resources, survey participants identified county wide Perinatal Equity Initiative and Sharp HealthCare internal resources such as BERT team as examples of community effort to address stigma. Furthermore, examples of strategies associated with internal health system processes were mentioned to reduce stigma related to COVID-19. Respondents specified that health offices continued to provide virtual support for patients and to reassure patients that accessing care is safe if proper guidelines were followed.

Please see Table 5 below for more information.

Table 5: Community Addressing Stigma Examples (n=5)

Overarching Categories and Responses	Frequency
Resources	3
Sharp HealthCare Internal Resources *"During the 7.5 years of my being first a patient and then signing up as a volunteer I've not run across any 'stigma' like behaviors at Grossmont. Rather, I've seen the reverse. When I was an 'inpatient' I was treated with great respect-a behavior treated to all my patient peers. When I became a volunteer we became a peer in a different role, but still one of the 'staff'."* *"Mental health awareness month and BERT team"* *Local Resources* *"The county wide Perinatal Equity Initiative"*	
Strategies	2
Internal Health System Processes *"Us in the office make calls and reassure the patients that it is safe to come if they follow the proper guidelines"* *"Virtual support continues to extend to patients even during COVID, helping to reduce stigma."*	
Total	**5**

Question 10. Addressing Stigma in Hospital and Health Systems

What advice do you have for hospitals and health systems to address stigma?

There were a total of two participants that responded to this open-ended question. Responses were categorized based on the Resources and Opportunities to Address Priority Health Needs graphic in the 2019 HASD&IC CHNA report (Appendix A), which included four main themes:

- Collaboration
- Systemic Change
- Strategies
- Resources

Addressing potential barriers to care, increasing community knowledge with educational campaigns, and improving patient experience were emphasized as strategies hospitals and health systems can address stigma. As stigma could be a barrier to care, adopting a "Health at Every Size" philosophy was identified as a better approach to treat overweight and obese patients rather than using the traditional BMI measurement. A respondent also specified that educating patients and their families with authentic presentations could increase awareness. Furthermore, a respondent discussed that hospital and healthcare systems should educate their support staff by providing time to explore conferences that address stigma.

Please see Table 6 below for more information.

Table 6: Addressing Stigma in Hospitals and Health Systems (n=2)

Overarching Categories and Responses	Frequency*
Strategy	3
Address Potential Barriers to Care *"As a dietitian, I see a lot of weight stigma from healthcare providers and felt by patients, as well. RDs working in eating disorder or following a Health at Every Size (HAES) philosophy can offer a lot of insight into how to better treat overweight and obese patients so they do not feel as stigmatized. We must move away from the use of BMI and be more sensitive to the many causes of obesity."* Increase Community Knowledge with Educational Campaigns *"Continue to increase awareness with authentic presentations from relatable people/patients/families."* Improve Patient Experience *"Support staff by giving them the out time to explore conferences that address stigma"*	
Total	**3**

*A total of 2 individuals submitted a response. Some individuals identified several examples for addressing stigma of in their singular responses.

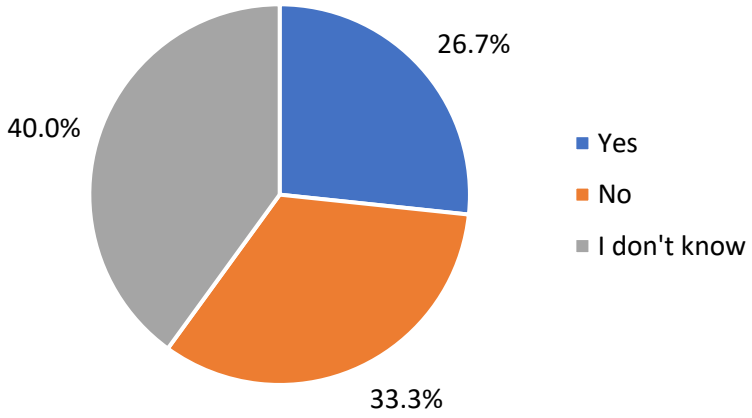
Public Charge

Question 11. Public Charge Impact on Health Care Access

Are individuals in your community having difficulty accessing health care due to uncertainty over public charge?

Among 15 survey participants who responded to the question related to public charge impact on health care access, 26.7% agreed that individuals in their communities had difficulty accessing health care due to uncertainty public charge, while 33.3% disagreed. Please see Figure 10 below for more information.

Figure 9: Community Having Difficulty Accessing Care Due to Public Charge (n=15)



Question 12. Public Charge Impact on the Community

In what ways does public charge impact your community?

There were a total of 4 participants who responded to this open-ended question. Responses were categorized based on the Modified Social-Ecological Model of Transgender Stigma & Stigma Interventions[1] (Appendix B), which included three main themes:

- Individual Stigma
- Interpersonal Stigma
- Structural Stigma

All four survey participants identified the impact of public charge on individual stigma. Respondents explained some instances where community members avoid stigma related to public charge due to the internalized fear and anxiety. Although many families—especially refugee families—were desperately in need of support, they refused or were reluctant to access public benefits such as Medi-Cal, supplemental security income, food stamps, and WIC (Women, Infants, and Children program) in fear that receiving such benefits would affect their application for residency.

Please see Table 7 below for more information.

Table 7: Examples of Ways Public Charge Impacts Community (n=4)

Overarching Categories and Responses	**Frequency***
Individual	5
Avoidance of Stigma	
"A family refusee to apply for Medi_Cal or public aid (Cash Aid and SNAP) in fear that it would affect their ability to apply for residency. They were desperately in need of support but refused. *Many families are expressing reluctance to access public health benefits they would likely qualify for including SSI and Food Stamps."*	
"Afraid to access WIC or other qualified services"	
"Accessibility and resources to help, internet and social services"	
Internalization of Stigma	
'Many are expressing fear and anxiety over this.'	
Total	**5**

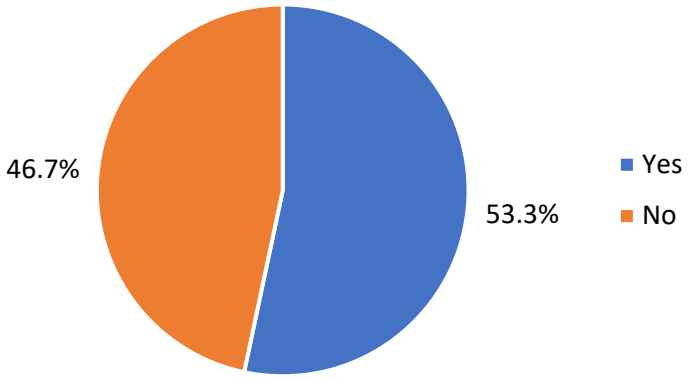
* The total frequency will be more than 4 due to individuals identifying several examples in their responses.

Question 13. Interest in Public Charge

Would you be interested in more information and/or training on public charge?

A total of 15 survey participants responded to interest in public charge. The majority of survey participants (53.3%) were interested in more information and/or training on public charge, while 46.7% were not interested. Please see Figure 11 below.

Figure 10: Interest in More Information and/or Training on Public Charge (n=15)



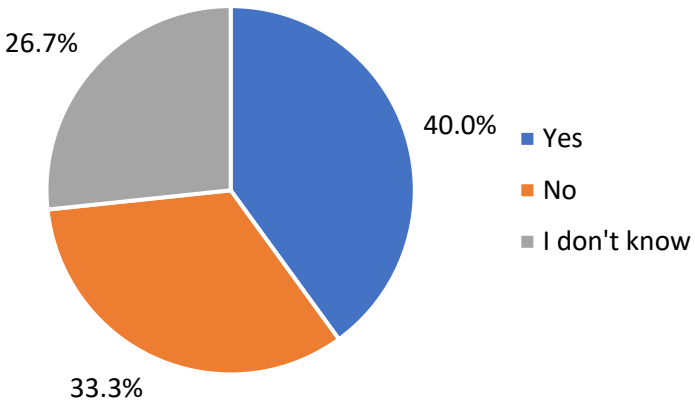
Immigration

Question 14. Immigration Impact on Health Care Access

Are individuals in your community having difficulty accessing health care due to their immigration status?

Among 15 survey participants who responded to immigration impact on health care access, 40.0% agreed that individuals in their communities had difficulty accessing health care due to their immigration status, while 33.3% disagreed. Please see Figure 12 below for more information.

Figure 11:Community Difficulty Accessing Care Due to Immigration Status (n=15)



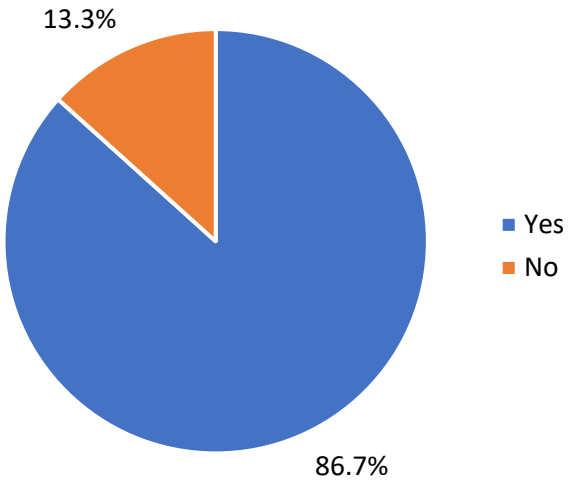
Financial Assistance Programs

Question 15. Knowledge on Financial Assistance Programs

Did you know hospitals offer these services?

A total of 15 survey participants responded to knowledge on financial assistance program. The majority of survey participants (86.7%) knew that hospitals offer financial assistance programs to their patients. Please see Figure 13 below for more information.

Figure 12: Knowledge of Hospitals Offering Financial Assistance Program Services (n=15)

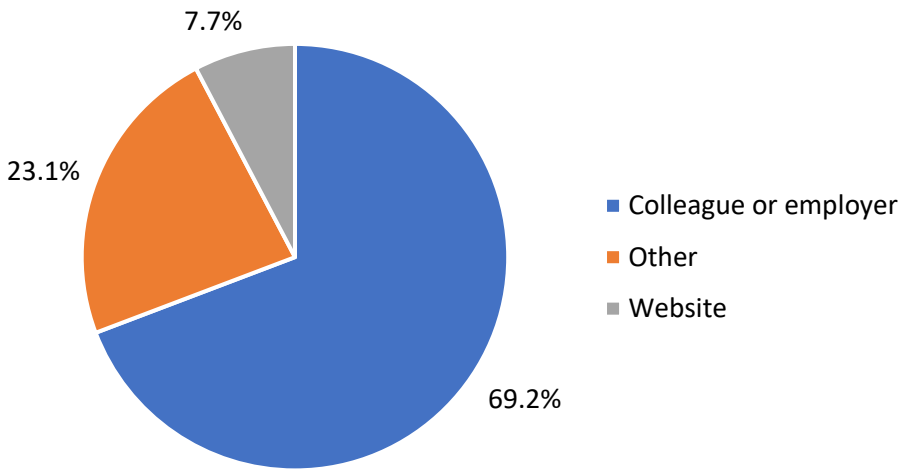


Question 16. Sources of Information on Financial Assistance Programs

How did you hear about the financial assistance programs?

A total of 13 survey participants responded to the financial assistance question with the majority of survey participants (69.2%) indicating that they heard about the financial assistance program from their colleagues or employers. Approximately 23.1% said that they got the information from other sources, while 7.7% said that they got the information from the website. Please see Figure 14 below.

Figure 13: How Participants Heard About the Financial Assistance Programs (n=13)



Three respondents provided examples for their choice of "Other" from question 16, specifying San Diego County Aging and Independent Service, network within Sharp HealthCare system, outside programs, and previous employer as other sources of information. Please see Table 8 below for more information.

Table 8. Examples of Other Sources of Information on Financial Assistance Programs (n=3)

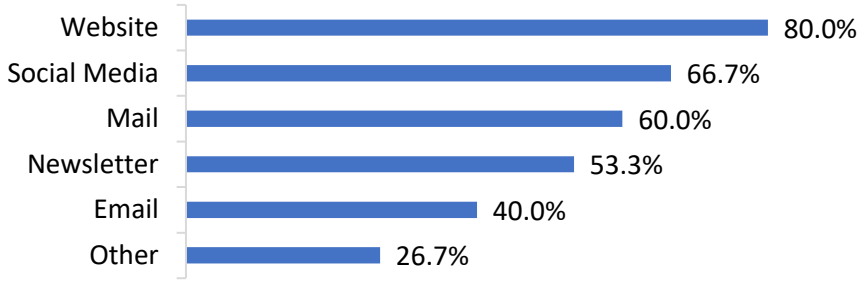
Responses	Frequency
"San Diego County Aging and independent service"	1
"Through networking within our healthcare system and through outside programs recommendation to similar assistance programs. "	1
"previous employer provided info to me"	1
Total	**3**

Question 17. Inform the Public on Financial Assistance Programs

How do you suggest we inform the public about financial assistance programs?

Among 15 survey participants responding to ways to inform the public on financial assistance programs, 80.0% chose website, 66.7% chose social media, 60.0% chose mail, 53% chose newsletter, 40.0% chose email, and 26.7% chose other. Please see Figure 15 below for more information.

Figure 14: Informing the Public About Financial Assistance Programs (n=15)



A total of 10 survey participants chose social media as the suggested method to inform the public about financial assistance programs. Facebook (n=9) was chosen by most of these respondents, followed by Twitter (n=5) and LinkedIn (n=4). Please see Table 9 below for more information.

Table 9. Examples of Social Media to inform the public on financial assistance programs (n=10)

Responses	Frequency*
"Facebook"	9
"Twitter"	5
"LinkedIn"	4
"Instagram"	2
"Anywhere"	1
"Other social media platforms that might be commonly used by low income or at risk groups"	1
Total	**22**

* The total frequency will be more than 10 due to individuals being able to specify more than one idea in their comments.

A total of 4 survey participants chose other from question 17. They suggested community engagement through educational events and presentations, community-based organizations, and local resource centers as a potential method to inform the public about financial assistance programs. Please see Table 10 below for more information.

Table 10. Examples of Other to inform the public on financial assistance programs (n=4)

Overarching Categories and Responses	Frequency
Community Engagement	3
"Educational events and presentations"	
"Community based organizations for walk ins"	
"Local community groups and resource centers"	
Other Comment	1
"You are aware that offering financial assistance does not impact the fear of accessing services related to immigration status, right? "	
Total	**4**

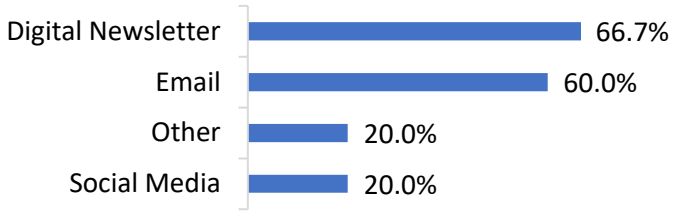
Future Communication

Question 18. Communicating Future Updates on CHNA

How would you advise Sharp to communicate future updates on the CHNA?

Among 15 survey participants responding to ways to future communication on CHNA updates, 66.7% advised Sharp to use digital newsletter, 60.0% advised using email, and 20.0% advised using social media. Please see Figure 16 below for more information.

Figure 15: How Sharp Could Communicate Future CHNA Updates (n=15)



A total of 3 survey participants advised Sharp to use social media to communicate future updates on the CHNA. Facebook (n=3) was chosen by most of these respondents, followed by LinkedIn (n=3) and twitter (n=2). Please see Table 11 below for more information.

Table 11. Examples of social media for future communication on CHNA updates (n=3)

Responses	Frequency*
"Facebook"	3
"LinkedIn"	3
"Twitter"	2
Total	**8**

* The total frequency will be more than 3 due to individuals being able to specify more than one idea in their comments.

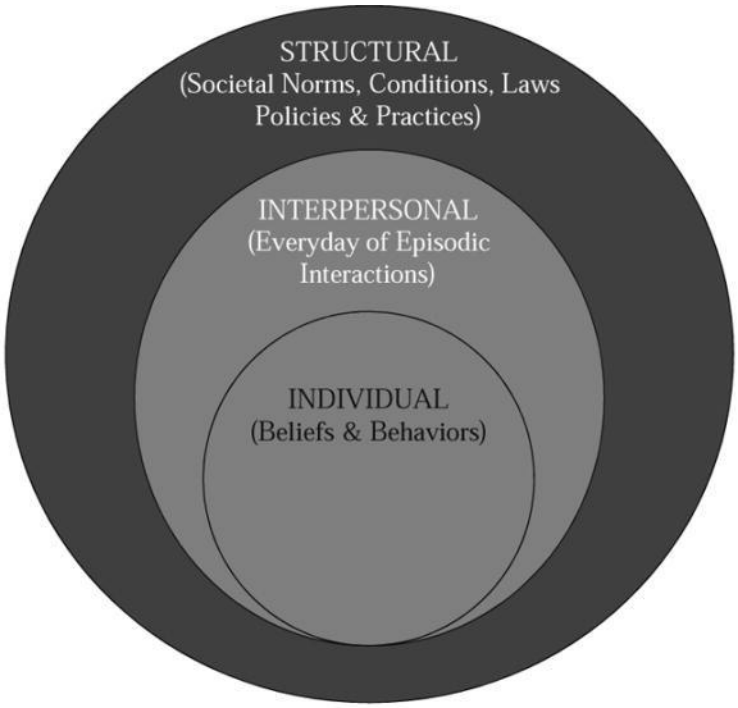
A total of 4 survey participants chose other from question 18. They advised using community engagement through conferences and community events and direct engagement through in-person contact with patients to communicate future updates on the CHNA. Please see Table 12 below for more information.

Table 12. Examples of other for future communications on CHNA updates (n=4)

Overarching Categories and Responses	Frequency
Community Engagement	2
"Conferences" *"Community events"*	
Direct Engagement	2
"Direct patient contact through navigation and social work" *"In-person when meeting with a patient that meets the criteria"*	
Total	**4**

Appendix A: Resources & Opportunities to Address Priority Health Needs

Appendix B: Modified Social-Ecological Model of Transgender Stigma & Stigma Interventions (Hughto, Sari, & Pachankis, 2015)[2]



Structural

Types of Stigma

- Gender conformity to natal sex norms
- Stigmatizing policies and enforcement practices
- Lack of provider training and education
- Healthcare access barriers
- Economic inequality
- Gender inequality

Interventions

- Non-discrimination policies
- Access to care policies
- Transgender health content in medical school curricula

Interpersonal

Types of Stigma

- Healthcare discrimination
- Workplace discrimination
- Family rejection
- Hate crimes
- Sexual assault
- Physical assault

Interventions

- Family/partner support groups
- Healthcare provider trainings
- Intergroup contact

Individual

Types of Stigma

- Concealment of stigma
- Avoidance of stigma
- Internalization of stigma

Interventions

- Counseling/therapy
- Self-affirmation
- Transgender support groups
- Collective activism

[2] Hughto, Jaclyn & Reisner, Sari & Pachankis, John. (2015). Transgender Stigma and Health: A Critical Review of Stigma Determinants, Mechanisms, and Interventions. Social Science & Medicine. 147. 222–231. 10.1016/j.socscimed.2015.11.010.

Appendix

F Sharp Insight Community 2019 CHNA Phase 2 Survey Report

Community Health Needs Assessment Phase 2 Survey

Sharp Insight Community Report

May 2020

Survey Methodology and Background

- **Survey was sent to:** 3,369 community members
- **Total respondents:** 620 completions
- **Data collected from:** May 8, 2020 – May 26, 2020
- **Median survey completion time:** 7 minutes 19 seconds
- **Survey goals:**
  - This survey is part of Sharp's 2019 CHNA Phase 2 and seeks participant feedback on the community health needs that were identified in Sharp's 2019 CHNA. Findings from this survey will help Sharp better understand how to address the identified needs.

Total Survey Responses: n=620
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Executive Summary

- 81% of respondents *agreed* or *strongly agreed* that the identified needs provided were representative of the needs of communities with greater health inequities in San Diego
- Most respondents (59%) indicated they *did* observe an impact on community health needs due to COVID-19. Respondents who recognized an impact mentioned a decreased access to healthcare specifically because of COVID-19.
- Access to care/fear of seeking care due to COVID-19 was a predominant concern (20%) affecting the overall health and well-being of communities facing inequities.
- Being unable to access health care (34%) and avoiding accessing health care (33%) were the top challenges affecting community members' ability to access health care.
- The small percentage of respondents who observed stigma in health care settings mentioned mental/behavioral health stigma (26%), other (18%), and racial disparities/racial bias (17%) as the top stigmas observed.
- Advertisements/media was named as the top example (35%) of a community effort in reducing stigma.
- When advising hospitals and health systems to address stigma, respondents suggested hospital/staff employee education as a strategy for hospitals and health systems to address stigma.

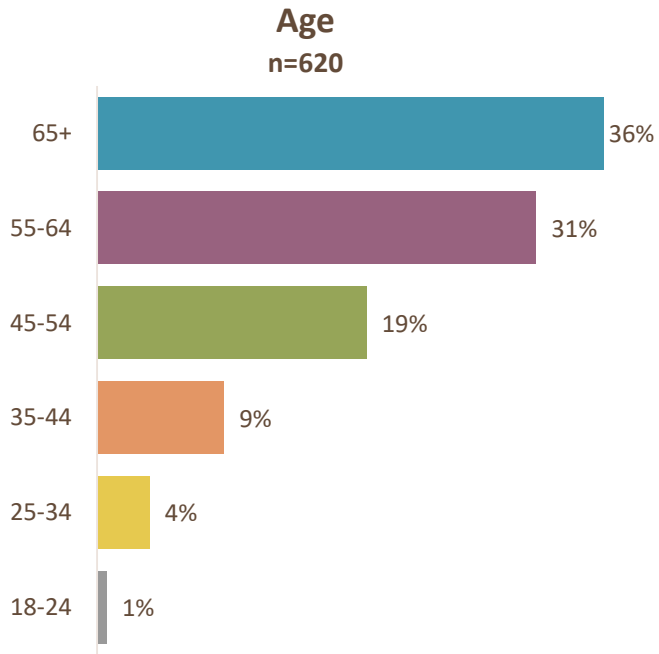
Total Survey Responses: n=620
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

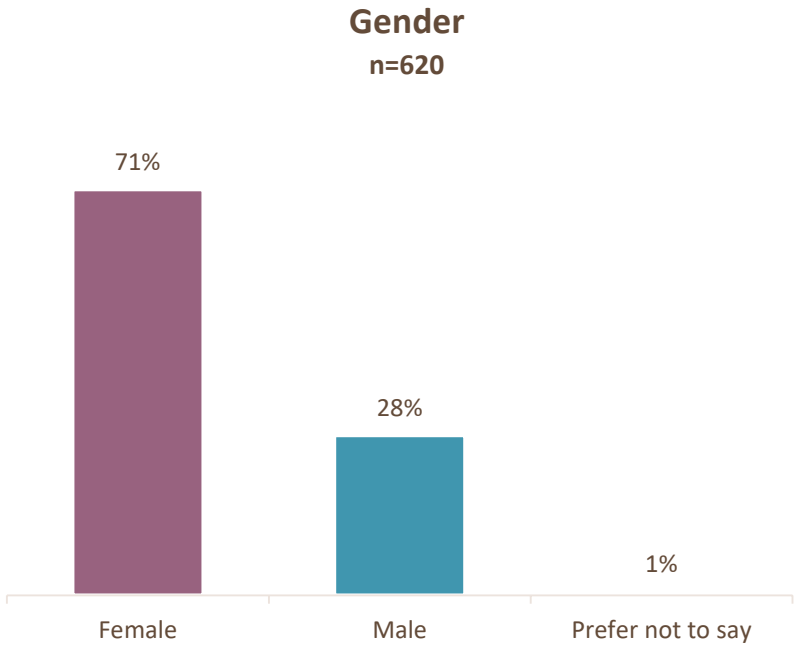
Executive Summary

- Most respondents (68%) indicated they did not know if individuals in their community were having difficulty accessing health care due to their immigration status.
- 59% of respondents were aware of financial assistance programs. Advertisements/media was the most noted source of awareness.
- Social media, websites, and email were the top suggestions to inform the public about financial assistance programs. Of respondents who selected “other”, most (68%) named advertisements/media as another way of informing the public about financial assistance programs.
- Respondents suggested the top ways of communicating future updates on the CHNA as email, digital newsletter, and social media. Facebook was the most (86%) noted social media outlet.
- Of respondents who selected “other” as a way of communicating future updates on the CHNA, most named non-technological and technological advertisements/media (72%) as the best mode of communication.

Total Survey Responses: n=620
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Panel Demographics

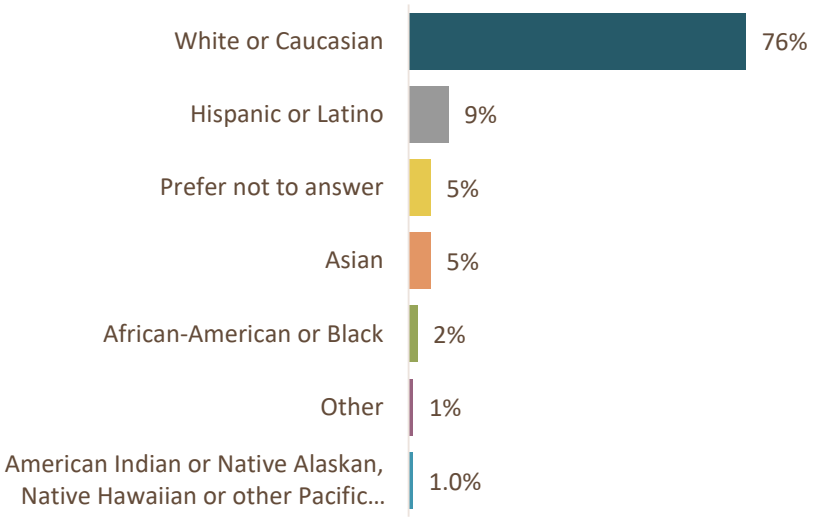




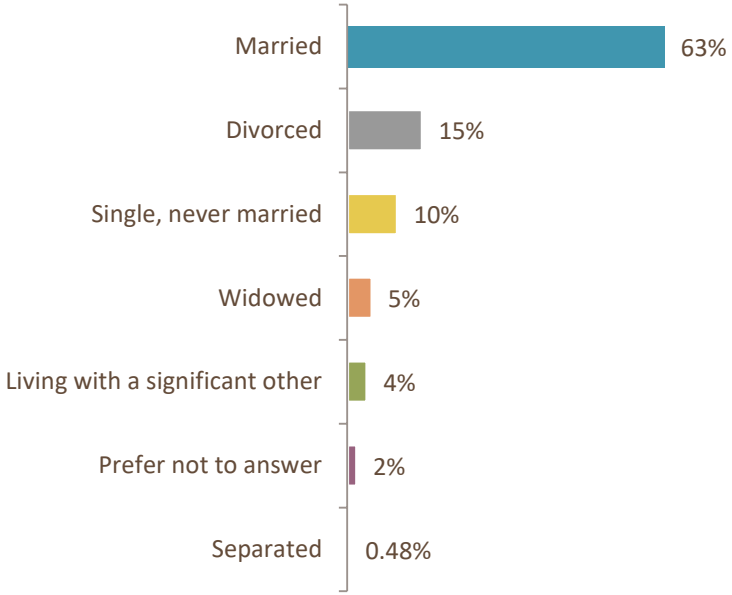
Panel Demographics
Total Survey Responses: n=620
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Panel Demographics

Ethnicity
n=620



Marital Status
n=620

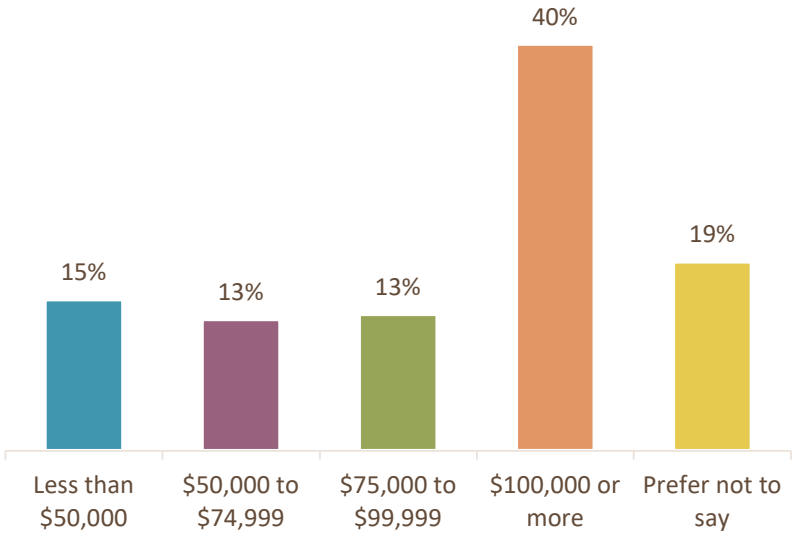


Panel Demographics
Total Survey Responses: n=620
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Panel Demographics

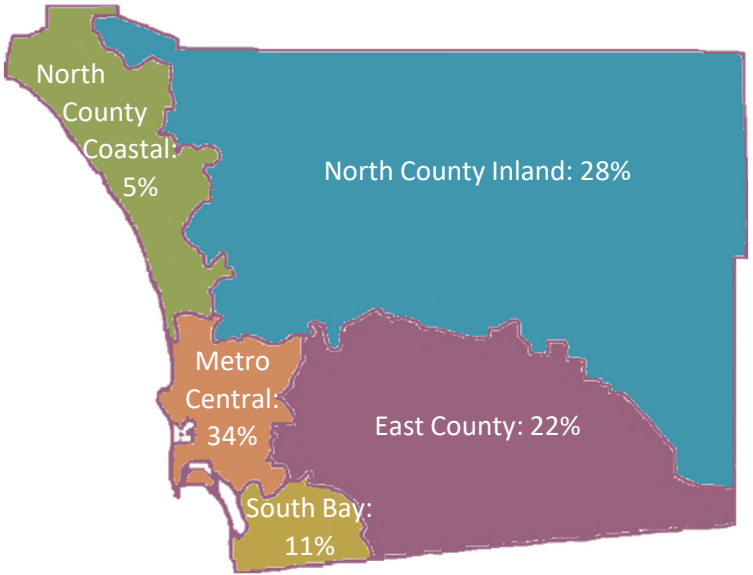
Household Income

n=620



Region of Residence

n=620



Panel Demographics
Total Survey Responses: n=620
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

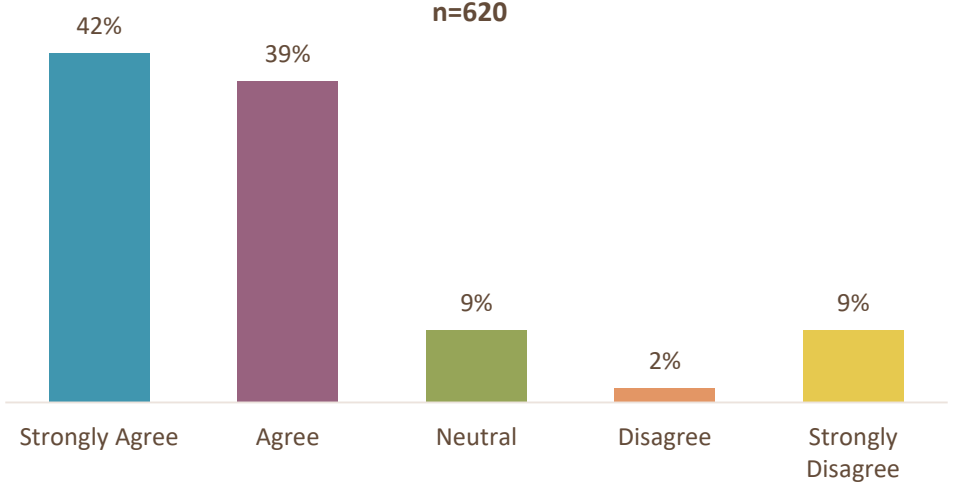
Survey Results

Needs of Communities with Greater Health Inequities

81% of respondents **strongly agreed** or **agreed** that the **needs listed were representative of the needs of communities with greater health inequities** in San Diego.

- *Access to Health Care*
- *Aging Concerns*
- *Behavioral Health*
- *Community and Social Support*
- *Cancer*
- *Chronic Conditions*
- *Economic Security*
- *Education*
- *Homelessness and Housing Instability*
- *Maternal and Prenatal Care, including High-Risk Pregnancy*
- *Unintentional Injury and Violence*

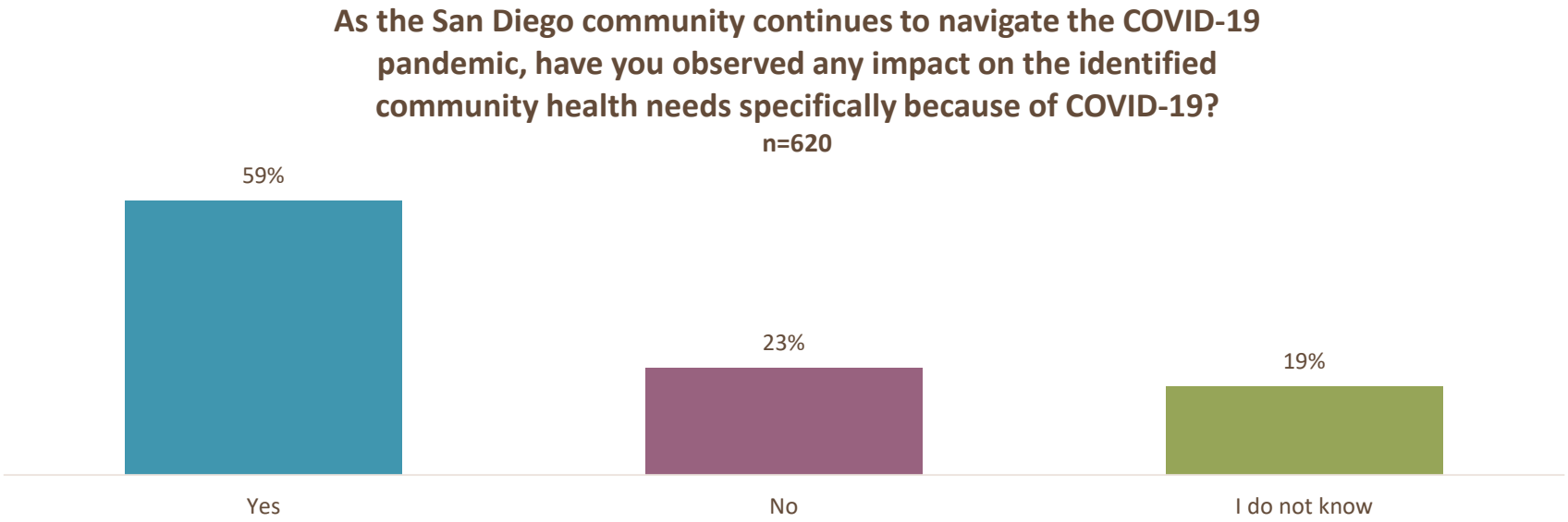
Please indicate your level of agreement with the following statement: The identified needs listed below represent the top needs of communities with greater health inequities in San Diego County:
n=620



Question: Please indicate your level of agreement with the following statement: The identified needs listed below represent the top needs of communities with greater health inequities in the San Diego County.
Total Survey Responses: n=620
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Impact of COVID-19 on Community Health Needs

59% of respondents reported that they **did observe an impact.** 23% of respondents **did not observe** an impact on the identified community health needs and **19%** of participants **did not know**.



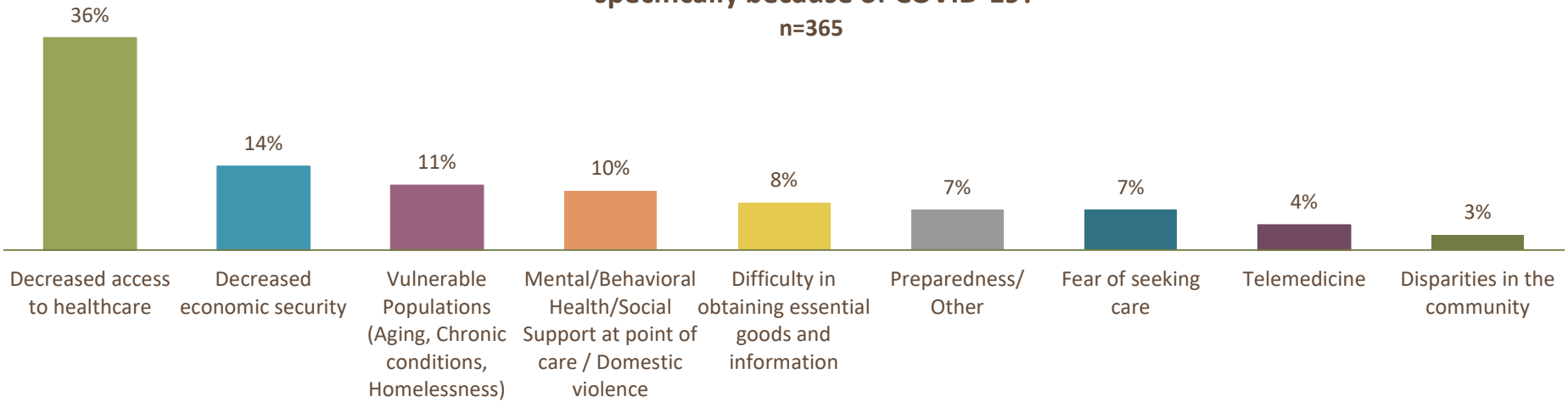
Question: As the San Diego community continues to navigate the COVID-19 pandemic, have you observed any impact on the identified community health needs specifically because of COVID-19?
Total Survey Responses: n=620
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Impact of COVID-19 on Community Health Needs

Those who selected that they did observe an impact on the identified community health needs specifically because of COVID-19 provided examples, and **36%** of those respondents referenced a **decreased access to healthcare**.

As the San Diego community continues to navigate the COVID-19 pandemic, have you observed any impact on the identified community health needs specifically because of COVID-19?

n=365



Question: As the San Diego community continues to navigate the COVID-19 pandemic, have you observed any impact on the identified community health needs specifically because of COVID-19?
Survey Responses: n=365
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Impact of COVID-19 on Community Health Needs

➢ **36%** of respondents mentioned **decreased access to healthcare**

"Access to health care for non COVID-19 issues."

"Access to healthcare greatly reduced."

"Access to prescription and over the counter medicines."

"Routine, yet regularly scheduled appointments cancelled. As a two time melanoma patient my four month checkup was postponed. Totally understand why and had no problem with doing it, but that was an impact."

"Healthcare is limited due to COVID-19. Certain services can't be accessed. Family support for hospitalized patients is difficult. Resources are focused on COVID-19 and other things just have to take a backseat for now."

"Limited access to health facilities. No communication with regular medical staff, closing of local Sharp HealthCare facilities."

"Access to health care with reduction in insurance, mental health needs/therapy due to increased anxiety, elder care – isolation."

"Unable to access adequate doctor visits. Phone visits are not adequate."

"People having to postpone 'non essential' care which could be misinterpreted. Who decides what is essential?"

"Unable to get preventative care appointments such as mammogram and dermatology screenings."

"Access to health care has gotten more difficult with many services being shut down to create capacity for COVI-19 patients ."

"My dad is prone to skin cancer and has had outpatient surgery to remove growths. However, due to Covid-19 his dermatologist is not currently scheduling appointments."

"Routine healthcare, surgeries and dental care have been postponed."

"Unable to obtain scheduled vaccines, dental office closed, issues for homeless and increase in domestic violence."

"Access to all services has been impacted. I have had a colonoscopy, mammogram as well as a dental appointment cancelled."

Question: As the San Diego community continues to navigate the COVID-19 pandemic, have you observed any impact on the identified community health needs specifically because of COVID-19?
Total Survey Responses: n=365
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Impact of COVID-19 on Community Health Needs

- **14%** of respondents mentioned **decreased economic security**

"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."

"Housing instability and economic security are challenged."

"Economic security as thousands are out of work or have their hours drastically reduced."

"Furloughed and unemployed workers lack of health care access; seniors higher mortality resulting in severe isolation; disparities in resources based on socioeconomic factors."

- **11%** of respondents mentioned **vulnerable populations (homeless, elderly, chronic conditions)**

"Our homeless clients in the community are reaching out more for help now that we've opened up the convention center but they still need housing."

"Our elderly population were left out of vital services and communication throughout. This population did not have access to their needs during this time (i.e. counselors, group meetings, etc.)"

"older adults are even more isolated due to their high morbidity/mortality risk with COVID. This puts them at greater risk for many other issues including depression, loneliness, poor nutrition, etc."

- **10%** of respondents mentioned **mental/behavioral health/social support at point of care/domestic violence**

"Patients deferring care due to lack of being able to have a support person with them."

"Mental health has become a large part of our needs during this crisis."

"Domestic violence, behavioral health (suicides, violence), health access and financial stability (lack of)."

"Two family members are impacted. One's depression and anxiety have worsened. One's alcohol over use has increased."

Question: As the San Diego community continues to navigate the COVID-19 pandemic, have you observed any impact on the identified community health needs specifically because of COVID-19?
Survey Responses: n=365
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Impact of COVID-19 on Community Health Needs

- **8%** of respondents mentioned **difficulty in obtaining essential goods/ testing/ info**

"Little info regarding access to COVID testing for the general public."

"Lack of childcare for healthcare workers."

"Timely access to important supplies (medical and other) needed for stay-at-home living (especially masks & sanitizers)."

"Longer lines for food & other necessities."

- **7%** of respondents mentioned a **lack of preparedness, compliance, other**

"People still refuse to wear masks and social distance."

"The need for oversight coordination has not been cohesive."

"All health needs have been impacted by COVID-19."

"Lack of PPE for Healthcare workers."

- **7%** of respondents mentioned a **fear of seeking care due to risk of transmission**

"I believe people are not seeking help because they are afraid."

"People not visiting health clinics due to fear of the pandemic. Verified by family, co-workers and family physicians."

"People are not seeking necessary treatment due to fear of visiting ED or UC."

- **4%** of respondents mentioned **telemedicine**

"Access to medical evaluations- telehealth is ineffective."

"No access to regular care or exams, video chat only."

"Older folks aren't comfortable with telemedicine."

- **3%** of respondents mentioned **disparities in the community**

"Higher adverse outcomes for people of color."

"Lack of health insurance for illegal immigrants."

"More African Americans getting COVID-19."

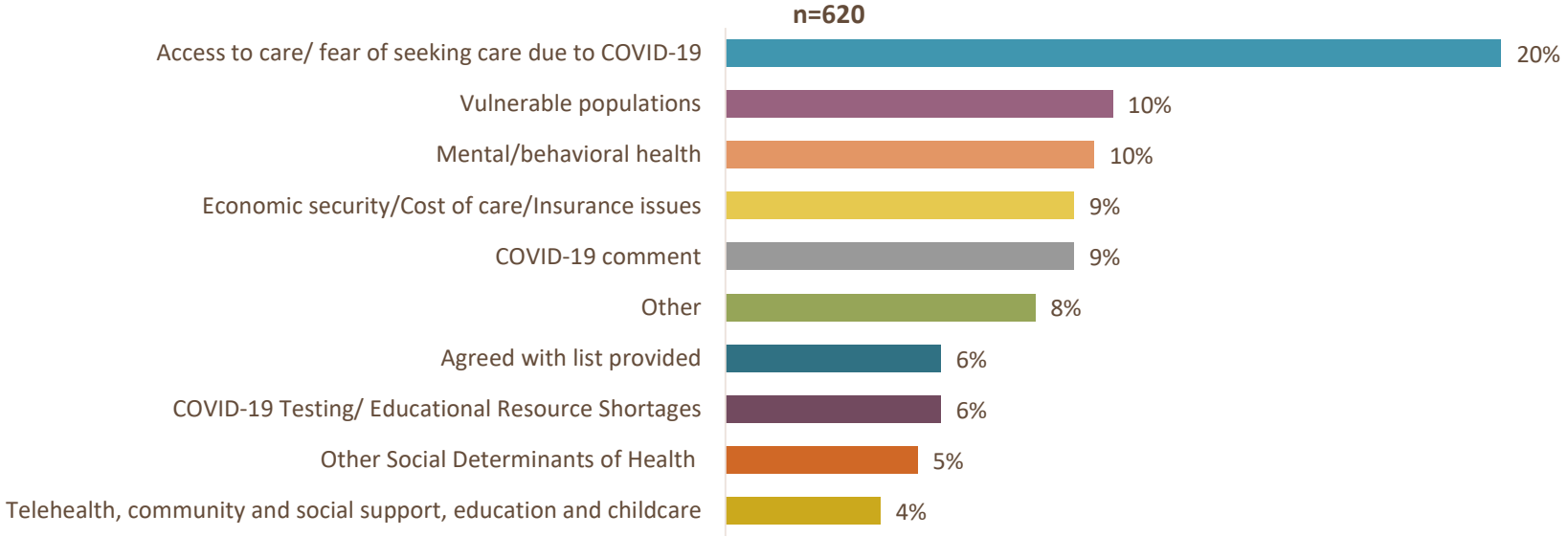
"Economically under resourced folks may not have the technology to access telehealth services."

Question: As the San Diego community continues to navigate the COVID-19 pandemic, have you observed any impact on the identified community health needs specifically because of COVID-19?
Survey Responses: n=365
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Health Needs Affecting Communities Facing Inequities

20% of respondents mentioned **access to care and a fear of seeking care due to COVID-19**, **10%** of respondents mentioned **vulnerable populations** and **10%** mentioned **mental/behavioral health** as affecting the overall health and well being of communities.

Please provide additional comments about the identified needs from the 2019 CHNA or other health needs that you believe affect the overall health and well-being of communities facing inequities within San Diego County



Question: Please provide additional comments about the identified needs from the 2019 CHNA or other health needs that you believe affect the overall health and well-being of communities facing inequities within San Diego County.
Total Survey Responses: n=620
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Health Needs Affecting Communities Facing Inequities

- **20%** of respondents mentioned **access to fear/fear of seeking care due to COVID-19**

"There are many health concerns that are taking a back burner because I am afraid to leave the house, and I assume others are doing the same."

"The virus has discouraged patients to come to the hospital until condition worsens."

"Almost no access to a primary care doctor. I have to go to urgent care or ER to see a doctor."

"Because of fears of contracting COVID-19, many people delayed care and are now entering hospitals in dire condition."

- **10%** of respondents mentioned **vulnerable populations (includes aging, chronic conditions, homeless, immigrants, LGBTQ+)**

"Support groups for chronic conditions, geriatric specialists needed."

"Fear of deportation or involvement with ICE may keep people from seeking needed care."

"Continued assault on Immigrants (no matter status), women's and LGBT health care access and rights. Transgender people."

"Homelessness is a major concern. "

"More attention and training needed for auto-immune diseases in primary care. "

- **10%** of respondents mentioned **mental/behavioral health concerns**

"Concerns for behavioral health, as prolonged isolation will also likely increase domestic violence and suicide of those in financial struggles."

"There is a great impact on mental health issues like anxiety."

"I am very concerned about the mental health impact of COVID-19 pandemic on everyone, especially those who face inequities."

"Parents are under tremendous stress to provide adequately for their families."

Question: Please provide additional comments about the identified needs from the 2019 CHNA or other health needs that you believe affect the overall health and well-being of communities facing inequities within San Diego County.
Total Survey Responses: n=620
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Health Needs Affecting Communities Facing Inequities

- **9%** of respondents mentioned **economic security/cost of care/insurance issues**

"People are afraid to leave their homes, are depressed about having to stay home, and don't know how they will pay rent, bills, much less how to put food on the table."

"Loss of employment costing people access to quality health care."

"People are suffering from economic instability."

"People have lost their jobs; school children are going hungry because they depend on breakfast/lunch from school."

- **9%** of respondents mentioned **COVID-19 comments**

"Trying to address each of the health needs of communities have become harder to address due to COVID-19."

"Risks health care providers face in caring for COVID-19 patients and layoffs of those healthcare providers not involved in COVID-19 patient care."

"People in my community are complying."

- **8%** of respondents mentioned **other**

"Hard to observe an impact when I have been home for 8 weeks."

"I am unsure of the meaning of this statement so do not wish to comment at this time."

"I appreciate the positive attitude of all the healthcare workers."

"A concern and need of mine."

Question: Please provide additional comments about the identified needs from the 2019 CHNA or other health needs that you believe affect the overall health and well-being of communities facing inequities within San Diego County.
Total Survey Responses: n=620
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Health Needs Affecting Communities Facing Inequities

- **6%** of respondents mentioned they **agreed with the list provided**

"The list is very accurate, I don't have additional comments"

"The list looks very comprehensive and accurate."

"The list seems inclusive of everything that comes to my mind."

"All of those needs have been affected by COVID-19 pandemic in some form or another."

- **6%** of respondents mentioned **COVID-19 testing**

"It has been a concern of mine that Sharp has not been able to offer COVID-19 testing to all patients. "

"Lack of available tests and testing sites. Masks, gloves, wipes, antibacterial solution, just to mention a few items. "

"Sharp HealthCare should offer COVID-19 testing to any patient that wants it regardless of symptom or asymptomatic status."

- **5%** of respondents mentioned **other social determinants of health (SDOH)**

"Continued assault on Immigrants (no matter status), women's and LGBT health care access and rights. Transgender people especially are being singled out by the administration and immigrants avoid getting the help they need."

"South Bay communities are experiencing higher number of COVID-19 positives cases and it is largely reflected in Latino communities. "

"There is an suicide, child abuse and domestic violence."

"Food insecurity leads to health and medical issues."

- **4%** of respondents mentioned **telehealth and community/social support, & child care**

"There needs to be more telemedicine options even after the COVID-19 crisis."

"Social disruption of activities, mainly sports and after school programs, lack of exercise and over eating."

"Access to healthcare limited to telehealth."

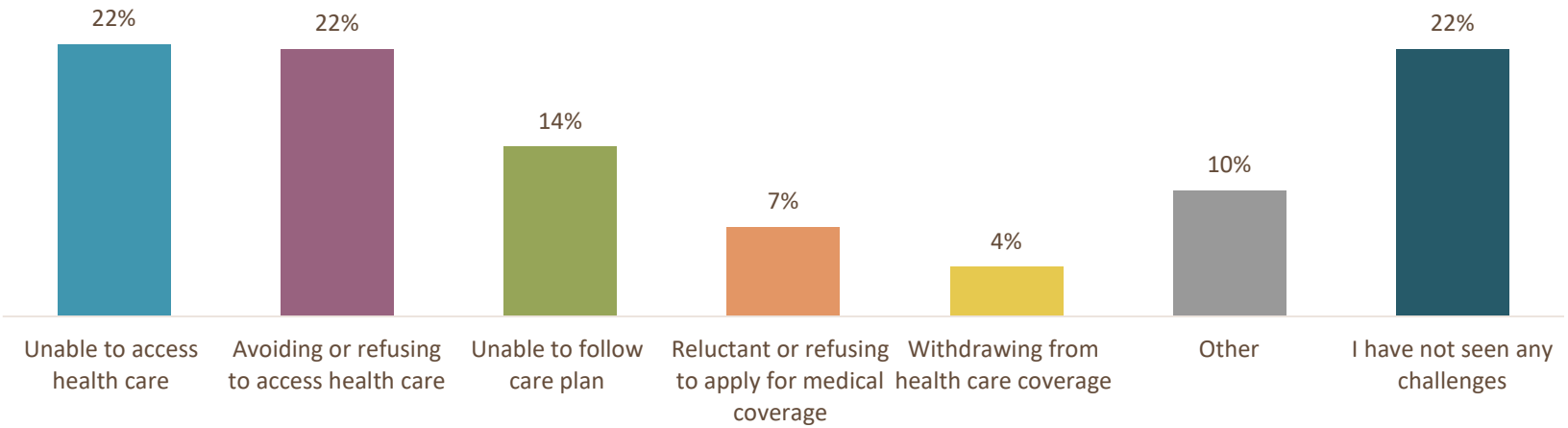
"Community support and housing stability are also concerns as more people are laid off"

Question: Please provide additional comments about the identified needs from the 2019 CHNA or other health needs that you believe affect the overall health and well-being of communities facing inequities within San Diego County.
Total Survey Responses: n=620
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Challenges in Access to Health Care

22% of respondents selected "**unable to access health care"** as a challenge observed in community members' ability to access health care. **22%** selected **"avoiding or refusing to access health care".**

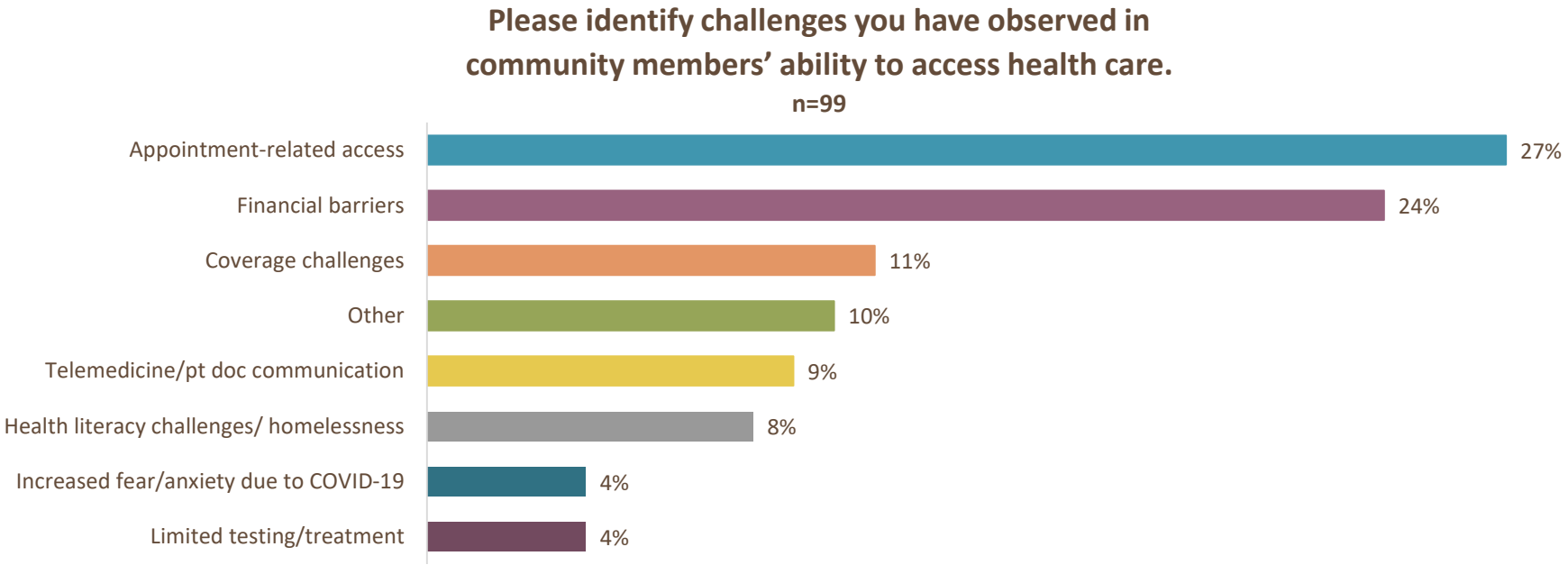
Please identify challenges you have observed in community members' ability to access health care. Select all that apply.
n=620



Question: Please identify challenges you have observed in community members' ability to access health care. Select all that apply.
Total Survey Responses: n=620
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Challenges in Access to Health Care

Of the 10% of participants who selected “other”, **27%** mentioned **appointment-related access**, and **24%** mentioned **financial barriers** as challenges observed in community members’ ability to access health care.



Question: Please identify challenges you have observed in community members’ ability to access health care. Other: please specify
Survey Responses: n=99
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Challenges in Access to Health Care

- **27%** of respondents mentioned **appointment-related access**

"Unable to access mental health services in a timely manner."

"Postponing routine health checks, and scheduled elective surgeries."

"Annual physical & eye exams are postponed to July 2020. Mammogram not scheduled after mid-July. "

"Clinics are not available for appointments or annual check ups."

"My primary concern is cancelled appointments and none are scheduled in the future."

"Inability to see a doctor in-person."

"It is hard to get an appointment for regular appointments and mental health appointments."

- **24%** of respondents mentioned **financial barriers**

" Unable to pay for health insurance while on unemployment."

"Unable to pay for premiums (even subsidized), co-pays, and prescriptions."

"Underemployed and unable to afford healthcare coverage via California Cares or other government subsidized health care."

"The cost of health care from insurance to the cost of prescriptions are way too high."

"Unaffordable health insurance, premiums deductibles too high."

"Unable to pay for adequate insurance due to increasingly high costs of premiums and deductibles."

- **11%** of respondents mentioned **coverage challenges**

"Many people do not have a job and therefore their healthcare."

"Insurance-based health care deprives too many community members of healthcare."

"Loss of coverage due to unemployment."

Question: Please identify challenges you have observed in community members' ability to access health care. Other: please specify
Survey Responses: n=99
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Challenges in Access to Health Care

- **10%** of respondents mentioned **other comments**

"Little info regarding access to COVID testing for the general public."

"I'm always amazed at how well you guys take care of me. I really don't see any complaint about Sharp."

"Medical professionals' age bias is apparent."

- **9%** of respondents mentioned **telemedicine/ patient-doctor communication**

"People can't get to see a doctor. The phone does not cut it."

"Many people do not have access to the technology which would allow them to obtain telehealth."

"Unable to get required tests until Sharp deemed ok. Phone appointments are not adequate."

- **8%** of respondents mentioned **health literacy challenges/ homelessness**

" My homeless neighbors use the hospital emergency department. As they age, their needs are more complex."

"Coverage is too confusing for those who need it most."

"Don't know how/where to apply."

- **4%** of respondents mentioned **increased fear/anxiety due to COVID-19**

"People are afraid to go to the Dr. or hospital for any reason for fear of catching COVID."

