



First 5 Commission of San Diego County
Improving the lives of children 0 to 5

FIRST 5 COMMISSION OF SAN DIEGO COUNTY NEEDS AND ASSETS ASSESSMENT OF CHILDREN'S HEALTH

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6121 Lakeside Drive, Suite 160
Reno, Nevada 89511
Phone: (775) 324-4567
Fax: (775) 324-4941
Internet: www.socialent.com



1330 21st Street, Suite 100
Sacramento, California 95814
Phone: (916) 930-9200
Fax: (916) 930-9010
www.centerforhealthimprovement.org

Acknowledgements

About The San Diego First 5 Commission

The San Diego First 5 Commission (Commission) was created in 1998 to improve the health of children prenatal to age five and their parents living in the county. The Commission and its initiatives are supported by a state tobacco product tax whose funds – according to Proposition 10 -- are dedicated to improving the health of young children.

About the Center for Health Improvement

The Center for Health Improvement (CHI) is an independent, nonprofit health policy center dedicated to improving population health and encouraging healthy behaviors. CHI uses evidence-based research as the basis for policy innovation and implementation. Since its inception in 1995, CHI has partnered with all levels of government, advocacy and community organizations, philanthropic foundations, and educators.

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SEI fulfills their mission by providing management support services, consulting, training, and computer software systems that merge the best management practices from the business world with those of nonprofit and public agencies. Based in Reno, Nevada, SEI serves nonprofit community service providers, state and local governmental agencies, foundations, and state and local associations throughout the United States.

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Susanne Boston, MPH
Health Information Specialist II
Health and Human Services Agency
North Coastal Region

Steve Briggs, Assistant Deputy Director
Health and Human Services Agency
County of San Diego

Madonna Carlson, R.N., M.Ed., Director
Regional Perinatal System for San Diego and
Imperial Counties

Alaina Dall, M.A.
Director of Policy and Community Health
Council of Community Clinics

Steven Eldred, MPH
Program Officer
The California Endowment

Amy Menolez, MPH
Community Health Promotion Specialist
Health and Human Services Agency East Region

Chyrel S. Salanguit, RN, PHN
Health and Human Services Agency
South Region Public Health Center

Yolanda Valdez, MSW
Special Projects Coordinator
Health and Human Services Agency Central
Region

Gayle White, MPH, RN
Maternal and Child Health Coordinator
County of San Diego Health and Human
Services Agency

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Marsha Barnes, School Nurse
San Diego Unified School District

Steve Escoboza, CEO & President
Healthcare Association of San Diego & Imperial
Counties

Carol Berridge, School Readiness Program
Manager
San Diego Unified School District

Kristin Gist, Director of Developmental Services
Children's Hospital

Paulina Bobenrieth, PHN Manager
South Region

Dianne Jacob, Board of Supervisors
San Diego County, Second District

Nancy Bowen, MD
Public Health Officer, San Diego County

Rosie Lopresti, School Nurse
Escondido Union School District

George Cameron, Commissioner
First 5 San Diego

Nick Macchione, HHSA Manager
North Coastal and North Inland Regions

Greg Cox, Board of Supervisors
San Diego County, District 1

Barbara Minnino, Executive Director
Vista Community Clinic

Patty Kay Danon, Chief of Staff
San Diego County Board of Supervisors,
District 1

Betty Morell, HHSA Manager
South Region

Kathy Dundovich
Department Administrator of Pediatrics
Kaiser San Diego

Stella Ohnersorgen, School Readiness Director
San Ysidro School District

Phyllis G. Elkind, MPH, Coordinator Children,
Youth and Families
County of San Diego HHSA

Rita Palet, School Readiness Coordinator
National City School District

Maria Theresa Porter, School Readiness Program
Specialist
Oceanside Unified School District

Janine Portillo, School Readiness Coordinator
Cajon Valley School District

Jan Spencely
The Methros Group

Leslie Ray
Senior Epidemiologist
County of San Diego Health and Human
Services Agency
Emergency Medical Services

Gael Strack
Assistant City Attorney, San Diego

Howard Taras, DDS
Pediatrics
University of California, San Diego

Rene Santiago, HHS Manager
North Central and Central Regions

Claudia Uribe, School Readiness Facilitator
San Ysidro School District

Jean Sheperd, Acting Director
San Diego County Health and Human Services
Agency

Joan Zinser, Deputy Director
San Diego County Health and Human Services
Agency

Pam Smith, HHS Manager
East Region

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EXECUTIVE SUMMARY

When it comes to children’s health, it’s tempting to imagine how much we could accomplish were we provided with access to unlimited resources. However, since we are seldom so lucky as that, we are instead faced with the daunting task of trying to determine how best to work with what we have, how to channel our resources into optimal programs, services, and research. This report, developed for the First 5 Commission of San Diego County, is full of the best available information on a wide range of children’s health indicators. It was designed to serve as an important tool in guiding efforts to best focus limited children’s health resources—financial and otherwise—within San Diego County.

Scope and Methodology

The project began with an exhaustive countywide scan of existing projects and research related to children, health needs and assets. The initial results were used both in the assessment and as a basis for linking to existing groups doing related work. We also conducted supplemental research to augment the results of previous county child health needs assessments. This allowed us to ensure that the assessment incorporated the most current data available, resolve any discrepancies between earlier reports, and obtain data from sources that may not have been previously included. Needs and assets were identified and analyzed both countywide and for each distinct County of San Diego Health and Human Services Agency (HHSA) region. Findings were based on available data from sources such as state or local surveys, as well as new data collected from key informants, current First 5 grantees, and regional meeting participants.

In addition to the identification of needs and assets, the interrelationship between health issues and school readiness were addressed where applicable. This was done through creation of a “significance” rating scale that integrates the *importance* of a health issue with respect to school readiness according to the best available research, the *magnitude* of the issue both countywide and by county region in terms of the number of children affected and the extent of the impact, and the size of the *gap* between the existing or projected assets and the level needed. The scale was applied countywide to provide a basis on which to compare the issues.

All data collection activities included identification of the top five health issues or priorities as part of the assessment process. As a result, the top five priorities were ranked and compared and are categorized by assessment activity as priorities for Grantees, Regional Meeting Participants, Key Informants, by occurrence rate, by significance rating and by cluster or the degree to which impacting one health issue positively impacts other health issues. A table with the comparison of the top five health issues or priorities ranked by assessment activity can be found on page 31 of this report.

Report Format

The first section of this report addresses a group of 18 **child health indicators** that were selected for inclusion based partly on their relationship to strategic priorities sought by First 5 San Diego. Each of the 18 indicators corresponds to child health indicators adopted by the California First 5 Commission as part of the statewide evaluation. The indicators are also in use by the other 57 counties and will therefore allow county and statewide comparison over time. Data on

each indicator are presented for San Diego County, and state and national data are often included for comparison. Section 1 presents a **countywide overview** of the data for each health issue. Section 2 presents several **recommendations** on focusing resources for the greatest benefit and strengthening future decision-making around children's health in San Diego County, while Sections 3 through 8 address the child health indicators in the form of **regional profiles**. The countywide profile also includes an assessment of the top five most pressing needs, an assessment of the assets (existing health programs and services), identification of emerging trends that may impact the selected health indicators, and a discussion of issues related to the availability of data. Several technical **appendices** are also included.

The 18 child health indicators analyzed in this report, centered around six overarching goals, address the following issues:

1. *Children are born healthy.*
 - Low birth weight
 - Adequate prenatal care
 - Births to teenage mothers
 - Smoking during pregnancy
2. *Children receive preventive and regular ongoing health care.*
 - Immunization
 - Well-baby and child checkups
 - Medical homes
 - Health insurance
 - Developmental screening
 - Developmental services
3. *Children are in healthy and safe environments.*
 - Child abuse
 - Recurrence of maltreatment
 - Unintentional injuries

4. *Children are healthy and well nourished.*
 - Breastfeeding
 - Expected weight
5. *Children have good oral health.*
 - Dental exams
 - Dental insurance
6. *Children are free of smoking-related illnesses.*
 - Childhood asthma

Key Findings

This is a data-rich report, addressing numerous children's health indicators and related issues. Each of the regional profiles presents findings specific to that region. Countywide findings are summarized below.

Findings by child health indicator

Low birth weight: Although San Diego County's rate of low birth weight babies is below rates seen for California and the United States, improvement is still needed if the county is to meet the national objective set forth in Healthy People 2010. Racial and ethnic disparities are also evident for this indicator.

Adequate prenatal care: timely initiation of prenatal care, during the first trimester, has been increasing within the county, with a corresponding decrease in the rate of late or nonexistent prenatal care. However, San Diego County rates are still lower than those for the state as a whole are when it comes to timely initiation of prenatal care, defined as care begun in the first trimester. While still low, the rates have been improving somewhat for Hispanic and Native American populations, but rates for Blacks have shown little improvement. Disparities are also clear by age, with the likelihood of first trimester care increasing with maternal age.

Births to teenage mothers: For the most part, data show improvements in the teen birth rates over the past decade. With 28 births per 1,000 teens age 15-17, San Diego County's rate was lower than the state average of 30.4 in 1999. However, while some rates have declined, racial and ethnic disparities persist. The teen birth rate for Hispanic teens in the county is many times that for Whites, and rates for Blacks and Native American populations are also high.

Smoking during pregnancy: At 111 per 1,000 population, the rate of smoking during pregnancy for San Diego County exceeded that of California (98 per 1,000) for the year 2000. Additionally, both the county and the state rates are significantly worse than the Healthy People 2010 objective of 10 per 1,000 population. Statewide data suggest smoking during pregnancy is most prevalent among Blacks and Whites, although with such a wide gap between current levels and the national objective there is room for improvement across all racial and ethnic groups. This is also true for low income women and those who have not completed high school.

Immunization: Since 1994, immunization rates have generally increased in the county. By the time children have reached school age, more than 98% have been immunized. Analysis by individual vaccine reveals mixed results in comparison to state and national levels, with San Diego County's rates sometimes higher (varicella, PCV, 4+ DtaP) and sometimes lower (polio and hepatitis B). The county has met Healthy People 2010 objectives for two of the six vaccination measures. While there is still work to do in this area, it is interesting to note one commonly seen disparity seems to have been reversed in the county, such that vaccination rates are actually higher for children living in families below the poverty level than for those with higher incomes.

Well-baby and child checkups: Currently, there is limited data on the number and percentage of children who are receiving timely well baby and child checkups in San Diego County.

According to the American Academy of Pediatrics guidelines for well-baby and well-child examinations, children should receive at least four, non-illness related medical health examinations before age one, and at least three examinations between the first and second birthdays. Well-baby and well-child visits are important because they can reduce the incidence of avoidable illness and general health problems. Well-baby checkups also allow for the provision of specific preventive measures, such as immunizations, dental and nutritional assessments and referrals, and lead, anemia, and tuberculosis screenings. Also, these visits allow the opportunity to provide health education for parents. The standards established by Medicaid indicate that each checkup should involve a health history; a physical examination; an assessment of development, nutrition, dental status, and immunizations; vision and hearing screenings; and blood work. ¹

Medical homes: Overall, the percentage of children with a primary care provider has increased over recent years, although decreases have been seen for some racial and ethnic groups. The percentage for Hispanic children has steadily increased, although this group is still the least likely to report children with a primary care provider. Children whose parents are Hispanic are more likely to utilize community clinics and community hospitals, while most other children are treated at doctor's offices or HMOs. Rates for both California and San Diego County are substantially lower than national rates and objectives concerning the proportion of children with a usual primary care provider or a "medical home". It is possible that this gap reflects differences in the local health care structure, with community clinics providing what by definition is a regular medical home.

Health insurance: Data suggest that San Diego County is making improvements around health insurance coverage for families with children under eighteen years of age. However, approximately 1 in 10 children under the age of five reportedly did not have insurance in 2001. This is high compared to the rest of the state, and falls short of the *Healthy People* objective, which calls for complete elimination of child health insurance gaps by 2010.

Developmental screening: Currently, there is limited data on the number and percentage of children who receive a developmental screening by kindergarten entry in San Diego County. Statewide, more than 18,000 newborns may be at risk of or demonstrate developmental delays or disabilities.² Screenings may occur in several locations: the pediatrician's office, school clinics, First 5 San Diego program locations, San Diego Children's Hospital, public health clinics, or at the San Diego Regional Center. San Diego Regional Center reports approximately 200 intakes per month. Of the 200 intakes, 120-150 receive a more detailed screening based on the severity of symptoms upon presentation or if the child is of the age three or under. Children age three or under receive screenings based on the funding and protocols of the Early Start program (Early Start is a federally funded program jointly administered in California through the Department of Developmental Services and the Department of Education).³ Early screening and assessment can significantly increase the quality of life for children and their parents and is cost-effective for the human service delivery system.⁴ Further, early intervention also directly affects children's educational outcomes.²

Developmental services: Similar to insufficient data regarding developmental screening for children in San Diego County, there is insufficient data regarding the number and percentage of children identified with disabilities and other special needs who receive developmental services by kindergarten entry.

The Department of Developmental Disabilities December 2003 monthly consumer report showed that there were 1799 children in the San Diego Regional Center that were identified as undergoing diagnosis and evaluation, were at-risk for developmental disabilities, or were active clients of the regional center.⁵ Statewide, regional centers provided services to 20,331 children under age 3 (1999-2000), local education agencies provided services to 5,096 children (2000), and Family Resource Centers provided parent-to-parent support to more than 15,000 family members (1998-1999).²

Child abuse: The rate of substantiated cases of child abuse and neglect in San Diego County appears to have decreased slightly since 1998, although this may be related to a change in the criteria used for such cases. Existing data are difficult to interpret, and are rarely available for children five and younger. Based on available data, San Diego County's rate of child abuse among children seventeen and younger appears to be slightly higher than the national rate.

Recurrence of maltreatment: The recurrence rates for maltreatment of children under five are similar for both San Diego County and California, with approximately 10% of victims experiencing a recurrence between 2002 and 2003. Data from 2001 put the national rate slightly better at just under 9%. Children under age four are most likely to experience a recurrence, as are white non-Hispanic children.

Unintentional injuries: The number of San Diego County hospitalizations for nonfatal unintentional injuries is not available for children age zero to five. The number for children age zero to four years old declined between 1999 and 2001, yet unintentional injury still leads all other causes of death for this age group in the county. In 2001, San Diego County's rate per 1000 of 3.0 exceeded the state average by 11% and the national average by 50%.

Breastfeeding: The rate of exclusive breastfeeding by San Diego County women at the time of hospital discharge has fluctuated over the past decade, with 590 per 1,000 women doing so in 2000. However, the rate of any breastfeeding has risen steadily since 1994 to 880 per 1,000. The county ranks 25th in the state for any breastfeeding, but only 33rd for exclusive breastfeeding. Breastfeeding rates are highest for non-Hispanic whites and lowest for African Americans.

Expected weight: Trend data from 1995-1999 show the rate of overweight in San Diego's children between ages five and nine has increased steadily. Although overweight is often perceived to be a problem associated only with older children, this is increasingly a problem for younger children as well. Data on low-income children aged zero to four years participating in federally funded maternal and child health programs suggest that nearly 14% of these children in San Diego County were already overweight in 2002. This is slightly higher than the national rate but lower than the state rate. Rates for older children aged 5-11 years in this program were even higher at 20%. Since the rate of overweight generally increases with age, it is clear that substantial progress will be needed even at the youngest ages in order to achieve the Healthy People 2010 objective of only 5% overweight at ages six through 11.

Although underweight affects fewer children age zero to five than does overweight, the rate in San Diego County exceeds those for both the state and the nation. Underweight in the county is most prevalent in children under one year of age, especially for non-Hispanic black and white infants.

Dental exams: San Diego County's results with respect to dental examinations for children are mixed. At 73%, the county substantially outperformed both the nation (66%) and the state (56%) in the percentage of children under

eighteen who received dental care in the previous 12 months in 2002. The county also exceeded the Healthy People 2010 objective of 56%. However, significant variation is reported by region, and racial and ethnic disparities and income disparities are also evident. Additionally, the county's performance on the percentage of young children receiving care prior to reaching school falls substantially short of the national objective of 90%. Approximately 45% of children aged 2-5 years in the county have reportedly never seen a dentist, and statewide, one quarter of preschoolers were found to have untreated tooth decay.

Dental insurance: In 2002, just over 70% of San Diego County parents reported that their children had dental insurance, which translates into over 200,000 children without coverage. Overall, coverage rates are higher for younger children, with 25% of preschoolers lacking insurance compared to 40% uninsured at high school age. Despite the existence of oral health programs targeted to young, uninsured patients, access to care can be problematic.

Childhood asthma: Available data on asthma hospitalizations among children under five suggest San Diego County is doing fairly well compared to the rest of the state and the nation, with only 3.0 hospitalizations per 1,000 population (compared to 6.3 per 1,000 for California and 6.7 nationally). Data for 2002 suggest the rate has been lowered further, although still not quite to the Healthy People 2010 level of 2.5 per 1,000. These data does not reflect the number of children treated for asthma, but not hospitalized.

Other findings: Top priorities

To complement the collection and analysis of available statistical data on the 18 child health indicators, this needs assessment also incorporated findings from four other sources: significance rating scores developed by the

Significance Rating Team, surveys conducted with forty-two First 5 San Diego grantees, key informant interviews conducted with 17 content and health system experts in San Diego County, and responses provided by participants during the six regional meetings held throughout the county. Based on data from these additional sources, three issues—encompassing five of the 18 child health indicators in this report—emerged as top priorities for San Diego County. These priorities highlight some of the most pressing needs suggested by the data in the earlier sections of this report and are as follows:

- Health insurance coverage for children and access to a regular medical home;
- Dental insurance coverage for children and receipt of annual dental examinations; and
- Children in the expected weight for their age and height.

Other findings: Assets

Not simply a needs assessment, this effort includes an assessment of current children's health related assets—health agencies, services, and programs—operating within San Diego County. Assets that specifically address the 18 health issues covered in this report were then assessed by First 5 San Diego grantees, key informants, and regional meeting participants.

Other findings: Emerging trends

Grantees, key informants and regional meeting participants were also asked to identify emerging trends that may impact the 18 child health indicators. These include:

- The impact of state budget cuts on insurance and access to health and dental care;
- Increased homelessness and the lack of affordable housing for families; and

- An increased need for culturally and linguistically appropriate services and collateral material.

Other findings: Additional data needs

Countywide data issues that it would be beneficial to address in the future were also identified, and include suggestions around possible new data collection, the need for alternative breakdowns, data updates, and data dissemination.

Recommendations

Based on findings of this needs and assets assessment, a set of recommendations was developed for the First 5 Commission of San Diego County to aid in focusing resources in a manner that can maximize the benefits to children's health and further strengthen future decision-making. Whenever possible, strategic decision-making around these recommendations should look to build upon identified assets.

Briefly, the recommendations are as follows:

1. Maximize Commission funding by supporting existing programs that positively impact multiple health issues of concern to the First 5 Commission of San Diego. Health issue clusters were developed to account for cases in which investment in one area would have compounding benefits on one or more additional health issues based on aggregate significance scores. The top five investment opportunities based on the significance rating clusters were identified and are included in Section 2, page 31 of this report.
2. Promote culturally and linguistically appropriate services that reduce barriers to accessing care.
3. Support and promote Early Parenting Education programs from the onset of pregnancy. These should provide education on effective parenting skills, as

well as topics such as nutrition, breastfeeding, dental examinations, and school readiness.

4. Ensure that children age zero to five have health insurance and a regular medical home as well as dental insurance and receive annual dental examination and necessary follow-up treatment.
5. Promote and support programs to prevent obesity.
6. Promote and support a collaborative effort to develop strategies for administering developmental disability screenings to all young children and ensure that those identified through the screening receive necessary referrals and services.
7. Address major data gaps encountered during the needs and assets assessment process.

Repository

In addition to this report, a rich repository of data, material, and research sources collected during the needs assessment process will be catalogued for future use by First 5 San Diego and other stakeholders. This repository will be available in an online format that can be made available for future research, evaluation and planning efforts. The repository can be found on the First 5 San Diego website <http://ccfc.ca.gov/sandiego/> It is hoped that in making these materials readily available, efforts to improve the health of children throughout San Diego County will be strengthened.

1.0-COUNTYWIDE PROFILE

The State Legislature established San Diego County on February 18, 1850 as one of the original 27 counties of California. At the time of its creation, San Diego County had an estimated population of 3,490. According to historians, this estimate included 798 settlers, as well as approximately 2,692 Native Americans. San Diego County includes a mixture of urban and rural communities, from coastal beachfront to mountains and desert. Today, San Diego County covers approximately 4,255 square miles - 65 miles from north to south and 86 miles from east to west.⁶

Roughly the size of the state of Connecticut, the county is bordered by Orange and Riverside Counties to the North, Mexico to the South, Imperial County to the East, and the Pacific Ocean to the West. Much of the county's land area is considered rural with agriculture being an important component of the county's economy.⁶

San Diego County is comprised of 18 incorporated cities and 17 unincorporated communities. San Diego County formerly had five organizations that provided either health services or social services to county residents. In late 1996, the County Board of Supervisors approved the merging of these organizations into the Health and Human Services Agency so that the delivery of health services and social services could be streamlined and integrated.

Additionally, to meet the needs of San Diego County's diverse populations, five geographic service regions were established, based on the six County of San Diego Health and Human Services Regions:

- Central Region
- East Region
- North Central Region
- North Coastal and North Inland Regions
- South Region

Some services are in higher demand in one region than they may be in another, and this regional system allows HHSA to focus services in areas where they are needed, to provide maximum efficiency.⁷

Demographics

Total Population

San Diego County is the third most populous of California's 58 counties and the sixth largest county in the United States. The total population in San Diego County grew by almost 13% between 1990 and 2000 similar to California's growth during that same time period.⁸

2001 Population

Population	San Diego County	State
Population, 2001 estimate	2,862,819	34,501,130
Population, percentage change, 1990 to 2000	12.6%	13.6%

Source: Area Connect. *California Population and Demographic Resources*. Available online at <http://www.areaconnect.com/population.htm?s=CA>

The county's total population in 2003 was almost 3 million. The total population in San Diego County is expected to increase by 37% to 3,855,085 between 2003 and 2030.⁹

Total Population Projection, 2003-2020

	2003	2010	2020	% increase
State	35,116,033	N/A	45,821,900	30.5%
San Diego County	2,961,579	3,211,721	3,800,000	30.6%

Source: Area Connect. *California Population and Demographic Resources*. Available online at <http://www.areaconnect.com/population.htm?s=CA>

Age and Gender

Of the almost three million people living in San Diego County, approximately 240,000 are children age zero to five.¹⁰ Throughout the county, there are more males than females in the zero to four age group. This is consistent throughout the regions with only one of the regions indicating it has more females than males age zero to four (South Region).¹¹

Number of Children, Aged 0 to 4 by Gender, 2002

Geographic Area	Total number	Male	Female
San Diego County	201,493	101,350	100,143
North Coastal Region	32,752	16,429	16,323
N Central Region	40,907	20,949	19,958
Central Region	38,249	19,147	19,102
South Region	29,228	14,376	14,852
East region	28,639	14,522	14,117
No Inland Region	31,718	15,927	15,791

Source: San Diego Association of Governments. *SANDAG January 1 Population Estimates, 2002*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG January 1 Population Estimates All Ages by Gender by Region.

The 2000 Census reports that the median age in San Diego County is 33 years. By 2020, the median age range is expected to be significantly higher—37 to 47 years.¹²

While the total population in San Diego County is expected to increase by 37% between 2003 and 2030, it is projected that the population of San Diego County's children zero to four will grow by less than half of that (14%).¹³

Projected Population Growth for San Diego County Through 2030

Year	2000	2010	2020	2030	Change
Total Population San Diego County	2,813,833	3,211,721	3,528,605	3,855,085	37% increase
Children 0-4 San Diego County	198,621	217,151	223,079	226,194	14% increase

Source: San Diego Association of Governments. *Final 2030 Cities/County Forecast*, SANDAG, December 2003.

Ethnicity

The county is already ethnically diverse and will be increasingly so in the future. Of residents under age 18, 37% are Hispanic, and the Hispanic population is expected to continue to grow at a rapid rate. Approximately 21.5% of the county's total population is immigrants, including refugees, who come from other countries, speak 68 different languages, and have a variety of needs as they assimilate into their new environment. The senior and disabled populations are growing disproportionately compared to the rest of the population.¹⁴

The following chart indicates the change in ethnicity projected between 2000 and 2020 for San Diego County children age zero to five. It indicates a decrease in the percentage of White children from 42% in 2000 to 33% by 2020, while the fastest growing ethnic group will be Hispanic children, growing from 42% in 2000 to 51% by 2020. ⁹

San Diego County Children age zero to five in 2000 and 2020

Ethnicity	2000	2020 Estimate
Total Children	240,000	327,000
White	42%	33%
Hispanic	42%	51%
Black	6%	5%
Asian	10%	11%
Others	>1%	>1%

Source: San Diego Association of Governments. *SANDAG, April, 2002 Mapping the Census: Race and Ethnicity in San Diego County*. INFO SANDAG SourcePoint.

While the total population in San Diego County grew by 13% between 1990 and 2000, the Hispanic population increased by 47%, more than triple the rate of the population as a whole.

Nationwide, while the total population grew at the about the same rate as San Diego County, its Hispanic population grew faster with a 58% gain. ⁹

In 2000, there were 750,965 Hispanics counted by the Census Bureau in San Diego County, representing 26.7% of the total population. The Hispanic population increase of 240,000 persons between 1990 and 2000 represents 76% of the county's growth (316,000 persons) in the 10-year period. Nearly all parts of the county experienced an increase in Hispanic population during the 1990s. The highest growth areas (greater than 3,000 person increase) are found all along the coastline of San Diego County. In North County, areas of rapid growth include sections of Oceanside, Vista, San Marcos, and Escondido. The City of San Diego experienced high increases in Hispanic population along the Interstate 805 corridor south of Interstate 8. There were also increases of more than 3,000 Hispanics in the fast growing communities in eastern Chula Vista. ⁹

Hispanics are highly concentrated (more than 65% of a census tract's population) in the southwest part of the County, including Southeastern San Diego, National City, Chula Vista, and the San Ysidro border area. Hispanics also are concentrated in some of the more rural communities, comprising between 20% and 65% of the population in sections of Fallbrook, Ramona, Pala, Pauma Valley, Jamul, and East County. ⁹

Hispanics have low percentages of population (9% or less) in Del Mar and the area east of Interstate 5 in the vicinity of Solana Beach and Encinitas. Other areas with low concentrations of Hispanics include Poway, Alpine, Coronado, La Jolla, Point Loma, and Torrey Pines. The few areas that had decreases in Hispanic population include central San Diego, coastal areas from Coronado to Del Mar, areas in Santee and east of Alpine, and a scattering of areas in North County.⁹

A total of 1,548,833 people in the county (55% of the total population) identify themselves exclusively as non-Hispanic Whites. Non-Hispanic Whites are fairly evenly distributed across the county, with a few exceptions. The highest concentrations of non-Hispanic Whites (more than 85% of a census tract's population) can be found in the cities of Carlsbad, Encinitas, Solana Beach, Del Mar, Poway, La Mesa, Santee, and the coastal sections of the City of San Diego. In addition, the communities of Fallbrook, Valley Center, San Diego Country Estates (east of Ramona), Julian, Lakeside, and Alpine also contain relatively high concentrations of non-Hispanic Whites.⁹

There are relatively low percentages of non-Hispanic Whites mostly south of Interstate 8, including areas such as National City, parts of Chula Vista, and parts of the City of San Diego including Mid-City and the border area of San Ysidro. These areas have 15% or fewer non-Hispanic White residents.⁹

A total of 154,487 people in the county (5.5% of the total population) identify themselves exclusively as non-Hispanic Blacks. Blacks or African Americans are concentrated in the Cities of Chula Vista, Imperial Beach, Lemon Grove, Oceanside, parts of the City of San Diego, and in the unincorporated community of Spring Valley east of Lemon Grove. In many parts of these communities, Blacks make up more than 15% of the population. Blacks also represent relatively

high shares of the population in the military areas of the County. Throughout the North Coastal Region, the cities of Carlsbad, Encinitas, Solana Beach, Del Mar, and in most of the inland cities and communities in the northern part of the county, Blacks represent 3% or less of the population.⁹

A total of 257,461 people in the county (9.1% of the total population) identify themselves exclusively as non-Hispanic Asians or Native Hawaiians or Other Pacific Islanders. Generally speaking, the Asian and Pacific Islander population is located in urban and suburban areas in the western section of the county. The highest concentrations (more than 20% of the area's population) of Asians or Pacific Islanders are located in National City, eastern Chula Vista, and the City of San Diego communities including Paradise Hills, Mira Mesa, and Rancho Peñasquitos. Areas of low concentration (less than 2% of the population) include most of the eastern two-thirds of the county, and the City of San Diego communities including Ocean Beach, Point Loma, and the neighborhoods immediately south and east of Centre City.⁹

A total of 15,253 people in the county (0.5% of the total population) identify themselves exclusively as non-Hispanic American Indians or Alaska Natives. The highest concentration (more than 0.7% of the area's total population) of American Indians and Alaska Natives can be found in the northeast and southeast sections of the county. The communities of Pala, Pauma Valley, Valley Center, Ramona and Julian in the north, and Alpine, Jamul, and Campo in the south, as well as the area northeast of Lakeside have a relatively high percentage of American Indian and Alaska Native residents. The Pala/Pauma Valley area and adjacent eastern area are home to six different Indian tribes: Los Coyotes, San Pasqual, Pala, Pauma, La Jolla, and Rincon. The Campo Indian Reservation is in the southeastern section of the county, while the Barona Indian reservation is located east of

Santee. In addition, American Indians and Alaska natives are concentrated on or near military bases.⁹

Households and Income

According to the 2000 census, San Diego County households lag slightly behind the state average in median income while at the same time have a lower percentage than the state of persons living below the poverty level. San Diego’s median income exceeds the national average, while the percentage of persons living below the poverty level equals that of the national average. Of those families living below the poverty level in San Diego County, 22.8% are families with female head of household and no husband present. Of the 12.4% living below the poverty level, 40.2% or 10,374 persons are female head of household families with related children under the age of five years old.¹²

2000 Median Income and Poverty Level

	Median Income	% of Persons below Poverty Level
National	\$41,994	12.4
State	\$47,493	14.2
San Diego County	\$47,067	12.4

Source: US Census Data. *Census 2000 Demographic Profiles*. Available online at <http://censtats.census.gov/data/CA/04006.pdf>

The median income in San Diego County is expected to increase by 17%, growing to \$64,644 by 2030. The number of households with incomes less than \$35,000 per year are expected to increase over the next ten years but decrease over the next 30 years, based on projections from the San Diego Association of Governments (SANDAG). The following table details the household income forecast.¹³

Household Income Projections through 2030

Income	2000	2010	2020	2030	Change Percent
Less than \$10,000	71,578	76,663	64,833	52,862	-26%
\$10,000-14,999	52,759	57,011	50,334	43,081	-18%
\$15,000-24,999	117,567	127,585	116,268	102,578	-13%
\$25,000-34,999	122,158	134,420	128,733	120,012	-2%
\$35,000-49,999	159,452	177,355	178,620	175,803	10%
\$50,000-74,999	200,041	226,585	245,609	262,751	31%
\$75,000-99,999	114,723	132,999	156,752	183,820	60%
\$100,000 or more	156,399	183,705	252,326	355,589	127%
Median Household Income	\$47,538	\$48,742	\$55,899	\$64,644	30%

Source: San Diego Association of Governments. *Final 2030 Cities/County Forecast*, SANDAG, December 19, 2003.

In 2000, San Diego County had over one million housing units and a homeownership rate of 55.4%, compared to California as a whole with more than 12 million housing units and a homeownership rate of 57%. Along with projected population growth, total housing units are expected to increase by 30% over the next thirty years with multiple family housing units accounting for almost half of the increase in units.¹³

2030 Housing Unit Projected Changes

	2000	2010	2020	2030	Change Percent
Total Housing Units	1,040,149	1,166,094	1,254,647	1,354,088	30%
Single Family	628,652	699,187	738,235	778,262	24%
Multiple Family	364,636	419,520	468,416	527,221	45%
Mobile Homes	46,861	47,387	47,996	48,605	4%

Source: San Diego Association of Governments. *Final 2030 Cities/County Forecast*, SANDAG, December 19, 2003.

Summary

San Diego County is unique as a California county in a number of ways. As noted previously, in addition to being geographically diverse, San Diego County is also extremely ethnically diverse. This will continue to be the case in the future due to both the growing Hispanic population and the high number of immigrants, including refugees. At the same time, the senior and disabled populations are expected to grow disproportionately compared to the rest of the county population. These characteristics will have an impact on services and strategies needed to address children's health in the future. As such, they must be considered when assessing the needs, assets, and trends related to children's health in San Diego.¹⁴

Countywide Needs Assessment

This section provides information on how health issues are impacting children under age six throughout San Diego County. Data for each child health indicator is reviewed for the county and compared to national, and state data, as well as *Healthy People 2010* objectives, where available. The 18 health issues included in the assessment were selected in part because they relate to particular strategic results sought by First 5 San Diego and are compatible with health issues being tracked by First 5 California and the other 57 County Children and Families Commissions. This will allow for state and county comparisons of data over time.

The issues include:

Children are born healthy

- Low birth weight

- Live births in which mothers received adequate prenatal care
- Births to young teenage mothers
- Women who refrain from smoking during pregnancy

Children receive preventive and ongoing regular health care

- Childhood immunizations (aged 19-35 months who receive the recommended vaccines)
- Children receive well-baby and child checkups by age two
- Children have a regular medical home
- Children have health insurance (and their enrollment is sustained with continuous health coverage for one year)
- Children receive a developmental screening by kindergarten entry
- Children identified with disabilities and other special needs receive developmental services by kindergarten entry

Children are in healthy and safe environments

- Children with substantiated or confirmed (open) cases of child abuse
- Child maltreatment with a recurrence within a 6-month period
- Children with nonfatal unintentional injuries

Children are healthy and well nourished

- Breastfeeding
- Children age zero to five years of age are in the expected range of weight for their height and age

Children have good oral health

- Children ages one and older receive annual dental exams
- Children have dental insurance with sustained enrollment and continuous health coverage for one year

Children are free of smoking-related illnesses

- Childhood Asthma

Needs Assessment and Significance Rating

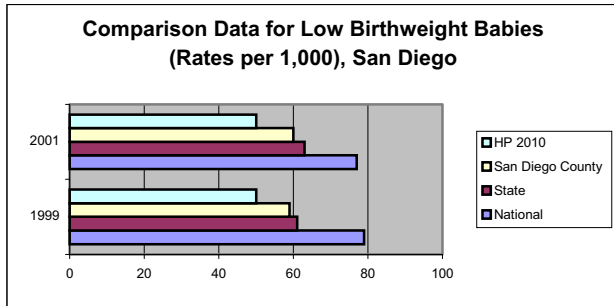
A summary of data by the 18 children's health issues is available as a companion document to this report and can be accessed at the First 5 San Diego website <http://ccfc.ca.gov/sandiego>. The status of each health issue as it pertains to San Diego County is as follows:

Children are born healthy

Low Birthweight

In 2002, the rate of low birthweight babies born in San Diego County was 61 per 1,000 population, which represents 2,682 infants. The rate of low birthweight babies in the county has remained steady between 1994 and 2002, dipping to its lowest rate of 56 per 1,000 in 1995 and peaking at 61 per 1,000 in 2002.¹⁵ Higher percentages of low birthweight babies were born to younger mothers (19 or younger) and older mothers (35 or older) between 1995 and 1999. A slight increasing trend was noted for mothers 35 or older during this period. While no discernible trends were observed among ethnic groups between 1995 and 1999, Blacks were roughly twice as likely to have low birthweight babies as Whites and Hispanics.¹⁶

The rate of low birthweight infants born in San Diego County in 2001 (60 per 1,000) is slightly lower than the state average of 63 per 1,000 and significantly lower than the national average of 77 per 1,000.^{15,17} However, San Diego County is well above the *Healthy People 2010* objective of 50 per 1,000.¹⁸



Sources: Community Health Improvement Partners. (2002). *Charting the Course III, 2001: A San Diego County Health Needs Assessment*. San Diego, CA. Community Health Improvement Partners
 California Department of Health Services. *County Health Status Profiles 2003*. Table 2-20. Number and Percent of Low Birthweight Births, California Counties. Available online at <http://www.dhs.cahwnet.gov/hisp/chs/phweek/cprofile2003/profile2003.pdf>, National Center for Health Statistics. *Birthweight and Gestation, 2001*. Available online at <http://www.cdc.gov/nchs/fastats/birthwt.htm>, U.S. Department of Health and Human Services. (2000, November) *Healthy People 2010*, 2nd ed. Washington, D.C.: U.S. Government Printing Office.

Adequate Prenatal Care Use

In San Diego County, the rate of births with prenatal care initiated during the first trimester in 2002 was 85.3%, or 853 per 1,000. In that year about 10.4%, or 104 per 1,000 women initiated care in the second trimester.¹⁹ The rate of women receiving third trimester or no prenatal care in 2002 was 26.5 per 1,000 births. The rate of first trimester prenatal care use rose from 1995-1999, from 771 per 1,000 births to 803 per 1,000. The rate of care initiated during the third trimester or no prenatal care use in San Diego County has decreased steadily since 1992, when the rate was 78 per 1,000 births.²⁰

Percentage of Women Initiating Prenatal Care During First Trimester by State and County, 2002

State	84.8%
San Diego County	85.3%
<i>Healthy People 2010 Objective</i>	90%

Source: California Department of Health Services. (2002) *Live Births by Trimester Prenatal Care Began, California Counties and Selected City Health Departments, 2002*, from birth records. Retrieved April 2, 2004 from: <http://www.dhs.ca.gov/hisp/chs/OHIR/vssdata/2002data/02ch2pdf/2-23-02c.pdf>

During the period of 1995-1999 in San Diego County, the White population had the highest

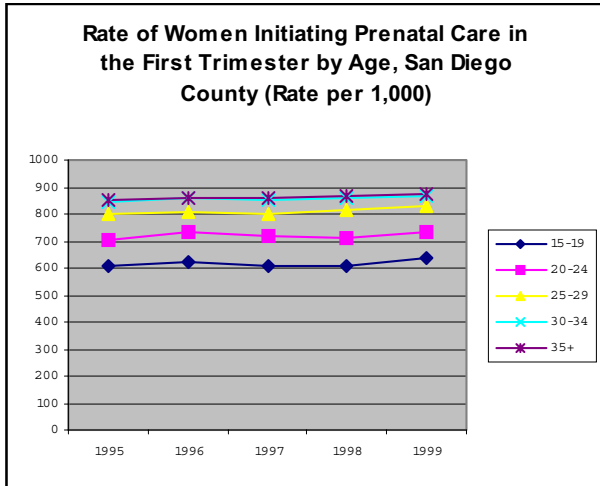
rate of early prenatal care use, followed by the Asian/Pacific Islander population. During this period, a slight increase in prenatal care use was observed in the Hispanic and Native American populations, with the greatest change in the Hispanic population (656 per 1,000 in 1995 to 728 per 1,000 in 1999).¹⁶

Rate of Women Initiating Prenatal Care During the First Trimester by Race/Ethnicity, San Diego County, 1995-1999 (rate per 1000 population)

Race/Ethnicity	1995	1996	1997	1998	1999
Asian /Pacific Islander	804	817	820	830	819
Black	761	773	754	755	771
Hispanic	656	691	687	700	728
Native American	734	738	744	766	777
Other	604	572	526	681	763
White	871	881	877	872	883

Source: Community Health Improvement Partners. (2001) *Charting the Course III: A San Diego Health Needs Assessment*. San Diego, Ca: Author.

In 1999, age groups of women who were most likely to obtain prenatal care during the first trimester were women age 25 or older. Women under the age of 15 were the least likely to obtain early prenatal care, at a rate of 409 per 1,000 not receiving care during the first trimester. Women ages 15-19 obtained prenatal care during the first trimester at a rate of 635 per 1,000 and women ages 20-24 at a rate of 735 per 1,000.¹⁶



Source: Community Health Improvement Partners. (2001) *Charting the Course III: A San Diego Health Needs Assessment*. San Diego, Ca: Author.

Births to Teen Mothers

In 2002, the rate of births to teen mothers of total births in San Diego County was 85 per 1,000 births. The rate of births to teen mothers in the county has decreased since 1992, when the rate of births to teen mothers was 106 per 1,000 births, but increased several times over this period, in 1995, at 111 per 1,000 births, and 1998-1999, at 98 and 99 per 1000, respectively.²¹ Data from 2001 demonstrate that the number, and therefore rate, of births to teens in San Diego County rises as teens become older.^{22,23}

Number and Rate of Births by Age of Mother for San Diego County, 2001

Age	Number of Births	Birth Rate (per 1,000)
15	171	8.8
16	394	20.8
17	658	35.3
18	1080	56.5
19	1651	77.8

Source: California Department of Health Services. (2002) *Live Births by Age of Mother, California Counties, 2001*, from birth records. Retrieved December 10, 2003 from: http://www.dhs.ca.gov/hisp/chs/OHIR/vssdata/2001data/01Ch2p df/2_29_2001.pdf

Over the period of 1999-2001, the birth rate to teen mothers ages 15-19 in San Diego County was 43.3 per 1,000 teens, declining slightly in 2001 to 40.6 per 1,000.^{24, 23} Over the period of

1995-1999, the rate of births to teen mothers in San Diego County ages 15-17 steadily decreased, dropping from 37.6 to 28 per 1,000.²³

2001 Teen Birth Rates (per 1,000 teens, age 15-19)

State	45.1
San Diego County	40.6

Source: California Department of Health Services. (2003) *Birth Rates by Year of Age for Teenage Mothers, 2001*, from birth records. Retrieved December 10, 2003 from: http://www.dhs.ca.gov/hisp/chs/OHIR/vssdata/2001data/01Ch2p df/2_29_2001.pdf

In 1999, the teen birth rate was highest among Hispanic teens, nearly twice the overall rate and seven times the rate of White teens. The rate for Black teens was also higher than average for the county. However, nearly all groups have showed a decline in birth rate since 1995.¹⁶

Birth rate (per 1,000) to San Diego County Teens Aged 15-17, by Ethnicity, 1995-1999

Race/Ethnicity	1995	1996	1997	1998	1999
Asian/Pacific Islander	22.3	18.8	17.8	13.0	16.4
Black	59.8	49.2	46.1	39.3	39.7
Hispanic	76.2	80.7	67.9	63.8	61.7
Native American	28.0	26.6	27.6	24.2	35.2
White	15.5	13.3	9.6	10.3	8.9

Source: Community Health Improvement Partners. (2001) *Charting the Course III: A San Diego Health Needs Assessment*. San Diego, Ca: Author

Children receive preventive and ongoing regular health care

Childhood Immunizations

In San Diego County in 2002, children received timely immunization at the following rates.²⁵

Estimated Vaccination Coverage with Individual Vaccines Among Children 19-35 Months of Age, San Diego County, 2002 (rate per 1000 population)

Vaccine	Rate per 1000
4+DtaP	830
3+Polio	872
1+MMR	901
3+Hib	918
3+HepB	867
1+Var	878
3+PCV	470

Source: Centers for Disease Control and Prevention, National Immunization Program. (2003) Estimated Vaccination Coverage with Individual Vaccines and Selected Vaccination Series Among Children 19-35 Months of Age by State and Immunization Action Plan Area US, *National Immunization Survey, Q1/2002-Q4/2002*. Retrieved December 15, 2003 from: <http://www.cdc.gov/nip/coverage/default.htm>

Since 1994, immunization levels for infants in San Diego County have generally increased, from a full immunization rate at two years of age of 660 per 1,000 in 1994 to 870 per 1,000 in 1999, with a slight dip to 770 per 1,000 in 1998. By the time children have reached school age, the immunization rate is greater than 98% or 980 per 1,000 children, among children attending kindergarten.²⁶

Nationally, children living in families with incomes below the federal poverty level are less likely to get the combined series of vaccines than children are in families that are living at or above the federal poverty level (71% versus 78% in 2000). In 2002, in San Diego County, the following are the immunization rates for children living above and below the federal poverty level:

Vaccination Coverage Among Children 19-35 Months of Age Living Above and Below the Federal Poverty Level in San Diego County, 2002

Vaccine	Above Poverty Level	Below Poverty Level
4+DTP	81.1%	N/A
3+Polio	85.6%	91.4%
1+MMR	87.6%	93.5%
3+Hib	88.9%	94.9%
3+HepB	84.1%	91.6%
1+Var	84.9%	93.7%
3+PCV	46.4%	N/A

Source: Centers for Disease Control and Prevention, National Immunization Program. (2003) Estimated Vaccination Coverage with Individual Vaccines and Selected Vaccination Series Among Children 19-35 Months of Age Living at or Below the Federal Poverty Level US, *National Immunization Survey, Q1/2002-Q4/2002*. Retrieved December 15, 2003 from: <http://www.cdc.gov/nip/coverage/default.htm>

Based on these data, it appears that children living in families below the federal poverty level in San Diego County are more likely to obtain vaccinations than those living in families with incomes above the federal poverty level.

National data also show that Native Americans are the least likely to obtain immunizations of all ethnic groups at 69%, followed by African Americans at 71% and Hispanics at 73%.¹ On the next page are the immunization rates by ethnicity for children in San Diego County:

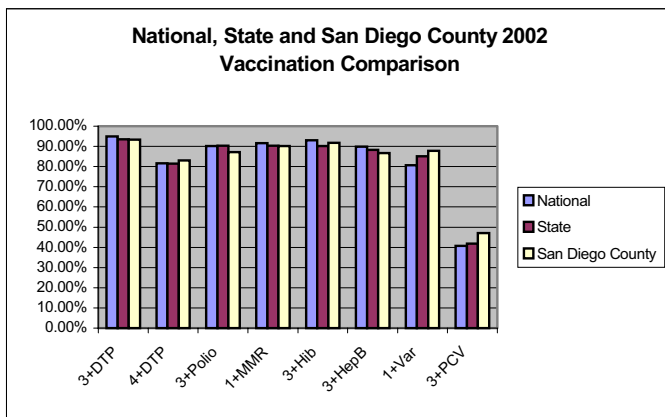
Vaccination Coverage Among Children 19-35 Months of Age by Ethnicity in San Diego County, 2002

Vaccine	White, Non-Hispanic	Hispanic
4+DTP	79.2%	87.8%
3+Polio	84.5%	90.3%
1+MMR	88.3%	93.4%
3+Hib	92.1%	94.3%
3+HepB	84.5%	89.3%
1+Var	82.1%	93.3%
3+PCV	N/A	N/A

Source: Centers for Disease Control and Prevention, National Immunization Program. (2003) Estimated Vaccination Coverage with Individual Vaccines and Selected Vaccination Series Among Children 19-35 Months of Age Living at or Below the Federal Poverty Level US, *National Immunization Survey, Q1/2002-Q4/2002*. Retrieved December 15, 2003 from: <http://www.cdc.gov/nip/coverage/default.htm>

The data in this table indicate that immunization rates are higher among Hispanic children than White children. Data for immunization rates in San Diego County are not available for the following ethnic groups: Black/non-Hispanic, American Indian or Alaska Native, Asian, Pacific Islander, Other, or Multiple Race.

In 2002, vaccinations occurred at the following rates at the national, state, and county levels compared to the Healthy People 2010 objectives for universally recommended vaccines among children aged 19 to 35 months:



Source: Centers for Disease Control and Prevention, National Immunization Program. (2003) Estimated Vaccination Coverage with Individual Vaccines and Selected Vaccination Series Among Children 19-35 Months of Age by State and Immunization Action Plan Area US, *National Immunization Survey, Q1/2002-Q4/2002*. Retrieved December 15, 2003 from: <http://www.cdc.gov/nip/coverage/default.htm> U.S. Department of Health and Human Services. (2000, November) *Healthy People 2010*, 2nd ed. Washington, D.C.: U.S. Government Printing Office

San Diego County does not meet *Healthy People 2010* objectives for 4+DTP, 3+Polio, 3+Hep B, or 1+Var.

Regular Medical Home

The 2001 San Diego County Health Needs Assessment (HNA) published by the County of San Diego Health and Human Services Agency, reports that the percentage of adults indicating that their children (all children between ages 0-18) have a regular primary care provider increased from 842 per 1,000 in 1999 to 867 per

1,000 in 2001. The HNA also reports that Hispanic children were the least likely to have a primary care provider. However, over the same three-year span, the number of Hispanics that reported a regular medical home steadily increased in (below 700 per 1,000 in 1999 to 800 per 1,000 in 2001). The rate of children of other race/ethnicity groups having a primary care provider decreased over the same time span. More than 10% or 130 per 1,000 Hispanic children under 18 did not have a usual place of health care compared with 70 per 1,000 African-American children and 50 per 1,000 White children.¹⁶

The 2001 California Health Interview Survey found that 713 per 1,000 children age zero to five in San Diego County went to a doctor's office, an HMO, or Kaiser for their usual source of care. A community clinic or a community hospital was used by 279 per 1,000 persons for their usual source of care.²⁷ A child's family income and race/ethnicity appear to affect where children obtain regular care. As family income increases, so does use of care at HMOs or physicians' offices.

Type of Usual Source of Care by Federal Poverty Level, Children Aged 0-5, San Diego County, 2001

Family income (based on federal poverty level) and location of care	Rate of children age zero to five obtaining care (per 1,000)
0-99% FPL	
Doctor's office/HMO/Kaiser	491
Community clinic/community hospital	509
100-199% FPL	
Doctor's office/HMO/Kaiser	531
Community clinic/community hospital	454
200-299% FPL	
Doctor's office/HMO/Kaiser	826
Community clinic/community hospital	174
300% and above FPL	
Doctor's office/HMO/Kaiser	894
Community clinic/community hospital	95

Source: UCLA Center for Health Policy Research. (2001) *California Health Interview Survey*, AskCHIS. Information retrieved December 18, 2003 from: <http://www.chis.ucla.edu/main>

Ethnicity also appears to affect where children obtain their usual health care. White and Asian or Pacific Islander children are more likely to receive care at a physician's office or an HMO, while Hispanic children are more likely to receive care at a community clinic.

Type of Usual Source of Care by Race/Ethnicity, Children Aged 0-5, San Diego County, 2001

Race/Ethnicity	Rate of children age zero to five obtaining care (per 1,000)
African American	
Doctor's office/HMO/Kaiser	621
Community clinic/community hospital	379
Asian	
Doctor's office/HMO/Kaiser	839
Community clinic/community hospital	161
Hispanic	
Doctor's office/HMO/Kaiser	472
Community clinic/community hospital	518
White	
Doctor's office/HMO/Kaiser	858
Community clinic/community hospital	133

Source: UCLA Center for Health Policy Research. (2001) *California Health Interview Survey*, AskCHIS. Information retrieved December 18, 2003 from: <http://www.chis.ucla.edu/main>

In San Diego County in 2001, 713 per 1,000 children age zero to five used a physician's office as the regular source of health care while in California in 2001, 776 per 1,000 children age zero to five used a physician's office as the regular source of health care.^{28,27} The California rate is lower than the national rate of 965 per 1,000 children aged zero to four and 950 per 1,000 children aged 5-11.²⁹ However, the definition of medical home at the national level differs from that used in the California Health Interview Survey (CHIS), which is the source for the California and San Diego County data.

Because medical home is defined in this report as the receipt of care in a physician's office, through an HMO, or through Kaiser, it does not take into account the services provided through the extensive network of community clinics in San Diego County. Therefore, as the reportedly high quality of service provided at these clinics allows their definition as medical homes, the rate given above for San Diego County may not accurately reflect the breadth of services that are

actually provided in the county. The *Healthy People 2010* objective for the proportion of children age 17 and under with a usual primary care provider is 970 per 1,000.¹⁸

Rate Of Children With A Medical Home, San Diego County, California, United States, Compared To Healthy People 2010 Objectives, 2001 (Rate Per 1,000)

National	965 (for children aged 0-4), 950 (for children aged 5-11)
State	776
San Diego County	713
<i>Healthy People 2010 objective</i>	970

Sources: Centers for Disease Control and Prevention. (2003, November) Summary Health Statistics for U.S. Children: National Health Interview Survey, 2001. *Vital and Health Statistics*, 10(216)., U.S. Department of Health and Human Services. (2000, November) *Healthy People 2010*, 2nd ed. Washington, D.C.: U.S. Government Printing Office.

Health Insurance

The 2001 San Diego County Health Needs Assessment (HNA) reports that the rate of households with children under age 18 with health insurance coverage has increased from 859 per 1,000 in 1999 to 887 per 1,000 in 2001. The HNA also reports that Hispanic children were the least likely to have health insurance.¹⁶ The HNA rate in 2001 is slightly lower than findings from the 2001 California Health Interview Survey, which indicates that in 2001, 898 per 1,000 children age zero to five in San Diego County were insured at the time of the survey. Of Hispanic children age zero to five 780 per 1,000 were insured, while 947 of 1,000 White children were insured.²⁸

In 2001, 102 per 1,000 children age zero to five did not have health insurance in San Diego County which is higher than the California rate of 68 per 1,000 and slightly lower than the national rate of 107 per 1,000.^{28,27,30} *Healthy People 2010* recommends increasing the proportion of all persons with health insurance to 100%.¹⁸ Therefore, the San Diego County, state, and national rates of children who are uninsured are higher than the *Healthy People 2010* objective.

Rates of Uninsured Children, San Diego County, California, United States, compared to Healthy People 2010 objectives, 2001

National	10.7
State	6.8
San Diego County	10.2
<i>Healthy People 2010 Objective</i>	0.0

Source: UCLA Center for Health Policy Research. (2001) *California Health Interview Survey*, AskCHIS. Information retrieved December 18, 2003 from: <http://www.chis.ucla.edu/main>, Inkelas, M., Halfon, N., Uyeda, K., Stevens, G., Wright, J., Holtby, S., et al (2003, July) *The Health of Young Children: Findings from the 2001 California Health Interview Survey*. Los Angeles and Sacramento: UCLA Center for Health Policy Research and First 5 California., US Census Bureau (2003, August) *Children With Health Insurance: 2001*. Washington, DC: US Department of Commerce. U.S. Department of Health and Human Services. (2000, November) *Healthy People 2010*, 2nd ed. Washington, D.C.: U.S. Government Printing Office.

Children are in healthy and safe environments

Children with substantiated or confirmed (open) cases of child abuse

In 2002, the rate of children with a substantiated case of child abuse or neglect ages 17 and under living in San Diego County was 14.8 per 1000 children.³¹ The number of substantiated cases of child abuse and neglect has declined slightly since 1998 when there were 18.4 substantiated cases per 1,000 children. However, sources indicate that in 1999 the criterion for a substantiated child abuse/neglect case was redefined and has become more specific.³¹

According to the Department of Social Services Data Analysis and Publications division, between January 2003 through July 2003, there were 19,988 children age zero to five statewide who were referred to the child welfare system, of which 16,057 were investigated.³¹

The national occurrence rate for substantiated cases for children under the age of 18 is 12.3 per 1,000.³² The state rate of substantiated child abuse incidents per 1,000 for California children under age 18 was reported at 20.5 in 1996.³³

The narrowing of child abuse/neglect criteria after 1999 may be responsible for the apparent reduction in number of substantiated cases beginning with the year 2000. For this reason, there is not enough data to present meaningful trend projections at this time. However, information prepared by the California Department of Health Services, EPIC Branch pooling California Department of Justice data, death records, homicide files, Fatal Child Abuse and Neglect System Program data and numbers from the Child Abuse Central Index does show some reductions in the rate of children with substantiated cases of child abuse over the ten-year time period 1990-2000, including the years prior to 1999.³⁴

Apparently there is an increase in referrals after age five because the children are entering school and are no longer confined to their homes; females do represent a larger number of the substantiated cases though there are fewer females statewide than males.³⁵

2000-2001 Two-Year Average Substantiated Cases Of Child Abuse Among Children 0-17 (rates per 1000 population)

National	12.4
State	20.5*
San Diego County (overall)	15.2

**1996 data included for comparison*

Source: Child and Family Health and Well-Being 2002 Report Card

Compared to the national and state rates of substantiated child abuse for children aged 17 years and younger, San Diego County rates are higher than the National substantiated child abuse rate. National substantiated child abuse rates are less than 13 per 1000 and the California state child abuse rate is just above 20 per 1000. Related data is scarce for children age zero to five in San Diego County.

