UC San Diego Health

2025 San Diego Regional Community Health Needs Assessment

Dear Community Members, Partners,
and Stakeholders,

I am honored to present the 2025 Community Health Needs Assessment (CHNA) Report, a comprehensive and collaborative effort to understand and address the health and social needs of our diverse San Diego County communities. This report represents the collective voices and experiences of over 1,600 community members, health care providers, and social service organizations who have generously shared their insights and perspectives.

This vital assessment was conducted within the context of four significant and ongoing stressors that continue to have profound effects on the health and well-being of those who live in San Diego County. Compounding factors such as financial hardships due to the region's high cost of living, growing health disparities, lingering impacts from the COVID-19 pandemic, and recent climate-related and public health crises underpin the report's key findings that highlight critical areas where our community needs support:

1. **Managing Specific Health Conditions:** The community identifies asthma, blood pressure, cancer, dental health, diabetes, and mental health as priority areas requiring more assistance.
2. **A Different Health Care Experience:** There is a clear need for health care systems to respect patients' time, provide timely care, offer better transportation options, foster better relationships with care providers, and assist with navigating the medical system and insurance.
3. **Recognition and Assistance with Disabilities and Trauma:** There is a need for greater recognition of disabilities and trauma, along with appropriate accommodations and support.
4. **Help with Crises:** The community requires more resources and better coordination to address climate-related and public health crises, such as extreme heat, wildfires, flooding, and the Tijuana River Valley sewage crisis.
5. **Better Data Collection, Sharing, and Coordination:** Improved data collection and sharing across health care, educational, and social service systems are essential to addressing community health needs effectively.

6. **Reducing Burden on Emergency Departments:** There is a need to alleviate the burden on emergency departments by improving access to primary and specialty care and enhancing discharge processes.
7. **Protection and Care for Health Care Providers:** The community recognizes the pressures faced by health care workers and emphasizes the importance of supporting and protecting them.

This report is not just a reflection of the challenges we face but also a testament to the resilience and strength of our community. It provides actionable insights and recommendations that will guide our efforts to develop, modify, and expand health and social service programs to better meet the needs of our residents.

I extend my heartfelt gratitude to all who participated in this assessment, including our community partners, health care providers, and the dedicated members of the CHNA Committee. Your contributions are invaluable, and together, we can work towards a healthier, more equitable future for all San Diegans.

Thank you for your continued support and commitment to improving the health and well-being of our community.

Sincerely,
Patty Maysent
Chief Executive Officer
UC San Diego Health

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Acknowledgements

2025 Participating Hospitals and Health Systems

Every private hospital, health system, health district and behavioral health hospital in San Diego County participates in this collective effort to better understand the health and social needs of San Diego communities. Participating hospitals and health systems supported the Community Health Needs Assessment (CHNA) process through the HASD&IC Board of Directors, HASD&IC Behavioral Health Workgroup, HASD&IC Case Management Workgroup, and the HASD&IC Board of Directors.

API ALVARADO PARKWAY INSTITUTE BEHAVIORAL HEALTH SYSTEM

Aurora San Diego Behavioral Health Care

Grossmont Healthcare District

KAISER PERMANENTE®

PALOMAR HEALTH Reimagining Healthcare

Paradise Valley Hospital

COUNTY OF SAN DIEGO

Rady Children's

Scripps

SHARP

Tri-City Medical Center

Select Specialty Hospital

UC San Diego Health™

VA U.S. Department of Veterans Affairs VA San Diego Healthcare System

Community Health Needs Assessment Committee

The Community Health Needs Assessment (CHNA) Committee (listed below) worked with HASD&IC staff to design and implement the 2025 Community Health Needs Assessment.

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Thanks to our Community Partners

We extend our heartfelt gratitude to all who participated in this collective effort. Health care and social services sectors have been overburdened since the pandemic, and the needs in our community have only grown over the past three years. We remain deeply grateful to all our community partners, who once again, without hesitation, answered our requests for data and key informant interviews, led field research, organized focus groups, and promoted the online survey. Our collaboration gives the CHNA Committee confidence that this report will be valuable to our partners in San Diego County, including policymakers, health care and social service providers, grant makers, and other civic leaders.

Alcohol & Drug Service Provider Association	Family Health Centers of San Diego
JIREH Providers	La Maestra Community Health Centers
Legal Aid Society of San Diego/Consumer Center for Health, Education and Advocacy	Lived Experience Advisers
National School District in Partnership with Rady Children's Hospital	North County Lifeline
PATH San Diego	Rural Health Discharge Program
San Diegans for Healthcare Coverage	San Diego Association for California Nurse Leaders
San Diego American Indian Health Center	San Diego County Promotores Coalition
San Diego County Public Health Services - Maternal, Child, and Family Health Services	San Diego Human Trafficking and CSEC Advisory Council Health Sub-Committee
San Diego Hunger Coalition	San Diego Refugee Communities Coalition
San Diego Youth Services	San Ysidro Health Center
The San Diego LGBT Community Center	YMCA of San Diego County

Special Thanks

San Diego Refugee Communities Coalition (SDRCC)

SAN DIEGO
Refugee Communities
COALITION

The SDRCC is a coalition of 12 ethnic-based community organizations. Members of SDRCC were invaluable research collaborators, conducting hundreds of field interviews in multiple languages, assisting with data analysis, and providing guidance throughout the CHNA.

Field interviews were conducted in collaboration with the Community Health Initiative of the San Diego Refugee Communities Coalition and the UC San Diego Center for Community Health, Refugee Health Unit within the Altman Clinical Translational Research Institute.

CHNA Project Implementation Team:

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Haitian Bridge Alliance

Horn of Africa

Karen Organization of San Diego

License to Freedom

Madjal: Arab Community Center of San Diego

Refugee Assistance Center

SDRCC Afghan

Slavic Refugee and Immigrant Services Organization

Somali Bantu Organization of San Diego

Southern Sudanese Community Center of San Diego

United Women of East Africa Support Team

San Diego County Promotores Coalition *(SDCPC)*

The SDCPC advances the work of Community Health Workers/Promotores. SDCPC members collected hundreds of field interviews, offered feedback on data collection tools and CHNA findings, and generously lent their expertise.

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CHNA Collaborative Research Partners

The CHNA Committee and the Hospital Association of San Diego & Imperial Counties

The Hospital Association of San Diego & Counties (HASD&IC) Board of Directors represents all member sectors and provides policy direction to ensure the interests of member hospitals and health systems are preserved and promoted. The CHNA Committee includes representatives from participating hospitals and health systems and provides overarching guidance regarding the research approach and community engagement. The CHNA Committee is responsible for implementing the San Diego CHNA and reports to the HASD&IC board.

San Diego State University (SDSU) Institute for Public Health (IPH)

SDSU | Institute for Public Health

For the 2025 CHNA, HASD&IC partnered with the San Diego State University (SDSU) Institute for Public Health (IPH). The IPH is the practice arm of the SDSU School of Public Health and facilitates public health practice in San Diego communities. Together, HASD&IC and IPH staff led the research design, data collection and analysis, and the summary of the findings for this report. IPH research collaborators included:

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Kaiser Permanente – San Diego, Zion, and San Marcos Medical Centers and Harder + Company Community Research

In addition to their participation in the HASD&IC facilitated 2025 collaborative CHNA process, Kaiser Permanente - San Diego, Zion, and San Marcos Medical Centers also conducted their own CHNAs in partnership with Harder+Company Community Research. These two processes were intentionally conducted simultaneously with ongoing, continuous feedback between the two groups; this allowed the groups' efforts to be complementary rather than duplicative. These efforts also enabled HASD&IC and Kaiser Permanente-San Diego, Zion and San Marcos 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.

Executive Summary

The Community Health Needs Assessment (CHNA) for 2025 represents a collaborative effort of all San Diego County hospitals and health care systems to understand the community's needs. Findings are used to develop, modify, and expand health and social service programs. The 2025 CHNA utilized a health equity framework and emphasized community-based research that was academic, analytical, actionable, and accountable.

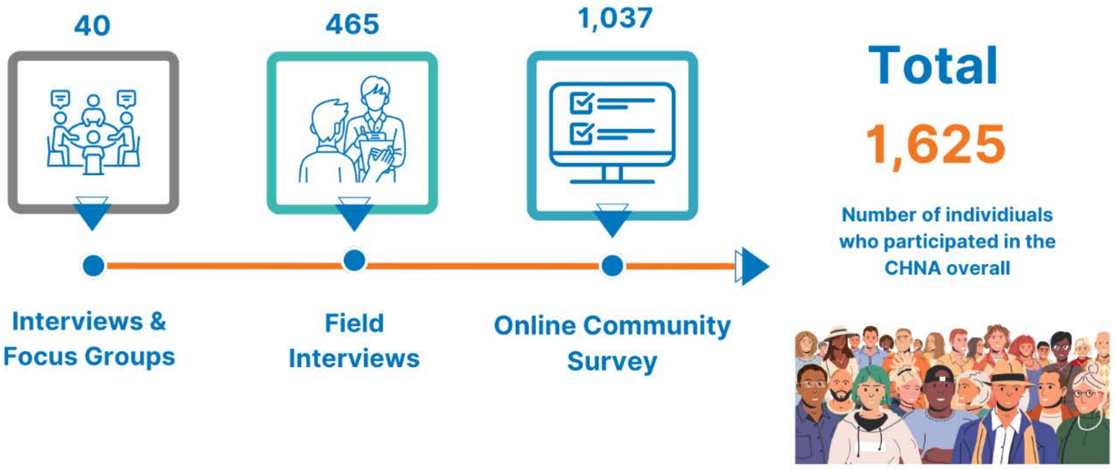
Methods

The CHNA research team conducted focus groups, key informant interviews, field interviews, and an online survey to gather data and reviewed publicly available demographic data, hospital discharge records, and existing research to gain a comprehensive understanding of community needs. Through this research, the team addressed the following research questions:

What are the most pressing needs of our community?

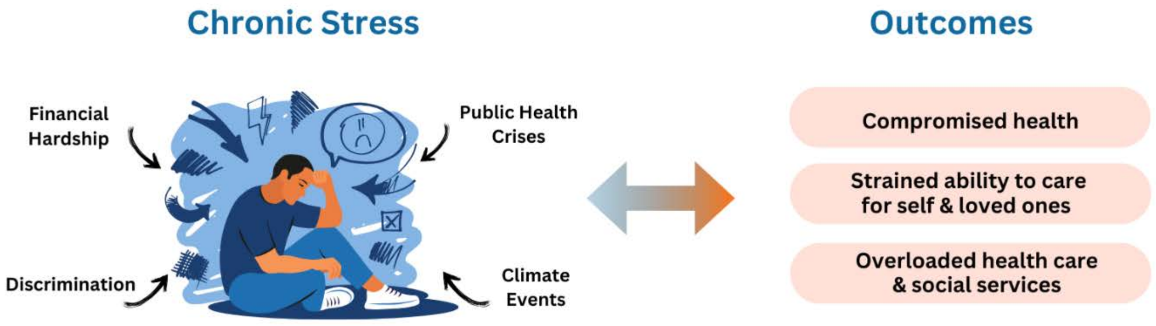
How can hospitals and health systems help address those needs?

Feeback was gathered from **1,625** members of the San Diego community. Research collaborators from the San Diego Refugee Communities Coalition and San Diego County Promotores Coalition completed 465 field interviews, the online survey was taken 1,037 times, and 40 groups of people (123 individuals) participated in key informant interviews and focus groups, exceeding the threshold for data validity.



Primary Finding

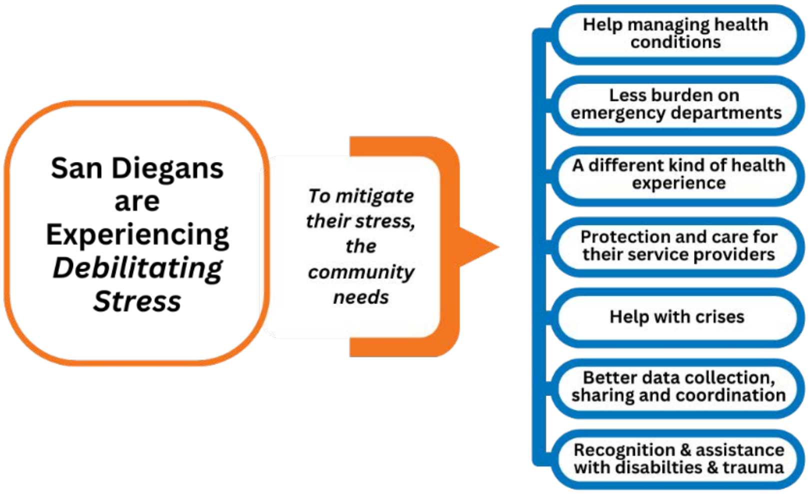
One theme emerged from all methods of data collection: ***Our community is under significant, ongoing, debilitating stress*****.** This stress, they said, is caused by the high cost of living in San Diego, rising levels of racism, prejudice, and discrimination, ongoing challenges from COVID 19, and recent public health emergencies. ***And it is severely impacting their health and their ability to manage their health care.*** This stress has resulted in a health care system trying to help more patients while health care workers are, themselves, experiencing hardship.



It is within this context of this enduring community stress that this needs assessment was conducted, and with that in mind, the assessment focused on what the community needs from hospitals and health care systems to mitigate this stress, and, therefore, improve their health.

Key Findings

When we asked how hospitals and health care systems could help improve their health, the community discussed several strategies, as illustrated in the graphic at right.



2025
CHNA
FINDING

The community named ***several specific health conditions*** they need more assistance with managing, listed in the graphic below in ***alphabetical order***.

The Community Needs Help Managing					
Asthma	Blood Pressure	Cancer	Dental Health	Diabetes	Mental Health

2025
CHNA
FINDING

The community also emphasized that they need ***a different kind of health care experience.***

- **Respect for Their Time**
- **Care When They Need It**
- **Better options for transportation**
- **Better relationships with care providers**
- **Help navigating medical system, insurance & follow-up care**

They need health care systems to be respectful of their time, to offer care when they need it. They need easier ways to get to health care, a better relationship with care providers, and help with navigating systems. This, they indicated, was where the health care community should be concentrating its efforts.

2025
CHNA
FINDING

While asking for change in the way they experience health care, the community was also emphatic that they ***appreciate their health care workers, understand the pressures they are under, and want them to be protected and cared for as well.*** They offered praise for health care workers and concern about staff shortages, worker burn-out, and vicarious trauma.

2025
CHNA
FINDING

One in 10 San Diegans lives with a disability, and many have experienced traumatic events. The community emphasized that ***people who are disabled or living with trauma need recognition, accommodations, compassion, and assistance with resources.***

Disability and Trauma-Related Needs				
Allowing service animals	Complying with the ADA	Improving websites and phone systems	Assistance with documentation & eligibility	Understanding trauma

2025 CHNA FINDING

San Diego County residents have experienced significant climate-related and public health crises in recent years and expressed ***an urgent need for help addressing these crises, including better data collection and more resources. Crises discussed:***

Heat: Extreme temperatures have severely affected residents' daily lives, with many reporting health issues such as migraines, blood pressure fluctuations, dehydration, and respiratory problems.

Wildfires: Wildfires and their associated smoke have caused widespread breathing difficulties.

Flooding: A major flood in January 2024 displaced over 1,200 households, primarily in Southeast San Diego. The flooding led to respiratory problems and an increase in illnesses like flu-like symptoms.

Tijuana River Valley Sewage Crisis: The ongoing sewage crisis has resulted in unbearable odors and significant health concerns for residents living near the Tijuana Riverbed.

2025 CHNA FINDING

The community needs ***better data collection, sharing, and coordination across systems,*** including hospitals and community clinics, social service providers, and schools. The lack of data coordination creates unnecessary challenges to good health.

2025 CHNA FINDING

The community is concerned about ***the capacity of San Diego County's emergency departments (EDs),*** noting that many people must rely on them for care that could be managed outside of emergency settings. The community reported several underlying causes for this usage, including difficulty obtaining primary and specialty care in a timely manner and a lack of alternative options for acute conditions like mental health.

What’s Already Working

The community discussed several health initiatives that are positively impacting the local population and asked that these types of efforts be expanded. Current successes include:

- Partnerships between schools & clinics
- Dental offices in clinics with sliding fee scales
- Home visits for chronic condition management
- Mobile health services
- Taxi voucher programs
- Voluntary identification for disabled individuals

Community Suggestions

The community also made several suggestions for ways in which hospitals and health care systems could help reduce their stress and improve their health.

