Live Well San Diego

Community Health Improvement Plan

and Regional Community Enrichment Plans

FY 2023-25

COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

Accredited Health Department · PHAB Advancing Public Health Performance · Public Health Accreditation Board

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MESSAGE FROM INTERIM AGENCY DIRECTOR

Eric C. McDonald, M.D., M.P.H., F.A.C.E.P.
Interim Agency Director
Chief Medical Officer
Health & Human Services Agency

Dear San Diego Residents:

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) 2023-25, 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 (CLTs).

The CLTs, among the many 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. These new CEPs reflect a concerted effort to actively engage the community after the COVID-19 pandemic, and the final plans reflect a slight shift in emphasis to housing and homelessness, behavioral health, and income and food security. This shift reflects a recognition across our communities of the importance that the social determinants of health factor in the prospects of all residents to "live well."

The five CLTs will be working toward implementing their CEP priorities over the next several years. Two HHSA departments—Homeless Solutions and Equitable Communities, and Public Health Services—have applied evidence-based research in ongoing support to help the CLTs develop the goals and objectives in the CEPs to improve the health and well-being of their communities. Success will now depend on the active involvement of partners represented in the CLTs, as well as partners across every sector of the *Live Well San Diego* initiative, from schools, government, community-based or faith-based organizations, healthcare, to many more. In this way, the work of the CLTs represents *Live Well San Diego* at its best, as a collective impact effort in which partners come

together with a shared vision and tap into each other's assets and strengths to bring about positive community change.

I want to thank all the CLTs, led by the Co-Chairs who are leaders in their communities, for their commitment to bring a better quality of life to their respective regions through active engagement in this planning process.

Be Well,

Eric C. McDonald, M.D., M.P.H., F.A.C.E.P.
Interim Agency Director & Chief Medical Officer
County of San Diego Health & Human Services Agency

LETTER FROM PUBLIC HEALTH OFFICER

Wilma J. Wooten, M.D., M.P.H.
Public Health Officer
Public Health Services

Dear San Diego Residents:

The Public Health Services department in the County of San Diego Health and Human Services Agency (HHSA) strives to support the *Live Well San Diego* vision to create a healthy, safe, and thriving community for the County's diverse residents. The *2023-25 Community Health Improvement Plan* (CHIP), comprised of the five Regional Community Enrichment Plans (CEPs), represents the third full planning cycle undertaken by this County to set goals and objectives for community action. The goals and objectives are driven by *Live Well San Diego* Regional Community Leadership Teams (CLTs). These CLTs focus on the needs and priorities unique to their respective regions.

My colleague, Barbara Jiménez, leads the community engagement work in the regions through her community engagement team within the Office of Equitable Communities, in the Department of Homeless Solutions and Equitable Communities. My public health team works alongside her team and the CLTs, providing data and analysis to support the planning efforts, and technical assistance for measuring progress toward implementation of these plans in the short-term, and impacts in terms of community change in the long-term. To maintain national public health accreditation, local health department must have shared overlapping goals and objectives.

Community planning has always been essential to public health work. The County has a very robust planning process and conducts a variety of assessments over the three-year cycle. The County, including the local health department, also have a long history of rigor in its performance management activities and applies research and evidence to the strategies and goals within these community plans and the department's own planning efforts. Producing a CHIP is a requirement of accredited public health departments. This County achieved initial accreditation in May 2016 and was reaccredited in August 2023. The primary methodology adhered to for the planning process was Mobilizing for Action through Planning and Partnership, a recognized method applied by

many health departments in the nation. However, in developing these CEPs, other methods such as the Malcolm Baldrige Communities of Excellence were drawn from, because HHSA has had a long-term commitment to adherence to the Baldrige Criteria for Excellence. And of course, the principles of *Live Well San Diego* as a collective impact effort shape the overall approach.

We are very excited to see what comes out of this concerted effort by the community to work together with the County of San Diego to make positive change happen.

All the Best,

Wilma J. Wooten, M.D., M.P.H.
Public Health Officer
Public Health Services

LETTER FROM COMMUNITY OPERATIONS OFFICER

Barbara Jiménez, M.P.H.
Community Operations Officer
Department of Homeless Solutions and Equitable Communities

Dear San Diego Residents:

I am honored every day to be able to work closely with the community through my role in leading the Department of Homeless Solutions and Equitable Communities. Our mission is to foster collaboration, particularly to support under-resourced and vulnerable groups, and help create a healthy, safe, and thriving County for all residents.

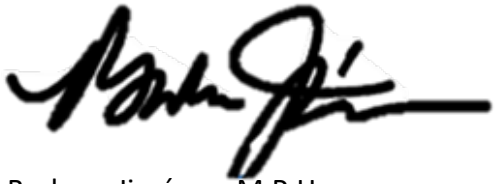
This new Community Health Improvement Plan (CHIP) 2023-25, which is comprised of Regional Community Enrichment Plans (CEPs), represents an effort to bring the community closer and enlist our partners in setting objectives for community enrichment by leveraging resources for collective impact. This work closely aligns with the *Live Well San Diego* vision; bringing us all together to advance our shared aspirations through mutually reinforcing activities. I am thankful for the Regional Community Leadership Teams (CLTs) who came to the table fully engaged to develop these plans that reflect what they care most about and are committed to improving their communities.

The COVID-19 pandemic brought change to the Health and Human Services Agency (HHSA). After the pandemic, there was an opportunity to reimagine community engagement and collaboration by building on existing approaches and devoting efforts to meet the needs of underserved communities with a focus on embracing diversity, social and health equity, economic inclusion, and poverty reduction. For over two decades, HHSA has built relationships with the community through a model of delivering services regionally. The Board of Supervisors created the Department of Homeless Solutions and Equitable Communities to support community-building activities, including CLTs. Regional Community Coordinators, a new role created to bring expertise into HHSA for community engagement work, Co-Chair the CLTs along with a community leader (sometimes more than one community leader serves as Co-Chair). The CLTs were revitalized with new ideas, strong leaders, and additional membership which brought new perspectives to the CLTs. Public Health Services, as it has done for every planning cycle, provides technical assistance in

terms of data, planning, and performance management. Several County departments support the implementation of the goals and objectives within the CEPs. Importantly, the CLTs also leverage partners throughout San Diego County and across every sector to help implement these plans.

This work is already underway. These regional CEPs are "living" documents that evolve to respond to new needs, adjust depending upon results, and reflect future strategies within each region. This is what true community engagement is all about—demonstrating commitment and being flexible in how we get things done together. We are very much looking forward to implementing these plans and seeing how the vision of the CLTs comes to fruition as they collectively achieve community and population change for a better future ahead.

Sincerely,



Barbara Jiménez, M.P.H.
Community Operations Officer
Department of Homeless Solutions and Equitable Communities

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SECTION 1: EXECUTIVE SUMMARY

This *Live Well San Diego* Community Health Improvement Plan (CHIP) is for the three-year planning cycle of 2022-23, 2023-24, and 2024-25. This CHIP features five Regional Community Enrichment Plans (CEPs), representing the goals and objectives of Community Leadership Teams (CLTs) within each of the Health and Human Services Agency (HHSA) regions. As such, this plan represents the review and deliberation on issues confronting each of the HHSA regions, and then the identification of goals and objectives that will guide the work of the partners on the ground for the next three years. The County of San Diego has six HHSA service delivery regions, with two regions (North Inland and North Coastal) combined administratively into one; resulting in five Community Leadership Teams altogether.

This CHIP is organized as follows, each section answering a key question:

- **Section 1: Executive Summary:** *What are the Community Health Improvement Plan and the regional Community Enrichment Plans?*

- **Section 2: Introduction:** *How was this community planning model conducted in San Diego County that reflects the County's unique nature and governance?*
    - The overall context is provided, and terminology explained given San Diego County's unique organizational structure and approach as part of the *Live Well San Diego* Collective Impact effort.

- **Section 3: Methodology and Alignment:** *What is the approach, and how do we keep it simple and straightforward, so the plans capture the voices of the community partners*?
    - This section describes the Collective Impact approach (connecting action to impact), and how specific community planning methodologies are applied including Mobilizing for Action through Planning and Partnership (MAPP) and the Malcolm Baldrige Communities of Excellence. Results-Based Accountability is also reflected in how performance data is used, and progress is tracked.

- **Section 4: Building the Community Enrichment Plans:** *How did we build plans that truly capture the needs, wants, and voice of the CLTs?*
    - The many steps involved in developing the CEPs are described, beginning with how the Community Health Assessment data was gathered, presented, and discussed with the CLTs to identify priorities. This was followed by deliberate and phased facilitation process that was undertaken to help each CLT reach consensus on goals and objectives for each of three priorities.

- **Section 5: The Five Regional Community Enrichment Plans**: *What are the priorities of each CLT and what actions are planned that the partners can embrace in the short term to make a difference in the long term?*
    - This section includes each Region's full CEP, organized by the three priorities, population indicators that the CLT hopes to change for the better, and the specific goals, objectives, and performance measures. Each CEP begins with a profile of the CLT and its members.

- **Section 6: Monitoring Progress for Community Change:** *What is the value of creating CEPs if we do not capture our progress?*
    - This section goes into the process for ensuring accountability on behalf of the community regarding progress in implementing the CEPs. The use of a scorecards for each CEP priority within a performance tracking tool is described. Results-Based Accountability is integral to the approach for each of these priorities because it captures collective action for impact.

- **Section 7: The Basis for Action**: *What is the rationale and research for action behind the objectives adopted by each CLT to improve their community?*
    - The literature on collective impact explains that it is important that every partner do what they do best toward a shared vision for community change. Improvements in the areas of concern, as reflected in the indicators adopted for each CEP priority, are long range. Thereby, it is important that we can provide research and evidence which shows that those short-term objectives will contribute to long-term population change.

- **Section 8: Appendices:** These Appendices provide important context to this community planning effort.

- Appendix I: The Community Health Status Assessment is such a critical part of the methodology because the data presented informs the deliberations of the CLTs. Details about the regional data presentations, surveys, and population indicators for the priorities that emerged are included in this appendix.
- Appendix II: Lays out the dashboards that identify key indicators for *Live Well San Diego*, and indicators that capture outcomes that are a focus of Public Health Service programs.
- Appendix II: Details how this CHIP and its component CEPs meet the latest 2022 public health accreditation requirements.

SECTION 2: INTRODUCTION

Overview: The overall context of this community planning effort is provided, and terminology explained, given San Diego County's unique organizational structure and approach as part of the *Live Well San Diego* Collective Impact effort.

The Basics: What is a CHIP and CEP?

The *Live Well San Diego* Community Health Improvement Plan (CHIP) fulfills a requirement of all accredited public health departments. This FY 2023-25 CHIP represents the third planning cycle for San Diego County. Locally, the CHIP is structured as five Community Enrichment Plans (CEPs), reflecting the unique structure of the Health and Human Services Agency, with six service delivery regions and five Community Leadership Teams (CLTs). North Inland and North Coastal regions are combined administratively and have one CLT.

In 2021, organizational changes since the COVID-19 pandemic led to the creation of the Homeless Solutions and Equitable Communities Department (HSEqC). This department includes the Office of Equitable Communities (OEqC) which coordinates the engagement activities across all regions. Public Health Services (PHS) continues to provide technical support for data, planning, and performance monitoring.

The Community Health Assessment and the CHIP and CEPs are closely connected, as shown in *Figure 1.* Both the CHA and CHIP are a product of the Mobilizing for Action through Planning and Partnership (MAPP),

Figure 1: Community Health Assessment and Planning

Source: County of San Diego, Public Health Services

which is the primary community planning methodology that is adhered to in developing the CHIP and CEPs. The CHA involves the collection of data that in turn informs to community partners as they identify goals and objectives for action.

This MAPP methodology is described in greater detail in the methodology section of this report. The term "Enrichment" for the CEPs was adopted because each plan embraces more than traditional community health goals; it captures all dimensions important to "living well."

Each CEP follows a specific structure that identifies the concerns of the CLT and the plan of action. The CEPs are organized by priority, with three for each CLT, that emerged from the planning process. The content is entirely driven by the CLTs through a series of meetings and ongoing dialogue, convened by OEqC with technical assistance from PHS.

Evolving Regional Structure to Strengthen Community Engagement

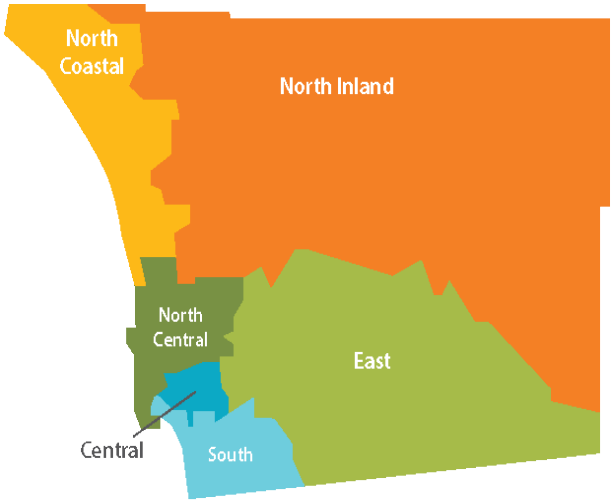
The nature of San Diego County demands a rigorous approach to building CEPs. San Diego County is a large and diverse county in terms of population and geography. The population today is 3.3 million, making it California's second-most populous county and the fifth-most populous in the United States. It is home to 18 Native American Tribal reservations, the most of any county in the United States, and 16 military installations. The county contains the busiest land-based port of entry in the world along the Mexico border and is uniquely bi-national.

In 1997, the county's size and diversity contributed to a decision by the Board of Supervisors to create six geographic regions by which Health and Human Services Agency (HHSA) would deliver services *(Figure 2).* The idea was to enable County government to better meet the needs of the county's varied communities. By 2010, a leadership team was formed in each region to help facilitate community-building and decision-making.

HHSA has evolved along with the rest of the County of San Diego over the years to meet new demands. *Live Well San Diego* is the collective initiative effort adopted by the Board of Supervisors, in 2010, and represents the shared vision that guides all County departments and partners. The regions have played a major part in *Live Well San Diego*, representing action on the ground through the *Live Well San Diego* regional leadership teams, called Community Leadership Teams (CLTs).

As part of the pandemic response, *Live Well San Diego* was an enormous benefit, providing a platform to enlist and engage partners in COVID-19 testing and vaccinations, contact tracing, and other activities, with continuous communications conducted through telebriefings organized by sector—referring to community and faith-based organizations, business and healthcare, education, and government—and even subsectors such as child care services, long-term facilities, and residential care facilities.

Figure 2: HHSA Service Delivery Regions



Source: [Community Leadership Teams | Live Well San Diego (livewellsd.org)]

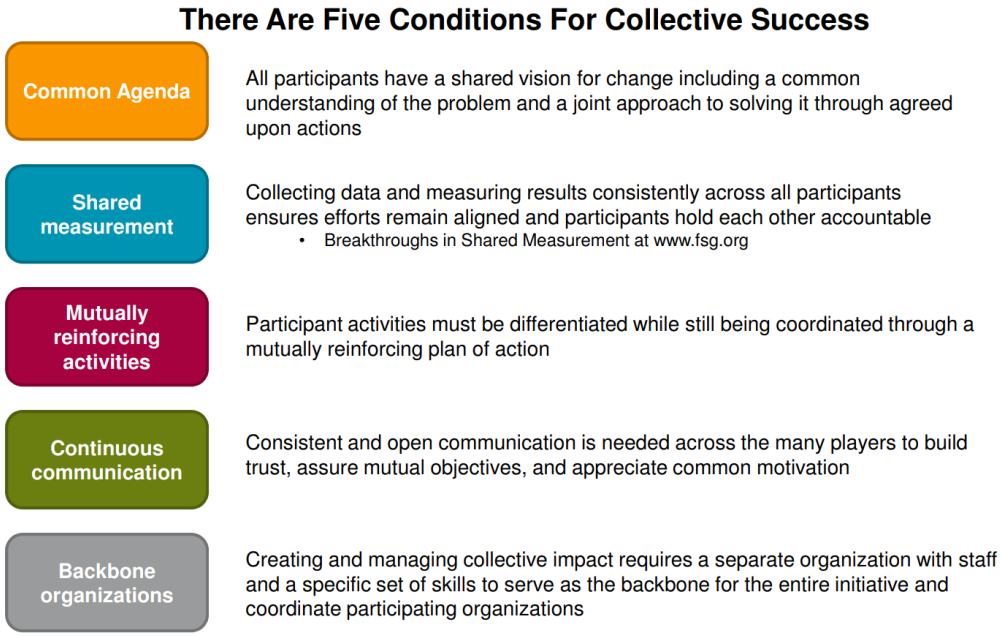
Coming out of the pandemic, the new department (HSEqC) and office (OEqC) focus was on enhancing community engagement and collaboration to meet needs of underserved communities and serve as the primary contact for partners to access integrated efforts across the County enterprise. After a hiatus during the pandemic, the CLTs were re-started and reinvigorated in early 2022. Regional community coordinators were hired for their experience in community engagement. New chairs and co-chairs for the CLTs assumed leadership roles. Community engagement staff within OEqC were tasked with supporting the CLTs in their review of community data as well as in the process of identifying priorities and developing the CHIP (referred to as CEPs). Public Health Services continued to provide technical support as it had done in previous planning cycles.

Overview of Methodologies Applied

The County of San Diego has creatively applied a mix of methodologies to generate CEPs that reflect priorities of the community leaders participating in the CLTs; leverage resources both internally within the County enterprise and externally with all partners; and put forth actionable objectives that will be monitored so that progress can be shared and discussed, and results demonstrated. The CEPs are designed to enable the County and the CLTs to share stories of their work and their contributions to their communities.

The overall methodology followed to build the *Live Well San Diego* CHIP and the Regional CEPs is collective impact. The Regional CEPs, which together comprise the countywide CHIP, represent planned activities to advance a "common agenda" represented by *Live Well San Diego* at the local level *(Figure 3).*

Figure 3: Collective Impact Model



Source: FSG at www.fsg.org and Stanford Social Innovation Review at ssir.org

In addition to collective impact, several other methodologies are applicable to this planning effort. These include the community planning process MAPP, which has already been referenced. This is a widely accepted community planning process used by many nationally accredited public health departments, including the County of San Diego. In addition to MAPP, the Communities for Excellence model is also being followed in the South Region; South Region was selected as a pilot in 2017 and continues to test and apply this approach. The Communities for Excellence is a systematic approach to excellence in communities that is based on the Malcolm Baldrige Framework. Both MAPP and Communities for Excellence are complementary methods, and are similarly rigorous and comprehensive, well suited to capturing the expanding *Live Well San Diego* collective impact effort.

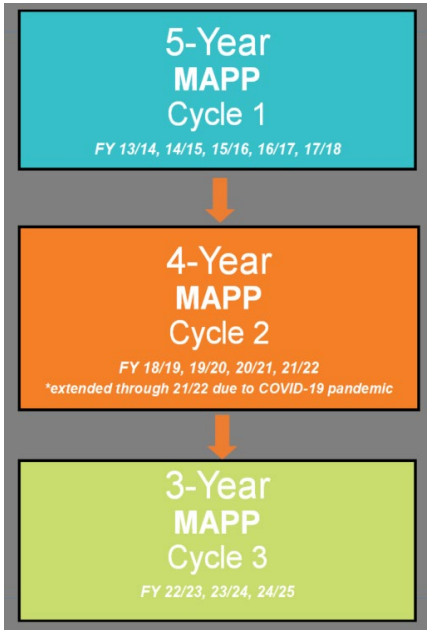
Finally, Results-Based Accountability (RBA) is another methodology applied, guiding how progress is tracked. RBA is a disciplined approach for communities to identify outcomes or positive changes to aspire to, and then committing to action and measuring progress at the program level, in the short-term, and the population level, in the long-term.

Descriptions of all methodologies are expanded upon in *Section 2: Methodology and Alignment.*

Building the Regional Community Enrichment Plans

This CHIP is the product of the 3rd MAPP cycle conducted in San Diego County. The 1st Cycle was a five-year cycle from FY 13-14 to FY 17-18. The Public Health Officer decided that the planning cycles should be shortened from five to three years so that the County could be more responsive to changes in the environment in its planning efforts. The 2nd cycle was intended to be a 3-year cycle; however, with the interruption of the COVID-19 pandemic, it was extended one year by the accrediting body to four years from FY 18-19 to FY 20-21 with the additional year of FY 21-22. During this 3rd MAPP cycle of FY 23-25, we have undertaken vigorous community assessment and planning activities that have led to the creation of a CHIP, comprised of CEPs that get closer to the vision and will of the community because they are created through the CLTs. *Figure 4.*

Figure 4: County of San Diego Community Planning Cycles



Source: County of San Diego, Public Health Services

The CLTs serve as the "voice" of the community. They are comprised of community leaders from every sector who meet regularly, often monthly, to discuss community concerns, build networks, and consider what actions they want to take to improve the health and well-being of residents within their communities.

During this 3rd Cycle, the CLTs showed great interest in data and were eager to learn about new issues or concerns revealed through discussion of the data. The regional community data presentations delivered to each CLT by the PHS Community Health Statistics Unit were well received. In some cases, multiple presentations were provided, and follow-up data was prepared to be responsive to many questions raised by CLT members. The content of the CEPs reflects the passion and commitment of each of the Leadership Teams as they took on issues of concern in a post-pandemic environment. The pandemic elevated concerns about equity and exposed new priorities related to the lack of affordability of housing, which is contributing to homelessness and is a major cause of economic insecurity; behavioral health concerns, particularly for youth, some of whom suffered with the isolation related to COVID-19 restrictions and closure of schools; and income and food insecurity. These concerns all fall under the umbrella of *Live Well San Diego* and reflect a deeper understanding and attention to social determinants of health.

Through a facilitated process over multiple meetings, each CLTs selected priorities based on community data presented at these regional community data presentations. Ultimately, key community or population indicators associated with each priority were selected, reflecting their concerns for the community. Then the CLTs were assisted in creating objectives and action steps that are community-led and that could reasonably be implemented by the CLTs and their partners. Because action on the ground can seem far removed from impact on the community, it is important that the strategies and objectives identified have some basis in research or practice. This information is woven into the narrative of the CEP, along with other elements that help to "tell the story" of community change, and monitor progress in the implementation of the CEP.

More on these efforts to develop the regional CEPs appears in *Section 3: Building the Community Enrichment Plans.*

SECTION 3: METHODOLOGY AND ALIGNMENT

Overview: San Diego County has creatively applied a mix of methodologies to generate Community Enrichment Plans (CEPs) that reflect the priorities of the community leaders participating in the Community Leadership Teams (CLTs). This section describes the Collective Impact approach (connecting action to impact), and how specific community planning methodologies are applied including Mobilizing for Action through Planning and Partnership (MAPP) and the Malcolm Baldrige Communities of Excellence. Results-based accountability is also reflected in how performance data is used, and progress tracked. Also, the importance of aligning priorities at the County, Agency, and departmental levels to leverage all available resources is explained, and how the overall approach meets the requirements of public health accreditation.

Live Well San Diego as a Collective Impact Effort

The overall methodology followed to build the *Live Well San Diego* Community Health Improvement Plan (CHIP) and the Regional CEPs is collective impact. The development of regional CEPs that comprise the CHIP is fundamental to the *Live Well San Diego* vision, a collective impact effort of the County of San Diego. *Live Well San Diego* engages over 550 partners across every sector, along with the entire County enterprise, with everyone working together to improve the health and well-being of our residents. Approved by the County Board of Supervisors (Board) in 2010, *Live Well San Diego* has three main components—Building Better Health, Living Safely, and Thriving. The framework of *Live Well San Diego* is reflected in the Pyramid to the right *(Figure 5)*

.

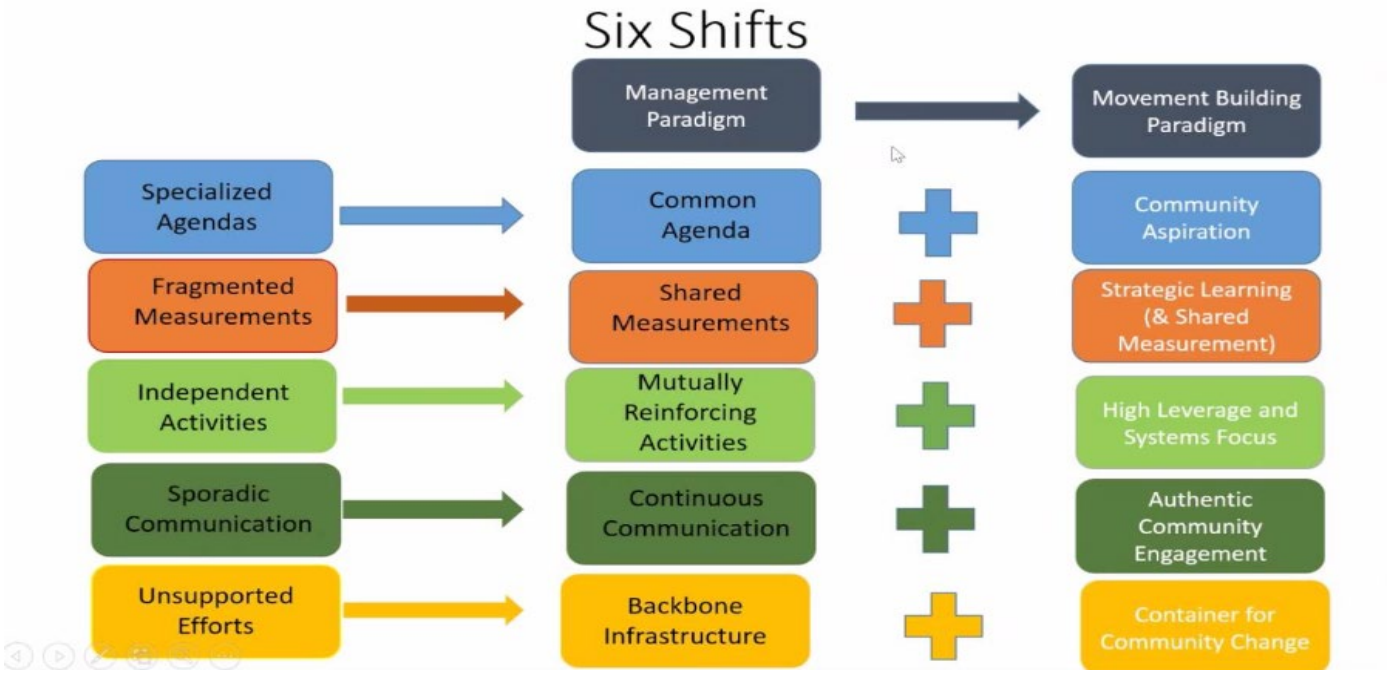
The Regional CEPs represent action on the ground to advance the vision of *Live Well San Diego.* Together, these five CEPs roll up into the County-wide CHIP. The CEPs represent planned activities to advance a shared vision represented by *Live Well San Diego* at the local level. A "common agenda" is one of the conditions of collective impact. Consistent with the "mutually reinforcing activities" condition of collective impact, these plans reflect an approach tailored to the needs and priorities of individual communities from the perspective of the CLTs *(Figure 5)* The roles of the various partners are differentiated, in that partners draw upon their own assets and capacities, but in a coordinated fashion as the CEP represents. As a 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." This planning cycle reflect an emphasis on priorities that speak to social determinants of health, such as housing and income security, which were among the priorities selected.

Figure 5: Live Well San Diego Pyramid.

Source: Data & Indicators at https://www.livewellsd.org/

This collective impact methodology is evolving and is now referred to as Collective Impact (CI) 3.0 *(Figure 6)*. The process that was undertaken to develop the CEPs and to begin their implementation reflects the movement-building approach of the Collective Impact 3.0 framework. This adapted framework was developed in 2015 by the Tamarack Institute, building upon the initial 2011 collective impact framework. Activities and community engagement that distinguished the Community Health Assessment (CHA) and the CHIP this planning cycle reflect the evolution of collective action and align with the five conditions of movement-building. These include community aspiration, strategic learning, high-leverage activities, authentic community engagement, and containers for change, the latter referring to the "backbone" organization (which is the County of San Diego for the *Live Well San Diego* collective impact effort) assisting partners in new ways to facilitate change. Overall, the CEPs reflect this shift from a management paradigm to a movement building paradigm to advance community change.

Figure 6: Collective Impact 3.0 Framework.



Source: Tamarack Institute, September 2016.

Mobilizing for Action through Planning and Partnership

In addition to collective impact, the community planning process called Mobilizing for Action through Planning and Partnership (MAPP) is adhered to. This is a widely accepted community planning process used by many nationally accredited public health departments, including the County of San Diego, and developed by the National Association of County & City Health Officials. *Figure 7* shows the components of MAPP.

Figure 7: Mobilizing for Action through Planning and Partnership

Source: National Association for County and City Health Officials

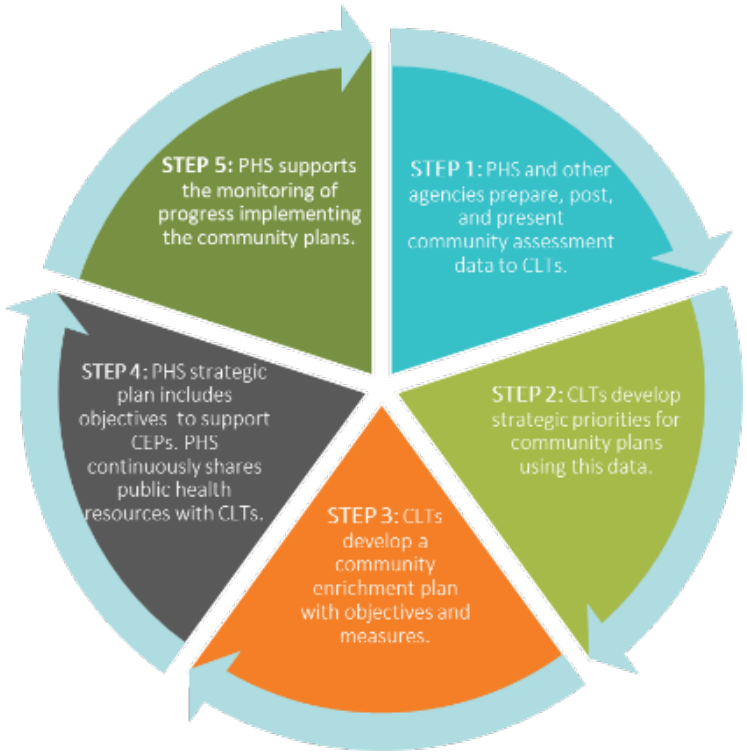
MAPP includes four assessments, which are depicted along the perimeter of the circle, and the process for engaging partners to produce plans, which is captured in the center of the circle. Although not specified here, these plans include a strategic plan for the public health department and a community plan (which is the CHIP). A survey was the approach used to collect primary data for the **Forces of Change Assessment** and **Community Themes & Strengths Assessment**, and the CLTs were the participants in this survey. The same survey helped to identify key concerns of each of the regional CLTs, which ultimately informed the selection of the three Priorities for each of the respective CEPs.

The **Local Public Health System Assessment** (LPHSA), another important source of primary data, have been conducted through formal events. The latest in 2020 was in a virtual format due to the COVID-19 pandemic. The LPHSA has proved to be a successful method for gathering invaluable qualitative data from numerous individuals across sectors on the strength of the system and its partners.

The **Community Health Status Assessment** includes a rich array of mostly quantitative data, collected through secondary sources, regarding the health and well-being of County residents. The associated product is the *FY 2023-25 Community Health Assessment*, issued in Summer of 2024, for the first time in the format of a dashboard to make it easier to keep updated and accessible to the public, in addition to the traditional report format.

These four MAPP assessments inform the CEPs, which together, as previously explained, roll up into the County-wide CHIP. There are five CLTs, and five corresponding CEPs, for the six Health and Human Services Agency (HHSA) regions, since North Coastal and North Inland are combined for this purpose. "Enrichment" is in the name of the CEPs to reflect that these plans recognize the importance of the social determinants of health that affect outcomes across all three components of *Live Well San Diego,* including Building Better Health, Living Safely, and Thriving.

Figure 8: Key Steps to Developing Regional Community Enrichment Plans



Source: County of San Diego, Public Health Services, Office of Performance and Improvement Management

Importantly, these assessments also inform the development of the Public Health Strategic Plan. The *FY 2023-25 Public Health Services Strategic Plan* is comprised of health equity and population goals by Branch, as well as measurable objectives and targets. The PHS Strategic Plan also includes objectives that align with the CEPs or CHIP because it is important that the department supports the community whenever possible in its efforts to implement the CEPs, particularly in the areas of chronic disease prevention; nutrition insecurity; and other policy, systems, and environmental change efforts in which PHS involvement can be important.

Continuous and Evolving Approach

The MAPP model is a continuous process. The CHA and CHIP are to be continuously refreshed and the respective documents issued on a regular annual cycle. San Diego has opted for a three-year cycle for the issuance of the formal CHA and CHIP documents. The steps that are part of this continuous process are depicted in *Figure 8*.

The CHA involves ongoing community collaboration and sharing of data with the CLTs and other community groups through data presentations by the Community Health Statistics Unit of PHS. Other experts and partners also share their data with the CLTs upon invitation. This is reflected in Step 1.

