Sharp Grossmont Hospital

Community Health Needs Assessment

Fiscal Year 2025

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

SHARP

Sharp Grossmont Hospital

Community Health Needs Assessment

Fiscal Year 2025

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Preface

Sharp Grossmont Hospital (SGH) prepared this Community Health Needs Assessment (CHNA) for fiscal year 2025 (FY 2025) in accordance with the requirements of Section 501(r)(3) within Section 9007 of the Patient Protection and Affordable Care Act (Affordable Care Act) and Internal Revenue Service (IRS) Form 990, Schedule H for not-for-profit hospitals.[1]

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

The Sharp Grossmont Hospital 2025 Community Health Needs Assessment (SGH 2025 CHNA) and FY 2026 – FY 2029 Implementation Strategy received approval from the SGH Board of Directors on Sept. 16, 2025.

Chris Howard
President and Chief Executive Officer
Sharp HealthCare

Section

1 Background

Sharp HealthCare (Sharp) has been actively involved in a continuous Community Health Needs Assessment (CHNA) process since 1995. This process began in accordance with the requirements of Senate Bill 697 (SB 697), community benefit legislation that requires not-for-profit hospitals in California to file a triennial CHNA that identifies and prioritizes community health needs.

Additionally, the Sharp Grossmont Hospital 2025 Community Health Needs Assessment (SGH 2025 CHNA) responds to Internal Revenue Service (IRS) regulatory requirements that private not-for-profit hospitals conduct and publish the CHNA with corresponding implementation strategies. These are the planned strategies intended to address the needs identified in the hospital's CHNA. In 2025, the Sharp Grossmont Hospital for Neurosciences opened, a specialty hospital now operating under the same license as the primary hospital facility. This CHNA reflects the needs assessment conducted for the primary hospital facility; future assessments will incorporate the specialty hospital as part of the licensed entity's comprehensive evaluation of community health needs.

SB 697 also requires submission of an annual community benefit report to the California Department of Health Care Access and Information[2] that describes programs and services provided to address those identified community health needs within their mission and financial capacity, as well as the financial value of those programs and services. To view the most recent Sharp HealthCare Community Benefit Plan and Report, please visit: https://www.sharp.com/about/community-benefit-report.

Both the HASD&IC and Sharp 2025 CHNAs build off the findings from the 2022 CHNAs. See **Appendix A** for a summary of the 2022 CHNA process and findings.

Section

2 Introduction & Acknowledgements

The 2025 CHNA is a collaborative effort of all hospitals and health care systems in San Diego County (SDC), including every private hospital, health system, public hospital, health district, and behavioral health hospital. This CHNA aims to understand the community's needs from a community perspective allowing for the development, modification, and expansion of meaningful and effective programs to address those needs.

We assessed community needs through field interviews, focus groups, key informant interviews, online surveys, publicly available data, and where applicable, previously published research. This work led to the development of the Hospital Association of San Diego and Imperial Counties 2025 Community Health Needs Assessment (HASD&IC 2025 CHNA) and Sharp HealthCare (Sharp) 2025 CHNAs. The process and findings of both efforts are described throughout this report.

HASD&IC 2025 CHNA: Participating Hospitals and Health Systems

Every private hospital, health system, health district and behavioral health hospital in SDC participates in this collective effort to better understand the health and social needs of SDC communities. Participating hospital and health systems supported the Hospital Association of San Diego and Imperial Counties (HASD&IC) Board of Directors, HASD&IC Behavioral Health Workgroup, and HASD&IC Case Management Workgroup.

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

HASD&IC 2025 CHNA Committee

The CHNA Committee (listed below) designed and implemented the HASD&IC 2025 CHNA process.

Erica Salcuni (Chair)
Sharp HealthCare

Anette Blatt (Vice-Chair)
Scripps Health

Christian Wallis
Amy Abrams
Grossmont Healthcare District

Lindsey Wright
Kaiser Permanente – San Diego, Zion, and San Marcos Medical Centers

Stephanie Gioia-Beckman
Rady Children's Hospital San Diego

David Mier
UC San Diego Health

Hospital Association of San Diego and Imperial Counties

Dimitrios Alexiou
President and Chief Executive Officer

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Project Manager, Special Programs & Initiatives

Stephanie Phann
Project Manager, Health Equity & Community Engagement

Caryn Sumek, MPH
Vice President

Natalie Rosare
Epidemiology Intern

Nhat Quang Thai
Epidemiologist

Lindsey Wade
Senior Vice President

Community Partners

We extend heartfelt gratitude to all community partners who participated in the 2025 CHNA processes. Health care and social services sectors have been overburdened since the pandemic, and the needs in our community have only grown over the past three years. We remain deeply grateful to all our community partners, who once again, without hesitation, answered our requests for data and key informant interviews, led field research, organized focus groups, and promoted the online survey. Our collaboration gives the CHNA Committee confidence that this report will be valuable to our partners in SDC, including policymakers, health care and social service providers, grant makers, and other civic leaders.

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

We would like to give special thanks to the San Diego Refugee Communities Coalition (SDRCC), a coalition of 12 ethnic-based community organizations. Members of SDRCC were invaluable research collaborators, conducting hundreds of field interviews in multiple languages, assisting with data analysis, and providing guidance throughout the CHNA. Field interviews were conducted in collaboration with the Community Health Initiative of the San Diego Refugee Communities Coalition and the UC San Diego Center for Community Health, Refugee Health Unit within the Altman Clinical Translational Research Institute.

SAN DIEGO Refugee Communities COALITION

SDRCC CHNA Project Implementation Team

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United Women of East Africa Support Team/San Diego Refugee Communities Coalition

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Amina Sheik Mohamed
UC San Diego Center for Community Health - Refugee Health Unit

Valerie Nash
Nash & Associates

Ruth Teseyem Tadesse
UC San Diego Center for Community Health - Refugee Health Unit

Reem Zubaidi
UC San Diego Center for Community Health - Refugee Health Unit

SDRCC Research Partnership Organizations

Haitian Bridge Alliance

Horn of Africa

Karen Organization of San Diego

License to Freedom

Majdal: Arab Community Center of San Diego

Refugee Assistance Center

SDRCC Afghan

Slavic Refugee and Immigrant Services Organization

Somali Bantu Organization of San Diego

Southern Sudanese Community Center of San Diego

United Women of East Africa Support Team

We also extend special thanks to the San Diego County Promotores Coalition (SDCPC), which advances the work of Community Health Workers/Promotores. SDCPC members collected hundreds of field interviews, offered feedback on data collection tools and CHNA findings, and generously lent their expertise.

San Diego County Promotores Coalition
Empowering Promotores Since 2009

Amanda Schultz
San Diego County Promotores Coalition

Deysi Merino
San Diego County Promotores Coalition

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County of San Diego Health & Human Services Agency

LIVE WELL SAN DIEGO

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Amelia Kenner-Brininger, MPH
Data and Strategy Chief

Alison Sipler, MPH, CHES
Program Coordinator

Collaborative Research Partners

The CHNA Committee and HASD&IC

The HASD&IC Board of Directors represents all member sectors and provides policy direction to ensure the interests of member hospitals and health systems are preserved and promoted. The CHNA Committee includes representatives from participating hospitals and health systems and provides overarching guidance regarding the research approach and community engagement. The CHNA Committee is responsible for implementing the HASD&IC 2025 CHNA and reports to the HASD&IC Board of Directors.

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

SDSU | Institute for Public Health

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

Corinne McDaniels-Davidson, PhD, MPH, MCHES®
Director, IPH
Associate Director of Public Health Practice, SDSU School of Public Health (SPH)
Associate Professor, Division of Health Promotion & Behavior Science, SDSU SPH
Deputy Associate Director, UCSD Moores Cancer Center Community Outreach & Engagement

Martha Crowe, MA
Project Lead, Research Associate, IPH

Kanako Sturgis, MPH
Senior Data/Evaluation Specialist, IPH

Adrian Trovato, MPH
Research Assistant, IPH

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

In addition to their participation in the HASD&IC 2025 CHNA process, Kaiser Permanente - San Diego, Zion, and San Marcos Medical Centers also conducted their own CHNAs in partnership with Harder+Company Community Research. These two processes were intentionally conducted simultaneously with ongoing, continuous feedback between the two groups; this allowed the groups' efforts to be complementary rather than duplicative. These efforts also enabled HASD&IC and Kaiser Permanente-San Diego, Zion and San Marcos to leverage each other's relationships in the community, resulting in greater community representation and the efficient use of resources. Data were shared between the groups. This innovative partnership resulted in a more robust CHNA for all SDC hospitals and health care systems.

SGH 2025 CHNA Planning Team

In addition, team members from Sharp led, supported or participated in key aspects of the SGH 2025 CHNA process, listed below.

Sharp HealthCare

Erica Salcuni
Manager, Community Benefit & Health Improvement

Kristine White
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Section

3 Executive Summary

The 2025 Community Health Needs Assessment (CHNA) represents a collaborative effort of all San Diego County (SDC) hospitals and health care systems to understand the community's top needs. CHNA findings are used to develop, modify, and expand health and social service programs. The 2025 CHNA, facilitated by Hospital Association of San Diego and Imperial Counties (HASD&IC), employed a research team which utilized a health equity framework and emphasized community-based research.

Sharp HealthCare (Sharp) hospitals, including Sharp Grossmont Hospital (SGH), develop CHNAs based on the collaborative CHNA process and findings. The Sharp CHNAs are adapted to inform program delivery within their primary service areas, particularly for high need community members. In addition, each Sharp hospital will develop and publish its three-year implementation strategy — a written plan to address the needs identified through the hospital's 2025 CHNA.

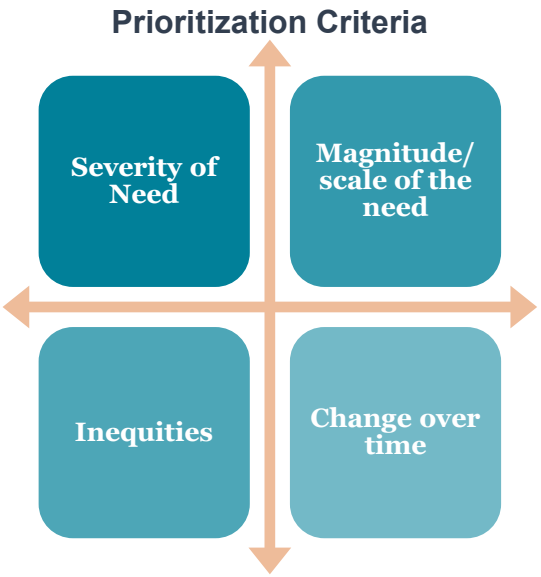
Community Defined

The HASD&IC 2025 CHNA encompasses all of SDC due to a broad representation of hospitals in the area. The primary communities served by SGH encompass SDC's East County, including the sub-regions areas of Jamul, Spring Valley, Lemon Grove, La Mesa, El Cajon, Santee, Lakeside, Harbison Canyon, Crest, Alpine, Laguna-Pine Valley and Mountain Empire. See the table below for the ZIP codes where the majority of SGH patients reside. As many of these communities span multiple regions in SDC, demographics are provided at the county level for the most accurate reflection of the community served by the hospital.

Primary Communities Served by SGH[3]

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

Prioritization of Community Needs



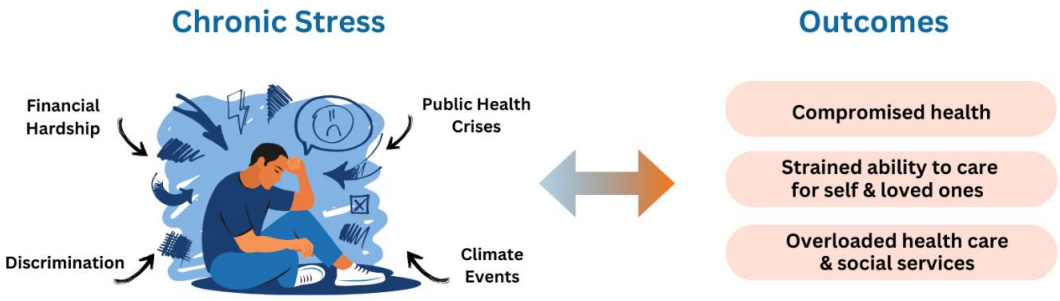
Once initial analyses were completed, the CHNA research team and committee of health systems met to determine which community needs should be central to this report. Prioritization criteria included:

Severity of need: What is the potential to cause death or disability?
Magnitude/scale of the need: How many people are affected?
Inequities: Are some populations at greater risk for this condition, based on geography, languages, ethnicity, culture, citizenship status, economic status, sexual orientation, age, gender, or others?
Change over time: Has the condition improved, stayed the same, or worsened?

Primary Finding: Chronic Stress

Chronic stress was consistently highlighted as a significant theme across all methods of qualitative data collection in the HASD&IC 2025 CHNA. This stress, community members said, is caused by the high cost of living in San Diego, rising levels of racism, prejudice, and discrimination, ongoing challenges from COVID-19, and recent public health emergencies. They indicated that this ongoing, debilitating stress is severely impacting their health and their ability to manage their health care.

Health care and social service providers indicated that this chronic stress has resulted in increasing numbers of community members who are sicker than ever, seeking help within a system that is overburdened. The graphic below illustrates this finding.



Methods

The HASD&IC 2025 CHNA research team conducted focus groups, key informant interviews, field interviews, and an online survey to gather qualitative data. They also reviewed publicly available demographic data, hospital discharge records, and existing research to gain a comprehensive understanding of community needs. Through this research, the team addressed the following research questions:

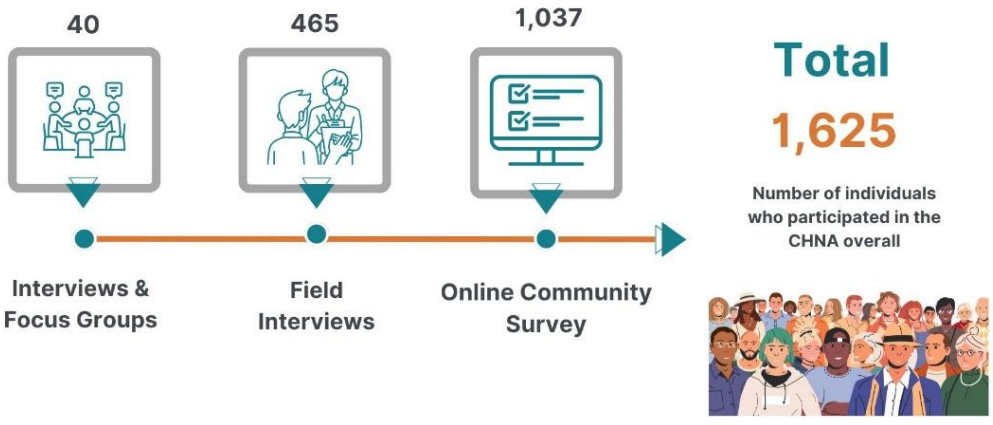
- What are the most pressing needs of our community?
- How can hospitals and health systems help address those needs?

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

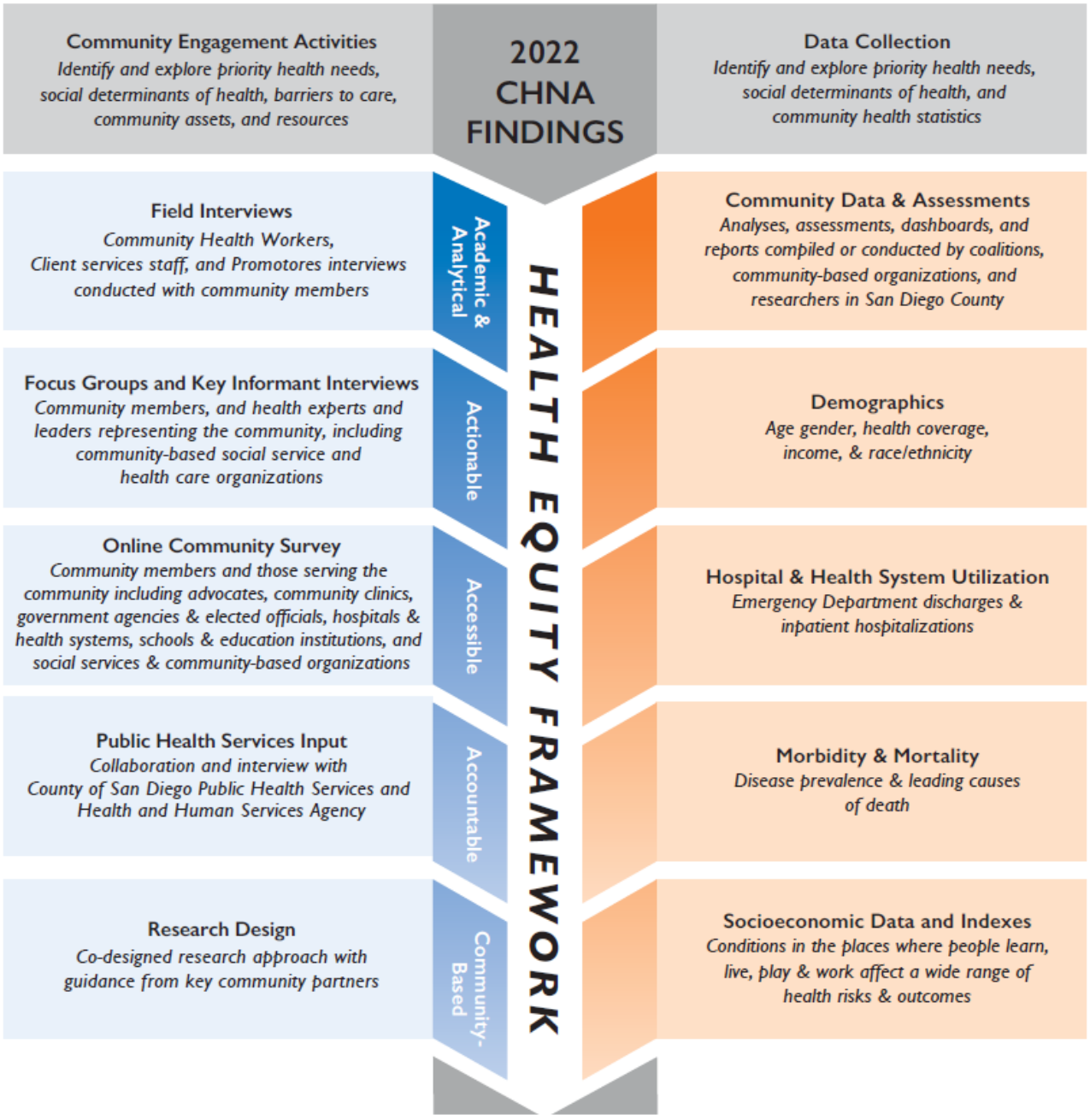
Sharp conducted additional patient data analysis and engaged nearly 270 additional community members to help inform activities specific to communities served by its hospitals and medical groups, including SGH.

See the following graphics for an overview of 2025 CHNA methods and approaches.

2025 CHNA Community Engagement Summary



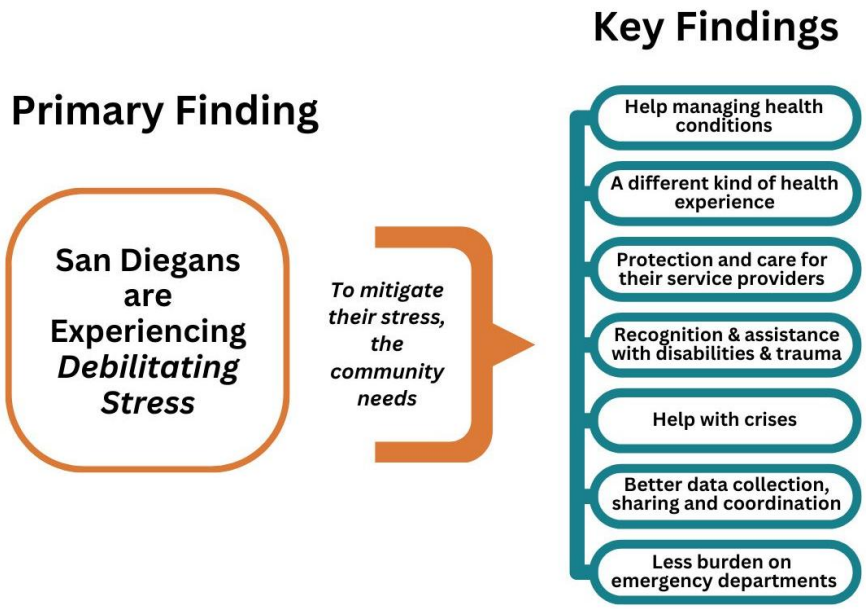
2025 COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) PROCESS MAP



Key Findings

Within the context of the primary finding, the 2025 CHNA focused on what the community needs from hospitals and health care systems to mitigate their stress, and, therefore, improve their health. The community discussed several strategies, represented as Key Findings in the graphic below.

2025 CHNA Findings Summary



2025 CHNA FINDING

Help Managing Health Conditions

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

Top Community Health Needs					
Asthma	Blood Pressure	Cancer	Dental Health	Diabetes	Mental Health

2025 CHNA FINDING

A Different Kind of Health Care Experience

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

Protection and Care for their Service Providers
The community also emphasized that they *appreciate their health care workers, understand the pressures they are under, and want them to be protected and cared for as well.* They offered praise for health care workers and concern about staff shortages, worker burnout, and vicarious trauma.

Recognition and Assistance with Disability and Trauma
One in 10 San Diegans lives with a disability[4], and many have experienced traumatic events. The community emphasized that *people who are disabled or living with trauma need recognition, accommodations, compassion, and assistance with resources,* including:

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

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

- **Heat:** Extreme temperatures have severely affected residents' daily lives, with many reporting health issues such as migraines, blood pressure fluctuations, dehydration, and respiratory problems.
- **Wildfires:** Wildfires and their associated smoke have caused widespread breathing difficulties.
- **Flooding:** A major flood in January 2024 displaced over 1,200 households, primarily in Southeast San Diego. The flooding led to respiratory problems and an increase in illnesses such as flu-like symptoms.
- **Tijuana River Valley Sewage Crisis:** The ongoing sewage crisis has resulted in unbearable odors and significant health concerns for residents living near the Tijuana Riverbed.