Child maltreatment with a recurrence within a 6-month period

In San Diego County during the period of July 1, 2002 to June 31, 2003, the following were the rates of maltreatment recurrence, by age:

San Diego County Rate of Maltreatment Recurrence by Age, 2002-2003

Age Class	Base Period (Number)	Recurrence (Number)	Recurrence rate (per 1,000)
Under 1	421	42	100
1-2	537	69	128
3-5	776	82	106

Source: Child Welfare Services Reports for California, UC Berkeley Center for Social Services Research

Thus the average recurrence rate of child maltreatment in San Diego County for children five years and younger is 111 per 1,000.³⁶

Recurrence of maltreatment is highest among children aged 1-2, at 128 per 1,000, and is somewhat lower for children aged 3-5, at 106 per 1,000. The lowest rate of reoccurring maltreatment is among children younger than one year of age, at 100 per 1,000.

In California in 2002-2003, the rates of maltreatment recurrence of children age zero to five were the following:

2002-2003 California Rate of Maltreatment by Age

Age Class	Base Period (Number)	Recurrence (Number)	Recurrence rate (per 1,000)
Under 1	5,195	566	109
1-2	5,529	645	117
3-5	8,488	926	109

Source: Child Welfare Services Reports for California, UC Berkeley Center for Social Services Research

The rates of maltreatment recurrence for California are similar to those for San Diego County.

Nationally, the U.S. Department of Health and Human Services reports that 8.9% of child abuse

and neglect victims in 2001 experienced a recurrence.

Based on data from the 1999 National Child Abuse and Neglect Data System, the youngest children, those under age 4, are most likely to experience a recurrence of maltreatment; White non-Hispanic children were more likely to experience a recurrence than their Black and Asian/Pacific Islander counterparts.³⁷

Unintentional Injury

Data on nonfatal hospitalized unintentional injuries are collected statewide for children under one year old, 1-4 years old, and 5-12 years old. During 2001, 617 nonfatal hospitalized unintentional injuries (or 3 per 1,000 population) were reported for children zero to four years old in San Diego County.³⁴ The numbers of nonfatal hospitalized unintentional injuries for children zero to four have been declining over the last three years (see chart below). However, unintentional injury leads all other causes of death for children aged five and under for San Diego County.³⁸

Nonfatal Hospitalized Unintentional Injuries For Children 0-4 in San Diego County, 1999-2001

	Number of hospitalizations
1999	745
2000	687
2001	617

Source: CA Department of Health Services EPIC Branch. Unintentional Injury Data by county. Retrieved on December 19, 2003 from: <http://www.applications.dhs.ca.gov/epicdata/>

Nationally, unintentional injury ranked as the number one cause of death for children aged one year to five years for the last ten years data are available (1990-2000), according to the Center for Disease Control's National Center for Injury Prevention and Control Web-based Injury Statistics Query and Reporting System (WISQARS) database. Statewide in 2001, 7,664 California children ages zero to four were hospitalized for an unintentional injury at a rate of 2.9 per 1,000 population.^{34,39} San Diego

County's rate is higher than the state and national rates (see table below).

Comparison of Nonfatal Hospitalized Unintentional Injuries for Children 0-4, 2001 (Rate per 1,000)

National	2.0
State	2.7
San Diego County	3.0

Source: CA Department of Health Services EPIC Branch. Nonfatal Hospitalized Injuries by Age Group, San Diego County Residents, 2001. Retrieved on December 31, 2003 from http://www.applications.dhs.ca.gov/epicdata/content/sum_causebyage.htm, CA Department of Health Services EPIC Branch. Nonfatal Hospitalized Injuries by Age Group, San Diego County Residents, 2001. Retrieved on December 31, 2003 from http://www.applications.dhs.ca.gov/epicdata/content/sum_causebyage.htm, California Department of Finance. (2002, February). *California Current Population Survey Report, March 2001 Data*. Retrieved December 31, 2003 from: <http://www.dof.ca.gov/HTML/DEMOGRAP/CPS-2001.doc>, Centers for Disease Control and Prevention. Unintentional Injury All Causes Hospitalized Nonfatal Injuries and Rates per 100,000, 2001. Retrieved December 31, 2003, from <http://webapp.cdc.gov/sasweb/ncipc/nfirates2001.html>

There is no *Healthy People 2010* objective for reducing the number of nonfatal hospitalized unintentional injuries in general, though there are objectives related to specific nonfatal unintentional injuries, such as motor vehicle injuries.¹⁸

A review of the major causes of unintentional injury by San Diego County are conducted either by major statistical area (MSA) or sub-regional area (SRA) for patients under the age of 20.⁴⁰ Though these data include children of all ages and do not necessarily reflect the regional designations of the public health department, the data are included for reference with regards to the extent to which unintentional injuries are reported throughout San Diego County, as well as the types of unintentional injuries reported.

1. Falls

The highest rate of EMT response to falls were reported in the East region, specifically the Anza-Borrego sub-regional area with a rate of 19.83 per 1,000.

2. *Motor vehicle occupant*
Some of the highest injury rates were located in more rural regions of San Diego County. In the more dense regions, high rates were reported in Poway 6.62 per 1,000, and in the Coastal sub-regional area (includes popular Pacific Beach and Mission Beach/Mission Bay), 6.13 per 1,000.

3. *Suffocation*
The highest rates of suffocation injuries were reported in the Santee (.88 per 1,000), Vista (0.49 per 1,000), and El Cajon (0.46 per 1,000) sub-regional areas.

4. *Poisoning*
Three MSAs reported the highest rates of overdose (OD)/poisoning injuries: North County West, East Suburban, and South Suburban. The highest rates among sub-regional areas for OD/poisoning were found in Harbison Crest (1.83 per 1,000), Ramona (1.23 per 1,000), Santee (1.07 per 1,000), and Fallbrook (0.8 per 1,000).

5. *Burn/Scald Patients*
Among SRAs, the highest rate of burns/scalds was reported in the Coronado SRA with 1.46 per 1,000 with the next highest reporting of burns/scalds in the Coastal SRA at a rate of 0.46 per 1,000.

6. *Pedestrians*
The SRAs of Harbison Crest, Mid-City and Chula Vista reported the highest pedestrian crash rates at 1.57 per 1,000, 0.87 per 1,000, and 0.7 per 1,000 respectively. Besides Harbison Crest, the two other SRA areas are urban with a high level of commuter traffic.

7. *Pedalcyclists*

Coronado and Harbison Crest sub-regional areas reported the highest rate of pedalcyclist injury (bicycle) at rates of 2.73 per 1,000, and 2.35 per 1,000. The Coronado area is known for its popular cycling areas.

8. *Drownings*
The East Suburban major statistical area of San Diego County reported the highest rate of drowning in the county at 0.0984 per 1,000 children.

9. *Sports-related injuries*
The Coronado SRA reported the highest rate of sports related injury countywide: 4.92 per 1,000, which was twice that of the next highest rate.

Children are healthy and well nourished

Breastfeeding

In San Diego County, the rate of women breastfeeding exclusively or at all is tracked by hospital at the time of discharge.⁴¹ However, not all hospitals provide data on breastfeeding rates at time of discharge, so the data in this report do not reflect the total population of women who give birth in hospitals in the county. In San Diego County, the rate of women exclusively breastfeeding at the time of hospital discharge in 2000 was 590 per 1,000 women, while the rate of women breastfeeding at all was 880 per 1,000 women. Since 1994, the number of women exclusively breastfeeding has risen about 7%, when the rate was 550 per 1,000, but is lower than the peak rate during 1997-98 of 620 per 1,000. However, the rate with any breastfeedingⁱ has risen steadily, by about 13% since 1994, when the rate was 780 per 1,000 women.⁴²

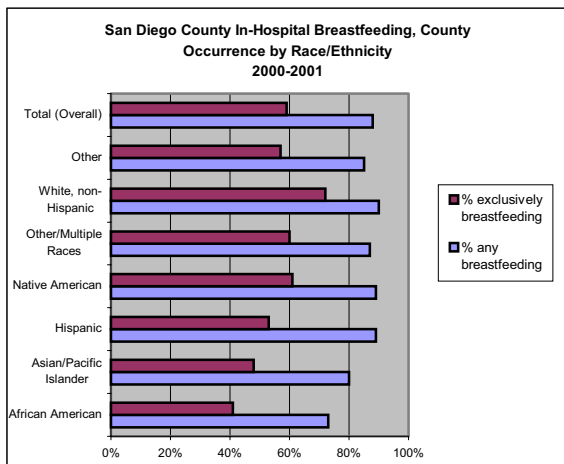
According to the California Department of Health Services, San Diego County ranks 33rd

ⁱ "Any breastfeeding" includes women who exclusively breastfeed, as well as women who supplement breastfeeding with formula.

for exclusive breastfeeding and 25th for any breastfeeding out of 58 California counties (with county number one being the county with the highest rate of breastfeeding).⁴²

National data track breastfeeding rates at time of discharge, as well as at six months after birth. National data for 2000 indicate that 684 per 1,000 women breastfed while in the hospital, while 314 per 1,000 were still breastfeeding their infants at six months of age.⁴³ *Healthy People 2010* objectives for breastfeeding are that 75% of infants are breastfed during the early postpartum period, 50% at six months, and 25% at one year of age.¹⁸

Data from 2000-2001 show that African American women in San Diego County tend to have the lowest rate of exclusive breastfeeding among all ethnic groups in the county followed by Asian/Pacific Islander women.⁴¹



Source: California Department of Health Services, Maternal and Child Health Branch, Epidemiology and Evaluation Section, Genetic Disease Branch. (2002) *2000-2001 Hospital Breastfeeding Tables*. Retrieved December 15, 2003 from: [http://www.mch.dhs.ca.gov/documents/pdf/2000-2001HospitalBreastfeedingTables\(Madera-Yolo\).pdf](http://www.mch.dhs.ca.gov/documents/pdf/2000-2001HospitalBreastfeedingTables(Madera-Yolo).pdf)

Range of Expected Weight for Height and Age
In the United States, underweight affects fewer children age zero to five than does overweight, and is not a problem for the vast majority of children. In 2002, data from the Pediatric Nutrition Surveillance (PedNSS) showed that the

prevalence of underweight among children younger than five years of age in this population was 54 per 1,000, which is similar to the expected rate of 5%, or 50 per 1,000.

Underweight prevalence has decreased steadily from 75 per 1,000 in 1990 to 54 per 1,000 in 2002. Similarly, the rate of underweight in California in this population has also decreased, from 66 per 1,000 in 1990 to 53 per 1,000 in 2002. However, underweight is disparate by race/ethnicity. In San Diego County and nationally, black infants are most likely to be underweight. However, in California, White infants are the most likely to be underweight.⁴⁴

For the United States as a whole, 135 per 1,000 children younger than five years of age were overweight in 2002. This rate has increased steadily since 1990, when the rate was 106 per 1,000. In California, the rate of overweight was 162 per 1,000 in 2002, which has also increased since 1990, when the rate was 134 per 1,000. Like underweight, overweight is disparate by ethnicity.⁴⁴

Pediatric Nutrition Surveillance, Underweight by Race/Ethnicity, California and the United States, 2002 (rate per 1,000)

Ethnicity	Rate of Underweight (per 1,000) for 0-59 months of age, California	Rate of Underweight (per 1,000) for 0-59 months of age, United States
American Indian/Alaska Native	56	32
Asian or Pacific Islander	59	61
Black, not Hispanic	64	66
Hispanic	47	50
Other	70	70
White, Not Hispanic	69	49
Total	53	54

Source: Centers for Disease Control and Prevention. (2003) *2002 Pediatric Nutrition Surveillance*. Retrieved December 22, 2003 from: <http://www.dhs.ca.gov/pcfh/cms/onlinearchive/pdf/chdp/informat ionnotices/2003/chdpin03q/contents.htm>

In 2002, the rates of underweight for children in San Diego County who were included in the CDC Pediatric Nutrition Surveillance (PedNSS)ⁱⁱ were the following.⁴⁴

Pediatric Nutrition Surveillance, Underweight by Race/Ethnicity, Age, San Diego County, 2002 (rate per 1,000)

Ethnicity	0-11 months	12-23 months	24-59 months	Total, 0-59 months	5-11 years
American Indian/ Alaska Native	N/A	N/A	30	57	N/A
Asian or Pacific Islander	84	50	66	69	50
Black, not Hispanic	101	60	44	69	38
Hispanic	81	46	44	59	23
White	96	60	45	72	37
Other	100	72	55	79	30
Total	88	53	46	65	27

Source: Centers for Disease Control and Prevention. (2003) *2002 Pediatric Nutrition Surveillance*. Retrieved December 22, 2003 from:

<http://www.dhs.ca.gov/pcfh/cms/onlinearchive/pdf/chdp/informat ionnotices/2003/chdpin03q/contents.htm>

In San Diego County, underweight is most prevalent among children ages 0-11 months and declines as the children become older. Underweight is also the most prevalent among black infants. However, by aged 24-59 months, the rate of underweight is relatively the same for all ethnicities. In 2002, the following were the rates of overweight, by age and ethnicity.⁴⁴

Pediatric Nutrition Surveillance, Overweight by Race/Ethnicity, Age, San Diego County, 2002 (rate per 1,000)

Ethnicity	0-11 months	12-23 months	24-59 months	Total, 0-59 months	5-11 years
American Indian/ Alaska Native	N/A	N/A	208	180	N/A
Asian or Pacific Islander	118	145	144	134	155
Black, not Hispanic	107	169	135	132	151
Hispanic	121	176	162	148	217
White, not Hispanic	88	152	120	111	172
Other	100	151	135	122	183
Total	113	168	153	139	203

Source: Centers for Disease Control and Prevention. (2003) *2002 Pediatric Nutrition Surveillance*. Retrieved December 22, 2003 from:

<http://www.dhs.ca.gov/pcfh/cms/onlinearchive/pdf/chdp/informat ionnotices/2003/chdpin03q/contents.htm>

In San Diego County, overweight affects children younger than age five at a greater rate than does underweight and is highest among children aged 5-11 years. Among children aged 0-23 months and children aged 5-11 years, Hispanic children are the most likely to be affected by overweight, and among children aged 23-59 months, American Indian children are the most likely to be affected by overweight.

For children age five to eleven in San Diego County, trend data from 1995-1999 shows that the rate of overweight increased steadily during that period.¹⁶

Children have good oral health

Annual Dental Exams

A United Way 2002 Outcomes and Community Impact Program survey found 73.1% of children under the age of 18 had received dental care services.⁴⁵ Currently, there is no countywide collection of data for children ages five and

ⁱⁱ PedNSS is a child-based public health surveillance system that monitors the nutritional status of low-income children in federally funded maternal and child health programs. Data are collected to monitor birth weight, under and overweight, short stature, anemia and breastfeeding, and represent 39 states, as well as the District of Columbia, Puerto Rico, American Samoa, and six tribal governments.

under.⁴⁶ Of the households surveyed in the 2002 report, 74.1% had a regular dental care provider. Fewer Hispanic children were reported to have a regular dental provider when compared with their Black, Asian, and White counterparts; both Black and Hispanic children had lower rates of dental visits in the past 12 months.

Just over 73% of San Diego County children under the age of 18 were reported to have received dental care within the last 12 months.⁴⁵ At this time, uniform, countywide data for children ages five and under is not available.⁴⁶ One goal of *Healthy People 2010* is to increase the percentage of children receiving dental care before reaching school to 90%. In the year 2002, 59% of White preschool-age children in San Diego County received dental care before beginning school. In rural areas only 48% of White preschoolers received dental care before beginning school.⁴⁷

In California, over half of rural preschool children have never had a dental visit.⁴⁸ One-third of the state’s preschoolers had at least one tooth that was decayed or filled, and one quarter had untreated tooth decay.⁴⁸

2002 Comparison Data - Percentage Of Children Under Age 18 Receiving Dental Care In Past 12 Months

National	66%
State	56%
San Diego County	73%
<i>Healthy People 2010 Objective</i>	56%

Source: Department of Health and Human Services. (2000, November) *Healthy People 2010*, 2nd ed. Washington, D.C.: U.S. Government Printing Office.
 United Way of San Diego County. (2002). Outcomes and Community Impact Program: Medical Security (Report 24). San Diego, CA: United Way of San Diego County. Retrieved November 15, 2003, from <http://www.unitedway-sd.org/2002reports.html>.
 Dental Health Report for San Diego County (Compiled 2002). A Report of the Dental Health Coalition.

The *Healthy People 2010* objective target is for 56% of children aged 2-17 to have annual dental visits (based on 1996 data). In San Diego County in general, 73% of children have seen a dentist in

the past 12 months, but certain regions, such as the Central Region report significantly lower numbers of children with a regular dental provider. Similarly lower numbers exist for some ethnic groups (Hispanics) and certain socio-economic levels (<\$39,000 per year).

Dental Insurance

While 70.7% of San Diego County households report children with dental insurance, the county is home to approximately 83,000 children without health insurance. Given estimates that correlate medical health coverage to dental health coverage, that figure amounts to about 2.6 times more children without dental insurance; therefore roughly 216,000 children under 17 countywide have no dental coverage.⁴⁷ Some estimates list the number as high as 233,132 children countywide.

Data from a four year period beginning in 1999 shows no significant trend in San Diego County, with the number of parents reporting their children currently have dental insurance decreasing in at 68.4% in 1999, to 72.4%, 74.5%, and 70.7% respectively through the year 2002.⁴⁵

Of California’s preschool and elementary school age children, 25% report they have no dental insurance, while 40% of high school age children have no dental insurance.⁴⁸ The United Way reports that 233,132 children countywide do not have dental insurance. Of those parents with dental health coverage for their children, about 65% reported satisfaction with their dental insurance coverage. Households living on annual incomes below \$20,000 reported the majority of Denti-Cal dental health coverage at 43%. The majority of county residents received their coverage through their employers. Dental insurance coverage from their parents’ employers represents the largest group of children who receive insurance.

There are various oral health promotion programs in the county (four sites including clinics, a hospital and other programs) that cater to young, uninsured clients.⁴⁷ There are also several regional dental health practitioner societies committed to improving oral health promotion among children. Some children are enrolled in private medical insurance that does not include dental insurance as part of their benefits package, but they may be eligible for Medi-Cal (Denti-Cal) coverage or Healthy Families but are not yet enrolled. In addition, some providers refuse to accept Denti-Cal or Healthy Families coverage and these children are largely without other options as fewer than one third of the community clinics in San Diego County have dental facilities. Of those clinics with dental facilities, the wait can be up to three months.⁴⁷

Children are free of smoking-related illnesses

Smoking During Pregnancy

In 2000, the rate of smoking during pregnancy in San Diego County was 111 per 1,000 population (95% CI = +/-3.4%; n=344).⁴⁹ Data for 1999 are available; however, because a different definition of smoking during pregnancy was used for the 1999 survey, county data comparisons cannot be accurately made to determine a trend. Data are unavailable prior to 1999.⁵⁰

In California, only about half of health maintenance organizations (HMOs) and MediCal managed care (MMC) plans require providers to document tobacco-use status in the medical record for every patient at every visit.⁵¹ In addition, health care providers may feel ill equipped to deliver smoking cessation interventions due to limited time, lack of training, and reimbursement concerns.⁵²

San Diego County’s rate of smoking during pregnancy (111 per 1,000 population) falls far short of the *Healthy People 2010* objective of 10 per 1,000 population.^{18,49} The county rate is also

higher than the state rate of 98 per 1,000 population (95% CI = +/-1.0%; n = 3,518)^{53,54}. Data on smoking during pregnancy by ethnicity for San Diego County is unavailable due to the small sample size.⁵⁰ However, state data from 2000 indicate that smoking during pregnancy is most prevalent among Blacks and Whites. State rates for American Indians are not available for the year 2000. At the same time, it is important to note that American Indians have the highest adult smoking prevalence rate of any ethnic group in California (30.3%), and in the U.S. in 1998, American Indians and Alaska Natives had the highest smoking rate during pregnancy of any other group.⁵²

Rates of Smoking during Pregnancy, 2000 (rate per 1,000)

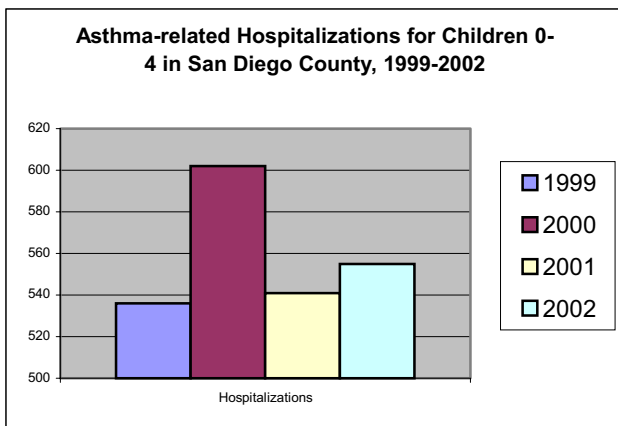
State	98
San Diego County	111
<i>Healthy People 2010 Objective</i>	10

Source: California Department of Health Services, Tobacco Control Section. (n.d.). *Smoking during pregnancy*. Retrieved December 15, from <http://www.dhs.ca.gov/tobacco/documents/Pregnancy.pdf>, Maternal and Child Health Branch, California Department of Health Services. Maternal and Infant Health Assessment Survey (MIHA), 2000, Schumacher, J. (2003, December 18). Personal communication with the Center for Health Improvement, Center for Health Improvement. (2003, August). *First 5 Community Guide to Supporting Effective Tobacco Cessation Services*. Sacramento, CA: California Children and Families Foundation and Center for Health Improvement.

Studies also show that the level of educational attainment and income affects the likelihood that women will smoke during pregnancy. In California, pregnant women who have not completed high school are 2.5 times more likely (and women with a high school degree/GED are 2.4 times more likely) to have smoked during the first and/or third trimester than women with a college degree or more. Further, women with an income between 0-100% of the 1999 Federal Poverty Level (FPL) experienced 2.8 times the smoking rate of women with an income over 400% of the 1999 FPL.⁵³

Asthma Hospitalizations

Asthma hospitalization rates are collected for children ages zero to four and 5-14 in the county. In 2002, the rate of asthma hospitalization for children zero to four in the county was 2.81 per 1,000 population.⁵⁵ Note that trends are difficult to assess using available data. Although data were collected between 1999 and 2002, beginning in 2001, the Office of Statewide Planning and Development began masking a portion of the identifying variables (including age) to protect patient confidentiality. Due to this masking, data cannot reliably be compared over the four-year span between 1999 and 2002.⁵⁶ However, numbers of hospitalizations for each year are included in the table below for reference.



Source: County of San Diego Health and Human Services Agency, Community Epidemiology. (Data table). Asthma Related Hospitalizations Among San Diego County Residents, 1997-2000. Retrieved December 18, 2003, from <http://www2.sdcounty.ca.gov/hhsa/documents/AsthmaHosp9700.pdf>

The rate of hospitalization for children zero to four with asthma in San Diego County was lower than the state and national rates in 2000 (see charts that follow). Among all San Diego County residents, rates were much higher for Blacks than for other ethnic groups and higher for females than for males.⁵⁷

San Diego County has not yet reached the *Healthy People 2010* objective of 2.5 asthma

hospitalizations per 1,000 population for children under five years of age, although significantly better than the rest of the state.¹⁸

Comparison of Asthma-Related Hospitalization Rates* Among Children 0-4, 2000 *Rates per 1,000 population

National	6.7
State	6.3
San Diego County	3.0
<i>Healthy People 2010 Objective</i>	2.5

Source: County of San Diego Health and Human Services Agency, Community Epidemiology. (Data tables). Asthma Related Hospitalizations Among San Diego County Residents, 1999-2002, Age Group by Region. Source: California Office of Statewide Health Planning and Development, 1999-2002 Patient Discharge Data. Rates calculated using SANDAG January 1, 1999 revised estimates and January 1, 2000, 2001, and 2002 estimates. Prepared by Community Epidemiology. (County Data Source)

Summary of Health Needs

In addition to the data on the 18 health needs, the needs assessment included data from grantee surveys, the significance rating scores, key informant interviews and participant feedback and surveys from the regional meetings. The specific findings of each group are presented below. In addition, several general core assumptions were identified that underscore the health needs in San Diego County.

First, needs assessment participants feel all 18 of the health issues are critical to children's health and as such, are not hierarchical but interdependent.

Second, while each health issue is described distinctly in the issue summaries and via the data, respondents did not differentiate overlapping needs related to the health issues. Therefore, when identifying needs, trends or when making recommendations, respondents often bundled health insurance and regular medical home, dental insurance and annual examinations, development screening, and developmental services.

Finally, children's mental health is acknowledged as a key component of overall health. However, the scope of this needs assessment purposefully did not address children's mental health as a separate planning effort is currently underway in San Diego County related to children's mental health.

When comparing needs by the various assessment activities, three health issues were identified across all assessment activities as the priorities for children age zero to five. They include:

- ☒ Children with health insurance and access to a medical home, (two health issues combined)
- ☒ Children with dental insurance receiving annual dental exams, (two health issues combined) and
- ☒ Children in the expected weight for their age and height.

The top five children's health needs based upon the assessment activity and resulting ranking are found in the table below.

Ranking Comparison (1-5) of Top Five Countywide Priorities by Assessment Activity, 2004

Countywide Needs	Occurrence Rate	Significance Rating Scores	Significance Rating Cluster	Key informant Interviews	First 5 Grantee Surveys	Regional Meeting feedback
Health Insurance and Regular Medical Home	3 (Regular Medical Home)	4 (Regular Medical Home) 5 (Health Insurance)	3 (Regular Medical Home) 5 (Health Insurance)	1 (Combination of health issues)	1	1 (Combination of health issues)
Dental Insurance and annual dental examination	2 (Dental Insurance) 4 (Dental exams)	3 (Dental Insurance)		2 (Combination of health issues)	2 (Dental Insurance)	2 (Combination of health issues)
Prenatal Care			1	4		
Developmental screening by Kindergarten/access to Disability services following developmental screening	No data available to calculate occurrence rate	No data available to calculate significance rating score		5	3	3 (Combination of health issues)
Children at expected weight for age and height	5	1		3	4	
Childhood Asthma					5	
Breastfeeding	1	2	4			
Behavioral/Mental Health assessment and counseling						4 (This issue not identified as one of the 18 health issues within the report)
Immunizations						5
Teenage Pregnancy			2			

This table illustrates the multiple assessment methods used to prioritize health issues. Each assessment activity resulted in the ranking of the top five health issues or priorities. The health issues or priorities that received at least one top five ranking are listed in the column on the left of the table. The individual

assessment activities are listed across the top of the table. Finally, the ranking on a scale of 1 to 5, 1 being the most important or highest priority health issue to 5 being the fifth highest priority are listed next to each top five issue and below the assessment activity that resulted in the ranking. For example, having health insurance and a regular medical home was ranked as one of the top five priorities in each of the assessment activities, with Grantees, Regional Meeting Participants and Key Informants all listing it as the number one priority.

In contrast, in the case of breastfeeding, this health issue had a high rate of occurrence, received a top five significance rating and had a high cluster rating but was not identified by Grantees, Key Informants or Regional Meetings as a top five priority. Therefore, the data indicates that investing in breastfeeding would be beneficial, but stakeholders prioritize other issues as more important. Similarly, either Grantees or Regional Meeting Participants identified both immunizations and asthma as a top five priority, but data did not indicate that investing in those health issues would be as beneficial as investing in breastfeeding. A description of each assessment activity ranking is as follows:

Legend for Comparison Table

Assessment Activity	Description of the Ranking Results for the Top Five Priorities by Assessment Activity
<i>Occurrence Rate</i>	Occurrence Rate was computed as the rate per 1,000 people within the defined total target population e.g. children age 0-5, directly affected by the health condition or issue. Therefore, the top five issues by Occurrence Rate indicate the health issues where the greatest number of persons can be impacted if an investment is made. A full description of Occurrence Rate is found in Appendix B of this Report.
<i>Significance Rate</i>	<p>The formulas used to compute the significance rating are as follows: Significance Rating = Magnitude * (Opportunity / 100) where Magnitude = Occurrence Rate * Impact Weight, and Opportunity = Gap Rating + Improvement Potential Rating</p> <p>The top five issues by Significance Rate identify those issues that occur most frequently, and that have the greatest opportunity for improvement as determined by the Significance Rating Team. Therefore the health issues with the greatest significance is rated 1 in the table above with the other 4 issues listed in numerical order from 2-5. A full description of Significance Rating is found in Appendix B of this Report.</p>
<i>Significance Cluster Rate</i>	Significance Cluster Rates are based upon the aggregate significance rating scale for each health issues and the compounding issues it impacts. This indicates where the most overall value may be realized by investing in a particular health issue, in terms of impacting the majority of the 18 children’s health issues included in this assessment. The Significance Rating Team felt cluster rates were more profound in terms of identifying a return on investment. A full description of Cluster rating is found in Appendix B of this Report.
<i>Key Informant Interviews</i>	The top five priorities for Key informants was calculated by aggregating the number of times a particular issue was identified as one of the top three priorities for San Diego County. Therefore, the health issue that was identified as the number one priority was listed as a top three priority by the majority of the Key Informants and received a “1”. The second most frequently mentioned top three priority received a “2”; the third most frequently identified top three priority received a “3” and so on, through “5”.

<p><i>First 5 Grantee Survey</i></p>	<p>The top five priorities for First 5 Grantees was calculated by aggregating the number of times a particular issue was identified as one of the top three priorities for San Diego County, based upon a survey administered to 41 Grantees. Therefore, the majority of the Grantees listed the health issue that was identified as the number one priority as a top three priority. The second most frequently mentioned top three priority received a “2”; the third most frequently identified top three priority received a “3” and so on, through “5”.</p>
<p><i>Regional Meeting Participants</i></p>	<p>Participants at each of the six Regional Meetings were asked to come to consensus regarding the top five priorities for their region. The top five health issues were then calculated by aggregating the number of times a particular issue was identified as one of the top three priorities by Region. Therefore, the health issue that was identified as the number one priority was listed by the greatest number of Regions as a top three priority and received a “1”. The second highest total by Region received a “2”; the third highest total received a “3” and so on, through “5”.</p>

Significance Rating of Health Needs

The purpose of the Significance Rating Scale (SRS) was to provide a rationale and consistent way to use the results of the health needs assessment to compare and prioritize disparate health issues, leading to more effective decision making around children's health issues.

A Significance Rating Team (SRT) was convened to perform three important roles throughout the needs assessment process. Members of the SRT were identified by First 5 Commission staff as individuals with an understanding of how data impacts policy, expertise in health related content areas, and the ability to conceptualize health issues globally in terms of ensuring overall health, rather than having an interest in a particular health issue.

The Significance Rating Team, using the Significance Rating Scale, evaluated each health issue. The rating results are found in the significance rating section, which provides detailed tables and a description of the rating process. The top five health issues, in rank order, by significance rating score are:

- ☒ Expected Weight
- ☒ Breastfeeding
- ☒ Dental Insurance
- ☒ Regular Medical Home
- ☒ Health Insurance

The top five health issues, in rank order, based upon the number of children affected (occurrence rate) are:

- ☒ Breastfeeding
- ☒ Dental Insurance
- ☒ Regular Medical Home
- ☒ Annual Dental Exams
- ☒ Expected Weight

The top five health issues, in rank order, based on the combined significance of health issues that can positively impact other of the 18 health issues (compound clusters) are:

- ☒ Prenatal Care
- ☒ Teenage Pregnancy
- ☒ Regular Medical Home
- ☒ Breastfeeding
- ☒ Health Insurance

First 5 Grantee Assessment of Health Needs

Forty-two First 5 San Diego grantees completed surveys regarding the top children's health needs countywide, the most important assets related to children's health, emerging trends and their perspectives related to assessing the health needs of children ages 0-5 in San Diego County. The top three health needs identified included:

- ☒ Children with health insurance and access to regular medical home (two health issues combined),
- ☒ Children in need of dental insurance, and
- ☒ Children with disabilities receiving developmental services by entry to kindergarten.

Overall, children having sustained health insurance coupled with access to quality care was identified by a majority of survey respondents as one of the top three health needs of children in the county.

Oral health was the next most frequently mentioned health need. The need for dental insurance, dental care or a combination of both was identified by 24% (10 respondents) as one of the top three children's health needs countywide. A related issue concerned the recruitment and compensation of pediatric dentists. Pediatric dentists are required to complete two additional years of schooling beyond traditional dental

school graduates, resulting in fewer dentists pursuing the specialty. This lack of pediatric dentists is exacerbated because a number of pediatric dentists in San Diego County have discontinued accepting Medi-Cal patients.

The third most commonly mentioned concern was ensuring that children who have been identified with disabilities and other special needs receive developmental services by entry into kindergarten. This issue was identified as one of the top three health needs of children in the county by 15% of survey respondents. In addition, 12% listed the related issue of children receiving a developmental screening by kindergarten entry. Two respondents included vision, dental and hearing screenings in this description.

Childhood asthma and related issues were cited as a primary health need of San Diego County's children by 10% of survey respondents.

Three respondents identified parent education as an important child health need. In particular, it was mentioned that parents should learn about healthy lifestyles. An additional three identified diet and nutrition, childhood obesity, and diabetes as a primary health concern for children age zero to five.

Other health needs identified by two respondents included:

- Prenatal care
- Children with substantiated or confirmed cases of child abuse/neglect
- Births to young teenage mothers
- Immunizations
- Vision care
- Family support / resources

Key Informant Assessment of Health Needs

Key informant interviews were conducted with 17 content and health system experts in San

Diego County specific to the 18 children's health issues examined as part of the needs assessment. The content expertise for each key informant varied greatly. However, because of the overlap among the 18 health issues, most key informants had content knowledge on many if not most of the issues for which they were interviewed.

When asked to identify top needs for children age zero to five in San Diego County, the key informants acknowledged that all 18 issues are critical in tracking progress on children's health. The five issues most frequently identified as the top needs for San Diego children age zero to five were:

- ✘ Health insurance and having a regular medical home (two health issues combined)
- ✘ Dental insurance and annual dental examinations (two health issues combined),
- ✘ Childhood obesity (children at expected weight for age and height),
- ✘ Prenatal care, and
- ✘ Developmental screening and obtaining services for disabilities by start of kindergarten.

Some specific comments and observations of key informants include:

Access to health care overall and having a medical home with continuous care was identified repeatedly as a major need in San Diego County. In addition, two key informants noted that health insurance retention is a major issue, with millions of dollars invested in San Diego County to conduct outreach and enrollment, yet little overall improvement has been realized in retaining health insurance.

Specifically, while outreach and enrollment have resulted in higher numbers of insured, the number of individuals and families that are losing health insurance continues to counteract

any gains made. Challenges in identifying and facilitating access to health care for children of undocumented workers was listed as a major concern.

Continuity of care and use of a medical home was an issue of concern raised by several key informants. They noted the increase in families using urgent care instead of a regular pediatrician. These families enter and exit the care provider's setting very quickly but are not establishing a bond with the physician. Often, the physician treating them does not have their complete medical record, and cannot look at data such as previous lab results so continuity of care is missing.

Dental insurance and access to annual dental examinations was identified by more than half of the key informants as a major issue facing children age zero to five. Key informants described the lack of access to dental services, the need for preventative screening and intervention and the need to educate providers on available dental resources, how to screen for oral health and where to refer children with oral health needs.

Developmental screenings for children age zero to five is also considered a major need according to key informants. It was noted that there are healthy children's programs but many children are not screened for developmental delays and/or disabilities and therefore do not receive the needed services to ensure they are ready to learn upon entering kindergarten. In addition, key informants said that many general physicians and pediatricians have difficulty identifying developmental delays, and are unsure of the referral options for children diagnosed with developmental delays.

When discussing immunizations and well baby checks, key informants noted that many children go for shots but do not actually see a doctor and

do not always have the recommended follow up visits or well baby checks.

In terms of prenatal care, key informants said that transportation continues to be a barrier to access around prenatal care. Repeatedly, they reported hearing that young pregnant women are having difficulty obtaining transportation to prenatal care.

Regional Meetings Assessment of Health Needs

Regional meetings were held in each of the six HHSA Regions related to the needs assessment. A total of 127 participants attended the meetings with meeting size ranging from 15 to 31. Participants were asked to identify their top three health issues by region. They worked in small groups to gain consensus on the top three health needs for the region. While individual participant responses identifying needs were not aggregated across the regions, the consensus process during the regional meetings indicates the top five needs impacting multiple regions and therefore considered countywide in scope.

- ✘ Health insurance and having an accessible regular medical home with affordable services (two health issues combined),
- ✘ Dental insurance and annual dental examinations (two health issues combined),
- ✘ Developmental screening and obtaining services for disabilities by start of kindergarten,
- ✘ Access to age-appropriate behavioral healthcare, including mental health assessment and counseling, and
- ✘ Immunizations.

In addition to the top five countywide needs, five out of six regions agreed that the following health needs also constitute significant attention:

- ☒ Childhood obesity (children at expected weight for age and height),
- ☒ Prenatal care,
- ☒ Well baby checks, and
- ☒ Births to teen moms.

At least three or four regional participants added the following health needs as posing a significant concern in their region:

- ☒ Increases in child neglect and abuse,
- ☒ Increased incidence of asthma,
- ☒ Vision services,
- ☒ Parents are not earning livable wages,
- ☒ Parents lack healthy lifestyle education, and
- ☒ Cultural isolation is increasing as the population grows.

In addition to feedback received from the community meetings, the Pediatric Leadership Council provided their insight into what they felt were the top health needs for children age zero to five in San Diego County. The top three health needs identified were:

- ☒ Health Insurance - access to care,
- ☒ Mental Health, and
- ☒ Preventative Care.

Furthermore, issues of lack of parent education, training for pediatricians on developmental issues, speech therapy services, and identification of services for young children with special needs were identified.

Assets Assessment

Over the past several years, San Diego County has demonstrated an ongoing commitment to improving the lives of children by creating the *Report Card of Child and Family Well-Being*. The *Report Card* tracks 20 key indicators to determine the county's progress in a number of health-related areas. While not specific to

children age zero to five, this has been an important asset in determining San Diego County's health priorities.

Several major county agencies/departments serve children, including the Health and Human Services Agency (HHSA), and the county's Public Safety Group (specifically the Probation Department, District Attorney's Office Juvenile Division, and Public Defender's Office). These are the core agencies with substantial budget commitments to children.

San Diego County has also dedicated county specific revenues to improving the lives of children, as well as appropriating funds beyond federal and state requirements. Federal and state tax revenues received by the county often are designated for specific programs, limiting the county's ability to spend money on additional, local worthy projects for children and families.

Despite such categorical mandates, county officials have added county funds to state and federal funds, to increase the number of children served, expand services, provide outreach and case management, or contract with community providers. In addition, The County of San Diego creatively braids public dollars with private sector resources. Funding from County of San Diego's budget for children's services is divided as follows:

Children’s Budget Summary, FY 2001-02 (in Millions of Dollars)

1. Employment, Income and Other Family Supports	\$335.9
2. Health and Medical care	54
3. Mental Health	106
4. Substance Abuse Prevention and Treatment	6.8
5. Early Childhood Care and Education	116.2
6. Youth Development	5.3
7. Child Protections	187.8
8. At risk Youth and Juvenile Justice	93
*Special Partnership Commissions	41.6
Total Children’s Budget	\$947.4

Source: San Diego County Operational Plan, Fiscal Years 2002-2003 and 2003-2004 retrieved from: http://www.co.san-diego.ca.us/auditor/pdf/adoptedplan_02-04_intro.pdf

First 5 Commission of San Diego County specifically funds a variety of services that impact children's health and school readiness. These programs are considered assets in the county. All funded programs target children age zero to five and their families.

Funded programs that currently comprise the safety net of First 5 programs are described below in alphabetical order. In many cases organizations offer programs in multiple locations. As such, programs are considered assets countywide but are also described based on the geographic area they primarily serve.

First 5 Funded Programs

Alpha of San Diego operates several programs including Alpha Vision and Health Care Advocacy and TOTS. They provide services in the Central, North Central, East and South Regions. First 5 funded services include vision screening to pre-school children, and vision and health care advocacy for children under 5 years of age.

American Lung Association of San Diego County has a Childhood Asthma Initiative

covering the East, North Central, North Coastal, and North Inland Regions. This program provides asthma care coordination and education for children and their parents and providers at various county locations, provides health assessments and treatment to children age zero to five, and provides weekly and/or monthly workshops for families (including consultation).

Bayside Community Center Giant Steps program operates in the North Central Region, providing in-home parent education using Parent as Teachers model and community-based parent education for pregnant and parenting families. They also conduct developmental and physical health assessments.

Catholic Charities Americans serves the East County Region providing home-based parent education using the Parent as Teachers model and developmental assessments and referral as needed to children age zero to five.

Centro de Salud de La, Comunidad de San Ysidro operates the Healthy Steps Project in the South Region. This includes two mobile service clinics that visit South Bay neighborhoods. The units are professionally staffed and provide health services and parent education to families with children age zero to five.

The Developmental Screening and Enhancement Project operates countywide to provide developmental screening and, if appropriate, referrals for further evaluation and services for children who “by pass” Polinsky Children’s Center, and are placed in foster or relative care home.

Children’s Hospital and Health Center operates Children’s Care Connection (C3) in the North Inland and North Coastal Regions to provide development assessments for children 18-36 months, developmental treatment for children 18 months – 5 years, and parent education for parents of children age zero to five.

Children's Hospital's, Anderson Center provides Welcome Baby Teeth services countywide. The program provides oral health screenings and preventive treatment, parent education to improve oral health, linkage of children to dentist in their communities, and care coordination for children with urgent care needs.

Children's Hospital's Children Partnership for Smoke Free Families operates a countywide program to provide resources and training to health care providers across the childbirth continuum, systematically implementing best practice smoking education and cessation interventions among pregnant women and new parents.

Community Health Group Foundation has a Parent Education Home Visits for Babies Under Age One serving the South, Central and East Regions. This program provides parent educators who visit Community Health Group Medical babies under age one upon their enrollment in the plan, and provides training on child development, home and car safety and health.

Community Health Improvement Partners (CHIP) San Diego operates the CAL KIDS Program Countywide to provide health insurance to children age zero to five ineligible for Medi-Cal.

Community Health Systems, Inc. (Fallbrook Family Health Center) operates the FFHC Health, Vision Treatment and Outreach Assessment program in North Inland Region in Fallbrook, Bonsal, and Rainbow. This program provides health, dental and vision assessment and treatment for children ages 18 months to five years.

Consensus Organizing Institute is the contractor for the All 4 Kids Community Engagement Project in the Central Region, El Cajon, Escondido and Oceanside to provide technical assistance in community organizing to collaboratives and parents in selected San Diego neighborhoods.

Episcopal Community Services S/E offers KidsFirst/Learning First in North Central Region. This program expands the continuum of care at Julian's Sanctuary, a transitional housing program for victims of domestic violence, to provide clinical developmental assessment and treatment for children 24 months to five years of age.

Fallbrook Union School District operates a Parents as Teachers program in North Inland to provide parents with information on child development prenatal to age five, and involve them in parent-child activities that encourage language, intellectual, motor and social emotional growth.

Family Health Center's Project Steps to SEED (Social, Emotional, and Educational Development) serves selected communities in the Central Region, East Region providing further development of three Family Resource Centers by improving assessment/treatment resources, and parent education opportunities, and serves families with children age zero to five.

County of San Diego Health and Human Services Agency CHDP – TR program offers the Healthy Mouths, Healthy Bodies, Healthy Minds program countywide. They provide dental screening and treatment service for low-income Child Health and Disability Prevention Treatment and Reimbursement eligible children age zero to five using community partner treatment providers.

Home Start, Inc offers Project PRAISE in North Central, Inland and Coastal Regions to provide children with home or center-based therapies to address developmental delays.

Homey's Youth Foundation has the Family Health and Literacy Project serving the Central Region, primarily Southeast San Diego and Mid-City, providing home-based school readiness, health assessment and education, literacy activities combined with school-based parenting classes, adult education courses for parents to advance career goals for families using the HIPPY (Home

Instruction for Preschool Parents) and Even Start programs.

Info Line of San Diego County has developed an Early Literacy Guide countywide, which is an early literacy resource guide for San Diego County.

Info Line of San Diego County, Inc. also offers Parenting Link countywide, provides referrals for families to parenting and childbirth education programs, and in-home resources via bilingual phone line and a website.

Jewish Family Services of San Diego operates a Parent Education Program countywide that provides parent education targeting the community-at-large including underserved populations, (teen parents, immigrants, homeless, ESL, etc.) using Systematic Training for Effective Parenting curriculum for parents of children age zero to five.

Joy of Sports Foundation's Star Program for Parents of Preschoolers is a countywide program providing the Star Power/Star Soccer training program to parents to build self-esteem and concentration skills within their children age three to five.

Lawrence Family Jewish Community Center runs the Nierman Pre-School, a countywide program providing developmental assessments for children 18 months to five years, and community-based parent education seminars on age appropriate early childhood development to families.

Mountain Health and Community Services, Inc. operates the Rural Children and Families Project in North Inland and East Regions, providing physical health assessments, treatment, and treatment plans for children age zero to five and parent support and education, including prenatal, in rural east San Diego County.

Multi-Cultural Child Development and School Readiness Center has the Immigrant Families

Parent Education Program in select communities of Central and East Regions to educate immigrant parents on appropriate ways to discipline, communicate and care for their children age zero to five.

National City Collaborative has the Male Improvement Program in the South Region- National City Community to provide outreach and home visitation to National City males with children age zero to five. Services include care coordination, home visitation and outreach. Men participate in a 10 week male "rites of passage" program, "Circulo de Hombres."

National City Public Library has the Words on Wheels (WOW Mobile) program in South Region- National City Community to provide area neighborhoods with a traveling resource of health information, family literacy, parenting and child development and other educational materials for parents and children.

North County Health Services Child Parenting Resource Center and Classes in the North Inland and North Coastal Regions provides a parent-child Resource Center at the North County Health Services San Marcos health center for pediatric patients aged zero to five as well as the children in the surrounding neighborhoods.

North County Health Service's Project All Ready in North Inland and North Coastal Regions offers on-site physical and dental assessment services to children in licensed childcare centers with a mobile medical team. The team provides healthcare assessments to include vision, hearing and dental screenings.

North County Serenity House offers the Healthy Access for Children in North Inland Region to provide on-site developmental assessments and treatment services to children of very low-income women in recovery who are otherwise unable to access these services.

North County Solutions for Change, Inc. has the Solutions for Kids program in North Central, North Coastal and North Inland Regions providing parent education to parents/families with children age zero to five years living at the Solutions Family Center transitional housing program.

Palomar Family Counseling Services Inc. has the Childnet Developmental Services in North Inland and North Coastal Regions to provide developmental assessment and treatment services on-site at child-care centers and family daycare homes for children ages 18 months to five years old and treatment to children and their families.

Palomar Pomerado Health operates the Welcome Home Baby Program in North Inland, North Central, and North Coastal Regions that provides a home visit program for first-time mothers and their babies for assessment and education.

Poway Unified School District operates the Ready to Learn Project in North Inland Region, providing parent education workshops that equip parents with specific skills and strategies to use with children, beginning at birth and through age five in order to ensure that these children begin their first year of formal schooling in kindergarten ready to learn and experience success. The project also offers a parent-monitored developmental assessment tool and referral services.

Regional Perinatal System of San Diego and Imperial Counties distributed the Kit for New Parents. San Diego Welcome Baby Program is a countywide program that developed partnerships with local agencies to distribute the Kit for New Parents to new mothers in San Diego County. The Kit includes six parenting videos, parenting education brochures and resource guide.

San Diego Birthing Project, has the Parent Education, In-Home Visitor Program serving South, Central and East Regions The San Diego Birthing Project serves children prenatal, at birth, postnatal, and through age one by utilizing an in-

home parenting program, providing health education and parenting skills to high-risk mothers.

San Diego Community College District Center for Education and Technology has the Child Health and Intergenerational Linkage Development Project (CHILD) in the Central Region to increase school readiness by enriching and broadening the scope of the Center for Education and Technology Parent Education Program offerings and activities for families, providing intergenerational support for parents.

San Diego Reads offers literacy training countywide, providing literacy training to library staff throughout the county.

Santee School District Children and Families Ready for School program in East Region provides academic and behavioral parent education classes for parents of children age zero to five. In addition, these services are offered to the growing population of English Language Learners (ELL). SAY San Diego Inc. has the Born to Learn/Start Smart program in North Central Region, providing parent information and education through in-home and center-based activities through Start Smart, community mobilization and conduct developmental assessments to low-income families and children in multicultural communities. Services are provided through an extensive network of Family Resource Centers and Healthy Start sites.

SAY San Diego, Inc offers the Healthy Start Military Family Cluster Our Kids Count! Program in North Central Region. The program offers parent outreach and education to families and children through home visitation and community and center-based activities. A multi-disciplinary team of staff, Public Health Nurse, CPS worker, naval Medical Center who are reflective of the military staff, and resident physicians from the Dyson Project provide additional resources and act as the conduit for

developmental assessment and treatment, other resources and cross referrals.

SDSU Foundation offers the Exceptional Families program countywide to provide parent-to parent support, resources, and referral information and education opportunities to families of children age zero to five with disabilities.

SDSU Foundation also presents KPBS, which has the Project Q Kids Raising Quality Children program countywide. In partnership, KPBS and KGTV have developed a project focusing on strengthening a parent's ability to help their children become ready-to-learn, using interstitials, newscasts, radio programs, print materials, and online content.

SDSU Foundation's Por la Vida Familias Saludables program serves the South, Central and East Regions, enrolling Latino families and children in a 12 session parenting curriculum. The project includes child-centered school readiness, referrals and follow-up.

Shiley Eye Center, Dept. of Ophthalmology, UCSD, operates the Mobile Preschool Eye Care Program in North, Central, South, North Coastal and North Inland Regions, providing critical mobile eye care to identify, treat and prevent vision disorders in low-income children, ages two to five. Referred from systematic preschool vision screenings, children receive full eye exams in the Eye Mobile at their preschool locations in order to assure that they have the vision needed to enter school ready to learn. Services include eye exams, follow-up monitoring, bilingual parent information on the importance of eye/brain development and compliance with treatment.

South Bay Union School District offers the Family Health Early Life Promotion (HELP) in South Region to provide parent education and involvement with the initial early healthy development of children. The program uses a variety of conduits to channel and direct

comprehensive child health development messages to parents and caregivers within the service areas of the Family HELP program.

St. Clare's Home, Inc. operates the Little Angel's Learning Center in North Inland and North Coastal Regions, providing developmental assessment and treatment services on-site at child-care centers and family daycare homes for children ages 18 months to five years old.

St. Vincent de Paul Village's Project S.A.F.E.C.H.I.L.D. program in the Central Region provides services for homeless children and their parents/caregivers as well as pregnant and postpartum women. Services provide families prenatal and parent education; developmental assessment for children 18 to 36 months including a mobile service, developmental treatment for children age zero to five; physical health assessment treatment for pregnant and postpartum women as well as children age zero to five.

Supreme Council of the Somali Community Somali Inc., offers the Somali Community Health Program in the Central Region providing community health nurse outreach to Somali children and family refugees countywide.

Therapeutic Services, Inc has the Building Bridges program in the East Region, providing pre-school readiness program bringing health and behavioral health assessment and treatment to 10 classes in La Mesa and Spring Valley School District.

UCSD Cooperative Extension offers the Off to a Good Start program in the South Region. Services include parent education workshops provided to parents with children age zero to five years of age and residing in the communities of Chula Vista, National City and San Ysidro. The workshops are designed to help parents provide activities that will guide their children's language acquisition and literacy skills, social, emotional,

physical development and meet their nutritional needs to assure school readiness.

UCSD Medical Center runs the Hillcrest Hearths and Hands Volunteer Doula Program in North Central, Central, South and East Regions. This program provides doula support services to women during pregnancy, birth and postpartum period at UCSD Medical Center, recruits and trains volunteers in doula skills and cultural competency through community outreach programs to serve pregnant women.

Union of Pan Asian Communities (UPAC) offers the Families Living in Good Health Together (FLIGHT) program countywide to provide bilingual parenting and health education workshops, case management services, referrals and follow-up, including interpretation, translation and transportation. Union of Pan Asian Communities (UPAC) also provides community organizational and family-based activities to develop early literacy skills for: Cambodian, Chinese, Hmong, Lao, Filipino, Samoan, and Vietnamese parents to children age zero to five.

Vista Community Clinic operates the Infancia Feliz program in North Coastal Region offering a culturally competent program designed to address the unique and complex needs of low-income Hispanic children zero to 18 months of age. The program utilizes a multifaceted intervention of home visitation, health education, and facilitated case management to increase access to care, improve infant health, and foster the parent-child relationship.

YMCA Childcare Resource Service has a Health Consultant and Behavioral Health Specialist countywide providing developmental, health, behavioral, hearing assessment, case management resource and referrals and parent education to families with children age zero to five.

The YMCA also has the San Diego CARES Program countywide to provide monetary stipends

to licensed childcare providers (in centers and family childcare homes) who complete child development classes and meet job retention requirements.

Assessment of Assets

Grantees, key informants and regional meeting participants were all asked to identify assets in San Diego specifically addressing the 18 children's health issues covered in the assessment. Three assets were identified by all three groups. They include:

- ✘ Public Health Nurses,
- ✘ Community Clinics, and
- ✘ First 5 funded programs and services

The Pediatric Leadership Council identified Children's Hospital and Clinics as a key countywide asset. In addition, the Council identified the following organizations and agencies as assets; the Community Clinic system, parent education efforts through the secondary school system, California Children Services, and the willingness of the community to collaborate on issues and work together to model different approaches to service delivery. The group also identified that many children have health insurance but the coverage typically provides poor reimbursement for services. Another positive asset or practice within the community identified by the Pediatric Leadership Council is how quickly pediatricians are connected to families after the birth of a child, in the first six months of a child's life, which provides a better opportunity to get that child off to the right start in terms of health.

A comparison by assessment activity is found in the following table.

Comparison of Top Five Assets Countywide by Assessment Activity, 2004

Countywide Assets	Key informant Interviews	First 5 Grantee Surveys	Regional Meeting feedback
Public Health Nurses	X	X	X
Community Clinics	X	X	X
2-1-1 Implementation		X	
First 5 funded programs and services, particularly home visitation	X	X	X
Children's Hospital		X	
Community Coalitions (Safe Kids, SD KHAN, I3, Breastfeeding, Asthma, Obesity)	X		X
Government funded health and dental insurance	X		X

First 5 Grantee Assessment of Health Assets Countywide

The top three assets related to children’s health mentioned by First 5 grantees were:

- ☒ Public Health Nurses (PHNs)
- ☒ Children’s Hospital
- ☒ Implementation of the 2-1-1 Referral Line

Public Health Nurses were identified as a key countywide asset by 19%, while 15% mentioned Children’s Hospital; and 10% listed 2-1-1 Implementation. In addition, First 5 San Diego and its grantee’s programs and the Community

Clinic System were mentioned multiple times as critical assets for ensuring and improving children's health.

