*Live Well San Diego*

# Community Health Improvement Plan and Regional Community Enrichment Plans

# 2019-2021

COUNTY OF SAN DIEGO
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This publication of the *Live Well San Diego Community Health Improvement Plan* utilizes data from 2014 through 2018 and is the culmination of activities undertaken when implementing the *Live Well San Diego Community Health Improvement Plan, FY 2014-18.*

This document was developed under the General Management System of the County of San Diego.

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# MESSAGE FROM AGENCY DIRECTOR

**Nick Macchione**
**Agency Director, Health and Human Services Agency**

Dear San Diegans:

On behalf of the County of San Diego, Health and Human Services Agency (HHSA), we are pleased to publish this *Live Well San Diego* Community Health Improvement Plan (CHIP) 2019-21, comprised of Community Enrichment Plans (CEPs), for each of the HHSA service regions. These new CEPs reflect the priorities of each of the *Live Well San Diego* regional Community Leadership Teams.

The Community Leadership Teams, among the many community partners, add to and help elevate the "voice" of the community and are increasingly driving the action on the ground to make the communities within the regional boundaries healthy, safe, and thriving. The CHIP lays out what the regional CEP priorities are for the next three years, and how these Community Leadership Teams will continue to bring partners together to make a difference in the community.

*Live Well San Diego* is an innovative collective impact strategy adopted by the San Diego County Board of Supervisors to help all residents be healthy, safe, and thriving. These plans show the regional growth of *Live Well San Diego* through the priorities and efforts on the ground that cut across all three components of the vision—Building Better Health, Living Safely, and Thriving to address the social determinants of health and reduce in equities in the region. These plans are reflections of the leadership and dedication of our communities to the lives of our fellow San Diegans.

The publishing of this document was delayed in part due to the COVID-19 pandemic that has been the focus for the County of San Diego and region. County staff, community leaders, and partner agencies across every sector are working tirelessly during this challenging time. Now, more than ever, community planning has to be responsive and adaptive to changing conditions and new demands. As such, these regional these regional CEPs will continue to be "living" documents that evolve to reflect future strategies within each region to create safe, healthy, and thriving communities.

I want to thank all of you for your work and effort, especially during this trying time, to helping make a difference for San Diego communities.

Live Well,

Nick Macchione, M.S., M.P.H., F.A.C.H.E.
Agency Director, Health and Human Services Agency


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# FORWARD

Dear San Diego County Residents:

The County of San Diego Health and Human Services Agency (HHSA) strives to create a healthy, safe, and thriving community for its diverse residents. This Community Health Improvement Plan (CHIP) 2019-21, comprised of Regional Community Enrichment Plans (CEPs), represents the second full planning cycle undertaken by this County to set goals and objectives for community action. These CEPs help guide efforts on the ground to provide opportunity for all residents to live well. The CEP goals and objectives are driven by *Live Well San Diego* Regional Community Leadership Teams (Leadership Teams), with these Leadership Teams focusing on the needs and priorities unique to their respective HHSA regions.

Since *Live Well San Diego* is a collective impact effort, each of the Leadership Teams leverages the resources and expertise of its partners, including PHS staff, other County departments, and other partners across every sector. This is consistent with another important condition of collective impact—mutually reinforcing activities. Public Health Services staff, in addition to supporting the development of the CEPs, provide grants and technical assistance services, to help communities make policy, systems, and environmental changes. Other County departments, such as Behavioral Health Services and Aging & Independence Services, also lend expertise and help promote healthy aging, offer resources to address substance abuse and mental health challenges, and link residents to services.

The CHIP explains the community planning process with attention to health equity, describes the important role that the Leadership Teams play in driving action on the ground, captures how collective impact is to be measured, and describes the foundational infrastructure that supports success. The priorities of the Regional CEPs are summarized as well as their alignment to other key national, State, and local plans. Each of the CEPs are presented in their entirety as sections within this document. The "Basis for Action," part of each CEP, tells the story of why the Leadership Team has chosen certain improvement objectives, and how these objectives are informed by the evidence or research to have an impact in the longer term.

It is important to note up front that COVID-19 pandemic, which is a public health threat unlike any we have seen in our lifetime, contributed to a delay in publishing this document and a shift in focus of the *Live Well San Diego* regional Community Leadership Teams. The collective efforts of all of our partners is being harnessed in the response to the pandemic. As a result, we can anticipate that these CEPs will be adapted or adjusted over time to reflect the new circumstances that we face together as a county.

Thank you for working together to improve the quality of life for San Diego residents.

Sincerely,

Wilma J. Wooten, M.D.

WILMA J. WOOTEN, M.D., M.P.H.
Director and Public Health Officer
Public Health Services

**Wilma J. Wooten**
**Director and Public Health Officer, Public Health Services**


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# EXECUTIVE SUMMARY



This *Live Well San Diego* Community Health Improvement Plan (CHIP) for San Diego County is comprised of five plans (referred to as Community Enrichment Plans), one for each of the five HHSA Regions (although there are six HHSA Regions, North Inland and Coastal Regions have a combined team and plan). The vision of *Live Well San Diego* guides virtually all the work of San Diego County government. This vision is increasingly embraced by partners across every sector, including almost 500 recognized partners, to help make lives healthy, safe, and thriving.

**Methodology**

The methodology followed to build the *Live Well San Diego* CHIP and the Regional CEPs reflects a collective impact approach. The Regional CEPs, upon which the Countywide CHIP is built, represent the planned activities to advance the shared vision of *Live Well San Diego* at the local level, which is one of the conditions of collective impact. Consistent with another important condition of collective impact, these plans reflect an approach tailored to the needs and priorities of individual communities from the perspective of the Leadership Teams.

The methodology that guides the community planning process is called Mobilizing for Action through Planning and Partnerships (MAPP). It is a widely accepted community planning process which is used by many nationally accredited public health departments, including the County of San Diego. The MAPP process is rigorous and comprehensive and is well suited to capturing the expanding *Live Well San Diego* collective impact effort. *Live Well San Diego* engages County government and partners across every sector in efforts to improve communities that goes well beyond traditional health, encompassing all the factors that contribute to "living well." The multi-stepped and very inclusive MAPP process helps to ensure the quality of the CEPs that roll up to the Countywide CHIP.

Details about the MAPP process and findings from the various assessments that are conducted as part of MAPP are described, including the migration from a five-year to three-year planning cycle. How the steps undertaken through MAPP also align with national public health accreditation requirements is explained. The County has paid special attention to health equity and disproportionality in its community planning activities and through other County initiatives. The nature of this focus, and how integral it is to the *Live Well San Diego* vision, is described.

**Building the Regional Community Enrichment Plans**

This section describes how these Regional CEPs were developed. The Leadership Teams, within each of the Regions, defined the content of these CEPs. There are five *Live Well San Diego* Regional Community Leadership Teams, one for each of the six HHSA regions (North Coastal and North Inland Regions have one combined team). These Leadership Teams serve as the "voice" of the community, as they are comprised of community leaders from every sector who meet regularly, often monthly, to discuss community concerns, network, and consider appropriate actions. There is an emphasis on leveraging the efforts of community-based agencies and partners with the Leadership Team setting the general direction for collaborative action.

# EXECUTIVE SUMMARY

The Regional CEPs, developed by the respective Leadership Teams, represent what these leaders have prioritized to advance *Live Well San Diego* at the local level. These CEPs represent not only what local leaders agree is important, based on such factors as data, community input, and political will, but also reflects what they believe are their unique strengths to use in collaboration with partners.

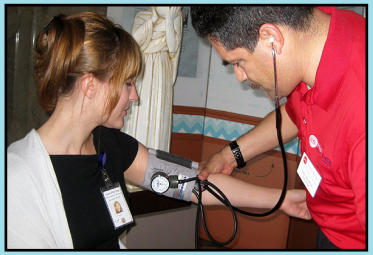
Regional Leadership Teams are drawing from the achievements during the first MAPP planning cycle and building upon these earlier successes. Rates of chronic diseases are trending downward in all regions, reflecting longer-term benefits of partners working together in collective effort. Integration of the results of the various assessments that are part of the MAPP process has contributed to an expanded focus of promoting health by addressing the social determinants. Coordination with the Hospital Association of San Diego and Imperial Counties (HASDIC) helped toward greater information sharing and efficiencies in collecting input from community leaders to frame the CEPs. A framework was created, with technical assistance from the Public Health Services team, that aligns closely with *Live Well San Diego* framework, yet provides opportunity for each Leadership Team to "own" their plan because it reflects their respective priorities and goals for community change and transformation.

These CEPs reflect growth or maturation since the first MAPP Cycle, from which the Regions and their Leadership Teams were successful stewards of numerous community-based projects that span a wide range of topics and innovative approaches. Many efforts reflect community outreach and education campaigns, fairs, special events; while others involve the development of resources and new ways to connect residents to resources. Other efforts are perhaps more challenging in that they involve making policy, systems and environmental (PSE) changes.

**Capturing Collective Impact**

The concrete actions captured in the CEPs are what the Leadership Teams believe will have the greatest impact to benefit their respective communities. This section explains how research or evidence is used to inform the objectives and actions that the Leadership Teams choose to take, as reflected in their respective CEPs. The "Basis for Action" is an appendix within each CEP that tells the story of why the Leadership Team selected each priority; what is the evidence of a problem; what the research says is the impact on health and well-being; and finally, what are evidence-informed practices for addressing this problem. This appendix in each CEP "tells the story" of what each Leadership Team is aspiring to do, and the changes they are seeking on behalf of their respective communities and the well-being of the residents.

Capturing collective impact is important for communicating with partners and for motivating action. This is being done through the use of *Live Well San Diego* Indicators that track to what degree residents are "living well." The Top 10 *Live Well San Diego* Indicators, and some supporting indicators, are used to mark progress. An additional dashboard of Indicators was created, consistent with requirements of nationally accredited public health departments. This dashboard, called the Public Health Services Dashboard, captures 10 indicators that are more closely connected to the programs of Public Health Services, with some overlap with the *Live Well San Diego* Indicators. PHS will use this dashboard to monitor the long-term impact of many public health programs and responsibilities. While each of the CEPs will be tracked in terms of performance metrics to assess short-term progress toward implementing every objective, Indicators are used to monitor long-term impact.

# EXECUTIVE SUMMARY

**Foundational Infrastructure that Supports Collective Impact**

The vision of *Live Well San Diego* emerged first, and has had such traction in large part due to the foundational infrastructure that the County of San Diego provides. One of the conditions of collective impact efforts is "backbone" support. This refers to having a team or organization dedicated to orchestrating the work of the collective initiative. The County of San Diego provides this "backbone" support to *Live Well San Diego*. Innovation and integration at both the County and Agency level contribute to strong prospects for success in a collective impact effort.

Aspects of the County enterprise that make it uniquely suited for assuming this role as "backbone" to the *Live Well San Diego* vision are described. In addition, the history of integration and innovation across HHSA are described. Public Health Services, which achieved national public health accreditation in May 2016, continues to focus on operational excellence not only to maintain accreditation status but to continue to grow as a model department. The *Live Well San Diego* vision also continues to reach a broader audience, internally and externally, with numerous "signature" events and initiatives that have captured the imagination and participation of hundreds of partners.

**Summary of Priorities for Action in Regional Community Enrichment Plans**

The evolution of community planning in the Regions from the first MAPP cycle to this second MAPP cycle is described. The new CEPs reflects the breadth in priorities adopted, evidence that all of the Leadership Teams recognize that it is through the social determinants of health that progress is best achieved. These priorities go well beyond what would fall under the Building Better Health component of *Live Well San Diego*. These priorities also cut across the Living Safely component and the Thriving component. This is not only responsive to the community data, information and survey feedback gathered through the MAPP assessments, it reflects what each Leadership Teams finds to be compelling. These leaders recognize that to "live well" means addressing the social determinants of health. It reinforces what leaders have always known, that socio-economic status and related factors affect everything else, without which the full potential of residents and the success of communities in which they live will not be fully realized.

**Alignment to Other Plans to Leverage Efforts**

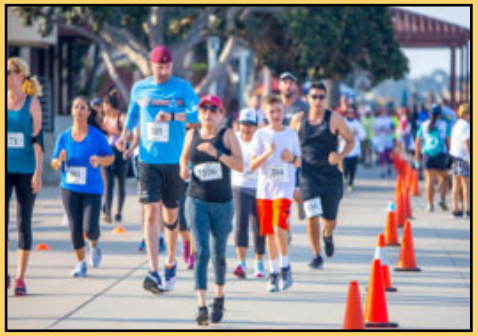
The CEPs were also aligned to other plans in order to best leverage efforts at levels of government and within the County of San Diego. They include federal and State plans, *Live Well San Diego*, and other PHS plans.

# INTRODUCTION

The purpose of this *Live Well San Diego* Community Health Improvement Plan (CHIP) 2019-21 for San Diego County is to set forth the priorities and path to help all residents live well. The CHIP is a planning document, required of all accredited public health departments, that follows the Mobilizing for Action through Planning and Partnerships (MAPP)* model for local community health planning. San Diego's planning process is robust for several reasons. The County is organized into six Health and Human Services regions with five regional Community Leadership Teams (one for each of the six HHSA regions—North Coastal and North Inland regions have one combined team). The Leadership Teams represent the "voice of the community" for each of the six regions, contributing to plans that are tailored to local needs. San Diego County adopted in 2010 a broad collective impact initiative, embracing partners across every region and sector, called *Live Well San Diego. Live Well San Diego* provides the framework and cohesiveness in efforts across San Diego county which is critical to achieving long-term impact. This CHIP captures the action on the ground to advance the vision across San Diego's diverse communities.

This CHIP is structured in a unique way. First, the history and methodology of conducting community health planning across San Diego County are explained. Five individual community plans follow. Each individual plan, developed and approved by the respective Leadership Teams, includes priorities, goals, improvement objectives, and associated measures. These five plans, referred to as Community Enrichment Plans (CEPs), capture what each Leadership Team hopes to accomplish in order to improve the quality of life for residents of their region. The term "Enrichment" was adopted because each plan embraces more than traditional community health goals. Each CEP captures objectives to transform communities so that all residents can be healthy, safe and thrive. Each CEP also includes a "Basis for Action," which explains why each priority was adopted, the research that supports its adoption, and how the CEP goals align with what the research says will advance the long-term outcomes that the Leadership Team is seeking.

This CHIP is the product of the second full MAPP cycle conducted in San Diego County. It represents continuous progress in community planning since 2014, when the first CHIP was published. This CHIP gets closer to the vision and will of the Leadership Teams who drive action on the ground to advance the *Live Well San Diego* vision. These Leadership Teams are encouraging action that is increasingly coordinated, leveraging what each partner in the community does best. Progress is being tracked—both in terms of the implementation of objectives, as well as short- and long-term impact of efforts collectively, through community- and population-level indicators. This disciplined approach will help the Leadership Teams and everyone involved in this collective impact effort learn from their own experience and from each other. Ultimately, each Leadership Team, just as all partners of *Live Well San Diego*, will become increasingly effective in advancing the shared vision by creating communities where every resident can be



*Mobilizing for Action through Planning and Partnership (MAPP), developed by the National Association of County and City Health Officials (NACCHO), is a community planning modelwidely used by many nationally accredited public health departments. See the Methodology Section for more information.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# METHODOLOGY


**Alignment to *Live Well San Diego* as a Collective Impact Effort**

The vision of *Live Well San Diego* guides virtually all the work of San Diego County government. This vision is also increasingly embraced by partners across every sector, including almost 500 recognized partners. *Live Well San Diego* represents all five conditions of collective impact: a shared vision or agenda for change, shared methods and goals for measuring progress, continuous communication across multiple channels, mutually reinforcing activities, as well as the fifth element, the "backbone" support in the form of the County of San Diego enterprise (Figure 1, next page).

The Regional CEPs, developed by the respective Leadership Teams, represent the planned activities to advance *Live Well San Diego* at the local level. These CEPs represent not only what local leaders agree is important but also reflect what they believe they are uniquely positioned to do best in collaboration with partners. This is consistent with another important condition of collective impact—"mutually reinforcing activities," in which partners have different approaches but their actions are coordinated. The Leadership Teams are helping guide and execute activities that are undertaken across the County enterprise and its partners.

To help the Regional Leadership Teams build their CEPs, the *Live Well San Diego* framework in its entirety—down to the goals and objectives within each of the individual Building Better Health, Living Safely and Thriving Strategic Plans—was used to elicit ideas and promote alignment of effort. The *Live Well San Diego* framework was also used to package the individual CEPs, as is shown in each plan, and to reflect that there is consistency and alignment among all five CEPs.

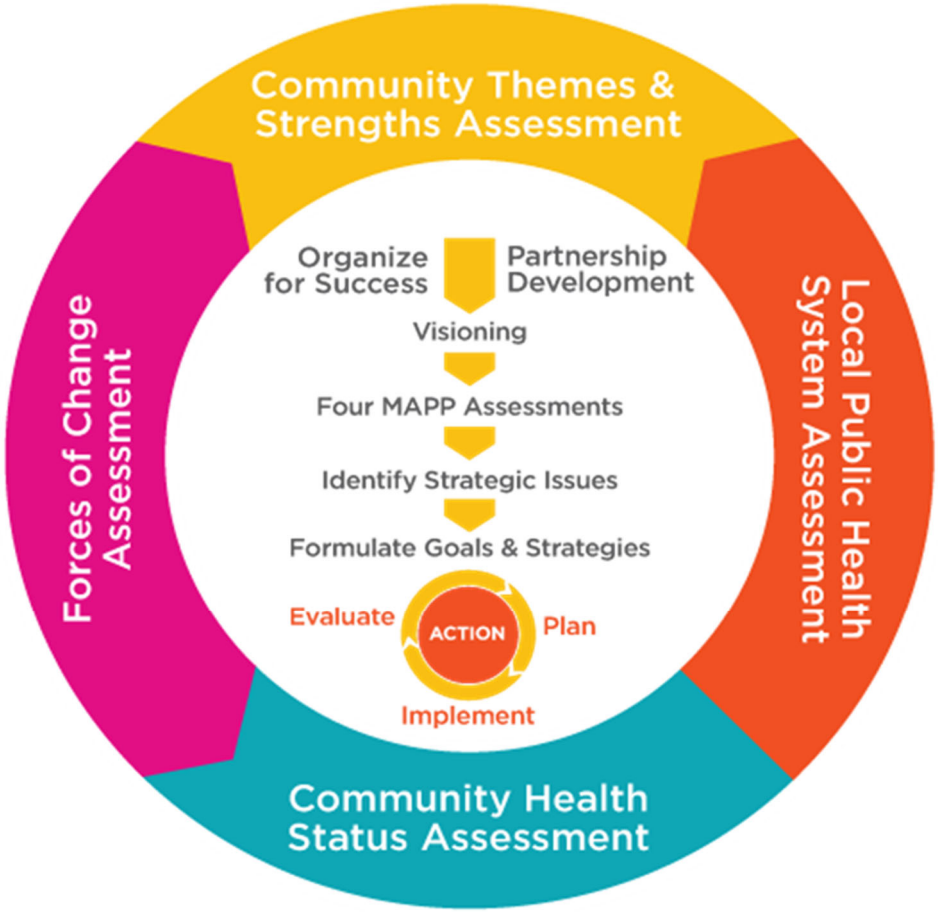
It should be noted that there were differences among regions in their planning processes, just as in their priorities. But this is the strength of a regional approach in a County as large and diverse as San Diego County. The planning process can be adapted to the uniqueness of each region and the preferences of the Leadership Team, including how each the Leadership Team organizes its meetings and structures the conversation. One example of this is a South Region pilot to adapt Malcolm Baldrige criteria for excellence to communities (referred to as Communities of Excellence 2026). A very deliberate and focused planning effort in South Region is reflected in their final CEP which is still structured around the *Live Well San Diego* framework.

# METHODOLOGY

**Figure 1. The Five Conditions of Collective Impact**


*Source: Collective Impact Forum based on 2011 Stanford Social Innovation Review article Collective Impact, written by John Kania, Managing Director at FSG, and Mark Kramer, Kennedy School at Harvard and Co-founder FSG.*

**Figure 2. MAPP Diagram**

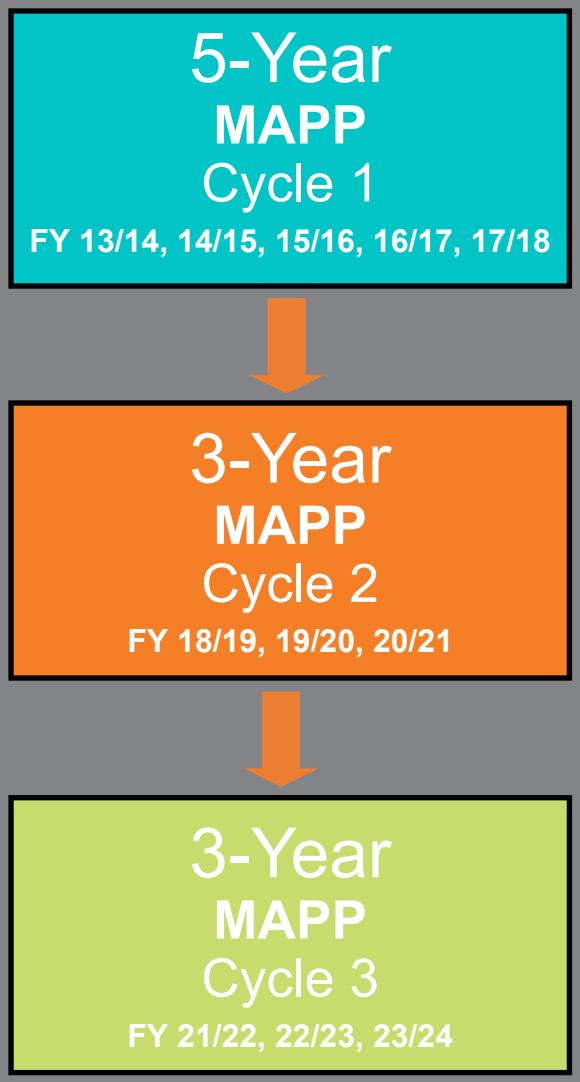



*Source: National Association of County & City Health Officials (NACCHO). Mobilizing for Action through Planning and Partnerships (MAPP). https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment/mapp. Accessed May 30, 2018.*

**Adherence to Mobilizing for Action through Planning and Partnerships (MAPP) Model**

The *Live Well San Diego* CHIP, and the Regional CEPs upon which the CHIP is built, were developed following a community planning model that is widely accepted and used by many nationally accredited public health departments, including San Diego County. Mobilizing for Action through Planning and Partnerships (MAPP) (Figure 2) was developed by the National Association of County and City Health Officials (NACCHO). This tool provides a systematic method for understanding forces of change, identifying strengths and weaknesses of the community as well as the public health system at-large, and engaging the community in a meaningful way to develop an improvement plan that includes strategies for action.

Figure 3. MAPP Cycle Change




The MAPP process is quite rigorous and comprehensive. It is well suited to capturing the expanding *Live Well San Diego* collective impact effort, which goes beyond traditional health to encompass all the factors that contribute to "living well." The MAPP planning process is composed of four different community assessments: 1) Community Themes and Strengths Assessment; 2) Local Public Health Systems Assessment; 3) Community Health Status Assessment; and 4) Forces of Change Assessment. The four Assessments do not have to be completed in a particular order, but each Assessment should contribute to identification of strategic issues and formulation of goals and strategies. The multi-stepped and very inclusive MAPP process helps to ensure the quality of San Diego County's CHIP and Regional CEPs.

The FY 2019-21 MAPP planning cycle led to several products. This includes the 2019-21 *Live Well San Diego* Community Health Assessment (CHA) (see this link: https://www.livewellsd.org/content/dam/livewell/community-action/2019-21-LWSD-Community-Health-Assessment.pdf.) The CHA provides a very comprehensive overview of health needs, trends, resources, and public health interventions occurring at the County and Regional level. There is also the report summarizing the findings of the Local Public Health System Assessment (LPHSA), published in 2018, that captures the findings of over 200 participants representing all different parts of the local public health system, not limited to the County public health department. Participants were asked to score the strength of the local public health system by each of the ten essential services at an event held in September 2016. And, ultimately, this document was produced, which includes the five Regional CEPs that roll up to this 2019-21 San Diego County Community Health Improvement Plan.

The first MAPP cycle for the County of San Diego, coordinated by Public Health Services (PHS), was for FY 2014-18, representing a five-year planning processing, with the LPHSA published in 2012, and the CHA and CHIP published in June 2014. Because community needs are changing rapidly, this second MAPP cycle, also coordinated by PHS, will be shorter, and follow a three-year cycle (Figure 3). This change was also prompted by collaboration with the Hospital Association of San Diego and Imperial Counties (HASDIC). Under the Community Benefits Program section of the Affordable Care Act, hospitals are required to perform their own community health status assessments and community planning process every three years. By aligning the County's cycle with the HASDIC cycle for this and future planning cycles, it is easier to share data, collaborate in conducting assessments, conduct countywide planning that reduces duplication and redundancy.

# METHODOLOGY

The rigor of the MAPP process is reflected in the Timeline below (Table 1). These steps capture the implementation of the previous FY 2014-18 MAPP cycle and the roll out of the FY 2019-21 MAPP cycle.

**Table 1. Timeline of MAPP Planning Cycle, CY 2014-2019.**

| Calendar Year | Timeline for MAPP Planning Cycle<br>County of San Diego |
|---|---|
| **2014** | FY 2014-18 Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) published. |
| **2015** | • Planning for second cycle of Mobilizing for Action through Planning and Partnerships (MAPP) begins. Community Health Status Assessment conducted:<br>◊ Community Health Statistics Unit delivers data presentations to Community Leadership Teams in every Region.<br>• Coordination with Hospital Association of San Diego and Imperial Counties (HASDIC) begins.<br>◊ HASDIC participates in data presentations to regions and provides input on survey of community leaders.<br>• Regions monitor progress of FY 2014-18 CHIPs ongoing. |
| **2016** | •Survey conducted of community leaders in each Region to assess:<br>◊ Forces of Change, and<br>◊ Community Themes and Strengths.<br>• Local Public Health System Assessment conducted (September 23).<br>• Regions monitor progress of FY 2014-18 CHIPs ongoing. |
| **2017** | •Begin identification of key priority areas for Community Enrichment Plans (CEPs).<br>•Regions monitor progress of FY 2014-18 CHIPs ongoing. |
| **2018** | • Regions continue to monitor progress of FY 2014-18 CHIPs.<br>• Meetings convened with Public Health Services (PHS) Branches in order to identify opportunities to coordinate CEPs and PHS Strategic Plan.<br>• *Live Well San Diego* Regional Results Summary published, featuring highlights from FY 2014-18 CHIP.<br>• Regions monitor progress of FY 2014-18 CHIPs ongoing. |
| **2019** | • Prepare new FY 2019-21 Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP), including regional CEPs.<br>• Regions monitor progress in implementing new FY 2019-21 CEPs.<br>• Publication of CHA and CHIP delayed until 2020 due to the COVID-19 pandemic response |

**Highlights from Community Health Assessment**

A Community Health Assessment (CHA) was conducted during this same 2019-21 MAPP cycle, and published at the same time as this CHIP. The CHA incorporates a vast amount of assessment data. The revelations from the CHA are reflected in the CEPs that were developed by the Leadership Teams. The full report, however, gives a complete picture of the important issues and trends impacting the health and well-being of San Diego County residents. The demographics of San Diego County reflect a diverse population of 3.3 million residents, with considerable variation in profiles between the different Regions.

A few highlights are shown in Table 2 below. There is positive news with chronic disease related deaths trending downward, however, more work is still needed to reduce risk behaviors that contribute to these diseases. While San Diego County performed well in terms of preventable hospitalizations, improvement is needed to reduce the rate of hospitalizations for certain chronic conditions like asthma and diabetes. Cancer and heart disease were the leading causes of death in San Diego County, no different than the nation as a whole. However, Alzheimer's disease deaths were more common in California, the County, and the HHSA regions than in the country overall. Where San Diego County does relatively well as compared to other jurisdictions in terms of infant mortality rates, however black infants were nearly 4 times as likely to die within their first year compared to white infants, reflecting a major health disparity concern.

**Table 2. Highlights of 2019-21 Community Health Assessment**

| Highlights by Area of Influence: | |
|---|---|
| HEALTH | **Health:** Some positive news for San Diego County is that the life expectancy of a baby born today was higher in San Diego County overall (82.0 years), and all HHSA regions, than the United States as a whole. However, when compared by race and ethnicity, not all residents had the same life expectancy. Black residents had the lowest life expectancy at 77.6 years. |
| KNOWLEDGE | **Knowledge:** There are mixed results in the assessment data related to knowledge and access to education. While the high school graduation rate in San Diego County (85.5%) was better than California, it is less than the overall rate in the United States (86.7%). There was considerable variation among Regions and by race and ethnicity, which is problematic given the importance of education to health and life success. Hispanics had the lowest percentage of adults 25 years and older with a high school diploma (only 65.6%). South Region had the lowest percentage of adults 25 years and older with a high school diploma (only 77.1%). |
| STANDARD OF LIVING | **Standard of Living:** San Diego County enjoys a relatively low unemployment rate, although there was considerable variation among Regions, with South, East and Central experiencing higher unemployment rates. Even though employment looked strong, one in seven San Diego County residents lived below the poverty level, and nearly one in three people lived below 200% of the poverty level. The high cost of housing impacts residents' standard of living, with many residents spending a significant portion of their income on housing. |
| COMMUNITY | **Community:** There are several areas of concern when examining the community indicators in San Diego County**.** The use of public transportation was significantly lower in San Diego County compared to California and the United States as a whole. A 2017 Climate Change Assessment reflects the major concerns for San Diego County were Wildfire, Heat, and Vector and that action is needed to protect and prepare residents. A very comprehensive report from the American Lung Association State of Tobacco Control gave San Diego County low marks in a national report—grades ranging from B to F—with the exception of a few cities in San Diego County that received higher grades specifically for their actions to create smoke-free outdoor air in public places. |
| SOCIAL | **Social:** Many residents—nearly one in three—volunteered, reflecting a strong spirit of community across the County. Voter participation in the Presidential General election also appeared to be increasing. However, the data revealed other areas of concern in terms of the social strength of the community and the welfare of vulnerable populations include food insecurity, linguistic isolation, and lack of health insurance. |

The full document is located at https://www.livewellsd.org/content/dam/livewell/community-action/2019-21-LWSD-Community-Health-Assessment.pdf.

**Consistent with Requirements for Accredited Public Health Departments**

By following the MAPP process, the County is adhering to Public Health Accreditation Board (PHAB) standards in the development of its comprehensive CHIP with individual CEPs by each Leadership Team. Table 3 illustrates how elements of the CHIP align with requirements for community planning of accredited public health departments. The Reaccreditation Measures, associated requirements and guidance, are cited along with information as to how the Countywide CHIP and Regional CEPs align.

**Table 3. Alignment with Community Planning Requirements for Accredited Public Health Departments**

| Reaccreditation Measure | Requirements | Guidance | Alignment to County-Wide CHIP and Regional CEPs |
|---|---|---|---|
| **Measure 5.2:** The health department encourages and participates in community collaborative implementation of the community health improvement plan and participates in its revision as community public health priorities are addressed and revised. | 1. The implementation of the community health improvement plan is tracked and the plan is revised, as needed. | a. Description of how the members of the community partnership share responsibility to implement and update the plan. Include how implementation responsibilities are assigned and how partners are accountable. | Each of the five Regional Leadership Teams is comprised of community members and stakeholders who are accountable for implementing the Regional CEP goals. Most of the Regional Leadership Teams have work groups for each of their CEP priorities that meet regularly, often as part of ongoing regional *Live Well San Diego* meetings, to discuss strategies and progress in the implementation of CEP goals, including who is responsible for which actions.<br><br>A work plan for the CEP is maintained by the regional community engagement staff in coordination with the Leadership Teams, in particular the work groups. Performance data are also entered into a performance management system, which is administered by the Public Health Services (PHS). |

| Reaccreditation Measure | Requirements | Guidance | Alignment to County-Wide CHIP and Regional CEPs |
|---|---|---|---|
| | | b. A description of the community process to track implementation of the plan. | The Regional Leadership Teams utilize a work plan to track implementation of their CEP. The work plans are updated during regular work group meetings and ongoing by regional community engagement team staff.<br><br>PHS also supports Leadership Teams in tracking implementation of their plan by administering a performance management system that includes the CEP priorities, goals, strategies, objectives, metrics, and activities. This system was transitioned from one application to another in the fall of FY 2019-20, which meant that in FY 2018-19 there was greater reliance on work plans maintained by the regional community engagement staff until the new system was fully implemented.<br><br>How the CEP objectives align or advance community well-being, as reflected in high-level Indicators, appears in Appendix IV, "Basis for Action" in each of the CEPs. The Basis for Action tells the story of why a priority is important; why the Leadership Team has chosen certain improvement objectives; and distills some of the data, research, and evidence that supports the plan of action reflected in the CEP. The Indicator data is maintained by the Community Health Statistics Unit, within PHS. |
| | | c. A description of the community process for reassessing and revising community priorities. Include how new or additional information or data that have been incorporated into the community health assessment are considered in the priority process. | The Community Health Statistics Unit within PHS provides annual presentations to each of the regional Leadership Teams which include an overview of key demographics and health trends, with data on the social determinants of health and by health equity lens. These data are also part of the new 2019-21 Community Health Assessment.<br><br>At least once each MAPP cycle, community leaders in each Region are surveyed and the results of these survey provide important qualitative data regarding community priorities for the Forces of Change Assessment, and Community Themes and Strengths Assessment, both components of the MAPP model. Leadership Teams in each Region then develop priorities, goals, and objectives over a series of meetings through an iterative planning process. |

| Reaccreditation Measure | Requirements | Guidance | Alignment to County-Wide CHIP and Regional CEPs |
|---|---|---|---|
| | | d. A description of the community partner process for updating the plan. | This 2019-21 Countywide CHIP and Regional CEPs represent the second cycle of MAPP for the County of San Diego. The previous CHIP covered 2014-18, a five-year cycle, whereas this cycle will be for a shorter, three-year period.<br><br>Adhering to the MAPP planning model, each Regional Leadership Team gathers community input through the various elements: survey data for the Forces of Change Assessment, and Community Themes and Strengths Assessment; as well as input from community partners who participate in the Local Public Health System Assessment.<br><br>Monthly Leadership Team meetings, which in most regions also involve work groups to focus on specific priorities, are the most important part of this process. It is at these meetings where the community partners actively engage in developing and updating the CEPs. It is an iterative process and reflects the dynamics of the community and the passion of the partners.<br><br>At these monthly Leadership Teams meetings, networking opportunities are offered so partners learn about each other and what each brings to the table. Presentations are delivered on key issues of concern or resources of value. This, in turn, informs the development of priorities and actions reflected in the CEPs. |
| | 2. Community Health Improvement Plan | a. Community priorities for action. | Each Leadership Team in the regions selects priorities for their CEP that capture what partners are most passionate about and see value in working together to address. Data, community interest, and political will are also factors at play in identifying priorities. Alignment to *Live Well San Diego* framework is important to these Leadership Teams who see themselves as part of this collective impact effort.<br><br>These priorities are identified by region in Tables 8 and 9 in the section called "Summary of Priorities for Action in Regional Community Enrichment Plans." The breadth of priorities covered across all regions as well as the uniqueness in individual priorities for each Region are displayed. |

| Reaccreditation Measure | Requirements | Guidance | Alignment to County-Wide CHIP and Regional CEPs |
|---|---|---|---|
| | | b. Desired measurable outcomes or indicators of health improvement and priorities for action. | The Regional CEPs are aligned to the Top 10 *Live Well San Diego* Indicators which are divided under five Areas of Influence that are essential for overall well-being: Health, Knowledge, Standard of Living, Community and Social. The Indicators capture the collective impact of programs, services, and interventions provided by government and community partners over the long term. Appropriately, these same Indicators are used to track long-term impacts of the Regional CEPs.<br><br>Each Regional CEP has a customized *Live Well San Diego* Dashboard where the data are presented by Region and Subregional Areas so that each Leadership Team can see trends within their respective communities. Additionally, a new PHS Dashboard has been created to track ten population health indicators as this is an expectation of accredited public health departments to help the Public Health Accreditation Board develop an inventory to begin assessing impact of accredited public health departments. These Indicators are also relevant to some activities within the CEPs. The "Basis for Action" Appendix in each CEP tells the story of why a priority is important and why the leadership Team has chosen certain improvement objectives. The Basis for Action ties together the short-term improvement objectives with the long-term Indicators. |
| | | c. Consideration of social determinants of health, causes of higher health risks and poorer health outcomes, and health inequities. | At its core, the *Live Well San Diego* vision is addressing the social determinants of health, recognizing that some communities struggle to achieve outcomes for living well. These communities bear a disproportionate burden of significant health issues, are more affected by crime, and are less engaged in civic activities. There are serious health inequities among residents, which is one of the fundamental ideals behind this collective impact effort. These concepts are more fully described in the section below "Attention to Health Equity and Disproportionality."<br><br>Every Leadership Team has developed a CEP that examines and attempts to address these inequities. The CEPs that emerged demonstrate alignment to *Live Well San Diego,* and the priorities reflect attention to the social determinants of health, along with root causes of higher health risks and poorer health outcomes. "The Basis for Action" section in each CEP cites data and research that supports interventions to address these root causes. Not only are priorities identified that are associated with building better health, but also with living safely and thriving, which capture the social determinants of health in the broadest sense. |

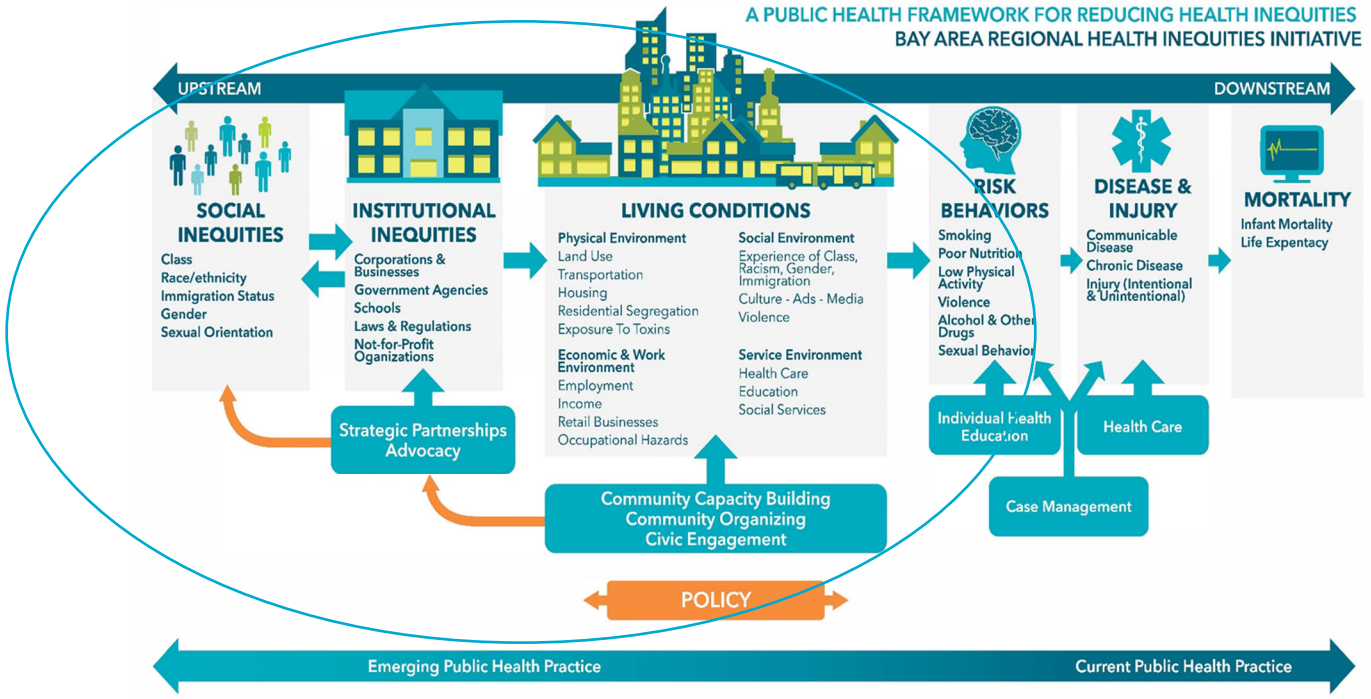
| Reaccreditation Measure | Requirements | Guidance | Alignment to County-Wide CHIP and Regional CEPs |
|---|---|---|---|
| | | d. Plans for policy and system level changes for the alleviation of identified causes of health inequity. Policy changes may address social and economic conditions that influence health and health equity including, for example, housing, transportation, education, job availability, neighborhood safety, and zoning. | A number of policy, system, and environmental (PSE) changes are reflected in the CEPs for each Region.<br><br>For example, Central Region Leadership Team, through its CEP, is supporting civic engagement activities with decisionmakers and municipal staff to help create a healthy food system. East Region Leadership Team is working toward addressing the needs of its older adult residents to create a more age-friendly community, including enhancing transportation options. North Central Region CEP includes several improvement objectives to increase neighborhood safety through environmental change, such as physical infrastructure enhancements including crosswalks and murals outside of schools. The North County Regions Leadership Team is working to reduce illegal access to substances and alcohol, and also to reduce crime and gang activity through PSE changes. South Region's Leadership Team is working on city policy and ordinance changes to promote smoke- and vape-free environments, and this is reflected in its CEP.<br><br>Resident Leadership Academies (RLAs) are important to this work. RLAs are a *Live Well San Diego* innovation in which community members are trained in community organizing so that they can take on leadership roles and become agents of change for healthier and safer communities. These changes are typically PSE changes to improve conditions in communities to promote the health and well-being of residents. In the CEPs, there is language calling for increasing the number of RLA graduates to provide local leadership and advocacy to improve the quality of life in the region, and for the implementation of improvement projects within the community. |
| | | e. Designation of the individuals and organizations that have accepted responsibility for implementing strategies. | Each Leadership Team includes individuals who represent a wide array of partner organizations. Each CEP includes an appendix which lists these organizations by sector—businesses, schools, cities and governments, community and faith-based organizations. *Live Well San Diego* embraces four Strategic Approaches: Building a Better Service Delivery System, Supporting Positive Choices, Pursuing Policy and Environmental Changes, and Improving the Culture from Within. These shared approaches are fundamental to *Live Well San Diego*. and are shared across all CEPs.<br><br>More detail as to leads and activities to advance each of the goals, improvement strategies, and associated strategies is contained in work plans that are maintained by the Leadership Teams and the HHSA staff who provide staff support to these Teams. |

**Attention to Health Equity and Disproportionality**

*Live Well San Diego* encompasses a focus on health equity and disproportionality in several ways. Health in San Diego County is viewed through the five health equity lenses of age, gender, geography, race/ethnicity, and socio-economic status. Where possible, all data are presented using these five lenses to better inform community planning. The social determinants of health have a significant impact on an individual's health, wellness, and quality of life. Looking at health through a health equity lens helps inform healthcare and other service providers as well as community leaders across all sectors of the challenges that certain groups face because of these differences.

The growing recognition that health inequities are the result of several deep-seated factors, including social inequities, institutional inequities and living conditions, depicted in the Bay Area Regional Health Inequities Initiative (BARHII) (Figure 4). Whereas the Regional community priorities in the first cycle of MAPP were mostly aligned to the Building Better Health component of *Live Well San Diego*, in particular those risky behaviors and conditions related to chronic diseases, this second cycle of MAPP has produced more priorities and goals that address living conditions and thereby are distributed across all the components—Building Better Health, Living Safely, and Thriving. The CEPs that emerged demonstrate how the Leadership Teams and community stakeholders in each of the regions are fully embracing the *Live Well San Diego* vision.

**Figure 4. Bay Area Regional Health Inequities Initiative Framework**




*Source: Bay Area Regional Health Equities Initiative, a coalition of the San Francisco Bay Area's public health departments, http://barhii.org/*

# METHODOLOGY

As progress towards achieving the *Live Well San Diego* vision was measured through the five health equity lenses, it became clear that certain communities were struggling to achieve outcomes for "living well." These communities bear a disproportionate burden of significant health issues, are more affected by crime, and are less engaged in civic activities. This analysis led to the County of San Diego Chief Administrative Officer (CAO) charging all County departments to make disproportionality a priority in 2016. In that same year, each County department shared best practices for addressing disproportionality and efforts to help certain groups adversely affected by barriers to being healthy, safe and thriving.

**"The goal of *Live Well* Communities is to address long-standing inequities in these geographic areas by focusing on key interventions to engage the community, strengthen existing services, and improve results."**

An initiative called *Live Well* Communities was started to focus on historically underserved areas of the County -- beginning in the communities of Southeastern San Diego, as well as nearby Lemon Grove, Spring Valley, and National City (Figure 5). The goal of *Live Well* Communities is to address long-standing inequities in these geographic areas by focusing on key interventions to engage the community, strengthen existing services, and improve results.

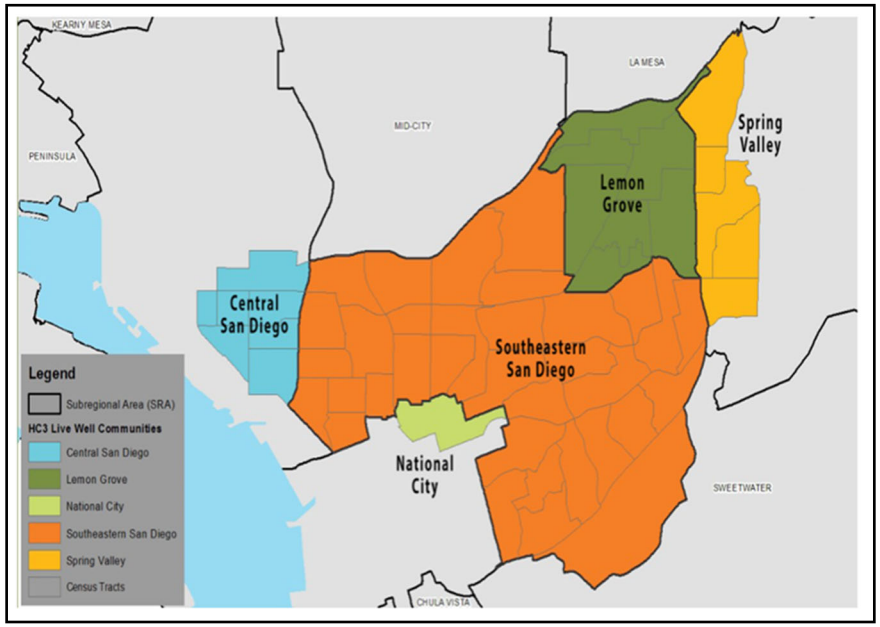
*Live Well* Communities have also influenced positive changes in policy that can be sustained for generations to come.

Elevating the topic of disparities and inequities within the space of child welfare and juvenile justice, the Clinton Health Matters Initiative (CHMI), the County of San Diego, and The San Diego Foundation partnered to improve the health and wellness of children and families who are served by San Diego County's child welfare and juvenile justice systems. CHMI and its partners formed the "Strong Families, Thriving Communities" coalition and developed the Bold Action Steps to address the social determinants of health for San Diego's children and families – including access to education, transportation, behavioral health services, substance abuse treatment, nutrition and exercise, and community safety, among other services.

The County of San Diego Health and Human Services Agency (HHSA) and Department of Public Health Services (PHS) have for some time been active innovators in health equity by leading and undertaking several interventions since the early 2000s with federal, state and local funding. These interventions focus on policy, systems, and environmental (PSE) changes at the community level, which contributed to the implementation of *Live Well* Communities. These interventions direct resources to communities that are economically disadvantaged and underserved.

A few of these interventions are listed in Table 4 (following page).

**Figure 5. Map of *Live Well* Communities**




*Source: For more information about the Live Well Communities Initiative, see http://www.livewellsd.org.*

**Table 4. Summary of County of San Diego Health Equity Efforts**

| | Key Health Equity Activities |
|---|---|
| 2001-2008 | • Developed the Reduce and Eliminate Health Disparities with Information Initiative (REHDII) to document local gaps and create strategies addressing federal health priority areas (2001).<br>• Formed the PHS Chronic Disease and Health Equity Unit devoted to the promotion of wellness and prevention of illness, disability and premature death due to chronic diseases and health disparities (2004).<br>• Elevated health equity as a priority with messaging and analysis of 3-4-50 data (referring to three behaviors (poor diet, physical inactivity, and tobacco use) that contribute to four chronic diseases (cancer, heart disease and stroke, type 2 diabetes, and pulmonary diseases such as asthma) that cause over 50 percent of all deaths worldwide). The HHSA Director began an "All Hands-on Deck" visioning process to identify solutions to mitigate the increased rates of chronic disease, especially for the regions that were most adversely affected (2008). |
| 2010-2019 | • Adopted the *Live Well San Diego* vision for a region that is *Building Better Health*, *Living Safely*, and *Thriving* (2010).<br>• Participated in the Public Health Institute cohort of the California/Hawaii Public Health Leadership Institute annual state-wide health equity conference (2010-2012).<br>• Formed a PHS Health Equity Committee to thread health equity activities throughout the department's operations and services (2012).<br>• Disseminated a survey to assess HHSA's health equity organizational capacity and staff competencies, adapted from the Bay Area Regional Health Inequities Initiative (BARHII) Local Health Departments Organizational Self-Assessment (2012).<br>• Launched the PHS Health Equity initiative at the Annual All-Staff meeting with guest speaker, Dr. Tony Iton, The California Endowment, and an innovator in strategies to improve the health status of disadvantaged populations (2014).<br>• Provided health equity training through PolicyLink to HHSA staff (2015).<br>• Adopted the PHS Health Equity Strategic Plan and Policy Procedure to develop a formal approach and framework for health equity in the department (2015).<br>• Launched the PHS Workforce Development Plan (WFD) in 2015 and promoted WFD through training on health equity, Diversity and Inclusion (D & I), customer service, trauma informed care, mental health first aid, etc. (2015-present).<br>• Launched HHSA's effort on trauma-informed care and aligned to the county-wide customer service effort, called H.E.A.R.T. for Helpfulness, Expertise, Attentiveness, Respect and Timeliness (2015).<br>• Adopted the D & I Strategic Plan and created an annual calendar of D & I activities (2016).<br>• Adopted Disproportionality as a County CAO Initiative (2016).<br>• Conducted 11 "Health Equity in Action" workshops with technical assistance from the California Department of Public Health Office of Health Equity (2016).<br>• Co-authored an article in the Journal of Public Health Management and Practice: Health Equity and Accreditation (2017).<br>• Finalized Public Health 101 (3 parts), Climate Change 101, and Health Equity 101 trainings with a goal of having 90% of PHS staff trained (2017).<br>• Promoted Cultural Competency and Customer Service training with a goal of having 90% staff trained (2017).<br>• Developed sets of health equity knowledge, skills, abilities and behaviors (2017).<br>• Developed Branch Performance Dashboards with a focus on health equity metrics (2018).<br>• Promoted Mental Health First Aid training with a goal to have 75% of PHS staff trained (2018).<br>• Reissued the BARHII survey to assess PHS organizational capacity and staff competencies to address health equity (2018).<br>• Launched the Health Equity Tool to assess if programs and services address health equity practices (2019). |

# METHODOLOGY

In developing objectives for their CEPs, the Leadership Teams considered health equity and drew upon the innovative work in PHS and the County enterprise. One very innovative mechanism, which is now actively deployed across the County, is the Resident Leadership Academy (RLA). The RLA provides community residents with training in how to become change agents advocating for healthier communities. Since 2011, the County has funded 56 Academies with 719 graduates. Over 70 Community Improvement Projects have been undertaken as part of the curriculum.

An example at the community-level of implementing PSE changes to address health equity and social determinants of health is a project of the Bayside Community Center RLA in the North Central Region. The community efforts spanned over two years, where RLA participants conducted a walk audit in Linda Vista, discovering that residents were very concerned about a dangerous intersection near a middle school where cars were often speeding and accidents had occurred.

**"The RLA provides community residents with training in how to become change agents advocating for healthier communities. Since 2011, the County has funded 56 Academies with 719 graduates. Over 70 Community Improvement Projects have been undertaken as part of the curriculum."**

The RLA led community engagement efforts to plan, design and create the traffic-calming mural over a 2 ½ year period. Interactive visioning workshops were held with residents to determine the overall mural design along with input from local artists.