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

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

Community Recommendations

What's Already Working

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

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

Community Suggestions

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

Patient support	▪ Ensuring that ***all individuals in the room during consultations introduce themselves*** and explain their roles ▪ Expanding the use of ***peer support for health care navigation*** ▪ Establishing ***a phone line for insurance-related inquiries*** ▪ Creating ***immediate feedback systems***, such as allowing patients to provide feedback directly after appointments ▪ Encouraging patients to have a ***friend, family member, or advocate attend appointments*** with them ▪ Enabling the ***easy identification of ADA coordinators*** to assist with disability accommodations
Health care worker support	▪ Providing ***opportunities for cultural exchanges and education*** in the community ▪ Acknowledging and ***addressing health care worker burn out and vicarious trauma*** ▪ Making efforts to ***reduce staff turnover***

	▪ Encouraging and providing paid time for ***health care worker community engagement*** ▪ Providing ***training opportunities around systemic racism, power dynamics, cultural competency, and health inequities*** and about interacting with ***populations with complex health needs*** ▪ Establishing ***low-cost, convenient education and training for medical assistants, certified nursing assistants, and licensed vocational nurses***
Hospital & emergency department discharges	▪ Releasing patients with a ***longer supply of prescription medications*** ▪ Increasing the ***availability of hospital social workers*** ▪ Establishing ***more recuperative care beds*** ▪ Increasing utilization of ***In-Home Supportive Services (IHSS)*** ▪ Expanding ***post-discharge home visiting programs***
Systemic efforts	▪ ***Advocating for policy changes*** that would make health care more convenient and cost effective for the community ▪ Designating a ***hospital administrator as a community advocate*** ▪ Gathering more community feedback about needs and ways to ***create community-centered programs and services*** to address those needs

Limitations

The 2025 CHNA engaged a broad spectrum of the public to better understand their needs. HASD&IC and Sharp data collection efforts allowed for feedback from nearly 1,900 members of the community, resulting in an assessment that represented more community members and patients — from more diverse backgrounds — than ever before.

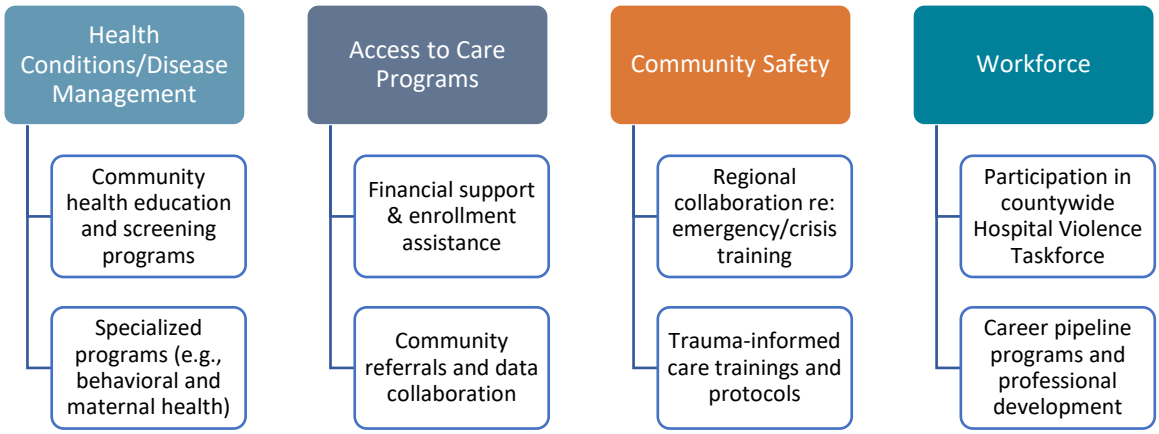
Limitations included sampling biases inherent to the use of hospital discharge data and purposive sampling techniques. In addition, certain populations of people who may be experiencing inequities, such as former foster youth, justice-impacted individuals, and people with chronic medical conditions,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

Next Steps

SGH developed its FY 2026 – FY 2029 Implementation Strategy to address select needs identified in the 2025 CHNA. Many of the programs listed have been in place at SGH for several years; leaders and team members across Sharp continuously evaluate their success to ensure they address and respond to the latest CHNA findings.

Categories of programs and activities included in the SGH FY 2026 – FY 2029 Implementation Strategy are summarized in the graphic below:

SGH FY 2026 – FY 2029 Implementation Strategy Overview



All Sharp 2025 CHNAs and FY 2026 – FY 2029 implementation strategies are available as of Sept. 30, 2025 on Sharp.com. Reports are also available on request by contacting communitybenefits@sharp.com.

Sharp extends deep gratitude for the contributions made by all who participated in the 2025 CHNA process. We are committed to providing a CHNA that is valuable to all our community partners and look forward to strengthening that value and those community partnerships in response.

Section

4 Methodology

The Sharp Grossmont Hospital 2025 Community Health Needs Assessment (SGH 2025 CHNA) draws from and is based on the process and findings of the Hospital Association of San Diego and Imperial Counties 2025 Community Health Needs Assessment (HASD&IC 2025 CHNA).

The SGH 2025 CHNA process included distinct patient, staff and community engagement activities to further explore the needs of communities served by Sharp HealthCare (Sharp) hospitals. Sharp also conducted strategic analysis of internal hospital data to explore observations and trends among its patient populations.

Guiding Research Principles

Several principles guided the 2025 CHNA process. These were based on Institute for Public Health (IPH) research guidelines, the 2022 CHNA Health Equity Framework, and input from the CHNA Committee, which are described below.

IPH Research Guidelines

Academic and Analytical

The CHNA Committee and research team employed research practices considered best for needs assessments. Strategies to ensure academic and analytical rigor included:

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

Actionable

Another goal of the CHNA was to structure the assessment so that the findings could realistically be used to improve community health.[5] The research team took a solutions-based approach that asked the community for input about ways to solve health-related problems.[6] Questions were designed to solicit useful information for hospitals, health care systems, and community partners.[7]

Accessible

Another priority was to ensure that everyone who contributed to this needs assessment, from hospital systems to community members, could understand the findings of the report. This includes use of what the U.S. government calls “plain language” so that the report would be as easy to read as possible.[8,9] Simple, clear language also supports the nearly 40% of our community who speaks English as a second language and makes translation into other languages easier. In addition to using plain language, the needs assessment prioritizes using the exact words of community members.

Accountable

Community members want to know that when they take the time to work with us, it will matter. The CHNA team recognizes our obligation to share the results of the CHNA with them. Data collected must be given back to the communities from which it was gathered and be used to create feasible, relevant solutions to the identified problems. This is a key ethical standard of all community-based work and a regulatory requirement for the CHNA. Holding ourselves accountable to our community also builds trust between the medical community and the people it serves, particularly the people for whom there is a history of mistrust of the medical community.[10,11]

Community-based

Research into the quality of CHNAs has noted that too often community voice is lacking.[12] A primary goal of the 2025 CHNA process was, therefore, to involve Community Health Workers (CHWs), community partners, and members of the community as research collaborators. The San Diego Refugee Communities Coalition (SDRCC) and the San Diego County Promotores Coalition (SDCPC) were among the community partners who helped design data collection tools, collect field interview data, and assist with data analysis.

Health Equity Framework

Developed to guide the HASD&IC 2022 CHNA, this framework was referenced to maintain a cycle of continuous improvement for community engagement and data analysis. See the figure below for an overview of the framework.

CHNA Health Equity Framework

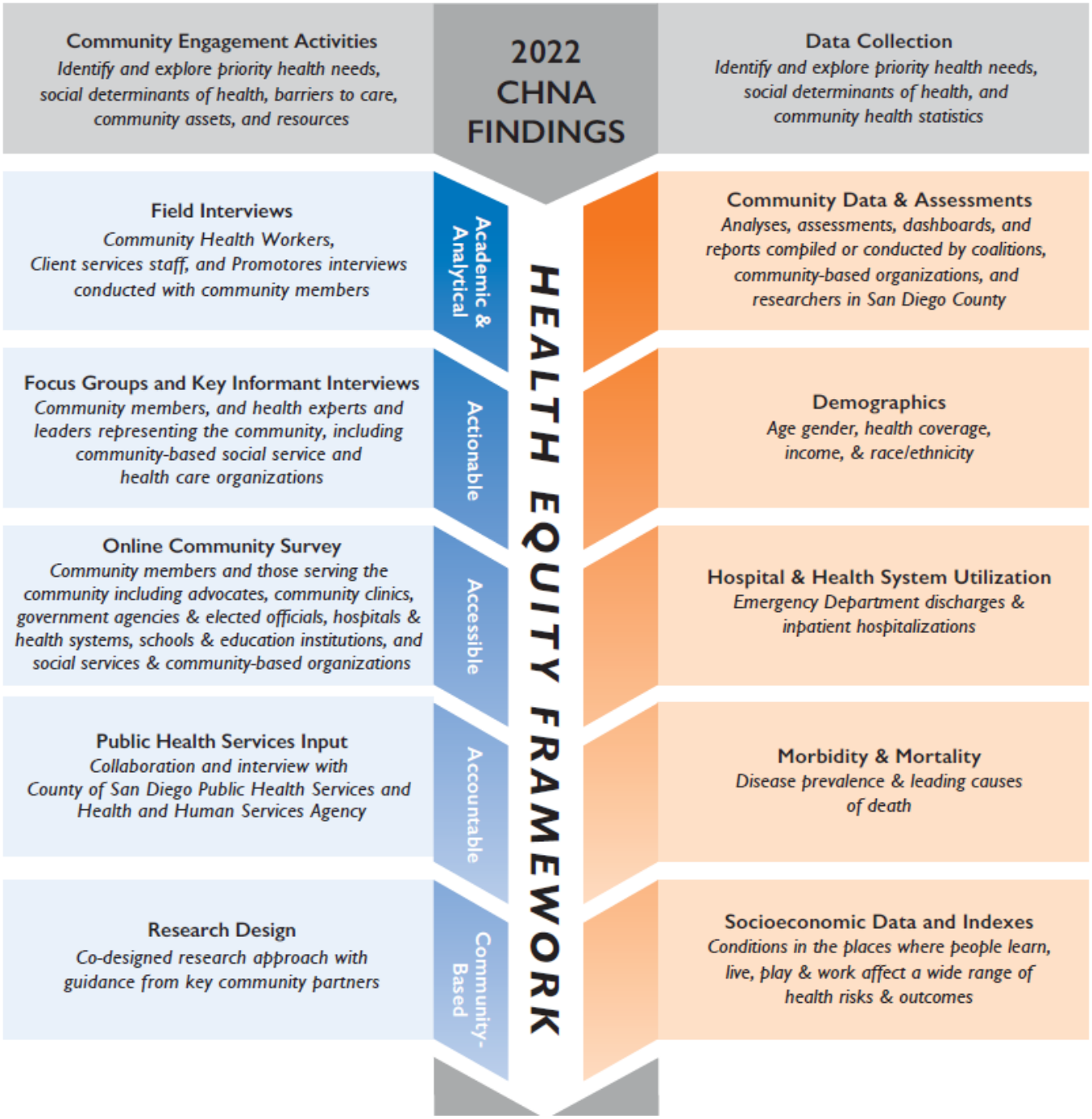
Methods

The 2025 CHNA used a variety of qualitative and quantitative data collection methods, which are summarized in this section. This approach allowed HASD&IC and Sharp to analyze all types of inputs to understand and prioritize community needs. Data collection was guided by our primary research questions:

- What are the most pressing needs of our community?
- How can hospitals and health systems help address those needs?

The 2025 CHNA process is mapped in the diagram on the following page.

2025 COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) PROCESS MAP



Quantitative Data

HASD&IC 2025 CHNA

The CHNA research team also consulted publicly available data to confirm and prioritize qualitative findings, as follows:

1. Demographic information from the American Community Survey of the Census Bureau and the 2018-2022 demographic data published by the County of San Diego.[13,14]
2. Hospital and emergency department (ED) discharge data for some health conditions.
3. Literature review of relevant published research, including approximately 60 CHNAs completed in other parts of the country.
4. The Healthy Places Index® (HPI) to identify populations of focus.[15]

Sharp 2025 CHNAs

Sharp reviewed and analyzed some of its own hospital data to supplement HASD&IC findings and highlight additional priorities based on the communities it serves. Like the qualitative data approach, this process identified behavioral health and maternal and infant health as focus areas for additional research.

Healthy Places Index

Like the HASD&IC 2025 CHNA, Sharp used the HPI to identify the communities in its hospitals' service areas experiencing health inequities. This included mapping Sharp's service areas on top of HPI data to identify under-resourced communities. The HPI evaluates communities by assigning them a "score" based on various health indicators. This score generates a percentile ranking that compares the community's overall health and wellbeing to others in the state. A higher percentile indicates a healthier community, while a lower percentile signifies a less healthy community. Sharp service area data was calculated and provided by Sharp's Strategic Planning Department by using internal data to determine the top ZIP codes where Sharp inpatients reside. Please refer to **Section 5: Description of Community** for additional detail on Sharp's application of HPI data.

SpeedTrack

SpeedTrack data tools were used to analyze Health Care Access and Information (HCAI) hospital discharge data, offering insights into Sharp's patient population about specific health needs. Sharp utilized the most recent available data to identify top diagnoses, trends, and demographic characteristics, such as age, gender, and race/ethnicity, among inpatients and emergency department visitors at each of its hospitals. For San Diego County (SDC) regional analyses, regions reflect Sharp

Strategic Planning Department's definitions. Please see **Appendix B** for more information.

Sharp Internal Data

Sharp's Clinical Analytics team developed and shared data on internal metrics that provide insights into demographic characteristics of various service lines in the organization. Due to a recent change in the internal electronic health record system, data availability was limited and undergoing continuous improvement processes at the time this CHNA was conducted. Upon review of data availability and constraints, two key dashboards were provided to supply the CHNA team with the most current and relevant data:

1. Health equity screenings dashboard, including data on health equity screenings administered and addressed by Sharp staff, and data from California Maternal Quality Care Collaborative (CMQCC).
2. Behavioral health-related ED discharge data with a focus on the most prevalent behavioral health/substance use diagnoses for all Sharp ED visits, including emergency, observation, and admitted cases.

The CMQCC health equity data representing the period between May 2024 and February 2025 was analyzed using a chi-square test of independence for each demographic dimension within each CMQCC category. The results included in this report reflect the demographic groups who saw a statistically significant negative outcome compared to other groups.

The behavioral health ED data representing the period from 2022 to 2024 was analyzed using a chi-square test of independence for each demographic dimension within each behavioral health category. The results included in this report reflect the demographic groups who saw a statistically significant negative outcome compared to other groups.

More information on this analysis is included in **Appendix C**.

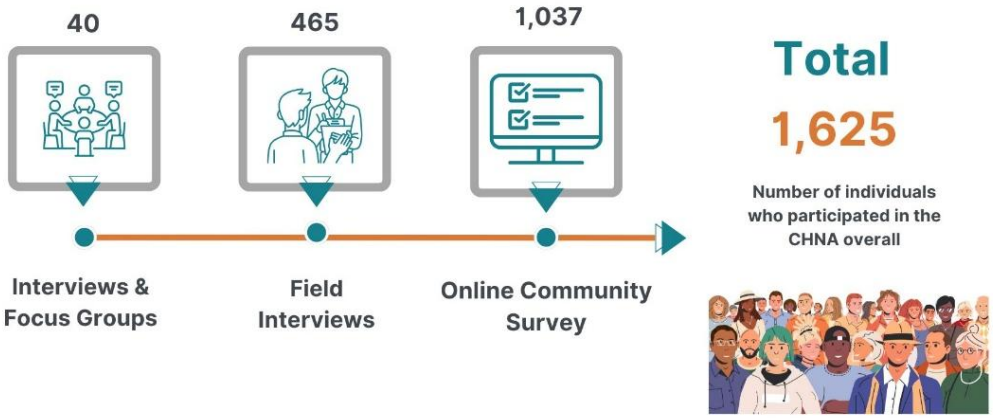
Qualitative Data: Community Engagement Activities

HASD&IC 2025 CHNA

Led by researchers at the IPH, the CHNA team collected data through focus groups, key informant interviews, field interviews, and an online survey. These community engagement activities resulted in a sample size of 1,625, which is comparable to that of the California Health Interview Survey by UCLA, a multi-year project supported by various funding sources.[16] In partnership with the SDRCC and SDCPC, the CHNA team completed 465 field interviews. Additionally, the online survey was taken 1,037 times,

and a total of 15 focus groups and 25 key informant interviews were conducted (40 groups in total, involving 123 individuals), exceeding the recommended number for data validity.[17,18] A summary of these activities is included in the figure below.

2025 CHNA Community Engagement Summary



Key Informant Interviews and Focus Groups

During initial planning, populations of focus were chosen based on feedback from the 2022 CHNA, data from the HPI[19] and research on health inequities.

Once agreement was reached about those populations, subjects were recruited for focus groups and key informant interviews using purposive sampling, which draws on the networks of the researchers and local resources to find people who have valuable information to contribute to the research questions.[20] Professionals, organizations, advocacy groups, and coalitions working with our populations of focus were contacted and asked for guidance about recruiting.

Focus group and interview questions were developed in consultation with the CHNA Committee.[21] Before each event, the CHNA team reviewed information about the scheduled guests to understand their roles, services offered, and populations served. Questions were then adapted specifically for those participants.

Key informant interviews and focus groups were semi-structured to ensure the primary research questions were addressed while also allowing for a conversational style so participants could discuss what was most important to them.[22] Questions focused on the most pressing health and social needs of the populations of focus, services and programs that were working well to address those, ideas about what could better address the community's needs, and what participants wanted hospitals and health care systems to know.

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

Two IPH research associates then separately analyzed the notes taken, the debriefing notes, and the transcripts to code the data. Using iterative thematic analysis, which included both deductive (using pre-determined categories) and inductive (creating new categories) approaches, the data were categorized into initial themes.[23]

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

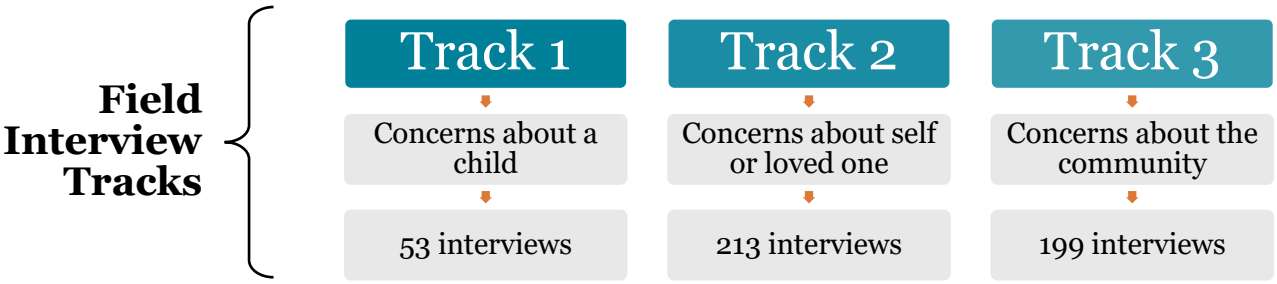
Field Interviews

Data were collected directly from the public through field interviews, which are short conversations with people who stopped outside of public places, like stores and transit stops. The purpose was to gather opinions from individuals who are likely to have no professional connection with the medical or social service community and therefore can be considered representative of the general public.[24]

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

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

The interview had three “tracks,” as outlined in the figure below.[25] Interviewees could discuss concerns about their children, themselves or a loved one, or the community. The third track allowed respondents to answer questions about health concerns in a less personal manner.[26]



The field interview was written in English and translated into Spanish. Data collectors who spoke other languages translated the English survey on the spot for community members, with data collected in at least 20 different languages.[27]

Field interviews were conducted by CHWs and staff from SDRCC and SDCPC as trusted members in their own communities across SDC. Interviews ranged from five to 45 minutes, depending on the input shared and level of translation needed. Feedback from the data collectors suggests this innovative approach was effective.

Online Community Survey

The online survey was informed by the survey utilized in the 2022 CHNA and available in English and Spanish.[28] The survey was distributed to community partners across San Diego. The County of San Diego distributed the survey to their regional groups and other health and public health listservs. Partners were asked to distribute the survey link to their colleagues and clients, a sampling strategy known as snowball sampling.[29]

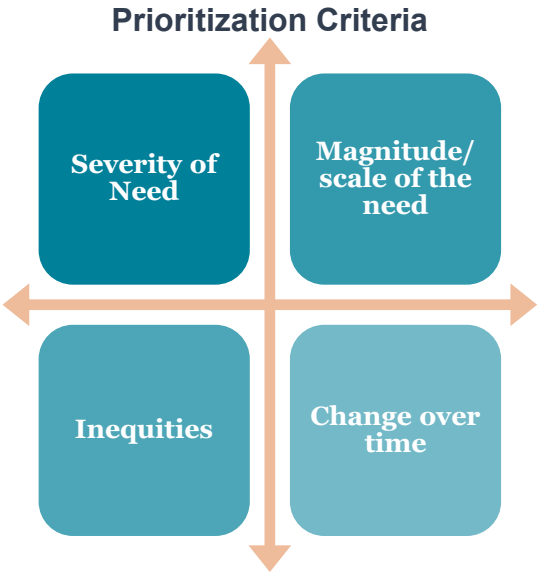
SGH 2025 CHNA

In addition to serving on the CHNA Committee in support of the collaborative HASD&IC 2025 CHNA process, Sharp conducted community engagement activities specifically for the community members it serves. Sharp solicited community input through the following strategies: additional key informant interviews, focus groups, and an online survey, as described below:

1. Facilitated by the IPH, additional key informant interviews and focus groups were conducted to identify community needs and emerging practices in areas central to Sharp's longstanding specialty care service lines, including behavioral health and maternal, prenatal and perinatal health.
2. An online survey was distributed to the Sharp Insights Community, representing current and former Sharp patients (or their families and caregivers), some Sharp-affiliated physicians and community members unaffiliated with Sharp.

See **Appendix D** for more information about these Sharp-specific community engagement efforts.

Prioritization of Community Needs



Once all data were collected and initial analyses were completed, the CHNA research team and committee of health systems met to determine which community needs should be central to this report. Prioritization criteria included:

Severity of need: What is the potential to cause death or disability?
Magnitude/scale of the need: How many people are affected?
Inequities: Are some populations at greater risk for this condition, based on geography, languages, ethnicity, culture, citizenship status, economic status, sexual orientation, age, gender, or others?
Change over time: Has the condition improved, stayed the same, or worsened?

Data Limitations and Information Gaps

The HASD&IC and Sharp CHNA efforts yielded a cumulative sample size of more than 1,900, exceeding the recommended sample size to ensure the validity of the data collected. Nevertheless, these data have limitations, described below.

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

Sharp underwent a transition to a new electronic health record system in March 2024. Due to this transition, internal hospital data availability was limited at the time this CHNA was conducted. Ongoing planning is underway to implement consistent and improved data tracking for future efforts.

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

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

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

Online surveys are also heavily weighted *against* certain populations, such as those without reliable internet and those who are not adept or comfortable with technology,[30, 31] potentially excluding the populations we most want to reach with the needs assessment.[32,33] Online surveys also do not allow for the kind of personal interactions we had during field interviews, key informant interviews, and focus groups which generated a depth and breadth of responses not possible in a survey format.

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

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

Finally, the field interview and online survey were designed at different times, so although the questions were similar, the topics and wording did not always align, limiting the ability to compare results.

For future needs assessments the CHNA research team recommends that:

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

Section

5 Description of Community

Sharp Grossmont Hospital

Sharp Grossmont Hospital (SGH) is a 542-bed acute care hospital, making it the largest facility in SDC's East County. SGH houses one of the busiest EDs in SDC and provides various health care services to the East County community, including heart care, oncology, orthopedics, behavioral health, pulmonary care, rehabilitation, stroke care, hospice care, women's health services and more.

