



# 2013 Community Health Needs Assessment



**December 2013**



## Table of Contents

Table of Contents.....	ii
I. Authors and Acknowledgements.....	1
Authors.....	1
Acknowledgements.....	1
II. Summary of Key Findings (Executive Summary).....	2
a. Health Needs.....	3
b. Health Drivers.....	4
III. Introduction and Background.....	5
St. Vincent Medical Center (SVMC).....	5
Good Samaritan Hospital (GSH).....	5
California Hospital Medical Center (CHMC).....	6
CHNA Consultants.....	7
Purpose of the Community Health Needs Assessment Report.....	7
IV. Methodology and Process.....	9
Metro Collaborative CHNA Framework and Process.....	9
Secondary Data.....	9
Primary Data—Community Input.....	11
Data Limitations and Gaps.....	12
V. Prioritization of Health Needs and Drivers of Health.....	13
Identifying Community Health Needs.....	13
Process and Criteria Used for Prioritization of Health Needs.....	13
Community Prioritization Forum.....	13
Administration of the Questionnaire (Survey).....	14
Analysis of Survey Scores.....	14
Prioritized Community Health Needs and Drivers (to be updated after prioritization process)...	14
VI. Community Health Profile.....	17
Service Area Definition.....	17
Demographic Overview.....	18
Estimated Current Year Population.....	18
Projected Five-Year Population.....	18
Race/Ethnicity.....	19
Foreign-Born Residents and U.S. Citizen Status.....	20
Language Spoken in the Home.....	20
Age Distribution.....	20
Marital Status.....	21
Education Levels.....	21
Household Description.....	22

Household Income .....	22
Households By Income Group .....	23
Employment Status.....	23
Federal Poverty Level.....	24
Students Receiving Free or Reduced-Price Meals .....	24
Medi-Cal Beneficiaries .....	24
Healthy Families Beneficiaries .....	25
Medicare Beneficiaries .....	26
Federally Qualified Health Centers.....	27
Access to Healthcare .....	28
Uninsured Adults .....	28
Uninsured Children .....	28
Difficulty Accessing Care .....	29
Dentist to Population Ratio.....	30
Natality .....	30
Births.....	30
Births by Mother’s Age .....	31
Births by Mother’s Ethnicity .....	31
Birth Weight.....	32
Breastfeeding.....	33
Mortality.....	33
Deaths.....	33
Deaths by Age Group .....	34
Cause of Death.....	35
<b>VII. Key Findings—Health Outcomes and Drivers .....</b>	<b>37</b>
1. Alcohol Abuse.....	37
Alcohol Outlets.....	37
Alcohol Use .....	38
Alcohol and Drug Treatment .....	38
Disparities .....	39
Associated Drivers of Health.....	39
Primary Data .....	39
2. Allergies .....	39
Prevalence.....	40
Disparities .....	40
Associate Drivers of Health.....	40
Primary Data .....	40
3. Alzheimer’s Disease.....	40
Mortality .....	41
Disparities .....	42
Associated Drivers of Health.....	42
Primary Data .....	42
4. Arthritis.....	42
Prevalence.....	42
Disparities .....	43
Associated Drivers of Health.....	43

---

Primary Data .....	43
5. Asthma.....	43
Prevalence.....	43
Disparities .....	44
Associated Drivers of Health.....	44
Primary Data .....	44
6. Breast Cancer .....	44
Prevalence.....	45
Mortality .....	45
Disparities .....	46
Associated Drivers of Health.....	46
Primary Data .....	46
7. Cancer, in General .....	46
Prevalence.....	47
Mortality .....	47
Disparities .....	48
Associated Drivers of Health.....	48
Primary Data .....	48
8. Cardiovascular Disease.....	48
Prevalence.....	49
Disease Management .....	49
Hospitalizations.....	49
Mortality .....	50
Disparities .....	51
Associated Drivers of Health.....	51
Primary Data .....	51
9. Cholesterol .....	51
Prevalence.....	52
Disparities .....	52
Associated Drivers of Health.....	53
Primary Data .....	53
10. Colorectal Cancer .....	53
Prevalence.....	54
Mortality .....	54
Disparities .....	55
Associated Drivers of Health.....	55
Primary Data .....	55
11. Diabetes.....	55
Prevalence.....	56
Disease Management .....	56
Hospitalizations.....	57
Mortality .....	58
Disparities .....	58
Associated Drivers of Health.....	59
Primary Data .....	59
12. Hypertension .....	60
Prevalence.....	60
Disease Management .....	60

Mortality .....	61
Disparities .....	61
Associated Drivers of Health .....	62
Primary Data .....	63
13. HIV/AIDS .....	63
Prevalence.....	63
Hospitalizations.....	64
Mortality .....	64
Disparities .....	65
Associated Drivers of Health.....	65
Primary Data .....	66
14. Mental Health.....	66
Prevalence.....	66
Anxiety .....	67
Depression .....	68
Alcohol- and Drug-Related Mental Illness .....	68
Hospitalizations.....	69
Suicide .....	70
Disparities .....	71
Associated Drivers of Health.....	72
Primary Data .....	72
15. Obesity/Overweight .....	73
Prevalence.....	73
Disparities .....	74
Associated Drivers of Health.....	75
Primary Data .....	76
16. Oral Health .....	76
Access.....	76
Affordability .....	77
Disparities .....	78
Associated Drivers of Health.....	79
Primary Data .....	80
17. Sexually Transmitted Diseases .....	80
Prevalence.....	80
Disparities .....	81
Associated Drivers of Health.....	81
Primary Data .....	81
18. Substance Abuse .....	81
Marijuana Use.....	82
Alcohol- and Drug-Related Mental Illness .....	82
Alcohol and Drug Treatment .....	83
Smokers.....	84
Disparities .....	84
Associated Drivers of Health.....	85
Primary Data .....	85
19. Vision .....	85
Prevalence.....	86
Disparities .....	86

---

Associated Drivers of Health.....	86
Primary Data .....	86
Appendix A—Data Collection Tools and Instruments .....	87
Appendix B—Stakeholders .....	95
Focus Group Participants (Identification).....	95
Interviews Participants (Identification).....	97
Prioritization Participants.....	101
Appendix C—Scorecard .....	106
Appendix D—Data Sources.....	114
Appendix E—Glossary.....	127
Appendix F—Prioritization Survey Criteria Scale.....	132
Appendix G—Health Need Profiles.....	133

## I. Authors and Acknowledgements

### Authors

#### The Center for Nonprofit Management

Maura J. Harrington, Ph.D., MBA

Jessica Vallejo

Heather Tunis

### Acknowledgements

The 2013 Metro Hospital Collaborative, composed of California Hospital Medical Center, Good Samaritan Hospital and St. Vincent Medical Center, worked in partnership to conduct this needs assessment.

California Hospital Medical Center: Lynn Yonekura, M.D., Director of Community Benefits

Good Samaritan Hospital: Sammy Feuerlicht, Vice President, Strategic Planning and Development  
Katrina R. Bada, Public Relations and Marketing

St. Vincent Medical Center: Jan Stein, Vice President and Executive Director,  
St. Vincent Foundation

The 2013 Metro Hospital Collaborative would like to thank Catherine Gaughen, Director of Public Affairs and Brand Communications, and Mario Ceballos, Community Benefit Manager, at Kaiser Foundation Hospital – Los Angeles as well as the many individuals who provided their expertise, time and perspective. For a full list of participants, please see Appendix B. Stakeholders.

## II. Summary of Key Findings (Executive Summary)

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, added new requirements that nonprofit hospital organizations must satisfy to maintain tax-exempt status under section 501(c)(3) of the Internal Revenue Code. One such requirement added by ACA, to Section 501(r) of the Code, requires nonprofit hospitals to conduct a community health needs assessment (CHNA) at least once every three years. As part of the CHNA, each hospital is required to collect input from designated individuals in the community, including public health experts as well as members, representatives or leaders of low-income, minority, and medically underserved populations, and individuals with chronic conditions.

For the 2013 CHNA, three hospitals in metropolitan Los Angeles — California Hospital Medical Center, Good Samaritan Hospital, and St. Vincent Medical Center — collaborated, as they have in the past, to work with the Center for Nonprofit Management consulting team in conducting the CHNA. The initial phase of the CHNA process, community input collected through 10 focus groups and 29 interviews with key stakeholders, including health care professionals, government officials, social service providers, community residents, leaders, and other relevant individuals. Appendix A presents the primary data collection tools and Appendix B lists the stakeholders involved. Concurrently, secondary data were collected and compared to relevant benchmarks including Healthy People 2020, Los Angeles County or California when possible. The data were also collected at smaller geographies, when possible, to allow for more in-depth analysis and identification of community health issues. In addition, prior CHNAs were reviewed to identify trends and ensure that previously identified needs were not overlooked. Primary and secondary data were compiled into a scorecard (Appendix C) to present health needs and health drivers with highlighted comparisons to the available data benchmarks. The scorecard was designed to allow for a comprehensive analysis across all data sources (Appendix D) and for use during the second, prioritization phase of the CHNA process.

For the 2013 CHNA, a process to prioritize health needs and drivers was introduced for the first time. This consisted of a facilitated group session that engaged participants from the first phase of collecting community input as well as other stakeholders in a review and discussion of secondary and primary data (compiled and presented in the scorecards and accompanying health need profiles) and an online survey. At the prioritization session, participants were provided with a brief overview of the CHNA process, a list of identified health needs and drivers in the scorecard format, and brief narrative summary descriptions (health need profiles) of the health needs identified through the data analysis process described above. Then, participants considered the scorecards and health needs profiles in discussing the data and identifying key issues or considerations.

The list below presents the prioritized health needs and drivers.

**a. Health Needs**

The following needs were identified through the analysis of primary and secondary data. They are presented in the table below in prioritized order.

**Prioritized Health Needs**

	<b>Severe Impact on the Community</b>	<b>Gotten Worse Over Time</b>	<b>Shortage of Resources in the Community</b>	<b>Community Readiness to Address/Support</b>	<b>Overall Rating</b>
1. Mental Health	3.0	2.8	2.7	2.4	8.8
2. Oral health	3.0	3.0	2.9	2.6	8.6
3. Substance Abuse	3.2	3.0	2.7	2.7	8.2
4. Diabetes	3.2	2.9	2.2	2.8	8.1
5. Obesity/Overweight	3.2	2.9	2.3	2.7	8.1
6. Alzheimer's Disease	3.0	3.0	2.7	2.6	7.9
7. Cardiovascular Disease	3.0	2.7	2.2	2.6	7.9
8. Alcoholism	3.1	2.8	2.8	2.8	7.8
9. Sexually Transmitted Diseases	2.8	2.6	2.3	2.4	7.6
10. Allergies	2.8	3.1	2.6	2.5	7.5
11. Asthma	2.9	2.9	2.3	2.5	7.4
12. Hypertension	3.0	2.6	2.2	2.7	7.4
13. Vision	2.8	2.9	3.0	2.7	7.4
14. Cholesterol	2.6	2.5	2.3	2.8	7.2
15. Cancer, general	3.0	2.3	2.0	2.7	7.0
16. Colorectal Cancer	2.8	2.3	2.2	2.8	7.0
17. Arthritis	2.6	2.4	2.4	2.5	6.8
18. Breast Cancer	2.7	2.1	2.3	2.9	6.8
19. HIV/AIDS	2.7	2.1	2.0	2.4	6.0

**Note:** Health needs are in prioritized ranking order.

## b. Health Drivers

The following health drivers were identified through the analysis of primary and secondary data. They are presented in the table below in prioritized order.

Prioritized Health Drivers

	Severe Impact on the Community	Gotten Worse Over Time	Shortage of Resources in the Community	Community Readiness to Address/Support	Overall Rating
1. Poverty (including unemployment)	3.4	3.3	2.9	2.5	11.7
2. Housing	3.4	3.3	3.0	2.7	9.0
3. Specialty Care Access	3.3	2.8	2.9	2.5	8.8
4. Homelessness	3.4	2.9	2.7	2.3	8.5
5. Disease Management	2.9	2.7	2.5	2.6	8.2
6. Health Care Access	3.2	2.5	2.6	2.8	8.2
7. Cultural Barriers	3.2	2.7	2.8	2.8	8.1
8. Immigrant Status	3.2	2.7	2.7	2.8	8.1
9. Social Barriers (i.e. family issues)	3.2	2.9	2.6	2.6	8.1
10. Alcohol and Substance Abuse	3.3	2.7	2.7	2.8	8.0
11. Community Violence	3.0	2.5	2.6	2.9	7.9
12. Coordinated Healthcare	3.0	2.3	2.6	2.6	7.7
13. Transportation	2.9	2.4	2.5	2.4	7.7
14. Healthy Eating	3.1	2.6	2.4	2.6	7.6
15. Physical Activity	3.0	2.7	2.4	2.6	7.6
16. Preventative Care Services	2.9	2.5	2.4	2.6	7.5
17. Health Education and Awareness	3.0	2.4	2.4	2.7	7.3

**Note:** Drivers are in prioritized ranking order.

### III. Introduction and Background

#### St. Vincent Medical Center (SVMC)

##### Overview and History

Established by the Daughters of Charity of St. Vincent de Paul in 1856, St. Vincent Medical Center (SVMC) has been meeting the needs of our community for more than a century. When the Daughters of Charity first arrived in 1856, Los Angeles was a small community with no formal medical care. The Daughters responded to this need by opening the city's first free-standing hospital in a tiny adobe house. As the community's health care needs grew, the Daughters adapted by opening larger facilities. Over the years, the hospital continued to grow and played an important role in the Los Angeles health care community.

Today SVMC is a 366-bed tertiary and surgical specialty care hospital located near downtown Los Angeles, offering advanced care delivered by some of the most well-respected medical professionals in the world including 474 physicians and over 1,300 employees. With a well-earned reputation for high quality of care, SVMC most recently received the Distinguished Hospital Award for Clinical Excellence from Healthgrades as being in the top 5 percent of all hospitals in the nation with the lowest risk-adjusted mortality and complication rates.

##### Mission

SVMC subscribes to the mission of the Daughters of Charity Health System: In the spirit of founders St. Vincent de Paul, St. Louise de Marillac, and St. Elizabeth Ann Seton, the Daughters of Charity Health System is committed to serving the sick and the poor. SVMC advances and strengthens the healing mission of the Catholic Church by providing comprehensive, excellent healthcare that is compassionate and attentive to the whole person: body, mind and spirit. SVMC promotes healthy families, responsible stewardship of the environment, and a just society through value-based relationships and community-based collaboration.

##### Services

SVMC specialty areas include: cardiac care, multi-organ transplantation, spine surgery, joint replacement and general orthopedics, oncology, neurosurgery and treatment of hearing disorders. In addition, SVMC offers the latest diagnostic and treatment technologies and a full continuum of care to benefit patients and their families. Other services provided include, but are not limited to, acute rehabilitation, transitional care, outpatient dialysis, emergency medicine, imaging and laboratory services. Prominent community benefit programs include the Asian Pacific Liver Center, Casa de Amigos Community Learning Center, Community Diabetes Education Program, Health Benefits Resource Center and Multicultural Health Awareness and Prevention Center.

##### Service Area

SVMC is located in Service Planning Area (SPA) 4 of Metro Los Angeles. The service area, however, extends over a larger regional area with patients from over 80 cities in Los Angeles, San Bernardino, Riverside and Orange Counties, as well as from across the United States and around the world.

#### Good Samaritan Hospital (GSH)

##### Overview and History

Good Samaritan Hospital (GSH) was founded in 1885 by Sister Mary Wood of the Episcopal Church as a 9-bed facility known as the Los Angeles Hospital and Home for Invalids. Today GSH extends far beyond a traditionally-defined community hospital as a regional tertiary medical facility that offers outstanding diagnostic, surgical and therapeutic care in a state-of-the-art setting. GSH is respected internationally as an academic medical center affiliated with the USC and UCLA Schools of Medicine. Recent recognitions include: one of the "Best Hospitals in America" by *U.S. News & World Report*, 1998; "Best Medical Center in Los Angeles" by the *Los Angeles Downtown News*, 2000-2004; and as one of HealthGrades, Inc. America's 50 Best Hospitals in 2007, 2008, 2009 and 2010.

A major research center and teaching hospital, GSH is a leader in the development of medical procedures to improve health outcomes and minimize suffering. Reflecting both Los Angeles' multicultural population and its international reputation and patient base, GSH employs over 1,500 people and has approximately 600 physicians on its medical staff. Together the medical staff and employees speak over 54 languages/dialects.

### **Mission**

GSH's mission is to provide accessible, quality, cost-effective and compassionate healthcare services that meet the needs of patients and their families, the community and physicians.

### **Services**

Located a few blocks west of downtown Los Angeles, Good Samaritan Hospital is a 408-bed hospital with approximately 17,000 in-patient admissions and more than 93,500 outpatient visits annually. More than 4,000 deliveries and 8,000 surgeries are performed annually in 18 surgical suites. Good Samaritan Hospital also experiences 25,400 emergency room visits annually. The tertiary medical center's programs include eight centers of excellence (cardiovascular diseases, neurosciences, orthopedics, kidney stone service, gastroenterology, perinatology/neonatology, tertiary retinal surgery and oncology, transfusion-free medicine & surgery) and other specialties.

## **California Hospital Medical Center (CHMC)**

### **Overview and History**

California Hospital Medical Center (CHMC) is a 316-bed private, non-profit, acute care hospital that began serving the downtown and central Los Angeles areas in a three-story framed structure in 1887. By 1902, CHMC was the largest and best-equipped physician-owned hospital west of Chicago. Less than 25 years later, the original frame buildings were replaced by a modern nine-story brick building, the first fireproof hospital in Los Angeles. In 1964, a nine-story north wing was added followed by the opening of a new Patient Care Tower in 1987, marking the beginning of CHMC's second century. In 1998, CHMC became an affiliate of Catholic Healthcare West. On December 1, 2004, CHMC's opened the first new trauma center in Los Angeles in more than a decade and one of only 13 in Los Angeles County.

The Central and South Central areas of Los Angeles served by CHMC in 1887 were originally affluent neighborhoods that later experienced shifts in demographics and became associated with poverty, crime, and other social problems. Despite the trend of many other hospitals and medical centers to follow affluent residents into the suburbs, CHMC remained stay in the central city to provide cost effective, culturally-sensitive care to the people in its service area.

CHMC is committed to serving its community and views community care beyond the treatment of immediate health problems. The hospital works with an extensive group of community health

educators, called Promotoras, and founded the nationally-recognized community learning center Hope Street Family Center (<http://www.healthychild.ucla.edu/HopestreetFamilyCenter.asp>) in 1992.

### **Mission**

CHMC is committed to improving the health status and increasing access to care for the multiethnic population of Central and South Central Los Angeles. CHMC builds on its affiliation with Catholic Healthcare West to create a broad-based network of care with other community resources that are responsive to the primary and specialty care service needs of the community. The hospital is also committed to achieving financial viability by working with its physicians, payers, and employees to create a climate of mutual opportunity and shared destiny; and to encourage innovative, cost-effective approaches to continuous quality improvement.

### **Services**

CMHC provides a myriad of tertiary care services in its 316-bed facility, and has specialties in areas such as comprehensive women's and children's services (including nurse-midwifery services and a teen-parent clinic), 24-hour emergency services (including a sexual assault and domestic violence response team and a Level II Trauma Center), family health services (including the California Family Care Medical Group and the USC Family Health Center), health ministry program, Hope Street Family Center and the Donald P. Loker Cancer Center.

### **CHNA Consultants**

The **Center for Nonprofit Management (CNM)** was hired as the consultant team to conduct the assessment for the Metro Collaborative. CNM is the leading management assistance organization in Southern California, providing training, consulting, technical assistance, capacity-building resources and services, and customized counsel to the nonprofit sector since 1979.

The principal members of the CNM evaluation team—Dr. Maura Harrington and Ms. Jessica Vallejo—have extensive experience with SB 697 community health needs assessments and public health data. The team was involved in conducting the 2004, 2007, and 2010 CHNAs for the Metro Hospital Collaborative (California Hospital Medical Center, Children's Hospital Los Angeles, Good Samaritan Hospital, Kaiser Foundation Hospital Los Angeles, QueensCare, and St. Vincent Medical Center) and is conducting 2013 CHNAs and/or the Community Benefit Implementation Strategy for five Kaiser hospitals and four other Los Angeles area hospitals. Dr. Harrington has worked on projects with the Pasadena Public Health Department, the California Wellness Foundation, and many other health-related entities. The CNM team has extensive experience with a broad range of evaluation projects involving qualitative and quantitative data collection and analysis and the preparation of reports and documentation appropriate for diverse audiences and constituencies.

### **Purpose of the Community Health Needs Assessment Report**

In 1994, California legislators passed Senate Bill 697 (SB 697), which requires all private nonprofit hospitals in the state to conduct a CHNA every three years. As part of SB 697, hospitals are also required to annually submit a summary of their community benefit contributions, particularly those activities undertaken to address the community needs arising during the CHNAs.

Federal requirements included in the Affordable Care Act, enacted on March 23, 2010, stipulate that hospital organizations with 501(c)(3) status must adhere to new regulations, one of which is a requirement to conduct a CHNA every three years. With regard to the CHNA, the ACA specifically

requires nonprofit hospitals to collect and take into account input from public health experts as well as community leaders and representatives of high-need populations (including minority groups, low-income individuals, medically underserved populations, and those with chronic conditions); identify and prioritize community health needs; document a separate CHNA for each individual hospital; and make the CHNA report widely available to the public. In addition, each nonprofit hospital must adopt an implementation strategy to address the identified community health needs and submit a copy of the implementation strategy along with the organization's annual Form 990.

## **IV. Methodology and Process**

### **Metro Collaborative CHNA Framework and Process**

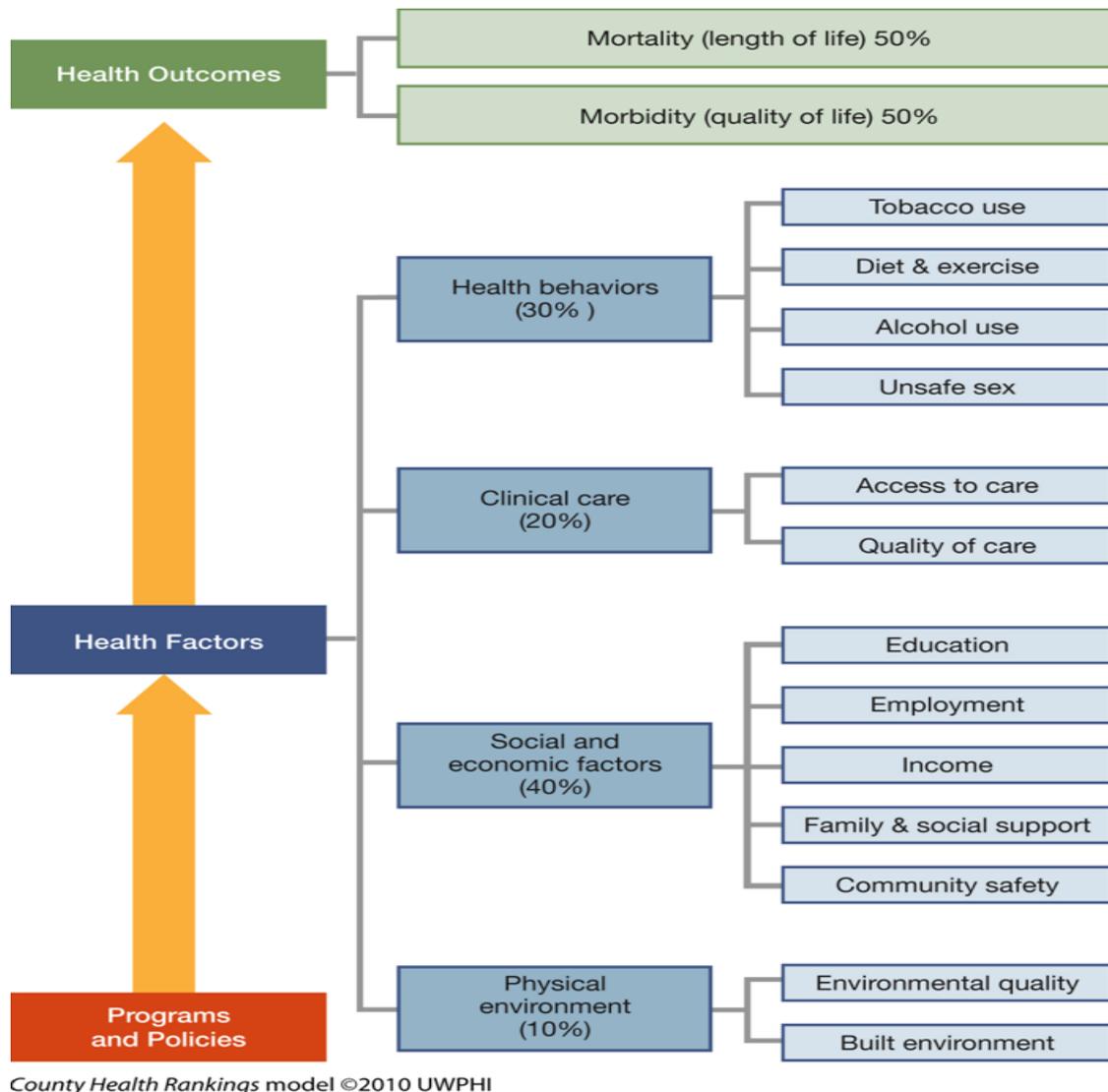
To ensure a level of consistency across the Metro Hospitals Collaborative, the CNM team included a list of over 100 indicators of secondary data that, when looked at together, help illustrate the health of a community. California data sources were used whenever possible. When California data sources weren't available, national data sources were used.

In addition to reviewing the secondary data available, the CNM CHNA team collected primary data through 10 focus groups and 29 individuals to discuss and identify key issues that most impact the health of the communities served by the three hospitals. The identified health needs and drivers of health were then presented during a community forum to allow for a richer discussion of secondary data and additional considerations. The focus groups, interviews, and community forum engaged a spectrum of local public health experts, community leaders, and residents.

### **Secondary Data**

Secondary data were collected from a wide range of local, county, and state sources to present demographics, mortality, morbidity, health behaviors, clinical care, social and economic factors, and physical environment. These categories are based on the Mobilizing Action Toward Community Health (MATCH) framework, which illustrates the interrelationships among the elements of health and their relationship to each other, including social and economic factors, health behaviors, clinical care, physical environmental, and health outcomes.

**Figure 1. Mobilizing Action Toward Community Health (MATCH)**



The CNM evaluation team identified a minimum set of required indicators for each of the data categories to be used for the CHNAs. Data sets were accessed electronically through local sources. When data were available by ZIP Code, the data from the ZIP Codes of the service area were compiled for a hospital’s service area indicator. For geographic comparisons across SPAs within the hospital service area, if the source provided data by ZIP Code, then ZIP Codes were aggregated into respective SPAs; when the data were not available by ZIP Code, then the data for the entire SPA was utilized.

Secondary data were input into tables for inclusion in the analysis. The tables present the data indicator, the geographical area the data represented, the data measurement (e.g. rate, number, percent), and the data source and year. Data are presented based on the data source and geographic level of available data. When possible, these data are presented in the context of larger geographies such as county or state for comparison.

To allow for a comprehensive analysis across data sources, and to assist with the identification of a health need, a matrix (Appendix C—Scorecard) was created listing all identified secondary indicators and primary issues in one location. The matrix included hospital-level secondary data (averaged), primary data counts (number of times an issue was mentioned) for both interviews and focus groups, and sub-populations noted as most severely impacted. The matrix also included benchmark data in the form of Healthy People 2020 (HP2020) benchmarks, which are nationally recognized, when the indicator matched the data on hand. If, however, an appropriate HP2020 indicator was not available, then the most recent county or state data source was used as a comparison.

Each data indicator for the hospital service area was first compared to the HP2020 benchmark, if available, and then to the geographic level for benchmark data to assess whether the hospital service area performance was better or worse than the benchmark. When more than one source (from the primary or secondary data) identified an issue, the issue was designated as a health need or driver.

Two additional steps of analysis were conducted. The first reviewed data in smaller relevant geographies, repeating the process described above to identify areas in which needs were more acute. In the second step, the previous CHNA was reviewed to identify trends and ensure that a previously identified need had not been overlooked.

### **Primary Data—Community Input**

Information and opinions were gathered directly from persons who represent the broad interests of the community served by the hospital. Between August and October 2013, 10 focus groups and 29 telephone interviews were conducted with a broad range of community stakeholders, including area residents. The purpose for the primary data collection component of the CHNA is to identify broad health needs and key drivers, as well as assets and gaps in resources, through the perceptions and knowledge of varied and multiple stakeholders.

The interviews were conducted primarily via telephone for approximately 30 to 45 minutes each; the conversations were confidential and interviewers adhered to standard ethical research guidelines. The interview protocol was designed to collect reliable and representative information about health and other needs and challenges faced by the community, access and utilization of health care services, and other relevant topics. (See Appendix A for data collection tools and instruments used in primary data collection.)

Focus groups took place in a range of locations throughout the service area, with translation and interpretation services provided when appropriate. Focus group sessions were 45 to 60 minutes each. As with the interviews, the focus group topics also were designed to collect representative information about health care utilization, preventive and primary care, health insurance, access and barriers to care, emergency room use, chronic disease management and other community issues. Participants included residents and representative groups from African-American, Latino and Asian-Pacific Islander communities. Interpretation services were provided in Spanish and Mandarin.

The stakeholders<sup>1</sup> engaged through the 10 focus groups and 29 interviews represent a broad range of individuals from the community, including health care professionals, government officials, social service providers, local residents, leaders, and other relevant community representatives, as per the IRS requirement. Please see Appendix B for a list of participants.

---

<sup>1</sup> A portion of the primary data was collected through a community health needs assessment conducted earlier this year by Kaiser Permanente Los Angeles Medical Center and was generously shared with the collaborative.

### **Data Limitations and Gaps**

The secondary data set includes a robust set of over 100 secondary data indicators that, when taken together, enable an examination of the broad health needs within a community. However, there are some limitations with regard to this data, as is true with any secondary data. Some data were available only at a county level, making an assessment of health needs at a neighborhood level challenging. Moreover, disaggregated data for age, ethnicity, race, and gender are not available for all data indicators, which limited the examination of disparities of health issues within the community. At times, a stakeholder-identified health issue may not have been reflected by the secondary data indicators. In addition, data are not always collected on an annual basis, meaning that some data are several years old.

## V. Prioritization of Health Needs and Drivers of Health

### Identifying Community Health Needs

For the purposes of the CHNA, a health need is defined as a poor health outcome and associated health driver(s), or a health driver associated with a poor health outcome where the outcome itself has not yet arisen as a need. As described previously, health needs arise from the comprehensive identification, interpretation, and analysis of a robust set of primary and secondary data. Appendix E—Glossary presents additional definitions.

Primary data were analyzed by inputting primary data into Microsoft Excel. The data were then reviewed using content analysis to identify themes and determine a comprehensive list of codes. The data were coded and the number of times an issue was identified was tallied. In addition, subpopulations mentioned as being most affected by a specific issue were noted.

Secondary data were entered into tables to be included in the analysis. When possible, benchmark data were included (Healthy People 2020, Los Angeles County, or California). County levels were used as the benchmark when available. However, if the data source was not available at the county level, state-level data was used.

Health needs and drivers were identified from both primary and secondary data sources using the magnitude or size of the problem relative to the portion of population affected by the problem, as well as the seriousness of the problem (impact at the individual, family, or community level). To examine the size and seriousness of the problem, these indicators from the secondary data were compared to the available benchmark (HP2020, county, or state). Those indicators that performed poorly against a benchmark were considered to have met the size and seriousness criteria and were added to the master list of health needs and drivers. Concurrently, health needs and drivers that were identified by stakeholders in the primary data collection were also added to the master list of health needs and drivers.

### Process and Criteria Used for Prioritization of Health Needs

A method was selected as the approach for the prioritization process that was inclusive of stakeholders, involved a moderate amount of rigor but not so much math or statistics as to be difficult to use and to communicate, such that rigor is balanced by a relatively easy-to-use methodology

### Community Prioritization Forum

The community forum was designed to provide the opportunity for a range of stakeholders to engage in a discussion of the data and participate in the prioritization process. All individuals who were invited to take part in the primary data collection, irrespective of whether or not they had participated in that phase, were invited to attend a community forum.

The forum included a brief presentation that provided an overview of the CHNA data collection and prioritization processes to date, and a review of the documents to be used in the discussion.

Participants were provided with a list of identified health needs and drivers in the scorecard format, developed from the matrix described previously in this report, and a narrative document of brief summary descriptions of the identified health needs.

Participants engaged in a facilitated discussion about the findings as presented in the scorecard and the narrative summaries, and prioritization of the identified health needs and drivers.

Each participant was then asked to complete a questionnaire (survey) and to rank each health need according to several criteria, as described below.

### **Administration of the Questionnaire (Survey)**

Community forum participants were asked to complete a questionnaire after the forum, rating each health need and driver according to severity, change over time, resources available to address the needs and/or drivers, and the community's readiness to support initiatives to address the needs and/or drivers. Please see Appendix F for a description of the scale used for each criterion to rank each health issue and driver.

### **Analysis of Survey Scores**

As described above, averages were computed for each criterion. The overall average was calculated by adding the total across severity (total possible score equals 4), change over time (total possible equals 4), and resources (total possible equals 4) for each survey (with a total possible score of 12). The total scores were divided by the total number of surveys for which data was provided, resulting in an overall average per health need.

### **Prioritized Community Health Needs and Drivers (to be updated after prioritization process)**

Table 1 and Table 2 include the prioritized health needs and drivers of health in prioritized over using the overall rating. Further detailed are included in Appendix G—Health Need Profiles.

**Table 1. Prioritized Health Needs**

	Severe Impact on the Community	Gotten Worse Over Time	Shortage of Resources in the Community	Community Readiness to Address/Support	Overall Rating
20. Mental Health	3.0	2.8	2.7	2.4	8.8
21. Oral health	3.0	3.0	2.9	2.6	8.6
22. Substance Abuse	3.2	3.0	2.7	2.7	8.2
23. Diabetes	3.2	2.9	2.2	2.8	8.1
24. Obesity/Overweight	3.2	2.9	2.3	2.7	8.1
25. Alzheimer's Disease	3.0	3.0	2.7	2.6	7.9
26. Cardiovascular Disease	3.0	2.7	2.2	2.6	7.9
27. Alcoholism	3.1	2.8	2.8	2.8	7.8
28. Sexually Transmitted Diseases	2.8	2.6	2.3	2.4	7.6
29. Allergies	2.8	3.1	2.6	2.5	7.5
30. Asthma	2.9	2.9	2.3	2.5	7.4
31. Hypertension	3.0	2.6	2.2	2.7	7.4
32. Vision	2.8	2.9	3.0	2.7	7.4
33. Cholesterol	2.6	2.5	2.3	2.8	7.2
34. Cancer, general	3.0	2.3	2.0	2.7	7.0
35. Colorectal Cancer	2.8	2.3	2.2	2.8	7.0
36. Arthritis	2.6	2.4	2.4	2.5	6.8
37. Breast Cancer	2.7	2.1	2.3	2.9	6.8
38. HIV/AIDS	2.7	2.1	2.0	2.4	6.0

**Note:** Health needs are in prioritized ranking order.

**Table 2. Prioritized Drivers of Health**

	Severe Impact on the Community	Gotten Worse Over Time	Shortage of Resources in the Community	Community Readiness to Address/Support	Overall Rating
18. Poverty (including unemployment)	3.4	3.3	2.9	2.5	11.7
19. Housing	3.4	3.3	3.0	2.7	9.0
20. Specialty Care Access	3.3	2.8	2.9	2.5	8.8
21. Homelessness	3.4	2.9	2.7	2.3	8.5
22. Disease Management	2.9	2.7	2.5	2.6	8.2
23. Health Care Access	3.2	2.5	2.6	2.8	8.2
24. Cultural Barriers	3.2	2.7	2.8	2.8	8.1
25. Immigrant Status	3.2	2.7	2.7	2.8	8.1
26. Social Barriers (i.e.	3.2	2.9	2.6	2.6	8.1

	Severe Impact on the Community	Gotten Worse Over Time	Shortage of Resources in the Community	Community Readiness to Address/Support	Overall Rating
family issues)					
27. Alcohol and Substance Abuse	3.3	2.7	2.7	2.8	8.0
28. Community Violence	3.0	2.5	2.6	2.9	7.9
29. Coordinated Healthcare	3.0	2.3	2.6	2.6	7.7
30. Transportation	2.9	2.4	2.5	2.4	7.7
31. Healthy Eating	3.1	2.6	2.4	2.6	7.6
32. Physical Activity	3.0	2.7	2.4	2.6	7.6
33. Preventative Care Services	2.9	2.5	2.4	2.6	7.5
34. Health Education and Awareness	3.0	2.4	2.4	2.7	7.3

**Note:** Health needs are in prioritized ranking order.

## VI. Community Health Profile

### Service Area Definition

The St. Vincent Medical Center (SVMC) provides health services in 21 ZIP Codes, nine cities or communities, and two Service Planning Areas (SPAs) within Los Angeles County. Table 3 shows a breakdown of the SVMC service area by city or community, ZIP Code, and SPA.

**Table 3. St. Vincent Medical Center (SVMC) Service Area**

City/Community	Primary ZIP Code	Service Planning Area
Crenshaw	90004	4 – Metro
Echo Park	90005	6 – South
Hollywood	90006	
Northeast Los Angeles	90007	
Pico-Union	90008	
South Central	90010	
West Hollywood	90011	
Westlake	90016	
Wilshire	90017	
	90018	
	90019	
	90020	
	90026	
	90027	
	90028	
	90029	
	90031	
	90037	
	90044	
	90046	
	90057	

## Demographic Overview

A description of the community serviced by SVMC is provided in the following data tables and narrative. Depending upon the availability of data for each indicator, SVMC information is presented by ZIP Code, or SPA (portions of SPAs 4 and 6 are serviced by SVMC).

### Estimated Current Year Population

In 2013, the total population within the SVMC service area is 1,044,500, making up 10.5% of the population of Los Angeles County. This represents an increase of 7.0% between 2010 and 2013 in the SVMC service area. The largest population increase occurred in ZIP Codes 90006 (50.5%) and 90004 (49.3%), and the only decrease in ZIP Code 90007 (-0.4%).

**Table 4. Estimated Current-Year Population**

ZIP Code	2010 Population	2013 Estimated Population	Percent Change
90004	30,994	61,172	49.3%
90005	38,292	38,398	0.3%
90006	29,575	59,804	50.5%
90007	42,780	42,613	-0.4%
90008	31,065	31,412	1.1%
90010	4,763	4,844	1.7%
90011	103,531	105,370	1.8%
90016	48,144	48,755	1.3%
90017	24,596	25,986	5.3%
90018	51,279	51,994	5.3%
90019	65,008	65,498	0.7%
90020	37,834	38,287	1.2%
90026	67,133	67,763	0.9%
90027	45,657	45,710	0.1%
90028	29,307	30,225	3.0%
90029	38,595	38,638	3.0%
90031	39,677	40,560	2.2%
90037	62,240	63,517	2.0%
90044	89,506	91,161	1.8%
90046	48,166	48,609	0.9%
90057	43,553	44,184	1.4%
SVMC Service Area	971,695	1,044,500	7.0%
Los Angeles County	9,818,605	9,969,384	1.5%

Data source: Nielsen Claritas  
Data year: 2013  
Source geography: ZIP Code

### Projected Five-Year Population

By 2018, the population is expected to increase in the SVMC service by about 2.5%, similar to the projected increase in Los Angeles County (2.9%) and continuing the growth trends observed over the past few years.