"I'm staying away, so I don't access routine health care. I would not want to be in wait areas."

"Concerns of getting COVID-19."

- **4%** of respondents mentioned **limited testing/ treatment**

" Health care is relatively limited. What happens when Medi-Cal patients are denied contact tracing related tests?"

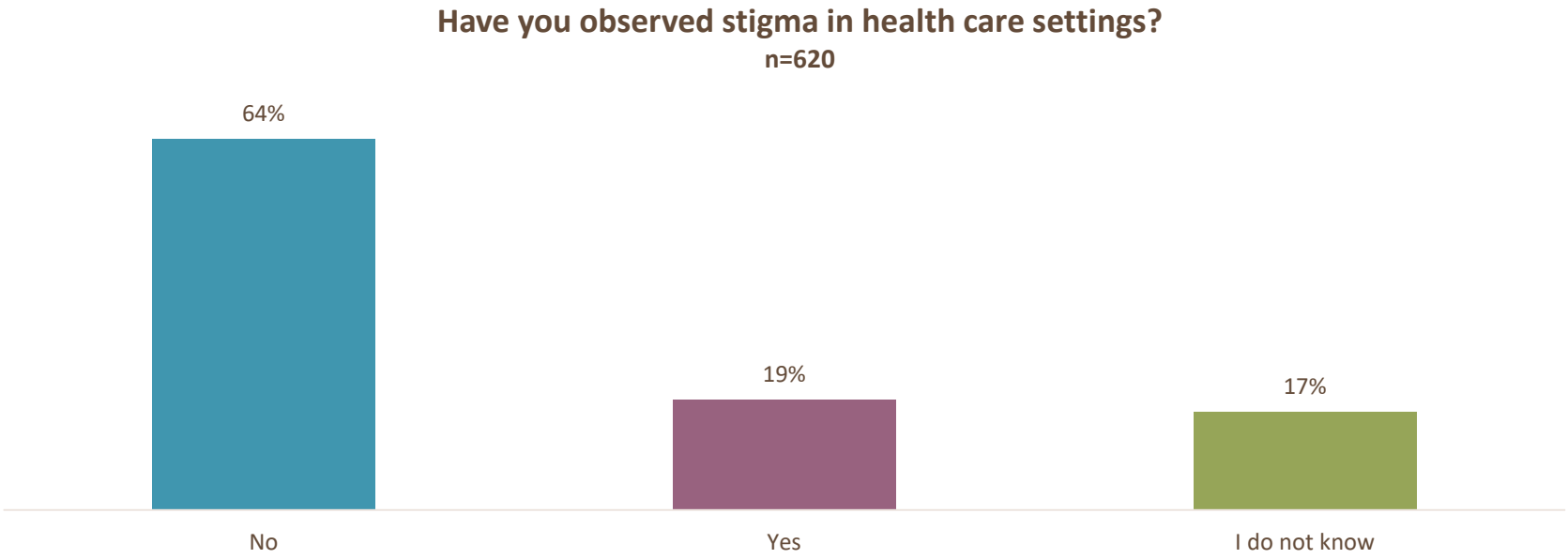
"Available treatment options for COVID-19."

"Unable to get testing for coronavirus if you're not showing symptoms."

Question: Please identify challenges you have observed in community members' ability to access health care. Other: please specify
Survey Responses: n=99
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Observing Stigma in Health Care Settings

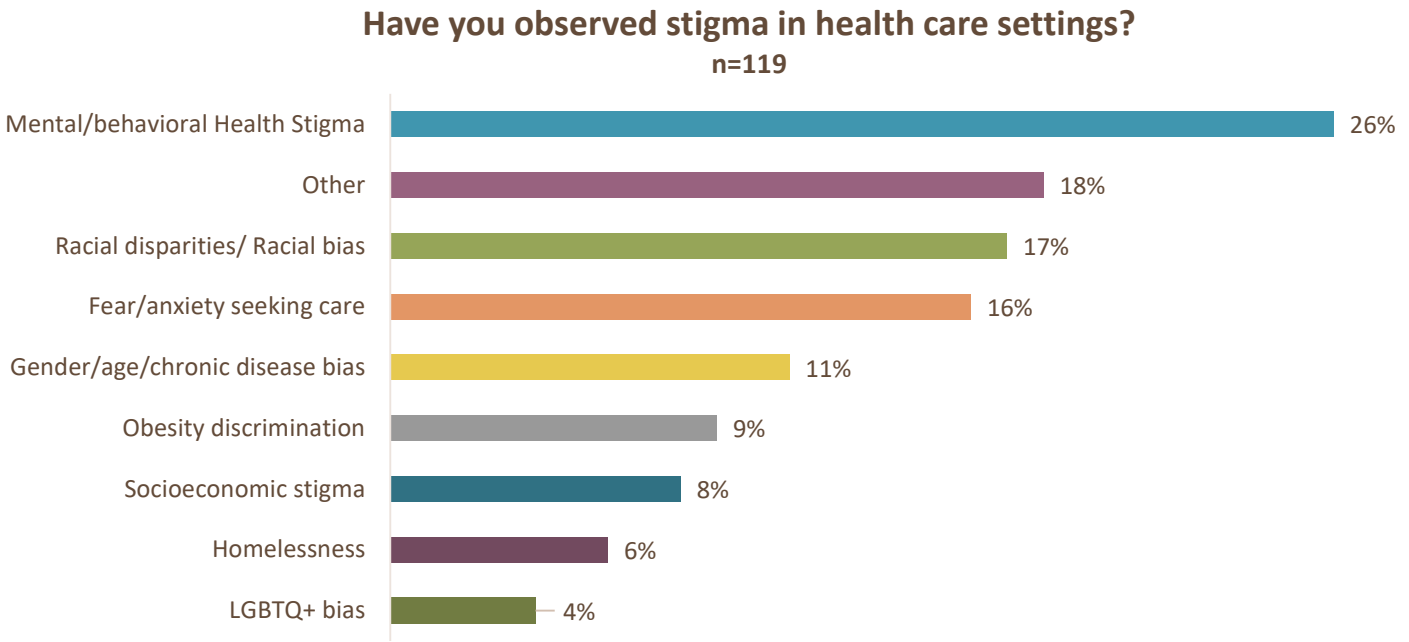
64% of respondents **had not observed** stigma in health care settings. **19%** of respondents **had observed** stigma in health care settings. **17%** of respondents **did not know** if they had observed stigma in health care settings.



Question: Have you observed stigma in health care settings?
Total Survey Responses: n=620
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Observing Stigma in Health Care Settings

19% of respondents had observed stigma in health care settings. Of those respondents, **26%** reported observing **mental/behavioral health stigma**, **18%** reported **other**, and **17%** reported **racial disparities/racial bias**.



Question: Have you observed stigma in health care settings?
Survey Responses: n=119
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Observing Stigma in Health Care Settings

- **26%** of respondents mentioned **mental/ behavioral health stigma**
  - "People are reluctant to get help for mental & behavioral health issues as it can impact employment, security clearances, etc."
  - "Many have a strong stigma attached to mental health services."
- **18%** of respondents mentioned **other**
  - "There are those who mistakenly think this virus is a hoax."
  - "Doctors not doing well in their exams like used to."
  - "Lack of visiting sick family members."
- **17%** of respondents mentioned **racial disparities/racial bias**
  - "Latinx & Black patients dismissed by English-only professionals who cannot understand them."
  - "Yes, when Hispanic undocumented are treated as if they were different than normal people. When people assume that because of their appearance, they don't have the resources to communicate, to buy something or some services."
- **16%** of respondents mentioned **fear/anxiety seeking care**
  - "My in-laws have a deep seeded fear of seeking medical help, especially with mental health and addition issues."
  - "My own fear in contacting a doctor."
- **11%** of respondents mentioned **gender/age/chronic disease discrimination**
  - "Male doctors downplaying symptoms felt by female patients equating symptoms to hysteria or 'period symptoms'…"
  - "Judgment for being too young for problems."

Question: Have you observed stigma in health care settings?
Survey Responses: n=119
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Observing Stigma in Health Care Settings

- **9%** of respondents mentioned **obesity discrimination**

"I am fat. If doctors can't figure out what's wrong, it's because I'm fat. So I don't bother going in most of the time, and especially for any new issue."

"Saw stigma and dismissal against overweight and women; leading their concerns to be taken less seriously."

- **8%** of respondents mentioned **socioeconomic stigma**

"Adult son is uninsured, stigma regarding going into free clinic."

"I hear people talk about this group or that group not being either educated enough to take care of themselves, or not being able to afford care."

- **6%** of respondents mentioned **homelessness**

"Homeless population."

"I've seen stigma in the ED aimed toward homeless and drug addicted folks. Need more hospital staff with street outreach experience."

- **4%** of respondents mentioned **LGBTQ bias**

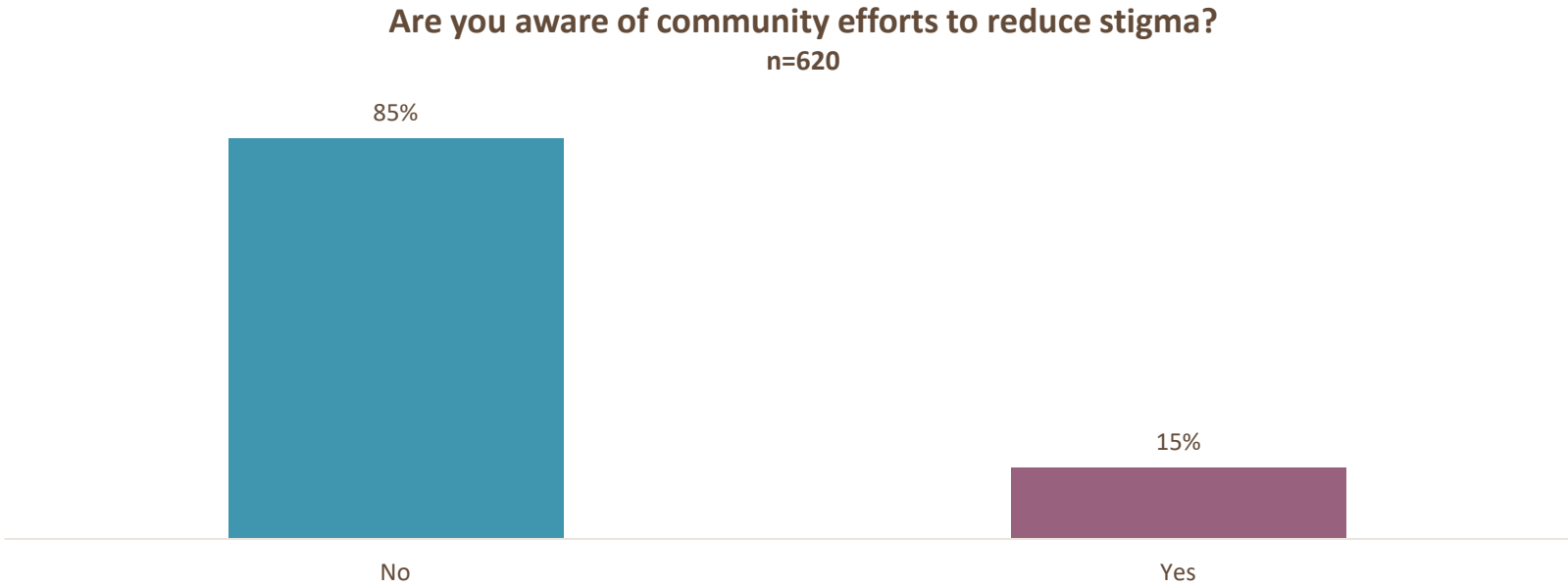
"Doctors uncomfortable that I am gay."

"Homeless LGBTQ+ youth."

Question: Have you observed stigma in health care settings?
Survey Responses: n=119
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Community Efforts to Reduce Stigma

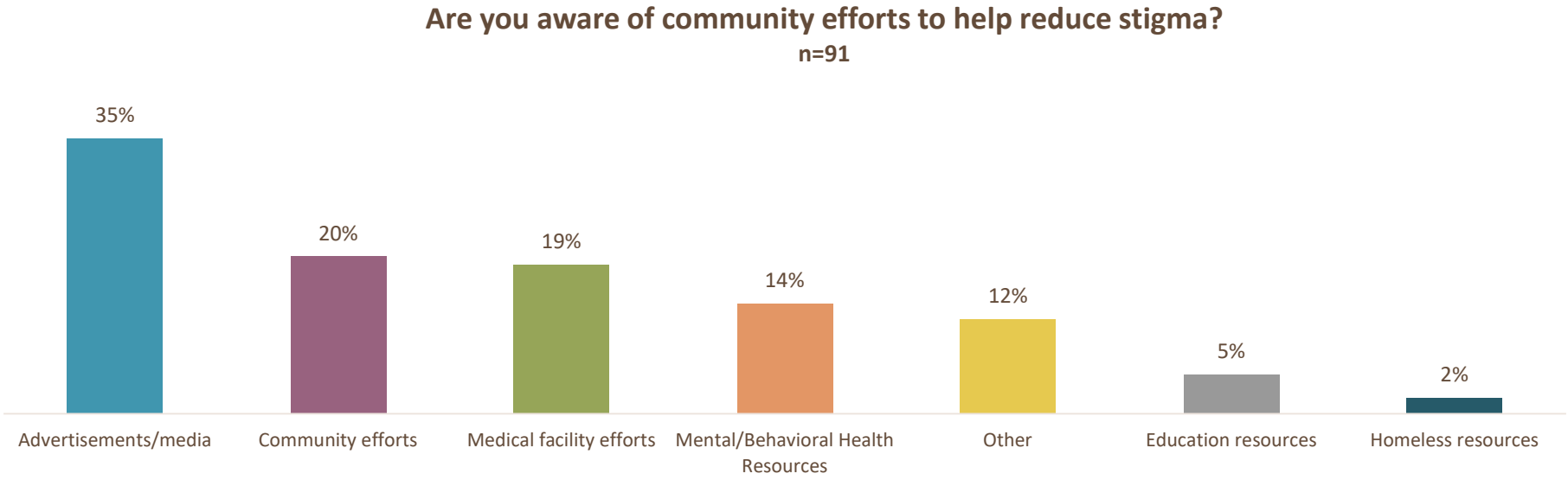
85% of respondents were **not aware** of community efforts to help reduce stigma. **15%** of respondents **were aware** of community efforts to help reduce stigma.



Question: Are you aware of community efforts to reduce stigma?
Total Survey Responses: n=620
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Community Efforts to Reduce Stigma

Of the 15% of respondents who were aware of community efforts to reduce stigma, **35%** indicated **advertisements/media** as an example of a community effort in reducing stigma. **20%** indicated **community efforts** and **19%** indicated **medical facility efforts**.



Question: Are you aware of community efforts to reduce stigma?
Survey Responses: n=91
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Community Efforts to Reduce Stigma

- **35%** of respondents mentioned **advertisements/media**

"There are significant efforts to reduce mental health stigma, shame over invisible illnesses, body shaming."

"Flyers and posters on college campuses."

"Commercials and ads surrounding mental health."

"More tv ads and stars encouraging people to get help."

- **20%** of respondents mentioned **community efforts**

"Father Joe and Alpha Project."

"Hospitals and community partners and community businesses."

"Live Well SD."

"Pride parade and related activities."

"Youth programs offered by the SD LGBT Center."

- **19%** of respondents mentioned **medical facility efforts**

"Caregivers concern for our well being."

"I see that all people are treated equally in hospitals and healthcare clinics throughout San Diego before the corona virus."

"My primary physician's office has a diverse staff."

"Outreach by community clinics."

Question: Are you aware of community efforts to reduce stigma?
Survey Responses: n=91
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Community Efforts to Reduce Stigma

- **14%** of respondents mentioned **mental/behavioral health resources**

"12 step programs."

"Mental health education."

"There are significant efforts to reduce mental health stigma, shame over invisible illnesses, body shaming."

- **12%** of respondents mentioned **other**

"Doctors not doing well in their exams like they used to."

"I find stigma outside the hospital, people consider me contaminated and don't want me around because I work in the ED."

- **5%** of respondents mentioned **education resources**

"By attempting to educate both those affected and those making judgements."

"I saw SharpNet offered training in understanding and interacting with obese patients."

- **2%** of respondents mentioned **homelessness**

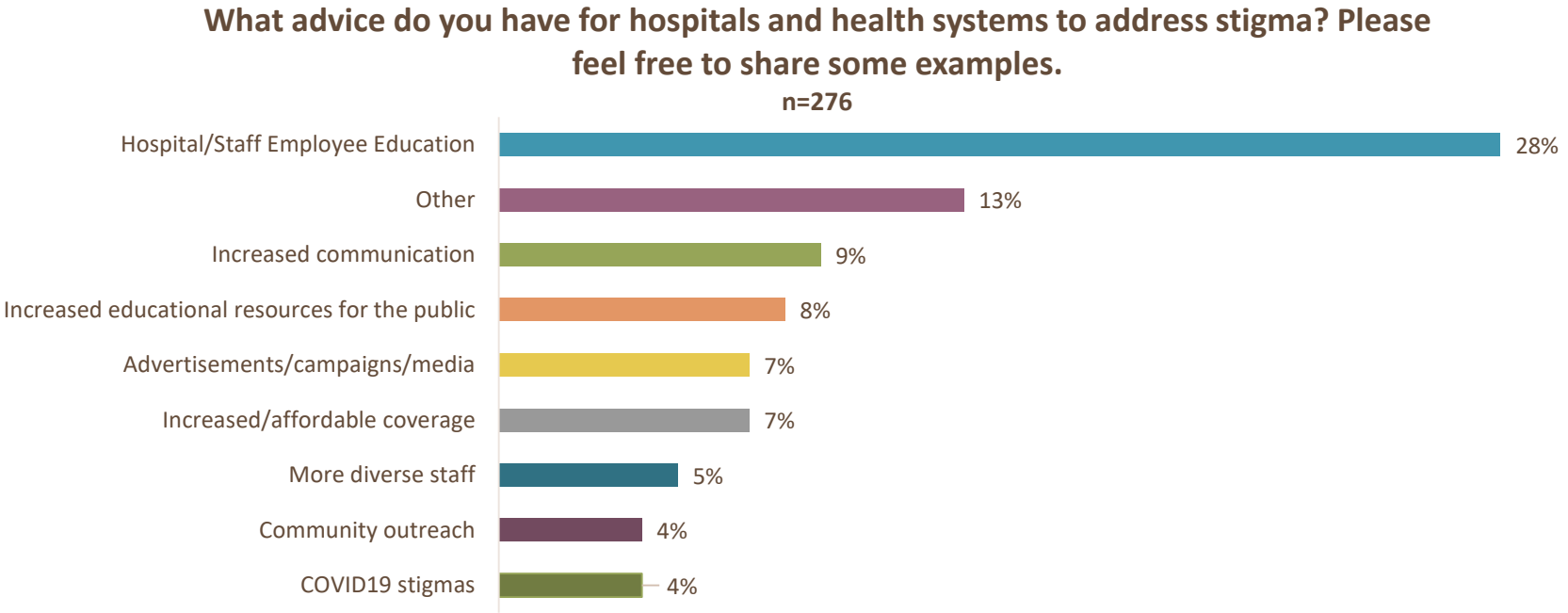
"Finding housing for homeless individuals including access to health care."

"Homeless encampments given extra help."

Question: Are you aware of community efforts to reduce stigma?
Survey Responses: n=91
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Advice to Reduce Stigma in Health Care Settings

Respondents were asked for advice for hospitals and health systems to address stigma. **28%** of respondents suggested **hospital/staff employee education**, **13%** suggested **other**, and **9%** suggested **increased communication**.



Question: What advice do you have for hospitals and health systems to address stigma? Please feel free to share some examples. (optional)
Survey Responses: n=276
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Advice to Reduce Stigma in Health Care Settings

- **28%** of respondents mentioned **hospital/staff employee education**
  - "I think training may be important."
  - "…I think being courteous and polite to every single person and treating each individual with dignity as a human being would be the best practice."
  - "Acknowledge it's a real thing; we all have some level of bias; do the work to educate yourself about yours and do better with your patients."
- **13%** of respondents mentioned **other**
  - "You are doing the best you can, especially now given the government climate that openly displays, with no consequence, daily acts of racism and hatred."
  - "Efforts to reduce stigma in the health care setting are very important. Please continue these efforts and foster respect for all patients"
- **9%** of respondents mentioned **increased communication**
  - "To have open communication by using neutral/nonjudgmental language when addressing mental health by avoiding such words such as adherence, non-compliant. Many patients welcome open and honest communication."
  - "Speak directly to patients."
  - "Keep communication open."
- **8%** of respondents mentioned **increased educational resources for the public**
  - "Keep putting information out to the public."
  - "More community awareness and the use on classes through the Senior Resource Center."
- **7%** of respondents mentioned **advertisements/campaigns/media**
  - "Advertising on TV that everyone deserves healthcare, and there is no shame in asking for help."
  - "Continue advertising and creating community resources."
  - "Stigma-related radio and TV advertising."

Question: What advice do you have for hospitals and health systems to address stigma? Please feel free to share some examples. (optional)
Survey Responses: n=276
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Advice to Reduce Stigma in Health Care Settings

- **7%** of respondents mentioned **increased/affordable coverage**

> "Enhance and expand the ACA."

> "Get rid of insurance. It is a costly, no value added aspect of healthcare that is making the entire society vulnerable to pandemics and other health challenges."

- **5%** of respondents mentioned **more diverse staff**

> "…You need to have health workers who speak their language."

> "…having persons of different cultural backgrounds to help smooth the transition into the facility."

- **4%** of respondents mentioned **community outreach**

> "I see reverse stigma in which the community members don't trust health care systems. This has an adverse effect on community members. Perhaps locating people within the community to help would be good."

> "Involve community members, specific to the area you are located."

- **4%** of respondents mentioned **COVID-19 stigmas**

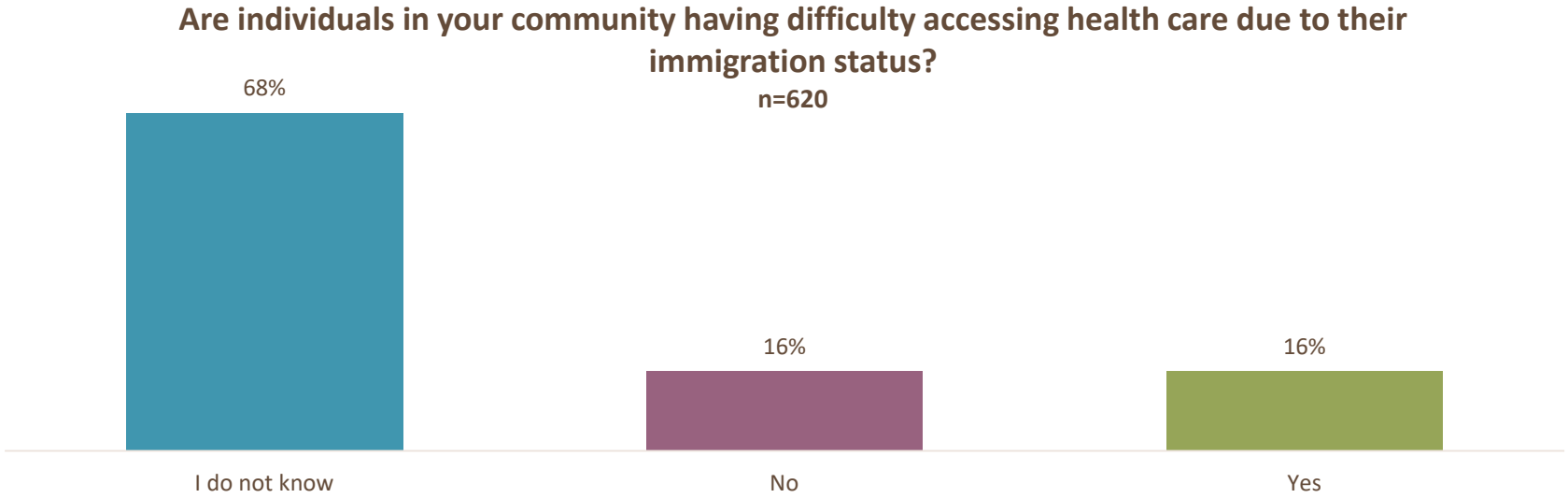
> "Open the Sharp Health Care offices to routine procedures after assuring a safe and clean environment.""

> "Remind people that COVID19 stigmas is still present and currently there is no vaccine."

Question: What advice do you have for hospitals and health systems to address stigma? Please feel free to share some examples. (optional)
Survey Responses: n=27
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Immigration Status and Health Care

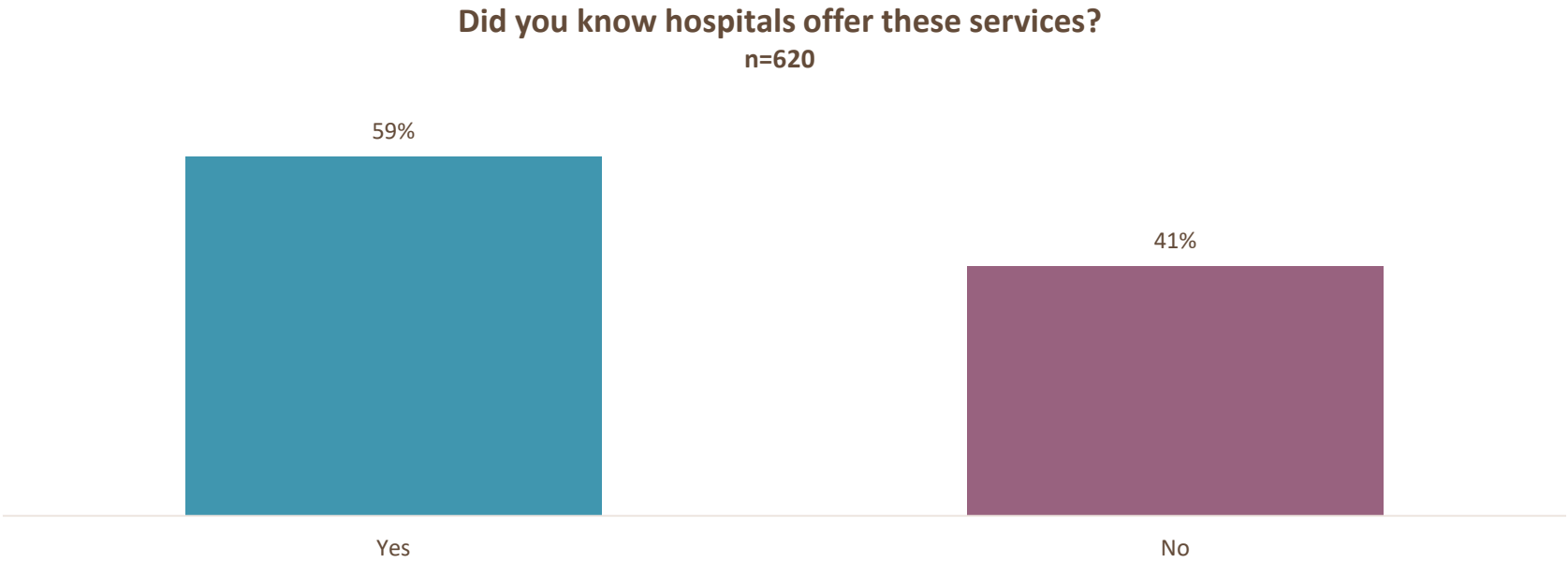
68% of respondents indicated that they **did not know** if individuals in their community were having difficulty accessing health care due to their immigration status. **16%** of respondents **were aware** of individuals in their community having difficulty accessing health care due to their immigration status.



Question: Are individuals in your community having difficulty accessing health care due to their immigration status?
Total Survey Responses: n=620
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Awareness of Patient Financial Assistance Programs

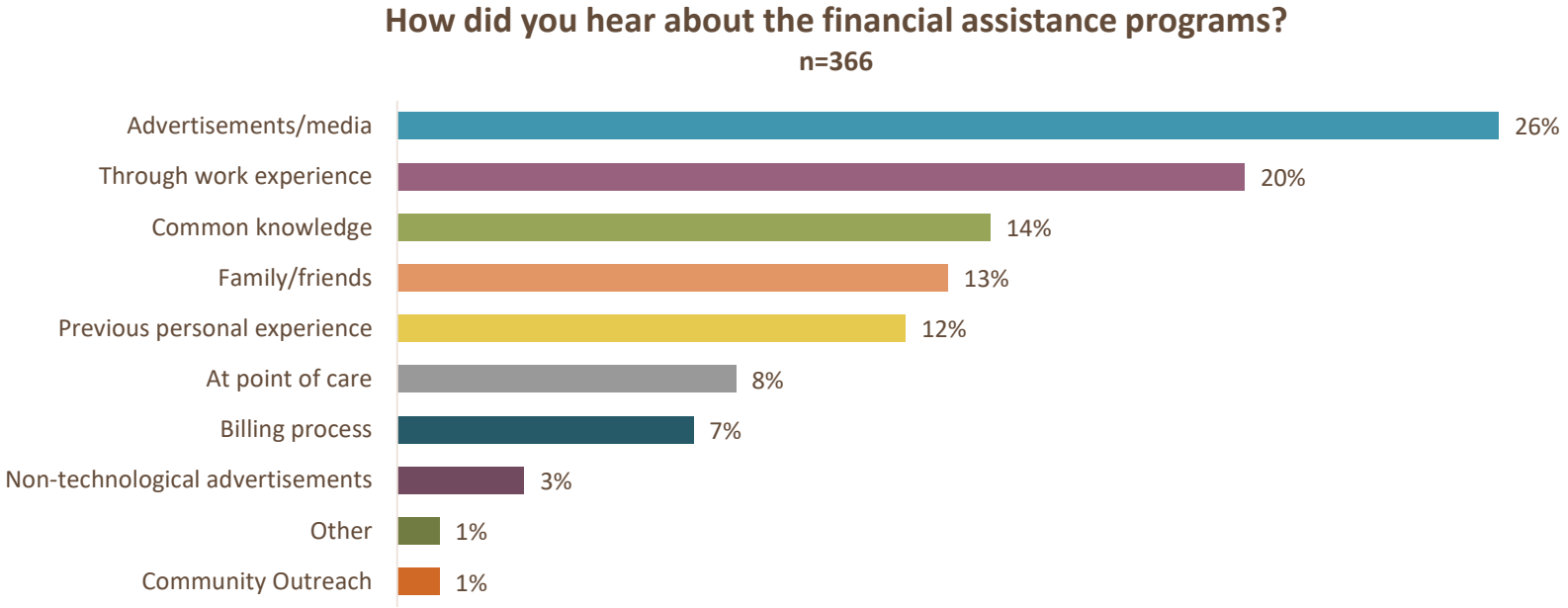
59% of respondents **knew about** financial assistance programs. **41%** of respondents **did not know** about financial assistance programs.



Question: Did you know hospitals offer these services?
Total Survey Responses: n=620
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Patient Financial Assistance Programs Source

26% of responses indicated they knew about financial assistance programs through **advertisements/media**, **20%** through **work experience**, and **14%** through **common knowledge.**



Question: How did you hear about the financial assistant programs?
Survey Responses: n=366
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Patient Financial Assistance Programs Source

- **26%** of respondents mentioned **advertisements/media**
  - "News and signage in hospitals and clinics"
  - "Listening to the news; reading articles about people who needed to pay for their healthcare out of pocket because they didn't have insurance or their insurance didn't cover their particular medical care needs."
  - "I have seen it referred to on television"
- **20%** of respondents mentioned **through work experience**
  - "I was there when the hospital social service worker assisted the client."
  - "Former employee of Sharp."
  - "As a Sharp volunteer."
  - "I'm a retired nurse."
- **14%** of respondents mentioned **common knowledge**
  - "I don't recall how I heard specifically."
  - "Common knowledge."
  - "I just assume they are available to those in need."
  - "I just know."
- **13%** of respondents mentioned **family/friends**
  - "Helped a family member obtain help."
  - "I believe it has been around for decades. I had a friend who needed such assistance once."
  - "From neighbors who received the assistance."
- **12%** of respondents mentioned **previous personal experience**
  - "As a stage-4 sarcoma patient have run into this topic in both support groups and one-on-one conversations with people on campus/offices, etc."
  - "Every admission."
  - "Had to previously have help with bills owed."

Question: How did you hear about the financial assistant programs?
Survey Responses: n=366
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Patient Financial Assistance Programs Source

- **8%** of respondents mentioned **at point of care**

"Through hospital."

"When I was uninsured and required medical care, a counselor visited me in the emergency room."

"At admissions."

- **7%** of respondents mentioned **billing process**

"Billing process at Sharp."

"I called a number that was on my bill."

"Info comes with my bills."

- **3%** of respondents mentioned **non-technological advertisements**

"Sharp brochures and website."

"Through information posted at medical facilities."

- **1%** of respondents mentioned **other**

"Adequate for some not for others."

"SRS does not offer. Although Sharp helped me financially, SRS is not offering what sharp does and they made it clear its not the same plan although it is still Sharp."

- **1%** of respondents mentioned **community outreach**

"Activism for the homeless."

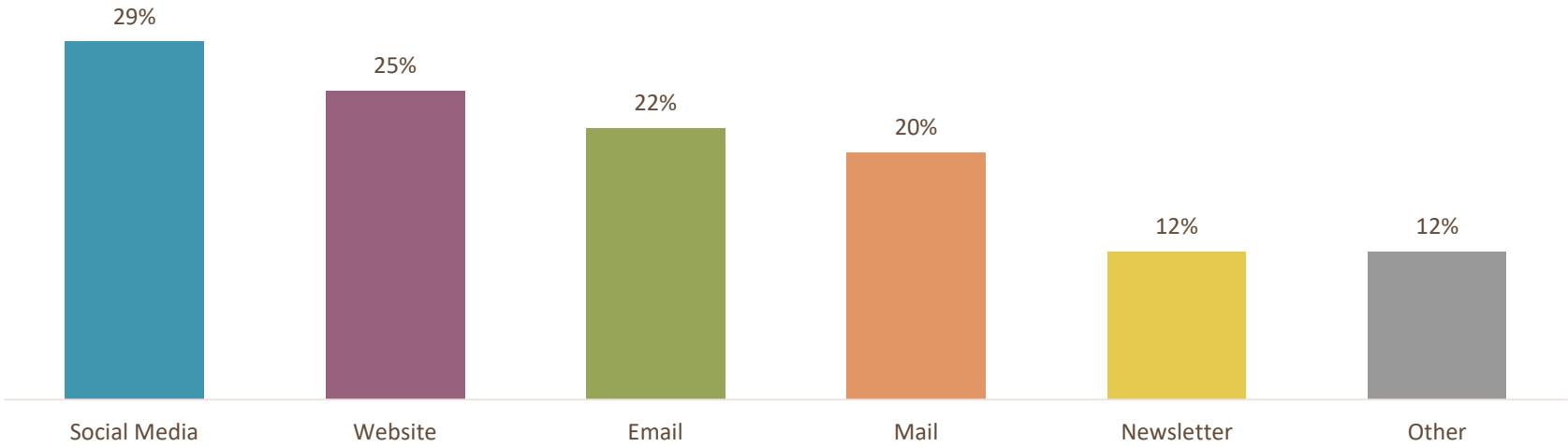
"As part of Feeding San Diego events at ECC."

Question: How did you hear about the financial assistant programs?
Survey Responses: n=366
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Informing the Public about Patient Financial Assistance Programs

Respondents were asked how the public should be informed about financial assistance programs. **29%** of responses suggested using **social media**, **25%** suggested using a website, and **22%** suggested using **email**.

How do you suggest we inform the public about financial assistance programs? Please select all that apply.
n=620



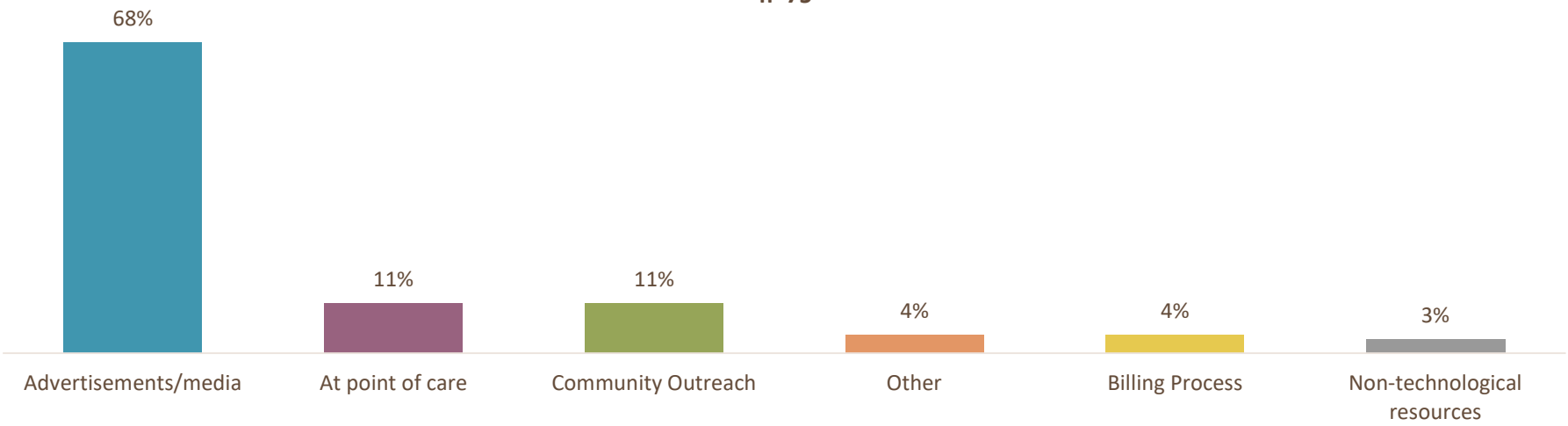
Question: How do you suggest we inform the public about financial assistance programs? Please select all that apply
Total Survey Responses: n=620
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Informing the Public about Patient Financial Assistance Programs

12% of respondents selected “other” when asked how the public should be informed about financial assistance programs. **68%** of those respondents suggested using **advertisements/media** to inform the public about financial assistance programs.

How do you suggest we inform the public about financial assistance programs? Other, please specify.

n=75



Question: How do you suggest we inform the public about financial assistance programs? Other, please specify
Survey Responses: n=75
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Informing the Public about Patient Financial Assistance Programs

- **68%** of respondents mentioned **advertisements/media**

"Advertisements on TV and radio."

"TV and radio, also in-show ads in streaming services like Spotify, Hulu, YouTube, Netflix, etc."

"Multi-lingual TV & radio ads."

"PSAs, TV, print spot/ads."

- **11%** of respondents mentioned **at point of care**

"At time of need. If you're admitted to an emergency room, the person taking your information should hand you information regarding a payment plan if needed."

"Inform the patients when they are accessing care."

"On-site information and education at all care point."

- **11%** of respondents mentioned **community outreach**

"In person outreach to homeless and non-citizens."

"Schools and school nurses."

"Hold ongoing information sessions in various parts of each community but not at the same location each time. For example, libraries, community centers, and senior centers are great places for monthly information and Q&A sessions. Be visible."

Question: How do you suggest we inform the public about financial assistance programs? Other, please specify
Survey Responses: n=75
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Informing the Public about Patient Financial Assistance Programs

- **4%** of respondents mentioned **other**

"As needed."

"Get rid of insurance and make healthcare accessible by every resident."

- **4%** of respondents mentioned **billing process**

"Accounting-collection. Social services."

"Dedicated individual that we can call."

"Had to previously have help with bills owed."

- **3%** of respondents mentioned **non-technological resources**

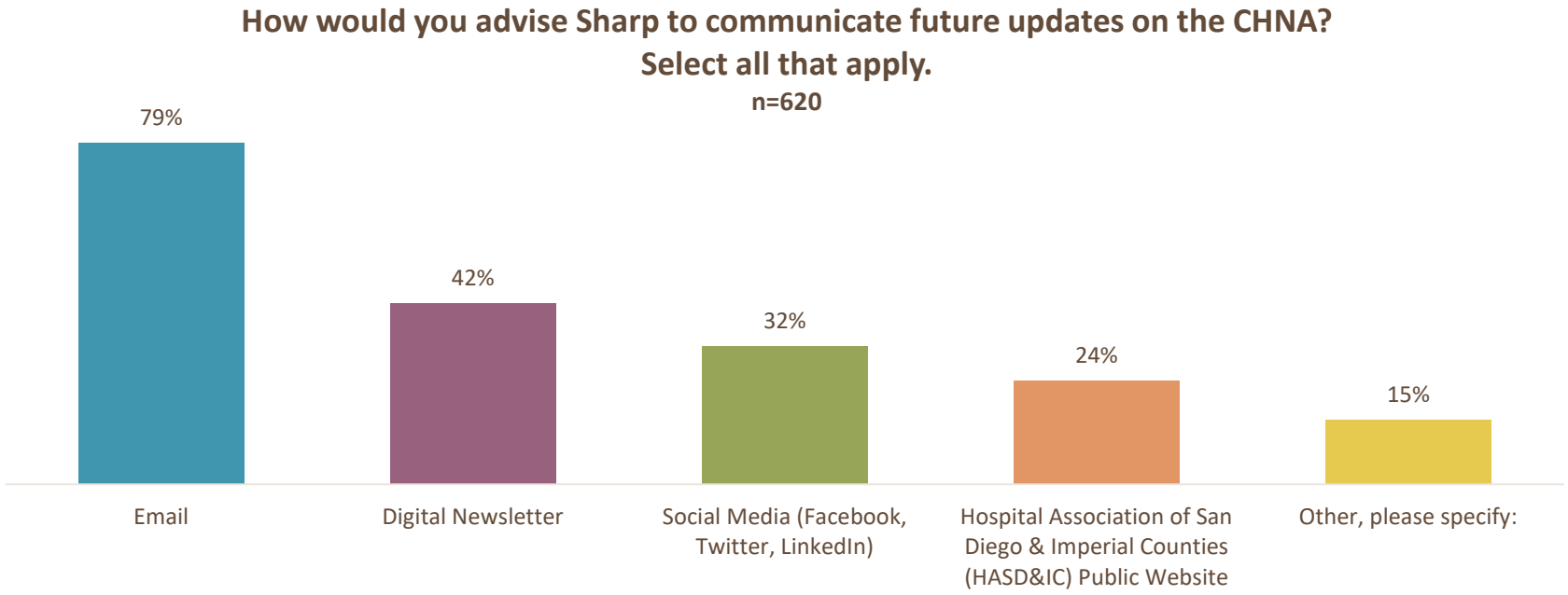
"Anyway you can there is programs to e-mail direct to certain financial levels."

"Some do not have access to technology – so need to figure out how to reach them."

Question: How do you suggest we inform the public about financial assistance programs? Other, please specify
Survey Responses: n=75
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Communicating Future CHNA Updates

Respondents were asked about the best way to communicate future updates on the CHNA. **79%** recommended using **email**, **42%** recommended a **digital newsletter**, and **32%** recommended **social media**.

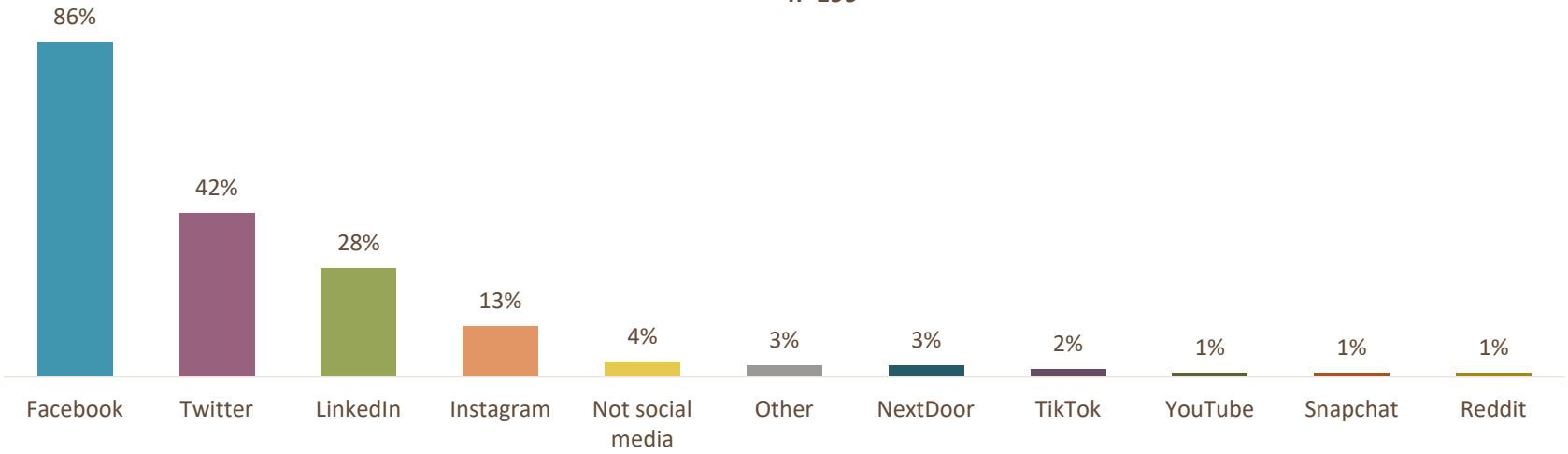


Question: How would you advise Sharp to communicate future updates on the CHNA? Select all that apply.
Total Survey Responses: n=620
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Communicating Future CHNA Updates

The following graph provides details for respondents who selected “Social Media” as the best way to communicate future updates on the CHNA. **86%** of respondents recommended **Facebook** to communicate future CHNA updates.

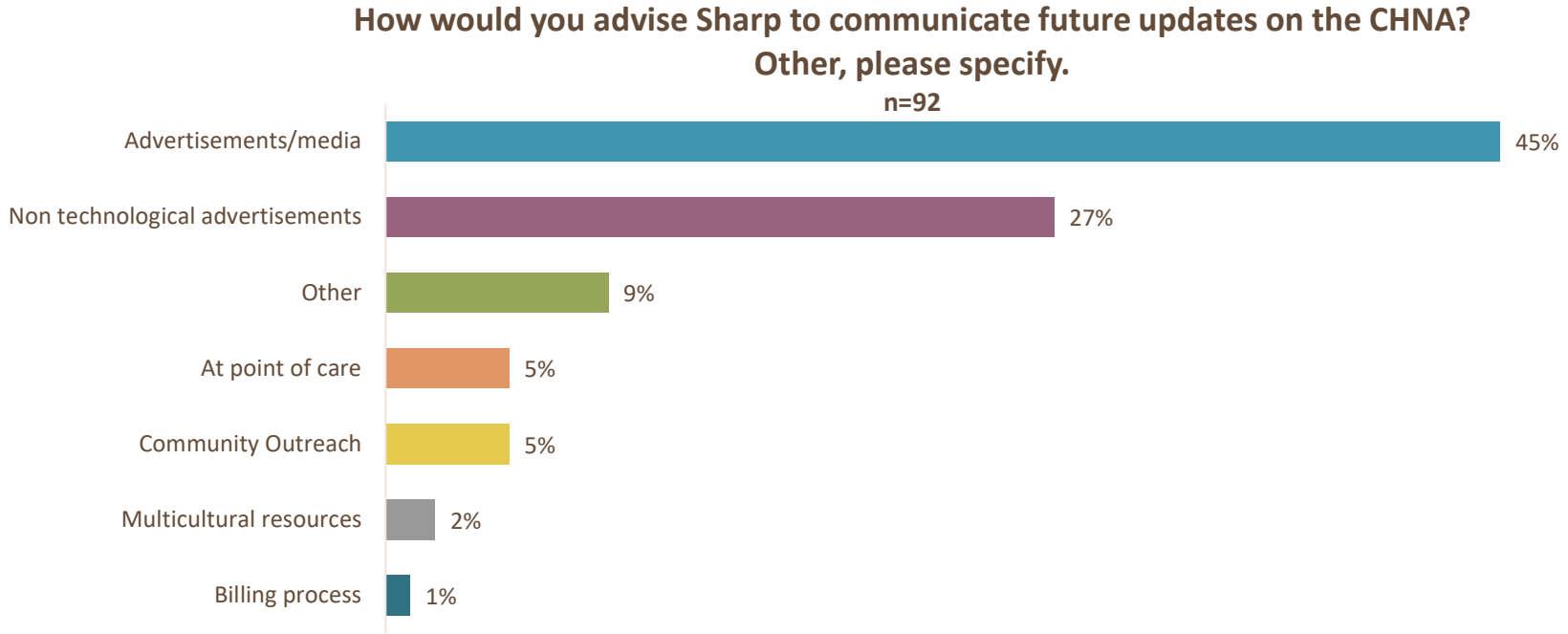
How would you advise Sharp to communicate future updates on the CHNA? Social Media (Facebook, Twitter, LinkedIn), please specify:
n=199



Question: How would you advise Sharp to communicate future updates on the CHNA? Social Media (Facebook, Twitter, LinkedIn), please specify.
Survey Responses: n=199
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Communicating Future CHNA Updates

The following graph provides details for respondents who selected "Other" as the best way to communicate future updates on the CHNA. **45%** of respondents recommended **advertisements/media** and **27%** recommended **non technological advertisements**.



Question: How would you advise Sharp to communicate future updates on the CHNA? Other, please specify
Survey Responses: n=92
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Communicating Future CHNA Updates

- **45%** of respondents mentioned **advertisements/media**

"Ads on Spotify, YouTube, Netflix, Hulu, etc."

"As a public service announcement."

"TV and radio ads."

"Information on commercial TV."

"Internet or external website."

- **27%** of respondents mentioned **non technological advertisements**

"Bus stops and billboards are accessible to all."

"US Mail to ensure tech-challenged seniors are reached."

"Poster-type notices in areas where those without access to digital communications can learn about updates and plans."

"Communication through direct phone or simple note or letter in mail."

- **9%** of respondents mentioned **other**

"Assign callers to check in with clients."

"I would use all source to communicate with."

"What does CHNA mean?"

Question: How would you advise Sharp to communicate future updates on the CHNA? Other, please specify
Survey Responses: n=92
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Communicating Future CHNA Updates

- **5%** of respondents mentioned **at point of care**

"Clinics: word of mouth."

"Education of materials at their care providers."

"At the hospital or in places that people who need assistance frequent. Odds are if you need this help you aren't checking e-mail blasts or digital newsletters and it's spam for everyone else too."

- **5%** of respondents mentioned **community outreach**

"Direct person to person contact by partnering with existing programs offered by the LGBT Center. Free clinics."

"Community events (concerts, churches)."

"Partner agencies."

- **2%** of respondents mentioned **multicultural resources**

"Provide multi-lingual information, especially in Spanish."

"Using subject matter experts that are of the same culture to speak on topics."

- **1%** of respondents mentioned **billing process**

"Send people info with their bills, because you definitely never forget to send those with great frequency."

Question: How would you advise Sharp to communicate future updates on the CHNA? Other, please specify
Survey Responses: n=92
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Breakout Groups

Needs of Communities with Greater Health Inequities cont'd..

38 of the 66 (57%) participants who "Strongly Disagreed" or "Disagreed" with the identified community health needs of the CHNA later mentioned examples of the needs mentioned in the additional qualitative example.
(6 of the 38 comments are listed as examples below)

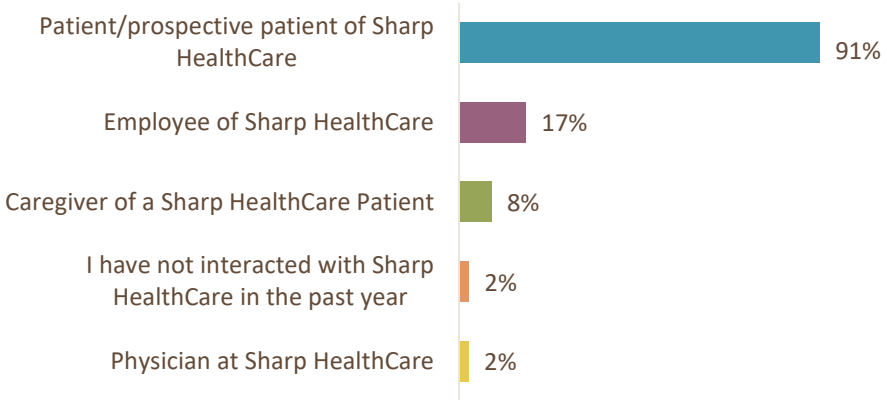
Level of Agreement with Identified Needs	Respondent Comment	Comment Theme
Disagree	Elective procedures	Access to health care
Strongly Disagree	Access to all services has been impacted	Access to health care
Strongly Disagree	Increase in self-harm, mental illness exacerbated/increasing, more anxiety and depression	Behavioral health
Strongly Disagree	Poverty, food security, cost of housing	Economic security
Strongly Disagree	Higher % of Latinos are testing + for COVID in the South Bay	Vulnerable populations
Strongly Disagree	Access to care is more difficult, especially for homeless and elderly	Access to health care, Vulnerable populations

Respondent level of agreement with identified needs listed in 2019 CHNA compared to additional comments provided.
Source: Sharp Insight Community – Invitation Survey and Community Health Needs Assessment Phase 2 Survey

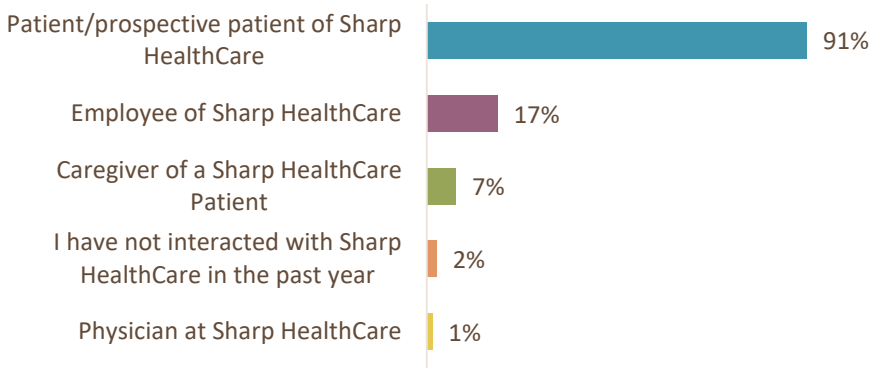
Sharp Insight Community Makeup

The following graphs provide a panel comparison of the entire SIC community and those who have taken the CHNA Phase 2 Survey.

How have you interacted with Sharp HealthCare in the past year? Select all that apply. (SIC Community)
n=3,311



How have you interacted with Sharp HealthCare in the past year? Select all that apply. (CHNA Phase 2 Respondents only)
n=620



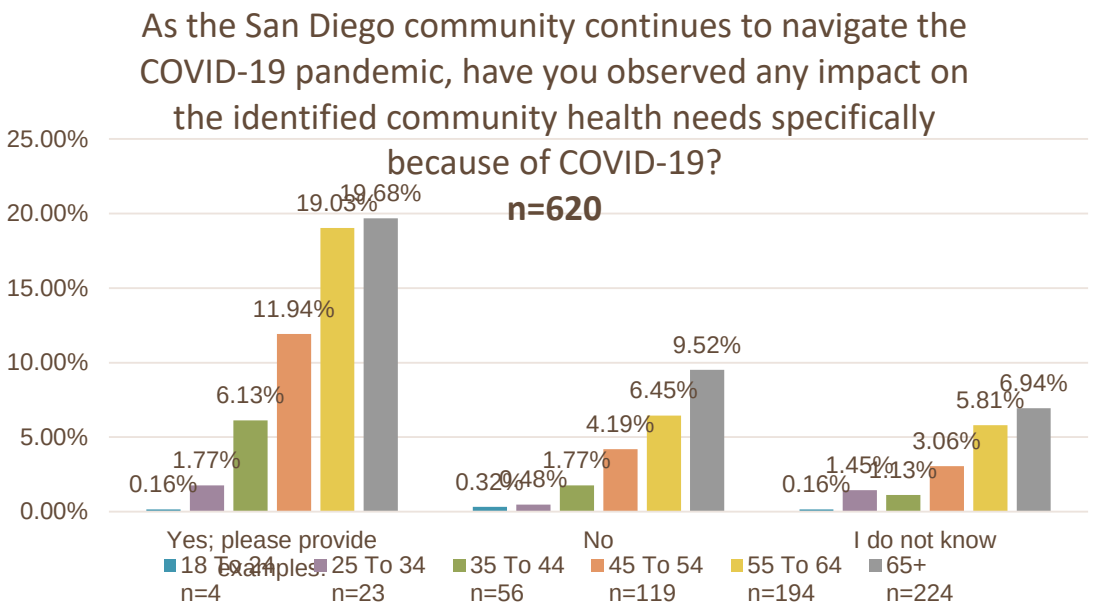
Question: How have you interacted with Sharp HealthCare in the past year?
Source: Sharp Insight Community – Invitation Survey and Community Health Needs Assessment Phase 2 Survey

Sharp Insight Community Recruitment

- Recruitment mostly done through social media advertisements
  - Advertisements posted on NBC, news websites, etc.
  - Most recruitment done through Facebook
- Last recruitment drive was conducted early 2019
  - Less than 50 people recruited

Age Breakout - Impact of COVID-19 on Community Health Needs

The following graph demonstrates age group breakouts for whether respondents observed impact on community health needs as a result of COVID-19. The percentages shown are out of total responses.

