2019 Community Health Needs Assessment

Kaiser Foundation Hospital: San Diego and Zion

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Approved by Kaiser Foundation Hospitals Board of Director's Community Health Committee

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KAISER PERMANENTE®

Kaiser Permanente Southern California Region Community Benefit CHNA Report for KFH – San Diego and Zion

Contents

I. Introduction/Background

A. About Kaiser Permanente (KP)

Founded in 1942 to serve employees of Kaiser Industries and opened to the public in 1945, Kaiser Permanente is recognized as one of America's leading health care providers and nonprofit health plans. We were created to meet the challenge of providing American workers with medical care during the Great Depression and World War II, when most people could not afford to go to a doctor. Since our beginnings, we have been committed to helping shape the future of health care. Among the innovations Kaiser Permanente has brought to U.S. health care are:

- Prepaid health plans, which spread the cost to make it more affordable
- A focus on preventing illness and disease as much as on caring for the sick
- An organized, coordinated system that puts as many services as possible under one roof—all connected by an electronic medical record

Kaiser Permanente is an integrated health care delivery system comprised of Kaiser Foundation Hospitals (KFH), Kaiser Foundation Health Plan (KFHP), and physicians in the Permanente Medical Groups. Today we serve more than 12 million members in nine states and the District of Columbia. Our mission is to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.

Care for members and patients is focused on their Total Health and guided by their personal physicians, specialists, and team of caregivers. Our expert and caring medical teams are empowered and supported by industry-leading technology advances and tools for health promotion, disease prevention, state-of-the-art care delivery, and world-class chronic disease management. Kaiser Permanente is dedicated to care innovations, clinical research, health education, and the support of community health.

B. About Kaiser Permanente Community Health

For more than 70 years, Kaiser Permanente has been dedicated to providing high-quality, affordable health care services and to improving the health of our members and the communities we serve. We believe good health is a fundamental right shared by all and we recognize that good health extends beyond the doctor's office and the hospital. It begins with healthy environments: fresh fruits and vegetables in neighborhood stores, successful schools, clean air, accessible parks, and safe playgrounds. Good health for the entire community requires equity and social and economic well-being. These are the vital signs of healthy communities.

Better health outcomes begin where health starts, in our communities. Like our approach to medicine, our work in the community takes a prevention-focused, evidence-based approach. We go beyond traditional corporate philanthropy or grantmaking to pair financial resources with medical research, physician expertise, and clinical practices. Our community health strategy focuses on three areas:

- Ensuring health access by providing individuals served at KP or by our safety net partners with integrated clinical and social services;

- Improving conditions for health and equity by engaging members, communities, and Kaiser Permanente's workforce and assets; and
- Advancing the future of community health by innovating with technology and social solutions.

For many years, we've worked side-by-side with other organizations to address serious public health issues such as obesity, access to care, and violence. And we've conducted Community Health Needs Assessments to better understand each community's unique needs and resources. The CHNA process informs our community investments and helps us develop strategies aimed at making long-term, sustainable change—and it allows us to deepen the strong relationships we have with other organizations that are working to improve community health.

C. Purpose of the Community Health Needs Assessment (CHNA) Report

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, included new requirements for nonprofit hospitals in order to maintain their tax-exempt status. The provision was the subject of final regulations providing guidance on the requirements of section 501(r) of the Internal Revenue Code. Included in the new regulations is a requirement that all nonprofit hospitals must conduct a community health needs assessment (CHNA) and develop an implementation strategy (IS) every three years (http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf). The required written IS plan is set forth in a separate written document. Both the CHNA Report and the IS for each Kaiser Foundation Hospital facility are available publicly at https://www.kp.org/chna.

D. Kaiser Permanente's approach to Community Health Needs Assessment

Kaiser Permanente has conducted CHNAs for many years, often as part of long standing community collaboratives. The new federal CHNA requirements have provided an opportunity to revisit our needs assessment and strategic planning processes with an eye toward enhanced compliance and transparency and leveraging emerging technologies. Our intention is to develop and implement a transparent, rigorous, and whenever possible, collaborative approach to understanding the needs and assets in our communities. From data collection and analysis to the identification of prioritized needs and the development of an implementation strategy, the intent was to develop a rigorous process that would yield meaningful results.

Kaiser Permanente's innovative approach to CHNAs includes the development of a free, web-based CHNA data platform that is available to the public. The data platform provides access to a core set of approximately 120 publicly available indicators to understand health through a framework that includes social and economic factors, health behaviors, physical environment, clinical care, and health outcomes. In addition, hospitals operating in the Southern California Region utilized the Southern California Public Health Alliance's Healthy Places Index Platform, which includes approximately 80 publicly available community health indicators with resolution at the census tract level.

In addition to reviewing and analyzing secondary data, each KFH facility, individually or with a collaborative, collected primary data through key informant interviews, focus groups, and surveys. Primary data collection consisted of reaching out to local public health experts, community leaders, and residents to identify issues that most impacted the health of the

community. The CHNA process also included an identification of existing community assets and resources to address the health needs.

Each hospital/collaborative developed a set of criteria to determine what constitutes a health need in their community. Once all the community health needs were identified, they were prioritized, based on identified criteria. This process resulted in a complete list of prioritized community health needs. The process and the outcome of the CHNA are described in this report.

In conjunction with this report, KFH-San Diego and Zion will develop an implementation strategy for the priority health needs the hospital will address. These strategies will build on Kaiser Permanente's assets and resources, as well as evidence-based strategies, wherever possible. The Implementation Strategy will be filed with the Internal Revenue Service using Form 990 Schedule H. Both the CHNA and the Implementation Strategy, once they are finalized, will be posted publicly on our website, https://www.kp.org/chna

II. Community Served
A. Kaiser Permanente's Definition of Community Served

Kaiser Permanente defines the community served by a hospital as those individuals residing within its hospital service area. A hospital service area includes all residents in a defined geographic area surrounding the hospital and does not exclude low-income or underserved populations. KFH-San Diego and Zion's medical service area are roughly equivalent to the entire San Diego County population. Therefore, the 2019 Community Health Needs Assessment (CHNA) report is comprised of county level data.

B. Map and Description of Community Served
i. Map

Figure A - KFH - San Diego and Zion Service Area
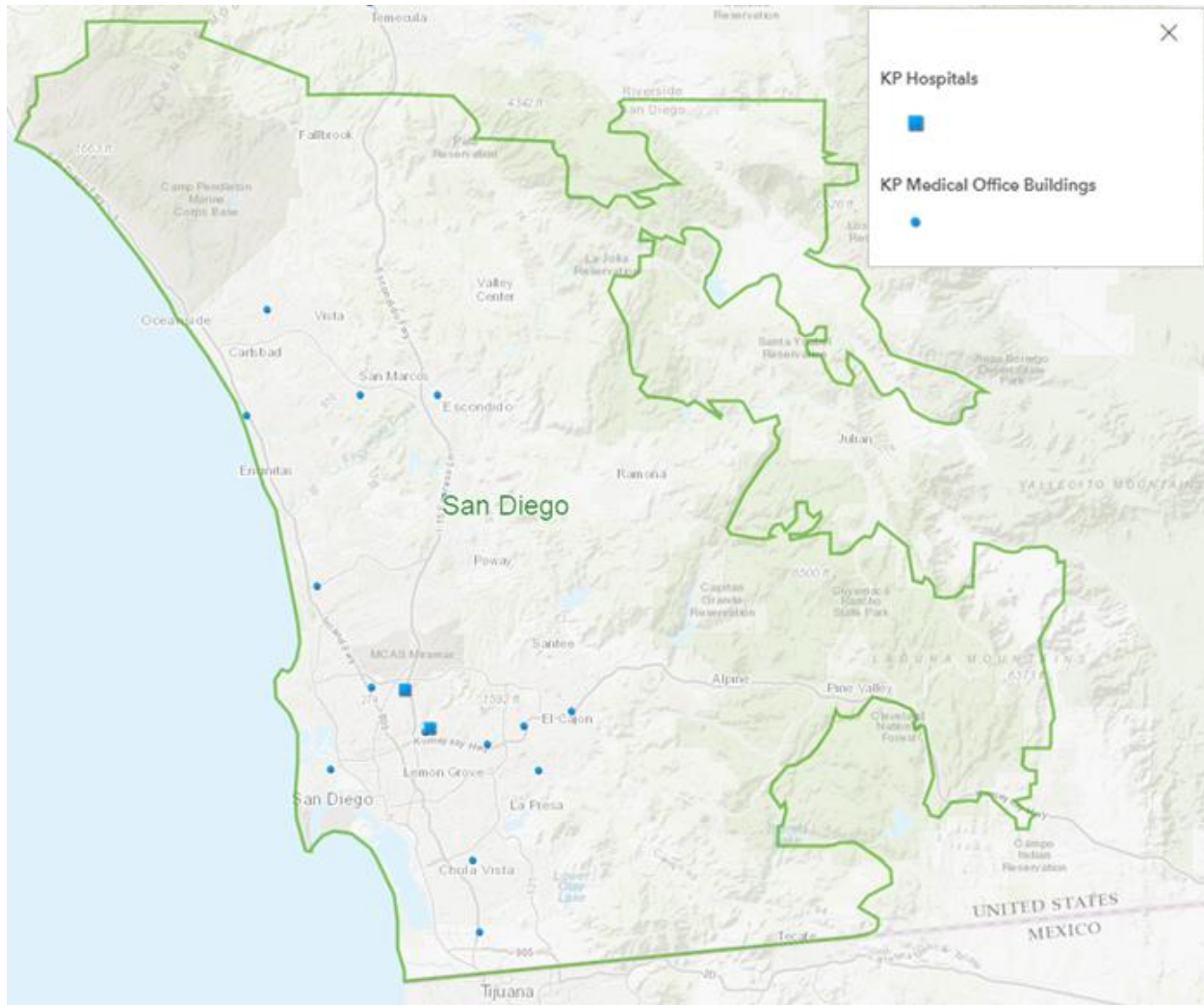
ii. Geographic description of the community served
The KFH-San Diego and Zion service area comprises a large part of San Diego County, including the following cities and communities: Bonita, Chula Vista, Coronado, Del Mar, Descanso, Dulzura, El Cajon, Encinitas, Leucadia, Olivenhain, Escondido, Fallbrook, Rainbow, Guatay, Imperial Beach, Jamul, La Jolla, La Mesa, Lakeside, Lemon Grove, Lincoln Acres, Mount Laguna, National City, Oceanside, Pala, Palomar Mountain, Pauma Valley, Pine Valley, Potrero, Poway, Ramona, Rancho Santa Fe, San Diego, San Luis Rey, San Marcos, San Ysidro, Santee, Solana Beach, Spring Valley, Tecate, Valley Center, Vista, and Warner Springs.

iii. Demographic profile of the community served

Demographic profile: KFH-San Diego and Zion

Race/Ethnicity		Socioeconomic	
Total Population	3,240,176	Living in Poverty (<100% federal poverty level)	13.98%
Asian	11.38%	Children in Poverty	17.98%
Black	4.75%	Unemployment	3.30%
Hispanic/Latino	33.12%	Uninsured Population	12.23%
Native American/Alaska Native	0.34%	Adults with No High School Diploma	13.60%
Pacific Islander/Native Hawaiian	0.43%		
Some Other Race	0.17%		
Multiple Races	3.16%		
White	46.64%		

iv. Severely under-resourced communities

Identifying disparities in the upstream factors that predict negative health outcomes is critical to Kaiser Permanente's community health mission. The map below displays the differences in opportunity for residents in the KFH-San Diego and Zion service area to live a long and healthy life[1]. Areas in dark blue represent census tracts in the lowest quartile of health opportunity across California. These areas are severely under-resourced across multiple domains of the social predictors of health (e.g. economics, education, transportation, built environment, etc.).

Note: this map displays an area slightly larger than service area boundaries and is taken directly from the Southern California Public Health Alliance's Healthy Places Index.

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[1] As defined by the California Healthy Places Index (HPI). HPI scores combine 25 metrics of the social predictors of health (each weighted to life expectancy) to produce a single health opportunity score for each census tract in CA. For more detailed maps and additional information about HPI methodology, please visit http://healthyplacesindex.org.

