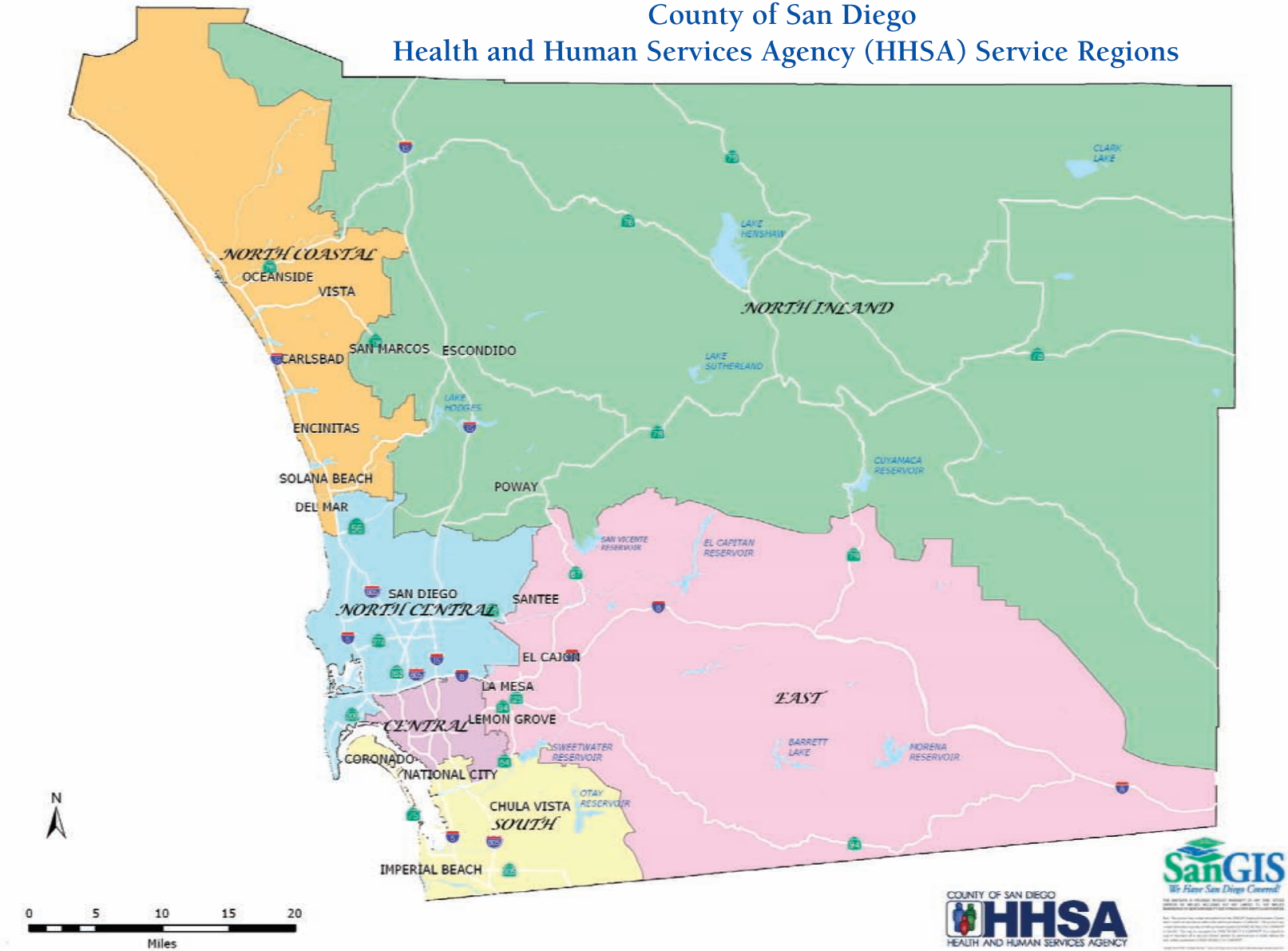
San Diego County
Report Card on Children & Families

REPORT CARD 2011

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



COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

SanGIS We Have San Diego Covered!

San Diego County Report Card on Children and Families

2011 Edition

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

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The Children's Initiative

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EXECUTIVE SUMMARY

The *2011 San Diego County Report Card on Children and Families* is a comprehensive report highlighting the health and well-being of children and youth in San Diego County. It was developed with a unique methodology that engages a broad array of stakeholders in a results-focused process. It reports not only on data trends, but equally on effective practices and specific recommendations to "turn the curve" and accelerate progress on indicator trends. The *2011 San Diego County Report Card on Children and Families* is the continuation of a series of report cards that provides an overview of the overall health and well-being of our county's children, youth, and families. The report is produced biennially by the Children's Initiative, a nonprofit child advocacy agency in San Diego, CA.

The Children's Initiative advanced a distinctive public/private partnership in the development and publication of this *2011 Report Card* using the advice and expertise of a broad array of stakeholders, including: public agency and government officials; subject matter experts in education, health, and other fields; providers and community-based organizations; and parents and youth. Funders include the: County of San Diego Health and Human Services Agency, California Endowment, McCarthy Family Foundation, Weingart Foundation, Lucile Packard Foundation for Children's Health, Mayer & Morris Kaplan Family Foundation, and Leichtag Foundation. The work of developing the *2011 Report Card* is guided by a dynamic Leadership Advisory Committee comprised of national experts and local leaders in the fields of health, education, child care, child welfare, juvenile justice, and injury and violence prevention. A Scientific Advisory Review Committee from these same fields of study has provided review and analysis to ensure validity and reliability for all indicators.

For this *2011 Report Card,* 25 indicators were selected to measure the health and well-being of children and families in San Diego County. The Children's Initiative, using nationally recognized criteria in results-based accountability projects, selected indicators by asking: Do we have reliable and consistent data? Does the indicator communicate to diverse audiences (e.g., families, communities, policy makers)? Does the indicator say something of importance about the desired outcome? Using this decision model, the Children's Initiative and the oversight committees defined a set of indicators that reflect some of the most important aspects of the lives of children and families.

An important feature of the *2011 Report Card* is the reporting of the current status of the indicators and the trends in the last few years as well as information on national best practices for prevention and intervention, and revised recommendations for action specific to San Diego County. This *2011 Report Card* also provides updates on current local efforts and progress since the last Report Card in 2009, providing valuable information that can help to guide policy development, target prevention and intervention efforts, and educate the public. The edition also includes boxes featuring specially highlighted topics.

Summary of Trends

The following information gives a snapshot of the direction of trends for the *2011 Report Card*. This summary highlights the direction of trends for indicators over time, using three distinct categories: improving, maintaining, or moving in the wrong direction. Note that these categories offer an assessment of the overall direction of the trend, not a test for statistical significance or a specific measure of year-to-year rates.

Birth to 3 (Infants and Toddlers)

Indicators to monitor the health and well-being of infants and toddlers point to limited progress. San Diego County compares positively to state and national rates. While no trends are moving in the wrong direction for infants and toddlers, trends in early prenatal care and low-birthweight birth remain of concern as they are not improving.

- **Prenatal care.** The trend in San Diego County has leveled off and is not improving. Our rate is still below the national objective.

- **Low birthweight.** The trend is maintaining in San Diego County and is still not approaching the national objective.

- **Breastfeeding initiation.** The San Diego rate was better than the state average and the national objective in 2010. Due to changes on the form that is the source of data, a trend line cannot be shown for years 2008 to 2010.

- **Births to teens.** The trend is improving. After a period of decline, progress leveled off between 2003 and 2008. From 2008 to 2009, however, the rate in San Diego County dropped from 18.9 to 16.2 births per 1,000 teens ages 15-17.

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. Based on the available data, childhood immunization is moving in the wrong direction.

- **Immunization.** The trend is moving in the wrong direction. Between 2006 and 2009, the rate of San Diego County children receiving the basic recommended series of immunizations declined from 85% to 77%. We have dropped below the national objective.

- **Early child care and education.** The trend is not improving. Although still above state and national levels, the rate of San Diego preschool age children enrolled in early care and education declined in 2009 to 51%, the lowest level since 2004.

Ages 6 to 12 (School Age)

For young school age children, more progress is needed. Real improvement was shown for fitness and weight; however, too many are still overweight. More improvement is also needed in school attendance and achievement for elementary grades. The trend in oral health is not improving.

- **Oral health.** The trend is not improving, making no real gain in recent years. In 2009, the proportion of San Diego County children ages 2-11 who had never been to a dentist was worse than the state average for the first time since 2001.

- **School attendance.** Since data were first collected in the 2006-07 school year for this new indicator no substantial progress has been made for the county overall. In San Diego County, the percent of students in grades K-5 attending less than 95% of school days was 29% in 2010-11.

- **School achievement.** The trend for achievement in English–language arts for third graders is maintaining. Between 2003 and 2008, the trend improved substantially (from 39% to 51%), then leveled off from 2008-09 to 2010-11—showing no improvement for these two school years.

- **Obesity.** The trend is improving. The proportion of students not in the "Healthy Fitness Zone" for weight (body composition and body mass index) in grades 5, 7, and 9 gradually declined from 2004-05 to 2009-10. San Diego County rates remain far from the national objective of having no more than 5% of children and youth reported as being overweight or obese.

Ages 13 to 18 (Adolescence)

Our adolescents are doing better than ever in school achievement. Yet too many of our youth remain at risk for car crashes, delinquency, and substance abuse.

- **School attendance.** In San Diego County, the percent of students in grades 6-12 attending less than 90% of school days is maintaining, with approximately one in ten students missing too many days in school year 2010-11.

- **School achievement.** The trend is improving. However, proficiency is higher for younger than for older students. While 64% of eighth graders are performing proficient or above, only half of eleventh graders scored proficient or above in English–language arts. San Diego student scores remain higher than the state rates.

- **Substance use.** The trend is improving for some substances. Students report less use of cigarettes and alcohol over time; however, recent increases in marijuana use have been reported.

- **Youth suicide.** It is not possible to judge the trend for this small number of youth.

- **Juvenile crime.** The number of juvenile arrests for felonies is not showing consistent improvement over time, while the number of misdemeanor arrests continues to decline. The overall, combined rate of juvenile arrests dropped from more than 50 per 1,000 juveniles in 2000 to 40 per 1,000 in 2009.

- **Juvenile probation.** The trend is improving. After peaking in 2007, the number of sustained petitions has declined in recent years.

- **Youth DUI.** The trend is improving. During the past decade, the number of youth DUI arrests is generally improving from a peak in 2001. In 2009, the number reached the lowest level in a decade, at 119 arrests. The trend in fatal and non-fatal youth DUI crashes is improving with some variation. Still, too many of our youth are continuing to use drugs and alcohol and drive.

Community and Family (Cross Age)

Our community and family indicators are generally improving. Of concern is the current economic situation many of our families are faced with, which in turn negatively affects outcomes in other areas of health and well-being. The trend in poverty is moving in the wrong direction, and the full impact of the recession is not yet known.

- **Poverty.** The trend is moving in the wrong direction. The San Diego County child poverty rate (representing those with income below 100% of the Federal Poverty Level) generally decreased between 2000 and 2007 (from 16.3% to 14.9%, respectively). Then, the rate climbed to 16.6% in 2008 and 16.8% in 2009. The proportion of families with income less than 200% of the Federal Poverty Level indicates that too many of our children live in families with income insufficient to meet basic needs such as housing, food, and transportation.

- **Nutrition assistance.** The trend is improving. Since 2006, the number of children and adults receiving nutrition assistance in San Diego County has more than doubled, reaching more eligible families. This is good news and a change from a few years ago when San Diego County had one of the lowest eligible participation rates in the nation.

- **Health coverage.** The trend is improving. The percent of children without health coverage for San Diego County was just under 5% in 2007 and 2009. Our county rate was comparable to the state average in 2009. Additional child health coverage options have become available since that time.

- **Domestic violence.** The trend is not improving. Although the rate of domestic violence per household is lower than a decade ago, the rate does not show consistent improvement and San Diego's rate is consistently higher than the state rate. More improvement is needed to reduce family violence.

- **Child abuse and neglect.** The trend is improving. San Diego County's rate of substantiated child abuse continues to decline, reaching 8.3 per 1,000 children in 2010, below the state average of 8.9 per 1,000 children. (Note that past rates shown in this trend have been recalculated based on revised population estimates.)

- **Child victims of violent crime.** The overall trend is maintaining. The number of violent crimes committed against children and youth peaks after school between the hours of 3 p.m. and 6 p.m.

- **Unintentional injury and death.** The trend is improving overall. From 2000 to 2009, the rate of fatal and non-fatal unintentional injuries to children dropped from 352 to 203 per 100,000.

- **Child mortality.** While showing year-to-year variations, the trend in infant mortality is improving. The rate of mortality for children ages 1-4 has generally maintained. For children ages 5-14, mortality rates have not showed sustained improvement since 2000, despite variations. In 2008, the rate for youth 15-17 reached its lowest rate of the decade but worsened again in 2009.

Recommendations for Action

As the County of San Diego embarks on a long-term health strategy agenda to improve the health and well-being of our region, this *2011 Report Card* is a road map for the building blocks of the health and well-being that our children and youth need to become healthy, vibrant, productive adults. The County of San Diego efforts first began as the health strategy "Building Better Health," based on a model of 3-4-50. Building Better Health recognized that three behaviors (poor nutrition, lack of exercise, and tobacco use) cause four diseases (heart disease, Type 2 diabetes, cancer, and lung disease) that cause 50% of deaths among our adult population.

From that effort the County of San Diego launched *Live Well, San Diego!* a broad ten-year strategy to improve the health and well-being of county residents. The four pillars of this strategy include: 1) Building a Better Service Delivery System, 2) Supporting Positive Healthy Choices, 3) Pursuing Policy and Environmental Changes, and 4) Improving the Culture from Within County Government.

This *2011 Report Card* supports the County *Live Well, San Diego!* agenda by documenting and highlighting indicators that reflect the health and well-being of our children and youth and are the foundation of a healthy and vibrant community. More importantly, the *2011 Report Card* makes focused recommendations to ensure our children and youth have a chance to become productive residents in our region. Many of the *2011 Report Card* recommendations align with those in *Live Well, San Diego!* Most of the *2011 Report Card* recommendations naturally fall under one of the four pillars supporting *Live Well, San Diego!* The following section offers examples of recommendations from the *2011 Report Card* that directly support the goals and objectives of *Live Well, San Diego!*

Live Well, San Diego!

I. Building a Better Service Delivery System

Provide Quality and Efficient Care through the integration of physical health, behavioral health, and social services. The *2011 Report Card* calls for offering oral health prevention services (e.g., fluoride varnish) and screening children for oral health problems in schools, Head Start, and other early educational settings.

This strategy relates to the following indicators: Early Care and Education, Oral Health, School Attendance.

Improve Access to Quality Care by maximizing funding and enrollment in federal and state programs to facilitate access to services, implementing technologies that create efficiencies in screening, referral, and service delivery. The *2011 Report Card* calls for increasing access to, support, and follow-up for One-e-App and Benefits CalWIN to assist families in applying for Medi-Cal and CalFresh, and simplifying application processes for other public and private assistance such as health coverage, income, job training/unemployment, California Alternative Rates for Energy (CARE), and housing programs.

This strategy relates to the following indicators: Low Birthweight, Breastfeeding, Oral Health, Obesity, School Attendance, School Achievement, Poverty, Nutrition Assistance, and Health Coverage.

Improve Systems by refining programs to improve cost efficiencies, coordination, and quality of care. The *2011 Report Card* recommends providing services for children with significant social, emotional,

development, or physical problems through KidSTART. Additionally, this Report Card calls for increased use of routine developmental screening in early childhood for early identification of young children exposed to violence and other trauma.

This strategy relates to the following indicators: Low Birthweight, School Attendance, School Achievement, Health Coverage, Child Abuse and Neglect, Child Victims of Violent Crime, and Child Mortality.

II. Supporting Positive Healthy Choices

Encourage Healthy Eating by increasing availability of fresh fruits and vegetables, promoting nutrition, and participating in CalFresh. The *2011 Report Card* calls for encouraging eligible families to participate in CalFresh (SNAP) nutrition assistance and WIC to improve child nutrition, starting before birth.

This strategy relates to the following indicators: Low Birthweight, Breastfeeding, Oral Health, School Attendance, School Achievement, Obesity, Poverty, and Nutrition Assistance.

Support Tobacco- and Drug-Free Lives by providing support for smoking cessation and drug-free lives. The *2011 Report Card* calls for promoting youth development activities, after school programs, and substance abuse prevention and early intervention programs.

This strategy relates to the following indicators: Prenatal Care, Low Birthweight, School Attendance, School Achievement, Substance Use, Youth Suicide, Juvenile Crime, Juvenile Probation, Youth DUI, Child Victims of Violent Crime, Unintentional Injury, and Child Mortality.

III. Pursuing Policy and Environmental Changes

Promote Access to Healthy Foods by promoting healthy eating and nutrition in all policies. The *2011 Report Card* calls for promoting and increasing the number of community/school gardens and farmer's markets, Farm-to-School, and related projects.

This strategy relates to the following indicators: Low Birthweight, Breastfeeding, Oral Health, School Attendance, School Achievement, Obesity, and Nutrition Assistance.

Favor Tobacco- and Drug-Free and Healthy Environments by supporting smoke- and drug-free environments and supporting policies that promote general health in the community. The *2011 Report Card* calls for continuing and expanding prescription drug turn-in and related programs that reduce youth access to substances. It also calls for interventions with youth who are chronically absent, truant, and experiencing high rates of behavioral problems at school.

These strategies relate to the following indicators: School Attendance, School Achievement, Juvenile Crime, Juvenile Probation, Substance Use, Youth Suicide, Youth DUI, and Child Mortality.

Strategic Framework for Health Improvement in San Diego County

Lately, there has been much talk and action in Washington D.C. regarding health care reform. While we care about health care coverage, which is the main thrust of the federal debate, prevention can be the key to improving health in San Diego. To see the possibilities for transforming the health of all San Diegans, one needs only to examine these three numbers: 3, 4, and 50.

Worldwide, three risk factors (tobacco use, poor diet, and physical inactivity) contribute to four of the most prevalent chronic diseases (cancer, cardiovascular disease, Type 2 diabetes, and respiratory disease) that are responsible for over 50% of all adult deaths worldwide. Local San Diego health statistics indicate 57% of all deaths are attributed to these four diseases, which are highly associated with the three behavioral risk factors. The potential to reduce disease and mortality by addressing these three factors represents a major opportunity to improve the health and well-being of all the members of our community.

Chronic diseases are common, costly, and yet preventable. These conditions cause pain and suffering, and decrease quality of life for tens of thousands of San Diegans each year. In San Diego County, over $4 billion is spent annually on health care costs for these four chronic diseases—excluding treatment of lung cancer.

Physicians make health recommendations to their patients that emphasize the importance of good nutrition, increased physical activity, and being smoke-free. But when people leave the office, does the community environment support healthy choices? Are they living in "healthy environments" that include access to fresh and healthful produce, walkable and safe neighborhoods, opportunities for recreation and social connections, and decreased exposure to tobacco products? Unfortunately for many individuals and families, the answer is probably "no." Too many people face obstacles in the community to a healthy lifestyle.

In addition to focusing on environments that support healthy choices, we must focus on mental health as a part of overall health. The links between mental health and physical health are clear. Risk factors for poor mental health include isolation, low self-esteem, discrimination, and school failure. Protective factors include a sense of belonging, attachment to social networks, social skills, and participation in school/community groups. An example of a strategy that links physical and mental well-being is increasing the number of children who walk to school—increasing physical activity can enhance self-esteem, broaden social networks, and decrease depression and isolation, as well as promote physical health and fitness.

How can we work to reduce the three behaviors and four diseases leading to over 50% of the adult mortality in our community? We must encourage and support healthy behaviors that then contribute to healthier outcomes for everyone and a reduction in chronic diseases. However, we cannot do this alone.

San Diego County has integrated these concepts into ***Live Well, San Diego!*** The goal is that by 2020, the people will receive cost-efficient, evidence-based integrated services that improve health (defined as physical, mental, social, and spiritual well-being). Prevention efforts will focus broadly, address the social determinants of health, and change the built environment. These activities will collectively create healthy communities throughout San Diego County to meaningfully improve the health of all. We welcome you to join the Health and Human Services Agency as it reaches beyond office walls to improve health in San Diego.

REPORT CARD SUMMARY TABLE

County, State, and National Comparisons

Key to table symbols.
Trend is improving.
Trend is maintaining.
Trend is moving in wrong direction.

Indicator		San Diego County	California	United States
Birth to Age 3 (Infants and Toddlers)				
Percent of mothers receiving early prenatal care		82.0	82.9	NA
Percent of infants born at low birthweight		6.7	6.8	8.2
Percent of mothers who initiate breastfeeding in hospital	NA	94.5[1]	90.8[1]	NA
Birth rate per 1,000 teens ages 15-17 years		16.2	17.5	20.1
Ages 3-6 (Preschool)				
Percent of young children (ages 19-36 months) who completed the basic immunization series		76.5	74.9	69.9
Percent of children ages 3-4 enrolled in early care and education		51.1	49.3	48.4
Ages 6-12 (School Age)				
Percent of children ages 2-11 who have never visited a dentist		13.2	11.6	NA
Percent of elementary school (K-5) students who did not attend school at least 95 percent of school days		29.2[1]	NA	NA
Percent of students in grade 3 scoring proficient or advanced on the English–Language Arts achievement test		51.0[1]	46.0[1]	NA
Percent of students not in the Healthy Fitness Zone (overweight or obese)				
Grade 5		28.5	31.5	NA
Grade 7		27.9	31.2	NA
Grade 9		25.6	28.7	NA

Indicator		San Diego County	California	United States
Ages 13-18 (Adolescents)				
Percent of middle and high school students (grades 6-12) who did not attend school at least 90 percent of school days		9.2[1]	NA	NA
Percent of students scoring proficient or advanced on the English–Language Arts achievement test				
Grade 8		64.0[1]	57.0[1]	NA
Grade 11		50.0[1]	45.0[1]	NA
Percent of students who report using cigarettes in past 30 days				
Grade 7		4.9[1]	5.0[3]	NA
Grade 9		9.4[1]	10.0[3]	13.5
Grade 11		12.2[1]	13.0[3]	22.3
Percent of students who report using alcohol in past 30 days				
Grade 7		10.7[1]	14.0[3]	NA
Grade 9		22.3[1]	25.0[3]	31.5
Grade 11		31.0[1]	34.0[3]	45.7
Percent of students who report using marijuana in past 30 days				
Grade 7		5.3[1]	6.0[3]	NA
Grade 9		15.0[1]	15.0[3]	15.5
Grade 11		20.8[1]	20.0[3]	23.2
Percent of male students (grades 9-12) who report they attempted suicide in previous 12 months	NA	6.9[1]	NA	4.6
Percent of female students (grades 9-12) who report they attempted suicide in previous 12 months	NA	11.2[1]	NA	8.1
Number of arrests for misdemeanor and felony crimes among youth ages 10-17		13,302	NA	NA
Number of sustained petitions (true finds) in Juvenile Court among youth ages 10-17		4,324[1]	NA	NA
Number of DUI arrests among youth under age 18		119	1,262	NA
Rate of fatal and non-fatal crashes involving drivers ages 16-20 under the influence of alcohol or drugs per 100,000 population		79.1	NA	NA

Indicator		San Diego County	California	United States
Community and Family (Cross Age)				
Percent of children ages 0-17 living in poverty		16.8	19.9	20.0
Number of eligible children receiving Food Stamps		127,308[2]	NA	NA
Percent of children ages 0-17 who are without health coverage		4.6	4.9	10.0
Rate of domestic violence reports per 1,000 households		16.0	13.1	NA
Rate of substantiated cases of child abuse and neglect per 1,000 children ages 0-17		8.3[1]	8.9[1]	NA
Rate of violent crime victimization per 10,000 children or youth				
Ages 0-11		5.8	NA	NA
Ages 12-17		64.8	NA	NA
Rate of unintentional injuries per 100,000 children ages 0-18		202.6	194.8	NA
Infant mortality rate per 1,000 live births		4.4	4.9	6.4
Rate of mortality per 100,000 children				
Ages 1-4		17.0	21.9	NA
Ages 5-14		11.2	11.3	NA
Ages 15-17		28.7	NA	NA

Table notes:

All data are for year 2009 or school year 2009-10 unless otherwise noted.

[1] Data from 2010 and/or school year 2010-11.

[2] Data from 2011.

[3] Aggregate three-year data from 2008-2010.

SAN DIEGO COUNTY REPORT CARD ON CHILDREN AND FAMILIES, 2011

Introduction

"Report cards" are used to measure and monitor the well-being of populations. This *2011 San Diego County Report Card on Children and Families* monitors how well San Diego County's children and youth and their families are doing in terms of health, education, safety, and economic security. Report cards can point to troublesome trends or positive results and make recommendations for change or continued support in policies and programs.

Results (or outcomes) are conditions of well-being for children, adults, families, or communities. They are what we hope to achieve as a community, including children who are healthy, ready for and succeeding in school, avoiding risky behaviors, and staying out of harm's way. Report cards include indicators that serve as benchmark measures to monitor our progress toward the desired results. They tell us how we are doing, whether or not we are moving in the right direction, and if trends point to problems in our safety net for children and youth. For this *2011 Report Card,* 25 indicators were selected to measure the health and well-being of infants and toddlers, preschoolers, school age children, adolescents, families, and communities, as well as status across age groups.

While there is no single silver bullet, research tells us much about what strategies have proven effective to improving the conditions of children and families. For each indicator, we have included an up-to-date list of what works, based on national research and best practices from across the United States. Finally, this *2011 Report Card* offers San Diego–specific recommendations, based on what works, in order to improve results for our children and their families. Getting good results often depends on effective implementation of integrated policies and strategies across programs and systems. Success equally depends on ensuring public and private agencies work together as partners.

The Report Card Development Process

The Children's Initiative *2011 Report Card* 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.

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 new report was published by the Children's Initiative in January 2008, and this is the third edition.

This *2011 Report Card* was developed and published as a public-private partnership. The work has been guided by a Leadership Advisory Committee comprised of local and national experts in the fields of health, education, child care, child welfare, juvenile justice, and injury and violence prevention. 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. The document also reflects the advice and expertise of a broad array of stakeholders, including: public agency and government officials; subject matter experts in education, health, 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, other providers, family advocates, and others to discuss the data, the trends, and what works.

Public and private funders for this *2011 Report Card* include the: County of San Diego Health and Human Services Agency, California Endowment, McCarthy Family Foundation, Weingart Foundation, Lucile Packard Foundation for Children's Health, Mayer & Morris Kaplan Family Foundation, and Leichtag Foundation.

Understanding This Report Card

Readers and those who use the data from the *2011 Report Card* will want to know how the data are presented and represented. The most recent data available at the time of production are used. Depending on the type and source of information, the most recent data available for this edition may be for 2008, 2009, or 2010. School related data may be for school year 2010-11.

