

Live Well San Diego
Report Card on
Children, Families,
and Community
2017

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Live Well San Diego Report Card on Children, Families, and Community 2017 Edition

Produced in partnership with the County of San Diego Board of Supervisors

District 1

Greg Cox

District 2

Dianne Jacob

District 3

Kristin Gaspar

District 4

Ron Roberts

District 5

Bill Horn

Chief Administrative Officer

Helen N. Robbins-Meyer

Health and Human Services Agency

Nick Macchione, Director

Funded by

County of San Diego Health and Human Services Agency

Kaiser Foundation Hospitals

The San Diego Foundation

Authored by

The Children's Initiative

Sandra L. McBrayer and Sarah Mostofi

Johnson Group Consulting, Inc.

Kay A. Johnson

This *Report Card* is available in electronic format at www.thechildrensinitiative.org



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EXECUTIVE SUMMARY

The *Live Well San Diego Report Card on Children, Families, and Community, 2017* supports the vision of *Live Well San Diego* toward building better health, living safely, and thriving for all residents of the County of San Diego. The *Report Card* documents the status of health, safety, and well-being of children and families in San Diego County, California. The Children’s Initiative worked with professionals in children’s services, government leaders, community organizations, schools, and foundations to drive a results-focused process to generate this report. This process allows us not only to report data trends, but to highlight effective practices and make specific recommendations to “turn the curve” and take effective actions to accelerate improvement in outcomes. The *Live Well San Diego Report Card on Children, Families, and Community, 2017* continues in a series of report cards that has monitored the health, safety, and well-being of our San Diego County children, youth, and families. This *Report Card* supports the *Live Well San Diego* vision of healthy, safe, and thriving communities by reporting on up-to-date data, emerging trends, national best practices, and local recommendations.

Aligned with the vision of *Live Well San Diego*, the *2017 Report Card* uses 25 indicators focused on children and families, as well as five indicators on adults. With these indicators, the *Report Card* measures health, safety, and thriving across the life span. Using nationally recognized criteria in results-based accountability, each indicator was selected to meet specific criteria: Are the data reliable and consistent? Does the indicator communicate to diverse audiences (e.g., families, communities, policy makers)? Does the indicator say something of importance about the desired outcome? Guided by the Leadership Advisory Oversight and Scientific Advisory Review Committees, the Children’s Initiative used this decision model to select indicators that reflect important results indicators for which reliable data are available.

The *Report Card* is produced and disseminated biennially by the Children’s Initiative. Public and private partnerships and funding support the development and publication of this *2017 Report Card*. The effort relies on advice and expertise from a diverse group of stakeholders including: subject matter and data experts in education, health, and juvenile justice, as well as government executives, community-based organizations, parents, and youth. Funders include: County of San Diego Health and Human Services Agency, Kaiser Foundation Hospitals, and The San Diego Foundation. A Leadership Advisory Oversight Committee comprised of national experts and influential local leaders in the fields of: health, education, child care, child welfare, juvenile justice, human services, and injury and violence prevention guides the development of the *Report Card*. The Leadership Advisory Oversight Committee is integral to the selection of indicators, content of feature boxes, identification of San Diego efforts, and development of recommendations. A Scientific Advisory Review Committee comprised of data and research experts from these same fields of study serves to ensure the validity, reliability, and quality of data used for all indicators and other information in the *Report Card*.

As in the past, the *Report Card* describes the current status of the indicators and trends over the last 10 years (when data are available). For each indicator, it provides a list of evidence-based and best practices for prevention and intervention. In addition, up-to-date recommendations for policy, programs and services, and family and community action specific to San Diego County are provided for each indicator topic. This edition continues use of “feature boxes” that highlight emerging concerns for children, youth, and families in San Diego County for which local trend data are not currently available. This *Report Card* focuses on infectious disease prevention, home visiting for families, and food insufficiency.

While most trends are improving (see summary of trends in introduction and summary table below), we have not yet assured a future in which we all are healthy, safe, and thriving. The findings in the *Report Card* tell us there is much more to be done to cultivate opportunities for all people to grow, enjoy good health, and have the highest possible quality of life.

Building on the Live Well San Diego Framework

Live Well San Diego is a multi-sector approach to health, safety, and wellness for individuals and the whole population. Based on a regional vision adopted by the San Diego County Board of Supervisors in 2010, it aligns the efforts of County Government, community partners, and individual residents. Progress towards the shared *Live Well San Diego* vision is measured within 5 Areas of Influence and by the top 10 *Live Well San Diego* Indicators. (See Figure 1.) To emphasize the alignment of the *2017 Report Card*, each of the indicators is marked with a symbol representing one of the 5 Areas of Influence of *Live Well San Diego*.

The *Live Well San Diego* vision is grounded in a new understanding about the determinants of health that is emerging from science. Long before illness, health starts at home, school, and work, where we live, learn, work, and play. The so-called “social determinants of health” beyond medical care are important. The vision of *Live Well San Diego* is also about assuring everyone the opportunity to make choices that allow them to live a long, healthy life, regardless of their income, education, or racial-ethnic background. It is designed to help all San Diego County residents be healthy, safe, and thriving.

The four strategic approaches of *Live Well San Diego* focus on how to collectively work to achieve success.

1. Building a better service delivery system. By improving the quality and efficiency of the delivery of County services to contribute to better outcomes for individuals and results.
2. Supporting positive choices. Inspiring residents to take action and responsibility for their health, safety, and well-being. Sharing information and resources to support residents in living healthy.
3. Pursuing policy and environmental changes. Improving communities and encouraging involvement to make it easier for everyone to live well. Creating environments and adopting policies that make it easier to live well. This includes reducing barriers in social and physical environments that affect health.
4. Improving the culture within. Increasing understanding among County employees about what it means to live well, and their role in helping other county residents live well and thrive.

Looking beyond childhood, pairs of indicators track trends for both children and adults: Oral Health, Obesity, Smoking, Poverty, and Health Coverage. The *2017 Report Card* provides additional information pages about how obesity, smoking, and poverty can have intergenerational, negative effects on health and well-being from prenatal to adulthood. These indicators align with *Live Well San Diego* representing measurable areas where change is needed to achieve the vision for healthy, safe, and thriving communities.




Live Well San Diego involves everyone. Meaningful change requires a collective effort in which all of us work together toward a shared purpose. Toward that end, the *Report Card* includes recommendations for action by policy makers, program and service providers, and families and communities. Leadership and action are needed from individuals, organizations, and public agencies. Partners include service providers, community and faith-based organizations, businesses and other employers, school districts, law enforcement and first responders, and military and veterans organizations. Together we can change how we work, learn, live, and play, and thereby offer everyone greater equity, improved health, more safety, and lives in which we thrive.

Figure 1.





























REPORT CARD SUMMARY TABLE

Table Key:

-  Trend is improving.
-  Trend is maintaining.
-  Trend is moving in wrong direction.

Live Well San Diego Areas of Influence



Indicator		San Diego County	California	United States	
Birth to Age 3 (Infants and Toddlers)					
 Percentage of mothers receiving early prenatal care		84.2	83.6	NA	
 Percentage of infants born at low birthweight		6.7	6.8	8.2	
 Percentage of mothers who initiated breastfeeding of newborn in hospital		96.2	94.0	NA	
 Birth rate per 1,000 females ages 15-17 years		6.0	7.4	8.8	
Ages 3-6 (Preschool)					
 Percentage of young children (ages 19-35 months) who completed the basic immunization series		80.6	65.3	70.7	
 Percentage of children ages 3-4 enrolled in early care and education		52.7	48.5	48.0	
Ages 6-12 (School Age)					
 Percentage of children under age 12 who had not visited a dentist in the past year or ever		20.6	17.0	NA	
 Percentage of adults ages 18 to 65 who had not visited a dentist within prior 12 months		23.9	30.2	NA	
 Percentage of elementary school (K-5) students who did not attend school at least 95 percent of school days		30.3	NA	NA	
 Percentage of students in grade 3 who met or exceeded standard in English–Language Arts/Literacy		52.0	NA	NA	
 Percentage of students not in the Healthy Fitness Zone and at risk (obese)					
	Grade 5		36.2	40.7	NA
	Grade 7		34.7	38.7	NA
	Grade 9		33.6	37.2	NA
 Percentage of adults ages 18 and older that are obese		25.3	27.9	NA	

Indicator		San Diego County	California	United States
Ages 13-18 (Adolescence)				
Percentage of middle and high school students (grades 6-12) who did not attend school at least 90 percent of school days		10.2	NA	NA
Percentage of students who met or exceeded standard in English–Language Arts/Literacy				
	Grade 8	55.0	NA	NA
	Grade 11	64.0	NA	NA
Percentage of students who report using cigarettes in prior 30 days				
	Grade 7	1.0	NA	NA
	Grade 9	2.0	NA	NA
	Grade 11	4.0	NA	NA
Percentage of students who report using e-cigarettes in prior 30 days				
	Grade 7	NA 3.0	NA	NA
	Grade 9	NA 6.0	NA	NA
	Grade 11	NA 9.0	NA	NA
Percentage of students who report using alcohol in prior 30 days				
	Grade 7	5.0	NA	NA
	Grade 9	12.0	NA	NA
	Grade 11	19.0	NA	NA
Percentage of students who report using marijuana in prior 30 days				
	Grade 7	2.0	NA	NA
	Grade 9	8.0	NA	NA
	Grade 11	15.0	NA	NA
Percentage of students who report using other drugs in prior 30 days				
	Grade 7	NA 3.0	NA	NA
	Grade 9	NA 10.0	NA	NA
	Grade 11	NA 16.0	NA	NA
Percentage of adults age 18 and older who report smoking		9.3	11.7	NA
Percentage of male students (grades 9-12) who report they attempted suicide in previous 12 months		4.7	NA	NA
Percentage of female students (grades 9-12) who report they attempted suicide in previous 12 months		9.3	NA	NA



































Indicator		San Diego County	California	United States	
	Number of arrests for felony and misdemeanor offenses among youth ages 10-17		4,661	55,412	NA
	Number of sustained petitions (true finds) in Juvenile Court among youth ages 10-17		1,883	NA	NA
	Number of DUI arrests among youth under age 21		694	NA	NA
	Rate of non-fatal crashes involving drivers ages 16-20 under the influence of alcohol or drugs per 100,000 population		51.7 ¹	NA	NA
Community and Family (Cross Age)					
	Percentage of children ages 0-17 living in poverty		16.4	19.9	19.5
	Percentage of adults ages 18-64 living in poverty		11.7	13.2	13.2
	Number of children ages 0-18 receiving CalFresh		183,299 ²	NA	NA
	Number of adults age 19 and older receiving CalFresh		229,566 ²	NA	NA
	Percentage of children ages 0-17 without health coverage	NA	NA	NA	NA
	Percentage of adults ages 18-64 without health coverage		9.2	11.2	NA
	Rate of domestic violence reports per 1,000 households		14.8	12.7	NA
	Rate of substantiated cases of child abuse and neglect per 1,000 children ages 0-17		6.0	8.0	NA
	Rate of violent crime victimization per 10,000 children or youth				
	Ages 0-11		6.8	NA	NA
	Ages 12-17		30.1	NA	NA
	Rate of non-fatal unintentional injuries per 100,000 children ages 0-18		198.4	164.7	167.7
	Mortality rate per 100,000 children				
	Ages 1-4		14.5	NA	NA
	Ages 5-14		20.6	NA	NA
	Ages 15-17		22.5	NA	NA
	Infant mortality rate per 1,000 live births		3.7	4.2	5.9

Table notes: Unless otherwise noted data are for year 2016, school year 2016-17, or California Health Interview Survey 2016.

¹ Data from 2014

² Data from 2017

LIVE WELL SAN DIEGO

REPORT CARD ON CHILDREN, FAMILIES, AND COMMUNITY, 2017

Introduction

The *Live Well San Diego Report Card on Children, Families, and Community, 2017* supports the vision of *Live Well San Diego* to create a region that is building better health, living safely, and thriving for all residents of San Diego County. The *Report Card* documents the status of health, safety, and well-being of children, families, and community in San Diego County, California.






Report cards monitor trends and can point to positive results or troublesome trends, as well as indicate the need for change or continued support of policies and programs. Results (or outcomes) are conditions of well-being for children, adults, and communities. Results are what we aim to achieve as a society. We strive to have children who are healthy, ready for and succeeding in school, avoiding risky behaviors, and safe in their homes, schools, and communities. For adults, optimal health, economic self-sufficiency, and safety are among the desired outcomes. Report cards use indicators to monitor progress toward desired results.

Aligned with the vision of *Live Well San Diego*, the *2017 Report Card* presents 25 indicators focused on children and families, as well as five indicators on adults. With these indicators, the *Report Card* measures health, safety, and thriving across the life span. Using nationally recognized criteria in results-based accountability, each indicator was selected to meet specific criteria: Are the data reliable and consistent? Does the indicator communicate to diverse audiences (e.g., families, communities, policy makers)? Does the indicator say something of importance about the desired outcome? Guided by the Leadership Advisory Oversight Committee and Scientific Advisory Review Committee, the Children's Initiative used this decision model to select indicators that reflect some of the most important aspects of the health and well-being for children, families, and community for which reliable data are routinely available.

Scientific advances and research into program effectiveness offer an opportunity to understand what works to improve health and well-being. For each indicator, the *Report Card* provides a list of evidence-based and best practices for prevention and intervention. These lists are generated from review of evidence-based and best practices from across the United States, as reported in professional journals, federal websites, and other authoritative sources. Key sources and references from our extensive literature reviews can be found online. (Visit www.thechildrensinitiative.org.)

Live Well San Diego is a multi-sector approach to health, safety, and wellness for individuals and the whole community. Based on a regional vision adopted by the San Diego County Board of Supervisors in 2010, it aligns the efforts of County Government, community partners, businesses, and individual residents. Progress towards the shared *Live Well San Diego* vision is measured within 5 Areas of Influence and by the top 10 *Live Well San Diego* Indicators. (See Figure 1.) The four strategic approaches of *Live Well San Diego* focus on how to collectively work to achieve success.

To emphasize the alignment of the *2017 Report Card*, each indicator is marked on the summary table and topic page with a symbol representing one of the 5 Areas of Influence of *Live Well San Diego*. These are:

-  HEALTH 1. Health - Enjoying good health and expecting a full life
-  KNOWLEDGE 2. Knowledge - Learning throughout the life span
-  STANDARD OF LIVING 3. Standard of living - Having enough resources for a quality life
-  COMMUNITY 4. Community - Living in a clean and safe neighborhood
-  SOCIAL 5. Social - Helping each other live well

The *Live Well San Diego* vision and this *Report Card* are grounded in a growing understanding about the factors that determine health and well-being over a lifetime. Long before illness, health starts at home, school, and work, where we live, learn, work, and play. The so-called “social determinants of health” (e.g., income, environment, community safety) stretch beyond medical interventions and are the main driving factors in how healthy and well we are. To change these factors, it takes more than a visit to a health provider; it requires change at the individual, family, and community levels. Policies, political priorities, and social supports are equally factors. The vision of *Live Well San Diego* is also about assuring everyone the opportunity to make choices that allow them to live a long, healthy life, regardless of their income, education, or racial-ethnic background. It is designed to help all San Diego County residents be healthy, safe, and thriving.

2017 Summary of Trends

The *2017 Report Card* continues to support and document the success of *Live Well San Diego*, showing trends for indicators that reflect the health, safety, and well-being of children, youth, and adults. The summary table and individual indicator pages show that 21 of 34 trends measured are improving, 10 are maintaining, and 3 are moving in the wrong direction. (See summary table and indicator pages.) While most trends for these indicators are improving, we have not yet assured a future in which we all are healthy, safe, and thriving. The findings in the *Report Card* tell us there is much more to be done to cultivate opportunities for all people to grow, enjoy good health, and have the highest possible quality of life.

Birth to Three (Infants and Toddlers)

Generally, San Diego County compares favorably to state and national rates, with most of the Birth to Three indicators (early prenatal care, low birthweight, and breastfeeding) maintaining. The trend in births to teens shows consistent positive improvement, paralleling a sharp reduction in births to teens for the state and the nation overall.

Ages 3 to 6 (Preschool)

To fully understand the issues for preschool age children, we need additional indicators. With only two reliable indicators for this age group, there is a challenge to develop and/or collect more data to better

measure their progress toward healthy development and school readiness. The early care and education trend is maintaining with half of our 3 and 4 year olds enrolled in preschool or other early education settings. The trend for immunization rates among toddlers shows substantial improvement for San Diego County, and the rate remains better than the state and the national objective.

Ages 6 to 12 (School Age)

Despite some progress for trends among school age children, continued efforts are needed to improve the health and well-being of this age group. The indicator of school attendance shows fluctuations over time and is moving in the wrong direction for elementary grades. The level of absenteeism among children in Kindergarten is of particular concern. The trends in obesity and oral health are maintaining; both need continued improvement. Countywide, school achievement test results showed improvement in English-Language Arts/Literacy among 3rd graders.

Ages 13 to 18 (Adolescence)

Improvements are shown across most of the indicators for this age group, yet continued efforts are needed in some areas. Parents, schools, and communities can work together to improve school attendance among youth. Reductions in reported use of alcohol, tobacco, and other substances are good news; however, too many youth are using dangerous substances and engaging in DUI. While numbers have dropped, further progress in juvenile crime and probation is also a desired result.

Community and Family (Cross Age)

Most of the community and family indicators are improving. Of concern is an increase in the rate of childhood mortality of children ages 5-14 and lack of progress in reducing infant mortality. The good news is that the economic situation of San Diego families is improving, with fewer children and families living in poverty. At the same time, many families have low incomes and face challenges in securing safe and affordable housing, food, and other basic needs. Progress in use of services and supports for low-income families (e.g., nutrition assistance, health coverage) continues. Rates of domestic violence and child victims of violent crime under age 12 are only maintaining, not improving.

Countywide Action for Meaningful Change

Meaningful change toward the *Live Well San Diego* vision will require a collective effort in which all of us work together. Toward that end, the *Report Card* includes recommendations for action by policy makers, program and service providers, and families and communities. Specific local recommendations are provided in three categories: 1) policy, 2) programs and services, and 3) family and community. These categories can help all stakeholders—community residents, government leaders, agency staff, professionals who deliver services, community-based organizations, businesses, and funders—understand what they can do to help guide policy development, increase access to effective prevention and intervention efforts, and educate residents and families. The recommendations are based on what works and what has yet to be done in San Diego County.

Live Well San Diego involves everyone. Leadership and action is needed from individuals, organizations, and public agencies. Partners include service providers, community and faith-based organizations, businesses and other employers, school districts, law enforcement and first responders, and military or veterans organizations. Together we can change how we work, learn, live, and play, and thereby offer each other greater equity, improved health, more safety, and lives in which we thrive.

The Report Card Process

The Children's Initiative *Report Card* series is based on a unique approach that engages a broad array of stakeholders in a results-focused process and reports not only on data trends but also on effective practices and specific recommendations to “turn the curve” or accelerate progress on our indicator trends. It builds upon and has become a nationally recognized report card model.

The *Report Card* is produced and disseminated biennially by the Children's Initiative, a nonprofit child advocacy agency in San Diego. Beginning in 1997-98, the San Diego County Health and Human Services Agency undertook the development and publication of the *Report Card on San Diego County Child and Family Health and Well-Being*. The last edition of that report was issued for the year 2005. In January 2006, the San Diego County Board of Supervisors approved the transfer of ownership and responsibility for the County Report Card to the Children's Initiative, a local nonprofit agency that serves as an advocate and custodian for effective policies, programs, and services that support children, youth, and families. The first version of the report in its new results-oriented format was published by the Children's Initiative in January 2008, and this is the sixth edition.

Public and private partnerships and funding support the development and publication of this *2017 Live Well San Diego Report Card on Children, Families, and Community*. Public and private funders for this edition include the County of San Diego Health and Human Services Agency, the Kaiser Foundation Hospitals, and the San Diego Foundation.

To develop this *Report Card*, the Children's Initiative worked with professionals in children's services, government leaders, community organizations, and foundations to drive a results-focused process. This process allows us not only to report data trends, but to highlight effective practices and to make specific recommendations to “turn the curve” and accelerate progress on indicator trends. The Children's Initiative calls on and utilizes advice and expertise from a diverse group of stakeholders including subject matter and data experts in the areas of juvenile justice, education, and health, as well as government executives, community-based organizations, parents, and youth.

A Leadership Advisory Committee comprised of national experts and influential local leaders in the fields of health, education, child care, child welfare, juvenile justice, human services, and injury and violence prevention guide the development of the *Report Card*. The Leadership Advisory is integral to the selection of indicators, content of feature boxes, and development of specific local recommendations.

The research and analysis has been overseen by a Scientific Advisory Review Committee, including statisticians, epidemiologists, and program data managers from these same fields of study. Whenever possible, County agency staff with responsibility for data presented are directly involved in the preparation of data and review of the *Report Card* trend data. This group has knowledge of particular methods for program-specific data, as well as broad understanding of the trends in their fields. They review data files, graphs, graph analysis, and the content of informational and feature boxes.

The process also incorporates the expertise of a broad array of local stakeholders concerned with the well-being of children and youth, including: public agency and government officials; subject matter experts in education, health, justice, and other fields; providers and community-based organizations; and parents and youth. The Children's Initiative staff and consultants meet regularly with educators, physicians, law enforcement, family advocates, and others to discuss the data, the trends, and what works.

Understanding the Data in this Report Card

Readers of the *Report Card* will want to know why indicators were selected, how the data are presented, and what they represent. The Children’s Initiative staff and advisory committees specifically selected the indicators in this report to have strong data and communication power, and to reflect broadly on a given topic. The adult indicators were selected based on these same criteria, plus the value of the measure for understanding the life course trajectory. Each adult measure helps us understand both the impact of child conditions on adulthood and the impact of adult (parent) conditions on children. The total group of 25 child and 5 adult indicators reflects a broad array of concerns, but not all the results that are important to families. For example, we do not report on housing, employment, transportation, or recreation.

For each indicator, graphs are prepared to illustrate trends over time. As in prior editions, the *2017 Report Card* describes trends over 10 years when data are available. No tests have been done to determine the statistical significance of changes; we are only observing whether the trends are improving, maintaining, or worsening. We take into account the overall direction of the trend, the starting and ending points, and recent shifts in the trend. Note that a one-year change in a specific rate may be the result of factors such as a temporary environmental change, a change in data sample, a small data sample, or some other extraneous influence, and it may not represent a true change in the direction of the trend.

The most recent data available at the time of report production are used for each edition. Depending on the type and source of information, the most recent data available for this edition may be from 2014, 2015, or 2016. School related data is generally provided for school year 2016-17. Most graphs use calendar years to track the trend.

When possible, comparison data are presented to assist in understanding how our county is doing compared to the California or United States averages, as well as to the federal Healthy People 2010 and 2020 Objectives set by the US Department of Health and Human Services. Where applicable, we have noted that the 2020 Objectives set a less rigorous target for the nation.

When possible, data are presented in percentages and rates, reflecting the norms and standards for a particular data source. Using these standardized measures makes it easier and more accurate to look at trends or make comparisons. A percentage is the most easily understood comparison and is used whenever appropriate. Rates per 1,000, 10,000, or 100,000 people are used when the incidence of a condition is low. When reliable population denominators are not available, graphs show the number of events. For example, we report the number of youth DUI arrests, the number of individuals receiving nutrition assistance through SNAP/CalFresh, and the number of youth with sustained petitions in juvenile court.

Graphs generally show data on a scale of 0 to 100, 0 to 50, or 0 to 25, depending on the level of the trend. For some indicators, however, the scale has been modified to better show year-to-year variations. When that occurs, the graph is marked with the words “note scale.”

Informational boxes for each indicator highlight local facts and provide additional data by region, gender, age, race-ethnicity, or other factors. Most of these informational boxes show numbers that illuminate the trend data, as well as facts from other sources. Where another source is used, it is identified under the data in the informational box.

This edition continues to include “feature boxes” that highlight emerging concerns for children, youth, and families in San Diego County for which local trend data are not currently available. This *2017 Report Card* focuses on infectious disease prevention, home visiting for families, and food insufficiency.

As described above, best practices were identified from respected sources such as professional journal publications, government agencies, and university or other research organizations. An effort has been made to offer comprehensive lists of evidence-based and best practices. These sections are not, however, intended to be exhaustive or complete lists of possibilities. (Selected references available online at www.thechildrensinitiative.org.)

Recommendations for action are based on a survey of community leaders and providers, advisory committee members, subject matter experts, and national consultants. As described above, for the *2017 Report Card*, local recommendations are presented in three categories: 1) policy, 2) programs and services, and 3) family and community.

Notes on Geographic, Demographic, and Racial/Ethnic Data

San Diego is a large county, stretching 65 miles from north to south and 86 miles from east to west, covering 4,261 square miles—slightly smaller than the state of Connecticut. It borders Orange and Riverside Counties to the north; the agricultural communities of Imperial County to the east; the Pacific Ocean to the west; and the state of Baja California, Mexico, to the south. With an elevation that goes from sea level to 6,500 feet, our county includes beaches, deserts, and mountains. Our communities incorporate urban, suburban, and rural neighborhoods. San Diego County comprises 18 incorporated cities and 17 unincorporated communities, and even these are divided into locally identified communities and neighborhoods. The County of San Diego Health and Human Services agency prepared geocoded maps for this *2017 Report Card* that illustrate the occurrence of selected indicators according to more precise and easily understood community boundaries (e.g., zip code areas).

The San Diego Association of Governments (SANDAG) reports on population estimates and their data are used here. The county’s total population for 2016 was estimated at 3,288,612 and it is the second most populous county in the state, after Los Angeles County. Children under age 18 represent 22% of our population, about 1 in 5 residents. (SANDAG estimate 2016).

The region’s population under 18 is distributed throughout urban, suburban, and rural areas. Areas with the high concentrations of child population—representing close to one-third of the population of children under age 18—are in Oceanside, Escondido, Vista, and Chula Vista.

San Diego County is an ethnically diverse community. According to the 2016 SANDAG population estimates (based on US Census data), the overall population (i.e., all ages) consists of: 46% non-Hispanic white; 33% Hispanic; 12% Asian, Hawaiian, or other Pacific Islander; 5% African-American; 3% other; and less than 1% Native American or Alaskan Native. The population of children is predominantly Hispanic (46%) and non-Hispanic white (33%) with the remainder similarly distributed to the overall population breakdown. San Diego County has 18 American Indian/Native American reservations, more than any other county in the United States, representing four tribal groups.

Indicator data on race and ethnicity are not uniformly available for indicators, varying by category, extent of data collection, and other factors. Data on race and ethnicity are shown only in select informational boxes.



Birth to Age 3 (Infants and Toddlers): EARLY PRENATAL CARE

Number of babies born in San Diego County in 2016
42,633

Why is this important?

Early and regular prenatal care is associated with a lower risk of preterm births, better birthweight, and healthier babies. Prenatal care from a qualified health professional helps to ensure the health of a woman and her baby. Optimal, high-quality care includes comprehensive medical services with health promotion and education, as well as psychosocial supports as needed. Linking to nutrition and social services can help. Starting even earlier, prior to pregnancy, preconception care is recommended to reduce risks to both mother and baby.

What is the indicator?

This indicator—the percentage of mothers receiving early prenatal care—reflects the proportion of women who receive prenatal care beginning in the first three months (referred to as the first trimester) of pregnancy. Prenatal care information is recorded on the birth certificate and reported as part of local, state, and federal vital statistics.

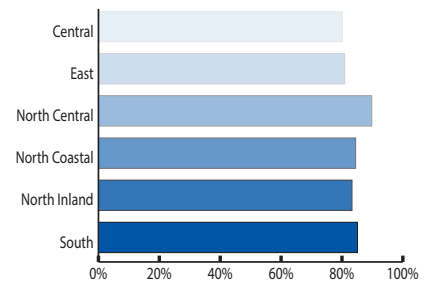
What is the trend?

The trend is maintaining. The percentage of mothers receiving early prenatal care has increased little. The national objective was made easier to achieve for the decade 2010 to 2020.

Among San Diego County women least likely to receive early prenatal care are teens under age 20, and mothers of any age who did not complete high school or GED.

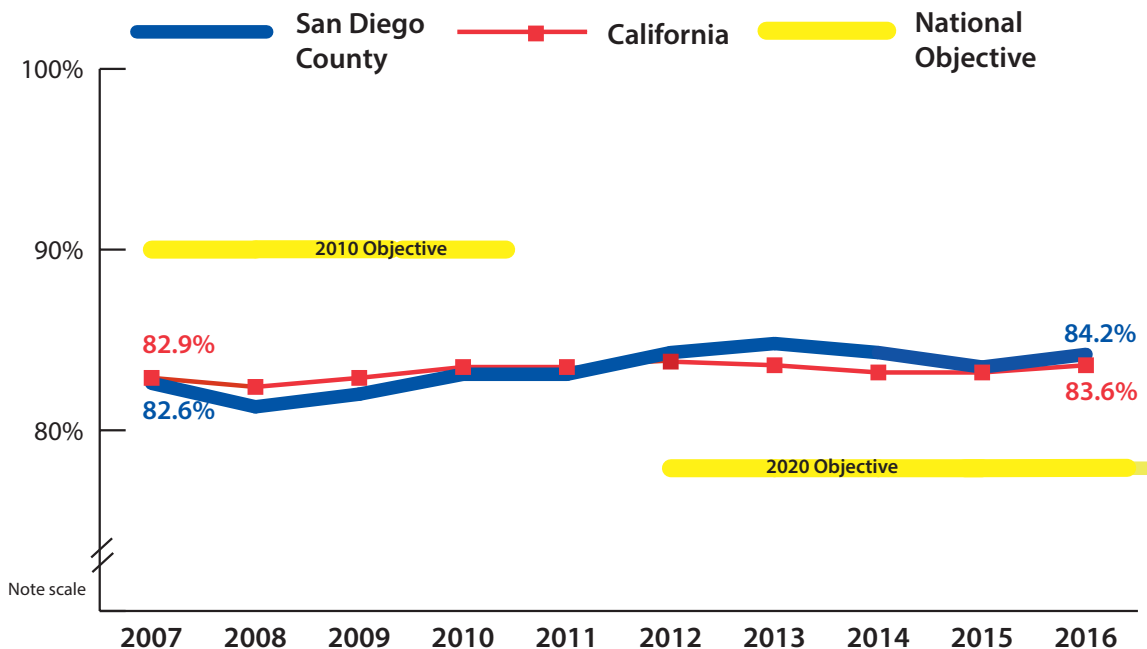
Source: Percentage of Mothers Receiving Early Prenatal Care, By Age and Educational Status of Mother, San Diego County, Three-Year Average 2013-2015

THE PERCENTAGE OF MOTHERS WHO RECEIVE EARLY PRENATAL CARE VARIES BY REGION.



Source: Percentage of Infants Born to Mothers Who Received Early Prenatal Care, By Region, San Diego County, Three-Year Average, 2013-2015

Percentage of Mothers Receiving Early Prenatal Care, San Diego County and California Compared to National Objective, 2007-2016



What strategies can make a difference?

Women’s use of prenatal care is affected by financial barriers (e.g., lack of health insurance), the context of care (e.g., lack of cultural competence, biased treatment by health providers), and the access to care (e.g., transportation, difficulties obtaining an appointment, inconvenient hours). In addition, personal attitudes and behaviors (e.g., lack of understanding about the importance of prenatal care, ambivalence about a pregnancy) may be barriers to early prenatal care. What works best is early, continuous, and high quality care that is appropriate for a woman’s risks, needs, and culture.