Figure B – Under-resourced Communities in KFH-San Diego and Zion
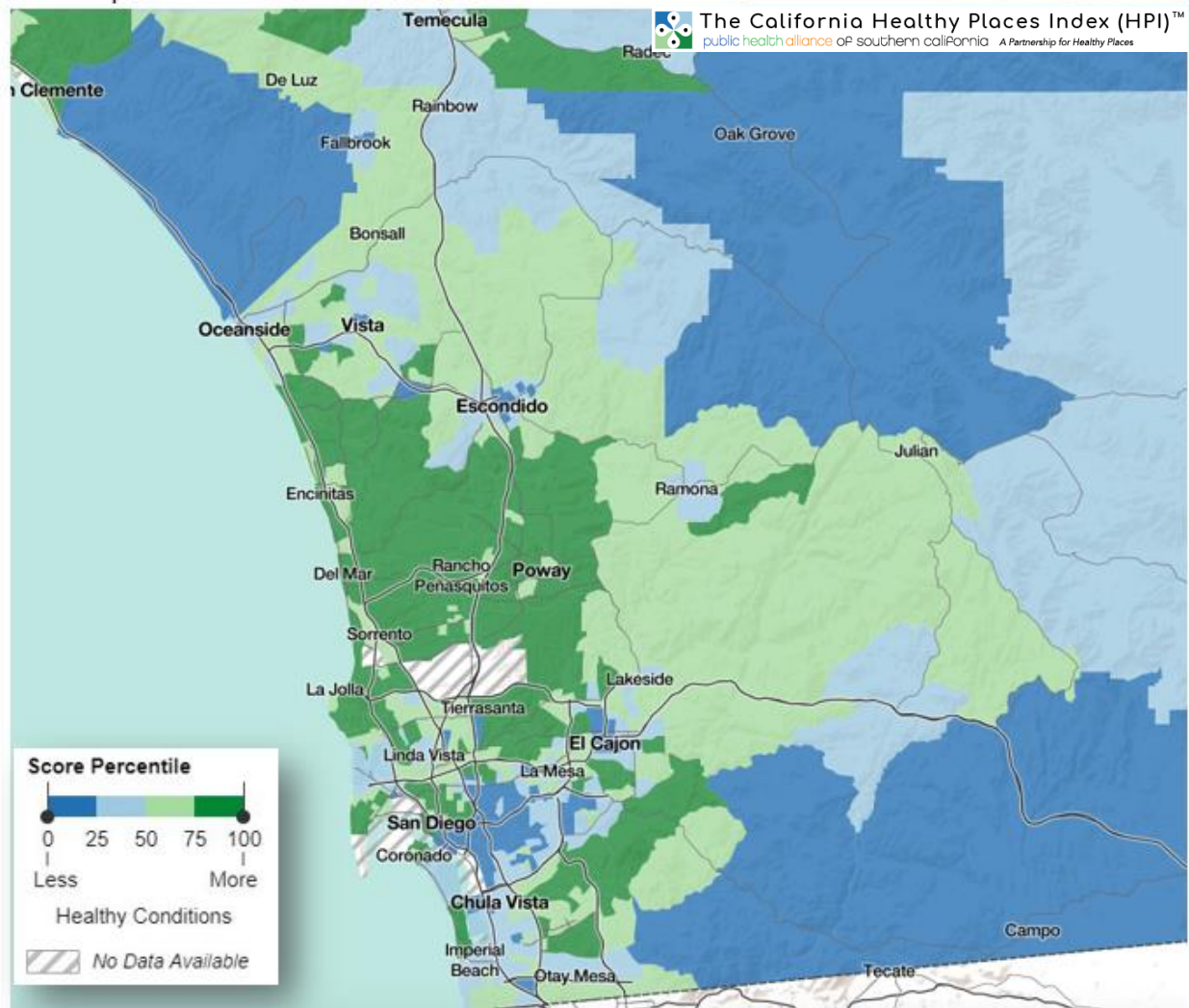
Source: The California Healthy Places Index, © 2018 Public Health Alliance of Southern California, http://healthyplacesindex.org/.

The HPI identifies the following severely under-resourced **cities** in the KFH-San Diego and Zion service area:

1. Campo
2. Boulevard
3. Jacumba
4. National City
5. Potrero

In addition, the HPI identifies the following severely under-resourced **census tracts within San Diego County cities**:

1. Bostonia
2. Chula Vista
3. El Cajon
4. Escondido
5. Imperial Beach
6. La Presa
7. La Mesa
8. Oceanside
9. San Diego
10. San Marcos
11. Vista

Furthermore, the availability of resources in the City of San Diego varies greatly from community to community. Examples of **communities** within the City of San Diego that are highly under-resourced include: City Heights, Tierrsanta, Otay Mesa, and San Ysidro. This is not a complete list; please see *http://healthyplacesindex.org/* for more details on communities and neighborhoods.

The opportunity to live a long and healthy life is powerfully influenced by a wide range of social factors including economics, education, transportation, built environment, and access to care[2]. In aggregate, residents living in the KFH-San Diego and Zion service area are in the 53rd percentile for health opportunity[3] among all California residents with approximately 607,127 people living in severely under-resourced census tracts[4]. In effect, this means that on average, 5 out of 10 Californians have a greater opportunity to live a long healthy life than residents living in this service area.

III. Who was involved in the assessment?
A. Identity of Hospitals and Other Partner Organizations that Collaborated on the Assessment

In addition to the KFH-San Diego and Zion specific CHNA process, KFH-San Diego and Zion participated in a collaborative CHNA process with the Hospital Association of San Diego and Imperial Counties (HASD&IC). HASD&IC's board of directors represents all member sectors and provides policy direction to ensure the interests of member hospitals and health systems are preserved and promoted. The CHNA Committee is comprised of representatives from all seven participating hospitals and health care systems and is responsible for the implementation and oversight of the 2019 CHNA. The CHNA Committee includes representative from the following:

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

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

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[2] Please read more about the strong scientific evidence for these relationships here.
[3] As described by the California Healthy Places Index.
[4] Calculations are estimates based on population-weighted HPI scores using the most recent US census data.
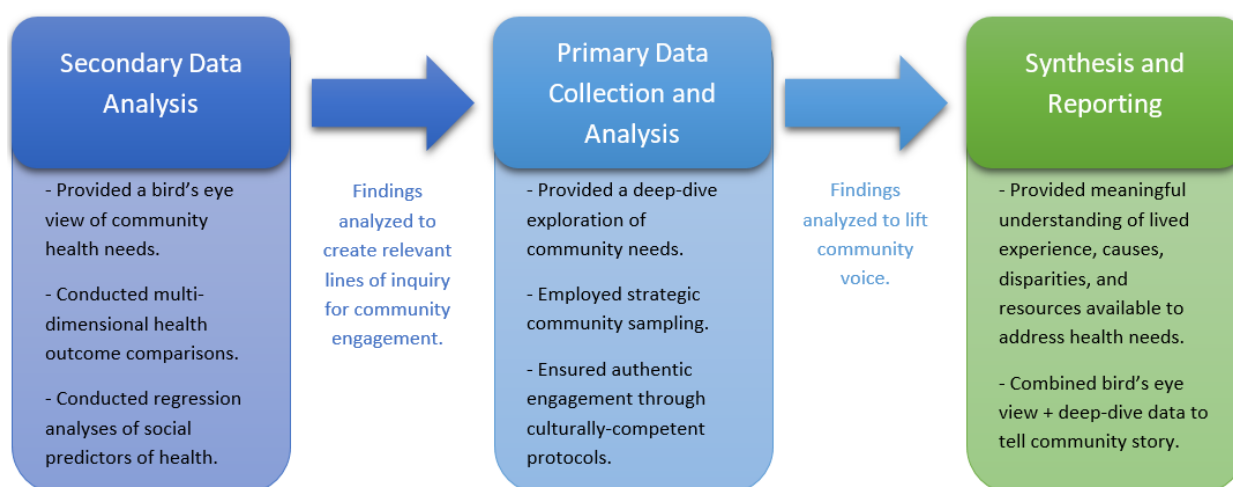
B. Identity and Qualifications of Consultants used to Conduct the Assessment

For the 2019 Community Health Needs Assessment process, KFH-San Diego and Zion contracted with the Institute for Public Health (IPH) at San Diego State University (SDSU). In the last 20 years, the IPH has partnered with over 70 local, state, national and international public and private community-based agencies and organizations representing more than 120 multiple-year contracts with a wide variety of needs and methodologies. The IPH has expertise in qualitative and quantitative community-based research methods. In addition, the IPH has extensive experience in conducting successful community engagement with diverse groups, including non-English speakers. The IPH has been working across cultures and with vulnerable populations for 25 years, including programs with Asian and Pacific Islander communities, African-American communities, East African communities, Latino communities, Native American communities, low-income communities, gay, bisexual, transgender individuals, people living with HIV/AIDS, people who are homeless, adolescents who are pregnant or parenting, and survivors of domestic violence and sexual assault, among others. IPH staff has special expertise in conducting culturally competent work and exploring sensitive issues. IPH community engagement efforts have included performing key informant interviews, leading focus groups, facilitating town hall meetings, and conducting patient and provider interviews.

IV. Process and Methods used to conduct the CHNA

KFH--San Diego and Zion conducted the CHNA in a mixed-methods sequential explanatory assessment intended to produce the most accurate, vivid, and meaningful story of community health possible. Secondary data was analyzed to provide a bird's eye view of the most pressing health issues across the service area and raise strategic lines of inquiry for community engagement. Findings from both the secondary and primary data collection processes were then combined to produce a robust story of community health needs (see Figure C below).

Figure C – Mixed-Method Assessment Approach to the CHNA

Secondary Data Analysis

- Provided a bird's eye view of community health needs.

- Conducted multi-dimensional health outcome comparisons.

- Conducted regression analyses of social predictors of health.

Findings analyzed to create relevant lines of inquiry for community engagement.

Primary Data Collection and Analysis

- Provided a deep-dive exploration of community needs.

- Employed strategic community sampling.

- Ensured authentic engagement through culturally-competent protocols.

Findings analyzed to lift community voice.

Synthesis and Reporting

- Provided meaningful understanding of lived experience, causes, disparities, and resources available to address health needs.

- Combined bird's eye view + deep-dive data to tell community story.

A. Secondary Data

i. Sources and dates of secondary data used in the assessment

KFH-San Diego and Zion used the Kaiser Permanente CHNA Data Platform and the Southern California Public Health Alliance Healthy Places Index to review approximately 200 indicators from publicly available data sources. For details on specific sources and dates of the data used, including any data in addition to sources mentioned above, please see Appendix A.

ii. Methodology for collection, interpretation, and analysis of secondary data

Findings from secondary data analysis provided a bird's-eye view of the community health needs and created relevant lines of inquiry for community engagement. The driving purposes behind these analyses were to:

1. Determine the geographic footprint of the most under-resourced communities in the KFH service area.

2. Identify the top social predictors of health (upstream factors) linked to community health outcomes in the KFH service area.

3. Provide an initial ranked list of health needs that could inform community engagement planning and the health need prioritization process for the KFH service area.

4. Provide descriptive information about the demographic profile of the KFH service area and support understanding of key CHNA findings.

First, the most under-resourced geographic communities were identified utilizing the Public Health Alliance of Southern California's Healthy Places Index (HPI) mapping function. The social predictors of health in this index include 25 indicators related to economic security, education, access to care, clean environment, housing, safety, transportation, and social support. (Please refer to Figure B to see this map[5]).

Second, social predictor of health indicators were used in multiple linear regression analyses to produce models identifying the social factors most predictive of negative health outcomes in KFH-San Diego and Zion service area census tracts. The results of these analyses found multiple social factors with statistically significant (p<.05) predictive relationships with important population health outcomes. (Please refer to Table 1 to see results).

Third, health outcome indicators were analyzed across multiple dimensions including: absolute prevalence, relative service area prevalence to the state average, reduction of life expectancy (calculated through empirical literature on disability-adjusted life years), impact disparities across racial and ethnic groups, and alignment with county rankings of top causes of mortality. (Please refer to Table 2 to see results).

Fourth, additional descriptive data were used to understand the demographics of the service area and provide context to findings from secondary and primary data analysis.

In sum, the use of secondary data in this CHNA process went beyond reporting publicly available descriptive data and generated new understandings of community health in the KFH

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[5] Maps from the California Healthy Places Index captured in this report are © 2018 Public Health Alliance of Southern California, https://phasocal.org/.

service area. Secondary data analyses and visualization tools (a) synthesized a wide variety of available health outcome data to provide a bird's-eye view of the KFH-San Diego and Zion service area needs and (b) provided a closer look at the impact of social factors that influence the opportunity of community residents in the service area to live long and healthy lives.

Kaiser Permanente Community Health staff and hospital leadership reviewed secondary data analysis findings to select health outcomes and social predictors of health for deeper exploration during the community engagement process. Health outcomes with high average scores across all dimensions (e.g. prevalence, severity, etc.) were selected as well as the social factors that were predictive of many negative health outcomes in the KFH service area. For further questions about the CHNA methodology and secondary data analyses, please contact CHNA-communications@kp.org.

In addition to the Kaiser Permanente analysis, hospital discharge and inpatient discharge data were exported and analyzed by the IPH from SpeedTrack's California Universal Patient Information Discovery, or CUPID application. SpeedTrack's application contains all hospital discharge data in California (from the California Office of Statewide Health Planning and Development (OSHPD)) for a 4 year time period (currently 2014-2017) in a format that allows for easy queries and comparisons of local and statewide hospital discharge data at the ZIP code level. Indicators representing health outcomes were selected for analysis. Selection criteria included relevance to the collaborative CHNA Committee health need categories.

The hospital discharge data were analyzed to determine the most common primary diagnosis categories upon discharge to assess which health conditions caused greatest hospital impact. These results were then analyzed for congruency with other data. Discharge data were then extracted for the CHNA-identified health conditions. Within each of these conditions, the data were stratified by age and race/ethnicity. Rates were calculated for each group and for each condition per 100,000 in the population. Overall three-year trends, from (2014-2016) were also calculated for each health condition as well as trends for each age group and race/ethnicity within each health condition.

Multiple linear regression models used nearly one dozen social indicators to predict each of the negative health outcomes below. An "X" indicates a statistically significant ($p<.05$) predictive relationship across all census tracts in the service area between a given social factor and a health outcome (e.g. "*service area census tracts reporting less health insurance also tended to report more heart attack ER visits, even when holding many other social factors constant*").

Table 1 – Social Factors Linked to Health Outcomes

	More Poor Mental Health Days	More Heart Attack ER Visits	Higher Asthma Prevalence	Higher Obesity Prevalence	Higher Diabetes Prevalence	Higher Stroke Prevalence	Higher Cancer Prevalence	Higher Percentage of Babies Born with Low Birth Weight	Higher Smoking Prevalence	More Pedestrian Injury	Number of Outcomes Affected
Lower Income	X	X	X	X	X	X	X		X	X	9
Less Health Insurance	X	X	X	X				X	X		6
Fewer Bachelor's Degrees	X	X		X	X			X	X		6
More Crowded Housing	X	X		X	X						4
More Racial Segregation			X			X		X		X	4
Less Access to Parks/Beaches	X		X		X				X		4
More Homeownership					X	X	X				3
Less Employment			X			X					2
More Bachelor's Degrees							X				1
Less Crowded Housing							X				1
Less Homeownership									X		1

How do service area health needs compare based on Kaiser Permanente Community Health values?