The project was approved by the City of San Diego Arts and Culture Commission, and was funded through a $1,500 grant awarded by the San Diego Association of Government's (SANDAG) Walk, Ride and Roll Program to fund the installation of the mural.

The Leadership Team in North Central Region provided support for the mural project. (Figure 6).

**Figure 6. Traffic Calming Mural**

# BUILDING THE REGIONAL COMMUNITY ENRICHMENT PLANS

**Regional Community Leadership Teams as the "Voice" of the Community**

Within the County, there are five *Live Well San Diego* regional Community Leadership Teams (Leadership Teams), one for each of the six HHSA regions (North Coastal and North Inland Regions have one combined team). See Figure 7, which is a map of the regions. The regions were originally formed when HHSA was created in 1997 in order for services to be better tailored to their needs and for the Agency to be more responsive to local voices and imperatives. Leadership Teams comprised of community members within each region were formed at about the time *Live Well San Diego* was launched in 2010, and became essential to the collective impact effort. These Leadership Teams tie together the collective efforts of community groups in each region and provide a central point for planning and organizing collaborative action. Each team is organized differently, but all share a common goal of furthering the *Live Well San Diego* vision.

In the years since the first CHIP, these Leadership Teams have flourished in their diverse membership and collaborative efforts. The Leadership Teams represent partners and community members embracing the *Live Well* vision to better serve their respective communities. Growing recognition of the importance of addressing the social determinants of health is reflected in the Leadership Teams incorporating the safety and thriving components of *Live Well San Diego* into their CEPs, in addition to the health component. Accordingly, the titles of the CHIPs were changed to CEPs, or from "health improvement" to "community enrichment," reflecting that the CEPs are taking the broadest approach to community well-being, consistent with *Live Well San Diego.*

**Figure 7. Map of HHSA Regions**


*Source: http://www.livewellsd.org/ see Section for "Community."*

Each Leadership Team, comprised of community leaders representing organizations across every sector, plays a vital role in driving action on the ground to advance *Live Well San Diego* by supporting and encouraging collaborative effort within the region and leveraging resources available throughout the county. Leadership Teams are supported by the HHSA Regional Director in each region. Additionally, engagement staff organize the meetings, provide support for all the activities, coordinate with partners, and help ensure that the plans and other requests of the Leadership Team are followed up on.

Leadership Teams meet regularly, often monthly, to network, discuss community concerns, and consider appropriate actions. It is important to know, however, that there are differences in how Leadership Teams are organized just as there are differences in priorities among regions. Some regions have designated work groups around key priorities. The meetings start with an opportunity for all members to come together and network, and then members break out into work groups to determine next steps and follow up on previous actions. For some regions, the work groups meet separately. North County is unique in that the work is done entirely as a group, without separate work groups, in order to leverage the efforts of community-based agencies and partners. South Region is participating in a pilot to adapt Malcolm Baldrige criteria for excellence to communities (referred to as Communities of Excellence 2026). This is a very deliberate and focused planning effort, which is also reflected in their final CEP. The CEP has fewer but broader issues which were identified through a very rigorous process in which community input was solicited. Additional regions, including North County regions, are looking to adopt this Communities of Excellence approach. In all cases, alignment to *Live Well San Diego* is maintained across all Regions and their CEPs.

The development of the CEPs within each region took place over several years through ongoing meetings of the respective Leadership Teams. The activities these Leadership Teams undertook follows, and the timeline for the MAPP planning cycle appears in Table 1 in the Methodology Section.

# BUILDING THE REGIONAL COMMUNITY ENRICHMENT PLANS

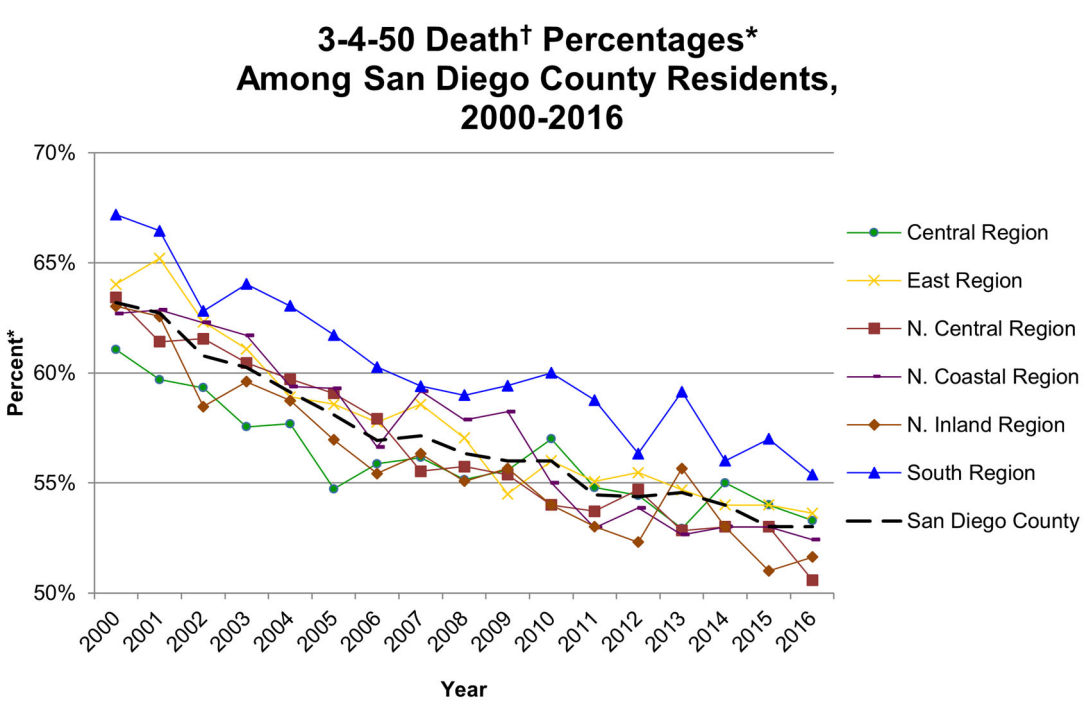
**Drawing from Achievements in the First Planning Cycle (FY 2014-18)**

In the first MAPP Cycle, the Regions and their Leadership Teams successfully implemented many community-based projects that span a wide range of topics and innovation approaches. Many efforts reflect community outreach and education campaigns, fairs, and special events; some efforts involve the development of resources and new ways to connect residents to resources; other efforts are perhaps more challenging in that they involve making policy, systems and environmental changes. These efforts are described in the *Live Well San Diego* Regional Results Summaries [http://www.livewellsd.org/content/livewell/home/about/materials.html]. These are just a few examples of projects the Regions, through their Leadership Teams, have implemented:

- Used "PhotoVoice" to improve neighborhood walkability and parks (Central Region)
- Created murals to calm traffic and build community places (North Central)
- Connected residents to resources through a "Let's Connect Expo" (South and Central)
- Convened and engaged residents in conversations to design the community's future (Central Region)
- Implemented joint-use agreements to allow for greater access to recreational fields (East Region)
- Promoted policy changes to prevent smoking (East Region)
- Supported health in schools through "Campus Community Connect" events and "Tools for Schools Toolkit" (North County)

While the impact goes beyond chronic disease prevention, for this first cycle of MAPP, "3-4-50" was an important way to show progress. "3-4-50" refers to three behaviors (poor diet, physical inactivity, and tobacco use) that contribute to four chronic diseases (cancer, heart disease and stroke, type 2 diabetes, and pulmonary diseases such as asthma) that cause over 50 percent of all deaths worldwide. Overall in San Diego County and within each Region, deaths due to chronic diseases are trending downward (Figure 8 and Table 5).

**Figure 8. 3-4-50 Death† Percentages* Among San Diego County Residents, 2000-2016.**




**3-4-50 deaths as a percentage of all causes of deaths.*
*†3-4-50 deaths include Stroke, Coronary Heart Diseases (CHD), Diabetes, COPD, Asthma, and Cancer.*
*Source: California Department of Public Health, 2000-2013 Death Statistical Master Files, 2014-2016 California Vital Records Business Intelligence System (VRBIS).*
*Prepared by: County of San Diego, Health and Human Services Agency, Public Health Services, Community Health Statistics Unit, 2018.*

**Table 5. 3-4-50 Death† Percentages* Among San Diego County Residents, 2000-2016.**

| Region | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Central Region | 61% | 60% | 59% | 58% | 58% | 55% | 56% | 56% | 55% | 56% | 57% | 55% | 54% | 53% | 55% | 54% | 53% |
| East Region | 64% | 65% | 62% | 61% | 59% | 59% | 58% | 59% | 57% | 54% | 56% | 55% | 55% | 55% | 54% | 54% | 54% |
| North Central Region | 63% | 61% | 62% | 60% | 60% | 59% | 58% | 56% | 56% | 55% | 54% | 54% | 55% | 53% | 53% | 53% | 51% |
| North Coastal Region | 63% | 63% | 62% | 62% | 59% | 59% | 57% | 59% | 58% | 58% | 55% | 53% | 54% | 53% | 53% | 53% | 52% |
| North Inland Region | 63% | 63% | 58% | 60% | 59% | 57% | 55% | 56% | 55% | 56% | 54% | 53% | 52% | 56% | 53% | 51% | 52% |
| South Region | 67% | 66% | 63% | 64% | 63% | 62% | 60% | 59% | 59% | 59% | 60% | 59% | 56% | 59% | 56% | 57% | 55% |
| San Diego County | 63% | 63% | 61% | 60% | 59% | 58% | 57% | 57% | 56% | 56% | 56% | 54% | 54% | 55% | 54% | 53% | 53% |

**3-4-50 deaths as a percentage of all cause of deaths.*
*†3-4-50 deaths include Stroke, Coronary Heart Diseases (CHD), Diabetes, COPD, Asthma, and Cancer.*
*Source: California Department of Public Health, 2000-2013 Death Statistical Master Files, 2014-2016 California Vital Records Business Intelligence System (VRBIS).*
*Prepared by: County of San Diego, Health and Human Services Agency, Public Health Services, Community Health Statistics Unit, 2018.*

# BUILDING THE REGIONAL COMMUNITY ENRICHMENT PLANS

**Integration of MAPP Assessments into Planning Process**

As early as 2015, each Region began the second cycle of planning (2019-21) using the Mobilizing for Action through Planning and Partnerships (MAPP) model to select and prioritize Regional issues while also identifying resources to address them. This process also included a partnership with the Hospital Association of San Diego and Imperial Counties (see next page). The Community Health Status Assessment was the first step taken in this MAPP process. PHS staff from the Community Health Statistics Unit prepared and provided extensive data presentations to each of the Regional Leadership Teams. These presentations, broken down by regional and subregional areas wherever possible, included relevant health, safety, and well-being trends. Data on demographics, chronic disease, communicable disease, maternal and child health, behavioral health, and Alzheimer's disease was presented. Data for all the social determinants of health were incorporated into these presentations, and whenever feasible, data were presented through a health equity lens—age, gender, geography, race/ethnicity, and socio-economic status.

Based on these presentations, the Leadership Teams began reassessing trends to determine which issues should be addressed for this MAPP cycle and what would align to the *Live Well San Diego* components of Building Better Health, Living Safely, and Thriving.

Annual updates were delivered to the Leadership Teams as they reconsidered and refreshed their priorities.

Because the MAPP process also calls for input from the community regarding Forces of Changes, and Community Themes and Strengths, a survey was designed and sent to Leadership Team members in each region, as well as additional partners active in regional work. The survey was designed to identify a diverse set of issues and concerns beyond traditional health concerns and reflecting the social determinants of health. While there is always some variation by region, all regions saw economic stability as a force of change, along with other health and social forces. Every region also rated mental health issues, along with alcohol and drug use, among the top five health problems for which there are the least amount of resources. Other health issues identified were obesity, asthma, diabetes, cancer and heart disease. These perspectives are later reflected in the priorities selected by each region for their CEP.

**"All five Regional Leadership Teams ranked mental health in their top five most important health problems. Every Region also rated mental health issues, along with alcohol and drug use, among the top five health problems for which there are the least amount of resources to address. Other health issues identified were obesity, asthma, diabetes, cancer and heart disease."**

A Local Public Health System Assessment, also a MAPP element, was conducted in September 2016. Over 200 participants from every sector provided input on the strength of the public health system, including all public, private, and voluntary entities that contribute to the delivery of the ten essential public health services. The good news is that scores increased for all but one essential service compared to the previous LPHSA conducted in 2012. Half of the ten services scoring at the highest category—Optimal Activity. The 2016 LPHSA also identified many opportunities for improvement and these are detailed in the final report County of San Diego Local Public Health System Assessment, published in June, 2018. Importantly, the area which showed the greatest improvement was Essential Service 4, "Mobilizing Community Partnerships." Arguably the engagement of community members through the Leadership Teams in each region have contributed to these gains.

The complete Community Health Assessment (CHA) of 2019-21, another MAPP element, captures a wealth of data produced by the Community Health Statistics Unit of Public Health Services. This document was published at the same time as the CHIP (December 2020). The data, trends and observations within the CHA helped to inform the Regional CEPs and thereby helps to explain some of the decisions made regarding priorities and goals. Highlights from this report are provided in Table 2 in the Methodology section. The full report, which is a rich compilation of data and information, is to be published shortly after this CHIP document.

# BUILDING THE REGIONAL COMMUNITY ENRICHMENT PLANS

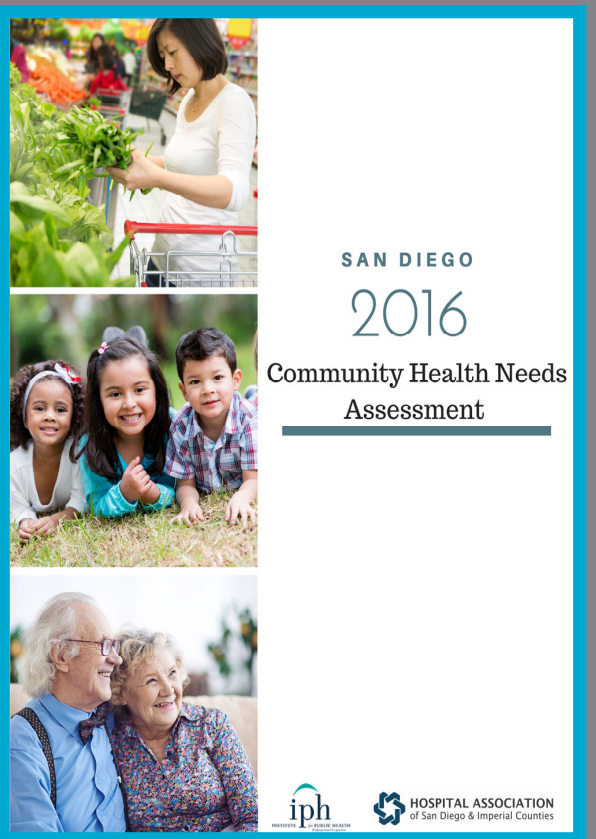
**Coordinating with the Hospital Association of San Diego and Imperial Counties (HASDIC)**

One significant difference from the last MAPP cycle is the change from a five-year cycle to a three-year cycle. This change was driven not only by the need to stay relevant given rapid changes in the environment, but also to facilitate better coordination with the hospitals and the association that represents them, HASDIC. Under the Community Benefits Program section of the Affordable Care Act, hospitals are required to perform their own Community Health Needs Assessments (CHNA) every three years. The purpose of aligning the County's CHA cycle with the HASDIC cycle was to better coordinate data sharing and collaborate in conducting the CHA to reduce duplication.

**The alignment of cycles supported three key goals:**

1. **Improved ability to share information between local hospitals and the County from shared assessments,**
2. **Reducing the burden on communities and organization who are involved in both assessment processes, and**
3. **Increasing the opportunity for partnership and collaboration between local hospitals and the County.**

HHSA and HASDIC are working together bi-directionally in conducting the CHA and the Community Health Needs Assessment (CHNA). For example, when HHSA developed the survey to capture community perceptions of priority health challenges and needed resources, HASDIC staff reviewed the survey and offered input and questions. In this way the results were useful for both assessments and the findings were incorporated into the CHNA report. More recently, HASDIC sought out input from the public health workforce to gather similar information about health concerns and priorities to inform its latest CHNA. Both the 2016 and 2019 HASDIC assessments can be found at https://hasdic.org/chna-assessment/. Table 1 provides a timeline of MAPP planning events that includes coordination with HASDIC.




**The Hospital Association of San Diego and Imperial Counties (HASDIC) 2016 Community Health Needs Assessment for San Diego.**

# BUILDING THE REGIONAL COMMUNITY ENRICHMENT PLANS

**Structure Created to Develop and Capture the Community Enrichment Plans**

Following the data presentations and survey analysis, the Leadership Teams in each region began formulating priorities, goals, and objectives during regular meetings. Throughout the process, attention was paid to ensuring alignment to the *Live Well San Diego* vision and the framework for each of its components (Building Better Health, Living Safely and Thriving), to help ensure that the priority areas and goals selected support the shared vision.

The formative strategies within each of the three *Live Well San Diego* components was shared with community engagement staff within each Region in working with their respective Leadership Teams to help elicit ideas for the CEPs. Through an iterative process over many meetings, the priorities, goals and objectives began to emerge.

Input from community leaders revealed that there was a new recognition from the bottom up, or local level, that addressing the social determinants of health was essential. This set the stage for the emergence of priorities and goals beyond traditional health concerns, to align with other components of the *Live Well San Diego* framework—Living Safely and Thriving.

The "Template for the Community Enrichment Plan" appears on the next page, followed by a "Key to the Community Enrichment Plan." The template shows how each CEP is structured and how CEPs are aligned to *Live Well San Diego*. The key explains all of the elements, the terminology and the icons used. Each of the CEPs is presented using this same template with the key appearing in the Appendix.

*Discussion Session on Essential Public Health Services 2: "Diagnose and Investigate" at Marina Village, San Diego County Local Public Health System Assessment, September 23, 2016.*

The content for the CEPs is displayed in order of: Priorities, Indicators, Goals, Improvement Objectives, and Metrics. Alignment is shown visually with the use of icons or colors. The Indicators align to *Live Well San Diego* Areas of Influence; Goals align to *Live Well San Diego* Components; and Improvement Objectives align to *Live Well San Diego* Strategic Approaches.

Although these Regional CEPs are aligned and structured uniformly, each CEP reflects the unique interests of the respective Leadership Teams and is distinct in terms of its focus, the specific steps identified to implement, and the metrics adopted.

# BUILDING THE REGIONAL COMMUNITY ENRICHMENT PLANS

## Template for the Community Enrichment Plan

**Priority:**

| 5 Areas of Influence | Top 10 *Live Well San Diego* Indicators<br>• Expanded Indicator<br>• *Supporting Indicator* | Public Health Services Indicators |
|---|---|---|
| HEALTH | Life Expectancy<br>Quality of Life<br>• Expanded Indicator<br>• *Supporting Indicator* | 3-4-50<br>ADRD Death Rate<br>Infant Mortality Rate<br>HIV Disease Diagnosis Estimates |
| KNOWLEDGE | Education<br>• Expanded Indicator<br>• *Supporting Indicator* | High School Education |
| STANDARD OF LIVING | Income—Spending Less than 1/3 of Income on Housing<br>Unemployment Rate<br>• Expanded Indicator<br>• *Supporting Indicator* | Unemployment Rate<br>Income Inequality<br>Poverty |
| COMMUNITY | Security—Crime Rate<br>Physical Environment (Air Quality)<br>Built Environment—Distance to Park<br>• Expanded Indicator<br>• *Supporting Indicator* | Childhood Lead in Schools |
| SOCIAL | Community Involvement—Volunteerism<br>Vulnerable Populations—Food Insecurity<br>• Expanded Indicator<br>• *Supporting Indicator* | Voting |

Template

**Goals Aligned to the Three Components of *Live Well San Diego* and Corresponding Icons and Color Bands**

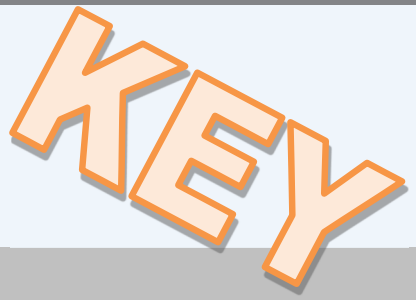
- Building Better Health — Goal X: X
- Living Safely — Goal X: X
- Thriving —Goal X: X

**Improvement Objectives and Metrics Aligned to the Four *Live Well San Diego* Strategic Approaches and Corresponding Icons**

| Strategic Approach | Improvement Objective and Metric |
|---|---|
| | X.X: Improvement Objective<br>◊ Metric |

# BUILDING THE REGIONAL COMMUNITY ENRICHMENT PLANS

## Key to the Community Enrichment Plan




This section explains the terms and elements that are being used in the CHIP and CEPs. Careful attention was made to ensure that clear alignment to the *Live Well San Diego* vision was achieved, while also adhering to standard planning terminology.

### Priority

The issue that was selected by the Leadership Team to address, based on a review of community health assessment and other data and the knowledge and passion of members in the Leadership Team.

### Five Areas of Influence

These are the dimensions that capture overall well-being: Health, Knowledge, Standard of Living, Community, and Social. The Areas of Influence reflect that good health goes beyond physical well-being to include the social determinants of health.

| Five Areas of Influence and the Corresponding Icons and Definitions | | | | |
|---|---|---|---|---|
| HEALTH | KNOWLEDGE | STANDARD OF LIVING | COMMUNITY | SOCIAL |
| Enjoying good health and expecting to live a full life | Learning throughout the lifespan | Having enough resources for a quality life | Living in a clean and safe neighborhood | Helping each other to live well |

# BUILDING THE REGIONAL COMMUNITY ENRICHMENT PLANS

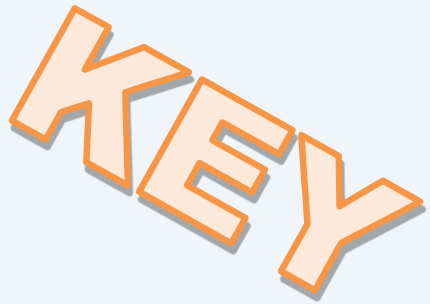
## Top 10 *Live Well San Diego* Indicators

Indicators are intended to capture the collective impact of programs, services, and interventions over the long term. The Top 10 *Live Well San Diego* Indicators define what it means to "live well" in San Diego. For each CEP Priority, the appropriate *Live Well San Diego* Indicators are identified in bold with the appropriate icon. "Expanded" Indicators, which are indented in bold, may be identified which are part of the *Live Well San Diego* framework and further describe each Top 10 indicator. This may also include a "Supporting" Indicator which is not part of the Top 10 but is viewed as an additional population measure that reflects progress in the medium- to long-range time span to achieving that priority. These are identified in italics.

**Due to space constraints, only those Indicators, Expanded Indicators, and Supporting Indicators that appear in the individual CEPs are presented in the Key.**

**For more information about the Indicators, see Link.**

**Top 10 *Live Well San Diego* Indicators**
- **Expanded Indicator**
- *Supporting Indicator*




**Life Expectancy** **Quality of Life**
- *Population with Suicidal Ideation*
- *Household Fresh Vegetable Use*
- *Routine Care*
- *Access to Affordable Fruits/Vegetables*
- *Childhood Obesity*
- *Child Dental Visits*
- *Seniors Walking for Transportation, Fun, or Exercise*
- *High School E-Cigarette Use*

**Education**
- *Chronic Absenteeism*

**Income-Spending Less than 1/3 of Household Income on Housing** **Unemployment Rate**
- **Percentage of Population with a Checking or Savings Account**

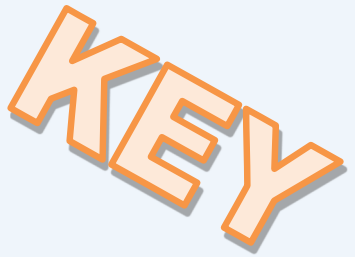
**Security-Crime Rate** **Physical Environment (Air Quality)** **Built Environment-Distance to Park**
- **Travel Time to Work Over 60 Minutes**
- *Probation Youth*
- *Risk of Recidivation*
- *Residents Experiencing Psychological Distress*
- *Active Transport to School*
- *Rate of ED Discharges for Opioid Disorders*
- *Fall Injury Hospitalization Rates*
- *Disaster Vulnerable Residents*

**Community Involvement-Volunteerism** **Vulnerable Populations-Food Insecurity**
- **Volunteerism**
- **Food Insecurity**

# BUILDING THE REGIONAL COMMUNITY ENRICHMENT PLANS

## Public Health Services Indicators

To maintain national public health accreditation, a dashboard has been developed to capture indicators that are most relevant to interventions in which Public Health Services plays a key role —this dashboard is referred to as the Public Health Services Dashboard. These indicators are part of a national database submitted to the Public Health Accreditation Board to show the significance and impact of maintaining public health accreditation that results in meeting targets for population health outcomes.




| Public Health Services Indicators | Description |
|---|---|
| **3-4-50 Percent** | Percent of deaths due to the four chronic diseases (cancer, heart disease and stroke, type 2 diabetes, and pulmonary diseases such as asthma). |
| **ADRD Death Rate** | Alzheimer's Disease and Related Dementias (ADRD) death rate per 100,000 population. |
| **Childhood Lead in Schools** | The number of cases from the San Diego Childhood Lead Poisoning Prevention Program. |
| **High School Education** | Overall Graduation Rate: The percentage of those over the age of 25 with a high school diploma or equivalent. |
| **HIV Disease Diagnosis Estimates** | HIV disease diagnosis case counts and percentages. |
| **Income Inequality** | Number of Total Earned Income Tax Credits. |
| **Infant Mortality Rate** | Three-year average Infant Mortality Rate per 1,000 live births. |
| **Poverty** | Percent of the population below poverty level. |
| **Unemployment Rate** | Percent of the total labor force that is unemployed (actively seeking employment and willing to work). |
| **Voting** | Percent of the population who voted in a Federal/State/Local election in the last 12 months. |

## Goal

A goal is an aspiration or broad statement of what the Leadership Team wants to achieve in the longer term (more than three years).

## *Live Well San Diego* Component

There are three major components to *Live Well San Diego*. Each Priority and Goal is aligned to one of these components—Building Better Health, Living Safely, and Thriving. The CEP goals show alignment to the *Live Well San Diego* components by including the respective icon and color (see below).

| Building Better Health | Living Safely | Thriving |
|---|---|---|

# BUILDING THE REGIONAL COMMUNITY ENRICHMENT PLANS

## Strategic Approach

The *Live Well San Diego* vision is achieved through four strategies, referred to as Strategic Approaches. These are *Building a Better Service Delivery System*, *Supporting Positive Choices*, *Pursuing Policy and Environmental Changes*, and *Improving the Culture from Within*. These Strategic Approaches are used as the strategies for the CEPs, which are how the Leadership Team will go about achieving the goal. The icons and definitions for the Strategic Approaches are listed below.

KEY

| *Live Well San Diego* Strategic Approaches | | | |
|---|---|---|---|
| **Building a Better Service Delivery System** | **Supporting Positive Choices** | **Pursuing Policy and Environmental Changes** | **Improving the Culture from Within** |
|  |  |  |  |
| Improving the quality and efficiency of County government and its partners in the delivery of services to residents, contributing to better outcomes for clients and results for communities. | Providing information and resources to inspire county residents to take action and responsibility for their health, safety, and well-being. | Creating environments and adopting policies that make it easier for everyone to live well, and encouraging individuals to get involved in improving their communities. | Increasing understanding among County employees and providers about what it means to live well and the role that all employees play in helping residents live well. |

## Improvement Objective

The Improvement Objective is the change or improvement that the Leadership Team seeks or hopes to accomplish in the shorter term (one to three years). The Improvement Objective reflects actions that the Leadership Team has decided to take and is supported by the research, evidence, or best practice to contribute to advancement of the goal and ultimately community change. For each Improvement Objective, the Strategic Approach is indicated with the corresponding icon in the CEP to indicate alignment.

## Metric

The metric indicates the target and how progress will be measured for each improvement objective.

**Actions Driven by Local Priorities and Local Capacities**

Leadership Teams in the regions are vitally important, particularly since they represent the "voice" of the community. They are very reliant on the strength of the partnerships they build, the existing resources and assets they can leverage, and their alignment with the *Live Well San Diego* collective impact effort.

Each CEP includes the priorities and goals that each Leadership Team aspires to achieve. The concrete actions are what the Leadership Team members believe are the ways they can make the greatest contribution to improving the health of their community. The objectives chosen by each Leadership Team are advanced by other community partners through mutually reinforcing activities, as is consistent with *Live Well San Diego*, a collective impact initiative.

These objectives adopted by the Leadership Teams are typically about mobilizing the community through outreach and education; connecting residents to resources; helping residents advocate for change; and facilitating policy, systems and environmental changes. These approaches reflect the unique capacity of individual Leadership Teams to foster and facilitate change.

Importantly, these new Regional CEPs reflect a wide scope of community priorities that go beyond the "downstream" health conditions and include the "upstream" social determinants of health, such as crime and violence, housing, education, and employment. This is consistent with the Bay Area Regional Health Inequities Initiative (BARHII), described earlier (see Figure 4) by seeking to address the living conditions among other upstream contributors to health inequities.

*North County Communities Leadership Team was formed in January 2012 to help guide planning for health, safety and thriving priorities in the Region and to foster information sharing and connectivity among group members.*

**Connecting Action to Impact**

Because there is a significant gap between the objectives that appear in each of the regional CEPs and the ultimate impacts in terms of community change that are being sought, evidence-informed strategies are critical to bridging this gap. This is why the "Basis for Action" is provided for each Regional CEP to connect action to impact. This tells the story of why the priorities that each Leadership Team selected make sense in terms of what the data show, and what the research says about how health and well-being is affected by this issue or concern. Importantly, evidence-informed practices are identified from the research, which help to explain the goals and objectives that each Leadership Team adopted.

The Basis for Action provides information that helps to show how the Leadership Team is being responsive to the unique needs of their regions and is adopting scalable, evidence-informed objectives. However, it is a simplified way of providing the rationale for action and does not substitute for capturing the whole story. A lot of factors and information influence the final CEP, including the varying experiences and perspectives of those who serve on a Leadership Team, events or crises that occur within or that impact communities within the Region, among many other factors. The Basis for Action serves to distill some of the data, research and evidence that supports the plan of action reflected in the CEP.

Why is it important to include the Basis for Action? The literature on collective impact explains that it is important that every partner do what they do best while being committed to the mutually reinforcing vision for collaborative community change, which is *Live Well San Diego* in this case. Leadership Teams are in a unique position to leverage the activities and efforts of others throughout the region. Choosing strategies and objectives that are evidence-informed is the best way to influence long-term population outcomes. The collective impact approach also calls for partners to identify not only what they can do best, but also at the scale to which they can be successful.

# CAPTURING COLLECTIVE IMPACT

**Indicators to Monitor Long-Term Impact**

***Top 10 Live Well San Diego Indicators Dashboard***

How do we know if the CEPs are contributing over the long-term to a community that is "living well?" The Top 10 *Live Well San Diego* Indicators (Figure 9) define what it means to "live well" in San Diego. Measured across the lifespan among all residents, these Indicators capture the collective impact of programs, services, and interventions provided by government and community partners striving to improve quality of life so all San Diego County residents can be healthy, safe, and thriving. The Indicators are divided under five Areas of Influence that are essential for overall well-being: Health, Knowledge, Standard of Living, Community and Social.

For each of the CEPs, a customized *Live Well San Diego* Dashboard is incorporated. The data for the Top 10 Indicators are presented by Region and Sub-Regional Areas so that each Leadership Team can see the status and monitor progress by communities within their Region. For each priority within the CEP, alignment to the Areas of Influence and to the corresponding Indicators is shown.

The Top 10 Indicators are part of an expanded indicator dashboard. "Expanded" Indicators refer to Indicators that are part of the Live Well San Diego framework and further describe each of the Top 10 Indicators. These "Expanded" Indicators help gauge progress in areas related to the corresponding Top Indicator. Additional community or population Indicators are also tracked, referred to as "Supporting" Indicators. "Supporting" Indicators are not part of the Top 10 Indicator framework but are viewed as an additional population measures that reflect progress in the medium- to long-range time span toward achieving that priority. Supporting measures are often more specific to concerns and/or improvement objectives of the Leadership Team. In this way, for each priority in a Region's CEP, several key population measures have been identified to track long-term impact—Top 10 *Live Well San Diego* Indicator, Expanded Indicator, and Supporting Indicator.

**Figure 9. Top 10 Live Well San Diego Dashboard: Top 10 Population Outcome Indicators**

| | Indicator | Description | We want to increase this / We want to decrease this |
|---|---|---|---|
| **HEALTH - Enjoying good health and expecting to live a full life** | | | |
| HEALTH | Life Expectancy | Average number of years a person is expected to live at birth. 2016. | ↑ |
| | Quality of Life | Percent of the population 18 & older, not residing in nursing homes or other institutions, that is sufficiently healthy to be able to live independently. 2017. | ↑ |
| **KNOWLEDGE - Learning throughout the lifespan** | | | |
| KNOWLEDGE | Education: High School Diploma or Equivalent | Overall Graduation Rate: the percentage of those over the age of 25 with a high school diploma or equivalent. 2017. | ↑ |
| **STANDARD OF LIVING - Having enough resources for a quality life** | | | |
| STANDARD OF LIVING | Unemployment Rate | Percent of the population that is unemployed. 2018. | ↓ |
| | Income: Percent of population spending less than 1/3 of income on housing | Percent of the population spending less that 1/3 of their income on housing. 2016. | ↑ |
| **COMMUNITY - Living in a clean and safe neighborhood** | | | |
| COMMUNITY | Security: Overall Crime Rate | Overall Crime rate per 100,000 population. 2017. | ↓ |
| | Physical Environment: Air Quality | Percent of days rated unhealthy for vulnerable populations. 2018. | ↓ |
| | Built Environment: Percent of population living within 1/4 mile of a park or community space | Percentage of population that resides within a quarter mile of a park or community space. 2018. | ↑ |
| **SOCIAL - Helping each other to live well** | | | |
| SOCIAL | Vulnerable Populations: Food Insecurity | Percent of adult population 200% below FPL not able to afford food. 2017. **Indicates statistically unstable estimates. Proceed with caution.* | ↓ |
| | Community Involvement: Volunteerism | Percent of residents who volunteer. 2017. | ↑ |

On the right track | Not on track | No change

***Public Health Services Dashboard***

An additional dashboard of Indicators was created, consistent with requirements of nationally accredited public health departments. This dashboard, called the "Public Health Services Dashboard," captures 10 Indicators that are more closely connected to the programs of PHS (see Figure 10). PHS will use this dashboard to monitor the long-term impact of many programs and varied responsibilities for advancing public health—such as HIV disease diagnosis estimates and levels of childhood lead poisoning in schools.

In those areas in which the Regions and PHS work together (such as reducing chronic disease and linking residents to preventive health care), this PHS Dashboard tracks indicators of mutual focus ("3-4-50" deaths due to chronic disease and infant mortality rate). Both Dashboards capture indicators of the social determinants of health such as high school graduation and unemployment rates.

The Public Health Accreditation Board is requiring public health departments seeking reaccreditation to develop dashboards as part of a national project to gather this information across all accredited departments in order to evaluate the benefits and impact of accreditation.

**Figure 10. San Diego County Public Health Services Dashboard: Top 10 Population Outcome Indicators**

| | Indicator | Description | We want to increase this / We want to decrease this |
|---|---|---|---|
| **HEALTH - Enjoying good health and expecting to live a full life** | | | |
| HEALTH | "3-4-50" Percent | Percent of deaths due to the four chronic diseases (cancer, heart disease and stroke, type 2 diabetes, and pulmonary diseases such as asthma). 2016. | ↓ |
| | ADRD Death Rate | Alzheimer's Disease and Related Dementias (ADRD) death rate per 100,000 population. 2016. | ↓ |
| | Infant Mortality Rate | Annual Infant Mortality Rate per 1,000 live births. 2016. | ↓ |
| | Infant Mortality Rate | Three-year average Infant Mortality Rate per 1,000 live births. 2013-2015. | ↓ |
| | HIV Disease Diagnosis Estimates | HIV Disease diagnosis case counts and percentages between 2012-2016 time period. | ↓ |
| **KNOWLEDGE - Learning throughout the lifespan** | | | |
| KNOWLEDGE | High School Education | Overall Graduation Rate: the percentage of those over the age of 25 with a high school diploma or equivalent. 2017. | ↑ |
| **STANDARD OF LIVING - Having enough resources for a quality life** | | | |
| STANDARD OF LIVING | Unemployment Rate | Percent of the total labor force that is unemployed (actively seeking employment and willing to work). 2018. | ↓ |
| | Income Inequality | Number of Total Earned Income Tax Credits. 2017 tax year. | ↓ |
| | Poverty | Percent of the population below poverty level. 2017. | ↓ |
| **COMMUNITY - Living in a clean and safe neighborhood** | | | |
| COMMUNITY | Childhood Lead in Schools | The number of cases San Diego Childhood Lead Poisoning Prevention Program. 2009-2013. | ↓ |
| **SOCIAL - Helping each other to live well** | | | |
| SOCIAL | Voting | Percent of the population who voted in a Federal/State/Local election in the last 12 months. 2018. | ↑ |

On the right track  Not on track  No change

To view more information about the *Live Well San Diego* Indicators and how we will measure progress, go to: http://www.sdcounty.ca.gov/hhsa/programs/sd/live_well_san_diego/indicators.html

# FOUNDATIONAL INFRASTRUCTURE THAT SUPPORTS COLLECTIVE IMPACT

**Setting the Stage for Collective Impact Effort**

The infrastructure for this collective impact effort began to emerge in the 1990s, when the Health and Human Services Agency (HHSA) of the County of San Diego was redesigned from six individual departments into one super agency. In 1996, interagency collaboration to improve service delivery became a reality when the Board of Supervisors approved the merger of individual County departments into a single Health and Human Services Agency. The business model was intended to achieve the potential benefits of merging these departments and programs so that they would work together synergistically.

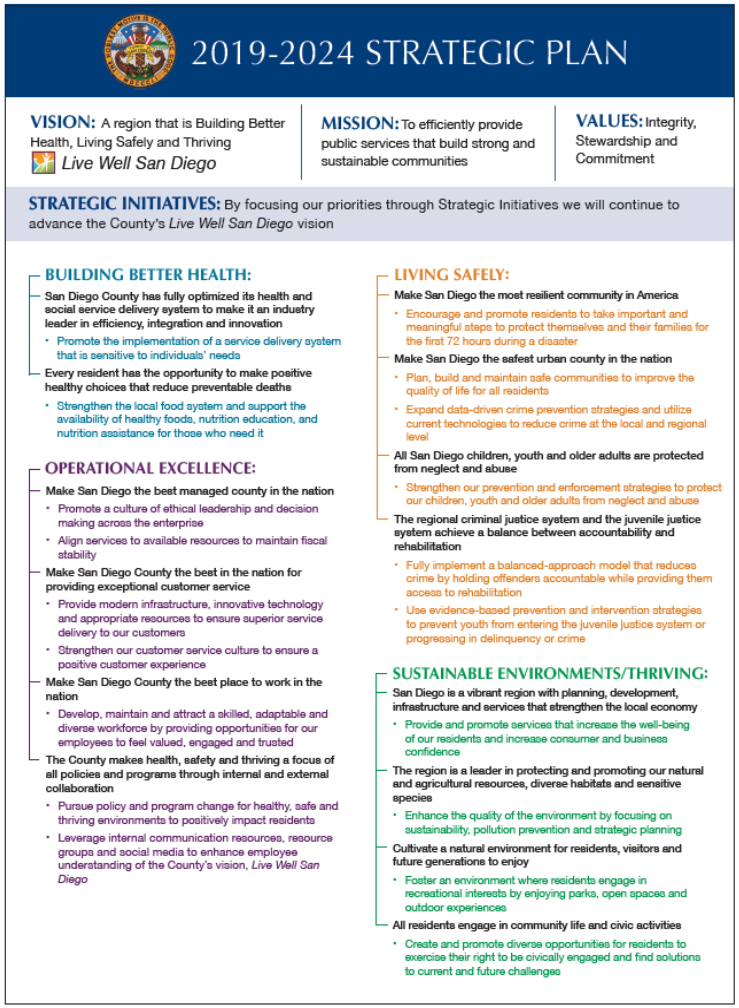
The hallmark of HHSA is its commitment to a service delivery system that is Regionalized and accessible, community-based, and customer-oriented. Organized into six geographic service Regions, HHSA's service delivery system reflects a community-based approach, using public-private partnerships to meet the needs of individuals and families in San Diego County. Customers are served in a variety of settings, including County facilities, hospitals, community clinics, agencies, or community-based organizations under contract with HHSA to provide key services, such as alcohol and drug treatment services, or medical care to the indigent. Throughout HHSA, the focus is on a "no wrong door" approach – a system that is easy to access, treats families as a whole, integrates resources and services, harnesses the power of technology and takes advantage of economies of scale. An important part of this redesign was creating the six Regions so that services could be better tailored to community needs. With the adoption of Building Better Health, as the first component of *Live Well San Diego*, the Regional Community Leadership Teams soon emerged as a way of elevating the community "voice" and engaging community leaders in helping to identify and address community needs.

Today, HHSA includes the six Regions and seven Departments, including Aging & Independence Services; Behavioral Health Services; Child Welfare Services; Eligibility Operations; Public Health Services, and Public Administrator/Public Guardian. Housing & Community Development Services was transitioned over to HHSA in FY 2017 -18 in recognition of the importance and connection between housing and health. HHSA's FY 2019-20 budget was $2.3 billion, over a third of the total County Operational Plan budget for FY 2019-20 of $6.25 billion. Total staffing was 6,771.5, which is 38 percent of total County staff years of 18,024.5.

The redesign of HHSA ultimately helped to make *Live Well San Diego* possible. The first component of *Live Well San Diego* was Building Better Health. This component originated at HHSA and the strategy was presented to the Board of Supervisors in 2010. As Building Better Health engaged all departments, the Chief Administrative Officer of the County saw the opportunity to expand *Live Well San Diego* across the enterprise as the scope also expanded to encompass living safely (presented in 2012) and thriving components (presented in 2014).

Today, both the County of San Diego and HHSA share the same vision: "A region that is Building Better Health, Living Safely and Thriving." The County Strategic Plan is completely aligned to the vision of *Live Well San Diego*. (see Figure 11).

**Figure 11: County of San Diego Strategic Plan, 2019-2024**




*Source: County of San Diego, Chief Administrative Office.*

# FOUNDATIONAL INFRASTRUCTURE THAT SUPPORTS COLLECTIVE IMPACT

**The County Enterprise Provides "Backbone" Support**

One of the conditions of collective impact efforts is "backbone" support. This refers to having a team or organization dedicated to orchestrating the work of the collective initiative. The County of San Diego provides this "backbone" support to *Live Well San Diego.* Success of the Leadership Teams in the Regions toward implementing their CEPs depends on the support provided by the County enterprise, including the Regional Director and community engagement teams in each Region.

The County enterprise is especially positioned to be the "backbone" to this collective effort. It is organized as a business model with five different groups and a reputation for being fiscally sound and well managed. Its General Management System—integrating strategic planning, operational planning, monitoring and control, functional threading, and rewards and recognition—is an award-winning, nationally recognized system that has helped to sustain and maintain success since the 1990s. Multiple departments have achieved national accreditation in addition to PHS (more detail on page 38).

The County has the data infrastructure to support success with the Community Health Statistics Unit (CHSU) within PHS. Also, for *Live Well San Diego*, a data infrastructure has been created to support "shared measurement," another key element of collective impact. The top 10 *Live Well San Diego* Indicators, and supporting Indicators, have been selected and are monitored continuously with a performance dashboard. Resources are also made available to help partners conduct their activities and to measure their collective impact. All of this data is easily accessible on the LiveWellSD.org website, dedicated to *Live Well San Diego*. In March of 2019, the County was recognized for its efforts to improve the health of populations and the performance of health systems with the 2019 State and Local Innovation Award sponsored by The Milbank Memorial Fund and AcademyHealth. This recognition reflects the success PHS, particularly through the work of the Community Health Statistics Unit, which is focused on making population data readily available to meet the needs of the public and providing analysis useful to decision-making.

The County also has deep expertise in policy, systems and environmental (PSE) change, and in building local capacity to bring about change. *Live Well San Diego*: Healthy Works is a collection of programs and resources that aim to prevent and control chronic disease through policy, systems, and environmental change, with focus on vulnerable, low-income communities. Programs such as *Live Well* Community Markets and *Live Well* @ Work tap into economic incentives to increase the availability and appeal of markets selling healthy foods in underserved communities and employee wellness committees and practices in the workplace. The County also innovates with its Resident Leadership Academies, referring to training of local residents to advocate for community health through PSE strategies. Some of these projects support the goals of the CEPs. Another creative approach to building local capacity is the Healthy Cities, Healthy Residents program. This program further strengthens local capacity through community-based organizations (CBOs) and coalitions of low-income residents, business owners, allied community groups and others, with the purpose of engaging city staff in implementing placemaking, active transportation, and food policy changes. PHS staff from the Chronic Disease and Health Equity Unit, provide the technical assistance.

Part of the "backbone support" that the County provides is assisting Leadership Teams and other community partners who are part of the collective impact effort of *Live Well San Diego*. A Leadership Team cannot on its own implement the objectives that appear in the CEP. The power of these Leadership Teams is in the direction that they set and their ability to leverage partners while maximizing available resources. This is the value of being part of the *Live Well San Diego* collective impact effort. Success in reaching the objectives, within this plan and other Regional CEPs, depends on leveraging the efforts of partners across all sectors as well as existing County programs and services.

For example, a goal to support healthy food choices and food systems will draw upon the Public Health Services Chronic Disease and Health Equity Program. Behavioral health activities, reflected in many Regional CEPs, are assisted by staff and programs within the County's Behavioral Health Services (BHS). BHS offers prevention and early intervention services and an array of treatment programs. Age Well San Diego, a Board initiative to create age-friendly communities, has an action plan that supports intergenerational activities and transportation policies, which closely align with CEP goals. The many assets and resources across San Diego County—public, private, and non-profit—are detailed in the 2019-21 Community Health Assessment. The Regional Director and community engagement staff within each Region assist the Leadership Team to achieve their CEP objectives by providing technical assistance and leveraging County initiatives, programs and services when appropriate.

There are many more examples of the assets and resources available across San Diego County that leverage the *Live Well San Diego* collective impact effort. See the 2019-21 Community Health Assessment to be published shortly after release of this CHIP.

# FOUNDATIONAL INFRASTRUCTURE THAT SUPPORTS COLLECTIVE IMPACT

**Advancing with *Live Well San Diego***

The launch of *Live Well San Diego* marked a major transformation of HHSA and the County enterprise as a whole. *Live Well San Diego* is a County-wide vision adopted by the San Diego County Board of Supervisors in 2010 that aligns the efforts of County government, community partners and individuals to help all San Diego County residents be healthy, safe, and thriving. The vision includes three components: Building Better Health, adopted on July 13, 2010, focuses on improving the health of residents and supporting healthy choices; Living Safely, adopted on October 9, 2012, focuses on protecting residents from crime and abuse, making neighborhoods safe, and supporting resilient communities; and Thriving, adopted on October 21, 2014, focuses on cultivating opportunities for all people to grow, connect and enjoy the highest quality of life.

*Live Well San Diego* has grown to be a nationally recognized collective impact effort. Numerous "signature" events such as the *Live Well* Advance Conference and *Live Well* 5K reflect the traction that this collective impact effort is gaining. In addition to the five Regional Leadership Teams that are growing in number of participants and activity, the number of officially designated *Live Well* partners has grown exponentially since the inception *of Live Well San Diego*. In 2012, there were just six *Live Well* partners; by June 2019, there are now almost 500. Some agencies that are represented on the Leadership Teams are also recognized *Live Well San Diego* partners. The history of *Live Well San Diego* is captured in Table 6 .

**Table 6. History of *Live Well San Diego*.**

| Year | Date | Significant *Live Well San Diego* Milestones |
|---|---|---|
| 2010 | July 13 | The County's Health Strategy Agenda, Building Better Health, is adopted. |
| | October 8 | 3-4-50: Chronic Disease in San Diego County report is released.<br>Economic Burden of Chronic Disease report is released. |
| 2011 | February 14 | First four Resident Leadership Academies established. |
| | June 29 | First Lady Michelle Obama's "Let's Move" initiative recognizes *Live Well San Diego* *Healthy Works™* school nutrition program. |
| | November 8 | *Live Well San Diego* Building Better Health: Highlights and Accomplishments report published. |
| 2012 | 2012 | *Live Well San Diego* Community Leadership Teams are formed in 2012 to help guide planning for health, safety and thriving priorities in each of the HHSA service regions to foster information sharing and connectivity between Recognized Partners, individuals and organizations from the community and County of San Diego staff. |
| | February 14 | Inaugural Love Your Heart blood pressure screening event takes place. |
| | May 2 | The City of Oceanside designated as the first partner to officially "adopt" *Live Well San Diego.* |
| | October 9 | Living Safely component adopted by Board of Supervisors. |
| | October 30 | *Live Well, San Diego!* Building Better Health: A Report on Year Two of a Ten-Year Initiative; Highlights and Accomplishments published. |

# FOUNDATIONAL INFRASTRUCTURE THAT SUPPORTS COLLECTIVE IMPACT

| | | |
|---|---|---|
| 2013 | 2013 | Developed in 2013, the BMI Toolkit includes measurement tools and worksheets to help create healthier school environments. |
| | April 15 | Northgate Gonzalez Markets named as the first *Live Well San Diego* Business & Media partner. |
| | April 17 | Chula Vista Elementary School District named as the first *Live Well San Diego* Schools & Education partner. |
| | September 22 | Meridian Baptist Church named as the first *Live Well San Diego* Community & Faith-based partner. |
| | October | Launch of *Live Well* @ Work Program. |
| | October 1-7 | Inaugural Check Your Mood depression screening becomes *Live Well San Diego* Signature Event during San Diego Depression Screening Week |
| | October 22 | The *Live Well San Diego* vision framework (pyramid) and Top 10 Indicators identified, LiveWellSD.org website launched, and the and the Third Annual Report published. |
| 2014 | May | *Live Well San Diego* Food System Working Group formed, and Chief Administrative Officer directed to develop a Food System Initiative. |
| | May 31 | Inaugural *Live Well San Diego* 5K run becomes *Live Well San Diego* Signature Event. |
| | August 15 | First Youth Resident Leadership Academy hosted. |
| | October 21 | Thriving component adopted by Board of Supervisors; *Live Well San Diego* Year 4 Annual Report published. |
| 2015 | October 27 | *Live Well San Diego* Partners Report: 5 Years of Healthy, Safe and Thriving Communities published. |
| | November 5 | *Live Well San Diego* Open Performance Data Access Portal launched. Later integrated into the San Diego County Data Portal. |
| 2016 | April | The County of San Diego joined the Age-Friendly Network of Age-Friendly Communities. |
| | May 31 | First *Live Well* Center opens in National City. |
| | September 6 | U.S.-Mexico Border Health Commission – Mexico Section, becomes first international *Live Well San Diego* recognized partner. |
| | October 25 | *Live Well San Diego* Partners Report: 6 years of Healthy, Safe and Thriving Communities published. |
| | November | *Live Well* Community Market Program officially approved. |
| | November 8 | First Annual *Live Well Advance* held. |
| 2017 | May 2 | County of San Diego HHSA South Region began Communities of Excellence journey. |
| | June 30 | *Live Well San Diego* Partners Report: Seven Years of Healthy, Safe, and Thriving Communities published. |
| | Summer | "Strong Families, Thriving Communities" coalition formed, led by the Clinton Health Matters Initiative, to improve the health and well-being of children and families that interact with San Diego's child welfare and juvenile justice systems. |
| | November 8 | Second Annual Live Well Advance: Living Across the Ages. |

# FOUNDATIONAL INFRASTRUCTURE THAT SUPPORTS COLLECTIVE IMPACT

| | | |
|---|---|---|
| 2018 | March 9 | Conversations about Southeast *Live Well* Center begin at the Central Region Leadership team meeting. |
| | May 15 | Age Well San Diego Action Plan approved by the Board of Supervisors. |
| | August 29 | *Live Well San Diego* Data Summit Planning4Health is held. |
| | October 2 | Third Annual *Live Well* Advance: Connecting the Unconnected to Live Well. |
| | October 2 | 2018 Live Well San Diego Annual Report released. |
| | December 4 | Third *Live Well* Center opens in Oceanside. |
| 2019 | May 3 | *Live Well San Diego* Communications Summit brought organizations together to learn how to collaborate for improved communications and how to use communications to create behavior change. |
| | October 21 | *Live Well San Diego* Annual Impact Report released. |

**Steps Toward Excellence**

The County of San Diego is widely recognized for its financial stewardship and its innovative approaches to improving services for residents. Each year, the County receives numerous national and state awards for innovation. In 2017-18, the County received 41 Achievement Awards from the National Association of Counties (NACo). These awards included one for "Person-Centered Service Coaching Program" for training of employees to deliver better services to customers with complex needs, and several awards for programs related to the Hepatitis A outbreak response, including the use of foot teams to reach the homeless and illicit drug using population, and the development of a mobile app to help staff quickly assess homeless encampment sites for sanitation needs. The California State Association of Counties awarded the County several awards including a Challenge Award, also for the County's response to the Hepatitis A outbreak in 2017.