The following strategies have been used to increase use of prenatal care:

- Ensure affordable health coverage for women of childbearing age (e.g., Affordable Care Act Exchange plans, Medi-Cal, and private plans with maternity coverage).
- Use staff to help women enroll in health coverage, connect with a prenatal provider, and use early and continuous care.
- Expedite health coverage for uninsured women who become pregnant.
- Include benefits coverage for comprehensive care (e.g., the California Comprehensive Perinatal Care Services package), which incorporates health education and risk counseling along with medical care.
- Assure that prenatal care services are available and accessible (e.g., accessible by public transportation, flexible service hours).
- Deliver prenatal services through safety-net providers such as community clinics and Federally Qualified Health Centers.
- Provide culturally and linguistically appropriate prenatal services.
- Begin evidence-based home visiting programs in the prenatal period, particularly for higher risk pregnant women.
- Pay trained and certified doulas and community health workers to provide health education, coaching, and support to pregnant women.
- Use evidence-based group-care approaches such as “Centering Pregnancy” to reduce costs and enhance the content of care.
- Offer transportation assistance such as vouchers for public transportation or taxis.

How can we improve the trend in San Diego County?

Based on what is underway and what works, the priorities for action are:

Policy

- Expand use of evidence-based home visiting services for pregnant women at-risk.
- Increase reimbursement for prenatal providers who offer Comprehensive Perinatal Care Services.

Programs & Services

- Monitor prenatal care use by region, community, and zip code to identify areas in need of more outreach and access.
- Increase access to translation and culturally and linguistically appropriate services for immigrant and refugee populations, beginning with prenatal visits and care coordination.

Family & Community

- Use community-based educational programs regarding access to prenatal care, smoking cessation services during pregnancy, home visiting, and other prenatal supports.
- Organize community-based networks of transportation for pregnant women to attend medical appointments and other necessary services.



Birth to Age 3 (Infants and Toddlers):

LOW BIRTHWEIGHT

Why is this important?

Compared to normal weight babies, low birthweight babies face 20 times the risk of dying in their first year. Preterm (premature) birth (prior to 37 weeks gestation) is a primary factor contributing to low birthweight rates, and together these two conditions are the leading cause of infant mortality. With neonatal intensive care, many infants born at low birthweight or preterm survive but experience short and long-term effects such as learning disabilities, vision, and hearing deficits. Those born at low birthweight also have higher risk for conditions such as high blood pressure, heart disease, and diabetes as adults.

What is the indicator?

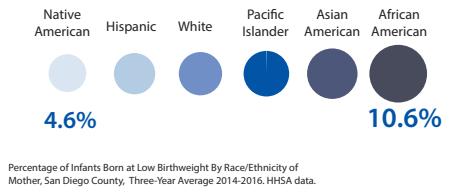
This indicator—the percentage of infants born at low birthweight—is defined as weighing less than 2500 grams (5.5 lbs), and very low birthweight is defined as weighing less than 1500 grams (3.3 lbs) at birth. Both are included in this measure. These data are recorded on birth certificates and reported as part of local, state, and federal vital statistics.

What is the trend?

The trend is maintaining. Low birthweight is not improving. San Diego County is close to the state level. The national objective was made easier to achieve for the decade 2010 to 2020.

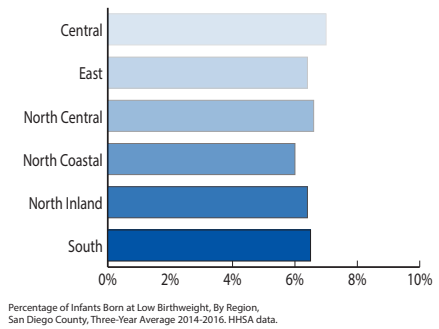
Number of babies born at low birthweight in San Diego County in 2016
2,851

African American babies are most likely to have low birthweight.

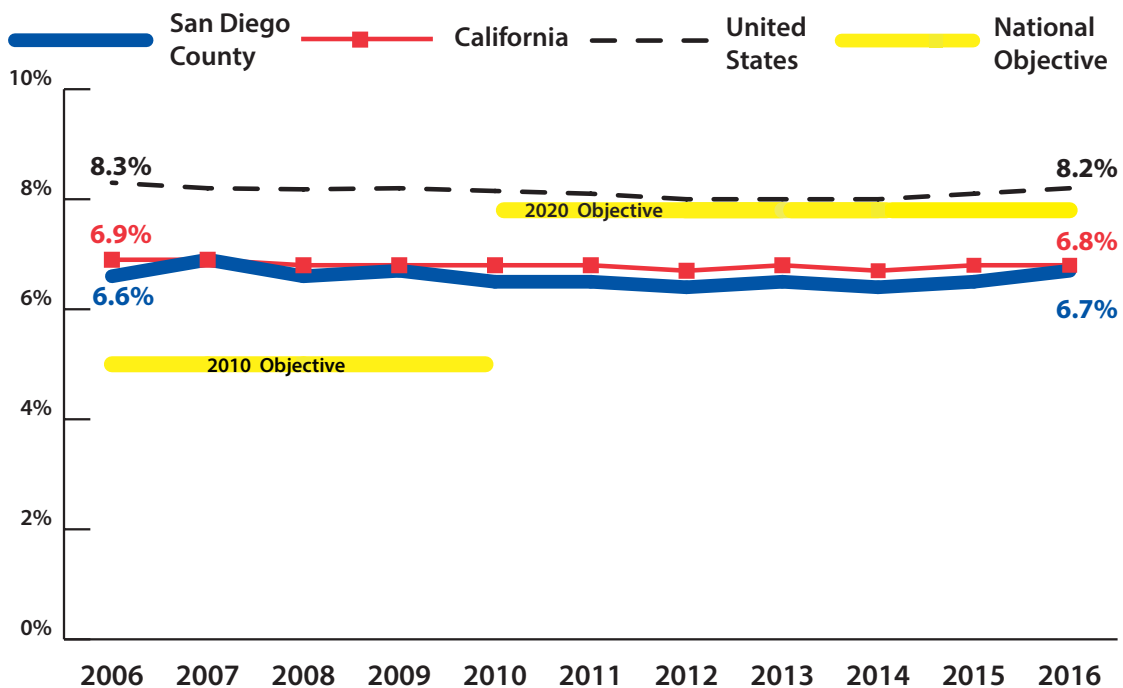


APPROXIMATELY 1 OUT OF EVERY 15 BABIES IS BORN AT LOW BIRTHWEIGHT.

BABIES ARE AT RISK IN EVERY REGION OF OUR COUNTY.



Percentage of Infants Born at Low Birthweight, San Diego County, California, and United States Compared to National Objective, 2006-2016



What strategies can make a difference?

While all of the causes of low birthweight and preterm birth are not fully understood, much can be done to reduce risks. Preventing unintended pregnancies is an important step. Smoking and heavy drinking while pregnant are two important behavioral factors associated with low birthweight and preterm birth. Very young teen mothers (under age 15) and women who have multiple births (twins, triplets, etc.) are more likely to have babies born at low birthweight or preterm. Women who receive late or no prenatal care and those who experience extreme stress and violence face higher risks. Quality prenatal care and appropriate care at the time of birth, such as regional perinatal care and neonatal intensive care, is critical to the health and survival of mothers and infants. For women who have a low birthweight or preterm birth, “interconception care” can reduce risks prior to any subsequent pregnancy they may choose to have.

The following strategies have been used to reduce low birthweight and preterm births:

- Educate women about the dangers of alcohol and drugs, tobacco, prescription drugs, sexually transmitted diseases, hypertension, obesity, and diabetes.
- Increase use of early and comprehensive prenatal care to screen for and address risk factors.
- Promote family planning and pregnancy spacing.
- Finance smoking cessation services (including mandatory Medi-Cal prenatal smoking cessation benefits) and eliminate exposure to secondhand smoke during pregnancy.
- Use intensive, evidence-based home visiting for high-risk pregnant women.
- Provide 17-P progesterone treatment and other interventions for women with prior preterm birth.
- Inform women how to recognize the signs and seek help for early labor and other complications.
- Educate women about the importance of continuing pregnancy for 39-40 weeks gestation.
- Stop paying for non-medically indicated, elective deliveries prior to 39 weeks gestation (i.e., early elective deliveries).
- Reduce stress and exposure to violence at home and in the community, including racism.
- Promote proper nutrition, exercise, and healthy weight before and during pregnancy.
- Prevent pregnancies among younger teens, especially younger than 15.
- Provide expedited housing assistance to pregnant women to reduce housing insecurity.
- Avoid multiple births that may result from assistive reproductive technology.
- Promote health and reduce risks before pregnancy with preconception care.
- Offer interconception care with augmented services post-pregnancy to the highest-risk women.

How can we improve the trend in San Diego County?

Based on what is underway and what works, the priorities for action are as follows:

Policy

- Monitor the pregnancy related quality improvement measures for the Healthcare Effectiveness Data Information Set (HEDIS) with Medi-Cal and private providers.
- Increase funding for provider education on tobacco and opioid use during pregnancy.

Programs & Services

- Increase use of evidence based home visiting programs for pregnant women in substance abuse treatment programs.
- Implement prenatal smoking cessation benefit in Medi-Cal, working with health providers and pharmacies.

Family & Community

- Develop community-led support groups for pregnant women to encourage use of prenatal care, good nutrition, smoking cessation, and exercise.
- Implement education campaigns about the importance of 39-40 weeks of pregnancy.



Birth to Age 3 (Infants and Toddlers):

BREASTFEEDING

Why is this important?

Breastfeeding is recommended for almost every baby and is one of the most effective and cost-effective preventive health practices. For children, it enhances immunity to disease and decreases the rate and severity of infections. Breastfeeding is associated with healthy development and reduced risk of obesity. It reduces lifelong risks for chronic health problems such as cardiovascular disease. Benefits for the mother include: reduced risk of breast, ovarian, and uterine cancer; quicker recovery from pregnancy; and less work missed due to child illness.

What is the indicator?

This indicator—the percentage of mothers who initiate breastfeeding before leaving the hospital—estimates what proportion of infants receive any breast milk. Recommendations call for 6 to 12 months of breastfeeding, but data on continuation rates are not available. These data are collected on newborn screening forms and reported by the California Department of Health Services, including virtually all births in California (military hospitals and home births are excluded).

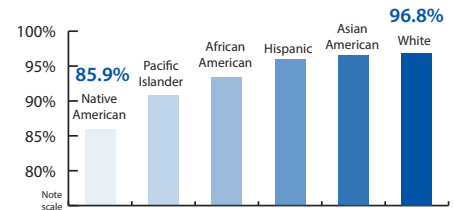
What is the trend?

The trend is maintaining. The percentage of mothers who initiate breastfeeding in San Diego remains consistently better than the state average and the national objective.

Number of mothers initiating breastfeeding in San Diego County in 2016

32,574

Breastfeeding rates vary by race-ethnicity.



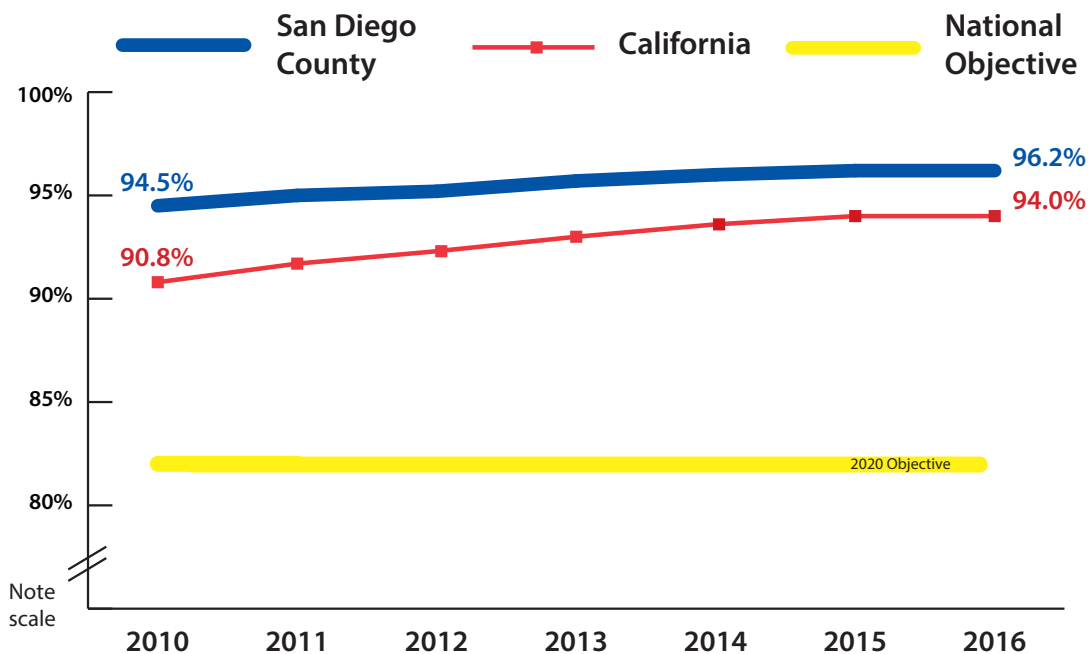
Percent of Mother's Initiating Breastfeeding in Hospital, By Race/Ethnicity, San Diego County, 2016. Multiple and other races not shown.

BREASTFEEDING BENEFITS BOTH MOTHERS AND CHILDREN. THE TOP BENEFITS OF BREASTFEEDING INCLUDE:

- Breast milk provides nearly perfect nutrition for infants, with antibodies to protect babies.
- For children, breastfeeding promotes healthy weight and has other positive health effects, in the short- and long-term.
- For mothers, breastfeeding helps to reduce the risk of breast and ovarian cancers and diabetes.

Sources: Centers for Disease Control and Prevention; National Institute of Child Health and Human Development; MedLine; and Office of the US Surgeon General.

Percentage of Mothers Who Initiated Breastfeeding of Newborn in Hospital, San Diego County and California Compared to National Objective, 2010-2016



What strategies can make a difference?

While health education is important, more is needed to increase rates of breastfeeding. Women need knowledge before giving birth and hands-on support, training, and equipment following birth. Hospital practices have a significant impact on women's ability to initiate breastfeeding and exclusively breastfeed (e.g., use no formula). Mothers who receive in-hospital support are more likely to continue breastfeeding at home. Lack of workplace support and public accommodations (space) for breastfeeding remain as major barriers to continuation of breastfeeding beyond the initial weeks of infant life. While exclusive breastfeeding is recommended for the first months, any breastfeeding can be advantageous.

The following strategies have been used to increase breastfeeding:

- Implement federal laws that protect breastfeeding in public and require workplace supports, including requirements for employers to provide reasonable, though unpaid, break time for a mother to express milk and a clean and private place, other than a restroom, to express her milk.
- Offer other workplace support (e.g., paid breaks and ways to safely store breast milk).
- Provide ongoing breastfeeding support, particularly from trained and experienced lactation consultants, home visitors, and others, as well as equipment such as breast milk pumps.
- Enroll eligible families in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), which offers incentives, education, and support for breastfeeding. Assure that all birthing hospitals and centers encourage breastfeeding through programs such as the evidence-based "Baby-Friendly" hospital policies, which support mothers in learning how to breastfeed and promote exclusive use of breast milk.
- Use breastfeeding promotion and education both before and following birth (e.g., add lactation consultants to prenatal clinic staff as well as hospitals).
- Eliminate provider bias and unequal treatment by race-ethnicity and income in breastfeeding promotion and education.
- Provide culturally and linguistically appropriate consumer information for mothers, with increased outreach and education for women of color.
- Use the *Business Case for Breastfeeding* "toolkit," of the US Department of Health and Human Services.
- Limit marketing and free distribution of breast-milk substitutes (i.e., formula).

How can we improve the trend in San Diego County?

Based on what is underway and what works, the priorities for action are:

Policy

- Make WIC enrollment available online.
- Ensure that all government and public education workplaces implement the federal law that requires appropriate and adequate space and break time for breastfeeding.

Programs & Services

- Disseminate culturally and linguistically appropriate information materials related to breastfeeding support (e.g., coverage for lactation consultants, breast pumps, and workplace protections).
- Implement the US Department of Agriculture Loving Support[©] Model in WIC to expand peer counseling and breastfeeding support.

Family & Community

- Promote breastfeeding-friendly environments in community settings such as libraries, recreation centers, and faith groups.
- Use community-based resources to distribute information, support, and breast milk pumps (e.g., BREEAST program).



Birth to Age 3 (Infants and Toddlers):

BIRTHS TO TEENS

Why is this important?

Teen pregnancy has declined but continues to be an issue of concern. Girls and boys are unprepared for the responsibility of pregnancy and parenting. They are less likely to obtain prenatal care and more likely to continue unhealthy behaviors, placing themselves and their baby at risk for health problems. The children of teen parents are at greater risk for maltreatment, developmental delays, and poor academic achievement. Teen mothers and fathers are less likely to complete school and become stable, economically self-sufficient families. Teen parenthood places two generations at risk.

What is the indicator?

This indicator—the birth rate per 1,000 teens ages 15-17 years—monitors trends in births for teens ages 15-17. Reliable data are available annually from birth certificates and reported as part of local, state, and federal vital statistics. It is not possible to get reliable data on the number of teens who become pregnant or are sexually active.

What is the trend?

The trend is improving. The rate of births to teens in San Diego County has dropped. This is consistent with the decline in the state and US rates overall.

Number of babies born to girls age 15-17 in San Diego County in 2016

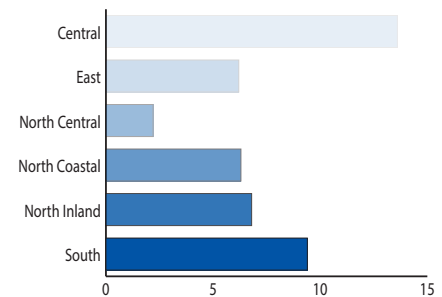
337

Teen parenthood affects the life course of two generations.

- * 50% OF TEEN MOTHERS DO NOT COMPLETE HIGH SCHOOL.
- * CHILDREN OF TEEN MOTHERS ARE MORE LIKELY TO DROP OUT OF HIGH SCHOOL, HAVE HEALTH PROBLEMS, AND BECOME TEEN PARENTS THEMSELVES.

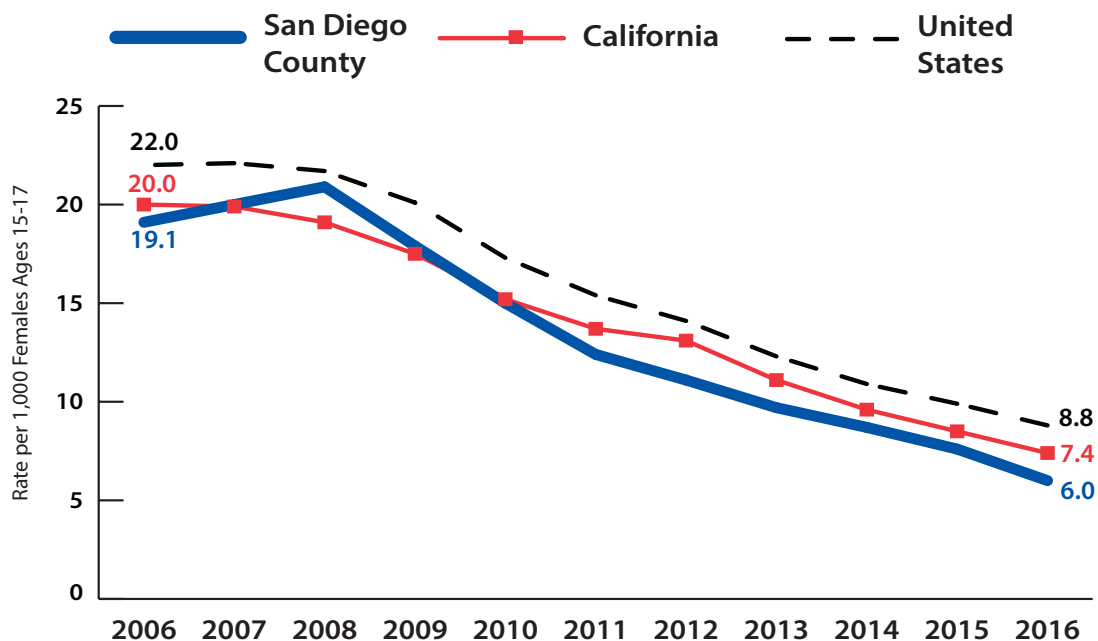
Source: Centers for Disease Control and Prevention.

BIRTH RATES PER 1,000 AMONG GIRLS AGES 15-17 VARY BY REGION AND COMMUNITY.



Source: Birth Rate per 1,000 Teens Ages 15-17, By Region, San Diego County, Three-Year Average, 2014-2016. HHSA data.

Birth Rate per 1,000 Females Ages 15-17, San Diego County, California, and United States, 2006-2016



What strategies can make a difference?

Reducing teen pregnancy requires a combination of supports and services. Implementation of best practices must be broad based and across systems, including: comprehensive life skills and reproductive health education, early prevention services and activities, family planning for those who are sexually active, and support for teen and family engagement and communication.

The following strategies have been used to decrease teen births:

- Promote strong, positive family engagement. Engage parents and youth to promote positive communication and healthy relationships.
- Teach comprehensive life skills and reproductive health education in schools through use of age-appropriate and evidence-based curricula for sex and STD/HIV education programs.
- Provide access to and financing of comprehensive and confidential adolescent health services, including family planning and STD services.
- Integrate and coordinate services such as school programs, reproductive health services, family life skills, social work, and health education interventions.
- Involve teen males in discussion and education; one of the most significant factors in the reduction of teen pregnancy is increased education and information for males.
- Encourage screening for Adverse Childhood Experiences and trauma-informed services to intervene with youth who have experienced sexual abuse and other maltreatment or trauma.
- Provide access to evidence-based programs aimed at preventing second teen pregnancies (e.g., Adult Identity Mentoring 4 Teen Moms known as AIM4TM).
- Support teen parents' efforts to continue in school, which helps them become more self-sufficient and helps to reduce subsequent pregnancies during teen years.
- Provide culturally relevant expanded learning programs, mentoring, and employment opportunities to engage teens after school and on weekends, as well as programs to engage youth during the summer and school holidays.

How can we improve the trend in San Diego County?

Based on what is underway and what works, the priorities for action are:

Policy

- Support evidence-based reproductive health and sex education programs for both male and female adolescents in schools, clinics, and community settings.
- Financially support adolescent health services on or near school campuses, ensuring they are culturally and linguistically appropriate.

Programs & Services

- Increase recruitment and participation of high school students in expanded learning programs.
- Provide access to free or low cost, long-acting, reversible contraceptives (LARCs) and counseling services for females.

Family & Community

- Educate parents and youth in positive communication and healthy relationships in schools, parent education classes, community-based organizations, and community centers.
- Develop community and family mentorship programs for youth transitioning into adolescence.



Ages 3–6 (Preschool): IMMUNIZATION

Why is this important?

Childhood immunizations are highly safe, effective and cost-effective when children receive vaccines according to the recommended schedule. They save millions of lives each year. The basic series protects children from 10 vaccine-preventable diseases, which can otherwise result in paralysis, hearing loss, convulsions, and death. Children who are not adequately immunized put others at risk for illness and death. Access to safe, effective, and recommended childhood vaccines is vital for the health of children. Up-to-date immunizations are key to preventing disease.

What is the indicator?

This indicator—the percentage of young children (ages 19-35 months) who have received the basic recommended childhood immunization series (4:3:1:3:3:1:4)—monitors use of recommended vaccines in the first three years of life. While the basic series of vaccines is due by age 24 months, no data exist to track children precisely at that age. These data are from the Immunization Survey conducted every third year by the County of San Diego Health and Human Services Agency.

What is the trend?

The trend is improving, with substantial improvement in the percentage of children ages 19-35 months who completed the recommended series.

Percentage of young children completing basic series of vaccines in San Diego County in 2016

80.6%

TOP BENEFITS OF IMMUNIZATION

1. Vaccines are highly safe and effective.
2. Immunization protects others you care about such as the elderly or infants.
3. Before age 2, children can be protected from 14 vaccine-preventable diseases.
4. Measles, whooping cough, and other diseases are still a threat.
5. Disease outbreaks happen when many parents fail to vaccinate their children.

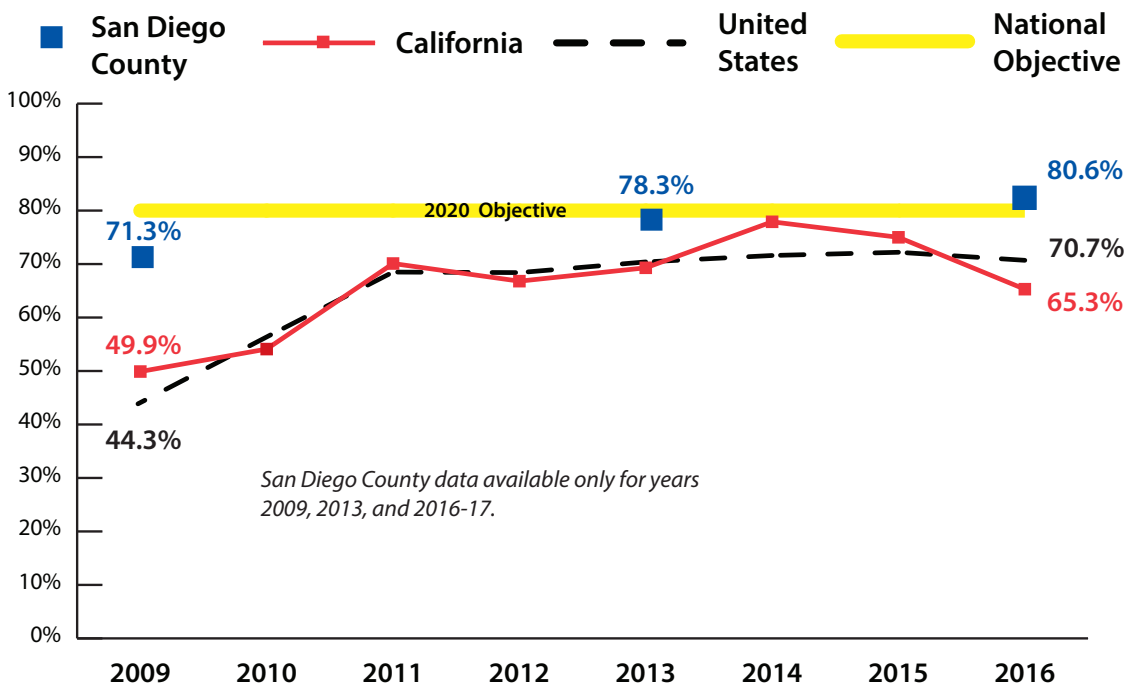
Sources: Centers for Disease Control and Prevention and National Vaccine Program Office, HHS.

Number of cases of pertussis (whooping cough) in San Diego County in 2017

1,011

Source: San Diego Health and Human Services Agency (HHSA), Immunization Program; and California Department of Health, 2018.

Percentage of Young Children (Ages 19-35 months) Who Completed the Basic Immunization Series, San Diego County, California, and United States Compared to National Objective, 2009-2016



Preventing Infectious Diseases

In the last 10 years in the United States, tens of millions of children and adults have contracted a preventable infectious disease. Recent outbreaks of hepatitis A, *E. coli*, *Salmonella*, Zika, measles, and pertussis (whooping cough) point to need for more prevention, early identification, and immediate treatment of infectious diseases. With immunizations, proper care, and other interventions, many infectious diseases can be prevented and even eradicated.

Infectious diseases are caused by pathogenic microorganisms such as bacteria, viruses, fungi, or parasites. While some organisms are harmless to people, other organisms can cause serious illness and even death. There are multiple ways infectious diseases spread, including from animals to people and from person-to-person exposure.

Zoonotic diseases are infectious diseases of animals that can cause illness and death when spread to humans. Some of the transmission for these infectious diseases is through direct or indirect contact with an infected animal. Such exposure may come from petting or touching animals, bites or scratches, contact with areas where animals live and roam, or contact with surfaces that have been contaminated. Examples include aquarium tank water, pet habitats, and pet food and water dishes. Some diseases are vector-borne, transmitted from animals to humans by mosquitoes, ticks and fleas.

Food-borne illnesses can lead to sickness, hospitalization and even death. Each year, 1 in 6 Americans get sick from eating or drinking something contaminated and unsafe such as unpasteurized milk, undercooked meat or eggs, or raw fruits and vegetables. *E. coli* and hepatitis A are common food-borne illnesses. Water-borne illnesses are less common in the United States, but may occur when water supplies are contaminated or disrupted by natural disasters.

Some infectious diseases may be spread from one person to another, either directly or indirectly. In direct physical contact, there is a transfer from one person to another. An example is when an infected individual has sexual contact with someone who is not infected—spreading diseases such as syphilis, HIV, or hepatitis C. Also classified as direct contact is droplet spread, which occurs when an infected person sneezes or coughs, sending large infectious droplets into the air (e.g., pertussis, meningococcus, and pneumonia). Infection also may be spread indirectly through food, water, blood, needles, and objects such as bedding and eating utensils.

To prevent infectious disease, we must decrease our exposure to organisms that cause diseases. Basic hygiene is a first defense. This includes: frequently washing your hands, ensuring safe food preparation and storage, and disinfecting kitchens, bathrooms, toys, and other shared items. We can reduce contact among people who are sick by: staying home when sick, covering coughs and sneezes, and practicing safe sex. When vaccines exist, the single most important form of prevention is immunization against vaccine-preventable diseases. With the advent of vaccine development, the world has seen a tremendous decline of vaccine-preventable diseases. In 1998, a fraudulent research paper was published linking the mumps, measles, and rubella vaccine to autism. While these claims were subsequently disproven, and the article retracted, many continue to be misinformed.

While the world has seen the spread of more infectious diseases for which there are no vaccines or specific treatments (e.g., chikungunya, Zika), surveillance, rigorous case investigations and contact tracing, and laboratory testing capacity are critical to containing disease outbreaks. Public health agencies: educate people, monitor disease patterns, help to ensure access to vaccines, protect the food and water supplies, investigate outbreaks, and contain epidemics. Beyond that, everyone shares responsibility for preventing the spread of infectious disease.

What strategies can make a difference?

National recommendations call for vaccinating young children, youth, and adults on particular schedules to protect all of us. Maintaining high immunization levels to ensure population-wide “herd” immunity is the key to preventing disease and protecting the more vulnerable (e.g., infants not yet immunized). Achieving high immunization rates for each new cohort of children requires ongoing awareness, acceptance, financing, and access. Success depends upon public-private partnerships involving health professionals who administer vaccines, policy makers, vaccine manufacturers, and, of course, families who voluntarily participate in immunization programs. Exemptions laws make a difference in rates. Provider attitudes and behaviors also have a significant effect on immunization coverage rates.