Trend charts are presented to illustrate the status of an indicator over time. No tests have been done to determine the statistical significance of changes; we are only observing whether the trends are improving, maintaining, or worsening. Notably, a one-year change in a specific rate may be the result of a temporary environmental change, a change in data sample, or some other extraneous influence, and may not represent a true change in the trend. When possible, comparison data are presented to assist in understanding how our county is doing compared to California or United States averages, as well as to the federal Healthy People 2010 Objectives set by the U.S. Department of Health and Human Services. (Note that the next report scheduled to be issued in 2013 will use Healthy People 2020.)

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. Most charts are shown for calendar years. Three-year averages are used when the population referred to is small, or when the data are likely to have year-to-year fluctuations that do not indicate actual underlying change in the indicator. For education data, the trends are shown in school years (e.g., 2010-11).

Most charts 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, however, the scale has been modified to better show the variation year-to-year. When that occurs, the chart is marked with the words "note scale." In a few instances, numbers instead of percentages or rates are used. This is done when it would be impossible to calculate the denominator—the number of individuals who might be subject to a condition. So, for example, we report the number of youth DUI arrests and the number of individuals receiving nutrition assistance through SNAP/CalFresh.

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 such as crime or mortality. The total group of 25 indicators reflects a broad array of concerns, but not all the results that are important to families. For example, we do not report on affordable housing, employment, or recreation opportunities.

In addition to reporting the current status of the indicators and the trends in the last few years, the *2011 Report Card* provides two important types of information: national best practices for prevention and intervention, and recommendations for action specific to San Diego County. Best practices were identified from respected sources such as professional journal publications, universities, government agencies, and other research organizations. These sections offer examples and are not intended to be exhaustive or complete lists of possibilities. Recommendations for action in this *2011 Report Card* are based on a survey of community leaders and providers, committee members, subject matter experts, and national consultants. Where available, updates on current local efforts and progress since the last Report Card are provided. This information can help to guide policy development, target prevention and intervention efforts, and educate the public.

Notes on Geographic 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 HHSA prepared geocoded maps for this *2011 Report Card* that illustrate the occurrence of selected indicators according to more precise and easily understood community boundaries (e.g., zip code areas).

The county's total population in 2010 was estimated at 3,224,000, and it is the second most populous county in the state, after Los Angeles County. Children under age 18 represent 24% of our population.

The San Diego Association of Governments (SANDAG) reports that the region's population under 18 is distributed throughout urban, suburban, and rural areas, notably in inland communities. Areas with the highest concentrations—with close to one-third of the population being children under age 18—are in Oceanside, Escondido, National City, and Chula Vista. The areas with lower proportions of child residents tend to be those found adjacent to the coastline, such as Coronado, Solana Beach, and Del Mar.

San Diego County is an ethnically diverse community. According to the 2010 Census, the overall population consists of: 48 percent non-Hispanic white; 32 percent Hispanic; 5 percent African-American; 11 percent Asian, Hawaiian, or other Pacific Islander; 4 percent other; and less than 1 percent Native American or Alaskan Native. The population of children is predominately Hispanic (41 percent) and non-Hispanic white (38 percent) 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. Data on race and ethnicity are not uniformly available for indicators. Where appropriate and available, tables with racial/ethnic variations are included.

Supporting Military Families in San Diego

San Diego County is home to the second largest concentration of military families in the nation, with 116,060 active duty service men and women, with approximately 48,000 school-aged children. Children growing up in military families face special circumstances. Frequent moves from town to town can make it difficult to maintain friendships, know where and what services are available, and keep up in school. Many local military families also struggle with San Diego's high cost of living, limited public transportation, and expensive housing options.

When one or both parents are deployed, families left behind must learn to cope with related stress, and to find sufficient financial and social supports. Parental deployment can have a profound effect on children—eliciting feelings of sadness, anger, anxiety, depression, and fear. Parents returning from deployment face significant readjustment issues including: post-traumatic stress, reintegration into the family, rebuilding personal relationships, and financial uncertainty. Multiple deployments are increasingly common, compounding risks and challenges. Veterans returning home and exiting the military may face difficulty securing employment especially during this time of economic uncertainty. These stressors, combined with limited supports, can contribute to increased incidence of divorce, child abuse, and domestic violence among deployed military families.

Military leaders have stated that the health, well-being, and readiness of the military family are tied to a successful thriving military force, but admit that there are gaps in services. Many reports suggest that government services need to be more responsive to the social and economic effects of deployment on families, particularly mental health. Reports from The Institute of Medicine and RAND state that returning soldiers are surviving more devastating injuries and increasing numbers are being diagnosed with trauma-based anxiety disorders, depression, suicidality, and substance abuse. Conversely, mental health and social work providers report overwhelming caseloads and extended waiting times for services. Closing these gaps is critical to both the immediate and long-term health and well-being of military personnel and their families.

San Diego has been taking steps to provide more direct support to our military families and servicemen and women. Local support for San Diego military families comes from within the military community with family support services and local websites such as sandiegomilitaryfamilies.com or homefrontsandiego.org. Community-based organizations—such as SAY San Diego, YMCA, and REBOOT—and school districts also play a role. The San Diego County Office of Education established a central coordinating military liaison to work with all 42 local school districts, identifying the unique needs of military children and working to locate available resources to assist them. REBOOT provides a three week "reverse boot camp" transition program with both cognitive-behavioral and employment preparation trainings to prepare veterans to be successful in civilian life. The Health and Human Services Agency has partnered with the Navy Region Southwest and Naval Medical Center to identify priority issues for action such as tobacco use, obesity prevention, mental health awareness, and immunization. As part of the *Live Well, San Diego!* initiative the Health and Human Services Agency and Mental Health Systems, Inc. operate Courage to Call—a veteran-staffed resource and referral helpline. While these efforts are valuable and much needed, more needs to be done to support our military families and ensure their children are given every opportunity to thrive in San Diego.

"Women who see a health care provider regularly during pregnancy have healthier babies, are less likely to deliver prematurely, and are less likely to have other serious problems related to pregnancy." *March of Dimes*

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

What is the indicator?

The percent of mothers receiving early prenatal care.

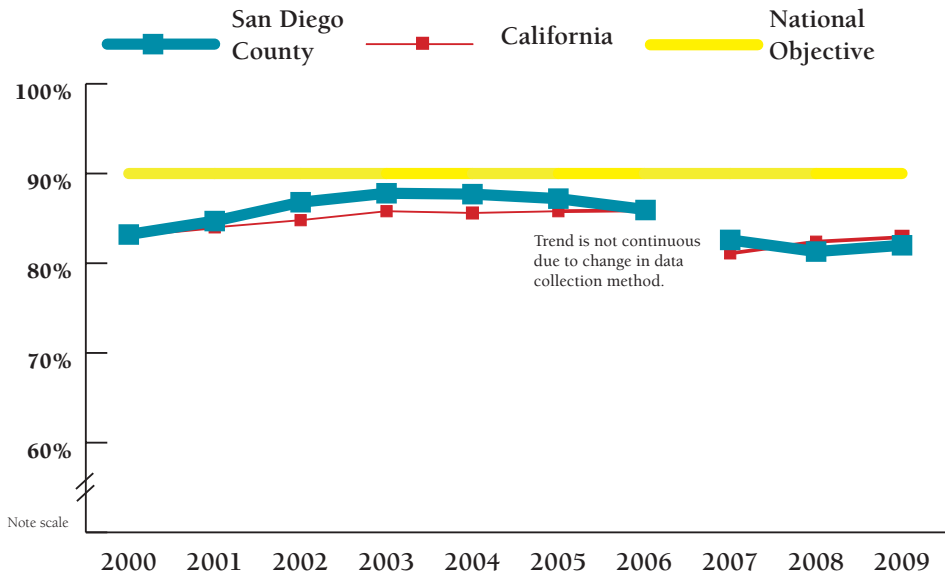
This indicator—the percent of mothers receiving early prenatal care—reflects the percent of women who receive prenatal care beginning in the first three months (referred to as the first trimester) of pregnancy. A related measure is "adequate" prenatal care, which accounts for both the timing of entry into care (early, late, etc.) and the number of visits. Prenatal care information is recorded on the birth certificate and reported as part of local, state, and federal vital statistics.

Why is this important?

Prenatal care from a qualified health professional is vital to ensure the health of a woman and her baby during pregnancy. Optimal care includes medical services and health promotion and education. According to the Centers for Disease Control and Prevention (CDC), early and comprehensive prenatal care is associated with healthier birth weight and a lower risk of premature birth. Inadequate prenatal care (starting late or too few visits) has been associated with premature birth, low-birthweight birth, and increased risk of mortality for the fetus, infant, and mother. CDC recommends starting care even before conception (preconception care) to reduce health risks to both mother and baby.

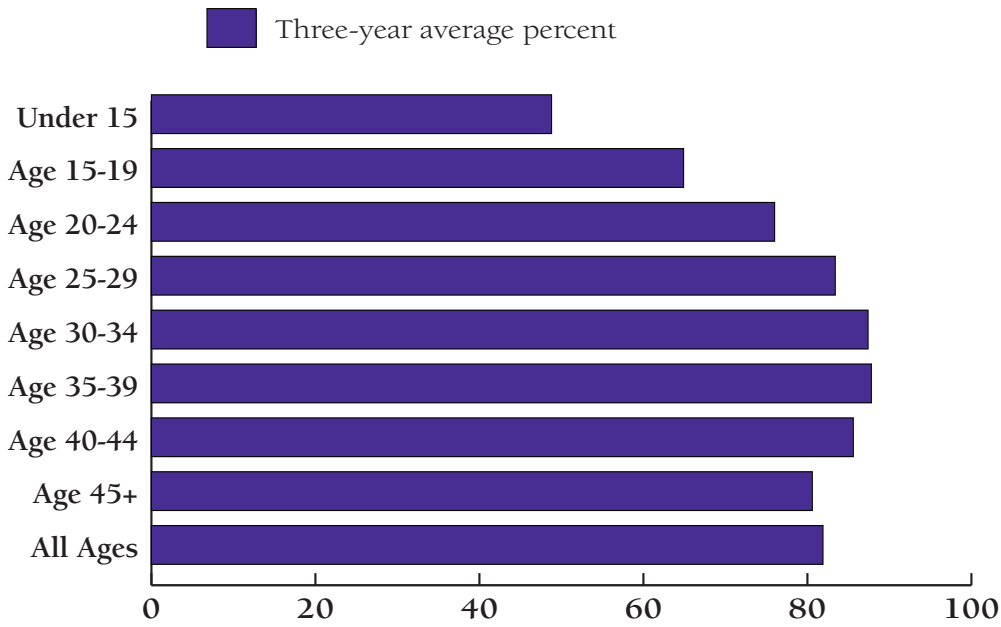
How are we doing?

Percent of Mothers Receiving Early Prenatal Care, San Diego County and California Compared to National Objective, 2000-2009



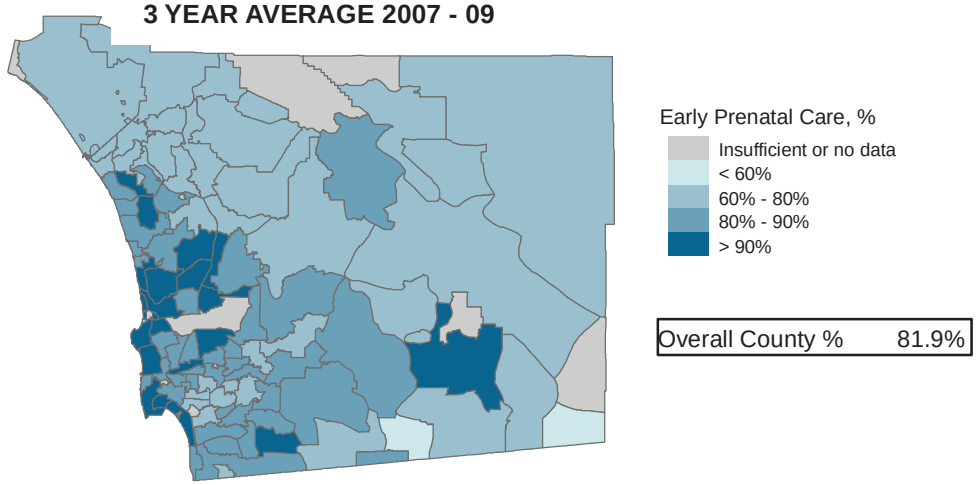
The trend in San Diego County has leveled off and is not improving. While our rate is comparable to the state rate, it is still below the national objective.

Percent of Mothers Receiving Early Prenatal Care, By Age, San Diego County, Three-Year Average 2007-09



San Diego's youngest mothers are less likely than older women to begin prenatal care early. This is particularly true among pregnant teens, but even those ages 20-24 fare less well.

PERCENT OF BIRTHS WHERE MOTHER RECEIVED EARLY PRENATAL CARE:
3 YEAR AVERAGE 2007 - 09



NOTE: Data from State of California, Dept. of Public Health, Center for Health Statistics, Birth Statistical Master File. Prepared by County of San Diego, HHSA, Maternal, Child and Family Health Services. Data is for births in 2007-2009 with known prenatal care start time. This is a measure of prenatal care initiation, not frequency of care. Data with missing or invalid zip code are excluded from the map (<1%).

What strategies can make a difference?

Many factors can affect whether or not a pregnant woman receives early prenatal care. An Institute of Medicine report identified four categories of barriers. First, financial barriers due to lack of health coverage still affect many poor and near-poor working families. Second, the context of care has a significant impact (e.g., negative attitudes and biased treatment by health care providers, long waits after arriving for appointments, lack of cultural competence). Third, the accessibility of care (e.g., transportation, difficulties obtaining an appointment, inconvenient hours) makes a difference. Last, personal attitudes and behaviors (e.g., ambivalence about the pregnancy, lack of understanding about the importance of prenatal care) are barriers to timely prenatal care. What works best is high quality, accessible care that is culturally appropriate and tailored to address a woman's needs.

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

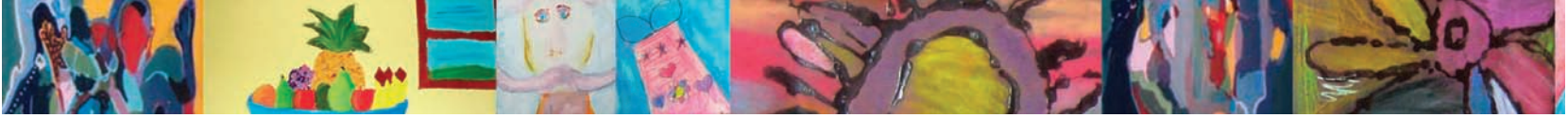
- Removing financial barriers through expanded eligibility for health coverage, typically using public subsidies to make insurance affordable (e.g., Medi-Cal, Healthy Families).
- Maximizing use of safety net providers such as community clinics, Federally Qualified Health Centers (FQHC) and local health departments in providing prenatal care or connecting women to other prenatal care providers.
- Assuring prenatal care services are available and accessible (e.g., accessible by public transportation, flexible service hours).
- Providing prenatal services that are culturally and linguistically appropriate.
- Using evidenced-based home visiting programs, particularly for high-risk mothers.
- Using approaches such as "Centering Pregnancy," a program developed in California, which uses group care sessions to reduce costs while providing more care.
- Assuring comprehensive care (e.g., the California Comprehensive Perinatal Care Services package), which incorporates education and counseling.
- Using outreach to encourage use of early and continuous care.
- Offering transportation assistance such as vouchers for public transportation or taxis.

How can we improve the trend in San Diego County?

San Diego is doing substantial work to improve the rate of early prenatal care. The 2009 and 2011 Report Cards recommend increased use of evidence-based home visiting, which has been shown to improve use of prenatal care and child outcomes. In 2009, the Health & Human Services Agency approved funding to implement the Nurse Family Partnership (NFP), a federally recognized, evidence-based home visiting program. The local program has been awarded $1.25 million in federal funding to expand capacity. With the creation of One-e-App and other strategies to simplify and expedite enrollment into prenatal coverage, there is potential to further improve.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with community clinics, hospitals, health care providers, First 5 San Diego, HHSA-Public Health, March of Dimes, United Way of San Diego County, faith communities, Metropolitan Transit System, municipalities, and California Health and Human Services Agency to:

1. Expand use of intensive home visiting for high risk pregnant women.
2. Promote the use of One-e-App and Benefits CalWIN to increase early enrollment into Medi-Cal prenatal coverage and WIC.
3. Assist community clinics in augmenting outreach and adopting the "Centering Pregnancy" (group prenatal care and education) approach, including culturally competent practices.



"A low birth weight infant can be born too small, too early, or both. These conditions often have separate causes." *Centers for Disease Control and Prevention*

Birth to Age 3 (Infants and Toddlers): LOW BIRTHWEIGHT

What is the indicator?

The percent of infants born at low birthweight.

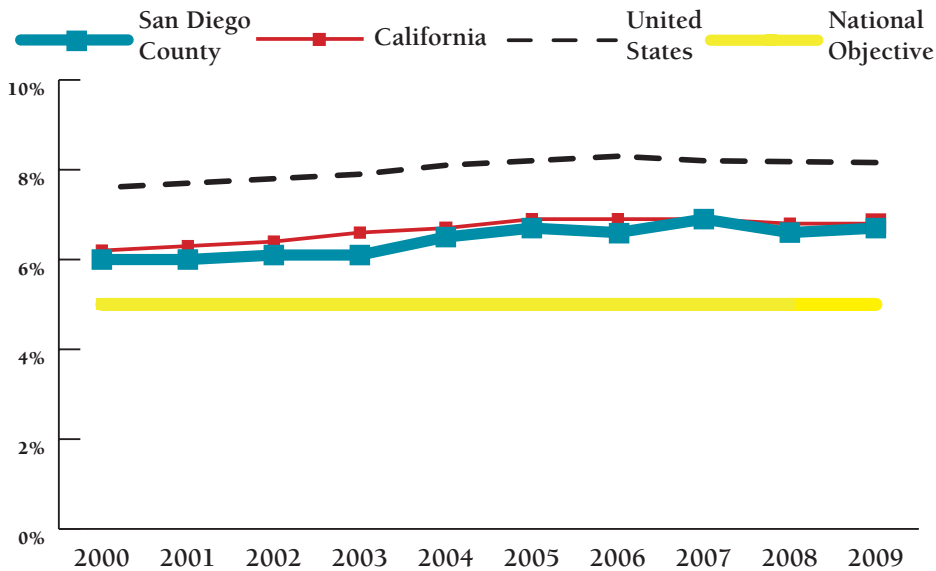
This indicator—the percent of infants born at low birthweight—is defined as weighing less than 2500 grams (5.5 lbs), and very low birthweight is defined as weighing less than 1500 grams (3.3 lbs) at birth. Both are included in this measure. These data are recorded on birth certificates and reported as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

Why is this important?

Babies born at low birthweight face 20 times the risk of dying in their first year of life. Preterm (premature) birth (prior to 37 weeks gestation) is a primary factor in the rate of low birthweight, and together these two conditions are the leading cause of infant mortality. With neonatal intensive care, many babies born too soon or too small survive. However, many who survive will experience problems such as cerebral palsy, vision and hearing disorders, learning disabilities and behavior disorders. Recent studies suggest that individuals born at low birthweight have higher risk for adult chronic health conditions such as high blood pressure, heart disease, and adult onset diabetes.

How are we doing?

Percent of Infants Born at Low Birthweight, San Diego County, California, and United States Compared to National Objective, 2000-2009



The trend is maintaining in San Diego County and is not approaching the national objective. The proportion of babies born at low birthweight remains of concern.

Stopping Preterm Elective Deliveries

In San Diego, California, and the nation, adverse birth outcomes such as prematurity (also known as preterm birth) and low birthweight are a major health issue for newborns. They carry significant health issues, developmental risks for children, increased stress for families and high costs for medical care. In San Diego, each year 4,400-5,000 babies are born preterm.

As reported by the Institute of Medicine/National Academy of Sciences, the causes of prematurity are complex, yet many can be prevented. Specific interventions can reduce the risk of having a baby born too soon or too small. For example, smoking, obesity, and diabetes all are associated with low birthweight and premature births and interventions to reduce their negative impact on pregnancy are available. Teaching women to eliminate smoking, increase proper health habits including eating healthy foods and increasing exercise, receiving prenatal care early in the pregnancy as well as identifying the signs of early labor and letting them know what action to take can help.

Another important way to reduce preterm births is to avoid elective deliveries prior to 39 weeks gestation. In a growing trend, pregnant women and their doctors are electing to induce labor or to schedule a Cesarean (C-section) birth before infants are fully developed. While in some cases, the health of the baby or mother may require such intervention, an increasing number of preterm deliveries are elective or optional. The March of Dimes, American College of Obstetrics and Gynecology, and other professional organizations have launched a nationwide effort to stop elective deliveries prior to 39 weeks gestation and eliminate this cause of preterm births and increased risk to newborns. Some San Diego providers, birth hospitals, and others have joined in these campaigns. Success in these campaigns will result from changes in women's knowledge of the risks, physician behavior, payment practices and birthing hospital monitoring and policies. Community-wide awareness can help eliminate this practice.

What strategies can make a difference?

The precise causes of low birthweight and preterm birth continue to be studied, and the Institute of Medicine has recommended addtional research. Yet, we can identify and reduce some of the contributing risks. Smoking and heavy drinking are two of the most widely known behavioral factors associated with low birthweight and premature birth. Biomedical risks include certain infections and low maternal pre-pregnancy weight. 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. Women who receive late or no prenatal care also are more at risk. Proper care around the time of birth is critical. Since the most reliable predictor for a low-birthweight birth is a prior low-birthweight birth, experts recommend "interconception care" to reduce risks prior to any subsequent pregnancy.

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

- Increasing use of prenatal care early and often to screen for and address risk factors.
- Educating women about risks for pregnancy complications such as use of alcohol and drugs, tobacco, certain prescription drugs, sexually transmitted diseases, hypertension, and diabetes.
- Using interconception care to provide augmented services for 24 months to the highest-risk, lowest-income women who have had a low-birthweight or preterm birth or fetal/infant death.
- Eliminating elective deliveries prior to 39 weeks gestation (i.e., elective preterm deliveries).
- Eliminating smoking and exposure to secondhand smoke before and during pregnancy.
- Reducing stress and exposure to violence.
- Promoting proper nutrition and healthy weight before and during pregnancy.
- Eliminating pregnancies among younger teens.
- Using intensive, evidence-based home visiting for high-risk pregnant women.
- Promoting family planning and pregnancy spacing.
- Avoiding multiple births that result from assistive reproductive technology.
- Promoting health and reducing risks before and between pregnancies (known as preconception and interconception care).

How can we improve the trend in San Diego County?

The 2009 and 2011 Report Cards recommend development of an interconception care initiative. While this has not occurred, the Health and Human Services Agency partnered with the March of Dimes in 2008 to initiate its "*Preconception WHEELS*" (Working to Help Educate and Empower ***healthy*** Lifestyles) project, with a tool that has been used to educate more than 8,000 women. First 5 San Diego provided support for Text4Baby, a CDC-approved free text messaging health program, and 1,600 expecting/new San Diego mothers have enrolled. The California American Congress of Obstetrics and Gynecology (ACOG) released in October 2011 a new set of interconception care materials for providers and women.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with health providers, March of Dimes, Health and Human Services Agency, WIC, Red Cross, San Diego State University, First 5 San Diego, United Way of San Diego County, community-based organizations, and faith communities to:

1. Eliminate elective preterm deliveries prior to 39 weeks gestation for non-medical reasons.
2. Develop an interconception care initiative to provide augmented services for 24 months to the highest-risk women who have had a low-birthweight or preterm birth or fetal/infant death.
3. Train providers to use evidence-based smoking cessation programs, such as the National Cancer Institute's "4 A's" with pregnant women.

"For nearly all infants, breastfeeding is the best source of infant nutrition and immunologic protection, and it provides remarkable health benefits to mothers as well."

Regina Benjamin, M.D., U.S. Surgeon General

Birth to Age 3 (Infants and Toddlers): BREASTFEEDING

What is the indicator?

The percent of mothers who initiate breastfeeding of newborn in hospital.

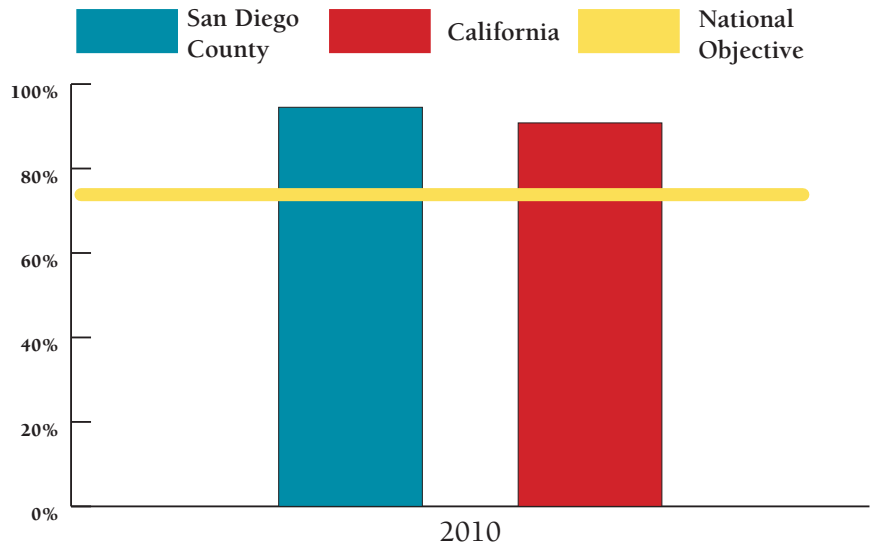
This indicator—the percent of mothers who initiate breastfeeding of newborn in hospital—estimates what proportion of infants receive breast milk. The data are collected on newborn screening forms and reported by the California Department of Health Services, including virtually all births in California (military hospitals and home births are excluded). National recommendations call for 6 to 12 months of breastfeeding, but data on continuation rates are available for only a small segment of the population.

Why is this important?

Breastfeeding is among the most effective and cost-effective preventive health practices. For children, it enhances immunity to disease and decreases the rate and severity of diarrhea, respiratory infections, and ear infections. Research shows that breastfeeding is correlated with improved brain development and is associated with reduced risk of childhood obesity. Breastfeeding also reduces lifelong risks for chronic health problems such as cardiovascular disease. Health benefits to the mother include reduced incidence of breast, ovarian, and uterine cancer; quicker recovery after pregnancy; and reduced loss of bone density. Lastly, lactating mothers miss less work due to child illness and incur fewer health costs.

How are we doing?

Percent of Mothers Who Initiate Breastfeeding of Newborn in Hospital, San Diego County and California Compared to National Objective, 2010



Due to changes on the form that is the source of data, a trend line cannot be shown for years 2008 to 2010. The San Diego rate in 2010 was better than the state average and the national objective.

What strategies can make a difference?

National, state, and local organizations have worked to increase public awareness of the importance of breastfeeding. Education is important, but not enough. Lack of workplace support remains a significant barrier to breastfeeding. On January 20, 2011, U.S. Surgeon General Regina M. Benjamin, M.D., released *The Surgeon General's Call to Action to Support Breastfeeding,* which builds upon provisions of the Affordable Care Act requiring employers to provide adequate and appropriate workplace accommodations. Specifically, the Fair Labor Standards Act was amended to require employers to provide reasonable, though unpaid, break time for a mother to express milk and a place, other than a restroom, that is private and clean where she can express her milk.

