

CHARTING THE COURSE II
1998

*A San Diego County
Health Needs Assessment*

Full Report

Community Health Improvement Partners

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Charting the Course II: A San Diego County Health Needs Assessment 1998

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INTRODUCTION AND BACKGROUND

Charting the Course II represents the most comprehensive assessment of health status in San Diego County to date. It provides a synthesis of detailed countywide health status data by region, ethnic/racial group and age. Health issue briefs describe comparisons to state and national data, factors that increase one's risk of suffering from a particular health problem, model treatment programs, and local, state and national resources that can be tapped to develop targeted health programs. A community input survey was conducted in which members of the community, through 13 different focus groups representing different ages, ethnicities/races and regions, discussed their health concerns. Finally, the Community Health Improvement Partners (CHIP) engaged in a priority setting process to rank the size, seriousness, and community concern for a number of health issues (see **Appendix A** for a description of CHIP).

Four documents comprise the full **Charting the Course II** report:

Full Report: Contains comprehensive regional, ethnic/racial and age group analysis of health issues; health issue briefs detailing health statistics, risk factors, prevention measures, model programs and resources for each health issue; and a full description of the needs assessment and priority setting process. A brief summary of the community input results is also incorporated. It is intended to be used by organizations who want to fine-tune or tailor existing health programs, or develop programs in response to community needs.

Executive Summary: Briefly summarizes the information contained in the full report. It contains health highlights, but not with the scope and depth of the full report. Health issue briefs are not included. It is most useful for individuals who want general information on health issues.

Community Input Supplement: Contains a comprehensive description of the process and results of facilitated discussions with 13 focus groups representing different age, ethnic/racial, geographic, and special interest groups. It contains detailed information about the views and opinions of consumers of health care. It is useful for individuals or organizations who need to know the consumer perspective in order to provide services in the most responsive way possible.

Statistical Supplement: Represents a report by the County of San Diego County Health and Human Services Agency, Office of Child, Youth and Family Health Assessment and Planning. It is comprised of numerous detailed tables of health statistics organized by region and subregional areas, age groupings, ethnicities/races, and in some cases gender. Data sources include

birth and death records, communicable disease reports, emergency medical services data, child abuse reports and referrals, and school data. It details all of the health issues mentioned in the full report, as well as other health issues not reviewed. It is, therefore, extremely useful in describing health problems and concerns on a community-specific level.

This report is the second edition of a countywide health needs assessment, the first of which was completed in December 1995. Initially the project was undertaken to comply with statewide community benefit legislation (SB 697) requiring private not-for-profit hospitals to conduct an assessment of health in their areas in order to better respond to community health needs. California requires the needs assessment to be updated every three years. Members of the Community Health Improvement Partners, many of whom are required to comply with this legislation, decided to collaborate and produce one comprehensive needs assessment in order to develop a more comprehensive report and to maximize resources.

In addition to fulfilling the requirements of SB 697, the needs assessment can serve a number of functions. It can become a springboard for the mobilization of resources, both economic and human, needed to confront the multitude of serious and confounding public health issues facing any community. In addition, it can be used to:

- Provide a community resource for individuals, agencies, and institutions to use to identify health concerns of their constituencies, neighborhoods, or geographic region;
- Monitor changes and trends in health status in San Diego, as it compares to state and national trends and goals;
- Provide the basis upon which community health programs and interventions can be targeted, developed and evaluated; and ultimately
- Improve the health of the community and its members.

The project has evolved into one that goes well beyond the state requirements and is broadly distributed to schools, libraries, businesses, policymakers and others who have an interest in health. It represents the best effort of CHIP, given limited resources, to display community health status in terms that both health professionals and the broad community can utilize.

Process and Approach

This health status assessment uses information from four primary sources:

- Health-related statistics gathered and analyzed by the County of San Diego Health and Human Services Agency
- Health-related scientific literature

- Results of facilitated discussions held with 13 focus groups representing a cross-section of age, ethnic/racial, geographic and special interest groups
- Results of a process used with CHIP members to set priorities among competing health issues, using objective rating scales related to a health issue's size, seriousness, and level of community concern

The CHIP Needs Assessment Committee, under direction of the CHIP Steering Committee, decided on the approach and methodology for the needs assessment. Once finalized, the Needs Assessment Committee obtained the necessary funding and identified who would be responsible for the various aspects of the report. They contracted consultants to write and produce the full report and executive summary, and another consulting firm to conduct and report upon the community input process. The County of San Diego Health and Human Services Agency produced the health status statistical supplement. The final reports were approved by the Needs Assessment committee prior to production and distribution.

The results are presented in a variety of formats to facilitate their utility. Health issues that are of concern to specific age groups, ethnic/racial groups, and geographic communities can be identified. Recommendations on how to use the information to develop community benefit plans are also included. A definition of terms such as "mortality rate," "age adjusted," "incidence," "years of productive life lost," and other technical terms is included in **Appendix B**.

Community Input

From May through July 1998, a total of 13 focus groups were conducted with health care consumers, facilitated and documented by a contracted consulting firm. A comprehensive report of their methodology and findings is presented in the companion report. Focus groups were conducted with representatives of the following:

- Latinos
- Asian/Pacific Islanders
- African Americans
- Parents of children under age 12 (Group was conducted in Spanish)
- Adolescents
- Seniors
- African American seniors
- Consumers of substance abuse services
- Five geographic regions (North Inland, North Central, North Coastal, Central, and South County).

Community Health Improvement Partners

Focus group participants were asked to discuss health issues generally, and were also asked to rank a list of health concerns (see **Appendix C**, Priority Issues, Average Ranking by Group). The following health issues received a significant amount of attention in the focus groups:

Community Concerns

- Access to health care and barriers to access, including cost, availability of services and medical insurance coverage;
- Promotion of healthy lifestyles, addressed by many as the key to creating healthy communities;
- Access to mental health services;
- Access to substance abuse prevention and treatment services;
- Adequate health education, specifically related to chronic illness and preventive care;
- Language and cultural barriers to health care access;
- Issues related to quality and the impact of managed care on personalized care and consumer confidence in health care providers;
- Teenage pregnancy;
- HIV/AIDS;
- Violence, specifically youth violence; and
- Childhood immunizations.

Priority Setting Process

In order for CHIP to set priorities among the multitude of serious health concerns facing San Diego County, the Needs Assessment Committee with the help of its consultants developed a schema for priority-setting based on models in the literature and community-based experience and needs. The model consisted of the following components:

- 1. Select health indicators to review**
- 2. Select health issues to investigate**
- 3. Identify priority-setting criteria**
- 4. Create fact sheets**
- 5. Score health issues by age group**
- 6. Reach consensus on scoring results**

STEP 1: Select health indicators to review

One of the first steps in the needs assessment process was to determine what types of health indicators or measures would be included in the review. Because there is so much information available through the San Diego County Health and Human Services Agency (HHS), the purpose of this step was to narrow down the number of indicators that would be described. As part of their preparation work, the HHS reviewed indicators of approximately ten other counties and cities who embarked upon a similar needs assessment process. HHS compiled a master list of indicators used by the other regions.

The next step was to survey representatives from CHIP member organizations as well as HHS managers and ask them which indicators would be most useful to include in the needs assessment. The HHS conducted several meetings in which they asked stakeholders to discuss the indicators, and ultimately to vote on which indicators should be included.

STEP 2: Select health issues to investigate

The Needs Assessment Work Team reviewed a comprehensive list of health issues in order to define those to include in the assessment. Twelve major health topics were identified, as indicated in **Figure 1**. A total of 40 fact sheets, were developed to correspond to these health topics and sub-topics.

The next step was to create a priority setting list or “ballot” for each of four age groups. The work team reviewed each health issue and determined to which age groups they applied. They developed four distinct priority setting ballots corresponding to each of the four age groups (see **Appendix D**). Each ballot listed not only the health issues for which fact sheets would be developed, but other examples as well. For example, in the category “chronic and disabling diseases,” a fact sheet was developed for the broad topic area, as well as for the sub-issue of asthma. In addition, physical and developmental disabilities were also acknowledged to be a part of chronic and disabling conditions for all ages, although a fact sheet was not created.

STEP 3: Select priority-setting criteria

Figure 1: Health Issues and Sub-Issues Selected for Fact Sheet Development

1. **CANCER**
 - Lung Cancer
 - Breast Cancer
 - Colorectal Cancer
2. **CARDIOVASCULAR DISEASES**
 - Coronary Heart Disease
 - Hypertension
3. **CHRONIC AND DISABLING CONDITIONS**
 - Diabetes
 - Asthma
4. **COMMUNICABLE DISEASES**
 - Tuberculosis
 - Influenza/Pneumonia
 - Immunizations
5. **HEALTH BEHAVIORS**
 - Nutrition and Exercise
6. **HIV/AIDS**
7. **INFANT HEALTH PROBLEMS**
 - Infant Mortality
 - Low Birthweight
8. **MENTAL HEALTH AND MENTAL DISORDERS**
 - Suicide
 - Depression
9. **REPRODUCTIVE HEALTH**
 - Sexually Transmitted Infections (Gonorrhea, Syphilis, Chlamydia)
 - Teen Pregnancy
10. **SUBSTANCE ABUSE**
 - Tobacco
 - Alcohol Abuse
 - Drug Abuse
11. **UNINTENTIONAL INJURIES**
12. **VIOLENT AND ABUSIVE BEHAVIOR**
 - Family Violence
 - Child Abuse
 - Partner Abuse
 - Elder Abuse
 - Intentional Injuries
 - Homicide
 - Rape and Sexual Assault
 - Youth Violence

In order to set priorities among competing health concerns, a relatively objective process was designed based on a model developed by John J. Hanlon, MD.¹ This method was selected because it is commonly used for setting priorities among public health issues, and it is endorsed by the Assessment Protocol for Excellence in Public Health (APEX-PH).²

According to this method, each health issue is scored using the same criteria, such as the size of the health concern, the seriousness, and/or other factors. Each criterion is worth a certain number of points. Once each health issue is scored for the criteria, the numbers are added together to a final score for each health issue. The issue with the highest number of points is considered to be the top priority, the second highest number of points the second priority, and so on.

The criteria and scoring methods selected for the purpose of the CHIP priority setting process were as follows:

Size: The size of the problem related to incidence (the number of new cases per year) and prevalence (the number of cases at one point in time) per 100,000 population. (Point value: 0-10 points)

Seriousness: Seriousness was determined by some or all of the following factors:

Case Fatality Rate (CFR): the proportion of people who die from a disease.

Years of Productive Life Lost (YPLL): age 65 minus the age when the person died.

Impact on Quality of Life: the severity of impact of a condition on one's ability to function and lead a productive life.

Economic Costs: if known, the costs of medical expenses, public services, and prevention programs to the individual, the family, the community or all three.

Social Impact: the impact of a health problem on others.

The point value of "seriousness" was 0-20 points or twice the weighting value of size or community concern because it was considered to have greater impact than either size or community concern.

Community Concern: This referred to the degree to which the community identified a particular health concern, condition or disease as problematic. The primary source for this information was the Community Input Supplement. Results from other community surveys were compiled by the County HHSA and incorporated when applicable. (Point value: 0-10 points).

STEP 4: Create Fact Sheets

A total of 40 fact sheets were developed relating to the 12 major health issues. The fact sheets summarized statistics supplied by the County HHSA for the selected health indicators, which included age adjusted rates broken down by age group, ethnic/racial group, and geographic subregional areas. Trend information was also provided. Some of the statistics were solicited for the first time specifically for the purpose of this needs assessment. Statistics were obtained from sources both inside the county and outside.

The data was incorporated into easy-to-read fact sheets. Each fact sheet detailed statistics and information pertaining to the scoring criteria (size, seriousness, and community concern) for easy reference during the scoring process. In addition they described most impacted populations by age, region, ethnicity/race, and other general information.

STEP 5: Score Health Issues by Age

A small group process was used to score the health issues on each age-specific ballot according to the three criteria. The scoring meetings were open sessions and well publicized to the entire CHIP partnership. The members of the Needs Assessment Work Team served as the core group for the scoring sessions, but others joined as well. The scoring groups included physicians from the County HHSA, UCSD Medical School, and Children's Hospital. Other representatives included a professor from the San Diego State University Graduate School of Public Health, and professionals from health systems, community health centers, the United Way, and others.

A total of three scoring meetings were held—one corresponding to each criterion. By scoring all issues according to one criterion in a given day, participants tended to clarify their standards for scoring and refine them as needed for consistency as the group moved from issue to issue.

The objective of each meeting was to reach consensus on a score for each health issue. Prior to the meetings, each participant received a written explanation of the scoring criteria, a blank scoring sheet for each age group that listed all of the pertinent health issues, and a packet of fact sheets. Each participant was asked to score the criterion prior to the meeting, and to be prepared to discuss the rationale behind the score. During the meeting itself, participants briefly discussed the health issue, explained individual scoring, then arrived at a group consensus score.

Scores from all three meetings for each of the criterion were compiled onto one overall scoring grid for each age group. Health issues were ranked according to the number of points they received. The health issue with the highest number of points was ranked as the highest priority; the health issue with the least number of points was ranked as the lowest priority.

Observations regarding the scoring process

Although the scoring process was relatively objective in the sense that uniform criteria were applied, there were some limitations as well. First, age-specific information was not always available for each health issue, although a note was usually included on the fact sheet as to the age group most affected. This made it more challenging at times to score health issues by age. Second, even with the information provided on the fact sheets, participants did not always feel they had enough information to make a scoring decision, especially in the area of community concern. Scoring decisions were made in part based upon personal experience and expertise when quantifiable data was not available. Third, it was difficult to arrive at a single score for a broad issue such as “Reproductive Health” when it included a range of issues including family planning, sexually transmitted infections, and teen pregnancy. Although teen pregnancy would get a high score on seriousness, STIs would not be as high. In these cases, scores tended to move to a central number and be less extreme.

Generally, individual scores were similar, but there were times when individual scores had a broad range—one person would score a 3 out of 10, and another would score a 9. In these cases, scores were averaged to balance stronger opinions for more extreme scores. **For these reasons, final scores should not be viewed as absolute answers, but rather flexible in either direction by a point or two.** Despite these limitations, the Hanlon method proved to be a relatively objective and consistent way of assessing health priorities.

STEP 6. Reach Consensus on Scoring Results

The results of the scoring process were presented to the CHIP Steering Committee for review, discussion and approval in November 1998. They agreed that although each age group had their own unique ranking of priorities, certain trends emerged. First, based upon input from virtually every community input group, “access to care”

(including long term care) remained an overriding concern for all age groups. Second, there were three health issues that appeared consistently in the top four among the age groups under age 65: substance abuse, mental health/mental disorders, and violent and abusive behavior. Similar to the needs assessment conducted in 1995, these top health issues are not typically addressed in the medical model, although statistics and community input indicate they are among the top concerns. For ages 65 and older, cardiovascular disease and other chronic diseases were of top concern. It should be noted that the priorities focus on problems, not on interventions. Many interventions related to priorities of older groups need to take place in younger age groups. A summary of the ranked order of health priorities by age along with their corresponding scores are as follows:

INFANTS AND CHILDREN

Table 1: Health Issues Ranked by Score for 0-14 Year Olds

Rank	Health Issue	Total Points
1 st	Violent and Abusive Behavior	28
2 nd	Infant Health Problems	24
2 nd	Substance Abuse	24
4 th	Other Chronic, Developmental and Disabling Conditions*	23
4 th	Communicable Diseases	23
4 th	Unintentional Injuries	23
7 th	Health Behaviors	21
8 th	HIV/AIDS	16

*Includes emotional and behavioral disorders

ADOLESCENTS AND YOUNG ADULTS

Table 2: Health Issues Ranked by Score for 15-24 Year Olds

Rank	Health Issue	Total Points
1 st	Substance Abuse	37
2 nd	Reproductive Health	31
2 nd	Violence and Abusive Behavior	31
4 th	Mental Health and Mental Disorders	29
5 th	Health Behaviors	22
6 th	HIV/AIDS	20
7 th	Other chronic, developmental and disabling conditions	19
7 th	Unintentional injuries	19

9 th	Communicable Diseases	7
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ADULTS

Table 3: Health Issues Ranked by Score for 25-64 Year Olds

Rank	Health Issue	Total Points
1 st	Substance Abuse	35
2 nd	Mental Health and Mental Disorders	30
2 nd	Health Behaviors	30
4 th	Violent and Abusive Behavior	28
5 th	Cardiovascular Disease	25
6 th	Cancer	23
7 th	Other chronic, developmental and disabling conditions	22
8 th	HIV/AIDS	20
9 th	Reproductive Health	16
9 th	Unintentional Injuries	16
11 th	Communicable Diseases	7

SENIORS

Table 4: Health Issues Ranked by Score for 65 Year Olds and Older

Rank	Health Issue	Total Points
1 st	Cardiovascular Disease	31
1 st	Other chronic, developmental and disabling conditions	31
3 rd	Mental Health and Mental Disorders	29
4 th	Cancer	28
5 th	Health Behaviors	26
6 th	Substance Abuse	23
6 th	Violent and Abusive Behaviors	23
8 th	Unintentional Injuries	17
9 th	Communicable Diseases	14
10 th	HIV/AIDS	3

Table 5 shows a ranking of health issues by total score for all age groups. Substance abuse in the 15-24 age group received the highest score, followed by the same issue for 25-64 year olds. The third ranking health issues by total score was reproductive health and violence for 15-24 year olds, and cardiovascular disease and other chronic diseases for seniors over age 65. Mental health and violence dominated the 4th through 6th positions. Interestingly, health behaviors for 25-64 year olds also filled the 4th slot, reflecting the concern that adults in their healthiest years need to exercise and have proper nutrition.

ALL AGE GROUPS

Table 5: Health Issues Ranked by Score Overall

Rank	Health Issue	Total Points	Age Group
1 st	Substance Abuse	37	15-24
2 nd	Substance Abuse	35	25-64
3 rd	Reproductive Health Violence Cardiovascular Disease Other Chronic Diseases	31	15-24 15-24 65+ 65+
4 th	Mental Health Health Behaviors	30	25-64 25-64
5 th	Mental Health Mental Health	29	15-24 65+
6 th	Violent and abusive behavior Violent and abusive behavior Violent and abusive behavior	28	0-14 25-64 65+

When reviewing the overall scores, **Figure 6** illustrates the relatively high scores for substance abuse, mental health and violence. Most of the high scoring issues were for adolescents and those older. In children, age 0-14, violent and abusive behavior, primarily child abuse, is identified as a critical health concern. The lower scores should not overshadow the other top issues for the youngest age group, including infant health problems and substance abuse. Although children are generally healthier than the other populations, many interventions need to take place in this age group to prevent future problems. After much discussion, the CHIP Steering Committee approved the results and emphasized the importance of recognizing the top health issues for **all** age groups rather than focusing on the highest scoring issues overall.

Health Issue Briefs

Research was conducted on each major health issue to provide communities and health-related organizations with information to analyze the health issue in depth and to develop appropriate and effective responses. A series of fact sheets were initially developed to assist CHIP participants in the needs assessment process in scoring the size, seriousness and community concern for each health problem and set priorities based on this information.

Subsequent to the priority setting process, the fact sheets were further developed into health issue briefs with in-depth information. The purpose of the briefs is to provide a summary of information available from a variety of sources about a particular health issue. Each brief is self-contained in that it includes not only a description of the issue, but community and national resources as well as a bibliography of references. The briefs can be photocopied and distributed as needed to individuals

and organizations who may wish to use them as resources to develop or enhance their own health programs. Each health issue brief contains the following information:

Background

This section provides an overview of the health issue including basic definitions and general information. Definitions of technical terminology as well as race/ethnicity are included in **Appendix B**.

Size

National, state, and local information is presented on the number of individuals that have been impacted by the health problem, including incidence, prevalence, and rates.

Seriousness

Level of severity is evaluated based on a number of factors including the average years of productive life lost per death; comparison of San Diego County indicators with goals for the nation as indicated in Healthy People 2000; economic, social, and quality of life costs; case fatality rates; and its overall rank as a cause of death. A summary of years of productive life lost across health issues and age groups is included in **Appendix H**.

Health Statistics, Rates and Trends

Trends and comparisons are presented using mortality and morbidity information to identify which problems are increasing in size and scope and how San Diego County compares to the state and the nation relative to the health problem. Generally speaking, rates are not age adjusted unless otherwise indicated.

Community Concern

This section describes the level of concern for each topic based on results from the community focus groups conducted as part of the assessment or other community surveys.

Risk Factors

Known risk factors for the health condition or problem are identified based on current research and data.