Patient support	• Ensuring that ***all individuals in the room during consultations introduce themselves*** and explain their roles • Expanding the use of ***peer support for health care navigation*** • Establishing ***a phone line for insurance-related inquiries*** • The creation of ***immediate feedback systems***, such as allowing patients to provide feedback directly after appointments • Encouraging patients to have a ***friend, family member, or advocate attend appointments*** with them • Enabling the ***easy identification of ADA coordinators*** to assist with disability accommodations
Health care worker support	• Providing ***opportunities for cultural exchanges and education*** in the community • Acknowledging and ***addressing health care worker burn out and vicarious trauma*** • Making efforts to ***reduce staff turnover*** • Encouraging and providing paid time for ***health care worker community engagement*** • Providing ***training opportunities around systemic racism, power dynamics, cultural competency, and health inequities*** and about interacting with ***populations with complex health needs***

	• Establishing ***low-cost, convenient education and training for medical assistants, certified nursing assistants, and licensed vocational nurses***
Hospital and emergency department discharges	• Releasing patients with a ***longer supply of prescription medications*** • Increasing the ***availability of hospital social workers*** • Establishing ***more recuperative care beds*** • Increasing utilization of ***In-Home Supportive Services (IHSS)*** • Expanding ***post-discharge home visiting programs***
Systemic efforts	• ***Advocating for policy changes*** that would make health care more convenient and cost effective for the community • Designating a ***hospital administrator as a community advocate*** • Gathering more community feedback about needs and ways to address those needs easier to receive, to ***create community-centered programs and services***

Limitations and Future Directions

The 2025 CHNA engaged a broad spectrum of the public to better understand their needs. Collaborative efforts allowed for feedback from more than 1,600 members of the community, resulting in an assessment that represented more community members – from more diverse backgrounds -- than ever before.

Limitations of the CHNA included sampling biases inherent to the use of hospital discharge data and purposive sampling techniques. In addition, certain populations of people who may be experiencing inequities, such as former foster youth, justice-impacted individuals, and people with chronic medical conditions, were underrepresented in focus groups and interviews. Finally, the volume of data collected exceeded the team's capacity for a full analysis within time, budget, and personnel constraints.

Introduction

Welcome to the Community Health Needs Assessment (CHNA) of 2025. In the pages of this report, we hope that you will connect with the voices of our community members. We are grateful for their willingness to share their needs and hopes for a healthier future. Our intention is for this report to be useful to hospitals and health care systems and the local organizations committed to meeting the community's needs.

The 2025 CHNA is a collaborative effort of *all* hospitals and health care systems in San Diego County, including every private hospital, health system, public hospital, health district, and behavioral health hospital. This CHNA aims to understand the community's needs *from a community perspective* allowing for the development, modification, and expansion of meaningful and effective programs to address those needs. Participation in this collaborative CHNA also helps not-for-profit hospitals meet regulatory requirements to conduct CHNAs every three years.

We assessed community needs through field interviews, focus groups, key informant interviews, an online survey, publicly available data, and where applicable, previously published research. The CHNA team collected data from 1,625 people across San Diego. This report presents the findings of that work.

Community Description

San Diego County is the fifth-most populous county in the United States with approximately 3.3 million residents. The population is exceptionally diverse. According to the most recent census data, the population is:[1]

- 43.1% non-Hispanic White
- 35% Hispanic
- 13% Asian
- 5.5% Black
- 5.1% Multiracial
- 1.4% as American Indian and Alaska Native
- 0.6% as Native Hawaiian or other Pacific Islander

San Diegans are diverse in other ways as well:[2] [3]

- 22.5% are foreign-born
- 38% speak a language other than English at home
- 7% of people under 65 are disabled

San Diego is home to many members of the military and veterans:

- 115,000 are active military serving at six bases
- 230,507 are veterans


LIVE WELL SAN DIEGO

2018-2022

DEMOGRAPHIC PROFILES

County of San Diego, Health and Human Services Agency, Public Health Services, Community Health Statistics Unit

Published February 2024

Comprehensive demographic information about San Diego County is available through the Community Health Statistics Unit.

https://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/community_health_statistics.html

I he community served by the hospitals represented in the report. Because of the comprehensive collaboration on this CHNA, the community served is the entire county. We designed the assessment to reach populations who are at risk of experiencing health inequities, including people living in rural areas, people experiencing homelessness, older adults, children and youth, and people who have been trafficked.

Research Methods & Approach

2025 CHNA Guiding Principles

Several principles guided this CHNA. These were based on IPH research guidelines, the 2022 CHNA Health Equity Framework, and input from the CHNA Committee.

CHNA Health Equity Framework

Equity

We commit to research and community engagement strategies that purposefully seek to quantify and describe inequities that disproportionately impact our disadvantaged populations due to structural components.

Inclusion

We commit to meaningful engagement with community organizations, community members, and leaders who serve diverse populations. We understand the importance of sharing a space for listening and honoring perspectives of those with lived experiences.

Empathy

We commit to employing a trauma-informed approach that works to break stigma by creating safe and meaningful opportunities to engage community members and community partners.

Responsibility

We commit to using evidence-informed research methods, analyzing the best available data, and making it available to community members and community partners.

Accountability

We commit to sharing the results of our research as well as our plans to address the findings with everyone who participates.

IPH Research Guidelines

1 **Academic & Analytical**
2 **Actionable**
3 **Accessible**
4 **Accountable**
5 **Community based**

1. Academic and Analytical

Identifying the needs of over 3 million people living across 4,000 square miles is a daunting task; nevertheless, the CHNA Committee worked to ensure as much methodological rigor as possible. To do so, we employed the research practices considered best for needs assessments.

Strategies to ensure academic and analytical rigor included:

Triangulation	Data are collected in multiple ways from multiple sources and analyzed independently by more than one researcher.
Saturation	Enough data are collected to feel confident that the research question has been answered.
Follow-Up	As data are analyzed, the integrity of the analysis is enhanced by returning to sources for clarification when possible.
Interrater Reliability	Two or more people come to the same conclusions when analyzing the data.
Concordance	Similar themes are identified across different data collection methods and sources.

2. Actionable

Another goal of the CHNA was to structure the assessment so that the findings could realistically be used to improve community health.[4] We took a solutions-based approach that asked the community for input about ways to solve health-related problems.[5] Questions were designed to solicit useful information for hospitals, health care systems, and community partners.[6]

3. Accessible

Another priority was to ensure that everyone who contributed to this needs assessment, from hospital systems to community members, could understand the findings of the report. We decided to use what the US government calls "plain language" so that the report would be as easy to read as possible.[7] [8] Simple, clear language also supports the nearly 40% of our community who speaks English as a second language and makes translation into other languages easier. In addition to using plain language, the needs assessment prioritizes using the exact words of community members.

4. Accountable

"You need to go into the communities and tell them tangible changes that have been made that can be reported out." – Key Informant

Community members want to know that when they take the time to work with us, it will matter. The CHNA team recognizes our obligation to share the results of the CHNA with them. Data collected must be given back to the communities from which it was gathered and be used to create feasible, relevant solutions to the identified problems. This is a key ethical standard of all community-based work and a regulatory requirement for the CHNA. Holding ourselves accountable to our community also builds trust between the medical community and the people it serves, particularly the people for whom there is a history of mistrust of the medical community.[9] [10]

5. Community-based

Research into the quality of CHNAs has noted that too often community voice is lacking:

> *"CHNAs are designed to help hospitals better tailor health services to the needs of local residents. However, CHNAs most often use quantitative, population-level data, and rarely incorporate the actual voices of local community members. This is particularly a problem for meeting the needs of residents who are also racial or ethnic minorities."*[11]

A primary goal of the 2025 CHNA process was, therefore, to involve Community Health Workers (CHWs), community partners, and members of the community as research collaborators. The San Diego Refugee Communities Coalition and the San Diego County Promotores Coalition helped design data collection tools, collected field interview data, and provided important assistance with data analysis.

Thanks to their efforts and the generosity of our community members, the CHNA team achieved our goal of gathering data from a larger, more representative sample of San Diegans than ever before.

Methods

The CHNA team, led by researchers at the IPH, collected data through focus groups, key informant interviews, field interviews, and an online survey, described below. The CHNA team also consulted publicly available data, such as demographic information from the American Community Survey of the Census Bureau and the 2018-2022 demographic data published by the County of San Diego.[12] [13] In addition, we examined hospital and emergency department discharge data for some conditions, reviewed relevant published research literature, [14] and read approximately 60 CHNAs completed in other parts of the country.[15] We also utilized the Healthy Places Index to identify populations of focus.[16]

In this way, we were able to analyze both quantitative and qualitative data to understand community needs. Quantitative data, data that are expressed numerically, are used to measure or count, to answer questions like, “how much?” Qualitative data, data that are expressed in words, are used to understand, to answer questions like “why?” or “in what context?” The use of different types of data and multiple methods of data collection helps ensure that our findings are valid.

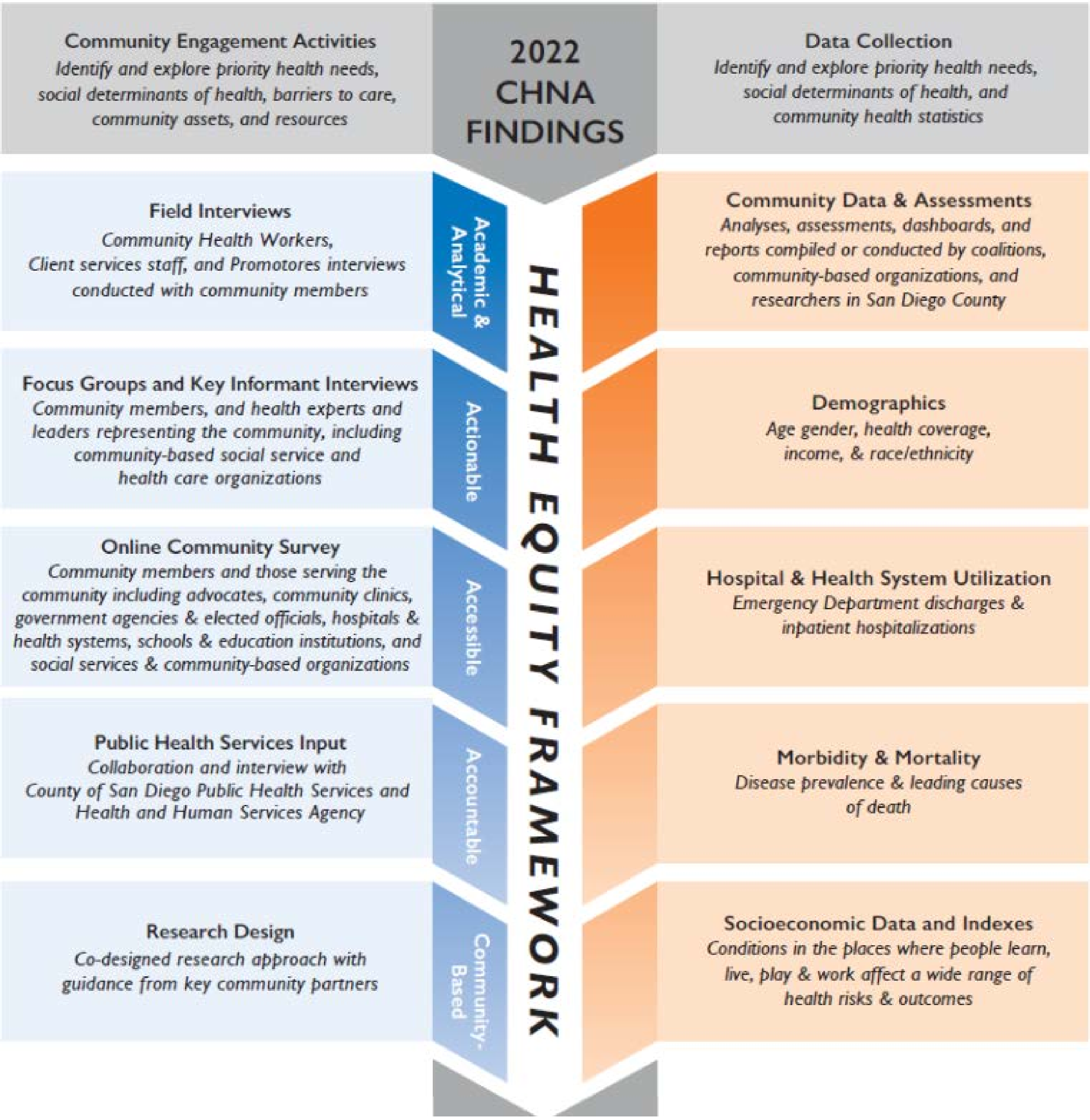
Data collection was guided by our primary research questions:

What are the most pressing needs of our community?

How can hospitals and health systems help address those needs?

The needs assessment process is mapped in the diagram on the following page.

2025 COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) PROCESS MAP



2022 CHNA FINDINGS

Community Engagement Activities
Identify and explore priority health needs, social determinants of health, barriers to care, community assets, and resources

Field Interviews
Community Health Workers, Client services staff, and Promotores interviews conducted with community members

Focus Groups and Key Informant Interviews
Community members, and health experts and leaders representing the community, including community-based social service and health care organizations

Online Community Survey
Community members and those serving the community including advocates, community clinics, government agencies & elected officials, hospitals & health systems, schools & education institutions, and social services & community-based organizations

Public Health Services Input
Collaboration and interview with County of San Diego Public Health Services and Health and Human Services Agency

Research Design
Co-designed research approach with guidance from key community partners

HEALTH EQUITY FRAMEWORK

- Academic & Analytical
- Actionable
- Accessible
- Accountable
- Community-Based

Data Collection
Identify and explore priority health needs, social determinants of health, and community health statistics

Community Data & Assessments
Analyses, assessments, dashboards, and reports compiled or conducted by coalitions, community-based organizations, and researchers in San Diego County

Demographics
Age gender, health coverage, income, & race/ethnicity

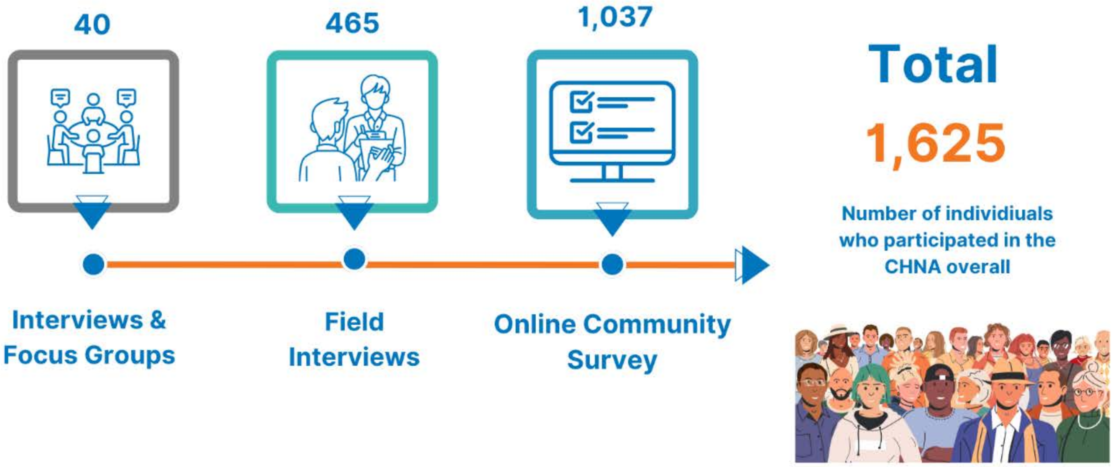
Hospital & Health System Utilization
Emergency Department discharges & inpatient hospitalizations

Morbidity & Mortality
Disease prevalence & leading causes of death

Socioeconomic Data and Indexes
Conditions in the places where people learn, live, play & work affect a wide range of health risks & outcomes

The Sample

The total sample size for the 2025 CHNA was 1,625. This sample size can be compared to that of the California Health Interview Survey conducted by UCLA, which is a multiple year effort backed by local, state, federal, and private funding. The San Diego County sample size for CHIS was 2,281 for 2023.[17] Our partners from the San Diego Refugee Communities Coalition and San Diego County Promotores Coalition completed 465 field interviews, and the online survey was taken 1,037 times. Additionally, fifteen focus groups and twenty-five key informant interviews were conducted overall, exceeding the recommended number for data validity.[18] [19]



Field Interviews

Data were collected directly from the public through field interviews. These are short interviews with people stopped outside of public places, like stores and transit stops. The purpose was to gather opinions from people who likely have no professional connection with the medical or social service community, people who can be considered representative of the general public.[20]

The CHNA team relied heavily on the expertise of Community Health Workers at the IPH, SDRCC, and SDCPC to develop the field interview tool. We wanted the tool to answer our research questions, be culturally relevant and sensitive, and as simple and short as possible. The CHNA team met with groups from all three organizations to create the tool and then, once finalized, offer training about how to use it. The tool was then piloted with staff at each organization.