**Table 5. Projected Five-Year Population**

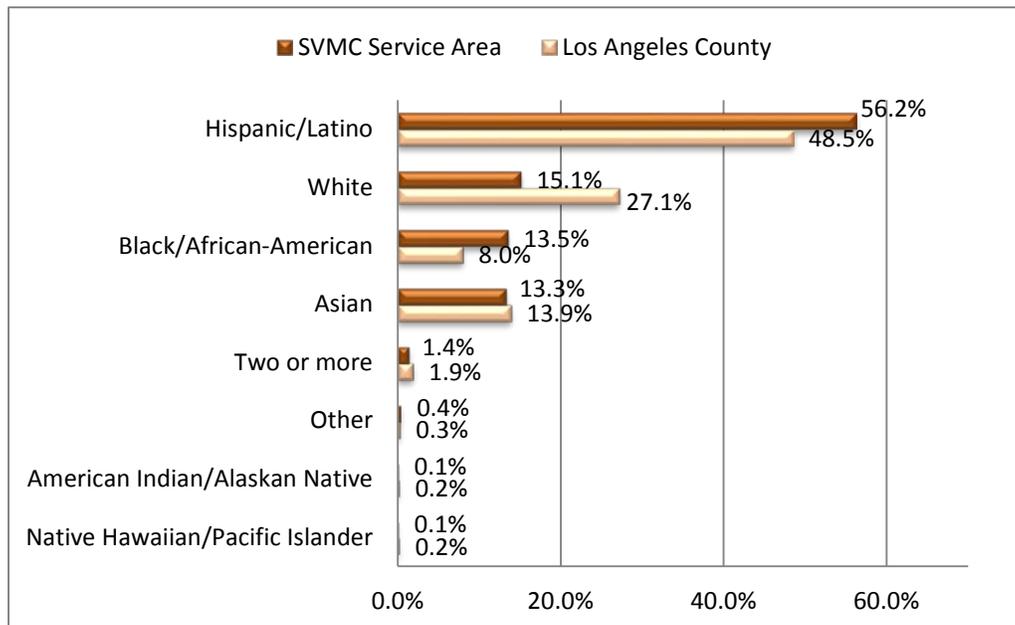
	2013 Estimated Population	2018 Projected Population	Percent Change
SVMC Service Area	1,044,500	1,071,748	2.5%
Los Angeles County	9,969,384	10,271,386	2.9%

Data source: Nielsen Claritas  
Data year: 2013  
Source geography: ZIP Code

**Race/Ethnicity**

In 2013, most of the population in the SVMC service area is Hispanic (56.2%, n=586,786) or White (15.1%, n=157,657), larger when compared to the percent of Hispanics in Los Angeles County (48.5%) and lower than the percent of Whites in Los Angeles County (27.1%). The third largest population in the SVMC service area is Black or African American (13.5%, n=140,835), less than in Los Angeles County (8.0%). The percentage of Asians in the SVMC service area and Los Angeles County were similar (13.3% and 13.9%, respectively).

**Figure 2. Race/Ethnicity**



**Table 6. Race/Ethnicity**

	SVMC Service Area		Los Angeles County	
	Number	Percentage	Number	Percentage
Hispanic/Latino	58,6786	56.2%	4,830,835	48.5%
White	157,657	15.1%	1,382,777	13.9%
Black/African-American	140,835	13.5%	2,703,183	27.1%
Asian	138,689	13.3%	797,783	8.0%
Two or more	14,330	1.4%	189,147	1.9%
Other	4,017	0.4%	26,994	0.3%

	SVMC Service Area		Los Angeles County	
	Number	Percentage	Number	Percentage
American Indian/Alaskan Native	1,519	0.1%	17,276	0.2%
Native Hawaiian/Pacific Islander	687	0.1%	22,389	0.2%
Total population	1,044,520	100.0%	9,969,384	100.0%

Data source: Nielsen Claritas

Data year: 2013

Source geography: ZIP Code

### Foreign-Born Residents and U.S. Citizen Status

In 2011, half of the residents in Los Angeles County were not U.S. citizens (54.5%) similar to the percentage in California (54.4%).

**Table 7. Citizenship Status**

	Los Angeles County		California	
	Number	Percentage	Number	Percentage
Naturalized U.S. Citizen	1,585,612	45.5%	4,580,888	45.5%
Not a U.S. Citizen	1,896,119	54.5%	5,461,686	54.4%

Data source: American Community Survey

Data year: 2011

Source geography: County

### Language Spoken in the Home

In 2013, over half of the population in the SVMC service area speaks Spanish (53.4%), far more than in Los Angeles County (39.7%). Another third of the population in the SVMC service area speaks English only (30.1%), a smaller percentage than in Los Angeles County (42.5%). Another 11.3% speak an Asian/Pacific Island language, a slightly smaller percentage than in Los Angeles County (10.9%). Slightly less speak an Indo-European language in the SVMC service area (4.3%) than in Los Angeles County (5.3%).

**Table 8. Language Spoken at Home**

	English Only	Asian/Pacific Islander	Indo-European	Spanish	Other
SVMC Service Area	30.1%	11.3%	4.3%	53.4%	0.9%
Los Angeles County	42.9%	10.9%	5.3%	39.7%	1.1%

Data source: Nielsen Claritas

Data year: 2013

Source geography: ZIP Code

### Age Distribution

Nearly half the population in the SVMC service area is between the ages of 25 and 54 (46.3%), similar to Los Angeles County (43.0%). Nearly a quarter (23.1%) is under the age of 18, which is slightly lower when compared to Los Angeles County (23.8%). Another 9.6% are 65 and older, slightly lower when compared to Los Angeles County (11.6%).

**Table 9. Age Distribution**

	0-4	5-9	10-15	15-17	18-20	21-24	25-34	35-44	45-54	55-64	65-74	75-84	85 and over
SVMC Service Area	6.9%	6.3%	6.1%	3.8%	4.6%	6.8%	18.0%	15.4%	12.9%	9.5%	5.4%	2.9%	1.3%
Los Angeles County	6.6%	6.4%	6.6%	4.2%	4.5%	6.0%	14.9%	14.3%	13.9%	11.1%	6.5%	3.5%	1.6%

Data source: Nielsen Claritas  
Data year: 2013  
Source geography: ZIP Code

On average, the population in the SVMC service area is in their mid-thirties, 35.4 years old, slightly younger than in Los Angeles County (36.8 years old).

**Table 10. Average Age (in years)**

ZIP Code	Average Age
SVMC Service Area	35.4
Los Angeles County	36.8

Data source: Nielsen Claritas  
Data year: 2013  
Source geography: ZIP Code

### Marital Status

Half of the population in the SVMC service area has never been married (50.8%), more when compared to Los Angeles County (40.6%). Over a quarter (28.0%) of the population in the SVMC service area is married with a spouse living in the home, a much smaller percentage than in Los Angeles County (39.2%). Nearly a fifth (9.0%) of the population in the SVMC service area is married with a spouse not living in the home, which is higher than in Los Angeles County (6.8%). A smaller percentage of the SVMC service area is divorced (7.5%) than in Los Angeles County (8.5%) and another 4.7% is widowed, a slightly higher percentage than in Los Angeles County (4.0%). Please refer to Table 11. for more information.

**Table 11. Marital Status**

	Never Married	Married, Spouse Present	Married, Spouse Absent	Widowed	Divorced
SVMC Service Area	50.8%	28.0%	9.0%	4.7%	7.5%
Los Angeles County	40.6%	39.2%	6.8%	4.0%	8.5%

Data source: Nielsen Claritas  
Data year: 2013  
Source geography: ZIP Code

### Education Levels

Overall, over a third (35.5%) of the population in the SVMC service area does not have any formal education—did not graduate from high school or has less than a ninth-grade education— more than in Los Angeles County (24.2%). In SVMC’s service area, a fifth (20.4%) of the population graduated from high school, similar to Los Angeles County (20.4%). Another 15.9% attended college but did not graduate, lower than in Los Angeles County (19.5%). Over a quarter graduated from college in the SVMC

service area (28.1%), also lower when compared to Los Angeles County (36.0%). Of those who graduated from college in the SVMC service area, most received a Bachelor’s degree (16.6%).

**Table 12. Educational Attainment**

	Less than Ninth Grade	Some High School, No Diploma	High School Graduate or GED	Some College, No Degree	Associate Degree	Bachelor’s Degree	Master’s Degree or Higher
SVMC Service Area	22.3%	13.2%	20.4%	15.9%	4.9%	16.6%	6.6%
Los Angeles County	14.2%	10.0%	20.4%	19.5%	6.7%	19.0%	10.2%

Data source: Nielsen Claritas  
Data year: 2013  
Source geography: ZIP Code

### Household Description

In 2013, there are a total of 365,433 households in the SVMC service area—an increase of about 1.7% since 2010 and making up about 11.1% of the households in Los Angeles County. By 2018, the number of households in the SVMC service area is expected to grow by about 3.0%.

In the SVMC service area, the average household size is 2.8 persons per household, which is slightly lower than in Los Angeles County (3.0 persons). Similarly, the median household income in the SVMC service area is 38.2% less (\$33,301) than in Los Angeles County (\$53,880).

**Table 13. Household Descriptions**

ZIP Code	2010 Household Count	2013 Estimate Count	2018 Projected Count	Median Household Income	Average Household Size
SVMC Service Area	359,297	365,433	376,704	\$33,301	2.8
Los Angeles County	3,241,204	3,293,054	3,398,794	\$53,880	3.0

Data source: Nielsen Claritas  
Data year: 2013  
Source geography: ZIP Code

In the SVMC service area, over three quarters (79.5%) of the population rent their homes, a much higher percentage than in Los Angeles County (52.5%). A much smaller percentage of people in the SVMC service own homes (20.5%) than in Los Angeles County (47.5%).

**Table 14. Housing**

ZIP Code	Owner-Occupied	Renter-Occupied
SVMC Service Area	20.5%	79.5%
Los Angeles County	47.5%	52.5%

Data source: Nielsen Claritas  
Data year: 2013  
Source geography: ZIP Code

### Household Income

In the SVMC service area, the median household income is \$33,301, much lower than the median household income in Los Angeles County (\$53,880). Similarly, the average household income in the

SVMC service area (\$53,880) is much lower (about 34.5% lower) than the Los Angeles County average (\$78,598).

**Table 15. Average and Median Household Income**

ZIP Code	Median Household Income	Average Household Income
SVMC Service Area	\$33,301	\$51,461
Los Angeles County	\$53,880	\$78,598

Data source: Nielsen Claritas  
Data year: 2013  
Source geography: ZIP Code

### Households By Income Group

Household income levels in the SVMC service area are mostly below \$15,000 (22.4%), \$15,000 to \$24,999 (16.5%), or \$35,000 to \$49,999 (14.9%) which is lower than in Los Angeles County, where most households have incomes between \$50,000 and \$74,999 (17.4%).

**Table 16. Household Income**

Income level	SVMC Service Area		Los Angeles County	
	Number	Percentage	Number	Percentage
Below \$15,000	81,772	22.4%	425,849	12.9%
\$15,000–\$24,999	60,427	16.5%	364,739	11.1%
\$25,000–\$34,999	48,812	13.4%	324,347	9.9%
\$35,000–\$49,999	54,425	14.9%	442,540	13.4%
\$50,000–\$74,999	53,623	14.7%	573,773	17.4%
\$75,000–\$99,999	26,994	7.4%	386,894	11.8%
\$100,000–\$124,999	14,910	4.1%	265,460	8.1%
\$125,000–\$149,999	7,802	2.1%	153,985	4.7%
\$150,000–\$199,999	8,093	2.2%	175,808	5.3%
\$200,000–\$249,999	2,596	0.7%	57,043	1.7%
\$250,000–\$499,999	3,955	1.1%	84,938	2.6%
Above \$500,000	2,024	0.6%	37,678	1.1%
Total	365,433	100.0%	3,293,054	100.0%

Data source: Nielsen Claritas  
Data year: 2013  
Source geography: ZIP Code

### Employment Status

In 2013, over half the population in the SVMC service area is employed (57.8%), the same as in Los Angeles County (57.8%). In addition, 8.9% are unemployed, which is higher than the 7.4% unemployment rate in Los Angeles County. Another third (33.3%) of the population in the SVMC service area is not in the labor force because they are students, retired, seasonal workers, or taking care of their homes and families (homemakers).

**Table 17. Employment Status**

ZIP Code	In Armed Forces	Employed	Unemployed	Not in Labor Force
SVMC Service Area	0.1%	57.8%	8.9%	33.3%
Los Angeles County	0.1%	57.8%	7.4%	34.8%

Data source: Nielsen Claritas  
Data year: 2013  
Source geography: ZIP Code

### Federal Poverty Level

In 2013, a slightly higher percentage of families in the SVMC service area live below the poverty level (16.5%) when compared to Los Angeles County (13.5%). Also, a higher percentage of families with children in the service area live below the poverty level (13.4%) than in the county (10.7%).

In the SVMC service area, less than half of families (46.8%) live at or above the poverty level, which is nearly half the percentage of families living at or above the poverty level in Los Angeles County (86.5%). Similarly, only a quarter of families with children (23.4%) live at or above the poverty level, which is half the percentage of those in Los Angeles County (44.4%).

**Table 18. Poverty**

ZIP Code	Families Below Poverty	Families Below Poverty with Children	Families at or Above Poverty	Families at or Above with Children
SVMC Service Area	16.5%	13.4%	46.8%	23.4%
Los Angeles County	13.5%	10.7%	86.5%	44.4%

Data source: Nielsen Claritas  
Data year: 2013  
Source geography: ZIP Code

### Students Receiving Free or Reduced-Price Meals

In 2011, the percentage of children eligible for a free or reduced-price lunch in school in the SVMC service area was much larger (87.4%) when compared to Los Angeles County (61.8%). SPA 6 had a larger percentage of children eligible for a free or reduced-price lunch in school (91.0%).

**Table 19. Children Eligible for Free or Reduced-Price Lunch**

	Percentage
Service Planning Area 4	83.8%
Service Planning Area 6	91.0%
SVMC Service Area	87.4% (avg.)
Los Angeles County	61.8%

Data source: California Department of Education (CDE)  
Data year: 2011  
Source geography: SPA

### Medi-Cal Beneficiaries

Medi-Cal, California's Medicaid program, is a public health insurance program that provides health care services at no or low cost to low-income individuals, including families and children, seniors, persons with disabilities, foster care children, and pregnant women. The federal government dictates a manda-

tory set of basic services, which include but are not limited to physician, family nurse practitioner, nursing facility, hospital inpatient and outpatient, laboratory and radiology, family planning, and early and periodic screening, diagnosis, and treatment for children. In addition to these mandatory services, California provides optional benefits such as outpatient drugs, home- and community-based waiver services, and medical equipment, etc.<sup>2</sup>.

In the SVMC service area, there are 381,429 Medi-Cal beneficiaries who make up 15.6% of the total Medi-Cal beneficiaries in Los Angeles County. In the SVMC service area, the largest percentage of Medi-Cal beneficiaries live in ZIP Codes 90011 (15.1%) and 90044 (12.5%).

**Table 20. Medi-Cal Beneficiaries**

ZIP Code	Number	Percentage
90004	17,095	4.5%
90005	12,581	3.3%
90006	24,706	6.5%
90007	15,860	4.2%
90008	10,034	2.6%
90010	538	0.1%
90011	57,546	15.1%
90016	15,661	4.1%
90017	10,054	2.6%
90018	18,623	4.9%
90019	17,890	4.7%
90020	9,351	2.5%
90026	18,416	4.8%
90027	9,197	2.4%
90028	6,812	1.8%
90029	14,108	3.7%
90031	15,457	4.1%
90037	33,668	8.8%
90044	47,510	12.5%
90046	5,367	1.4%
90057	20,955	5.5%
SVMC Service Area	381,429	100.0%
Los Angeles County	2,444,850	

Data source: California Department of Health Care Services (DHCS)

Data year: 2011

Source geography: ZIP Code

### Healthy Families Beneficiaries

The Healthy Families Program offers low-cost insurance that provides health, dental, and vision coverage to children who do not have insurance or who do not qualify for no-cost Medi-Cal<sup>3</sup>. However, as of

<sup>2</sup> State of California Department of Health Care Services (2012). Medi-Cal's Coordinated Care Initiative Population Combined Medicare & Medi-Cal Cost, Utilization, and Disease Burden, Sacramento, CA. Available at <http://www.dhcs.ca.gov/dataandstats/statistics/Documents/Dual%20Data%20Sets%20Medicare.pdf>. Accessed [July 16, 2013].

<sup>3</sup> State of California Healthy Families Program (2008). About the Healthy Families Program. Sacramento, CA. Available at <http://www.healthyfamilies.ca.gov/About/>. Accessed [July 10, 2013].

January 1, 2013, no new enrollments of children into the Healthy Families Program were allowed; and existing enrollees are being transitioned into the Medi-Cal program due to a change in state law<sup>4</sup>.

As of December 2012, there were 572 new enrollments into the Healthy Families program in the SVMC service area. On average, 4.8% of children in the SVMC service area were enrolled in Healthy Families that year. In the SVMC service area, most Healthy Family program enrollees lived in ZIP Codes 90010 (7.2%).

**Table 21. Healthy Families Enrollment**

ZIP Code	Number	Percentage
90004	30	5.2%
90005	25	4.4%
90006	25	4.4%
90007	21	3.7%
90008	19	3.3%
90010	41	7.2%
90011	28	4.9%
90016	38	6.6%
90017	11	1.9%
90018	31	5.4%
90019	29	5.1%
90020	38	6.6%
90026	26	4.5%
90027	28	4.9%
90028	19	3.3%
90029	27	4.7%
90031	36	6.3%
90037	27	4.7%
90044	25	4.4%
90046	27	4.7%
90057	21	3.7%
SVMC Service Area	572	100.0%
Los Angeles County	215,543	

Data source: Managed Risk Medical Insurance Board

Data year: 2012

Source geography: ZIP Code

### Medicare Beneficiaries

Medicare is a federal program administered by the Centers for Medicare & Medicaid Services (CMS). Medicare provides health insurance for people age 65 or older, those under age 65 with certain disabilities or ALS (amyotrophic lateral sclerosis, or Lou Gehrig’s disease), and people of any age with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant)<sup>5</sup>.

<sup>4</sup> State of California Healthy Families Program (2008). About the Healthy Families Program. Sacramento, CA. Available at <http://www.healthyfamilies.ca.gov/About/>. Accessed [July 10, 2013].

<sup>5</sup> State of California Department of Health Care Services (2012). Medi-Cal’s Coordinated Care Initiative Population Combined Medicare & Medi-Cal Cost, Utilization, and Disease Burden, Sacramento, CA. Available at <http://www.dhcs.ca.gov/dataandstats/statistics/Documents/Dual%20Data%20Sets%20Medicare.pdf>. Accessed [July 16, 2013].

The Medicare program provides insurance through various parts, such as Parts A, B, C, and D. Medicare Part A provides insurance for inpatient hospital, skilled nursing facility, and home health services. Medicare Part B, which is an optional insurance program, provides coverage for physician services, outpatient hospital services, durable medical equipment, and certain home health services. Medicare Part C, which is commonly referred to as Medicare Advantage, offers health plan options that are provided by Medicare-approved private insurance companies (e.g., HMOs, PPOs). Medicare Part D represents optional insurance coverage for prescription drugs. Medicare Advantage Plans provide the benefits and services covered under Parts A and B and often provide Medicare Part D prescription drug coverage<sup>6</sup>.

In 2011, a third (30.7%) of the population in the SVMC service area was enrolled in Medicare, slightly lower than in Los Angeles County (36.9%). SPA 4 (33.6%) had a larger percentage of people enrolled in Medicare when compared to the SVMC service area average, but lower than Los Angeles County (36.9%).

**Table 22. Medicare Beneficiaries**

	Percentage
Service Planning Area 4	33.6%
Service Planning Area 6	27.8%
SVMC Service Area	30.7% (avg.)
Los Angeles	36.9%

Data source: Los Angeles County Health Survey  
Data year: 2011  
Source geography: SPA

### Federally Qualified Health Centers

Federally Qualified Health Centers (FQHCs) are community-based and patient-directed organizations that serve populations with limited access to health care. They consist of public and private nonprofit health care organizations that meet certain criteria under the Medicare and Medicaid programs and receive funds under the Health Center Program (Section 330 of the Public Health Service Act).

In 2012, half of the FQHCs in Los Angeles County (n=183) are located in the SVMC service area (n=92). Seventy of those are in SPA 4 and the other 22 are in SPA 6.

**Table 23. Federally Qualified Health Centers**

	Number
Service Planning Area 4	70
Service Planning Area 6	22
SVMC Service Area	92
Los Angeles County	183

Data source: U.S. Department of Health and Human Services  
Health Resources and Services Administration (HRSA)  
Data year: 2012  
Source geography: SPA

<sup>6</sup> State of California Department of Health Care Services (2012). Medi-Cal's Coordinated Care Initiative Population Combined Medicare & Medi-Cal Cost, Utilization, and Disease Burden, Sacramento, CA. Available at <http://www.dhcs.ca.gov/dataandstats/statistics/Documents/Dual%20Data%20Sets%20Medicare.pdf>. Accessed [July 16, 2013].

## Access to Healthcare

Access to health care services is important for everyone’s quality of life, and requires the ability to navigate the health care system, access a health care location where services are provided, and find a health care provider with whom the patient can communicate and trust<sup>7</sup>. Access to health care impacts overall physical, social, and mental health status, the prevention of disease and disability, the detection and treatment of health conditions, quality of life, preventable death, and life expectancy<sup>8</sup>.

### Uninsured Adults

In 2011, close to a quarter (23.2%) of the SVMC service area population was uninsured, a higher percentage when compared to Los Angeles County (17.4%) and the Healthy People 2020 goal of 0.0%. SPA 4 (23.4%) had a slightly higher percentage of its population who were uninsured.

**Table 24. Uninsured Population**

	Percentage
Service Planning Area 4	23.4%
Service Planning Area 6	23.0%
SVMC Service Area	23.2% (avg.)
Los Angeles County	17.4%
Healthy People 2020	0.0%

Data source: Los Angeles County Health Survey  
Data year: 2011  
Source geography: SPA

### Uninsured Children

In 2011, a larger percentage (7.6%) of children in the SVMC service area did not have health insurance (or were uninsured) when compared to Los Angeles County (5.0%), and the service area did not meet the goal of Healthy People 2020 (0.0%). More specifically, SPA 6 had a higher percentage (8.6%) of children without health insurance (or who were uninsured) than the overall SVMC service area (7.6%) and Los Angeles County (5.0%).

**Table 25. Uninsured Children**

	Percentage
Service Planning Area 4	6.6%
Service Planning Area 6	8.6%
SVMC Service Area	7.6% (avg.)
Los Angeles County	5.0%
Healthy People 2020	0.0%

Data source: Los Angeles County Health Survey  
Data year: 2011  
Source geography: SPA

<sup>7</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=1>. Accessed [July, 18, 2013].

<sup>8</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=1>. Accessed [July, 18, 2013].

### Difficulty Accessing Care

In 2011, the percentage of adults who lacked a consistent source of primary care was slightly greater (24.7%) in the SVMC service area when compared to Los Angeles County (20.9%). Specifically, SPA 6 (26.5%) had greater percentages of those who lacked a consistent source of primary care when compared to the overall SVMC service area (24.7%) and Los Angeles County (20.9%).

**Table 26. Lack of a Consistent Source of Primary Care for Adults**

	Percentage
Service Planning Area 4	22.8%
Service Planning Area 6	26.5%
SVMC Service Area	24.7% (avg.)
Los Angeles County	20.9%

Data source: Los Angeles County Health Survey  
Data year: 2011  
Source geography: SPA

In addition, a much larger percentage of adults (41.3%) in the SVMC service area had difficulty accessing medical care when compared to Los Angeles County (31.7%). Specifically, a greater percentage of adults in SPA 6 (44.6%) had difficulty accessing medical care when compared to the overall SVMC service area (41.3%) and Los Angeles County (31.7%).

**Table 27. Difficulty Accessing Medical Care for Adults**

	Percentage
Service Planning Area 4	38.0%
Service Planning Area 6	44.6%
SVMC Service Area	41.3% (avg.)
Los Angeles County	31.7%

Data source: Los Angeles County Health Survey  
Data year: 2011  
Source geography: SPA

A larger percentage (14.9%) of children between the ages of 0 and 17 in the SVMC service area has difficulty accessing medical care when compared to Los Angeles County (12.3%). An even larger percentage of children in SPA 6 (17.7%) have a difficult time accessing medical care than those in the overall SVMC service area (14.9%) and Los Angeles County (12.3%).

**Table 28. Difficulty Accessing Medical Care for Children between the Ages of 0 and 17**

	Percentage
Service Planning Area 4	12.1%
Service Planning Area 6	17.7%
SVMC Service Area	14.9% (avg.)
Los Angeles County	12.3%

Data source: Los Angeles County Health Survey  
Data year: 2011  
Source geography: SPA

In 2011, a much smaller percentage (38.0%) of adults in the SVMC service areas have dental coverage when compared to Los Angeles County (48.2%) and, specifically, a smaller percentage of adults in SPA 6 (37.1%).

**Table 29. Dental Insurance Coverage for Adults**

	Percentage
Service Planning Area 4	38.9%
Service Planning Area 6	37.1%
SVMC Service Area	38.0%
Los Angeles County	48.2%

Data source: Los Angeles County Health Survey  
Data year: 2011  
Source geography: SPA

### Dentist to Population Ratio

As of May 2013, there were a total of 8,417 dentists in Los Angeles County, making up over a quarter (26.7%) of dentists in California.

In order for an area to be determined a Dental Health Professional Shortage Area, the area must have a population-to-dentist ratio of at least 5,000:1.<sup>9</sup> Los Angeles County does not meet the criteria, with a ratio of 1,184:1.

**Table 30. Dentist Availability**

	Number	Population-to-Dentist Ratio
Los Angeles County	8,417	1,184:1
California	31,559	

Data source: Office of Statewide Health and Planning and Development (OSHPD)  
Data year: 2013  
Source geography: County

## Nativity

### Births

In 2011, there were a total of 14,901 births in the SVMC service area, making up 11.5% of the births in Los Angeles County (n=129,087). Most births in SVMC's service area occurred in ZIP Codes 90011 (n=2,269) and 90044 (n=1,698).

**Table 31. Births**

ZIP Code	Number	Percentage
90004	810	5.4%
90005	496	3.3%
90006	931	6.2%
90007	390	2.6%
90008	389	2.6%

<sup>9</sup> United States Department of Health and Human Services (n.d.). Dental HPSA Designation Overview. Rockville, MD. Available at <http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/dentalhpsaoverview.html>. Accessed [July 10, 2013].

ZIP Code	Number	Percentage
90010	23	0.2%
90011	2,269	15.2%
90016	671	4.5%
90017	362	2.4%
90018	719	4.8%
90019	850	5.7%
90020	514	3.4%
90026	826	5.5%
90027	392	2.6%
90028	242	1.6%
90029	455	3.1%
90031	534	3.6%
90037	1,220	8.2%
90044	1,698	11.4%
90046	328	2.2%
90057	782	5.2%
SVMC Service Area	14,901	100.0%
Los Angeles County	129,087	

Data source: California Department of Public Health  
Data year: 2011  
Source geography: ZIP Code

### Births by Mother's Age

In 2010, most births in the SVMC service area were to women between the ages of 30 and 34 (39.9%) and those 35 years old or older (33.2%), followed by women 20 to 29 (26.5%) and those under 20 years old (0.4%). The largest percentage of births occurred to mothers between the ages 20 and 29 (45.8%) in Los Angeles County, different from the SVMC service area.

Table 32. Births by Mother's Age

Age Group	SVMC Service Area		Los Angeles County	
	Number	Percentage	Number	Percentage
Under 20 years old	160	0.4%	11,766	8.9%
20–29 years old	658	26.5%	60,520	45.8%
30–34 years old	233	39.9%	33,624	25.4%
35 years old and older	169	33.2%	26,263	19.9%
Total	524	100.0%	132,173	100.0%

Data source: California Department of Public Health  
Data year: 2010  
Source geography: ZIP Code

### Births by Mother's Ethnicity

By ethnicity, most births in the SVMC service area in 2010 were to White mothers (56.3%), followed by mothers who are Asian/Pacific Islander (29.8%). Different trends were noted in Los Angeles County where most births occurred to Hispanic mothers (61.4%).

**Table 33. Births by Mother’s Ethnicity**

Ethnicity	SVMC Service Area		Los Angeles County	
	Number	Percentage	Number	Percentage
Hispanic	34	6.5%	81,102	61.4%
African-American	13	2.5%	10,201	7.7%
Two or More Races	12	2.3%	2,016	1.5%
White	295	56.3%	22,398	16.9%
Other Race	13	2.5%	1,137	0.9%
Asian/Pacific Islander	156	29.8%	15,153	11.5%
Native American or Alaskan Native	1	0.2%	168	0.1%
<b>Total</b>	<b>524</b>	<b>100.0%</b>	<b>132,175</b>	<b>100.0%</b>

Data source: California Department of Public Health

Data year: 2010

Source geography: ZIP Code

### Birth Weight

In 2011, 931 babies in the SVMC service area were born with low birth weight and another 197 with very low birth weight. The largest percentage of babies born with low birth weight were in ZIP Codes 90011 (16.6%) and 90044 (14.0%). Similarly, ZIP Codes 90044 (15.3%) and 90011 (9.5%) experienced the greatest percentages of babies born with very low birth weight.

**Table 34. Birth Weight**

ZIP Code	Low Birth Weight		Very Low Birth Weight	
	Number	Percentage	Number	Percentage
90004	45	4.8%	9	4.6%
90005	28	3.0%	11	5.6%
90006	51	5.5%	10	5.1%
90007	15	1.6%	3	1.5%
90008	28	3.0%	12	6.1%
90010	1	0.1%	0	0.0%
90011	148	15.9%	18	9.1%
90016	44	4.7%	13	6.6%
90017	28	3.0%	1	0.5%
90018	55	5.9%	13	6.6%
90019	52	5.6%	8	4.1%
90020	26	2.8%	11	5.6%
90026	48	5.2%	14	7.1%
90027	26	2.8%	4	2.0%
90028	18	1.9%	4	2.0%
90029	22	2.4%	2	1.0%
90031	25	2.7%	8	4.1%
90037	84	9.0%	17	8.6%
90044	125	13.4%	29	14.7%
90046	21	2.3%	3	1.5%
90057	41	4.4%	7	3.6%
<b>SVMC Service Area</b>	<b>931</b>	<b>100.0%</b>	<b>197</b>	<b>100.0%</b>

Data source: California Department of Public Health

Data year: 2011  
Source geography: ZIP Code

## Breastfeeding

Breastfeeding is an important element in the development of newborns. In 2011, nearly half (48.2%) of mothers breastfed their babies for at least six months in the SVMC service area, more than in Los Angeles County (44.9%) but fewer than the Healthy People 2020 goal of  $\geq 60.6\%$ . Over half (52.5%) of women in SPA 4 breastfed their babies for at least six months—a larger percentage than in Los Angeles County (44.9%) but a much smaller percentage when compared to the Healthy People 2020 goal.

**Table 35. Breastfeeding at Least Six Months**

	Percentage
Service Planning Area 4	52.5%
Service Planning Area 6	43.8%
SVMC Service Area	48.2%
Los Angeles County	44.9%
Healthy People 2020	$\geq 60.6\%$

Data source: Los Angeles County Health Survey  
Data year: 2011  
Source geography: SPA

Similarly, a third (30.5%) of mothers in the SVMC service area breastfed their babies for at least twelve months, a larger percentage than in Los Angeles County (19.9%) but lower than the Healthy People 2020 goal ( $\geq 34.1\%$ ). A larger percentage (41.0%) of mothers in SPA 4, however, breastfed their babies at least twelve months—more than in Los Angeles County (19.9%), and exceeding the Healthy People 2020 goal ( $\geq 34.1\%$ ).

**Table 36. Breastfeeding at Least Twelve Months**

	Percentage
Service Planning Area 4	41.0%
Service Planning Area 6	20.0%
SVMC Service Area	30.5%
Los Angeles County	19.9%
Healthy People 2020	$\geq 34.1\%$

Data source: Los Angeles County Health Survey  
Data year: 2011  
Source geography: SPA

## Mortality

### Deaths

In 2010, the 5,265 deaths in the SVMC service area comprised 9.1% of the total deaths in Los Angeles County. In the SVMC service area, most deaths occurred in ZIP Code 90044 (9.4%).

**Table 37. Total Deaths**

ZIP Code	Number	Percentage
90004	261	5.0%
90005	163	3.1%

ZIP Code	Number	Percentage
90006	233	4.4%
90007	120	2.3%
90008	285	5.4%
90010	12	0.2%
90011	321	6.1%
90016	330	6.3%
90017	96	1.8%
90018	359	6.8%
90019	358	6.8%
90020	134	2.5%
90026	292	5.5%
90027	347	6.6%
90028	171	3.2%
90029	225	4.3%
90031	243	4.6%
90037	280	5.3%
90044	473	9.0%
90046	351	6.7%
90057	211	4.0%
<b>SVMC Service Area</b>	<b>5,265</b>	<b>100.0%</b>
<b>Los Angeles County</b>	<b>55,331</b>	

Data source: California Department of Public Health (CDPH)

Data year: 2010

Source geography: ZIP Code

### Deaths by Age Group

In 2010, there were a total of 5,265 deaths in the SVMC service area. The highest percentage of deaths occurred among those 85 years old and older (27.8%) and those between 75 and 85 years old (22.6%), similar percentages when compared to Los Angeles County (32.2% and 24.4%, respectively). Slightly more deaths occurred among those 65 and 74 years old (15.7%) in the SVMC service area when compared to Los Angeles County (15.5%). Similarly, slightly more deaths also occurred among those between 55 and 64 years old (14.8%) in the SVMC service area when compared to Los Angeles County (12.6%).

**Table 38. Total Deaths, by Age Group**

Age Group	SVMC Service Area		Los Angeles County	
	Number	Percentage	Number	Percentage
Less than 1 year old	88	1.7%	613	1.1%
1–4 years old	6	0.1%	105	0.2%
5–14 years old	13	0.2%	159	0.3%
15–24 years old	103	2.0%	771	1.4%
25–34 years old	133	2.5%	1,018	1.8%
35–44 years old	210	4.0%	1,716	3.1%
45–54 years old	452	8.6%	4,123	7.5%
55–64 years old	781	14.8%	6,955	12.6%

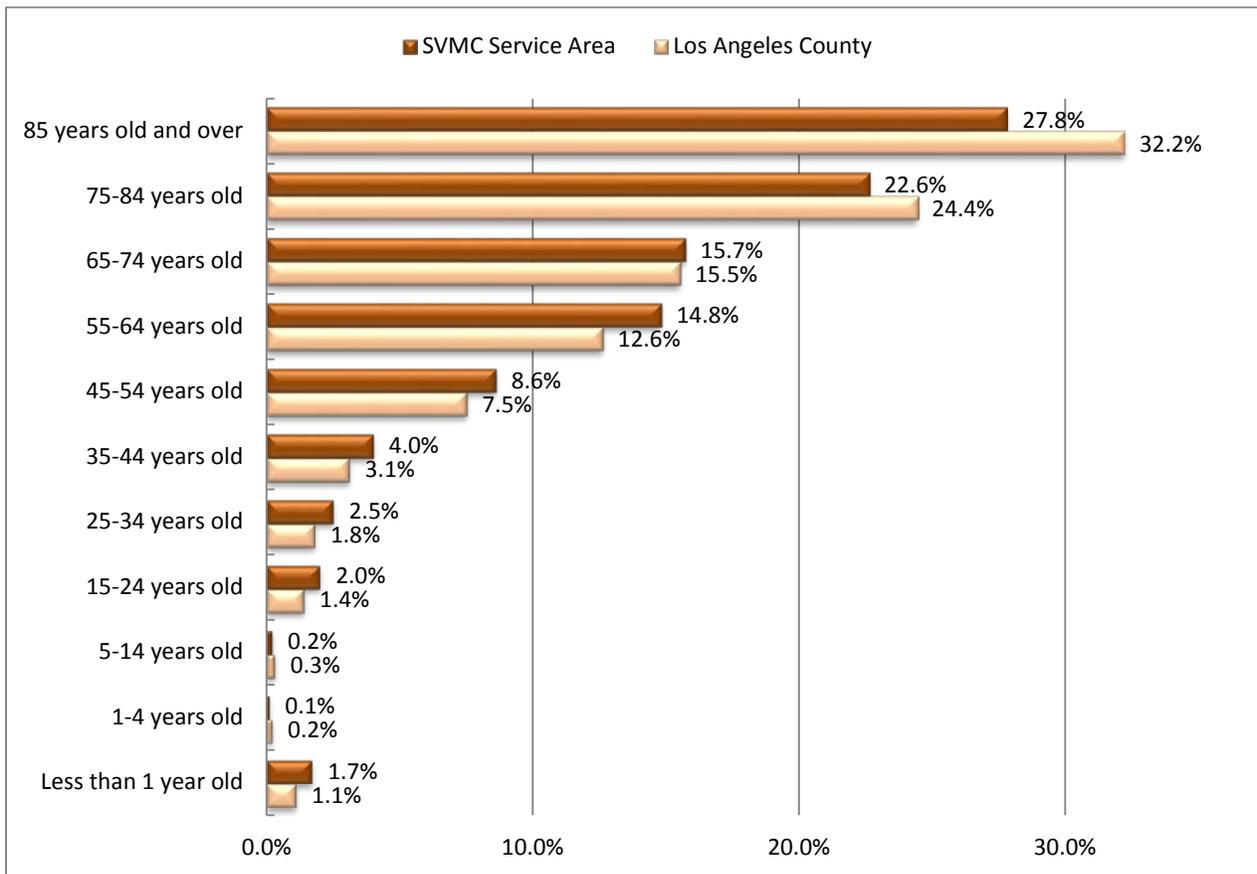
Age Group	SVMC Service Area		Los Angeles County	
	Number	Percentage	Number	Percentage
65–74 years old	829	15.7%	8,572	15.5%
75–84 years old	1,188	22.6%	13,481	24.4%
85 years old and over	1,462	27.8%	17,818	32.2%
Total	5,265	100.0%	55,331	100.0%

Data source: California Department of Public Health (CDPH)

Data year: 2010

Source geography: ZIP Code

Figure 3. Total Deaths, by Age Group



### Cause of Death

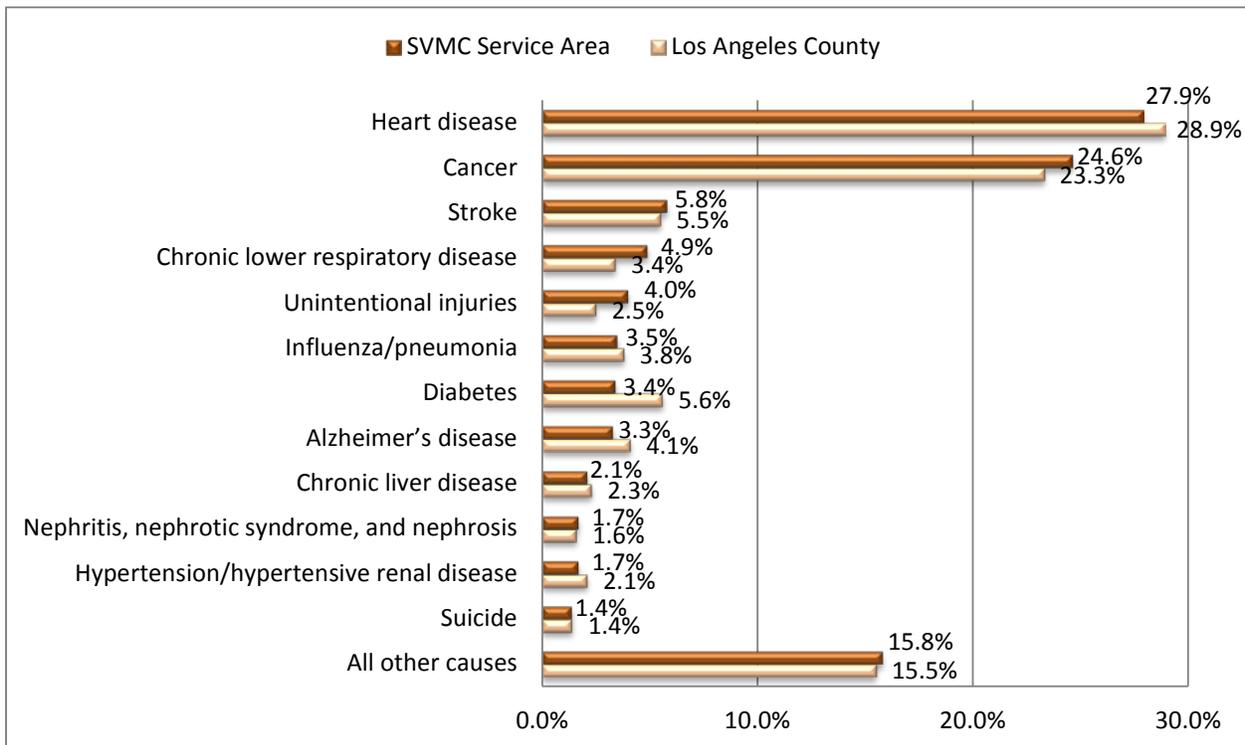
In 2010, the most common cause of death in the SVMC service area (28.8%) was heart disease, also the leading cause of death in Los Angeles County (27.9%). The second leading cause of death in the SVMC service area (23.6%) was cancer, also the second leading of death in Los Angeles County (24.6%). The third leading cause of death in the SVMC service area (5.7%) was nephritis, nephrotic syndrome, and nephrosis which is the tenth leading cause of death in Los Angeles County (1.7%).