The following strategies have been used to increase immunization rates:

- Regularly collect immunization data and conduct surveys to monitor who is up-to-date.
- Contact and provide intensive support and information for families whose children are not up-to-date for recommended vaccines, including those who refuse and/or have less access.
- Educate parents about the importance and safety of childhood vaccines from birth to age 21.
- Implement laws and regulations limiting immunization exemptions.
- Implement community-wide and targeted campaigns and education to inform parents about the importance of immunizing “every child by two,” the value of adolescent vaccines, and the risk of vaccine-preventable disease among even adults and seniors.
- Encourage providers to participate in immunization registries.
- Engage health providers and health plans in quality improvement projects.
- Educate health providers about the importance and acceptability of giving vaccines, even if a child is mildly ill or during an office visit that is not a well-child visit.
- Provide access to vaccines through pediatricians, family physicians, local health departments, community clinics, pharmacies, and other locations.
- Employ data and geographic mapping to identify clusters of underimmunized children and focus efforts on those areas.
- Assure an adequate supply of affordable vaccines, including sufficient funding for the federal Vaccines for Children program.
- Protect vaccine providers from liability concerns by continuing the National Vaccine Injury Compensation Program.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

- | Policy | Programs & Services | Family & Community |
|--|---|--|
| <ul style="list-style-type: none">• Collect and report San Diego County immunization survey data every other year.• Monitor immunizations exemptions, according to state rules. | <ul style="list-style-type: none">• Engage all primary care providers to ensure children, youth, and adults are up-to-date on recommended immunizations.• Maintain high levels of participation in the San Diego Immunization Registry for health providers. | <ul style="list-style-type: none">• Educate parents and others about the safety and benefits of immunization across the county.• Use community-based campaigns to promote recommended vaccines among middle and high school students. |



Ages 3–6 (Preschool):

EARLY CARE AND EDUCATION

Why is this important?

Early childhood care and education in a quality setting improves school readiness and development, as well as long-term education and employment outcomes. Quality early care and education from birth to 5 years also produces economic benefits to society that far exceed the initial investment, particularly investments in low-income children. Child care quality is important because most young children spend time in the care of others while their parents work. Quality in preschool and Head Start also matters.

What is the indicator?

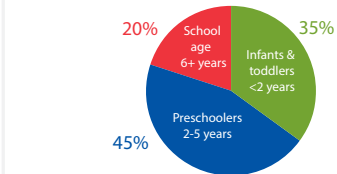
This indicator—the percentage of children ages 3-4 enrolled in early care and education—shows trends in early childhood care and education for our county’s preschool age children who are regularly attending an out-of-home and non-relative early care and education setting. The setting about which parents report may be a child care center, family child care setting, preschool, nursery school, or Head Start program. The data are collected by the US Census Bureau American Community Survey.

What is the trend?

The trend is maintaining. The percentage of children ages 3-4 enrolled in early care and education was higher in San Diego County than the state and US averages in 2016.

53%
of children ages 3 and 4 were enrolled in preschool or other early education settings in San Diego County in 2016

PARENTS REQUEST CHILD CARE FOR ALL AGES OF CHILDREN. SLOTS IN LICENSED CHILD CARE ARE AVAILABLE FOR ONLY 1 IN 3 FAMILIES THAT NEED THEM.

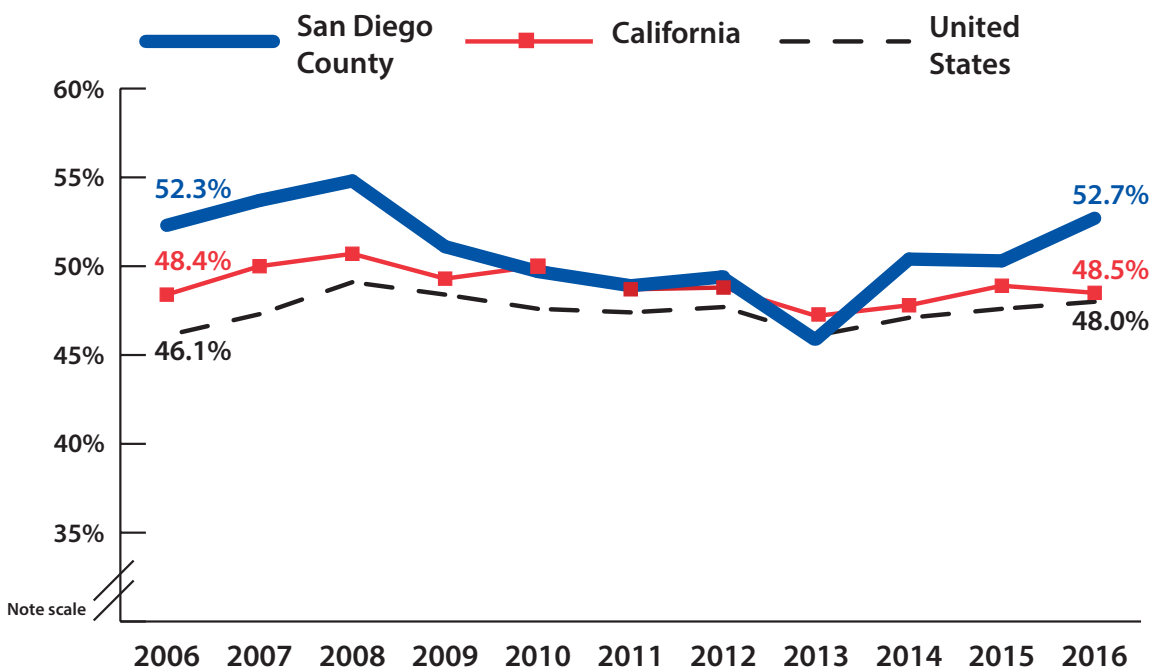


Source: Percentage of Parent Requests for Licensed Child Care by Age of Child, 2014. KidsData.org based on California Child Care Resource & Referral Network, California Child Care Portfolio.

MORE THAN 50,000 OF 3 AND 4 YEAR OLD CHILDREN IN SAN DIEGO COUNTY ARE IN PRESCHOOL OR OTHER EARLY CARE AND EDUCATION. THE QUALITY AND TYPE OF SERVICES VARIES BY COMMUNITY, FAMILY INCOME, AND AGE OF CHILD.

Source: Percentage of 3 and 4 Year Olds Enrolled in Preschool or Other Early Care and Education, San Diego County, 2016. American Community Survey, Census Bureau estimates.

Percentage of Children Ages 3-4 Enrolled in Early Care and Education, San Diego County, California, and United States, 2006-2016



What strategies can make a difference?

Parents are children’s first and most important teachers. Yet most young children in the United States spend time in the care of other adults in early care and education settings. Early care and education includes child care, preschool/pre-kindergarten (pre-K), and Head Start. Children in high quality early care and education environments gain more advanced language, better school readiness, and enhanced social skills. Research has shown that low quality early care and education may do harm rather than good, particularly for low-income and higher risk children who need enrichment to their home experience.

The following strategies have been used to increase access to quality early care and education:

- Offer child care resource and referral lines and/or centers that assist families in finding affordable, quality services.
- Increase the affordability, accessibility, and quality of infant and toddler care.
- Increase access to quality preschool, Head Start, and pre-K programs. Combining programs into a “preschool for all” campaign helps to maximize resources.
- Ensure a comprehensive early childhood education system at the local level that offers parents varied, high quality options to meet families’ needs.
- Implement a quality rating system (e.g., 1-5 stars) to give families information to identify quality programs and provide incentives to providers that reach high standards.
- Target child care subsidies for low-income families to quality early care and education (i.e., with high quality rating or other demonstrated quality performance).
- Provide appropriate reimbursement rates for early care and education providers.
- Provide inclusive child care to serve children with special health care needs and disabilities.
- Adopt teacher training and credentialing standards associated with quality.
- Provide no-cost technical assistance and training to family child care homes/centers to ensure good quality care and financial sustainability.
- Create career pathways for low-income mothers to train for jobs as assistants, teachers, and other staff in early care and education.
- Train and deploy child care health consultants and child care mental health consultants to provide supportive services to children in early care and education settings.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

- | <i>Policy</i> | <i>Programs & Services</i> | <i>Family & Community</i> |
|--|--|---|
| <ul style="list-style-type: none">• Optimize participation in the California Transitional Kindergarten Stipend Program funding for 2018-2019.• Annually review and prioritize the recommendations of the Child Care and Development Planning Council. | <ul style="list-style-type: none">• Expand the number of high quality early care and education sites (Tier 4 and 5).• Increase use of early childhood mental health services and consultation in child care and preschool settings. | <ul style="list-style-type: none">• Distribute culturally and linguistically appropriate consumer information on how to choose quality child care and preschool settings.• Expand awareness of the San Diego County Centralized Eligibility List for early care and education. |

Home Visiting Programs for Families

Home visiting programs are a preventive intervention designed to support pregnant women, new mothers, and young children, giving families the tools and know-how to succeed as parents. A major federal home visiting program has stimulated expansions and identified evidence-based home visiting program models that have shown positive effects in the short term and across the life span. California emphasizes the importance of home visiting for overburdened families who are at risk for Adverse Childhood Experiences (ACEs), including child maltreatment, domestic violence, substance abuse, and mental illness. In San Diego County, community agencies have deployed trained home visitors using evidence-based programs to help improve the well-being of families.

Social isolation, limited knowledge of parenting, low educational attainment, and lack of basic resources (e.g., poverty, food insufficiency, housing instability) place some children and families at higher risk for poor outcomes. Decades of research shows that home visits by a trained professional during pregnancy and in the first few years of life can improve maternal and child health, parenting skills, school readiness, child safety (e.g., less maltreatment, fewer injuries), and family economic self-sufficiency. Home visitation services generally support families by:

- Helping parents develop strong, nurturing relationships with their young children
- Coaching on positive parenting practices such as age-appropriate discipline techniques and reading
- Providing information and guidance on healthy and safe living environments for families
- Connecting families to community resources, including health, nutrition, and social services

The California Home Visiting Program provides funds to San Diego County as part of the federal Maternal, Infant, and Early Childhood Home Visiting Program. These funds may be used to support the Healthy Families America and/or Nurse-Family Partnership models, both of which are operating in San Diego County.

The San Diego County First 5 First Steps (F5FS) home visiting initiative is in its fourth year of implementation. The two evidence-based models used are Healthy Families America and Parents As Teachers. Targeted populations are pregnant women and families with children age 6 months and younger, particularly low-income, pregnant and parenting teens, military families, immigrant, and refugee families. During fiscal year 2016-2017, 648 pregnant women or parents and 579 children received home visiting services through this initiative.

Early Head Start is another evidence-based home visiting model operating in more than 20 sites across San Diego County. The home-based Early Head Start model serves low-income families from prenatal to age three with federal funding to local agencies. Research shows positive impact on child outcomes (e.g., language, behavior problems, and health) and maternal outcomes (e.g., parenting, mental health, and employment).

SafeCare® is an evidence-based home visiting model designed to systematically address issues related to child abuse and/or neglect among young children ages 0-5 years. Currently, in some regions, SafeCare is funded by the United Way of San Diego and the County of San Diego. Researchers at the Chadwick Center for Children and Families at Rady Children's Hospital in San Diego have studied SafeCare and adapted it for Latino families.

In addition to federally approved, evidence-based home visiting models, agencies in San Diego County have implemented the Black Infant Health, federal Healthy Start, perinatal case management, public health home nursing, and Adolescent Pregnancy and Parenting Programs. Each of these programs uses home-based services.

Looking ahead, California recently adopted legislation to establish the CalWORKs Home Visiting Initiative to provide up to 24 months of evidence-based home visiting services to support families with infants born in poverty expand their educational, economic, and financial opportunities. All California counties will be eligible to apply.



Ages 6–12 (School Age):

ORAL HEALTH

Why is this important?

Every child needs oral health to have good health overall. Dental caries (the disease that causes cavities and tooth decay) is the most common chronic disease of childhood. Untreated cavities cause pain and affect school achievement, sleep, and nutrition. About one-quarter of US children—mostly poor, minority, and/or with special health care needs—experience 80% of all tooth decay. Although preventable, tooth decay is on the rise among young children. Nationally, 14% of preschool age children (3–5 years) and 17% of children ages 6–9 have untreated decay.

What is the indicator?

The indicator—the percentage of children under age 12 who had not visited a dentist in more than one year or ever—represents the most important years to prevent and treat dental disease and decay. National recommendations from dentists and pediatricians call for children to begin dental care at age 12 months and make at least annual visits. These data are routinely reported in the California Health Interview Survey.

What is the trend?

The trend is maintaining. The percentage of children under 12 who have not had a dental visit in the past year or never had a visit has fluctuated over the past few years. This may be due to changes in survey data.

Estimated number in 2016 of San Diego County children ages 2–11 who had not visited a dentist in more than a year or ever

55,000

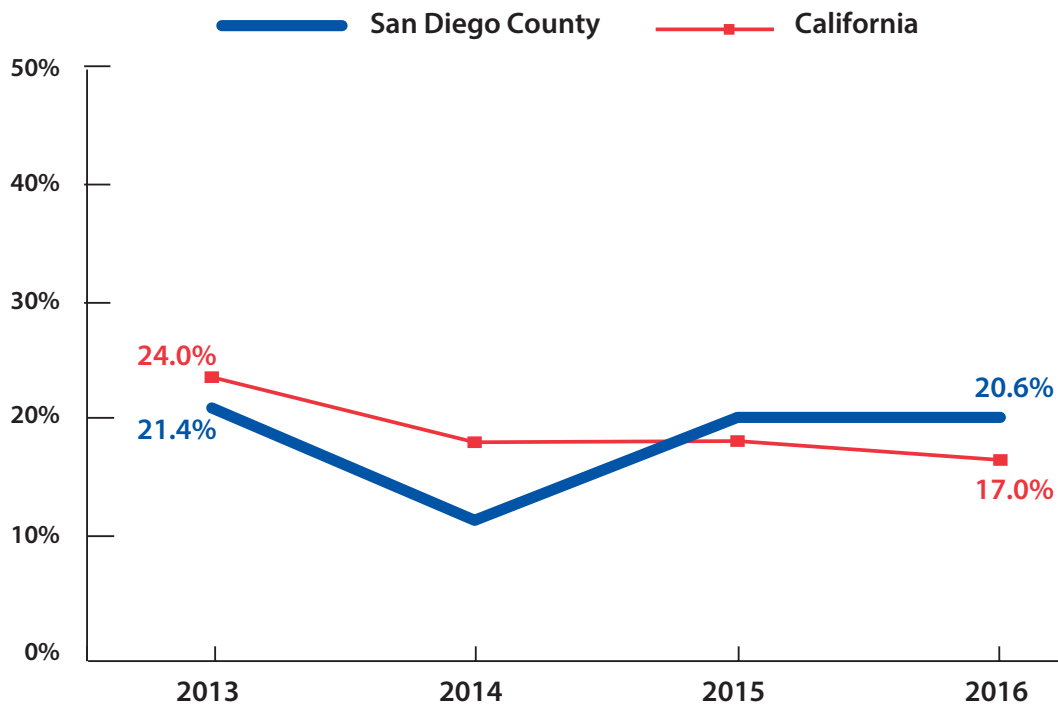
Untreated child dental problems lead to poor school performance, increased school absences, and unnecessary pain and costs.

Source: Children's Dental Health Project.

MORE THAN 160 DENTISTS IN SAN DIEGO COUNTY REPORT SERVING CHILDREN COVERED BY MEDI-CAL; however, half of these do not accept new Medi-Cal patients, and many do not serve very young children, or cannot accommodate children with special needs and disabilities.

Source: Insure Kids Now, USHHS, 2018.

Percentage of Children Under Age 12 Who Had Not Visited a Dentist in More Than One Year or Ever, San Diego County and California, 2013–2016





Adult: ORAL HEALTH

Why is this important?

About one-quarter of adults do not receive needed dental care and millions suffer with untreated disease and tooth loss. Adult concerns include dental caries, cancers, and periodontal disease. Each year, mouth and throat cancers are diagnosed in approximately 30,000 people and about 8,000 US adults die of these diseases. The life course perspective points to need for a two-generational approach. Limited use of dental care by parents often predicts and is related to inadequate oral hygiene and dental care for children. Lack of insurance, poverty, dental experiences, and family misinformation are factors.

What is the indicator?

This indicator—the percentage of adults ages 18 to 65 who had not visited a dentist within prior 12 months—represents the proportion of adults who did not have the recommended annual visit to prevent and treat dental disease and decay. These data are routinely reported in the California Health Interview Survey.

What is the trend?

The trend is improving. The percentage of San Diego County adults who had not visited a dentist in the prior 12 months declined between 2013 and 2016. Survey data not available for 2015.

Estimated number of San Diego County adults ages 18-65 who had not visited a dentist within prior 12 months, 2016

493,000

Dental coverage for adults in Medi-Cal (Denti-Cal) improved in January 2018. Now includes:

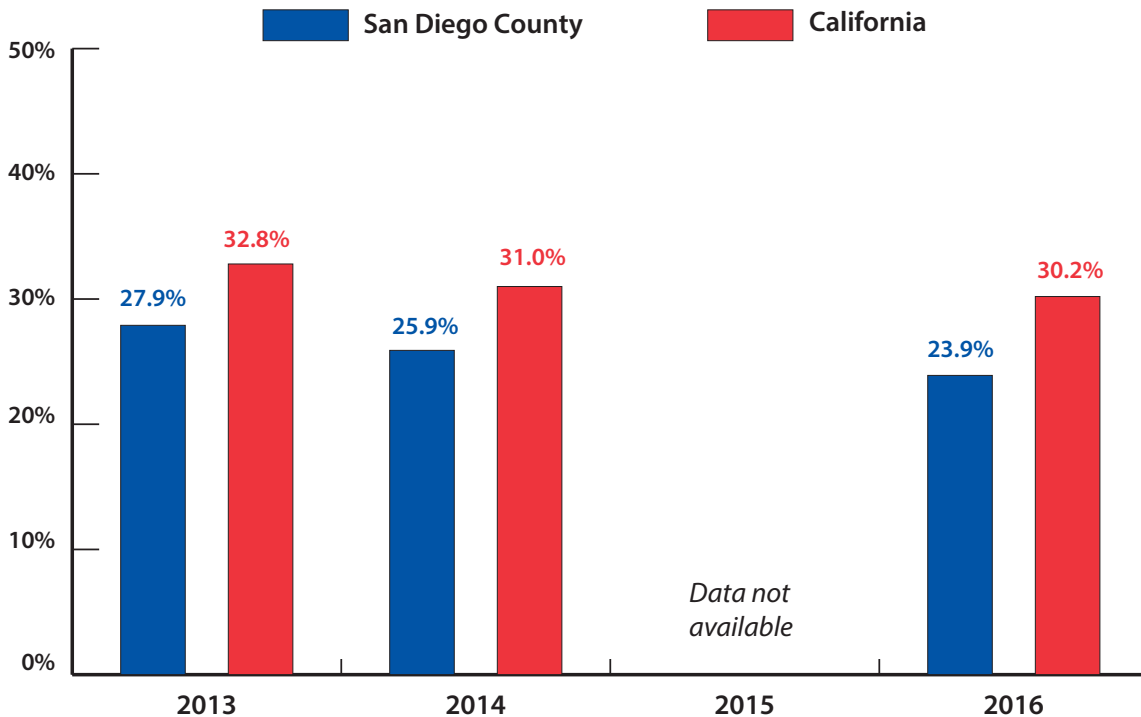
- exams, x-rays, fluoride, and cleaning
- fillings, extractions, crowns, and some root canals
- full and partial dentures
- periodontal care

Source: Denti_Cal, California Department of Health Care Services.

Less than half of pregnant women in San Diego County received dental care during pregnancy. Recommendations and referrals from prenatal providers to dental providers make a significant difference.

Source: California Department of Public Health, Maternal and Infant Health Assessment (MIHA) 2012.

Percentage of Adult Ages 18–65 Who Had Not Visited a Dentist within Prior 12 Months, San Diego County and California, 2013, 2014, and 2016



What strategies can make a difference?

Preventing dental caries and promoting oral health are necessary for assuring good overall health among children and adults. The key elements for assuring optimal oral health, beginning in childhood and continuing throughout life, are: (1) sound nutrition, (2) effective “self-care” practices (e.g., brushing and flossing), and (3) access to dental prevention and treatment services through a “dental home” starting at age 1. We know that good oral health habits and routine dental care “run in the family,” with adults’ attitudes and habits reflected in what children learn and do throughout their lives.

The following strategies have been used across the country to achieve success in improving the oral health status of children and adults:

- Continue coverage for dental services, particularly through Medicaid (Medi-Cal/Denti-Cal) and expand coverage under other publicly subsidized health plans.
- Inform children, adults, and senior citizens about their dental coverage.
- Encourage use of 211, Healthy Kids, and other online resources to help families find a dentist who will accept their coverage and serve their child, particularly for younger children and those with special health care needs.
- Increase effective use of primary health care providers (e.g., pediatricians, family physicians, nurse practitioners), early childhood education, and community-based organizations to educate parents about the importance of oral health and to screen children for oral health problems.
- Implement health promotion campaigns that increase families’ awareness of the importance of brushing and flossing (from infancy), as well as preventive dental visits.
- Promote and conduct oral health assessments through home visiting, Head Start, WIC, elementary schools, expanded learning programs, and other settings where children are served.
- Assure access to preventive services, including sealants and fluoride varnish, using dental providers, as well as preschools, elementary schools, and other community settings.
- Expand access to dental services in low-income and underserved communities (e.g., dental services in community clinics, mobile dental clinics).
- Increase the number of trained dental professionals, including dentists and dental hygienists. (This strategy includes increasing the number of training slots and offering loan repayment options in exchange for serving in low-income communities.)
- Assure community water fluoridation.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

- | Policy | Programs & Services | Family & Community |
|--|---|--|
| <ul style="list-style-type: none">• Financially support oral health assessments at kindergarten entry (California Education Code Section 494528).• Expand the Share the Care program which provides no-cost dental services to uninsured young children and pregnant women. | <ul style="list-style-type: none">• Monitor the number of children with Medi-Cal/Denti-Cal coverage who have a dental health home and receive at least an annual dental visit.• Ensure that all San Diego County dental providers who accept Denti-Cal are listed in the national Healthy Kids dentist registry. | <ul style="list-style-type: none">• Conduct education campaigns regarding the need for home and professional dental care, particularly for children under age 5.• Assist families in using the national Healthy Kids dentist registry to find services. |



Ages 6–12 (School Age):

SCHOOL ATTENDANCE

Why is this important?

One of the strongest predictors of school achievement is attendance. Whether children miss school as a result of illness, family vacations, or truancy, chronic absenteeism is an important “early warning sign” that a student is at risk for school failure and early dropout. Students in elementary school are learning basic reading, math, social, and study skills critical to success, and chronic absences as early as kindergarten can lead to deficits in achievement.

What is the indicator?

This indicator—the percent of elementary school (K-5) students who did not attend school at least 95% of school days—monitors school attendance based on 95% attendance on the Second Principal Apportionment (P2) reporting date of each district’s school year (not average daily attendance). It includes students who are absent approximately nine days per school year, for any reason. These school district data represent 87% of the student population in San Diego County.

What is the trend?

The trend is moving in the wrong direction. The percentage of students in grades K-5 who did not attend at least 95% of school days has fluctuated somewhat but generally increased since 2006.

Number of students with enrollment reported in San Diego County, School Year 2016-17

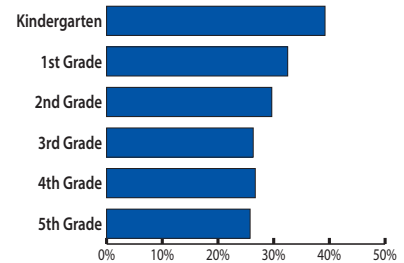
K-5th Grade

232,050

More than 60,000 students in grades K-5 attended less than 95% of school days in 2016-17

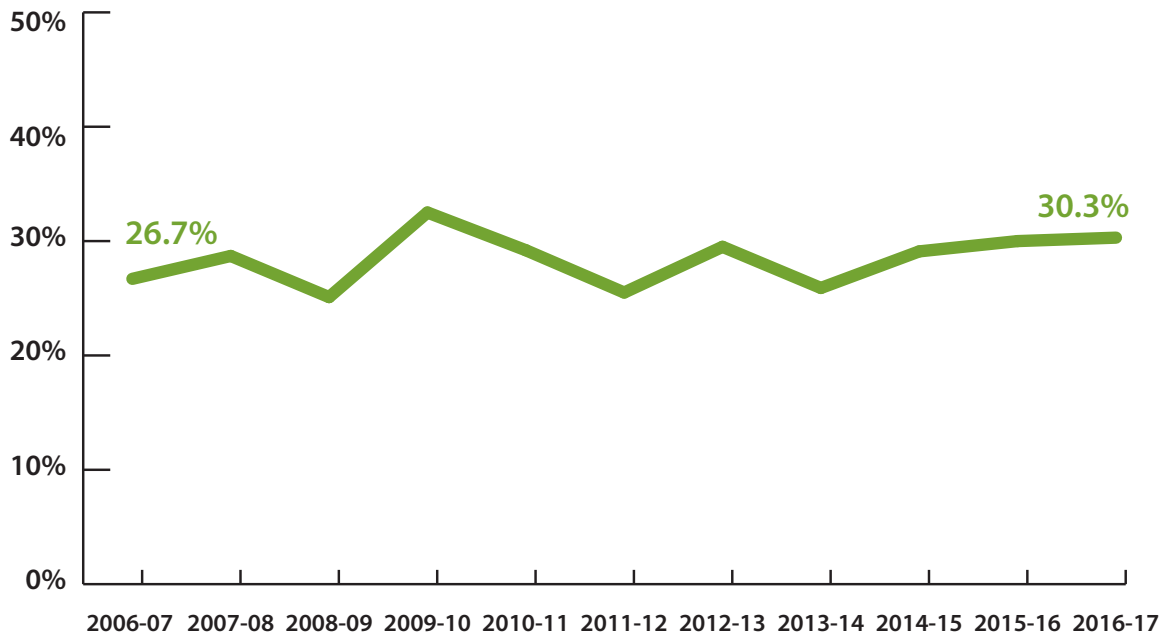
Source: San Diego school district reporting on P2 data for 2016-17 school year.

Percentage of Students K-5 Who Attended Less than 95% of School Days, By Grade



Source: San Diego school district reporting on P2 data for 2016-17 school year.

Percentage of Elementary School Students (Grades K-5) Who Did Not Attend at Least 95% of School Days, San Diego County, School Years 2006-07 to 2016-17



What strategies can make a difference?

While school attendance may be affected by many factors, such as illness, transportation difficulties, child care, parent illness, or family dysfunction (e.g., poor supervision, parental substance abuse, neglect), focused and coordinated strategies can make a difference. To address frequent absences, schools, parents, community providers, and law enforcement must work together to develop policies, services, and programs that support students and their families.

The following strategies have been used across the country to improve attendance:

- Implement evidence-informed and well-communicated attendance policies and practices, beginning in kindergarten.
- Develop accurate and daily monitoring of attendance, beginning in kindergarten, with feedback to parents (e.g., using multiple languages, the Internet, e-mail, and other forms of communication).
- Use evidence-informed practices and policies to engage and educate parents on the importance of regular attendance through education, outreach, and publicity (e.g., Attendance Works toolkit for engaging parents).
- Create a school climate and practices that promote parent and family involvement, orienting families to school policies.
- Provide positive reinforcement and acknowledgement for even small improvements (e.g., attendance recognition events, commendation letters, front-of-line privileges at lunch, extra computer time at school).
- Use specific, targeted interventions for students with chronic attendance problems, including referrals to a trained professional (e.g., school counselor, social worker, health professional).
- Provide personalized early outreach and interventions that address the specific cause of absenteeism, involving families as partners (i.e., do not wait until absenteeism for a student reaches a serious or crisis level).
- Keep students safe and supported at school and on their way to and from school, giving focus to sustained implementation of evidence-based anti-bullying programs.
- Use community outreach staff to make visits to home of families whose children have chronic absenteeism in order to assess family needs and to support parents.
- Link schools, parents, health and mental health professionals, and community supports in efforts to reduce absenteeism.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

- | Policy | Programs & Services | Family & Community |
|--|---|--|
| <ul style="list-style-type: none">• Implement monthly attendance tracking systems monitored by the school principal and district office to provide early interventions for chronically absent students, from kindergarten through grade 12.• Allocate funding for attendance intervention services such as home visits, school site social workers and positive reinforcement programs. | <ul style="list-style-type: none">• Use community outreach staff to educate families with children who are chronically absent.• Develop and consistently use best practices such as improved attendance recognition events, family engagement activities, and positive reinforcement programs. | <ul style="list-style-type: none">• Offer ongoing education and outreach to preschool and kindergarten parents to educate them about the importance of consistent school attendance.• Host quarterly community and school “meet and greets” and informal events with teachers, principals, and school staff to build strong parent and student connections to school. |



Ages 6–12 (School Age):

SCHOOL ACHIEVEMENT GRADE 3

Why is this important?

Achievement assessments are important tools for measuring students' academic strengths and areas for improvement, thus helping students, teachers, and parents better understand the student's academic needs. Teachers can use results to improve instruction based on the needs of their students. The standardized and objective data gathered from formal assessments in the early grades provide teachers with information about individual students, as well as the class as a whole, to guide instruction toward greater proficiency across subject areas and assist students preparing for future grades. Parents also need to know achievement levels.

What is the indicator?

This indicator—the percentage of students in 3rd grade who have met or exceeded the state standards for English–Language Arts/Literacy—reflects reporting of Common Core, Smarter Balance test results. These data are reported annually by the California Department of Education.

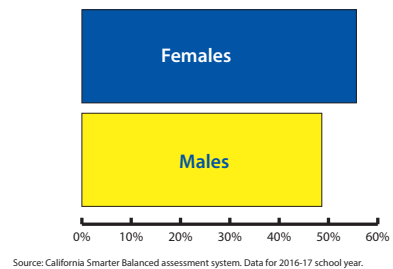
What is the trend?

The trend is improving. The percentage of 3rd grade students who met or exceeded the standard in the English Language Arts/Literacy was 52% in 2016-17, 51% in 2015-16, and 46% in 2014-15 school years.

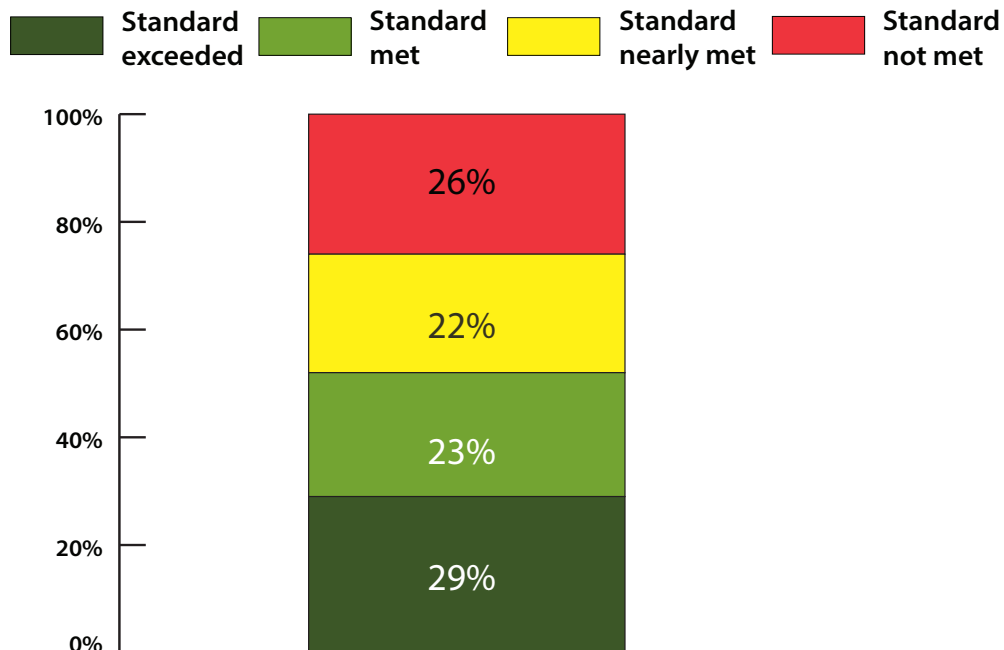
Number of 3rd grade students in San Diego County in 2016-17
37,004

48% of 3rd graders did not meet or exceed the achievement standard in English-Language Arts.
Source: California Smarter Balanced assessment system. Data for 2016-17 school year.