People who were 18 years old or older and lived in San Diego County were eligible to complete the interview. As a thank you, they received gift cards upon completion of the interview.

The interview had three “tracks.”[21] Interviewees could discuss concerns about their children, themselves or a loved one, or the community, as shown below. The third track allowed respondents to answer questions about health concerns in a less personal manner.[22]

What is a Community Health Worker (CHW)?

CHWs are frontline workers who are trusted members of a community who speak the community’s language. They are a link between health/social services and the community and promote access to services. They also advocate for cultural and linguistic competency and provide outreach, community education, and support.

Field Interview Tracks

Track 1	Track 2	Track 3
Concerns about a child	Concerns about self or loved one	Concerns about the community
53 interviews	213 interviews	199 interviews

The field interview was written in English and translated into Spanish. Data collectors who spoke other languages translated the English survey on the spot for community members. Our results were far-reaching; data were collected from community members in ***16*** different languages.[23]

Field interviews were conducted by CHWs and staff from SDRCC and SDCPC in their own communities across San Diego County. Interviews lasted anywhere from 5 to 45 minutes, depending on the amount of input respondents shared and level of translation needed. Feedback from the data collectors suggests this innovative approach was effective. As trusted members of the communities, they successfully recruited many people to complete the interview.

Focus Groups and Key Informant Interviews

Sampling/Recruitment

In initial planning meetings with the CHNA Committee, populations of focus were chosen based on feedback from the last CHNA, data from the Healthy Places Index (HPI)[24], and research on health inequities.

Once agreement was reached about those populations, subjects were recruited for focus groups and key informant interviews using purposive sampling, which draws on the networks of the researchers and local resources to find people who have valuable information to contribute to the research questions.[25] Professionals, organizations, advocacy groups, and coalitions working with our populations of focus were contacted and asked for guidance about recruiting.

Focus group and interview questions were developed in consultation with the CHNA Committee.[26] Before each event, the CHNA team reviewed information about the scheduled guests to understand their roles, services offered, and populations served. Questions were then adapted specifically for those participants.

Key informant interviews and focus groups were semi-structured to ensure the primary research questions were addressed while also allowing for a conversational style so participants could discuss what was most important to them.[27] Questions focused on the most pressing health and social needs of the populations of focus, services and programs that were working well to address those, ideas about what could better address the community’s needs, and what participants wanted hospitals and health care systems to know.

Key informant interviews and focus groups were facilitated by an IPH research associate with expertise in qualitative research methods. Seven focus groups were held virtually over Zoom, and one was in person. All 12 key informant interviews were held on Zoom. With permission from the participants, interviews and focus groups were recorded and then transcribed. After each, the facilitator and note takers debriefed to discuss the themes that emerged.

Two IPH research associates then separately analyzed the notes taken, the debriefing notes, and the transcripts to code the data. Using iterative thematic analysis, which included both deductive (using pre-determined categories) and inductive (creating new categories) approaches, the data were categorized into initial themes.[28]

The CHNA team then met to compare these analyses. Similar codes were merged into one when they pertained to similar topics and then clustered into main themes and sub themes. Each theme was supported by statements and quotes from the interview or group. When questions arose, researchers followed up with participants to ask clarifying questions.

Online Survey

The online survey was informed by the survey utilized in the 2022 CHNA and available in English and Spanish.[29] The survey was distributed to community partners across San Diego. The County of San Diego distributed the survey to their regional Live Well Groups as well as other health and public health listservs, including five different regional community updates through the Office of Equitable Communities. Community partners were asked to distribute the survey link to their colleagues and clients, a sampling strategy known as snowball sampling.[30] The survey was taken 1,037 times.

Prioritization

Once initial analyses were completed, the CHNA committee met to determine which community needs should be central to this report. We considered:

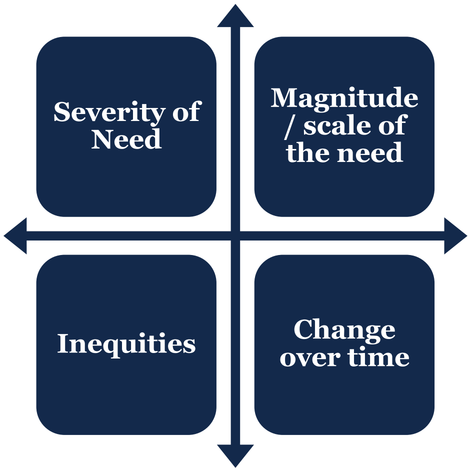
Severity of need: What is the potential to cause death or disability?

Magnitude/scale of the need: How many people are affected?

Inequities: Are some populations at greater risk for this condition, based on geography, languages, ethnicity, culture, citizenship status, economic status, sexual orientation, age, gender, or others?

Change over time: Has the condition improved, stayed the same, or worsened?

Prioritization Criteria



The findings from these assessment methods are presented in the next section of this report.

Primary Finding

San Diegans are Experiencing Debilitating Stress

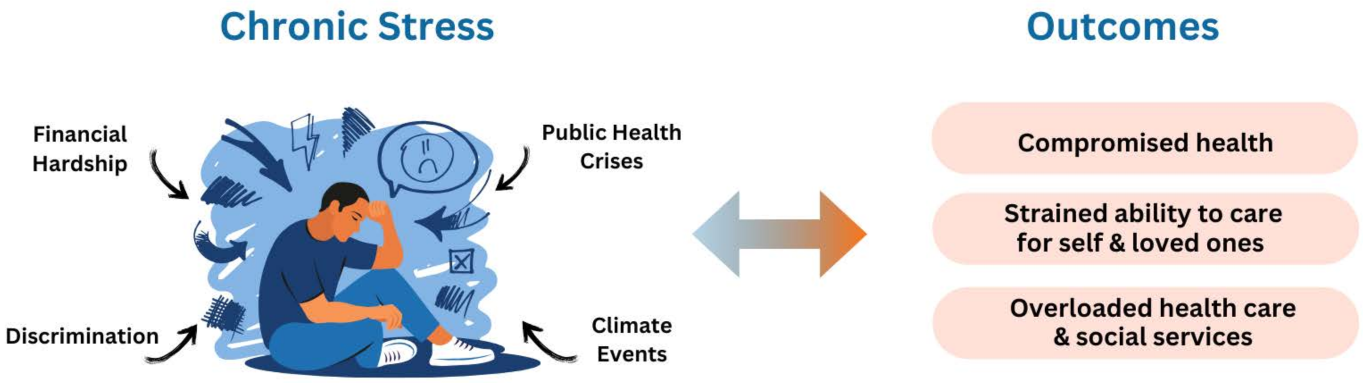
“*You are stressed out all the time, you don’t know what to do, you feel lost*.”
– Focus Group Participant

“We all carry our backpack of stresses. The things we keep quietly and the things we speak out loud.” – Focus Group Participant

“*Our patients are in a very chronic stressful reaction.”* -- Key Informant

Our community is under significant, ongoing, debilitating stress. This was what our community emphasized in field interviews, key informant interviews, focus groups, and the online survey. And this stress, they said, has devastating impacts on their bodies and their ability to manage their health care and that of their loved ones.

Health care and social service providers told us that that this chronic, severe stress has resulted in increasing numbers of community members who are sicker than ever, seeking help within a system that is overburdened. The result is that, at the very time our community needs care the most, the capacity to provide that care has diminished. The graphic below illustrates this finding.



The impacts of stress on human biology are well-documented. In fact, a search of “chronic stress impact on health” in the National Library of Medicine database yields more than 600,000 research articles. This research illustrates that chronic stress is associated with

- decreased immune system functioning
- cardiovascular and respiratory disease
- diabetes
- drug dependency
- cancer morbidity and mortality
- gastrointestinal issues
- sleep disturbances
- obesity
- cognitive impairments
- mental health concerns, and
- chronic illnesses.[31]

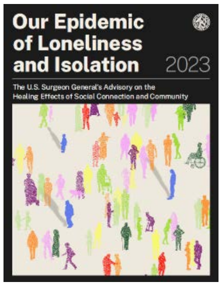
In fact, critical protective materials on chromosomes, called telomeres, deteriorate when people are exposed to ongoing stress and trauma.[32] Emerging research has also documented that DNA modifications caused by trauma can be passed to offspring, continuing a cycle of poor health in future generations.[33]

Three recent national reports have called attention to the impact of chronic stress on health.

In their report ***Stress in America 2023: A Nation Recovering from Collective Trauma,*** the American Psychological Association details increasing rates of chronic illnesses and mental health conditions and the struggle of many Americans to plan for the future because of stress in their daily lives.[34]

Stress in America 2023

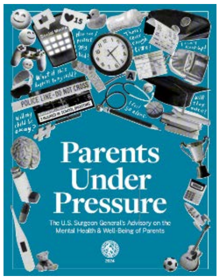
A nation recovering from collective trauma


Our Epidemic of Loneliness and Isolation 2023

The U.S. Surgeon General's Advisory on the Healing Effects of Social Connection and Community

A 2023 Surgeon General's Advisory, ***Our Epidemic of Loneliness and Isolation,*** documented the significant negative health consequences of the stress caused by Americans' pervasive levels of loneliness.[35]

In 2024, an additional Advisory, ***Parents Under Pressure*** was released, outlining the incredible pressure parents and caregivers are facing and the impacts of this stress on parent and child well-being.[36]


Parents Under Pressure

The U.S. Surgeon General's Advisory on the Mental Health & Well-Being of Parents

2024

The community agrees with the national research. In field interviews, when asked what factors contribute to poor health, the most common answer was, simply, "stress." Other similar answers included "personal issues," "financial concerns," and "work issues."[37] The community also emphasized that being under constant stress interferes with their capacity to seek out, receive, and manage the health care that they need to maintain their well-being. Health care workers, social service providers, hospitals, and health care systems are a part of this community. They, too, reported being overwhelmed by high levels of stress.

Stressors

- Financial Distress
- Climate public health events
- Racism, prejudice, discrimination
- Continued challenges from the COVID-19 pandemic

Stressor: Financial Distress

"Do I pay for food, or do I use my last money to get some tampons?" – Key Informant

"Even amongst us, the staff here … we're like, man, things are rough… Our own pockets are suffering. And we're coming to work to try to help other people but sometimes we're short and it's like, what do we do? We have a full-time job and we're here to help people, but then who helps us?" - Focus Group Participant

1/3 of people in San Diego do not earn enough to be self-sufficient

The San Diego Foundation Economic Equity Report

Our community is struggling.[38] In field interviews, the community emphasized that financial hardships are worsening people's health, and in the online survey, "not having enough money to pay the bills" was selected as a top community concern.

According to Self-Sufficiency Standards calculated by the County of San Diego, ***the minimum hourly wage for one person to support themselves in San Diego is $28.42 – $58,744 a year***. In a household with two adults and two children, their yearly income needs to be $97,861.[39] The current minimum wage in the City of San Diego is $17.25 per hour (slightly more than the California state minimum wage of $16.50 per hour). At $17.25 an hour, a person's full time annual income is $35,880.

About 11% of people in San Diego County live below the federal poverty line,[40] and more than a third do not make enough money to be self-sufficient. These numbers are even more startling for many people of color: 51% of Hispanic San Diegans and 46% of Black San Diegans do not earn self-sufficient wages.[41]

Two specific financial burdens were mentioned most frequently by the community: *the costs of housing and food*.

Housing Costs

"We have an unprecedented number of people who are living in their cars."
– Key Informant

"I've been looking at places, and I have two kiddos, and my elderly mother lives with us. So for a three bedroom, it's crazy, crazy, $4,000." – Focus Group Participant

"[Older] people are getting priced out of their units because we don't have rent control. And you have seniors who are on fixed income who can't sustain those units if they don't have that long-term subsidy. So, you're seeing a lot of first-time homeless folks. And the fact that the 55 and over number continues to grow is very concerning." - Key Informant

The 2023 San Diego County Housing report notes that San Diego's average monthly rent is $2,391, necessitating a wage of $45.98 per hour to make the rent affordable for an individual. More than half of people renting in San Diego spend 30% or more of their income on rent or mortgage payments. The situation for low-income households is especially troubling: 82% of extremely low-income households spend more than half their income on housing.[42]

In the online survey and field interviews, housing costs were often named as contributing to poor health. And in focus groups and interviews, the community spoke frequently of their constant worry over having a place to live. Service providers told us that many of their clients now live out of their cars. Some groups of people, like older adults, were recognized as being at particular risk of losing their homes.

Food Prices

"We're having a rough time accessing food sometimes … and I can't even imagine putting myself in the shoes of our clients that … have to say, well, I have to drive the kids to school, but then I also have to feed them, so let me figure out what our priorities are."
- Focus Group Participant

Food prices across the US have risen substantially over the past several years. In 2022, the price of groceries increased by 11.4%, and in 2023, they rose an additional 5%.[43] The cost of a home-cooked meal in San Diego in 2023 was $3.64, surpassing the maximum CalFresh benefit of $2.83 per meal by 29%, meaning that even when families receive this benefit to help cover the cost of food, it isn't enough.[44][45]

People who rely on benefits like CalFresh are often faced with terrible decisions about their benefits: they can't survive without them and even a slight rise in wages may render them ineligible. Service providers told us stories of clients who had to turn down raises because the increase in their pay would lead to the loss of benefits, while not providing enough income to make up the difference.

Stressor: Racism, prejudice, discrimination

“*You learn as a person of color early on that your voice is not heard and not wanted*.” – Key Informant

“*Young people who are in LGBTQ communities or in families that have LGBTQ members are being suppressed. And outwardly, emotionally, experiencing violence…that is the biggest health crisis that is happening to young people right now.*” – Key Informant

Community members reported that levels of racism, prejudice, and discrimination seem to be rising in San Diego County. They told stories of experiencing racism and homophobia and anti-transgender violence in the community. They also talked about witnessing hostility against unhoused people.