For a list of SGH's programs and services offered, please visit https://www.sharp.com/locations/hospitals/sharp-grossmont#grossmont-services. For an overview of the Sharp HealthCare (Sharp) system, please refer to **Appendix E**.

Communities Served

The primary communities served by SGH encompass SDC's East County, including the sub-regions of Jamul, Spring Valley, Lemon Grove, La Mesa, El Cajon, Santee, Lakeside, Harbison Canyon, Crest, Alpine, Laguna-Pine Valley and Mountain Empire. See the table and map below of where the majority of SGH patients reside. For a map of community and region boundaries in San Diego County (SDC) overall, please refer to **Appendix B**.

Primary Communities Served by SGH[3]

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

Map of SGH's Primary and Secondary Communities[34]

While most communities served by SGH include ZIP codes that reside in SDC's East County, SGH's communities served span multiple regions in SDC. Feedback on community health needs was solicited from both community members and service providers living and working throughout the county to assess priority health issues for the community.

Demographics

Wherever possible, the following descriptions will focus on primary and secondary communities served by SGH. However, where secondary data sources are not available at this level of specificity, broader summaries of SDC are provided. See the table below for SDC's east region's most recently available demographics.

SDC's East Region Demographics, 2022[35]

Age	#	%
0 to 14 Years	95,104	18.9%
15 to 24 Years	63,823	12.7%
25 to 44 Years	140,213	27.9%
45 to 64 Years	125,105	24.9%
65+ Years	78,394	15.6%

Race/ Ethnicity	#	%
White	275,950	54.9%
Hispanic	144,807	28.8%
Black	28,164	5.6%
Asian	23,790	4.7%
Native Hawaiian or Pacific Islander	1,848	0.4%
American Indian/Alaska Native	1,482	0.3%
Other	1,999	0.4%
Two or More Races	24,599	4.9%

Gender	#	%
Male	248,785	49.5%
Female	253,854	50.5%

Education	%
< High School Graduate	10.0%
High School Graduate	24.3%
Some College or Associate of Arts/ Associate of Science Degree	37.0%
Bachelor's Degree	18.7%
Graduate Degree	10.0%

Primary Language Spoken at Home	%
English Only	70.3%
Non-English Language and English "Very Well"	18.7%
Spanish and English "Less Than Very Well"	5.7%
API Language and English "Less Than Very Well"	1.4%
Other Language and English "Less Than Very Well"	3.9%

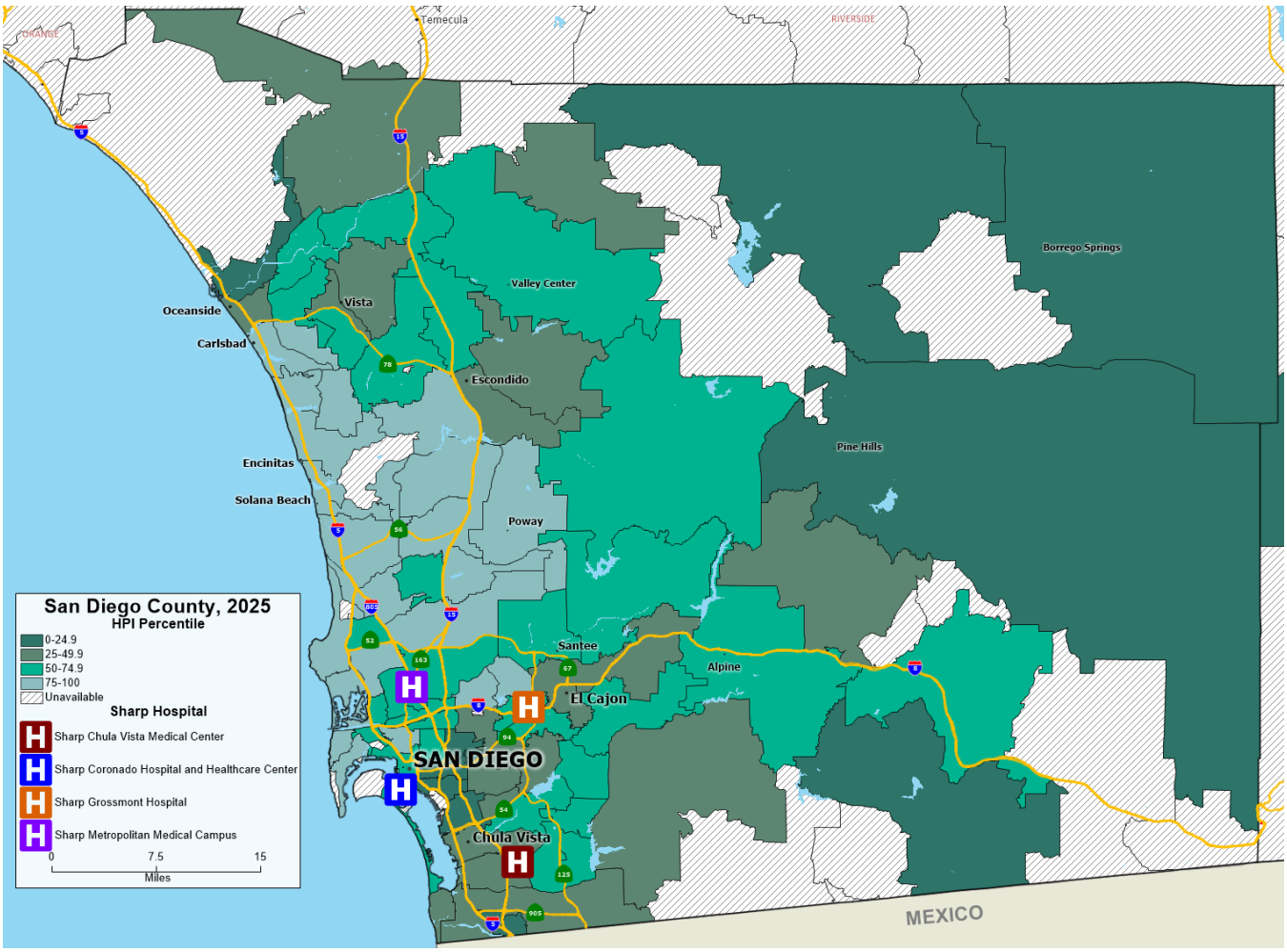
Percent Below Poverty Level	%
Population	11.7%
Families	8.3%
Families with Children	11.8%

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

Identifying SGH's High-Need Areas

Identifying specific geographic areas with health inequities is critical to understanding community health. The map below demonstrates how Sharp, including SGH, serves some of the most vulnerable communities in SDC, especially in the central and southern portions of the county. Regions in the lower percentiles (dark green) demonstrate higher need compared to those in the higher percentiles (light green). ZIP codes 92004 (Borrego Springs), 92036 (Julian) and 91906 (Campo) are among the high-need communities in SDC's East County.

SDC Healthy Places Index® (HPI)[36] Map with Sharp Locations, 2025



The top chronic conditions among SDC residents at Sharp hospitals were hypertension, diabetes, hyperlipidemia, anemia, heart failure and non-ischemic heart disease. The primary social drivers of health concerns among SDC inpatients at Sharp hospitals were housing and economic issues, employment, social environment, primary support group and family, and upbringing.[37]

See **Appendix F** for an overview of inpatient demographics and HPI methodology.

Sharp Inpatients' Health Equity Needs

In March 2024, Sharp, including SGH, began tracking health equity screenings administered to inpatients seen to determine if patients required assistance with health equity-related needs alongside their medical care. The health equity screening categories included food insecurity, housing instability, interpersonal safety, transportation needs, and utility difficulties.

Sharp analyzed the health equity screenings conducted through March 2025:

- Nearly 1 in 5 (17%) Sharp inpatients screened positive for a health equity need and of those inpatients, approximately 3 in 4 (72%) inpatients received an intervention to address their need.
- SGH had the highest volume of inpatients screened overall as well as volume of inpatients screening positively for all health equity categories compared to other Sharp hospitals.
- SGH inpatients saw a higher need for utility difficulties (20% positive screening rate) and food insecurity (20% positive screening rate).

Please see **Appendix C** for additional information on this analysis.

Section

6 Findings

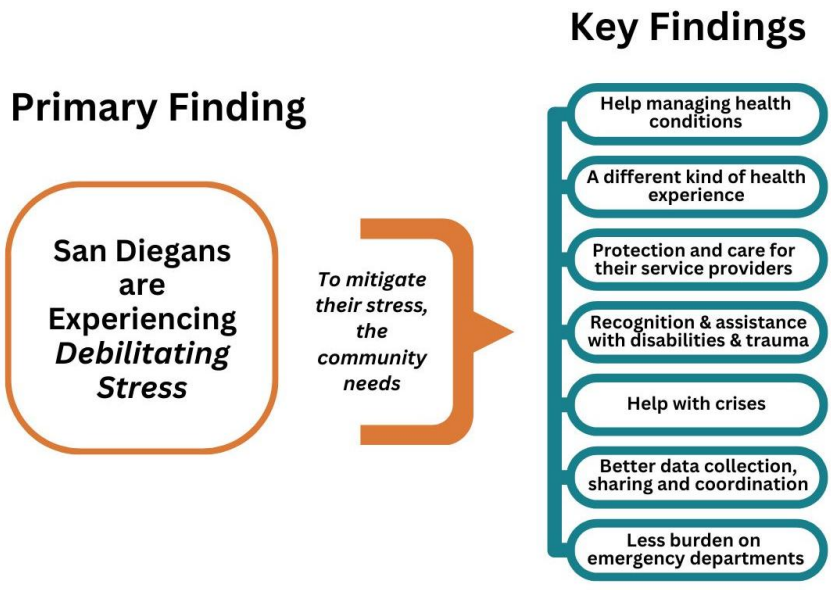
This section presents the top community needs identified in the Sharp Grossmont Hospital 2025 Community Health Needs Assessment (SGH 2025 CHNA) by describing significant findings from the research. The Hospital Association of San Diego and Imperial Counties 2025 Community Health Needs Assessment (HASD&IC 2025 CHNA) process included strong representation of the community served by SGH and a significant portion of its findings reflect the same needs of community members served by the hospital.

Community voice is crucial in understanding the needs of the San Diego community. The feedback obtained from the community via focus groups and informational interviews helped inform the needs identified below. To review community feedback provided through the research process, please see **Appendix G**.

2025 Top Community Needs

Overall Findings

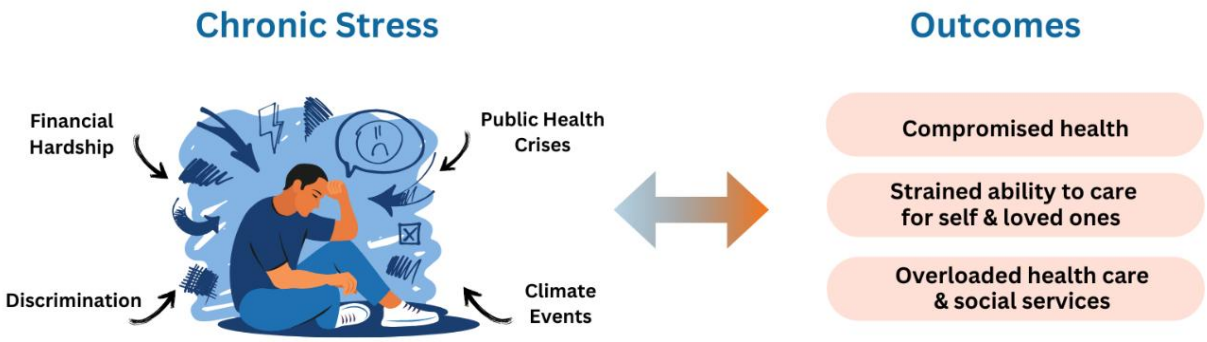
The 2025 CHNA identified the following priority community needs for San Diego County (SDC):



Primary Finding

San Diegans are experiencing ongoing, debilitating stress. Chronic stress was consistently highlighted as a significant theme across all methods of qualitative data collection in HASD&IC 2025 CHNA. This stress, community members said, is caused by the high cost of living in SDC, rising levels of racism, prejudice, and discrimination, ongoing challenges from COVID-19, and recent public health emergencies. They indicated that this ongoing, debilitating stress is severely impacting their health and their ability to manage their health care.

Health care and social service providers indicated that this chronic stress has resulted in increasing numbers of community members who are sicker than ever, seeking help within a system that is overburdened. The graphic below illustrates this finding.



Health Impacts of Chronic Stress

The impacts of stress on human biology are well-documented.[38,39,40] This research illustrates that chronic stress is associated with:

- decreased immune system functioning
- cardiovascular and respiratory disease
- diabetes
- drug dependency
- cancer morbidity and mortality
- gastrointestinal issues
- sleep disturbances
- obesity
- cognitive impairments
- mental health concerns, and
- chronic illnesses[41]

Critical protective materials on chromosomes, called telomeres, deteriorate when people are exposed to ongoing stress and trauma.[42] Emerging research has also

documented that DNA modifications caused by trauma can be passed to offspring, continuing a cycle of poor health in future generations.[43]

In field interviews, when asked what factors contribute to poor health, the most common answer was, simply, “stress.” Other similar answers included “personal issues,” “financial concerns,” and “work issues.”[44] The community also emphasized that being under constant stress interferes with their capacity to seek out, receive, and manage the health care that they need to maintain their well-being. Health care workers, social service providers, hospitals, and health care systems are a part of this community. They, too, reported being overwhelmed by high levels of stress.

Participants in the Sharp Consumer Insights survey have also faced environmental illness, financial strain, and discrimination in their pursuit of health care.

When it comes to issues experienced or barriers felt when seeking health care, respondents have most often experienced illnesses related to their environment: 17% have frequently, often or sometimes experienced illness related to their environment (air quality, etc.), and these issues have been experienced more by women (20%) than by men (11%).

Some respondents put off health care due to financial concerns. Significantly more respondents age 64 and under (18%) report they have (frequently, often, or sometimes) delayed doctor visits in the last three years so that they can afford living expenses, compared to respondents age 65 and above (5%).

In addition, 1 in 10 reported they have experienced racism, prejudice or discrimination in a health care setting in the last three years, with 80% of survey respondents being current Sharp patients.

Please see the Primary Findings section of the HASD&IC 2025 CHNA for more information about the stressors described by community members during the 2025 CHNA process.

Key Findings

The SGH 2025 CHNA top community needs align with those in the HASD&IC CHNA, listed below in no specific order:

- **Help Managing Health Conditions**
- **A Different Kind of Health Experience**
- **Protection and Care for Service Providers**
- **Disabilities and Trauma**
- **Help with Crises**
- **Better Data Collection, Sharing and Coordination**
- **Less Burden on Emergency Departments (EDs)**

The following pages provide a detailed description of findings for each identified need.[45]

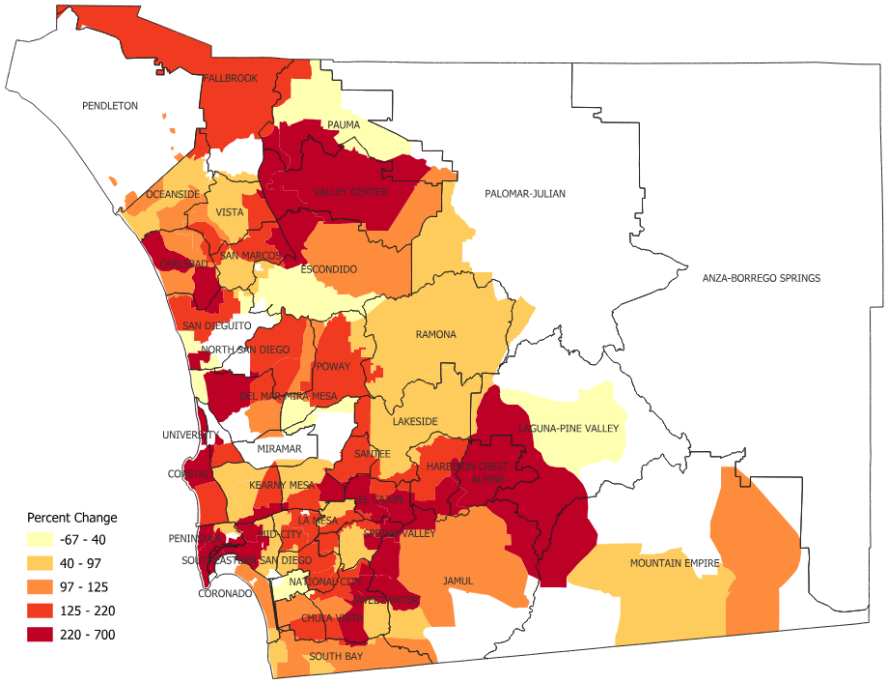
Help Managing Health Conditions

The HASD&IC and Sharp 2025 CHNAs identified that the community needs help managing several specific health conditions. Detailed findings about each condition are presented in this section, in *alphabetical order below*.

Top Community Health Needs					
Asthma	Blood Pressure	Cancer	Dental Health	Diabetes	Mental Health

Asthma

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



In field interviews, 11% of people who had concerns about their children named asthma as the primary concern. In San Diego, people who live in census tracts that were previously redlined are much more likely to be treated in EDs for asthma.[46,47]

The community emphasized that the severe flooding and the sewage crisis in some regions of San Diego in 2024 have worsened respiratory issues.[48]

Sharp hospital discharges with asthma as the principal diagnosis increased significantly between 2021 and 2023, including the East County, which saw a 32.2% increase. In the same period, East County also saw a 34.0% increase in Sharp ED discharges with asthma as the principal diagnosis.

Blood Pressure

In field interviews, blood pressure was the most frequently named health concern for adults, named by 29% of people. Additionally, nearly 1 in 10 people who were worried about their children's health said blood pressure was the most serious concern. Hospital discharge data supports the community's concern. From 2020-2022, rates of ED discharges for hypertension increased across all ages, including children. Every week in 2022, there were more than 15 pediatric hospital discharges with a primary diagnosis of hypertension.[49]

Between 2021 and 2023, heart failure and shock diagnoses made up one-third of Sharp inpatient discharges among SDC residents related to circulatory system diseases. Hypertension saw the largest increase in discharges, rising by 49%.

Hypertension is a prevalent issue among senior inpatients, and was one of the leading inpatient principal diagnoses at SGH among SDC residents over age 65 in 2023. In the same year, the most common chronic conditions in Sharp inpatient discharges among SDC residents age 65 and older were hypertension, hyperlipidemia, diabetes, heart failure, non-ischemic heart disease, atrial fibrillation and flutter, anemia, ischemic heart disease, chronic kidney disease, and hypothyroidism.[37]

Participants in the Sharp Consumer Insights Community survey noted hypertension/ high blood pressure as both the most common and most impactful health condition they and/or their loved ones are facing (51% reporting the condition as the most experienced health condition among them and/or their loved ones; 42% reporting it as having the most impact on them and/or their loved ones). In addition, more than a quarter of respondents (28%) indicated heart disease as having the most impact on them and/or their loved ones.

Cancer

Cancer is the leading cause of death in SDC.[50] From 2018-2022, 25,321 San Diegans died of cancer. From 2017-2021, 77,781 cases of cancer were reported, a rate of 426 per every 100,000 people. The highest rates of cancer in SDC are among Native Alaskans/American Indians (453.1 per 100,000).[51] In the online survey, 24% of respondents chose cancer as a top health concern. In our interviews and focus groups, participants talked about how difficult it is to manage cancer care. Between 2017 and

2021, SDC saw the largest rate increases in cancers of the pancreas (11.6%), prostate (9.5%), breast (8.2%), leukemia (7.4%) and ovary (4.9%).[52]

From 2021 to 2023, Sharp inpatient discharges for cancer increased among SDC residents across all regions, with the highest volume of patients from SDC's East County. In 2023, approximately half (50.8%) of Sharp inpatient cancer discharges from SDC residents were from patients ages 65-84, and Sharp hospitals saw a higher rate of SDC cancer inpatients insured by Medi-Cal (21.8%) compared to other SDC hospitals (16.6%).[37]

In the Sharp Consumer Insights Community survey, 17% of participants reported current experience with cancer among themselves and/or their loved ones, while nearly a third (31%) reported cancer as the most impactful health condition among themselves and/or their loved ones.

Dental Care

CHNA research participants frequently discussed concerns about the challenges San Diegans face with obtaining dental care. They noted that for people under extreme stress, dental care does not seem important.

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

In the Sharp Consumer Insights Community survey, 14% of participants reported having current experience with teeth-related health issues (e.g., dental, mouth, gum, jaw) among themselves and/or their loved ones, while 11% reported such issues as having the most impact on them and/or their loved ones.

Additional findings related to dental health are included in the HASD&IC 2025 CHNA.

Diabetes

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

In field interviews:

- 25% of people with health concerns for themselves or an adult loved one named diabetes as a top health concern.

- 15% of those who were concerned about their children's health named diabetes as their most serious concern.

In the online survey:

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

In SDC, 9.8% of people have diabetes.[53] Death rates from diabetes are much higher for Non-Hispanic Black residents (47.4 per 100,000) compared to the overall death rate due to diabetes in SDC (27.6 per 100,000).[54]

From 2021 to 2023, Sharp SDC inpatients with Type 2 Diabetes Mellitus as the principal diagnosis increased by 16.6% in East County. Additionally, in the same period, Hispanic inpatients represented 46.0% of Type 2 Diabetes Mellitus discharges among SDC residents at Sharp hospitals, the largest proportion among all race/ethnicity groups. Asian inpatients had the highest increase in discharges at 41.7%.[37]

Although all racial and ethnic groups saw a decline in Type 2 Diabetes Mellitus ED discharges among SDC residents in 2023, Hispanic patients still made up 49% of these discharges.[37]

In focus groups and interviews, the community discussed the challenges many people have with maintaining the ongoing self and medical care required for diabetes. Among these challenges were having easy access to and knowledge about the right foods for people with diabetes to eat, monitoring blood sugar levels, and administering medications. They also talked about community members being hospitalized for diabetes-related health problems and then being unable to sustain the progress they made once released from the hospital:

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

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

Nearly a quarter (23%) of participants in the Sharp Consumer Insights Community survey indicated they and/or their loved ones have current experience with diabetes, while one-quarter (25%) noted diabetes as having the most impact on them and/or their loved one.

Mental Health and Substance Use

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

In the online survey, mental health was identified as a top health concern, with 43% of survey respondents identifying mental health as the health condition having the most serious impact on adults. The top five behavioral health concerns identified for adults and older adults were:

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

When asked about younger age groups, 40% of survey respondents identified mental health as the health condition having the most serious impact on children. The top five behavioral health conditions identified for children were:

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

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

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

In SDC, death by suicide is most common among males, people age 65 or older, Non-Hispanic Whites, and people living in the east region.[55]

Inpatient hospital discharge data from 2020 and 2022 show statistically significant increases in discharges for suicide attempts for people 0-17 years old (17%). The most alarming increases across race/ethnicity were seen in Asian individuals (48%) and Black individuals (18%).[56]

Community members discussed mental health extensively. They noted a severe shortage of mental health professionals, another well documented challenge.[57] They said, consistently, that finding a mental health professional who accepts insurance — or who will take Medi-Cal — and has convenient hours was nearly impossible.