**Table 39. Total Deaths, by Cause**

Cause	SVMC Service Area		Los Angeles County	
	Number	Percentage	Number	Percentage
Heart disease	1550	28.9%	15,451	27.9%
Cancer	1249	23.3%	13,624	24.6%
Diabetes	301	5.6%	1,866	3.4%
Stroke	296	5.5%	3,231	5.8%
Alzheimer's disease	221	4.1%	1,827	3.3%
Influenza/pneumonia	202	3.8%	1,922	3.5%
Chronic lower respiratory disease	185	3.4%	2,710	4.9%
Unintentional injuries	132	2.5%	2,213	4.0%
Chronic liver disease	122	2.3%	1,144	2.1%
Hypertension/hypertensive renal disease	113	2.1%	919	1.7%
Nephritis, nephrotic syndrome, and nephrosis	85	1.6%	946	1.7%
Suicide	75	1.4%	760	1.4%
All other causes	834	15.5%	8,718	15.8%
<b>Total</b>	<b>5,365</b>	<b>100.0%</b>	<b>55,331</b>	<b>100.0%</b>

Data source: California Department of Public Health (CDPH)  
Data year: 2010  
Source geography: ZIP Code

**Figure 4. Total Deaths, by Cause**



## VII. Key Findings—Health Outcomes and Drivers

### 1. Alcohol Abuse

Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse contribute significantly to costly social, physical, mental, and public health problems, including teenage pregnancy, HIV/AIDS, STDs, domestic violence, child abuse, motor vehicle accidents (unintentional injuries), physical fights, crime, homicide, and suicide. Heavy alcohol consumption is an important determinant of future health needs, including cirrhosis, cancers, and untreated mental and behavioral health needs. In addition to considerable health implications, substance abuse has been a major focal point in discussions about social values: people argue over whether substance abuse is a disease with genetic and biological foundations or a matter of personal choice<sup>10</sup>.

#### Alcohol Outlets

The density of alcohol outlets is associated with heavy drinking, drinking and driving, higher rates of motor vehicle-related pedestrian injuries, child abuse and neglect, and other violence<sup>11</sup>. In 2012, the average alcohol outlet rate per 1,000 persons in the SVMC service area was 2.2. The highest rates were reported in ZIP Codes 90010 (11.8) and 90028 (6.4).

**Table 40. Alcohol Outlet Rate per 1,000 Persons**

ZIP Code	Rate
90004	1.8
90005	3.3
90006	2.0
90007	1.1
90008	0.6
90010	11.8
90011	0.8
90016	0.7
90017	2.4
90018	0.5
90019	1.2
90020	1.5
90026	1.8
90027	2.0
90028	6.4
90029	1.8
90031	1.3
90037	0.6
90044	0.5
90046	2.7

<sup>10</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=32>. Accessed [February 26, 2013].

<sup>11</sup> Stewart, K. (n.d.). How Alcohol Outlets Affect Neighborhood Violence. Calverton, MD. Available at <http://urbanillinois.us/sites/default/files/attachments/how-alcohol-outlets-affect-nbhd-violence.pdf>. Accessed [July 11, 2013].

ZIP Code	Rate
90057	1.0
SVMC Service Area	2.2 (avg.)

Data source: California Department of Alcoholic Beverage Control  
Data year: 2012  
Source geography: ZIP Code

### Alcohol Use

In 2011, nearly half (46.6%) of the population in the SVMC service area consumed alcohol, a slightly lower rate than in Los Angeles County (51.9%). Also, SPA 4 reported a slightly higher percentage (50.6%) than the SVMC service area (46.6%).

**Table 41. Alcohol Use in the Past Month**

	Percentage
Service Planning Area 4	50.6%
Service Planning Area 6	42.6%
SVMC Service Area	46.6% (avg.)
Los Angeles County	51.9%

Data source: Los Angeles County Health Survey  
Data year: 2011  
Source geography: SPA

A slightly larger percentage (3.6%) of the population in the SVMC service area reported drinking heavily when compared to Los Angeles County (3.5%), with SPA 4 reporting a higher percentage (4.6%). A higher percentage (18.1%) of the population in the SVMC service area also reported binge drinking when compared to Los Angeles County (15.4%); the rate was notably higher in SPA 4 (19.2%).

**Table 42. Level of Alcohol Consumption in the Past Month**

	Heavy Drinking	Binge Drinking
Service Planning Area 4	4.6%	19.2%
Service Planning Area 6	2.5%	16.9%
SVMC Service Area (avg.)	3.6% (avg.)	18.1% (avg.)
Los Angeles County	3.5%	15.4%

Data source: Los Angeles County Health Survey  
Data year: 2011  
Source geography: SPA

### Alcohol and Drug Treatment

In 2011, a slightly larger percentage (2.8%) of the population in the SVMC service area had needed or sought treatment for an alcohol or substance abuse problem in the past five years when compared to Los Angeles County (2.5%). The percentage was even higher in SPA 4 (3.3%).

**Table 43. Needed or Wanted Treatment for Alcohol or Drug Issues in the Past Five Years**

	Percentage
Service Planning Area 4	3.3%
Service Planning Area 6	2.3%

	Percentage
SVMC Service Area	2.8% (avg.)
Los Angeles County	2.5%

Data source: Los Angeles County Health Survey

Data year: 2011

Source geography: SPA

### Disparities

Stakeholders identified the homeless, children and youth, the uninsured, youth in or transitioning out of the foster care system, and low income populations as the most severely impacted sub-populations.

Stakeholders also identified Los Angeles as generally impacted by alcohol abuse.

### Associated Drivers of Health

Several biological, social, environmental, psychological, and genetic factors are associated with alcohol and substance abuse. These factors may include gender, race and ethnicity, age, income level, educational attainment, and sexual orientation. Substance abuse is also strongly influenced by interpersonal, household, and community factors. Among adolescents, family, social networks, and peer pressure are key influencers of substance abuse<sup>12</sup>. Alcohol and substance abuse may also contribute to teenage pregnancy, HIV/AIDS, STDs, domestic violence, child abuse, motor vehicle accidents (unintentional injuries), physical fights, crime, homicide (intentional injuries), and suicide<sup>13</sup>. For data concerning health drivers, please refer to Appendix C—Scorecard.

### Primary Data

Stakeholders indicated that alcohol and substance abuse often are associated with mental illness and poverty and attribute the prevalence of alcohol abuse to the lack of access to treatment. They also added that there have been successful efforts to reduce underage drinking at Berendo and Nightingale Middle Schools and Fairfax High School in Los Angeles where the purpose of such efforts was to create “buffer zones” around these schools and also educate family members around alcohol abuse.

## 2. Allergies

Allergies are an overreaction of the immune system to substances that usually cause no reaction in most individuals. These substances can trigger sneezing, wheezing, coughing and itching. Allergies have been linked to a variety of common and serious chronic respiratory illnesses such as sinusitis and asthma. Factors such as family history with allergies, the types and frequency of symptoms, seasonality, duration and even location of symptoms (indoors or outdoors, for example) are all taken into consideration in allergies diagnosis. Allergic reactions can be severe and even fatal. With proper management and patient education, allergic diseases can be controlled and people with allergies can lead normal and productive lives<sup>14</sup>. Many allergens are also asthma triggers that irritate the lungs, inducing an asthma attack. Other social and economic factors have been known to cause or trigger allergic reactions

<sup>12</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://www.healthypeople.gov/2020/lhi/substanceabuse.aspx?tab=determinants>. Accessed [February 27, 2013].

<sup>13</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=32>. Accessed [February 26, 2013].

<sup>14</sup> Asthma and Allergy Foundation of America (AAFA). Allergies. Milwaukee, WI. Available at [http://www.aaaai.org/conditions-and-treatments/allergies.aspx]. Accessed [March 1, 2013].

including poor housing conditions (living with cockroaches, mites, asbestos, mold etc.). Living in an environment or home with smokers has also been known exacerbate allergies and/or asthma.

### Prevalence

In 2007, a third of teens (32.5%) in the SVMC service area were diagnosed with allergies—higher when compared to Los Angeles County. An even larger percentage of teens were diagnosed with allergies in SPA 6 (45.6%) when compared to SVMC’s service area (32.5%) and Los Angeles County (24.9%).

**Table 44. Allergy Prevalence Among Teens**

	Percentage
Service Planning Area 4	19.4%
Service Planning Area 6	45.6%
SVMC Service Area	32.5% (avg.)
Los Angeles County	24.9%

Data source: Los Angeles County Health Survey  
Data year: 2007  
Source geography: SPA

### Disparities

Stakeholders added that Asian populations seemed to be the most affected by allergies.

### Associate Drivers of Health

Allergic reactions are known to be caused by pollen, dust, food, insect stings, animal dander, mold, medications, and latex<sup>15</sup>. Many allergens are also asthma triggers that irritate the lungs, inducing an asthma attack. Social and economic factors have been known to cause or trigger allergic reactions including poverty leading to poor housing conditions (living with cockroaches, mites, asbestos, mold etc.) and living in an environment or home with smokers. For data concerning health drivers, please refer to Appendix C—Scorecard.

### Primary Data

Stakeholders indicated that allergies were associated with poor air quality and other environmental factors.

## 3. Alzheimer’s Disease

An estimated 5.4 million Americans have Alzheimer’s disease, which is the sixth-leading cause of death in the U.S.<sup>16</sup>. Alzheimer’s, an irreversible and progressive brain disease, is the most common cause of dementia among older people. The disease is characterized by the loss of cognitive functioning and ranges in severity from the mildest stage of minor cognitive impairment to the most severe stage, when the person with Alzheimer’s must depend completely on others for tasks of daily living. People with Alzheimer’s disease and other dementias have more hospital stays, skilled nursing facility stays, and home health care visits than other older people<sup>17</sup>.

<sup>15</sup> American Academy of Allergy Asthma and Immunology. Allergies. Landover, MD. Available at [http://www.aafa.org/display.cfm?id=9]. Accessed [March 1, 2013].

<sup>16</sup> Alzheimer’s Association. 2012 Alzheimer’s Disease Facts and Figures. Available at [http://www.alz.org/downloads/facts\_figures\_2012.pdf]. Accessed [March 6, 2013].

<sup>17</sup> National Institutes of Health. About Alzheimer’s Disease: Alzheimer’s Basics. Available at [http://www.nia.nih.gov/alzheimers/topics/alzheimers-basics]. Accessed [March 5, 2013].

The likely causes of Alzheimer’s disease include some combination of age-related changes in the brain, a family history of Alzheimer’s, and genetic, environmental, and lifestyle factors. Some data suggest that cardiovascular disease risk factors (e.g., physical inactivity, high cholesterol, diabetes, smoking, and obesity) and traumatic brain injury are associated with a higher risk of developing Alzheimer’s disease<sup>18</sup>.

Currently there is no cure for Alzheimer’s disease, although treatment can help manage symptoms and slow progression of the disease<sup>19</sup>. People with Alzheimer’s can experience a significant improvement in quality of life with active medical management for the disease. Active management includes: “(1) appropriate use of available treatment options, (2) effective management of coexisting conditions, (3) coordination of care among physicians, other health care professionals and lay caregivers, (4) participation in activities and adult day care programs and (5) taking part in support groups and supportive services such as counseling”<sup>20</sup>.

### Mortality

In 2010, Alzheimer’s mortality rate in the SVMC service area was three times higher (10.5) than California (2.9). The highest rates were reported in ZIP Codes 90044 (24.0), 90006 (18.0), 90011 (17.0), and 90026 (17.0).

**Table 45. Alzheimer’s Disease Mortality Rate Per 10,000 Persons**

ZIP Code	Rate
90004	8.0
90005	8.0
90006	18.0
90007	7.0
90008	9.0
90010	0.0
90011	17.0
90016	14.0
90017	5.0
90018	7.0
90019	15.0
90020	5.0
90026	17.0
90027	5.0
90028	15.0
90029	6.0
90031	10.0
90037	9.0
90044	24.0
90046	11.0

<sup>18</sup> Alzheimer’s Association. *2012 Alzheimer’s Disease Facts and Figures*. Available at [[http://www.alz.org/downloads/facts\\_figures\\_2012.pdf](http://www.alz.org/downloads/facts_figures_2012.pdf)]. Accessed [March 6, 2013].

<sup>19</sup> National Institutes of Health. *About Alzheimer’s Disease: Alzheimer’s Basics*. Available at [<http://www.nia.nih.gov/alzheimers/topics/alzheimers-basics>]. Accessed [March 5, 2013].

<sup>20</sup> Alzheimer’s Association. *2012 Alzheimer’s Disease Facts and Figures*. Available at [[http://www.alz.org/downloads/facts\\_figures\\_2012.pdf](http://www.alz.org/downloads/facts_figures_2012.pdf)]. Accessed [March 6, 2013].

ZIP Code	Rate
90057	11.0
SVMC Service Area	10.5 (avg.)
California	2.9

Data source: California Department of Public Health (CDPH)

Data year: 2010

Source geography: ZIP Code

### Disparities

Stakeholders identified people over the age of 85 years of age who are uninsured, low-income, Latinos, and Asians as the most severely impacted.

Stakeholders identified Chinatown and Los Angeles as the most severely impacted.

### Associated Drivers of Health

The greatest risk factor for Alzheimer’s disease is advancing age. Other risk factors include a family history of Alzheimer’s, genetic mutations, cardiovascular disease risk factors (e.g., physical inactivity, high cholesterol, diabetes, smoking, and obesity) and traumatic brain injury<sup>21</sup>. For data concerning health drivers, please refer to Appendix C—Scorecard.

### Primary Data

Stakeholders attributed the prevalence of Alzheimer’s disease to the increase in the aging population.

Stakeholders identified an increased need for Alzheimer’s disease-related services including diagnosis.

*“Submitting to the inevitable (old age) – they feel there is nothing they can do about getting old and the health issues that comes with old age.”  
(Resident Focus Group Participant)*

## 4. Arthritis

Arthritis affects one in five adults in the United States and continues to be the most common cause of physical disability. Arthritis costs more than \$128 billion per year currently in the United States and is projected to increase over time as the population ages. Interventions such as increased physical activity, education about disease self-management and weight loss among overweight/obese adults can reduce arthritis pain and functional limitations however these resources are underutilized<sup>22</sup>.

### Prevalence

In 2011, the percentage of the SVMC service area with arthritis was lower (15.9%) when compared to Los Angeles County (17.4%). SPA 4 had a slightly higher percentage (16.0%) of those with arthritis when compared to the SVMC service area (15.9%).

**Table 46. Arthritis Prevalence**

	Percentage
Service Planning Area 4	16.0%
Service Planning Area 6	15.7%

<sup>21</sup> Alzheimer’s Association. *2012 Alzheimer’s Disease Facts and Figures*. Available at [http://www.alz.org/downloads/facts\_figures\_2012.pdf]. Accessed [March 6, 2013].

<sup>22</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. *Healthy People 2020*. Washington, DC. Available at [http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=3]. Accessed [February 26, 2013].

	Percentage
SVMC Service Area	15.9% (avg.)
Los Angeles County	17.4%

Data source: Los Angeles County Health Survey

Data year: 2011

Source geography: SPA

### Disparities

Stakeholders identified Asians and specifically the Filipino population and the aging as being the most severely impacted.

### Associated Drivers of Health

The following factors are associated with arthritis including being overweight or obese, lack of education around self-management strategies and techniques, and limited or no physical activity<sup>23</sup>. For data concerning health drivers, please refer to Appendix C—Scorecard.

### Primary Data

Stakeholders indicated that the aging populations were the most impacted by arthritis.

## 5. Asthma

Asthma is a disease that affects the lungs and is one of the most common long-term diseases of children. Adults also may suffer from asthma and the condition is considered hereditary. In most cases, the causes of asthma are not known, and no cure has been identified. Although asthma is always present in those with the condition, attacks only occur when the lungs are irritated. Asthma symptoms include wheezing, breathlessness, chest tightness, and coughing. Some asthma triggers include tobacco smoke, dust mites, outdoor air pollution, cockroach allergen, pet dander, mold, smoke, other allergens and certain infections known to cause asthma such as the flu, colds, and respiratory related viruses. Other contributing factors include exercising, certain medication, bad weather, high humidity, cold/dry air, certain foods and fragrances<sup>24</sup>.

### Prevalence

In 2011, the percentage of those diagnosed with asthma in the SVMC service area was lower (6.9%) than in Los Angeles County (9.0%). SPA 6 has a slightly higher percentage (9.4%) than the SVMC service area (6.9%) and Los Angeles County (9.0%).

**Table 47. Asthma Prevalence Among Children 0-17**

	Percentage
Service Planning Area 4	4.3%
Service Planning Area 6	9.4%
SVMC Service Area	6.9% (avg.)

<sup>23</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at [<http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=3>]. Accessed [February 26, 2013].

<sup>24</sup> Centers for Disease Control and Prevention (CDC). Asthma-Basic Information. Atlanta, GA. Available at [<http://www.cdc.gov/asthma/faqs.htm>]. Accessed [March 1, 2013].

	Percentage
Los Angeles County	9.0%

Data source: Los Angeles County Health Survey  
Data year: 2011  
Source geography: SPA

## Disparities

Stakeholders identified children as the most severely impacted sub-populations.

## Associated Drivers of Health

Many allergens are also asthma triggers that irritate the lungs, inducing an asthma attack. Allergic reactions are known to be caused by pollen, dust, food, insect stings, animal dander, mold, medications, and latex<sup>25</sup>. Other social and economic factors have been known to cause or trigger allergic reactions including poverty, which leads to poor housing conditions (living with cockroaches, mites, asbestos, mold etc.). Living in an environment or home with smokers has also been known exacerbate allergies and/or asthma. For data concerning health drivers, please refer to Appendix C—Scorecard.

## Primary Data

Stakeholders linked poor air quality, lack of access to medical care, and patients' inability to obtain the needed asthma medication to asthma prevalence.

## 6. Breast Cancer

In the United States, breast cancer is the most common non-skin cancer and the second leading cause of cancer-related death in women. Each year, a small number of men also are diagnosed with and die from breast cancer. The overall breast cancer death rate has dropped steadily over the past 20 years. However, it is estimated that approximately \$16.5 billion is spent in the U.S. each year on breast cancer treatment<sup>26</sup>.

The incidence of breast cancer is highest in White women for most age groups, but African-American women have higher incidence rates before 40 years of age and higher breast cancer mortality rates than women of any other racial/ethnic groups in the United States at every age. The gap in mortality between African-American and White women is wider now than in the early 1990s<sup>27</sup>.

Risk factors for breast cancer include older age, certain inherited genetic alterations, hormone therapy, having chest radiation therapy, drinking alcohol, and obesity. Exercise and maintaining a healthy weight may reduce the chance of breast cancer<sup>28</sup>. Mammograms and clinical breast exams are commonly used to screen for breast cancer. In 2011, 79.2% of women reported having had a mammogram during the last two years which is slightly lower than in Los Angeles County at 79.8%; both areas fall below the HP2020 goal of 81.1%.

<sup>25</sup> American Academy of Allergy Asthma and Immunology. Allergies. Landover, MD. Available at [http://www.aafa.org/display.cfm?id=9]. Accessed [March 1, 2013].

<sup>26</sup> National Cancer Institute. *A Snapshot of Breast Cancer*. Available at [http://www.cancer.gov/researchandfunding/snapshots/pdf/Breast-Snapshot.pdf]. Accessed [March 6, 2013].

<sup>27</sup> National Cancer Institute. *A Snapshot of Breast Cancer*. Available at [http://www.cancer.gov/researchandfunding/snapshots/pdf/Breast-Snapshot.pdf]. Accessed [March 6, 2013].

<sup>28</sup> National Cancer Institute. *Breast Cancer: Prevention, Genetics, Causes*. Available at [http://www.cancer.gov/cancertopics/prevention-genetics-causes/breast]. Accessed [March 6, 2013].

### Prevalence

In 2009, the breast cancer incidence rate per 100,000 persons was slightly lower in Los Angeles County (116.0) than California (122.0) but still five times higher than the Healthy People 2020 goal ( $\leq 20.6$ ).

**Table 48. Breast Cancer Incidence Rate Per 100,000 Persons**

	Rate
Los Angeles County	116.0
California	122.0
Healthy People 2020	$\leq 20.6$

Data source: The Centers for Disease Control and Prevention, and the National Cancer Institute: State Cancer Profiles

Data year: 2009

Source geography: County

### Mortality

In 2008, the breast cancer mortality rate per 100,000 persons was much lower in the SVMC service area (18.1) than in California (21.2). Breast cancer mortality rates were highest in ZIP Codes 90008 (42.4), 90027 (35.9), and 90057 (32.3).

**Table 49. Breast Cancer Mortality Rate Per 100,000 Persons**

ZIP Code	Rate
90004	11.1
90005	9.2
90006	8.8
90007	4.0
90008	42.4
90010	0.0
90011	7.6
90016	28.7
90017	9.1
90018	28.0
90019	29.9
90020	13.5
90026	12.6
90027	35.9
90028	6.5
90029	28.8
90031	18.4
90037	20.6
90044	14.9
90046	17.3
90057	32.3
SVMC Service Area	18.1 (avg.)
Los Angeles County	21.2

Data source: California Department of Public Health (CDPH)

Data year: 2008

Source geography: ZIP Code

## Disparities

Stakeholders identified low income women, Latino and Asian women, and those who had experienced trauma and/or domestic violence as the most severely impacted.

Stakeholders identified the areas of Pico Union and Westlake districts as the most impacted.

## Associated Drivers of Health

Risk factors for breast cancer include older age, certain inherited genetic alterations, hormone therapy, having chest radiation therapy, heavy alcohol consumption, and obesity<sup>29</sup>. Breast cancer is associated with overall cancer mortality and access to breast cancer screening. Exercise and maintaining a healthy weight may reduce the chance of breast cancer. For data concerning health drivers, please refer to Appendix C—Scorecard.

*“Mammograms for women under 40 years of age – mammograms are very expensive and difficult to obtain. Even if (cancer) has been detected it is very hard to obtain services.”  
(Focus group participant)*

## Primary Data

Stakeholders attributed the high rates of breast cancer to a lack of education around health, and a lack of access to health care including mammograms. As a result, more women are finding out late in their cancer trajectory (stages 3 and 4).

## 7. Cancer, in General

Cancer is the second leading cause of death in the United States, claiming the lives of more than half a million Americans every year<sup>30</sup>. Cancer incidence rates per 100,000 persons show that the three most common cancers among American men are prostate cancer (137.7), lung cancer (78.2), and colorectal cancer (49.2). Likewise, the leading causes of cancer death among men are lung cancer (62.0), prostate cancer (22.0), and colorectal cancer (19.1). Among women, the three most common cancers are breast cancer (123.1), lung cancer (54.1), and colorectal cancer (37.1). Lung (38.6), breast (22.2), and colorectal (13.1) cancers are also the leading causes of cancer-related deaths among women<sup>31</sup>.

The number of new cancer cases can be reduced, and many cancer deaths can be prevented. Research shows that screening for cervical and colorectal cancers, as recommended, helps prevent these diseases by finding precancerous lesions so they can be treated before they become cancerous. Screening for cervical, colorectal, and breast cancers also helps find these diseases at an early, often highly treatable stage<sup>32</sup>. The most common risk factors for cancer are growing older, obesity, tobacco, alcohol, sunlight exposure, certain chemicals, some viruses and bacteria, family history of cancer, poor diet, and lack of physical activity<sup>33</sup>.

<sup>29</sup> National Cancer Institute. *Breast Cancer: Prevention, Genetics, Causes*. Available at [http://www.cancer.gov/cancertopics/prevention-genetics-causes/breast]. Accessed [March 6, 2013].

<sup>30</sup> Centers for Disease Control and Prevention. *Using Science to Reduce the Burden of Cancer*. Available at [http://www.cdc.gov/Features/CancerResearch/]. Accessed [March 7, 2013].

<sup>31</sup> Ibid

<sup>32</sup> Centers for Disease Control and Prevention. *Cancer Prevention*. Available at [http://www.cdc.gov/cancer/dcpc/prevention/index.htm]. Accessed [March 7, 2013].

<sup>33</sup> National Cancer Institute. *Risk Factors*. Available at [http://www.cancer.gov/cancertopics/wyntk/cancer/page3]. Accessed [March 7, 2013].

## Prevalence

In 2010, the cervical cancer incidence rate per 100,000 persons was higher in the SVMC service area (9.4) than in California (8.0) and was four times higher than the Healthy People 2020 goal ( $\leq 2.2$ ).

**Table 50. Cervical Cancer Incidence Rate Per 100,000 Persons**

	Rate
SVMC Service Area	9.4
California	8.0
Healthy People 2020	$\leq 2.2$

Data source: The Centers for Disease Control and Prevention, and the National Cancer Institute: State Cancer Profiles

Data year: 2010

Source geography: County

Similarly, the prostate cancer incidence rate per 100,000 persons in SVMC service area was lower (134.3) than California (140.3) and was six times higher than the Healthy People 2020 goal ( $\leq 21.2$ ).

**Table 51. Prostate Cancer Incidence Rate Per 100,000 Persons**

	Rate
SVMC Service Area	134.3
California	140.3
Healthy People 2020	$\leq 21.2$

Data source: The Centers for Disease Control and Prevention, and the National Cancer Institute: State Cancer Profiles

Data year: 2010

Source geography: County

## Mortality

The cancer mortality rate per 100,000 persons was much higher in the SVMC service area (59.5) than in California (15.1).

**Table 52. Cancer Mortality Rate Per 100,000 Persons**

	Rate
SVMC Service Area	59.5
California	15.1

Data source: The Centers for Disease Control and Prevention, and the National Cancer Institute: State Cancer Profiles

Data year: 2010

Source geography: County

In 2010, the cervical cancer mortality rate per 100,000 persons was much higher in the SVMC service area (22.0) than in Los Angeles County (3.0).

**Table 53. Cervical Cancer Mortality Rate Per 100,000 Persons**

	Rate
SVMC Service Area	22.0
Los Angeles County	3.0

---

Data source: The Centers for Disease Control and Prevention,  
and the National Cancer Institute: State Cancer Profiles  
Data year: 2010  
Source geography: County

## Disparities

Stakeholders identified the homeless as the most severely impacted. They also added that Asian males as impacted most by prostate and stomach cancer.

## Associated Drivers of Health

A primary method of preventing cancer is screening for cervical, colorectal, and breast cancers<sup>34</sup>. The most common risk factors for cancer are growing older, obesity, tobacco, alcohol, sunlight exposure, certain chemicals, some viruses and bacteria, family history of cancer, poor diet, and lack of physical activity<sup>35</sup>. For data concerning health drivers, please refer to Appendix C—Scorecard.

## Primary Data

Stakeholders indicated that people have limited access to health education about cancer and to prevention services. One stakeholder added that there is a shortage of oncologists who speak the same language as their patients adding that “few doctors have experience engaging in dialogue with patients and family members in a comprehensive approach. There’s a sense that the doctors don’t have the patient’s well-being in mind.” There has also been an increase in Latinos, Asian-Pacific Islanders, and Native Americans who are being diagnosed with late stage cancer. Improvements in messaging and service delivery are needed in order to encourage community members to access health care earlier.

## 8. Cardiovascular Disease

Cardiovascular disease—also called heart disease and coronary heart disease—includes several health conditions related to plaque buildup in the walls of the arteries, or atherosclerosis. As plaque builds up, the arteries narrow, restricting blood flow and creating the risk of heart attack. Currently, more than one in three adults (81.1 million) in the United States lives with one or more types of cardiovascular disease. In addition to being one of the leading causes of death in the United States, heart disease results in serious illness and disability, decreased quality of life, and hundreds of billions of dollars in economic loss every year.<sup>36</sup>

Cardiovascular disease encompasses and/or is closely linked to a number of health conditions that include arrhythmia, atrial fibrillation, cardiac arrest, cardiac rehab, cardiomyopathy, cardiovascular conditions in childhood, high cholesterol, congenital heart defects, diabetes, heart attack, heart failure, high blood pressure, HIV, heavy alcohol consumption, metabolic syndrome, obesity, pericarditis, peripheral artery disease (PAD), and stroke.<sup>37</sup>

---

<sup>34</sup> Centers for Disease Control and Prevention. *Cancer Prevention*. Available at [<http://www.cdc.gov/cancer/dccp/prevention/index.htm>]. Accessed [March 7, 2013].

<sup>35</sup> National Cancer Institute. *Risk Factors*. Available at [<http://www.cancer.gov/cancertopics/wyntk/cancer/page3>]. Accessed [March 7, 2013].

<sup>36</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at [<http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=21>]. Accessed [February 28, 2013].

<sup>37</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at [<http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=21>]. Accessed [February 28, 2013].

## Prevalence

In 2011, a slightly larger percentage (24.4%) of the population in the SVMC service area were diagnosed with heart disease than in Los Angeles County (24.0%), with an even greater percentage in SPA 6 (28.4%).

**Table 54. Heart Disease Prevalence**

	Percentage
Service Planning Area 4	20.4%
Service Planning Area 6	28.4%
SVMC Service Area	24.4% (avg.)
Los Angeles County	24.0%

Data source: Los Angeles County Health Survey  
Data year: 2011  
Source geography: SPA

## Disease Management

Of those in the SVMC service area with heart disease, nearly three quarters (70.6%) receive assistance from a care provider in managing their disease. SPA 6 has an even larger percentage (75.9%) of those who receive assistance from a care provider in managing their disease than the SVMC service area (70.6%) and Los Angeles County (73.3%).

**Table 55. Heart Disease Management**

	Percentage
Service Planning Area 4	65.3%
Service Planning Area 6	75.9%
SVMC Service Area	70.6% (avg.)
Los Angeles County	73.3%

Data source: California Health Interview Survey (CHIS)  
Data year: 2011-2012  
Source geography: SPA

## Hospitalizations

In 2010, the hospitalization rate resulting from heart failure was much higher (424.6) per 100,000 persons in the SVMC service area when compared to California (367.1). The highest heart failure hospitalization rates were reported in the SVMC service area ZIP Codes 90008 (730.0), 90027 (688.8), 90018 (644.9), 90016 (626.1), and 90044 (601.5).

**Table 56. Hospitalizations Resulting From Heart Failure Per 100,000 Persons**

ZIP Code	Rate
90004	291.1
90005	212.3
90006	305.8
90007	320.1
90008	730.0
90010	157.9
90011	326.3

ZIP Code	Rate
90016	626.1
90017	391.3
90018	644.9
90019	356.8
90020	287.4
90026	331.5
90027	688.8
90028	417.9
90029	471.3
90031	401.9
90037	501.0
90044	601.5
90046	473.4
90057	380.0
SVMC Service Area	424.6 (avg.)
California	367.1

Data source: Office of Statewide Health Planning and Development (OSHPD)  
Data year: 2010  
Source geography: ZIP Code

### Mortality

In 2010, a much higher heart disease mortality rate per 10,000 persons was reported in the SVMC service area (73.8) when compared to California (15.6). The highest heart disease mortality rates were reported in ZIP Codes 90044 (137.0), 90027 (123.0), and 90046 (114.0).

**Table 57. Heart Disease Mortality Rate Per 10,000 Persons**

ZIP Code	Rate
90004	66.0
90005	49.0
90006	65.0
90007	30.0
90008	94.0
90010	2.0
90011	86.0
90016	96.0
90017	27.0
90018	96.0
90019	106.0
90020	34.0
90026	89.0
90027	123.0
90028	52.0
90029	75.0
90031	71.0
90037	69.0
90044	137.0

ZIP Code	Rate
90046	114.0
90057	69.0
SVMC Service Area	73.8 (avg.)
California	15.6

Data source: California Department of Public Health (CDPH)

Data year: 2010

Source geography: ZIP Code

### Disparities

Stakeholders identified low income populations as the most severely impacted by cardiovascular disease.

Stakeholders also identified South Los Angeles as the most severely impacted area.

### Associated Drivers of Health

The burden of cardiovascular disease is disproportionately distributed across the population. Significant disparities are evident based on gender, age, race/ethnicity, geographic area, and socioeconomic status with regard to prevalence of risk factors, access to treatment, appropriate and timely treatment, treatment outcomes, and mortality<sup>38</sup>.

Other risk factors for cardiovascular disease include high blood pressure, high cholesterol, smoking, diabetes, poor diet, physical inactivity, and overweight and obesity. Cardiovascular disease is closely linked with and can often lead to stroke<sup>39</sup>. For data concerning health drivers, please refer to Appendix C—Scorecard.

### Primary Data

Stakeholders linked cardiovascular disease to obesity, diabetes, and hypertension. They attributed high rates of cardiovascular disease to the lack of access to healthy foods, living in food deserts, living an unhealthy lifestyle, a lack of access to medical care, and the lack of transportation to obtain medical care. Cardiovascular disease was also identified as the number one cause of death.

## 9. Cholesterol

Cholesterol is a waxy, fat-like substance necessary in the body. However, too much cholesterol in the blood can build up on artery walls, leading to heart disease—one of the leading causes of death in the United States—and stroke. About one of every six adults in the United States has high blood cholesterol. In addition, 2,200 Americans die of heart disease each day, an average of one death every 39 seconds<sup>40</sup>.

Some health conditions, as well as lifestyle and genetic factors, can put people at a higher risk for developing high cholesterol. Age is a contributing factor; as people get older, cholesterol levels rise. Diabetes can also lead to the development of high cholesterol. Some behaviors can also lead to high cholesterol,

<sup>38</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=21>. Accessed [February 28, 2013].

<sup>39</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=21>. Accessed [February 28, 2013].

<sup>40</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. High Cholesterol. Atlanta, GA. Available at <http://www.cdc.gov/cholesterol/index.htm>. Accessed [March 4, 2013].

including a diet high in saturated fats, trans fatty acids (trans fats), dietary cholesterol, or triglycerides. Being overweight and physically inactive also contribute to high cholesterol. Finally, high cholesterol can be hereditary<sup>41</sup>.

### Prevalence

In 2011, just under a quarter (23.5%) of the population in the SVMC service area was diagnosed with high cholesterol, slightly less when compared to Los Angeles County (25.6%). SPA 4 had a larger percentage (24.1%) of those diagnosed with high cholesterol than the SVMC service area (23.5%) but still lower than Los Angeles County (25.6%).

**Table 58. Cholesterol Prevalence**

	Percentage
Service Planning Area 4	24.1%
Service Planning Area 6	22.9%
SVMC Service Area	23.5% (avg.)
Los Angeles County	25.6%

Data source: Los Angeles County Health Survey  
Data year: 2011  
Source geography: SPA

### Disparities

In 2011, more than half (50.2%) of the population in Los Angeles County who were 65 or older had high cholesterol, as did nearly half (43.9%) of those between the ages of 60 and 64. Over a third (37.2%) of those between the ages of 50 and 59 had high cholesterol, and over a quarter (27.2%) of those between the ages of 40 and 49. Another 15.9% of those between the ages of 30 and 39 had high cholesterol, as well as 6.8% of the population between the ages of 25 and 29 plus another 4.3% between the ages of 18 and 24.

**Table 59. Cholesterol Prevalence By Age**

Age Group	Percentage
18–24 years old	4.3%
25–29 years old	6.8%
30–39 years old	15.9%
40–49 years old	27.2%
50–59 years old	37.2%
60–64 years old	43.9%
65 years old and older	50.2%

Data source: Los Angeles County Health Survey  
Data year: 2011  
Source geography: County

By ethnicity, over a third (38.6%) of the American Indian/Alaskan Native population had high cholesterol and another third (29.7%) of the White population did as well. Over a quarter of (26.9%) of the African-American population had high cholesterol, and a quarter (25.8%) of the Asian/Pacific Islander popula-

<sup>41</sup>U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. High Cholesterol. Atlanta, GA. Available at <http://www.cdc.gov/cholesterol/index.htm>. Accessed [March 4, 2013].

tion. Less than a quarter (22.2%) of the Latino population in Los Angeles County are diagnosed with high cholesterol.

**Table 60. Cholesterol Prevalence By Ethnicity**

Age Group	Percentage
Latino	22.2%
White	29.7%
African-American	26.9%
Asian/Pacific Islander	25.8%
American Indian/Alaskan Native	38.6%

Data source: Los Angeles County Health Survey

Data year: 2011

Source geography: County

Stakeholders identified Asian men as the most severely impacted.

### Associated Drivers of Health

Some health conditions, as well as lifestyle and genetic factors, can put people at a higher risk for developing high cholesterol. Age is a contributing factor; as people get older, cholesterol level tends to rise. Diabetes can also lead to the development of high cholesterol. Some behaviors can also lead to high cholesterol, including a diet high in saturated fats, trans fatty acids (trans fats), dietary cholesterol, or triglycerides. Being overweight and physical inactivity can also contribute to high cholesterol. Finally, high cholesterol can be hereditary<sup>42</sup>. For data concerning health drivers, please refer to Appendix C—Scorecard.

### Primary Data

Stakeholders linked high cholesterol to poor nutrition and poor lifestyle choices.

## 10. Colorectal Cancer

Colorectal cancer, defined as cancer that starts in the colon or the rectum, is the second leading cause of cancer-related deaths in the United States and is expected to cause about 50,830 deaths during 2013. The lifetime risk of developing colorectal cancer is about one in 20 (5.1%), with the risk being slightly lower in women than in men<sup>43</sup>. In addition, colorectal cancer is associated with overall cancer mortality, heavy alcohol consumption, obesity, diabetes prevalence and colon cancer screening.