The following table ranks health needs based on several principle values: The prevalence of the health outcome compared to the California state average, the impact of the health outcome on length and quality of life, the disparity of disease prevalence across racial/ethnic groups, and the alignment with county rankings of top causes of mortality.[6]

Table 2 – Ranked Health Outcome Comparison Table

Health Outcome Category Name	Prevalence in Service Area	Difference From State Average	Reduction in Life Expectancy	Worst Performing Race/Ethnicity vs. Average	Listed in Partner County Top 5 Causes of Death
Mental Health*	11.3%	-0.83% (Better than CA)	61.3% Reduction	40% Worse than Average	No
HIV/AIDS/STD	0.5%	0.09% (Worse than CA)	58.2% Reduction	211% Worse than Average	No
Asthma	13.8%	-1% (Better than CA)	13.3% Reduction	156% Worse than Average	Yes
Cancer*	4.0%	0.67% (Worse than CA)	51% Reduction	11% Worse than Average	Yes
Stroke*	3.4%	-0.3% (Better than CA)	57% Reduction	30% Worse than Average	Yes
Obesity	24.1%	-5.5% (Better than CA)	37% Reduction	52% Worse than Average	No
Substance/Tobacco Use	5.2%	-1.79% (Better than CA)	69.7% Reduction	48% Worse than Average	No
Maternal/Infant Health	6.5%	-0.3% (Better than CA)	17.9% Reduction	28% Worse than Average	No
CVD*	5.2%	-1.75% (Better than CA)	30% Reduction	38% Worse than Average	Yes
Oral Health	10.5%	-0.8% (Better than CA)	2.8% Reduction	17% Worse than Average	No
Diabetes*	7.4%	-1% (Better than CA)	24.1% Reduction	6% Worse than Average	No
Violence/Injury	0.0%	-0.001% (Better than CA)	13.2% Reduction	7% Worse than Average	No

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[6]Indicators for prevalence and racial disparities are publicly available. Technical documentation and data dictionary for this table available upon request. Health need category names provided by Kaiser Permanente Program Office. Reduction in life expectancy estimated based on disability-adjusted life years research. "Mental Health" indicators refer to "poor mental health". "Violence/Injury" prevalence is rounded down but not technically zero. "Yes" indicates health outcome is listed in the top five causes of death for the county covering the majority of this service area. If asthma is listed as "Yes", then chronic lower respiratory disease was listed in the county rankings. Asterisks are outcomes measured by Kaiser Permanente's Program Office.

B. Community Input

Secondary data analyses produced high-level findings about community health needs. These findings were used to create targeted lines of inquiry intended to learn more about the story of community health by exploring the lived experience of community members, the causes of health needs, the racial or geographic disparities in health needs, and the community resources available to address health needs. These lines of inquiry were guided by the following strategic learning questions (see Appendix E for more details about how these questions were developed):

1. How do inequalities and disparities affect the community's health, particularly communities most impacted?
2. How does economic insecurity impact the daily lives of community members? What factors contribute to gaining economic security?
3. What is the lived experience of undocumented residents and what health disparities do they face? How are immigration laws impacting the community's willingness to access resources they may need (health care, food assistance, etc.)? How do you address those fears?
4. How have housing factors shaped the lack of opportunity and health inequity in San Diego?
5. What are the assets in the community that improve education attainment? How does the lack of education impact the community? Why are community members not graduating from high school and/or college?
6. What are the environmental factors that are affecting communities with high rates of asthma and obesity?
7. What is the lived experience of those living with food insecurity and the factors they face daily?

The community engagement plan and the community's answers to these questions (primary data) were organized and analyzed using the CHNA Community Engagement Framework (see Figure D below).

Figure D. Community Engagement Framework
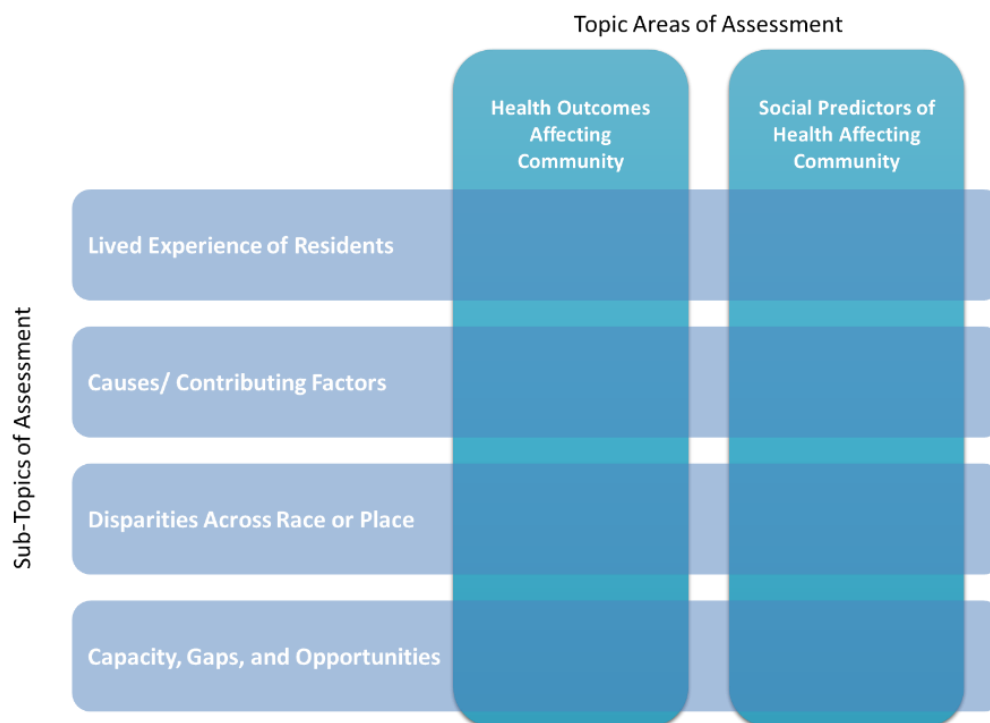
i. Description of who was consulted

Residents, community leaders, and government and public health department representatives were selected for the CHNA sample. Selection criteria across these groups included (a) those best able to respond in rich detail to the strategic learning questions, (b) those who had expertise in local health needs, (c) those who resided and/or provided services in an under-resourced or medically underserved community, and (d) those able to represent the health needs of a given racial or ethnic minority group. Given the large size of the KFH-San Diego and Zion service area, community engagement efforts set out to target those geographies most under-resourced and where health outcomes were the poorest (see Figure B for a map referencing the most underserved areas of KFH-San Diego and Zion). Once selected for engagement, participants were provided the opportunity to share their perspective on targeted health needs and raise any additional health needs outside the strategic lines of inquiry. For a complete list of individuals who provided input on this CHNA, see Appendix B.

ii. Methodology for collection and interpretation

In seeking information to help answer strategic lines of inquiry, primary data was collected through the following methods:

KFH-San Diego and Zion performed focus groups and expert interviews, while HASD&IC was responsible for additional focus groups and the design and distribution of the survey. The purpose of the expert interviews and focus groups was to identify health outcomes and health drivers, as well as assets and barriers to accessing resources for health issues across the

region. The purpose of the survey was to identify a ranked list of health outcomes and health drivers in order of importance within the community. A list of individuals and organizations who provided input via the community engagement process may be found in Appendix B.

Focus groups and interviews were conducted in a semi-structured manner. Expert facilitators from the IPH utilized the strategic lines of questioning developed by KFH-San Diego and Zion and approved by the CHNA Committee to generate discussion about specific community health needs as well as open ended questions for broader discussions. In addition, when appropriate, community discussions were allowed to flow in a conversational manner to ensure that community members had the freedom to discuss issues of importance to them. One focus group was conducted via a conference call; all others were conducted in-person. For in-person group events, food was provided for the participants. Participation incentives, in the form of gift cards, were also provided when the groups were comprised of community members and the contact person for that group suggested that incentives would be helpful and/or appropriate. Each engagement event began with a discussion about the purpose and process of the CHNA. The IPH facilitator then received consent to proceed and reassured participants that their participation was voluntary and their feedback would be anonymous. Interpretative services were arranged for any group that requested them.

For each focus group and key informant interview, an additional IPH staff member took notes and then summarized them. These summaries were then entered into the qualitative research software (NVivo) as stand-alone sets of data. When all groups had been conducted, the team used the software tools to analyze the data. All health needs and drivers that were mentioned were tabulated. The IPH then made a complete list of all of the conditions mentioned in focus groups or interviews, counted how many groups or informants listed those conditions, and noted how many times they had been prioritized by a focus group. This qualitative data analysis was designed to identify emergent themes in answer to the strategic lines of questioning as well as open-ended questions about health needs more broadly.

The CHNA survey was distributed to a broad range of community-based organizations via email. The email explained the purpose of the survey and instructions for completing the survey. These organizations were also asked to forward the survey on to the community members they serve if they felt it was appropriate. Survey questions included queries regarding the point of view from which the respondent was answering the survey (e.g. a community resident versus a local government agency) and where the respondent or his/her clients live in the County. Respondents were then asked to rank given lists of health conditions and social determinants for impact on the community. They were also asked to comment on whether these conditions had improved, stayed the same, or gotten worse over the past three years. The surveys were designed in and distributed via an online survey software (Qualtrics). This allowed for the automatic capture of all survey data, which was subsequently imported into SAS for analysis. Mean rankings for each health condition and social determinant were calculated, as were the percentage of respondents who thought each condition had improved, stayed the same, or gotten worse.

C. Written Comments

KP provided the public an opportunity to submit written comments on the facility's previous CHNA Report through CHNA-communications@kp.org. This email will continue to allow for written community input on the facility's most recently conducted CHNA Report.

As of the time of this CHNA report development, KFH-San Diego and Zion received one written comments related to the previous CHNA Report. These comments referred to questions about the 2016 Implementation Strategy plan and were addressed by Community Benefit Manager Lindsey Wright.

D. Data Limitations and Information Gaps

As with any community needs assessment process, the data available for use is limited. In the KP CHNA data platform, for example, some data were only available at a county level, making an accurate translation to neighborhood-level health needs challenging. In the Healthy Places Index platform, census tracts with very low populations were represented as missing data (to reduce unreliability of measurement). This caused under-sampling of rural areas. In both platforms, disaggregated data around age, ethnicity, race, and gender were not available for many indicators which limited the ability to examine disparities of health within the community. Additionally, data in both platforms were not often collected on a yearly basis and therefore may not represent 2018 values.

The primary data also have limitations. For the community engagement process, every effort was made to target those populations who experience the greatest health inequities. Community participation from these groups was strong; however, participants included only those community members who were interested and able to engage in the process. The first-person voices of certain groups, therefore, were underrepresented, such as those who suffer from severe physical or cognitive impairments and those without access to transportation to the community engagement events.

CHNA surveys were distributed and collected electronically. Without access to community members' email addresses, surveys were distributed through those community-based organizations who were willing to share the survey with their clients. As a result, community member response to the survey was low.

V. Identification and Prioritization of the Community's Health Needs

A. Identifying Community Health Needs

i. Definition of "health need"

For the purposes of the CHNA, Kaiser Permanente defines a "health need" as a health outcome and/or the related conditions that contribute to a defined health need. Health needs are identified by the comprehensive identification, interpretation, and analysis of a robust set of primary and secondary data.

ii. Criteria and analytical methods used to identify the community health needs

The secondary data analyses performed by Kaiser Permanente Regional analysts, coupled with the County of San Diego leading cause of death 2016 data, were utilized to generate a list of health conditions affecting the community. In addition, the IPH extensively analyzed hospital emergency department and in-patient discharge data to determine which health conditions were

most impactful on hospitals. The resulting list of 13 community health needs, therefore, reflects the most predominant health needs of both community members and health care systems.

The Kaiser Permanente CHNA data platform included data on more than 20 potential health predictors of health. Using this list as a catalyst, the CHNA Committee met and grouped the drivers into larger categories based on the committee members' expertise and experience. A draft list of these categories was compiled and distributed to the CHNA Committee for approval. With the committee's unanimous approval, 15 social predictors of health were identified as the principal influencers of health in San Diego County.

B. Process and Criteria used for Prioritization of Health Needs

KFH-San Diego and Zion created a set of criteria to utilize in the prioritization process. Each health need was analyzed in terms of the severity of the need, such as its potential to cause death or disability, and how the disease in San Diego County compared to relevant benchmark for the state and the nation. The magnitude of the need, in terms of the number of people affected, was also analyzed. In addition, disparities or inequities related to the health need were considered, including whether subgroups (based on geography, languages, ethnicity, culture, citizenship status, economic status, sexual orientation, age, and gender, among others) in San Diego County are disproportionately affected by the health need. Trends in improvement or worsening of the health need were also examined. Finally, community input from the community engagement process informed the prioritization as did the existence of resources, expertise, and partnerships to effectively address the health need.

In order to prioritize the identified health needs using these criteria, KFH-San Diego and Zion analyzed five sets of data: (1) the initial secondary data analyses; (2) County of San Diego leading causes of death 2016 data; (3) community engagement data, including findings from focus groups and interviews; (4) 2019 CHNA survey data; and (5) hospital discharge trend data drawn from California's Office of Statewide Health Planning and Development (OSHPD) via SpeedTrack. A list was compiled of all conditions that were identified as one of the top ten priorities across these sources. For OSHPD data, those conditions that had shown increases in emergency department or inpatient discharges or for which large racial/ethnic disparities were seen were included as priorities. When a condition was identified by more than one source, it was moved to a "potential priority list" with the number of data sources identifying it as a priority noted. Those conditions identified by the most number of sources that also met the prioritization criteria (listed above) were chosen as a top priority. To prioritize social predictors of health, a similar process was used; however, for this prioritization, only three data sources were utilized: (1) the secondary data analyses performed by Kaiser Permanente Regional analysts; (2) the 2019 CHNA survey data; and (3) the community engagement data.