The County has maintained a strong fiscal position with AAA credit ratings from all three major rating agencies. It received the Diamond Award from the San Diego Association of Governments for its efforts to support employee use of environmentally sustainable transportation choices, and is the first County in California and second in the nation to receive the U.S. Green Building Council's highest distinction of Platinum LEED for Communities certification. San Diego County also received the Distinguished Budget Presentation Award on July 1, 2017 from the Government Finance Officers Association. The County's 24-hour skilled nursing facility, Edgemoor, received the Gold Quality Service Excellence Award, which is the highest national honor bestowed by the American Health Care Association and National Center for Assistant Living. Edgemoor was one of only three facilities nationwide to receive this award in 2017.

Multiple County departments have achieved national accreditation in addition to PHS (more detail on the following page), including Parks and Recreation which, in 2016, was the first department in California to be reaccredited for reaching quality benchmarks across its system of 120 parks, preserves, historic sites, sports complexes and community centers. The County Office of Emergency Services also earned national re-accreditation in 2017, one of the first in the country and the first of local governments in California.

# FOUNDATIONAL INFRASTRUCTURE THAT SUPPORTS COLLECTIVE IMPACT

***Malcolm Baldrige Program Participation and Awards***

In alignment with the County's expectation of operational excellence, HHSA is pursuing the national Baldrige Award, which recognizes organizations based on performance excellence. In December 2017, the County's Health and Human Services Agency received the California Award for Performance Excellence—Eureka Silver Level. The honor shows HHSA used effective strategies and practices throughout the organization and gleaned valuable insights on how to improve the quality of life for customers. This is an achievement since very few local governments have reached this level. South Region is currently a pilot for the Communities for Performance Excellence, which aims to adapt Malcolm Baldrige criteria for excellence to communities (referred to as Communities of Excellence 2026). A deliberate and focused planning effort in South Region is reflected in their final CEP.

BALDRIGE FOUNDATION

BALDRIGE - *America's Best Investment*



***Public Health Accreditation***

The County of San Diego Health and Human Services Agency achieved national accreditation for public health services from the Public Health Accreditation Board (PHAB) on May 17, 2016. This accreditation signifies that the County has demonstrated conformity with national standards to provide essential public health services, which include : investigating public health problems such as foodborne illness, active tuberculosis and communicable disease; educating the public about public health issues like Alzheimer's disease, chronic disease and maternal and child health issues; enforcing public health laws and regulations related to beach closures, hazardous materials and restaurant inspections; and preparing for and responding to public health threats, emergencies and disasters such as wildfires, Ebola and Zika virus.

ACCREDITED HEALTH DEPARTMENT • PUBLIC HEALTH ACCREDITATION BOARD •

PHAB

*Advancing public health performance*

Community Health Assessments and Community Health Improvement Plans are among the deliverables expected of accredited public health departments, and these key documents must be refreshed routinely. Preparations have begun for seeking re-accreditation for which the County is due in 2021, five years after becoming accredited.

# SUMMARY OF PRIORITIES FOR ACTION IN REGIONAL COMMUNITY ENRICHMENT PLANS

Several tables appear below that capture the Regional CEP priorities in a slightly different fashion. These tables show how the Regional CHIPs, now called CEPs, have evolved over time.

**Priority Areas of Original Community Health Improvement Plans by Region**

Table 7 illustrates the priorities adopted for the Regional plans in the FY 2014-18 cycle, priorities that largely fell within the Building Better Health component.

**Table 7. Priority Areas by Region in Original Community Health Improvement Plans (CHIPs) FY 2014-18.**

| Region | Health Priority Areas | | | | | |
|---|---|---|---|---|---|---|
| | Active Living | Healthy Eating | Health Care Access | Behavioral Health/ Substance Use | Safety/ Violence | Other |
| Central | | ✓ | ✓ | ✓ | ✓ | Worksite Wellness* |
| East | ✓ | ✓ | | ✓ | | |
| North Central | ✓ | | ✓ | ✓ | | |
| North County | ✓ | ✓ | | ✓ | | |
| South | ✓ | | ✓ | | ✓ | |

*Includes elements that address active living, healthy eating, and behavioral health/substance use.

*Source: County of San Diego, Health and Human Services Agency, Live Well San Diego Community Health Improvements Plan, June 2014.*

# SUMMARY OF PRIORITIES FOR ACTION IN REGIONAL COMMUNITY ENRICHMENT PLANS

**New Community Enrichment Plans Reflect Evolution in Coverage**

The CEPs that evolved from this second MAPP cycle (2019-21) show a broader range of coverage in terms of priorities. Table 8 shows the *Live Well San Diego* Strategic Framework, including the themes within each component, and it is indicated if the Regional CEP has a priority that is the same or similar theme. This table shows that, for nearly every theme, several Leadership Teams are active, suggesting some depth in effort across the *Live Well San Diego* Components.

**Table 8. *Live Well San Diego* Theme by Regional Community Enrichment Plans—FY 2019-2021**

| COVERAGE OF *LIVE WELL SAN DIEGO* THEMES BY REGIONAL PLANS | | | | | | |
|---|---|---|---|---|---|---|
| | | Central | East | North Central | North County | South |
| **Building Better Health** | | | | | | |
| | Improve Access to Quality Care | ✦ | ✦ | ✦ | ✦ | |
| | Increase Physical Activity | | ✦ | ✦ | ✦ | |
| | Support Healthy Eating | ✦ | | ✦ | ✦ | |
| | Stop Tobacco and Other Drug Use | | | ✦ | ✦ | ✦ |
| **Living Safely** | | | | | | |
| | Protect Residents from Crime and Abuse | ✦ | ✦ | | ✦ | |
| | Increase Neighborhood Safety | ✦ | ✦ | ✦ | ✦ | |
| | Create Communities that are Resilient from Disaster and Emergencies | | | | ✦ | |
| **Thriving** | | | | | | |
| | Improve Built and Natural Environment | | ✦ | ✦ | ✦ | |
| | Increase Life Enrichment | ✦ | ✦ | ✦ | | ✦ |
| | Increase Prosperity, Education, and the Economy | ✦ | ✦ | | ✦ | ✦ |

*Note:* Grey areas represent where the Regional Community Enrichment Plan does not have a Priority that falls directly under the individual Theme for *Live Well San Diego*.
*Source: County of San Diego, Health and Human Services Agency. Prepared by PHS Administration staff based on Regional Community Enrichment Plans 2019-21.*

# SUMMARY OF PRIORITIES FOR ACTION IN REGIONAL COMMUNITY ENRICHMENT PLANS

In Table 9, the priorities appears as they do in the individual CEPs and are organized across the *Live Well San Diego* components. As already described, these priorities go well beyond what would fall under the *Building Better Health* component of *Live Well San Diego*. These priorities fall equally in number in the *Living Safely* and *Thriving* components. Many of the same priorities are repeated across components because they have goals that align to more than one component.

These priorities not only responds to the community data, information, and survey feedback gathered through the MAPP assessments, it reflects what the Leadership Teams found to be compelling. This demonstrates that leaders recognize that to "live well" means that the social determinants of health must be addressed. It reinforces what leaders have always known: without addressing these factors, the potential of residents and the community in which they live cannot be fully realized.

Although every CEP is taking broad strokes at addressing the social determinants of health, some differences between Leadership Teams and their CEPs are revealed. These selected priorities reflect the unique perspective and "voice" of each Leadership Team.

Central and South CEP priorities are captured as Areas of Influence followed by a more detailed name of the priority. The South Region CEP is notably different than the other CEPs. This is the result of the Region's unique planning process as a pilot for adapting Malcolm Baldrige criteria for excellence to communities (referred to as Communities of Excellence 2026). This process involves an intense focus on a smaller set of priorities—chronic disease prevention, school attendance, and economic vitality. The priorities are interrelated, which is intentional in order to have a bigger impact. To illustrate, even though the South Region CEP does not have a priority that falls under Living Safely, the Leadership Team believes that addressing chronic disease, improving school attendance, and increasing economic vitality will ultimately make their communities safer.

**Table 9. Priorities of Regional Community Enrichment Plans (CEPs) by *Live Well San Diego* Component – FY 2019-2021**

| COVERAGE OF *LIVE WELL SAN DIEGO* COMPONENT BY REGIONAL PRIORITY | | | |
|---|---|---|---|
| **Region** | **BUILDING BETTER HEALTH** | **LIVING SAFELY** | **THRIVING** |
| **Central** | • Health—Access to Quality **Care**<br>• Health—Support Healthy **Eating** | • Community—Improve **Trauma** Informed Systems<br>• Community—Reduce **Crime** | • Social—Enhance **Civic** Life |
| **East** | • **Aging** Communities<br>• **Behavioral** Health Wellness<br>• **Child and Family** Wellness | • **Aging** Communities<br>• **Behavioral** Health Wellness | • **Aging** Communities<br>• **Child and Family** Wellness |
| **North Central** | • **Behavioral** Health<br>• **Physical** Activity and **Environmental** Change | • **Behavioral** Health<br>• **Physical** Activity and **Environmental** Change | • **Physical** Activity and **Environmental** Change |
| **North County Regions** | • **Behavioral** Health/Mental Health Services<br>• **Nutrition**<br>• **Physical** Activity | • **Crime**<br>• **Disaster** Preparedness<br>• Illegal Access to **Substances and Alcohol**<br>• Unintentional **Injuries** | • **Education** and Workforce Development<br>• **Housing**<br>• **Transportation** |
| **South** | • Health—Preventing **Chronic** Disease | | • Knowledge—Improving **School** Attendance<br>• Standard of Living—Promoting **Economic** Vitality |

*Note: South and Central Region priorities are identified first with the Area of Influence followed by the specific priority. Only one grey area denoted because Regional Community Enrichment Plan does not have priority that aligns directly with the individual Theme for Live Well San Diego. However, in this case, South Region has priorities that ultimately should contribute to safer communities (see explanation above).*

*Source: County of San Diego, Health and Human Services Agency. Prepared by PHS Administration staff based on Regional Community Enrichment Plans 2019-21.*

# SUMMARY OF PRIORITIES FOR ACTION IN REGIONAL COMMUNITY ENRICHMENT PLANS

**Topics Covered Across All Community Enrichment Plans**

One additional way to look at the CEPs is in terms of the topics they cover. Table 10 serves as an inventory of the topics that are covered by the individual CEPs altogether.

**Table 10. List of Topics Covered by Community Enrichment Plans**

| TOPICS | REGION(S) with Priority that Covers Topic |
|---|---|
| Access to Care/Preventive Care | Central and North Central |
| Aging | East |
| Behavioral Health | East, North Central, and North County Regions (Includes North Coastal and North Inland) |
| Child and Family Wellness | East |
| Chronic Disease | All Regions |
| Civic Life | Central |
| Crime | Central and North County Regions |
| Disaster Preparedness | North County Regions |
| Economic Vitality | South |
| Education and Workforce Development (includes School Attendance) | North County Regions and South |
| Healthy Eating/Nutrition | Central and North County Regions |
| Housing | North County Regions |
| Illegal Access to Substances and Alcohol | North County Regions |
| Physical Activity (includes Environmental Change) | North Central and North County Regions |
| Unintentional Injuries | North County Regions |
| Transportation | North County Regions |
| Trauma Informed Care | Central |

# LEVERAGING EFFORTS BY ALIGNING TO OTHER PLANS

So much more can be done with limited resources when residents, agencies, and partners across every sector work together. That is why strategic alignment is so critical. Strategic alignment to other key plans ensures existing resources are being leveraged for collective impact efforts at the federal, state, and local levels (see Figure 12).

At the local level, strategic alignment advances the vision of *Live Well San Diego*. Public Health Services (PHS) has several plans that provide additional infrastructure and capacity to support Regional Community Leadership Teams (Leadership Teams) in their efforts to advance their Community Enrichment Plan (CEP) priorities. The support entails programs, services, staff, technical expertise, and funding, which is indicated in the PHS Strategic Plan, Health Equity Strategic Plan, Performance and Quality Improvement Plan, and Workforce Development Plan. This section shows the alignment through a series of tables.

**Figure 12. Alignment of Community Health Improvement Plan and Regional Community Enrichment Plans**

# LEVERAGING EFFORTS BY ALIGNING TO OTHER PLANS

**Alignment to Federal and State Plans**

Table 13 on the following page aligns Regional Leadership Team priorities as reflected in the CEPs to federal and State plans (e.g., National Prevention Strategy, Healthy People 2020, and Let's Get Healthy California). These plan are described as:

**The National Prevention Strategy**, launched by the Surgeon General in 2011, is a guide for the nation to provide the most useful and attainable means for leading a healthy lifestyle. Four Strategic Directions provide a strong foundation for all of our nation's prevention efforts and include core recommendations necessary to build a prevention-oriented society.

**Healthy People 2020** was first unveiled in November 2000 by the U.S. Department of Health and Human Services. The framework provides science-based, 10-year national objectives for improving the health of all Americans. For three decades, Healthy People has established benchmarks and monitored progress over time. Healthy People 2020 was launched in December 2010 and the development of Healthy People 2030 is underway. Healthy People 2020 contains 42 topic areas with more than 1,200 objectives. A smaller set of objectives are referred to as the Leading Health Indicators to which the CEP priorities are aligned.

**Let's Get Healthy California** is a shared vision for the future health of Californians, reflecting a commitment to become a healthier state through joint efforts in six project goals and key indicators by which to measure progress. The Let's Get Healthy California Task Force was started in 2012 with the purpose of developing a 10-year plan. Three of the goals capture health across the lifespan; three additional goals capture pathways to health. This is the State's collective impact effort in which all residents, communities, and organizations are encouraged to participate and to share their innovation.

**Alignment to Federal and State Plans continued**

**Table 13. Alignment of Regional CEP Priorities to Federal and State Plans**

| Community Enrichment Plan Priorities | Regions in which Priority is in CEP | National Prevention Strategy Priority Area | Healthy People 2020 Topic Area | Let's Get Healthy California (California SHIP) Goal |
|---|---|---|---|---|
| **Access to Care/ Preventive Care** | Central and North Central | Reproductive and Sexual Health<br>Mental and Emotional Well-Being | Access to Health Services<br>Cancer<br>Diabetes<br>Heart Disease and Stroke<br>Immunization and Infectious Disease<br>Maternal, Infant, and Child Health<br>Oral Health<br>Sexually Transmitted Diseases<br>Social Determinants of Health | End-of-Life<br>Healthy Beginnings<br>Living Well<br>Lowering the Cost of Care<br>Redesigning the Health System |
| **Aging** | East | Active Living<br>Injury and Violence Free-Living | Older Adults<br>Physical Activity | End-of-Life<br>Living Well |
| **Behavioral Health** | East, North Central, and North County Regions | Mental and Emotional Well-Being | Access to Health Services<br>Immunization and Infectious Disease<br>Mental Health and Mental Disorders<br>Social Determinants of Health | Healthy Beginnings<br>Living Well<br>Redesigning the Health System |
| **Child and Family Wellness** | East | Active Living<br>Mental and Emotional Well-Being | Access to Health Services<br>Adolescent Health<br>Physical Activity | Healthy Beginnings<br>Living Well |
| **Chronic Disease** | South | Tobacco-Free Living | Tobacco Use | Healthy Beginnings<br>Living Well |
| **Civic Life** | Central | --- | --- | Creating Healthy Communities |
| **Crime** | Central and North County Regions | Injury and Violence-Free Living | Injury and Violence Prevention | Creating Healthy Communities |
| **Disaster Preparedness** | North County Regions | --- | Preparedness | Creating Healthy Communities |

# LEVERAGING EFFORTS BY ALIGNING TO OTHER PLANS

| Community Enrichment Plan Priorities | Regions in which Priority is in CEP | National Prevention Strategy Priority Area | Healthy People 2020 Topic Area | Let's Get Healthy California (California SHIP) Goal |
|---|---|---|---|---|
| **Economic Vitality** | South | --- | Health-Related Quality of Life and Well-Being<br>Social Determinants of Health | Healthy Beginnings |
| **Education and Workforce Development (includes School Attendance)** | North County Regions and South | Mental and Emotional Well-Being<br>Tobacco-Free Living | Mental Health and Mental Disorders<br>Social Determinants of Health<br>Tobacco Use | Healthy Beginnings<br>Living Well |
| **Healthy Eating/ Nutrition** | Central and North County Regions | Healthy Eating | Nutrition and Weight Status | Creating Healthy Communities<br>Healthy Beginnings<br>Living Well |
| **Housing** | North County Regions | --- | Social Determinants of Health | --- |
| **Illegal Access to Substances and Alcohol** | North County Regions | Tobacco-Free Living<br>Preventing Drug Abuse and Excessive Alcohol Use | Substance Abuse<br>Tobacco Use | Healthy Beginnings<br>Living Well |
| **Physical Activity (includes Environmental Change)** | North Central (Includes Environmental Change) | Active Living | Diabetes<br>Physical Activity | Creating Healthy Communities<br>Healthy Beginnings<br>Living Well |
| **Unintentional Injuries** | North County Regions | Injury and Violence-Free Living | Environmental Health<br>Injury and Violence Prevention | --- |
| **Transportation** | North County Regions | Active Living | Social Determinants of Health | --- |
| **Trauma Informed Care** | Central | Mental and Emotional Well-Being | Health-Related Quality of Life and Well-Being | Healthy Beginnings<br>Living Well<br>Redesigning the Health System |

# LEVERAGING EFFORTS BY ALIGNING TO OTHER PLANS

**Alignment to Public Health Services Strategic Plan**

The *Live Well San Diego* Community Health Improvement Plan (CHIP) and Regional Community Enrichment Plans (CEPs) are aligned to the County of San Diego Public Health Services (PHS) FY 2018-2021 Strategic Plan. The PHS Strategic Plan has a specific objective that falls under PHS Administration (PHS Admin) to support the development of a CHIP. The tables in this section align relevant Regional CEP goals to the PHS Strategic Plan Branch goals.

PHS has seven branches that provide the Leadership Teams in each of the Regions support and infrastructure to sustain efforts to advance their public health goals. Tables in this section describe particular ways in which PHS Epidemiology and Immunization Services (EISB), Maternal Child and Family Health Services (MCFHS), Public Health Preparedness and Response (PHPR), and PHS Admin provide technical assistance for selected CEP objectives.

For example, MCFHS has goals to promote early detection and prevention of disease and disabilities for at-risk populations. EISB has goals related to promoting immunizations and reducing childhood lead poisoning. These preventive health activities are also being advanced at the regional level in the East and North Central Regions and this is called out in their CEPs.

MCFHS has a goal to prevent chronic disease — primarily through policy, systems and environmental change efforts— to create healthy environments for residents in all San Diego communities. Every Regional CEP has adopted objectives to advance the same goal. The Regional CEP objectives reflect a wide range of innovative approaches, including: increasing access to healthy foods through *Live Well Community Markets*; conducting outreach and enrollment in federal nutrition programs; and increasing opportunities for physical activity by promoting active transportation options, including walking and biking.

The PHPR branch has a goal to foster collaboration with health systems to respond, to monitor, and plan for public health threats.

In addition, the PHS Admin has a goal to develop a pipeline for the future public health workforce that aligns with the North County Regions and South Region Leadership Team goals.

# LEVERAGING EFFORTS BY ALIGNING TO OTHER PLANS

***Linkages to PHS Strategic Plan—EISB***

Central, East and North Central Regional Leadership Teams have selected goals relevant to the EISB Immunization unit and Childhood Lead Poisoning Prevention Program (*Table 14*). EISB supports the Regional Leadership Teams with these goals by ensuring children are immunized in San Diego County by delivering educational presentations to the community, developing health promotion material, and providing vaccination services. In addition, EISB promotes the prevention of lead exposure through outreach and education efforts.

**Table 14. Alignment to Regional CEPs and PHS Strategic Plan EISB Goals.**

| PHS Strategic Plan | Alignment to Regional CEPs | | | | |
|---|---|---|---|---|---|
| | Central | East | North Central | North County Regions | South |
| **EISB Goal 2:** Promote high-quality immunization practices among public and private providers. | **Goal 1**:Improve resident's health through access to healthcare insurance, mental health, appropriate care, and support of continuum of care | **Goal 6:** Increase education and awareness of preventive healthcare services. | **Goal 2:** Provide quality and efficient care<br><br>**Goal 4:** Improve access to quality care. | --- | --- |
| **EISB Goal 5:** Reduce childhood lead poisoning through education, outreach, and early identification and treatment of children with elevated blood lead levels. | **Goal 1**:Improve resident's health through access to healthcare insurance, mental health, appropriate care, and support of continuum of care | **Goal 6:** Increase education and awareness of preventive healthcare services. | **Goal 2:** Provide quality and efficient care<br><br>**Goal 4:** Improve access to quality care. | --- | --- |

***Linkages to PHS Strategic Plan—MCFHS***

All Regional Leadership Teams have selected goals relevant to the MCFHS Branch units and programs, which include: Chronic Disease and Health Equity Unit, Child Health and Disability Prevention Program, Perinatal Care Network Program, and Office of Violence Prevention Program (*Table 15*). MCFHS supports the Regional Leadership Teams with these goals by providing technical assistance on policy, system, and environmental change efforts relevant to chronic disease, disability, perinatal care, and trauma informed care.

**Table 15 Alignment to Regional CEPs and PHS Strategic Plan MCFHS Goals.**

| PHS Strategic Plan | Alignment to Regional CEPs | | | | |
|---|---|---|---|---|---|
| | Central | East | North Central | North County Regions | South |
| **MCFHS Goal 1:** Create environments and policies that promote health equity and encourage healthy behaviors and healthy communities in order to reduce chronic disease and promote health equity for all residents. | **Goal 2:** Build resident capacity and leadership through the creation of healthy food choices and accessible food systems.<br><br>**Goal 3:** Champion practices and policies that promote a healthy food system. | **Goal 3:** Support school attendance.<br><br>**Goal 7:** Engage communities in civic life opportunities.<br><br>**Goal 8:** Enhance collaboration with school partners to address barriers to student achievement, engagement, and school climate | **Goal 3:** Support tobacco- and drug free lives.<br><br>**Goal 5:** Encourage healthy eating.<br><br>**Goal 6:** Promote access to healthy foods<br><br>**Goal 7:** Create opportunities to be physically active. | **Goal 2:** Reduce the prevalence of poor nutrition, food insecurity, and hunger among North San Diego County residents.<br><br>**Goal 3:** Increase physical activity among North San Diego County residents.<br><br>**Goal 6:** Reduce unintentional injuries within all age groups | **Goal 1:** Create smoke/ vape-free environments.<br><br>**Goal 2:** Address barriers to student engagement and achievement<br><br>**Goal 3:** Increase prosperity, education, and the economy. |

**Table 15 Continued. Alignment to Regional CEPs and PHS Strategic Plan MCFHS Goals.**

| PHS Strategic Plan | Alignment to Regional CEPs | | | | |
|---|---|---|---|---|---|
| | Central | East | North Central | North County Regions | South |
| **MCFHS Goal 1 Continued:** Create environments and policies that promote health equity and encourage healthy behaviors and healthy communities in order to reduce chronic disease and promote health equity for all residents. | **Goal 6:** Enhance civic life by growing local leaders. | **Goal 9:** Advance active living among older adults.<br>**Goal 11:** Enhance transportation options for older adults.<br>**Goal 12:** Increase civic life through participation.<br>**Goal 13:** Increase and identify housing options for older adults. | **Goal 8:** Increase neighborhood safety with environmental change.<br>**Goal 9:** Increase opportunities for youth and adults to enjoy recreation and nature. | **Goal 8:** Identify opportunities for community partners and residents to provide input towards North County transportation efforts.<br>Goal 9: Increase advocacy towards North County housing efforts. | --- |
| **MCFHS Goal 3:** Promote early detection and prevention of disease and disabilities of CHDP-eligible children, all first-grade enterers, and high-risk infants in San Diego County. | --- | **Goal 1:** Provide quality and efficient care | **Goal 4:** Improve access to quality care. | --- | --- |

**Table 15 Continued. Alignment to Regional CEPs and PHS Strategic Plan MCFHS Goals.**

| PHS Strategic Plan | Alignment to Regional CEPs | | | | |
|---|---|---|---|---|---|
| | Central | East | North Central | North County Regions | South |
| **MCFHS Goal 6:** Ensure that pregnant women receive appropriate perinatal support and services and infants are born healthy. | --- | **Goal 6:** Increase education and awareness of preventive healthcare services. | **Goal 4:** Improve access to quality care. | --- | --- |
| **MCFHS Goal 10:** Prevent, reduce, and respond to family violence in San Diego County through trauma informed practices. | **Goal 5:** Expand understanding of the impact of trauma to make communities safer. | **Goal 2:** Increase awareness of the impact of trauma.<br><br>**Goal 4:** Decrease stigma around behavioral health. | **Goal 1:** Increase awareness about the impact of trauma. | **Goal 1:** Increase awareness and access of mental health resources to North San Diego County residents at earliest point possible. | --- |

# LEVERAGING EFFORTS BY ALIGNING TO OTHER PLANS

***Linkages to PHS Strategic Plan PHPR***

The North County Regions Leadership Team has a goal relevant to the PHPR *(Table 16*). PHPR supports the North County Regional Leadership Team with this goal by fostering collaborative efforts with the health system to respond, monitor, and plan for public health threats.

**Table 16. Alignment to Regional CEPs and PHS Strategic Plan PHPR Goal.**

| PHS Strategic Plan | Alignment to Regional CEPs | | | | |
|---|---|---|---|---|---|
| | Central | East | North Central | North County Regions | South |
| **PHPR Goal 1:** Strengthen community resilience to ensure timely assessment and sharing of essential information to reduce exposure to disaster/public health risk. | --- | --- | --- | **Goal 7:** Increase disaster preparedness and community recovery efforts. | --- |

***Linkages to PHS Strategic Plan PHS Admin***

The North County Regions and South Region Leadership Teams have selected goals relevant to PHS Admin (*Table 17*). PHS Admin supports the Leadership Teams in advancing their goals by collaborating with local universities to onboard students for volunteer or internship experiences and develop a pipeline for the future public health workforce. PHS Admin also provides the technical support to help Regions and their Leadership Teams to produce these CEPs by advising on the structure of the CEPs, providing community data, and writing and formatting this document.

**Table 17. Alignment to Regional CEPs and PHS Strategic Plan PHS Admin Goal.**

| PHS Strategic Plan | Alignment to Regional CEPs | | | | |
|---|---|---|---|---|---|
| | Central | East | North Central | North County Regions | South |
| **PHS Admin Goal 5:** Ensure that the County and its residents are served by an agile, adaptable, highly skilled, public health workforce. | --- | --- | --- | **Goal 10:** Leverage partnerships with businesses and local schools in North County to support education and workforce efforts. | **Goal 3:** Increase prosperity, education, and the economy. |

# LEVERAGING EFFORTS BY ALIGNING TO OTHER PLANS

**Link to Other HHSA and County Programs, Which Also Advance the Public's Health**

These Regional CEPs capture many objectives that advance public health even if not called out specifically in the PHS Strategic Plan. For example, all of the Regions are undertaking activities to promote awareness and access to behavioral health resources, and/or reducing access to illegal substances, particularly among youth. Regional CEPs reflect recognition of the impact of trauma and increasing the knowledge of residents and community partners of the importance of trauma-informed approaches and services.

Crime prevention objectives are incorporated in several Regional CEPs, particularly for the Central Region and North County Regions, the latter with a focus on addressing gang activity. Most of the Regions have adopted objectives that are in line with County's Age Well initiative to improve the quality of life for seniors—in terms of access to health care, housing and other resources, coordinating intergenerational recreation and other activities. These CEPs also reflect objectives related to civic life or engagement, such as promoting volunteerism and the development of local leaders through Resident Leadership Academies (RLAs). These RLAs are designed to help these leaders implement innovative approaches to reduce chronic disease within their communities. Newer avenues of efforts are reflected in objectives calling for education and advocacy on housing and transportation options, and promoting workforce development and economic vitality.

# CONCLUSION

This Community Health Improvement Plan (CHIP) is an important document in the evolution of *Live Well San Diego.* The CHIP reflects the community planning efforts of Regional Community Leadership Teams that are at the heart of *Live Well San Diego*. The Leadership Teams are key to driving big, long-term change across every HHSA region by aligning local activity to interventions shown to work.

This CHIP includes five individual Community Enrichment Plans (CEPs). Each CEP is as unique as its Leadership Team, capturing each team's perspective and passion. The priorities, goals, and objectives within each CEP represent each Leadership Team's commitment toward action. Typically, these commitments are made in partnership with other organizations, across every sector, as well as County government.

All five Leadership Teams are learning and growing. These Teams meet regularly and are increasing in terms of number of members and variety of sectors participating. Their role and influence are gaining traction across each region. Each Leadership Team has expanded its scope by adopting priorities that go well beyond traditional health issues and address the social determinants of health.

The connection between action and intended impact is made explicit. Each CEP clarifies how these actions reflect practices that research has shown to work—along a continuum from promising practice, to evidence-informed, to evidence-based. This approach recognizes that the actions of any individual Leadership Team will not, in and of itself, lead to community change significant enough to register as an improvement in a Top 10 *Live Well San Diego* Indicator or any other indicator. However, the actions of these Leadership Teams together, along with the efforts of many other partners, will lead to positive change in the long run. In fact, gains are already in evidence . Death due to chronic disease has been trending downward in every region since 2000.

As illustrated in summary tables in this CHIP, each CEP captures priorities and goals on a wide range of topics that span across every theme within the *Live Well San Diego* components of Building Better Health, Living Safely, and Thriving.

Leadership Teams, through their CEPs, are working to address the social determinants of health because they know that socio-economic status, education, the community context such as crime, as well as other factors impact a resident's ability to live well. The scope of the CEPs is broader compared to 2014 when the Leadership Teams focused almost exclusively on the Building Better Health component of *Live Well San Diego*.

Monitoring progress will be critical. Progress towards implementing the objectives will be monitored, as will the long-term impact in terms of community or population well-being. The former will be monitored using performance measures associated with each objective; the later will be monitored using population or community indicators associated with each priority. Those indicators most relevant to the CEP priority have been identified from an array of indicators, including the Top 10 *Live Well San Diego* Indicators. The regions and their respective Leadership Teams will be supported by Public Health Services in the ongoing tracking of the CEPs so that we can all learn what works best and share those lessons across the *Live Well San Diego* collective impact effort.

These CEPs are "living" documents. Communities are dynamic, and their Leadership Teams will, should, and already do reflect this dynamism. As a result, the CEPs will be, to some extent, always changing—incorporating new or modified goals; focusing efforts on one objective or another; discovering that there may be a better way to measure progress with an alternative metric. Some regions are changing the way they do planning—going deeper into a smaller number of priorities—in line with South Region, a pilot to the Communities for Performance Excellence, in which Malcolm Baldrige criteria for excellence were adapted for community planning. Regions are also banding together and having their Leadership Teams address a common concern using a shared "logic model" to define interventions and measure results. This is consistent with the collective impact model, which is essentially a way for everyone to learn together what works best to achieve the shared vision for healthy, safe and thriving communities.

*Live Well San Diego*

# Community Enrichment Plan

## CENTRAL REGION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**2019-2021**

This document is the culmination of activities undertaken when implementing the *Live Well San Diego Community Health Improvement Plan, FY 2014-18.*

This document was developed under the General Management System of the County of San Diego, and is in support of *Live Well San Diego*.

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# REGIONAL DIRECTOR'S LETTER

## From the Regional Director

Dear Community Partner,

On behalf of the *Live Well San Diego* Central Region Leadership Team (*LWSD* CRLT), it is our pleasure to bring you the Central Region Community Enrichment Plan (CEP). This is our plan for advancing the *Live Well San Diego* vision in the Central Region.

The *Live Well San Diego* Central Region Leadership Team has a mission to improve the well-being of the Central Region community through collaboration and system changes that promote healthy, safe, and thriving communities. In order to realize the mission, the LWSD CRLT uses the *Live Well San Diego* vision as a blueprint for guiding actions, and data to identify priorities and partnerships. In addition, the Southeastern Live Well Center Advisory Committee was formed through the LWSD CRLT to provide direct input from the community to the County to ensure the upcoming Southeastern Live Well Center meets the needs of the community and aligns with the *Live Well San Diego* vision. The CEP reflects the priorities, goals and objectives, and measures from the strategic planning process with partner and resident input.

It is important to note that the COVID-19 pandemic contributed to a delay in the publication of this document, and shifted the focus of County staff, this Leadership Team, and residents. However, CEP is a dynamic plan that will evolve over the next planning cycle to incorporate priorities and goals that reflect the impact of this public health emergency on our region. We will continue to track progress in the implementation of objectives within the CEP and other activities that contribute to population level indicators that show we are making a real difference for residents within Central Region.

Our goal is to positively impact the lives of every resident in the Central Region in order for them to be healthy, safe and thrive.

Live Well,

**BARBARA JIMÉNEZ, MPH, Director of Regional Operations**
Central and South Regions
County of San Diego – Health and Human Services Agency
*Live Well San Diego CRLT* Co-chair

**ADOLFO GONZALES, Chief Probation Officer**
Probation Department
*Live Well San Diego CRLT* Co-chair

**BARRY POLLARD, Executive Director**
Urban Collaborative Project
*Live Well San Diego* CRLT Co-chair


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# BACKGROUND

## INTRODUCTION

This Community Enrichment Plan (CEP) represents the priorities of the *Live Well San Diego* Central Region Leadership Team (*LWSD* CRLT). The CEP priorities, goals, strategies, improvement objectives, and associated measures were identified and developed by the *LWSD* CRLT because they address the challenges, and build on the strengths of Central Region **[see Appendix I for the key to the CEP terminology and elements]**. This CEP also represents the ways in which the *LWSD* CRLT believes it can make the most significant contribution to help every resident Live Well. This CEP is part of a County of San Diego Community Health Improvement Plan (CHIP), aligned to the *Live Well San Diego* vision, that captures the content of all plans for each of the six Health and Human Services Agency (HHSA) Regions and their respective Leadership Teams. Each Leadership Team, comprised of community leaders representing organizations across every sector, plays a vital role in driving action on the ground to advance the *Live Well San Diego* vision by supporting and encouraging collective effort within the Region and leveraging resources available throughout the County.

## *LIVE WELL SAN DIEGO* CENTRAL REGION LEADERSHIP TEAM PLANNING PROCESS & SELECTION OF PRIORITIES

Formed in June 2010, the *Live Well San Diego* Central Region Leadership Team has helped assess, develop, and guide priorities and activities that improve well-being in the region using evidence-based strategies. In 2014, the *LWSD* CRLT developed an initial Community Health Assessment and CHIP. Since then, the *LWSD* CRLT has evolved to address health in the broadest sense that includes the social and physical environments in which residents live, also referred to as the social determinants of health. This is reflected in the changing of the name of individual CHIPs to Community Enrichment Plans (CEPs), as the Leadership Team priorities address objectives beyond just health.

The *Live Well San Diego* Central Region Leadership Team members have evolved since 2010 and today encompasses a broad range of community partners and stakeholders **[see Appendix II for the list of members of the Central Region Leadership Team]**. In 2015, the *LWSD* CRLT began using the Mobilizing for Action through Planning and Partnerships (MAPP) community planning model to select and prioritize regional issues and identified resources to address them. The *LWSD* CRLT received data presentations on relevant health, safety, and well-being trends and completed a survey to gather perspectives on challenges and priorities for Living Well that covered all components—Building Better Health, Living Safely, and Thriving. Whenever feasible, data was presented through a health equity lens—age, gender, geography, race/ethnicity, and socio-economic status. The survey contained questions relating to both Forces of Change applicable to the community, and Community Themes and Strengths, as these are two of the four MAPP assessments (see Methodology section, page 8).

# BACKGROUND

Following the data presentations and survey analysis, the *LWSD* CRLT's priorities, goals, and improvement objectives emerged during regular meetings through an iterative planning process. Unique to Central Region is the integration of some of the Promise Zone work within the CEP. A portion of the City of San Diego within the Central Region was designated as a Promise Zone by the federal government where local leaders in distressed areas work together to boost economic activity and job growth. This effort is in sync with the interests of the *LWSD* CRLT, and this CEP incorporates actions identified by a Promise Zone work group to increase access to health care and healthy foods. Throughout the process, attention was paid to ensure alignment to the *Live Well San Diego* framework to show how the priority areas and goals selected by the *LWSD* CRLT support the shared vision.


## *LIVE WELL SAN DIEGO* CENTRAL REGION LEADERSHIP TEAM PRIORITIES

### BUILDING BETTER HEALTH

- Health - Access to Quality Care
- Health - Support Healthy Eating

### LIVING SAFELY

- Community - Reduce Crime
- Community - Improve Trauma Informed Systems

### THRIVING

- Social - Enhance Civic Life

*Note that in Central Region, the Priorities are equivalent to Areas of Influence (e.g., Health, Community, Social) followed by language that reflects the focus of the associated goals.*

## HOW THE COUNTY SUPPORTS IMPLEMENTATION OF THE COMMUNITY ENRICHMENT PLANS

The *Live Well San Diego* Central Region Leadership Team cannot on its own implement the improvement objectives that appear in the CEP. The *LWSD* CRLT is part of the much bigger collective impact effort of the *Live Well San Diego* vision. This means that success in reaching the improvement objectives, within this plan and other Regional CEPs, depends on leveraging the efforts of partners across all sectors as well as existing County programs and services. For example, a goal to support healthy food choices and food systems will draw upon the County of San Diego Public Health Services Department Chronic Disease and Health Equity program. Behavioral health activities, reflected in many Regional CEPs, are assisted by staff and programs within the County of San Diego Behavioral Health Services Department, which offers prevention and early intervention services and an array of treatment programs. Age Well San Diego, a San Diego County Board of Supervisor initiative to create age-friendly communities, has an action plan that supports intergenerational activities and transportation policies, which closely align with CEP goals. The many assets and resources across San Diego County—public, private, and non-profit—are detailed in the FY 2019-2021 Community Health Assessment. The County of San Diego Regional Director and community engagement staff within each Region assist the Leadership Team to achieve their CEP improvement objectives by providing technical assistance and leveraging County initiatives, programs, and services whenever possible **[see the 2019-2021 Community Health Assessment for more discussion of assets and resources available across San Diego County]**.

## BUILDING THE REGIONAL COMMUNITY ENRICHMENT PLAN

The *Live Well San Diego* vision, and the three components, Building Better Health, Living Safely, and Thriving, serve as the framework for the *Live Well San Diego* CHIP as well as the Regional CEPs (as depicted in the *Live Well San Diego* Pyramid, Figure 1). The final CEP is organized in the language of the Leadership Teams—that is the priorities, goals, and objectives as these leaders defined them. The structure of the CEP content and alignment to *Live Well San Diego* is illustrated in the "Template for the Community Enrichment Plan" which follows (see Figure 2). The "Key to the Community Enrichment Plan," which explains all of the elements, terminology and icons used, is Appendix I.

The content for the CEPs is displayed—Priorities, Indicators, Goals, Improvement Objectives, and Metrics. Alignment is shown visually with the use of icons or colors. Indicators align to *Live Well San Diego* Areas of Influence; Goals align to *Live Well San Diego* Components; and Improvement Objectives align to *Live Well San Diego* Strategic Approaches. *Note that in Central Region, the Priorities are equivalent to Areas of Influence (e.g., Health, Knowledge, Standard of Living, Community, Social) followed by language that reflects the focus of the associated Goals.*

It should be noted that several types of Indicators are identified by Priority. These Indicators include the Top 10 *Live Well San Diego* Indicators, Expanded Indicators, and Supporting Indicators, depending upon which Indicators align to the priority **[see Appendix I for an explanation of the difference between types of Indicators].** Also, Indicators from a newly created Public Health Services Indicators dashboard appear, an expectation of accredited public health departments **[see Appendix III for the *Live Well San Diego* and Public Health Services Indicators Dashboards]**. Any positive movement of the Indicators is achieved over the long term by implementing evidence-informed strategies as described in the Basis for Action **[see Appendix IV for the Basis for Action]**.

**Figure 1. *Live Well San Diego* Vision Pyramid.**

# BUILDING THE REGIONAL COMMUNITY ENRICHMENT PLAN

Regional CEPs do not always cover every Component of the *Live Well San Diego* framework. Each Region's Leadership Team makes the determination of what **Priorities** they will undertake, recognizing that these Leadership Teams must be responsive to the unique needs of their Regions and focus their efforts on those issues or concerns in which members believe the Leadership Team can have the greatest impact through collective action.

Also, these plans are iterative in that **Priorities**, **Goals,** and **Improvement Objectives** can change over time as the Leadership Team responds to evolving needs of the community.

## Figure 2. Template for the Community Enrichment Plan

**Priority:**

| 5 Areas of Influence | Top 10 *Live Well San Diego* Indicators<br>• Expanded Indicator<br>• *Supporting Indicator* | Public Health Services Indicators |
|---|---|---|
| HEALTH | Life Expectancy<br>Quality of Life<br>• Expanded Indicator<br>• *Supporting Indicator* | 3-4-50<br>ADRD Death Rate<br>Infant Mortality Rate<br>HIV Disease Diagnosis Estimates |
| KNOWLEDGE | Education<br>• Expanded Indicator<br>• *Supporting Indicator* | High School Education |
| STANDARD OF LIVING | Income—Spending Less than 1/3 of Income on Housing<br>Unemployment Rate<br>• Expanded Indicator<br>• *Supporting Indicator* | Unemployment Rate<br>Income Inequality<br>Poverty |
| COMMUNITY | Security—Crime Rate<br>Physical Environment—Air Quality<br>Built Environment—Distance to Park<br>• Expanded Indicator<br>• *Supporting Indicator* | Childhood Lead in Schools |
| SOCIAL | Community Involvement—Volunteerism<br>Vulnerable Populations—Food Insecurity<br>• Expanded Indicator<br>• *Supporting Indicator* | Voting |



**Goals Aligned to the Three Components of *Live Well San Diego* and Corresponding Icons and Color Bands**

| |
|---|
| Building Better Health — Goal X: X |
| Living Safely —Goal X: X |
| Thriving —Goal X: X |

**Improvement Objectives and Metrics Aligned to the Four *Live Well San Diego* Strategic Approaches and Corresponding Icons**

| Strategic Approach | Improvement Objective and Metric |
|---|---|
| | X.X: Improvement Objective |
| | ◊ Metric |

# *LIVE WELL SAN DIEGO*
# COMMUNITY ENRICHMENT PLAN – CENTRAL REGION


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**Priority:**
**HEALTH— Access to Quality Care**

| Area of Influence | Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | Public Health Services Indicator |
|---|---|---|
| HEALTH | **Life Expectancy**<br>**Quality of Life**<br>• **None Applicable**<br>• *Population with Suicidal Ideation* | **3-4-50 Deaths** |

## GOAL 1: Improve Residents' Health through Access to Healthcare Insurance, Mental Health, Appropriate Care, and Support of Continuum of Care

**Improvement Objectives and Metrics**

1.1: Increase healthcare coverage among Promise Zone residents to improve access to both physical and behavioral health services.

- ◊ Number of distributed materials and clinic applications provided to Promise Zone residents by outreach and enrollment coordinators
- ◊ Number of Promise Zone residents referred to healthcare coverage

1.2: Foster and enhance connections between health providers, schools, and community groups to provide coordinated healthcare.

- ◊ Increase the San Diego Promise Zone community collaborations such as writing grants, community events, cross trainings, etc.

1.3: Provide outreach to San Diego Promise Zone residents to increase healthcare enrollment and maintain coverage.

- ◊ Number of people successfully enrolled or re-enrolled into healthcare coverage

**Priority:**
**HEALTH— Support Healthy Eating**

| Area of Influence | Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | Public Health Services Indicator |
|---|---|---|
| HEALTH | **Life Expectancy**<br>**Quality of Life**<br>• **None Applicable**<br>• *Household Fresh Vegetable Use* | **3-4-50 Deaths** |
| SOCIAL | **Food Insecurity** | |

## GOAL 2: Build Resident Capacity and Leadership through the Creation of Healthy Food Choices and Accessible Food Systems

**Improvement Objectives and Metrics**

2.1: Increase availability of fresh fruits and vegetables in the community.

- ◊ Number of markets participating in Live Well Community Markets program
- ◊ Number of new community gardens installed

2.2: Support planning and policy efforts to ensure sustainable, equitable, healthy, affordable, and accessible food for all residents.

- ◊ Number of civic engagement activities with decision makers and municipal staff

2.3: Advance a healthy food environment in Southeastern San Diego by supporting the Good Food District.

- ◊ Number of modified retail food environments

2.4: Engage and align with existing food systems groups and organizations.

- ◊ Number of community-based organizations and/or events that distributed the food resource list

2.5: Promote Urban Agriculture Incentive Zones (UAIZ) Program.

◊ Number of property owners that designate land for urban farming

2.6: Implement healthy land use policies (e.g., incentives for healthy retail, urban agriculture).

◊ Number of land use policy changes

## GOAL 3: Champion Practices and Policies that Promote a Healthy Food System

**Improvement Objectives and Metrics**

3.1: Enhance the connection between food systems and career paths.

◊ Number of graduates in culinary training programs

3.2: Increase outreach and enrollment in federal nutrition programs.

◊ Number of people enrolled in federal nutrition programs

◊ Number of outreach and enrollment activities

**Priority:**
**COMMMUNITY— Reduce Crime**

| Area of Influence | Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | Public Health Services Indicator |
|---|---|---|
| COMMUNITY | **Crime Rate**<br>• **None Applicable**<br>• *Probation Youth*<br>• *Risk of Recidivation* | **None Applicable** |

## GOAL 4: Prevent and Protect Residents from Crime

**Improvement Objectives and Metrics**

4.1.Intervene early with at-risk youth using community-based interventions, including mentoring or diversion programs.

◊ Community Mentor Summit convened

4.2: Take steps to assess cause of gang activity and take actions to protect residents from crime.

◊ Number of community partnerships established to address gang activity

**Priority:**
**COMMUNITY— Improve Trauma Informed Systems**

| Area of Influence | Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | Public Health Services Indicator |
|---|---|---|
| COMMUNITY | **Crime Rate**<br>• **None Applicable**<br>• *Rate of ED Discharges for Opioid Disorders* | **None Applicable** |

## GOAL 5: Expand Understanding of the Impact of Trauma to Make Communities Safer

**Improvement Objectives and Metrics**

5.3: Increase awareness among residents and community partners of the importance of trauma- informed approaches and services.

◊ Number of screenings of the resiliency films, titled “Resilience ” and “Paper Tigers” (number of people viewing)

**Priority:**
**SOCIAL— Enhance Civic Life**

| Area of Influence | Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | Public Health Services Indicator |
|---|---|---|
|  | **Volunteerism**<br>• **None Applicable** | **None Applicable** |

## GOAL 6: Enhance Civic Life by Growing Local Leaders

**Improvement Objectives and Metrics**

6.1: Scale up Resident Leadership Academies (RLAs) across the Regions to expand into emerging issues impacting the community.

◊ Number of RLA graduates

# APPENDIX


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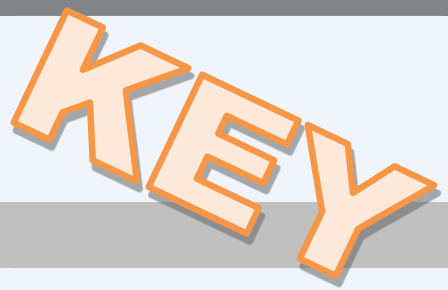
# APPENDIX I—KEY TO THE COMMUNITY ENRICHMENT PLAN

This section explains the terms and elements that are being used in the CHIP and CEPs. Careful attention was made to ensure that clear alignment to the *Live Well San Diego* vision was achieved, while also adhering to standard planning terminology.




## Priority

The issue that was selected by the Leadership Team to address, based on a review of community health assessment and other data and the knowledge and passion of members in the Leadership Team.

## Five Areas of Influence

These are the dimensions that capture overall well-being: Health, Knowledge, Standard of Living, Community, and Social. The Areas of Influence reflect that good health goes beyond physical well-being to include the social determinants of health.

| Five Areas of Influence and the Corresponding Icons and Definitions | | | | |
|---|---|---|---|---|
| HEALTH | KNOWLEDGE | STANDARD OF LIVING | COMMUNITY | SOCIAL |
| Enjoying good health and expecting to live a full life | Learning throughout the lifespan | Having enough resources for a quality of life | Living in a clean and safe neighborhood | Helping each other to live well |

# APPENDIX I—KEY TO THE COMMUNITY ENRICHMENT PLAN

## Top 10 *Live Well San Diego* Indicators

Indicators are intended to capture the collective impact of programs, services, and interventions over the long term. The Top 10 *Live Well San Diego* Indicators define what it means to "live well" in San Diego. For each CEP Priority, the appropriate *Live Well San Diego* Indicators are identified in bold with the appropriate icon. "Expanded" Indicators, which are indented in bold, may be identified which are part of the *Live Well San Diego* framework and further describe each Top 10 indicator. This may also include a "Supporting" Indicator which is not part of the Top 10 but is viewed as an additional population measure that reflects progress in the medium- to long-range time span to achieving that priority. These are identified in italics.

**Due to space constraints, only those Indicators, Expanded Indicators, and Supporting Indicators that appear in the individual CEPs are presented in the Key.**

**Top 10 *Live Well San Diego* Indicators**
- **Expanded Indicator**
- *Supporting Indicator*

KEY

**Life Expectancy** **Quality of Life**
- *Population with Suicidal Ideation*
- *Household Fresh Vegetable Use*
- *Routine Care*
- *Access to Affordable Fruits/Vegetables*
- *Childhood Obesity*
- *Child Dental Visits*
- *Seniors Walking for Transportation, Fun, or Exercise*
- *High School E-Cigarette Use*

**Education**
- *Chronic Absenteeism*

**Income-Spending Less than 1/3 of Income on Housing** **Unemployment Rate**
- **Percentage of Population with a Checking or Savings Account**

**Security—Crime Rate** **Physical Environment—Air Quality** **Built Environment—Distance to Park**
- **Travel Time to Work Over 60 Minutes**
- *Probation Youth*
- *Risk of Recidivation*
- *Residents Experiencing Psychological Distress*
- *Active Transport to School*
- *Rate of ED Discharges for Opioid Disorders*
- *Fall Injury Hospitalization Rates*
- *Disaster Vulnerable Residents*

**Community Involvement—Volunteerism** **Vulnerable Populations—Food Insecurity**
- **Volunteerism**
- **Food Insecurity**

# APPENDIX I—KEY TO THE COMMUNITY ENRICHMENT PLAN

## Public Health Services Indicators


To maintain national public health accreditation, a dashboard has been developed to capture indicators that are most relevant to interventions in which Public Health Services plays a key role — this dashboard is referred to as the Public Health Services Dashboard. These indicators are in bold and defined on this page. The indicators are part of a national database submitted to the Public Health Accreditation Board to show the significance and impact of maintaining public health accreditation that results in meeting targets for population health outcomes.

| Public Health Services Indicators | Description |
|---|---|
| **3-4-50 Percent** | Percent of deaths due to the four chronic diseases (cancer, heart disease and stroke, type 2 diabetes, and pulmonary diseases such as asthma). |
| **ADRD Death Rate** | Alzheimer's Disease and Related Dementias (ADRD) death rate per 100,000 population. |
| **Childhood Lead in Schools** | The number of cases from the San Diego Childhood Lead Poisoning Prevention Program. |
| **High School Education** | Overall Graduation Rate: The percentage of those over the age of 25 with a high school diploma or equivalent. |
| **HIV Disease Diagnosis Estimates** | HIV disease diagnosis case counts and percentages. |
| **Income Inequality** | Number of Total Earned Income Tax Credits. |
| **Infant Mortality Rate** | Three-year average Infant Mortality Rate per 1,000 live births. |
| **Poverty** | Percent of the population below poverty level. |
| **Unemployment Rate** | Percent of the total labor force that is unemployed (actively seeking employment and willing to work). |
| **Voting** | Percent of the population who voted in a Federal/State/Local election in the last 12 months. |

## Goal

A goal is an aspiration or broad statement of what the Leadership Team wants to achieve in the longer term (more than three years).