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

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

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

Sharp Findings – Behavioral Health

Between 2021 and 2023, the total number of behavioral health-related inpatient discharges at Sharp hospitals increased by 14.7%. Among Sharp acute care hospitals, SGH sees the largest proportion of SDC inpatient hospital discharges with a behavioral health-related principal diagnosis. In 2023, Sharp inpatient behavioral health discharges among SDC residents with diagnoses classified as depressive disorders, alcohol-related disorders, and schizophrenia spectrum and other psychotic disorders made up approximately 75% of all discharges.[37]

Between 2021 and 2023, Sharp behavioral health inpatients from certain SDC ZIP codes experienced significant increases in discharge volumes, with 91950 and 92173 seeing increases of 43.5%, and 61.8%, respectively. These dramatically exceed the average increase of 4.9% for other SDC ZIP codes. These ZIP codes fall within the 25th percentile or lower on the Healthy Places Index.[37]

Participants in the Sharp-specific focus groups and key informant interviews shared a variety of input based on their personal experiences either living with, or working with individuals who have, behavioral health concerns. They noted the following:

General Mental Health:

- Accessing mental health care is especially challenging for people with public insurance, such as those with Medi-Cal, and for those who are uninsured or underinsured. This was raised as a particular concern for those who need intensive outpatient programs, which they also emphasized as being important programs for people with mental health concerns.

- They would like to see mental health care shift from a medical model to a “recovery model,” which would focus less on medicalization and restraints to more of a holistic model addressing all the needs of those with mental illness.
- They told stories of traumatic experiences during voluntary and involuntary mental health hospitalizations such as being secluded, restrained and assaulted.

Maternal Mental Health:

- Postpartum mental health care is a significant need in the community.
- Patients who need post-natal treatment for mental health concerns often desperately need, but cannot obtain, care for their newborns that will allow them to receive the care they need.
- Many new mothers in the Sharp Maternal Mental Health Program are experiencing very high levels of anxiety and obsessive-compulsive disorder.
- There is a need for additional ways to screen parents for mental health issues and offer resources.
- Partners and family members of new mothers and birthing parents also need education and support.
- Patients without insurance are unable to access the Sharp Maternal Mental Health Program and are a hugely underserved population.

In the Sharp Consumer Insights Community survey, participants noted they and/or their loved ones had current experience with anxiety (23%) and depression (17%). In addition, anxiety was reported by 23% of participants and depression was reported by 19% of participants as the most impactful health condition among themselves and/or their loved ones.

A Different Kind of Health Experience

The HASD&IC and Sharp CHNAs identified that the community needs a different kind of health and health care experience.

Overall Findings

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

The community spoke about five major themes related to the kind of health care experience they need, which will be described within this finding.

Respect for their time

Timely care

Better options for transportation

Better relationships with care providers

Help navigating medical system, insurance & follow-up care

Respect for Their Time

Community members were clear that setting appointments and receiving health care is burdensome. Nearly a third (32%) of online survey respondents said that they have “no time” for care, noting it takes too much time away from work and caring for family. Long waits at medical offices, urgent cares, EDs, and on phone lines make community members feel disrespected and keep them from getting the care they need. They repeatedly reported that they need shorter waiting times on the phone and in waiting rooms to care for their health. Transportation challenges compound this problem.

Timely Care

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

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

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

Similarly, nearly half (46%) of participants in the Sharp Consumer Insights Community survey said that increasing the number of available appointments would make it easier for them to get the health care they need.

Better Transportation Options

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

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

Focus group and key informant interview participants noted that insurance sometimes covers rideshare services like Lyft/Uber, and pointed out that many people do not know about it and/or do not understand the rules about how to obtain it. Additionally, insurance may only allow for one or two rides per month, and some patients need multiple trips for labs or other appointments. When people do access ride sharing options, they are problematic, at times.

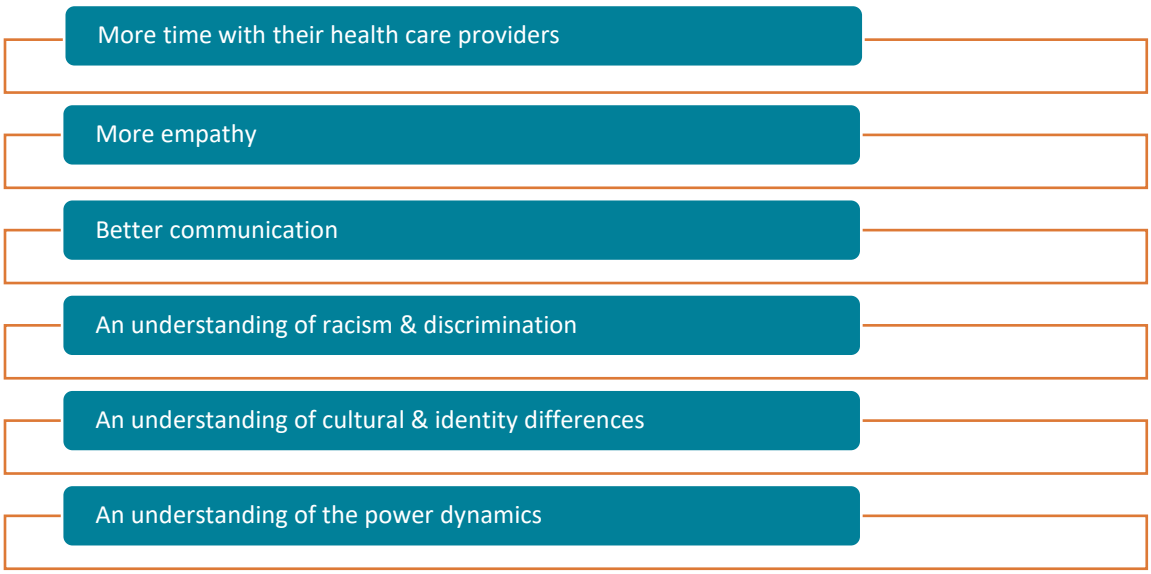
For those with mobility issues, ride share drivers are not always able to assist them with issues like guiding their walker. And for some, getting into a car with a stranger feels uncomfortable or scary.

Public transportation in San Diego was noted to be expensive and inconvenient in both the HASD&IC and Sharp CHNA efforts. For example, participants in the Sharp-specific focus group for maternal health shared how many patients cannot access prenatal or postnatal care due to transportation barriers.

Better Relationship with Care Provider

"Relational care leads to better health outcomes." – Key Informant

Community members want a different kind of relationship with the people who are involved in their care. When asked what a better relationship with their care providers included, community members highlighted these attributes:



More Time with Health Care Providers

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

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

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

More Empathy

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

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

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

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

"Be more patient and believe the patient"

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

In addition, participants in the Sharp-specific focus group for maternal health and pregnancy-related care discussed differences between health care provider expertise and patient wishes and satisfaction.

Better Communication

Research participants indicated that they need better communication between health care workers and patients. In particular, the community is calling for better translation services and clearer, more relatable explanations of their health conditions and treatment.

Participants in the Sharp-specific focus group about maternal health and pregnancy-related care discussed challenges associated with treating pregnant and newly parenting people who have been exposed to health misinformation on social media, particularly TikTok.

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

  One in four field interview participants commented that having help in their

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

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

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

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

Accountability in translation was also named as an important issue:

"Yeah, one thing worth noting…the translator was ... like taking stuff out of the translation. And luckily, the parent caught that. That kind of messed up the dynamic between the therapist, the parent and the kid, as well as the translator, that they ended up just ending the meeting… So accountability within what's being translated." – Focus Group Participant

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

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

Acknowledgement and Understanding of Racism and Discrimination

Participants in the needs assessment were aware of health inequities, and many had experienced these inequities themselves. They frequently discussed the underlying causes of many of those inequities — racism and discrimination.[58]

An Understanding of Cultural and Identity Differences

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

- *Conscious efforts to not misgender/deadname*
  Deadnaming is when someone is referred to by a name they do not, or no longer, use. Misgendering is labeling someone as a gender with which they do not identify: this often shows up as calling someone by the wrong pronouns. Both are common experiences for the LGBTQIA+ community when receiving health care.

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

  It was also noted in the Sharp-specific focus group for behavioral health that it is extremely difficult to find appropriate and affirming mental health care for trans and gender non-conforming people, and most mental health care providers are underinformed about the specific needs of this community.

- *Conscious efforts to understand cultural differences*
  Awareness of cultural differences is vital to good health care, the community told us. In some communities, people explained, a lack of cultural understanding has resulted in people being unable to access care. In the online survey, 14% of people chose “health care providers do not understand my culture” as one of the challenges of getting the health care they need.

  The Sharp-specific focus group for maternal health noted San Diego’s diverse population and how different cultural practices can be present during pregnancy and postpartum care, such as with breastfeeding.

An Understanding of Power Dynamics

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

Additionally, some community members perceive health care providers and hospitals as

being part of a system of authority. Community members expressed fear and concern about the power of hospital systems being used against them or their families with, for example, immigration authorities.

Help Navigating Medical System, Insurance and Follow-Up Care

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

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

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

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

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

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

- Young adults who are transitioning to adulthood, particularly those who had been in the foster care system or who are having a physical or mental health crisis, often have no idea how to get care.
- Older adults struggle with accessing electronic medical records and appointment systems and with changes to their care when they switch over to public insurance once they are eligible for Medicare. We heard stories of older adults being unable to get prescriptions filled because they were unable to get in with their new primary care physicians for months after becoming eligible for Medicare.
- People who live in rural areas struggle to find care that is reasonably close to them.
- People who care for adults and children.

In the online survey,

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

Protection and Care for Service Providers

The HASD&IC and Sharp CHNAs identified that the community needs more protection and care for service providers.

While community members participating in CHNA research had suggestions for ways that their health care experience could be improved, they also frequently praised the people who provide their care. Beyond appreciating service providers' efforts, the community indicated they wanted to see hospital systems take care to protect and preserve the local workforce.

The community is aware of the trauma experienced during the COVID-19 pandemic, and the pressures health care providers have faced since. They noted that a lot of providers left the field after the pandemic and believe that San Diego is losing health care providers to places with a lower cost of living. We heard about shortages in primary care and specialty medicine. One focus group participant summed it up this way:

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

Another said:

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

In field interviews, many people expressed appreciation for hospitals, health care systems, and care providers and asked the CHNA researchers to share these sentiments:

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

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

Data indicate that health care workers are experiencing chronic stress, mental health issues, and burnout.[59] In a survey of health care workers nationwide, more than a quarter of health care providers reported mental health symptoms significant enough to meet the diagnostic criteria for a mental illness, and of those only 38% sought care. Health care workers reported that they did not seek care because of challenges with getting time off work, the cost, and concerns about their care remaining confidential.

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

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

It was noted in the Sharp-specific focus group for behavioral health that staff retention has an impact on patients who benefit from consistency in treatment, and that staff burnout negatively affects people who need mental health support.

Disabilities and Trauma

The HASD&IC and Sharp CHNAs identified that the community needs more recognition of and assistance with disabilities and trauma.

One in 10 San Diegans lives with a disability,[4] and has concerns about their health, which was apparent in both the field interviews and online survey.

In field interviews, of those who were concerned about themselves or an adult they loved, "physical disability" was chosen by 13% of respondents as the condition they were most concerned about; for those discussing a child, developmental disabilities concerned 15% of people the most, and physical disabilities concerned 11% the most.[60]

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

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

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

They also talked about trauma and its impact on health.[61,62] They noted the collective trauma experienced by the community as a result of COVID-19 and of events like floods and wildfires. They discussed the cultural trauma experienced by people of color. They talked about historical trauma caused by generations of oppression through processes like redlining. And they discussed different kinds of trauma experienced by individuals, like those who served in the military during combat and people who had many adverse childhood experiences (ACEs).[63]

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

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

Allowing Service Animals

Disabled community members told us that some medical facilities do not allow them to bring in their service animals. They report that security guards seem confused about whether animals are allowed and, if so, in what areas of the facility. The Americans with Disabilities Act (see side bar, below) is clear, however, that service animals must be allowed.[64] They also asked for assistance from medical personnel completing paperwork that documents their disabilities for housing purposes so that their animals will be allowed in rental properties.

Compliance with ADA

The Americans with Disabilities Act

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

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

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

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

Websites, Portals, Phone Systems

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

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

Assistance with Identification, Documentation, and Eligibility

Community members told us that they need assistance from medical providers in identifying their disabilities and then helping them figure out if they qualify for services, particularly those that would assist them in obtaining and keeping their housing.[65]

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

Some mentioned that primary care doctors do not consistently document persistent disability symptoms as needed to qualify for disability benefits and that some are reluctant to complete medical verifications for housing accommodations, like service or emotional support animals.[66]

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

Understanding Trauma

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

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

In addition, it was noted in the Sharp-specific key informant interview for maternal health that sometimes maternal mental health conditions arise from trauma occurring during childbirth. They explained that this is an area that is under-researched.

Help with Crises

The HASD&IC and Sharp CHNAs identified that the community needs more help with crises. SDC residents have experienced serious climate-related and other public health crises over the past several years. The community expressed clearly that these events have impacted their health and they need more help than they have received.

Heat

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

Community members commented explicitly on the impact of heat on their health, associating the extreme heat with migraines, fluctuations in blood pressure, dehydration, and respiratory problems. They also discussed power outages and the cost of energy, which impacts those who are dependent on electricity-powered medical devices.[67]

Wildfires

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

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

Flooding

On January 22, 2024, a severe flood hit San Diego. It was the fourth wettest day on record in the county, with more than five inches of rain falling in some locations. The City of San Diego Fire Department received nearly 900 phone calls, and 248 rescues were conducted.[68] Flooding was most severe in Southeast San Diego, including the neighborhoods of Shelltown, Encanto, Southcrest, and Mount Hope, along with National City. The storm displaced a total of 1,224 households, some of which are still displaced as of the end of 2024.[69] These floods were likely the result of the failure to clear the debris from the nearby Chollas Creekbed.

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

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

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

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

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

Tijuana Riverbed Sewage Crisis

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

"*El olor del sur está horrible*." [**Translation**: the odor from the South is horrible]

"*El olor es insoportable y podemos enfermar*." [**Translation**: the smell is unbearable, and we can get sick]

A Community Assessment for Public Health Emergency Response (CASPER) report conducted by the Centers for Disease Control and Prevention (CDC) in October 2024 documented that nearly all (94%) of the residents in the area of the Tijuana River Valley had noticed a sewage-like smell, and the vast majority indicated an increase in stress and a decrease in quality of life. Nearly half experienced health problems as a result of the crisis and nearly two-thirds experienced symptoms of an acute mental health issue.[70,71] Other findings from the CASPER report include:

- **80%** say quality of life has been negatively impacted
- **77%** believe air quality is not ok
- **71%** believe household tap water is not safe to drink
- **65%** experienced one or more behavioral health indicators of potential acute mental health issues
- **65%** have had one or more worsening health conditions in the past month, including allergies, migraines, chest or lung pain and asthma
- **59%** report increased stress
- **45%** report at least one health symptom from the crisis. Of those, 70% said symptoms improved when they left the area.

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

Better Data Collection, Sharing and Coordination

The HASD&IC and Sharp CHNAs identified that the community needs better data collection, sharing and coordination among health and social services providers. The feedback from community members, health care professionals, and community-based organizations was that the lack of data collection, sharing, and coordination across systems creates unnecessary challenges to good health.

Better Data Collection in Crises

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

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

Better Data Sharing between Hospitals and FQHCs

Another issue that was shared by multiple participants in focus groups and interviews is the inability of Federally Qualified Health Centers (FQHCs) to access the hospital electronic health record (EHR) systems. FQHCs can sometimes access a portion of the patients' records but are often unable to view important components of patient care like imaging studies and medications given at the hospital.

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

Better Data Sharing between Medical, Educational, and Social Services

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

Sharp Data – Maternal and Child Health

In the 2022 Sharp CHNAs, Maternal and Child Health, Including High-Risk Pregnancy, was identified as a community need. Given that Sharp Mary Birch Hospital for Women & Newborns (SMBHWN) is Southern California's only standalone women's hospital, Sharp continued to assess this need. In addition to evaluating maternal and infant health, the need for improved data on the quality of care and outcomes for maternal health prompted Sharp to begin tracking data on key maternal health measures. Further, Sharp started tracking outcomes and measures on key maternal health indicators as

defined by the California Maternal Quality Care Collaborative (CMQCC), including Exclusive Breast Milk Feeding (EBF) rates, Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth rates, and Vaginal Birth After Cesarean (VBAC) rates. Please see **Appendix C** for more detailed information on this analysis. Key findings are listed below.

Exclusive Breast Feeding

The EBF measure refers to newborns exclusively fed human milk during the newborn's entire hospitalization. For this measure, a higher EBF rate is ideal.[72] For EBF, groups that saw significant disparities in outcomes were inpatients over age 30, inpatients with hypertension, patients who spoke primary languages other than English and ASL, and those whose racial/ethnic identity is non-White.

NTSV Cesarean Birth Rates

The Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate, which identifies the proportion of live babies born at or beyond 37.0 weeks gestation to women in their first pregnancy, that are singleton (no twins or beyond) and in the vertex presentation (no breech or transverse positions), via cesarean birth. For this measure, lower NTSV cesarean birth rates are ideal.[73] For NTSV cesarean births, groups that saw significant disparities included inpatients over age 30, inpatients whose payor is Medicare or self-pay, and patients with hypertension (excluding gestational hypertension).

VBAC Rates

Vaginal birth after cesarean (VBAC) refers to the practice in which a baby is delivered vaginally (naturally) after a previous child had been born via a cesarean section (C-section).[74] For the purposes of this analysis, this excludes deliveries with complications (abnormal presentation, preterm delivery, fetal death, multiple gestation, or breech presentation). For this measure, higher VBAC rates are ideal. For VBAC, groups that saw disparities were those over age 30, insured by Medi-Cal (Medicaid), Medicare, or self-pay, as well as inpatients who identify as Hispanic or Latino, Asian, Other, or Native Hawaiian or Pacific Islander.

Less Burden on Emergency Departments

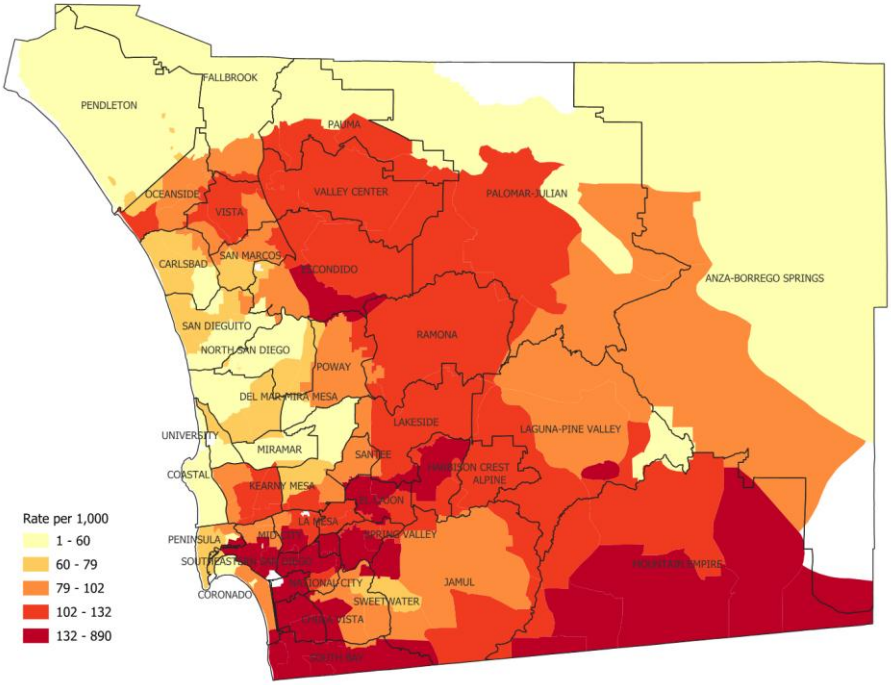
The HASD&IC and Sharp CHNAs identified that the community needs less burden on EDs.

The community spoke to us about long waits in overcrowded EDs and told us they use EDs frequently for their care. They utilize EDs, they said, at least in part because of long wait times to see primary and specialty care providers. Health care providers also told us that EDs are overburdened and emphasized that they must prioritize caring for life-

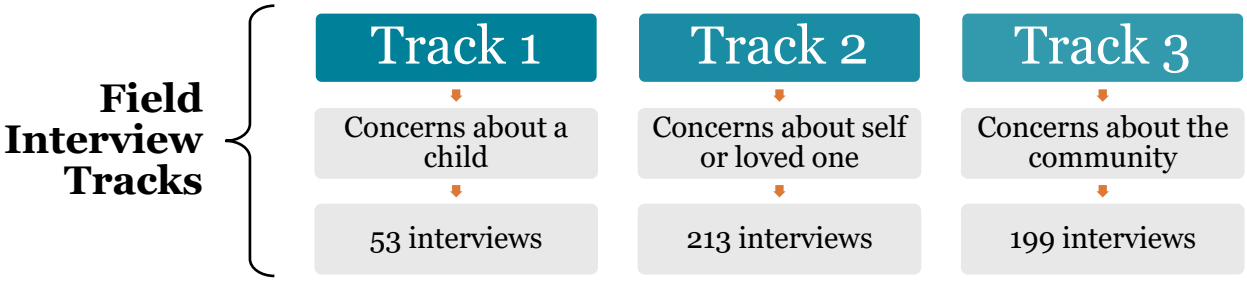
threatening conditions and referring non-emergent issues for follow-up with non-emergency care providers. The result is that sometimes the conditions that bring people to the ED go unaddressed.

Emergency Department Utilization

The following maps illustrate regional differences in the usage of EDs for avoidable conditions [75] in 2022.[76]



The field interviews were an opportunity to explore how often members of the general public call 911 or seek care at the ED. The questions below were posed to interview participants who shared concerns about a child (Track 1 in figure below), about themselves or a loved one (Track 2 in figure below), or about the community (Track 3 in figure below) recognizing that these individuals could offer valuable insights based on their lived experiences.



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

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

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

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

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

Question: Has this person received care at the ED for these concerns in the last 12 months?