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

- Assuring that all birthing hospitals and centers encourage breastfeeding through programs such as the "Baby-Friendly Hospitals Initiative," which supports mothers in learning how to breastfeed and promotes exclusive use of breast milk.
- Enacting laws that protect breastfeeding in public and require workplace supports.
- Offering workplace breastfeeding support (e.g., breaks/flexible schedules, designated areas for milk expression, and options to safely store breast milk).
- Providing breastfeeding support and lactation education, resources, and warmlines/help desks, particularly from trained and experienced lactation consultants, home visitors, and/or nurses.
- Encouraging eligible families to use the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), which offers incentives and support for breastfeeding.
- Providing ongoing culturally informed education for mothers and health care providers.
- Using the Business Case for Breastfeeding national "toolkit," prepared by the U.S. Department of Health and Human Services.
- Limiting the marketing of breast milk substitutes (i.e., formula).

How can we improve the trend in San Diego County?

Building on previous Report Card recommendations, the Children's Initiative has distributed over 50 Business Case for Breastfeeding toolkits to local businesses, business associations, economic development corporations, and public serving agencies. Also in line with past recommendations, an additional San Diego birthing hospital has achieved Baby-Friendly certification: Kaiser Permanente. In tandem with changes in federal policy, California's Senate Bill 502, the Hospital Infant Feeding Act, mandates that all acute care and birthing hospitals develop, post, and practice an infant feeding policy, and provide either a breastfeeding consultant or a referral to one.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with health providers, local Chambers of Commerce, businesses and business associations, San Diego Workforce Partnership, WIC, First 5 San Diego, Health and Human Services Agency, Childhood Obesity Initiative, and health plans to:

1. Assist businesses in implementing the new federal law that requires appropriate and adequate space and break time for breastfeeding and provide businesses with the national toolkit, particularly where young and low-income women are employed.
2. Expand Baby-Friendly Hospital policies to all birthing hospitals and facilities throughout San Diego County.
3. Increase the availability of lactation support to all first-time mothers, both at home and work.

"When it comes to teens' decisions about sex, parents underestimate their own influence and overestimate the influence of others." *National Campaign to Prevent Teen Pregnancy*

Birth to Age 3 (Infants and Toddlers):
BIRTHS TO TEENS

What is the indicator?

The birth rate per 1,000 teens ages 15-17 years.

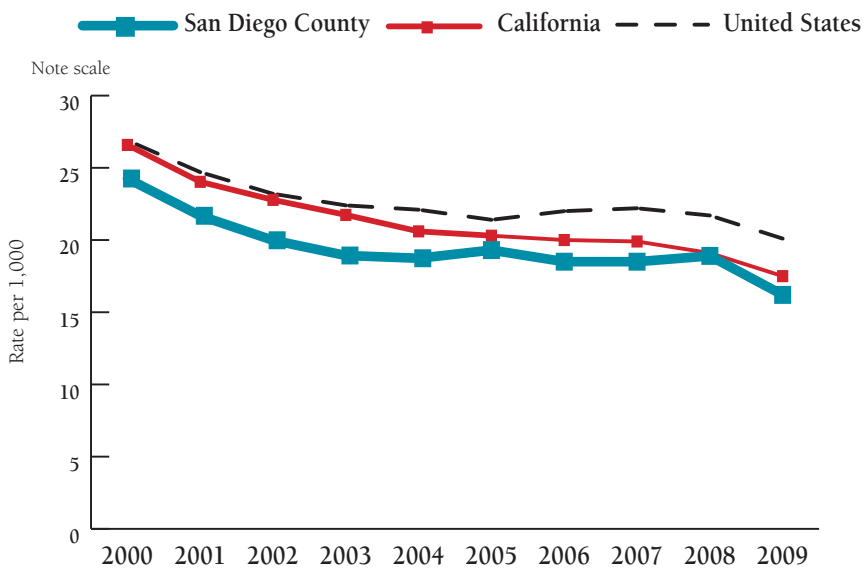
This indicator—the birth rate per 1,000 teens ages 15-17 years—monitors trends in teen births for teens ages 15-17. Reliable data are available annually from birth certificates and reported as part of local, state, and federal vital statistics. It is not possible to get reliable data on the number of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

Why is this important?

The United States has the highest teen pregnancy rate of any industrialized country. Teens are generally unprepared for the responsibility of pregnancy and parenting. They are less likely to obtain prenatal care and more likely to continue unhealthy behaviors, placing the baby at risk for future developmental and health problems. Teen parents are less likely to complete their education, and thus are at greater risk of earning below poverty incomes. Their babies are at greater risk for neglect and abuse. Teen parenthood places two generations at risk. A major concern is the number of adult-age males fathering children born to teens.

How are we doing?

**Birth Rate per 1,000 Teens Ages 15-17,
San Diego County, California, and United States, 2000-2009**



The trend is improving. After a period of decline, progress leveled off between 2003 and 2008. From 2008 to 2009, however, the rate in San Diego County dropped from 18.9 to 16.2 births per 1,000 teens ages 15-17. San Diego's rate remains better than state and U.S. averages.

What strategies can make a difference?

The CDC and the National Campaign to Prevent Teen and Unplanned Pregnancy have studied factors related to the trends. There is no single preventive intervention that is effective across the complex array of factors that underly teen pregnancy. Best practices must be broad based and across systems that include: comprehensive education, early prevention services and activities, age appropriate interventions, and teen and family support.

The following strategies have been used across the country to decrease teen births:

- Promoting positive family involvement, including supervision, goals, and expectations. Teens who report a good relationship with their parents are less likely to engage in sexual activity and other risky behaviors.
- Involving males in discussion and education; one of the most significant factors in the reduction of teen pregnancy is increased education and information for males.
- Providing access to comprehensive and confidential reproductive health services, including education about contraceptive methods and family planning services.
- Teaching comprehensive life skills and reproductive health education in schools through use of effective curriculum-based sex and STD/HIV education programs.
- Providing after school programs and activities to engage teens in the critical hours.
- Providing programs to engage youth during the summer and school holidays.
- Prioritizing groups at special risk and involving community members to increase cultural relevance.
- Encouraging teen parents to continue in school to help reduce subsequent pregnancies.

How can we improve the trend in San Diego County?

Nationally, the Affordable Care Act (the federal health reform legislation) provides new opportunities to improve teen health and prevent teen pregnancy including, in 2010, $100 million in grants to support evidence-based and innovative teen pregnancy prevention efforts and $33 million to states for the Abstinence Education Grant Program. Locally, federal funds have been granted to local efforts, including: $1,289,263 to San Diego Youth Services for teen pregnancy prevention and $372,340 to the San Diego Unified District Adolescent Pregnancy and Parenting Program (SANDAPP). SANDAPP provided case management and counseling to 1,460 pregnant and parenting teens during school year 2010-11. While the national rate of repeat teen pregnancies is estimated at 20%, the rate for teens served for a year or more by SANDAPP is only 1.8%.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with parents and parent organizations, schools and school districts, teen pregnancy prevention programs, Health and Human Services Agency, First 5 San Diego, SANDAPP, health providers, community-based organizations, and California Health and Human Services Agency to:

1. Apply for new federal resources available under the Affordable Care Act, through either state or federal competitive grant offerings.
2. Increase parent-to-teen communication using effective programs and strategies such as Plain Talk/Hablando Claro from the Annie E. Casey Foundation and scripts from the National Campaign to Prevent Teen and Unplanned Pregnancy .
3. Expand health services that counsel teens regarding abstinence and contraception to help teens to make safe and healthy choices.

"Vaccines...not only help protect vaccinated individuals, but also help protect entire communities by preventing and reducing the spread of infectious diseases."

Centers for Disease Control and Prevention

Ages 3–6 (Preschool): IMMUNIZATION

What is the indicator?

The percent of young children (ages 19-36 months) who completed the basic immunization series (4:3:1:3:3:1).

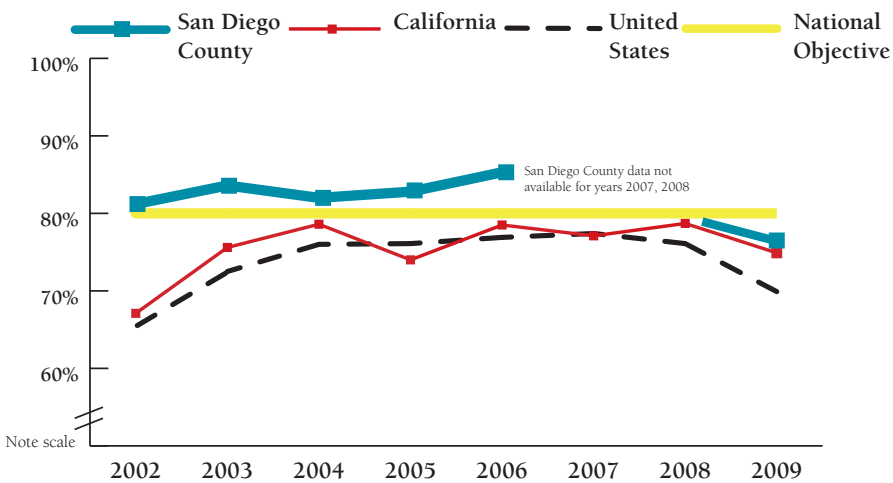
The childhood immunization indicator is the percent of young children (ages 19-36 months) who have received the current basic recommended childhood immunization series. While the basic series of vaccines are due by age 24 months, no data exist to track for children precisely that age. These data are collected from the Immunization Survey conducted every third year by the County of San Diego Health and Human Services Agency Immunization Branch.

Why is this important?

Childhood immunizations are highly effective and cost-effective. They save millions of lives each year. A cost-benefit analysis by the CDC demonstrated that every dollar spent on immunization saves $6.30 in direct medical costs. Prior success was the result of a massive public/private partnership involving researchers, policy makers, vaccine manufacturers, public and private health professionals who administer vaccines, and, of course, families who voluntarily participate in immunization programs. After years of steady improvement, however, our national rate of children receiving even the most basic series of vaccinations (4:3:1:3) has remained almost unchanged since 2003.

How are we doing?

Percent of Young Children (Ages 19-36 months) Who Completed the Basic Immunization Series, San Diego County, California, United States, and National Objective, 2002-2009



The trend is moving in the wrong direction. Between 2006 and 2009, the rate of San Diego County children receiving the basic recommended series of immunizations declined from 85% to 77%. County performance fell below the national objective, although still above declining state and U.S. averages.

What strategies can make a difference?

Maintaining immunization rates needed to achieve "herd" immunity for the whole population is key to preventing disease and protecting the more vulnerable (e.g., infants not yet immunized, individuals with compromised immune systems). Achieving high immunization rates for each new cohort of children requires awareness, acceptance, financing, and access. San Diego has been affected by levels of unimmunized and under-immunized children. In 2008, San Diego experienced the largest outbreak of measles since a 1991 epidemic—traced to one voluntarily unimmunized child. In 2010, San Diego underwent the worst outbreak of pertussis (whooping cough) in 60 years, with over 1,100 cases.

The following strategies have been used across the country to increase immunization rates:

- Assuring an adequate supply of affordable vaccine. For the basic early childhood series, this has largely been accomplished through the federal Vaccines for Children (VFC) program.
- Educating health providers and parents about the importance and acceptability of giving vaccines, even if a child is mildly ill or at an office visit that is not a well-child visit.
- Providing access to vaccines through pediatricians, family physicians, local health departments, community clinics, and other locations.
- Using immunization registries to monitor who is up-to-date or has missed a vaccination.
- Reaching out and providing support and information for families whose children are not up-to-date for recommended vaccines.
- Prioritizing groups at special risk, including families who refuse immunizations and those with less access.
- Using community-wide campaigns and education to inform parents about the importance of immunizing "every child by two" and the continued risk of vaccine-preventable disease.
- Supporting providers with quality improvement projects such as AFIX (Assessment, Feedback, Incentives and eXchange), a nationally recommended quality improvement strategy.
- Protecting providers who deliver vaccines from excessive liability costs and concerns by continuing the National Vaccine Injury Compensation Program.

How can we improve the trend in San Diego County?

San Diego has multiple programs that align with Report Card recommendations. The San Diego Immunization Coalition works to educate parents and providers about the importance of vaccination. The Health and Human Services Agency offers programs to improve provider practices and encourages schools and health and child care providers to use the web-based Immunization Registry. The San Diego Health Professionals Immunization Initiative develops educational resources and works to improve immunization rates.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with the San Diego Immunization Coalition, American Academy of Pediatrics, Health and Human Services Agency, First 5 San Diego, parents and parent organizations, health providers, community-based organizations, faith communities, and 211 to:

1. Partner with First 5 San Diego and HHSA to expand the community-wide campaign to inform parents and caregivers about the importance of immunization, particularly those who refuse immunizations, have less access, and/or are not up-to-date.
2. Educate health providers and parents about giving vaccines, even at times when a child is mildly ill or at an office visit that is not a well child visit.
3. Encourage all providers to participate in the immunization registry system, which helps identify children who have missed vaccinations.

"In short, high-quality preschool programs offer societal benefits that far outweigh program costs by improving later education, employment, earnings, and crime outcomes of students who attend preschool." *Committee for Economic Development*

Ages 3–6 (Preschool): EARLY CARE AND EDUCATION

What is the indicator?

The percent of children ages 3-4 enrolled in early care and education.

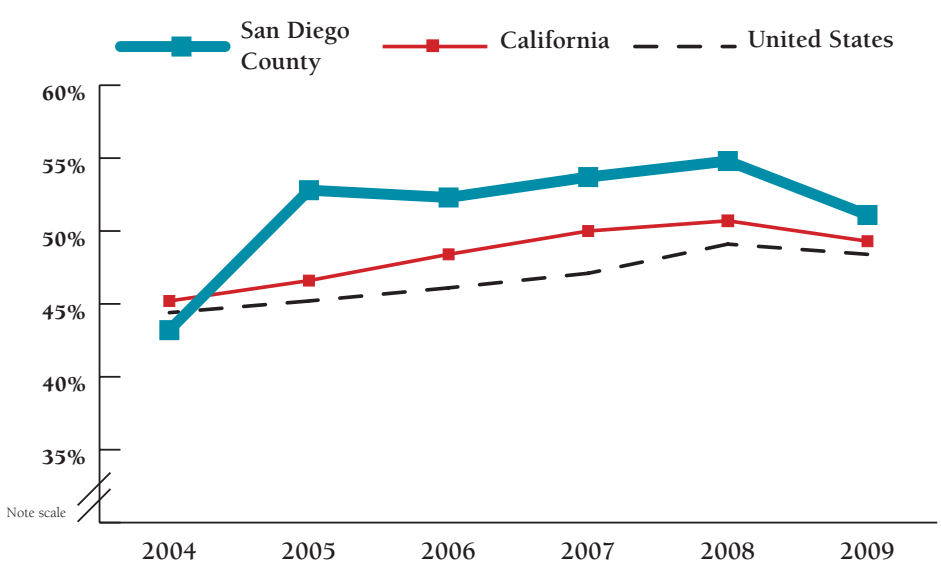
This indicator—the percent of children ages 3-4 enrolled in early care and education—shows trends in early childhood care and education for our county's preschool age children who are regularly attending an out-of-home and non-relative early care and education setting. This setting may be a child care center, family child care setting (licensed or unlicensed), preschool, or Head Start program. The data is routinely gathered and reported by the U.S. Census Bureau American Communities Survey.

Why is this important?

Research tells us that to assure health and development we must provide nurturing and enriching from before birth through childhood. Early childhood care and education in a quality setting (including child care, preschool, Head Start, etc.) can improve the school readiness and overall development of young children, as well as education and employment outcomes throughout life. Thus, quality early care and education from birth to five years can not only help a child, but also produce economic benefits to society that far exceed the initial investment. The greatest cost benefit is through investments in low-income children.

How are we doing?

Percent of Children Ages 3-4 Enrolled in Early Care and Education, San Diego County, California, and United States, 2004-2009



The trend is not improving. At 51%, the rate of San Diego children enrolled in early care and education declined in 2009 although it remains slightly above state (49%) and U.S. average (48%) levels.

What strategies can make a difference?

Efforts are aimed at assuring every child has an early care and education experience that fits their family's needs. While parents are a child's first teacher, most children spend a large proportion of their early years in the care of others. Early care and education includes child care, preschool/pre-kindergarten, and Head Start. Research over the past three decades shows that children in high quality early care and learning environments gain more advanced language, school readiness, and better social skills. For example, a RAND study estimated that high-quality universal preschool for 4-year-olds in San Diego could result in: 1,000 fewer children retained a grade; 4,600 fewer child years of special education; 730 fewer dropouts; and 2,150 fewer juvenile petitions.

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

- Providing child care subsidies for low-income families to assure access to quality services.
- Offering child care resource and referral lines or centers that assist families in finding services that meet their needs.
- Implementing quality rating systems to give families information to identify quality programs.
- Adopting teacher training and credentialing standards associated with quality.
- Increasing access to and quality of infant and toddler care.
- Increasing access to quality preschool or pre-kindergarten (pre-K) programs and Head Start, which have been shown to provide a boost in skills for children ages 3 to 5.
- Providing technical assistance to family day care centers to insure good quality care and financial sustainability.
- Training and deploying child care health and mental health consultants to provide supportive services to children in early care and education settings.
- Assuring a comprehensive early childhood system that offers parents varied options.

How can we improve the trend in San Diego County?

San Diego has implemented two of our former and current recommendations for early care and education. To improve the quality of care and education through increased and improved training opportunities for early childhood providers, San Diego State University now offers a Child and Family Development certificate program based on statewide competency standards. Providing more physical and mental health support for preschool children and programs, First 5 San Diego funded KidSTART to insure that comprehensive assessment, referral, and treatment is provided for children with significant developmental, social, emotional, and physical health issues. (This effort also supports a *Live Well, San Diego!* strategy.)

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with First 5 San Diego, Child Care and Development Planning Council, child care resource and referral agencies, early care and education providers, community colleges and universities, faith communities, Health and Human Services Agency, mental health service providers, businesses, and municipalities to:

1. Increase the amount of available child care subsidies so that more low-income and working poor families have access to quality child care, particularly for infants and toddlers.
2. Improve the quality of child care by providing more training opportunities and support for child care providers, as well as facility improvements and educational materials.
3. Train and fund more health and mental health consultants to provide services to improve the quality of early care and education settings.

"Good health requires good oral health, yet millions of Americans lack access to basic oral health care." *Institute of Medicine*

Ages 6–12 (School Age): ORAL HEALTH

What is the indicator?

The percent of children ages 2-11 who have never visited a dentist.

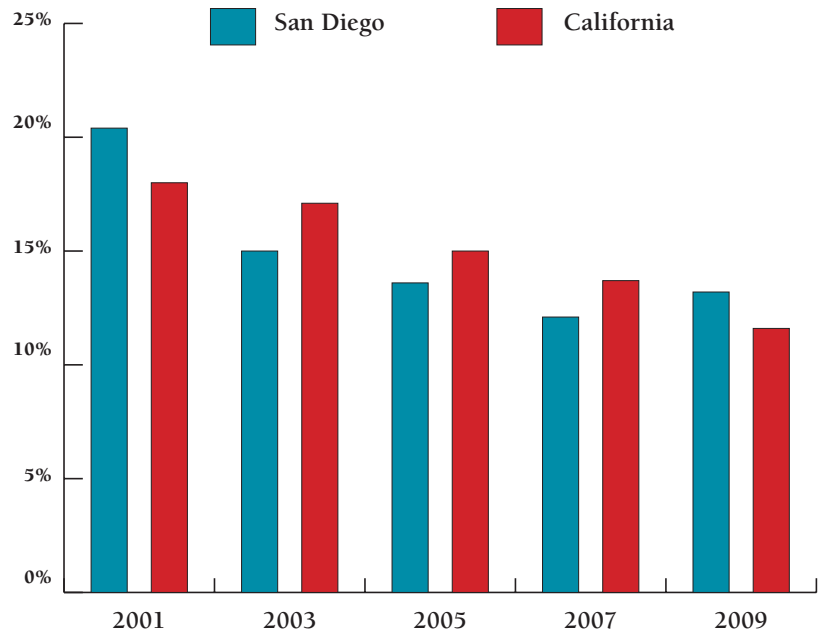
The indicator for oral health is the percent of children ages 2-11 who have never visited a dentist. This age range represents the most important years to prevent and treat dental disease and decay. National recommendations from dentists and pediatricians call for dental care to start at 12 months, and the California Child Health and Disability Prevention (CHDP) program recommends referrals to a dentist at age one. These data are routinely reported in the California Health Interview Survey.

Why is this important?

One-quarter of U.S. children—mostly poor, minority, and/or with special health care needs—experience 80% of all decayed teeth. Even decayed "baby" teeth affect child health and adult teeth. Dental caries (the disease that causes cavities and tooth decay) is the single most common chronic disease of childhood. Children with untreated cavities often live with chronic pain, which affects concentration, school achievement, mood, sleep, nutrition, and even play. By age 17, more than 7% of U.S. children have lost a permanent tooth to tooth decay. Routine and preventive dental care is essential to: 1) educate families, 2) apply protection such as fluoride treatments and sealants, and 3) provide intervention for dental caries.

How are we doing?

Percent of Children Ages 2-11 Who Had Never Visited a Dentist, San Diego County and California, 2001, 2003, 2005, 2007, and 2009



The trend is not improving, making no real gain between 2005 and 2009. In 2009, the proportion of San Diego County children age 2-11 who had never been to a dentist (13.2%) was worse than the state average (11.6%) for the first time since 2001.

What strategies can make a difference?

Dental care is important for assuring good health. Experts tell us that the key elements for assuring optimal oral health in children 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" beginning at age 1. Many prevention strategies work best when started with infants and toddlers; starting with school age children is often too late.

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

- Increasing children's coverage for dental services, particularly through Medicaid/Medi-Cal and Healthy Families/Children's Health Insurance Program (CHIP).
- Increasing 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.)
- Expanding access to dental services in low-income and underserved communities (e.g., dental services in community clinics, mobile dental clinics).
- Increasing effective use of primary health care providers (e.g., pediatricians), early childhood education, and community-based organizations to educate parents about the importance of oral health and how to screen children for oral health problems.
- Assuring community water fluoridation.
- Assuring access to preventive services, including sealants and fluoride varnish.
- Implementing health promotion campaigns that increase families' awareness of the importance of brushing and flossing (from infancy), as well as preventive dental visits.

How can we improve the trend in San Diego County?

San Diego has made strides in the implementation of Report Card recommendations. First 5 San Diego has championed water fluoridation expansion in San Diego, with 83% of our water districts fluoridating or soon to fluoridate water. Capacity for low-income and Medi-Cal children has also been expanded through the First 5 San Diego Oral Health Initiative, which funds services at 21 dental clinics and health clinics. The Oral Health Initiative also developed an award-winning "Good Start" media campaign to educate parents. Additionally, the La Maestra Family Clinic was awarded funds from the Affordable Care Act to purchase and operate a dental van to screen and treat children at school campuses in National City, El Cajon, and City Heights.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with the First 5 San Diego Oral Health Initiative, Share the Care, Dental Health Initiative, Health and Human Services Agency, dental and pediatric professionals, parents and parent organizations, community clinics, faith communities, schools, and local media partners to:

1. Encourage each dental provider to accept as new patients five children with Medi-Cal coverage and become their dental home.
2. Offer oral health prevention and screening services in schools and other early educational settings. This builds on the state law (California Education Code Section 49452.8) requiring oral health assessment at kindergarten.
3. Provide training to primary health care providers and early childhood education providers on how to educate parents about the importance of oral health and how to screen children for oral health problems.

"Students who are frequently absent fall behind in academics and miss important concepts that enhance their ability to understand...or, ultimately, plan for the future."

California Department of Education

Ages 6–12 (School Age): SCHOOL ATTENDANCE

What is the indicator?

The percent of elementary school (K-5) students who did not attend school at least 95% of school days.

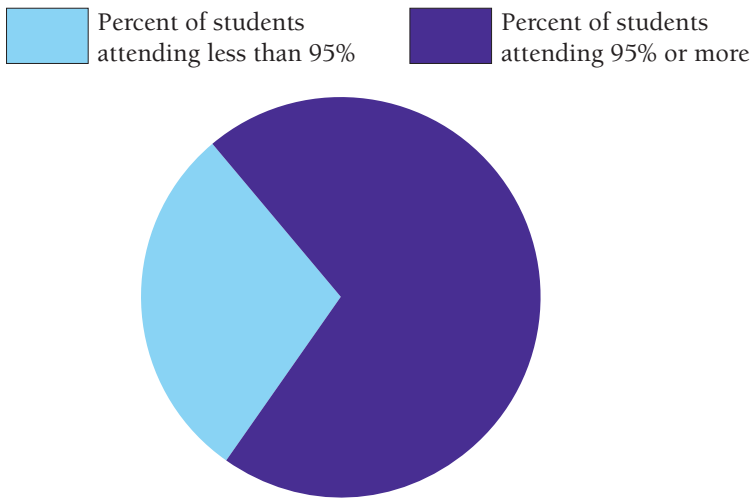
This indicator—the percent of elementary school (K-5) students who did not attend school at least 95% of school days—monitors school attendance based on 95% attendance on the Second Principal Apportionment (P2) reporting date of each district's school year. It includes students who are absent approximately nine days of the school year, for any reason. These data include school districts representing 98% of the student population. Note, this is not average daily attendance.

Why is this important?

School attendance is one of the strongest predictors of school success or failure. Students in elementary school are learning the basic reading, writing, math, reasoning, social, and study skills that are critical to success and fulfillment in the higher grades. Chronic absence as early as kindergarten can lead to deficits in later school achievement and reduced chances of graduation. Whether children miss school as a result of illness, family vacations, or truancy, missing too many days of school affects: the student who must catch up on missed learning, the teacher who must re-teach the material, and the other students whose educational progress is slowed as a result.

How are we doing?

Percent of Elementary School Students (Grades K-5) Who Did Not Attend at Least 95% of School Days, School Year 2010-11



The trend is not improving. In San Diego County, the percent of students in grades K-5 attending less than 95% of school days increased from 25% in school year 2008-09 to 29% in 2010-11.

What strategies can make a difference?

A child's attendance at school may be affected by many factors, such as illness, transportation problems, child care, and parent illness. To address frequent absences and truancies, schools, parents, community prevention and intervention providers, and law enforcement must work together to develop policies, services, and programs that support families.

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

- Creating a school climate and practices that promote parent and family involvement.
- Increasing parent and community awareness of the importance of regular attendance through education, outreach, and publicity.
- Developing accurate and daily monitoring of attendance, with feedback to parents (e.g., using multiple languages, the Internet, e-mail, and other forms of communication).
- Developing and implementing sound, reasonable, and well-communicated attendance policies and practices.
- Providing positive reinforcement practices such as parent/student commendation letters and attendance recognition events.
- Providing acknowledgment for small improvements (e.g., front-of-line privileges at lunch, extra computer time at school).
- Providing early interventions that address the specific cause of absenteeism, and involve families as partners.
- Keeping the students safe and supported at school and on their way to and from—in particular, implementing evidence-based anti-bullying programs on a sustained basis.
- Targeting interventions for students with chronic attendance problems.
- Linking 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?