High Risk Populations

Specific racial/ethnic groups, age groups, geographic regions, or special populations that have a high incidence or prevalence of the condition or a high number of deaths due to the health problem are highlighted. A summary of health issues by racial/ethnic group is included in **Appendix E**. Mortality rates by age groups are included in **Appendix F**. A map of geographic subregional areas is included in **Appendix H**.

Prevention

Effective preventive approaches based on current research and data are summarized

for each health topic.

Model Programs

Promising programs or practices for each health issue are identified, based on current literature and recommendations from professionals working in the field. The model programs are presented as examples and are not inclusive of all effective programs. The identified programs do not necessarily represent the views of CHIP.

Resources

Organizations to contact for further information and expertise are identified for each health topic. The resources identified are not inclusive of all information sources and are intended as a starting point for further information. Many of the resources and references contain on-line web addresses from the Internet. These web sites were verified at the time of publication and are subject to change. The data, programs, and resources presented in this document represent only a sampling of the information that is available. For more information on local, state, or national data, programs, or resources, consult the following sources:

- ◀The National Center for Health Statistics, which has statistics and other information on a variety of health topics. Their web address is www.cdc.gov/nchswww/fastats/fastats.html
- ◀Centers for Disease Control and Prevention, which offers an on-line public health information system that provides access to a number of CDC reports, guidelines and data on a variety of health issues. Their web address is www.cdc.gov
- ◀California Department of Health Services, www.dhs.cahwnet.gov
- ◀County of San Diego Health and Human Services Agency, www.co.sandiego.ca.us
- ◀The United Way Resource Center which publishes *Directions*, a directory of health and human services in San Diego County. For more information, call (619) 531-4799.
- ◀United Way also operates **INFO LINE**, a hotline for information on health and human services in San Diego County. **INFO LINE** can be reached at (619) 230-0997.
- ◀The United Way *Inform San Diego* website which also has information on health and human services in San Diego County. The web address is www.informsandiego.com
- ◀The San Diego Mental Health Association which publishes a directory of support groups in San Diego County for a variety of health issues. For more information, call (619) 543-0412.

SUMMARY OF KEY FINDINGS

This section summarizes the key findings of the needs assessment. It identifies some of the most pressing health aspects of the priorities identified by CHIP, as well as health issues by ethnicity/race, age and region. While this section provides a summary of key findings, it is not intended to discuss these complicated issues in depth, but rather to provide a brief synopsis of issues for easy reference. A table of health indicators by ethnic/racial group is included as **Appendix E**. A table of mortality rates by age group is in **Appendix F**.

Priority Health Issues

Access to care

Uninsured: Approximately 25% of the San Diego County population is uninsured, while 83% of the uninsured are members of working families.³ An estimated 110,000 children from low-income families in San Diego County are uninsured.

Barriers to care: Barriers include not having a regular source of care, lack of health insurance, lack of accessible facilities or providers, and personal barriers such as culture, language, and knowledge.

Adolescents: As reported in the **Community Input Supplement**, youth want more information about teen pregnancy prevention, sexually transmitted infections, birth control and prenatal care. Teens that get pregnant do not know where to access prenatal health care services. They believe clinics need to be more youth friendly with sympathetic staff, simple forms, and peer mentors.

Seniors: As reported in the **Community Input Supplement**, seniors want more education about health issues that impact them, such as diabetes, arthritis, medications, dietary recommendations, or other treatments. They want more education about Medicare, the role of HMOs, and how to negotiate the health system. In-home education, community education, and peer senior-to-senior education would be helpful.

Safe Harbor: Increasing Access to Health Care in San Diego: This CHIP Access to Care workgroup report outlines the access issue in great detail and identifies a number of strategies.

Mental Health

Access to mental health services: Access to services, particularly for those without health insurance, was a primary concern to participants in the

community focus groups. Lack of insurance coverage creates significant barriers for people attempting to manage their illness.

Suicide: Suicide rates were highest among those over age 65 in 1996. Whites committed suicide at much higher rates than other ethnic/racial groups. Suicide is the third leading cause of death among youth between the ages of 15 and 24.⁴ A total of 13.9% of San Diego high school girls surveyed in 1997 said they attempted to commit suicide in the past year, and 29.3% said they thought seriously about suicide.²¹

Substance Abuse

Drug-related deaths: San Diego County experiences a more serious problem than other parts of the nation, with a 1996 rate of drug-related deaths nearly three times as high as the Healthy People 2000 objective.

Whites ages 25-64: In San Diego, the highest number of drug-related deaths in 1996 affected individuals between the ages of 25 and 64, with Whites having the highest rates of any ethnic/racial group.

Adolescents: Over 47% of youth surveyed in San Diego City high schools in 1997 reported current alcohol use.²¹ It places adolescents at higher risk for unintentional injuries and unsafe sexual behavior, and increases their risk of developing serious alcohol dependency problems as they mature. Teen smoking is on the increase, with nearly 25% of all high school students reporting current tobacco use in a 1997 survey.²¹

Violence

Child abuse, partner violence and elder abuse: These are persistent problems that are taking their tolls on individuals and families. During fiscal years 1995 and 1996, the Mid City and Kearny Mesa SRAs had the highest average rates of child abuse referrals/reports (182.5 and 174.0, respectively) compared to all other subregional areas in the county.

Homicide: Rates have declined in recent years but it is the leading cause of death for African-American and Hispanic men between the ages of 15 and 24 in the US, and the second leading cause of death for all youth between the ages of 15 and 24.⁴

Juvenile crime: Over 37% of high school students in San Diego reported physical fighting and over 18% reporting weapon carrying in 1997.²¹

Health Issues by Ethnicity/Race

Blacks

(Note: “Blacks” refers to African Americans, Black Puerto Ricans, Jamaicans, Nigerians, West Indians, Haitians and others. See **Appendix B** to see how ethnicities/races are defined. In this document, the term used by the reference source is the one most commonly used.)

- In 1996, Blacks in San Diego had poorer health status than other ethnic/racial groups, especially related to deaths from cancer (including breast, lung and colorectal), coronary heart disease, influenza and pneumonia, unintentional injuries, homicide, and infant mortality. They had the highest percent of low birthweight babies than any other ethnic/racial group, and the highest rate of asthma hospitalizations.
- Between 1993 and 1996, births to teens were higher than the county average, but not as high as the rate for Hispanics.

Hispanics

- In 1996, Hispanics were higher than the county average for asthma hospitalizations.
- The rate of deaths due to homicide in 1996 was higher than the county average.
- Hispanics as a group had the lowest rate of prenatal care and the highest rate of teen births in the county between 1993 and 1996.
- Hispanics tend to have more individuals who are uninsured, both adults and children, compared to other ethnic/racial groups.

Whites

- In 1996, Whites had higher rates of suicide and drug-related deaths than other ethnic/racial groups.
- In 1996, Whites had higher rates of cancer deaths, including breast and lung cancer, than countywide averages.

Health Issues by Age

Infants and Children (Birth to 14 years old)

Infant Mortality: In 1996, 243 infants died before their first birthday in San Diego County. The infant mortality rate decreased from 6.2 deaths per 1,000 births in 1993 to 5.4 per 1,000 in 1996. The Black infant mortality rate in San Diego during the same year was almost twice that of the overall county in 1996.

Low Birthweight: In 1996, 5.8% of all newborns had a low birthweight (less than 2,500 grams) in San Diego County. This is a slight decrease from 6.0% in 1993.

Prenatal care: The key determinant to an infant's well being at birth is the health of the mother during pregnancy and the care the mother receives during the prenatal period.⁴

Unintentional injuries: These are the number one killer of children under 14 years old.⁴ Falls account for 30% of fatal and nonfatal unintentional injuries for children, followed by motor vehicle crashes, fires and poison.⁴

Adolescents and Young Adults (Ages 15-24)

Unintentional injuries: These were the number one cause of death for this age group.⁴

Homicide: This is the second leading cause of death for this age group. It is the leading cause of death for African-American and Hispanic men between the ages of 15 and 24 in the US.⁴

Suicide: Suicide is the third leading cause of death for adolescents and young adults.⁴

Other health issues: Sexually transmitted infections and teen pregnancy are concerns for the younger ages in this grouping. Adolescents and young adults are developing healthy and/or unhealthy habits related to diet and nutrition, or use of tobacco and other drugs, that may persist throughout their lives.

Adults (Ages 25-64)

Drug-related deaths: The rate of these deaths was higher for this age group than any other age group in 1996.

Leading causes of death: Cancer is the leading cause of death, followed by coronary heart disease and unintentional injuries.

Older Adults (Age 65 and Over)

Leading causes of death: Coronary heart disease was the leading cause of death for seniors, followed by cancer. Seniors had the highest rate of deaths due to influenza and pneumonia, deaths due to unintentional injuries, and suicide in comparison with other age groups.

Health Issues by Region

The county is divided into the six regions indicated below for the purpose of this report. Each region is comprised of a number of communities, which are also referred to as subregional areas or SRAs. See **Appendix G** for a map of subregional areas in San Diego County.

Central Region: *Includes subregional areas of Central San Diego, Southeast, and Mid-City*

This region has more outstanding health issues than any of the other regions. In 1996 it had the highest rates of cancer deaths, coronary heart disease deaths, infant mortality, suicide, drug-related deaths and homicide. It had the highest rate of individuals who had positive tuberculosis skin tests. Child abuse reports/referral rates were higher than any other region. The region had a greater problem with lung cancer deaths, influenza and pneumonia deaths, and deaths due to unintentional injuries.

North Central Region: *Includes subregional areas of Peninsula, Kearny Mesa, Coastal, University, Del Mar-Mira Mesa, North San Diego, Miramar and Elliot-Navajo*

While the North Central region had lower mortality from most major health problems than the County as a whole, some of the subregions within the region experienced more significant health problems. Peninsula had the second highest rate of deaths due to breast cancer of all county SRAs; Del Mar-Mira Mesa had 19.9 active TB cases per 100,000 (compared to 12.2 countywide). Coastal had a higher rate of suicides and drug-related deaths than countywide. Kearny Mesa had higher than countywide rates on cancer deaths (including lung and breast cancer), coronary heart disease deaths, influenza and pneumonia deaths, infant mortality, and suicide.

South Region: *Includes subregional areas of Coronado, National City, Sweetwater, Chula Vista, and South Bay*

In 1996, the South region had the highest rate of breast cancer deaths of all county regions. This region had higher rates of deaths due to breast cancer, coronary heart disease, and flu and pneumonia, as well as infection caused by tuberculosis than the countywide average. The Chula Vista SRA had the second highest rate of cancer deaths in general and the highest rate of lung cancer and breast cancer deaths compared to all other county SRAs. In 1996 the National City SRA had the highest rate of coronary heart disease deaths, pneumonia and influenza deaths, and tuberculosis than any other SRA in the county. The tuberculosis rate is four times as high in Baja California than in California, and the impact is seen in the high tuberculosis rates in the South region and other regions of the county.

North Coastal: *Includes San Dieguito, Carlsbad, Oceanside, Pendleton, and Vista*

The North Coastal region has lower rates of mortality from major causes than other county regions, with the exception of cancer deaths and infant mortality which are above countywide averages. The Oceanside SRA had a higher rate of cancer deaths in 1996 than any other SRA in the county. Between 1993 and 1996, Oceanside was tied with Mid-City for the highest infant mortality rate. Child abuse reports and referrals were also much higher in this region for fiscal years 1995 and 1996 than the rest of the county. The Oceanside jurisdiction had more reported rapes than the county overall with .6 per 1,000 population compared to .3 countywide.

East Region: *Includes subregional areas of Jamul, Spring Valley, Lemon Grove, La Mesa, El Cajon, Santee, Lakeside, Harbison-Crest, Alpine, Laguna-Pine Valley and Mountain Empire*

The East region had a higher rate of lung cancer deaths and deaths from pneumonia or influenza than any other region in the county. It also had higher rates of death due to cancer, coronary heart disease, influenza and pneumonia, suicide and unintentional injury than the county as a whole. El Cajon has significant problems related to violence, as indicated by a high rate of child abuse referrals, homicides, rapes and aggravated assaults. Drug-related deaths and unintentional injuries are also significant concerns.

North Inland Region: *Includes subregional areas of Poway, Ramona, Escondido, San Marcos Valley Center, Pauma, Fallbrook, Palomar-Julian, and Anza-Borrego Springs*

The North Inland region has lower mortality rates than the county overall for the health issues tracked, with the exception of breast cancer and unintentional injuries. The subregional area of Escondido, however, had a number of additional health concerns, including heart disease, drug-related deaths, influenza and pneumonia deaths, and interpersonal violence (child abuse and rape). Escondido had the highest rate of deaths due to unintentional injuries (34.9/100,000 compared to 22.8 countywide).

ACCESS TO CARE

Access to health care is one of the most pressing health concerns in San Diego County, and it continues to be CHIP's number one priority. Limitations in access to care include not having a regular source of care, being uninsured, inadequate health insurance, lack of nearby facilities or necessary providers, physical barriers for the handicapped, and personal barriers such as cultural, language, and knowledge barriers.¹⁷

A recent study by the California Healthcare Foundation concluded that not having a regular physician was an even stronger barrier to access than not having health insurance coverage. The study found that patients without a regular physician were more likely to delay seeking care and to report no physician or emergency department visits within the last year.⁵

People who lack adequate access to care are more likely to have:⁶

- ◀ Poorer health status
- ◀ Higher rates of preventable health problems
- ◀ Higher rates of illness, injury, and mortality
- ◀ Financial barriers to accessing preventive health services
- ◀ Financial barriers to accessing acute care for chronic conditions such as asthma, diabetes, and high blood pressure

The CHIP Access to Care workgroup report, **Safe Harbor: Increasing Access to Health Care in San Diego**, outlines this issue in great detail and identifies a number of strategies to address the problem.

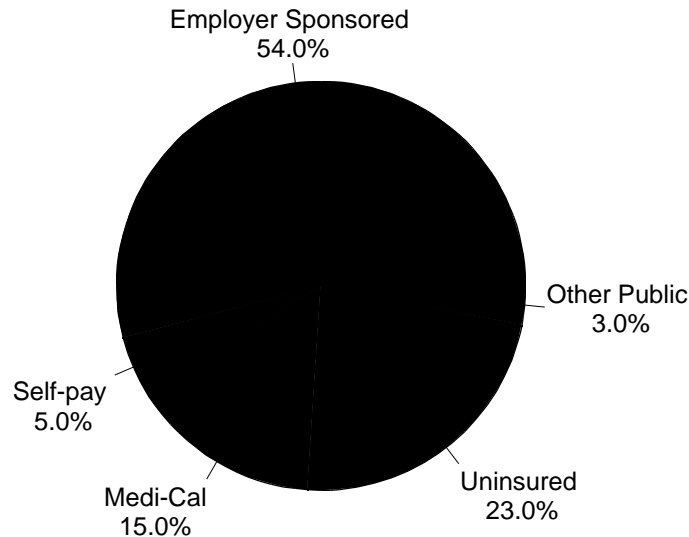
San Diego County

In San Diego County over 623,000 people (23%) were uninsured in 1998 – approximately 147,000 children and 476,000 adults.³ Fifty-one percent are uninsured because they can not afford health insurance. Two-thirds of the uninsured are low-income, at or near 200% of the poverty level. Ninety-one percent are in working

Access to Care
◀ Number one CHIP priority health issue
◀ Barriers to access include: <ul style="list-style-type: none">♦ Lack of health care insurance♦ Insurance that denies coverage or does not approve needed care♦ Lack of a regular medical provider♦ Lack of nearby facilities♦ Shortage of providers or specialists♦ Physical barriers for the handicapped♦ Different language or cultural background♦ Transportation and child care problems♦ Clinic hours conflict with work schedules
◀ 23% of the San Diego population is uninsured.
◀ 110,000 children in San Diego are uninsured.

families.⁶ Of those under age 65 who have health insurance, 54% are covered through their employer, and 15% are enrolled in Medi-Cal (Figure 2).

Figure 2: Health Insurance Coverage of San Diego Residents Under Age 65, 1998⁷



A recent phone survey of 3,600 households in San Diego County, conducted by the United Way, found that a high percentage of adults had problems accessing services in the past year including substance abuse services (65%), respite care services (65%), mental health services (29%), physical health services (17%), and prescriptions (7%). When asked about the need for coping services for adults, 76% reported problems accessing self-improvement services, 50% reported problems accessing support groups, and 26% reported problems accessing professional counseling.⁸

California and the Nation

California

A new report from the California Health Care Foundation shows that the number of uninsured Californians is increasing at a rate of 50,000 per month, resulting in 7 million people without health insurance in 1997.⁷ The report found that 38% of Latinos and 24% of Asian Americans are uninsured, and that nearly one-third of uninsured adults did not seek medical attention when they needed it due to expense.⁷ A recent nationwide survey by the Urban Institute found that low-income families in California are more likely to have poor health and are less likely to have access to health care compared to families in other states.⁹

The Nation

A 1996 nationwide study conducted by the Agency for Health Care Policy and Research reported that 11.6% of families in the United States (12.8 million families) experienced difficulty in obtaining timely medical care or did not receive needed health care services at all. Of the families that experienced barriers to health care,

59% were unable to afford it, and 20% experienced barriers to care such as lack of transportation or communication problems. Lack of child care and lack of time to make a physician visit were also barriers. In some areas there was a shortage of needed specialists.¹⁷

However, there were also barriers to care for families who had health insurance coverage. Of the families that experienced barriers to care, 19% cited insurance-related reasons as a major obstacle to obtaining health care, including their insurance company not approving, covering, or paying for care; having preexisting conditions; referrals being required but not obtainable; and providers not accepting their insurance plan. These results suggest that insurance coverage is not the only answer to assuring access to healthcare, but rather changes are needed within health plans as well to remove these types of barriers.¹⁷

San Diego Community Input

As part of the overall health needs assessment, community input groups were conducted. Access to health care was consistently raised as a major health care issue in the focus groups. Participants identified many factors that influence access to care including cost, availability, and medical insurance coverage. Cost of service issues included not being able to afford health insurance, not being eligible for Medi-Cal or Medicare, employers not offering health insurance to employees, and not being able to afford office co-pays and out-of-pocket specialty care fees.

Focus group participants named limitations in the following as access problems: acute and preventive care, emergency and trauma care, specialty physicians, specialists who accept Medi-Cal, hours of operation, and transportation. Issues related to insurance coverage included (a) being forced to join an HMO if receiving Medi-Cal or Medicare benefits; (b) making too much money to qualify for public assistance, and being employed at a workplace that doesn't offer insurance; and (c) lack of supplemental insurance for seniors to assist in covering out-of-pocket expenses, such as prescriptions.

Seniors

Generally speaking, seniors participating in focus groups expressed that they wanted more education about health issues that impact them, such as diabetes and arthritis. They felt that physicians are not giving them enough explanation about health problems, medications, dietary recommendations, or other treatments. They would like to be notified when flu shots and other routine preventive health activities are needed. In addition to information about health issues, they want to be educated about the administrative part of health care, such as Medicare and the role of health maintenance organizations. Community members expressed the need for help negotiating the health system, better access to specialists, and problem solving strategies on how to deal with very limited approved prescription drug lists. In-home education, community education, and peer senior-to-senior education would be helpful.

Adolescents

Adolescents have specialized needs in terms of access to health care. This group is often neglected in health program development activities because there is a general perception that adolescents are healthy and therefore do not need to use the health care system. They do, however, have concerns about access to information and services pertaining to sexual activity and reproductive health. In their focus group, adolescents reported they needed more education about sexually transmitted infections (STIs), birth control and teen pregnancy. They need information about available services, such as where to be tested or treated for STIs, where to obtain low-cost birth control, and for pregnant teens, where to access prenatal care. Focus group participants felt that a resource directory for teens would be helpful. In terms of the clinic services, teens expressed they had difficulty in obtaining transportation to clinics. They said that health care services are not youth friendly, staff act cynically toward youth who request a pregnancy test, and forms are complicated to complete. They recommended that clinics use adolescent peer mentors to help teen patients access the services and information they need.

A recent national phone survey of adolescents found many did not know how to access care for their mental health and reproductive health needs. Only 5% of adolescents named their primary care physician as a source of confidential care.¹⁰

High Risk Populations

In San Diego, the highest proportions of uninsured are among women and ethnic minorities.⁶ Nearly one-third of women under age 65 depend on the health care safety net. Hispanics are disproportionately represented among the uninsured in San Diego. Rates of uninsured children in San Diego are highest among Hispanics and Blacks. Most individuals who are uninsured are working or are dependents of someone who is working in most cases full time. Either their employer does not offer health insurance, or the employee cannot afford to pay the premium because of low pay.