## *Live Well San Diego* Component

There are three major components to *Live Well San Diego*. Each Priority and Goal is aligned to one of these components—Building Better Health, Living Safely, and Thriving. The CEP goals show alignment to the *Live Well San Diego* components by including the respective icon and color (see below).

| Building Better Health | Living Safely | Thriving |
|---|---|---|

# APPENDIX I—KEY TO THE COMMUNITY ENRICHMENT PLAN

## Strategic Approach

The *Live Well San Diego* vision is achieved through four strategies, referred to as Strategic Approaches. These are *Building a Better Service Delivery System*, *Supporting Positive Choices*, *Pursuing Policy and Environmental Changes*, and *Improving the Culture from Within*. These Strategic Approaches are used as the strategies for the CEPs, which are how the Leadership Team will go about achieving the goal. The icons and definitions for the Strategic Approaches are listed below.

| *Live Well San Diego* Strategic Approaches | | | |
|---|---|---|---|
| **Building a Better Service Delivery System** | **Supporting Positive Choices** | **Pursuing Policy and Environmental Changes** | **Improving the Culture from Within** |
|  |  |  |  |
| Improving the quality and efficiency of County government and its partners in the delivery of services to residents, contributing to better outcomes for clients and results for communities. | Providing information and resources to inspire County residents to take action and responsibility for their health, safety, and well-being. | Creating environments and adopting policies that make it easier for everyone to live well, and encouraging individuals to get involved in improving their communities. | Increasing understanding among County employees and providers about what it means to live well and the role that all employees play in helping residents live well. |

## Improvement Objective

The Improvement Objective is the change or improvement that the Leadership Team seeks or hopes to accomplish in the shorter term (one to three years). The Improvement Objective reflects actions that the Leadership Team has decided to take and is supported by the research, evidence, or best practice to contribute to advancement of the goal and ultimately community change. For each Improvement Objective, the Strategic Approach is indicated with the corresponding icon in the CEP to indicate alignment.

## Metric

The metric indicates the target and how progress will be measured for each improvement objective.

# APPENDIX II— LIST OF *LIVE WELL SAN DIEGO* CENTRAL REGION COMMUNITY LEADERSHIP TEAM MEMBERS

## *LIVE WELL SAN DIEGO* CENTRAL REGION LEADERSHIP TEAM MEMBERS

**CO-CHAIRS:**

Barbara Jiménez, Director of Regional Operations, HHSA-Central & South Regions, County of San Diego
Adolfo Gonzales, Chief, Probation, County of San Diego
Barry Pollard, Executive Director, Urban Collaborative Project

**Members:** The current *Live Well San Diego* Central Region Leadership Team consists of the agencies and organizations listed below. Some members regularly attend meetings whereas other valued partners are contributing in other meaningful ways to the development and implementation of the CEP. **Some members are also *Live Well San Diego* Recognized Partners which is indicated with an asterisk (*).**

**CENTRAL REGION LEADERSHIP TEAM MEMBERS BY SECTOR**

| Cities & Governments | Business & Media | Community & Faith-Based | Schools & Education |
|---|---|---|---|
| City of San Diego* | Sirius Fitness*<br>Northgate Gonzalez Markets* | Be There San Diego*<br>San Diego Black Nurses Association*<br>La Maestra Family Health Center*<br>National Conflict Resolution Center*<br>Logan Heights Community Development Corp.*<br>Project New Village*<br>The Urban Collaborative Project*<br>SAY (Social Advocates for Youth) San Diego*<br>UCSD Center for Community Health<br>Multicultural Health Foundation*<br>Project AWARE*<br>Second Chance*<br>Paving Great Futures*<br>Community Health Improvement Partners*<br>Family Health Centers of San Diego*<br>San Ysidro Health Center* | San Diego Unified School District* |

**Other Valued Partners**

Cultural Brokers Program
Project Save Our Children
Urban Beats
Black American Political Association of California
Alliant University
New Harvest Christian Fellowship
San Diego Police Department
Sons & Daughters of Guam Club, Inc.

# APPENDIX II— LIST OF *LIVE WELL SAN DIEGO* CENTRAL REGION COMMUNITY LEADERSHIP TEAM MEMBERS

| Cities & Governments | Business & Media | Community & Faith-Based | Schools & Education |
|---|---|---|---|
| | | YMCA*<br>Harmonium Inc.*<br>Inner City Athletic Club*<br>Mental Health America<br>Shakti Rising<br>Youth Empowerment*<br>National Conflict Resolution Center*<br>Fern Street Community Arts*<br>Barrio Logan College Institute*<br>Bayview Baptist Church*<br>Planned Parenthood*<br>San Diego Hunger Coalition*<br>Urban Collaborative Project*<br>United Women of East Africa*<br>Project Concern International*<br>Union of Pan Asian Communities<br>RISE San Diego*<br>American Heart Association and<br>American Stroke Association*<br>Home Start, Inc.*<br>San Diego Workforce Partnership*<br>Urban Corps of San Diego County*<br>Urbanlife Ministries San Diego*<br>Kitchens for Good*<br>Chicano Federation of San Diego County*<br>Urban League* | |

# APPENDIX III—INDICATORS

## TOP 10 *LIVE WELL SAN DIEGO* INDICATORS DASHBOARD ALIGNED TO *LWSD* AREAS OF INFLUENCE

*Live Well San Diego* Dashboard
Top 10 Population Outcome Indicators: CENTRAL REGION

| | Indicator | Description | We want to increase this / We want to decrease this | San Diego County | Central Region | Central San Diego | Mid-City | Southeastern San Diego |
|---|---|---|---|---|---|---|---|---|
| **HEALTH - Enjoying good health and expecting to live a full life** | | | | | | | | |
| HEALTH | Life Expectancy | Average number of years a person is expected to live at birth. 2016. | ↑ | 82.1 | 80.9 | 81.8 | 80.6 | 80.1 |
| | Quality of Life | Percent of the population 18 and older, not residing in nursing homes or other institutions, that is sufficiently healthy to be able to live independently. 2017. | ↑ | 94.9% | 95.0% | 95.8% | 95.6% | 93.3% |
| **KNOWLEDGE - Learning throughout the lifespan** | | | | | | | | |
| KNOWLEDGE | Education: High School Diploma or Equivalent | Overall Graduation Rate: the percentage of those over the age of 25 with a high school diploma or equivalent. 2017. | ↑ | 86.1% | 79.4% | 86.9% | 77.2% | 72.6% |
| **STANDARD OF LIVING - Having enough resources for a quality life** | | | | | | | | |
| STANDARD OF LIVING | Unemployment Rate | Percent of the population that is unemployed. 2018. | ↓ | 3.9% | 4.6% | 3.5% | 4.8% | 6.0% |
| | Income: Percent of population spending less than 1/3 of income on housing | Percent of the population spending less that 1/3 of their income on housing. 2016. | ↑ | 52.9% | 48.0% | 51.5% | 44.6% | 47.5% |
| **COMMUNITY - Living in a clean and safe neighborhood** | | | | | | | | |
| COMMUNITY | Security: Overall Crime Rate | Overall Crime rate per 100,000 population. 2017. | ↓ | 2032.6 | N/A | N/A | N/A | N/A |
| | Physical Environment: Air Quality | Percent of days rated unhealthy for vulnerable populations. 2018. | ↓ | 6.1% | N/A | N/A | N/A | N/A |
| | Built Environment: Percent of population living within 1/4th a mile of a park or community space | Percentage of population that resides within a quarter mile of a park or community space. 2018. | ↑ | 61.3% | 78.1% | 79.4% | 76.6% | 74.5% |
| **SOCIAL - Helping each other to live well** | | | | | | | | |
| SOCIAL | Vulnerable Populations: Food Insecurity | Percent of adult population 200% below FPL not able to afford food. 2017. **Indicates statistically unstable estimates. Proceed with caution.* | ↓ | 37.6% | 39.8% | N/A | N/A | N/A |
| | Community Involvement: Volunteerism | Percent of residents who volunteer. 2017. | ↑ | 25.5% | N/A | N/A | N/A | N/A |

On the right track  Not on track  No change

To view more information about the *Live Well San Diego* Indicators and how we will measure progress go to:
http://www.sdcounty.ca.gov/hhsa/programs/sd/live_well_san_diego/indicators.html

## PUBLIC HEALTH SERVICES INDICATORS DASHBOARD

### San Diego County Public Health Services Dashboard
### Top 10 Population Outcome Indicators: CENTRAL REGION

LIVE WELL SAN DIEGO

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY PUBLIC HEALTH SERVICES

| | Indicator | Description | We want to increase this / We want to decrease this | San Diego County | Central Region | Central San Diego | Mid-City | Southeastern San Diego |
|---|---|---|---|---|---|---|---|---|
| **HEALTH - Enjoying good health and expecting to live a full life** | | | | | | | | |
| HEALTH | "3-4-50" Percent | Percent of deaths due to the four chronic diseases (cancer, heart disease and stroke, type 2 diabetes, and pulmonary diseases such as asthma). 2016. | ↓ | 53% | 53% | 50% | 52% | 58% |
| | ADRD Death Rate | Alzheimer's Disease and Related Dementias (ADRD) death rate per 100,000 population. 2016. | ↓ | 121.1 | 82.0 | 85.4 | 81.0 | 87.8 |
| | Infant Mortality Rate | Annual Infant Mortality Rate per 1,000 live births. 2016. | ↓ | 3.7 | 3.8 | N/A | N/A | N/A |
| | Infant Mortality Rate | Three-year average Infant Mortality Rate per 1,000 live births. 2013-2015. | ↓ | 4 | 4.8 | N/A | N/A | N/A |
| | HIV Disease Diagnosis Estimates | HIV Disease diagnosis case counts and percentages between 2012-2016 time period. | ↓ | 100% (2,462) | 44% (1,081) | N/A | N/A | N/A |
| **KNOWLEDGE - Learning throughout the lifespan** | | | | | | | | |
| KNOWLEDGE | High School Education | Overall Graduation Rate: the percentage of those over the age of 25 with a high school diploma or equivalent. 2017. | ↑ | 86.1% | 79.4% | 86.9% | 77.2% | 72.6% |
| **STANDARD OF LIVING - Having enough resources for a quality life** | | | | | | | | |
| STANDARD OF LIVING | Unemployment Rate | Percent of the total labor force that is unemployed (actively seeking employment and willing to work). 2018. | ↓ | 3.9% | 4.6% | 3.5% | 4.8% | 6.0% |
| | Income Inequality | Number of Total Earned Income Tax Credits. 2017 tax year. | ↓ | 7059 | 1811 | N/A | N/A | N/A |
| | Poverty | Percent of the population below poverty level. 2017. | ↓ | 13.4% | 20.6% | 17.4% | 25.2% | 19.6% |
| **COMMUNITY - Living in a clean and safe neighborhood** | | | | | | | | |
| COMMUNITY | Childhood Lead in Schools | The number of cases San Diego Childhood Lead Poisoning Prevention Program. 2009-2013. | ↓ | 105 | 33 | N/A | N/A | N/A |
| **SOCIAL - Helping each other to live well** | | | | | | | | |
| SOCIAL | Voting | Percent of the population who voted in a Federal/State/Local election in the last 12 months. 2018. | ↑ | 43.8% | 35.7% | 41.8% | 33.0% | 30.6% |

On the right track  Not on track  No change

To view more information about the *Live Well San Diego* Indicators and how we will measure progress go to:
http://www.sdcounty.ca.gov/hhsa/programs/sd/live_well_san_diego/indicators.html

# APPENDIX IV - BASIS FOR ACTION

The Basis for Action tells the story of why a priority is important and why the Leadership Team has chosen certain improvement objectives for its CEP. This information helps to show how the Leadership Team is being responsive to the unique needs of their region and is adopting scalable, evidence-informed improvement objectives. However, this Basis for Action is a simplistic way of capturing the rationale for action and does not tell the whole story. A lot of factors and information influence the final CEP, including the varying experiences and perspectives of those who serve on a Leadership Team, events or crises that occur within or that impact communities within the Region, among many other factors. The Basis for Action serves to distill some of the data, research, and evidence that supports the plan of action reflected in the CEP.

This information is organized by the Priorities of the CEP. This is what appears:

- "What the Numbers Say" captures a few data points that reflect the conditions in Central Region that helped persuade the Leadership Team to make this a priority.
- "What the Research Says about this Priority Concern" captures research that explains how this priority concern impacts health and well-being.
- "What Interventions Work According to the Research" identifies those practices that work based on the research. These interventions fall along a continuum in terms of the degree to which their effectiveness has been demonstrated—from promising practice to evidence-informed to evidence-based.
- "How are Regional Goals and Improvement Objectives Consistent with these Interventions" describes how what the Leadership Team is planning to do is consistent with the interventions that have been shown to work.

Why is it important to include the Basis for Action? The literature on collective impact explain that it is important that every partner do what they do best while being committed to the mutually-reinforcing vision for collaborative community change, which is the *Live Well San Diego* vision in this case. Leadership Teams are in a unique position to leverage the activities and efforts of others throughout the Region. Choosing strategies and improvement objectives that are evidence-informed is the best way to influence long-term population outcomes. The collective impact approach also calls for partners to identify not only what they can do best, but also at the scale to which they can be successful.

*Footnotes are used to identify the source of the data — For "What the Numbers Say," footnotes appear in alphabetical order at the end of the appendix. All other footnotes to the research that follows appear in numerical order and immediately below each Priority section.*

| Priority | Alignment with *Live Well San Diego* Component | AREAS OF INFLUENCE<br>Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | AREAS OF INFLUENCE<br>Public Health Services Indicator |
|---|---|---|---|
| **HEALTH—<br>Access to Quality Care** | **Building Better Health**  | **HEALTH**<br>**Life Expectancy**<br>**Quality of Life**<br>• **None Applicable**<br>• *Population with Suicidal Ideation* | **HEALTH**<br>• **3-4-50 Deaths** |

| | |
|---|---|
| What the Numbers Say | • According to the California Health Interview Survey, nearly **1 in 8** Central Region residents did not have a usual source of care. [A]<br>• Just over **1 in 9** Central Region residents has seriously thought about committing suicide, according to the California Health Interview Survey. [A] |
| What the Research Says about this Priority Concern<br>**how health and well-being is affected* | Access to comprehensive, quality health care services is important for promoting and maintaining health, preventing and managing disease, reducing unnecessary disability and premature death, and achieving health equity for all Americans. Access to care often varies based on race, ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, gender identity, and residential location. [1] |
| What Interventions Work According to the Research<br>* *practices that work based on the research* | Research supports these types of interventions:<br>• Address barriers to health services, which include high cost of care, inadequate or lack of insurance coverage, limited availability of services, and lack of competent care.[1]<br>• Help connect individuals to an ongoing source of care and a primary care provider.[1]<br>• Promote health benefits legislation, which is associated with increased access to care, increased diagnosis of mental health conditions, reduced prevalence of poor mental health and reduced suicide rates.[2] |
| How are Regional Goals and Improvement Objectives Consistent with these Interventions<br>**consistency between what the Leadership Team is planning to do and the interventions that have been shown to work.* | Central Region is home to three of the county's most economically disadvantaged neighborhoods, which together comprise the San Diego Promise Zone. The San Diego Promise Zone is characterized by high unemployment, low educational attainment, insufficient access to healthy foods, concentrated poverty, rising crime, and the least affordable housing in the nation. Mental healthcare and access to all types of healthcare is a struggle in the Promise Zone, which is why the Central Region is working to improve these outcomes. The Leadership Team is focused on reducing barriers to health services as is recommended in the research by working with San Diego Promise Zone residents to increase healthcare enrollment, encouraging maintenance of coverage, and fostering greater coordination of care. |

1. https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services

2. https://www.thecommunityguide.org/content/now-published-benefit-mental-health-benefit-laws

| **Priority** | **Alignment with *Live Well San Diego* Component** | **AREAS OF INFLUENCE**<br>**Top 10 *Live Well San Diego* Indicator**<br>• **Expanded Indicator**<br>• *Supporting Indicator* | **AREAS OF INFLUENCE**<br>**Public Health Services Indicator** |
|---|---|---|---|
| **HEALTH—**<br>**Support Healthy Eating** | **Building Better Health**  | **HEALTH**<br>**Life Expectancy**<br>**Quality of Life**<br>• **None Applicable**<br>• *Household Fresh Vegetable Use*<br>**SOCIAL**<br>**Food Insecurity**<br>• **None Applicable** | **HEALTH**<br>• **3-4-50 Deaths** |

| | |
|---|---|
| What the Numbers Say | • When Central Region residents are surveyed about access to affordable fresh fruits and vegetables, just under **50%** said these were always available in their neighborhoods.[B]<br>• **2 in 5** Central Region residents have gone to a fast food or drive-in restaurant **more than 9** times in the last month, according to ESRI Community Analyst.[C]<br>• According to the California Health Interview Survey, **2 in 5** Central Region residents under the 200% Federal Poverty Level were food insecure.[A] |
| What the Research Says about this Priority Concern<br>**how health and well-being is affected* | Previous studies suggest that children living in food-insecure households face elevated risks of many problematic health and development outcomes, such as chronic conditions, compared with children in otherwise similar food-secure households. [1,2,3] Food security is especially important for children because their nutrition affects not only their current health, but also their physical, mental, and social development—and thus their future health and well-being.[3]<br><br>Obesity among food insecure people – as well as among low-income people – occurs in part because they are subject to the same influences as other Americans (e.g., more sedentary lifestyles, increased portion sizes), but also because they face unique challenges in adopting healthy behaviors. Food insecure and low-income people are especially vulnerable to obesity[4] because of factors such as 1) limited resources and lack of access to healthy, affordable foods;[5] 2) fewer opportunities for physical activity;[6] 3) cycles of food deprivation and overeating;[7] 4) high levels of stress;[8] and, 5) greater exposure to marketing of obesity-promoting products.[9] |

| | |
|---|---|
| What Interventions Work According to the Research<br>* *practices that work based on the research* | Research supports these types of interventions:<br>• Support a community market program to increase availability of fresh and healthy foods in underserved communities. The Live Well Community Markets in San Diego County have been shown to increase access based on estimates of visits from customers eligible for nutrition programs.[10]<br>• Promote Urban Agriculture as this can contribute to food security and allow low-income consumers to have easier access to fresh produce.[11]<br>• Support community gardens because they offer physical and mental health benefits. A community gardening program can reduce food insecurity, improve dietary intake, and strengthen family relationships.[12]<br>• Partner with food banks, advocacy organizations, and affiliated community organization such as Boys and Girls Clubs, to raise awareness of the importance of healthy eating.[13]<br>• Encourage participation in after-school meal programs for low-income, at-risk students, especially in school districts similar to those in the Promise Zone.[13] |
| How are Regional Goals and Improvement Objectives Consistent with these Interventions<br>**consistency between what the Leadership Team is planning to do and the interventions that have been shown to work* | Central Region's goals and improvement objectives are consistent with the research in that the focus is increasing availability of healthy foods through community markets and gardens. The Leadership Team is also calling for outreach and enrollment in federal nutrition programs and enlisting community-based organizations in efforts to distribute resources about nutrition and food availability. Finally, the Leadership Team is adopting a policy, systems, and environmental change approach by adopting improvement objectives related to civic engagement, land use policy changes through agriculture incentive zones and healthy land use policies. |


1. Chilton, Mariana, Maureen M. Black, Carol Berkowitz, Patrick H. Casey, John Cook, Ruth Rose Jacobs, Alan Meyers, Deborah A. Frank, Diana Cutts, Timothy Heeren, Stephanie Ettinger de Cuba, and Sharon Coleman. 2009. "Food insecurity and risk of poor health among US-born children of immigrants," American Journal of Public Health 99(3): 556-62.

2. Hernandez, Daphne C., and Alison Jacknowitz. 2009. "Transient, but not persistent, adult food insecurity influences toddler development," The Journal of Nutrition139(8): 1517-24.

3. Kirkpatrick, Sharon I., Lynn McIntyre , and Melissa L. Potestio. 2010. "Child hunger and long-term adverse consequences for health," Archives of Pediatrics and Adolescent Medicine 164(8): 754-62.

4. http://frac.org/initiatives/hunger-and-obesity/why-are-low-income-and-food-insecure-people-vulnerable-to-obesity/

5. Beaulac et al., 2009; Larson et al., 2009.

6. Estabrooks et al., 2003; Moore et al., 2008; Powell et al., 2004.

7. Bruening et al., 2012; Dammann & Smith, 2010; Ma et al., 2003; Olson et al., 2007; Smith & Richards, 2008.

8. Block et al., 2009; Gundersen et al., 2011; Lohman et al., 2009; Moore & Cunningham, 2012.

9. Institute of Medicine, 2013; Kumanyika & Grier, 2006; Lewis et al., 2005; Yancey et al., 2009.

10. https://ucsdcommunityhealth.org/work/livewellcommunitymarketprogram/

11. http://www.fao.org/urban-agriculture/en/

12. Carney PA, Hamada JL, Rdesinski R, Sprager L, Nichols KR, Liu BY, Pelayo J, Sanchez MA, Shannon J; 'Impact of a community gardening project on vegetable intake, food security and family relationships: a community-based participatory research study'; J Community Health. 2012 Aug;37(4):874-81. doi: 10.1007/s10900-011-9522-z.

13. CACFP At-Risk Afterschool Meals Best Practices, 2011: http://www.fns.usda.gov/sites/default/files/Best_Practices_Report.pdf.

| **Priority** | **Alignment with *Live Well San Diego* Component** | **AREAS OF INFLUENCE**<br>**Top 10 *Live Well San Diego* Indicator**<br>• **Expanded Indicator**<br>• *Supporting Indicator* | **AREAS OF INFLUENCE**<br>**Public Health Services Indicator** |
|---|---|---|---|
| **COMMUNITY—**<br>**Reduce Crime** | **Living Safely** | **COMMUNITY**<br>**Crime Rate**<br>• **None Applicable**<br>• *Probation Youth*<br>• *Risk of Recidivation* | • **None Applicable** |
| | | | |
| What the Numbers Say | • As of May 6, 2019, **21% (276)** of the youth on probation supervision resided in the Central Region out of the 1,341 youth on probation County-wide.<br>• The top two offenses for youth on probation supervision in the Central Region included robbery **(47 youth)** and burglary **(30 youth).**<br>• **72%** of youth residing in the Central Region were assessed as high to medium risk to recidivate.[D] | | |
| What the Research Says about this Priority Concern<br>**how health and well-being is affected* | Exposure to crime and violence has been shown to increase stress, which may:[1,2]<br>• Worsen hypertension and other stress-related disorders;<br>• Contribute to the increased prevalence of certain illnesses, such as upper respiratory illness and asthma, in neighborhoods with high levels of violence, and;<br>• Lead people to engage in unhealthy behaviors such as smoking to reduce or cope with stress.<br><br>The unhealthy behaviors, to which exposure to violence within neighborhoods has been shown to contribute, include substance abuse and sexual risk-taking behaviors, as well as risky driving practices. These concerns are exacerbated by the fact that neighborhoods with high violence are thought to encourage isolation and therefore inhibit the social support needed to cope with stressful events.[2] | | |
| What Interventions Work According to the Research<br>* *practices that work based on the research* | National research shows that many community-based prevention and intervention strategies can help prevent teens ages 12-17 from joining a gang. This research supports these types of interventions:[3]<br>• Engage community groups, individuals, and institutions to respond to the multiple needs of youth and their families through case management for the highest-risk youth and their families; provide an array of services, after-school activities, and community activities to strengthen families. | | |

| | |
|---|---|
| | • Provide mentoring of at-risk and gang youths, counseling, referral services, gang conflict mediation, and anti-gang programs at schools in the community.<br>• Provide social support for disadvantaged and at-risk youth from helping teachers, responsible adults, parents, and peers. |
| How are Regional Goals and Improvement Objectives Consistent with these Interventions<br>**consistency between what the Leadership Team is planning to do and the interventions that have been shown to work* | Central Region's goals and improvement objectives focus on early interventions that engage the community. The approach includes convening a summit and developing community partnerships that will help at-risk youth and remedy some of the causes that contribute to gang activity. The benefits of this kind of approach is consistent with the research and integral to building community capacity to reduce gang activity and crime. |

1. Ellen IG, Mijanovich T, Dillman KN. Neighborhood effects on health: Exploring the links and assessing the evidence. Journal of Urban Affairs. 2001;23:391-408.

2. Johnson SL, Solomon BS, Shields WC, McDonald EM, McKenzie LB, Gielen AC. Neighborhood violence and its association with mothers' health: Assessing the relative importance of perceived safety and exposure to violence. J Urban Health. 2009;86:538-550.

3. https://www.nationalgangcenter.gov/spt/Planning-Implementation/Best-Practices/12

| **Priority** | **Alignment with *Live Well San Diego* Component** | **AREAS OF INFLUENCE**<br>**Top 10 *Live Well San Diego* Indicator**<br>• **Expanded Indicator**<br>• *Supporting Indicator* | **AREAS OF INFLUENCE**<br>**Public Health Services Indicator** |
|---|---|---|---|
| **COMMUNITY—**<br>**Improve Trauma Informed Systems** | **Living Safely**  | **COMMUNITY**<br>**Crime Rate**<br>• **None Applicable**<br>• *Residents Experiencing Psychological Distress* | • **None Applicable** |

| | |
|---|---|
| What the Numbers Say | According to the California Health Interview Survey, **1 in 10** Central Region residents had likely had serious psychological distress in the past year.[A] |
| What the Research Says about this Priority Concern<br>**how health and well-being is affected* | Adverse Childhood Experiences (ACEs) refers to childhood experiences that have a tremendous impact on future violence victimization and perpetration, and lifelong health and opportunity. ACEs are linked to: risky health behaviors, chronic disease and health conditions, mental and behavioral health issues, and early death.[1,2] |
| What Interventions Work According to the Research<br>* *practices that work based on the research* | Research supports these types of interventions:[1]<br>• Educate and increase awareness among residents and community partners of the impact of trauma and strategies for resilience.<br>• Reducing stress, building responsive relationships, and strengthening life skills are among the best ways to prevent the long-term effects of ACEs.<br>• Implement trauma-informed care or practice, especially in those occupations and settings that serve individuals who are more likely to have experienced toxic stress, such as social work, medicine, education, and public agencies. |
| How are Regional Goals and Improvement Objectives Consistent with these Interventions<br>**consistency between what the Leadership Team is planning to do and the interventions that have been shown to work* | Central Region's goals and improvement objectives focus on the first step: increasing awareness among residents and communities of the impact of trauma and knowledge of what can be done to promote resiliency. This helps agencies become more trauma-informed, and communities and individuals alike to enjoy better health outcomes and quality of life. |

1. https://developingchild.harvard.edu/resources/aces-and-toxic-stress-frequently-asked-questions/

2. https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/aboutace.html

| **Priority** | **Alignment with *Live Well San Diego* Component** | **AREAS OF INFLUENCE**<br>**Top 10 *Live Well San Diego* Indicator**<br>• **Expanded Indicator**<br>• *Supporting Indicator* | **AREAS OF INFLUENCE**<br>**Public Health Services Indicator** |
|---|---|---|---|
| **SOCIAL—**<br>**Enhance Civic Life** | **Thriving** | **SOCIAL**<br>**Volunteerism**<br>• **None Applicable** | • **None Applicable** |

| | |
|---|---|
| What the Numbers Say | Only **1 in 7** Central Region Residents volunteered for a charitable organization in the last 12 months.[E] |
| What the Research Says about this Priority Concern<br>**how health and well-being is affected* | Over two decades of research indicates that volunteering provides not just social benefits, but individual health benefits as well. There is a strong relationship between volunteering and health—those who volunteer have lower mortality rates, greater functional ability, and lower rates of depression later in life than those who do not volunteer. In fact, evidence suggests the possibility that the best way to prevent poor health in the future (which could be a barrier to volunteering) is to volunteer.[1] |
| What Interventions Work According to the Research<br>* *practices that work based on the research* | Research supports these types of interventions:[1]<br>• Create tools, training, and websites with valuable information that can encourage persons with questions or doubts about abilities to research volunteer opportunities, and help retain volunteers. [2,3]<br>• Use opportunities to incorporate into service those groups currently underrepresented, such as at-risk youth, immigrants, the disabled, rural residents, and veterans. Importantly, communities benefit when those most familiar with local needs are engaged in providing these volunteer services. |
| How are Regional Goals and Improvement Objectives Consistent with these Interventions<br>**consistency between what the Leadership Team is planning to do and the interventions that have been shown to work* | Central Region's goals and improvement objectives are consistent with the research in that they involve increasing participation in Resident Leadership Academies (RLAs) to address emerging issues in the community. |

1. https://results.livewellsd.org/en/stat/goals/single/5c79-znka
2. Susan Ellis (1996) From the Top Down: The Executive Role in Volunteer Program Success, and Steve McCurley and Rick Lynch (1996) Volunteer Management: Mobilizing all the Resources in the Community.
3. http://www.nationalservice.gov/pdf/Management_Brief.pdf.

## Citations for "What the Numbers Say":


A. UCLA Center for Health Policy Research. 2015-2017 California Health Interview Survey, AskCHIS. Retrieved April, 2019.

B. UCLA Center for Health Policy Research. 2017 California Health Interview Survey, AskCHIS. Retrieved April, 2019.

C. 2018 ESRI Community Analyst, Retrieved April 2019.

D. County of San Diego Probation Department, Research, Policy, and Science Division

E. Live Well San Diego Indicator. Corporation for National and Community Service, 2015.

*Live Well San Diego*

# Community Enrichment Plan

## EAST REGION

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

ACCREDITED HEALTH DEPARTMENT · PUBLIC HEALTH ACCREDITATION BOARD · PHAB Advancing public health performance

**2019-2021**

This document is the is the culmination of activities undertaken when implementing the *Live Well San Diego Community Health Improvement Plan, FY 2014-18.*

This document was developed under the General Management System of the County of San Diego, and is in support of *Live Well San Diego*.

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# REGIONAL DIRECTOR'S LETTER

## From the Regional Director

Dear Community Partner,

On behalf on the *Live Well San Diego* East Region Leadership Team, we are pleased to bring you the 2019-2021 Community Enrichment Plan (CEP). This is our community plan for advancing the *Live Well San Diego* vision in the East Region, through the collective effort of community groups and residents by collaborating and working together to implement changes in the community.

The East Region of San Diego County is the second largest geographical area in the County. It is one of two regions that share an international border with Mexico, and the only region to share a boundary with another County and country. East Region is a very diverse geographically, and includes vast valleys, arid landscapes, and mountainous terrain. The East Region has a population of over 471,000 residents and is comprised of incorporated and unincorporated areas, suburban and rural communities, and Indian reservations. The Region includes four cities—El Cajon, La Mesa, Lemon Grove, and Santee. The communities of Alpine, Harbison Crest, Jamul, Lakeside, Mountain Empire, and Spring Valley are also part of this distinctive region.

The CEP was developed through a thoughtful, responsive and iterative process, engaging the East Region Leadership Team as the "voice" of the community. Because of the COVID-19 pandemic, the publication of this document was delayed. The focus of County staff, this Leadership Team and residents has also shifted to respond to this public health emergency. However, it is important to note that this CEP is a dynamic plan that will evolve over the next planning cycle to incorporate priorities and goals that reflect the impact of this public health emergency on our region and what local leaders believe is most important to do to help every resident be healthy, safe and thrive.

Thank you for all that you do to help every resident Live Well!

Best regards,

**Jennifer Bransford-Koons, Director**
East & North Central Regions
County of San Diego Health & Human Services Agency
*Live Well San Diego* East Region Leadership Co-chair

**R. Daniel Hernandez, Director of Community Relations**
San Ysidro Health
*Live Well San Diego* East Region Leadership Co-chair


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## INTRODUCTION

This Community Enrichment Plan (CEP) represents the priorities of the *Live Well San Diego* East Region Leadership Team. The CEP priorities, goals, strategies, improvement objectives, and associated measures were identified and developed by the East Region Leadership Team because they address the challenges, as well as build on the strengths of East Region **[see Appendix I for the key to the CEP terminology and elements]**. This CEP also represents the ways in which the East Region Leadership Team believes it can make the most significant contribution to help every resident Live Well. This CEP is part of a County of San Diego Community Health Improvement Plan (CHIP), aligned to the *Live Well San Diego* vision, that captures the content of all plans for each of the six Health and Human Services Agency (HHSA) Regions and their respective Leadership Teams. Each Leadership Team, comprised of community leaders representing organizations across every sector, plays a vital role in driving action on the ground to advance the *Live Well San Diego* vision by supporting and encouraging collective effort within the Region and leveraging resources available throughout the County.

## *LIVE WELL SAN DIEGO* EAST REGION LEADERSHIP TEAM PLANNING PROCESS & SELECTION OF PRIORITIES

Formed in February 2011, the *Live Well San Diego* East Region Leadership Team has helped assess, develop, and guide priorities and activities that improve well-being in the region using evidence-based strategies. In 2014, the East Region Leadership Team developed an initial Community Health Assessment and CHIP. Since then, the Leadership Team has evolved to address health in the broadest sense that includes the social and physical environments in which residents live, also referred to as the social determinants of health. This is reflected in the changing of the name of individual CHIPs to Community Enrichment Plans (CEPs), as the Leadership Team priorities address objectives beyond just health.

The *Live Well San Diego* East Region Leadership Team has evolved since 2011 and today encompasses a broad range of community partners and stakeholders **[see Appendix II for the list of members of the East Region Leadership Team]**. The East Region Leadership Team began the second iteration of their CEP in 2015, using the Mobilizing for Action through Planning and Partnerships (MAPP) community planning model to select and prioritize regional issues while also identifying resources to address them. The East Region Leadership Team received data presentations on relevant health, safety, and well-being trends and completed a survey to gather perspectives on challenges and priorities for Living Well that covered all components—Building Better Health, Living Safely, and Thriving. Whenever feasible, data were presented through a health equity lens—age, gender, geography, race/ethnicity, and socio-economic status. The survey contained questions relating to both Forces of Change applicable to the community, and Community Themes and Strengths, as these are two of the four MAPP assessments.

# BACKGROUND

Following the data presentations and survey analysis, the East Region Leadership Team's priorities, goals, and improvement objectives emerged during regular meetings through an iterative planning process. The East Region Leadership Team has three work groups: Aging Communities, Behavioral Health and Wellness, and Children and Families Wellness Network. These work groups developed work plans to inform the CEP. Throughout the process, attention was paid to ensuring alignment to the *Live Well San Diego* framework to show how the priority areas and goals selected by the East Region Leadership Team are supporting the shared vision.

## *LIVE WELL SAN DIEGO* EAST REGION LEADERSHIP TEAM PRIORITIES

### BUILDING BETTER HEALTH

- Behavioral Health and Wellness
- Children and Family Wellness Network
- Aging Communities

### LIVING SAFELY

- Aging Communities
- Behavioral Health and Wellness

### THRIVING

- Children and Family Wellness Network
- Aging Communities


## HOW THE COUNTY SUPPORTS IMPLEMENTATION OF THE COMMUNITY ENRICHMENT PLANS

The East Region Leadership Team cannot on its own implement the improvement objectives that appear in the CEP. The East Region Leadership Team is part of the much bigger collective impact effort of the *Live Well San Diego* vision. This means that success in reaching the improvement objectives, within this plan and other Regional CEPs, depends on leveraging the efforts of partners across all sectors as well as existing County programs and services. For example, a goal to support healthy food choices and food systems will draw upon the County of San Diego Public Health Services Department Chronic Disease and Health Equity program. Behavioral health activities, reflected in many Regional CEPs, are assisted by staff and programs within the County of San Diego Behavioral Health Services Department which offers prevention and early intervention services and an array of treatment programs. Age Well San Diego, a San Diego County Board of Supervisor initiative to create age-friendly communities, has an action plan that supports intergenerational activities and transportation policies, which closely align with CEP goals. The many assets and resources across San Diego County—public, private, and non-profit—are detailed in the FY 2019-2021 Community Health Assessment. The Regional Director and community engagement staff within each Region assist the Leadership Team to achieve their CEP improvement objectives by providing technical assistance and leveraging County initiatives, programs, and services whenever possible. **[see the 2019-2021 Community Health Assessment for more discussion of assets and resources available across San Diego County].**

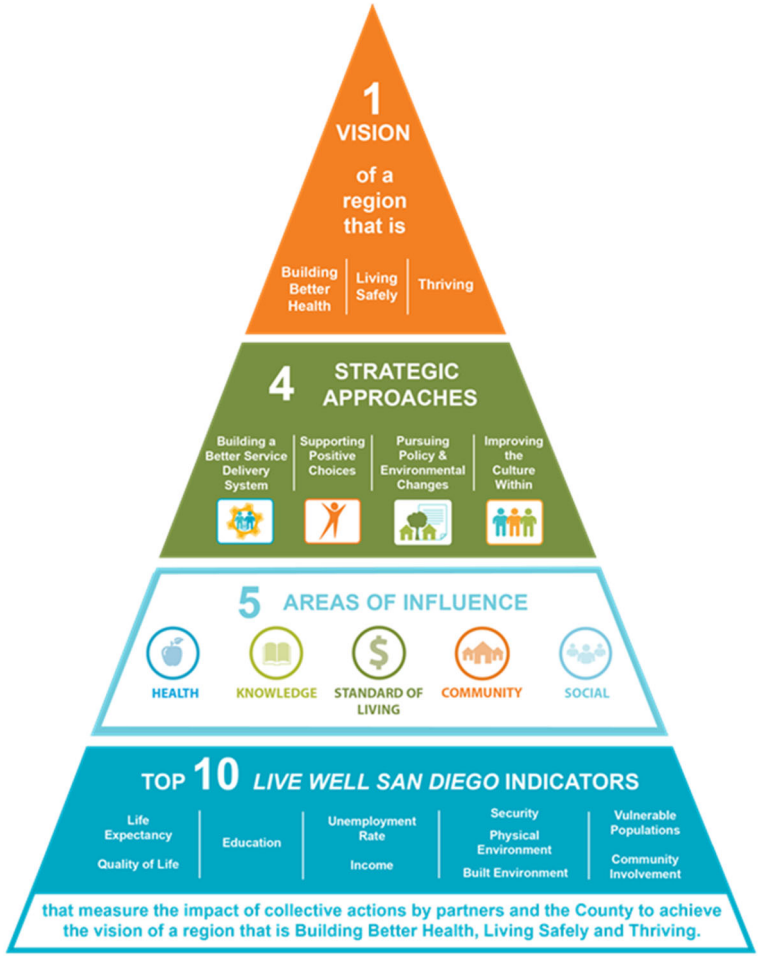
## BUILDING THE REGIONAL COMMUNITY ENRICHMENT PLAN

The *Live Well San Diego* vision, and the three Components, Building Better Health, Living Safely, and Thriving, serve as the framework for the *Live Well San Diego* CHIP as well as the Regional CEPs (as depicted in the *Live Well San Diego* Pyramid, Figure 1). The final CEP is organized in the language of the Leadership Teams—that is the priorities, goals and objectives as these leaders defined them. The structure of the CEP content and alignment to *Live Well San Diego* is illustrated in the "Template for the Community Enrichment Plan" which follows (see Figure 2). The "Key to the Community Enrichment Plan," in Appendix I, explains all of the elements, the terminology and icons used.

The content for the CEPs is displayed in order of: Priorities, Indicators, Goals, Improvement Objectives, and Metrics. Alignment is shown visually with the use of icons or colors. Indicators align to *Live Well San Diego* Areas of Influence; Goals align to *Live Well San Diego* Components; and Improvement Objectives align to *Live Well San Diego* Strategic Approaches.

It should be noted that several Indicators are identified by Priority. These Indicators include the Top 10 *Live Well San Diego* Indicators, Expanded Indicators, and Supporting Indicators, depending upon which Indicators align to the priority (an explanation of the difference between types of Indicators is explained in Appendix I). Also, Indicators from a newly created Public Health Services Indicators dashboard appear, an expectation of accredited public health departments **[see Appendix III for the *Live Well San Diego* and Public Health Services Indicators Dashboards]**. Any positive movement of the **Indicators** is achieved over the long term by implementing evidence-informed strategies as described in the Basis for Action **[see Appendix IV for the Basis for Action]**.

**Figure 1. *Live Well San Diego* Vision Pyramid.**



Regional CEPs do not always cover every Component of the *Live Well San Diego* framework. Each Region's Leadership Team makes the determination of what **Priorities** they will undertake, recognizing that these Leadership Teams must be responsive to the unique needs of their regions and focus their efforts on those issues or concerns in which members believe the Leadership Team can have the greatest impact through collective action.

Also, these plans are iterative in that **Priorities**, **Goals,** and **Improvement Objectives** can change over time as the Leadership Team responds to evolving needs of the community.

# PRIORITIES, GOALS, & IMPROVEMENT

## Figure 2. Template for the Community Enrichment Plan

**Priority:**

| Areas of Influence | Top 10 *Live Well San Diego* Indicators<br>• Expanded Indicator<br>• *Supporting Indicator* | Public Health Services Indicators |
|---|---|---|
| HEALTH | Life Expectancy<br>Quality of Life<br>• Expanded Indicator<br>• *Supporting Indicator* | 3-4-50<br>ADRD Death Rate<br>Infant Mortality Rate<br>HIV Disease Diagnosis Estimates |
| KNOWLEDGE | Education<br>• Expanded Indicator<br>• *Supporting Indicator* | High School Education |
| STANDARD OF LIVING | Income-Spending Less than 1/3 of Income on Housing<br>Unemployment Rate<br>• Expanded Indicator<br>• *Supporting Indicator* | Unemployment Rate<br>Income Inequality<br>Poverty |
| COMMUNITY | Security—Crime Rate<br>Physical Environment—Air Quality<br>Built Environment—Distance to Park<br>• Expanded Indicator<br>• *Supporting Indicator* | Childhood Lead in Schools |
| SOCIAL | Community Involvement—Volunteerism<br>Vulnerable Populations—Food Insecurity<br>• Expanded Indicator<br>• *Supporting Indicator* | Voting |



**Goals Aligned to the Three Components of *Live Well San Diego* and Corresponding Icons and Color Bands**

| |
|---|
| Building Better Health—Goal X: X |
| Living Safely—Goal X: X |
| Thriving—Goal X: X |

**Improvement Objectives and Metrics Aligned to the Four *Live Well San Diego* Strategic Approaches and Corresponding Icons**

| Strategic Approach | Improvement Objective and Metric |
|---|---|
| | X.X: Improvement Objective |
| | ◊ Metric |

# *LIVE WELL SAN DIEGO*
# COMMUNITY ENRICHMENT PLAN – EAST REGION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## Priority: Behavioral Health Wellness

| Area of Influence | Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | Public Health Services Indicator |
|---|---|---|
| HEALTH | **Life Expectancy**<br>**Quality of Life**<br>• **None Applicable**<br>• *Population with Suicidal Ideation*<br>• *Residents Experiencing Psychological Distress* | **3-4-50 Deaths** |
| COMMUNITY | **Crime Rate**<br>• **None Applicable** | |

## GOAL 1: Provide Quality and Efficient Care

**Improvement Objectives and Metrics**

1.1: Promote behavioral health wellness, and improve access to behavioral health services, across East Region

- ◊ Number of awareness campaigns (i.e. It's Up to Us) promoted for the community to address suicide prevention and harm reduction
- ◊ Number of trainings, presentations, and/or other educational opportunities coordinated with agencies and offered within schools and other settings, and number of participants (BHS, QPR, Mental Health 101)
- ◊ Number of sites that have conducted Check Your Mood screenings

1.2: Increase awareness of behavioral health resources.

- ◊ Number of partners participating in awareness campaigns and sharing resources (Access and Crisis Line) with the community
- ◊ Number of suicide prevention trainings, presentations, and/or other educational opportunities participated in or delivered

## GOAL 2: Increase Awareness of Impact of Trauma

**Improvement Objectives and Metrics**

2.1: Increase knowledge among residents and community partners of the importance of trauma-informed approaches and services.

- ◊ Number of community event screenings of films that provide information about the impact of toxic stress on the health and development of children and youth (titled "Resilience" and "Paper Tigers").
- ◊ Number of people viewing film

[1]*The Child and Family Wellness Workgroup and the Behavioral Health Wellness Workgroup are both working on trauma and resiliency. This explains the overlap in some of their objectives.*

### Priority: Child and Family Wellness

| Area of Influence | Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | Public Health Services Indicator |
|---|---|---|
| KNOWLEDGE | **High School Graduation**<br>• **None Applicable**<br>• *Chronic Absenteeism* | **3-4-50 Deaths**<br>**High School Graduation** |
| HEALTH | **Life Expectancy**<br>**Quality of Life**<br>• **None Applicable**<br>• *Child Dental Visits* | |
| COMMUNITY | **Crime Rate**<br>• **None Applicable** | |

## GOAL 3: Support School Attendance

**Improvement Objectives and Metrics**

3.1: Increase number of families walking and biking to school to school in East Region school districts.

- ◊ Number of community events or sites promoting parent walking clubs
- ◊ Number of schools participating in Walk and Bike to School Days

3.2: Provide direct support to schools' experiencing above-average levels of chronic absenteeism.

- ◊ Number of families participating in enrichment events, educational activities and other experiences on campus, designed to create a positive relationship with school communities

3.3: Provide Grossmont Union High School District Health Career Pathways teachers Resident Leadership Academy materials to conduct cohorts with students, to encourage school and community connectiveness.

- ◊ Number of students graduating from Resident Leadership Academy

## GOAL 4: Decrease Stigma Around Behavioral Health

**Improvement Objectives and Metrics**

4.1: Host school-based screenings and community dialogs around films that provide information about the impact of toxic stress on the health and development of children and youth ("Resilience" and "Paper Tigers")[1].

- ◊ Number of school-based events screenings of the Resilience film
- ◊ Number of people viewing film
- ◊ Number of community presentations conducted

4.2: Participate in East Region "What I Wish My Parents Knew" events, through event promotion, and the recruitment of resources providers and speakers.

- ◊ Number of "What I Wish My Parents Knew" events held in the Region
- ◊ Number of guests attending "What I Wish My Parents Knew"

[1]*The Child and Family Wellness Workgroup and the Behavioral Health Wellness Workgroup are both working on trauma and resiliency. This explains the overlap in some of their objectives.*

## GOAL 5: Connect Students to Resources

**Improvement Objectives and Metrics**

5.1: Collaborate with Regional school districts to provide support and resources to students suffering from homelessness.

- ◊ Number of trainings, presentations, and/or other educational opportunities on alternative housing options
- ◊ Number of new housing resources identified
- ◊ Number of resource cards that are distributed at community events and/or to community-based organizations

## GOAL 6. Increase Education and Awareness of Preventative Healthcare Services

**Improvement Objectives and Metrics**

6.1: Increase education and awareness of preventive healthcare services in infants and children.

- ◊ Number of community events or sites to promote preventive screenings (e.g., cancer, cardiovascular, lead, oral health, fluoride varnish, sealant, exams, and vaccinations)
- ◊ Number of social media campaigns developed or delivered

## GOAL 7: Engage Communities in Civic Life Opportunities

**Improvement Objectives and Metrics**

7.1: Scale up Resident Leadership Academies (RLAs) across the Region to expand into emerging issues impacting the community.

- ◊ Number of RLA graduates to provide local leadership and advocacy to improve the quality of life in the Region
- ◊ Number of RLAs to implement plans to improve the quality of life in the Region

## GOAL 8: Enhance Collaboration with School Partners to Address Barriers to Student Achievement/Engagement, and School Climate

**Improvement Objectives and Metrics**

8.1: Increase school attendance and reduce dropout rates for Pre-K through 12th grade students in East Region.

- ◊ Number of trainings, presentations, and/or other outreach provided to students, parents, and administrators
- ◊ Change in the percent of school attendance rates

### Priority: Aging Communities

| Area of Influence | Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | Public Health Services Indicator |
|---|---|---|
| HEALTH | **Life Expectancy**<br>**Quality of Life**<br>• **None Applicable**<br>• *Seniors Walking for Transportation, Fun, or Exercise* | **3-4-50 Deaths** |
| COMMUNITY | **Crime Rate**<br>• **None Applicable** | |
| SOCIAL | **Volunteerism**<br>• **None Applicable** | |

## GOAL 9: Advance Active Living Among Older Adults

**Improvement Objectives and Metrics**

9.1: Increase intergenerational interventions that promote physical activity across the life span.

- ◊ Number of intergenerational games hosted
- ◊ Number of new intergenerational programs created and delivered to increase social participation among older adults

## GOAL 10: Protect Older Adults from Crime & Abuse

**Improvement Objectives and Metrics**

10.1: Increase public awareness and education on the importance of reporting abuse and neglect of anyone, especially children, vulnerable adults, seniors, and animals.

- ◊ Number of events convened with partners that include information about adult abuse and neglect, coordinating with HHSA Aging & Independence Services

## GOAL 11: Enhance Transportation Options for Older Adults

**Improvement Objectives and Metrics**

11.1: Increase access to quality care and resources for an aging community.

- ◊ Number of trainings, presentations, and/or other educational opportunities on transit systems, and walking and other travel opportunities
- ◊ Number of community events conducted that involve planning for transportation options in coordination with Aging & Independence Services

## GOAL 12: Increase Civic Life Through Participation

**Improvement Objectives and Metrics**

12.1: Increase community engagement among older adults through volunteerism, recreation, and social participation opportunities for older adults in the East Region.

- ◊ Number of intergenerational activities promoted and/or coordinated
- ◊ Number of community events promoting resources
- ◊ Number of community projects implemented in partnership with schools

## GOAL 13: Increase and Identify Housing Options for Older Adults

**Improvement Objectives and Metrics**

13.1: Reduce homelessness and those at-risk for homelessness in the aging population by increasing access to and awareness of housing, Accessory Dwelling Units (ADUs), and assisted-living facilities.

- ◊ Number of trainings, presentations, and/or other educational opportunities on alternative housing options
- ◊ Number of new housing resources identified
- ◊ Number of housing resource cards that are distributed to the community

# APPENDIX


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# APPENDIX I—KEY TO THE COMMUNITY ENRICHMENT PLAN


This section explains the terms and elements that are being used in the CHIP and CEPs. Careful attention was made to ensure that clear alignment to the *Live Well San Diego* vision was achieved, while also adhering to standard planning terminology.

## Priority

The issue that was selected by the Leadership Team to address, based on a review of community health assessment and other data and the knowledge and passion of members in the Leadership Team.

## Five Areas of Influence

These are the dimensions that capture overall well-being: Health, Knowledge, Standard of Living, Community, and Social. The Areas of Influence reflect that good health goes beyond physical well-being to include the social determinants of health.

| Five Areas of Influence and the Corresponding Icons and Definitions | | | | |
|---|---|---|---|---|
| HEALTH | KNOWLEDGE | STANDARD OF LIVING | COMMUNITY | SOCIAL |
| Enjoying good health and expecting to live a full life | Learning throughout the lifespan | Having enough resources for a quality of life | Living in a clean and safe neighborhood | Helping each other to live well |

# APPENDIX I—KEY TO THE COMMUNITY ENRICHMENT PLAN

## Top 10 *Live Well San Diego* Indicators

Indicators are intended to capture the collective impact of programs, services, and interventions over the long term. The Top 10 *Live Well San Diego* Indicators define what it means to "live well" in San Diego. For each CEP Priority, the appropriate *Live Well San Diego* Indicators are identified in bold with the appropriate icon. "Expanded" Indicators, which are indented in bold, may be identified which are part of the *Live Well San Diego* framework and further describe each Top 10 indicator. This may also include a "Supporting" Indicator which is not part of the Top 10 but is viewed as an additional population measure that reflects progress in the medium- to long-range time span to achieving that priority. These are identified in italics.