The number of new colorectal cancer cases and the number of deaths from colorectal cancer are decreasing. The likely causes are regular screenings and improved treatment. Regular screenings can often detect colorectal cancer early on when the disease is most likely to be curable. Screenings can also

<sup>42</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. High Cholesterol. Atlanta, GA. Available at <http://www.cdc.gov/cholesterol/index.htm>. Accessed [March 4, 2013].

<sup>43</sup> American Cancer Society. *Colorectal Cancer*. Available at <http://www.cancer.org/cancer/colonandrectumcancer/detailedguide/colorectal-cancer-key-statistics>. Accessed [March 4, 2013].

find polyps, which can be removed before turning into cancer<sup>44</sup>. As a result, there are now more than one million survivors of colorectal cancer in the United States<sup>45</sup>.

Given the success of colorectal cancer screening, public health organizations are working to increase awareness of these screenings among the general public and health care providers. Currently, only about half of Americans ages 50 or older have had any colorectal cancer screening<sup>46</sup>.

### Prevalence

In 2010, the colorectal cancer incidence rate per 100,000 persons was slightly higher in the SVMC Service Area (38.2) than in California (37.3) but nearly three times as high as the Healthy People 2020 goal ( $\leq 14.5$ ).

**Table 61. Colorectal Cancer Incidence Rate Per 100,000 Persons**

	Rate
SVMC Service Area	38.2
California	37.3
Healthy People 2020	$\leq 14.5$

Data source: The Centers for Disease Control and Prevention, and the National Cancer Institute: State Cancer Profiles  
Data year: 2010  
Source geography: County

### Mortality

In 2008, the mortality rate was lower in the SVMC service area (9.8) than in California (11.2). However, ZIP Codes 90008 (33.8), 90031 (20.0), 90046 (18.3), 90016 (17.2), and 90028 (11.8) reported higher rates than California (11.2).

**Table 62. Colorectal Cancer Mortality Rate Per 100,000 Persons**

ZIP Code	Rate
90004	4.1
90005	4.4
90006	5.8
90007	2.0
90008	33.8
90010	0.0
90011	10.1
90016	17.2
90017	4.1
90018	6.2

<sup>44</sup> American Cancer Society. *Colorectal Cancer*. Available at [\[http://www.cancer.org/cancer/colonandrectumcancer/detailedguide/colorectal-cancer-detection\]](http://www.cancer.org/cancer/colonandrectumcancer/detailedguide/colorectal-cancer-detection). Accessed [March 4, 2013].

<sup>45</sup> American Cancer Society. *Colorectal Cancer*. Available at [\[http://www.cancer.org/cancer/colonandrectumcancer/detailedguide/colorectal-cancer-key-statistics\]](http://www.cancer.org/cancer/colonandrectumcancer/detailedguide/colorectal-cancer-key-statistics). Accessed [March 4, 2013].

<sup>46</sup> Ibid

ZIP Code	Rate
90019	11.2
90020	4.5
90026	11.1
90027	9.9
90028	11.8
90029	4.7
90031	20.0
90037	5.2
90044	11.0
90046	18.3
90057	10.8
SVMC Service Area	9.8 (avg.)
Los Angeles County	11.2

Data source: California Department of Public Health (CDPH)

Data year: 2008

Source geography: ZIP Code

### Disparities

Stakeholders identified Asian males as the most impacted.

### Associated Drivers of Health

The major factors that can increase the risk of colorectal cancer are increasing age and family history of colorectal cancer. Other less significant factors include a history of inflammatory bowel disease, inherited risk, heavy alcohol use, cigarette smoking, obesity, diabetes prevalence, and colon cancer screening<sup>47</sup>. Regular physical activity and diets high in vegetables, fruits, and whole grains have been linked with a decreased incidence of colorectal cancer<sup>48</sup>. For data concerning health drivers, please refer to Appendix C—Scorecard.

### Primary Data

Stakeholders mentioned colorectal cancer as an issue that was affecting the community. They also added that there has been an increase in those diagnosed with colorectal cancer among Asian men.

## 11. Diabetes

Diabetes affects an estimated 23.6 million people and is the seventh leading cause of death in the United States. Diabetes lowers life expectancy by up to 15 years, increases the risk of heart disease by two to four times, and is the leading cause of kidney failure, lower-limb amputations, and adult-onset blindness<sup>49</sup>. A diabetes diagnosis can also indicate an unhealthy lifestyle—a risk factor for further health issues—and is also linked to obesity.

<sup>47</sup> National Cancer Institute. *Colorectal Cancer Prevention*. Available at [http://www.cancer.gov/cancertopics/pdq/prevention/colorectal/Patient/page3#Keypoint4]. Accessed [March 4, 2013].

<sup>48</sup> American Cancer Society. *Colorectal Cancer*. Available at Available at [http://www.cancer.org/cancer/colonandrectumcancer/detailedguide/colorectal-cancer-risk-factors]. Accessed [March 4, 2013].

<sup>49</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. *Healthy People 2020*. Washington, DC. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=32>. Accessed [February 26, 2013].

Given the steady rise in the number of people with diabetes, and the earlier onset of Type 2 diabetes, there is growing concern about substantial increases in diabetes-related complications and their potential to impact and overwhelm the health care system. There is a clear need to take advantage of recent discoveries about the individual and societal benefits of improved diabetes management and prevention by bringing life-saving findings into wider practice, and complementing those strategies with efforts in primary prevention among those at risk for developing diabetes<sup>50</sup>.

In addition, evidence is emerging that diabetes is associated with other co-morbidities, including cognitive impairment, incontinence, fracture risk, and cancer risk and prognosis<sup>51</sup>.

### Prevalence

In 2011, 8.7% of the population 18 years old and older in the SVMC service area was diagnosed with diabetes, a smaller percentage than in Los Angeles County (9.5%). In SPA 6, a larger percentage was diagnosed with diabetes (10.1%) than the SVMC service area (8.7%) and Los Angeles County (9.5%).

**Table 63. Diabetes Prevalence**

	Percentage
Service Planning Area 4	7.3%
Service Planning Area 6	10.1%
SVMC Service Area	8.7% (avg.)
Los Angeles County	9.5%

Data source: Los Angeles County Health Survey

Data year: 2011

Source geography: SPA

### Disease Management

In 2009, over three quarters (80.1%) those that are diabetic and take medication for diabetes felt confident that they are able to manage their condition—a slightly less than the percentage for Los Angeles County (86.4%). A much smaller percentage of the population in SPA 6 (69.4%) felt very confident in their ability to management their diabetes, however, when compared to Los Angeles County (86.4%).

**Table 64. Diabetes Management**

	Percentage
Service Planning Area 4	90.7%
Service Planning Area 6	69.4%
SVMC Service Area	80.1% (avg.)
Los Angeles County	86.4%

Data source: California Health Interview Survey (CHIS)

Data year: 2011-2012

Source geography: SPA

<sup>50</sup>U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=32>. Accessed [February 26, 2013].

<sup>51</sup>U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=32>. Accessed [February 26, 2013].

## Hospitalizations

In 2010, the diabetes hospitalization rate per 100,000 persons under 18 years of age in the SVMC service area was far less (21.6) than that of California (34.9). ZIP Codes in the SVMC service area 90028 (70.3), 90008 (68.5), and 90016 (65.1) reported the highest rates in the SVMC service area.

The diabetes hospitalization rate per 100,000 adults in the SVMC service area (193.3) was much higher when compared to California (145.6). The highest rates among adults in the SVMC service area were reported in ZIP Codes 90008 (371.2), 90044 (356.4), and 90016 (355.1).

The hospitalization rate per 100,000 persons resulting from uncontrolled diabetes was nearly three times higher (20.3) in the SVMC service area when compared to California (9.5). The highest rates in the SVMC service area were reported in ZIP Codes 90018 (45.5), 90029 (38.3), 90016 (36.4), and 90017 (32.5).

**Table 65. Diabetes Hospitalizations Per 100,000 Persons**

ZIP Code	Diabetes Hospitalizations (Youth)	Diabetes Hospitalizations (Adults)	Hospitalizations Resulting from Uncontrolled Diabetes
90004	0.0	141.5	22.7
90005	0.0	106.2	8.7
90006	13.6	224.7	16.5
90007	27.2	151.5	12.9
90008	68.5	371.2	25.7
90010	0.0	26.3	0.0
90011	11.0	197.3	21.2
90016	65.1	355.1	36.4
90017	0.0	130.4	32.5
90018	7.7	274.4	45.5
90019	7.2	181.5	19.8
90020	26.5	87.3	0.0
90026	28.8	145.9	17.4
90027	0.0	152.8	7.8
90028	70.3	149.8	12.7
90029	0.0	196.8	38.3
90031	38.8	203.5	22.2
90037	31.5	285.5	26.6
90044	48.5	356.4	29.1
90046	0.0	94.7	1.9
90057	9.6	226.7	28.0
SVMC Service Area	21.6 (avg.)	193.3 (avg.)	20.3 (avg.)
California	34.9	145.6	9.5

Data source: Office of Statewide Health Planning and Development (OSHPD)

Data year: 2010

Source geography: ZIP Code

## Mortality

In 2010, 9.6 per 10,000 persons died as a result of diabetes— much higher than in Los Angeles County (1.9). The highest mortality rates in the SVMC service area were reported in ZIP Codes 90044 (21.0), 90016 (17.0), 90006 (16.0), and 90037 (15.0).

**Table 66. Diabetes Mortality Rate Per 10,000 Persons**

ZIP Code	Number
90004	10.0
90005	5.0
90006	16.0
90007	8.0
90008	12.0
90010	0.0
90011	12.0
90016	17.0
90017	5.0
90018	8.0
90019	14.0
90020	2.0
90026	9.0
90027	6.0
90028	6.0
90029	9.0
90031	13.0
90037	15.0
90044	21.0
90046	5.0
90057	8.0
SVMC Service Area	9.6 (avg.)
California	1.9

Data source: California Department of Public Health (CDPH)  
Data year: 2010  
Source geography: ZIP Code

## Disparities

In 2011, nearly a quarter (24.1%) of the population age 65 older in Los Angeles County was identified as diabetic. Another 18.9% of the population age 60 to 64 were diabetic, as was another 13.4% of the population age 50 to 59. A smaller percentage of the population age 40 to 49 (7.9%) was diabetic, along with even smaller percentages of those age 30 to 39 (3.7%), 25 to 29 (2.4%), and 18 to 24 (1.1%).

**Table 67. Diabetes Prevalence By Age**

Age Group	Percentage
18–24 years old	1.1%
25–29 years old	2.4%
30–39 years old	3.7%
40–49 years old	7.9%

Age Group	Percentage
50–59 years old	13.4%
60–64 years old	18.9%
65 years old and older	24.1%

Data source: Los Angeles County Health Survey  
Data year: 2011  
Source geography: County

In addition, larger percentages of the population in Los Angeles County who were diabetic are African-American (12.6%), followed by 9.5% of Latinos, 9.3% of Asian/Pacific Islanders, and 8.5% of Whites.

**Table 68. Diabetes Prevalence By Ethnicity**

Age Group	Percentage
Latino	9.5%
White	8.5%
African-American	12.6%
Asian/Pacific Islander	9.3%
American Indian/Alaskan Native	n/a

Data source: Los Angeles County Health Survey  
Data year: 2011  
Source geography: County

Stakeholders identified Asians, African Americans, Filipinos, Latinos, Native Americans, low income youth, women, the aging population, uninsured, and undocumented as the most impacted sub-populations.

Stakeholders identified geographic areas including Chinatown, East Los Angeles, and northeast portions of Los Angeles County as particularly impacted by diabetes.

**Associated Drivers of Health**

Factors associated with diabetes include being overweight; having high blood pressure, high cholesterol, high blood sugar (or glucose); physical inactivity, smoking, unhealthy eating, age, race, gender, and having a family history of diabetes<sup>52</sup>. For data concerning health drivers, please refer to Appendix C—Scorecard.

*“The main issue is families and culture. They tend to eat the same kind of food as in the past even if it’s unhealthy.”  
(Resident Focus Group Participant)*

**Primary Data**

Stakeholders linked diabetes to obesity and hypertension. They also attributed the prevalence of diabetes to a number of factors including the high cost and lack of access to healthy food, as well as living in a food desert and lifestyle choices. Other factors include lack of access to health services, language barriers, and transportation.

*“As immigrants assimilate, especially Latinos, many stop practicing traditions they grew up with or customs that included activity and take up unhealthy habits, become inactive and consume high levels of fat and salt.”  
Health Professional, National Health Organization*

They also linked diabetes to obesity and physical inactivity. Stakeholders also stated that diabetes is a growing issue among communities of color.

## 12. Hypertension

Hypertension, defined as a blood pressure reading of 140/90 or higher, affects one in three adults in the United States<sup>53</sup>. With no symptoms or warning signs and the ability to cause serious damage to the body, the condition has been called a silent killer. If untreated, high blood pressure can lead to heart failure, blood vessel aneurysms, kidney failure, heart attack, stroke, and vision changes or blindness<sup>54</sup>. High blood pressure can be controlled through medicines and lifestyle change; however, patient adherence to treatment regimens is a significant barrier to controlling high blood pressure<sup>55</sup>.

High blood pressure is associated with smoking, obesity, the regular consumption of salt and fat, excessive drinking, and physical inactivity. Those at higher risk of developing hypertension include people who have previously had a stroke and those who have high cholesterol or heart or kidney disease. African-Americans and people with a family history of hypertension are also at an increased risk of having hypertension<sup>56</sup>.

### Prevalence

In 2011, close to a quarter (24.4%) of the population in the SVMC service area was diagnosed with hypertension (or high blood pressure), slightly higher than in Los Angeles County (24.0%). SPA 6 had a higher percentage (28.4%) of those diagnosed with hypertension.

**Table 69. Hypertension Prevalence**

	Percentage
Service Planning Area 4	20.4%
Service Planning Area 6	28.4%
SVMC Service Area	24.4% (avg.)
Los Angeles County	24.0%

Data source: Los Angeles County Health Survey

Data year: 2011

Source geography: SPA

### Disease Management

In 2011-2012, more than half (64.6%) of the population in the SVMC service took medication to control high blood pressure—not as many as in Los Angeles County (70.4%).

**Table 70. High Blood Pressure Management**

	Percentage
Service Planning Area 4	69.5%

<sup>53</sup> National Institutes of Health. *Hypertension (High Blood Pressure)*. Available at <http://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=97>. Accessed [March 12, 2013].

<sup>54</sup> National Heart, Lung, and Blood Institute. *Blood Pressure: Signs & Symptoms*. Available at <http://www.nhlbi.nih.gov/health/health-topics/topics/hbp/signs.html>. Accessed [March 12, 2013].

<sup>55</sup> National Institutes of Health. *Hypertension (High Blood Pressure)*. Available at <http://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=97>. Accessed [March 12, 2013].

<sup>56</sup> The Patient Education Institute. *Essential Hypertension*. Available at <http://www.nlm.nih.gov/medlineplus/tutorials/hypertension/hp039105.pdf>. Accessed [March 12, 2013].

	Percentage
Service Planning Area 6	61.1%
SVMC Service Area	65.3% (avg.)
Los Angeles County	70.4%

Data source: California Health Interview Survey (CHIS)

Data year: 2011-2012

Source geography: SPA

## Mortality

In 2010, 5.1 per 10,000 persons died as a result of hypertension— four times as many those who died of hypertension in Los Angeles County (1.0). The highest mortality rates in the SVMC service area were reported in ZIP Codes 90044 (12.0) and 90046 (12.0).

**Table 71. Hypertension Mortality Rate Per 10,000 Persons**

ZIP Code	Rate
90004	7.0
90005	4.0
90006	4.0
90007	0.0
90008	5.0
90010	0.0
90011	8.0
90016	9.0
90017	0.0
90018	7.0
90019	9.0
90020	3.0
90026	3.0
90027	5.0
90028	2.0
90029	3.0
90031	5.0
90037	5.0
90044	12.0
90046	12.0
90057	4.0
SVMC Service Area	5.1 (avg.)
California	1.0

Data source: California Department of Public Health (CDPH)

Data year: 2010

Source geography: ZIP Code

## Disparities

In 2011, more than half (57.7%) of the population age 65 and older in Los Angeles County was diagnosed with hypertension. Similarly, nearly half (42.9%) of the population between age 60 and 64 had hypertension, over a third (34.5%) of the population between age 50 and 59, and nearly a quarter (22.9%) of those between age 40 and 49. The prevalence of hypertension diminishes among the younger

population—only 10.0% of those between age 30 and 39, 5.0% of those between age 25 and 29, and 4.1% of those between age 18 and 24.

**Table 72. Hypertension Prevalence By Age**

Age Group	Percentage
18–24 years old	4.1%
25–29 years old	5.0%
30–39 years old	10.0%
40–49 years old	22.9%
50–59 years old	34.5%
60–64 years old	42.9%
65 years old and older	57.7%

Data source: Los Angeles County Health Survey  
Data year: 2011  
Source geography: County

By ethnicity, nearly half (43.3%) of the American Indian/Alaskan Native population in Los Angeles County had hypertension, along with over a third (39.2%) of the African-American population, over a quarter (27.4%) of the White population, and a quarter (25.0%) of the Asian/Pacific Islander population. Nearly a fourth (18.0%) of the Latino population had hypertension in Los Angeles County.

**Table 73. Hypertension Prevalence By Ethnicity**

Age Group	Percentage
Latino	18.0%
White	27.4%
African American	39.2%
Asian/Pacific Islander	25.0%
American Indian/Alaskan Native	43.3%

Data source: Los Angeles County Health Survey  
Data year: 2011  
Source geography: County

Stakeholders indicated that hypertension mostly impacts Latinos, African-Americans, the homeless, uninsured, underinsured, and day laborers.

Stakeholders indicated that Los Angeles is generally impacted by hypertension.

**Associated Drivers of Health**

Smoking, obesity, the regular consumption of salt and fat, excessive drinking, and physical inactivity are risk factors for hypertension. People who have previously had a stroke, have high cholesterol, or have heart or kidney disease are also at higher risk of developing hypertension. For data concerning related health drivers, please refer to Appendix C—Scorecard.

*“Hypertension is going up because people are not getting it checked, they are not aware they have it, they are not going to doctors on regular basis, and as the population ages they have a tendency to have higher blood pressure.”*  
*(Foundation Relations Director, Health*

**Primary Data**

Stakeholders indicated that hypertension is closely related and linked to diabetes, obesity, stress, and lifestyle choices. Stakeholders added that people were not getting regular medical check-ups and were waiting until an emergency, often because the cost of seeking treatment is high and there is a lack of access to health care. Stakeholders also mentioned that effective management of such disease remains a major hurdle given the shortage in programs and education.

**13. HIV/AIDS**

More than 1.1 million people in the United States are living with HIV and almost one in five (18.1%) are unaware of their infection<sup>57</sup>. HIV infection weakens the immune system, making those living with HIV highly susceptible to a variety of illnesses and cancers, including tuberculosis (TB), cytomegalovirus (CMV), cryptococcal meningitis, lymphomas, kidney disease, and cardiovascular disease<sup>58</sup>. Without treatment, almost all people infected with HIV will develop AIDS<sup>59</sup>. While HIV is a chronic medical condition that can be treated, the disease cannot yet be cured.

The risk of acquiring HIV is increased by engaging in unprotected sex, having another sexually transmitted infection, sharing intravenous drugs, having been diagnosed with hepatitis, tuberculosis, or malaria, and having been exposed to the virus as a fetus or infant before or during birth or through breastfeeding from a mother infected with HIV<sup>60</sup>. Racial disparities in HIV prevalence persist; African Americans and Hispanics/Latinos are disproportionately affected by HIV and experience the most severe burden of HIV compared with other races and ethnicities in the United States. Prevention efforts to reduce the spread of HIV in the United States encompass many components, such as behavioral interventions, HIV testing, and linkage to treatment and care<sup>61</sup>.

*“However, despite many gains in HIV/AIDS disease management, we still see people of color who are poor with such an advanced disease at diagnosis that they’re really on the edge of death. It’s surprising to see individuals still come in so late, immune system ravaged and at 80% of body weight.”*  
*(Executive Director, Community Based Organization)*

**Prevalence**

In 2012, the HIV/AIDS incidence rate per 100,000 was twice as high (55.7) in the SVMC service area than in Los Angeles County (24.9). The rate was even higher in SPA 4 (79.0) than in the SVMC service area (55.7) and three times higher than Los Angeles County (24.9).

**Table 74. HIV/AIDS Incidence Rate Per 100,000 Persons**

	Rate
--	------

<sup>57</sup> Centers for Disease Control and Prevention. *Drug-Associated HIV Transmission Continues in the United States*. Available at [http://www.cdc.gov/hiv/resources/factsheets/idu.htm]. Accessed [February 28, 2013].

<sup>58</sup> Mayo Clinic. *Complications*. Available at [http://www.mayoclinic.com/health/hiv-aids/DS00005/DSECTION=complications]. Accessed [March 1, 2013].

<sup>59</sup> National Institutes of Health, *HIV Infection*. Available at [http://www.nlm.nih.gov/medlineplus/ency/article/000602.htm]. Accessed [March 1, 2013].

<sup>60</sup> National Institute of Allergy and Infectious Diseases. *HIV Risk Factors*. Available at [http://www.niaid.nih.gov/topics/hivaids/understanding/pages/riskfactors.aspx]. Accessed [March 6, 2013].

<sup>61</sup> Centers for Disease Control and Prevention. *CDC’s HIV Prevention Progress in the United States*. Available at [http://www.cdc.gov/hiv/resources/factsheets/cdcprev.htm]. Accessed [February 28, 2013].

	Rate
Service Planning Area 4	79.0
Service Planning Area 6	32.3
SVMC Service Area	55.7 (avg.)
Los Angeles County	24.9

Data source: Los Angeles County Department of Public Health, Annual HIV Surveillance Report  
Data year: 2012  
Source geography: SPA

### Hospitalizations

In 2010, HIV/AIDS hospitalization rate per 100,000 was three times as high in the SVMC service area (43.4) than in California (11.0). The highest rates in the SVMC service area were reported in ZIP Codes 90010 (105.3) and 90028 (101.0).

**Table 75. HIV/AIDS Hospitalization Rate Per 100,000 Persons**

ZIP Code	Rate
90004	41.8
90005	18.6
90006	18.6
90007	4.9
90008	71.1
90010	105.3
90011	21.2
90016	71.4
90017	42.1
90018	50.7
90019	20.2
90020	20.5
90026	33.9
90027	55.4
90028	101.0
90029	44.0
90031	10.2
90037	12.8
90044	22.3
90046	88.5
90057	57.8
SVMC Service Area	43.4 (avg.)
California	11.0

Data source: California Department of Public Health (CDPH)  
Data year: 2010  
Source geography: ZIP Code

### Mortality

In 2012, HIV/AIDS mortality rates per 100,000 persons were twice as high in the SVMC service area (6.8) than in Los Angeles County (3.0). An even higher rate was reported in SPA 6 (7.0).

**Table 76. HIV/AIDS Mortality Rate Per 100,000 Persons**

	Rate
Service Planning Area 4	6.4
Service Planning Area 6	7.1
SVMC Service Area	6.8 (avg.)
Los Angeles County	3.0

Data source: Los Angeles County Department of Public Health, Annual HIV Surveillance Report  
Data year: 2012  
Source geography: SPA

### Disparities

Stakeholders indicated the homeless, GLBTG (gay, lesbian, bisexual, transgender, and queer culture), teenagers, low-income women, and teenagers transitioning into adults as the most severely impacted sub-populations.

*“There is a different group being identified. Women find out that they are HIV positive after their partner becomes ill or dies of the disease. We do workshops and use a promotora model to enter the community and break the silence and isolation.”*  
(Executive Director, Community Based Organization)

Stakeholders identified South Los Angeles as being the most severely impacted.

### Associated Drivers of Health

*“It is like what it was 20 years ago: clients are facing discrimination, living in secrecy among peers, in the community, and now back to the family as well. As a result, they are facing emotional issues and mental issues in addition to physical issues.”*  
(CEO, Community Based Foundation)

The following factors are associated with HIV/AIDS: injection drug use, risky sexual behaviors<sup>62</sup>, poverty, heavy alcohol consumption, liquor store access, and HIV screenings. HIV prevalence is highest among gay, bisexual, and other men who have sex with men, and among African Americans<sup>63</sup>.

Untreated HIV infection is associated with many diseases including cardiovascular disease, kidney

disease, liver disease, and cancer<sup>64</sup>. Persons with HIV infection are disproportionately affected by viral hepatitis, and those co-infected with HIV and viral hepatitis experience greater liver-related health problems than those who do not have HIV infection<sup>65</sup>.

*“HIV related illness is decreasing, but there are many affected children (children of infected parents). The number of infected kids 10 years old and under is decreasing but there is an increase in infected teens ages 10 and over.”*  
(CEO, Community Based Foundation)

<sup>62</sup> Centers for Disease Control and Prevention. *Drug-Associated HIV Transmission Continues in the United States*. Available at [http://www.cdc.gov/hiv/resources/factsheets/idu.htm]. Accessed [February 28, 2013].

<sup>63</sup> Centers for Disease Control and Prevention. *HIV in the United States: At A Glance*. Available at [http://www.cdc.gov/hiv/resources/factsheets/us.htm]. Accessed [February 28, 2013].

<sup>64</sup> Centers for Disease Control and Prevention. *Basic Information about HIV and AIDS*. Available at [http://www.cdc.gov/hiv/topics/basic/index.htm]. Accessed [March 1, 2013].

<sup>65</sup> Centers for Disease Control and Prevention. *HIV and Viral Hepatitis*. Available at [http://www.cdc.gov/hiv/resources/factsheets/hepatitis.htm]. Accessed [March 1, 2013].

For data concerning related health drivers, please refer to Appendix C—Scorecard.

### Primary Data

Stakeholders stated that there have been fewer newly diagnosed HIV/AIDS cases and improvements in care management though there is still a need for more education and prevention services and other measures around HIV/AIDS including family-based programming and services, mental health services (to alleviate the depression and anxiety experienced by those with HIV/AIDS), and more collaboration from hospitals.

## 14. Mental Health

Mental illness is a common cause of disability. Untreated disorders may leave individuals at risk for substance abuse, self-destructive behavior, and suicide. Additionally, mental health disorders can have a serious impact on physical health and are associated with the prevalence, progression, and outcome of chronic diseases<sup>66</sup>. Suicide is considered a major preventable public health problem. In 2010, suicide was the tenth leading cause of death among Americans of all ages, and the second leading cause of death among people between the ages of 25 and 34<sup>67</sup>. An estimated 11 attempted suicides occur per every suicide death.

Research shows that more than 90% of those who die by suicide suffer from depression or other mental disorders, or a substance-abuse disorder (often in combination with other mental disorders)<sup>68</sup>. Among adults, mental disorders are common, with approximately one-quarter of adults being diagnosable for one or more disorders<sup>69</sup>. Mental disorders are not only associated with suicide, but also with chronic diseases, a family history of mental illness, age, substance abuse, and life-event stresses<sup>70</sup>.

Interventions to prevent suicide include therapy, medication, and programs that focus on both suicide risk and mental or substance-abuse disorders. Another intervention is improving primary care providers' ability to recognize and treat suicide risk factors, given the research indicating that older adults and women who die by suicide are likely to have seen a primary care provider in the year before their death<sup>71</sup>.

### Prevalence

In 2011, adults experienced an average of 5.9 days of poor mental and/or physical health-related unhealthy days in the SVMC service area, which is slightly higher when compared to Los Angeles County

---

<sup>66</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://healthypeople.gov/2020/topicobjectives2020/overview.aspx?topicid=28>. Accessed [April 30, 2013].

<sup>67</sup> Centers for Disease Control and Prevention. *10 Leading Causes of Death by Age Group, United States – 2010*. Available at [http://www.cdc.gov/injury/wisqars/pdf/10LCID\\_All\\_Deaths\\_By\\_Age\\_Group\\_2010-a.pdf](http://www.cdc.gov/injury/wisqars/pdf/10LCID_All_Deaths_By_Age_Group_2010-a.pdf). Accessed [March 12, 2013].

<sup>68</sup> National Institute of Mental Health. *Suicide in the U.S.: Statistics and Prevention*. Available at <http://www.nimh.nih.gov/health/publications/suicide-in-the-us-statistics-and-prevention/index.shtml>. Accessed [March 12, 2013].

<sup>69</sup> National Institute of Mental Health. *Any Disorder Among Adults*. Available at [http://www.nimh.nih.gov/statistics/1ANYDIS\\_ADULT.shtml](http://www.nimh.nih.gov/statistics/1ANYDIS_ADULT.shtml). Accessed [March 12, 2013].

<sup>70</sup> Public Health Agency of Canada. *Mental Illness*. Available at <http://www.phac-aspc.gc.ca/cd-mc/mi-mm/index-eng.php>. Accessed [March 12, 2013].

<sup>71</sup> National Institute of Mental Health. *Suicide in the U.S.: Statistics and Prevention*. Available at <http://www.nimh.nih.gov/health/publications/suicide-in-the-us-statistics-and-prevention/index.shtml>. Accessed [March 12, 2013].

(5.4). The number of days reported in SPA 6 (6.1) was also slightly higher than the SVMC service area (5.9) and Los Angeles County (5.4).

**Table 77. Unhealthy Days Resulting From Poor Mental and/or Physical Health Reported By Adults**

	Days
Service Planning Area 4	5.7
Service Planning Area 6	6.1
SVMC Service Area	5.9 (avg.)
Los Angeles County	5.4

Data source: Los Angeles County Health Survey

Data year: 2011

Source geography: SPA

In 2011-2012, a larger percentage (9.2%) of adults in the SVMC service area reported experiencing serious psychological distress in the past year when compared to Los Angeles County (8.0%), with an even larger percentage (9.6%) reported in SPA 4. SPA 6 (8.7%) also experienced a larger percentage of adults experiencing serious psychological distress in the past year when compared to Los Angeles County (8.0%).

**Table 78. Adults with Serious Psychological Distress in the Last Year**

	Percentage
Service Planning Area 4	9.6%
Service Planning Area 6	8.7%
SVMC Service Area	9.2% (avg.)
Los Angeles County	8.0%

Data source: California Health Interview Survey (CHIS)

Data year: 2011-2012

Source geography: SPA

In 2011, a slightly larger percentage (64.4%) of the population in the SVMC service area reported having the necessary social and emotional support when compared to Los Angeles County (64.0%). An even larger percentage reported having the necessary social and emotional support in SPA 4 (74.8%) when compared to the SVMC service area (64.4%) and Los Angeles County (64.0%).

**Table 79. Adequate Social and Emotional Support**

	Percentage
Service Planning Area 4	74.8%
Service Planning Area 6	53.9%
SVMC Service Area	64.4% (avg.)
Los Angeles County	64.0%

Data source: Los Angeles County Health Survey

Data year: 2011

Source geography: SPA

## Anxiety

In addition, the percentage of the population in the SVMC service area diagnosed with anxiety was slightly lower (11.1%) when compared to Los Angeles County (11.3%) however the percentage was higher in SPA 4 (12.0%).

**Table 80. Anxiety Prevalence**

	Percentage
Service Planning Area 4	12.0%
Service Planning Area 6	10.1%
SVMC Service Area	11.1% (avg.)
Los Angeles County	11.3%

Data source: Los Angeles County Health Survey  
Data year: 2011  
Source geography: SPA

### Depression

The percentage of the population in the SVMC service area diagnosed with depression was slightly lower (12.1%) when compared to Los Angeles County (12.2%). However, the percentage was higher in SPA 4 (13.4%) when compared to the SVMC service area (12.1%) and Los Angeles County (12.2%).

**Table 81. Depression Prevalence**

	Percentage
Service Planning Area 4	13.4%
Service Planning Area 6	10.8%
SVMC Service Area	12.1% (avg.)
Los Angeles County	12.2%

Data source: Los Angeles County Health Survey  
Data year: 2011  
Source geography: SPA

### Alcohol- and Drug-Related Mental Illness

Alcohol and drug use is often associated with and linked to mental illness. In 2010, the rate per 100,000 adults of alcohol- and drug-induced mental illness in the SVMC service area was slightly higher (112.9) when compared to California (109.1). However, rates in the SVMC service area were especially high in ZIP Codes 90046 (210.0), 90027 (179.4), 90010 (157.9), 90028 (156.7), 90057 (135.6), 90016 (132.4), and 90031 (129.7).

**Table 82. Alcohol- and Drug-Induced Mental Illness Rate Per 100,000 Adults**

ZIP Code	Rate
90004	72.4
90005	66.3
90006	71.0
90007	95.3
90008	99.0
90010	157.9
90011	79.9
90016	132.4
90017	79.9
90018	111.5
90019	100.8
90020	79.6

ZIP Code	Rate
90026	110.5
90027	179.4
90028	156.7
90029	93.2
90031	129.7
90037	112.4
90044	98.0
90046	210.0
90057	135.6
SVMC Service Area	112.9 (avg.)
California	109.1

Data source: Office of Statewide Health Planning and Development (OSHPD)  
Data year: 2010  
Source geography: ZIP Code

### Hospitalizations

In 2010, the mental health hospitalization rate per 100,000 adults in the SVMC service area was much higher (715.0) than in California (551.7). The highest rates in the SVMC service area were in ZIP Codes 90028 (1,030.9), 90044 (979.9), 90037 (969.9), 90018 (973.4), 90008 (924.9), and 90016 (916.0). Please note that these zip codes are located in Downtown Los Angeles and may be biased by the high number of homeless and service providers in the area.

**Table 83. Mental Health Hospitalization Rate Per 100,000 Adults**

ZIP Code	Rate
90004	619.2
90005	607.7
90006	713.0
90007	471.7
90008	924.9
90010	789.5
90011	739.2
90016	916.0
90017	723.7
90018	973.4
90019	674.9
90020	372.1
90026	467.1
90027	739.7
90028	1,030.9
90029	450.6
90031	343.4
90037	969.9
90044	979.9
90046	889.2
90057	620.0

ZIP Code	Rate
SVMC Service Area	715.0 (avg.)
California	551.7

Data source: Office of Statewide Health Planning and Development (OSHPD)  
Data year: 2010  
Source geography: ZIP Code

Similarly, the mental health hospitalization rate per 100,000 youth under 18 years of age was much higher (308.5) in the SVMC service area when compared California (256.4). In the SVMC service area, rates were highest in ZIP Codes 90037 (572.4), 90010 (520.8), and 90046 (505.2). Again, please note that these zip codes are located in or around Downtown Los Angeles and might be biased by the high number of homeless and service providers in the area.

**Table 84. Mental Health Hospitalization Per 100,000 Youth (Under 18 Years)**

ZIP Code	Rate
90004	376.1
90005	313.2
90006	264.4
90007	217.6
90008	191.9
90010	520.8
90011	408.8
90016	260.3
90017	109.0
90018	278.1
90019	294.1
90020	158.8
90026	374.9
90027	36.1
90028	351.4
90029	178.3
90031	349.3
90037	572.4
90044	418.8
90046	505.2
90057	299.1
SVMC Service Area	308.5 (avg.)
California	256.4

Data source: Office of Statewide Health Planning and Development (OSHPD)  
Data year: 2010  
Source geography: ZIP Code

### Suicide

In 2010, the suicide rate per 10,000 persons in the SVMC service area was slightly lower (0.7) when compared to California (1.0), and above the Healthy People 2020 goal (<=1.0). In the SVMC service area, the highest rates were reported in ZIP Codes 90046 (2.7), 90020 (1.5), 90028 (1.4), and 90027 (1.3).

**Table 85. Suicide Rate Per 10,000 Persons**

ZIP Code	Rate
90004	0.5
90005	0.5
90006	0.5
90007	0.0
90008	0.3
90010	0.0
90011	0.6
90016	0.2
90017	0.4
90018	0.6
90019	0.6
90020	1.5
90026	1.0
90027	1.3
90028	1.4
90029	0.3
90031	0.5
90037	0.3
90044	0.5
90046	2.7
90057	1.3
SVMC Service Area	0.7 (avg.)
California	1.0
Healthy People 2020	<=1.0

Data source: California Department of Public Health (CDPH)  
Data year: 2010  
Source geography: ZIP Code

### Disparities

Mental health, particularly depression, affects everyone. However, in Los Angeles County, those most affected are between the ages of 50 and 64. Around 18.8% of those age 50 to 59 have been diagnosed with depression, as have 18.0% of those age 60 to 64. Another 14.1% of those between age 40 and 49, and smaller percentages of those age 65 and older (10.6%), 25 to 29 (10.1%), 30 to 39 (9.4%), and 18 to 24 (6.0%), have been diagnosed with depression.

**Table 86. Depression Prevalence By Age**

Age Group	Percentage
18–24 years old	6.0%
25–29 years old	10.1%
30–39 years old	9.4%
40–49 years old	14.1%
50–59 years old	18.8%

Age Group	Percentage
60–64 years old	18.0%
65 years old and older	10.6%

Data source: Los Angeles County Health Survey  
Data year: 2011  
Source geography: County

By ethnicity, larger percentages of Whites (17.1%), African-Americans (15.9%), and American Indian/Alaskan Natives (15.0%) in Los Angeles County were diagnosed with depression, as were smaller percentages of Latinos (9.7%) and Asian/Pacific Islanders (6.7%).

**Table 87. Depression Prevalence By Ethnicity**

Age Group	Percentage
Latino	9.7%
White	17.1%
African-American	15.9%
Asian/Pacific Islander	6.7%
American Indian/Alaskan Native	15.0%

Data source: Los Angeles County Health Survey  
Data year: 2011  
Source geography: County

Stakeholders identified battered women, the homeless, low-income, veterans, undocumented immigrants, men in gangs, prisoners released early coming out with psychiatric issues, and youth (foster youth aging out of the foster system and high school youth) as the most severely impacted.

Stakeholders identified Skid Row in Downtown Los Angeles, East and Southeast Los Angeles and Chinatown.

*“People who have lost their job recently and the newly homeless are the most affected. There is also a stigma about mental health and some people won’t seek help, don’t know about resources, how to get on Medicare or Medical, or get access to other health resources.”  
(Vice President of Human Resources, Community Based Organization)*

**Associated Drivers of Health**

Mental health is associated with many other health factors, including poverty, heavy alcohol consumption, and unemployment. Chronic diseases such as cardiovascular disease, diabetes, and obesity are also associated with mental health disorders such as depression and suicide<sup>72</sup>. For data concerning health drivers, please refer to Appendix C—Scorecard.

*“Mental and emotional health is the most difficult to promote because most are either in denial or embarrassed about having a health issue and so do not speak up or do anything about it.”  
(Resident Focus Group Participant)*

**Primary Data**

<sup>72</sup> Centers for Disease Control and Prevention. *Mental Health and Chronic Diseases*. Available at <http://www.cdc.gov/nationalhealthysite/docs/Issue-Brief-No-2-Mental-Health-and-Chronic-Disease.pdf>. Accessed [May 1, 2013].

Stakeholders stated that community members had a difficult time obtaining treatment for mental health issues because of strict insurance guidelines and the cost of treatment and medication. Transportation was also a barrier. Stakeholders identified multiple factors that contributed to poor mental health including stress caused by the economic downturn, unemployment, immigration status, abuse (emotional, physical, and sexual), bullying, and increasing violence.