Grantees also noted that funding and multiple funding sources are an asset in San Diego County. They identified Family Resource Centers and noted that the strong collaborations within communities enhanced resources as well. Health Insurance Advocates were also listed as an asset related to children's health.

Governmental and private resources including Healthy Families, California Early Start, and employer provided health insurance are also assets.

Grantees felt that establishing regional meetings to get the communities’ input and a focus on preventive health strengthens children's health. The schools and school readiness programs are also assets. Information from San Diego Child and Family Health and Well-Being Report Card; United Way Infoline; and the California Health Interview Survey is valuable to grantees as well.

Key Informant Assessment of Health Assets Countywide

San Diego County has an intricate, multidimensional system of care to address children's health needs. Key informants described a complex system comprised of countywide, regional and community based services. Services are often targeted toward specific populations, serving clients based on socio-economic status, immigration status, age, ethnicity or specific health concern. As such, a number of assets were identified for the 18 health issues. However, the top five assets noted throughout the key informant interviews included:

- ☒ Public Health Nurses
- ☒ Community Clinics

- ☒ First 5 funded programs and services, particularly home visitation
- ☒ Community Coalitions (Safe Kids, SD KHAN, San Diego Immunization Initiative (I3), Breastfeeding, Dental Health, Asthma, Children and Weight)
- ☒ Government funded health and dental insurance

Public Health Nurses were cited by key informants as providing critical services to children age zero to five throughout the county. In addition, community clinics are considered a central asset related to prenatal care as well as for immunizations and well baby checks, and often serve as a medical home for children age zero to five. Key informants felt that the network of community clinics provides outreach and coordinates important services for pregnant women and new mothers.

A number of collaborations, and their corresponding programs and services were identified as assets. For example, the Improving Access to Health Care Committee and its Outreach and Eligibility Subcommittee was listed as an asset working to understand and address the challenges of health care enrollment, access and retention. The Safe Kids Coalition, San Diego KHAN, and a number of other coalitions including the Breastfeeding Coalition, Dental Health Coalition, Asthma Coalition and Children and Weight Coalition were repeatedly mentioned as positively impacting children's health. San Diego Kid's Health Access Network was cited as an effective community collaborative that monitors trends, provides technical assistance and referrals while mobilizing the community around children's health issues.

A number of First 5 San Diego funded programs were listed as assets. These programs provide services throughout San Diego County and address one or more of the 18 health issues (for a

summary of currently funded programs see pages 38 through 43.

Key informants repeatedly cited home visiting programs throughout San Diego County as an asset. While several home visiting models were identified, there was consensus that home visiting offers a continuity of care that can ensure children's health. Components of home visiting programs listed by key informants included outreach for prenatal care, assistance for public insurance, provision of prenatal care, OBGYN visits, follow up, enrolling children into newborn care and home visits.

It was also noted that First 5 currently funds home visiting programs but that funding will end in October 2004.

In terms of health and dental insurance, Healthy Families, Medi-Cal and Denti-Cal are considered important assets for children age zero to five.

The Family Justice Center, providing one stop legal, domestic violence and supportive services for families opened in October of 2002. This is an asset serving families confronting child abuse and domestic violence.

Regional Meetings Assessment of Health Assets Countywide

In each of the six regional meetings, participants were asked to identify the regional assets that effectively address one or more of the 18 health issues. While not specifically countywide, many of the assets serve multiple regions and communities throughout San Diego County. The assets identified are found in the assets section of each regional summary.

Emerging Trends

Grantees, key informants and regional meeting participants were each asked to identify any trends emerging that directly or indirectly impact the 18 health issues.

A comparison of the results is found in the following table.

Comparison of Top Five Trends Countywide by Assessment Activity, 2004

Countywide Trends	Key informant Interviews	First 5 Grantee Surveys	Regional Meeting feedback
State Budget Cuts impacting insurance and access to health and dental care	X	X	X
Increase in Childhood Obesity		X	X
Increased homelessness, lack of affordable housing for families	X	X	X
Budget cuts and defunded programs resulting in reduction in needed preventative and health services	X	X	
Lack of continuity of health care	X		
Increased need for culturally and linguistically appropriate services and collateral material	X	X	X
Increased number of children 0-5 who are not screened for developmental delays.			X

The Pediatric Leadership Council identified many of the same trends identified by the other participants in the needs assessment process. In addition, a lack of health insurance coverage for many services, especially specialty care, constant change of pediatricians every year for many children, and issues with cross border health care. Also identified was a service gap for

children age two to five in speech development and behavioral services.

First 5 Grantee Assessment of Emerging Trends

The five primary emerging trends of concern to grantees include:

- ✘ The impact of state budget cuts on health and dental insurance including but not limited to the Healthy Families insurance program,
- ✘ Obesity related illnesses including diabetes are on the rise, even though awareness of obesity as a health issue is emerging across cultures and obesity prevention and education programs are now being offered in several regions,
- ✘ Budget cuts resulting in clinics closing and health services being eliminated,
- ✘ The lack of culturally and linguistically appropriate services including a lack of translation or interpretation services to assist non-English speaking patients and health care providers, and
- ✘ Increased poverty resulting in homelessness, more stress on families, loss of health insurance and increased domestic violence and or child abuse incidents.

Emerging trends identified by grantees described either positive or negative impacts on the county. The most frequently noted emerging positive trend was an increased number of programs providing developmental screening services, primarily due to First 5 funding.

Grantees noted that county public health is increasingly addressing cultural needs as well as health issues with immigrant families. They also said that increased attention of media and stakeholders focusing on children age zero to five has improved public awareness of children's health and oral health needs, which has resulted in a better understanding of how development

impacts all other aspects of the lives of children (medical, school readiness, family relations, etc.).

Grantees identified increased asthma monitoring (e.g., San Diego Asthma Report Card) as a positive trend. They also cited the increased availability of immunizations as a positive trend countywide.

A negative trend mentioned was the continued duplication of services to families causing splintering of funding. Grantees also said that there are fewer out stationed services at community family resource centers due to budget constraints.

Children's health needs appear to be increasing in the areas of behavioral and mental health issues. In addition, some grantees noted an increase in the number of students without immunizations.

A lack of recognition of oral health as part of overall health and limited money to address the shortage of pediatric dentists, compensation for pediatric dentistry, and compensation for general anesthesia were listed as negative trends countywide.

A rise in asthma with a corresponding lack of effective management of asthma resulting in emergency room visits was noted as a negative trend.

Finally, a decrease in funding resulting in fewer school nurses was another trend identified by grantees.

Key Informant Assessment of Emerging Trends

Key informants also identified a number of emerging trends in the key informant interviews. The most frequently cited trends were systemic

in nature, cutting across multiple health issues. They included:

- ✘ The impact of the state budget on health insurance, dental insurance and caps in enrollment for both types of insurance,
- ✘ Concern that the budget and current economic conditions have already begun to chip away at San Diego's health service system infrastructure, with clinics closing and a number of programs eliminated or reducing services,
- ✘ Increase in poor economic circumstances that results in homelessness and lack of affordable housing and quality child care,
- ✘ A lack of continuity of care for families receiving medical care, and
- ✘ Concern that resources will shift away from prevention despite the cost benefits of investing in prevention.

In addition to these system wide issues, specific trends were described relating to many of the 18 health issues. As noted previously, key informants had specific content expertise and often were not in a position to be aware of emerging trends for specific health issues outside their area of expertise. Therefore, their comments are summarized but not included in aggregate when identifying the top emerging trends.

Several key informants expressed a concern that specific San Diego County assets are currently challenged by the state budget, citing that budget constraints will put prevention programs at risk. Key informants expressed a concern that San Diego County will regress because state budget issues will affect children's access to health care, resulting in fewer children with public insurance. Key informants noted that some providers in community clinics have already been laid off.

Another trend cited was an overall reduction in resources for existing programs and services addressing children's health. Key informants noted that First 5 funds innovative programs but a number of programs will have their funding end in 2004 and may not be in a position to sustain them. In addition, key informants observed that the county has reprioritized and is now funding new priorities at the expense of programs that impact children's health.

Key informants said that given current economic conditions, the rate of children without medical and dental insurance is going up and will likely continue to do so. They described the trend of reduction in employer sponsored health and dental coverage and families opting out of health insurance because of high co-pays, or costs for dependent insurance not covered by the employer.

Key informants felt that San Diego County previously had made great progress with the business community related to health insurance, but after 2001, the rates of employer covered health insurance have worsened. In addition, any cap on Healthy Families, coupled with changes proposed for Medi-Cal will reduce access and coverage. Key informants felt that this has already had a direct impact on family resource centers.

One key informant further illustrated this concern saying for example that Children's Hospital is experiencing serious financial problems that will result in closing four satellite programs in February 2004. Some of the programs are the only providers for children with Medi-Cal that also accept Healthy Families. The key informant noted that there are cuts the community has not yet felt.

Access to prenatal care has increased and the trend noted by key informants was that more women had access to prenatal care and obtained care in the first trimester. However, a concern

cited by key informants is the impact the state budget crisis will have on access to prenatal care. Depending on what happens in budget and state programs, prenatal care for immigrants may not be accessible for undocumented women.

In addition, the state budget proposes a decrease in Medi-Cal providers, which may result in providers opting out of prenatal care. Key informants predict this could result in a crisis of prenatal care providers. A final trend noted was that in certain parts of the county, women without transportation do not have access to prenatal care.

Key informants reported hearing about and seeing an increase in childhood obesity and linked it to an increased incidence in diabetes. They also said that obesity is specifically a concern with Hispanic and African American children. One key informant noted seeing a 200% increase in number of referrals for overweight and Type 2 diabetes to their endocrinologist over the last few years.

A higher incidence of asthma and the need to deal with environmental control was a trend identified by key informants. In addition, some key informants described hearing that more children who are overweight and have asthma are not participating in health education. Physical education instructors keep them out of physical education to prevent asthma attacks rather than promoting exercise by encouraging children to use inhalers 20 minutes before exercise.

Childhood immunization levels have gone up over the past few years. Key informants feel that the County has done a good job of increasing access to childhood immunizations but expressed concern about what will happen at state and local levels because of budget issues. One key informant described the challenge of an anti-immunization backlash, growing from a school of thought connecting immunizations with autism and developmental disabilities. The key

informant noted that when children do not get immunized because of a lack of insurance or due to wrong information, the community is at risk.

A trend noted for both well baby checks and immunization is a drop off in follow up visits after 12 months. They cited this in particular with Hispanic families and described cultural issues in which going to a physician when well is considered unnecessary.

Key informants stated that low birthweight rates seem to be rising particularly for the Latino population. It was also noted that the increase in births to mothers age 35 and older and technological breakthroughs with premature infants contribute to the increase in low birthweight.

Two trends were identified related to pregnancy in teens. Key informants noted that children are becoming sexually active at younger ages and teen pregnancy is occurring more frequently in teens under the age of 15. In addition, several key informants describe a transgenerational trend of children of teen mothers now becoming teen mothers themselves. They described the need to treat teen pregnancy as a public health crisis as there is a higher incidence of developmental delay and behavior problems and higher incidence of child abuse with children of teen mothers.

A positive trend is an increase in breastfeeding and women breastfeeding longer. However, key informants did not think the rate of women exclusively breastfeeding is increasing. It was also noted that in intensive care units, providers are so focused on helping premature infants gain weight that they do not promote breastfeeding for the babies.

Another trend identified in key informant interviews is a significant increase in children 0-5 who are entering foster care in San Diego County.

Regional Meetings Assessment of Emerging Trends

In each of the six regional meetings, participants were asked to identify the emerging trends in that region that effectively address one or more of the 18 health issues. While not specifically countywide, many of the trends are being felt countywide. Trends that were identified in a majority of regions or were described as a countywide trend are included here. Detailed descriptions of the trends by region are found in the regional summaries. The top five trends identified in the majority of regional meetings are:

- ✘ The impact of the state budget on health insurance, dental insurance and caps in Healthy Families enrollment for both types of coverage,
- ✘ The increased number of children 0-5 who are not screened for developmental delays. The results include behavioral issues in school settings, increased child abuse, and higher social services costs in the long run,
- ✘ Increase in poor economic circumstances that results in homelessness and lack of affordable housing and quality child care,
- ✘ A lack of continuity of care and lack of specialists for families needing services, and
- ✘ Childhood obesity; it's related causes including poor parental modeling and decreased physical education and its health consequences such as musculoskeletal disease, diabetes, and asthma.

In addition to these system wide issues, specific trends were described related to many of the 18 health issues. As noted previously, regional participants had specific content expertise and often were not in a position to be aware of emerging trends for specific health issues outside their area of expertise. Therefore, their comments are summarized but not included in

aggregate when identifying the top emerging trends.

Several regional participants expressed a concern that specific County of San Diego services are challenged by the state budget, citing that budget constraints will put prevention programs at risk. Regional participants expressed a concern that The County of San Diego will regress because state budget issues will further affect children's access to health and dental care, resulting in fewer children with public insurance. Regional participants noted issues with decreased access to services, increases in waiting lists, and a lack of specialty medical and dental providers. Another trend cited was an overall reduction in resources for existing programs and services addressing children's health. Regional participants noted that although collaboration is increasing, it often results in decreased funding overall. Programs are expected to do more with less. Regional participants, as well as several key informants, observed that the County has reprioritized and is now funding new priorities at the expense of existing programs that impact children's health.

Regional participants said that given current economic conditions, the rate of children without medical and dental insurance is going up and will likely continue to do so. They described the trend of reductions partially as the result of the growth of small business that are not required to cover employees. There has also been a high turnover in employment status (job loss) for residents resulting in loss of coverage. Projected caps on Healthy Families, coupled with changes proposed for Medi-Cal will reduce access and coverage. Regional participants felt that this has already had a direct impact on family resource centers.

As with the key informants, several regional meeting participants expressed concern that Children's Hospital is experiencing serious financial problems that will result in closing four

satellite programs in February 2004 which impacts the level of services available in the regions. Some of the programs are the only providers for children with Medi-Cal and that also accept Healthy Families. This loss is compounded with a decrease in physicians and oral care specialists who will not accept Medi-Cal.

A higher incidence of asthma, its related health consequences, and the need to deal with environmental control was a trend identified by regional participants.

The overall consensus was that despite concern for undocumented immigrants and some ethnic groups, childhood immunization levels have gone up over the past few years. Regional participants feel that the County has done a good job of increasing access to childhood immunizations but expressed concern about what will happen at state and local levels because of budget issues.

Regional participants expressed concern for a lack of consistent preventative child care, especially well baby checks. The lack of reasonable access, education, transportation, and a regular medical home has added to the decrease in follow-up and preventative care.

Key informants stated that low birthweight seems to be going up and a particular trend was an increase in low birthweight among families who engage in in-vitro fertilization.

Two trends were identified related to pregnancy in teens. Regional participants noted that there is a cycle of teen pregnancy in some families. There is also an increase in teen moms who deliver babies with special needs. There was one concern expressed about increased substance use among teen fathers.

Most regional participants agreed that there is a fear among immigrants that prohibits them from

enrolling in Healthy Families and Medi-Cal even though they have no other resources. The result is a lack of prenatal and preventative child health care and the over use of local emergency services.

There was agreement on the lack of behavioral health care provided in San Diego County. This includes child assessment, counseling, and appropriate medication monitoring. The absence of behavioral healthcare, most notably mental health has contributed to increasing behavioral problems and violence.

Participants feel that there is a need for cultural-specific education regarding healthy eating. They felt that Hispanics are disproportionately raising overweight children by promoting a high sugar and high fat diet.

Increased linguistic and cultural diversity continues to be a significant barrier in all of the regions. There is a lack of bilingual/bicultural healthcare and human service professionals to provide culturally relevant services. Further, outreach efforts are not tailored to reach and engage some ethnic groups. In three of the six regions, it was felt that available services are not accessed because of language, most notably with Hispanics and Asians.

Conflicting comments were made by the regional participants about the availability of kinship programs. One participant noted an upward trend and one participant noted a decrease in services.

At least five of the six regions expressed concern about the negative impacts of lower wage paying jobs. First, to make ends meet, parents must increase the number of jobs they hold. This trend has taken away the already minimal amount of family time for children. Children are being improperly supervised in inadequate childcare arrangements, at home alone, or placed with underage siblings. It is believed that this has caused an increase in obesity, perhaps an

increase in violent behavior. In addition, children unsupervised often participate in more sedentary activities such as watching television and playing video games instead of physical activity or engaging with their families. The possibility of increased child deaths due to children going onto the highways may also be the result of a lack of supervision.

Overall, the lack of transportation contributes to many of the problems in San Diego County. Participants felt that in many cases, existing services are not accessed because clients cannot get to their appointments.

Some of the positive trends noted by some of the regional participants included:

- Community revitalization efforts,
- Willingness for agency collaboration and partnership,
- Increased priorities for homeless
- Increased media attention being given to children age zero to five.

Data Issues

Data on certain child health indicators are not available and, therefore, cannot be included in this report. Data that are not available countywide include:

- Number and percentage of children identified with disabilities and other special needs who receive developmental services by kindergarten entry,
- Women who refrain from smoking during pregnancy, and
- Children receiving well baby checks.

In addition, data available from SANDAG do not easily correspond with data collected and used by the HHSA regions. This makes it difficult to compare data. Further, data is often collected by age ranges other than the range of zero to five and is frequently not available to be

disaggregated to capture the zero to five age range.

Grantee Comments on Data

Grantees were not specifically asked to comment on the data collected for the needs assessment. Several did make comments on their surveys about the data collected and reported in the needs assessment. They suggested:

- ☒ Disaggregating data based on socio-economic status and ethnic groups;
- ☒ Disaggregating data based on region wherever possible; and
- ☒ Investing in ongoing updates and dissemination of needs assessment data

Key Informant Comments on Data

Key informants made several observations about the data found in the 18 health issue summaries and how it could be more meaningful related to the health issue. Specific suggestions included:

- Births to teen mothers data are focused on ages 15-19 but key informants indicated they have started seeing girls younger than 15 having babies. They believe it is important to break the data down by younger ages.
- Key informants suggested that it is significant to sort out low and very low birth weight and to track by region.
- Due to the definition of the American Association of Pediatrics which was used in collecting regular medical home information, regular medical home data does not currently include children receiving care from the community clinics. Key informants recommended including community clinics, as well as trying to collect information on children who do not have a regular medical home, to better identify who does not have any access to healthcare.

- Key informants expressed the need to have a way to track children, particularly children age zero to five. They noted previous efforts to develop a children's health passport and suggested there needs to be a better way to collect data, by region and by ethnicity.
- Because obesity is increasing, one key informant would like to see data on Body Mass Index collected for children at least age 3 and up.
- Key informants cited a need for an organized immunization registry, saying that San Diego Immunization Initiative (I3) is a good idea but needs to be better funded and countywide.

Another key informant noted that collecting data on hospitalizations is deceptive given the number of families in San Diego County that depend on HMOs for private insurance. Specifically, she noted that a decrease in the number of hospitalizations might be based on the HMO approving an outpatient visit (23-hour emergency room visit) rather than an admission to the hospital, which then appears as a decrease in hospital stay. This may impact asthma hospitalizations and child injury rates.

Regional Meeting Comments on Data

Participants at regional meetings were asked to provide feedback on the data collected and reported in the needs assessment. The top five suggestions in furthering the development of data on the 18 health issues as noted in the regional meetings are:

- ☒ Disaggregating data based on age, socio-economic status, primary language, and ethnic groups by health issue;
- ☒ Disaggregating data based on region and by health issue wherever possible;
- ☒ Investing in ongoing updates and dissemination of needs assessment data;

- ✘ Improve providers on-going access to the data; ensure inclusive distribution of outcome results with interpretation; and
- ✘ Determine consistent outcomes for services. Educate the providers, clients, and families about the outcomes and teach them to be more informed. Establish a system of on-going accountability after education is complete.

Additional responses that were provided by the regional participants include:

- The need to look at interrelated data sets such as the relationship between the decrease in maternal health services and the increase in child abuse,
- Insurance utilization,
- Conduct an epidemiological health census to determine the health of populations not receiving services (e.g., HIV, pesticide exposure in camps where thousands of homeless illegal immigrants are living),
- Need to be concerned about teen pregnancy at an earlier age, starting at 13 years of age, and
- Work with schools to identify the number of girls getting pregnant
 - Number early pregnancy tests
 - View school nurses as an asset

First 5 Grantee Recommendations

Surveyed grantees had differing perspectives involving a variety of issues, many of which concerned the services their agencies provide. Respondents primarily suggested:

- ✘ The need to integrate services throughout the health care and service delivery system; for example dental exams and complete treatment should be part of health assessments for entry into kindergarten,

- ✘ One-stop-shop health care opportunities such as health fairs should be offered more frequently to assist families with transportation and time issues,
- ✘ Medical and dental care providers need to be linked to translation services for non-English speaking families and those for whom English is a second language,
- ✘ Follow up by health care providers needs to improve; and primary care providers need training about community resources available to their patients.

Several grantees made the case that funding should continue for already existing programs that are addressing the 18 health indicators.

Additional feedback included the following:

- ✘ Place maternal depression on the radar because children of depressed mothers suffer from almost all of the 18 priority issues at higher rates (also comment received from the Technical Professional Advisory Committee (TPAC)),
- ✘ Taking the impact of family stress on children's health into consideration.
- ✘ Considering the issue of affordable housing as a primary issue because it is reaching a critical level,
- ✘ Use an existing provider, such as the Union of Pan Asian Communities (UPAC) to serve as a resource to all other funded projects to enhance their cultural and linguistic programs as well as extend their outreach and capacity to serve communities, and
- ✘ Vision care should be one of the 18 health indicators because it is crucial to ensure that children are prepared for school and are ready to learn. Between 25 and 28% of children, need glasses to assure that they enter school ready to learn.

Key Informant Recommendations

Three overarching recommendations were suggested by a number of key informants. The recommendations focused on:

- ☒ Medical and dental insurance and care
- ☒ Developmental screening
- ☒ Home visitation

Key informants said that The County of San Diego needs to better fund community clinics and develop a uniform method for determining ability to pay. Currently families pay on a sliding fee scale but each clinic sets up their own scale.

Key informants recommend supporting dental insurance, preventative care and fluoridation. They also suggested promoting programs that enlist general physicians in screening for oral health.

Overall, key informants wished for a continued focus of First 5 San Diego in ensuring that children are ready for school, children are fully immunized, and well baby checks are conducted so children are ready for school.

Provision of timely developmental screenings is a recommendation from key informants. They note that cerebral palsy is a problem in terms of disability screening. Specifically, pediatricians do not know how to identify cerebral palsy, which can be identified earlier if screening were to take place in first 18 months. Autism should also be identified by 18 months of age to positively impact children's health.

Home visiting as a standard practice was recommended by multiple key informants. They also recommended that First 5 San Diego funding should continue for home visiting programs as other funding is not available. One key informant said, "We have a home visitation program that is doing great, incredibly successful. There is not an initiative to reapply for that funding through First 5 San Diego. There

are a number of services that will go away for this population if no initiative is established."

Other recommendations made by key informants include:

To address childhood obesity, key informants recommended supporting nutritional education for parents, including cooking classes and engaging the entire family to affect change. Key informants recommended supporting movements to get soda machines out of schools and said that school lunches need to improve and that school breakfast is one of the better investments to ensure children's health.

Another recommendation was for more training in what low birthweight infants need in terms of developmental medical follow-up that would make them more ready for school.

Key informants recommending the continued provision of childcare, saying it is an opportunity to provide programming for both children and families.

One key informant mentioned that Children Now sponsored a symposium that promoted group pediatric visits as a best practice. The visits included screening by a developmental specialist at the same time that well baby checks are conducted to help teach parents to assess their child's development.

Several key informants suggested that First 5 continue to fund services rather than focus solely on capital projects.

Regional Meeting Participant Recommendations

In each of the six regional meetings, participants were asked to make recommendations to improve the status of the 18 health issues. While not specifically countywide, many of the recommendations were cited in multiple regions. The top five recommendations are:

- ☒ Preserve current funding of First 5 services and programs that address health indicators before considering new programs,
- ☒ Find ways to increase medical/dental and behavioral health coverage, including improved systems for determining pay source and insurance utilization,
- ☒ Improve commitment to preventative services including developmental screening, well-baby checks, targeted outreach efforts to ethnic groups, and healthy living styles,
- ☒ Continue to promote fair and equitable partnerships with social service and public/private organizations,
- ☒ Improve care coordination, data collection and dissemination for the purpose of quality assurance
- ☒ Primary care providers need training about community resources available to their patients.

Regional participants also had a degree of agreement on the following recommendations:

Monitor the causes and effects of cultural isolation especially for Hispanics, Asians, African Americans, and the growing Middle Eastern population. Address the significant training needs for organizations and those who provide the outreach to targeted areas. Track the penetration rate for outreach and change the methods as needed.

Another recommendation identified by the regional participants, as well as the key informants, was for more training in what low birthweight infants need in terms of developmental medical follow-up that would make them more ready for school.

The County needs to promote access for specialized services by ensuring that there is reasonable compensation for professionals who are willing to provide them. This includes mental health assessment and counseling.

2.0-RECOMMENDATIONS

The primary purpose of conducting this assessment was to give The First 5 San Diego Commission the best available information to use in determining how to focus resources in order to produce the greatest overall health benefits for children age zero to five. The project was structured as a “needs and assets” assessment, and strategic decision-making should look to build upon those identified assets wherever possible.

This report consolidates information from a very broad range of local, state and national sources. However, there are still some important gaps in the available data which, if addressed, could affect policy and funding decisions for the Commission. The following are recommendations to further strengthen the information for future decision-making and for focusing resources to produce the greatest overall impact on the health of children age zero to five:

1. ***Maximize Commission funding by supporting existing programs that positively impact multiple health issues of concern to the First 5 Commission of San Diego.***

First 5 Commission of San Diego County currently funds a variety of services that impact children's health and school readiness. These programs are considered assets in the County by key informants, regional meeting participants and grantees providing services to children 0 -5. Together they make up an important part of the infrastructure that promotes children's health in the County. However, a variety of economic factors are threatening to erode the overall safety net for children's health with private and public organizations experiencing considerable budget challenges from the national, state and local

economic circumstances. Key informants and regional participants alike repeatedly cited their concern regarding the impact of the State budget crisis on children's health. They noted that a number of children's health programs have already experienced a reduction in funding. In addition, First 5 funding for some children's health programs is ending in 2003. In many cases, the shift in economic circumstances at the national, state and local level has hampered efforts to ensure ongoing sustainability of children's health programs. Therefore, funded programs that currently comprise the safety net of First 5 programs could be eliminated in the not too distant future.

First 5 cannot continue to support all existing programs. However, there are a number of programs that provide services that impact multiple health issues of concern to the Commission. There is an opportunity for the Commission to make strategic investments in select programs that leverage their impact by addressing multiple health issues. During the significance rating process, team members defined compounding health issues as those health issues where investment in one health issue would significantly improve or impact one or more of the other health issues, based upon the research available. This resulted in the creation of health issue clusters. The health clusters show the aggregate significance rating scale for each health issue and the compounding issues it impacts. This indicates where the greatest return on investment may be realized by continuing support for a particular health issue. The top five investment opportunities related to the health issues in the First 5 needs assessment include:

- Ensuring Prenatal Care
- Preventing Teen Pregnancy

- Ensuring a Medical Home
- Promoting Breast Feeding
- Ensuring Health Insurance

Prenatal care, which has the highest leveragability rating, illustrates the value of such a strategic investment. Prenatal care should begin during the first trimester of pregnancy.

“Inadequate prenatal care” is considered to be care that begins in the second or third trimester of pregnancy, or is not obtained at all. Research indicates that good health starts at conception. The health and choices made by the mother during pregnancy, including the extent to which timely and adequate health care is received during pregnancy, play major roles in determining the health of the child at birth. Health status at birth and during the infant and toddler years, in turn, has a great effect on the continued health of a person as they grow and impacts school readiness.

Regular health care visits by pregnant women are very important for maximizing the likelihood of having healthy babies. Prenatal care enables health professionals to check for normal development of the fetus, monitor conditions like gestational diabetes that can impact the health of the mother and baby alike, encourage mothers to avoid smoking and alcohol/drug use during pregnancy, and react quickly when problems develop. Prenatal care visits can help prevent low birth weight babies and provide education and support for breastfeeding.

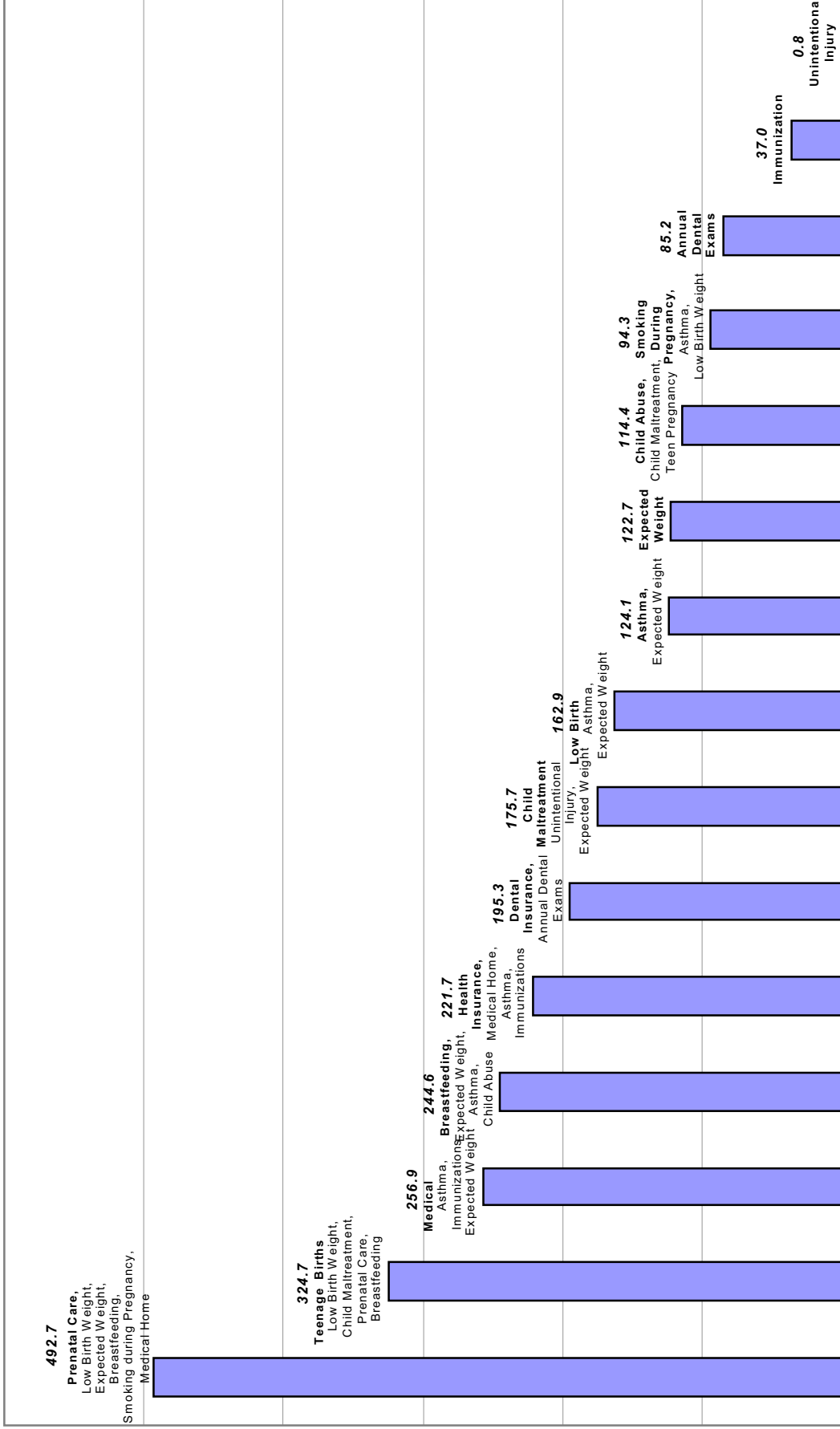
Another illustration of the value of supporting select “safety net” programs is teen pregnancy prevention. Teen parents are generally unprepared for the financial, emotional, and psychological challenges of early childbearing. The effects of these challenges are borne primarily by the children of teen mothers, followed by the mothers themselves, the mothers’ families, and, finally, by the government and taxpayers. Teenage mothers often face major disadvantages both before and

after they have their first birth. Research has shown that, compared with older mothers, teen mothers display a higher likelihood of welfare dependence, are more likely to experience relationship instability, have a higher incidence of low birth weight babies and cases of child maltreatment, have lower educational attainment, and are less likely to cultivate stimulating home environments for their children. Clearly, investing in teen pregnancy prevention helps avoid circumstances detrimental to children’s health.

The table on the following page illustrates the “clustered” significance rating for the children’s health issues that were rated by the Significance Rating Team. The highest rated cluster is prenatal care. Research shows that when expectant mothers access prenatal care in the first trimester and continue that care throughout the pregnancy, this positively impacts the likelihood of low birth weight, expected weight, whether the mothers will breastfeed, rate of smoking during pregnancy and ensuring the children have a medical home. Therefore, investing in prenatal care affords a greater leveragability or return on investment than those health issues that do not impact other health issues, such as unintentional injury.

The health issue clusters that will result in the greatest return on investment by impacting one or more of the other health issues in this needs assessment are as follows:

Cluster Comparison



2. ***Promote culturally and linguistically appropriate services that reduce barriers to accessing care.***

San Diego County is extremely ethnically diverse and will be increasingly so in the future. Approximately one in five county residents are immigrants, including refugees, who come from other countries. Residents speak 68 different languages, and have a variety of needs as they assimilate into their new environment. Key informant interviews, regional meeting participants and grantees all indicated that a primary concern related to children's health is the lack of culturally and linguistically appropriate providers and services including a lack of translation or interpretation services to assist non-English speaking patients.

Because culture and language are vital factors in how health care services are delivered and received, it is important that health care providers understand and respond with sensitivity to the needs and preferences that culturally and linguistically diverse patients/consumers bring to the health encounter. Providing culturally and linguistically appropriate services has the potential to improve access to care, quality of care, and ultimately, health outcomes.

In recent decades, there has been increasing recognition of the prevalence of racial and ethnic disparities in health care delivery and outcomes in the United States. Culturally and linguistically diverse groups and individuals of limited English proficiency typically experience less adequate access to care, lower quality of care, and poorer health status and outcomes. This was shown in recent reports by the [Institute of Medicine](#) and the [Commonwealth Fund](#). The Office of Minority Health (OMH) undertook the development of national standards to provide a much-needed alternative to the current patchwork of independently developed definitions, practices, and requirements

concerning culturally and linguistically appropriate services. Standards that could be considered in the County of San Diego include:

1. Provide all clients with limited English proficiency (LEP) access to bilingual staff or interpretation services.
2. Translate and make available signage and commonly used written patient educational material and other materials for members of the predominant language groups in service areas.
3. Ensure that interpreters and bilingual staff can demonstrate bilingual proficiency and receive training that includes the skills and ethics of interpreting, and knowledge in both languages of the terms and concepts relevant to clinical or non-clinical encounters. Family or friends are not considered adequate substitutes because they usually lack these abilities.
4. Ensure that the clients' primary spoken language and self-identified race/ethnicity are included in the health care organization's management information system as well as any patient records used by provider staff.

By investing in such interventions as translation, First 5 could impact the quality of health care for a significant number of children and families in San Diego County and ultimately improve the health outcomes of children 0-5.

3. ***Support and promote Early Parenting Education programs from the onset of pregnancy.***

The parent or caregiver who is sensitive and consistent in responding to an infant's cues and signals helps establish a secure attachment and relationship with their baby. Brain development research has demonstrated that children who develop within this kind of relationship explore the world around them and, when faced with

stress, can seek and accept help from the parent or primary caregiver. Strong attachment and a good relationship can strongly influence the way the child relates not only to a parent or primary caregiver, but also to others now and later. Therefore, the earlier parents learn the importance of developing this positive relationship with their child, the better.

Regional Community Meeting participants, key informants, and grantees identified the importance of providing parent training specifically about nutrition, breastfeeding, annual dental exams, and school readiness. In this way, many other health indicators can be positively impacted through this effort.

These stakeholders additionally noted that parent training through Home Visiting programs has been especially effective, especially when delivered by peers who speak the same language. When training is held in a community setting, these stakeholders advised that it should occur in places where parents will feel comfortable, where they have a sense of trust and feel safe, such as at neighborhood schools or hospitals.

A longitudinal study of the Chicago Child Parent Centers found that providing early parenting education through home visiting generated a significant return on investment.⁵⁸ Specific areas where savings to society were identified included reduced need for grade retention and special education, reduced juvenile and adult crime arrests, averted costs to crime victims, reduced child welfare expenditures and greater earning potential due to attainment of advanced education.

Six national home visiting models have influenced the development of most home visiting programs in the country. When looking at home visiting programs to promote school readiness outcomes, programs are found to be most effective when they maintain a clear focus on their

goals; are linked with other needed services, especially those that offer services directly focused on the child; and when the home visiting and associated services are of the highest quality.⁵⁹ High quality programs should include certain characteristics such as:

- A recruitment and retention component designed to hire, train and retain the best home visitors available,
- An evaluation component to monitor performance on program standards,
- Services provided would be culturally and linguistically appropriate.

Successful parenting education programs have resulted in parents having a more favorable view of their child. Whether this is due to parents having more developmentally appropriate expectations of the child or positive changes in the child's behavior because of more effective parenting is unknown.⁶⁰

The Los Angeles County Children and Families Commission has developed a series of trainings for families. New and expectant parents can now get answers to their questions about pregnancy and raising their young children by calling a toll-free number. Those with access to the Internet can log onto the service at www.first5laconnect.org and view information on everything from breastfeeding to infant health to nutrition to dental care at no charge. Both the telephone line and the website are free and confidential. First 5 LA CONNECT has been created to simply and easily connect parents to the information they need. Parenting audio tapes are available on line that have been developed by the American Academy of Pediatrics. The Commission should investigate the availability of this type of information and parent education services becoming available as a component of The County of San Diego 211 services.

4. *Ensure that children age zero to five have health insurance and a regular medical*

home as well as dental insurance and receive annual dental exams and any needed follow-up treatment (e.g., fillings). Improve data collection both regionally and countywide to obtain information on the number of children age zero to five that lack dental insurance and regular dental exams.

Health insurance and regular medical home was ranked as the number one priority by Key Informants, First 5 Grantees and by Regional Meeting Participants who took part in the needs assessment. In addition, dental insurance and/or annual dental examinations were ranked as the second priority by all three participant groups. All four issues were ranked in the top five in occurrence rate and Significance Rating Scores.

For many who participated in the needs assessment, they do not differentiate oral health from overall health of children. Therefore, participants often recommended ensuring that children have health and dental insurance as well as a regular medical home and annual exams. The data supports this recommendation.

In 2001, 102 per 1,000 children age zero to five did not have health insurance in San Diego County which is higher than the California rate of 68 per 1,000 and slightly lower than the national rate of 107 per 1,000.^{61,62,63} *Healthy People 2010* recommends increasing the proportion of all persons with health insurance to 100%.⁶⁴ Therefore, the San Diego County, state, and national rates of children who are uninsured are higher than the *Healthy People 2010* objective.

In addition, in San Diego County in 2001, 287 per 1,000 children age zero to five did not use a physician's office as the regular source of their health care while in California in 2001, only 224 per 1,000 children age zero to five did not use a physician's office as the regular source of health care.^{65,66}

Approximately 42% of children age two to five in California have never seen a dentist. In San Diego, the percentage is approximately 45%. However, enrollment in private or public insurance does not ensure utilization. Although about 72% of young children in San Diego have dental insurance, initiation of dental care is low even for insured children.⁶⁷

According to a survey of San Diego County children under the age of 18, 27% did not receive dental care within the past 12 months and approximately 29% do not have dental insurance.⁴⁵ Children without dental insurance are less likely to see a dentist than those with insurance, and even among children with insurance, many may still face barriers to dental care (e.g., inability of parents to pay a co-pay for the dental exam or parents' ignorance of the importance of dental exams for their young children).

Children can experience negative school readiness effects due to oral health problems. When their dental needs are neglected, children with poor oral health have trouble eating, sleeping, speaking, and learning.^{88, 48} Further, the social impacts of disfiguring tooth decay reduce a child's chance for happiness and success.⁴⁷ Severely poor oral health can reduce normal dietary intake thus putting a child at risk of becoming underweight, which can have other significant health impacts.⁴⁷

While uniform, county-wide data for children age zero to five are not available at this time, oral health was consistently identified as a top priority by First 5 grantees, participants of regional community meetings, and key informants during this needs assessment process. In fact, an analysis of grantee surveys and regional community meeting feedback shows that in each HHSA region, oral health was identified as a priority health need. Collecting uniform data countywide and by region on the number of children age zero to five who receive annual dental care and who have dental

insurance would provide helpful quantitative data to help us better understand the extent of the problem in the county.

5. *Promote and support programs that will prevent obesity.*

Key Informants and First 5 Grantees both ranked children at their expected weight as a top five health priority, specifically mentioning childhood obesity as a growing concern.

There are three opportunities available to the Commission when looking at childhood obesity. The first option is to provide nutrition education to parents from the birth of their first child to support them in providing a nutritious diet and teach them the importance of physical activity as well as the importance of limiting television viewing and video games. One way to take advantage of resources already available from the Commission would be to include additional nutrition educational materials in the Welcome Home Baby Kits. These materials could specifically address parents as role models for children's nutritional habits and educating parents on the need for appropriate role modeling of healthy nutrition and physical activity behaviors. The Pediatric Leadership Council is very interested in this issue and would be a great resource to collaborate with on these materials.

Several Key Informants noted the need to provide nutrition education to families rather than focusing on the child, citing that the entire family system contributes to whether children are at their expected weight. In fact, one asset in place throughout the county is the family nutrition education services through Kaiser Permanente. More programs that educate families and systems about nutrition and exercise are needed. Promoting policies and programs that educate parents, teach nutrition and make exercise and nutritious food a part of their curriculum would greatly impact this important issue in San Diego County.

Secondly, support programs, activities, or facilities that make low cost physical activity available in a safe environment to families with young children.

Lastly, through your school readiness activities provide advocacy and support to child care providers, Early Head Start and Head Start programs and encourage them to provide more nutritious meals that are lower in fat and higher in fresh fruits and vegetables. This will especially assist vulnerable children who are eligible for free or reduced meal programs and their younger siblings, ensuring they have proper nutrition and therefore are ready to learn when they reach kindergarten.

Overweight is also associated with poor body image, low self-esteem and depression, due to a perceived stigma associated with overweight, and possible social discrimination, all of which can affect school performance and certainly school readiness.⁹⁷

According to a survey administered by the American Obesity Association (AOA), parents seem to understand the importance of physical activity for their children. However, they appear to underestimate the risks of overweight to their children as well as the challenge of changing lifelong behaviors related to eating and physical activity levels.⁶⁸

The number of overweight children and adolescents has increased steadily over the last 30 years, and has recently reached epidemic proportions. An overweight child who maintains overweight into adolescence has a 50% chance of becoming an obese adult. Short-term health effects from obesity include several heart disease risk factors, including high blood pressure and high cholesterol, sleep apnea, and various orthopedic, respiratory, and skin disorders. Overweight children are also at risk for type II diabetes, which was once only seen in adults, but

is now seen in children with increasing regularity. Complications associated with this disease are kidney disease, blindness and amputation. Long-term health problems associated with obesity include cardiovascular disease, gallbladder disease, osteoarthritis, stroke, and colon and breast cancer⁸².

The American Medical Association recently identified the prevention of obesity as a priority after the Surgeon General announced that obesity is the greatest threat to public health today. In San Diego County, overweight affects children younger than age five at a greater rate than does underweight, and is highest among children ages 5-11 years. Among children aged 0-23 months and children aged 5-11 years, Hispanic children are the most likely to be affected by overweight, and among children aged 23-59 months, American Indian children are the most likely to be affected by overweight.

The National Center for Chronic Disease Prevention and Health Promotion funded 20 states to initiate obesity prevention projects. Descriptions of these projects can be found on the web at http://www.cdc.gov/nccdphp/dnpa/obesity/state_programs/index.htm.

6. Promote and support a collaborative effort of interested and necessary agencies to develop strategies to ensure that developmental disability screenings are administered to all children in San Diego County prior to kindergarten (or earlier) and that those identified through the screening are referred and provided with necessary services.

Currently no reliable data exists to determine the prevalence or the actual number of children age zero to five that are being screened for a developmental disability. However, the California Department of Developmental Services (DDS) has noted an increase in the

number of persons served through the DDS system that is disproportionate to the increase in California population.ⁱⁱⁱ Note that this data is not delineated for the zero to five population.

	Average Percent Growth (1992-2002)
CA population	1.35%
Persons Served Through DDS System	5.01%

	Persons Served Through DDS System in California
1992	Over 100,000
2002	Over 180,000

Based on San Diego County’s history of developing and implementing successful collaboratives such as the San Diego County Asthma Coalition, SD KHAN, Breastfeeding Coalition, and many others identified by regional meeting participants, key informants and grantees during the needs and assets assessment process, it is recommended that the First 5 San Diego Commission serve as the convener to identify local issues and opportunities and to develop a collaborative approach to this issue.

A strategy that the Commission and the collaborative should implement is to work with local pediatricians, treatment providers (Early Start), preschools, child care agencies, the San Diego Regional Center, the county public health department, and county mental health department to develop a consistent screening and

ⁱⁱⁱ California Department of Developmental Services, DDS Fact Book 6th Edition (2003), www.dds.cahwnet.gov/factsstats/pdf/factbook_6th.pdf

referral strategy for children at either the 18 or 24 month wellness check up.

A second strategy for the Commission around children with special needs should be to work with this collaborative and research opportunities that may become available from the recently released First 5 California Special Needs Initiative.

Collecting uniform data countywide and by region on the number of children age zero to five being screened and receiving services prior to entering kindergarten would provide helpful quantitative data to help better understand the extent of the problem in the county. Improving data access will help the Commission understand how they can impact health issues in the county, assist with funding recommendations and will be of significant benefit to the Commission and the community when updating the children's health needs and assets assessment.

Early screening, assessment, and receipt of needed services for children can significantly increase their quality of life and that of their parents and is cost-effective for the human service delivery system.⁶⁹ Further, early intervention also directly affects children's educational outcomes.⁷⁰

7. Address major data gaps encountered during the needs and assets assessment process

The information obtained for this needs assessment provides a tremendous foundation to begin to understand and address the children's health issues identified as affecting San Diego County. However, there are still some significant gaps in the availability of data that, if addressed, could potentially affect the policy and funding decisions of the First 5 Commission.

Limited or No Data Available for Three Health Issues

Based on limited or no available data, there were three health issues identified during the needs assessment process for San Diego County that could not be ranked using the significance rating scale for this report due to lack of data related to occurrence, they include:

- The number of children that receive a developmental screening by kindergarten entry
- The number of children identified with disabilities and other special needs that receive developmental services by kindergarten entry
- The number of children receiving well-baby and child checkups by age 2

More complete information is needed about the current capacity and service levels for the screening and provision of services to children with special needs. Data gaps noted for this area all relate to the general issues of insufficient information on the presence and integration of current programs and services. The lack of integrated case management systems or services makes it difficult, if not impossible, to identify the number and consistency with which children are being screened, referred to, and if needed, provided the appropriate services for success later in school.

Availability of data for the zero to five age group

There were numerous health issues where data were available for children, but the age range for children described and tracked within the data sets varied from the zero to five age group that the Commission is interested in tracking. For instance, some agencies/organizations collect data for children age zero to four, while others collect data on children up to 18 years of age. When the data are available up to 18 years of age, it typically cannot be disaggregated to

capture only the zero to five age group. The ability to disaggregate data from the perspective of age range and taking data from a county level to a regional perspective is important for better results of targeted programs and services in the county.

To better understand the health needs and the impact that First 5 San Diego is having on children age zero to five, the Commission is encouraged to take the lead in convening key stakeholders throughout the county to address these issues of data gaps. Current data gaps and issues should be looked at in order to see which issues might be resolved through local efforts and partnerships versus those that need to be addressed at the state level.

In addition, this group could begin developing consistent baseline data and educating all participants, both county and community organizations, regarding why and how data is being collected and what the end results of their efforts will be such as, how the data will be utilized and what impact it will have on programming and funding.

Regional Breakout of Data

The Commission requested that the needs and assets assessment report provide both a countywide and regional component. When working with Commission and county staff to obtain the most up to date data for the HHSA regions, it became apparent that the county has two resources for regional data, the Health and Human Services Agency and SANDAG. However, the boundaries used to identify a region in San Diego County are different for these two organizations. Consistency and ease in collecting and disseminating data to county departments, agencies or community-based organizations that can affect those outcomes is imperative. Having multiple boundaries and definitions of regions makes this problematic and significantly reduces the value of the data.

For data gaps that are not resolved by the preceding steps, it is recommended that the Commission prioritize the gaps according to the relative significance of the health issue involved and invest in new issue-specific research to address those gaps. Improving data access will help the Commission understand how they can impact health issues in the county, assist in making funding recommendations, and will be of significant benefit to the Commission and the community when updating the children's health needs and assets assessment.

3.0-REGIONAL PROFILE – NORTH CENTRAL

The North Central Region comprises the central-western portions of the County. The region has both inland and coastal communities stretching from Del Mar in the north to Point Loma in the south, and east to Scripps Ranch and Mira Mesa. There are thirty-nine distinct communities in the North Central Region that exist within twenty different zip codes; three of which are military reservations and two that are major universities. The North Central Region is ethnically and culturally diverse with more than fifty (50) languages and dialects spoken.⁷¹

Demographics

Total Population

Approximately 585,400 people live in the North Central Region, which is the largest region in the county.^{72,71} Total population estimates are up from 2002 by a little less than four percent (4%). The region's population has steadily grown by approximately 3.8% for the last three years (2001-2003).

Total Population Growth, 2001-2003⁷³

	2001	2003	% Increase
North Central Region	564,192	585,400	3.8%
County	2,856,000	2,961,579	3.7%

Source: San Diego Association of Governments. *SANDAG January 1 Population Estimates, 2003*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG January 1 Population Estimates All Ages by Gender by Region.

The North Central Region is expected to reach a population of 714,339 by the year 2030. The rate of population growth is projected to increase steadily between 2010 and 2030. However, the rate of population growth will be slower than that of overall San Diego County and California.

Population Forecast for the North Central Region, San Diego County, and California, 2010-2030

	2010	2020	2030
Population Forecast, North Central Region	612,099	654,703	714,339
% increase from prior period	4.6%	7.0%	9.1%
Population Forecast, San Diego County	3,211,721	3,528,605	3,855,085
% change from prior period	8.4%	9.9%	9.3%
Population Forecast, California	39,957,616	45,448,627	51,868,655
% increase	15.3% ^{iv}	13.7%	14.1%

Source: San Diego Association of Governments. *SANDAG Population Forecast, 2010-2030*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG Population Forecast, 2010-2030.

California Department of Finance. (2001) *Population Projections*. Available online at:

<http://www.dof.ca.gov/HTML/DEMOGRAP/projca.pdf>

ⁱ Baseline population from year 2000: 34,635,395

Age and Gender

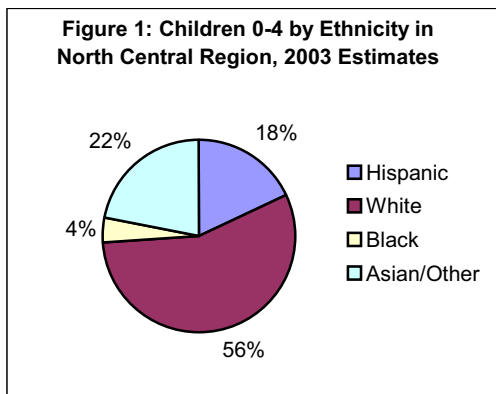
In 2003, 585,400 people lived in the North Central Region—up approximately 4% from 572,187 in 2002. Approximately 40,907 children aged zero to four lived in the North Central Region in 2003 or 7.0% of the total regional population. The percentage of children zero to four in the region is slightly higher than the percentage of children zero to four who live in the county.⁷⁴

There is a unique spatial distribution of population density within the North Central Region. Nearly 20% of North Central's population is below the age of 18 and 12% is over the age of 65. The community of Murphy Canyon (92124 zip code) has the youngest population in the region with 55% under 18. Over 20% of the population in the communities of Allied Gardens and Del Cerro (92120 zip code) are over the age of 65. Though total median for the North Central region is not available, the median income range is \$50,000 - \$74,999 and the average of the median incomes for each zip code in the region is \$64,360.⁷¹

In 2003, the population overall and for children in the region was 51% male and 49% female.⁷²

Ethnicity

The majority of the children age zero to four who live in the region are White. Figure 1 below shows a breakdown in the ethnic make-up of the population of children age zero to four in the region.



Source: San Diego Association of Governments. *SANDAG January 1 Population Estimates, 2003*. Prepared by Community Epidemiology, September 16, 2003. SANDAG January 1 Population Estimates All Ages by Race by Region.

The population of all ethnic communities is expected to increase, with the greatest increases seen by Pacific Islanders and American Indians.

Total Population Forecast by Ethnicity, North Central Region, 2010-2030

North Central	2010	2020	2030	% change from 2010 to 2030
Total (all races and ethnicities)	612,099	654,703	714,339	16.70%
Hispanic	79,523	89,848	102,207	28.53%
White	376,272	381,232	392,157	4.22%
Black	20,579	23,166	25,440	23.62%
American Indian or Alaska Native	3,342	4,218	4,821	44.25%
Asian	91,530	98,759	109,529	19.66%
Hawaiian or other Pacific Islander	9,170	13,437	19,330	110.80%
Other	8,124	15,198	25,156	209.65%
Two or more races	23,559	28,845	35,699	51.53%

Source: San Diego Association of Governments. *SANDAG Population Forecast by Age and Ethnicity, 2010-2030*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG Population Forecast, 2010-2030.

Among children age zero to four, the overall population is expected to increase; however, population decreases are expected in the Hispanic, White, and Asian communities.

Population Forecast by Ethnicity for Children Aged 0-4, North Central Region, 2010-2030

Ethnicity	2010	2020	2030	% change from 2010 to 2030
Total (all races and ethnicities)	34,902	35,282	36,701	5.15%
Hispanic	6,325	6,198	6,110	-3.40%
White	17,821	17,659	17,775	-0.26%
Black	1,577	1,704	1,715	8.75%
American Indian or Alaska Native	184	241	272	47.83%
Asian	6,250	5,471	5,552	-11.17%
Hawaiian or other Pacific Islander	407	504	641	57.49%
Other	1,195	1,969	2,967	148.28%
Two or more races	1,143	1,536	1,669	46.02%

Source: San Diego Association of Governments. *SANDAG Population Forecast by Age and Ethnicity, 2010-2030*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG Population Forecast, 2010-2030.

The cultural and ethnically diverse population in the North Central Region is not homogenously distributed throughout the region: instead there are specific spatial clusters of racial and ethnic diversity in specific communities.⁷¹

Households and Income

In 2000, the median range for household income in the North Central Region was \$50,000-\$59,999. This is higher than the median income for San Diego County in 2000, which was \$47,268.