Percentage of 3rd Graders Who Met or Exceeded English-Language Arts Achievement Standard, By Gender



Percentage of Students in Grade 3 By Test Results in English-Language Arts/Literacy, San Diego County, School Year 2016-17



What strategies can make a difference?

Parents, early care and education providers, schools, and community programs all have a role to play in improving achievement in the early grades. Success in instilling language and reading skills begins with early language experiences and literacy skills incorporated into all areas of a child’s life. Building strong pre-reading and early reading skills, listening to stories, growing vocabulary in conversation with caregivers, and reading age-appropriate books all have value in the critical period from birth to third grade.

The following strategies have been used across the country to increase proficiency in language arts:

- Expand use of evidence-based programs that support early childhood and family literacy and make books available, such as Raising A Reader or Reach Out and Read.
- Promote family reading and talking to infants, toddlers, and preschoolers in order to build vocabulary and other language arts skills.
- Include appropriate pre-reading and reading skills development in early care and education settings, including child care and preschool.
- Limit “screen time,” including computers, television, and video games, ideally with no screen time for children under age 2.
- Assess children in pre-K and at school entry to identify those with additional need for reading education and skills, and then provide services for children based on assessed needs.
- Offer intensive English-language arts instruction (particularly important in grades K, 1, and 2), including: phonics-based instruction, word/language study, small group instruction, and use of interesting and relevant reading materials.
- Use culturally and linguistically appropriate teaching strategies, including opportunities for students to share their cultural heritage and life experiences.
- Offer appropriate services for parents of young children who do not speak English or who speak English as a second language.
- Provide Supplemental Educational Services to children who require special assistance.
- Develop age, culturally, and linguistically appropriate intervention programs across settings where children are learning, including before and after school, summer, and in-school reading support.
- Encourage reading across the curriculum in schools (e.g., story problems in math).
- Ensure professional development for all teachers (e.g., Peer Assisted Learning Strategies).
- Promote independent reading and writing at home and at school.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

Policy

- Prioritize and financially support literacy services and tutoring in grades 1 and 2 for low level readers in schools and Expanded Learning settings.
- Provide structured summer learning programs for grades 1 to 3 to prevent learning loss.

Programs & Services

- Increase use of one-on-one and small group tutoring for low level readers in grades 1-3 in schools and expanded learning settings.
- Implement programs that promote child and family literacy and family reading, such as Raising A Reader and Reach Out and Read.

Family & Community

- Distribute free children’s books and reading material at schools, clinics, libraries, neighborhood events, faith based events, and local businesses.
- Host family reading events at schools, community centers, regional Live Well centers, libraries, and the local community settings.



Ages 6–12 (School Age): CHILD OBESITY

Why is this important?

Too many children do not have healthy weight. Healthy weight is important for children’s health and well-being throughout life. An estimated 80% of children who are overweight at ages 10-15 will become obese by the age of 25, with increased risk for high blood pressure, high cholesterol, and Type 2 diabetes. One in three children will develop diabetes linked to excess weight. In addition, many overweight and obese children experience bullying, isolation, and discrimination.

What is the indicator?

This indicator—the percentage of students not in the Healthy Fitness Zone and at health risk in grades 5, 7, and 9—monitors obesity. The California Physical Fitness Test is given to students in grades 5, 7, and 9 each year. The criteria recently changed to better fit with federal criteria. This indicator uses parts of the test that measure body composition and body mass index (BMI) and reports on those who are at high risk (obese). These data are reported by the California Department of Education.

What is the trend?

The trend is maintaining. At all three grade levels, approximately one-third of students are not in the Healthy Fitness Zone. They either need improvement (i.e., overweight) or are at health risk (i.e., obese).

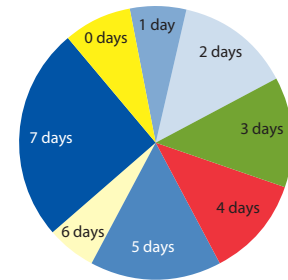
Estimated number of San Diego County children under age 18 who were over the recommended weight for their age in 2016

51,000

COMBINED OBESITY AND OVERWEIGHT RATES RANGE FROM 15-50% BY SCHOOL DISTRICT. IN A MAJORITY OF SAN DIEGO COUNTY SCHOOL DISTRICTS MORE THAN ONE-THIRD OF STUDENTS IN GRADES 5, 7, AND 9 WERE OVERWEIGHT OR OBESE.

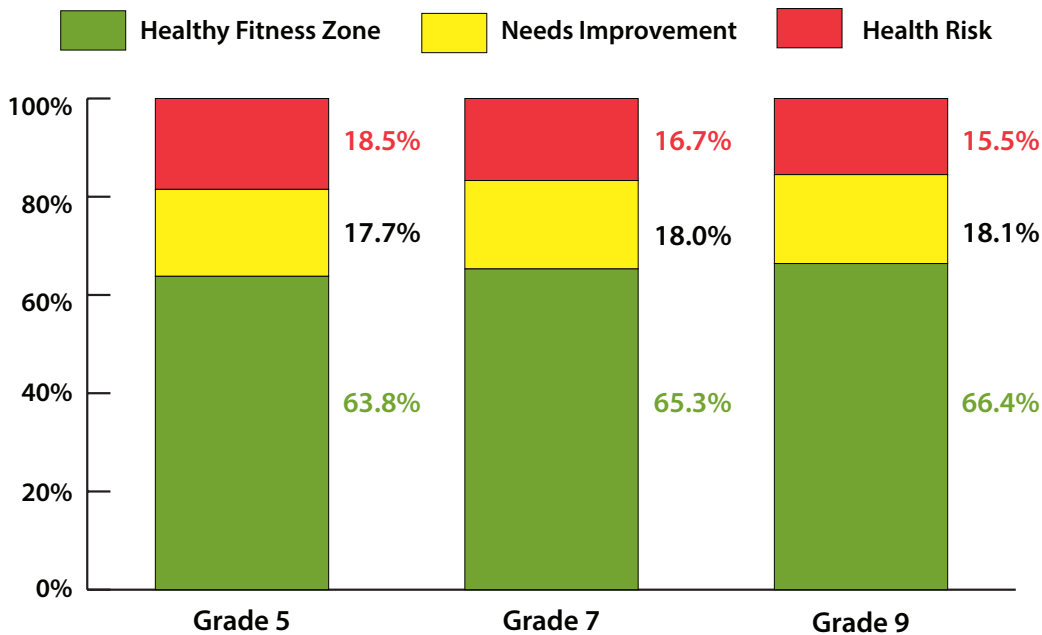
Source: Data by school district for school year 2014-15. The State of Childhood Obesity in San Diego County 2016. San Diego County Childhood Obesity Initiative.

ONLY ONE-QUARTER OF SAN DIEGO COUNTY CHILDREN AGES 5-11 ENGAGE IN AT LEAST ONE HOUR OF PHYSICAL ACTIVITY OR EXERCISE DAILY (7 DAYS PER WEEK).



Source: California Health Interview Survey, 2012-2016.

Percentage of Students Who Are in Healthy Fitness Zone, Need Improvement, or Are At Health Risk, Grades 5, 7, and 9, San Diego County, School Year 2016-17





Adult: ADULT OBESITY

Why is this important?

More than one-third of U.S. adults are obese. Reflecting both genetic and behavioral factors, having obese parents places a child at increased risk for being overweight or obese throughout life. Obese children are at increased risk for adult chronic conditions including high blood pressure, heart disease, and Type 2 diabetes. Factors affecting this intergenerational, life-course trajectory include: trauma and adverse childhood experiences, poor nutrition, and lack of exercise. Social determinants are also linked to obesity, including: poverty, parental education, residential location, access to nutritious food, access to health care, and availability of safe recreational areas.

What is the indicator?

The indicator—the percentage of adults ages 18 and older that are obese—measures those adults at highest risk for health conditions related to their weight and body mass index (BMI). These data are routinely reported in the California Health Interview Survey.

What is the trend?

The trend is moving in the wrong direction at the county and state levels, with more adults being obese. San Diego County and California were well below but are closer to the national objective.

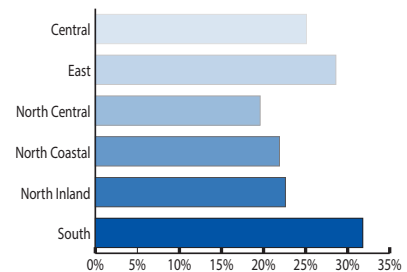
Estimated number of obese adults age 18 and older in San Diego County, 2016

618,000

Obese adults (with BMI of 30 or more) have a weight at least 20% heavier than the ideal for their height.

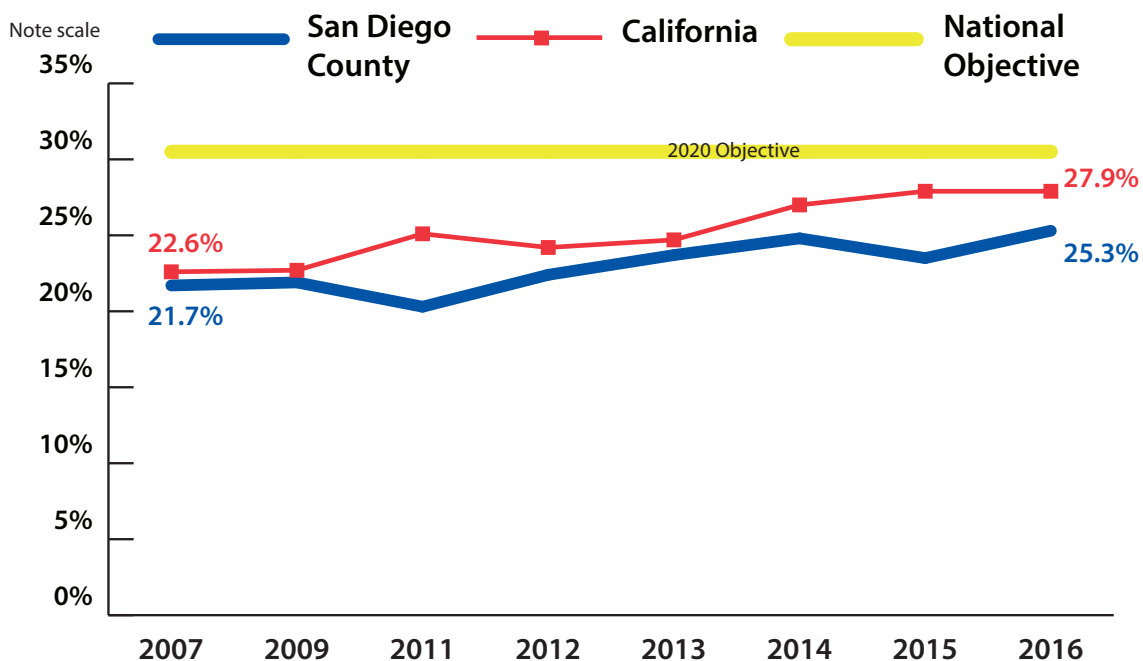
Source: San Diego County Health and Human Services Agency (HHSA). Obesity Fact Sheet.

OVERALL 1 OUT OF EVERY 4 ADULTS IN SAN DIEGO COUNTY IS OBESE. WHILE THERE IS SOME VARIATION BY REGION, OBESITY IS COMMON IN EVERY PART OF OUR COUNTY.



Source: California Health Interview Survey (CHIS), 2014-2015-2016.

Percentage of Adults Ages 18 and Older that are Obese, San Diego County and California Compared to National Objective, Select Years 2007-2016



What strategies can make a difference?

Promoting healthy weight and physical fitness among children is a nationwide priority. National, state, and community level efforts are underway to promote healthy weight among more children. Most programs and strategies aim to increase the availability to nutritious food, physical activity, healthy lifestyle choices, and access to safe recreation areas. For adults, combinations of interventions to modify diet and lifestyle have been shown to be most effective.

The following strategies have been used across the country to address weight and obesity issues:

- Expand levels of physical activity for all children and parents in school and community settings.
- Encourage eligible families to participate in WIC, which now offers healthier food packages.
- Use fitness, weight, and health assessments in communities and in schools starting at kindergarten, with interventions and referrals provided as needed.
- Expand nutrition education (including advice on shopping and cooking) in community-based programs.
- Increase the availability and affordability of fresh fruits and vegetables for homes and schools.
- Make drinking water more readily available at school, especially during lunch period.
- Reduce access to soft drinks, candy, and other foods and drinks high in sugar and calories, while low in nutrition, including requirements for public vending machines.
- Offer smaller portion size options in schools and other public settings where meals are served.
- Promote tax credits and incentives to develop and expand the availability of farmer's markets, farm-to-school programs, community gardens, and similar projects in low-income communities.
- Support student capacity to walk to and from school, using models such as walking school bus or safe passages.
- Provide education and support to increase breastfeeding.
- Encourage eligible families to participate in the Supplemental Nutrition Assistance Program (SNAP, known as CalFresh in California).
- Provide extended hours and nighttime lights and security at public parks, sporting complexes, school fields, and community recreation centers.
- Encourage employers to sponsor health education, healthy weight interventions, fitness clubs, and subsidized health club memberships.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

Policy

- Use City and County incentives and tax reductions to attract supermarkets and grocery stores to underserved communities.
- Improve public transportation to healthy food retailers and limit the proliferation of fast food establishments in low-income communities.

Programs & Services

- Develop public and parent awareness campaigns on healthy food choices, importance of family meals, and appropriate portion sizes.
- Increase access to safe drinking water in schools to provide a healthy alternative to sugar-sweetened beverages.

Family & Community

- Implement health and nutrition classes and events such as family cooking lessons, healthy shopping trips, health screenings, and building community food gardens.
- Expand community health fairs with health care providers, Health and Human Services Agency, and community-based organizations to educate the community about healthy lifestyle choices and CalFresh.



Ages 13–18 (Adolescence):

SCHOOL ATTENDANCE

Why is this important?

Students who regularly attend school have a much greater likelihood of academic success and high school graduation, which are strongly correlated with better employment and lifelong earnings. Poor attendance is an important warning sign and is associated with lower achievement, literacy problems, reduced high school completion, and delinquent behavior. Poor attendance is not just truancy-related. Whether students miss school as a result of illness, family vacations, or delinquent behaviors, missing too many days of school directly affects learning and life.

What is the indicator?

This indicator—the percent of middle and high school students who did not attend school at least 90 percent of school days—monitors school attendance based on 90 percent attendance on the Second Principal Apportionment (P2) reporting date of each district. This is not average daily attendance and is equivalent to approximately 18 absences per school year. The data shown represent 85% of middle and high school students.

What is the trend?

The trend is maintaining. The percentage of students in grades 6-12 who did not attend at least 90% of school days has fluctuated somewhat but did not improve since 2006. Attendance varies by school and district.

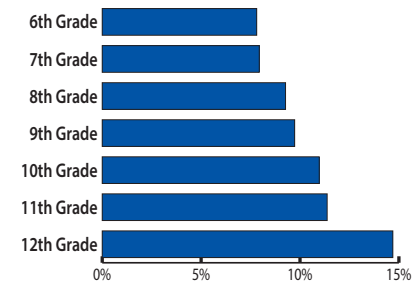
Number of students enrolled in grades 6-12 in San Diego County for school year 2016-17

272,882

Nearly 24,000 students in grades 6-12 attended less than 90% of school days in 2016-17.

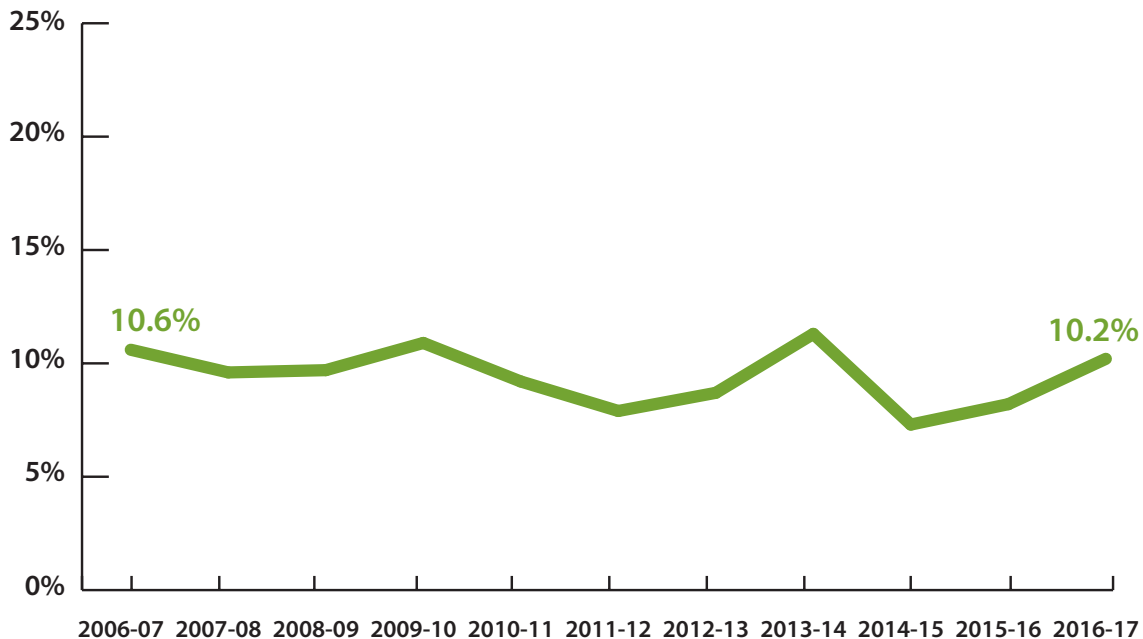
Source: San Diego school district reporting on P2 data for 2016-17 school year.

Percentage of Students Who Attended Less than 90% of School Days, By Grade



Source: San Diego school district reporting on P2 data for 2016-17 school year.

Percentage of Middle and High School Students (Grades 6-12) Who Did Not Attend at Least 90% of School Days, San Diego County, School Years 2006-07 to 2016-17



What strategies can make a difference?

A coordinated and multifaceted set of strategies is needed to reduce poor attendance patterns at the individual and school level. To address attendance issues with middle and high school students we must bring together schools, parents, community providers, and law enforcement to develop policies, programs, and supports focused on both prevention and intervention services.

The following strategies have been used across the country to increase school attendance:

- Develop parent, community, and school partnerships addressing the importance of regular attendance and parent involvement.
- Adopt proven and effective attendance policies, with a strong communications strategy to engage parents and school staff in their implementation.
- Create a school climate that engages parents as partners in education.
- Use accurate monthly and daily monitoring for attendance, with feedback to parents (e.g., using multiple languages, the Internet, e-mail, and other forms of communication).
- Train staff to identify the early signs of chronic absenteeism and truancy.
- Use visits to the home to engage families and identify unmet needs and support parents.
- Coordinate district calendars to operate schools on same days.
- Use early interventions and provide positive reinforcement (e.g., commendation letters, attendance recognition).
- Provide expanded learning programs and workplace service learning opportunities to engage teens after school, in the evening, and on weekends.
- Increase student success and engagement in learning through targeted interventions such as: career academies, service learning, school-to-work programs, and technical education programs.
- Keep students safe and supported at school and with social media—in particular, implementing evidence-based anti-bullying and anti-cyber-bullying strategies.
- Build linkages between schools, mental health providers, and law enforcement.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

Policy

- Implement monthly attendance tracking systems monitored by the school principal and school district to provide early interventions for chronically absent students in middle and high school.
- Support the expansion of career and technical education, career pathways, and internships in high schools.

Programs & Services

- Develop programs that provide credit recovery, tutoring, and mentoring services for at risk middle and high school students.
- Develop and expand career technical education, service learning, and work–place learning opportunities in middle and high schools.

Family & Community

- Recognize student attendance improvement efforts in community events, libraries, school marques, regional Live Well centers, places of worship, and local businesses.
- Develop youth led events on school campuses in the evenings, weekends, and summer that engage middle and high school youth.



Ages 13–18 (Adolescence):

SCHOOL ACHIEVEMENT GRADES 8 & 11

Why is this important?

Skills in English-language arts (e.g., reading and writing) and math are top predictors of school achievement and success in life. Formal academic assessments measure students’ skills and mastery of subject matter. Assessments help gauge students’ progress. The standardized and objective data on achievement help students, teachers, and parents understand strengths and areas for improvement. Teachers can use results to better develop instruction to help students gain proficiency and prepare for higher learning and a 21st century career.

What is the indicator?

This indicator—the percentage of students in 8th and 11th grades who have met or exceeded the state standard for English–Language Arts/Literacy—reflects the Common Core, Smarter Balance test results. These data are reported annually by the California Department of Education.

How are we doing?

The trend is improving. In the 2015-16 and 2016-17 school years, more than half of 8th graders and approximately two-thirds of 11th graders met or exceeded the standard for English–Language Arts/Literacy.

Number of students in San Diego County, 2016-17

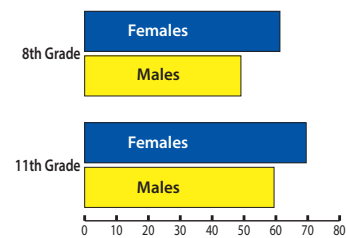
8th Grade
37,784

11th Grade
38,788

45% of 8th graders did not meet or exceed the achievement standard in English-Language Arts.

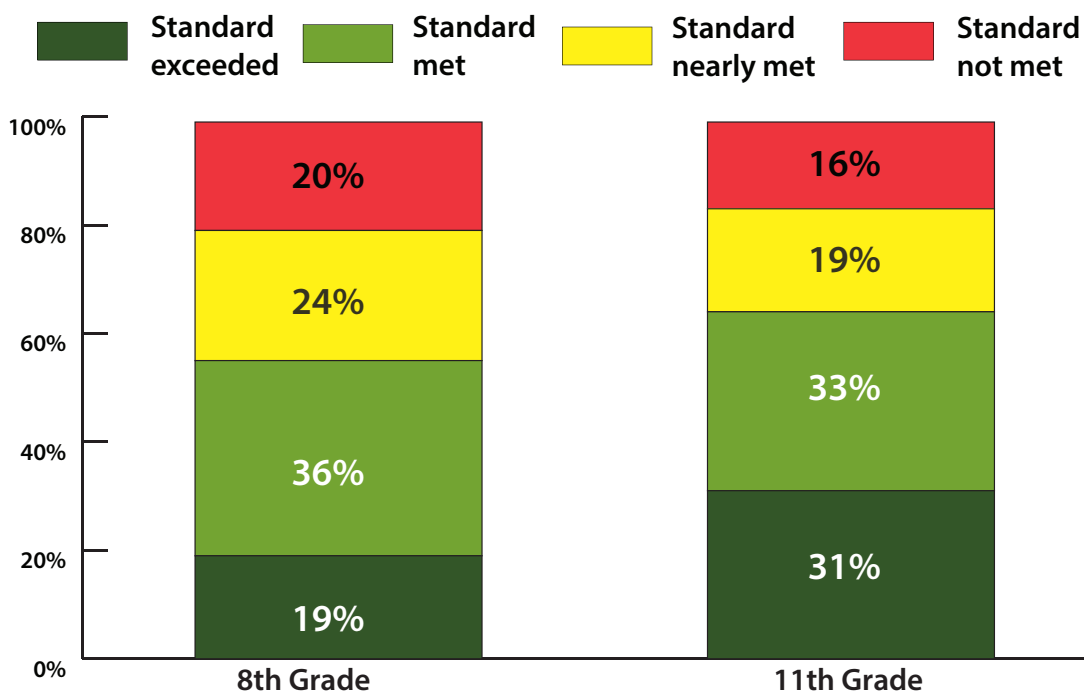
Source: California Smarter Balanced assessment system. Data for 2016-17 school year.

Percentage of Students Who Met or Exceeded English-Language Arts/Literacy Standard, By Gender



Source: California Smarter Balanced assessment system. Data for 2016-17 school year.

Percentage of Students in Grade 8 and 11 By Test Results in English-Language Arts/Literacy, San Diego County, School Year 2016-17



What strategies can make a difference?

Identifying and intervening for learning and achievement problems are critical in upper grades. Distinct from elementary students, older students need more intensive remediation and support when they are behind in English-language arts proficiency. As students enter middle and high school, feeling successful at and connected to school becomes increasingly important to staying in school and graduating.

The following strategies have been used across the country to increase proficiency in English-language arts among older students:

- Expand and target support services to underperforming students, especially 8th and 9th graders (e.g., reading specialists, tutors, one-to-one instruction).
- Assess and address underlying issues of poor academic performance (e.g., substance abuse, mental health, safety concerns) in partnership with community and health partners.
- Provide support for the middle school to high school transition, particularly for underperforming students.
- Recognize and reward small improvements in reading and language arts skills.
- Increase focus on reading comprehension.
- Provide reading materials that resonate with youth interests, as well as being culturally and linguistically appropriate.
- Adopt evidence-based and appropriate intervention programs, including before school, after school, and summer programming, and in-school reading support (e.g., Quantum Opportunity Program).
- Provide specialized reading trainings and instructional strategies for teachers and classroom support staff (e.g., Cognitively Guided Instruction).
- Use smaller schools, schools within school models, and industry-specific academies.
- Promote and support reading and writing at school and at home.
- Create opportunities for reading achievement in the community (e.g., contests, awards, library programs).
- Improve students' and parents' feeling of connection to school.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

Policy

- Financially support tutoring, mentoring, and literacy services for underperforming students in grades 8 and 9.
- Provide mental health and substance abuse prevention services to middle and high school students.

Programs & Services

- Provide high school bridging programs and school transition support for middle school students.
- Develop summer, weekend, and evening programming, on and off campus, that includes both enrichment and academic support for low performing students.

Family & Community

- Create partnerships in the community with schools, parents, and businesses to recognize student achievements and improvements.
- Host unstructured teacher-parent gatherings to build trust, connections to education, and increased family engagement.



Ages 13–18 (Adolescence):

SUBSTANCE USE

Why is this important?

Use of tobacco, alcohol, and other drugs can stunt an adolescent’s physical and mental development. Studies show that prolonged use of alcohol and drugs affects academic success, employment potential, and mental health. Use of illegal drugs represents only a share of the problem. Alcohol use is fairly common by high school. Use of smokeless tobacco and e-cigarettes is a problem and is increasing. The misuse of prescription drugs (e.g., OxyContin, Adderall, and Vicodin) can also have serious consequences and is likely to continue into adulthood.

What is the indicator?

This indicator—the percentage of students in grades 7, 9, and 11 who reported having used cigarettes, e-cigarettes, alcohol, marijuana, or other drugs in the last 30 days—monitors a portion of substance use. These data are collected with the California Healthy Kids Survey, administered biennially to students in grades 7, 9, and 11. These questions mirror the questions in the Youth Risk Behavior Survey, a CDC-designed survey.

How are we doing?

Data not shown indicate that at each grade level, the trends are improving, with a decrease in cigarette, alcohol, and marijuana use. Trend data are not available for e-cigarettes or other vaping devices.

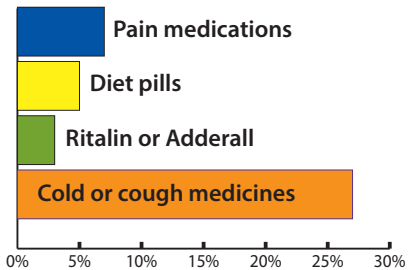
Percentage of 9th grade students who ever used e-cigarettes or vaping

18%

In 11th grade, White, African American, Hispanic, and Native American students are about equally likely to use alcohol or marijuana (15-17%).

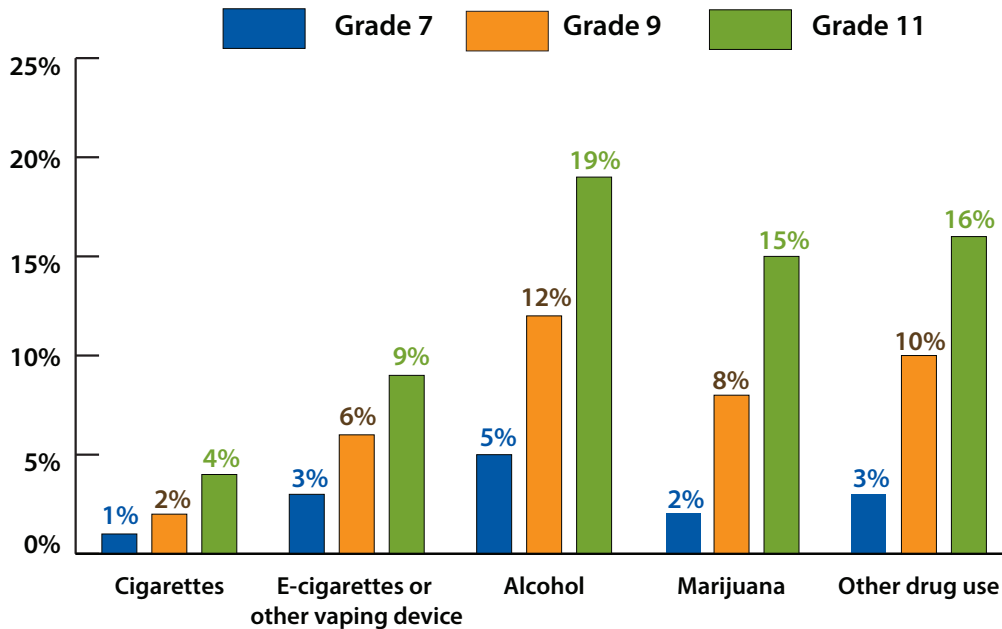
Source: San Diego County Office of Education. School year 2016-17.

Percentage of San Diego County 9th Grade Students Who Report Ever Misusing Prescription and Over-the-Counter Medicines, 2016-17



Source: San Diego County Office of Education. School year 2016-17.

Percentage of Students Grades 7, 9, and 11 Who Reported Use of Cigarettes, E-cigarettes, Alcohol, Marijuana, or Other Drugs in Prior 30 Days, San Diego County, School Year 2016-17





Adults: SUBSTANCE USE

Why is this important?

While smoking among adults has continuously declined in recent years, about 1 in 5 US adults smokes tobacco. One-quarter of adults living in poverty are smokers. Cigarette smoking is the leading cause of preventable disease and death. Half of adults who continue to smoke will die from smoking-related causes. Millions more suffer with a smoking-related disease such as cancer or heart disease. Adult smoking affects the health of the next generation. Smoking contributes to preterm and low birthweight births. Infants exposed to cigarette smoke are more likely to die in the first year of life. Children exposed to secondhand smoke are more likely to have asthma. Parental smoking increases the chances of smoking among children and youth.

What is the indicator?

This indicator—the percentage of adults ages 18 and older who reported smoking—reflects one type of substance use. These data show current but not former smokers. These data are routinely collected in the California Health Interview Survey.

How are we doing?

The trend is improving. The percentage of adults smoking in San Diego County is lower than the state average and the national objective.

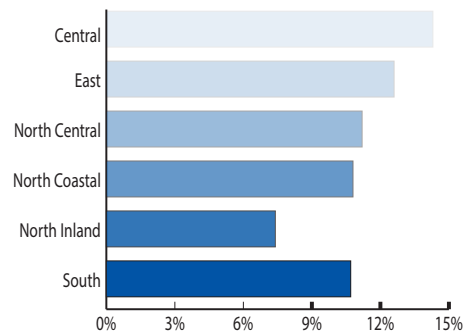
Estimated number of adult smokers in San Diego County in 2016

226,000

Among San Diego County adults, 11% of males and 7% of females smoke.