Stakeholders also added that there has been a noted increase in psychiatric emergencies and the use of physical restraints on patients. There has also been an increase in demand for mental health services; however this need remains unmet and there are often waiting lists for people who need immediate help.

### 15. Obesity/Overweight

Obesity, a condition in which a person has an abnormally high and unhealthy proportion of body fat, has risen to epidemic levels in the United States; 68 percent of adults age 20 years and older are overweight or obese<sup>73</sup>. Excess weight is a significant national problem and indicates an unhealthy lifestyle that influences further health issues.

Obesity reduces life expectancy and causes devastating and costly health problems, increasing the risk of coronary heart disease, stroke, high blood pressure, diabetes, and a number of other chronic diseases. Findings suggest that obesity also increases the risks for cancers of the esophagus, breast (post-menopausal), endometrium, colon and rectum, kidney, pancreas, thyroid, gallbladder, and possibly other cancer types<sup>74</sup>. Obesity is associated with factors including poverty, inadequate fruit/vegetable consumption, breastfeeding, and lack of access to grocery stores, parks, and open space.

#### Prevalence

In 2011, a quarter (25.9%) of adults in the SVMC service area were overweight, fewer than in Los Angeles County (34.2%). Similarly, a smaller percentage of adults (15.6%) were obese in the SVMC service area when compared to Los Angeles County (24.7%) and the Healthy People 2020 goal (<=30.5%).

**Table 88. Overweight and Obese Populations (Adults)**

	Percent Overweight	Percent Obese
Service Planning Area 4	32.9%	10.4%
Service Planning Area 6	18.9%	20.7%
SVMC Service Area	25.9% (avg.)	15.6% (avg.)
Los Angeles County	34.2%	24.7%
Healthy People 2020		<=30.5%

Data source: California Health Interview Survey (CHIS)  
Data year: 2011-2012  
Source geography: SPA

<sup>73</sup> National Cancer Institute. *Obesity and Cancer Risk*. Available at <http://www.cancer.gov/cancertopics/factsheet/Risk/obesity>. Accessed [March 10, 2013].

<sup>74</sup> National Cancer Institute. *Obesity and Cancer Risk*. Available at <http://www.cancer.gov/cancertopics/factsheet/Risk/obesity>. Accessed [March 10, 2013].

A slightly smaller percentage (14.5%) of teens between the ages of 12 and 17 in the SVMC service area were overweight or obese when compared to Los Angeles County (33.6%), with SPA 6 having a greater percentage (19.0%).

**Table 89. Overweight and Obese Teens (12-17 years old)**

	Percentage
Service Planning Area 4	10.0%
Service Planning Area 6	19.0%
SVMC Service Area	14.5% (avg.)
Los Angeles County	17.1%

Data source: California Health Interview Survey (CHIS)

Data year: 2011-2012

Source geography: SPA

A slightly larger percentage (16.1%) of children ages 2 to 11 in the SVMC service area were overweight when compared to Los Angeles County (13.3%), with SPA 6 having a larger percentage (17.1%).

**Table 90. Overweight Children (2-11 years old)**

	Percentage
Service Planning Area 4	15.0%
Service Planning Area 6	17.1%
SVMC Service Area	16.1% (avg.)
Los Angeles County	13.3%

Data source: California Health Interview Survey (CHIS)

Data year: 2011-2012

Source geography: SPA

### Disparities

Overall, over a third or more of the population in Los Angeles County, regardless of age, is overweight, particularly larger percentages of those between age 50 and 59 (39.8%), those 65 and older (39.2%), and those between age 40 and 49 (38.7%). Similarly, over a third of those between the ages of 30 and 39 (37.6%), 60 and 64 (35.8%), 25 and 29 (34.4%), and 18 and 24 (31.4%) are also overweight.

Over a third of those who are middle-aged and older are obese— specifically, larger percentages of those between age 60 and 64 (29.8%), 30 and 39 (27.8%), and 40 and 49 (27.3%). Another quarter of those between age 50 and 59 are obese in Los Angeles County.

**Table 91. Overweight/Obesity Prevalence By Age**

Age Group	Percent Overweight	Percent Obese
18–24 years old	31.4%	15.4%
25–29 years old	34.4%	19.9%
30–39 years old	37.6%	27.8%
40–49 years old	38.7%	27.3%
50–59 years old	39.8%	25.5%
60–64 years old	35.8%	29.8%
65 years old and older	39.2%	19.0%

Data source: Los Angeles County Health Survey  
Data year: 2011  
Source geography: County

By ethnicity, larger percentages of American Indians/Alaskan Natives (45.2%) and Latinos (40.6%) in Los Angeles County are overweight, along with over a third of African-Americans (38.9%), Whites (34.0%), and Asian/Pacific Islanders (32.9%). Also, over a third of Latinos (31.6%) and African-Americans (31.0%) in Los Angeles County are obese, along with over a quarter (25.8%) of American Indians/Alaskan Natives.

**Table 92. Overweight/Obesity Prevalence By Ethnicity**

Age Group	Percent Overweight	Percent Obese
Latino	40.6%	31.6%
White	34.0%	18.0%
African-American	38.9%	31.0%
Asian/Pacific Islander	32.9%	8.9%
American Indian/Alaskan Native	45.2%	25.8%

Data source: Los Angeles County Health Survey  
Data year: 2011  
Source geography: County

Stakeholders identified Latinos, African-Americans, low-income, and adults and children as the most severely impacted.

Stakeholders also identified South Los Angeles, Inglewood, Compton, and Pasadena as the most impacted.

### Associated Drivers of Health

Obesity is associated with factors such as poverty, inadequate consumption of fruits and vegetables, physical inactivity, and lack of access to grocery stores, parks, and open space. Obesity increases the risk of coronary heart disease, stroke, high blood pressure, diabetes, and a number of other chronic diseases. The condition also increases the risks of cancers of the esophagus, breast (postmenopausal),

endometrium, colon and rectum, kidney, pancreas, thyroid, gallbladder, and possibly other cancer types<sup>75</sup>. For data concerning health drivers, please refer to Appendix C—Scorecard.

### Primary Data

Stakeholders attributed being obese and overweight to a lack of access to green space, living in food deserts, lack of access to healthy foods such as fruit and vegetables, lack of safety at parks, and lifestyle choices such as a lack of physical activity. Stakeholders added that obesity and being overweight was closely linked to diabetes and hypertension and that these are a growing issue.

*“Obesity is escalating at a high rate. This causes other chronic diseases and ailments which shortens a person’s life span”  
(Health Professional, National Health Organization)*

*If you want to exercise in parks in South East LA you would get shot; safety is a major concern.  
(Business and Education Leader Focus Group Participant)*

Stakeholders also added communication agents would be important in countering the increase in obesity rates. One stakeholder added, “most people are hearing this message from teachers at schools, from the doctor or nurse, from their priest, in programs at the library, etc. It’s effective to educate all collaborators and partners to deliver a similar message over time.”

## 16. Oral Health

Oral health is essential to overall health, and is relevant as a health need because engaging in preventive behaviors decreases the likelihood of developing future oral health and related health problems. In addition, oral diseases such as cavities and oral cancer cause pain and disability for many Americans<sup>76</sup>.

Behaviors that may lead to poor oral health include tobacco use, excessive alcohol consumption, and poor dietary choices. Barriers that prevent or limit a person’s use of preventive intervention and treatments for oral health include limited access to and availability of dental services, a lack of awareness of the need, cost, and fear of dental procedures. Social factors associated with poor dental health include lower levels or lack of education, having a disability, and other health conditions such as diabetes<sup>77</sup>.

### Access

In the SVMC service area, a third of adults (38.0%) have dental insurance coverage, a lower rate than in Los Angeles County (48.2%) where nearly half of adults have coverage. SPA 4 (38.9%) has a slightly higher percentage of adults with dental insurance coverage than the SVMC service area but still much lower than adults in Los Angeles County (48.2%).

<sup>75</sup> National Cancer Institute. *Obesity and Cancer Risk*. Available at <http://www.cancer.gov/cancertopics/factsheet/Risk/obesity>. Accessed [March 10, 2013].

<sup>76</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. *Healthy People 2020*. Washington, DC. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=32>. Accessed [February 26, 2013].

<sup>77</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. *Healthy People 2020*. Washington, DC. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=32>. Accessed [February 26, 2013].

**Table 93. Dental Insurance Coverage (Adults)**

	Percentage
Service Planning Area 4	38.9%
Service Planning Area 6	37.1%
SVMC Service Area	38.0% (avg.)
Los Angeles County	48.2%

Data source: Los Angeles County Health Survey  
Data year: 2011  
Source geography: SPA

As of May 2013, there are a total of 8,417 dentists in Los Angeles County, making up over a quarter (26.7%) of dentists in California.

For an area to be determined a Dental Health Professional Shortage Area, there must be a population-to-dentist ratio of at least 5,000:1<sup>78</sup>. Los Angeles County does not meet this criterion, as the ratio is 1,184:1.

**Table 94. Dentist Availability**

	Number	Population to Dentist Ratio
Los Angeles County	8,417	1,184:1
California	31,559	

Data source: Office of Statewide Health and Planning and Development (OSHDP)  
Data year: 2013  
Source geography: County

Although the population-to-dentist ratio is not high enough in Los Angeles County to be considered critical, there is still an issue with access to dental care and its associated cost.

### **Affordability**

Often, dental insurance is limited and coverage is minimal, so people have to pay high out-of-pocket costs. In addition, most people do not have dental insurance coverage; the cost of dental services is too high and therefore unattainable for the average person.

In the SVMC service area, over a third (36.3%) of adults could not afford dental care—including regular check-ups—which is slightly higher when compared to Los Angeles County (30.3%). SPA 4 reported an even higher percentage (37.6%) than the SVMC service area (36.3%) and Los Angeles County (30.3%). SPA 6 also reported a larger percentage (35.0%) than Los Angeles County (30.3%).

**Table 95. Unable to Afford Dental Care (Adult)**

	Percentage
Service Planning Area 4	37.6%
Service Planning Area 6	35.0%
SVMC Service Area	36.3% (avg.)

<sup>78</sup> United States Department of Health and Human Services (n.d.). Dental HPSA Designation Overview. Rockville, MD. Available at <http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/dentalhpsaoverview.html>. Accessed [July 10, 2013].

	Percentage
Los Angeles County	30.3%

Data source: Los Angeles County Health Survey  
Data year: 2011  
Source geography: SPA

In Los Angeles County, a number of free or low-cost dental services are available for children through community clinics and state and county programs. However, many of those entities have been impacted by budget cuts, which have significantly limited the availability of those services.

In the SVMC service area, a larger percentage (13.1%) of children were unable to afford dental care when compared to Los Angeles County (12.6%). SPA 6 reported a larger percentage (14.9%) than the SVMC service area (13.1%) and Los Angeles County (12.6%).

**Table 96. Unable to Afford Dental Care (Child)**

	Percentage
Service Planning Area 4	11.3%
Service Planning Area 6	14.9%
SVMC Service Area	13.1% (avg.)
Los Angeles County	12.6%

Data source: Los Angeles County Health Survey  
Data year: 2011  
Source geography: SPA

### Disparities

In 2011, most adults in Los Angeles County were unable to afford dental care, regardless of age. However, a larger percentage of adults between the ages of 25 and 29 (38.7%), 30 and 39 (35.0%), and 50 and 59 (33.0%) were unable to afford dental care.

**Table 97. Unable to Afford Dental Care By Age (Adult)**

Age Group	Percentage
18–24 years old	27.0%
25–29 years old	38.7%
30–39 years old	35.0%
40–49 years old	30.4%
50–59 years old	33.0%
60–64 years old	27.0%
65 years old and older	19.1%

Data source: Los Angeles County Health Survey  
Data year: 2011  
Source geography: County

**Table 98. Unable to Afford Dental Care By Age (Child)**

Age Group	Percentage
3–5 years old	10.9%
6–11 years old	10.6%
12–17 years old	15.3%

Age Group	Percentage
-----------	------------

Data source: Los Angeles County Health Survey

Data year: 2011

Source geography: County

By ethnicity, over a third of African-American (38.0%) and Latino (36.6%) adults were unable to afford dental care, as were over a quarter of Asian/Pacific Islanders (27.3%) and American Indian/Alaskan Native (25.6%) adults and close to a quarter of White (21.0%) adults.

**Table 99. Unable to Afford Dental Care By Ethnicity (Adult)**

Age Group	Percentage
Latino	36.6%
White	21.0%
African-American	38.0%
Asian/Pacific Islander	27.3%
American Indian/Alaskan Native	25.6%

Data source: Los Angeles County Health Survey

Data year: 2011

Source geography: County

By ethnicity, larger percentages of Latinos (14.4%) and African-American (14.4%) children had a difficult time obtaining dental care due to affordability, along with smaller percentages of Asian/Pacific Islander (9.1%) and White (8.7%) children. Data for American Indian/Alaskan Native children were not available, or the numbers were too small to report.

**Table 100. Unable to Afford Dental Care By Ethnicity (Child)**

Age Group	Percentage
Latino	14.4%
White	8.7%
African-American	14.4%
Asian/Pacific Islander	9.1%
American Indian/Alaskan Native	0.0%

Data source: Los Angeles County Health Survey

Data year: 2011

Source geography: County

Stakeholders identified low-income adults, uninsured, the homeless (specifically veterans), Latinos, and those with diabetes as the most severely impacted.

Stakeholders identified Chinatown-and Skid Row in Downtown Los Angeles as the most severely impacted.

### Associated Drivers of Health

Poor oral health can be prevented by: decreasing sugar intake and increasing healthy eating habits to prevent tooth decay and premature tooth loss; consuming more fruits and vegetables to protect against oral cancer; smoking cessation; decreased alcohol consumption to reduce the risk of oral cancers, periodontal disease, and tooth loss; using protective gear when playing sports; and living in a safe physical

environment<sup>79</sup>. In addition, oral health conditions such as periodontal (gum) disease have been linked to diabetes, heart disease, stroke, and premature, low-weight births<sup>80</sup>. For data concerning health drivers, please refer to Appendix C—Scorecard.

### Primary Data

Stakeholders attributed poor oral health to the lack of affordable dental services, lack of access to dental services, and lack of education about health oral health behaviors such as brushing habits, when to visit doctors, etc. They also added that Medi-Cal phasing out dental coverage severely impacted adults.

*“I needed two root canals so I visited a private dentist but the cost was double what USC charges, so I went to USC.”  
(Focus Group Participant)*

## 17. Sexually Transmitted Diseases

STDs refer to diseases that are transmitted primarily through sexual activity. Despite cost and other consequences and complications, and the fact that they are preventable, STDs remain a significant health issue in the United States. Untreated STDs can lead to serious long-term health consequences, especially for adolescent girls and young women. The spread of STDs is directly affected by social, economic, and behavioral factors. Such factors include race and ethnicity, poverty, access to care, substance abuse, and sexual behaviors<sup>81</sup>.

### Prevalence

In 2011, the acute hepatitis C prevalence rate per 100,000 persons was much lower in the SVMC service area (0.1) than in Los Angeles County (4.0).

**Table 101. Acute Hepatitis C Prevalence Rate Per 100,000 Persons**

	Rate
Service Planning Area 4	0.2
Service Planning Area 6	0.0
SVMC Service Area	0.1 (avg.)
Los Angeles County	4.0

Data source: Los Angeles County Department of Public Health

Data year: 2011

Source geography: SPA

The chlamydia prevalence rate per 100,000 persons was much higher in the SVMC service area (793.6) than in Los Angeles County (512.9). The rate was even higher in SPA 6 (999.5) than in the SVMC service area (793.6) and Los Angeles County (512.9).

<sup>79</sup> World Health Organization, Oral health Fact Sheet. Geneva, Switzerland. Available at <http://www.who.int/mediacentre/factsheets/fs318/en/index.html>. Accessed [February 26, 2013].

<sup>80</sup> Centers for Disease Control and Prevention. *Mental Health and Chronic Diseases*. Available at <http://www.cdc.gov/chronicdisease/resources/publications/aag/pdf/2011/Oral-Health-AAG-PDF-508.pdf>. Accessed [May 1, 2013].

<sup>81</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. *Healthy People 2020*. Washington, DC. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=37>. Accessed [October 24, 2013].

**Table 102. Chlamydia Prevalence Rate Per 100,000 Persons**

	Rate
Service Planning Area 4	587.7
Service Planning Area 6	999.5
SVMC Service Area	793.6 (avg.)
Los Angeles County	512.9

Data source: Los Angeles County Department of Public Health  
Data year: 2011  
Source geography: SPA

Similarly, the gonorrhea prevalence rate per 100,000 persons was twice the rate in the SVMC service area (218.3) than that in Los Angeles County (103.4). The rate was even higher in SPA 6 (231.9) than the SVMC service area (218.3) and Los Angeles County (103.4).

**Table 103. Gonorrhea Prevalence Rate Per 100,000 Persons**

	Rate
Service Planning Area 4	204.7
Service Planning Area 6	231.9
SVMC Service Area	218.3 (avg.)
Los Angeles County	103.4

Data source: Los Angeles County Department of Public Health  
Data year: 2011  
Source geography: SPA

### Disparities

Stakeholders identified low income minorities and those between the ages of 18 and 30 as the most impacted.

Stakeholders also identified the west side of SPA 4 and West Hollywood as the most impacted.

### Associated Drivers of Health

The spread of STDs is directly linked to race and ethnicity, poverty, access to care, substance abuse, and sexual behaviors<sup>82</sup>. For data concerning health drivers, please refer to Appendix C—Scorecard.

### Primary Data

Stakeholders mentioned the increase in STD rates, specifically syphilis and chlamydia.

## 18. Substance Abuse

Tobacco use is the most preventable cause of death and disease in the United States. Each year, approximately 443,000 Americans die from tobacco-related illnesses. For every person who dies from tobacco use, 20 more suffer with at least one serious tobacco-related illness. In addition, tobacco use

<sup>82</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=37>. Accessed [October 24, 2013].

costs the U.S. \$193 billion annually in direct medical expenses and lost productivity<sup>83</sup>. Tobacco use is known to cause cancer, heart disease, lung disease (such as emphysema, bronchitis, and chronic airway obstruction), premature birth, low birth weight, stillbirth, and infant death<sup>84</sup>.

Additionally, secondhand smoke has been known to cause heart disease and lung cancer in adults and severe asthma attacks, respiratory infections, ear infections, and sudden infant death syndrome (SIDS) in infants and children<sup>85</sup>. Smokeless tobacco use such as chewing tobacco can also cause a variety of oral health problems, like cancer of the mouth and gums, tooth loss, and periodontitis. In addition, cigar smoking may cause cancer of the larynx, mouth, esophagus, and lung<sup>86</sup>.

### Marijuana Use

In 2011, a larger percentage of teens between the ages of 12 and 17 reported using marijuana in the past year (17.3%) in the SVMC service area than in Los Angeles County (10.2%). Over a quarter of teens in SPA 4 (26.3%) reported using marijuana in the past year, larger than the SVMC service area (17.3%) and twice as many than in Los Angeles County (10.2%).

**Table 104. Teens 12-17 Who Have Used Marijuana in the Last Year**

	Percentage
Service Planning Area 4	26.3%
Service Planning Area 6	8.2%
SVMC Service Area	17.3% (avg.)
Los Angeles County	10.2%

Data source: Los Angeles County Health Survey

Data year: 2011

Source geography: SPA

### Alcohol- and Drug-Related Mental Illness

Alcohol and drug use is often associated with and linked to mental illness. In 2010, the rate per 100,000 adults of alcohol- and drug-induced mental illness in the SVMC service area was slightly higher (112.9) when compared to California (109.1). However, rates in the SVMC service area were especially high in ZIP Codes 90046 (210.0), 90027 (179.4), 90010 (157.9), 90028 (156.7), 90057 (135.6), 90016 (132.4), and 90031 (129.7).

<sup>83</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=41>. Accessed [July 11, 2013].

<sup>84</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=41>. Accessed [July 11, 2013].

<sup>85</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=41>. Accessed [July 11, 2013].

<sup>86</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=41>. Accessed [July 11, 2013].

**Table 105. Alcohol- and Drug-Induced Mental Illness Rate Per 100,000 Adults**

ZIP Code	Rate
90004	72.4
90005	66.3
90006	71.0
90007	95.3
90008	99.0
90010	157.9
90011	79.9
90016	132.4
90017	79.9
90018	111.5
90019	100.8
90020	79.6
90026	110.5
90027	179.4
90028	156.7
90029	93.2
90031	129.7
90037	112.4
90044	98.0
90046	210.0
90057	135.6
SVMC Service Area	112.9 (avg.)
California	109.1

Data source: Office of Statewide Health Planning and Development (OSHPD)

Data year: 2010

Source geography: ZIP Code

### Alcohol and Drug Treatment

In 2011, a slightly larger percentage (2.8%) of the population in the SVMC service area had needed or sought treatment for an alcohol or substance abuse problem in the past five years when compared to Los Angeles County (2.5%). The percentage was even higher in SPA 4 (3.3%).

**Table 106. Needed or Wanted Treatment for Alcohol or Drug Issues in the Past Five Years**

	Percentage
Service Planning Area 4	3.3%
Service Planning Area 6	2.3%
SVMC Service Area	2.8% (avg.)
Los Angeles County	2.5%

Data source: Los Angeles County Health Survey

Data year: 2011

Source geography: SPA

## Smokers

In 2011, a larger percentage (14.1%) of the population in the SVMC service area reporting smoking when compared to Los Angeles County (13.1%), with a particularly high percentage of smokers in SPA 4 (14.9%).

**Table 107. Currently Smoking**

	Percentage
Service Planning Area 4	14.9%
Service Planning Area 6	13.3%
SVMC Service Area	14.1% (avg.)
Los Angeles County	13.1%

Data source: Los Angeles County Health Survey  
Data year: 2011  
Source geography: SPA

## Disparities

In 2011, most tobacco users in Los Angeles County were between the ages of 25 and 29 (20.3%). Another 16.0% were between the ages of 30 and 39 and another 14.5% were between the ages of 50 and 59. Smaller percentages of the population in Los Angeles County who use tobacco are between the ages of 18 and 24 (9.7%), 60 and 64 (8.4%), and 65 years old or older (7.6%).

**Table 108. Tobacco Use By Age**

Age Group	Percentage
18–24 years old	9.7%
25–29 years old	20.3%
30–39 years old	16.0%
40–49 years old	13.1%
50–59 years old	14.5%
60–64 years old	8.4%
65 years old and older	7.6%

Data source: Los Angeles County Health Survey  
Data year: 2011  
Source geography: County

In addition, larger percentages of the population in Los Angeles County who are tobacco users are American Indian/Alaskan Native (29.5%), African-American (17.2%), or White (15.2%). Smaller percentages of the population in Los Angeles County who use tobacco are Latino (11.9%) or Asian/Pacific Islanders (9.2%).

**Table 109. Tobacco Use By Ethnicity**

Age Group	Percentage
Latino	11.9%
White	15.2%
African-American	17.2%
Asian/Pacific Islander	9.2%
American Indian/Alaskan Native	29.5%

Data source: Los Angeles County Health Survey

Data year: 2011

Source geography: County

Stakeholders identified the homeless, youth 12 years old and older, the uninsured, youth in or transitioning out of the foster care system, and low-income populations as the most severely impacted.

Stakeholders also identified Los Angeles and particularly Skid Row as the most impacted.

### Associated Drivers of Health

Factors that influence the use of tobacco include race/ethnicity, age, education, and socioeconomic status. Significant disparities in tobacco use exist geographically and typically result from differences in smoke-free protections, tobacco prices, and program funding for tobacco prevention<sup>87</sup>.

Tobacco use is linked to and associated with cancer, heart disease, lung disease (such as emphysema, bronchitis, and chronic airway obstruction), premature birth, low birth weight, stillbirth, and infant death<sup>88</sup>. In addition, secondhand smoke has been known to cause heart disease and lung cancer in adults and severe asthma attacks, respiratory infections, ear infections, and sudden infant death syndrome (SIDS) in infants and children<sup>89</sup>. For data concerning health drivers, please refer to Appendix C—Scorecard.

### Primary Data

Stakeholders mentioned the increased of new drugs on the streets which contribute to other health and mental health issues. Stakeholders also added that substance abuse often is associated with mental illness and poverty and attribute the prevalence of alcohol and substance abuse to the lack of access to treatment.

## 19. Vision

People with diabetes are at an increased risk of vision problems as diabetes can damage the blood vessels of the eye, potentially leading to blindness. Diabetics are 40% more likely to suffer from glaucoma and 60% more likely to develop cataracts compared to people without diabetes. People who have had diabetes for a long time or whose blood glucose or blood pressure is not under control are also

<sup>87</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=41>. Accessed [July 11, 2013].

<sup>88</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=41>. Accessed [July 11, 2013].

<sup>89</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=41>. Accessed [July 11, 2013].

at risk of developing retinopathy<sup>90</sup>. These kinds of vision impairment, cannot be corrected with glasses and typically require laser therapy or surgery<sup>91</sup>. Vision loss also makes it difficult for people to live independently.

As diabetes rates continue to rise among all age groups, vision complications tied to the disease are expected to increase as well. Vision care providers should expect to see more complications in the younger population as more children and adolescents are diagnosed with diabetes<sup>92</sup>.

Many eye problems are not evident until quite advanced, but early detection and treatment can be effective in saving vision. For example, screening for people with diabetes can almost completely eliminate diabetes-related blindness. However, only about half of diabetics in the United States currently get regular eye exams<sup>93</sup>.

### Prevalence

In 2011, a smaller percentage of diabetic adults had an eye exam where their pupils were dilated in the SVMC service area (50.2%) than in Los Angeles County (63.3%). Far fewer in SPA 4 (37.3%) had an eye exam than in the SVMC service area (50.2%) and Los Angeles County (63.3%).

**Table 110. Diabetic Adults Who Had An Eye Exam Where Pupils Were Dilated**

	Percentage
Service Planning Area 4	37.3%
Service Planning Area 6	63.0%
SVMC Service Area	50.2% (avg.)
Los Angeles County	63.3%

Data source: Los Angeles County Health Survey

Data year: 2011

Source geography: SPA

### Disparities

Stakeholders did not identify sub-populations or geographic disparities.

### Associated Drivers of Health

Diabetes-related vision problems are linked to the length of time one has had diabetes, high blood glucose, and high blood pressure. For data concerning health drivers, please refer to Appendix C—Scorecard.

### Primary Data

Stakeholders added that vision care services were not readily or easily accessible.

<sup>90</sup> American Diabetes Association. *Living with Diabetes*. Available at [<http://www.diabetes.org/living-with-diabetes/complications/mens-health/serious-health-implications/blindness-or-vision-problems.html>]. Accessed [March 5, 2013].

<sup>91</sup> Geneva Pittman, *Vision Loss Tied to Diabetes on the Rise*. Available at [<http://www.reuters.com/article/2012/12/11/us-diabetes-vision-loss-idUSBRE8BA1AP20121211>]. Accessed [March 5, 2013].

<sup>92</sup> Geneva Pittman, *Vision Loss Tied to Diabetes on the Rise*. Available at [<http://www.reuters.com/article/2012/12/11/us-diabetes-vision-loss-idUSBRE8BA1AP20121211>]. Accessed [March 5, 2013].

<sup>93</sup> Geneva Pittman, *Vision Loss Tied to Diabetes on the Rise*. Available at [<http://www.reuters.com/article/2012/12/11/us-diabetes-vision-loss-idUSBRE8BA1AP20121211>]. Accessed [March 5, 2013].

## Appendix A—Data Collection Tools and Instruments

### Metro CHNA 2013 Resident Focus Group Protocol

#### **Introduction:**

Thank you for participating in this focus group discussion. We are holding discussion groups as part of a community needs assessment for a collaborative of Los Angeles-based hospitals (Good Samaritan, St. Vincent, CA Hospital) to help them better understand community needs and identify the type of support the collaborative can provide to its diverse communities. Therefore, we would like get your ideas about the most important health issues facing your community. In addition, we will ask about what community members need to be healthier as well as the availability of services to meet those needs. Please share your honest opinions and experiences and allow other to express theirs freely. Your responses will not be associated with your name in the report and only to ensure your confidentiality and anonymity. Does anyone have any questions before we get started?

**Note to facilitator:** Review health data for appropriate hospital in order to effectively probe where appropriate.

#### HEALTH NEEDS AND DRIVERS OF HEALTH

---

1. What are some of the **major health issues** that affect individuals in your community overall?
  - a. Have they gotten **better or worse** over time (past 5 years)?
  - b. What populations are **most affected** by these needs? Why? (*ask by issue, if possible*)
2. Are there **social or environmental factors** that have contributed to health needs or trends? Which? **Other factors?** (i.e. such as substance use, unemployment, etc.)

#### COMMUNITY ASSETS

---

3. For those of you who **have a chronic health condition** such as asthma, diabetes or heart diseases, how do you keep your **condition under control**?
  - a. What would help you manage your condition better? (i.e. support from health care provider, disease specific information, etc.)
4. What other **health or social services are available** to you in the community?
  - a. **Where** do community members go to receive or obtain information on health services?
  - b. Does **access differ** for certain populations or groups?
  - c. How do you prefer to **receive information** about important health issues or available services? [newspaper, radio, community clinic, flyers, billboards]

#### ACCESS TO PRIMARY CARE

---

5. What kind of **insurance programs** do you and your family use?
  - a. What **other kinds** of insurance programs are you aware of?
  - b. If you are **uninsured**, why?
  - c. How does insurance **impact/effect your ability** to get the health care you or your family members need?
  
6. What health **services are most difficult to access or are missing** in the community? [**DO NOT SAY ALOUD:** *For example, this could include community clinics, healthcare providers for low-income/uninsured, health workshops, dental care, vision care, substance abuse services, mental health care, free health fairs, resources for pregnant women, etc.*]
  - a. Does this affect certain **communities/geographic areas** more than others? Which?
  - b. What **factors** contribute to this?
  
7. What other **challenges** keep individuals from **seeking help/care**? [**DO NOT SAY ALOUD:** *For example, this could be a lack of awareness of available resources, language barriers, lack of bilingual healthcare providers, immigration status/issues, lack of transportation or childcare, cultural values/beliefs, unsafe neighborhood, working multiple jobs/lack of time, etc.*]
  
8. Which **healthy behavior is the most difficult to encourage/promote** in the community? Why?
  - d. Are there any healthy behaviors that are the hardest to promote for **certain communities/geographic areas**? Which? Why?
  - e. Based on your knowledge of this community, what are some **possible strategies** for addressing this?

## HEALTH CARE UTILIZATION

---

9. What does **preventative/preventive healthcare** mean to you?
  - a. What do you do to stay healthy?
  - b. Do culture or community norms influence the health behaviors of community members? How?
  
10. If you are not feeling well [not an emergency], where do you usually **go for care**? [*Prompt for other providers: alternative health care including curanderos, traditional healers, use of herbs and natural medicines*]
  - a. Where are they **located**? How do you **get there**?
  - b. Do you feel that it's getting easier or harder to **obtain healthcare**? Why?

## HOSPITALS ROLE

---

11. What **role could hospitals** play in addressing the health service needs of this community?

## Metro CHNA 2013 Resident Focus Group Protocol

### **Introduction:**

Gracias por participar en esta plática. Mi organización fue contratada por tres hospitales (Good Samaritan, St. Vincent, CA Hospital) para llevar a cabo un estudio sobre la salud de las comunidades en el condado para mejorar los servicios médicos y sociales y para identificar el tipo de apoyo necesario para combatir la mala salud en la comunidad. Por eso es importante que nos digan cuales son los problemas de salud más grandes en su comunidad para poder identificar áreas de necesidad y los servicios disponibles para servir esas necesidades. Por favor sean honestos y respetuosos de los demás. Esto será completamente confidencial. ¿Tienen preguntas antes de empezar?

### **NECESIDADES DE SALUD GENERALES**

---

1. ¿Cuales son algunos de los **temas de salud afectando** la comunidad?
  - a. ¿Han **mejorado o no** en los últimos 5 años?
  - b. ¿Quiénes son **los más afectados**? ¿Por qué?
2. ¿Existen **elementos sociales o condiciones** que han contribuido a la mala salud de la comunidad? ¿Cuáles? ¿**Otros factores**? (*Por ejemplo: abuso de alcohol o drogas, desempleo, etc.*)

### **SERVICIOS EXISTENTES (SALUD Y SOCIALES)**

---

3. ¿Los que tienen **problemas de salud** como diabetes o problemas del corazón, como mantienen su enfermedad **bajo control**?
  - a. ¿Qué otro tipo de ayuda necesita para mantener su enfermedad bajo control? (*Por ejemplo: apoyo de su doctor, información, etc.*)
4. ¿Cuáles **servicios de salud o sociales** están disponibles en su comunidad?
  - a. ¿**A dónde van** residentes para obtener información sobre servicios de salud?
  - b. ¿Hay **diferencias** en acceso para diferentes grupos?
  - c. ¿Cómo **prefiere recibir** este tipo de información?

### **USO DE SERVICIOS DE SALUD**

---

5. ¿Qué tipo de **seguro médico** utilizar usted y su familia?
  - a. ¿Hay **otros tipos** de seguro médico?
  - b. ¿**Si no tienen** seguro médico, porque?
  - c. ¿**Cómo le afecta** tener seguro médico cuando necesita atención médica?
6. ¿Ahí **servicios que son difíciles de utilizar** en la comunidad? [*Por ejemplo, puede ser clínicas comunitarias, proveedores de salud para gente con bajos recursos o sin seguro médico, clases de*

*salud, cuidado dental o de visión, servicios para el abuso de sustancias, servicios de salud mental, ferias de salud gratuitas, recursos para mujeres embarazadas]*

- a. ¿Cuáles comunidades son las **más afectadas**? ¿Por qué?
  - b. ¿Cuáles son las **barreras**?
7. ¿Hay otros problemas o **situaciones que impiden** a la gente buscar ayuda? *[Por ejemplo, falta de conocimiento de recursos disponibles, lenguaje, falta e proveedores bilingües, estatus inmigratorio, falta de transportación cuidado de niño, valores o crianzas de cultura, falta de seguridad en la comunidad, falta de tiempo, etc.]*
8. ¿Cuál **comportamiento saludable** es más difícil de promover en la comunidad? ¿Por qué?
- a. ¿Cuáles comunidades son las **más afectadas**? ¿Por qué?
  - b. ¿Cuáles son las mejores formas de tratar de cambiar esto?

### **USO DE SERVICIOS MÉDICOS**

---

9. ¿Para usted **que es medicina preventiva**?
- c. ¿**Qué hace** para mantenerse saludable?
  - d. ¿Hay **algo que afecta** los comportamientos saludables como cultura o costumbres? ¿Cómo?
10. ¿A dónde van cuando **no se sienten bien**? *[Por ejemplo: curanderos, naturalistas, etc.]*
- e. ¿En **dónde** están localizados? ¿**Cómo llega** a ese lugar?
  - f. ¿Siente que se está **facilitando el uso** de servicios médicos? ¿Por qué?

### **PAPEL DE HOSPITALES**

---

11. ¿**Cómo pueden responder los hospitales** a las necesidades de salud en la comunidad?

## Metro CHNA 2013 Providers Focus Group Protocol

### **Introduction:**

The Center for Nonprofit Management is working with a collaborative of Los Angeles-based hospitals (Good Samaritan, St. Vincent, CA Hospital) to conduct their 2013 Community Health Needs Assessment. We are talking to health experts to obtain their perspective on the most important health issues facing the local community and to identify areas of need as well as the availability of services to meet those needs. All the information collected will help local medical centers improve and better target their services. The information you provide will not be associated with your name and will only be reported in an aggregated manner.

**Note to facilitator:** Review health data for appropriate hospital in order to effectively probe where appropriate.

**Area of expertise:**

**Primary service area:**

**Population served:**

### **GENERAL ISSUES**

---

12. What are some of the **major health issues** that affect individuals in your service population?
  - a. Have they gotten **better or worse** over time (past 5 years)?
  - b. What populations are **most affected** by these needs? Why? (*ask by issue, if possible*)
13. Are there **social or environmental factors** that have contributed to health needs or trends? Which? **Other factors?** (i.e. such as substance use, unemployment, etc.)

### **COMMUNITY ASSETS**

---

14. What **health or social services are available** in your local community?
  - f. **Where** do community members go to receive or obtain information on health services?
  - g. Does **access differ** for certain populations or groups?
  - h. From your experience, what are the best ways to **disseminate information** about important health issues or available services? [newspaper, radio, community clinic, flyers, billboards]

### **ACCESS TO PRIMARY CARE**

---

15. What health **services are most difficult to access or are missing** in the community? [**DO NOT SAY ALOUD:** *For example, this could include community clinics, healthcare providers for low-income/uninsured, health workshops, dental care, vision care, substance abuse services, mental health care, free health fairs, resources for pregnant women, etc.*]
- Does this affect certain **communities/geographic areas** more than others? Which?
  - What **factors** contribute to this?
16. What kinds of **challenges** does your service population experience when trying to get the care they need? [e.g., transportation, language barriers, lack of information, no health insurance, economic constraints]
- Who tends to have the **most difficulty**?
  - How might these **challenges be addressed**?
17. Which **healthy behaviors is the most difficult to encourage/promote** in the community? Why?
- Are there any healthy behaviors that are the hardest to promote for **certain communities/geographic areas**? Which? Why?
  - Based on your knowledge of this community, what are some **possible strategies** for addressing this?

---

#### HEALTH CARE UTILIZATION

18. To what extent does your service population **utilize basic health care services** (including preventive care) and **where** do community members **access those services**? What other community **assets are available** to community members?

---

#### HOSPITALS ROLE

19. What specifically could **hospitals** do to help address the needs you identified?
20. Do you see any potential areas for **collaboration or coordination** among service providers to better meet the needs of your service population? Explain.

---

#### OUTREACH

21. What would be the most effective **way to provide information** to your service population about the availability of health and other services?
- Is there a **particular message** that would appeal to community members?
22. Is there **anything else** you would like to add?

## Metro CHNA 2013 Stakeholder Interview Protocol

### **Introduction:**

The Center for Nonprofit Management is working with a collaborative of Los Angeles-based hospitals including California Hospital Medical Center, Good Samaritan Hospital, and St. Vincent Medical Center, to conduct their 2013 Community Health Needs Assessment. We are talking to health experts to obtain their perspective on the most important health issues facing the local community and to identify areas of need as well as the availability of services to meet those needs. All the information collected will help local medical centers improve and better target their services. The information you provide will not be associated with your name and will only be reported in an aggregated manner.

**Area of expertise:**

**Primary service area:**

**Population served:**

### **GENERAL ISSUES**

---

23. What are some of the **major health issues** that affect individuals in your service population?
- Have they gotten **better or worse** over time (past 5 years)?
  - What populations are **most affected** by these needs? Why? (*ask by issue, if possible*)
24. Are there **social or environmental factors** that have contributed to health needs or trends? Which? **Other factors?** (i.e. such as substance use, unemployment, etc.)

### **COMMUNITY ASSETS**

---

25. Where do **community members go** if they have chronic health issues?
- Where do they go if they **need specialized care**?
  - Where do they go if they **need mental health care**?
26. What other **health or social services are available** to in your local community?
- Where** do community members go to receive or obtain information on health services?
  - From you experience, what are the best ways to **disseminate information** about important health issues or available services? [newspaper, radio, community clinic, flyers, billboards]
  - Does **access differ** for certain populations or groups?

## HEALTH CARE UTILIZATION

---

27. To what extent does your service population **utilize basic health care services** (including preventive care) and **where** do community members **access those services**? What other community **assets are available** to community members?