C. Prioritized Description of all the Community Needs Identified through the CHNA

KFH-San Diego and Zion identified: access to health care; diabetes; economic security; mental health and wellness; and substance and opioid misuse as the priority health needs within the service area. In addition to the five priority needs, KFH-San Diego and Zion identified Cardiovascular Disease, which is a leading cause of mortality, as a secondary need due to its continued relevance within San Diego County. In addition, health conditions that predominantly affect seniors, such as Alzheimer's, Parkinson's, dementia, falls, and limited mobility were

identified as important by the Community Health Needs Assessment and were, therefore, chosen as another secondary need. San Diego County data shows, for example, that hospital discharges have increased from 2014-2016 for both Alzheimer's and dementia, and Alzheimer's and Parkinson's disease were within the top 12 leading causes of death in San Diego County in 2016. A short description of the impact of the priority health needs on KFH-San Diego and Zion residents is provided below. For more details on each priority need, please see Appendix C.

Access to health care (including primary, specialty, and mental health care). Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of life for everyone. Limited access to health care can impact people's ability to reach their full potential, negatively affecting their quality of life. In San Diego County, individuals who belong to some racial/ethnic minority groups have more limited access to health care. For example, those who identify as Hispanic, Native American/Alaskan Native and "other" are disproportionately without health insurance (20.8%, 23.6%, and 24.8% respectively), compared to the overall rate of 12.2%. In addition, Black individuals experience more "preventable hospital events" (44.8 per 1,000) than the general population (31.5 per 1,000) suggesting that these individuals may have more difficulty accessing primary care resources. Medicare beneficiaries, a group made up primarily of people 65 years old and older, are also less likely to receive regular care from a primary care physician (PCP). Of this group, only 67.4% have seen a PCP in the last year, compared to the 71.8% of the general population. Access to care was a frequent theme of conversations during the community engagement process. Participants detailed barriers to care for low income individuals, for people living in certain geographic regions, for people from minority racial/ethnic backgrounds, for immigrants, for sexual minorities, and for homeless individuals. Access to behavioral health services – for mental health services and for substance use disorders was described as particularly problematic. .

Diabetes. Diabetes is an important health need because of its prevalence and its potential to have a devastating impact on morbidity and mortality. Diabetes is also largely preventable; rates of diabetes are, therefore, potentially amenable to health promotion efforts. Diabetes is the seventh leading cause of death in San Diego County, and emergency department discharges for diabetes increased by 7% from 2014-2016. In 2016, the rates were highest for those 65 and older and for Black individuals (rate of 309, 432, per 100,000, respectively) compared to the overall rate of 158 per 100,000 population. During focus groups, health care personnel working in clinics and hospital settings discussed diabetes and its management as one of the "biggest health issues" they face; they also indicated that the public seems unaware about how to prevent the onset of diabetes. Community residents also identified diabetes management as a significant health problem for San Diego County. In particular, the cost of insulin was cited as a significant barrier to care for diabetes management, and because insulin needs to be refrigerated, diabetes management was noted as especially challenging for those without a refrigerator, such as those who are homeless.

Economic security. Research has increasingly shown that social and economic conditions are among the strongest determinants of population health and health disparities. In San Diego County, census tracts reporting lower income also report more poor mental health days, more visits to emergency departments for heart attacks, and higher rates of asthma, obesity,

diabetes, stroke, cancer, low birth weight babies, smoking, and pedestrian injuries. Many San Diego County residents are economically insecure. In the KFH-San Diego and Zion service area, 18% of children live in poverty ($25,100 for a family of 4). For children of color, the situation is far worse: 41.1% of multiracial, 40.1% of Hispanic, 32.7% of Black, 32.3% of Native American/Alaska Natives, and 39.3% of children who identify as "other" races live in poverty. In addition, a third of working-age families can not cover their basic expenses, 13.3% of residents are food insecure at some point during the year, and 43.9% of San Diegans live in cost burdened households – spending more than 30% of their income on housing alone. Across the community engagement events, residents described pervasive economic insecurity in San Diego County that impacts "every aspect" of people's daily lives. They emphasized the link between the chronic stress of economic insecurity and mental health and detailed the impact of economic insecurity on physical well-being and on a community's sense of hope.

Mental health and wellness. Mental health issues affect nearly 1 in 5 people, and when left untreated, are a leading cause of disability, are associated with chronic disease, and may lead to premature mortality. In San Diego County, 12.4 people per every 100,000 die from suicide annually, and approximately 10% of all adults seriously consider committing suicide. While the rate of suicide decreased slightly (1.3%) from 2014-2016, the rates of suicide for people who identify as Asian/Pacific Islander, Black, and "other," increased in those same years (13.3%, 47.2%, 93.0%). In addition, more people are being discharged from emergency departments for anxiety than in the past – rates increased by 4% from 2014-2016, with an 84% increase in discharge rates for the youngest San Diegans -- those 0-10 years old. In the community engagement process, residents described the desperation of people who need but cannot get quality, timely mental health services; they emphasized that while accessing services is hard for everyone, for people who may be at the highest risk for trauma related mental illness – like veterans, refugees, and the LGBTQ community, and for those who are uninsured, access to this care seems nearly impossible.

Substance and opioid misuse. Substance use, particularly opioid misuse, is a health crisis that has reached epidemic proportions both nationally and locally. In San Diego County, the rate of discharge from emergency departments for chronic substance abuse increased by 559% from 2014-2016; rates for those 65 years and older increased the most – by 714%. The rate of discharge for opioid misuse for this age group was even more startling – it rose by 1,734% over this two year period. Rates of discharge from emergency departments for acute substance abuse also rose. Rates increased for people of all racial and ethnic backgrounds; however, the most substantial increase (177%) was for Blacks. Heavy alcohol consumption is also problematic in San Diego County. Nearly 20% of adults ages 18 and older self-report excessive alcohol use. Participants in the community engagement process discussed the link between mental health and substance misuse, arguing that the failure to provide preventive and acute mental health services often leads to self-medicating with drugs and alcohol. They also report an insufficient supply of substance use disorder outpatient and in-patient drug treatment programs as a critical need in San Diego County.

D. Community Resources Potentially Available to Respond to the Identified Health Needs

The service area for KFH-San Diego and Zion contains community-based organizations, government departments and agencies, hospital and clinic partners, and other community members and organizations engaged in addressing many of the health needs identified by this assessment. In addition, 2-1-1 San Diego is an important community resource and information hub. Through its 24/7 phone service and online database, it helps connect individuals with community, health, and disaster services. In recognition that available programs and services are continuously changing, we encourage the community to access the most available data through 2-1-1 San Diego. For more specific information about the programs within each category, please contact 2-1-1 San Diego or visit their website (http://www.211sandiego.org/).

Additional key resources available to respond to the identified health needs of the community are listed in Appendix D Community Resources.

VI. KFH-San Diego and Zion's 2016 Implementation Strategy Evaluation of Impact

A. Purpose of 2016 Implementation Strategy Evaluation of Impact

KFH-San Diego and Zion's 2016 Implementation Strategy Report was developed to identify activities to address health needs identified in the 2016 CHNA. This section of the CHNA Report describes and assesses the impact of these activities. For more information on KFH-San Diego and Zion's Implementation Strategy Report, including the health needs identified in the facility's 2016 service area, the health needs the facility chose to address, and the process and criteria used for developing Implementation Strategies, please visit https://about.kaiserpermanente.org/content/dam/internet/kp/comms/import/uploads/2013/10/IS-Report-San-Diego-Final-Submission-Rev-11.30.17.pdf. For reference, the list below includes the 2016 CHNA health needs that were prioritized to be addressed by KFH-San Diego and Zion in the 2016 Implementation Strategy Report.

1. Access to Care
2. CVD/Stroke
3. Mental and Behavioral Health
4. Obesity/HEAL/Diabetes

KFH-San Diego and Zion are monitoring and evaluating progress to date on its 2016 Implementation Strategies for the purpose of tracking the implementation and documenting the impact of those strategies in addressing selected CHNA health needs. Tracking metrics for each prioritized health need include the number of grants made, the number of dollars spent, the number of people reached/served, collaborations and partnerships, and KFH in-kind resources. In addition, KFH-San Diego and Zion tracks outcomes, including behavior and health outcomes, as appropriate and where available.

The impacts detailed below are part of a comprehensive measurement strategy for Community Health. KP's measurement framework provides a way to 1) represent our collective work, 2) monitor the health status of our communities and track the impact of our work, and 3) facilitate shared accountability. We seek to empirically understand two questions 1) how healthy are Kaiser Permanente communities, and 2) how does Kaiser Permanente contribute to community health? The Community Health Needs Assessment can help inform our comprehensive

community health strategy and can help highlight areas where a particular focus is needed and support discussions about strategies aimed at addressing those health needs.

As of the documentation of this CHNA Report in March 2019, KFH-San Diego and Zion had evaluation of impact information on activities from 2017 and 2018. These data help us monitor progress toward improving the health of the communities we serve. While not reflected in this report, KFH-San Diego and Zion will continue to monitor impact for strategies implemented in 2019.

B. 2016 Implementation Strategy Evaluation of Impact Overview

In the 2016 IS process, all KFH hospital facilities planned for and drew on a broad array of resources and strategies to improve the health of our communities and vulnerable populations, such as grantmaking, in-kind resources, collaborations and partnerships, as well as several internal KFH programs including, charitable health coverage programs, future health professional training programs, and research. Based on years 2017 and 2018, an overall summary of these strategies is below, followed by tables highlighting a subset of activities used to address each prioritized health need.

KFH programs: From 2017-2018, KFH supported several health care and coverage, workforce training, and research programs to increase access to appropriate and effective health care services and address a wide range of specific community health needs, particularly impacting vulnerable populations. These programs included:

- Medicaid: Medicaid is a federal and state health coverage program for families and individuals with low incomes and limited financial resources. KFH provided services for Medicaid beneficiaries, both members and non-members.

- Medical Financial Assistance: The Medical Financial Assistance (MFA) program provides financial assistance for emergency and medically necessary services, medications, and supplies to patients with a demonstrated financial need. Eligibility is based on prescribed levels of income and expenses.

- Charitable Health Coverage: Charitable Health Coverage (CHC) programs provide health care coverage to low-income individuals and families who have no access to public or private health coverage programs.

- Workforce Training: Supporting a well-trained, culturally competent, and diverse health care workforce helps ensure access to high-quality care. This activity is also essential to making progress in the reduction of health care disparities that persist in most of our communities.

- Research: Deploying a wide range of research methods contributes to building general knowledge for improving health and health care services, including clinical research, health care services research, and epidemiological and translational studies on health care that are generalizable and broadly shared. Conducting high-quality health research and disseminating its findings increases awareness of the changing health needs of diverse communities, addresses health disparities, and improves effective health care delivery and health outcomes

Grantmaking: For 70 years, Kaiser Permanente has shown its commitment to improving community health through a variety of grants for charitable and community-based organizations. Successful grant applicants fit within funding priorities with work that examines social determinants of health and/or addresses the elimination of health disparities and inequities. From 2017-2018, Kaiser Permanente paid 104 grants amounting to a total of $4,624,628 in service of KFH-San Diego and Zion 2016 health needs. Additionally, KFH-San Diego and Zion has funded significant contributions to the California Community Foundation in the interest of funding effective long-term, strategic community benefit initiatives within KFH-San Diego and Zion. During 2017-2018, a portion of money managed by this foundation was used to pay 24 grants totaling $3,959,889 in service of 2016 health needs.

In-kind resources: In addition to our significant community health investments, Kaiser Permanente is aware of the significant impact that our organization has on the economic vitality of our communities as a consequence of our business practices including hiring, purchasing, building or improving facilities and environmental stewardship. We will continue to explore opportunities to align our hiring practices, our purchasing, our building design and services and our environmental stewardship efforts with the goal of improving the conditions that contribute to health in our communities. From 2017-2018, KFH-San Diego and Zion leveraged significant organizational assets in service of 2016 Implementation Strategies and health needs. See table below for illustrative examples.

Collaborations and partnerships: Kaiser Permanente has a long legacy of sharing its most valuable resources: its knowledge and talented professionals. By working together with partners (including nonprofit organizations, government entities, and academic institutions), these collaborations and partnerships can make a difference in promoting thriving communities that produce healthier, happier, more productive people. From 2017-2018, KFH-San Diego and Zion engaged in several partnerships and collaborations in service of 2016 Implementation Strategies and health needs. See table below for illustrative examples.