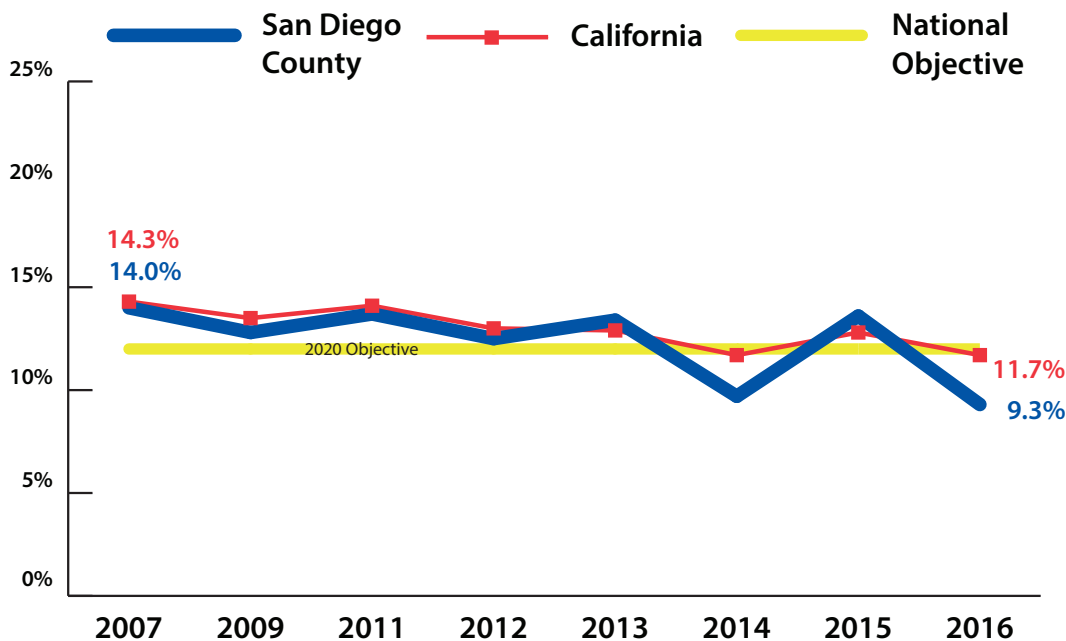
Source: California Health Interview Survey, 2016.

ADULT SMOKING VARIES BY REGION, FROM 10% TO 14%.



Percentage of Adults Ages 18 and Older Who Reported Smoking, By Region, San Diego County. Source: California Health Interview Survey, 2014-2015-2016.

Percentage of Adults Ages 18 and Older Who Reported Smoking, San Diego County and California Compared to National Objective, Select Years 2007-2016



Smoking tobacco affects children and families across the life course.

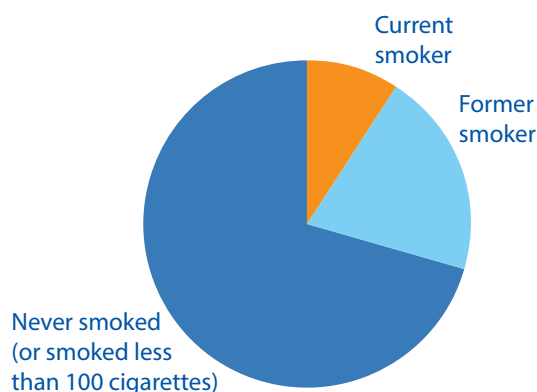
BEFORE BIRTH

Across the US, 1 in 10 women smoke in the last 3 months of pregnancy.

- Women who smoke during pregnancy are more likely to have a miscarriage, preterm birth, low birthweight birth, or baby born with certain birth defects.
- Among women who quit smoking during pregnancy, 40% started smoking again within six months after delivery.
- Research in San Diego shows that brief tobacco cessation counseling by a trained health provider, combined with support, significantly increases pregnancy quit rates.



Smoking During Pregnancy. Source: Centers for Disease Control and Prevention (CDC), Pregnancy Risk Assessment and Monitoring System (PRAMS) 2011 data for 24 states.



Adult Smoking Status in San Diego County. Source: California Health Interview Survey, 2016.

DURING CHILDHOOD

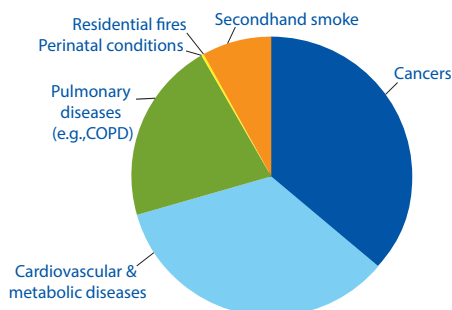
Adult smoking exposes children to secondhand smoke in the home.

- Children who breathe in cigarette smoke are more likely to have ear infections and respiratory problems (e.g., bronchitis, pneumonia, and asthma attacks).
- Nearly 10% of San Diego adults are current smokers.
- Nationally about 3 in 10 parents smoke. Parents in stressful life situations such as poverty, depression, or single-parenthood are more likely to be smokers.

YOUTH ARE AFFECTED

Parent smoking increases smoking among youth.

- Children and adolescents who live in families with smokers are more likely to develop the habit.
- 12-year-olds whose parents smoked were twice as likely to begin daily smoking by age 21 than their peers whose parents did not smoke.
- Smoking often leads to early deaths, resulting in various diseases, health conditions, and hazardous environments.



Deaths Among People Ages 35 and Older Attributable to Smoking, By Cause, San Diego County

Source: San Diego County Health and Human Services Agency. Data for 2015.

What strategies can make a difference?

Prevention and intervention policies, programs, and services are needed to reduce substance use and addiction. Education in schools, as well as community settings, is essential. Successful community-level prevention strategies rely on coalitions and agencies to select and implement approaches that have proven effective. Treatment services for individuals are most effective when they are available immediately, community based, and holistic.

The following strategies have been used to decrease substance use among youth and adults:

- Work with parents, schools, communities, and businesses to eliminate youth access to tobacco, alcohol, illicit drugs, and nonprescribed medications.
- Develop and enforce local ordinances prohibiting the sale of tobacco, e-cigarettes, and alcohol to minors, as well as over-the-counter substances that can be misused (e.g., bath salts, spice).
- Reduce use of prescription pain medications (e.g., opioids) among youth and adults.
- Raise the legal age to buy tobacco to 21.
- Use coalitions and partnerships to educate youth, parents, and other adults in the community about the dangers of substance use, the sources of substances, and the trends in use across ages.
- Increase the availability of community-based drug and alcohol treatment programs, both day treatment and residential, for youth and adults.
- Increase the availability of support groups for alcohol and substance users.
- Use programs proven to increase students' ability to resist social pressure to use substances.
- Teach parents the skills they need to improve family communication and bonding through programs such as Guiding Good Choices.
- Promote youth development and build resistance, resiliency, and problem-solving skills.
- Work with peers to reduce group supported substance use and/or reduce motivation to associate with networks of peers who use substances.
- Widely use culturally competent and effective substance abuse education for youth and adults.
- Use interactive games and other technology-based approaches to reduce substance use.
- Ensure substance abuse treatment is available to youth in custody, in foster care, and in transition from detention.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

Policy

- Develop local approaches to consistently enforce federal and state regulations concerning the packaging and marketing of e-cigarettes, liquid nicotine, and cannabis edibles that resemble kid-friendly products.
- Strengthen and enforce local government policies to reduce youth access to e-cigarettes and liquid nicotine.

Programs & Services

- Increase the availability of residential bed space for substance abuse treatment for youth and adults in community settings throughout San Diego County.
- Increase culturally appropriate mental health services and counseling for youth and young adults in schools and in community settings.

Family & Community

- Work with local businesses to eliminate the promotion and access by youth to tobacco, liquid nicotine, alcohol, and e-cigarettes.
- Host events in local community centers, regional Live Well centers, schools, and libraries that promote family engagement, healthy behaviors, and positive youth development.



Ages 13–18 (Adolescence):

YOUTH SUICIDE

Why is this important?

Suicide is preventable. Support, guidance, and interventions can be provided to youth. Many youth who attempt suicide are injured or hospitalized as a result of their attempts. Many other youth report suicide attempts and suicide ideation (contemplation). The most common methods among young people are firearms, suffocation, and poison/overdose. Beyond the tragedy of death, suicide has a lasting traumatic effect on the family, friends, and community.

What is the indicator?

This indicator—the percentage of high school students who self-report having made a suicide attempt in the previous 12 months—reflects trends among a subset of youth. These data are collected and reported from the San Diego Unified School District’s Youth Risk Behavior Surveillance System (YRBSS). YRBSS is a national survey designed by the CDC and used by state, territorial, and local education and health agencies. The survey monitors health-risk behaviors among youth. San Diego Unified enrollment accounts for 25% of all county students.

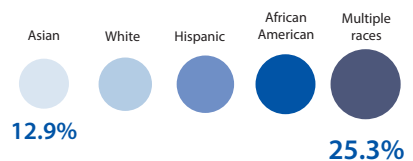
What is the trend?

The trend is improving. The percentage of high school students who reported they had attempted suicide has slightly improved since the 2010-11 school year.

Average number of youth suicides per year in San Diego County

10

The percentage of students reporting they seriously considered attempting suicide varies by race/ethnicity.



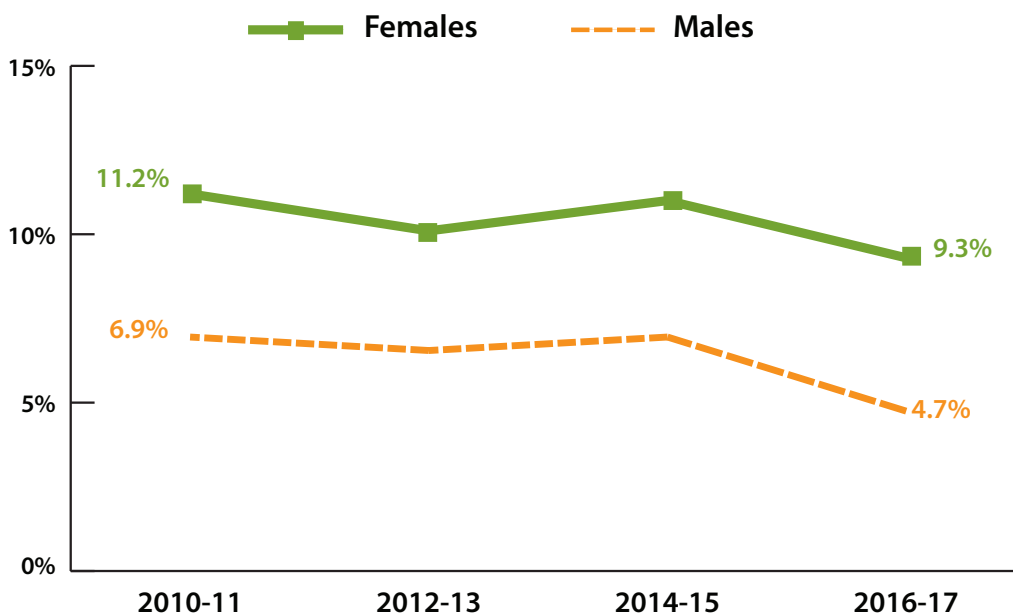
Source: Youth Risk Behavior Survey, San Diego Unified School District, 2017.

Number of San Diego Unified High School students reporting suicide attempts in prior 12 months

166

Source: Youth Risk Behavior Survey, San Diego Unified School District, 2017.

Percentage of Students Grades 9-12 Who Reported They Had Attempted Suicide in the Past 12 Months, By Gender, San Diego Unified School District, Select School Years 2010-11 to 2016-17



What strategies can make a difference?

Youth suicide prevention requires education and engagement of adults and youth, across a range of services and settings. Youth typically do not seek assistance from mental health professionals when they are depressed. Peers, teachers, health professionals, and parents are the people most likely to have contact with a depressed youth and to identify warning signs, and are thus in the best position to intervene early.

The following strategies have been used to prevent youth suicide:

- Expand school-based programs that promote help-seeking behaviors, teach problem-solving skills, and provide assessment and referrals (e.g., Cognitive Behavioral Intervention for Trauma in Schools).
- Educate families, schools, and community leaders about the signs of depression and suicidal ideation (i.e., thinking or talking about dying or committing suicide).
- Engage and educate peers and adult “gatekeepers” (e.g., teachers, school bus drivers, coaches) to recognize the warning signs and risk factors associated with depression and suicide—in particular, training peers to respond to suicidal statements as an emergency and to tell a trusted adult and to use crisis hotlines.
- Train primary health care providers to screen for signs of depression and suicide ideation.
- Reduce the stigma associated with seeking support and help for mental health problems.
- Educate parents and others about eliminating access to lethal means, particularly firearms, which remain a major instrument used by youth who attempt suicide.
- Limit access to prescription medications and other substances that may be used in attempting suicide.
- Increase access to mental health services appropriate for youth, including outpatient treatment and residential beds for youth.
- Use the federal Substance Abuse and Mental Health Services Administration (SAMHSA) *Preventing Suicide* toolkit for high schools.
- Provide interventions tailored to at risk youth of various cultural and ethnic backgrounds.
- Improve data collection and reporting, particularly school-based child health surveys.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

Policy

- Increase funding for early assessment, intervention, and referrals for depression, trauma, and mental health issues for middle and high school students.
- Develop and effectively enforce school policies on diversity and inclusion, anti-bullying, and positive school culture.

Programs & Services

- Train school personnel, expanded learning staff, parents, and students about the warning signs and risks of depression, isolation, self-harm, poor self-esteem, and suicide ideations; and appropriate action steps to take when signs are present.
- Provide culturally and linguistically appropriate mental health interventions and treatment at school and in the community.

Family & Community

- Work with families and communities to destigmatize seeking mental health support and services for youth.
- Educate parents and others about eliminating access to lethal means of suicide, particularly unsupervised access to firearms.



Ages 13–18 (Adolescence):

JUVENILE CRIME

Why is this important?

Being arrested for a crime as a juvenile can have immediate and lifelong consequences for the youth and their families. An arrest record and involvement with the juvenile justice system can affect young people’s educational attainment and relationships with their families and their communities. Depending on the type of crime, it can also hinder future employment opportunities and college acceptance. It also has negative impact on communities. Crime diminishes the sense of safety for communities and can be costly to victims and their families.

What is the indicator?

This indicator—the number of arrests for misdemeanor and felony crimes among youth ages 10-17—reports on trends in crimes. Arrests for status offenses such as curfew violations or truancy are not included. Only the most serious charge is reported in each arrest. Data are collected by law enforcement, stored in the Automated Regional Justice Information System (ARJIS), and routinely reported by SANDAG.

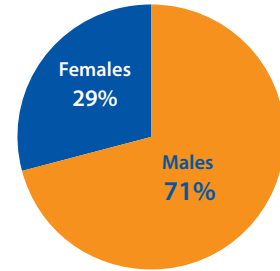
What is the trend?

The trend is improving. The number of arrests among youth has dropped dramatically between 2006 and 2016, parallel to a national decline.

Number of juvenile felony and misdemeanor arrests in San Diego County in 2016

4,661

Males represent nearly three-quarters of juvenile arrests.



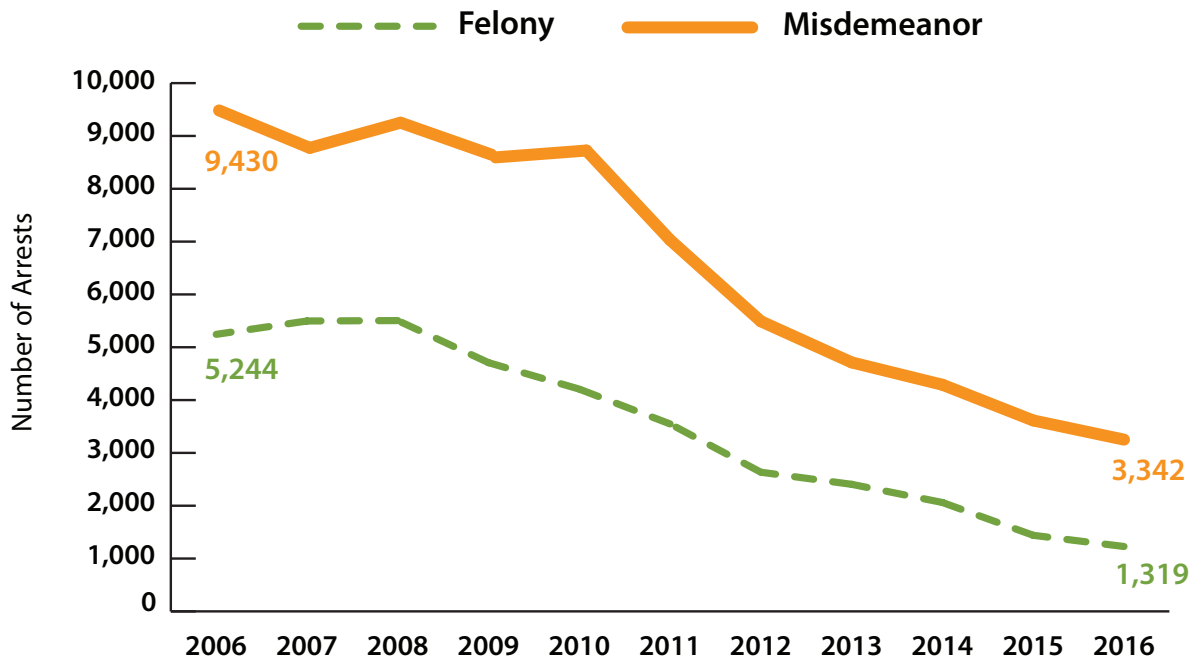
Source: SANDAG. Data for 2016.

393

Fewer juvenile arrests in San Diego County in 2016 than in 2015

Source: SANDAG Annual Arrest Report, 2016.

Number of Arrests for Felony and Misdemeanor Offenses, Youth Ages 10-17, San Diego County, 2006-2016



Ten Most Common Crimes Committed by Juveniles, Ages 10-17, San Diego County, 2016

<i>Crime</i>	<i>Level</i>	<i>Number</i>
Petty Theft	Misdemeanor	698
Manslaughter/Assault & Battery	Misdemeanor	658
Drug Law Violations	Misdemeanor	520
Aggravated Assault	Felony	312
Drunk/Liquor Laws	Misdemeanor	286
Burglary	Felony	195
Weapons Offenses	Felony	177
Robbery	Felony	158
Drug Law Violations	Felony	120
Weapons Offenses	Misdemeanor	112

Both misdemeanor and felony level crimes were among the top 10. The largest number of crimes committed by youth was in the category of petty theft, followed closely by manslaughter/assault and battery. Drugs and alcohol continue to play a role in common crimes. Data not shown show that smaller numbers of crimes (i.e., less than 100) were committed in categories such as motor vehicle theft and DUI.

What strategies can make a difference?

Identifying young people when they first begin to experiment with risky behaviors and providing them with services that focus on youth development, resiliency, and leadership can reduce the chances that they will enter or escalate in the juvenile justice system. Prevention, early intervention, and appropriate services for offenders are all important to reducing the number of juvenile crimes.

The following strategies have been used to decrease juvenile crime:

- Deliver high quality and age-appropriate after school programming for students K-12.
- Increase availability of mentoring programs for a wide array of students.
- Identify and provide early intervention for youth who are truant.
- Expand programs offering life skills training, vocational education, college readiness, career development, internships, and employment opportunities.
- Consistently provide trauma-informed assessments, interventions, and treatment.
- Improve access to culturally appropriate, community-based mental health and substance abuse services for youth at school and in the community.
- Use approaches that have been shown to be effective in reducing disproportionate arrests and detention, particularly for youth of color.
- Provide education in problem-solving, anger management, mediation, and conflict resolution.
- Offer academic support, credit recovery, and tutoring for low performing students.
- Expand prevention programs to connect youth to school, encourage positive behavior, and reduce gang involvement (e.g., Gang Violence Reduction Program).
- Provide appropriate, community-based alternatives to detention.
- Expand community-based Juvenile Diversion programs for low level offenders, in partnership with police and sheriff departments.
- Provide tailored programs that connect higher risk youth with mentors who have shared life experience in communities with high crime rates.
- Support successful and safe transitions for youth moving from detention, out-of-home placement, or incarceration back to their families and communities, particularly for young parents with their own children.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

Policy

- Ensure a unified and consistent implementation of juvenile diversion services by all law enforcement jurisdictions in the county.
- Develop government and school supported services for youth during weekends, summer, and school holidays including: internships, enrichment and education programs, and sports and recreation opportunities.

Programs & Services

- Expand career and college readiness, career development, internships, and employment opportunities for middle and high school youth in low-income communities.
- Develop community mentoring programs connecting middle and high school students with mentors with shared life experience in communities with high crime rates.

Family & Community

- Educate and inform parents about local public and private resources that support families and their children.
- Develop pathways and outreach for parents to become involved in youth activities such as coaching and volunteering with youth sports, mentoring, volunteering at school events, and participating in community beautification projects.



Ages 13–18 (Adolescence):

JUVENILE PROBATION

Why is this important?

A youth who enters the juvenile justice system and has a sustained petition (also known as “true find”) is placed on probation. Probation is structured supervision to ensure that young people successfully complete their court orders and get back on track. While probation is an important tool, it is costly for the public and often represents failure to address early warning signs of risky behavior and unmet needs of youth. Entering the juvenile justice system after committing a crime has a negative impact on a young person’s life immediately and in the future.

What is the indicator?

This indicator—the number of sustained petitions (true finds) in juvenile court among youth ages 10-17—reports on the juvenile equivalent of being found guilty in adult court. This indicator includes only sustained petitions for misdemeanor or felony offenses. Status offenses such as curfew or truancy violations are not included here. These data are routinely reported by the San Diego County Probation Department.

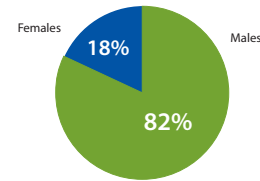
What is the trend?

The trend is improving. The number of sustained petitions in juvenile court has decreased steadily since 2007.

Number of youth that received sustained petitions (“true finds”) for misdemeanor or felony offenses in San Diego County in 2016

1,883

Males represented more than 8 out of 10 youth who had sustained petitions.



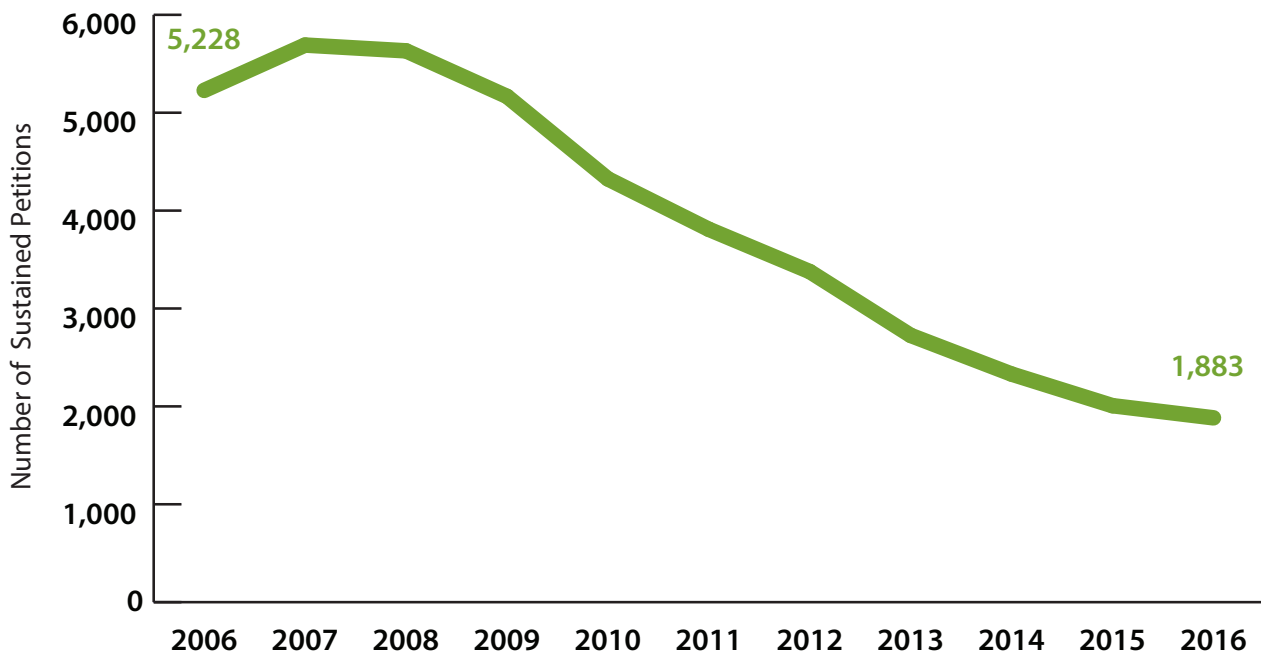
Source: California Department of Justice, Criminal Justice Statistics Center, SANDAG, 2016.

124

Fewer sustained petitions in San Diego County in 2016 than in 2015

Source: California Department of Justice, Criminal Justice Statistics Center, SANDAG, 2016.

Number of Sustained Petitions (“True Finds”) in Juvenile Court, Youth Ages 10-17, San Diego County, 2006-2016



What strategies can make a difference?

Holding young people accountable for their actions, while supporting them in making better decisions, provides them with an understanding of appropriate boundaries, an opportunity to learn from their mistakes, and the ability to get back on track. Consistent use of evidence-based strategies from arrest and detention, to aftercare and probation completion are key to success. Providing appropriate interventions, along with consistent and direct community supervision and support, has been found to be effective in preventing increased delinquent behaviors, reducing recidivism, and improving public safety.

The following strategies have been used to reduce arrests and escalation in the justice system.

- Use nationally recognized juvenile institutional procedures that reflect a rehabilitative and therapeutic approach to nutrition, peer support, mental health therapy, and positive youth development practices.
- Implement nationally recognized and evidence-based youth development, family engagement, and recidivism reduction models.
- Provide trauma-informed mental health evaluation and clinical supervision, substance abuse services, and cognitive behavioral therapy.
- Develop transition plans for youth, including comprehensive re-entry and aftercare services.
- Provide immediate and ongoing access to mental health services and residential bed space for juvenile offenders.
- Offer job readiness, career and technical education, internships, and subsidized employment approaches for youth on probation.
- Provide academic support for reading proficiency, credit recovery, and high school completion for low performing students.
- Provide alternatives to detention, such as community-based supervision with wrap-around services, cool beds, and day reporting centers.
- Offer no cost parent education and training to improve family communication, youth development, decision making, and conflict resolution skills for youth on probation and their families.
- Implement interventions to reduce gang involvement and to help youth exit a gang lifestyle.
- Provide restorative justice evidence-based practices, such as victim-offender mediation, empathy training, and restitution.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

Policy

- Implement a structured decision-making disposition matrix to determine the appropriate level of restrictive and supportive services for youth involved in the justice system.
- Adopt recognized juvenile institutional approaches that reflect a rehabilitative and therapeutic approach including: nutritious and appetizing meals, youth councils, cognitive behavioral therapy, positive youth development practices, and reduction of chemical agents.

Programs & Services

- Provide community-based residential options for youth in the justice system including mental health beds, cool beds, and licensed foster care beds.
- Expand programs that reduce reliance on detention for violations of probation and non-violent crimes such as community assessment teams, drop-in centers, lived experience mentoring, case planning, and alternatives to detention.

Family & Community

- Engage community members as mentors to elementary and middle school youth.
- Provide employment opportunities at local businesses and public agencies for high school youth on probation.



Ages 13–18 (Adolescence):

YOUTH DUI

Why is this important?

Youth have higher motor vehicle crash rates than adults, with driving under the influence (DUI) a major contributing factor. Whether due to alcohol and/or drugs, DUI is a serious hazard to health and safety for youth and the community at large. Many youth report that it is “no trouble” obtaining alcohol. One in 10 high school students reports drinking and driving, and 1 in 4 reports riding with a driver who has been drinking. Youth are more likely to be involved in a vehicle crash than adults. Motor vehicle crashes are a leading cause of death for youth ages 15 to 20, accounting for one-third of all US teen deaths.

What is the indicator?

This indicator—the number of DUI arrests among youth under age 21—measures one aspect of the problem of alcohol- and drug-related collisions. This is a subset of a larger number of youth who engage in DUI but are not caught. These data are routinely reported by the California Department of Motor Vehicles.

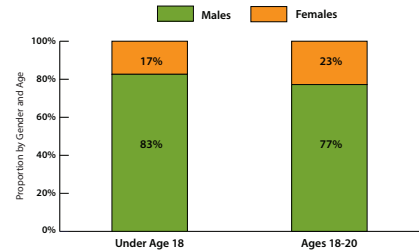
What is the trend?

The trend is improving. The number of DUI arrests among youth under 18 and 18-20 years old has declined in recent years.

Number of DUI arrests among drivers under age 21 in San Diego County in 2016

694

Proportion of DUI Arrests Among Youth Under Age 18 and 18-20, By Gender, San Diego County, 2016



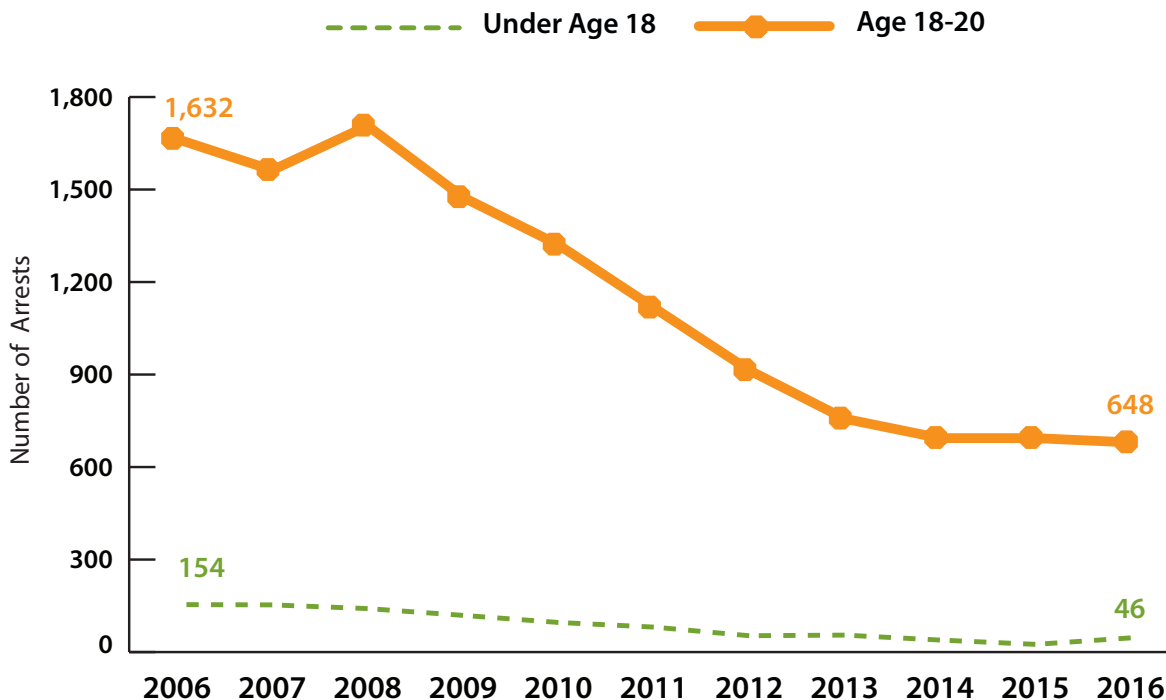
Source: San Diego County Health and Human Services Agency, Public Health Services Community Health Statistics.