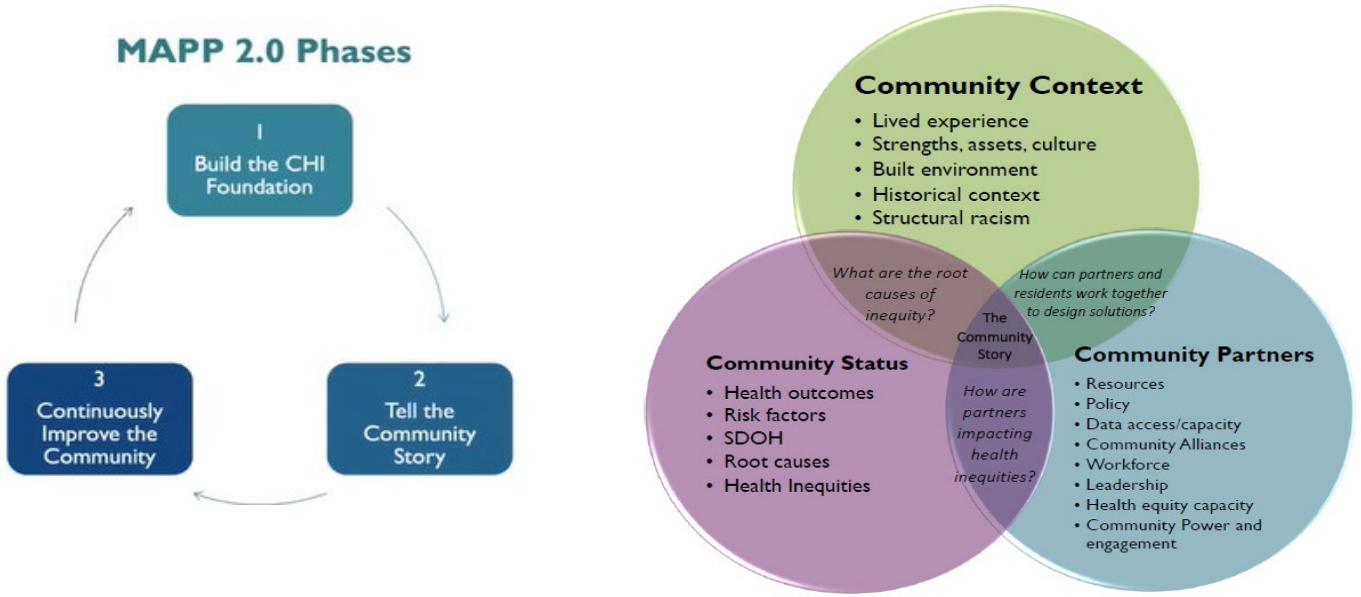
Community assessment data is used by the CLTs to develop their strategic priorities and ultimately their CEPs with goals and objectives, as shown in Step 2 and 3. This is achieved through active engagement and facilitation, supported by the Office of Equitable Communities (OEqC) and with technical assistance from PHS. PHS shares its resources to help the CLTs implement their CEPs, and the CLTs also leverage the resources of other County departments and partners, as Step 4 shows. Step 5 indicates that PHS in turn supports the monitoring the implementation of these community plans.

New MAPP 2.0 Model to Influence New Cycle of CHA and CHIP

Just as the approach is continuous, the MAPP model itself has evolved and is now referred to as MAPP 2.0. This new model will be followed during the next three-year planning cycle (FY 2026-28). The revision to the MAPP model is intended to enable health departments to be better positioned to communicate their achievements through storytelling, using quantitative and qualitative data. The new MAPP model also reflects an emphasis for continuous improvement through application of quality improvement approaches to community interventions. The assessments called for may be considered more extensive, as depicted in *Figure 9*. The County is already making plans to adapt its approach to reflect this new model.

However, while the Local Public Health Systems Assessment is no longer a recommended assessment in this new MAPP model, the County will likely continue to conduct a LPHSA because this assessment has provided very useful qualitative data on the perceived strengths and weaknesses of the public health system. Another important change for the next MAPP cycle (FY 2026-28) is that the County will coordinate with the Medi-Cal managed care plans in the development of the CHA and CHIP. This is due to State guidance that all parties should work together in population health and community planning to reduce duplication of efforts and to expand data sharing and participation across all assessments.

Figure 9: Mobilizing for Action through Planning and Partnership 2.0



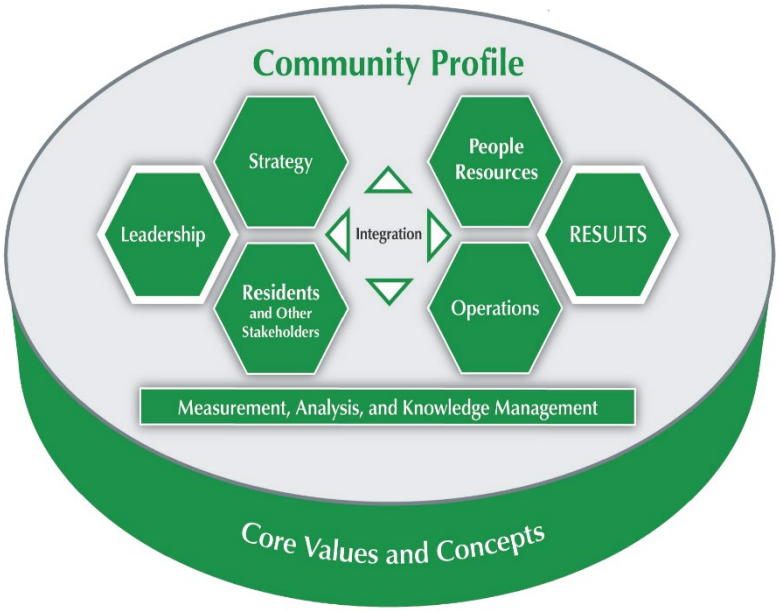
Source: National Association of County & City Health Officials (NACCHO)

The Local Public Health System Assessment will continue to be conducted in San Diego County.

Communities of Excellence, Malcolm Baldrige

In addition to MAPP, the Communities for Excellence (CoE) model is also being followed. This model is adapted from the Malcolm Baldrige Excellence Framework, which helps organizations improve their competitiveness through a non-prescriptive, systems framework. The CoE model applies similar concepts to communities, emerging out of the recognition that addressing the challenges communities face today requires a high level of commitment among leaders across sectors and generations and the adoption of a systems approach to improving conditions, outcomes, and resilience of these communities.

Figure 10: Communities of Excellence Framework



Source: Baldrige Performance Excellence Program, [Home: Communities of Excellence 2026]

Both MAPP and CoE are complementary methods, and both methods are a good fit with the expanding *Live Well San Diego* collective impact effort. As early as 2017, South Region was one of two pilot community sites for CoE; today there are 26 communities participating. The framework reflects the development of a robust community profile, the clarification of core values and concepts, and the integration of every aspect of the community to bear on results that the community seeks. For South Region, this approach provided additional depth and rigor to their leadership and community building efforts (*Figure 10*).

San Diego County was asked to pilot the CoE framework in South Region because of the County's success in the application of Baldrige Criteria for Performance Excellence to HHSA. In December 2017, the HHSA received the California Award for Performance Excellence (CAPE) – Eureka Silver Level, a recognition that very few local governments have achieved. The CAPE Eureka Award process is modeled after the Malcolm Baldrige National Quality Award in which performance is assessed across all seven criteria for performance excellence. HHSA continues to apply Baldrige standards to strategies and practices throughout the organization to improve services to its customers and remains involved in the CoE effort within South Region to see if this type of approach will enhance its community building activities.

Results-Based Accountability as Measurement Method for Collective Impact

Finally, Results-Based Accountability (RBA) is another methodology applied, guiding how progress is tracked. RBA is a disciplined way for communities to identify outcomes or positive change to which aspire, and then committing to action and measuring progress at the program level to bring about this change. In essence, two levels of accountability area are established—the first at the population level, the second at the program performance level.

In the case of the CEPs, the program accountability could also be referred to as accountability for community action. RBA is closely adhered to by identifying population indicators and developing shared goals, objectives, and performance measures of community activities or initiatives that are included in each of the CEPs. Public Health Services procured an automated performance tracking system to help ensure the sharing of progress information and accountability.

More detail on RBA is provided *Section 5: Monitoring Progress for Community Change.*

Alignment and Why Important

New County and Agency Priorities in Post-Pandemic Environment

Aligning priorities across the County, Agency, and with the community is critically important. It is the best way to leverage limited resources. One of the most important benefits of having a collective impact effort like *Live Well San Diego* is that we can all come together with a shared vision, and through mutually reinforcing activities, improve the health and well-being of all residents.

Chronic disease prevention inspired the launch of *Live Well San Diego*. However, new issues have emerged from the COVID-19

andemic that are shaping the County's approach, such as equity, justice, sustainability, and the importance of engaging with the community. The Board of Supervisors (Board) recognized the need to reorient the County, and while accountability to taxpayers remains critical, ensuring that services are centered on the needs of the community was elevated. This shift inspired the revision of the County's operating manual, referred to as the General Management System (GMS) *(Figure 11).* The GMS has been credited with helping the enterprise maintain strong financial and operational systems. Now, at the core of the GMS is "Community Engagement," based on the principle that "all that we do should be for, and created in partnership with, the people we serve." The outer ring is new to the GMS model; it captures the core values of the County—integrity, equity, access, belonging, excellence, and sustainability. The GMS has five elements, which is like the original GMS model, but with a few important adjustments. These five elements are: strategic planning, operational planning, evaluation & accountability, continuous collaboration, and employee investment & satisfaction. Changes to these elements reflect new attention toward outcomes, collaboration, and investment in the workforce. All Groups within the County, including HHSA, follow the GMS, participate in the annual planning process, and align their activities with the County's new Strategic Plan.

Figure 11: County of San Diego General Management System Reimagined, 2021.

Source: CAO Recommended Operational Plan FY 2022-23 and 2023-24, Introduction.

In addition to the reimagined GMS, a new County Strategic Plan was adopted that includes five new Strategic Initiatives: sustainability, equity, community, justice, and empower. Subsequently, the HHSA revisited its Strategic Plan to be in alignment with the new County Strategic Plan. This Agency Strategic Plan is referred to as the "Agency Promise." It includes six Strategic Initiatives *(Figure 12).* Each department is expected to identify objectives and measures that directly align with these Initiatives, as an important way to ensure

that these Initiatives reach down into individual departments. The figure below shows the "Agency Promise" Initiatives on top, as they align to the County Initiatives below.

Figure 12: Strategic Initiatives Alignment: Six Agency Initiatives (top) that directly support five County Strategic Initiatives (bottom).

Source: 2022-24 HHSA Strategic Plan, also referred to as the "Agency Promise."

Community voices after the pandemic drove these changes in priorities across the County and Agency. Unsurprisingly, these same issues "bubbled up" or emerged at the CLT meetings. As a result of regional data presentations provided by the PHS Community Health Statistics Unit, and follow-up surveys and discussion among members of each of the five CLTs, priorities for their respective CEPs were a bit different from the past. In the previous planning cycle, chronic disease prevention and more traditional health concerns played a bigger part, with some attention to the social determinants of health. This planning cycle, the social determinants of health were of an even greater emphasis. Housing and homelessness; behavioral health issues, particularly among the youth; and income and food insecurity were the priorities shared across all the CLTs.

More information on the priorities by region can be found in *Section 4: Building the Community Enrichment Plans.*

Maintaining Conformance to Accreditation Requirements

A comprehensive planning process was followed in the development of the County-wide CHIP and regional CEPs. This process conforms with national public health accreditation requirements of the Public Health Accreditation Board (PHAB), the accrediting organization for public health departments. Public Health Services (PHS) was accredited, in May 2016, and reaccredited in August 2023. PHS is committed to adhering to PHAB reaccreditation standards, which is framed by the Ten Essential Public Health Services and Foundational Public Health Services and reflects input from experts on the future of public health. The requirements are captured in *Figure 13* below:

Figure 13: Reaccreditation Requirements for CHIP Development

Accreditation requirements for community planning specify that the County must adopt a CHIP with:

- At least two or more health priorities to be addressed collaboratively.
- One or more measurable objectives(s) for each of the health priorities.
- Improvements strategies and activities that are evidence-based, practice-based, promising practices or may be innovative to meet the needs of the population.
    - Each activity or strategy must include a timeframe and a designation of organizations that have accepted responsibility for implementing it.
    - At least two of the strategies or activities must include a policy recommendation, one of which must be aimed at alleviating causes of health inequities.
- Assets or resources that will be used to address at least one of the specific priority areas.
- Description of the process used to track the status of the effort or results of the actions taken to implement strategies or activities.

Source: Standards & Measures for Reaccreditation, Version 2022., Public Health Accreditation Board.
5.2 Develop and Implement Community Health Improvement Strategies Collaboratively. The language for 5.2.1.A for adopting a CHIP has been abbreviated.

This San Diego County CHIP fulfills all standards for 5.2.1 A "Adopt a Community Health Improvement Plan." This CHIP includes five individual Community Enrichment Plans by region, each of which contains three Priorities. This means there are 15 Priorities being addressed across the County through this process. Measurement is at multiple levels. Key population indicators are identified for each Priority, and at least one performance measure is assigned to each of the several objectives for each goal. This ensures tracking of and accountability for actions taken to implement these CEPs, as detailed in *Section 6: Monitoring Progress for Community Change*. There are four strategic approaches (based on research and best practice) that were adopted as part of *Live Well San Diego*. These four strategic approaches, as well as more specific supporting evidence or research behind the strategies and actions, are described within the CEPs themselves, and more fully in *Section 7: The Basis for Action*.

All CEPs objectives have a timeframe that is consistent with the three-year planning cycle. This CHIP is late in its publication, so each Regional CLT is already implementing these objectives. The intention is that the objectives would be completed by the end of FY 2024-25 (the last year of this planning cycle) unless otherwise specified. Much of the content of the CEPs reflects the *Live Well San Diego* strategic approaches referenced above: to *build a better service delivery system* for residents and *to support residents in making positive choices* to improve their health and well-being. For example, compiling resources; linking residents to services; conducting resource fairs; and offering workshops are the types of activities that are captured in CEP objectives. But there are also strategies that reflect *pursuit of policy, systems, and environmental change efforts*. Several strategies explicitly reflect policy recommendations—for example, Central Region has a "Housing for All" Policy that calls for partners to work collaboratively as a network to expand homeless outreach and advocacy.

SECTION 4: BUILDING THE COMMUNITY ENRICHMENT PLANS

Overview: The many steps involved in developing the Community Enrichment Plans (CEPs) are described, beginning with Community Health Status Assessment data gathered, presented, and discussed with the Community Leadership Teams (CLTs) to identify priorities. This was followed by the deliberate and phased facilitation process that was undertaken to help each CLT reach consensus on goals and objectives for each of their three priorities. The structure that was developed to capture the CEPs and how population indicators and performance measures are tied together with a narrative or story is also explained in this section.

Developing Priorities by Regional Community Leadership Team

Regional Data Presentations

The first step in the community planning process was to help each of the five regional CLTs identify their priorities. The building of the CEPs began when annual regional data presentations were delivered to the CLTs from January to March of 2022.

These regional data presentations mark the beginning of the three-year planning cycle (FY 2023-25) when the CLTs were reconstituted in 2022 after the COVID-19 pandemic. The CLTs began meeting again and re-started their planning efforts. The community engagement activity in the regions, including support to the CLTs, was now under the Office of Equitable Communities (OEqC), within the new Department of Homeless Solutions and Equitable Communities. Public Health Services (PHS) provided data, planning, and performance management support.

The Community Health Statistics Unit (CHSU), part of PHS, delivered these presentations virtually given barriers to in-person meetings due to the COVID-19 pandemic. These in-depth presentations covered health statistics, including, mortality and morbidity data for specific populations, health conditions, and behaviors. These data were presented alongside demographic data including social determinants of health (SDOH) such as income, educational attainment, and access to healthcare. Data were also presented through a health equity lens whenever feasible, most specifically by geography since the CLTs were focused on concerns and issues with their

communities. Resources such as the Community Profiles and Racial Equity Dashboard were also presented to the CLTs for additional information.

In addition to CHSU, other expert speakers were engaged at each of the CLTs to share perspectives. Some of these experts were among the CLT members. Regional community coordinators and OEqC staff facilitated discussions over several meetings to frame priorities. CHSU would also provide follow up data to assist CLTs as they continued these dialogues.

As part of the Mobilizing for Action through Planning and Partnerships (MAPP) Community Health Status Assessment process, community themes, strengths, and forces of change assessments were conducted. A short survey was designed and administered by PHS to capture data in some of these assessments. The survey was administered immediately after the regional data presentations, from January to March 2022, so that leaders had fresh information and data about conditions within in their individual region. This survey included several questions:

1. Which social determinants of health were having the greatest impact on their communities;
2. What were the top 10 priorities affecting the health and well-being of communities within an individual region, and;
3. What strategies held the greatest promise for each of the 10 top priorities identified.

The key social determinants of health that CLTs selected as having the biggest impact were economic instability, lack of resources, the impact of COVID-19, and unhealthy behaviors (dietary choices and substance abuse). For priority issues, each of the CLT respondents selected the same three priorities as the top issues. These are **housing and homelessness, behavioral health, and economic and food insecurity.** Socio-economic status, and drug and alcohol use disorders also appear to be near the top issues of concerns. While chronic disease remains a top priority among regions, the focus has been shifting in the last few years to addressing social determinants of health contributing to chronic disease.

Ultimately, three priorities emerged from each CLT *(Table 1).* There was remarkable consistency in priorities across all regions.

Table 1: Common Themes that Emerged Across Regions from Community Health Status Assessment

Common Themes Across Regions:

Housing and Homelessness, Behavioral Health, Economic and Food Insecurity

Region	THREE PRIORITIES		
South	Homelessness	Behavioral Health	Food Insecurity
East	Thriving and Inclusive Communities	Behavioral Health Solutions: Prevention and Early Intervention	Resilient Youth and Families
Central	Housing for All	Health and Wellbeing	Education and Economic Development
North Central	Food and Housing Insecurity	Behavioral Health	Youth
North County (Coastal and Inland)	Homelessness	Mental Health	Substance Abuse

Source: Office of Equitable Communities on behalf of Community Leadership Teams

Engaging the Leadership Teams to Develop CEP Content

The Health and Human Services Agency (HHSA), through the leadership of Public Health Services (PHS), continues to innovate in designing and facilitating the planning and engagement processes for the CEPs that are community-driven, data-driven, and outcomes-focused. The planning and engagement process for the CEP is a strong representation of how a planning framework can be applied within local communities on their terms to define public health needs, priorities, and actions through community-based partnerships.

Developing a community-driven CEP that effectively represents the diverse communities and public health needs of this county requires active engagement of community-based organizations that are "on the ground." These are trusted and knowledgeable health and social service providers, many of which are contracted service providers for HHSA. Along with PHS' expertise and community relationships, HHSA's efforts to collaborate with these partners is led by the OEqC in the Department of Homeless Solutions and Equitable Communities (HSEqC).

OEqC is focused on enhancing community engagement and collaborating and devoting efforts to meet the needs of underserved communities with a focus on embracing diversity, social and health equity, economic inclusion, and poverty reduction. OEqC provides dedicated staff to collaborate with each community to create positive change and serve as the primary community contact for partners to access integrated efforts across the County enterprise. OEqC ensures equity among all San Diegans using a regional model to enhance community engagement and meet the needs of underserved communities. A primary venue for engaging community-based organizations and partners is through CLTs, which are organized by five geographic regions: Central, East, North, North Central, North County, and South. North County Regions CLT is a combination of North Coastal and North Inland Regions as these regions are combined administratively.

To effectively engage the CLT's, PHS collaborated with OEqC to design and conduct a planning and engagement process that supported developing a CEP for each of the five regions. While the over-arching process focused on developing plans in the CEP framework, PHS worked with OEqC and each of the five CLTs to ensure their engagement methods and activities reflected each CLT's unique priorities, norms, culture, expectations, and similar considerations. The resulting five CEPs are reflections of each CLT and their communities.

Planning and Engagement Objectives

In designing the planning and engagement process, PHS and OEqC defined the following objectives to guide and focus their efforts. While each CLT employed unique methods and activities, ultimately their efforts aimed to achieve these objectives.

- **Apply the CEP framework in a collaborative, tailored engagement process.** While the CEP framework provides the organizing structure, *how* each CLT develops the priorities, goals, objectives, actions, and metrics should be done in relevant and meaningful ways to its context and culture as a team and community.
- **Co-design the planning and engagement process with the community.** Each CLT includes Co-Chairs that are representatives of local community-based organizations and partners that work closely with OEqC staff in planning and coordinating CLT meetings and activities. Regional Community Coordinators, who are OEqC staff hired for their community engagement experience, also serve as Co-Chairs to each CLT. Fostering shared leadership is critical to developing a collaborative approach for the CEP.
- **Be data-driven and leverage existing strengths, assets, and resources.** PHS and HHSA maintain and track a wealth of community health data that are foundational to define shared understandings of public health conditions and to make prevention and intervention investments. Local community-based organizations and the CLTs have deep experience in serving their communities and are very knowledgeable about local strengths, assets, and resources. Collectively, these data and knowledge must be organized, shared, and understood to inform strategic and practical decisions for the community's future.
- **Define CEP priorities and goals from local needs and desired outcomes.** While many communities share some priorities (e.g., mental health and homelessness,) there should not be a "copy and paste" approach in defining priorities and goals. Each region's unique context, conditions, and needs that define their priorities should be respected and reflected in their CEP.
- **Create objectives and action steps that are community-led and implementable.** Ensuring that PHS and community partners are collaborative in both planning and implementation requires creating objectives and action steps that have clearly defined timelines, roles and responsibilities, and resource requirements. Community partners should be empowered to lead this process in defining, owning, and implementing actions, with intentional and responsive support from PHS and other HHSA entities.
- **Ensure each CEP includes metrics that track actions, outcomes, and impact.** While the development of indicators and performance measures are primarily the responsibility of PHS, both types of metrics are critical to tracking and reporting on progress. These are relevant not just to show progress on action steps, but most importantly in generating results as revealed

by indicators of public health improvements and community impacts. Additionally, defining measures that are accessible, trackable, and meaningful contribute to sustaining community partners' commitment to ongoing implementation and future planning in the long-term.

Framing and Organizing the Engagement Effort

With the CEP framework providing the organizing structure for defining priorities, goals, objectives, actions, and metrics, the following key questions provided the basis for framing discussions and input with CLT members. Each CLT applied varying versions of these questions, tailored to their specific context.

- What does public health data from our local communities suggest are major priority areas? How do your experiences in delivering health and social services to communities in need reflect these data?
- In defining goals for a priority area, what are major outcomes that you believe should drive our collective efforts?
- To achieve a specific goal, what are substantive milestones, achievements, and changes in community conditions that will reflect progress and meaningful impact?
- What action steps will be required to achieve a specific objective? What assets can we best leverage to make progress toward an objective? What organization(s) would be best to lead a given action step, and are other organizations needed in support roles? What is a reasonable timeframe to complete each action step?

Generally, the CLTs convene monthly as full leadership teams. Some CLTs also have working groups that convene in additional monthly meetings, with each focused on one of the priority areas. Most CEP engagement methods and activities occurred as part of these meetings, primarily in-person and some in virtual or videoconference formats.

The following are specific engagement methods and activities that occurred as part of developing the CEPs. Some CLT meetings included multiple methods or activities to ensure objectives were achieved.

Planning Meetings with CLT Co-Chairs

Prior to each CLT meeting, PHS and OEqC team members and the Co-Chairs convened in planning meetings to review progress in CEP development, define the objectives for the next CLT meeting, and design the agenda and activities. Typically, PHS and OEqC team members developed initial recommendations for the objectives, agenda, presentation materials, and engagement activities for further development with the Co-Chairs. The planning meetings also ensured that the Co-Chairs could define their preferred roles and responsibilities as part of facilitating engagement activities in the CLT meetings.

Small Group Discussions

With most CLT meetings typically involving 40-to-80 participants, small group discussion formats allowed for closer discussions and ideas sharing. Additionally, depending upon a meeting's objectives and discussion topics, small group discussion topics were either the same or unique to every group. Flexible meeting design allowed for more small groups to occur if a high number of participants wanted to focus on a specific topic. Co-Chairs, PHS, and OEqC team members served as small group facilitators and used a facilitation guide designed for each meeting. Additional team members served as note-takers via laptop, notepad, or flipchart to ensure documentation of all participants' comments.

Working Group Discussions

As previously noted, all CLTs include working groups organized by their CEP priority areas. Some of these working groups are long-standing within some CLTs, while others are more recently organized. Participants are encouraged to join a working group and priority area for which they believe they can add the greatest value and support in planning and implementation. Some full CLT meetings included dedicated time for working group discussions, while some CLTs conduct separate and regular meetings outside of the full meetings. No matter their format, working group discussions contributed to in-depth discussion and CEP development within each of the priority areas, particularly in defining objectives and action steps, and after the CEPs are in place, for monitoring implementation.

Large Group Discussions

The large group discussion format served multiple purposes. Frequently, a large group discussion followed small or working group discussions during CLT meetings, allowing participants to share summaries of outcomes and progress from small groups to the full membership. This helped all participants to keep abreast of progress across the priority areas, and to identify any opportunities for closer collaboration and resource-sharing. The large group format also allowed participants to introduce themselves to each other and make announcements about important community health events and developments in their community. Additionally, this format

allowed for interactive polling exercises, presentations from subject matter experts and guest speakers, and follow-up Q&A and discussions.

Interactive Polling

The use of interactive polling tools assisted the CLT's in multiple ways. These tools are typically web-based programs that allow the meeting facilitators to design and pose a range of question types including multiple choice, short answer, open-ended, ranking, and prioritization. Participants log-on to the web-based software from their smartphone, tablet, or laptop to respond to questions. Interactive polling assisted in collecting real-time input from CLT meeting participants and allowed for immediate viewing of the input and results. Meeting facilitators typically used these real-time results to facilitate additional discussion among participants to learn more about their input, choices, and priorities. The polling software collected data for PHS and OEqC to download and incorporate into the meeting summary reports and emerging CEP priorities and objectives. The highly interactive nature and transparency of these polling tools contribute to building participants' confidence that their input is collected and incorporated into developing the CEP.

Presentations and Q&A with Subject Matter Experts

Most CLTs regularly invite subject matter experts to deliver presentations on local programs, services, or initiatives that relate to the regional CLT priority areas. These presentations proved to be useful in spurring additional ideas on how to leverage local assets and resources as part of their CEP development. For example, epidemiologists from the PHS CHSU delivered presentations to each of the CLTs at their regular meetings, providing a wealth of community health data countywide and specific to their region. These presentations included focused sections on each CLT's priority areas to further inform community needs. After the presentations, the CLTs accessed the presentation materials and web-based databases for additional data, as needed. These CHSU presentations, referred to as regional data presentations throughout this CHIP, were key reference points for each CLT in developing their respective priorities.

Open House and World Café

Many CLT participants have expertise, ideas, and resources to offer across more than one priority area, thus can feel constrained by participating in a single working group. To remedy this, PHS and OEqC regularly employed an open house or world café to contribute to all priority areas during CEP development. An open house format allows individuals to move between "stations" to review displayed information and provide input at their pace. Similarly, the world café format organizes small groups of participants to move between the stations together in a "moving small group" format. Each successive small group reviews the preceding groups' input displayed on

posters and flipcharts and builds on their contributions. In both formats the stations are staffed by a PHS, OEqC, or a Co-Chair team member to assist participants in understanding the displayed information and encourage them to provide input directly on the posters. These formats provided all participants with multiple opportunities to engage in all priority areas to learn about the emerging CEP elements, at minimum, if not contributing their expertise, ideas, and commitments to supporting implementation.

Partner Networking and Information Sharing

CLT members in each region greatly value the ability to grow their network of community-based partnerships among other service providers and advocates with shared and mutually supportive services, programs, and initiatives. These regional CLT meetings regularly include opportunities for information sharing among members in one-on-one formats and by posting information on a "community bulletin board" in the meeting room. OEqC team members also manage a monthly e-blast to each regional CLT with these informational items.

PHS and OEqC Collaboration: Best Practices and Coordination

With five regional CLTs simultaneously developing their CEPs, there were many "moving parts" during the planning process, requiring significant coordination among project leaders. PHS and OEqC team members regularly collaborated during the process (approximately monthly) with "all hands" meetings to share their progress, lessons learned, and experiences with engagement methods and activities across the regional CLTs. Additionally, these meetings allowed for PHS to provide technical assistance to OEqC to guide their CLTs within the CEP framework. Furthermore, these opportunities to compare emerging outcomes and draft CEP elements helped PHS and OEqC to maintain fidelity to each CLT's outcomes and preferences while promoting consistency in language, level of details, and similar considerations across the CEPs. This coordination also provided time and space to consider near and long-term support and resource needs that PHS, OEqC, and other HHSA entities could provide each CLT to support CEP implementation.

Structure of the Community Enrichment Plans

The structure of the CEPs was very intentional to facilitate capturing the ideas that emerged from this robust planning effort. Also, the structure enabled CLTs to effectively track their progress and "tell a story" about their efforts to improve their communities. This structure called for each CLT to identify a positive community change that they are seeking over the long term, and then identify

objectives that some or all partners will commit to undertake in the short term to make change happen and improve their communities. In this way, the CEP structure reflects the Collective Impact and the Results-Based Accountability (RBA) methodologies.

Each regional CEP is comprised of the three priorities that their respective CLT has identified in Table 1. Each of these three priorities align with one of the three *Live Well San Diego* components of Building Better Health, Living Safely, and Thriving.

The CEP structure has five parts to it.

- The first part is "**Name of Region and Priority**," referring to background on the region, a map of the region, the priority areas, and partner organizations that play key roles as Co-Chairs. Other partners are identified within the work group or priority in which they are involved (see "Partners Taking Action" section of each CEP).

- The second part is "**Telling the Story of this Priority**." This part explains why the priority was selected, the strategy for change, and who the partners are by sector. This narrative captures how the issue became a matter of concern for the CLTs and the general approach that the CLT is adopting to address the concern.

- The third part is "**What is Our Concern?**" and includes the population indicators that are to be monitored over the long-term to gauge improvement, and information about current trends.

- The fourth part is "**What are We Doing About It?"** which captures the goals, objectives, and measures that the CLTs agreed to undertake to bring about positive community change. These objectives are typically modest, reflect what partners can do by leveraging their respective resources, capacities, and community assets.

- The fifth part is "**Monitoring,**" which includes a link to scorecards in the performance management application that track the measures by the respective priority. (There is a scorecard for each of the three priorities within the five CEPs). In addition to communicating progress, these scorecards help to provide accountability among the partners.

A Template for the CEP Appears on the Next Page (Figure 14).

Figure 14: Community Enrichment Plan Template

[NAME OF REGION] COMMUNITY ENRICHMENT PLAN
In the Regional Color

South | Central | East | North Central | North County Regions

Description of Region
Profile of Leadership Team
Three CEP Priorities
Partner Organizations Serving as Co-Chairs to the CLT and Work Groups

Map of Region

Three Sections Follow—One for Each Priority—Using Colors that Match Live Well San Diego Components:

Building Better Health, Living Safely, and Thriving.

Name of Priority

Mission and Vision for Priority *(if one created)*

Telling the Story of this Priority

Narrative that includes:

Why is this a Priority?: Explanation of key trends, data, or concerns of the CLT that led to this priority to be identified as critical.

Strategy for Change: The strategic approaches relevant to the approach adopted in the CEP are identified. These are selected from among the four *Live Well San Diego* strategic approaches, and typically more than one approach is relevant:

Building a Better Service Delivery System 

Supporting Positive Choices 

Pursuing Policy and Environmental Changes 

Improving the Culture from Within 

In addition to identifying the strategic approaches, a description of the approach is provided that reflects the specific goals and objectives within the CEP. Relevant research and evidence might be referenced but are more fully detailed in **Section 7: Basis for Action.**

Partners Taking Action: A table that presents partners who are active in advancing this Priority as part of the Work Group. Partners are identified by Sector—Community and Faith-Based Organizations, Business and Healthcare, Education, and Government.

What is our Concern?

Population Indicators: Indicators identified by the CLT and staff that capture the priority concern, by the *Live Well San Diego* Areas of Influence, with explanation of the trends of these indicators. Arrows show the direction of the trend over five years, and the color indicates the nature of the trend (Green indicates positive direction; and Red indicates negative direction). When trend data are not available, this is stated.

REGIONAL POPULATION INDICATORS THAT AFFECT THIS PRIORITY:

Population Indicators fall across the Areas of Influence. These different dimensions capture what is important for someone to "live well."

Population indicator appears here (aligned to appropriate Area of Influence)

- Explanation of trend of indicator appears here.

To the right of the indicator, an arrow indicates the direction of the five-year trend and whether on the right track (green) or if not on track (red). If no trend data available, this is indicated.

Key

Arrow depicts direction of 5-year trend	On the Right Track	Not On Track	Trend not Available

What Are We Doing About It?

All of these components below—Goals, Objectives, and Performance Measures—capture what the CLT intends to achieve through collective efforts. These are numbered sequentially to make it easier to keep track of and monitor progress.

Goal X: Aspiration or broad statement of what the CLT wants to achieve collectively in the longer term (three to five years)

Objective X.X: The change or improvement the CLT hopes to accomplish by individual or multiple partners in the shorter term (one year)

Measure X.X.X: How progress is to be measured (qualitative and quantitative target appears first).

Monitoring

This indicates that the Priority, including all associated measures, are being tracked as a scorecard within a performance management application. Progress can be seen by clicking the link provided to the priority scorecard. [LINK will appear].

Source: This template developed by County of San Diego, Public Health Services, Office of Performance and Improvement Management.

SECTION 5: THE FIVE REGIONAL COMMUNITY ENRICHMENT PLANS

Overview: The five Community Enrichment Plans (CEP) for FY 2023-25 appear in this section. The format used matches the template provided in the previous section. Each CEP is organized by the three priorities; population indicators that the CLT hopes to change for the better; and the specific goals, objectives, and performance measures. Each CEP begins with a profile of the region, the CLT, and its members.

COMMUNITY ENRICHMENT PLAN CENTRAL REGION

LETTER FROM CENTRAL REGION CO-CHAIRS

Barry Pollard

Crystal Skerven

Dear Community Partner

On behalf of the **Central Region Leadership Team (CRLT)**, we are very pleased to present the Community Enrichment Plan (CEP) for FY 2023-2025. This CEP reflects a focus on three key concerns or priorities – **Health and Well-Being**, **Housing for All**, and **Education and Economic Development**. Within this CEP, you will find the "story" about the concerns of the CRLT, community data which help explain why these topics rose to the top, and goals and objectives that reflect what the partners plan to do to make things better. The CEP also identifies the many partners who not only helped develop this plan but who will help to implement it. Progress toward implementing objectives will be monitored and shared using a performance scorecard, and indicators will help us gauge improvements at a community level.

We are so proud of this leadership team's commitment to improving the lives of residents in this region. The Central Region of San Diego County has assets and challenges. It is a highly urbanized area with many diverse communities, including Central San Diego, Mid-City, and Southeastern San Diego. Central Region is among the most economically disadvantaged regions, with the highest proportion of residents living below 100% of the federal poverty level. Given the varying needs and disparities impacting residents' overall health and well-being, Central Region community leaders are inspired to take actions to build a stronger community.

This effort to develop a new CEP began in early 2022 as this region, just like the rest of the country, was coming out of the COVID-19 pandemic. The CRLT was revitalized, and this CEP reflects fresh perspectives of its members. The County of San Diego placed new emphasis on community engagement in hiring regional community coordinators to ensure the five community leadership teams (CRLT included) were fully engaged as the "voice" for community change. This CEP is dynamic, and implementation has already begun. Priorities and goals will evolve as lessons are learned. This dynamism will help ensure that the CEP continues to be responsive to the CRLT.

Thank you for your efforts and energies to help every resident Live Well!