Number of Households by Household Income Category, North Central Region, 2000

Household income	Number of Households	% of total households
Less than \$10,000	13,277	6.04%
\$10,000 to \$14,999	8,832	4.02%
\$15,000 to \$24,999	20,423	9.30%
\$25,000 to \$34,999	23,862	10.86%
\$35,000 to \$49,999	34,180	15.56%
\$50,000 to \$74,999	46,566	21.20%
\$75,000 to 99,999	28,762	13.09%
\$100,000 or more	43,760	19.92%
Total	219,662	100.00%

Source: San Diego Association of Governments. *SANDAG Census Data for 2000 – Households and Income*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG Census Data, 2000.

In 2000, 5861 out of 125,367 families, or 4.7% of total families, were considered to be living below the federal poverty level, as defined by the Census Bureau for 2000.

Below is a summary of households by type. The greatest number of households are categorized as “non-family with no children”. Of family households with children, the greatest number of

households fall into the category, "married couple, family household with children."

Number of Households by Household Type, North Central Region, 2000

Type of Household	Number of Households	%
Non family households	64,013	20.39%
Other non family households	30,282	9.65%
Non family households - no children	66,430	21.16%
Non family no children	93,665	29.83%
Family households with children	58,937	18.77%
Non family with children	630	0.20%

Source: San Diego Association of Governments. *SANDAG Census Data for 2000 – Households and Income*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG Census Data, 2000.

Regional Needs Assessment

This section provides information on how health issues are impacting children under age five in the North Central Region. Data for each child health indicator are reviewed for the region and compared to national, state, and county data, as well as *Healthy People 2010* objectives, where available. Indicators related to developmental services, developmental screening, and well-baby/well-child checks are not listed due to insufficient data at the county and regional levels. Where health issues were identified as a priority through key informant interviews, North Central Region community meeting participant feedback, and First 5 grantee surveys, this is noted.

Children are Born Healthy

Low Birthweight

In 1999, the North Central Region had a lower occurrence of low birthweight babies than the nation, state, or county.⁷⁵ (See chart below.) However, between 1998 and 2000, the North Central Region had the third highest rate of low birthweight in the county (60 per 1,000) and by 2000, had not yet met the *Healthy People 2010* target of 50 per 1,000.⁷⁵

1998-2000 Three-Year Average Comparison of Low Birthweight Rates Among Regions (Rates Per 1,000 Population)¹⁶

South	55
North Coastal	56
North Inland	56
North Central	60
East	61
Central	69

Source: Community Health Improvement Partners. (2002). *Charting the Course III, 2001: A San Diego County Health Needs Assessment*. San Diego, CA. Community Health Improvement Partners

Adequate Prenatal Care Use

In 1999, the North Central Region had the highest rate of early prenatal care utilization.¹⁶ During the period of 1995-1999, rates of early prenatal care use in San Diego County improved in most county regions, including the North Central Region. The percentage of women initiating prenatal care in the first trimester has risen in the North Central Region over the last five years - from 88.2% in 1995 to 90.2% in 1999. In 1999, the region had a higher prenatal care utilization rate than both the county and the state.⁷⁶ Even though the North Central Region is doing better than San Diego County and the state for women initiating prenatal care during the first trimester, this health issue was identified as a priority based on recent trends in the region through key informant interviews, North Central Region community meeting participant feedback, and First 5 grantee surveys.

Percentage of Women Initiating Prenatal Care During the First Trimester by Region, San Diego County, 1995-1999

Region	1995	1996	1997	1998	1999
North Central	88.2	89.7	89.1	89.6	90.2
East	83.1	84.7	84.3	84.7	85.9
North Inland	76.8	77.6	77.0	78.9	79.6
North Coastal	74.7	75.2	72.7	70.5	72.3
South	73.1	76.4	76.5	78.9	80.1
Central	70.0	72.1	72.8	72.5	76.0

Source: Community Health Improvement Partners. (2002). *Charting the Course III, 2001: A San Diego County Health Needs Assessment*. San Diego, CA. Community Health Improvement Partners

Percentage of Women Initiating Prenatal Care During the First Trimester by State, County, and Region, 1999

North Central Region	90.2%
State	82.2%
County	80.3%

Source: Community Health Improvement Partners. (2002). *Charting the Course III, 2001: A San Diego County Health Needs Assessment*. San Diego, CA. Community Health Improvement Partners

Births to Teen Mothers

The teen birth rate declined steadily in the North Central Region between 1995 and 1999, and the region had the lowest teen birth rate among all county regions in 1999, with 11.0 births per 1,000 teens.¹⁶

1999 Teen Birth Rates by Year and Region (per 1,000 teens, ages 15-17)

Region	1995	1996	1997	1998	1999
North Central	17.0	16.9	14.6	12.4	11.0
East	26.2	25.2	22.1	20.2	21.4
North Inland	26.4	26.1	23.0	20.5	22.6
North Coastal	37.4	38.6	28.9	27.4	24.3
South	44.7	41.7	37.4	37.3	35.4
Central	60.6	63.0	52.7	49.8	45.1

Source: Community Health Improvement Partners. (2002). *Charting the Course III, 2001: A San Diego County Health Needs Assessment*. San Diego, CA. Community Health Improvement Partners

In 1999, the teen birth rate was significantly lower in the North Central Region than in the county and in the state.⁷⁷ This health issue was identified as a priority based on recent trends in the region through key informant interviews, North Central Region community meeting participant feedback, and First 5 grantee surveys. In particular, concerns regarding children becoming sexually active at younger ages and teen pregnancy occurring more frequently in teens under the age of fifteen.

1999 Teen Birth Rates (per 1000 teens, ages 15-17)

State	30.4
County	27.7
North Central	11.0

Sources: Community Health Improvement Partners. (2002). *Charting the Course III, 2001: A San Diego County Health Needs Assessment*. San Diego, CA. Community Health Improvement Partners
 California Department of Health Services. (2003) *Birth Rates by Year of Age for Teenage Mothers, 2001*, from birth records. Retrieved December 10, 2003 from: http://www.dhs.ca.gov/hisp/chs/OHIR/vssdata/2001data/01Ch2p df/2_29_2001.pdf

Smoking During Pregnancy

No data are available for rates on smoking during pregnancy by region in San Diego County.⁷⁸ However, the county’s rate of smoking during pregnancy falls short of the *Healthy People 2010* objective of 10 per 1,000 population.^{18, 49} The county rate is also higher than the state rate of 98 per 1,000 population.^{53, 54} National rates of smoking during pregnancy cannot be directly compared to state rates because data for smoking during pregnancy in California were not collected in National Center for Health Statistics’ standard format and are therefore not easily compared.⁷⁹

Rates of Smoking during Pregnancy Per 1,000 Population

San Diego County	111
State	98
Health People 2010 Objective	10

Sources: U.S. Department of Health and Human Services. (2000, November) *Healthy People 2010*, 2nd ed. Washington, D.C.: U.S. Government Printing Office.
 Schumacher, J. (2003, December 17). Personal communication with the Center for Health Improvement.
 Maternal and Child Health Branch, California Department of Health Services. Maternal and Infant Health Assessment Survey (MIHA), 2000.
 California Department of Health Services, Tobacco Control Section. (n.d.). *Smoking during pregnancy*. Retrieved December 15, from <http://www.dhs.ca.gov/tobacco/documents/Pregnancy.pdf>
 Maternal and Child Health Branch, California Department of Health Services. Maternal and Infant Health Assessment Survey (MIHA), 2000.

Children Receive Preventive and Ongoing Regular Health Care

Childhood Immunizations

No regional information on childhood immunization is currently available. However, in San Diego County in 2002, children received timely immunizations at the following rates.²⁵

Estimated Vaccination Coverage with Individual Vaccines Among Children 19-35 Months of Age, San Diego County, 2002 (rate per 1000 population)

Vaccine	Rate
4+DTaP	830
3+Polio	872
1+MMR	901
3+Hib	918
3+HepB	867
1+Var	878
3+PCV	470

Source: Centers for Disease Control and Prevention, National Immunization Program. (2003) Estimated Vaccination Coverage with Individual Vaccines and Selected Vaccination Series Among Children 19-35 months of Age by State and Immunization Action Plan Area, US. *National Immunization Survey, Q1/2002-Q4/2002*. Retrieved December 15, 2003 from: <http://www.cdc.gov/nip/coverage/default.htm>

San Diego County does not meet *Healthy People 2010* objectives for diphtheria-tetanus-acellular pertussis (4+DtaP), Polio (3+), hepatitis B (3+Hep B), or varicella (1+Var).¹⁸

Regular Medical Home

The 2001 California Health Interview Survey found that 713 per 1000 children age zero to five in San Diego County went to a doctor's office, an HMO, or Kaiser for their usual source of care, and are therefore considered to have a regular medical home. For their usual source of care 279 per 1000 went to a community clinic or a community hospital.²⁸

There are no data available on the rate of children with a medical home by San Diego County regions, aged zero to five. However, there are data available for children aged 0-18. In 2001, the North Central region had the second lowest rate of children with primary care providers, at 847 per 1000. The only region with a lower rate was the Central Region.¹⁶

Rate of Children Who Have Someone Their Parent Considers Their Primary Care Provider, 1999-2001 (rates per 1000 population)

Region	1999	2000	2001
N. Coastal	826	871	871
N. Central	911	909	847
Central	766	775	788
South	798	828	911
East	883	881	909
N. Inland	871	870	882

Source: Community Health Improvement Partners. (2001) *Charting the Course III: A San Diego Health Needs Assessment*. San Diego, Ca: Author.

None of the San Diego County regions meet the Healthy People 2010 objective of 97% for having a regular primary care provider for children aged 0-17. Key informants, First 5 grantees, and community meeting attendees in the North Central Region identified this issue as a priority issue.

Health Insurance

There are no San Diego County regional data available for children age zero to five. However, there are regional data available for children aged 0-18. In 2001, the North Central region saw an increase in health insurance coverage from 1999, from 91.2% to 95.3% of the population.¹⁶ The region had the highest rate of health insurance coverage in 2001 of all regions, and the rate was higher than the overall San Diego County rate of 88.7%. None of the county regions met the Healthy People 2010 objective of health insurance for 100% of the population. Key informants, First 5 grantees, and community meeting attendees in the North Central region identified this issue as a priority issue.

Percentage of Households with Children Aged 0-18 Reporting Health Insurance Coverage San Diego County, 1999-2001

Region	1999	2000	2001
San Diego County	85.9	88.8	88.7
N. Coastal	82.0	88.3	89.2
N. Central	91.2	95.4	95.3
Central	80.7	85.0	79.7
South	84.0	84.2	88.8
East	92.0	91.8	91.3
N. Inland	85.5	87.4	87.3

Source: Community Health Improvement Partners. (2001) *Charting the Course III: A San Diego Health Needs Assessment*. San Diego, Ca: Author.

Children are in Healthy and Safe Environments

Children with substantiated or confirmed (open) cases of child abuse

Among regions in the county, the North Central Region has by far the lowest rate of substantiated cases of child abuse, at 7.6 per 1000. The North Central Region surpasses San Diego County with a lower than average incidence of substantiated cases of child abuse.

2000-2001 Two Year Average Substantiated Cases of Child Abuse for San Diego Residents Aged 17 Years and Younger (rates per 1,000 population)³¹

National	N/A
State	N/A
San Diego County (overall)	15.2
North Central	7.6
North Inland	11.5
South	11.9
North Coastal	12.5
East	18.2
Central	25.1

Sources: County of San Diego Health and Human Services Agency. (2002). San Diego County Child and Family Health & Well-Being Report Card. San Diego, CA: County of San Diego Health and Human Services Agency. Retrieved on November 15, 2003, from <http://www.co.san-diego.ca.us/cnty/cntydepts/health/services/rptcard/index.html>. National Clearinghouse on Child Abuse and Neglect Information, National Adoption Information Clearinghouse. Child Maltreatment 2001: Summary of Key Findings. Retrieved on December 16th, 2003 from: <http://nccanch.acf.hhs.gov/pubs/factsheets/canstats.cfm>

Child Maltreatment

No regional data are available regarding the recurrence of child maltreatment. However, a new Quality Assurance Unit is being developed within the County Child Welfare Department which will be able to provide some disaggregated data on this health issue.

The average recurrence rate of child maltreatment in San Diego County for children age zero to five years old is 11%. The rate of recurrence for all of California is the same. Nationally, the U.S. Department of Health and Human Services reports that 8.9% of child abuse and neglect victims experience a recurrence. This health issue was identified as a priority through key informant interviews, North Central Region community meeting participant feedback, and First 5 grantee surveys.

Non-Fatal Unintentional Injury

Though data by region on non-fatal unintentional injuries are unavailable, information on the major causes of unintentional injury by San Diego County region, either major statistical area

(MSA) or sub-regional area (SRA) for patients under the age of 20, is available.⁴⁰

During 2001, 617 nonfatal hospitalized unintentional injuries (or 3 per 1,000 population) were reported for children age zero to four in San Diego County.³⁴ The numbers of nonfatal hospitalized unintentional injuries for children age zero to four have declined over the last three years. However, unintentional injury leads all other causes of death for children aged 5 and under for San Diego County.³⁸

Children are Healthy and Well Nourished

Breastfeeding

Regional data on breastfeeding are not tracked in San Diego County. However, there are two hospitals in the North Central Region, Kaiser-San Diego and Alvarado Hospital that report on these data. Kaiser-San Diego reports that 85% of women were doing any breastfeeding, while 56% of women were exclusively breastfeeding upon discharge in fiscal year 2000-2001. Alvarado Hospital reports that 78% of women were doing any breastfeeding, while 41% of women were exclusively breastfeeding upon discharge in fiscal year 2000-2001. Rates for exclusive breastfeeding are average compared with other hospitals (see table on next page).

San Diego County In-Hospital Breastfeeding Rates, 2000-2001

Hospital	% any breastfeeding	% exclusively breastfeeding
Scripps Memorial Hospital Encinitas	95%	82%
Paradise Valley Hospital	92%	68%
Pomerado Hospital	92%	82%
Fallbrook Hospital	91%	50%
Palomar Medical Center	89%	56%
Tri-City Medical Center	89%	59%
Scripps Memorial Hospital Chula Vista	88%	42%
UCSD Medical Center	87%	64%
Grossmont Hospital	86%	62%
Kaiser-San Diego	85%	56%
Alvarado Hospital	78%	41%

Source: California Department of Health Services, Maternal and Child Health Branch, Epidemiology and Evaluation Section, Genetic Disease Branch. (2002) *2000-2001 Hospital Breastfeeding Tables*. Retrieved December 15, 2003 from: [http://www.mch.dhs.ca.gov/documents/pdf/2000-2001HospitalBreastfeedingTables\(Madera-Yolo\).pdf](http://www.mch.dhs.ca.gov/documents/pdf/2000-2001HospitalBreastfeedingTables(Madera-Yolo).pdf)

The following tables illustrate how these rates differed by ethnicity.

Kaiser-San Diego, 2000-2001

Ethnicity	% any breastfeeding	% exclusively breastfeeding
African American	72%	41%
Asian/Pacific Islander	80%	42%
Hispanic	86%	55%
Native American	N/A	N/A
Other/Multiple Races	87%	60%
White, non-Hispanic	85%	62%

Source: California Department of Health Services, Maternal and Child Health Branch, Epidemiology and Evaluation Section, Genetic Disease Branch. (2002) *2000-2001 Hospital Breastfeeding Tables*. Retrieved December 15, 2003 from: [http://www.mch.dhs.ca.gov/documents/pdf/2000-2001HospitalBreastfeedingTables\(Madera-Yolo\).pdf](http://www.mch.dhs.ca.gov/documents/pdf/2000-2001HospitalBreastfeedingTables(Madera-Yolo).pdf)

Alvarado Hospital, 2000-2001

Ethnicity	% any breastfeeding	% exclusively breastfeeding
African American	71%	22%
Asian/Pacific Islander	53%	17%
Hispanic	82%	41%
Native American	N/A	N/A
Other/Multiple Races	78%	37%
White, non-Hispanic	84%	56%

Source: California Department of Health Services, Maternal and Child Health Branch, Epidemiology and Evaluation Section, Genetic Disease Branch. (2002) *2000-2001 Hospital Breastfeeding Tables*. Retrieved December 15, 2003 from: [http://www.mch.dhs.ca.gov/documents/pdf/2000-2001HospitalBreastfeedingTables\(Madera-Yolo\).pdf](http://www.mch.dhs.ca.gov/documents/pdf/2000-2001HospitalBreastfeedingTables(Madera-Yolo).pdf)

In San Diego County, the rate of women exclusively breastfeeding at the time of hospital discharge in 2000 was 590 per 1000 women, while the rate of women breastfeeding at all was 880 per 1000 women.

National data for 2000 indicate that 684 per 1,000 women breastfed while in the hospital, while 314 per 1,000 were still breastfeeding their infants at six months of age.⁴³ *Healthy People 2010* objectives for breastfeeding are that 75% of infants are breastfed during the early postpartum period, 50% at six months, and 25% at one year of age¹⁸

Range of Expected Weight for Height and Age
 In San Diego County in 2002, the rate of underweight for children aged 0-59 months was 65 per 1000, and the rate of overweight was 139 per 1000 among children who were included in the CDC Pediatric Nutrition Surveillance. Therefore, the rate of expected weight for height and age for children aged 0-59 months was 796 per 1000⁴⁴. The San Diego County rate for underweight is higher than the state and national rates, and the rate of overweight is higher than the national rate but lower than the state rate. Both rates are significantly worse than the *Healthy People 2010* objectives of 50 per 1000.

Pediatric Nutrition Surveillance, Underweight and Overweight Rates for Children aged 0-59 months, 2002 (per 1000)

Location	Underweight Total	Overweight Total
San Diego County	65	139
California	53	162
United States	54	135
<i>Healthy People 2010</i>	50	50

Sources: Centers for Disease Control and Prevention. (2003) *2002 Pediatric Nutrition Surveillance*. Retrieved December 22, 2003 from: <http://www.dhs.ca.gov/pcfh/cms/onlinearchive/pdf/chdp/informationnotices/2003/chdpin03q/contents.htm>, U.S. Department of Health and Human Services. (2000, November) *Healthy People 2010*, 2nd ed. Washington, D.C.: U.S. Government Printing Office.

There are no regional data available for San Diego County on child underweight rates.⁸⁰ However, in San Diego County, the most prevalent age group found to be underweight were children aged 0-11 months. This was found to decline as children became older. Black infants were most likely to be underweight at an early age. However, by age 24-59 months, the rate of underweight was relatively the same for all ethnicities.

In San Diego County, the issue of overweight was found to affect children younger than age five at a greater rate than did underweight. Among children aged 0-23 months, Hispanic children were found to be the most likely to be

affected by overweight, while among children aged 23-59 months, Native American children were the most likely to be affected by overweight.⁴⁴

This health issue was identified as a priority through key informant interviews, North Central Region community meeting participant feedback, and First 5 grantee surveys.

Children have Good Oral Health

Annual Dental Exams

The use of dental services among children in the North Central Region is quite high as compared to county, state, and national rates. Among other regions in the county in 2002, the North Central Region had the highest percentage of children who had received dental care in the past 12 months. The North Central Region has surpassed the *Healthy People 2010* objective that 56% of children aged 2-17 have annual dental visits (based on 1996 data).

2002 Comparison Data – Percentage of Residents Under Age 18 Receiving Dental Care in Past 12 Months

North Central	80%
East	74%
North Inland	74%
San Diego County	73%
South	72%
North Coastal	71%
Central	69%
National	66%
State	56%

Source: United Way of San Diego County. (2002). Outcomes & Community Impact Program: Medical Security (Report 24). San Diego, CA: United Way of San Diego County. Retrieved November 15, 2003, from, <http://www.unitedway-sd.org/2002reports.html>.

Dental Insurance

The North Central Region has the highest number of insured children (see chart below).⁴⁵ This health issue was identified as a priority through key informant interviews, North Central Region community meeting participant feedback, and First 5 grantee surveys.

Percentage of San Diego County Residents Age 18 and Younger Who Are Reported to Have Dental Insurance

National	N/A
State	N/A
North Central	81%
East	74%
North Inland	72%
San Diego County	71%
South	68%
North Coastal	67%
Central	64%

Source: United Way of San Diego County. (2002). Outcomes & Community Impact Program: Medical Security (Report 24). San Diego, CA: United Way of San Diego County. Retrieved November 15, 2003, from <http://www.unitedway-sd.org/2002reports.html>

Children are Free of Smoking-related Illness

Asthma Hospitalizations

Trends are difficult to assess using available data. Although data were collected between 1999 and 2002, beginning in 2001, the Office of Statewide Planning and Development began masking a portion of the identifying variables (including age) to protect patient confidentiality. Due to this masking, data cannot reliably be compared over the four-year span between 1999 and 2002.⁵⁶ However, data for the North Central Region are included in the tables below for reference. Among children age zero to four, asthma hospitalization rates in the North Central Region went down between 1999 and 2000, and remained constant in 2001 and 2002.

Asthma-Related Hospitalizations Among North Central Region Children Aged 0-4, 1999-2002⁸¹

	1999	2000	2001	2002
# Hospitalized	82	78	81	86
Rate*	2.6	2.5	2.3	2.3

*Rates Per 1,000 Population

Source: County of San Diego Health and Human Services Agency, Community Epidemiology. (Data tables). Asthma Related Hospitalizations Among San Diego County Residents, 1999-2002, Age Group by Region. Source: California Office of Statewide Health Planning & Development, 1999-2002 Patient Discharge Data. Rates calculated using SANDAG January 1, 1999 revised estimates and January 1, 2000, 2001, and 2002 estimates. Prepared by Community Epidemiology.

Rates in the North Central Region have met or exceeded the *Healthy People 2010* objective of 2.5 hospitalizations per 1,000 population and fall below the county’s average.

Asthma-related Hospitalization Comparisons for Children Aged 0-4, 2002⁸¹

N Coast	1.7
N Central	2.3
N Inland	2.5
Healthy People 2010	2.5
County	2.8
East	2.9
South	3.2
Central	4.3

* Rates per 1,000 population

Source: County of San Diego Health and Human Services Agency, Community Epidemiology. (Data tables). Asthma Related Hospitalizations Among San Diego County Residents, 1999-2002, Age Group by Region. Source: California Office of Statewide Health Planning & Development, 1999-2002 Patient Discharge Data. Rates calculated using SANDAG January 1, 1999 revised estimates and January 1, 2000, 2001, and 2002 estimates. Prepared by Community Epidemiology.

Summary of Health Needs

Core Assumptions

To summarize the health needs for the North Central Region of San Diego County, the needs assessment included data from the 18 health issue summaries, grantee surveys, key informant interviews, and participant feedback and surveys from the North Central Regional Community Meeting. This meeting included 17 participants representing 13 different organizations, including but not limited to, organizations such as the American Red Cross, San Diego County Dental Society, Blue Cross of California, the American Council on Exercise, Catholic Charities, UPAC, and regional county staff representation.

Several core assumptions underscore the health needs in the North Central Region.

First, needs assessment participants feel all 18 of the health issues are critical to children’s health

and as such, are not hierarchical but interdependent.

Second, while each health issue is described distinctly in the issue summaries and via the data, respondents did not differentiate overlapping needs related to the health issues. Therefore, when identifying needs, trends or when making recommendations, respondents often bundled health insurance and regular medical home, dental insurance and annual examinations, developmental screening, and developmental services.

Finally, children's mental health is acknowledged as a key component of overall health. The scope of this needs assessment purposefully did not address children's mental health, as a separate planning effort is currently underway in San Diego County related to children's mental health.

Needs that Emerged from the Data

In the North Central Region, the most pressing health need when looking at the data alone is childhood obesity. Though not a health indicator reviewed for this needs assessment, domestic violence is also a problem in the region. The rate of domestic violence reported in the North Central Region over the period of 1999 to 2001 is 14.0 households per 1,000.

Needs Identified by Stakeholders and Key Informants

Six different priorities emerged when grantee surveys, regional community meeting results, and key informant interviews were analyzed however.

A North Central Regional Community meeting was held where participants were asked to identify their top three health issues by region related to the 18 identified children's health issues for the county. They worked in small groups to gain consensus on the top three health needs for the region. Individual survey responses from grantees identifying health needs were also

aggregated for the region. The top six health needs impacting the North Central Region according to the feedback received from these groups include:

- ✘ Children have a regular medical home, well-child checks and health insurance;
- ✘ Live births in which mothers received adequate prenatal care;
- ✘ Children age zero to five in their expected range of weight for their height and age;
- ✘ Child abuse and recurrence in a 6-month period;
- ✘ Children screened and receiving services after a disability or special need has been diagnosed; and
- ✘ Children receiving regular dental care.

When key informants were asked what they felt were the top children's health needs for the region were, they concurred with the above list as well. However, teen pregnancy, childhood asthma, and lead poisoning were added to the list.

School Readiness Implications

Each of these health issues can have a negative impact on a child's ability to learn and be prepared for kindergarten. Regular access to health care promotes good health, which can also allow children to focus on the learning process. Likewise, regular access to dental services can prevent poor oral health. Good oral health can allow normal eating, sleeping, speaking and learning. The social impact of disfiguring tooth decay can also reduce a child's chance for happiness and success.

Early access to prenatal care can prevent adverse pregnancy outcomes, such as low birth weight, which has been associated with long-term disabilities, such as cerebral palsy, autism, mental retardation, vision and hearing impairments, and other developmental disabilities.

An overweight child who maintains overweight into adolescence has a 50% chance of becoming an obese adult. Short-term health effects from obesity include several heart disease risk factors, including high blood pressure and high cholesterol, sleep apnea, and various orthopedic, respiratory, and skin disorders. Overweight children are also at risk for type II diabetes, which was once only seen in adults, but is now seen in children with increasing regularity. Complications associated with this disease are kidney disease, blindness and amputation. Long-term health problems associated with obesity include cardiovascular disease, gallbladder disease, osteoarthritis, stroke, and colon and breast cancer.⁸²

Developmental disabilities impact a child's readiness for school. Depending on the developmental disability, school readiness can be impacted differently.

Finally, child abuse victims are more likely to report a wide range of medical, emotional, psychological, and behavioral disorders as well as depression, alcoholism, drug abuse and severe obesity, all of which can impact a child's readiness to learn.⁸³

Assets Assessment

Over the past several years, San Diego County has demonstrated an ongoing commitment to improving the lives of children by creating the *Report Card of Child and Family Well-Being (Report Card)*. The *Report Card* tracks 20 key indicators to determine the county's progress in a number of health-related areas. While not specific to children 0-5, this has been an important asset in determining San Diego County's health priorities.

Several major County of San Diego agencies/departments serve children, including the Health and Human Services Agency (HHSA), and the County's Public Safety Group

(specifically the Probation Department, District Attorney's Office Juvenile Division, and the Public Defender's Office). These are the core agencies with substantial budget commitments to children. Although these assets are countywide, they impact each region and in fact these county agencies were identified as assets during many of the regional community meetings.

In the North Central Region a number of assets were identified either in surveys, by key informants or during regional community meetings. The identified assets were organized into four categories: programs and services, organizations, collaborations and systems.

Programs and Services

Grantees and regional community meeting participants as assets for children age zero to five and their families in the North Central Region identified the following programs and services.

- School based nutrition programs
- C-3 Lead out program Safe Kids Coalition (Bayside)
- Children's Hospital pediatric residency providing dental care for children 0-5
- Hope Infant Program
- Food Stamps
- Healthy Steps
- City of San Diego Park and Recreation programs
- Families Living In Good Health Together
- First 5 grantees
- YMCA
- Women, Infants, and Children Program
- Cooperative Extension Nutrition Education
- La Leche League / Door of Hope
- AIM - Access for Infants and Mothers
- Healthy Start
- Head Start
- State-funded Preschool
- United Way Infoline
- Perinatal Care Network

- Catholic Charities Family Support Services (in-home developmental assessments, free parenting classes)
- Christian Community Service Agency
- Giant Step - Bayview Community Center
- Options for Recovery - Foster Care
- FLIGHT - Family Living Improves Health Together
- Head Start
- Early Head Start
- Mark Twain School Program for pregnant teens
- Early Intervention / Early Start Program
- Chadwick Children's Center
- New Alternatives
- Home Start
- Homeless Shelters & free clinics
- Health Promoters

The organizations below were also identified as assets for children and families in the North Central Region.

Organizations

- Hospitals - Scripps La Jolla, SHARP, Children's Hospital
- Exceptional Family Resource Center
- University of San Diego
- Union of Pan Asian Communities (UPAC) interpretation services
- Catholic Charities
- Boys and Girls Club
- University of California, San Diego
- HHS Regional Center
- Bayside Community Center
- Council of Community Clinics
- San Diego State University Foundation
- YMCA Childcare Resource and Service
- Casey Family programs
- Kristie's Place
- Children's Hospital
- Religious institutions that serve children (e.g. child care)
- Polinsky Children's Center

- County Public Health
- Pacific Safety Council / Buckle Up SD
- March of Dimes
- Neighborhood House
- Door of Hope - Salvation Army
- Service Clubs - Lions, Kiwanis
- Law enforcement – California Highway Patrol, Sheriff's Department
- Family Health Centers

Collaborations

There are many collaborative efforts throughout the North Central Region as well as willingness among agencies to link clients with services more efficiently and effectively. Specific collaborations identified by grantees and regional community meeting participants include the following:

- San Diego Nutrition Network
- Dental Health Coalition
- Breastfeeding Coalition
- Coalition on Children and Weight
- Bayside / Linda Vista Collaborative
- Peninsula Collaborative
- Beach Pride
- Military Family Cluster
- Mira Mesa
- Military Health Start
- Family Support Services, Public Health Nurses and Child Protective Service workers collaborating around children 0-5
- Safe Kids Coalition
- Pacific Beach
- Clairemont
- Point Loma
- San Diego Immunization Initiative (I3)
- Community Partnership for Wellness
- Community Engagement and Action Forum (CEAF)
- "Information Assessment" Collaboration for 2-1-1 Implementation
- Developmental Screening and Enhancement System (DSEP)

- San Diego Child & Family Health and Well-Being Report Card

Systems

Systems that were identified as assets for children’s health by grantees and regional community meeting participants in the North Central Region include:

- Schools
- Foster Care System
- Health Department
- SANDAPP (through San Diego Unified School District)
- Public Health Centers
- Insurance - Healthy Families, Medi-Cal, Children's Hospital, CHDP, Kaiser

Some assets listed by grantees and regional community meeting participants described characteristics of the people living in or providing services to children and families in the North Central Region. The following list identifies those assets.

Community Characteristics

- Advocates who protect and ensure children's programs and prenatal services
- Higher income and education levels of community members
- High quality programs with highly educated providers are offered

Emerging Trends

Grantees, key informants and regional meeting participants were each asked to identify emerging trends that directly or indirectly impact the 18 health issues.

Emerging trends described either positive or negative impacts on the North Central Region. The top five negative trends identified in surveys and at the regional community meeting include:

- State budget cuts impacting all services for children and families (including health insurance)
- Decreased number of health and dental care providers due to low reimbursement rates from Medi-Cal especially
- Increased childhood obesity and passive activities such as watching television and playing video games / decreased levels of physical activity in school and at home
- Increased cost of living
- Increased number of families under stress and without support (those who’ve been affected by loss of jobs, housing or services and military families affected by the war)

Positive trends noted in the North Central Region included the County of San Diego Public Health Department partnering with community-based organizations to address needs through public health nurses; increased media attention focusing on children age zero to five; increased awareness of pediatricians about childhood obesity; and an increase in awareness regarding the impact of oral health disease on children’s overall health.

Also mentioned was an increase in culturally, linguistically appropriate education and materials for clients and an increased number of culturally competent staff, and staff who speak the language of the population. There is also an increased level of provider education regarding breastfeeding and HIV / drug use as well as hepatitis; and an increase in asthma monitoring.

Another trend which is not necessarily positive or negative but impacts service delivery is that the region has experienced an increase in the number of immigrant non-English speaking families coupled with an increase in the variety of languages spoken.

Key Informants

Trends impacting children's health that were noted by key informants in the North Central Region included an increased number of children with poor nutrition who are actually overfed but undernourished. Also noted was a rise in domestic violence and youth related gang violence.

Data Issues

Data on certain child health indicators are not available and, therefore, cannot be included in this report. For some indicators, no data were available, while for a few indicators, data for children ages 0-5 were not available. Those indicators are as follows.

Data Unavailable by HHS Region

- Smoking During Pregnancy
- Childhood Immunizations
- Well Baby Checks
- Developmental Screening
- Developmental Services
- Recurrence of Child Maltreatment
- Expected Weight for Height and Age

Data Unavailable for Children 0-5 by Region

- Regular Medical Home
- Health Insurance
- Confirmed Cases of Child Abuse
- Annual Dental Exams
- Dental Insurance

Other Data Limitations

County and regional data for developmental services, developmental screening, and well-baby/well-child checks are not available, and therefore, not listed in the "needs assessment" section of this chapter. Some information on these issues is included in the countywide section of this report.

While regional data are available for nonfatal unintentional injuries by major statistical area (MSA) and sub-regional area (SRA) for persons under the age of 20,⁶ data on children age zero to five by *HHS* region are not available.

Regional data on breastfeeding are not tracked in San Diego County; however, some hospitals in the county track the rate of women breastfeeding "exclusively" or "at all" by hospital at the time of discharge.

Though data are available by region with regards to asthma-related hospitalizations from 1999-2002, trends are difficult to assess because beginning in 2001, the Office of Statewide Planning and Development began masking a portion of the identifying variables (including age) to protect patient confidentiality. Due to this masking, data cannot reliably be compared over the four-year span between 1999 and 2002. County epidemiology staff have raised this issue with state government staff.⁵⁶

Finally, SANDAG collects data by age using 0 to 4 while First 5 is interested in data for children under age 6, which again leads to difficulty in directly comparing data.

Grantees, key informants and regional community meeting participants were also asked what data related issues they see in the North Central Region. Grantees and regional meeting participants would like to see the following data issues addressed.

- Improve regional access to data – it may be available at the county level, but regions are not getting it.
- Collect and make medical data available similar to how SANDAG does with demographic data that all regions can access.
- Distribute data collection results regularly and simply.
- Begin collecting data that relates to behaviors and beliefs (the whys behind health impacting behaviors).
- Organize data about assets by region with directions for interpretation as a separate section.
- Check on whether data on child maltreatment reoccurrence is 12 months vs. 6 months - maybe moving to 12 months

A key informant also mentioned a concern about an apparent dichotomy that children in the region generally appear to be doing better, but some are doing worse. At aggregate levels, the data shows that overall children seem to be doing well. However, when the data are disaggregated, providers can see issues related to specific populations such as burden of disease, socio-economic status, different racial groups, special populations (by age as well). This will enable them to plan and deliver services more effectively.

North Central Region Priorities

At the end of the regional community meeting, participants were asked to identify priorities regarding children’s health issues in the North Central Region. Many of the identified priorities are linked with several health issues and focus on early prevention and intervention. The North Central Regional Community Meeting participants identified the following priorities.

Medical home
Rationale: Regular check ups necessitate culturally appropriate services, materials, and translation for diverse populations to result in service utilization.
Educating parents and providers on issues and resources
Rationale: Parents need to know about health related issues and the resources available in order to better care for their children. Service providers need to know the issues that children and families are faced with and what resources are available to them.
Establishing consistent baseline data and ensuring providers track it
Rationale: Collecting baseline data across service providers will maximize data collection and service efforts. Health education, information, and resources can then be planned and provided to specific populations.
Disaggregating data by specific groups
Rationale: Disaggregating data by race, socio-economic status, education levels, special needs, etc. by region will enable service providers and funders to see true needs of specific populations.

4.0-REGIONAL PROFILE – NORTH COASTAL

Between 2003 and 2030, the total population for the North Coastal region is expected to increase 28% to 629,712. Though the population will continue to increase between 2010 and 2030, the rate of increase will slow, from 12.9% in 2010, to 5.4% in 2030. By 2030, the population growth rate for the region will be slower than the population growth rates for San Diego County and for California.

Demographics

Total Population

In 2003, approximately 489,965 people lived in the North Coastal Region, the third largest region in San Diego County.⁷² The largest urban city in the region is Oceanside, with a population of 161,029, according to the 2000 Census.⁸⁴ The population of Oceanside is expected to grow by almost 30% by the year 2020, a rate similar to that of both the county and state as a whole (San Diego County = 30.6%, California = 30.5%). There are five incorporated cities in the North Coastal Region — Carlsbad, Oceanside, Pendleton, San Dieguito, and Vista.

From 2001 to 2003, the North Coastal Region grew more quickly than the county as a whole as illustrated in the table below.

Total Population Growth, 2001-2003⁸

	2001	2003	% Increase
North Coastal Region	466,130	489,965	5.1%
County	2,856,000	2,961,579	3.7%

Source: Area Connect. *California Population and Demographic Resources*. Available online at <http://www.areaconnect.com/population.htm?s=CA>

Population Forecasts for the North Coastal Region, San Diego County, and California, 2010-2030

Year	2010	2020	2030
Population Forecast, North Coastal	553,212	597,519	629,712
% increase	12.9%	8.0%	5.4%
Population Forecast, San Diego	3,211,721	3,528,605	3,855,085
% increase	8.4%	9.9%	9.3%
Population Forecast, California	39,957,616	45,448,627	51,868,655
% increase	15.3% ^v	13.7%	14.1%

Source: San Diego Association of Governments. *SANDAG Population Forecast, 2010-2030*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG Population Forecast, 2010-2030. California Department of Finance. (2001) *Population Projections*. Available online at: <http://www.dof.ca.gov/HTML/DEMOGRAP/projca.pdf>

Age and Gender

The North Coastal Region has the 3rd highest population of children under 18 years of age of all six county regions—122,397. Twenty-seven percent of those, or 32,752, are between the ages of zero to four, which is comprised of 16,429 males and 16,323 females.⁷² Since 2001, the total population of children zero to four in this region has declined 2% from 33,442 to 32,752.⁷²

Forty-nine percent female and 51% male make up the total population of this region. As of the 2000 Census, the population was comprised of the following percentage of population age groups.

^v Baseline population from year 2000: 34,635,395

Percentage of Population by Age Group in the North Coastal Region⁷¹

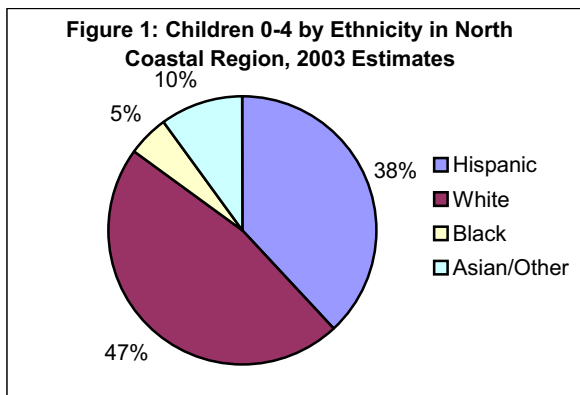
Age Group	0 -17	18 - 64	65+
Percentage of Population	25.8%	62.5%	11.7%

Source: San Diego County Health and Human Services Agency. *North County Business Plan: Fiscal Years 2003/04 and 2004/05*. Available online at <http://www2.sdcounty.ca.gov/hhsa/documents/BP-North-0305.pdf>

The age group expected to grow the most quickly in Oceanside by the year 2020 are people over 65 years of age. The median age for that city as of 2000 was 33.3. The estimated median age in Oceanside as of 2020 will be 37.7.⁸⁴

Ethnicity

The majority of the population aged zero to four in the North Coastal Region is White. Figure 1 below shows the ethnic make-up of the population aged zero to four in the region.



Source: San Diego Association of Governments. SANDAG January 1 Population Estimates, 2003. Prepared by Community Epidemiology, September 16, 2003. SANDAG January 1 Population Estimates All Ages by Race by Region.

By the year 2020, in the city of Oceanside, the percentage of Whites is expected to drop 10%, while the percentage of Hispanics is expected to grow by 8% and the percentage of Asian/Other is expected to grow by 4%.⁸⁴

For the whole North Coastal region, by 2030, the total population is expected to increase by close

to 14%. The greatest rates of increase in population will be among Hispanics, Pacific Islanders, and Asians, while among Blacks, the population is expected to decrease by 3%.

Total Population Forecast by Ethnicity, North Coastal Region, 2010-2030

North Coastal	2010	2020	2030	% change from 2010 to 2030
Total (all races and ethnicities)	553,212	597,519	629,712	13.83%
Hispanic	157,177	183,088	206,672	31.49%
White	319,594	326,882	325,148	1.74%
Black	19,820	19,861	19,175	-3.25%
American Indian or Alaska Native	2,379	2,538	2,557	7.48%
Asian	26,534	29,585	31,841	20.00%
Hawaiian or other Pacific Islander	8,241	10,252	12,625	53.20%
Other	3,871	7,133	11,088	186.44%
Two or more races	15,596	18,180	2,606	32.12%

Source: San Diego Association of Governments. SANDAG Population Forecast by Age and Ethnicity, 2010-2030. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG Population Forecast, 2010-2030.

Among children aged zero to four, population increase in the North Central Region will be greatest among Asian and Pacific Islander children, while population will decrease among White, Black, and American Indian children.

Population Forecast by Ethnicity for Children Aged 0-4, North Coastal Region, 2010-2030

North Coastal	2010	2020	2030	% change from 2010 to 2030
Total (all races and ethnicities)	39,127	39,936	39,443	0.81%
Hispanic	15,912	16,698	16,726	5.12%
White	17,625	17,391	16,707	-5.21%
Black	1,804	1,794	1,627	-9.81%
American Indian or Alaska Native	185	190	175	-5.41%
Asian	1,599	1,409	1,03	-12.26%
Hawaiian or other Pacific Islander	470	482	529	12.55%
Other	583	838	1,152	97.60%
Two or more races	949	1,134	1,124	18.44%

Source: San Diego Association of Governments. *SANDAG Population Forecast by Age and Ethnicity, 2010-2030*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG Population Forecast, 2010-2030.

Households and Income

The median household income of Oceanside was \$46,301 according to the 2000 Census, up from \$33,830 in 1990.⁸⁴ For the whole North Coastal Region, the median household income range in 2000 was considerably higher, at \$50,000-\$59,999. This is higher than the San Diego County median income of \$47,268 for the same year, and is also higher than the California median income for 1999 of \$47,493. The greatest number of households in the region fall into \$75,000-\$99,999 income category.

Number of Households by Household Income Category, North Coastal Region, 2000

Household income	Number of Households	% of total households
Less than \$10,000	8,453	5.12%
\$10,000 to \$14,999	6,996	4.23%
\$15,000 to \$24,999	17,844	10.80%
\$25,000 to \$34,999	19,199	11.62%
\$35,000 to \$49,999	26,261	15.89%
\$50,000 to \$74,999	32,649	19.75%
\$75,000 to 99,999	20,540	12.43%
\$100,000 or more	33,321	20.16%
Total	165,263	100.00%

Source: San Diego Association of Governments. *SANDAG Census Data – Households and Income, 2000*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG Census Data, 2000.

According to the US Census Bureau, in 2000, 6765 out of 114327 families in the North Coastal region, or 5.9%, had incomes that fell below the federal poverty level.

During the three years spanning CalWORKs fiscal years between 1998/1999 and 2000/2001, 15.6 per 1,000 families in the North Coastal Region received CalWORKs. This region had the second lowest rate of families receiving CalWORKs in the county, next to the North Central region.³¹

In 2000 in the North Coastal region, the most common type of household was the family household with children, followed by the non-family household with no children.

Number of Households by Household Type, North Central Region, 2000

Type of Household	Number of Households	%
Non family households	37144	17.18%
Other non family households	13792	6.38%
Non family households - no children	52253	24.17%
Non family no children	50262	23.25%
Family households with children	62074	28.71%
Non family with children	674	0.31%

Source: San Diego Association of Governments. *SANDAG Census Data – Households and Income, 2000*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG Census Data, 2000.

Regional Needs Assessment

This section provides information on how health issues are impacting children under age five in the North Coastal Region. Data for each child health indicator are reviewed for the region and compared to national, state, and county data, as well as *Healthy People 2010* objectives, where available. Indicators related to developmental services, developmental screening, and well-baby/well-child checks are not listed due to insufficient data at the county and regional levels. Where health issues were identified as a priority through key informant interviews, North Coastal Region community meeting participant feedback, and First 5 grantee surveys, this is noted.

Children are Born Healthy

Low Birthweight

Between 1998 and 2000, the North Coastal Region had one of the lowest rates of low birthweight births when comparing all six

regions in the county, second only to the South Region. However, the North Coastal Region still had a higher percentage of low birthweight than the *Healthy People 2010* target of 50 per 1000. However, the rate is lower than the county, state and national rates were in 2001.

1998-2000 Three-Year Average of Low Birthweight Births Between Regions (Rates Per 1,000 Population)¹⁶

South	55
North Coastal	56
North Inland	56
North Central	60
East	61
Central	69

Source: Community Health Improvement Partners. (2002). *Charting the Course III, 2001: A San Diego County Health Needs Assessment*. San Diego, CA. Community Health Improvement Partners

Adequate Prenatal Care Use

In 1999, the North Coastal Region had the lowest early prenatal care utilization rate of all county regions, also lower than the prenatal care utilization rates in both the county and the state. North Coastal is one of three regions that have prenatal care use rates lower than the county and the state. It is also lower than the *Healthy People 2010* objective of an early prenatal care use rate of 90%. This health issue was identified as a priority through key informant interviews, North Coastal Region community meeting participant feedback, and First 5 grantee surveys.

Percentage of Women Initiating Prenatal Care During the First Trimester by State, County, and Region, 1999

State	82.2%
County	80.3%
South	80.1%
North Coastal	72.3%
North Inland	79.6%
North Central	90.2%
East	85.9%
Central	76.0%

Source: California Department of Health Services. (2000) *Live Births by Trimester Prenatal Care Began, California Counties and Selected City Health Departments, 1999*, from birth records. Retrieved December 10, 2003 from: <http://www.dhs.ca.gov/hisp/chs/OHIR/vssdata/1999data/99ch2pdf/2-33-99vJC.pdf>

Births to Teen Mothers

The teen birth rate in the North Coastal Region as of 1999 was 24.3 per 1,000, lower than the county, state and national levels. There is no *Healthy People 2010* objective for teen birth rates. The teen birth rate varies substantially by region in San Diego County as shown in the table below.

1999 Teen Birth Rates (per 1,000 teens, ages 15-17)

San Diego County	43.0
State	48.1
National	48.5
South	35.4
North Coastal	24.3
North Inland	22.6
North Central	11.0
East	21.4
Central	45.1

Source: California Department of Health Services. (2003) *Birth Rates by Year of Age for Teenage Mothers, 2001*, from birth records. Retrieved December 10, 2003 from:

http://www.dhs.ca.gov/hisp/chs/OHIR/vssdata/2001data/01Ch2p df/2_29_2001.pdf

Source: Community Health Improvement Partners. (2002). *Charting the Course III, 2001: A San Diego County Health Needs Assessment*. San Diego, CA. Community Health Improvement Partners

Smoking During Pregnancy

No data are available for rates on smoking during pregnancy by region in San Diego County.⁷⁸ However, the county's rate of smoking during pregnancy falls short of the *Healthy People 2010* objective of 10 per 1,000 population.^{18, 49} The county rate is also higher than the state rate of 98 per 1,000 population.^{53, 54} This health issue was identified as a priority through key informant interviews, North Coastal Region community meeting participant feedback, and First 5 grantee surveys. National rates of smoking during pregnancy cannot be directly compared to state rates because data for smoking during pregnancy in California were not collected in National Center for Health Statistics' standard format and are therefore not easily compared.⁷⁹

Rates of Smoking During Pregnancy Per 1,000 Population

San Diego County	111
State	98
Health People 2010 Objective	10

Schumacher, J. (2003, December 17). Personal communication with the Center for Health Improvement.

Maternal and Child Health Branch, California Department of Health Services. Maternal and Infant Health Assessment Survey (MIHA), 2000.

California Department of Health Services, Tobacco Control Section. (n.d.). *Smoking during pregnancy*. Retrieved December 15, from

<http://www.dhs.ca.gov/tobacco/documents/Pregnancy.pdf>

Maternal and Child Health Branch, California Department of Health Services. Maternal and Infant Health Assessment Survey (MIHA), 2000.

Children Receive Preventive and Ongoing Regular Health Care

Childhood Immunizations

No regional information on childhood immunizations is currently available. However, in San Diego County in 2002, children received timely immunizations at the following rates.²⁵

Estimated Vaccination Coverage with Individual Vaccines Among Children 19-35 Months of Age, San Diego County, 2002 (rate per 1000 population)

Vaccine	Rates
4+DTaP	830
3+Polio	872
1+MMR	901
3+Hib	918
3+HepB	867
1+Var	878
3+PCV	470

Source: Centers for Disease Control and Prevention, National Immunization Program. (2003) Estimated Vaccination Coverage with Individual Vaccines and Selected Vaccination Series Among Children 19-35 Months of Age by State and Immunization Action Plan Area US, *National Immunization Survey, Q1/2002-Q4/2002*. Retrieved December 15, 2003 from: <http://www.cdc.gov/nip/coverage/default.htm>

San Diego County does not meet *Healthy People 2010* objectives for diphtheria-tetanus-acellular pertussis (4+DtaP), Polio (3+), hepatitis B (3+Hep B), or varicella (1+Var).¹⁸ This health issue was identified as a priority through key informant interviews, North Coastal Region community meeting participant feedback, and First 5 grantee surveys.

Regular Medical Home

The 2001 California Health Interview Survey found that 713 per 1000 children age zero to five in San Diego County went to a doctor's office, an HMO, or Kaiser for their usual source of care, and are therefore considered to have a regular medical home. For their usual source of care, 279 per 1000 went to a community clinic or a community hospital.²⁸

There are no data available on the rate of children with a medical home by San Diego County regions, aged zero to five. However, there are data available for children aged 0-18. Between 1999 and 2000, the North Coastal Region experienced an increase in the number of children with primary care providers, through this remained level into 2001. In 2001, the North Coastal Region had the third lowest rate of children with primary care providers, only higher than the Central and North Central Regions.¹⁶

Rate of Children Age 0- 18 Who Have Someone Their Parent Considers Their Primary Care Provider, 1999-2001 (rates per 1000 population)

Region	1999	2000	2001
N. Coastal	826	871	871
N. Central	911	909	847
Central	766	775	788
South	798	828	911
East	883	881	909
N. Inland	871	870	882

Source: Community Health Improvement Partners. (2001) *Charting the Course III: A San Diego Health Needs Assessment*. San Diego, Ca: Author.

None of the San Diego County regions meet the Healthy People 2010 objective of 97% for having a regular primary care provider for children age 0-17.

Health Insurance

There are no San Diego County regional data available for children age zero to five. However,

there are regional data available for children age 0-18. In 2001, the North Coastal Region saw an increase in health insurance coverage from 1999, from 82% to 89.2%.¹⁶ The region had the third highest percentage of health insurance coverage in 2001 of all regions. The percentage was also higher than the overall San Diego County percentage of 88.7% in 2001. In San Diego County in 2001, there were no regions that met the Healthy People 2010 objective of health insurance for 100% of the population. This issue was identified as a priority issue by key informants, First 5 grantees, and community meeting attendees in the North Coastal region.

Percentage of Households with Children Aged 0-18 Reporting Health Insurance Coverage San Diego County, 1999-2001

Region	1999	2000	2001
San Diego County	85.9	88.8	88.7
N. Coastal	82.0	88.3	89.2
N. Central	91.2	95.4	95.3
Central	80.7	85.0	79.7
South	84.0	84.2	88.8
East	92.0	91.8	91.3
N. Inland	85.5	87.4	87.3

Source: Community Health Improvement Partners. (2001) *Charting the Course III: A San Diego Health Needs Assessment*. San Diego, Ca: Author.

Children are in Healthy and Safe Environments

Confirmed Cases of Child Abuse

Compared to the national and California state rates of substantiated child abuse for children aged 17 years and younger, all San Diego County regions rank higher per 1,000. National substantiated child abuse rates are less than 2 per 1000 and the California state child abuse rate is just above 2 per 1000. The North Coastal Region has the third highest rate of the six regions in the county at 12.5 per 1000. While this is not nearly as high as the Central Region with the highest rate at 25.1 per 1000, the North Coastal Region is significantly higher than the state and national rates.

2000-2001 Two-Year Average Substantiated Cases of Child Abuse for San Diego Residents Ages 17 years and Younger (rate per 1,000)^{31, 32}

National	1.24
State	2.1*
San Diego County	15.2
South	11.9
North Coastal	12.5
North Inland	11.5
North Central	7.6
East	18.2
Central	25.1

*1996 data included for comparison

Sources: County of San Diego Health and Human Services Agency. (2002). San Diego County Child and Family Health & Well-Being Report Card. San Diego, CA: County of San Diego Health and Human Services Agency. Retrieved on November 15, 2003, from <http://www.co.san-diego.ca.us/enty/entydepts/health/services/rptcard/index.html>. National Clearinghouse on Child Abuse and Neglect Information, National Adoption Information Clearinghouse. Child Maltreatment 2001: Summary of Key Findings. Retrieved on December 16th, 2003 from: <http://nccanch.acf.hhs.gov/pubs/factsheets/canstats.cfm>

While *Healthy People 2010* does not have an objective for substantiated cases of child abuse, child abuse is a *Healthy People 2010* priority as demonstrated by the objective to reduce maltreatment and maltreatment fatalities of children under age 18 years.

Recurrence of Child Maltreatment

No regional data are available regarding the recurrence of child maltreatment. However, a new Quality Assurance Unit is being developed within the County Child Welfare Department which will be able to provide some disaggregated data on this health issue.

The average recurrence rate of child maltreatment in San Diego County for children age zero to five years old is 11%. The rate of recurrence for all of California is the same. Nationally, the U.S. Department of Health and Human Services reports that 8.9% of child abuse and neglect victims experience a recurrence.

Nonfatal Unintentional Injuries

Region-specific information on non-fatal unintentional injuries is not available. However, information on the major causes of unintentional

injury by San Diego County region, either major statistical area (MSA) or sub-regional area (SRA) for patients under the age of 20, is available.⁴⁰ One of the highest rates of suffocation injuries (.49 per 1,000) was reported in Vista, a city within the North Coastal Region.

Statewide, there were 8,004 nonfatal hospitalized injuries in 2000. There were 617 nonfatal hospitalized injuries in San Diego County in 2001. Incidents at both the county and state have decreased since 1999.

Children are Healthy and Well-Nourished

Breastfeeding

Regional data are not tracked in San Diego County. However, the one hospital in the North Coastal Region, Tri-City Medical Center, that does report breastfeeding rates, reports that 89% of women were doing any breastfeeding, while 59% of women were exclusively breastfeeding upon discharge in fiscal year 2000-2001. Rates for exclusive breastfeeding are average compared with other hospitals (see table below).

San Diego County In-Hospital Breastfeeding Rates, 2000-2001

Hospital	% any breastfeeding	% exclusively breastfeeding
Scripps Memorial Hospital Encinitas	95%	82%
Paradise Valley Hospital	92%	68%
Pomerado Hospital	92%	82%
Fallbrook Hospital	91%	50%
Palomar Medical Center	89%	56%
Tri-City Medical Center	89%	59%
Scripps Memorial Hospital Chula Vista	88%	42%
UCSD Medical Center	87%	64%
Grossmont Hospital	86%	62%
Kaiser-San Diego	85%	56%
Alvarado Hospital	78%	41%

Source: California Department of Health Services, Maternal and Child Health Branch, Epidemiology and Evaluation Section, Genetic Disease Branch. (2002) *2000-2001 Hospital Breastfeeding Tables*. Retrieved December 15, 2003 from: [http://www.mch.dhs.ca.gov/documents/pdf/2000-2001HospitalBreastfeedingTables\(Madera-Yolo\).pdf](http://www.mch.dhs.ca.gov/documents/pdf/2000-2001HospitalBreastfeedingTables(Madera-Yolo).pdf)

The table below illustrates how these rates differed by ethnicity.