Average number of crashes per year in San Diego County involving at least one 16-20 year-old driver who had been drinking or was under the influence of drugs in 2012-2014

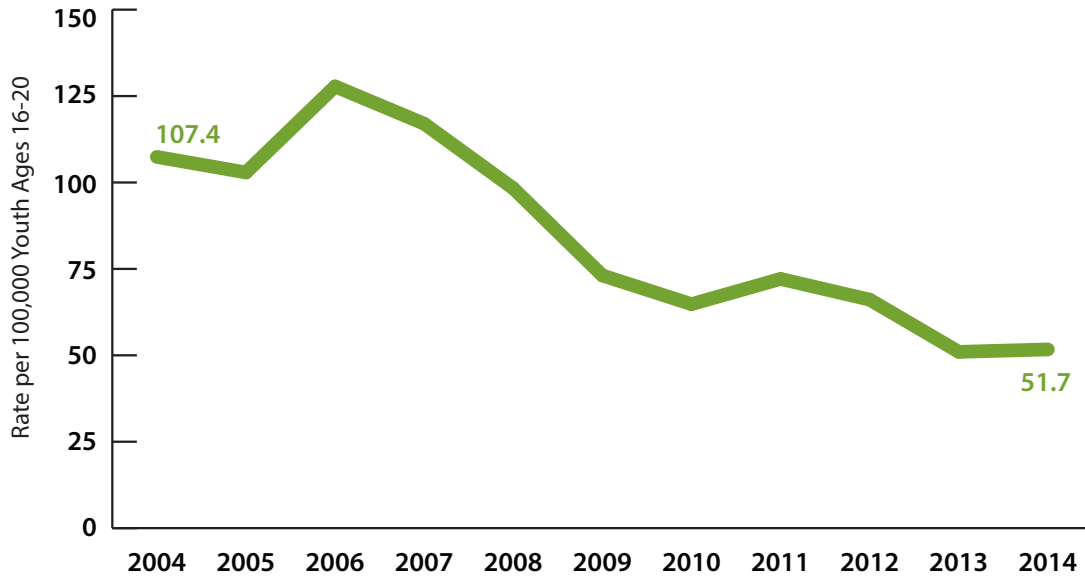
140

Source: San Diego County Health and Human Services Agency, Public Health Services Community Health Statistics.

Number of DUI Arrests, Youth Under Age 18 and 18-20, San Diego County, 2006-2016



**Rate of Non-Fatal Crashes Involving Drivers Ages 16-20
Under the Influence of Alcohol or Drugs, Per 100,000 Population,
San Diego County, 2004-2014**



The trend in non-fatal crashes is improving. The rate per 100,000 declined dramatically between 2006 and 2009. Progress continues but has leveled off since 2009.

What strategies can make a difference?

Both drinking and DUI are against the law for youth under age 21. Parents, youth, community leaders, and law enforcement all have a role to play in reducing youth DUI and its consequences. A continuum of efforts and interventions are needed to eliminate access to substances, improve driving behaviors, enforce the law, and teach youth to make safe and positive decisions.

The following strategies have been used to reduce DUI and related crashes:

- Enforce existing blood-alcohol level laws (i.e., zero BAC), minimum legal drinking age laws, and zero tolerance laws for drivers younger than 21 years old in all states.
- Maintain a legal drinking age of 21.
- Eliminate youth access to alcohol and drugs.
- Change social norms regarding the use of alcohol and drugs by youth.
- Institute community-based and school-based programs to increase student and parent awareness about the dangers of drinking and driving.
- Educate adults about the risks and liabilities of “supervised” drinking.
- Offer timely, affordable, and high quality driver education and training lasting at least three months.
- Implement graduated driver licensing that includes a mandatory waiting period, nighttime driving restriction, at least 30 hours of supervised driving, and passenger restrictions.
- Limit youth driving privileges during the first 12 months with a new license.
- Promptly suspend the driver’s licenses of youth and adults who drive while intoxicated.
- Conduct sobriety checkpoints, particularly targeted at communities with highest incidence of alcohol- and drug-related accidents involving youth and in locations where youth congregate.
- Promote youth development programs and activities to empower youth and build resistance and problem-solving skills.
- Implement safe and engaging weekend and evening activities (e.g., midnight basketball, beach clean ups).

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

Policy

- Expand availability of affordable, high quality driver education programs to all high school students.
- Increase parent education and the enforcement of social host ordinances throughout San Diego County.

Programs & Services

- Implement effective life skills programs to raise awareness of the dangers of DUI by addressing family and peer influence, internal pressures, and external marketing.
- Develop healthy and safe weekend and evening activities that are engaging for both youth and families.

Family & Community

- Host community fairs and local events promoting healthy and safe lifestyle choices including education on safe driving for teens.
- Conduct parent education sessions focusing on improved parent-child relations, communication, and problem-solving skills.



STANDARD OF LIVING

Community and Family (Cross Age):

CHILD POVERTY

Why is this important?

Child poverty is associated with insufficient food and housing, parental depression or substance abuse, maltreatment, low quality education and child care, and other community and environmental hazards. The “dose” of poverty matters; the more severe the poverty or the more years spent in poverty, the worse the impact. Adolescents raised in poverty are more likely to engage in risky behaviors including: smoking, substance abuse, sexual activity, and school drop out. Increasing income for poor families—even without other changes—can positively affect children’s development.

What is the indicator?

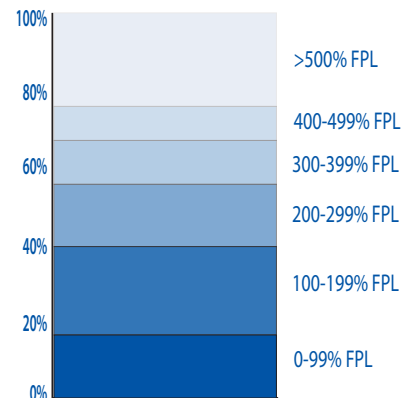
The indicator—the percentage of children under age 18 living below 100% of the Federal Poverty Level—reflects the proportion of children living in households with annual income below federal guidelines for “poverty.” The Federal Poverty Level was set at \$24,600 for a family of four in 2017. These data are routinely reported by the US Census Bureau and SANDAG.

How are we doing?

The trend is improving since 2012, returning to the level it was before the recession that began in 2008. The percentage of children in poverty in San Diego County is lower than the state and US averages.

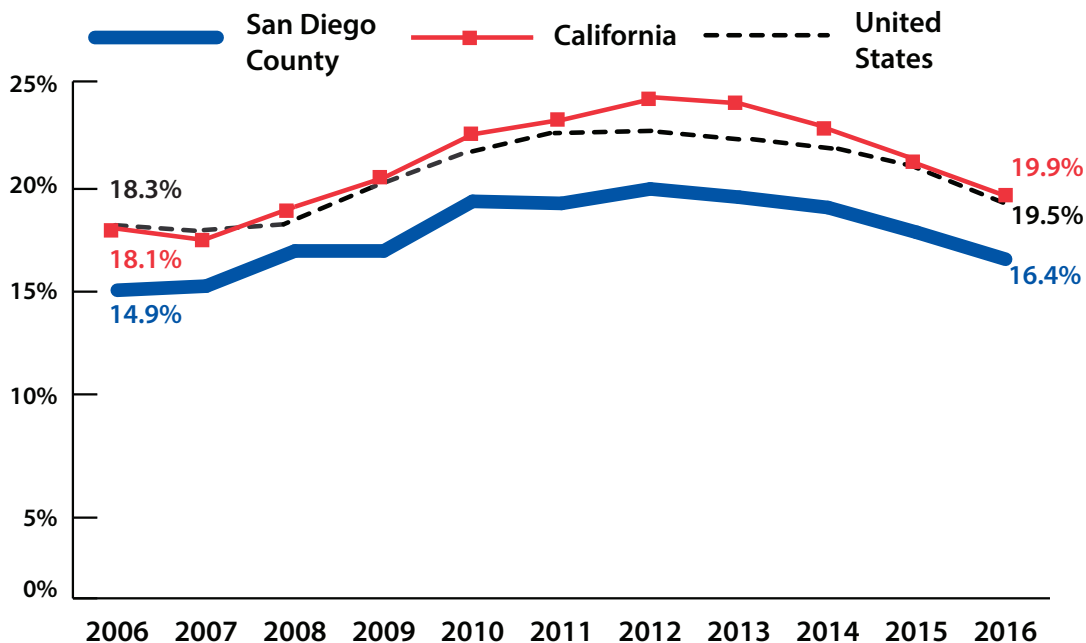
1 in 6
San Diego County children under age 18 lived in poverty in 2016

SAN DIEGO COUNTY HAS CHILDREN LIVING AT ALL INCOME LEVELS. WHILE ONE THIRD OF CHILDREN LIVE IN WELL-OFF FAMILIES WITH INCOME ABOVE 400% OF THE FEDERAL POVERTY LEVEL (FPL), 40% OF CHILDREN LIVE IN A LOW-INCOME FAMILY, WITH INCOME BELOW 200% FPL.



Source: U.S. Census Bureau, American Community Survey, 2016.

Percentage of Children Ages 0-17 Living in Poverty, San Diego County, California, and United States, 2006-2016





Community and Family (Cross Age):

ADULT POVERTY

Why is this important?

Poverty is associated with insufficient food and nutrition, housing instability, and community safety. Many younger adults, who are often parents, continue to be un- or under-employed, with income insufficient to raise them above the poverty level. From a lifecourse perspective, poverty is an important social determinant, with potentially lifelong negative effects. Childhood poverty is associated with adult health conditions such as: obesity, mental health conditions, asthma, and heart disease. Lower educational attainment and less annual income throughout life are also associated with the experience of childhood poverty.

What is the indicator?

The indicator—the percentage of adults ages 18-64 living below 100% of the Federal Poverty Level—reflects the proportion of non-elderly adults living in poverty. The 2017 Federal Poverty Level was set at an annual income of \$24,600 for a family of four. Note that not all of these adults have children. These data are routinely reported by the US Census Bureau and SANDAG.

How are we doing?

The trend is improving since 2013, returning to the level it was in 2009 after the start of the great recession. The percentage of adults living in poverty in San Diego County is below both the state and US averages.

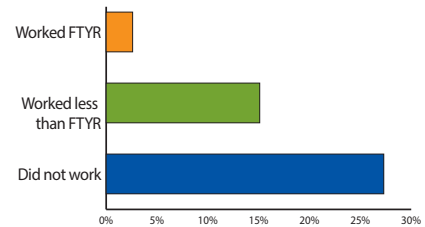
Estimated number of San Diego County adults ages 18-64 living in poverty in 2016

243,918

Percentage of San Diego County families with children under age 18 living in poverty in 2016

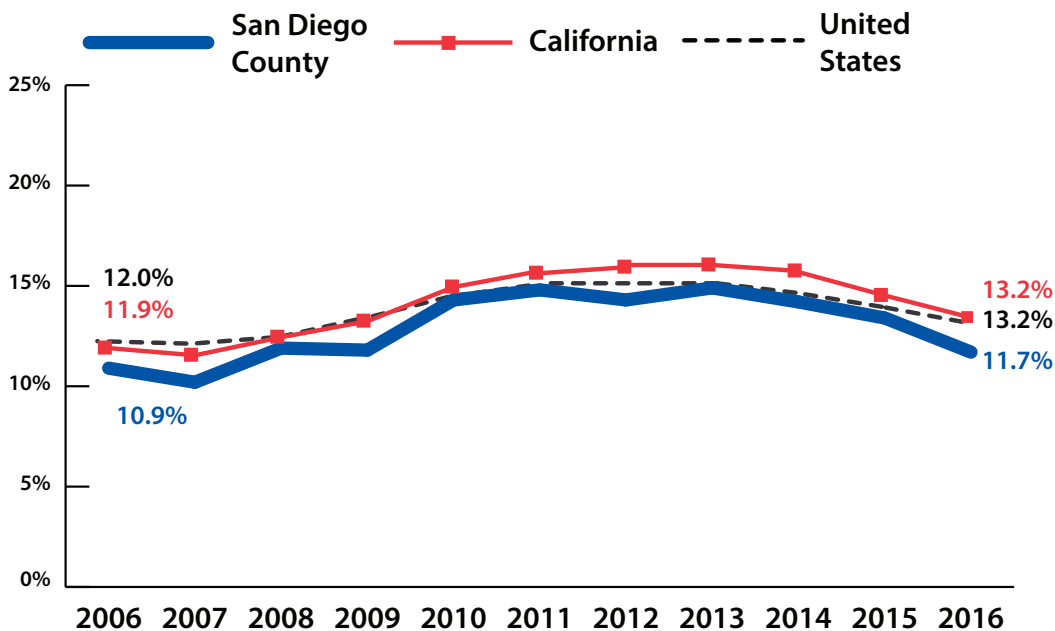
12.9%

BETTER EMPLOYMENT—WORK FULL-TIME AND YEAR ROUND (FTYR)—DECREASES POVERTY. GRAPH SHOWS PERCENTAGE OF SAN DIEGO ADULTS (16-64 YEARS) IN POVERTY BY WORK STATUS IN 2016.



Source: US Census Bureau, American Community Survey, 2016.

Percentage of Adults Ages 18-64 Living in Poverty, San Diego County, California, and United States, 2006-2016



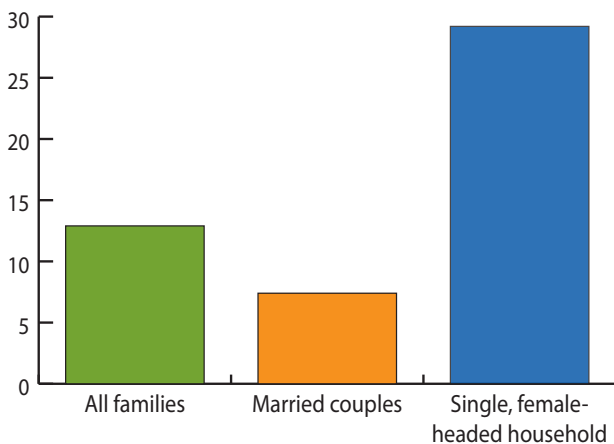
Poverty creates risks and challenges for the next generation.

A lifetime of elevated risks. Poverty is high among children and youth.

- Among San Diego County children under age 18, 16% lived below poverty in 2016—1 out of 6 infants, preschoolers, school age children, and adolescents.
- Across the US, more than 1 in 10 children are poor for half or more of their childhood years.
- Persistent, longer term poverty compounds children's risks for poor health, unsafe housing, risky behaviors, low school achievement, and lower wages as adults.



Percentage of Children Under Age 18 Living Below the Federal Poverty Level, San Diego County. Source: US Census Bureau, American Community Survey, 2016.



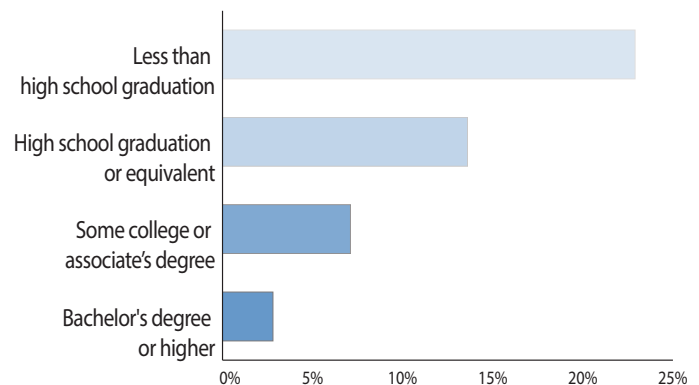
Percentage of Families with Children Under Age 18 Living in Poverty by Type of Household, San Diego County. Source: US Census Bureau, American Community Survey, 2016.

Additional support matters. Single parents and their children are more likely to live in poverty.

- Among families with children under age 18, married-couple families are much less likely to be poor.
- Among single, female-headed households with two or more children in San Diego County, about half lived below poverty in 2016.
- The financial and emotional contributions of fathers, along with public supports for single parents, matter to child health and well-being.

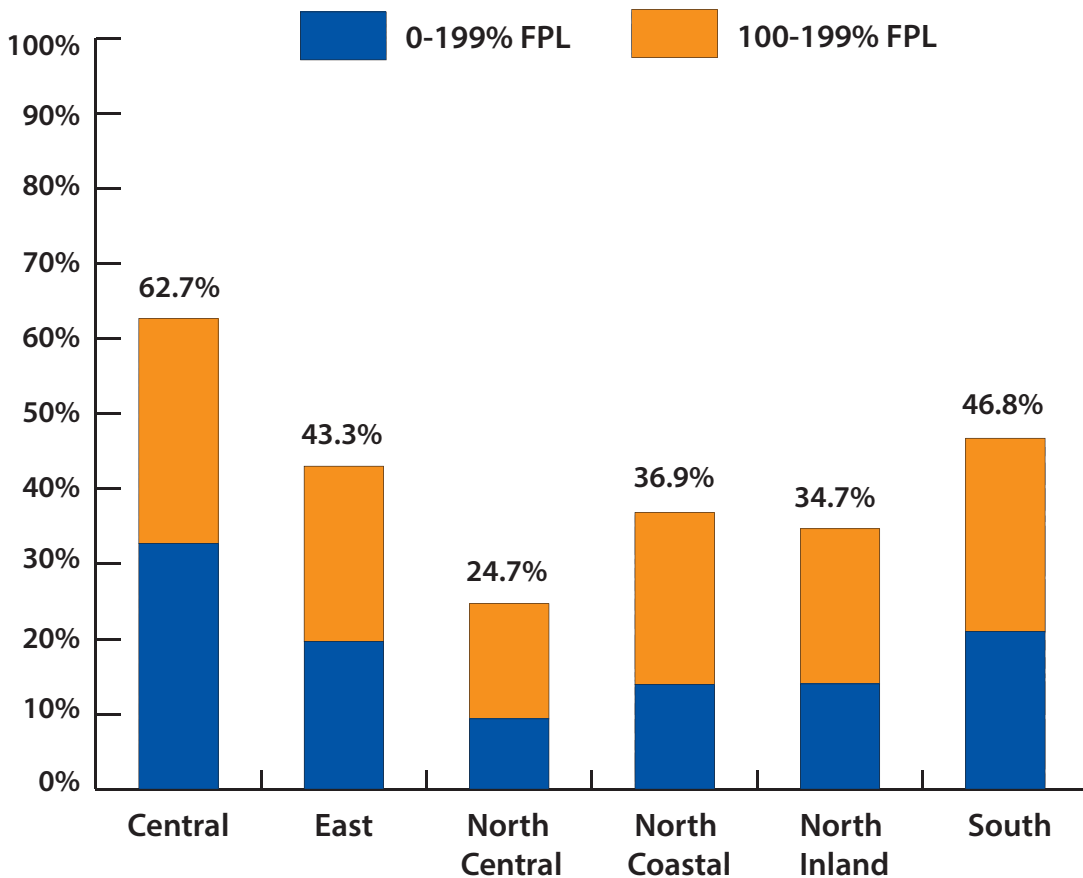
Educational attainment has effects across the life course. Parents' education level affects both generations.

- In San Diego, the poverty rate for those with less than a high school graduation was 17% for married-couple families and 38% for single female-headed families.
- Higher educational attainment among parents—even a GED—reduces the chances the family will live in poverty and increases the chances that their children will be healthy, achieve in school, and be successful in their own lives.



Percentage of Families Living in Poverty by Educational Status of Household Head, San Diego County. Source: US Census Bureau, American Community Survey, 2016.

Percentage of Children Under Age 18 in Low-Income Households, By Poverty Level and Region, San Diego County, 2016



Poverty is defined as having income below 100% of the Federal Poverty Level, and low-income children are those living below 200% of the Federal Poverty Level. The percentage of San Diego County children under age 18 who are low income varies considerably by region. Children and families in the Central Region are much more likely to live with the risks of poverty—1 in 6 are low income. Notably, however, approximately 4 out of every 10 children in the East and South Regions and more than one-third of children in the North Coastal and North Inland Regions live in low-income families.

What strategies can make a difference?

Poverty places families at risk. In San Diego County, the level of income sufficient to meet basic needs such as housing and food is closer to 200% of the Federal Poverty Level. Government programs and subsidies for low-income working families can help families move out of poverty. Assistance with income, housing, job training, food, child care, utilities, and health coverage encourage and reward work by helping families close the gap between wages and basic expenses. The Earned Income Tax Credit (EITC), child tax credits, and other tax credits for low-income families are effective in improving outcomes in terms of health and well-being.

The following strategies have been used across the country to reduce child and adult poverty:

- Assist families who qualify for the federal and state EITC, child tax credits, and refundable tax credits for low-income individuals and families.
- Focus “welfare to work” programs on barriers to employment such as low education, poor work history, lack of transportation, substance abuse, and domestic violence.
- Streamline application processes and assist qualified families to enroll in anti-poverty programs such as child care subsidies, nutrition assistance, cash assistance, and housing assistance.
- Strengthen referrals and connections among agencies providing assistance to poor families.
- Encourage employers to “ban the box” to reduce the impact of prior incarceration on employment.
- Implement jobs programs aimed at reducing unemployment and advancing job creation.
- Give priority in housing assistance to pregnant women and families with infants in order to reduce housing instability, preterm birth, and infant mortality.
- Increase adults’ access to literacy, post-secondary, and vocational education programs.
- Offer low-cost job training and GED courses for unemployed and working parents.
- Provide child care at employment education and training sites.
- Increase levels of educational achievement and reduce the number of high school dropouts.
- Assist families in opening Individual Development Accounts (IDAs) to help them get bank accounts, save money, and accumulate assets.
- Offer Individual Training Accounts (ITAs), which serve as vouchers that can be exchanged for training at approved learning institutions.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

- | Policy | Programs & Services | Family & Community |
|---|---|--|
| <ul style="list-style-type: none">• Increase staff to provide outreach and eligibility assistance for health coverage, child care subsidies, nutrition and housing assistance in communities with the highest poverty rates.• Set a countywide priority on expanded use of tax credit and savings programs for eligible residents. | <ul style="list-style-type: none">• Continue online applications for all public and private assistance programs, such as WIC, CalWORKs, and CalFresh.• Inform and assist eligible families to use federal and state Earned Income Tax Credits, Individual Training Accounts, and other public anti-poverty programs. | <ul style="list-style-type: none">• Use the IRS Volunteer Income Tax Advocate (VITA) program to help low-income families prepare tax returns and receive EITC.• Organize local ride share programs for increased access to employment opportunities for youth and adults. |



Community and Family (Cross Age): NUTRITION ASSISTANCE

Why is this important?

At any age, adequate nutrition is essential to health. The federal Supplemental Nutrition Assistance Program (SNAP), known in California as CalFresh, provides nutrition assistance to low-income individuals and families. The combined use of SNAP and EITC can lift a family of four with one minimum-wage earner to reach or surpass the poverty line. Young children enrolled in SNAP have lower rates of nutritional and vitamin deficiency. Nutrition assistance also benefits the community: every \$1.00 of SNAP generates \$1.85 in local economic activity. Another advantage is the ability to quickly meet nutrition needs in emergency or changing economic situations.

What is the indicator?

This indicator—the number of CalFresh (SNAP) recipients who are children ages 0-18 and adults age 19 and older—tracks how many eligible San Diego County residents are participating in CalFresh. This information is collected through the County of San Diego Health and Human Services Agency.

What is the trend?

The trend has improved since 2011. More eligible low-income children and adults are participating in CalFresh.

Percentage of San Diego County households that experience food insecurity

21%

Source: Kids Data; Feeding America. Data for 2014.

In San Diego County, 47% of CalFresh recipients are children under age 18.

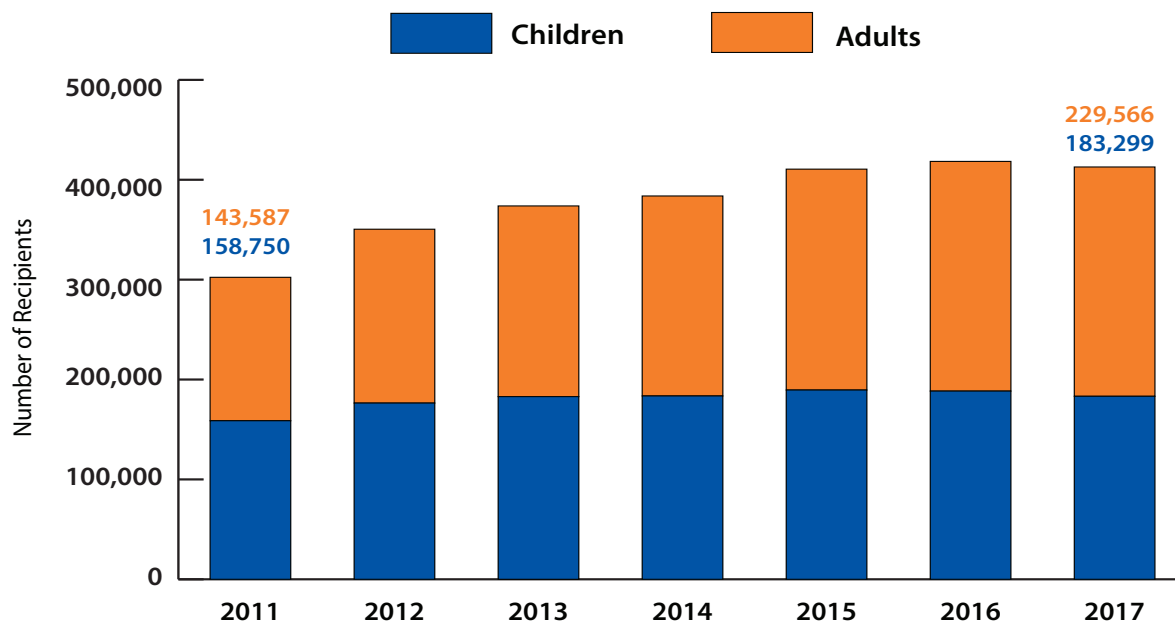
Source: San Diego County Health and Human Services Agency. Data for 2015-2017.

Average daily CalFresh benefit per person

\$4.14

Source: San Diego County Health and Human Services Agency. 2018.

Number of CalFresh (SNAP) Recipients, Children Age 0-18 and Adults Age 19 and Older, San Diego County, 2011-2017



Addressing Food Insecurity

The San Diego Hunger Coalition reports that more than 500,000 San Diegans (1 in 6), lack access to adequate food. These households—including families with children, military families and veterans, and senior citizens—do not have reliable access to a sufficient quantity of affordable, nutritious food or the food necessary for a healthy, productive life. This is called food insecurity, which can result in individual hunger, discomfort, and malnutrition. In San Diego County, 1 in 5 children live in households experiencing food insecurity. It is important to note that food insecurity does not happen in isolation. Low-income families, veterans, seniors, and others often face other overlapping issues such as low wages, unaffordable housing, and high health and childcare costs.

Faced with a rising cost of living and stagnant wages, families must make difficult decisions about how to allocate limited financial resources. The National Low Income Housing Coalition estimates that a household with two full-time workers making minimum wage needs to spend about 50% of its income on a two-bedroom rental in San Diego. Given other major expenses, such as transportation, health care, child care, and unexpected emergencies, there may not be much left to spend on food. Not having a partner or spouse to supplement income also influences the ability to access adequate food; 65% of low-income single parent households are food insecure. Additionally, physical and mental health issues can be barriers to food access. For example, 49% of food insecure adults in San Diego County have a disability.

The US Department of Agriculture reports that families with very low food security: cannot afford to eat balanced meals, cut the size of meals, skip meals, worry about running out of food, and/or go hungry. People experiencing food insecurity may be forced to resort to emergency food, scavenging, stealing, or other ways to cope. In addition, those living in communities that lack affordable and nutritious food (also known as “food deserts”) may experience less access, higher prices, and/or lower quality food.

Food insecurity at any age results in significant negative health, education, and safety concerns that can persist throughout an individual’s life. Children of food insecure mothers are more likely to be born at low birthweight, resulting in increased risk of inadequate health and development. Children who do not get enough to eat—especially during their first three years—begin life at a disadvantage. Deficiencies of key nutrients can lead to delays in development and learning. Elementary school students from food insecure homes have lower math scores, experience increased learning difficulties, and are more likely to repeat a grade. Children who are food insecure often have poor sleep patterns, leading to decreases in attention and memory. Children living without adequate food are at higher risk of dropping out of school, with long-lasting economic consequences of lower earnings and benefits. Among adults and children, food insecurity may lead to weight loss or obesity, risk for poor physical and mental health, and higher rates of chronic disease over the life course.

Federal nutrition programs are a key component to providing adequate food to populations with the highest need. Programs such as the Supplemental Nutrition Assistance Program (SNAP/CalFresh), the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), the National School Lunch Program, and the Child and Adult Care Food Program help families bridge food gaps and increase access to healthy food. Additionally, communities, businesses and government agencies can work together to ensure livable wages, affordable housing, adequate and affordable public transportation, and affordable health care and child care for all. By strengthening communities, building on public and private programs that increase self-sufficiency and access to food, we can make San Diego hunger free.

What strategies can make a difference?

Nutrition assistance has changed with the times, now more often being electronic (electronic benefit transfer—EBT) systems, supporting better food choices, and being used at a wider variety of outlets where food is sold. SNAP/CalFresh offers effective aid to improve the nutritional status of low-income families; however, utilization rates have been low in some communities. Improving the use of nutrition assistance by eligible individuals involves outreach campaigns, interagency strategies, and non-traditional points of access. Increased use of SNAP/CalFresh, as well as the WIC program, means better nutrition for families and community economic development.

Nationally, the following strategies have been used to increase SNAP/CalFresh participation:

- Simplify the application process, both online and on paper, and advertise the availability of online applications via libraries, food stores, pharmacies, etc.
- Provide assistance in completing applications, with appropriate certification periods and follow-up after application to assure completion.
- Use direct certification processes (e.g., automatically qualifying for school meals if they receive SNAP).
- Direct outreach to underserved populations such as military families, Native Americans, immigrants, refugees, seniors, residents in rural communities, and persons with disabilities.
- Include SNAP eligibility information and prescreening in hotlines and helplines (e.g., 211).
- Increase partnerships for outreach with schools, food banks, employers, and utility companies.
- Extend hours (e.g., evenings and weekends) of application centers.
- Employ multilingual and culturally diverse outreach and enrollment workers in application offices, as well as in community settings such as schools, community clinics, fast food outlets, and shelters.
- Provide science-based nutrition education through direct education (e.g., nutrition classes for children and/or adults), indirect education (e.g., brochures, videos), and social marketing.
- Offer incentives to SNAP clients, such as providing coupons or vouchers to purchase fruits and vegetables at farmer's markets or other retailers, or giving a certain amount of money back on an EBT card for every dollar spent on fruits and vegetables.
- Encourage food pantries to accept SNAP and/or assist in SNAP enrollment.
- Promote use of SNAP at farmer's markets, in Community Supported Agriculture, and at other farm-to-consumer venues.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

Policy

- Annually review the application and eligibility processes for continued quality improvement for simplification and ease of use.
- Ensure that multilingual and culturally diverse outreach/enrollment workers are located in community clinics, all regional Live Well centers, community-based organizations, and homeless shelters, including weekend and evening hours.

Programs & Services

- Use outreach enrollment strategies for underserved families, prioritizing military, Native Americans, refugees, college students, and those living in rural areas.
- Distribute linguistically and culturally appropriate CalFresh eligibility information to schools, community clinics, colleges, community-based organizations, shelters, and Native American reservations.