**Due to space constraints, only those Indicators, Expanded Indicators, and Supporting Indicators that appear in the individual CEPs are presented in the Key.**

**Top 10 *Live Well San Diego* Indicators**
- **Expanded Indicator**
- *Supporting Indicator*

**Life Expectancy**

**Quality of Life**

- *Population with Suicidal Ideation*
- *Household Fresh Vegetable Use*
- *Routine Care*
- *Access to Affordable Fruits/Vegetables*
- *Childhood Obesity*
- *Child Dental Visits*
- *Seniors Walking for Transportation, Fun, or Exercise*
- *High School E-Cigarette Use*

KEY

**Education**

- *Chronic Absenteeism*

**Income—Spending Less than 1/3 of Income on Housing**

**Unemployment Rate**

- **Percentage of Population with a Checking or Savings Account**

**Security—Crime Rate**

**Physical Environment—Air Quality**

**Built Environment—Distance to Park**

- **Travel Time to Work Over 60 Minutes**
- *Probation Youth*
- *Risk of Recidivation*
- *Residents Experiencing Psychological Distress*
- *Active Transport to School*
- *Rate of ED Discharges for Opioid Disorders*
- *Fall Injury Hospitalization Rates*
- *Disaster Vulnerable Residents*

**Community Involvement—Volunteerism**

**Vulnerable Populations—Food Insecurity**

- **Volunteerism**
- **Food Insecurity**

# APPENDIX I—KEY TO THE COMMUNITY ENRICHMENT PLAN

## Public Health Services Indicators

To maintain national public health accreditation, a dashboard has been developed to capture indicators that are most relevant to interventions in which Public Health Services plays a key role —this dashboard is referred to as the Public Health Services Dashboard. These indicators are in bold and defined on this page. The indicators are part of a national database submitted to the Public Health Accreditation Board to show the significance and impact of maintaining public health accreditation that results in meeting targets for population health outcomes.


| Public Health Services Indicators | Description |
|---|---|
| **3-4-50 Percent** | Percent of deaths due to the four chronic diseases (cancer, heart disease and stroke, type 2 diabetes, and pulmonary diseases such as asthma). |
| **ADRD Death Rate** | Alzheimer's Disease and Related Dementias (ADRD) death rate per 100,000 population. |
| **Childhood Lead in Schools** | The number of cases from the San Diego Childhood Lead Poisoning Prevention Program. |
| **High School Education** | Overall Graduation Rate: The percentage of those over the age of 25 with a high school diploma or equivalent. |
| **HIV Disease Diagnosis Estimates** | HIV disease diagnosis case counts and percentages. |
| **Income Inequality** | Number of Total Earned Income Tax Credits. |
| **Infant Mortality Rate** | Three-year average Infant Mortality Rate per 1,000 live births. |
| **Poverty** | Percent of the population below poverty level. |
| **Unemployment Rate** | Percent of the total labor force that is unemployed (actively seeking employment and willing to work). |
| **Voting** | Percent of the population who voted in a Federal/State/Local election in the last 12 months. |

## Goal

A goal is an aspiration or broad statement of what the Leadership Team wants to achieve in the longer term (more than three years).

## *Live Well San Diego* Component

There are three major components to *Live Well San Diego*. Each Priority and Goal is aligned to one of these components—Building Better Health, Living Safely, and Thriving. The CEP goals show alignment to the *Live Well San Diego* components by including the respective icon and color (see below).

| Building Better Health | Living Safely | Thriving |
|---|---|---|

# APPENDIX I—KEY TO THE COMMUNITY ENRICHMENT PLAN

## Strategic Approach

The *Live Well San Diego* vision is achieved through four strategies, referred to as Strategic Approaches. These are *Building a Better Service Delivery System*, *Supporting Positive Choices*, *Pursuing Policy and Environmental Changes*, and *Improving the Culture from Within*. These Strategic Approaches are used as the strategies for the CEPs, which are how the Leadership Team will go about achieving the goal. The icons and definitions for the Strategic Approaches are listed below.

| *Live Well San Diego* Strategic Approaches | | | |
|---|---|---|---|
| **Building a Better Service Delivery System** | **Supporting Positive Choices** | **Pursuing Policy and Environmental Changes** | **Improving the Culture from Within** |
|  |  |  |  |
| Improving the quality and efficiency of County government and its partners in the delivery of services to residents, contributing to better outcomes for clients and results for communities. | Providing information and resources to inspire county residents to take action and responsibility for their health, safety, and well-being. | Creating environments and adopting policies that make it easier for everyone to live well, and encouraging individuals to get involved in improving their communities. | Increasing understanding among County employees and providers about what it means to live well and the role that all employees play in helping residents live well. |

## Improvement Objective

The Improvement Objective is the change or improvement that the Leadership Team seeks or hopes to accomplish in the shorter term (one to three years). The Improvement Objective reflects actions that the Leadership Team has decided to take and is supported by the research, evidence, or best practice to contribute to advancement of the goal and ultimately community change. For each Improvement Objective, the Strategic Approach is indicated with the corresponding icon in the CEP to indicate alignment.

## Metric

The metric indicates the target and how progress will be measured for each improvement objective.

# APPENDIX II— LIST OF *LIVE WELL SAN DIEGO* EAST REGION LEADERSHIP TEAM MEMBERS

## EAST REGION
## LEADERSHIP TEAM MEMBERS

**CO-CHAIRS:**

Jennifer Bransford-Koons, Director of Regional Operations, HHSA-East & North Central Regions
R. Daniel Hernandez, Director of Community Relations, San Ysidro Health

**Members:** The current *Live Well San Diego* East Region Leadership Team consists of the agencies and organizations listed below. Some members regularly attend meetings whereas other valued partners are contributing in other meaningful ways to the development and implementation of the CEP. **Some members are also *Live Well San Diego* Recognized Partners which is indicated with an asterisk (*).**

**EAST REGION LEADERSHIP TEAM MEMBERS BY SECTOR[1]**

| Cities & Governments | Community & Faith-Based | Schools & Education | Other Valued Partners |
|---|---|---|---|
| City of El Cajon*<br>City of La Mesa*<br>City of Santee* | Bayside Community Center*<br>Community, Action, Service & Advocacy (CASA)*<br>Community Health Improvement Partners (CHIP)*<br>El Cajon Collaborative*<br>East Region Collaborative Network*<br>Family Health Centers of San Diego*<br>Home Start, Inc.*<br>I Love a Clean San Diego*<br>Institute for Public Strategies*, East County Community Coalition Program<br>McAlister Institute*<br>Meals on Wheels*<br>Mountain Health & Community Services, Inc.*<br>PATH San Diego*<br>Rady Children's Hospital*<br>San Diego Council on Literacy* | Grossmont-Cuyamaca Community College District*<br>La Mesa-Spring Valley School District*<br>Lemon Grove School District*<br>Grossmont Union High School District* | AKA Head Start<br>American Heart Association*<br>County of San Diego, HHSA, Behavioral Health Services<br>County of San Diego, HHSA, Aging and Independence Services<br>County of San Diego, HHSA, Child Welfare Services<br>County of San Diego, Land Use and Environment Group, Parks and Recreation Department<br>County of San Diego, HHSA, Public Health Nursing<br>County of San Diego, HHSA, Public Health Services<br>Dairy Council of California<br>East County Chamber of Commerce/Homeless Task Force* |
| **Businesses & Media**<br>• Kim Center for Social Balance* | | | |

[1]Partners listed are based on sign in sheets from the Live Well San Diego leadership team meetings in the past year. This list is not inclusive of all partners that are actively engaged in the community at large.

# APPENDIX II— LIST OF *LIVE WELL SAN DIEGO* EAST REGION LEADERSHIP TEAM MEMBERS

| Cities & Governments | Community & Faith-Based | Schools & Education | Other Valued Partners |
|---|---|---|---|
| | San Diego County Breastfeeding Coalition*<br>Santee Community Collaborative*<br>San Ysidro Health*<br>Spring Valley Youth and Family Coalition*<br>St. Madeline Sophie's Center*<br>YMCA* | | East County Resident Leadership Academy members<br>Fleet and Family Support Center<br>Grossmont Healthcare District*<br>Grossmont Union High School District*<br>Lemon Grove HEAL Zone<br>Mental Health America<br>Mountain Empire Collaborative<br>San Diego Center for Children*<br>San Diego Children and Nature*<br>San Diego Community Action Network<br>Jacobs and Cushman San Diego Food Bank*<br>San Diego Foundation<br>San Diego River Park Foundation<br>San Diego Youth Services*<br>Santee Solutions<br>Southern Caregiver Resource Center*<br>Vets' Community Connections*<br>Vista Hill*<br>Vizer App<br>YALLA San Diego* |

# APPENDIX III—INDICATORS

## TOP 10 *LIVE WELL SAN DIEGO* INDICATORS DASHBOARD ALIGNED TO *LWSD* AREAS OF influence

*Live Well San Diego* Dashboard
Top 10 Population Outcome Indicators: EAST REGION

| | Indicator | Description (We want to increase this / We want to decrease this) | | San Diego County | East Region | Alpine | El Cajon | Harbison Crest | Jamul | La Mesa | Laguna-Pine Valley | Lakeside | Lemon Grove | Mountain Empire | Santee | Spring Valley |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **HEALTH - Enjoying good health and expecting to live a full life** | | | | | | | | | | | | | | | | |
| HEALTH | Life Expectancy | Average number of years a person is expected to live at birth. 2016. | ↑ | 82.1 | 79.5 | 81.2 | 79.7 | 79.4 | 79.1 | 79.4 | N/A | 78.6 | 78.3 | N/A | 80.8 | 78.3 |
| | Quality of Life | Percent of the population 18 & older, not residing in nursing homes or other institutions, that is sufficiently healthy to be able to live independently. 2017. | ↑ | 94.9% | 93.2% | 93.8% | 92.5% | 94.3% | 94.3% | 94.0% | 96.5% | 93.7% | 93.4% | 88.7% | 94.5% | 92.1% |
| **KNOWLEDGE - Learning throughout the lifespan** | | | | | | | | | | | | | | | | |
| KNOWLEDGE | Education: High School Diploma or Equivalent | Overall Graduation Rate: the percentage of those over the age of 25 with a high school diploma or equivalent. 2017. | ↑ | 86.1% | 87.8% | 93.0% | 83.9% | 90.5% | 88.0% | 91.5% | 92.0% | 90.6% | 79.6% | 78.3% | 92.7% | 87.6% |
| **STANDARD OF LIVING - Having enough resources for a quality life** | | | | | | | | | | | | | | | | |
| STANDARD OF LIVING | Unemployment Rate | Percent of the population that is unemployed. 2018. | ↓ | 3.9% | 4.8% | 3.1% | 6.2% | 2.3% | 3.7% | 4.0% | 4.1% | 4.3% | 5.9% | 5.5% | 3.8% | 4.9% |
| | Income: Percent of population spending less than 1/3 of income on housing | Percent of the population spending less that 1/3 of their income on housing. 2016. | ↑ | 52.9% | 53.7% | 50.3% | 49.8% | 61.8% | 57.4% | 51.9% | 65.4% | 57.8% | 51.3% | 53.5% | 59.3% | 52.9% |
| **COMMUNITY - Living in a clean and safe neighborhood** | | | | | | | | | | | | | | | | |
| COMMUNITY | Security: Overall Crime Rate | Overall Crime rate per 100,000 population. 2017. | ↓ | 2032.6 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| | Physical Environment: Air Quality | Percent of days rated unhealthy for vulnerable populations. 2018. | ↓ | 6.1% | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| | Built Environment: Percent of population living within 1/4th a mile of a park or community space | Percentage of population that resides within a quarter mile of a park or community space. 2018. | ↑ | 61.3% | 51.5% | 18.6% | 54.9% | 29.0% | 13.7% | 74.0% | 14.3% | 43.4% | 67.2% | 9.1% | 50.4% | 52.3% |
| **SOCIAL - Helping each other to live well** | | | | | | | | | | | | | | | | |
| SOCIAL | Vulnerable Populations: Food Insecurity | Percent of adult population 200% below FPL not able to afford food. 2017. *Indicates statistically unstable estimates. Proceed with caution. | ↓ | 37.6% | 37.5%* | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| | Community Involvement: Volunteerism | Percent of residents who volunteer. 2017. | ↑ | 25.5% | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |

On the right track  Not on track  No change

To view more information about the *Live Well San Diego* Indicators and how we will measure progress go to: http://www.sdcounty.ca.gov/hhsa/programs/sd/live_well_san_diego/indicators.html

# APPENDIX III—INDICATORS

## San Diego County Public Health Services Dashboard
## Top 10 Population Outcome Indicators: EAST REGION

| | Indicator | Description | We want to increase this / We want to decrease this | San Diego County | East Region | Alpine | El Cajon | Harbison Crest | Jamul | La Mesa | Laguna-Pine Valley | Lakeside | Lemon Grove | Mountain Empire | Santee | Spring Valley |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **HEALTH - Enjoying good health and expecting to live a full life** | | | | | | | | | | | | | | | | |
| HEALTH | "3-4-50" Percent | Percent of deaths due to the four chronic diseases (cancer, heart disease and stroke, type 2 diabetes, and pulmonary diseases such as asthma). 2016. | ↓ | 53% | 54% | 58% | 53% | 53% | 59% | 48% | 60% | 56% | 53% | 58% | 56% | 54% |
| | ADRD Death Rate | Alzheimer's Disease and Related Dementias (ADRD) death rate per 100,000 population. 2016. | ↓ | 121.1 | 154.2 | 158.4 | 155.1 | 141.8 | 121.9 | 210.0 | N/A | 128.7 | 161.8 | 96.5 | 145.9 | 145.8 |
| | Infant Mortality Rate | Annual Infant Mortality Rate per 1,000 live births. 2016. | ↓ | 3.7 | 3.7 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| | Infant Mortality Rate | Three-year average Infant Mortality Rate per 1,000 live births. 2013-2015. | ↓ | 4 | 5.2 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| | HIV Disease Diagnosis Estimates | HIV Disease diagnosis case counts and percentages between 2012-2016 time period. | ↓ | 100% (2,462) | 10% (237) | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| **KNOWLEDGE - Learning throughout the lifespan** | | | | | | | | | | | | | | | | |
| KNOWLEDGE | High School Education | Overall Graduation Rate: the percentage of those over the age of 25 with a high school diploma or equivalent. 2017. | ↑ | 86.1% | 87.8% | 93.0% | 83.9% | 90.5% | 88.0% | 91.5% | 92.0% | 90.6% | 79.6% | 78.3% | 92.7% | 87.6% |
| **STANDARD OF LIVING - Having enough resources for a quality life** | | | | | | | | | | | | | | | | |
| STANDARD OF LIVING | Unemployment Rate | Percent of the total labor force that is unemployed (actively seeking employment and willing to work). 2018. | ↓ | 3.9% | 4.8% | 3.1% | 6.2% | 2.3% | 3.7% | 4.0% | 4.1% | 4.3% | 5.9% | 5.5% | 3.8% | 4.9% |
| | Income Inequality | Number of Total Earned Income Tax Credits. 2017 tax year. | ↓ | 7059 | 1104 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| | Poverty | Percent of the population below poverty level. 2017. | ↓ | 13.4% | 13.2% | 6.7% | 19.3% | 8.9% | 8.5% | 12.3% | 11.0% | 10.1% | 15.9% | 19.2% | 7.2% | 12.5% |
| **COMMUNITY - Living in a clean and safe neighborhood** | | | | | | | | | | | | | | | | |
| COMMUNITY | Childhood Lead in Schools | The number of cases San Diego Childhood Lead Poisoning Prevention Program. 2009-2013. | ↓ | 105 | 11 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| **SOCIAL - Helping each other to live well** | | | | | | | | | | | | | | | | |
| SOCIAL | Voting | Percent of the population who voted in a Federal/State/Local election in the last 12 months. 2018. | ↑ | 43.8% | 45.1% | 54.7% | 41.2% | 44.9% | 55.7% | 46.5% | 54.0% | 45.0% | 38.3% | 47.9% | 47.2% | 45.9% |

On the right track  Not on track  No change

To view more information about the *Live Well San Diego* indicators and how we will measure progress go to: http://www.sdcounty.ca.gov/hhsa/programs/sd/live_well_san_diego/indicators.html

# APPENDIX IV - BASIS FOR ACTION

The Basis for Action tells the story of why a priority is important and why the Leadership Team has chosen certain improvement objectives for its CEP. This information helps to show how the Leadership Team is being responsive to the unique needs of their region and is adopting scalable, evidence-informed improvement objectives. However, this Basis for Action is a simplistic way of capturing the rationale for action and does not tell the whole story. A lot of factors and information influence the final CEP, including the varying experiences and perspectives of those who serve on a Leadership Team, events or crises that occur within or that impact communities within the Region, among many other factors. The Basis for Action serves to distill some of the data, research, and evidence that supports the plan of action reflected in the CEP.

This information is organized by the Priorities of the CEP. This is what appears:

- "What the Numbers Say" captures a few data points that reflect the conditions in East Region that helped persuade the Leadership Team to make this a priority.
- "What the Research Says about this Priority Concern" captures research that explains how this priority concern impacts health and well-being.
- "What Interventions Work According to the Research" identifies those practices that work based on the research. These interventions fall along a continuum in terms of the degree to which their effectiveness has been demonstrated—from promising practice to evidence-informed to evidence-based.
- "How are Regional Goals and Improvement Objectives Consistent with these Interventions" describes how what the Leadership Team is planning to do is consistent with the interventions that have been shown to work.

Why is it important to include the Basis for Action? The literature on collective impact explain that it is important that every partner do what they do best while being committed to the mutually-reinforcing vision for collaborative community change, which is the Live Well San Diego vision in this case. Leadership Teams are in a unique position to leverage the activities and efforts of others throughout the Region. Choosing strategies and improvement objectives that are evidence-informed is the best way to influence long-term population outcomes. The collective impact approach also calls for partners to identify not only what they can do best, but also at the scale to which they can be successful.

*Footnotes are used to identify the source of the data. For "What the Numbers Say," footnotes appear in alphabetical order at the end of the appendix. All other footnotes to the research that follows appear in numerical order and immediately below each Priority section.*

| **Priority** | **Alignment with *Live Well San Diego* Component** | **AREAS OF INFLUENCE**<br>**Top 10 *Live Well San Diego* Indicator**<br>• **Expanded Indicator**<br>• *Supporting Indicator* | **AREAS OF INFLUENCE**<br>**Public Health Services Indicator** |
|---|---|---|---|
| **Behavioral Health Wellness** | **Building Better Health**<br>  <br>**Living Safely**<br>  | **HEALTH**<br>**Life Expectancy**<br>**Quality of Life**<br>• **None Applicable**<br>• *Population Considering Suicide*<br>• *Residents Experiencing Psychological Distress*<br>**COMMUNITY**<br>**Crime Rate**<br>• **None Applicable** | **HEALTH**<br>• **3-4-50 Deaths** |

| | |
|---|---|
| What the Numbers Say | • According to the California Health Interview Survey, **10.8%** of East Region residents have seriously thought about committing suicide.[A]<br>• According to the California Health Interview Survey, nearly **1 in 11** East Region adults has likely had serious psychological distress during the past year.[A] |
| What the Research Says about this Priority Concern<br>**how health and well-being is affected* | Mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery.[1] Adverse Childhood Experiences (ACEs) refers to childhood experiences that have a tremendous impact on future violence victimization and perpetration, and lifelong health and opportunity. ACEs are linked to risky health behaviors, chronic disease and health conditions, mental and behavioral health issues, and early death.[2] |

| | |
|---|---|
| What Interventions Work According to the Research<br>* *practices that work based on the research* | Research supports these types of interventions:<br>• Provide school-based preventative interventions aimed at improving social and emotional outcomes.[1]<br>• Use interventions targeting families dealing with adversities to increase effective parenting and reduce risk for depression among children.[1]<br>• Educate and increase awareness among residents and community partners of the impact of trauma and strategies for resilience.[2]<br>• Reducing stress, building responsive relationships, and strengthening life skills are among the best ways to prevent the long-term effects of ACEs.[2]<br>• Implement trauma-informed care or practice, especially in those occupations and settings that serve individuals who are more likely to have experienced toxic stress, such as social work, medicine, education, and public agencies.[2] |
| How are Regional Goals and Improvement Objectives Consistent with these Interventions<br>**consistency between what the Leadership Team is planning to do and the interventions that have been shown to work* | East Region is working towards improving behavioral health wellness through a variety of awareness campaigns, trainings, and mental health screenings. These include promoting the It's Up to Us suicide prevention campaign, promoting the Access and Crisis Line and resources, and implementing Check Your Mood screenings. The Region is also working to address trauma informed approaches and services in the community through screenings of the Resilience and Paper Tigers films, as well as conducting community presentations to increase knowledge about ACEs among residents. |

1. https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders

2 https://developingchild.harvard.edu/resources/aces-and-toxic-stress-frequently-asked-questions/

| **Priority** | **Alignment with *Live Well San Diego* Component** | **AREAS OF INFLUENCE**<br>**Top 10 *Live Well San Diego* Indicator**<br>• **Expanded Indicator**<br>• *Supporting Indicator* | **AREAS OF INFLUENCE**<br>**Public Health Services Indicator** |
|---|---|---|---|
| **Child and Family Wellness** | **Building Better Health**<br>  <br>**Thriving**<br>  | **HEALTH**<br>**Life Expectancy**<br>**Quality of Life**<br>• **None Applicable**<br>• *Child Dental Visits*<br>**KNOWLEDGE**<br>**Graduation Rate**<br>• **None Applicable**<br>• *Chronic Absenteeism*<br>**COMMUNITY**<br>**Crime Rate**<br>• **None Applicable** | **HEALTH**<br>• **3-4-50 deaths**<br>**KNOWLEDGE**<br>• **High School Graduation** |
| | | | |
| What the Numbers Say | • According to the California Health Interview Survey, **1 in 8** East County children had never been to a dentist.[B]<br>• Compared to San Diego County **(11%)** and California overall **(11.1%)**, La Mesa Spring Valley District **(12.7%)** and Grossmont Union High **(15.2%)** had higher percentages of chronically absent students in the 2017-2018 school year, according to the California Department of Education.[C] | | |
| What the Research Says about this Priority Concern<br>**how health and well-being is affected* | Child and family wellness include many aspects of well-being throughout the lifespan. Evidence shows that experiences in early and middle childhood are extremely important for a child's healthy development and lifelong learning.[1] These determinants include preventative healthcare, school attendance, homelessness, and community involvement. On-time vaccination throughout childhood is essential because it helps provide immunity before children are exposed to potentially life-threatening diseases.[2] Chronic absence — missing 10 percent or more of school days due to absence for any reason can translate into third-graders unable to master reading, sixth-graders failing subjects and ninth-graders dropping out of high school.[3] Homelessness is linked to poor physical health for children including low birth weight, malnutrition, ear infections, exposure to environmental toxins and chronic illness (e.g., asthma). Homeless children also are less likely to have adequate access to medical and dental care.[4] Community involvement is also important to child and family well-being. Participation in a neighborhood association leads to increased social capital, increased social cohesion, and increased community involvement.[5] Volunteering is an investment in local communities and the people who live in them and promotes civic responsibility.[6] | | |

| | |
|---|---|
| What Interventions Work According to the Research<br>* *practices that work based on the research* | Research supports these types of interventions:<br>• Implementing interventions to assist chronically absent students that can improve their attendance.[7]<br>• Implementing school and child care center-located vaccination programs to increase vaccination rates.[8]<br>• Improving discharge planning from foster care and juvenile justice to connect youth to education, housing, health and behavioral health supports, income supports, and health coverage prior to discharge.[9]<br>• Improving access to emergency assistance, housing, and supports for historically underserved groups of youth.[9]<br>• Implementing neighborhood associations to increase social capital and social cohesion in communities.[5] |
| How are Regional Goals and Improvement Objectives Consistent with these Interventions<br>**consistency between what the Leadership Team is planning to do and the interventions that have been shown to work* | The East Region has established goals for addressing the various aspects of child and family wellness in their community. They are working to improve rates of absenteeism in schools that are struggling with the issue through educational and community events that create a positive relationship with the school community to help emphasize the importance of good attendance and the impact this has on a student's future. The Region is working to help homeless students through identifying new housing options for homeless youth, distributing resource cards at community events, and by working with local school districts to increase resources for these students. To improve health earlier in life, the East Region is implementing awareness campaigns that promote health screenings such as lead, oral health, and vaccinations among infants and children. To increase community involvement, an underlying factor in making overarching change in a community, the Region is working to increase participation in the Resident Leadership Academies, a program for local leadership and advocacy to improve the quality of life, which has been shown to increase social cohesion, activism, and civic participation. The East Region also focuses on behavioral health specifically in school settings, to decrease the stigma surrounding mental health by promoting trainings and offering workshops that identify solutions to issues teenagers face today. The Region is also providing film screenings on Resilience and Paper Tigers with dialogue that focus on resiliency instead of trauma. |

1. https://www.healthypeople.gov/2020/topics-objectives/topic/early-and-middle-childhood
2. https://www.cdc.gov/vaccines/parents/index.html
3. https://www.attendanceworks.org/chronic-absence/the-problem/
4. https://www.apa.org/pi/families/poverty
5. http://www.Countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/neighborhood-associations
6. Corp for National & Community Service, Youth Engagement Zone; http://www.nationalservice.gov/pdf/factsheet_lsa.pdf.
7. http://www.Countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/attendance-interventions-for-chronically-absent-students
8. https://www.thecommunityguide.org/findings/vaccination-programs-schools-and-organized-child-care-centers
9. https://www.usich.gov/resources/uploads/asset_library/USICH_OpeningDoors_Amendment2015_FINAL.pdf

| **Priority** | **Alignment with *Live Well San Diego* Component** | **AREAS OF INFLUENCE**<br>**Top 10 *Live Well San Diego* Indicator**<br>• **Expanded Indicator**<br>• *Supporting Indicator* | **AREAS OF INFLUENCE**<br>**Public Health Services Indicator** |
|---|---|---|---|
| **Aging Communities** | **Building Better Health**<br>  <br>**Living Safely**<br>  <br>**Thriving**<br>  | **HEALTH**<br>  **Life Expectancy**<br>  **Quality of Life**<br>• **None Applicable**<br>• *Seniors walking for transportation, fun, or exercise.*<br>**COMMUNITY**<br>  **Crime Rate**<br>• **None Applicable**<br>**SOCIAL**<br>  **Volunteerism**<br>• **None Applicable** | **HEALTH**<br>• **3-4-50 Deaths** |
| | | | |
| What the Numbers Say | • In East Region, **less than 1/3** of residents aged 65 years and older reported walking regularly for transportation, fun, or exercise.[A]<br>• Among householders 65 years and older in the East Region, **40.4%** of houses were owner occupied without a mortgage, **34.0%** were owner occupied with a mortgage, and **25.6%** were renter occupied in 2017.[D]<br>• In East Region, only **2.1%** of residents aged 65 years and older who are still employed took public transportation other than a taxicab.[D] | | |
| What the Research Says about this Priority Concern<br>**how health and well-being is affected* | Seniors and aging citizens face a variety of concerns related to health, housing, transportation, and community involvement. For older adults, transportation is a crucial factor in preserving dignity, maximizing independence, and providing access to the full range of activities that contribute to their quality of life.[1] Isolation is a concern among the elderly, leading to poorer health outcomes and depression.[2] Transportation can also affect isolation, which is associated with poorer health outcomes.[3] For older adults that own their homes, mobility modifications are of more concern than cost, and for those who rent, affordability is a pervasive problem. To cope with high housing and rent costs, many participants live with other family members. Many older adults reported experiencing a lack of privacy or a feeling of being burdensome when residing with family members. Some seniors are currently homeless or on the brink of homelessness.[4] Research also shows that each year hundreds of thousands of elderly adults across the county are abused.[5] Elder abuse is associated with increased rates of hospitalization, is underreported, and costs victims billions of dollars each year.[6] | | |

| | |
|---|---|
| What Interventions Work According to the Research<br>* *practices that work based on the research* | Research supports these types of interventions:<br>• Implementing social support interventions in community settings to increase physical activity and improve physical fitness among adults.[7]<br>• Addressing elder abuse by ending isolation, creating and improving transportation, law enforcement, senior centers and social services.<br>• Implementing intergenerational communities to increase social connectedness, social cohesion, and civic participation. Intergenerational communities promote interaction and cooperation between individuals of different ages and focus on the needs of all residents, especially children and older adults.[8]<br>• Creating educational, social, and physical activity programs for older adults to improve mental and physical health outcomes among participants. Such programs have been shown to reduce loneliness, protect against social isolation, and improve emotional well-being and quality of life for older adults.[3]<br>• Using programs such as the Housing First programs to reduce homelessness, increase housing stability and reduce hospital utilization.[9] |
| How are Regional Goals and Improvement Objectives Consistent with these Interventions<br>**consistency between what the Leadership Team is planning to do and the interventions that have been shown to work* | The East Region is working towards addressing the needs of its older adult residents to create a more age-friendly community. To increase physical activity and social opportunities among older adults, the Region is implementing intergenerational games and programs in the community. In addition to creating more social opportunities for seniors, the Region is increasing awareness of abuse and neglect that can occur in older adults. Housing and transportation are other needs that the Region is working to improve for seniors. The East Region is increasing age- and dementia-friendly transportation opportunities, working with community partners to offer training on usage of public transit, providing technical assistance workshops, and working to reduce homelessness among the aging community through access to new housing options such as accessory dwelling units or granny flats. |

1. http://www.localcommunities.org/lc/867/FSLO-1091237016-865867.pdf

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4. https://www.sandiegoCounty.gov/content/dam/sdc/hhsa/programs/ais/documents/TO%20CPS%20FOR%20PRINT%20-%20Age%20Well%20San%20Diego%20Action%20Plan_2018May08%20FINAL%20(kc)%201118am.pdf

5. https://www.nia.nih.gov/health/elder-abuse

6. https://ncea.acl.gov/NCEA/media/Publication/NCEA_TheFactsofEA.pdf

7. https://www.thecommunityguide.org/findings/physical-activity-social-support-interventions-community-settings

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B. UCLA Center for Health Policy Research. 2013-2017 California Health Interview Survey, AskCHIS. Retrieved April, 2019.

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*Live Well San Diego*

# Community Enrichment Plan

## NORTH CENTRAL REGION


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**2019-2021**

This document is the culmination of activities undertaken when implementing the *Live Well San Diego Community Health Improvement Plan, FY 2014-18.*

This document was developed under the General Management System of the County of San Diego, and is in support of *Live Well San Diego*.

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# REGIONAL DIRECTOR'S LETTER

## From the Regional Director

Dear Community Partner,

On behalf on the *Live Well San Diego* North Central Region Leadership Team, we are pleased to bring you the 2019-2021 Community Enrichment Plan (CEP). This is our community plan for advancing the *Live Well San Diego* vision in the North Central Region, through the collective effort of community groups and residents by collaborating and working together to implement changes in the community.

The North Central Region is one of the most diverse geographical regions in the County, including miles of pristine pacific coastline, steep canyons, valleys, and mountainous terrains. The Region encompasses the northern half of the City of San Diego, and in all, consists of 24 smaller communities including Linda Vista, Mission Valley, Clairemont and La Jolla. The North Central Region has a population of over 618,000 residents and is comprised of coastal towns, university communities, suburban areas, and military facilities.

The CEP was developed through a thoughtful, responsive and iterative process, engaging the North Central Region Leadership Team as the "voice" of the community. Because of the COVID-19 pandemic, the publication of this document was delayed and the focus of County staff, this Leadership Team and residents also had to shift to respond to this public health emergency. However, the *Live Well San Diego* vision endures as a blueprint for actions. As a dynamic plan, this CEP will continue to evolve over the next planning cycle to reflect the impact of this public health emergency on our region and what our local leaders believe going forward are the most important things to do to help every resident in North Central Region be healthy, safe and thrive.

Thank you for all that you do to help every resident Live Well!

**Jennifer Bransford-Koons, Director**
East & North Central Regions
County of San Diego Health & Human Services Agency
*Live Well San Diego* East Region Leadership Co-chair

**Karen Lenyoun, Program Manager— EYC**
National Alliance on Mental Illness (NAMI)
*Live Well San Diego* North Central Region Leadership Co-chair


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## INTRODUCTION

This Community Enrichment Plan (CEP) represents the priorities of the North Central Region Leadership Team. The CEP priorities, goals, strategies, improvement objectives, and associated measures were identified and developed by the North Central Region Leadership Team because they address the challenges as well as build on the strengths of North Central Region **[see Appendix I for the key to the CEP terminology and elements]**. This CEP also represents the ways in which the North Central Leadership Team believes it can make the most significant contribution to help every resident Live Well. This CEP is part of a County of San Diego Community Health Improvement Plan (CHIP), aligned to the *Live Well San Diego* vision, that captures the content of all plans for each of the six Health and Human Services Agency (HHSA) Regions and their respective Leadership Teams. Each Leadership Team, comprised of community leaders representing organizations across every sector, plays a vital role in driving action on the ground to advance the *Live Well San Diego* vision by supporting and encouraging collective effort within the Region and leveraging resources available throughout the County.

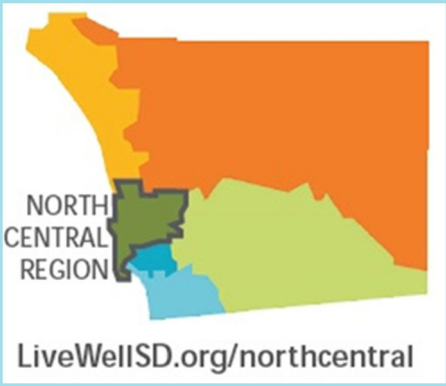
## *LIVE WELL SAN DIEGO* NORTH CENTRAL REGION LEADERSHIP TEAM PLANNING PROCESS AND SELECTION OF PRIORITIES

Formed in June 2012, the North Central Region Leadership Team has helped assess, develop, and guide priorities and activities that improve well-being in the region using evidence-based strategies. In 2014, the North Central Region Leadership Team developed an initial Community Health Assessment and CHIP. Since then, the Leadership Team has evolved to address health in the broadest sense that includes the social and physical environments in which residents live, also referred to as the social determinants of health. This is reflected in the changing of the name of individual CHIPs to Community Enrichment Plans (CEPs), as the Leadership Team priorities address objectives beyond just health.

The North Central Region Leadership Team has evolved since 2012 and today encompasses a broad range of community partners and stakeholders **[see Appendix II for the list of members of the North Central Region Leadership Team]**. The North Central Region Leadership Team began the second iteration of their CEP in 2015, using the Mobilizing for Action through Planning and Partnerships (MAPP) community planning model to select and prioritize regional issues while also identifying resources to address them. The North Central Leadership Team received data presentations on relevant health, safety, and well-being trends and completed a survey to gather perspectives on challenges and priorities for Living Well that covered all components—Building Better Health, Living Safely, and Thriving. Whenever feasible, data were presented through a health equity lens—age, gender, geography, race/ethnicity, and socio-economic status. The survey contained questions relating to both Forces of Change applicable to the community, and Community Themes and Strengths, as these are two of the four MAPP assessments.

# BACKGROUND

Following the data presentations and survey analysis, the North Central Leadership Team's priorities, goals, and improvement objectives emerged during regular meetings through an iterative planning process. The North Central Region Leadership Team has three work groups: Preventative Healthcare, Behavioral Health, and Physical Activity. These work groups developed work plans to inform the CEP. Throughout the process, attention was paid to ensuring alignment to the *Live Well San Diego* framework to show how the priority areas and goals selected by the North Central Leadership Team are supporting the shared vision.




## *LIVE WELL SAN DIEGO* NORTH CENTRAL REGION LEADERSHIP TEAM PRIORITIES

### BUILDING BETTER HEALTH

- Behavioral Health
- Preventative Care
- Physical Activity and Environmental Change

### LIVING SAFELY

- Behavioral Health
- Physical Activity and Environmental Change

### THRIVING

- Physical Activity and Environmental Change

## HOW THE COUNTY SUPPORTS IMPLEMENTATION OF THE COMMUNITY ENRICHMENT PLANS

The North Central Leadership Team cannot on its own implement the improvement objectives that appear in the CEP. The North Central Leadership Team is part of the much bigger collective impact effort of the *Live Well San Diego* vision. This means that success in reaching the improvement objectives, within this plan and other Regional CEPs, depends on leveraging the efforts of partners across all sectors as well as existing County programs and services. For example, a goal to support healthy food choices and food systems will draw upon the County of San Diego Public Health Services Department Chronic Disease and Health Equity program. Behavioral health activities, reflected in many Regional CEPs, are assisted by staff and programs within the Behavioral Health Services Department, which offers prevention and early intervention services and an array of treatment programs. Age Well San Diego, a San Diego County Board of Supervisor initiative to create age-friendly communities, has an action plan that supports intergenerational activities and transportation policies, which closely align with CEP goals. The many assets and resources across San Diego County—public, private, and non-profit—are detailed in the FY 2019-2021 Community Health Assessment. The County of San Diego Regional Director and community engagement staff within each Region assist the Leadership Team to achieve their CEP improvement objectives by providing technical assistance and leveraging County initiatives, programs, and services whenever possible **[see the 2019-2021 Community Health Assessment for more discussion of assets and resources available across San Diego County]**.

## BUILDING THE REGIONAL COMMUNITY ENRICHMENT PLAN

The *Live Well San Diego* vision, and the three components, Building Better Health, Living Safely, and Thriving, serve as the framework for the *Live Well San Diego* CHIP as well as the Regional CEPs (as depicted in the *Live Well San Diego* Pyramid, Figure 1). The final CEP is organized in the language of the Leadership Teams—that is the priorities, goals, and objectives as these leaders defined them. The structure of the CEP content and alignment to *Live Well San Diego* is illustrated in the "Template for the Community Enrichment Plan" which follows (see Figure 2). The "Key to the Community Enrichment Plan," which explains all of the elements, terminology and icons used, is Appendix I.

The content for the CEPs is displayed—Priorities, Indicators, Goals, Improvement Objectives, and Metrics. Alignment is shown visually with the use of icons or colors. Indicators align to *Live Well San Diego* Areas of Influence; Goals align to *Live Well San Diego* Components; and Improvement Objectives align to *Live Well San Diego* Strategic Approaches. *Note that in Central Region, the Priorities are equivalent to Areas of Influence (e.g., Health, Knowledge, Standard of Living, Community, Social) followed by language that reflects the focus of the associated Goals.*

It should be noted that several types of Indicators are identified by Priority. These Indicators include the Top 10 *Live Well San Diego* Indicators, Expanded Indicators, and Supporting Indicators, depending upon which Indicators align to the priority (an explanation of the difference between types of Indicators is explained in Appendix I). Also, Indicators from a newly created Public Health Services Indicators dashboard appear, an expectation of accredited public health departments **[see Appendix III for the *Live Well San Diego* and Public Health Services Indicators Dashboards]**. Any positive movement of the Indicators is achieved over the long term by implementing evidence-informed strategies as described in the Basis for Action **[see Appendix IV for the Basis for Action]**.

**Figure 1. *Live Well San Diego* Vision Pyramid.**

# BUILDING THE REGIONAL COMMUNITY ENRICHMENT PLANS

Regional CEPs do not always cover every Component of the *Live Well San Diego* framework. Each Region's Leadership Team makes the determination of what **Priorities** they will undertake, recognizing that these Leadership Teams must be responsive to the unique needs of their Regions and focus their efforts on those issues or concerns in which members believe the Leadership Team can have the greatest impact through collective action.

Also, these plans are iterative in that **Priorities**, **Goals,** and **Improvement Objectives** can change over time as the Leadership Team responds to evolving needs of the community.

## Figure 2. Template for the Community Enrichment Plan

**Priority:**

| 5 Areas of Influence | Top 10 *Live Well San Diego* Indicators<br>• Expanded Indicator<br>• *Supporting Indicator* | Public Health Services Indicators |
|---|---|---|
| HEALTH | **Life Expectancy** **Quality of Life**<br>• Expanded Indicator<br>• *Supporting Indicator* | 3-4-50<br>ADRD Death Rate<br>Infant Mortality Rate<br>HIV Disease Diagnosis Estimates |
| KNOWLEDGE | **Education**<br>• Expanded Indicator<br>• *Supporting Indicator* | High School Education |
| STANDARD OF LIVING | **Income—Spending Less than 1/3 of Income on Housing** **Unemployment Rate**<br>• Expanded Indicator<br>• *Supporting Indicator* | Unemployment Rate<br>Income Inequality<br>Poverty |
| COMMUNITY | **Security—Crime Rate** **Physical Environment—Air Quality** **Built Environment—Distance to Park**<br>• Expanded Indicator<br>• *Supporting Indicator* | Childhood Lead in Schools |
| SOCIAL | **Community Involvement—Volunteerism** **Vulnerable Populations—Food Insecurity**<br>• Expanded Indicator<br>• *Supporting Indicator* | Voting |



**Goals Aligned to the Three Components of *Live Well San Diego* and Corresponding Icons and Color Bands**

- Building Better Health—Goal X: X
- Living Safely—Goal X: X
- Thriving—Goal X: X

**Improvement Objectives and Metrics Aligned to the Four *Live Well San Diego* Strategic Approaches and Corresponding Icons**

| Strategic Approach | Improvement Objective and Metric |
|---|---|
| | X.X: Improvement Objective |
| | ◊ Metric |

# *LIVE WELL SAN DIEGO*
# COMMUNITY ENRICHMENT PLAN – NORTH CENTRAL REGION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## Priority: Behavioral Health

| Area of Influence | Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | Public Health Services Indicator |
|---|---|---|
| HEALTH | **Life Expectancy**<br>**Quality of Life**<br>• **None Applicable**<br>• *Population with Suicidal Ideation*<br>• *Psychological Distress* | **3-4-50 Deaths** |
| COMMUNITY | **Crime Rate**<br>• **None Applicable**<br>• *High School E-Cigarette Use* | |

## GOAL 1: Increase Awareness About the Impact of Trauma

**Improvement Objectives and Metrics**

1.1: Increase knowledge among residents and community partners of the importance of trauma-informed approaches and services.

◊ Number of community event screenings of films that provide information about the impact of toxic stress on the health and development of children and youth (titled “Resilience” and “Paper Tigers”)

## GOAL 2: Provide Quality and Efficient Care

**Improvement Objectives and Metrics**

2.1: Decrease stigma and increase awareness of mental health issues in the community.

◊ Number of trainings, presentations, social media campaigns, and educational opportunities provided in schools or other settings

◊ Number of sites that have conducted Check Your Mood screenings

2.2: Increase access to behavioral and mental health services.

◊ Number of partners participating in awareness campaigns and sharing resources (Access and Crisis Line) with the community

◊ Number of suicide prevention trainings, presentations, and/or other educational opportunities participated in or delivered

## GOAL 3: Support Tobacco- and Drug-Free Lives

**Improvement Objectives and Metrics**

3.1: Increase awareness and perception of harm around drug and alcohol use and abuse for youth.

◊ Number of youth-focused messaging (social media, infographics)

## Priority: Preventative Care

| Area of Influence | Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | Public Health Services Indicator |
|---|---|---|
| HEALTH | **Life Expectancy**<br>**Quality of Life**<br>• **None Applicable**<br>• *Household Fresh Vegetable Use*<br>• *Routine Care*<br>• *Access to Affordable Fruits/Vegetables* | **3-4-50 Deaths** |

## GOAL 4: Improve Access to Quality Care

**Improvement Objectives and Metrics**

4.1: Increase prevention screenings to identify health issues early to improve health and well-being.

- ◊ Number of community events or sites to promote preventative screenings (e.g., cancer, cardiovascular, lead, oral health, fluoride varnish, sealant, exams, and vaccinations)
- ◊ Number of social media campaigns developed or delivered

## GOAL 5: Encourage Healthy Eating

**Improvement Objectives and Metrics**

5.1: Increase awareness, accessibility, availability, and education around the importance of healthy food.

- ◊ Number of social media campaigns, trainings, presentations, and/or other educational opportunities participated in or delivered
- ◊ Number of people receiving nutrition education from Nutrition Education and Obesity Prevention (NEOP) Specialists
- ◊ Number of people receiving resources to increase access to healthy food and beverages

5.2: Increase availability of fresh fruits and vegetables in the community.

- ◊ Number of stores or locations for which outreach is conducted in order to encourage implementation of "Harvest of the Month," referring to efforts to increase access to fruits and vegetables
- ◊ Number of schools for which outreach is conducted in order to adopt and/or set up composting bins
- ◊ Number of new community gardens installed, promoted, or collaborated with for assistance

## GOAL 6. Promote Access to Healthy Foods

**Improvement Objectives and Metrics**

6.1 Engage and align with existing food systems groups and organizations.

- ◊ Number of community-based organizations and/or events that distributed the food resource list
- ◊ Number of My Plate resources implemented to sites or distribution centers
- ◊ Number of food bank distribution sites to promote resources

### Priority: Physical Activity and Environmental Change

| Area of Influence | Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | Public Health Services Indicator |
|---|---|---|
| HEALTH | **Life Expectancy**<br>**Quality of Life** | **3-4-50 Deaths** |
| COMMUNITY | • **None Applicable**<br>• *Childhood Obesity*<br>**Distance to Park or Community Spaces** | |
| SOCIAL | • **None Applicable**<br>• *Active Transport to School* | |

## GOAL 7: Create Opportunities to be Physically Active

**Improvement Objectives and Metrics**

7.1: Increase opportunities for physical activity and active transportation for residents walking and biking to area schools and the skate park in Linda Vista.

- ◊ Number of libraries with backpacks for the "Check Out Nature" backpack program
- ◊ Number of schools participating in Walk to School or Bike to School events

## GOAL 8: Increase Neighborhood Safety with Environmental Change

**Improvement Objectives and Metrics**

8.1: Increase neighborhood safety through environmental change.

- ◊ Number of physical infrastructure changes (i.e., crosswalks and bike lanes installed, signage, and other safety measures)
- ◊ Number of murals outside of Linda Vista schools
- ◊ Number of community clean-ups to improve neighborhood environment

## GOAL 9: Increase Opportunities for Youth and Adults to Enjoy Recreation and Nature

**Improvement Objectives and Metrics**

9.1: Increase opportunities for youth and adults to enjoy recreation in nature trails within their neighborhood.

- ◊ Number of individuals checking out nature backpacks from local libraries
- ◊ Number of groups checking out backpacks from the "Check Out Nature" backpack program
- ◊ Number of community events, concerts, and movies in the park

# APPENDIX


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# APPENDIX I—KEY TO THE COMMUNITY ENRICHMENT PLAN

This section explains the terms and elements that are being used in the CHIP and CEPs. Careful attention was made to ensure that clear alignment to the *Live Well San Diego* vision was achieved, while also adhering to standard planning terminology.


## Priority

The issue that was selected by the Leadership Team to address, based on a review of community health assessment and other data and the knowledge and passion of members in the Leadership Team.

## Five Areas of Influence

These are the dimensions that capture overall well-being: Health, Knowledge, Standard of Living, Community, and Social. The Areas of Influence reflect that good health goes beyond physical well-being to include the social determinants of health.

| Five Areas of Influence and the Corresponding Icons and Definitions | | | | |
|---|---|---|---|---|
| HEALTH | KNOWLEDGE | STANDARD OF LIVING | COMMUNITY | SOCIAL |
| Enjoying good health and expecting to live a full life | Learning throughout the lifespan | Having enough resources for a quality of life | Living in a clean and safe neighborhood | Helping each other to live well |

# APPENDIX I—KEY TO THE COMMUNITY ENRICHMENT PLAN

## Top 10 *Live Well San Diego* Indicators

Indicators are intended to capture the collective impact of programs, services, and interventions over the long term. The Top 10 *Live Well San Diego* Indicators define what it means to "live well" in San Diego. For each CEP Priority, the appropriate *Live Well San Diego* Indicators are identified in bold with the appropriate icon. "Expanded" Indicators, which are indented in bold, may be identified which are part of the *Live Well San Diego* framework and further describe each Top 10 indicator. This may also include a "Supporting" Indicator which is not part of the Top 10 but is viewed as an additional population measure that reflects progress in the medium- to long-range time span to achieving that priority. These are identified in italics.

**Due to space constraints, only those Indicators, Expanded Indicators, and Supporting Indicators that appear in the individual CEPs are presented in the Key.**

**Top 10 *Live Well San Diego* Indicators**
- **Expanded Indicator**
- *Supporting Indicator*

**Life Expectancy** **Quality of Life**

- *Population with Suicidal Ideation*
- *Household Fresh Vegetable Use*
- *Routine Care*
- *Access to Affordable Fruits/Vegetables*
- *Childhood Obesity*
- *Child Dental Visits*
- *Seniors Walking for Transportation, Fun, or Exercise*
- *High School E-Cigarette Use*

KEY

**Education**

- *Chronic Absenteeism*

**Income-Spending Less than 1/3 of Income on Housing** **Unemployment Rate**

- **Percentage of Population with a Checking or Savings Account**

**Security—Crime Rate** **Physical Environment—Air Quality** **Built Environment—Distance to Park**

- **Travel Time to Work Over 60 Minutes**
- *Probation Youth*
- *Risk of Recidivation*
- *Residents Experiencing Psychological Distress*
- *Active Transport to School*
- *Rate of ED Discharges for Opioid Disorders*
- *Fall Injury Hospitalization Rates*
- *Disaster Vulnerable Residents*

**Community Involvement—Volunteerism** **Vulnerable Populations—Food Insecurity**

- **Volunteerism**
- **Food Insecurity**

# APPENDIX I—KEY TO THE COMMUNITY ENRICHMENT PLAN

## Public Health Services Indicators


To maintain national public health accreditation, a dashboard has been developed to capture indicators that are most relevant to interventions in which Public Health Services plays a key role — this dashboard is referred to as the Public Health Services Dashboard. These indicators are in bold and defined on this page. The indicators are part of a national database submitted to the Public Health Accreditation Board to show the significance and impact of maintaining public health accreditation that results in meeting targets for population health outcomes.

| Public Health Services Indicators | Description |
|---|---|
| **3-4-50 Percent** | Percent of deaths due to the four chronic diseases (cancer, heart disease and stroke, type 2 diabetes, and pulmonary diseases such as asthma). |
| **ADRD Death Rate** | Alzheimer's Disease and Related Dementias (ADRD) death rate per 100,000 population. |
| **Childhood Lead in Schools** | The number of cases from the San Diego Childhood Lead Poisoning Prevention Program. |
| **High School Education** | Overall Graduation Rate: The percentage of those over the age of 25 with a high school diploma or equivalent. |
| **HIV Disease Diagnosis Estimates** | HIV disease diagnosis case counts and percentages. |
| **Income Inequality** | Number of Total Earned Income Tax Credits. |
| **Infant Mortality Rate** | Three-year average Infant Mortality Rate per 1,000 live births. |
| **Poverty** | Percent of the population below poverty level. |
| **Unemployment Rate** | Percent of the total labor force that is unemployed (actively seeking employment and willing to work). |
| **Voting** | Percent of the population who voted in a Federal/State/Local election in the last 12 months. |

## Goal

A goal is an aspiration or broad statement of what the Leadership Team wants to achieve in the longer term (more than three years).

## *Live Well San Diego* Component

There are three major components to *Live Well San Diego*. Each Priority and Goal is aligned to one of these components—Building Better Health, Living Safely, and Thriving. The CEP goals show alignment to the *Live Well San Diego* components by including the respective icon and color (see below).

| Building Better Health | Living Safely | Thriving |
|---|---|---|

# APPENDIX I—KEY TO THE COMMUNITY ENRICHMENT PLAN

## Strategic Approach

The *Live Well San Diego* vision is achieved through four strategies, referred to as Strategic Approaches. These are *Building a Better Service Delivery System*, *Supporting Positive Choices*, *Pursuing Policy and Environmental Changes*, and *Improving the Culture from Within*. These Strategic Approaches are used as the strategies for the CEPs, which are how the Leadership Team will go about achieving the goal. The icons and definitions for the Strategic Approaches are listed below.

| *Live Well San Diego* Strategic Approaches | | | |
|---|---|---|---|
| **Building a Better Service Delivery System** | **Supporting Positive Choices** | **Pursuing Policy and Environmental Changes** | **Improving the Culture from Within** |
|  |  |  |  |
| Improving the quality and efficiency of County government and its partners in the delivery of services to residents, contributing to better outcomes for clients and results for communities. | Providing information and resources to inspire County residents to take action and responsibility for their health, safety, and well-being. | Creating environments and adopting policies that make it easier for everyone to live well, and encouraging individuals to get involved in improving their communities. | Increasing understanding among County employees and providers about what it means to live well and the role that all employees play in helping residents live well. |

## Improvement Objective

The Improvement Objective is the change or improvement that the Leadership Team seeks or hopes to accomplish in the shorter term (one to three years). The Improvement Objective reflects actions that the Leadership Team has decided to take and is supported by the research, evidence, or best practice to contribute to advancement of the goal and ultimately community change. For each Improvement Objective, the Strategic Approach is indicated with the corresponding icon in the CEP to indicate alignment.