Tri-City Medical Center, 2000-2001

Ethnicity	% any breastfeeding	% exclusively breastfeeding
African American	70%	41%
Asian/Pacific Islander	79%	52%
Hispanic	91%	52%
Native American	N/A	N/A
Other/Multiple Races	85%	61%
White, non-Hispanic	89%	73%

Source: California Department of Health Services, Maternal and Child Health Branch, Epidemiology and Evaluation Section, Genetic Disease Branch. (2002) *2000-2001 Hospital Breastfeeding Tables*. Retrieved December 15, 2003 from: [http://www.mch.dhs.ca.gov/documents/pdf/2000-2001HospitalBreastfeedingTables\(Madera-Yolo\).pdf](http://www.mch.dhs.ca.gov/documents/pdf/2000-2001HospitalBreastfeedingTables(Madera-Yolo).pdf)

In San Diego County, the rate of women exclusively breastfeeding at the time of hospital discharge in 2000 was 590 per 1,000 women, while the rate of women breastfeeding at all was 880 per 1,000 women.

National data for 2000 indicate that 684 per 1,000 women breastfed while in the hospital, while 314 per 1,000 were still breastfeeding their infants at six months of age.⁴³ *Healthy People 2010* objectives for breastfeeding are that 75% of infants are breastfed during the early postpartum period, 50% at six months, and 25% at one year of age.¹⁸

Range of Expected Weight for Height and Age

In San Diego County in 2002, the rate of underweight for children aged 0-59 months was 65 per 1000, and the rate of overweight was 139 per 1000 among children who were included in the CDC Pediatric Nutrition Surveillance. Therefore, the rate of expected weight for height and age for children aged 0-59 months was 796 per 1000⁴⁴. The San Diego County rate for underweight is higher than the state and national rates, and the rate of overweight is higher than the national rate but lower than the state rate.

Both rates are significantly worse than the *Healthy People 2010* objective of 50.

Pediatric Nutrition Surveillance, Underweight and Overweight Rates for Children aged 0-59 months, 2002 (per 1000)

Location	Underweight Total	Overweight Total
San Diego County	65	139
California	53	162
United States	54	135
<i>Healthy People 2010</i>	50	50

Sources: Centers for Disease Control and Prevention. (2003) *2002 Pediatric Nutrition Surveillance*. Retrieved December 22, 2003 from: <http://www.dhs.ca.gov/pcfh/cms/onlinearchive/pdf/chdp/informat ionnotices/2003/chdpin03q/contents.htm>, U.S. Department of Health and Human Services. (2000, November) *Healthy People 2010*, 2nd ed. Washington, D.C.: U.S. Government Printing Office.

There are no regional data available for San Diego County on child underweight rates.⁸⁰ However, in San Diego County, the most prevalent age group found to be underweight were children aged 0-11 months. This was found to decline as children became older. Black infants were most likely to be underweight. However, by age 24-59 months, the rate of underweight was relatively the same for all ethnicities.

In San Diego County, the issue of overweight was found to affect children younger than age five at a greater rate than did underweight. Among children aged 0-23 months, Hispanic children were found to be the most likely to be affected by overweight, while among children aged 23-59 months, Native American children were the most likely to be affected by overweight.⁴⁴

Children have Good Oral Health

Annual Dental Exams

While no data are available for children age zero to five, there are data available for children aged 0-18. Seventy-one percent of children younger than 18 years in the North Coastal Region had received dental care in the past 12 months in

according to United Way data compared in 2002. A little over 73% of children in San Diego County had received dental care in the previous 12 months. This is far higher than either the state rate of 56% or the national rate of 66%. This health issue was identified as a priority through key informant interviews, North Coastal Region community meeting participant feedback, and First 5 grantee surveys.

2002 Comparison Data – Percentage of Residents Under age 18 Receiving Dental Care in the Past 12 Months⁴⁵

National	66%
State	56%
San Diego County	73%
South	72%
North Coastal	71%
North Inland	74%
North Central	80%
East	74%
Central	69%

Source: United Way of San Diego County. (2002). Outcomes & Community Impact Program: Medical Security (Report 24). San Diego, CA: United Way of San Diego County. Available online at <http://www.unitedway-sd.org/2002reports.html>.

The *Healthy People 2010* objective target is for 56% of children age 2-17 to receive annual dental exams.

Dental Insurance

Twenty-five percent of California’s preschool and elementary school age children and 40% of high school age children have no dental insurance.⁴⁸ Slightly more than 70% of San Diego County households reported children with dental insurance.⁴⁷ The North Coastal Region has 67% of children under 18 who are reported to have dental insurance, a significantly higher rate than that of the state, but slightly lower than the county. Of all six regions, North Coastal has the second lowest rate as illustrated in the table below.

Percentage of San Diego County Residents Age 18 and Younger that are Reported to Have Dental Insurance⁴⁵

San Diego County	71%
South	68%
North Coastal	67%
North Inland	72%
North Central	81%
East	74%
Central	64%

Source: United Way of San Diego County. (2002). *Outcomes & Community Impact Program: Medical Security (Report 24)*. San Diego, CA: United Way of San Diego County. Retrieved November 15, 2003, from <http://www.unitedway-sd.org/2002reports.html>.

Children are Free of Smoking-related Illnesses

Childhood Asthma

The North Coastal Region has the lowest rate of asthma-related hospitalizations compared to any other region in the county. It has even exceeded the *Healthy People 2010* objective of 2.5 hospitalizations per 1,000 population.

Asthma-related Hospitalization Comparisons for Children Aged 0-4, 2002*⁸¹ (rates per 1000)

North Coastal	1.7
North Central	2.3
North Inland	2.5
Healthy People 2010	2.5
County	2.8
East	2.9
South	3.2
Central	4.3

Source: San Diego County Health and Human Services Agency, Community Epidemiology Asthma Related Hospitalizations Among San Diego County Residents, 1999-2002, Age Group by Region. Source: California Office of Statewide Health Planning & Development, 1999-2002 Patient Discharge Data. Rates calculated using SANDAG January 1, 1999 revised estimates and January 1, 2000, 2001, and 2002 estimates. Prepared by Community Epidemiology.

Summary of Health Needs

Core Assumptions

To summarize the health needs for the North Coastal Region of San Diego County, the needs assessment included data from the 18 health issue summaries, grantee surveys, key informant interviews, and participant feedback and surveys from the North Coastal Regional Community

Meeting. This meeting included 16 participants representing 15 different organizations, including but not limited to, organizations such as the American Red Cross, CHDP Foster care Program, YMCA Kinship Support Services, Children’s Hospital – Children’s Care Connection, UPAC, Vista Community Clinic and regional county staff representation.

Several core assumptions underscore the health needs in the North Coastal Region.

First, needs assessment participants feel all 18 of the health issues are critical to children’s health and as such, are not hierarchical but interdependent.

Second, while each health issue is described distinctly in the issue summaries and via the data, respondents did not differentiate overlapping needs related to the health issues. Therefore, when identifying needs, trends or when making recommendations, respondents often bundled health insurance and regular medical home, dental insurance and annual dental examinations and developmental screening and developmental services.

Finally, children’s mental health is acknowledged as a key component of overall health. However, the scope of this needs assessment purposefully did not address children’s mental health as a separate planning effort is currently underway in San Diego County related to children’s mental health.

Needs that Emerged from the Data

In the North Coastal Region, the most pressing health needs when looking at the data alone include child abuse, adequate prenatal care, and children receiving annual dental exams.

Needs Identified by Stakeholders and Key Informants

Three different priorities emerged when grantee surveys, regional community meeting results, and key informant interviews were analyzed however.

A North Coastal Regional Community Meeting was held and participants were asked to identify their top three health issues by region related to the 18 identified children's health issues for the county. They worked in small groups to gain consensus on the top three health needs for the region. Individual survey responses from grantees identifying health needs were also aggregated for the region. The top five health needs impacting the North Coastal Region according to these groups include:

- ☒ Children having health insurance with continuous coverage and well-child check ups;
- ☒ Prenatal care;
- ☒ Women refraining from smoking during pregnancy;
- ☒ Childhood immunizations;
- ☒ Children receiving regular dental care.

When key informants were asked what they felt were the top children's health needs for the region were, they concurred with most issues in the above list as well with several additions. First, in the North Coastal Region there is a high level of African American infant mortality. In addition, child abuse reports for the region that are associated with domestic violence is of great concern. Hundreds of children are taken into legal custody by the county each year. Most of those children are between the ages of one and three. Speech problems was additionally mentioned as a concern in the North Coastal Region, and finally, language barriers associated with accessing health care need to be addressed. Parents who have health insurance, but who do not speak English have a difficult time completing paperwork, reading health information and communicating with health care providers in general.

School Readiness Implications

All of these health issues can have a negative impact on a child's ability to learn and be prepared for kindergarten. Health insurance allows children to receive necessary preventive care services, such as vaccinations that can

prevent disease.¹⁶ Risks related to sub-standard oral health that can result from a lack of access to regular oral health care include pain, inability to eat comfortably or chew well, and distraction from play and learning.⁴⁸ Early prenatal care can decrease the likelihood of adverse birth outcomes, such as low birth weight, which is associated with long-term disabilities, such as cerebral palsy, autism, mental retardation, vision and hearing impairments, and other developmental disabilities, all of which can affect the child's ability to perform in school.⁸⁵

Exposure to smoke in the womb as a result of maternal smoking may have significant effects on a child's readiness for school. Eye problems, asthma, and ADHD are only a few of the adverse health effects that make learning more difficult for children and that can have an impact on school readiness.⁸⁶

Finally, vaccinations prevent diseases that can result in long-term developmental or physical impairments that can affect a child's ability to learn.¹

Assets Assessment

Over the past several years, San Diego County has demonstrated an ongoing commitment to improving the lives of children by creating the "*Report Card of Child and Family Well-Being*." The *Report Card* tracks 20 key indicators to determine the county's progress in a number of health-related areas. While not specific to children age zero to five, this has been an important asset in determining San Diego County's health priorities.

Several major county agencies/departments serve children, including the Health and Human Services Agency (HHS), and the county's Public Safety Group (specifically the Probation Department, District Attorney's Office Juvenile Division, and Public Defender's Office). These are the core agencies with substantial budget commitments to children. Although these assets

are countywide, they impact each region and in fact these county agencies were identified as assets during many of the regional community meetings.

In the North Coastal Region a number of assets were identified either in surveys, by key informants or during regional community meetings. The identified assets were organized into four categories: programs and services, organizations, collaborations and systems.

Programs and Services

Grantees and regional community meeting participants as assets identified the following programs and services for children age zero to five and their families in the North Coastal Region.

- Casa de Amparao
- Parent Resources Center (North County High School)
- In Hospital Mom/Baby Program
- CASA Child Development Center - Referrals through CPS/Private Schools
- Casa de Ninos
- Balderama Children's Center
- Migrant Education Oceanside School District
- Red Cross - Infant Car Seat / Safety education for parents
- Family Caregiving training
- Preventive Health and Education
- Welcome Home Baby
- Palomar Family Counseling Child Net
- Black Infant Health
- Developmental Screening Enhancement Project
- Healthy Families Healthy Access program
- Welcome Home Baby
- CHDP Foster Care Program
- Early Access Primary Care (for those who don't qualify for Healthy Families)
- Screening programs through First 5 (through child care centers)

- Hope Infant Program
- North County children's services and development education
- Women, Infant, and Children Programs
- Head Start / Early Head Start Programs
- Dental programs and access
- Case management services
- Prenatal Care Programs
- United Way Infoline
- 2-1-1 Line forthcoming
- Family Resource Centers - substance abuse for moms and kids

The organizations below were also identified as assets for children and families in the North Coastal Region.

Organizations

- Current Prop 10 funded agencies such as Children's Care Connection
- American Lung - Asthma Home visitation
- Vista Community Clinic (VCC)
- Children's Hospital
- Chadwick Center - home visitation
- AIM
- Las Valientes
- Children's Care Connection (3-Cs)
- Home Start
- YMCA Kinship program
- North County Lifeline
- Chavez Resource Center
- Libby Lake Community Center
- Crown Heights Community Center
- North Coastal Region Community Resource Center
- North County Health Services
- Make Yours a Fresh Start Family – American Cancer Society
- Children's Hospital, San Diego (Services and Staff)

Collaborations

There are many collaborative efforts throughout the North Coastal Region as well as willingness among agencies to link clients with services more efficiently and effectively. Specific collaborations identified by grantees and regional community meeting participants include the following:

- San Diego Child & Family Health and Well-Being Report Card
- Faith-based Community and Oceanside City Council - Networking meetings
- Council of Community Clinics
- Hospital Collaboratives
- CDBG (City) Collaborative
- Neighborhood Resource Centers
- Make Yours a Fresh Start Collaborative
- Family Visitation (CASW)
- First 5 Health Access Collaborative - Vista Community Clinic lead from North Coastal
- County - New Alternatives Assessment Center
- Partnership for Smoke free Families (Camp Pendleton)
- Pediatricians' Offices
- Child Assessment Network North (CANN)
- San Diego KHAN (Kids Health Access Network)

Systems

Systems that were identified as assets for children's health by grantees and regional community meeting participants in the North Coastal Region include:

- Health care network including Community Health Centers, Clinics and hospitals
- Vista Family History Center (part of a system of centers where families can find their ancestry)
- Medi-Cal eligibility staff
- EPSDT

- Public Health Nurses
- Regional Perinatal System
- County Social Workers
- Migrant Education/Health
- School Readiness programs through school districts
- HHSA Regional Centers
- Child Health and Disability Prevention (CHDP)
- Public Parks

Some assets listed by grantees and regional community meeting participants described characteristics of the people living in or providing services to children and families in the North Coastal Region. The following list identifies those assets.

Community Characteristics

- Awareness of importance of serving children prior to school entry
- North Coastal is gearing up toward linking children to needed services - stronger system of care in North Coastal and North Inland.
- Children have a high rate of dental exams
- Children have a low rate of asthma-related illnesses
- Getting seen by a provider, not only when sick
- Faith-based communities
- Parents who love their children

Assets According to Key Informants

In addition to the assets identified during regional community meetings and surveys, key informants in North Coastal identified several additional assets including the Black Infant Health Program, San Diego Kids Health Access Network (KHAN), and out stationed eligibility technicians at hospitals who assist individuals and families with enrollment in public assistance programs.

The Children's Mental Health program, dental providers serving patients at some community clinics and the Safe Community Collaboration, a

collaboration of faith-based organizations that partner to provide foster children with blankets, clothes and other needs were identified as assets. Foster families themselves were additionally mentioned as well as Parish Nurses who work through faith-based organizations.

Emerging Trends

Grantees, key informants and regional meeting participants were each asked to identify emerging trends that directly or indirectly impact the 18 health issues.

Emerging trends described either positive or negative impacts on the North Coastal Region. The top five negative trends identified in surveys and at the regional community meeting include:

- State budget cuts impacting all services for children and families (especially health insurance)
- Decreased number of health and dental care providers due to low reimbursement rates
- Decreased quality, affordable housing for families
- Increased number of families under stress and without support
- Teen pregnancy

Among the more positive trends noted in the North Coastal Region were better collaboration among agencies, an increased number of early screening and intervention services, and increased media attention focusing on children 0-5. Also mentioned was that there was more parent involvement in children's lives, nutrition was being seen as a priority, and increased asthma monitoring. Also mentioned was the availability of mental health services for postpartum moms.

Key Informants

Additional trends impacting children's health that were noted by key informants in the North Coastal Region included that children enrolled in publicly sponsored health insurance programs

are not accessing health care. An increased number of children with poor nutrition and dental care habits leading to serious dental care needs once those children receive care. Also noted was a rise in domestic violence and that unmet needs are generally in the fast growing Spanish-speaking population.

Data Issues

Data on certain child health indicators are not available and, therefore, cannot be included in this report. For some indicators, no data was available, while for a few indicators, data for children ages 0-5 wasn't available. Those indicators are as follows.

No Regional Data At All

- Smoking During Pregnancy
- Childhood Immunizations
- Well Baby Checks
- Developmental Screening
- Developmental Services
- Recurrence of Child Maltreatment
- Expected Weight for Height and Age

No Regional Data for Children 0-5

- Regular Medical Home
- Health Insurance
- Confirmed Cases of Child Abuse
- Annual Dental Exams
- Dental Insurance

County and regional data for developmental services, developmental screening, and well-baby/well-child checks are not available, and therefore, not listed in the "needs assessment" section of this chapter. Some information on these issues is included in the countywide section of this report.

While regional data is available for nonfatal unintentional injuries by major statistical area (MSA) and sub-regional area (SRA) for patients under the age of 20,⁶ data on children age zero to five by *HHS*A region is not available.

Regional data on breastfeeding are not tracked in San Diego County; however, some hospitals in the county track the rate of women breastfeeding “exclusively” or “at all” by hospital at the time of discharge.

Though data are available by region with regards to asthma-related hospitalizations from 1999-2002, trends are difficult to assess because beginning in 2001, the Office of Statewide Planning and Development began masking a portion of the identifying variables (including age) to protect patient confidentiality. Due to this masking, data cannot reliably be compared over the four-year span between 1999 and 2002. County epidemiology staff have raised this issue with state government staff.⁵⁶

Finally, SANDAG collects data by age using 0 to 4 while First 5 is interested in data for children under age 6, which again leads to difficulty in reliable data comparison.

Grantees, key informants and regional community meeting participants were also asked what data related issues they see. Grantees and regional meeting participants would like to see the following data issues addressed.

- Consistent data tracking and sharing across programs and organizations (technological issues as well) should occur. Use the model of Council of Community Clinics involving Memoranda of Understanding for sharing info across agencies due to new HIPPA laws.
- Track data by census track
- Tracking data by regional boundaries is not as useful as being able to disaggregate data by MSA or community.
- The county database should include HHS Medi-Cal retention data which has been collected monthly for several years. That data include those families losing coverage each month for reasons including "failure to provide" renewal

documents. The county has shown great commitment to improving these outcomes.

North Coastal Priorities

At the end of the regional community meeting, participants were asked to identify priorities regarding children’s health issues in the North Coastal Region. Many of the identified priorities are linked with several health issues and focus on early prevention and intervention. The North Coastal Regional Community Meeting participants identified the following priorities.

Awareness of resources for linking clients to services (i.e., 2-1-1, Information and Referral website).
Rationale: Many people are not accessing services because they simply do not know about them. This may be due to language barriers and lack of marketing.
User-friendly transportation to services
Rationale: When location is a barrier, easy-to-use accessible transportation can provide a solution.
Access to services for all people
Rationale: When people cannot access services due to citizenship or language barriers, they may spread communicable diseases that could otherwise have been prevented.
Parent education and support
Rationale: The earlier that parents understand their child’s development, the earlier they may notice health concerns as well as development issues that could cause lifelong health problems if left untreated

5.0-REGIONAL PROFILE – NORTH INLAND

By 2030, the total population is expected to increase to 705,812. Between 2003 and 2030, the total population will increase 36%. Between 2010 and 2030 the rate of population growth will continue to increase, and will be greater than the rate of population growth for San Diego County. However, the rate of population growth will be slightly slower than that for California.

Demographics

Total Population

In 2003, approximately 520,306 people lived in the North Inland Region, the second largest population of the six regions in the county (and occupying the largest land mass).⁷² The largest urban city in the region is Escondido, which had a population of 133,559 as of the 2000 Census.⁸⁷ The population of Escondido is expected to grow by almost 20% by the year 2020, a slower rate than both the county and state as a whole (San Diego County = 30.6%, California = 30.5%). There are ten primary communities in the North Inland Region — Anza Borrego Springs, Escondido, Fallbrook, North San Diego, Palomar/Julian, Pauma, Poway, Ramona, San Marcos, and Valley Center.

From 2001 to 2003, the North Inland Region grew slightly more quickly than the county as a whole as illustrated in the table below.

Total Population Growth, 2001-2003⁸

	2001	2003	% Increase
North Inland Region	500,471	520,306	4%
County	2,856,000	2,961,579	3.7%

Source: Area Connect. *California Population and Demographic Resources*. Available online at <http://www.areaconnect.com/population.htm?s=CA>

Population Forecasts for the North Inland Region, San Diego County, and California, 2010-2030

Year	2010	2020	2030
Population Forecast, North Inland	547198	623755	705812
% increase	5.2%	14.0%	13.2%
Population Forecast, San Diego County	3,211,721	3,528,605	3,855,085
% increase	8.4%	9.9%	9.3%
Population Forecast, California	39,957,616	45,448,627	51,868,655
% increase	15.3% ^{vi}	13.7%	14.1%

Source: San Diego Association of Governments. *SANDAG Population Forecast, 2010-2030*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG Population Forecast, 2010-2030. California Department of Finance. (2001) *Population Projections*. Available online at: <http://www.dof.ca.gov/HTML/DEMOGRAP/projca.pdf>

Age and Gender

One hundred thirty-six thousand one hundred eighty-three (136,183) children under the age of 18 make up 26% of the North Inland Region population. This region has the 4th highest population of children between 0-4 years of age of all county regions, comprising 6% of the region's population. Of those, 15,927 are male, and 15,791 are female.⁷² Since 2001, the total population of children 0-4 in this region has declined 7.6% from 34,324 to 31,718.⁷²

Females make up 50.5% of the total population in the region and males make up 49.5%. As of the 2000 Census, the population was comprised of the following age groups.

^{vi} Baseline population from year 2000: 34,635,395

Percentage of Population by Age Group in the North Inland Region⁷¹

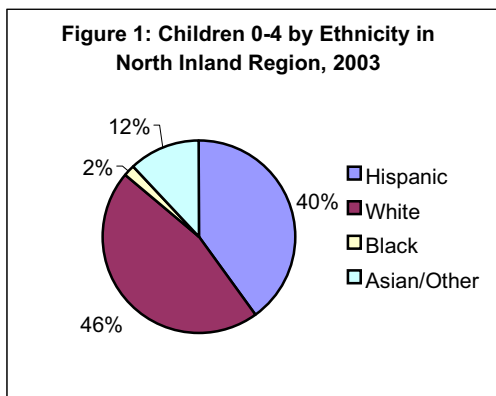
Age Group	0 -17	18 - 64	65+
Percentage of Population	28.1%	59.3%	12.6%

Source: San Diego County Health and Human Services Agency. *North County Business Plan: Fiscal Years 2003/04 and 2004/05*. Available online at <http://www2.sdcounty.ca.gov/hhsa/documents/BP-North-0305.pdf>

The median age in the city of Escondido as of 2000 was 31.3. The estimated median age in that city as of 2020 is expected to be 31.5.⁸⁷

Ethnicity

The majority of the population age zero to four in the North Inland Region is White. Figure 1 on the next page shows the ethnic make-up of the population age zero to four in the region.



Source: San Diego Association of Governments. SANDAG January 1 Population Estimates, 2003. Prepared by Community Epidemiology, September 16, 2003. SANDAG January 1 Population Estimates All Ages by Race by Region.

In the North Inland Region, the total population is expected to increase by close to 30% between 2010 and 2030. The population will increase significantly among most ethnic communities, with the exception of American Indians, among whom the population will decrease by 3%. The greatest rates of population increase will occur among Pacific Islander, Hispanic, and Black residents.

Total Population Forecast by Ethnicity, North Inland Region, 2010-2030

North Inland	2010	2020	2030	% change from 2010 to 2030
Total (all races and ethnicities)	547198	623755	705812	28.99%
Hispanic	163188	205000	256065	56.91%
White	297008	307673	317042	6.75%
Black	10592	13779	16798	58.59%
American Indian or Alaska Native	3999	3914	3881	-2.95%
Asian	47275	55628	59839	26.58%
Hawaiian or other Pacific Islander	5268	8287	11802	124.03%
Other	4709	9814	16089	241.66%
Two or more races	15159	19660	24296	60.27%

Source: San Diego Association of Governments. SANDAG Population Forecast by Age and Ethnicity, 2010-2030. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG Population Forecast, 2010-2030.

By the year 2020, in the city of Escondido, the largest city in the region, the percentage of Whites is expected to drop 44%, while the percentage of Hispanics is expected to grow by 82% and the percentage of Asian/Other is expected to grow by 55%. One exception in the Asian/Other group includes American Indians. Although that ethnic group is included with Asian/Others, they are expected to experience a 24.5% decrease in population by 2020.⁸⁷

Among children age zero to four, the population will increase at a slower rate than the total population for the North Inland region. Population rates will decrease among White, Asian, and American Indian children, and will increase substantially among Hispanic, Black, and Pacific Islander children.

Population Forecast by Ethnicity for Children Aged 0-4, North Inland Region, 2010-2030

North Inland	2010	2020	2030	% change from 2010 to 2030
Total (all races and ethnicities)	39,586	42,791	45,371	14.61%
Hispanic	17,311	19,384	21,278	22.92%
White	15,865	15,957	15,691	-1.10%
Black	916	1,181	1,302	42.14%
American Indian or Alaska Native	373	334	276	-26.01%
Asian	3,334	3,103	3,092	-7.26%
Hawaiian or other Pacific Islander	263	332	425	61.60%
Other	882	1,532	2,307	161.56%
Two or more races	642	968	1,000	55.76%

Source: San Diego Association of Governments. *SANDAG Population Forecast by Age and Ethnicity, 2010-2030*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG Population Forecast, 2010-2030.

Households and Income

In the North Inland Region, the median household income range in 2000 was \$50,000-\$59,999. This is slightly higher than the median income for San Diego County, which is \$47,268, and is also higher than the California median income, which is \$47,493. The greatest number of households fall into the \$75,000-99,999 income category, which is somewhat higher than the median range for the region.

Number of Households by Household Income

Category, North Inland Region, 2000

Household income	Number of Households	% of total households
Less than \$10,000	7862	4.78%
\$10,000 to \$14,999	6775	4.11%
\$15,000 to \$24,999	16622	10.10%
\$25,000 to \$34,999	17451	10.60%
\$35,000 to \$49,999	24317	14.77%
\$50,000 to \$74,999	34950	21.23%
\$75,000 to 99,999	22904	13.91%
\$100,000 or more	33764	20.50%
Total	164645	100.00%

Source: San Diego Association of Governments. *SANDAG Census Data – Households and Income, 2000*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG Census Data, 2000.

The median household income of the city of Escondido was \$42,567 according to the 2000 Census, up from \$33,279 in 1990.⁸⁷ During the three years spanning CalWORKs fiscal years between 1998/1999 and 2000/2001, 16.4 families out of 1,000 in the North Inland Region received CalWORKs. At that time, it had the third lowest rate of CalWORKs recipients of the six San Diego County regions.³¹

According to the US Census Bureau, in 2000, 7318 out of 123533 families, or 5.9% of all families in the North Inland Region had incomes below the federal poverty level for that year.

The most common type of household in the North Inland Region in 2000 was the family household with children, the majority of whom were married couples with children. The next most common type of household was the non-family, no children household.

Number of Households by Household Type, North Inland Region, 2000

Type of Household	Number of Households	%
Non family households	32057	15.58%
Other non family households	9055	4.40%
Non family households - no children	56181	27.30%
Non family no children	40463	19.67%
Family households with children	67352	32.73%
Non family with children	649	0.32%

Source: San Diego Association of Governments. *SANDAG Census Data – Households and Income, 2000*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG Census Data, 2000.

Regional Needs Assessment

This section provides information on how health issues are impacting children under age five in the North Inland Region. Data for each child health indicator are reviewed for the region and compared to national, state, and county data, as well as *Healthy People 2010* objectives, where available. Indicators related to developmental services, developmental screening, and well-baby/well-child checks are not listed due to insufficient data at the county and regional

levels. Where health issues were identified as a priority through key informant health interviews, North Inland Region community meeting participant feedback, and First 5 grantee surveys, this is noted.

Children are Born Healthy

Low Birthweight

Between 1998 and 2000, the North Inland Region had one of the lowest percentages of low birthweight births when comparing all six regions in the county. It was second only to the South Region where the number of low birthweight births was lowest. This is still a higher percentage of low birthweight than the *Healthy People 2010* target of 5.0%. However, the rate is lower than the county, state and national rates were in 2001.

1998-2000 Three-Year Average Comparison of Low Birthweight Rates Among Regions (Rates Per 1,000 Population)¹⁶

South	55
North Coastal	56
North Inland	56
North Central	60
East	61
Central	69

Source: Community Health Improvement Partners. (2002). *Charting the Course III, 2001: A San Diego County Health Needs Assessment*. San Diego, CA. Community Health Improvement Partners

Adequate Prenatal Care Use

In 1999, the North Inland Region had one of the lowest early prenatal care utilization rates along with the Central and North Coastal Regions. North Inland had the second lowest rate of prenatal care use of all regions, and was one of three regions with prenatal care use rates lower than the county and the state.

The rate of prenatal care use in the North Inland Region is also lower than the *Healthy People 2010* objective of an early prenatal care use rate of 90%. During the period of 1995-1999, rates of early prenatal care use in San Diego County

steadily improved in most county regions, including North Inland.

Percentage of Women Initiating Prenatal Care During First Trimester by State, County, and Region, 1999

State	82.2%
County	80.3%
South	80.1%
North Coastal	72.3%
North Inland	79.6%
North Central	90.2%
East	85.9%
Central	76.0%

Source: California Department of Health Services. (2000) *Live Births by Trimester Prenatal Care Began, California Counties and Selected City Health Departments, 1999*, from birth records. Retrieved December 10, 2003 from:

<http://www.dhs.ca.gov/hisp/chs/OHIR/vssdata/1999data/99ch2pdf/2-33-99vJC.pdf>

Community Health Improvement Partners. (2002). *Charting the Course III, 2001: A San Diego County Health Needs Assessment*. San Diego, CA. Community Health Improvement Partners

Births to Teen Mothers

The teen birth rate in the North Inland Region as of 1999 was 22.6 per 1000, lower than the county, state or national level. There is no *Healthy People 2010* objective for teen birth rates. The teen birth rate varies substantially by region in San Diego County as shown in the table below.

1999 Teen Birth Rates (per 1000 teens, ages 15-17)

San Diego County	43.0
State	48.1
National	48.5
South	35.4
North Coastal	24.3
North Inland	22.6
North Central	11.0
East	21.4
Central	45.1

Source: California Department of Health Services. (2003) *Birth Rates by Year of Age for Teenage Mothers, 2001*, from birth records. Retrieved December 10, 2003 from:

http://www.dhs.ca.gov/hisp/chs/OHIR/vssdata/2001data/01Ch2pdf/2_29_2001.pdf

Community Health Improvement Partners. (2002). *Charting the Course III, 2001: A San Diego County Health Needs Assessment*. San Diego, CA. Community Health Improvement Partners

Smoking During Pregnancy

No data are available for rates on smoking during pregnancy by region in San Diego

County.⁷⁸ However, the county’s rate of smoking during pregnancy falls short of the *Healthy People 2010* objective of 10 per 1,000 population.^{18, 49} The county rate is also higher than the state rate of 98 per 1,000 population.^{53,54}

National rates of smoking during pregnancy cannot be directly compared to state rates because data for smoking during pregnancy in California were not collected in National Center for Health Statistics’ standard format and are therefore not easily compared.⁷⁹

Rates of Smoking During Pregnancy Per 1,000 Population

San Diego County	111
State	98
Health People 2010 Objective	10

Sources: U.S. Department of Health and Human Services. (2000, November) *Healthy People 2010*, 2nd ed. Washington, D.C.: U.S. Government Printing Office.

Schumacher, J. (2003, December 17). Personal communication with the Center for Health Improvement.

Maternal and Child Health Branch, California Department of Health Services. Maternal and Infant Health Assessment Survey (MIHA), 2000.

California Department of Health Services, Tobacco Control Section. (n.d.). *Smoking during pregnancy*. Retrieved December 15, from

<http://www.dhs.ca.gov/tobacco/documents/Pregnancy.pdf>

Maternal and Child Health Branch, California Department of Health Services. Maternal and Infant Health Assessment Survey (MIHA), 2000.

Children Receive Preventive and Ongoing Regular Health Care

Childhood Immunizations

No regional information on childhood immunizations is currently available. However, in San Diego County in 2002, children received timely immunization at the following rates.²⁵

Estimated Vaccination Coverage with Individual Vaccines Among Children 19-35 Months of Age, San Diego County, 2002 (rate per 1000 population)

Vaccine	Rates
4+DTaP	830
3+Polio	872
1+MMR	901
3+Hib	918
3+HepB	867
1+Var	878
3+PCV	470

Source: Centers for Disease Control and Prevention, National Immunization Program. (2003) Estimated Vaccination Coverage with Individual Vaccines and Selected Vaccination Series Among Children 19-35 Months of Age by State and Immunization Action Plan Area US, *National Immunization Survey, Q1/2002-Q4/2002*. Retrieved December 15, 2003 from: <http://www.cdc.gov/nip/coverage/default.htm>

San Diego County does not meet *Healthy People 2010* objectives for diphtheria-tetanus-acellular pertussis (4+DtaP), Polio (3+), hepatitis B (3+Hep B), or varicella (1+Var).¹⁸

Regular Medical Home

The 2001 California Health Interview Survey found that 713 per 1000 children age zero to five in San Diego County went to a doctor's office, an HMO, or Kaiser for their usual source of care, and are therefore considered to have a regular medical home. For their usual source of care 279 per 1000 went to a community clinic or a community hospital.²⁸

There are no data available on the rate of children with a medical home by San Diego County regions, aged zero to five. However, there are data available for children aged 0-18. In 2001, the North Inland Region had the third highest number of parents reporting that their children had primary care providers, at a rate of 882 per 1000. This rate has increased steadily since 1999, from 871 per 1000.¹⁶

Rate of Children Who Have Someone Their Parent Considers Their Primary Care Provider, 1999-2001 (rates per 1000 population)

Region	1999	2000	2001
N. Coastal	826	871	871
N. Central	911	909	847
Central	766	775	788
South	798	828	911
East	883	881	909
N. Inland	871	870	882

Source: Community Health Improvement Partners. (2001) *Charting the Course III: A San Diego Health Needs Assessment*. San Diego, Ca: Author.

None of the San Diego County regions meet the *Healthy People 2010* objective for having a regular primary care provider for children aged 0-17, of 97%.

Health Insurance

There are no San Diego County regional data available for children age zero to five. However, there are regional data available for children aged 0-18. In 2001, the North Inland region saw an increase in health insurance coverage from 1999, from 85.5% to 87.3% of children covered.¹⁶ However, the region had the second lowest rate of health insurance coverage in 2001 of all regions, and lower than the San Diego County percentage of 88.7%. In San Diego County in 2001, there were no regions that met the *Healthy People 2010* objective of health insurance for 100% of the population. This issue was identified as a priority issue by key informants, First 5 grantees, and community meeting attendees in the North Inland region.

Percentage of Households with Children Aged 0-18 Reporting Health Insurance Coverage San Diego County, 1999-2001

Region	1999	2000	2001
San Diego County	85.9	88.8	88.7
N. Coastal	82.0	88.3	89.2
N. Central	91.2	95.4	95.3
Central	80.7	85.0	79.7
South	84.0	84.2	88.8
East	92.0	91.8	91.3
N. Inland	85.5	87.4	87.3

Source: Community Health Improvement Partners. (2001) *Charting the Course III: A San Diego Health Needs Assessment*. San Diego, Ca: Author.

Children are in Healthy and Safe Environments

Confirmed Cases of Child Abuse

Compared to national and California state rates of substantiated child abuse for children ages 17 years and younger, San Diego County regions all rank higher per 1,000. National substantiated child abuse rates are less than 2 per 1000 and the California state child abuse rate is just above 2 per 1000. The North Inland Region has the second lowest rate of substantiated cases of child abuse of the six regions in the county at 11.5 per 1000. While this is not nearly as high as the Central Region with the highest rate at 25.1 per 1000, it's substantially higher than the state and national rates.

2000-2001 Two Year Average Substantiated Cases of Child Abuse for San Diego Residents Aged 17 Years and Younger (rates per 1000 population)^{31, 32}

National	1.24
State	2.1*
San Diego County (overall)	15.2
South	11.9
North Coastal	12.5
North Inland	11.5
North Central	7.6
East	18.2
Central	25.1

*1996 data included for comparison

Sources: County of San Diego Health and Human Services Agency. (2002). San Diego County Child and Family Health & Well-Being Report Card. San Diego, CA: County of San Diego Health and Human Services Agency. Retrieved on November 15, 2003, from <http://www.co.sandiego.ca.us/cnty/cntydepts/health/services/rptcard/index.html>. National Clearinghouse on Child Abuse and Neglect Information, National Adoption Information Clearinghouse. Child Maltreatment 2001: Summary of Key Findings. Retrieved on December 16th, 2003 from: <http://nccanch.acf.hhs.gov/pubs/factsheets/canstats.cfm>

While the *Healthy People 2010* does not have an objective for substantiated cases of child abuse, child abuse is a *Healthy People 2010* priority as demonstrated by the objective to reduce maltreatment and maltreatment fatalities of children under age 18 years.

Recurrence of Child Maltreatment

No regional data are available regarding the recurrence of child maltreatment. However, a new Quality Assurance Unit is being developed within the County Child Welfare Department which will be able to provide some disaggregated data on this health issue.

The average recurrence rate of child maltreatment in San Diego County for children age zero to five years old is 11%. The rate of recurrence for all of California is the same. Nationally, the U.S. Department of Health and Human Services reports that 8.9% of child abuse and neglect victims experience a recurrence.

Nonfatal Unintentional Injuries

Although region specific information is not available, some community specific information

for certain types of accidental injuries is available. One of the highest injury rates to occupants of motor vehicles, for example, occurs in the more rural regions of San Diego County. In the more dense regions, high rates of injury to occupants of motor vehicles were reported in Poway, a city in the North Inland Region (6.62 per 1000). One of the highest rates among sub-regional areas for overdose/poisoning was found in the North Inland community of Fallbrook (0.8 per 1000).

Statewide, there were 8,004 nonfatal hospitalized injuries in 2000 for the total population. There were 617 nonfatal hospitalized injuries in San Diego County in 2001 for children age zero to four. Incidents at both the county and state have decreased since 1999.

Children are Healthy and Well Nourished

Breastfeeding

Regional data are not tracked in San Diego County. However, three hospitals in the North Inland Region, reported percentages of women who were doing any breastfeeding, as well as women who were exclusively breastfeeding upon discharge in fiscal year 2000-2001. The three hospitals in the North Inland Region (Pomerado, Fallbrook, and Palomar Medical Center) reported the following rates of any breastfeeding or exclusive breastfeeding.

San Diego County In-Hospital Breastfeeding Rates, 2000-2001

Hospital	% any breastfeeding	% exclusively breastfeeding
Scripps Memorial Hospital Encinitas	95%	82%
Paradise Valley Hospital	92%	68%
Pomerado Hospital	92%	82%
Fallbrook Hospital	91%	50%
Palomar Medical Center	89%	56%
Tri-City Medical Center	89%	59%
Scripps Memorial Hospital Chula Vista	88%	42%
UCSD Medical Center	87%	64%
Grossmont Hospital	86%	62%
Kaiser-San Diego	85%	56%
Alvarado Hospital	78%	41%

Source: California Department of Health Services, Maternal and Child Health Branch, Epidemiology and Evaluation Section, Genetic Disease Branch. (2002) *2000-2001 Hospital Breastfeeding Tables*. Retrieved December 15, 2003 from: [http://www.mch.dhs.ca.gov/documents/pdf/2000-2001HospitalBreastfeedingTables\(Madera-Yolo\).pdf](http://www.mch.dhs.ca.gov/documents/pdf/2000-2001HospitalBreastfeedingTables(Madera-Yolo).pdf)

The tables below illustrate how these rates differed by ethnicity.

Fallbrook Hospital, 2000-2001

Ethnicity	% any breastfeeding	% exclusively breastfeeding
African American	N/A	N/A
Asian/Pacific Islander	N/A	N/A
Hispanic	91%%	39%
Native American	N/A	N/A
Other/Multiple Races	86%	N/A
White, non-Hispanic	93%	72%

Source: California Department of Health Services, Maternal and Child Health Branch, Epidemiology and Evaluation Section, Genetic Disease Branch. (2002) *2000-2001Hospital Breastfeeding Tables*. Retrieved December 15, 2003 from: [http://www.mch.dhs.ca.gov/documents/pdf/2000-2001HospitalBreastfeedingTables\(Madera-Yolo\).pdf](http://www.mch.dhs.ca.gov/documents/pdf/2000-2001HospitalBreastfeedingTables(Madera-Yolo).pdf)

Palomar Medical Center, 2000-2001

Ethnicity	% any breastfeeding	% exclusively breastfeeding
African American	71%	45%
Asian/Pacific Islander	78%	41%
Hispanic	90%	51%
Native American	N/A	N/A
Other/Multiple Races	86%	60%
White, non-Hispanic	89%	69%

Source: California Department of Health Services, Maternal and Child Health Branch, Epidemiology and Evaluation Section, Genetic Disease Branch. (2002) *2000-2001Hospital Breastfeeding Tables*. Retrieved December 15, 2003 from: [http://www.mch.dhs.ca.gov/documents/pdf/2000-2001HospitalBreastfeedingTables\(Madera-Yolo\).pdf](http://www.mch.dhs.ca.gov/documents/pdf/2000-2001HospitalBreastfeedingTables(Madera-Yolo).pdf)

Pomerado Hospital, 2000-2001

Ethnicity	% any breastfeeding	% exclusively breastfeeding
African American	90%	67%
Asian/Pacific Islander	94%	77%
Hispanic	90%	76%
Native American	N/A	N/A
Other/Multiple Races	94%	82%
White, non-Hispanic	93%	86%

Source: California Department of Health Services, Maternal and Child Health Branch, Epidemiology and Evaluation Section, Genetic Disease Branch. (2002) *2000-2001Hospital Breastfeeding Tables*. Retrieved December 15, 2003 from: [http://www.mch.dhs.ca.gov/documents/pdf/2000-2001HospitalBreastfeedingTables\(Madera-Yolo\).pdf](http://www.mch.dhs.ca.gov/documents/pdf/2000-2001HospitalBreastfeedingTables(Madera-Yolo).pdf)

In San Diego County, the rate of women exclusively breastfeeding at the time of hospital discharge in 2000 was 590 per 1000 women, while the rate of women breastfeeding at all was 880 per 1000 women.

National data for 2000 indicate that 684 per 1000 women breastfed while in the hospital, while 314 per 1000 were still breastfeeding their infants at six months of age.⁴³ *Healthy People 2010* objectives for breastfeeding are that 75% of infants are breastfed during the early postpartum period, 50% at six months, and 25% at one year of age.¹⁸

Range of Expected Weight for Height and Age

In San Diego County in 2002, the rate of underweight for children aged 0-59 months was 65 per 1000, and the rate of overweight was 139 per 1000 among children who were included in the CDC Pediatric Nutrition Surveillance. Therefore, the rate of expected weight for height and age for children aged 0-59 months was 796 per 1000⁴⁴. The San Diego County rate for underweight is higher than the state and national rates, and the rate of overweight is higher than the national rate but lower than the state rate. Both rates exceed *Healthy People 2010* objectives.

2002 Pediatric Nutrition Surveillance, Underweight and Overweight Rates for Children aged 0-59 months (per 1000)

Location	Underweight Total	Overweight Total
San Diego County	65	139
California	53	162
United States	54	135
<i>Healthy People 2010</i>	50	50

Sources: Centers for Disease Control and Prevention. (2003) *2002 Pediatric Nutrition Surveillance*. Retrieved December 22, 2003 from: <http://www.dhs.ca.gov/pcfh/cms/onlinearchive/pdf/chdp/informationnotices/2003/chdpin03q/contents.htm>, U.S. Department of Health and Human Services. (2000, November) *Healthy People 2010*, 2nd ed. Washington, D.C.: U.S. Government Printing Office.

There are no regional data available for San Diego County on child underweight rates.⁸⁰ However, in San Diego County, the most prevalent age group found to be underweight were children aged 0-11 months. This was found to decline as children became older. Black infants were most likely to be underweight. However, by age 24-59 months, the rate of underweight was relatively the same for all ethnicities.

In San Diego County, the issue of overweight was found to affect children younger than age five at a greater rate than did underweight. Among children aged 0-23 months, Hispanic children were found to be the most likely to be affected by overweight, while among children aged 23-59 months, Native American children were the most likely to be affected by overweight.⁴⁴

Children have Good Oral Health

Annual Dental Exams

While no data are available for children 0-5 on the percentage of children that receive annual dental exams, there are data available for children under the age of 18. Seventy-four percent of children younger than 18 years in the North Inland Region had received dental care in the past 12 months according to United Way data compared in 2002. Seventy-three percent of children in San Diego County had received dental care in the previous 12 months. This was far higher than either the state rate of 56%, or the national rate of 66%.

2002 Comparison Data – Percentage of Residents Under Age 18 Receiving Dental Care in the Past 12 Months⁴⁵

National	66%
State	56%
San Diego County	73%
South	72%
North Coastal	71%
North Inland	74%
North Central	80%
East	74%
Central	69%

Source: United Way of San Diego County. (2002). *Outcomes & Community Impact Program: Medical Security (Report 24)*. San Diego, CA: United Way of San Diego County. Available online at <http://www.unitedway-sd.org/2002reports.html>.

The *Healthy People 2010* objective target is that 56% of children ages 2-17 receive annual dental exams. This health issue was identified as a priority through key informant health interviews, North Inland Region community meeting participant feedback, and First 5 grantee surveys.

Dental Insurance

Twenty-five percent of California’s preschool and elementary school age children and 40% of high school age children have no dental insurance.⁴⁸ Slightly more than 70% of San Diego County households reported children with dental insurance.⁴⁷ In the North Inland Region, 72% of children under 18 are reported to have dental insurance, a significantly higher rate than that of the state, but slightly lower than the county. Of all six regions, North Inland has the third highest rate as illustrated in the table below.

Percentage of San Diego County Residents Age 18 and Younger Who Are Reported to Have Dental Insurance⁴⁵

San Diego County	71%
South	68%
North Coastal	67%
North Inland	72%
North Central	81%
East	74%
Central	64%

Source: United Way of San Diego County. (2002). *Outcomes & Community Impact Program: Medical Security (Report 24)*. San Diego, CA: United Way of San Diego County. Retrieved November 15, 2003, from <http://www.unitedway-sd.org/2002reports.html>.

Children are Free of Smoking-related Illnesses

Childhood Asthma

The North Inland Region has the third lowest rate of asthma-related hospitalizations compared to any other region in the county. It meets the *Healthy People 2010* objective of 2.5 hospitalizations per 1,000.

Asthma-related Hospitalization Comparisons for Children Aged 0-4, 2002*⁸¹ (rates per 1000 population)

North Coastal	1.7
North Central	2.3
North Inland	2.5
<i>Healthy People 2010</i>	2.5
County	2.8
East	2.9
South	3.2
Central	4.3

* Rates per 1,000 population

Source: San Diego County Health and Human Services Agency, Community Epidemiology Asthma Related Hospitalizations Among San Diego County Residents, 1999-2002, Age Group by Region. Source: California Office of Statewide Health Planning & Development, 1999-2002 Patient Discharge Data. Rates calculated using SANDAG January 1, 1999 revised estimates and January 1, 2000, 2001, and 2002 estimates. Prepared by Community Epidemiology.

Summary of Health Needs

Core Assumptions

To summarize the health needs for the North Inland Region of San Diego County, the needs assessment included data from the 18 health issue summaries, grantee surveys, key informant interviews, and participant feedback and surveys from the North Inland Regional Community Meeting. This meeting included 20 participants representing 18 different organizations, including but not limited to, organizations such as the Children's Hospital – Anderson Center, San Diego Choice Program, Hope Infant Program, Palomar/Pomeroado Health, Neighborhood Healthcare Program, Dental Health Initiative/Share the Care Program, and regional county staff representation.

Several core assumptions underscore the health needs in the North Inland Region.

First, needs assessment participants feel all 18 of the health issues are critical to children's health and as such, are not hierarchical but interdependent.

Second, while each health issue is described distinctly in the issue summaries and via the data, respondents did not differentiate overlapping needs related to the health issues. Therefore, when identifying needs, trends or when making recommendations, respondents often bundled health insurance and regular medical home, dental insurance and annual dental examinations and developmental screening and developmental services.

Finally, children's mental health is acknowledged as a key component of overall health. However, the scope of this needs assessment purposefully did not address children's mental health as a separate planning effort is currently underway in San Diego County related to children's mental health.

Needs that Emerged from the Data

In the North Inland Region, the most pressing health needs when looking at the data alone include the number of women initiating adequate prenatal care (in the first trimester) and the incidents of child abuse.

Needs Identified by Stakeholders and Key Informants

Three different priorities emerged when grantee surveys, regional community meeting results, and key informant interviews were analyzed however.

A North Inland Regional Community Meeting was held and participants were asked to identify their top three health issues by region related to the 18 identified children's health issues for the county. They worked in small groups to gain

consensus on the top three health needs for the region. Individual survey responses from grantees identifying health needs were also aggregated for the region. The top three health needs impacting the North Inland Region according to these groups include:

- ☒ Children having health insurance with continuous coverage
- ☒ Children in the expected weight for their height and age, and
- ☒ Children having regular dental care

When key informants were asked what they felt were the top children's health needs for the region were, they concurred with the above list as well.

School Readiness Implications

Each of the identified health issues can have a negative impact on a child's ability to learn and be prepared for kindergarten. Health insurance allows children to receive necessary preventive care services, such as vaccinations that can prevent disease.¹⁶ Risks related to sub-standard oral health that can result from a lack of access to regular oral health care include pain, inability to eat comfortably or chew well, and distraction from play and learning.⁴⁸

An overweight child who maintains overweight into adolescence has a 50% chance of becoming an obese adult. Short-term health effects from obesity include several heart disease risk factors, including high blood pressure and high cholesterol, sleep apnea, and various orthopedic, respiratory, and skin disorders. Overweight children are also at risk for type II diabetes, which was once only seen in adults, but is now seen in children with increasing regularity. Complications associated with this disease are kidney disease, blindness and amputation. Long-term health problems associated with obesity include cardiovascular disease, gallbladder disease, osteoarthritis, stroke, and colon and breast cancer.⁸²

Assets Assessment

Over the past several years, San Diego County has demonstrated an ongoing commitment to improving the lives of children by creating the *Report Card of Child and Family Well-Being (Report Card)*. The *Report Card* tracks 20 key indicators to determine the county's progress in a number of health-related areas. While not specific to children 0-5, this has been an important asset in determining San Diego County's health priorities.

Several major county agencies/departments serve children, including the Health and Human Services Agency (HHSA), and the county's Public Safety Group (specifically the Probation Department, District Attorney's Office Juvenile Division, and Public Defender's Office). These are the core agencies with substantial budget commitments to children. Although these assets are countywide, they impact each region and in fact these county agencies were identified as assets during many of the regional community meetings.

In the North Inland Region a number of assets were identified either in surveys, by key informants or during regional community meetings. The identified assets were organized into four categories: programs and services, organizations, collaborations and systems.

Programs and Services

The following programs and services were identified by grantees and regional community meeting participants as assets for children 0-5 and their families in the North Inland Region.

- Family based nutrition
- Home visiting
- Parent education
- Communication through community outreach
- Childhood obesity prevention
- Health education/outreach activities
- Healthy Families
- Mobile Clinic

- Migrant Education
- Early Start - Hope Infant Program
- Parent Resource Center
- New Alternatives
- District Attorney Representation - Paternity Issues
- Home Start
- Lifeline
- Welcome Baby Program
- Panarama Teen Center
- First 5 Resource Center
- State Preschool
- Healthy Smiles
- School Readiness Program of the Escondido Union School District
- Homeless Services program of the Escondido Union School District
- Welcome Baby Teeth
- United Way Infoline
- Children's Care Connection
- Early Start
- Legal Aide - Consumer Advocate Program

Organizations

The organizations below were also identified as assets for children and families in the North Inland Region.

- InterFaith
- Navy Relief
- YMCA
- Women, Infants, and Children Program
- Center for Community Solutions
- VISTA Community Clinic
- Children's Hospital
- Fallbrook Family Health Center
- Local churches in Fallbrook
- HeadStart / Early Head Start
- Urgent care centers
- Boys and Girls Club
- HHSA
- Regional Center

Collaborations

There are many collaborative efforts throughout the North Inland Region as well as willingness among agencies to link clients with services more efficiently and effectively. Specific collaborations identified by grantees and regional community meeting participants include the following.

- North County Collaboratives
- San Diego Child & Family Health and Well-Being Report Card
- Community Based Organizations and Faith-Based Organizations Collaboration
- City of Escondido's involvement in creating low-income housing
- Agencies and services willing and able to work with families in all North county regions
- Community Action for Escondido
- HHSA North Inland Business Plan Collaboration
- Warner Springs & Julianne Healthy Start
- Child Assessment Network North (CANN)
- Gateway
- Pomorado Health Initiative
- Student Attendance Review Board (teen pregnancy / 0-5 as siblings)
- North County Health Link (School and Public Health Nurses)
- North Inland Health Access Collaborative (First 5)

Systems

Systems that were identified as assets for children's health by grantees and regional community meeting participants in the North Inland Region include:

- Data systems
- Health care network including Community Health Centers, Clinics and hospitals
- Vista Family History Center (part of a system of centers where families can find their ancestry)
- 2-1-1 Line forthcoming

- Public Health Nurses and their strength, knowledge, and dedication

Some assets listed by grantees and regional community meeting participants described characteristics of the people living in or providing services to children and families in the North Inland Region. The following list identifies those assets.

Community Characteristics

- Awareness of importance of serving children prior to school entry
- North Inland is gearing up toward linking children to needed services Stronger system of care in North Coastal and North Inland.
- Desire to not just identify needs, but link children and families to needed services
- Family-oriented population

Assets According to Key Informants

In addition to the assets identified during regional community meetings and surveys, key informants in the North Inland Region identified several additional assets including the Black Infant Health Program, San Diego Kids Health Access Network (KHAN), and out stationed eligibility technicians at hospitals who assist individuals and families with enrollment in public assistance programs.

The Children’s Mental Health program, dental providers serving patients at some community clinics and the Safe Community Collaboration, a collaboration of faith-based organizations that partner to provide foster children with blankets, clothes and other needs were identified as assets. Foster families themselves were additionally mentioned as well as Parish Nurses who work through faith-based organizations.

A parent advisory committee, vision and hearing services and Spanish-speaking people were also identified as assets by key informants.

Emerging Trends

Grantees, key informants and regional meeting participants were each asked to identify emerging trends that directly or indirectly impact the 18 health issues.

Emerging trends described either positive or negative impacts on the North Inland Region. The top five negative trends identified in surveys and at the regional community meeting include:

- State budget cuts impacting all services for children and families (especially health insurance)
- Decreased number of health and dental care providers due to low reimbursement rates
- Increased childhood obesity and diabetes
- Increased lack of quality, affordable housing for families
- Increased number of families under stress and without support

Among the more positive trends noted in the North Inland Region were better collaboration among agencies, an increased number of early screening and intervention services, and increased media attention focusing on children 0-5. Also mentioned were increased breastfeeding knowledge and support, increased immunization rates, and increased asthma monitoring. More agencies providing services for children age zero to five was additionally mentioned.