Family & Community

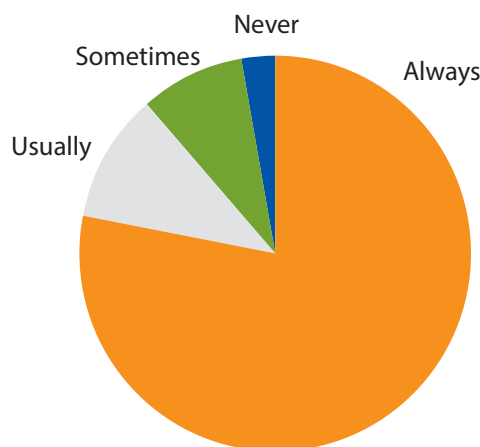
- Host local food pantries at schools, community organizations, faith groups, and community centers.
- Expand the number of school and community gardens.

Food, nutrition, and healthy weight across the lifecycle.

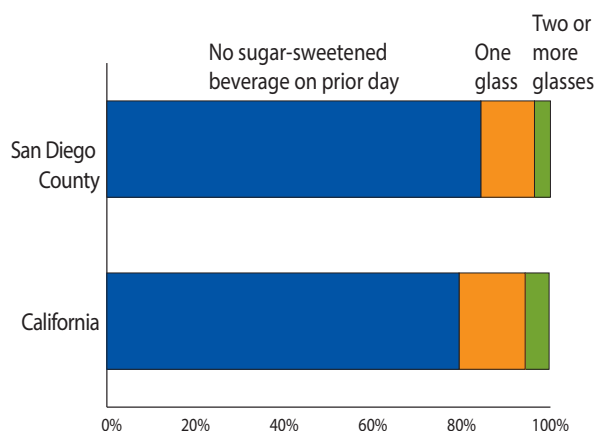
ACCESS TO HEALTHY FOOD MATTERS

Poor families face challenges in securing safe and nutritious food for infants and children.

- For babies, breast milk is the best food. Mothers need knowledge, supplies, and support from the workplace to succeed in breastfeeding.
- For children, good nutrition in child care or schools, as well as access to sufficient amounts of healthy food at home, are key.
- Food insufficiency is a challenge for many. More than 1 in 10 San Diegans are never or only sometimes able to find fresh fresh fruits and vegetables in their neighborhood.



Percentage of Adults by Ability to Find Fresh Fruits and Vegetables in Their Neighborhood, San Diego County, 2016. Source: California Health Interview Survey.



Percentage of Children and Adolescents Ages 2-17 Who Consumed Sugar-Sweetened Beverages in Prior Day, San Diego County and California, 2014-2016. California Health Interview Survey.

BUILDING SOUND HEALTH POLICIES

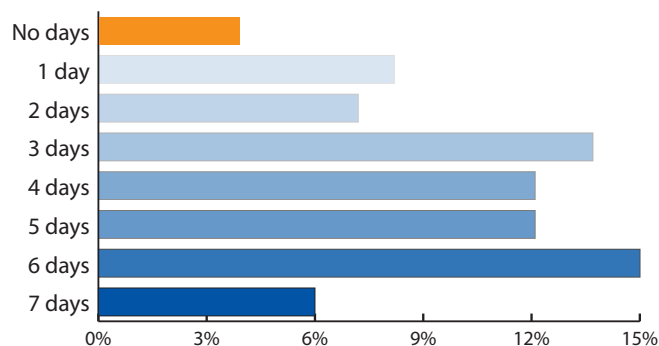
Policies can provide nutritional assistance, reduce access to soda, and improve nutrition.

- As a result of public policies San Diego children are less likely than children in California to consume sugar-sweetened beverages (e.g., soda and sweetened juices).
- Public programs such as SNAP and WIC provide nutrition assistance to increase access to healthy foods.
- Public policies that promote access to farmer's markets, incentives to buy fruits and vegetables, and support better nutrition in schools all make a difference.

HEALTHY WEIGHT IN FAMILIES

Parents affect children's weight and health across the life course.

- Reflecting both genetics and behavioral factors, having obese parents increases children's risks for being overweight or obese. Families can't change their genes, but they can encourage healthy eating habits and physical activity.
- Healthy weight and regular physical exercise are important across the lifecycle. Only one-quarter of San Diego County children exercise for at least one hour daily.
- Children who are obese are more likely to be obese as adults, putting them at increased risk for serious diseases and health conditions, including type 2 diabetes, heart disease, cancers, hypertension, and breathing problems.



Percentage of Children by Number of Days Physically Active at Least One Hour in Past Week, San Diego County, 2013-2016. Source: California Health Interview Survey.



Community and Family (Cross Age):

CHILD HEALTH COVERAGE

Why is this important?

Lack of health coverage is the single greatest barrier to receiving needed medical care. Uninsured children are less likely than their insured counterparts to receive preventive services and needed treatments. For children with special health needs (i.e., conditions and disabilities that require extra care and treatment), lack of coverage can mean more hospitalizations for untreated asthma, untreated vision or hearing problems, and worsening disabilities. Research shows that children with publicly subsidized health coverage (e.g., Medi-Cal) use services in approximately the same amounts and patterns as those who have private insurance. Increasing parents' coverage also has benefits for children.

What is the indicator?

Data are not available to monitor the trend for the indicator on the percentage of children ages 0-17 without health coverage in San Diego County. Instead, the graph shows children's coverage by type. These data are routinely reported through the California Health Interview Survey.

What is the trend?

No San Diego County trend is available due to small numbers and lack of reliable data for most recent years. Generally, the percentage of children without health insurance has declined to between 2% and 5%.

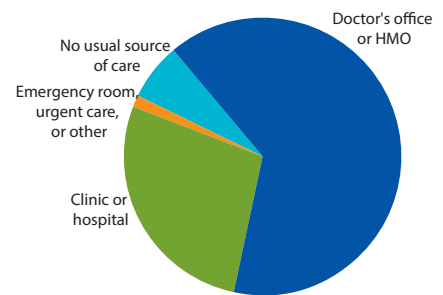
Estimated number of children ages 0-17 who were uninsured in San Diego County, 2016

29,000

EXPANSIONS TO MEDI-CAL AND OTHER PUBLIC COVERAGE, MEAN ONLY 2-5% OF CHILDREN REMAIN UNINSURED.

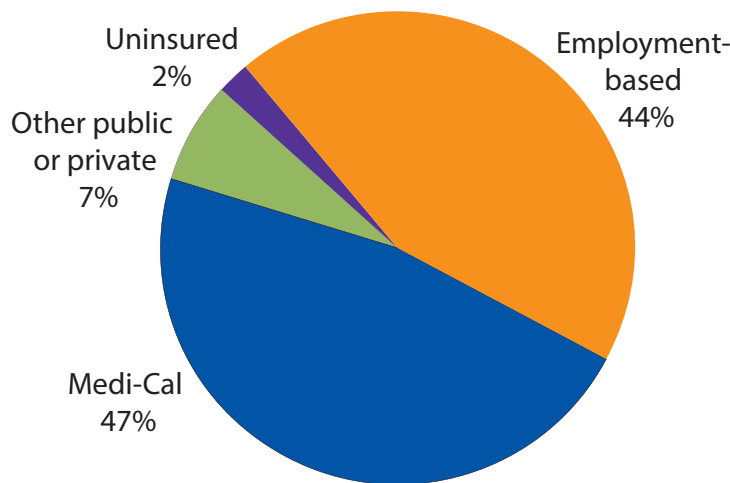
Source: California Health Interview Survey, 2014-2016.

Most, but not all, San Diego County children have a usual health care provider. Having one leads to better health and reduced costs.



Source: California Health Interview Survey (CHIS), 2014.

Percentage of Children Ages 0-17, By Type of Health Coverage, San Diego County, 2015-2016





Community and Family (Cross Age):

ADULT HEALTH COVERAGE

Why is this important?

Lack of health insurance makes a difference for adults, children, and families. Uninsured adults are less likely to have access to health care. When adults forgo preventive services or needed treatments, their health conditions may worsen and lead to higher costs, chronic problems, and premature death. Children's health is adversely affected when their parents are uninsured. Children are more likely to be insured if their parents are insured. In households with continuous coverage, the odds increase that children are insured. Children with uninsured parents are significantly more likely to have no usual source of primary care (i.e., a medical home) and to have unmet health needs.

What is the indicator?

The indicator—the percentage of adults ages 18-64 without health coverage—monitors public and private health coverage. These data are routinely reported through the California Health Interview Survey.

What is the trend?

The trend is improving. With major expansions of health coverage under federal and state health reform policies, fewer working age adults are uninsured. San Diego County is doing better than the state average.

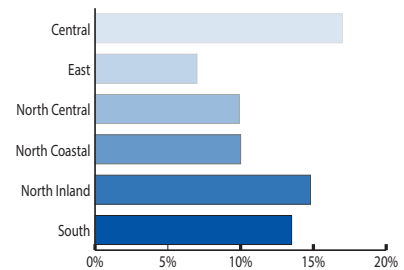
Estimated number of adults ages 18-64 who were uninsured in San Diego County, 2016

187,000

African Americans between the ages of 18 and 24 years in San Diego County were the least likely to have health insurance.

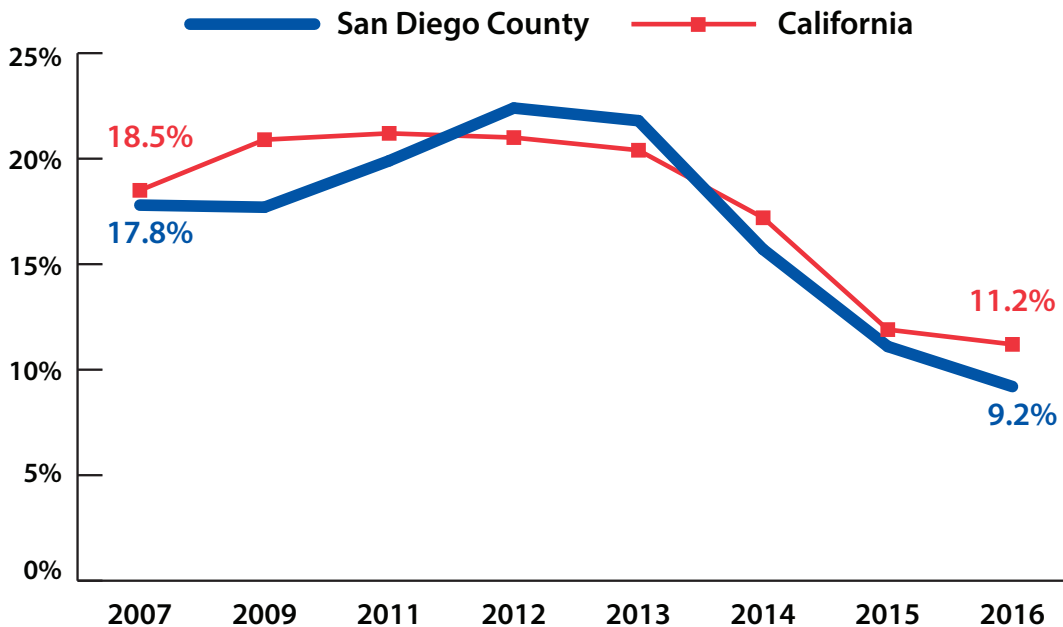
Source: Identifying Health Disparities to Achieve Health Equity in San Diego County: Race/ethnicity. San Diego County Health and Human Services Agency, 2016.

WHILE 9 OUT OF 10 OF ADULTS 18-64 HAVE HEALTH INSURANCE IN SAN DIEGO COUNTY, THE RISK OF BEING UNINSURED VARIES BY REGION.



Source: Percentage of Adults Ages 18-64 without Health Coverage, By Region. California Health Interview Survey (CHIS), 2014-2015-2016.

Percentage of Adults Ages 18-64 without Health Coverage, San Diego County and California, Selected Years 2007-2016



What strategies can make a difference?

The Affordable Care Act increased coverage for millions of uninsured adults under age 65, particularly those with low wages living just above the poverty level. Under this program, known as Covered California, more affordable and subsidized health plans offering essential, minimum benefits are now available. Medicaid (known as Medi-Cal in California) provides coverage to the poorest children and adults. Most uninsured children with family income below 200% of the Federal Poverty Level are eligible for publicly subsidized coverage.

The following strategies have been used across the country to increase health coverage for children:

- Use simplified and streamlined enrollment, consumer outreach, and information, and other approaches to expand coverage.
- Simplify and streamline the application process and enrollment policies (e.g., shorter forms, applications by mail or Internet, no asset tests, no application fees, no test of employment).
- Provide automatic eligibility determinations and renewals for health coverage when families complete applications or recertification for other public assistance programs.
- Use health navigators (Covered California's Navigator Program) in partnership with community organizations (e.g., San Diego 211 infoline, Access California, Health Center Partners of Southern California, Family Health Centers). Navigators assist through a variety of outreach, education, enrollment, and renewal support services.
- Offer additional assistance through community health workers, home visitors, and others.
- Develop effective outreach and enrollment strategies such as tools from the Connecting Kids to Coverage National Campaign used at the state and community level, including:
 1. Campaigns to promote awareness of available coverage (e.g., social media tools, culturally specific marketing tools, outreach through employers, billboards and posters);
 2. Assistance in distributing and completing applications in schools, homeless shelters, community-based organizations, health care providers, faith communities, and the workplace;
 3. Incentives for schools, employers, and community-based organizations to identify eligible families and help them enroll their children.
- Ensure that families are informed about the different health coverage policies that might work for them and about affordable health plans that provide adequate coverage for children and adults.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

Policy

- Provide County funding to support outreach, education, and enrollment in health coverage, with help in understanding coverage options.
- Implement continuous, annual eligibility periods for children in Medi-Cal.

Programs & Services

- Prioritize staff outreach and support for health care enrollment in areas with high concentrations of low-income families.
- Work with hospitals to ensure that all newborns are enrolled in coverage prior to leaving the hospital.

Family & Community

- Collaborate with community partners to educate families about health coverage options and how to find a provider in their coverage network.
- Distribute culturally and linguistically appropriate consumer information to families about access to and benefits of preventive health services.



DOMESTIC VIOLENCE

Why is this important?

Domestic violence has negative impacts for everyone involved. The abused partner may suffer both physical and emotional trauma, as well as post-traumatic stress. Exposed children live in fear, often perform poorly in school, and typically do not participate in normal childhood play and social activities. Children who have these adverse experiences—even when the violence is not directed at them—have increased risk of victimization, aggression, problems with social relationships, and lifelong health problems. Domestic violence typically escalates over time, moving from verbal abuse, to emotionally abusive behavior, to physical abuse, and may result in death.

What is the indicator?

This indicator—the rate of domestic violence reports per 1,000 households—measures reports of domestic and intimate partner violence made to San Diego County law enforcement agencies. Police reports are closer to the actual rate of occurrence than arrest rates. These data are routinely reported by ARJIS and the California Department of Justice.

What is the trend?

The trend is maintaining for both San Diego County and California. Progress has slowed since 2008.

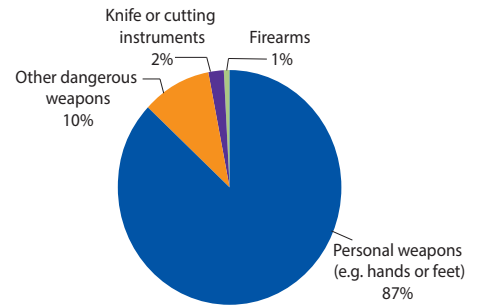
Number of domestic violence incidents reported to law enforcement in San Diego County in 2016

16,719

NATIONALLY, CHILDREN LIVE IN HALF OF ALL THE HOUSEHOLDS AFFECTED BY DOMESTIC VIOLENCE AND 80% OF THOSE CHILDREN ARE DIRECTLY EXPOSED TO THE VIOLENCE.

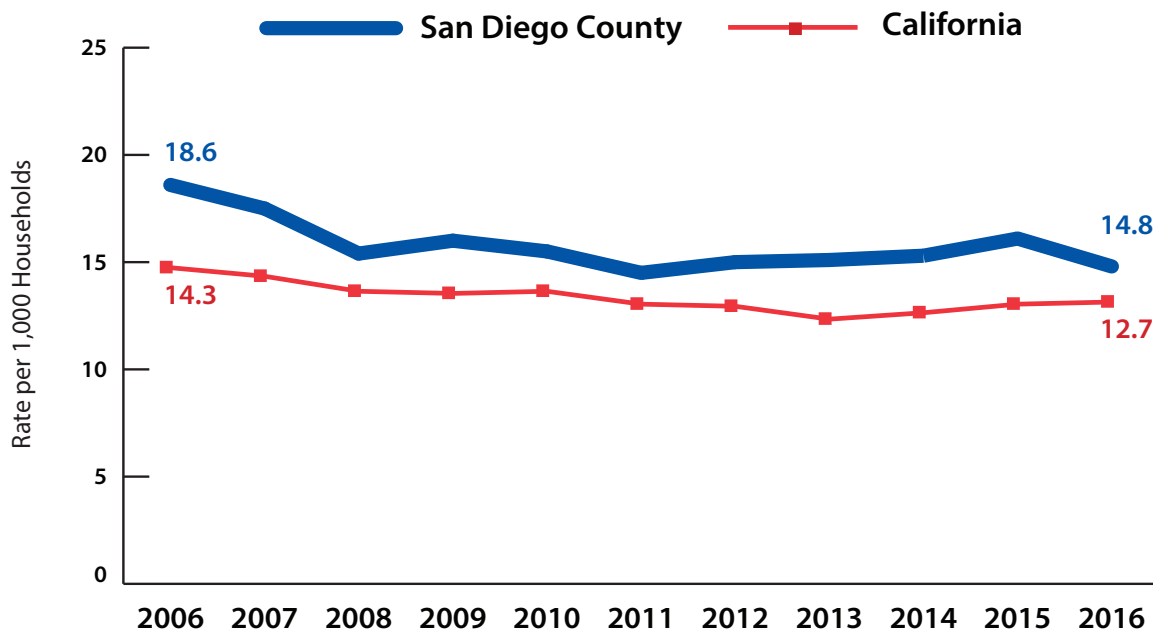
Source: Fantuzzo J and Fusco R. Children's Direct Exposure to Types of Domestic Violence Crime: A population-based investigation. *Journal of Family Violence*. 2007.

The graph represents the three quarters of domestic violence incidents which involved a weapon. Weapons included: hands and feet, knives, guns, and others.



Source: California Department of Justice Office of the Attorney General and Automated Regional Justice Information System (ARJIS), SANDAG, 2016.

Rate of Domestic Violence Reports Per 1,000 Households, San Diego County and California, 2006-2016



What strategies can make a difference?

With action, domestic violence is preventable. Primary (before the fact) and secondary (after the fact) prevention strategies must both be used. Effective strategies include early screening and identification, trauma-informed services for adult victims and children, and restraints and consequences for perpetrators. Multi-agency, cross-systems efforts are essential.

The following strategies have been used across the country to reduce the incidence of domestic violence:

- Update regularly data collection protocols and practices, including cross-system protocols related to domestic violence and intimate partner violence.
- Implement routine developmental screening in early childhood (i.e., with validated tools by early care and education and health professionals) for early identification of young children exposed to violence and other trauma.
- Screen routinely for domestic violence and child abuse in health care settings or home visits, with follow-up referrals as necessary.
- Provide cross-system targeted training on domestic violence, conflict resolution, healthy relationships, self-sufficiency, and related topics for staff that work with at-risk families.
- Link data and cases across child abuse, domestic violence, and court systems to assure more consistent handling of domestic violence, intimate partner violence, and child abuse cases.
- Educate judges about domestic violence to ensure consistency in sentencing (i.e., prevalence across racial/ethnic and income groups, similar to assault).
- Help victims develop and continually update their safety plans.
- Assure enforcement of perpetrators' mandated treatment, including monitoring of active participation in yearlong violence prevention programs and other terms of probation.
- Enforce the removal/submission of firearms among individuals who have been convicted of domestic violence.
- Use school and youth programs to educate young people about how to have healthy relationships and the risk of teen dating violence, as well as to provide resources to support youth.
- Provide trauma-informed services (e.g., shelters, legal assistance, counseling, case management) for victims and their children.
- Implement risk assessment and management for domestic violence perpetrators.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

Policy

- Prioritize and financially support therapeutic early care and education programs on school campuses and in communities for children exposed to violence.
- Annually collect and report zip code level data from the Law Enforcement Domestic Violence Supplemental Form in relation to children exposed to domestic violence.

Programs & Services

- Expand the availability of therapeutic early care and education services for children exposed to violence.
- Provide trauma informed services at schools, community-based organizations, all regional Live Well centers, and government facilities in areas with high rates of domestic violence reporting.

Family & Community

- Expand parent and community awareness about local safe zones for domestic violence victims to receive assistance and support in implementing their emergency safety plan.
- Raise community-wide awareness about healthy relationships, communication, and domestic violence prevention and intervention.



Community and Family (Cross Age):

CHILD ABUSE AND NEGLECT

Why is this important?

Child abuse and neglect have profound and long-term effects on a child’s physical, mental, and emotional development. Physical effects include injury and even death, and psychological effects include depression, anger, anxiety, and aggression. Children who have been abused or neglected often have social and behavioral problems. The Adverse Childhood Experience (ACE) studies show that child abuse and neglect can have a lifelong impact on health and well-being, including increased risk of heart disease, obesity, and depression as an adult.

What is the indicator?

This indicator—the rate of substantiated cases of child abuse and neglect per 1,000 children ages 0-17—shows the trend in reports of child abuse and neglect that are found through investigation to have sufficient evidence to warrant a child welfare services case being opened or having the family referred for services. These data come from reports filed by the County of San Diego Health and Human Services Agency to a statewide database managed by the University of California Berkeley.

What is the trend?

The trend is improving. The rate per 1,000 in San Diego County has declined continuously since 2007, but progress has slowed since 2013.

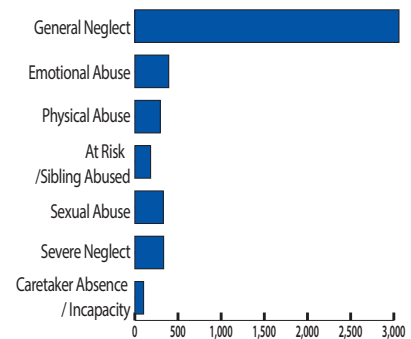
Number of substantiated cases of abuse and neglect in San Diego County in 2016

4,698

CHILD ABUSE IS NOT CONCENTRATED IN ONE GEOGRAPHIC AREA. In 2016, 18 zip codes across the county had rates for substantiated cases of child abuse and neglect at 10 per 1,000 or higher.

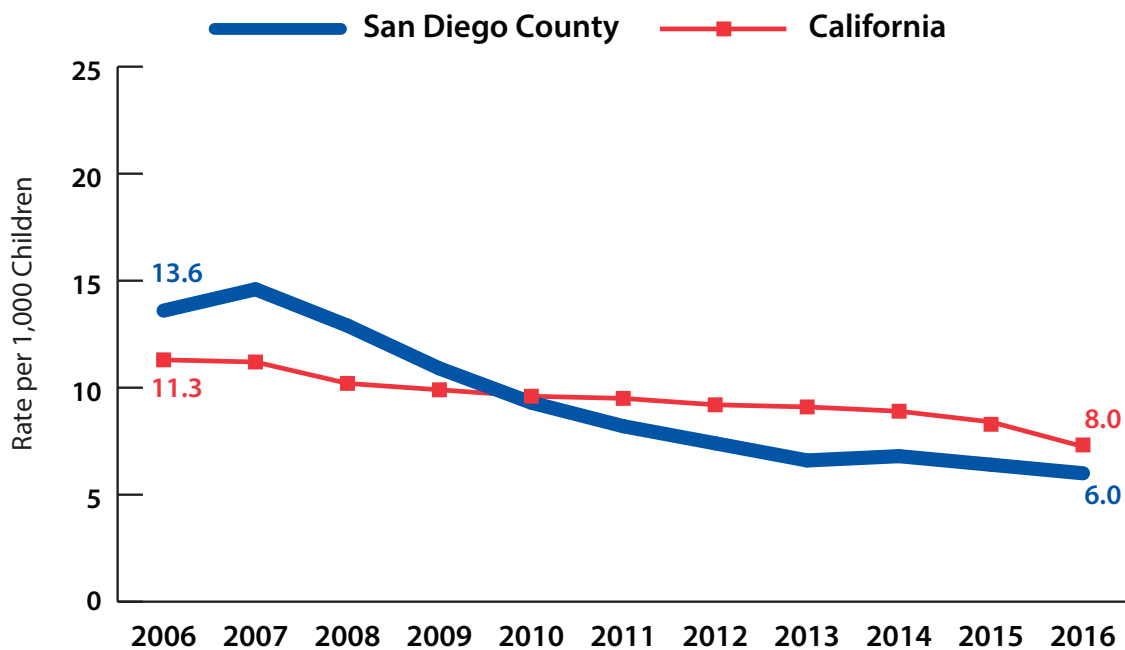
Source: California Child Welfare Indicators Project Reports, University of California at Berkeley Center for Social Services Research, 2016.

Number of Substantiated Child Abuse and Neglect Reports in San Diego County, By Type, 2016



Source: California Child Welfare Indicators Project Reports, University of California at Berkeley Center for Social Services Research, 2016.

Rate of Substantiated Cases of Child Abuse and Neglect Per 1,000 Children Ages 0-17, San Diego County and California, 2006-2016



What strategies can make a difference?

Many parental and family factors are associated with child abuse and neglect, including: parental history of abuse, substance abuse, unemployment, poverty, domestic violence, anger, isolation, mental health, and stress. Effective interventions must be tailored to individual situations. Using trauma-informed approaches is essential. At the same time, preventing the harm of child abuse and neglect will require county-wide, systemic community efforts.

The following strategies have been used nationally to reduce the incidence of child abuse and neglect:

- Provide interventions to improve parent-child relationships, positive parenting skills, fulfill basic needs, and increase social supports for at risk families.
- Use evidence-based parenting classes and support groups to teach age-appropriate communication and positive discipline from birth (e.g., Incredible Years, Strengthening Families).
- Provide high quality, evidence-based home visiting programs for at risk families that have been shown to be effective in preventing child abuse and neglect (e.g., Nurse Family Partnership, Healthy Families America).
- Implement evidence-based home visitation models that has been shown to reduce child abuse and neglect among families with identified risk or history of maltreatment (e.g., SafeCare, Child First).
- Implement the Positive Parenting Program (Triple-P), shown to be effective in prevention of childhood social-emotional and behavioral problems and child maltreatment.
- Train health providers, teachers, and other care providers to recognize signs of abuse and neglect, as well as providing information regarding community resources available.
- Use trauma-informed services in the health, child welfare, mental health, and justice systems to reduce multi-generational abuse.
- Use approaches such as the Period of PURPLE Crying (an evidence-based shaken baby syndrome prevention program) to help parents and other caregivers.
- Provide respite care for families facing high-stress and/or emergency situations.
- Use the court to support use of effective, trauma-informed family interventions designed to reduce abuse and neglect.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

Policy

- Prioritize and financially support the expansion of evidence-based home visiting services for families at risk.
- Train all public agency direct service staff including child welfare, mental health, behavioral health, and juvenile justice staff in trauma informed care.

Programs & Services

- Expand evidence-based parenting programs such as Positive Parenting Program (Triple-P) and other proven parent education programs in zip codes with high rates of substantiated child abuse.
- Connect at risk families with employment training, child care resources, affordable housing, counseling and other support services.

Family & Community

- Develop community-based support groups to provide families with support for peer connections, transportation, mentoring, and community resources.
- Raise awareness about community resources and regional Live Well centers that provide basic necessities such as food, clothing, diapers, and access to other public supports.



CHILD VICTIMS OF VIOLENT CRIME

Why is this important?

Child victims of violent crime often experience negative effects on development, school achievement, mental health, and substance use. Post-traumatic stress disorder may result for the victim. Sadly, crimes are committed against children at every age. Nationally, youth ages 12 to 14 were more likely than older adolescents to be victims of any violent crime, particularly assault. Teens are two to three times more likely than adults to be the victims of assault, robbery, or rape. Most female victims are attacked by someone they know, typically adult men. The rates and types of crimes vary by age of youth, race/ethnicity, urban or rural area, and time of day, but all are preventable.

What is the indicator?

This indicator—the rate of violent crime victimization of children—reflects trends in four types of crime (aggravated assault, robbery by force or threat, rape/sexual assault, homicide). The data are from ARJIS, so only those incidents that result in an arrest report are represented.

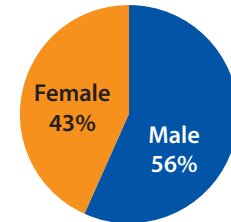
What is the trend?

The trend is maintaining for children ages 0-11. For youth ages 12-17, the trend is maintaining, following a period of improvement prior to 2014.

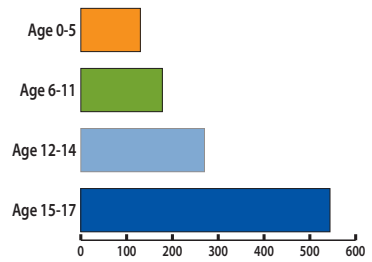
Number of children ages 0-18 who were victims of violent crime in San Diego County, 2016

1,122

Males were more likely than females to be child victims of violent crime.