39% increase in hate crimes reported by San Diego County residents from 2022-2023

San Diego Association of Governments

These experiences are reflected in local statistics. The San Diego Association of Governments collects data from numerous local police and sheriff departments. Their data show steady increases in hate crimes since 2021, with a 39% increase from 2022 to 2023. The majority of the crimes were motivated by race, ethnicity or national origin (more than half of which were anti-Black), followed by sexual orientation, religion, and disability. [46] Nationally, the American Psychological Association states that 45% of LGBTQIA+ adults, 43% of Black adults, 40% of Latino adults, and 34% of disabled adults report that discrimination is a significant daily stressor.[47]

Stressor: Ongoing challenges from pandemic, including long COVID

“*When I'm down, I'm completely down... sometimes I tell my kids I feel like... I can't formulate sentences the way that I want to. The brain fog is so severe*.” – Key Informant with Long COVID

San Diego County reported 156,475 confirmed COVID cases and 626 deaths from COVID in the 2022-2023 fiscal year.[48] In 2023-2024, 48,876 confirmed cases of COVID were documented, along with 362 deaths (compared to 63 from the flu).[49] These numbers are likely an undercount due to changes in testing habits and reporting requirements.[50]

Impact of COVID-19

PTSD
Grief
Burn-out
Collective trauma
Lack of social skills
Workforce shortages
Health complications
Delays in motor skills
Academic deficiencies

While this is a substantial decrease from COVID deaths in 2020-2021, the community emphasized to us that they continue to observe and experience lasting consequences from COVID. They discussed deficiencies in academics, motor skills, and social abilities in children. Health care workers and other service providers told us about workforce shortages, staff burn-out, and diagnoses of PTSD from working during the pandemic. We also heard about the grief of losing loved ones to COVID and the difficulties of adjusting to complications from COVID, including Long COVID.[51]

In the American Psychological Association's *Stress in America 2023: A Nation Recovering from Collective Trauma* report, the APA observed "*signs of collective trauma among all age cohorts*" resulting from the pandemic, and their Chief Executive Officer, Dr. Aurther Evans emphasized *"While the early-pandemic lockdowns may seem like the distant past, the aftermath remains*."[52]

Stressor: Climate and Public Health Events

> *"At least 200 to 300 homes had water up to a foot under their ceiling, completely submerged…and no one has tracked anything. No one has tracked mold exposure. No one has tracked deaths. No one has tracked mental health outcomes… no one's tracking hospitalizations, urgent care visits, primary care visits. No one is tracking all of the symptoms that come with it. I've had reports from family members … having pneumonia and then dying days later, lots of people ingested the water. We have lots of rashes and all kinds of skin conditions. And again ... the specific community that was impacted has high rates of asthma, high rates of eczema, high rates of cardiovascular disease, all these things like that."* – Key Informant

> "*El olor es insoportable, y podemos enfermar*."
> [**Translation:** The smell is unbearable, and we can get sick.] – Field Interview Participant
>
> "*En donde vivo los apartamentos se ponen muy calientes que a mi mamá se le baja la presión y a mi me dan muchos diles de cabeza (la migraña)*."
> [**Translation**: Where I live, the apartments get so hot that my mom's blood pressure drops, and I get a lot of headaches (migraines).] - Field Interview Participant

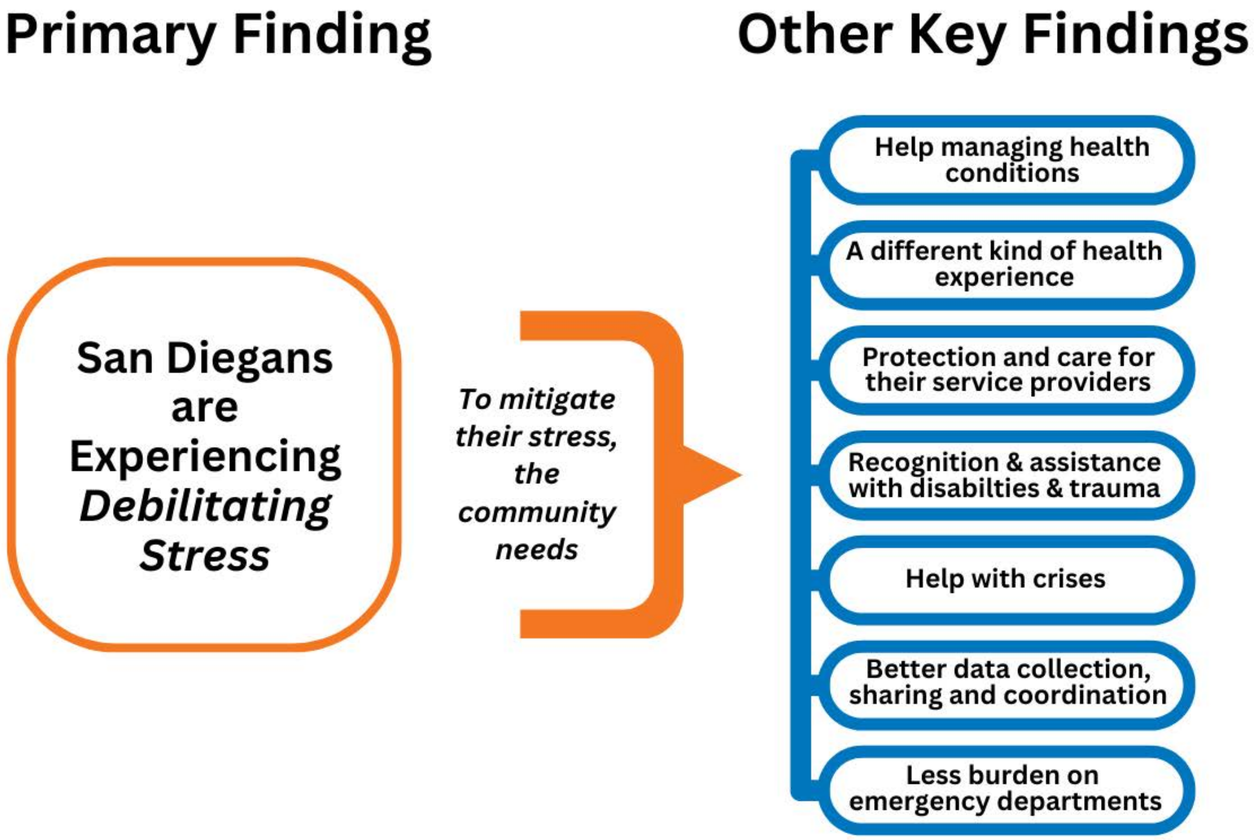
The past few years have brought San Diego several serious climate-related and other public health disasters.[53] [54] In field interviews, nearly half of respondents said that it had been so hot that it impacted their daily lives; in the online survey 57% reported heat-related interruptions to their daily lives. Across data sources, many people reported experiencing flooding, with devastating consequences for neighborhoods in Southeast and South San Diego.[55] Others reported living through wildfires, smoke, high winds, and storms. And for those residing along the Tijuana riverbed, they contended with horrible smells and fumes that some researchers have documented as toxic to health.[56] [57] [58]

These disastrous events, along with continuing repercussions from the pandemic, pervasive racism and prejudice, and financial hardship, along with other stressors, have plunged our community into a continuous state of extreme stress.

It is within this context of this enduring and severe stress that this needs assessment was conducted, and with that in mind, we asked the community what they needed from hospitals and health care systems to mitigate it, and, therefore, improve their health.

Key Findings

The community was sympathetic toward and understanding of the pressures facing health care providers and recognized that hospitals and health care systems cannot solve complicated societal issues, like the current housing crisis and high cost of living in San Diego. When we asked how hospitals and health care systems could help reduce their stress and improve their health, however, needs assessment participants outlined several strategies, as illustrated in the graphic below and discussed in the following pages.



The Community Needs Help Managing Several Specific Health Conditions

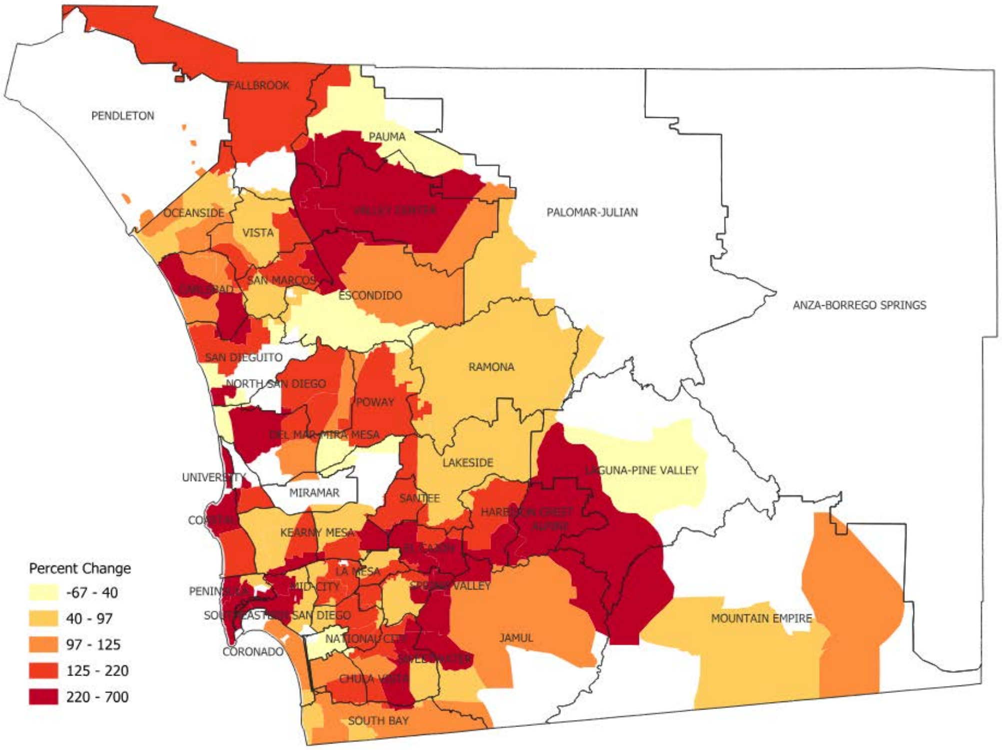
2025 CHNA FINDING

When we asked the community about specific health conditions they were concerned about, they discussed several conditions. We present detailed findings about each, in ***alphabetical order below***.

The Community Needs Help Managing					
Asthma	**Blood Pressure**	**Cancer**	**Dental Health**	**Diabetes**	**Mental Health**

Asthma

Between 2022 and 2023, data show a statistically significant increase in inpatient hospital discharge rates for asthma. For all patients, the rate increased by 100%, and for children (ages 0-17), they increased by an alarming 266%, as shown in the map below.



In field interviews, 11.3% of people who had concerns about their children named asthma as the primary concern. In San Diego, people who live in census tracts that were previously redlined are much more likely to be treated in emergency departments for asthma.[59] [60]

The community emphasized that the severe flooding and the sewage crisis in some regions of San Diego in 2024 have worsened respiratory issues.[61]

Blood Pressure

In field interviews, blood pressure was the most frequently named health concern for adults, named ***by 29% of people***. Additionally, 9% of people who were worried about ***their children's health said blood pressure was the most serious concern***. Hospital discharge data supports the community's concern. From 2020-2022, rates of ED discharges for hypertension increased across all ages, including children. Every week in 2022, there were more than 15 pediatric hospital discharges with a primary diagnosis of hypertension.[62]

Cancer

Cancer is the leading cause of death in San Diego County.[63] From 2018-2022, 25,321 San Diegans died of cancer. From 2017-2021, 77,781 cases of cancer were reported, a rate of 426 per every 100,000 people. The highest rates of cancer in San Diego are among Native Alaskans/American Indians (453.1 per 100,000).[64] In the online survey, 24% of respondents chose cancer as a top health concern. In our interviews and focus groups, participants talked about how difficult it is to manage cancer care.

The following story from a key informant, speaking about their own experience with cancer, is illustrative of what we heard:

> *"I was diagnosed with melanoma in September, and I had to have surgery in November, and I had three surgeons. I had a general surgeon, a plastic surgeon, and an ENT. And I kept getting calls from each of these three offices, saying, 'Be here at seven, be here at nine, be here at 10:30.' And so finally I said, 'You need to get your (act) together and somebody tell me what first time I need to be there because your offices are not communicating.' And if I was not someone that …understood the health care system, I'm going to show up at the last time the person told me to at that last phone call…*

> *So I had a conversation with the general surgeon who was kind of leading all of this, and I was like, 'You need a patient navigator…' he's like, 'Well, we use them for breast cancer patients but not melanoma patients…' I can only imagine if I wasn't as mouthy as I am, if I wasn't the advocate for myself that I am, and if English was my second language. It was miserable enough experience for me who is someone of privilege who does understand the system. I shouldn't have to worry about that when I have cancer…*
>
> *Here's another thing. So we went in for surgery that day, and no one told us that children aren't allowed under 12 in the hospital. So we were trying to not have my daughter worry. She's six. And so we get to the door at the hospital and they're like, 'Kids can't come in.' And I'm like, 'Are you kidding me?' So then we had to, on the fly, change our plans for my daughter, which created more anxiety for her. And then I go through the first procedure and get to the second one, and by that time my husband's back and they're like, 'Your surgery has been pushed until 1:30...'*
>
> *And so I had no childcare plan, nobody to pick up my kid from school. But nobody bothered to call and tell me. I cannot imagine a single mother who used public transportation to get there and was planning on getting out of the hospital as uncomfortable as they were going to be. They had to pick up their child at school that day, even though they were in pain and still medicated…and the system did not care about that."*

Dental Care

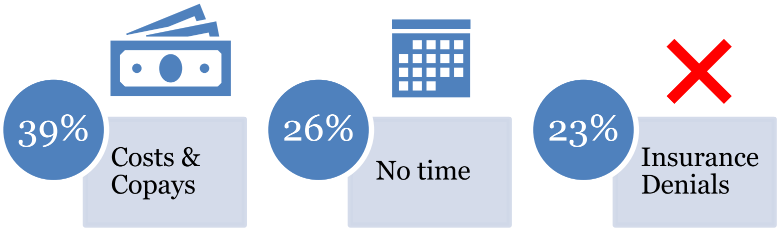
Our participants frequently discussed concerns about the challenges San Diegans face in obtaining dental care. They noted that for people under extreme stress, dental care does not seem important. One community member who had previously experienced homelessness described it this way:

> *"Because we haven't been in so long, and we are still on Medi-Cal, even the thought of calling to find (a dentist) in my neighborhood…is an overwhelming feeling… I've lost two teeth… I had beautiful teeth. You don't get to, I don't want to say pamper yourself, you don't get to do those everyday things. That's not even pampering. We're just talking about human things."* – Key Informant

Other concerns community members voiced about dental care included not having dental insurance, finding dentists who accept their insurance, believing dental care is not a high health or financial priority, challenges finding dentists who speak the community member's language, and feeling unsure about whether their concerns will be addressed or if dentists will "*extend the process*" to make more money. Dental care was noted to be of particular concern for seniors, immigrants, pregnant people, people experiencing homelessness, and children.

In the online survey, participants were asked to choose the ***top reasons that people do not or cannot maintain good oral health care*****.** The reasons chosen most often are highlighted below:

Online Survey: Top 3 Dental Challenges



Diabetes

Across all data collection strategies, the community talked about diabetes as one of their most worrisome health concerns.

In field interviews:

- 25% of people with health concerns for themselves or an adult loved one named it as a top health concern
- 15% of those who were concerned about their children's health named diabetes as their most serious concern.

In the online survey:

- 29% of respondents indicated that diabetes was the health condition having the greatest impact on adults in San Diego – the second most frequently chosen condition after mental health.

In San Diego, 9.8% of people have diabetes.[65] Death rates from diabetes are much higher for Non-Hispanic Black residents (47.4 per 100,000) compared to the overall death rate due to diabetes in San Diego County (27.6 per 100,000).[66]

Diabetes is a chronic condition that requires ongoing self- and medical care. In focus groups and interviews, our community discussed the challenges many people have in maintaining this care, including having easy access to and knowledge about the right foods for people with diabetes to eat, monitoring blood sugar levels, and administering medications. They also talked about community members being hospitalized for diabetes-related health problems and then being unable to sustain the progress they make once released from the hospital:

> *"...Then they get out, and they go back to their former way of eating. Nobody's there to come in and give them their injections or check their blood sugars all the time."* - Focus Group Participant

One community member told us the story of her daughter's diabetes: her adolescent daughter, she told us, is not compliant with medical advice, so her sugars are always high. As a result, the daughter ends up in the emergency department at least once or twice a year. This community member was desperately seeking a program or services that would work directly with her daughter on this issue.

Mental Health and Substance Use

As with past CHNAs, the community reports being very concerned about mental health and substance use.

In the online survey, mental health was identified as a top health concern.

43% of survey respondents identified mental health as the health condition having the most serious impact on adults.

The top 5 behavioral health concerns identified for adults and older adults were:

- Depression
- Anxiety
- Co-occurring disorders/conditions (mental health conditions that occur alongside substance use disorders)
- Chronic stress
- Alcohol misuse

40% of survey respondents identified mental health as the health condition having the most serious impact on children.

The top 5 behavioral health conditions identified for children were:

- Anxiety/Depression
- Adverse Childhood Experiences (ACES)
- Early Childhood Development & Disabilities (Autism, learning delays)
- Attention-Deficit/Hyperactivity Disorder (ADHD)
- Suicide & Suicidal Thoughts

In field interviews, mental health was also identified most often as a top health concern.

- 27% of people who were worried about their own health or that of an adult loved one ***reported that mental health was their most serious concern***, second only to blood pressure.
- For those worried about a child's health, 17% named ***mental health*** and another 17% named ***behavioral problems*** as the primary concern.