Key Informants

Trends impacting children’s health that were noted by key informants in the North Inland Region included that children enrolled in publicly sponsored health insurance programs are not accessing health care. An increased number of children with poor nutrition and dental care habits leading to serious dental care needs once those children receive care. Also noted was a rise in domestic violence and an increase in the number of children with developmental disabilities.

Data Issues

Data on certain child health indicators were not available and, therefore, was not included in this report. For some indicators, no data were available, while for a few indicators, data specifically for children age zero to five were not available. Those indicators for which data was not available were as follows.

Data Unavailable by Region

- Smoking During Pregnancy
- Childhood Immunizations
- Well Checks
- Developmental Screening
- Developmental Services
- Recurrence of Child Maltreatment
- Expected Weight for Height and Age

Data Unavailable for Children 0-5 by Region

- Regular Medical Home
- Health Insurance
- Confirmed Cases of Child Abuse
- Annual Dental Exams
- Dental Insurance

County and regional data for developmental services, developmental screening, and well-baby/well-child checks are not available, and therefore, not listed in the “needs assessment” section of this chapter. Some information on these issues is included in the countywide section of this report.

While regional data is available for nonfatal unintentional injuries by major statistical area (MSA) and sub-regional area (SRA) for patients under the age of 20,⁶ data on children 0-5 by *county* region is not available.

Regional data on breastfeeding are not tracked in San Diego County; however, some hospitals in the county track the rate of women breastfeeding “exclusively” or “at all” by hospital at the time of discharge.

Though data are available by region with regards to asthma-related hospitalizations from 1999-2002, trends are difficult to assess because beginning in 2001, the Office of Statewide Planning and Development began masking a portion of the identifying variables (including age) to protect patient confidentiality. Due to this masking, data cannot reliably be compared over the four-year span between 1999 and 2002. County epidemiology staff have raised this issue with state government staff.⁵⁶

Finally, SANDAG collects data by age using 0 to 4 while First 5 is interested in data for children under age 6, which again leads to a difficulty in reliably comparing data.

Grantees, key informants and regional community meeting participants were also asked what data related issues they see. Grantees and regional meeting participants would like to see the following data issues addressed.

- Establish consistent outcomes across programs to a) establish baselines; b) improve communication between providers as well as with funders and data analysts; c) compare what works and what does not; and d) utilize for case management across the region.
- Disaggregate data by ethnicities and regions because those groups have different needs within the different regions.
- Track the number of families referred to services that then receive or access them.
- Measure patient satisfaction in well-care, urgent care and dental care (i.e., brevity, waiting time, attention).

Additional feedback regarding data issues included that there is a disconnect between data collectors and service providers’ understanding of the rationale behind outcomes. A need to educate service providers and grantees about

outcomes measurement was identified. Doing this would help set the context by providing rationale and teaching providers to consider how services can be provided more efficiently and effectively. Service providers could then consider evaluation needs when planning and providing services to children and families.

North Inland Priorities

At the end of the regional community meeting, participants were asked to identify priorities regarding children’s health issues in the North Inland Region. Many of the identified priorities are linked with several health issues and focus on early prevention and intervention. The North Inland Regional Community Meeting participants identified the following priorities.

Low birthweight
Rationale: Low birthweight is associated with long-term disabilities, such as cerebral palsy, autism, mental retardation, vision and hearing impairments, and other developmental disabilities. ¹⁶ Many of these long-term disabilities could have an impact on a child’s readiness for school.
Free Parent education
Rationale: Good parenting and help to be good parents is increasingly seen as a solution to a range of social problems alongside actions to reduce inequality.
Coordination of services
Rationale: Coordinating services for families allows them to access needed services more easily and prevents duplication of services.
Oral Health

Rationale: Children experience pain and suffering when their dental needs are neglected. ⁸⁸ Health care costs increase when cavities and tooth decay are ignored. In addition, poor oral health may prevent normal eating, sleeping, speaking, and learning. ⁴⁷
Unintentional injuries
Unintentional injuries cause lost quality of life from pain and loss of motor and/or cognitive function. ⁸⁹ Moreover, mild brain injury can result in problems with memory, learning and future school performance.
Breastfeeding
Rationale: Breast milk is the most complete nutrition for infants, and children who are breastfed tend to be less likely to be overweight later in life. Breastfed children also seem to have greater brain development than non-breastfed children, which can affect a child's performance in school ⁹⁰ .
Maximizing the opportunity for new parents’ learning right after the birth of a child
Rationale: The emotional vulnerability, hopefulness as well as despair experienced by many new parents may result in more openness to learning. The child’s risk of abuse and neglect is also reduced when early intervention and education are administered.

6.0-REGIONAL PROFILE: SOUTH

Between 2003 and 2030, the population in the South Region will continue to increase, but at a continually slower rate. By 2030, the rate of population increase will be slower than the rates for San Diego County and for California. In 2030, it is estimated that the total population will be 588,810.

Demographics

Total Population

In 2003, approximately 426,453 people lived in the South Region of San Diego County. The South Region has the fewest number of residents of all of the county regions.⁷² From 2001-2003, the total population grew by approximately 7.7%. This rate of growth is more than twice the San Diego County rate of growth for the same period, at 3.7%.^{74,72}

Total Population Growth, 2001-2003

	2001	2003	% Increase
South Region	396,003	426,453	7.7%
San Diego County	2,856,000	2,961,579	3.7%

Sources: San Diego Association of Governments. *SANDAG January 1 Population Estimates, 2001*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG January 1 Population Estimates All Ages by Gender by Region. San Diego Association of Governments. *SANDAG January 1 Population Estimates, 2003*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG January 1 Population Estimates All Ages by Gender by Region.

Population Forecasts for the South Region, San Diego County, and California, 2010-2030

Year	2010	2020	2030
Population Forecast, South Region	498,198	562,769	588,810
% increase	16.8%	13.0%	4.6%
Population Forecast, San Diego County	3,211,721	3,528,605	3,855,085
% increase	8.4%	9.9%	9.3%
Population Forecast, California	39,957,616	45,448,627	51,868,655
% increase	15.3% ^{vii}	13.7%	14.1%

Source: San Diego Association of Governments. *SANDAG Population Forecast, 2010-2030*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG Population Forecast, 2010-2030.

California Department of Finance. (2001) *Population Projections*. Available online at:

<http://www.dof.ca.gov/HTML/DEMOGRAP/projca.pdf>

The average household size in the region was 3.14 persons in 2001, which is projected to rise to 3.31 persons per household in 2020.⁹¹

Age and Gender

In the South Region there were 114,958 children aged 0-17 in 2003. Of this number, 29,228 children were between the ages of zero and four, which represents over 25% of all children under age 18. Children age zero to four represent 6.9% of the total population. Among children age zero to four, there were 14,376 males and 14,852 females. Between 2001 and 2003, the population of children age zero to four increased from 27,800, or by 5.1%.^{74,72}

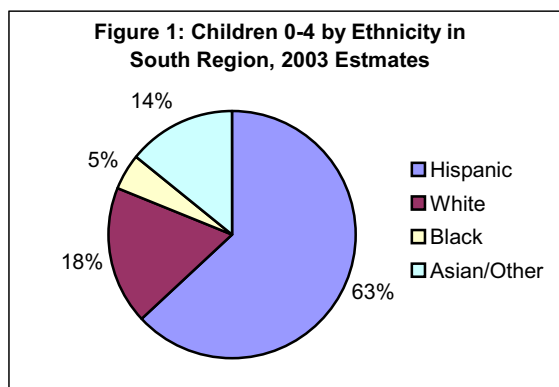
In 2003, there were 216,836 males and 209,617 females, which represent 50.8% and 49.2% of the total population, respectively.⁷² The median

^{vii} Baseline population from year 2000: 34,635,395

age in 2001 was 31.5 years, and is expected to increase to 34.2 in 2020. This is younger than the median age for San Diego County, 34.8 years of age in 2001, which is projected to be 36.4 in 2020.⁹¹

Ethnicity

The majority (63%) of the population age zero to four in the South Region was Hispanic in 2003, followed by White (18%), Asian or other (14%) and Black (5%).



Source: San Diego Association of Governments. *SANDAG January 1 Population Estimates, 2003*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG January 1 Population Estimates All Ages by Gender by Region.

From 2001-2003, the total Hispanic population for the region increased 8.6%, the total white population increased 4.1%, the total black population increased 10.3%, and the total Asian/other population increased 10.6%. For children age zero to four, the Hispanic population increased 5.8%, the white population increased 5.4%, the black population increased 6.1%, and the Asian/other population increased 1.9%.^{92,93}

Between 2010 and 2030, the total population for the South Region will increase over 18%. The greatest rates of population increase will be seen in the Hispanic, Black, and Pacific Islander populations (39%, 24%, and 75%, respectively), while the White population will see a significant population decrease, by 45%.

Total Population Forecast by Ethnicity, South Region, 2010-2030

South	2010	2020	2030	% change from 2010 to 2030
Total (all races and ethnicities)	498198	562769	588810	18.19%
Hispanic	276414	342065	385074	39.31%
White	111967	90811	61110	-45.42%
Black	22397	26199	27794	24.10%
American Indian or Alaska Native	1757	2031	2086	18.73%
Asian	61378	67773	69239	12.81%
Hawaiian or other Pacific Islander	6747	9253	11823	75.23%
Other	3404	6773	10798	217.22%
Two or more races	14134	17864	20886	47.77%

Source: San Diego Association of Governments. *SANDAG Population Forecast by Age and Ethnicity, 2010-2030*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG Population Forecast, 2010-2030.

Among children age zero to four, from 2010 to 2030, the total population will decrease by around 6%, with decreasing population levels also seen among White, American Indian, and Asian children. The greatest rates of increase will occur among Pacific Islander children, and children who are categorized as "other" or as "two or more races."

Population Forecast by Ethnicity for Children Aged 0-4, South Region, 2010-2030

South	2010	2020	2030	% change from 2010 to 2030
Total (all races and ethnicities)	34088	34421	31913	-6.38%
Hispanic	21928	23225	22142	0.98%
White	5048	3914	2466	-51.15%
Black	1651	1907	1843	11.63%
American Indian or Alaska Native	67	68	53	-20.90%
Asian	4110	3463	3237	-21.24%
Hawaiian or other Pacific Islander	278	296	318	14.39%
Other	422	692	993	135.31%
Two or more races	584	856	861	47.43%

Source: San Diego Association of Governments. *SANDAG Population Forecast by Age and Ethnicity, 2010-2030*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG Population Forecast, 2010-2030.

Households and Income

The 2000 Census reported that the median household income for the South region was \$43,884, which is slightly lower than the San Diego County median income of \$47,268, and is also lower than the California median income, at \$47,493. More than 40% of households in the region have an annual income lower than \$35,000.

Number of Households by Household Income Category, South Region, 2000

Household income	Number of Households	% of total households
Less than \$10,000	9781	8.25%
\$10,000 to \$14,999	7315	6.16%
\$15,000 to \$24,999	15544	13.11%
\$25,000 to \$34,999	16714	14.08%
\$35,000 to \$49,999	20196	17.03%
\$50,000 to \$74,999	23378	19.71%
\$75,000 to 99,999	12394	10.45%
\$100,000 or more	13288	11.21%
Total	118610	100.00%

Source: San Diego Association of Governments. *SANDAG Census Data – Households and Income, 2000*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG Census Data, 2000.

Within the South region, there are additional disparities in household income. In zip code 91915 (Eastlake Greens), household income in 2000 was \$76,346, while in the city of San Ysidro, the median household income was \$27,943. In the region there are 121 housing units that are operated by the County Housing Authority for low-income families, for which there is an average wait time of two to six years.⁹¹

According to the US Census Bureau, in 2000, 10,080 out of 91,428 families, or 11% of the families in the South Region, had incomes lower than the federal poverty level.

In 2000, the most common type of household in the South Region was the family household with children, followed by the non-family, no children household.

Number of Households by Household Type, South Region, 2000

Type of Household	Number of Households	%
Non family households	21228	14.56%
Other non family households	5954	4.08%
Non family households - no children	35745	24.52%
Non family no children	26759	18.35%
Family households with children	55683	38.19%
Non family with children	423	0.29%

Source: San Diego Association of Governments. SANDAG Census Data – Households and Income, 2000. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG Census Data, 2000.

Regional Needs Assessment

This section provides information on how health issues are impacting children under age five in the South Region. Data for each child health indicator is reviewed for the region and compared to national, state and county data, as well as Healthy People 2010 objectives, where available. Indicators related to developmental services, developmental screening, and well-baby/well-child checks are not listed due to insufficient data at the county and regional levels. Where health issues were identified as a priority by key informants, regional community meeting participants, and First 5 grantees, this is noted.

Children are Born Healthy

Low Birthweight

In 1999, the South Region had the lowest rate of low birth weight of all of the county regions, at 52 per 1000. This rate is lower than the San Diego County, state, and national rates, but is

slightly higher than the *Healthy People 2010* target of 50 per 1000.

1999 Comparison Data (Rates Per 1,000 Population)¹⁶

Healthy People objective	50
National	79
State	61
County	59
South	52
North Coastal	55
North Inland	55
North Central	58
East	58
Central	74

Source: Community Health Improvement Partners. (2001) *Charting the Course III: A San Diego Health Needs Assessment*. San Diego, Ca: Author.

Adequate Prenatal Care Use

In 1999, the South region had the third highest rate of early prenatal care initiation, after the North Central and East regions, at 80.1% or 801 per 1000. During the period of 1995-1999, rates of early prenatal care use in San Diego County steadily improved in most county regions, including the South region.

Percentage of Women Initiating Prenatal Care During the First Trimester by Region, San Diego County, 1995-1999¹⁶

Region	1995	1996	1997	1998	1999
North Coastal	74.7	75.2	72.7	70.5	72.3
North Central	88.2	89.7	89.1	89.6	90.2
Central	70.0	72.1	72.8	72.5	76.0
South	73.1	76.4	76.5	78.9	80.1
East	83.1	84.7	84.3	84.7	85.9
North Inland	76.8	77.6	77.0	78.9	79.6

Source: Community Health Improvement Partners. (2001) *Charting the Course III: A San Diego Health Needs Assessment*. San Diego, Ca: Author.

However, the early prenatal care use rate in the South Region was slightly lower than the San Diego County rate and lower than the state rate in 1999. The South region rate of early prenatal care use also falls short of the *Healthy People 2010* target of 90% or 900 per 1000.

Percentage of Women Initiating Prenatal Care During the First Trimester by State, County, and Region, 1999¹⁶

Healthy People 2010 objective	90
State	82.2
County	80.3
South	80.1
North Coastal	72.3
North Inland	79.6
North Central	90.2
East	85.9
Central	76.0

Source: Community Health Improvement Partners. (2001) *Charting the Course III: A San Diego Health Needs Assessment*. San Diego, Ca: Author.
Births to Teen Mothers

Between 1995-1999, the teen birth rate declined in all regions in San Diego County, including the South region. However, in 1999, the South region had the second highest teen birth rate of all county regions, at 35.4 births per 1000 teens. This issue was identified as a priority by key informants, First 5 grantees, and community meeting attendees.

1999 Teen Birth Rates (per 1000 teens, ages 15-17)¹⁶

Region	1995	1996	1997	1998	1999
South	44.7	41.7	37.4	37.7	35.4
North Coastal	37.4	38.6	28.9	27.4	24.3
North Inland	26.4	26.1	23.0	20.5	22.6
North Central	17.0	16.9	14.6	12.4	11.0
East	26.2	25.2	22.1	20.2	21.4
Central	60.6	63.0	52.7	49.8	45.1

Source: Community Health Improvement Partners. (2001) *Charting the Course III: A San Diego Health Needs Assessment*. San Diego, Ca: Author.

In 1999, the teen birth rate in the South region was higher than the rates for San Diego County and for the state.

1999 Teen Birth Rates (per 1000 teens, ages 15-17)¹⁶

State	30.4
County	28.0
South	35.4
North Coastal	24.3
North Inland	22.6
North Central	11.0
East	21.4
Central	45.1

Source: Community Health Improvement Partners. (2001) *Charting the Course III: A San Diego Health Needs Assessment*. San Diego, Ca: Author.
California Department of Health Services. (2003) *Birth Rates by Year of Age for Teenage Mothers, 2001*, from birth records. Retrieved December 10, 2003 from: http://www.dhs.ca.gov/hisp/chs/OHIR/vssdata/2001data/01Ch2p df/2_29_2001.pdf

Smoking During Pregnancy

There are no data available for rates on smoking during pregnancy by region.⁷⁸ However, the San Diego County rate of smoking during pregnancy is 111 per 1000 women, which is higher than the Healthy People 2010 objective of 10 per 1000 women, and higher than the state rate of 98 per 1000. National rates of smoking during pregnancy cannot be directly compared to state rates because data for smoking during pregnancy in California were not collected in National Center for Health Statistics' standard format and are therefore not easily compared.⁷⁹

Rates of Smoking During Pregnancy Per 1,000 Population

National	122*
County	111
State	98
Health People 2010 Objective	10

Sources: U.S. Department of Health and Human Services. (2000, November) *Healthy People 2010*, 2nd ed. Washington, D.C.: U.S. Government Printing Office. Schumacher, J. (2003, December 17). Personal communication with the Center for Health Improvement. Maternal and Child Health Branch, California Department of Health Services. Maternal and Infant Health Assessment Survey (MIHA), 2000. California Department of Health Services, Tobacco Control Section. (n.d.). *Smoking during pregnancy*. Retrieved December 15, from <http://www.dhs.ca.gov/tobacco/documents/Pregnancy.pdf> Maternal and Child Health Branch, California Department of Health Services. Maternal and Infant Health Assessment Survey (MIHA), 2000.

Children Receive Preventive and Ongoing Regular Health Care

Childhood Immunizations

No regional data on immunization rates in San Diego County are available at this time.⁹⁴ However, in San Diego County in 2002, children received timely immunization at the following rates:²⁵

Estimated Vaccination Coverage with individual Vaccines Among Children 19-35 Months of Age, San Diego County, 2002 (rates per 1000 population)

Vaccine	Rate
4+DTaP	830
3+Polio	872
1+MMR	901
3+Hib	918
3+HepB	867
1+Var	878
3+PCV	470

Source: Centers for Disease Control and Prevention, National Immunization Program. (2003) Estimated Vaccination Coverage with Individual Vaccines and Selected Vaccination Series Among Children 19-35 Months of Age by State and Immunization Action Plan Area US, *National Immunization Survey, Q1/2002-Q4/2002*. Retrieved December 15, 2003 from: <http://www.cdc.gov/nip/coverage/default.htm>

San Diego County does not meet Healthy People 2010 objectives (90% vaccinated) for 4+DtaP, 3+Polio, 3+Hep B, or 1+Var.

Regular Medical Home

The 2001 California Health Interview Survey found that 713 per 1000 children age zero to five in San Diego County went to a doctor's office, an HMO, or Kaiser for their usual source of care, and are therefore considered to have a regular medical home. For their usual source of care 279 per 1000 went to a community clinic or a community hospital.²⁸

There are no data available on the rate of children with a medical home by San Diego County regions, aged zero to five. However, there are data available for children aged 0-18. In 2001, the region with the greatest number of parents reporting that their children had primary care providers was the South region, at a rate of 911 per 1000, which was also the region that experienced the greatest increase since 1999, by 14%.¹⁶

Rate of Children Who Have Someone Their Parent Considers Their Primary Care Provider, 1999-2001 (rates per 1000 population)

Region	1999	2000	2001
N. Coastal	826	871	871
N. Central	911	909	847
Central	766	775	788
South	798	828	911
East	883	881	909
N. Inland	871	870	882

Source: Community Health Improvement Partners. (2001) *Charting the Course III: A San Diego Health Needs Assessment*. San Diego, Ca: Author.

None of the San Diego County regions meet the Healthy People 2010 objective for having a regular primary care provider for children aged 0-17, of 97%. This issue was identified as a

priority issue by key informants, First 5 grantees, and community meeting attendees in the South region.

Health Insurance

There are no San Diego County regional data available for children age zero to five. However, there are regional data available for children aged 0-18. In 2001, the South region saw an increase in health insurance coverage from 1999, from 840 per 1000 to 888 per 1000.¹⁶ However, the region had the third lowest rate of health insurance coverage in 2001 of all regions. In San Diego County in 2001, there were no regions that met the Healthy People 2010 objective of health insurance for 100% of the population. This issue was identified as a priority issue by key informants, First 5 grantees, and community meeting attendees in the South region.

Percentage of Households with Children Aged 0-18 Reporting Health Insurance Coverage San Diego County, 1999-2001

Region	1999	2000	2001
San Diego County	85.9	88.8	88.7
N. Coastal	82.0	88.3	89.2
N. Central	91.2	95.4	95.3
Central	80.7	85.0	79.7
South	84.0	84.2	88.8
East	92.0	91.8	91.3
N. Inland	85.5	87.4	87.3

Source: Community Health Improvement Partners. (2001) *Charting the Course III: A San Diego Health Needs Assessment*. San Diego, Ca: Author.

Children Are in Healthy and Safe Environments

Confirmed Cases of Child Abuse

The South region had the third lowest rate of substantiated cases of child abuse at 11.9 per 1000, after the North Central and North Inland Regions. The South region rate is lower than the overall county rate of 15.2 per 1000.

2000-2001 Two Year Average Substantiated Cases of Child Abuse for San Diego Residents Aged 17 Years and Younger (rates per 1000 population)^{31, 32}

National	12.4
State	20.5*
San Diego County (overall)	15.2
South	11.9
North Coastal	12.5
North Inland	11.5
North Central	7.6
East	18.2
Central	25.1

*1996 data included for comparison

Sources: County of San Diego Health and Human Services Agency. (2002). San Diego County Child and Family Health & Well-Being Report Card. San Diego, CA: County of San Diego Health and Human Services Agency. Retrieved on November 15, 2003, from <http://www.co.san-diego.ca.us/cnty/cntydepts/health/services/rptcard/index.html>. National Clearinghouse on Child Abuse and Neglect Information, National Adoption Information Clearinghouse. Child Maltreatment 2001: Summary of Key Findings. Retrieved on December 16th, 2003 from: <http://nccanch.acf.hhs.gov/pubs/factsheets/canstats.cfm>

Recurrence of Child Maltreatment

There are no specific regional data available at this time. However, a new Quality Assurance Unit is being developed within the County Child Welfare Department which will be able to provide some disaggregated data on this health issue.

The average recurrence rate of child maltreatment in San Diego County for children age zero to five is 11%. The rate of recurrence for all of California is the same. Nationally, the U.S. Department of Health and Human Services reports that 8.9% of child abuse and neglect victims experience a recurrence.

Nonfatal Unintentional Injuries

Though data by region on non-fatal unintentional injuries are unavailable, information on the major causes of unintentional injury by San Diego County region, either major statistical area (MSA) or sub-regional area (SRA) for patients under the age of 20, is available.⁴⁰

Statewide there were 7,664 nonfatal hospitalized injuries in 2001, and there were 617 nonfatal hospitalized injuries in San Diego County in 2001, or a rate of 3 per 1000, for children age zero to four.^{34,74} Incidents at both the county and state levels have decreased since 1999. Chula Vista, which is in the South Region, reported the third highest pedestrian crash rate in the county, at 0.7 per 1000. This is an urban area with a high level of commuter traffic. Coronado reported the highest rate of pedalcyclist injury (bicycle) at a rate of 2.73 per 1000, and the highest rate of sports related injury countywide at 4.92 per 1000, which was twice that of the next highest rate.⁴⁰

Children are Healthy and Well-Nourished

Breastfeeding

In San Diego County, the rate of women breastfeeding exclusively or at all is tracked by hospital at the time of discharge, and is not available by county region.⁴¹ The hospitals that track breastfeeding rates at discharge in the South region are Paradise Valley Hospital and Scripps Memorial Hospital, Chula Vista.

Scripps Memorial Hospital, Chula Vista had the second lowest rate of exclusive breastfeeding of all San Diego County hospitals in 2000-2001 (42%). Paradise Valley Hospital had the third highest exclusive breastfeeding rate, at 68%. The rate of exclusive breastfeeding at Scripps Memorial Hospital, Chula Vista was lower than the overall county rate of 590 per 1000 women, while the rate at Paradise Valley Hospital was higher. The Healthy People 2010 objective is that at least 75% of women breastfeed during the early postpartum period.

San Diego County In-Hospital Breastfeeding Rates, 2000-2001⁴¹

Hospital	% any breastfeeding	% exclusively breastfeeding
Alvarado Hospital	78%	41%
Fallbrook Hospital	91%	50%
Grossmont Hospital	86%	62%
Kaiser-San Diego	85%	56%
Palomar Medical Center	89%	56%
Paradise Valley Hospital	92%	68%
Pomerado Hospital	92%	82%
Scripps Memorial Hospital Chula Vista	88%	42%
Scripps Memorial Hospital Encinitas	95%	82%
Tri-City Medical Center	89%	59%
UCSD Medical Center	87%	64%

Source: California Department of Health Services, Maternal and Child Health Branch, Epidemiology and Evaluation Section, Genetic Disease Branch. (2002) *2000-2001 Hospital Breastfeeding Tables*. Retrieved December 15, 2003 from: [http://www.mch.dhs.ca.gov/documents/pdf/2000-2001HospitalBreastfeedingTables\(Madera-Yolo\).pdf](http://www.mch.dhs.ca.gov/documents/pdf/2000-2001HospitalBreastfeedingTables(Madera-Yolo).pdf)

Each hospital also tracks breastfeeding rates at time of discharge by ethnicity. At Paradise Valley Hospital, African American women had the lowest rate of exclusive breastfeeding, and at Scripps Memorial Hospital, Chula Vista, women of other or multiple races had the lowest rate of exclusive breastfeeding. Hispanic women had the highest rate of exclusive breastfeeding at both hospitals at 42%. This was also the rate for exclusive breastfeeding among Asian or Pacific Islander women at Scripps Memorial Hospital, Chula Vista.

Paradise Valley Hospital, 2000-2001

Ethnicity	% any breastfeeding	% exclusively breastfeeding
African American	67%	42%
Asian/Pacific Islander	89%	56%
Hispanic	95%	72%
Native American	N/A	N/A
Other/Multiple Races	91%	71%
White, non-Hispanic	78%	62%

Source: California Department of Health Services, Maternal and Child Health Branch, Epidemiology and Evaluation Section, Genetic Disease Branch. (2002) *2000-2001 Hospital Breastfeeding Tables*. Retrieved December 15, 2003 from: [http://www.mch.dhs.ca.gov/documents/pdf/2000-2001HospitalBreastfeedingTables\(Madera-Yolo\).pdf](http://www.mch.dhs.ca.gov/documents/pdf/2000-2001HospitalBreastfeedingTables(Madera-Yolo).pdf)

Scripps Memorial Hospital, Chula Vista, 2000-2001

Ethnicity	% any breastfeeding	% exclusively breastfeeding
African American	72%	N/A
Asian/Pacific Islander	87%	42%
Hispanic	89%	42%
Native American	N/A	N/A
Other/Multiple Races	79%	35%
White, non-Hispanic	80%	41%

Source: California Department of Health Services, Maternal and Child Health Branch, Epidemiology and Evaluation Section, Genetic Disease Branch. (2002) *2000-2001 Hospital Breastfeeding Tables*. Retrieved December 15, 2003 from: [http://www.mch.dhs.ca.gov/documents/pdf/2000-2001HospitalBreastfeedingTables\(Madera-Yolo\).pdf](http://www.mch.dhs.ca.gov/documents/pdf/2000-2001HospitalBreastfeedingTables(Madera-Yolo).pdf)

Range of Expected Weight for Height and Age

In San Diego County in 2002, the rate of underweight for children aged 0-59 months was 65 per 1000, and the rate of overweight was 139 per 1000 among children who were included in the CDC Pediatric Nutrition Surveillance. Therefore, the rate of expected weight for height and age for children aged 0-59 months was 796 per 1000⁴⁴. The San Diego County rate for underweight is higher than the state and national rates, and the rate of overweight is higher than the national rate but lower than the state rate. Both rates exceed *Healthy People 2010* objectives.

Pediatric Nutrition Surveillance, Underweight and Overweight Rates for Children aged 0-59 months, 2002 (per 1000)

Location	Underweight Total	Overweight Total
San Diego County	65	139
California	53	162
United States	54	135
<i>Healthy People 2010</i>	50	50

Sources: Centers for Disease Control and Prevention. (2003) *2002 Pediatric Nutrition Surveillance*. Retrieved December 22, 2003 from: <http://www.dhs.ca.gov/pcfh/cms/onlinearchive/pdf/chdp/informationnotices/2003/chdpin03q/contents.htm>, U.S. Department of Health and Human Services. (2000, November) *Healthy People 2010*, 2nd ed. Washington, D.C.: U.S. Government Printing Office.

There are no regional data available for San Diego County on child underweight rates.⁸⁰ However, in San Diego County, the most prevalent age group found to be underweight were children aged 0-11 months. This was found to decline as children became older. Black infants were most likely to be underweight. However, by age 24-59 months, the rate of underweight was relatively the same for all ethnicities.

In San Diego County, the issue of overweight was found to affect children younger than age five at a greater rate than did underweight. Among children aged 0-23 months, Hispanic children were found to be the most likely to be affected by overweight, while among children aged 23-59 months, Native American children were the most likely to be affected by overweight.⁴⁴

Children Have Good Oral Health

Annual Dental Exams

While there are no regional data available for children age zero to five on annual dental exams, there are data available for children aged 0-18. In 2002, the South region had the third lowest percentage of children who receive regular dental exams, at 72%, which is slightly lower than the overall percentage for the county at

73%. However, the percentage of children receiving regular dental exams in the South region is higher than both the state and national rates for 2002. This percentage is also higher than the *Healthy People 2010* objective of 56% of children aged 2-17 receiving annual dental care. This issue was identified as a priority issue by key informants, First 5 grantees, and community meeting attendees in the South region.

2002 Comparison Data-Percentage of Residents Under Age 18 Receiving Dental Care in Past 12 Months⁴⁵

National	66%
State	56%
San Diego County	73%
South	72%
North Coastal	71%
North Inland	74%
North Central	80%
East	74%
Central	69%

Source: United Way of San Diego County. (2002). Outcomes & Community Impact Program: Medical Security (Report 24). San Diego, CA: United Way of San Diego County. Retrieved November 15, 2003, from, <http://www.unitedway-sd.org/2002reports.html>.

Dental Insurance

In San Diego County in 2002, 70.7% of households reported children with dental insurance. The rate in the South Region is somewhat lower than this rate, at 68%. The South region had the third lowest rate of dental insurance coverage for children aged 18 and younger for all county regions, only higher than the Central and North Coastal regions. This issue was identified as a priority issue by key informants, First 5 grantees, and community meeting attendees in the South region.

Percentage of San Diego County Residents Age 18 and Younger Who Are Reported to Have Dental Insurance⁴⁵

San Diego County	71%
South	68%
North Coastal	67%
North Inland	72%
North Central	81%
East	74%
Central	64%

Source: United Way of San Diego County. (2002). Outcomes & Community Impact Program: Medical Security (Report 24). San Diego, CA: United Way of San Diego County. Retrieved November 15, 2003, from <http://www.unitedway-sd.org/2002reports.html>

Children are Free of Smoking-related Illnesses

Childhood Asthma

The South Region has the second highest rate of asthma hospitalizations of all county regions, at 3.2 per 1000. This rate is higher than the San Diego County rate of 2.8 per 1000, and is higher than the *Healthy People 2010* objective of 2.5 per 1000.

Asthma-related Hospitalization Comparisons for Children Aged 0-4, 2002^{*55}

N Coast	1.7
N Central	2.3
N Inland	2.5
Healthy People 2010	2.5
County	2.8
East	2.9
South	3.2
Central	4.3

* Rates per 1,000 population

Source: County of San Diego Health and Human Services Agency, Community Epidemiology. (Data tables). Asthma Related Hospitalizations Among San Diego County Residents, 1999-2002, Age Group by Region. Source: California Office of Statewide Health Planning & Development, 1999-2002 Patient Discharge Data. Rates calculated using SANDAG January 1, 1999 revised estimates and January 1, 2000, 2001, and 2002 estimates. Prepared by Community Epidemiology.

Summary of Health Needs

Core Assumptions

To summarize the health needs for the South Region of San Diego County, the needs assessment included data from the 18 health issue summaries, grantee surveys, key informant interviews, and participating feedback and surveys from the South Regional Community Meeting. This meeting included 28 participants representing 20 different organizations, including but not limited to, organizations such as the Chicano Federation of San Diego County, San Ysidro Health Center, Family HELP Project, Healthcare Association of San Diego and Imperial Counties, National City Collaborative, Paradise Valley Hospital, Emory Elementary School, Chula Vista Elementary School District, and regional county staff representation.

Several core assumptions underscore the health needs in the South Region.

First, needs assessment participants feel all 18 of the health issues are critical to children's health and as such, are not hierarchical but interdependent.

Second, while each health issue is described distinctly in the issue summaries and via the data, respondents did not differentiate overlapping needs related to the health issues. Therefore, when identifying needs, trends or when making recommendations, respondents often bundled health insurance and regular medical home, dental insurance and annual dental examinations and developmental screening and developmental services.

Finally, children's mental health is acknowledged as a key component of overall health. However, the scope of this needs assessment purposefully did not address children's mental health as a separate planning effort is currently underway in San Diego County related to children's mental health.

Needs that Emerged from the Data

In the South Region, the most pressing health needs when looking at the data alone include lowering the teen birth rate, lowering the asthma hospitalization rate and improving the number of children receiving annual dental exams.

Needs Identified by Stakeholders and Key Informants

However, several different priorities emerged when grantee surveys, regional community meeting results, and key informant interviews were analyzed.

A South Regional Community Meeting was held and participants were asked to identify their top three health issues by region related to the 18 identified children's health issues for the county. They worked in small groups to gain consensus on the top three health needs for the region. Individual survey responses from grantees identifying health needs were also aggregated for the region.

The top three health needs impacting the South Region according to these groups include:

- Children have a regular medical home and have health insurance
- Children have access to regular dental care and dental insurance
- Lowering the teen birth rate

When key informants were asked what they felt were the top children's health needs for the region, they concurred with the above list as well.

School Readiness Implications

These health needs can have significant school readiness implications. Lack of care can delay diagnosis of health problems or can exacerbate existing health conditions. Receiving regular health care services can promote school readiness because ill health and physical or developmental problems can impede academic

and social development, for instance, by leading to increased absenteeism.¹

Poor oral health may prevent normal eating, sleeping, speaking, and learning.⁴⁷ Lack of dental coverage prohibits access to most dental care, which leaves children vulnerable to risks related to poor oral health, including pain, inability to eat comfortably or chew well, and distraction from play and learning.

Finally, infants born to teen mothers are more likely to have a low birth weight; the low birth weight rate among babies born to teens is 21% higher than that for babies of women ages 20-24. Children who are born at a low birth weight are more likely to have problems such as hyperactivity or dyslexia, which can affect performance in school. In addition, children of teen parents are 50% more likely to repeat a grade, typically perform worse on standardized tests, and are less likely to graduate from high school.^{95, 16}

Assets Assessment

Over the past several years, San Diego County has demonstrated an ongoing commitment to improving the lives of children by creating the *Report Card of Child and Family Well-being*. The *Report Card* tracks 20 key indicators to determine the county's progress in a number of health-related areas. While not specific to children 0-5, this has been an important asset in determining San Diego County's health priorities.

Several major county agencies/departments serve children, including the Health and Human Services Agency (HHSA), and the county's Public Safety Group, (specifically the Probation Department, District Attorney's Office Juvenile Division, and the Public Defender's Office). These are the core agencies with substantial budget commitments to children. Although these assets are countywide, they impact each region

and in fact these county agencies were identified as assets during many of the regional community regions.

The South Region is home to the Family Resource Center in Chula Vista, which provides several services to region residents, including eligibility determination for CalWorks and Medi-Cal. The Family Resource Center also provides food stamps for eligible residents and access to funding through the General Relief program, which is a state program that provides "last resort" financial assistance to indigent county residents.

The Public Health Center in Chula Vista provides several clinical services and public health nursing programs to improve child health. Clinical services include well-child exams and immunizations given at the Child Health and Youth Clinic; additional immunization services provided at the Immunization Clinic; tuberculosis testing and treatment; testing and treatment for most sexually transmitted diseases; and pregnancy tests (which can be covered by presumptive Medi-Cal eligibility for qualifying residents). Public Health Nursing Special Programs include prenatal assessment and case management for high risk pregnant women; the Health Infant Program, which is a postpartum intervention program for up to one year after delivery for mothers who used drugs and alcohol during pregnancy; a tuberculosis case management program; and referrals for prevention or follow-up of child abuse and neglect, Sudden Infant Death Syndrome follow-up, prenatal care and postpartum guidance, and communicable disease follow-up.

Children's Services in National City and Chula Vista provides several child social services, including a child abuse hotline, court intervention services, development of long-term plans for children who are not reunited with their families after abuse intervention, and family preservation services.

California Children Services (CCS) has several locations throughout the South region, and is a statewide health care program that provides coverage for chronic, severe medical conditions. CCS provides Medical Therapy Units and licensed physical and occupational therapists who provide evaluation, treatment, consultation services, and case management services for children and young adults with cerebral palsy, spina bifida, and other neurological and musculoskeletal disorders.

Finally, the Office of Violence Prevention provides several services, including:

- Youth violence prevention efforts through skill-building education;
- Coordination of domestic violence review and response teams;
- Coordination of a domestic violence hotline;
- Coordination of domestic violence shelters and case management services.⁹¹

In the South Region a number of assets were identified either in surveys, by key informants or during regional community meetings. The identified assets were organized into four categories: programs and services, organizations, collaborations, and systems.

Programs and Services

The following programs and services were identified by grantees and regional community meeting participants as assets for children 0-5 and their families in the South region.

- Healthy Steps
- Welcome Baby Kits
- School Health Programs/Nurses
- Special Education Services through school districts
- Sight for Students
- Head Start
- Healthy Families
- SR - PAT
- San Diego Children's Program
- WOW mobile - video/book

- Women, Infants, and Children Program/AIM
- FLIGHT
- Public Health Nurses
- ECS Head start
- ECE Programs – home visiting, preschools, parent education, mobile vans
- Teen parenting programs through schools
- Male involvement program for teen fathers

Organizations

The organizations below were also identified as assets for children and families in the South Region.

- San Ysidro Community Clinics
- Paradise Valley Hospital
- Scripps
- Children's
- Sharp Hospital
- Public Health Department
- Catholic Charities
- MAAC Project
- YMCA childcare resource center
- South Bay Community Service
- Boys and Girls Club
- UCP - Toy Lending Library
- Elks Club
- Kiwanis
- Lions
- Shriners
- Union of Pan Asian Communities (UPAC)
- Chicano Federation
- HHSA - Public Health
- San Ysidro Health Center
- San Diego Regional Center for Developmentally Disabled
- Hope Infant Program through COE

Collaborations

There are many collaborative efforts throughout the South Region as well as willingness among agencies to link clients with services more efficiently and effectively. Specific

collaborations identified by grantees and regional community meeting participants include the following:

- Chula Vista Collaborative
- National City Collaborative
- Partnership for the Public's Health
- Partnership for Prevention
- Exceptional Family Center and 12 Family Resource Centers (neighborhood based)
- Perinatal Network
- Breastfeeding Coalition
- Network of Community Collaboratives
- School Health Innovative Programs (Chula Vista, Sweetwater, etc.- to keep kids in school)
- Health Services Advisory Committee (three times a year for South Bay)
- Episcopal Community Service

Systems

Systems that were identified as assets for children's health by grantees and regional community meeting participants in the South Region include:

- Gateway
- Regional Centers
- Children's Service Bureau
- CCS
- South Western College
- Police/Fire departments
- Domestic Violence Response Team
- Tijuana Medical Service
- Libraries/Lending library
- School Nurses
- Community Clinics

Community Characteristics

Some assets listed by grantees and regional community meeting participants described characteristics of the people living in or providing services to children and families in the South Region. The following list identifies those assets:

- More Health facilities in the community

- More attention to preventive health care
- More information provided in different languages
- American Lung Association Asthma Initiative
- Willingness of community members to learn about ways to keep children safe
- Free immunizations at centers/clinics

Assets according to Key Informants

In addition to the assets identified during regional community meetings and surveys, key informants in the South region identified several additional assets, including local dentists who provide free services to low-income students, a school behavioral specialist, a speech therapist, and Off to a Good Start and Por La Vida, both of which offer parenting classes that address nutrition.

Emerging Trends

Grantees, key informants and regional meeting participants were each asked to identify emerging trends that directly or indirectly impact the 18 health issues.

Emerging trends described either positive or negative impacts on the South Inland region. The negative trends identified in surveys and at the regional community meeting include:

- Lack of affordable housing
- Low-income families not able to afford insurance, less access to Healthy Families insurance
- A lot more culturally and linguistically appropriate information concerning children's health and resources available but not reaching all community members.
- More juvenile diabetes / overweight children
- More children entering school w/ undiagnosed developmental issues, longer waiting time to even obtain

developmental screenings / at the 3-5 year age group

- Increase in people crossing the border for services (medical, pharmacological)
- Decrease in reimbursement levels which leads to decrease in available providers
- Increase in emergency room use
- Decrease in availability of transportation for services
- Lack of collaboration/communication on available services, especially new programs
- Birth rates of Hispanics are rising compared to other ethnicities

A more positive trend noted in the South Region was that the region is aware of the importance of providing preventive health care services. Other positive trends include:

- Increase in security of health issues for second and third generation families
- Increase in community revitalization
- Increase in use of promotoras to improve community health

Key Informants

Trends impacting children's health that were noted by key informants in the South Region include an increase in overweight and obesity among children, as a result of more sedentary activity and a lack of physical education in schools, as well as an increase in the number of teenage mothers. Asthma is also more common among school children than in the past.

More children are being raised by grandparents or other relatives (other than parents) than before, and more households include three or more generations. In addition, homelessness has become a larger issue, as has access to health and dental insurance.

Several key informants also noted the increase in behavioral issues among young children, and an increase in speech difficulties. Some also noted

the difficulty of finding transportation to school for many children.

On a positive note, one informant noted the increased accessibility of local family resource centers, many of which are located on school campuses.

Data Issues

Data on certain child health indicators are not available and, therefore, cannot be included in this report. For some indicators, no data were available, while for a few indicators, data specifically for children ages 0-5 were not available. Those indicators are as follows.

No Regional Data At All

- Smoking During Pregnancy
- Childhood Immunizations
- Well Checks
- Developmental Screening
- Developmental Services
- Recurrence of Child Maltreatment
- Expected Weight for Height and Age

No Regional Data for Children 0-5

- Regular Medical Home
- Health Insurance
- Confirmed Cases of Child Abuse
- Annual Dental Exams
- Dental Insurance

County and regional data for developmental services, developmental screening, and well-baby/well-child checks are not available, and therefore, not listed in the “needs assessment” section of this chapter. Some information on these issues is included in the countywide section of this report.

While regional data is available for nonfatal unintentional injuries by major statistical area (MSA) and sub-regional area (SRA) for patients under the age of 20, data on children 0-5 by *county* region is not available.

Regional data on breastfeeding are not tracked in San Diego County; however, some hospitals in the county track the rate of women breastfeeding “exclusively” or “at all” by hospital at the time of discharge.

Though data are available by region with regards to asthma-related hospitalizations from 1999-2002, trends are difficult to assess because beginning in 2001, the Office of Statewide Planning and Development began masking a portion of the identifying variables (including age) to protect patient confidentiality. Due to this masking, data cannot reliably be compared over the four-year span between 1999 and 2002. County epidemiology staff have raised this issue with state government staff.⁵⁶

Finally, SANDAG collects data by age using 0-4, while First 5 is interested in data for children under age 6, which again leads to a disparity in data.

Grantees, key informants and regional community meeting participants were also asked what data-related issues they have identified. Grantees and regional meeting participants would like to see the following data issues addressed:

- The use of bench marking and results based accountability methods in order to link problem-solving with outcomes
- Causality issues/why things are the way they are (linkages)
- Identify barriers to accessing services or finding out what is not working

South Region Priorities

At the end of the regional community meeting, participants were asked to identify priorities. South Region attendees identified the following:

Special needs related to being a border county as traditional methods to improve access to services may not work.

Rationale: Border counties often have large immigrant populations, who disproportionately lack access to health care and receive fewer health services when compared to native-born citizens. Immigrants often do not have a usual source of care, and particularly for undocumented immigrants, fear and confusion can keep people from accessing services. Finally, linguistic and cultural barriers may keep immigrants from accessing services.^{viii}

Focus on recruiting/retaining local community members who are familiar with the region, to get education and remain or return to provide services

Rationale: Lay person community health promoters (often termed "promotoras") can be effective in providing health education services and outreach to the communities that they are from. Promoters are trained to provide information on various health issues, depending on the target community, and can be a link to other health care services. Promoters have been utilized successfully to address several health-related issues, including diabetes and asthma management, and reproductive health.^{ix}

Improved coordination of services in the region

^{viii} Kaiser Commission on Medicaid and the Uninsured. (2003, August) *Immigrants' Health Care Coverage and Access*. Retrieved March 16, 2004 from: <http://www.kff.org/uninsured>

^{ix} Pearlman, Eve. (2002, January-February) *Promotoras: Community Health Leaders*. Retrieved March 16, 2004 from: <http://www.4children.org/news/102promote.htm>

Rationale: Improved coordination of services in the region can prevent redundancy in service provision among different agencies and organizations. Improved coordination can also improve the care received and can ensure that children do not "fall through the cracks" when obtaining publicly funded health services.
Offer intervention/prevention services as early as possible (e.g. prenatal care)
Rationale: Early preventive services can prevent illness from occurring and can encourage long-term health. In the case of prenatal care, early prenatal care access can result in better pregnancy outcomes, if the mother is educated about issues such as proper nutrition, effects of drug and alcohol use, etc. In addition, early prenatal care can connect women to health services that can improve the child's health well past childhood (e.g. immunizations, Women, Infants, and Children Program, etc.) ^x
Create a health collaborative that would map resources and track health and service data, in order to bring stakeholders to the table to coordinate resources, using the East Region as a model.
Rationale: A health collaborative to map resources can help coordinate services for families and allow them to access needed services more easily. Such coordination may also prevent duplication of services.
Preserve funds for programs that are serving vulnerable populations' health needs.

Rationale: Vulnerable populations include anyone who cannot successfully integrate into the mainstream of health care resources, and can include chronically disabled or poor children, immigrants and undocumented workers, etc. If these populations cannot easily access health care, then they are reliant on programs that cover the gaps in service. Therefore, if these programs are not available, these populations do not have other options for accessing health care, and will likely suffer poorer health over the long-term. ^{xi}
Coordinate health care efforts with mental health care.
Rationale: Mental health is an important component to overall child health, and if mental health services are coordinated with physical health services, then it may be likely that more children may have access to needed mental health services.

^x American College of Obstetricians and Gynecologists & Women's Health Care Physicians. (2002, January) *Prenatal Care in the Community – How Eight Safety Net Hospital Systems are Managing Care for Low-income Women*. Washington, DC: ACOG

^{xi} Campos-Outcalt, D., Fernandez, R., Hollow, W., Lundeen, S., Nelson, K., Schuster, B., et. al. (1994) *Providing Quality Health Care to Vulnerable Populations*. Retrieved March 16, 2004 from: <http://www.primarycaresociety.org/1994d.htm>

7.0-REGIONAL PROFILE – CENTRAL REGION

Population forecasts indicate that the population growth rate for the Central Region will increase through 2030, when the population will be 640,706. Between 2003 and 2030, the rate of population growth for the Central Region will be 31%, greater than the population growth rates for both San Diego County and California.

Demographics

Total Population

Approximately 488,205 people lived in the Central Region in 2003, which is an average population size compared to other regions in the county.⁷² Over the past 10 years, the Central Region has generally grown significantly slower than the county as a whole. The Central Region has experienced a growth rate of 6.16%, compared to the county rate of 10.6%. However, in portions of the region covered by the 92115 and 92105 zip codes, the population has grown faster than the county average.⁹⁶ Between 2001 and 2003, the population grew at less than one-third the rate of San Diego County.

Population Growth for the Central Region, 2001-2003

	2000	2003	% increase
Central Region	483,055	488,205	1.1%
San Diego County	2,856,000	2,961,579	3.7%

Sources: San Diego Association of Governments. *SANDAG January 1 Population Estimates, 2001*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG January 1 Population Estimates All Ages by Gender by Region. San Diego Association of Governments. *SANDAG January 1 Population Estimates, 2003*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG January 1 Population Estimates All Ages by Gender by Region.

Total Population Forecast for the Central Region, 2010-2030

Year	2010	2020	2030
Population, Central region	512,187	560,181	640,706
% increase	4.9%	9.4%	14.4%
Population, San Diego County	3,211,721	3,528,605	3,855,085
% increase	8.4%	9.9%	9.3%
Population, California	39,957,616	45,448,627	51,868,655
% increase	15.3% ^{xii}	13.7%	14.1%

Source: San Diego Association of Governments. *SANDAG Population, 2010-2030*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG Population Forecast, 2010-2030.

California Department of Finance. (2001) *Population Projections*. Available online at:

<http://www.dof.ca.gov/HTML/DEMOGRAP/projca.pdf>

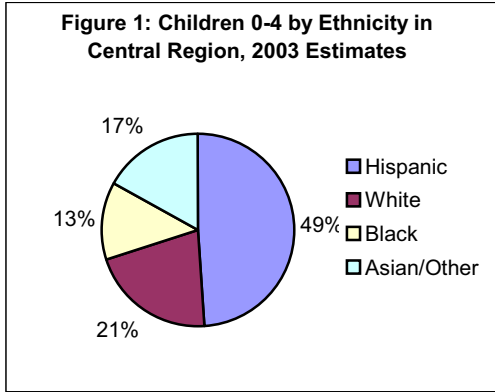
Age and Gender

Approximately 38,249 children age zero to four lived in the Central region in 2003—or 7.8% of the total regional population.⁷² Slightly more men than women of all ages live in the Central Region.⁷² Among children age zero to four, 50% are male and 50% are female.⁷² The median age in the region (29.6 years) is lower than the median age in the county (33.2 years).⁹⁶

Ethnicity

In 2003, the majority of children age zero to four in the Central Region were Hispanic.⁹³ Figure 1 on the next page shows a breakdown in the ethnic make-up of the population of children age zero to four in the region.

^{xii} Baseline population from year 2000: 34,635,395



Source: San Diego Association of Governments. *SANDAG January 1 Population Estimates, 2003*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG January 1 Standard Age Group by Race by Region

Currently, significant growth in the Hispanic population and slight growth in the Asian population is occurring in the Region.⁹⁶ This trend will continue through 2030. The only ethnic group that will not increase in population size by 2030 in the Central Region is the White population.

Population Forecast for Total Population, Central Region, 2010-2030

Central	2010	2020	2030	% Change, 2010-2030
Total (all races and ethnicities)	512186	560181	640706	25.09%
Hispanic	222014	261602	320627	44.42%
White	129646	130976	127902	-1.35%
Black	65936	61978	67488	2.35%
American Indian or Alaska Native	2179	2464	2730	25.29%
Asian	62973	64088	68336	8.52%
Hawaiian or other Pacific Islander	7686	10028	13693	78.16%
Other	4343	8037	13544	211.86%
Two or more races	17409	21008	26386	51.57%

Source: San Diego Association of Governments. *SANDAG Population Forecast by Age and Ethnicity, 2010-2030*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG Population Forecast, 2010-2030.

Among children age zero to four, all ethnic groups will increase in population with the exception of the White, Black, and Asian populations. The greatest number of children will continue to be of Hispanic ethnicity.

Population Forecast for Children Aged 0-4, Central Region, 2010-2030

Central	2010	2020	2030	% Change 2010-2030
Total (all races and ethnicities)	37098	37137	38597	4.04%
Hispanic	21997	22990	24687	12.23%
White	3750	3483	3169	-15.49%
Black	5150	4809	4366	-15.22%
American Indian or Alaska Native	135	157	151	11.85%
Asian	4305	3342	3157	-26.67%
Hawaiian or other Pacific Islander	458	500	601	31.22%
Other	616	931	1422	130.84%
Two or more races	687	925	1044	51.97%

Source: San Diego Association of Governments. *SANDAG Population Forecast by Age and Ethnicity, 2010-2030*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG Population Forecast, 2010-2030.

Draft

Households and Income

As reported in the *County of San Diego Health and Human Services Agency Central Region Business Plan*, the Central Region has a high concentration of incomes below poverty level. The median household income in 2000 was \$30,692, which was lower than the median income for the county in the same year, \$47,268, and was lower than the California median income at \$47,493, for 1999. In 2000, the poverty rate in the region was 19.22%, --more than double the county rate of 8.9% and more than triple the rate in all other regions in the county except the South Region.⁹⁶ The income category with the greatest number of households is households with incomes less than \$10,000/year.

Households by Income Category, Central Region, 2000

Household income	Number of Households	% of total households
Less than \$10,000	20,928	12.81%
\$10,000 to \$14,999	14,215	8.70%
\$15,000 to \$24,999	27,856	17.06%
\$25,000 to \$34,999	23,976	14.68%
\$35,000 to \$49,999	27,027	16.55%
\$50,000 to \$74,999	26,362	16.14%
\$75,000 to 99,999	11,331	6.94%
\$100,000 or more	11,650	7.12%
Total	163,345	100.00%

Source: San Diego Association of Governments. *SANDAG Census Data – Households and Income, 2000*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG Census Data, 2000.

Female-headed households with children 0-18 years of age are more common in the Central Region (10.9%) than in the county in general

(7.8%).⁹⁶ The most common type of household in the Central Region in 2000 was the "non family, no children" household, followed by family households with children.

Number of Households by Type, Central Region, 2000

Type of Household	Number of Households	%
Non family households	50,596	21.66%
Other non family households	19,690	8.43%
Non family households - no children	34,467	14.75%
Non family no children	69,602	29.79%
Family households with children	58,592	25.08%
Non family with children	684	0.29%

Source: San Diego Association of Governments. *SANDAG Census Data – Households and Income, 2000*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG Census Data, 2000.

Regional Needs Assessment

This section provides information on how health issues are impacting children under age five in the Central Region. Data for each child health indicator are reviewed for the region and compared to national, state, and county data, as well as Healthy People 2010 objectives, where available. Indicators related to developmental services, developmental screening, and well-baby/well-child checks are not listed due to insufficient data at the county and regional levels. Where health issues were identified as a priority by key informants, regional community meeting participants, and First 5 grantees, this is noted.

Children are Born Healthy

Low birthweight

Between 1998 and 2000, the percent of low birthweight births was higher in the Central Region than in other regions.¹⁶

1998-2000 Three-Year Average Comparison Data Among Regions (Rates Per 1,000 Population)¹⁶

South	55
North Coastal	56
North Inland	56
North Central	60
East	61
Central	69

Source: Community Health Improvement Partners. (2001) *Charting the Course III: A San Diego Health Needs Assessment*. San Diego, Ca: Author.

In 1999, the Central Region had the highest rate of low birthweight babies than any other region and was the only region to have a higher rate than the state and county averages. All regions had higher rates of low birthweight babies than the Healthy People 2010 target.¹⁶

1999 Comparison Data (Rates Per 1,000 Population)¹⁶

National	79
State	61
County	59
Central	74

Source: Community Health Improvement Partners. (2001) *Charting the Course III: A San Diego Health Needs Assessment*. San Diego, Ca: Author.