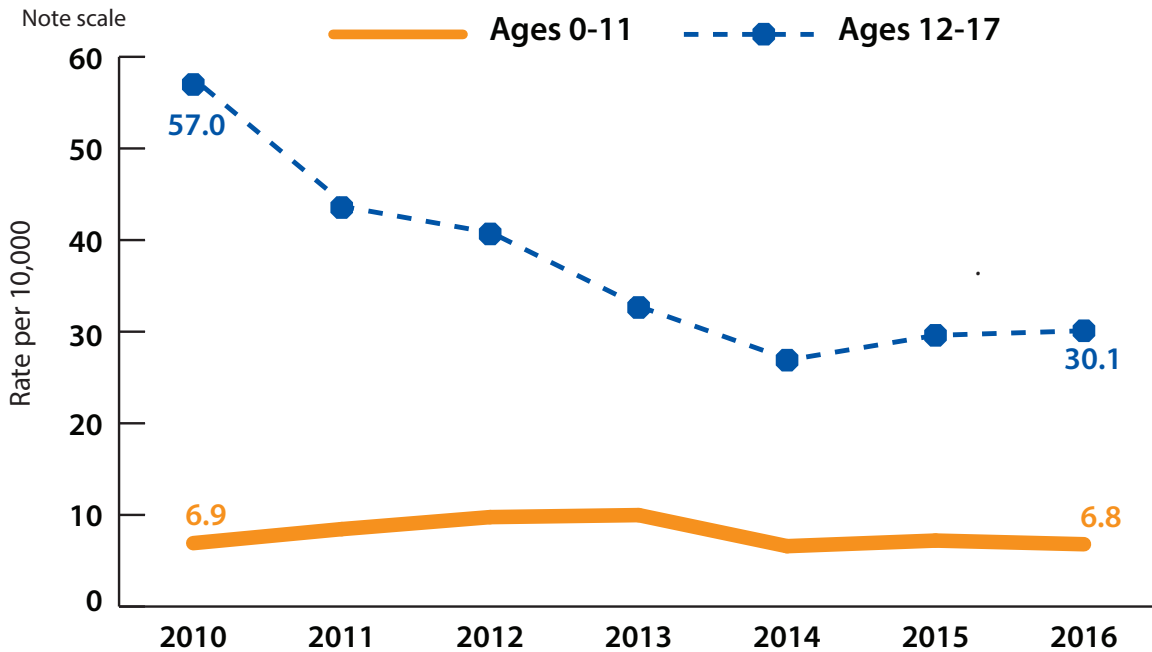


Number of Child Victims of Violent Crime, By Age, San Diego County, 2016



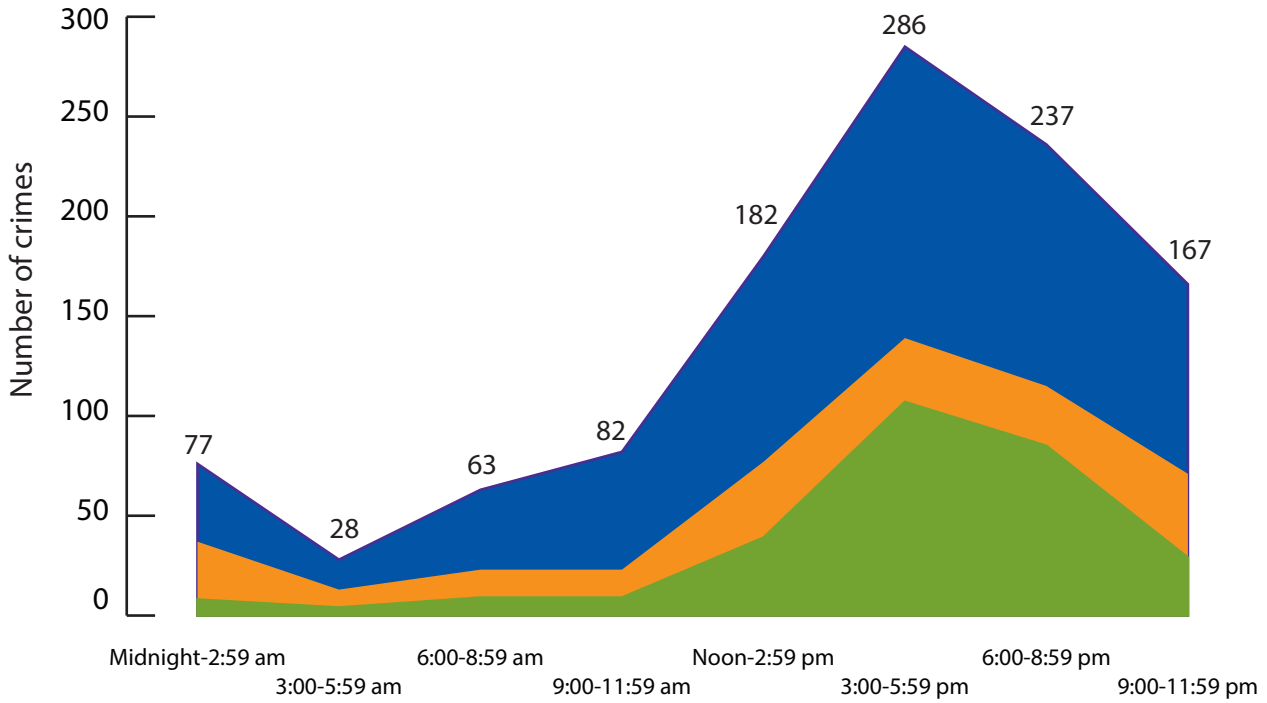
Source: Automated Regional Justice Information System (ARJIS), SANDAG, 2016.

Rate of Violent Crime Victimization Per 10,000 Children, Ages 0–11 and 12–17, San Diego County, 2010-2016



Number of Violent Crimes with Child Victims Ages 0-17, By Time of Day, San Diego County, 2016

■ Aggravated assault
 ■ Rape
 ■ Robbery



The number of violent crimes committed against children and youth increases dramatically after school, peaking between the hours of 3:00 p.m. and 6:00 p.m. High numbers of crimes continue into the evening until midnight. (Note that six homicides occurring between 3:00 pm and 3:00 am do not show on graph.)

What strategies can make a difference?

Reducing all forms of child victimization (e.g., bullying, harassment, hate crimes, and other crimes) has become a nationwide priority. Consistent adult supervision, safe communities, and positive, pro-social behaviors all support the reduction of violent crimes against children. Providing children, youth, and families opportunities for services after school, in the evening, and on weekends is proven to help keep kids safe.

Nationally, the following strategies have been used to reduce violent crime victimization of children and youth:

- Train parents, school personnel, after school staff, youth-serving organizations, health providers, and juvenile justice professionals in the identification and prevention of bullying, racism, intimidation, sexual harassment, and hate crimes.
- Support safe passages for children and youth to and from school.
- Ensure adequate adult supervision of children and youth in non-school hours.
- Increase youth and parent knowledge of and ability to protect against sexual assault and rape.
- Implement gender-specific services.
- Develop anti-violence and anti-bullying programs such as: Olweus Bullying Prevention, PeaceBuilders, Promoting Alternative Thinking Strategies (known as PATHS), and Resolving Conflict Creatively Program.
- Implement conflict resolution programs in schools, after school programs, and in youth-serving community organizations.
- Expand programs aimed at reducing gang participation.
- Provide after school and evening activities in high crime communities, including after school programs, teen centers, job internships, etc.
- Use schools as community hubs, including ball fields, libraries, and other common spaces.
- Educate parents, caregivers, and youth-serving organizations about Internet safety, including monitoring and restriction of use and Internet controls.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

Policy

- Require mandated annual training for all school staff, youth-serving contractors, and government staff on topics related to keeping children and youth safe.
- Provide restorative principles and practices and conflict resolution programs in middle and high schools throughout San Diego County.

Programs & Services

- Provide youth with gender-specific violence prevention services relating to risk and resiliency factors.
- Provide free and low cost academic and employment opportunities for youth during after school, holiday, weekend, and summer hours.

Family & Community

- Work with community members, local businesses, and faith groups to develop Safe Passages to and from school.
- Educate parents about free or low cost local school and community supervision options for children and youth during non-school hours.



Community and Family (Cross Age):

UNINTENTIONAL INJURY

Why is this important?

Injuries are not accidents. They can be prevented by changing the environment, behaviors, products, social norms, and policies. More children die or become seriously hurt from injuries than from all childhood diseases combined. Childhood injuries can result in children having long-term disabilities. Native American, rural, and older children and youth are most at risk. Motor vehicle crashes, falls, drowning, burns, poisoning, and suffocation are common causes of unintentional injury. Childhood injuries cost society more than \$400 billion annually in lost productivity and associated medical expenses.

What is the indicator?

This indicator—the rate of non-fatal unintentional injuries per 100,000 children ages 0-18—shows trends in how many children are injured severely enough to require hospitalization. Data on fatal unintentional injuries are not shown. These data are routinely reported on hospital discharge reports.

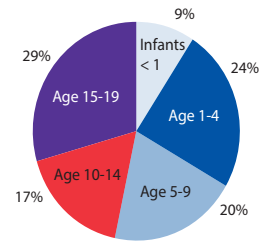
What is the trend?

The trend is improving; however, the rate of non-fatal unintentional injuries in San Diego County continues to be above (worse than) the state and US rates.

Number of non-fatal unintentional injuries requiring hospitalization among children ages 0-18 in San Diego County in 2014

1,532

Distribution of Children's Non-fatal Unintentional Injuries By Age, 2014



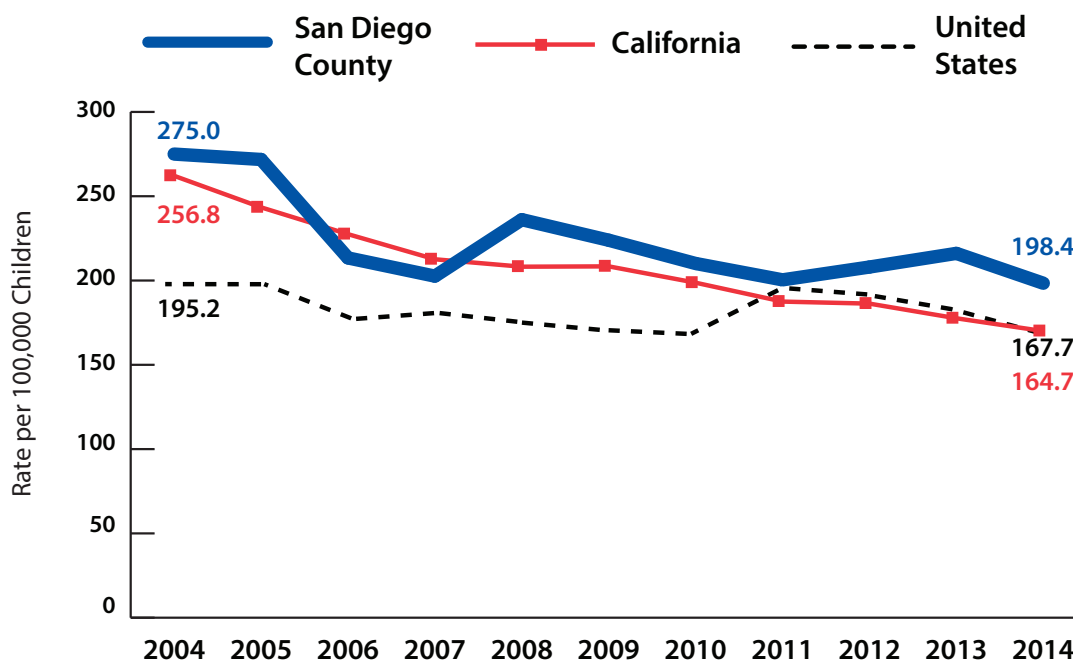
Source: California Office of Statewide Health Planning and Development, Emergency Department Data. Prepared by Department of Public Health, Safe and Active Communities Branch, 2014.

Number of emergency room visits related to unintentional injuries among children ages 0-18 in San Diego County in 2014

53,350

Source: California Office of Statewide Health Planning and Development, Emergency Department Data. Prepared by Department of Public Health, Safe and Active Communities Branch, 2014.

Rate of Non-Fatal Unintentional Injuries per 100,000, Children Ages 0-18, San Diego County, California, and United States, 2004-2014



What strategies can make a difference?

Unintentional injuries are the leading cause of death among children. To reduce injuries, it is important that each cause be addressed individually. Specific prevention and intervention approaches are needed for various causes. Legal mandates, enforcement, and public education about safety are the primary strategies for reducing injuries.

The following two categories of strategies have been used to reduce unintentional injuries:

Providing education about:

- Firearm safety, including safe gun storage (e.g., Asking Saves Kids—ASK).
- Safe sleep environments for infants.
- Protective restraints such as child car seats, booster seats, and seat belts.
- Common causes of choking and suffocation.
- Protective gear such as helmets for biking, snowboarding, skiing, skateboarding, off-road vehicles, and other sports.
- Common causes of drowning including swimming pools, buckets of water, and bathtubs.
- Home safety such as outlet covers, cabinet locks, safety gates, and hot water heater controls.
- Fire prevention and reaction, including fire skills training.
- Hazardous clothing, including flammable sleepwear and suffocation from costumes.
- Safe driving practices for parents and youth.
- Parental supervision and child-proofing environments (e.g., lead paint, access to poison).
- Signs and symptoms of head injury and appropriate follow-up actions.
- Family disaster preparedness.

Enacting and enforcing legislation and regulations to require:

- Protective restraints such as car seat belts, child safety car seats, and booster seats.
- Smoke detectors, hot water heater controls, and safety gates in rental and owned properties.
- Pool fencing, self-closing gates, and pool alarms.
- Graduated licensing for teens.
- Toy manufacturer safety standards.
- Use of helmets for all sport recreation activities (motorized and non-motorized) that place children at risk for traumatic brain injury and other head injuries.
- Prohibitions on cell phone use (including hands-free) and texting among youth while driving.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

Policy

- Increase enforcement of safety regulations such as car seats, texting while driving, helmets for biking and skateboarding, appropriate safety gear when playing sports, fencing around pools, and rental property regulations.
- Expand the number and availability of certified child passenger safety technicians across the county.

Programs & Services

- Conduct child injury prevention workshops for parents, early care and education providers, and school personnel on proper use of helmets, protective safety gear for sports, toy safety, and drowning and burn prevention.
- Increase the availability of free or affordable high-quality safety products including car seats, safety gates, furniture and TV straps, smoke detectors, and gun locks.

Family & Community

- Increase availability of swimming lessons and water safety in communities.
- Provide culturally and linguistically appropriate education materials on automobile safety, including: age and weight appropriate car and booster seat use, seat belt use for children and youth, and the dangers of distracted driving.



Community and Family (Cross Age): CHILDHOOD MORTALITY

Why is this important?

Child mortality is a key indicator of community well-being. Many child deaths are preventable. Child mortality is related to a variety of health factors (e.g., risk of disease, safety practices) and socioeconomic conditions (e.g., housing, environmental hazards). The leading causes of death vary by age. Two-thirds of infant deaths occur in the first month, primarily due to low birthweight, preterm birth, or birth defects. Older children are more likely to die of external causes such as motor vehicle crashes, drowning, suicide, and homicide. Unintentional injuries are another leading cause of death, accounting for nearly a third of deaths among children ages 1 to 4 and 5 to 14, and more than 4 in 10 deaths among teens ages 15 to 19.

What is the indicator?

This indicator—the rate of mortality for children ages 0-17—monitors the rates at which infants, children, and youth die. These data are from death certificates and reported as part of local, state, and federal vital statistics.

What is the trend?

While the trend shows year-to-year fluctuations, it is improving over time for children ages 1-4 and youth ages 15-17. The trend is moving in the wrong direction children ages 5-14.

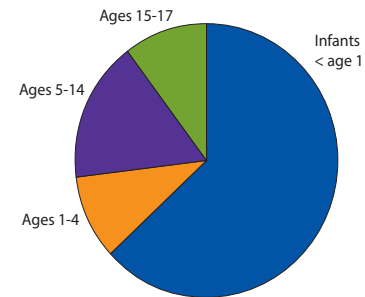
Number of deaths among infants under age 1 in San Diego County in 2016

160

Number of deaths among children ages 1-17 in San Diego County in 2016

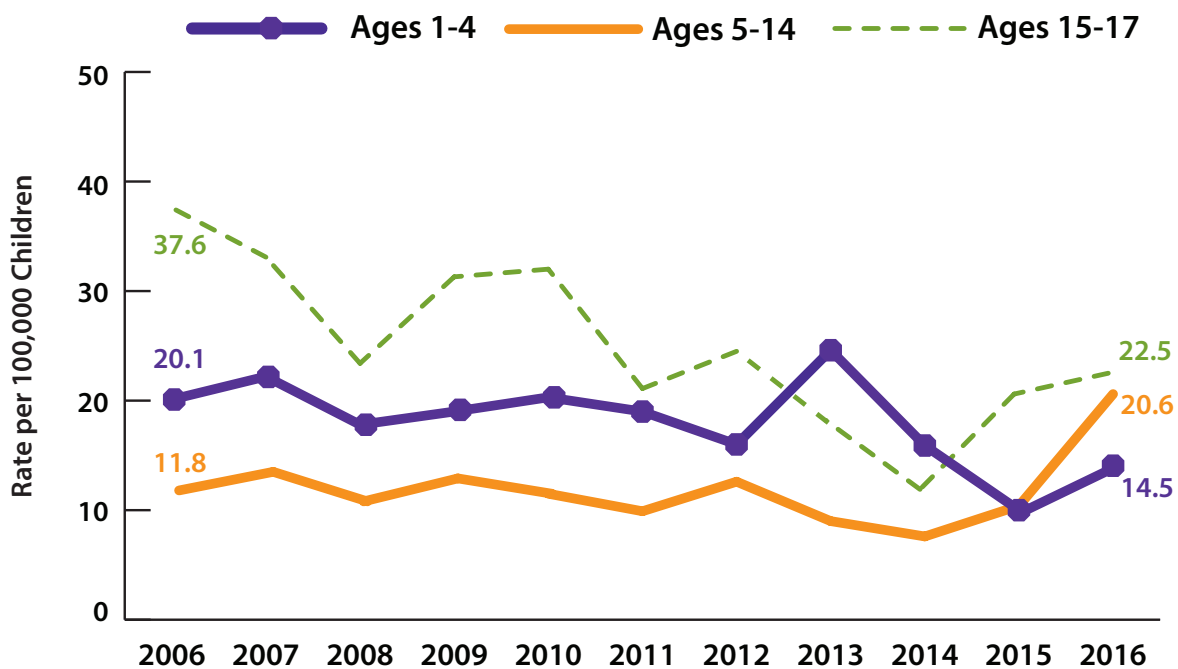
93

Distribution of Child Deaths, San Diego County, By Age, 2016

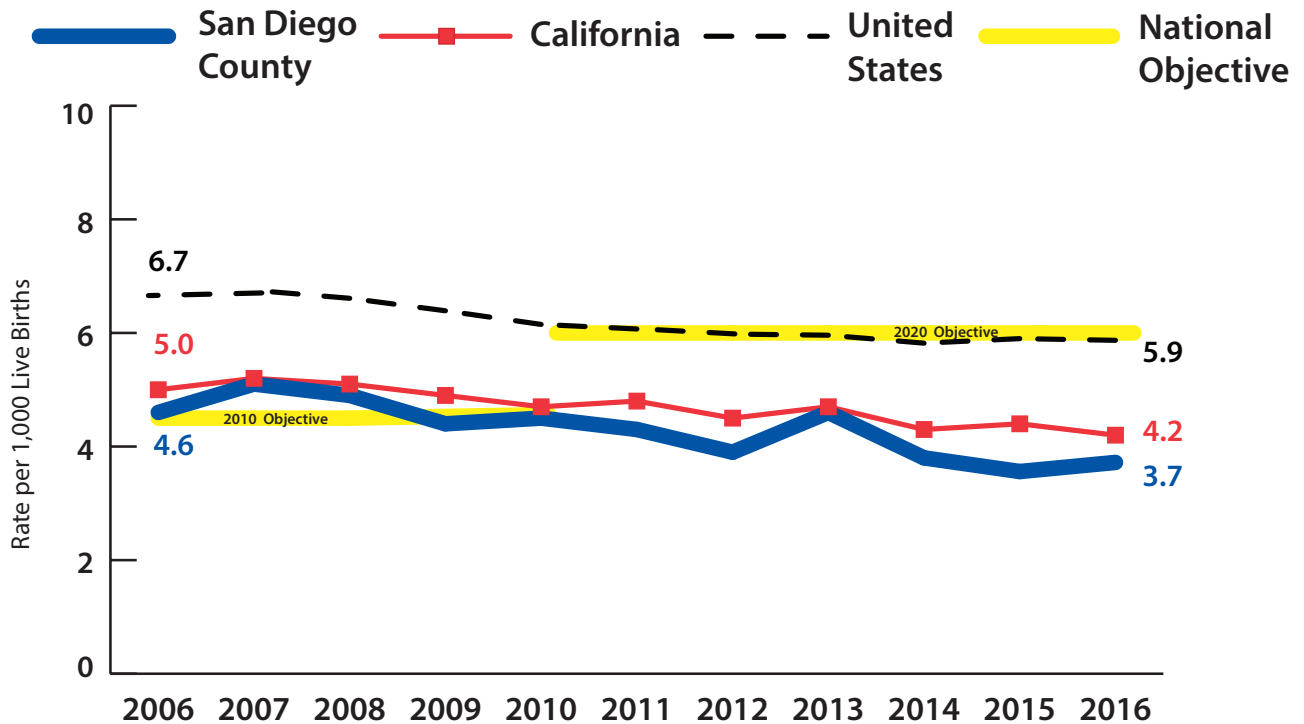


Source: Child mortality prepared by San Diego County Health and Human Services Agency; and infant death statistics from CDC Wonder, 2016.

Mortality Rate per 100,000 Children Ages 1-4, 5-14, and 15-17, San Diego County, 2006-2016



Infant Mortality Rate per 1,000 Live Births, San Diego County, California, and United States Compared to National Objective, 2006-2016



The infant mortality rate is maintaining, not consistently improving, in San Diego County. Slightly more improvement was shown for California and the United States. Both the county and state rates are better than the US average, and the county rate is among the lowest in the nation. At the same time, the San Diego County infant mortality rate is worse than that of several other large and diverse California counties. The national objective was made easier to achieve for the decade 2010-2020.

What strategies can make a difference?

Many of the recommendations throughout this *Report Card* are key to childhood mortality prevention. Infant, child, and adolescent mortality rates reflect an array of risks and conditions such as lack of access to health services, poor maternal health, risk of disease, environmental hazards, risky behaviors, housing safety, and other factors. The most common causes of unintentional injury—motor vehicle crashes, falls, drowning, burns, poisoning, and suffocation—are also common causes of death. To respond, communities must develop and implement strategies that are age appropriate and developmentally suitable.

The following strategies have been used across the country to reduce childhood mortality:

- Conduct community campaigns on factors that place infants, children, and adolescents at risk for premature death.
- Support child death or fatality review teams to identify risk factors, policies, and interventions that could prevent future deaths.
- Ensure access to services and supports that reduce the underlying causes of most infant deaths, including preterm and low-birthweight birth.
- Educate parents before they leave the hospital with a newborn about sleeping position (“safe sleep” and “back to sleep”) to prevent sudden unexplained infant death (SUID), and about shaken baby syndrome.
- Provide free or reduced cost car and booster seats for infants, toddlers, and young children.
- Provide free or reduced cost child safety helmets, gun locks, cribs, and electrical outlet covers.
- Use interventions (e.g., home visiting, Strengthening Families, Triple P) to reach and intervene with families at risk for child abuse and neglect.
- Promote use of immunizations to reduce vaccine-preventable disease such as measles, mumps, diphtheria, pertussis (whooping cough), rubella, and polio.
- Educate parents about positive parenting practices and age-appropriate discipline techniques.
- Educate parents and children about the risks of drowning at home and in the community.
- Promote gun safety (e.g., safe gun storage, “safe surrender” programs).
- Implement suicide awareness and prevention programs.
- Require driver safety education programs for teen drivers.
- Reduce family and community violence.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

Policy

- Enforce local ordinances that require landlords to provide safe housing including: smoke and carbon monoxide detectors, safety gates for pools, window locks, and safety gates on stairs.
- Expand gun safety programs in schools and communities, including firearm safety, safe gun storage, and free gun lock distribution.

Programs & Services

- Educate parents about child safety including: risks of drowning at home and in the community, infant safe sleep practices, motor vehicle and bike safety, and safe gun storage.
- Implement parent health education efforts regarding the importance of positive parenting practices, smoking cessation, abstaining from alcohol and drug use, and safe sleep for babies.

Family & Community

- Implement strengths-based parent support groups in community centers, libraries, regional Live Well centers, and early care and education settings.
- Host community meetings and trainings on improving community and home safety including: driving safety, preventing family and community violence, conducting home safety assessments, and Internet safety for children and youth.

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ACKNOWLEDGEMENTS

The Children's Initiative would like to thank all of the individuals who gave of their time, expertise, and wisdom in the development, design, and production of this *2017 Live Well San Diego Report Card*. Without their informed guidance and invaluable assistance, this report would not have been possible.

Leadership Advisory Oversight Committee

Don Buchheit
Student Support Services
San Diego County Office of Education

Cynthia Burke, Ph.D.
Applied Research Division
San Diego Association of Governments

Steve Eldred
The California Endowment

Dale Fleming
Office of Strategy and Innovation
Health and Human Services Agency
County of San Diego

Kimberly Giardina
Child Welfare Services
Health and Human Services Agency
County of San Diego

Suzanne Lindsay, Ph.D.
Institute for Public Health
San Diego State University

Rueben Littlejohn
Probation Department
County of San Diego

Sandra L. McBrayer
The Children's Initiative

Dana Richardson
Community Health and Engagement
Community Health Improvement
Partners

Ron Rode
Research and Evaluation Department
San Diego Unified School District

Barbara Ryan
Rady Children's Hospital
San Diego County School Boards
Association

Dean Sidelinger, M.D.
Health and Human Services Agency
County of San Diego

Howard Taras, M.D.
Child Development and Community
Health, Department of Pediatrics
University of California at San Diego

Lindsey Wade
Public Policy
Hospital Association of San Diego &
Imperial Counties

Scientific Advisory Review Committee

Tod Chee
Information Technology Services
Health and Human Services Agency
County of San Diego

Jim Crittenden
Student Attendance, Safety, and Well-
Being
San Diego County Office of Education

Grace Miño
Criminal Justice Research Division
San Diego Association of Governments

Sutida Jariangprasert
Maternal, Child, and Family Health
Services
Health and Human Services Agency
County of San Diego

Kay Johnson
Johnson Group Consulting, Inc.

David Lawrence, Ph.D.
SafetyLit Foundation

Lilibeth Lumberras
Business Intelligence Unit
Probation Department
County of San Diego

Tanya Penn
Institute for Public Health
San Diego State University

Leslie Ray
Community Health Statistics
Health and Human Services Agency
County of San Diego

Diana R. Simmes
Department of Pediatrics
University of California at San Diego

Ashley Stegall
Maternal, Child, and Family Health
Services
Health and Human Services Agency
County of San Diego

Feature Box Contributors

Food Insecurity
Heidi Gjertsen, Ph.D.
San Diego Hunger Coalition

Home Visiting
Jennifer Wheeler
Health & Human Services Agency
County of San Diego

Infectious Disease Prevention
Wilma J. Wooten, M.D.
Public Health Services
Health and Human Services Agency
County of San Diego

Data Sources and Experts

Sanaa Abedin
Health & Human Services Agency
County of San Diego

Shabbir Ahmad, DVM, Ph.D.
Maternal, Child and Adolescent Health
Program, Center for Family Health
California Department of Public Health

Isabel Corcos, Ph.D.
Community Health Statistics Unit
Health and Human Services Agency
County of San Diego

Luis Fernandez
Child Welfare Services/Data Unit
Health and Human Services Agency
County of San Diego

David Grant, Ph.D.
California Health Interview Survey

Julia Guerrero
Health and Human Services Agency
County of San Diego

Darlanne Hocht Mulmat
Applied Research Division – Public
Policy
San Diego Association of Governments

Elaine Higgs
Child Welfare Services
Health and Human Services Agency
County of San Diego

Sandy Keaton
Applied Research/Criminal Justice
Division
San Diego Association of Governments

Rachel Miller
Sexual Health Education Program
San Diego Unified School District

Sladjana Oulad Daoud
California Department of Motor Vehicles

Patrice Rogers
California Department of Motor Vehicles

Adriana Ramirez
Health & Human Services Agency
County of San Diego

Carina Saraiva
Maternal, Child and Adolescent Health
Program/Center for Family Health
California Department of Public Health

Dan Sue
Automated Regional Justice Information
System (ARJIS)
San Diego Association of Governments

Helen N. Tashima
Office of Traffic Safety
California Department of Motor Vehicles

Ben Trigg
WestEd/California Healthy Kids Survey

Wendy Wang
Public Health Services, Immunization
Program
Health and Human Services Agency
County of San Diego

Rick Wanne
Eligibility Operations
County of San Diego, Health & Human
Services Agency

Karen Waters-Montijo
Epidemiology and Immunization
Services Branch
Health and Human Services Agency
County of San Diego

Wilma Wooten, M.D.
Public Health Officer
Health and Human Services Agency
County of San Diego

The Children’s Initiative Board of Directors

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Imperial Counties

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County of San Diego

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Neutral Mediation and Arbitration
JAMS

Barbara Ryan
Vice President, Government Affairs
Rady Children’s Hospital
San Diego County School Boards
Association

Sandra L. McBrayer
Chief Executive Officer
The Children’s Initiative

The Children’s Initiative Report Card Project Team

Sarah Mostofi
Report Card Project Director
The Children’s Initiative

Sarah Williams
Program Assistant
The Children’s Initiative

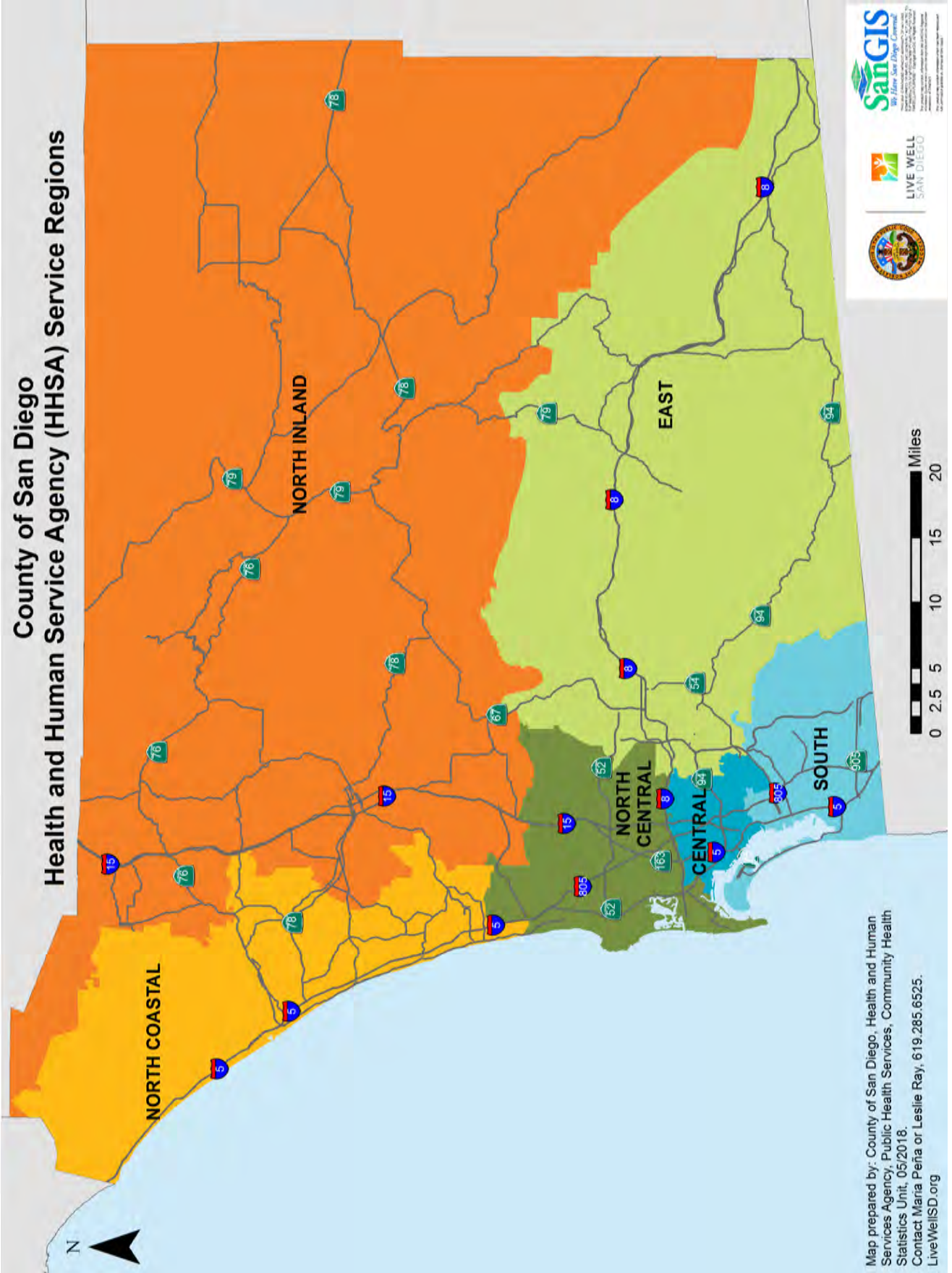
Tommy Winfrey
Juvenile Justice Program Associate
The Children’s Initiative

National Consultant

Kay Johnson
Johnson Group Consulting, Inc.

References, data sources, and technical notes can be found online at www.thechildrensinitiative.org

County of San Diego Health and Human Service Agency (HHS) Service Regions



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Contact Maria Peña or Leslie Ray, 619.285.6525.
LiveWellSD.org

4438 Ingraham Street
San Diego, CA 92109
Phone: 858.581.5880 • Fax: 858.581.5889
www.thechildrensinitiative.org

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