A new study by the Robert Wood Johnson Foundation and the Henry J. Kaiser Family Foundation identifies significant sociocultural barriers to health care for minority and immigrant groups, including a lack of respect among health care providers for patients of diverse cultural backgrounds.¹¹

Barriers to care for two vulnerable populations are described in more detail below: children and Latinas.

Children

Low income uninsured children have fewer physician visits per year, are less likely to receive adequate preventive services including immunizations, and are less likely to be seen by a physician when they are ill.⁶ According to the California Center for Health Improvement, a 1997 statewide survey of parents found that 35% of insured children and 55% of uninsured children have problems accessing health services. Obtaining dental care was a problem for 37% of those surveyed. This was followed by obtaining health care information after hours (33%), obtaining basic health care (29%), obtaining preventive care services (21%), obtaining mental health services

(20%), obtaining substance abuse services (11%) and obtaining transportation (22%).¹²

Nationally, nearly one-fourth of all uninsured children eligible for Medicaid are not enrolled in the program, which amounts to 4.7 million children nationwide.¹³ In San Diego County, as many as 30% (about 50,000) of San Diego's uninsured children may be eligible for Medi-Cal, but a parent has not applied for them due to lack of awareness, cultural barriers, or a complicated enrollment process.⁶ The Healthy Families program increases the number of children who are eligible for public health programs, and therefore will reduce the number of children who face barriers to health care.⁶

Latinas

In California, Latinas are more likely to be uninsured than any other female group. A recent study by the Latino Coalition for a Healthy California found the following health care access barriers for Latinas:¹⁴

- ◀Language – In California, nearly one third of Latino households speak only Spanish and bilingual services are not readily available in the health care system.
- ◀Education – Latinos have a high drop out rate making it more difficult for them to access health care information.
- ◀Employment – Latinas are overrepresented in low-skill, low-wage jobs that do not provide health insurance and are making insufficient income to purchase coverage.
- ◀Poverty – Low income women are less likely to use health care services, particularly screening services and preventive care, compared to women of a higher socioeconomic status. Twenty-three percent of Latinas have household incomes below the federal poverty level.
- ◀Medi-Cal – Less than 25% of Latinas use Medi-Cal, despite their high poverty levels.

Recommendations to Improve Access to Care

General Recommendations

The **Safe Harbor** report makes the following recommendations to improve access to care:⁶

- ◀Expand access to care through existing public programs.
- ◀Ensure that individuals eligible for publicly subsidized programs receive them.
- ◀Encourage more appropriate use of the existing system of care.
- ◀Address cultural, transportation, and service hours barriers to care.
- ◀Enhance access to mental health services.

The **Healthy People 2010** draft report makes the following recommendations to improve access to care:¹⁷

- ◀ Increase the number of people with health insurance coverage.
- ◀ Increase the number of people with a regular physician.
- ◀ Increase the number of health care providers including physicians, physician assistants, and nurses who receive appropriate training to address important health disparities including disease prevention and health promotion, minority health, women's health, and geriatrics. Health promotion includes education, preventive care, screening, and recommendations on how to incorporate lifestyle advice and prevention into routine practice.
- ◀ Increase the availability of evening and weekend care.

Focus Group Recommendations

Focus group participants offered the following general suggestions on how health care facilities can increase access to care for all populations:

- ◀ Offer more evening and weekend hours.
- ◀ Invest in transportation services for people who need them.
- ◀ Teach patients and community members about the appropriate use of health care services, how insurance works, and how to negotiate the complicated maze of Medicare.
- ◀ Offer translation services and make them readily available to patients.
- ◀ Provide resources for uninsured patients who use the emergency room; teach them where they can access care and how to get care early so a health problem does not become an emergency.
- ◀ Ask physicians to donate care, especially specialty care, at a community clinic on a monthly basis.
- ◀ Make front offices as efficient as possible to minimize wait times, which means less time away from work.

Adolescents

Based on input from the adolescent focus group, health care facilities can improve access to services for adolescents as follows:

- ◀ Set up a safe environment for youth with dedicated youth clinic hours and youth-friendly staff.
- ◀ Ensure that pediatricians and family physicians receive continuing education about adolescent issues.
- ◀ Create and distribute adolescent resource cards with teen hotlines and other referral information, as well as an adolescent resource directory.
- ◀ Provide transportation, especially to and from school to the clinic in coordination with parents of youth.
- ◀ Provide assistance with forms.

Seniors

Based on input from the seniors' focus group, health care facilities can improve access to care for seniors as follows:

- ◀ Offer more educational classes on major health issues and chronic conditions for seniors including diabetes and arthritis.
- ◀ Provide more information on flu shots and other preventive health measures.
- ◀ Offer senior-to-senior peer advice.
- ◀ Retain on-site experts in Medicare and insurance that can help to navigate the system.
- ◀ Provide assistance with forms.

Ethnic Minorities, including Immigrant Groups

A number of actions can be taken by **health care providers** to ease communication problems for ethnic minorities. A report issued by the Robert Wood Johnson Foundation and the Henry J. Kaiser Family Foundation¹¹ recommends health care providers:

- ◀ Use interpreters to increase patients' comfort level.
- ◀ Assign health workers to work as liaisons between health care personnel and the community.
- ◀ Provide cultural sensitivity training to health care personnel.

Public agencies can reduce access to care barriers if they:¹¹

- ◀ Provide funding to support community health care workers and interpreters.
- ◀ Implement standards for cultural understanding by providers.
- ◀ Provide community education and outreach on available services and access for Medicaid recipients.

A number of innovative programs have helped to improve access to care for ethnic minorities, including immigrant groups.¹¹ For example, a program to improve immigrant health educates and deploys male farmworkers as family health promoters in their communities. The program has increased the number of immigrant women receiving prenatal care, the number of fathers accompanying their partners to prenatal care visits, and the number of parents bringing their children in for routine medical care. Other programs conducted surveys and focus groups of low income or minority women to better understand their barriers to care.

San Diego Programs

Center for Consumer Health Education and Advocacy¹⁵

The purpose of the Center for Consumer Health Education and Advocacy is to educate consumers about their health care rights and responsibilities, solve problems associated with managed care plans and health care enrollment, collect data about

Community Health Improvement Partners

health problems, and identify problems in the health care system. It is being established by the Health Consumer Alliance, a new initiative that is operating offices in a number of counties statewide to protect the rights of consumers of publicly-funded health care.

San Diego Kids Health Assurance Network (619) 692-8428 or (800) 675-2229

- ◀Improves access to quality medical care for low income San Diego children
- ◀Provides referrals to children's health care services for low income families including Medi-Cal and Healthy Families
- ◀Provides a centralized resource and referral system
- ◀Conducts outreach
- ◀Operates an 800 number telephone information and referral system to connect uninsured children with a medical care home
- ◀Facilitates a coordinated outreach campaign with public and private partnerships to link uninsured children with health care options
- ◀Recruits pediatricians through partnership with the American Academy of Pediatrics to provide low cost or no cost care to children who do not otherwise qualify for care
- ◀Convenes and facilitates meetings to enhance communication on health care options and outreach efforts

San Diego Children's Dental Health Initiative - Share the Care (619) 692-8858

- ◀Public-private partnership between the County of San Diego Health and Human Services Agency, the San Diego County Dental Society, and the San Diego County Dental Coalition
- ◀Targets families who have limited resources
- ◀Provides access to dental care and dental education for children pre-school age to 19 years in San Diego county
- ◀Finds free or low-cost emergency dental care
- ◀Offers preventive services through neighborhood-based programs
- ◀Provides information and education to parents and providers, emphasizing the need for ongoing preventive dental care

Reach Out Project (619) 299-3122

- ◀Provides no-cost community health care referral services to San Diego's underserved and uninsured populations
- ◀Helps remove the fragmentation of existing health care services by directing individuals to existing funded programs or a provider who has agreed to see patients on a discounted basis
- ◀Makes discounted services available from primary care and specialty physicians, as well as diagnostic, ancillary, and inpatient services

- ◀Makes dental and counseling services available through an established referral network
- ◀Serves approximately 1,800 patients per year

Additional Programs

Countywide Managed Care for Indigents - Hillsborough County, Florida¹⁶

- ◀Managed care health system for the uninsured that saved Hillsborough County \$90 million over four years
- ◀Brought together a complex network of public and private providers including primary care physicians, specialists, and hospitals
- ◀Saved \$6 million by diverting 8,000 emergency room visits to primary care
- ◀Reduced hospital admissions by 28%, hospital days by 40%, and average length of stay from 10.2 days to 5.6 days
- ◀Reduced per capita monthly health care costs from \$600 to \$233
- ◀Enrolled over 60% of the eligible population in the program
- ◀Increased the number of primary care access sites from four to twelve
- ◀Funded by a _ cent sales tax
- ◀Social work case managers in participating health care facilities enroll eligible patients in program and assess their social and financial needs
- ◀Provides intensive inpatient utilization review and discharge planning
- ◀A 24 hour telephone information and medical triage line diverts potential emergency room visits for non-urgent conditions to primary care providers
- ◀Controls increasing uncompensated care costs by providing primary and preventive services and reducing costly inpatient and emergency care
- ◀Outcomes include increased access to primary care, a reduction in hospital admissions, shorter hospital stays, and lower per patient costs
- ◀Improves the efficiency of health care delivery to low income patients
- ◀Emphasis on primary care, prevention, and early diagnosis and treatment
- ◀Improves community health and spends public health dollars more efficiently

Integrated Family Health and Social Services, Project Vida – El Paso, Texas¹⁶

- ◀Provides integrated family health and social services through a network of private and public partnerships and connections between local providers, institutions, and programs
- ◀Provides family-centered, one-stop shopping including primary health care, education, housing improvement, gang activity prevention activities, and social services ranging from a food co-op to a thrift store and gift shop

Community Health Improvement Partners

- ◀Registered over 1,300 families for health and social services, built 20 units of new affordable rental housing, and had a 20% increase in standardized reading scores in the local elementary school
- ◀Gives families a greater sense of responsibility and control
- ◀Targets one of the nation's statistically poorest, highest crime, urban areas
- ◀Offers health care to 350 patients monthly who had no primary care provider
- ◀Ninety-seven percent of registered infants and children are on schedule for immunizations
- ◀Saved county hospital over \$150,000 in 1995 by preventing inappropriate emergency room usage
- ◀Community residents evaluate the program, set priorities for services, and volunteer to help reduce education, language, and cultural barriers
- ◀Program has developed strong relationships and joint activities with local churches, local schools, and nursing and medical students

Peer Outreach and Access for High-Risk Youth, Hollywood Center, Los Angeles, California¹⁶

- ◀Increases access to primary care and social services for homeless and high-risk youth, in a youth friendly, culturally appropriate environment
- ◀Addresses the needs of youth by focusing on health, social, and emotional issues
- ◀Emphasizes a comprehensive approach to care that includes medical care, dental care, psychiatric services, substance abuse counseling, pregnancy testing, HIV testing and counseling, job training and placement, mentoring, and peer education about HIV, substance abuse, domestic violence, gangs, and other critical issues
- ◀Seventy-five percent of the youth screened for HIV return for results and counseling
- ◀Each youth is evaluated with the HEADDSS Survey (Home, Education, Activities, Drugs/Depression, Sex/Suicide) to determine their areas of risk and is offered a range of appropriate services

Child Health Outreach and Enrollment Model, Sunset Park Family Health Center, Brooklyn, New York¹⁶

- ◀A network of eleven elementary and middle school-based medical centers that serve 11,000 children (95% of the schools' enrollments), regardless of ability to pay
- ◀Provides access to a wide range of primary and specialty health services to children and families who previously had little or no regular care including primary, dental, ophthalmological, and mental health care
- ◀Decreased the number of uninsured children by 30% from 1995 to 1997 and has shifted 50% of Medicaid enrolled children into managed care
- ◀Raised immunization rates and improved maintenance of chronic diseases such as

asthma and diabetes

- ◀Reduced inappropriate usage of emergency rooms
- ◀Increased school attendance rates dramatically
- ◀Conducts school health outreach to bring immigrant families into the health care system through translation services and culturally sensitive counseling

Resources

Community Health Improvement Partners, Access to Care Work Team,
telephone (619) 544-0777

California Health Care Foundation, www.chcf.org

California Center for Health Improvement, www.policymatters.org

Health Care Financing Administration, www.hcfa.gov

Healthy Families, www.healthyfamilies.ca.gov

Families USA Foundation, www.familiesusa.org

Bureau of Primary Health Care, www.bphc.hrsa.dhhs.gov

Managed Risk Medical Insurance Board, www.mrmib.ca.gov

100% Campaign – Health Insurance for Every California Child,
www.100percentcampaign.org

SUMMARY OF OTHER HEALTH ISSUES

This section provides an overview of health issues in San Diego County. Additional information regarding background information, risk factors, high risk populations, prevention, model programs, resources, and references is contained in the health issue briefs. **Appendix E** provides a summary of health issues by racial/ethnic group.

Appendix F summarizes mortality rates by age groups. **Appendix H** describes years of productive life lost to age 65 for various health issues.

Cancer

Cancer is the second leading cause of death in the United States. Nearly every family has been touched by its impact. Cancer affects the elderly and African Americans at a higher rate than the young and those of other races. The most common cancers that cause death include cancer of the lung, breast, prostate, and colon/rectum.

Overall cancer trends in San Diego reflect national trends: local rates are decreasing slightly for all cancer deaths, including lung, breast, and colorectal cancer. Lung cancer continues to be the most common cause of cancer mortality among men and women in the US, and represents 25% of all cancer deaths in San Diego County.

Breast cancer affects one in eight American women in their lifetime, and is the second most common cause of death from cancer in women behind lung cancer.¹⁷ Black women are at greater risk of death from breast cancer, due in large part to the lack of early detection and adequate treatment. Colorectal cancer is the second leading cause of cancer deaths in the nation, and affects seniors at higher rates than other age groups. Colorectal cancer is extremely curable if detected early.

Statistics reflect only a portion of the enormous impact of cancer. Fortunately, there is evidence that the prospect of preventing and surviving cancer continues to improve. An estimated 50% or more of cancer incidence can be prevented through smoking cessation and changed dietary habits. Early detection of breast and colon/rectal cancers can contribute significantly to the chance of survival. Survival rates are continuing to improve due to advances in early detection and treatment.

Cancer	
◀Mortality rate	
Overall:	113.1/100,000
Lung:	29.5/100,000
Breast:	19.9/100,000
Colorectal:	10.6/100,000
◀Overall mortality rates from cancer decreased between 1993 and 1996	
◀San Diego County meets the Healthy People 2000 Goal	
◀Asian and Pacific Islanders in CHIP focus groups expressed concerns about cancer	
◀African Americans and Whites have higher cancer mortality rates than other ethnic/racial groups	

Cardiovascular Diseases

Cardiovascular disease includes: (1) heart disease, which is also called coronary heart disease or ischemic heart disease; (2) stroke, which is a form of cerebrovascular disease that affects the arteries of the central nervous system, and (3) high blood pressure, which is a risk factor for stroke and heart disease.

Cardiovascular Diseases

- ◀ 25% of all deaths in were related to cardiovascular disease in 1996.
- ◀ The rate of heart disease deaths is increasing.
- ◀ San Diego meets the Healthy People 2000 goal for cardiovascular disease-related mortality.
- ◀ African Americans have a significantly higher rate of mortality from cardiovascular disease than other ethnic/racial

Heart disease is the leading cause of death and a common cause of morbidity in the US. It accounts for 40% of all deaths. Over six million people are hospitalized annually, and the economic costs attributable to cardiovascular disease are estimated at \$259.1 billion.¹⁷

In San Diego County, the heart disease-related deaths are increasing, although the mortality rate in the county is less than the Healthy People 2000 Objective (which are national health status goals set by the US Department of Health and Human Services). Blacks have a much higher rate of deaths from cardiovascular disease than the overall population (155.7/100,000 compared to 93.1/100,000). In San Diego, over 18% of males and 22% of females surveyed have been told they had high blood pressure by a health care practitioner.¹⁸ The major risk factors of cardiovascular disease, including smoking, diet, and exercise, are amenable to prevention and intervention.

Chronic and Disabling Conditions

Over 90 million Americans live with a chronic or disabling condition, including arthritis, heart disease, back conditions, diabetes, cancer, visual impairments, asthma, speech and hearing impairments, and physical disabilities. Over 60% of the nation's medical costs are spent on chronic ailments.¹⁹

Diabetes affects an estimated 170,000 individuals in San Diego County, and the rates of diabetes are higher among minority groups than Whites. Nearly one-third of the individuals that have diabetes are unaware of the condition, and approximately half of all diagnosed cases are among persons over age 65. Diabetes can cause serious complications including vision impairments, kidney disease, nerve disease, and cardiovascular disease. The risk of diabetes increases significantly with age, affecting 18.4% of all seniors.²⁰

In San Diego County, the estimated prevalence of diabetes is more than twice the Healthy People 2000 goal. Risk factors for diabetes include family history, obesity, sedentary lifestyle, poor diet, and age; however, diabetes can be effectively controlled with medication and lifestyle changes.

Asthma affects nearly 5% of the US population, and is a primary cause of hospitalizations. In 1996, hospitalizations due to asthma were much higher for African Americans and Hispanics than for Whites in San Diego County. While asthma rates appear to be rising nationwide, asthma-related hospital admissions decreased in San Diego County between 1995 and 1996. Young people under age 17, especially those of African or Hispanic origin, have the highest rates of asthma-related hospital admissions.

Chronic and Disabling Conditions

- ◀ African Americans and seniors responded in focus groups that chronic diseases were prevalent in their communities, but they were not receiving adequate care.
- ◀ The estimated prevalence of diabetes in San Diego is over twice the Healthy People 2000 objective.
- ◀ African Americans and Latinos have asthma hospitalization rates much higher than other ethnic/racial groups.

Communicable Diseases

Although many experts predicted that the public health significance of infectious diseases would continue to wane this century in the United States, they remain major sources of morbidity and mortality in this country. Between 1980 and 1992, data show that overall mortality from infectious diseases rose 58% in the United States. A significant proportion of this increase is accounted for by the increasing burden of HIV-associated disease. However, even when HIV-associated diagnoses are removed, mortality from infectious diseases still increased 22 percent during this time.¹⁷

In San Diego County, **tuberculosis** is a serious concern. While the trend in the county has decreased from 17.9 cases per 100,000 population to 12.2 from 1993 to 1997, the rate is still significantly higher than the Healthy People 2000 objective of 3.5. San Diegans with the highest tuberculosis infection rate are those from the Philippines and Mexico, and individuals over age 65. Tuberculosis is most often curable, but strict medication regimens must be adhered to. Since tuberculosis rates are four times higher in Baja California than California, cooperation is needed between the two states to alleviate the problem in the border region.

Tuberculosis

- ◀ San Diego County's rate of active tuberculosis (12.2) is much higher than the Healthy People 2000 objective.
- ◀ The trend of active TB cases decreased between 1993 and 1997.
- ◀ Central San Diego and National City have the highest rates of active TB.

Influenza and Pneumonia

- ◀ The rate of pneumonia and influenza-related deaths increased from 1993 – 1996.
- ◀ Over 17 average years of productive life is lost (YPLL) for each influenza and pneumonia-related death.
- ◀ National City and Escondido have the highest rates of influenza and pneumonia-related

Pneumonia and influenza are also infectious diseases which take their toll primarily on seniors and individuals with chronic health problems. In San Diego, the rate of deaths from pneumonia and influenza is increasing (from 32.0/100,000 in 1993 to 35.1/100,000 in 1996), and is higher than the California rate. African Americans in San Diego County have a higher influenza and pneumonia-related death rate than other ethnic/racial groups. Individuals over age 65 are the most significantly affected, with a rate of 281.9 deaths/100,000 population in 1996. Influenza immunizations for high-risk and senior populations are an extremely effective prevention method.

Immunizations

- ◀ San Diego does not meet the Healthy People 2000 goal in immunizations.
- ◀ In 1996, only 78% of 2-year-olds were adequately immunized.

Childhood immunizations have been a serious concern in San Diego, although the percent of two year olds that have been adequately immunized has increased from 65% to 78% in the last five years. This increase can be attributed in large part to intensive public health efforts, including education. San Diego County does not meet the national Healthy People 2000 objective of 90% however.