Sincerely,

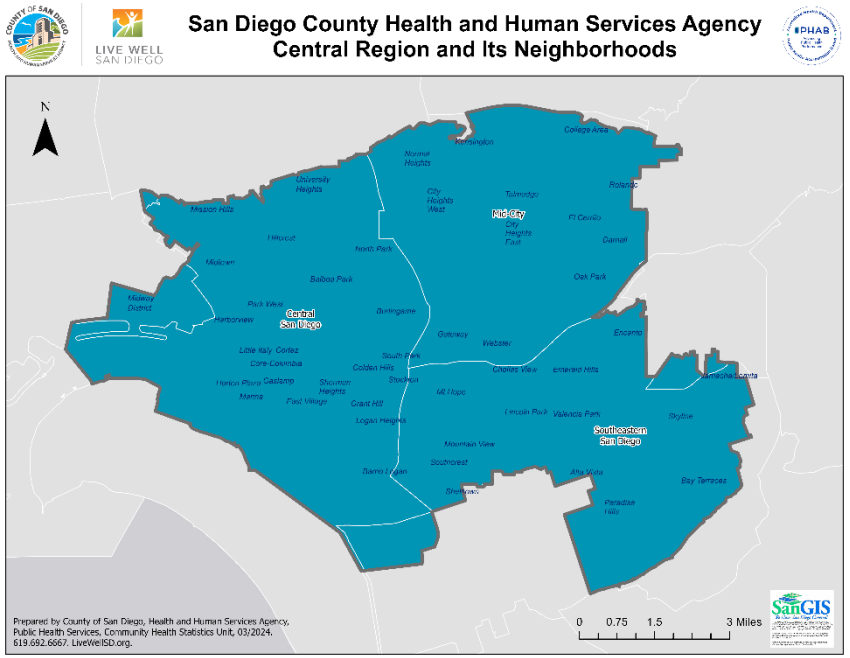
Barry Pollard
Executive Director
Urban Collaborative Project

Crystal Skerven, MSW
Chief, Regional Community Coordinator, Central Region
Department of Homeless Solutions and Equitable Communities
County of San Diego, Health & Human Services Agency

CENTRAL REGION COMMUNITY ENRICHMENT PLAN

About the Region

The Central Region of San Diego County is a highly urbanized area with many diverse communities found throughout its three subregional areas (SRAs), including Central San Diego, Mid-City, and Southeastern San Diego. Central Region is located on the San Diego Bay and includes downtown San Diego and outlying urban communities, including North Park, College Area, Encanto, Paradise Hills, Barrio Logan, Hillcrest, Mission Hills, and University Heights. In addition to Central Region's geographic diversity, its residents represent various demographic, economic, and social backgrounds.



Of the nearly 3.3 million residents in San Diego County, 508,539 people resided in this densely populated Region, representing 15.5% of the county's population as of 2022. Central Region has a racially/ethnically diverse regional population primarily composed of Hispanic residents as well as the home to the highest proportion of non-Hispanic Black residents. Central Region is among the most economically disadvantaged regions, with the highest proportion of residents living below 100% of the federal poverty level and the lowest median household income. Considering the varying needs and disparities impacting residents' overall health and well-being, Central Region community leaders continue to take actions that help fulfill the *Live Well San Diego* vision.

About the Leadership Team

Live Well San Diego Central Region Leadership Team (CRLT) is comprised of diverse partners and agencies who work together to advance a shared vision of a region that is healthy, safe, and thriving. The CRLT Goals are: 1) identify needs, priorities, and opportunities for collaboration to advance equity in the region; 2) provide a space where the community can convene and share invaluable input to inform programs and services, and; 3) identify opportunities for collaboration through project development and

promoting partner initiatives. The Leadership Team meets on the fourth Monday of each month, alternating between virtual and in-person.

The Priority Areas and Work Groups are:

Health and Well-being, Housing for All, and Education and Economic Development

Partner Organizations

These are the partner organizations in which representatives are (or have) served as Co-Chairs of the Priority Work Groups. Additional partners are recognized below by the Priority Work Groups on which they participate.

ORGANIZATIONS SERVING AS CO-CHAIRS TO CRLT

Barry Pollard, Executive Director, Urban Collaborative Project

Health & Well-being Work Group
Samantha Williams, Founder & CEO, JIREH Providers
Pamela Castillo, Marketing Coordinator, San Diego PACE

Housing for All Work Group
Carmina Paz, Program Manager, Urban Collaborative Project CDC
Wilford Smith, Jr., Courage to Call

Education & Economic Development Work Group
Anita López, SoyLopez Consulting Firm

With support from the Department of Homeless Solutions and Equitable Communities, Health & Human Services Agency, County of San Diego

CENTRAL REGION PRIORITY: HEALTH AND WELL-BEING

Mission Statement for this Priority: To create a space where key stakeholders, community-based organizations, and residents can address social and structural determinants of health by empowering and uplifting communities in the Central Region.

Vision Statement for this Priority: The Central Region will foster a community-oriented health ecosystem where people of all ages who live, work, and play in the Central Region are healthy, safe, and thriving.

Telling the Story of This Priority

Why Is This a Priority?

The Health and Well-being Work Group, in supporting the *Live Well San Diego* vision, is committed to fostering a healthier Central Region. The Work Group raised concerns about the high rates of chronic diseases in Central Region, lack of access to health care, and other barriers to good health such as income and food insecurity. Regional Data Presentations delivered to Central Region Leadership Team (CRLT) by the Community Health and Statistics Unit revealed lower rates of health insurance coverage compared to the county at large, high levels of food insecurity, and the prevalence of chronic diseases—with heart disease being the foremost cause of mortality. Discussions followed as to the need to increase the availability of healthy food options and to reduce barriers to better health among residents of Central Region.

Strategy for Change


The Health and Well-being Work Group is pursuing a strategy that reflects two strategic approaches: **Building a Better Service Delivery System** and **Improving the Culture from Within**.

The strategy behind the Health and Well-Being Work Group is to bring a community approach to improve the accessibility and affordability of healthy foods. Using mapping tools and surveys, the Work Group will identify gaps in priority services including chronic disease prevention and behavioral health. Partners will work collaboratively to advocate for additional and a more equitable distribution of resources. Expanding partnerships between community-based organizations and service providers to improve access to health services and insurance coverage is part of this approach. Through this work, and collaboration on community events, the culture of health will improve among partners and residents across the region. *See Basis for Action for more information about the research or evidence that supports this approach.*

Partners Taking Action:

	Community & Faith-Based Organizations	Business & Healthcare	Education	Government
Co-Chairs		**San Diego PACE** **JIREH Providers**		**Department of Homeless Solutions and Equitable Communities, Health & Human Services Agency (HHSA), County of San Diego (CoSD)**
Participating Organizations	Community Health Improvement Partners	A Healthier Me		2-1-1 San Diego
	NAACP	Alzheimer's Association		In Home Supportive Services/Public Authority Advisory Committee
	Urban Collaborative Project CDC	Bayview Crisis Stabilization Unit		
		Docfully Healthcare		
		Family Health Center San Diego		
		Molina Healthcare		
		San Diego Urban League		
		St. Paul's PACE		
		UCSD Health		

What is Our Concern?REGIONAL POPULATION INDICATORS THAT AFFECT THIS PRIORITY:

HEALTH

Percent of deaths in Central Region due to 3-4-50 chronic diseases (cancer, heart disease & stroke, type II diabetes, and lung disease).

- In 2022, 8 of the top 10 leading causes of death were due to chronic disease in Central Region.
- Although the percentage of deaths due to 3-4-50 chronic diseases decreased in the Central Region from 2018 (51%) to 2022 (45%), it remained higher than the county overall.

HEALTH

Total death count in Central Region due to diseases of the heart.

- In Central Region, diseases of the heart were the number one leading cause of death in 2022, accounting for 21.4% of the total deaths in the region.

STANDARD OF LIVING

Percentage of residents in Central Region that have health insurance.

- Despite an overall increase in the percentage of county residents with health insurance from 2017 to 2022, Central Region had the lowest proportion of residents with health insurance (90.0%) compared to all other HHSA regions in 2022.

SOCIAL

Percentage of population in Central Region that are food insecure.

- On average, nearly 1 in 3 adults with income less than 200% FPL reported having an inability to afford enough food in Central Region between 2018-2022.

HEALTH

Age-adjusted emergency department (ED) discharge rate due to opioid overdoses in Central Region.

- Age-adjusted ED discharge rates due to opioid overdoses in Central Region nearly doubled from 2017 (31.6 per 100,000) to 2021 (54.0 per 100,000).

Key

Arrow depicts direction of 5-year trend	On the Right Track	Not On Track	Trend not Available

What are We Doing About It?

Goal 1. Increase the availability of and community access to healthy food within Central Region.

Objective 1.1. Identify 4 opportunities in communities identified as less healthy—1 and 2, Healthy Place Index (HPI)—to increase access to healthy food (community gardens, community food grant programs, existing food resource programs, food sheds, food preparation education).

Measure 1.1.1. Degree of knowledge (1 to 5) of CBOs and community members who are surveyed about their knowledge of healthy food resources in the Region.

Objective 1.2. Expand Work Group to include organizations providing healthy food programs and services (e.g. Mundo Gardens, Urban League, CalFresh, etc.).

Measure 1.2.1. Two additional organizations participate in efforts to increase availability of, and access to, healthy food within Central Region.

Goal 2. Reduce barriers to health through a community-led systems change approach to ensure equitable distribution of and access to resources and inclusive services.

Objective 2.1. Map existing community education and support programs and services and gaps to be filled in Central Region, particularly for: (i) chronic disease, stroke, and heart disease, and (ii) high-risk and under-served groups.

Measure 2.1.1. Two community events held in which partners hosted or participated, focused on priority gaps such as chronic disease and behavioral health issues.

Objective 2.2. Develop and advocate for funding and resource recommendations to fill program and service gaps in Central Region.

Measure 2.2.1. Degree of progress (0 to 4) to research and develop a list of potential funding opportunities by June 2024.

Objective 2.3. Identify opportunities for community-based organizations and service providers in Central Region to partner with large health providers to improve equitable and inclusive services and access.

Measure 2.3.1. Two community events held in which partners hosted or participated, focused on priority gaps such as chronic disease and behavioral and mental health issues.

Objective 2.4. Expand community outreach efforts to increase enrollment rates for health insurance and Medi-Cal coverage in Central Region.

Measure 2.4.1. Degree of knowledge (1 to 5) of Medi-Cal program options among community members attending presentations and/or educational events held on the Medi-Cal program options.

Monitoring

The Central Region Health and Well-Being Priority, including all associated measures, are being tracked as a Scorecard within a performance management application. Data are collected and progress is reported on a quarterly basis. You can see our progress by going to the link: Central Region Health and Well-Being Priority Scorecard

CENTRAL REGION PRIORITY: HOUSING FOR ALL

Vision Statement for this Priority: To shorten, reduce, and prevent the unhoused experience in San Diego County's Central Region by collaboratively working towards equitable housing for all.

Mission Statement for this Priority: To empower our community to effectively provide equitable resources, holistic, support services, and permanent housing solutions for the Central Region's unhoused population through a collaborative, person-centered approach.

Telling the Story of This Priority

Why is This a Priority?

In the Central Region, housing insecurity and homelessness have emerged as pressing challenges, exacerbated by soaring housing costs, escalating living expenses, and an urgent need for more housing and more affordable housing options. The complexity of this crisis, along with the growing number of persons experiencing homelessness, has propelled this issue to be among the top concerns of the Central Region Leadership Team (CRLT). The Housing for All Work Group was established out of recognition of the need for improved coordination and collaborative efforts to better support residents.

Strategy for Change:

The Housing for All Work Group is pursuing a strategy that reflects three strategic approaches: **Building a Better Service Delivery System, Supporting Positive Choices**, and **Pursuing Policy and Environmental Changes**.

The Housing for All Work Group is focused on improving equitable access to data, resources, and services for housing. Digital tools including a database or directory of services are important to this strategy. Workshops and resource fairs to share resources and explore successful models are also part of the strategy. The Work Group is dedicated to empowering residents with the knowledge and resources needed to secure and maintain housing, while also advocating for increased funding and equitable housing resources. The foundation of this effort is the cultivation of strong partnerships among public agencies, housing developers, community-based

organizations, and community members to ensure equitable access to housing. *See Basis for Action for more information about the research or evidence that supports this approach.*

Partners Taking Action:

	Community & Faith-Based Organizations	Business & Healthcare	Education	Government
Co-Chairs	**Courage to Call** **The Urban Collaborative Project CDC**			**Department of Homeless Solutions and Equitable Communities, Health & Human Services Agency (HHSA), County of San Diego (CoSD)**
Participating Organizations	Downtown San Diego Partnership	St. Paul's PACE		Public Health Services, HHSA, CoSD
		SD Workforce Partnership		
		Sickle Cell Disease Association		
		San Ysidro Health		

What is Our Concern?

REGIONAL POPULATION INDICATORS THAT AFFECT THIS PRIORITY:

STANDARD OF LIVING

Self-sufficiency income in Central Region for a household with 2 adults and 1 school-aged child and 1 pre-school-aged child.

TREND NOT AVAILABLE

- For a household with two adults, one preschool-age child, and one school-age child, an annual salary of $83,270.57 was needed to make ends meet in Central Region in 2022. A family making the California minimum wage would fall short of the minimum self-sufficiency income needed to survive in Central Region by about $20,871 a year.

STANDARD OF LIVING

Median household income in Central Region.

- The median household income in Central Region increased from $56,665 in 2017 to $81,448 in 2022, however, it remained lower than all other HHSA regions and the county overall.

SOCIAL

Total persons experiencing homelessness in the City of San Diego.

- The City of San Diego is primarily located in Central and North Central Regions of San Diego County, with a small portion extending into South Region. The number of persons experiencing homelessness in the City of San Diego increased by 35.0% between 2022 and 2023, with 63.0% of the total unhoused population located within this geography. *

*#WeAllCount Point-In-Time Count 2023, Regional Task Force on Homelessness.

Key

Arrow depicts direction of 5-year trend	On the Right Track	Not On Track	Trend not Available

What Are We Doing About It?

Goal 1. Create equitable opportunities for community engagement through accessible data, resources, and services in relation to housing for all.

Objective 1.1. Build the Central Region ONE HUB database and directory of services with public and nonprofit organizations that are providing housing and homeless support services.

Measure 1.1.1. At least 15 public and non-profit organizations that provide housing and homeless services in Central Region included in the ONE HUB database.

Objective 1.2. Create and use maps to identify existing services to support unhoused people and locations of greatest needs for investment.

Measure 1.2.1. Degree of progress (0 to 4) in conducting a high-level scan to identify existing services that support unhoused people, utilizing the ONE HUB database, by end of Spring 2024.

Objective 1.3. Track and monitor homelessness and housing developments in Central Region.

Measure 1.3.1. Once a month, a refresh is conducted of information and data on homelessness and housing development in Central Region for the ONE HUB database and directory of services.

Objective 1.4. Increase local access to support and services through regular resource fairs and events.

Measure 1.4.1. Two resource fairs, events, presentations, and tabling conducted in which housing and home supports and services are promoted.

Objective 1.5. Educate the public about the system, resources, and successful models (e.g., Housing First) to strengthen the community's ability to secure and maintain housing.

Measure 1.5.1. One workshop or event is convened about the system, resources, and successful models (e.g., Housing First) to strengthen the community's ability to secure and maintain housing.

Goal 2. Advocate for addressing housing challenges through strong partnerships between public agencies, housing developers, community-based organizations, and community members.

Objective 2.1. Build collaborative partnerships to expand homelessness outreach and advocacy in Central Region.

Measure 2.1.1. At least 15 partners brought together to work collaboratively (form a network) to expand homeless outreach and advocacy.

Objective 2.2. Advocate for additional housing in Central Region through identification of data, funding, available land, and zoning changes.

Measure 2.2.1. Up to 10 partners collectively advocate for more granular and accurate public data of housing- and homelessness-related services, including performance and cost.

Monitoring

The Central Region Housing for All Priority, including all associated measures, are being tracked as a Scorecard within a performance management application. Data are collected and progress is reported on a quarterly basis. You can see our progress by going to the link: Central Region Housing for All Priority Scorecard

CENTRAL REGION PRIORITY: EDUCATION AND ECONOMIC DEVELOPMENT

Mission Statement for this Priority: To identify, develop, and implement an effective socio-economic ecosystem in the Central Region by co-creating equitable investments and initiatives that promote and align with supportive pathways for economic development access to quality education, health, and wellness.

Vision Statement for this Priority: A thriving Central Region where all individuals and families are empowered through equitable investments for economic and educational excellence.

Telling the Story of This Priority

Why is This a Priority?

Recognizing the critical need to improve economic opportunities and educational resources, the Central Region Leadership Team (CRLT) has prioritized education, economic development, and workforce development within Central Region. The Regional Data Presentation delivered by the Community Health Statistics Unit revealed important trends in unemployment and educational attainment from 2017 to 2022. These trends are positive in some cases, with reduced rates of unemployment and improved educational attainment levels. However, the persistence of higher unemployment rates compared to the average across the County of San Diego, and educational disparities within Central Region, especially in communities like Southeastern San Diego and Mid-City subregional areas (SRAs), underscore the urgency for focused interventions.

Strategy for Change:

The Education and Economic Development Work Group is pursuing a strategy reflecting three strategic approaches: **Building a Better Service Delivery System**, **Supporting Positive Choices**, and **Improving the Culture from Within**.

The Education and Economic Development strategy is built using a multifaceted, community-led approach that seeks to expand resources for community-based organizations, improve equity and access in education and workforce development, and bolster

educational attainment for children and youth. Through outreach and training efforts, residents are provided opportunities to advance their education and strengthen job skills. Altogether these goals, objectives, and activities are intended to strengthen the economic capacity of the Region and help each partner as an employer play a role in developing the workforce of Central Region. *See Basis for Action for more information about the research or evidence that supports this approach.*

Partners Taking Action:

	Community & Faith-Based Organizations	Business & Healthcare	Education	Government
Co-Chairs		**SoyLopez Consulting** **Urban Collaborative Project CDC**		**Department of Homeless Solutions and Equitable Communities, Health & Human Services Agency (HHSA), County of San Diego (CoSD)**
Partner Organizations	Community Wraparound	Logan Heights CDC	California State University of San Marcos	Public Health Services, HHSA, CoSD
	Rise Up Industries	San Diego Urban League	Learn4Life	
		SD Workforce Partnership	Outside the Lens	

**Note: These do not represent all partners to the Central Region Community Leadership Team. Only those partners actively involved in advancing this priority are listed here.*

What is Our Concern?

REGIONAL POPULATION INDICATORS THAT AFFECT THIS PRIORITY:

KNOWLEDGE

Percentage of population in Central Region aged 25 and over with at least a bachelor's degree.

- The percentage of adults 25 years and older with a bachelor's degree or higher in Central Region increased from 2017 (31.8%) to 2022 (35.9%). However, this percentage has remained lower than the county overall from 2017 to 2022.

- Educational disparities were seen within Central Region. In 2022, Central San Diego SRA had the highest proportion of adults 25 years and older with a bachelor's degree or higher (50.8%), while Southeastern San Diego SRA had the lowest (18.3%).

KNOWLEDGE

Percentage of population in Central Region aged 25 and over with at least a high school diploma or equivalent.

- The percentage of adults aged 25 years and older without a high school diploma in Central Region decreased by 20.5% from 2017 (19.8%) to 2022 (15.7%). Despite this improvement in educational attainment, Central Region had the second-highest percentage of adults aged 25 and older without a high school diploma compared to all other HHSA regions in 2022.

STANDARD OF LIVING

Percentage of the total labor force in Central Region that is unemployed.

- In Central Region, the 5-year average unemployment percent decreased from 7.8% in 2017 to 6.7% in 2022, however, it remained higher than the county overall.
- Among Central Region SRAs, Southeastern San Diego and Mid-City had the highest 5-year average percent of unemployment with 7.7% and 7.6%, respectively, in 2022.

Key

Arrow depicts direction of 5-year trend	On the Right Track	Not On Track	Trend not Available

What are We Doing About It?

Goal 1. Expand the amount of resources and funding for community-based organizations in Central Region to implement programs and services.

Objective 1.1. Increase the capacity of local community-based organizations to pursue County, government, and philanthropic grants and contracts.

Measure 1.1.1. Degree of satisfaction or knowledge gained (1 to 5) based on a survey of providers who participate in training offered by the County Department of Procurement and Contracting or other entity.

Measure 1.1.2. Two grants pursued within the year by partners to solicit additional resources to support work on priorities identified by this Community Leadership Team.

Measure 1.1.3. Three workshops/presentations conducted to train community-based organizations on how to secure resources and funding.

Measure 1.1.4. Degree of progress (0 to 4) to complete a high-level scan to identify organizations that can support community-based organizations to pursue and maintain county, government, and philanthropic grants and contracts.

Goal 2. Improve community access to and participation in equity-focused workforce development and education resources that offer career pathways and livable wages.

Objective 2.1. Map workforce development initiatives in the Central Region to identify gaps and opportunities, especially for high-need populations (e.g., re-entry from incarceration, trauma recovery, immigrant, non-English speaking, etc.).

Measure 2.1.1. Degree of progress (0 to 4) toward completing a high-level scan to identify gaps in workforce development initiatives in the region.

Objective 2.2. Engage workforce and education organizations to increase outreach and training for career development.

Measure 2.2.1. Three workshops sponsored on career innovation, social learning, or systemic change with partners.

Measure 2.2.2. Five partners who support career paths for high school students or support community college programs.

Objective 2.3. Remove access barriers to education and career development (e.g., mobility, childcare, limited hours, etc.)

Measure 2.3.1. Five partners who assist with addressing access barriers to education and career development.

Goal 3. Strengthen educational attainment levels and opportunities for children and youth in Central Region.

Objective 3.1. Partner with K-12 schools in Central Region to identify age and grade levels with the lowest performance and highest barriers to success and the greatest needs for intervention and support.

Measure 3.1.1. Three customized workshops and presentations to help K-12 students succeed (and help parents support students) in preparing for careers, including apprenticeships.

Measure 3.1.2. Degree of satisfaction or knowledge gained (1 to 5) based on a survey of participants at workshops and presentations convened.

Monitoring

The Central Region Education and Economic Development Priority, including all associated measures, are being tracked as a Scorecard within a performance management application. Data are collected and progress is reported on a quarterly basis. You can see our progress by going to the link: Central Region Education and Economic Development Priority Scorecard

CENTRAL REGION PHOTO GALLERY

COMMUNITY ENRICHMENT PLAN EAST REGION

LETTER FROM EAST REGION CO-CHAIRS

Kenya Taylor

Kelly Anne Rodriguez

Dear Community Partner

On behalf of the **East Region Leadership Team (ERLT)**, we are very pleased to present the Community Enrichment Plan (CEP) for FY 2023-2025. This CEP reflects a focus on three key concerns or priorities – **Behavioral Health Solutions—Prevention and Early Intervention**, **Resilient Youth & Families**, and **Thriving & Inclusive Communities**. Within this CEP, you will find the "story" about the concerns of the ERLT, community data which help explain why these concerns rose to the top, and goals and objectives that capture partners plan for bringing about positive change. The CEP also identifies the many partners who not only helped develop this plan but who will help to implement it. Progress toward implementing objectives will be monitored and shared using a performance scorecard, and indicators will help us gauge improvements at a community level.

The East Region of San Diego boasts a very diverse geographic area and includes incorporated and unincorporated areas, suburban and rural communities, and Indian reservations. East Region's population reflects various demographic and social backgrounds, being home to one of the highest proportions of veterans, residents living with a disability, and older adults 65 years and older in San Diego County. Considering the varying needs and disparities impacting residents' overall health and well-being, East Region community leaders are committed to action to help fulfill the *Live Well San Diego* vision.

This effort to develop a new CEP began in early 2022 as this region, just like the rest of the country, was coming out of the COVID-19 pandemic. The ERLT was revitalized, and this CEP reflects fresh perspectives of its many new members. The County of San Diego placed new emphasis on community engagement in hiring regional community coordinators to ensure the five community leadership teams (ERLT included) were fully engaged as the "voice" for community change. Implementation has already begun, and priorities and goals will evolve as lessons are learned. This dynamism will help to ensure that the CEP continues to be responsive to the needs of this leadership team.

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

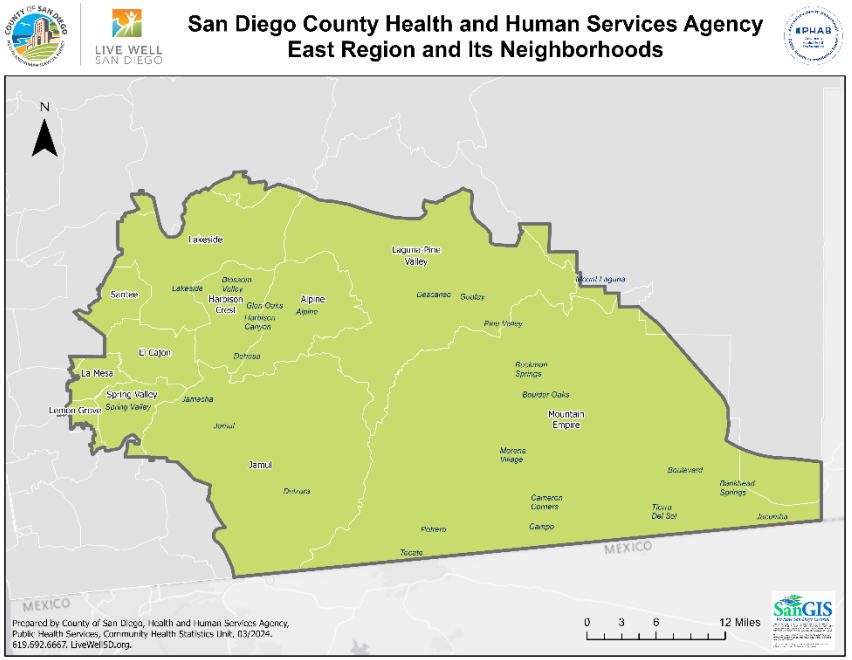
Kenya Taylor
President
NAACP San Diego Chapter

KellyAnne Rodriguez, MPH
Chief, Regional Community Coordinator, East Region
Department of Homeless Solutions and Equitable Communities
County of San Diego, Health & Human Services Agency

EAST REGION COMMUNITY ENRICHMENT PLAN

About the Region

The East Region of San Diego County is the second-largest geographical area in the county, and it is one of two regions that share an international border with Mexico. It is also the only region that shares a boundary with another county and a country. The region boasts a very diverse geographic area, with vast valleys, arid landscapes, and mountainous terrains found throughout East Region's eleven subregional areas (SRAs), including Alpine, El Cajon, Harbison Crest, Jamul, La Mesa, Laguna-Pine Valley, Lakeside, Lemon Grove, Mountain Empire, Santee, and Spring Valley. These SRAs include incorporated and unincorporated areas, suburban and rural communities, and Indian reservations where over 502,500 people reside, representing 15.3% of San Diego County's population.



East Region's population reflects various demographic and social backgrounds, being home to one of the highest proportions of veterans, residents living with a disability, and older adults 65 years and older in San Diego County. Considering the varying needs and disparities impacting residents' overall health and well-being, East Region community leaders continue to take actions that help fulfill the *Live Well San Diego* vision.

About the Leadership Team

The East Region Leadership Team (ERLT) meets in-person on the third Thursday of every month. Partners from all sectors come together to network, share ideas, and collaborate to address issues facing East Region residents.

Framework for the ERLT's Community Enrichment Plan

ERLT developed a framework for its CEP, after much exploration and discussion, incorporating the Mission, Vision, and Values into the strategic actions listed in each Priority. In addition, each Priority and subsequent Work Group has a Vision for its respective Priority.

- **Mission:** To improve the overall health and well-being of East Region residents through diverse and inclusive community engagement.
- **Vision**: A region that is building better health, living safely, and thriving.
- **Core Values**: Respect, Community, Acceptance, Diversity, Resilience, Partnership, Leadership, Teamwork Representation, Inclusivity, Service for All

East Region Leadership Team 2023 Group Photo

Priority Areas and Work Groups

Behavioral Health Solutions—Prevention and Early Intervention, Resilient Youth and Families, and Thriving and Inclusive Communities.

Partner Organizations

These are the partner organizations in which representatives serve (or previously served) as Co-Chairs of the Priority Work Groups. Additional partners are recognized below by the Priority Work Groups on which they participate.

REPRESENTATIVES AND THEIR ORGANIZATIONS SERVING AS CO-CHAIRS TO ERLT

Behavioral Health Solutions—Prevention And Early Intervention Work Group
Kenya Taylor, President, NAACP, San Diego Chapter

Resilient Youth and Families Work Group
Rynna Herwehe, Health Program Specialist, All Kids Academy Headstart

Thriving and Inclusive Communities
Seraphina Eberhardt, Program Manager, Institute for Public Strategies

With support from the Department of Homeless Solutions and Equitable Communities, Health & Human Services Agency, County of San Diego

EAST REGION PRIORITY: BEHAVIORAL HEALTH SOLUTIONS—PREVENTION AND EARLY INTERVENTION

Vision Statement for this Priority*:* Empowering East Region residents to access diverse behavioral health prevention and early intervention resources they need to thrive.

Telling the Story of This Priority

Why is this a Priority?

The East Region Leadership Team (ERLT) identified behavioral health, with a focus on prevention and early intervention, as a priority area. Concerns about anxiety and drug and alcohol disorders, possibly exacerbated by the isolation during the COVID-19 response, fueled interest in this priority. The Regional Data Presentation delivered by the Community Health Statistics Unit provided insights regarding behavioral health needs across the region. The data showed alcohol disorders on the rise, anxiety and fear-related disorders at high rates, and a jump in emergency discharge rates due to opioid overdoses. There was also some data that showed that adolescents were cautious or skeptical about seeking help for mental health and substance use challenges, which meant that adopting creative strategies in early intervention was critical.

Strategy for Change

The Behavioral Health Solutions: Prevention and Early Intervention Work Group is pursuing a strategy that reflects three strategic approaches: **Building a Better Service Delivery System, Supporting Positive Choices**, and **Improving the Culture from Within**.

The ERLT is working to connect communities to various Behavioral Health (BH) resources and services. These resources support a care continuum, support harm reduction programs, promote prevention strategies, and promote stigma-free behavioral health campaigns. Implementing these changes will increase both access and awareness of readily available services as well as reduce the volume of Emergency Department visits in the region. Addressing this priority will require collaboration between service providers and community members.

Partners Taking Action

	Community & Faith-Based Organizations	Business & Healthcare	Education	Government
Co-Chairs	**NAACP, San Diego Chapter**			**Department of Homeless Solutions and Equitable Communities, Health & Human Services Agency (HHSA), County of San Diego (CoSD)**
Participating Organizations	**Business & Healthcare**			
	Alzheimer's Association	Neighborhood Healthcare	St. Paul's PACE	Southern Caregiver Resource Center
	Global Medical Response	San Diego PACE	Southern Indian Health	Volunteers in Medicine
	Grossmont Healthcare District	San Diego Youth Services		
	Community & Faith-Based Organizations			
	Crisis House	Institute for Public Strategies	San Diego Community Health Improvement Partners (CHIP)	THRIVE Lemon Grove
	Friday Cafe	San Diego Community Health Improvement Partners (CHIP)		
	Government			
	Behavioral Health Services, CoSD	El Cajon Library, CoSD	Public Health Services, CoSD	Sheriff's Department, CoSD
	Courage to Call	Parks & Recreation Department, CoSD		

What is Our Concern?

REGIONAL POPULATION INDICATORS THAT AFFECT THIS PRIORITY:

Age-adjusted emergency department (ED) discharge rate due to anxiety and fear-related disorders in East Region.

- Age-adjusted ED discharge rates due to anxiety and fear-related disorders in East Region decreased by 10.0% from 2017 (306.9 per 100,000) to 2021 (276.2 per 100,000). Although there was a decrease, these rates remained higher than the county overall.

Age-adjusted emergency department (ED) discharge rate due to alcohol-related disorders in East Region.

- Age-adjusted ED discharge rates due to alcohol-related disorders in East Region increased by 8.4% from 2017 (291.5 per 100,000) to 2021 (315.9 per 100,000).

Age-adjusted emergency department (ED) discharge rate due to opioid overdoses in East Region.

- Age-adjusted ED discharge rates due to opioid overdoses in East Region increased by 67.9% from 2017 (26.3 per 100,000) to 2021 (44.2 per 100,000), the second-greatest increase in rates among all HHSA regions.

Key

 Arrow depicts direction of 5-year trend	On the Right Track	Not On Track	Trend not Available

What are We Doing About It?

Goal 1. Residents have easy access to community resources specific to behavioral health prevention and early intervention.

Objective 1.1. Build awareness of community resources to support behavioral health prevention and early intervention.

Measure 1.1.1. By June 2024, degree of completion (0 to 4) to develop a one-stop shop flyer for all behavioral health resources.

Measure 1.1.2. Attend at least 8 events added each month to promote prevention and early intervention through outreach and materials.

Measure 1.1.3. At least 5 events posted to the community calendar each month to inform community members on activities related to health and wellness.

Measure 1.1.4. Increase by 5 percent the number of subscribers to the County *Live Well San Diego* newsletter by June 2024.

Goal 2. Behavioral health services are available to meet the needs of residents at every stage of life.

Objective 2.1. Improve access to behavioral health services by strengthening the network of professional providers in East Region.

Measure 2.1.1. 150 self-care tips for Check Your Mood event distributed to mental health professionals by February 2024.

Measure 2.1.2. Degree of completion (0 to 4) in coordinating a new career development opportunity with Grossmont Healthcare District by June 2025.

Goal 3. Empower East Region residents to access diverse behavioral health and prevention and early intervention resources they need to thrive.

Objective 3.1. Increase availability of trainings to service providers that support mental health prevention and early intervention.

Measure 3.1.1. At least 25 community members and partners attend harm reduction training coordinated by the Community Leadership Team.

Measure 3.1.2. Degree of completion (0 to 4) to provide Mental Health First Aid training by June 2025.

Monitoring

The East Region Behavioral Health Solutions: Prevention And Early Intervention Priority, including all associated measures, are being tracked as a Scorecard within a performance management application. Data are collected and progress is reported on a quarterly basis. You can see our progress by going to the link: East Region Behavioral Health Solutions: Prevention And Early Intervention Scorecard

EAST REGION PRIORITY: RESILIENT YOUTH & FAMILIES

Vision Statement for this Priority: Support a safe environment of networks and resources (to be safe and healthy) that connects and empowers youth and families in the East Region.

Telling the Story of This Priority

Why is this a Priority?