## ACCESS TO PRIMARY CARE

---

28. What health **services are most difficult to access or are missing** in the community? [**DO NOT SAY ALOUD:** *For example, this could include community clinics, healthcare providers for low-income/uninsured, health workshops, dental care, vision care, substance abuse services, mental health care, free health fairs, resources for pregnant women, etc.*]
- e. Does this affect certain **communities/geographic areas** more than others? Which?
  - f. What **factors** contribute to this?
29. What kinds of **challenges** does your service population experience when trying to get the care they need? [e.g., transportation, language barriers, lack of information, no health insurance, economic constraints]
- c. Who tends to have the **most difficulty**?
  - d. How might these **challenges be addressed**?

## HOSPITALS ROLE

---

30. What specifically could **hospitals** do to help address the needs you identified?
31. Do you see any potential areas for **collaboration or coordination** among service providers to better meet the needs of your service population? Explain.

## OUTREACH

---

32. What would be the most effective **way to provide information** to your service population about the availability of health and other services?
- b. Is there a **particular message** that would appeal to community members?
33. Is there **anything else** you would like to add?

## Appendix B—Stakeholders

### Focus Group Participants (Identification)

Leaders, Representatives, or Members of Medically Underserved Persons, Low-Income Persons, Minority Populations, and Populations With Chronic Disease Needs					
	Group Size	Description of Leadership, Representative, or Member Role	What Group(s) Do They Represent?	Date of Consult	Type of Consult
1.	6 participants	Health care providers	Health access, children, youth and families, minority populations	10/12/12	Focus Group
2.	6 participants	Promotoras	Minority populations, underserved, dental care, reproductive care, outreach	10/12/12	Focus Group
3.	10 participants	Residents and clients	Latino, minority, and underserved populations	10/30/12	Focus Group
4.	4 participants	Residents and clients	Pilipino, Tagalog-speaking, minority, and underserved populations	9/26/12	Focus Group
5.	6 participants	Residents and clients	Chinese/Mandarin-speaking, minority, and underserved populations	9/26/12	Focus Group

<b>Leaders, Representatives, or Members of Medically Underserved Persons, Low-Income Persons, Minority Populations, and Populations With Chronic Disease Needs</b>					
	<b>Group Size</b>	<b>Description of Leadership, Representative, or Member Role</b>	<b>What Group(s) Do They Represent?</b>	<b>Date of Consult</b>	<b>Type of Consult</b>
6.	16 participants	Social service providers	Social service providers serving low-income, minority, chronic disease populations	9/18/12	Focus Group
7.	3 participants	Business and education leaders	Serving youth, business development, and land use	10/3/12	Focus Group
8.	16 participants	Residents and clients	Latino, minority, and underserved populations	9/20/2013	Focus Group
9.	9 participants	Promotoras	Minority populations, underserved, dental care, reproductive care, outreach	9/23/2013	Focus Group
10.	9 participants	Residents and clients	Latino, minority, and underserved populations	10/17/2013	Focus Group

**Interviews Participants (Identification)**

<b>Individuals with special knowledge of or expertise in public health</b>						
	<b>Name (Last First)</b>	<b>Title</b>	<b>Affiliation</b>	<b>Public Health Knowledge/ Expertise</b>	<b>Date of Consult</b>	<b>Type of Consult</b>
1.	Alexander, Patricia	Community Liaison Representative	Los Angeles County Department of Public Health	Public health and health services	9/29/13	Interview
2.	Alfaro, Verenisa	Clinical Social Worker	LAUSD Parent & Community Engagement	Social services	10/10/13	Interview
3.	Anderson, Margot	CEO	The Laurel Foundation	Business management, camp management, serving youth and families with HIV/AIDS	9/25/12	Interview
4.	Ballesteros, Al	CEO	JWCH Institute (John Wesley Community Health)	FQHC, primary care, mental health care for homeless and dual-diagnosis, HIV services	10/19/12	Interview
5.	Blakeney, Karen	Executive Director	Chinatown Service Center	Serving Asian Pacific immigrant and Latino communities (family resource center, clinics, workforce development)	10/22/12	Interview
6.	Boller, Robert	Director of Programs	Project Angel Food	Men, women, and children affects by HIV/AIDS, cancer, and other life-threatening illnesses.	9/6/13	Interview

<b>Individuals with special knowledge of or expertise in public health</b>						
	<b>Name (Last First)</b>	<b>Title</b>	<b>Affiliation</b>	<b>Public Health Knowledge/ Expertise</b>	<b>Date of Consult</b>	<b>Type of Consult</b>
7.	Bryan, Cynthia	Vice President, Human Resources	Didi Hirsh Mental Health Services	Human resource management	10/2/12	Interview
8.	Chidester, Cathy	Director of EMS	Los Angeles County ER Services	Public health and health services, emergency response services	9/4/13	Interview
9.	Coan, Carl	Executive Director	Eisner Pediatric Child and Family Center	Public health, human genetics, health care administration, and management	8/30/13	Interview
10.	Cox, Debra	Senior Director Foundation Relations	American Heart Association	Health equity, research, and funding	10/5/12	Interview
11.	Donovan, Kevin	Staff Analyst	Los Angeles County Department of Public Health, Maternal, Child and Adolescent Health Programs	Maternal, child, and adolescent health	10/2/12	Interview
12.	Kappos, Barbara	Executive Director	East Los Angeles Women’s Center	Domestic violence, sexual assault, and HIV	10/19/12	Interview
13.	Kim, Chrissy InHwe	Director of Health Program	American Cancer Society	General cancer education, research, and resources.	10/11/13	Interview
14.	Mandel, Susan, Ph.D.	President, CEO	Pacific Clinics	Clinical management and administration	10/3/12	Interview

Individuals with special knowledge of or expertise in public health						
	Name (Last First)	Title	Affiliation	Public Health Knowledge/ Expertise	Date of Consult	Type of Consult
15.	Marin, Maribel	Los Angeles Executive Director	211	Information and referral service serving LA County	10/15/12	Interview
16.	Martinez, Margie	CEO	Community Health Alliance of Pasadena	Public health	10/22/12	Interview
17.	Mondy, Cristin	Health Officer	Los Angeles County Department of Public Health	Public health and health services	10/8/13	Interview
18.	Munoz, Randy	Vice Chair	Latino Diabetes Association	Diabetes, preventive medicine, low-income, undocumented, and un/underinsured	10/22/12	Interview
19.	Murphy, Colleen	Director of Community Initiatives	PATH	Homeless population	8/29/13	Interview
20.	Nathason, Niel, DDS	Associate Dean	USC School of Dentistry	Low-income dental care services including children, youth, and adults, both in mobile and clinical contexts. Primary populations are low-income, disadvantaged and/or indigent.	9/12/12	Interview

<b>Individuals with special knowledge of or expertise in public health</b>						
	<b>Name (Last First)</b>	<b>Title</b>	<b>Affiliation</b>	<b>Public Health Knowledge/ Expertise</b>	<b>Date of Consult</b>	<b>Type of Consult</b>
21.	Portillo, Cesar	VP Advancement	LA Child Guidance Center	Low-income health care services including children, youth, and adults. Primary populations are low-income, disadvantaged and/or indigent.	9/10/13	Interview
22.	Rayfield, Beth	Director of Development	Coalition for Humane Immigrant Rights of Los Angeles	International labor union; organizing, working conditions, and contractual rights	10/2/12	Interview
23.	Reyna, Franco	Associate Director	American Diabetes Association	Diabetes, preventive medicine, low-income, undocumented, and un/underinsured	10/8/13	Interview
24.	Sayno, Jeanette H.	Bi-lingual Community Outreach Development Worker	FASGI	Low-income health and mental care services for low-income seniors.	9/13/13	Interview
25.	Schiffer, Wendy MSPH	Director of Planning and Evaluation	California Children's Medical Services	Public health and health services	10/3/12	Interview

<b>Individuals Consulted from Federal, Tribal, Regional, State or Local Health Departments or Other Departments or Agencies with Current Data or Other Relevant Information</b>						
	<b>Name (Last, First)</b>	<b>Title</b>	<b>Affiliation</b>	<b>Type of Department</b>	<b>Date of Consult</b>	<b>Type of Consult</b>
1.	Chidester, Cathy MSN	Director of EMS	Los Angeles County Emergency Medical Services (EMS)	Coordinating emergency services, including fire department, hospitals, and ambulance companies	10/17/12	Interview
2.	Donovan, Kevin	Staff Analyst	Los Angeles County Department of Public Health— Maternal, Child and Adolescent Health Programs	Local health department	10/2/12	Interview
3.	Murata, Dennis	Deputy Director	Los Angeles County Department of Mental Health	Local health department	10/22/12	Interview

### Prioritization Participants

	<b>Name (Last, First)</b>	<b>Affiliation</b>	<b>Public Health Knowledge/Expertise</b>	<b>Prioritization Session</b>	<b>Prioritization Survey</b>
1.	Bantug, Shirley B.	Filipino American Service Group, Inc.	Low-income health and mental care services for low-income seniors	Yes	Yes
2.	Boller, Robert	Project Angel Food	Men, women, and children with HIV/AIDS, Cancer, and life-threatening illnesses	No	Yes
3.	Brown, Tony	Heart of Los Angeles (HOLA)	Underserved youth living in high-risk communities	Yes	Yes
4.	Cervantes, Rachel	Alexandria House	Women and children in need of transitional housing and services	Yes	Yes

	<b>Name (Last, First)</b>	<b>Affiliation</b>	<b>Public Health Knowledge/Expertise</b>	<b>Prioritization Session</b>	<b>Prioritization Survey</b>
5.	Coan, Carl	Eisner Pediatric and Family Medical Center	Public health, human genetics, health care administration, and management	Yes	Yes
6.	del Rosario, Jesse	Filipino American Service Group, Inc.	Low-income health and mental care services for low-income seniors.	Yes	Yes
7.	Diaz, Carmen Molina	USC School of Dentistry	Low-income dental care services including children, youth, and adults, both in mobile and clinical contexts. Primary populations are low-income, disadvantaged and/or indigent.	No	Yes
8.	Donahue, Carole	SOSMentor	At-risk and underserved youth, health education, and advocacy	No	Yes
9.	Forman, Linda	Alliance for Housing and Healing	Men, women, children and families living with HIV/AIDS	Yes	Yes
10.	Gibb, Gordon	St. Barnabas Senior Services	Ageing population, nutrition and health education	Yes	Yes
11.	Goddard II, Terry	Alliance for Housing and Healing	Men, women, children and families living with HIV/AIDS	No	Yes
12.	Gorman, Dale	Kids Community Dental Clinic	Low-income children and their families in need of oral health care services	No	Yes

	<b>Name (Last, First)</b>	<b>Affiliation</b>	<b>Public Health Knowledge/Expertise</b>	<b>Prioritization Session</b>	<b>Prioritization Survey</b>
13.	Gramajo, Lilian	St. Vincent Medical Center	Public health and health services	No	Yes
14.	Guzman, Laura M.	Braille Institute	Blind and visually impaired both	Yes	Yes
15.	Hoh, John MD	Asian Pacific Health Care Venture, Inc	Health services including general diagnosis and treatment, behavioral health services, walk-in pregnancy testing, testing for HIV/AIDS and STIs, and screenings for bone density, breast, and cervical cancer.	No	Yes
16.	Howland, Susan	Alzheimer's Association	Alzheimer's disease and dementia	Yes	Yes
17.	Joe, Connie Chung	Korean American Family Services (KFAM)	Health and social services for Korean-American families	Yes	Yes
18.	Jordan, Christine	Toberman Neighborhood Center	Social support services and program for at-risk children and families	No	Yes
19.	Krowe, William	Alexandria House	Women and children in need of transitional housing and services	Yes	Yes
20.	Leal, Jesus	St. Vincent Medical Center, Casa de Amigos Community Learning Center	Public health and health services	No	Yes
21.	Lee, Susan	CSH - Corporation for Supportive Housing	Housing support services for at-risk populations	No	Yes

	<b>Name (Last, First)</b>	<b>Affiliation</b>	<b>Public Health Knowledge/Expertise</b>	<b>Prioritization Session</b>	<b>Prioritization Survey</b>
22.	Martin, Margaret	Harmony Project	At-risk youth in underserved communities	Yes	Yes
23.	Matos, Veronica	Heart of Los Angeles (HOLA)	Underserved youth living in high-risk communities	Yes	Yes
24.	Nathason, Niel	USC School of Dentistry	Low-income dental care services including children, youth, and adults, both in mobile and clinical contexts. Primary populations are low-income, disadvantaged and/or indigent.	No	Yes
25.	Nunez, Trini E.	A Window Between Worlds	Domestic violence support services	Yes	Yes
26.	Pardo, Luis	Worksite Wellness LA	Low-income, underserved families; health education	No	Yes
27.	Portillo, Cesar	Los Angeles Child Guidance Center	Low-income health care services including children, youth, and adults. Primary populations are low-income, disadvantaged and/or indigent.	Yes	Yes
28.	Reyes, Perla S.	Mother Movement	At-risk mothers	Yes	Yes
29.	Rivera, Jennifer	Los Angeles County Department of Public Health - Community Health Service	Public health and health services	Yes	Yes
30.	Sayno, Jeanette H.	Filipino American Service Group, Inc.	Low-income health and mental care services for low-income seniors.	Yes	Yes

	<b>Name (Last, First)</b>	<b>Affiliation</b>	<b>Public Health Knowledge/Expertise</b>	<b>Prioritization Session</b>	<b>Prioritization Survey</b>
31.	Strickland, Myungeum	Angelus Plaza Senior Housing	Low-income seniors	Yes	Yes

## Appendix C—Scorecard

2013 Metro Collaborative CHNA - Health Needs and Drivers Summary Scorecard

DATA INDICATOR	Year of Data	Healthy People 2020 Target	Comparison Level	Comparison Average	CHMC Service Area Average	GSH Service Area Average	SVMC Service Area Average	Focus Groups**	Interviews**
<b>HEALTH NEEDS</b>									
<b>Alcohol Abuse</b>									
Percent of adults 18 and older who reported binge drinking in the past month <sup>^</sup>	2011		LAC	15.4%	<b>17.2%</b>	<b>18.1%</b>	<b>18.1%</b>		
Percent of adults 18 and older who reported drinking alcohol in the past month <sup>^</sup>	2011		LAC	51.9%	<b>54.3%</b>	46.6%	46.6%		
Percent of adults 18 and older who reported heavy drinking in the past month <sup>^</sup>	2011		LAC	3.5%	<b>3.8%</b>	<b>3.6%</b>	<b>3.6%</b>		
Percent of adults 18 and older who reported they needed or wanted treatment for alcohol or drug program (excluding tobacco) in the past 5 years <sup>^</sup>	2011		LAC	2.5%	2.4%	<b>2.8%</b>	<b>2.8%</b>		
<i>Alcoholism</i>								2	6
<b>Allergies</b>									
Percent of teens with allergies <sup>^</sup>	2007		LAC	24.9%	27.1%	<b>32.5%</b>	<b>32.5%</b>		
<i>Allergies</i>								2	5
<b>Alzheimer's Disease</b>									
Rate of Alzheimer's disease mortality rate per 10,000 pop.†	2010		CA	2.9	<b>9.8</b>	<b>7.0</b>	<b>10.5</b>		
<i>Memory loss</i>								1	3
<b>Arthritis</b>									
Percent of adults diagnosed with arthritis <sup>^</sup>	2011		LAC	17.4%	16.3%	15.9%	15.9%		
<i>Arthritis</i>								3	2
<b>Asthma</b>									
Percent of children 17 and under who were diagnosed with asthma <sup>^</sup>	2011		LAC	9.0%	7.5%	6.9%	6.9%		
<i>Asthma</i>								2	4
<b>Breast Cancer</b>									
Rate of breast cancer incidence per 100,000 pop.*	2009	<=20.6	CA	122.0	116.0	116.0	116.0		
Rate of breast cancer mortality per 100,000 pop.†	2008		LAC	21.2	17.1	12.7	18.1		
<i>Breast cancer</i>								0	5
<b>Cancer, in general</b>									
Percent of women that had a cervical cancer screening in the last 3 years <sup>^</sup>	2011	<=93%	LAC	82.8%	84.1%	84.7%	84.7%		
Percent of women that had a mammogram in the last 2 years <sup>^</sup>	2011	<=81.1%	LAC	79.8%	<b>79.2%</b>	<b>79.2%</b>	<b>79.2%</b>		
Rate of cancer mortality per 100,000 pop.†	2010		CA	15.1	<b>58.5</b>	<b>34.4</b>	<b>59.5</b>		
Rate of cervical cancer incidences per 100,000 pop.*	2010	<=2.2	CA	8.0	9.4	9.4	9.4		
Rate of cervical cancer mortality per 100,000 pop.†	2008		LAC	3.0	<b>5.3</b>	1.6	<b>22.0</b>		
Rate of prostate cancer incidences per 100,000 pop.*	2010	<=21.2	CA	140.3	134.3	134.3	134.3		
<i>Brain cancer</i>								0	1
<i>Cancer, in general</i>								3	3
<i>Cervical cancer</i>								0	1

2013 Metro Collaborative CHNA - Health Needs and Drivers Summary Scorecard

DATA INDICATOR	Year of Data	Healthy People 2020 Target	Comparison Level	Comparison Average	CHMC Service Area Average	GSH Service Area Average	SVMC Service Area Average	Focus Groups**	Interviews**
<b>Legend</b> †Data from secondary sources aggregated using ZIP codes in the hospital service area ^Data from secondary sources reflecting the entire Service Planning Area (SPA) *Data reflect the county level An <i>italicized indicator</i> denotes qualitative data collected in the community focus group Comparison levels: CA - California LAC - LA County									
<i>Ovarian cancer</i>								0	1
<i>Prostate cancer</i>								0	1
<i>Stomach cancer</i>								0	1
<b>Cardiovascular Disease</b>									
Percent of adults receiving heart disease management services from a care provider^	2011-2012		LAC	73.3%	71.0%	70.6%	70.6%		
Percent of heart disease prevalence^	2011		LAC	24.0%	22.6%	<b>24.4%</b>	<b>24.4%</b>		
Rate of cardiovascular disease mortality per 10,000 pop.†	2010		CA	15.6	<b>68.3</b>	<b>42.0</b>	<b>73.8</b>		
Rate of heart disease hospitalization per 100,000 pop.†	2010		CA	367.1	<b>445.3</b>	<b>418.3</b>	<b>424.6</b>		
<i>Cardiovascular disease</i>								5	5
<b>Cholesterol</b>									
Percent of adults 18 and older ever diagnosed with high cholesterol^	2011		LAC	25.6%	24.6%	23.5%	23.5%		
<i>Cholesterol</i>								2	2
<b>Colorectal Cancer</b>									
Percent who had a doctor recommend a colon test in the past 5 years^	2011-2012		LAC	35.1%	34.5%	24.1%	24.1%		
Percent who had a sigmoidoscopy, colonoscopy, or FOBT^	2011-2012	<=70.5%	LAC	75.7%	<b>75.2%</b>	<b>70.1%</b>	<b>70.1%</b>		
Rate of colorectal cancer incidences per 100,000 pop.*	2010	<=14.5	CA	37.3	<b>38.2</b>	<b>38.2</b>	<b>38.2</b>		
Rate of colorectal cancer mortality per 100,000 pop.†	2008		LAC	11.2	8.8	6.5	9.8		
<i>Colorectal cancer</i>								0	3
<b>Diabetes</b>									
Percent of adults 18 and older ever diagnosed with diabetes^	2011		LAC	9.5%	8.2%	8.7%	8.7%		
Percent of adults who feel confident in their ability to manage their diabetes^	2011-2012		LAC	86.4%	<b>79.8%</b>	<b>80.1%</b>	<b>80.1%</b>		
Rate of adult diabetes hospitalizations per 100,000 pop.†	2010		CA	145.6	<b>228.2</b>	<b>197.3</b>	<b>193.3</b>		
Rate of diabetes mortality per 10,000 pop.†	2010		CA	1.9	<b>8.4</b>	<b>9.8</b>	<b>9.8</b>		
Rate of hospitalizations for uncontrolled diabetes per 100,000 pop.†	2009		CA	9.5	<b>24.1</b>	<b>22.5</b>	<b>20.3</b>		
Rate of youth diabetes hospitalizations per 100,000 pop.†	2010		CA	34.9	26.8	9.1	21.6		
<i>Diabetes</i>								8	11
<b>Hypertension</b>									
Percent of adults ever diagnosed with high blood pressure^	2011	<=26.9%	LAC	24.0%	22.6%	<b>24.4%</b>	<b>24.4%</b>		
Percent of adults taking any medications to control their high blood pressure^	2009	<=69.5%	LAC	70.4%	<b>68.5%</b>	<b>65.3%</b>	<b>65.3%</b>		
Rate of hypertension mortality per 10,000 pop.†	2010		CA	1.0	<b>5.1</b>	<b>2.6</b>	<b>5.1</b>		
<i>Hypertension</i>								4	4
<b>HIV/AIDS</b>									
Rate of HIV mortality per 100,000 pop.^	2012		LAC	3.0	<b>5.7</b>	<b>6.8</b>	<b>6.8</b>		
Rate of HIV/AIDS hospitalizations per 100,000 pop.†	2010		CA	11.0	<b>36.5</b>	<b>56.1</b>	<b>43.4</b>		

2013 Metro Collaborative CHNA - Health Needs and Drivers Summary Scorecard

DATA INDICATOR	Year of Data	Healthy People 2020 Target	Comparison Level	Comparison Average	CHMC Service Area Average	GSH Service Area Average	SVMC Service Area Average	Focus Groups**	Interviews**
<b>Legend</b> †Data from secondary sources aggregated using ZIP codes in the hospital service area ^Data from secondary sources reflecting the entire Service Planning Area (SPA) *Data reflect the county level An <i>italicized indicator</i> denotes qualitative data collected in the community focus group Comparison levels: CA - California LAC - LA County									
Rate of HIV/AIDS incidences per 100,000 pop.^ <i>HIV/AIDS</i>	2012		LAC	24.9	<b>38.9</b>	<b>55.7</b>	<b>55.7</b>	2	2
<b>Mental Health</b>									
Average number of poor mental and/or physical health days in the past month reported by adults^	2011		LAC	5.4	5.3	<b>5.9</b>	<b>5.9</b>		
Percent of adults 18 and older ever diagnosed with anxiety^	2011		LAC	11.3%	<b>11.5%</b>	11.1%	11.1%		
Percent of adults 18 and older ever diagnosed with depression^	2011		LAC	12.2%	<b>12.1%</b>	12.1%	12.1%		
Percent of adults who had serious psychological distress in the last year^	2011-2012		LAC	8.0%	<b>8.1%</b>	<b>9.2%</b>	<b>9.2%</b>		
Percent of adults who received adequate social an emotional support^	2011		LAC	64.0%	70.3%	<b>64.4%</b>	<b>64.4%</b>		
Rate of adult alcohol and drug induced mental illness per 100,000 pop. †	2010		CA	109.1	102.0	<b>199.9</b>	<b>112.9</b>		
Rate of adult hospitalizations per 100,000 pop. †	2010		CA	551.7	<b>763.1</b>	<b>1091.3</b>	<b>715.0</b>		
Rate of suicides per 10,000 pop. †	2010	<=1.0	CA	1.0	0.6	<b>1.1</b>	0.7		
Rate of youth (under 18) hospitalizations per 100,000 pop. †	2010		CA	256.4	<b>343.5</b>	<b>302.4</b>	<b>308.5</b>		
<i>Anxiety</i>								2	5
<i>Attention deficit hyperactivity disorder (ADHD)</i>								1	5
<i>Autism</i>								1	3
<i>Behavioral issues</i>								0	2
<i>Bi-polar disease</i>								0	2
<i>Depression</i>								3	4
<i>Developmental delays</i>								0	1
<i>Mental health (general)</i>								2	10
<i>Post Traumatic Stress Disorder</i>								1	1
<i>Stress</i>								4	2
<i>Suicide</i>								1	2
<b>Obesity/Overweight</b>									
Percent of adults who are obese^	2011-2012	<=30.5%	LAC	24.7%	15.7%	15.6%	15.6%		
Percent of adults who are overweight^	2011-2012		LAC	34.2%	29.4%	25.9%	25.9%		
Percent of children 2-11 years old who are overweight^	2011-2012		LAC	13.3%	12.0%	<b>16.1%</b>	<b>16.1%</b>		
Percent of teens 12-17 years old who are overweight or obese^	2011-2012		LAC	17.1%	13.6%	14.5%	14.5%		
<i>Obesity</i>								6	12
<b>Oral Health (see Specialty Care Access below)</b>									
<i>Oral health</i>								7	10
<b>Sexually Transmitted Diseases</b>									
Rate of hepatitis C prevalence per 100,000 pop.^	2011		LAC	4.0	0.1	0.1	0.1		
Rate of chlamydia prevalence per 100,000 pop.^	2011		LAC	512.9	<b>592.4</b>	<b>793.6</b>	<b>793.6</b>		

2013 Metro Collaborative CHNA - Health Needs and Drivers Summary Scorecard

DATA INDICATOR	Year of Data	Healthy People 2020 Target	Comparison Level	Comparison Average	CHMC Service Area Average	GSH Service Area Average	SVMC Service Area Average	Focus Groups**		Interviews**	
<b>Legend</b> †Data from secondary sources aggregated using ZIP codes in the hospital service area ^Data from secondary sources reflecting the entire Service Planning Area (SPA) *Data reflect the county level An <i>italicized indicator</i> denotes qualitative data collected in the community focus group Comparison levels: CA - California LAC - LA County											
Rate of gonorrhea prevalence per 100,000 pop.^ <i>Chlamydia</i> <i>Gonorrhea</i> <i>Hepatitis C</i> <i>Sexually transmitted diseases</i> <i>Sexually transmitted infections</i>	2011		LAC	103.4	154.7	218.3	218.3	0	1	0	1
<b>Substance Abuse</b> Percent of adults 18 and older who are currently smoking^ Percent of adults 18 and older who reported they needed or wanted treatment for alcohol or drug program (excluding tobacco) in the past 5 years^ Percent of teens 12-17 who used marijuana in the past year^ Rate of alcohol/drug induced mental disease hospitalizations per 100,000 pop.† <i>Substance abuse</i>	2011 2011 2011-2012 2010		LAC LAC LAC CA	13.1% 2.5% 10.2% 109.1	12.7% 2.4% 14.2% 102.0	14.1% 2.8% 17.3% 199.9	14.1% 2.8% 17.3% 112.9			5	6
<b>Vision</b> Percent of adults who had an eye exam with dilated pupils in last year^ <i>Vision</i>	2009		LAC	63.3%	57.6%	50.2%	50.2%	2	4		
<b>DRIVERS OF HEALTH</b>											
<b>Alcohol and Substance Abuse</b> Percent of adults 18 and older who are currently smoking^ Rate of alcohol retailers per 1,000 pop.† <i>Liquor store access</i> <i>Marijuana dispensaries (increase)</i>	2011 2012		LAC	13.1% N/A	12.7% 1.8	14.1% 3.7	14.1% 2.2	2	0	1	2
<b>Community violence</b> Percent of adults 18 and older who perceive their neighborhood to be safe from crime^ Percent of caregivers of children under 18 years old who perceive their neighborhood safety to be fair or poor^ <i>Bullying</i> <i>Community violence</i>	2011 2011		LAC LAC	84.3% 29.0%	83.4% 31.7%	74.6% 39.9%	74.6% 39.9%	2	1	3	8
<b>Coordinated Healthcare</b> <i>Coordinated healthcare</i> <i>Inability to navigate healthcare system</i> <i>Patient advocacy</i>								0	5	2	2
								2	2		

2013 Metro Collaborative CHNA - Health Needs and Drivers Summary Scorecard

DATA INDICATOR	Year of Data	Healthy People 2020 Target	Comparison Level	Comparison Average	CHMC Service Area Average	GSH Service Area Average	SVMC Service Area Average	Focus Groups**	Interviews**
<b>Legend</b> †Data from secondary sources aggregated using ZIP codes in the hospital service area ^Data from secondary sources reflecting the entire Service Planning Area (SPA) *Data reflect the county level An <i>italicized indicator</i> denotes qualitative data collected in the community focus group Comparison levels: CA - California LAC - LA County									
<b>Cultural Barriers</b> Percent who have a hard time understanding doctor^ <i>Cultural competency</i> <i>Stigma</i>	2009		LAC	4.7%	4.5%	<b>6.7%</b>	<b>6.7%</b>	3 3	3 3
<b>Disease Management</b> Percent of adults receiving heart disease management services from a care provider^ Percent of adults who feel confident in their ability to manage their diabetes^ Percent of adults who take medication to control their high blood pressure^ <i>Inability to manage chronic disease</i>	2011-2012 2011-2012 2011-2012		LAC LAC LAC	73.3% 86.4% 70.4%	<b>71.0%</b> <b>79.8%</b> <b>68.5%</b>	<b>70.6%</b> <b>80.1%</b> <b>65.3%</b>	<b>70.6%</b> <b>80.1%</b> <b>65.3%</b>	0	3
<b>Health Care Access</b> Number of Federally Qualified Health Centers^ Percent of adults 18 and older who could not afford needed prescription drugs in the past year^ Percent of adults 18 and older who delayed or didn't get medical care^ Percent of adults 18 and older who delayed or didn't get prescriptions^ Percent of adults 18 and older without health insurance^ Percent of adults who have a usual source of care^ Percent of adults 18 and older who had a difficult time accessing medical care^ Percent of children who had a difficult time accessing medical care^ Percent of youth 17 and under without health insurance^ Percent who visited the emergency room in the past 12 months^ <i>Access to health care services</i> <i>Access to medication (dispensaries and cost)</i> <i>Capacity issues including program cuts</i> <i>Lack of local urgent care and hospital locations</i> <i>Time spent with patient (insufficient)</i> <i>Uninsured</i> <i>Waiting time (prolonged)</i>	2012 2011 2011-2012 2011-2012 2011 2011-2012 2011 2011 2011-2012		LAC LAC LAC LAC LAC LAC LAC LAC	183 15.4% 12.2% 9.5% 28.5% 83.3% 31.7% 12.3% 5.0% 18.2%	30 14.8% <b>13.3%</b> <b>10.5%</b> 28.3% <b>83.4%</b> <b>32.0%</b> 11.1% <b>5.3%</b> <b>18.7%</b>	46 <b>17.1%</b> 11.8% <b>10.2%</b> <b>36.9%</b> 80.0% <b>41.3%</b> <b>14.9%</b> <b>7.6%</b> <b>19.4%</b>	46 <b>17.1%</b> 11.8% <b>10.2%</b> <b>36.9%</b> 80.0% <b>41.3%</b> <b>14.9%</b> <b>7.6%</b> <b>19.4%</b>	4 1 0 0 1 1 1	17 1 5 3 0 5 6
<b>Healthy Eating</b> Percent of adults 18 and older who consumed at least one soda or sweetened drink a day^ Percent of adults 18 and older who reported eating fast food at least once a week^ Percent of children 17 and under who reported drinking at least one soda or sweetened drink per day^ Percent of adults 18 and older who reported eating five or more servings of fruit and vegetables per day^ Percent of children 17 and under who consumed fast food in the last week^	2011 2011 2011 2011-2012 2011		LAC LAC LAC LAC LAC	35.5% 40.0% 38.3% 48.4% 50.5%	32.2% 36.4% 37.1% 47.7% 46.7%	<b>36.6%</b> 39.4% <b>43.0%</b> 44.3% <b>51.2%</b>	<b>36.6%</b> 39.4% <b>43.0%</b> 44.3% <b>51.2%</b>		

2013 Metro Collaborative CHNA - Health Needs and Drivers Summary Scorecard

<b>DATA INDICATOR</b>	Year of Data	Healthy People 2020 Target	Comparison Level	Comparison Average	CHMC Service Area Average	GSH Service Area Average	SVMC Service Area Average	Focus Groups**	Interviews**
<p><b>Legend</b></p> <p>†Data from secondary sources aggregated using ZIP codes in the hospital service area</p> <p>^Data from secondary sources reflecting the entire Service Planning Area (SPA)</p> <p>*Data reflect the county level</p> <p>An <i>italicized indicator</i> denotes qualitative data collected in the community focus group</p> <p>Comparison levels: CA - California LAC - LA County</p>									
<p>Percent of youth eating less than five servings of fruits/vegetables per day<sup>^</sup></p> <p><i>Access to healthy food options</i></p>	2011-2012		LAC	55.4%	54.2%	55.4%	55.4%	9	14
<p><b>Health Education and Awareness</b></p> <p>Percent of population who received a high school diploma†</p> <p>Percent of population who speak a language other than English at home†</p> <p><i>Health education and awareness</i></p> <p><i>Information regarding eligibility of benefits and available services</i></p> <p><i>Language barrier</i></p> <p><i>Multi-lingual health information</i></p>	2013 2013		LAC LAC	20.4% 57.1%	<b>21.7%</b>	20.7% <b>75.3%</b>	20.4% <b>69.9%</b>	8 2 6 0	15 4 10 4
<p><b>Homelessness</b></p> <p>Number of homeless persons<sup>^</sup></p> <p>Percent of adults 18 and older below the 300% Federal Poverty Line who reported being homeless in the past two years<sup>^</sup></p> <p><i>Homelessness</i></p>	2013 2011		LAC LAC	53,798 4.2%	32,177 <b>4.9%</b>	21,704 <b>4.9%</b>	21,704 <b>4.9%</b>	2	7
<p><b>Housing</b></p> <p><i>Affordable housing</i></p> <p><i>Poor housing conditions</i></p>								2 4	3 2
<p><b>Immigration Status</b></p> <p>Percent who are foreign born and are not U.S. Citizens<sup>^</sup></p> <p><i>Immigration status</i></p>	2010		LAC	19.2%	<b>20.0%</b>	<b>27.1%</b>	<b>27.1%</b>	5	9
<p><b>Physical Activity</b></p> <p>Percent of adults 18 and older who do not participate in weekly physical activity<sup>^</sup></p> <p>Percent of adults reporting no walking space or open/green space in their neighborhood<sup>^</sup></p> <p>Percent of adults who visited a park, playground, or other open space in the past month<sup>^</sup></p> <p>Percent of children 17 and under who do not participate in weekly physical activity<sup>^</sup></p> <p>Percent of children who visited a park, playground, or other open space in the past month<sup>^</sup></p> <p>Rate of open space per 10,000 children 0-5 years old†</p> <p><i>Green space</i></p> <p><i>Physical activity</i></p>	2011 2011 2011-2012 2011 2011-2012 2013		LAC LAC LAC LAC LAC CA	12.0% 14.2% 66.4% 10.9% 80.9% 82418.2	10.9% 14.4% 68.6% 9.5% 81.8% 27.2	11.3% <b>17.7%</b> 66.4% <b>11.7%</b> <b>80.4%</b> 0.5	11.3% <b>17.7%</b> 66.4% <b>11.7%</b> <b>80.4%</b> 1.3	1 2	5 5
<p><b>Preventative Care Services</b></p> <p>Percent of adults 18 and older who received a flu vaccination in the past 12 months<sup>^</sup></p> <p>Percent of adults 65 and older who received a pneumonia vaccination in the past 12 months<sup>^</sup></p> <p>Percent who did not visit a doctor at least once in the past 12 months<sup>^</sup></p> <p><i>Preventative care</i></p>	2011 2011 2011-2012		LAC LAC LAC	33.7% 61.3% 18.0%	<b>32.4%</b> <b>60.5%</b> 17.8%	<b>29.3%</b> <b>57.5%</b> <b>20.5%</b>	<b>29.3%</b> <b>57.5%</b> <b>20.5%</b>	0	5

2013 Metro Collaborative CHNA - Health Needs and Drivers Summary Scorecard

DATA INDICATOR	Year of Data	Healthy People 2020 Target	Comparison Level	Comparison Average	CHMC Service Area Average	GSH Service Area Average	SVMC Service Area Average	Focus Groups**	Interviews**
<b>Legend</b> †Data from secondary sources aggregated using ZIP codes in the hospital service area ^Data from secondary sources reflecting the entire Service Planning Area (SPA) *Data reflect the county level An <i>italicized indicator</i> denotes qualitative data collected in the community focus group Comparison levels: CA - California LAC - LA County									
<b>Poverty (including unemployment)</b>									
Percent of adults unable to afford enough food (food insecurity) <sup>†</sup>	2011-2012		LAC	42.2%	<b>43.0%</b>	<b>43.0%</b>	<b>43.0%</b>		
Percent of families living below poverty <sup>†</sup>	2013		LAC	13.5%	<b>27.6%</b>	<b>26.6%</b>	<b>26.0%</b>		
Percent of families with children living below poverty <sup>†</sup>	2013		LAC	10.7%	<b>23.1%</b>	<b>20.8%</b>	<b>21.1%</b>		
Percent of households with children under 18 who received food stamps/SNAP in the past 12	2010		LAC	27.1%	<b>54.0%</b>	<b>35.4%</b>	<b>35.4%</b>		
Percent of people 16 and older who are not employed <sup>†</sup>	2013		LAC	34.8%	<b>35.6%</b>	<b>35.8%</b>	33.3%		
Percent of students receiving free or reduced meals in school <sup>†</sup>	2011		LAC	61.8%	<b>69.4%</b>	<b>87.4%</b>	<b>87.4%</b>		
Rate of unemployment*	2013		CA	8.1	<b>9.2</b>	<b>9.2</b>	<b>9.2</b>		
<i>Poverty</i>								5	9
<i>Underemployment</i>								1	1
<i>Unemployment</i>								5	7
<i>Worsening economy</i>								0	4
<b>Specialty Care Access</b>									
Percent of adults 18 and older unable to obtain dental care including check-ups in the past year because they could not afford it <sup>†</sup>	2011		LAC	30.3%	29.9%	<b>36.3%</b>	<b>36.3%</b>		
Percent of adults 18 and older with dental insurance <sup>†</sup>	2011		LAC	48.2%	46.8%	<b>38.0%</b>	<b>38.0%</b>		
Percent of children 17 and under without dental insurance <sup>†</sup>	2011		LAC	78.2%	76.2%	75.8%	75.8%		
Percent of children 3-17 years old who were unable to afford dental care and check-ups in the past year <sup>†</sup>	2011		LAC	12.6%	11.7%	<b>13.1%</b>	<b>13.1%</b>		
Percent of children who have never been to the dentist <sup>†</sup>	2011-2012		LAC	9.2%	8.1%	7.9%	7.9%		
Percent of diabetic adults who had an eye exam in the last year <sup>†</sup>	2009		LAC	63.3%	<b>57.6%</b>	<b>50.2%</b>	<b>50.2%</b>	1	3
<i>Dental services</i>								1	3
<i>Specialty care services (i.e. vision, auditory)</i>									
<b>Social Barriers</b>									
Percent of adults 15 and older who are divorced <sup>†</sup>	2013		LAC	8.5%	7.3%	7.2%	7.5%		
Percent of children living with both parents in one household <sup>†</sup>	2013		LAC	32.4%	<b>27.2%</b>	<b>26.3%</b>	<b>26.7%</b>		
<i>Child care</i>								4	2
<i>Family issues (i.e. single parent home)</i>								2	3
<i>Time to visit a physician</i>								2	3
<b>Transportation</b>									
<i>Transportation</i>								7	11

2013 Metro Collaborative CHNA - Health Needs and Drivers Summary Scorecard

DATA INDICATOR	Year of Data	Healthy People 2020 Target	Comparison Level	Comparison Average	CHMC Service Area Average	GSH Service Area Average	SVMC Service Area Average	Focus Groups**	Interviews**
----------------	--------------	----------------------------	------------------	--------------------	---------------------------	--------------------------	---------------------------	----------------	--------------

**Legend**

†Data from secondary sources aggregated using ZIP codes in the hospital service area  
 ^Data from secondary sources reflecting the entire Service Planning Area (SPA)  
 \*Data reflect the county level  
 An *italicized indicator* denotes qualitative data collected in the community focus group  
 Comparison levels: CA - California LAC - LA County

**FOOTNOTES**

N/A=no data available  
 \*\* = Count reflects the number of times a participant identified a health need or driver during the focus groups or interviews.