## Metric

The metric indicates the target and how progress will be measured for each improvement objective.

# APPENDIX II— LIST OF *LIVE WELL SAN DIEGO* NORTH CENTRAL COMMUNITY LEADERSHIP TEAM MEMBERS

## NORTH CENTRAL REGION LEADERSHIP TEAM MEMBERS

**CO-CHAIRS:**

Jennifer Bransford-Koons, Director of Regional Operations, HHSA-East & North Central Regions

Karen C. Lenyoun, Program Manager, Elevate Youth California Project, National Alliance on Mental Illness (NAMI)

**Members:** The current *Live Well San Diego* North Central Community Leadership Team consists of the agencies and organizations listed below. Some members regularly attend meetings whereas other valued partners are contributing in other meaningful ways to the development and implementation of the CEP. **Some members are also *Live Well San Diego* Recognized Partners which is indicated with an asterisk (*).**

### NORTH CENTRAL COMMUNITY LEADERSHIP TEAM MEMBERS BY SECTOR[1]

| Cities & Governments | Schools & Education | Community & Faith-Based | Other Valued Partners |
|---|---|---|---|
| • County of San Diego, HHSA, Aging and Independence Services<br>• County of San Diego, HHSA, Agency Executive Office<br>• County of San Diego, HHSA, AIS Diabetes Program<br>• County of San Diego, HHSA, Behavioral Health Services<br>• County of San Diego, HHSA, Community Health Statistics | • University of California, San Diego<br>• University of California Division of Agriculture and Natural Resources<br>• University of California Expanded Food and Nutrition Education Program<br>• San Diego Unified School District* | • 2-1-1*<br>• American Lung Association in California*<br>• Bayside Community Center*<br>• Community Health Improvement Partners (CHIP) *<br>• Family Health Centers of San Diego*<br>• Institute of Violence, Abuse, and Trauma*<br>• Jewish Family Services of San Diego* | • Access, Inc. (Youth and Immigration Services)*<br>• Aetna Better Health<br>• American Heart Association*<br>• American Red Cross (Women, Infants & Children Program)*<br>• Beach Area Family Health Center*<br>• Cross Cultural Horizons<br>• Linda Vista Multi-Cultural Fair<br>• Mental Health Systems*<br>• NAMI San Diego (Career Pathways)*<br>• Salud Health Info<br>• SCOO-SOI |

# APPENDIX II— LIST OF *LIVE WELL SAN DIEGO* NORTH CENTRAL COMMUNITY LEADERSHIP TEAM MEMBERS

| Cities & Governments | Schools & Education | Community & Faith-Based | Other Valued Partners |
|---|---|---|---|
| • County of San Diego, HHSA, East and North Central Regions<br>• County of San Diego, HHSA, Health Coverage Access<br>• County of San Diego, HHSA Live Well San Diego Support Team<br>• County of San Diego, HHSA, North Central Family Resource Center<br>• County of San Diego, HHSA, Public Health Services<br>• County of San Diego, LUEG, Air Pollution and Control District<br>• County of San Diego, LUEG, Parks and Recreation Department | | • Kids Turn San Diego*<br>• McAlister Institute*<br>• Neighborhood House Association*<br>• Ovarian Cancer Alliance of San Diego*<br>• Jacobs & Cushman San Diego Food Bank*<br>• San Diego OASIS*<br>• SAY San Diego*<br>• Scripps Ranch Civic Association*<br>• Susan G. Komen San Diego*<br>• Union of Pan-Asian Communities*<br>• University City Community Association* | |

[1]Partners listed are based on sign in sheets from the Live Well San Diego leadership team meetings in the past year. This list is not inclusive of all partners that are actively engaged in the community at large.

# APPENDIX III—INDICATORS

## TOP 10 *LIVE WELL SAN DIEGO* INDICATORS DASHBOARD ALIGNED TO *LWSD* AREAS OF influence

### *Live Well San Diego* Dashboard
### Top 10 Population Outcome Indicators: NORTH CENTRAL REGION

| | Indicator | Description | We want to increase this / We want to decrease this | San Diego County | North Central Region | Coastal | Del Mar-Mira Mesa | Elliott-Navajo | Kearny Mesa | Miramar | Peninsula | University |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **HEALTH - Enjoying good health and expecting to live a full life** | | | | | | | | | | | | |
| HEALTH | Life Expectancy | Average number of years a person is expected to live at birth. 2016. | ↑ | 82.1 | 84.1 | 86.3 | 85.2 | 83.5 | 82.0 | N/A | 84.6 | 84.3 |
| | Quality of Life | Percent of the population 18 and older, not residing in nursing homes or other institutions, that is sufficiently healthy to be able to live independently. 2017. | ↑ | 94.9% | 96.2% | 96.8% | 97.1% | 95.5% | 95.4% | 98.4% | 95.7% | 97.1% |
| **KNOWLEDGE - Learning throughout the lifespan** | | | | | | | | | | | | |
| KNOWLEDGE | Education: High School Diploma or Equivalent | Overall Graduation Rate: the percentage of those over the age of 25 with a high school diploma or equivalent. 2017. | ↑ | 86.1% | 95.2% | 97.5% | 94.5% | 96.2% | 91.7% | 97.2% | 96.5% | 98.0% |
| **STANDARD OF LIVING - Having enough resources for a quality life** | | | | | | | | | | | | |
| STANDARD OF LIVING | Unemployment Rate | Percent of the population that is unemployed. 2018. | ↓ | 3.9% | 3.0% | 2.7% | 2.9% | 2.8% | 3.4% | 4.2% | 3.0% | 3.0% |
| | Income: Percent of population spending less than 1/3 of income on housing | Percent of the population spending less that 1/3 of their income on housing. 2016. | ↑ | 52.9% | 56.3% | 55.9% | 63.7% | 56.8% | 54.5% | 10.1% | 53.0% | 51.9% |
| **COMMUNITY - Living in a clean and safe neighborhood** | | | | | | | | | | | | |
| COMMUNITY | Security: Overall Crime Rate | Overall Crime rate per 100,000 population. 2017. | ↓ | 2032.6 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| | Physical Environment: Air Quality | Percent of days rated unhealthy for vulnerable populations. 2018. | ↓ | 6.1% | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| | Built Environment: Percent of population living within 1/4th a mile of a park or community space | Percentage of population that resides within a quarter mile of a park or community space. 2018. | ↑ | 61.3% | 70.2% | 73.5% | 72.1% | 59.0% | 72.9% | 2.8% | 77.7% | 68.3% |
| **SOCIAL - Helping each other to live well** | | | | | | | | | | | | |
| SOCIAL | Vulnerable Populations: Food Insecurity | Percent of adult population 200% below FPL not able to afford food. 2017. *Indicates statistically unstable estimates. Proceed with caution. | ↓ | 37.6% | 31.6% | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| | Community Involvement: Volunteerism | Percent of residents who volunteer. 2017. | ↑ | 25.5% | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |

On the right track  Not on track  No change

To view more information about the *Live Well San Diego* Indicators and how we will measure progress go to: http://www.sdcounty.ca.gov/hhsa/programs/sd/live_well_san_diego/indicators.html

# APPENDIX III—INDICATORS

## PUBLIC HEALTH SERVICES INDICATORS DASHBOARD

### San Diego County Public Health Services Dashboard
### Top 10 Population Outcome Indicators: NORTH CENTRAL REGION

| | Indicator | Description | We want to increase this / We want to decrease this | San Diego County | North Central Region | Coastal | Del Mar-Mira Mesa | Elliott-Navajo | Kearny Mesa | Miramar | Peninsula | University |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **HEALTH - Enjoying good health and expecting to live a full life** | | | | | | | | | | | | |
| HEALTH | "3-4-50" Percent | Percent of deaths due to the four chronic diseases (cancer, heart disease and stroke, type 2 diabetes, and pulmonary diseases such as asthma). 2016. | ↓ | 53% | 51% | 49% | 56% | 52% | 48% | 56% | 49% | 52% |
| | ADRD Death Rate | Alzheimer's Disease and Related Dementias (ADRD) death rate per 100,000 population. 2016. | ↓ | 121.1 | 114.2 | 117.2 | 68.4 | 142.9 | 156.8 | N/A | 113.4 | 99.5 |
| | Infant Mortality Rate | Annual Infant Mortality Rate per 1,000 live births. 2016. | ↓ | 3.7 | 3.9 | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| | Infant Mortality Rate | Three-year average Infant Mortality Rate per 1,000 live births. 2013-2015. | ↓ | 4 | 3.3 | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| | HIV Disease Diagnosis Estimates | HIV Disease diagnosis case counts and percentages between 2012-2016 time period. | ↓ | 100% (2,462) | 13% (326) | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| **KNOWLEDGE - Learning throughout the lifespan** | | | | | | | | | | | | |
| KNOWLEDGE | High School Education | Overall Graduation Rate: the percentage of those over the age of 25 with a high school diploma or equivalent. 2017. | ↑ | 86.1% | 95.2% | 97.5% | 94.5% | 96.2% | 91.7% | 97.2% | 96.5% | 98.0% |
| **STANDARD OF LIVING - Having enough resources for a quality life** | | | | | | | | | | | | |
| STANDARD OF LIVING | Unemployment Rate | Percent of the total labor force that is unemployed (actively seeking employment and willing to work). 2018. | ↓ | 3.9% | 3.0% | 2.7% | 2.9% | 2.8% | 3.4% | 4.2% | 3.0% | 3.0% |
| | Income Inequality | Number of Total Earned Income Tax Credits. 2017 tax year. | ↓ | 7059 | 1300 | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| | Poverty | Percent of the population below poverty level. 2017. | ↓ | 13.4% | 10.4% | 10.5% | 6.2% | 7.6% | 12.2% | 6.6% | 9.1% | 21.7% |
| **COMMUNITY - Living in a clean and safe neighborhood** | | | | | | | | | | | | |
| COMMUNITY | Childhood Lead in Schools | The number of cases San Diego Childhood Lead Poisoning Prevention Program. 2009-2013. | ↓ | 105 | 9 | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| **SOCIAL - Helping each other to live well** | | | | | | | | | | | | |
| SOCIAL | Voting | Percent of the population who voted in a Federal/State/Local election in the last 12 months. 2018. | ↑ | 43.8% | 49.5% | 54.2% | 50.1% | 52.0% | 46.4% | 37.7% | 49.9% | 46.9% |

On the right track  Not on track  No change

To view more information about the *Live Well San Diego* Indicators and how we will measure progress go to: http://www.sdcounty.ca.gov/hhsa/programs/sd/live_well_san_diego/indicators.html

# APPENDIX IV — BASIS FOR ACTION

The Basis for Action tells the story of why a priority is important and why the Leadership Team has chosen certain improvement objectives for its CEP. This information helps to show how the Leadership Team is being responsive to the unique needs of their region and is adopting scalable, evidence-informed improvement objectives. However, this Basis for Action is a simplistic way of capturing the rationale for action and does not tell the whole story. A lot of factors and information influence the final CEP, including the varying experiences and perspectives of those who serve on a Leadership Team, events or crises that occur within or that impact communities within the Region, among many other factors. The Basis for Action serves to distill some of the data, research, and evidence that supports the plan of action reflected in the CEP.

This information is organized by the Priorities of the CEP. This is what appears:

- "What the Numbers Say" captures a few data points that reflect the conditions in North Central Region that helped persuade the Leadership Team to make this a priority.
- "What the Research Says about this Priority Concern" captures research that explains how this priority concern impacts health and well-being.
- "What Interventions Work According to the Research" identifies those practices that work based on the research. These interventions fall along a continuum in terms of the degree to which their effectiveness has been demonstrated—from promising practice to evidence-informed to evidence-based.
- "How are Regional Goals and Improvement Objectives Consistent with these Interventions" describes how what the Leadership Team is planning to do is consistent with the interventions that have been shown to work.

Why is it important to include the Basis for Action? The literature on collective impact explain that it is important that every partner do what they do best while being committed to the mutually-reinforcing vision for collaborative community change, which is the *Live Well San Diego* vision in this case. Leadership Teams are in a unique position to leverage the activities and efforts of others throughout the Region. Choosing strategies and improvement objectives that are evidence-informed is the best way to influence long-term population outcomes. The collective impact approach also calls for partners to identify not only what they can do best, but also at the scale to which they can be successful.

*Footnotes are used to identify the source of the data. For "What the Numbers Say" footnotes appear in alphabetical order at the end of the appendix. All other footnotes to the research that follows appear in numerical order and immediately below each Priority section.*

| Priority | Alignment with *Live Well San Diego* Component | AREAS OF INFLUENCE<br>Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | AREAS OF INFLUENCE<br>• **Public Health Services Indicator** |
|---|---|---|---|
| **Behavioral Health Wellness** | **Building Better Health**<br>  <br>**Living Safely**<br>  | **HEALTH**<br>**Life Expectancy**<br>**Quality of Life**<br>• **None Applicable**<br>• *Population Considering Suicide*<br>• *Residents Experiencing Psychological Distress*<br>**COMMUNITY**<br>**Crime Rate**<br>• **None Applicable**<br>• *High School E-Cigarette Use* | **HEALTH**<br>• **3-4-50 Deaths** |

| | |
|---|---|
| What the Numbers Say | • According to the California Health Interview Survey, **11.3%** of North Central Region residents have seriously thought about committing suicide.[A]<br>• Over **1 in 13** 11th graders in San Diego Unified School district were using electronic cigarettes in the 2016-2017 school year.[B]<br>• According to the California Health Interview Survey, nearly **1 in 12** North Central Region adults has likely had serious psychological distress during the past year.[A] |
| What the Research Says about this Priority Concern<br>**how health and well-being is affected* | Behavioral health encompasses many areas, including mental illness, mental health, and substance abuse. Mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery.[1] Adverse Childhood Experiences (ACEs) refers to childhood experiences that have a tremendous impact on future violence victimization and perpetration, and lifelong health and opportunity. ACEs are linked to risky health behaviors, chronic disease and health conditions, mental and behavioral health issues, and early death.[2]<br><br>Substance use is also an issue within behavioral health. Tobacco use is the number one preventable cause of death and disease in the United States. Every day, almost 2,500 children under 18 years of age try their first cigarette, and more than 400 of them will become regular daily smokers.[3] Since 2014, E-cigarettes have been |

| | |
|---|---|
| | the most commonly used tobacco product among U.S. youth. In 2018, more than 3.6 million U.S. youth, including 1 in 5 high school students and 1 in 20 middle school students, were using e-cigarettes.[4] Early initiation of drinking is associated with development of an alcohol use disorder later in life.[5] Although drinking by persons under the age of 21 is illegal, people aged 12 to 20 years drink 11% of all alcohol consumed in the United States.[5] More than 90% of this alcohol is consumed in the form of binge drinks.[6] |
| What Interventions Work According to the Research<br>* *practices that work based on the research* | Research supports these types of interventions:<br>• Provide school-based preventative interventions aimed at improving social and emotional outcomes.[1]<br>• Use interventions targeting families dealing with adversities to increase effective parenting and reduce risk for depression among children.[1]<br>• Educate and increase awareness among residents and community partners of the impact of trauma and strategies for resilience.[2]<br>• Reduce youth exposure to alcohol advertising, and development of comprehensive community-based programs.[5,6]<br>• Implement trauma-informed care or practice, especially in those occupations and settings that serve individuals who are more likely to have experienced toxic stress, such as social work, medicine, education, and public agencies.[2]<br>For reducing E-cigarette usage:<br>• Ensure school is tobacco-free.[5]<br>• Restrict E-cigarette use around young people.[5]<br>• Prohibit smoking in indoor areas of workplaces and public places.[6] |
| How are Regional Goals and Improvement Objectives Consistent with these Interventions<br>**consistency between what the Leadership Team is planning to do and the interventions that have been shown to work* | North Central Region is working to address several areas of behavioral health including mental health care, trauma, and tobacco and drug use. To increase access to behavioral and mental health services, the Region is promoting awareness campaigns, sharing resources with the community, and working to decrease the stigma of mental health issues. The Region is raising awareness of Adverse Childhood Experiences through screenings of the Resilience and Paper Tigers films, which address toxic stress in childhood and the effects it has on health, to increase awareness and prevention of trauma. To support tobacco- and drug-free lives, North Central Region is working to impact youth through social media messaging and other advertising campaigns that promote national awareness months (such as Alcohol Awareness Month in April and Recovery Awareness Month in October,) and the harm around drug and alcohol abuse. |

1. https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders

2 https://developingchild.harvard.edu/resources/aces-and-toxic-stress-frequently-asked-questions/

3. https://www.lung.org/stop-smoking/smoking-facts/tobacco-use-among-children.html

4. https://www.cdc.gov/tobacco/data_statistics/fact_sheets/youth_data/tobacco_use/index.htm

5. U.S. Department of Health and Human Services. The Surgeon General's Call to Action to Prevent and Reduce Underage DrinkingExternal. Rockville, MD: U.S. Department of Health and Human Services; 2007.

6. Office of Juvenile Justice and Delinquency Prevention. *Drinking in America: Myths, Realities, and Prevention Policy*External. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, 2005.

| **Priority** | **Alignment with *Live Well San Diego* Component** | **AREAS OF INFLUENCE**<br>**Top 10 *Live Well San Diego* Indicator**<br>• **Expanded Indicator**<br>• *Supporting Indicator* | **AREAS OF INFLUENCE**<br>• **Public Health Services Indicator** |
|---|---|---|---|
| **Preventative Care** | **Building Better Health** | **HEALTH**<br>**Life Expectancy**<br>**Quality of Life**<br>• **None Applicable**<br>• *Household Fresh Vegetable Use*<br>• *Routine Care*<br>• *Access to Affordable Fruits/Vegetables* | **HEALTH**<br>• **3-4-50 Deaths** |
| | | | |
| What the Numbers Say | • **1 in 4** North Central residents had not had a routine check-up with a doctor in the past 12 months.[C]<br>• Nearly **40%** of North Central Region residents reported that they did not always have fresh fruits/vegetables in their neighborhood that were affordable.[C]<br>• Nearly **1 in 8** North Central households did not use fresh fruit or vegetables in the last 6 months.[D] | | |
| What the Research Says about this Priority Concern<br>**how health and well-being is affected* | Preventative care includes health services like screenings, check-ups, and patient counseling that are used to prevent illnesses, disease, and other health problems, or to detect illness at an early stage when treatment is likely to work best. Getting recommended preventative services and making healthy lifestyle choices are key steps to good health and well-being. A recent CDC report indicates that millions of infants, children, and adolescents in the U.S. did not receive selected clinical preventative services.[4] Preventative care also encompasses health behaviors such as healthy eating and access to healthy foods. Previous studies suggest that children living in food-insecure households face elevated risks of many problematic health and development outcomes, such as chronic conditions, compared with children in otherwise similar food-secure households.[1,2,3] Food security is especially important for children because their nutrition affects not only their current health, but also their physical, mental, and social development.[3] | | |

| | |
|---|---|
| What Interventions Work According to the Research<br><br>* *practices that work based on the research* | Research supports these types of interventions:<br><br>• Partner with food banks, advocacy organizations and affiliated community organizations to raise awareness of healthy eating support options.[5]<br><br>• Implement community gardens to promote physical and mental health benefits, reduce food insecurity, improve dietary intake and strengthen family relationships.[6]<br><br>• Increase awareness of services provided by federally qualified health centers (FQHCs) to increase access to primary care and improve health outcomes for patients.[7]<br><br>• Support a community market program to increase availability of fresh and healthy foods in underserved communities including The Live Well Community Market program in San Diego County, which has been shown to increase access based on estimates of visits from customers eligible for nutrition programs.[8] |
| How are Regional Goals and Improvement Objectives Consistent with these Interventions<br><br>**consistency between what the Leadership Team is planning to do and the interventions that have been shown to work* | Preventative care is important to the health of the North Central Region, and includes health screenings and access to healthy food, which directly affect health outcomes. The Region is focusing on increasing preventative healthcare screenings at community events, and by raising awareness of the importance of these screenings through social media. Access to healthy food is being addressed in several ways. The Region is working to increase educational resources on how to access fresh and healthy food, as well as why it's important. The Region is also improving access to healthy food in low-income and food insecure communities through policy, systems, and environmental changes, as well as supporting school and community gardens. In addition, the Region will engage with existing food groups and organizations to disseminate resources about food service locations and distributions, as well as provide education and resources on nutrition, preparing and cooking fresh and healthy food. |

1. Chilton, Mariana, Maureen M. Black, Carol Berkowitz, Patrick H. Casey, John Cook, Ruth Rose Jacobs, Alan Meyers, Deborah A. Frank, Diana Cutts, Timothy Heeren, Stephanie Ettinger de Cuba, and Sharon Coleman. 2009. "Food insecurity and risk of poor health among US-born children of immigrants," American Journal of Public Health 99(3): 556-62.

2. Hernandez, Daphne C., and Alison Jacknowitz. 2009. "Transient, but not persistent, adult food insecurity influences toddler development," The Journal of Nutrition139(8): 1517-24.

3. Kirkpatrick, Sharon I., Lynn McIntyre , and Melissa L. Potestio. 2010. "Child hunger and long-term adverse consequences for health," Archives of Pediatrics and Adolescent Medicine 164(8): 754-62.

4. https://www.cdc.gov/prevention/index.html (preventative care)

5. CACFP At-Risk Afterschool Meals Best Practices, 2011: http://www.fns.usda.gov/sites/default/files/Best_Practices_Report.pdf.

6. Carney PA, Hamada JL, Rdesinski R, Sprager L, Nichols KR, Liu BY, Pelayo J, Sanchez MA, Shannon J; 'Impact of a community gardening project on vegetable intake, food security and family relationships: a community-based participatory research study'; J Community Health. 2012 Aug;37(4):874-81. doi: 10.1007/s10900-011-9522-z.

7. http://www.Countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/federally-qualified-health-centers-fqhcs

8. https://ucsdcommunityhealth.org/work/livewellcommunitymarketprogram/

| Priority | Alignment with *Live Well San Diego* Component | AREAS OF INFLUENCE<br>Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | AREAS OF INFLUENCE<br>• **Public Health Services Indicator** |
|---|---|---|---|
| **Physical Activity and Environmental Change** | **Building Better Health**<br>  <br>**Living Safely**<br>  | **HEALTH**<br>**Life Expectancy**<br>**Quality of Life**<br>• **None Applicable**<br>• *Childhood Obesity*<br>**COMMUNITY**<br>**Percentage of Population Living Within ¼ Mile of a Park or Community Space**<br>• *Active Transport to School*<br>**SOCIAL**<br>• **None Applicable** | **HEALTH**<br>• **3-4-50 Deaths** |

| | |
|---|---|
| What the Numbers Say | • In San Diego Unified School district, **38.7%** of 5th graders, **35.1%** of 7th graders, and **33.4%** of 9th graders were overweight or obese in 2017.<br>• Nearly **3 in 10** North Central Region residents did not live within a quarter mile of a park or community space.[F]<br>• Less than **2 out of 5** North Central Region children and teens walked, biked, or skated from school in the past week.[E] |
| What the Research Says about this Priority Concern<br>**how health and well-being is affected* | Physical activity is important for people of all ages, and can help reduce and prevent chronic diseases, reduce depression in children, and improve balance and joint mobility for the elderly.[1] Access to parks or a community space can influence choices to engage in physical activity and community involvement. Using parks and recreation services has been shown to have positive health impacts, including the physical, social, and mental aspects of health.[2] |

| | |
|---|---|
| What Interventions Work According to the Research<br><br>* *practices that work based on the research* | Research supports these types of interventions:<br>• Promote principles from the Safe Routes to Schools (SRTS) program to increase the number of students walking or biking to school through improvements to pedestrian or bicycle transportation systems and environmental design interventions. SRTS is a suggested strategy to increase physical activity among students.[3]<br>• Promote policies to provide for the safe and convenient travel of all users of the roadway, including pedestrians, bicyclists, public transit users, motorists, children, seniors, and people with disabilities.[1]<br>• Implement policies and practices related to transportation and land use, investments in commercial and residential developments, and the location of schools and worksites to ultimately influence the distances people travel to work, the convenience of purchasing healthy foods, and the safety and attractiveness of neighborhoods for walking and accessing neighborhood parks.[1] |
| How are Regional Goals and Improvement Objectives Consistent with these Interventions<br><br>**consistency between what the Leadership Team is planning to do and the interventions that have been shown to work* | The North Central Region is seeking to improve and increase built environments in their community that promote physical activity and positive health outcomes. By improving the built environment, more residents can safely walk and bike to outdoor recreational sites. This would in turn encourage a more active region and increase use of these public spaces, as well as increase the number of children walking to school and experiencing the benefits of daily exercise. The North Central Region is working to increase activity among residents of all ages, and to encourage them to explore nature in their neighborhoods. Programs that will be implemented include a nature adventure backpack program in partnership with local libraries. The libraries offer backpacks that can be checked out by children and encourage exploration of nature trails. The Region is also partnering with organizations to promote physical activity through intergenerational games and community clean-ups. |

1. https://www.cdc.gov/physicalactivity/about-physical-activity/why-it-matters.html
2. https://results.livewellsd.org/en/stat/goals/single/d2gt-yvbi
3. http://www.Countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/safe-routes-to-schools

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A. UCLA Center for Health Policy Research. 2015-2017 pooled California Health Interview Survey, AskCHIS. Retrieved April, 2019.

B. Healthy Kids Survey https://calschls.org/reports-data/dashboard/. Retrieved April, 2019

C. UCLA Center for Health Policy Research. 2017 California Health Interview Survey, AskCHIS. Retrieved April, 2019.

D. 2018 ESRI Community Analyst, Retrieved April 2019

E. UCLA Center for Health Policy Research. 2014-2017 pooled Child and Adolescent dataset, California Health Interview Survey, AskCHIS. Retrieved April, 2019.

F. County of San Diego, Land Use & Environment Group, Planning and Development Services, 2018. Accessed: 8/2018.

*Live Well San Diego*

# Community Enrichment Plan

## NORTH COUNTY REGIONS


COUNTY OF SAN DIEGO
HHSA
HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL
SAN DIEGO

ACCREDITED HEALTH DEPARTMENT
PHAB
Advancing public health performance
PUBLIC HEALTH ACCREDITATION BOARD

**2019-2021**

This document is the culmination of activities undertaken when implementing the *Live Well San Diego Community Health Improvement Plan, FY 2014-18.*

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HEALTH
CITIES & GOVERNMENTS
BUSINESSES & MEDIA
SOCIAL
KNOWLEDGE
LIVE WELL
SAN DIEGO
COMMUNITY & FAITH-BASED
SCHOOLS & EDUCATION
COMMUNITY
STANDARD OF LIVING


COUNTY OF SAN DIEGO
HHSA
HEALTH AND HUMAN SERVICES AGENCY
LIVE WELL
SAN DIEGO
ACCREDITED HEALTH DEPARTMENT
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# REGIONAL DIRECTOR'S LETTER

## From the Regional Director

Dear Community Partner,

We are very pleased to bring to you this FY 2019-21 Community Enrichment Plan (CEP) for North County Regions. This is our community plan for advancing the *Live Well San Diego* vision in this Region. The CEP replaces our FY 2013-18 Community Health Improvement Plan (CHIP) issued back in 2014.

This CEP was developed through a thoughtful, responsive and iterative process, engaging the North County Community Leadership Team (NCCLT) as the "voice" of the community. We have adopted the name of "Community Enrichment Plan" because the plan addresses health in the broadest sense, including the social and physical environments in which residents live, also referred to as the social determinants of health.

The priorities, goals, objectives, actions and associated measures that appear in this community plan address challenges as well as build on strengths of North County Regions. This CEP represents not only what local leaders agree is important but also reflects what they believe we are uniquely positioned to do best in collaboration with partners. This CEP also builds upon our achievements implementing the first Regional CHIP.

As everyone is aware, this country has been hit by a global pandemic (COVID-19), a public health threat unlike any we have seen in our lifetime. This contributed to a delay in the publication of this CEP, and also means that our priorities and goals must remain dynamic to reflect the wider-ranging impacts of the pandemic and new realities that we face. Fortunately, members of our Leadership Team, partners across every sector, and our residents have stepped up to the challenge. The power of collective impact and the *Live Well San Diego* vision has never been so clear and as we work together to help all residents be safe, healthy and thrive.

Please let us know if you have any questions about the CEP. Thank you for all that you do to help every resident become healthy, live safely and thrive.

**Chuck Matthews**
County of San Diego
NCCLT Co-Chair

**Don Stump**
North County Lifeline
NCCLT Co-Chair

**Greg Anglea**
Interfaith Community Services
NCCLT Co-Chair


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## INTRODUCTION

This Community Enrichment Plan (CEP) represents the priorities of the *Live Well San Diego* North County Community Leadership Team (NCCLT). The CEP priorities, goals, strategies, improvement objectives, and associated measures were identified and developed by the NCCLT because they address the challenges as well as build on the strengths of the North County Regions **[see Appendix I for the key to the CEP terminology and elements].** This CEP also represents the ways in which the NCCLT believes it can make the most significant contribution to help every resident Live Well. This CEP is part of a County of San Diego Community Health Improvement Plan (CHIP), aligned to the Live Well San Diego vision, that captures the content of all plans for each of the six Health and Human Services Agency (HHSA) Regions and their respective Leadership Teams. Each Leadership Team, comprised of community leaders representing organizations across every sector, plays a vital role in driving action on the ground to advance *Live Well San Diego* by supporting and encouraging collective effort within the Region and leveraging resources available throughout the County.

## *LIVE WELL SAN DIEGO* NORTH COUNTY COMMUNITY LEADERSHIP TEAM PLANNING PROCESS AND SELECTION OF PRIORITIES

Formed in January 2012, the North County Community Leadership Team has helped assess, develop, and guide priorities and activities that improve well-being in the Region using evidence-based strategies. In 2014, the NCCLT developed an initial Community Health Assessment and CHIP. Since then, the Leadership Team has evolved to address health in the broadest sense that includes the social and physical environments in which residents live, also referred to as the social determinants of health. This is reflected in the changing of the name of individual CHIPs to Community Enrichment Plans (CEPs), as the Leadership Team priorities address objectives beyond just health.

The North County Community Leadership Team has evolved since 2010, and today encompasses a broad range of community partners and stakeholders **[see Appendix II for the list of members of the North County Community Leadership Team]**. The NCCLT began the second iteration of their CEP in 2015, using the Mobilizing for Action through Planning and Partnerships (MAPP) community planning model to select and prioritize Regional issues while also identifying resources to address them. The NCCLT received data presentations on relevant health, safety, and well-being trends and completed a survey to gather perspectives on challenges and priorities for Living Well that covered all components—Building Better Health, Living Safely, and Thriving. Whenever feasible, data were presented through a health equity lens—age, gender, geography, race/ethnicity, and socio-economic status. The survey contained questions relating to both Forces of Change applicable to the community, and Community Themes and Strengths, as these are the two of the four MAPP assessments.

Following the data presentations and survey analysis, North County Leadership Team's priorities, goals, and improvement objectives emerged during regular meetings through an iterative planning process. Unique to North County Regions is that the work is done altogether, without work groups, and there is emphasis

# BACKGROUND

## *LIVE WELL SAN DIEGO* NORTH COUNTY COMMUNITY LEADERSHIP TEAM PRIORITIES

### BUILDING BETTER HEALTH

- Behavioral Health/ Mental Health Services
- Nutrition
- Physical Activity

### LIVING SAFELY

- Illegal Access and Use of Substances and Alcohol
- Crime
- Unintentional Injuries
- Disaster Preparedness

### THRIVING

- Transportation
- Housing
- Education and Workforce Development


on leveraging the efforts of community-based agencies and partners rather than duplicating assets that already exist. Throughout the process, attention was paid to ensuring alignment to the *Live Well San Diego* framework to show how the priority areas and goals selected by the NCCLT are supporting the shared vision.

## HOW THE COUNTY SUPPORTS IMPLEMENTATION OF THE COMMUNITY ENRICHMENT PLANS

The North County Community Leadership Team (NCCLT) cannot on its own implement the improvement objectives that appear in the CEP. The NCCLT is part of the much bigger collective impact effort of the *Live Well San Diego* vision. This means that success in reaching the improvement objectives, within this plan and other Regional CEPs, depends on leveraging the efforts of partners across all sectors as well as existing County programs and services. For example, a goal to support healthy food choices and food systems will draw upon the County of San Diego Public Health Services Department Chronic Disease and Health Equity program. Behavioral health activities, reflected in many Regional CEPs, are assisted by staff and programs within the County of San Diego Behavioral Health Services Department, which offers prevention and early intervention services and an array of treatment programs. Age Well San Diego, a San Diego County Board of Supervisor initiative to create age-friendly communities, has an action plan that supports intergenerational activities and transportation policies, which closely align with CEP goals. The many assets and resources across San Diego County—public, private, and non-profit—are detailed in the FY 2019-2021 Community Health Assessment. The County of San Diego Regional Director and community engagement staff within each Region assist the Leadership Team to achieve their CEP improvement objectives by providing technical assistance and leveraging County initiatives, programs, and services whenever possible **[see the 2019-2021 Community Health Assessment for more discussion of assets and resources available across San Diego County]**.

## *BUILDING THE REGIONAL COMMUNITY ENRICHMENT PLAN*

The *Live Well San Diego* vision, and the three Components, Building Better Health, Living Safely, and Thriving, serve as the framework for the *Live Well San Diego* CHIP as well as the Regional CEPs (as depicted in the *Live Well San Diego* Pyramid, Figure 1). The final CEP is organized in the language of the Leadership Teams—that is the priorities, goals and objectives as these leaders defined them. The structure of the CEP content and alignment to *Live Well San Diego* is illustrated in the "Template for the Community Enrichment Plan," which follows (see Figure 2). The "Key to the Community Enrichment Plan," which explains all of the elements, terminology and icons used, is Appendix I.

The content for the CEPs is displayed in order of: Priorities, Indicators, Goals, Improvement Objectives, and Metrics. Alignment is shown visually with the use of icons or colors. Indicators align to *Live Well San Diego* Areas of Influence; Goals align to *Live Well San Diego* Components; and Improvement Objectives align to *Live Well San Diego* Strategic Approaches.

It should be noted that several types of Indicators are identified by Priority. These Indicators include the Top 10 *Live Well San Diego* Indicators, Expanded Indicators, and Supporting Indicators, depending upon which Indicators align to the priority (an explanation of the difference between types of Indicators is explained in Appendix I). Also, Indicators from a newly created Public Health Services Indicators dashboard appear, an expectation of accredited public health departments **[see Appendix III for the *Live Well San Diego* and Public Health Services Indicators Dashboards]**. Any positive movement of the **Indicators** is achieved over the long term by implementing evidence-informed strategies as described in the Basis for Action **[See Appendix IV for the Basis for Action]**.

**Figure 1. *Live Well San Diego* Vision Pyramid.**

# BUILDING THE REGIONAL COMMUNITY ENRICHMENT PLANS

Regional CEPs do not always cover every Component of the *Live Well San Diego* framework. Each Region's Leadership Team makes the determination of what **Priorities** they will undertake, recognizing that these Leadership Teams must be responsive to the unique needs of their Regions and focus their efforts on those issues or concerns in which members believe the Leadership Team can have the greatest impact through collective action.

Also, these plans are iterative in that **Priorities**, **Goals,** and **Improvement Objectives** can change over time as the Leadership Team responds to evolving needs of the community.

## Figure 2. Template for the Community Enrichment Plan

**Priority:**

| 5 Areas of Influence | Top 10 *Live Well San Diego* Indicators<br>• Expanded Indicator<br>• *Supporting Indicator* | Public Health Services Indicators |
|---|---|---|
| HEALTH | Life Expectancy<br>Quality of Life<br>• Expanded Indicator<br>• *Supporting Indicator* | 3-4-50<br>ADRD Death Rate<br>Infant Mortality Rate<br>HIV Disease Diagnosis Estimates |
| KNOWLEDGE | Education<br>• Expanded Indicator<br>• *Supporting Indicator* | High School Education |
| STANDARD OF LIVING | Income-Spending Less than 1/3 of Income on Housing<br>Unemployment Rate<br>• Expanded Indicator<br>• *Supporting Indicator* | Unemployment Rate<br>Income Inequality<br>Poverty |
| COMMUNITY | Security—Crime Rate<br>Physical Environment—Air Quality<br>Built Environment—Distance to Park<br>• Expanded Indicator<br>• *Supporting Indicator* | Childhood Lead in Schools |
| SOCIAL | Community Involvement—Volunteerism<br>Vulnerable Populations—Food Insecurity<br>• Expanded Indicator<br>• *Supporting Indicator* | Voting |



**Goals Aligned to the Three Components of *Live Well San Diego* and Corresponding Icons and Color Bands**

- Building Better Health—Goal X: X
- Living Safely—Goal X: X
- Thriving—Goal X: X

**Improvement Objectives and Metrics Aligned to the Four *Live Well San Diego* Strategic Approaches and Corresponding Icons**

| Strategic Approach | Improvement Objective and Metric |
|---|---|
| | X.X: Improvement Objective |
| | ◊ Metric |

# *LIVE WELL SAN DIEGO*
# COMMUNITY ENRICHMENT PLAN – NORTH COUNTY REGIONS


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## Priority: Behavioral & Mental Health Services

| Area of Influence | Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | Public Health Services Indicator |
|---|---|---|
| HEALTH | **Life Expectancy**<br>**Quality of Life**<br>• **None Applicable**<br>• *Population with Suicidal Ideation* | **3-4-50 Deaths** |

## GOAL 1: Increase Awareness and Access of Mental Health Resources to North San Diego County Residents at Earliest Point Possible

**Improvement Objectives and Metrics**

1.1: Reduce stigma associated with seeking and obtaining behavioral health services so that residents can obtain needed care.

◊ Number of sites that conduct Check Your Mood screenings

1.2: Integrate and coordinate prevention activities in the schools regarding mental health and suicide.

◊ Number of schools utilizing the Here Now program

1.3: Increase knowledge among residents and community partners of the importance of trauma-informed approaches and service.

◊ Number of screenings (people attending screenings) of the resiliency film (titled “Resilience” and “Paper Tigers”)

## Priority: Nutrition

| Area of Influence | Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | Public Health Services Indicator |
|---|---|---|
| HEALTH | **Life Expectancy**<br>**Quality of Life**<br>• **None Applicable** | **3-4-50 Deaths** |
| SOCIAL | **Food Insecurity**<br>• **None Applicable**<br>• *Household Fresh Vegetable Use* | |

## GOAL 2: Reduce the Prevalence of Poor Nutrition, Food Insecurity, and Hunger among North San Diego County

**Improvement Objectives and Metrics**

2.1: Increase outreach and enrollment in federal nutrition programs.

◊ Number of people enrolled in federal nutrition programs

2.2: Support intergenerational interventions that promote healthy eating.

◊ Number of events (participants) involving different generations promoting healthy eating

2.3 Support employer education and enhance worksite wellness efforts.

◊ Number of organizations participating in worksite wellness as tracked through the Live Well @ Work website

## Priority: Physical Activity

| Area of Influence | Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | Public Health Services Indicator |
|---|---|---|
| HEALTH | **Life Expectancy**<br>**Quality of Life**<br>• **None Applicable**<br>• *Seniors Walking for Transportation, Fun, or Exercise* | **3-4-50 Deaths** |

## GOAL 3: Increase Physical Activity among North San Diego County Residents

**Improvement Objectives and Metrics**

3.1: Increase intergenerational interventions that promote physical activity across the life span.

◊ Number of participants in the intergenerational activities

3.2: Expand Safe Routes to Schools activities to increase physical activity.

◊ Number of schools participating in Walk to School Day

## Priority: Illegal Access to Substances and Alcohol

| Area of Influence | Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | Public Health Services Indicator |
|---|---|---|
| COMMUNITY | **Crime Rate**<br>• **None Applicable** | **None Applicable** |

### GOAL 4: Reduce Illegal and Underage Access, Use and Abuse of Alcohol, Marijuana, Prescription, and Over-the-Counter Medications, Controlled Substances and Other Drugs

**Improvement Objectives and Metrics**

4.1: Educate the community on proper disposal of prescription drugs.

◊ Volume of prescription drugs collected at drop-off sites

## Priority: Crime

| Area of Influence | Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | Public Health Services Indicator |
|---|---|---|
| COMMUNITY | **Crime Rate**<br>• **None Applicable**<br>• *Rate of ED Discharges for Opioid Disorders* | **None Applicable** |

## GOAL 5: Reduce Crime with a Focus on Preventing Gang Activity

**Improvement Objectives and Metrics**

5.1: Take steps to assess causes of gang activity and take actions to protect residents from crime

- ◊ Number of community partners enlisted in efforts to reduce crime

## Priority: Reduce Unintentional Injuries

| Area of Influence | Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | Public Health Services Indicator |
|---|---|---|
| COMMUNITY | • **None Applicable**<br>• *Fall Injury Hospitalization Rates* | **None Applicable** |

## GOAL 6: Reduce Unintentional Injuries within all Age Groups

**Improvement Objectives and Metrics**

6.1: Reduce unintentional injuries related to distracted driving for all age groups.

- ◊ Measure is to be determined

6.2: Promote healthy transportation safety through engineering solutions and personal safety equipment.

- ◊ Number of community presentations (e.g., Sheriff's Department) on helmet safety

6.3: Identify fall prevention community resources for older adults.

- ◊ Number of resource-sharing events provided to older adults at events in North County

## Priority: Disaster Preparedness

| Area of Influence | Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | Public Health Services Indicator |
|---|---|---|
|  <br>COMMUNITY | • **None Applicable**<br>• *Disaster Vulnerable Residents* | **None Applicable** |
|  <br>SOCIAL | | |

## GOAL 7: Increase Disaster Preparedness and Community Recovery Efforts

**Improvement Objectives and Metrics**

7.1: Increase preparedness education and exercises in local schools, businesses, and organizations to prepare residents for an adverse event.

◊ Number of active shooter educational presentations

7.2: Actively engage local schools to devise plans to enhance awareness and response.

◊ Expansion of Tools for Schools Toolkit to include Disaster Curriculum

## Priority: Transportation

| Area of Influence | Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | Public Health Services Indicator |
|---|---|---|
| COMMUNITY | **Physical Environment—Air Quality**<br>• **Travel Time to Work Over 60 Minutes** | **None Applicable** |

## GOAL 8: Identify Opportunities for Community Partners and Residents to Provide Input towards North County Transportation Efforts

**Improvement Objectives and Metrics**

8.1: Increase opportunities for residents to promote and advocate for improved transportation in their communities.

◊ Number of community partners offering and promoting these opportunities

## Priority: Housing

| Area of Influence | Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | Public Health Services Indicator |
|---|---|---|
| COMMUNITY | **Income (spending less than 1/3 on housing)**<br>• **None Applicable** | **None Applicable** |
| STANDARD OF LIVING | | |

### GOAL 9: Increase Advocacy towards North County Housing Efforts

**Improvement Objectives and Metrics**

9.1: Increase awareness and education for community partners and residents to advocate for local housing options in North County.

◊ Number of community partners offering and promoting these opportunities

## Priority: Education and Workforce Development

| Area of Influence | Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | Public Health Services Indicator |
|---|---|---|
| KNOWLEDGE | **High School Graduation**<br>• **None Applicable**<br>**Income (spending less than 1/3 on housing)** | • **High School Graduation**<br>• **Unemployment Rate**<br>• **Income Inequality**<br>• **Poverty** |
| STANDARD OF LIVING | **Unemployment Rate**<br>• **None Applicable** | |

## GOAL 10: Leverage Partnerships with Businesses and Local Schools in North County to Support Education and Workforce Efforts for 2019-21

**Improvement Objectives and Metrics**

10.1: Investigate opportunities to generate Regional partnerships and collaboration to support internships for "opportunity youth" in North County.

- ◊ Number of "opportunity youth" in North County and/or success stories captured

# APPENDIX


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# APPENDIX I—KEY TO THE COMMUNITY ENRICHMENT PLAN

This section explains the terms and elements that are being used in the CHIP and CEPs. Careful attention was made to ensure that clear alignment to the *Live Well San Diego* vision was achieved, while also adhering to standard planning terminology.


## Priority

The issue that was selected by the Leadership Team to address, based on a review of community health assessment and other data and the knowledge and passion of members in the Leadership Team.

## Five Areas of Influence

These are the dimensions that capture overall well-being: Health, Knowledge, Standard of Living, Community, and Social. The Areas of Influence reflect that good health goes beyond physical well-being to include the social determinants of health.

| Five Areas of Influence and the Corresponding Icons and Definitions | | | | |
|---|---|---|---|---|
| HEALTH | KNOWLEDGE | STANDARD OF LIVING | COMMUNITY | SOCIAL |
| Enjoying good health and expecting to live a full life | Learning throughout the lifespan | Having enough resources for a quality of life | Living in a clean and safe neighborhood | Helping each other to live well |

# APPENDIX I—KEY TO THE COMMUNITY ENRICHMENT PLAN

## Top 10 *Live Well San Diego* Indicators

Indicators are intended to capture the collective impact of programs, services, and interventions over the long term. The Top 10 *Live Well San Diego* Indicators define what it means to "live well" in San Diego. For each CEP Priority, the appropriate *Live Well San Diego* Indicators are identified in bold with the appropriate icon. "Expanded" Indicators, which are indented in bold, may be identified which are part of the *Live Well San Diego* framework and further describe each Top 10 indicator. This may also include a "Supporting" Indicator which is not part of the Top 10 but is viewed as an additional population measure that reflects progress in the medium- to long-range time span to achieving that priority. These are identified in italics.

**Due to space constraints, only those Indicators, Expanded Indicators, and Supporting Indicators that appear in the individual CEPs are presented in the Key.**

**Top 10 *Live Well San Diego* Indicators**
- **Expanded Indicator**
- *Supporting Indicator*

**Life Expectancy** **Quality of Life**

- *Population with Suicidal Ideation*
- *Household Fresh Vegetable Use*
- *Routine Care*
- *Access to Affordable Fruits/Vegetables*
- *Childhood Obesity*
- *Child Dental Visits*
- *Seniors Walking for Transportation, Fun, or Exercise*
- *High School E-Cigarette Use*

KEY

**Education**

- *Chronic Absenteeism*

**Income-Spending Less than 1/3 of Income on Housing** **Unemployment Rate**

- **Percentage of Population with a Checking or Savings Account**

**Security—Crime Rate** **Physical Environment—Air Quality** **Built Environment—Distance to Park**

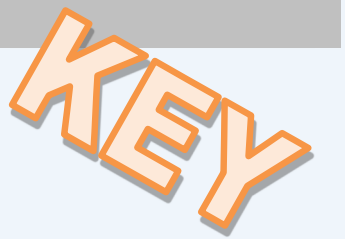
- **Travel Time to Work Over 60 Minutes**
- *Probation Youth*
- *Risk of Recidivation*
- *Residents Experiencing Psychological Distress*
- *Active Transport to School*
- *Rate of ED Discharges for Opioid Disorders*
- *Fall Injury Hospitalization Rates*
- *Disaster Vulnerable Residents*

**Community Involvement—Volunteerism** **Vulnerable Populations—Food Insecurity**

- **Volunteerism**
- **Food Insecurity**

# APPENDIX I—KEY TO THE COMMUNITY ENRICHMENT PLAN

## Public Health Services Indicators




To maintain national public health accreditation, a dashboard has been developed to capture indicators that are most relevant to interventions in which Public Health Services plays a key role —this dashboard is referred to as the Public Health Services Dashboard. These indicators are in bold and defined on this page. The indicators are part of a national database submitted to the Public Health Accreditation Board to show the significance and impact of maintaining public health accreditation that results in meeting targets for population health outcomes.

| Public Health Services Indicators | Description |
|---|---|
| **3-4-50 Percent** | Percent of deaths due to the four chronic diseases (cancer, heart disease and stroke, type 2 diabetes, and pulmonary diseases such as asthma). |
| **ADRD Death Rate** | Alzheimer's Disease and Related Dementias (ADRD) death rate per 100,000 population. |
| **Childhood Lead in Schools** | The number of cases from the San Diego Childhood Lead Poisoning Prevention Program. |
| **High School Education** | Overall Graduation Rate: The percentage of those over the age of 25 with a high school diploma or equivalent. |
| **HIV Disease Diagnosis Estimates** | HIV disease diagnosis case counts and percentages. |
| **Income Inequality** | Number of Total Earned Income Tax Credits. |
| **Infant Mortality Rate** | Three-year average Infant Mortality Rate per 1,000 live births. |
| **Poverty** | Percent of the population below poverty level. |
| **Unemployment Rate** | Percent of the total labor force that is unemployed (actively seeking employment and willing to work). |
| **Voting** | Percent of the population who voted in a Federal/State/Local election in the last 12 months. |

## Goal

A goal is an aspiration or broad statement of what the Leadership Team wants to achieve in the longer term (more than three years).

## *Live Well San Diego* Component

There are three major components to *Live Well San Diego*. Each Priority and Goal is aligned to one of these components—Building Better Health, Living Safely, and Thriving. The CEP goals show alignment to the *Live Well San Diego* components by including the respective icon and color (see below).

| | | |
|---|---|---|
| **Building Better Health** | **Living Safely** | **Thriving** |

# APPENDIX I—KEY TO THE COMMUNITY ENRICHMENT PLAN

## Strategic Approach

The *Live Well San Diego* vision is achieved through four strategies, referred to as Strategic Approaches. These are *Building a Better Service Delivery System*, *Supporting Positive Choices*, *Pursuing Policy and Environmental Changes*, and *Improving the Culture from Within*. These Strategic Approaches are used as the strategies for the CEPs, which are how the Leadership Team will go about achieving the goal. The icons and definitions for the Strategic Approaches are listed below.

| *Live Well San Diego* Strategic Approaches | | | |
|---|---|---|---|
| **Building a Better Service Delivery System** | **Supporting Positive Choices** | **Pursuing Policy and Environmental Changes** | **Improving the Culture from Within** |
|  |  |  |  |
| Improving the quality and efficiency of County government and its partners in the delivery of services to residents, contributing to better outcomes for clients and results for communities. | Providing information and resources to inspire County residents to take action and responsibility for their health, safety, and well-being. | Creating environments and adopting policies that make it easier for everyone to live well, and encouraging individuals to get involved in improving their communities. | Increasing understanding among County employees and providers about what it means to live well and the role that all employees play in helping residents live well. |

## Improvement Objective

The Improvement Objective is the change or improvement that the Leadership Team seeks or hopes to accomplish in the shorter term (one to three years). The Improvement Objective reflects actions that the Leadership Team has decided to take and is supported by the research, evidence, or best practice to contribute to advancement of the goal and ultimately community change. For each Improvement Objective, the Strategic Approach is indicated with the corresponding icon in the CEP to indicate alignment.

## Metric

The metric indicates the target and how progress will be measured for each improvement objective.