Health Behaviors

Good nutrition and physical activity are the keystones to good health. Healthy eating and exercise contribute significantly to a longer and higher quality life, and are fundamental to the prevention of cardiovascular disease, cancer, diabetes, and a host of other chronic as well as acute health conditions. **In San Diego County the percentage of adults surveyed who say they participate in regular physical activity is less than the Healthy People 2000 objective** (80.4% compared to the goal of 85%). In addition, the percentage of adults who say they exercise three out of seven days decreased between 1993 and 1997.¹⁸ Diet and exercise were major concerns among Asians and Pacific Islanders participating in CHIP focus groups, as was obesity among African American women.

HIV/AIDS

The HIV/AIDS epidemic is a relatively recent public health phenomenon in the United States and globally. The disease was first recognized in 1981, and the primary population group affected was white homosexual men. However, other AIDS cases quickly followed, soon appearing among persons with hemophilia, persons who injected illegal drugs, and ethnic and racial minorities.¹⁷

Since the early 1980s, it has become clear that there are at least four distinct HIV/AIDS epidemics of public health significance:

- An epidemic among men who have sex with men, facilitated by frequent changes of sex partners in highly infected sexual networks and high-risk sexual practices.
- An epidemic among injecting drug users facilitated by the multi-person use of needles and syringes that are contaminated with HIV-infected blood.
- An epidemic among heterosexual persons (principally in minority communities) facilitated by high rates of other sexually transmitted diseases that can increase both susceptibility to and transmissibility of HIV infection, and high-risk sexual practices. Female partners of male injection drug users have contracted HIV in ever-increasing numbers.
- A perinatal epidemic among infants caused by undetected and untreated HIV infection in pregnant women.¹⁷

HIV/AIDS
<ul style="list-style-type: none"> ◀As of February, 1998, a total of 9,200 AIDS cases have been diagnosed. Of those, 3,713 are currently living with AIDS ◀The trends in the number of AIDS cases reported per year decreased from 1992 to 1996. ◀The local rate of diagnosed AIDS is lower than the Healthy People 2000 objective

In San Diego County, the number of new AIDS cases reported each year has decreased between 1992 (1,088) and 1996 (717). The rate of new AIDS cases in 1996 in San Diego was 27/100,000, which is higher than the rate in California (22/100,000), but lower than the Healthy People 2000 objective (39/100,000). African Americans have the highest incidence of diagnosed AIDS cases in San Diego and California. Effective public health prevention techniques include education, use of condoms, safe sex practices, needle exchange programs, and pre-pregnancy testing.

Infant Health Problems

Improving the health of mothers and infants is a national and local priority. Infant mortality is an important measure of a nation's health and a worldwide indicator of health status and social well being. As of 1993, the US infant mortality rate ranked 25th among industrialized nations. In San Diego the rate of infant mortality (5.4/100,000 in 1996) is lower than the state rate, and meets the Healthy People 2000 goal of 7.0. However, the infant mortality rate among African Americans in San Diego (10.6/100,000) is almost twice that of the overall county. Low infant birthweight is also an important indicator of maternal and child health. In San Diego, the rate of low birthweights, under 5.5 pounds at birth, does not meet the Healthy People 2000 goal for all babies and more specifically for African American babies.

Infant Health Problems
<ul style="list-style-type: none"> ◀The trend in infant mortality in San Diego County is decreasing, and meets the Healthy People 2000 objective. ◀The African American infant mortality rate in San Diego in 1996 was almost twice that of the Overall county rate. ◀The San Diego County percentage of low birthweight (5.8%) does not meet the Healthy People 2000 objective

Low birthweight can result in life-long health problems including mental retardation, cerebral palsy and vision and hearing impairments. Infant deaths and health problems can be significantly impacted by simple yet effective prevention efforts for the mother, including early and regular prenatal care, avoidance of alcohol, tobacco, and other drugs, a nutritious diet, regular exercise, and social support.

Mental Health and Mental Disorders

Mental Health and Mental Disorders

Mental health was a priority concern for a majority of CHIP focus group participants, especially related to the lack of access to services.

A national study showed that 48.4% of adults reported a psychiatric disorder some time in their lifetimes.

The San Diego County rate of suicide (11.6) is higher than the Healthy People 2000 objective (10.5).

Whites have a higher suicide rate than other ethnic/racial groups in San Diego.

Mental health is defined as the ability of an individual to negotiate the daily challenges and social interactions of life without experiencing cognitive, emotional, or behavioral dysfunction. To a greater or lesser degree, mental illnesses affect children, adolescents, adults, Americans of all ethnicities and racial groups, both sexes, and all educational and socioeconomic strata. Nationally, an estimated 40 million Americans experienced some type of mental disorder within the past year. An estimated eight million people between the ages of 15 and 54 experienced both a mental disorder and a substance use disorder within the past year. It is estimated that approximately 35% of the population aged 15 to 54 will develop an undiagnosed mental illness over the course of their lifespan.¹⁷ Access to mental health services, particularly for those without health insurance, is a primary concern, and creates significant barriers for people attempting to manage their illness.

Suicide is perhaps the most devastating end result of a bout with mental illness. In San Diego, 337 people committed suicide in 1996, which is a decrease from 14.2/100,000 in 1993 to 12.6/100,000 in 1996. However, the local rate is still higher than the Healthy People 2000 objective of 10.5. Suicide is the third leading cause of death among youth between the ages of 15 and 24. In San Diego high schools, 13.9% of girls surveyed said they attempted to commit suicide in the past year, and 29.3% said they thought seriously about suicide.²¹

Reproductive Health

The area of reproductive health includes health problems related to sexually transmitted infections, including chlamydia, gonorrhea, and syphilis, as well as health and social problems related to teen pregnancy.

There are over 20 types of sexually transmitted infections (STIs), with the US having the highest rates of STIs in the industrialized world.¹⁷ They are major concerns for adolescents, and can contribute to infertility, pregnancy complications, adverse birth outcomes, chronic infection, cervical cancer, and even death.

In 1997 there were 6,398 reported cases of chlamydia, 1,508 cases of gonorrhea, and 23 cases of syphilis in San Diego County. Chlamydia affects one out of every ten teenage girls, and can result in infertility. The rates in San Diego County are higher than the California and national rates. For gonorrhea, the reported rate in San Diego County is lower than the Healthy People 2000 objective, and decreased significantly from 1993 to 1997. The reported rate of syphilis is also decreasing and is significantly lower in San Diego County than the Healthy People 2000 objective.

Teenage pregnancy is a serious concern for adolescents. In San Diego there were 1,884 births to girls between the ages of 12 and 17 in 1996, however the rate of births to girls between the ages of 15 and 17 has decreased in recent years. Hispanic youth have the highest rates of teenage pregnancy, resulting in a greater impact in some communities with large Latino populations (Central San Diego, Vista, Chula Vista).

Reproductive Health

- ◀ There are over 20 types of sexually transmitted infections (STIs). In San Diego in 1997, there were 6,398 reported cases of chlamydia. STIs can cause infertility, adverse pregnancy outcome, cancer or even death.
- ◀ Age groups most impacted by STIs are adolescents and young adults (15-24). The highest rates of reportable STIs are in the subregional areas of Central and Southeast San Diego.
- ◀ The rate of teen pregnancies in San Diego decreased between 1993 and 1996, and meets the Healthy People 2000 objective.
- ◀ Hispanic girls have the highest rate of teen pregnancy in San Diego.
- ◀ Teen pregnancy was identified as a major concern among the adolescent, Latino, and African American community focus groups.

Substance Abuse

Substance abuse and substance abuse-related problems are among society's most pervasive health and social concerns. Substance abuse includes the misuse and abuse of tobacco, alcohol, and other drugs. Over 100,000 people die each year in the US as a result of alcohol alone. Illicit drug abuse and related AIDS deaths account for at least another 12,000 deaths annually. It costs every man, woman, and child in America nearly \$1,000 annually to cover the costs of health care, law enforcement, motor vehicle crashes, crime, and lost productivity due to substance abuse.¹⁷

Smoking is a serious concern due to its toll on health. Tobacco use is the leading preventable cause of death in the US and results in more years of productive life lost than any other condition each year. Teen smoking is on the increase, with nearly 25% of all high school students reporting current tobacco use in 1997.²¹ Trends for chronic lung disease deaths are also increasing in San Diego County, with the highest rates affecting the white population.

Substance Abuse

- ◀ Substance abuse is a major concern among San Diegans, particularly among adolescents.
- ◀ Teen smoking is increasing, nearly 25% of high school students reported current tobacco use in 1997.
- ◀ Over 47% of youth surveyed in San Diego City high schools reported current alcohol use.
- ◀ San Diego has a more serious drug problem than other parts of the nation. The drug-related death rate is nearly three times as high as the Healthy People 2000 objective.

Alcohol use and abuse is a priority concern for adolescents as well as adults. Over 47% of youth surveyed in San Diego City high schools reported current alcohol use.²¹ Alcohol is involved in nearly half of all fatal auto collisions and murders, accidental deaths, suicides, and crimes. Alcohol places adolescents at higher risk for unintentional injuries and unsafe sexual behavior, and increases their risk of developing serious alcohol dependency problems as they mature.

Drug abuse has declined nationally, although the number of drug-related deaths for adolescents has nearly doubled nationally in the last four years. San Diego County experiences a more serious problem than other parts of the nation, with a rate of drug-related deaths nearly three times as high as the Healthy People 2000 objective. In San Diego, the highest number of drug-related deaths affect individuals between the ages of 25 and 65, with Whites having the highest rates of any ethnic/racial group. Risk factors for adolescent drug abuse include a family history of abuse, low self-esteem, poverty, and low educational achievement. Effective prevention and

intervention practices are multi-faceted and complex. However, prevention which builds on the strengths and assets and ameliorates the risks of individuals, families, and communities can be effective if soundly and diligently implemented.

Unintentional Injuries

Unintentional injuries are the leading cause of death for people ages 1 to 34. They include motor vehicle crashes, falls, drownings, poisonings, recreational and sports-related injuries, burns, choking, unintentional shootings, and suffocation, and can be effectively addressed through proven prevention techniques. Seniors are particularly

Unintentional Injuries

- ◀ Leading cause of death for people aged 1-34.
- ◀ Seniors have a higher rate of deaths from unintentional injuries than any other age group.
- ◀ Deaths due to falls are increasing.
- ◀ Environmental prevention (helmets, safety belts, speed limits, pool covers) are effective.

vulnerable to falls, and the rate of deaths from unintentional injuries is higher for seniors than any other age group. Death and injury due to motor vehicle crashes are of a particular concern for young people in the 15-24 age group.

While motor vehicle crashes and deaths are a major concern on San Diego freeways, San Diego County has met the Healthy People 2000 goal of 14.2/100,000 (the San Diego rate was 9.9/100,000 in 1996). San Diego County data points to an increasing trend in deaths due to falls in recent years, which disproportionately affect the frail and elderly population.

Environmental methods of prevention have been shown to be extremely effective in reducing deaths due to

unintentional injuries. Examples include the use of helmets while participating in sports activities and while operating motorcycles or bicycles; mandatory fencing around swimming pools; child safety caps on medication, pesticides and home cleaning chemicals; reduction of the speed limit and sanctions against driving while under the influence of drugs or alcohol; and architectural modifications on homes and buildings to use more ramps, railings, and slip resistant flooring.

Violent and Abusive Behavior

Violent and abusive behavior includes family violence against children, partners, and elders, as well as intentional injuries such as homicide, rape and assault, and youth violence. Violence is pervasive in society and has changed the quality of life for those it directly impacts, as well as for those who exist in an environment and social milieu of violence. Americans are shocked by reports of children killing other children in schools. Intimate partner violence and sexual assault threaten women in all walks of life. On an average day in America, 70 people die from homicide and a minimum of 18,000 people survive interpersonal assaults.¹⁷

Poverty, discrimination, and a lack of education and employment opportunities are important risk factors for violence. Multidisciplinary strategies for reducing violence need to begin early in life, before violent behavioral patterns are adopted.

Child abuse is particularly devastating. In 1996, 15 children under the age of 14 were murdered due to child abuse; four of these were under the age of one. There were over 120 child abuse reports made for every 1,000 children under age 18. Most of these referrals were made for neglect (52%), physical abuse (24%), or sexual abuse (12%).

Partner violence is also pervasive, with up to one in four women being subjected to partner abuse in their lifetimes according to some studies.²² In San Diego, there were a total of 26,327 incidents of domestic violence reported in 1996. The problem is generational, with boys who witness spousal violence having a higher statistical chance of being an abusive adult, and girls who witness this abuse having a higher chance of being battered.

Elder abuse has recently been recognized as a major public health problem. Although it is estimated that elder abuse is significantly under-reported, there were 1,358.6 reports/100,000 seniors in 1997-98 in community settings in San Diego and 87.0/100,000 in institutional settings. It is estimated that only 1 in 14 cases of elder abuse are reported.²³

Overview of Health Issues

Violent and Abusive Behavior

- ◀ Over 120 child abuse reports are made for every 1,000 children under 18 in San Diego.
- ◀ There were 26,327 incidents of domestic violence reported in San Diego in 1996.
- ◀ Homicides rates are declining, but are still the leading cause of death for African American and Hispanic men between 15 and 24.
- ◀ Rapes among juveniles are on the rise in San Diego, while trends for many other violent crimes are on the way down.
- ◀ Over 18% of high school students surveyed reported carrying a weapon to school one or more times during the last 30 days.
- ◀ Approximately 78% of rapes are committed by a person the victim knows.

Intentional injuries are a major cause of mortality in the US (50,000 deaths per year), and are closely associated with drug and alcohol use and ownership of weapons. While a major problem in San Diego, **homicide** rates have declined in recent years (from 9.4/100,000 in 1993 to 6.2/100,000 in 1996). Still, homicide is the leading cause of death for African American and Hispanic men between the ages of 15 and 24 in the US, and the second leading cause of death for all youth between the ages of 15 and 24.

Although many violent crimes are on the decrease locally, **rapes** among juveniles in San Diego continue to rise. There is an average of two rapes per day reported regionwide, with 882 women reported being raped in San Diego in 1997. It is estimated that only 10-16% of rapes are ever reported. Young women are the most affected, with women between the ages of 16 and 24 being three more times likely to be raped than women in other age groups. Approximately 78% of rapes are committed by a person the victim knows.²⁴

Youth violence has become a common part of American culture. Over 37% of high school students in San Diego reported physical fighting one or more times during the 12 months preceding a survey, and over 18% reported weapon carrying (gun, knife, or club) one or more times in the 30 days preceding a survey.²¹ While juvenile arrest rates are at unacceptably high levels, especially for African American and Hispanic youth, the arrest rate has decreased in recent years from 80.3/100,000 juveniles in 1992 to 71.6/100,000 in 1996.

Public health interventions for violence of all types are being designed, implemented, tested, and evaluated at many levels in society today. Most effective methods address the multi-factorial mechanisms that contribute to violence on an individual, family, community, and societal level.

DEMOGRAPHICS AND HEALTH ISSUES BY REGION

The following section describes each region’s population characteristics and primary health issues. The regions correspond to the County of San Diego Health and Human Services Agency service regions (See **Appendix G** for a Map of Subregional Areas). Each region is comprised of a number of subregional areas (SRAs) which correspond with those used by the San Diego Association of Governments (SANDAG).

Jurisdictions are used when describing reported rapes and aggravated assaults. A jurisdiction refers to a territory over which authority is exercised, such as an incorporated city (by the local police department), an unincorporated area (by the San Diego Sheriff), the harbor area (by Harbor Police) or other territory.

The County of San Diego Health and Human Services Agency (HHS) provided data tables for the purpose of this review on the following topics:

- Cancer deaths
 - Lung cancer deaths
 - Breast cancer deaths
 - Colorectal deaths*
 - Asthma hospitalizations*
 - Coronary heart disease deaths
 - Tuberculosis
 - Influenza and pneumonia deaths
 - First trimester prenatal care*
 - Third trimester or no prenatal care*
 - Infant mortality
 - Low birthweight*
 - Birth rate to teenagers age 12-14*
 - Birth rate to teenagers age 15-17*
 - Suicide
 - Drug-related deaths
 - Unintentional injury deaths
 - Child abuse referrals/reports
 - Homicide
 - Reported rapes by jurisdiction
 - Reported aggravated assaults by jurisdiction
- *data reported by ethnicity/race and age but not by region

Detailed regional information is available for regions and SRAs in the **Statistical Supplement** to this report, and in most cases includes occurrences and rates for each year between 1993 and 1996. Rates are interpreted with caution when there are five or fewer events, or when the rate corresponds with a very small percentage of the total countywide number of occurrences. These instances are referred to infrequently below, and are noted.

In many cases, the mortality rates are “age adjusted.” This is a mathematical calculation that minimizes the effects of differences in age composition when comparing rates for different populations. For example, if an area has a high cancer death rate, it may simply be because more seniors that live in that area. Calculating an age-adjusted rate removes this effect and allows for standard comparison across regions. **If there is no note saying “age adjusted,” the assumption is that it is not age adjusted.**

San Diego County

Demographic Highlights

As of January 1, 1997, a total of 2,724,437 individuals reside in San Diego County. This is an increase of over 36,000 from 1994 when the total was 2,687,800. Figure 3 shows a breakdown of the population by subregion in 1997. According to population estimates conducted by the state Department of Finance²⁵, San Diego County is now the fifth fastest-growing county in the state, whereas during the previous year it was eighth. During the 1997-1998 two-year period, about 60% of the growth was due to people who migrated to the area, meaning the growth was attributed to people who moved here rather than new births. Of all new comers, about 27% were from other countries. Overall, the county grew at a rate of 2.4%, which is well over California's growth rate of 1.6%. This change reverses the trend of the early nineties when the population growth was slowing down. The rise in population is most likely due to a healthy economy and strong job growth.

Ethnic/Racial Distribution

There have been minor changes in ethnic/racial distribution between 1994 (the data reported upon in the 1995 edition of *Charting the Course*) and 1997. **Appendix J, Table 3** provides a countywide overview of the ethnic/racial distribution of the population as of January 1, 1997, along with the 1994 comparisons in Table 4. The percentage of Hispanic residents has increased from 22.4% in 1994 to 23.6% in 1997. There has been a corresponding decline of Whites from 62.7% of the population to 61.3% between 1994 and 1997. The percentage of Blacks increased very slightly from 6.0% in 1994 to 6.1% of the population in 1997. Asian/Other increased from 8.8% to 9.0%. Figure 4 shows the 1997 ethnic/racial distribution in San Diego County.

The South region had the highest percent of Hispanics with 45% of the population. The highest percent of Whites reside in the east region (77%). Blacks comprise the largest population in the Central region with 17%. Asian and other are highest in the Central, North Central and South regions.

Age Distribution

Most regions have age groupings that closely parallel county averages (see **Appendix J, Table 5**). The exception may include Central, with a somewhat higher than average percentage of infants/children ages 0-14 (26%), and a lower than average population in the 65+ age group (9%). The highest percent of 15-24 year olds are in the South region, comprising 17% of the population. The 25-64 age group make up the highest percent of the North Central region, especially in University, Coastal and Del Mar-Mira Mesa. The highest percent of seniors reside in North Inland areas (14%), especially in Anza-Borrego, Palomar-Julian and Valley Center. Figure 5 shows the 1997 age distribution for San Diego county.