**CALIFORNIA HOSPITAL MEDICAL CENTER SERVICE AREA:**

- Primary  
 90003 (South Los Angeles, SPA 6)  
 90006 (Pico Heights, SPA 4)  
 90007 (South Los Angeles, SPA 6)  
 90011 (South Los Angeles, SPA 6)  
 90015 (Downtown Los Angeles, SPA 4)  
 90016 (West Adam, SPA 6)  
 90018 (Jefferson Park, SPA 6)  
 90019 (Country Club Park/Mid City, SPA 4)  
 90037 (South Los Angeles, SPA 6)  
 90044 (Athens, SPA 8)  
 90062 (South Los Angeles, SPA 6)  
 90071 (ARCO Towers, SPA 4)
- Secondary  
 90001 (South Los Angeles/Florence, SPA 6)  
 90002 (Watts, SPA 6)  
 90004 (Hancock Park, SPA 4)  
 90005 (Koreatown, SPA 4)  
 90008 (Baldwin Hills/Crenshaw, SPA 6)  
 90010 (Wilshire, SPA 4)  
 90017 (Downtown Los Angeles, SPA 4)  
 90020 (Hancock Park, SPA 4)  
 90026 (Echo Park/Silverlake, SPA 4)  
 90043 (Hyde Park, SPA 6)  
 90047 (South Los Angeles, SPA 6)  
 90057 (Westlake, SPA 4)

**GOOD SAMARITAN HOSPITAL SERVICE AREA:**

- 90004 (Hancock Park, SPA 4)  
 90005 (Koreatown, SPA 4)  
 90006 (Pico Heights, SPA 4)  
 90007 (South Los Angeles, SPA 6)  
 90010 (Wilshire, SPA 4)  
 90012 (Chinatown, SPA 4)  
 90013 (Downtown Los Angeles, SPA 4)  
 90014 (Los Angeles, SPA 4)  
 90015 (Downtown Los Angeles, SPA 4)  
 90017 (Downtown Los Angeles, SPA 4)  
 90018 (Jefferson Park, SPA 6)  
 90020 (Hancock Park, SPA 4)  
 90021 (Downtown Los Angeles, SPA 4)  
 90026 (Echo Park/Silverlake, SPA 4)  
 90057 (Westlake, SPA 4)  
 90071 (ARCO Towers, SPA 4)

**ST. VINCENT MEDICAL CENTER SERVICE AREA:**

- 90004 (Hancock Park, SPA 4)  
 90005 (Koreatown, SPA 4)  
 90006 (Pico Heights, SPA 4)  
 90007 (South Los Angeles, SPA 6)  
 90008 (Baldwin Hills/Crenshaw, SPA 6)  
 90010 (Wilshire, SPA 4)  
 90011 (South Los Angeles, SPA 6)  
 90016 (West Adam, SPA 6)  
 90017 (Downtown Los Angeles, SPA 4)  
 90018 (Jefferson Park, SPA 6)  
 90019 (Country Club Park/Mid City, SPA 4)  
 90020 (Hancock Park, SPA 4)  
 90026 (Echo Park/Silverlake, SPA 4)  
 90027 (Griffith Park/Los Feliz, SPA 4)  
 90028 (Hollywood, SPA 4)  
 90029 (Downtown Los Angeles, SPA 4)  
 90031 (Montecito Heights, SPA 4)  
 90037 (South Los Angeles, SPA 6)  
 90044 (Athens, SPA 8)  
 90046 (Mount Olympus, SPA 4)

## Appendix D—Data Sources

Category	Indicator	Data Area	Data Source	Geography	Benchmark
Access to Care	Absence of Dental Insurance Coverage (Adults)	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average
Access to Care	Absence of Dental Insurance Coverage (Children 0-17)	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average
Access to Care	Beneficiaries Eligible and Enrolled in Medi-Cal	CA Only	California Department of Health Care Services (DHCS), 2011	ZIP Code	County Average
Access to Care	Covered by Medi-Cal	CA Only	California Health Interview Survey (CHIS), 2011-2012	ZIP Code	County Average
Access to Care	Delayed or didn't get medical care	CA Only	California Health Interview Survey (CHIS), 2011-2012	ZIP Code	County Average
Access to Care	Delayed or didn't get prescriptions	CA Only	California Health Interview Survey (CHIS), 2011-2012	ZIP Code	County Average
Access to Care	Difficulty Accessing Medical Care	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average
Access to Care	Difficulty Understanding Doctor	CA Only	California Health Interview Survey (CHIS), 2011-2012	ZIP Code	County Average
Access to Care	Do Not Have a Usual Source of Care	CA Only	California Health Interview Survey (CHIS), 2011-2012	ZIP Code	County Average
Access to Care	Healthy Families Enrollment	CA Only	Managed Risk Medical Insurance Board, 2010	ZIP Code	County Average
Access to Care	Lack of a Consistent Source of Primary Care	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average
Access to Care	Medicare Beneficiaries	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average
Access to Care	Needed help for mental/emotional/alcohol-drug issues but did not receive treatment	CA Only	California Health Interview Survey (CHIS), 2011-2012	SPA	County Average

Access to Care	Received a Flu Vaccination in the Past 12 Months (Adults)	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average
Access to Care	Received a Pneumonia Vaccination in the Past 12 Months (Adults 65 and older)	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average
Access to Care	Unable to Afford Dental Care (Adults)	CA Only	California Health Interview Survey (CHIS), 2011-2012	SPA	County Average
Access to Care	Unable to Afford Dental Care (Children 3-17)	CA Only	California Health Interview Survey (CHIS), 2011-2012	SPA	County Average
Access to Care	Unable to Afford Medications	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average
Access to Care	Unable to Afford Mental Health Care	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average
Access to Care	Unable to Afford to See Doctor for a Health Problem	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average
Access to Care	Uninsured Population (0-17 years old)	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average
Access to Care	Uninsured Population (18-64 years old)	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average
Access to Care	Visited the Emergency Room in the last 12 months	CA Only	California Health Interview Survey (CHIS), 2011-2012	ZIP Code	County Average
Clinical Care	Adults ages 50 and older ever have a sigmoidoscopy, colonoscopy, or FOBT	CA Only	California Health Interview Survey (CHIS), 2011-2012	SPA	County Average
Clinical Care	Adults ages 50 and older have a sigmoidoscopy, colonoscopy in the last 5 years	CA Only	California Health Interview Survey (CHIS), 2011-2012	SPA	County Average
Clinical Care	Breast Cancer Screening (Mammogram) in the last 2 Years (Women 50-74)	U.S.	Los Angeles County Health Survey, 2011	SPA	County Average
Clinical Care	Cervical Cancer Screening in last 3 years (Women 18-65)	U.S.	Los Angeles County Health Survey, 2011	SPA	County Average
Clinical Care	Colon Cancer Screening (Sigmoid/Colonoscopy)	CA Only	California Health Interview Survey (CHIS), 2011-2012	SPA	County Average

Clinical Care	Dental Care Utilization (Child)	CA Only	California Health Interview Survey (CHIS), 2011-2012	SPA	County Average
Clinical Care	Diabetes Management (not able to control/manage diabetes)	CA Only	California Health Interview Survey (CHIS), 2011-2012	SPA	County Average
Clinical Care	Federally Qualified Health Centers	U.S.	U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA), 2012	ZIP Code	County Average
Clinical Care	Hard Time Understanding Doctor	CA Only	California Health Interview Survey (CHIS), 2011-2012	SPA	County Average
Clinical Care	Heart Disease Management (Recieved Plan from Health Professional)	CA Only	California Health Interview Survey (CHIS), 2011-2012	SPA	State Average
Clinical Care	High Blood Pressure Management (takes medicine)	CA Only	California Health Interview Survey (CHIS), 2011-2012	SPA	State Average
Clinical Care	Influenza Vaccinations (Age 18+)	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average
Clinical Care	Influenza Vaccinations (Age 65+)	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average
Clinical Care	Lack of Prenatal Care	CA Only	California Department of Public Health, 2011	ZIP Code	State Average
Clinical Care	Pneumonia Vaccinations (Age 65+)	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average
Clinical Care	Visited the Doctor at Least Once in the Past 12 Months	CA Only	California Health Interview Survey (CHIS), 2011-2012	SPA	County Average
Demographics	Change in Total Population	U.S.	U.S. Census Bureau, 2000 Census of Population and Housing, Summary File 1; U.S. Census Bureau, 2010 Census of Population and Housing, Summary File 1	ZIP Code	County Average
Demographics	Children Entering Foster Care	CA Only	California Department of Social Services & University of California Berkeley Child Welfare Dynamic Report System, 2012	ZIP Code	County Average
Demographics	Citizenship Statis	U.S.	American Community Survey 5-Year Estimates, 2011	County	State Average

Demographics	Ethnicity	U.S.	Nielsen Claritas SiteReports, 2013	ZIP Code	County Average
Demographics	Household count	U.S.	Nielsen Claritas SiteReports, 2013	ZIP Code	County Average
Demographics	Language Spoken at home	U.S.	Nielsen Claritas SiteReports, 2013	ZIP Code	County Average
Demographics	Marital Status	U.S.	Nielsen Claritas SiteReports, 2013	ZIP Code	County Average
Demographics	Median Age	U.S.	Nielsen Claritas SiteReports, 2013	ZIP Code	County Average
Demographics	Total Female Population	U.S.	Nielsen Claritas SiteReports, 2013	ZIP Code	County Average
Demographics	Total Male Population	U.S.	Nielsen Claritas SiteReports, 2013	ZIP Code	County Average
Demographics	Total Population	U.S.	Nielsen Claritas SiteReports, 2013	ZIP Code	County Average
Demographics	Total Population Age 0-4	U.S.	Nielsen Claritas SiteReports, 2013	ZIP Code	County Average
Demographics	Total Population Age 18-24	U.S.	Nielsen Claritas SiteReports, 2013	ZIP Code	County Average
Demographics	Total Population Age 25-34	U.S.	Nielsen Claritas SiteReports, 2013	ZIP Code	County Average
Demographics	Total Population Age 35-44	U.S.	Nielsen Claritas SiteReports, 2013	ZIP Code	County Average
Demographics	Total Population Age 45-54	U.S.	Nielsen Claritas SiteReports, 2013	ZIP Code	County Average
Demographics	Total Population Age 5-17	U.S.	Nielsen Claritas SiteReports, 2013	ZIP Code	County Average
Demographics	Total Population Age 55-64	U.S.	Nielsen Claritas SiteReports, 2013	ZIP Code	County Average
Demographics	Total Population Age 65 or Older	U.S.	Nielsen Claritas SiteReports, 2013	ZIP Code	County Average

Health Behaviors	Alcohol Use	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average
Health Behaviors	Alcohol Outlets	U.S.	California Department of Alcoholic Beverage Control (ABC), 2012	ZIP Code	State Average
Health Behaviors	Binge Drinking	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average
Health Behaviors	Breastfeeding in the last 6 months	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average
Health Behaviors	Children drinking two or more glasses of soda	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average
Health Behaviors	Children eating less than 5 servings of Fruit/Vegetable a Day	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average
Health Behaviors	Frequent Fast Food Restaurants At Least Once a Week (Adults)	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average
Health Behaviors	Frequent Fast Food Restaurants At Least Once a Week (Children)	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average
Health Behaviors	Heavy Drinking	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average
Health Behaviors	Inadequate Fruit/Vegetable Consumption	U.S.	California Health Interview Survey (CHIS), 2011-2012	SPA	County Average
Health Behaviors	Needed or wanted treatment for alcohol or drug program (excluding tobacco) in the past 5 years	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average
Health Behaviors	Physical Inactivity (Adults)	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average
Health Behaviors	Physical Inactivity (Youth)	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average
Health Behaviors	Serious Psychological Distress in Last Year	CA Only	California Health Interview Survey (CHIS), 2011-2012	SPA	County Average
Health Behaviors	Smokers	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average

Health Outcome	Anxiety Prevalance	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average
Health Outcome	Arthritis Prevalence	CA Only	Los Angeles County Department of Public Health, Los Angeles County Health Survey, 2011	SPA	County Average
Health Outcome	Asthma Hospitalizations (adults)	CA Only	Office of Statewide Health and Planning and Development (OSHPD), 2010.	Zip Code	State Average
Health Outcome	Asthma Hospitalizations (under 18)	CA Only	Office of Statewide Health and Planning and Development (OSHPD), 2010.	ZIP Code	State Average
Health Outcome	Asthma Prevalence (under 18)	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average
Health Outcome	Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) (Child)	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average
Health Outcome	Breast Cancer Incidence	U.S.	The Centers for Disease Control and Prevention, and the National Cancer Institute: State Cancer Profiles, 2006-2010	County	State Average
Health Outcome	Cerebrovascular Disease Hospitalization (Stroke) Rate per 100,000 persons	CA Only	Office of Statewide Health and Planning and Development (OSHPD), 2009	Zip Code	State Average
Health Outcome	Cervical Cancer Incidence	U.S.	The Centers for Disease Control and Prevention, and the National Cancer Institute: State Cancer Profiles, 2006-2010	County	Healthy People 2020
Health Outcome	Chlamydia Incidence	U.S.	Los Angeles County Department of Public Health, Sexually Transmitted Disease Morbidity Report, 2011	SPA	County Average
Health Outcome	Colon and Rectum Cancer Incidence	U.S.	The Centers for Disease Control and Prevention, and the National Cancer Institute: State Cancer Profiles, 2006-2010	County	Healthy People 2020
Health Outcome	Diabetes Hospitalizations (adult)	CA Only	Office of Statewide Health and Planning and Development (OSHPD), 2010	ZIP Code	State Average
Health Outcome	Diabetes Hospitalizations (uncontrolled)	CA Only	California Office of Statewide Health, Planning and Development (OSHPD), Patient Discharge Data, 2010	ZIP Code	State Average

Health Outcome	Diabetes Hospitalizations (under 18)	CA Only	Office of Statewide Health and Planning and Development (OSHPD), 2010	ZIP Code	State Average
Health Outcome	Diabetes Prevalence (Adults)	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average
Health Outcome	Disabled (Adults)	CA Only	California Health Interview Survey (CHIS), 2011-2012	SPA	State Average
Health Outcome	Gonorrhea	U.S.	Los Angeles County Department of Public Health, Sexually Transmitted Disease Morbidity Report, 2011	SPA	County Average
Health Outcome	Health Status (Child)	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average
Health Outcome	Heart Disease (Hypertension) Prevalence	CA Only	California Health Interview Survey (CHIS), 2011-2012	County	State Average
Health Outcome	Heart Disease Hospitalization	CA Only	Office of Statewide Health and Planning and Development (OSHPD), 2010	ZIP Code	State Average
Health Outcome	Hepatitis A Prevalence Rate per 100,000 persons	County	Los Angeles County Department of Public Health, Acute Communicable Disease Control Program, Annual Morbidity Report and Special Studies Report, 2010	SPA	County Average
Health Outcome	Hepatitis B (Acute) Prevalence Rate per 100,000 persons	County	Los Angeles County Department of Public Health, Acute Communicable Disease Control Program, Annual Morbidity Report and Special Studies Report, 2011	SPA	County Average
Health Outcome	Hepatitis C (Acute) Prevalence (number of cases reported)	County	Los Angeles County Department of Public Health, Acute Communicable Disease Control Program, Annual Morbidity Report and Special Studies Report, 2012	SPA	County Average
Health Outcome	High Blood Pressure Prevalence	County	Los Angeles County Health Survey, 2011	SPA	County Average
Health Outcome	High Cholesterol Prevalence	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average
Health Outcome	HIV Hospitalizations	CA Only	California Office of Statewide Health, Planning and Development (OSHPD), Patient Discharge Data, 2010	ZIP Code	State Average

Health Outcome	HIV Incidence Rate per 100,000 persons	U.S.	Los Angeles County Department of Public Health, Annual HIV Surveillance Report, 2012	SPA	County Average
Health Outcome	Mental Health Hospitalizations (under 18)	CA Only	Office of Statewide Health and Planning and Development (OSHPD), 2010	Zip Code	County Average
Health Outcome	Obese/overweight (teen)	LAC Only	California Health Interview Survey (CHIS), 2011-2012	SPA	
Health Outcome	Obesity (Adult)	LAC Only	California Health Interview Survey (CHIS), 2011-2012	SPA	
Health Outcome	Osteoporosis Prevalance	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average
Health Outcome	Overweight (Adult)	LAC Only	California Health Interview Survey (CHIS), 2011-2012	SPA	
Health Outcome	Overweight (child)	LAC Only	California Health Interview Survey (CHIS), 2011-2012	SPA	
Health Outcome	Overweight (Youth)	CA Only	California Department of Education, Fitnessgram Physical Fitness Testing Results, 2011	School District	State Average
Health Outcome	Population with Any Disability (Disability status due to physical, mental or emotional condition)	CA Only	California Health Interview Survey (CHIS), 2011-2012	SPA	State Average
Health Outcome	Premature Death	U.S.	Los Angeles County Department of Public Health. Mortality In Los Angeles County 2009 and Mortality Trends 2000-2009, Leading Causes of Death and Premature Death with Trends for 2000-2009	SPA	County Average
Health Outcome	Prostate Cancer Incidence	U.S.	The Centers for Disease Control and Prevention, and the National Cancer Institute: State Cancer Profiles, 2006-2010	County	State Average
Health Outcome	Syphilis	County	Los Angeles County Department of Public Health, Acute Communicable Disease Control Program, Annual Morbidity Report and Special Studies Report, 2012	SPA	County Average

Health Outcome	Tuberculosis	County	Los Angeles County Department of Public Health, Acute Communicable Disease Control Program, Annual Morbidity Report and Special Studies Report, 2011	SPA	County Average
Health Outcome	Uncontrolled Diabetes Hospitalizations		Office of Statewide Health and Planning and Development (OSHPD), 2010	Zip Code	State Average
Health Outcome	Very Low Birthweight	CA Only	California Department of Public Health, 2010	Zip Code	County Average
Health Outcome - Mortality	Stroke Mortality	CA Only	California Department of Public Health, Death Statistical Master File, 2008-2010	ZIP Code	State Average
Health Outcome - Mortality	Suicide	CA Only	California Department of Public Health, Death Statistical Master File, 2008-2010	ZIP Code	Healthy People 2020
Health Outcomes	Low Birth Weight	CA Only	California Department of Public Health, Birth Profiles by ZIP Code, 2010	ZIP Code	State Average
Health Outcomes	Lung Cancer Incidence	U.S.	The Centers for Disease Control and Prevention, and the National Cancer Institute: State Cancer Profiles, 2005-2009	County	State Average
Health Outcomes	Mental Health Hospitalizations (adults)	CA Only	Office of Statewide Health and Planning and Development (OSHPD), 2010	Zip Code	County Average
Health Outcomes - Mortality	Alzheimer's mortality age-adjusted	CA Only	Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology, 2009	SPA	County Average
Health Outcomes - Mortality	Cancer Mortality	CA Only	California Department of Public Health (CDPH), 2010	ZIP Code	Healthy People 2020
Health Outcomes - Mortality	Cardiovascular Disease Mortality	CA only	Office of Statewide Health and Planning and Development (OSHPD), 2010	Zip Code	State Average
Health Outcomes - Mortality	Cervical Cancer Mortality	CA only	California Department of Public Health, Death Statistical Master File, 2008	ZIP Code	Healthy People 2020
Health Outcomes -	Chronic Liver Disease Mortality	CA Only	California Department of Public Health (CDPH), 2010	ZIP Code	County Average

Mortality					
Health Outcomes - Mortality	Chronic Lower Respiratory Disease Mortality	CA Only	California Department of Public Health (CDPH), 2010	ZIP Code	County Average
Health Outcomes - Mortality	Colon Cancer Mortality	CA Only	California Department of Public Health, Death Statistical Master File, 2008	ZIP Code	County Average
Health Outcomes - Mortality	Deaths	CA Only	California Department of Public Health (CDPH), 2010	ZIP Code	Healthy People 2020
Health Outcomes - Mortality	Diabetes Mortality	CA Only	California Department of Public Health (CDPH), 2010	ZIP Code	County Average
Health Outcomes - Mortality	Heart Disease Mortality	CA Only	California Department of Public Health (CDPH), 2010	ZIP Code	Healthy People 2020
Health Outcomes - Mortality	HIV mortality rate oer 100,000 persons	CA Only	Los Angeles County Department of Public Health, Annual HIV Surveillance Report, 2012	SPA	County Average
Health Outcomes - Mortality	Hypertension and Hypertensive Renal Disease Mortality	CA Only	California Department of Public Health (CDPH), 2010	ZIP Code	Healthy People 2020
Health Outcomes - Mortality	Influenza and Pneumonia Mortality	CA Only	California Department of Public Health (CDPH), 2010	ZIP Code	County Average
Health Outcomes - Mortality	Mortality Rates by Age	CA Only	California Department of Public Health, Death Statistical Master File, 2008-2010	ZIP Code	Healthy People 2020
Health Outcomes - Mortality	Unintentional Injury Mortality Rate per 100,000 persons	CA Only	California Department of Public Health (CDPH)	ZIP Code	County Average
Physical Environment	Liquor Store Access (Alcohol Outlet Rate per 1,000 persons)	CA Only	California Department of Alcoholic Beverage Control, Active License File, April 2012	ZIP Code	State Average

Physical Environment	Protected Open Space per 10,000 children 0-5	CA Only	California Protected Areas Database, 2013	ZIP Code	County Average
Physical Environment	Visited park in last month (adult)	CA Only	California Health Interview Survey (CHIS), 2011-2012	SPA	County Average
Physical Environment	Visited park in last month (child)	CA Only	California Health Interview Survey (CHIS), 2011-2012	SPA	County Average
Physical Environment	Walking Space in Neighborhood (adults)	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average
Physical Environment	WIC Participants	CA Only	PHFE WIC Data Mining Project, LA County WIC Data, 2012	ZIP Code	County Average
Social & Economic Factors	Adequate Social or Emotional Support	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average
Social & Economic Factors	Births by Mother's Age	CA Only	California Department of Public Health (CDPH), 2011	ZIP Code	County Average
Social & Economic Factors	Births by Mother's Ethnicity	CA Only	California Department of Public Health (CDPH), 2011	ZIP Code	County Average
Social & Economic Factors	Children Eligible for Free/Reduced Price Lunch	U.S.	California Department of Education (CDE), 2011	SPA	State Average
Social & Economic Factors	Education Attainment	U.S.	Nielsen Claritas SiteReports, 2013	ZIP Code	County Average
Social & Economic Factors	Employment Status	U.S.	Nielsen Claritas SiteReports, 2013	ZIP Code	County Average
Social & Economic Factors	Families At or Above Poverty Level	U.S.	Nielsen Claritas SiteReports, 2013	ZIP Code	County Average
Social & Economic Factors	Families Below Poverty Level	U.S.	Nielsen Claritas SiteReports, 2013	ZIP Code	County Average

Social & Economic Factors	Families With Children At or Above Poverty Level	U.S.	Nielsen Claritas SiteReports, 2013	ZIP Code	County Average
Social & Economic Factors	Families With Children Below Poverty Level	U.S.	Nielsen Claritas SiteReports, 2013	ZIP Code	County Average
Social & Economic Factors	Homeless by Age	County	Los Angeles Homeless Services Authority, Greater Los Angeles Homeless County Report, 2011	SPA	County Average
Social & Economic Factors	Homeless Count	County	Los Angeles Homeless Services Authority, Greater Los Angeles Homeless County Report, 2011	SPA	County Average
Social & Economic Factors	Household Average Income	U.S.	Nielsen Claritas SiteReports, 2013	ZIP Code	County Average
Social & Economic Factors	Household Median Income	U.S.	Nielsen Claritas SiteReports, 2013	ZIP Code	County Average
Social & Economic Factors	Housing (Owner versus Renter)	U.S.	Nielsen Claritas SiteReports, 2013	ZIP Code	County Average
Social & Economic Factors	Neighborhood Safety (adults)	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average
Social & Economic Factors	Neighborhood Safety (children)	CA Only	Los Angeles County Health Survey, 2011	SPA	County Average
Social & Economic Factors	Not a U.S. Citizen	U.S.	U.S. Census Bureau Public Use Microdata Statistics (PUMS)	SPA	County Average
Social & Economic Factors	Supplemental Nutrition Assistance Program (SNAP) Recipients	U.S.	U.S. Census Bureau, Small Area Income and Poverty Estimates (SAIPE), 2009	County	State Average
Social & Economic Factors	Unable to Afford Enough Food (Food Insecurity) (Adults)	CA Only	California Health Interview Survey (CHIS), 2011-2012	SPA	County Average

Social & Economic Factors	Unemployment Rate	U.S.	U.S. Bureau of Labor Statistics, May, 2013 Local Area Unemployment Statistics	County	State Average
---------------------------	-------------------	------	--	--------	---------------

## Appendix E—Glossary

This glossary has been developed to provide definitions for key terms and terminology used throughout the Glendale Hospital Collaborative 2013 Community Health Needs Assessments (CHNA). The terms with endnotes have been developed to standardize terminology and create a shared understanding of the terms.

### Age-adjusted rate

---

The incidence or mortality rate of a disease can depend on age distribution within a community. Because chronic diseases and some cancers affect older adults disproportionately, a community with a higher number of older adults might have a higher mortality or incidence rate for some diseases than another community with a higher percentage of population of younger people. An age-adjusted incidence or mortality rate allows for taking the proportion of persons in corresponding age groups into consideration when reviewing statistics, which allows for more meaningful comparisons between communities with different age distributions.

### Benchmark<sup>1</sup>

---

A benchmark is a measurement that serves as a standard by which other measurements and/or statistics may be measured or judged. A “benchmark” indicates a standard by which a community can determine how well or not well the community is performing in comparison to the standard for specific health outcomes. For the purpose of the CHNA reports, one of three benchmarks has been used to make comparisons with the medical center area. These include statistics published by Healthy People 2020, Los Angeles County, and California.

### Community assets

---

Those people, places, and relationships that provide resources, individually or in the aggregate, to bring about the maximal functioning of a community. (*Example: Federally Qualified Health Care Centers, primary care physicians, hospitals and medical clinics, community-based organizations, social service and other public agencies, parks, community gardens, etc.*)

### Community Health Needs Assessment<sup>2</sup>

---

Abbreviated as CHNA, a systematic process involving the review of public data and input from a broad cross-section of community resources and participants to identify and analyze community health needs and assets.

### Community served

---

Based on Affordable Care Act (ACA) regulations, the “community served” is to be determined by each individual hospital. The community served is generally defined by a geographical location such as a city, county, or metropolitan region. A community served may also take into consideration certain hospital focus areas (i.e., cancer, pediatrics), though is not defined so narrowly as to intentionally exclude high-need groups such as the elderly or low-income individuals.

---

**Consultants**

---

Individuals or firms with specific expertise in designing, conducting, and managing a process on behalf of the client.

---

**Data set**

---

A data set refers to a set or grouping of secondary, usually quantitative, data.

---

**Data source**

---

Data source refers to the original source (i.e., database, interview, focus group, etc.) from which quantitative or qualitative data were collected.

---

**Disease burden**

---

Disease burden refers to the impact of a health issue not only on the health of the individuals affected by the disease, but also on the financial cost of addressing the health issue, such as public expenditures. The burden of disease can also refer to the disproportionate impact of a disease on certain populations, which may negatively affect quality of life, socioeconomic status, and other factors.

---

**Drivers of health**

---

Drivers of health are risk factors that may positively or negatively impact a health outcome.

---

**FQHC<sup>3</sup>**

---

Federally qualified health centers (FQHCs) include all organizations receiving grants under Section 330 of the federal Public Health Service Act (PHS). FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors. Certain tribal organizations and FQHC look-alikes (organizations that meet PHS Section 330 eligibility requirements but do not receive grant funding) also may receive special Medicare and Medicaid reimbursements.

---

**Focus group**

---

A gathering of people (also referred to as stakeholders) for the purpose of sharing and discussing a specific topic—in this case, community health.

---

**Health disparity**

---

Diseases and health problems do not affect all populations in the same way. Health disparity refers to the disproportionate impact of a disease or a health problem on specific populations. Much health disparity research literature focuses on racial and ethnic differences—as to how these communities experience specific diseases—however, health disparity can also be correlated with gender, age, and other factors, such as veteran, disability, and housing status.

---

**Health driver**

---

Health drivers are behavioral, environmental, social, economic, and clinical-care factors that positively or negatively impact health. For example, smoking (behavioral) is a health driver for lung cancer, and

access to safe parks (environmental) is a health driver for obesity/overweight. Some health drivers, such as poverty or lack of insurance, impact multiple health issues.

---

#### **Health indicator<sup>4</sup>**

A characteristic of an individual, population, or environment that is subject to measurement (directly or indirectly) and can be used to describe one or more aspects of the health of an individual or population. *(Example: Percent of children overweight in Los Angeles County, incidence of breast cancer in Los Angeles County)*

---

#### **Health need**

The Mobilizing Action Toward Community Health (MATCH) framework to understand population health defines a health need as any of the following that arise from a comprehensive review and interpretation of a robust data set: a) a poor *health outcome* and its associated health driver and/or b) a *health drive/factor* associated with poor health outcome(s), where the outcome itself has not yet arisen as a need. *(Example: obesity and overweight, diabetes, physical inactivity, access to healthcare)*

---

#### **Health outcomes<sup>5</sup>**

Snapshots of diseases in a community that can be described in terms of both morbidity and mortality. *(Example: diabetes prevalence, hypertension mortality, suicide rate)*

---

#### **Healthy People 2020<sup>6</sup>**

Healthy People 2020 provides science-based, 10-year national objectives for improving the health of all Americans. For three decades, Healthy People has established benchmarks and monitored progress over time in order to encourage collaborations across communities and sectors, empower individuals toward making informed health decisions, and measure the impact of prevention activities.

---

#### **Incidence<sup>7</sup> rate**

Incidence is a measure of the occurrence of new disease or health problem in a population of people at risk for the disease within a given time period. *(Example: 1,000 new cases of diabetes in 2011)* Incidence rate is expressed either as a fraction (e.g., percentage) or a density rate (e.g., x number of cases per 10,000 people) to allow for comparison between different communities. Incidence rate should not be confused with *prevalence rate*, which measures the proportion of people found to have a specific disease or health problem (see *prevalence rate*).

---

#### **Morbidity rate**

Morbidity rate refers to the prevalence of a disease. Morbidity rate is usually expressed as a density rate (e.g. x number of cases per 10,000 people). Prevalence is often used to measure the level of morbidity in a population.<sup>8</sup>

---

#### **Mortality rate**

Mortality rate refers to the number of deaths in a population resulting from a disease. Mortality rate is usually expressed as a density rate (e.g., x number of cases per 10,000 people).

---

**Percent**

---

A percent is the portion of the total population that currently has a given disease or health problem. Percent is used to communicate prevalence, for example, and to give an idea of the severity (or lack thereof) of a disease or health problem.

---

**Prevalence<sup>9</sup>**

---

Prevalence is the proportion of total population that currently has a given disease. (*Example: 1,000 total cases of diabetes in 2011*)

---

**Prevalence rate**

---

Prevalence rate is the proportion of total population that currently has a given disease or health problem. Prevalence rate is expressed either as a fraction (e.g., percentage) or a density rate (e.g., x number of cases per 10,000 people) to allow for comparison between different communities. Prevalence rate is distinct from incidence rate, which focuses on *new* cases. For instance, a community may experience a decrease in new cases of a certain disease (incidence) but an increase in the total number of people suffering that disease (prevalence) because people are living longer as a result of better screening or treatment for that disease.

---

**Primary data**

---

Primary data are new data collected or observed directly from first-hand experience. They are typically qualitative (not numerical) in nature. For this CHNA, primary data were collected through focus groups and interviews with key stakeholders. Primary data describes what is important to the people who provide the information and is useful in interpreting secondary data (see *qualitative data, quantitative data, secondary data*). (*Example: Focus groups, community forum*)

---

**Qualitative data<sup>10</sup>**

---

These are typically descriptive in nature and not numerical; however, qualitative data can be coded into numeric categories for analysis. Qualitative data is considered to be more subjective than quantitative data, but they provide information about what is important to the people (see *stakeholder*) who provide the information. (*Example: focus group data*)

---

**Quantitative data<sup>11</sup>**

---

Data that has a numeric value. Quantitative data is considered to be more objective than qualitative data (*Example: state or national survey data*)

---

**Risk factor<sup>12</sup>**

---

Characteristics (genetic, behavioral, and environmental exposures and sociocultural living conditions) that increase the probability that an individual will experience a disease (morbidity) or specific cause of death (mortality). Some risk factors can be changed through behavioral or external changes or influences (e.g., smoking) while others cannot (e.g., family history).

---

**Secondary data**

---

Data that has already been collected and published by another party. Typically, secondary data collected for CHNAs is quantitative (numerical) in nature (*Example: California Health Interview Survey [CHIS]*,

*Behavioral Risk Factor Surveillance System [BRFSS]*) Secondary data are useful in highlighting in an objective manner health outcomes that significantly impact a community.

---

## Stakeholders

---

Stakeholders are people who represent and provide informed, interested perspectives regarding an issue or topic. In the case of CHNAs, stakeholders include health care professionals, government officials, social service providers, community residents, and community leaders, among others.

---

<sup>1</sup> Merriam-Webster Dictionary. Retrieved from <http://www.merriam-webster.com/dictionary/benchmark>.

<sup>2</sup> World Health Organization (WHO). Retrieved from <http://www.who.int/hia/evidence/doh/en/>.

<sup>3</sup> U.S. Department of Health and Human Services. Rural Health IT Toolbox. Retrieved from <http://www.hrsa.gov/healthit/toolbox/RuralHealthITToolbox/Introduction/qualified.html>. Accessed [April 30, 2013].

<sup>4</sup> "Health Promotion Glossary," World Health Organization, Division of Health Promotion, Education and Communications (HPR), Health Education and Health Promotion Unit (HEP), Geneva, Switzerland, 1998.

<sup>5</sup> "Health Promotion Glossary," World Health Organization, Division of Health Promotion, Education and Communications (HPR), Health Education and Health Promotion Unit (HEP), Geneva, Switzerland, 1998.

<sup>6</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://healthypeople.gov/2020/default.aspx>. Accessed [April 30, 2013]

<sup>7</sup> Aschengrau, A. & Seage, G.R. (2008). *Essentials of Epidemiology in Public Health*. Sudbury, Massachusetts: Jones and Barlett Publishers.

<sup>8</sup> New York State Department of Health. Basic Statistics: About Incidence, Prevalence, Morbidity, and Mortality—Statistical Teaching Tools. Retrieved from <http://www.health.ny.gov/diseases/chronic/basicstat.htm>. Accessed on [May 1, 2013].

<sup>9</sup> Aschengrau, A. & Seage, G.R. (2008). *Essentials of Epidemiology in Public Health*. Sudbury, Massachusetts: Jones and Barlett Publishers.

<sup>10</sup> Catholic Health Association of the United States (March, 2011). Assessing & addressing community health needs: Discussion Draft. Retrieved from [http://www.chausa.org/Assessing\\_and\\_Addressing\\_Community\\_Health\\_Needs.aspx](http://www.chausa.org/Assessing_and_Addressing_Community_Health_Needs.aspx).

<sup>11</sup> Catholic Health Association of the United States (March, 2011). Assessing & addressing community health needs: Discussion Draft. Retrieved from [http://www.chausa.org/Assessing\\_and\\_Addressing\\_Community\\_Health\\_Needs.aspx](http://www.chausa.org/Assessing_and_Addressing_Community_Health_Needs.aspx).

<sup>12</sup> Adapted from: Green L. & Kreuter M. (2005). *Health program planning: An educational and ecological approach*. 4th edition. New York, NY: McGraw Hill.

## Appendix F—Prioritization Survey Criteria Scale

### Community Health Needs Assessment Prioritization Criteria Scale

#### SEVERITY

1 (Not Severe)	2 (Moderately Severe)	3 (Severe)	4 (Very Severe)
The community is slightly impacted and the health need does not generally impact the lives of those affected by it.	The community is slightly impacted and the health need slightly impacts the lives of those affected by it.	The community is greatly impacted but the health need does not generally impact the lives of those affected by it.	The community is greatly impacted and the health need greatly impacts the lives of those affected by it.

#### CHANGE OVER TIME

1 (Great Improvements)	2 (Moderate Improvements)	3 (No improvements)	4 (Getting Worse)
The health need has greatly improved and will likely continue to improve in the future.	The health need has remained the same will either stay the same or improve in the future.	The health need has remained the same but will likely get worse in the future.	The health need has gotten worse and will likely continue to do so.

#### RESOURCES

1 (Vast Resources)	2 (Moderate Resources)	3 (Gaps in Resources)	4 (Serious Shortage of Resources)
There are extensive resources in the community that address this health need and community members are aware of them.	There are moderate resources in the community that address this health need but not many community members are aware of them.	There are few resources in the community to address this health need but there is a potential to leverage existing resources to create interventions.	There are little to no resources available in the community to address this health need and no existing resources to create interventions.

#### COMMUNITY'S READINESS TO SUPPORT

1 (Not Supportive)	2 (Somewhat Supportive)	3 (Supportive)	4 (Extremely Supportive)
Community is not ready to address the issue.	Community is interested in the issue, but unlikely to be able to support efforts.	Community is supportive, but has limited ability to effectively implement programs.	Community is ready to effectively implement programs to address this need.

## Appendix G—Health Need Profiles

### Health Need Profile – Alcohol Abuse

#### About Alcohol Abuse— why is it important?

Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse contribute significantly to costly social, physical, mental, and public health problems, including teenage pregnancy, HIV/AIDS, STDs, domestic violence, child abuse, motor vehicle accidents (unintentional injuries), physical fights, crime, homicide, and suicide. Heavy alcohol consumption is an important determinant of future health needs, including cirrhosis, cancers, and untreated mental and behavioral health needs. In addition to considerable health implications, substance abuse has been a major focal point in discussions about social values: people argue over whether substance abuse is a disease with genetic and biological foundations or a matter of personal choice<sup>1</sup>.

**Statistical data – how is alcohol abuse measured? What is the prevalence/incidence rate of alcohol abuse in the community?**

#### Alcohol Abuse Indicators

Indicators	Year	Comparison		CHMC <sup>2</sup> Service Area	GSH <sup>3</sup> Service Area	SVMC <sup>4</sup> Service Area
		Level	Avg.			
Percent of adults 18 and older who reported binge drinking in the past month	2011	LAC	15.4%	17.2%	18.1%	18.1%
Percent of adults 18 and older who reported drinking alcohol in the past month	2011	LAC	51.9%	54.3%	46.6%	46.6%
Percent of adults 18 and older who reported heavy drinking in the past month	2011	LAC	3.5%	3.8%	3.6%	3.6%
Percent of adults 18 and older who reported they needed or wanted treatment for alcohol or drug program (excluding tobacco) in the past 5 years	2011	LAC	2.5%	2.4%	2.8%	2.8%

LAC=Los Angeles County  
CA=California

#### Sub-populations experiencing the greatest impact (disparities)

Stakeholders identified the homeless, children and youth, the uninsured, youth in or transitioning out of the foster care system, and low income populations as the most severely impacted sub-populations.