Adequate Prenatal Care Use

In 1999, the Central Region had one of the lowest early prenatal care utilization rates, significantly worse than the majority of other regions in San Diego County and the state.¹⁶

Percentage of Women Initiating Prenatal Care During the First Trimester, San Diego County, 1999

South	80.1%
North Coastal	72.3%
North Inland	79.6%
North Central	90.2%
East	85.9%
Central	76.0%

Source: Community Health Improvement Partners. (2001) *Charting the Course III: A San Diego Health Needs Assessment*. San Diego, Ca: Author.

During the period of 1995-1999, rates of early prenatal care use in San Diego County steadily improved in most county regions, including the Central Region.

Percentage of Women Initiating Prenatal Care in the First Trimester in the Central Region 1995-1999

	1995	1996	1997	1998	1999
Central	70.0%	72.1%	72.8%	72.5%	76.0%

Source: Community Health Improvement Partners. (2001) *Charting the Course III: A San Diego Health Needs Assessment*. San Diego, Ca: Author.

Percentage of Women Initiating Prenatal Care During the First Trimester by State, County, and Region, 1999

State	82.2%
County	80.3%
Central Region	76.0%

Source: Community Health Improvement Partners. (2001) *Charting the Course III: A San Diego Health Needs Assessment*. San Diego, Ca: Author.

Births to Teen Mothers

Though the teen birth rate has declined in the Central Region between 1995 and 1999, the Central Region had the highest teen birth rate in the county in 1999, with a rate of 45.1 per 1000.¹⁶

1999 Teen Birth Rates by Year and Region (per 1000 teens, ages 15-17)

Region	1995	1996	1997	1998	1999
South	44.7	41.7	37.4	37.7	35.4
North Coastal	37.4	38.6	28.9	27.4	24.3
North Inland	26.4	26.1	23.0	20.5	22.6
North Central	17.0	16.9	14.6	12.4	11.0
East	26.2	25.2	22.1	20.2	21.4
Central	60.6	63.0	52.7	49.8	45.1

Source: Community Health Improvement Partners. (2001) *Charting the Course III: A San Diego Health Needs Assessment*. San Diego, Ca: Author.

In 1999, the Central Region was one of only two regions with a higher rate of teen births than the county and state rates.^{16,77}

1999 Teen Birth Rates (per 1000 teens, ages 15-17)

State	30.4
County	28.0
Central	45.1

Source: Community Health Improvement Partners. (2001) *Charting the Course III: A San Diego Health Needs Assessment*. San Diego, Ca: Author.
California Department of Health Services. (2003) *Birth Rates by Year of Age for Teenage Mothers, 2001*, from birth records. Retrieved December 10, 2003 from: http://www.dhs.ca.gov/hisp/chs/OHIR/vssdata/2001data/01Ch2pdf/2_29_2001.pdf

Smoking During Pregnancy

No data are available for rates on smoking during pregnancy by region in San Diego County.⁷⁸ However, the county's rate of smoking during pregnancy falls short of the Healthy People 2010 objective of 10 per 1,000 population.^{18, 49} The county rate is also higher than the state rate of 98 per 1,000 population.^{53,54} National rates of smoking during pregnancy cannot be directly compared to state rates because data for smoking during pregnancy in California were not collected in National Center for Health Statistics' standard format and are therefore not easily compared.⁷⁹

Rates of Smoking During Pregnancy Per 1,000 Population

San Diego County	111
State	98
Health People 2010 Objective	10

Sources: U.S. Department of Health and Human Services. (2000, November) *Healthy People 2010*, 2nd ed. Washington, D.C.: U.S. Government Printing Office.
Schumacher, J. (2003, December 17). Personal communication with the Center for Health Improvement. Maternal and Child Health Branch, California Department of Health Services. Maternal and Infant Health Assessment Survey (MIHA), 2000.
California Department of Health Services, Tobacco Control Section. (n.d.). *Smoking during pregnancy*. Retrieved December 15, from <http://www.dhs.ca.gov/tobacco/documents/Pregnancy.pdf>
Maternal and Child Health Branch, California Department of Health Services. Maternal and Infant Health Assessment Survey (MIHA), 2000.

Children Receive Preventive and Ongoing Regular Health Care

Childhood Immunizations

No regional information on childhood immunizations is currently available. However, in San Diego County in 2002, children received timely immunizations at the following rates.²⁵

Estimated Vaccination Coverage with Individual Vaccines Among Children 19-35 Months of Age, San Diego County, 2002 (rate per 1000 population)

Vaccine	Rate
4+DTaP	830
3+Polio	872
1+MMR	901
3+Hib	918
3+HepB	867
1+Var	878
3+PCV	470

Source: Centers for Disease Control and Prevention, National Immunization Program. (2003) Estimated Vaccination Coverage with Individual Vaccines and Selected Vaccination Series Among Children 19-35 Months of Age by State and Immunization Action Plan Area US, *National Immunization Survey, Q1/2002-Q4/2002*. Retrieved December 15, 2003 from: <http://www.cdc.gov/nip/coverage/default.htm>

San Diego County does not meet *Healthy People 2010* objectives for diphtheria-tetanus-acellular pertussis (4+DtaP), Polio (3+), hepatitis B (3+Hep B), or varicella (1+Var).¹⁸

Draft

Regular Medical Home

There are no data available on the rate of children with a medical home by San Diego County regions, aged zero to five. However, there are data available for children aged 0-18. In 2001, the Central Region was least likely to report children having a regular primary care provider, at a rate of 788 per 1000. All regions, including the Central Region, report an increase in the number of parents reporting that their children had primary care providers between 1999 and 2001, with the exception of the North Central Region, which declined, and the North Coastal Region, which stayed the same.¹⁶ No region has yet met the *Healthy People 2010* objective for having a regular primary care provider for children aged 0-17. Key informants, First 5 grantees, and community meeting attendees in the Central region identified this issue as a priority issue.

Rate of Children Who Have Someone Their Parent Considers Their Primary Care Provider, 1999-2001 (rates per 1000 population)

Region	1999	2000	2001
N. Coastal	826	871	871
N. Central	911	909	847
Central	766	775	788
South	798	828	911
East	883	881	909
N. Inland	871	870	882

Source: Community Health Improvement Partners. (2001) *Charting the Course III: A San Diego Health Needs Assessment*. San Diego, Ca: Author.

Health Insurance

There are no San Diego County regional data available for children age zero to five. However, there are regional data available for children aged 0-18. In 2001, children in the Central Region were least likely to have health insurance coverage, at 797 per 1000 children.¹⁶ Further, the Central Region's rate of uninsured children is

higher than the San Diego County rate.¹⁶ In San Diego County in 2001, there were no regions that met the *Healthy People 2010* objective of health insurance for 100% of the population. Key informants, First 5 grantees, and community meeting attendees in the Central region identified this issue as a priority issue.

Percentage of Households with Children Aged 0-18 Reporting Health Insurance Coverage San Diego County, 1999-2001

Region	1999	2000	2001
San Diego County	85.9	88.8	88.7
N. Coastal	82.0	88.3	89.2
N. Central	91.2	95.4	95.3
Central	80.7	85.0	79.7
South	84.0	84.2	88.8
East	92.0	91.8	91.3
N. Inland	85.5	87.4	87.3

Source: Community Health Improvement Partners. (2001) *Charting the Course III: A San Diego Health Needs Assessment*. San Diego, Ca: Author.

Children Are in Healthy and Safe Environments

Confirmed Cases of Child Abuse

Between 2000 and 2001, the Central Region reported the highest number of substantiated cases of child abuse of any region in the county. Rates in the Central Region exceed both the national and county levels.^{31, 32}

2000-2001 Two Year Average Substantiated Cases of Child Abuse for San Diego Residents Aged 17 Years and Younger (rates per 1000 population)

National	12.4
State	20.5*
San Diego County (overall)	15.2
Central	25.1
East	18.2
North Coastal	12.5
South	11.9
North Inland	11.5
North Central	7.6

*1996 data included for comparison

Sources: County of San Diego Health and Human Services Agency. (2002). San Diego County Child and Family Health & Well-Being Report Card. San Diego, CA: County of San Diego Health and Human Services Agency. Retrieved on November 15, 2003, from <http://www.co.san-diego.ca.us/enty/entydepts/health/services/rptcard/index.html>. National Clearinghouse on Child Abuse and Neglect Information, National Adoption Information Clearinghouse. Child Maltreatment 2001: Summary of Key Findings. Retrieved on December 16th, 2003 from: <http://nccanch.acf.hhs.gov/pubs/factsheets/canstats.cfm>

Recurrence of Child Maltreatment

No regional data are available regarding the recurrence of child maltreatment. However, a new Quality Assurance Unit is being developed within the County Child Welfare Department which will be able to provide some disaggregated data on this health issue.

The average recurrence rate of child maltreatment in San Diego County for children age zero to five is 11%. The rate of recurrence for all of California is the same. Nationally, the U.S. Department of Health and Human Services reports that 8.9% of child abuse and neglect victims experience a recurrence.

Nonfatal Unintentional Injuries

Data by region on non-fatal unintentional injuries are unavailable. Statewide, there were 7,664 nonfatal hospitalized injuries in 2001. There were 617 nonfatal hospitalized injuries in San Diego County in 2001 among children age zero to four. Incidents at both the county and state have decreased since 1999.

Children are Healthy and Well-Nourished

Breastfeeding

In San Diego County, the rate of women breastfeeding exclusively or at all is tracked by hospital at the time of discharge, and is not available by county region.⁴¹ In the Central Region, UCSD Medical Center reports breastfeeding data. Approximately 87% of women perform some breastfeeding, while only 64% breastfeed exclusively. See table below for comparison to other hospitals in the region.

San Diego County In-Hospital Breastfeeding Rates, 2000-2001

Hospital	% any breastfeeding	% exclusively breastfeeding
Scripps Memorial Hospital Encinitas	95%	82%
Paradise Valley Hospital	92%	68%
Pomerado Hospital	92%	82%
Fallbrook Hospital	91%	50%
Palomar Medical Center	89%	56%
Tri-City Medical Center	89%	59%
Scripps Memorial Hospital Chula Vista	88%	42%
UCSD Medical Center	87%	64%
Grossmont Hospital	86%	62%
Kaiser-San Diego	85%	56%
Alvarado Hospital	78%	41%

Source: California Department of Health Services, Maternal and Child Health Branch, Epidemiology and Evaluation Section, Genetic Disease Branch. (2002) 2000-2001 Hospital Breastfeeding Tables. Retrieved December 15, 2003 from: [http://www.mch.dhs.ca.gov/documents/pdf/2000-2001HospitalBreastfeedingTables\(Madera-Yolo\).pdf](http://www.mch.dhs.ca.gov/documents/pdf/2000-2001HospitalBreastfeedingTables(Madera-Yolo).pdf)

Each hospital also tracks breastfeeding rates at time of discharge by ethnicity. At University of California San Diego Medical Center (UCSD), the lowest percentage of exclusive breastfeeding occurs among African Americans. See table on the next page.

UCSD Medical Center, 2000-2001

Ethnicity	% any breastfeeding	% exclusively breastfeeding
African American	67%	45%
Asian/Pacific Islander	90%	63%
Hispanic	89%	65%
Native American	N/A	N/A
Other/Multiple Races	86%	60%
White, non-Hispanic	89%	69%

Source: California Department of Health Services, Maternal and Child Health Branch, Epidemiology and Evaluation Section, Genetic Disease Branch. (2002) *2000-2001 Hospital Breastfeeding Tables*. Retrieved December 15, 2003 from: [http://www.mch.dhs.ca.gov/documents/pdf/2000-2001HospitalBreastfeedingTables\(Madera-Yolo\).pdf](http://www.mch.dhs.ca.gov/documents/pdf/2000-2001HospitalBreastfeedingTables(Madera-Yolo).pdf)

Range of Expected Weight for Height and Age
In San Diego County in 2002, the rate of underweight for children aged 0-59 months was 65 per 1000, and the rate of overweight was 139 per 1000 among children who were included in the CDC Pediatric Nutrition Surveillance. Therefore, the rate of expected weight for height and age for children aged 0-59 months was 796 per 1000⁴⁴. The San Diego County rate for underweight is higher than the state and national rates, and the rate of overweight is higher than the national rate but lower than the state rate. Both rates exceed *Healthy People 2010* objectives.

2002 Pediatric Nutrition Surveillance, Underweight and Overweight Rates for Children aged 0-59 months (per 1000)

Location	Underweight Total	Overweight Total
San Diego County	65	139
California	53	162
United States	54	135
<i>Healthy People 2010</i>	50	50

Sources: Centers for Disease Control and Prevention. (2003) *2002 Pediatric Nutrition Surveillance*. Retrieved December 22, 2003 from: <http://www.dhs.ca.gov/pcfh/cms/onlinearchive/pdf/chdp/informationnotices/2003/chdpin03q/contents.htm>, U.S. Department of Health and Human Services. (2000, November) *Healthy People 2010*, 2nd ed. Washington, D.C.: U.S. Government Printing Office.

There are no regional data available for San Diego County on child underweight rates.⁸⁰ However, in San Diego County, the most prevalent age group found to be underweight were children aged 0-11 months. This was found to decline as children became older. Black infants were most likely to be underweight. However, by age 24-59 months, the rate of underweight was relatively the same for all ethnicities.

In San Diego County, the issue of overweight was found to affect children younger than age five at a greater rate than did underweight. Among children aged 0-23 months, Hispanic children were found to be the most likely to be affected by overweight, while among children aged 23-59 months, Native American children were the most likely to be affected by overweight.⁴⁴ Key informants, First 5 grantees, and community meeting attendees in the Central region identified this issue as a priority issue.

Children Have Good Oral Health

Annual Dental Exams

According to a 2002 United Way Survey, the Central Region had the lowest percentage of children under age 18 in the county receiving dental care in the prior 12 months (69%).⁴⁵ Key informants, First 5 grantees, and community

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meeting attendees in the Central region identified this issue as a priority issue.

community meeting attendees in the Central region identified this issue as a priority issue.

2002 Comparison Data-Percentage of Residents Under Age 18 Receiving Dental Care in Past 12 Months⁴⁵

National	66%
State	56%
San Diego County	73%
South	72%
North Coastal	71%
North Inland	74%
North Central	80%
East	74%
Central	69%

Source: United Way of San Diego County. (2002). Outcomes & Community Impact Program: Medical Security (Report 24). San Diego, CA: United Way of San Diego County. Retrieved November 15, 2003, from, <http://www.unitedway-sd.org/2002reports.html>.

Dental Insurance

According to a United Way Survey among regions in the county, the Central Region had the fewest numbers of insured children ages 0-18 (see chart below).⁴⁵ Key informants, First 5 grantees, and community meeting attendees in the Central region identified this issue as a priority issue.

Percentage of San Diego County Residents Age 18 and Younger Who Are Reported to Have Dental Insurance

San Diego County	71%
North Central	81%
East	74%
North Inland	72%
South	68%
North Coastal	67%
Central	64%

Source: United Way of San Diego County. (2002). Outcomes & Community Impact Program: Medical Security (Report 24). San Diego, CA: United Way of San Diego County. Retrieved November 15, 2003, from <http://www.unitedway-sd.org/2002reports.html>

Childhood Asthma

Among children age zero to four, asthma hospitalization rates were highest in the Central Region in 2002. However, the rate of asthma hospitalizations went down between 2001 and 2002. Key informants, First 5 grantees, and

Asthma-related Hospitalizations Among San Diego County Children Aged 0-4 by Region, 2001-2002⁵⁵

	2001		2002	
	#hosp.	Rate*	#hosp.	Rate*
N Coast	56	1.7	55	1.7
N Central	81	2.4	86	2.3
Central	181	5.0	158	4.3
South	77	2.8	91	3.2
East	62	2.1	84	2.9
N Inland	84	2.4	81	2.5

*Rates Per 1,000 Population

Source: County of San Diego Health and Human Services Agency, Community Epidemiology. (Data tables). Asthma Related Hospitalizations Among San Diego County Residents, 1999-2002, Age Group by Region. Source: California Office of Statewide Health Planning & Development, 1999-2002 Patient Discharge Data. Rates calculated using SANDAG January 1, 1999 revised estimates and January 1, 2000, 2001, and 2002 estimates. Prepared by Community Epidemiology.

The Central Region has more asthma related hospitalizations than the county on average and has not yet met the Healthy People 2010 objective, (2.5).

Asthma-related Hospitalization Comparisons for Children Aged 0-4, 2002⁵⁵

Healthy People 2010	2.5
County	2.8
Central	4.3

* Rates per 1,000 population

Source: County of San Diego Health and Human Services Agency, Community Epidemiology. (Data tables). Asthma Related Hospitalizations Among San Diego County Residents, 1999-2002, Age Group by Region. Source: California Office of Statewide Health Planning & Development, 1999-2002 Patient Discharge Data. Rates calculated using SANDAG January 1, 1999 revised estimates and January 1, 2000, 2001, and 2002 estimates. Prepared by Community Epidemiology.

Summary of Health Needs

Core Assumptions

To summarize the health needs for the Central Region of San Diego County, the needs assessment included data from the 18 health

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issue summaries, grantee surveys, key informant interviews, and participating feedback and surveys from the Central Regional Community Meeting. This meeting included 31 participants representing 24 different organizations, including but not limited to, organizations such as the Children’s Hospital, San Diego CHOICE Program, Health Net, Sweet Success – California District, North Park Family Resource Center, Central Family Resource Center and Logan Heights Family Resource Center, YMCA Child Care Resource Service and regional county staff representation.

Several core assumptions underscore the health needs in the South Region.

First, needs assessment participants feel all 18 of the health issues are critical to children’s health and as such, are not hierarchical but interdependent.

Second, while each health issue is described distinctly in the issue summaries and via the data, respondents did not differentiate overlapping needs related to the health issues. Therefore, when identifying needs, trends or when making recommendations, respondents often bundled health insurance and regular medical home, dental insurance and annual examinations, and developmental screening and developmental services.

Finally, children’s mental health is acknowledged as a key component of overall health. However, the scope of this needs assessment purposefully did not address children’s mental health as a separate planning effort is currently underway in San Diego County related to children’s mental health.

Needs that Emerged from the Data

For all 18 children’s health indicators where regional data were available, the Central Region rates poorest of any region in the county.

Needs Identified by Stakeholders and Key Informants

However, when grantee surveys, regional community meeting results, and key informant interviews were analyzed, four distinct priorities emerged.

Central Regional Community meeting was held and participants were asked to identify their top three health issues by region related to the 18 identified children's health issues for the county. They worked in small groups to gain consensus on the top three health needs for the region. Individual survey responses from grantees identifying health needs were also aggregated for the region. The top four health priorities impacting the Central Region according to these groups were:

- Children have sustained health insurance and access to a regular medical home
- Childhood overweight and obesity
- Children ages 1 and older receive annual dental exams and have sustained dental insurance
- Childhood Asthma

When key informants were asked what they felt were the top children's health needs for the region, they concurred with the above list as well, though mentioned the high teen birth rate as an issue to target as well.

School Readiness Implications

Each of the health issues listed above can impact a child's readiness for school. For example, lack of health care as a result of a lack of insurance or medical home can delay diagnosis of health problems or can exacerbate existing health conditions. Receiving regular health care services can promote school readiness because ill health and physical or developmental problems can impede academic and social development, for instance, by leading to increased absenteeism.¹

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Overweight is associated with poor body image, low self-esteem, and depression due to a perceived stigma associated with overweight and possible social discrimination, all of which can affect school performance.⁹⁷

Poor oral health may prevent normal eating, sleeping, speaking, and learning, and a lack of dental coverage prohibits access to most dental care, which leaves children vulnerable to risks related to poor oral health, including pain, inability to eat comfortably or chew well, and distraction from play and learning.⁴⁷

Finally, among children age zero to four, asthma hospitalization rates were highest in the Central Region in 2002.⁵⁵ A child's ability to learn in school is also affected by asthma due to increased school absenteeism.⁹⁸

Assets Assessment

Over the past several years, San Diego County has demonstrated an ongoing commitment to improving the lives of children by creating the "*Report Card of Child and Family Well-Being*." The *Report Card* tracks 20 key indicators to determine the county's progress in a number of health-related areas. While not specific to children age zero to five, this has been an important asset in determining San Diego County's health priorities.

Several major county agencies/departments serve children, including the Health and Human Services Agency (HHSA), and the county's Public Safety Group (specifically the Probation Department, District Attorney's Office Juvenile Division, and Public Defender's Office). These are the core agencies with substantial budget commitments to children

In the Central Region a number of assets were identified either in surveys, by key informants or during regional community meetings. The identified assets were organized into four

categories: programs and services, organizations, collaborations, and systems.

The following programs and services were identified by grantees and regional community meeting participants as assets for children 0-5 and their families in the Central Region.

Programs and Services

- First 5 Grantees in Central Region, who are encouraged to collaborate
- Women, Infants and Children
- Share the Care (Dental emergency access/education)
- Parenting Link (One-stop shopping safeguard to dental/health issues)
- Salvation Army - Door of Hope (juvenile court, community schools)
- Red Cross - free car seats
- Programs that don't inquire into immigration status
- Logan Family Resource Center
- California Kids
- Culturally sensitive programs/location/staff
- Mid City Clinic
- La Maestra
- Comprehensive health center in southeast
- Healthy Families
- Health education & early literacy for families that speak Asian languages - Union of Pan Asian Communities (UPAC)
- Adult School
- Dental Care Program
- Family Resource Centers
- San Diego Children's Dental Health Center
- Community Clinics
- Head Start
- St. Vincent dePaul
- YMCA-Child care/Domestic Violence
- Joan Krock Center
- Family Health Center
- Anderson Center for Dental Care

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- Two low fee & no fee health clinics - Logan & St. Vincent de Paul
- Shelters for homeless families
- Language banks
- Childcare Training Programs
- YMCA Childcare Resource Service

Organizations

The organizations below were also identified as assets for children and families in the Central Region.

- City Heights Wellness Center (Scripps)
- County Central Region Programs
- Union of Pan Asian Communities (UPAC)
- Healthy San Diego
- Maternal Family Child Health Services formerly Children Youth & Families
- Dental Health
- Child Protective Services
- San Diego City Schools
- Alliance for African Assistance
- HHS Public Health Centers
- Family Health Center
- St. Vincent De Paul
- Logan
- Bamio Station - preschool/teen programs
- SANDAPP
- Catholic Charities
- American Assoc. of Pediatrics
- African Alliance
- SAY San Diego
- Horn of Africa
- International Rescue
- I A Pediatric Dentistry
- United Way

Collaborations

There are many collaborative efforts throughout the Central Region as well as willingness among agencies to link clients with services more efficiently and effectively. Specific collaborations identified by grantees and regional

community meeting participants include the following:

- Coalition on Children and Weight
- Access to Care SDKHAN
- Dental Health Coalition
- Neighborhood Housing Association
- Central Region Alliance
- East County Alpha Kappa Alpha (AKA)
- Chicano Federation
- Faith Community
- Bayview Baptist Church
- Nazarene Church
- Faith Baptist Church
- Mid City Collaborative
- Safe Kids Coalition
- Dental Health Coalition
- Breastfeeding Coalition
- SCHIP School Health Children's Initiative
- Reach Out

Systems

Systems that were identified as assets for children's health by grantees and regional community meeting participants in the Central Region include:

- Central Region Administrator works with schools
- Community Clinics
- Children's Hospital, outpatient clinic
- Children's Dental Health Center
- Regional Prenatal system (First 5 funded referrals to pregnant women & other programs)
- Medi-Cal system
- Head Start/Child development centers at elementary schools
- California Endowment
- Price Foundation
- San Diego Foundation
- Alliance Healthcare Foundation
- Children's Hospital & Pediatric Trauma Center
- First 5 San Diego
- Share the Care (Dental Care)

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- CHDP
- Public Health Nursing
- San Diego Regional Center
- CCS
- PCN Perinatal Care Network
- Regional Perinatal System
- Good public transportation (e.g., trolley)

Some assets listed by grantees and regional community meeting participants described characteristics of the people living in or providing services to children and families in the Central Region. The following list identifies those assets.

Community Characteristics

- Local medical clinics and resources are becoming more plentiful in the Central Region
- Willingness of community members to learn about ways to keep children safe

Assets According to Key Informants

In addition to the assets identified during regional community meetings and surveys, key informants in the Central Region identified several additional assets including

- Community action teams to address pediatric asthma, substance abuse, using promotora model for health promotion.
- VIP Tractor—provides immunizations
- Shiley Eye Center at UC San Diego
- Dr. Nathaniel Liu of the Tooth Fairy Program provides dental screenings and dental follow up
- School district provides hearing screenings for children if the teacher identifies it as a problem, but don't have anyone who screens all children

Emerging Trends

Grantees, key informants, and regional meeting participants were each asked to identify emerging trends that directly or indirectly impact the 18 health issues.

Emerging trends described either positive or negative impacts on the Central Region. The negative trends identified in surveys and at the regional community meeting include:

- Greater number of young children (infants) born to homeless families and greater transience among homeless families
- Barriers to accessing birth control, increase in the number of teen pregnancies among specific subpopulations
- Children lack access to recreation facilities
- Lack of day care in region
- Increasing numbers of children presenting with asthma respiratory illnesses
- Fear of applying for Medi-Cal / Healthy Families Programs / CHDP Gateway because of immigration status
- Increased inability to get behavioral health care services
- Self-medication due to lack of health insurance and parents limited knowledge of health system
- Ethnic differences in unhealthy eating styles, need for nutrition education
- Decrease in funds to support programs across the board (haven't hit bottom)
- Medi-cal, Denti-cal, Healthy Families less able to use technology - need more grass roots + cultural organizing
- Increase in number of refugee families
- Children not adequately prepared for school - low testing scores
- Transportation
- Family strength training programs being cut
- Increased awareness by population in general and providers of developmental disabilities but no money to address problem

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Among the more positive trends noted in the Central Region were:

- A more holistic approach to community health
- The emergence of health education programs and rising awareness of need
- More culturally and linguistically appropriate information concerning children's health and resources are available.

Also, it was noted at the community meeting that family awareness of early immunizations is improving in the Central Region.

Key Informants

Trends impacting children's health that were noted by key informants in the Central Region include the increase in child obesity, and that though children are overfed, they are undernourished because of the types of food they are eating. Another serious trend that was noted was the increase in domestic and gang violence in the region.

Also noted was the disparity among different groups in their access to health, and the difficulty of charting improvement and decline.

Other trends observed include an increase in the number of children with asthma and food allergies, an increase in behavioral problems and aggression among school children, and an increase in the lack of affordable housing in the Central Region.

Data Issues

Data on certain child health indicators are not available and, therefore, cannot be included in this report. For some indicators, no data was available, while for a few indicators, data specifically for children age zero to five was not available. Those indicators are as follows.

No Regional Data At All

- Smoking During Pregnancy
- Childhood Immunizations
- Well Baby Checks
- Developmental Screening
- Developmental Services
- Recurrence of Child Maltreatment
- Expected Weight for Height and Age

No Regional Data for Children 0-5

- Regular Medical Home
- Health Insurance
- Confirmed Cases of Child Abuse
- Annual Dental Exams
- Dental Insurance

Other Data Limitations

County and regional data for developmental services, developmental screening, and well-baby/well-child checks are not available, and therefore, not listed in the “needs assessment” section of this chapter. Some information on these issues is included in the countywide section of this report.

While regional data is available for nonfatal unintentional injuries by major statistical area (MSA) and sub-regional area (SRA) for patients under the age of 20,⁶ data on children 0-5 by HHS region is not available.

Regional data on breastfeeding are not tracked in San Diego County; however, some hospitals in the county track the rate of women breastfeeding “exclusively” or “at all” by hospital at the time of discharge.

Though data are available by region with regards to asthma-related hospitalizations from 1999-2002, trends are difficult to assess because beginning in 2001, the Office of Statewide Planning and Development began masking a portion of the identifying variables (including age) to protect patient confidentiality. Due to this masking, data cannot reliably be compared over the four-year span between 1999 and 2002.

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County epidemiology staff have raised this issue with state government staff.⁵⁶

Finally, SANDAG collects data by age using zero to four while First 5 is interested in data for children under age 6, which again leads to a disparity in data.

Grantees, key informants and regional community meeting participants were also asked what data related issues they see. Grantees and regional meeting participants would like to see the following data needs addressed:

- Need to look at interrelated data sets, and the decrease in mental health services resulting in increase child abuse
- Insurance utilization
- Teen pregnancy ages (look at below age 15) age 13-19
- Girls getting pregnant
 - Number of schools
 - Number of early pregnancy tests
 - School nurses as assets
- Disaggregate Asian data
- Break down for each health issue by ethnicity
- Primary language is more valuable in terms of services
- Need both genetic and cultural data

Central Priorities

At the end of the regional community meeting, participants were asked to identify priorities. Meeting attendees identified the following:

Need more awareness of resources available to ease access
Rationale: If the breadth of resources in the county is not known, then there may be unnecessary duplication of services, or providers and educators may not be able to refer patients to available services. Awareness of resources can ensure that the resources are used effectively.
Need to address the problem of how to conceptualize effective implementation
Rationale: By understanding how to best address the health issues affecting children in the Central Region, and the results of different courses of action, the region can best implement a plan that will maximize the use of available resources and assets.

Central Region community meeting attendees also noted that the information that providers have regarding the Central Region is invaluable, and that the ease with which the attendees settled on top priorities resulted from community awareness of the priorities.

8.0-REGIONAL PROFILE: EAST

Between 2010 and 2030, the East region population will continue to increase at a greater rate, from 4.9% in 2010 to 8.8% in 2030. The overall rate of population growth for the East Region will be slower than that for San Diego County and for California.

The region includes both urban and rural communities and is home to several Native American reservations. There are four incorporated cities in East County—El Cajon, La Mesa, Lemon Grove, and Santee. The largest urban city is El Cajon, with a population of 163,206.⁹⁹

Demographics

Total Population

Approximately 451,250 people live in the East Region, which is the second largest region in the county.^{11, 99} Between 2001 and 2003, the population in the East Region grew at a slower rate than the San Diego County population.

Population Increase, East Region and San Diego County, 2001-2003

	2001	2003	% increase
East region	446,149	451,250	1.1%
San Diego County	2,856,000	2,961,579	3.7%

San Diego Association of Governments. *SANDAG January 1 Population Estimates, 2001*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG January 1 Population Estimates All Ages by Gender by Region. San Diego Association of Governments. *SANDAG January 1 Population Estimates, 2003*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG January 1 Population Estimates All Ages by Gender by Region.

Population Forecast for the East Region, San Diego County, and California, 2010-2030

Year	2010	2020	2030
East Region	470,942	511,232	556,264
% increase	4.9%	8.6%	8.8%
San Diego County Population	3,211,721	3,528,605	3,855,085
% increase	8.4%	9.9%	9.3%
California Population	39,957,616	45,448,627	51,868,655
% increase	15.3% ^{xiii}	13.7%	14.1%

Sources: San Diego Association of Governments. *SANDAG Population Forecast, 2010-2030*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG Population Forecast, 2010-2030.

California Department of Finance. (2001) *Population Projections*. Available online at:

<http://www.dof.ca.gov/HTML/DEMOGRAP/projca.pdf>

Age and Gender

In 2002, 448,750 people lived in the East Region—up slightly from 446,149 in 2001. Approximately 28,975 children age zero to four lived in the East Region in 2002 or 6.4% of the total regional population. The percentage of children age zero to four in the Region is comparable to the percentage of children age zero to four who live in the county.⁷⁴

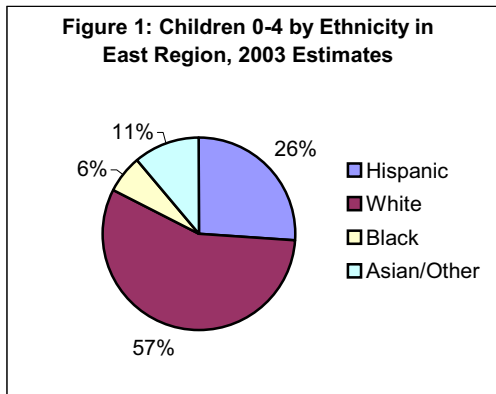
The median age in the Region is 33 to 42 years old. By 2020, the median age is expected to be slightly older—37 to 47 years old. The older population (55 and above) currently comprises 20% of the Region’s population and is expected to grow to 30% by the year 2020.⁹⁹

^{xiii} Baseline population from year 2000: 34,635,395

In 2002, the population overall in the Region was 49% male and 51% female. Conversely, among children age zero to four in the Region, 51% are male and 49% are female.¹¹

Ethnicity

The majority of the children age zero to four who live in the region are White. Figure 1 below shows a breakdown in the ethnic make-up of the population of children 0-4 in the East Region.



San Diego Association of Governments. *SANDAG January 1 Population Estimates, 2003*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG January 1 Population Estimates All Ages by Gender by Region.

Between 2010 and 2030, the percentage of Whites is expected to increase modestly, while the percentage of several communities, including Hispanics, Blacks, Asians, and Hawaiian/Pacific Islanders is expected to grow by over 30%.⁹⁹ The percentage of American Indians is expected to decrease.

Total Population Forecast by Ethnicity, East Region, 2010-2030

Ethnicity	2010	2020	2030	% change from 2010 to 2030
Total (all races and ethnicities)	470,942	511,232	556,264	18.12%
Hispanic	103,391	123,926	146,553	41.75%
White	290,751	292,728	295,982	1.80%
Black	27,160	33,862	40,063	47.51%
American Indian or Alaska Native	2,976	2,685	2,489	-16.36%
Asian	19,557	23,051	26,531	35.66%
Hawaiian or other Pacific Islander	5,535	7,374	9,710	75.43%
Other	3,966	7,236	11,421	187.97%
Two or more races	17,606	20,370	23,515	33.56%

Source: San Diego Association of Governments. *SANDAG Population Forecast by Age and Ethnicity, 2010-2030*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG Population Forecast, 2010-2030.

The rate of population increase among children age zero to four will be slower than the rate among the total population. The fastest rate of population increase between 2010 and 2030 will be among Black children and Pacific Islander children, at 31% and 34%, respectively, while there will be a modest decrease among White children, at 1.3%.

Population Forecast by Ethnicity for Children Aged 0-4, East Region, 2010-2030

Ethnicity	2010	2020	2030	% change from 2010 to 2030
Total (all races and ethnicities)	31,337	32,545	33,173	5.86%
Hispanic	9,634	10,104	10,197	5.84%
White	16,258	16,112	16,047	-1.30%
Black	2,625	3,182	3,431	30.70%
American Indian or Alaska Native	263	201	167	-36.50%
Asian	1,108	1,032	1,090	-1.62%
Hawaiian or other Pacific Islander	273	302	367	34.43%
Other	487	712	993	103.90%
Two or more races	689	900	881	27.87%

Source: San Diego Association of Governments. *SANDAG Population Forecast by Age and Ethnicity, 2010-2030*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG Population Forecast, 2010-2030.

Households and Income

The County of San Diego, Health and Human Services Agency reports that the average annual income in the East Region falls between \$24,692 and \$32,622.⁹⁹ The median household income falls within the range of \$45,000-\$49,999. This is in the same range as the San Diego County median income of \$47,268 and the California median income of \$47,493. However, in the East Region, the income category that includes the greatest number of households is the \$60,000-\$74,999 category.

Number of Households by Household Income Category, East Region, 2000

Household income	Number of Households	% of total households
Less than \$10,000	11,102	6.91%
\$10,000 to \$14,999	8,530	5.31%
\$15,000 to \$24,999	18,947	11.80%
\$25,000 to \$34,999	20,694	12.89%
\$35,000 to \$49,999	27,156	16.91%
\$50,000 to \$74,999	35,686	22.23%
\$75,000 to 99,999	18,505	11.53%
\$100,000 or more	19,936	12.42%
Total	160,556	100.00%

Source: San Diego Association of Governments. *SANDAG Census Data – Households and Income, 2000*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG Census Data, 2000.

According to the US Census Bureau, in 2000, 7994 out of 113664 families, or 7% of families in the East Region, had an income of lower than the Federal Poverty Level.

In the East Region, the most common type of household are family households with children, followed by non-family households without children.

Number of Households by Type, East Region, 2000

Type of Household	Number of Households	%
Non family households	35,076	21.66%
Other non family households	11,816	8.43%
Non family households - no children	51,106	14.75%
Non family no children	46,049	29.79%
Family households with children	62,558	25.08%
Non family with children	843	0.29%

source: San Diego Association of Governments. *SANDAG Census Data – Households and Income, 2000*. Prepared by Community Epidemiology, September 16, 2003. Source: SANDAG Census Data, 2000.

Regional Needs Assessment

This section provides information on how health issues are impacting children under age five in the East region. Data for each child health indicator is reviewed for the region and compared to national, state and county data, as well as Healthy People 2010 objectives, where available. Indicators related to developmental services, developmental screening, and well-baby/well-child checks are not listed due to insufficient data at the county and regional levels. Where health issues were identified as a priority through key informant interviews, East Region community meeting participant feedback, and First 5 grantee surveys, this is noted.

Children are Born Healthy

Low Birthweight

In 1999, the East Region had a lower occurrence of low birthweight babies than the nation, state, or county. ¹⁶ (See chart below.) However, between 1998 and 2000, the East Region had the

second highest rate of low birthweight in the county (61 per 1,000)¹⁶ and has not yet met the Healthy People 2010 target, (50).

1999 Comparison Data (Rates Per 1,000 Population)¹⁶

National	79
State	61
County	59
East region	58
Healthy People 2010 Target	50

Source: Community Health Improvement Partners. (2001) *Charting the Course III: A San Diego Health Needs Assessment*. San Diego, Ca: Author.

Adequate Prenatal Care Use

In 1999, the East Region had the second highest early prenatal care utilization rate in the county after the North Central Region.¹⁶ During the period of 1995-1999, rates of early prenatal care use in San Diego County steadily improved in most county regions, including the East Region. The percent of women initiating prenatal care in the first trimester has risen in the East Region over the last five years—from 831 per 1,000 in 1995 to 859 per 1,000 in 1999. In 1999, the East Region had a higher prenatal care utilization rate than both San Diego County and California.¹⁶

Percentage of Women Initiating Prenatal Care During the First Trimester by Region, San Diego County, 1995-1999

Region	1995	1996	1997	1998	1999
North Coastal	74.7	75.2	72.7	70.5	72.3
North Central	88.2	89.7	89.1	89.6	90.2
Central	70.0	72.1	72.8	72.5	76.0
South	73.1	76.4	76.5	78.9	80.1
East	83.1	84.7	84.3	84.7	85.9
North Inland	76.8	77.6	77.0	78.9	79.6

Source: Community Health Improvement Partners. (2001) *Charting the Course III: A San Diego Health Needs Assessment*. San Diego, Ca: Author.

Percentage of Women Initiating Prenatal Care During the First Trimester by State, County, and Region, 1999

East region	85.9%
State	82.2%
County	80.3%

Source: Community Health Improvement Partners. (2001) *Charting the Course III: A San Diego Health Needs Assessment*. San Diego, Ca: Author.

Births to Teen Mothers

The teen birth rate declined steadily in the East Region between 1995 and 1998 and then increased slightly in 1999. The East Region had the second lowest teen birth rate among all county regions in 1999, with 21.4 births per 1000 teens.¹⁶

1999 Teen Birth Rates by Year and Region (per 1000 teens, ages 15-17)

Region	1995	1996	1997	1998	1999
North Central	17.0	16.9	14.6	12.4	11.0
East	26.2	25.2	22.1	20.2	21.4
North Inland	26.4	26.1	23.0	20.5	22.6
North Coastal	37.4	38.6	28.9	27.4	24.3
South	44.7	41.7	37.4	37.7	35.4
Central	60.6	63.0	52.7	49.8	45.1

Source: Community Health Improvement Partners. (2001) *Charting the Course III: A San Diego Health Needs Assessment*. San Diego, Ca: Author.

In 1999, the teen birth rate was lower in the East Region than in San Diego County and in the state.⁷⁷

1999 Teen Birth Rates (per 1000 teens, ages 15-17)

State	30.4
County	28.0
East region	21.4

Source: Community Health Improvement Partners. (2001) *Charting the Course III: A San Diego Health Needs Assessment*. San Diego, Ca: Author.

California Department of Health Services. (2003) *Birth Rates by Year of Age for Teenage Mothers, 2001*, from birth records. Retrieved December 10, 2003 from: http://www.dhs.ca.gov/hisp/chs/OHIR/vssdata/2001data/01Ch2p df/2_29_2001.pdf

Smoking During Pregnancy

There are no data available for rates on smoking during pregnancy by region.⁷⁸ However, the San

Diego County rate of smoking during pregnancy is 111 per 1000 women, which is higher than the *Healthy People 2010* objective of 10 per 1000 women, and higher than the state rate of 98 per 1000. National rates of smoking during pregnancy cannot be directly compared to state rates because data for smoking during pregnancy in California were not collected in National Center for Health Statistics' standard format and are therefore not easily compared.⁷⁹

Rates of Smoking During Pregnancy Per 1,000 Population

County	111
State	98
Health People 2010 Objective	10

Sources: U.S. Department of Health and Human Services. (2000, November) *Healthy People 2010*, 2nd ed. Washington, D.C.: U.S. Government Printing Office. Schumacher, J. (2003, December 17). Personal communication with the Center for Health Improvement. Maternal and Child Health Branch, California Department of Health Services. Maternal and Infant Health Assessment Survey (MIHA), 2000. California Department of Health Services, Tobacco Control Section. (n.d.). *Smoking during pregnancy*. Retrieved December 15, from <http://www.dhs.ca.gov/tobacco/documents/Pregnancy.pdf> Maternal and Child Health Branch, California Department of Health Services. Maternal and Infant Health Assessment Survey (MIHA), 2000.

Children Receive Preventive and Ongoing Regular Health Care

Childhood Immunizations

No regional data on immunization rates in San Diego County are available at this time.⁹⁴ However, in San Diego County in 2002, children received timely immunizations at the following rates.²⁵

Estimated Vaccination Coverage with Individual Vaccines Among Children 19-35 Months of Age, San Diego County, 2002 (rate per 1000 population)

Vaccine	Rate
4+DTaP	830
3+Polio	872
1+MMR	901
3+Hib	918
3+HepB	867
1+Var	878
3+PCV	470

Source: Centers for Disease Control and Prevention, National Immunization Program. (2003) Estimated Vaccination Coverage with Individual Vaccines and Selected Vaccination Series Among Children 19-35 Months of Age by State and Immunization Action Plan Area US, *National Immunization Survey, Q1/2002-Q4/2002*. Retrieved December 15, 2003 from: <http://www.cdc.gov/nip/coverage/default.htm>

San Diego County does not meet *Healthy People 2010* objectives (90% vaccinated) for 4+DtaP, 3+Polio, 3+Hep B, or 1+Var.

Regular Medical Home

The 2001 California Health Interview Survey found that 713 per 1000 children age zero to five in San Diego County went to a doctor's office, an HMO, or Kaiser for their usual source of care, and are therefore considered to have a regular medical home. In addition, 279 per 1000 went to a community clinic or a community hospital for their usual source of care.²⁸

There are no data available on the rate of children age zero to five with a medical home by San Diego County region. However, there are data available for children aged 0-18. In 2001, the East Region had the second highest number of parents reporting that their children had primary care providers, at a rate of 909 per 1000. The East Region also reported an increase between 1999 and 2001 in the percent of adults reporting that their children have a primary care provider.¹⁶ The East Region did not meet the *Healthy People 2010* objective for having a regular primary care provider for children aged 0-17.

Rate of Children Who Have Someone Their Parent Considers Their Primary Care Provider, 1999-2001 (rates per 1000 population)

Region	1999	2000	2001
N. Coastal	826	871	871
N. Central	911	909	847
Central	766	775	788
South	798	828	911
East	883	881	909
N. Inland	871	870	882

Source: Community Health Improvement Partners. (2001) *Charting the Course III: A San Diego Health Needs Assessment*. San Diego, Ca: Author.

Health Insurance

There are no San Diego County regional data available for children age zero to five. However, there are regional data available for children aged 0-18. Between 1999 and 2001, the East Region reported an increase in the percent of households with children reporting health insurance coverage. In 2001, more than 90% of children in the East Region had health insurance, at a rate of 913 per 1000, and the East Region had the second highest rate of insurance coverage among all six regions.¹⁰⁰

Despite the positive trend reflected by the data, feedback gathered from key informant interviews, a regional community meeting, and First 5 grantee surveys indicate that lack of health insurance is one the most pressing health needs among children age zero to five in the East Region. One key informant noted that retention of coverage and utilization of services has been a priority issue for years and that the current budget crisis exacerbates existing concerns, especially due to potential caps to Healthy Families and possible reductions in physician reimbursement.

Percentage of Households with Children Aged 0-18 Reporting Health Insurance Coverage San Diego County, 1999-2001

Region	1999	2000	2001
San Diego County	85.9	88.8	88.7
N. Coastal	82.0	88.3	89.2
N. Central	91.2	95.4	95.3
Central	80.7	85.0	79.7
South	84.0	84.2	88.8
East	92.0	91.8	91.3
N. Inland	85.5	87.4	87.3

Source: Community Health Improvement Partners. (2001) *Charting the Course III: A San Diego Health Needs Assessment*. San Diego, Ca: Author.

Children Are in Healthy and Safe Environments

Confirmed Cases of Child Abuse

Among regions in the county, the East Region has the second highest percentage of substantiated cases of child abuse. In addition, the East Region is one of only two regions with a higher percentage of substantiated cases of child abuse than the county as a whole.

2000-2001 Two Year Average Substantiated Cases of Child Abuse for San Diego Residents Aged 17 Years and Younger (rates per 1000 population)³¹

National	12.4
State	20.5*
San Diego County (overall)	15.2
North Central	7.6
North Inland	11.5
South	11.9
North Coastal	12.5
East	18.2
Central	25.1

*1996 data included for comparison

Sources: County of San Diego Health and Human Services Agency. (2002). San Diego County Child and Family Health & Well-Being Report Card. San Diego, CA: County of San Diego Health and Human Services Agency. Retrieved on November 15, 2003, from <http://www.co.sandiego.ca.us/enty/entydepts/health/services/rptcard/index.html>. National Clearinghouse on Child Abuse and Neglect Information, National Adoption Information Clearinghouse. Child Maltreatment 2001: Summary of Key Findings. Retrieved on December 16th, 2003 from: <http://nccanch.acf.hhs.gov/pubs/factsheets/canstats.cfm>

Recurrence of Child Maltreatment

There are no specific regional data available at this time. However, a new Quality Assurance Unit is being developed within the County Child Welfare Department which will be able to provide some disaggregated data on this health issue.

The average recurrence rate of child maltreatment in San Diego County for children age zero to five is 11%. The rate of recurrence for all of California is the same. Nationally, the U.S. Department of Health and Human Services reports that 8.9% of child abuse and neglect victims experience a recurrence.

Nonfatal Unintentional Injuries

Data by region on non-fatal unintentional injuries are unavailable. Statewide, there were 7,664 nonfatal hospitalized injuries in 2001. There were 617 nonfatal hospitalized injuries in San Diego County in 2001. Incidents at both the county and state have decreased since 1999.

Children are Healthy and Well-Nourished

Breastfeeding

In San Diego County, the rate of women breastfeeding exclusively or at all is tracked by hospital at the time of discharge after childbirth, and is not available by county region.⁴¹ In the East Region, Grossmont Hospital reports that 86% of women do some breastfeeding and 62% of women are exclusively breastfeeding. The percentage of women who do some breastfeeding is low compared to other hospitals in the county, while the percentage of women exclusively breastfeeding is slightly above average (see table on next page).

San Diego County In-Hospital Breastfeeding Rates, 2000-2001

Hospital	% any breastfeeding	% exclusively breastfeeding
Scripps Memorial Hospital Encinitas	95%	82%
Paradise Valley Hospital	92%	68%
Pomerado Hospital	92%	82%
Fallbrook Hospital	91%	50%
Palomar Medical Center	89%	56%
Tri-City Medical Center	89%	59%
Scripps Memorial Hospital Chula Vista	88%	42%
UCSD Medical Center	87%	64%
Grossmont Hospital	86%	62%
Kaiser-San Diego	85%	56%
Alvarado Hospital	78%	41%

Source: California Department of Health Services, Maternal and Child Health Branch, Epidemiology and Evaluation Section, Genetic Disease Branch. (2002) *2000-2001 Hospital Breastfeeding Tables*. Retrieved December 15, 2003 from: [http://www.mch.dhs.ca.gov/documents/pdf/2000-2001HospitalBreastfeedingTables\(Madera-Yolo\).pdf](http://www.mch.dhs.ca.gov/documents/pdf/2000-2001HospitalBreastfeedingTables(Madera-Yolo).pdf)

African American and Asian/Pacific Islanders have the lowest rates of breastfeeding among all ethnicities tracked at Grossmont Hospital.

Grossmont Hospital, 2000-2001

Ethnicity	% any breastfeeding	% exclusively breastfeeding
Hispanic	89%	61%
White, non-Hispanic	87%	67%
Other/Multiple Races	83%	61%
African American	78%	47%
Asian/Pacific Islander	65%	29%
Native American	N/A	N/A

Source: California Department of Health Services, Maternal and Child Health Branch, Epidemiology and Evaluation Section, Genetic Disease Branch. (2002) *2000-2001 Hospital Breastfeeding Tables*. Retrieved December 15, 2003 from: [http://www.mch.dhs.ca.gov/documents/pdf/2000-2001HospitalBreastfeedingTables\(Madera-Yolo\).pdf](http://www.mch.dhs.ca.gov/documents/pdf/2000-2001HospitalBreastfeedingTables(Madera-Yolo).pdf)

Range of Expected Weight for Height and Age
 In San Diego County in 2002, the rate of underweight for children aged 0-59 months was 65 per 1000, and the rate of overweight was 139 per 1000 among children who were included in the CDC Pediatric Nutrition Surveillance. Therefore, the rate of expected weight for height and age for children aged 0-59 months was 796 per 1000⁴⁴. The San Diego County rate for underweight is higher than the state and national rates, and the rate of overweight is higher than the national rate but lower than the state rate. Both rates are significantly worse than the *Healthy People 2010* objectives.

2002 Pediatric Nutrition Surveillance, Underweight and Overweight Rates for Children aged 0-59 months (per 1000)

Location	Underweight Total	Overweight Total
San Diego County	65	139
California	53	162
United States	54	135
<i>Healthy People 2010</i>	50	50

Sources: Centers for Disease Control and Prevention. (2003) *2002 Pediatric Nutrition Surveillance*. Retrieved December 22, 2003 from: <http://www.dhs.ca.gov/pcfh/cms/onlinearchive/pdf/chdp/informat ionnotices/2003/chdpin03q/contents.htm>, U.S. Department of Health and Human Services. (2000, November) *Healthy People 2010*, 2nd ed. Washington, D.C.: U.S. Government Printing Office.

There are no regional data available for San Diego County on child overweight rates.⁸⁰ However, in San Diego County, the most prevalent age group found to be underweight were children aged 0-11 months. This was found to decline as children became older. Black infants were most likely to be underweight. However, by age 24-59 months, the rate of underweight was relatively the same for all ethnicities.

In San Diego County, the issue of overweight was found to affect children younger than age five at a greater rate than did underweight. Among children aged 0-23 months, Hispanic children were found to be the most likely to be affected by overweight, while among children aged 23-59 months, Native American children were the most likely to be affected by overweight.⁴⁴

Children Have Good Oral Health

Currently, there is no countywide collection of data for children ages five and under.⁴⁶ Though data on annual dental exams and dental insurance indicate that children under 18 have high rates of insurance and use of dental services compared to other regions in the county, feedback gathered from key informant interviews, a regional community meeting, and First 5 grantee surveys indicate that oral health is one the most pressing health needs among children age zero to five in the East Region.

Annual Dental Exams

The use of dental services among children in the East Region is quite high as compared to county, state, and national rates. Among other regions in the county in 2002, the East and North Inland Regions both had the second highest percentage of children under age 18 who had received dental care in the past 12 months. The East Region has surpassed the Healthy People 2010 objective that 56% of children aged 2-17 have annual dental visits (based on 1996 data).

2002 Comparison Data - Percentage of Children Under Age 18 Receiving Dental Care in Past 12 Months⁴⁵

North Central	80%
East	74%
North Inland	74%
San Diego County	73%
South	72%
North Coastal	71%
Central	69%
National	66%
State	56%

Source: United Way of San Diego County. (2002). Outcomes and Community Impact Program: Medical Security (Report 24). San Diego, CA: United Way of San Diego County. Retrieved November 15, 2003, from, <http://www.unitedway-sd.org/2002reports.html>.

Dental Insurance

After the North Central Region, the East Region has the highest number of children under age 18 reported to have dental insurance(see chart below).⁴⁵

Percentage of San Diego County Residents of Age 18 and Younger Who Are Reported to Have Dental Insurance

National	N/A
State	N/A
North Central	81%
East	74%
North Inland	72%
San Diego County	71%
South	68%
North Coastal	67%
Central	64%

Source: United Way of San Diego County. (2002). Outcomes and Community Impact Program: Medical Security (Report 24). San Diego, CA: United Way of San Diego County. Retrieved November 15, 2003, from <http://www.unitedway-sd.org/2002reports.html>

Childhood Asthma

Trends between 1999 and 2002 are difficult to assess using available data (see data availability limitations section on p. 64). However, data for the East Region are included in the tables below for reference. Among children age zero to four, asthma hospitalization rates in the East Region went up between 1999 and 2000 and between 2001 and 2002.

Asthma-related Hospitalizations Among East Region Children Aged 0-4, 1999-2002⁵⁵

	1999	2000	2001	2002
Number of Children Hospitalized	84	122	62	84
Rate*	2.7	4.0	2.1	2.9

*Rates Per 1,000 Population

Source: County of San Diego Health and Human Services Agency, Community Epidemiology. (Data tables). Asthma Related Hospitalizations Among San Diego County Residents, 1999-2002, Age Group by Region. Source: California Office of Statewide Health Planning and Development, 1999-2002 Patient Discharge Data. Rates calculated using SANDAG January 1, 1999 revised estimates and January 1, 2000, 2001, and 2002 estimates. Prepared by Community Epidemiology.

Rates in the East Region are slightly higher than the county on average. The East Region has not yet met the Healthy People 2010 objective of 2.5 hospitalizations per 1,000 population.

Asthma-related Hospitalization Comparisons for Children Aged 0-4, 2002⁵⁵

North Coast	1.7
North Central	2.3
North Inland	2.5
Healthy People 2010	2.5
County	2.8
East	2.9
South	3.2
Central	4.3

* Rates per 1,000 population

Source: County of San Diego Health and Human Services Agency, Community Epidemiology. (Data tables). Asthma Related Hospitalizations Among San Diego County Residents, 1999-2002, Age Group by Region. Source: California Office of Statewide Health Planning and Development, 1999-2002 Patient Discharge Data. Rates calculated using SANDAG January 1, 1999 revised estimates and January 1, 2000, 2001, and 2002 estimates. Prepared by Community Epidemiology.

Summary of Health Needs

Core Assumptions

To summarize the health needs for the East Region of San Diego County, the needs assessment included data from the 18 health issue summaries, grantee surveys, key informant interviews, and participating feedback and surveys from the East Regional Community Meeting. This meeting included 15 participants representing 14 different organizations, including but not limited to, organizations such as the Alpha San Diego Program, Family Health Centers of San Diego, El Cajon Community Development Corporation, Share the Care Program, Center for Community Solutions, Emergency Medical Services, and regional county staff representation.