Discussions within the East Region Leadership Team (ERLT) brought the issues that affect education, youth, and families to the forefront, leading to the creation of the Resilient Youth and Families Priority. The Regional Data Presentation delivered by the Community Health Statistics Unit included data that reflected some concerning trends for the Region's youth and families. East Region has the highest percentage of grandparents raising grandchildren without a parent present. Educational trends were mixed, with some improvement recently in the percentage of adults with a bachelor's degree or higher, however, the percentage remained lower than the county overall. Work Group members were committed to determining how schools could do more to contribute to the well-being of youth and families. The strategies here reflect the Work Group's finding that improved health and community outcomes can be attained through educational achievement.

Strategy for Change

The Resilient Youth and Families Work Group is pursuing a strategy that reflects two strategic approaches: **Building a Better Service Delivery System** and **Supporting Positive Choices**.

In keeping with the Vision, the Work Group implements a strategy fostering safe environments that provide access to education, resources, and basic needs support. Recognizing the role schools play as a community connector, the Work Group focuses on objectives that increase access to educational activities and boost resources for families through events and fairs. For example, the ERLT seeks to establish a community hub for service providers to connect with families in the La Mesa-Spring Valley School District. Additionally, to further understand and improve community outcomes, meetings will be conducted gathering East Region schools, CLT partners, and other community organizations.

Partners Taking Action

	Community & Faith-Based Organizations	Business & Healthcare	Education	Government
Co-Chairs			**All Kids Academy Headstart**	**Department of Homeless Solutions and Equitable Communities, Health & Human Services Agency (HHSA), County of San Diego (CoSD)**
Participating Organizations	**Education**			
	Cajon Valley Union School District	Grossmont Union High School District	Santee School District	UC San Diego
	Foster and Kinship Care Education Programs at Grossmont College	La Mesa-Spring Valley School District		
	Community & Faith-Based Organizations			
	The Children's Initiative	Institute for Public Strategies	McAllister Teen Center	San Diego Workforce Partnership
	Business & Healthcare		**Government**	
	Family Health Centers of San Diego		Public Health Services, HHSA, CoSD	

What is Our Concern?

REGIONAL POPULATION INDICATORS THAT AFFECT THIS PRIORITY:

KNOWLEDGE

Percentage of adults 25 years and older with at least a high school diploma in East Region.

- The percentage of adults aged 25 years and older without a high school diploma in East Region decreased by 17.7% from 2017 (12.2%) to 2022 (10.0%). However, educational disparities were seen among communities in East Region.

- In 2022, the proportion of adults 25 years and older without a high school diploma was 3.6 times higher in Mountain Empire SRA (14.1%) compared to Alpine SRA (3.9%).

KNOWLEDGE

Percentage of adults 25 years and older with some college education in East Region.

- Among all HHSA regions, East Region had the highest percentage of adults 25 years and older with some college education in 2022, however, this percentage remained unchanged from 2017 (36.9%) to 2022 (37.0%).

KNOWLEDGE

Percentage of adults 25 years and older with a bachelor's degree or higher in East Region.

- The percentage of adults 25 years and older with a bachelor's degree or higher in East Region increased from 2017 (26.0%) to 2022 (28.7%). However, this percentage has remained lower than the county overall from 2017 to 2022.

COMMUNITY

Percentage of grandparents raising grandchildren in East Region.

- Over a quarter of grandparents in East Region were responsible for their grandchild(ren) in 2022 (25.5%), a decrease from 2017 (28.7%). However, this percentage was higher than the county overall from 2017 to 2022.

Key

 Arrow depicts direction of 5-year trend	On the Right Track	Not On Track	Trend not Available

What are We Doing About It?

Goal 1. Support a safe environment of networks and resources (to be safe and healthy) that connects and empowers youth and families in East Region.

Objective 1.1. Increase access to no-cost educational programming and events for youth and families in FY 23-24.

Measure 1.1.1. Degree of completion (0 to 4) of a formal list which is created of educational opportunities for youth and families by June 2024.

Measure 1.1.2. At least 2 educational opportunities for youth and families coordinated per fiscal year.

Measure 1.1.3. Degree of completion (0 to 4) to launch a series of sessions called What I Wish My Parents Knew by June 2024.

Measure 1.1.4. At least 5 resource fairs hosted at key locations in East Region to share resources and educational and community programming annually.

Objective 1.2. Increase opportunities for families and students to receive resources and basic-needs support through a school-centered approach in FY 23-24.

Measure 1.2.1. At least 5 meetings with East County schools, CBOs, and FBOs to collaborate and learn about the needs and resources available in East Region by June 2024.

Measure 1.2.2. Degree of completion (0 to 4) of action plan by date for a new community hub at La Mesa-Spring Valley School District where service providers visit weekly/monthly with resources and educational materials.

Measure 1.2.3. At least 2 trainings facilitated for Tools for Schools at School Districts by June 2024.

Measure 1.2.4. At least 5 school events and fairs where resources for youth and families were promoted annually.

Monitoring

The East Region Resilient Youth and Families Priority, including all associated measures, is being tracked as a Scorecard within a performance management application. Data are collected and progress is reported on a quarterly basis. You can see our progress by going to the link: East Region Resilient Youth and Families Priority Scorecard

EAST REGION PRIORITY: THRIVING & INCLUSIVE COMMUNITIES

Vision Statement for this Priority: Communicating and engaging residents in developing and promoting diverse and inclusive programs to help our community thrive.

Telling the Story of This Priority

Why is this a Priority?

Based on discussions within the East Region Leadership Team (ERLT), the community partners identified a variety of populations and needs across East County, including rural communities, immigrants and refugees, seniors/older adults, economic and workforce development, and the lack of affordable housing. A perspective of diversity, equity, and inclusion (DEI) was adopted as integral to the approach to help all communities in East County thrive. The Community Health Statistics Unit delivered their Regional Data Presentation, which gave further shape to these concerns. East Region suffers from high rates of food insecurity, lower median incomes, and a high cost of living compared to the county overall. Additionally, East Region is home to many vulnerable immigrant and refugee communities. The East Region Thriving & Inclusive Communities Work Group was created to identify and implement solutions tailored to these various challenges.

Strategy for Change

The Thriving and Inclusive Communities Work Group is pursuing a strategy that reflects three strategic approaches: **Supporting Positive Choices**, **Pursuing Policy and Environmental Changes**, and **Improving the Culture from Within**.

The ERLT is working to create inclusive and thriving communities in the East Region by collaborating with important stakeholders and promoting sustainable funding and resources. The Thriving & Inclusive Communities Work Group has centered its strategy on activities to promote community engagement because this can have a positive impact on long-term health outcomes and community prosperity. Activities include developing and distributing flyers for community members, participating in resource fairs, and inviting guest speakers to present at the ERLT. In addition, the ERLT strategy is to take steps to promote educational and vocational opportunities for the diverse residents within East County.

Partners Taking Action:

	Community & Faith-Based Organizations	Business & Healthcare	Education	Government
Co-Chairs	**Institute for Public Strategies**			**Department of Homeless Solutions and Equitable Communities, Health & Human Services Agency (HHSA), County of San Diego (CoSD)**
Participating Organizations	**Community & Faith-Based Organizations**			
	East County Homeless Task Force	Lakeside Amity	Little House Inc	Regional Task Force on Homelessness
	El Cajon Collaborative	Lakeside Collaborative		
	Business & Healthcare			
	Grossmont Healthcare District		San Diego Pace	
	Neighborhood Healthcare		St. Paul's PACE	
	Education		**Government**	
	Grossmont Cuyamaca Community College District		Public Health Services, HHSA, CoSD	
	Santee Collaborative		City of Santee	

What is Our Concern?

REGIONAL POPULATION INDICATORS THAT AFFECT THIS PRIORITY:

Percentage of residents living under 200% Federal Poverty Level (FPL) in East Region.

- The percentage of residents living below 200% FPL in East Region decreased from 31.5% in 2017 to 27.0% in 2022. Despite improvements to the standard of living, this percentage was higher than the county overall (24.6%) in 2022.

STANDARD OF LIVING

Percentage of adults with income less than 200% Federal Poverty Level (FPL) who are food insecure in East Region.

- Nearly 2 out of every 5 adults with an income less than 200% FPL in East Region (39.4%) reported being food insecure between 2018-2022, which was higher than all other HHSA regions.

STANDARD OF LIVING

The median household income in East Region.

- The median household income in East Region increased by 30.6% from $71,075 in 2017 to $92,827 in 2022. Despite the increase, East Region had the second-lowest median household income among all HHSA regions in 2022.

STANDARD OF LIVING

The self-sufficiency income for a family of 2 adults and 2 children in East Region.

- For a household with two adults, one preschool-age child, and one school-age child, an annual salary of $85,218.11 was needed to make ends meet in East Region in 2022. A family making the California minimum wage would fall short of the minimum self-sufficiency income needed to survive in East Region, by about $22,818 a year.

TREND NOT AVAILABLE

Key

Arrow depicts direction of 5-year trend	On the Right Track	Not On Track	Trend not Available

What are We Doing About It?

Goal 1. Communicating and engaging residents in developing and promoting diverse and inclusive programs to help our community thrive.

Objective 1.1. Increase information and resource sharing between East Region organizations and community members.

Measure 1.1.1. 5 community events added to the calendar each month by June 2024.

Measure 1.1.2. At least 3 ER-TIC events shared in the HHSA Community Events East Region weekly newsletter by June 2024.

Measure 1.1.3. At least 10 new East Region residents sign up to receive the East Region weekly newsletter each month.

Measure 1.1.4. 3 guest speakers present at the East Region Leadership Team and Work Groups each year.

Measure 1.1.5. 100 pamphlets about the East Region Homeless Task Force distributed to residents.

Objective 1.2. Support priority populations and communities in the East Region.

Measure 1.2.1. 3 resource fairs conducted for priority populations.

Measure 1.2.2. At least 100 flyers distributed to seniors and older adults for resources and programs.

Objective 1.3. Promote economic development and job opportunities to residents in East Region.

Measure 1.3.1. At least 3 East Region organizations highlighted for their workforce development efforts.

Measure 1.3.2. At least 100 vocational and educational career opportunities promoted to residents in East Region.

Measure 1.3.3. At least 100 trainings and certification programs promoted in various languages in East Region.

Measure 1.3.4. At least 3 tours and presentations provided for East Region high school students about careers and workforce opportunities.

Monitoring

The East Region Thriving and Inclusive Communities Priority, including all associated measures, are being tracked as a Scorecard within a performance management application. Data are collected and progress is reported on a quarterly basis. You can see our progress by going to the link: East Region Thriving and Inclusive Communities Priority Scorecard

EAST REGION PHOTO GALLERY

COMMUNITY ENRICHMENT PLAN NORTH CENTRAL REGION

LETTER FROM NORTH CENTRAL REGION CO-CHAIRS

Karen Lenyoun

Justine Kozo

Dear Community Partner

On behalf of the **North Central Region Leadership Team (NCeCLT)**, we are very pleased to present the Community Enrichment Plan (CEP) for FY 2023-25. This CEP reflects a focus on three key concerns or priorities – **Behavioral Health**, **Youth**, and **Food & Housing Insecurity**. Within this CEP, you will find the "story" about the concerns of the NCeCLT, community data which help explain why these concerns rose to the top, and goals and objectives that reflect what the partners plan to do to bring about positive change. The CEP also identifies the many partners who not only helped develop this plan but who will help to implement it. Progress toward implementing objectives will be monitored and shared using a performance scorecard, and indicators will help gauge any improvements at a community level.

The North Central Region is the most populous region in San Diego County, with over 642,500 residents who reside throughout the region's coastal towns, university communities, suburban areas, and military facilities. This region also represents most of the City of San Diego. Economic disparities exist between communities within the North Central Region despite being home to some of the county's wealthier neighborhoods and residents with the highest educational attainment. Considering the varying needs and disparities impacting residents' overall health and well-being, North Central Region community leaders continue to take actions that help fulfill the *Live Well San Diego* vision.

This effort to develop a new CEP began in early 2022 as this region, just like the rest of the country, was coming out of the COVID-19 pandemic. The NCeCLT was revitalized, and this CEP reflects fresh perspectives of its many new members. The County of San Diego placed new emphasis on community engagement in hiring regional community coordinators to ensure the five community leadership teams (NCeCLT included) were fully engaged as the "voice" for community change. Implementation has already begun, and priorities and goals will evolve as lessons are learned over this planning cycle and into the next. This dynamism will help to ensure that the CEP continues to be responsive to the needs of this leadership team.

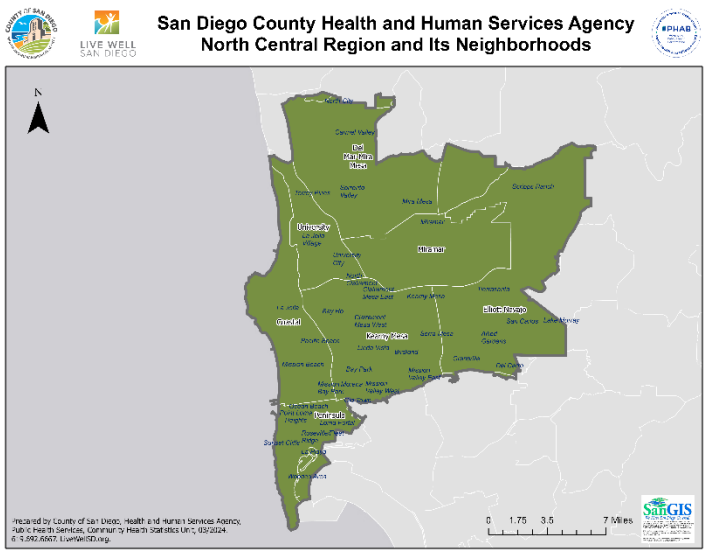
Thank you for all that you do to help every resident Live Well!

Karen Lenyoun
Public Health Advocate

Justine Kozo, MPH
Chief, Regional Community Coordinator, North Central Region
Department of Homeless Solutions and Equitable Communities
County of San Diego, Health & Human Services Agency

North Central Region Community Enrichment Plan

About the Region



The North Central Region of San Diego County is one of the most diverse geographical regions in the county, with miles of pristine Pacific coastline, steep canyons, valleys, and mountainous terrains. The region comprises seven subregional areas (SRAs): Coastal, Del Mar-Mira Mesa, Elliott-Navajo, Kearny Mesa, Miramar, Peninsula, and University. The region also represents most of the City of San Diego, encompassing the northern half and 24 smaller communities, including Ocean Beach, Linda Vista, Mission Valley, Clairemont, La Jolla, and Tierrasanta.

The North Central Region is the most populous region in San Diego County, with over 642,500 residents who reside throughout the region's coastal towns, university communities, suburban areas, and military facilities. While residents in North Central Region come from different racial/ethnic backgrounds, the region has the highest proportion of non-Hispanic Asian residents. Economic disparities exist between communities within the North Central Region despite being home to some of the county's wealthier neighborhoods and residents with the highest educational attainment. Considering the varying needs and disparities impacting residents' overall health and well-being, North Central Region community leaders continue to take actions that help fulfill the *Live Well San Diego* vision.

About the Community Leadership Team

The North Central Community Leadership Team (NCeCLT) plays a vital role in driving the region's initiatives forward. Their meetings, held in-person, every 2nd Wednesday of the month, serve as a platform for collaboration, discussion, and decision-making. During these meetings, members of the CLT have the opportunity to share updates, exchange ideas, and strategize on how to carry out the region’s vision statement.

Vision Statement: A vibrant, diverse, and welcoming community with access to equitable resources and services.

Priority Areas and Work Groups

Behavioral Health, Food and Housing Insecurity, and Youth

Partner Organizations

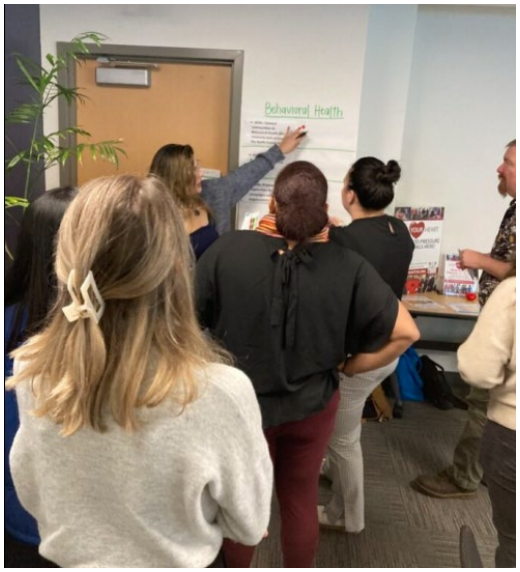
These are the partner organizations in which representatives are (or have) served as Co-Chairs of the CLT. Additional partners are recognized below by the Priority Work Groups on which they participate.

ORGANIZATIONS SERVING AS CO-CHAIRS TO NCeCLT
Karen Lenyoun, Public Health Advocate, Urban Strategic Solutions ***With support from the Department of Homeless Solutions and Equitable Communities, Health & Human Services Agency, County of San Diego***

NORTH CENTRAL REGION PRIORITY: BEHAVIORAL HEALTH

Telling the Story of This Priority

Why is this a Priority?



Members of the North Central Community Leadership Team (NCeCLT) identified behavioral health as a key concern for the region, particularly among teens. Exacerbated by isolation during the COVID-19 pandemic, leaders were concerned that teens were struggling and needed better access to behavioral health support. The Regional Data Presentation delivered by the Community Health Statistics Unit provided insights regarding these challenges. Data showed that self-harm and suicide were the second leading cause of death for teens. Yet there are challenges in getting help to these teens. Data showed that of those teens who did not seek mental health help from an online tool, more than half said this was due to lack of time or skepticism about its effectiveness. Other concerning trends include a dramatic increase in opioid overdoses among all residents.

Strategy For Change:

The Behavioral Health Work Group is coordinating a multifaceted strategic approach: **Building a Better Service Delivery System**, **Supporting Positive Choices**, and **Improving the Culture from Within**.

The NCeCLT formed the Behavioral Health Work Group, focusing on increasing awareness and promoting behavioral health resources and services in the North Central Region that support a continuum of care. This includes inviting key partner organizations to present on their programs, developing an asset map of NCeCLT organizations with behavioral health services, and disseminating helpful information to the community. The Work Group also supports harm reduction substance abuse prevention strategies and stigma-free behavioral health campaigns through NCeCLT trainings. Trainings, promoting and sharing resources, and collaboration among NCeCLT partners, demonstrate how building, maintaining, and strengthening community coalitions can help address

behavioral health issues. One example includes a training hosted by the NCeCLT that focused on administering and distributing Naloxone to partner organizations. Through collaboration with key stakeholders leveraging partner resources, the NCeCLT is working to ensure that behavioral health remains a top priority in the region. *See Basis for Action for more information about the research or evidence that supports this approach.*

Partners Taking Action:

	Community & Faith-Based Organizations	Business & Healthcare	Education	Government
Participating Organizations	SAY San Diego	Alzheimer's Association	Bastyr University	Behavioral Health Services, Health & Human Services Agency (HHSA), County of San Diego (CoSD)
	San Diego Community Health Improvement Partners (CHIP)	Child Development Associates	UC San Diego	Public Health Services, HHSA, CoSD
	Vision y Compromiso	Southern Caregiver Resource Center	University of San Diego	
		St. Paul's PACE		

**Note: These do not represent all partners in the North Central Region Community Leadership Team. Only those partners actively involved in advancing this priority are listed here.*

What is Our Concern?

REGIONAL POPULATION INDICATORS THAT AFFECT THIS PRIORITY:

HEALTH Age-adjusted death rate due to opioid overdoses in North Central Region.

- Age-adjusted death rates due to opioid overdoses in North Central Region more than doubled from 2017 (7.2 per 100,000) to 2021 (18.7 per 100,000).

Age-adjusted emergency department (ED) discharge rate due to anxiety and fear-related disorders in North Central Region.

- Age-adjusted ED discharge rates due to anxiety and fear-related disorders in North Central Region decreased by 9.1% from 2017 (172.7 per 100,000) to 2021 (156.9 per 100,000). Although there has been a decrease in rates, anxiety and fear-related disorders remained among the top three leading behavioral health conditions for ED discharges within the region.

Age-adjusted emergency department (ED) discharge rate due to suicide attempt/ideation in North Central Region.

- Age-adjusted ED discharge rates due to suicide attempt/ideation in North Central Region decreased by 58.6% from 2017 (125.1 per 100,000) to 2021 (198.4 per 100,000). Although there has been a decrease in rates, suicide attempt/ideation remained among the top three leading behavioral health conditions for ED discharges within the region.

Key

Arrow depicts direction of 5-year trend	On the Right Track	Not On Track	Trend not Available

What are We Doing About It?

Goal 1. Connect communities to Behavioral Health resources and services in North Central Region to support a care continuum.

Objective 1.1. Develop an asset map of behavioral health resource organizations in North Central Region.

Measure 1.1.1. Degree to which (0 to 4) an asset map created that includes all (100%) of Behavioral Health service organizations by the end of FY 23-24.

Objective 1.2. Increase accessibility of information about North Central behavioral health service organizations.

Measure 1.2.1. Within six months (beginning January 2024 by June 2024), the list of organizations and map are uploaded to an online portal.

Goal 2. Support harm reduction substance use prevention strategies.

Objective 2.1. Offer trainings in harm reduction to North Central organizations.

Measure 2.1.1. Two harm reduction trainings offered each fiscal year at NCeCLT meetings.

Objective 2.2. Promote harm reduction strategies at NCeCLT meetings.

Measure 2.2.1. Two harm reduction strategies promoted each fiscal year.

Goal 3. Promote Behavioral Health and stigma-free campaigns among North Central organizations.

Objective 3.1. Promote initiatives/campaigns at NCeCLT meetings.

Measure 3.1.1. At least four initiatives/campaigns promoted each fiscal year.

Objective 3.2. Disseminate informational materials, behavioral health data, and campaigns.

Measure 3.2.1. At least four times per year, material is disseminated.

Monitoring

The North Central Region Behavioral Health Priority, including all associated measures, is being tracked as a Scorecard within a performance management application. Data are collected and progress is reported on a quarterly basis. You can see our progress by going to the link: North Central Region Behavioral Health Priority Scorecard

NORTH CENTRAL REGION PRIORITY: FOOD AND HOUSING INSECURITY

Telling the Story of This Priority

Why is this a Priority?

Concerns about food and housing insecurity emerged from discussions among the members of the North Central Community Leadership Team (NCeCLT). The Regional Data Presentation delivered by the Community Health Statistics Unit reinforced these concerns and also captured considerable disparities across the region, which has mixed-income neighborhoods including under-resourced and some of the county's wealthier neighborhoods. More than a third of low-income adults in the North Central Region reported being food insecure, and more than a third of households showed housing insecurity to be a serious problem. The City of San Diego (which encompasses North Central, Central, and parts of South Regions) saw a jump in homelessness between 2022 and 2023 alone, and many households spent a third of their income on housing. A recent survey of community members also identified homelessness and housing insecurity as top concerns.

Strategy for Change

The Food and Housing Insecurity Work Group is implementing a two-tiered strategic approach: **Building a Better Service Delivery System** and **Supporting Positive Choices**.

The NCeCLT is undertaking a number of actions to address food and housing insecurity in North Central Region. Several objectives aim to educate partners on food and housing issues using the Leadership Team meetings by hosting partner presentations and providing trainings. One strategy looks to connect communities to food and housing resources and services by creating a repository of resources. Stigma is a major barrier to reaching residents who may be struggling economically. This is why stigma-free campaigns are part of the strategy. Stakeholders, including partners represented in the NCeCLT, will play a crucial role in implementing ways to improve the accessibility of healthy foods. One objective is to promote farmers' markets across the region that accept CalFresh and to promote food distribution sites. To inform activities to address the housing issue, the Work Group calls for active participation in

the #WeAllCount Point-in-Time count, which is a vital County-wide effort to document the number of unhoused individuals. *See Basis for Action for more information about the research or evidence that supports this approach.*

Partners Taking Action:

	Community & Faith-Based Organizations	Business & Healthcare	Education	Government
Participating Organizations	Bayside Community Center	St. Paul's PACE	University of California San Diego	Department of Homeless Solutions and Equitable Communities, Health & Human Services Agency (HHSA), County of San Diego (CoSD)
	+BOX			Public Health Services, Community Health Statistics Unit, HHSA, CoSD
	Courage 2 Call			
	Downtown San Diego Partnership			
	Jewish Family Services			

**Note: These do not represent all partners to the North Central Region Community Leadership Team. Only those partners actively involved in advancing this priority are listed here.*

What is Our Concern?

REGIONAL POPULATION INDICATORS THAT AFFECT THIS PRIORITY:

STANDARD OF LIVING

Adults with income less than 200% Federal Poverty Level (FPL) who are food insecure in North Central Region.

- Over a third of adults with income less than 200% FPL in North Central Region (35.9%) reported being food insecure between 2018-2022. Compared to all other HHSA regions, North Central Region had the second-highest proportion of food insecurity.

Percentage of the population in North Central Region with income below the Federal Poverty Level (FPL).

- The percentage of North Central Region residents living below 100% FPL decreased from 10.5% in 2017 to 9.3% in 2022. Despite improvements in the poverty level, the percentage of the population living below 100% FPL decreased the least in North Central Region (-11.1%) from 2017 to 2022 compared to all other HHSA regions.

Percentage of the population spending more than 30% of their income on housing in North Central Region.

- In 2022, 39.0% of households in Noth Central Region spent more than 30% of their income on housing costs; this is only slightly lower than in 2017 when 40.0% of households spent this much on housing. Nearly 2 out of every 5 households across the North Central Region were still cost-burdened in 2022.

Total persons experiencing homelessness in the City of San Diego.

- The City of San Diego primarily consists of the Central and North Central Regions of San Diego County, with a small portion extending into the South Region. The number of persons experiencing homelessness in the City of San Diego increased by 35.0% between 2022 and 2023, with 63.0% of the total unhoused population located within this geography.

Key

Arrow depicts direction of 5-year trend	On the Right Track	Not On Track	Trend not Available

What are We Doing About It?

Goal 1. Support North Central partner organizations' food and housing initiatives and projects.

Objective 1.1. Highlight North Central initiatives focused on food equity and housing at the NCeCLT meetings.

Measure 1.1.1. At least three initiatives will be highlighted at NCeCLT meetings in FY 23-24.

Objective 1.2. Promote participation in trainings and activities related to housing and food security.

Measure 1.2.1. A minimum of three trainings/activities, including the Point-in-Time count, are promoted in FY 23-24.

Measure 1.2.2. 10 participants will participate in the Hunger Free Navigator training program in FY 23-24.

Goal 2. Promote stigma-free food and housing insecurity campaigns and programs in North Central Region.

Objective 2.1. Highlight and support farmer's markets that accept CalFresh and food distributions in North Central Region.

Measure 2.1.1. A minimum of three farmer's markets, that accept CalFresh and food distributions, are identified, promoted, and supported in FY 23-24.

Measure 2.1.2. Five farmer's markets and food distribution sites that receive flyers about resources available through Live Well on Wheels.

Objective 2.2. Promote stigma-free campaigns related to homelessness.

Measure 2.2.1. At least two stigma-free homelessness campaigns are promoted at NCeCLT meetings in FY 23-24.

Goal 3. Connect communities to food and housing resources and services in North Central Region.

Objective 3.1. Create a repository of local food and housing-related resources in North Central Region.

Measure 3.1.1. Degree of completion (0 to 4) of one asset map of North Central organizations providing food resources/assistance is created in FY 23-24.

Measure 3.1.2. Degree of completion (0 to 4) of one asset map of North Central organizations providing housing resources/assistance is created in FY 23-24.

Measure 3.1.3. Degree of completion (0 to 4) of pocket guide of housing and food-related resources and programs in North Central Region.

Measure 3.1.4. Degree of completion (0 to 4) of Community Calendar of food distributions and farmer's market events in North Central Region.

Objective 3.2. Disseminate information obtained in the repository to local community organizations and schools.

Measure 3.2.1. A minimum of five community organizations and/or schools disseminate repository resources by June 30, 2025.

Monitoring

The North Central Region Food and Housing Insecurity Priority, including all associated measures, is being tracked as a Scorecard within a performance management application. Data are collected and progress is reported on a quarterly basis. You can see our progress by going to the link: North Central Region Food and Housing Insecurity Priority Scorecard

NORTH CENTRAL REGION PRIORITY: YOUTH

Telling the Story of This Priority

Why is this a Priority?

The North Central Community Leadership Team (NCeCLT) identified challenges that youth were facing that made it difficult for them to thrive and become successful adults. Of particular concern were mental health challenges and disparities in educational achievement among North Central communities. There was recognition that the COVID-19 pandemic may have exacerbated these concerns. Based on youth risk behavior surveillance data from the Centers for Disease Control and Prevention, mental health problems were worsening among high school students. Attention to the special difficulties that foster children face was also part of these concerns for youth. As a result of these trends, the Youth Work Group was formed to focus on diverse youth and their needs.

Strategy for change.

The Youth Work Group is focusing on a three-layered strategic approach: **Building a Better Service Delivery System**, **Supporting Positive Choices**, and **Pursuing Policy and Environmental Changes**.

The NCeCLT formed the Youth Work Group to advance the well-being of youth in the region. Recognizing the benefits of community engagement with youth, the NCeCLT identified several objectives such as sharing resources with schools and families and participating in and/or sponsoring events for youth. A major focus is disseminating mental health education materials through numerous events, presentations, and campaigns. Increasing learning opportunities for families and youth is also a focus, including disseminating career training and workforce development information. This priority aims to improve the accessibility, effectiveness, and coordination of youth services and support systems in the region. It also emphasizes the importance of prevention by equipping youth and their families with the knowledge, skills, and support systems to make positive choices and effectively navigate challenges. *See Basis for Action for more information about the research or evidence that supports this approach.*

Partners Taking Action:

	Community & Faith-Based Organizations	Business & Healthcare	Education	Government
Participating Organizations	Big Brothers Big Sisters of San Diego County	Family Health Centers of San Diego	San Diego Unified School District	San Diego County Office of Education
	PRIDE Industries	North Central Teen Recovery Center	UC San Diego	
	Promises 2 Kids		University of San Diego	
	SAY San Diego			
	YMCA of San Diego			

What is Our Concern?

REGIONAL POPULATION INDICATORS THAT AFFECT THIS PRIORITY:

HEALTH

Percentage of teens aged 12-17 in San Diego County who did not get mental health help online.

TREND NOT AVAILABLE

- From 2021-2022, 2 out of every 3 teens aged 12-17 in San Diego County (67.6%) did not get mental health help online because they did not think it would be helpful/needed or did not have the time.

KNOWLEDGE

Percentage of adults 25 years and older with a high school diploma or equivalent in North Central Region.

- The percentage of adults aged 25 years and older without a high school diploma in North Central Region slightly decreased from 5.2% in 2017 to 5.1% in 2022. Despite an improvement in educational attainment in the region, disparities were seen among communities in North Central Region.
- In 2022, Kearny Mesa SRA had the highest proportion of adults 25 years and older without a high school diploma (8.1%), while Miramar SRA had the lowest (0.0%).

STANDARD OF LIVING

Percentage of teens aged 12-17 in North Central Region living below the Federal Poverty Level (FPL).

- The percentage of teens aged 12-17 living below 100% FPL in North Central Region decreased by 11.6% from 2017 (9.3%) to 2022 (8.3%).

- In 2022, over 1 in 8 teens aged 12-17 in Kearny Mesa SRA were living below 100% FPL, despite living within a region with one of the lowest proportions of residents living below 100% FPL.

STANDARD OF LIVING

Percentage of the population living below the Federal Poverty Level (FPL) in University subregional area (SRA).

- Among North Central Region SRAs, University had the highest percentage of the population living below 100% FPL in 2017 (22.9%) and 2022 (22.2%). This proportion was over twice as high as the region (9.3%) and the county overall (10.6%) in 2022.
- In 2022, University SRA had a higher percentage of families with children under 18 years living below 100% FPL (9.6%) than North Central Region (6.6%) and all other SRAs in the region.

Key

 Arrow depicts direction of 5-year trend	On the Right Track	Not On Track	Trend not Available

What are We Doing About It?

Goal 1. Increase awareness of North Central partner organizations' youth initiatives, projects, and programs.

Objective 1.1. Create an asset map of youth-serving organizations and programs in North Central Region.

Measure 1.1.1. Degree to which (0 to 4) an asset map of youth-serving organizations and programs completed in FY 23-24.

Objective 1.2. Highlight North Central partner organizations' youth initiatives, projects, and programs at the NCeCLT.

Measure 1.2.1. A minimum of three partner organizations' initiatives, projects, and programs are shared at NCeCLT meetings in FY 23-24.

Objective 1.3. Participate in North Central partner organization youth-focused events.

Measure 1.3.1. A minimum of 10 events sponsored by North Central partners are attended in FY 23-24.

Goal 2. Increase dissemination of mental health educational materials (resource guides, programs, and services) to schools in North Central within the 23-24 school year.

Objective 2.1. Partner with North Central schools to facilitate mental health presentations and tabling events.

Measure 2.1.1. A minimum of five tabling events are supported at North Central schools in FY 23-24.

Measure 2.1.2. A minimum of five presentations are coordinated at North Central schools in FY 23-24.

Objective 2.2. Promote mental health resources and campaigns on social media accounts.

Measure 2.2.1. Three social media posts are created to promote national awareness months each FY.

Measure 2.2.2. Degree of completion (0 to 4) of the campaign "What I Wish My Parents Knew" (created and promoted by end of FY 23-24).

Goal 3. Increase learning opportunities for families and youth in North Central Region.

Objective 3.1. Develop a formal list of available educational opportunities for youth and families.

Measure 3.1.1. Degree of completion (0 to 4) of a formal list that contains available educational opportunities for youth and families within FY 23-24.

Objective 3.2. Disseminate career training exploration/workforce development through schools in North Central Region.

Measure 3.2.1. Five career presentations delivered at same number of North Central high schools in FY 23-24.

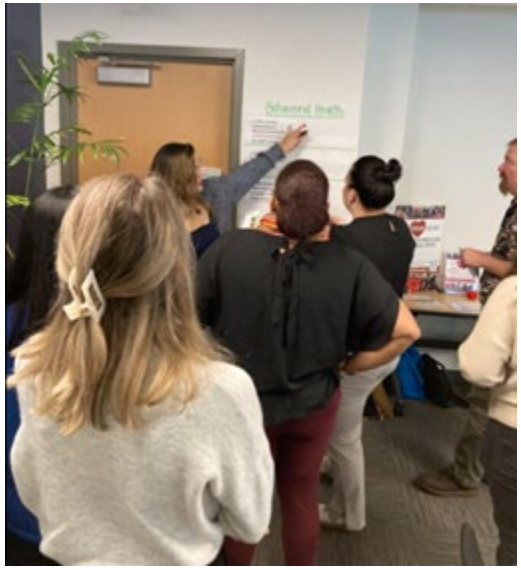
Objective 3.3. Disseminate CalFresh information to schools in North Central Region.