# APPENDIX II— LIST OF *LIVE WELL SAN DIEGO* NORTH COUNTY COMMUNITY LEADERSHIP TEAM MEMBERS

## NORTH COUNTY REGIONS COMMUNITY LEADERSHIP TEAM MEMBERS

**CO-CHAIRS:**

Chuck Matthews, Ph.D., M.S.W., M.B.A., Director, North Coastal and North Inland Regions, HHSA
Don Stump, Executive Director, North County Lifeline
Greg Anglea, Chief Executive Officer, Interfaith Community Services

**Members:** The current *Live Well San Diego* North County Community Leadership Team consists of the agencies and organizations listed below. Some members regularly attend meetings whereas other valued partners are contributing in other meaningful ways to the development and implementation of the CEP. **Some members are also *Live Well San Diego* Recognized Partners which is indicated with an asterisk (*).**

**NORTH COUNTY COMMUNITY LEADERSHIP TEAM MEMBERS BY SECTOR**

| Cities & Governments | Business & Media | Community & Faith-Based | Schools & Education |
|---|---|---|---|
| City of Carlsbad* | Altman Plants* | 1to1 Movement* | Bastyr University California* |
| City of Del Mar* | Cafe Merlot* | Academy of Integrative Health and Medicine* | Bella Mente Montessori Academy* |
| City of Encinitas* | Cardiff 101 Main Street Association* | Adapt Functional Movement Center | Bonsall Unified School District* |
| City of Escondido* | Daily Harvest Express* | African American Association of County Employees* | Borrego Springs Unified School District* |
| City of Oceanside* | Dirty Dogs* | Agua Hedionda Lagoon Foundation* | California State University, San Marcos* |
| City of San Marcos* | Encinitas 101 Main Street Association* | All Star Vets* | Cardiff School District* |
| City of Solana Beach* | Encinitas Chamber of Commerce* | Borrego Community Health Foundation* | Carlsbad Unified School District* |
| | Fallbrook Chamber of Commerce* | California Center for the Arts Escondido* | Del Mar Union School District* |
| | Fashion Week San Diego* | California Indian Legal Services* | Encinitas Union School District* |
| | Fidelity Security Solutions, LLC* | Casa De Amparo* | Escondido Union High School District* |
| | homePERQs* | Center for Community Solutions* | Escondido Union School District* |
| | Heritage Senior Care | Center for World Music* | Fallbrook Union Elementary School District* |
| | Leucadia 101 Main Street Association* | Community Alliance for Healthy Minds* | Julian Union Elementary School District* |
| | Lifestyles INFOCUS* | Community Housing Works* | Julian Union High School District* |
| | North San Diego Business Chamber* | Community Resource Center* | MiraCosta Community College District* |
| | Oceanside Chamber of Commerce* | Encinitas Community Garden* | |
| | Palomar Health* | Escondido Community Child Development Center* | |
| | Rock Steady Boxing San Diego* | Escondido Education COMPACT* | |
| | San Diego Gas & Electric* | | |

# APPENDIX II— LIST OF *LIVE WELL SAN DIEGO* NORTH COUNTY COMMUNITY LEADERSHIP TEAM MEMBERS

| Cities & Governments | Business & Media | Community & Faith-Based | Schools & Education |
|---|---|---|---|
| | San Marcos Chamber of Commerce*<br>The Patio Playhouse*<br>The Super Dentists<br>Vista Chamber of Commerce* | FAB (Fashion Art Business) Authority*<br>Facilitating Access to Coordinated Transportation, Inc.*<br>Fallbrook Healthcare District*<br>Fallbrook Land Conservancy*<br>Fallbrook Wellness Directory*<br>Financial Coach 4 U*<br>Green Oak Ranch*<br>Halau Hula O Ka'eo*<br>HealthRIGHT 360*<br>Healthy Day Partners*<br>Hope through Housing Foundation*<br>Integral Communities*<br>Interfaith Community Services*<br>Junior Achievement of San Diego County*<br>Lake San Marcos Community Association*<br>Lean and Green Kids*<br>Leap to Success*<br>Live Well San Diego Lions Club*<br>Lux Art Institute*<br>MAAC*<br>Move Your Feet Before You Eat Foundation*<br>Neighborhood Healthcare*<br>North County African American Women's Association*<br>North County Community Action Network*<br>North County Eco Alliance*<br>North County Health Services*<br>North County LGBTQ Resource Center*<br>North County Lifeline*<br>North County Philanthropy Council*<br>Poway OnStage*<br>ProduceGood*<br>Puppy Prodigies*<br>Ramona HEART Mural Project*<br>Ramona Valley Vineyard Association* | Oceanside Unified School District*<br>Ramona Unified School District*<br>San Dieguito Union High School District*<br>San Marcos Unified School District*<br>San Pasqual Union School District*<br>Solana Beach School District*<br>Spencer Valley Elementary School District*<br>The Classical Academies*<br>The League Of Amazing Programmers*<br>Vallecitos School District*<br>Vista Unified School District*<br>Warner Unified School District* |

# APPENDIX II— LIST OF *LIVE WELL SAN DIEGO* NORTH COUNTY COMMUNITY LEADERSHIP TEAM MEMBERS

| Cities & Governments | Business & Media | Community & Faith-Based | Schools & Education |
|---|---|---|---|
| | | Rancho Bernardo Community Council*<br>Rancho Bernardo High School Foundation/Broncos Baseball*<br>Rancho Bernardo High School Friends of the Library*<br>San Diego Children's Discovery Museum*<br>San Diego County Farm Bureau*<br>San Dieguito River Park Joint Powers Authority*<br>Solana Center for Environmental Innovation*<br>Straight from the Heart, Inc.*<br>Surfing Madonna Oceans Project*<br>Sustainable Surplus Exchange*<br>TERI Inc. (Campus of Life)*<br>The Continuing Education Center of Rancho Bernardo*<br>The Elizabeth Hospice*<br>The Escondido Creek Conservancy*<br>The Fellowship Center*<br>The Shine Project Foundation*<br>Traveling Stories*<br>VETality Corp*<br>Vista Community Clinic*<br>TransFamily Support Services | |

## Other Valued Partners

Alliance for Regional Solutions
Caster Family Center, University of San Diego
Fallbrook Family Health Center/Community Health Systems Inc.
North Inland Community Prevention Program
North County Gang Commission
Safe Families for Children
San Diego Department of Child Support Services
San Diego County Sheriff's Department
San Dieguito Alliance for Drug Free Youth
San Marcos Prevention Coalition
Tri-City Wellness & Fitness Center
U.S. Census Bureau

# APPENDIX III—INDICATORS

## TOP 10 *LIVE WELL SAN DIEGO* INDICATORS DASHBOARD ALIGNED TO *LWSD* AREAS OF INFLUENCE

*Live Well San Diego* Dashboard
Top 10 Population Outcome Indicators: NORTH COASTAL REGION

| | Indicator | We want to increase this / Description / We want to decrease this | | San Diego County | North Coastal Region | Carlsbad | Oceanside | Pendleton | San Dieguito | Vista |
|---|---|---|---|---|---|---|---|---|---|---|
| **HEALTH - Enjoying good health and expecting to live a full life** | | | | | | | | | | |
| HEALTH | **Life Expectancy** | Average number of years a person is expected to live at birth. 2016. | ↑ | 82.1 | 83.3 | 83.7 | 81.9 | N/A | 85.6 | 82.2 |
| | **Quality of Life** | Percent of the population 18 and older, not residing in nursing homes or other institutions, that is sufficiently healthy to be able to live independently. 2017. | ↑ | 94.9% | 95.5% | 95.6% | 94.3% | 99.2% | 96.2% | 96.2% |
| **KNOWLEDGE - Learning throughout the lifespan** | | | | | | | | | | |
| KNOWLEDGE | **Education: High School Diploma or Equivalent** | Overall Graduation Rate: the percentage of those over the age of 25 with a high school diploma or equivalent. 2017. | ↑ | 86.1% | 88.3% | 94.8% | 84.6% | 98.7% | 95.8% | 79.5% |
| **STANDARD OF LIVING - Having enough resources for a quality life** | | | | | | | | | | |
| STANDARD OF LIVING | **Unemployment Rate** | Percent of the population that is unemployed. 2018. | ↓ | 3.9% | 3.5% | 3.6% | 3.8% | 9.7% | 3.2% | 2.8% |
| | **Income: Percent of population spending less than 1/3 of income on housing** | Percent of the population spending less that 1/3 of their income on housing. 2016. | ↑ | 52.9% | 53.2% | 58.1% | 50.0% | 16.7% | 59.5% | 48.6% |
| **COMMUNITY - Living in a clean and safe neighborhood** | | | | | | | | | | |
| COMMUNITY | **Security: Overall Crime Rate** | Overall Crime rate per 100,000 population. 2017. | ↓ | 2032.6 | N/A | N/A | N/A | N/A | N/A | N/A |
| | **Physical Environment: Air Quality** | Percent of days rated unhealthy for vulnerable populations. 2018. | ↓ | 6.1% | N/A | N/A | N/A | N/A | N/A | N/A |
| | **Built Environment: Percent of population living within 1/4th a mile of a park or community space** | Percentage of population that resides within a quarter mile of a park or community space. 2018. | ↑ | 61.3% | 50.8% | 40.9% | 60.1% | 15.7% | 55.0% | 49.3% |
| **SOCIAL - Helping each other to live well** | | | | | | | | | | |
| SOCIAL | **Vulnerable Populations: Food Insecurity** | Percent of adult population 200% below FPL not able to afford food. 2017. *Indicates statistically unstable estimates. Proceed with caution. | ↓ | 37.6% | 35.5% | N/A | N/A | N/A | N/A | N/A |
| | **Community Involvement: Volunteerism** | Percent of residents who volunteer. 2017. | ↑ | 25.5% | N/A | N/A | N/A | N/A | N/A | N/A |

On the right track  Not on track  No change

To view more information about the *Live Well San Diego* Indicators and how we will measure progress go to: http://www.sdcounty.ca.gov/hhsa/programs/sd/live_well_san_diego/indicators.html

# APPENDIX III—INDICATORS

## *Live Well San Diego* Dashboard
## Top 10 Population Outcome Indicators: NORTH INLAND REGION

| | Indicator | Description | We want to increase this / We want to decrease this | San Diego County | North Inland Region | Anza-Borrego Springs | Escondido | Fallbrook | North San Diego | Palomar-Julian | Pauma | Poway | Ramona | San Marcos | Valley Center |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **HEALTH - Enjoying good health and expecting to live a full life** | | | | | | | | | | | | | | | |
| HEALTH | Life Expectancy | Average number of years a person is expected to live at birth. 2016. | ↑ | 82.1 | 82.7 | N/A | 81.0 | 81.5 | 85.2 | N/A | 73.4 | 83.5 | 82.8 | 82.4 | 82.5 |
| | Quality of Life | Percent of the population 18 and older, not residing in nursing homes or other institutions, that is sufficiently healthy to be able to live independently. 2017. | ↑ | 94.9% | 95.1% | 89.6% | 94.6% | 94.1% | 96.1% | 92.7% | 95.6% | 95.8% | 96.0% | 94.6% | 95.5% |
| **KNOWLEDGE - Learning throughout the lifespan** | | | | | | | | | | | | | | | |
| KNOWLEDGE | Education: High School Diploma or Equivalent | Overall Graduation Rate: the percentage of those over the age of 25 with a high school diploma or equivalent. 2017. | ↑ | 86.1% | 86.0% | 88.7% | 77.6% | 83.0% | 96.5% | 88.9% | 81.5% | 94.3% | 87.5% | 80.9% | 88.5% |
| **STANDARD OF LIVING - Having enough resources for a quality life** | | | | | | | | | | | | | | | |
| STANDARD OF LIVING | Unemployment Rate | Percent of the population that is unemployed. 2018. | ↓ | 3.9% | 3.2% | 8.3% | 3.6% | 3.9% | 2.4% | 5.4% | 4.9% | 2.8% | 3.8% | 3.2% | 3.1% |
| | Income: Percent of population spending less than 1/3 of income on housing | Percent of the population spending less that 1/3 of their income on housing. 2016. | ↑ | 52.9% | 54.2% | 48.1% | 48.1% | 51.6% | 61.4% | 52.4% | 51.3% | 63.4% | 55.7% | 48.9% | 52.6% |
| **COMMUNITY - Living in a clean and safe neighborhood** | | | | | | | | | | | | | | | |
| COMMUNITY | Security: Overall Crime Rate | Overall Crime rate per 100,000 population. 2017. | ↓ | 2032.6 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| | Physical Environment: Air Quality | Percent of days rated unhealthy for vulnerable populations. 2018. | ↓ | 6.1% | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| | Built Environment: Percent of population living within 1/4th a mile of a park or community space | Percentage of population that resides within a quarter mile of a park or community space. 2018. | ↑ | 61.3% | 41.5% | 4.3% | 49.9% | 27.5% | 47.5% | 7.3% | 21.2% | 41.8% | 25.6% | 47.4% | 7.1% |
| **SOCIAL - Helping each other to live well** | | | | | | | | | | | | | | | |
| SOCIAL | Vulnerable Populations: Food Insecurity | Percent of adult population 200% belowFPL not able to afford food. 2017. *Indicates statistically unstable estimates. Proceed with caution. | ↓ | 37.6% | 38.3% | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| | Community Involvement: Volunteerism | Percent of residents who volunteer. 2017. | ↑ | 25.5% | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |

On the right track  Not on track  No change

To view more information about the *Live Well San Diego* Indicators and how we will measure progress go to: http://www.sdcounty.ca.gov/hhsa/programs/sd/live_well_san_diego/indicators.html

## PUBLIC HEALTH SERVICES INDICATORS DASHBOARD

### San Diego County Public Health Services Dashboard
### Top 10 Population Outcome Indicators: NORTH COASTAL REGION

LIVE WELL SAN DIEGO

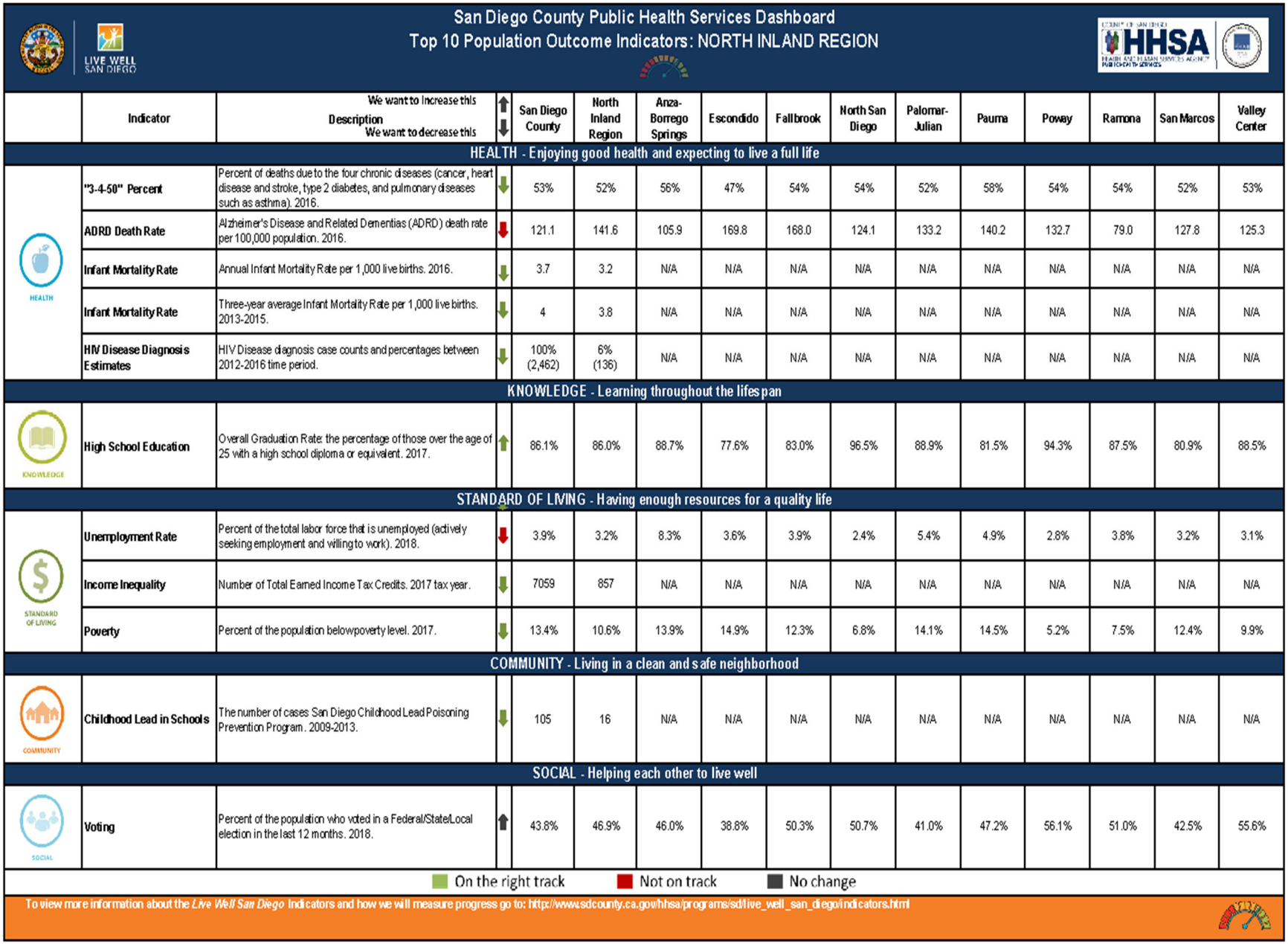
COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY PUBLIC HEALTH SERVICES

| | Indicator | Description | We want to increase this / We want to decrease this | San Diego County | North Coastal Region | Carlsbad | Oceanside | Pendleton | San Dieguito | Vista |
|---|---|---|---|---|---|---|---|---|---|---|
| **HEALTH - Enjoying good health and expecting to live a full life** | | | | | | | | | | |
| HEALTH | "3-4-50" Percent | Percent of deaths due to the four chronic diseases (cancer, heart disease and stroke, type 2 diabetes, and pulmonary diseases such as asthma). 2016. | ↓ | 53% | 52% | 52% | 55% | N/A | 47% | 54% |
| | ADRD Death Rate | Alzheimer's Disease and Related Dementias (ADRD) death rate per 100,000 population. 2016. | ↓ | 121.1 | 126.6 | 150.7 | 117.0 | N/A | 163.3 | 126.7 |
| | Infant Mortality Rate | Annual Infant Mortality Rate per 1,000 live births. 2016. | ↓ | 3.7 | 3.4 | N/A | N/A | N/A | N/A | N/A |
| | Infant Mortality Rate | Three-year average Infant Mortality Rate per 1,000 live births. 2013-2015. | ↓ | 4 | 3.5 | N/A | N/A | N/A | N/A | N/A |
| | HIV Disease Diagnosis Estimates | HIV Disease diagnosis case counts and percentages between 2012-2016 time period. | ↓ | 100% (2,462) | 8% (198) | N/A | N/A | N/A | N/A | N/A |
| **KNOWLEDGE - Learning throughout the lifespan** | | | | | | | | | | |
| KNOWLEDGE | High School Education | Overall Graduation Rate: the percentage of those over the age of 25 with a high school diploma or equivalent. 2017. | ↑ | 86.1% | 88.3% | 94.8% | 84.6% | 98.7% | 95.8% | 79.5% |
| **STANDARD OF LIVING - Having enough resources for a quality life** | | | | | | | | | | |
| STANDARD OF LIVING | Unemployment Rate | Percent of the total labor force that is unemployed (actively seeking employment and willing to work). 2018. | ↓ | 3.9% | 3.5% | 3.6% | 3.8% | 9.7% | 3.2% | 2.8% |
| | Income Inequality | Number of Total Earned Income Tax Credits. 2017 tax year. | ↓ | 7059 | 738 | N/A | N/A | N/A | N/A | N/A |
| | Poverty | Percent of the population below poverty level. 2017. | ↓ | 13.4% | 10.7% | 7.7% | 13.3% | 8.8% | 7.1% | 13.6% |
| **COMMUNITY - Living in a clean and safe neighborhood** | | | | | | | | | | |
| COMMUNITY | Childhood Lead in Schools | The number of cases San Diego Childhood Lead Poisoning Prevention Program. 2009-2013. | ↓ | 105 | 20 | N/A | N/A | N/A | N/A | N/A |
| **SOCIAL - Helping each other to live well** | | | | | | | | | | |
| SOCIAL | Voting | Percent of the population who voted in a Federal/State/Local election in the last 12 months. 2018. | ↑ | 43.8% | 46.1% | 53.6% | 42.0% | 37.7% | 55.9% | 37.9% |

On the right track  Not on track  No change

To view more information about the *Live Well San Diego* Indicators and how we will measure progress go to: http://www.sdcounty.ca.gov/hhsa/programs/sd/live_well_san_diego/indicators.html

# APPENDIX III—INDICATORS



San Diego County Public Health Services Dashboard
Top 10 Population Outcome Indicators: NORTH INLAND REGION

LIVE WELL SAN DIEGO

HHSA

| | Indicator | Description | We want to Increase this / We want to decrease this | San Diego County | North Inland Region | Anza-Borrego Springs | Escondido | Fallbrook | North San Diego | Palomar-Julian | Pauma | Poway | Ramona | San Marcos | Valley Center |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **HEALTH - Enjoying good health and expecting to live a full life** | | | | | | | | | | | | | | | |
| HEALTH | "3-4-50" Percent | Percent of deaths due to the four chronic diseases (cancer, heart disease and stroke, type 2 diabetes, and pulmonary diseases such as asthma). 2016. | ↓ | 53% | 52% | 56% | 47% | 54% | 54% | 52% | 58% | 54% | 54% | 52% | 53% |
| | ADRD Death Rate | Alzheimer's Disease and Related Dementias (ADRD) death rate per 100,000 population. 2016. | ↓ | 121.1 | 141.6 | 105.9 | 169.8 | 168.0 | 124.1 | 133.2 | 140.2 | 132.7 | 79.0 | 127.8 | 125.3 |
| | Infant Mortality Rate | Annual Infant Mortality Rate per 1,000 live births. 2016. | ↓ | 3.7 | 3.2 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| | Infant Mortality Rate | Three-year average Infant Mortality Rate per 1,000 live births. 2013-2015. | ↓ | 4 | 3.8 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| | HIV Disease Diagnosis Estimates | HIV Disease diagnosis case counts and percentages between 2012-2016 time period. | ↓ | 100% (2,462) | 6% (136) | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| **KNOWLEDGE - Learning throughout the lifespan** | | | | | | | | | | | | | | | |
| KNOWLEDGE | High School Education | Overall Graduation Rate: the percentage of those over the age of 25 with a high school diploma or equivalent. 2017. | ↑ | 86.1% | 86.0% | 88.7% | 77.6% | 83.0% | 96.5% | 88.9% | 81.5% | 94.3% | 87.5% | 80.9% | 88.5% |
| **STANDARD OF LIVING - Having enough resources for a quality life** | | | | | | | | | | | | | | | |
| STANDARD OF LIVING | Unemployment Rate | Percent of the total labor force that is unemployed (actively seeking employment and willing to work). 2018. | ↓ | 3.9% | 3.2% | 8.3% | 3.6% | 3.9% | 2.4% | 5.4% | 4.9% | 2.8% | 3.8% | 3.2% | 3.1% |
| | Income Inequality | Number of Total Earned Income Tax Credits. 2017 tax year. | ↓ | 7059 | 857 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| | Poverty | Percent of the population belowpoverty level. 2017. | ↓ | 13.4% | 10.6% | 13.9% | 14.9% | 12.3% | 6.8% | 14.1% | 14.5% | 5.2% | 7.5% | 12.4% | 9.9% |
| **COMMUNITY - Living in a clean and safe neighborhood** | | | | | | | | | | | | | | | |
| COMMUNITY | Childhood Lead in Schools | The number of cases San Diego Childhood Lead Poisoning Prevention Program. 2009-2013. | ↓ | 105 | 16 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| **SOCIAL - Helping each other to live well** | | | | | | | | | | | | | | | |
| SOCIAL | Voting | Percent of the population who voted in a Federal/State/Local election in the last 12 months. 2018. | ↑ | 43.8% | 46.9% | 46.0% | 38.8% | 50.3% | 50.7% | 41.0% | 47.2% | 56.1% | 51.0% | 42.5% | 55.6% |

On the right track  Not on track  No change

To view more information about the *Live Well San Diego* Indicators and how we will measure progress go to: http://www.sdcounty.ca.gov/hhsa/programs/sd/live_well_san_diego/indicators.html

# APPENDIX IV - BASIS FOR ACTION

The Basis for Action tells the story of why a priority is important and why the North County Community Leadership Team (NCCLT) has chosen certain improvement objectives for its CEP. This information helps to show how the NCCLT is being responsive to the unique needs of their regions and is adopting scalable, evidence-informed improvement objectives. However, this Basis for Action is a simplistic way of capturing the rationale for action and does not tell the whole story. A lot of factors and information influence the final CEP, including the varying experiences and perspectives of those who serve on a Leadership Team, events or crises that occur within or that impact communities within the Region, among many other factors. The Basis for Action serves to distill some of the data, research, and evidence that supports the plan of action reflected in the CEP.

This information is organized by the Priorities of the CEP. This is what appears:

- "What the Numbers Say" captures a few data points that reflect the conditions in North County Regions that helped persuade the NCCLT to make this a priority.
- "What the Research Says about this Priority Concern" captures research that explains how this priority concern impacts health and well-being.
- "What Interventions Work According to the Research" identifies those practices that work based on the research. These interventions fall along a continuum in terms of the degree to which their effectiveness has been demonstrated—from promising practice to evidence-informed to evidence-based.
- "How are Regional Goals and Improvement Objectives Consistent with these Interventions " describes how what the NCCLT is planning to do is consistent with the interventions that have been shown to work.

Why is it important to include the Basis for Action? The literature on collective impact explain that it is important that every partner do what they do best while being committed to the mutually-reinforcing vision for collaborative community change, which is the *Live Well San Diego* vision in this case. Community Leadership Teams are in a unique position to leverage the activities and efforts of others throughout the Region. Choosing strategies and improvement objectives that are evidence-informed is the best way to influence long-term population outcomes. The collective impact approach also calls for partners to identify not only what they can do best, but also at the scale to which they can be successful.

*Footnotes are used to identify the source of the data. For "What the Numbers Say," footnotes appear in alphabetical order at the end of the appendix. All other footnotes to the research that follows appear in numerical order and immediately below each Priority section.*

| Priority | Alignment with *Live Well San Diego* Component | AREAS OF INFLUENCE<br>Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | AREAS OF INFLUENCE<br>Public Health Services Indicator |
|---|---|---|---|
| **Behavioral & Mental Health Services** | **Building Better Health** | **HEALTH**<br>**Life Expectancy**<br>**Quality of Life**<br>• **None Applicable**<br>• *Population with Suicidal Ideation* | **HEALTH**<br>• **3-4-50 Deaths** |

| | |
|---|---|
| What the Numbers Say | **1 in 10** North Inland and North Coastal residents have seriously thought about committing suicide. [A] |
| What the Research Says about this Priority Concern<br>**how health and well-being is affected* | Mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery.[1] Adverse Childhood Experiences (ACEs) refers to childhood experiences that have a tremendous impact on future violence victimization and perpetration, and lifelong health and opportunity. ACEs are linked to risky health behaviors, chronic disease and health conditions, mental and behavioral health issues, and early death.[2] |
| What Interventions Work According to the Research<br>* *practices that work based on the research* | Research supports these types of interventions:<br>• Provide school-based preventative interventions aimed at improving social and emotional outcomes.[1]<br>• Use interventions targeting families dealing with adversities to increase effective parenting and reduce risk for depression among children.[1]<br>• Educate and increase awareness among residents and community partners of the impact of trauma and strategies for resilience.[2]<br>• Implement trauma-informed care or practice, especially in those occupations and settings that serve individuals who are more likely to have experienced toxic stress, such as social work, medicine, education, and public agencies.[2] |
| How are Regional Goals and Improvement Objectives Consistent with these Interventions<br>**consistency between what the Leadership Team is planning to do and the interventions that have been shown to work* | The North County Regions are addressing a wide range of mental and behavioral health issues in their community. Educating residents about mental health through Check Your Mood screenings is a strategy used to reduce stigma and help residents obtain the care they need. Addressing mental health through school-based programming is being implemented through the Here Now program, an intervention regarding mental health and suicide. Adverse Childhood Experiences, or ACEs, have been shown to be common for many. The North County regions are screening the resiliency film to raise awareness of ACEs, the health impacts they cause, and to spark discussion in the community about how to prevent these adverse events. |

1. https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders

2 https://developingchild.harvard.edu/resources/aces-and-toxic-stress-frequently-asked-questions/

| **Priority** | **Alignment with *Live Well San Diego* Component** | **AREAS OF INFLUENCE**<br>**Top 10 *Live Well San Diego* Indicator**<br>• **Expanded Indicator**<br>• *Supporting Indicator* | **AREAS OF INFLUENCE**<br>**Public Health Services Indicator** |
|---|---|---|---|
| **Nutrition** | **Building Better Health** | **HEALTH**<br>**Life Expectancy**<br>**Quality of Life**<br>• **None Applicable**<br>• *Household Fresh Vegetable Use*<br>**SOCIAL**<br>**Food Insecurity**<br>• **None Applicable** | **HEALTH**<br>• **3-4-50 Deaths** |

| | |
|---|---|
| What the Numbers Say | **1 in 10** North Inland and North Coastal households did not use fresh fruit or vegetables in the last 6 months.[B] |
| What the Research Says about this Priority Concern<br>**how health and well-being is affected* | Previous studies suggest that children living in food-insecure households face elevated risks of many problematic health and development outcomes, including chronic conditions, compared with children in otherwise similar food-secure households.[1,2,3] Food security is especially important for children because their nutrition affects not only their current health, but also their physical, mental, and social development, and thereby their future health and well-being.[3] Programs such as the Special Supplemental Nutrition Program for Woman, Infants, and Children (WIC), in which federal grants go to states for food and nutrition education for low-income pregnant and post-partum women, infants and young children, have been shown to have positive effects on food insecurity.[4] |
| What Interventions Work According to the Research<br>* *practices that work based on the research* | Research supports these types of interventions:<br>• Partner with food banks, advocacy organizations and affiliated community organizations to raise awareness of the importance of healthy eating.[4]<br>• Use effective workplace programs and policies such as making healthy foods available and accessible through vending machines or cafeterias.[5]<br>• Improve access to programs such as the Special Supplemental Nutrition Program for Woman, Infants, and Children (WIC) to secure food and nutrition education for low-income pregnant and post-partum women, infants and young children.[4]<br>• Increase enrollment in Supplemental Nutrition Assistance Program (CalFresh) to provide monthly food benefits to individuals and families with low-income and provide economic benefits to communities.[6] |

| Priority | Alignment with *Live Well San Diego* Component | AREAS OF INFLUENCE<br>Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | AREAS OF INFLUENCE<br>Public Health Services Indicator |
|---|---|---|---|
| **Nutrition** | **Building Better Health**  | **HEALTH**<br>**Life Expectancy**<br>**Quality of Life**<br>• **None Applicable**<br>• *Household Fresh Vegetable Use*<br>**SOCIAL**<br>**Food Insecurity**<br>• **None Applicable** | **HEALTH**<br>• **3-4-50 Deaths** |
| How are Regional Goals and Improvement Objectives Consistent with these Interventions<br>**consistency between what the Leadership Team is planning to do and the interventions that have been shown to work* | The North County Regions are focusing on improving nutrition in several ways. The first is emphasizing outreach to residents that may be eligible for federal nutrition programs such as WIC and CalFresh, but who are not enrolled in them. The regions are also working to improve healthy eating through intergenerational interventions that promote healthy eating for all ages and leverage current relationships with existing food banks and affiliated community organizations. In addition to addressing nutrition in low-income residents and families, the North County Regions are working to support worksite wellness and to implement programs that improve healthy options in the workplace. | | |

1. Chilton, Mariana, Maureen M. Black, Carol Berkowitz, Patrick H. Casey, John Cook, Ruth Rose Jacobs, Alan Meyers, Deborah A. Frank, Diana Cutts, Timothy Heeren, Stephanie Ettinger de Cuba, and Sharon Coleman. 2009. "Food insecurity and risk of poor health among US-born children of immigrants," American Journal of Public Health 99(3): 556-62.

2. Hernandez, Daphne C., and Alison Jacknowitz. 2009. "Transient, but not persistent, adult food insecurity influences toddler development," The Journal of Nutrition139(8): 1517-24.

3. Kirkpatrick, Sharon I., Lynn McIntyre , and Melissa L. Potestio. 2010. "Child hunger and long-term adverse consequences for health," Archives of Pediatrics and Adolescent Medicine 164(8): 754-62.

4. http://www.cdss.ca.gov/inforesources/calfresh

5. https://www.cdc.gov/workplacehealthpromotion/model/index.html

6. https://www.cbpp.org/sites/default/files/atoms/files/2-9-15PolicyBasics-WIC.pdf

| Priority | Alignment with *Live Well San Diego* Component | AREAS OF INFLUENCE<br>Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | AREAS OF INFLUENCE<br>Public Health Services Indicator |
|---|---|---|---|
| **Physical Activity** | **Building Better Health**  | **HEALTH**<br>**Life Expectancy**<br>**Quality of Life**<br>• **None Applicable**<br>• *Seniors Walking for Transportation, Fun, or Exercise* | **HEALTH**<br>• **3-4-50 Deaths** |

| | |
|---|---|
| What the Numbers Say | Only **2 out of 5** North Inland and North Coastal Residents aged 65 years and over reported walking regularly for transportation, fun, or exercise.[A] |
| What the Research Says about this Priority Concern<br>**how health and well-being is affected* | Physical activity is important for people of all ages, and can help reduce and prevent chronic diseases, improve mood, and improve balance and joint mobility for the elderly.[1] Access to parks or a community space can influence choices to engage in physical activity and community involvement. Using parks and recreation services has been shown to have positive health impacts, including the physical, social, and mental aspects of health.[2] |
| What Interventions Work According to the Research<br>* *practices that work based on the research* | Research supports these types of interventions:<br>• Promote principles from the Safe Routes to Schools (SRTS) program to increase the number of students walking or biking to school through improvements to pedestrian or bicycle transportation systems and environmental design interventions. SRTS is a suggested strategy to increase physical activity among students.[3]<br>• Promote policies to provide for the safe and convenient travel of all users of the roadway, including pedestrians, bicyclists, public transit users, motorists, children, seniors, and people with disabilities.[1]<br>• Implement intergenerational communities to increase social connectedness, social cohesion, and civic participation. Intergenerational communities promote interaction and cooperation between individuals of different ages and focus on the needs of all residents, especially children and older adults.[4] |
| How are Regional Goals and Improvement Objectives Consistent with these Interventions<br>**consistency between what the Leadership Team is planning to do and the interventions that have been shown to work* | Physical activity is important for all ages, and the North County Regions are working to increase physical activity among residents throughout their lifespan. Safe Routes to Schools are being implemented to increase the number of schools that support Walk to School Day. When children, teens and parents walk or bike to school or work, they get more physical activity compared to those who drive or are driven. The regions are also implementing intergenerational games that promote physical activity and social interaction between participants of all ages. These games contribute to both the physical and mental well-being of seniors, children, and all ages in between. |

1. https://www.cdc.gov/physicalactivity/about-physical-activity/why-it-matters.html
2. https://results.livewellsd.org/en/stat/goals/single/d2gt-yvbi
3. http://www.Countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/safe-routes-to-schools
4. http://www.Countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/intergenerationalcommunities

| **Priority** | **Alignment with *Live Well San Diego* Component** | **AREAS OF INFLUENCE**<br>**Top 10 *Live Well San Diego* Indicator**<br>• **Expanded Indicator**<br>• *Supporting Indicator* | **AREAS OF INFLUENCE**<br>**Public Health Services Indicator** |
|---|---|---|---|
| **Illegal Access to Substances and Alcohol** | **Living Safely**  | **COMMUNITY**<br>  **Crime Rate**<br>• **None Applicable**<br>• *Rate of ED Discharges for Opioid Disorders* | • **None Applicable** |

| | |
|---|---|
| What the Numbers Say | The rates of Emergency Room Discharges for an opioid disorder were **171.0 per 100,000** in North Inland Region and **145.2 per 100,000** in North Coastal Region in 2016.[C] |
| What the Research Says about this Priority Concern<br>**how health and well-being is affected* | Studies have shown that residential supplies of pharmaceutical controlled substances—those found in our home medicine cabinets—have become the supply of choice for young people and criminals. Some of these pharmaceutical controlled substances, which can be highly addictive, are opioids. Many abusers, a high percentage of which are teens, are known to have obtained their controlled substances from the homes of family and friends. In addition, research has shown that our environment has been threatened by medications being flushed down toilets. Most controlled substances are created synthetically and are not removed through normal water-treatment processes. This can result in the discharge of these substances into the environment and into our ground water supplies.[1] |
| What Interventions Work According to the Research<br>* *practices that work based on the research* | Research supports these types of interventions:<br>Implementing drug disposal programs has been shown to reduce illicit drug use, unintentional poisoning, and to reduce pharmaceutical contamination of water.[2] |
| How are Regional Goals and Improvement Objectives Consistent with these Interventions<br>**consistency between what the Leadership Team is planning to do and the interventions that have been shown to work* | Addressing the nationwide opioid epidemic at a local level is an important step to lowering opioid use in the North County Regions. The regions are working to educate the community on the importance of properly disposing prescription drugs and providing drop-off sites where residents can safely turn in medications that could otherwise be abused. |

1. https://www.sdsheriff.net/prescription-drugs/dropbox.html

2. http://www.Countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/proper-drug-disposal-programs

| Priority | Alignment with *Live Well San Diego* Component | AREAS OF INFLUENCE<br>Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | AREAS OF INFLUENCE<br>Public Health Services Indicator |
|---|---|---|---|
| **Crime** | **Living Safely**  | **COMMUNITY**<br>**Crime Rate**<br>• **None Applicable** | • **None Applicable** |
| What the Numbers Say | • Between 2014 and 2018, crime increased **18%** in Carlsbad.<br>• Between 2017 and 2018, crime increased **6%** in Escondido.[D] | | |
| What the Research Says about this Priority Concern<br>**how health and well-being is affected* | Exposure to crime and violence has been shown to increase stress, which may:[1,2]<br>• Worsen hypertension and other stress-related disorders;<br>• Contribute to the increased prevalence of certain illnesses, such as upper respiratory illness and asthma, in neighborhoods with high levels of violence, and;<br>• Lead people to engage in unhealthy behaviors such as smoking to reduce or cope with stress.<br>• North County Regions have had many issues with gangs in the last decade, especially along Highway 78, also called the "78 Corridor." The gangs included juveniles and adults. Females were also among the gang members. School districts with poorer academic performance were more likely to have gang activity according to staff reports.[3] | | |
| What Interventions Work According to the Research<br>** practices that work based on the research* | National research shows that many community-based prevention and intervention strategies can help prevent teens (ages 12-17) from joining a gang. These include:[4]<br>• Engage community groups, individuals, and institutions to respond to the multiple needs of youth and their families through case management for the highest-risk youth and their families. This includes providing an array of services, after-school activities, and community activities to strengthen families.<br>• Provide mentoring services to at-risk and gang youths, counseling, referral services, gang conflict mediation, and anti-gang programs at schools in the community.<br>• Provide social support for disadvantaged and at-risk youth from helping teachers, responsible adults, parents, and peers. | | |
| How are Regional Goals and Improvement Objectives Consistent with these Interventions<br>**consistency between what the Leadership Team is planning to do and the interventions that have been shown to work* | Preventing crime and gang activity can be effectively addressed through community interventions, through schools, mentoring services, and by supporting families. The North County Regions are working to assess the causes of gang activity so they can implement strategies to address issues earlier, before criminal behavior begins. By working with various community partners, this focus at the individual level should help to reduce crime over the longer term. | | |

1. Ellen IG, Mijanovich T, Dillman KN. Neighborhood effects on health: Exploring the links and assessing the evidence. Journal of Urban Affairs. 2001;23:391-408.
2. Johnson SL, Solomon BS, Shields WC, McDonald EM, McKenzie LB, Gielen AC. Neighborhood violence and its association with mothers' health: Assessing the relative importance of perceived safety and exposure to violence. J Urban Health. 2009;86:538-550.
3. https://www.sandag.org/uploads/publicationid/publicationid_1578_12941.pdf
4. https://www.nationalgangcenter.gov/spt/Planning-Implementation/Best-Practices/12

| Priority | Alignment with *Live Well San Diego* Component | AREAS OF INFLUENCE<br>Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | AREAS OF INFLUENCE<br>Public Health Services Indicator |
|---|---|---|---|
| **Unintentional Injuries** | **Living Safely**  | **COMMUNITY**<br>• **None Applicable**<br>• *Fall Injury Hospitalization Rates* | • **None Applicable** |
| What the Numbers Say | Fall injuries accounted for nearly **4 in 5** hospitalizations for unintentional injuries in North Inland and North Coastal Regions.[C] | | |
| What the Research Says about this Priority Concern<br>**how health and well-being is affected* | Unintentional injuries can take many forms. Bicycle trips account for only one percent of all trips in the United States, yet bicyclists face a higher risk of crash-related injury and deaths than occupants in motor vehicles.[1] Distracted driving is driving while doing another activity that takes your attention away from driving. Distracted driving can increase the chance of a motor vehicle crash.[2] Falls are a threat to the health of older adults and can reduce their ability to remain independent. Many falls do not cause injuries. But one out of five falls does cause a serious injury such as a broken bone or head injury. These injuries can make it hard for a person to get around, do everyday activities, or live on their own.[3] | | |
| What Interventions Work According to the Research<br>* *practices that work based on the research* | Research supports these types of interventions:<br>• Educate residents about the importance of wearing bicycle helmets to reduce the risk of head and brain injuries in the event of a crash. All bicyclists, regardless of age, can help protect themselves by wearing properly fitted bicycle helmets every time they ride.[1]<br>• Enact laws—such as banning texting while driving or using graduated driver licensing systems for teen drivers—to help raise awareness about the dangers of distracted driving and to help prevent it from occurring.[2]<br>• Prevent falls through implementing exercises that make your legs stronger and improve your balance.[3]<br>• Encourage everyone to have their vision checked regularly and wear eyeglasses with that are up-to-date with prescription.[3]<br>• Make it safer for seniors by eliminating tripping hazards in their residence by installing grab bars outside the tub or shower, adding railings to both sides of the stairs, and installing brighter light bulbs.[3] | | |
| How are Regional Goals and Improvement Objectives Consistent with these Interventions<br>**consistency between what the Leadership Team is planning to do and the interventions that have been shown to work* | The North County Regions are addressing three main areas of injury that includes those of all ages. For children and adults alike, the regions are promoting safe transportation through Sheriff's Department presentations on helmet safety. The regions are also working to address injuries for all driving-age residents caused by distracted driving through school programming. For those who are elderly in the community, falls are a common risk. The North County Regions are implementing resource sharing events for older adults that educate and provide assistance to prevent fall injuries. | | |

1. https://www.cdc.gov/motorvehiclesafety/bicycle/index.html
2. https://www.cdc.gov/motorvehiclesafety/Distracted_Driving/index.html
3. https://www.cdc.gov/homeandrecreationalsafety/falls/index.html

| Priority | Alignment with *Live Well San Diego* Component | AREAS OF INFLUENCE<br>Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | AREAS OF INFLUENCE<br>Public Health Services Indicator |
|---|---|---|---|
| **Disaster Preparedness** | **Living Safely**  | **COMMUNITY**<br>• **None Applicable**<br>• *Disaster Vulnerable Residents*<br>**SOCIAL**<br>• **None Applicable** | • **None Applicable** |
| What the Numbers Say | • In Escondido alone, the approximate number of residents that would be exposed in the case of an earthquake is **64,489**, and in the case of a wildfire, **134,425**.[E, G]<br>• In Carlsbad, the approximate number of residents that would be exposed in the case of an earthquake is **10,495**, and in the case of a wildfire, **99,892**.[F, G] | | |
| What the Research Says about this Priority Concern<br>**how health and well-being is affected* | Natural disasters cause widespread loss of life and property each year. The North County regions are at risk for a variety of natural disasters. Several communities have a large amount of wildland/urban interface and are at risk for wildfire. Earthquakes have the potential for significant loss of property and life, as well as disruption of services. Hazardous material spills are possible due to major freeways passing through the regions, and flooding from dammed reservoirs or rainfall could occur.[1] Man-made events or terrorism are also a concern due to current geopolitical realities, such as active shooter incidents.[2] | | |
| What Interventions Work According to the Research<br>** practices that work based on the research* | Research supports these types of interventions:<br>• Resources such as posters and pocket guides can raise awareness for things such as indicators of an active shooter incident.[2]<br>For Wildfire Preparedness:[3]<br>• Create a family disaster plan.<br>• Have fire extinguishers on hand.<br>• Plan and practice several different evacuation routes and designate an emergency meeting location.<br>• Assemble an emergency supply kit (water, food, medicine).<br>• Maintain a list of emergency contact numbers. | | |
| How are Regional Goals and Improvement Objectives Consistent with these Interventions<br>**consistency between what the Leadership Team is planning to do and the interventions that have been shown to work* | In the event of a natural or man-made disaster, the North County Regions are working to prepare residents for these unfortunate situations. The regions are working with schools, businesses, and other organizations to educate and promote exercises that will increase the preparedness of residents should an adverse event occur. The regions are engaging local schools to develop disaster plans, and to increase awareness and understanding of how to respond to adverse events. North County Regions are using an expanded disaster curriculum contained in the Tools for Schools Toolkit while working with local school districts. | | |

1. http://www.arcgis.com/apps/webappviewer/index.html?id=1f35f94756bc45f9960717cbd15488a8
2. https://www.dhs.gov/cisa/private-citizen
3. http://www.readysandiego.org/content/dam/oesready/en/Resources/wildfire_preparedness_guide.pdf

# APPENDIX IV - BASIS FOR ACTION

| **Priority** | **Alignment with *Live Well San Diego* Component** | **AREAS OF INFLUENCE**<br>**Top 10 *Live Well San Diego* Indicator**<br>• **Expanded Indicator**<br>• *Supporting Indicator* | **AREAS OF INFLUENCE**<br>**Public Health Services Indicator** |
|---|---|---|---|
| **Transportation** | **Living Safely**<br>  <br>**Thriving**<br>  | **COMMUNITY**<br>• **Physical Environment —Air Quality**<br>  <br>• **Travel Time to Work Over 60 Minutes** | • **None Applicable** |

| | |
|---|---|
| What the Numbers Say | **1 in 12** workers over age 16 in North Inland Region and **1 in 11** workers over age 16 in North Coastal Region travel 60 minutes or more to work.[G] |
| What the Research Says about this Priority Concern<br>**how health and well-being is affected* | There is strong evidence that expanding public transportation systems can have many positive impacts on the well-being of residents and the community at-large. Public transportation systems can increase physical activity, particularly when implemented as part of a multi-component land use approach. Transit users appear to have higher levels of physical activity than their peers. Expanding public transportation infrastructure may decrease disparities in access to services, employment, and recreation opportunities for individuals with low incomes, individuals with disabilities, and the elderly.[1] Public transit can also promote community connectivity if it enables more residents to participate in civic and other activities. |
| What Interventions Work According to the Research<br>* *practices that work based on the research* | Research supports these types of interventions:<br>• Expand public transportation infrastructure to decrease disparities in access to services, employment, and recreation opportunities for individuals with low incomes, individuals with disabilities, and the elderly.[1]<br>• Introduce new rail lines in urban areas that can increase transit use in cities where many commuters drive to a central business district, significantly reducing trip time for commuters and other travelers.[1] |
| How are Regional Goals and Improvement Objectives Consistent with these Interventions<br>**Consistency between what the Leadership Team is planning to do and the interventions that have been shown to work.* | In the North County Regions, transportation is a prominent issue. Many areas in the regions are rural, and far from public transport options that are currently available. The North County Regions are working to improve ways in which residents can advocate for transportation improvements in their communities. This includes working with community partners who are offering opportunities for residents to have a say in transportation in their regions. |

1. http://www.Countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/public-transportation-systems

| Priority | Alignment with *Live Well San Diego* Component | AREAS OF INFLUENCE<br>Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | AREAS OF INFLUENCE<br>Public Health Services Indicator |
|---|---|---|---|
| **Housing** | **Thriving**  | **COMMUNITY**<br>• **None Applicable**<br>**STANDARD OF LIVING**<br>• **Income (spending less than 1/3 on housing)**<br>• **None Applicable** | • **None Applicable** |
| What the Numbers Say | Nearly **50%** of North County Regions' residents spend more than **1/3** of their income on housing.[H] | | |
| What the Research Says about this Priority Concern<br>**how health and well-being is affected* | Research has shown that high housing costs are associated with poor health outcomes, especially in children.[1,2,3] Families that use most of their income for shelter spend less money on books, computers, and educational outings needed for healthy child development.[4] Almost half of the poorest households headed by persons who are 65 years or older pay 50 percent or more of their income for housing.[5] Hardships are also very common among working families who often pay more than half of their income on housing. Among these hardships are food insecurity, lack of health insurance, lack of a car, and—to the extent it is used as a strategy to cope with high housing costs—the physical and emotional discomforts of crowding.[6,7] | | |
| What Interventions Work According to the Research<br>* *practices that work based on the research* | Research supports these types of interventions:[1]<br>• Provide Rental Assistance to low- and moderate-income families as well as homeless veterans, homeless<br>• families with disabilities, and chronically homeless individuals.[7]<br>• Support the transition for foster youth timing out of foster care by providing temporary housing assistance.[4]<br>• Enhance quality of life through comprehensive program tailored to help rental assistance participants succeed<br>• at becoming self-sufficient.<br>• Assist first-time homebuyers with down payment and closing costs in order to keep their monthly housing costs low. | | |
| How are Regional Goals and Improvement Objectives Consistent with these Interventions<br>**consistency between what the Leadership Team is planning to do and the interventions that have been shown to work.* | Housing is a difficult issue to address due to the many factors that contribute to the problem. The North County regions are working to empower residents to advocate for local housing change in the community. By teaming up with community partners, the regions hope to raise awareness and develop new solutions to make more affordable housing available to North County residents, particularly seniors, homeless youth, and veterans. | | |


1. Murasko, J. E. (2008). An evaluation of the age-profile in the relationship between household income and the health of children in the United States. Journal of Health Economics, 27(6), 1489-1502.
2. Mason, K. E., Baker, E., Blakely, T., & Bentley, R. J. (2013). Housing affordability and mental health: does the relationship differ for renters and home purchasers?. Social Science & Medicine.
3. Pollack, C. E., Griffin, B. A., & Lynch, J. (2010). Housing affordability and health among homeowners and renters. American journal of preventive medicine, 39(6), 515-521.
4. Sandra J. Newman and C. Scott Holupka, Ph.D.;(8/8/2013; pub 5/29/2014) "Housing affordability and Child Well-Being."
5. Center for Housing Policy tabulations of 2009 American Housing Survey.
6. Lipman, Barbara J, 'Something's Gotta Give: Working Families and the Cost of Housing (April 2005) http://www.nhc.org/media/documents/somethings_gotta_give.pdf.
7. Fletcher, Jason M., Tatiana Andreyeva, and Susan H. Busch. 2009. Assessing the Effect of Changes in Housing Costs on Food Insecurity.Journal of Children and Poverty 15(2): 79-93.
8. Traci Pederson (6/12/2014); reviewed by John M. Grohol, Psy D; http://psychcentral.com/news/2014/06/12/for-poor-highs-and-lows-of-housing-

| Priority | Alignment with *Live Well San Diego* Component | AREAS OF INFLUENCE<br>Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | AREAS OF INFLUENCE<br>Public Health Services Indicator |
|---|---|---|---|
| **Education and Workforce Development** | **Thriving**  | **KNOWLEDGE**<br>**High School Graduation**<br>• **None Applicable**<br>**STANDARD OF LIVING**<br>**Unemployment Rate**<br>**Income (spending less than 1/3 on housing)**<br>• **None Applicable** | • **None Applicable** |

| | |
|---|---|
| What the Numbers Say | In North San Diego, there were **9,282** opportunity youth and **8.2%** disconnected youth in 2016.[I] |
| What the Research Says about this Priority Concern<br>**how health and well-being is affected* | "Opportunity youth" refers to those residents who are ages 16-24 who are neither in school nor employed. There are approximately 37,000 opportunity youth in San Diego County. Disparities can be seen between different areas of the County, through socio-economic lenses, and between different race/ethnicity groups.[1] Disconnected youth are at an increased risk of violent behavior, smoking, alcohol consumption and marijuana use, and may have emotional deficits and less cognitive and academic skills than their peers who are working and/or in school.[2,3,4,5] Studies show that both a lack of educational attainment and unemployment is linked to depression, anxiety, and poor physical health.[6] |
| What Interventions Work According to the Research<br>* *practices that work based on the research* | Research supports these types of interventions:[7]<br>• Embed the development of soft skills (communication, resilience, collaboration, etc.) as well as job readiness skills like interviewing and resume development at all levels of education.<br>• Expand efforts to engage students in learning about the universe of career options and how to pursue them — beginning early.<br>• Expand and strengthen career pathways, dual enrollment, admission guarantees and other proven strategies that increase the likelihood of youth matriculating in their chosen post-secondary option. |
| How are Regional Goals and Improvement Objectives Consistent with these Interventions<br>*consistency between what the Leadership Team is planning to do and the interventions that have been shown to work.* | The North County Regions are working to improve education and workforce development for opportunity youth who need support from the community. The regions are looking into opportunities to generate partnerships in the Region to support internships for opportunity youth and to improve their outcomes in future educational, employment endeavors. At the same time, this can lead to improved health outcomes for the youth and a stronger workforce in the North County Regions. |

1. https://www.opportunitysd.org/datadashboard
2. Besharov DJ, Gardiner KN (1998): Preventing Youthful Disconnectedness. Children and Youth Services 20, 797-818.
3. Tandon SD, Barshall B, Templeman AJ, Sonenstein FL: Health Access and Status of Adolescents and Young Adults Using Youth Employment and Training Programs in an Urban Environment. Journal of Adolescent Health 43(2008), 30-37.
4. Vancea, M., & Utzet, M. (2017). How unemployment and precarious employment affect the health of young people: A scoping study on social determinants. Scandinavian Journal of Public Health., 45(1), 73-84.
5. Morrell, S., Taylor, R., & Kerr, C. (1998). Jobless. Unemployment and young people's health. Medical Journal of Australia., 168(5), 236-240.
6. Thurston RC, Kubzansky LD, Kawachi I, Berkman, LF (2006): Do Depression and Anxiety Mediate the Link Between Educational Attainment and CHD? Psychosomatic Medicine 68, 25-32.
7. https://www.opportunitysd.org/recommendations

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A. UCLA Center for Health Policy Research. 2015-2017 California Health Interview Survey, AskCHIS. Retrieved April, 2019.