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

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

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

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

What Brings Community Members to the ED

Chronic Health Conditions

In 2023, the top chronic conditions found in Sharp ED discharges for SDC patients age 65 or older included hypertension, hyperlipidemia, diabetes, rheumatoid arthritis and osteoarthritis, atrial fibrillation and flutter, hypothyroidism, chronic kidney disease, heart failure and non-ischemic heart disease, anemia, and ischemic heart disease.[37]

Mental Health

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

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

Substance Use Disorders

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

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

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

> "*It's an interesting conundrum in that sometimes they'll only get enough [medication] to literally just lower their blood pressure enough to get out of the ED but not given anything for continued safety. And then sometimes they are given the prescription, but…then they don't have the support that they need or maybe a connection to an ambulatory withdrawal [program]. There's a disconnect between those two services…And so then people leave and they're drinking and taking the medication from the ED which is obviously concerning.*" – Focus Group Participant

Challenges to Receiving Primary and Specialty Care

Community members spoke about being unable to schedule an appointment for months when trying to receive the care they needed for medical issues that they knew were not emergencies. Sometimes, they noted, their health would then deteriorate to the point that they needed to receive emergency care. Once there, they are referred for follow up appointments but often return after being unable to access the appropriate level of care in a timely manner.

> *"Appointments with doctors are two or three months out, so people will go to the ED and the ED staff will tell them to go to the PCP, and when the patient can't do that because of the wait time, they go back to the ED, and*

the ED staff will see the same patients and will feel irritated, and the community member feels dismissed." – Focus Group Participant

In addition, because of long wait times for specialty care, primary care physicians are sometimes directing their patients to the ED for services:

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

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

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

The community also discussed populations who tend to receive care in EDs, including people who are experiencing homelessness.

Sharp ED Data[37]

In 2023, Sharp accounted for nearly a third (30%) of ED discharges in SDC. Between 2021 and 2023:

- The top chronic conditions in Sharp ED discharges among SDC residents included hypertension, diabetes, hyperlipidemia, asthma, fibromyalgia, and chronic pain and fatigue.
- Primary Social Drivers of Health concerns documented among Sharp ED discharges from SDC residents were education and literacy, housing and economic concerns, other psychosocial circumstances, employment, and primary support group and family.
- The top three principal languages among SDC residents at Sharp EDs were English (82%), Spanish (13%), and Arabic (2%).
- Patients insured by Medi-Cal made up nearly 45% of visits in Sharp EDs, while Medicare patients made up nearly 22% of ED visits.

Section

7 Community Suggestions

What's Working?

Participants in the HASD&IC and Sharp 2025 CHNA surveys, focus groups, field interviews and key informant interviews frequently praised professionals and volunteers in the community who are working hard to improve our health. They discussed a variety of existing efforts they felt were already working to address community health. See the table below for a summary of these efforts.

Care That Comes to the Community	▪ ***Partnerships between schools and community clinics**, like those providing primary and specialty care programs and services such as dental and behavioral health.* ▪ ***Dental offices in community health clinics** that work on sliding fee scales.* ▪ ***Home visits** to assist with chronic conditions like diabetes and high blood pressure. Delivery of fresh produce during visits was noted as especially helpful.* ▪ ***Mobile health care services** coming into communities, workplaces, schools.*
Transportation Assistance	▪ ***Free parking available onsite** of some medical buildings and hospitals.* ▪ ***Taxi voucher programs** operated through some clinics that help them get to appointments.*
Personalized Support for High-Risk Patients	▪ ***Voluntary identification programs that allow for people to be discreetly recognized as disabled** through wearable and/or portable items such as lanyards, key chains, bracelets, or information cards.[77]* ▪ ***Specialized Substance Use Disorder (SUD) Nurses** within EDs who communicate and coordinate with substance use detoxification and treatment facilities.* ▪ ***Discharge kits** for conditions like congestive heart failure that include equipment and easy to understand, color-coded instructions.*
Community & Hospital Support Programs	▪ ***Online and in-person support groups** for mental health.* ▪ ***Crisis houses**, which are intermediary placements that provide a home-like setting for people who have a mental health crisis.* ▪ ***Intensive outpatient programs (IOPs)** for mental health, which provide a basis for continued learning and set patients up for successful outcomes. Sharp IOPs specific to maternal mental health and perinatal health were also noted:*

	○ ***Maternal Mental Health*** *(Sharp Mesa Vista): Serves new moms and/or pregnant people dealing with mental health challenges.* ○ ***Perinatal*** *(Sharp Grossmont Hospital): Provides added support for labor/delivery/post-partum needs of patients with Medi-Cal.* ▪ ***Peer support specialists*** *were noted as critical in delivering mental health services.* ▪ ***Community Health Workers (CHWs)*** *(Sharp Rees-Stealy) were noted as trusted members of the communities they serve, reaching Medi-Cal patients in ways other providers cannot.*

Community Suggestions

A key component of a CHNA is asking the community about solutions they believe would be effective in meeting their needs. Participants in the HASD&IC and Sharp 2025 CHNA surveys, focus groups, field interviews and key informant interviews proposed a variety of suggestions to better address the community's needs which are outlined below.

Support for Patients	▪ ***Introductions:*** *Ensure all health workers introduce themselves and explain roles in patient settings.* ▪ ***Navigation Assistance:*** *Use peer support and establish a navigation phone line to help patients understand their insurance or obtain referrals.* ▪ ***Immediate Feedback Systems:*** *Implement systems for real-time patient feedback on care experiences.* ▪ ***Presence of Advocates:*** *Encourage patients to have advocates during medical appointments (e.g., a health care peer, relative or friend).* ▪ ***ADA Coordinators:*** *Designate and promote the availability of easily identifiable coordinators at medical facilities for disability accommodation.* ▪ ***Reliable Health Information:*** *Provide scientific information to counter health misinformation.* ▪ ***Reduced Barriers to Care:*** *Address transportation and childcare needs for prenatal/postnatal care (e.g., more virtual/telehealth options).* ▪ ***Postpartum Mental Health Services:*** *Expand mental health support and resources for postpartum mothers, as well as new dads.* ▪ ***Ease of Receiving Care:*** *Increase appointment availability, offer multiple services at one location, and improve care coordination.*

Health Care Worker Support	▪ ***Cultural Exchanges:*** *Facilitate cultural exchanges to build trust and educate health care workers, especially efforts where providers come into communities.* ▪ ***Vicarious Trauma****: Address stress and trauma among health care workers to improve patient care.* ▪ ***Turnover:*** *Reduce turnover by improving job satisfaction and consistency in care.* ▪ ***Community Engagement:*** *Encourage health care workers to volunteer and engage with underserved communities.* ▪ ***Training Opportunities:*** *Provide training on cultural competency, trauma-informed care, and health inequities; ensure low-cost/convenient education and*

	training for medical assistants, certified nursing assistants, and licensed vocational nurses.
Hospital & Emergency Department Discharges	▪ ***Medication Supply:*** *Release patients with a longer supply (e.g., 30 days) of prescription medicines upon discharge from emergency department.* ▪ ***Discharge Coordination:*** *Enhance coordination with hospital social workers to manage discharges effectively, whether patient is transitioning to another institution or back home.* ▪ ***Recuperative Care Beds:*** *Increase recuperative care facilities for homeless patients post-hospitalization, including longer periods of insurance authorization.* ▪ ***In-Home Supportive Services (IHSS):*** *Expand IHSS utilization for older adults and those with disabilities.* ▪ ***Home Visits:*** *Expand home visiting programs for recently discharged patients, especially those targeting special populations (e.g., people who live in rural areas).*
Systemic Efforts	▪ ***Advocacy:*** *Advocate within health systems and legislatively for better health care experiences; designate administrative champions.* ▪ ***Community-Centered Programs:*** *Involve the community in addressing local health problems at the neighborhood level.* ▪ ***Holistic Mental Health Care:*** *Shift to a recovery model focusing on holistic care for mental illness, focusing less on medicalization and restraints.* ▪ ***Inclusive Care:*** *Improve mental health care for trans and gender non-conforming individuals, including enhanced education for providers.*

Section

8 Next Steps

The 2025 CHNA reports will be available as a resource to the broader community to advance community health improvement efforts. HASD&IC and the CHNA Committee are proud of their collaborative relationships with local community organizations and are committed to regularly seeking input from the community to inform community health strategies. Follow up research will be conducted to gather community feedback on the 2025 CHNA process and strengthen partnerships around identified community needs.

Although CHNA requirements do not apply to every regional health system or district that participated in the HASD&IC process, each works closely with their patient communities and constituents to address select needs with programs, resources and partnerships. Please see **Appendix H** for a list of community resources and assets in San Diego County.

Sharp HealthCare Implementation Strategies

In addition to making CHNA reports publicly available, private, not-for-profit hospitals and health systems such as Sharp are required to respond to CHNA findings with implementation strategies. These documents track the progress of efforts that address selected identified health needs.

SGH developed its FY 2026 – FY 2029 Implementation Strategy to address select needs identified in the 2025 CHNA. Many of the programs listed have been in place at SGH for several years; leaders and team members across Sharp continuously evaluate their success to ensure they address and respond to the latest CHNA findings. Categories of programs and activities included in the SGH FY 2026 – FY 2029 Implementation Strategy are summarized in **Appendix I**.

All Sharp 2025 CHNAs and FY 2026 – 2029 Implementation Strategies are available as of Sept. 30, 2025 at: http://www.sharp.com/about/community/health-needs-assessments.cfm. Reports are also available on request by contacting communitybenefits@sharp.com.

Appendix

A HASD&IC and SGH 2022 CHNAs: Summary of Process and Findings

Hospital Association of San Diego and Imperial Counties 2022 Community Health Needs Assessment (HASD&IC 2022 CHNA)

The graphic below represents the findings revealed through the HASD&IC 2022 CHNA process. The needs identified as the most critical for San Diegans are listed in the center of the circle in alphabetical order. The blue outer arrows of the circle represent the negative impact of two foundational challenges — health disparities and workforce shortages — which greatly exacerbated every identified need at the center of the circle. The orange bars within the outer circle illustrate the underlying themes of stigma and trauma — the quiet yet insidious barriers that became more pervasive during the COVID-19 pandemic.

The graphic demonstrates how each component of the findings — the top identified community needs, the foundational challenges, and the key underlying themes — impact one another. In particular, the foundational challenges (health disparities and workforce shortages) and underlying themes (stigma and trauma) interact with each other to amplify the identified community needs as well as disrupt efforts that advance health equity and improve community well-being. The complete HASD&IC 2022 CHNA can be found at: https://hasdic.org/chna/.

HASD&IC 2022 CHNA Findings – Top Community Needs for San Diego County

Following the completion of the HASD&IC 2022 CHNA, the CHNA Committee conducted a Phase 2 effort which included an online survey — the 2022 CHNA Feedback Survey — which was distributed via email to community-based organizations, social service providers, resident-led organizations, federally qualified health centers, government agencies, and hospitals and health systems that serve a diverse array of people in San Diego County.

The survey was open from October 2022 through February 2023. Since survey participants were able to forward emails containing the survey link to their colleagues, the total response rate was unable to be calculated. A total of 377 respondents completed the survey.

The purpose of the survey was to evaluate the accuracy of the 2022 CHNA findings, assess the relative importance of identified needs, key underlying themes, and foundational challenges, and gather feedback on future research topics of interest. See below for a summary of participation and findings for Phase 2 of the HASD&IC 2022 CHNA.

HASD&IC 2022 CHNA Phase 2 Survey Summary of Participation and Findings

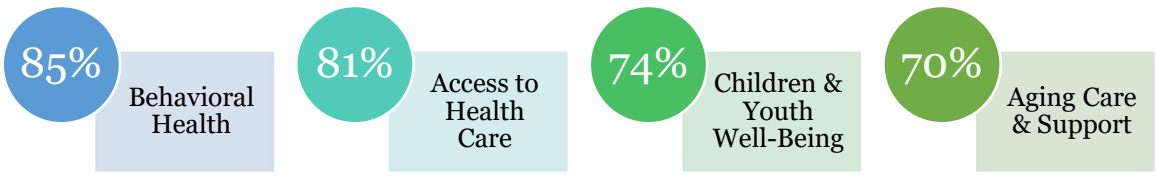
29%	18%	53%
Community Members	Community-Based Organizations	Hospitals & Health Systems

93% of respondents (270 out of 290) agreed or strongly agreed that the 2022 CHNA findings represented the top health and social needs of San Diegans based on the question: "Do you agree that these findings represent the top health and social needs in your community or the clients, patients, and communities you serve?"

HASD&IC 2022 CHNA Phase 2 Summary of Responses to Key Questions

Identified Community Needs That Are Very Important

Question: *Please share your perspective on the importance of each of the identified community needs.* (n=290)
The following percentages of respondents indicated the following needs as being ***very important***.



Foundational Challenges & Key Underlying Themes That Are Very Important

Question: *Please share your perspective on the importance of the key underlying themes and foundational challenges.* (n=291)
The following percentages of respondents indicated the key underlying themes and foundational challenges as being ***very important***.

Sharp Grossmont Hospital 2022 CHNA (SGHs 2022 CHNA)

Sharp utilized the results of the collaborative HASD&IC 2022 CHNA along with additional data analysis and community engagement specific to the communities served by SGH to complete the SGH 2022 CHNA. View the full results of the SGH 2022 CHNA on sharp.com at: http://www.sharp.com/about/community/health-needs-assessments.cfm.

Upon completion of the SGH 2022 CHNA, Sharp also conducted a Phase 2 effort which included follow-up surveys to those whose input helped identify the top community needs during Phase 1 of the 2022 CHNA. This included a survey facilitated by the Institute for Public Health (IPH) and distributed to Sharp staff, and another survey facilitated by Sharp Consumer Research and distributed to the Sharp Insights Community. See below for a summary of participation, key questions and findings from the SGH 2022 CHNA Phase 2 surveys.

SGH 2022 Phase 2 Survey for Sharp Staff

Facilitated by the IPH, an electronic survey was distributed to Sharp staff on September 27, 2023. A total of 70 employees representing ten different Sharp entities and approximately a dozen occupations completed the surveys. Three-quarters of those who participated in the survey worked in social work or case management positions. The majority of respondents were affiliated with the three entities that take care of Sharp's most vulnerable populations. Over a third of respondents have worked for Sharp for more than five years.

IPH Phase 2 survey questions focused on understanding how to address the social drivers of health and barriers to care for vulnerable populations that were identified in Phase 1 of the 2022 CHNA. Key questions included:

- What are the most concerning social determinants of health for Sharp's vulnerable patient population?
- Are you aware of community resources to refer patients to that will address the social determinants of health of concern?

- Which barriers to care does Sharp address most and least effectively?
- Are there tools that Sharp can provide to help you address the social determinants of health and their associated barriers to care?

Survey results indicated the following:

- Respondents believe financial strain and issues related to housing are the most concerning social determinants of health and the greatest contributors to health inequities in Sharp's patient populations.
- Less than half of respondents are aware of community resources that would help their patients address financial strain and housing issues.
- Even when aware of referrals to make, employees noted that resources are so scarce that patients are often unable to access the community resources that do exist. One commented for example: "While there are places to refer people, they are left frustrated with the resources available."
- Several respondents noted that financial strain is resulting in patients being unable to afford medications.
- Respondents identified the "disproportionate impact of health conditions on specific populations" as the barrier to care for which Sharp is doing the most effective work.
- Employees gave positive feedback about the tools Sharp offers to address barriers to care. Suggestions for additional tools that would be helpful included raising awareness about existing resources and expanding staff.

SGH 2022 Phase 2 Survey for Sharp Insights Community

Facilitated by Sharp's Consumer Research team, an electronic survey was distributed to the Sharp Insight Community (consisting of current and former Sharp patients (or their families and caregivers), some Sharp-affiliated physicians, and community members unaffiliated with Sharp) on August 21, 2023. A total of 438 people completed the survey.

The Sharp Insight Community Phase 2 survey sought participant feedback on the top health and social needs and barriers to care identified in Phase 1 of the 2022 CHNA. Key findings included:

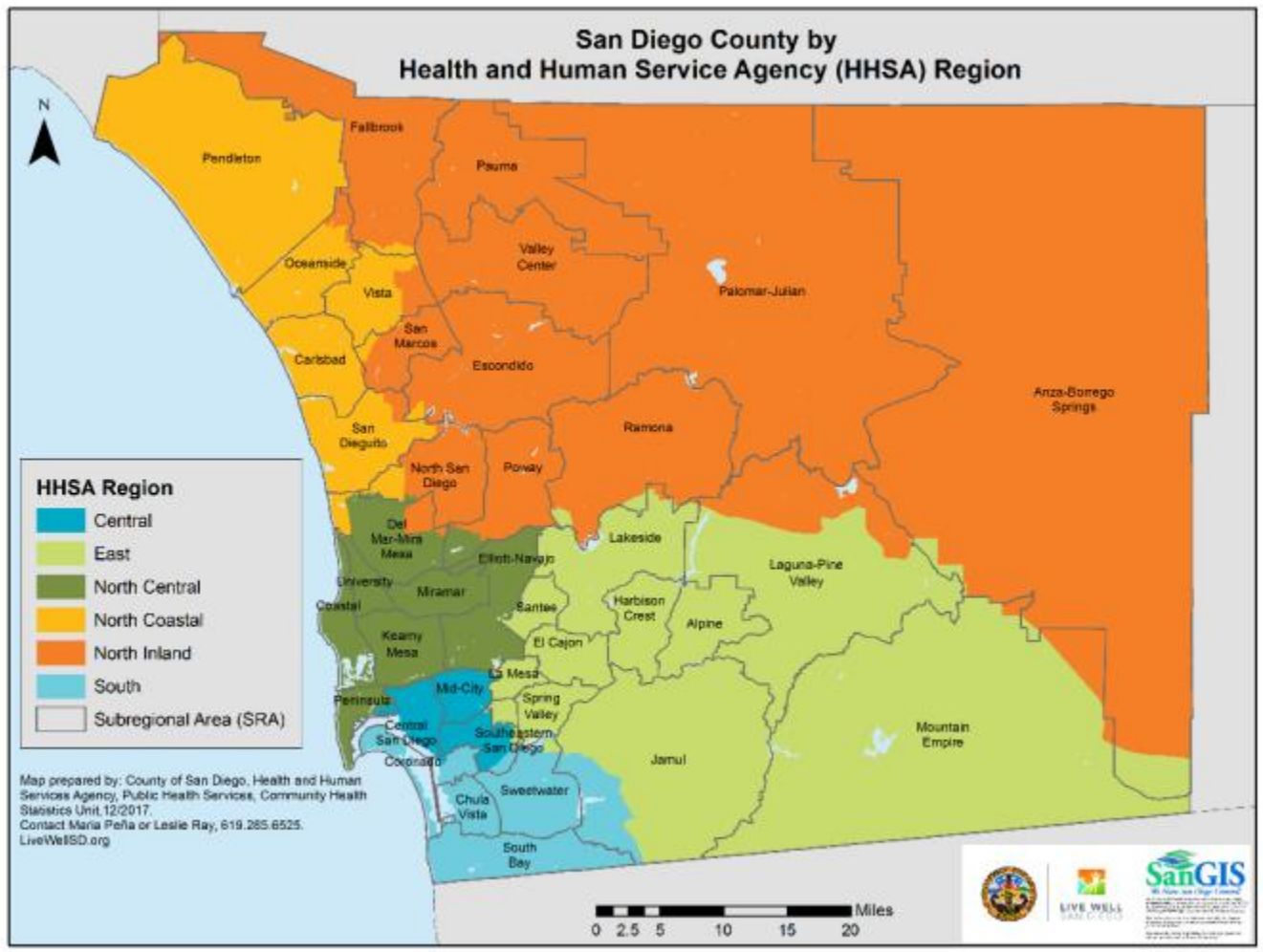
- 95% of respondents "agreed" or "strongly agreed" with the top health needs described by the Phase 2 CHNA.
- Access to health care, aging care and support and behavioral health were the highest ranked health and social needs.
- While many respondents commented all of the health and social needs found by the CHNA were important, respondents left additional comments about access to healthcare, senior care, mental health, homelessness and health disparities.
- 82% of respondents selected "agreed" or "strongly agreed" that health disparities have a major impact on their community.
- 87% of respondents selected "agreed" or "strongly agreed" that workforce has a major impact on their community.
- 73% of respondents selected "agreed" or "strongly agreed" that the barrier of stigma has a major impact on their community.

- 83% of respondents selected ”agreed” or “strongly agreed” that the barrier of trauma has a major impact on their community.
- When respondents were asked about additional feedback on the key barriers mentioned in the CHNA, the top theme found in these comments was discrimination, followed by a reference to the staffing shortage, health care costs and their own survey comprehension.

Appendix

B Maps

San Diego County Community and Region Boundaries Map[78]



Sharp HealthCare Locations

San Diego County Region Definitions by Sharp's Strategic Planning Department

ZIP Code	Region
92037	Metro Central
92038	Metro Central
92039	Metro Central
92092	Metro Central
92093	Metro Central
92101	Metro Central
92102	Metro Central
92103	Metro Central
92104	Metro Central
92105	Metro Central
92106	Metro Central
92107	Metro Central
92108	Metro Central
92109	Metro Central
92110	Metro Central
92111	Metro Central
92112	Metro Central
92113	Metro Central
92114	Metro Central
92115	Metro Central
92116	Metro Central
92117	Metro Central
92118	Metro Central
92120	Metro Central
92121	Metro Central
92122	Metro Central
92123	Metro Central
92124	Metro Central
92132	Metro Central
92133	Metro Central
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92136	Metro Central
92137	Metro Central
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92147	Metro Central
92152	Metro Central
92155	Metro Central
92160	Metro Central
92161	Metro Central
92162	Metro Central
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92171	Metro Central
92174	Metro Central
92175	Metro Central
92176	Metro Central
92177	Metro Central
92178	Metro Central
92182	Metro Central
92184	Metro Central
92186	Metro Central
92187	Metro Central
92190	Metro Central
92191	Metro Central
92192	Metro Central
92193	Metro Central
92194	Metro Central
92195	Metro Central

ZIP Code	Region
91901	East County
91903	East County
91905	East County
91906	East County
91916	East County

91917	East County
91931	East County
91934	East County
91935	East County
91941	East County
91942	East County
91943	East County
91944	East County
91945	East County
91946	East County
91948	East County
91962	East County
91963	East County
91976	East County
91977	East County
91978	East County

91979	East County
91980	East County
91987	East County
91990	East County
92004	East County
92019	East County
92020	East County
92021	East County
92022	East County
92036	East County
92040	East County
92071	East County
92072	East County
92090	East County
92119	East County
92159	East County

ZIP Code	Region
91902	South Bay
91908	South Bay
91909	South Bay
91910	South Bay
91911	South Bay
91912	South Bay
91913	South Bay
91914	South Bay
91915	South Bay
91921	South Bay
91932	South Bay

91933	South Bay
91947	South Bay
91950	South Bay
91951	South Bay
92139	South Bay
92143	South Bay
92149	South Bay
92153	South Bay
92154	South Bay
92158	South Bay
92173	South Bay
92179	South Bay

ZIP Code	Region
92007	North Coastal
92008	North Coastal
92009	North Coastal
92010	North Coastal
92011	North Coastal
92013	North Coastal
92014	North Coastal
92018	North Coastal
92023	North Coastal

92024	North Coastal
92049	North Coastal
92051	North Coastal
92052	North Coastal
92054	North Coastal
92055	North Coastal
92056	North Coastal
92057	North Coastal
92058	North Coastal
92067	North Coastal

92068	North Coastal
92075	North Coastal
92081	North Coastal
92083	North Coastal
92084	North Coastal
92085	North Coastal
92091	North Coastal
92130	North Coastal

ZIP Code	Region
92003	North Inland
92025	North Inland
92026	North Inland
92027	North Inland
92028	North Inland
92029	North Inland
92030	North Inland
92033	North Inland
92046	North Inland
92059	North Inland
92060	North Inland
92061	North Inland
92064	North Inland
92065	North Inland
92066	North Inland
92069	North Inland
92070	North Inland
92074	North Inland
92078	North Inland
92079	North Inland
92082	North Inland
92086	North Inland
92088	North Inland
92096	North Inland
92126	North Inland
92127	North Inland
92128	North Inland
92129	North Inland
92131	North Inland
92150	North Inland
92172	North Inland
92196	North Inland
92197	North Inland
92198	North Inland
92199	North Inland

Appendix

C Sharp 2025 Clinical Data Analytics

Health Equity

Positive Screenings

Following the implementation of the Epic electronic health record system in March 2024, Sharp began tracking health equity screenings administered to hospital inpatients through an internal dashboard. The health equity screenings included the following categories:

- **Food Insecurity**
  - CMS defines food insecurity as limited access to adequate food.
  - Epic Screening Question in Admission Navigator Section: *Within the last 12 months, you worried that your food would run out before you got the money to buy more?*
  - Individuals who screened positive received intervention in the form of an order consult to a social worker or case management.
- **Housing Instability**
  - CMS defines housing instability as difficulty paying rent, frequent moves, or lack of a stable residence.
  - Epic Screening Question in Admission Navigator Section: *In the last 12 months, was there a time when you did not have a steady place to sleep or slept in a shelter (including now)?*
  - Individuals who screened positive received intervention in the form of an order consult to a social worker or case management.
- **Interpersonal Safety**
  - CMS defines interpersonal safety as a patient's exposure to abuse or intimate partner violence.
  - Epic Screening Question in Admission Navigator Section: *Within the last year, have you been afraid of your partner or ex-partner?*
  - Individuals who screened positive received intervention in the form of an order consult to a social worker or case management.
- **Transportation Need**
  - CMS defines transport needs as limitations that prevent one from getting to places needed for daily life.
  - Epic Screening Question in Admission Navigator Section: *In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications?*
  - Individuals who screened positive received intervention in the form of an order consult to a social worker or case management.
- **Utility Difficulties**
  - CMS defines utility difficulties as challenges patients face in accessing and maintaining essential services like electricity, water, or heating.