Measure 3.3.1. 10 schools provided information about CalFresh resources in FY 23-24.

Monitoring

The North Central Region Youth Priority, including all associated measures, is being tracked as a Scorecard within a performance management application. Data are collected and progress is reported on a quarterly basis. You can see our progress by going to the link: North Central Region Youth Priority Scorecard

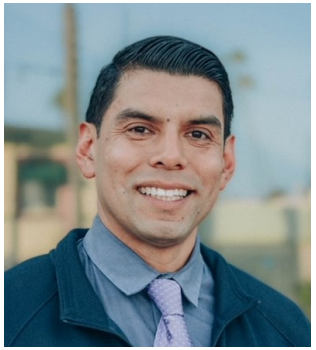
NORTH CENTRAL REGION PHOTO GALLERY



COMMUNITY ENRICHMENT PLAN
NORTH (INLAND AND COASTAL) REGIONS

LETTER FROM NORTH (INLAND AND COASTAL REGIONS) COUNTY CO-CHAIRS

Nannette Stamm



Jaime Figueroa

On behalf of the **North County Community Leadership Team (NCCLT)**, we are very pleased to present the Community Enrichment Plan (CEP) for FY 2023-2025. This CEP reflects a focus on three key concerns or priorities – **Substance Abuse Prevention**, **Mental Health**, and **Homelessness**. Within this CEP, you will find the "story" about the concerns of the NCCLT, community data which help explain why these concerns rose to the top, and goals and objectives that reflect what the partners plan to do to bring about positive change. The CEP also identifies the many partners who not only helped develop this plan but who will help to implement it. Progress toward implementing objectives will be monitored and shared using a performance scorecard, and indicators will help gauge any improvements at a community level.

The North County Region of San Diego County consists of two regions: the North Coastal and North Inland Regions. With over 532,500 residents, the North Coastal Region covers over a dozen communities that span from Del Mar in the south to the Orange County border in the north, including Vista and Rancho Santa Fe to the east. The North Inland Region is home to over 606,800 residents and includes dozens of smaller communities throughout a vast geographic expanse comprised of suburban areas, remote desert communities, historic mountain towns, rural homes and farms, and Indian reservations. These regions, when combined, make up the northern half of San Diego County and represent over a third of the county's population. Given the varying needs and disparities impacting residents' overall health and well-being, North County community leaders are committed to actions to help fulfill the *Live Well San Diego* vision.

This effort to develop a new CEP began in early 2022 as this region, just like the rest of the country, was coming out of the COVID-19 pandemic. The NCCLT was revitalized, and this CEP reflects fresh perspectives of its many new members. The County of San Diego placed new emphasis on community engagement in hiring regional community coordinators to ensure the five community leadership teams (NCCLT included) were fully engaged as the "voice" for community change. Implementation has already begun, and priorities and goals will evolve as lessons are learned over this planning cycle and into the next. This dynamism will help to ensure that the CEP continues to be responsive to the needs of this leadership team.

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

Nanette Stamm, MPH
Chief Community Health Officer
Vista Community Clinic

Jamie Figueroa, JD
Donor Relations Manager
True Care

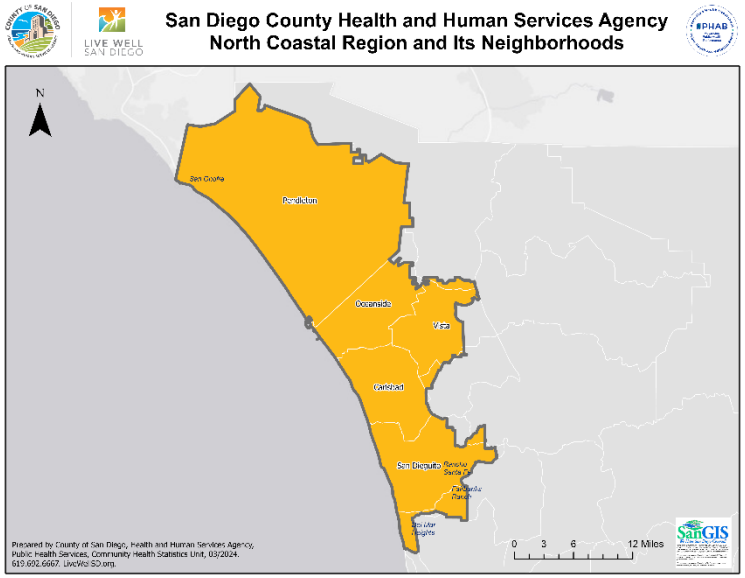
Herminia Ramirez

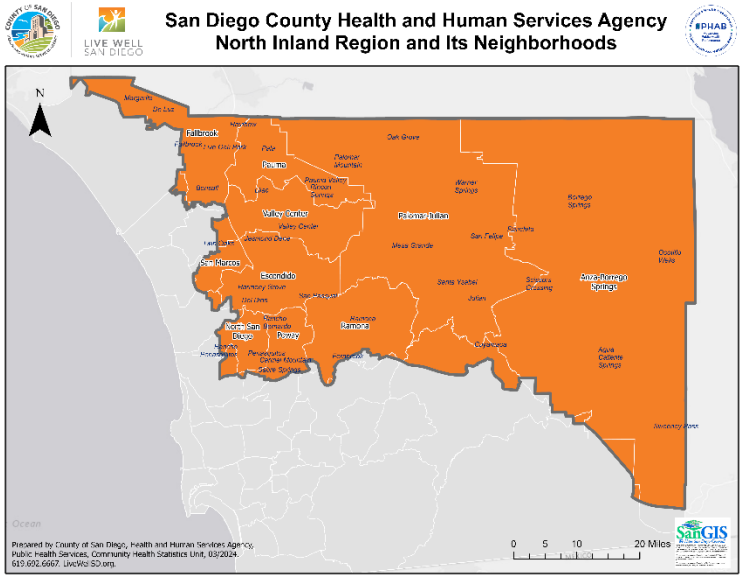
Herminia Ramirez, MPH
Chief, Regional Community Coordinator, North Inland Region
Department of Homeless Solutions and Equitable Communities
County of San Diego, Health & Human Services Agency

Belinda Slattebo

Belinda Slattebo
Chief, Regional Community Coordinator, North Coastal Region
Department of Homeless Solutions and Equitable Communities
County of San Diego, Health & Human Services Agency

NORTH (INLAND AND COASTAL REGIONS) COUNTY COMMUNITY ENRICHMENT PLAN





About These Two Regions

The North County Region of San Diego County consists of two regions, **North Coastal** and **North Inland Regions**, whose cities, communities, organizations, and residents work together to promote a healthy, safe, and thriving region.

With over 532,500 residents, the **North Coastal Region** comprises five subregional areas (SRAs): Carlsbad, Oceanside, Pendleton, San Dieguito, and Vista. These areas cover over a dozen communities that span from Del Mar in the south to the Orange County

border in the north, including Vista and Rancho Santa Fe to the east. The North Coastal Region is also home to the US Marine Corps' largest installation, Camp Pendleton.

The **North Inland Region** comprises ten SRAs, including Anza-Borrego Springs, Escondido, Fallbrook, North San Diego, Palomar-Julian, Pauma, Poway, Ramona, San Marcos, and Valley Center, with over 606,800 residents. Dozens of smaller communities in the North Inland Region are found throughout this vast geographic expanse, which includes suburban areas, remote desert communities, historic mountain towns, rural homes and farms, and Indian reservations.

These regions, when combined, make up the northern half of San Diego County and represent over a third of the county's population (34.6%). Considering the varying needs and disparities impacting residents' overall health and well-being, North County community leaders continue to take actions that help fulfill the Live Well San Diego vision.

About the Community Leadership Team

The North County Community Leadership Team (NCCLT), which serves both regions, is a community hub that convenes partner organizations throughout North Inland and North Coastal Regions. Participants strategize, learn, and network in a collaborative format. The CLT meets on the first Wednesday of every month.

Priority Areas and Work Groups

Mental Health, Substance Use Prevention, and Homelessness

Partner Organizations

These are the partner organizations in which representatives are (or have) served as Co-Chairs of the CLT. Additional partners are recognized below by the Priority Work Groups on which they participate.

ORGANIZATIONS SERVING AS CO-CHAIRS TO NCCLT

Nannette Stamm, MPH, Chief Community Health Officer, Vista Community Clinic
Jaime Figueroa, JD, Donor Relations Manager, TrueCare

With support from the Department of Homeless Solutions and Equitable Communities, Health & Human Services Agency, County of San Diego

NORTH COUNTY PRIORITY: SUBSTANCE ABUSE PREVENTION

Telling the Story of This Priority

Why is this a Priority?

Substance use issues affect youth and high-risk groups throughout San Diego County. Substance abuse negatively affects the health and life quality of users. In the Regional Data Presentation, delivered by the Community Health Statistics Unit, data presented revealed a steep rise in age-adjusted death rates due to opioid overdose in North County. Alcohol use is also a concern, being one of the top 3 behavioral health causes for emergency room discharges and hospitalizations. These, and other substance use challenges have led to the creation of the Substance Use Prevention Priority.

Strategy for Change

The Substance Use Prevention Work Group is pursuing a strategy that reflects two strategic approaches: **Building a Better Service Delivery System** and **Supporting Positive Choices**.

The Substance Use Prevention Work Group is striving to reduce youth substance use through outreach, family-targeted education, and building new partnerships. These activities are designed to meet families where they are at and incorporate strategies that are conscious of cultural needs and experiences. In addition, the Work Group is leveraging the role schools play in the lives of youth and families. Interventions at the school/district level are designed to increase collaboration and efforts among North County schools/districts. For example, a comprehensive list of community resources and services will be developed to help schools better support their students.

Partners Taking Action

	Community & Faith-Based Organizations	Business & Healthcare	Education	Government
Participating Organizations	Mental Health Services Turn BHS	Vista Community Clinic	Mira Costa College	City of Oceanside
	Coalition for Drug Free Escondido		Vista Unified School District	Department of Homeless Solutions and Equitable Communities, Health & Human Services Agency (HHSA), County of San Diego (CoSD)
	Mano a Mano			Public Health Services, HHSA, CoSD
	North County Informador			Marine Corps Community Services (MCCS) San Diego
	San Dieguito Alliance			

What is Our Concern?

REGIONAL POPULATION INDICATORS THAT AFFECT THIS PRIORITY:

HEALTH Age-adjusted death rates due to opioid overdoses in North Coastal and North Inland Regions.

- From 2017 to 2021, the age-adjusted death rates due to opioid overdoses increased by 169.1% (8.7 to 23.3 per 100,000) in the North Coastal Region and by 117.0% (7.5 to 16.3 per 100,000) in the North Inland Region.

HEALTH Age-adjusted emergency department (ED) discharge rates due to alcohol-related disorders in North Coastal and North Inland Regions.

- Alcohol-related disorders were among the top three leading behavioral health conditions for ED discharges in North Coastal and North Inland Regions every year from 2017 to 2021.
- Age-adjusted ED discharge rates due to alcohol-related disorders slightly increased by 0.1% in North Coastal Region and decreased by 13.2% in North Inland Region, from 2017 to 2021.

Key

 Arrow depicts direction of 5-year trend	On the Right Track	Not On Track	Trend not Available

What are We Doing About It?

Goal 1. Reduce substance use among youth and high-risk groups through culturally relevant and community-based prevention and intervention efforts.

Objective 1.1. Reduce youth substance use through family and culturally-focused approaches.

Measure 1.1.1. Engage at least 2 new partner organizations to participate in collaborative activities or events related to substance use prevention among youth and high-risk groups.

Measure 1.1.2. At least 2 parent-focused substance use prevention trainings offered.

Measure 1.1.3. At least 1 implemented recruitment strategy to promote Camp Hope & Pathways programs in FY 23-24.

Objective 1.2. Increase collaborative and integrated efforts among North County school districts.

Measure 1.2.1. Degree of completion (0 to 4) to create a list of programs and services available in North County school districts to share with the community to increase knowledge of, and access to, these resources by April 2024.

Measure 1.2.2. At least 2 new partners engaged of partner organizations who participate and collaborate in youth-related efforts.

Measure 1.2.3. Complete 12 updates to the North County Newsletter providing potential funding opportunities to subscribers.

Measure 1.2.4. Provide at least 2 Spanish workshops and presentations, in which partners are involved, that are conducted for students (and parents) on youth programs and services.

Objective 1.3. Increase the visibility of prevention and intervention resources at community-based locations in North County.

Measure 1.3.1. Degree of completion (0 to 4) to create a list of existing community-based prevention and intervention resources available in North County by May 2024.

Measure 1.3.2. At least 3 outreach strategies developed, in collaboration with community health workers, to increase community awareness of community-based resources and sites.

Measure 1.3.3. At least 3 promotional efforts of resources and programs undertaken to increase the visibility of prevention and intervention resources in North County.

Objective 1.4. Educate and train community leaders to become advocates through Resident Leadership Academies.

Measure 1.4.1. At least 1 Resident Leadership Academy facilitated in North County in FY 23-24.

Measure 1.4.2. Degree of completion (0 to 4) to create a list of potential funding opportunities to support Resident Leadership Academies by the end of FY 23-24.

Monitoring

The North County Region Substance Use Prevention Priority, including all associated measures, is being tracked as a Scorecard within a performance management application. Data are collected and progress is reported on a quarterly basis. You can see our progress by going to the link: North County Region Substance Use Prevention Priority Scorecard

NORTH COUNTY PRIORITY: MENTAL HEALTH

Telling the Story of This Priority

Why is this a Priority?

Mental/behavioral health challenges affect all residents of San Diego County. The formation of the Mental Health Priority and Work Group grew from serious concerns that too many residents were struggling with behavioral health challenges that could be remedied if they could get help and support. The Community Health Statistics Unit delivered a Regional Data Presentation that reflected the scope of the problem. In North County, one out of every four adults reported needing help with emotional, mental, or substance abuse problems. Emergency department discharge rates for suicide attempt/ideation have increased over the past five years, with a dramatic increase in North Inland Region. Emergency department age-adjusted discharge rates for anxiety and fear-related disorders have declined recently, however, it is still one of the top three behavioral health issues for ED discharges, indicating the need for support services.

Strategy for Change

The Mental Health Work Group is pursuing a strategy that reflects three strategic approaches: **Building a Better Service Delivery System**, **Supporting Positive Choices**, and **Improving the Culture from Within**.

The Mental Health Work Group has developed a strategy to improve mental health outcomes in North County. The Work Group has several activities that build community awareness of mental health and mental health services, reduce stigma, and promote healthy behaviors. The strategy also works to strengthen information, navigation, and referrals within the system, which allows residents a more streamlined experience that delivers support where and when they need it. The strategy also calls for helping the workforce or providers of behavioral health care and services. The Work Group calls for first conducting a needs assessment of those in the field and then providing resources for providers to better serve the community. In this way, the strategy represents a holistic approach that supports not only North County residents but the system of care.

Partners Taking Action.

Participating Organizations				
	Community & Faith-Based Organizations			
	MAAC Project	Equation Collaborative	MANA	Lifeline Community Services
	Interfaith Services	Pacific Housing Inc	PlusBox	Southern Caregiver Resource Center
	Nature Unplugged	NC Lifeline	Empowering Latino Futures (ELF)	
	San Diego Community Health Improvement Partners (CHIP)	Universidad Popular	Las Valientes	
	Government			
	Behavioral Health Advisory Board, Health & Human Services Agency, County of San Diego (CoSD)	City of Oceanside	Medical Care Services, HHSA, CoSD	Department of Homeless Solutions and Equitable Communities, HHSA, CoSD
	Public Health Services, HHSA, CoSD			
	Education		**Business & Health Care**	
	Education Begins in the Home	Universidad Popular	Fallbrook Regional Health District	Las Valientes, Caregiver Center
			Palomar Health	Vista Community Clinic

What is Our Concern?

REGIONAL POPULATION INDICATORS THAT AFFECT THIS PRIORITY:

HEALTH

Percentage of adults in North Coastal and North Inland Regions that reported they needed help for emotional/mental health problems or use of alcohol/drugs.

- In 2022, 20.5% of adults in North Coastal Region and 28.8% of adults in North Inland Region reported needing help for emotional/mental health problems or alcohol/drug use.

- The reported need for help with emotional/mental health problems or alcohol/drug use in North County increased from 20.1% in 2018 to 25.0% in 2022.

HEALTH Age-adjusted emergency department (ED) discharge rates for suicide attempt/ideation in North Coastal and North Inland Regions.

- From 2017 to 2021, the age-adjusted ED discharge rates due to suicide attempt/ideation increased by 27.7% (150.7 to 192.5 per 100,000) in the North Coastal Region and by 145.4% (98.5 to 241.9 per 100,000) in the North Inland Region.

HEALTH Age-adjusted emergency department (ED) discharge rates for anxiety and fear-related disorders in North Coastal and North Inland Regions.

- From 2017 to 2021, the age-adjusted ED discharge rates due to anxiety and fear-related disorders decreased by 26.6% (193.6 to 142.1 per 100,000) in the North Coastal Region and by 29.3% (209.9 to 148.3 per 100,000) in the North Inland Region.
- Although there has been a decrease in rates, anxiety and fear-related disorders were among the top three leading behavioral health conditions for ED discharges in North Coastal and North Inland Regions every year from 2017 to 2021.

Key

Arrow depicts direction of 5-year trend	On the Right Track	Not On Track	Trend not Available

What are We Doing About It?

Goal 1. Improve the community's awareness of and access to mental health prevention efforts and services that are responsive to all needs, culturally relevant, and locally based.

Objective 1.1. Improve the mental health information and referral system in North County.

Measure 1.1.1. At least 2 new partners engaged to work collaboratively on increasing the community's awareness of and access to mental health prevention efforts.

Measure 1.1.2. Conduct at least 1 informational workshop or seminar in collaboration with community organizations to educate residents about available mental health services and how to access services in Spanish and English.

Objective 1.2. Strengthen community-based organizations' ability to navigate and connect their clients to services in North County.

Measure 1.2.1. Degree of completion (0 to 4) to create an asset map and compilation of existing mental health services (access, referral system, level of types of car-acuity, cost/coverage) in North County by September 2024.

Measure 1.2.2. At least two web pages identified to increase awareness of mental health services by December 2024.

Measure 1.2.3. 5% increase in the number of page views accessing the site.

Objective 1.3. Design and conduct community outreach campaigns that reduce stigma and build awareness of supportive services in North County.

Measure 1.3.1. At least one region-specific stigma reduction campaign held in North County.

Measure 1.3.2. At least 2 initiatives/campaigns promoted each fiscal year.

Measure 1.3.3. At least 2 new outreach initiatives implemented to address mental health stigma.

Measure 1.3.4. At least 4 times per year, material on stigma reduction is disseminated in North County.

Objective 1.4. Assist our mental health workforce in North County in accessing personal care and professional support.

Measure 1.4.1. Degree of completion (0 to 4) to conduct a needs assessment or listening session to identify mental health needs and priorities for North County's workforce by November 2024.

Measure 1.4.2. Degree of completion (0 to 4) to develop an asset map and compilation of mental health resources to improve the health and well-being of North County's workforce by December 2024.

Measure 1.4.3. At least 20 members are provided this compilation of workforce mental health resources.

Monitoring

The North County Region Mental Health Priority, including all associated measures, is being tracked as a Scorecard within a performance management application. Data are collected and progress is reported on a quarterly basis. You can see our progress by going to the link: North County Region Mental Health Priority Scorecard

NORTH COUNTY PRIORITY: HOMELESSNESS

Telling the Story of This Priority

Why is this a Priority?

Addressing homelessness is a critical priority for the North County Central Leadership Team (NCCLT), as it is linked to various issues affecting mental health, substance use, and overall quality of life. Housing insecurity exacerbates existing health disparities and presents significant challenges and safety concerns for homeless individuals and communities alike. Through prioritizing homelessness, the North region will be able to create a healthier, high-quality life for the individuals who are suffering from housing insecurity. The Regional Data Presentation delivered by the Community Health Statistics Unit reflected the growing homelessness problem. The Homelessness Work Group investigated ways to improve access to resources and shelter information to increase the likelihood that individuals are connected to support, particularly those with complex needs and conditions.

Strategy for Change

The Homelessness Work Group is pursuing a strategy that reflects two strategic approaches: **Building a Better Service Delivery System** and **Pursuing Policy and Environmental Changes**.

The homelessness strategy will help identify gaps in current housing-related initiatives. This priority strives to prevent homelessness through integrated, holistic, and accessible services that are delivered through innovative collaborations and resources. This goal will be pursued through expansion of prevention and early intervention efforts, strengthening education and advocacy towards legislation for rent control and assistance, and increasing the number of available shelter beds. These actions will in turn decrease the number of homeless individuals in North County.

Partners Taking Action

	Community & Faith-Based Organizations	Business & Healthcare	Education	Government
Participating Organizations	YMCA	TrueCare	San Marcos Unified School District (SMUSD)	Department of Homeless Solutions and Equitable Communities, Health & Human Services Agency (HHSA), County of San Diego (CoSD)
	Coalition for a Drug-free Escondido		Education Compact	Public Health Services, HHSA, CoSD
	Courage to Call			City of Carlsbad
	Operation Hope Shelter			City of Vista
	Interfaith Services			City of San Marcos
	ELSB			
	ELSB			

What is Our Concern?

REGIONAL POPULATION INDICATORS THAT AFFECT THIS PRIORITY:

STANDARD OF LIVING

Cost of living for a household with 2 adults and 2 children in North Coastal and North Inland Regions.

TREND NOT AVAILABLE

- In North Coastal Region, a household with two adults, one preschool-age child, and one school-age child, would need an annual salary of about $94,332 to make ends meet in 2022. A family making the California minimum wage would fall short of the minimum self-sufficiency income needed to survive in North Coastal Region, by about $31,932 a year.
- In North Inland Region, a household with two adults, one preschool-age child, and one school-age child, would need an annual salary of about $90,290 to make ends meet in 2022. A family making the California minimum wage would fall short of the minimum self-sufficiency income needed to survive in North Inland Region, by about $27,890 a year.

SOCIAL

Persons experiencing homelessness in North Coastal and North Inland Regions.

- Between 2022 and 2023, the number of persons experiencing homelessness increased by 5.0% in the North Coastal Region and decreased by 6.0% in the North Inland Region. Overall, for North County, the number of persons experiencing homelessness slightly decreased for this same period.
- In 2023, a combined 14% of the total unhoused population were located within the North Coastal Region (8%) and the North Inland Region (6%), with the Cities of Oceanside and Escondido being most impacted.

Key

 Arrow depicts direction of 5-year trend	On the Right Track	Not On Track	Trend not Available

What are We Doing About It?

Goal 1. Prevent homelessness through integrated, holistic, and accessible services that are delivered through innovative collaborations and resources.

Objective 1.1. Expand prevention and early intervention efforts among high-risk groups in North County.

Measure 1.1.1. Degree of completion (0 to 4) to develop a list of resources to identify gaps and strengths in current efforts to support high-risk populations (e.g., seniors, undocumented individuals, kids aging out of foster care) by November 2024.

Measure 1.1.2. At least 2 new communication strategies created to increase awareness of resources available.

Measure 1.1.3. Degree of completion (0 to 4) to develop a list of potential funding opportunities for programs and services tailored to senior and other high-risk groups (e.g., rental assistance, case management, Home Safe, and Project CARE) by August 2023.

Objective 1.2. Strengthen education and advocacy towards legislation for rent control and assistance among landlords and local jurisdictions.

Measure 1.2.1. Provide at least 1 presentation to landlords to better engage in community meetings addressing homelessness.

Measure 1.2.2. At least 1 workshop or event is convened to increase knowledge and education about homelessness, resources, and successful models to strengthen the community's ability to secure and maintain housing.

Measure 1.2.3. At least 2 partners engaged to work collaboratively to expand homeless outreach and advocacy.

Objective 1.3. Increase the number of available shelter beds and emergency shelters in North County.

Measure 1.3.1. Degree of completion (0 to 4) to compile a list of the number of shelters and beds in North County by March of 2024.

Measure 1.3.2. At least 1 collaborative activity implemented, or programs established to support new shelter/emergency bed programs in North County.

Monitoring

The North County Region Homelessness Priority, including all associated measures, is being tracked as a Scorecard within a performance management application. Data are collected and progress is reported on a quarterly basis. You can see our progress by going to the link: North County Region Homelessness Priority Scorecard

NORTH COUNTY REGION PHOTO GALLERY

COMMUNITY ENRICHMENT PLAN SOUTH REGION

LETTER FROM SOUTH REGION CO-CHAIRS

Valerie Brew

Janet Barragan

Dear Community Partner

On behalf of the **South Region Leadership Team (SRCLT)**, we are very pleased to present the Community Enrichment Plan (CEP) for FY 2023-2025. This CEP reflects a focus on three key concerns or priorities – **Behavioral Health**, **Homelessness**, and **Food Insecurity**. Within this CEP, you will find the "story" about the concerns of the SRCLT, community data which help explain why these concerns rose to the top, and goals and objectives that reflect what the partners plan to do to bring about positive community change. The CEP also identifies the many partners who not only helped develop this plan but who will help to implement it. Progress toward implementing objectives will be monitored and shared using a performance scorecard, and indicators will help gauge any improvements at a community level.

The South Region of San Diego County is a highly diverse border region which is bound to the West by the Pacific Ocean and to the South by the Mexican border, where the community of San Ysidro hosts the busiest border crossing in the world. In addition to the South Region's geographic diversity, its residents represent various demographic, economic, and social backgrounds. South Region has the highest proportion of Hispanic residents and one of the highest proportions of children and young adults. South Region is among the most economically disadvantaged regions, with an unemployment rate higher than all other regions in the county. Given the varying needs and disparities impacting residents' overall health and well-being, South Region community leaders are committed to actions to help fulfill the *Live Well San Diego* vision.

This effort to develop a new CEP began in early 2022 as this region, just like the rest of the country, was coming out of the COVID-19 pandemic. As a Baldrige Communities of Excellence Silver Award recipient, SRCLT adhered to this methodology in its planning activities. The SRCLT was revitalized, and this CEP reflects fresh perspectives of its many new members. The County of San Diego placed new emphasis on community engagement in hiring regional community coordinators to ensure the five community leadership teams (NCCLT included) were fully engaged as the "voice" for community change. Implementation has already begun, and priorities and goals will evolve as lessons are learned over this planning cycle and into the next. This dynamism will help to ensure that the CEP continues to be responsive to the needs of this leadership team.

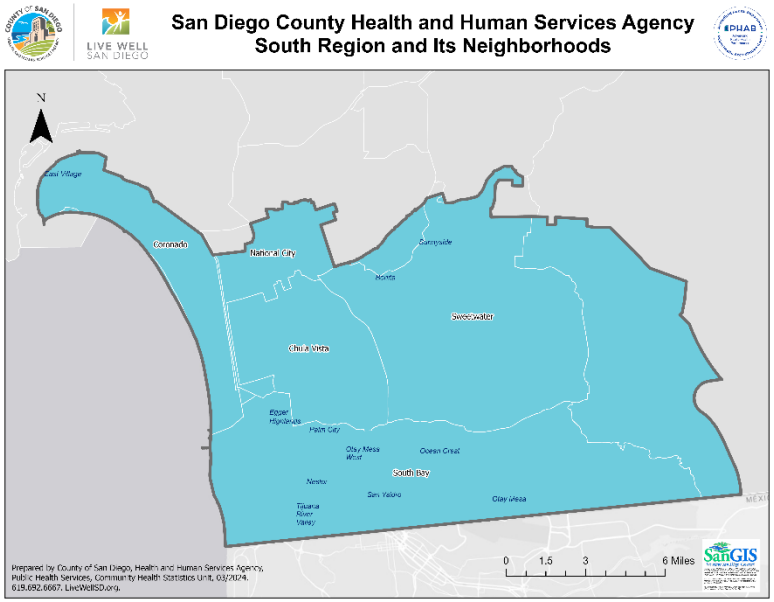
Thank you for all that you do to help every resident Live Well!

Valerie Brew
Department Director
SBCS Corporation

Janet Barragán, MSW
Chief, Regional Community Coordinator, South Region
Department of Homeless Solutions and Equitable Communities
County of San Diego, Health & Human Services Agency

SOUTH REGION COMMUNITY ENRICHMENT PLAN

About the Region



The South Region of San Diego County is a highly diverse border region with urban, suburban, and rural areas amidst its five subregional areas (SRAs), including Chula Vista, Coronado, National City, South Bay, and Sweetwater. The region is bound to the West by the Pacific Ocean and to the South by the Mexican border, where the community of San Ysidro hosts the busiest border crossing in the world. South Region is also home to nearly a dozen communities, including Bonita, Nestor, Palm City, and Otay Mesa.

In addition to the South Region's geographic diversity, its residents represent various demographic, economic, and social backgrounds. As of 2022, 496,613 people resided in South Region, representing 15.1% of San Diego County's population. South Region has the highest proportion of Hispanic residents and one of the highest proportions of children and young adults aged 0 to 24 years old. South Region is among the most economically disadvantaged regions, with an unemployment rate higher than all other regions in the county. Considering the varying needs and disparities impacting residents' overall health and well-being, South Region community leaders continue to take actions that help fulfill the *Live Well San Diego* vision.

About the Community Leadership Team

The South Region Leadership Team (SRCLT) is a Baldrige Communities of Excellence Silver Award recipient, awarded for the commitment to improve the health and well-being of residents and the pursuit of excellence in communities in the South Region. In addition to being part of the *Live Well San Diego* collective impact initiative, the SRCLT applied the Baldrige framework to enhance community outcomes, including criteria such as systems change, meaningful collaboration, data-driven planning, and leadership development.

The SRCLT meetings serve as a forum for fostering cross-sector collaboration. The leadership team convenes every other month, while priority Work Groups convene monthly. The meetings bring together a diverse group of stakeholders, with over 100 partners representing various sectors. Its strategic focus is aligning initiatives to address key community needs and enhance overall well-being. These regular engagements reflect collaborative synergy, a platform for dynamic discussions and strategic planning, and concerted efforts toward fostering a thriving and resilient community within the South Region.

Framework for the SRCLT's Community Enrichment Plan

SRCLT developed a framework for its CEP, consistent with the Baldrige methodology, after much exploration and discussion.

- **Mission:** Improving the well-being of the South Region community through collaboration and policy, systems, and environmental changes that promote equitable, healthy, safe, and thriving communities.
- **Vision:** An equitable community that is building better health, living safely, and thriving.
- **Core Values:** Commitment, Shared Leadership, Collaboration, Diversity
- **Core Competencies:** Collaboration & Trust, Community Engagement & Empowerment, Connecting Residents to Resources

Priority Areas and Work Groups

Behavioral Health, Homelessness, and Food Insecurity

Partner Organizations

These are the partner organizations in which representatives are (or have) served as Co-Chairs of the Priority Work Groups. Additional partners are recognized below by the Priority Work Groups on which they participate.

REPRESENTATIVES OF ORGANIZATIONS SERVING AS CO-CHAIRS TO SRCLT

Valerie Brew, Department Director, SBCS Corporation
Janet Barragán, Departmental Chief, Regional Community Coordinator, Department of Homeless Solutions and Equitable Communities – Office of Equitable Communities, Health & Human Services Agency, County of San Diego

Behavioral & Mental Health Work Group
Angel Ibarra, Associate Director, Episcopal Community Services
Pualani Vazquez, Injury Prevention Community Outreach Coordinator, Scripps Health

Homelessness Work Group
Susan Bower, Regional Task Force on Homelessness
Carla Vanegas, Outreach Manager, San Diego Rescue Mission
Veronica Medina, Coordinator of Pupil Services, San Ysidro School District

Food Insecurity Work Group
Karen Clay, CEO, I Love to Glean
Cynthia Fuller Quinonez, Retired healthcare, food service manager, and food system activist

Backbone Entity: Department of Homeless Solutions and Equitable Communities, Health & Human Services Agency, County of San Diego

SOUTH REGION PRIORITY: BEHAVIORAL HEALTH

Vision Statement for this Priority: Create solutions that provide equitable access and remove barriers to behavioral and mental health resources and services for an improved quality of life.

Mission Statement for this Priority: To transform mental health and well-being through community-led solutions so that all people who live, work, and play in San Diego South Region can be met where they are at with the resources they need.

Telling the Story of This Priority

Why is this a Priority?

Behavioral Health emerged as a priority of the South Region Leadership Team (SRCLT) for several reasons. Members expressed concerns that too many residents were struggling with depression, anxiety, and other behavioral health challenges, exacerbated by the isolation residents endured during the pandemic. Opioid addiction was also getting more attention in South Region as it was across the county. In April 2023, the Community Health Statistics Unit delivered the Regional Data Presentation. Several trends caught the attention of the SRCLT, including increases in emergency department discharge rates due to opioid overdoses and also in hospitalization rates due to suicide attempts. Among South Region subregional areas (SRAs), South Bay had the highest age-adjusted hospitalization rates due to suicide attempt/ideation. Although there has been a generally positive (and downward) trend in emergency department discharge rates for anxiety and related disorders, the most recent data shows an uptick.

Strategy for Change

The Behavioral and Mental Health Work Group is pursuing a strategy that reflects two strategic approaches: **Building a Better Service Delivery System** and **Supporting Positive Choices**.

This Community Enrichment Plan calls for outreach to residents regarding behavioral and mental health resources and increasing equitable access to care. This strategy is supported by research on community-based interventions that includes coordinating community and partner organizations for increased behavioral and mental health awareness and prevention. Actions to provide mental health awareness, prevention, and resources through resilience fairs and outreach events reflect community outreach approaches that support residents' linkage to existing services and navigation of health and social care systems. *See Basis for Action for more information about the research or evidence that supports this approach.*

Partners Taking Action:

	Community & Faith-Based Organizations	Business & Healthcare	Education	Government
Co-Chairs	**Episcopal Community Services** **SBCS Corporation**	**Scripps Mercy Hospital**		**Department of Homeless Solutions and Equitable Communities, Health & Human Services Agency (HHSA), County of San Diego (CoSD)**
Participating Organizations	**Community & Faith-Based Organizations**			
	Institute for Public Strategies (IPS)	Crisis House	Survivors of Suicide Loss (SOSL)	San Diego in Recovery
	South Bay Border View YMCA	Bilateral Safety Corridor Coalition (BSCC)	CARE Community Center	Veterans Yoga Project
	Mundo Gardens	PACEs Connection	Community Health Improvement Partners (CHIP)	MAAC Project
	VVSD/Courage to Call	San Diego Rescue Mission	Casa Familiar	2-1-1 San Diego
	Business & Healthcare			
	Molina Health Care	Family Health Center	Independent Living Assoc. (ILA) San Diego County	Alliance Healthcare
	Scripps Mercy Hospital	Newport Healthcare	Psychiatric Emergency Response Team (PERT)	Child Development Associates (CDA)
	San Ysidro Health PACE	Behavioral Health Advisory Board (BHAB)	Chula Vista Crisis Stabilization Unit Paradise Valley Hospital	
	Education		**Government**	
	San Ysidro School District	Learn4Life	San Diego County Suicide Prevention Council	Public Health Services, HHSA, COSD

What is Our Concern?