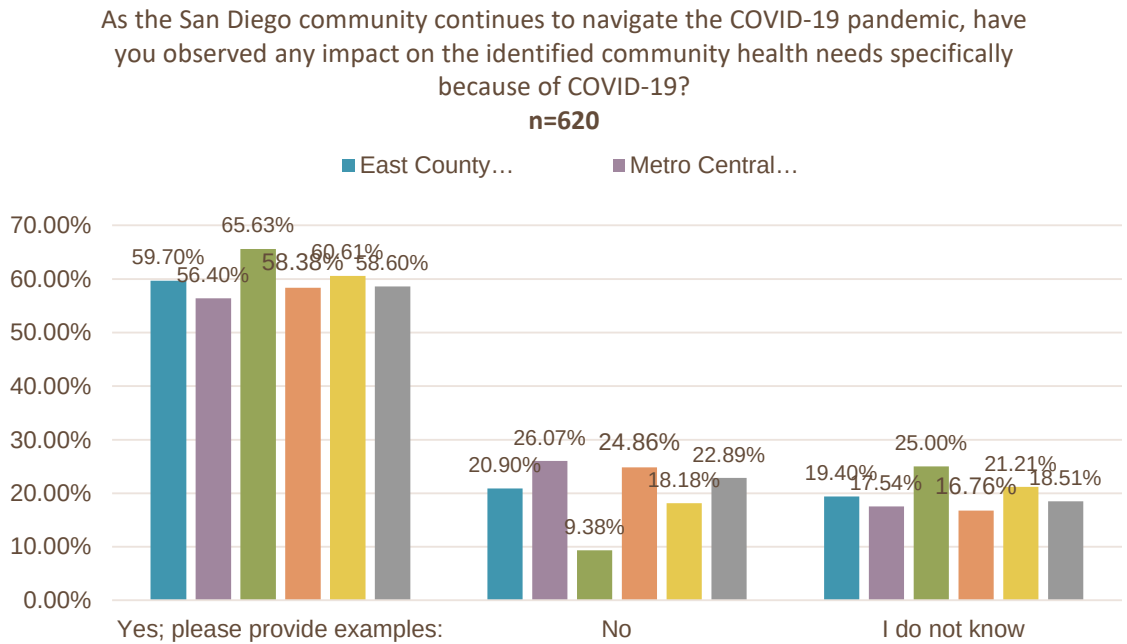


Result: The chi-square test demonstrates that there is no association between belonging to the 65+ age group and respondents observing an impact on the community health needs due to COVID-19.

Question: As the San Diego community continues to navigate the COVID-19 pandemic, have you observed any impact on the identified community health needs specifically because of COVID-19?
Total Survey Responses: n=620
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Regional Breakout- Impact of COVID-19 on Community Health Needs

The following graph demonstrates regional breakouts for whether respondents observed impact on community health needs as a result of COVID-19. The percentages are out of total responses per region.

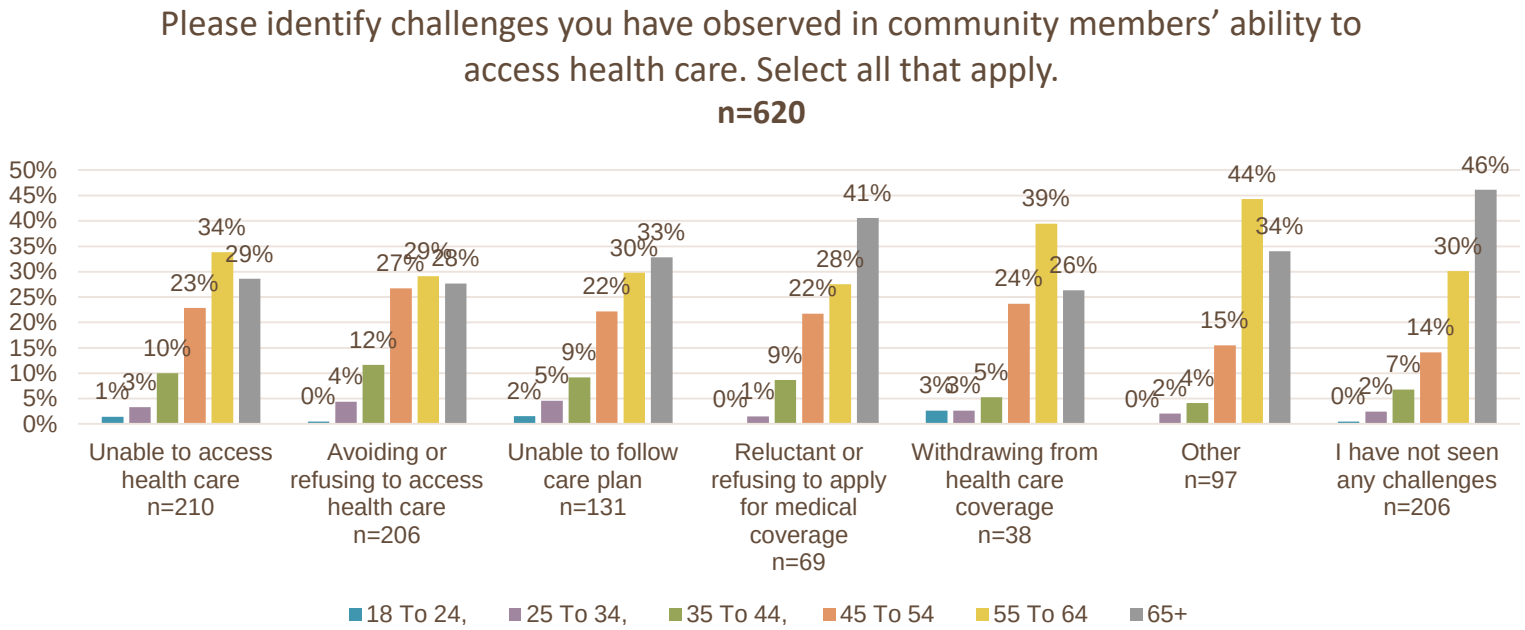


Result: The chi-square test demonstrates that there is no association between being from East County or South County and observing an impact on the identified community health needs specifically because of COVID-19.

Question: As the San Diego community continues to navigate the COVID-19 pandemic, have you observed any impact on the identified community health needs specifically because of COVID-19?
Total Survey Responses: n=620
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Age Group Breakout- Challenges in Access to Health Care

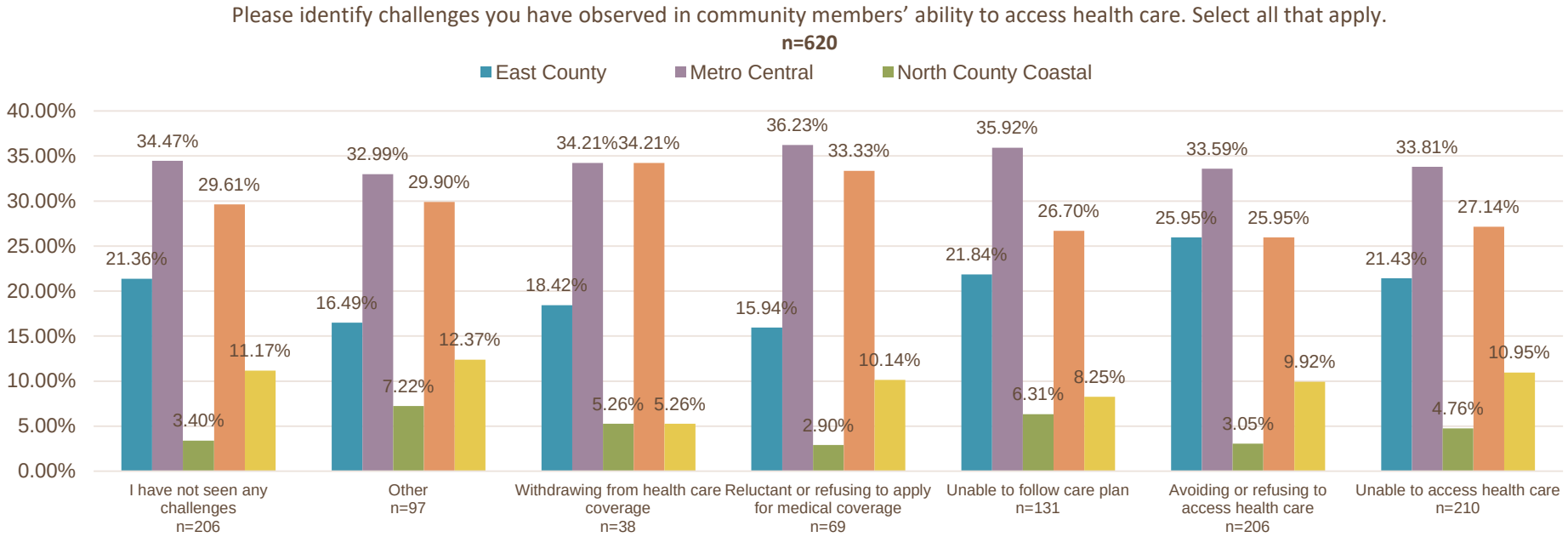
The following graph demonstrates age group breakouts for challenges observed in ability to access health care. The percentages are shown out of response options per selectable category.



Question: Please identify challenges you have observed in community members' ability to access health care. Select all that apply.
Total Survey Responses: n=620
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Region Breakout– Challenges In Access Health Care

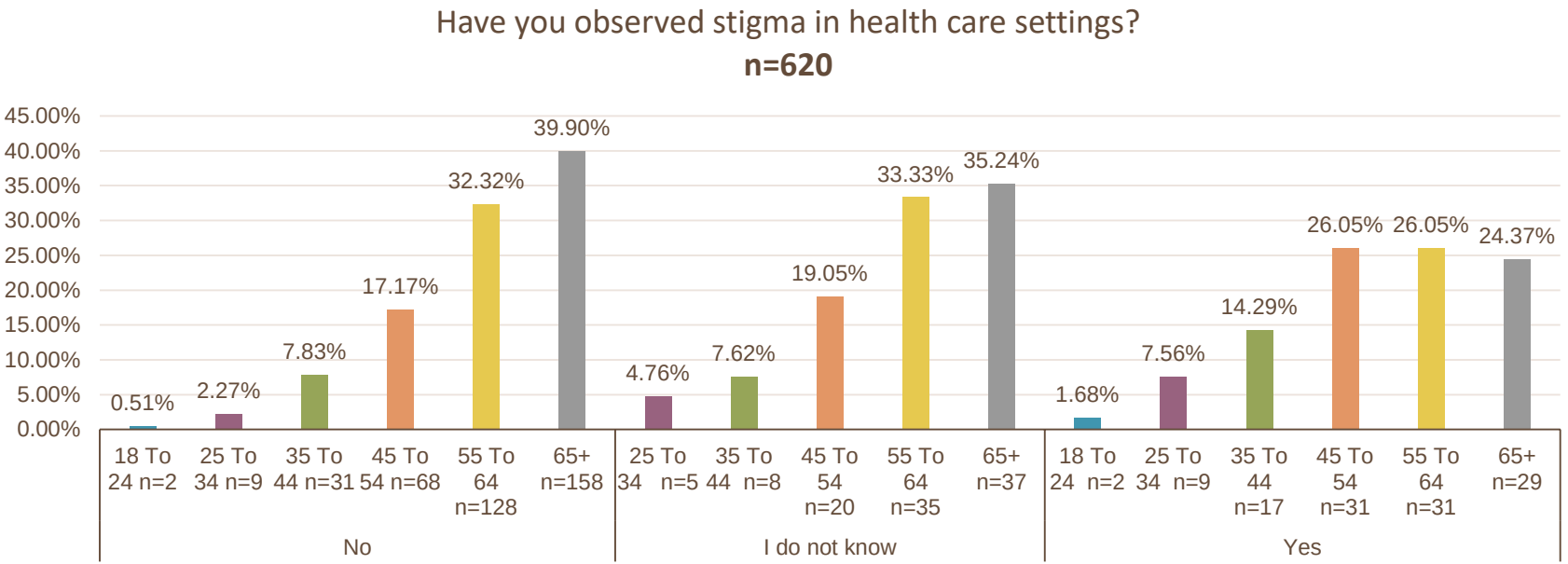
The following graph demonstrates regional group breakouts for challenges observed in ability to access health care. The percentages are shown out of response options per selectable category.



Question: Please identify challenges you have observed in community members' ability to access health care. Select all that apply.
Total Survey Responses: n=620
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Age Group Breakouts - Observing Stigma in Health Care Settings

The following graph demonstrates age group breakouts for whether stigma was observed in health care settings. Percentages reflect the proportion of respondents' selection.

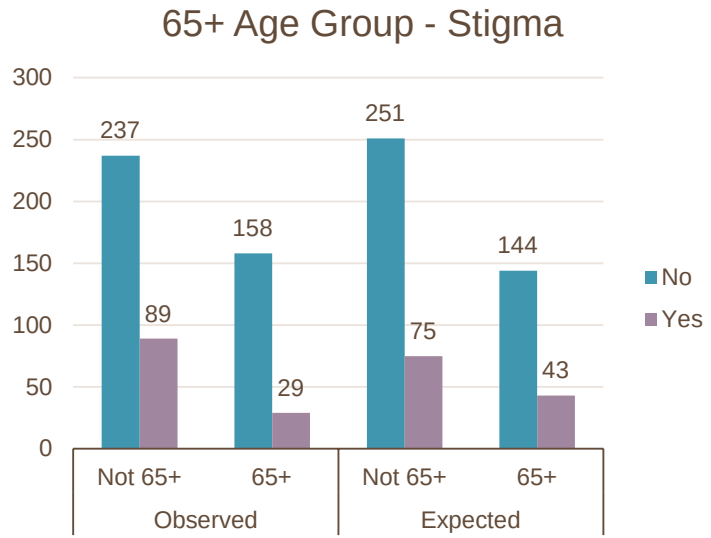


Question: Have you observed stigma in health care settings?
Total Survey Responses: n=620
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

65+ Age Group Breakout – Observing Stigma in Health Care Settings

Statistically Significant Differences

A chi-square test was performed to determine whether there is an association between the 65+ age group and observing stigma in health care settings. The observed frequency of the 65+ age group with regard to stigma was compared with the expected frequency of that particular field. The chart below represents these frequencies. Respondents who did not indicate age/region were excluded from the sample for significance testing. Respondents who selected "I don't know" were excluded from the sample for not being conducive to significance testing.

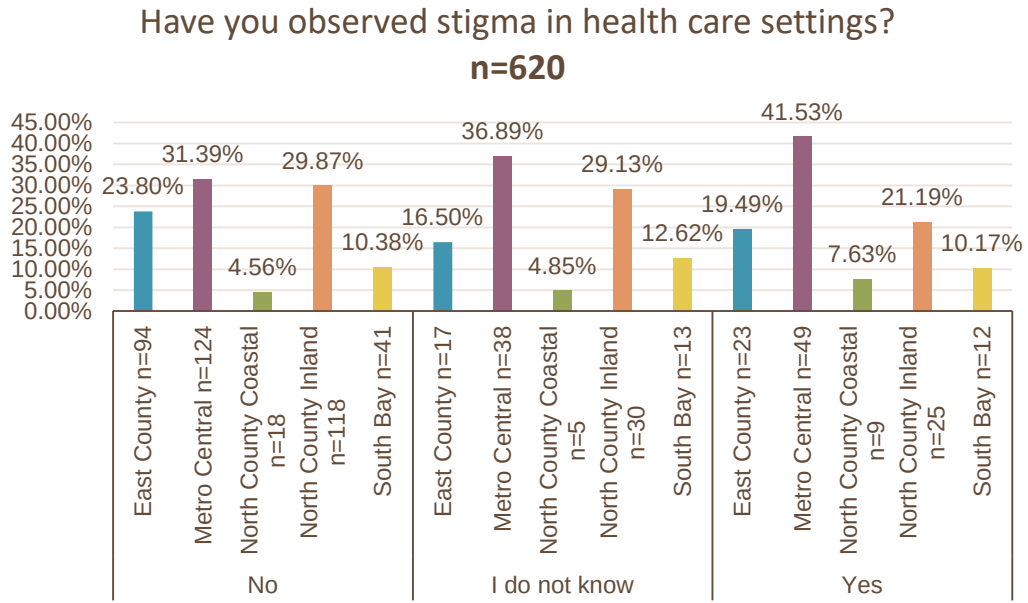


Result: The chi-square test demonstrates that there is an association between belonging to the 65+ age group and observing stigma in health care settings.

Question: Have you observed stigma in health care settings?
Sample Size: n=513
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey
Chi-square test details on Appendix A

Region Breakouts - Observing Stigma in Health Care Settings

The following graph demonstrates region breakouts for whether stigma was observed in health care settings. Percentages reflect the proportion of respondents' selection.



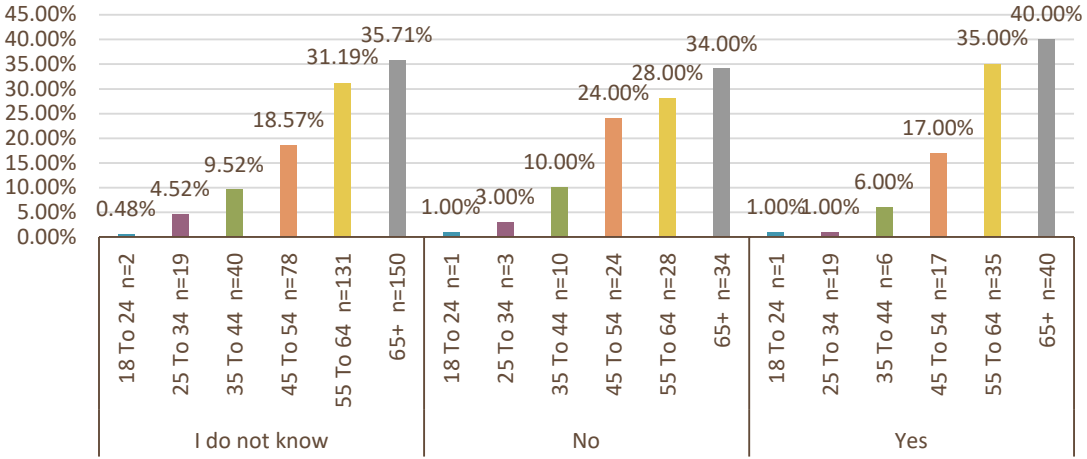
No statistically significant associations were found between being from the South Bay or East County and observing stigma in health care settings.

Question: Have you observed stigma in health care settings?
Total Survey Responses: n=620
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Age Group Breakouts - Immigration Status and Health Care

The following graph demonstrates age group breakouts for whether individuals in their community were having difficulty accessing health care due to their immigration status. Percentages reflect the proportion of respondents' selection.

Are individuals in your community having difficulty accessing health care due to their immigration status?
n=620

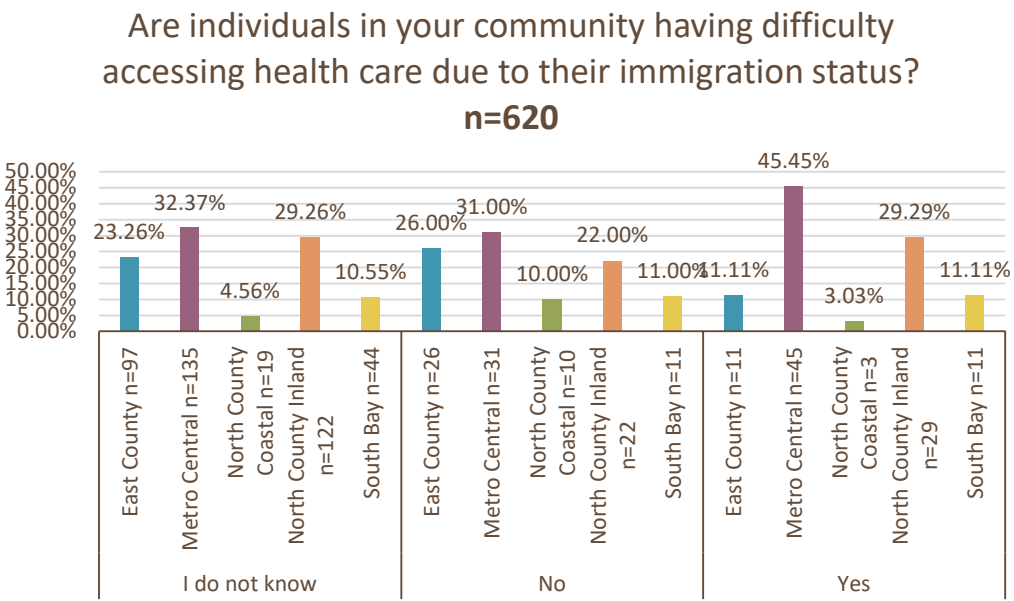


No statistically significant associations were found between belonging to the 65+ age group and noticing immigration status affect access to health care.

Question: Are individuals in your community having difficulty accessing health care due to their immigration status?
Total Survey Responses: n=620
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Region Breakouts - Immigration Status and Health Care

The following graph demonstrates regional breakouts for whether individuals in their community were having difficulty accessing health care due to their immigration status. Percentages reflect the proportion of respondents' selection.



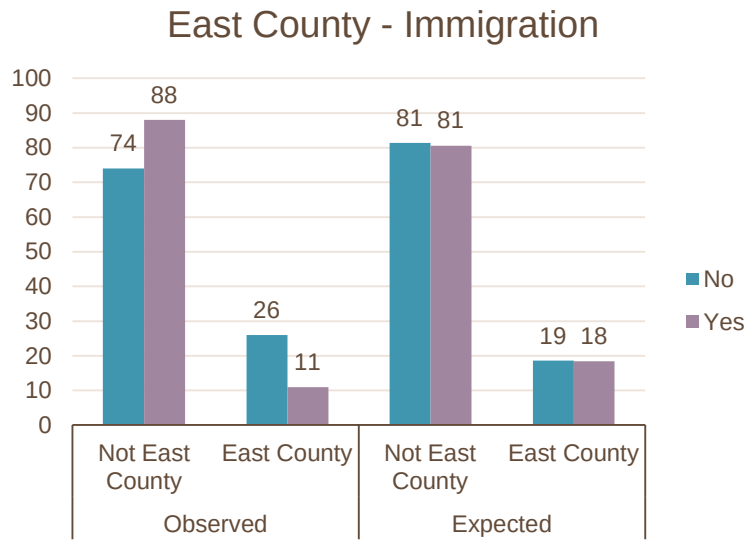
No statistically significant associations were found between being from the South Bay and noticing immigration status affect access to health care.

Question: Are individuals in your community having difficulty accessing health care due to their immigration status?
Total Survey Responses: n=620
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

East County Breakout – Immigration Status and Health Care

Statistically Significant Differences

A chi-square test was performed to determine whether there is an association between being from the East County group and noticing immigration status affect access to health care. The observed frequency of the East County group with regard to immigration was compared with the expected frequency of that particular field. The chart below represents these frequencies. Respondents who did not indicate age/region were excluded from the sample for significance testing. Respondents who selected "I don't know" were excluded from the sample for not being conducive to significance testing.

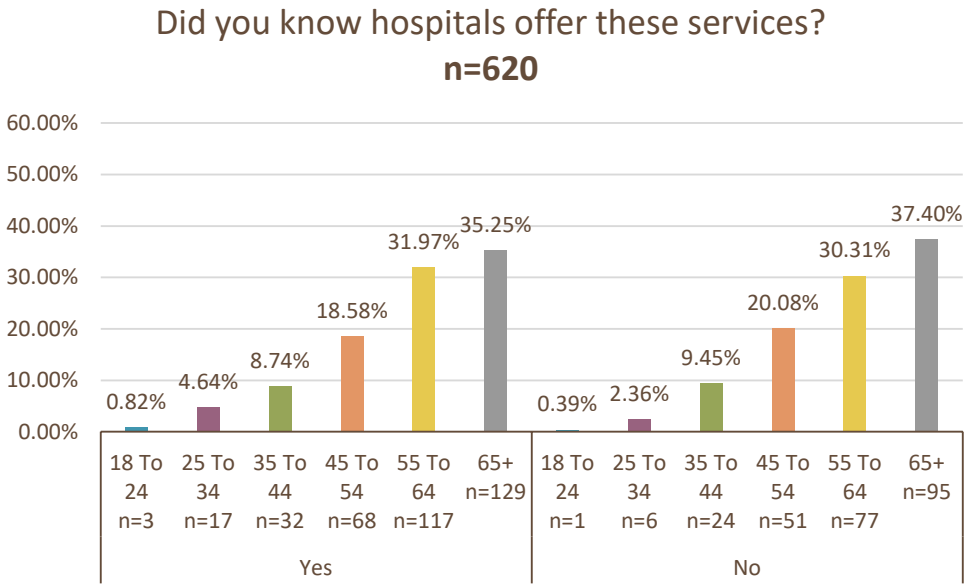


Result: The chi-square test demonstrates that there is an association between being from East County and noticing immigration status affect access to health care.

Question: Are individuals in your community having difficulty accessing health care due to their immigration status?
Total Survey Responses: n=199
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey
Chi-square test details on Appendix B

Age Group Breakouts - Awareness of Patient Financial Assistance Programs

The following graph demonstrates age group breakouts for whether individuals were aware of patient financial assistance programs. Percentages reflect the proportion of respondents' selection.

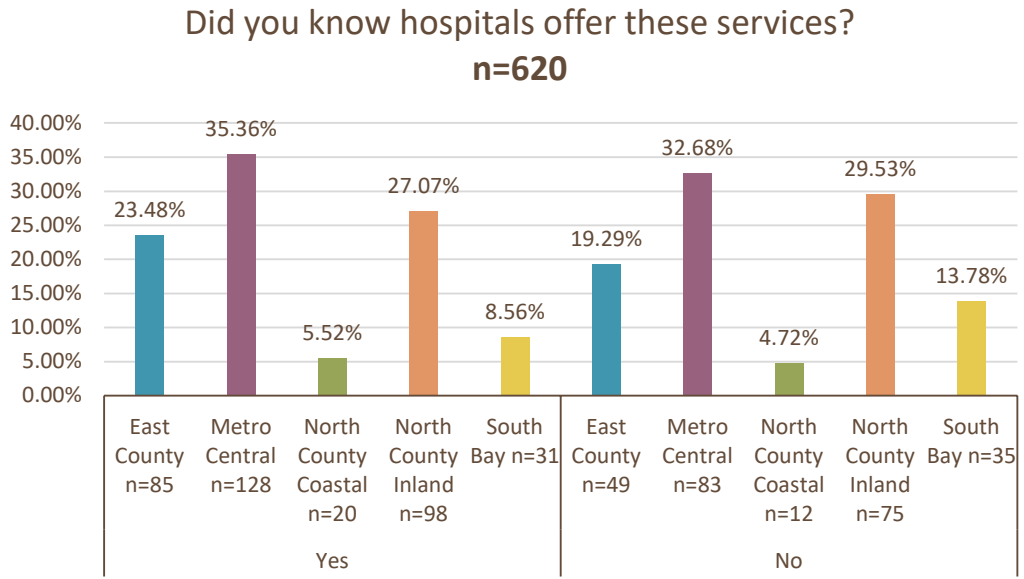


No statistically significant associations were found between belonging to the 65+ age group and being aware of patient financial assistance programs.

Question: Did you know hospitals offer these services?
Total Survey Responses: n=620
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Region Breakouts - Awareness of Patient Financial Assistance Programs

The following graph demonstrates regional breakouts for whether individuals were aware of patient financial assistance programs. Percentages reflect the proportion of respondents' selection.



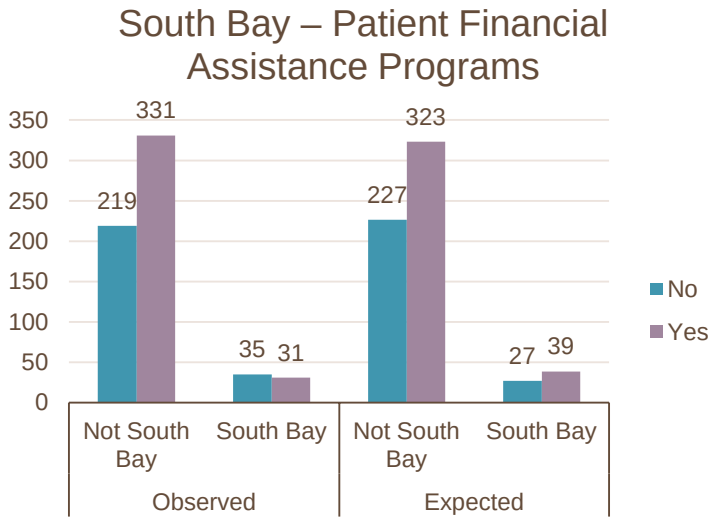
No statistically significant associations were found between being from East County and being aware of patient financial assistance programs.

Question: Did you know hospitals offer these services?
Total Survey Responses: n=620
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

South Bay Breakout – Awareness of Patient Financial Assistance Programs

Statistically Significant Differences

A chi-square test was performed to determine whether there is an association between being from the South Bay and being aware of patient financial assistance programs. The observed frequency of the South Bay group with regard to patient financial assistance programs was compared with the expected frequency of that particular field. The chart below represents these frequencies. Respondents who did not indicate age/region were excluded from the sample for significance testing. Respondents who selected "I don't know" were excluded from the sample for not being conducive to significance testing.



Result: The chi-square test demonstrates that there is an association between being from the South Bay and being aware of patient financial assistance programs.

Question: Did you know hospitals offer these services?
Total Survey Responses: n=616
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey
Chi square test details on Appendix C

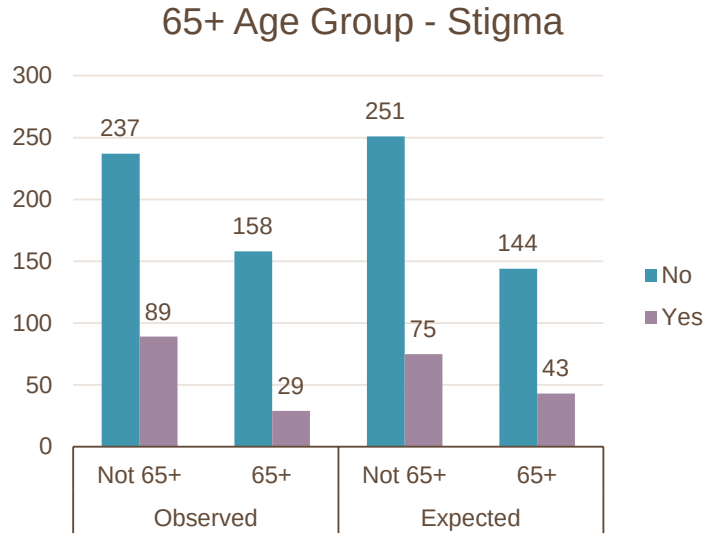
Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Appendix

65+ Age Group Breakout – Observing Stigma in Health Care Settings

Statistically Significant Differences

A chi-square test was performed to determine whether there is an association between the 65+ age group and observing stigma in health care settings. The observed frequency of the 65+ age group with regard to stigma was compared with the expected frequency of that particular field. The chart below represents these frequencies. Respondents who did not indicate age/region were excluded from the sample for significance testing. Respondents who selected "I don't know" were excluded from the sample for not being conducive to significance testing.



Hypothesis: There is an association between being 65+ and whether stigma is observed in health care settings.

Null hypothesis: There is no association between being 65+ and observing stigma in health care settings.

Significance Level	5%
Degrees of Freedom	1
Test Statistic	9.331
p-value	0.002
Critical Value	3.841

The p-value is below the significance level, therefore we reject the null hypothesis.

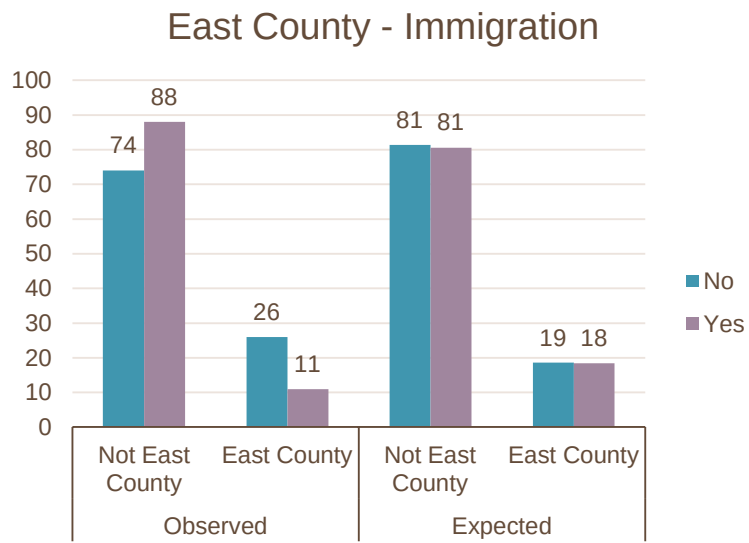
The chi-square test demonstrates that there is an association between belonging to the 65+ age group and observing stigma in health care settings.

Question: Have you observed stigma in health care settings?
Sample Size: n=513
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

East County Breakout – Immigration Status and Health Care

Statistically Significant Differences

A chi-square test was performed to determine whether there is an association between being from the East County group and noticing immigration status affect access to health care. The observed frequency of the East County group with regard to immigration was compared with the expected frequency of that particular field. The chart below represents these frequencies. Respondents who did not indicate age/region were excluded from the sample for significance testing. Respondents who selected "I don't know" were excluded from the sample for not being conducive to significance testing.



Hypothesis: There is an association between being from East County and noticing immigration status affect access to health care.

Null hypothesis: There is no association between being from East County and noticing immigration status affect access to health care.

Significance Level	5%
Degrees of Freedom	1
Test Statistic	7.286
p-value	0.007
Critical Value	3.841

The p-value is below the significance level, therefore we reject the null hypothesis.

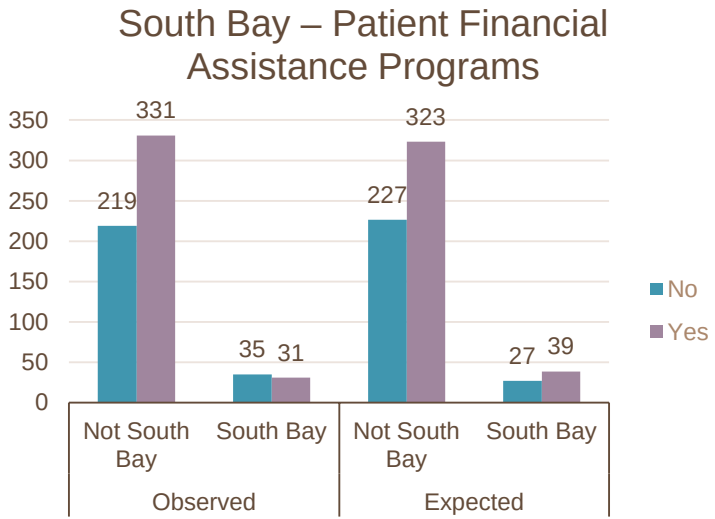
The chi-square test demonstrates that there is an association between being from East County and noticing immigration status affect access to health care.

Question: Are individuals in your community having difficulty accessing health care due to their immigration status?
Total Survey Responses: n=199
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

South Bay Breakout – Awareness of Patient Financial Assistance Programs

Statistically Significant Differences

A chi-square test was performed to determine whether there is an association between being from the South Bay and being aware of patient financial assistance programs. The observed frequency of the South Bay group with regard to patient financial assistance programs was compared with the expected frequency of that particular field. The chart below represents these frequencies. Respondents who did not indicate age/region were excluded from the sample for significance testing. Respondents who selected "I don't know" were excluded from the sample for not being conducive to significance testing.



Hypothesis: There is an association between from the South Bay and being aware of patient financial assistance programs.

Null hypothesis: There is no association between being from the South Bay and being aware of patient financial assistance programs.

Significance Level	5%
Degrees of Freedom	1
Test Statistic	4.245
p-value	0.039
Critical Value	3.841

The p-value is below the significance level, therefore we reject the null hypothesis.

The chi-square test demonstrates that there is an association between being from the South Bay and being aware of patient financial assistance programs.

Question: Did you know hospitals offer these services?
Total Survey Responses: n=616
Source: Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

Sharp Insight Community

Community Health Needs Assessment Phase 2

Survey Results

15%

Needs of Communities with Greater Health Inequities

Top needs identified by the 2019 CHNA:

- Access to Health Care
- Aging Concerns
- Behavioral Health
- Community and Social Support
- Cancer
- Chronic Conditions
- Economic Security
- Education
- Homelessness and Housing Instability
- Maternal and Prenatal Care, including High-Risk Pregnancy
- Unintentional Injury and Violence

81%

"Agreed" or "strongly agreed" that the needs listed were representative of the needs facing communities with greater inequity in San Diego County.

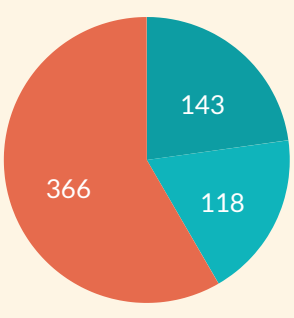
Community Health Needs

20% Of respondents mentioned **"access to care"** and **"fear of seeking care due to COVID-19"**

- 10% Vulnerable populations
- 10% Mental/behavioral health
- 9% Economic security/cost of care/insurance
- 9% COVID-19 Comments
- 8% Other
- 6% Agreed with the list provided
- 6% COVID-19 Testing/ Educational Resource Shortages
- 5% Other Social Determinants of Health

Impact of COVID-19 on Community Health Needs

58% **Observed** an impact on the community health needs due to COVID-19



- Did not observe an impact (22.81%)
- Did not know (18.82%)
- Observed an impact (58.37%)

- 36% Decreased access to healthcare
- 14% Decreased economic security
- 11% Vulnerable populations (Aging, chronic conditions, homelessness)
- 10% Mental/Behavioral health/Social suppport at point of care
- 8% Difficulty obtaining essential good and information
- 7% Fear of seeking care
- 4% Mental/Behavioral health/Social suppport at point of care
- 3% Disparities in the community

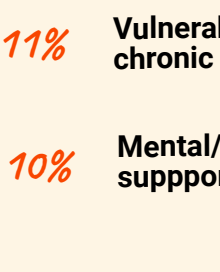
CHALLENGES IN ACCESS TO HEALTHCARE

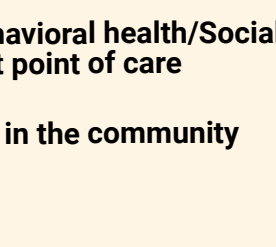
- 22% Unable to access healthcare
- 22% Avoiding or refusing to access health care
- 22% I have not seen any challenges
- 14% Unable to follow care plan
- 10% Other
- 7% Reluctant or refusing to apply for medical coverage

(select all that apply)

STIGMA

19% Observed stigma in health care settings of respondents





Stigma Observations

- 26% Mental/behavioral health stigma
- 18% Other
- 17% Racial disparities/racial bias

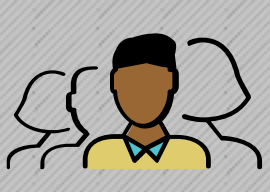
Community efforts at reducing stigma

- 35% Advertisements/media
- 20% Community efforts
- 19% Medical facility efforts

Advice to address stigma

- 28% Hospital/Staff Employee Education
- 13% Other
- 9% Increased communication

IMMIGRATION STATUS



68%

DID NOT KNOW IF INDIVIDUALS IN THEIR COMMUNITY WERE HAVING DIFFICULTY ACCESSING HEALTH CARE DUE TO THEIR IMMIGRATION STATUS

PATIENT FINANCIAL ASSISTANCE PROGRAMS

59% RESPONDENTS AWARE OF FINANCIAL ASSISTANCE PROGRAMS

Financial Assistance Program Awareness Sources

- 26% Advertisements/ Media
- 20% Through work experience
- 14% Common knowlege
- 13% Family/friends
- 12% Previous personal experience
- 8% At point of care
- 7% Billing process
- 3% Non technological advertisements
- 1% Other
- 1% Community Outreach

Informing the Public about Patient Financial Assistance Programs

- 29% Social Media
- 25% Website
- 27% Email
- 20% Mail
- 17% Newsletter
- 12% Other

Of the 12% who selected "other", 68% suggested using advertisements/media

CHNA UPDATES

Communicating Future CHNA Updates

- 79% Email
- 42% Digital Newsletter
- 32% Social Media
- 24% HASD&IC Public Website
- 15% Other

86% of respondents named **Facebook** as the most noted social media outlet

72% of respondents who chose "other" named **non-technological and technological advertisements/media** as the best mode of communication

Appendix

G 2019 Sharp CHNA Community Guide

Sharp HealthCare Community Health Needs Assessment Guide

SHARP

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.

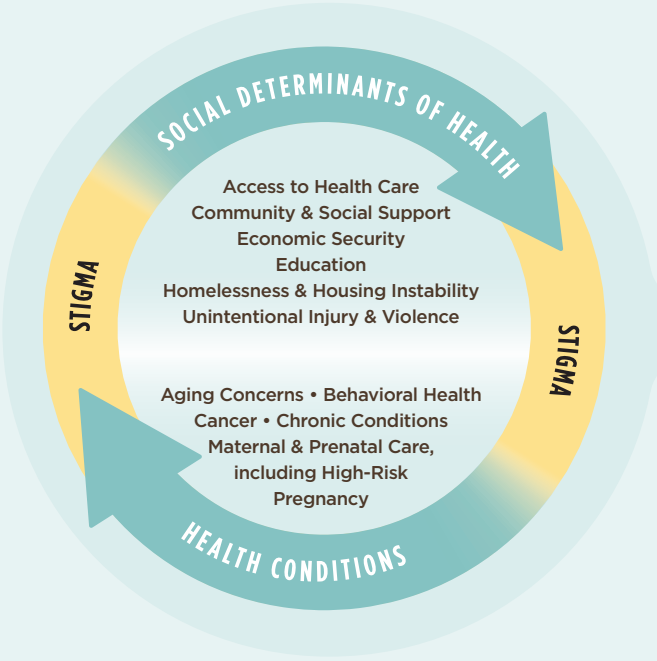
To address these new requirements, since 2013, Sharp has partnered with other hospitals and health care systems in San Diego County to create a collaborative, countywide CHNA — an effort led by the Hospital Association of San Diego and Imperial Counties (HASD&IC) and in contract with the Institute for Public Health (IPH) at San Diego State University. The collaborative CHNA provides the foundation for the development of CHNAs for each Sharp hospital.

In 2019, Sharp contracted separately with IPH to develop tailored CHNAs through two phases:

Phase 1

Sharp conducted focus groups, interviews and an online survey 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 better understand the unique needs of individuals who live in the communities it serves. Phase 1 findings identified the priority needs, including health conditions and social determinants of health (SDOH — conditions in the places where people live, learn, work and play)[1] highlighted in the figure below.

Sharp 2019 CHNA — Identified Priority Health Needs



The figure illustrates the interactive nature of SDOH and health conditions — each influencing the other. The 2019 CHNA community engagement activities also revealed an underlying theme of stigma, which will be analyzed further in Phase 2 of the CHNA.

Phase 2

Upon the completion of Phase 1, Sharp distributed online surveys to Sharp providers, patients and community members who participated in the Phase 1 CHNA process, in order to collect feedback on the 2019 CHNA findings and process, including input on the identified needs. This feedback helps guide planning for future CHNAs, as well as programs to address those identified needs.

[1] https://www.cdc.gov/socialdeterminants/index.htm

Annual Implementation Strategy

In response to the 2019 CHNA findings, each Sharp hospital created an implementation strategy that highlights the programs, services and resources provided by the hospital to address the identified priority health needs in its community. The table below presents an overview of the types of strategies offered by Sharp. To view the entire implementation strategy for each Sharp hospital, please visit **sharp.com/about/community/health-needs-assessments.cfm**.

Strategy	Identified Community Need					
	Social Determinants of Health					
	Access to Health Care	Community & Social Support	Economic Security	Education	Homelessness & Housing Instability	Unintentional Injury & Violence
Community education and resources through health fairs, seminars, lectures, educational classes, conferences and events	✔	✔	✔	✔		✔
Clinical community linkage programs	✔	✔	✔		✔	✔
Collaboration with community organizations	✔	✔	✔	✔	✔	✔
Education/training for staff and community health professionals	✔	✔	✔	✔	✔	✔
Flu shots	✔	✔				
Screening programs	✔	✔	✔	✔	✔	
Support groups/programs	✔	✔	✔			✔

Strategy	Health Conditions						
				Chronic Conditions			
	Aging Concerns	Behavioral Health	Cancer	Cardiovascular Disease	Diabetes	Obesity	Maternal & Prenatal Care (including High-Risk Pregnancy)
Community education and resources through health fairs, seminars, lectures, educational classes, conferences and events	✔	✔	✔	✔	✔	✔	✔
Clinical community linkage programs	✔	✔	✔	✔	✔	✔	✔
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)	✔	✔	✔	✔			✔

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 Erica Salcuni, Manager, Community Benefit and Health Improvement, at erica.salcuni@sharp.com.

A Health Care Organization Designed Not For Profit, But For People

Appendix

H Sharp 2022 Clinical Data Analytics

Project Overview: To support the Sharp HealthCare (Sharp) 2022 Community Health Needs Assessment (CHNA) process, Clinical Analytics developed content to support investigation into key questions or issues related to the health and wellbeing of Sharp patients and the local San Diego community.

Stakeholder/Customer(s): Sharp Community Benefit, Clinical Effectiveness, Sharp Rees-Stealy Medical Group, Sharp Community Medical Group, Oncology and Behavioral Health service line leadership and the System Emergency Department (ED) Collaborative

Project Goals and Planned Actions: Sharp's CHNA is a report issued every three years, which supports Sharp's community pillar — one of seven Pillars of Excellence that provide the foundation for Sharp vision to transform the health care experience. For more information on Sharp's Pillars of Excellence, see **Appendix B: An Overview of Sharp HealthCare**. Through the 2022 CHNA process, Sharp will be able to analyze data for key questions related to the needs of our community. Ultimately, the data will be used to assist in the development of programs and services to support the health of the community, including strategies to address health equity.

Analytics Deliverables: Clinical Analytics created a full report including data tables, visualizations, and narratives to provide effective data storytelling.

Key Business Requirements and Metrics:
Data Source(s): Hospital and clinic electronic medical record and claims data, managed care enrollment, clinical registries

Population Definition:
Relevant Date(s): Include patients discharged between fiscal year 2016 and 2021 (FY 2016 and FY 2021), to allow for a five-year view to analyze trends for activity or behavior prior to and during the COVID-19 pandemic

Topics of Interest:[208]

1) For all Sharp hospital visits (ED, outpatient, and inpatient), has there been an increase in the percentage of patients with a behavioral health or substance use diagnosis (regardless of primary reason for the visit)?

2) What is the overall trend of oncology screening visit volumes, specifically for mammogram and colonoscopy? Have visit volumes recovered since the onset of

[208] All data includes race, ethnicity, gender, home zip code, and primary language spoken data elements to allow for basic equity analysis.

the COVID-19 pandemic? What are the effects of these volume trends? Analysis includes:

   a. Analysis of trends among new onset cancer diagnoses by stage

3) Are patients' health conditions worsening due to lack of care during the pandemic? What are the mortality trends for non-COVID patient populations during the pandemic?

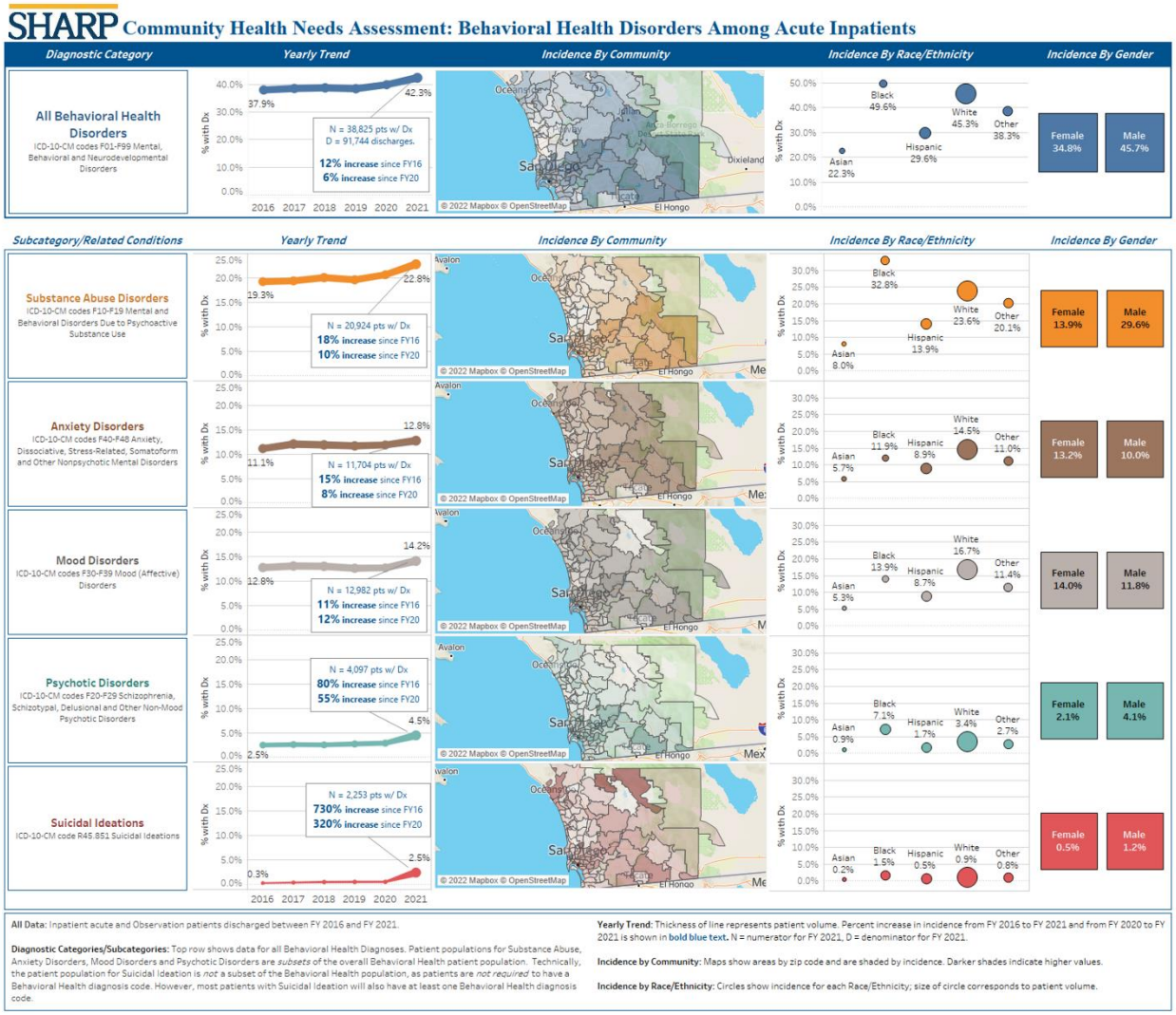
4) How do comorbid conditions (i.e. hypertension, diabetes, obesity) affect outcomes for COVID-19 patients? Analysis includes:

   a. Likelihood of inpatient hospital admission based on certain comorbidities
   b. Likelihood of requiring intensive care unit (ICU) or Critical Care treatment based on certain comorbidities
   c. Likelihood of survival to discharge based on certain comorbidities

Sharp 2022 CHNA Clinical Analytics: Key Takeaways

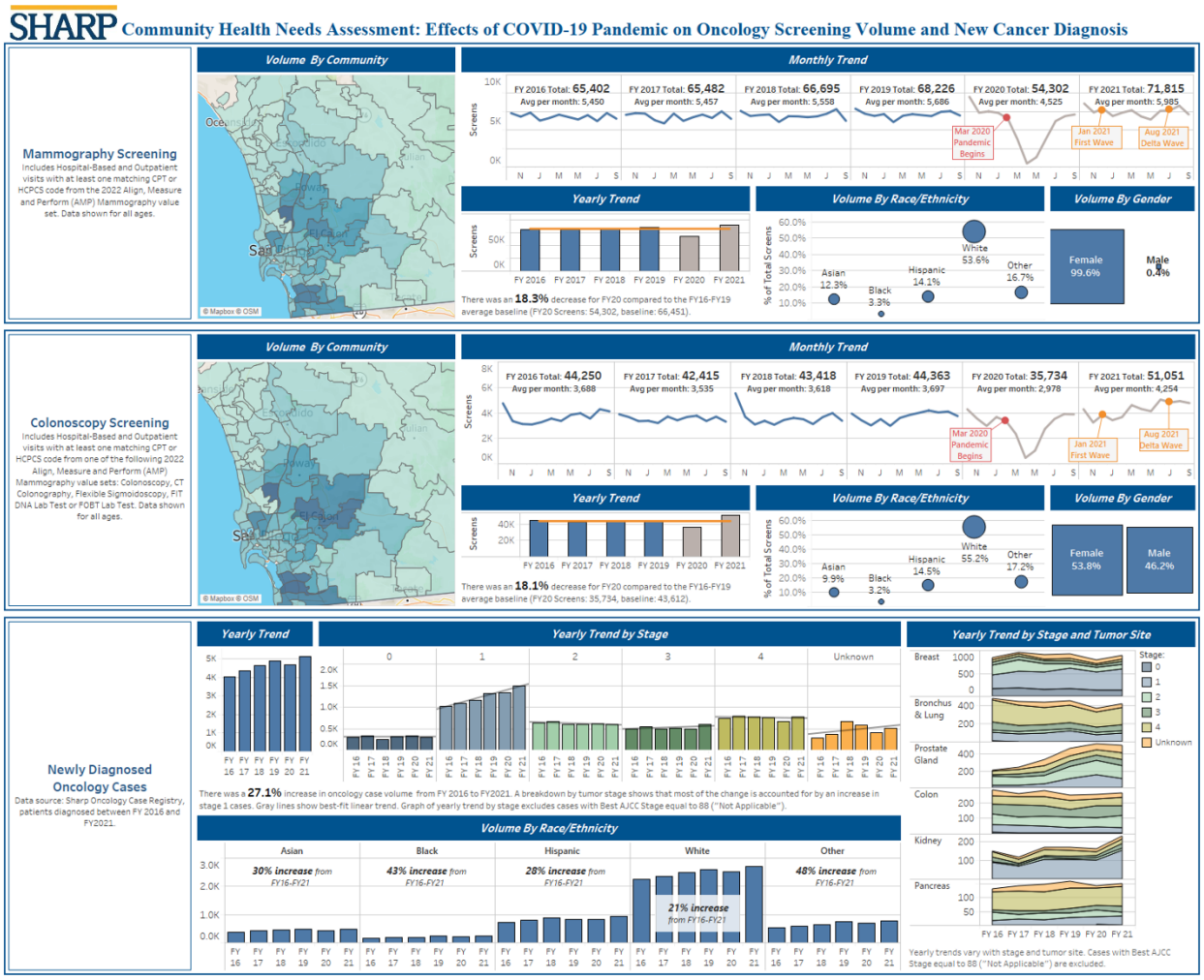
Behavioral Health Disorders among Acute Inpatients

In FY 2021, Sharp's acute care hospitals admitted over 38,000 individuals as inpatients with a behavioral health diagnosis. This is a steady increase year-over-year from FY 2016. This increase is likely the result of both improved documentation and actual disease prevalence in the community. Follow-up actions are being planned with Sharp behavioral health leadership on how to create a shared vision to address the growing behavioral health disease burden among the inpatient population.



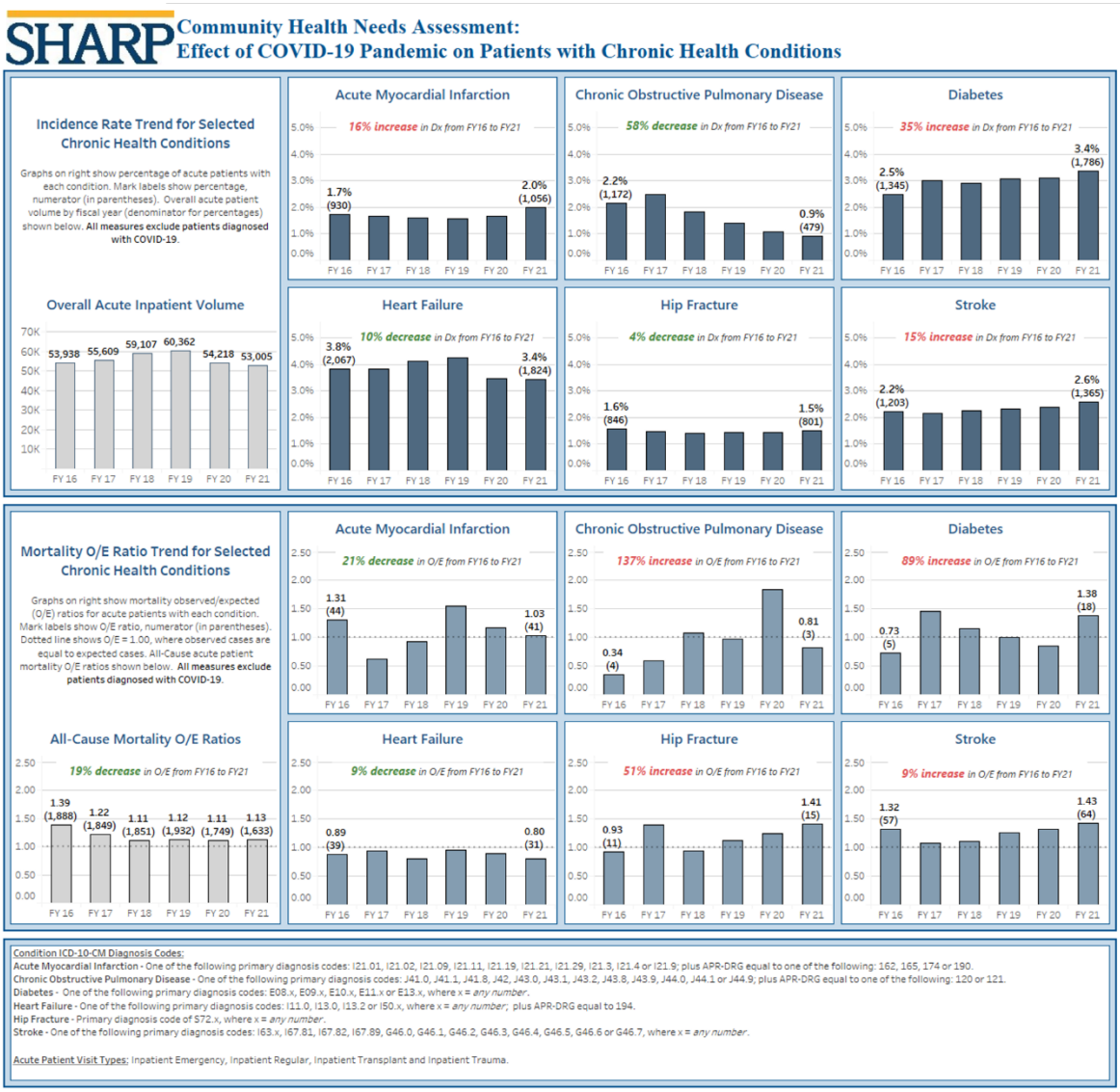
Impact of COVID-19 Pandemic on Oncology Screening Volumes and New Cancer Diagnoses

As expected, screening volumes dipped significantly during the COVID-19 pandemic. While there has been a rise in stage 1 cancer diagnoses, this is a continued trend from previous years and may or may not be related to the reduction in screenings from the previous year. More time and analysis is needed to assess the impact of the screening reduction on oncology patient volumes.