Figure 3: Population by Region, San Diego County, 1997²⁷

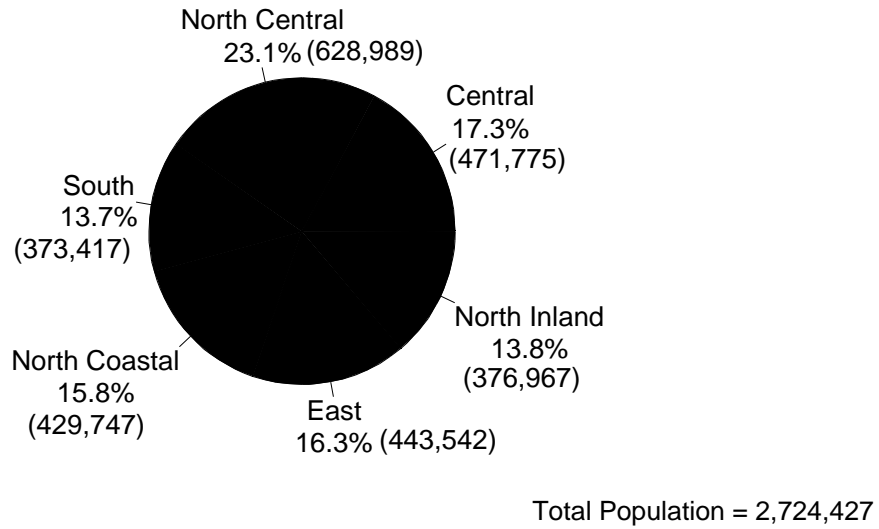


Figure 4: Ethnic/Racial Distribution, San Diego County, 1997²⁷

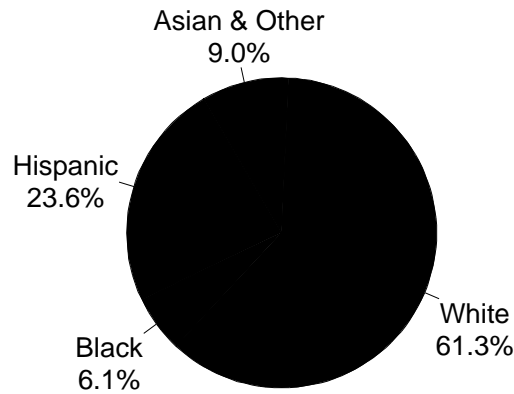
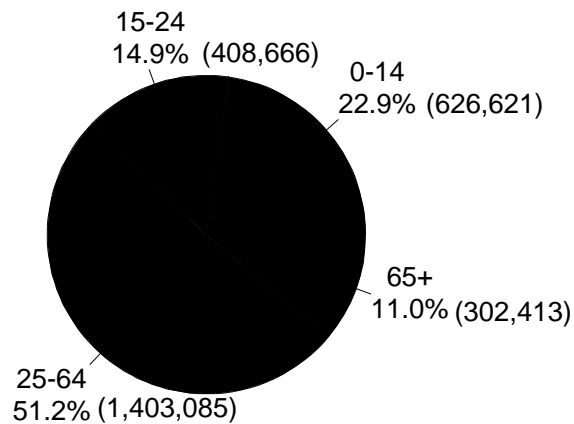


Figure 5: Age Distribution, San Diego County, 1997²⁷

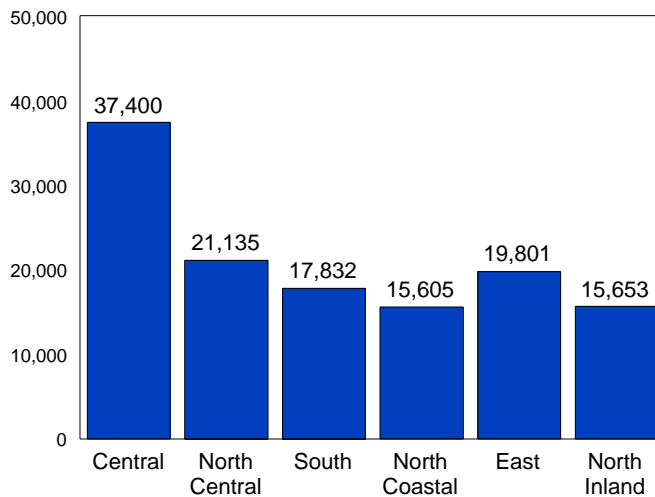


The median age of the population increased only slightly from age 32.0 in 1994 to 32.9 in 1997. The 0-14 population increased from 22.4% of the population in 1994 to 23.0% in 1997. Seniors over age 64 also increased from 11.1% in 1994 to 11.5% in 1997.²⁶ The 15-24 age group and the 25-64 age group both decreased slightly.

Economics

In terms of economics, San Diego County is strong, and has improved dramatically since the early nineties. With a 3% unemployment rate, a greater percentage of people are employed now than any time in modern history. There is a thriving high tech economy with jobs for highly skilled, college educated professionals. However, not all San Diegans are benefiting from the strong economy. There is an ever-increasing low wage service sector in which individuals working full time have a difficult time covering basic living expenses. The poverty rate (earning less than \$16,276 for a family of four in 1997) increased from 11% to 19% between 1980 and 1997. About 59% of adults living in poverty are working. Latinos and African Americans are more likely to be poor. Adequate health care is a problem for people who are working but considered to be too poor to afford insurance or routine preventive care.²⁵

Figure 6: Number of Households <\$14,999 Income by Region, 1997²⁷



Approximately 14.5% of all households (135,695 out of 936,077 households) had an annual income of less than \$15,000 in 1996. This number decreased to 127,429 out of 943,904 total households or 13.5% of households in 1997. (See **Figure 5** for the number of households by region.) The countywide median income between 1990 and 1997 decreased from \$35,022 to \$33,640 in terms of “constant” dollars that eliminate the effects of inflation. The median income between SRAs differs substantially as reflected in **Appendix J**, Table 1.

In 1996, the latest year for which statistics are available, about 11.4% of the county population received Medi-Cal benefits (see **Appendix J**, Table 2). The percentages varied from region to region, with North Central having the lowest percent of residents enrolled in Medi-Cal (5.2%) and the Central region having the highest percent (25.3%). Regions with a higher percent of Medi-Cal recipients typically need

to address barriers to health care and the effects of poverty on health to a greater degree than regions with a lower percent.

Central Region

Includes subregional areas of Central San Diego, Southeast, and Mid-City

Demographic Highlights

In 1997 the Central region had a population of 471,775 (17% of the county total). The Central region is more ethnically diverse than San Diego County overall. Whites and Hispanics claim about the same percentages of the population – 36% and 34% respectively. Approximately 17% of the region is Black, compared to only 6% countywide. A total of 13% are in the Asian/Other category compared to 9% countywide.

Southeast San Diego has the highest percentage of Blacks and Mid-City has the third highest percentage of Blacks in the county. Southeast San Diego also is unique in that it has the second highest percentage of Asian/Other and the lowest percentage of Whites. **Appendix J**, Table 6 provides a detailed breakdown of the central region by ethnicity/race as of January 1, 1997.

The Central region is slightly younger than the population overall. Approximately 26% of its residents are under age 14, compared to 23% countywide. Adolescents and young adults between ages 15 and 24 comprise 16% of the population compared to 14% of the county overall. There is a lower percentage of individuals in the 25-64 and 65+ age categories compared to countywide statistics (see **Appendix I**, Table 7).

Figure 7: Ethnic/Racial Distribution, Central Region, 1997²⁷

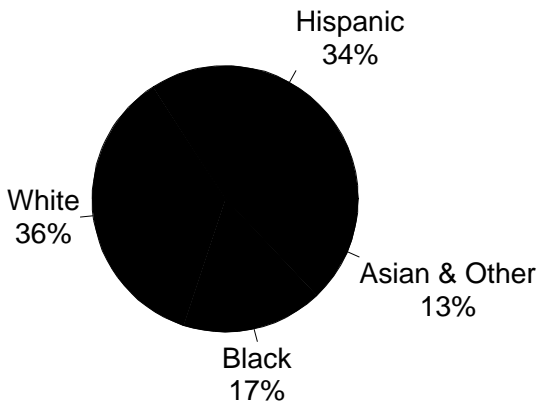


Figure 8: Ethnic/Racial Distribution, Central Region Compared to County, 1997²⁷

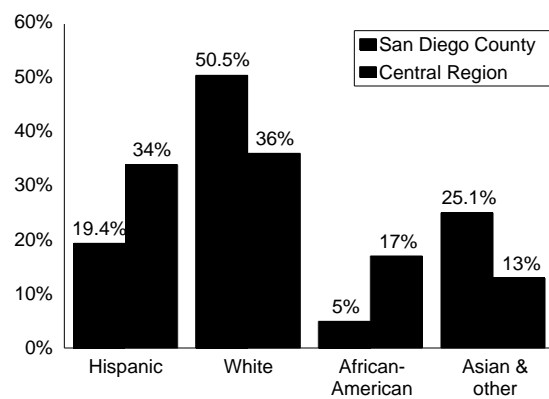


Figure 9: Population Distribution by SRA, Central Region, 1997²⁷

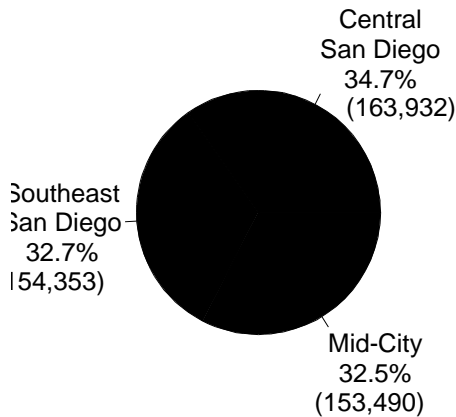
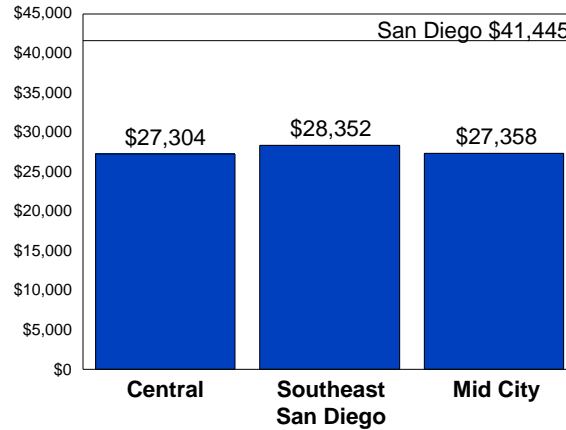


Figure 10: Median Income by SRA, Central Region, 1997²⁷



Economically, 26.2% of households in 1996 had an income of less than \$15,000 per year.²⁸ This is more than 50% higher than the South region, which had the second highest percent with 16.1% earning less than \$15,000. During the same year, 25.3% of the population in the Central region received Medi-Cal benefits compared to a countywide total of 11.4%

Health Highlights

CENTRAL REGION HEALTH ISSUES

- Cancer deaths**
- Lung cancer deaths
- Coronary heart disease deaths**
- Tuberculosis**
- Influenza and pneumonia deaths
- Infant Mortality**
- Suicide**
- Drug-related deaths**
- Unintentional injury deaths
- Child abuse reports/referrals**
- Homicide deaths**

**higher rate than any

The Central region of San Diego has a higher rate of serious health problems than any of the other regions. In 1996 it had the highest rates of cancer deaths, coronary heart disease deaths, infant mortality, suicide, drug-related deaths and homicide. It had the highest percentage of individuals who had positive tuberculosis skin tests. Child abuse reports/referral rates were higher than any other region. The region had a higher rate of lung cancer deaths, influenza and pneumonia deaths, and deaths due to unintentional injuries. **Appendix I**, Table 1 shows a summary of regional rates compared to countywide rates.

In 1996 there were 122.7 deaths per 100,000 population in the Central region due to any type of **cancer**, compared to 113.1 countywide. This rate is higher than the rate in any other county region. In addition, deaths due to **lung cancer**, a total of 34.5 per 100,000 population, was greater than the countywide rate of 29.5. A cancer prevention and early detection campaign may be needed in the Central region to educate individuals about decreasing one’s risk of cancer through diet, and to encourage routine cancer screenings for early detection. Because lung cancer rates are so high, smoking cessation programs and programs to discourage smoking, especially among teens, are needed in this area.

In 1996 there were 111.8 deaths per 100,000 population due to **coronary heart disease** compared to a countywide rate of 93.1. Again, prevention measures such as education about nutrition and exercise are needed in the Central region for heart disease. Education is also needed on how to recognize the signs and symptoms of a heart attack and what to do if one experiences these symptoms.

Communicable diseases are also a problem in the Central region, where in 1997 there were 26.5 per 100,000 population reported active **tuberculosis** cases compared to 12.2 countywide. It is not surprising the Central region had the highest rate of reported TB cases than all other regions because Central San Diego has a large immigrant population, and 66% of San Diego's TB cases were reported among individuals born outside of the United States. The **influenza and pneumonia death** rate was also slightly above the countywide average (17.4 deaths per 100,000 compared to 16.8 countywide), suggesting a need for increased attention in this area for flu vaccines and other preventive measures.

The **infant mortality** rate is higher in the Central region where there were 6.9 deaths per 1,000 births overall between 1993 and 1996 compared to 5.8 deaths per 1,000 births countywide. In 1996 almost twice as many Black babies died (10.6 per 1,000 live births) than White babies (5.6 per 1,000 live births) countywide. Because there is a relatively high Black population in the Central region (17% compared to 6% for the county overall), targeted programs are needed to educate women about the importance of receiving prenatal care and to assure both the baby and the mother receive needed health care during the baby's first year of life.

The Central region saw a higher rate of **suicide** in 1996 than any other San Diego County region. In 1996 there were 16.7 suicides per 100,000 population compared to 11.6 suicides countywide. There was also a higher rate of **drug-related deaths** in the Central region than any other region with 15.9 per 100,000 compared to a countywide rate of 8.9 per 100,000. The **homicide** rate was higher than for any other region with 11.8 per 100,000 compared to 6.2 per 100,000 countywide. There was a higher rate of death due to unintentional injuries, such as motor vehicle crashes and falls, than the countywide rate with 25.4 deaths per 100,000 compared to 22.8 deaths countywide. These four types of death are similar in that they all end lives prematurely, and sadly, seem to be occurring in a region that is younger overall than other county regions.

The **child abuse report/referral** rate was higher in this region than any other region, with 161.1 per 1,000 of the less than 18-year-old population compared to 118.0 countywide. A number of factors may contribute to this high rate of abuse, including poverty, family dysfunction and disintegration, alcohol, drugs, and other factors. The area is in desperate need of measures to decrease family violence, perhaps through a variety of venues such as social services, health care services, community violence prevention services, law enforcement and the judicial process (See Family Violence health issue briefs for sample resources.)

Central San Diego SRA

Central San Diego SRA Health Issues

- Coronary heart disease deaths
- Drug-related deaths++
- Suicide++
- Unintentional injury deaths

++higher rate than any other SRA

Of the three subregional areas (SRAs) in the Central region (Central San Diego, Southeast San Diego, and Mid-City), Central San Diego had higher rates of deaths due to drugs and suicide than any other SRA (see **Appendix I**, Table 2). The subregion was also higher than the countywide average rate in coronary heart disease deaths and unintentional injury deaths.

In 1996 the rate of drug-related deaths in this SRA (27.5 per 100,000) was three times the countywide rate of 8.9. Suicide rates, 24.0 per 100,000, were more than twice as high as the countywide rate of 11.6. Deaths due to unintentional injuries were 32.6 for the SRA, compared to 25.4 for the Central region and 22.8 countywide.

These types of deaths are claiming lives prematurely, and could be due to a number of factors related to poverty, mental health problems, lack of opportunity, or a variety of other issues related to poor quality of life. The coronary heart disease death rate was also very high at 129.6 per 100,000 compared to 111.8 for the region and 93.1 countywide.

North Central Region

Includes subregional areas of Peninsula, Kearny Mesa, Coastal, University, Del Mar-Mira Mesa, North San Diego, Miramar and Elliot-Navajo.

Demographic Highlights

A total of 628,989 individuals resided in the region in 1997, comprising 23% of the San Diego County population. The majority of individuals residing in the North Central region of San Diego are White (74%). This percentage is much higher than the 61% total White population in the county. North Central has the lowest percentage of Hispanics in the region, with only 10%, compared to 24% in the county. Its Black population of 3% is lower than the county total of 6%. It exceeds the county percentage of Asian/Other category, with these groups comprising 12% of the total as compared to 9% in the county.

The University subregion has one of the lowest percentages of Hispanics in the county. Del Mar-Mira Mesa, North San Diego, and Elliott-Navajo are also low for this ethnic/racial group. Peninsula, Coastal and Elliott-Navajo are among the highest subregions in the county for the percentage of Whites with a total of 80% or more of the population. Among Blacks, Miramar has the fourth highest percentage in the county (13%), whereas only one percent of the Coastal subregion is Black. Del Mar-Mira Mesa is unique in that it has the highest percentage of Asian/Other in the county (25%). **Appendix J**, Table 8 provides a detailed breakdown of the North Central region by ethnicity/race as of January 1, 1997.

With regard to age, the North Central region has the highest percentage of individuals ages 25 to 64 in the county, with 56% of its total population in this category. In the

age 14 and younger category the total percentage of population is 19%, compared to 23% in the county. Adolescents and young people between the ages of 15 to 24 comprise 13% of the population. These figures are comparable to other regions and the 14% countywide total. The percentage of individuals 65 years and older, 12%, is approximately the same as in other regions and the 11% county percentage (see Appendix J, Table 9).

Figure 11: Ethnic/Racial Distribution, North Central Region, 1997²⁷

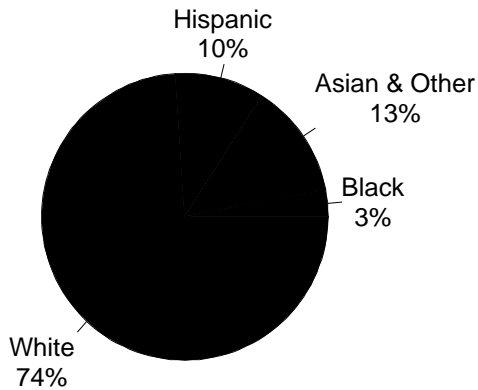


Figure 12: Ethnic/Racial Distribution, North Central Region Compared to County, 1997²⁷

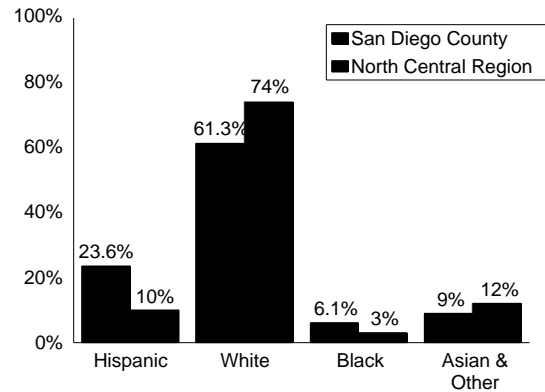


Figure 13: Population Distribution by SRA, North Central Region, 1997²⁷

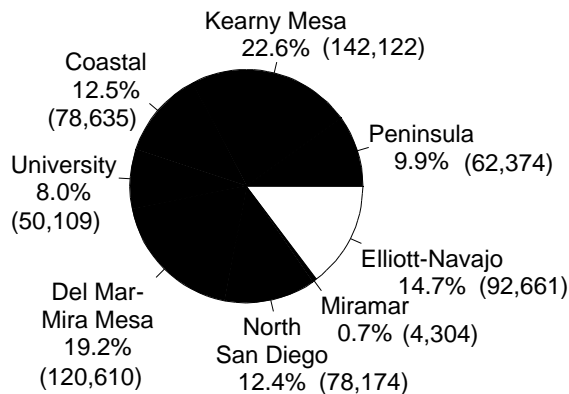
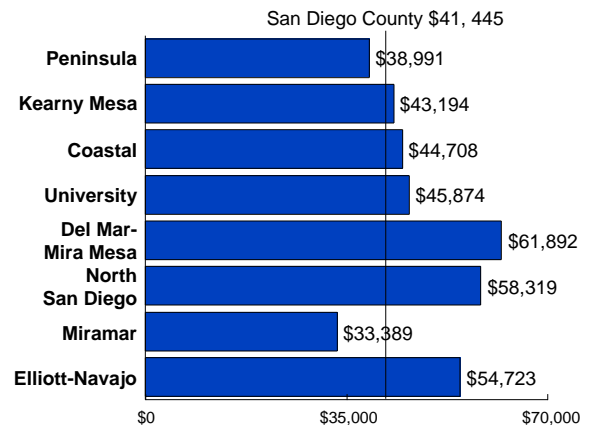


Figure 14: Median Income by SRA, North Central Region, 1997²⁷



Coastal and University are among the lowest two subregions in the county in the 0-14 age group (12% for both SRAs compared to 23% countywide). Miramar is distinct in that it has the second highest population in the 15-24 age group (42% compared to 14% countywide), and the second lowest in both the 25-64 age group (34%) and a mere 1% in the 65+ group. Del Mar-Mira Mesa is one of the highest subregions in the 25-64 age group (59%), and Coastal is among the highest 10 in the 65+ age category (17% compared to 11% countywide).

This region had the lowest percent of households in poverty and Medi-Cal recipients in 1996. Only 9.4% of households in this region had an income of less than \$15,000 compared to a countywide average of 14.5%. Medi-Cal recipients comprised only 5.2% of the population compared to the countywide average of 11.4%.²⁸

Health Highlights

NORTH CENTRAL REGION HEALTH ISSUES

(No rates higher than
countywide averages)

The North Central Region is doing better than the county overall in many key health areas. For example, in 1996 it only had 106.4 deaths per 100,000 population for cancer compared to 113.1 countywide. It had 78.3 coronary heart disease deaths per 100,000 population compared to 93.1 countywide. The pneumonia and influenza death rate (14.7 per 100,000 population) was also lower than the countywide rate of 16.8. There were 9.6 suicides per

100,000 population for this region, although throughout the county there is a rate of 11.6. Drug-related deaths occurred at a rate of 6.4 per 100,000 population, about 25% less than the countywide rate of 8.9. The homicide death rate was 4.0 compared to 6.2 countywide.