Building on previous Report Card recommendations for improving attendance, San Diego Unified School District developed a data dashboard that allows administrators to quickly identify at-risk students by instantly accessing attendance statistics. In the last several years, Cajon Valley and San Ysidro School Districts have also increased efforts to monitor rates of chronic absence at the school site level and have made attendance improvement a district strategic goal. Julian Elementary District has implemented a very comprehensive and supportive set of attendance improvement strategies that have nearly eliminated chronic absenteeism at the elementary level.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with schools and school districts, San Diego County Office of Education, California Department of Education, families, parents and parent associations, businesses, Health and Human Services Agency, United Way of San Diego County, community-based organizations, and local media partners to:

1. Develop parent-school partnerships to increase communication, connection to school, and parent and family involvement.
2. Develop and implement effective school policies and practices related to attendance (e.g., collect and review attendance data, identify students who are absent, and take action).
3. Connect families to community resources to reduce barriers to attendance.

Data to Action for Improving Attendance

In 2008, the Children's Initiative launched a ground-breaking project to address chronic absenteeism in San Diego County. The goal of the project was to reduce chronic absenteeism at schools with the highest rates of students missing too much school. The "Data to Action: Improving Attendance" project used Report Card attendance data to identify and assist local elementary school districts with more than 30 percent of grade K-5 students missing nine or more school days per year.

The Children's Initiative identified eight local school districts who agreed to be partners in this project, with each district selecting a single elementary school with a high rate of absenteeism to serve as a pilot site. Using Results Based Accountability principles, the project started by gathering additional data and engaging stakeholders to gain a deeper level of understanding about the problem. First, key school staff were interviewed to assess attendance procedures and practices in place and understand factors impacting attendance rates. Following that, focus groups were conducted with parents of poor attenders to gain the family perspective on barriers and needed resources. Research was conducted to identify national and local best practices in attendance improvement with a local team of education and health experts guiding the project.

Once the relevant data and information was in hand, the project team synthesized the information into specific attendance improvement toolkits customized for the needs, barriers, and assets at each school. Project staff provided technical assistance throughout the school year, working with the schools and districts to develop an intervention plan with policies and practices to improve attendance. The strategic approaches fell into four main categories: 1) improving school and district policies and practices, 2) supporting positive student motivation and behavior, 3) improving communication and partnership between families and schools, and 4) reducing the impact of circumstantial barriers on regular attendance.

The results of this project are promising and clearly demonstrate that chronic absence is a problem with a solution. Project districts that chose to incorporate policies and practices to improve attendance have reported better attendance rates. All schools in the project reduced their rates of chronic absence, and some made major gains. For example, several schools reduced the rate of chronic absenteeism by half in three years, and one school has virtually eliminated the problem. All pilot project schools report improved student motivation and increased partnerships with families.

"Education is the most powerful weapon which you can use to change the world."

Nelson Mandela

Ages 6–12 (School Age):

SCHOOL ACHIEVEMENT GRADE 3

What is the indicator?

The percent of students in grade 3 scoring proficient or advanced on the English-Language Arts achievement test.

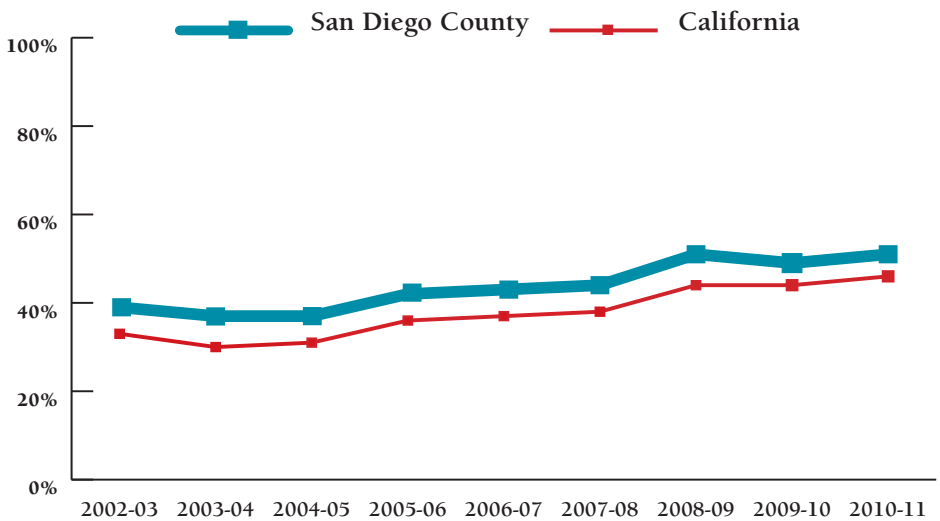
This indicator—the percent of students in grade 3 scoring proficient or advanced on the English-Language Arts achievement test—measures students' scores on the English-Language Arts test of the annual California Standardized Testing and Reporting (STAR) program. Administered annually to students in grades 2 through 11, STAR covers multiple subjects including English, Mathematics, Science, and History. These data are routinely reported by the California Department of Education.

Why is this important?

Performance on the English-Language Arts test is widely accepted as the best predictor of school achievement overall, in part because mastery of language skills is a critical foundation to understanding information taught about other subjects. Early attainment of basic literacy skills is critical. In the primary grades, children are learning to read; but from that point on, they must read to learn. Moreover, poor readers are missing content learning that hinders them from learning other subjects. A child who does not master the basic skills does not have the foundation for future success.

How are we doing?

Percent of Students in Grade 3 Scoring Proficient or Advanced in English-Language Arts Test, San Diego County and California, School Years 2002-03 to 2010-11



The trend for achievement in English-language arts for third graders is maintaining. Between 2002-03 and 2008-09, the trend improved substantially (from 39% to 51%), then leveled off from 2008-09 to 2010-11, showing no improvement for these two school years. Some racial/ethnic groups had improvement; however, disparities continue to exist.

What strategies can make a difference?

The best approach to instilling language arts and other reading skills is to begin learning experiences early and to incorporate literacy and reading skills into all areas of a child's life.

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

- Assessing children at school entry and in the early grades to identify those in need of additional supports and remedial reading education skills.
- Targeting services for parents of young children who do not speak English or who speak English as a second language.
- Offering intensive English-language arts instruction including: phonics based instruction, word/language study, small group instruction, and use of interesting and relevant reading materials. This is particularly important before grade 3.
- Accessing Supplemental Educational Services (SES) that provide free tutoring to children who require special assistance to succeed in school.
- Developing appropriate intervention programs, including before and after school, summer, and in-school reading support.
- Providing mentors and tutors immediately for children who have started to fall behind.
- Promoting independent reading and writing—at home and at school.
- Supporting reading across the curriculum in schools.
- Expanding the use of special programs that support early childhood and family literacy, such as Raising A Reader or Reach Out and Read, Parents as Teachers.
- Ensuring professional development for teachers (e.g., Peer Assisted Learning Strategies).
- Using teaching strategies that are culturally and linguistically appropriate, including opportunities for students to share their cultural heritage and life experiences.
- Limiting time with television and video games.

How can we improve the trend in San Diego County?

Aligning with 2009 and 2011 Report Card recommendations to provide reading assistance to students, the County Office of Education received a grant from Target to include Migrant Education students in the Everyone a Reader tutoring program. The program currently serves 100 primary grade students located in Fallbrook, Escondido, and Vista. Additionally, in support of previous Report Card recommendations to support early childhood and family literacy, in 2011 United Way San Diego in partnership with the Union-Tribune and the County Office of Education launched a "Volunteer for Education" campaign, challenging San Diegans to volunteer as readers, mentors, and tutors to young students. The goal over the next three years is to recruit 10,000 volunteers.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with schools and school districts, San Diego County Office of Education, California Department of Education, First 5 San Diego, parents and parent associations, United Way of San Diego County, Union-Tribune, literacy and reading support organizations, libraries, and San Diego Council on Literacy to:

1. Implement a single, standardized, county-wide kindergarten entrance assessment of school readiness.
2. Develop an individualized plan to begin immediate intervention when a child lacks basic pre-reading and reading related skills, including use of special reading programs.
3. Promote and assure access to the Supplemental Educational Services (SES) program, which provides free tutoring to children who need additional support.

"Today, one in three American children is either overweight or obese… too many of our children are... on track to lead shorter lives than their parents." ***First Lady Michelle Obama***

Ages 6–12 (School Age): OBESITY

What is the indicator?

The percent of students not in the Healthy Fitness Zone in grades 5, 7, and 9.

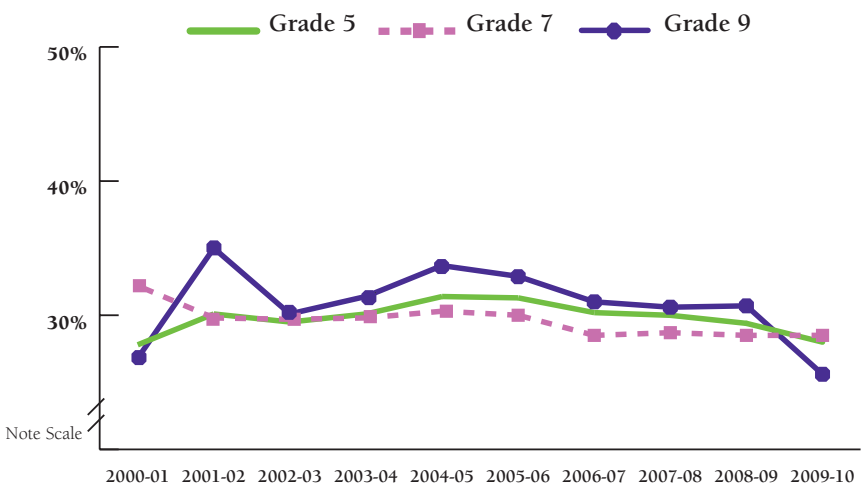
This indicator—the percent of students not in the Healthy Fitness Zone in grades 5, 7, and 9—measures overweight and/or obesity. The California Fitness Exam is a test of physical fitness given to students in grades 5, 7, and 9 every year, and it assesses the "Healthy Fitness Zone." This indicator uses components of the test that measure body composition and body mass index (BMI). Students who score outside the upper end of a specified range are not in the Healthy Fitness Zone. These data are routinely reported by the California Department of Education.

Why is this important?

Being over healthy weight can have short and long term consequences for children's health and well-being. A recent study found that 80% of children who were overweight at ages 10-15 were obese by the age of 25, as well as at increased risk for high blood pressure, high cholesterol, and Type 2 diabetes. In addition to the physical health risks, many overweight and obese children experience social discrimination and bullying. The CDC predicts that one in three of today's children will develop diabetes in his or her lifetime as a result of obesity and overweight.

How are we doing?

Percent of Students Not in Healthy Fitness Zone, Grades 5, 7, and 9, San Diego County, School Years 2000-01 to 2009-10



The trend is improving. The proportion of students not in the Healthy Fitness Zone for body composition or body mass index (BMI) in grades 5, 7, and 9 gradually declined from 2004-05 to 2009-10. Ninth graders made the most progress, with a decline of 24%. San Diego County rates remain far from the 2010 national objective of 5%.

What strategies can make a difference?

Across the country, communities are taking action to achieve healthy weight among children, aiming to increase access to nutritious food, improve the physical environment, and modify social norms.

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

- Increasing rates of breastfeeding.
- Increasing healthy nutrition education and services to children and their parents.
- Expanding the availability and affordability of fresh fruits and vegetables in schools at all grades and in low-income neighborhoods.
- Promoting the availability of farmer's markets, farm-to-school programs, community gardens, and similar projects in low-income communities.
- Using fitness and weight assessments starting at kindergarten, with interventions as needed.
- Increasing routine physical activity for children in and out of school, including options for children with disabilities.
- Providing extended hours and nighttime lights and security at public parks, sporting complexes, school fields, and community recreation centers.
- Encouraging smaller portion size options in schools and other public settings.
- Reducing access in schools and other public places to soft drinks, candy, and other foods and drinks high in sugar and calories, while low in nutrition.
- Requiring that public vending machines and snack bars have nutritious selections.
- Encouraging eligible families to participate in WIC, which now provides healthier foods.
- Encouraging eligible families to participate in the Supplemental Nutrition Assistance Program (SNAP, known as CalFresh in California) in order to secure and use Food Stamps.

How can we improve the trend in San Diego County?

Aligning with prior Report Card recommendations, the San Diego Obesity Initiative garnered national attention for its trendsetting strategies. Recent efforts include: "healthy" redevelopment projects in low-resource neighborhoods; health care providers to incorporate obesity prevention into their practices; and a Farm-to-School program that makes locally grown fresh produce more available to students. The Health and Human Services Agency partnered with the International Rescue Committee on the Fresh Fund program, using federal dollars to match funds that families enrolled in WIC, SSI, and CalFresh spend on produce. School districts have also supported Report Card recommendations to combat obesity by improving wellness policies. For example, Chula Vista Elementary School District partnered with the Health and Human Services Agency to conduct a BMI assessment of students to determine the rate of overweight and obesity in their district. San Diego Unified, Cajon Valley, and National City School Districts are piloting new strategies for serving free, nutritional breakfast in schools.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with the San Diego County Childhood Obesity Initiative, Health and Human Services Agency, First 5 San Diego, parents and parent organizations, schools and school districts, 211, municipalities, community-based organizations, neighborhood associations, local farmers, food banks, San Diego Hunger Coalition, Feeding America, local businesses, and faith communities to:

1. Promote physical activity and healthy eating habits through schools, community clinics, WIC centers, early care and education settings, and community centers.
2. Encourage eligible families to participate in WIC to improve child nutrition starting at birth.
3. Promote and increase the number of community/school gardens and farmer's markets to increase access to fresh fruits and vegetables.

"Regular school attendance is a necessary part of the learning process and the means to graduation with a good education." *California Department of Education*

Ages 13–18 (Adolescence): SCHOOL ATTENDANCE

What is the indicator?

The percent of middle and high school students (grades 6-12) who did not attend school at least 90 percent of school days.

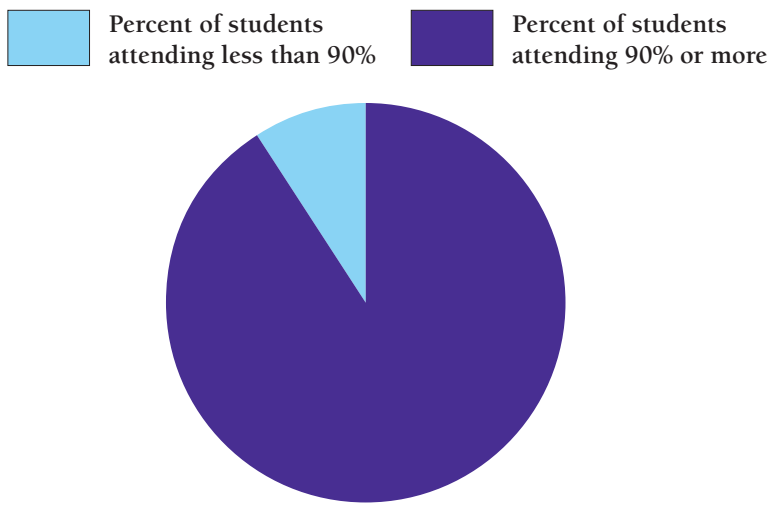
This indicator—the percent of middle and high school students who did not attend school at least 90 percent of school days—monitors school attendance based on 90 percent attendance on the Second Principal Apportionment (P2) reporting date of each district's school year. It includes students who are absent approximately 18 days of the school year, for any reason. These data include school districts representing 98% of the student population. Note, this is not average daily attendance.

Why is this important?

School attendance is a very strong predictor of school success. Students who attend school 90 percent of the time have a much better chance of academic success, and academic success is strongly correlated with better employment and higher earnings. Students who attend regularly have stronger social relationships and connectedness to school. Chronically poor attendance is associated with lower achievement, lower test scores, literacy problems, dropout, and delinquent behavior. Poor attendance is not just truancy-related. Whether children miss school as a result of illness, family vacations, or substance abuse problems, missing too many days of school directly affects learning and life.

How are we doing?

Percent of Middle and High School Students (Grades 6-12) Who Did Not Attend at Least 90% of School Days, School Year 2010-11



In San Diego County, the percent of students in grades 6-12 attending less than 90 percent of school days is maintaining with 9% in school year 2010-11.

What strategies can make a difference?

To address attendance issues with middle and high school students we must bring together schools, parents, community providers, and law enforcement to develop policies, services, programs, and support that focus on both prevention and intervention services.

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

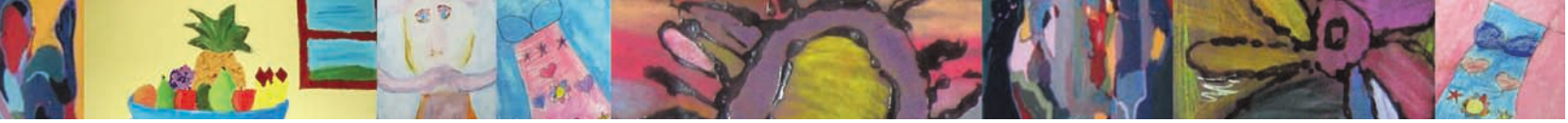
- Creating a school climate and practices that promote parents as partners in education.
- Increasing parent and community awareness of the importance of regular attendance through education, outreach, and publicity.
- Developing accurate and daily monitoring of attendance, with feedback to parents (e.g., using multiple languages, the Internet, e-mail, and other forms of communication).
- Implementing sound, reasonable, and well-communicated attendance policies.
- Providing positive reinforcement such as commendation letters and attendance recognition.
- Providing early interventions that address the specific cause of absenteeism, such as parent involvement, tutoring, credit recovery, mentoring, and connection to support resources.
- Keeping students successful and engaged in learning through targeted interventions such as career academies; service learning; school-to-work programs; and college, career, and technical education programs.
- Keeping the students safe and supported at school and with social media—in particular, implementing evidence-based anti-bullying and anti-cyber-bullying strategies.
- Providing after school programs and activities to engage teens in the critical hours.
- Building linkages between schools, mental health providers, and law enforcement.

How can we improve the trend in San Diego County?

In line with past and current Report Card recommendations, San Diego Unified School District created the Dropout Prevention Office, a dedicated department to implement policies and to provide ongoing support to high schools, such as developing an attendance recognition and incentive program for ninth grade students. This Office also implemented Project Recovery to identify, locate, and recover high school age students who have not returned to school. Grossmont High School District takes action through several innovative programs including home visits by dropout prevention specialists, targeted intervention in the freshman year, providing a fifth year of school with supports to insure graduation, and placing a Family Resource Center on every campus.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with schools and school districts, San Diego County Office of Education, California Department of Education, San Diego Workforce Partnership, parents and parent associations, local businesses, law enforcement agencies, Probation Department, and community-based organizations to:

1. Develop parent-school partnerships to increase communication, connection to school, and parent and family involvement.
2. Develop and implement effective school policies and practices related to attendance (e.g., collect and review attendance data, identify students who are absent, and take action).
3. Increase the availability of service learning; school to work opportunities; and college, career, and technical education programs.



"Our progress as a nation can be no swifter than our progress in education. The human mind is our fundamental resource." ***President John F. Kennedy***

Ages 13–18 (Adolescence):

SCHOOL ACHIEVEMENT GRADES 8 AND 11

What is the indicator?

The percent of students in grades 8 and 11 scoring proficient or advanced on the English-Language Arts achievement test.

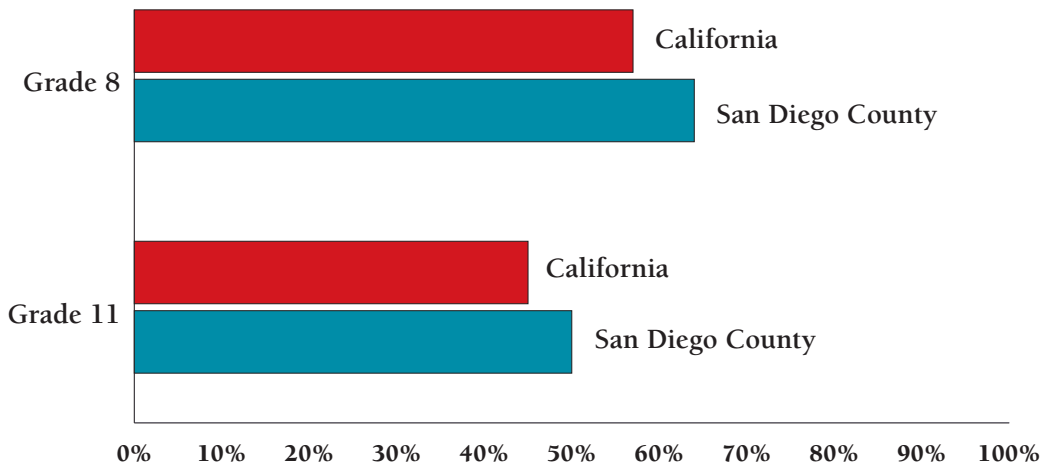
This indicator—the percent of students in grades 8 and 11 scoring proficient or advanced on the English-Language Arts achievement test—measures students' scores on the English-Language Arts test of the annual California Standardized Testing and Reporting (STAR) program. Administered annually to students in grades 2 through 11, STAR covers multiple subjects including English, Mathematics, Science, and History. These data are routinely reported by the California Department of Education.

Why is this important?

English-language arts skills (e.g., reading and writing) are a top predictor of school achievement, and low literacy is one of the greatest predictors of not finishing school. School success is a critical predictor of good outcomes in many vital areas of life. High school achievement is associated with positive self-image, resistance to delinquency, increased likelihood of graduation and college attendance, and higher earnings. Poor English-language arts and reading skills are correlated with unemployment and poverty as an adult. Currently, the 25 fastest growing U.S. careers have the highest literacy demands. Nationally, while reading levels have risen for primary grades, results for older students have stagnated.

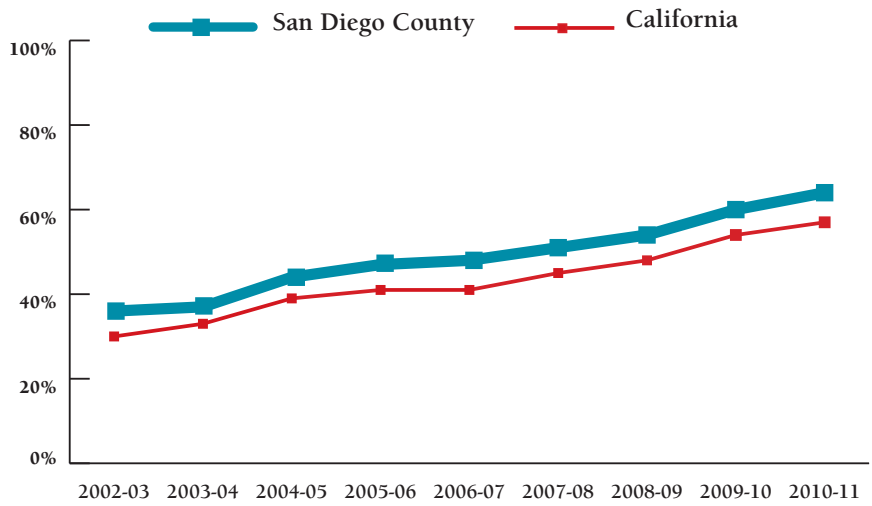
How are we doing?

Percent of Students Scoring Proficient or Advanced in English-Language Arts Test, Grades 8 and 11, San Diego County and California, School Year 2010-11



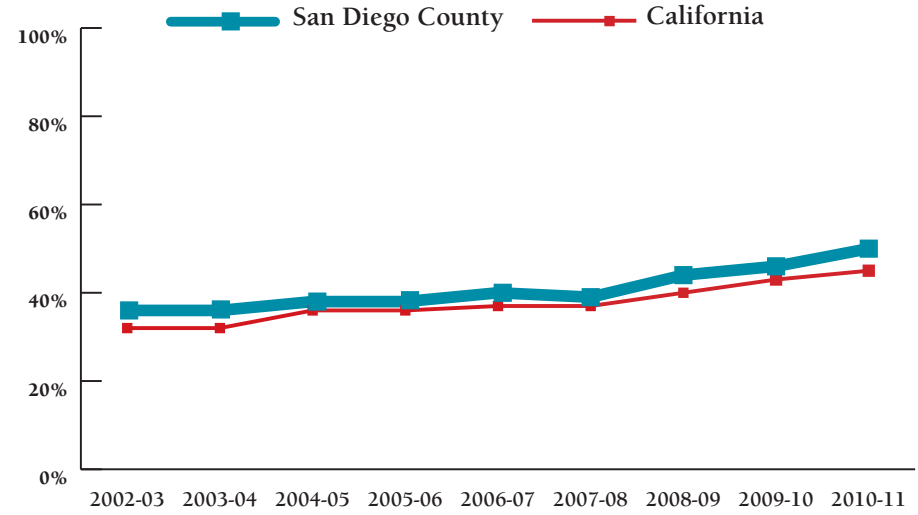
The trend is improving. However, proficiency is higher for younger than for older students. While 64% of 8th graders are high performers, only half of 11th graders scored proficient or above in English-language arts. San Diego student scores remain higher than the state rates.

Percent of Students Scoring Proficient or Advanced in English-Language Arts Test, Grade 8, San Diego County and California, School Years 2002-03 to 2010-11



The trend has improved substantially, going from 36% to 64% for 8th graders between school years 2002-03 and 2010-11. San Diego County students consistently perform better than the state average.

Percent of Students Scoring Proficient or Advanced in English-Language Arts Test, Grade 11, San Diego County and California, School Years 2002-03 to 2010-11



The trend for San Diego County students is improving steadily, going from 36% to 50% for 11th graders between school years 2002-03 and 2010-11.

What strategies can make a difference?

As students enter middle and high school, feeling successful at and connected to school becomes increasingly important for staying in school and graduating. Identifying and intervening for learning and achievement problems are critical in upper grades.

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

- Expanding and targeting supportive services to underperforming students (e.g., reading specialists, tutors, one-to-one instruction).
- Evaluating and addressing underlying issues of poor academic performance (e.g., substance abuse, mental health, safety concerns).
- Providing supports for the middle school to high school transition, particularly for underperforming students.
- Providing specialized reading trainings and instructional strategies for teachers and classroom support staff (e.g., Cognitively Guided Instruction).
- Developing appropriate intervention programs, including before, after school, and summer programming, and in-school reading support (e.g., Quantum Opportunity Program).
- Increasing focus on reading comprehension.
- Providing ongoing recognition for small improvements in reading and language arts skills.
- Encouraging reading and writing at school and at home.
- Developing smaller schools, schools within school models, and industry-specific academies.
- Improving students' feeling of connection to school.

How can we improve the trend in San Diego County?