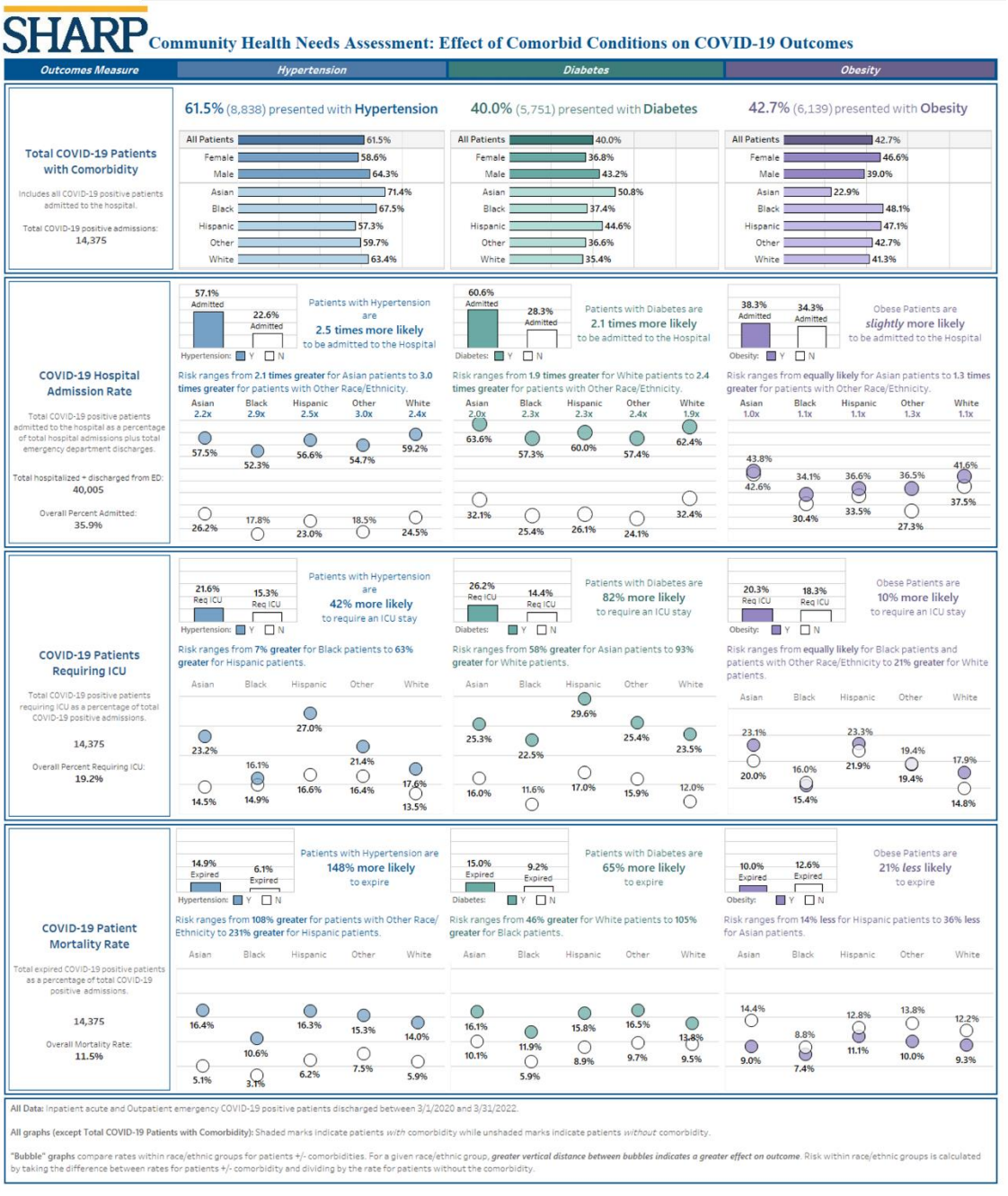
Effect of COVID-19 Pandemic on Patients with Chronic Health Conditions

Examining observed to expected mortality (O/E) ratios[168] during the time period FY 2016 to FY 2021, there was an increase in deaths due to chronic obstructive pulmonary disease, diabetes, acute myocardial infarction, and hip fracture. There was a slight increase in deaths due to stroke and a slight decrease in deaths due to heart failure. However, further analysis is needed to determine if this variation is statistically significant.



Effect of Comorbid Conditions on COVID-19 Outcomes

Among COVID-19 patients admitted to the hospital, 61% presented with hypertension, 39% presented with diabetes, and 43% presented with obesity. Patients presenting to the ED with COVID-19 and hypertension are 2.5 times as likely to be admitted to the hospital compared to patients with COVID-19 without hypertension. There was a varying risk breakdown by race and ethnicity for hypertension, diabetes, and obesity. Patients with diabetes were much more likely to require a stay in the ICU. COVID-19 patients with hypertension and diabetes had higher mortality rates than those without those conditions. Further analysis is required to fully understand these trends.



Appendix

I IPH Sharp Provider/Human Resources 2022 CHNA Survey & Findings

SHARP 2022 COMMUNITY HEALTH NEEDS ASSESSMENT

Sharp Patient and Employee Electronic Survey Results

FEBRUARY 2, 2022

INSTITUTE FOR PUBLIC HEALTH
San Diego State University

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Executive Summary

Sharp Healthcare's triennial Community Health Needs Assessments (CHNAs) enable Sharp to take a community-informed approach to program planning and meet the requirements of California Senate Bill 697 of 1994 and the Patient Protection and Affordable Care Act of 2013, which mandate CHNAs for not-for-profit hospitals and health care systems. Sharp's 2022 CHNA process focused on the impact of the COVID-19 pandemic. It also touched on telemedicine and the impact of Sharp employee education efforts. Two surveys were distributed to Sharp staff. The first assessed the impact of COVID-19 on Sharp *patients* (Survey One), and the second assessed the impact on Sharp *employees* (Survey Two). A total of 108 employees representing different Sharp entities and occupations completed the surveys.

Survey One results showed that COVID-19 has had significant, serious effects on the needs of Sharp patients. The patient needs identified as most concerning related to behavioral health: increased isolation among seniors; increased rates of anxiety and depression; and decreased access to emotional and social support and behavioral health services. Respondents indicated that certain populations have been especially impacted by COVID-19 (e.g., seniors, people with limited English proficiency, racial/ethnic minorities among others), but respondents also noted that the pandemic's impact is pervasive, affecting all patients.

Survey One respondents gave many examples of Sharp programs and resources that address these needs, including education, referrals for case management and other services, patient outreach and follow-up, and behavioral health telehealth options. However, most respondents believed that more efforts are critical. They proposed suggestions around increasing "human contact" in order to better meet patient needs. Implementing more follow-up calls, home visits, caregiver support, and strategies for safe visitation during the pandemic were frequent recommendations. Further, respondents emphasized that Sharp must seek to increase the number and availability of behavioral health providers — including those who speak patients' primary languages — and to decrease access barriers to these providers.

Survey One also queried employees about the use of telemedicine, specifically virtual video visits. Results showed that virtual video visits are not always easy for patients to use due to lack of access, knowledge and affordability, as well as unreliable technology. In addition, many patients prefer in-patient visits. Nearly all respondents agreed, however, that telehealth modalities – including video and phone – are potentially beneficial to patients.

Survey Two findings highlighted serious concerns about the well-being of Sharp employees, particularly their levels of anxiety, stress, depression, and frustration. Respondents indicated that employees are more likely to wish to change careers or leave the workforce, are more isolated, urgently need access to behavioral health assistance and have limited access to emotional and social supports. Most respondents believed that these concerns will not lessen in the coming year.

Sharp has implemented solid strategies to address employee anxiety, stress, and frustration through programs like the Employee Assistance Program (EAP), Best Health, Safe Speak, leadership development, and wellness resources. However, Survey Two participants noted that Sharp lacks adequate efforts to address the increased

desire to change careers or leave the workforce. Suggestions to better meet employee needs included expanding current mental health supports, increasing communication about available behavioral health services, hiring more staff, offering on-site childcare, making EAP entity-based rather than centralized, increasing communication between employees and leadership, work-life balance programs, reevaluating the compensation philosophy, better new graduate programs, and flexibility in hiring new staff. Survey respondents recognized that Sharp has many competing priorities that inhibit or complicate the implementation of these recommendations, including finances, inadequate staffing, staff and leadership being stretched too thin, space, COVID-related restrictions, interest, and pressure about patient satisfaction scores.

Both surveys asked respondents to comment on their utilization of educational opportunities at Sharp. Most respondents attended educational sessions, and the most popular sessions included Leadership Development, Safe Speak, and Current Conversations. For those who were unable to attend, work schedule conflicts were the primary reason given. Respondents shared that Sharp's current educational opportunities better prepared them to meet patient needs, relate to patients and fellow team members, and to protect their own mental health and well-being. Respondents identified care in the senior community, defining and applying cultural humility, and implicit/unconscious bias and its impact on decision making as the topics of greatest interest for future educational sessions.

I. Introduction

Since 1995, Sharp Healthcare (Sharp) has conducted triennial needs assessments in the community to identify the priority health needs of the people and communities Sharp serves. These Community Health Needs Assessments (CHNA) serve two purposes: (1) they allow Sharp to take a community-informed approach to program planning, including the creation of new programs and the expansion or modification of existing programs; and (2) they meet the requirements of both California Senate Bill 697 of 1994, which requires California not-for-profit hospitals and health care systems to complete triennial CHNAs, as well as the Patient Protection and Affordable Care Act of 2013, which mandates CHNAs for **all** not-for-profit hospitals and health care systems in the U.S..

The focus of the 2022 CHNA was informed by the significant, severe consequences of the global COVID-19 pandemic on both the community and the health care system. As of February 2022, 8.4 million people in California have reportedly tested positive for COVID-19, and more than 80,000 have died.[1] In San Diego County alone, nearly 700,000 people have tested positive for COVID-19, and 4,686 have died.[2] The ongoing emergence of new variants of COVID-19 lends even more urgency to this issue as hospitals and health care systems, Sharp among them, grapple with how to meet the ongoing demands on its providers and systems while continuing to provide the highest quality of health care to a growing patient population with more intense needs.

In May of 2020, as part of Phase 2 of the 2019 Sharp CHNA, a small survey was conducted with 16 Sharp employees. Results from the survey clearly showed that COVID-19 was already negatively affecting the community; three-quarters of respondents (75.0%) indicated that they observed some impact on the CHNA-identified community health needs due to COVID-19. In that survey, participants noted that a number of areas of community need had been affected by COVID-19, including access to health care, aging concerns, behavioral health, cancer, community and social support, economic security, education, housing instability and homelessness, maternal health, and stigma.

The 2022 CHNA, described in part in this report, built on these data to create a more comprehensive assessment of the current state of health and well-being for the patients, employees, and community members served by Sharp. Two surveys were created. The goal of the first (called Survey One in this report) was to further understand Sharp employees' perceptions about how COVID-19 is affecting their patients, Sharp's existing efforts to address these effects, and ideas about how to better serve the patient population.

It is becoming increasingly evident that COVID-19 is also taking a toll on health care workers and those working within health care systems.[3] Sharp's 2022 CHNA, thus also included a focus on the needs of these essential workers. The goal of the second survey (Survey Two) was to garner information about the needs of Sharp employees based on the perspective of non-clinical Sharp employees who manage human resource and other

[1] https://www.nytimes.com/interactive/2021/us/california-covid-cases.html
[2] https://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/community_epidemiology/dc/2019-nCoV/status.html

employee-related functions. The methods utilized and the findings from both surveys are presented in this report.

Sharp contracted with the San Diego State University (SDSU) Institute for Public Health (IPH) to design the survey instrument and analyze and report results.

II. Methodology

Survey questions were developed in collaboration between Sharp and SDSU IPH and focused on the impact of COVID-19 on patients and employees (see Appendix B and Appendix D for a copy of both surveys). Question design was informed by survey findings from phase two of the 2019 CHNA.

The survey was created in Qualtrics, a survey software, and distributed via an emailed link to two sets of Sharp employees. Survey One was distributed to a set of clinical employees who have extensive knowledge about patient well-being, including case managers and case management leadership, cancer navigators, social workers, diabetes educators, and others who came from a variety of Sharp entities including Sharp Community Medical Group, Sharp Grossmont Hospital, and Sharp Memorial Hospital. Survey Two was distributed to employees who are focused on employee-related services, primarily human resources teams from Sharp System Services.

The link for Survey One was emailed to employees on October 6, 2021, and the link for Survey Two was emailed October 12, 2021. Each email included an explanation about the purpose of the survey and instructions for completion. A reminder to complete the survey was emailed a week later. The survey closed on October 22, 2021.

Descriptive statistics were utilized to analyze the results of all close-ended survey questions. Percentages were calculated based on the total number of survey participants responding to the question. Content analysis was utilized for open-ended questions, and results were grouped into categories and themes.

III. Survey One Results: Patient Impacts

Sharp HealthCare Representation and Entity Affiliation

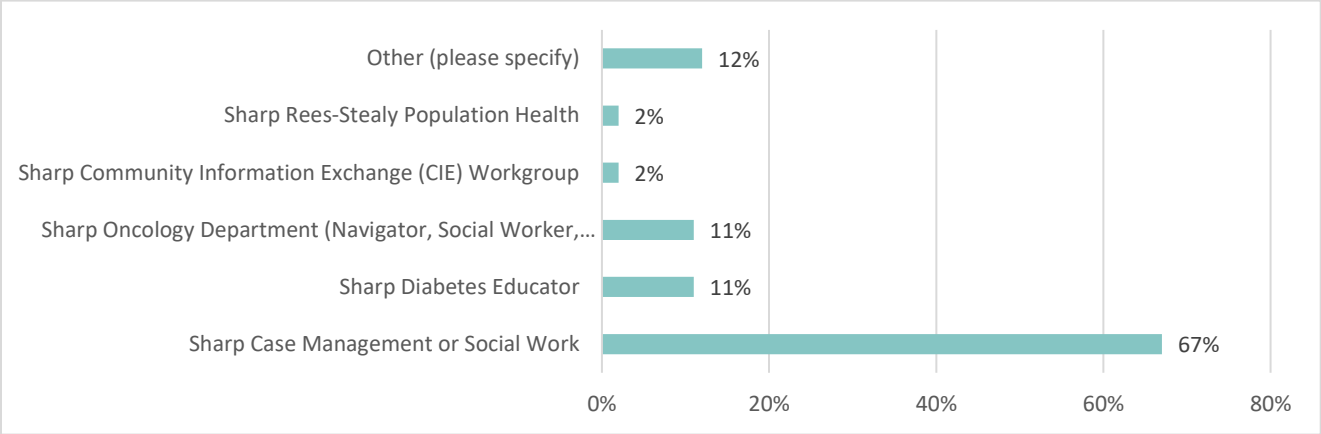
The first survey (Survey One) focused on the impact of COVID-19 on patients, and 92 employees responded.

Question 1. Sharp HealthCare Representation (n=92)

Who/what group do you currently represent at Sharp HealthCare? (check all that apply)

As seen in the Figure 1 below, the majority of respondents (67%) indicated that they were social workers or case managers. Other representation included Sharp Oncology Department (11%), Diabetes Educators (11%), Sharp Community Information Exchange (2%), Sharp Rees-Stealy Population Health (2%), and other (12%). Other groups listed included: Behavioral Health Unit; Geriatric Emergency Department at Sharp Grossmont Hospital; Hospice and Palliative Care; Intern for Social Work; Patient Access Services II; Registered Nurse Supervisor Sharp Mesa Vista Hospital Outpatient Services; Sharp Community Medical Group Case Management; Sharp Addiction Medicine Service Line; Sharp HealthCare Clinical Effectiveness, Admin; Sharp Mesa Vista Mental Health Outpatient; and Sharp Psychiatric Outpatient.

Figure1. Sharp HealthCare Representation

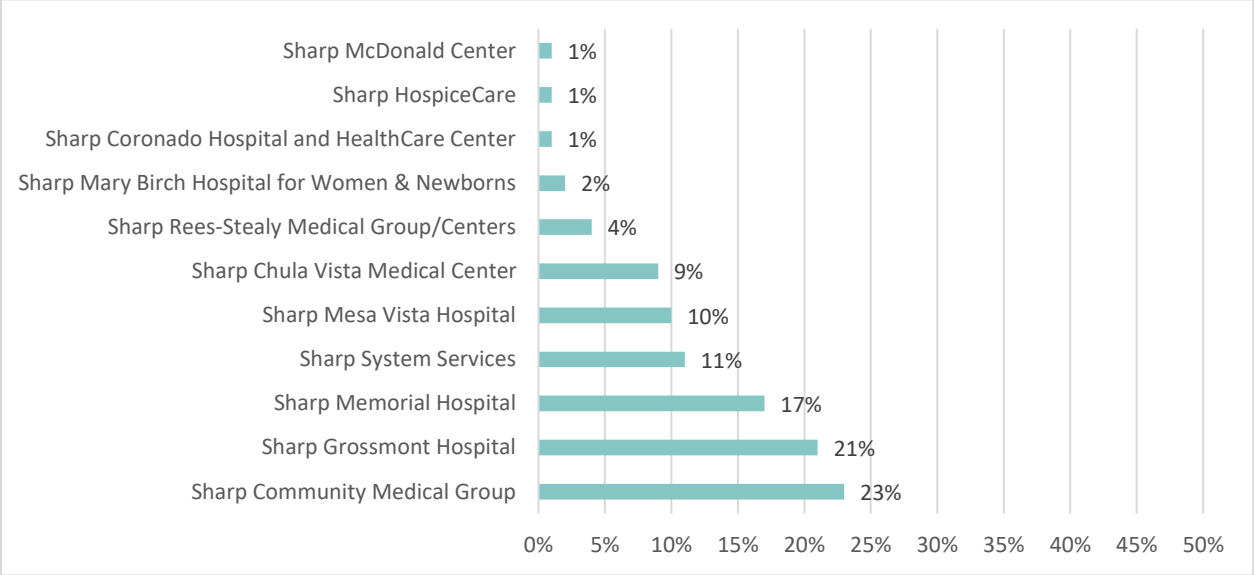


Question 2. Sharp Entity Affiliation (N=92)

What Sharp entity are you affiliated with?

Survey One respondents came from a variety of Sharp HealthCare entities, including Sharp Community Medical Group, (23%) Sharp Grossmont Hospital (21%), and Sharp Memorial Hospital (17%), as detailed in Figure 2, below.

Figure 2. Sharp HealthCare Affiliation



Impact of COVID-19

The next set of questions focused on the impact of COVID-19 on patients' clinical and social needs. Respondents indicated the level of impact COVID-19 has had -- no impact, minor impact, moderate impact, major impact, or don't know –on a list of ten clinical needs and seven social needs. They were then asked to choose which of those patient needs were most severely impacted by COVID. For those chosen, respondents were then asked to comment on particular populations affected, Sharp programs and services that address those needs, and other ideas about ways to address the needs.

A total of 92 people responded to these questions. Note that respondents could answer, "Don't know how patients are currently impacted." These responses were excluded from the analysis; therefore, the total number of responses to each question varies.

As described below, the six clinical and social needs identified as the most seriously impacted by COVID during the past year were: (1) increased isolation among seniors; (2) increased anxiety; (3) increased depression; (4) limited access to behavioral health services; (5) increased financial insecurity; and (6) limited access to emotional and social support.

Question 3. COVID-19 Impact on Clinical Needs(n=92)

How is COVID currently impacting the clinical needs of patients?

As seen in Table 1, most survey participants felt that COVID-19 had a moderate to major impact on all but one of the patients' clinical needs listed (access to essential patient or durable medical equipment supplies). They were nearly unanimous that COVID-19 had a moderate or major impact on the isolation of seniors/older adults and on rates of anxiety and depression. The vast majority of survey respondents also indicated that COVID-19 has had a major or moderate impact on limiting access to behavioral health care (91%); limiting access to specialty care (86%); increasing fear about utilizing health care (85%); and limiting access to primary care (79%).

*Table 1. Current Impact of Clinical Needs on Patients**

Clinical Needs of Patients	No impact at all	Minor impact	Moderate impact	Major impact	Total respondents
Increased isolation among seniors/older adults	1%	0%	22%	76%	89
Increased anxiety	0%	2%	26%	72%	90
Increased depression	1%	3%	23%	73%	88
Limited access to behavioral health care	0%	9%	18%	73%	78
Limited access to specialty care	0%	14%	35%	51%	84
Increased fear in utilization of health care services	0%	15%	54%	31%	87
Limited access to primary care	1%	20%	46%	33%	83
Difficulty accessing video visits	5%	19%	50%	26%	84
Decreased health literacy	1%	36%	48%	15%	81
Limited access to essential patient supplies or durable medical equipment (DME)	4%	46%	34%	15%	67

*Percentages in table may not add up to 100% due to rounding

Respondents listed 12 additional needs impacted by COVID in the "other" category, as summarized below:

- Access to transportation has decreased because of lack of available drivers (MTS)
- It is more difficult to have contact with family and to have family at the bedside, which is especially important for highly vulnerable patients, such as those with dementia
- For those with no computer access, it is more difficult to make in-person appointments
- For clinic staff, compassion for those who don't have computer access has decreased
- Patients are more fearful -- in general and of coming in for annual cancer screenings
- Patients have decreased access to behavioral health intensive outpatient programs
- Patients are exposed to misinformation
- Substance use issues have increased
- It is more challenging to get timely patient care / appointment availability
- Housing is less stable

Question 4. COVID-19 Impact on Social Needs (n=92)

How is COVID currently impacting the social needs of patients?

As seen in Table 2, most respondents indicated that COVID 19 had impacted all the social needs listed. More than 90% reported that COVID-19 had a moderate or major impact on access to emotional and social support, financial insecurity, and employment stability. Survey participants also noted that COVID-19 has had a moderate to major impact on access to community resources and transportation and the stigma experienced in health care settings.

Table 2. Current Impact of Social Needs on Patients

Social Needs of Patients	No impact at all	Minor impact	Moderate impact	Major impact	Total
Limited access to emotional or social support (e.g., support groups)	1%	5%	31%	64%	88
Increased financial insecurity	1%	8%	34%	57%	86
Increased employment instability/unemployment	2%	2%	40%	56%	86
Limited access to community resources (e.g., housing, financial assistance, in-home support, etc.)	1%	10%	38%	51%	84
Limited access to transportation	1%	16%	38%	45%	85
Increased food insecurity	2%	24%	45%	29%	83
Increased stigma experienced in health care settings*	7%	23%	37%	33%	75

*Percentages in table may not add up to 100% due to rounding

Survey participants also reported that COVID-19 impacted the following social needs that were not listed, summarized below:

- Patients have decreased interactions with close family members/friends
- Patients have more fear about finances due to unemployment. They worry about being unable to provide for family

- Patients have decreased access to services

Question 5. Patient Needs Most Impacted by COVID-19 (n= 92)

Please choose three issues listed below which have most impacted the patients with whom you interacted during the past year.

Survey respondents were then asked to choose up to three each of the listed patient clinical and social needs that had been most impacted by COVID during the past year. Needs chosen most frequently included: (1) increased isolation among seniors/adults (52%); (2) increased anxiety (46%); (3) increased depression (34%); (4) limited access to behavioral health care (32%); (5) increased financial insecurity (22%); and (6) limited access to social support (20%). Please see Appendix A for data on all 17 needs.

Table 3. Patient Needs Most Impacted By COVID

Patient Needs Most Impacted by COVID	%	# of Respondents
1. Increased isolation among seniors/older adults	**52%**	**48**
2. Increased anxiety	**46%**	**42**
3. Increased depression	**34%**	**31**
4. Limited access to behavioral health care	**32%**	**29**
5. Increased financial insecurity	**22%**	**20**
6. Limited access to emotional or social support (e.g., support groups)	**20%**	**18**
7. Increased employment instability/unemployment	14%	13
8. Increased fear in utilization of health care services	14%	13
9. Limited access to primary care	13%	12
10. Limited access to community resources (e.g., housing, financial assistance, in-home support, etc.)	13%	12
11. Difficulty accessing video visits	10%	9
12. Limited access to specialty care	9%	8
13. Increased food insecurity	7%	6
14. Increased stigma experienced in health care settings*	7%	6
15. Limited access to transportation	5%	5
16. Decreased health literacy (e.g., capacity to process or understand basic health information and services in order to make appropriate health decisions)	2%	2
17. Limited access to essential patient supplies or durable medical equipment (DME)	2%	2
Total**		**92**

*Stigma can be generally defined as negative attitudes or beliefs towards another individual or group which can result in shame, *embarrassment, or fear. The stigma referenced below could either be directly related to a COVID-19 diagnosis or vaccination status, or unrelated (e.g., based on age, race/ethnicity, gender, etc.).*

**Responses will add up to be more than 100% due to the ability of participants to choose all that apply.

Questions 6-10. Details About the Patient Needs Most Impacted by COVID

For each of needs respondents chose as most impacted by COVID, they were then asked follow-up questions (questions #6-10), as detailed below.

6. Are there specific populations of patients who have been especially impacted by COVID in relation to *[insert need]*? (Check all that apply)
7. Are there particular racial or ethnic groups of patients who have been more impacted by COVID in relation to *[insert need]*? (Check all that apply)
8. Has Sharp implemented programs/services that have helped address *[insert need]*?
9. Please provide one to two examples of Sharp's efforts to address this issue. (open-ended)
10. What ideas do you have that might further address this issue? (open-ended)

Responses to these questions for the six most frequently chosen issues are described below. Data about the needs less frequently cited as most impacted can be found in Appendix A.

Need 1: Increased Isolation Among Seniors/Older Adults

Q6. Populations Impacted

*Are there **specific populations** of patients who have been especially impacted by COVID in relation to increased isolation among seniors/older adults? (Check all that apply)*

Those most impacted by COVID-19 in relation to increased isolation among seniors included caregivers of adults or older adults, patients using Medi-Cal or MediCare, and those with limited English proficiency. Other populations specified by respondents included: patients with co-morbidities and those who are immunosuppressed; seniors; seniors without transportation; people of limited income who are unable to afford caregivers or another place to live; and people who do not have Medi-Cal or who do not qualify for it.

Table 4. Populations of Patients Impacted by COVID in Relation to Increasing Isolation in Seniors/Older Adults

Populations of Patients	%	# of Respondents
Caregivers of adults or older adults	67%	28
Patients utilizing Medi-Cal	38%	16
Limited English proficiency	33%	14
Patients utilizing Medicare	29%	12
Parents of infants, toddlers, or school aged children	17%	7
Refugee or newly immigrated	14%	6
Pregnant Women	7%	3
LGBTQIA+ individuals	2%	1
Other (please specify)	14%	6
Total*		**42**

*Responses will add up to be more than 100% due to the ability of participants to choose all that apply.

Q7. Racial or Ethnic Groups Impacted

*Are there particular **racial or ethnic groups** of patients who have been more impacted by COVID in relation to increased isolation among seniors/older adults? (Check all that apply)*

The racial or ethnic groups most frequently chosen as being most impacted in relation to isolation of seniors/older adults included Black/African American, Hispanic, and Multiracial.

Table 5. Racial or Ethnic Groups Impacted by COVID in Relation to Increasing Isolation in Seniors/Older Adults

Racial or Ethnic Groups	%	# of Respondents
Black/African American	57%	13
Hispanic	52%	12
Multiracial	26%	6
White	22%	5
American Indian/Alaska Native	9%	2
Asian	9%	2
Native Hawaiian/Other Pacific Islanders	4%	1
Other *(all racial/ethnic groups-2 responses, people in poverty level before the pandemic)*	13%	3
Total*		**23**

*Responses will add up to be more than 100% due to the ability of participants to choose all that apply.

Q8. Programs/Services Implemented

*Has Sharp **implemented programs/services** that have helped address increased isolation among seniors/older adults?*

Survey respondents were divided about whether Sharp has programs that help address increased isolation among seniors; 44% indicated yes, and 56% indicated no.

Q9. Examples of Programs/Services Implemented

*Please provide one to two **examples** of Sharp's efforts to address increased isolation among seniors/older adults? (open- ended) (n=19)*

Examples of Sharp's efforts to address increased isolation among seniors/older adults provided by respondents included educational efforts, additional outreach and referrals for resources and support, the Senior Resource Center, and increased use of telehealth. These are summarized in Table 6, below.

Table 6. Programs and/or Services Implemented to Address the Increasing Isolation in Seniors/Older Adults

1
Outreach, Follow-up, and Referrals • Referrals provided for outpatient services, education, case management, community resources for home care companies • Social worker support
Education • Staff education through emails, Sharp.com, and newsletter • Educational posters in hospital • Health wellness and disease program via case management • Community education groups
Geriatric Emergency Department & Senior Resource Center • Geriatric Emergency Department RN follow-ups, daily phone calls by Sharp Checks-in through Senior Center • Senior Resource Center, Geriatric Emergency Management Nurses • Senior resource center and sharp checks in
Telehealth • Telehealth (in general) • Telehealth for behavioral health and addiction services • Telehealth for the case managers to video visit with patients • Virtual and in person caregiver support/emotional support groups

Q10. Additional Ideas to Address Increasing Isolation in Seniors/Older Adults

*What **ideas** do you have that might further address increased isolation among seniors/older adults (open-ended)?*

Ideas for ways in which Sharp could further address increased isolation among seniors/older adults are described below in Table 7. These ideas centered around finding ways to allow visitation during COVID-19, establishing or expanding home visiting and other follow-up services, expanding or resuming senior services, offering more patient education and referrals, improving access to technology, and supporting caregivers.

Table 7. Ideas to Address the Increasing Isolation in Seniors/Older Adults

Ideas
Increase Follow-up Calls and Home Visits • Make calls and do home visits after discharge, post-op, for hospice, for routine care and "well-being visits" • Provide ambulatory case management • Establish a volunteer program where individuals go to senior homes and visit, take walks, do small chores, make telephone calls for conversation • Incorporate volunteer dogs to come with a caregiver to visit those who would enjoy. This could be like Meals on Wheels with a companion to eat for a meal
Offer More Patient Support and Referrals • Make referrals to social support groups • Raise awareness about Sharp Mesa Vista Senior Intensive Outpatient Program • Have someone on-site from the Senior Resource Center to see patients at bedside
Educate Patients • Offer more patient and education, including TV and website education
Enable Visitation

• Allow a support person when patient is admitted in the hospital • Design methods to increase access to patients in hospitals or facilities where visitation is limited. Put technology to work in an organized programmatic manner • Allow video visits using telehealth technology
Improve Access to Technology • Provide community resources that can improve senior video or digital access and instruction.
Support Caregivers • Offer much needed support to caregivers of those with advanced dementia, including affordable memory care

Need 2: Increased Anxiety

Q6. Populations Impacted

*Are there **specific populations** of patients who have been especially impacted by COVID in relation to increased anxiety? (Check all that apply)*

Those noted as being most impacted by COVID-19 in relation to increased anxiety included caregivers of adults or older adults, patients using Medi-Cal or MediCare, those with limited English proficiency, and pregnant women.

Table 8. Populations of Patients Impacted by COVID in Relation to Increased Anxiety

Populations of Patients	%	# of Respondents
Caregivers of adults or older adults	61%	20
Patients utilizing Medi-Cal	33%	11
Limited English proficiency	30%	10
Pregnant Women	30%	10
Patients utilizing Medicare	30%	10
Parents of infants, toddlers, or school aged children	27%	9
Refugee or newly immigrated	18%	6
LGBTQIA+ individuals	9%	3
Other (minority patients, seniors (n=2), recently laid off/unemployed	12%	4
Total*		**33**

*Responses will add up to be more than 100% due to the ability of participants to choose all that apply.

Q7. Racial or Ethnic Groups Impacted

*Are there particular **racial or ethnic groups** of patients who have been more impacted by COVID in relation to increased anxiety? (Check all that apply)*

The racial or ethnic groups noted as being most impacted by COVID-19 in relation to increased anxiety included Hispanic, Black/African American and White.

Table 9. Racial or Ethnic Groups Impacted by COVID in Relation to Increased Anxiety

Racial or Ethnic Groups	%	# of Respondents

Hispanic	88%	15
Black/African American	65%	11
White	53%	9
Asian	41%	7
Multiracial	35%	6
American Indian/Alaska Native	24%	4
Native Hawaiian/Other Pacific Islanders	12%	2
Other (POC & low-income people have a harder time finding providers they can trust)	6%	1
Total*		**17**

*Responses will add up to be more than 100% due to the ability of participants to choose all that apply.

Q8. Programs/Services Implemented

Has Sharp implemented programs/services that have helped address increased anxiety?

More than half (64%) of respondents believed that Sharp has not established programs to address increased anxiety.

Q9. Examples of Programs/Services Implemented

Please provide one to two examples of Sharp's efforts to address this issue. (open-ended)

Examples shared of ways Sharp has addressed increased anxiety are summarized in Table 10 below. Primary categories of Sharp programs and services included: outreach, follow-up, and referrals; education; telehealth, and adapting programs to fit COVID restrictions and concerns.

Table 10. Programs and/or Services Implemented to Address Increased Anxiety

Identified Programs
Outreach, Follow-Up, and Referrals • Outreach to assess and offer assistance • Oncology patient navigator and social worker outreach calls to patients
Education • Sharp workshops regarding mindfulness, compassion, and stress management, including Best Health webinars and Safe Talk • TV and hospital posters
Telehealth • Online support groups – quickly implemented in virtual format • Online individual counseling • Implementation of telehealth assessment and programming • Sessions address anxiety and other issues
Adapting Existing Programs for COVID • COVID-specific anxiety screening • Adapting mental health programming to address COVID concerns • Continuing to address anxiety in Intensive Outpatient Programs

Q10. Additional Ideas to Address Issue

6. *What ideas do you have that might further address increased anxiety (open-ended)?*

Ideas to further address increased anxiety are summarized in Table 11 below. Categories included: creating, continuing, or expanding existing behavioral health programs; providing follow-up phone calls or home visits; expanding the availability of and access to behavioral health care services; providing help for staff; educating patients; and offering services in the patients' primary language.

Table 11. Ideas to Address Increased Anxiety

Ideas
Follow-up with Phone Calls or Home Visits • Offer more human contact, including follow-up phone calls and regularly touching base to assess and reassess the situation/status
Create, Continue, or Expand Behavioral Health and Support Programs • Offer more individual therapy, support groups, and other behavioral and social support programs • Give patients more resources and tools for self-care • Continue online support groups and counseling
Increase Availability of and Access to Behavioral Health Services • Expand access to psychiatry in the hospital to include care to address mild depression and anxiety • Make post-discharge psychiatry appointments before discharge • Increase access to behavioral health specialists • Incentivize therapists to take more insurances/take new patients
Offer Behavioral Health Services in Patients' Primary Languages • Hispanics need support in their language
Provide Education and Help for Staff • Decrease staff anxiety, dissatisfaction by increasing self-care opportunities • Increase the number of support staff • Educate staff about connecting with patients' emotional needs • Increase staff awareness, knowledge and related to the signs and symptoms of anxiety, calming interventions and wellness strategies and professional mental health resources
Educate Patients • Provide patients with written materials (newsletters) that explain issues of safety • Continue with TV and hospital posters

Need 3: Increased Depression

Q6. Populations Impacted

*Are there **specific populations** of patients who have been especially impacted by COVID in relation to increased depression? (Check all that apply)*

Those noted as being most impacted by COVID-19 in relation to increased depression included caregivers of adults or older adults, patients using Medi-Cal or MediCare, and those with limited English proficiency.

Table 12. Populations of Patients Impacted by COVID in Relation to Increased Depression

Populations of Patients	%	# of Respondents
Caregivers of adults or older adults	65%	17
Patients utilizing Medi-Cal	62%	16
Patients utilizing Medicare	54%	14
Limited English proficiency	38%	10
LGBTQIA+ individuals	27%	7
Parents of infants, toddlers, or school aged children	27%	7
Pregnant Women	27%	7
Refugee or newly immigrated	19%	5
Other *(minority patients, "sandwich" family households)*	8%	2
Total*		**26**

*Responses will add up to be more than 100% due to the ability of participants to choose all that apply.

Q7. Racial or Ethnic Groups Impacted

*Are there particular **racial or ethnic groups** of patients who have been more impacted by COVID in relation to increased depression? (Check all that apply)*

All (100%) of respondents to this question noted that Hispanic individuals have been especially affected by increased depression due to COVID, and 92% of respondents noted that Black/African Americans have been particularly affected, followed by Multiracial (67%) and Asian (58%). It is notable, however, that half of respondents also indicated that American Indian/Alaska Native, Native Hawaiian/Other Pacific Islanders, and Whites have been particularly impacted.

Table 13. Racial or Ethnic Groups Impacted by COVID in Relation to Increased Depression

Racial or Ethnic Groups	%	# of Respondents
Hispanic	100%	12
Black/African American	92%	11
Multiracial	67%	8
Asian	58%	7
American Indian/Alaska Native	50%	6
Native Hawaiian/Other Pacific Islanders	50%	6
White	50%	6
Total*		**12**

*Responses will add up to be more than 100% due to the ability of participants to choose all that apply.

Q8. Programs/Services Implemented

*Has Sharp **implemented programs/services** that have helped address increased depression?*

Two-thirds of respondents indicated that Sharp has not implemented programs/services to help address increased depression.

Q9. Examples of Programs/Services Implemented

*Please provide one to two **examples** of Sharp's efforts to address this issue. (open-ended)*

Respondents' examples of Sharp's efforts to address increased depression are summarized in Table 14, below.

Table 14. Programs and/or Services Implemented to Address Increased Depression

Identified Programs
Behavioral Health Referrals, Assessments, Services, and Resources • Comprehensive assessments • Referrals for psychiatric evaluations • Case management and behavioral health programs, including DBT/CBT, intensive outpatient program, and Sharp Mesa Vista psychiatric hospital • Resources on the website
Education • Training for staff on how to recognize and treat depression • Community education
Telehealth • Telehealth services for Behavioral health and addiction service lines
Staff Support • Improved access to EAP (employee)

Q10. Additional Ideas to Address Issue

*What **ideas** do you have that might further address increased depression (open-ended)?*

Several ideas were offered for ways that Sharp might further address increased depression, including the creation or expansion of programs; education and help for staff; education for patients; and the expansion of access to behavioral health services.

Table 15. Ideas to Address Increased Depression

Ideas
Create or Expand Support Programs • Implement additional supportive services for patients, including opportunities for socialization • Expand support services for caregivers
Increase Access to and Availability of Behavioral Health Care • Increase access to behavioral health providers including for those who do not have cell phones with which to make phone appointments with the clinic • Increase the number of behavioral health providers in the community, especially those who accept Medicare patients
Provide Education and Help for Staff • Address work-related stress that leads to increased anxiety and depression among health care workers, including by offering self-care workshops • Increase awareness, knowledge and skills for all Sharp health care professionals related to the signs and symptoms of depression, appropriate responses and interventions, and the availability of mental health professional resources
Educate Patients • Implement public health education and initiatives to reduce the stigma around behavioral health care • Provide patients with additional tools for self-care management

Need 4: Limited Access to Behavioral Health Care

Q6. Populations Impacted

*Are there **specific populations** of patients who have been especially impacted by COVID in relation to limited access to behavioral health care? (Check all that apply)*

Survey respondents indicated that the populations who have been especially affected by COVID-19 in relation to limited access to behavioral health care include patients utilizing Medi-Cal and Medicare and patients with limited English proficiency. In addition, five people indicated that "everyone" has been impacted, and one indicated that the "elderly" (seniors) have been particularly impacted.

Table 16. Populations of Patients Impacted by COVID in Relation to Limited Access to Behavioral Health Care

Populations of Patients	%	# of Respondents
Patients utilizing Medi-Cal	65%	15
Limited English proficiency	52%	12
Patients utilizing Medicare	48%	11
Refugee or newly immigrated	35%	8
Caregivers of adults or older adults	35%	8
Parents of infants, toddlers, or school aged children	22%	5
Pregnant Women	22%	5
LGBTQIA+ individuals	17%	4
Other *(All/Everyone-5 responses, elderly)*	26%	6
Total*		**23**

*Responses will add up to be more than 100% due to the ability of participants to choose all that apply.

Q7. Racial or Ethnic Groups Impacted

*Are there particular **racial or ethnic groups** of patients who have been more impacted by COVID in relation to limited access to behavioral health care? (Check all that apply)*

Half of respondents noted that Hispanic, Black/African American, and Multiracial individuals have particularly impacted by COVID-19 in relation to limited access to behavioral health care.

Table 17. Racial or Ethnic Groups Impacted by COVID in Relation to Limited Access to Behavioral Health Care

Racial or Ethnic Groups	%	# of Respondents
Hispanic	50%	7
Black/African American	43%	6
Multiracial	36%	5
American Indian/Alaska Native	29%	4
Native Hawaiian/Other Pacific Islanders	29%	4
White	21%	3
Asian	14%	2

Other *(all/everyone-3 responses, no particular group-2 responses)*	36%	5
Total*		**14**

*Responses will add up to be more than 100% due to the ability of participants to choose all that apply.

Q8. Programs/Services Implemented

*Has Sharp **implemented programs/services** that have helped address limited access to behavioral health care?*

More than half (57%) of the respondents believed that Sharp has not implemented programs/services to address the limited access to behavioral health care.

Q9. Examples of Programs/Services Implemented

*Please provide one to two **examples** of Sharp's efforts to address this issue. (open-ended)*

Respondents' examples of Sharp's efforts to address limited access to behavioral health care are summarized in Table 18, below.

Table 18. Programs and/or Services Implemented to Address Limited Access to Behavioral Health Care

Identified Programs
Behavioral Health Referrals, Assessments, Services, and Resources • Sharp Rees-Stealy Perinatal/Maternal Anxiety and Depression Program • Sharp Rees-Stealy behavioral health management, including outpatient and inpatient programs and the emergency department • Case management, social work, and behavioral health programs • Out of Network approvals when network is overstretched
Education • Training for identifying and intervening with behavioral health issues in patients • Communication about resources for how staff or members can access mental health services
Telehealth • Encouraged telehealth behavioral health visits when possible • Use of video visits, but not all members can access this modality
Staff Support • Internally, EAP (Employee Assistance Program) counseling • Support groups on Fridays for various employee populations

Q10. Additional Ideas to Address Issue

*What **ideas** do you have that might further address limited access to behavioral health care? (open-ended)*

Respondents offered many suggestions about ways to address limited access to behavioral health care. These suggestions centered primarily on expanding the availability of and access to behavioral health care. However, respondents recognized the complexity of the issue, noting challenges with the number of behavioral health care providers, limited insurance coverage for behavioral health care, and the need to integrate behavioral and physical health care.

Table 19. Ideas to Address Limited Access to Behavioral Health Care

Ideas
Increase Availability of and Access to Behavioral Health Care • Increase the number of providers, including psychiatrists, psychologists, and other therapists, potentially by contracting with additional providers (both group and individual therapists) • Increase the number of therapists who are willing to see members in office • Expand the availability of intensive outpatient programming availability. This was so limited during the pandemic due to staffing issues • Serve Medi-Cal only patients; expand programs for those on Medi-Cal, including those with serious mental illness • Increase funding for behavioral health • Open more local facilities that increase access to services
Clarify Process to Access Care • Clarify the process to access care • Improve search function on Sharp health plan website for behavioral health care
Create Community-based Outreach and Service Programs • Create community outreach programs • Provide support for patients within their community
Establish Integrated Care • Develop an integrated health care model- physical health, mental health and integrative healing providers under one roof treating the whole person. • If behavioral health could be integrated into our service areas, we could get insurance coverage and increase staff to start to meet needs
Offer Behavioral Health Services in Patient Primary Languages • Have services in primary language
Expand Telehealth • Increase televisits or group visits
Continue Advocacy • Continue to advocate at the local, state, and national level

Need 5: Increased Financial Insecurity

Q6. Populations Impacted

*Are there **specific populations** of patients who have been especially impacted by COVID in relation to increased financial insecurity? (Check all that apply)*

Patients noted to be especially impacted by COVID in relation to increased financial insecurity included patients who use Medi-Cal; refugee or newly immigrated patients; individuals with limited English proficiency, and caregivers of adults or older adults.

Table 20. Populations of Patients Impacted by COVID in Relation to Increased Financial Insecurity

Populations of Patients	%	# of Respondents
Patients utilizing Medi-Cal	47%	8
Refugee or newly immigrated	41%	7
Limited English proficiency	41%	7
Caregivers of adults or older adults	41%	7
Parents of infants, toddlers, or school aged children	35%	6
Patients utilizing Medicare	29%	5
Pregnant Women	24%	4
LGBTQIA+ individuals	12%	2
Other *(all populations – 2 responses, patients who had COVID-related layoffs or reduced hours)*	18%	3
Total*		**17**

*Responses will add up to be more than 100% due to the ability of participants to choose all that apply.

Q7. Racial or Ethnic Groups Impacted

*Are there particular **racial or ethnic groups** of patients who have been more impacted by COVID in relation to increased financial insecurity? (Check all that apply)*

Hispanic and Black/African American patients were cited as being particularly impacted by increased financial insecurity.

Table 21. Racial or Ethnic Groups Impacted by COVID in Relation to Increased Financial Insecurity

Racial or Ethnic Groups	%	# of Respondents
Hispanic	82%	9
Black/African American	73%	8
White	36%	4
American Indian/Alaska Native	27%	3
Asian	27%	3
Native Hawaiian/Other Pacific Islanders	18%	2
Multiracial	9%	1
Other *(all ethnicities, all racial/ethnic groups)*	18%	2
Total*		**14**

*Responses will add up to be more than 100% due to the ability of participants to choose all that apply.

Q8. Programs/Services Implemented

*Has Sharp **implemented programs/services** that have helped address increased financial insecurity?*

Most respondents (70%) indicated that Sharp has not implemented programs to address increased financial insecurity.

Q9. Examples of Programs/Services Implemented

*Please provide one to two **examples** of Sharp's efforts to address this issue. (open-ended) (n=5)*

Examples given about how Sharp has addressed increased financial insecurity are summarized below:

- Financial and foundation assistance, including Medication Foundation assistance and grocery gift cards granted to patients
- Community resources, including referrals to CalFresh and local food pantries and direct support through assistance such as Lyft rides to appointments
- Clinical programs, such as telehealth and case management outreach

Q10. Additional Ideas to Address Issue

What ideas do you have that might further address increased financial insecurity (open-ended)? (n=4)

Only a few responses were received about additional ideas to address financial insecurity, including:

- Designating funds from the Foundation for patients who meet specific criteria for a financial award
- Creating a Food is Medicine campaign
- Fortifying administrative teams to help with screening patients for Medi-Cal and Social Security applications.

Need 6: Limited Access to Emotional or Social Support (e.g., support groups)

Q6. Populations Impacted

*Are there **specific populations** of patients who have been especially impacted by COVID in relation to limited access to emotional or social support? (Check all that apply)*

Respondents noted that caregivers of adults or older adults, parents, people with limited English proficiency, and patients utilizing Medicare have been particularly impacted by COVID in relation to limited access to emotional or social support.

Table 22. Populations of Patients Impacted by COVID in Relation to Limited Access to Emotional or Social Support

Populations of Patients	%	# of Respondents
Caregivers of adults or older adults	62%	8
Parents of infants, toddlers, or school aged children	54%	7
Limited English proficiency	46%	6
Patients utilizing Medicare	46%	6
Pregnant Women	38%	5
Patients utilizing Medi-Cal	38%	5
LGBTQIA+ individuals	31%	4
Refugee or newly immigrated	23%	3

Other *(minority patients, substance use disorders, those without smart phones or computers for online support groups, seniors)*	31%	4
Total*		**13**

*Responses will add up to be more than 100% due to the ability of participants to choose all that apply.

Q7. Racial or Ethnic Groups Impacted

*Are there particular **racial or ethnic groups** of patients who have been more impacted by COVID in relation to limited access to emotional or social support? (Check all that apply)*

Hispanic, Multiracial, Black/African American, and Asian patients were noted to be especially impacted by COVID-19 in relation limited access to emotional social support.

Table 23. Racial or Ethnic Groups Impacted by COVID in Relation to Limited Access to Emotional or Social Support

Racial or Ethnic Groups	%	# of Respondents
Hispanic	71%	5
Multiracial	57%	4
Black/African American	43%	3
Asian	43%	3
White	29%	2
American Indian/Alaska Native	14%	1
Native Hawaiian/Other Pacific Islanders	14%	1
Other *(minority patients)*	14%	1
Total*		**7**

*Responses will add up to be more than 100% due to the ability of participants to choose all that apply.

Q8. Programs/Services Implemented

*Has Sharp **implemented programs/services** that have helped address limited access to emotional or social support]?*

Most respondents (71%) indicated that Sharp has not implemented services to address limited access to emotional or social support.

Q9. Examples of Programs/Services Implemented

*Please provide one to two **examples** of Sharp's efforts to address this issue. (open-ended)*

Virtual support groups were the only example offered about Sharp's efforts to address access to emotional or social support.

Q10. Additional Ideas to Address Issue

*What **ideas** do you have that might further address limited access to emotional or social support (open-ended)? (n=4)*

Suggestions offered for ways to further address access to emotional or social support included hosting outdoor support groups with simultaneous video/audio access, reconvening Spanish support groups, expanding behavioral health care, and conducting more telephonic outreach.

Virtual Video Visits

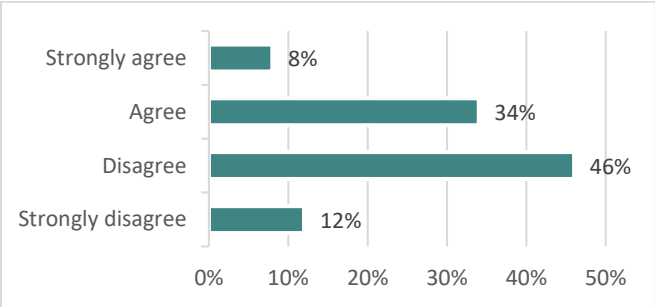
The next set of survey questions asked respondents to comment on the use of virtual video visits for health care, including ease of access to virtual video visits, causes of challenges with access, preferences for in-person or virtual video visits, and the use of different telehealth modalities.

Question 11. Access (n=74)

My patients can easily access virtual video visits.

Survey respondents had mixed feedback about how easily patients can access virtual video visits; 42% agreed or strongly agreed that patients could easily access video visits, while 58% disagreed or strongly disagreed.

Figure 3. Patient Easy Access Virtual Video Visits

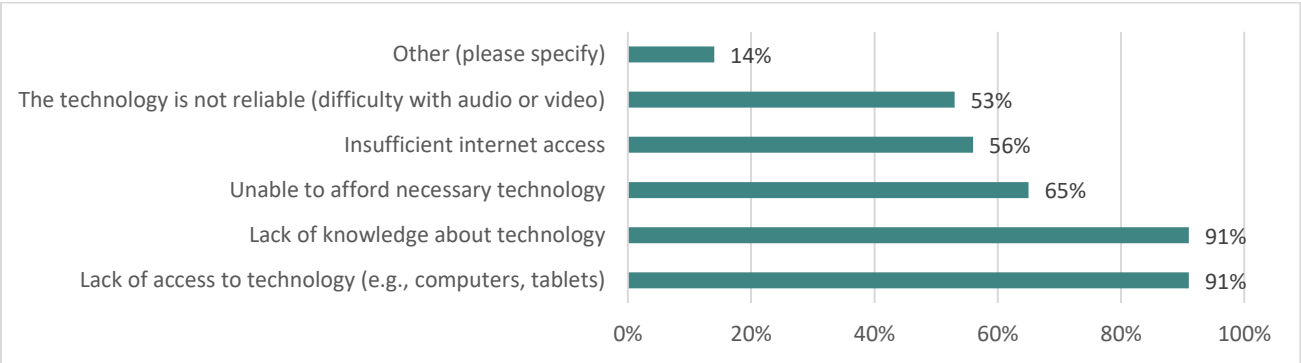


Question 12. Causes for difficulty with virtual video visits (n=43)

What causes patients to have difficulty accessing virtual video visits? (Check all that apply)

Most survey respondents noted that lack of access to and knowledge about technology is a primary barrier to accessing virtual video visits. Inability to afford technology, insufficient internet access, and unreliable technology were also reported as challenges to access.

Figure 4. Causes for Difficulty with Virtual Visits



*Responses will add up to be more than 100% due to the ability of participants to choose all that apply.

Other reasons given for difficulties accessing virtual video visits focused on availability, patient preference, language issues, and the presence of psychiatric issues:

- Not all providers within SCMG offer virtual visits to patients.
- They (*patients*) don't see the value, they want to see the provider
- Lack of interpersonal connection via screens, lack of privacy, avoidance
- Preference of face-to-face visits with practitioner
- Language issues
- Psychiatric symptoms (paranoia, anxiety, disorganized thinking)

Question 13. Preference for in person visits (n=87)

Do you have patients who prefer in-person visits for reasons other than challenges with access to virtual video visits?

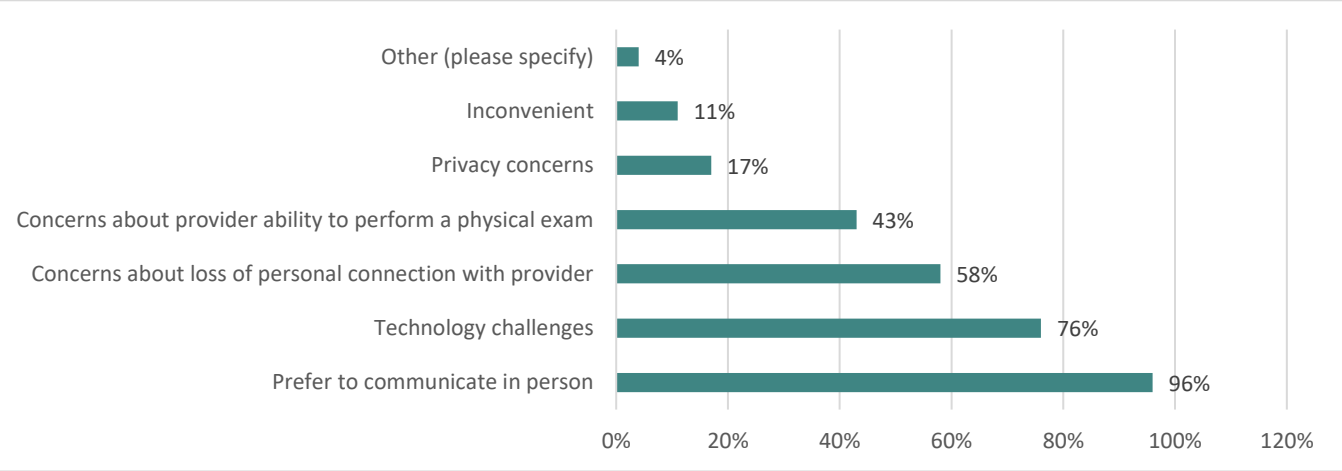
Most (87%) survey participants agreed that some patients prefer in-person visits for reasons beyond challenges with access.

Question 14. In-person Visit Preference (n=76)

Why do those patients prefer in-person visits? (Check all that apply)

The primary reason (96%) offered for preferring in-person visits was simply that patients prefer to communicate in person. This was followed by technology challenges (76%), concerns about loss of personal connection between provider and patient (58%), and concerns about medical personnel's ability to perform a physical exam (43%).

Figure 5. Reasons for in-person visit preference[&]



[&]Responses will add up to be more than 100% due to the ability of participants to choose all that apply.