Data from the most recent Youth Behavioral Risk Survey (YRBS) in the San Diego Unified School District supports this concern. More than 40% of high school students reported feeling sad or hopeless almost every day for more than two weeks in a row – so sad that they stopped some of their usual activities; 21% reported seriously considering attempting suicide; and 10% reported a suicide attempt in the past year. About a quarter of students said that their mental health was most of the time or always not good (including stress, anxiety, and depression).[67]

40% *of San Diego Unified High School Students report feeling sad or hopeless almost every day*

21% *of San Diego Unified High School Students reported having seriously considered suicide.*

In San Diego County, death by suicide is most common among males, people 65 or older, Non-Hispanic Whites, and people living in the East region.[68]

Inpatient hospital discharge data from 2020 and 2022 ***show statistically significant increases in discharges for suicide attempts for people 0-17 years old (17%). The most alarming increases across race/ethnicity were seen in Asian individuals (48%) and Black individuals (18%).***[69]

In our assessment, community members discussed mental health extensively. They noted a severe shortage of mental health professionals, a challenge documented extensively in 2022 by the San Diego Workforce Partnership.[70] They said, consistently, that finding a mental health professional who accepts insurance – or who will take Medi-Cal -- and has convenient hours was nearly impossible.

They noted that, too often, mental health professionals were not representative of the people who most need the care, with too few therapists who are people of color or members of the LGBTQIA+ community.

Mental health care was described as fragmented, particularly upon discharge from an inpatient or emergency department admission. People are unsure of where to go in a mental health crisis, and for those with subacute mental health concerns – those who are not actively suicidal but who may become so – the situation is even worse.

> *"We know that sending someone to an emergency department for a mental health crisis is not our preferred access point, but it very often ends up being the access point."* - Focus Group Participant

The Community Needs a Different Kind of Health Care Experience

2025
CHNA
FINDING

When asked how hospitals and health care systems could improve community health, reduce community stress, and address the concerns they identified, the community had a clear answer***: they need a different kind of health care experience.*** This, they indicated, was where the health care community should be concentrating its efforts.

5 themes emerged when the community spoke about the kind of health care experience they need:

- **Respect for their time**
- **Timely care**
- **Better options for transportation**
- **Better relationships with care providers**
- **Help navigating medical system, insurance & follow-up care**

Health care experience theme:
The community needs respect for their time

"[I was] in the emergency room [for] 10 hours with my baby in my arms waiting to be seen." – Field Interview Participant

Community members were clear that setting appointments and receiving health care is burdensome: 32% of people in the online survey said that they have "no time" for care. It takes, they noted, too much time away from work and caring for family members. Long waits at medical offices, urgent cares, emergency departments, and on phone lines make community members feel disrespected and keep them from getting the care they need. Transportation challenges compound this problem. One community member summed up what they wanted hospitals to know in this way:

> "*Que las citas al medico sean mas cercanas y no tener que esperar tanto tiempo*" [**Translation**: Have the medical appointments be closer and not have to wait so long.]

Over and over again, community members reported that they need shorter waiting times on the phone and in waiting rooms in order to care for their health.

Health care experience theme:
The community needs more timely care

> *"People are frustrated that they have to wait two months to see a doctor when they have an immediate health concern."* - Field Interview Participant
>
> "*El tiempo de espera para una biopsia es de 6 meses o más!!*" [**Translation**: The waiting time for a biopsy is 6 months or longer!] – Field Interview Participant

In the online survey, ***long wait times for appointments*** was the most frequently chosen challenge to getting needed health care. Long waits, respondents indicated, sometimes result in delayed care or receiving care through an emergency department when the situation is not an emergency. Specialty care was described as being especially difficult to obtain, and some informants noted that receiving imaging/radiology services has become especially challenging.

Long wait times for appointments were again the most frequently identified barrier to getting needed health care in field interviews.

Community members also shared that they need more appointment availability outside of work and school hours.

Health care experience theme: The community needs better options for transportation

"*Provide more routine transportation to medical services.*" – Field Interview Participant

"*Providing more transportation for the elderly might help them get the help they need.*" – Field Interview Participant

"*Sometimes it's hard for people who are unable to take care of themselves to make it to the hospitals because they don't always have someone to take them.*" – Field Interview Participant

Community members frequently discussed the location of health care sites, and many people said that medical offices, hospitals, and clinics are too far from home. Limited options for affordable, convenient transportation can make it exceptionally challenging to receive needed health care. ***24% of respondents in the online survey selected transportation as a top challenge accessing health care.***

In field interviews, the community chose both ***"transportation"*** and ***"having care closer to home"*** as two of the most important things that would make it easier to get needed care.

Focus group and key informant interview participants noted that insurance sometimes covers rideshare services like Lyft/Uber, and pointed out that many people don't know about it and/or don't understand the rules about how to obtain it. Additionally, insurance may only allow for one or two rides per month, and some patients need multiple trips for labs or other appointments. When people do access ride sharing options, they are, at times problematic. For people who live in rural areas, a focus group participant told us, for example:

> “*We had a patient whose insurance contracted with Uber. So Uber was supposed to come pick her up from her house. She lived in Boulevard, and Uber could not find her. And because that happened, Uber canceled on her. She missed her appointment and had to be seen two weeks later*.”

For those with mobility issues, ride share drivers are not always able to assist them with issues like guiding their walker. And for some, getting into a car with a stranger feels uncomfortable or scary.

Public transportation in San Diego was noted to be expensive and inconvenient. In focus groups, it was noted:

> *“The bus takes forever, and if you have multiple kids, it’s challenging. It’s also expensive.”*

> *“Transportation really sucks. So, you're not able to get around and it's expected that you walk, even after you get off, half a mile to get to your destination, and you're not able to get back to where you need to get back to. So, people just don't bother with it in some cases.”*

Health care experience theme:
The community needs a better relationship with their health care providers

“Relational care leads to better health outcomes.” – Key Informant

Community members want a different kind of relationship with the people who are involved in their care.

A better relationship with their care providers includes:

- More time with their health care providers
- More empathy
- Better communication
- An understanding of racism & discrimination
- An understanding of cultural & identity differences
- An understanding of the power dynamics

The following is a story one key informant told us when explaining why they felt that relationships between health care workers and patients need to be examined and improved.

> *“I do my own self breast exams every now and then. I happened to find a lump. It was very disturbing. The lump is huge, probably … about half of the size of a golf ball. So I go to my provider…Primary care doctor refers me for imaging. So I go to the site… where I'm supposed to get the imaging done. I share… what I found. They couldn't find it. We know the disparity rates in cancer and Black women… and just all the issues that come with that.*
>
> *And so I'm lifting my arm. I don't understand why she can't feel it. It is very pronounced and obvious to me. We go through three different types of imaging. Ultimately… the highest imaging for mammography was done. I had to fight for that though. I had to fight for it to the point of tears. I was so done. I was so irritated and frustrated with arguing with the provider about why she couldn't, not only feel what I was feeling, but also see on imaging what I was seeing. She was adamant that it was not there…By the time we were done, they found 11 different fibroadenomas in my breast. The largest one I think was like 3.5 by 5.*
>
> *I was just so frustrated. And I am like, if I didn't know any better myself to push for it, to advocate for it, to talk to them about Black women and dense breast tissue, and pushing… and I'm just like, 'Why couldn't you just listen to me?' And I did feel like, because I told you that I'm an [advanced care clinician], obviously there's some clinical knowledge there, and I felt like what I was saying was making sense, but I might as well have been talking like somebody off of Charlie Brown because it just wasn't received. And also, at some point, I began to be treated as if I was hostile. There were some, ‘should we call security?’ moments in there. And I remember calling my husband just in tears, I don't know what to do in this moment. I can't believe I'm experiencing this, but obviously I can believe it because it happens to so many people.”*

This story exemplifies what we heard from many community members: that at times in their appointments, they were rushed, felt dismissed, experienced racism and discrimination, and were caught in a power dynamic in which they had no power.

A better relationship with their care providers includes:

More Time with Health Care Providers

> *"The vast majority of doctors simply seem to be more concerned with churning through patients rather than the care and attention they give them. This has life-threatening consequences."* – Field Interview Participant
>
> "*Shorter visits make it harder for patients to get the information they need and ask the questions they have*." – Focus Group Participant

Community members understood and acknowledged the pressure health care workers are under to see as many patients in a day as possible; nevertheless, having more time with care providers was brought up repeatedly as essential to good health.

In field interviews, participants consistently expressed that they wanted us to tell hospitals and health care systems that they need more time for appointments so that they can fully discuss their concerns.

This was also noted in the online survey as a factor that keeps people from getting the care they need.

A better relationship with their care providers includes:

More Empathy

> "*Many people I work with feel dismissed because they [could not] communicate their problems or felt they were not believed, so it made them avoid going to the [ED] or a doctor and [they] only went when pain was overwhelming. People are made to feel that they're lying or exaggerating*" -- Focus Group Participant

Community members emphasized that they want caring, compassionate care from their providers and too often feel dismissed.

In field interviews, when ***asked "what they wanted hospitals and health care systems to know,"*** the most common answer related to the quality of interactions between health care providers and patients.

Participants were direct in expressing that they want health care workers, particularly doctors, to be more empathetic, nurturing, and patient. Examples of their comments illustrate this recurring concern:

"To have more genuine compassion, understanding, patience, and care for their patients."

*"Por favor sean mas empaticos con sus pacientes y pensar mejor cómo dar el diagnóstico de un paciente con medir sus palabras o pensar antes de decir su enfermedad" [*__Translation__*: Please be more empathetic with your patients and think better about how to give a patient's diagnosis by measuring your words or thinking before saying their illness.]*

"Believe the patients"

"Be more patient and believe the patient"

"Doctors should be more empathetic with the patient"

*"Que los medicos tengan un poco de consideracion en las necesidades del paciente." [*__Translation__*: That the doctors have a little consideration of the patient's needs.]*

*"Que los medicos sean mas empaticos con el paciente y puedan cubrir sus necesidades." [*__Translation__*: That the doctors be more empathetic with the patient and be able to meet their needs.]*

A better relationship with their care providers includes:

Better Communication

> *“I had an experience with a patient recently [when I did not speak the language she spoke] … The translator was saying extra things, and it was a male translating for a female, and the patient was saying one little thing and not understanding, and we would say something quick like, 'Push strong.’ And the translator just said a lot of different words, and I wasn't sure if that's normal, but the translator then admitted, ‘Oh, I'm explaining it to her.’ And I'm like, ‘No, no, no, you just translate exactly what we say, don't say extra things.' And we ended up switching to a female translator and then the patient was actually vocalizing what was going on, what she was feeling, and she was able to push more effectively. Probably because she felt more comfortable…That is my concern …for patients, even if you use a translator, they may say extra things, or the patient may not feel comfortable because it's a phone or it could be a gender preference… or whatever.*
>
> *But yeah, this poor woman had to push for over an hour because of the way the baby's head was, and this was her baby number four, and she'd never pushed this long before. And they were very confused. I was trying to explain, it's because the baby is looking up, it's not coming out the easiest way. And in the end, baby came out fine. It was all beautiful and happy ending, but the actual pushing part was very challenging. And now in hindsight, probably very uncomfortable for her, with the translator she had … she never let on that she was uncomfortable with the male translator, but she was.”* – Key Informant

This story exemplifies one of the key findings from our assessment: the community needs better communication between health care workers and patients. In particular, the community is calling for better translation services and clearer, more relatable explanations of their health conditions and treatment.

Translation

For community members whose first language is not English, an important component of improving their relationships with the people who care for them is to have readily available, more accurate, more appropriate translation. A significant concern is the limited availability of staff proficient in Spanish.

More than ***100 languages are spoken in San Diego County****, and more than 35% of people in San Diego County speak a language other than English at home.*

County of San Diego, Health and Human Services Agency, Public Health Services, Community Health Statistics Unit

25% of field interview participants commented that having help in their language would help adults get the care they need, and 28% noted that it would help them get the care they need for their child. Translation also frequently came up when the community was asked what they would like for hospitals and health care systems to know.

When timely, appropriate translation is not available for people, other options are utilized. From some community members, ***we heard about children serving as interpreters for their parents.*** This results, at times, in children hearing personal details about their parents' health and in inaccurate translation:

> "*You learn so much about the intimate facts of your parents' life that maybe you shouldn't*." – Focus Group Participant

> *"There are pressures among children being translators, [children] who are born here about not being able to translate the Haitian Creole well enough."* –Focus Group Participant

Often, interpretation services are used on phone lines and tablets, which can lead to discomfort for patients:

> *"When the interpretation phone line is used, the community does not know the translator, so they feel uncomfortable divulging information to a voice they don't know. It's also difficult to translate over the phone*." – Focus Group Participant

Accountability in translation was also named as an important issue:

> *"Yeah, one thing worth noting…the translator was ... like taking stuff out of the translation. And luckily, the parent caught that. That kind of messed up the dynamic between the therapist, the parent and the kid, as well as*

> *the translator, that they ended up just ending the meeting… So accountability within what's being translated*." -- Focus Group Participant

Better Explanations

In addition, community members expressed that they do not always fully understand their health conditions or how to manage them. In the online survey, 12% of people checked "I don't understand my health condition" as a reason that keeps them from getting them the health care they need. We heard concerns about adequate explanations as well:

> "*People will go to the doctor and come back not knowing or understanding what they have. People are not taking medication regularly because they feel they don't need it unless they are not feeling well." –* Focus Group Participant

> **"***Take the time to explain what is going on! Why you are giving a certain medication, why it is preferable compared to other medications?"* – Focus Group Participant

Participants also said that when some people are discharged from the emergency department or after a hospital admission, they do not seem to remember and/or understand the discharge instructions and do not find the printed instructions useful.

A better relationship with their care providers includes:

Acknowledgement and Understanding of Racism and Discrimination

> *"I don't think they're aware of their cultural biases... And I'll give a personal example. I went to [an] emergency room… and I have insurance, had my insurance card, all those things. And when I went in, I was having complications from medical treatment that I had in Mexico. And immediately, they wanted to turn me away, and I had to fight and be like, 'No, I am a patient [in this health care system]. You need to treat me for my current symptoms.' I really had to fight and advocate, because I was being judged that I was coming from across the border seeking emergency services... Yeah, it was just not a very great experience. And there might be some people who feel intimidated, and would have turned around and walked out, and ended up internal bleeding to death, and die, or something like that. So even down to the administrative intake people, really being aware of the language they're using when somebody comes*

> *into their clinic, emergency room, whatever it is, down to the appointment hotlines … of leaving personal bias, opinions out."* – Focus Group Participant

Participants in the needs assessment were aware of health inequities, and many had experienced these inequities themselves. They frequently discussed the underlying causes of many of those inequities - racism and discrimination.[71]

As illustrated in the story above and the one that began this section, community members find it both frustrating and disrespectful when they feel health care workers do not have an understanding of those inequities and seem unaware of their own inherent biases and prejudices. Another participant noted:

> "*We need to recognize the systemic racism that has been built into our medical systems and to make a commitment, collectively, to resolve it*." – Focus Group Participant

A better relationship with their care providers includes:

An Understanding of Cultural and Identity Differences

> "*I am never called my name through my doctor. I always have to be called my legal name, and I have to redirect it, and I have to change it. And the next person walks in, and they call me my legal name, and it's just a constant…for many people if they walk in, and they're deadnamed, they're going to turn around and walk out."* – Focus Group Participant

Similar to their feelings about racism and discrimination, community members talked extensively about feeling as if their cultural backgrounds and other identities – such as being a member of the LGBTQIA+ community – were not understood or respected.

Conscious efforts to not misgender/deadname

Deadnaming is when someone is referred to by a name they do not, or no longer, use. Misgendering is labeling someone as a gender with which they do not identify: this often shows up as calling someone by the wrong pronouns. Both are common experiences for the LGBTQIA+ community when receiving health care. Our community members described it like this:

> *"For the whole LGBT community, that cultural humility, that cultural competency is so important…Even well-meaning medical providers don't know that they're causing harm*." – Key Informant

> *"My transgender clients that already changed their name. They call them sometimes with the other name. They told me, 'I feel so ashamed… When they say Victor, I want to look at the other side. I want to be called Victoria.'"* – Focus Group Participant

Several community members told us they followed the required procedures to update their names in the electronic medical records, but that health care providers continued to call them by the wrong name or pronouns.