Supporting Report Card recommendations, Grossmont Union High School District offers career technical education, laboratories, and applied learning spaces with state-of-the art equipment to prepare students for the workforce. For the third year in a row, the district was awarded a Jimmie Johnson Foundation/Lowe's Toolbox for Education Champions Grant to improve classroom technology. Partnering with San Diego State University, Sweetwater Union High School District is continuing their Compact for Success program, providing guaranteed college admission for students who achieve specified benchmarks in education. Over 3,000 Sweetwater students have gone to San Diego State University thus far, and the number of graduates who qualify for admission has grown by more than 500%. Also in line with prior Report Card recommendations, more than 27 school districts offer after school programs at more than 320 sites throughout our county.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with schools and school districts, San Diego County Office of Education, California Department of Education, San Diego Workforce Partnership, local businesses and business associations, substance abuse prevention programs, mental health providers, and literacy support organizations to:

1. Provide academic intervention for underperforming students, such as reading specialists and academic tutors during the school day, after school, and in summer programs.
2. Provide social intervention services such as substance abuse and mental health counseling, summer work experiences, mentoring, and internships.
3. Offer supports for the middle school to high school transition, particularly for underperforming students.

"Kids who learn from their parents about the dangers of substance abuse, underage drinking and other harmful activities are less likely to use those substances."

National Parent Teacher Association

Ages 13–18 (Adolescence): SUBSTANCE USE

What is the indicator?

The percent of students (grades 7, 9, and 11) who reported using cigarettes, alcohol, or marijuana in the past 30 days.

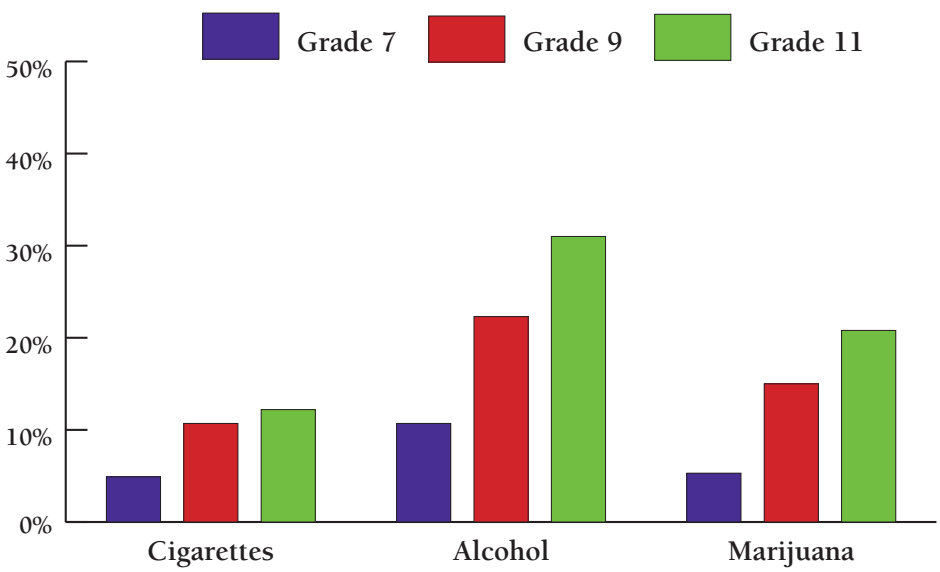
This indicator reports the percentage of students in grades 7, 9, and 11 who report having used cigarettes, alcohol, or marijuana in the last 30 days. These data are collected with the California Healthy Kids Survey, administered biennially to students in grades 7, 9, and 11 throughout the state of California. These questions mirror the questions in the Youth Risk Behavior Survey, a CDC-designed survey in use across the country.

Why is this important?

The use of tobacco, drugs, and alcohol can stunt an adolescent's physical and mental growth and development. Studies show that prolonged use of alcohol and drugs can negatively affect academic success, employment potential, and mental health. Students are starting use of illicit drugs at younger ages. Misuse of prescription medications and smokeless tobacco are increasing, with one in five teens abusing prescription drugs in 2009. The prescription medications most commonly abused by youth are Oxycontin, Adderall, and Vicodin. Misuse of prescription drugs is right behind marijuana use, and the misuse is likely to continue into adulthood.

How are we doing?

Percent of Students Grades 7, 9, and 11 Who Reported Use of Cigarettes, Marijuana, or Alcohol in Prior 30 Days, San Diego County, School Year 2010-11



The percent of students reporting use of cigarettes and alcohol decreased in recent years; however, increases in marijuana use have been reported. Older students continue to be more likely than their younger counterparts to use substances.

What strategies can make a difference?

Strategies must focus on both prevention and intervention policies, services, and programs. Services are most effective when they are available immediately, community based, and holistic.

The following strategies have been used across the country to decrease young people's use of cigarettes, alcohol, and drugs:

- Working with parents, schools, and community to eliminate youth access to tobacco, alcohol, illicit drugs, and nonprescribed medications.
- Increasing students' ability to resist social pressure to use tobacco, alcohol, illicit drugs, and nonprescribed medications through family, school, and community programs (e.g., LifeSkills Training, Child Development Project, Council on Prevention and Education: Substances, Inc.).
- Teaching parents the skills they need to improve family communication and bonding through programs such as Guiding Good Choices.
- Building resistance, resiliency, social competency, and problem-solving skills.
- Promoting youth development, including increasing connectedness to school.
- Enforcing local ordinances prohibiting the sale of tobacco and alcohol to minors, as well as over-the-counter substances that can be misused (e.g., bath salts, spice).
- Working with parents and community to educate about the dangers of substance use.
- Incorporating culturally competent and relevant substance abuse education, especially in areas with a high density of minority youth.
- Increasing availability of community-based drug and alcohol treatment programs, both day treatment and residential.

How can we improve the trend in San Diego County?

In line with Report Card recommendations, the Julian Backcountry Coalition was successful in securing a five-year Drug Free Communities (DFC) grant. The latest results from a national evaluation found that coalitions funded by DFC grants have been successful in reducing drug and alcohol use in their communities and in changing the risk perception of youth. Local accomplishments include the initiation of a community survey, a drug take back event, and community education. Recognizing the dangers of misuse of prescription drugs, the County of San Diego created a Prescription Drug Task Force, which led to placement of 22 protected drop-off boxes around the county. The boxes combined with "take back" events have secured more than 10,000 pounds of unused prescription drugs.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with schools and school districts, parents and parent associations, San Diego County Office of Education, Health and Human Services Agency, substance abuse prevention agencies, Probation Department, law enforcement, municipalities, community-based organizations, faith communities, and media partners to:

1. Promote youth development activities, after school programs and early prevention programs including: Community Assessment Teams, Friday Night Live, Club Live, Botvin's Life Skills Training, 21st Century, ASES, and ASSETS after school programs.
2. Expand access to treatment and evaluate regional needs for culturally competent substance abuse prevention and intervention services.
3. Continue and expand prescription drug turn-in and related programs that reduce youth access to substances.

The Real Deal on Youth Substance Abuse

One major challenge in determining the extent of youth drug use is the difficulty in obtaining consistent and reliable data. While many have expressed concern that misuse of prescription drugs is a growing problem in San Diego and anecdotal reports from parents, schools, and law enforcement point to misuse of prescription drugs or new designer drugs, there are no reliable and valid population data to measure the extent or magnitude of this issue.

Youth substance use generally cannot be recorded through direct observation, and most use does not result in a public record from which data can be collected. The most common source for this type of information from a general population is from survey data, often using self-reporting as the method. The *San Diego County Report Card on Children and Families* has historically reported on youth substance use with data from the validated, statewide California Healthy Kids Survey. However, this survey does not currently measure the number of students using prescribed medications for non-medical reasons, in other words, illicit use of prescription drugs. Nor does it take into consideration new and emerging drugs used by youth such as "spice" and "salts."

The Children's Initiative was asked by researchers at San Diego State University School of Social Work and University of Florida College of Health and Human Performance to convene and foster a partnership with the San Diego Unified School District. The purpose was to engage the District in a University of Florida pilot project designed to improve measurement of misuse of prescription drugs by youth. A new survey was piloted in five schools across the country, including one local high school in San Diego County in school year 2010-11 for grades 9-12. The pilot survey included items from California Healthy Kids Survey but was more detailed and extensive in scope.

Locally results of this survey mirror concerns reported by the Centers for Disease Control and Prevention (CDC). In San Diego, 13% of students reported having used a prescription medication (e.g., Oxycontin, Percocet, Vicodin, Ritalin) without a medical prescription. Most students report using their own prescription in a way not prescribed, or having obtained medication from a friend or from a parent with or without permission. Most students reported that they used prescription medication to get high, relieve pain or stress, experiment, or escape problems.

In order to get a comprehensive view of the misuse of prescription drugs and the use of designer drugs it is important for California to include more detailed questions in future California Healthy Kids Survey, as well as to ensure adequate funding is provided to assist schools in routinely administering the survey.

"We must promote public awareness that suicides are preventable." David Satcher, former U.S. Surgeon General

Ages 13–18 (Adolescence): YOUTH SUICIDE

What is the indicator?

The percent of students who reported they attempted suicide in the previous 12 months.

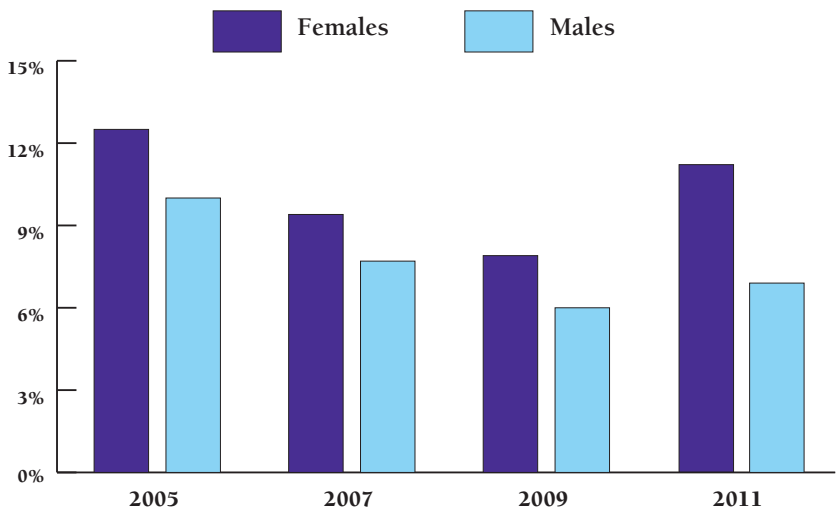
This indicator reports the percent of high school students who self-report having made a suicide attempt in the previous 12 months. For the 2011 Report Card, these data are collected and reported from the San Diego Unified School District's Youth Risk Behavior Surveillance System (YRBSS) in school year 2010-11. YRBSS is a national school-based survey conducted by the CDC and by state, territorial, and local education and health agencies and tribal governments. The survey is designed to monitor health-risk behaviors that contribute to the leading causes of death and disability among youth and adults. San Diego Unified enrollment accounts for 26% of all county students.

Why is this important?

Over the past decade, suicide was the second leading cause of non-natural death for San Diego County children ages 10-14. Each year approximately 13 San Diego youth commit suicide; other youth are hospitalized as a result of attempted suicide. The three most common methods among young people are firearms, suffocation, and poison. In addition to the tragedy of death, suicide has a lasting emotional and even traumatic effect on the community, particularly family and friends. Survivors are often left with emotions of guilt, grief, and confusion. Perhaps most important is the fact that suicide is preventable.

How are we doing?

Percent of Students Grades 9-12 Who Reported They Had Attempted Suicide in the Past 12 Months, By Gender, San Diego Unified School District, 2005-2011



Due to significant decreases in funding for the administration of the California Healthy Kids Survey suicide module, trend data for a large number of school districts cannot be reported. San Diego Unified School District administers the YRBSS. Note that year-to-year variations for this small number may not be statistically significant or reliable.

What strategies can make a difference?

Youth suicide prevention requires education of adults and youth. Youth typically do not contact professional help when they are depressed. Peers, teachers, health professionals, and parents are the people most likely to have contact with a depressed youth, and thus in the best position to intervene.

The following strategies have been used across the country to prevent youth suicide:

- Emphasizing and reinforcing the fact that suicide is preventable.
- Raising family, school, and community awareness of the signs of depression and suicidal ideation (i.e., thinking or talking about dying or committing suicide).
- Educating parents and others about eliminating access to lethal means, particularly firearms, which remain a major instrument used by youth who attempt suicide.
- Educating peers and adult "gatekeepers" (e.g., teachers, school bus drivers, coaches) to recognize the warning signs and risk factors associated with suicide—in particular, training peers to respond to suicidal statements as an emergency and to tell a trusted adult and use crisis hotlines.
- Training primary health care providers to screen for signs of depression and suicide ideation.
- Reducing the stigma associated with seeking support and help for mental health problems.
- Expanding school-based programs that promote help-seeking behaviors; teach problem-solving skills; and provide assessment, motivational counseling, and peer support (e.g., Cognitive Behavioral Intervention for Trauma in Schools [CBITS]).
- Providing interventions tailored to at-risk youth of various cultural and ethnic backgrounds.
- Improving data collection and reporting, particularly school-based child health surveys.

How can we improve the trend in San Diego County?

Several of the 2009 recommendations were implemented in the last year, with the San Diego Unified School District providing education about suicide signs and risk and protective factors through its Suicide Prevention Education Awareness and Knowledge (SPEAK) program. During the 2010-11 school year, 71% of attending students reported increased knowledge of the warning signs of suicidal ideation and 87% reported increased knowledge of how to get help for those in need. The Health and Human Services Agency launched an $8.4 million "It's Up 2 Us" campaign to destigmatize mental health issues and encourage people to seek help. The Agency also improved access to mental health support line services, Peer2Peer Youth Talkline and Family SupportLine, based on community feedback.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with schools and school districts, San Diego County Office of Education, American Academy of Pediatrics, Health and Human Services Agency, mental health providers, parents and parent organizations, faith communities, community-based organizations, and suicide prevention programs to:

1. Provide education for families, health providers, educators, and peers about the warning signs and risk factors of depression and suicide and steps to take when signs are present.
2. Support additional mental health training and services and access to a variety of clinical interventions, as well as programs that focus on suicide prevention such as Yellow Ribbon Suicide Prevention Program, QPR (Question, Persuade, and Refer), and Safe TALK.
3. Assure a consistent and secure funding stream for school districts to administer the California Healthy Kids Survey, including the full component of suicide questions.

"Of course, the best way to approach juvenile justice issues is to begin by identifying ways to keep kids out of trouble in the first place." *Eric Holder, U.S. Attorney General*

Ages 13–18 (Adolescence): JUVENILE CRIME

What is the indicator?

The number of arrests for misdemeanor and felony crimes among youth ages 10-17.

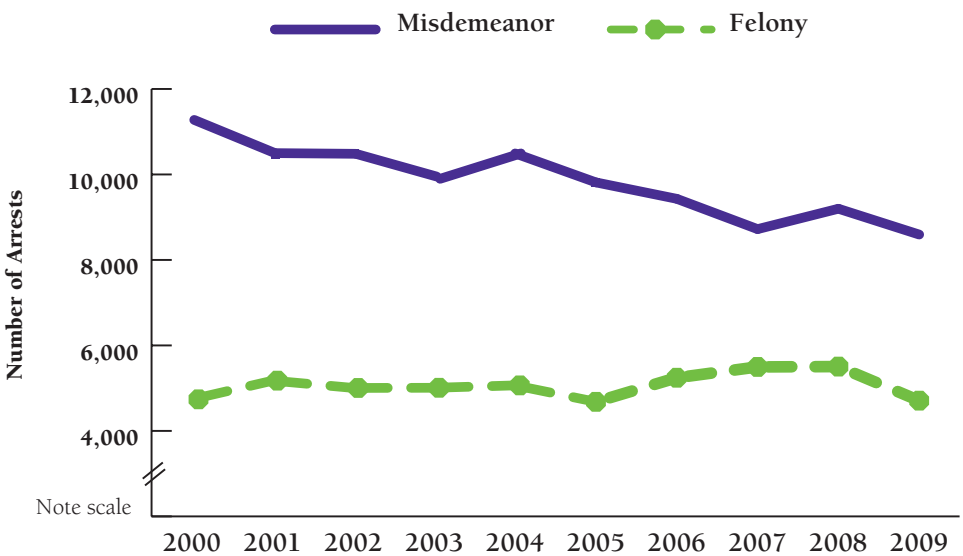
This indicator reports the number of arrests for misdemeanor and felony crimes among youth ages 10-17. Arrests for status offenses such as curfew violations or truancy are not included. One arrest may have more than one charge associated with it. Only the most serious offense is reported in each arrest. Data are collected by law enforcement, stored in the Automated Regional Justice Information System (ARJIS), and routinely reported by the San Diego Association of Governments (SANDAG).

Why is this important?

Juvenile crime is costly on multiple levels. First and foremost, there is the potential loss of a productive life for the young person. In addition, crime diminishes the sense of safety in the community, and it costs victims their property, money, health, and sense of well-being. Other costs are incurred by government for maintaining the juvenile justice system, medical expenses, loss of work time, and lowered property values.

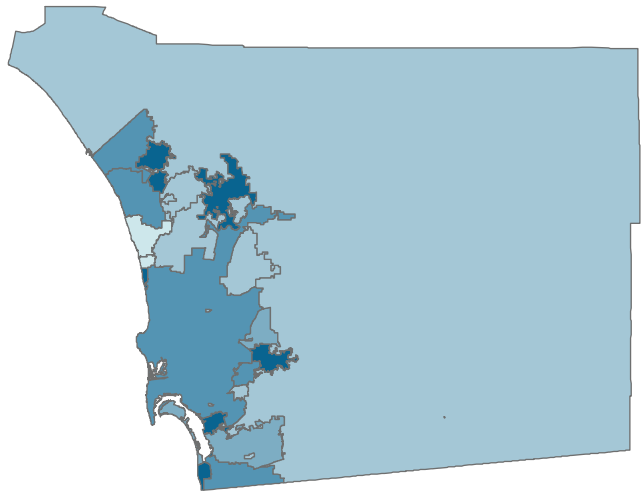
How are we doing?

Number of Arrests for Felony and Misdemeanor Offenses, Youth Ages 10-17, San Diego County, 2000-2009



The number of juvenile arrests for felonies is not showing consistent improvement over time. The number of misdemeanor arrests continues to decline. The overall, combined rate of juvenile arrests dropped from 51 per 1,000 juveniles in 2000 to 40 per 1,000 in 2009.

RATE OF ARRESTS PER 1000 YOUTH AGES 10-17, 2009



Overall County Rate 39.8

NOTE: Juvenile arrest data provided by CA Deapartment of Justice, Criminal Justice Statistics Center. Juvenile arrest total includes felony and misdemeanor offenses. Status offenses are not included. Data represents location of arrest not residence of youth. Rates are based upon 2010 American Community Survey. Rates per 1,000 youth are not presented if number of arrests is less than 30.

Ten Most Common Crimes Committed By Juveniles, Ages 10-17, San Diego County, 2009

Crime	*Level*	*Number*
Petty theft	Misdeameanor	1,655
Drug violations	Misdeameanor	1,338
Burglary	Felony	1,249
Manslaughter/assault and battery	Misdeameanor	1,012
Drunk/liquor laws	Misdeameanor	972
Aggravated assault	Felony	933
Weapons offenses	Felony	458
Robbery	Felony	390
Larceny	Felony	389
Vandalism	Misdeameanor	386

The largest number of crimes committed by youth was in the category of petty thefts, followed by drug violations and burglaries. Aggravated assaults—in second place in 2007—moved down to sixth place by 2009.

What strategies can make a difference?

Research indicates that identifying young people when they first begin to experiment with risky behaviors and providing them with programs that focus on prevention and early intervention services can reduce the chances that they will enter or escalate in the juvenile justice system.

The following strategies have been used across the country to decrease juvenile crime:

- Providing quality after school programs for elementary, middle, and high school students.
- Providing substance abuse prevention and intervention programs.
- Expanding use of life skills training, vocational education, career development, internships, and employment opportunities.
- Increasing access to mental health services for elementary, middle, and high school students.
- Offering academic support for high school completion.
- Providing problem-solving, anger management, mediation, and conflict resolution instruction (e.g., Resolving Conflict Creatively Program).
- Expanding prevention programs to elementary and middle school youth that reduce gang involvement, connect youth to school, and encourage positive, pro-social behavior (e.g., Second Step: A Violence Prevention Program).
- Expanding Juvenile Diversion programs and truancy identification and support.
- Developing and implementing juvenile accountability practices that include skill building, reparation to victims, and community service.
- Supporting community policing practices.

How can we improve the trend in San Diego County?

In support of Report Card recommendations, the Children's Initiative partners with school districts, the District Attorney's Office, and the Truancy Court, who refer over 80 youth annually for truancy intervention services. Preliminary research conducted by SANDAG suggests that these services not only increased school attendance but also increased grade point averages (GPAs). In one district, referred students' GPAs went from failing to passing. The Children's Initiative also works with San Diego Project Safe Neighborhoods, a federal project administered by the U.S. Attorney's Office aimed at reducing gun and gang crime and violence. Trained mentors work with youthful offenders both in custody and in the community to complete court ordered conditions, provide academic support, and offer positive activities for the youth.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with the Probation Department, local law enforcement agencies, community-based organizations, Juvenile Court, District Attorney's Office, U.S. Attorney's Office, San Diego Workforce Partnership, parents and parent organizations, schools, faith communities, Health and Human Services Agency, local businesses, and business associations to:

1. Identify and intervene with youth who are chronically absent, truant, and experiencing high rates of behavioral problems at school.
2. Expand internship programs, job shadowing, and summer and after school employment opportunities for high school youth.
3. Provide uniform assessment and screening of at-risk youth using the newly implemented "Positive Achievement Change Tool" (PACT) across governmental and community-based partners.

"The solution to adult problems tomorrow depends in large measure upon how our children grow up today." *Margaret Mead*

Ages 13–18 (Adolescence): JUVENILE PROBATION

What is the indicator?

The number of sustained petitions ("true finds") in Juvenile Court among youth ages 10-17.

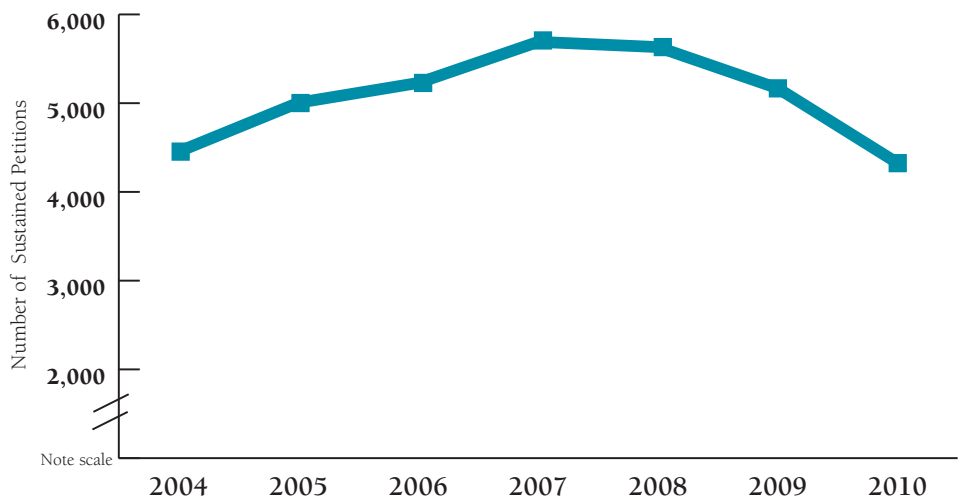
This indicator reports the number of sustained petitions (true finds) in the juvenile court system—the juvenile equivalent of being found guilty in adult court—among youth ages 10-17. This indicator includes only sustained petitions for misdemeanor or felony offenses. Status offenses such as curfew or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

Why is this important?

Breaking the law and engaging in risky and dangerous behaviors negatively impact a young person's life immediately and in the future. A youth who enters the juvenile justice system and has a sustained petition is likely to be placed on probation. Probation generally follows more serious or escalated criminal behavior. While probation is an important tool, it is costly for the public and often represents failures to address early warning signs of risky behavior and problems among youth.

How are we doing?

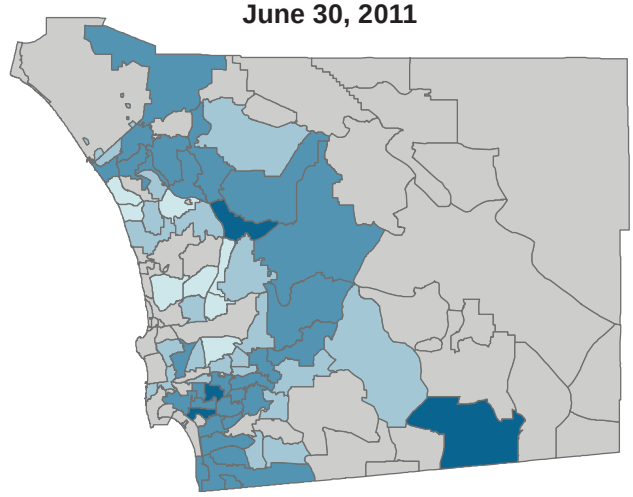
Number of Sustained Petitions ("True Finds") in Juvenile Court, Youth Ages 10-17, San Diego County, 2004-2010



The trend is improving. After peaking in 2007, the number of sustained petitions has declined in recent years, to just below the level in 2004.

RATE OF YOUTH AGES 10-17 ON PROBATION PER 1,000 YOUTH AGES 10-17:

June 30, 2011



NOTE: 2011 Probation data were provided by the County of San Diego Probation Department. Rates calculated using SANDAG 2010 demographic estimates. Zip codes with juvenile probation incidence under 10 not included in rate calculations.

Stakeholders Aim to Stop Disproportionate Minority Contact

Disproportionate Minority Contact (DMC) has been discussed throughout our country for many years. In 1992, when the Juvenile Justice and Delinquency Prevention Act (JJDPA) was amended, the federal government acknowledged that youth of color are treated differently in the justice system. Youth of color are being arrested, detained, and incarcerated at higher numbers than their white counterparts.

In 2005, California Corrections Standards Authority (CSA) formed a statewide DMC Committee and reached out to several county Probation Departments to begin identification and analysis of DMC at the local level. Guided by lessons learned from three California counties that piloted research into this issue, CSA developed a multifaceted approach of direct service, education, and support.

Locally, the Children's Initiative formed a San Diego DMC Committee comprised of local law enforcement, Probation Department, District Attorney's Office, Public Defender's Office, County Office of Education, and community providers. The Committee identified SANDAG as the research partner and secured resources to analyze DMC in the local juvenile justice system. SANDAG research revealed DMC issues at three of the nine decision points in the juvenile justice process: arrest, detainment into Juvenile Hall, and institutional commitment.

The DMC Committee used this research to develop a comprehensive County DMC Reduction Plan. The plan contains eleven recommendations and specific action steps to reduce DMC in San Diego County. The Committee surveyed key stakeholders and prioritized the recommendations. While progress has been made on all eleven recommendations, resources have been concentrated on the recommendations to *Address the Pathways to Delinquency/Enhance Prevention Services* and *Improve Access to the Juvenile Justice System*.