REGIONAL POPULATION INDICATORS THAT AFFECT THIS PRIORITY:

HEALTH

Age-adjusted emergency department discharge rates due to anxiety and fear-related disorders in South Region.

- Age-adjusted emergency department (ED) discharge rates due to anxiety and fear-related disorders in South Region have decreased since 2017, a positive trend. However, the ED discharge rate increased from 220.6 per 100,000 in 2020 to 253.1 per 100,000 in 2021, which is in the wrong direction.

HEALTH

Emergency department (ED) encounters due to nonfatal opioid overdoses and opioid overdose deaths among residents in South Region. *

- The rate of nonfatal opioid overdose ED encounters has increased from 2017-2021 in South Region, with a 108% increase (35.1 per 100,000 residents to 73.0 per 100,000 residents).
- The rate of opioid overdose deaths from 2018-2022 has increased in South Region, with a 241% increase (4.2 per 100,000 residents to 14.5 per 100,000 residents).

HEALTH

Suicide deaths among residents in South Region. *

- The rate of suicide deaths has increased from 2018-2022 in South Region, with a 16% increase (7.9 per 100,000 residents to 9.1 per 100,000 residents).

*Prepared by County of San Diego, Health and Human Services Agency, Behavioral Health Services

Key

Arrow depicts direction of 5-year trend	On the Right Track	Not On Track	Trend not Available

What are We Doing About It?

Goal 1. Increase community involvement to address behavioral and mental health needs in South Region.

Objective 1.1. Collectively coordinate two community resilience fairs for South Region, to discuss mental health awareness, prevention, and resources.

Measure 1.1.1. At least 2 community resilience fairs coordinated by June 2024.

Goal 2. Increase equitable access to behavioral and mental health resources and services in South Region.

Objective 2.1. Collaborate with partners and community groups to increase awareness and prevention of behavioral and mental health issues.

Measure 2.1.1. Five partner and/or community-led resource fairs and events are supported by this Work Group by December 2024.

Goal 3. Increase the quality of life of all people who live, work, and play in South Region.

Objective 3.1. Collaborate with South Region partners and community groups to host workshops ensuring equitable access to mental and emotional support and care for an increase in quality of life.

Measure 3.1.1. Two workshops convened by partners by March 2025 to promote equitable access to mental and emotional support and care are provided.

Monitoring

The South Region Behavioral Health Priority, including all associated measures, is being tracked as a Scorecard within a performance management application. Data are collected and progress is reported on a quarterly basis. You can see our progress by going to the link: South Region Behavioral Health Priority Scorecard

SOUTH REGION PRIORITY: HOMELESSNESS

Vision Statement for this Priority: A regional collective impact body striving to ensure any experience of homelessness among people living in South Region is rare, brief, and non-recurring.

Telling the Story of This Priority

Why is this a Priority?

Concerns about the growing homeless population became a focus of the South Region Community Leadership Team (SRCLT). The high cost of living in San Diego County as a whole, and relatively low-income levels of population within South Region, were thought to be contributors. At the Regional Data Presentations delivered by the Community Health Statistics Unit, demographic information was shared including poverty data, which show higher rates of poverty in South Region which affects housing affordability. Results of the Regional Task Force on Homelessness 2023 Point-In-Time Count revealed that the homeless populations were largest in the Cities of Chula Vista and National City. A review of all the data reflected economic needs and disparities across the region. The Homelessness Work Group was charged with bringing community partners together to address homelessness, its causes, and its impacts.

Strategy for Change:

The Homelessness Work Group is pursuing a strategy that reflects three strategic approaches: **Building a Better Service Delivery System**, **Supporting Positive Choices**, and **Improving the Culture from Within**.

Their strategy calls for the establishment of a multi-disciplinary network of cross-jurisdictional providers and resources working collaboratively to prevent and end homelessness in South Region. The strategy goals include **increasing community engagement, coordinating outreach efforts, and identifying services and resources**. To increase community engagement, the Work Group will actively involve and mobilize community members to contribute to the overall goal of preventing and ending homelessness. Coordinating outreach efforts across all jurisdictions demonstrates a commitment to a collaborative and unified approach to ensure that outreach strategies are comprehensive and reach individuals in need across different areas within South Region. A crucial aspect of the strategy involves identifying all services and resources addressing homelessness. This is foundational for building a comprehensive understanding of the available support systems and gaps that need to be addressed. *See Basis for Action for more information about the research or evidence that supports this approach.*

Partners Taking Action:

	Community & Faith-Based Organizations	Business & Healthcare	Education	Government
Co-Chairs	**Regional Task Force on Homelessness** **SBCS Corporation** **San Diego Rescue Mission**		**San Ysidro School District**	**Department of Homeless Solutions and Equitable Communities, Health & Human Services Agency (HHSA), County of San Diego (CoSD)**

Participating Organizations			
Community & Faith-Based Organizations			
Childhood Obesity Initiative	Life Acts – Life Christian Center	San Diego Hunger Coalition	
GABS Nonprofit	Legal Aid Society of San Diego	South Bay Sustainable Communities	
I Love to Glean	Olivewood Gardens & Learning Center		
Independent Living Association (by Community Health Improvement Partners)	Produce Good		
Business & Healthcare	**Education**	**Government**	
Acadia Healthcare	Child Development Associates	City of Chula Vista, Office of Sustainability	
Ekologic	Learn4Life San Diego	Chula Vista Office of Sen. Steve Padilla (SD)	
Sickle Cell Disease Foundation	UCSD Center of Community Health	Office of Emergency Services, COSD	
YMCA of San Diego County		Public Health Services, HHSA, COSD	

What is Our Concern?

REGIONAL POPULATION INDICATORS THAT AFFECT THIS PRIORITY:

STANDARD OF LIVING

Percentage of households in South Region spending more than 30% of their income on monthly housing costs.

- In 2022, 45.1% of households in South Region spent more than 30% of their income on housing costs; this is only slightly better than in 2017 when 46.6% of households spent this much on housing. Housing costs were less affordable to nearly half of all households across the region.

SOCIAL

Persons experiencing homelessness in South Region. *

- There was an increase of 27% in the number of persons experiencing homelessness in South Region between 2022 and 2023, with the Cities of Chula Vista and National City being most impacted.

*#WeAllCount Point-In-Time Count 2023, Regional Task Force on Homelessness.

Key

Arrow depicts direction of 5-year trend	On the Right Track	Not On Track	Trend not Available

What are We Doing About It?

Goal 1. Increase community engagement to address homelessness in South Region.

Objective 1.1. Ensure all South Region partners who provide supportive services, housing, and/or other resources to people experiencing homelessness are engaged in the Work Group and there are ongoing efforts of engagement of new partners.

Measure 1.1.1. Up to 10 Homelessness Work Group meetings convened annually in South Region.

Measure 1.1.2. Degree to which (0 to 4) a comprehensive list is created of partners in South Region who offer supportive services, housing, or other resources by end of FY 23-24.

Goal 2. Coordinate outreach efforts across all jurisdictions.

Objective 2.1. Establish a collective coordination effort across all jurisdictions to ensure homeless outreach activities are provided comprehensively throughout the region, using consistent approaches to help access shelter and housing by December 2024.

Measure 2.1.1. 10 partner events are attended by South Region Homelessness Work Group members in FY 23-24.

Goal 3. Identify all services and resources addressing homelessness.

Objective 3.1. Identify key gaps and needs in South Region by understanding what is currently available through outreach, services, housing, and funding resources for people who are homeless or at risk of being homeless by July 2024.

Measure 3.1.1. Degree to which (0 to 4) a comprehensive list of resources for individuals experiencing homelessness is created by the end of FY 23-24.

Measure 3.1.2. Three partner organizations' initiatives, projects, and programs are shared at South Region Homelessness Work Group meetings in FY 23-24.

Monitoring

The South Region Homelessness Priority, including all associated measures, is being tracked as a Scorecard within a performance management application. Data are collected and progress is reported on a quarterly basis. You can see our progress by going to the link: South Region Homelessness Priority Scorecard

SOUTH REGION PRIORITY: FOOD INSECURITY

Vision Statement for this Priority: Everyone in the South Region community has sustainable access to culturally appropriate, affordable, healthy food from local sources through partner collaboration and support.

Telling the Story of This Priority

Why is this a Priority?

The relatively low standard of living for individuals and families in the South Region has been a longstanding concern. Individuals and families throughout the county continue to struggle to afford enough healthy food. Nutrition insecurity was exacerbated by the COVID-19 pandemic, and more recently, family budgets have been affected by high rates of inflation. Regional Data Presentations delivered to the South Region Leadership Team (SRCLT) by the Community Health and Statistics Unit revealed the extent of income and food insecurity. More than a quarter of the population is living below 200 percent of the Federal Poverty Level (FPL) in South Region. The San Diego Hunger Coalition shared their dashboard of data by supervisorial district (District 1) for nutrition insecurity, revealing that over a quarter of the population is also nutrition insecure and, of even greater concern is that almost two out of five children and youth are nutrition insecure.

Strategy for Change:



The Food Insecurity Work Group is pursuing a strategy that reflects three strategic approaches: **Building a Better Service Delivery System**, **Supporting Positive Choices**, and **Pursuing Policy and Environmental Changes.**

The SRCLT Food Insecurity Work Group is working to improve food security in South Region by collaborating with stakeholders and promoting funding opportunities and resources. Members of the Food Insecurity Work Group work collectively to implement objectives, goals, and activities that focus on improving access to food in South Region. Activities include supporting food insecurity initiatives and projects, such as seeking grant funding for the establishment of a South Region cold food facility, a promising practice to strengthen the local and regional food system. Additionally, the Food Insecurity Work Group holds a space at its monthly meetings to promote resources, food recovery systems, and to support policy solutions (such as reducing greenhouse gas emissions through landfill diversion and recovery). SRCLT's efforts include generating partner collaboration for increased program and resource

development to help improve how residents in need are linked to healthy and nutritious foods. *See Basis for Action for more information about the research or evidence that supports this approach.*

Partners Taking Action:

	Community & Faith-Based Organizations	Business & Healthcare	Education	Government
Co-Chairs	**I Love to Glean**		**Good Food Activist, Executive Chef, and Culinary Educator**	**Department of Homeless Solutions and Equitable Communities, Health & Human Services Agency (HHSA), County of San Diego (CoSD)**

Participating Organizations			
Community & Faith-Based Organizations			
All Peoples Church	Life Acts – Life Christian Center	San Diego Hunger Coalition	
American Heart Association	Lord's Harvest	SBCS	
First Unitarian Universalist Church of San Diego South Bay Food Pantry	MAAC Project	The Rock Church	
Friendships for Hope	Mundo Gardens	US for Warriors Foundation	
Health Care Without Harm	Olivewood Gardens		
I Love to Glean	Operations Promise		
Institute for Public Strategies	San Diego Food Bank		
Business & Healthcare	**Education**	**Government**	
Molina Healthcare	UCSD Center for Community Health	District 1 Office of Chair Vargas, Board of Supervisors, COSD	
San Ysidro Health	Childhood Obesity Initiative	Public Health Services, HHSA, COSD	
Suncoast Market Co-op	SDSU Center for Community Energy and Environmental Justice	North County Food Policy Council	
Scripps Mercy Hospital			

What is Our Concern?

REGIONAL POPULATION INDICATORS THAT AFFECT THIS PRIORITY:

STANDARD OF LIVING

Percentage of residents in South Region living under the Federal Poverty Level (FPL).

- Despite a decrease from 2017, when 14.3% of residents lived in poverty, 10.3% of residents in South Region were still living below 100% of the federal poverty level in 2022.

SOCIAL

Overall food insecurity rate in Board of Supervisors District 1. *

TREND NOT AVAILABLE

- Supervisorial District 1 encompasses most of the South Region. In 2022, an estimated 181,451 people, or 28% of those living in Supervisorial District 1, were nutrition insecure.

SOCIAL

Food insecurity rate for children and youth in Board of Supervisors District 1. *

TREND NOT AVAILABLE

- In 2022, 39% of children and youth (0-18 years of age) living in Supervisorial District 1, which represents most of the South Region, were nutrition insecure.

SOCIAL

Food insecurity rate for older adults in Board of Supervisors District 1. *

TREND NOT AVAILABLE

- In 2022, 28% of older adults (over 60 years of age) living in Supervisorial District 1, which represents most of the South Region, were nutrition insecure.

*Board of Supervisors District 1 Nutrition Insecurity Dashboard, December 2022, sandiegohungercoalition.org

Key

Arrow depicts direction of 5-year trend	On the Right Track	Not On Track	Trend not Available

What are We Doing About It?

Goal 1. Increase community partner collaboration to address food insecurity in South Region.

Objective 1.1. Ensure South Region partners who provide food, supportive services, and resources to people experiencing food insecurity are engaged in the Work Group by June 2024.

Measure 1.1.1. Degree to which (0 to 4) an asset map or directory of food insecurity programs and resources is created in FY 23-24.

Goal 2. Establish a Food Hub in South Region.

Objective 2.1. Establish collective coordination effort across multiple organizations to develop a centralized food hub to share food among partners to distribute to residents in South Region by December 2024.

Measure 2.1.1. One data presentation on food insecurity in South Region each year.

Measure 2.1.2. Up to $80,000 of grant funding received to tackle food insecurity by Work Group in FY 23-24.

Goal 3. Support South Region partner organizations' food insecurity initiatives and projects.

Objective 3.1. Establish a collective coordination effort across all partners to ensure resources are provided comprehensively throughout South Region by December 2024.

Measure 3.1.1. One trauma-informed training provided to partners with food distribution operations by December 2024.

Monitoring

The South Region Food Insecurity Priority, including all associated measures, is being tracked as a Scorecard within a performance management application. Data are collected and progress is reported on a quarterly basis. You can see our progress by going to the link: South Region Food Insecurity Priority Scorecard

SOUTH REGION PHOTO GALLERY

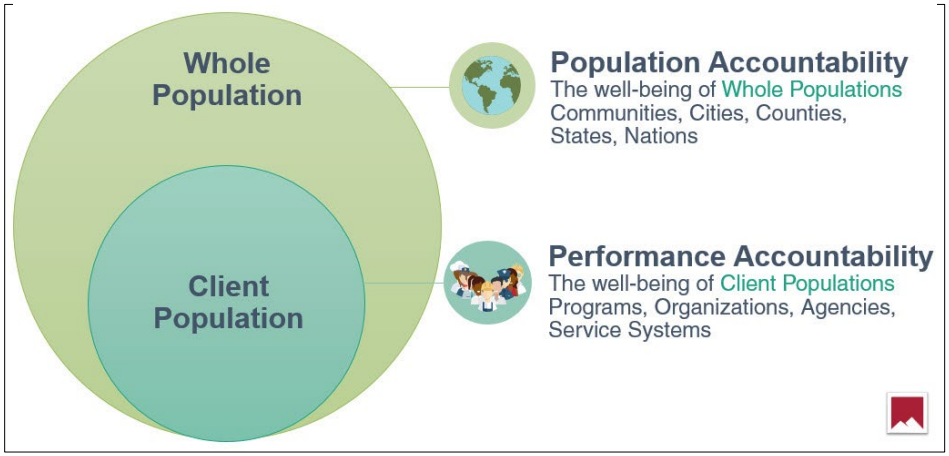
SECTION 6: MONITORING PROGRESS FOR COMMUNITY CHANGE

Overview: This section goes into the process for ensuring accountability on behalf of the community in terms of progress implementing the Community Enrichment Plans (CEPs). The use of scorecards for each CEP priority within a performance tracking tool is described. Results-Based Accountability (RBA) is integral to the approach for each of these priorities because it captures collective action for impact.

Results-Based Accountability Used to Measure Progress

Just as the County's approach to planning follows the Mobilizing for Action through Planning and Partnership and Communities of Excellence models, there are performance management methodologies which are adhered, specifically the RBA methodology. RBA is a disciplined way of thinking and taking action that communities can use to improve the lives of children, youth, and families. It incorporates "population accountability" and "performance accountability." *See Figure 15.* The structure of the CEPs and associated scorecards follow this methodology, which is also an approach that fits well with collective impact efforts.

Figure 15: Results-Based Accountability



Source: Clear Impact, documentation on Results-Based Accountability for communities, [Results-Based Accountability Resource Library - Clear Impact](#).

The well-being of the community is what the Community Leadership Teams (CLTs) have their eyes on, and population indicators are selected or identified to monitor community impact related to the priority or issue of concern. These population indicators would capture the change that the CLTs are seeking. The performance measures capture the activities undertaken by the partners to bring about change. The objectives and associated performance measures are scalable, reasonable, possible for partners to commit to, and represent activities that the CLTs believe will "turn the curve" with respect

to the population or community change that they want to see. Mutually reinforcing activities by partners is in line with the collective impact approach of *Live Well San Diego*.

Unlike traditional RBA, each CEP includes measures that are not about the well-being of client populations. Instead, the focus is typically actions or initiatives to reach out and engage residents and agencies to work together to address the conditions affecting the health and well-being of residents (also referred to as the social determinants of health). A better name for these performance measures might be "community action measures."

RBA includes the idea of "turn the curve" thinking in which key population measures are tracked and analyzed to identify if progress, however, small is achieved through collective action, which in turn is also measured. The activities reflect contemplation about contributing factors based on evidence and research that can be acted upon. Ideas that have not been tested can also be adopted under this framework, if the partners believe that these actions can make a difference. By structuring the CEPs around this framework, the CLTs underscore their commitment to not just do something, but to undertake activities for which there is some evidence that these activities will help bring about meaningful, measurable improvements in community health.

Population Indicators Compared to Measures of Community Action

This focus on accountability and results is what informs the structure of each Scorecard (for each Community Enrichment Plan Priority. The structure includes the identification of pressing health concerns through review and discussion of data trends and population indicators, and then development of goals and objectives, with associated performance measures, by consensus among partners. The differences between population and program accountability as these apply to CEPs appears in *Table 2* below.

Population Indicators

The population indicators are to be monitored over the long term, and there is no expectation that positive change will be realized in the immediate future. As population data, these indicators are typically rates based on numbers of residents (death rates, disease rates, poverty rates, education levels, estimates of persons experiencing homelessness). Indicators are geographically specific—by county, region, supervisorial district, or community—to the extent the data are available. In some cases, the population indicators selected by the CLT are also *Live Well San Diego* indicators or supporting indicators, or indicators that Public Health Services has identified as key outcome indicators for public health programs. *(See Appendix II: Live Well San Diego and PHAB Outcomes Dashboards).* The indicators selected by the CLT are specific to the concerns that have been elevated at meetings in the regions. The

data are provided by the Community Health Statistics Unit, which is continually collecting data as part of the Community Health Status Assessment. Also, other partners and agencies present data to the CLTs that may catch the attention of the CLT and lead to the selection of an alternative indicator.

Performance Measures of Community Action

The individual performance measures for community action align with the objectives that were developed and agreed to by the CLTs. The measures themselves are recommended by the community health engagement team in the Office of Equitable Communities, in consultation with Public Health Services staff. With few exceptions, these measures are relatively simple—these measures count activities, or deliverables, or capture progress in implementing a project. The simplicity is intentional for several reasons—to make clear the connection between the objective and measure, to make it relatively easy to collect data and maintain the measure, and to help ensure quarterly tracking and reporting is not onerous. By concentrating on small, yet significant steps, the CLT can be more confident of sustained progress and a meaningful impact on community health outcomes.

Table 2: Differences between Population and Program Accountability as Applies to Community Enrichment Plan

RBA Terminology	Corresponding Question in the Community Enrichment Plan	Type of Metric	Frequency	Examples
Population Accountability	What is Our Concern?	Population Indicators	New data only every few years, monitored over the long term.	• Emergency department discharge rates due to anxiety and fear related disorders in this Region. • Percentage of residents living under 200% Federal Poverty Level (FPL) in this Region. • Percentage of adults 25 years and older with at least a high school diploma in this Region
Program Accountability	What are We Doing about It?	Performance Measures of Community Action	Data refreshed quarterly, monitored continuously.	• At least 25 community members and partners attend harm reduction training coordinated by the Community Leadership Team in this Region. • At least 5 resource fairs hosted at key locations in this Region to share educational and community programing annually. • At least 100 vocational and educational career opportunities promoted to residents in this Region.

Source: County of San Diego, Public Health Services, Office of Performance and Improvement Management

Target Setting

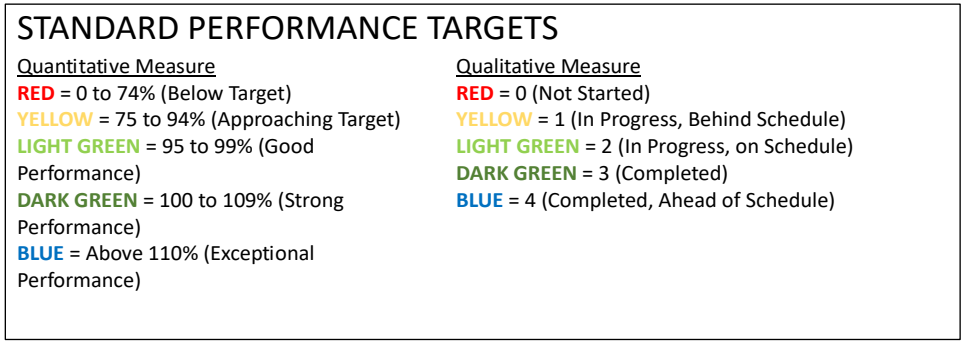
Another important distinction between population indicators and performance measures is that targets are established for every objective and corresponding performance measure in the CEPs. These targets specify exactly what the CLT hopes to implement or accomplish within a specified time frame, typically within three-year planning cycle. These targets for every performance measure establish some degree of accountability for partners to get things done. By contrast, targets do not appear in the CEPs for population indicators. This is because population change is difficult to bring about and requires a collective effort over a longer period. That said, there are goals or targets for some of these population indicators that have been set at the national level. Healthy People 2030 is a federal initiative in which measurable objectives with targets have been established to enhance health and well-being in the United

States. Some of the indicators selected by the CLTs may have Healthy People 2030 targets.[1] However, the targets of these population health objectives are not included in the CEPs because the idea is to use the indicators to gauge community impact of collective efforts that go well beyond the actions of the CLT and that likely will take much longer to realize gains than during the three-year planning cycle.

While population indicators are not used in these CEPs to set targets, these indicators are very useful as trend data to illustrate the evolving collective impact of the CLTs. Monitoring trends over time allows stakeholders to view progress, setbacks, and the trajectory of efforts from different viewpoints. This enriches the narrative, turning data into a continually evolving story with the potential for ongoing refinement. The CEP becomes not just about the data but understanding the narrative that unfolds through the changing trends, depicting the adaptability embedded in this approach to community development.

Targets for the performance measures within the CEPs are typically set for numbers of events or activities conducted or individuals reached or served. Performance relative to target is standardized and shows as a color from the lower end of the scale—**Red** for *0 to 74% compared to target*; to the higher end of the scale—**Blue** *for 110% or more compared to target.* If the objective is about implementing a project, a standard scale has been adopted so that progress can be consistently reported. The standard scale is from the lower end of the scale—0 for *Not Started*; to the higher end of the scale—4 for *Completed, Ahead of Schedule*. *See Figure 16.*

Figure 16: Color Band Guide in Performance Management Application



Source: Clear Impact, County of San Diego, Public Health Services, Community Enrichment Plan Scorecards.

In the *San Diego County Public Health Services Dashboard*, targets have been adopted to monitor progress on population health indicators over the long term. Some targets are adapted from the Health People 2030 and/or have been established as the shared goal for collective impact efforts led by Public Health Services, such as the San Diego Getting to Zero initiative and the Tuberculosis Elimination Initiative. *See Appendix II.*

Ongoing Monitoring and Communication of Progress on CEP Priorities

The scorecards represent a way to help community members understand the data and what it means in terms of progress implementing the CEPs. The scorecards can also help to motivate but only if they are kept up to date. The 15 scorecards by priority (5 regions with 3 priorities each—15 scorecards) are updated every quarter, beginning in FY 2023-24. This process is known as the "Quarterly Community Enrichment Plan Refresh," coordinated by Public Health Services working with designated community engagement staff within the Office of Equitable Communities.

This quarterly refresh schedule fosters accountability and allows CLTs to be aware of progress or challenges in the implementation of their CEP. This structured approach aids in the communication of progress on regional priorities, allowing stakeholders to track performance trends over time and identify areas for improvement collaboratively. Recognizing the strength of data-driven narratives, County staff and the CLTs have a more effective way of telling stories and can make the data "come alive" with context and meaning for the partners and others in the community. For these collective impact efforts at the regional level, sharing and talking about the data is essential.

Making Performance Data Accessible to the Public

Another benefit of creating automated performance Scorecards for each region's three priorities is that links can be pushed out so that the members of the CLT or other community partners can easily check their progress. See *Table 3* below which contains links to the scorecards by region by priority. The first scorecard listed for each region is the "Overview Scorecard" which includes all three priorities and the goals within each priority, without the objectives and performance measures. This scorecard is best for providing a general picture of the content of the region's CEP.

These same links to the scorecards also appear at the bottom of each priority within the CEP in *Section 5: The Five Regional Community Enrichment Plans.*

Table 3: Links to Community Enrichment Plans by Region and Priority

COMMUNITY ENRICHMENT PLAN 2023-25	
CENTRAL REGION SCORECARDS	**EAST REGION SCORECARDS**
Overview: Priorities and Goals Only	Overview: Priorities and Goals only
Housing for All	Behavioral Health Solutions: Prevention and Early Intervention
Health and Well Being	Thriving and Inclusive Communities
Education and Economic Development	Resilient Youth and Families

NORTH CENTRAL REGION SCORECARDS	**NORTH COUNTY REGIONS SCORECARDS**
Overview: Priorities and Goals Only	Overview: Priorities and Goals Only
Food and Housing Insecurity	Homelessness
Behavioral Health	Substance Use Prevention
Youth	Mental Health

SOUTH REGION SCORECARDS
Overview: Priorities and Goals Only
Homelessness
Food Insecurity
Behavioral and Mental Health

Source: County of San Diego, Public Health Services, Clear Impact performance management application administered by Office of Performance and Improvement Management.

SECTION 7: BASIS FOR ACTION

The literature on collective impact explains that it is important that every partner do what they do best toward a shared vision for community change. Improvements in the areas of concern, as reflected in the indicators adopted for each Community Enrichment Plan (CEP) priority, are long-range. Therefore, it is important that we can provide research and evidence that show that those short-term objectives will contribute to long-term population change. This section provides this research and evidence. While some of the evidence is more comprehensive in some areas than others, this is an important part of building up shared knowledge of what works best and has the best prospects for leading to positive change in population health and well-being.

Why Research and Evidence to Support Community Action is Important

There can be significant gaps between the time that actions or objectives are taken at the community level (as is captured in these regional CEPs) and the long-term impacts on the community. The passage of time and the contributions of many partners, through mutually reinforcing activities, are essential to bring about meaningful change.

This is why research, and evidence-based or informed strategies, are so critical. It helps bridge this gap. Lessons learned or insights gained from previous community actions and public health interventions can inform the goals and objectives identified by the community. This Basis for Action provides information that helps to show how the Community Leadership Team (CLT) is trying to make a difference by adopting scalable, evidence-informed objectives to meet the unique needs of their communities.

Applying research and evidence to community improvement practice is a long-established practice and expectation of accredited public health departments. There is a growing body of literature as is reflected here.

By Region and Priority, the Strategic Approaches and Supporting Research

For each priority within individual regional CEPs, the overall basis for action is reflected in terms of the *Live Well San Diego* strategic approaches. Information is also provided from the literature as to how the strategy, programs, and efforts are evidence-based or practice-based. However, in some cases, the strategies reflect innovative or promising practices to meet the needs of the population because research may not yet exist to support the strategy or action.

You will find below the following organized by regional CEP, and by priority within the individual CEP.

1) The *Live Well San Diego strategic* approaches that the priority reflects and explanation of how it does so.
2) The research that supports the goals and objectives contained in the CEP.
3) The specific references to this research.

Additional background information appears immediately before and before discussion by priority. This includes a description of the four overarching *Live Well San Diego strategic* approaches *(Figure 17).* Also, a *Table 4* provides key resources and sources of information that are cited repeatedly across the priorities, suggesting these are the most robust sources of information that support community planning efforts.

Figure 17: Live Well San Diego Strategic Approaches

Source: Live Well San Diego Overview, https://www.livewellsd.org/

Table 4: Key Resources and Sources of Evidence-Based Approaches

KEY RESOURCES	
County Health Rankings and Roadmaps	National Association of County and City Health Officials (NACCHO) Toolbox
Healthy People 2030	The Community Guide
***KEY SOURCES**	
Centers for Disease Control and Prevention (CDC)	National Health Care for the Homeless Council (NHCHC)
County Health Rankings and Roadmaps	National Institutes of Health (NIH)
Models: Collective Impact, Housing First	Substance Abuse and Mental Health Services Administration (SAMHSA)

Source: County of San Diego, Public Health Services, Analysis by Community Health Statistics Unit

CENTRAL REGION PRIORITY | HEALTH AND WELL-BEING

Strategic Approaches Reflected:

Building a Better Service Delivery System

- Identifying "less healthy" communities in Central Region to ensure equitable distribution of health and well-being resources and services that help address priority gaps for health issues such as chronic disease and behavioral and mental health.
- Increasing community access to health and well-being resources by reducing barriers to care and service gaps.

Improving the Culture from Within

- Expanding collaborative efforts to increase the availability of healthy foods among Central Region residents by engaging organizations that help provide healthy food programs and services.
- Facilitating partnerships among community-based organizations and service providers with larger health providers.

Research that Supports these Actions:

The Central Region Leadership Team's (CRLT) objectives that improve the accessibility and affordability of healthy foods reflect guidelines set forth by the Centers for Disease Control and Prevention to support better health outcomes, including increased access and purchase of healthy foods, better dietary habits, and favorable weight outcomes.[1-3] The multilevel approach to promoting and supporting fruit and vegetable incentive programs exemplifies evidence-based strategies that approach food insecurity and other associated circumstances (e.g., housing, mental health) more effectively and holistically.[3,4]

Improving equitable and inclusive health services and access among high-risk and under-served groups may be achieved depending on the needs related to chronic disease and other conditions. For example, access may be improved through childcare or transportation assistance for some community members, while others may require individually tailored approaches.[5] Enrollment rates for health insurance –specifically Medicaid/Medi-Cal—may be improved through maintaining or increasing enrollment workers' presence in the community to support application processing among vulnerable populations.[6]

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CENTRAL REGION PRIORITY | HOUSING FOR ALL

Strategic Approaches Reflected:

Building a Better Service Delivery System

- Developing tools, including maps and the Central Region ONE HUB database and directory, to improve access to housing data, resources, and services.
- Improve monitoring of homelessness and housing developments while increasing local access to supportive housing services through community outreach.

Supporting Positive Choices

- Strengthening the ability of Central Region residents to secure and maintain housing by providing education on the housing system and awareness of resources available.

Pursuing Policy and Environmental Changes

- Advocating for additional funding and housing developments through partnerships between public agencies, housing developers, community-based organizations, and community members to improve equitable access to housing.

Research that Supports these Actions:

The Central Region Leadership Team's (CRLT) objectives that address housing and homelessness are grounded in a range of strategies focused on partnerships and collaboration. Facilitating community partner participation in network-building and resource dissemination is critical to ensure accessibility of community resources that can help address homelessness.[1,2] Collect impact efforts that increase outreach for accessing shelter and support services are foundational to addressing the complexity of issues that are typical of people experiencing homelessness.[3,4]

Public education on the availability of resources and effective models—particularly those that are holistic in addressing health, security, and wellness for those who need addiction or mental health support—may contribute to public support for and enrollment in effective supportive housing programs.[5,6]

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CENTRAL REGION PRIORITY | EDUCATION AND ECONOMIC DEVELOPMENT

Strategic Approaches Reflected:

Building a Better Service Delivery System

- Improving access and participation in equity-focused workforce development and educational resources, particularly among high-need populations (e.g., youth, re-entry from incarceration, trauma recovery, immigrant, non-English speaking, etc.).
- Increasing accessibility to education and career development programs by removing barriers (e.g., mobility, childcare, limited hours, etc.).

Supporting Positive Choices

- Increasing outreach and training efforts for career development through workshops and presentations by engaging workforce and educational organizations.
- Providing workshops that bring awareness of educational and economic development opportunities, including apprenticeships, career innovation, and social learning to strengthen educational attainment and career paths among Central Region residents.

Improving the Culture from Within

- Engaging community-based organizations to pursue resources and funding opportunities, such as grants and contracts, that can increase their capacity to implement programs and services.

Research that Supports these Actions:

The Central Region Leadership Team's (CRLT) objectives reflect research on the role of community-based organizations and collaboration that address the community's access to resources for workforce development and education. Financial and technical assistance focused on building the capacity of and empowering community-based organizations through partnerships among foundations, city, and neighborhood groups can support neighborhood stabilization and renewal in urban areas.[1,2] Identifying high-need, at-risk populations for career development support can be successful through partnerships with community colleges, community partners, and workforce experts through collaboration, intentional tapping of local knowledge, and using career navigators.[3] Workforce development professionals can be major advocates and change agents in addressing education and career development barriers at the local and regional levels.[4]

Addressing educational disparities may be done through a variety of measures depending upon the root cause of disparities. For example, given the highly diverse cultures, backgrounds, and languages of Central Region youth, exploring the level of biases and stereotyping among school administrators and educators may prove fruitful in reducing disparities.[5] Additional sources of disparities may be identified through addressing child health, early education, poverty reduction, and school accountability standards,[6] as well as addressing social psychological interventions that help students cope with threats to their identity that reduce motivation.[7]

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EAST REGION PRIORITY	BEHAVIORAL HEALTH SOLUTIONS – PREVENTION AND EARLY INTERVENTION

Strategic Approaches Reflected:

Building a Better Service Delivery System

- Increasing outreach efforts and materials to promote behavioral health prevention and early intervention resources among East Region residents.

Supporting Positive Choices

- Providing community members with information on health and wellness events and activities that support behavioral health prevention and early intervention.