C. 2016 Implementation Strategy Evaluation of Impact by Health Need

KFH-San Diego and Zion Priority Health Needs

Need	Summary of impact	Examples of most impactful efforts
Access to Care	*During 2017 and 2018, Kaiser Permanente paid 13 grants, totaling $1,084,667 addressing the priority health need in the KFH-San Diego and Zion service area. In addition, a portion of money managed by a donor advised fund at California Community Foundation was used to pay 5 grants, totaling $915,000 that address this need.*	**Providing Affordable Healthcare** Over two years (2017-2018), KFH-San Diego and Zion provided $51,879,621 in medical care services to 102,574 Medi-Cal recipients (both health plan members and non-members) and $20,082,314 in medical financial assistance (MFA) for 24,336 beneficiaries. **Building Primary Care Capacity~** The California Primary Care Association (CPCA) provides education, training, and advocacy to their member community health centers to best serve their low-income, underserved, and diverse patients. In 2018, Kaiser Permanente paid $126,666 to CPCA to: • Hold statewide convenings and conferences and topic-specific peer networks to support over 1,200 California community health centers. • Provide 90 in-person and web-based trainings to over 4,400 attendees and 2,890 individual instances of technical

		assistance.
		Preserving and Expanding California Coverage Gains~ Insure the Uninsured Project (ITUP) works to preserve and expand access to health care and coverage in California and to reduce access barriers for uninsured and underinsured populations. Over two years (2017-2018), Kaiser Permanente paid $150,000 to ITUP to: • Conduct and disseminate health policy research. • Convene 13 regional statewide work groups. • Provide technical assistance to safety net providers and other stakeholders navigating health reform challenges. • Serve as a bridge between health policy and the health care sector to reach 19 million Californians.
		Supporting Hepatitis A Health Emergency On September 1, 2017, the County of San Diego declared a local health emergency. Approximately 584 cases of Hepatitis A were diagnosed between November 2016 and December 2017. This health concern included 400 hospitalizations and 20 deaths. The populations most impacted were homeless and/or illicit drug users who had poor access to health insurance. In response, Kaiser Permanente San Diego partnered with the County Public Health Team and the City of San Diego to form a Community Health Task Force. This task force recruited 30 employees and physicians to provide free vaccinations to homeless individuals on the street or in shelters to help eradicate the outbreak and reduce illness. Additionally, the task force also provided free vaccinations to law enforcement and first responders who interacted with the high-risk population. Results: • The County of San Diego ended public health emergency in Q1 2018 • New best practices established for coordination of services during a public health crisis to prevent loss of life and provide on the ground critical community support. • Kaiser Permanente was quickly able to partner with the County for a new public health outbreak of Meningitis B in the college community in Q4 2018 to deliver vaccinations to impacted at-risk populations.
CVD/Stroke	*During 2017 and 2018, Kaiser Permanente paid 12 grants, totaling $319,000 addressing the priority health need in the KFH-San Diego and Zion service area.*	**Addressing Stroke Treatment Methodologies and Policies** San Diego Stroke Consortium hosts a best practice-sharing forum on stroke treatment methodologies and policies has been very effective in building community engagement and collaboration. Strike Out Stoke consists of various stroke care leaders like Scripps Health, Sharp HealthCare, and Palomar Health. KFH-SD San Diego Quality Improvement and Patient Safety Division partners with the County of San Diego and stroke receiving centers. Over two years (2017-2018), Kaiser Permanente: • Circulated educational resources about the signs, symptoms, and prevention of stroke, and how to recognize those recovering from stroke at the Strike Out Stoke event. • Hosted an educational event on StrokeNet and other related topics and was attended by a total of 80 stroke care leaders.
		Bridging the Community to Clinic Gaps through the Mobile

		Health Vehicle

Health Vehicle
Over two years (2017-2018), in partnership with 40 local healthcare and social service providers, Kaiser Permanente helped bridge the community to clinic gaps that exist in Southwest San Diego and to increase health equity at the monthly Big Lots Community Outreach Event. The Mobile Health Vehicle also participated in the County of San Diego's "Love Your Heart" event which is an annual county blood pressure screening event in February of 2018. Through these partnerships, Kaiser Permanente:
- Provided 884 blood pressure screenings, 440 blood sugars screenings, 231 health education sessions, 274 mammograms, and 127 HIV tests over two years (2017 – 2018), at the Big Lots Community Outreach event.
- Provided 756 blood pressure screenings at five different County of San Diego locations in 2018 for "Love Your Heart."

Focusing on Social Determinants of Health and Data
Be There San Diego (BTSD) has focused on the social determinants of health (SDOH) with their University of Best Practices (UBP) and Data for Quality Group (DQG) work. The UBP is a monthly learning collaborative environment for clinical leaders from the San Diego medical groups, including FQHCs, health plans and other interested stakeholders. The DQG is a smaller group of medical leaders who are committed to sharing data and making targeted improvements. They have added a SDOH focus to both pieces of work during 2017 and 2018. In 2017 they focused on the development of organizations recommendations for food security, physical activity and access to nutritious foods within San Diego's healthcare organizations, including community clinics. In 2018 they have focused adding race/ethnicity data to the DQG data collection and reporting efforts. Over two years (2017-2018), Kaiser Permanente paid $150,000 to Be There San Diego to:
- Complete and disseminate organizations' recommendations regarding food security, physical activity and nutrition working with the BTSD medical leadership.
- Add physical activity as a keynote to the annual Heart Attack and Stroke Free Zone Summit.
- Add race data from 5 of 12 medical groups participating in DQG.
- Add reporting by race during the December 2018 DQG.
- Create a new acceptance amongst the medical leaders of reporting on race/ethnicity.

Mental and Behavioral Health

During 2017 and 2018, Kaiser Permanente paid 45 grants, totaling $1,568,000 addressing the priority health need in the KFH-San Diego and Zion service area. In addition, a portion of money managed by a donor advised fund at California Community Foundation was used to pay 1 grant, totaling $40,000 that addresses this need.

Strengthening Mental Health Policies and Practices in Schools~
Children Now educates policymakers, school district leaders, and other key stakeholders about best practices and policy solutions to address suspension and expulsion policies that disproportionately impact students of color, improve school climate, and increase students' access to mental health services. Over two years (2017-2018), Kaiser Permanente paid $150,000 to Children Now to:
- Inform over 200 key legislators and stakeholders.
- Support the California Department of Education in the development of the Whole Child Resource Map.
- Lead committees for both the State School Attendance Review Board and the Superintendent's Mental Health Policy Workgroup.

Delivering Mental Health Therapy to Refugee Students*

		Cajon Valley Union School District, in partnership with Survivors of Torture, improves access and connection to mental health care in the school setting. In 2018, Kaiser Permanente paid $40,000 to the school district to: • Expand mental health therapy for 100 refugee students fleeing war and persecution.
		Providing Substance Abuse Recovery Support The Vista Hill Foundation operates the ParentCare Family Recovery Center which offers comprehensive treatment and support components to address the wide range of issues that afflict women struggling with substance use disorder. ParentCare is unique in that it operates on a bio-psycho-social model, thereby accepting dually diagnosed patients. Most women lack health insurance, and their only option is a long wait list for a community clinic (meantime, often failing in their drug/alcohol treatment due to their untreated mental health symptoms.) Over two years (2017-2018), Kaiser Permanente paid $36,000 to Vista Hill Foundation to: • Serve a total of 352 women through group counseling for dual diagnosis issues and provided psychiatric care to 120 women. • Offer 205 yoga/mindfulness groups. • Attain an 85% completion rate of being employed or enrolled in school. • In 2017, at completion, 85% reported being employed or enrolled in school. 97% of clients who finished the program now report that their quality of life is excellent or good and 90% report owning or renting their own residence. In 2018, at completion 80% report being employed or enrolled in school. 91% of clients who finished the program last year now report that their quality of life is excellent or good and 85% report owning or renting their own residence.
		Fostering Healthier Choices Through School-Based Performances The Kaiser Permanente Educational Theatre program is designed to inspire children, teens and adults to make healthier choices by providing school-based performances addressing health literacy, conflict resolution, healthy eating and active living, adolescent bullying awareness and STD prevention. In 2017 and 2018 Educational Theatre: • Provided 433 performance events in 141 schools • Reached 57,385 youth and adults in the community
Obesity/ HEAL/ Diabetes	*During 2017 and 2018, Kaiser Permanente paid 34 grants, totaling $1,652,961 addressing the priority health need in the KFH-San Diego and Zion service area. In addition, a portion of money managed by a donor advised fund at California Community Foundation was used to pay 18 grants, totaling $3,004,889 that address this need.*	**Advocating for Maternal, Infant, and Child Health**~ The California WIC Association (CWA) supports efforts to increase local WIC agencies' capacity, increase state and federal decision makers' understanding of WIC services, and increase the capacity of community health centers to build a breastfeeding continuum of care in low-income communities. Over two years (2017-2018), Kaiser Permanente paid $100,000 to CWA to: • Pilot two video conferencing projects increasing awareness and consideration within the CA WIC community. • Collaborate with health centers to share WIC staff for nutrition and breastfeeding counseling (Watts Health Care and clinics in San Diego). • Work to strengthen ties with CPCA and present at CPCA's annual conference. • Visit all CA legislators with 44 appointments and drop-in visits.

- Provide extensive information to legislators on nutrition and breastfeeding counseling, food benefits, local economic impacts to grocers, health outcomes, access to farmers markets, and updates on immigration threats.
- Participated in Capitol WIC Education Day in Sacramento with 50 attendees from 30 WIC agencies from all over the state.

Fighting Food Insecurity~
California Association of Food Banks' (CAFB) Farm to Family program's goal is to improve health food access by providing fresh produce to food banks, CalFresh outreach and enrollment, advocacy to support anti-hunger policies, and technical assistance to members. In 2018, Kaiser Permanente paid $95,000 to CAFB to:
- Distribute 250,000 pounds of subsidized fresh fruits and vegetables to 11 member food banks.
- Maintain the State Emergency Food Assistance Program to provide food and funding of emergency food to food banks.

Supporting Healthy Eating and Active Living through Systems Change*
Community Health Improvement Partners' (CHIP) HEAL Zone site makes policy, system, and environmental changes to increase healthy eating and physical activity opportunities in the City of Lemon Grove. In 2018, Kaiser Permanente paid $333,333 to CHIP to:
- Provide a weekly farmers market with 12 vendors to 100 residents
- Influence the City of Lemon Grove to pass policies in parks to ban the use of alcohol and marijuana, and to install 12 bilingual signs.
- Repaint bathrooms, fix lights and water fountains, and clean up trash at both Lemon Grove and Berry Street Park.
- Sign a 2-year lease with the City of Lemon Grove to operate a large community garden.

Increasing Access to Nutritious Foods Through A Community Garden
Kaiser Permanente donated 5-acres of vacant land in El Cajon to create New Roots Fresh Farm Community Garden, a garden which is intended to help families become healthy, increase physically activity, and build community through gardening. The gardeners provide one another with nutrition education and work together to help engage the community. There are 48 active growing spaces for refugees and underserved populations. Additionally, there are 88 raised beds split between 9 market gardeners selling at various farmers' markets throughout San Diego County. Over two years (2017-2018), the create New Roots Fresh Farm Community Garden:
- Harvested over 82,850 pounds of vegetables
- Produced approximately $111,7000 of produce

Fighting Against Hunger
Hunger Free San Diego is a research/planning initiative. Primary goals: maximize utilization of federal nutrition programs bringing hundreds of millions of new dollars to our fight against hunger; improve coordination/capacity of local hunger relief; and integrate food assistance/referral into everyday environments (clinics, housing, churches, etc.). Over two years (2017-2018), Kaiser Permanente paid $150,000 to the San Diego Hunger Coalition to:

		- Provide an annual brief with numbers/demographics of food insecure population - Create a resource mapping of all food assistance in SD County by program type (91% is from federal nutrition programs) - Calculate meal gap - Create a Hunger Free Kids report with utilization of child nutrition programs in 25 highest need districts - Provide successful dual-enrollment/Medi-Cal In-Reach pilot with HHSA: 21% applied for CalFresh (statewide average is <10%); will scale up model for SSI recipients newly eligible for CF

VII. Appendices

- A. Secondary Data Sources and Dates
  - i. KP CHNA Data Platform secondary data sources
  - ii. Additional secondary data sources
- B. Community Input Tracking Form
- C. Health Need Profiles
- D. Community Resources
- E. Strategic Lines of Inquiry for Community Engagement

Appendix A. Secondary Data Sources and Dates

i. Secondary sources from the KP CHNA Data Platform

	Source	Dates
1.	American Community Survey	2012-2016
2.	American Housing Survey	2011-2013
3.	Area Health Resource File	2006-2016
4.	Behavioral Risk Factor Surveillance System	2006-2015
5.	Bureau of Labor Statistics	2016
6.	California Department of Education	2014-2017
7.	California EpiCenter	2013-2014
8.	California Health Interview Survey	2014-2016
9.	Center for Applied Research and Environmental Systems	2012-2015
10.	Centers for Medicare and Medicaid Services	2015
11.	Climate Impact Lab	2016
12.	County Business Patterns	2015
13.	County Health Rankings	2012-2014
14.	Dartmouth Atlas of Health Care	2012-2014
15.	Decennial Census	2010
16.	EPA National Air Toxics Assessment	2011
17.	EPA Smart Location Database	2011-2013
18.	Fatality Analysis Reporting System	2011-2015
19.	FBI Uniform Crime Reports	2012-14
20.	FCC Fixed Broadband Deployment Data	2016
21.	Feeding America	2014
22.	FITNESSGRAM® Physical Fitness Testing	2016-2017
23.	Food Environment Atlas (USDA) & Map the Meal Gap (Feeding America)	2014
24.	Health Resources and Services Administration	2016
25.	Institute for Health Metrics and Evaluation	2014
26.	Interactive Atlas of Heart Disease and Stroke	2012-2014
27.	Mapping Medicare Disparities Tool	2015
28.	National Center for Chronic Disease Prevention and Health Promotion	2013
29.	National Center for Education Statistics-Common Core of Data	2015-2016
30.	National Center for Education Statistics-EDFacts	2014-2015
31.	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2013-2014
32.	National Environmental Public Health Tracking Network	2014
33.	National Flood Hazard Layer	2011
34.	National Land Cover Database 2011	2011
35.	National Survey of Children's Health	2016
36.	National Vital Statistics System	2004-2015
37.	Nielsen Demographic Data (PopFacts)	2014
38.	North America Land Data Assimilation System	2006-2013
39.	Opportunity Nation	2017
40.	Safe Drinking Water Information System	2015
41.	State Cancer Profiles	2010-2014
42.	US Drought Monitor	2012-2014
43.	USDA - Food Access Research Atlas	2014

ii. Additional secondary data sources

Source	Dates
1. California Department of Public Health	2016
2. California Healthy Places Index	2018
3. California HIV Surveillance Report	2015
4. Office of Environmental Health Hazard Assessment	2011-2013
5. California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. SpeedTrack©	2014-2016
6. American Community Survey	2013-2017
7. Kidsdata.org	2014
8. Center on Policy Initiatives	2015