Together the partners have secured funding to hire retired probation officers to staff a service/information window in juvenile court. The officers inform youth and families attending court about the court process, conditions of probation, and next steps. The officers also serve as a resource directory for the youth and families in the juvenile justice system. The partners have also identified areas of our county which have a high percentage of youth of color involved in the justice system and provided these youth with case management, mentoring, and tutoring assistance to reduce their risk of entering or escalating in the juvenile justice system.

While San Diego is actively engaged in reducing DMC, more resources and assistance are needed to take efforts to scale and ensure that equity exists in our juvenile justice system for all youth no matter what race, ethnicity, or background.

What strategies can make a difference?

Clear, direct, and immediate consequences and support when youth are engaging in risky behaviors and breaking the law provides them with an understanding of appropriate boundaries, an opportunity to learn from their mistakes, and the ability to get back on track. Treatment, consistent and direct community supervision, and—when needed—incarceration have been found to be effective in preventing increased delinquent behaviors, reducing recidivism, and improving public safety.

The following strategies have been used across the country to reduce arrests and escalation in the justice system. These strategies must be provided consistently from arrest and detention, to after care, and through probation completion.

- Providing alternatives to detention, such as community-based supervision with wrap-around services, electronic monitoring, and day reporting centers.
- Providing mental health evaluation and clinical supervision, substance abuse services, and cognitive-behavioral treatment.
- Providing academic support for reading proficiency, credit recovery, and high school completion.
- Offering job readiness, vocational education, and career development support.
- Providing community-based drug treatment (day and/or residential services).
- Providing therapies such as Assertive Community Treatment, Multisystemic Therapy, Functional Family Therapy, and/or Aggression Replacement Training.
- Implementing interventions to reduce gang involvement and to help gang-involved youth exit a gang lifestyle.
- Providing restorative justice evidence-based practices, such as victim-offender mediation, empathy training, and restitution.
- Offering parent training to improve family communication, negotiation, and decision-making skills and to establish positive discipline.

How can we improve the trend in San Diego County?

San Diego made great strides toward implementing Report Card recommendations to expand diversion services through the procurement of Title II Juvenile Justice Federal Formula Grants totaling more than $2 million (for North County Lifeline and South Bay Community Services) to provide alternatives to detention and increase diversion services for youthful offenders. Responding to community need, San Diego also developed a new Juvenile Behavioral Health Court: Juvenile Forensic Assistance for Stabilization & Treatment (JFAST). JFAST is a collaborative court that provides individualized oversight and treatment services for youth, when they have an identified mental health need.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with the Probation Department, Juvenile Court, local law enforcement agencies, juvenile diversion programs, community-based organizations, parent and parent organizations, school districts, faith communities, San Diego Workforce Partnership, Health and Human Services Agency, substance abuse prevention programs, and mental health service providers to:

1. Increase alternatives to detention, such as community-based supervision with wraparound services, electronic monitoring, and day reporting centers.
2. Increase job training and employment assistance for higher risk youth and court-involved youth, as well as job shadowing and summer and after school employment opportunities.
3. Expand community-based mental health and drug treatment services for at-risk youth.

"Underage drinking is everybody's problem—and its solution is everyone's responsibility."

Kenneth P. Moritsugu, Former Acting U.S. Surgeon General

Ages 13–18 (Adolescence): YOUTH DUI

What is the indicator?

The number of DUI arrests among youth under age 18.

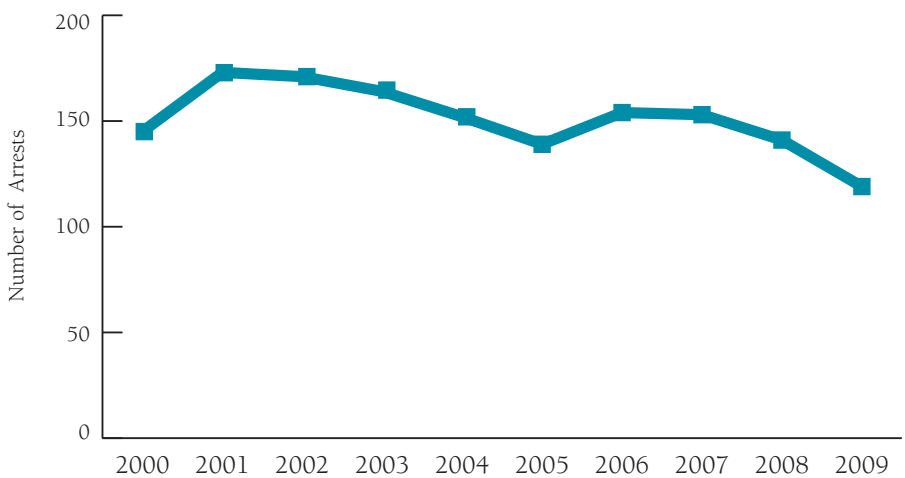
This indicator is the number of Driving Under the Influence (DUI) arrests among youth under age 18 as reported by the California Department of Motor Vehicles. It was selected as a gateway indicator for youth involved in alcohol- and drug-related collisions. Examining the statistics about our youth driving under the influence will help to identify opportunities for prevention and intervention, rather than looking only at the tragic end result of death and injury collisions.

Why is this important?

Driving under the influence of alcohol and drugs is a serious hazard to health and safety. Youth (ages 16-20) are not of legal age to drink, yet they report that it is "no trouble" to obtain alcohol. U.S. teens have higher motor vehicle crash rates than adults, and DUI is an important contributing factor. One out of ten high school students drives after drinking, and one in four rides with a driver who has been drinking. At any level of impairment, youth are more likely to be involved in a vehicle crash than adults. Motor vehicle crashes are the leading cause of death for U.S. 15- to 20-year-olds, accounting for one-third of all teen deaths. Alcohol is involved in one in three of all crash deaths, and more than two-thirds of children killed in crashes were either riding with or struck by a drinking driver.

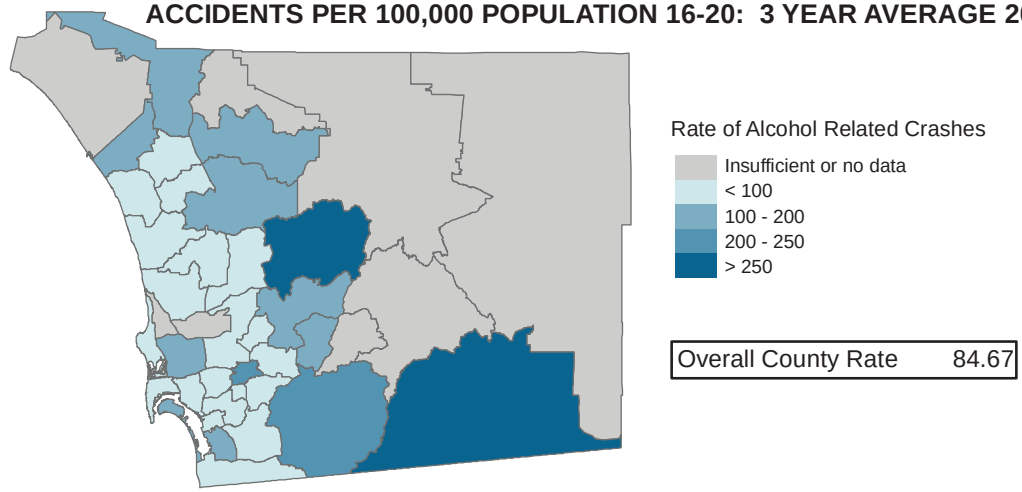
How are we doing?

Number of DUI Arrests, Youth under Age 18, San Diego County, 2000-2009



During the past decade, the number of youth DUI arrests peaked in 2001 and fluctuated in recent years. In 2009, the number reached the lowest level in a decade, at 119 arrests.

RESIDENCE OF DRIVERS AGES 16-20 WHO WERE DRINKING AND INVOLVED IN MOTOR VEHICLE ACCIDENTS PER 100,000 POPULATION 16-20: 3 YEAR AVERAGE 2007-09



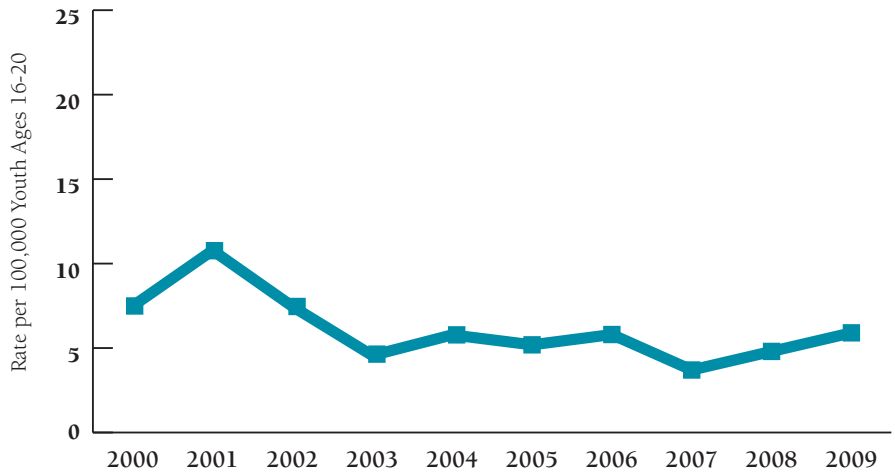
NOTE: Crashes involving drivers ages 16-20 who had been drinking from Statewide Integrated Traffic Records System 2007-2009. Residence zip codes from CA Department of Motor Vehicles Research and Development Branch. Data prepared by County of San Diego Public Health Services, Emergency Medical Services. Rates calculated using SANDAG 2007-2009 demographic estimates.

The Children's Initiative has partnered with the California Department of Motor Vehicles to study where the youth who are drinking, driving, and crashing live in the County. For the years 2007-2009, the communities with the highest rates per 100,000 youth ages 16-20 were Mountain Empire, Ramona, Jamul, La Mesa, Fallbrook, and Chula Vista.

Proportion of DUI Arrests, Under Age 18, By Gender, San Diego County, 2000-2009

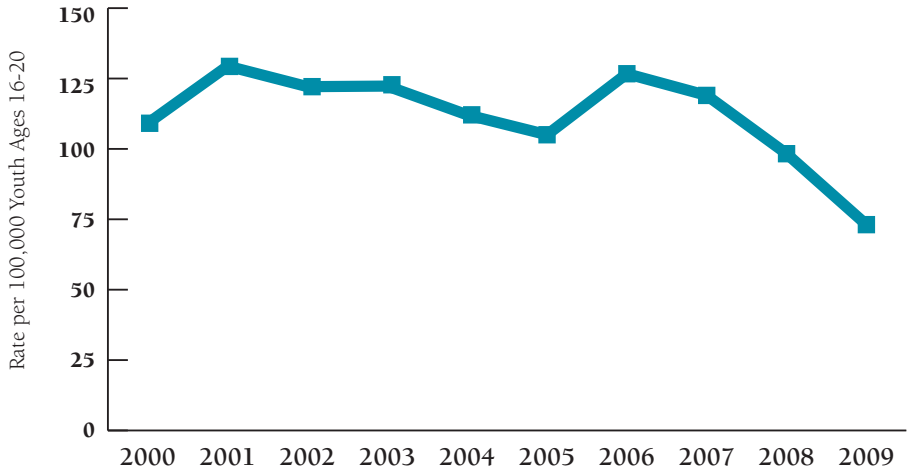
The proportion of males (76%) who experience DUI arrests continues to be about three times that shown for females (24%).

Rate of Fatal Crashes Involving Drivers Ages 16-20 Under the Influence of Alcohol or Drugs, Per 100,000 Population, San Diego County, 2000-2009



The trend is maintaining for fatal crashes. From a peak in 2001 of 11 per 100,000, the rate has remained at approximately 4-6 per 100,000 between 2003 and 2009.

Rate of Non-Fatal Crashes Involving Drivers Ages 16-20 Under the Influence of Alcohol or Drugs, Per 100,000 Population, San Diego County, 2000-2009



The trend in non-fatal crashes has declined steadily since 2006, and is currently the lowest rate since 2000.

What strategies can make a difference?

Driving under the influence is a behavior affected and supported by multiple factors, including social practices, perception that discovery and consequences are unlikely, impaired judgment and decision making, convenience, and peer group pressures. Youth need to be prepared to make safe decisions.

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

- Eliminating youth access to alcohol.
- Changing social norms regarding the use of alcohol and drugs.
- Empowering youth and building resistance and problem-solving skills.
- Providing quality driver education and training lasting at least three months.
- Implementing graduated driver licensing that includes a mandatory waiting period, nighttime driving restriction, at least 30 hours of supervised driving, and passenger restrictions.
- Limiting youth driving privileges during the first 12 months with a new license.
- Developing multi-faceted, youth-focused approaches to alcohol control and DUI prevention.
- Supporting safe weekend and evening activities.
- Maintaining a legal drinking age of 21.
- Aggressively enforcing 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.
- Promptly suspending the driver's licenses of people who drive while intoxicated.
- Conducting sobriety checkpoints, particularly targeted at communities with highest incidence of alcohol- and drug-related accidents involving youth and in locations where youth congregate.
- Educating parents about the risks and liabilities of "supervised" drinking.
- Instituting community- and school-based programs to increase student and parent awareness about the dangers of drinking and driving.
- Enforcing mandatory seatbelt laws.

How can we improve the trend in San Diego County?

California as yet has not moved in the direction of prior Report Card recommendations to restore driver education and training in schools. The Health and Human Services Agency, Sheriff's Department, local schools, and community partners collaborated to provide free Start Smart classes at Sheriff substations. The Children's Initiative continues to partner with the California Department of Motor Vehicles to identify communities with high rates of youth drinking, driving, and crashing to target education where needed.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with local law enforcement agencies, Health and Human Services Agency, Probation Department, local law enforcement agencies, school districts, parents and parent associations, driver education providers, businesses and business associations, automobile insurance companies, substance abuse prevention agencies, and media partners to:

1. Increase parent and community commitment to eliminating youth DUI by developing multi-faceted, community-based approaches to alcohol control and DUI prevention.
2. Eliminate youth access to alcohol and other drugs by educating parents about the importance of home precautions, enforcing penalties on adults and/or establishments who provide alcohol to youth, and aggressively enforcing zero tolerance laws.
3. Conduct sobriety checkpoints in communities of residence of youth with the highest incidences of youth DUI motor vehicle crashes.

"Although children account for less than a quarter of the total population in the U.S., they make up more than a third of the poor population." *National Center for Children in Poverty*

Community and Family (Cross Age): POVERTY

What is the indicator?

The percent of children ages 0-17 living in poverty.

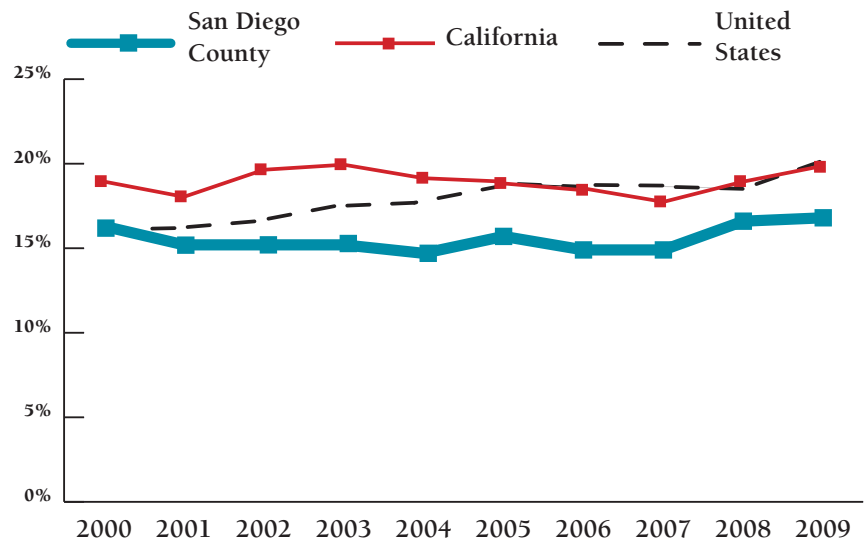
The indicator is the percent of children under age 18 living below 100% of the Federal Poverty Level. The Federal Poverty Level was set at an annual income of $22,350 for a family of four in 2011. In San Diego County, the level of income sufficient to meet basic expenses such as housing and food is closer to 200% of poverty ($44,700), given our higher cost of living. These data are routinely reported by the U.S. Census Bureau and SANDAG. Data by region come from the California Health Interview Survey.

Why is this important?

Living in poverty puts children at increased risk for a wide range of problems. The "dose" of poverty matters; that is, the more severe the poverty or the more years a child lives in poverty, the worse the impact. Poor children are disproportionately exposed to environmental toxins, inadequate nutrition, parental depression or substance abuse, abuse, violence, trauma, and low quality education and child care. Teens in poor families are more likely to engage in risky behaviors, including smoking, sexual activity, drug and alcohol abuse, and delinquent behaviors. Research shows that increasing the incomes of low-income families—without any other changes—can positively affect children's development.

How are we doing?

Percent of Children Ages 0-17 Living in Poverty, San Diego County, California, and United States, 2000-2009



The trend is moving in the wrong direction. The child poverty rate for San Diego County decreased between 2000 and 2007, then, climbed to 16.6% in 2008 and 16.8% in 2009. The child poverty rate in 2009 was the highest for the county since 2000.

What strategies can make a difference?

In the current economic recession, many families with children are among the newly poor; other families who were already poor have been even harder hit. Government programs and subsidies for low-income working families can help families move out of poverty. Such benefits encourage, support, and reward work by helping families close the gap between low wages and basic expenses. Other effective practices address family, cultural, neighborhood, educational, and job skill factors.

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

- Focusing "welfare to work" programs on barriers to employment such as low education, poor work history, substance abuse, and domestic violence.
- Encouraging families to use the federal and state Earned Income Tax Credit (EITC), refundable tax credits for low-income individuals and families.
- Implementing jobs programs aimed at reducing unemployment and advancing job creation.
- Assuring assistance through anti-poverty programs such as child care subsidies, nutrition assistance, cash assistance, and housing assistance.
- Increasing parents' access to literacy, post-secondary, and vocational education.
- Offering low-cost job training and GED courses for unemployed and working parents.
- Providing child care at education and training sites.
- Increasing levels of education achievement and reducing numbers of dropouts.
- Assisting families to open Individual Development Accounts (IDAs) to help them get bank accounts, save money, and accumulate assets.
- Offering Individual Training Accounts (ITAs), which serve as vouchers that can be exchanged for training at approved learning institutions.

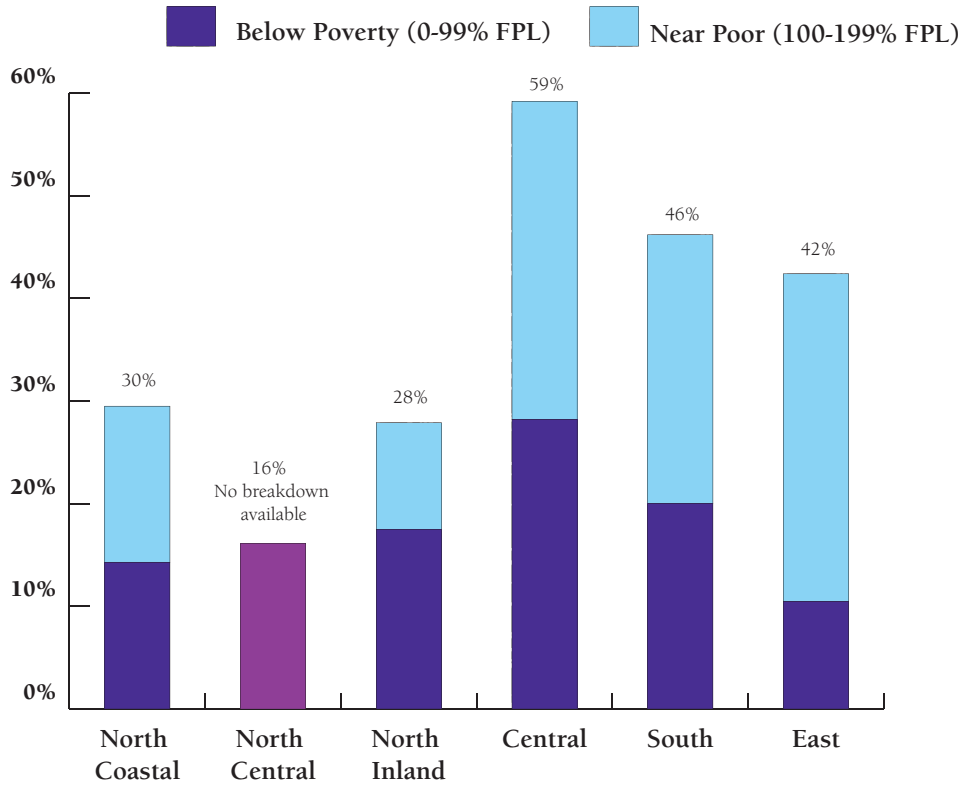
How can we improve the trend in San Diego County?

San Diego continues to work to improve outreach and access to public assistance programs and EITC, as recommended in previous Report Cards. Through a countywide collaboration among the Health and Human Services Agency, Internal Revenue Service, United Way of San Diego County, local colleges and universities, AARP, and others, low-income and unemployed residents were provided free tax preparation and assistance with EITC. Supporting Report Card recommendations to help families move from welfare to work, the San Diego Workforce Partnership and Health and Human Services Agency implemented the Bridge to Employment program, with the support of a $25 million federal grant, which is expected to train 2,550 low-income adults for employment in the health professions.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with the San Diego Workforce Partnership, community development corporations, schools, community colleges and universities, community-based organizations, faith communities, United Way of San Diego County, 211, Chambers of Commerce, businesses, mental health providers, and Health and Human Services Agency to:

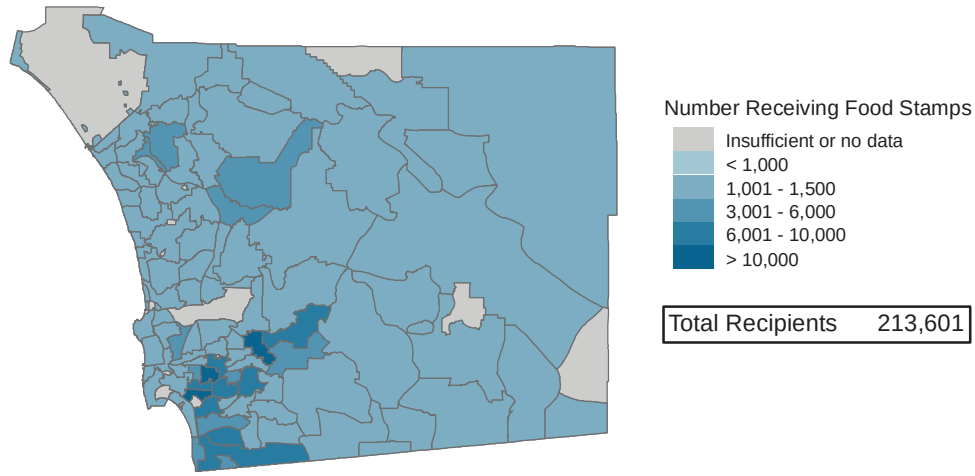
1. Increase access to, support, and follow-up for One-e-App and Benefits CalWIN to assist families in applying for Medi-Cal and CalFresh, and simplify application processes for other public and private assistance such as employment, California Alternative Rates for Energy (CARE), income, and housing programs.
2. Offer information and assistance through the San Diego Workforce Partnership network of providers to help families effectively use EITC, IDAs, and ITAs.
3. Provide free and low-cost job training and GED courses for unemployed and working parents.

Percent of Children Under Age 18 Living in Low-Income Households, By Poverty Level and Region, San Diego County, 2009



In parts of San Diego County, approximately one-half of children are living in low-income households, earning below 200% of the Federal Poverty Level (FPL). The proportion of families with income less than 200% of FPL indicates that too many of our children live in families with income insufficient to meet basic needs such as housing, food, and transportation in San Diego County.

NUMBER OF FOOD STAMP RECIPIENTS: DECEMBER 2010



NOTE: Data from CalWIN MR009E, December 2010.

"In the United States, more than one out of six children lives in a household with food insecurity, which means they do not always know where they will find their next meal."
Feeding America

Community and Family (Cross Age): NUTRITION ASSISTANCE

What is the indicator?

The number of children ages 0-18 receiving Food Stamps.

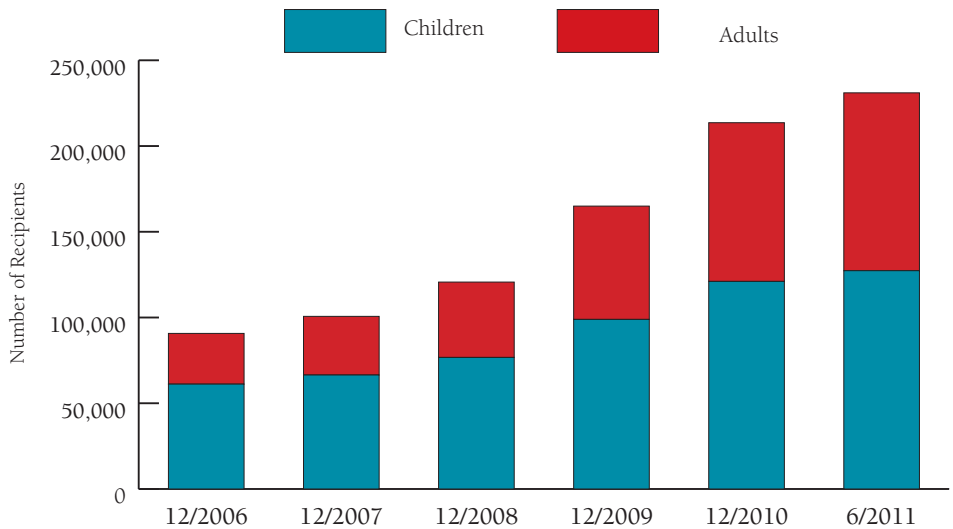
This indicator—the number of children ages 0-18 receiving Food Stamps—tracks how many eligible San Diego County children are participating in the federal Supplemental Nutrition Assistance Program (SNAP), known in California as the CalFresh program. This information is collected through the Health and Human Services Agency Benefits CalWIN program.

Why is this important?

Sufficient food is one of humanity's most fundamental needs—without basic food people cannot survive. As an economy worsens, more people go hungry. SNAP provides nutrition assistance to low-income individuals and families, a simple and effective way to assist those in need of food. The combined use of Food Stamps and EITC can lift a family of four with one minimum-wage earner to reach or even surpass the poverty line. Without these benefits, such a family would live in extreme poverty. Nutrition assistance also benefits the community: every $1.00 of Food Stamps generates $1.85 in local economic activity. Another benefit of SNAP is the ability to quickly meet nutrition needs in emergency or suddenly changing economic situations.

How are we doing?

Number of Food Stamp Recipients, Children Ages 0-18 and Adults, San Diego County, 2006-2011



The trend is improving. Since 2006, the number of children and adults receiving Food Stamps in San Diego County has more than doubled, reaching many more eligible families.