Improving the Culture from Within

- Strengthening the East Region's behavioral health provider network for improve access to services.
- Coordinating harm reduction training for service providers, including community members and partners, to support East Region residents in accessing behavioral health prevention and early intervention.

Research that Supports these Actions:

The East Region Leadership Team's (ERLT) objectives to improve awareness and access to behavioral health prevention and early intervention reflect guidelines set forth by the National Institute of Mental Health.[1] Behavioral and mental health are essential to overall health and quality of life as these are more than the absence of a mental illness. Those living in or near poverty typically have less access to care and an increased risk for mental health problems.[2] ERCLT's approaches to improve access to behavioral health services and early intervention resources recognize the importance of empowering East Region residents to seek professional support before severe or distressing mental health symptoms become overwhelming.[1]

Objectives for this priority recognize that significant disparities exist in accessing behavioral health services and care in rural areas,[3] among diverse populations,[4] and among immigrant and refugee populations,[5] all of which are significant demographics in the East Region of San Diego County. Awareness and empowerment among these populations can be enhanced through information, education, and communication activities, helping to reduce stigma and increase early identification and help-seeking of mental health resources.[6,7]

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EAST REGION PRIORITY — RESILIENT YOUTH AND FAMILIES

Strategic Approaches Reflected:

Building a Better Service Delivery System

- Coordinating resource fairs for East Region youth and families to increase access to no-cost educational and community programming and resources.
- Increase access to resources and support for basic needs among East Region youth and families through a school-centered approach.

Supporting Positive Choices

- Promoting educational programs and opportunities to empower youth and families in East Region to access resources.

Research that Supports these Actions:

The East Region Leadership Team's (ERLT) objectives aim to foster safe and livable environments for youth and families by cultivating networks that support access to educational programming, basic needs, and resources through a school-centered approach. Access to the safety net and education resources, such as the food stamp program (FSP), improves livability, education, and health outcomes for youth and families,[1] which are strengthened by a collaborative approach in the community[2] and active family involvement.[3] Schools are where therapeutic services for children and adolescents are commonly delivered.[4]

Objectives for this priority recognize the significance that schools have in helping children develop their social, coping, and problem-solving skills, which can be readily used in their daily interactions.[4] Furthermore, family involvement in their children's education supports higher levels of achievement in reading and math.[3] School-centered interventions are more likely to be successful than those applied elsewhere since they address problems at the source.[4] Additionally, the opportunity to leverage school-centered approaches to supporting families may support long-term social and neighborhood change.[5]

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EAST REGION PRIORITY — THRIVING AND INCLUSIVE COMMUNITIES

Strategic Approaches Reflected:

Supporting Positive Choices

- Promoting community programs, such as economic development and job opportunities, among East Region residents through resource fairs and school-based presentations.

Pursuing Policy and Environmental Changes

- Engaging residents to participate in the development and promotion of inclusive and diverse community programming.

Improving the Culture from Within

- Increasing knowledge and awareness of East Region community programming among partners and community organizations through information and resource sharing.

Research that Supports these Actions:

The East Region Leadership Team's (ERLT) objectives that focus on supporting priority populations of low socio-economic status to thrive through inclusive services reflect research on the importance of information sharing and community health awareness. Community building through collective actions involving residents and community organizations can improve health access, particularly among priority populations, by supporting their ability to engage and participate in community programming. [1]

Objectives for this priority recognize that well-functioning community health platforms can serve as vehicles for health information and can convene local resources to support successful public health interventions.[2] Community engagement interventions and high-quality social connections have a positive impact on a range of health outcomes across various conditions.[3,4] Support focused on a comprehensive array of programs for vulnerable groups will strengthen the effectiveness of these efforts.[5]

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NORTH CENTRAL REGION PRIORITY | BEHAVIORAL HEALTH

Strategic Approaches Reflected:

Building a Better Service Delivery System

- Improving and optimizing the delivery of behavioral health resources to residents by fostering awareness of substance use and harm reduction strategies among North Central Region partner organizations.
- Increasing resource accessibility through the creation of asset maps, which consolidate information regarding behavioral health organizations in North Central Region.

Supporting Positive Choices

- Supporting continuum of care by extending behavioral health resources and services through different avenues, such as an asset map of community organizations, online portals, and Naloxone distribution sites.

Improving the Culture from Within

- Promoting behavioral health data transparency, trainings, initiatives, and campaigns among partner organizations.
- Increasing awareness about behavioral health data and campaigns among partner organizations to improve their role in helping residents access behavioral health resources.

Research that Supports these Actions:

The North Central Community Leadership Team's (NCeCLT) objectives draw upon behavioral health frameworks, including engagement in community coalitions, harm reduction strategies such as overdose prevention, and campaigns to reduce stigma related to substance use.[1,2] Actions to provide bidirectional training opportunities among partner organizations and seek additional resources and partners for collaboration reflect how building, maintaining, and strengthening community coalitions can help address behavioral health issues.[1] For instance, increasing the number of partner organizations that become Naloxone distribution sites in North Central Region exemplifies these actions. Training partner organizations on the use of Naloxone kits, which are safe, cost-effective, and help reduce deaths due to overdose, help increase resource delivery and overdose reversals.[3] Collective measures reinforced by community members at various levels support harm reduction efforts that reduce stigma and promote well-being, including prevention and risk reduction for people who use drugs (PWUD).[2-4] Overall, North Central Region's collaborative efforts to maintain transparency and provide resources to the community seek to maximize health and wellbeing outcomes.[4]

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NORTH CENTRAL REGION PRIORITY | FOOD AND HOUSING INSECURITY

Strategic Approaches Reflected:

Building a Better Service Delivery System

- Improving access to nutritious foods by supporting farmer's markets that accept CalFresh and food distributions.

Supporting Positive Choices

- Educating and informing partners and residents about this important issue of food and housing insecurity. Includes a focus on equity and reducing stigma, especially stigma associated with homelessness.
- Serving as a repository of information by creating maps and formal lists for housing, food, and mental health resources in North Central Region.

Research that Supports these Actions:

The North Central Community Leadership Team's (NCeCLT) objectives that improve the accessibility and affordability of healthy foods reflect guidelines set forth by the Centers for Disease Control and Prevention to support better health outcomes, including increased access and purchase of healthy foods, better dietary habits, and favorable weight outcomes.[1-3] The multilevel approach to promoting and supporting fruit and vegetable incentive programs exemplifies evidence-based strategies that approach food insecurity and other associated circumstances (e.g., housing, mental health) more effectively and holistically.[3,4]

Objectives for this priority recognize the bi-directionality of food and housing insecurity and the importance of addressing these issues equitably, particularly by improving the method by which residents in need are linked to food and housing resources.[5] NCCLT's efforts to highlight housing resources and promote stigma-free campaigns among partner organizations reflect recommendations to advance housing policies through justice and action-oriented research to advance health equity.[6]

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NORTH CENTRAL REGION PRIORITY	YOUTH

Strategic Approaches Reflected:

Building a Better Service Delivery System

- Promoting and increasing accessibility of mental health education and economic development opportunities through formal lists, asset maps, and social media accounts.

Supporting Positive Choices

- Engaging and educating families and youth through school-based tabling events, presentations, and workshops to bring awareness about mental health resources.
- Inspiring families and youth to pursue options that can benefit their health, economic and educational development, and overall well-being.

Pursuing Policy and Environmental Changes

- Cultivating partnerships and programming that are conducive to discussions regarding mental health and food insecurity among youth.

Research that Supports these Actions:

The North Central Community Leadership Team's (NCeCLT) objectives are reminiscent of community-based participatory research (CBPR) and Youth Participatory Action Research (YPAR) approaches, which empower individuals and organizations to engage in collective actions that address community and societal issues from the perspective of their members.[1,2] Engaging families and youth in youth-serving organizations and programs within school-based settings has demonstrated positive behavioral changes, including encouraging evidence of building strengths and mental capital among youth and supporting positive parenting.[3]

While there are challenges, the use of social media as a means to educate and promote mental well-being among adolescents has demonstrated potential in nurturing positive mental health outcomes as these platforms are often utilized by youth to learn about mental health.[4] Overall, NCCLT's Youth objectives reflect intervention processes at the individual, familial, organizational, and community levels through family and youth outreach, dissemination and literacy of information, and collective efficacy in addressing mental health and food insecurity while also promoting educational and workforce development.[5]

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NORTH COUNTY PRIORITY | SUBSTANCE USE PREVENTION

Strategic Approaches Reflected:

Building a Better Service Delivery System

- Improving substance use prevention and intervention efforts among youth and high-risk groups by employing culturally-focused collaborative approaches throughout North County school districts.

Supporting Positive Choices

- Providing substance use prevention and intervention resources through school and community-based outreach strategies and promotional efforts.
- Engaging parents in substance use prevention, including Spanish workshops and presentations with information on youth programs and services that help reduce youth substance use.

Research that Supports these Actions:

The North County Community Leadership Team's (NCCLT) objectives that address substance use prevention are grounded in research on culturally-focused, family-based, and community-driven approaches and solutions. Culturally-based prevention programs can be successful in reducing risk factors associated with substance use among youth, particularly when efforts meet youth and their families where they are at and are conscious of their culturally-based needs, experiences, and expectations related to substance use and childhood adversity.[1-4]

Collaborative school-based substance use prevention efforts between public health and schools can be effective when interventions are evidence-based and tailored to the specific needs of schools and students.[5] Similarly, community-based prevention and intervention resources may be effective when well-coordinated across family, parenting, media, policy initiatives, and internet-based interventions.[6] Community leadership in addressing substance use—particularly when youth participate in meaningful ways—can strengthen community change efforts.[7-9]

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NORTH COUNTY PRIORITY | MENTAL HEALTH

Strategic Approaches Reflected:

Building a Better Service Delivery System

- Developing an asset map and compilation of mental health services in North County to improve community-based organizations' capacity to disseminate information and connect clients to services.

Supporting Positive Choices

- Supporting access to mental health prevention efforts and services by helping reduce stigma and increasing awareness of resources through outreach campaigns among North County residents.
- Promoting workshops and initiatives by community organizations that educate North County residents to navigate mental health services.

Improving the Culture from Within

- Increasing awareness and outreach of supportive services for the health and well-being of North County's mental health workforce.
- Promoting mental health prevention efforts that are culturally relevant to North County residents.

Research that Supports these Actions:

The North County Community Leadership Team's (NCCLT) objectives to improve mental health awareness and accessibility of services among residents are grounded in research that emphasize the importance of strengthening referral and navigation systems, having resources at the community level, and supporting the mental health workforce. In strengthening information, referral, and navigation resources and systems, community-driven resources and systems can strengthen child and parent mental health when multigenerational primary care elements are at the core of the intervention.[1-3] Community outreach campaigns can contribute to reducing stigma and building awareness of supportive services and should closely consider methodologies and approaches depending upon the target audiences.[4-6] Furthermore, efforts to support the mental health workforce with personal care and professional support is critical to the overall health of the system and quality care for community members.[7,8]

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NORTH COUNTY PRIORITY | HOMELESSNESS

Strategic Approaches Reflected:

Building a Better Service Delivery System

- Establishing new shelter/emergency bed programs in North County through collaborative partnerships.
- Identifying gaps in current housing services to expand prevention and early intervention efforts that increase support towards high-risk populations, including older adults, undocumented individuals, and youth aging out of the foster care system.

Pursuing Policy and Environmental Changes

- Advocating for housing initiatives such as legislation for rent control and assistance by engaging landlords and local jurisdictions to help address homelessness in North County.
- Employing integrated and holistic approaches to help prevent homelessness in North County through collaborative efforts.

Research that Supports these Actions:

The North County Community Leadership Team's (NCCLT) objectives that address homelessness are based on research and policy analysis across a range of sectors. Early intervention and prevention efforts hold great promise in reducing homelessness and improving outcomes in youth school success, mental health, substance use, and physical health, as well as reducing reentry into homelessness.[1-3] Improved access to resource and shelter information can strengthen providers' ability to connect people to needed supports, particularly those with complex needs and conditions.[4,5]

Rent control and assistance advocacy may prove effective in improving available housing to address homelessness when local regulations, economic forces, and real estate trends are closely considered.[6-8] As housing affordability continues to be constrained, increasing prevention and early intervention measures can help reduce the need for shelter and emergency beds.[9]

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SOUTH REGION PRIORITY — BEHAVIORAL HEALTH

Strategic Approaches Reflected:

Building a Better Service Delivery System

- Encouraging community involvement through collective collaborative efforts for behavioral and mental health resident outreach (e.g., awareness, education, prevention).

Supporting Positive Choices

- Increasing equitable access to care and support through resources and services as a means for increased quality of life.

Research that Supports these Actions:

The South Region Leadership Team's (SRLT) objectives draw upon community-based interventions, including coordinating community and partner organizations for increased behavioral and mental health awareness and prevention. Activities to coordinate and support programs and initiatives among community organizations, such as developing productive and cohesive working relationships, establishing roles and responsibilities, and identifying programs and initiatives that address behavioral and mental health, reflect factors that promote strong community coalitions.[1] SRCLT's community-based approach may also contribute to reducing socioeconomic inequities among outcomes such as health behavior and health status.[2]

Objectives for this priority focus on increasing South Region residents' quality of life by providing equitable behavioral and mental health access through coordinated and augmented community involvement. Actions to provide mental health awareness, prevention, and resources through resilience fairs and outreach events reflect community outreach approaches that support residents' linkage to existing services and navigation of health and social care systems.[3]

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SOUTH REGION PRIORITY | HOMELESSNESS

Strategic Approaches Reflected:

Building a Better Service Delivery System

- Engaging community partners and coordinating outreach efforts to comprehensively provide services and resources throughout South Region that address the key gaps and needs of people experiencing homelessness.

Supporting Positive Choices

- Identifying and promoting initiatives, programs, and projects, including housing and funding resources for South Region residents experiencing or at risk of homelessness.

Improving the Culture from Within

- Increasing understanding and support among partner organizations for collaborative activities and actions that address homelessness in South Region.

Research that Supports these Actions:

The South Region Leadership Team's (SRLT) objectives reflect key strategies that help address homelessness by engaging community partners for collaborative and supportive inter-agency efforts crucial for network building and resource dissemination.[1,2] Coordinated efforts to increase outreach activities for the comprehensive delivery of housing services and resources among people experiencing homelessness throughout South Region also reflect the collective impact model, which helps address complex issues such as homelessness.[3,4]

Objectives for this priority guide collective efforts among community partners and agencies to maximize the impact of the workgroup's activities while ensuring that all members are proactively engaged, and information is readily shared.[4] Overall, SRCLT's goals align with advocacy-oriented and interdisciplinary recommendations, forming a collaborative coalition that not only addresses homelessness but also contributes to the promotion of health equity through improved housing solutions.[5]

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SOUTH REGION PRIORITY | FOOD INSECURITY

Strategic Approaches Reflected:

Building a Better Service Delivery System

- Increasing engagement and coordinating collective efforts among community partners to develop resources (e.g., asset map, food, and program directory) and support projects and initiatives that address food insecurity among South Region residents.

Supporting Positive Choices

- Promoting projects and initiatives to provide comprehensive distribution of resources to South Region residents experiencing food insecurity.

Pursuing Policy and Environmental Changes

- Acquiring grant funding to develop a centralized food hub for food sharing and distribution among partner organizations working with residents experiencing food insecurity.

Research that Supports these Actions:

The South Region Leadership Team's (SRLT) objectives are reflective of a collective impact model that attempts to address complex issues such as food insecurity by coordinating community partners through common goals and objectives, sharing mutual measurement systems, mutually reinforcing projects and initiatives, maintaining consistent communication, and having a central infrastructure such as a workgroup.[1,2] In addition to collective efforts for partner engagement, establishing resources such as a centralized food hub is a promising practice to strengthen local and regional food systems and improve the accessibility of healthy foods among South Region residents.[3]

Objectives for this priority draw upon approaches recommended by the Centers for Disease Control and Prevention and the United States Department of Agriculture to increase partner outreach and support the comprehensive distribution of food to residents through a food hub.[4,5] SRCLT's efforts to address food insecurity by generating partner collaboration for increased program and resource development help improve how residents in need are linked to healthy and nutritious foods.

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SECTION 8: APPENDICES

Overview: These three Appendices provide additional background information about this community planning process. **Appendix I** provides additional details about the presentations, surveys, and population data of focus that are part of, or emerged from, the Community Health Status Assessment (CHSA). **Appendix II** lays out the dashboards that identify key indicators for *Live Well San Diego*, and indicators that capture outcomes that are priorities for PHS. **Appendix III** details how this Community Health Improvement Plan (CHIP), and its component Community Enrichment Plans (CEPs), meet the latest 2022 public health accreditation requirements.

APPENDIX I: Background on the Regional Data Presentations that Inform the Community Leadership Teams

Regional data presentations, and surveys of Community Leadership Team (CLT) members, are key steps to the community planning process and helped the CLTs identify priorities for their Community Enrichment Plans (CEPs), that altogether comprise this Community Health Improvement Plan (CHIP). The comprehensive community data and analysis that were developed and presented to the CLTs are part of the new Community Health Assessment (CHA), to be released in the summer of 2024. Key population indicators that reflect the priorities that emerged from the CLT conversations, and that ultimately appear in the CEPs, are also incorporated.

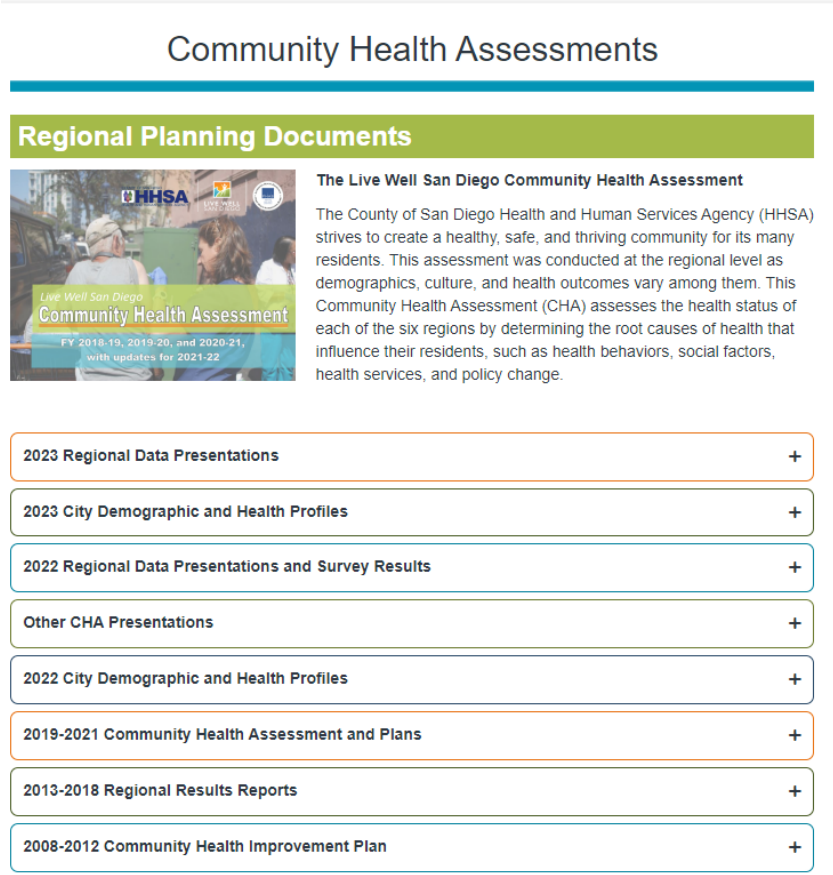
Regional Data Presentations

The Community Health Statistics Unit, part of Public Health Services, delivers regional data presentations annually to the CLTs. Regional data presentations provide CLTs and partners with up-to-date demographic characteristics and health statistics, including factors related to the social determinants of health, for San Diego County and each of the six Health and Human Service Agency (HHSA) regions.

Data from the 2022 regional data presentations marked the beginning of this CHIP's three-year planning cycle. In January 2022, Central Region received the first regional data presentation during their CLT meeting. In the same month, staff from the Office of Equitable Communities (OEqC) were presented with new initiatives and resources for community health and well-being data. South, East, and North Central Regions were provided their respective regional data presentations in February of 2022. In March 2022, North County received the final Regional Data Presentation which included information for the North Coastal and North Inland Regions of San Diego County. These presentations are delivered by CHSU not only at the beginning of the planning cycle, but every year, so that the CLTs are informed of any new data, trends, and issues so that they can adjust their activities, including their CEPs, accordingly.

Information presented during the regional data presentations at the CLT meetings are readily available through the Community Health Statistics Unit Community Health Assessments webpage (*Figure 18).* Additional regional planning documents that are part of the deliberative process for priority setting, including previous cycles of the CHA and CHIP, are also accessible.

Figure 18: Regional Planning Documents, Community Health Assessment



Source: Public Health Services, Community Health Statistics Unit webpage

Survey of Community Leadership Teams

As part of the annual CHA process, a brief survey was conducted after the regional data presentations to gather input from CLT members on their perceptions of needs and priorities for their region.

PHS administered the survey immediately after the regional data presentations from January to March 2022. The survey was conducted through an online service called Survey Monkey beginning at the end of January 2022 through the end of March

2022. A total of 94 responses were collected from 74 community leaders (some community leaders serve on more than one CLT and provided multiple responses).

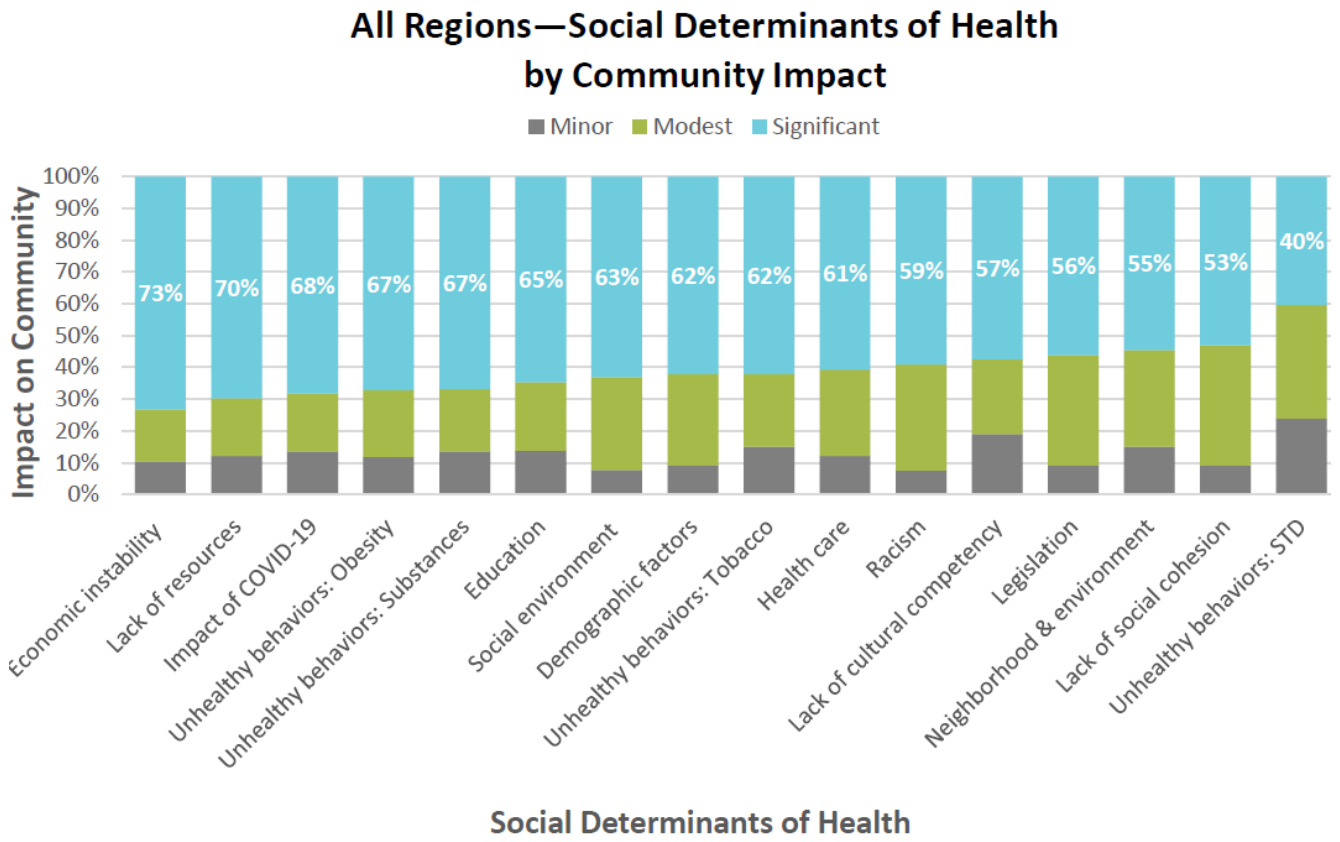
The main findings of the survey were as follows:

- Sectors that were the most represented included Community-Based and Faith-Based Organizations, Healthcare, Education, and Cities and Government. It is noteworthy that the Youth Sector comprised 13 percent of all respondents, reflecting growing participation among this sector in *Live Well San Diego* and related community activities.

- For social determinants of health, the CLTs indicated that economic instability, lack of resources, the impact of COVID-19, and unhealthy behaviors (Dietary Choices and Substance Abuse) were having the biggest impact in their regions. *See Figure 19* for all social determinants of health that were identified as having a significant impact.

- For priority issues, each of the CLT respondents selected the same three priorities as the top issues. These are **housing insecurity, homelessness, and mental health issues**. Socio-economic status, and drug and alcohol use disorders also appear to be near the top issues of concerns. While chronic disease remains a top priority among regions, the focus has been shifting in the last few years to addressing social determinants of health contributing to chronic disease. This is evident in the previous CEPs for FY 2019-21 and in the results of this survey. CLT priorities go beyond the Building Better Health component of *Live Well San Diego* and extend to Living Safely and Thriving.

Figure 19: Results of Survey of Regional Community Leadership Teams, 2022, Social Determinants of Health by Community Impact, All Regions



Source: [Regional & Community Data (sandiegocounty.gov)]

Key Population Data by Community Enrichment Plan Priority

Regional data presentations also helped with priority setting by allowing CLTs to ask questions, request additional data, and dive deeper into relevant community issues. Furthermore, presentations from subject matter experts facilitated discussions, partner networking, and information sharing.

Part of the process for developing the CEPs was the identification of key population indicators that best captured the areas of concern or priorities for the CLT. As population data, these indicators are typically rates of numbers of residents (death rates, disease rates, poverty rates, education levels, estimates of persons experiencing homelessness). Indicators are geographically specific—by county, region, supervisorial district, or community—to the extent the data are available.

In some cases, the population indicators selected by the CLT are also *Live Well San Diego* indicators or supporting indicators, or indicators that Public Health Services has identified as key outcome indicators for its public health programs, referred to as the *San Diego County Public Health Services Dashboard* (*Appendix II*).

Figure 20: Indicators that Informed Priorities (Central Region as Example)

Regior

Indicators that Informed Central Region Priorities — Region: Central Region

Education and Economic Development	16.5% of adults 25 years and older did not have a high school diploma in Central Region.
	22.2% of adults 25 years and older had a bachelor's degree.
	The average unemployment rate from 2017-21 was 6.9% in Central Region, down from 8.8% from 2012-2016.
Health and Wellbeing	89.7% of people living in Central Region have health insurance.
	58% of the total death count in Central Region were due to chronic disease in 2021.
	19.6% of the total death count in Central Region were diseases of the heart, the number one leading cause of death.
	78.7% of the population resides within a quarter mile of a park or community space.
Housing for All	Self-sufficiency Income for a household with 2 adults and 2 children is $83,270.57 annually in Central Region.
	Median household income increased from $53,523 in 2016 to $73,726 in 2021.
	4801 persons experiencing homelessness in San Diego (city) in 2022. Females make up 30% of this total, veterans account for 11%, families account for 11%, and youth make up 14%.

Source: 2023-25 Community Health Assessment, Regional Priorities and Indicators selected by region.

The indicators selected by the CLT are specific to the concern that has been elevated. They are the same indicators that appear in each of the CEPs and answer the question: "What is Our Concern?" The data are provided by the CHSU which is continually collecting data to be incorporated into the CHA. Other partners and agencies present data to the CLTs that may catch the attention of the CLT and be selected as an alternative indicator.

For more information, please refer to the 2023-25 CHA, “Indicators that Informed [each Region’s] Priorities.”

APPENDIX II: Dashboards: *Live Well San Diego* Indicators Dashboard and Public Health Services Outcomes Dashboard:

For collective impact, it is important that there are shared community or population indicators that all the *Live Well San Diego* partners aspire to achieve and reflect a shared vision. This of course includes the CLTs who represent action on the ground. These indicators represent long-term desired community change that will hopefully be moved by short-term collective action.

The *Live Well San Diego Top 10 Indicators Dashboard (and Expanded Indicators)* has been in place for several years and is the primary tool for tracking the long-term progress achieved through *the Live Well San Diego* collective impact effort. These indicators will enable us to measure progress towards one vision of a Healthy, Safe and Thriving County. There is also the *San Diego County Public Health Service Dashboard*. Like the *Live Well San Diego* Dashboard, the PHS Dashboard is organized across five (5) Areas of Influence—Health, Knowledge, Standard of Living, Community, and Social. However, the PHS Dashboard has outcome measures that are more directly related to the programs and services of public health and that are delivered by PHS coordinating with other health care and community partners. This PHS Dashboard is a requirement of accredited public health departments, in part to advance research in that the Public Health Accreditation Board is conducting to study long term impacts of public health efforts across public health departments.

Both Dashboards appear below—with the respective Countywide dashboards appearing first followed by these dashboards by region. The *Live Well San Diego Dashboard* can also be accessed as an interactive dashboard: *Live Well San Diego Indicators Dashboard.*

Live Well San Diego Dashboard Top 10 Population Outcome Indicators

	Indicator	Description	*We want to increase this* / *We want to decrease this*	San Diego County	Central Region	East Region	North Central Region	North Coastal Region	North Inland Region	South Region
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. 2021.	↑	80.6	80.3	78.0	86.6	81.5	78.9	77.9
	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. 2021.	↑	95.0%	95.2%	93.7%	96.2%	95.5%	94.9%	93.8%
KNOWLEDGE - Learning throughout the lifespan										
KNOWLEDGE	**Education: High School Diploma or Equivalent**	Percent of population aged 25 and over with at least a High School Diploma or Equivalent. 2021.	↑	88.3%	83.5%	89.8%	94.7%	89.8%	88.6%	81.1%
STANDARD OF LIVING - Having enough resources for a quality life										
STANDARD OF LIVING	**Unemployment Rate**	Percent of the total labor force that is unemployed. 2023.	↓	4.9%	5.4%	5.7%	3.9%	4.4%	4.0%	6.7%
	Income: Percent of population spending less than 1/3 of income on housing	Percent of the population spending less than 1/3 of their income on housing. 2021.	↑	55.5%	51.7%	54.9%	58.6%	55.0%	58.0%	52.7%
COMMUNITY - Living in a clean and safe neighborhood										
COMMUNITY	**Security: Overall Crime Rate**	Overall Crime rate per 100,000 population. 2020.	↓	1830.5	N/A	N/A	N/A	N/A	N/A	N/A
	Physical Environment: Air Quality	Percent of days that air quality was rated as unhealthy for sensitive populations. 2022.	↓	2.1%	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. 2021.	↑	62.0%	78.7%	51.7%	71.5%	50.2%	42.6%	77.7%
SOCIAL - Helping each other to live well										
SOCIAL	**Vulnerable Populations: Food Insecurity**	Percent of adult population below 200% FPL not able to afford food. 2022.	↓	31.8%	32.3%	28.5%	32.0%	29.8%	40.2%	25.9%
	Community Involvement: Volunteerism	Percent of residents who volunteer. 2019.	↑	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 measure progress, go to: http://www.sdcounty.ca.gov/hhsa/programs/sd/live_well_san_diego/indicators.html

COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

San Diego County Public Health Services Dashboard
Top 10 Population Outcome Indicators: San Diego County Regions

	Indicator	Description	We want to increase this / We want to decrease this	San Diego County	Central Region	East Region	North Central Region	North Coastal Region	North Inland Region	South Region	Target
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). 2021.	↓	43%	42%	44%	45%	41%	42%	42%	Prevent the percent of deaths due to the four chronic diseases (cancer, heart disease and stroke, type 2 diabetes, and pulmonary diseases such as asthma) to no more than **50%**.
	Infant Mortality Rate	Three-year average Infant Mortality Rate per 1,000 live births. 2018-2020.	↓	3.7	4.2	3.9	3.1	3.1	3.2	4.5	Reduce the 3-year average rate of infant deaths to **5.0 per 1,000** births by 2030.
	HIV Disease Diagnosis Estimates	Reported HIV Disease diagnosis case counts and percentages between 2017-2021 time period.	↓	100% (1,934)	40% (771)	10% (199)	14% (264)	9% (181)	6% (119)	21% (400)	Reduce the number of new HIV diagnoses by **90%** (from 2017 baseline level of 422 to 42) by 2030.
	Tuberculosis Incidence Rate	Annual Tuberculosis Incidence Rate per 100,000 population. 2021.	↓	6.1	8.5	3.8	5.3	2.0	3.5	12.3	Reduce Incidence of Tuberculosis in the county to **5 cases per 100,000** by 2030.
KNOWLEDGE - Learning throughout the lifespan											
KNOWLEDGE	High School Education	Overall Graduation Rate: the percentage of those age 25 years and older with a high school diploma or equivalent. 2021.	↑	88.3%	83.5%	89.8%	94.7%	89.8%	88.6%	81.1%	Increase the percentage of adults, age 25 years and older, with a high school diploma or equivalent to **90%**.
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). 2023.	↓	4.9%	5.4%	5.7%	3.9%	4.4%	4.0%	6.7%	No SMART Target. We want this to decrease over time.
	Income Inequality	Number of Total Earned Income Tax Credits. 2021 tax year.	↓	12,948	1,358	2,384	2,369	1,070	1,851	3,916	No SMART Target. We want this to decrease over time.
	Poverty	Percent of the population below poverty level. 2021.	↓	10.7%	16.2%	12.1%	9.1%	8.6%	8.7%	10.9%	Reduce the proportion of people living below the poverty threshold to **10%** by 2030.
COMMUNITY - Living in a clean and safe neighborhood											
COMMUNITY	Childhood Lead in Schools	The number of child cases with a blood lead level of 14.5mcg/dl or greater in the San Diego Childhood Lead Poisoning Prevention Program. 2018-2022.	↓	102	24	14	18	11	5	14	Ensure **95%** of children with blood levels <3.5 mcg/dL receive case management services within two months of referral.
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. 2023.	↑	62.8%	56.0%	63.4%	67.8%	64.7%	65.4%	57.0%	No SMART Target. We want this to increase over time.