Conscious efforts to understand cultural differences

Awareness of cultural differences is vital to good health care, the community told us. In some communities, people explained, a lack of cultural understanding has resulted in people being unable to access care. In the online survey, 14% of people chose "health care providers do not understand my culture" as one of the challenges of getting the health care they need. Many participants said they wanted to tell hospitals and health care systems to find ways to be more culturally sensitive:

> "*To be more culturally appropriate when relaying a message or information.*" – Field Interview Participant

> "*Que sean concientes de la cultura y e idioma que hablamos algunas familias latinas*" [**Translation**: That they be aware of the culture and language that some of us, Latino families, speak.] – Field Interview Participant

> *"Culturally, male doctors are not allowed to touch female community members. This is a problem with prenatal care in particular*." – Focus Group Participant

A better relationship with their care providers includes:

An Understanding of Power Dynamics

> *"One of our welcome desk staff gets misgendered all the time, and it has significantly impacted their mental health. It has impacted their mood. There's anger, there's frustration… And the power differential in that. There are people that think doctors and nurses are gods and have all the answers for everything and anything they say is right. And when that power differential is there and you're misgendered, your chart has the wrong pronouns, you are called the wrong pronouns in the room, it's*

> *hurtful. It's hurtful to your spirit. But I think that many providers don't understand the power differential that happens in that room.* – Key Informant

A common theme that emerged from our focus groups and interviews was that the perceived power differential many people feel in health care settings makes appointments with health care providers uncomfortable. The community spoke to us about what it feels like to be on the side of a power dynamic where they are dependent on having a good experience at the doctor's office, sometimes for a life-or-death matter. This power dynamic can interfere, our community said, with a patient's ability to ask questions and understand instructions about the management of their care:

> "*Stepping into the doctor's office can be intimidating, especially for my clients of color who get in there and aren't necessarily talked to as a person or respected*." -Focus Group Participant

> *"The moment a doctor steps into the room or a health care provider steps into the room, there's a dynamic there whether we try or not, but that awareness I think is so important*." –Focus Group Participant

> *"I can remember I had to go through IVF to have my daughter, and I walked into the office one time and there was a tech that had a gown, threw it on the table and said 'Pants off, gown open in the front,' and walked out and shut the door. And I was like, 'Are you serious?' And I'm a pretty privileged person. I was like, 'No, this is not how we treat people.' In that moment, I don't think that employee recognized the power differential*." – Key Informant

Additionally, some community members perceive health care providers and hospitals as being part of a system of authority. Community members expressed fear and concern about the power of hospital systems being used against them or their families with, for example, immigration authorities. This comment exemplifies that finding:

> *"Health care providers and hospital systems need to find a way to break that association with being an intimidating institution…to reidentify themselves as: I'm here for your health. I'm not here to exploit you. I'm not here to give you the runaround. I'm not here to do all of these other things that institutions are being associated with in their lives."* – Focus Group Participant

Health care experience theme:
The community needs help navigating the medical system, insurance, and follow-up care

> *"I get frustrated when I call and I'm on hold for five minutes. I'm like, I don't have time for this. Got to go. I'll call you back later. And I have pretty decent coping skills, I'd like to think. But …all of us work with patients who don't always have [good coping skills]. Some do. But I know for the patients we serve an overwhelming majority don't and so I don't know what to do with that, but it's complicated for sure*." – Focus Group Participant

Making appointments, getting referrals, finding specialists, and completing follow up care were all noted as exceptionally challenging by our community members, even for those who work within those systems.

In field interviews, people identified the following as ***things that would make it easier for them to get health care:***

- help in my language
- help navigating how to get services
- help advocating for what I need
- help understanding my insurance

In the online survey, ***commonly chosen challenges to getting health care included:***

- insurance denials/coverage issues
- I don't know how to use my insurance
- finding needed care: how/where to find services, fill out paperwork, schedule appointments

We also heard that certain populations experience particular difficulty navigating their health care.

- ***Young adults who are transitioning to adulthood,*** particularly those who had been in the foster care system or who are having a physical or mental health crisis, often have no idea how to get care.

- ***Older adults struggle with accessing electronic medical records and appointment systems*** and with changes to their care when they switch over to public insurance once they are eligible for Medicare. We heard stories of older adults being unable to get prescriptions filled because they were unable to get in with their new primary care physicians for months after becoming eligible for Medicare.

- ***People who live in rural areas struggle to find care*** that is reasonably close to them.

- ***People who care for adults and children.***

In the online survey,

- ***18% of respondents*** indicated that ***having no childcare*** available made getting health care challenging
- ***12% of respondents*** indicated their responsibilities in ***caring for another adult*** made getting health care challenging.

The Community Needs Protection and Care for Their Service Providers

2025 CHNA FINDING

While the community had suggestions for ways that their health care experience could be improved, they also frequently praised the people who provide their care. They were clear that they appreciate their efforts and want their care providers to be protected and cared for.

The community is aware of the pressures health care providers have faced and the trauma experienced during the COVID pandemic. They noted that a lot of health care providers left the field after the pandemic and believe that San Diego is losing health care providers to places with a lower cost of living. We heard about shortages in primary care and specialty medicine. One focus group participant summed it up this way:

> "*We have a problem. We don't have enough people to serve the people*."
> – Focus Group Participant

Another said:

> *"What I'm hearing from the clinics, what I'm hearing from the clients...and from [hospital] sites is they're losing people, providers. Not just doctors, but those new grads can't afford to live in San Diego. They can't afford to raise a family in San Diego. They're going to Montana, they're going to Idaho, they're going to someplace where they can buy a home, everybody appreciates them, and they've got a work-life balance*." – Key Informant

In field interviews, many people expressed appreciation for hospitals, health care systems, and care providers and asked us to tell them:

"They do a good job and try the best they can."

"They are doing great work."

"Tell them to keep helping those in need."

"Thanks for your wonderful work. Keep it up."

"Tell them to keep doing what they are doing."

"Agreadecida con los cuidados obtendios: **Translation:** *Thankful for the care received*

"Que los servicios medicos han sido excelentes tiempo de pandemia." **Translation:** *The medical services have been excellent during the pandemic.*

Data indicate that health care workers are experiencing chronic stress, mental health issues, and burnout.[72] In a survey of health care workers nationwide, more than a quarter of health care providers reported mental health symptoms significant enough to meet the diagnostic criteria for a mental illness, and of those only 38% sought care. Health care workers reported that they did not seek care because of challenges with getting time off work, the cost, and concerns about their care remaining confidential. The community is aware that health care workers are also experiencing significant stress and emphasized both their gratitude for them and desire for health care workers to be cared for and protected.

26% of health care workers report mental health symptoms *severe enough to be diagnosed with a mental illness.*

Center for Disease Control and Prevention, Morbidity and Mortality Weekly report, January 16, 2025

The Community Needs More Recognition of and Assistance with Disabilities and Trauma

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> *"I was having a very hard time just making it through the front, the parking, the front door of the hospital to the doctor's office… through the front desk and through the initial testing of… the things the nurses do to get your vitals, to get to the space where she and I could be together to have our doctor's appointment. It was what had seemed so easy…it was all one activity in my mind when I would go to the doctor's office before. And now, having the illness and the symptoms that I had, every step of getting to the doctor was like an almost insurmountable obstacle*." – Key Informant

One in 10 San Diegans lives with a disability,[73] and has concerns about their health, which was apparent in both the field interviews and online survey.

In field interviews, of those who were concerned about themselves or an adult they loved, "physical disability" was chosen by 13% of respondents as the condition they were most concerned about; for those discussing a child, developmental disabilities concerned 15% of people the most, and physical disabilities concerned 11% the most. [74]

In the online survey, 9% of people indicated that not having accommodations for their physical or developmental disability keeps them from receiving the health care they need.

Community members discussed disabilities extensively, referencing that some are apparent and others are not, such as chronic pain, learning disabilities, or neurodivergence:

> *"Most people are familiar with wheelchair and physical accessibility. They're familiar with auxiliary aids for hearing. They're familiar with large print or braille for vision. They're not familiar with … the other 90% of disabilities and potential disability accommodations."* – Key Informant

They also talked about trauma and its impact on health.[75] [76] They noted the collective trauma experienced by the community as a result of COVID and of events like floods and wildfires. They discussed the cultural trauma experienced by people of color. They talked about historical trauma caused by generations of oppression through processes like redlining. And they discussed different kinds of trauma experienced by individuals, like those who served in the military during combat and people who had many adverse childhood experiences (ACEs).[77]

The community recognizes that people who are disabled and those who have experienced trauma need accommodations, compassion, and assistance with resources. They also feel this is an area in which hospitals and health care systems could improve.

Disability and Trauma-Related Needs				
Allowing service animals	Complying with the ADA	Improving websites and phone systems	Assistance with documentation & eligibility	Understanding trauma

Allowing Service Animals

Disabled community members told us that some medical facilities do not allow them to bring in their service animals. They report that security guards seem confused about if the animals are allowed and, if so, in what areas of the facility. The Americans with Disabilities Act (see side bar, below) is clear, however, that service animals must be allowed.[78] They also asked for assistance from medical personnel completing paperwork that documents their disabilities for housing purposes so that their animals will be allowed in rental properties.

Compliance with ADA

The Americans with Disabilities Act

- State and local governments, businesses, and nonprofit organizations that serve the public generally must allow service animals to accompany people with disabilities in all areas of the facility where the public is allowed to go.
- For example, in a hospital it usually would be inappropriate to exclude a service animal from areas such as patient rooms, clinics, cafeterias, or examination rooms.

The community also discussed not having an adequate response when they ask for needed accommodations. It was explained to us that once a request for an accommodation is received, an ADA "engagement process" is supposed to begin. At that point, someone who has been designated as the facility's ADA coordinator is supposed to figure out how to "effectively accommodate" that individual.

Often, they noted ADA accommodation requests are sent through the grievance departments, and when this happens:

> *"You just end up now moving through a grievance process that doesn't have ADA coordination, and now you've lost the trust of your member. You've probably added to the post-traumatic stress of whatever situation they're dealing with."* –Key Informant

Websites, Portals, Phone Systems

Community members expressed that phone systems, websites, and electronic health portals can be difficult for people with disabilities to utilize. This can be true for people with visual and auditory challenges and also for people with other, less obvious, disabilities:

> *"You're dealing with so many people with brain disorders…everything from post-traumatic stress, which shows visual brain deterioration and brain changes [to] the neurodivergent community...Anybody dealing with an illness that affects your cognitive functioning."* – Key Informant

Community members also noted that some health care websites do not clearly list phone numbers, which can create barriers for individuals with disabilities or varying levels of comfort or ability with technology.

Assistance with Identification, Documentation, and Eligibility

Community members told us that they need assistance from medical providers in identifying their disabilities and then helping them figure out if they qualify for services, particularly those that would assist them in obtaining and keeping their housing.[79]

> *"If their medical providers were a little more active in terms of 'do you have a disability? Is it impacting your housing?' This would go a long way to help with housing and other accommodations."* – Focus Group Participant

Some mentioned that primary care doctors do not consistently document persistent disability symptoms as needed to qualify for disability benefits and that some are reluctant to complete medical verifications for housing accommodations, like service or emotional support animals.[80]

> *"And doctors don't in turn, do a good job of documenting persistent symptoms and ongoing need despite treatment. There's no attorney in the world that will succeed in getting that person on Supplemental Security Income (SSI). It's just impossible."* – Focus Group Participant

> *"Sometimes that emotional support animal will be the difference between someone remaining, maintaining their anxiety and being able to remain stable. And the verification piece is such a huge barrier to supporting a number of government benefits and then particularly relating to housing, SSI."* – Focus Group Participant

They also discussed a lack of understanding among health care providers about criteria for In-Home Support Services (IHSS) and how to accurately complete forms for those services. At the same time, the community recognizes the reasons underlying the reluctance:

> *"Doctors don't like filling out forms because…the models of insurance these days are, 'Doctors, you've got 15 minutes with your patient. You've got to get into that next exam room to see the next patient' and under the cap model, and for that doctor or that medical group to make their ends meet, they have to see 40 patients a day or whatever that specific quota is, but it's not small… And so I think a lot of doctors look down upon the need to fill out these forms, even though there have been some statutory changes that allow doctors to bill for it under Medi-Cal. I just don't think that doctors are taking the opportunity to do that. It becomes a real big barrier."* – Focus Group Participant

Understanding Trauma

Community members also told us that they need health care workers to understand the biology of trauma, its potential impacts on health, and importantly, its impact on people's interactions with the health care system. They talked about coming to health care providers with fears related to medical care based on their own past experiences or that of their parents, grandparents, or other people in their community:

> "*I have a student that's in the care of a grandparent who's a veteran, so there's a long history of trauma for them being a veteran and trying to get health care, and it shows*." -- Focus Group Participant

> "*Those things linger into other generations, so that although...we're somewhat removed from what our parents…went through, the mindset about going to the doctor and about checkups, it lingers and it plays a role into how we engage with our health care system*." --Key Informant

The Community Needs More Help with Crises

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San Diego County residents have experienced several serious climate-related and other public health crises over the past several years. The community expressed clearly that these events have impacted their health and they need more help than they have received.

Heat

In both the online survey and field interviews, a large proportion of people reported being so hot that they could not complete their daily activities.

Community members commented explicitly on the impact of heat on their health, associating the extreme heat with migraines, fluctuations in blood pressure, dehydration, and respiratory problems. They also discussed power outages and the cost of energy, which impacts those who are dependent on electricity-powered medical devices. [81]

Wildfires

Many community members have been impacted by wildfires and related smoke in the past several years. In the online survey, 30% of respondents indicated that they had been exposed to unsafe conditions or had difficulty breathing due to wildfires and/or related smoke.

In addition to concerns about rising temperature levels and wildfires, our community discussed two recent events extensively: the flooding that occurred in January 2024, and fumes emanating from the Tijuana River Valley beginning in September 2024. Although this report discusses these as "events," the community noted emphatically that that both of these crises were preventable as they resulted from long-term, documented but unaddressed problems.

Flooding

> *"One of the main things … we knew was going to be an issue is the fact that if you had water a foot under your ceiling, all of your medication has been washed away, all of your medical equipment has been washed away. We are still dispersing hospital beds to folks, wheelchairs, canes, walkers…We are replacing all of the blood pressure cuffs and the glucometers, the things that are daily medications that you need to take*

> *and daily health screenings that you need to be able to provide yourself. Of course, the storage to store insulin and all these things have also gone out the window.*
>
> *When I was in a room with probably about 150 flood survivors, and I knew people had become sick, but I thought it was like, 'Oh, one out of five, one out of three.' When I asked the question, 'How many people had either been hospitalized, had to go to urgent care for flu-like symptoms, or currently have a cough?' When I tell you 97% of the room raised their hand, it was so scary to me to know that all these people have experienced some type of breathing abnormality or sickness related to this flood that's just gone unaddressed."* – Key Informant

On January 22, 2024, a severe flood hit San Diego. It was the fourth wettest day on record in the county, with more than 5 inches of rain falling in some locations. The City of San Diego Fire Department received nearly 900 phone calls, and 248 rescues were conducted.[82] Flooding was most severe in Southeast San Diego, including the neighborhoods of Shelltown, Encanto, Southcrest, and Mount Hope, along with National City. The storm displaced a total of 1,224 households, some of which are still displaced as of the end of 2024.[83] These floods were likely the result of the failure to clear the debris from the nearby Chollas Creekbed.

Health data related to the floods have not been collected. It is unclear how many people died or the breadth and severity of the health problems have resulted from the floods, but community members described devastating impacts. Leaders in and residents of these neighborhoods described feeling abandoned and not having the basic resources they needed to care for themselves and their families.

In reaction to the floods, a contracted agency was brought in to assist with housing, and many community members were placed in temporary housing in other cities:

> *"When you're not feeling well, and you're housed in Long Beach and still got to get to work in Chula Vista or Southeast or wherever you work at… We found out that a significant number of the children housed that far, none of [them] were in school. These were people on IEP (individualized education program) plans, had all kinds of other educational needs that were not being met. We have people with access and functional needs, who are elderly, who are disabled."* – Key Informant

Mental health was also noted to be especially affected by the flooding, and we heard stories of a young person committing suicide, children witnessing the deaths of loved ones, and survivors suffering from traumatic stress.

The community is calling for more attention to be paid to the neighborhoods affected by these floods, for more care and concern from health care systems, for better tracking of health outcomes from the floods, and for a plan for if this should happen again.