What strategies can make a difference?

While SNAP offers an effective aid to improve the nutritional status of low-income families, utilization rates have been low. Successful strategies to improve access and utilization rates involve outreach campaigns, cross-agency strategies, and creative points of access. Increased use of SNAP/CalFresh means better nutrition for families and community economic development.

Nationally, the following strategies have been used to increase SNAP participation.

- Simplifying the application process, both on-line and on paper.
- Providing outreach and enrollment centers in targeted and rural communities.
- Extending hours (e.g., evenings and weekends) in application centers.
- Using multilingual staff.
- Reaching out to underserved populations such as military families, Native Americans, immigrants, seniors, residents in rural communities, and persons with disabilities.
- Increasing outreach partners such as schools, health providers, food banks, tax preparers, and utility companies.
- Stationing outreach and enrollment workers in community settings, schools, treatment settings, and shelters.
- Providing assistance in completing applications, with appropriate certification periods and follow-up after application to assure completion.
- Creating a welcoming environment in application offices.
- Conducting a public awareness/education campaign.
- Including Food Stamp eligibility information and prescreening in hotlines and helplines.

How can we improve the trend in San Diego County?

There has been significant progress in the implementation of all three Report Card 2009 recommendations to improve access to Food Stamp benefits throughout San Diego County. As part of a multifaceted effort to improve access to CalFresh and other benefits, the Health and Human Services Agency partnered with several community-based organizations to implement video interviewing for residents in northern rural areas. This effort has increased enrollment in those areas and reduced travel for both customers and employees, saving the county $15,000. To streamline services to families to receive eligible benefits, 211 San Diego piloted a project that allows families to use a "voice signature" over the phone to apply for benefits using One-e-App, simplifying and speeding the application process. San Diego is the first California county to allow a community-based organization to use this innovative method.

Based on what works and what we have been doing, the top three recommendations for San Diego are to work with self-sufficiency programs, family resource centers, faith communities, United Way of San Diego County, 211, San Diego Food Bank, schools, community colleges, local universities, Health and Human Services Agency, San Diego Hunger Coalition, San Diego Workforce Partnership, community-based organizations, and California Department of Social Services to:

1. Promote the use of electronic application processes, including One-e-App, Benefits CalWIN, 211, video interviewing, and telephonic signature to assist families in applying for CalFresh and other public and private assistance programs.
2. Conduct a public awareness/education campaign to educate eligible families about nutrition assistance provided through the SNAP program.
3. Target outreach to underserved families, particularly military families, Native Americans, immigrants, and families living in rural areas.

"We share a common vision of a future when all Americans can live a healthy lifestyle, have access to the health care they need, and enjoy the highest quality care possible."

Kathleen Sebelius, Secretary of U.S. Department of Health and Human Services

Community and Family (Cross Age): HEALTH COVERAGE

What is the indicator?

The percent of children ages 0-17 who are without health coverage.

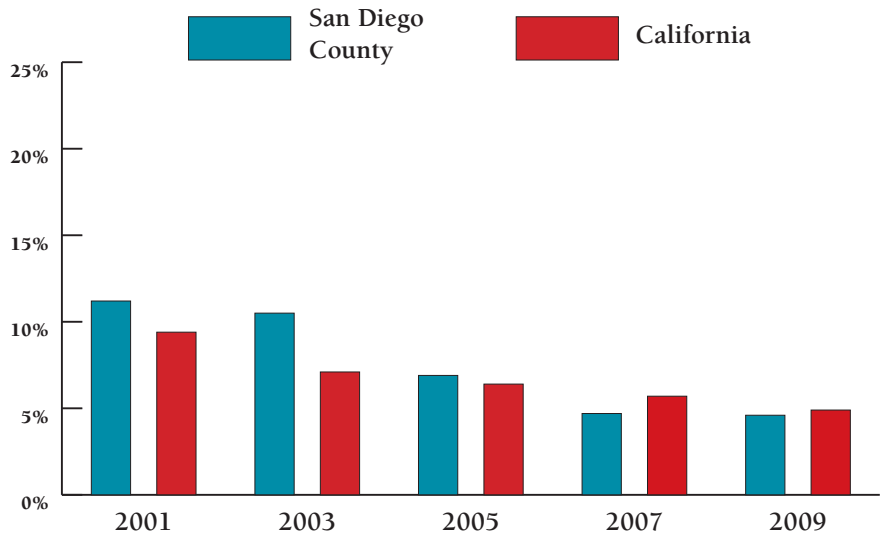
This indicator monitors the percent of children who are without health coverage in San Diego County. This information is collected every other year and reported through the California Health Interview Survey.

Why is this important?

The single greatest barrier to receiving medical care is lack of health coverage. Uninsured children are less likely than their insured counterparts to receive preventive services and needed treatments. For children with special health needs (i.e., chronic conditions that require extra care and treatment), lack of coverage can mean more hospitalizations for untreated asthma, poorly treated vision or hearing problems, and worsening disabilities. Research has shown 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.

How are we doing?

Percent of Children Ages 0-17 without Health Coverage, San Diego County and California, 2001, 2003, 2005, 2007, and 2009



The trend is improving. The percent of children without health coverage for San Diego County was just under 5% in 2007 and 2009. Our county rate was comparable to the state average in 2009.

What strategies can make a difference?

With expansions of Medicaid (known as Medi-Cal in California), the state Children's Health Insurance Program (CHIP, known as Healthy Families in California), and the Kaiser Child Health Plan, most uninsured children with family income below 300% of the Federal Poverty Level are eligible for publicly subsidized coverage. Federal CHIP law emphasizes use of effective strategies to improve outreach and enrollment for children who are eligible but remain uninsured. The Affordable Care Act ("health reform") will increase coverage for uninsured parents, particularly those with low wages.

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

- Implementing policies developed under the implementation of the Affordable Care Act regarding simple enrollment, consumer informing, and other approaches to expand coverage.
- Simplifying and streamlining the application process and enrollment policies (e.g., shorter forms, applications by mail or Internet, no asset tests, and no application fees).
- Providing automatic eligibility determinations and renewals for health coverage when families complete applications or recertification for other public assistance programs.
- Developing effective outreach and enrollment strategies such as those used in the "Covering Kids" projects at the state and community level across the country, including:
  - Campaigns to promote awareness of available coverage (e.g., culturally specific marketing tools, outreach through employers, billboards and posters).
  - Assistance in distributing and completing applications in schools, homeless shelters, community-based organizations, health provider sites, and the workplace.
  - Incentives for schools, employers, and community-based organizations to identify families and help them enroll their children.
- Using federally required outreach workers at locations such as community clinics and WIC.
- Expanding publicly subsidized health insurance to low-income and uninsured parents.

How can we improve the trend in San Diego County?

Prior Report Cards recommended that state and federal agencies work towards a permanent solution for Healthy Families. Some progress has been made through implementation of the Affordable Care Act. San Diego County received $50 million in federal funding to assist with early implementation of some health reforms. The funds will be matched with local money set aside for indigent health care. Using this funding, the county has enrolled over 15,000 residents in the federal Low Income Health Program to assist families not eligible for Medi-Cal. (See box at right.)

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with the Health and Human Services Agency, First 5 San Diego, health providers, health plans, Family Resource Centers, parents and parent associations, 211, San Diego Workforce Partnership, Chambers of Commerce, California Department of Health Services, faith communities, and community-based organizations to:

1. Inform families about their new rights and eligibility for additional coverage and benefits under the California expansion of health reform.
2. Provide outreach to assure that families who have become unemployed or underemployed have knowledge and access to apply for Medi-Cal and Healthy Families coverage, as well as newly subsidized plans.
3. Use navigators, community health workers, community health teams, and other emerging strategies to assist families in gaining access to coverage and using needed health services.

Implementing Health Reform in San Diego County

California is one of a small number of states that are rapidly moving ahead with implementation of health reform. The federal Patient Protection and Affordable Care Act set all states on a timeline to implement reforms between now and January 1, 2014. California secured a federal Medicaid waiver, known as "California's Bridge to Reform" to help accelerate this process.

As a result, California is the first state to create its own Health Insurance Exchange, which will be the marketplace for individuals and small businesses to purchase health plans, that is being designed now. The California Health Benefit Exchange was established as an independent public entity within state government with oversight from a five member board appointed by the governor and legislature. Because of California's front-runner status and the sheer size of its coverage expansion, many other states will look to California's experience as a roadmap for the development of their own Health Insurance Exchanges.

As with many federal programs, California will delegate considerable responsibility to counties for carrying out key health reform activities. San Diego has opportunities to make decisions that will affect the health of families and children. Both local government and community-based organizations have roles to play. For example, local organizations can provide information to families about their coverage options, instruction on how to use new online resources, and support for navigating the health system as it changes over the coming years. Local governments will share responsibility for providing information but also play a critical role in supporting individuals and families in enrolling in coverage and gaining access to services.

San Diego County is one of 58 counties in California that have substantial responsibility for assuring "safety net" health services for low-income residents. An analysis of six California counties, including San Diego, by the Center for Studying Health System Change concluded that county-level decisions about contracts with hospitals and managed care plans are important tools for assuring access for low-income residents in San Diego County. Thus, while San Diego County does not own a public hospital or clinic, local government decisions and actions directly affect safety net access.

With this in mind, in 2010 the County of San Diego built upon its central role in promoting the health and well-being of San Diegans by rolling out a ten-year regional wellness initiative—*Live Well, San Diego!*—aimed at improving all aspects of health. As part of this effort, in May 2011, the County Board of Supervisors approved the implementation of the Low-Income Health Program (LIHP). LIHP funds health coverage for uninsured, legal residents of the County ages 19 through 64 years with income at or below 133% of the Federal Poverty Level. The expanded coverage was offered beginning July 1, 2011. LIHP uses a network of community health centers along with hospitals, community physicians, and mental health providers throughout San Diego County to provide health care services.

The Health and Human Services Agency contracts with clinic systems and hospitals to assure access to quality, comprehensive care, including both physical and mental health. Through LIHP, eligible and enrolled individuals will have access to a patient-centered medical home, which will help improve outcomes for patients, as well as encourage efficient use of resources. "The LIHP addresses a key component to our *Live, Well, San Diego!* strategy in providing access to quality health care for over 20,000 medically indigent adults throughout the region," said Health and Human Services Agency Director, Nick Macchione, regarding adoption of this policy. "County Board of Supervisors Chairman Bill Horn noted: "Not only is this program leveraging important federal dollars to provide this care, it is also providing more integrated care to more people."

"Domestic, dating and sexual violence are costly and pervasive problems in this country, causing victims, as well as witnesses and bystanders, in every community to suffer incalculable pain and loss." ***Futures Without Violence***

Community and Family (Cross Age): DOMESTIC VIOLENCE

What is the indicator?

The rate of domestic violence reports per 1,000 households.

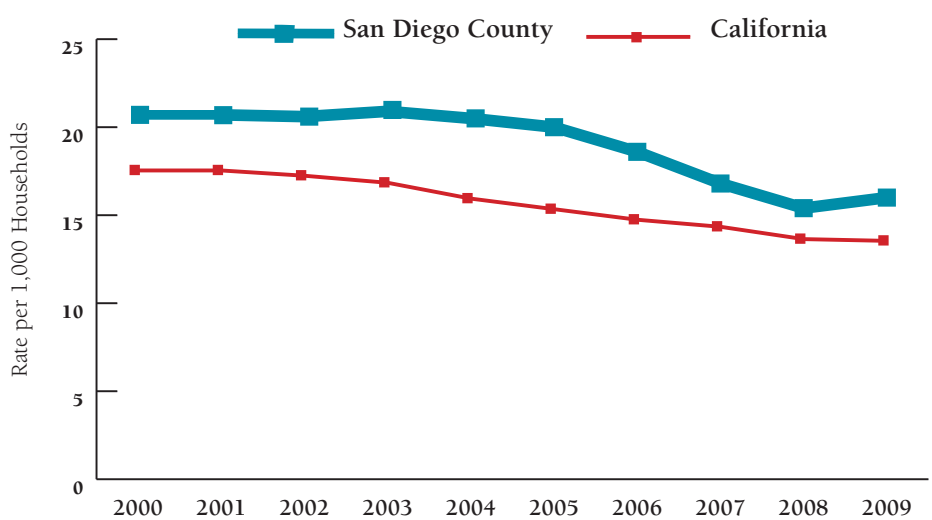
This indicator—the rate of domestic violence reports per 1,000 households—documents the rate of reports of domestic violence and intimate partner violence made to San Diego County law enforcement agencies. The rate of police reports is generally closer to the actual rate at which violence is occurring than is the number of arrests or convictions made. The number of reports is considered to be an underestimate. These data are reported by ARJIS and the California Department of Justice.

Why is this important?

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

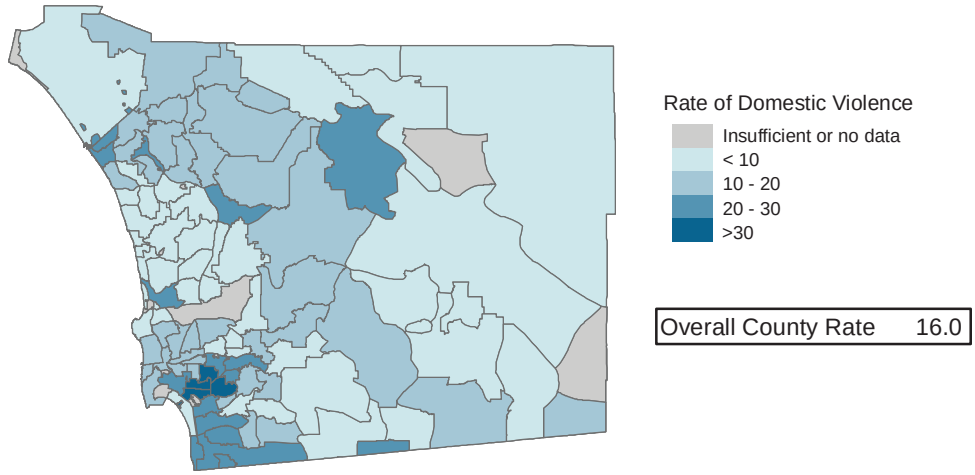
How are we doing?

Rate of Domestic Violence Reports Per 1,000 Households, San Diego County and California, 2000-2009



The trend is not improving and remains above the state rate. Central San Diego (see map at right) continues to show the highest rate of domestic violence per 1,000 households.

RATE OF DOMESTIC VIOLENCE INCIDENTS PER 1,000 HOUSEHOLDS: 2009



NOTE: Data from Automated Regional Justice Information System, ARJIS. Data prepared by County of San Diego Health and Human Services Agency with assistance from the District Attorney's Office. Rates calculated using SANDAG 2009 Household Estimates.

Taking Count of Children Exposed to Domestic Violence

Researchers estimate that anywhere from 3 to 10 million children are exposed to domestic violence each year in the United States. Living in a household with violence is a life fraught with extreme stress and trauma, and the effects on children are lifelong. The problem is, no one really knows the true number of children who are at risk due to domestic violence. Researchers across the country collect statistics regarding the involved adults, but not about their children. Consistency in reporting is the first step in building a valid and reliable dataset to understand and respond to the problem.

To address this critical gap in information, the Children's Initiative reviewed domestic violence reporting procedures and documentation among San Diego County's law enforcement jurisdictions. Our review revealed that although all jurisdictions are required by California state law (DV 13700 P.C.) to utilize a Domestic Violence (DV) Supplemental reporting form to record demographic and injury information, the content of this form had not been standardized. At that time, each jurisdiction designed their own form and only listed child information if the child was a witness to the specific incident.

Reaching out to all local police chiefs and the Sheriff, and working with the San Diego County District Attorney's Office, the Children's Initiative was given responsibility to develop a universal standard Domestic Violence Supplemental reporting form for San Diego County. This new DV Supplemental form, among other benefits, now requires responding officers to record information about any children that live with either the suspect or the victim, whether or not they witnessed or were present during the precipitating event. This is important, because when a child lives in a household or with a parent involved in violence, that child is affected despite efforts a parent may make to keep the violence out of sight of the child. Children do not "sleep" through a domestic violent assault.

In 2011, the Children's Initiative started to gather and analyze the data from the new DV Supplemental form. Although consistency issues are still being addressed, preliminary data shows that hundreds of children per month are being exposed to domestic violence. As this work continues, data collection processes are being refined, and data are becoming more reliable. In the future, the Report Card will be able to tell us for the first time ever in San Diego County, how many of our children are at risk due to violence in their homes and which communities have high incidences of domestic violence so that services can be enhanced.

What strategies can make a difference?

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

- Screening routinely for domestic violence and child abuse in health care settings or home visits, with follow-up referrals as necessary.
- Linking 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.
- Educating judges about domestic violence to ensure consistency in sentencing (i.e., prevalence across racial/ethnic and income groups, similar to assault).
- Assuring enforcement of perpetrators' mandated treatment, including monitoring of active participation in yearlong violence prevention programs and other terms of probation.
- Enforcing the removal/submission of firearms among individuals who have been convicted of domestic violence.
- Implementing 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.
- Using 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.
- Providing readily accessible trauma-informed services (e.g., shelters, legal assistance, counseling, case management) for victims and their children.
- Helping victims develop and continually update their safety plans.
- Providing cross-system targeted training on domestic violence, conflict resolution, healthy relationships, self-sufficiency, and related topics for staff that work with at-risk families.
- Updating regularly the protocols and policies, including cross-system protocols, related to domestic violence and intimate partner violence.

How can we improve the trend in San Diego County?

San Diego has implemented a Report Card recommendation on initiating cross-system training. The San Diego Domestic Violence Council works to educate professionals and community members countywide with trainings throughout the year. Child Welfare Services has implemented a domestic violence protocol for their workers and provided training on domestic violence and trauma effects. The District Attorney's Office, in partnership with law enforcement agencies, the Health and Human Services Agency, and nonprofit organizations, launched the multidisciplinary Domestic Violence High Risk Case Response Team to respond to victims and children in very high risk situations. Three local support agencies also provide emergency cell phones to victims: YWCA, Center for Community Solutions, and the Family Justice Center.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with the Health and Human Services Agency, law enforcement agencies, courts, Probation Department, schools, faith communities, mental health providers, health providers, early care and education, and other service providers to:

1. Ensure consistent and reliable use of domestic violence protocols, including use of the domestic violence supplemental form, among all law enforcement agencies.
2. Increase cross-system training in identification, screening, and assessment of domestic violence and intimate partner violence (e.g., public health nurses, teachers, mental health providers, alcohol and drug counselors, law enforcement officers).
3. Increase the use of routine developmental screening in early childhood for early identification of young children exposed to violence and other trauma.

"The ultimate goal is to stop child maltreatment before it starts."

Centers for Disease Control and Prevention

Community and Family (Cross Age): CHILD ABUSE AND NEGLECT

What is the indicator?

The rate of substantiated cases of child abuse and neglect per 1,000 children ages 0-17.

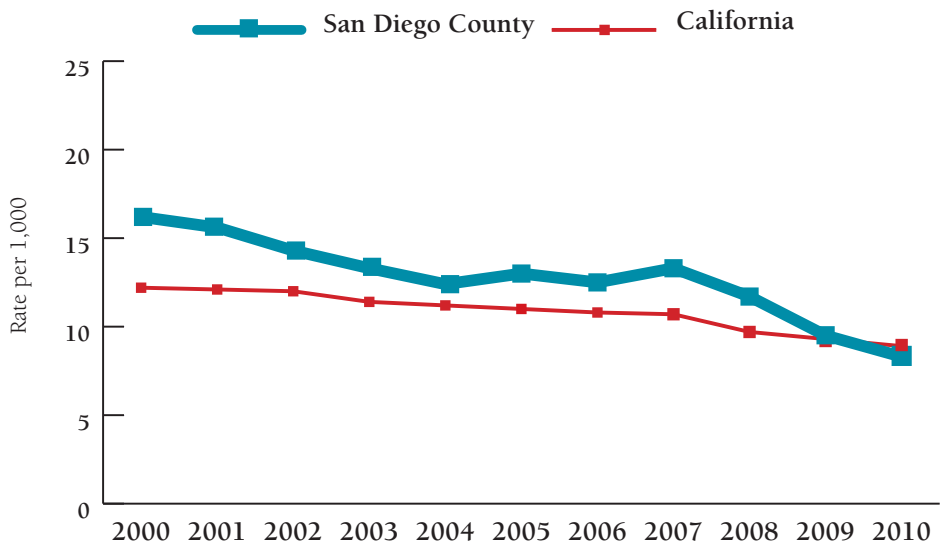
This indicator—the rate of substantiated cases of child abuse and neglect per 1,000 children ages 0-17—shows the trend in reports of child abuse and neglect that are found through investigation to have sufficient evidence to warrant a child welfare services case being opened or having the family referred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

Why is this important?

Child abuse and neglect has profound and often long-term effects on a child's physical, mental, and emotional health, and even brain and cognitive development. Physical effects include injury and disability, and even death; psychological effects include depression, anger, self-harm behaviors, anxiety, and aggression. Children who have been abused or neglected often have social and behavioral problems, and research shows that they are less likely to succeed in school. Recent attention has also been drawn to shaken baby syndrome, as these deaths appear to be increasing.

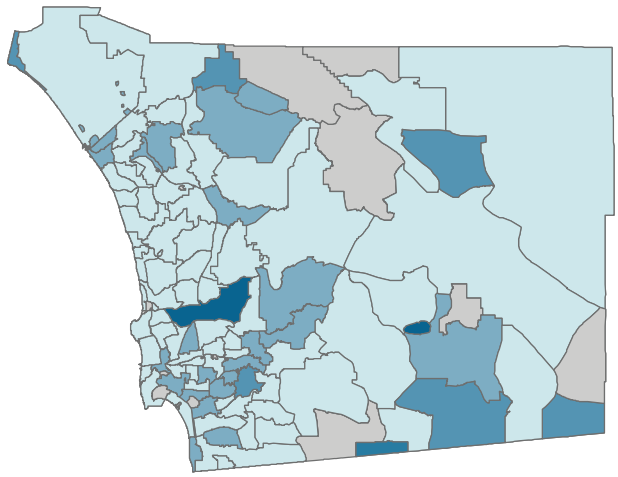
How are we doing?

Rate of Substantiated Cases of Child Abuse and Neglect Per 1,000 Children Ages 0-17, San Diego County and California, 2000-2010



The trend is improving. San Diego County's rate of substantiated child abuse continues to decline and in 2010 reached 8.3 per 1,000 children. (Note that past rates shown in this trend have been recalculated based on revised population estimates.)

RATE OF SUBSTANTIATED REFERRALS OF CHILD ABUSE & NEGLECT, 2010



NOTE: Data provided by CWS Data & QA Unit from a query of Child Welfare Services Case Management System (CWS/CMS). Includes children 17 and under. Excludes 152 referrals with out of county, incorrect , or blank zip codes in CWS/CMS. SANDAG 2010 Population Estimates.

What strategies can make a difference?

Child abuse and neglect are associated with many factors, including parental substance abuse, unemployment, poverty, history of abuse, domestic violence, anger, isolation, mental health, and stress. Effective interventions should be tailored to the individual situation. The Adverse Childhood Events (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.

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

- Developing parenting classes and support groups to teach age-appropriate communication and positive discipline from birth (e.g., Incredible Years or Strengthening Families curriculum)
- Providing family interventions to improve parent-child relationship skills and increasing social supports for at-risk families.
- Providing high quality, evidence-based home visiting programs for at-risk families from prenatal to 5 years (Nurse Family Partnership, Healthy Families America, Parents as Teachers, Healthy Steps).
- Implementing the SafeCare model, an intensive, evidence-based home visitation program focused on children from birth to 12 years old that has been shown to reduce child abuse and neglect among families with a history for maltreatment.
- Using efforts such as the Period of PURPLE Crying (an evidence-based shaken baby syndrome prevention program) to help parents and other caregivers.
- Implementing the Positive Parenting Program (Triple-P), shown to be effective in prevention of childhood social-emotional and behavioral problems and child maltreatment.
- Providing respite care for families facing high-stress and/or emergency situations.
- Using the court to mandate and support family treatments and interventions designed to reduce abuse and neglect.
- Training health providers, teachers, and other care providers to recognize signs of abuse and neglect, as well as providing information regarding community resources available.

How can we improve the trend in San Diego County?

Progress is being made towards the implementation of Report Card recommendations to expand intensive home visiting and implement a continuum of evidence-based programs across the county. SafeCare is an evidence-based intensive home visiting prevention and education program being used for high-risk families in the San Diego Child Welfare system. Locally implemented in 2008 with support from United Way of San Diego County, the program has trained 44 home visitors throughout the county and served more than 1,100 at-risk families with more than 2,100 children.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with Health and Human Services Agency, United Way of San Diego County, First 5 San Diego, parents and parent associations, schools, the courts, Probation Department, law enforcement, mental health providers, community-based organizations, and faith communities to:

1. Increase access to parenting education designed to promote positive parenting practices and using evidence-based curricula for parents with identified risks.
2. Expand intensive home visiting for at-risk families, including but not limited to teen, single, and low-income parents.
3. Implement evidence-based, trauma-informed service delivery approaches across systems (e.g., child welfare, law enforcement).

"And in our country today, the greatest threat to the lives of children and adolescents is not disease or starvation or abandonment, but the terrible reality of violence."

Donna Shalala, former Secretary of U.S. Department of Health and Human Services

Community and Family (Cross Age): CHILD VICTIMS OF VIOLENT CRIME

What is the indicator?

The rate of violent crime victimization per 10,000 children or youth ages 0-11 and 12-17.

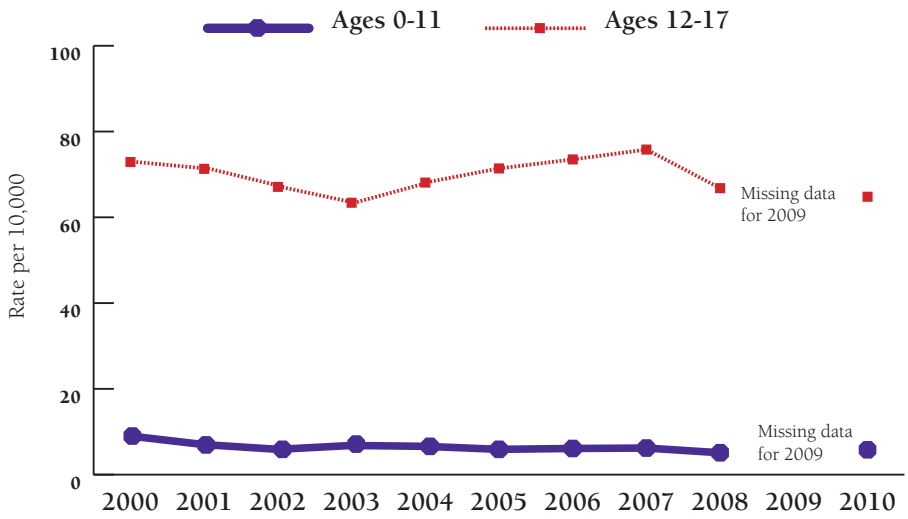
This indicator—the rate of violent crime victimization of children—reflects trends in four types of crime (homicide, rape/sexual assault, aggravated assault, robbery by force or threat). The data are from ARJIS, so only those incidents that result in an arrest report are represented.