Other reasons offered for a preference for in-person visits included:

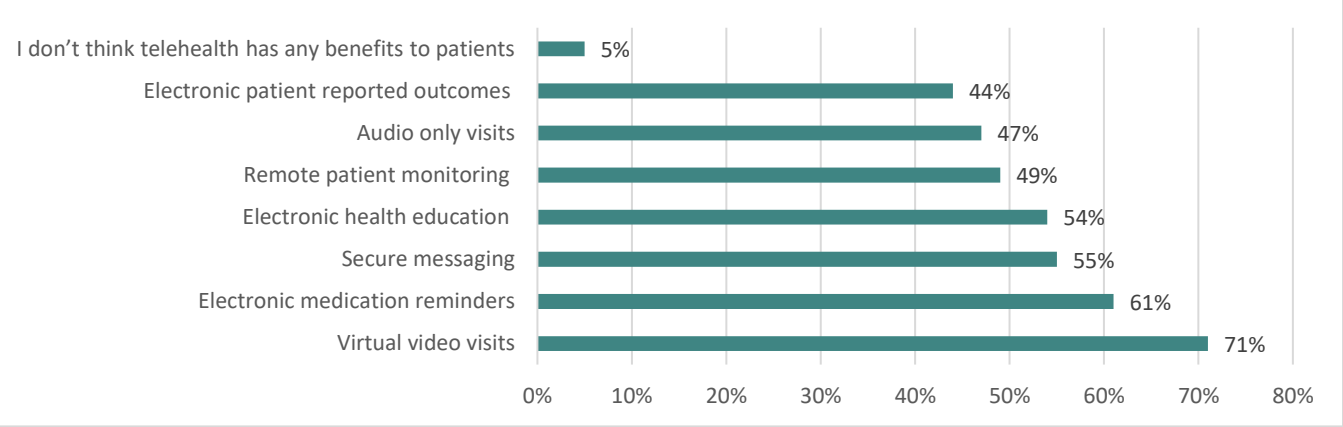
- Hearing impairment makes digital or telephonic communication challenging
- Quality of in-person interventions superior to virtual interventions

Question 15. Telehealth modalities (n=87)

Considering your answers above, please select all of the telehealth modalities you believe could benefit your patients and your ability to care for them (check all that apply):

More than half of respondents indicated that their ability to care for patients, and patients themselves, could benefit from virtual video visits, electronic medication reminders, secure messaging, and electronic health education. Many also believed that remote patient monitoring, audio-only visits, and electronic patient reported outcomes could also be beneficial. Only 5% of respondents reported that they did not think telehealth has any benefits to their patients.

*Figure 6. Telehealth Modalities**



*Responses will add up to be more than 100% due to the ability of participants to choose all that apply.
Note: Examples were provided after some answer choices, please see appendix for full description.

Educational Opportunities

The final section of Survey One asked participants to share information about the educational sessions they have attended and the impact of those sessions. They were also asked about potential topics for future educational opportunities.

Question 16. Attendance (n=84)

Have you attended any of the following educational opportunities over the past 12 months? (Check all that apply)

Thirty-eight percent (38%) of the survey respondents indicated that they had not attended any educational opportunities in the last year. Of those who did attend, sessions included Leadership Development[3] (40%); Current Conversations[4] (27%); SGH Multidisciplinary Grand Rounds[5] (21%); Breakfast Forum [6](17%); Safe Speak[7] (13%); and Other – Best Heath Parenting in Education (n=2), HR education, Educational, E-mail, and COVID Conversations (5%).

[3] Leadership Development: Sharp hosts quarterly Leadership Development Sessions to provide Sharp leaders with system updates and opportunities for professional growth. The sessions are taught by internal and external speakers and subject matter experts in various fields.

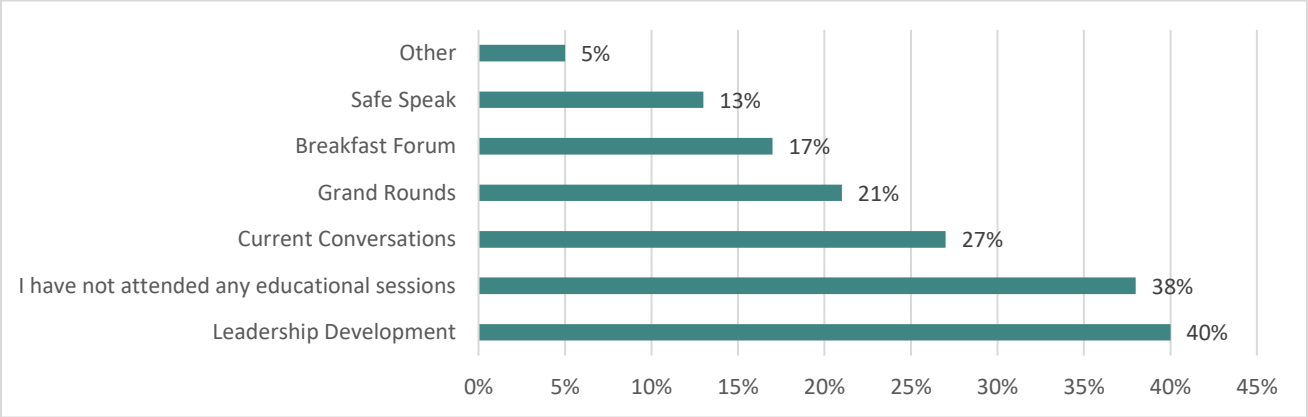
[4] Current Conversations: Current Conversations is an online forum that allows for educational and engaging conversations with expert speakers about current topics surrounding identity. Current Conversations welcomes Sharp employees, Sharp-affiliated physicians and Sharp volunteers to participate in moderated virtual discussions on topics including race, ethnicity, gender, religion, culture, and more. Participation in Current Conversations is unlimited, and non-confidential.

[5] SGH Multidisciplinary Grand Rounds: An accredited continuing education activity intended for physicians, nurse practitioners, physician assistants, pharmacists and others interested in the latest updates in evidence-based practice, clinical guidelines, and patient care techniques. As a multidisciplinary activity, it covers a range of specialties and best practice concepts across a variety of topics including, but not limited to, cardiology, oncology, gastroenterology, behavioral health, and public health. Topics are selected based on current clinical needs and incorporate concepts and content related to diversity, equity, and inclusion.

[6] Breakfast Forum: A Sharp CME-accredited, virtual health equity education series for Sharp employees and Sharp-affiliated physicians, coordinated by the Sharp Equality Alliance.

[7] Safe Speak: Sharp offers Safe Speak support sessions to provide Sharp employees and Sharp-affiliated physicians with a safe space to connect with peers, speak openly, find support, brainstorm solutions, and share their unique experiences related to current events (e.g., racial, societal, cultural, political, etc.). Attendance is limited during Safe Speak sessions to support confidentiality.

*Figure 7. Educational Session Attendance**



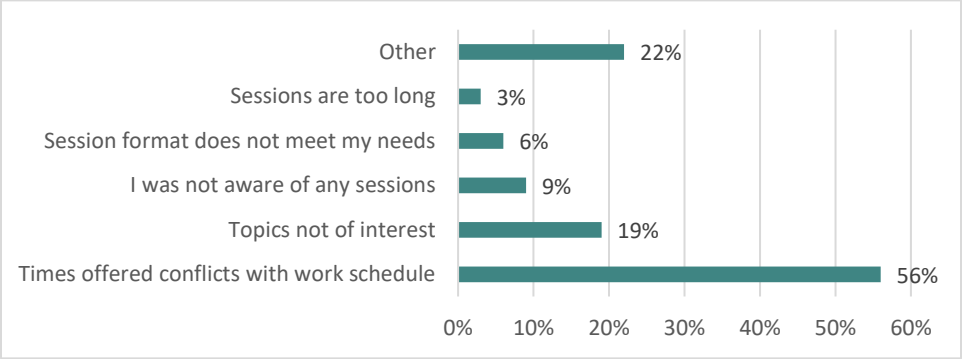
*Responses will add up to be more than 100% due to the ability of participants to choose all that apply.

Question 17. Reasons for not attending (n=32)

Why have you not attended any education sessions? (Check all that apply)

The most frequently chosen reason for not attending educational sessions (56%) was that the times offered conflicted with work schedules, followed by topics not of interest (19%). Seven (22%) of respondents gave other reasons, which included: (1) Lack of time (n=5); (2) I am a per diem worker; and (3) Just started in this position.

Figure 8. Reasons for not Attending Educational Sessions



*Responses will add up to be more than 100% due to the ability of participants to choose all that apply.

Question 18. Impact (n=52)

How have these educational opportunities impacted you and/or your work? (Check all that apply)

While 35% of the survey respondents were unsure about the impact or believed that the sessions had no impact on their work, many respondents noted clear positive impacts (see Figure 9):

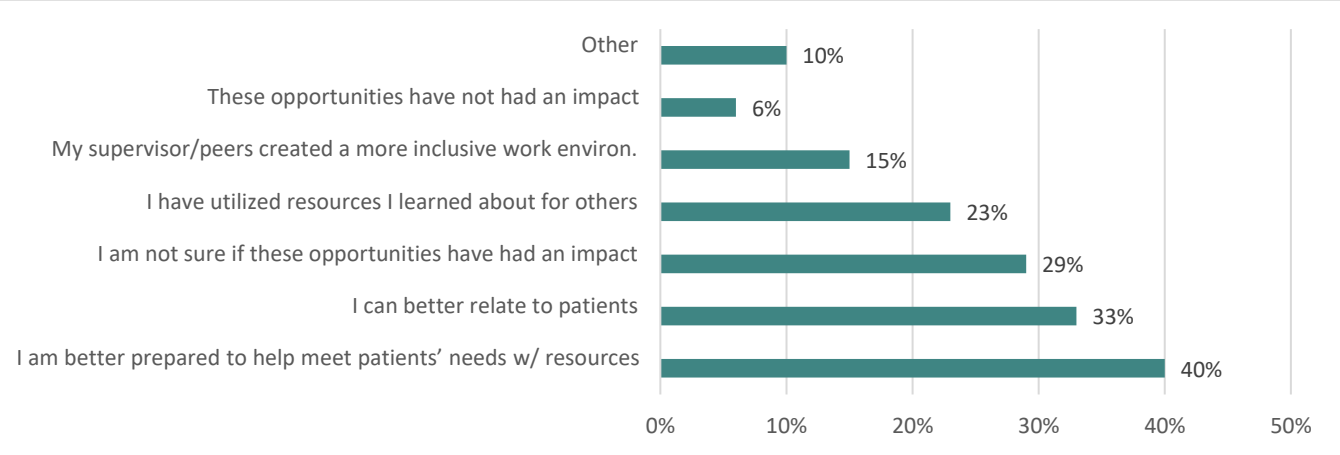
- 40% reported that the education made them better prepared to meet patient needs
- 33% said the education allowed them to relate better to their patients
- 23% noted that they had utilized the resources they learned about to help family friends and neighbors, and

- 15% shared that their supervisor or peers had created a more inclusive work environment as a result of the education

Other respondents noted that the educational opportunities helped them:

- Care for their parent
- Recognize and focus on their own mental health and wellness and thus be a better employee and care provider
- Better understand and be aware of behavioral health/substance use issues
- Achieve personal growth and stress relief

*Figure 9. Impact of Educational Opportunities**



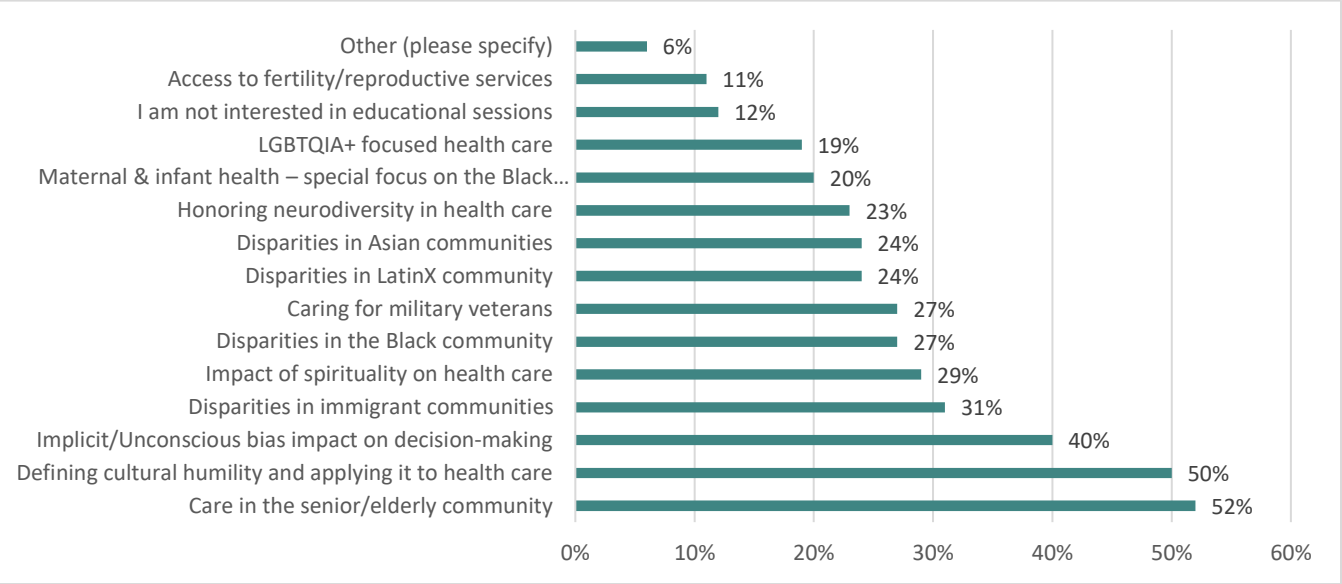
*Responses will add up to be more than 100% due to the ability of participants to choose all that apply.
Note: Answer choices above are summarized, please see appendix for full description.

Question 19. Learning Interests (n=84)

What specific educational topics would you be most interested in learning more about? (Check all that apply)

Survey respondents were interested in many future educational topics. The most frequent topics chosen were care in the elderly/senior community, defining cultural humility and applying it to health care, and implicit/unconscious decision making (see Figure 10). Other topics suggested included: (1) maternal and infant health for all racial backgrounds; (2) behavioral health-focused topics including stigma, disparities, supports, and resources; and (3) solid organ and stem cell transplants.

Figure 10. Educational Learning Interests



*Responses will add up to be more than 100% due to the ability of participants to choose all that apply.

IV. Survey Two Results: Employee Impacts

Sharp HealthCare Representation and Entity Affiliation

Survey Two focused on employee well-being, and 16 human resources team members who received the survey link responded.

Question 1. Sharp Entity Affiliation (n=16)

What Sharp entity are you affiliated with?

Due to the small number of participants in the IPH Sharp Human Resources Survey, responses to this question have been excluded from this document to preserve anonymity.

Impact of COVID-19

The first set of questions asked about how COVID-19 has affected Sharp employees and whether the impact is expected to worsen or improve over the next year. Respondents were also asked to indicate which needs they thought had impacted employees the most and to answer follow-up questions about those identified needs.

Question 2. Impact on Sharp Employees (n=16)

How is COVID currently impacting Sharp team members?

More than three quarters of respondents indicated that COVID-19 was having a moderate or major negative impact on employees in many ways, including increased anxiety and stress, frustration and disengagement/empathy fatigue, levels of depression. desire to change careers or leave the workforce, urgency for access to behavioral health assistance, and limited access to emotional and social supports.

Survey participants indicated that COVID-19 was currently impacting the following most significantly for employees: increased anxiety or stress, increased frustration or disengagement (empathy fatigue), and increased desire to change careers or leave the workforce (see Table 25).

Table 24. Current Impact on Sharp Team Members

Issue	No impact at all	Minor impact	Moderate impact	Major impact	Mean	Total Respondents
Increased anxiety or stress	6%	13%	6%	75%	2.5	16
Increased frustration or disengagement (empathy fatigue)	6%	6%	19%	69%	2.5	16
Increased depression	13%	6%	31%	50%	2.3	16
Increased desire to change careers or to leave the workforce	6%	6%	38%	50%	2.2	16
Increased urgency for and acuity of behavioral health assistance	13%	7%	33%	47%	2.1	15
Increased isolation	6%	13%	56%	25%	2	16
Limited access to emotional or social support (e.g., support groups)	13%	13%	50%	25%	1.9	16
Limited access to dependent care (childcare or elder care)	19%	13%	44%	25%	1.8	16
Increased financial insecurity	13%	25%	44%	19%	1.7	16
Increased stigma in the workplace*	13%	31%	38%	19%	1.6	16
Limited access to health care – either primary care or specialty care	21%	29%	36%	14%	1.4	14
Increased fear in utilization of health care services	13%	53%	20%	13%	1.4	15
Limited access to community resources (e.g., transportation, financial assistance)	21%	21%	50%	7%	1.3	14
Increased food insecurity	25%	42%	33%	0%	1.1	12
Other (please specify) *						

*Other responses (n=3):

- Egocentric: Moderate Impact
- Feeling overworked: Major impact
- Feeling undervalued: Major impact

Question 3. Future Impact (n=15)

How do you think COVID will impact Sharp team members over the next year?

Survey participants were asked to indicate whether these needs would improve, stay the same, or worsen over the coming year. A score of "1" was given when a respondent chose "get better," a score of "0" was given when the respondent chose "stay the same," and a score of "-1" was given when a respondent chose "get worse." These scores were then averaged. Those issues with a mean more than zero, therefore, are listed as expected to

improve, those with a mean score of 0 are listed as expected to stay the same, and those with a negative mean score are listed as expected to worsen.

From the responses to this question, it's clear that respondents believed that most issues identified by the survey will continue to worsen over the next year.

Table 25. Impact on Sharp Team Members Over the Next Year

Future Impact*	Get worse	Stay about the same	Get better	Mean score	Total Respondents
Issues identified as expected to improve over the next year based on mean score					
Increased fear in utilization of health care services	23%	38%	38%	0.2	13
Increased isolation	20%	47%	33%	0.1	15
Limited access to dependent care (childcare or elder care)	21%	43%	36%	0.1	14
Issues identified as expected to stay the same over the next year based on mean score					
Limited access to health care – either primary care or specialty care	29%	43%	29%	0	14
Increased stigma in the workplace	38%	23%	38%	0	13
Issues identified as expected to worsen over the next year based on mean score					
Limited access to emotional or social support (e.g., support groups)	31%	46%	23%	-0.1	13
Increased food insecurity	27%	64%	9%	-0.2	11
Limited access to community resources (e.g., transportation, financial assistance)	33%	58%	8%	-0.3	12
Increased anxiety or stress	53%	33%	13%	-0.4	15
Increased depression	47%	47%	7%	-0.4	15
Increased urgency for and acuity of behavioral health assistance	60%	27%	13%	-0.5	15
Increased financial insecurity	54%	46%	0%	-0.5	13
Increased frustration or disengagement (empathy fatigue)	60%	40%	0%	-0.6	15
Increased desire to change careers or to leave the workforce	64%	29%	7%	-0.6	14

Question 4. Employee Needs Most Impacted by COVID (n=15)

Please choose three issues listed below which have most impacted Sharp team members during the past year - we will then ask you more questions about those specific issues.

As described in Table 27 below, the three primary needs chosen as most significantly affecting Sharp employees last year were: 1) increased anxiety or stress; 2) increased frustration or disengagement; and 3) increased desire to change careers or to leave the workforce.

Table 26. Needs Most Significantly Impacting Employees

Issue	%	# of respondents
1. Increased anxiety or stress	**93%**	**14**
2. Increased frustration or disengagement (empathy fatigue)	**73%**	**11**
3. Increased desire to change careers or to leave the workforce	**60%**	**9**
4. Increased depression	20%	3
5. Increased urgency for and acuity of behavioral health assistance	13%	2
6. Limited access to dependent care (childcare or elder care)	13%	2
7. Limited access to emotional or social support (e.g., support groups)	7%	1
8. Limited access to health care – either primary care or specialty care	7%	1
9. Increased isolation	7%	1
10. Limited access to community resources (e.g., transportation, financial assistance)	0%	0
11. Increased food insecurity	0%	0
12. Increased financial insecurity	0%	0
13. Increased stigma in the workplace*	0%	0
14. Increased fear in utilization of health care services	0%	0
15. Other (feeling overworded with little additional resources)	7%	1
Total		**15**

For each of those three needs, respondents were asked a series of follow-up questions:

Questions 5-9. Details about Employee Needs Most Impacted by COVID

For each top need chosen by a respondent, they were then asked five questions (#5-9):

5. Has Sharp implemented programs/services that have helped address this issue for Sharp team members?
6. Please provide one to two examples of Sharp's efforts to address this issue. (open-ended)
7. What recommendations do you have that might further improve this issue? (open-ended)
8. What (if any) are the competing priorities that could prevent Sharp from implementing these recommendations?
9. Please provide suggestions for how Sharp can make time or resources available to address these recommendations.

Responses to these questions for the three most frequently chosen issues are described below. Data pertaining to Issues 4 through 15 can be found in the Appendix.

Need 1: Increased Anxiety or Stress

Q5. Programs/Services Implemented

*Has Sharp **implemented programs/services** that have helped address this issue for Sharp team members?*

Respondents were unanimous (100%) that Sharp has implemented programs and services to help employees with increased anxiety or stress.

Q6. Examples of Sharp's Efforts

*Please provide one to two **examples** of Sharp's efforts to address this issue. (open-ended)*

Respondents provided many examples of Sharp's focus on employee wellness to reduce employee stress and anxiety, including:

- EAP programs
- Best Health
- Child and dependent care support: *"the childcare benefit is amazing."*
- Wellness programs and resources, including mindfulness, Stress First Aid, SEA Speaks Communication, Sharp Care 4 You, Wellness Rounding, Safe Speak Virtual, in person sessions around the organization, daily emails to team members on how to take care of themselves and their family
- Leader education
- Sharp Health Plan to expand behavioral services to include external partners

Q7. Recommendations

What recommendations do you have that might further improve this issue? (open-ended)

Several recommendations were made about further improving employee stress and anxiety. These are summarized below:

- Continue to support, develop, and strengthen current mental health supports
- Increase communication about services available
- Have more well- trained therapists
- Offer more real time mental support
- Consider volume of work and competing priorities for employees
- Hire more staff
- Provide on-site child-care: Implement risk management evaluation for on-location childcare and use third parties to limit risk while creating a competitive lead against other medical organizations
- Increase open communication time slots on current issues
- Make EAP support entity-based vs centralized

Q8. Competing Priorities

What (if any) are the competing priorities that could prevent Sharp from implementing these recommendations?

Survey respondents named several competing priorities that might prohibit the implementation of their recommendations:

- Finances: Employees could be referred to non-Sharp entities which may have a financial impact.
- Time
- Staffing and schedules
- COVID
- Interest
- Space
- Employees' perception they are too busy to care for themselves.
- Employees' perceptions that the people offering the resources have not gone through the same experiences; therefore, the resources are not of value.

Q9. Time and Resource Suggestions

Please provide suggestions for how Sharp can make time or resources available to address these recommendations.

Suggestions for how to make time and resources available to implement recommendations included:

- Continue to engage leaders
- Promote employees across the organization
- Hire additional staff
- Grants/support from executive leadership
- Promote education reimbursement programs
- Provide more story telling in communications on the impact of the expanded behavioral health services
- Survey employees (especially high COVID areas) and ask them what their needs are/were - give them time to complete, video those willing to share their loss/stories with others. Perhaps make this an internship project
- Have town halls at different Sharp entities
- Open designated virtual locations for employees to be able to sign into virtual presentations if they do not have their own computers at their desks or homes
- Create additional initiatives within each program
- Partner with an organization that can assist in supporting a new initiative

Need 2: Increased Frustration or Disengagement (empathy fatigue)

Q5. Programs/Services Implemented (n=11)

*Has Sharp **implemented programs/services** that have helped address this issue for Sharp team members?*

Most survey participants (73%) indicated that Sharp has established programs to address increased frustration or disengagement (empathy fatigue).

Q6. Examples of Sharp's Efforts

*Please provide one to two **examples** of Sharp's efforts to address this issue. (open-ended)*

Several examples of Sharp's efforts to address increased frustration or disengagement (empathy fatigue); many were similar to those efforts outlined as addressing increased stress and anxiety, including:

- EAP
- Compassion cultivation
- Best Health
- Leader training
- Safe Speak
- Increased awareness of how to handle stress in the workplace
- Wellness resources, especially mindfulness.

Q7. Recommendations

What recommendations do you have that might further improve this issue?

Suggestions to further improve increased employee frustration or disengagement are summarized below:

- Compassion cultivation course is a 6-8 week intensive; perhaps create something on smaller scale with a broader audience
- Continue with the current programs, with greater publicity
- Leaders should meet the team members in person to listen to their needs rather than sending emails or memos
- Create opportunities for employees to hear from others, including leaders, who may have experienced the same thing
- Improve security measures
- Hold patients/visitors accountable for inappropriate behavior

Q8. Competing Priorities

What (if any) are the competing priorities that could prevent Sharp from implementing these recommendations?

Comments describing competing priorities that may present barriers to the implementation of recommendations to address increased frustration and disengagement are summarized below:

- COVID
- Lack of time and bandwidth for leadership; leaders are stretched thin
- Staff and resource shortages
- Patient satisfaction scores

Q9. Time and Resources Suggestions

Please provide suggestions for how Sharp can make time or resources available to address these recommendations.

Suggestions were made to foster availability of time and resources needed to address increased frustration and disengagement included:

- Invest in and provide the necessary resources to assist leaders
- Create videos that can be accessed at employee's leisure, not all will heal or seek help at the same rate
- Prioritize employee well-being

Need 3: Increased Desire to Change Careers or to Leave the Workforce

Q5. Programs/Services Implemented (n=9)

*Has Sharp **implemented programs/services** that have helped address this issue for Sharp team members?*

In response to the question about whether Sharp program and services to address the increased desire to change careers or leave the workforce, the majority of survey participants (78%) answered "no."

Q6. Examples of Sharp's Efforts

*Please provide one to two **examples** of Sharp's efforts to address this issue. (open-ended)*

Three examples of Sharp's efforts to address the increased desire to change careers or leave the workforce were provided:

- Financial incentives
- Extender programs
- Retention programs

Q7. Recommendations

What recommendations do you have that might further improve this issue?

Recommendations for how to improve the issue of employees wanting to change careers or leave the workforce are summarized below:

- In departments of low morale, increase communication to discover underlying issues
- Create work-life balance programs
- Reevaluate compensation philosophy
- Create better new graduate programs
- Increase flexibility of hiring new staff

Q8. Competing Priorities

What (if any) are the competing priorities that could prevent Sharp from implementing these recommendations?

Comments about priorities that could prevent Sharp from implementing recommendations to address the increased desire to change careers or leave the workforce, included:

- Manager, supervisor resistance to change in the department
- Staff shortages
- Fear of financial failure
- Money and desire

Q9. Time and Resources Suggestions

Please provide suggestions for how Sharp can make time or resources available to address these recommendations.

Suggestions for how Sharp can make time or resources available to address the issue of increased desire to change careers or leave the workforce included:

- Make EAP team building programs available
- Elimination of silos

Educational Opportunities

The final set of questions in Survey Two asked about the respondents' participation in education activities over the past year.

Question 10. Attendance (n=15)

Have you attended any of the following educational opportunities over the past 12 months? (Check all that apply)

The two most frequently attended educational opportunities were Leadership Development (93%) and Safe Speak (87%), followed by Current Conversations (60%). See Table 37.

Table 27. Attendance of Educational Opportunities

Educational Opportunities	%*	Count
Leadership Development	93%	14
Safe Speak	87%	13
Current Conversations	60%	9
Breakfast Forum	27%	4
I have not attended any educational sessions	7%	1
Grand Rounds	0%	0
Other (mindfulness training)	7%	1
Total		**15**

*Percentages will add up to be more than 100% due to the ability of participants to choose all that apply.

Question 11. Reason for not attending (n=1)

Why have you not attended any education sessions? (Check all that apply)

Likely because most respondents had attended educational sessions, only one answer was provided to this question: "*Many times they conflict with my schedule/role. Not enough time to fit it all in.*"

Question 12. Impact (n=14)

How have these educational opportunities impacted you and/or your work? (Check all that apply)

Survey respondents chose a number of ways in which the educational opportunities have impacted them and their work. The most frequently chosen answers included: I can relate better to Sharp team members (93%); I have learned to protect my own mental and emotional well-being (93%); and I have utilized resources I learned about for friends, family, and neighbors (64%). See Table 29.

Table 28. Impact of Educational Opportunities

Educational Opportunities	%*	Count
I can better relate to Sharp team members	93%	13
I have learned how to protect my own mental and emotional well-being	93%	13
I have utilized resources I learned about for my family, friends, or neighbors	64%	9
My supervisor or peers have created a more inclusive work environment	21%	3
I am better prepared to help meet employees' needs with resources at Sharp or in the community	7%	1
I am not sure if these opportunities have had an impact	7%	1
These opportunities have not had an impact	0%	0
Other *(no responses were written in)*	14%	2
Total*		**14**

*Responses will add up to be more than 100% due to the ability of participants to choose all that apply.

Question 13. Learning interest (n=15)

What specific educational topics would you be most interested in learning more about? (Check all that apply)

Respondents were interested in a variety of educational topics, with the most interest expressed in implicit/unconscious bias impact on decision-making (80%); defining cultural humility and applying it to health care (53%); impact of spirituality on health care (27%), maternal and infant health – special focus on the Black community (27%); disparities in the Black community (27%); and caring for military veterans (27%). See Table 30.

Table 29. Educational Topics of Interest

Educational Topics	%*	Count
Implicit/Unconscious bias impact on decision-making	80%	12
Defining cultural humility and applying it to health care	53%	8
Impact of spirituality on health care	27%	4
Maternal and infant health – special focus on the Black community	27%	4
Disparities in the Black community	27%	4
Caring for military veterans	27%	4
Care in the senior/elderly community	20%	3
Disparities in Asian communities	20%	3
Honoring neurodiversity in health care	13%	2
Access to fertility/reproductive services	13%	2
LGBTQIA+ focused health care	13%	2
I am not interested in educational sessions	13%	2
Disparities in immigrant communities	7%	1
Disparities in LatinX community	7%	1
Other *(hard to fit it all into the workday)*	7%	1
Total*		**15**

*Responses will add up to be more than 100% due to the ability of participants to choose all that apply.

V. Conclusions

The Sharp 2022 CHNA survey received a robust response from Sharp team members. Altogether, 108 employees representing many occupations and entities of Sharp answered the surveys. These team members were responsive to all survey questions and made good use of the open-ended questions to share ideas about how to improve both patient and employee care.

Together, the results of the two surveys suggest that both patients and employees are hurting. And while survey respondents recognized and appreciated the services and resources Sharp offers, they also reported that more personal support for patients and employees is needed. At the same time, respondents were cognizant that Sharp's health care system, its leaders, providers, and staff are all stretched thin, rendering meeting these critical needs extremely challenging. The results of the survey are summarized below, using the respondents' own words to contextualize the data whenever possible.

Patient Impacts (Survey One)

Survey results provide clear evidence that COVID-19 has had significant, serious effects on the patients who Sharp serves. More than three-quarters of survey participants indicated that COVID-19 has had a negative impact on a wide variety of clinical and social issues, including: isolation among seniors/adults; anxiety; depression; access to primary and behavioral health care; fear about utilizing health care; financial security; access to social and emotional support, community resources, and transportation; employment stability; and food security.

When asked to choose which issues were of most concern for patients, survey respondents answers were primarily centered on issues related to behavioral health. Respondents reported that the issues most impacting patients were increased isolation among seniors and increased rates of anxiety and depression. At the same time, respondents indicated that patients have decreased access to the very resources that would help address these growing needs: emotional and social support and behavioral health services. And while certain populations were of particular concern – among them caregivers of older adults, Medi-Cal and Medicare beneficiaries, people of limited English Proficiency, and racial/ethnic minorities (especially Hispanic and Black/African American people), many respondents noted that these issues are affecting everyone.

> *"There is a mental health pandemic that is not being addressed across the board."*
> -- Survey One Respondent

When asked if Sharp had programs and services to address these critical issues, the majority of survey respondents answered "no." For example, 56% of respondents said Sharp is not implementing programs/services to address increased isolation in seniors, and 71% of people said that Sharp is not addressing limited access to emotional and social support. Nevertheless, many examples of relevant Sharp programs and resources that target these types of behavioral health issues were offered. Sharp efforts noted by respondents included educational efforts like posters, newsletters, and emails, referrals for case management and other services, outreach and follow-up with patients, and telehealth options such as online support groups.

> *Case management, social work, and behavioral health programs are available at Sharp. However, many of these programs have limited resources, staffing shortages, and large caseloads that do not allow adequate time to impact care.*
> --Survey One Respondent

Several themes recurred among the respondents when queried about additional ways to address these issues. Respondents' recommendations focused on providing more "human contact," including implementing more follow-up calls with patients, and ideally, home visits; providing supportive services to caregivers; and enabling safe visitation even during COVID-19. They also discussed raising awareness about existing resources and expanding resources that are already in place. Another area of focus was on increasing the number and availability of behavioral health providers, potentially through contractors, although respondents noted that behavioral health contractors are not widely available. They also discussed decreasing barriers to access to behavioral health providers. Recommendations included ensuring that everyone, including employees, understands how to access services; addressing insurance coverage issues; and simplifying process to make appointments. Respondents also mentioned creating more community-based programs, and several recommendations emphasized the importance of offering behavioral health services in the patient's primary language. Several respondents noted the challenges associated with implementing these suggestions, including limited resources within Sharp and with other behavioral health providers.

Virtual Visits (Survey One)

When asked about virtual video visits, the majority of survey participants indicated that virtual video visits were **not** easy for patients to access due to lack of access to, knowledge about, and ability to afford technology, as well as insufficient internet access and unreliable technology. Most also agreed that many patients prefer in-patient visits for a better connection with their provider and confidence in their care. Despite these results, 95% of respondents agreed that many telehealth modalities are potentially beneficial to patients, especially virtual video visits, electronic medical reminders, secure messaging, and electronic health education.

Employee Impacts (Survey Two)

Although the sample size was smaller (n=16) for the survey that assessed COVID-19 impacts on employees, results suggest serious concerns about the well-being of Sharp employees as well. The vast majority of survey participants (>75%) believe that COVID-19 has affected employees' levels of anxiety, stress, depression, and

frustration. They indicated that employees are more likely to wish to change careers or leave the workforce and that they are more isolated. At the same time, team members are feeling more urgency about accessing behavioral health assistance but have limited access to emotional and social supports. Few respondents indicated that they expected these issues to get better in the coming year; most indicated that they would either stay about the same or worsen.

Fortunately, survey respondents believe that Sharp is implementing programs to address two of the most pressing of these concerns, including 1) increased anxiety or stress and 2) increased frustration or disengagement. For example, 100% of respondents agreed that Sharp has programs to address employees' increased anxiety and stress. Frequently cited examples of Sharp's efforts in these areas include the EAP, Best Health, Safe Speak, leadership training, and wellness resources, especially mindfulness. Recommendations for other ways Sharp could address these issues included: expanding mental health supports currently in place and increasing communication about available services; hiring more staff; on-site childcare; making EAP entity-based rather than centralized; and having leadership meet with team members.

> *"Create opportunities for employees to hear from others, maybe even leaders, who may have experienced the same thing."* - Survey Two Respondent

> *"Leaders should meet with team members where they are to listen to their needs rather than sending emails or memos."* – Survey Two Respondent

The third issue chosen as most severely impacting employees was an increased desire to change careers or leave the workforce, and for this issue, 78% of survey respondents indicated that Sharp does not have programs or services in place to alleviate this problem. Survey participants also noted the difficulty of addressing this issue, noting how ubiquitous it is. Recommendations about efforts that could be made to address the increased desire to change careers or leave the workplace including increasing communication to discover underlying issues, work-life balance programs, reevaluating the compensation philosophy, better new graduate programs, and flexibility in hiring new staff.

> *"It's hard to {make recommendations} as many healthcare workers are deciding to get out altogether.*
> - -Survey Two Respondent

Survey respondents recognized and appreciated Sharp's many competing priorities to manage. They understood that the major barrier to more fully meeting patient and employee needs is limited resources for multiple, competing priorities. Major competing priorities listed included finances and fear of financial failure, staffing, staff and leadership stretched too thin, space, COVID-related restrictions, interest, employees feeling that they don't have the time to care for themselves, and patient satisfaction scores.

> *"Actually, that is it…too many competing priorities without though on teams and individual employees."*
> -Survey Two Respondent

To address these constraints, suggestions included supporting leaders, engaging leaders in this issue, making presentations virtual or available via video at any time, using interns, grants and support from executive leadership, and partnering with other organizations on new initiatives.

> *"How can we expect leaders to support their team when they are so stretched? As a director, I have no leads or supervisors to assist me. I want so much to be there for my team, but I cannot due to the lack of resources for me."*
> --Survey Two Respondent.

Respondents emphasized the importance of addressing employee well-being and reducing turnover, as described by this Survey Two respondent:

> *"Our conservative approach over the years has kept lay-offs at a minimum and has kept our ratings high. Ow we're experiencing turnover like never before which requires us to change with the time...combine better pay with a sense of community, and our staff will feel valued and will most likely stay as a proud member of what our organization offers the community."*
> --Survey Two Respondent.

Education (Surveys One and Two)

Both surveys asked respondents to comment on their utilization of educational opportunities at Sharp. In Survey One, 62% of respondents had attended educational sessions; in Survey Two nearly everyone had. The most popular sessions included Leadership Development, Safe Speak, and Current Conversations. For those who were unable to attend, work schedule conflicts were the primary reason given; however, some noted feeling too overwhelmed to participate. Most respondents felt that the sessions were impactful. They indicated that these educational opportunities better prepared them to meet patient needs, to relate to patients, to relate to fellow team members, and to protect their own mental health and well-being. The topics of greatest interest for future educational sessions were care in the senior community, defining and applying cultural humility, and implicit/unconscious bias and its impact on decision making.

> *"I can't even begin to think of what I might benefit from, there is not time to care for oneself."*
> -- Survey One Respondent

Final Thoughts and Next Steps

As evidenced throughout this report, the need for increased support and human connection in health care – both for patients and staff – is essential to address the most acute needs experienced by Sharp's community. Patients would benefit from follow-up calls, home visits, and visitors when they are in the hospital. Employees would like to have more opportunities to meet with and hear from leadership, to hear about other employees' experiences, and to participate in educational sessions on their own time. In addition, most critically, it seems clear that the community is in a behavioral health crisis. And while the behavioral health of patients and employees is worsening, the availability of behavioral health providers has decreased and access to timely behavioral health care services has become even more difficult. Respondents emphasized that efforts must be made to increase the availability of behavioral health care providers and to ensure easy access to them for both patients and employees. These findings will help guide Sharp's internal discussions and program planning to address these complex issues with engagement, care and empathy.

Appendix A: Survey One, Additional Data

Q3. Impact on Clinical Needs (n=92)

A response of No impact received a score of zero while major impact received a score of three, therefore the highest score possible was three.

The table below lists the mean impact score for each issue, a high mean score represents the greater impact across issues. Increased isolation among seniors/older adults, increased anxiety, and increased depression were all identified as having the most impact on patients' clinical needs due to COVID.

Table 30. The Average (mean) Impact of COVID-19 on Clinical Needs.

Clinical Issue	Mean Impact	Std Deviation	# of Respondents
Increased isolation among seniors/older adults	2.7	0.5	89
Increased anxiety	2.7	0.5	90
Increased depression	2.7	0.6	88
Limited access to behavioral health care	2.6	0.6	78
Limited access to specialty care	2.4	0.7	84
Increased fear in utilization of health care services	2.2	0.7	87
Limited access to primary care	2.1	0.8	83
Difficulty accessing video visits	2	0.8	84
Decreased health literacy (e.g., capacity to process or understand basic health information and services in order to make appropriate health decisions)	1.8	0.7	81
Limited access to essential patient supplies or durable medical equipment (DME)	1.6	0.8	67

Q4. Impact on Social Needs (n=92)

Table 31. The Average (mean) Response to the Impact of COVID-19 on Social Needs

Social Needs	Mean Impact	Std Deviation	# of Respondents
Limited access to emotional or social support (e.g., support groups)	2.6	0.6	88
Increased financial insecurity	2.5	0.7	86
Increased employment instability/unemployment	2.5	0.7	86
Limited access to community resources (e.g., housing, financial assistance, in-home support, etc.)	2.4	0.7	84
Limited access to transportation	2.3	0.8	85
Increased food insecurity	2.0	0.8	83
Increased stigma experienced in health care settings*	2.0	0.9	75

Q5. Top 3 issues that impacted patients

Issues Impacting Patients	%	# of Respondents
1. Increased isolation among seniors/older adults	52%	48
2. Increased anxiety	46%	42
3. Increased depression	34%	31
4. Limited access to behavioral health care	32%	29
5. Increased financial insecurity	22%	20
6. Limited access to emotional or social support (e.g., support groups)	20%	18
7. Increased employment instability/unemployment	14%	13
8. Increased fear in utilization of health care services	14%	13
9. Limited access to primary care	13%	12
10. Limited access to community resources (e.g., housing, financial assistance, in-home support, etc.)	13%	12
11. Difficulty accessing video visits	10%	9
12. Limited access to specialty care	9%	8
13. Increased food insecurity	7%	6
14. Increased stigma experienced in health care settings*	7%	6
15. Limited access to transportation	5%	5
16. Decreased health literacy (e.g., capacity to process or understand basic health information and services in order to make appropriate health decisions)	2%	2
17. Limited access to essential patient supplies or durable medical equipment (DME)	2%	2
Total**		**92**

*Stigma can be generally defined as negative attitudes or beliefs towards another individual or group which can result in shame, embarrassment, or fear. The stigma referenced below could either be directly related to a COVID-19 diagnosis or vaccination status, or unrelated (e.g., based on age, race/ethnicity, gender, etc.).
**Responses will add up to be more than 100% due to the ability of participants to choose all that apply.

The tables below are for Issues 7 through 17. Five questions were asked for each issue (Q9-13)

Need 7: Increased employment instability/unemployment (n=13)

9. Are there specific populations of patients who have been especially impacted by COVID in relation to [Field-1]? (Check all that apply)

#	Answer	%	Count
4	Parents of infants, toddlers, or school aged children	60%	6
6	Caregivers of adults or older adults	60%	6
2	Limited English proficiency	50%	5
1	Refugee or newly immigrated	40%	4
7	Patients utilizing Medi-Cal	30%	3
3	LGBTQIA+ individuals	20%	2
5	Pregnant Women	10%	1

8	Patients utilizing Medicare	10%	1
9	Other (please specify)	20%	2
	Total	100%	10

Increased employment instability/unemployment - Other (please specify) - Text

Vaccine mandates for children and adults are destroying freedom of choice and trust in government and healthcare institutions.
all populations

10. Are there particular racial or ethnic groups of patients who have been more impacted by COVID in relation to [Field-1]? (Check all that apply)

#	Answer	%	Count
5	Hispanic	60%	3
6	Multiracial	60%	3
7	White	60%	3
1	Black/African American	40%	2
3	Asian	40%	2
2	American Indian/Alaska Native	20%	1
4	Native Hawaiian/Other Pacific Islanders	20%	1
8	Other (*all racial/ethnic groups*)	20%	1
	Total	100%	5

11. 13_Q11 - Has Sharp implemented programs/services that have helped address [Field-1]?

#	Answer	%	Count
1	Yes	15%	2
2	No	85%	11
	Total	100%	13

12. Increased employment instability/unemployment - Please provide one to two examples of Sharp's efforts to address this issue.

Employee assistance
help with childcare services

13. Increased employment instability/unemployment - What ideas do you have that might further address

Supporting completion of SDI (State disability) paperwork. We have major barriers to have MDs complete applications, delaying income for pts who are unable to work. Supporting mental health and substance abuse access to help pts recover and get back to work. .
Do not force people to leave this state due to loss of freedom and tyranny.
n/a
Continue to offer support through employee assistance
Really don't have any ideas unfortunately

[Field-

Need 8: Increased fear in utilization of health care services (n=13)

9. Are there specific populations of patients who have been especially impacted by COVID in relation to [Field-1]? (Check all that apply)

#	Answer	%	Count
6	Caregivers of adults or older adults	36%	4
8	Patients utilizing Medicare	27%	3
2	Limited English proficiency	18%	2
4	Parents of infants, toddlers, or school aged children	18%	2
5	Pregnant Women	18%	2
3	LGBTQIA+ individuals	9%	1
7	Patients utilizing Medi-Cal	9%	1
1	Refugee or newly immigrated	0%	0
9	Other (*Organ Transplant patients, Populations appropriate for cancer screenings*)	18%	2
	Total	100%	11

10. Are there particular racial or ethnic groups of patients who have been more impacted by COVID in relation to [Field-1]? (Check all that apply)

#	Answer	%	Count
1	Black/African American	0%	0
2	American Indian/Alaska Native	0%	0
3	Asian	0%	0
4	Native Hawaiian/Other Pacific Islanders	0%	0
5	Hispanic	0%	0
6	Multiracial	0%	0
7	White	0%	0
8	Other (*No particular racial or ethnic groups)*	100%	1
	Total	100%	1

11. Has Sharp implemented programs/services that have helped address [Field-1]?

	Percentage	Count
Yes	77%	10
No	23%	3
Total	13	13

12. Increased fear in utilization of health care services - Please provide one to two examples of Sharp's efforts to address this issue.

Educating staff through continual Covid updates via email and Sharp.com
Case managers are assisting patient's w/ coordination of services & are continuously providing education on COVID safety measures
telehealth visits
pROMOTING tELEHEALTH
Commercials on TV, written materials addressing concerns
TV commercials emphasizing safety in return; Patient information distributed on measures taken to increase their safety and steps we are taking.
Screening and assuring patients of precautions taken to make our environment safe
family resource tent at hospital entrance
TV commercials and other media outlets emphasizing safety at clinics and hospitals. Increased availability of telehealth options.
Posters and signs in Hospitals. TV informationals

13. Increased fear in utilization of health care services - What ideas do you have that might further address [Field-1]?

Education
Community Outreach and marketing, use of the Senior Resource Center
continues education
UNKNOWN
Continue commercials
TV commercials and education on TV and websites

Need 9: Limited access to primary care (n=12)

9. Are there specific populations of patients who have been especially impacted by COVID in relation to [Field-1]? (Check all that apply)

#	Answer	%	Count
6	Caregivers of adults or older adults	56%	5

8	Patients utilizing Medicare	56%	5
2	Limited English proficiency	33%	3
7	Patients utilizing Medi-Cal	33%	3
1	Refugee or newly immigrated	11%	1
3	LGBTQIA+ individuals	0%	0
4	Parents of infants, toddlers, or school aged children	0%	0
5	Pregnant Women	0%	0
9	Other (please specify)	22%	2
	Total	100%	9

10. Limited access to primary care - Other (please specify) - Text

All who have experienced ER visit and or hospitalization were impacted
i believe all groups are affected

11. Are there particular racial or ethnic groups of patients who have been more impacted by COVID in relation to [Field-1]? (Check all that apply)

#	Answer	%	Count
5	Hispanic	67%	2
1	Black/African American	33%	1
6	Multiracial	33%	1
7	White	33%	1
2	American Indian/Alaska Native	0%	0
3	Asian	0%	0
4	Native Hawaiian/Other Pacific Islanders	0%	0
8	Other (*i believe all groups are affected*)	33%	1
	Total	100%	3

12. Has Sharp implemented programs/services that have helped address [Field-1]?

#	Answer	%	Count
1	Yes	50%	6
2	No	50%	6
	Total	100%	12

13. Limited access to primary care - Please provide one to two examples of Sharp's efforts to address this issue.

telemed visits
1.Telehealth visits by providers and Case Managers 2.Ramp up PDC CM program (SCMG)
SRS has an efficient call center and follow my health system that allows communication with PCPs. Access to PCP with telehealth apts and flexibility to see other PCPs besides patients assigned PCP for an immediate concern. SCMG has overall poor access/communication with PCP and poor access to appointments.
Assistance with scheduling primary care appointments
Working with PCP offices to assist with staffing shortages, hiring new PCPs
Telehealth PCP visits

14. Limited access to primary care - What ideas do you have that might further address [Field-1]?

Offer more in-office visits. Not all pts have facetime capability, and those who are hard of hearing do not like phone appts.
Members were having difficulty accessing MD /staff when offices are physically closed-MD offices should ensure that someone is consistently able to take messages and respond to messages in a timely manner
SCMG doctors should all be on the same EHR. SCMG needs a streamlined call center/system to address patients needs, schedule appointments, and for doctors to be able to communicate and access one another's progress notes and plan of care.
Increased providers which would allow patients to see primary care more expeditiously
SCMG does not have Home visiting NPs or PAs. Pts need more appt availability, not sure how to get more staff on the panel.
not at this time
do not know answer to this question

Need 10: Limited access to community resources (e.g., housing, financial assistance, in-home support, *etc.)*

9. Are there specific populations of patients who have been especially impacted by COVID in relation to [Field-1]? (Check all that apply)

#	Answer	%	Count
7	Patients utilizing Medi-Cal	63%	5
1	Refugee or newly immigrated	50%	4
2	Limited English proficiency	38%	3
6	Caregivers of adults or older adults	38%	3
8	Patients utilizing Medicare	38%	3
5	Pregnant Women	13%	1
3	LGBTQIA+ individuals	0%	0
4	Parents of infants, toddlers, or school aged children	0%	0
9	Other (*Every population is impacted, Everybody has limited access d/t Covid rules/regulations*)	25%	2
	Total	100%	8

10. Are there particular racial or ethnic groups of patients who have been more impacted by COVID in relation to [Field-1]? (Check all that apply)

#	Answer	%	Count
1	Black/African American	75%	3
5	Hispanic	75%	3
3	Asian	25%	1
7	White	25%	1
2	American Indian/Alaska Native	0%	0
4	Native Hawaiian/Other Pacific Islanders	0%	0
6	Multiracial	0%	0
8	Other (everybody)	25%	1
	Total	100%	4

11. Has Sharp implemented programs/services that have helped address [Field-1]?

#	Answer	%	Count
1	Yes	10%	1
2	No	90%	9
	Total	100%	10

12. . Limited access to community resources (e.g., housing, financial assistance, in-home support, etc.) - Please provide one to two examples of Sharp's efforts to address this issue

    CIE integration, social work case management

13. Limited access to community resources (e.g., housing, financial assistance, in-home support, etc.) - What ideas do you have that might further address [Field-1]?

None at this time.
I am unaware for actions taken by Sharp
HIRE MORE SOCIAL WORKERS! Sharp Rees-Stealy should have a behavioral health/social work department
Sharp sponsored ILF or RCU for patients requiring further support post-discharge and are at risk for homelessness.

Need 11: Difficulty accessing video visits (n=12)

9. Are there specific populations of patients who have been especially impacted by COVID in relation to [Field-1]? (Check all that apply)

#	Answer	%	Count
1	Refugee or newly immigrated	29%	2
2	Limited English proficiency	29%	2
6	Caregivers of adults or older adults	29%	2
7	Patients utilizing Medi-Cal	14%	1
8	Patients utilizing Medicare	14%	1
3	LGBTQIA+ individuals	0%	0
4	Parents of infants, toddlers, or school aged children	0%	0
5	Pregnant Women	0%	0
9	Other (please specify)	57%	4
	Total	100%	7

Difficulty accessing video visits - Other (please specify) - Text

elderly population who are not tech savvy
Older adult population
Elderly technology-challenged patients
Seniors who do not have a computer or knowledge of how to use.

10. Are there particular racial or ethnic groups of patients who have been more impacted by COVID in relation to [Field-1]? (Check all that apply)

#	Answer	%	Count
6	Multiracial	100%	1
1	Black/African American	0%	0
2	American Indian/Alaska Native	0%	0
3	Asian	0%	0
4	Native Hawaiian/Other Pacific Islanders	0%	0
5	Hispanic	0%	0
7	White	0%	0
8	Other (please specify)	0%	0
	Total	100%	1

11. Has Sharp implemented programs/services that have helped address [Field-1]?

#	Answer	%	Count
1	Yes	56%	5
2	No	44%	4
	Total	100%	9

12. Difficulty accessing video visits - Please provide one to two examples of Sharp's efforts to address this issue.

phone visits often offered.
lending equipment such as iPads to residential facility, phone contact
On-site training with patients to increase competency in using telehealth services.
MEND PROGRAM
Sending link to phone via text or email.

13. Difficulty accessing video visits - What ideas do you have that might further address [Field-1]?

all providers should use the same telemed methods/platform to make it easier for pts to access video visits
No all medical insurance pay for the kind of service
supplying more iPads
There needs to be more staffing resources to literally "hold patients hands" to walk them through how to access the telemedicine visits as the current process to send them an e-mail with instructions is less than adequate. When we first had a staff person who could assist them with this over the phone LIVE, things flowed much more efficiently. But with financial constraints, we were not allowed to continue utilizing this person or continue this practice. Current high volumes and staffing levels prohibit regular dept staff ability to do this.
None at this time
Other than the MEND staff, there should be Sharp staff that can do a practice run of video visits to certain populations, like the elderly.
Internet access
Offer options to all patients when calling in for an appointment .

Need 12: Limited access to specialty care (n=9)

9. Are there specific populations of patients who have been especially impacted by COVID in relation to [Field-1]? (Check all that apply)

#	Answer	%	Count
8	Patients utilizing Medicare	33%	2
1	Refugee or newly immigrated	17%	1
2	Limited English proficiency	17%	1
3	LGBTQIA+ individuals	17%	1

4	Parents of infants, toddlers, or school aged children	17%	1
5	Pregnant Women	17%	1
6	Caregivers of adults or older adults	17%	1
7	Patients utilizing Medi-Cal	17%	1
9	Other (please specify)	17%	1
	Total	100%	6

Limited access to specialty care - Other (please specify) - Text

cancer patients - due to MDs being overwhelmed

10. Are there particular racial or ethnic groups of patients who have been more impacted by COVID in relation to [Field-1]? (Check all that apply)

#	Answer	%	Count
1	Black/African American	100%	2
2	American Indian/Alaska Native	100%	2
5	Hispanic	100%	2
3	Asian	50%	1
6	Multiracial	50%	1
7	White	50%	1
4	Native Hawaiian/Other Pacific Islanders	0%	0
8	Other (please specify)	0%	0
	Total	100%	2

11. Has Sharp implemented programs/services that have helped address [Field-1]?

#	Answer	%	Count
1	Yes	43%	3
2	No	57%	4
	Total	100%	7

12. Limited access to specialty care - Please provide one to two examples of Sharp's efforts to address this issue.

Expansion of social work interventions for at-risk populations.

Working with cancer specialists across the system to improve access within and among various practices

Case management and SW consults

13. Limited access to specialty care - What ideas do you have that might further address [Field-1]?

Unfortunately, we seem to have a shortage of specialists and staffing in specialty areas.

Clarity around process to access specialty care services

Need 13: Increased food insecurity (n=8)

9. Are there specific populations of patients who have been especially impacted by COVID in relation to [Field-1]? (Check all that apply)

#	Answer	%	Count
7	Patients utilizing Medi-Cal	100%	4
8	Patients utilizing Medicare	75%	3
1	Refugee or newly immigrated	50%	2
3	LGBTQIA+ individuals	50%	2
6	Caregivers of adults or older adults	50%	2
2	Limited English proficiency	25%	1
4	Parents of infants, toddlers, or school aged children	25%	1
5	Pregnant Women	25%	1
9	Other (please specify)	0%	0
	Total	100%	4

10. Are there particular racial or ethnic groups of patients who have been more impacted by COVID in relation to [Field-1]? (Check all that apply)

#	Answer	%	Count
1	Black/African American	100%	2
2	American Indian/Alaska Native	100%	2
3	Asian	100%	2
4	Native Hawaiian/Other Pacific Islanders	100%	2
5	Hispanic	100%	2
7	White	100%	2
6	Multiracial	50%	1
8	Other (please specify)	0%	0
	Total	100%	2

11. Has Sharp implemented programs/services that have helped address [Field-1]?

#	Answer	%	Count
1	Yes	67%	4
2	No	33%	2
	Total	100%	6

12. Increased food insecurity - Please provide one to two examples of Sharp's efforts to address this issue.

Foundation Assistance Program
Feeding America & San Diego food bank donations & volunteers
Providing resources to sign up for Calfresh and local food pantries

13. Increased food insecurity - What ideas do you have that might further address [Field-1]?

other than individual teams helping to find resources
Food is Medicine campaign

Need 14: Increased stigma experienced in health care settings (n=6)*

9. Are there specific populations of patients who have been especially impacted by COVID in relation to [Field-1]? (Check all that apply)

#	Answer	%	Count
2	Limited English proficiency	80%	4
1	Refugee or newly immigrated	20%	1
4	Parents of infants, toddlers, or school aged children	20%	1
5	Pregnant Women	20%	1
3	LGBTQIA+ individuals	0%	0
6	Caregivers of adults or older adults	0%	0
7	Patients utilizing Medi-Cal	0%	0
8	Patients utilizing Medicare	0%	0
9	Other (please specify)	20%	1
	Total	100%	5

Increased stigma experienced in health care settings* - Other (please specify) - Text
none in particular

10. Are there particular racial or ethnic groups of patients who have been more impacted by COVID in relation to [Field-1]? (Check all that apply)

#	Answer	%	Count
1	Black/African American	33%	1
5	Hispanic	33%	1
6	Multiracial	33%	1
2	American Indian/Alaska Native	0%	0
3	Asian	0%	0
4	Native Hawaiian/Other Pacific Islanders	0%	0
7	White	0%	0
8	Other (*none in particular*)	33%	1
	Total	100%	3

11. Has Sharp implemented programs/services that have helped address [Field-1]?

#	Answer	%	Count
1	Yes	17%	1
2	No	83%	5
	Total	100%	6

12. Increased stigma experienced in health care settings* - Please provide one to two examples of Sharp's efforts to address this issue.