Appendix B. Community Input Tracking Form

	Data collection method	Title/name	Number	Target group(s) represented	Role in target group	Date input was gathered
Organizations						
1	*Focus Group**	**Health Center Partners,** *Promotoras*	*3*	*Minority, medically underserved, and low income*	*Leader*	*10/9/18*
2	*Focus Group**	**Alliance for Regional Solution,** *Homeless providers, healthcare providers, government, law enforcement, non-profits*	*40*	*Minority, medically underserved, and low income*	*Leader*	*10/24/18*
3	*Focus Group**	**School Based Health Center – Southwest High School,** *Clinic staff including providers, school staff, parent, intern*	*17*	*Minority, medically underserved, and low income*	*Leader*	*11/28/18*
4	*Focus Group**	**San Diego Hunger Coalition**, *Task Force Meeting Members*	*11*	*Minority, medically underserved, and low income*	*Leader*	*11/29/18*
5	*Focus Group*	**California State University of San Marcos, School of Nursing, Student Healthcare Project,** *Director, and Student Nurses*	*10*	*Minority, medically underserved, and low income*	*Leader*	*1/29/19*
6	*Focus Group*	**Casa Familiar, South Bay Community Center, and San Ysidro Health,** *Promotoras*	*14*	*Minority, medically underserved, and low income*	*Leader*	*1/31/19*
7	*Focus Group**	**Regional Task Force on the Homeless**, *General Membership Meeting Members*	*12*	*Minority, medically underserved, and low income*	*Leader*	*1/31/19*
8	*Focus Group**	**Family Health Centers of San Diego,** *Special populations health educators and program coordinators*	*13*	*Minority, medically underserved, and low income*	*Leader*	*2/4/19*
9	*Focus Group**	**University of California San Diego School of Medicine Center for Community Health, Partnership for the Advancement of New Americans, United Women of East Africa**	*3*	*Minority, medically underserved, and low income*	*Leader*	*2/7/19*
10	*Key Informant Interview*	**University of California San Diego School of Medicine Center for Community Health**, *Executive Director*	*1*	*Minority, medically underserved, and low income*	*Leader*	*11/5/18*
11	*Key Informant Interview*	**Mountain Health,** *CEO*	*1*	*Minority, medically underserved, and low income*	*Leader*	*11/30/18*
12	*Key Informant Interview*	**O'Farrell Charter School,** *Teacher*	*1*	*Minority, medically underserved, and low income*	*Leader*	*12/4/18*
13	*Key Informant Interview*	**Jewish Family Service,** *Director of Nutrition*	*1*	*Minority, medically underserved, and low income*	*Leader*	*12/4/18*
14	*Key Informant Interview*	**Think Dignity,** *Executive Director*	*1*	*Minority, medically underserved, and low income*	*Leader*	*12/5/18*
15	*Key Informant Interview*	**ElderHelp,** *Advocate*	*1*	*Minority, medically underserved, and low income*	*Leader*	*12/12/18*

*Collaborative Hospital Association of San Diego and Imperial Counties CHNA Committee

	Data collection method	Title/name	Number	Target group(s) represented	Role in target group	Date input was gathered
16	Key Informant Interview	**San Diego American Indian Health Center,** Substance Abuse Treatment Provider	1	Minority, medically underserved, and low income	Leader	1/18/19
17	Key Informant Interview	**Dreams for Change**, CEO	1	Minority, medically underserved, and low income	Leader	1/22/19
18	Key Informant Interview	**International Rescue Committee**, Senior Food and Farming Program Manager	1	Minority, medically underserved, and low income	Leader	1/29/19
19	Key Informant Interview	**Pillars of the Community**, Program Coordinator	1	Minority, medically underserved, and low income	Leader	1/31/19
20	Key Informant Interview	**Otay Elementary, Chula Vista School District,** School Counselor	1	Minority, medically underserved, and low income	Leader	2/4/19
21	Key Informant Interview	**San Diego County Health and Human Services Agency,** Director and Deputy Chief Administrative Officer	1	Health department	Leader	2/19/19
Community residents						
22	Focus Group*	**Community Housing Works,** Residents	20	Minority, medically underserved, and low income	Member	1/16/18
23	Focus Group	**Environmental Health Coalition,** Community Advisory Members	9	Minority, medically underserved, and low income	Member	11/14/18
24	Focus Group	**Monarch School,** Parents of homeless youth	8	Minority, medically underserved, and low income	Member	12/4/18
25	Focus Group*	**Chaldean & Middle-Eastern Social Services,** Community Advisory Board Members	10	Minority, medically underserved, and low income	Member	12/4/18
26	Focus Group	**Vista Community Clinic,** Youth Patient Advisory Board Members	7	Minority, medically underserved, and low income	Member	12/5/18
27	Focus Group*	**Vista Community Clinic,** Patient Advisory Board Members	10	Minority, medically underserved, and low income	Member	12/5/18
28	Focus Group	**Education Without Borders, San Diego State University,** Students	8	Minority, medically underserved, and low income	Member	1/22/19
29	Focus Group	**Family Health Centers of San Diego,** Patients, community members	12	Minority, medically underserved, and low income	Member	2/6/19
30	Focus Group*	**San Diego Youth Services,** Youth Action Board Members	7	Minority, medically underserved, and low income	Member	2/7/19
31	Survey	**2019 Community Health Needs Survey**	306	Minority, medically underserved, and low income	Leaders	1/29/19 – 2/12/19
32	Survey	**2019 Community Health Needs Survey**	47	Minority, medically underserved, and low income	Resident Members	1/29/19 – 2/12/19

*Collaborative Hospital Association of San Diego and Imperial Counties CHNA Committee

Appendix C. Health Need Profiles

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Access to Health Care in San Diego County:
Fears over immigration force families to make agonizing choices

Camila and Mateo have lived in the United States for 12 years; after receiving employment-based work visas, they immigrated when their children were 2 and 4 years old. They have worked in rural San Diego on farms since then, but they did not keep their visas up to date. Recently, their 14 year old son, Caio, needed a physical in order to play school sports – his last physical was many years ago. Because they are uninsured, Camila and Mateo searched for a health clinic that provides medical care on a sliding scale – and took a two hour trip on public transportation to get Caio there. Caio is active and seems healthy, so it was a shock when, during the exam, the physician noted that Caio had high blood pressure and a heart murmur.
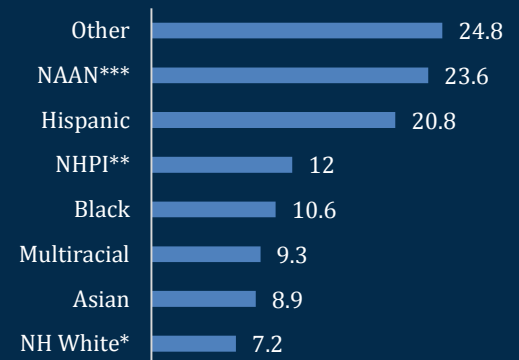
> *"I am the only one in my family that can translate during appointments for everybody in my family. It's a lot of responsibility." – College student, focus group participant*

Using Caio and his sister Maria as interpreters, the physician explained that Caio needed further cardiac testing to determine whether he had an underlying heart condition. Caio is likely eligible for MediCal but his parents are scared that if they apply for MediCal for Caio, they will be deported. Now Camila and Mateo are facing an agonizing decision – should they risk deportation to get medical testing for their son who seems so healthy? And if so, how will they get him to the appointments on public transportation and without losing their jobs?

UNINSURED IN SAN DIEGO COUNTY

12.2% of people in San Diego County are uninsured.

- Those who identify as Hispanic, Native American/Alaskan Native and "other" are disproportionately without health insurance

- A lack of health insurance is a driver of several health conditions, including more poor mental health days, more heart attack emergency department visits, higher asthma prevalence, higher obesity prevalence, a higher percentage of babies born with low birth weight, and a higher prevalence of smoking.

% of San Diegans Uninsured

Group	%
Other	24.8
NAAN***	23.6
Hispanic	20.8
NHPI**	12
Black	10.6
Multiracial	9.3
Asian	8.9
NH White*	7.2

*non-Hispanic White, **Native Hawaiian & Pacific Islander, ***Native American & Alaskan Native

Community Strengths

- Several local nonprofits and senior centers offer transportation services for seniors to medical appointments, including Jewish Family Services, and Elderhelp.

- Mountain Health serves people regardless of their ability to pay and has locations in rural areas where healthcare can be harder to access. Mountain Health offers medical care, Behavioral Health Services, Dental Services, optometry, pharmacy, and x-ray.

Camila and Mateo's situation is far too common in San Diego County. A key finding of the community engagement process was that fears about immigration status and deportation are more pronounced than in the past and that some San Diegans do not receive necessary medical care because of this.

"Some medical plans will provide you with a bus pass as a benefit, but you have to arrange it ahead of time, and it takes too long to get to the doctor when you use public transportation."
–Community resident, focus group participant

In addition, language issues were cited as an important barrier to care – and, with nearly 24% of the San Diego County population born outside the United States and 38% of the population who speak a language other than English at home – this likely affects a large proportion of the community.

"It's really hard to navigate the healthcare system. I have insurance, but still, I don't know who to contact when I have an issue." –Community resident, focus group participant

Community Engagement Findings

Access to health care (including mental health services) was identified as a priority health issue in the Community Engagement Process. The community also expressed that:

1. *Transportation is a common barrier to accessing health care. People need convenient, inexpensive, user-friendly transportation; this is particularly important among seniors.*
2. *Fears about immigration status have increased, and often people will not go to medical appointments for fear of deportation.*
3. *It is challenging to find medical care that is culturally and linguistically competent. This can create mistrust between community members and health care providers.*

PREVENTIVE CARE IN SAN DIEGO COUNTY

San Diego County has fewer hospital discharges for preventable conditions than the state average (35.9 per 1,000); however, Black individuals have a far greater number of these events than white individuals.

Preventable Hospital Events in San Diego

44.8	30.5	31.5
Black	White	Overall
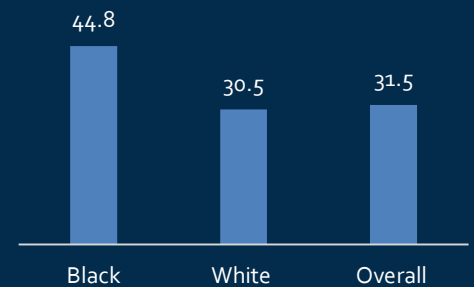
The percent of the San Diego County population who have seen a primary care physician in the last year, 71.8%, is slightly lower than the state average of 72.4%.

For Medicare beneficiaries, this gap is larger: only 67.4% of Medicare beneficiaries in San Diego County have seen a PCP in the past year, compared to the state average of 72.9%.

Medicare Beneficiaries who Have Seen a PCP Within Past Year

67.40%	72.90%
San Diego County	California

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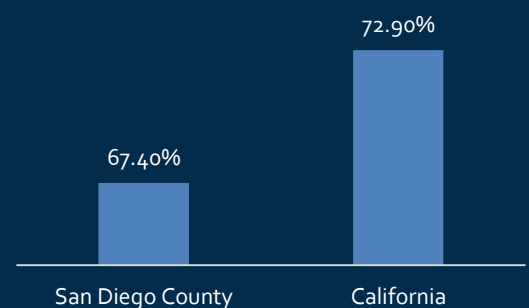
Diabetes in San Diego County:
San Diegans experience wide disparities in diabetes diagnoses

James is a 56 year old, African-American attorney who has always enjoyed good health. James, however, spends most of his day at his desk, rarely has time to exercise, and is 40 pounds overweight.

> *"Diabetes and diabetes management are the biggest health issues we face in our clinics." – Focus group participant, student nurse*

In recent months, James has noticed that he seems to be thirstier than usual and that he gets shaky when he doesn't eat lunch. James assumes these symptoms are a natural part of the aging process, and, besides, prides himself on rarely seeing a doctor, so he ignores these symptoms. Last Saturday, James had plans to eat dinner out with his partner, so he decided to wait to eat until then. Late that afternoon, James became shaky and confused, and his vision became blurred. His partner took him to an emergency department (ED), where James was diagnosed with Type II diabetes. James was surprised, but is now taking his health more seriously; he's signed up for the diabetes care program through his insurance and is taking online classes to learn to manage his diabetes.

DIABETES IN SAN DIEGO COUNTY

Prevalence:
- 7.5% of adults have diabetes; lower than the state average of 8.4%
- Rates of diabetes rise with age with the highest rates among those 65+
- African Americans are disproportionately seen at an ED for Type II diabetes
- Asian/Pacific Islanders are disproportionately hospitalized with gestational diabetes

Opportunities for Prevention:
- 96% of the population lives in close proximity to a park or recreational facility, an indicator of strong "exercise opportunities"
- San Diego County receives a 7.9/10 on the "Food Environment Index," a measure of affordable, close, and nutritious food retailers. This exceeds the national benchmark of 7.39

Geography:
Diabetes occurs more often in certain areas of San Diego, including those areas that report:
- More home ownership
- Lower income
- More crowded housing
- Fewer Bachelor's degrees
- Less beach/park access

ED discharges for diabetes remained fairly stable from 2014-2016, but disparities are evident. Rates are highest for those 65 and older and for Black individuals. Increases in discharge rates occurred for those 27-44 years old and for Asian/Pacific Islander and Black individuals. Hospital discharges for gestational diabetes are decreasing, but disparities are evident here as well: people of Asian/Pacific Islander descent and those who identify their race as "other" are disproportionally impacted by gestational diabetes.