- Epic Screening Question in Admission Navigator Section: *In the past 12 months, has the electric, gas, oil, or water company threatened to shut off services in your home?*
- Individuals who screened positive received intervention in the form of an order consult to a social worker or case management.

The health equity positive screenings data representing the time period between March 2024 to March 2025 was analyzed by calculating the percentage of positive health equity screenings among each demographic group to determine which group saw the highest proportion of positive screenings. Further, due to differences in the patient population sizes within each demographic group, positive screening rates were calculated to determine if certain demographic groups had a higher proportion of positive screenings. An example of this analysis is detailed in the table below.

Sharp Inpatient Utility Difficulties Screenings by Preferred Language, March 2024 – March 2025

Preferred Language	Screened for Utility Difficulties	Positive Screening Total	Pct. of Positive Screenings Among Group
American Sign Language (ASL)	20	3 (0.0%)	15.0%
Asian/Pacific Islander Languages	1,074	107 (1.2%)	10.0%
English Language	40,788	7,779 (83.6%)	19.1%
Middle Eastern Languages	853	97 (1.0%)	11.4%
Spanish Language	7,861	1,214 (13.1%)	15.4%
Other/Unknown	733	100 (1.1 %)	13.6%
Total	**51,329**	**9,300**	**--**

The table below provides a breakdown of the health equity screenings performed between March 2024 and March 2025.

Sharp Inpatient Health Equity Screenings, March 2024 – March 2025

Health Equity Screening	Screening Count	Positive Screening Rate	Intervention Rate
Food Insecurity	52,996	18.1%	72.7%
Housing Instability	67,820	16.6%	72.1%
Interpersonal Safety	56,503	16.8%	72.7%
Transportation Need	63,596	16.7%	72.1%
Utility Difficulties	51,329	18.1%	72.4%

Patient payor and demographic data, including age, preferred language, race/ethnicity, disability status, sex assigned at birth, gender identity and sexual orientation were analyzed. To determine whether any patient groups had high health equity needs, two analyses were conducted. This included an analysis comparing the proportion of positive screenings between groups and the groups' positive screening rates.

It is important to note that among patients who received a health equity screening, approximately 3 in 4 patients did not provide information on their sexual orientation. Further, since less than half of patients screened disclosed their sexual orientation, this presents an opportunity for improvement on data collection for this category.

For the first analysis comparing outcomes among demographic groups, a comparison of the proportion of positive screening volumes was conducted. The largest volume of patients who had positive health equity screenings where inpatients who identify as male, white, over age 65, who speak English as a primary language, insured by a private payor and did not have a disability.

In the second analysis, a comparison of the positive screening rates between groups was conducted. The table below details the groups with the highest positive screenings rates.

Sharp Inpatients Health Equity Positive Screenings High-Need Groups, March 2024 - March 2025

Health Equity Screening	Highest Screening Rates Within Groups
All Screenings	Sex: Male Race/Ethnicity: American Indian or Alaska Native Primary Payor: Medicaid (Medi-Cal)
Food Insecurity	Age: 35-49 Gender Identity: Transgender Preferred Language: English
Housing Instability	Age: 50-64 Gender Identity: Genderqueer Preferred Language: ASL
Interpersonal Safety	Age: 50-64 Gender Identity: Transgender Disability Status: Has a disability
Transportation Need	Age: 50-64 Gender Identity: Genderqueer Preferred Language: ASL
Utility Difficulties	Age: 35-49 Gender Identity: Genderqueer

Among inpatients who received a health equity screening, approximately 5% of patients identified as having a disability. Disability types included: cognitive disability, hearing disability, mobility disability, selfcare disability, & vision disability. For most health equity screenings, patients without a disability screened positive at higher rates compared to patients with disabilities. Interpersonal safety was the only health equity category where patients with a disability saw a slightly higher positive screening rate (16.9%) within the group compared to non-disabled patients (16.8%).

CMQCC Measures

Following Sharp's implementation of a new electronic health record system, in May 2024, Sharp began to track outcomes and measures on key maternal health indicators as defined by

the California Maternal Quality Care Collaborative (CMQCC), including Exclusive Breast Milk Feeding (EBF) Rates, Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rates, and Vaginal Birth After Cesarean (VBAC) Rates. Data analyzed accounted for the time period between May 2024 to February 2025 and will continue to be collected and monitored.

The data was analyzed using a chi-square test of independence for each demographic dimension within each CMQCC category. In these analyses, demographic dimensions containing unknown values were analyzed with and without the unknown values to determine if the weight of the outcome from the unknown group was statistically significant. While disability status was part of this dashboard, there were no patients who identified as having a disability in this analysis, therefore this data was not included. The table below provides a detailed breakdown of statistically significant findings for each CMQCC category and the corresponding variable analyzed.

CMQCC Statistically Significant Findings, May 2024 – February 2025

CMQCC Category	Variables	Result
EBF	EBF by Age	***Without unknown***: A chi-square test of independence was performed to examine the relation between exclusive breast-feeding and mother's age. The relation between these variables was significant, χ^2 (2, N = 3,510) = 7.2249, p < 0.05. Compared to other age groups, mothers ages 18-29 were more likely to exclusively breastfeed.
EBF	EBF by Hypertension	A chi-square test of independence was performed to examine the relation between the patient's hypertension status and EBF cases observed. The relation between these variables was significant, χ^2 (4, N = 3,734) = 26.6956, p < .001. Patients who had did not have hypertension were more likely to exclusively breastfeed than patients with hypertension, including gestational, Eclampsia & Preeclampsia with severe features, Preeclampsia without severe features and chronic hypertension.
EBF	EBF by Primary Language	***Without unknown***: A chi-square test of independence was performed to examine the relation between exclusive breast-feeding and mother's primary language. The relation between these variables was significant, χ^2 (4, N = 5,365) = 16.6080, p < 0.05. Compared to other languages, mothers whose primary language is English were more likely to exclusively breastfeed.
EBF	EBF by Race/Ethnicity	A chi-square test of independence was performed to examine the relation between exclusive breastfeeding and mother's race/ethnicity. The relation between these variables was significant, χ^2 (5, N = 5,522) = 30.5702, p < 0.001. Compared to other race/ethnicities, mothers who identified as White were more likely to exclusively breastfeed.
NTSV Cesarean Birth	NTSV Cesarean Birth by Age	A chi-square test of independence was performed to examine the relation between the patient's age and NTSV cesarean birth cases observed. The relation between these variables was significant, χ^2 (3, N = 3,453) = 115.6284, p < .001. Patients age

		30 and over were more likely to have a NTSV cesarean birth than patients under age 29.
NTSV Cesarean Birth	NTSV Cesarean Birth by Housing Instability	A chi-square test of independence was performed to examine the relation between housing instability and NTSV cesarean birth cases observed. The relation between these variables was significant, χ^2 (2, N = 3,453) = 12.3029, p < .01. Patients who were not screened for housing instability were more likely to have a NTSV cesarean birth than patients who received a housing instability screening.
NTSV Cesarean Birth	NTSV Cesarean Birth by Hypertension	A chi-square test of independence was performed to examine the relation between the patient's payor type and NTSV cesarean birth cases observed. The relation between these variables was significant, χ^2 (4, N = 3,453) = 43.6208, p < .001. Patients who had eclampsia & preeclampsia with severe features, chronic hypertension, and preeclampsia without severe features were more likely to have a NTSV cesarean birth than patients with gestational hypertension or without hypertension.
NTSV Cesarean Birth	NTSV Cesarean Birth by Primary Payor	A chi-square test of independence was performed to examine the relation between the patient's payor type and NTSV cesarean birth cases observed. The relation between these variables was significant, χ^2 (4, N = 3,453) = 12.6615, p < .05. Patients whose primary payor was self-pay or Medicare were more likely to have a NTSV cesarean birth than patients insured by Medi-Cal (Medicaid), private or other payor.
VBAC	VBAC by Age	A chi-square test of independence was performed to examine the relation between age and VBAC cases observed. The relation between these variables was significant, χ^2 (2, N = 1,644) = 12.9669, p < .001. Patients ages 18-29 were more likely to have a VBAC than patients age 30 and over.
VBAC	VBAC by Food Insecurity	A chi-square test of independence was performed to examine the relation between food insecurity and VBAC cases observed. The relation between these variables was significant, χ^2 (2, N = 1,644) = 20.2952, p < .001. Patients who were screened for food insecurity, regardless of positive or negative screening, were more likely to have a VBAC than patients who were not screened.
VBAC	VBAC by Housing Instability	A chi-square test of independence was performed to examine the relation between housing instability and VBAC cases observed. The relation between these variables was significant, χ^2 (2, N = 1,644) = 38.7520, p < .001. Patients who were screened negative for housing instability were more likely to have a VBAC than patients who screened positive and those who were not screened.
VBAC	VBAC by Primary Payor	A chi-square test of independence was performed to examine the relation between the patient's payor type and VBAC cases observed. The relation between these variables was significant, χ^2 (4, N = 1,644) = 13.4285, p < .01. Patients whose primary payor was private insurance or other payors were more likely to have a VBAC than patients insured by Medi-Cal (Medicaid), Medicare or self-pay.

VBAC	VBAC by Race/Ethnicity	A chi-square test of independence was performed to examine the relation between the patient's race/ethnicity and VBAC cases observed. The relation between these variables was significant, χ^2 (8, N = 1,644) = 23.0620, p < .01. Patients whose race/ethnicity was White, Black or African American, Unknown or Declined were more likely to have a VBAC than patients who identify as Hispanic or Latino, Asian, Other, or Native Hawaiian or Pacific Islander.
VBAC	VBAC by Transportation Needs	A chi-square test of independence was performed to examine the relation between transportation needs and VBAC cases observed. The relation between these variables was significant, χ^2 (2, N = 1,644) = 13.9533, p < .001. Patients who were screened negative for transportation needs were more likely to have a VBAC than patients who screened positive and those who were not screened.
VBAC	VBAC by Utility Difficulties	A chi-square test of independence was performed to examine the relation between utility difficulties and VBAC cases observed. The relation between these variables was significant, χ^2 (2, N = 1,644) = 12.9002, p < .01. Patients who were screened negative for utility difficulties were more likely to have a VBAC than patients who screened positive and those who were not screened.

Behavioral Health Emergency Department Data

With two specialty facilities specializing in behavioral health and substance use disorders, Sharp continues to provide the SDC community with much-needed care. During the COVID-19 pandemic, the need for behavioral health services became more intensified.[79] Moreover, Sharp sought to further analyze trends in behavioral health care needs and potential disparities experienced across demographic groups.

As a result, Sharp created an internal behavioral health dashboard that began tracking behavioral-health-related emergency department visits across its hospitals to monitor changes and disparities experienced by patients accessing behavioral health care in the emergency department (ED). The dashboard provided insight into the most prevalent behavioral health and substance abuse diagnoses for all Sharp ED visits, including emergency, observation, and admitted cases. The diagnoses included were:

- All Behavioral Health Diagnoses (ICD-10-CM codes F01-F99 Mental, Behavioral and Neurodevelopmental Disorders)
- Substance Abuse Disorders (ICD-10-CM codes F10-F19 Mental and Behavioral Disorders Due to Psychoactive Substance Abuse)
- Anxiety Disorders (ICD-10-CM codes F40-F48 Anxiety Dissociative, Stress-Related, Somatoform and Other Non-Psychotic Mental Health Disorders)
- Mood Disorders (ICD-10-CM codes F30-F39 Mood (Effective) Disorders)
- Psychotic Disorders (ICD-10-CM codes F20-F29 Schizophrenia, Schizotypal, Delusional & Other Non-Mood Psychotic Disorders)

The diagnoses are grouped by ICD-10 groupings and further categorized by biological sex and age. At the time this analysis was conducted, race/ethnicity and primary payor data were unavailable, but have since been integrated into the dashboard.

In these analyses, demographic dimensions containing unknown values were analyzed with and without the unknown values using a chi-square test of independence to determine if the weight of the outcome from the unknown group was statistically significant.

Although overall emergency department volumes at Sharp hospitals increased annually,[80] the number of Behavioral Health Disorders diagnosed in the ED decreased between 2022 and 2024. The table below provides a more detailed breakdown of this analysis' statistically significant results.

Sharp ED Behavioral Health Disorder Discharges Statistically Significant Findings, 2022 – 2024

Behavioral Health Category	Variables	Result
All BH Disorders	Behavioral Health Disorders by Year	A chi-square test of independence was performed to examine the relation between calendar year and the behavioral health disorder diagnoses observed in Sharp's EDs. The relation between these variables was significant, χ^2 (2, N = 980371) = 488.7588, p < .001. Compared to 2022, patients seen in a Sharp emergency department in 2024 were less likely to receive a behavioral health diagnosis.
All BH Disorders	Behavioral Health Disorders by Biological Sex	A chi-square test of independence was performed to examine the relation between the patient's biological sex and the behavioral health disorder diagnoses observed in Sharp's EDs. The relation between these variables was significant, χ^2 (2, N = 980,371) =3503.3835, p < .001. Patients seen in a Sharp emergency department between 2022 and 2024 were more likely to receive a behavioral health diagnosis if their biological sex was male or unknown.
All BH Disorders	Behavioral Health Disorders by Age	A chi-square test of independence was performed to examine the relation between patient age and the behavioral health disorder diagnoses observed in Sharp's EDs. The relation between these variables was significant, χ^2 (4, N = 980,371) = 9738.1717, p < .001. Patients seen in a Sharp emergency department between 2022 and 2024 were more likely to receive a behavioral health diagnosis if they were age 35 or older.
SUD	Substance Abuse Disorders by Year	A chi-square test of independence was performed to examine the relation between calendar year and the substance use disorder diagnoses observed in Sharp's EDs. The relation between these variables was significant, χ^2 (2, N = 980371) = 389.9412, p < .001. Compared to 2022, patients seen in a Sharp emergency department in 2024 were less likely to receive a substance use disorder diagnosis.

SUD	Substance Abuse Disorders by Biological Sex	A chi-square test of independence was performed to examine the relation between the patient's biological sex and the substance use disorder diagnoses observed in Sharp's EDs. The relation between these variables was significant, χ^2 (2, N = 980,372) = 10823.0099, p < .001. Patients seen in a Sharp emergency department between 2022 and 2024 were more likely to receive a substance use disorder diagnosis if their biological sex was male.
SUD	Substance Abuse Disorders by Age	A chi-square test of independence was performed to examine the relation between patient age and the substance use disorder diagnoses observed in Sharp's EDs. The relation between these variables was significant, χ^2 (4, N = 980,371) = 9426.1346, p < .001. Patients seen in a Sharp emergency department between 2022 and 2024 were more likely to receive a substance use disorder diagnosis if they were between ages 35 to 64.
Anxiety Disorders	Anxiety Disorders by Year	A chi-square test of independence was performed to examine the relation between calendar year and the anxiety disorder diagnoses observed in Sharp's EDs. The relation between these variables was significant, χ^2 (2, N = 980,371) = 269.134, p < .001. Compared to 2022, patients seen in a Sharp emergency department in 2024 were less likely to receive a anxiety disorder diagnosis.
Anxiety Disorders	Anxiety Disorders by Biological Sex	A chi-square test of independence was performed to examine the relation between the patient's biological sex and the anxiety disorder diagnoses observed in Sharp's EDs. The relation between these variables was significant, χ^2 (2, N = 980,371) = 822.0636, p < .001. Patients seen in a Sharp emergency department between 2022 and 2024 were more likely to receive an anxiety disorder diagnosis if their biological sex was female or unknown.
Anxiety Disorders	Anxiety Disorders by Age	A chi-square test of independence was performed to examine the relation between patient age and the anxiety disorder diagnoses observed in Sharp's EDs. The relation between these variables was significant, χ^2 (4, N = 980,371) = 1291.6807, p < .001. Patients seen in a Sharp emergency department between 2022 and 2024 were more likely to receive an anxiety disorder diagnosis if they were age 35 or older.
Mood Disorders	Mood (Effective) Disorders by Year	A chi-square test of independence was performed to examine the relation between calendar year and the mood disorder diagnoses observed in Sharp's EDs. The relation between these variables was significant, χ^2 (2, N = 980,371) = 28.8763, p < .001. Compared to 2023, patients seen in a Sharp emergency department in 2022 or 2024 were less likely to receive a mood disorder diagnosis.
Mood Disorders	Mood (Effective) Disorders by Biological Sex	A chi-square test of independence was performed to examine the relation between the patient's biological sex and the mood disorder diagnoses observed in Sharp's EDs. The relation between these variables was significant, χ^2 (2, N = 980,371) = 547.0657, p < .001. Patients seen in a Sharp emergency department between 2022 and 2024 were more likely to receive

		a mood disorder diagnosis if their biological sex was female or unknown.
Mood Disorders	Mood (Effective) Disorders by Age	A chi-square test of independence was performed to examine the relation between patient age and the mood disorder diagnoses observed in Sharp's EDs. The relation between these variables was significant, χ^2 (4, N = 980,371) = 7425.5265, p < .001. Patients seen in a Sharp emergency department between 2022 and 2024 were more likely to receive a mood disorder diagnosis if they were age 50 or older.
Psychotic Disorders	Psychotic Disorders by Year	A chi-square test of independence was performed to examine the relation between calendar year and the psychotic disorder diagnoses observed in Sharp's EDs. The relation between these variables was significant, χ^2 (2, N = 980,371) = 29.8071, p < .001. Compared to 2022 and 2023, patients seen in a Sharp emergency department in 2024 were less likely to receive a psychotic disorder diagnosis.
Psychotic Disorders	Psychotic Disorders by Biological Sex	A chi-square test of independence was performed to examine the relation between the patient's biological sex and the psychotic disorder diagnoses observed in Sharp's EDs. The relation between these variables was significant, χ^2 (2, N = 980,371) = 1494.3323, p < .001. Patients seen in a Sharp emergency department between 2022 and 2024 were more likely to receive a psychotic disorder diagnosis if their biological sex was male or unknown.
Psychotic Disorders	Psychotic Disorders by Age	A chi-square test of independence was performed to examine the relation between patient age and the psychotic disorder diagnoses observed in Sharp's EDs. The relation between these variables was significant, χ^2 (4, N = 980,371) = 1482.6377, p < .001. Patients seen in a Sharp emergency department between 2022 and 2024 were more likely to receive a psychotic disorder diagnosis if they were age 18-64.

Appendix

D Sharp Community Engagement Activities

In addition to serving on the CHNA Committee in support of the collaborative HASD&IC 2025 CHNA process, Sharp HealthCare (Sharp) conducted community engagement activities specifically for the community members it serves through partnership with the Institute for Public Health (IPH) at San Diego State University (SDSU) as well as with the Sharp Insights Community. These efforts are summarized below.

IPH Focus Groups and Key Informant Interviews

Sharp partnered with the IPH to conduct an additional assessment to better understand the specific needs of Sharp patients.

Two semi-structured focus groups were held to explore the chosen areas of focus. The first focus group addressed mental health. Twelve members of a peer advisory board, comprised of people with lived experience and expertise in mental illness, were asked to participate, many of whom were certified Peer Support Specialists. The second group centered on health during pregnancy, labor, delivery, and post-partum. This group was comprised of five Sharp employees who work in this field across the Sharp system.

After initial analyses of the focus groups were completed, two key informant interviews were conducted to gain additional context about the areas of focus. The first interview was held with staff at Sharp Rees Steely to understand how they utilize Community Health Workers (CHWs) to assist patients. This was chosen based on feedback from the focus group that more peer and navigation support is needed for people to receive appropriate and effective mental health treatment. The second interview was held with a staff member from Sharp Mesa Vista Hospital's Maternal Mental Health program. The purpose of this interview was to better understand the mental health needs of and possible interventions for pregnant and newly parenting people. This topic was chosen based on feedback from the focus group that mental health care was a priority need for this population.

Sharp Insight Community Survey

Facilitated by NRC Health, an online survey was sent to the Sharp Insights Community, representing current and former Sharp patients (or their families and caregivers), some Sharp-affiliated physicians and community members unaffiliated with Sharp. Survey questions sought to learn about participants' current perceptions of the social and health problems they believe most impact their households and identify the types of health care services that would make it easier for them to access care. A total of 252 people completed the survey.