Tijuana Riverbed Sewage Crisis

Air quality was also an issue frequently discussed by community members, particularly for those who live near the Tijuana Riverbed. For decades, this riverbed has been a source of concern for people living on both sides of the border. Pollution from sewage has caused beach closures, environmental problems, and health issues. In 2024, this sewage crisis became an even greater emergency. Field interview participants noted things like:

> "*El olor del sur está horrible*." [**Translation**: the odor from the South is horrible]
>
> "*El olor es insoportable y podemos enfermar*." [**Translation**: the smell is unbearable, and we can get sick]

A Community Assessment for Public Health Emergency Response (CASPER) report conducted by the Centers for Disease Control and Prevention (CDC) in October 2024 documented that nearly all (94%) of the residents in the area of the Tijuana River Valley had noticed a sewage-like smell, and the vast majority indicated an increase in stress and a decrease in quality of life. Nearly half experienced health problems as a result of the crisis and nearly 2/3 experienced symptoms of an acute mental health issue.[84].[85]

Other findings from the CASPER report include:

80% say quality of life has been negatively impacted

77% believe air quality is not ok

71% believe household tap water is not safe to drink

65% experienced one or more behavioral health indicators of potential acute mental health issues

65% have had one or more worsening health conditions in the past month, including allergies, migraines, chest or lung pain and asthma

59% report increased stress

45% report at least one health symptom from the crisis. Of those, 70% said symptoms improved when they left the area.

At the time of this writing, the sewage crisis was still ongoing, and it is not yet clear how residents of this area will be impacted or how those impacts will be addressed. The community who spoke of this crisis made clear, however, that they need more help than they are currently receiving.

The Community Needs Better Data Collection, Sharing, and Coordination

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FINDING

We heard from community members, health care professionals, and community-based organizations that the lack of data collection, sharing, and coordination across systems creates unnecessary challenges to good health.

Better Data Collection in Crises

During the recent flooding, comprehensive data were not collected about who was impacted, when, and how. This made an understanding of how the floods impacted the health of our communities nearly impossible. This also impacts the survivors themselves who did not see their experience reflected in data about the event.

One person who worked extensively with flood survivors noted that many agencies were involved in caring for people – community groups, local government agencies, health care systems, and social service providers , but these entities cannot easily share data, creating burdens both for the survivors and the people who are trying to help them.

> "*It is so absurd and ridiculous, and we're all not just doing double data entry. We're just reworking the same wheel over and over again. And none of us have gotten it right, and none of us have been able to share the results or the information that we have.*" – Key Informant

Better Data Sharing between Hospitals and FQHCs

Another issue that was shared by multiple participants in focus groups and interviews is the inability of Federally Qualified Health Centers (FQHCs) to access the hospital electronic medical record (EMR) systems. FQHCs can sometimes access a portion of the patients' records but are often unable to view important components of patient care like imaging studies and medications given at the hospital. Stories we heard from FQHC personnel illustrate this challenge:

> *"For one patient with a complicated congestive heart disease, it took three weeks to get charting notes from the ED."* -- Focus Group Participant

> *"Give me the discharge diagnosis, give me a way that I can get the records in real time, because that's the only thing that's going to give our physicians comfort in seeing the patient."* – Key Informant

> *"We don't have the ability to share patient information electronically. That's a big issue…. people are readmitted to the hospital that could have been prevented because we could have been on board and been the ones managing their care to help them through whatever they're recovering from…As a provider, you're really dependent on having that current documentation of what they've been doing for the last month or what happened in the ER or most recent hospitalization and then we can explain it to the patient again."* – Focus Group Participant

Informants also talked about data sharing in a broader sense. They see value in sharing aggregate data between hospitals and clinics to understand each other's "pain points" and figure out how to better work together to meet community needs.

> *"If we could get the data and work together if there was the time, then we could say 'okay where are our issues. What can you do about working with us on this?' We talk about need first. We talk about need, we talk about pain points. Then we can come together and say 'you know what? I think we could design a program like this…let's start talking about what can be done more in the community with the data.'"* – Key Informant

Better Data Sharing between Medical, Educational, and Social Services

Other care providers also commented on the many systems in place in the county that cannot share data about community members, limiting their ability to understand what they need. Hospitals or other health care providers cannot, for example, access the Homeless Management Information System (HMIS). The Community Information Exchange (CIE) does not "speak" to HMIS. School nurses cannot access electronic medical records (EMR). Finally, when an individual's primary care is received through street medicine, like it is for many people experiencing homelessness, information is not shared between those health care providers and hospitals. Comments about this issue included the following:

> *"We're not all on the same platform. So, it's a lot of piecemealing information…Because we have a system that we use, which is called HMIS, Homeless Management Information System. Hospitals don't have access to that. So, you're not able to see who this person is working with or if they even have a unit, sometimes they might be housed…And so, that's where I think we lose that continuity and people going to the streets without the proper follow up and then someone to do the warm hand-off to."* – Key Informant

"I think sometimes the hospitals use the CIE for discharge referrals and not all providers are necessarily in there. Or if they have an account, they might not be tracking what's going on. I think through the different systems, HMIS, the CIE, there's a lot of systems to navigate. We are navigating multiple systems, and those systems don't speak. And so how are substance use referrals being placed? If it's through the CIE, who's managing and following up on those? What's the opportunity to have those intercepted and redirected to the appropriate level of care, I think would be incredibly helpful." – Focus Group Participant

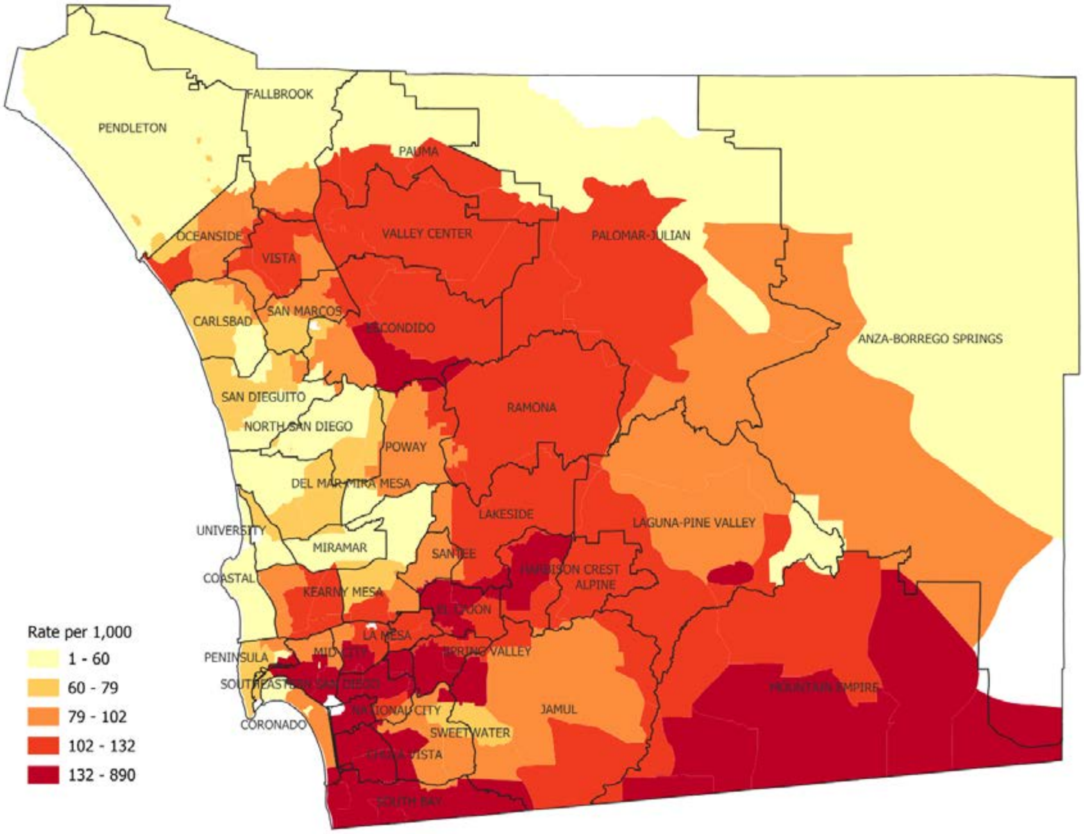
The Community Needs Less Burden on Emergency Departments

2025
CHNA
FINDING

The community spoke to us about long waits in overcrowded emergency departments and told us they use EDs frequently for their care. They utilize EDs, they said, at least in part because of long wait times to see primary and specialty care providers. Health care providers also told us that EDs are overburdened and emphasized that they must prioritize caring for life-threatening conditions and referring non-emergent issues for follow-up with non-emergency care providers. The result is that sometimes the conditions that bring people to the ED go unaddressed.

Emergency Department Utilization

The following maps illustrate regional differences in the usage of EDs for avoidable conditions [86] in 2022. [87]



The field interviews were an opportunity to explore how often members of the general public call 911 or seek care at the Emergency Department (ED). The questions were posed to interview participants who shared concerns about a child (Track 1) or about themselves or a loved one (Track 2), recognizing that these individuals could offer valuable insights based on their lived experiences.

Field Interview Tracks

Track 1	Track 2	Track 3
Concerns about a child	Concerns about self or loved one	Concerns about the community
53 interviews	213 interviews	199 interviews

Question: *In the last 12 months, has 911 been called for an issue related to this person's health?*

Among interviewees concerned about a **child's health:**

- **27%** reported that 911 had been called for the child.

Among interviewees concerned about **an adult, friend, or family member's health**:

- **12%** reported that 911 had been called for that person

Question: *Has this person received care at the Emergency Department (ED) for these concerns in the last 12 months?*

Among interviewees concerned about a **child's health:**

- **More than one third** said the child had visited the ED.
- Of those children who had visited the ED, **74% had multiple ED visits.**

Among interviewees concerned about **an adult, friend, or family member's health**:

- **Nearly one third** said the adult had visited the ED.
- Of those adults who had visited the ED, **58% had multiple ED visits.**

What Brings Community Members to the EDs

Mental Health

People experiencing a mental health crisis often turn to emergency departments for assistance. While this can be important, as one informant emphasized, to determine that symptoms are indeed being caused by a mental health issue rather than medical concern, many noted that although the ED is not the best place to receive mental health care, people often have nowhere else to go:

> "*Our system is picking up the slack for resources that don't exist in the community, like a true residential co-occurring program that has the same level of care that someone might get in a commercially insured [health] plan."* --Focus Group Participant

Substance Use Disorders

The community also talked about the extreme difficulty of finding the right level of treatment for people with substance use disorders. Detoxification facilities are often full, and substance use treatment programs generally cannot manage someone whose withdrawal is so severe that it has the potential to cause severe medical problems. Emergency departments are not set up to be detoxification facilities. Care coordination between hospitals and treatment facilities was also noted to be especially challenging:

> "*And I know that's no fault of the EDs. There's just nowhere else to send these [people] to so they are housed and they are sheltered while they're in withdrawal… but we're getting [them] back when we shouldn't and we're having to send them back to the [ED] three, four times before they finally realize, okay, [this treatment facility] is not able to handle the medical conditions that are happening here, the mental health conditions that are happening here. So I think it would be really beneficial to have and build out those relationships with the community providers just so (there is) understanding of what the capabilities are of each individual provider. And it would just help streamline some of that stuff. Some of those gaps would probably be closed."* -- Focus Group Participant

Alcohol use disorder was discussed as a particularly difficult condition to manage when people are not already connected to treatment. The need for more ambulatory options for alcohol withdrawal was described in this way:

> "*It's an interesting conundrum in that sometimes they'll only get enough [medication] to literally just lower their blood pressure enough to get out*

> *of the ED but not given anything for continued safety. And then sometimes they are given the prescription, but …then they don't have the support that they need or maybe a connection to an ambulatory withdrawal [program]. There's a disconnect between those two services …And so then people leave and they're drinking and taking the medication from the ED which is obviously concerning.*" --Focus Group Participant

Challenges to Receiving Primary and Specialty Care

Community members spoke of trying to receive the care they needed for medical issues they knew were not emergencies, but not being able to schedule an appointment for months. Sometimes, they noted, their health would then deteriorate to the point that they needed to receive emergency care. Once there, they are referred for follow up appointments and:

> *"Appointments with doctors are two or three months out, so people will go to the ED and the ED staff will tell them to go to the PCP, and when the patient can't do that because of the wait time, they go back to the ED, and the ED staff will see the same patients and will feel irritated, and the community member feels dismissed."* – Focus Group Participant

Because of long wait times for specialty care, primary care physicians are sometimes directing their patients to the emergency department for services:

> *"Doctors are sending people to EDs saying, 'I want you to say this when you get there so that I can get you into gastroenterology' or, 'I can get you in to see orthopedics [at the ED] because I'm not going to be able to get you in soon enough through a referral.'"* – Focus Group Participant

Another underlying cause of ED visits the community discussed was when patients hit "roadblocks" in caring for chronic conditions or in understanding how to care for themselves after a hospitalization:

> "*Patients hit roadblocks getting to follow up care - like transportation or difficulty with making appointments, and then they don't follow through because it's too much work and then they end up back in the hospital or in the ED."* – Focus Group Participant

The community also discussed particular populations who tend to receive care in emergency departments, including people who are experiencing homelessness. One informant described it this way:

“*What we find is that if you and I aren't feeling well, we may call our doctor, we'll try to figure out solutions and we may end up in the ED, but our first resort to getting our health care met isn't going to the ED.*

Whereas, our participants or individuals on the street, that's the first access point for them, is going to the EDs and trying to get those basic health care needs met. And in some cases, the primary reason that they need treatment for doesn't really get addressed, especially if somebody has chemical dependency or substance issues.

And there is the assumption, and in some cases that could be true, the assumption that unhoused individuals seek the ED to access bed and meal. Therefore, the level of care, medical care they should receive is overshadowed by that.” – Key Informant

What's Already Working?

Community members frequently praised professionals and volunteers in the community who are working hard to improve our health. When asked what was working to address community health, they discussed the following and said that they would welcome the expansion of these types of programs.

Care that comes to the community

- ***Partnerships between schools and community clinics,*** like those providing primary and specialty care programs and services such as dental and behavioral health.
- ***Dental offices in community health clinics*** that work on sliding fee scales.
- ***Home visits*** to assist with chronic conditions like diabetes and high blood pressure and with preventive dental care for youth like the application of fluoride varnish. The delivery of fresh produce during these visits was noted as especially helpful.
- ***Mobile health care services*** coming into communities, work places, and schools.

Transportation assistance

- ***Free parking available onsite*** of some medical buildings and hospitals.
- ***Taxi voucher programs*** operated through some clinics that help them get to appointments.

Personalized support for high-risk patients

- ***Voluntary identification programs that allow for people to be discreetly recognized as disabled*** through wearable and/or portable items such as lanyards, key chains, bracelets, or information cards.[88]
- ***Specialized Substance Use Disorder (SUD) Nurses*** **within** Emergency Departments who communicate and coordinate with substance use detoxification and treatment facilities
- ***Discharge Kits*** for conditions like congestive heart failure that include equipment and easy to understand, color-coded instructions.

Community Suggestions

An important component of a community-based needs assessment is asking the community about the kinds of solutions they believe would be effective in meeting their needs. Suggestions to better address the needs outlined can be categorized into four main areas:

Support for Patients

The community had several ideas for ways in which patients' care experiences could be improved.