Why is this important?

Violent crimes perpetrated against children are a tragedy that impacts life forever; altering trust, hampering development, increasing mental health problems, and disrupting success in school. Nationally, children and youth are most likely to be victims of violent crime, particularly those ages 12-24. 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 by adult men. With the exception of assault, African-American children are more likely to be the victims of violent crime than those of any other race or ethnicity.

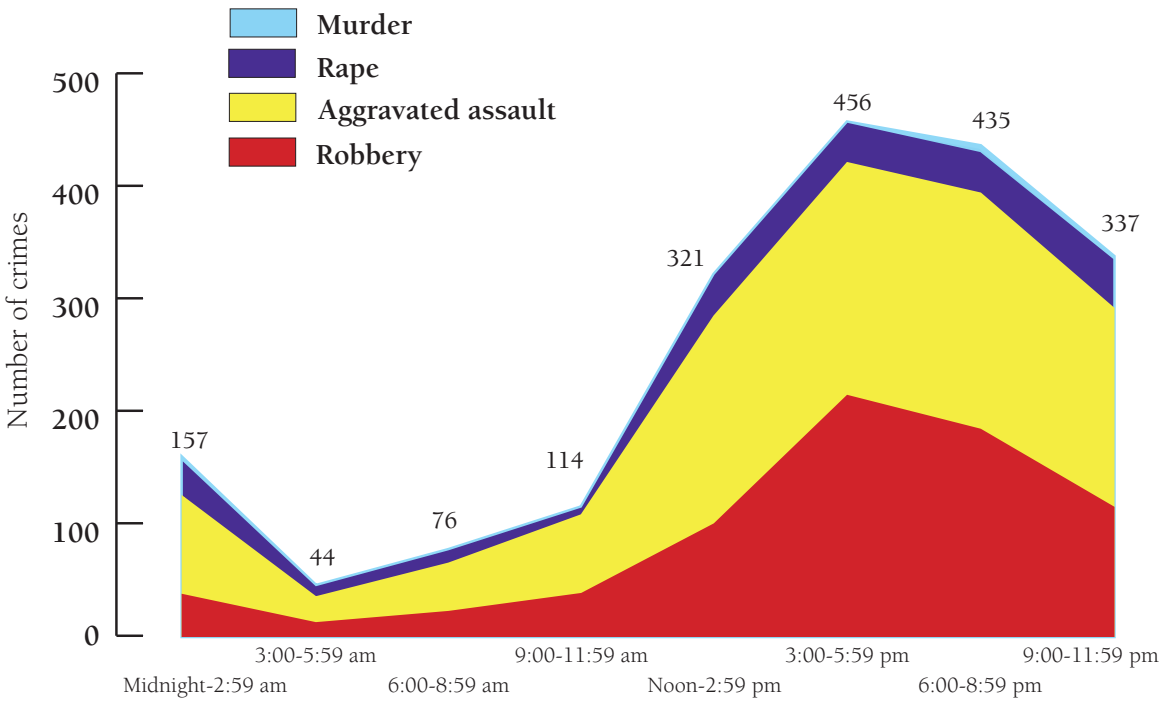
How are we doing?

Rate of Violent Crime Victimization Per 10,000 Children, Ages 0-11 and 12-17, San Diego County, 2000-2010



The overall trend is not improving, despite fluctuations. The rates for all ages birth to 17 were 25.8 in 2008 and 25.2 in 2010.

Number of Violent Crimes with Child Victims Ages 0-17, By Time of Day, San Diego County, 2010



The number of violent crimes committed against children and youth increases dramatically after school, peaking between the hours of 3 p.m. and 6 p.m. High numbers of crimes continue into the evening until midnight.

What strategies can make a difference?

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

- Ensuring adequate adult supervision of children and youth in non-school hours.
- Training 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.
- Supporting safe passages for children and youth to and from school.
- Developing anti-violence and anti-bullying prevention programs such as: Olweus Bullying Prevention; PeaceBuilders; Promoting Alternative Thinking Strategies (PATHS); and Resolving Conflict Creatively Program (RCCP).
- Implementing conflict resolution programs in schools, after school programs, and in youth-serving community organizations.
- Expanding programs aimed at reducing gang participation.
- Providing after school and evening activities in high crime communities, including after school programs, teen centers, job internships, etc.
- Using schools as community hubs, including ball fields, libraries, and other common spaces.
- Implementing gender-specific services for girls.
- Increasing youth and parent knowledge of and ability to protect against sexual assault and rape.
- Educating 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?

San Diego Unified School District supported one of the recommendations in the 2009 Report Card to expand anti-violence and anti-bullying programs in schools by adopting a strong anti-bullying policy in 2011. The Bullying, Harassment and Intimidation Prohibition Policy was developed in partnership with community groups and the Safe Schools Advisory. The policy mandates that school officials report incidents of bullying or harassment, and that schools implement prevention programs and disciplinary actions for offenders. In 2011, the State of California passed Assembly Bill, AB 9, "Seth's Law," which requires all California school districts to adopt anti-bullying policies.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with schools and school districts, San Diego County Office of Education, parents and parent associations, community-based organizations, faith communities, community centers, neighborhood associations, municipalities, law enforcement, courts, and Probation Department to:

1. Implement a campaign to increase adult supervision of 12- to 17-year-old youth in non-school hours, specifically between 3 p.m. and midnight.
2. Providing after school and evening activities in high crime communities, including after school programs, teen centers, job internships, etc.
3. Expand programs to prevent bullying, racism, intimidation, sexual harassment, and hate crimes through schools, after school programs, youth-serving community centers, community-based organizations, and juvenile detention facilities.

"Safety and injury prevention must be among our highest public health priorities as a nation." *David Satcher, Former U.S. Surgeon General*

Community and Family (Cross Age): UNINTENTIONAL INJURY

What is the indicator?

The rate of unintentional injuries per 100,000 children ages 0-18.

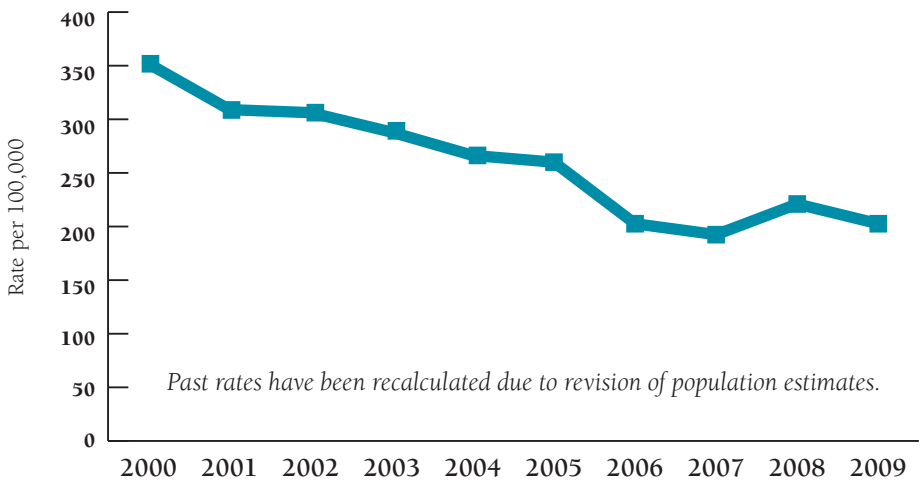
This indicator—the rate of unintentional injury hospitalizations and deaths per 100,000 children 0-18—shows trends in how many children are injured severely enough to require hospitalization or who die of accidental causes. These data are routinely reported on hospital discharge reports and death certificates.

Why is this important?

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

How are we doing?

Rate of Fatal and Non-Fatal Unintentional Injuries per 100,000 Children Ages 0-18, San Diego County, 2000-2009



The trend is improving overall. From 2000 to 2009, the rate of fatal and non-fatal unintentional injuries to children dropped from 352 per 100,000 to 203 per 100,000.

What strategies can make a difference?

Although unintentional injuries are the leading cause of death it is important that each cause be addressed individually. Specific prevention and intervention approaches may be needed for each cause. Legal mandates 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).
- Protective gear such as helmets for biking, snowboarding, skiing, skateboarding, off-road vehicles, and other sports.
- Protective restraints such as child car seats, booster seats, and seat belts.
- Crib safety for infants.
- Common causes of choking and suffocation.
- 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:

- Smoke detectors, hot water heater controls, and safety gates in rental and owned properties.
- Protective restraints such as car seat belts, child safety car seats, and booster seats.
- 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?

One Report Card recommendation—to increase parent education about home safety precautions—was supported by the CalWORKs Safety Education and Training Initiative. This program deploys a team of injury prevention specialists to help low-income families assess their child's risk, develop a family safety plan, and provide safety products and education. In six weeks the program served more than 700 families. Follow-up results indicate that 77% of the families had made the appropriate safety changes.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with Safe Kids San Diego, Injury Free Coalition for Kids, parents and parent associations, schools and school districts, coaches and physical education teachers, local law enforcement, Health and Human Services Agency, landlord associations, and municipalities to:

1. Increase enforcement of existing child vehicle restraint laws and helmet laws.
2. Increase education to parents and caregivers regarding home safety precautions.
3. Develop and/or increase enforcement of safety regulations in rental properties and stronger penalties for violations.

"A nation's ability to reduce child mortality rates is a measure of that society's overall well-being, and failure to address preventable causes of child mortality is a national tragedy." *American Academy of Pediatrics*

Community and Family (Cross Age): CHILDHOOD MORTALITY

What is the indicator?

The mortality rate per 1,000 children ages 0-17.

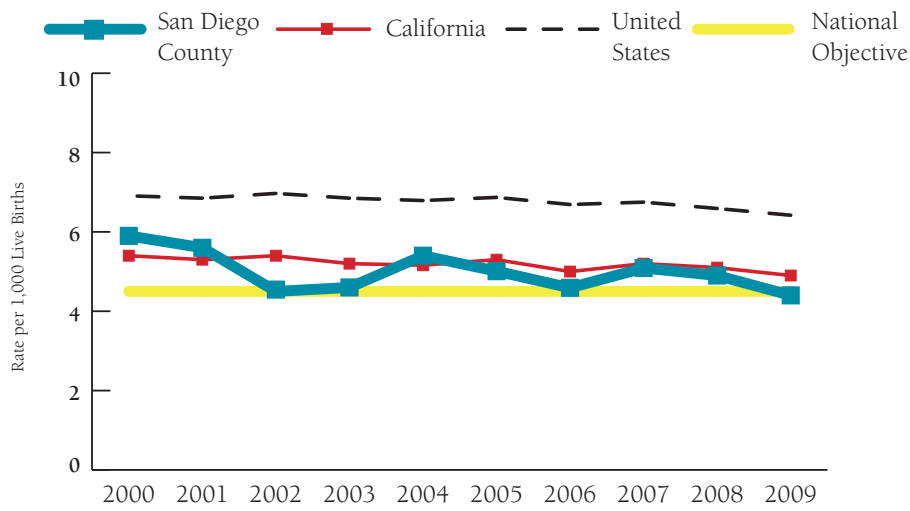
This indicator—the rate of mortality for children ages 0-17—monitors the rate at which infants, children, and youth die. These data are recorded on death certificates and routinely reported as part of local, state, and federal vital statistics.

Why is this important?

Child mortality is one of the most fundamental indicators of a community or country's well-being. Child mortality is related to a variety of health factors (e.g., risk of disease, safety practices) and socioeconomic conditions (e.g., housing). The leading causes of death vary by age. About two-thirds of infant deaths occur in the first month after birth, primarily due to conditions such as low birthweight, preterm birth, or birth defects. There are almost twice as many deaths in the first year of life as in the next 13 years altogether. Then, in adolescence mortality rates rise rapidly again. Older children are more likely to die of external causes such as motor vehicle crashes, drowning, suicide, and homicide. Many child deaths are preventable.

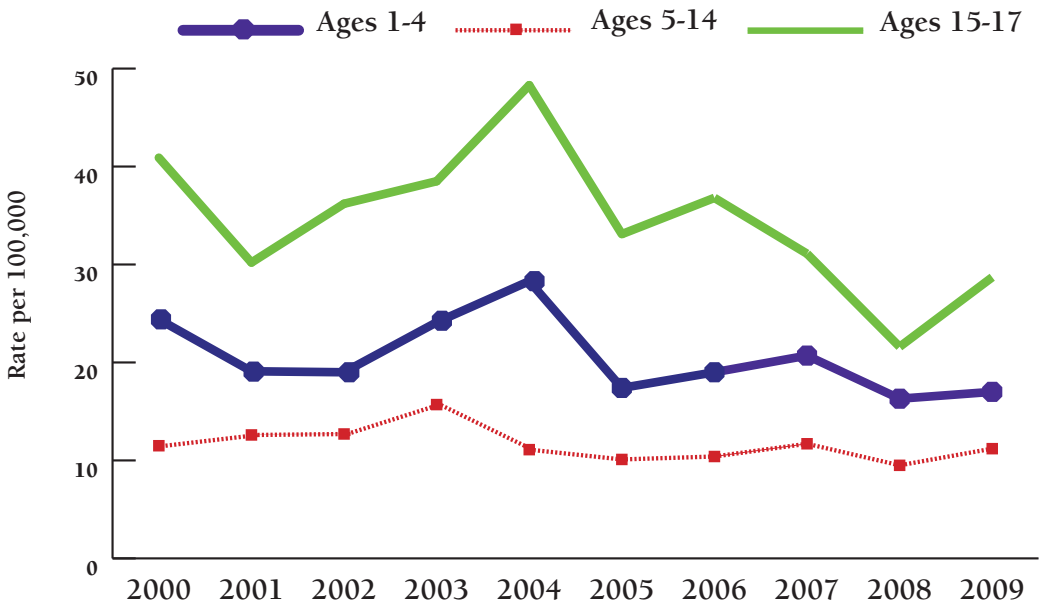
How are we doing?

Infant Mortality Rate Per 1,000 Live Births, San Diego County, California, and United States Compared to National Objective, 2000-2009



The trend is improving. San Diego's infant mortality rate of 4.4 per 1,000 in 2009 was better than state or U.S. averages and surpassed the national objective of 4.5 per 1,000 live births. (Note that small year-to-year variations in infant mortality at the county level may not be statistically significant or reflect valid trends.).

Mortality Rate Per 100,000 Children Ages 1-4, 5-14, and 15-17, San Diego County, 2000-2009



The trend is not improving. The rate of mortality for children ages 1-4 has generally maintained. For children ages 5-14, mortality rates have not showed sustained improvement since 2000, despite variations. In 2008, the rate for youth 15-17 reached its lowest rate of the decade but went up again in 2009.

What strategies can make a difference?

Childhood mortality rates reflect an array of risks and conditions such as disease, poor maternal health, adverse living conditions, environmental hazards, lack of access to health services, risky behavior, and other factors. Studies show that communities must develop and implement strategies that are age appropriate and developmentally suitable. Many of the recommended actions throughout this Report Card are part of childhood mortality prevention.

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

- Conducting community campaigns on factors that place infants, children, and adolescents at risk for premature death.
- Educating parents before they leave the hospital with a newborn about sleeping position ("back to sleep") to prevent sudden infant death syndrome (SIDS), and about shaken baby syndrome.
- Providing car and booster seats for infants, toddlers, and young children.
- Ensuring access to services and supports that reduce the underlying causes of infant death, including preterm and low-birthweight birth.
- Educating parents and children about the risks of drowning at home and in the community.
- Promoting gun safety (e.g., safe gun storage, "safe surrender" programs).
- Using interventions for socially isolated families and families at risk for child abuse and neglect.
- Implementing suicide awareness and prevention programs.
- Requiring driver safety education programs for teen drivers.
- Supporting child death or fatality review teams to identify risk factors and interventions that could prevent future deaths.

How can we improve the trend in San Diego County?

As part of the *Live Well, San Diego!* initiative, and in support of the Report Card recommendation to expand campaigns about prevention of shaken baby syndrome, the Health and Human Services Agency produced a video on preventing head trauma from abuse as part of their safety campaign in the fall of 2011. The video is designed for social workers and public health nurses to use on their home visits with new and expectant parents and will also be played in the lobbies of county facilities.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with Safe Kids San Diego, Injury Free Coalition for Kids, San Diego Child Fatality Review Team, Health and Human Services Agency, First 5 San Diego, United Way of San Diego County, parents and parent associations, schools and school districts, community clinics, American Academy of Pediatrics, faith communities, community-based organizations, local law enforcement, municipalities, and media partners to:

1. Enforce safe driving regulations, including use of car seats and seat belts, eliminating cell phone use, and restrictions on new drivers.
2. Expand public education and social marketing campaigns regarding prevention of shaken baby syndrome, sudden infant death syndrome, drowning, and fatal injuries, particularly in Spanish and other threshold languages.
3. Continue and expand gun safety programs, particularly safe gun storage, to protect children of all ages from firearm-related injuries, as well as suicide, homicide, and firearm-related accidental deaths.

ACKNOWLEDGEMENTS

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Birth to Age 3 (Infants and Toddlers)

Prenatal Care
California Department of Public Health, Center for Health Statistics, Birth Statistical Master Files. Prepared by County of San Diego, Health & Human Services Agency, Maternal, Child & Family Health Services.

National objective is from Healthy People 2010, U.S. Department of Health and Human Services. http://www.healthypeople.gov/2010/

Low Birthweight
- California Department of Public Health, Center for Health Statistics, Birth Statistical Master Files. Accessed via County of San Diego, Health & Human Services Agency, Maternal, Child & Family Health Services (MCFHS) website. http://www.co.san-diego.ca.us/hhsa/programs/phs/maternal_child_family_health_services/statistics.html
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Breastfeeding Initiation
- Newborn Screening Test Form. Data compiled by State of California, Department of Health Services, Maternal, Child and Adolescent Health/Office of Family Planning Branch.
- National objective is from Healthy People 2010. http://www.healthypeople.gov/2010/

Births to Teens
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Ages 3 to 6 (Preschool)

Immunization
- San Diego Immunization Partnership. Public Health Services, County of San Diego Health and Human Services Agency.
- National objective is from Healthy People 2010, U.S. Department of Health and Human Services. http://www.healthypeople.gov/2010/

Early Care and Education

- U.S. Census Bureau, 2005-2009 American Community Survey, Table S1401. http://factfinder.census.gov/servlet/DatasetMainPageServlet?_program=ACS&_submenuId=&_lang=en&_ts=

Ages 6 to 12 (School Age)

Oral Health

- California Health Interview Survey (CHIS), University of California, Los Angeles (UCLA) Center for Health Policy Research. http://www.chis.ucla.edu/

School Attendance

- Data provided by San Diego County school districts. These data represent 98% of county student population.

School Achievement (Grade 3)

- California Standardized Testing and Reporting Program, as reported by the California Department of Education, Standards and Assessment Division on the DataQuest website. http://data1.cde.ca.gov/dataquest/

Obesity

- California Fitness Test, as reported by the California Department of Education, Standards and Assessment Division on the DataQuest website. http://data1.cde.ca.gov/dataquest/
- National objective is from Healthy People 2010, U.S. Department of Health and Human Services. http://www.healthypeople.gov/2010/

Ages 13 to 18 (Adolescence)

School Attendance

- Data provided by San Diego County school districts. These data represent 98% of county student population.

School Achievement (Grades 8 and 11)

- California Standardized Testing and Reporting Program, as reported by the California Department of Education, Standards and Assessment Division on the DataQuest website. http://data1.cde.ca.gov/dataquest/

Substance Use

- California Healthy Kids Survey, WestEd, prepared by San Diego County Office of Education, Safe Schools Unit.
- Centers for Disease Control and Prevention. U.S. Data: Youth Risk Behavior Surveillance Survey, United States, 2007. *Morbidity and Mortality Report*. June 6, 2008; 57(SS04):1-131.

Youth Suicide

- Youth Risk Behavior Surveillance Survey, prepared by San Diego Unified School District, HIV Prevention and Sex Education Program, P.E., Health and Athletics Department.

Juvenile Arrests

- State Department of Justice, Criminal Justice Statistics Center, SANDAG Annual Arrest Reports 2000 through 2006.

Juvenile Probation

- San Diego County Probation Department Research Unit. Data specially prepared for this Report Card.

Youth DUI

- California Department of Motor Vehicles, Research Unit; 2002 through 2011 Annual Report of the California DUI Management Information System.
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- County of San Diego Emergency Medical Services, Epidemiology, SWITRS Database, 1996–2009. Data specially prepared for this Report Card.

Cross Age: Community and Family

Poverty
- U.S. Census Bureau, Small Area Income and Poverty Estimate, years 2000-2009. http://www.census.gov/hhes/www/saipe/

Food Stamps:
- Health and Human Services Agency, CalWIN program.

Health Coverage
- California Health Interview Survey (CHIS), University of California, Los Angeles (UCLA) Center for Health Policy Research. http://www.chis.ucla.edu/
- DeNavas-Walt C et al. *Income, Poverty and Health Insurance Coverage in the United States: 2009.* Current Population Reports—Consumer Income. U.S. Department of Commerce, Economics and Statistics Administration. U.S. Bureau of the Census. September 2010. http://www.census.gov/prod/2010pubs/p60-238.pdf

Domestic Violence
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- Automated Regional Justice Information System (ARJIS), SANDAG. Data specially prepared for this Report Card.
- California Department of Justice, Reports and Research Papers, Estimates, Historical County and City Estimates. *http://www.dof.ca.gov/research/demographic/reports/estimates/e-5/2001-10/view.php*

Child Abuse and Neglect
- Children's Research Center (CRC) Query of the Child Welfare Services Case Management System (CSW/CMS); U.C. Berkeley Center for Social Services Research: CWS/CMS Dynamic Report System. http://cssr.berkeley.edu/ucb_childwelfare
- Data prepared by County of San Diego Health and Human Services Agency, Child Welfare Services Data & Quality Assurance Unit.
- California Department of Finance annual population projections (Based on the 2000 U.S. Census).

Violent Crime Victimization of Children
- Automated Regional Justice Information System (ARJIS), SANDAG. Data specially prepared for this *Report Card.*
- San Diego Association of Governments, SANDAG Current Estimates (2010 Update). http://datawarehouse.sandag.org/

Unintentional Injury Hospitalizations and Deaths
- California Department of Health Services, EPICenter. http://epicenter.cdph.ca.gov/ReportMenus/CustomTables.aspx
- Centers for Disease Control and Prevention. WISQARS. http://www.cdc.gov/ncipc/wisqars/

Child Mortality
- California Department of Health Services, Center for Health Statistics Vital Statistics Query System. Death records for years 2000 to 2009. http://www.applications.dhs.ca.gov/vsq/default.asp
- California Department of Public Health, Center for Health Statistics, Death Statistical Master Files. SANDAG January 1 Population Estimates. Prepared by County of San Diego, Health & Human Services Agency, Community Epidemiology.
- California Department of Public Health, Birth and Death Records. http://www.cdph.ca.gov/data/statistics/Documents/VSC-2008-0405.pdf and http://www.cdph.ca.gov/data/statistics/Documents/VSC-2009-0407.pdf
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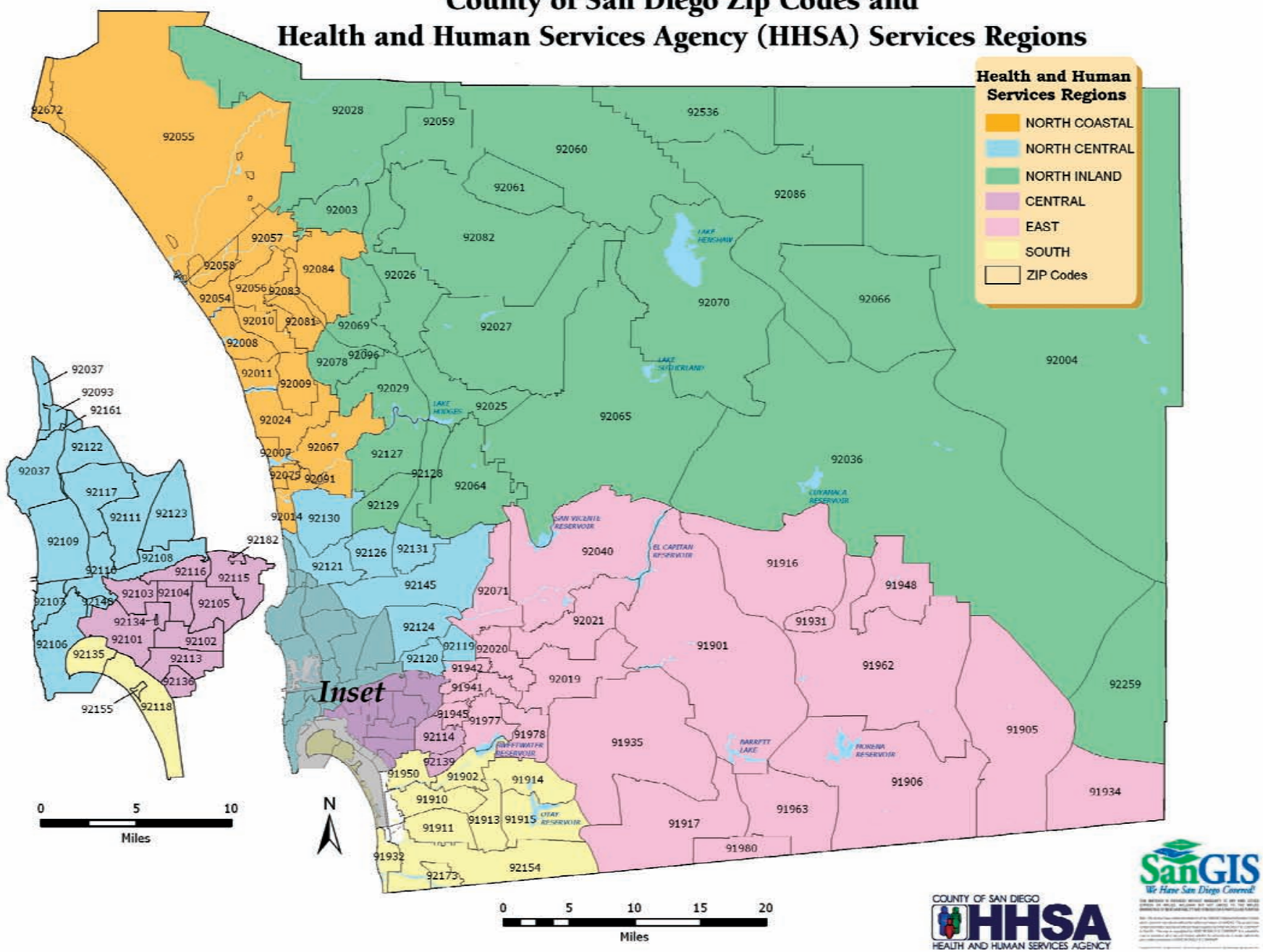
County of San Diego Zip Codes and Health and Human Services Agency (HHSA) Services Regions



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