Appendix

E An Overview of Sharp HealthCare

Sharp HealthCare (Sharp) is an integrated, regional health care delivery system based in San Diego, California. The Sharp system includes four acute care hospitals; four specialty hospitals; three affiliated medical groups; 27 medical clinics; six urgent care centers; three skilled nursing facilities; two inpatient rehabilitation centers; hospice and home infusion programs; numerous outpatient facilities and programs; three charitable foundations; and a variety of other community health education programs and related services. Sharp also offers individual and group HMO coverage through Sharp Health Plan. Serving a population of approximately 3.3 million in San Diego County (SDC), as of September 30, 2024, Sharp is licensed to operate 2,210 beds and has approximately 2,800 Sharp-affiliated physicians and more than 20,000 employees.

FOUR ACUTE CARE HOSPITALS:

Sharp Chula Vista Medical Center (449 licensed beds)

The largest provider of health care services in SDC's fast-growing south region, Sharp Chula Vista Medical Center (SCVMC) operates the region's busiest emergency department (ED) and is the closest hospital to the busiest international border in the world. SCVMC is home to the region's most comprehensive heart program, services for orthopedic care, and cancer treatment. SCVMC is also the largest provider of health care services for women and infants in the south region, and offers the only bloodless medicine program in SDC.

Sharp Coronado Hospital and Healthcare Center (181 licensed beds)

Sharp Coronado Hospital and Healthcare Center (SCHHC) provides services that include acute, subacute and long-term care, liver care, integrative and rehabilitative therapies, orthopedics, a community fitness center and emergency services.

Sharp Grossmont Hospital (542 licensed beds)

Sharp Grossmont Hospital (SGH) is the largest provider of health care services in San Diego's east region and has one of the busiest EDs in SDC. SGH is known for outstanding programs in heart care, oncology, orthopedics, rehabilitation, stroke care and women's health.

Sharp Memorial Hospital (656 licensed beds)

A regional tertiary care leader, Sharp Memorial Hospital (SMH) provides specialized care in cancer treatment, orthopedics, organ transplantation, bariatric surgery, heart care and rehabilitation. SMH also houses the county's largest emergency and trauma center.

FOUR SPECIALTY CARE HOSPITALS:

Sharp Grossmont Hospital for Neuroscience (50 licensed beds)

As SDC's first comprehensive specialty hospital of its kind, Sharp Grossmont Hospital for Neuroscience is transforming the future of neurological care with compassionate and innovative treatments for brain, nerve and spine conditions. Sharp Grossmont Hospital for Neuroscience offers multidisciplinary, comprehensive care, as well as specialized inpatient and outpatient treatment for a wide range of neurological conditions, such as brain and spine tumors, complex spine surgeries, comprehensive stroke care, movement disorders, neuro-ophthalmology and spine and back care.

Sharp Mary Birch Hospital for Women & Newborns (206 licensed beds)

A freestanding women's hospital specializing in labor and delivery services, high-risk pregnancy, obstetrics, gynecology, gynecologic oncology and neonatal intensive care, Sharp Mary Birch Hospital for Women & Newborns (SMBHWN) is the largest maternity hospital in San Diego and delivers more babies than nearly any other hospital in California.

Sharp Mesa Vista Hospital (160 licensed beds)

As the most comprehensive behavioral health hospital in SDC, Sharp Mesa Vista Hospital (SMV) provides services to treat anxiety, depression, substance use, eating disorders, bipolar disorder and more for patients of all ages.

Sharp McDonald Center (16 licensed beds)

Sharp McDonald Center (SMC) is the only medically supervised substance use recovery center in SDC. Offering the most comprehensive hospital-based treatment program in SDC, SMC provides services such as addiction treatment, medically supervised detoxification and rehabilitation, day treatment, outpatient and inpatient programs and aftercare.

Collectively, the operations of SMH, SMBHWN, SMV and SMC are reported under the not-for-profit public benefit corporation of SMH and are referred to herein as the Sharp Metropolitan Medical Campus. The operations of Sharp Rees-Stealy Medical Centers (SRSMC) are included under the not-for-profit public benefit corporation of Sharp, the parent organization. The operations of SGH are reported under the not-for-profit public benefit corporation, Grossmont Hospital Corporation. The operations of Sharp HospiceCare are reported under SGH.

Mission Statement

It is Sharp's mission to improve the health of those we serve with a commitment to excellence in all that we do. Sharp's goal is to offer quality care and services that set community standards, exceed patients' expectations and are provided in a caring, convenient, cost-effective and accessible manner.

Vision and Values

Sharp's vision is to transform the health care experience and be the best place to work, the best place to practice medicine and the best place to receive care. Sharp will become the best health system in the universe.

Sharp's core values are Integrity, Caring, Safety, Innovation and Excellence.

Culture: The Sharp Experience

For over two decades, Sharp has been transforming the health care experience for patients and their families, physicians and staff. Through a sweeping organization-wide performance-and-experience-improvement initiative called The Sharp Experience, the entire Sharp team has recommitted to purposeful, worthwhile work and creating the kind of health care people want and deserve. Sharp is San Diego's health care leader because it remains focused on the most important element of the health care equation: the people. Through this transformation, Sharp continues to live its mission to care for all people, with special concern for the underserved and San Diego's diverse population. Sharp has been serving the San Diego community for 70 years and will continue to do so.

To learn more about The Sharp Experience and its impact, please visit https://www.sharp.com/about/the-sharp-experience.

Pillars of Excellence

In support of Sharp's organizational commitment to transform the health care experience, Sharp's Pillars of Excellence guide its team members, providing framework and alignment for everything Sharp does.

Sharp is a seven-pillar organization: Quality, Safety, Service, People, Finance, Growth and Community. Notably, the Community Pillar emphasizes being an exemplary public citizen by elevating health equity and wellness in our community and environment.

Awards

For a comprehensive list of Sharp's awards and recognitions, please visit https://www.sharp.com/about/awards.

Appendix

F Healthy Places Index® (HPI)

The Healthy Places Index (HPI)

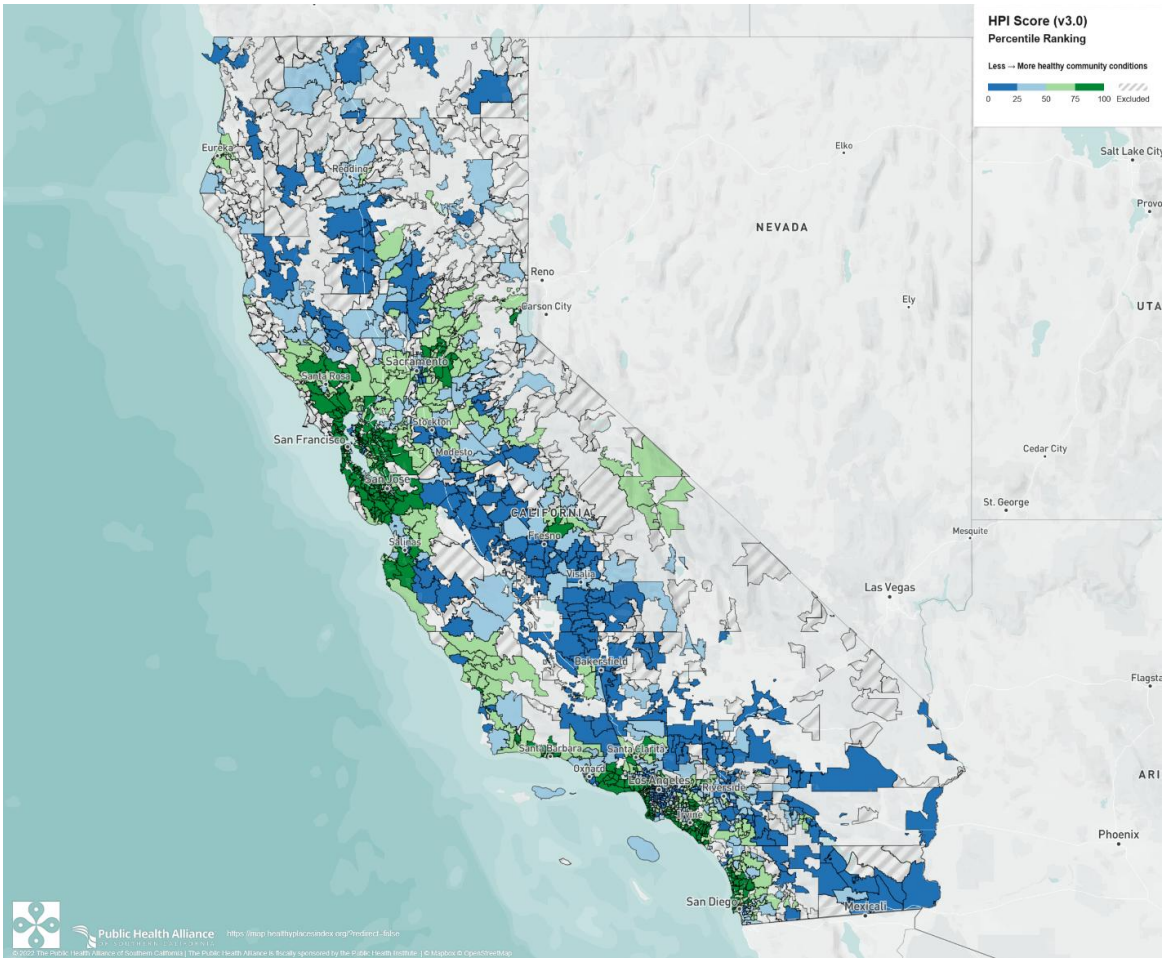
The HPI is a project of the Public Health Alliance of Southern California, a coalition of the executive leadership of 10 local health departments in Southern California, representing more than 60% of the state's population.[81] The HPI identifies the severity of health inequity for various geographic areas across the State of California.

On April 6, 2022, the HPI's third update (3.0) was released. The HPI 3.0 evaluates the relationship between 23 identified key drivers of health and life expectancy at birth. These indicators span across economic, education, social transportation, healthcare access, neighborhood, housing, and environmental measures.[82] Based on that analysis, it produces a score ranking from 1 to 99 that shows the relative impact of conditions in a selected geographic area compared to all other such places in the State of California. The HPI scores and compares geographies across the state via ranking. Then, the HPI score rank is divided into four quartiles for comparisons across geographic regions, such as census tracts, cities, counties, congressional districts, school districts, ZIP codes and unincorporated areas. See the map image below for an overview of HPI score percentiles across the state of California.

HPI scores are categorized across four percentiles, with a score in the 0-25th percentile indicating a geographic area (ZIP codes were used in this report) with the highest need/high health inequity (dark green in this CHNA's HPI map), and a score in the 75th-100th percentile representing a geographic area with the low need/low health inequity (light green in this CHNA's HPI map). For a detailed description of the HPI please visit https://www.healthyplacesindex.org/about-hpi.

HPI 3.0 maintained continuity by using the same data sources and methodology as HPI 2.0, with the American Community Survey (ACS) 2015-2019 forming a significant part of the indicators. The indicators were scaled using Z-Scores and averaged across policy domains like economic, education, and health care access. Additionally, HPI 3.0 included updated race/ethnicity data and added over 370 decision support indicators related to health outcomes and social vulnerabilities. For a more detailed description of the scoring methodology and data sources used to calculate HPI scores, please see the HPI 3.0 Technical Report https://cdn.prod.website-files.com/613a633a3add5db901277f96/63320a9e98493bbdcc03d509_HPI3TechnicalReport2022-09-20.pdf.

California HPI Map Percentiles by ZIP Code, HPI 3.0 (2022)[1]



In this report, the HPI 3.0 was used to obtain HPI scores for SDC ZIP codes. See the table below for a breakdown of the HPI score for each SDC ZIP code. In conjunction with Sharp hospitals' service area ZIP codes, this data helped inform which ZIP codes were identified as having high need for each hospital's service area. Further, this information will help Sharp leaders target key communities when developing community outreach programs.

HPI Score by San Diego County ZIP Code, HPI 3.0 (2022)[1]

ZIP Code	Population	HPI Value	HPI Score Percentile	Community	Sharp-Defined SDC Region
92113	58,408	-0.762059024	7.8%	Southeast San Diego	Metro Central
92004	2,299	-0.686683805	9.9%	Borrego Springs	East County
92173	31,000	-0.656620013	11.0%	San Ysidro	South Bay
92036	2,593	-0.647975472	11.5%	Julian	East County
91906	4,428	-0.623917866	12.3%	Campo	East County

[1] California Healthy Places Index Map. © 2022 Public Health Alliance of Southern California. All rights reserved.

92058	46,029	-0.575329091	14.2%	Oceanside	North Coastal
92105	73,623	-0.5285025	16.6%	City Heights	Metro Central
92086	1,543	-0.484211317	18.8%	Warner Springs	North Inland
91950	62,859	-0.419525885	22.2%	National City	South Bay
92102	44,010	-0.391576213	23.7%	East San Diego	Metro Central
91932	26,492	-0.314822319	28.2%	Imperial Beach	South Bay
92154	88,979	-0.30699724	28.6%	Otay Mesa	South Bay
92061	2,660	-0.301086984	29.0%	Pauma Valley	North Inland
92025	52,985	-0.257382126	32.0%	Escondido	North Inland
92115	64,343	-0.25266205	32.8%	College Area	Metro Central
92114	68,851	-0.232579495	33.8%	Encanto	Metro Central
92021	70,148	-0.216762488	34.9%	El Cajon	East County
91911	84,026	-0.211806577	35.4%	Chula Vista	South Bay
92020	59,743	-0.208672108	35.8%	El Cajon	East County
91945	27,236	-0.180376629	37.9%	Lemon Grove	East County
91977	64,750	-0.157099824	38.9%	Spring Valley	East County
92027	56,788	-0.130475487	41.0%	Escondido	North Inland
92139	36,105	-0.103815566	42.9%	Paradise Hills	South Bay
92083	39,509	-0.094849654	43.9%	Vista	North Coastal
91910	74,855	-0.078679915	44.6%	Chula Vista	South Bay
92028	48,173	-0.076232248	44.8%	Fallbrook	North Inland
92084	51,619	-0.071461284	45.1%	Vista	North Coastal
92054	41,807	-0.063234911	45.8%	Oceanside	North Coastal
91916	1,939	-0.05175212	46.8%	Descanso	East County
91935	8,550	-0.033674237	48.4%	Jamul	East County
92026	50,321	0.001587679	50.3%	Escondido	North Inland
92040	46,306	0.002761057	50.4%	Lakeside	East County
92111	50,693	0.067582927	54.8%	Linda Vista	Metro Central
91962	2,106	0.075428353	55.2%	Pine Valley	East County
92082	18,705	0.07860298	55.5%	Valley Center	North Inland
92057	60,414	0.081301417	55.8%	Oceanside	North Coastal
92069	50,376	0.084552118	56.2%	San Marcos	North Inland
92101	41,159	0.115246517	57.5%	Downtown	Metro Central
91942	40,151	0.129877022	58.7%	La Mesa	East County
91978	10,506	0.130423187	58.9%	Spring Valley	East County
92110	30,108	0.146135253	59.8%	Old Town	Metro Central
92019	43,272	0.156462241	60.5%	El Cajon	East County
91913	54,114	0.166560156	60.8%	Chula Vista - Eastlake	South Bay
92003	5,160	0.172023596	61.1%	Bonsall	North Inland
92124	32,600	0.178722675	61.3%	Tierrasanta	Metro Central
92081	29,596	0.178748739	61.4%	Vista	North Coastal
91941	31,918	0.180594289	61.5%	La Mesa	East County

91901	18,162	0.181089715	61.6%	Alpine	East County
92056	52,337	0.192207942	62.3%	Oceanside	North Coastal
92122	48,071	0.192850411	62.4%	University City	Metro Central
92065	37,505	0.193973572	62.6%	Ramona	North Inland
91915	33,485	0.203277256	63.2%	Chula Vista - Eastlake	South Bay
92123	32,473	0.225432167	64.3%	Serra Mesa	Metro Central
92108	22,280	0.227723908	64.4%	Mission Valley	Metro Central
92104	45,435	0.243026738	65.3%	North Park	Metro Central
92071	57,710	0.247721698	65.7%	Santee	East County
91902	18,896	0.312277907	69.9%	Bonita	South Bay
92116	33,408	0.319693216	70.4%	Normal Heights	Metro Central
92078	50,510	0.332123889	70.8%	San Marcos	North Inland
92118	22,548	0.372886471	73.3%	Coronado	Metro Central
92126	82,658	0.372986203	73.4%	Mira Mesa	North Inland
91914	17,379	0.388498911	74.0%	Chula Vista - Eastlake	South Bay
92029	19,382	0.403983084	75.2%	Escondido	North Inland
92117	56,983	0.405805612	75.5%	Clairemont Mesa	Metro Central
92064	49,805	0.444799247	78.1%	Poway	North Inland
92106	20,155	0.463087453	79.4%	Point Loma	Metro Central
92010	16,346	0.479039115	80.8%	Carlsbad	North Coastal
92109	47,111	0.49544253	81.6%	Pacific Beach	Metro Central
92008	27,151	0.495509097	81.7%	Carlsbad	North Coastal
92007	11,417	0.498576573	81.8%	Cardiff by the Sea	North Coastal
92107	31,223	0.498576633	81.9%	Ocean Beach	Metro Central
92120	30,550	0.507314203	82.4%	Grantville	Metro Central
92119	24,831	0.525876381	83.3%	San Carlos	East County
92067	7,724	0.528966399	83.5%	Rancho Santa Fe	North Coastal
92129	54,762	0.592955593	86.3%	Rancho Penasquitos	North Inland
92024	51,381	0.614400981	87.1%	Encinitas	North Coastal
92128	51,357	0.623867537	87.9%	Carmel Mntn. Ranch	North Inland
92127	49,935	0.631154987	88.0%	Rancho Bernardo	North Inland
92121	4,729	0.635138068	88.2%	Sorrento Valley	Metro Central
92075	12,752	0.6723909	89.7%	Solana Beach	North Coastal
92011	24,144	0.677437865	90.0%	Carlsbad	North Coastal
92103	34,700	0.702652005	91.5%	Hillcrest	Metro Central
92037	38,168	0.716918173	92.1%	La Jolla	Metro Central
92130	56,134	0.758128322	92.9%	Carmel Valley	North Coastal
92009	46,612	0.771196948	93.3%	Carlsbad	North Coastal
92131	34,727	0.785960442	93.5%	Scripps Ranch	North Inland
92145	1,883	0.79126638	93.8%	NAS Miramar	Metro Central
92014	13,568	0.82918647	94.8%	Del Mar	North Coastal

Appendix

G Community Voice

Overview

Community voice is essential for understanding key issues that impact the health and well-being of communities served by the local health care system. This involvement ensures that the needs and perspectives of diverse populations are represented. The following quotes were provided by San Diego County (SDC) community members and key informants as part of HASD&IC and Sharp 2025 CHNA community engagement activities.

Chronic Stress

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

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

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

Stressor: Financial Distress

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

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

Stressor: Housing Costs

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

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

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

Stressor: Food Prices

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

Stressor: Racism, Prejudice, Discrimination

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

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

Stressor: Ongoing Challenges from Pandemic, including Long COVID

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

Stressor: Climate and Public Health Events

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

"El olor es insoportable, y podemos enfermar." [Translation: The smell is unbearable, and we can get sick.] – Field Interview Participant

"En donde vivo los apartamentos se ponen muy calientes que a mi mamá se le baja la presión y a mi me dan muchos diles de cabeza (la migraña)." [Translation: Where I live, the apartments get so hot that my mom's blood pressure drops, and I get a lot of headaches (migraines).] – Field Interview Participant

Help Managing Health Conditions

Cancer

“I was diagnosed with melanoma in September, and I had to have surgery in November, and I had three surgeons. I had a general surgeon, a plastic surgeon, and an ENT. And I kept getting calls from each of these three offices, saying, 'Be here at seven, be here at nine, be here at 10:30.’ And so finally I said, 'You need to get your (act) together and somebody tell me what first time I need to be there because your offices are not communicating.’ And if I was not someone that…understood the health care system, I'm going to show up at the last time the person told me to at that last phone call…So I had a conversation with the general surgeon who was kind of leading all of this, and I was like, 'You need a patient navigator…' he's like, 'Well, we use them for breast cancer patients but not melanoma patients…’ I can only imagine if I wasn't as mouthy as I am, if I wasn't the advocate for myself that I am, and if English was my second language. It was miserable enough experience for me who is someone of privilege who does understand the system. I shouldn't have to worry about that when I have cancer… Here's another thing. So we went in for surgery that day, and no one told us that children aren't allowed under 12 in the hospital. So we were trying to not have my daughter worry. She's six. And so we get to the door at the hospital and they're like, 'Kids can't come in.' And I'm like, 'Are you kidding me?’ So then we had to, on the fly, change our plans for my daughter, which created more anxiety for her. And then I go through the first procedure and get to the second one, and by that time my husband's back and they're like, 'Your surgery has been pushed until 1:30...' And so I had no childcare plan, nobody to pick up my kid from school. But nobody bothered to call and tell me. I cannot imagine a single mother who used public transportation to get there and was planning on getting out of the hospital as uncomfortable as they were going to be. They had to pick up their child at school that day, even though they were in pain and still medicated…and the system did not care about that.” – Key Informant

Dental Health

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

Diabetes

“...Then they get out, and they go back to their former way of eating. Nobody’s there to come in and give them their injections or check their blood sugars all the time.” – Focus Group Participant

Mental Health

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

“More people need IOP...[It’s a] place like university, where we learn skills we will use for the rest of our life.” – Sharp Focus Group on Mental Health

“[My organization] is running nine virtual support meetings per week, led by volunteers... There’s an in-person support group meeting at Morley Field, people come out even in the rain. Support groups are still vibrant.” – Sharp Focus Group on Mental Health

“I'm not sure we've made the transition from a medical model to a recovery model... [right now] there is a mindset that it’s medication. Recovery is not medication. Recovery is, where is my support system? What other tools do I have? What am I doing for my own wellness?” – Sharp Focus Group on Mental Health

“I’m glad we’ve gone more towards zero seclusion and restraint. [I recently saw] a really beautiful situation at the psych hospital, this person was very agitated, I saw staff clear the room, circle her, let her go through what she wanted to do before they did anything, and that’s the kind of thing that’s neat to see happening. I want to see more of that. More compassion.” – Sharp Focus Group on Mental Health

“There’s a big need in the community for…mental health…moms that you can see having postpartum, almost breakdown, and looking to rehome their animals because they just can’t handle it all…I think people have kind of blown it off over the years as not being a real thing, or it’s just the “baby blues” or whatever, but it’s real for these moms, and they have a lot of trauma they carry with them post-delivery sometimes.” – Sharp Focus Group on Maternal Health

“One of the biggest needs is our mental health part, it’s such a problem right now...I don’t feel like we have enough resources...We typically don’t see a patient for postpartum until 6 to 8 weeks because we’re medical based…[it would] be really beneficial to have somebody who can check back with those patients not six weeks later, but when they’re in the midst of havoc in their home, they’re in pain, they’re exhausted, and everything is happening to them.” – Sharp Focus Group on Maternal Health