Participants in the Community Health Needs Assessment cited diabetes management as a particular challenge for those who are homeless or insecurely housed

Most San Diegans manage their diabetes well, but disparities persist:

- 82.6% of percent of Medicare patients with diabetes have had a hemoglobin A1c blood sugar test by a health care professional in the past year
- This rate is 6% lower for African American individuals than for white individuals

Relative to state averages, San Diego County has a lower proportion of people with risk factors for diabetes. While 19% of adults in San Diego County are obese, this is lower than the California average of 22.4% and exceeds the national benchmark of 27.5%. Similarly, 16.9% of youth in San Diego County are obese, compared to 20.1% in California. San Diegans also have lower rates of soft drink consumption (16% vs 18.1%) and both youth physical inactivity (31.1% vs 37.8%) an adult physical inactivity (15.6% vs 17.3%).

Community Engagement Findings

Diabetes was identified as a priority health issue in the Community Engagement Process. The community also expressed that:

1. *The cost of insulin is a barrier to effective diabetes management.*
2. *Because insulin needs to be refrigerated, diabetes management is particularly challenging for those without access to a refrigerator, including those who are homeless.*
3. *The public is unaware about the steps they can take to prevent the onset of diabetes; this is particularly true among young people.*

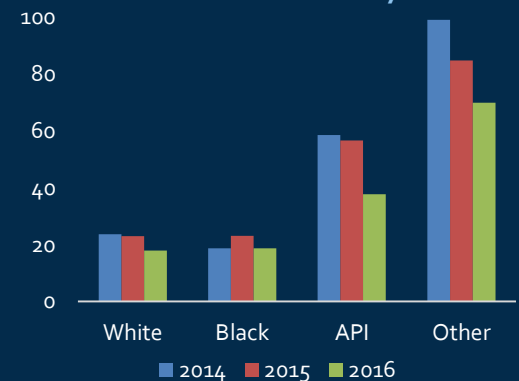# HOSPITAL DISCHARGES IN SAN DIEGO COUNTY

ED Discharge Rates for Diabetes by Race
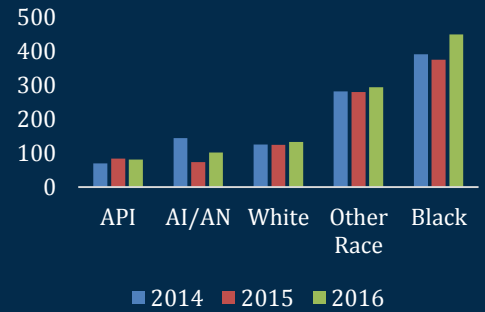
ED Dishcarges Diabetes by Age
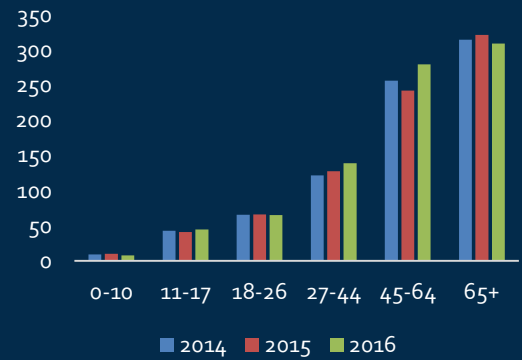
Hospital Discharge for Gestational Diabetes by Race

API - Asian Pacific Islander
AI/AN - American Indian/Alaskan Native/Eskimo/Aleu

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Economic Insecurity in San Diego County:
San Diegans employed full-time worry about losing their homes

Courtney is a single 35 year old mom, with kids ages 4, 10, and 13. Courtney works at a grocery store making $15 an hour. It's not much, but she is above the federal poverty level, and she receives health insurance. Like many San Diegans, Courtney is considered a "cost burdened household" because her housing costs exceed one-third of her income. The cheapest apartment Courtney could find is a 2-bedroom, 1 bath apartment in City Heights. Rent is $1,300 a month. Courtney spends another $800 a month on child care for her four year old – she is on the waiting list for subsidized child care through the County. This leaves her with $500 a month to take

> "If I was living alone, I wouldn't feel so bad, but I have kids, and this makes it so much harder. I don't feel safe about keeping my home. What if I can't provide for my children?"
> – Community resident/ environmental activist and focus group participant

care of other expenses. Somehow, Courtney makes it work. She receives help from the Supplemental Nutrition Assistance Program (SNAP) and also regularly visits food pantries for groceries.

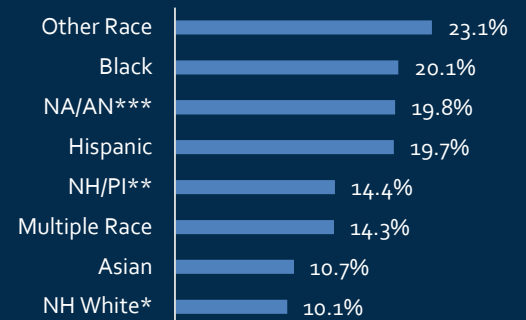*The average cost of childcare in San Diego County is between $686 and $829 per month.*

She's even figured out how to find free recreational activities for her children. Recently, Courtney found out that the store where she works is closing. She hopes to be transferred to another store, but this may not happen. Courtney is scared. She has no savings, and if she loses her job, she won't be able to pay her rent. She is desperate to keep her children safe and sheltered.

POVERTY IN SAN DIEGO COUNTY

In San Diego County, residents belonging to minority ethnic groups are disproportionately affected by poverty.

San Diego County Population Below Poverty Level

Race	Percentage
Other Race	23.1%
Black	20.1%
NA/AN***	19.8%
Hispanic	19.7%
NH/PI**	14.4%
Multiple Race	14.3%
Asian	10.7%
NH White*	10.1%

*non-Hispanic White, **Native Hawaiian & Pacific Islander, ***Native American & Alaskan Native

San Diegans are struggling:

- 18% of all children live below the federal poverty level ($25,100 for a family of 4)
- 33% of working age families can't cover their basic expenses
- 13% of San Diegans experience food insecurity
- 7% of San Diegans receive SNAP Benefits

Community Strengths

- Unemployment in San Diego County is 3.3% - lower than the state, regional, and national averages.
- The Supplemental Nutrition Assistance Program (SNAP) through CalFresh helps low-income families buy groceries.
- Many organizations in San Diego County are devoted to fighting hunger, including: the Morning Pantry, San Diego Food Bank, Veterans Village, LGBT Center, Feeding San Diego, Hunger Coalition, HomeStart-Cal Fresh, and Kitchens for Good.

Courtney's situation is not unusual. One-third of households in San Diego County have incomes that do not cover the cost of living. More than a quarter of families that include two working adults have incomes too low to cover the most basic expenses. Housing costs are a major contributor to the high cost of living in San Diego County– 25% of people in San Diego County spend over half their income on housing. Lower incomes are associated with a wide range of health problems, including:

> "At my children's school, we sometimes give out food to families. Sometimes moms go through the line twice – it feels horrible to see moms begging for food."
> – Community resident and focus group participant

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

Community Engagement Findings

Economic insecurity was identified as a key health driver in KFH-San Diego and Zion's community health needs assessment. Community members also expressed that:

1. *Poverty, the high cost of living, low wages, and rent increases disproportionate to income significantly impact the health of the community.*
2. *Residents too often face housing issues such as overcrowding and substandard conditions.*
3. *Homelessness affects many people, including families, students, seniors, and youth who are under 18 years of age.*
4. *Food insecurity and lack of access to healthy food are major problems within San Diego County communities.*
5. *The lack of nutritious food affects both mental and physical health.*

HOUSING IN SAN DIEGO COUNTY

- *43.9%* of San Diegans live in cost-burdened households, devoting more than 30% of their income to housing
- *45.4%* of San Diegans have housing problems: their household does not have full kitchen facilities, their unit is severely overcrowded, or their household is cost burdened
- *25.2%* of San Diegans have severe housing problems: their household lacks full kitchen or plumbing facilities, is severely overcrowded (>2 people per room) or severely cost burdened (>50% of income is spent on housing)
- On a given night, *8,576* people experience homelessness in San Diego County

FOOD INSECURITY IN SAN DIEGO COUNTY

- 2 out of 5 children are food insecure in San Diego County
- 37% of adults living in San Diego County are food insecure
- 49% of San Diego County's food insecure adults are living with a disability

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Mental Health and Wellness in San Diego County:
San Diegans are struggling to get the care they need

Lily is a 15 year old vivacious, hard-working girl who earns straight A's and suffers from severe anxiety. Her mom reports that Lily worries excessively about her grades. Sometimes she spends hours agonizing over what clothes to wear or how to respond to a friend's text. Her stomach often hurts and she can only seem to get a few hours of sleep a night. Last month, Lily missed 10 days of school because she was too anxious to attend. Lily's school only has one counselor for their 1,500 students.

Lily's mom has insurance through her job as a shipping clerk, so she contacted her insurance representative for a list of approved

> "Finding a therapist who has immediate availability is extremely challenging… for people without insurance, it's impossible."
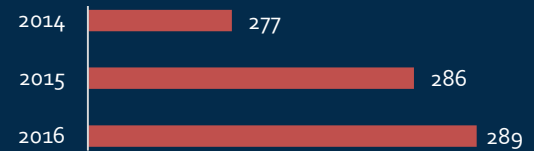> —Nursing student and focus group participant

therapists and contacted them all. The first available appointment was more than 20 miles from home and during school hours – and it was in 8 weeks. Lily's mom und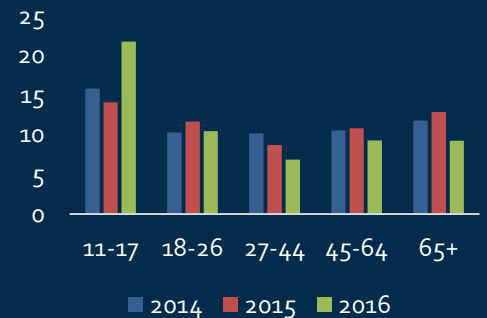erstands that their case is not considered an emergency, but as she witnesses her sweet daughter decline, to her, nothing could be more urgent. Unfortunately, before this appointment, Lily had a debilitating panic attack. She couldn't stop crying and was convinced that if she left the house, something horrible will happen. At a loss for what to do, Lily's mom took her to an emergency department (ED). They were able to stabilize her, and she was released home with instructions to follow up with their primary care physician and to see a therapist.

Emergency Department Discharges for Anxiety

Year	Discharges
2014	277
2015	286
2016	289

Hospital Discharges for Anxiety by Age

Bar chart showing hospital discharges for anxiety by age groups (11-17, 18-26, 27-44, 45-64, 65+) for years 2014, 2015, 2016.

Community Strengths

- It's Up to Us is a public education campaign by the San Diego County Health and Human Services Agency that offers free materials to promote awareness of mental health issues and available resources.

- The Psychiatric Emergency Response Team (PERT) pairs a law enforcement officer with a mental health professional to provide on-site emergency assistance for people having a mental health crisis.

- The San Diego American Indian Health Center provides culturally appropriate programs such as weekly talking circles that help address social and mental health issues for the Native American urban population.

- The Positive Choice Integrative Wellness Center at Kaiser Permanente offers a wide range of programs to manage stress and promote emotional well-being.

Lily's experience is not unique. Rates of ED discharges for anxiety have increased by about 4% since 2014, with the most substantial increases for people 11-17. Rates of discharge for self-inflicted injury are highest among those 15-24. In addition, among adults in San Diego County:

Participants in the Community Health Needs Assessment consistently cited access to mental health care as a priority health need for San Diegans of all ages

- 14.6% of Medicare beneficiaries suffer from depression
- 10.3% have seriously considered suicide
- 12.4 per 100,000 commit suicide every year

And while the rates of suicide decreased 1.3% from 2014-2016 among all San Diegans, for people of Asian/Pacific Islander descent, Black individuals, and people who identify their race as "other," these rates *increased* during the same years by 13.3%, 47.2%, and 93% respectively.

San Diegans report an average of 3.4 poor mental health days per month. People living in areas where there are fewer individuals with Bachelor's degrees, less health insurance, lower incomes, more crowded housing, and less beach/park access tend to report a greater number of poor mental health days than those in other areas.