Case management referral & education

13. Increased stigma experienced in health care settings* - What ideas do you have that might further address [Field-1]?

I dont' have any ideas
continuous education & follow up
increase social assistance to visitors to reduce anxiety

Need 15: Limited access to transportation (n=6)

9. Are there specific populations of patients who have been especially impacted by COVID in relation to [Field-1]? (Check all that apply)

#	Answer	%	Count
7	Patients utilizing Medi-Cal	75%	3
2	Limited English proficiency	50%	2
8	Patients utilizing Medicare	50%	2
1	Refugee or newly immigrated	25%	1
6	Caregivers of adults or older adults	25%	1
3	LGBTQIA+ individuals	0%	0
4	Parents of infants, toddlers, or school aged children	0%	0
5	Pregnant Women	0%	0
9	Other (*homeless*)	25%	1
	Total	100%	4

10. Are there particular racial or ethnic groups of patients who have been more impacted by COVID in relation to [Field-1]? (Check all that apply)

#	Answer	%	Count
1	Black/African American	33%	1
5	Hispanic	33%	1
6	Multiracial	33%	1
2	American Indian/Alaska Native	0%	0
3	Asian	0%	0
4	Native Hawaiian/Other Pacific Islanders	0%	0
7	White	0%	0
8	Other (*Same question as stated above*)	33%	1
	Total	100%	3

11. Has Sharp implemented programs/services that have helped address [Field-1]?

#	Answer	%	Count
1	Yes	40%	2
2	No	60%	3
	Total	100%	5

12. Limited access to transportation - Please provide one to two examples of Sharp's efforts to address this issue.

Sharp Van services has really helped

Caregiver Training

13. Limited access to transportation - What ideas do you have that might further address [Field-1]?

Increase community outreach information of shuttle access
Easier access to Sharp Van services...patient rarely seem to know this service exists...so just making more people aware.
more telehealth

Need 16: Decreased health literacy (e.g., capacity to process or understand basic health information and services in order to make appropriate health decisions) (n=2)

9. Are there specific populations of patients who have been especially impacted by COVID in relation to [Field-1]? (Check all that apply)

#	Answer	%	Count
6	Caregivers of adults or older adults	100%	2
1	Refugee or newly immigrated	50%	1
2	Limited English proficiency	50%	1
3	LGBTQIA+ individuals	50%	1
4	Parents of infants, toddlers, or school aged children	50%	1
5	Pregnant Women	50%	1
7	Patients utilizing Medi-Cal	50%	1
8	Patients utilizing Medicare	50%	1
9	Other (please specify)	0%	0
	Total	100%	2

10. Are there particular racial or ethnic groups of patients who have been more impacted by COVID in relation to [Field-1]? (Check all that apply)

#	Answer	%	Count
6	Multiracial	100%	1
1	Black/African American	0%	0
2	American Indian/Alaska Native	0%	0
3	Asian	0%	0
4	Native Hawaiian/Other Pacific Islanders	0%	0
5	Hispanic	0%	0
7	White	0%	0
8	Other (please specify)	0%	0
	Total	100%	1

11. Has Sharp implemented programs/services that have helped address [Field-1]?

#	Answer	%	Count
1	Yes	0%	0
2	No	100%	2
	Total	100%	2

12. Decreased health literacy (e.g., capacity to process or understand basic health information and services in order to make appropriate health decisions) - Please provide one to two examples of Sharp's efforts to address this issue.
    - No response
13. Decreased health literacy (e.g., capacity to process or understand basic health information and services in order to make appropriate health decisions) - What ideas do you have that might further address [Field-1]?
    - Hosting educational session on Navigating the health care system by disease
    - Utilization of alternative communication of health information. Visual or audio version of the education material

Need 17: Limited access to essential patient supplies or durable medical equipment (DME) (n=2)

9. Are there specific populations of patients who have been especially impacted by COVID in relation to [Field-1]? (Check all that apply)

#	Answer	%	Count
1	Refugee or newly immigrated	0%	0
2	Limited English proficiency	0%	0
3	LGBTQIA+ individuals	0%	0
4	Parents of infants, toddlers, or school aged children	0%	0
5	Pregnant Women	0%	0
6	Caregivers of adults or older adults	0%	0
7	Patients utilizing Medi-Cal	0%	0
8	Patients utilizing Medicare	0%	0
9	Other (*no particular grp*)	100%	1
	Total	100%	1

10. Are there particular racial or ethnic groups of patients who have been more impacted by COVID in relation to [Field-1]? (Check all that apply)
    - No response
11. Has Sharp implemented programs/services that have helped address [Field-1]?

#	Answer	%	Count
1	Yes	50%	1
2	No	50%	1
	Total	100%	2

12. Limited access to essential patient supplies or durable medical equipment (DME) - Please provide one to two examples of Sharp's efforts to address this issue.
    - No response
13. Limited access to essential patient supplies or durable medical equipment (DME) - What ideas do you have that might further address [Field-1]?

    DME suppliers are outsourced so Sharp may need to connect with DME providers and develop strategies to have DME deliveries at a more efficient and timely manner

Q19. Learning Interests (n=84)

What specific educational topics would you be most interested in learning more about? (Check all that apply)

Educational Topics	%	# of Respondents
Care in the senior/elderly community	52%	44
Defining cultural humility and applying it to health care	50%	42
Implicit/Unconscious bias impact on decision-making	40%	34
Disparities in immigrant communities	31%	26
Impact of spirituality on health care	29%	24
Disparities in the Black community	27%	23
Caring for military veterans	27%	23
Disparities in LatinX community	24%	20
Disparities in Asian communities	24%	20
Honoring neurodiversity in health care	23%	19
Maternal & infant health – special focus on the Black community	20%	17
LGBTQIA+ focused health care	19%	16
I am not interested in educational sessions	12%	10
Access to fertility/reproductive services	11%	9
Other (please specify)	6%	5
Total	**100%**	**84**

Appendix B: Survey One Template

***Note**: Survey below intended to capture Sharp employees' perceptions about how COVID-19 is affecting their patients*

Welcome

On behalf of Sharp HealthCare, thank you for taking time to complete this survey. Your honest feedback will help improve the health of our patients and community.

This short survey should take you no more than 10 minutes to complete. All responses are confidential and will be reported back in aggregate form.

We are going to start by asking a few questions to help us understand who you are.

1. Who/what group do you currently represent at Sharp HealthCare? (Check all that apply)
    - Sharp Case Management or Social Work
    - Sharp Community Information Exchange (CIE) Workgroup
    - Sharp Diabetes Educator
    - Sharp Oncology Department (Navigator, Social Worker, Radiation Oncologist, etc.)
    - Sharp Patient Access Services
    - Sharp Rees-Stealy Population Health
    - Sharp Senior Resource Center
    - Sharp ThinkFirst Program
    - Other (please specify)
2. What Sharp entity are you affiliated with?
    - Sharp Chula Vista Medical Center
    - Sharp Community Medical Group
    - Sharp Coronado Hospital and HealthCare Center
    - Sharp Grossmont Hospital
    - Sharp HospiceCare
    - Sharp Mary Birch Hospital for Women & Newborns
    - Sharp Memorial Hospital
    - Sharp Mesa Vista Hospital
    - Sharp McDonald Center
    - Sharp Rees-Stealy Medical Group/Centers
    - Sharp System Services

Current Impact

In Sharp's CHNA survey in 2020, administered to Sharp team members, respondents indicated that COVID had impacted patients and/or the patient experience in several ways. Thinking about the patients with whom you interact, please rate how you think COVID is *currently* impacting them.

3. How is COVID currently impacting the *clinical needs* of patients?

Clinical Issues	No impact at all	Minor impact	Moderate impact	Major impact	Don't Know how pts are currently impacted
a. Increased fear in utilization of health care services					
b. Increased isolation among seniors/older adults					
c. Difficulty accessing video visits					
d. Increased anxiety					
e. Increased depression					
f. Limited access to primary care					
g. Limited access to specialty care					
h. Limited access to behavioral health care					
i. Limited access to essential patient supplies or durable medical equipment (DME)					
j. Decreased health literacy (e.g., capacity to process or understand basic health information and services in order to make appropriate health decisions)					
k. Other (please specify)					
l. Other (please specify)					

4. How is COVID currently impacting the social needs of patients?

**Stigma can be generally defined as negative attitudes or beliefs towards another individual or group which can result in shame, embarrassment, or fear. The stigma referenced below could either be directly related to a COVID-19 diagnosis or vaccination status, or unrelated (e.g., based on age, race/ethnicity, gender, etc.).*

Social Needs	No impact at all	Minor impact	Moderate impact	Major impact	Don't Know how pts are currently impacted
a. Limited access to emotional or social support (e.g., support groups)					
b. Increased food insecurity					
c. Increased financial insecurity					
d. Increased employment instability/unemployment					
e. Limited access to transportation					
f. Limited access to community resources g. (e.g., housing, financial assistance, in-home support, etc.)					

h. Increased stigma experienced in health care settings*					
i. Other (please specify)					
j. Other (please specify)					

Top needs most impacting patients

5. Please choose three issues listed below which have most impacted the patients with whom you interacted during the past year – we will then ask you more questions about those specific issues:

**Stigma can be generally defined as negative attitudes or beliefs towards another individual or group which can result in shame, embarrassment, or fear. This stigma referenced below could either be directly related to a COVID-19 diagnosis, or unrelated (e.g., based on age, race/ethnicity, gender, etc.).*

1. Increased fear in utilization of health care services
2. Increased isolation among seniors/older adults
3. Difficulty accessing video visits
4. Increased anxiety
5. Increased depression
6. Limited access to primary care
7. Limited access to specialty care
8. Limited access to behavioral health care
9. Limited access to essential patient supplies or durable medical equipment (DME)
10. Limited access to emotional or social support (e.g., support groups)
11. Increased food insecurity
12. Increased financial insecurity
13. Increased employment instability/unemployment
14. Limited access to transportation
15. Limited access to community resources (e.g., housing, financial assistance, in-home support, etc.)
16. Increased stigma experienced in health care settings*
17. Decreased health literacy (e.g,. capacity to process or understand basic health information and services in order to make appropriate health decisions)

6. Are there specific populations of patients who have been especially impacted by COVID in relation to [Issue]? (Check all that apply)

Individuals who are:

- ○ Refugee or newly immigrated
- ○ Limited English proficiency
- ○ LGBTQIA+ individuals
- ○ Parents of infants, toddlers, or school aged children
- ○ Pregnant Women
- ○ Caregivers of adults or older adults
- ○ Patients utilizing Medi-Cal
- ○ Patients utilizing Medi**c**are
- ○ Other (please specify): _____

- Don't know

7. Are there particular racial or ethnic groups of patients who have been more impacted by COVID in relation to [Issue One]? (Check all that apply)
   - Black/African American
   - American Indian/Alaska Native
   - Asian
   - Native Hawaiian/Other Pacific Islanders
   - Hispanic
   - Multiracial
   - White
   - Other (please specify): _____
   - Don't know

8. Has Sharp implemented programs/services that have helped address [*Issue*]?
   - Yes
   - No

9. IF yes: Please provide one to two examples of Sharp's efforts to address this issue.
10. What ideas do you have that might further address [*Issue*]?

REPEAT questions 6-10 above for each of the 3 issues identified

Virtual Video Visits

The use of telehealth services virtual video visits has significantly increased since the COVID-19 pandemic began. Please answer the following questions about your current experiences with virtual video visits.

11. My patients can easily access virtual video visits.
    - Strongly agree
    - Agree
    - Disagree
    - Strongly disagree
    - Do not know

12. If disagree or strongly disagree: What causes patients to have difficulty accessing virtual video visits? (Check all that apply):
    - Lack of access to technology (e.g., computers, tablets)
    - Unable to afford necessary technology
    - The technology is not reliable (difficulty with audio or video)
    - Lack of knowledge about technology
    - Insufficient internet access
    - Other (please specify):

13. Do you have patients who prefer in-person visits for reasons other than challenges with access?
    - YES
    - NO

14. (If yes to Q13) Why do those patients prefer in-person visits? (Check all that apply)
    - Concerns about ability of medical personnel to perform a physical exam
    - Prefer to communicate in person
    - Concerns about loss of personal connection between provider and patient
    - Inconvenient
    - Technology challenges
    - Privacy concerns
    - Other, please specify_____

15. Considering your answers above, please select all of the telehealth modalities you believe could benefit your patients and your ability to care for them (Check all that apply):
    a. Virtual video visits
    b. Audio only visits (e.g., telephone)
    c. Secure messaging (e.g., email, portal messages, text)
    d. Remote patient monitoring (e.g., blood pressure, glucose, weight)
    e. Electronic medication reminders
    f. Electronic patient reported outcomes (e.g., pain score, depression or mood screening)
    g. Electronic health education (e.g., self-care skills, wellness, disease specific)
    h. I don't think telehealth has any benefits to patients

Stigma and Health Equity-Related Educational Opportunities

In recent years, and in response to 2019 CHNA findings, Sharp has implemented a number of educational offerings related to stigma, health equity, and patient-centered care. Given its importance, we would like to hear your feedback and recommendations related to this education.

Background: Stigma can be generally defined as negative attitudes or beliefs towards another individual or group which can result in shame, embarrassment, or fear. Stigma in health care settings was identified in the 2019 CHNA as a key health equity issue. Community members highlighted stigma a central barrier to accessing care, seeking treatment and managing health, all which lead to significant health disparities. Further, stigma was observed by a significant proportion of Sharp health care professionals who participated the Phase 2 CHNA Survey conducted in Summer 2020.

16. Have you attended any of the following educational opportunities over the past 12 months? (Check all that apply)
    - Current Conversations (IF CHOOSE - go to Q18)
    - Safe Speak (IF CHOOSE - go to Q18)
    - Breakfast Forum (IF CHOOSE - go to Q18)
    - Grand Rounds (IF CHOOSE - go to Q18)
    - Leadership Development (IF CHOOSE - go to Q18)
    - Other (something other than those items listed above) (IF CHOOSE - go to Q18)
    - I have not attended any educational sessions (IF CHOOSE THIS- go to Q17)

17. IF Q16 response "*I have not attended….":* Why have you not attended any education sessions? (Check all that apply.)
    - Topics not of interest

- Times offered conflicts with work schedule
- Sessions are too long
- Session format does not meet my needs
- I was not aware of any sessions
- Other

18. IF Q16 *response was any of the first six responses then ask this*: How have these educational opportunities impacted you and/or your work? (Check all that apply)
    - I can better relate to patients
    - I am better prepared to help meet patients' needs with resources at Sharp or in the community
    - My supervisor or peers have created a more inclusive work environment
    - I have utilized resources I learned about for my family, friends, or neighbors
    - These opportunities have not had an impact
    - I am not sure if these opportunities have had an impact
    - Other

19. What specific educational topics would you be most interested in learning more about? (Check all that apply)
    - Impact of spirituality on health care
    - Access to fertility/reproductive services
    - LGBTQIA+ focused health care
    - Disparities in LatinX community
    - Disparities in immigrant communities
    - Care in the senior/elderly community
    - Disparities in the Black community
    - Disparities in Asian communities
    - Honoring neurodiversity in health care
    - Caring for military veterans
    - Maternal and infant health – special focus on the Black community
    - Implicit/Unconscious bias impact on decision-making
    - Defining cultural humility and applying it to health care
    - Other (please specify)
    - I am not interested in educational sessions

We thank you for your time spent taking this survey.

Your response has been recorded.

Appendix C: Survey Two, Additional Data

Q1. Sharp Entity Affiliation (n=16)

What Sharp entity are you affiliated with?

Due to the small number of participants in the IPH Sharp Human Resources Survey, responses to this question have been excluded from this document to preserve anonymity.

Q2. Impact on Sharp team members (n=16)

How is COVID currently impacting Sharp team members?

Issues	Mean	Std Deviation	# of respondents
Increased anxiety or stress	2.5	0.9	16
Increased frustration or disengagement (empathy fatigue)	2.5	0.9	16
Increased desire to change careers or to leave the workforce	2.3	0.8	16
Increased depression	2.2	1.0	16
Increased urgency for and acuity of behavioral health assistance	2.1	1.0	15
Increased isolation	2.0	0.8	16
Limited access to emotional or social support (e.g., support groups)	1.9	0.9	16
Limited access to dependent care (childcare or elder care)	1.8	1.0	16
Increased financial insecurity	1.7	0.9	16
Increased stigma in the workplace*	1.6	0.9	16
Limited access to health care – either primary care or specialty care	1.4	1.0	14
Limited access to community resources (e.g., transportation, financial assistance)	1.4	0.9	14
Increased fear in utilization of health care services	1.3	0.9	15
Increased food insecurity	1.1	0.8	12
Other (please specify)*			

*Other responses (n=3):

- Egocentric: Moderate Impact
- Feeling overworked: Major impact
- Feeling undervalued: Major impact

Q3. Future Impact (n=15)

How do you think COVID will impact Sharp team members over the next year?

Respondents were asked to indicate whether these issues would improve, stay the same, or worsen over the coming year. A score of “1” was given when a respondent chose “get better,” a score of “0” was given when the respondent chose “stay the same,” and a score of -1 was given when a respondent chose “get worse.” These scores were then averaged. Those issues with a mean score over 1, therefore, are listed as expected to improve,

those with a mean score of 0 are listed as expected to stay the same, and those with a negative mean score are listed as expected to worsen.

Future Impact	Mean score
Issues identified as expected to improve over the next year	
Increased fear in utilization of health care services	0.2
Increased isolation	0.1
Limited access to dependent care (childcare or elder care)	0.1
Issues identified as expected to stay the same over the next year	
Limited access to health care – either primary care or specialty care	0.0
Increased stigma in the workplace*	0.0
Issues identified as expected to worsen over the next year	
Limited access to emotional or social support (e.g., support groups)	-0.1
Increased food insecurity	-0.2
Limited access to community resources (e.g., transportation, financial assistance)	-0.3
Increased anxiety or stress	-0.4
Increased depression	-0.4
Increased urgency for and acuity of behavioral health assistance	-0.5
Increased financial insecurity	-0.5
Increased frustration or disengagement (empathy fatigue)	-0.6
Increased desire to change careers or to leave the workforce	-0.6

Issue	Mean	Std Deviation	Count
Increased fear in utilization of health care services	0.2	0.8	13
Increased isolation	0.1	0.7	15
Limited access to dependent care (childcare or elder care)	0.1	0.7	14
Limited access to health care – either primary care or specialty care	0.0	0.8	14
Increased stigma in the workplace*	0.0	0.9	13
Limited access to emotional or social support (e.g., support groups)	-0.1	0.7	13
Increased food insecurity	-0.2	0.6	11
Limited access to community resources (e.g., transportation, financial assistance)	-0.3	0.6	12
Increased anxiety or stress	-0.4	0.7	15
Increased depression	-0.4	0.6	15
Increased urgency for and acuity of behavioral health assistance	-0.5	0.7	15
Increased financial insecurity	-0.5	0.5	13
Increased frustration or disengagement (empathy fatigue)	-0.6	0.5	15
Increased desire to change careers or to leave the workforce	-0.6	0.6	14

*Stigma can be generally defined as negative attitudes or beliefs towards another individual or group which can result in shame, embarrassment, or fear. The stigma referenced below could either be directly related to a COVID-19 diagnosis or vaccination status, or unrelated (e.g., based on age, race/ethnicity, gender, etc.).

Q4: Top 3 issues that impacted patients the most this past year

Please choose three issues listed below which have most impacted the Sharp team members during the past year - we will then ask you more questions about those specific issues.

Issue	%	# of respondents
1. Increased anxiety or stress	**93%**	**14**
2. Increased frustration or disengagement (empathy fatigue)	**73%**	**11**
3. Increased desire to change careers or to leave the workforce	**60%**	**9**
4. Increased depression	20%	3
5. Increased urgency for and acuity of behavioral health assistance	13%	2
6. Limited access to dependent care (childcare or elder care)	13%	2
7. Limited access to emotional or social support (e.g., support groups)	7%	1
8. Limited access to health care – either primary care or specialty care	7%	1
9. Increased isolation	7%	1
10. Limited access to community resources (e.g., transportation, financial assistance)	0%	0
11. Increased food insecurity	0%	0
12. Increased financial insecurity	0%	0
13. Increased stigma in the workplace*	0%	0
14. Increased fear in utilization of health care services	0%	0
15. Other (feeling overworded with little additional resources)	7%	1
Total*		15
*Totals may add up to be more than 100% due to		

The tables below include data from Issues 4-9. Issues 10 through 14 were not identified and therefore there is no data to report.

Need 4: Increased depression

5. Issue Increased depression _Q5 - Has Sharp implemented programs/services that have helped address this issue for Sharp team members?

#	Answer	%	Count
1	Yes	100%	3
2	No	0%	0
	Total	100%	3

6. Increased depression - Please provide one to two examples of Sharp's efforts to address this issue.
    - lots of wellness forums
    - n/a
    - Best Health & Wellness
7. Increased depression - What recommendations do you have that might further improve this issue?

- Sharp Team members are doing a great job.

8. Increased depression - What (if any) are the competing priorities that could prevent Sharp from implementing these recommendations?
    - None
9. Increased depression - Please provide suggestions for how Sharp can make time or resources available to address these recommendations.
    - Sharp Team members have been very proactive and not afraid to tackle all issues.

Need 5: Increased urgency for and acuity of behavioral health assistance

5. Has Sharp implemented programs/services that have helped address this issue for Sharp team members?

#	Answer	%	Count
1	Yes	100%	2
2	No	0%	0
	Total	100%	2

6. Increased urgency for and acuity of behavioral health assistance - Please provide one to two examples of Sharp's efforts to address this issue.
    - Expanded behavioral health services.
    - employee assistance program
7. Increased urgency for and acuity of behavioral health assistance - What recommendations do you have that might further improve this issue?
    - hire more team members to handle the large number of employees needing EAP
8. Increased urgency for and acuity of behavioral health assistance - What (if any) are the competing priorities that could prevent Sharp from implementing these recommendations?
    - limited skilled therapist
9. Increased urgency for and acuity of behavioral health assistance - Please provide suggestions for how Sharp can make time or resources available to address these recommendations.
    - No response

Need 6: Limited access to dependent care (childcare or elder care)

5. Issue 10_Q5 - Has Sharp implemented programs/services that have helped address this issue for Sharp team members?

#	Answer	%	Count
1	Yes	100%	2
2	No	0%	0
	Total	100%	2

6. Limited access to dependent care (childcare or elder care) - Please provide one to two examples of Sharp's efforts to address this issue.

    - Introduced Care.com for childcare and elder care backup care. Provided a financial assistance program for childcare services and tutoring to employees. Also, introduced a parenting affinity group.

7. Limited access to dependent care (childcare or elder care) - What recommendations do you have that might further improve this issue?
    - No response
8. Limited access to dependent care (childcare or elder care) - What (if any) are the competing priorities that could prevent Sharp from implementing these recommendations?
    - No response
9. Limited access to dependent care (childcare or elder care) - Please provide suggestions for how Sharp can make time or resources available to address these recommendations.
    - No response

Need 7: Limited access to emotional or social support (e.g., support groups)

5. Has Sharp implemented programs/services that have helped address this issue for Sharp team members?

#	Answer	%	Count
1	Yes	100%	1
2	No	0%	0
	Total	100%	1

6. Limited access to emotional or social support (e.g., support groups) - Please provide one to two examples of Sharp's efforts to address this issue.
    - Parenting Support groups, covid conversations, current conversations, etc.
7. Limited access to emotional or social support (e.g., support groups) - What recommendations do you have that might further improve this issue?
    - increased focus on improving access to these programs. more visible executive sponsorship and endorsement for participation
8. Limited access to emotional or social support (e.g., support groups) - What (if any) are the competing priorities that could prevent Sharp from implementing these recommendations?
    - No response
9. Limited access to emotional or social support (e.g., support groups) - Please provide suggestions for how Sharp can make time or resources available to address these recommendations.
    - No response

Need 8: Limited access to health care – either primary care or specialty care

5. Limited access to health care – either primary care or specialty care - Has Sharp implemented programs/services that have helped address this issue for Sharp team members?

#	Answer	%	Count
1	Yes	0%	0
2	No	100%	1
	Total	100%	1

6. Limited access to health care – either primary care or specialty care Please provide one to two examples of Sharp's efforts to address this issue.
    - No response
7. Limited access to health care – either primary care or specialty care - What recommendations do you have that might further improve this issue?
    - It is difficult to get into health care providers in person or tele medicine
8. Limited access to health care – either primary care or specialty care - What (if any) are the competing priorities that could prevent Sharp from implementing these recommendations?
    - No response
9. Limited access to health care – either primary care or specialty care - Please provide suggestions for how Sharp can make time or resources available to address these recommendations.
    - No response

Need 9: Increased isolation

5. Has Sharp implemented programs/services that have helped address this issue for Sharp team members?

#	Answer	%	Count
1	Yes	100%	1
2	No	0%	0
	Total	100%	1

6. Increased isolation - Please provide one to two examples of Sharp's efforts to address this issue.
    - Ability for teams to meet on line, both for actual work and for special interest items; Best Healh
7. Increased isolation - What recommendations do you have that might further improve this issue?
    - No response
8. Increased isolation - What (if any) are the competing priorities that could prevent Sharp from implementing these recommendations?

- No response

9. Increased isolation - Please provide suggestions for how Sharp can make time or resources available to address these recommendations.
    - No response

Need 15: Other

5. Issue Other_Q5 - Has Sharp implemented programs/services that have helped address this issue for Sharp team members?

#	Answer	%	Count
1	Yes	0%	0
2	No	100%	1
	Total	100%	1

6. Other (please specify) - Please provide one to two examples of Sharp's efforts to address this issue.
    - No response
7. Other (please specify) - What recommendations do you have that might further improve this issue?
    - Invest in providing support to leaders so they can support their team members.
8. Other (please specify) - What (if any) are the competing priorities that could prevent Sharp from implementing these recommendations?
    - Budget; Sharp's priorities is often the executive team and not the front line leaders
9. Other (please specify) - Please provide suggestions for how Sharp can make time or resources available to address these recommendations.
    - No response

Appendix D: Survey Two Template

Sharp CHNA survey questions (for HR staff about employees)

Welcome

On behalf of Sharp HealthCare, thank you for taking time to complete this survey. Your honest feedback will help improve the health of our staff and community.

This short survey should take you no more than 10 minutes to complete. All responses are confidential and will be reported back in aggregate form.

We are going to start by asking a question to help us understand who you are.

1. What Sharp entity are you affiliated with?
    - Sharp Chula Vista Medical Center
    - Sharp Community Medical Group
    - Sharp Coronado Hospital and HealthCare Center
    - Sharp Grossmont Hospital
    - Sharp HospiceCare
    - Sharp Mary Birch Hospital for Women & Newborns
    - Sharp Memorial Hospital
    - Sharp Mesa Vista Hospital
    - Sharp McDonald Center
    - Sharp Rees-Stealy Medical Group/Centers
    - Sharp System Services

Current & Future Impact

In Sharp's CHNA survey in 2020, administered to Sharp staff, respondents indicated that COVID had impacted community members in several ways. Thinking about your role as an HR professional, please rate how you think COVID is *currently* impacting Sharp team members and whether you think the *future impact* of these issues will get worse, stay the same, or improve over the next year

2. How is COVID **currently impacting** Sharp team members?

**Stigma can be generally defined as negative attitudes or beliefs towards another individual or group which can result in shame, embarrassment, or fear. The stigma referenced below could either be directly related to a COVID-19 diagnosis or vaccination status, or unrelated (e.g., based on age, race/ethnicity, gender, etc.).*

	No impact at all	Minor impact	Moderate impact	Major impact	Don't Know how staff are currently impacted
1. Increased fear in utilization of health care services					
2. Increased isolation					

3. Increased anxiety or stress					
4. Increased frustration or disengagement (empathy fatigue)					
5. Increased depression					
6. Increased desire to change careers or to leave the workforce					
7. Increased urgency for and acuity of behavioral health assistance					
8. Limited access to health care – either primary care or specialty care					
9. Limited access to emotional or social support (e.g., support groups)					
10. Limited access to dependent care (childcare or elder care)					
11. Limited access to community resources (e.g., transportation, financial assistance)					
12. Increased food insecurity					
13. Increased financial insecurity					
14. Increased stigma in the workplace*					
15. Other (please specify)					
16. Other (please specify)					

3. How do you think COVID will impact Sharp team members over the next year?

**Stigma can be generally defined as negative attitudes or beliefs towards another individual or group which can result in shame, embarrassment, or fear. This stigma referenced below could either be directly related to a COVID-19 diagnosis or vaccination status, or unrelated (e.g., based on age, race/ethnicity, gender, etc.).*

Type of Issues	**Get better**	**Stay about the same**	**Get worse**	**Don't know**
1. Increased fear in utilization of health care services				
2. Increased isolation				
3. Increased anxiety or stress				
4. Increased frustration or disengagement (empathy fatigue)				
5. Increased depression				
6. Increased desire to change careers or to leave the workforce				
7. Increased urgency for and acuity of behavioral health assistance				
8. Limited access to health care – either primary care or specialty care				
9. Limited access to emotional or social support (e.g., support groups)				
10. Limited access to dependent care (childcare or elder care)				

11. Limited access to community resources (e.g., transportation, financial assistance)				
12. Increased food insecurity				
13. Increased financial insecurity				
14. Increased stigma in the workplace*				
15. Other (please specify)				
16. Other (please specify)				

Top issues most impacting Sharp team members

4. Please choose **three issues** listed below which has most impacted Sharp team members during the past year – we will ask you more questions about those specific issues:

1. Increased fear in utilization of health care services
2. Increased isolation
3. Increased anxiety or stress
4. Increased frustration or disengagement (empathy fatigue)
5. Increased depression
6. Increased desire to change careers or to leave the workforce
7. Increased urgency for and acuity of behavioral health assistance
8. Limited access to health care – either primary care or specialty care
9. Limited access to emotional or social support (e.g., support groups)
10. Limited access to dependent care (childcare or elder care)
11. Limited access to community resources (e.g., transportation, financial assistance)
12. Increased food insecurity
13. Increased financial insecurity
14. Increased stigma in the workplace*
15. Other (please specify)
16. Other (please specify)

**Stigma can be generally defined as negative attitudes or beliefs towards another individual or group which can result in shame, embarrassment, or fear. This stigma referenced above could either be directly related to a COVID-19 diagnosis or vaccination status, or unrelated (e.g., based on age, race/ethnicity, gender, etc.).*

Please answer about the issue: [*auto populate with 1st Issue*]*:*

Please answer about the issue: *Other* [*auto populate with 1st Other Issue (if identified)*]*:*

5. Has Sharp implemented programs/services that have helped address this issue for Sharp team members?
    - Yes
    - No
6. IF yes: Please provide one to two examples of Sharps efforts to address this issue.
7. What recommendations do you have that might further improve this issue?

IF RESPONDED TO QUESTION 7- QUESTIONS 8&9 BELOW

8. What (if any) are the competing priorities that could prevent Sharp from implementing these recommendations?

   Open-ended
9. Please provide suggestions for how Sharp can make time or resources available to address these recommendations.

   Open-ended

REPEAT questions #5-9 for each of the 3 issues identified

Stigma and Health Equity-Related Educational Opportunities

In recent years, and in response to 2019 CHNA findings, Sharp has implemented a number of educational offerings related to stigma, health equity, and patient-centered care. Given its importance, we would like to hear your feedback and recommendations related to this education.

Background: Stigma can be generally defined as negative attitudes or beliefs towards another individual or group which can result in shame, embarrassment, or fear. Stigma in health care settings was identified in the 2019 CHNA as a key health equity issue. Community members highlighted stigma as a central barrier to accessing care, seeking treatment and managing health, all which lead to significant health disparities. Stigma was also observed by a significant proportion of Sharp health care professionals who participated the Phase 2 CHNA Survey conducted in Summer 2020. Further, stigma associated with COVID-19 diagnoses or vaccination status has recently been identified as a key issue.

10. Have you attended any of the following educational opportunities over the past 12 months? (Check all that apply)
    - Current Conversations (IF CHOOSE - go to Q12)
    - Safe Speak (IF CHOOSE - go to Q12)
    - Breakfast Forum (IF CHOOSE - go to Q12)
    - Grand Rounds (IF CHOOSE - go to Q12)
    - Leadership Development (IF CHOOSE - go to Q12)
    - Other (something other than those items listed above) (IF CHOOSE - go to Q12)
    - I have not attended any educational sessions (IF CHOOSE - go to Q11)

11. IF Q10 chose "*I have not attended…":* Why have you not attended any education sessions? (check all that apply)?
    - Topics not of interest
    - Times offered conflicts with work schedule
    - Sessions are too long
    - Session format does not meet my needs
    - I was not aware of any sessions
    - Other (please specify)

12. IF Q10 – any of the first 6 responses: How have these educational opportunities impacted you and/or your work? (Check all that apply)
    - I can better relate to Sharp team members
    - I am better prepared to help meet employees' needs with either resources from Sharp or the community[8]
    - My supervisor and/or peers have created a more inclusive work environment
    - I have utilized resources I learned about for my colleagues, family, friends or neighbors
    - I've learned how to protect my own mental and emotional well-being
    - These opportunities have not had an impact
    - I am not sure if these opportunities have had an impact
    - Other (please specify)

13. What specific educational topics would you be most interested in learning more about? (Check all that apply)
    - Impact of spirituality on healthcare
    - Access to fertility/reproductive services
    - LGBTQIA+ focused health care
    - Disparities in LatinX community
    - Disparities in immigrant communities
    - Care in the senior/elderly community
    - Disparities in the Black community
    - Disparities in Asian communities
    - Honoring neurodiversity in health care
    - Caring for military veterans
    - Maternal and infant health – special focus on the Black community
    - Implicit/Unconscious bias impact on decision-making
    - Defining cultural humility and applying it to health care
    - Other (please specify)
    - I am not interested in educational sessions

We thank you for your time spent taking this survey.
Your response has been recorded.

[8] *In the Qualtrics survey the wording for bullet two was: 'I am better prepared to help meet patients' needs with either resources from Sharp or the community'. The word patients' should have been employees'. Because the survey was given to human resource team members and all survey questions centered around employees, we believe that individuals responded about Sharp employees and their own experiences in this question.*

Appendix

J Sharp Insight Community 2022 CHNA Survey & Findings

Sharp 2022 Community Health Needs Assessment (CHNA) Insight Community Survey
Draft Questions/Question Concepts

Project Requester: Jillian Warriner

Department: Strategic Planning

Project Lead: Aisha Kazmi and Cassie Nordeman

Goals: 1. To explore the current impact of COVID-19 on the community health needs identified from the 2019 CHNA. 2. To collect feedback on Sharp programs designed to address these identified community health needs.

Target Audience: Everyone in community

EMAIL INVITATION:

Email subject line:

Help us positively impact the health of our community

Email body:

Hi [%PanelistName%],

We have a new survey activity for you. Your honest feedback will help us better identify and address health needs within your community. This activity should take about 10 minutes to complete. All of your responses are confidential and will be reported in an aggregate form. Thank you for your time and for your valuable opinion!

(*insert link to survey here)

EMAIL REMINDER:

Email subject line:

Reminder: Help us positively impact the health of our 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 our community's most critical health needs. The activity will close on [Closing Date] at 11:59 PM.

SURVEY DRAFT:

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 care.

This activity should take about 10 minutes of your time.

Page 2 -

1. How is COVID-19 currently impacting you? As you rate the following items, please think about your experiences during the pandemic and if/how that has changed from your experiences prior to the pandemic?

Type of Issues	0 No impact at all	1 Minor impact	2 Moderate impact	3 Major impact	Not Applicable
Increased fear of utilization of health care services					
Increased isolation or decreased access to social support					
Increased anxiety or depression					
Decreased access to in person medical care					
Decreased access to in person behavioral health care					
Decreased access to medications or medical supplies (e.g., blood pressure cuffs, diabetes testing kits, etc.)					
Decreased access to healthy food					
Increased financial uncertainty					
Increased housing instability/homelessness					
Increased unemployment					
Decreased access to transportation					
Decreased access to community resources (e.g., housing, utilities, financial support etc.)					
Increased stigma experienced in health care settings*					

- **For the purposes of this survey, stigma can be generally defined as negative attitudes or beliefs towards another individual or group which can result in shame, embarrassment, or fear. The stigma referenced above could either be directly related to a COVID-19 diagnosis or vaccination status, or unrelated (e.g., based on age, race/ethnicity, gender, etc.).*

2. Please share any comments regarding other ways that COVID-19 is currently impacting your community (optional)

Page 3 –

In addition, COVID-19 changed much of Sharp's in person care to virtual care (appointments, etc.)

3. In the past year, have you interacted with a Sharp health care professional (physician, nurse, etc.) through a telehealth visit? (select all that apply)
    a. Yes—through a virtual video visit.
    b. Yes—through an audio-only (telephone call) visit.
    c. No

4. *(If yes)* How effective was the telehealth visit in addressing your health needs?
   Rating scale: Effective – Slightly effective – Not Effective (3-point scale)
    a. Virtual video visit
    b. Audio-only (telephone) visit

5. (*if yes)* Overall, did you like your telehealth visit?
    a. Yes
        i. What did you like? Please check all that apply.
            1. Convenience
            2. Quicker appointment
            3. Safety
            4. Addressed concern(s)
            5. Other: [Free response]
    b. No
        i. What did you dislike? Please check all that apply.
            1. Did not address concern(s)
            2. Inconvenient
            3. Technology challenges
            4. Privacy concerns
            5. Had to see a health care professional in person anyway
            6. Other: Free response
6. *(all)* How likely are you to choose telehealth visits when they are available?

   Very unlikely – unlikely – neutral – likely – very likely (5-point scale)

The inability to follow a care plan was another challenge observed by community members in last year's Sharp Insight Community Survey conducted in May 2020.

7. Please select the items from the list below that you believe contribute to this challenge (select all that apply).

    a. Financial barriers
    b. Transportation barriers
    c. Lack of support system (friends/family)
    d. Did not understand care plan
    e. I don't know
    f. Other (please specify)
    g. These items do not contribute to the inability to follow a care plan (exclusive answer)

Page 4 –

We also learned about how COVID-19 impacted the availability of and access to supportive resources in the community.

COVID-19 created challenges with access to community resources such as transportation, healthy food, utilities assistance and other needs. Sharp offers programs to assist with access to community resources, and we would like your feedback on those programs.

8. Did you participate in Sharp HealthCare programs designed to help connect patients to support services or community resources?
    a. Yes
    b. No

Question 8 Logic: If no, skip to question 11. If yes, go to question 9.

9. Please select the programs that you participated in:
    a. Sharp Patient Transportation services
    b. 2-1-1 San Diego referral
    c. Other community resource referral (food, housing, transportation, etc.)
    d. Community Information Exchange (CIE) referral
    e. Other (please specify)
10. Did these Sharp programs help connect you to the support services /community resources you were looking for?
    a. Yes
    b. No

    Optional: Please comment on why these programs did not connect you to the services...

Page 5 - Health Concerns

We also learned about the impact of COVID-19 on specific health concerns from the Insight Community Survey conducted last May. For instance:

Aging Concerns: Insight Community survey respondents identified fear and isolation, difficulty accessing care, and difficulty accessing telehealth services due to lack of technology or ability to afford technology as key aging concerns/issues among seniors.

11. Did you or a loved one participate in Sharp HealthCare programs designed to serve older adults/ their caregiver/loved ones with aging concerns?
    a. Yes
    b. No

    Logic: If no, skip to Question 14.

12. If yes, please select from the list below those programs (check all that apply).
    a. Sharp Senior Resource Center
    b. Sharp Senior Health Centers

c. Senior Health Education (e.g. Medicare, mental health, exercise, etc.)
d. Caregiver or family support programs

Behavioral Health: **In addition, Insight Community survey respondents noted an increase in anxiety, isolation and depression due to COVID-19.**

13. Did you participate in any Sharp programs designed to address behavioral health concerns?
    a. Yes
    b. No
    c. Prefer not to say

Logic: If no or prefer not to say, skip to Question 16.

14. If yes, then please check all that apply below.
    a. Sharp behavioral health (anxiety, depression, etc.) screenings or assessments
    b. Sharp behavioral health clinical services
    c. Sharp behavioral health classes or seminars
    d. Sharp behavioral health support groups
    e. Other (please note below)

Page 6- Stigma, Bedside Manner, Inclusion

We also heard about the existence and impact of *stigma in responses from the Insight Community Survey conducted in May, 2020. We would like to get your feedback on current observations of stigma in health care. *For the purposes of this survey, stigma can be generally defined as negative attitudes or beliefs towards another individual or group which can result in shame, embarrassment, or fear. Stigma could either be directly related to a COVID-19 diagnosis or vaccination status, or unrelated (e.g., based on age, race/ethnicity, gender, etc.).

Please select your level of agreement with the following statements:

15. Based on your experiences at Sharp in the past year, please select your level of agreement with the following statements.

    [Likert Scale – Strongly Disagree to Strongly Agree, I have not observed a change]

    a. My physician can more easily relate to me and my concerns for my own physical/mental health
    b. There is an increased level of comfort being my authentic self with my health care providers
    c. My physician's office feels like a safer space. (Examples: Inclusive forms, meet my needs with relation to marital status, pronouns, signage, diverse reading material in the waiting area)
    d. My physician shows more humility and an eagerness to learn when they don't understand something
    e. My physician references fewer common stereotypes/generalizations for people like me

Page "X" – End of survey

Thank you for taking the time to complete this activity. Your feedback provides valuable insight on the health needs in our community. We look forward to sharing the survey findings and continuing this conversation with you in the near future.

Sharp 2022 Community Health Needs Assessment

Sharp Insight Community Survey Report

Nov 2021

Survey Methodology and Background

- **Survey was sent to:** 3,156 Sharp Insight Community members
- **Total respondents:** 619
- **Data collected from:** October 7, 2021 – October 17, 2021
- **Median survey completion time:** 6 minutes 42 seconds
- **Survey goals:**
  1. To explore the current impact of COVID-19 on the community health needs identified from the 2019 CHNA.
  2. To collect feedback on Sharp programs designed to address these identified community health needs.

Total Survey Responses: n=619
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

Executive Summary

- Respondents reported that **increased anxiety** or **depression**, increased **isolation** or decreased **access to social support**, decreased **access to in-person medical care**, and decreased **access to in-person behavioral health care** all had a minor impact on the community due to COVID-19.
- In the past year, **45%** of respondents had interacted with a Sharp health care professional (physician, nurse, etc.) through a **telehealth visit. 33%** of respondents who liked their visit attributed their liking to **convenience**. Most of those who reported they **disliked** their telehealth visit attributed this to either a **physical** or **general disconnect** with their provider.
- Most (**77%**) of respondents who reported going to a **virtual telehealth** visit reported it being ”**effective**”, and most (**69%**) of respondents who reported going to an audio-only telehealth visit reported it being ”effective”.

Total Survey Responses: n=619
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

Executive Summary

- The majority of respondents (**96%) did not participate** in **Sharp HealthCare programs** designed to help connect patients to support services or community resources
- Those who did participate named **other, 2-1-1 San Diego referral**, **and other community resource referral** as the **most utilized programs** for supportive resources in the community
- **78%** of respondents who utilized services said that it **helped to connect** them to the support services/community resources they were looking for

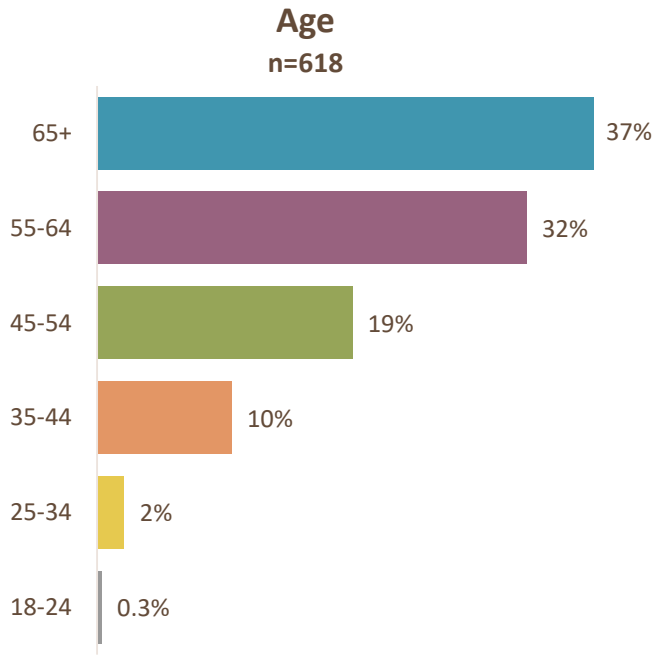
Total Survey Responses: n=619
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

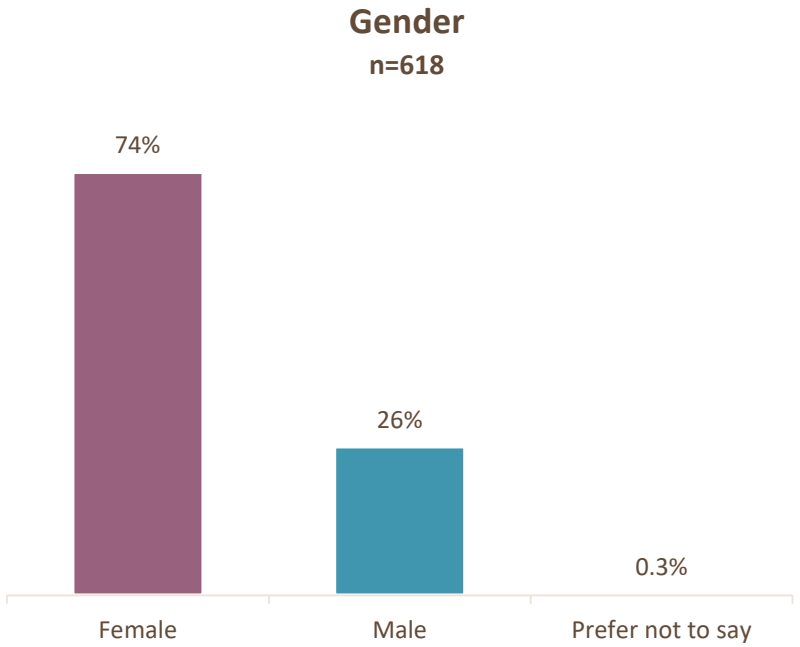
Executive Summary

- The majority of respondents (**96%) did not participate** in Sharp HealthCare programs to support with **aging concerns**
- Those who did participate named **caregiver or family support** programs, **senior health** education, and the **Sharp Senior Resource Center** as the **most utilize**d programs
- The majority of respondents (**95%**) **did not participate** in Sharp programs to address **behavioral health concerns**
- Those who did participate named Sharp **behavioral health screenings or assessments**, Sharp behavioral health **support groups**, and **other** as the **most utilize**d programs
- The **majority** of respondents were **already satisfied** with their **physician's bedside manner** with regard to stigma, bedside manner and inclusion

Total Survey Responses: n=619
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

Panel Demographics

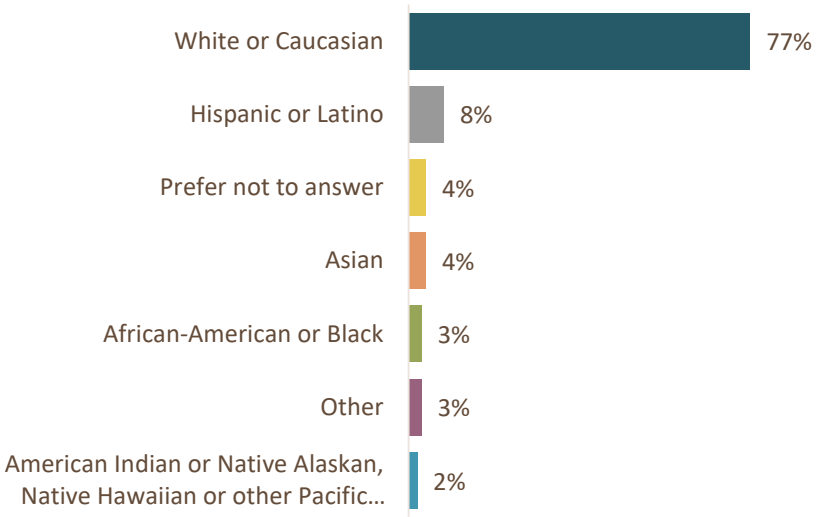




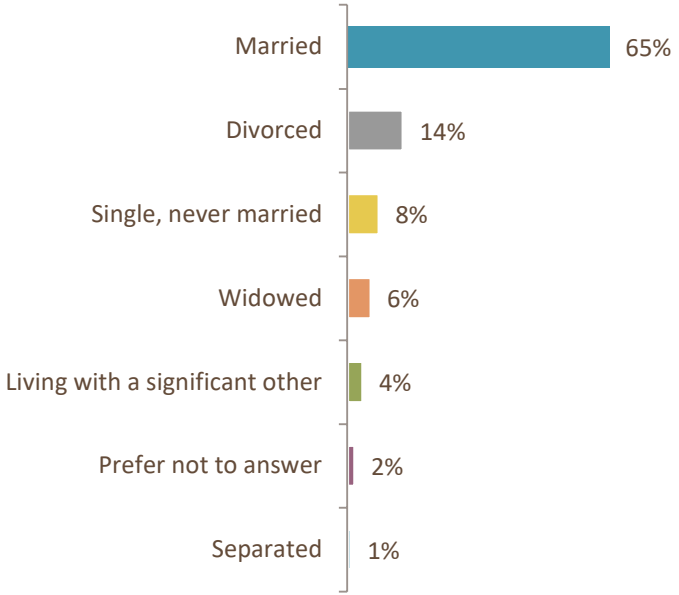
Panel Demographics
Total Survey Responses: n=619
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

Panel Demographics

Ethnicity
n=618



Marital Status
n=618

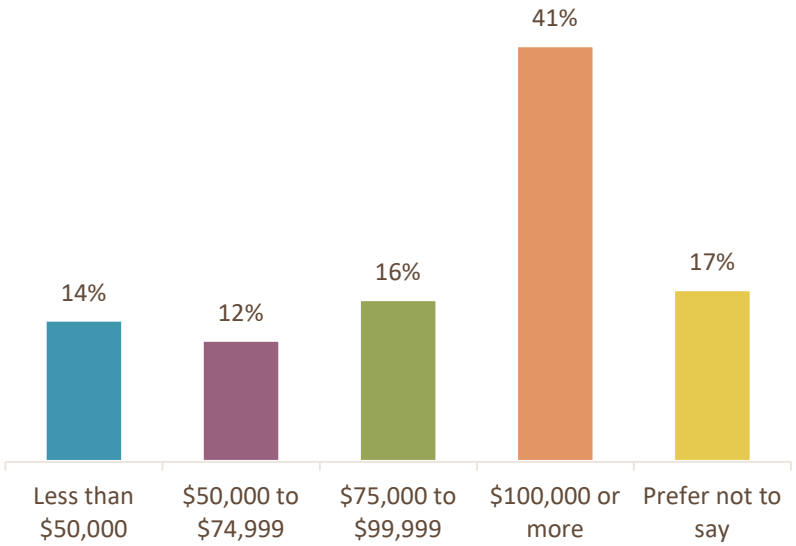


Panel Demographics
Total Survey Responses: n=619
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

Panel Demographics

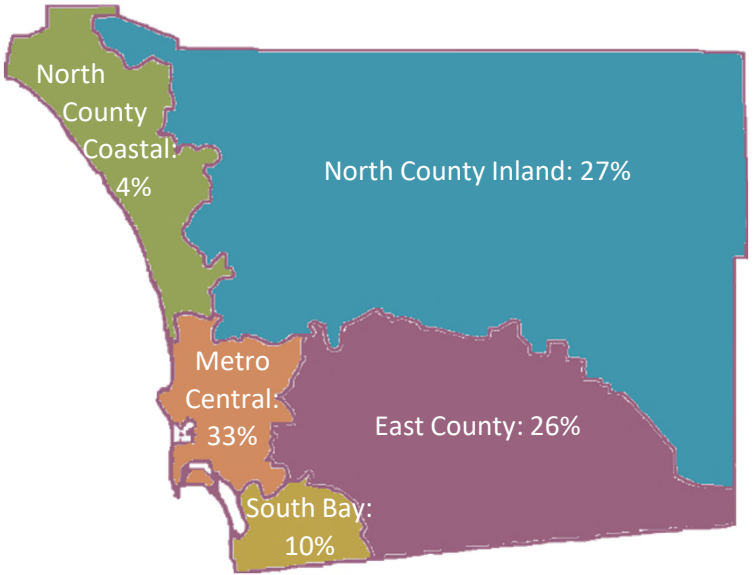
Household Income

n=618



Region of Residence

n=615

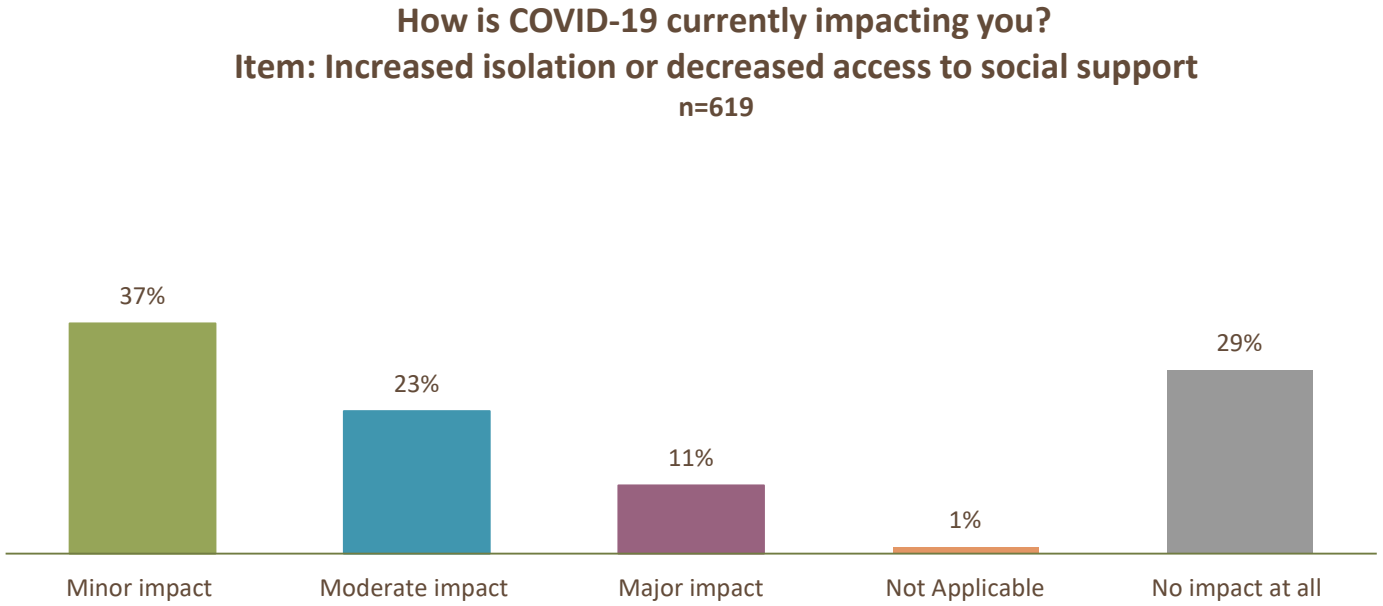


Panel Demographics
Total Survey Responses: n=619
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

Sharp Insight Community – Community Health Needs Assessment Phase 2 Survey

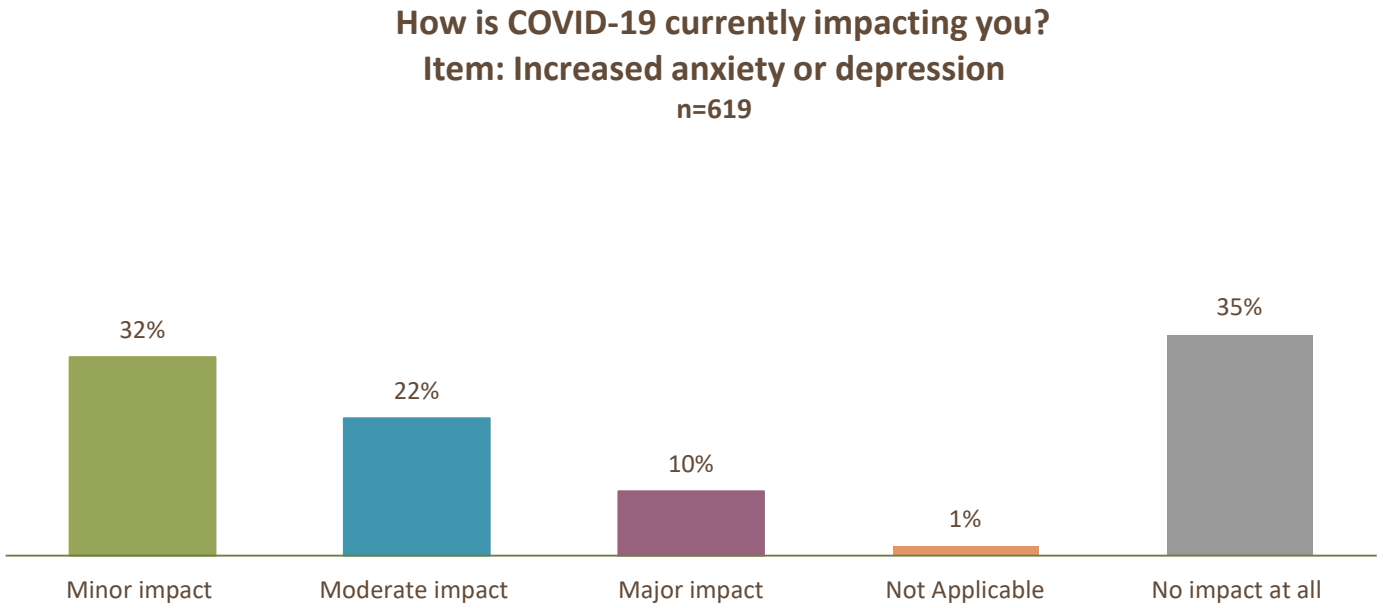
Survey Results

COVID-19 Impact: Increased Isolation/ Decreased Access to Social Support



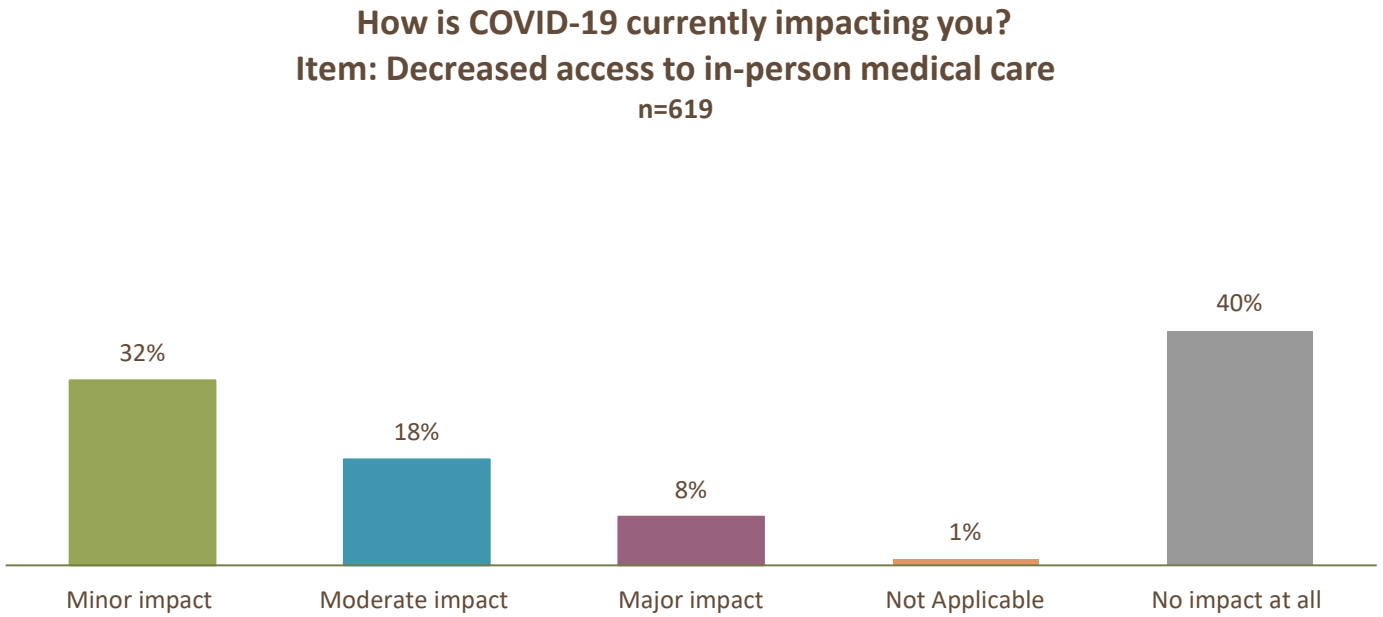
Question: How is COVID-19 currently impacting you? As you rate the following items, please think about your experiences during the pandemic and if/how that has changed from your experiences prior to the pandemic.
Survey Responses: n=619
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