However there are exceptions to these positive rates within SRAs in the region. In 1996, the Peninsula SRA had the second highest rate of deaths due to breast cancer (31.8 per 100,000 population compared to 19.9 countywide).

The Del Mar-Mira Mesa SRA had 19.9 active TB cases per 100,000 in 1997 compared to 12.2 countywide. It also had a higher homicide rate than other SRAs in this region, with 7.7 per 100,000 population compared to 6.2 countywide.

North San Diego SRA had the highest rate of deaths due to influenza or pneumonia at 18.5 per 100,000 population compared to 16.8 countywide and 14.7 in the North Central region overall. North San Diego SRA had 24.5 deaths per 100,000 population due to unintentional injuries in 1996 compared to a countywide rate of 22.8.

The Coastal SRA had a higher rate of suicides in 1996 with 13.5 per 100,000 compared to 11.6 countywide. The drug-related death rate was much higher in the Coastal SRA with 17.7 per 100,000 in 1996 compared to 8.9 countywide. Peninsula SRA was also above the countywide rate with 10.0 drug-related deaths per 100,000.

Kearny Mesa SRA

The Kearny Mesa SRA is higher than the countywide rates for cancer deaths (including lung and breast cancer), coronary heart disease deaths, influenza and pneumonia deaths, infant mortality and suicide. In addition it has the second highest rate of child abuse referrals/reports in the county (Mid-City has the highest).

The **cancer death** rate at 123.3 per 100,000 in 1996 was higher than the countywide rate of 113.1. The **lung cancer death** rate was also relatively high (34.8 per 100,000 compared to 29.5 countywide), as was the **breast cancer death** rate (21.7 per 100,000 compared to 19.9 countywide). Although the **coronary heart disease death** rate was low in the North Central region (78.3 per 100,000), it was high in Kearny Mesa (105.0 per 100,000 compared to 93.1 countywide). The **influenza and pneumonia death** rate (17.8) was slightly above the countywide average (16.8). The **infant mortality** rate (6.6 per 1,000 births) was also high compared to the countywide rate of 5.8. The **suicide** rate, at 14.3 per 100,000, was higher than the countywide rate of 11.6.

Kearny Mesa SRA Health Issues
Cancer deaths
Lung cancer deaths
Breast cancer deaths
Coronary heart disease deaths
Influenza and pneumonia deaths
Infant mortality
Suicide
Child abuse

The most outstanding health issue for Kearny Mesa, however, is **child abuse referral/reports**. During fiscal years 1995 and 1996, there was an average of 174.0 per 1,000 youth under age 18 compared to 118.0 countywide. With the exception of Mid City (182.5), this is the highest rate, accounting for 5,683 child abuse referrals/reports.

South Region

Includes subregional areas of Coronado, National City, Sweetwater, Chula Vista, and South Bay

Demographic Highlights

As of January 1, 1997 the South region had a total population of 373,417, or 14% of the total county population.

Generally speaking the South region is characterized by the highest percentage of Hispanics in San Diego County (45%) and a relatively low percentage of White residents (38%). These percentages vary substantially from the county percentages of 24% and 61%, respectively. The percentage of Black residents, 5%, is nearly the same as the 6% total in the county. In the Asian/Other category the population of the South Region is 12% as compared to 9% countywide. Some SRAs have an even higher percent in the Asian/Other category, including National City (17%), Sweetwater (15%) and South Bay (14%). In general there is a larger population of Filipinos in the South region compared to other parts of the county. Coronado is the exception to the regional characteristics with a population that is mostly White (79%)

with only 9% Hispanic. **Appendix J**, Table 10 provides a detailed breakdown of the South Region by ethnicity/race as of January 1, 1997.

The South Region is slightly younger than the population of San Diego County, with 25% of its population comprising the 0-14 category and an additional 17% of its residents included in the 15-24 age grouping. These totals are somewhat higher than the county percentages of 23% and 14% for comparable categories. Likewise, the percentage of individuals that is in the 25-64 age group, 48%, and those belonging to the 65+ category, 10%, are slightly lower than the county percentages of 51% and 11% for similar age groupings (see **Appendix J**, Table 11).

Twenty-eight percent of National City and South Bay are comprised of 0-14 year olds, among the highest percents in the county. Coronado, on the other hand, ranks among the lowest for this same group (12% of the population compared to 23% countywide). In the age 15-24 category, Coronado and National City have percentages that are among the highest for subregions in the county (33% and 22% respectively compared to 14% countywide). On the other hand, Coronado and National City are included among the lowest subregions for the percentage of individuals that are ages 25-64 – only 42% of the population for both SRAs compared to 51% countywide. For additional details, see **Appendix J**, Table 11.

Figure 15: Ethnic/Racial Distribution, South Region, 1997²⁷

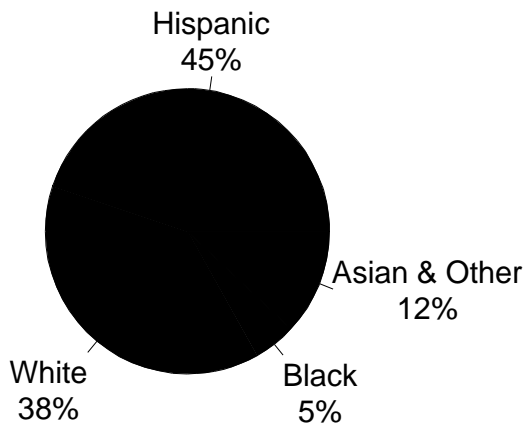


Figure 16: Ethnic/Racial Distribution, South Region Compared to County, 1997²⁷

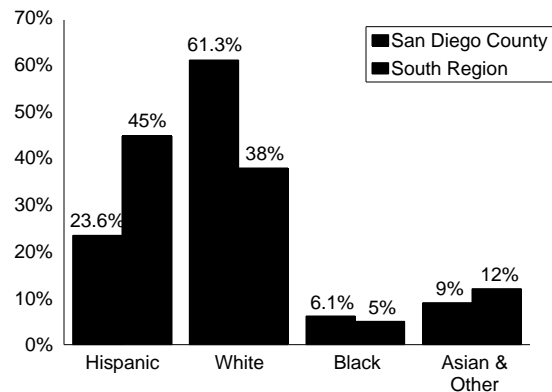


Figure 17: Population Distribution by SRA, South Region, 1997²⁷

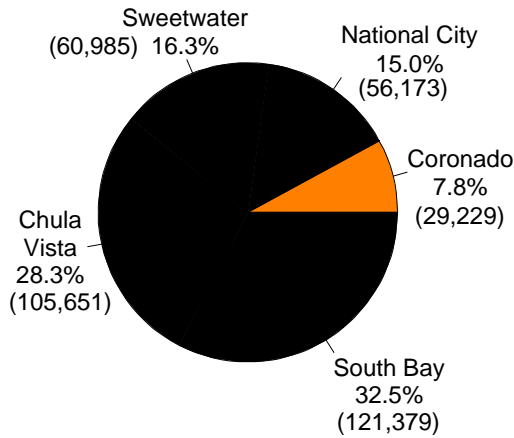
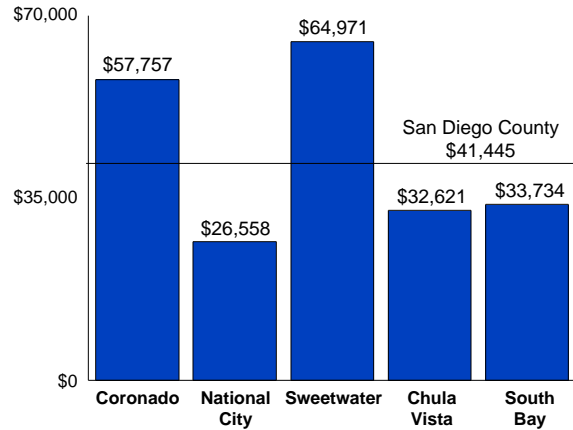


Figure 18: Median Income by SRA, South Region, 1997²⁷



In terms of economics, the South region had the second highest percent of households with an income of less than \$15,000 in 1996 at 16.1%. During the same year, 12.3% of the population in this region received Medi-Cal compared to a countywide total of 11.4% for all regions combined.²⁸ In the Coronado Zip code of 92118, which extends to the end of the Silver Strand and excludes the Naval Air Station, only 8% of households have an income of less than \$15,000. Only 2% of this Zip code’s population are enrolled in Medi-Cal.²⁸

Health Highlights

Compared to San Diego County as a whole, certain health problems were more severe in the South region than the county overall, namely deaths due to breast cancer, coronary heart disease, and flu and pneumonia, as well as tuberculosis disease (see **Appendix I**, Table 4).

In 1996, the South region had the highest rate of **breast cancer** deaths of all county regions with 23.9 deaths per 100,000 population, compared to an overall county rate of 19.9. These statistics point to a need for increased education and cancer screening. With regard to breast cancer, more women need to be educated about early detection, and about where they can obtain these screenings based upon their insurance status and language and transportation needs.

The death rate from **coronary heart disease** was also relatively high with 105.9 per 100,000 population in 1996 (598 deaths), compared to an overall rate of 93.1 deaths countywide. Individuals in this region need additional education about diet and exercise, as well as access to cholesterol and other screenings that could inform them about their risks for coronary heart disease.

SOUTH REGION HEALTH ISSUES

- Breast cancer deaths**
- Coronary heart disease deaths
- Flu and pneumonia deaths
- Tuberculosis

**higher rate than any other region

Flu and pneumonia claimed 115 lives in 1996, or 18.9 per 100,000 population compared to a countywide rate of 16.8. These deaths imply a need for providers to emphasize flu vaccine efforts in the South region, and to address poverty issues such as lack of heat, poor nutrition, or lack of access to health care that prevent adequate care of flu/pneumonia.

Tuberculosis occurs more frequently in the South region. In 1997, 19.5 individuals per 100,000 population were diagnosed with active TB (18 cases) in the South region, whereas San Diego County had a rate of 12.2. Sixty-six percent of reported active TB cases occurred in individuals born outside of the US, particularly from the Philippines and Mexico.

Two subregional areas stand out in the South region as having higher rates of death and other problems: Chula Vista and National City. Detailed information for these two SRAs are provided in more detail below.

Chula Vista SRA

Chula Vista SRA Health Issues	
Cancer deaths	
Lung cancer deaths++	
Breast cancer deaths++	
Coronary heart disease deaths	
Tuberculosis	
Pneumonia and influenza deaths	
Child abuse referrals/reports	
Suicide	
Drug-related deaths	
++higher rate than any	

The Chula Vista SRA stood out as having higher rates of health problems than the South region and the county overall with cancer deaths, coronary heart disease deaths, pneumonia and influenza deaths, suicide and drug-related deaths. (See **Appendix I**, Table 4.)

Chula Vista had the second highest rate of **cancer** deaths in general (144.3 per 100,000 compared to 113.1 countywide), and the highest rate of **lung cancer** deaths (42.1 deaths per 100,000 compared to 29.5 countywide) and breast cancer deaths (42.4 deaths per 100,000). Breast cancer death rates were much higher here than in any other SRA and well above the overall county rate of 19.9. The rate of **coronary heart disease** deaths was also high (127.5 per 100,000 compared to 105.9 for the South region and 93.1 countywide).

Rates were also higher for flu and pneumonia deaths, drug abuse, suicide and unintentional injuries, although in some cases the numbers were relatively small. Of the 115 **flu or pneumonia** deaths that took the lives of South region residents, almost 50

occurred in Chula Vista. Fifteen individuals committed **suicide**. **Drug abuse** claimed 14 Chula Vista lives in 1996 out of a total of 29 in the South region.

Slightly above the countywide average rate was the **child abuse report/referral** rate with 118.8 reports/referrals per 1,000 of the less than 18-year-old population, compared to 118.0 countywide. The active tuberculosis rate at 18.0 per 100,000 population in 1997 was lower than the rate for the region (19.5) but higher than the countywide average rate (12.2).

National City SRA

In 1996 the National City SRA had the highest rate of coronary heart disease deaths, pneumonia and influenza deaths, and active tuberculosis (TB) than any other SRA in the county (see **Appendix I**, Table 4).

National City had a higher death rate for **coronary heart disease** than any other SRA in the county (162.4 per 100,000 population compared to 93.1 countywide). A total of 30 people died from **pneumonia or influenza**, for a rate of 41.7 per 100,000. National City had the highest rate of reported active cases of **TB** (32.0 per 100,000 population) compared to the South region (24.7) and the county (12.2). The South Bay SRA also had a high TB rate with 24.7 reported active cases per 100,000 population.

National City had higher rates than the countywide population for some key health issues. The SRA had a higher **cancer** death rate with 117.5 per 100,000 population compared to 109.2 in the South region and 113.1 in the county. The **breast cancer** death rate was higher than the county with 22.9 per 100,000 population whereas the county rate was 19.9. Although the region only had 16.6 deaths per 100,000 population due to unintentional injuries, the National City SRA had a higher rate with 23.0. The child abuse referral/report rate at 119.5 per 1,000 of the under-18 population was slightly higher than the county rate of 118.0, and much higher than the rate of the South region (96.9).

Parts of the South region have higher rates of **reported rapes** than the county overall. In 1997 there were 25 rapes reported in the National City law enforcement jurisdiction (.44 per 1,000 population, not age adjusted) and 19 in the Imperial Beach law enforcement jurisdiction (.68 per 1,000 population) compared to .32 for San Diego countywide. The National City jurisdiction also had more reported **aggravated assaults** than the county overall with 5.3 per 1,000 population compared to 4.5 countywide. The Imperial Beach jurisdiction was even higher with 5.6 reports per 1,000 population.

The US-Mexico Border Region

With its proximity to the US-Mexico border, the South region and much of San Diego experience the health impacts of a highly mobile trans-border population. There are approximately 6 million northbound border crossings each month at the San Diego/Tijuana border crossing.²⁹ The population in the US border region is growing three times as fast as the nation overall, and Mexico’s population is expected to double in nine years.³⁰ Travelers, tourists, families that relocate and migrant workers contribute to the spread of disease between Mexico and the US.

National City SRA Health Issues
Cancer deaths
Breast cancer deaths
Coronary heart disease deaths++
Tuberculosis++
Pneumonia and influenza deaths++
Unintentional injuries
Child abuse referrals/reports
Rape reports
Aggravated assault reports
++ higher rate than any

Infectious diseases are a shared concern at the US-Mexico border. Active **tuberculosis** rates are four times as high in Baja California than California, so cooperative efforts are needed to treat active TB on both sides of the border in order to alleviate the problem in the region overall.³¹ **HIV/AIDS** rates are five times higher in the US than in Mexico, so the disease travels more often from north to south of the border. Mexico, however, does not have the resources for education, prevention, and treatment. The disparity between the two countries could lead to a perpetuation of the disease in this region unless coordinated programs for both prevention and treatment are implemented.³² Close cooperation between California and Baja California health authorities are needed to address infectious diseases in the region as a whole.

Many **chronic diseases** seen at the border reflect those that are more common among the Hispanic population. Adult-onset **diabetes** has been a key focus because there are three times more cases among Hispanics than the US population as a whole. Diabetes is more of a problem at the border for many reasons including failure of early detection and diagnosis, lack of insurance coverage resulting in a lack of access to care, and limited disease management protocols, including diet, that appeal to Hispanic patients. Health education, prevention, and early detection efforts need to be culturally and linguistically appropriate in order to reach the Hispanic population in the border region.³³

Access to care in the border region can be more challenging for various reasons. Individuals from Mexico who are legally residing in the United States but maintain strong ties to Mexico may be unsure about eligibility for public benefits and not access programs such as Medi-Cal or Healthy Families for which they or their children may be eligible. This is especially true if a family member is undocumented or applying for citizenship, and the individual residing here legally does not want to threaten their family member's immigration status. Access is further complicated by a lack of physicians who are bilingual and who are culturally sensitive to Latinos. As a result it is common for Hispanic citizens residing on the US side of the border to travel to Mexico for health care where their language and culture are understood, and where services are less expensive.³³

North Coastal Region

Includes San Dieguito, Carlsbad, Oceanside, Pendleton, and Vista

Demographic Highlights

In 1997 the total population count for the North Coastal region was 429,747, or 16% of San Diego County. Its ethnic/racial distribution closely approximates that of the county overall. Hispanics represent 23% of the population, nearly equal to the county percentage. The region has 66% Whites, similar to the 61% Whites residing in the county. The percentage of Black residents is exactly the same in both the region and in the county, with 6% in each group. There is a slightly lower percentage for the Asian/Other category, with 5% for the region and 9% in the county.

The San Dieguito and Carlsbad subregions have a significantly higher than average percentage of Whites, with 79% and 78% respectively. Both subregions have significantly lower percentages of Blacks than the countywide average. On the other hand, Oceanside ranks among the lowest subregions in the county for percentage of White residents with only 56% compared to 61% countywide. Pendleton has the second highest percentage of Blacks (19%) of all county SRAs. **Appendix J**, Table 12, provides a detailed breakdown of the North Coastal region by ethnicity/race as of January 1, 1997.

Figure 19: Ethnic/Racial Distribution, North Coastal Region, 1997²⁷

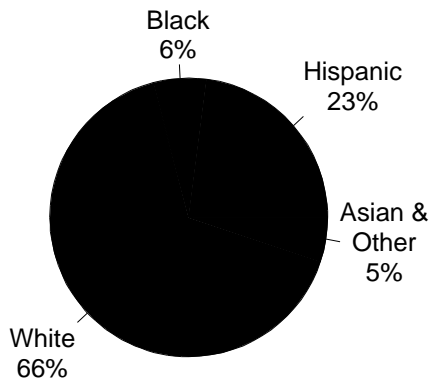


Figure 20: Ethnic/Racial Distribution, North Coastal Region Compared to County, 1997²⁷

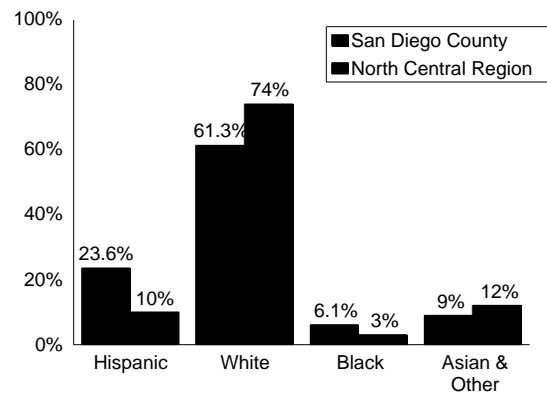


Figure 21: Population Distribution by SRA, North Coastal Region, 1997²⁷

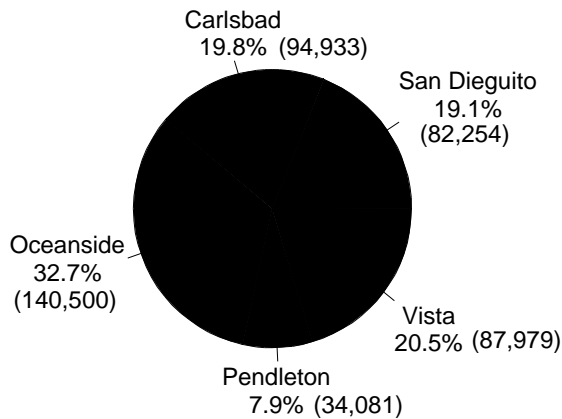
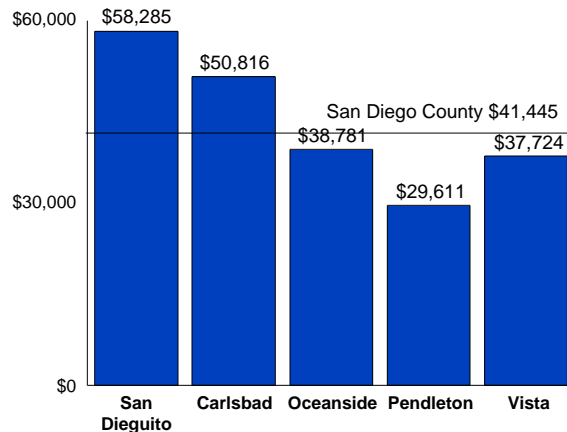


Figure 22: Median Income by SRA, North Coastal Region, 1997²⁷



The age groupings in the North Coastal region are nearly identical to those of San Diego County. In the infant to 14 years of age category the region has 24% of its total population, compared to 23% in the county. The next grouping, adolescents and young adults between the ages of 15-24, represents 15% of the population compared to 14% countywide. A total of 49% of the residents are in the 25-64 age grouping, closely comparable to the 51% in the county. The 65+ category is comprised of 12% of the region's population compared to 11% for the county total. (See **Appendix J**, Table 13.)