Community Engagement Findings

Mental health and wellness was identified as a priority health issue in KFH-San Diego and Zion's community health needs assessment. Community members also expressed that:

1. *Trauma and, as a result, PTSD are common among the homeless veteran population, refugee population, and the LGBTQ community.*
2. *Stress, anxiety, and depression seem to be on the rise and impact physical as well as and mental health. These issues sometimes lead people to "self-medicate" with drugs and alcohol.*
3. *Adults and children have great difficulty accessing timely, appropriate mental health services.*

DEPRESSION, SELF-INFLICTED INJURIES, AND SUICIDE IN SAN DIEGO COUNTY

Emergency Department Discharges, Self-Inflicted Injury by Age
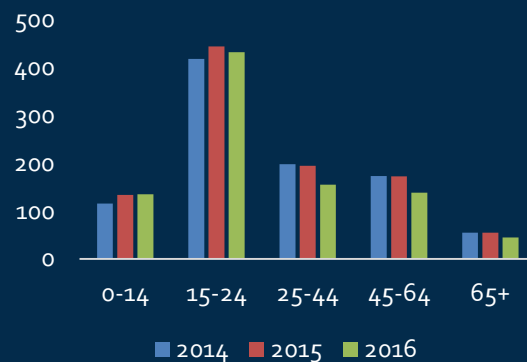
Suicide Rate by Race

API – Asian Pacific Islander

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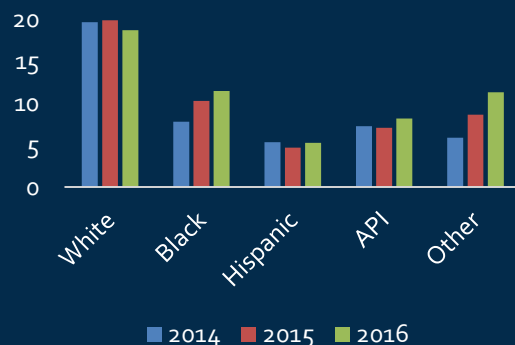
Substance & Opioid Misuse in San Diego County:
Unintentional addiction to opioids is a crisis for seniors

Eddie is a 74-year-old widower who worked for 35 years as a heavy machine operator; he retired at the age of 70 and has since struggled with debilitating back pain. Eddie was unable to get adequate pain relief from over-the-counter medications, so three months ago, his primary care physician prescribed him hydrocodone every 4-6 hours as needed. Eddie understood this to mean that he should take hydrocodone four times a day, and he does so diligently. Recently, Eddie underwent a painful oral surgery and was pre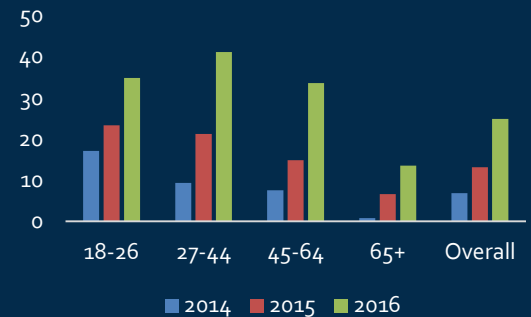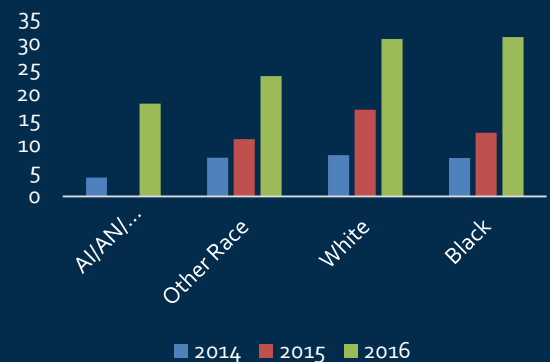scribed oxycodone – he remembered to tell the surgeon about his blood pressure medications but not his pain medications. A week after this surgery, Eddie was in terrible pain, so he took an extra oxycodone and one hydrocodone (at his regular time), as well as his blood pressure medication. Eddie became very dizzy and passed out, hitting his head on the side of a coffee table. At the Emergency Department (ED), Eddie was counseled to stop taking both the hydrocodone and the oxycodone, but when he did this, Eddie experienced severe withdrawal symptoms and his back pain was excruciating. Eddie doesn't know what to do. Like many seniors, Eddie has unintentionally become an opioid addict and is ill-equipped with the knowledge or resources to address his addiction.

> "The real crisis with drugs isn't at the border, it's internal. It's the opioid crisis, not the drug cartels."
> - Senior & community resident, Focus group participant

ED Discharges Opioid Misuse by Age

Chart: ED Discharges Opioid Misuse by Age. Categories: 18-26, 27-44, 45-64, 65+, Overall. Legend: 2014, 2015, 2016.

ED Discharges Opioid Misuse by Race

Chart: ED Discharges Opioid Misuse by Race. Categories: AI/AN/..., Other Race, White, Black. Legend: 2014, 2015, 2016.

Community Strengths

- The percent of Medicare Part D prescription claims in San Diego County for opioids is 5.2%. This is significantly lower than the state average of 7.0% and slightly lower than the national average of 5.6%.
- For seniors struggling with addiction, KFH-San Diego and Zion offers care managers through their Special Needs Program for Advantage Medicare Medi-Cal plan members. These care managers can help seniors find the substance abuse treatment they need. Addiction medicine is also available to all KP members.
- 2-1-1 San Diego operates 24 hours a day, 365 days each year and has up to date information about the availability of rehabilitation beds and other substance use disorder resources

In recent years, older adults have been particularly affected by substance use issues. Although rates of ED discharge for **opioid misuse** are highest for those 27 -44 years old, from 2014-2016, the largest increase (1,734%) in the rate of ED discharge for opioid misuse was for those 65+over (see previous page graphs). ED discharge rates for **chronic substance abuse** also grew substantially (by 559%) from 2014-2016. The steepest increase was for those 65 years old and older; discharge rates for these individuals increased by 714%.

Heavy alcohol consumption is also high in San Diego County. Nearly 20% of adults ages 18 and older self-report excessive alcohol use, exceeding the state and national averages of approximately 18%.

Rates of ED discharge for **acute substance abuse** increased by 51% from 2014-2016. These rates rose the most for 0-17 year olds (61%), followed by 27-44 year olds (59%), and 18-26 olds (57%). Rates increased across all racial groups, but the most substantial increase (177%) was among Black individuals (see graph, right).

Community Engagement Findings

Substance and opioid misuse were identified as a priority health issue in the KFH-San Diego and Zion's community health needs assessment. Community members also expressed that:

1. *Both alcohol and substance misuse often co-occur with mental and physical health issues, and it is challenging to find care that addresses all of these issues.*

2. *People frequently use drugs, especially marijuana, to self-medicate for mental health issues, like anxiety, for which they have not received adequate support.*

3. *Generations of mistreatment have caused trauma in the Native American community. These years of accumulated stress have lead people to feel hopeless --which contributes to substance misuse.*

4. *Drug addiction treatment options are inadequate and in short supply. Homeless individuals, in particular, face significant barriers to accessing services due to rules and regulations of detox centers.*
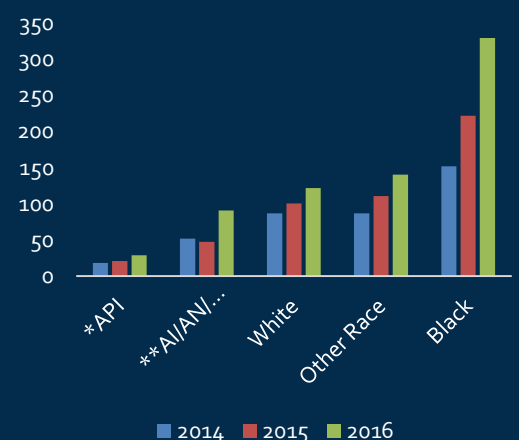
SUBSTANCE MISUSE IN SAN DIEGO COUNTY

ED Discharges Chronic Substance Use by Age

2014 ■ 2015 ■ 2016

ED Discharges Acute Substance Use by Age

2014 ■ 2015 ■ 2016
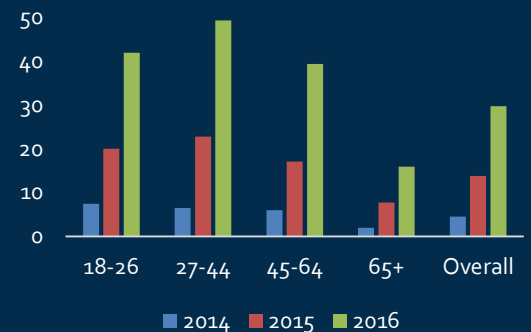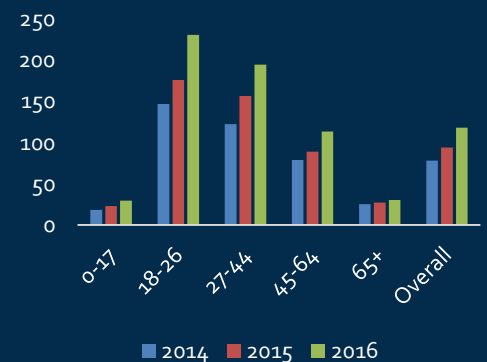
ED Discharges Acute Substance Use by Race

2014 ■ 2015 ■ 2016

*Asian/Pacific Islander
**American Indian/Alaskan Native/Eskimo/Ale

Appendix D. Community Resources

Identified need	Resource provider name	Summary description
Access to health care	Family Health Centers of San Diego	For more than four decades, Family Health Centers of San Diego's mission has been to provide affordable, high-quality health care and support services to all people, with a special commitment to the uninsured, low-income and medically underserved.
	La Maestra Community Health Centers	For the past 24 years, La Maestra Community Health Centers has provided culturally and linguistically competent primary care, specialty services including behavioral and mental health, chronic disease management and essential support services to men, women and children in San Diego's most culturally diverse and lowest income communities.
Diabetes	Mama's Kitchen	With the tremendous support from our caring community, Mama's Kitchen prepares and delivers nutritious meals for those struggling with AIDS, cancer, or diabetes. Mama's Kitchen strives to help their clients stay healthy, preserve their dignity, and keep their families together by providing free, culturally appropriate home-delivered meals, along with pantry services and nutrition education.
	The San Diego American Indian Health Center	The San Diego American Indian Health Center is a patient-centered health home that provides comprehensive medical, dental, behavioral health, and community wellness services that are available to all San Diegans. Their Diabetes Prevention Program offers healthy eating, physical activity, and weight management in a fun and supportive environment for Native Americans who are at an increased risk of developing diabetes.
Economic security	Alliance for Regional Solutions	The Alliance for Regional Solutions includes over 60+ nonprofit organizations throughout North County. Member organizations include educational entities, healthcare providers, social service agencies, government agencies, and philanthropic bodies and work with almost every community of concern, including low-income, minority, disabled, senior populations, and other under-represented groups, serving thousands of individuals and families dependent on this network of support. Together, they manage the Winter Shelter Network, including shelters in Carlsbad, Vista, Oceanside and Escondido.
	Jewish Family Service	Jewish Family Service is a client-centered, impact-driven organization working to build a stronger, healthier, more resilient San Diego. They provide food resources and social, behavioral and economic support services to children and youth, adults and families, older adults, refugees and immigrants and military families throughout San Diego County.
Mental health	North County Lifeline	North County Lifeline's mission is to build self-reliance among youth, individuals and families through problem solving, skill-building and accessible community-based services. Their programs include youth development, housing and stability, child abuse, prevention and intervention, and behavioral health.
	San Diego Center for Children	The San Diego Center for Children is committed to a Continuum of Behavioral Healthcare for children and families to access better health, improved relationships and greater quality of life. Their programs include prevention, assessment, transition, outpatient therapy, school-based therapies, education, wrap around and residential services and foster care.
Substance & opioid misuse	McAlister Institute	McAlister Institute has grown into one of San Diego County's largest alcohol and other drug treatment providers. Together, McAlister Institute's 25 programs represent a continuum of care which spans prevention, outreach, intervention, deferred entry programs, outpatient treatment, short-term residential, long-term residential, and sober living.
	Social Advocates for Youth	SAY San Diego partnerships and services address the comprehensive needs of the entire individual or family rather than focusing on one symptom or problem. Their Alcohol, Tobacco and Other Drug Prevention Program is designed to incorporate the concept of community partnerships, the application of new, science-based knowledge of alcohol, tobacco and other drug problem reduction, and the development of a system-wide, outcome-driven prevention strategy to address the increasing trend of alcohol, tobacco and other drug use among adolescents in San Diego County. Mobilizing residents of the community is essential to affect environmental and systems change.

Appendix E. Strategic Lines of Inquiry for Community Engagement

Southern California Kaiser Permanente's approach to the 2019 CHNA employed a mixed-methods sequential explanatory assessment design intended to produce the most accurate, vivid, and meaningful story of community health possible. This appendix reports an overview of the assessment design and the resulting list of strategic questions that guided community engagement for this report.

i. Overview of Question Design Process

· Secondary data from over 200 relevant indicators were analyzed by Kaiser Permanente Regional analysts to provide a bird's eye view of the most pressing health issues across the service area.

· These analyses were reviewed and discussed by Kaiser Permanente clinicians, experts, and hospital leaders who had knowledge of the local community. These discussions helped provide additional context to findings and identify targeted strategic lines of inquiry that provided the foundation of a relevant community engagement plan. For example, Kaiser Permanente social workers might review the data during this phase and provide their perspective that immigration policies could be influencing Hispanic/Latino resident willingness to access care.

· Across these internal sensemaking sessions, strategic lines of inquiry were synthesized by consultants and re-framed to work as a driving force behind community engagement planning. These strategic questions were also designed to be answerable by human beings (not more secondary data). Strategic questions targeted the root causes of health needs, racial/ethnic disparities in impact, community lived experience, or the resources available to address a health need (e.g. *to what extent are current immigration policies inhibiting resident willingness to access healthcare and other community resources and how can these obstacles be overcome?*).

· Strategic questions were not asked *directly* of engagement participants but were instead used to build a sampling frame and culturally competent in-person engagement protocols. For example, a question asking about the impact of immigration policies on resident willingness to access health care would lead to: a) recruitment of community residents and experts who could provide rich answers to the question and b) tailored interview and focus group protocols for engagement participants that would conversationally surface the answer in a manner consistent with best practices in qualitative data collection.

· By using a series of strategic questions in this way, primary data collection allowed for authentic community engagements with residents and stakeholders that could "dive deep" on issues relevant to the community (and ground truth their relevance).

· Regardless of the strategic focus of the engagements, however, they also provided the opportunity for the community to raise any other health needs not targeted through the strategic lines of inquiry and these data were also included primary data analysis.