COVID-19 Impact: Increased Anxiety or Depression



Question: How is COVID-19 currently impacting you? As you rate the following items, please think about your experiences during the pandemic and if/how that has changed from your experiences prior to the pandemic.
Survey Responses: n=619
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

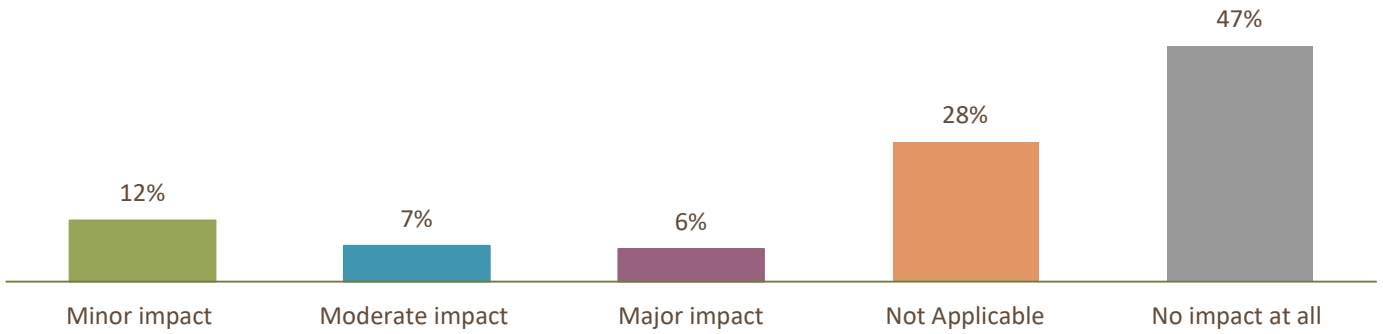
COVID-19 Impact: Decreased Access to In-Person Medical Care



Question: How is COVID-19 currently impacting you? As you rate the following items, please think about your experiences during the pandemic and if/how that has changed from your experiences prior to the pandemic.
Survey Responses: n=619
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

COVID-19 Impact: Decreased Access to in-Person Behavioral Health Care

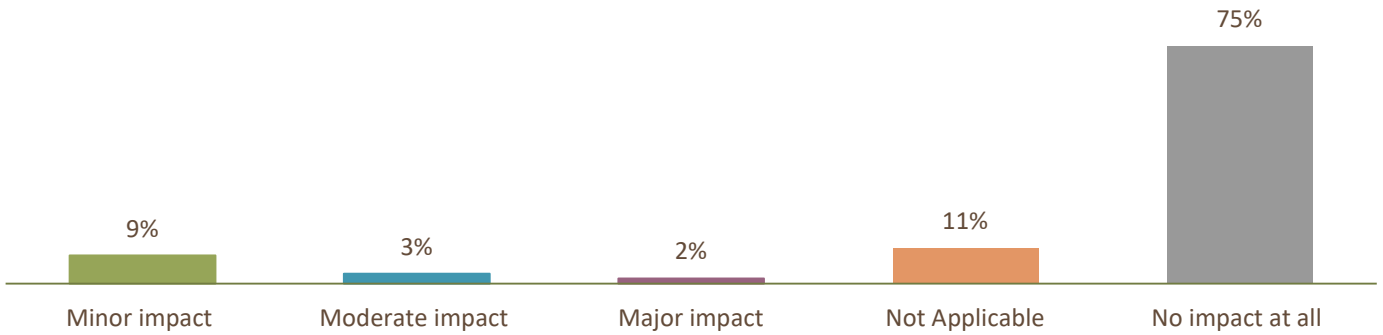
How is COVID-19 currently impacting you?
Item: Decreased access to in-person behavioral health care
n=619



Question: How is COVID-19 currently impacting you? As you rate the following items, please think about your experiences during the pandemic and if/how that has changed from your experiences prior to the pandemic?
Survey Responses: n=619
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

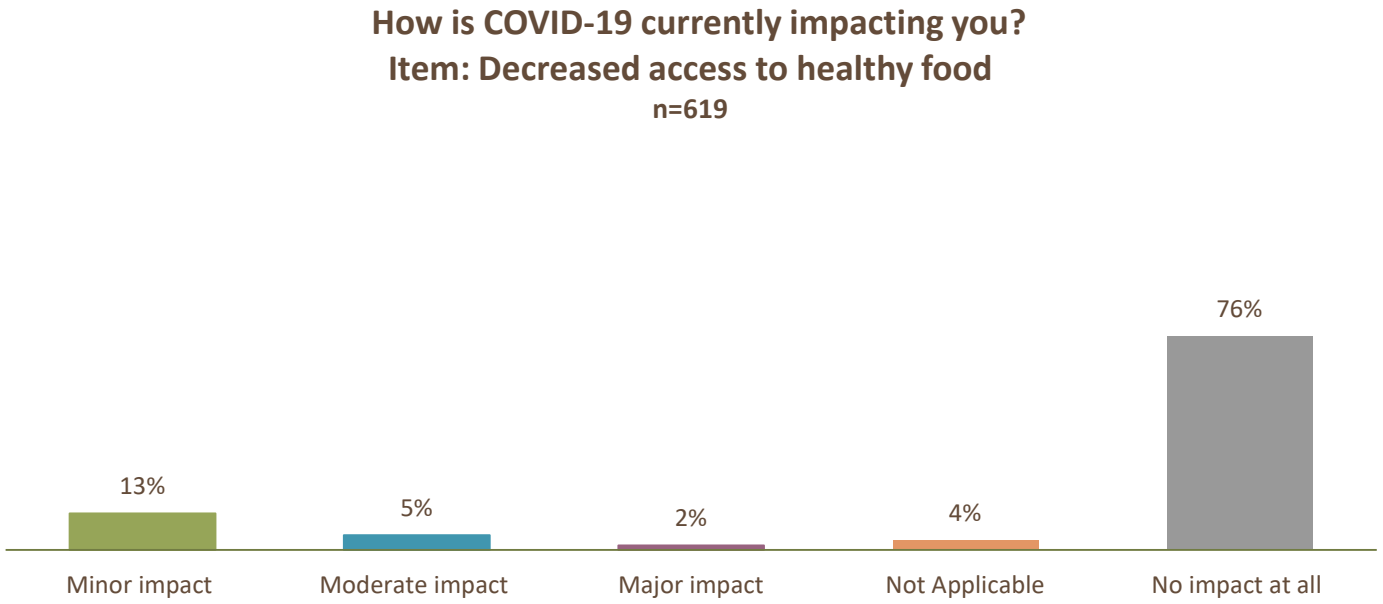
COVID-19 Impact: Decreased access to medications or medical supplies (e.g., blood pressure cuffs, diabetes testing kits, etc.)

How is COVID-19 currently impacting you?
Item: Decreased access to medications or medical supplies (e.g. blood pressure cuffs, diabetes testing kits, etc.)
n=619



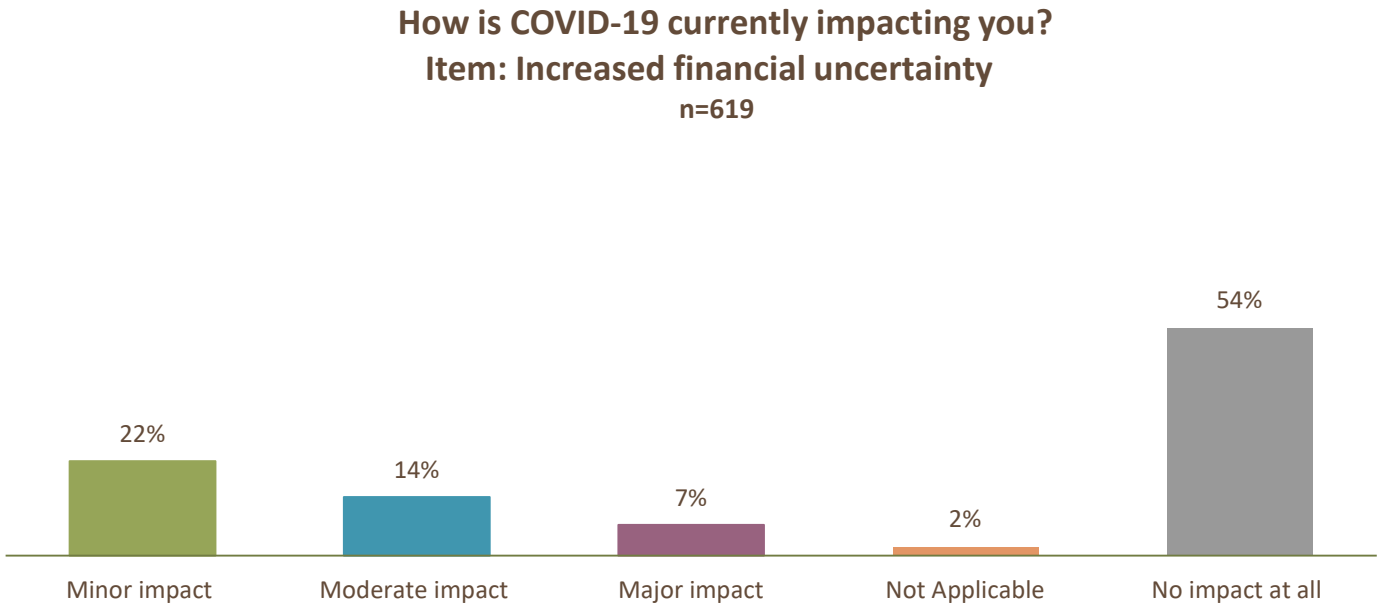
Question: How is COVID-19 currently impacting you? As you rate the following items, please think about your experiences during the pandemic and if/how that has changed from your experiences prior to the pandemic.
Survey Responses: n=619
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

COVID-19 Impact: Decreased Access to Healthy Food



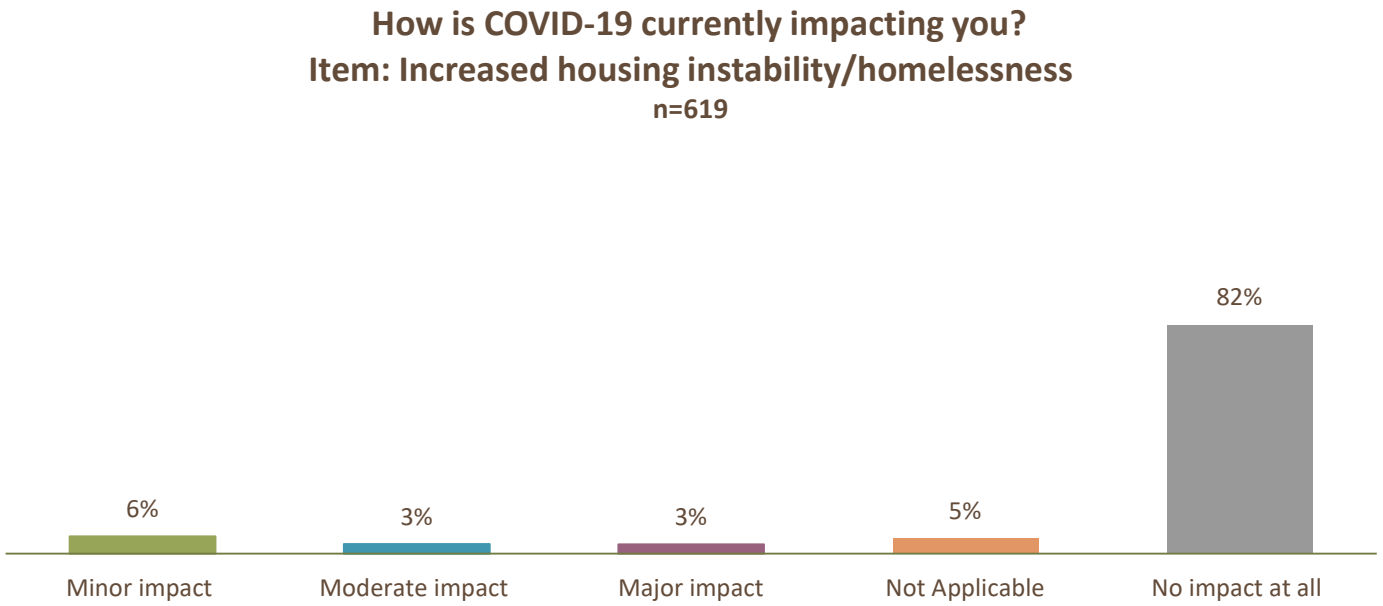
Question: How is COVID-19 currently impacting you? As you rate the following items, please think about your experiences during the pandemic and if/how that has changed from your experiences prior to the pandemic.
Survey Responses: n=619
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

COVID-19 Impact: Increased Financial Uncertainty



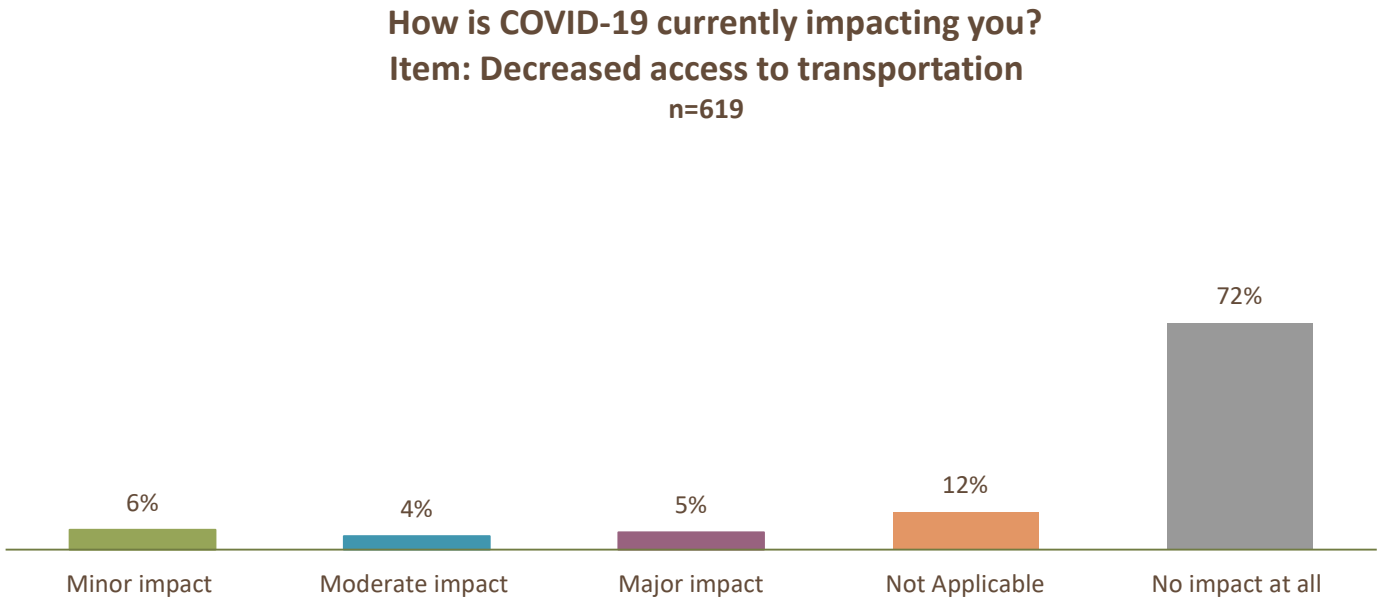
Question: How is COVID-19 currently impacting you? As you rate the following items, please think about your experiences during the pandemic and if/how that has changed from your experiences prior to the pandemic.
Survey Responses: n=619
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

COVID-19 Impact: Increased Housing Instability/Homelessness



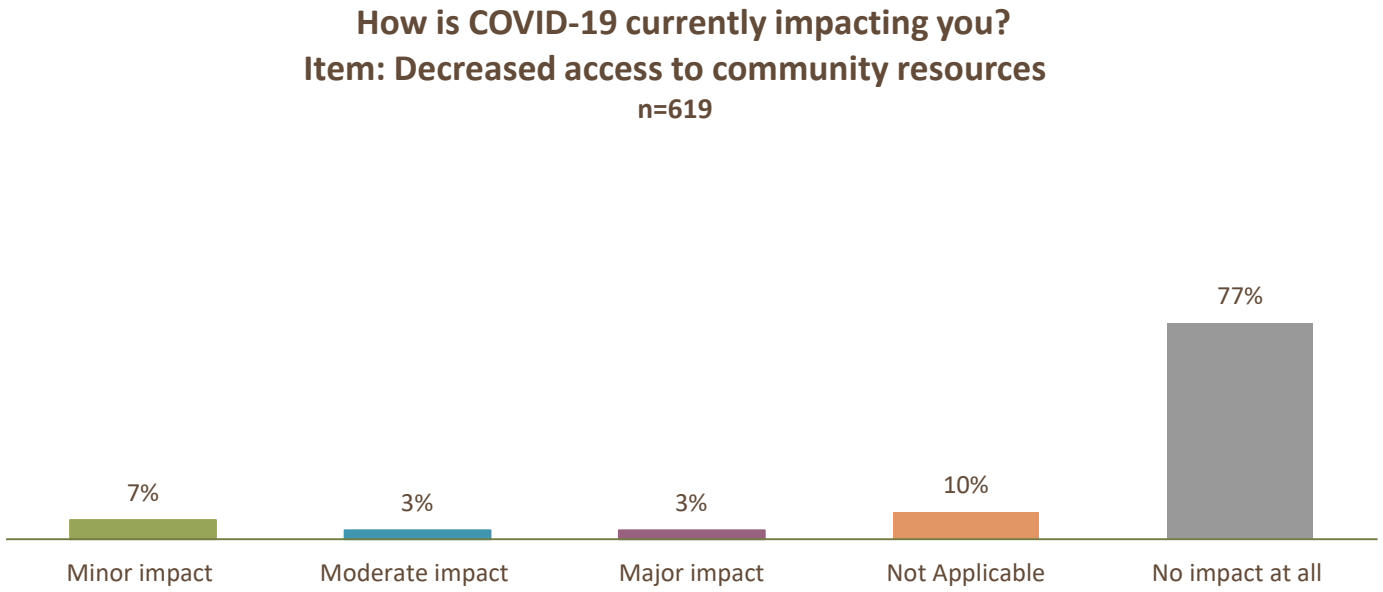
Question: How is COVID-19 currently impacting you? As you rate the following items, please think about your experiences during the pandemic and if/how that has changed from your experiences prior to the pandemic.
Survey Responses: n=619
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

COVID-19 Impact: Decreased Access to Transportation



Question: How is COVID-19 currently impacting you? As you rate the following items, please think about your experiences during the pandemic and if/how that has changed from your experiences prior to the pandemic.
Survey Responses: n=619
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

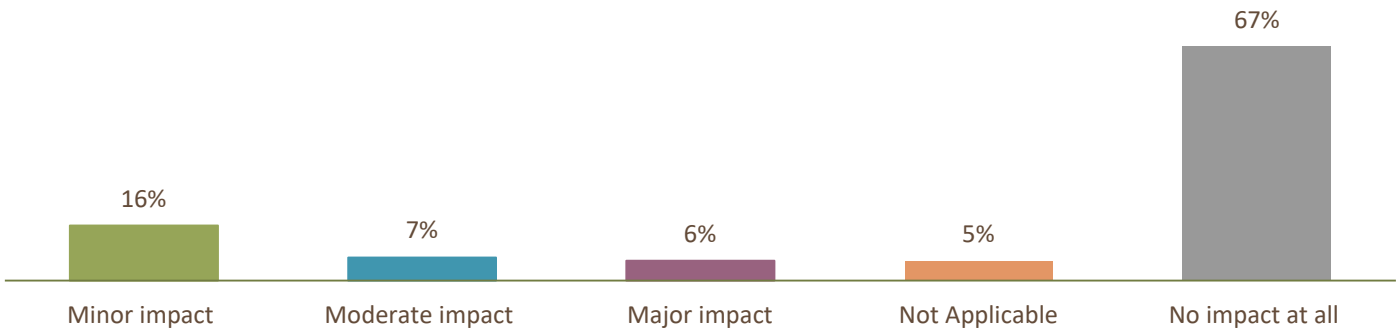
COVID-19 Impact: Decreased Access to Community Resources (e.g., housing, utilities, financial support etc.)



Question: How is COVID-19 currently impacting you? As you rate the following items, please think about your experiences during the pandemic and if/how that has changed from your experiences prior to the pandemic.
Survey Responses: n=619
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

COVID-19 Impact: Increased Stigma Experienced in Health Care Settings

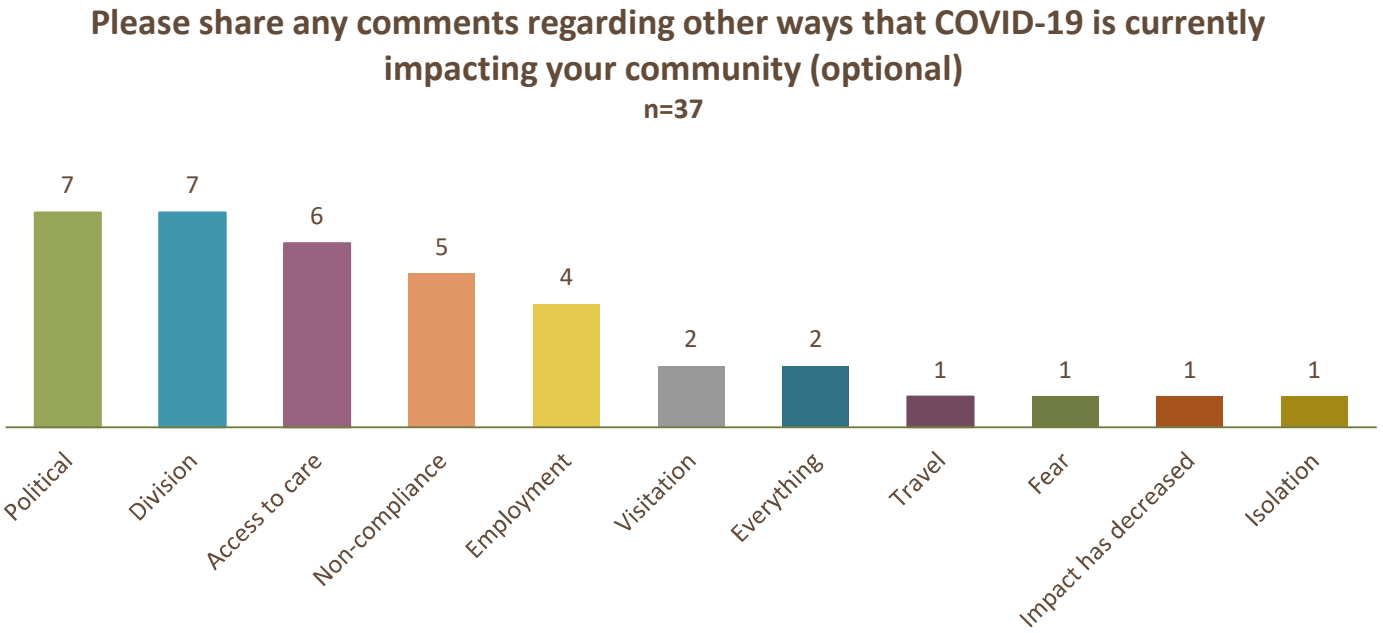
How is COVID-19 currently impacting you?
Item: Increased stigma* experienced in health care settings
n=619



*For the purposes of this survey, stigma can be generally defined as negative attitudes or beliefs towards another individual or group which can result in shame, embarrassment, or fear. The stigma referenced above could either be directly related to a COVID-19 diagnosis or vaccination status, or unrelated (e.g., based on age, race/ethnicity, gender, etc.).

Question: How is COVID-19 currently impacting you? As you rate the following items, please think about your experiences during the pandemic and if/how that has changed from your experiences prior to the pandemic.
Survey Responses: n=619
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

COVID-19 Impact on Community: Comments



Question: Please share any comments regarding other ways that COVID-19 is currently impacting your community.
Survey Responses: n=37
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

COVID-19 Impact on Community: Comments

- 7of respondents mentioned **political comments**

"My 55+ community is tired of wearing masks."

"I see a lot of anger and intolerance around and that is impacting my well being."

"I hate the polarization of opinions on personal health care. My body, my choice. It is no one else's business."

- 7 of respondents mentioned **division**

"Families and friends split by opinions on vaccines. Watching our nation split apart by fear of unemployment, hunger, illness, crime."

"Increased divisiveness and suspicion, apprehension between the pro-vax/pro-science and the antivax communities, causing anxiety and stress within the general public. "

- 6 of respondents mentioned **access to care**

"Disappointed that I could not get covid booster from the sharp location close to me."

"It seems that everything takes longer to schedule now. Doctor's appointments, DMV appointments, etc. Also, WFH in a small apartment with a roommate working was hard."

"Many changes good or bad are blamed on COVID-19. We have tried to get in person counseling for an adolescent and still haven't found anyone after 3 months. They are all virtual, which is not effective."

- 5 of respondents mentioned **non-compliance**

"I find it weird how some members of the community can react negatively to mandated protocols to safeguard everyone's health relative to the COVID PANDEMIC."

"It is difficult to deal with family and friends who approach COVID-19 safety differently."

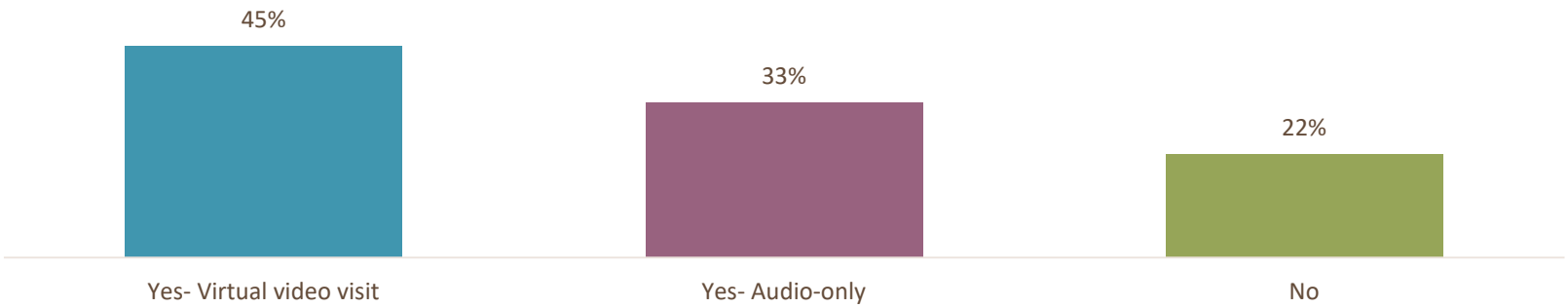
"I don't feel safe traveling so I am alienated from my children and grandchildren. This has created a loss of family cohesiveness. My grandchildren don't even know who I am. This is heartbreaking."

Question: Please share any comments regarding other ways that COVID-19 is currently impacting your community (optional)
Total Survey Responses: n=37
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

Telehealth Visits

45% of respondents reported they had interacted with a Sharp healthcare professional through a **virtual video visit** in the past year, while **33%** had interacted through an **audio-only visit**, and **22%** responded **"no"** to both.

Question: In the past year, have you interacted with a Sharp health care professional (physician, nurse, etc.) through a telehealth visit? (select all that apply)
n=619

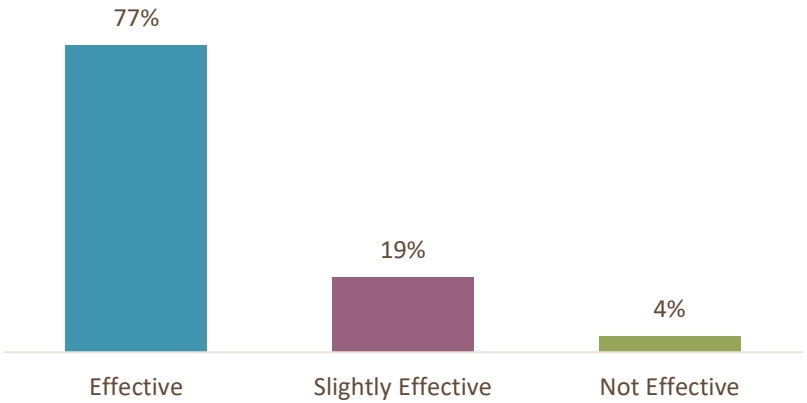


Question: In the past year, have you interacted with a Sharp health care professional (physician, nurse, etc.) through a telehealth visit?
Survey Responses: n=619
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

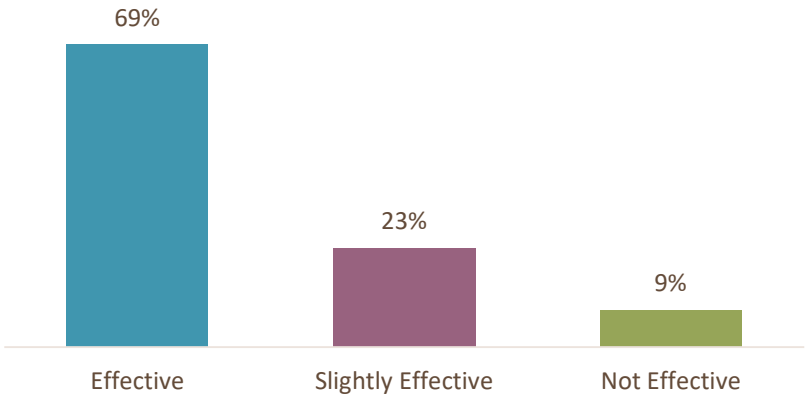
Telehealth Visits: Virtual Video Visits Effectiveness

Of those who had a **virtual video visit** in the past year, **77%** reported their visit as being **"effective"** .Of those who had an **audio-only visit** in the past year, **69%** reported their visit as being **"effective".**

Question: How effective was (virtual video video) telehealth visit in addressing your health needs?
n=336



Question: How effective was (audio-only) telehealth visit in addressing your health needs?
n=235

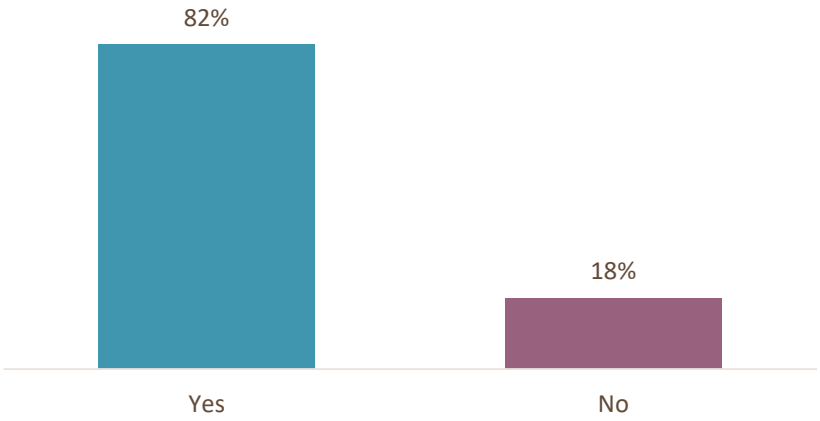


Question: In the past year, have you interacted with a Sharp health care professional (physician, nurse, etc.) through a telehealth visit?
Survey Responses: n=619
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

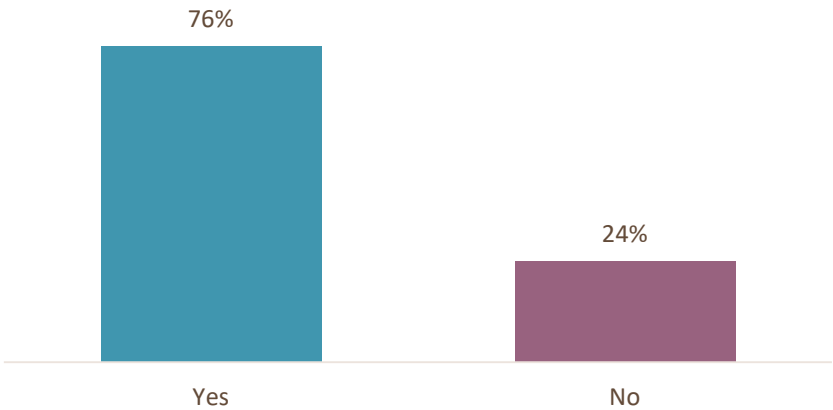
Telehealth Visits: Virtual Video Visits Overall Like/Dislike

Of those who had a **virtual video visit** in the past year, **82%** reported that overall, they **liked** their telehealth visit. Of those who had an **audio-only visit** in the past year, **76%** reported that overall, they **liked** their telehealth visit.

Question: Did you like your (virtual video) telehealth visit?
n=336



Question: Did you like your (audio-only) telehealth visit?
n=235

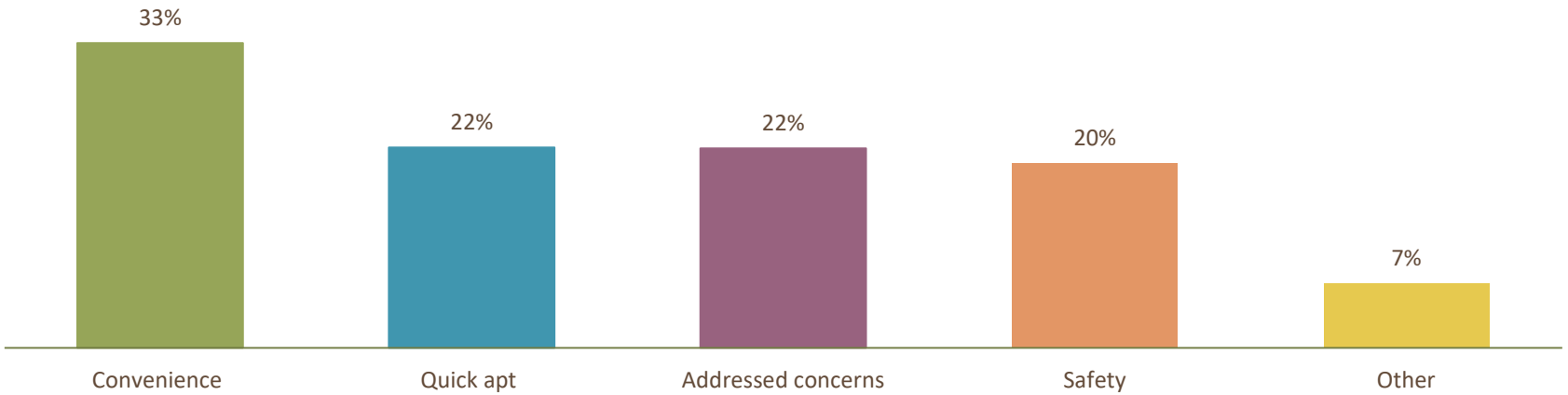


Question: In the past year, have you interacted with a Sharp health care professional (physician, nurse, etc.) through a telehealth visit?
Total Survey Responses: n=619
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

Telehealth Visits: What did you like?

Of respondents who reported that they "**liked**" their telehealth visit, **33%** attributed this to **convenience, 22%** attributed this to a **quick appointment**, **22%** attributed this to their **concerns being addressed**, and **20%** attributed this to **safety**.

Question: Did you like your telehealth visit? (Selection: Yes) What did you like?
n=336

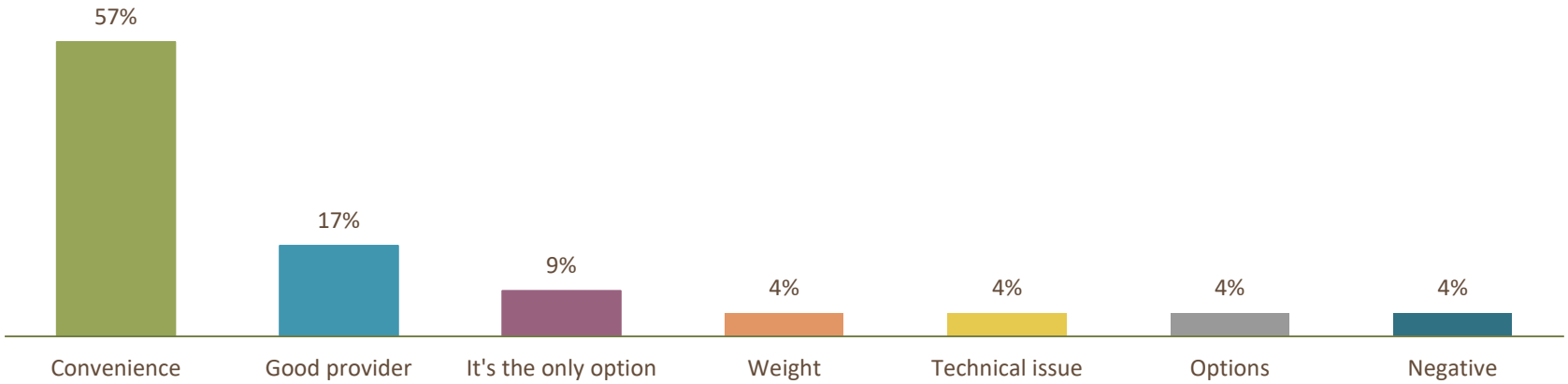


Question: What did you like?
Survey Responses: n=336
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

Telehealth Visits: What did you like? (other)

Of respondents who reported that they "**liked**" their telehealth visit, and selected **"Other"** as a reason why, **57%** attributed this to **convenience**, while **17%** attributed this to having a **good provider**.

Question: Did you like your telehealth visit? (Selection: Yes) What did you like? (Other)
n=23



Question: What did you like? (other)
Survey Responses: n=23
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

Telehealth Visits: What did you like? (other) comments

Of the 23 respondents who reported that they "**liked**" their telehealth visit, and selected **"Other"** as a reason why, **13** attributed this to **convenience**, while **5** attributed this to having a **good provider**.

- **13** respondents mentioned **convenience (travel, stress, waiting)**

"Did not have time to take off of work."

"Saved on time and travel expenses."

"This was a propitious option that thanks to technology was available for non-emergent needs."

- **5** respondents mentioned a **good provider**

"Very good doctor!"

"My doctor. "

- **2** respondents reported that **it's the only option**

"Only available access to my heath care."

"It was the only option available at the time."

- **1** respondent mentioned **bypass weight/vitals**

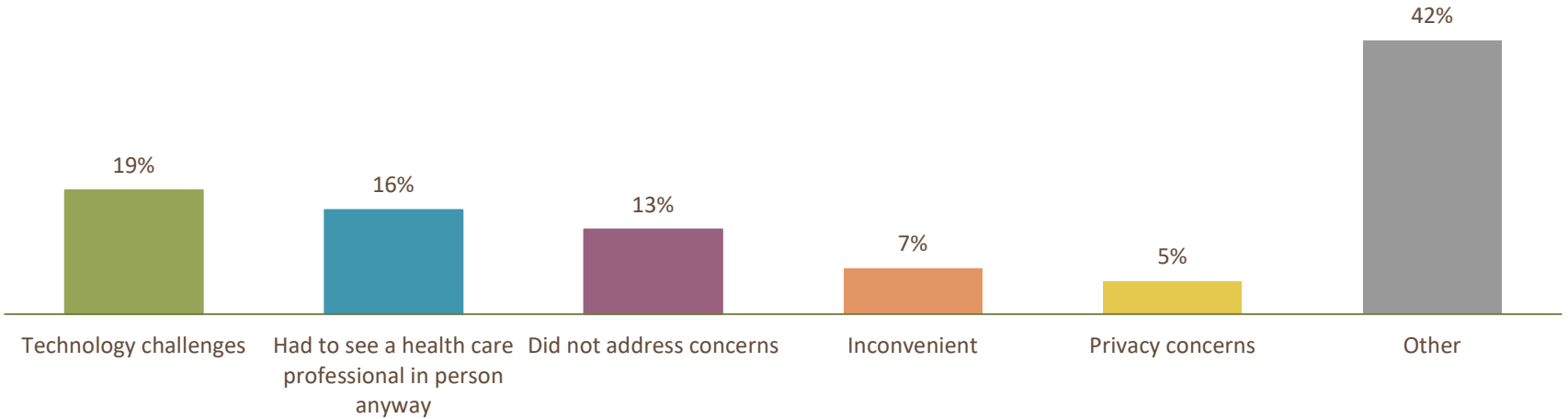
"Didn't have to weigh in."

Question: What did you not like about your telehealth visit? (other)
Survey Responses: n=23
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

Telehealth Visits: What did you dislike?

Of respondents who reported that they **"disliked"** their telehealth visit, **42%** selected **"other"** as a reason why they **disliked** their visit, while **19%** attributed their dislike to **technology challenges**, and **16%** attributed it to **needing to see a healthcare professional in person anyway**.

Question: Did you like your telehealth visit? (Selection: No) What did you dislike?
n=103

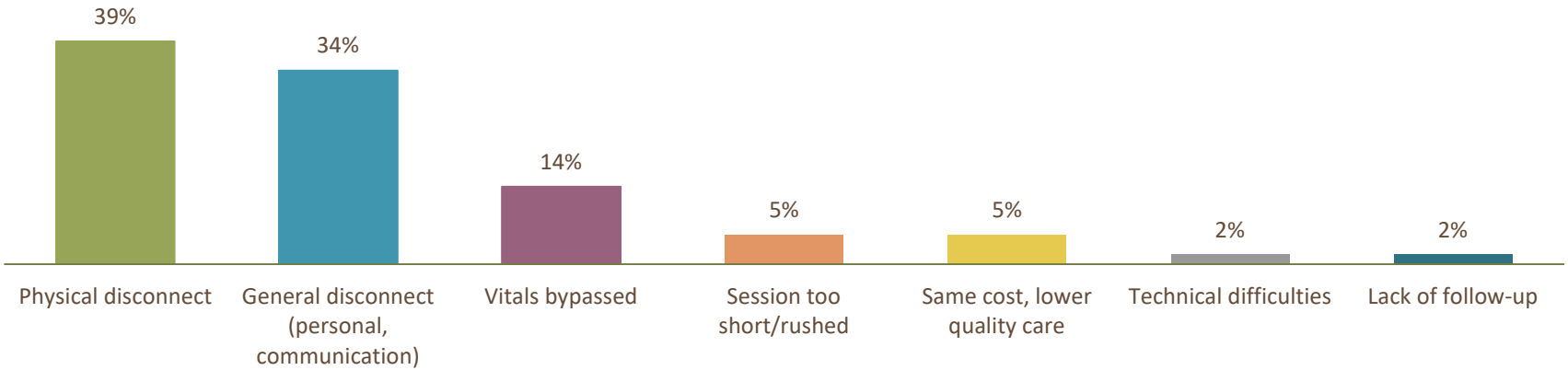


Question: What did you dislike?
Survey Responses: n=103
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

Telehealth Visits: What did you dislike? (other)

A **physical disconnect(23)** and a **general disconnect (20)** were the most cited reasons as to why respondents **"disliked"** their telehealth visit.

Question: Did you like your telehealth visit? (Selection: No) What did you dislike? (Selection: Other)
n=62



Question: What did you dislike? (Other)
Survey Responses: n=62
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

Telehealth Visits: What did you dislike? (other) comments

A **physical disconnect(23)** and a **general disconnect (20), bypassing of vitals/screening(8)**, and the **appointment being rushed(3)** were all mentioned reasons why respondents disliked their telehealth visit.

- **39%** of respondents mentioned **physical disconnect**

"Would rather see a doctor in person."

"I don't like video calls. Would much rather see my doctor in person as it's more personal."

"Can't feel or touch."

"I don't like video calls. Would much rather see my doctor in person as it's more personal ."

- **34%** of respondents mentioned a **general disconnect**

"I don't like video calls. Would much rather see my doctor in person as it's more personal."

"The MD asked me to take photos of the affected areas & upload them via FMH. The photos were necessary, but he was having a difficult time interpreting them to make a recommendation. An in-person visit would've been much easier. This was for my child. "

- **14%** of respondents mentioned **bypassed vitals/screening**

"I need my blood pressure checked as I have Afib, I need to see a Dr. in person to check this."

"Awkward to do dermatology screening by phone."

"Blood pressure not taken. Feel better talking with my doctor in person."

- **5%** of respondents mentioned the session being **too short/ rushed**

"Addressed main issue but not others, too brief."

"Too short , expensive , cold."

"I felt rushed."

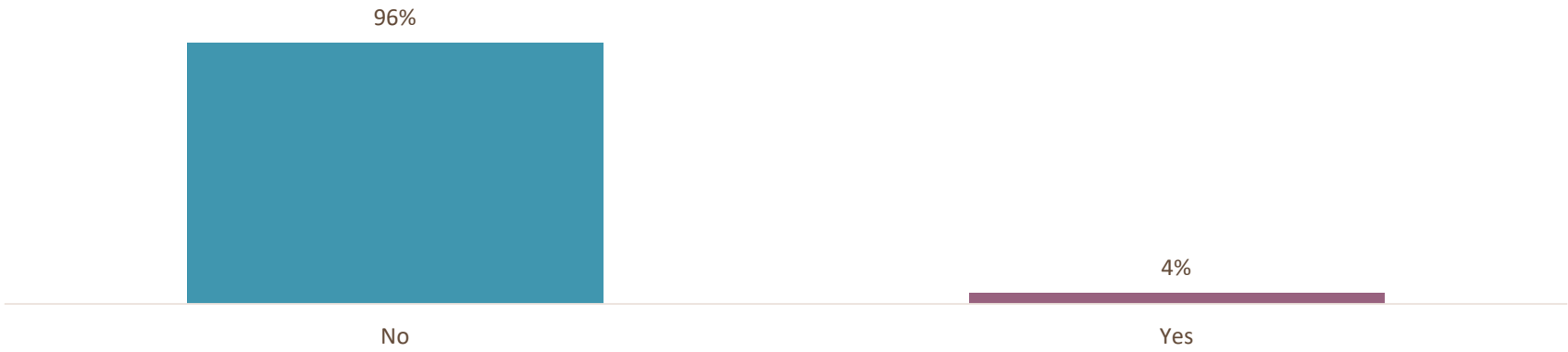
Question: What did you dislike about your telehealth visit? (other)
Survey Responses: n=62
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

Impact of COVID-19 on Supportive Resources in the Community

96% of respondents **did not participate** in Sharp HealthCare programs designed to help connect patients to support services or community resources**. 4%** of respondents **did participate.**

Did you participate in Sharp HealthCare programs designed to help connect patients to support services or community resources?

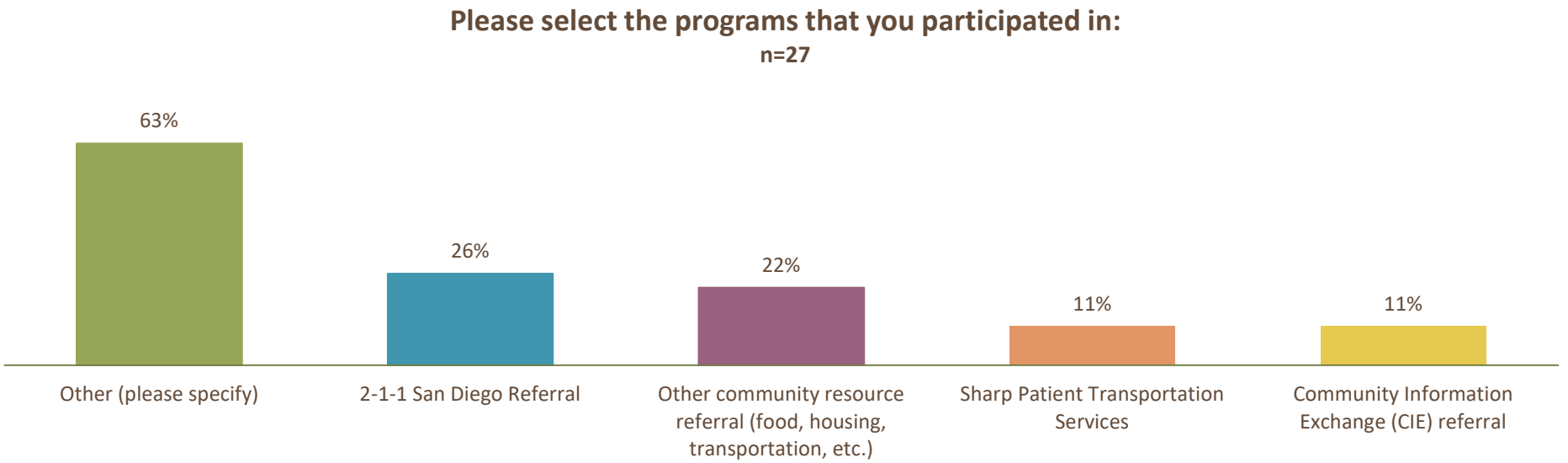
n=619



Question: Did you participate in Sharp HealthCare programs designed to help connect patients to support services or community resources?
Total Survey Responses: n=619
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

Impact of COVID-19 on Supportive Resources in the Community

Those who participated in Sharp HealthCare programs designed to help connect patients to support services or community resources were asked to specify which programs they utilized.

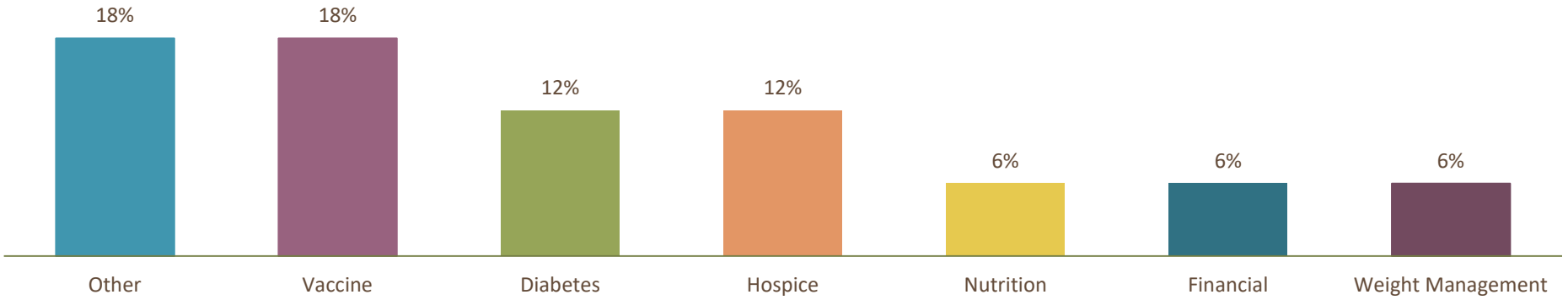


Question: Please select the programs that you participated in:
Survey Responses: n=27
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

Impact of COVID-19 on Supportive Resources in the Community

Those who participated in Sharp HealthCare programs designed to help connect patients to support services or community resources were asked to specify which programs they utilized.

Please select the programs that you participated in: other, please specify
n=17



Question: Please select the programs that you participated in: other, please specify
Survey Responses: n=17
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

Impact of COVID-19 on Supportive Resources in the Community

- **18%** of respondents mentioned **other**
- **18%** of respondents mentioned **vaccine**
- **12%** of respondents mentioned **diabetes**

"My Agile Life."	"Vaccination clinics."	"Diabetes care."
"Sharp Resilience meetings."	"Vaccinations."	"Diabetes education."

Question: Please select the programs that you participated in: other, please specify
Survey Responses: n=17
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

Impact of COVID-19 on Supportive Resources in the Community

- **12%** of respondents mentioned **hospice**

"Hospice."

"Hospice care for family member."

- **6%** of respondents mentioned **nutrition**

"Healthy eating program."

- **6%** of respondents mentioned **financial**

"Sharp COVID fund for medication copayment financial assistance."

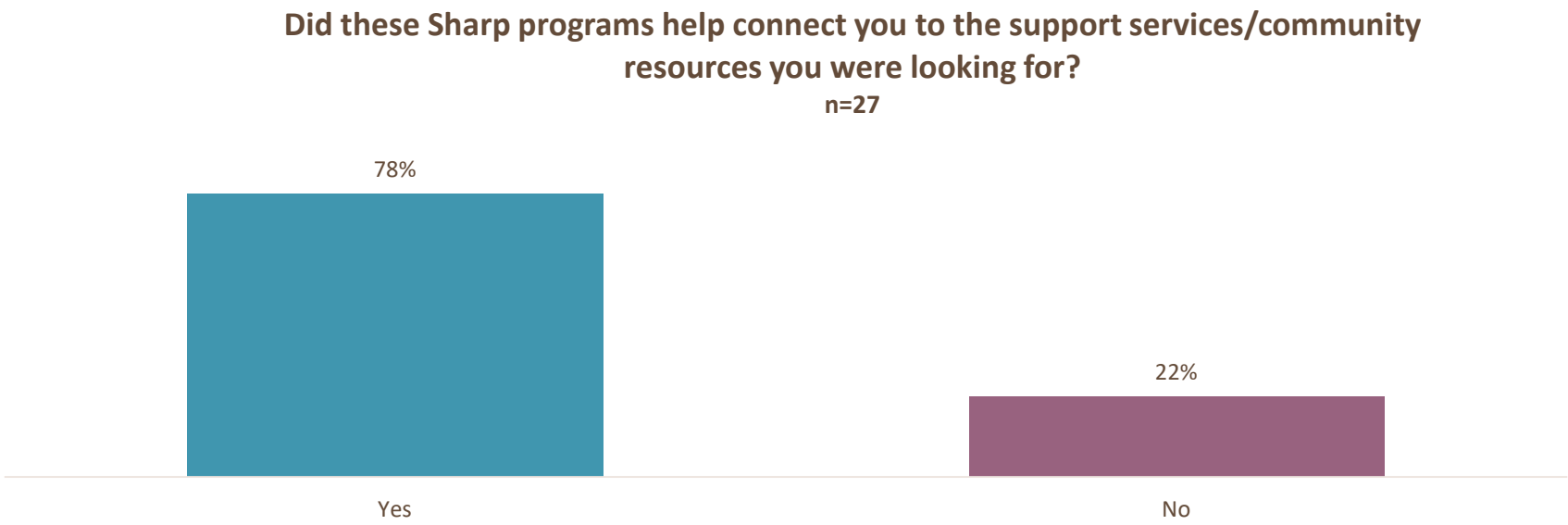
- **6%** of respondents mentioned **weight management**

"Weight management."

Question: Please select the programs that you participated in: other, please specify
Survey Responses: n=17
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

Impact of COVID-19 on Supportive Resources in the Community

78% of respondents **did find Sharp programs to be helpful** in connecting them to the support services/community resources they were looking for. **22%** of respondents **did not find the Sharp programs to be helpful**.



Question: Did these Sharp programs help connect you to the support services/community resources you were looking for?
Survey Responses: n=27
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

Impact of COVID-19 on Supportive Resources in the Community

Respondents who indicated that the Sharp programs were not helpful were asked to comment on why the programs did not connect them to the services they needed. Response theme frequencies are shown below.

- **18%** of respondents mentioned **other**

> "Shuttle services limited."

- **33%** of respondents mentioned **access**

> "Specialist/resource access."