San Dieguito and Carlsbad have fewer than average percentage of young adults ages 15-24, with both ranking among the lowest percentages in the county with only 11% of their respective populations. On the other hand, among older adults ages 25-64, the percentage of residents in San Dieguito is among the highest in the county with 58% of their population. Pendleton ranks highest among all subregions for young adults ages 15-24 which comprise a full 49% of their population. Pendleton has no residents in the 65+ category, and is ranked lowest in the county for this age group (see **Appendix J**, Table 13).

With regard to economics, 12.1% of households in the region earned an income of less than \$15,000 per year in 1996, compared to 14.5% countywide. Approximately 9.2% of the population were Medi-Cal recipients during the same year compared to 11.4% countywide.²⁸

Health Highlights

NORTH COASTAL REGION HEALTH ISSUES

- Cancer deaths
- Infant Mortality

With the exception of two issues, the North Coastal region overall has lower rates of health problems than other county regions (see **Appendix I**, Table 5).

In 1996 there was a higher cancer death rate in the North Central region than in the county overall, with 116.1 deaths per 100,000 compared to 113.1. The infant mortality rate was also high with 6.4 deaths per 1,000 births between 1993 and 1996, compared to 5.8 countywide.

Some SRAs had outstanding health issues within the North Coastal Region. Carlsbad, for example, had a slightly higher breast cancer death rate in 1996 with 21.0 deaths per 100,000 compared to 19.9 countywide. San Dieguito had 10.7 drug-related deaths per 100,000 population compared to a countywide rate of 8.9. Oceanside and Vista had a number of outstanding health issues in 1996 as will be described in more detail below.

Oceanside SRA

Oceanside SRA Health Issues

- Cancer deaths++
- Lung cancer deaths
- Coronary heart disease
- Infant Mortality++ (tied)
- Child abuse referrals/reports
- Rape reports
- Aggravated assault reports

++higher rate than any

As described in **Appendix I**, Table 5, the Oceanside SRA had the highest rate of cancer deaths in 1996 with 147.3 per 100,000 compared to 113.1 countywide and 116.1 in the North Coastal region. (The Mountain Empire and Ramona had higher rates, but the low number of occurrences in a small population mean rates are unreliable.) Lung cancer deaths were also higher with 35.5 per 100,000 in Oceanside compared to 29.5 countywide. The coronary heart disease death rate was higher with 101.7 per 100,000 population in 1996 compared to a countywide rate of 93.1.

Infants and children in Oceanside are suffering higher rates of infant mortality and child abuse referrals/reports than other SRAs in the county. Between 1993 and 1996 Oceanside was tied with Mid-City for the highest **infant mortality** rate with 7.6 deaths per

1,000 births compared to a countywide rate of 5.8. The **child abuse report/referral** rate was also much higher for the fiscal years 1995 and 1996 average than the rest of the county with 146.1 per 1,000 population under age 18 compared to 118.0 countywide.

In terms of interpersonal violence, the Oceanside jurisdiction had a higher rate of reported **rapes** than the county overall with .6 per 1,000 population compared to .3 countywide. The **aggravated assault** report rate was also above average with 5.1 per 1,000 population in 1997 compared to 4.5 countywide.

Vista SRA

The Vista SRA also had its share of health problems in 1996 (see **Appendix I**, Table 5). Its rate of cancer deaths (131.0 per 100,000 population) was much higher than the countywide rate (113.1). The lung cancer death rate was slightly higher than the countywide rate (31.7 compared to 29.5 per 100,000 population), as was the breast cancer death rate (21.7 compared to 19.9). The death rate for coronary heart disease (109.0 per 100,000 population) was also higher than the countywide rate (93.1). There was a higher influenza and pneumonia death rate with 20.0 per 100,000 compared to 16.8 in the county overall and only 14.0 in the North Coastal region.

Vista SRA Health Issues
Cancer deaths
Lung cancer deaths
Breast cancer deaths
Coronary heart disease deaths
Influenza and pneumonia deaths
Infant Mortality
Drug-related deaths
Unintentional injury deaths
Homicides

The infant mortality rate was lower in Vista (6.2 per 1,000 births) than in the North Coastal region (6.4) but higher than the countywide rate (5.8). The homicide death rate was as high in Vista (11.7 per 100,000) as in the Central San Diego region (11.8).

Vista had higher rates of deaths that ended lives prematurely. There was a much higher rate of drug-related deaths in 1996 (12.2 per 100,000 population) than for the county (8.9). Unintentional injuries claimed 24.5 lives per 100,000 population in Vista compared to 22.8 in the county overall.

East Region

Includes subregional areas of Jamul, Spring Valley, Lemon Grove, La Mesa, El Cajon, Santee, Lakeside, Harbison-Crest, Alpine, Laguna-Pine Valley and Mountain Empire

Demographic Highlights

The East region’s 1997 population of 443,542 comprised 16% of the total county population. The region has a much lower proportion of Hispanics and a correspondingly higher percentage of Whites than the overall county, although its ethnic/racial distribution is quite similar to the North Central region. The percentages of Hispanics living in the region, 15%, and Whites, 77%, markedly differ from countywide percentages of 24% Hispanic and 61% White. The East region has 4%

each in the Black and Asian/Other category as compared to the county percentages of 4% and 9% for comparable groups.

Although the East region has a lower than average percentage of Hispanics, Alpine ranks among the lowest SRA in the county with this group comprising only 9% of the total population. Harbison-Crest, Alpine and Lakeside are 86-87% White, among the highest percentages in the county. These communities are followed closely by Jamul, La Mesa, Santee, and Laguna-Pine Valley with higher than average percentages of Whites.

All communities except Spring Valley and Lemon Grove have significantly lower than average percentages of Blacks. Again, all subregions have less than average Asian/Other, with Laguna-Pine Valley ranking among the lowest three SRAs in the county. **Appendix J**, Table 14, provides a detailed breakdown of the eastern region by ethnicity/race as of January 1, 1997.

Figure 23: Ethnic/Racial Distribution by SRA, East Region, 1997²⁷

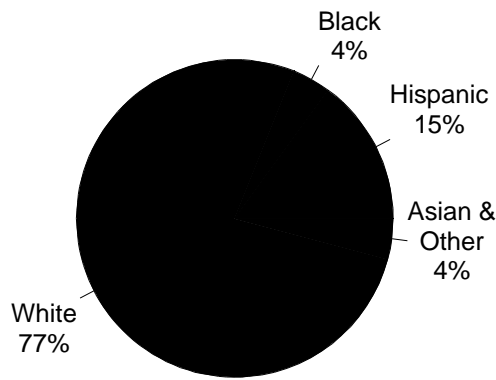


Figure 24: Ethnic/Racial Distribution, East Region Compared to County, 1997²⁷

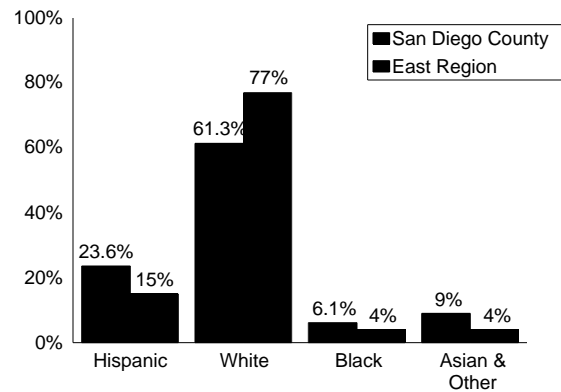


Figure 25: Population Distribution by SRA, East Region, 1997²⁷

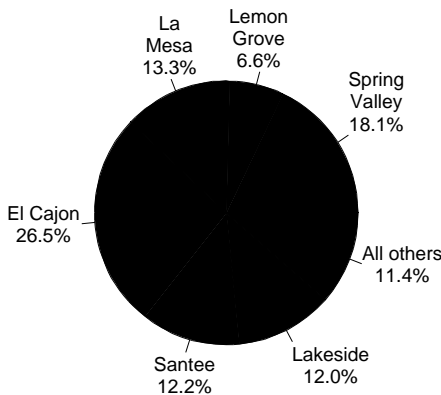
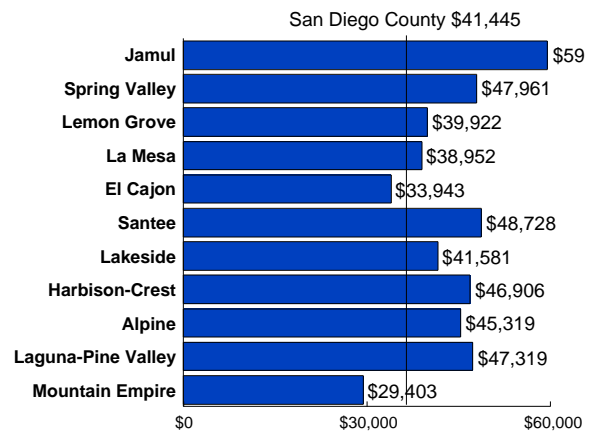


Figure 26: Median Income by SRA, East Region, 1997²⁷



Age groupings in the East region closely approximate countywide percentages (see **Appendix J**, Table 15). In the 0-14 age category, the percentage of infants and children is identical, with 23% in both. The remaining age groupings are within 1% of county percentages. In the 15-24 age group the East region has 13% compared to 14% for the county. The 25-64 group has 52% in the region and 51% in the county. Similarly, the 65+ group has 12% in the region and 11% in the county.

Although age grouping percentages do not vary significantly from countywide averages, the exceptions include Laguna-Pine Valley and La Mesa. Laguna ranks among the highest subregions in the county for the percentage of individuals age 25-64 (59%), and La Mesa ranks among the highest SRAs in terms of the percentage of older adults in the age 65+ category (18%).

In 1996, the East region had more poverty with approximately 15% of households earning less than \$15,000 compared to 14.5% countywide. During the same year, 12.5% of the population were Medi-Cal recipients compared to 11.4% for San Diego overall.²⁸

Health Highlights

As indicated in **Appendix I**, Table 6, the East region had a higher rates of lung cancer deaths and deaths from pneumonia or influenza than any other county region. It was above countywide rates for cancer deaths, lung cancer deaths, coronary heart disease deaths, suicide and unintentional injury deaths.

In 1996 the **cancer** death rate was higher in the East region than for the county overall with 120.5 deaths per 100,000 population compared to 113.1 countywide. Santee and La Mesa SRAs were particularly high with rates of 123.7 and 120.4 respectively. The **lung cancer** death rate was the highest of all regions with 35.9 per 100,000 population compared to 29.5 countywide. Cancer prevention and early detection efforts are needed in this region to decrease these types of deaths.

EAST REGION HEALTH
Cancer deaths
Lung cancer deaths**
Coronary heart disease deaths
Influenza and pneumonia deaths**
Suicide
Unintentional injury deaths
**higher rate than any other region

The coronary heart disease death rate was also higher in the region with 105.4 deaths per 100,000 in 1996 compared to an average rate of 29.5 for the county. This points to a need for more education and screening programs for coronary heart disease prevention in the East region.

The influenza and pneumonia death rate was higher in the East region than any other region with 20.7 deaths per 100,000 population compared to 16.8 countywide. The rates were high not only in the larger SRAs such as La Mesa (18.7) and El Cajon (19.1), but also in the smaller SRAs such as Jamul and the Mountain Empire which each had six deaths due to influenza or pneumonia. Because of the small numbers, the rates are unreliable, but the number of deaths appears to be too high relative to the small populations. Additional prevention strategies are needed to reach the more rural areas as well as the urban and suburban areas.

In 1996 there were 62 suicides in the East region (13.1 per 100,000 population compared to 11.6 countywide). The death rate due to unintentional injuries such as motor vehicle crashes and falls was also high with 24.3 per 100,000 in 1996 compared to an average rate of 22.8 for the county.

El Cajon SRA

El Cajon SRA Health Issues

Drug-related deaths

Unintentional injury deaths

Child abuse
referrals/reports

Homicide deaths

Rape reports, El Cajon
jurisdiction

The El Cajon SRA had high rates of drug-related deaths, unintentional injury deaths, child abuse referrals/reports, homicides, and reported rapes and aggravated assaults (see **Appendix I**, Table 6).

First, although drug-related deaths were not as great a problem in the East region overall, the rates were much higher in El Cajon than the average countywide rate (12.6 per 100,000 population compared to 8.9). For this reason, El Cajon would be a prime candidate for drug prevention and treatment programs.

The rate of deaths from motor vehicle crashes, falls, and other **unintentional injuries** (28.5 per 100,000 population in 1996) was much higher than the countywide average (22.8) and the East region (24.3). There were eight **homicides** in El Cajon (7.7 per 100,000 population) and six in Spring Valley (7.6). These rates are higher than the countywide rate of 6.2 per 100,000.

With a total of 4,055 child abuse referrals/reports, the El Cajon rate (122.2 per 1,000 population under age 18) was higher than for the county overall (118.0). The Mountain Empire had 277 reports/referrals, which, because of its small population, gives it a rate of 184.0. Again, because of the low number of occurrences this rate needs to be interpreted with caution, but it does point to a disproportionate number of child abuse referrals/reports in the Mountain Empire SRA.

Finally, the El Cajon law enforcement jurisdiction had a higher rate of reported rapes and aggravated assaults. In 1997 there were .6 **reported rapes** per 1,000 total population compared to a countywide rate of .3. It was one of three jurisdictions tied for the highest rates of **reported assaults** with 5.6 per 1,000 population (Imperial Beach and the City of San Diego were the other two) compared to a countywide rate of 4.5.

North Inland Region

Includes subregional areas of Poway, Ramona, Escondido, San Marcos Valley Center, Pauma, Fallbrook, Palomar-Julian, and Anza-Borrego Springs

Demographic Highlights

In 1997 the North Inland region comprised 14% of the total county population with 376,967 residents in the region. Hispanics comprise 23% in the North Inland region, nearly identical to the percentages for the county and the North Coastal region. On the other hand, the percentage of Whites, 71%, is much higher than the county percentage of 61% for this group. Only 1% of the population is Black, much lower than the 6% for the county. Likewise, there are fewer individuals comprising the Asian/Other category, with 5% in the region and 9% in the county.

Poway ranks as one of the lowest two subregions in the county for percentage of Hispanics (7%), and among the five highest for White residents (84%). Ramona and Palomar have high percentages of Whites, as well (80% for both). All communities have significantly less than average percentages of Black residents, with Valley Center, Pauma, and Anza-Borrego having no Blacks.

Many of the communities have lower than average percentages of Asian/Other, with Anza-Borrego having the lowest percentage in the county (1%). Although Pauma has no Black residents, it is the most ethnically diverse community in the North Inland region, with a Hispanic population that ranks among the highest three in the county (49%), a White population that ranks among the lowest (31%), and an Asian/Other ethnic/racial grouping that ranks among the highest three (20%). **Appendix J**, Table 16, provides a detailed breakdown of the North Inland region by ethnicity/race as of January 1, 1997.

Figure 27: Ethnic/Racial Distribution, North Inland Region, 1997²⁷

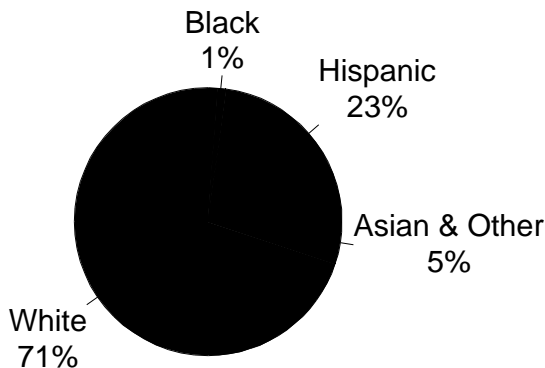


Figure 28: Ethnic/Racial Distribution, North Inland Region Compared to County, 1997²⁷

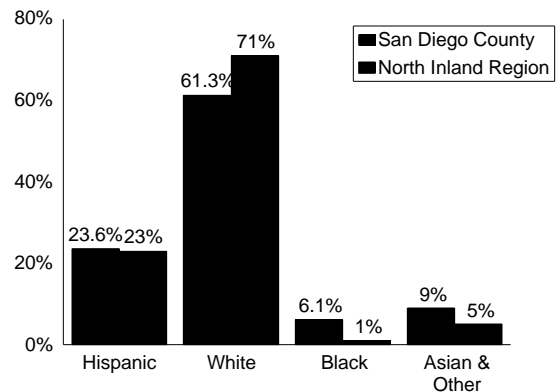


Figure 29: Population Distribution by SRA, North Inland Region, 1997²⁷

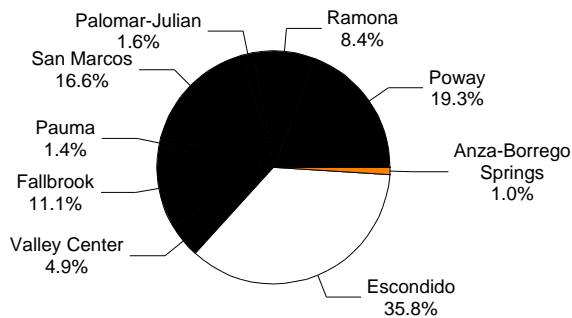
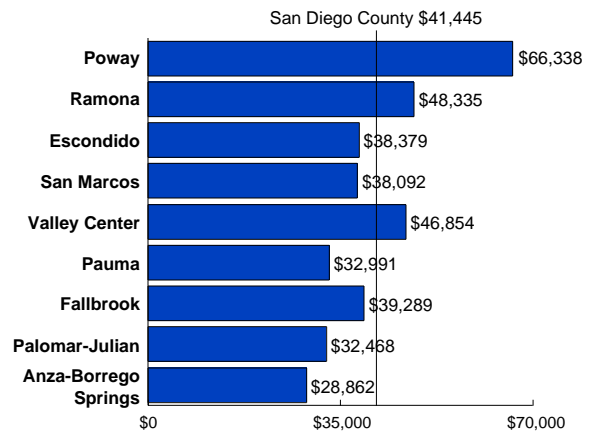


Figure 30: Median Income by SRA, North Inland Region, 1997²⁷



Age groupings in the North Inland region closely approximate countywide percentages and also for the East region (see **Appendix J**, Table 17). Twenty-three percent of the population is in the 0-14 category, 13% is in the 15-24 age grouping, and 50% in the 25-64 age grouping. A total of 14% of its population is in the 65+ group, the highest percentage among all regions in the county and above the 11% countywide.

Although the majority of communities in this region do not vary significantly in the percentages of age groupings ranging from 0-64, the exceptions are the Anza-Borrego SRA and the group of subregions with high rankings in the 65+ category. Anza-Borrego ranks among the lowest four in the county for infants/children in the age 0-14 category (13%), below average in the age 15-24 category (10%), among the lowest for percentage of individuals age 25-64 (41%), and ranks as the highest in the county for the 65+ age group (36%). San Marcos, Valley Center, Palomar-Julian and Fallbrook also have some of the highest percentages of the population in the age 65+ category.

With regard to economics, the North Inland region had a lower percent of households in poverty with 13.4% earning less than \$15,000 per year in 1996 compared to 14.5% for the county overall. During the same year only 8.4% received Medi-Cal benefits compared to 11.4% countywide.²⁸

Health Highlights

The North Inland region in general had lower rates than the county overall on the health issues tracked for this report. The only two areas where it was worse than the county rate was in breast cancer deaths and unintentional injury deaths. With regard to **breast cancer** deaths, this region had a rate of 23.0 per 100,000 population in 1996 compared to 19.9 countywide. The rate was especially high in the Escondido SRA (24.2), which had a total of 24 deaths.

In terms of **unintentional injury** deaths, the North Inland region had the highest rate of any region with 28.7 deaths per 100,000 population. There were 16 fall-related deaths and 54 deaths caused by motor vehicle crashes. A total of 25 motor vehicle deaths were among Escondido SRA residents, and the SRA had the highest rate of unintentional injuries of the entire county (34.9). Programs are needed to encourage use of seat belts, child safety seats, and other measures to decrease the rate of unintentional injury deaths.

Escondido SRA

As shown in **Appendix I**, Table 7, Escondido had a number of outstanding health issues in 1996 in addition to breast cancer and unintentional injuries mentioned above.