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

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. 2021.	↑	80.6	80.3	84.7	82.0	74.0
	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. 2021.	↑	95.0%	95.2%	96.0%	95.2%	94.2%
KNOWLEDGE - Learning throughout the lifespan								
KNOWLEDGE	**Education: High School Diploma or Equivalent**	Percent of population aged 25 and over with at least a High School Diploma or Equivalent. 2021.	↑	88.3%	83.5%	90.4%	78.8%	79.3%
STANDARD OF LIVING - Having enough resources for a quality life								
STANDARD OF LIVING	**Unemployment Rate**	Percent of the total labor force that is unemployed. 2023.	↓	4.9%	5.4%	4.3%	6.2%	6.3%
	Income: Percent of population spending less than 1/3 of income on housing	Percent of the population spending less than 1/3 of their income on housing. 2021.	↑	55.5%	51.7%	54.9%	46.6%	52.5%
COMMUNITY - Living in a clean and safe neighborhood								
COMMUNITY	**Security: Overall Crime Rate**	Overall Crime rate per 100,000 population. 2020.	↓	1830.5	N/A	N/A	N/A	N/A
	Physical Environment: Air Quality	Percent of days that air quality was rated as unhealthy for sensitive populations. 2022.	↓	2.1%	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. 2021.	↑	62.0%	78.7%	80.2%	75.1%	76.6%
SOCIAL - Helping each other to live well								
SOCIAL	**Vulnerable Populations: Food Insecurity**	Percent of adult population below 200% FPL not able to afford food. 2022.	↓	31.8%	32.3%	N/A	N/A	N/A
	Community Involvement: Volunteerism	Percent of residents who volunteer. 2019.	↑	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 measure progress go to: http://www.sdcounty.ca.gov/hhsa/programs/sd/live_well_san_diego/indicators.html

COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

San Diego County Public Health Services 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	Target
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). 2021.	↓	43%	42%	40%	42%	44%	Prevent the percent of deaths due to the four chronic diseases (cancer, heart disease and stroke, type 2 diabetes, and pulmonary diseases such as asthma) to no more than **50%**.
	Infant Mortality Rate	Three-year average Infant Mortality Rate per 1,000 live births. 2018-2020.	↓	3.7	4.2	N/A	N/A	N/A	Reduce the 3-year average rate of infant deaths to **5.0 per 1,000** births by 2030.
	HIV Disease Diagnosis Estimates	Reported HIV Disease diagnosis case counts and percentages between 2017-2021 time period.	↓	100% (1,934)	40% (771)	N/A	N/A	N/A	Reduce the number of new HIV diagnoses by **90%** (from 2017 baseline level) by 2030.
	Tuberculosis Incidence Rate	Annual Tuberculosis Incidence Rate per 100,000 population. 2021.	↓	6.1	8.5	N/A	10.8	12.8	Reduce Incidence of Tuberculosis in the county to **5 cases per 100,000** by 2030.
KNOWLEDGE - Learning throughout the lifespan									
KNOWLEDGE	High School Education	Overall Graduation Rate: the percentage of those age 25 years and older with a high school diploma or equivalent. 2021.	↑	88.3%	83.5%	90.4%	78.8%	79.3%	Increase the percentage of adults, age 25 years and older, with a high school diploma or equivalent to **90%**.
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). 2023.	↓	4.9%	5.4%	4.3%	6.2%	6.3%	No SMART Target. We want this to decrease over time.
	Income Inequality	Number of Total Earned Income Tax Credits. 2021 tax year.	↓	12,948	1,358	N/A	N/A	N/A	No SMART Target. We want this to decrease over time.
	Poverty	Percent of the population below poverty level. 2021.	↓	10.7%	16.2%	11.9%	22.7%	13.7%	Reduce the proportion of people living below the poverty threshold to **10%** by 2030.
COMMUNITY - Living in a clean and safe neighborhood									
COMMUNITY	Childhood Lead in Schools	The number of child cases with a blood lead level of 14.5mcg/dl or greater in the San Diego Childhood Lead Poisoning Prevention Program. 2018-2022.	↓	102	24	N/A	N/A	N/A	Ensure **95%** of children with blood levels <3.5 mcg/dL receive case management services within two months of referral.
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. 2023.	↑	62.8%	56.0%	61.4%	53.7%	51.9%	No SMART Target. We want this to increase over time.

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

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. 2021.	↑	80.6	78.0	79.3	82.4	N/A	N/A	77.6	N/A	81.4	75.7	N/A	78.2	80.2
	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. 2021.	↑	95.0%	93.7%	97.4%	93.2%	91.1%	94.6%	94.3%	96.1%	92.9%	93.3%	93.7%	93.8%	93.8%
KNOWLEDGE - Learning throughout the lifespan																
KNOWLEDGE	Education: High School Diploma or Equivalent	Percent of population aged 25 and over with at least a High School Diploma or Equivalent. 2021.	↑	88.3%	89.8%	95.5%	86.6%	91.5%	90.8%	93.6%	91.4%	91.1%	83.7%	85.2%	92.2%	90.5%
STANDARD OF LIVING - Having enough resources for a quality life																
STANDARD OF LIVING	Unemployment Rate	Percent of the total labor force that is unemployed. 2023.	↓	4.9%	5.7%	6.1%	6.7%	3.4%	2.9%	5.7%	7.9%	4.1%	5.5%	6.0%	5.1%	5.7%
	Income: Percent of population spending less than 1/3 of income on housing	Percent of the population spending less than 1/3 of their income on housing. 2021.	↑	55.5%	54.9%	58.0%	47.7%	63.2%	65.8%	53.0%	63.4%	59.8%	52.5%	64.0%	60.0%	56.2%
COMMUNITY - Living in a clean and safe neighborhood																
COMMUNITY	Security: Overall Crime Rate	Overall Crime rate per 100,000 population. 2020.	↓	1830.5	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Physical Environment: Air Quality	Percent of days that air quality was rated as unhealthy for sensitive populations. 2022.	↓	2.1%	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. 2021.	↑	62.0%	51.7%	19.0%	54.6%	28.9%	13.9%	73.9%	16.5%	43.1%	68.5%	8.1%	52.9%	51.9%
SOCIAL - Helping each other to live well																
SOCIAL	Vulnerable Populations: Food Insecurity	Percent of adult population below 200% FPL not able to afford food. 2022.	↓	31.8%	28.5%	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. 2019.	↑	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 measure progress go to: http://www.sdcounty.ca.gov/hhsa/programs/sd/live_well_san_diego/indicators.html

COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

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	Target
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). 2021.	↓	43%	44%	41%	43%	43%	41%	42%	43%	47%	44%	44%	45%	44%	Prevent the percent of deaths due to the four chronic diseases (cancer, heart disease and stroke, type 2 diabetes, and pulmonary diseases such as asthma) to no more than **50%**.
	Infant Mortality Rate	Three-year average Infant Mortality Rate per 1,000 live births. 2018-2020.	↓	3.7	3.9	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Reduce the 3-year average rate of infant deaths to **5.0 per 1,000** births by 2030.
	HIV Disease Diagnosis Estimates	Reported HIV Disease diagnosis case counts and percentages between 2017-2021 time period.	↓	100% (1,934)	10% (199)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Reduce the number of new HIV diagnoses by **90%** (from 2017 baseline level) by 2030.
	Tuberculosis Incidence Rate	Annual Tuberculosis Incidence Rate per 100,000 population. 2021.	↓	6.1	3.8	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Reduce Incidence of Tuberculosis in the county to **5 cases per 100,000** by 2030.
KNOWLEDGE - Learning throughout the lifespan																	
KNOWLEDGE	**High School Education**	Overall Graduation Rate: the percentage of those age 25 years and older with a high school diploma or equivalent. 2021.	↑	88.3%	89.8%	95.5%	86.6%	91.5%	90.8%	93.6%	91.4%	91.1%	83.7%	85.2%	92.2%	90.5%	Increase the percentage of adults, age 25 years and older, with a high school diploma or equivalent to **90%**.
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). 2023.	↓	4.9%	5.7%	6.1%	6.7%	3.4%	2.9%	5.7%	7.9%	4.1%	5.5%	6.0%	5.1%	5.7%	No SMART Target. We want this to decrease over time.
	Income Inequality	Number of Total Earned Income Tax Credits. 2021 tax year.	↓	12,948	2,384	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	No SMART Target. We want this to decrease over time.
	Poverty	Percent of the population below poverty level. 2021.	↓	10.7%	12.1%	9.3%	17.7%	6.7%	6.0%	11.4%	6.2%	8.0%	9.6%	28.2%	8.3%	11.8%	Reduce the proportion of people living below the poverty threshold to **10%** by 2030.
COMMUNITY - Living in a clean and safe neighborhood																	
COMMUNITY	**Childhood Lead in Schools**	The number of child cases with a blood lead level of 14.5mcg/dl or greater in the San Diego Childhood Lead Poisoning Prevention Program. 2018-2022.	↓	102	14	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Ensure **95%** of children with blood levels <3.5 mcg/dL receive case management services within two months of referral.
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. 2023.	↑	62.8%	63.4%	71.6%	58.9%	69.6%	73.8%	64.6%	72.7%	64.2%	58.8%	69.1%	65.5%	63.7%	No SMART Target. We want this to increase over time.

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

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. 2021.	↑	80.6	86.6	84.9	84.3	84.1	81.1	N/A	86.9	88.9
	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. 2021.	↑	95.0%	96.2%	97.2%	96.7%	95.3%	95.3%	96.5%	96.6%	97.1%
KNOWLEDGE - Learning throughout the lifespan												
KNOWLEDGE	Education: High School Diploma or Equivalent	Percent of population aged 25 and over with at least a High School Diploma or Equivalent. 2021.	↑	88.3%	94.7%	97.7%	93.7%	96.6%	91.8%	100.0%	96.5%	96.6%
STANDARD OF LIVING - Having enough resources for a quality life												
STANDARD OF LIVING	Unemployment Rate	Percent of the total labor force that is unemployed. 2023.	↓	4.9%	3.9%	3.2%	3.6%	3.3%	4.2%	8.9%	4.4%	4.8%
	Income: Percent of population spending less than 1/3 of income on housing	Percent of the population spending less than 1/3 of their income on housing. 2021.	↑	55.5%	58.6%	57.2%	65.6%	58.9%	57.7%	18.8%	54.6%	51.1%
COMMUNITY - Living in a clean and safe neighborhood												
COMMUNITY	Security: Overall Crime Rate	Overall Crime rate per 100,000 population. 2020.	↓	1830.5	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Physical Environment: Air Quality	Percent of days that air quality was rated as unhealthy for sensitive populations. 2022.	↓	2.1%	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. 2021.	↑	62.0%	71.5%	73.3%	71.5%	60.8%	75.7%	2.8%	79.5%	69.1%
SOCIAL - Helping each other to live well												
SOCIAL	Vulnerable Populations: Food Insecurity	Percent of adult population below 200% FPL not able to afford food. 2022.	↓	31.8%	32.0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Community Involvement: Volunteerism	Percent of residents who volunteer. 2019.	↑	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 measure progress go to: http://www.sdcounty.ca.gov/hhsa/programs/sd/live_well_san_diego/indicators.html

COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

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

PHAB Advancing Public Health Performance

	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	Target
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). 2021.	↓	43%	45%	42%	48%	46%	46%	49%	42%	41%	Prevent the percent of deaths due to the four chronic diseases (cancer, heart disease and stroke, type 2 diabetes, and pulmonary diseases such as asthma) to no more than **50%**.
	Infant Mortality Rate	Three-year average Infant Mortality Rate per 1,000 live births. 2018-2020.	↓	3.7	3.1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Reduce the 3-year average rate of infant deaths to **5.0 per 1,000** births by 2030.
	HIV Disease Diagnosis Estimates	Reported HIV Disease diagnosis case counts and percentages between 2017-2021 time period.	↓	100% (1,934)	14% (264)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Reduce the number of new HIV diagnoses by **90%** (from 2017 baseline level) by 2030.
	Tuberculosis Incidence Rate	Annual Tuberculosis Incidence Rate per 100,000 population. 2021.	↓	6.1	5.3	N/A	N/A	N/A	10.4	N/A	N/A	N/A	Reduce Incidence of Tuberculosis in the county to **5 cases per 100,000** by 2030.
KNOWLEDGE - Learning throughout the lifespan													
KNOWLEDGE	**High School Education**	Overall Graduation Rate: the percentage of those age 25 years and older with a high school diploma or equivalent. 2021.	↑	88.3%	94.7%	97.7%	93.7%	96.6%	91.8%	100.0%	96.5%	96.6%	Increase the percentage of adults, age 25 years and older, with a high school diploma or equivalent to **90%**.
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). 2023.	↓	4.9%	3.9%	3.2%	3.6%	3.3%	4.2%	8.9%	4.4%	4.8%	No SMART Target. We want this to decrease over time.
	Income Inequality	Number of Total Earned Income Tax Credits. 2021 tax year.	↓	12,948	2,369	N/A	N/A	N/A	N/A	N/A	N/A	N/A	No SMART Target. We want this to decrease over time.
	Poverty	Percent of the population below poverty level. 2021.	↓	10.7%	9.1%	7.2%	5.3%	7.0%	10.7%	4.6%	9.9%	21.7%	Reduce the proportion of people living below the poverty threshold to **10%** by 2030.
COMMUNITY - Living in a clean and safe neighborhood													
COMMUNITY	**Childhood Lead in Schools**	The number of child cases with a blood lead level of 14.5mcg/dl or greater in the San Diego Childhood Lead Poisoning Prevention Program. 2018-2022.	↓	102	11	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Ensure **95%** of children with blood levels <3.5 mcg/dL receive case management services within two months of referral.
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. 2023.	↑	62.8%	67.8%	70.1%	68.5%	70.6%	65.7%	49.3%	69.5%	66.8%	No SMART Target. We want this to increase over time.

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

Live Well San Diego Dashboard
Top 10 Population Outcome Indicators: North Coastal Region

	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	**Life Expectancy**	Average number of years a person is expected to live at birth. 2021.	↑	80.6	81.5	85.5	78.6	N/A	85.7	77.0
	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. 2021.	↑	95.0%	95.5%	95.2%	94.7%	99.0%	96.5%	95.9%
KNOWLEDGE - Learning throughout the lifespan										
KNOWLEDGE	**Education: High School Diploma or Equivalent**	Percent of population aged 25 and over with at least a High School Diploma or Equivalent. 2021.	↑	88.3%	89.8%	94.8%	85.4%	97.9%	95.8%	83.3%
STANDARD OF LIVING - Having enough resources for a quality life										
STANDARD OF LIVING	**Unemployment Rate**	Percent of the total labor force that is unemployed. 2023.	↓	4.9%	4.4%	4.2%	4.4%	13.9%	3.5%	4.5%
	Income: Percent of population spending less than 1/3 of income on housing	Percent of the population spending less than 1/3 of their income on housing. 2021.	↑	55.5%	55.0%	59.4%	52.8%	12.5%	60.4%	55.4%
COMMUNITY - Living in a clean and safe neighborhood										
COMMUNITY	**Security: Overall Crime Rate**	Overall Crime rate per 100,000 population. 2020.	↓	1830.5	N/A	N/A	N/A	N/A	N/A	N/A
	Physical Environment: Air Quality	Percent of days that air quality was rated as unhealthy for sensitive populations. 2022.	↓	2.1%	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. 2021.	↑	62.0%	50.2%	41.4%	59.6%	15.7%	54.9%	49.1%
SOCIAL - Helping each other to live well										
SOCIAL	**Vulnerable Populations: Food Insecurity**	Percent of adult population below 200% FPL not able to afford food. 2022.	↓	31.8%	29.8%	N/A	N/A	N/A	N/A	N/A
	Community Involvement: Volunteerism	Percent of residents who volunteer. 2019.	↑	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 measure progress go to: http://www.sdcounty.ca.gov/hhsa/programs/sd/live_well_san_diego/indicators.html

COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

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

	Indicator	Description	We want to increase this / We want to decrease this	San Diego County	North Coastal Region	Carlsbad	Oceanside	Pendleton	San Dieguito	Vista	Target
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). 2021.	↓	43%	41%	42%	42%	N/A	44%	39%	Prevent the percent of deaths due to the four chronic diseases (cancer, heart disease and stroke, type 2 diabetes, and pulmonary diseases such as asthma) to no more than **50%**.
	Infant Mortality Rate	Three-year average Infant Mortality Rate per 1,000 live births. 2018-2020.	↓	3.7	3.1	N/A	N/A	N/A	N/A	N/A	Reduce the 3-year average rate of infant deaths to **5.0 per 1,000** births by 2030.
	HIV Disease Diagnosis Estimates	Reported HIV Disease diagnosis case counts and percentages between 2017-2021 time period.	↓	100% (1,934)	9% (181)	N/A	N/A	N/A	N/A	N/A	Reduce the number of new HIV diagnoses by **90%** (from 2017 baseline level) by 2030.
	Tuberculosis Incidence Rate	Annual Tuberculosis Incidence Rate per 100,000 population. 2021.	↓	6.1	2.0	N/A	N/A	N/A	N/A	N/A	Reduce Incidence of Tuberculosis in the county to **5 cases per 100,000** by 2030.
KNOWLEDGE - Learning throughout the lifespan											
KNOWLEDGE	High School Education	Overall Graduation Rate: the percentage of those age 25 years and older with a high school diploma or equivalent. 2021.	↑	88.3%	89.8%	94.8%	85.4%	97.9%	95.8%	83.3%	Increase the percentage of adults, age 25 years and older, with a high school diploma or equivalent to **90%**.
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). 2023.	↓	4.9%	4.4%	4.2%	4.4%	13.9%	3.5%	4.5%	No SMART Target. We want this to decrease over time.
	Income Inequality	Number of Total Earned Income Tax Credits. 2021 tax year.	↓	12,948	1,070	N/A	N/A	N/A	N/A	N/A	No SMART Target. We want this to decrease over time.
	Poverty	Percent of the population below poverty level. 2021.	↓	10.7%	8.6%	7.8%	10.3%	9.6%	5.8%	9.0%	Reduce the proportion of people living below the poverty threshold to **10%** by 2030.
COMMUNITY - Living in a clean and safe neighborhood											
COMMUNITY	Childhood Lead in Schools	The number of child cases with a blood lead level of 14.5mcg/dl or greater in the San Diego Childhood Lead Poisoning Prevention Program. 2018-2022.	↓	102	14	N/A	N/A	N/A	N/A	N/A	Ensure **95%** of children with blood levels <3.5 mcg/dL receive case management services within two months of referral.
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. 2023.	↑	62.8%	64.7%	71.2%	61.7%	49.3%	73.5%	57.4%	No SMART Target. We want this to increase over time.

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

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. 2021.	↑	80.6	78.9	N/A	77.8	78.3	86.0	N/A	81.0	83.8	79.0	81.5	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. 2021.	↑	95.0%	94.9%	98.7%	94.5%	94.7%	95.7%	95.5%	96.5%	95.7%	95.4%	93.5%	95.7%
KNOWLEDGE - Learning throughout the lifespan															
KNOWLEDGE	Education: High School Diploma or Equivalent	Percent of population aged 25 and over with at least a High School Diploma or Equivalent. 2021.	↑	88.3%	88.6%	90.8%	81.3%	86.2%	96.7%	91.4%	89.7%	94.4%	87.2%	86.9%	89.6%
STANDARD OF LIVING - Having enough resources for a quality life															
STANDARD OF LIVING	Unemployment Rate	Percent of the total labor force that is unemployed. 2023.	↓	4.9%	4.0%	9.8%	3.7%	5.1%	3.9%	3.2%	3.6%	4.9%	3.8%	3.5%	4.4%
	Income: Percent of population spending less than 1/3 of income on housing	Percent of the population spending less than 1/3 of their income on housing. 2021.	↑	55.5%	58.0%	70.2%	50.4%	51.8%	63.8%	52.8%	70.2%	65.8%	61.5%	56.7%	59.7%
COMMUNITY - Living in a clean and safe neighborhood															
COMMUNITY	Security: Overall Crime Rate	Overall Crime rate per 100,000 population. 2020.	↓	1830.5	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 that air quality was rated as unhealthy for sensitive populations. 2022.	↓	2.1%	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. 2021.	↑	62.0%	42.6%	3.7%	50.4%	29.9%	47.5%	12.2%	20.3%	42.9%	25.2%	47.5%	8.2%
SOCIAL - Helping each other to live well															
SOCIAL	Vulnerable Populations: Food Insecurity	Percent of adult population below 200% FPL not able to afford food. 2022.	↓	31.8%	40.2%	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. 2019.	↑	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 measure progress go to: http://www.sdcounty.ca.gov/hhsa/programs/sd/live_well_san_diego/indicators.html

COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

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

	Indicator	We want to increase this / Description / 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	Target
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). 2021.	⇩	43%	42%	36%	42%	42%	42%	38%	37%	42%	46%	44%	40%	Prevent the percent of deaths due to the four chronic diseases (cancer, heart disease and stroke, type 2 diabetes, and pulmonary diseases such as asthma) to no more than **50%**.
	Infant Mortality Rate	Three-year average Infant Mortality Rate per 1,000 live births. 2018-2020.	⇩	3.7	3.2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Reduce the 3-year average rate of infant deaths to **5.0 per 1,000** births by 2030.
	HIV Disease Diagnosis Estimates	Reported HIV Disease diagnosis case counts and percentages between 2017-2021 time period.	⇩	100% (1,934)	6% (119)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Reduce the number of new HIV diagnoses by **90%** (from 2017 baseline level) by 2030.
	Tuberculosis Incidence Rate	Annual Tuberculosis Incidence Rate per 100,000 population. 2021.	⇩	6.1	3.5	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Reduce Incidence of Tuberculosis in the county to **5 cases per 100,000** by 2030.
KNOWLEDGE - Learning throughout the lifespan																
KNOWLEDGE	**High School Education**	Overall Graduation Rate: the percentage of those age 25 years and older with a high school diploma or equivalent. 2021.	⇧	88.3%	88.6%	90.8%	81.3%	86.2%	96.7%	91.4%	89.7%	94.4%	87.2%	86.9%	89.6%	Increase the percentage of adults, age 25 years and older, with a high school diploma or equivalent to **90%**.
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). 2023.	⇩	4.9%	4.0%	9.8%	3.7%	5.1%	3.9%	3.2%	3.6%	4.9%	3.8%	3.5%	4.4%	No SMART Target. We want this to decrease over time.
	Income Inequality	Number of Total Earned Income Tax Credits. 2021 tax year.	⇩	12,948	1,851	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	No SMART Target. We want this to decrease over time.
	Poverty	Percent of the population below poverty level. 2021.	⇩	10.7%	8.7%	5.3%	12.8%	13.0%	5.3%	11.7%	6.5%	4.2%	5.5%	8.5%	9.5%	Reduce the proportion of people living below the poverty threshold to **10%** by 2030.
COMMUNITY - Living in a clean and safe neighborhood																
COMMUNITY	**Childhood Lead in Schools**	The number of child cases with a blood lead level of 14.5mcg/dl or greater in the San Diego Childhood Lead Poisoning Prevention Program. 2018-2022.	⇩	102	5	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Ensure **95%** of children with blood levels <3.5 mcg/dL receive case management services within two months of referral.
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. 2023.	⇧	62.8%	65.4%	72.5%	57.9%	69.0%	69.0%	69.4%	66.0%	72.5%	65.3%	61.9%	75.0%	No SMART Target. We want this to increase over time.

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

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. 2021.	↑	80.6	77.9	73.3	83.1	74.7	76.0	87.7
	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. 2021.	↑	95.0%	93.8%	92.7%	96.2%	90.9%	93.9%	95.4%
KNOWLEDGE - Learning throughout the lifespan										
KNOWLEDGE	**Education: High School Diploma or Equivalent**	Percent of population aged 25 and over with at least a High School Diploma or Equivalent. 2021.	↑	88.3%	81.1%	74.6%	97.5%	73.4%	75.8%	91.4%
STANDARD OF LIVING - Having enough resources for a quality life										
STANDARD OF LIVING	**Unemployment Rate**	Percent of the total labor force that is unemployed. 2023.	↓	4.9%	6.7%	10.0%	2.9%	6.5%	6.5%	5.0%
	Income: Percent of population spending less than 1/3 of income on housing	Percent of the population spending less than 1/3 of their income on housing. 2021.	↑	55.5%	52.7%	51.6%	51.1%	46.8%	49.3%	58.8%
COMMUNITY - Living in a clean and safe neighborhood										
COMMUNITY	**Security: Overall Crime Rate**	Overall Crime rate per 100,000 population. 2020.	↓	1830.5	N/A	N/A	N/A	N/A	N/A	N/A
	Physical Environment: Air Quality	Percent of days that air quality was rated as unhealthy for sensitive populations. 2022.	↓	2.1%	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. 2021.	↑	62.0%	77.7%	78.5%	89.7%	72.5%	80.5%	76.5%
SOCIAL - Helping each other to live well										
SOCIAL	**Vulnerable Populations: Food Insecurity**	Percent of adult population below 200% FPL not able to afford food. 2022.	↓	31.8%	25.9%	N/A	N/A	N/A	N/A	N/A
	Community Involvement: Volunteerism	Percent of residents who volunteer. 2019.	↑	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 measure progress go to: http://www.sdcounty.ca.gov/hhsa/programs/sd/live_well_san_diego/indicators.html

COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

San Diego County Public Health Services 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	Target
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). 2021.	↓	43%	42%	42%	47%	43%	40%	43%	Prevent the percent of deaths due to the four chronic diseases (cancer, heart disease and stroke, type 2 diabetes, and pulmonary diseases such as asthma) to no more than **50%**.
	Infant Mortality Rate	Three-year average Infant Mortality Rate per 1,000 live births. 2018-2020.	↓	3.7	4.5	N/A	N/A	N/A	N/A	N/A	Reduce the 3-year average rate of infant deaths to **5.0 per 1,000** births by 2030.
	HIV Disease Diagnosis Estimates	Reported HIV Disease diagnosis case counts and percentages between 2017-2021 time period.	↓	100% (1,934)	21% (400)	N/A	N/A	N/A	N/A	N/A	Reduce the number of new HIV diagnoses by **90%** (from 2017 baseline level) by 2030.
	Tuberculosis Incidence Rate	Annual Tuberculosis Incidence Rate per 100,000 population. 2021.	↓	6.1	12.3	15.1	N/A	N/A	17.3	8.6	Reduce Incidence of Tuberculosis in the county to **5 cases per 100,000** by 2030.
KNOWLEDGE - Learning throughout the lifespan											
KNOWLEDGE	High School Education	Overall Graduation Rate: the percentage of those age 25 years and older with a high school diploma or equivalent. 2021.	↑	88.3%	81.1%	74.6%	97.5%	73.4%	75.8%	91.4%	Increase the percentage of adults, age 25 years and older, with a high school diploma or equivalent to **90%**.
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). 2023.	↓	4.9%	6.7%	10.0%	2.9%	6.5%	6.5%	5.0%	No SMART Target. We want this to decrease over time.
	Income Inequality	Number of Total Earned Income Tax Credits. 2021 tax year.	↓	12,948	3,916	N/A	N/A	N/A	N/A	N/A	No SMART Target. We want this to decrease over time.
	Poverty	Percent of the population below poverty level. 2021.	↓	10.7%	10.9%	13.0%	5.6%	15.8%	13.1%	6.2%	Reduce the proportion of people living below the poverty threshold to **10%** by 2030.
COMMUNITY - Living in a clean and safe neighborhood											
COMMUNITY	Childhood Lead in Schools	The number of child cases with a blood lead level of 14.5mcg/dl or greater in the San Diego Childhood Lead Poisoning Prevention Program. 2018-2022.	↓	102	18	N/A	N/A	N/A	N/A	N/A	Ensure **95%** of children with blood levels <3.5 mcg/dL receive case management services within two months of referral.
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. 2023.	↑	62.8%	57.0%	51.0%	69.0%	47.3%	49.3%	68.7%	No SMART Target. We want this to increase over time.

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—Conformity to Accreditation Requirements

By following the Mobilizing for Action through Planning and Partnerships (MAPP) process, the County is adhering to Public Health Accreditation Board (PHAB) standards in the development of its comprehensive Community Health Improvement Plan (CHIP) with individual Community Enrichment Plans (CEPs) by each Community Leadership Team (CLT). *Table 5* details how elements of the CHIP and individual CEPs conform with all requirements for community planning as reflected in the latest reaccreditation standards, Standards & Measures for Reaccreditation Version 2022. The reaccreditation measure, associated requirements, and guidance are cited along with information as to how the Countywide CHIP and Regional CEPs align.

Table 5. Alignment with Community Planning Requirements for Reaccredited Public Health Departments

Reaccreditation Measure	Requirements	Guidance	Alignment to County-Wide CHIP and Regional CEPs
Measure 5.2.1 A Adopt a community health improvement plan	1. A community health improvement plan	a. At least two or more **health priorities** to be addressed collaboratively.	Each regional CLT selected three priorities—**for a total of 15 priorities** across all 5 Community Enrichment Plans. These priorities reflect what partners are most passionate about and see value in working together to address over the next three years. These priorities are identified in *Section 3: "Building the Community Enrichment Plans."* The priorities are quite similar across CLTs, for topics such as **housing and homelessness; behavioral health issues, particularly among the youth; and income and food insecurity**. Data, community interest, and political shifts are also factors at play in identifying these priorities. The regional data presentations are a key part of this process, called the Community Health Status Assessment, and help inform discussions among the CLT members. Alignment to the *Live Well San Diego* framework is important to these CLTs who see themselves as part of this larger collective impact effort.
		b**. Measurable objective(s)** for each priority.	Measurable objective(s) for each of the priorities are reflected in each CEP. Each CEP has a performance management scorecard that contains goals, objectives, and measures for each priority and data is refreshed on a quarterly basis. Measurable

Reaccreditation Measure	Requirements	Guidance	Alignment to County-Wide CHIP and Regional CEPs
			objectives enable the CLTs to determine if progress is being made towards addressing each priority. Objectives are set to be achieved within three years of the MAPP Cycle, FY 2023-25.
		c. Improvement strategy(ies) or activity(ies) for each priority.	Each CEP has **evidence-based, practice-based, and promising practice strategies associated with the corresponding priority**, which are reflected in *Section 7 "Basis for Action."* Because there is a significant gap between the actions or objectives that appear in each CEP and the ultimate impacts in terms of community changes that are being sought, evidence-informed strategies are critical to bridging this gap. Each CEP priority has a "Strategy for Change" element in which **strategy, description of the approach, and relevant research and evidence** is described. Much more information appears in the "Section 7: Basis for Action." The relevant strategic approaches are identified from *Live Well San Diego* framework—Building a Better Service Delivery System, Supporting Positive Choices, Pursuing Policy, and Environmental Changes, and Improving the Culture from Within. Section 7: "Basis for Action" also references evidenced-based strategies from a variety of **resources**, including: Guide to Community Preventive Services/Community Guide, Healthy People 2030, County Health Rankings and Roadmaps, National Association of County and City Health Officials Toolbox, and *Live Well San Diego*, in addition to **key sources**: Centers for Disease Control, National Health Care for the Homeless Council, National Institutes of Health, Substance Abuse and Mental Health Services Administration. Within Section 7, the "Research that Supports these Actions," and a "Reference Box" with details the **resources and key sources** are included, specific to each priority. To achieve the CEP priorities, a few of the strategies support recommendations related to **policy or changes to existing policies**. Policy recommendations address

Reaccreditation Measure	Requirements	Guidance	Alignment to County-Wide CHIP and Regional CEPs
			opportunities for all to achieve optimal health and well-being, social and economic conditions that influence health equity including housing, education, workforce development, food insecurity, behavioral health and substance use, and neighborhood safety. Policy recommendations were developed by the community stakeholders and members in the respective regions impacted by health inequities in the identification, development, and implementation of policy changes to improve conditions impacting their health. The **timeframe** for completing strategies, activities, and measures in these CEPs is by the end of the MAPP Cycle of FY 2023-25, unless otherwise specified in the CEP goal or objective. Each of the five CLTs is comprised of community members and stakeholders who are **accountable** for implementing the regional CEP goals. The CLTs have work groups for each of their CEP priorities that meet regularly, often as part of their ongoing monthly meetings, to discuss strategies and progress in the implementation of CEP goals, including who is responsible for which actions. Progress on the strategies is also **monitored in a scorecard for reach CEP** that is part of an online performance management system. Additional 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 CLTs and the HHSA staff who provide staff support to these Teams.
		d. Identification of the **assets or resources** that will be used to address at least one of the specific priority	The communities in San Diego County have an abundance of resources that can be l**everaged through the *Live Well San Diego* collective impact effort. These resources are** available from community-based organizations to faith-based organizations, to healthcare outlets such as hospitals and community clinics that can enhance community well-being. **Several grant-funded programs** are also in place within the County, and legislation within the State influences the promotion

Reaccreditation Measure	Requirements	Guidance	Alignment to County-Wide CHIP and Regional CEPs
		areas.	of health behaviors. Assets and resources within San Diego County are leveraged to improve the health and well-being of residents who live within the Region. Many resources are aligned to the regional priorities identified by the CLTs, which include homelessness, mental health, and food insecurity. As part of collective impact, government, business, philanthropy, non-profit organizations, and citizens are working together to achieve significant and lasting social change, to improve the health and well-being of residents of San Diego County. The *Live Well San Diego* initiative has over **550 community partners** from different sectors that also provide resources and services (e.g., schools, faith-based, government, healthcare, business, tribal, military or veteran). The Community Health Assessment also identifies assets and resources that were used as part of the MAPP planning process to prepare the CHIP and regional CEPs. **Some objectives in the CEPs call specifically for identifying assets**—for example, Central Region CEP calls for building a "one hub" database and directory of services for housing and homeless support. Several CEPs include objectives related to developing an asset map of resources to be able to better direct residents to assistance that is already available.
		e. Description of the process used to **track the status** of the effort or results of the actions taken to implement CHIP strategies or activities.	Public Health Services supports CLTs in **tracking implementation of their CEP by administering a performance management system** that includes the CEP population health indicators, priorities, goals, objectives, measures, and activities. Each CLT has a performance scorecard and data is refreshed on a quarterly basis. In addition to the **scorecards**, CLTs utilize **work plans** to track implementation of more detailed community engagement activities. The work plans are updated during regular work group meetings and ongoing by regional community engagement team staff.

Live Well San Diego
Community Health Improvement Plan
and Regional Community Enrichment Plans
FY 2023-25

COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

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