Introductions for Patients

A simple suggestion made was to ensure that each health care worker who enters an exam or hospital room explains who they are and why they are there. One participant explained that everyone should know:

> *"Why is this other person in the room while all my business is being talked about in front of them?"* – Focus Group Participant

Navigation Assistance

The community would like to see the ***expanded use of peers for health care navigation***. This was discussed as a particularly effective option for people who had previous negative experiences within the health care system. In our focus groups and interviews, we had several in-depth conversations about this idea. Excerpts from those discussions include:

> *"What we found to be successful is accompanying people, going with them, and really trying to reduce the trauma associated with [medical care] or the fear associated with it, making those phone calls with them or doing it for them initially, modeling and then being able to create that treatment."*– Focus Group Participant

> "*Let's go back to the power. It's also intimidating to ask someone in a position of power like a doctor questions. You might feel stupid, and it might be easier to ask someone who is part of the community, who is more like a peer, the question. And if they can't answer, then they could get you the answer or be the in-between and be there with you when you get the answer to help the physician or the nurse or whoever it might be speak in more layman's terms about what's going on."* – Focus Group Participant

> *"We need relatable peers that could be in critical positions like doulas and midwives, in every level of care, not just in birth, not just death but in every other level of care, around mammograms, around cervical screening, around prostate screening, around my diet."* – Focus Group Participant

Another solution suggested was ***a phone line that could serve as a navigation hub***, especially for insurance issues:

> "*A separate available support to call to get help with referrals, getting needs met*." – Focus Group Participant

> *"How do we make it accessible to all people, so that they have maybe not a specific advocate. But like a hub they can call ...a place that helps point them in the right direction, taking into consideration what their insurance covers*." – Focus Group Participant

> *"Many community members do not know anything about insurance or how to access it. It would be helpful to have someone in place to explain everything about insurance, which are the best options, the cost of it, where to call, where to go."* – Focus Group Participant

Systems for Immediate Feedback

Community members told us that they need a way to give feedback about their care experiences immediately after their appointment, rather than through the usual surveying. They also expressed concerns about whether patient satisfaction surveys effectively ensure accountability within health care systems.

Participants talked about ideas like ***having the person who checks them out ask how they felt their service was on that day***. Another mentioned having visible signage that tells patients what to do if they felt they were treated unfairly. Comments included:

> *"And there is no honest, there's no safe space to really say how these populations feel when they are in the health care system. Of course, I know that because I've been one of them. I've been on both sides. And you take what you get and you don't really know what to do with it.*" – Key Informant

> *"Someone there to have a heart to heart about how their experience was, ideally someone from the community and then to have accountability about that performance feedback*." – Focus Group Participant

Others felt that ***a more formal system of agreement*** between a health care worker and patient was necessary:

> *“And so when it comes to policy, there are so many creative and innovative ways that we could ensure that people are just listened to…a patient needs to be able to sign off on something where the provider and the patient agree. ‘I was heard. I have reported these symptoms.’*"– Key Informant

The Presence of Advocates

One solution the community offered was to ensure that people are allowed and encouraged to have people with them for medical appointments who are willing and able to advocate for them. This, they said, could be through the use of peer support or less formal means, like ensuring that a relative or friend accompanies them to their appointments. The community would appreciate it, they said, ***if their health care workers would suggest and encourage them to bring someone with them*** to their appointments.

Designate and Publicize ADA Coordinators at Medical Facilities

Community members expressed a desire for a designated point of contact at hospitals to assist with disability accommodations or address concerns about potential rights violations. They would like to be able to ***easily identify whom they should speak with,*** and they would like a phone number, in addition to an email, listed as contact information. They also asked that someone be available 24/7 to work with them.

Support for Health Care Workers

Many of the community’s suggestions about improving community health centered on providing more support for health care workers, including more opportunities for community involvement, training and education, focusing on reducing turn over

Cultural Exchanges and Education

Because San Diego is so diverse, some participants felt that having cultural exchanges, where health care providers come into communities to learn about their cultural practices, would be immensely helpful. ***Spending a few hours with an organization that serves groups like refugees***, for example, and perhaps learning a few phrases of their language, would go a long way not only in educating health care workers but also in building trust in that community. These are suggestions that have been successfully implemented in other parts of the country. [89] [90]

Addressing Vicarious Trauma

Health care providers are, like the community, under ongoing stress. They can also suffer from vicarious trauma[91,92] as they care for the community. ***Supporting them and reducing their stress, the community said, will lead to better care for patients***.

> *“With health care staffing being what it is, we don't want to create a moral injury or burnout with staff. We want to make sure that they feel safe and that they've done right by their patients and that they don't have regrets.”*
> – Key Informant [93]

> *“What I can tell you is sometimes this vicarious trauma comes around because the frustration of seeing people coming asking for help and sometimes we don't have much to give. Resources are getting little and little and little.”* – Focus Group Participant

Reducing Staff Turnover

The community was emphatic that they care about health care workers, understand how difficult their jobs can be, and would like efforts made to improve their satisfaction so that staff turnover is reduced, leading to more consistency in care provision.

Efforts to reduce staff turnover were named as essential to patient well-being:

> *"Focusing on reducing staff turnover is a huge part of the solution for improving patient health and their willingness to get and manage care."* – Key Informant

Community Engagement

The people we spoke with who work within the health care system are interested in ***becoming more engaged with the community and volunteering to help those in underserved areas***. We also heard, however, that to do so they need to take vacation hours from their jobs. One relatively simple solution offered was to offer support to health care providers for volunteer activities.

Having providers in the community and allowing them paid time off to volunteer would help build relationships with community members and create a more trusting relationship:

> *"I think it will also go a long way if there were some opportunity, even on a policy level, on a volunteer level…for providers to volunteer in the communities… to participate in these community health resource fairs… where are our providers that all of our patients actually see routinely?"* – Key Informant

Training Opportunities

The community believes that a key factor in improving the community's health care experience is to provide adequate training for all health care workers ***about issues like power dynamics in relationships, systemic racism, cultural competency, and health inequities.*** One specific type of training suggested by a key informant was on the use of motivational interviewing in health care appointments:

> *"Even when we look at motivational interviewing, like at scale, it's amazing. I love it. It's not realistic, obviously in practice because you just don't have the time. That's not the way our system is set up to do that. But for those that do and when you can, it is extremely informative and it does help. But there are specific populations…where it's critical, if you are not figuring out... why, instead of just adding a fifth hypertensive medication, why don't we deal with the first four that you probably haven't taken, couldn't afford to pick up from the pharmacy, were told something by a family member or a friend as to why you shouldn't take them, or the fact that it's causing an adverse outcome. Those are all the basics, and we don't really have stop gaps."* – Focus Group Participant

They also suggested trainings ***to build sensitivity to and skills for interacting with populations that may have complex health issues***, such as people experiencing homelessness and people who are seeking alternative kinds of medicine:

> *"When we talk about training and what needs to change, it's how physicians and doctors are treating people who are unhoused. So, I think we've had doctors who are very dismissive who would conclude right away, this is what this person has or minimize their pain. Then, you add in racial overtones to that too.*
>
> *And then, you have a lot of our Black and Brown people who do not want to go to a traditional medical setting, health care setting… I think the system has to change."* –Focus Group Participant

The community also suggested that training about trauma and the provision of trauma-informed care be provided to health care workers.

Finally, it was noted that opportunities for ***low-cost and convenient education and training – particularly for medical assistants, certified nursing assistants, and licensed vocational nurses –*** are limited in San Diego[94]. The amount of debt people must take on to receive the training they need is not always recovered because of the hourly wages of paraprofessionals like medical assistants.

> "*We would be producing a lot more medically trained professionals to handle the shortages that we have if we had programs and if we didn't have to rely on privately owned schools*." – Key Informant

Discharge Enhancement

The community pointed out that if services upon and after discharge from the ED and inpatient hospitalizations could be enhanced, the community's health would be improved. The burden on the medical system would also likely be reduced. Their suggestions included increasing the amount of medication given to a patient when discharged, improving discharge coordination, expanding recuperative care beds, utilizing In-Home Supportive Services, and implementing more post-discharge home visiting programs.

Medication Upon Discharge

One suggestion made by several of our participants was to find a way to ***release people from the emergency department with a longer supply of their prescription medicines***:

> "*Traditionally, you get a 10-day supply, and then you run out. And then at that point you're not healthy yet because you haven't gotten through a full cycle, you haven't had that appointment yet, and you're needing to call 911, and you're getting readmitted to the hospital or to the ED.*" – Key Informant

Some programs have been able to ensure that their participants have been able to secure 30 days' worth of medication, and this has reportedly been helpful:

> *"The patients that are leaving the hospital, they get 30 days' worth of medication because when you're going to schedule follow-up appointments with your PCP, you may not be seen for two or three weeks. And until then, at least you have enough medication to get you through until you see your provider again."* – Focus Group Participant

Discharge Coordination with Hospital Social Workers

Community members were ***impressed with the efforts of hospital social workers*** to manage discharges, and they noted that when patients are able to work with one, additional trips to emergency departments, as well as hospital readmissions, can sometimes be avoided. They also noted, however, that this resource is not always available:

> "*At the hospitals where we have social workers that is the person who bridges the gap, but not all programs have social workers, and we certainly aren't represented 24/7.*" – Key Informant

Community members noted that hospital social workers are able to help transition people between hospitals and other institutions and to set up resources for patients to ensure that they are able to manage their care at home.

More Recuperative Care Beds

Recuperative care facilities are designed to help people who are experiencing homelessness who have been hospitalized and need a place to recover when they no longer require the level of care a hospital provides. [95] [96]

Participants in this assessment feel that ***these programs offer the potential to relieve some of the burden on emergency departments***, noting that many more are needed and longer periods of insurance authorization are also essential:

> *"If we had that ability to have that medical recuperative care, the hospital frees up beds, people aren't sitting in the hallways or in the emergency rooms or wherever they are. And the nurses are able to take care of the people that are truly in need of care. And then we're able to work with them in the way that we should be able to work with them... We can work on referrals for housing, and then we can work on, let's get you back to work. So those are the kinds of things that we can do that, why in the world would I saddle hospitals where I depend on them to save lives with a community mission that I have plenty of people and organizations in the community that do it better, are wired for it. That's what they do."* – Key Informant

> "*Recuperative beds work but there aren't enough of them. When they are used, the hospital can call an organization…and find out when a recuperative bed will open, and then the org can work on the authorization piece, and then if the hospital can hold for a few days to get the discharge that prevents street discharge …and when we do that, there's continuity of care, which we really love and appreciate, and want more of...the issue though is we just don't have enough of those recuperative care beds. And the [insurance] plans only pay for 90 days to achieve permanent housing and for us to achieve (that) within 90 days is very…it's impossible.*" -- Key Informant

Utilization of In-Home Supportive Services (IHSS)

In-Home Supportive Services are available through the County to people who qualify who are older adults or have disabilities,[97] and IHSS social workers can come into the hospital to do an assessment pre-discharge to identify what needs the patients have for community care workers. ***The community noted that they would like to see better utilization, and potentially expansion, of IHSS***. They also note, however, that:

> *"It's almost never done...They're strapped for resources. California, the governor's budget, has already proposed to further cut IHSS resources available to counties to provide services. So they're under the gun in a lot of ways, but in the end, those services help avoid homelessness [and hospitalizations]."* – Focus Group Participant

Home Visits after Discharge

Home visiting programs were described as especially helpful to people who have been recently discharged from an ED or after an inpatient hospitalization. The community suggested that ***expanding these types of programs would be especially beneficial to their health.***

In addition, programs targeting special populations, such as people who live in rural areas, were described as particularly successful. Having medical professionals check on them after a hospital discharge and help them with medical tasks like making appointments, arranging transportation for those appointments, and setting up prescriptions with pharmacies was discussed as especially helpful, as was helping with a range of household tasks, like grocery shopping, yard work, and ensuring that their living environment is free of hazards. One interview participant told us:

> *"A lot of people, they don't want to be in the hospital. They don't want to be in a SNF [skilled nursing facility], they don't want to be in some type of alternative care facility. They want to stay at home. And we hear that all the time from them. They just want to be home. So the best way to do that is to make them self-sufficient, to give them the tools to take care of themselves better."* – Focus Group Participant

Systemic Efforts

The community also had ideas that involve systemic efforts to advocate for change and become more community-involved. Community members would like hospitals to take a greater role in advocating for beneficial policy changes. They would also like hospitals and health care systems to consult with community members more often to understand and address community health issues.

Advocacy

Some of the solutions posed had to do with advocating – within health care systems or at the legislative level – for changes that would create better health care experiences.

One issue that was discussed is that Federally Qualified Health Centers can only get Medi-Cal reimbursement for one visit per patient per day, meaning patients with Medi-Cal coverage cannot see two different specialists on the same day. As one key informant put it:

> *"It's too bad because the patient comes to the clinic and they should be able to get everything done at one time, but you have to work with what you've got. If your medical appointment is on Monday and your PT is on Tuesday and then we can bill for those. This same-day barrier contributes to patient non-compliance, due to transportation and childcare needed for two days rather than one, the patient may decide to go without. Conversely, if the provider thinks the second visit is critical to patient care, both visits are rendered on the same day and the provider goes without payment.* -- Key Informant

Another suggestion was that each hospital should ***designate administrative champions who have the power to make changes***, and that these champions would put out calls to action to bring to light complex issues like systemic racism and the efforts needed to address it.

Community-Centered Programs

Another foundational concept discussed by the community was to involve the community in addressing the health problems occurring in their neighborhoods. One informant explained that while data can identify the health problems, ***community input is really needed to figure out how to address those problems:***

> *“The key to unlocking a lot of the disinformation, the misinformation, is really pulling people in to be a part of something big, especially when you know that there is a lot of health inequities, there are a lot of data that is trending in the wrong direction. And if you really want to [draw them in] without making them feel like you're beating them over the head with the information, you’ve got to make them a part of it*.” – Key Informant

Another informant suggested that having teams of people, including community members, to address the emerging health problems would be helpful, something they called “health population teams:”

> *“One example that I always compare to is catheter infections. We know in the hospital, if there's no zirconia infections, catheter, when those things start to trend up, we put policies in place. We create whole teams to strategically look at something and to say, ‘How do we bring this back down? How do we fix the situation?’ And so I feel like there has to be a health population team that really looks at the vulnerable populations and brings them into the fold to have these same conversations that we're having today... Because of course, the community is the best voice, they're very informed.”* – Key Informant

Limitations and Future Directions

One of the primary goals of the CHNA Committee for this year's needs assessment was to hear directly from as many members of the public as possible. This was accomplished through a partnership with two community health worker organizations who went out "into the field" and engaged hundreds of members of the public to talk to them about their health and well-being, needs, and thoughts on our county's hospitals and health care systems.

This innovative methodology ensured that the needs discussed in this year's CHNA represented more community members – from more diverse backgrounds -- than ever before.

Many service organizations and experts also contributed to this CHNA, lending us the perspective of people who are committed to helping San Diegans achieve good health. Their expertise was invaluable.

A sample size of more than 1,600 for a time- and budget-limited county-wide needs assessment is above and beyond what we hoped, or expected, to achieve. This far exceeds the recommended sample size to ensure the validity of the data collected, and is a huge step forward in ensuring the representativeness of the needs assessment.

Nevertheless, these data have limitations. Hospital data used to discuss rates of health conditions, for example, are underestimations of those rates because the data are limited to those who have received care at a hospital.

The purposive sampling we used to recruit participants for focus groups also means that these samples are limited to those people who are connected enough in the community to be exposed to recruitment efforts.

The online survey, while quite successful in terms of the number of responses, was heavily weighted toward professionals. The majority (68%) of the people who completed it indicated that they represented:

- a hospital, health system or health district
- a social service provider/community-based organization
- education/academic institution or school district
- advocate (community, legal, health)
- or an elected official or government agency (county, local, or state employee or representative).

Online surveys are also heavily weighted *against* certain populations, such as those without reliable internet and those who are not adept or comfortable with technology[98,99], potentially excluding the populations we most want to reach with the needs assessment.[100,101] Online surveys also do not allow for the kind of personal interactions we had during field interviews, key informant interviews, and focus groups which generated a depth and breadth of responses not possible in a survey format.

Although community members actively participated in our interviews and focus groups, we also recognize that we did not reach some groups about whom the community had special concerns, including former foster youth, justice-impacted individuals, and people with chronic medical conditions.

The extent of data collected for this assessment exceeded our ability to fully analyze it given time, budget, and personnel constraints. Our hope is that the data will continue to be analyzed in the future as they contain important information about our community's needs.

Finally, the field interview and online survey were designed at different times, so the questions, while similar, were not always aligned in terms of topics and wording, limiting our ability to compare the results of the two.

For future needs assessments we recommend, therefore:

1) That the majority of data collection occur within the community, relying more on field interviews. Ideally, participants could be offered the opportunity to participate in more in-depth interviews for a larger incentive, allowing researchers to explore our questions deeply with the public.
2) That focus groups be conducted with other populations of concern, such as foster youth, and patient populations such as people with chronic conditions like diabetes, hypertension, and cancer.
3) That resource allocation be expanded for more comprehensive data analyses.
4) That online survey and field interview questions align more closely.

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