“What was surprising to me...was the high levels of anxiety...So [We are] seeing a lot of moms who are afraid to get in the car with baby. Refuse to leave them with anybody, have terrible intrusive thoughts of what might happen to them if they leave them alone. Germ-related concerns, fears of baby getting kidnapped, dying in their sleep, [thoughts] that are really disturbing and disruptive.” – Sharp Maternal Mental Health Key Informant

A Different Kind of Health Care Experience

Respect for Their Time

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

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

Timely Care

“People are frustrated that they have to wait two months to see a doctor when they have an immediate health concern.” – Field Interview Participant

"El tiempo de espera para una biopsia es de 6 meses o más!!" [Translation: The waiting time for a biopsy is 6 months or longer!] – Field Interview Participant

“[Staff were] making it known there was a limit on Medi-Cal [mental health] beds, so we had to wait days and days...before she could proceed to the next level...We’re less value because we’re Medi-Cal…it wasn’t a matter of urgency or need, it was a matter of money and insurance. For a person who’s tender, to hear ‘less valued,’ to overhear this, it was very frustrating.” – Sharp Focus Group on Mental Health

“Tried for over 1 year to get well women [appointment]. No dr. available.” – Sharp Insight Community Member

Better Options for Transportation

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

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

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

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

“The bus takes forever, and if you have multiple kids, it’s challenging. It’s also expensive.” – Focus Group Participant

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

Better Relationships with Care Providers

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

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

More Time with Health Care Providers

“The vast majority of doctors simply seem to be more concerned with churning through patients rather than the care and attention they give them. This has life-threatening consequences.” – Field Interview Participant

“Shorter visits make it harder for patients to get the information they need and ask the questions they have.” – Focus Group Participant

More Empathy

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

“It seems when it comes to psychiatrists and medical doctors, that there is a lack of compassion and lack of understanding that the patient has insight into what’s going on with them, what’s wrong, what they need help with.” – Sharp Focus Group on Mental Health

“I work with seniors. Almost every single person in our room has been hospitalized and traumatized by those stays. Members that have hip spasms from being forcefully injected with medication. People who have been secluded, restrained, assaulted. I hope it’s getting better, but anyone who’s been in the mental health system for more than a decade has experienced trauma in some of these places.” – Sharp Focus Group on Mental Health

Better Communication

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

“You learn so much about the intimate facts of your parents’ life that maybe you shouldn’t.” – Focus Group Participant

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

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

“Yeah, one thing worth noting…the translator was...like taking stuff out of the translation. And luckily, the parent caught that. That kind of messed up the dynamic between the therapist, the parent and the kid, as well as the translator, that they ended up just ending the meeting…So accountability within what's being translated.” – Focus Group Participant

“Who knows the right way to reach people, but even the pediatricians this morning were like, do we have TikTok? And actually we do. I know our marketing team gets out there and does some videos, but I don't think it's enough.” – Sharp Focus Group on Maternal Health

Better Explanations

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

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

Acknowledgement and Understanding of Racism and Discrimination

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

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

An Understanding of Cultural and Identity Differences

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

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

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

“To be more culturally appropriate when relaying a message or information.” – Field Interview Participant

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

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

“[After getting insurance]...I filled out some health history online and put in there that I was transgender. I had some case manager call and tell me about services that were offered for gender non-conforming people, which seemed cool. I eventually did [call the service number] but it kinda was the exact opposite of the original phone call…I went and tried to get help and there were problems all around...trying to find a therapist specifically [through my healthcare group] that was knowledgeable about gender theory is almost completely non-existent, at least through the website.” – Sharp Focus Group on Mental Health

“My PCP denied my request for gender affirming care due to me having manic depression, that doesn’t have any correlation to that...I found one time that someone wrote “transgendered” in my medical chart. That’s such a completely outdated, not even real term. I was just so taken aback at that, wow, the amount of knowledge around gender…is very little.” – Sharp Focus Group on Mental Health

“We get hit with a lot of homeless moms, a lot of immigrant moms, and they come here and have a lot of needs that, I don’t know if the hospital can provide. We can provide the medical aspect, but they come with a lot of other needs.” – Sharp Focus Group of Maternal Health

An Understanding of Power Dynamics

“One of our welcome desk staff gets misgendered all the time, and it has significantly impacted their mental health. It has impacted their mood. There's anger, there's frustration…And the power differential in that. There are people that think doctors and nurses are gods and have all the answers for everything and anything they say is right. And when that power differential is there and you're misgendered, your chart has the wrong pronouns, you are called the wrong pronouns in the room, it's hurtful. It's hurtful to your spirit. But I think that many providers don't understand the power differential that happens in that room. – Key Informant

“Stepping into the doctor’s office can be intimidating, especially for my clients of color who get in there and aren’t necessarily talked to as a person or respected.” – Focus Group Participant

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

“I can remember I had to go through IVF to have my daughter, and I walked into the office one time and there was a tech that had a gown, threw it on the table and said ‘Pants off, gown

open in the front,' and walked out and shut the door. And I was like, 'Are you serious?' And I'm a pretty privileged person. I was like, 'No, this is not how we treat people.' In that moment, I don't think that employee recognized the power differential." – Key Informant

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

Help Navigating Medical System, Insurance & Follow-up Care

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

"We had a large population of patients that were not accessing prenatal care in their first trimester. There was a big initiative to try to get that out there in the community, [to] get your prenatal care in time...There was apparently a perception that if they didn't have insurance in place, they couldn't get care. So, we worked really hard to make sure they understood that we could help them with the presumptive eligibility process so they could get the care. So with time, the word is definitely out there and we are seeing patients in really early. That is a big, big shift from when I first started in this area." – Sharp Focus Group on Maternal Health

Protection and Care for Service Providers

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

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

"I never seemed to have a PCP…for more than 4 or 5 months and when it would change, I wasn't alerted when there was a new one…I had Sharp for about two years; it was happening every four to five months. I had six different PCPs and with my mental health history, I had to go through that story again, with every single new PCP." – Sharp Focus Group on Mental Health

"Your medical care providers are too overbooked." – Sharp Insight Community Member

Recognition of and Assistance with Disabilities and Trauma

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

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

Compliance with ADA

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

Websites, Portals, Phone Systems

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

Assistance with Identification, Documentation, and Eligibility

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

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

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

“Doctors don't like filling out forms because…the models of insurance these days are, ‘Doctors, you've got 15 minutes with your patient. You've got to get into that next exam room to see the next patient’ and under the cap model, and for that doctor or that medical group to make their

ends meet, they have to see 40 patients a day or whatever that specific quota is, but it's not small…And so I think a lot of doctors look down upon the need to fill out these forms, even though there have been some statutory changes that allow doctors to bill for it under Medi-Cal. I just don't think that doctors are taking the opportunity to do that. It becomes a real big barrier." – Focus Group Participant

Understanding Trauma

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

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

"What a doctor or nurse may perceive as a normal childbirth, the mom may be experiencing as traumatic for various reasons...Maybe she has a history of trauma herself, and it's brought up fear in her, or the fear she's having during the process, her experience of the physician, or the pain and being afraid of the pain, or being scared that baby's not going to be healthy." – Sharp Maternal Mental Health Key Informant

More Help with Crises

Flooding

"One of the main things…we knew was going to be an issue is the fact that if you had water a foot under your ceiling, all of your medication has been washed away, all of your medical equipment has been washed away. We are still dispersing hospital beds to folks, wheelchairs, canes, walkers…We are replacing all of the blood pressure cuffs and the glucometers, the things that are daily medications that you need to take and daily health screenings that you need to be able to provide yourself. Of course, the storage to store insulin and all these things have also gone out the window. When I was in a room with probably about 150 flood survivors, and I knew people had become sick, but I thought it was like, 'Oh, one out of five, one out of three.' When I asked the question, 'How many people had either been hospitalized, had to go to urgent care for flu-like symptoms, or currently have a cough?' When I tell you 97% of the room raised their hand, it was so scary to me to know that all these people have experienced some type of breathing abnormality or sickness related to this flood that's just gone unaddressed." – Key Informant

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

Tijuana Riverbed Sewage Crisis

"El olor del sur está horrible." [Translation: the odor from the South is horrible] – Field Interview Participant

"El olor es insoportable y podemos enfermar." [Translation: the smell is unbearable, and we can get sick] – Field Interview Participant

Better Data Collection, Sharing, and Coordination

Better Data Collection in Crises

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

Better Data Sharing between Hospitals and FQHCs

“For one patient with a complicated congestive heart disease, it took three weeks to get charting notes from the ED.” – Focus Group Participant

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

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

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

“[We] partner with our other NICUs as well to share information, to share education, to share best practices, to make sure everybody through our educators and our clinical nurse specialists are doing consistently the same care. So that when we have a patient transfer…we're giving them consistent information…our physicians from the NICU work at all of our satellite hospitals.” – Sharp Focus Group on Maternal Health

Better Data Sharing between Medical, Educational, and Social Services

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

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

Less Burden on Emergency Departments

What Brings Community Members to the EDs

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

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

“It's an interesting conundrum in that sometimes they'll only get enough [medication] to literally just lower their blood pressure enough to get out of the ED but not given anything for continued safety. And then sometimes they are given the prescription, but…then they don't have the support that they need or maybe a connection to an ambulatory withdrawal [program]. There's a disconnect between those two services…And so then people leave and they're drinking and taking the medication from the ED which is obviously concerning.” – Focus Group Participant

“Appointments with doctors are two or three months out, so people will go to the ED and the ED staff will tell them to go to the PCP, and when the patient can't do that because of the wait

time, they go back to the ED, and the ED staff will see the same patients and will feel irritated, and the community member feels dismissed." – Focus Group Participant

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

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

"What we find is that if you and I aren't feeling well, we may call our doctor, we'll try to figure out solutions and we may end up in the ED, but our first resort to getting our health care met isn't going to the ED. Whereas, our participants or individuals on the street, that's the first access point for them, is going to the EDs and trying to get those basic health care needs met. And in some cases, the primary reason that they need treatment for doesn't really get addressed, especially if somebody has chemical dependency or substance issues. And there is the assumption, and in some cases that could be true, the assumption that unhoused individuals seek the ED to access bed and meal. Therefore, the level of care, medical care they should receive is overshadowed by that." – Key Informant

Community Suggestions

Support for Patients

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

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

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

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

“A separate available support to call to get help with referrals, getting needs met.” – Focus Group Participant

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

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

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

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

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

“Probably the biggest burden we see on these moms is childcare. Even in seeking out treatment...giving permission basically to say, yeah, you’re a new mom. Yes, you have a new baby who needs you, and it’s okay for you to take a couple hours for yourself to go see a therapist...If we had the ability in our program, I would love to be able to have a childcare provider...to take care of baby while mom sought treatment.” – Sharp Focus Group on Maternal Health

“...one of the issues that a lot of our patients have is that they have other children at home that are not really ready for school…They don’t have anybody to take care of their kids, and they don’t come because they don’t have that.” – Sharp Focus Group on Mental Health

“We probably need to look more into virtual visits, especially if you’re talking about follow up, because a lot of this stuff could be done in a virtual visit...It’s going be more convenient for a provider to be able to do so, probably do it more quickly and then you would also mitigate the issue with the travel and the children at home.” – Sharp Focus Group on Mental Health

“We had done some research on the front end with some out of state programs that were large, and seeing a lot of success. And one of the things they said was the virtual aspect of it…has been really integral for our population. [They] found that really skyrocketed their availability and access to patients. So our program is virtual two days out of those three.” – Sharp Maternal Mental Health Key Informant

“The in-person piece is so valuable because that’s where the moms are really finding connection. They like being online and obviously they just love the support of having other moms that are experiencing the same thing. It really helps to keep the shame at bay and the stigma at bay, but actually being in the same room with them and their crying babies and their crawling babies makes them feel connected. And we’ve seen some lovely moments of, baby’s crying and mom’s trying to speak. And another mom, her baby is sleeping. So she’ll take the other one and hold them for a minute so mom can share in the group. That kind of camaraderie and non-judgment of, I’m having a hard time doing both right now, and being able to say, yeah, I get it, girl. Let me see baby for a second, I’ll hold her for you. So that kind of community, I think, is really important.” – Sharp Maternal Mental Health Key Informant

“...If a patient doesn’t use [at-home medical] devices, and [Community Health Workers] find that the patient hasn’t weighed themselves or taken their blood pressure, they can reach out to the patient and say, ’hey, we see that you haven’t logged in today, just wondering if you’re okay.’ And so every day we find more and more ways that we can use these community health workers.” – Sharp Key Informant

“We’re also trying to take our diabetes and hypertension population that receives social worker behavioral health services and show that they have better outcomes because their behavioral health needs are being addressed, so they’re more able to take care of themselves...it’s exciting because, we all know from friends and family members that if they’re in a funk, they’re not going to take care of themselves, right?” – Sharp Key Informant

“Thankfully, a lot of OBs in the Sharp system are providing the Edinburgh scale, and Mary Birch is providing it regularly with their social work department when moms are either in their triage or have already delivered. So that’s a really early catch. I would say even during pregnancy, first meetings with your OB is at least a time to educate on it. Like, let us know if you start to experience any increased hopelessness or fears or sadness, or if you even have thoughts about this pregnancy that you’re uncomfortable with.” – Sharp Maternal Mental Health Key Informant

“And now we’ve learned that suicide prevention, like anybody should be having this conversation...like everywhere. It’s okay to say, are you having thoughts of harming yourself? I think the same is true with this population...It’s okay to talk about it and say something.” – Sharp Maternal Mental Health Key Informant

“Often, they will be seeing the pediatrician before they’re seeing the OB...They see the OB for follow up, but then they don’t see them again…we’re really trying to encourage [pediatricians]…are you checking on mom’s mental health in that first year or so?? How is baby? But how is mom? Even to provide a little screening tool, like they do with kids…how lovely to be able to give that to mom in the first year too.” – Sharp Maternal Mental Health Key Informant

“For the community aspect, [we need] support for the partners and the family members of these moms. We are trying to do as much family work as we can when it’s appropriate for our patients, but the partners are really wanting to help. They are needing the education. They

want to know how to help their partner in this moment. What's hurtful? What's helpful? How can they support? So I think, more programs that are out there for dads, and for any partner, including grandma, sister, best friend. But I think dads is an unserved population; the male population is underserved." – Sharp Maternal Mental Health Key Informant

Support for Health Care Workers

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

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

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

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

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

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

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

"[Community Health Workers] are exuberant and excited and they have been a huge support to our nursing case management and social work staff." – Sharp Key Informant

Discharge Enhancement

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

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

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

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

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

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

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

Systemic Efforts

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

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

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

Appendix

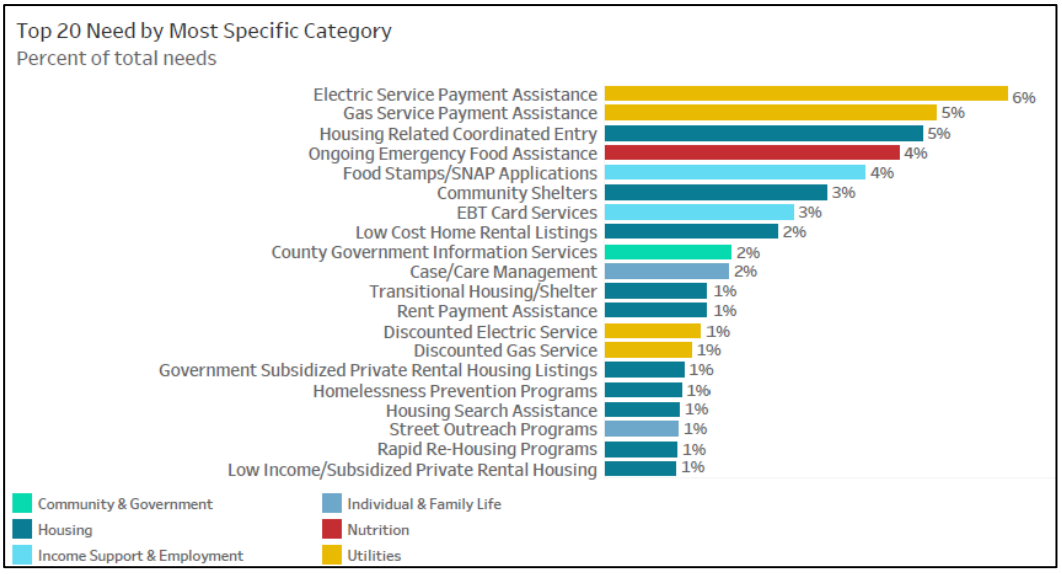
H San Diego County Resources & Assets to Meet Community Needs

San Diego's rich service ecosystem includes community-based organizations, government agencies, hospital and health systems, federally qualified health centers, and other community organizations that seek opportunities to collaborate to improve community health. This service ecosystem is engaged in addressing all of the health needs identified by this assessment.

Community Resources in San Diego County

2-1-1 San Diego is an important community resource and information hub. Through its 24/7 phone service and online database, it helps connect individuals with community, health, and disaster services. In recognition that available programs and services are continuously changing, we encourage community members to access the most available, current data through 2-1-1 San Diego. In addition to connecting individuals to community services over the phone, 2-1-1 San Diego also manages the Community Information Exchange (CIE). The CIE is a network comprised of more than 139 health, social, and government organizations coordinating care through a shared technology platform and data integration. As of January 2025, there are more than 350,000 San Diegans who have consented to share their information with CIE members.

The following graphic lists the top 20 needs organized by specific category and percentage of 2-1-1 clients in 2023[83]. Needs represent the reasons or descriptions of the type of help that was provided and are documented when clients receive referrals to community services. There were 545,082 total needs for this client population. For more information about the needs within each service category, contact 2-1-1 San Diego or visit http://www.211sandiego.org/.



Healthcare Facilities in San Diego County

The California Department of Health Care Access and Information (HCAI) is an excellent resource to find more detailed information on every health care facility licensed in California. The following data is available on their Healthcare Facility Attributes website: https://hcai.ca.gov/data-and-reports/healthcare-facility-attributes/.

Facility Profiles – Interactive map to find a summary profile of facility information, including license, service level, revenue, payer mix, length of stay, and building safety information. Use the map or search functions to find hospital, long-term care, clinical, home health, and hospice facilities.

Licensed Facility Information System (LFIS) – View facility license information of California hospitals, long-term care facilities, primary care and specialty clinics, home health agencies and hospices.

Licensed Healthcare Facility Listing – A list of California healthcare facilities licensed by California Department of Public Health, Licensing and Certification.

Licensed Facility Crosswalk – This dataset provides a simple crosswalk using Department of Health Care Access and Information (HCAI) assigned licensed facility identification numbers linked with matched California Department of Public Health (CDPH), Licensing and Certification facility lists based on license number. This is not a comprehensive matched list, facility identification numbers that did not match are also included from both the HCAI and CDPH lists. Facility Status or Facility Level designations may explain some HCAI non-matches, for additional information contact HCAI directly. Please contact CDPH directly for more information regarding un-matched facility identifiers that do not have corresponding HCAI identifiers.

Appendix

I SGH FY 2026 – FY 2029 Implementation Strategy Summary

Sharp has numerous support programs for patients and employees to help address the top community needs identified in the 2025 CHNA and will continue to examine them with a goal to expand and improve offerings. The following pages include, but are not limited to, strategies designed to address community needs identified through SGH's 2025 CHNA process, as follows:

Sharp Identified Area of Need	2025 CHNA Findings Addressed
Health Conditions	Help managing health conditions
Access to Healthcare	A different kind of healthcare experience; Better data collection, sharing and coordination; Less burden on emergency departments
Community Safety	Recognition and assistance for disabilities and trauma; Help with crises
Workforce	Protection and care for service providers

Needs Not Addressed

SGH recognizes that it cannot meet every health need identified in the community and will instead focus efforts on the areas where its expertise and resources allow for the greatest impact. While we acknowledge the importance of all identified needs, some—such as dental health—will not be directly addressed through current SGH initiatives due to existing limitations and the availability of other community resources.

A summary of the SGH FY 2026-2029 implementation strategy is included on the following page.

SGH FY 2026 – FY 2029 IMPLEMENTATION STRATEGY SUMMARY
HEALTH CONDITIONS
• Increase access to care for community members living with chronic lung diseases (e.g., asthma, COPD) • Promote health literacy among seniors and community members through various education and screening initiatives • Improve behavioral health outcomes for safety net patients through early assessment, intervention and resource provision • Promote early cancer detection and diagnosis for patients and community members; improve care navigation services for newly diagnosed patients • Provide diabetes and cardiovascular health education, screenings, and resources to community members through classes and community events • Provide prenatal and post-partum support and education to improve health outcomes for new mothers, newborns and families
ACCESS TO HEALTHCARE
▪ Continuation of multiple programs that offer financial support and enrollment assistance for patients needing guidance on available funding options ▪ Continue data sharing and collaboration with the 211 San Diego Community Information Exchange ▪ Ongoing assessment of homeless data to identify opportunities for community partnerships and interventions ▪ Explore and expand Sharp HealthCare integrated delivery system access to post-acute recuperative care services ▪ Offer a Care Transitions Intervention program to help patients transition safely from hospital to home environment ▪ Collaborate with local organizations to assist patients who live in rural, eastern San Diego areas
COMMUNITY SAFETY
▪ Increase awareness of injury and violence prevention for patients and community members through education and outreach ▪ Implement human trafficking and trauma-informed care trainings and protocols at Sharp ▪ Lead and/or participate in local and state disaster preparedness exercises in collaboration with public health agencies and other health care partners
WORKFORCE
• Increase regional awareness and collaboration between regional health care providers, law enforcement and community leaders regarding violence against health care workers (e.g., participation in San Diego Hospital Violence Task Force) • Collaborate with local schools to provide opportunities for students to explore and train for a variety of health care professions

For complete details on the progress of programs developed by SGH in response to the 2025 CHNA findings, please refer to the SGH FY 2026 – FY 2029 Implementation Strategy on Sharp.com.

References

[1] See Section 9007(a) of the Patient Protection and Affordable Care Act (Affordable Care Act), Pub. L. No. 111-148, 124 Stat.119, enacted March 23, 2010. Notice 2011-52.
[2] Formerly named Office of Statewide Health Planning and Development (OSHPD).
[3] Sharp HealthCare (Sharp) fiscal year 2024, Epic via Looker (internal data warehouse)
[4] From the County of San Diego Demographics report: "*This indicator provides number and percentage of persons with a disability (one or more). Disability is a dynamic concept that changes over time as one's health improves or declines, as technology advances, and as social structures adapt. Measuring this complex concept of disability with a short set of six questions is difficult. Overall, the American Community Survey (ACS) attempts to capture six aspects of disability, which can be used together to create an overall disability measure, or independently to identify populations with specific disability*."
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[67] San Diego has the most expensive energy prices in the country. See: https://www.bls.gov/regions/midwest/data/averageenergyprices_selectedareas_table.htm
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could have been avoided with proper primary or urgent care. The algorithm is widely used in healthcare policy and research to assess ED utilization and improve healthcare delivery.
More details available upon request.

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