Note that several core assumptions underscore the health needs in the East Region. First, needs assessment participants feel all 18 of the health issues are critical to children's health and as such, are not hierarchical but interdependent.

Second, while each health issue is described distinctly via the data, respondents did not differentiate overlapping needs related to the health issues. Therefore, when identifying needs and trends or when making recommendations, respondents often bundled health insurance and regular medical home, dental insurance and annual examinations, and developmental screening and developmental services.

Finally, children's mental health is acknowledged as a key component of overall health. However, the scope of this needs assessment purposefully did not address children's mental health because a separate planning effort is currently underway in San Diego County related to children's mental health.

Needs that Emerged from the Data

In the East Region, the most pressing health needs when looking at the data alone include low

birthweight, child abuse, and asthma. The East Region had the second highest rate of low birthweight in the county between 1998 and 2000 and the second highest percentage of substantiated cases of child abuse among children 0-17. In addition, asthma-related hospitalizations in the East Region are slightly higher than the county on average.

Needs Identified by Stakeholders and Key Informants

Three different health needs emerged when grantee surveys and regional community meeting results were analyzed however. The top three health priorities according to these groups are that:

- ☒ Children have health insurance (and their enrollment is sustained with continuous health coverage for 1 year)
- ☒ Children have dental insurance (and their enrollment is sustained with continuous health coverage for 1 year) & Children ages 1 and older receive annual dental exams
- ☒ Children receive a developmental screening by kindergarten entry & Children identified with disabilities and other special needs receive developmental services by kindergarten entry

When key informants were asked what they felt were the top children's health needs for the Region were, they concurred with the above list as well, but also indicated that the four issues revealed by the data are also important priorities.

School Readiness Implications

All six health issues, those according to the data as well as the stakeholders, can have a negative impact on a child's ability to learn and be prepared for kindergarten. For example:

- Low birthweight is associated with long-term disabilities, such as cerebral palsy, autism, mental retardation, vision and

hearing impairments, and other developmental disabilities.¹⁶

- Abused children exhibit learning difficulties, such as lack of concentration, difficulty completing assignments, learning impairments, and delays in development of motor and verbal skills. Child abuse has also been associated with attention-deficit disorders, which may adversely affect a child's readiness to learn.
- A child's ability to learn in school is also affected by asthma due to increased school absenteeism.⁹⁸
- Regular access to health care promotes good health, which can also allow children to focus on the learning process, allowing them to become more ready for school.^{27, 16}
- Poor oral health may prevent normal eating, sleeping, speaking, and learning.⁴⁸ The social impacts of disfiguring tooth decay also reduce a child's chance for happiness and success.⁴⁷
- Developmental disabilities impact a child's readiness for school. Depending on the developmental disability, school readiness can be impacted differently.

Assets Assessment

San Diego County has several countywide assets that impact the East Region. For example, over the past several years, San Diego County has demonstrated an ongoing commitment to improving the lives of children by creating the "Report Card of Child and Family Well-Being." The Report Card tracks 20 key indicators to determine the county's progress in a number of health-related areas. While not specific to children age zero to five, this has been an important asset in determining San Diego County's health priorities.

In addition, several major county agencies/departments serve children, including the Health and Human Services Agency

(HHSA), and the county's Public Safety Group (specifically the Probation Department, District Attorney's Office Juvenile Division, and Public Defender's Office). These are the core agencies with substantial budget commitments to children.

Although these assets are countywide, they impact each region and in fact these county agencies were identified as assets during many of the regional community meetings.

In the East Region a number of assets were identified either in surveys, by key informants, or during regional community meetings. The identified assets were organized into four categories: programs and services, organizations, collaborations, and systems.

Programs and Services

The following programs and services were identified by grantees and regional community meeting participants as assets for children age zero to five and their families in the East Region.

- State Preschool System (works through school districts; works closely with kindergarten and conducts outreach to young siblings)
- Head Start (e.g., AKA Head Start)
- Cross generational programs with children and retired population (e.g. through County Aging and Inpt Services)
- First 5 New Parent Kits
- Grossman Teen Pregnancy and Children's programs
- Nurse-Family Partnership
- Family Resource Centers (e.g., Spring Valley FRC)
- Public Health Nurses
- Women, Infants, and Children Program (WIC)
- Developmental Screening and Enhancement Project at Children's Hospital
- In-Home Support Services workers
- Neighborhood House EHS - Spring Valley - Home visitor program

- Medi-Cal
- Vaccines for Children Program / CHDP Services
- Language banks

Organizations

The organizations below were also identified as assets for children and families in the East Region.

- Health and Human Services Agency
- Grassroots organizations
- Polinsky Children's Center
- Family Health Centers of San Diego
- Neighborhood Health Care
- La Maestra
- Homeless Agencies (Alpha Project)
- Children's Regional Center Hospital
- Anderson Center
- Home Start
- Grossman Hospital
- Schools
- Grossman High School Child Development Center
- Cajon Valley High School – services for pregnant teens
- United Way Info line
- School District (as referral agency)
- East County Career Center

Collaborations

There are many collaborative efforts throughout the East Region. In particular, the East Region Collaborative Network is a highly valued asset in the East Region and was mentioned as a best practice model by stakeholders in other regions as well. The East Region Collaborative Network brings the coordinators of all of the regional collaboratives together (e.g., El Cajon, Santee, Spring Valley) to share ideas and resources. Additional collaborations identified by grantees and regional community meeting participants include the following:

- County Office of Education & nurses (e.g., La Mesa Spring Valley School District)
- Children's Services

- East Region Dental Health Task Force (establishing more dental facilities in Spring Valley, El Cajon, and Lakeside)
- DSEPB Collaborative with East County
- I 3 Coalition
- Collaborations of health and social service agencies

Stakeholders also noted the willingness among local agencies to collaborate and share assets, especially First 5 grantees, and the willingness of community members to learn about ways to keep children safe.

Systems

Systems that were identified as assets for children’s health by grantees and regional community meeting participants in the East Region include:

- Community Clinics/low-income clinics
- School Districts - Early Start

Other assets identified by stakeholders include the presence of multi-language personnel and informed and educated parents.

Assets According to Key Informants

In addition to the assets identified during regional community meetings and surveys, key informants in the East Region identified several additional assets including:

- Neighborhood Kids East County
- Little House Family Services, which facilitates homevisits for some of the children in the East Region’s school readiness program.
- Two Women, Infants and Children (WIC) Offices
- Community clinic and public health department. Housed together, they provide an immunization clinic and CHDP physicals. The community clinic will also be helping families with Healthy Families applications.

Emerging Trends

Grantees, key informants and regional meeting participants were each asked to identify emerging trends that directly or indirectly impact the 18 health issues.

Emerging trends described either positive or negative impacts on the East Region. The top three negative trends identified in surveys and at the regional community meeting include:

- Family economic hardships and lack of affordable housing leading to housing overcrowding, families living in motels, parents commuting longer distances for work, and homelessness.
- Decreased access to oral health services due to a reduction of previously available dental screenings, lack of places to refer children for dental services after the screenings, and fewer providers who accept Medi-Cal.
- Barriers to health insurance for reasons such as fear of applying for Healthy Families and Medi-Cal due to immigration status.

Among the more positive trends noted in the East Region were increased media attention focusing on children age zero to five, increased services for the homeless, expected increases in available services for dental services due to collaborative work, and increased asthma monitoring (e.g., San Diego Asthma Report Card). Additionally, stakeholders noted that since the school shootings, a collaborative has been formed between Grossmont Union High School, HHS, and Lakeside.

Key Informants

Trends impacting children’s health that were noted by key informants in the East Region included that preschool children are increasingly overweight, poor oral health continues to be a problem, and more children with autism are being identified in the schools. Stakeholders also noted that it will become increasingly difficult to

get providers to serve patients on Medi-Cal due to low reimbursement rates; that the population is aging; and that more case management is occurring through CPS especially.

A disturbing trend noted in older children is youth violence and teen suicide, which has improved, though youth violence is still a concern in the East Region.

Positive trends noted include that immunization rates are getting better and that the East Region is fortunate to have a very dedicated group, the Dental Health Task Force, working to improve dental services to children and families.

Data Issues

Data on certain child health indicators are not available and, therefore, cannot be included in this report. For some indicators, no data was available, while for a few indicators, data for children age zero to five wasn't available. Those indicators are as follows.

Data Unavailable by Region

- Smoking During Pregnancy
- Childhood Immunizations
- Well Baby Checks
- Developmental Screening
- Developmental Services
- Recurrence of Child Maltreatment
- Expected Weight for Height and Age

Data Unavailable for Children 0-5 by Region

- Regular Medical Home
- Health Insurance
- Confirmed Cases of Child Abuse
- Annual Dental Exams
- Dental Insurance

Other Data Limitations

County and regional data for developmental services, developmental screening, and well-baby/well-child checks are not available, and therefore, not listed in the “needs assessment”

section of this chapter. Some information on these issues is included in the countywide section of this report.

While regional data is available for nonfatal unintentional injuries by major statistical area (MSA) and sub-regional area (SRA) for patients under the age of 20,⁶ data on children age zero to five by HHS region is not available.

Regional data on breastfeeding are not tracked in San Diego County; however, some hospitals in the county track the rate of women breastfeeding “exclusively” or “at all” by hospital at the time of discharge.

Though data are available by region with regards to asthma-related hospitalizations from 1999-2002, trends are difficult to assess because beginning in 2001, the Office of Statewide Planning and Development began masking a portion of the identifying variables (including age) to protect patient confidentiality. Due to this masking, data cannot reliably be compared over the four-year span between 1999 and 2002. County epidemiology staff have raised this issue with state government staff.⁵⁶

In addition, data available from SANDAG does not easily correspond with data collected by First 5, as First 5 uses the HHS regions to report data, while SANDAG reports data countywide, by census tract, by town or zip code. This makes it difficult to compare data collected between the two sources. Further, SANDAG collects data by age using zero to four while First 5 is interested in data for children under age 6, which again leads to a disparity in data.

Grantees, key informants and regional community meeting participants were also asked what data related issues they see. Grantees and regional meeting participants would like to see the following data issues addressed.

- Track number of developmental delays among no foster care (general population).

- Track number of children age zero to five getting a dental exam.
- Report data by zip codes.
- Track occurrence of health issues by demographic criteria.
- Track births to teens under 15 year of age.
- Make sure that the definition of developmental/disability services is consistent across agencies
- Improve data collection on number of homeless children age zero to five.

East Region Priorities

Regional community meeting attendees were asked to make recommendations to address the health needs of children age zero to five. (These recommendations for priorities can be found in Appendix E). Based on these recommendations, as well as the health needs, assets, and trends identified in the meeting, participants were asked to identify their top priorities for the East Region. Many of the identified priorities are linked with several health issues and focus on early prevention and intervention. The East Region Community Meeting participants identified the following priorities:

Improve transportation
Rationale: When location is a barrier, easy-to-use accessible transportation can provide a solution.
Address lack of affordable housing and homelessness

Rationale: Lack of affordable housing can lead to housing overcrowding, families living in motels, and even homelessness. When children are homeless during critical stages of their social, physical, emotional, and cognitive development, the results can be devastating. Problems such as lack of access to basic child care, crowded conditions, exposure to environmental hazards (e.g., peeling lead paint, broken windows), and violent surroundings are common to homeless children.
Support the East Region Collaborative Network
Rationale: The East Region Collaborative Network has been identified as a best practice in the region and facilitates valuable information sharing. The work of the Collaborative has led to many positive changes, such as a dental coalition and a better understanding of the critical need for affordable dental care.
Build upon the work funded through HHSA
Rationale: The HHSA is working to address many of the health issues covered in this needs assessment via an RFP. These HHSA grantee programs provide an opportunity for First 5 to build upon.
Developmental delay services and linkages
Rationale: Developmental disabilities impact a child’s readiness for school. Depending on the developmental disability, school readiness can be impacted differently.

APPENDIX A – NEEDS ASSESSMENT TOOLS



KEY INFORMANT INTERVIEWS

One component of the children's health needs assessment was to conduct key informant interviews with select stakeholders and content experts familiar with the issues related to children's health in San Diego. Each key informant was provided, prior to the interview, issue summaries for 15 issues that were included in the assessment. The summaries included background information on the issue, why it is important and the data collected county wide and regionally that tells how we are doing related to the particular issue.

Some interviewees with very specific content knowledge used the issue summaries as a starting point for addressing key informant interviews while others used it as background material and did not necessarily refer to the summaries during the interview.

The purpose of the key informant interviews was to identify:

- most recent data on health priorities and strategies currently in place within San Diego
- emerging trends that may not yet be evident from data but which may impact children's health in the future,
- areas of need that should be included in the assessment to compare with data already collected
- assets within the community that may be called upon to address unmet needs including partnerships and other resources

The key informant interviews were conducted by phone or in person and lasted between 30 and 60 minutes based upon the interviewee's familiarity with all the regions in San Diego County.

In addition to commenting on the specific health issues, key informants were asked the following questions:

- From your perspective, what are the children's health needs in San Diego that you are most worried about at this time?
- Are there unique health needs in a particular region that you would highlight as a concern?
- Are there any issues that were not of major concern a year ago that have emerged as an issue related to children's health?

- In thinking about children's health for San Diego County and the six HHSA regions, can you forecast some issues that may not yet be on the community's radar screen that you think should be tracked or attended to over time?
- Can you think of any particular program or practice that has been successful in addressing issue(s) related to children's health in San Diego?
- If you could replicate one or more programs county wide to address children's health, which program(s) would you suggest and why?
- What are you most pleased about in San Diego County related to children's health?

First 5 San Diego Needs and Assets Assessment Regional Community Meeting Evaluation

Please take a moment to complete this evaluation before you leave. Your feedback is invaluable in helping us assess our performance and improve our services. Thank you!

On a scale of 1 to 5, with **5** being the *highest or best* and **1** being the *lowest or least effective*, please evaluate the following:

Was the overall meeting format effective? 5 4 3 2 1

Content Usefulness:

Was the content of the Introduction to the Children’s Health Needs Assessment useful and relevant? 5 4 3 2 1

Was the content of the Regional Health Needs Priorities discussion useful and relevant? 5 4 3 2 1

Small Group Discussion:

Did you attend the small group discussions on all three needs assessment areas (needs, assets, and trends)

Yes No

Were the small group discussions informative and relevant? 5 4 3 2 1

How useful was the Needs Assessment Survey as a tool to allow you to provide feedback and additional information to the Needs Assessment Team. 5 4 3 2 1

Overall, I would rate this meeting as: 5 4 3 2 1

1. What did you find *most* valuable about today's meeting?

2. Is there anything that you felt was missing from the meeting or could have been done to improve the effectiveness of the meeting?

3. Please provide any additional comments you wish to share below.

Optional: Please provide the following information if you would like to be contacted regarding any additional comments you have provided on today's meeting.

Name:

Project:

Position/Title:

Lead Organization:

Address:

Phone:

Fax:

Email:

APPENDIX B – SIGNIFICANCE RATING

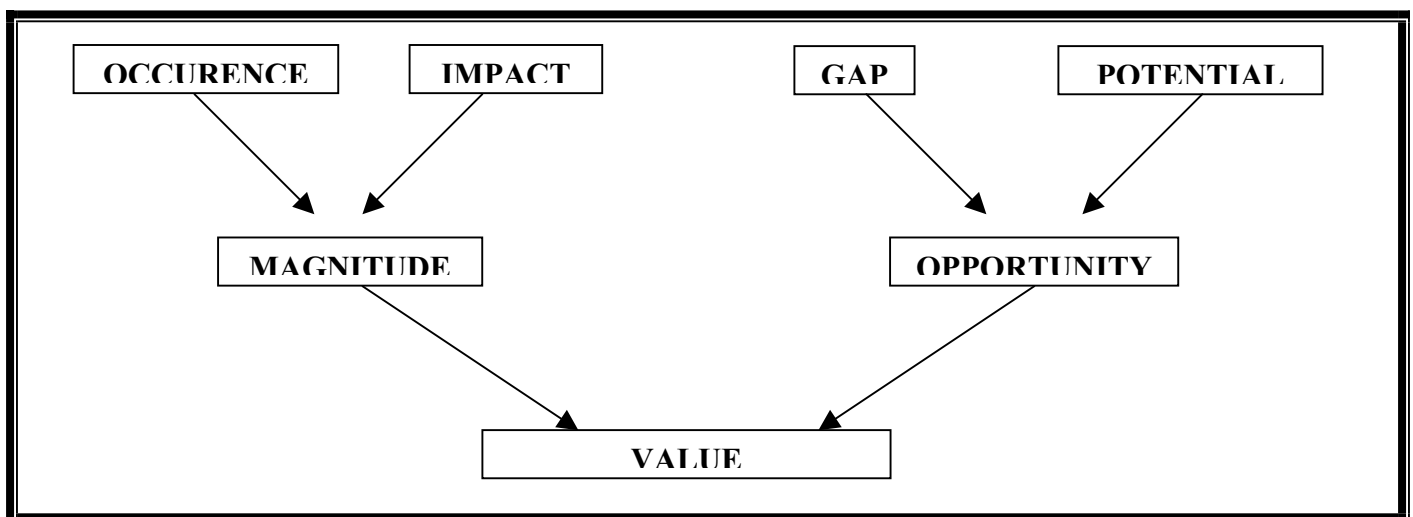
Addressing community health needs requires a thorough understanding of health issues and the ability to prioritize health needs in order to determine how best to invest limited resources to improve the health status of target populations. Traditional needs assessment techniques, however, often do not provide a cohesive way to compare diverse health issues to each other; large volumes of data are produced without a clear methodology for how that data will be used for decision-making.

The purpose of the Significance Rating Scale (SRS) was to provide a rationale and consistent way to use the results of the health needs assessment to compare and prioritize disparate health issues, leading to more effective decision making. Specifically, the SRS was designed to achieve the following three objectives:

- Provide a framework for determining where investments in additional services or projects are most likely to have the greatest impact – in short, to produce the greatest overall health/social value from available resources.
- Provide an effective way to communicate the criteria used to select health priorities and make investment decisions so that policy makers, service providers, and the public at large can understand the rationale behind these critical decisions.
- Provide a more consistent way to incorporate new data and assess the impact of changing conditions over time so that health priorities can be periodically reevaluated in an efficient and effective manner.

RATING TOOL

The SRT Model includes the following elements:



- Occurrence Rate is computed as the rate per 1,000 people within the defined total target population, e.g. children age 0-5, directly affected by the health condition or issue. Example: if the best available data suggests that there are 28,500 children age 0-5 with untreated dental caries or another type of oral disease, the occurrence rate would be 28.5.
- Impact Weight is a value from 0.0 to 1.0 (0.0 = no impact whatsoever, 1.0 = extreme impact) that reflects the degree to which people who have the health condition/issue are affected by the condition/issue **relative to the other issues being prioritized**, based on using the best available data to evaluate the following criteria:
 - Short-term health effect (presence of disease, pain, physical limitation, and complications that impact the person's quality of life). Short-term effects are those effects that impact the target population during the prenatal to five time frame.
 - Long-term health effect (presence of any known links between the issue and longer-term mortality and morbidity). Long-term effects are those that impact the target population beyond age six.
 - School readiness effect (impact of condition on children's ability to learn, emotional/mental/cognitive readiness for school, and performance in school)
 - Gap Rating is a value from 0-50 representing the extent to which the issue can be addressed effectively by existing services and systems without requiring additional investment. A value of 0 means there is no gap in services (sufficient capacity exists to serve everyone who needs and is willing to access services to address the health issue), and 50 means there is a substantial gap in services **relative to the other issues being prioritized**. Evidence used to assign the Gap Rating can include estimates of the percentage of the population not being served due to a lack of adequate service capacity and/or the presence of tangible barriers to accessing services. Tangible barriers may include culture and/or cultural beliefs, language and transportation.
 - Improvement Potential Rating is a value from 0-50 representing the extent to which improvement in the health issue is likely to occur if additional investments are made. A value of 0 means none of the people affected by the health issue are likely to be helped, and 50 means all or almost all of the people affected by the health issue are likely to be helped **relative to the other issues being prioritized**. Criteria to use in assigning this value are:
 - Comparisons of local conditions to state and/or national averages (example: if the rate of unintentional injuries within the county is twice the state average, there is evidence of significant potential for improvement since many other counties are experiencing much lower rates)
 - Comparisons to Healthy People 2010 objectives
 - Extent to which community assets are identified that can be applied or leveraged to address the health issue

Where Significance Rating values were close between health issues, “tiebreaker” factors were considered when prioritizing the health issues. One factor was the quality of the available data. Another factor of note was the trend data in cases where it highlighted the likelihood of future improvements or degradations if no new interventions occur to “turn the curve,” and the projected magnitude of those improvements and degradations. Finally, the degree to which a health issue would impact school readiness was also used as a tiebreaker.

Significance Rating Results

A Significance Rating Team (SRT) was convened to perform three important roles throughout the needs assessment process. Members of the SRT were identified by First 5 San Diego Commission staff as individuals with an understanding of how data impacts policy, expertise in health related content areas, and the ability to conceptualize health issues globally in terms of ensuring overall health, rather than having an interest in a particular health issue.

The SRT met twice during the development of the needs assessment. The first meeting was used to orient SRT members to the rating model, facilitate confirmation of the criteria to be used in applying the rating tool and provide an overview and practice opportunity for using the rating model on a particular health issues. The SRT reviewed, discussed and agreed upon the criteria to determine the Impact Weight, Gap Rating and Improvement Potential Rating described later in this appendix. They also helped define the health issues to be prioritized.

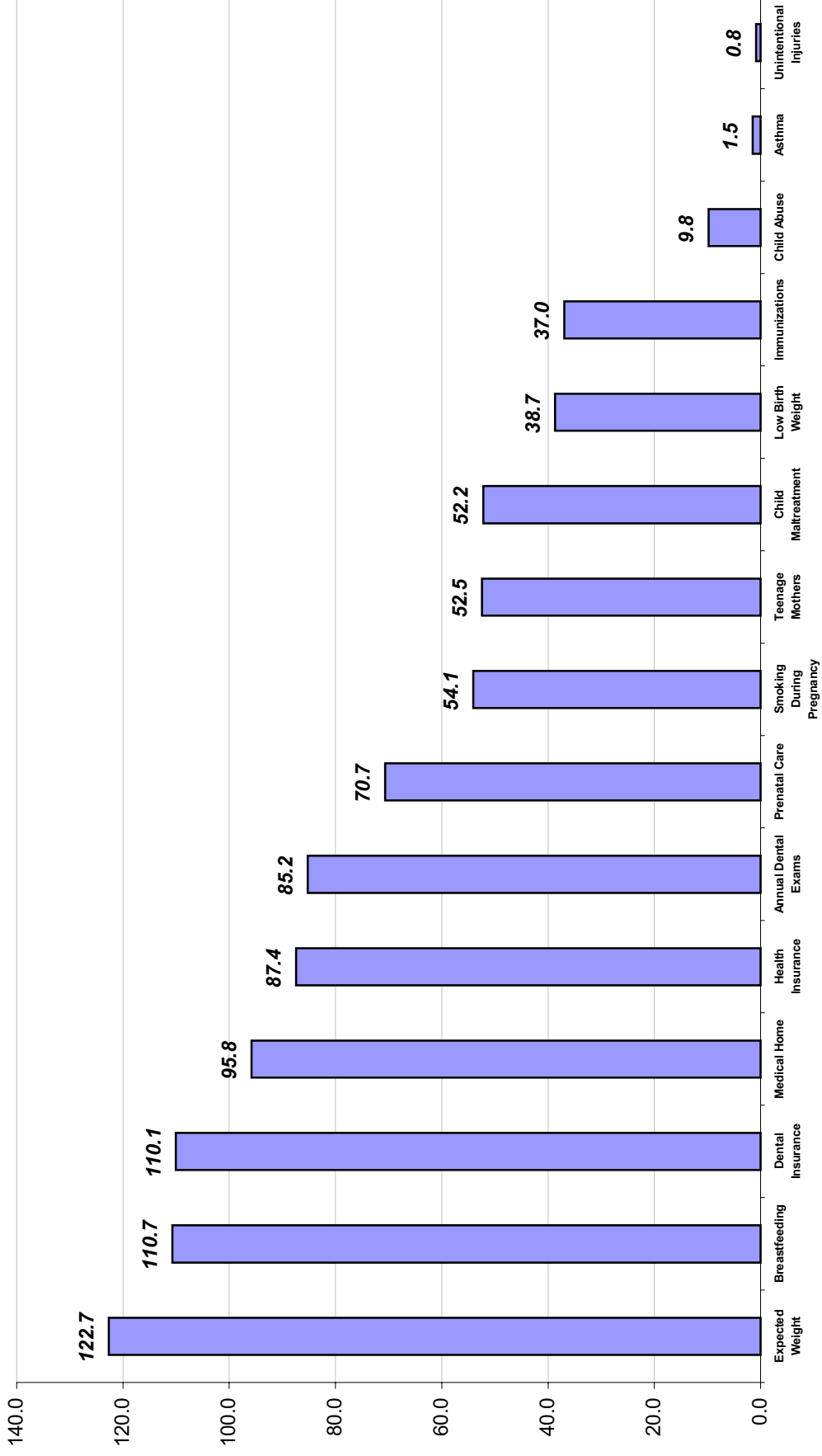
Following this initial meeting, SRT members received the data for the issues in the form of issue summaries. Between the first and second meeting, SRT members individually ranked 15 of the 18 health issues from highest to lowest SRS value. They were unable to rank three of the health issues as no occurrence data were available. Those health issues are identified in the data development section of the countywide summary. Each SRT member submitted their results to the Assessment Team who synthesized the results into a set of ratings, reflective of the work of the SRT.

A follow up meeting took place in February 2004 once the results were completed. The purpose of the follow up meeting was to discuss the preliminary ratings resulting from the SRT team member ratings and to validate or adjust the ratings based on SRT feedback. Team members reviewed their ratings compared to the overall results. A variety of tests were performed to validate the rating results. During the meeting, team members defined compounding health issues as those health issues where improvement in the health issue would significantly improve or impact one or more of the other 18 health issues, based upon the research available.

This discussion led to the creation of health issue clusters. The health clusters show the aggregate significance rating scale for each health issue and the compounding issues it impacts. This indicates where the most overall value may be realized by investing in a particular health issue. Both significance rating and cluster scores are provided in the following tables.

The 2003 First 5 San Diego Children's Health Needs Assessment Significant Rating Scores for each issue are provided in the graph on the next page:

Significance Rating Comparison

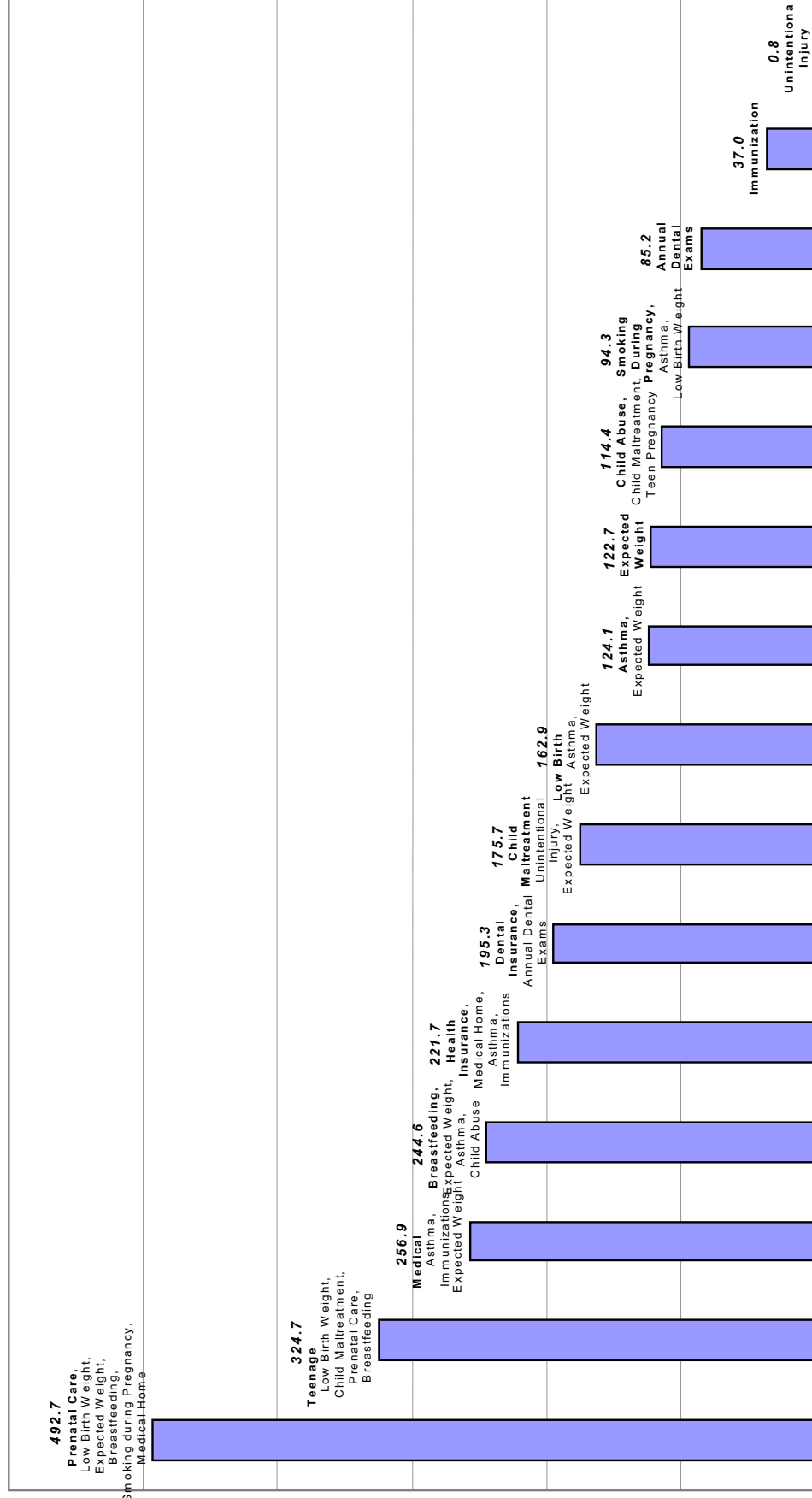


Significance rating scores were greatly impacted by the occurrence of the health issue impacting the target population for the health issue. For that reason, it is helpful to review the occurrence ratings, as they indicate where the largest impact may be felt by investing in particular issues.

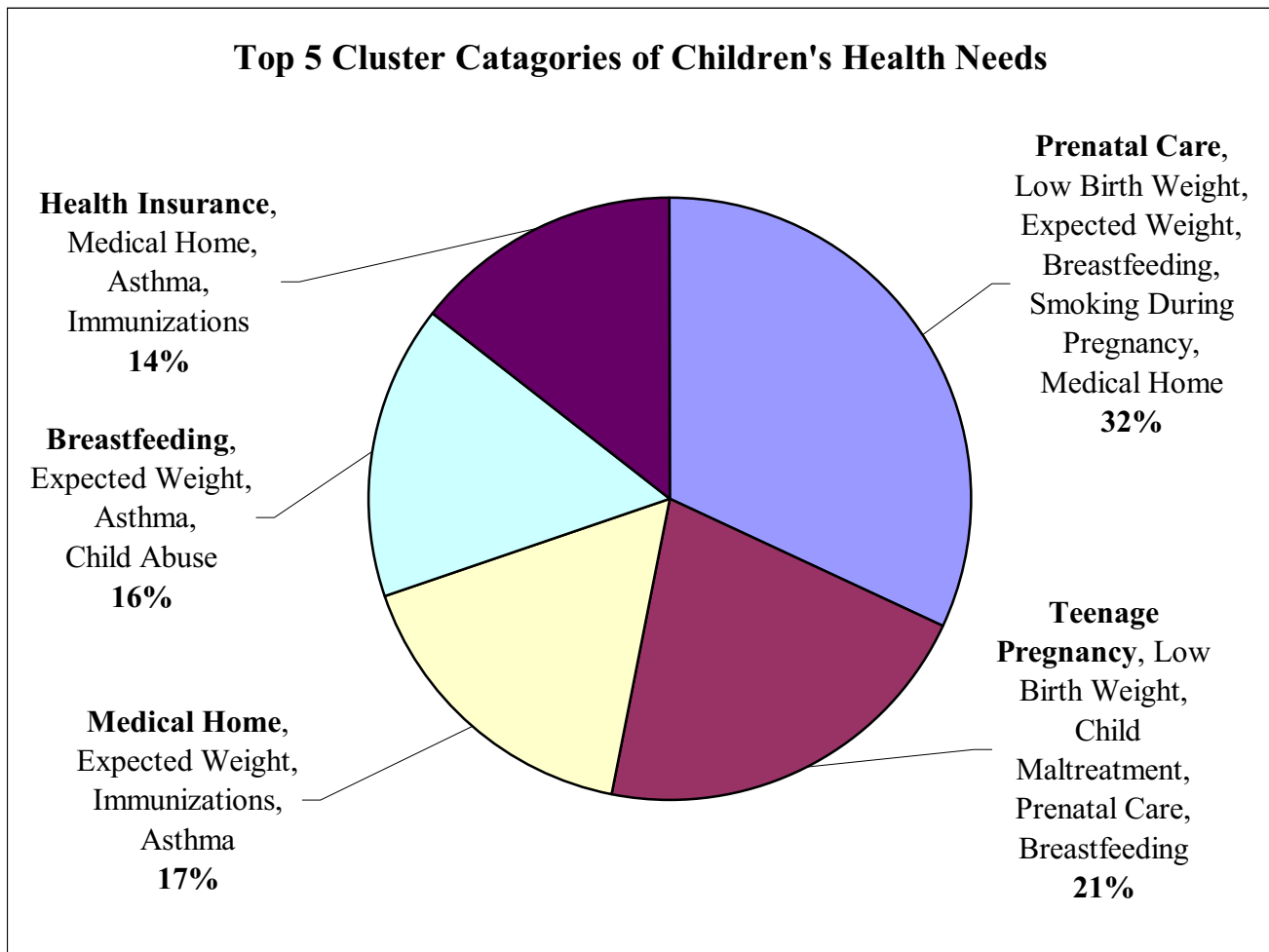
Health Issues	Occurrence Rate
Children are born healthy	
Low birth weight	61.0
Live births in which mothers received adequate prenatal care	147.0
Births to young teenage mothers	85.0
Women who refrain from smoking during pregnancy	110.0
Children receive preventive and ongoing regular health care	
Childhood immunizations (aged 19-35 months who receive the recommended vaccines)	130.0
Children have a regular medical home	287.0
Children have health insurance (and their enrollment is sustained with continuous health coverage for 1 year)	146.0
Children are in healthy and safe environments	
Children with substantiated or confirmed (open) cases of child abuse	14.8
Child maltreatment with a recurrence within a 6-month period	111.0
Children with nonfatal unintentional injuries	3.0
Children are healthy and well nourished	
Breastfeeding	410.0
Children 0 to 5 years of age are in the expected range of weight for their height and age	204.0
Children have good oral health	
Children ages 1 and older receive annual dental exams	269.0
Children have dental insurance (and their enrollment is sustained with continuous health coverage for 1 year)	293.0
Children are free of smoking-related illnesses	
Childhood asthma	2.8

Many of the health issues selected for the needs assessment directly affect one or more of the other health issues as noted in the issue summaries. The Significance Rating Team used the issue summaries to identify those issues that research indicated would be positively or negatively impacted should a particular health issue improve or deteriorate. These form Significance Rating Clusters of health issues, please see the comparison of cluster issues in the graph below.

Cluster Comparison



The top five clusters that if invested in would positively impact the greatest number of the 18 health issues are:



Therefore, the top five health issues by Significance Rating Score, Occurrence Rating and Cluster Rating are:

Comparison of Top 5 Health Issues by Significance Rating, Occurrence and Cluster Scores

Health Issues	Significance Rating	Occurrence Rate	Cluster Scores
Expected weight	1	5	
Breastfeeding	2	1	4
Dental Insurance	3	2	
Regular Medical Home	4	4	3
Health Insurance	5		5
Dental Exams		4	
Prenatal Care			1
Teenage Pregnancy			2

Legend for Comparison Table

Assessment Activity	Description of the Ranking Results for the Top Five Priorities by Assessment Activity
<i>Occurrence Rate</i>	Occurrence Rate was computed as the rate per 1,000 people within the defined total target population e.g. children age 0-5, directly affected by the health condition or issue. Therefore, the top five issues by Occurrence Rate indicate the health issues where the greatest number of persons can be impacted if an investment is made.
<i>Significance Rate</i>	The formulas used to compute the significance rating are as follows: $Significance\ Rating = Magnitude * (Opportunity / 100)$ where $Magnitude = Occurrence\ Rate * Impact\ Weight$, and $Opportunity = Gap\ Rating + Improvement\ Potential\ Rating$ The top five issues by Significance Rate identify those issues that occur most frequently, and that have the greatest opportunity for improvement as determined by the Significance Rating Team. Therefore the health issues with the greatest significance is rated 1 in the table above with the other 4 issues listed in numerical order from 2-5.
<i>Significance Cluster Rate</i>	Significance Cluster Rates are based upon the aggregate significance rating scale for each health issues and the compounding issues it impacts. This indicates where the most overall value may be realized by investing in a particular health issue, in terms of impacting the majority of the 18 children’s health issues included in this assessment.

APPENDIX C – DATA REPOSITORY

APPENDIX D – ISSUE BRIEFS

The issue briefs are, on average, 3-4 page documents that provide information on specific health indicators that are of interest to the First 5 San Diego Commission. Each issue brief includes the following components:

- A short description of the indicator, which describes the parameters of the indicator e.g., for the issue brief addressing child immunization, the indicator is defined as "vaccination coverage levels for universally recommended vaccines among children aged 19-35 months."
- General issue information, which elaborates on the indicator description as necessary
- A countywide assessment, which provides occurrence data on the indicator at the county level; the impact weight of the indicator, which provides information on the potential impact of the indicator on overall child health; and the gap rating, which provides information on how many individuals are impacted by the indicator, and if the impact affects certain groups more strongly (e.g. by age, ethnicity, etc.). Finally, the countywide assessment includes a section on improvement potential, which describes how well the county is doing on a particular indicator compared to California, the United States, and *Healthy People 2010* goals.
- A regional assessment, which provides occurrence data and improvement potential at the county regional level. In the occurrence section, the county regions are compared, when information is available, and in the improvement potential section, the counties are compared to San Diego County, California, the United States, and *Healthy People 2010* goals.

To obtain individual copies of the issue briefs, please go to the First 5 San Diego Commission website at <http://ccfc.ca.gov/sandiego/> to access the issue briefs.

APPENDIX E – REGIONAL COMMUNITY MEETING RECOMMENDATIONS

North Central Region

- Continue resource support for collaborations. Funders can mandate entities to collaborate. Invest in collaboratives to best utilize and increase knowledge about currently available resources.
- Expand funding for education. There are limited services and limited knowledge about how to link families with services.
- Link families with services once screening and diagnosis of disabilities is done.
- Promote parenting classes and support groups for teen moms.
- Support males being more involved in children's lives (could be helpful by creating Home visiting programs that speak to men).
- Educate parents and caregivers to get rid of bottles and sipper cups.
- Promote water drinking for good health.
- Train Pediatricians and general Dentists to serve children. Increase the number of programs to get health professionals trained and certified.
- Increase awareness of importance of Prenatal Care.
- Address transportation and other barriers to Home Visitation.
- Provide prenatal care through School nurses.
- Augment dental reimbursement rates for Healthy Families to increase provider participation.
- Pilot development screening programs at preschools.
- Provide multilingual materials and education for parents.
- Educate pediatricians regarding the importance of child obesity, oral health and nutrition.
- Support change in WIC diet guidelines.
- Increase opportunities for low cost physical activities.
- Advocate for community water fluoridation.
- Create incentives for healthy food.
- Educate preschools about nutrition and obesity. Make it part of licensing.
- Support and provide more education on the importance of early intervention 0-5.
- Decrease barriers to care (i.e., provide transportation vouchers).
- Provide more education about vaccine safety and prevention.
- Look closely at current grantees and services, and eliminate potential duplication of services.

North Coastal Region

- Sustain funding for continued support of existing First 5 San Diego grantees especially those providing health and dental care and home visiting programs for high-risk populations in outlying areas. Consider funding fewer programs for longer periods of time. This will also reduce

duplication and ensure diversification of services. Avoid cutting already funded operational programs and make renovation and capital funds available as well.

- Establish an up-to-date monitoring / surveillance system for certain health needs (i.e., data is often 2-3 years old).
- Support more school nurses especially for providing immunizations.
- Focus on basic health prevention issues (i.e., on nutrition/ physical activities in relation to diabetes/obesity)
- Support and promote healthier school lunches.
- Support and promote community physical activities for children (i.e., after school or through physical education classes).
- Maximize resources through collaborations/ communication to avoid duplication of services (more information sharing inter-agencies).
- Sponsor more intervention services.
- Implement tobacco prevention and cessation within all funded agencies to work towards “undoing” tobacco. Also ask for any funded agency not to take funding from tobacco industry.
- Need more health training for child care providers.
- Re-institute the phone hotline for medical nurse advice to prevent overuse of hospital emergency rooms.
- Sponsor outreach programs to increase enrollment in services.

Key Informants in the North Coastal Region also recommended the following:

- Put the focus back on the full range of ages from prenatal to 5 years old. When the net is wider, services can be provided much more effectively.

North Inland Region

- Expand existing Parent Education programs to provide free parent education on child development, preventing obesity and related issues, and children’s oral health needs at sites that parents see as safe places such as schools, hospitals, or Family Resource Centers in neighborhoods.
- Look at models for redesigning service provision to improve access and waiting time for care (Camp Pendleton Streamline, Roger Coleman and others that are working)
- Sustain funding for continued support of existing First 5 San Diego grantees especially those providing health and dental care and home visiting programs for high-risk populations in outlying areas. Consider funding fewer programs for longer periods of time. This will also reduce duplication and ensure diversification of services. Avoid cutting already funded operational programs.
- Coordinate faith based activities around 0-5 year olds to reduce duplication of services.
- Work closely with schools and/or school districts to identify siblings (0-5) with health issues or needs.
- Create a program to retain and increase the number of service providers. The expense of workers compensation and other insurance requirements are a big problem.
- Advocate for increasing the capacity of Medi-Cal, Denti-Cal and Healthy Families programs.

- Support or require integrated case management. Have one provider whose sole job it is to coordinate services for children and families across services as well as geographic areas like the Regional Center coordinates services but doesn't directly provide them.
- Support more school nurses especially for 3-5 year olds in state preschool programs that have the most at risk or borderline children.
- Link and provide services for children who've been screened and diagnosed with special needs or disabilities.
- Support programs to increase the quality of child care.
- Support safe outdoor public recreation environments for children.
- Advocate for community water fluoridation.
- Increase collaboration with school districts and health systems (safe places) to link families with services.
- Support assessments for children under 1 year of age.
- Establish an up-to-date monitoring / surveillance system for certain health needs (i.e., data is often 2-3 years old)
- Needs assessments should be integrated on a continuous basis so that as a cluster of agencies begins to track a different issue other agencies are aware of the change and track that also so that we have a thorough assessment.

Key Informants in the North Inland Region also recommended the following:

- Put the focus back on the full range of ages from prenatal to 5 years old. When the net is wider, services can be provided much more effectively.
- Support the use of behavioral checklists (toddler checklist) to discern signs of autism.
- Have parents complete the ages and stages questionnaire (ASQ) through First 5 San Diego. The ASQ asks questions about social development, motor skills, emotional, and more for children 0 to 4 years old.
- Pediatricians need to be conducting developmental screenings.

South Region

- Community water fluoridation
- Centralized resource list
- Training for general dentists on pediatric dentistry
- Improved reimbursement rates
- Culturally competent providers
- Affordable/accessible transportation to health services
- Addressing trust and fears to obtaining healthcare
- Improve parent education efforts
- Develop sustainable funding streams
- Secure a legislative champion for children and family issues
- Develop education programs for healthy pregnancies
- Integrated case management/services - database
- Expand mentoring mom programs - culturally relevant/take to other cultures

- Access to pregnancy prevention
- Expand parent education programs through WIC as point of entry
- Health literacy for new Americans/immigrants
- Increase efforts to improve parenting skills development, e.g. through home visiting nurses trainings

Key informants also recommended the following:

- Ensure that parent education efforts are delivered in a structured manner, and that parents use the information they are given
- Increase vision and hearing screening in schools

Central Region

- Schools must be engaged with other systems
- Use prenatal period to engage mothers in continuum of services
- Information about car seats
- Focus on parenting education
- Look at policies to promote insurance access
- Invest in education and public awareness regarding monetary value of prevention
- Promote free services
- Perform outreach
- Increase early intervention services
- Replicate Quarterly for programs in Central Region who have address Children's Health Coalition
- Collaboration of collaborative chairs to share information
- Need translation services, materials to address refugee needs
- Universal child care that incorporates parent education (e.g. nutrition, child development& resource acquaintance) for parents with children 0-5
- One Stop Shop to streamline culturally sensitive services
- Provide services to better reach non-literate populations
- More funding for nutrition programs
- Culturally sensitive free parenting classes in multiple languages
- More collaboration using the East Region model
- Work on increasing continuity of care and use best practices for region/county
- OBGYN transition to pediatricians (align incentives) (risk pool resources vs. grants)(March of Dimes - passport project)
- California Endowment funding
- Welcome Back Support - place professionals for other countries, not licensed in CA, to bridge the gap (600 waiting)
- Targeted Cultural Competency training - inventory of culturally competent providers
- Multi-year grant funding to encourage collaboration with incentives
- Continue to educate on the importance of first 5 years
- Increase resources that have been translated and coordinate resources

East Region

- Institute a county dental service program
- Provide home visits for every child 0-5. Could be paraprofessionals; expand revisiting program
- Expand parent education services beyond 1st year of life.
- Make additional requirements for families on cash aid such as services and resources available
- Provide universal health and dental care
- Improve regional public transportation
- Require that all physicians provide developmental screenings by age 18 mos
- Require physicians to do special dental screenings for all children
- Provide parent education on oral health with translation services and materials
- Provide culturally competent and appropriate services
- Translate New Parent Kit into other languages

APPENDIX F – REGIONAL COMMUNITY MEETING PARTICIPANTS

Central Region Participants			
Phyllis	Elkind	Coordinator - CHDP	HHSA - Children, Youth & Families
Irene	Linayao-Putman	Director of Health Promotions	Union of Pan Asian Communities
Jeanne	Carrillo	N/A	Universal Care
Madonna	Carlson	Director	Regional Perinatal System
Arlene B.	Griffin	Family Service Coordinator	San Diego CHOICE Program
Teresa	Ganger	Site Coordinator	North Park Family Resource Center
Jennifer	Travis	Intern	Share the Care Program
Peggy	Yamagata	Program Manager	HHSA - Dental Health Initiative
Jolie	Ramage	Analyst III	HHSA - SPD Administration
Alemi	Daba	Director	Alliance to African American
Cathy	Lurty	Health Promotions	Blue Cross
Lisa	Haney	Anderson Center	Children's Hospital
Cindy	Muehleisen		San Diego County SMILES
Chang	Amy	Health Educator	Union of Pan Asian Communities
Lan	Le	Health Educator	Union of Pan Asian Communities
Esther	Salazar	Clinical Social Worker	Mental Health Provider
Maria Theresa	Llamado	Public Health Nurse	HHSA - Central Region Health Center
Elaine R.	Simon, R.N. Djifroudi, R.N.	Program Coordinator	Sweet Success - California District
Marjan	Flores	Health Director	YMCA Child Care Resource Service
Desiree	Roxas	Program Coordinator	Logan Heights Family Resource Center
Cristie	Cureg	Public Health Nurse	HHSA - Central Region Health Center
Dr. Amethyst C.	Adam	Medical Director	HHSA - Maternal, Child & Family Health Services
Shuki	Munoz	PHN	HHSA - CR PHC
Tina	Shorack	Asst. Deputy Director	HHSA Community Epidemiology
Heather	Lobo	Health Information Spec	HHSA
Diana	Lorentz	Health Promotions	HHSA
Elise	Hamilton	Community Specialist	Health Net
Brenda	Hazlewood	Clinical Psychologist	Children's Hospital
Lisa	Keyes	Child Development Specialist	Children's Hospital - DSEP
Anne	Escoboza	President and CEO	Healthcare Association of San Diego and Imperial Counties
Steven A.			
East Region Participants			
Andrea	Muratet	Coordinator	Family Health Centers of San Diego
Elisa	Ayala	Dental Health Educator	Children's Hospital - Anderson Center
Kim	Contardi	Community Health Promotion Specialist	HHSA - Immunization Program

East Region Participants			
James	Gearity	Senior Research Assistant Community Development Coordinator	Children's Hospital - DSEP
Lisa	Lind		El Cajon Community Development Corporation
Christine	Alcala	Public Health Nurse Director, Behavioral Health Services	HHSA - Nurse Family Partnership Program
Catherine	Padilla		YMCA Child Care Resource Service
Brenda M.	Marnufo Waddinton- Beal	Intern R.N.	Share the Care Program Alpha San Diego
Barbara	Sanders	HSPS	HHSA - SPD Administration
Maria	Gardina	QI Spec	EMS
Les	Tobler	UCSD - Women's Health	UCSD
Lynne	Lange	Youth Service Worker	San Diego Choice Program
Jennie	Hays- Zavala	PHN, East HHSA	San Diego County
Judith	Hartman	Regional Director Director of East County Services	Family Health Centers of San Diego
Gene	Ash		Center for Community Solutions
Vivian			
North Central Region Participants			
Marge	Wurgel	Community Education and Outreach Manager	HHSA - Immunization Program
Katherine	Kousser	HSPS	HHSA - SPD Administration
Wayne	Spruce		CCS
Samuel	Casas	Safety First Associate Public Health Nurse Supervisor	American Red Cross
Stephanie	Sweley		HHSA - Children's Services
Amy	Chang	Health Educator	Union of Pan Asian Communities
Danny	Nguyen	Intern - Social Work	Polinsky Children's Center
Lucia	Sanchez	Intern - Social Work	Polinsky Children's Center
Nga	Tran	Health Educator	Union of Pan Asian Communities
Susan	Lovelace	Executive Director Community Health Promotion Specialist	San Diego County Dental Society
Holly	Rucker		HHSA - North Central Region
Christine	McNamara	Program Coordinator	UC Cooperative Extension
Judy	Vickrey		HHSA Children's Options Healthcare Association of San Diego and Imperial Counties
Steven A.	Escoboza	President and CEO Program Director - Operations FitKids	American Council on Exercise
Deidre	Kleske		Blue Cross of California
Brenda	White	Outreach Specialist	Union of Pan Asian Communities
Xona	Her Cruz	Health Educator	Union of Pan Asian Communities
Cynthia	Custodio	Health Educator	Union of Pan Asian Communities
Lily	Phaymany	Project Coordinator	Union of Pan Asian Communities
Susan	Morgan		First 5 San Diego Commission
Dawn	Engel	Program Manager	Catholic Charities - Family Support Services Continuum

North Coastal Region Participants			
Janaan	Miles	Community Center Manager	American Red Cross
Carol	Mudgett	Program Planning and Dev Mgr	North Coast Health Services
Rosie	Rodriguez	Project Coordinator	Vista Community Clinic
Analilea	Ortega	Coordinator	YMCA - Kinship Support Services
Tammy	Vo-Ngo	Public Health Nurse - CHIP Fostercare	HHSA - North Coastal Region
Gail	Maher	Team Nurse	Children's Hospital Chadwick Family Support
Judi	Mills	Outreach Coordinator	University of California - San Diego
Alicia	Lockett	Business Manager	Welcome Home Baby
Alicia	Santos	COO	North County Health Services
Tana	Lepule	Health Educator	Union of Pan Asian Communities
Steve	Gardner	HSPS	HHSA - SPD Administration
Roslyn	Reece		HHSA Children's Services
Frances	Yanez	Behavior Specialist	Blue Cross of California
Brenda	White	Outreach Specialist	Blue Cross of California
Ruth	Kyola	Medi-Cal Retention Consultant	
Steven A.	Escoboza	President and CEO	Healthcare Association of San Diego and Imperial Counties
North Inland Region Participants			
Kay	Stuckhardt	Project Coordinator Supervisor Human Services	Children's Hospital - Anderson Center
Nolan	Egemo	Specialist	HHSA - North Inland Family Resource Center
Bea	Moniz	Foster Care PHN Director of Program	HHSA - North Inland
Chris	Lilly	Intergration	Neighborhood Healthcare
Beatriz	Cornejo	Family Service Specialist	San Diego CHOICE Program
Linda	Guhlow	Nurse Consultant Health & Human Services	HOPE Infant Program
Rick	Clark	Administrator	HHSA - Children's Services
Diane	Hall	PHN Manager	HHSA - North Inland Public Health Center
Suneel	Bhaskar	HPPS	HHSA - SPD Administration
Kim	Frink		First 5 San Diego
Nancy	Cohen	C3 Program Coordinator	C3 Children's Hospital
Kitty	Roche	PHN II	HHSA
Donna	Erfe	PHN II	HHSA
Alicia	Liriano	Health Promotions Director	North County Health Services
Helen	Jacobsen	Dietician	Neighborhood House Assoc. Head Start
Nick	Yphentides	Physician	DSEP Clinics - Palomar Hospital
Danae	Ramirez		Office of Supervisor Pam Slater
Chris	Walsh	Behavioral Health	
Norma	Rincon	Social Worker	HHSA
Rachael A.	Butt	R.N.	HOPE Infant Program
Ida	Cross	Director, Child Care Svcs.	Chicano Federation of San Diego County
Jo Ann	Leone	Director	National City Collaborative
Robin	Johnson	QM Nurse	Blue Cross SSP

South Region Participants

Mary Jo	Buettner	Director	Chula Vista Community Collaborative
Martha	Laignelet	Family Support Mgr.	Episcopal Community Services - Head Start
Cynthia	Custodio	Health Educator	Union of Pan Asian Communities
Erin	Alleman	Health Promotion Specialist	HHSA - San Diego County
John	McDonald	COO	San Ysidro Health Center, Inc.
Monica	Lynch, R.N.	School Nurse	Emory Elementary School
Reina	Menasim	Family Help Coordinator Public Health Nurse	Family HELP Project
Paulina	Bobenreith	Manager	HHSA - South Region Public Health Center
John	Chavez	Board Memberr	San Ysidro Health Center, Inc.
JoAnn	Leone	Director	National City Collaborative Healthcare Association of San Diego and Imperial Counties
Steve	Escovoza	President & CEO	
Georgina	Guerrero	Family Service Specialist	San Diego CHOICE Program
Steven	Shubert	Sr. Mgmt. Analyst	San Ysidro Health Center, Inc.
Tana	Lepule	Health Educator Child Development Specialist	Union of Pan Asian Communities
Erin	Pennell	School Readiness Program Project Specialist	South Bay Community Services
Barbara	Rensink	Program Development Specialist	Chula Vista Elementary School District
Leticia	Lleva	Community Engagement Coordination	Whittier Institute for Diabetes/Project Dulce
Martha	Garcia	Coordinator	First 5 Commission of San Diego
Annie	Moore	Coordinator	YMCA - Kinship Support Services
Janet	Trautmann	Public Health Nurse Manager - Center for Health Promotion	HHSA - South Region Public Health Center
Jane	Campbell	Health Promotion Specialist	Paradise Valley Hospital
Theresa	Gonzalez	Program Coordinator	HHSA - Lead Prevention Program
Jan	Ferree		Anderson Center for Dental Care - Children's Hospital

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