With 258 cancer deaths out of 4,347 countywide, Escondido had a **cancer** death rate of 121.8 per 100,000 in 1996 compared to the countywide average of 113.1. The **coronary heart disease** death rate was also high with 98.2 deaths per 100,000 (276 cases)—much higher than the North Inland region rate (80.3) or the countywide average (93.1).

There were 98 deaths in Escondido due to **influenza or pneumonia**; this yielded a rate of 29.9 per 100,000 population compared to a countywide rate of only 16.8. This SRA has the second highest rate in the county. Clearly, more attention and resources are needed in Escondido to reduce the number of flu/pneumonia deaths.

Escondido experienced 13 **drug-related deaths** out of a total of 23 for the North Inland region and 251 countywide. Although the number is small, it yields a rate of 9.1 deaths per 100,000 population in Escondido, which is higher than the rate for the region (6.1) and the county overall (8.9).

NORTH INLAND REGION HEALTH
Breast cancer deaths
Unintentional injury deaths**
**higher rate than any

Escondido SRA Health Issues
Cancer deaths
Breast cancer deaths
Coronary heart disease deaths
Influenza and pneumonia deaths
Drug-related deaths
Unintentional injury deaths++
Child abuse referrals/reports
Rape reports

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The rate of **child abuse referrals/reports** (126.5 per 1,000 population under age 18) was much higher for Escondido than the North Inland region (96.0) or the county overall (118.0). Immediate attention is needed to decrease child abuse. The rate of reported **rapes** was also high with .6 per 1,000 population compared to .3 countywide. All of these health problems point to a need in Escondido for additional resources to improve health.

HEALTH ISSUES BY ETHNICITY/RACE

Health status is a function of social and economic conditions, physical environment, personal behavior, access to medical care, and genetics. Due to the interactions and associations of the foregoing factors, some ethnic/racial groups experience fewer or more health problems than others. **Appendix E** identifies the ethnic/racial differences in health status according to the health issues tracked for this analysis.

Whites

Whites as a whole have higher mortality rates than county-wide average rates on a number of measures. They had the highest **suicide** rate in 1996 (13.9 per 100,000 population versus 11.6 countywide), and the highest **drug-related death** rate (10.2 per 100,000 versus 8.9 countywide) of any ethnic/racial group.

Whites have higher rates than the countywide average of cancer deaths (118.8 per 100,000 versus 113.1 countywide), breast cancer deaths (21.4 per 100,000 compared to 19.9 countywide), and lung cancer deaths (32.0 per 100,000 compared to 29.5 countywide). There were 95.6 deaths per 100,000 due to coronary heart disease compared to 93.1 countywide. The influenza and pneumonia death rate was slightly higher than the countywide rate (17.4 deaths per 100,000 versus 16.8). The infant mortality rate was slightly above average in 1996 with 5.6 per 1,000 births compared to 5.4 countywide.

Whites had a lower percentage of low birthweight babies, and a lower rate of births to teens, especially to those ages 15-17, than the county overall. The homicide rate was also much lower than the county overall (3.8 per 100,000 compared to 6.2 countywide.)

Health Issues for Whites
Cancer deaths
Breast cancer deaths
Lung cancer deaths
Coronary heart disease deaths
Influenza and pneumonia deaths
Infant mortality
Suicide**
Drug-related deaths**
Unintentional injury deaths
**higher rate than any other ethnicity/race

Hispanics

Overall, the health of Hispanics compares favorably to other groups on the measures reviewed for the purpose of this report. The cancer death rate is only 77.1 per 100,000 population compared to the countywide rate of 113.1. Breast and lung cancer death rates are also below the county average. There are only 70.5 deaths per 100,000 due to coronary heart disease compared to 93.1 in the county overall. Deaths due to influenza and pneumonia, suicide, and drugs are also lower than the county average. The infant mortality rate is 4.4 deaths per 1,000 births, which is lower than the county average of 5.4.

Hispanics were higher than the county average on rate of asthma hospitalizations and homicides. There were 146.8 asthma hospitalizations per 100,000 population in 1996, although the county rate was only 112.2 per 100,000. This points to a need to focus on asthma education and screenings for the Hispanic population in a culturally and linguistically sensitive manner. The rate of **homicides** (9.6 per 100,000 population) in 1996 was higher than the county average (6.2 per 100,000), but not as high as the homicide death rate for Blacks (14.0).

Health Issues for Hispanics
asthma hospitalizations
lowest percent of women getting prenatal care in the first trimester**
highest percent of women seeking prenatal care in the third trimester or not at all**
births to teenagers age 15-17**
births to teenagers age 12-14
homicide

Hispanics as a group had the lowest percentage of early prenatal care and the highest rate of teen births in the county. In 1996, only 69.1% of pregnant women started **prenatal care in the first trimester**, the lowest in the county. A total of 9.3% obtained **prenatal care in the third trimester** or not at all, which is the highest percent in the county. The lack of prenatal care could result in increased health risk for the pregnant woman and poor birth outcomes. Since Hispanics are more likely to be uninsured than other groups (see below), the lack of prenatal care may be due to a lack of insurance. This issue is further complicated by the fact that some Hispanic women may be entitled to publicly-assisted prenatal care, but don't know if they are eligible due to their immigration or residency status. The **birth rate to teenagers ages 15-17** was by far the highest of any other ethnicity/race with 80.9 births per 1,000 population. **Birth rates to Hispanic teenagers ages 12-14** were also high with 2.4 per 1,000 population, but not as high as for Blacks (2.8).

Access to care is a problem for Hispanics, mainly due to their lack of insurance. They are more likely to be uninsured and less likely to be covered by employer-paid insurance than any other ethnic/racial group.³⁴ In 1995, 38% of all Hispanics under age 65 were uninsured. This was more than twice the rate of non-Hispanic whites (15%). Only 39% of California Hispanics had employment-based insurance, whereas 70% of non-Latino whites had coverage through their employers. In addition, many uninsured children eligible for Medi-Cal or the state Healthy Families program have not been enrolled by their parents.³⁵ These are disproportionately Hispanic children and often are children of the working poor.³⁵ Although Hispanics make up 60% of eligible children for Healthy Families, as of November 1998 they made up only 40% of those who have enrolled.

Blacks

Blacks have higher mortality rates and, as a group, demonstrate more indicators of poor health than any other ethnic/racial group. This is more associated with factors such as social and economic conditions, personal behavior, access to care and other factors rather than genetics. This information raises red flags for a number of health issues and points to a profound need to address these concerns among segments of the Black population who are doing worse than the county overall.

The cancer death rate among Blacks was 157.5 compared to 113.1 for the county overall in 1996. Breast cancer deaths occurred at a rate of 29.2 per 100,000 compared to 19.9 countywide. The lung cancer death rate was also much higher than the county with 46.5 per 100,000 versus 29.5 in the county overall. The colorectal cancer death rate was also higher than the county rate (19.6 per 100,000 compared to 10.6 countywide).

A total of 155.7 individuals per 100,000 died from coronary heart disease, whereas the county rate was only 93.1. Blacks had more asthma hospitalizations than any other ethnicity/race with 276.8 per 100,000 population compared to 112.2 countywide. Influenza and pneumonia death rates were also higher than the county with 20.0 per 100,000 for Blacks and only 16.8 in the county. There were 55.4 deaths per 100,000 due to unintentional injuries. This is much worse than the county rate of 22.8. The homicide rate was also high with 9.6 deaths per 100,000 compared to 6.2 in the county overall.

The infant mortality rate was higher among Blacks than any other ethnic/racial group with 10.6 deaths per 1,000 births whereas the county rate is 5.4. A higher percent of Black babies are born with a low birthweight (under 2,500 grams) – 10.5% in 1996 compared to 5.8% for the county overall. Blacks have the highest birth rate to teenagers ages 12-14 (2.4 per 1,000 compared to 1.1 countywide). The birth rate to teenagers age 15-17 is higher than the county average (49.5 per 1,000 population versus 36.9 countywide) but not as high as the rate for Hispanics (80.9). The drug-related death rate is high (9.9 per 100,000 population compared to 8.9 countywide) but not as high as for Whites (10.2). The only health issue for which Blacks are below the county rate is for suicide. The rate among Blacks is 9.6 per 100,000 compared to a county rate of 11.6.

Health Issues for Blacks

- Cancer deaths**
- Breast cancer deaths**
- Lung cancer deaths**
- Colorectal cancer deaths**
- Coronary heart disease deaths**
- Asthma hospitalizations**
- Influenza and pneumonia deaths**
- Infant mortality**
- Low birthweight**
- Births to teenagers age 12-14**
- Births to teenagers age 15-17
- Drug-related deaths
- Unintentional injury deaths**
- Homicide**

Asians and Pacific Islanders

Asians/Pacific Islanders did better than the county average on all health indicators except three. In 1996 they had lower rates of cancer deaths (96.8 per 100,000 compared to 113.1 countywide), breast cancer deaths (13.1 per 100,000 compared to

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19.9 countywide), and lung cancer deaths (22.0 versus 29.5 per 100,000). The coronary heart disease death rate (65.3) was much lower than the county rate (93.1). The influenza and pneumonia death rate was low (12.5 per 100,000 versus 16.8 countywide). The suicide rate was low (6.6 per 100,000 compared to 11.6 countywide), and the drug-related death rate (0.4 per 100,000 versus 8.9 countywide) was very low.

Health Issues for Asians and Pacific Islanders

- Low birthweight
- Unintentional injury deaths
- Homicide deaths

There were only three health indicators where Asians and Pacific Islanders were above the county rate. They had the second highest percent of low birthweight babies weighing less than 2,500 grams (7.5% of all births compared to 5.8% countywide). The homicide death rate was high with 7.4 deaths per 100,000 population compared to 6.2 countywide. Asians and Pacific Islanders had the second highest rate of deaths due to unintentional injuries with 34.2 per 100,000 compared to 22.8 countywide.

Native Americans

Because of the relatively small number of Native Americans in San Diego County, there were usually less than five occurrences of an event for most health measures and therefore rates calculated for these measures were unreliable and not discussed below. Native Americans were below county rates on deaths due to cancer, coronary heart disease, unintentional injury, and homicides. They were also low on asthma hospitalizations and birth rate to teenagers.

Health Issues for Native Americans

- Low percent of women seeking prenatal care in the first trimester
- High percent of women seeking prenatal care in the third trimester or not at all
- Low birthweight

Three health indicators related to pregnancy and birth were worse than the county rates and percentages. Only 73.8% of Native American women obtained prenatal care in the first trimester, compared to 78.8% overall for the county. A total of 7.7% obtained prenatal care in the third trimester or not at all. Lack of prenatal care is contributing to a high percentage of low birthweight babies among Native Americans. Among this population, 6.6% were born at low birthweight compared to 5.8% countywide. Targeted efforts are needed to increase prenatal care among Native American women in the first trimester, and to decrease the number of low birthweight babies.

In the remaining health areas, 13 Native American deaths were due to cancer in 1996 (65.2 per 100,000 compared to 113.1 countywide) and 19 were due to coronary heart disease (84.9 per 100,000 versus 93.1 countywide). Eleven teenagers between ages 15 and 17 gave birth (26.6 per 1,000 population). The unintentional injury death rate was 18.4 per 100,000 (7 deaths) compared to a rate of 22.8 countywide. All of these rates are better than the countywide rates.

HEALTH ISSUES BY AGE

Infants and Children (Birth to 14 years old)

The key determinant to an infant's well being at birth is the health of the mother during pregnancy and the care the mother receives during the prenatal period. Early and continuous prenatal care is associated with reduced rates of infant death and low birthweight. More than half of all infant deaths are caused by disorders relating to low birthweight, congenital anomalies, sudden infant death syndrome, and respiratory distress syndrome. Many low birthweight births can be prevented if the mother does not smoke, drink alcohol or use other drugs. Pregnancy before age 18 is a risk factor for low birthweight.

In 1996, 243 infants died before their first birthday in San Diego County. **Appendix F** shows mortality rates by age groupings in San Diego County for 1996. The rate decreased from 6.2 deaths per 1,000 births in 1993 to 5.4 per 1,000 in 1996. The African American infant mortality rate in San Diego during the same year (10.6/1,000) was almost twice that of the overall county in 1996. Infant mortality has the highest number of years of productive life lost (YPLL) per death with an average of 62.5 years per death (see **Appendix H**). In 1996, 5.8% of all newborns had a low birthweight (less than 2,500 grams) in San Diego County. This is a decrease from 6.0% in 1993.

Definition: Years of Productive Life Lost (YPLL)

Total YPLL = Age 65 minus the age when the person died, totaled for all persons dying from that cause.

Average YPLL = Total YPLL

With regard to children between the ages of 1 and 14, there are a number of health concerns. Unintentional injuries have replaced infectious diseases as being the major cause of death or disability. Unintentional injuries are the number one killer of children under 14 years old, but they are also one of the most preventable causes of deaths. In 1996 there were 4.9 deaths per 100,000 population of children between ages 1 and 14 in San Diego County. Falls account for 30% of fatal and nonfatal unintentional injuries for children, followed by motor vehicle crashes, fires and poisoning.³⁶ Infections and respiratory problems are still issues for children, especially since they are the main reasons children miss school. Reports of asthma in children are increasing nationwide, especially for young people who live in cities. Violence is still a major problem. In San Diego County there were 121.7 child abuse referrals/reports per 1,000 of the less than 18-year-old population during fiscal year 1996-97.

An accurate picture of children's health needs to go beyond mortality and morbidity data and include emotional, psychological, and learning problems. Chronic physical conditions such as hearing and speech impairment are also problems. Low income children are more likely to suffer from these problems than other children. In addition, childhood is a time to establish healthy behaviors related to eating, hygiene, exercising regularly, and avoiding the use of cigarettes, alcohol, or drugs.

Adolescents and Young Adults (Ages 15-24)

The three leading causes of death for adolescents nationwide are unintentional injuries, homicide and suicide. Unintentional injuries resulted in an average of 30.1 years of potential life lost (YPLL) per death, which is the fourth highest number countywide. The rate of homicides was highest in the 15-24 age group (9.1 per 100,000 population). Homicide results in the second highest cause of YPLL per death with an average of 34.7 years lost for individuals of all ages. It is the leading cause of death for African-American and Hispanic men between the ages of 15 and 24 in the US, and the second leading cause of death for all youth between the ages of 15 and 24.³⁷ With regard to suicide, there were 10.4 suicides per 100,000 population in this age group. Approximately 13.9% of San Diego high school girls surveyed said they attempted to commit suicide in the past year, and 29.3% said they thought seriously about suicide.²¹

Adolescents and young adults are developing health-related behaviors that are likely to persist throughout their lives. This is especially important for choices made pertaining to smoking and using alcohol or other drugs. In 1996 there were 4.4 drug-related deaths per 100,000 population ages 15-24 in San Diego County. Over 47% of youth surveyed in San Diego City high schools reported current alcohol use.²¹ Risk factors for adolescent alcohol and drug abuse include a family history of abuse, low self-esteem, poverty, and low educational achievement. It places adolescents at higher risk for unintentional injuries and unsafe sexual behavior, and increases their risk of developing serious dependency problems as they mature. Teen smoking is on the increase, with nearly 25% of all high school students reporting current tobacco use in 1997.²¹ The younger a person is when they start smoking, the less likely they are to ever quit.

Sexual behavior is also an issue for this age group. Sexually transmitted infections are major concerns for adolescents, and can contribute to infertility, pregnancy complications, adverse birth outcomes, chronic infection, cervical cancer, and even death. Teen pregnancy is also a problem. In San Diego County there were 1,884 births to girls between the ages of 12 and 17 in 1996, however the rate of births to girls between the ages of 15 and 17 has decreased in recent years. Hispanic youth have the highest rates of teenage birth.

This is a critical age for adopting lifelong health habits to prevent development of chronic diseases later in life. Low fat diets and regular exercise help to prevent coronary heart disease, high blood pressure and certain types of cancer as an individual grows older.

Adults (Ages 25-64)

Many of the leading causes of death for this age group (coronary heart disease, stroke, unintentional injuries) are preventable by adopting a healthy diet that is low in fat and calories, getting adequate exercise, not being overweight, not smoking, not drinking excessively, and using safety devices such as seatbelts. Decreases in the rate of cigarette smoking have helped to reduce rates of coronary heart disease since 1970. Cancer is the number one cause of death for people ages 25-64. In San Diego County there were 86.5 cancer deaths per 100,000 population in this age group in 1996. Breast cancer resulted in 23.9 adult deaths per 100,000 population.

In 1996, adults ages 25-64 died from unintentional injuries at a rate of 27.7 per 100,000 population in San Diego County. Drug-related deaths were highest in the 25-64 age category, resulting in an average of 24.3 YPLL per death for individuals of all ages. This age group also had a high rate of suicides, 16.0 per 100,000 population. Interpersonal violence is a problem for this age group, especially for women. In 1996 there were a total of 26,327 reported incidents of domestic violence in San Diego County. Between 1993 and 1997 the reported number of rapes increased by 10% in San Diego County from 802 to 882.

Older Adults (Age 65 and Over)

Healthy behaviors can contribute to quality of life after age 65. Quitting smoking can also increase life expectancy, reduce the risk of heart disease and improve respiratory function and circulation. Good nutrition, reducing sodium intake, and reducing weight can help keep blood pressure under control and reduce the risk of heart disease and stroke. Regular exercise helps to reduce the incidence of coronary heart disease, hypertension, noninsulin-dependent diabetes mellitus, depression, and anxiety.

As would be expected, seniors had higher mortality rates for almost all causes than any other age group. Coronary heart disease was the leading cause of death for seniors, accounting for 1,297 deaths per 100,000 population, followed by cancer (1,015.4 deaths per 100,000). Although these diseases have the highest number of deaths, the deaths occur later in life. Therefore the average years of productive life lost before reaching age 65 are lower than other types of deaths: 9.3 years average lost per individual (of all ages) for lung cancer; 10.5 years per individual for coronary heart disease; and 16.4 years for cervical cancer. Other types of cancer fall within this range for years of productive life lost.

Seniors had the highest rate of deaths due to influenza and pneumonia claiming 281.9 lives per 100,000 population in this age group. They had the highest rate of deaths due to unintentional injuries, with 55.0 per 100,000 population and the highest rate of suicide at 24.1 per 100,000 population. Drugs were the cause of death for 4.2 per 100,000 seniors in 1996. In 1997-98, there were 1,358.6 reports of elder abuse in San Diego communities, and 87.0 reports per 100,000 senior population in institutional settings.

NEXT STEPS

The 1998 CHIP Community Health Status Assessment represents a first step toward improving the health of our community. The assessment documents the problems, identifies high risk populations and geographic areas, and points to potential preventive approaches. The next steps—putting the information into action—are the most critical.

Individual communities, organizations, hospitals, consumer groups, and others can use this information to establish and monitor preventive health programs in their communities. Some of the critical steps involved in developing an effective community health program are:

- Determine those underlying conditions (behavioral, social, economic, etc.) that contribute to an unsatisfactory health outcome;
- Focus your prevention/intervention efforts on underlying conditions, e.g., diet and exercise for heart disease; family support and alcohol/drug prevention for child abuse or domestic violence prevention;
- Identify community resources and existing efforts focused on the health concern;
- Identify gaps in services; underserved populations or communities;
- Establish coalitions and networking with other groups and individuals with similar concerns;
- Involve representatives of the “target” group, e.g., patients, consumer representatives, community residents, to gather input and perspective on your proposed intervention and ensure that your program is culturally appropriate;
- Develop an effective program plan that encompasses state-of-the-art knowledge and information, identifies measurable outcomes, establishes milestones and a monitoring system, identifies a realistic timeline, and specifies who is responsible for what.

There are numerous models that can be used as a framework for health program planning. Commonly used models include:

- PRECEDE³⁸ (Predisposing, Reinforcing, and Enabling Causes in Educational Diagnosis and Evaluation);
- PATCH³⁹ (Planned Approach To Community Health);
- Healthy Communities⁴⁰
- Asset Building⁴¹
- Planning for Community-Oriented Health Systems⁴²

The data contained in the health status assessment, along with specific mortality and morbidity data contained in the (County health statistics) can be analyzed to yield community-specific information, on a regional, community, zip code, or census tract level. Focus group findings for specific populations can also be used to further define the issues and their underlying causes or contributing factors.

Community Health Improvement Partners

It is anticipated that the findings of the CHIP Needs Assessment will provide a framework for communities, institutions, coalitions, and others to identify and address specific health concerns. It will enable them to develop or enhance programs targeted toward specific populations by region, ethnicity/race, age or other characteristics. It will also provide the in-depth information needed to make programmatic decisions. This thoughtful process will lead to the improvement of the health of San Diego.

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