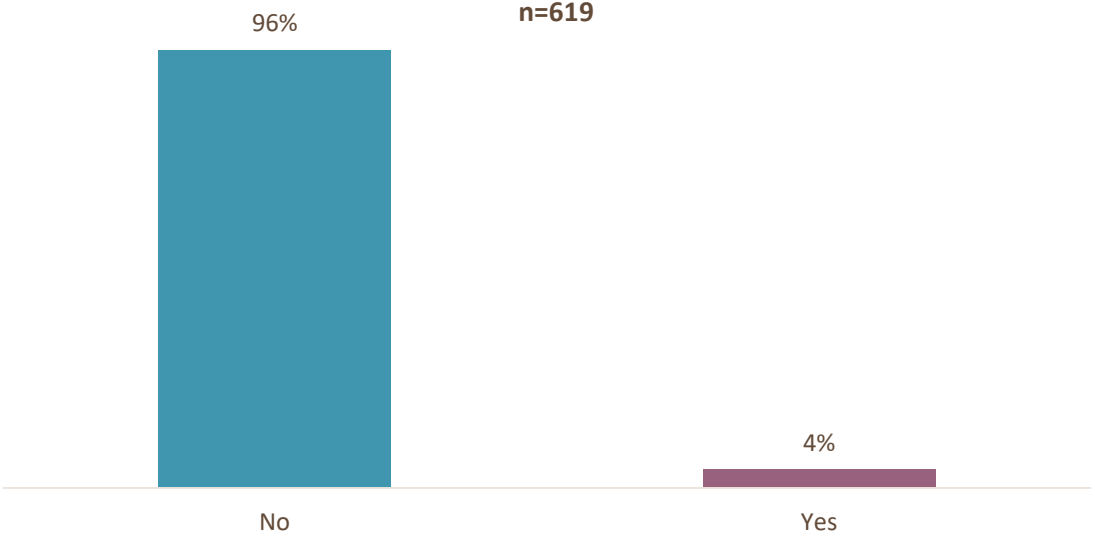
Question: Please comment on why these programs did not connect you to the services you were looking for.
Survey Responses: n=3
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

Health Concerns: Aging Concerns

96% of respondents **did not participate** in Sharp HealthCare programs designed to serve older adults and their caregivers with aging concerns. **4% did participate**.

Did you or a loved one participate in Sharp HealthCare programs designed to serve older adults/their caregiver/loved ones with aging concerns?

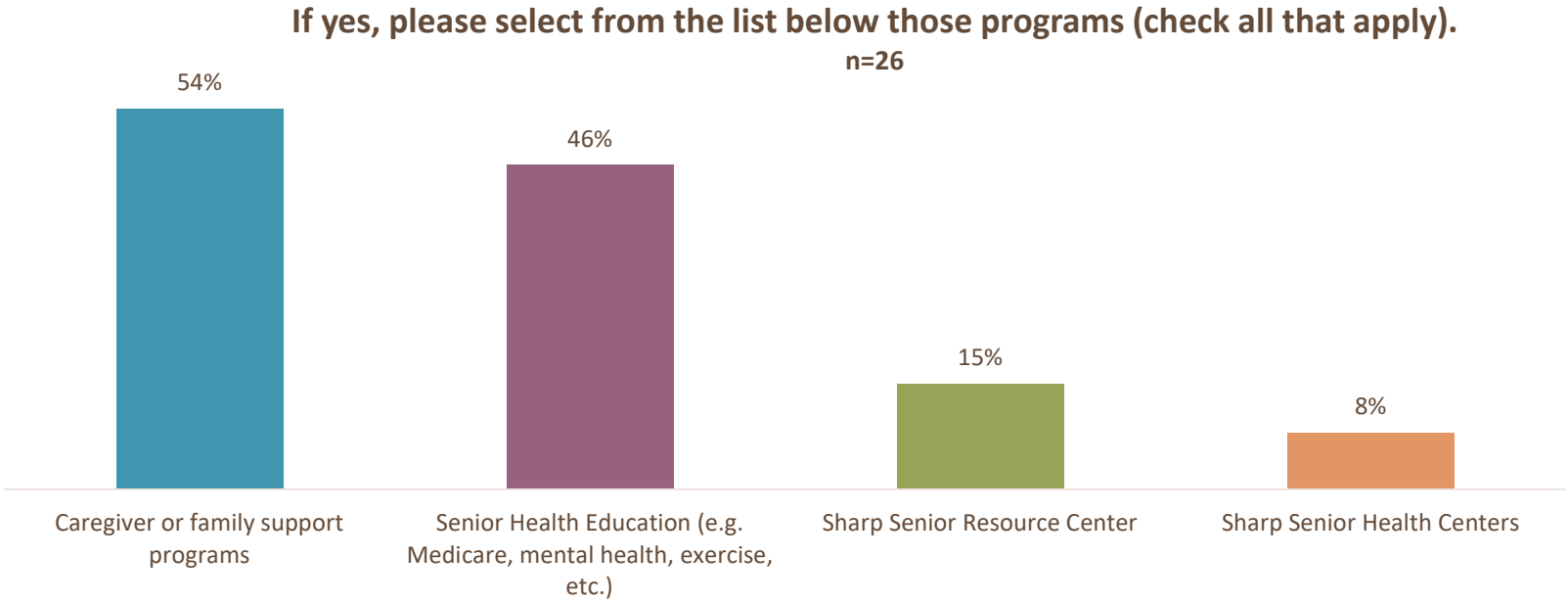
n=619



Question: Did you or a loved one participate in Sharp HealthCare programs designed to serve older adults/their caregiver/loved ones with aging concerns?
Total Survey Responses: n=619
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

Health Concerns: Aging Concerns

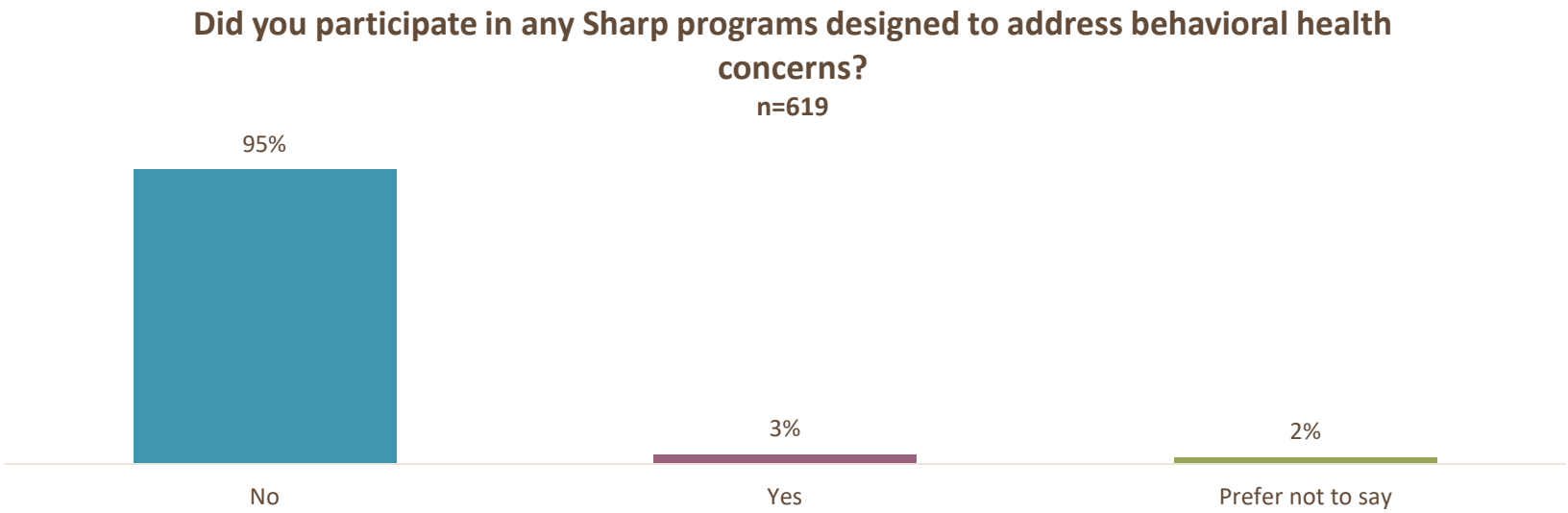
Caregiver or family support programs (**54%**), senior health education (**46%**), and the Sharp Senior Resource Center (**15%**) were the most highly utilized programs.



Question: If yes, please select from the list below those programs (check all that apply).
Survey Responses: n=26
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

Health Concerns: Behavioral Health

95% of respondents **did not participate** in any Sharp programs designed to address behavioral health concerns. **3% did participate**.



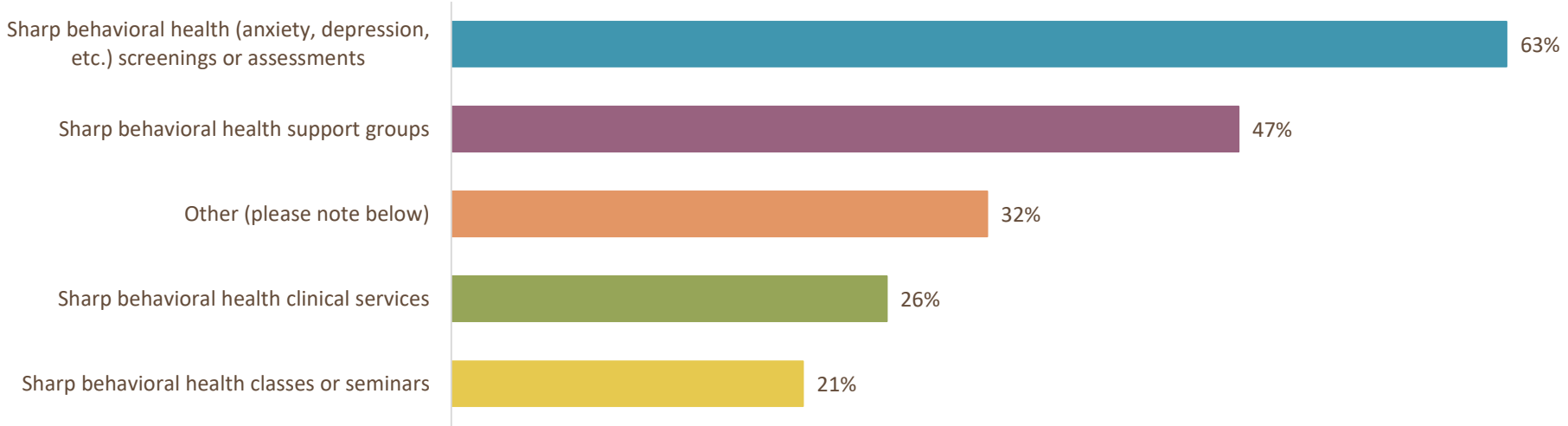
Question: Did you participate in any Sharp programs designed to address behavioral health concerns?
Total Survey Responses: n=619
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

Health Concerns: Behavioral Health

Respondents were asked to select which of the following Sharp programs they utilized to address behavioral health concerns. **Sharp behavioral health screenings or assessments** (**63%**), **Sharp behavioral health support groups** (**47%**), and **Other (please note below)** (**32%**), were the most highly utilized.

If yes, then please check all that apply below.

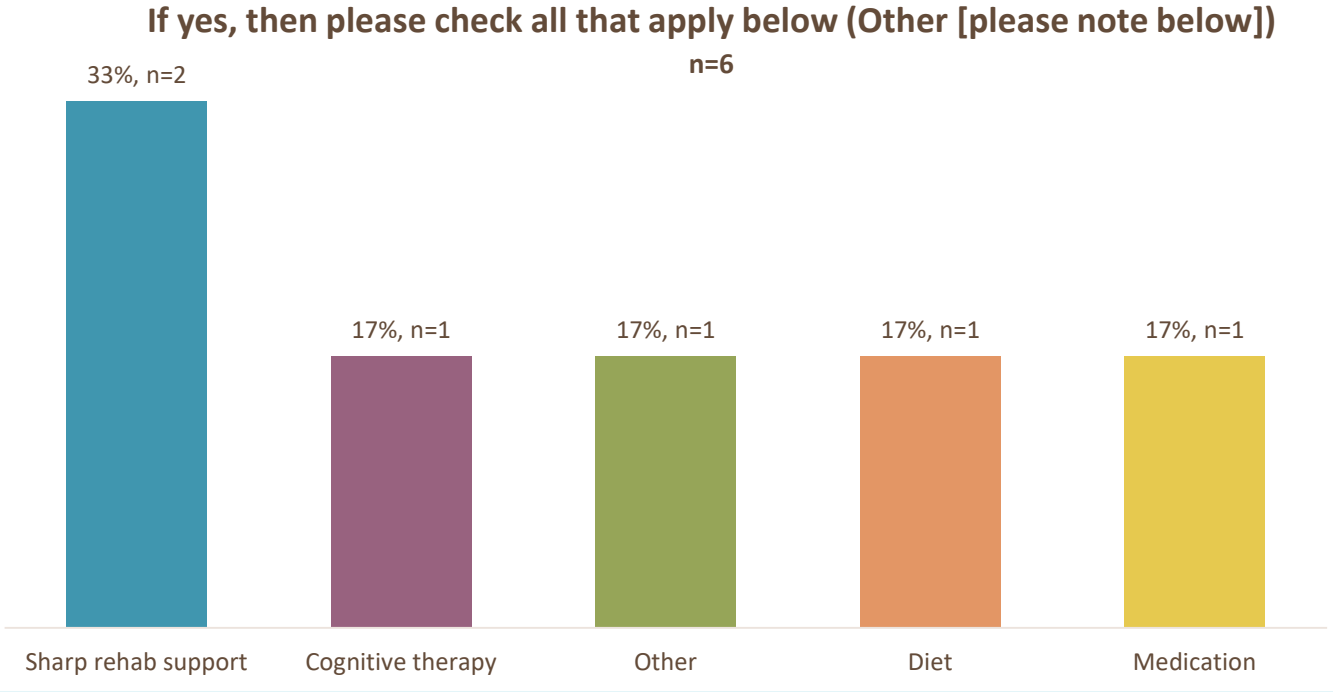
n=19



Question: If yes, then please check all that apply below.
Survey Responses: n=19
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

Health Concerns: Behavioral Health

Respondents who indicated “Other (please note below)” were asked to specify which Sharp programs they utilized to address behavioral health concerns. Frequencies are shown below.



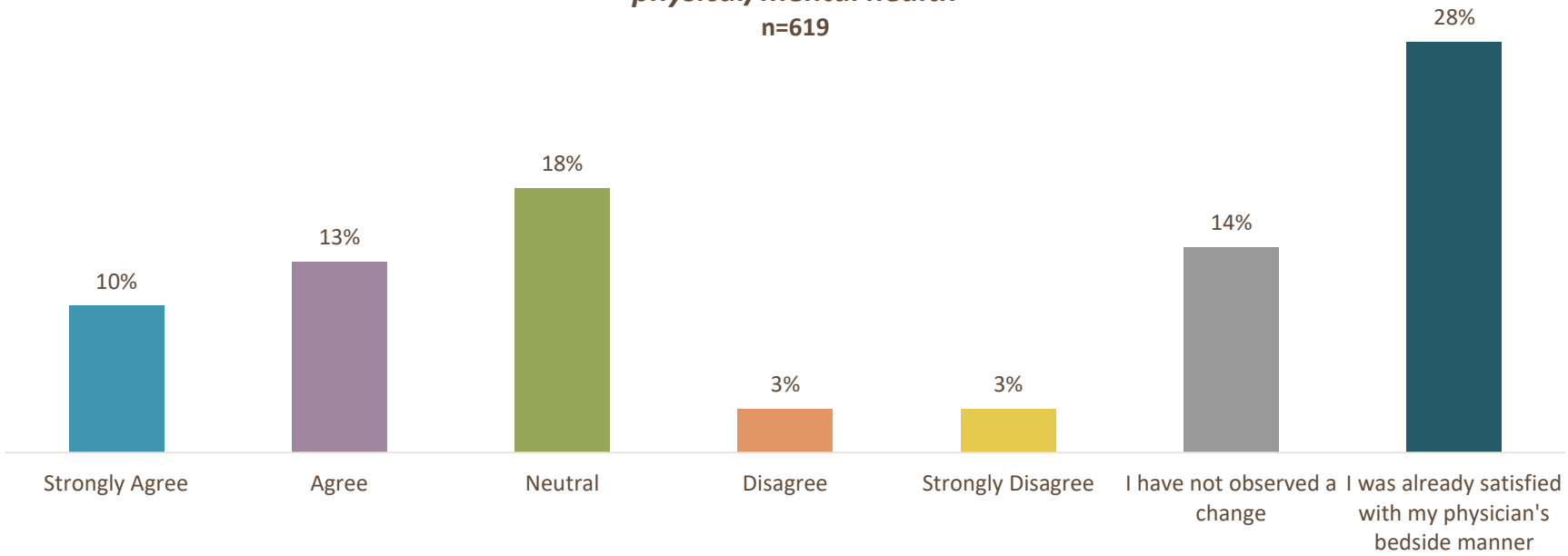
Question: If yes, then please check all that apply below (Other [please note below]).
Survey Responses: n=6
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

Stigma, Bedside Manner, Inclusion

Respondents feedback on current observations of stigma in health care are seen below.

Based on your experiences at Sharp in the past year, please select your level of agreement with the following statements: *My physician can more easily relate to me and my concerns for my own physical/mental health*

n=619



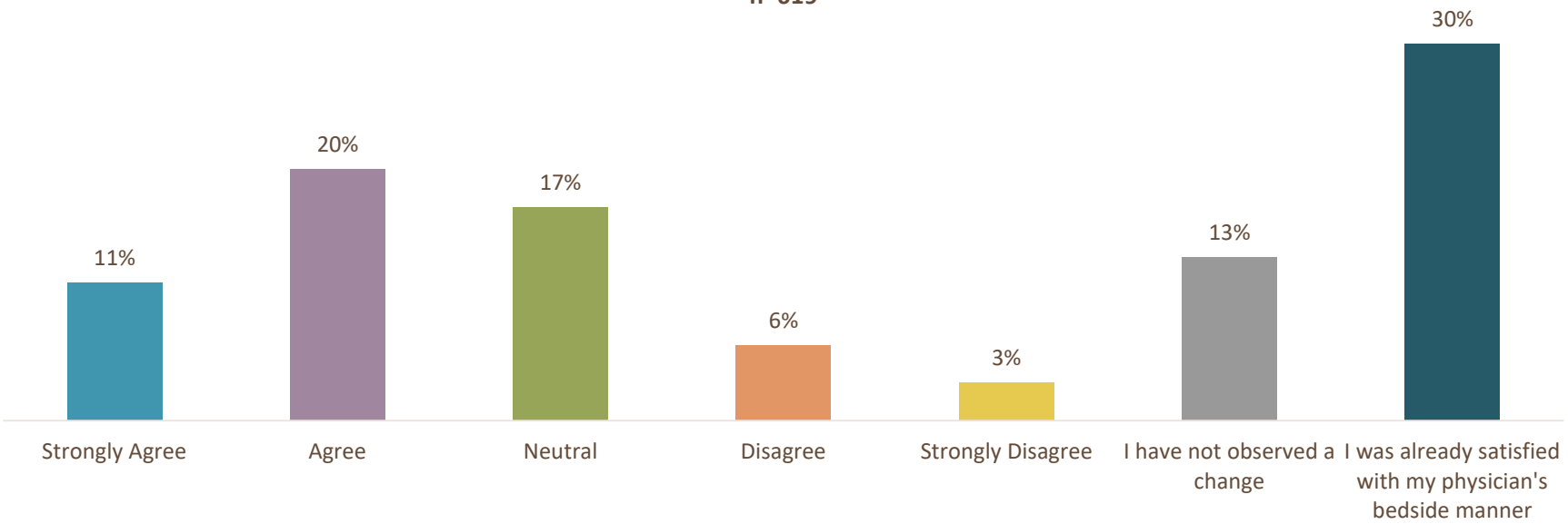
Question: Based on your experiences at Sharp in the past year, please select your level of agreement with the following statements.
Total Survey Responses: n=619
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

Stigma, Bedside Manner, Inclusion

Respondents feedback on current observations of stigma in health care are seen below.

Based on your experiences at Sharp in the past year, please select your level of agreement with the following statements: *There is an increased level of comfort being my authentic self with my care providers*

n=619

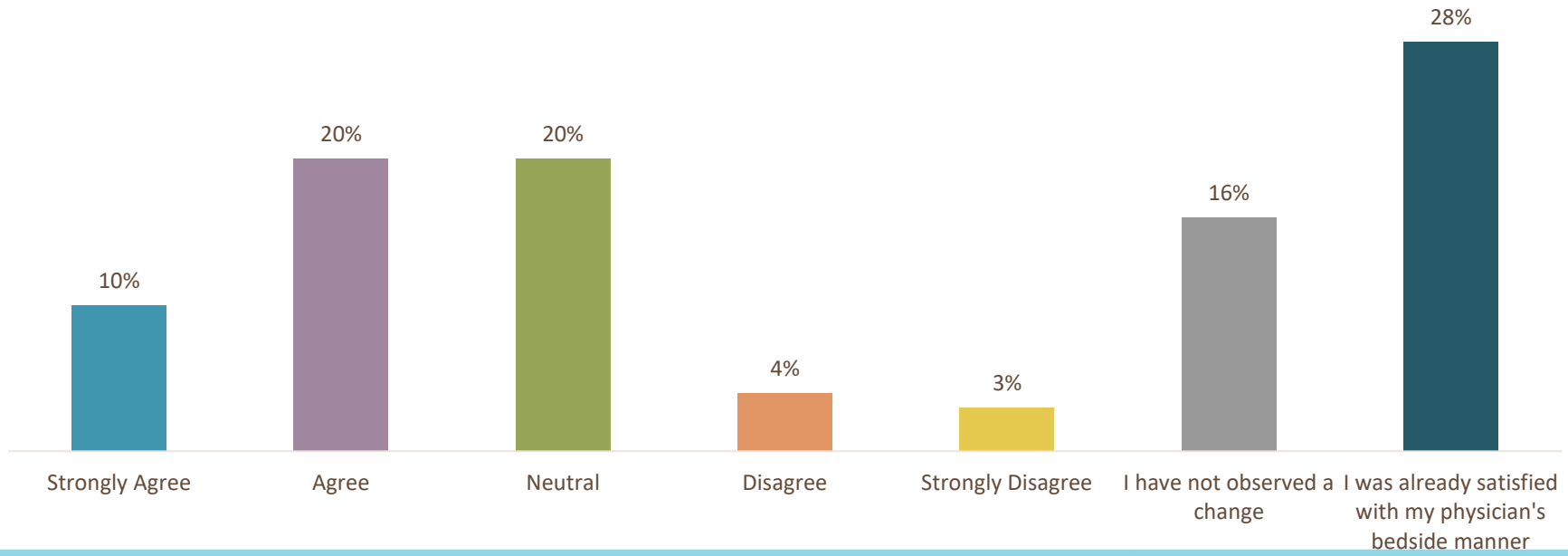


Question: Based on your experiences at Sharp in the past year, please select your level of agreement with the following statements.
Total Survey Responses: n=619
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

Stigma, Bedside Manner, Inclusion

Respondents feedback on current observations of stigma in health care are seen below.

Based on your experiences at Sharp in the past year, please select your level of agreement with the following statements: *My physician's office feels like a safer space* *(Examples: Inclusive forms, meet my needs with relation to marital status, pronouns, s*



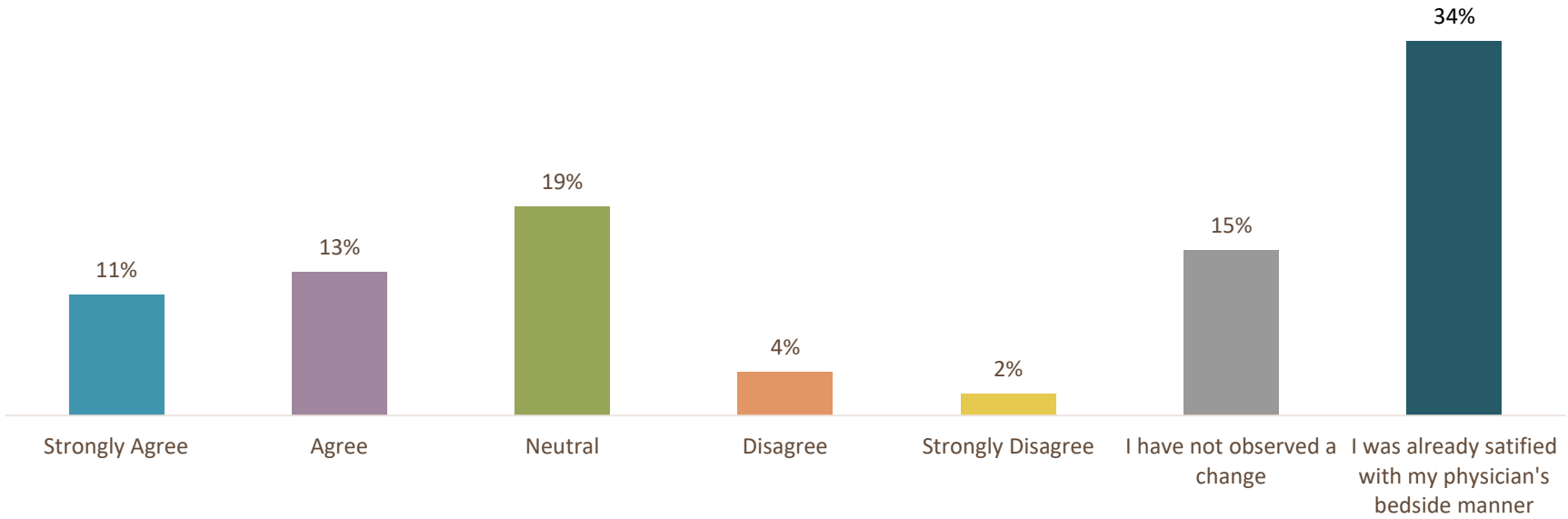
Question: Based on your experiences at Sharp in the past year, please select your level of agreement with the following statements.
Total Survey Responses: n=619
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

Stigma, Bedside Manner, Inclusion

Respondents feedback on current observations of stigma in health care are seen below.

Based on your experiences at Sharp in the past year, please select your level of agreement with the following statements: *My physician shows more humility and an eagerness to learn when they don't understand something*

n=619



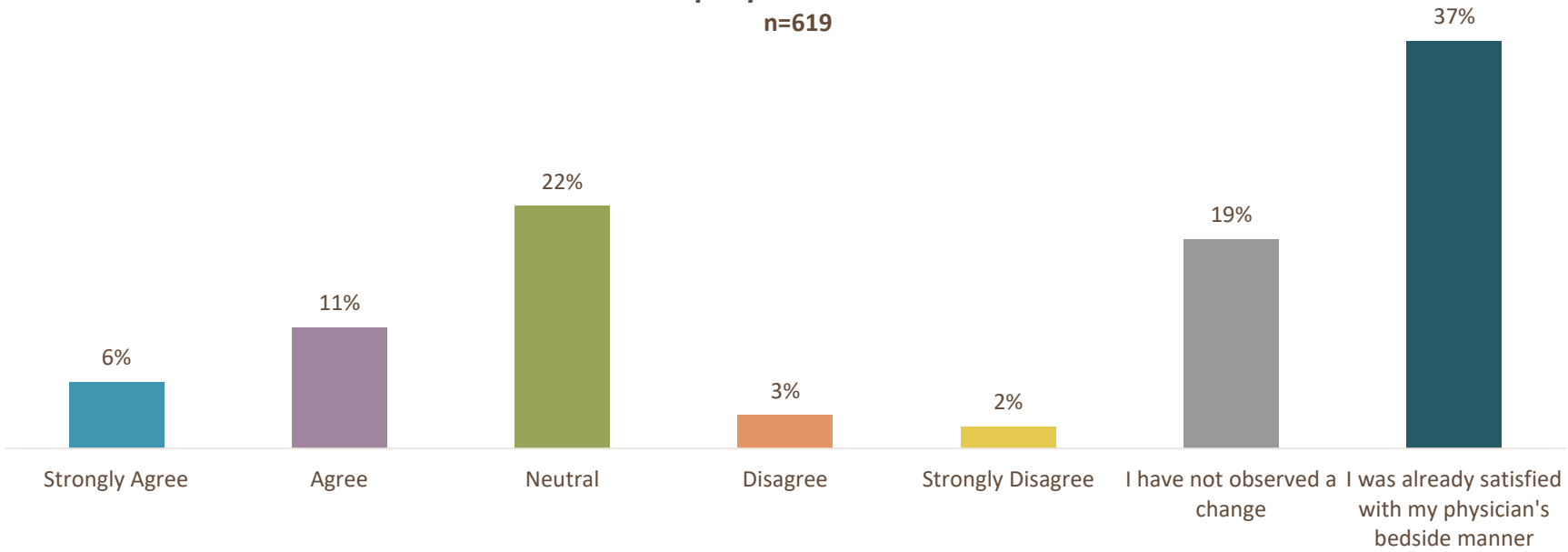
Question: Based on your experiences at Sharp in the past year, please select your level of agreement with the following statements.
Total Survey Responses: n=619
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

Stigma, Bedside Manner, Inclusion

Respondents feedback on current observations of stigma in health care are seen below.

Based on your experiences at Sharp in the past year, please select your level of agreement with the following statements: *My physician references fewer common stereotypes/generalizations for people like me*

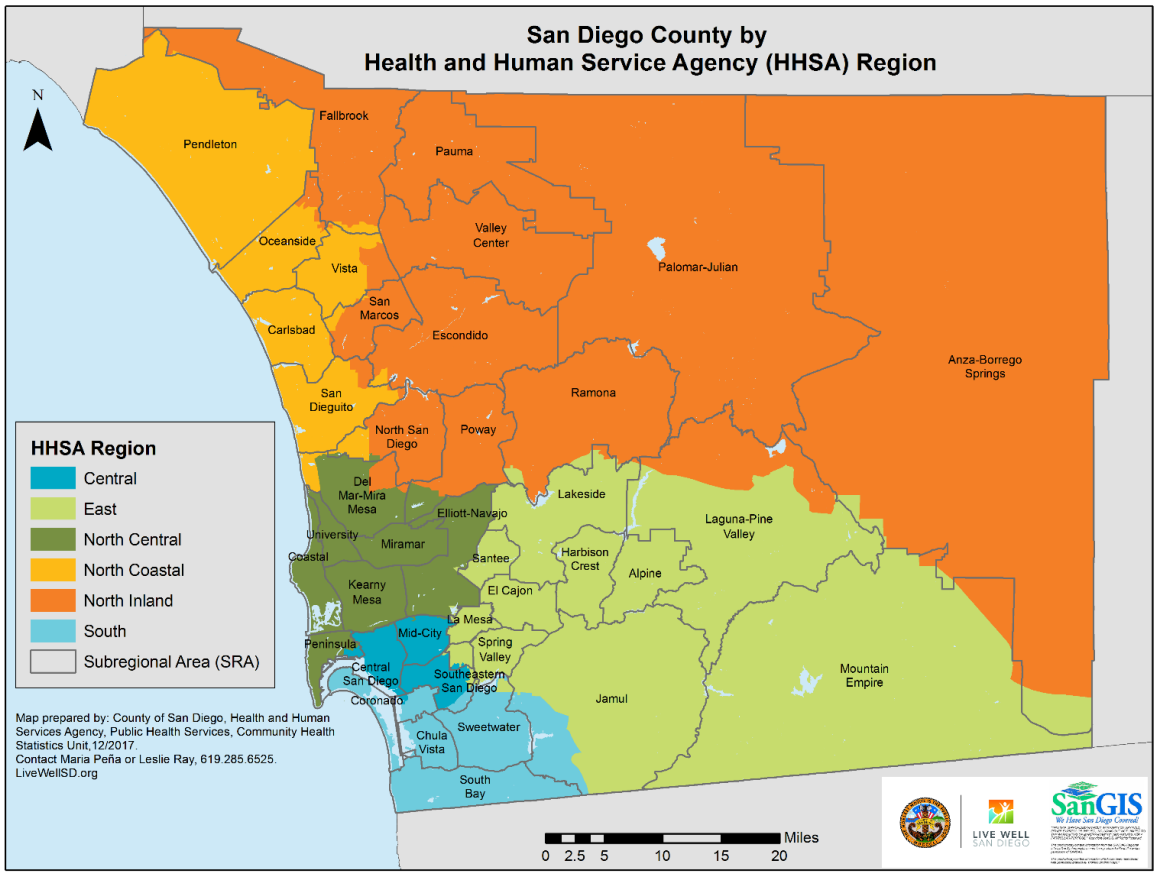
n=619



Question: Based on your experiences at Sharp in the past year, please select your level of agreement with the following statements.
Total Survey Responses: n=619
Source: Sharp Insight Community – Community Health Needs Assessment Phase 1 Survey

Appendix

K Map of Community and Region Boundaries in San Diego County



Appendix

L Dignity Health and IBM Watson Health Community Need Index

2021 Community Need Index

Methodology and Source Notes

Overview

In 2004, Dignity Health and IBM Watson Health™ jointly developed a Community Need Index ("CNI") to assist in the process of gathering vital socio-economic factors in the community.

Based on demographic and economic statistics, the CNI provides a score for every populated ZIP code in the United States on a scale of 1.0 to 5.0. A score of 1.0 indicates a ZIP code with the least need, while a score of 5.0 represents a ZIP code with the most need compared to the US national average (score of 3.0).

The CNI is strongly linked to variations in community healthcare needs and is a good indicator of a community's demand for a range of healthcare services. Not-for-profit and community-based hospitals, for whom community need is central to the mission of service, are often challenged to prioritize and effectively distribute hospital resources. The CNI can be used to help them identify specific initiatives best designed to address the health disparities of a given community.

Additionally, the CNI can be shared with community partners and used to justify grants or resource allocations for community initiatives. The increased transparency of hospital operations, with quality report cards and financial disclosures, has highlighted the need for community benefit efforts to become strategic and targeted. While local community needs assessments will always play a central role in this process, they are often voluminous and difficult to communicate. The CNI should be used as part of a larger community need assessment to pinpoint specific areas that have greater need than others.

Methodology

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

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 population that is minority (including Hispanic ethnicity)
    - Percentage of population over age 5 that speaks English poorly or not at all
3. **Education Barrier**
    - Percentage of population over 25 without a high school diploma

4. **Insurance Barrier**
    - Percentage of population in the labor force, aged 16 or more, without employment
    - Percentage of population without health insurance
5. **Housing Barrier**
    - Percentage of households renting their home

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

For the two barriers with only one statistic each (education and housing), IBM Watson Health™ used only the single statistic listed to calculate the barrier score. For the three barriers with more than one component statistic (income, cultural and insurance), IBM Watson Health™ first analyzed the variation and contribution of each statistic for its barrier, and then weighted each component statistic appropriately when calculating the barrier score.

After each ZIP code is assigned its barrier scores (from 1 to 5), the five barrier scores are averaged together to yield the CNI score. Each of the five barrier scores receives equal weight (20% each) in the composite CNI score. A score of 1.0 indicates a ZIP code with the least need, while a score of 5.0 represents a ZIP code with the most need.

Data Sources

- 2021 Demographic Data, © 2021 The Claritas Company
- 2021 Poverty Data, © 2021 The Claritas Company
- 2021 Insurance Coverage Estimates, IBM Watson Health™

Applications and Caveats

- CNI scores are not calculated for non-populated ZIP codes. These ZIP codes include such areas as national parks, public spaces, post office boxes, airports, and large unoccupied buildings.
- IBM Watson Health uses a weighted average technique based on 2021 population numbers to calculate the CNI score for a given community: First, the CNI value for each ZIP code is multiplied by the 2021 population for the same ZIP code. Second, the "CNI X 2021 population" products for the community ZIP codes are summed. Finally, the summed value is divided by the 2021 community population. The result yields a weighted CNI average for all ZIP codes combined.
- CNI scores for ZIP codes with small populations (fewer than 100 people) may be less accurate. This is because the sample of respondents to the 2010 census is too small to provide accurate statistics for such ZIP codes. This issue is mitigated by either eliminating such ZIP codes from your analysis completely, or by making sure that low population ZIP codes are combined with other surrounding high population ZIP codes using the weighted average technique described above.

Appendix

M HASD&IC 2022 CHNA Community Engagement Quotes

Access to Health Care

Aging Care & Support

Behavioral Health

Children & Youth Well-Being

Chronic Health Conditions

Community Safety

Economic Stability

Access to Health Care

"The number one challenge is access to care, it simply doesn't exist in the community."

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

KEY INFORMANT

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

KEY INFORMANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

KEY INFORMANT

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

FOCUS GROUP PARTICIPANT

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

KEY INFORMANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

"Telehealth is preferred for some since they can have someone on the phone with them – but the level of care is not as good because the person is not there for physical exam."

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

KEY INFORMANT

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

KEY INFORMANT

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

KEY INFORMANT

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

KEY INFORMANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

KEY INFORMANT

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

KEY INFORMANT

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

KEY INFORMANT

"For PeP, the sensitive time frame is extremely hard to meet because some providers will require an in person appointment before prescribing, that is if you can even talk with a provider directly within 3 days to have them write the prescription."

KEY INFORMANT

"In particular for the Transgender, Gender Variant, and Intersex population, being deadnamed,[72] misgendered, or treated in a non-gendering affirming manner causes trauma and leads to deferred care and exacerbation of symptoms."

KEY INFORMANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

KEY INFORMANT

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

KEY INFORMANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

KEY INFORMANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

KEY INFORMANT

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

FOCUS GROUP PARTICIPANT

Aging Care & Support

"Shallow rental subsidies, tied to rent burden rather than a set amount, are proving to be very effective. Early research suggests that subsidies should be set at 35% of the individual's rent burden."[209]

KEY INFORMANT

"Navigating systems, such as housing, is a huge issue. When seniors have abrupt changes in circumstances, where do we send them? Where does someone call when their husband dies? Or their wife dies? It feels like there is no right door. These people need help."

KEY INFORMANT

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

KEY INFORMANT

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

KEY INFORMANT

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

KEY INFORMANT

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

KEY INFORMANT

*"When we see seni*ors that need psychiatric treatment, there is a good chance they are admitted medically because there are no psych beds."

FOCUS GROUP PARTICIPANT

[209] Key Informant also mentioned this study: https://files.hudexchange.info/resources/documents/COVID-19-Homeless-System-Response-Shallow-Rental-Subsidies.pdf

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

KEY INFORMANT

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

KEY INFORMANT

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

KEY INFORMANT

Behavioral Health

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

KEY INFORMANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

KEY INFORMANT

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

FOCUS GROUP PARTICIPANT

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

KEY INFORMANT

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

FOCUS GROUP PARTICIPANT

"We need more ACT program slots paired with housing so that people can get services and stay connected to care."

KEY INFORMANT

"Our Emergency Department is not set-up to be a sobering center. We need additional resources for patients seeking treatment, especially if they are ready seek services. If they are put on a wait list, they may not ready when services finally become available."

KEY INFORMANT

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

FOCUS GROUP PARTICIPANT

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

KEY INFORMANT

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

FOCUS GROUP PARTICIPANT

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

KEY INFORMANT

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

KEY INFORMANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

KEY INFORMANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PATICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

Children & Youth Wellbeing

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

KEY INFORMANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

KEY INFORMANT

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

KEY INFORMANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

KEY INFORMANT

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

KEY INFORMANT

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

KEY INFORMANT

"I'm the oldest sibling of six. So sometimes my mom leaves and goes for the groceries or does anything, and then sometimes I'll have to take care of my little siblings while I'm in class. I've been failing with

homework sometimes because I take care of my siblings as well. And I don't finish homework. I wasn't finishing homework until like 10 or 12 o'clock in the night."

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

KEY INFORMANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

Chronic Health Conditions

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

KEY INFORMANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

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

FOCUS GROUP PARTICIPANT

Community Safety

"Specifically thinking about how in particular the last year and three months since George Floyd's passing and his death, how that has...impacted our clients in particular. Thinking about many of the clients that we work with, for example, who are young black men and helping them have to navigate complicated feelings and valid feelings around social inequity, but also simultaneously having to find ways to safety plan with them and recognize that, "Yes, you absolutely want to be involved and also you fit a very specific demographic that's at risk."

FOCUS GROUP PARTICIPANT

"Public safety and the over-policing of our neighborhoods, whether it's through ICE or through police or overzealous district attorneys [are of concern]."

KEY INFORMANT

"It's basically like being in a constant environment of surveillance where you're worried to drop your kids off at school, where you're worried to get in the car and go someplace because you could be pulled over, detained and made late to your job, made late to different types of things, at best. At worst, beaten up, killed, disrespected and abused in front of your children."

KEY INFORMANT

"Domestic violence is very prevalent in the community and it's making people have a hard time leaving. They don't want to leave because they don't want to be in homelessness, right? But they're sticking around. All the DV shelters at any given time are most likely full, so there's just not enough resources out there for victims of domestic violence and if they do decide to leave their situation, a lot of them don't have a place to go, they don't have that family member or those friends that they can rely on."

FOCUS GROUP PARTICIPANT

"We've seen a lot of increase in intimate partner violence or family based violence, and even had clients who have needed to work on getting restraining orders and things like that through the pandemic... Having to do remote court sessions with clients is not trauma-informed... It was just like, 'here's a link. Sign on to this link,' and then all of the sudden your perpetrator is on your computer."

FOCUS GROUP PARTICIPANT

"For survivors across the continuum…folks very much see trafficking as a black and white thing. On the continuum of sex work, you're either fully enthusiastically engaged or you're being exploited, end of story. There's no in between of your circumstance of poverty or other things that might occur that might cause you to engage in some form of sex work, whether that is fully consensual or fully exploited."

FOCUS GROUP PARTICIPANT

"I think what we see a lot is a very specific perspective that trafficking has to be this thing that is extremely violent and is extremely in this underbelly of society and not recognizing that sometimes it happens because a family needs to put food on the table."

FOCUS GROUP PARTICIPANT

"We know when people are dealing with immense trauma, that they react in a multitude of ways. I've even found that in the work I do with the forensics where we have nurses who are particularly trauma informed, but even they really struggle to see the indicators and the risk factors of patients that come in, in relation to trafficking and exploitation."

FOCUS GROUP PARTICIPANT

"There have been some challenges with the national hotline recently, partly because of increasing calls about conspiracy theories. We need a locally supported, cross-sector, trauma informed hotline to help human trafficking survivors connect to services and supports."

FOCUS GROUP PARTICIPANT

"A trauma-informed environment uses supportive language conversation with patients, colleagues, and in documentation. Using language that supports the dignity of patients creates an environment where patients feel safe and improves health outcomes."

FOCUS GROUP PARTICIPANT

"Clinicians prefer screening tools, but patients can resist disclosure and screening does not provide the support patients need. A trauma-informed assessment tool like the evidence based PEARR tool is ideal to facilitate discussions between patients and clinicians about personal safety and how relationships impact our health. When a patient is ready for more support a hand-off to social work or community support should be done with consent and transparency."

FOCUS GROUP PARTICIPANT

"I always get apprehensive when a family starts verbally escalating because I always feel like that translates into possible threat of physical violence. It's not just nursing, not just clinical social work. It's ancillary staffing. It's everyone involved."

FOCUS GROUP PARTICIPANT

"We've been working with hospital leadership [and] nursing leadership on the ED side to bolster the security presence."

FOCUS GROUP PARTICIPANT

"I feel like there's always these elements there and it spills over into the daily. You experience it at airports, on airplanes. It's that same underlying sense of people are in a different mindset now and on edge a little bit. No one ever voluntarily wants to come to the emergency department. It's never the case that people look forward to coming ...into the environment that they don't want to be in."

FOCUS GROUP PARTICIPANT

Economic Stability

"In the population we serve and in a variety of places, people did lose their jobs, they lost income. We did try to connect them as much when we could, or they qualified for unemployment…"

FOCUS GROUP PARTICIPANT

"And our families [that are] at [the] federal poverty level…they're struggling even more now on their economic security."

FOCUS GROUP PARTICIPANT

"Front-line workers, those individuals that work in restaurants or in the transportation business, maintenance...in many cases, the lower-paying jobs…. place them at greatest risk to exposure because they are in contact with the general public. And then people of color have most of those jobs. And…in many cases, a greater risk of complications because of their comorbid conditions. So, all of those factors place these populations at greater risk for developing the disease if they're exposed, and further for being hospitalized or dying from the illness."

KEY INFORMANT

"While the temporary expansion of federal nutrition assistance programs during COVID has played a pivotal role in helping many households meet their food needs each month; we know that looming expirations of these flexibilities will result in potentially devastating benefits cliffs for hundreds of thousands of San Diegans. In addition to navigating broader long-term economic impacts of COVID, recipients will once again need to think about how to meet their food needs after CalFresh/SNAP runs out two-thirds of the way through the month and face ensuing intersectional health implications of episodic hunger."

KEY INFORMANT

"I'm not talking about a concern. I'm talking about a deep fear. I never knew the rawness of it, how afraid they are."

FOCUS GROUP PARTICIPANT

"Our undocumented folks have really, really struggled in particular... The last administration being in place during the beginning of the pandemic...created this space where undocumented folks felt like they couldn't come forward for any type of help whatsoever to any government agency."

FOCUS GROUP PARTICIPANT

"While there have been a lot of really fantastic resources that have come out [during the pandemic] like rental assistance and stuff like that, our folks who are undocumented don't qualify for that."

KEY INFORMANT

"We've seen a lot of folks experience labor trafficking through spaces where maybe they were told, "Hey, we'll give you free room and board and we'll pay you if you do this in-home healthcare service for us." Then ended end up being labor trafficking, a process as a result where literally there's that coercion of, they care about the person that they're caring for, and so they don't want to leave that person."

KEY INFORMANT

"Housing insecurity, period, and the threat of that has become a really big driver in the pandemic in particular for both sex and labor trafficking."

FOCUS GROUP PARTICIPANT

"Thinking about housing insecurity in particular and the struggle for many of our clients to find places that they could live that are affordable, especially because the pandemic has actually made housing costs skyrocket throughout San Diego County. And so it's made it that much more difficult for folks with unstable income"

KEY INFORMANT

"People are desperate for housing. Our calls are housing, housing, housing. Getting a vaccine becomes low on the list when you need housing."

FOCUS GROUP PARTICIPANT

"When the moratorium on evictions are lifted, I believe that there are going to be many families losing their homes, where they rent. I think it's really difficult for some families to catch up. I mean, if you're living month to month, and then you're [trying to] catch up [on] payments and [do] not have access to rental assistance, even though it's out there…There will be a wave of families losing their homes."

KEY INFORMANT

"When a household's budget is already limited due to expenses or when an unexpected surgery occurs and now, a person or family does not have enough savings to count on, less money becomes available to spend on food."

FOCUS GROUP PARTICIPANT

"Even if parents can find an infant toddler slot, it's going to cost them ... it's [said to be] more than college tuition a year."

KEY INFORMANT

"The desperation that families feel to get that child care subsidy is fierce and it leads to just this …level of stress and anger that we hear from parents rightfully so that they cannot access this thing that would change their lives, this one resource right that could open the door to a completely different future."

KEY INFORMANT

"I get a lot of clients…that are afraid to go back to get their needs met because they can't afford their copayments, or they have huge astronomical bills from the hospital they can't pay."

FOCUS GROUP PARTICIPANT

"I took a [community member] that was having severe pain to the ER and guided them via text on what to do or ask for. He was worried to go in because of lack of insurance and the fear of receiving a large hospital bill."

FOCUS GROUP PARTICIPANT

Appendix

N Map of Sharp HealthCare Locations

Appendix

O Sharp HealthCare Involvement in Community Organizations

The list below shows the involvement of Sharp HealthCare executive leadership and other staff in community organizations and coalitions in fiscal year 2021. Community organizations are listed alphabetically.

- 2-1-1 San Diego (2-1-1)
- 2-1-1 Community Information Exchange (CIE)
- 2-1-1 CIE Advisory Board
- A New PATH (Parents for Addiction, Treatment and Healing)
- Adult Protective Services
- Advanced Care at Home Coalition
- Alliance for African Assistance
- Alliant International University
- Alzheimer's San Diego
- Alzheimer's San Diego Community Advisory Council
- American Association of Critical-Care Nurses
- American Cancer Society
- American Case Management Association
- American College of Healthcare Executives
- American Diabetes Association
- American Heart Association
- American Hospital Association
- American Hospital Association Regional Policy Board
- American Lung Association
- America's Physician Groups
- American Red Cross
- Angels Foster Family Network
- Asian Business Association of San Diego (ABASD)
- ABASD Board of Directors
- 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 for Healthcare Philanthropy
- Association of Black Psychologists – San Diego Chapter
- Association of California Nurse Leaders
- Association of Fundraising Professionals – San Diego Chapter
- Association of Oncology Social Work
- Association of Women's Health, Obstetric and Neonatal Nurses

- Azusa Pacific University
- Back to Work San Diego
- Balboa Institute of Transplantation
- Bayside Community Center
- Be There San Diego
- Beacon Council's Patient Safety Collaborative
- Black Tech Link
- Borrego Health
- Boy Scouts of America
- 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 (CAHHS)
- CAHHS Committee on Volunteer Services and Directors' Coordinating Council
- California Association Medical Staff Services – San Diego Chapter
- California Association of Physician Groups
- California College San Diego
- California Doctor of Physical Therapy Advisory Committee
- California Health Care Foundation California Physician Orders for Life-Sustaining Treatment (POLST) eRegistry Evaluation Team
- California Health Foundation & Trust
- California Hospice and Palliative Care Association
- California Hospital Association (CHA)
- CHA Advisory Board
- CHA San Diego Association of Directors of Volunteer Services
- CHA Workforce Committee
- California Maternal Quality Care Collaborative
- California Perinatal Quality Care Collaborative
- California School-Age Families Education
- California Society for Clinical Social Work Professionals
- California State University Dominguez Hills
- California State University San Marcos
- Cameron Family YMCA
- Caregiver Coalition of San Diego
- Chicano Federation
- Chula Vista Chamber of Commerce
- Chula Vista Fire Department
- Chula Vista Police Foundation
- City of Chula Vista
- City of Coronado
- City of San Diego
- City of San Diego Community Health Advisory Team
- Climate Action Campaign
- Coalition for Compassionate Care of California

- Community Center for the Blind and Visually Impaired
- Community Health Improvement Partners (CHIP) Behavioral Health Work Team
- CHIP ILA Work Team
- CHIP Suicide Prevention Council (SPC)
- CHIP SPC Media and Higher Education Subcommittees
- Concorde Career College
- Concordia University
- Connect
- Consortium for Nursing Excellence, San Diego
- Coronado Chamber of Commerce
- Coronado Community Center
- Coronado Fire Department
- Coronado Police Department
- Coronado Public Library
- Coronado SAFE (Student and Family Enrichment)
- Coronado Senior Planning Committee
- Council of Women's and Infants' Specialty Hospitals
- County of San Diego Aging and Independence Services (AIS)
- County of San Diego AIS Health Promotion Committee
- County of San Diego Emergency Medical Care Committee
- County of San Diego Emergency Medical Services
- County Service Area – 69 Advisory Board
- Cristo Rey San Diego High School
- Doris A. Howell Foundation for Women's Health Research
- Downtown San Diego Partnership
- Downtown San Diego Silvercrest Residence
- East County Action Network
- East County Elder Abuse Council
- East County Senior Service Providers
- Emergency Nurses Association – San Diego Chapter
- Employee Assistance Professionals Association
- EMSTA College
- Equality Alliance of San Diego County
- Epilepsy Foundation San Diego County
- Episcopal Community Services
- Evidence-Based Practice Institute
- Family Health Centers of San Diego
- Father Joe's Villages
- Feeding San Diego
- Gary and Mary West Senior Wellness Center
- Girl Scouts San Diego
- Glendale Career College
- Grand Canyon University
- Grossmont College

- Grossmont Health Occupations
- Grossmont Imaging LLC Board
- Grossmont Union High School District
- Health and Science Pipeline Initiative
- Health Industry Collaboration Effort, Inc.
- Health Information and Management Systems Society
- Health Insurance Counseling & Advocacy Program
- Health Plan Alliance
- Health Sciences High and Middle College (HSHMC)
- HSHMC Board
- Health Services Advisory Group
- Health Transformation Alliance
- Home Start, Inc.
- Hospice and Palliative Nurses Association — San Diego Chapter
- Hospital Association of San Diego and Imperial Counties (HASD&IC)
- HASD&IC Board of Directors
- HASD&IC Community Health Needs Assessment Committee
- Hunger Advocacy Network
- I Love a Clean San Diego
- Integrated Healthcare Association
- Integrative Therapies Collaborative
- International Association of Eating Disorders Professionals
- International Bipolar Foundation
- Jacobs & Cushman San Diego Food Bank
- Jewish Family Service of San Diego (JFS)
- JFS Behavioral Health Committee
- JFS Public Affairs Committee
- John A. Davis Family YMCA
- John D. Spreckels Center & Bowling Green
- Kitchens for Good
- La Maestra Community Health Centers
- La Mesa Lion’s Club
- La Mesa Park & Recreation Foundation
- Lantern Crest Senior Living Advisory Board
- Las Damas de San Diego International Nonprofit Organization
- Las Patronas
- Live Well San Diego Check Your Mood Committee
- Mama’s Kitchen
- MANA de San Diego
- March of Dimes
- McGrath Family YMCA
- Meals on Wheels San Diego County
- Meals on Wheels San Diego County East County Advisory Board
- Midwestern University

- MiraCosta College
- National Active and Retired Federal Employees Association
- National Alliance on Mental Illness
- National Association of Emergency Medical Services Educators
- National Association of Orthopedic Nurses
- National Conflict Resolution Center
- National Eating Disorders Association
- National Hospice and Palliative Care Organization
- National University
- Neighbor 2 Neighbor
- Neighborhood Healthcare
- North San Diego Business Chamber
- North San Diego Business Chamber Health Committee
- Optimist Club of Coronado
- Pacific Arts Movement Advisory Board
- Palomar Community College
- Partnership for Smoke-Free Families
- Peninsula Shepherd Senior Center
- Perinatal Care Network
- Perinatal Social Work Cluster
- Philippine Nurses Association of San Diego County, Inc.
- Phlebotomy Training Academy
- Pima Medical Institute
- Point Loma/Hervey Library
- Point Loma Nazarene University
- Potiker Family Senior Residence
- Poway Chamber of Commerce Government Affairs Committee
- Practice Greenhealth
- Press Ganey
- Psychiatric Emergency Response Team
- Public Health Emergency Hospital Preparedness Program
- Risk Management Society – San Diego Chapter
- Rotary Club of Chula Vista
- Rotary Club of Coronado
- San Diego Adolescent Pregnancy and Parenting Program
- San Diego Association of Diabetes Educators
- San Diego Association of Health Underwriters
- San Diego Black Nurses Association, Inc.
- San Diego Blood Bank
- San Diego Blood Bank Board of Directors
- San Diego Brain Injury Foundation Board of Directors
- San Diego City College
- San Diego Clinical Pastoral Educators

- San Diego Coalition for Compassionate Care/San Diego Physician Orders for Life-Sustaining Treatment (POLST) Coalition
- San Diego Coalition for Mental Health
- San Diego Community Action Network
- San Diego Community College District Corporate Council
- San Diego County Breastfeeding Coalition Advisory Board
- San Diego County Coalition for Improving End-of-Life Care
- San Diego County Community Emergency Response Team
- San Diego County Council on Aging
- San Diego County Health Services Capacity Task Force
- San Diego County Healthcare Disaster Coalition
- San Diego County Hospice Veteran Partnership
- San Diego County Medical Society Bioethics Commission
- San Diego County Older Adult Behavioral Health System of Care Council
- San Diego County Promotoras Coalition
- San Diego County Public Health Nursing Advisory Board
- San Diego County Stroke Consortium
- San Diego East County Chamber of Commerce
- San Diego East County Chamber of Commerce Government Affairs Committee
- San Diego East County Chamber of Commerce Leadership East County Program
- San Diego Economic Development Council
- San Diego Education Collaborative
- San Diego Family Care
- San Diego Fire-Rescue Department
- San Diego Freedom Ranch
- San Diego Health Connect
- San Diego Health Connect POLST e-registry workgroup
- San Diego Housing Commission
- San Diego Imaging – Chula Vista
- San Diego-Imperial County Council of Hospital Volunteers
- San Diego Mental Health Coalition
- San Diego Mesa College
- San Diego Military Family Collaborative
- San Diego National Association of Hispanic Nurses
- San Diego Police Foundation
- San Diego Pride
- San Diego Psychological Association Membership and Public Education Media Committees
- San Diego Public Health Advisory Council
- San Diego Regional Chamber of Commerce
- San Diego Regional Economic Development Corporation
- San Diego Regional Human Trafficking and Commercial Sexual Exploitation of Children (CSEC) Advisory Council

- San Diego Regional Human Trafficking and CSEC Advisory Council – Health Subcommittee
- San Diego Rescue Mission
- San Diego River Park Foundation
- San Diego Square
- San Diego State University (SDSU)
- SDSU Institute for Public Health (IPH)
- San Diego Women, Infants and Children Program
- San Diego Workforce Partnership
- San Joaquin Valley College
- Santee Chamber of Commerce Government Affairs Committee
- SAY San Diego
- Second Chance
- Serra Mesa Planning Group Board
- Serving Seniors
- Sharp and Children's MRI Board
- Sharp and University of California (UC) San Diego Health's Joint Venture
- Soroptimist International of Coronado
- South County Action Network
- Southern California Association of Neonatal Nurses
- Southern Caregiver Resource Center
- Southwestern College
- Special Needs Trust Foundation
- St. Paul's PACE
- St. Paul's Senior Services
- St. Peter's by the Sea Lutheran Church
- Susan G. Komen® San Diego Development Committee
- The National Alliance for Caregiving
- Trauma Center Association of America Board of Directors
- UC San Diego
- UC San Diego Extension
- Union of Pan Asian Communities
- University of Massachusetts Global
- University of San Diego (USD)
- USD – The Nonprofit Institute Advisory Board
- USD – The Nonprofit Institute Board Chairs Learning Group
- University of Southern California
- University of St. Augustine for Health Sciences
- USS Midway Museum
- VA San Diego Healthcare System
- VA San Diego Mental Health Council
- Vietnamese American Youth Alliance
- Vista Hill Foundation
- Vista Hill ParentCare

- Wave Academy
- We Honor Veterans
- West Coast University – Los Angeles Campus
- Westminster Manor
- Wreaths Across America San Diego
- YMCA of San Diego County
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