B. 2018 ESRI Community Analyst, Retrieved April 2019.

C. Source: California Office of Statewide Health Planning and Development (OSHPD) Emergency Department Discharge Data, SANDAG Current Population Estimates.

D. SANDAG Crime in the San Diego Region Mid-Year 2018 Statistics Report. https://www.sandag.org/uploads/publicationid/publicationid_4532_24498.pdf

E. County of San Diego, Office of Emergency Services Hazmat Mitigation Plans. https://www.sandiegoCounty.gov/content/dam/sdc/oes/emergency_management/HazMit/2017/City-of-Escondido-HazMit-Section-5.pdf

F. County of San Diego, Office of Emergency Services Hazmat Mitigation Plans. https://www.sandiegoCounty.gov/content/dam/sdc/oes/emergency_management/HazMit/2017/City-of-Carlsbad-HazMit-Section-5.pdf

G. Source: U.S. Census Bureau; 2013-2017 American Community Survey 5-Year Estimates, Table DP03, B08012.

*Live Well San Diego*

# Community Enrichment Plan

## SOUTH REGION

COUNTY OF SAN DIEGO
HHSA
HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL
SAN DIEGO

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**2019-2021**

This document is the culmination of activities undertaken when implementing the *Live Well San Diego Community Health Improvement Plan, FY 2014-18.*

This document was developed under the General Management System of the County of San Diego, and is in support of *Live Well San Diego*.

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## From the Regional Director

Dear Community Partner,

On behalf of the *Live Well San Diego* South Region Leadership Team (*LWSD* SRLT), it is our pleasure to bring you the most recent South Region Community Enrichment Plan (CEP). This is our plan for advancing the *Live Well San Diego* vision in the South Region.

The *Live Well San* Diego South Region Leadership Team has a mission to improve the well-being of the South Region community through collaboration and system changes that promote healthy, safe, and thriving communities. In order to realize the mission, the LWSD SRLT uses the *Live Well San Diego* vision as a blueprint for guiding actions, and data to identify priorities, and adopted the Communities of Excellence Framework, adapted from the Baldrige Framework for organizational performance excellence, for strategic planning. The CEP reflects the priorities, goals and objectives, and measures from the strategic planning process with partner and resident input.

I am so proud of the work of this Leadership Team that has come together to identify what is essential to creating a stronger Region and healthier and happier residents. Unfortunately, as we are all know, this nation is experiencing a global pandemic (COVID-19), a public health threat unlike any we have seen in our lifetime. This has contributed to the delay in publishing this CEP but this also speaks to the importance that our plan be dynamic as we shift our focus .

This Leadership Team, partners across every sector, and our residents have stepped up to the challenges COVID-19 presents. I believe that it is the *Live Well San Diego* vision and our collective efforts that have helped put us in a much better position to overcome and even grow as a Region.

Thank you for all that you do to help South Region and its residents be healthy, safe and thriving.

**BARBARA JIMÉNEZ, MPH, Director of Regional Operations**
Central and South Regions
County of San Diego – Health and Human Services Agency
*Live Well San Diego* SRLT Co-chair

**KATHRYN LEMBO, President and CEO**
South Bay Community Services
*Live Well San Diego* SRLT Co-chair


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## INTRODUCTION

This Community Enrichment Plan (CEP) represents the priorities of the *Live Well San Diego* South Region Leadership Team *(LWSD SRLT*). The CEP priorities, goals, strategies, improvement objectives, and associated measures were identified and developed by the *LWSD SRLT* because they address the challenges and build on the strengths of South Region **[see Appendix I for the key to the CEP terminology and elements]**. This CEP also represents the ways in which the *LWSD SRLT* believes it can make the most significant contribution to help every resident live well. This CEP is part of a County of San Diego Community Health Improvement Plan (CHIP), aligned to the *Live Well San Diego* vision, that captures the content of all plans for each of the six Health and Human Services Agency (HHSA) Regions and their respective Leadership Teams. Each Leadership Team, comprised of community leaders representing organizations across every sector, plays a vital role in driving action on the ground to advance the *Live Well San Diego vision* by supporting and encouraging collective effort within the Region and leveraging resources available throughout the County.

## *LIVE WELL SAN DIEGO* SOUTH REGION LEADERSHIP TEAM PLANNING PROCESS & SELECTION OF PRIORITIES

Formed in October 2010, the *Live Well San Diego* South Region Leadership Team works toward improving community wellness and reducing health disparities among children and families living in the South Region of San Diego. The *LWSD SRLT* brings together public health agencies, local governments, school districts, health care and community-based organizations to promote policy, environmental and systems changes to create safe, healthy and equitable communities. The *LWSD SRLT* is participating in the Communities of Excellence 2026 Framework which is an opportunity to enhance community operations and relationships that has been adapted from the Baldrige Performance Excellence Framework. In 2014, the *LWSD SRLT* developed an initial Community Health Assessment and CHIP. Since then, the *LWSD SRLT* has evolved to address health in the broadest sense that includes the social and physical environments in which residents live, also referred to as the social determinants of health. This is reflected in the changing of the name of individual CHIPs to Community Enrichment Plans (CEPs), as the Leadership Team priorities address objectives beyond just health.

The number of *LWSD SRLT* members has grown since 2010 and today encompasses a broad range of community partners and stakeholders **[see Appendix II for the list of members of the *Live Well San Diego* South Region Leadership Team]**. The *LWSD SRLT* received data presentations on relevant health, safety, and well-being trends and completed a survey to gather perspectives on challenges and priorities for Living Well that covered all components—Building Better Health, Living Safely, and Thriving. Whenever feasible, data was presented through a health equity lens—age, gender, geography, race/ethnicity, and socio-economic status. The survey contained questions relating to both forces of change applicable to the community, and Community Themes and Strengths, as these are two of the four MAPP assessments (see Methodology section, page 8).

# BACKGROUND

Following the data presentations and survey analysis, priorities, goals, and improvement objectives of the *LWSD SRLT* emerged during regular meetings through an iterative planning process. The *LWSD SRLT* has three work groups to address priorities: Chronic Disease Prevention; Schools; and Economic Vitality. The work groups each developed work plans that were aligned to the *Live Well San Diego* framework and were also consistent with the Communities of Excellence model.


## *LIVE WELL SAN DIEGO* SOUTH REGION LEADERSHIP TEAM AREAS OF INFLUENCE – PRIORITIY ARE-

### BUILDING BETTER HEALTH

- Health- Preventing Chronic Disease

### LIVING SAFELY

- Ongoing

### THRIVING

- Knowledge- Improving School Attendance
- Standard of Living- Promoting Economic Vitality

*Note that in South Region, the Priorities are equivalent to Areas of Influence (e.g., Health, Community, Social) followed by language that reflects the focus of the associated goals.*

## HOW THE COUNTY SUPPORTS IMPLEMENTATION OF THE COMMUNITY ENRICHMENT PLANS

The *Live Well San Diego* South Region Leadership Team cannot on its own implement the improvement objectives that appear in the CEP. The *LWSD SRLT* is part of the broader collective impact effort called the *Live Well San Diego* vision. This means that success in reaching the improvement objectives, within this plan and other Regional CEPs, depends on leveraging the efforts of partners across all sectors as well as existing County programs and services. For example, a goal to support healthy food choices and food systems will draw upon the County of San Diego Public Health Services Department Chronic Disease and Health Equity program. Behavioral health activities, reflected in many Regional CEPs, are accomplished by staff and programs within the County of San Diego Behavioral Health Services Department, which offers prevention and early intervention services and an array of treatment programs. Age Well San Diego, a San Diego County Board of Supervisor initiative to create age-friendly communities, has an action plan that supports intergenerational activities and transportation policies, which closely align with CEP goals. The many assets and resources across San Diego County—public, private, and non-profit—are detailed in the FY 2019-2021 Community Health Assessment. The County of San Diego Regional Director and community engagement staff within each Region assist the Leadership Team to achieve their CEP improvement objectives by providing technical assistance and leveraging County initiatives, programs and services whenever possible **[see the 2019-2021 Community Health Assessment for more discussion of assets and resources available across San Diego County]**.

## *BUILDING THE REGIONAL COMMUNITY ENRICHMENT PLAN*

The *Live Well San Diego* vision, and the three components, Building Better Health, Living Safely, and Thriving, serve as the framework for the *Live Well San Diego* CHIP as well as the Regional CEPs (as depicted in the *Live Well San Diego* Pyramid, Figure 1). The final CEP is organized in the language of the Leadership Teams—that is the priorities, goals and objectives as these leaders defined them. The structure of the CEP content and alignment to *Live Well San Diego* is illustrated in the "Template for the Community Enrichment Plan" which follows (see Figure 2). The "Key to the Community Enrichment Plan," which explains all of the elements, terminology and icons used, is Appendix I.

The content for the CEPs is displayed in order of: Priorities, Indicators, Goals, Improvement Objectives, and Metrics. Alignment is shown visually with the use of icons or colors. Indicators align to *Live Well San Diego* Areas of Influence; Goals align to *Live Well San Diego* Components; and Improvement Objectives align to *Live Well San Diego* Strategic Approaches. *Note that in South Region, the Priorities are equivalent to Areas of Influence (e.g., Health, Knowledge, Standard of Living, Community, Social) followed by language that reflects the focus of the associated Goals.*

It should be noted that several types of Indicators are identified by Priority. These Indicators include the Top 10 *Live Well San Diego* Indicators, Expanded Indicators, and Supporting Indicators, depending upon which Indicators align to the priority **[see Appendix I for an explanation of the difference between types of Indicators]**. Also, Indicators from a newly created Public Health Services Indicators dashboard appear, an expectation of accredited public health departments **[see Appendix III for the *Live Well San Diego* and Public Health Services Indicators Dashboards]**. Any positive movement of the **Indicators** is achieved over the long term by implementing evidence-informed strategies as described in the Basis for Action **[see Appendix IV for the Basis for Action]**.

**Figure 1. *Live Well San Diego* Vision Pyramid.**

# BUILDING THE REGIONAL COMMUNITY ENRICHMENT PLANS

Regional CEPs do not always cover every Component of the *Live Well San Diego* framework. Each Region's Leadership Team makes the determination of what **Priorities** they will undertake, recognizing that these Leadership Teams must be responsive to the unique needs of their Regions and focus their efforts on those issues or concerns in which members believe the Leadership Team can have the greatest impact through collective action.

Also, these plans are iterative in that **Priorities**, **Goals,** and **Improvement Objectives** can change over time as the Leadership Team responds to evolving needs of the community.

## Figure 2. Template for the Community Enrichment Plan

**Priority:**

| 5 Areas of Influence | Top 10 *Live Well San Diego* Indicators<br>• Expanded Indicator<br>• *Supporting Indicator* | Public Health Services Indicators |
|---|---|---|
| HEALTH | **Life Expectancy** **Quality of Life**<br>• Expanded Indicator<br>• *Supporting Indicator* | 3-4-50<br>ADRD Death Rate<br>Infant Mortality Rate<br>HIV Disease Diagnosis Estimates |
| KNOWLEDGE | **Education**<br>• Expanded Indicator<br>• *Supporting Indicator* | High School Education |
| STANDARD OF LIVING | **Income-Spending Less than 1/3 of Income on Housing** **Unemployment Rate**<br>• Expanded Indicator<br>• *Supporting Indicator* | Unemployment Rate<br>Income Inequality<br>Poverty |
| COMMUNITY | **Security—Crime Rate** **Physical Environment—Air Quality** **Built Environment—Distance to Park**<br>• Expanded Indicator<br>• *Supporting Indicator* | Childhood Lead in Schools |
| SOCIAL | **Community Involvement—Volunteerism** **Vulnerable Populations—Food Insecurity**<br>• Expanded Indicator<br>• *Supporting Indicator* | Voting |



**Goals Aligned to the Three Components of *Live Well San Diego* and Corresponding Icons and Color Bands**

- Building Better Health—Goal X: X
- Living Safely—Goal X: X
- Thriving—Goal X: X

**Improvement Objectives and Metrics Aligned to the Four *Live Well San Diego* Strategic Approaches and Corresponding Icons**

| Strategic Approach | Improvement Objective and Metric |
|---|---|
| | X.X: Improvement Objective<br>◊ Metric |

# *LIVE WELL SAN DIEGO*
# COMMUNITY ENRICHMENT PLAN – SOUTH REGION


COUNTY OF SAN DIEGO
HHSA
HEALTH AND HUMAN SERVICES AGENCY
LIVE WELL
SAN DIEGO
ACCREDITED HEALTH DEPARTMENT
PHAB
Advancing
public health
performance
PUBLIC HEALTH ACCREDITATION BOARD

**Priority:**

**HEALTH—Preventing Chronic Disease**

| Area of Influence | Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | Public Health Services Indicator |
|---|---|---|
| HEALTH | **Life Expectancy**<br>**Quality of Life**<br>• **None Applicable**<br>• *High School E-Cigarette Use* | **3-4-50 Deaths** |

## GOAL 1: Create Smoke-Vape Free Environments

**Improvement Objectives and Metrics**

1.1: Collaborate with schools and community groups to educate and increase awareness of the dangers of smoking and vaping in school -aged children and their parents/guardians.

- ◊ Number of presentations on smoking and vaping prevention to students, parents, school faculty and youth organization (number of presentations and participants and percent change in knowledge)

1.2: Support four healthcare organizations in San Diego South Region to update smoke-free and vape-free policies and education/ counseling to their patients.

- ◊ Number of materials and presentations provided to healthcare organizations to improve their ability to counsel and refer patients who smoke or vape or are exposed, and to update policies and support policy change

1.3: Update/strengthen city policies and ordinances to promote smoke/vape-free environments in all five South Region cities to increase alignment with the American Lung Association Tobacco Control Report Card

- ◊ Number of smoke-free policies updated or adopted (e.g., multi-unit housing, dining patios, trade schools, senior housing
- ◊ Number of presentations provided to city staff to increase their knowledge of and ability to advance policy change

**Priority:**
**KNOWLEDGE—Improving School Attendance**

| Area of Influence | Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | Public Health Services Indicator |
|---|---|---|
| KNOWLEDGE | **High School Graduation**<br>• **None Applicable**<br>• *Chronic Absenteeism* | **High School Graduation** |

## Goal 2: Address Barriers to Student Engagement and Achievement

**Improvement Objectives and Metrics**

2.1: Enhance collaboration with school districts to improve attendance and graduation rates by addressing barriers to student engagement and achievement.

- ◊ Number of presentations on the importance of school attendance to students and parents (number of presentations and participants and percent change in knowledge)
- ◊ Number of students utilizing behavioral health services
- ◊ Percent of school attendance rates
- ◊ Graduation rates (high school, college)
- ◊ Vaping rates

**Priority:**
**STANDARD OF LIVING—Promoting Economic Vitality**

| Area of Influence | Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | Public Health Services Indicator |
|---|---|---|
| KNOWLEDGE | **Unemployment Rate**<br>• **Percentage of Population with a Checking or Savings Account** | **High School Graduation**<br>**Unemployment Rate**<br>**Income Inequality**<br>**Poverty** |
| STANDARD OF LIVING | | |

## GOAL 3: Increase Prosperity, Education, and the Economy

**Improvement Objectives and Metrics**

3.1: Create a pilot internship program with an emphasis on skill sets to develop workforce readiness.

- ◊ Percentage of participants who graduate from internship programs who reach their employment status goals
- ◊ Percentage of participants seeking full-time employment who are employed full-time upon graduation
- ◊ Percentage of high school students in program seeking part-time employment are employed part-time upon graduation from program
- ◊ Percentage of companies who agreed that the internship program was beneficial and are willing to host interns for another year

3.2: Implement financial literacy program within the workforce readiness internship program.

- ◊ Percentage internship participants who complete the financial literacy program
- ◊ Percentage of internship graduates who demonstrate financial literacy skills

3.3: Implement a Youth Leadership Academy within the workforce readiness internship program.

- ◊ Number of RLA graduates to provide local leadership and advocacy to improve the quality of life in the Region

# APPENDIX


COUNTY OF SAN DIEGO
HHSA
HEALTH AND HUMAN SERVICES AGENCY
LIVE WELL
SAN DIEGO
ACCREDITED HEALTH DEPARTMENT
PHAB
Advancing
public health
performance
PUBLIC HEALTH ACCREDITATION BOARD

# APPENDIX I—KEY TO THE COMMUNITY ENRICHMENT PLAN

This section explains the terms and elements that are being used in the CHIP and CEPs. Careful attention was made to ensure that clear alignment to the *Live Well San Diego* vision was achieved, while also adhering to standard planning terminology.


## Priority

The issue that was selected by the Leadership Team to address, based on a review of community health assessment and other data and the knowledge and passion of members in the Leadership Team.

## Five Areas of Influence

These are the dimensions that capture overall well-being: Health, Knowledge, Standard of Living, Community, and Social. The Areas of Influence reflect that good health goes beyond physical well-being to include the social determinants of health.

| Five Areas of Influence and the Corresponding Icons and Definitions | | | | |
|---|---|---|---|---|
| HEALTH | KNOWLEDGE | STANDARD OF LIVING | COMMUNITY | SOCIAL |
| Enjoying good health and expecting to live a full life | Learning throughout the lifespan | Having enough resources for a quality of life | Living in a clean and safe neighborhood | Helping each other to live well |

# APPENDIX I—KEY TO THE COMMUNITY ENRICHMENT PLAN

## Top 10 *Live Well San Diego* Indicators

Indicators are intended to capture the collective impact of programs, services, and interventions over the long term. The Top 10 *Live Well San Diego* Indicators define what it means to "live well" in San Diego. For each CEP Priority, the appropriate *Live Well San Diego* Indicators are identified in bold with the appropriate icon. "Expanded" Indicators, which are indented in bold, may be identified which are part of the *Live Well San Diego* framework and further describe each Top 10 indicator. This may also include a "Supporting" Indicator which is not part of the Top 10 but is viewed as an additional population measure that reflects progress in the medium- to long-range time span to achieving that priority. These are identified in italics.

**Due to space constraints, only those Indicators, Expanded Indicators, and Supporting Indicators that appear in the individual CEPs are presented in the Key.**

**Top 10 *Live Well San Diego* Indicators**
- **Expanded Indicator**
- *Supporting Indicator*

**Life Expectancy** **Quality of Life**

- *Population with Suicidal Ideation*
- *Household Fresh Vegetable Use*
- *Routine Care*
- *Access to Affordable Fruits/Vegetables*
- *Childhood Obesity*
- *Child Dental Visits*
- *Seniors Walking for Transportation, Fun, or Exercise*
- *High School E-Cigarette Use*

KEY

**Education**

- *Chronic Absenteeism*

**Income-Spending Less than 1/3 of Income on Housing** **Unemployment Rate**

- **Percentage of Population with a Checking or Savings Account**

**Security—Crime Rate** **Physical Environment—Air Quality** **Built Environment—Distance to Park**

- **Travel Time to Work Over 60 Minutes**
- *Probation Youth*
- *Risk of Recidivation*
- *Residents Experiencing Psychological Distress*
- *Active Transport to School*
- *Rate of ED Discharges for Opioid Disorders*
- *Fall Injury Hospitalization Rates*
- *Disaster Vulnerable Residents*

**Community Involvement—Volunteerism** **Vulnerable Populations—Food Insecurity**

- **Volunteerism**
- **Food Insecurity**

# APPENDIX I—KEY TO THE COMMUNITY ENRICHMENT PLAN

## Public Health Services Indicators


To maintain national public health accreditation, a dashboard has been developed to capture indicators that are most relevant to interventions in which Public Health Services plays a key role —this dashboard is referred to as the Public Health Services Dashboard. These indicators are in bold and defined on this page. The indicators are part of a national database submitted to the Public Health Accreditation Board to show the significance and impact of maintaining public health accreditation that results in meeting targets for population health outcomes.

| Public Health Services Indicators | Description |
|---|---|
| **3-4-50 Percent** | Percent of deaths due to the four chronic diseases (cancer, heart disease and stroke, type 2 diabetes, and pulmonary diseases such as asthma). |
| **ADRD Death Rate** | Alzheimer's Disease and Related Dementias (ADRD) death rate per 100,000 population. |
| **Childhood Lead in Schools** | The number of cases from the San Diego Childhood Lead Poisoning Prevention Program. |
| **High School Education** | Overall Graduation Rate: The percentage of those over the age of 25 with a high school diploma or equivalent. |
| **HIV Disease Diagnosis Estimates** | HIV disease diagnosis case counts and percentages. |
| **Income Inequality** | Number of Total Earned Income Tax Credits. |
| **Infant Mortality Rate** | Three-year average Infant Mortality Rate per 1,000 live births. |
| **Poverty** | Percent of the population below poverty level. |
| **Unemployment Rate** | Percent of the total labor force that is unemployed (actively seeking employment and willing to work). |
| **Voting** | Percent of the population who voted in a Federal/State/Local election in the last 12 months. |

## Goal

A goal is an aspiration or broad statement of what the Leadership Team wants to achieve in the longer term (more than three years).

## *Live Well San Diego* Component

There are three major components to *Live Well San Diego*. Each Priority and Goal is aligned to one of these components—Building Better Health, Living Safely, and Thriving. The CEP goals show alignment to the *Live Well San Diego* components by including the respective icon and color (see below).

| Building Better Health | Living Safely | Thriving |
|---|---|---|

# APPENDIX I—KEY TO THE COMMUNITY ENRICHMENT PLAN

## Strategic Approach


The *Live Well San Diego* vision is achieved through four strategies, referred to as Strategic Approaches. These are *Building a Better Service Delivery System*, *Supporting Positive Choices*, *Pursuing Policy and Environmental Changes*, and *Improving the Culture from Within*. These Strategic Approaches are used as the strategies for the CEPs, which are how the Leadership Team will go about achieving the goal. The icons and definitions for the Strategic Approaches are listed below.

| *Live Well San Diego* Strategic Approaches | | | |
|---|---|---|---|
| **Building a Better Service Delivery System** | **Supporting Positive Choices** | **Pursuing Policy and Environmental Changes** | **Improving the Culture from Within** |
|  |  |  |  |
| Improving the quality and efficiency of County government and its partners in the delivery of services to residents, contributing to better outcomes for clients and results for communities. | Providing information and resources to inspire county residents to take action and responsibility for their health, safety, and well-being. | Creating environments and adopting policies that make it easier for everyone to live well, and encouraging individuals to get involved in improving their communities. | Increasing understanding among County employees and providers about what it means to live well and the role that all employees play in helping residents live well. |

## Improvement Objective

The Improvement Objective is the change or improvement that the Leadership Team seeks or hopes to accomplish in the shorter term (one to three years). The Improvement Objective reflects actions that the Leadership Team has decided to take and is supported by the research, evidence, or best practice to contribute to advancement of the goal and ultimately community change. For each Improvement Objective, the Strategic Approach is indicated with the corresponding icon in the CEP to indicate alignment.

## Metric

The metric indicates the target and how progress will be measured for each improvement objective.

# APPENDIX II— LIST OF *LIVE WELL SAN DIEGO* SOUTH REGION LEADERSHIP TEAM MEMBERS

## SOUTH REGION LEADERSHIP TEAM MEMBERS

**CO-CHAIRS:**

Barbara Jiménez, Director of Regional Operations, Health and Human Services Agency-Central & South Regions
Kathryn Lembo, President/CEO, South Bay Community Services

**Members:** The current *Live Well San Diego* South Region Community Leadership Team consists of the agencies and organizations listed below. Some members regularly attend meetings whereas other valued partners are contributing in other meaningful ways to the development and implementation of the CEP. **Some members are also *Live Well San Diego* Recognized Partners which is indicated with an asterisk (*).**

### SOUTH REGION COMMUNITY LEADERSHIP TEAM MEMBERS BY SECTOR

### COMMUNITY & FAITH-BASED/OTHER VALUED PARTNERS

### CITIES & GOVERNMENTS

### BUSINESS & MEDIA

### SCHOOLS & EDUCATION

**Figure P.1a(4)-1 People and Organizational Resources**

| Key Community Group ** LWSD Recognized Partners* | Health | Know-ledge | Stand-ard of Living | Commu-nity | Social | Key Community Group **LWSD Recognized Partners* | Health | Know-ledge | Stand-ard of Living | Com-munity | Social |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 2-1-1 San Diego* | • | | • | | • | Mabuhay Foundation* | | | | • | • |
| Access Inc. Youth and Immigration Services* | | | • | | | MANA de San Diego* | | • | | | • |
| Accion | | | • | | | Maxim Healthcare Services | • | | | | |
| Agent Prolific | | | • | | | McAlister Institute* | • | | • | | |
| Alliance Healthcare Foundation* | • | | | | | MediExcel* | • | | | | |
| American Heart Association* | • | | | | | Mental Health America of San Diego* | | | | | |
| American Lung Association* | • | • | | • | | Mexican American Business and Professional Associ-ation (MABPA)* | | | | | • |

# APPENDIX II— LIST OF *LIVE WELL SAN DIEGO* SOUTH REGION LEADERSHIP TEAM MEMBERS

| Key Community Group<br>** LWSD Recognized Partners* | Health | Know-ledge | Stand-ard of Living | Com-munit y | Social | Key Community Group<br>**LWSD Recognized Partners* | Health | Know-ledge | Stand-ard of Living | Com-munit y | Social |
|---|---|---|---|---|---|---|---|---|---|---|---|
| API Initiative | | | | | | Molina Healthcare | | | | | |
| Arts for Learning San Diego* | | | | • | | National City Chamber of Commerce* | | | • | | • |
| Boys and Girls Club* | • | • | • | | • | National City Collaborative | • | • | • | • | • |
| California Department of Rehabilitation | • | | | | | National Conflict Resolution Center* | | • | | | • |
| California State Assembly | • | • | • | • | • | National School District* | • | • | • | • | • |
| Casa Familiar* | • | • | • | • | • | National University | | • | | | |
| Center for Sustainable Energy | | | | • | | Nitai Partners, Inc. | | | | • | |
| Child Development Associates Inc. | | • | | | | Northgate Gonzalez Markets* | • | | | | • |
| Chula Vista Community Collaborative (CVCC)* | • | • | • | • | • | Olivewood Gardens and Learning Center* | • | • | | | • |
| Chula Vista Elementary School District (CVESD)* | • | • | • | • | • | Operation Samahan Health Centers* | • | • | | | • |
| Chula Vista Elite Athlete Training Center* | • | • | | | | Palomar Health* | | | | | |
| Circulate San Diego* | | | | • | | Paradise Valley Hospital* | • | | | | • |
| City of Chula Vista * | • | • | • | • | • | Parent Institute for Quality Education | | | | | |
| City of Coronado* | • | • | • | • | • | Partners in Life | | | | | |
| City of Imperial Beach* | • | • | • | • | • | Point Loma Credit Union | | | • | | |
| City of National City* | • | • | • | • | • | Professional Land Corporation | | | • | | |
| City of San Diego* | • | | | • | | Public Consulting Group (PCG) | | • | • | | • |
| CityReach Church San Diego | | | • | | • | Pure Game | | | | | • |
| Communities of Excellence 2026* | | | | | | Rady's Childrens Hospital* | • | | | • | |
| Community Action Service Advocacy (CASA)* | • | | | • | | Reach Out to Families | | • | | | • |
| Community Based Organization Boards | • | • | • | • | • | Reality Changers | | • | • | | • |
| Community Health Improvement Partners (CHIP)* | • | • | • | • | • | Retina World Congress | | • | • | | |
| Community Housing Works* | | | • | | | San Diego Association of Government (SANDAG)* | | | | • | |
| Community/Private Entity Decision Makers | • | • | • | • | • | San Diego Blood Bank* | • | | | | |
| Community Rowing of San Diego* | | | | | | San Diego County Credit Union* | | | • | | • |
| Community Through Hope | | | | | | San Diego County US Census Bureau | | | | | |
| Coronado Unified School District* | | • | | | | San Diego Foundation | | | • | • | |
| COSD Board of Supervisors | • | • | • | • | • | San Diego Health Connect* | • | • | | | |
| COSD Community Services Group (CSG) – Libraries | | • | • | | • | San Diego Housing Commission | | | • | | • |
| COSD HHSA Aging and Independence Services (AIS) | • | • | • | • | • | San Diego Hunger Coalition* | • | | | | • |
| COSD HHSA Behavioral Health Services (BHS) | • | | • | | • | San Diego Workforce Partnership* | | | • | | |
| COSD HHSA Child Welfare Services (CWS) | • | | • | • | • | San Ysidro Health Center* | • | • | | | • |
| COSD HHSA Community Health Promotion | • | • | • | • | • | San Ysidro School District* | • | • | | | • |
| COSD HHSA Executive Office | • | • | • | • | • | SCORE San Diego | | | • | | |
| COSD HHSA Family Resource Centers (FRC) | • | | • | | • | Scripps Family Medicine Residency Program | • | • | | | |
| COSD HHSA Housing and Community Development Services | | | • | | • | Scripps Mercy Hospital, Chula Vista | • | • | | | • |
| COSD HHSA Public Health Services/Center | • | • | | | | Sharp Chula Vista Medical Center | • | • | | | • |
| COSD Public Safety Group (PSG) - Sheriff's Department and Probation Department | | | | • | • | South Bay Community Services (SBCS)* | • | • | • | • | • |

# APPENDIX II— LIST OF *LIVE WELL SAN DIEGO* SOUTH REGION LEADERSHIP TEAM MEMBERS

| Key Community Group<br>** LWSD Recognized Partners* | Health | Know-ledge | Stand-ard of Living | Com muni ty | Social | Key Community Group<br>**LWSD Recognized Partners* | Health | Know-ledge | Stand-ard of Living | Com-munit y | Social |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Dairy Council of CA | • | | | | • | South Bay Union School District* | | • | | | |
| DREAMbuilders | | | | | | South County Economic Development Council* | | | • | | • |
| Drug Enforcement Administration | | | | • | | South Teen Recovery Center | • | | | | |
| Edward Jones Investments | | | • | | | Southern Caregiver Resource Center* | | | • | | • |
| Egge | | | | | | Southwestern College | | • | | | • |
| Elite Athlete Services | | | | | | StateFarm Insurance Company | | | • | | |
| Environmental Health Coalition | • | | | • | | Stretchtopia* | • | | | | |
| Family Health Centers of San Diego* | • | • | | | • | SunCoast Co-op Market (IB Health Grocery Initiative) | • | | • | | |
| Financial Coach 4U* | | | • | | | Super Saludable | • | | | • | |
| Fit As Well | • | | | | | Sweetwater Authority | | | | • | |
| Fleet Science Center | | • | | | | Sweetwater Union High School District* | | • | | | • |
| GHI Mortgage | | | • | | | The Awareness Center | • | | | | |
| Goddess in Motion Institute* | • | | • | | | The Super Dentists* | | | | | |
| Holistic Chamber of Commerce | • | | | • | | Thomas Strafford Investments | | | • | | |
| Hope Through Housing* | | | | | | Trade Schools: Pima, UEI | | • | | | |
| Imperial Beach Collaborative | • | • | • | • | • | Uncle Keith's Gourmet Foods | | | • | | |
| Imperial Beach Community Clinic Health Center* | • | • | | | • | University of California San Diego (UCSD) | • | • | • | • | • |
| Imperial Beach Neighborhood Center | | | • | | • | United Way San Diego* | | | • | • | |
| Institute for Public Strategies* | • | • | • | • | • | Urban League of San Diego County* | | | • | | • |
| JLC Consulting | | • | | | • | US-Mexico Border Health Commission | • | • | | | • |
| Junior Achievement of San Diego County* | | • | • | | • | Victory Gardens San Diego | | | | | |
| Kaiser Permanente* | • | • | | | | Westpac Wealth Partners | | | • | | |
| La Maestra Community Health Centers * | • | • | | | • | WILDCOAST* | • | | | • | |
| Legal Aid Society of San Diego* | | • | | | • | YALLA San Diego | • | • | | | • |
| LifeVantage | • | | | | | YMCA Childcare Resource Service | • | • | • | | • |
| Logan Heights Community Development Corporation* | • | • | • | • | • | YMCA (San Diego County, Bayside, South Bay Family) * | • | • | | | • |
| MAAC Project* | • | • | • | • | • | Zavero Consulting Inc. | | | | | |

# APPENDIX III—INDICATORS

## TOP 10 *LIVE WELL SAN DIEGO* INDICATORS DASHBOARD ALIGNED TO *LWSD* AREAS OF INFLUENCE

### *Live Well San Diego* Dashboard
### Top 10 Population Outcome Indicators: SOUTH REGION

| | Indicator | Description | We want to increase this / We want to decrease this | San Diego County | South Region | Chula Vista | Coronado | National City | South Bay | Sweetwater |
|---|---|---|---|---|---|---|---|---|---|---|
| **HEALTH - Enjoying good health and expecting to live a full life** | | | | | | | | | | |
| HEALTH | Life Expectancy | Average number of years a person is expected to live at birth. 2016. | ↑ | 82.1 | 81.7 | 81.4 | 84.9 | 79.3 | 80.9 | 84.0 |
| | Quality of Life | Percent of the population 18 and older, not residing in nursing homes or other institutions, that is sufficiently healthy to be able to live independently. 2017. | ↑ | 94.9% | 93.9% | 92.4% | 95.5% | 92.3% | 93.9% | 95.6% |
| **KNOWLEDGE - Learning throughout the lifespan** | | | | | | | | | | |
| KNOWLEDGE | Education: High School Diploma or Equivalent | Overall Graduation Rate: the percentage of those over the age of 25 with a high school diploma or equivalent. 2017. | ↑ | 86.1% | 77.3% | 70.6% | 97.8% | 72.8% | 71.6% | 88.5% |
| **STANDARD OF LIVING - Having enough resources for a quality life** | | | | | | | | | | |
| STANDARD OF LIVING | Unemployment Rate | Percent of the population that is unemployed. 2018. | ↓ | 3.9% | 5.1% | 6.9% | 2.5% | 5.1% | 6.0% | 3.4% |
| | Income: Percent of population spending less than 1/3 of income on housing | Percent of the population spending less that 1/3 of their income on housing. 2016. | ↑ | 52.9% | 50.8% | 49.1% | 52.5% | 45.9% | 50.5% | 56.1% |
| **COMMUNITY - Living in a clean and safe neighborhood** | | | | | | | | | | |
| COMMUNITY | Security: Overall Crime Rate | Overall Crime rate per 100,000 population. 2017. | ↓ | 2032.6 | N/A | N/A | N/A | N/A | N/A | N/A |
| | Physical Environment: Air Quality | Percent of days rated unhealthy for vulnerable populations. 2018. | ↓ | 6.1% | N/A | N/A | N/A | N/A | N/A | N/A |
| | Built Environment: Percent of population living within 1/4th a mile of a park or community space | Percentage of population that resides within a quarter mile of a park or community space. 2018. | ↑ | 61.3% | 77.4% | 78.6% | 91.2% | 70.9% | 79.7% | 76.0% |
| **SOCIAL - Helping each other to live well** | | | | | | | | | | |
| SOCIAL | Vulnerable Populations: Food Insecurity | Percent of adult population 200% below FPL not able to afford food. 2017. *Indicates statistically unstable estimates. Proceed with caution. | ↓ | 37.6% | 40.1%* | N/A | N/A | N/A | N/A | N/A |
| | Community Involvement: Volunteerism | Percent of residents who volunteer. 2017. | ↑ | 25.5% | N/A | N/A | N/A | N/A | N/A | N/A |

On the right track  Not on track  No change

To view more information about the *Live Well San Diego* Indicators and how we will measure progress go to: http://www.sdcounty.ca.gov/hhsa/programs/sd/live_well_san_diego/indicators.html

## PUBLIC HEALTH SERVICES INDICATORS DASHBOARD

### San Diego County Public Health Services Dashboard
### Top 10 Population Outcome Indicators: SOUTH REGION

LIVE WELL SAN DIEGO

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY PUBLIC HEALTH SERVICES

| | Indicator | Description | We want to increase this / We want to decrease this | San Diego County | South Region | Chula Vista | Coronado | National City | South Bay | Sweetwater |
|---|---|---|---|---|---|---|---|---|---|---|
| **HEALTH - Enjoying good health and expecting to live a full life** | | | | | | | | | | |
| HEALTH | "3-4-50" Percent | Percent of deaths due to the four chronic diseases (cancer, heart disease and stroke, type 2 diabetes, and pulmonary diseases such as asthma). 2016. | ↓ | 53% | 55% | 55% | 47% | 58% | 56% | 54% |
| | ADRD Death Rate | Alzheimer's Disease and Related Dementias (ADRD) death rate per 100,000 population. 2016. | ↓ | 121.1 | 106.6 | 138.5 | 138.7 | 99.1 | 97.0 | 82.8 |
| | Infant Mortality Rate | Annual Infant Mortality Rate per 1,000 live births. 2016. | ↓ | 3.7 | 4.3 | N/A | N/A | N/A | N/A | N/A |
| | Infant Mortality Rate | Three-year average Infant Mortality Rate per 1,000 live births. 2013-2015. | ↓ | 4 | 3.8 | N/A | N/A | N/A | N/A | N/A |
| | HIV Disease Diagnosis Estimates | HIV Disease diagnosis case counts and percentages between 2012-2016 time period. | ↓ | 100% (2,462) | 19% (480) | N/A | N/A | N/A | N/A | N/A |
| **KNOWLEDGE - Learning throughout the lifespan** | | | | | | | | | | |
| KNOWLEDGE | High School Education | Overall Graduation Rate: the percentage of those over the age of 25 with a high school diploma or equivalent. 2017. | ↑ | 86.1% | 77.3% | 70.6% | 97.8% | 72.8% | 71.6% | 88.5% |
| **STANDARD OF LIVING - Having enough resources for a quality life** | | | | | | | | | | |
| STANDARD OF LIVING | Unemployment Rate | Percent of the total labor force that is unemployed (actively seeking employment and willing to work). 2018. | ↓ | 3.9% | 5.1% | 6.9% | 2.5% | 5.1% | 6.0% | 3.4% |
| | Income Inequality | Number of Total Earned Income Tax Credits. 2017 tax year. | ↓ | 7059 | 1249 | N/A | N/A | N/A | N/A | N/A |
| | Poverty | Percent of the population below poverty level. 2017. | ↓ | 13.4% | 15.4% | 18.5% | 4.9% | 22.6% | 17.9% | 7.1% |
| **COMMUNITY - Living in a clean and safe neighborhood** | | | | | | | | | | |
| COMMUNITY | Childhood Lead in Schools | The number of cases San Diego Childhood Lead Poisoning Prevention Program. 2009-2013. | ↓ | 105 | 15 | N/A | N/A | N/A | N/A | N/A |
| **SOCIAL - Helping each other to live well** | | | | | | | | | | |
| SOCIAL | Voting | Percent of the population who voted in a Federal/State/Local election in the last 12 months. 2018. | ↑ | 43.8% | 37.0% | 30.7% | 50.2% | 25.6% | 29.3% | 51.4% |

On the right track  Not on track  No change

To view more information about the *Live Well San Diego* Indicators and how we will measure progress go to: http://www.sdcounty.ca.gov/hhsa/programs/sd/live_well_san_diego/indicators.html

# APPENDIX IV - BASIS FOR ACTION

The Basis for Action tells the story of why a priority is important and why the Leadership Team has chosen certain improvement objectives for its CEP. This information helps to show how the Leadership Team is being responsive to the unique needs of their region and is adopting scalable, evidence-informed improvement objectives. However, this Basis for Action is a simplistic way of capturing the rationale for action and does not tell the whole story. A lot of factors and information influence the final CEP, including the varying experiences and perspectives of those who serve on a Leadership Team, events or crises that occur within or that impact communities within the region, among many other factors. The Basis for Action serves to distill some of the data, research, and evidence that supports the plan of action reflected in the CEP.

This information is organized by the Priorities of the CEP. This is what appears:

- "What the Numbers Say" captures a few data points that reflect the conditions in South Region that helped persuade the Leadership Team to make this a priority.
- "What the Research Says about this Priority Concern" captures research that explains how this priority concern impacts health and well-being.
- "What Interventions Work According to the Research" identifies those practices that work based on the research. These interventions fall along a continuum in terms of the degree to which their effectiveness has been demonstrated—from promising practice to evidence-informed to evidence-based.
- "How are Regional Goals and Improvement Objectives Consistent with these Interventions " describes how what the Leadership Team is planning to do is consistent with the interventions that have been shown to work.

Why is it important to include the Basis for Action? The literature on collective impact explain that it is important that every partner do what they do best while being committed to the mutually-reinforcing vision for collaborative community change, which is the *Live Well San Diego* vision in this case. Leadership Teams are in a unique position to leverage the activities and efforts of others throughout the Region. Choosing strategies and improvement objectives that are evidence-informed is the best way to influence long-term population outcomes. The collective impact approach also calls for partners to identify not only what they can do best, but also at the scale to which they can be successful.

*Footnotes are used to identify the source of the data—for "What the Numbers Say" footnotes appear in alphabetical order at the end of the appendix. All other footnotes to the research that follows appear in numerical order and immediately below each Priority section.*

# APPENDIX IV - BASIS FOR ACTION

| Priority | Alignment with *Live Well San Diego* Component | AREAS OF INFLUENCE<br>Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | AREAS OF INFLUENCE<br>Public Health Services Indicator |
|---|---|---|---|
| **Behavioral Health Wellness** | **Building Better Health**  | **HEALTH**<br>**Life Expectancy**<br>**Quality of Life**<br>• **None Applicable**<br>• *High School E-Cigarette Use* | **HEALTH**<br>• **3-4-50 Deaths** |

| | |
|---|---|
| What the Numbers Say | Nearly **1 in 5** eleventh graders in Coronado Unified School District and **1 in 14** eleventh graders at Sweetwater Union High reported using an electronic cigarette on one or more days in the past 30 days in 2016-2017.[A] |
| What the Research Says about this Priority Concern<br>**how health and well-being is affected* | Tobacco use is the number one preventable cause of death and disease in the United States. Every day, almost 2,500 children under 18 years of age try their first cigarette, and more than 400 of them will become regular daily smokers. Half of them will ultimately die from using tobacco products.[1] Since 2014, e-cigarettes have been the most commonly used tobacco product among U.S. youth. In 2018, more than 3.6 million U.S. youth, including 1 in 5 high school students and 1 in 20 middle school students, were using e-cigarettes. E-cigarette aerosol is not harmless, as most e-cigarettes contain nicotine – the addictive drug in regular cigarettes, cigars, and other tobacco products. Nicotine exposure during adolescence can impact learning, memory, and attention. In addition to nicotine, the aerosol that users inhale and exhale from e-cigarettes can potentially expose both themselves and bystanders to other harmful substances, including heavy metals, volatile organic compounds, and ultrafine particles that can be inhaled deeply into the lungs.[2] |
| What Interventions Work According to the Research<br>* *practices that work based on the research* | Research supports these types of interventions:<br>• Restrict e-cigarette use around young people.<br>• Encourage residents to visit tobacco-free locations.<br>• Ensure school is tobacco-free.<br>• Make your home tobacco-free.<br>• Talk with a healthcare provider about the health risks of e-cigarettes to young people.[3]<br>• Prohibit smoking in indoor areas of workplaces and public places.[4] |

| | |
|---|---|
| How are Regional Goals and Improvement Objectives Consistent with these Interventions<br>**consistency between what the Leadership Team is planning to do and the interventions that have been shown to work* | The South Region is working to prevent chronic disease by focusing on tobacco usage in three different approaches. The first is within schools and community groups, where they plan to collaborate to educate and increase awareness of the dangers of smoking and vaping in school-aged children and their parents/guardians. This will take the form of presentations on smoking and vaping prevention provided to parents, students, school faculty, and youth organizations.<br><br>The second approach that will be addressed is through the healthcare system. South Region will work with four healthcare organizations to update smoke-free and vape-free policies and education/counseling to patients. This includes providing materials and giving presentations to healthcare organizations on how to improve their ability to counsel and refer patients who smoke or vape or are exposed to secondhand smoke, and on how to update policies and support policy change.<br><br>The third approach that South Region is pursuing is through city policies and ordinances to promote smoke and vape-free environments in all five South Region cities in order to better align with the American Lung Association Tobacco Control Report Card. This will be encouraged by presentations provided to city staff to increase their knowledge of and ability to advance policy change. The Region will also work to increase the number of smoke free policies adopted by personal and public spaces such as multi-unit housing, dining patios, trade schools, and senior housing. Experts from the Communities Action Service Advocacy and American Lung Association explained that policy had the greatest impact on reducing or eliminating tobacco use. |

1. https://www.lung.org/stop-smoking/smoking-facts/tobacco-use-among-children.html

2. https://e-cigarettes.surgeongeneral.gov/documents/surgeon-generals-advisory-on-e-cigarette-use-among-youth-2018.pdf

3. https://e-cigarettes.surgeongeneral.gov/takeaction.html

4. https://www.cdc.gov/tobacco/data_statistics/fact_sheets/youth_data/tobacco_use/index.htm

| Priority | Alignment with *Live Well San Diego* Component | AREAS OF INFLUENCE<br>Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | AREAS OF INFLUENCE<br>Public Health Services Indicator |
|---|---|---|---|
| **KNOWLEDGE - Improving School Attendance** | **Thriving** | **KNOWLEDGE**<br>**High School Graduation**<br>• **None Applicable**<br>• *Chronic Absenteeism* | **HEALTH**<br>• **3-4-50 Deaths** |

| | |
|---|---|
| What the Numbers Say | • In 2017, over **1 in 5** residents 25 years and older did not have a high school diploma or equivalent or greater.[B]<br>• Absentee Rates:[C] Sweetwater Union High: **12.6%**, San Ysidro High: **18.1%**, San Diego County: **11.0%**, California: **11.1%** |
| What the Research Says about this Priority Concern<br>**how health and well-being is affected* | Across the United States, chronic absenteeism is a widespread issue. In 2015-2016, nearly 1 in 6 students missed 15 or more days of school in the U.S. Chronic absenteeism can be caused by adverse factors in a student's life, such as poverty, family circumstances, violence in the community, and health issues.[3] Students who are chronically absent from school are at high risk of falling behind in school, which can lead to missing early learning milestones in preschool, kindergarten, and first grade. Absenteeism is also a predictor of students dropping out of school, and students who do so are more likely to experience poor health and economic outcomes later in life.[1] |
| What Interventions Work According to the Research<br>* *practices that work based on the research* | Research supports these types of interventions:[2]<br>• Attendance interventions for chronically absent students provide support and resources to address: individual factors that contribute to absences such as low self-esteem, school anxiety, social skills, or medical conditions; familial factors such as discipline, parental support, or poverty; and school factors such as attendance policies, teacher/student relationships, and bullying. Such programs can be implemented by schools, community organizations, courts, police agencies, or multi-sector collaborations. |
| How are Regional Goals and Improvement Objectives Consistent with these Interventions<br>*consistency between what the Leadership Team is planning to do and the interventions that have been shown to work* | The South Region is focusing on improving attendance for students of all ages in Regional school districts. This goal was adopted after a review of the Local Control and Accountability Plans of all six school districts in San Diego South Region revealed that increasing attendance was a priority area across all districts. To enhance collaborations between the Region and the school districts, the Leadership Team hopes to improve attendance and graduation rates by addressing barriers to student engagement and success. Presentations will be delivered on the importance of school attendance to both students and parents, and the impact this has on the health, well-being and success of students both during their school years and after graduation when students enter the workforce. |

1. https://www.investopedia.com/articles/investing/100615/why-financial-literacy-and-education-so-important.asp
2. http://www.Countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/attendance-interventions-for-chronically-absent-students
3. https://www2.ed.gov/datastory/chronicabsenteeism.html

| Priority | Alignment with *Live Well San Diego* Component | AREAS OF INFLUENCE<br>Top 10 *Live Well San Diego* Indicator<br>• **Expanded Indicator**<br>• *Supporting Indicator* | AREAS OF INFLUENCE<br>Public Health Services Indicator |
|---|---|---|---|
| **STANDARD OF LIVING- Promoting Economic Vitality** | **Thriving**  | **STANDARD OF LIVING**<br>**Unemployment Rate**<br>• **None Applicable**<br>• *Percentage of Population with a Checking or Savings Account* | **STANDARD OF LIVING**<br>• **Unemployment Rate**<br>• **Income inequality**<br>• **Poverty** |

| | |
|---|---|
| What the Numbers Say | • In 2018, South Region had the highest unemployment rate in the County, at **5.1%.**<br>• Checking Account: At **52%,** the South Region had the second lowest percentage of population with checking accounts in the County in 2018.[E]<br>• Savings Account: At **56%,** the South Region had the second lowest percentage of population with savings accounts in the County in 2018.[E] |
| What the Research Says about this Priority Concern<br>**how health and well-being is affected* | An important indicator of economic vitality is workforce readiness. A lack of education and job preparedness contributes to unemployment, underemployment, and lower income, all factors affecting economic vitality. A survey from the San Diego Workforce Partnership reported that "insufficient soft skills" was one of the top reasons for hiring difficulty.[4]<br><br>Financial literacy is critical for families to obtain and retain self-sufficiency. Financial literacy includes understanding how a checking account works, how to use a credit card and avoid credit card debt, and how to balance a budget. It also includes how to save to buy a home, to cover tuition costs for children, and for retirement. Many individuals in the South Region do not maintain savings or checking accounts, and centers that cash checks are common.[2] |
| What Interventions Work According to the Research<br>* *practices that work based on the research* | Research supports these types of interventions:[3]<br>• Experts suggest high-performing summer jobs programs: recruit employers and worksites, match participants with age- and skill-appropriate opportunities, provide training and professional development on work readiness, provide support to both youth and supervisors, and connect the summer program with other community resources.<br>• Summer youth employment programs have the potential to lead to increased job and social skills, decreased crime, increased employment, and increased earnings. |

| | |
|---|---|
| How are Regional Goals and Improvement Objectives Consistent with these Interventions<br>**consistency between what the Leadership Team is planning to do and the interventions that have been shown to work.* | The Economic Vitality Leadership Team is working to improve workforce readiness among underemployed and unemployed residents by encouraging participation in a pilot internship program that helps develop skills. This involves monitoring how many individuals are employed upon graduation from this program, as well as the percentage of high school students that are employed part-time upon graduation from the internship program. The South Region is also working to increase the number of companies that host interns in the internship program.<br><br>Within the workforce readiness internship, the South Region is implementing a financial literacy program that will teach participants how to be fiscally responsible. The Leadership Team adopted this plan in order to teach residents in the South Region the importance of saving and to provide the tools and knowledge to budget and create financial goals.<br><br>The South Region will focus on promoting leadership within the community through their Resident Leadership Academy. The Resident Leadership Academy is a community leadership model that has demonstrated success in the South Region. The Resident Leadership Academy empowers residents in South Region communities. This empowerment leads to improved quality of life in neighborhoods, with changes promoting physical activity and healthy food choices and addressing many other community issues. |

1. https://results.livewellsd.org/en/stat/goals/single/5c79-znka.

2. https://www.investopedia.com/articles/investing/100615/why-financial-literacy-and-education-so-important.asp

3. http://www.Countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/summer-youth-employment-programs

4. https://workforce.org/

## Citations for "What the Numbers Say":


A. Healthy Kids Survey https://calschls.org/reports-data/dashboard/. Retrieved April, 2019

B. Live Well San Diego Indicator American Community Survey (ACS) Table S1501 5-yr estimates, 2017. Accessed 05/2018.

C. California Department Of Education. https://dq.cde.ca.gov/dataquest/dataquest.asp. Retrieved April, 2019

D. Unemployment Indicator. ESRI Community Analyst Data System, 2018.

E. Percent of the population with a checking account, either interest or non-interest checking accounts. ESRI Community Analyst Data System, 2018.