#### Geographic areas of greatest impact (disparities)

By ZIP code, the following disparities were found:

- Rates of alcohol/drug induced mental disease hospitalizations per 100,000 persons, which were higher when compared to California (109.1) in:

CHMC Service Area	GSH Service Area	SVMC Service Area
○ 90001-South Los Angeles (190.9)	○ 90010-Wilshire (157.9)	○ 90010-Wilshire (157.9)
○ 90010-Wilshire (157.9)	○ 90012-Chinatown (119.0)	○ 90016-West Adams (132.4)
○ 90016-West Adams (132.4)	○ 90013-Downtown Los Angeles (925.9)	○ 90018-Jefferson Park (111.5)
○ 90018-Jefferson Park (111.5)	○ 90014-Los Angeles (670.9)	○ 90026-Echo Park/Silverlake (110.5)
○ 90026-Echo Park/Silverlake		

CHMC Service Area	GSH Service Area	SVMC Service Area
(110.5)	○ 90018-Jefferson Park (111.5)	○ 90027-Griffith Park/Los Feliz (179.4)
○ 90037-South Los Angeles (112.4)	○ 90021-Downtown Los Angeles (202.5)	○ 90028-Hollywood (156.7)
○ 90047-South Los Angeles (117.3)	○ 90026-Echo Park/Silverlake (110.5)	○ 90031-Montecito Heights (129.7)
○ 90057-Westlake (135.6)	○ 90057-Westlake (135.6)	○ 90037-South Los Angeles (112.4)
		○ 90046-Mount Olympus (210.0)
		○ 90057-Westlake (135.6)

Stakeholders also identified Los Angeles as generally impacted by alcohol abuse.

**Associated drivers and risk factors – what is driving the high rates of alcohol abuse in the community?**

Several biological, social, environmental, psychological, and genetic factors are associated with alcohol and substance abuse including gender, race and ethnicity, age, income level, educational attainment, and sexual orientation. Substance abuse is also strongly influenced by interpersonal, household, and community factors. Family, social networks, and peer pressure are key influencers of substance abuse among adolescents<sup>5</sup>. Teenage pregnancy, HIV/AIDS, STDs, domestic violence, child abuse, motor vehicle accidents (unintentional injuries), physical fights, crime, homicide (intentional injuries), and suicide can be attributed to alcohol and substance abuse<sup>6</sup>. For data concerning health drivers, please refer to the *Scorecard*.

The density of alcohol outlets is associated with heavy drinking, drinking and driving, higher rates of motor vehicle-related pedestrian injuries, child abuse and neglect, and other violence<sup>7</sup>.

**Community Input – what do community stakeholders think about the issue of alcohol abuse?**

Stakeholders indicated that alcohol and substance abuse often are associated with mental illness and poverty and attribute the prevalence of alcohol abuse to the lack of access to treatment. They also added that there have been successful efforts to reduce underage drinking at Berendo and Nightingale Middle Schools and Fairfax High School in Los Angeles where the purpose of such efforts was to create “buffer zones” around these schools and educate family members around alcohol abuse.

<sup>1</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=32>. Accessed [February 26, 2013].

<sup>2</sup> California Hospital Medical Center

<sup>3</sup> Good Samaritan Hospital

<sup>4</sup> St. Vincent Medical Center

<sup>5</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at [<http://www.healthypeople.gov/2020/lhi/substanceabuse.aspx?tab=determinants>]. Accessed [February 27, 2013].

<sup>6</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at [<http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=32>]. Accessed [February 26, 2013].

<sup>7</sup> Stewart, K. (n.d.). How Alcohol Outlets Affect Neighborhood Violence. Calverton, MD. Available at <http://urbanillinois.us/sites/default/files/attachments/how-alcohol-outlets-affect-nbhd-violence.pdf>. Accessed [July 11, 2013].

**Health Need Profile – Allergies**

**About Allergies— why is it important?**

Allergies are an overreaction of the immune system to substances that usually cause no reaction in most individuals. These substances can trigger sneezing, wheezing, coughing and itching. Allergies have been linked to a variety of common and serious chronic respiratory illnesses such as sinusitis and asthma. Factors such as family history with allergies, the types and frequency of symptoms, seasonality, duration and even location of symptoms (indoors or outdoors, for example) are all taken into consideration in allergies diagnosis. Allergic reactions can be severe and even fatal. With proper management and patient education, allergic diseases can be controlled and people with allergies can lead normal and productive lives<sup>1</sup>. Many allergens are also asthma triggers that irritate the lungs, inducing an asthma attack. Other social and economic factors have been known to cause or trigger allergic reactions including poor housing conditions (living with cockroaches, mites, asbestos, mold etc.). Living in an environment or home with smokers has also been known exacerbate allergies and/or asthma.

**Statistical data – how are allergies measured? What is the prevalence/incidence rate of allergies in the community?**

**Allergies Indicators**

Indicators	Year	Comparison		CHMC <sup>2</sup>	GSH <sup>3</sup>	SVMC <sup>4</sup>
		Level	Avg.	Service Area	Service Area	Service Area
Percent of teens with allergies	2007	LAC	24.9%	27.1%	32.5%	32.5%

LAC=Los Angeles County  
CA=California

**Sub-populations experiencing the greatest impact (disparities)**

Stakeholders identified Asian populations as the most affected by allergies.

**Geographic areas of greatest impact (disparities)**

Geographic disparities were not identified through statistical data or stakeholders.

**Associated drivers and risk factors – what is driving the high rates of allergies in the community?**

Allergic reactions are known to be caused by pollen, dust, food, insect stings, animal dander, mold, medications, and latex<sup>5</sup>. Many allergens are also asthma triggers that irritate the lungs, inducing an asthma attack. Social and economic factors have been known to cause or trigger allergic reactions including poverty leading to poor housing conditions (living with cockroaches, mites, asbestos, mold etc.) and living in an environment or home with smokers. For data concerning health drivers, please refer to the *Scorecard*.

**Community Input – what do community stakeholders think about the issue of allergies?**

Stakeholders indicated that allergies were associated with poor air quality and other environmental factors.

<sup>1</sup> Asthma and Allergy Foundation of America (AAFA). Allergies. Milwaukee, WI. Available at [<http://www.aaaai.org/conditions-and-treatments/allergies.aspx>]. Accessed [March 1, 2013].

<sup>2</sup> California Hospital Medical Center

<sup>3</sup> Good Samaritan Hospital

<sup>4</sup> St. Vincent Medical Center

<sup>5</sup> American Academy of Allergy Asthma and Immunology. Allergies. Landover, MD. Available at [<http://www.aafa.org/display.cfm?id=9>]. Accessed [March 1, 2013].

**Health Need Profile – Alzheimer’s Disease**

**About Alzheimer’s disease – why is it important?**

An estimated 5.4 million Americans have Alzheimer’s disease, which is the sixth-leading cause of death in the U.S.<sup>1</sup>. Alzheimer’s, an irreversible and progressive brain disease, is the most common cause of dementia among older people. The disease is characterized by the loss of cognitive functioning and ranges in severity from the mildest stage of minor cognitive impairment to the most severe stage, when the person with Alzheimer’s must depend completely on others for tasks of daily living. People with Alzheimer’s disease and other dementias have more hospital stays, skilled nursing facility stays, and home health care visits than other older people<sup>2</sup>. The likely causes of Alzheimer’s disease include some combination of age-related changes in the brain, a family history of Alzheimer’s, and genetic, environmental, and lifestyle factors. Some data suggest that cardiovascular disease risk factors (e.g., physical inactivity, high cholesterol, diabetes, smoking, and obesity) and traumatic brain injury are associated with a higher risk of developing Alzheimer’s disease<sup>3</sup>.

**Statistical data – how is Alzheimer’s disease measured? What is the prevalence/incidence rate of Alzheimer’s disease in the community?**

**Alzheimer’s Disease Indicators**

Indicators	Year	Comparison		CHMC <sup>4</sup> Service Area	GSH <sup>5</sup> Service Area	SVMC <sup>6</sup> Service Area
		Level	Avg.			
Rate of Alzheimer’s disease mortality rate per 10,000 pop.	2010	CA	2.9	<b>9.8</b>	<b>7.0</b>	<b>10.5</b>

LAC=Los Angeles County  
CA=California

**Sub-populations experiencing the greatest impact (disparities)**

Stakeholders identified people over the age of 85 years of age who are uninsured, low-income, Latinos, and Asians as the most severely impacted.

**Geographic areas of greatest impact (disparities)**

By ZIP code, the following disparities were found:

- Rates of Alzheimer’s disease-related mortality per 10,000 persons, which were higher when compared to California (2.9) in:

CHMC Service Area	GSH Service Area	SVMC Service Area
○ 90001-South Los Angeles (11.0)	○ 90004-Hancock Park (8.0)	○ 90004-Hancock Park (8.0)
○ 90002-Watts (7.0)	○ 90005-Koreatown (8.0)	○ 90005-Koreatown (8.0)
○ 90003-South Los Angeles (8.0)	○ 90006-Pico Heights (18.0)	○ 90006-Pico Heights (18.0)
○ 90004-Hancock Park (8.0)	○ 90007-South Los Angeles (7.0)	○ 90007-South Los Angeles (7.0)
○ 90005-Koreatown (8.0)	○ 90012-Chinatown (5.0)	○ 90008-Baldwin Hills/Crenshaw (9.0)
○ 90006-West Adams (18.0)	○ 90013-Downtown Los Angeles (12.0)	○ 90011-South Los Angeles (17.0)
○ 90007-South Los Angeles (7.0)	○ 90014-Los Angeles (3.0)	○ 90016-West Adams (14.0)
○ 90008-Baldwin Hills/Crenshaw (9.0)	○ 90015-Downtown Los Angeles (4.0)	○ 90017-Downtown Los Angeles (4.0)
○ 90011-South Los Angeles (17.0)	○ 90017-Downtown Los Angeles (4.0)	○ 90018-Jefferson Park (7.0)
○ 90015-Downtown Los Angeles (4.0)	○ 90018-Jefferson Park (7.0)	○ 90019-Country Club/Mid City (115.0)
○ 90016-West Adams (14.0)		

CHMC Service Area	GSH Service Area	SVMC Service Area
<ul style="list-style-type: none"> <li>○ 90017-Downtown Los Angeles (4.0)</li> <li>○ 90018-Jefferson Park (7.0)</li> <li>○ 90019-Country Club/Mid City (115.0)</li> <li>○ 90020-Hancock Park (5.0)</li> <li>○ 90026-Echo Park/Silverlake (17.0)</li> <li>○ 90037-South Los Angeles (9.0)</li> <li>○ 90043-Hyde Park (12.0)</li> <li>○ 90044-Athens (24.0)</li> <li>○ 90047-South Los Angeles (7.0)</li> <li>○ 90057-Westlake (90057)</li> <li>○ 90062-South Los Angeles (7.0)</li> </ul>	<ul style="list-style-type: none"> <li>○ 90020-Hancock Park (5.0)</li> <li>○ 90026-Echo Park/Silverlake (17.0)</li> <li>○ 90057-Westlake (11)</li> </ul>	<ul style="list-style-type: none"> <li>○ 90020-Hancock Park (5.0)</li> <li>○ 90026-Echo Park/Silverlake (17.0)</li> <li>○ 90027-Griffith Park/Silverlake (17.0)</li> <li>○ 90028-Hollywood (15.0)</li> <li>○ 90029-Downtown Los Angeles (6.0)</li> <li>○ 90031-Montecito Heights (10.0)</li> <li>○ 90037-South Los Angeles (9.0)</li> <li>○ 90044-Athens (24.0)</li> <li>○ 90046-Mount Olympus (11.0)</li> <li>○ 90057-Westlake (90057)</li> </ul>

Stakeholders identified Chinatown and Los Angeles as the most severely impacted.

**Associated drivers and risk factors – what is driving the high rates of Alzheimer’s disease in the community?**

The greatest risk factor for Alzheimer’s disease is advancing age. Other risk factors include a family history of Alzheimer’s, genetic mutations, cardiovascular disease risk factors (e.g., physical inactivity, high cholesterol, diabetes, smoking, and obesity) and traumatic brain injury<sup>7</sup>. For data concerning health drivers, please refer to the *Scorecard*.

**Community Input – what do community stakeholders think about the issue of Alzheimer’s disease?**

Stakeholders attributed the prevalence of Alzheimer’s disease to the increase in the aging population. Stakeholders identified an increased need for Alzheimer’s disease-related services including diagnosis.

*“Submitting to the inevitable (old age) – they feel there is nothing they can do about getting old and the health issues that comes with old age.”*  
*(Resident Focus Group Participant)*

<sup>1</sup> Alzheimer’s Association. *2012 Alzheimer’s Disease Facts and Figures*. Available at [http://www.alz.org/downloads/facts\_figures\_2012.pdf]. Accessed [March 6, 2013].

<sup>2</sup> National Institutes of Health. *About Alzheimer’s Disease: Alzheimer’s Basics*. Available at [http://www.nia.nih.gov/alzheimers/topics/alzheimers-basics]. Accessed [March 5, 2013].

<sup>3</sup> Alzheimer’s Association. *2012 Alzheimer’s Disease Facts and Figures*. Available at [http://www.alz.org/downloads/facts\_figures\_2012.pdf]. Accessed [March 6, 2013].

<sup>4</sup> California Hospital Medical Center

<sup>5</sup> Good Samaritan Hospital

<sup>6</sup> St. Vincent Medical Center

<sup>7</sup> Alzheimer’s Association. *2012 Alzheimer’s Disease Facts and Figures*. Available at [http://www.alz.org/downloads/facts\_figures\_2012.pdf]. Accessed [March 6, 2013].

Health Need Profile – Arthritis

**About Arthritis— why is it important?**

Arthritis affects one in five adults in the United States and continues to be the most common cause of physical disability. Arthritis costs more than \$128 billion per year currently in the United States and is projected to increase over time as the population ages. Interventions such as increased physical activity, education about disease self-management and weight loss among overweight/obese adults can reduce arthritis pain and functional limitations however these resources are underutilized<sup>1</sup>.

**Statistical data – how is arthritis measured? What is the prevalence/incidence rate of arthritis in the community?**

Arthritis Indicators

Indicators	Year	Comparison		CHMC <sup>2</sup> Service Area	GSH <sup>3</sup> Service Area	SVMC <sup>4</sup> Service Area
		Level	Avg.			
Percent of adults diagnosed with arthritis <sup>^</sup>	2011	LAC	17.4%	16.3%	15.9%	15.9%

LAC=Los Angeles County  
CA=California

**Sub-populations experiencing the greatest impact (disparities)**

Stakeholders identified Asian and specifically the Filipino population and aging populations as being the most severely impacted.

**Geographic areas of greatest impact (disparities)**

Stakeholders did not identify geographic disparities.

**Associated drivers and risk factors – what is driving the high rates of arthritis in the community?**

The following factors are associated with arthritis including being overweight or obese, lack of education around self-management strategies and techniques, and limited or no physical activity<sup>5</sup>. For data concerning health drivers, please refer to the *Scorecard*.

**Community Input – what do community stakeholders think about the issue of arthritis?**

Stakeholders indicated that aging populations were the most impacted by arthritis.

<sup>1</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at [http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=3]. Accessed [February 26, 2013].

<sup>2</sup> California Hospital Medical Center

<sup>3</sup> Good Samaritan Hospital

<sup>4</sup> St. Vincent Medical Center

<sup>5</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at [http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=3]. Accessed [February 26, 2013].

**Health Need Profile – Asthma**

**About Asthma— why is it important?**

Asthma is a disease that affects the lungs and is one of the most common long-term diseases of children. Adults also may suffer from asthma and the condition is considered hereditary. In most cases, the causes of asthma are not known, and no cure has been identified. Although asthma is always present in those with the condition, attacks only occur when the lungs are irritated. Asthma symptoms include wheezing, breathlessness, chest tightness, and coughing. Some asthma triggers include tobacco smoke, dust mites, outdoor air pollution, cockroach allergen, pet dander, mold, smoke, other allergens and certain infections known to cause asthma such as the flu, colds, and respiratory related viruses. Other contributing factors include exercising, certain medication, bad weather, high humidity, cold/dry air, certain foods and fragrances<sup>1</sup>.

**Statistical data – how is asthma measured? What is the prevalence/incidence rate of asthma in the community?**

**Asthma Indicators**

Indicators	Year	Comparison		CHMC <sup>2</sup>	GSH <sup>3</sup>	SVMC <sup>4</sup>
		Level	Avg.	Service Area	Service Area	Service Area
Percent of children 17 and under who were diagnosed with asthma	2011	LAC	9.0%	7.5%	6.9%	6.9%

LAC=Los Angeles County

**Sub-populations experiencing the greatest impact (disparities)**

Stakeholders identified children as the most severely impacted sub-populations.

**Geographic areas of greatest impact (disparities)**

Stakeholders did not identify geographic disparities.

**Associated drivers and risk factors – what is driving the high rates of asthma in the community?**

Many allergens are also asthma triggers that irritate the lungs, inducing an asthma attack. Allergic reactions are known to be caused by pollen, dust, food, insect stings, animal dander, mold, medications, and latex<sup>5</sup>. Other social and economic factors have been known to cause or trigger allergic reactions including poverty, which leads to poor housing conditions (living with cockroaches, mites, asbestos, mold etc.). Living in an environment or home with smokers has also been known exacerbate allergies and/or asthma. For data concerning health drivers, please refer to the *Scorecard*.

**Community Input – what do community stakeholders think about the issue of asthma?**

Stakeholders linked poor air quality, lack of access to medical care, and patients’ inability to obtain the needed asthma medication to asthma prevalence.

<sup>1</sup> Centers for Disease Control and Prevention (CDC). Asthma-Basic Information. Atlanta, GA. Available at [<http://www.cdc.gov/asthma/faqs.htm>]. Accessed [March 1, 2013].

<sup>2</sup> California Hospital Medical Center

<sup>3</sup> Good Samaritan Hospital

<sup>4</sup> St. Vincent Medical Center

<sup>5</sup> American Academy of Allergy Asthma and Immunology. Allergies. Landover, MD. Available at [<http://www.aafa.org/display.cfm?id=9>]. Accessed [March 1, 2013].

**Health Need Profile – Breast Cancer**

**About Breast Cancer— why is it important?**

In the United States, breast cancer is the most common non-skin cancer and the second leading cause of cancer-related death in women. Each year, a small number of men also are diagnosed with and die from breast cancer. The overall breast cancer death rate has dropped steadily over the past 20 years. However, it is estimated that approximately \$16.5 billion is spent in the U.S. each year on breast cancer treatment<sup>1</sup>.

Risk factors for breast cancer include older age, certain inherited genetic alterations, hormone therapy, having chest radiation therapy, drinking alcohol, and obesity. Exercise and maintaining a healthy weight may reduce the chance of breast cancer<sup>2</sup>. Mammograms and clinical breast exams are commonly used to screen for breast cancer.

**Statistical data – how is breast cancer measured? What is the prevalence/incidence rate of breast cancer in the community?**

**Breast Cancer Indicators**

Indicators	Year	Comparison		CHMC <sup>3</sup>	GSH <sup>4</sup>	SVMC <sup>5</sup>
		Level	Avg.	Service Area	Service Area	Service Area
Rate of breast cancer incidence per 100,000 pop.*	2009	CA	122.0	116.0	116.0	116.0
Rate of breast cancer mortality per 100,000 pop....	2008	LAC	21.2	17.1	12.7	18.1

LAC=Los Angeles County

CA=California

\*Healthy People 2020 goal <=20.6 per 100,000 pop.

**Sub-populations experiencing the greatest impact (disparities)**

Stakeholders identified low income women, Latino and Asian women, and those who had experienced trauma and/or domestic violence as the most severely impacted.

*“Mammograms for women under 40 years of age- mammogram are very expensive and difficult to obtain. Even if has been detected it is very hard to obtain services.”  
(Focus group participant)*

**Geographic areas of greatest impact (disparities)**

By ZIP code, the following disparities were found:

- Rates of breast cancer mortality per 100,000 persons, which were higher when compared to California (21.2) in:

CHMC Service Area	GSH Service Area	SVMC Service Area
○ 90001-South Los Angeles (29.1)	○ 90012-Chinatown (24.5)	○ 90016-West Adams (28.7)
○ 90008-Baldwin Hills/Crenshaw (42.4)	○ 90013-Downtown Los Angeles (37.4)	○ 90018-Jefferson Park (28.0)
○ 90016-West Adams (28.7)	○ 90018-Jefferson Park (28.0)	○ 90019-Country Club Park/Mid City (29.9)
○ 90018-Jefferson Park (28.0)	○ 90057-Westlake (32.3)	○ 90026-Echo Park/Silverlake (110.5)
○ 90019-Country Club Park/Mid City (29.9)		○ 90027-Griffith Park/Los Feliz (35.9)
○ 90043-Hyde Park (48.0)		○ 90029-Downtown Los Angeles (28.8)
○ 90047-South Los Angeles (24.6)		○ 90057-Westlake (32.3)
○ 90057-Westlake (32.3)		

Stakeholders identified the areas of Pico Union and Westlake districts as the most impacted.

**Associated drivers and risk factors – what is driving the high rates of breast cancer in the community?**

---

Risk factors for breast cancer include older age, certain inherited genetic alterations, hormone therapy, having chest radiation therapy, heavy alcohol consumption, and obesity<sup>6</sup>. Breast cancer is associated with overall cancer mortality and access to breast cancer screening. Exercise and maintaining a healthy weight may reduce the chance of breast cancer. For data concerning health drivers, please refer to the *Scorecard*.

**Community Input – what do community stakeholders think about the issue of breast cancer?**

---

Stakeholders attributed the high rates of breast cancer to a lack of education around health, and a lack of access to health care including mammograms. As a result, more women are finding out late in their cancer trajectory (stages 3 and 4).

---

<sup>1</sup> National Cancer Institute. *A Snapshot of Breast Cancer*. Available at [<http://www.cancer.gov/researchandfunding/snapshots/pdf/Breast-Snapshot.pdf>]. Accessed [March 6, 2013].

<sup>2</sup> National Cancer Institute. *Breast Cancer: Prevention, Genetics, Causes*. Available at [<http://www.cancer.gov/cancertopics/prevention-genetics-causes/breast>]. Accessed [March 6, 2013].

<sup>3</sup> California Hospital Medical Center

<sup>4</sup> Good Samaritan Hospital

<sup>5</sup> St. Vincent Medical Center

<sup>6</sup> National Cancer Institute. *Breast Cancer: Prevention, Genetics, Causes*. Available at [<http://www.cancer.gov/cancertopics/prevention-genetics-causes/breast>]. Accessed [March 6, 2013].

**Health Need Profile – Cardiovascular Disease**

**About Cardiovascular Disease— why is it important?**

Cardiovascular disease—also called heart disease and coronary heart disease—includes several health conditions related to plaque buildup in the walls of the arteries, or atherosclerosis. As plaque builds up, the arteries narrow, restricting blood flow and creating the risk of heart attack. Currently, more than one in three adults (81.1 million) in the United States lives with one or more types of cardiovascular disease. In addition to being one of the leading causes of death in the United States, heart disease results in serious illness and disability, decreased quality of life, and hundreds of billions of dollars in economic loss every year<sup>1</sup>.

Cardiovascular disease encompasses and/or is closely linked to a number of health conditions that include arrhythmia, atrial fibrillation, cardiac arrest, cardiac rehab, cardiomyopathy, cardiovascular conditions in childhood, high cholesterol, congenital heart defects, diabetes, heart attack, heart failure, high blood pressure, HIV, heavy alcohol consumption, metabolic syndrome, obesity, pericarditis, peripheral artery disease (PAD), and stroke<sup>2</sup>.

**Statistical data – how is cardiovascular disease measured? What is the prevalence/incidence rate of cardiovascular disease in the community?**

**Cardiovascular Disease Indicators**

Indicators	Year	Comparison		CHMC <sup>3</sup> Service Area	GSH <sup>4</sup> Service Area	SVMC <sup>5</sup> Service Area
		Level	Avg.			
Percent of adults receiving heart disease management services from a care provider	2011-2012	LAC	73.3%	71.0%	70.6%	70.6%
Percent of heart disease prevalence	2011	LAC	24.0%	22.6%	<b>24.4%</b>	<b>24.4%</b>
Rate of cardiovascular disease mortality per 10,000 pop....	2010	CA	15.6	<b>68.3</b>	<b>42.0</b>	<b>73.8</b>
Rate of heart disease hospitalization per 100,000 pop....	2010	CA	367.1	<b>445.3</b>	<b>418.3</b>	<b>424.6</b>

LAC=Los Angeles County  
CA=California

**Sub-populations experiencing the greatest impact (disparities)**

Stakeholders identified low-income populations as the most severely impacted by cardiovascular disease.

**Geographic areas of greatest impact (disparities)**

By ZIP code, the following disparities were found:

- Rates of hospitalizations resulting from heart failure per 100,000 persons, which were higher when compared to California (367.1) in:

CHMC Service Area	GSH Service Area	SVMC Service Area
○ 90002-Watts (437.3)	○ 90013-Downtown Los Angeles (993.9)	○ 90008-Baldwin Hills/Crenshaw (730.0)
○ 90003-South Los Angeles (479.9)	○ 90014-Los Angeles (1,013.6)	○ 90016-West Adams (626.1)
○ 90008-Baldwin Hills/Crenshaw (730.0)	○ 90017-Downtown Los Angeles (391.3)	○ 90017-Downtown Los Angeles (391.3)
○ 90016-West Adams (626.1)	○ 90018-Jefferson Park (644.9)	○ 90018-Jefferson Park (644.9)
○ 90017-Downtown Los Angeles (391.3)	○ 90057-Westlake (380.0)	○ 90027-Griffith Park/Los Feliz (688.8)
○ 90018-Jefferson Park (644.9)		

CHMC Service Area	GSH Service Area	SVMC Service Area
<ul style="list-style-type: none"> <li>○ 90037-South Los Angeles (501.0)</li> <li>○ 90043-Hyde Park (723.4)</li> <li>○ 90044-Athens (601.5)</li> <li>○ 90047-South Los Angeles (860.0)</li> <li>○ 90057-Westlake (380.0)</li> <li>○ 90062-South Los Angeles (649.0)</li> </ul>		<ul style="list-style-type: none"> <li>○ 90028-Hollywood (417.9)</li> <li>○ 90029-Downtown Los Angeles (471.3)</li> <li>○ 90031-Montecito Heights (401.9)</li> <li>○ 90037-South Los Angeles (501.0)</li> <li>○ 90044-Athens (601.5)</li> <li>○ 90046-Mount Olympus (473.4)</li> <li>○ 90057-Westlake (380.0)</li> </ul>

- Rates of heart disease mortality per 100,000 persons, which were higher when compared to California (15.6) in:

CHMC Service Area	GSH Service Area	SVMC Service Area
<ul style="list-style-type: none"> <li>○ 90001-South Los Angeles (57.0)</li> <li>○ 90002-Watts (70.0)</li> <li>○ 90003-South Los Angeles (74.0)</li> <li>○ 90004-Hancock Park (66.0)</li> <li>○ 90005-Koreatown (49.0)</li> <li>○ 90006-Pico Heights (65.0)</li> <li>○ 90007-South Los Angeles (30.0)</li> <li>○ 90008-Baldwin Hills/Crenshaw (94.0)</li> <li>○ 90011-South Los Angeles (86.0)</li> <li>○ 90015-Downtown Los Angeles (16.0)</li> <li>○ 90016-West Adams (96.0)</li> <li>○ 90017-Downtown Los Angeles (27.0)</li> <li>○ 90018-Jefferson Park (96.0)</li> <li>○ 90019-Country Club Park/Mid City (106.0)</li> <li>○ 90020-Hancock Park (34.0)</li> <li>○ 90026-Echo Park/Silverlake (89.0)</li> <li>○ 90037-South Los Angeles (69.0)</li> <li>○ 90043-Hyde Park (112.0)</li> <li>○ 90044-Athens (137.0)</li> <li>○ 90047-South Los Angeles (136.0)</li> <li>○ 90057-Westlake (69.0)</li> <li>○ 90062-South Los Angeles (58.0)</li> </ul>	<ul style="list-style-type: none"> <li>○ 90004-Hancock Park (66.0)</li> <li>○ 90005-Koreatown (49.0)</li> <li>○ 90006-Pico Heights (65.0)</li> <li>○ 90007-South Los Angeles (30.0)</li> <li>○ 90012-Chinatown (66.0)</li> <li>○ 90013-Downtown Los Angeles (34.0)</li> <li>○ 90014-Los Angeles (24.0)</li> <li>○ 90015-Downtown Los Angeles (16.0)</li> <li>○ 90017-Downtown Los Angeles (27.0)</li> <li>○ 90018-Jefferson Park (96.0)</li> <li>○ 90020-Hancock Park (34.0)</li> <li>○ 90026-Echo Park/Silverlake (89.0)</li> <li>○ 90057-Westlake (39.0)</li> </ul>	<ul style="list-style-type: none"> <li>○ 90004-Hancock Park (66.0)</li> <li>○ 90005-Koreatown (49.0)</li> <li>○ 90006-Pico Heights (65.0)</li> <li>○ 90007-South Los Angeles (30.0)</li> <li>○ 90008-Baldwin Hills/Crenshaw (94.0)</li> <li>○ 90011-South Los Angeles (86.0)</li> <li>○ 90016-West Adams (96.0)</li> <li>○ 90017-Downtown Los Angeles (27.0)</li> <li>○ 90018-Jefferson Park (96.0)</li> <li>○ 90019-Country Club Park/Mid City (106.0)</li> <li>○ 90020-Hancock Park (34.0)</li> <li>○ 90026-Echo Park/Silverlake (89.0)</li> <li>○ 90027-Griffith Park/Los Feliz (123.0)</li> <li>○ 90028-Hollywood (52.0)</li> <li>○ 90029-Downtown Los Angeles (75.0)</li> <li>○ 90031-Montecito Heights (71.0)</li> <li>○ 90037-South Los Angeles (69.0)</li> <li>○ 90044-Athens (137.0)</li> <li>○ 90046-Mount Olympus (473.4)</li> <li>○ 90057-Westlake (69.0)</li> </ul>

Stakeholders also identified South Los Angeles as the most severely impacted area.

**Associated drivers and risk factors – what is driving the high rates of cardiovascular disease in the community?**

The burden of cardiovascular disease is disproportionately distributed across the population. Significant disparities are evident based on gender, age, race/ethnicity, geographic area, and socioeconomic status with regard to prevalence of risk factors, access to treatment, appropriate and timely treatment, treatment outcomes, and mortality<sup>6</sup>. Other risk factors for cardiovascular disease include high blood pressure, high cholesterol, smoking, diabetes, poor diet, physical inactivity, and overweight and obesity. Cardiovascular disease

is closely linked with and can often lead to stroke<sup>7</sup>. For data concerning health drivers, please refer to the *Scorecard*.

**Community Input – *what do community stakeholders think about the issue of cardiovascular disease?***

---

Stakeholders linked cardiovascular disease to obesity, diabetes, and hypertension. They attributed high rates of cardiovascular disease to the lack of access to healthy foods, living in food deserts, living an unhealthy lifestyle, a lack of access to medical care, and the lack of transportation to obtain medical care. Cardiovascular disease was also identified as the number one cause of death.

---

<sup>1</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=21>. Accessed [February 28, 2013].

<sup>2</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=21>. Accessed [February 28, 2013].

<sup>3</sup> California Hospital Medical Center

<sup>4</sup> Good Samaritan Hospital

<sup>5</sup> St. Vincent Medical Center

<sup>6</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=21>. Accessed [February 28, 2013].

<sup>7</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=21>. Accessed [February 28, 2013].

Health Need Profile – **Cholesterol**

**About Cholesterol— why is it important?**

Cholesterol is a waxy, fat-like substance necessary in the body. However, too much cholesterol in the blood can build up on artery walls, leading to heart disease—one of the leading causes of death in the United States—and stroke. About one of every six adults in the United States has high blood cholesterol. In addition, 2,200 Americans die of heart disease each day, an average of one death every 39 seconds<sup>1</sup>.

Some health conditions, as well as lifestyle and genetic factors, can put people at a higher risk for developing high cholesterol. Age is a contributing factor; as people get older, cholesterol levels rise. Diabetes can also lead to the development of high cholesterol. Some behaviors can also lead to high cholesterol, including a diet high in saturated fats, trans fatty acids (trans fats), dietary cholesterol, or triglycerides. Being overweight and physically inactive also contribute to high cholesterol. Finally, high cholesterol can be hereditary<sup>2</sup>.

**Statistical data – how is cholesterol measured? What is the prevalence/incidence rate of cholesterol in the community?**

**Cholesterol Indicators**

Indicator	Year	Comparison		CHMC <sup>3</sup> Service Area	GSH <sup>4</sup> Service Area	SVMC <sup>5</sup> Service Area
		Level	Avg.			
Percent of adults 18 and older ever diagnosed with high cholesterol	2011	LAC	25.6%	24.6%	23.5%	23.5%

LAC=Los Angeles County

**Sub-populations experiencing the greatest impact (disparities)**

Stakeholders identified Asian men as the most severely impacted.

**Geographic areas of greatest impact (disparities)**

Stakeholders did not identify geographic disparities.

**Associated drivers and risk factors – what is driving the high rates of cholesterol in the community?**

Some health conditions, as well as lifestyle and genetic factors, can put people at a higher risk for developing high cholesterol. Age is a contributing factor; as people get older, cholesterol level tends to rise. Diabetes can also lead to the development of high cholesterol. Some behaviors can also lead to high cholesterol, including a diet high in saturated fats, trans fatty acids (trans fats), dietary cholesterol, or triglycerides. Being overweight and physical inactivity can also contribute to high cholesterol. Finally, high cholesterol can be hereditary<sup>6</sup>. For data concerning health drivers, please refer to the *Scorecard*.

**Community Input – what do community stakeholders think about the issue of cholesterol?**

Stakeholders linked high cholesterol to poor nutrition and poor lifestyle choices.

<sup>1</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. High Cholesterol. Atlanta, GA. Available at <http://www.cdc.gov/cholesterol/index.htm>. Accessed [March 4, 2013].

<sup>2</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. High Cholesterol. Atlanta, GA. Available at <http://www.cdc.gov/cholesterol/index.htm>. Accessed [March 4, 2013].

<sup>3</sup> California Hospital Medical Center

<sup>4</sup> Good Samaritan Hospital

<sup>5</sup> St. Vincent Medical Center

<sup>6</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. High Cholesterol. Atlanta, GA. Available at <http://www.cdc.gov/cholesterol/index.htm>. Accessed [March 4, 2013].

**Health Need Profile – Colorectal Cancer**

**About Colorectal Cancer– why is it important?**

Colorectal cancer, defined as cancer that starts in the colon or the rectum, is the second leading cause of cancer-related deaths in the United States and is expected to cause about 50,830 deaths during 2013. The lifetime risk of developing colorectal cancer is about one in 20 (5.1%), with the risk being slightly lower in women than in men<sup>1</sup>. In addition, colorectal cancer is associated with overall cancer mortality, heavy alcohol consumption, obesity, diabetes prevalence and colon cancer screening.

The number of new colorectal cancer cases and the number of deaths from colorectal cancer are decreasing. The likely causes are regular screenings and improved treatment. Regular screenings can often detect colorectal cancer early on when the disease is most likely to be curable. Screenings can also find polyps, which can be removed before turning into cancer<sup>2</sup>. As a result, there are now more than one million survivors of colorectal cancer in the United States<sup>3</sup>.

Given the success of colorectal cancer screening, public health organizations are working to increase awareness of these screenings among the general public and health care providers. Currently, only about half of Americans ages 50 or older have had any colorectal cancer screening<sup>4</sup>.

**Statistical data – how is colorectal cancer measured? What is the prevalence/incidence rate of colorectal cancer in the community?**

**Colorectal Cancer Indicators**

Indicators	Year	Comparison		CHMC <sup>5</sup> Service Area	GSH <sup>6</sup> Service Area	SVMC <sup>7</sup> Service Area
		Level	Avg.			
Percent who had a doctor recommend a colon test in the past 5 years	2011-2012	LAC	35.1%	<b>34.5%</b>	<b>24.1%</b>	<b>24.1%</b>
Percent who had a sigmoidoscopy, colonoscopy, or FOBT <sup>1</sup>	2011-2012	LAC	75.7%	<b>75.2%</b>	<b>70.1%</b>	<b>70.1%</b>
Rate of colorectal cancer incidences per 100,000 pop. <sup>2</sup>	2010	CA	37.3	<b>38.2</b>	<b>38.2</b>	<b>38.2</b>
Rate of colorectal cancer mortality per 100,000 pop.....	2008	LAC	11.2	8.8	6.5	9.8

LAC=Los Angeles County

CA=California

Healthy People 2020 goal: <sup>1</sup><=70.5%; <sup>2</sup><=14.5 per 100,000 pop.

**Sub-populations experiencing the greatest impact (disparities)**

Stakeholders identified Asian males as the most impacted.

**Geographic areas of greatest impact (disparities)**

By ZIP code, the following disparities were found:

- Rates of colorectal cancer mortality per 100,000 persons, which were higher when compared to California (11.2) in:

CHMC Service Area	GSH Service Area	SVMC Service Area
○ 90008-Baldwin Hills/Crenshaw (33.8)	○ 90012-Chinatown (17.3)	○ 90008-Baldwin Hills/Crenshaw (33.8)
○ 90016-West Adams (17.2)	○ 90014-Los Angeles (22.2)	○ 90016-West Adams (17.2)
○ 90043-Hyde Park (14.0)		○ 90028-Hollywood (11.8)

CHMC Service Area	GSH Service Area	SVMC Service Area
○ 90047-South Los Angeles (17.7)		○ 90031-Montecito Heights (20.0) ○ 90046-Mount Olympus (18.3)

Stakeholders identified Asian males as the most impacted.

**Associated drivers and risk factors – what is driving the high rates of colorectal cancer in the community?**

The major factors that can increase the risk of colorectal cancer are increasing age and family history of colorectal cancer. Other less significant factors include a personal history of inflammatory bowel disease, inherited risk, heavy alcohol use, cigarette smoking, obesity, diabetes prevalence, and colon cancer screening<sup>8</sup>. Regular physical activity and diets high in vegetables, fruits, and whole grains have been linked with a decreased incidence of colorectal cancer<sup>9</sup>. For data concerning health drivers, please refer to the *Scorecard*.

**Community Input – what do community stakeholders think about the issue of colorectal cancer?**

Stakeholders mentioned colorectal cancer as an issue that was affecting the community. They also added that there has been an increase in those diagnosed with colorectal cancer among Asian men.

<sup>1</sup> American Cancer Society. *Colorectal Cancer*. Available at [<http://www.cancer.org/cancer/colonandrectumcancer/detailedguide/colorectal-cancer-key-statistics>]. Accessed [March 4, 2013].

<sup>2</sup> American Cancer Society. *Colorectal Cancer*. Available at [<http://www.cancer.org/cancer/colonandrectumcancer/detailedguide/colorectal-cancer-detection>]. Accessed [March 4, 2013].

<sup>3</sup> American Cancer Society. *Colorectal Cancer*. Available at [<http://www.cancer.org/cancer/colonandrectumcancer/detailedguide/colorectal-cancer-key-statistics>]. Accessed [March 4, 2013].

<sup>4</sup> American Cancer Society. *Colorectal Cancer*. Available at [<http://www.cancer.org/cancer/colonandrectumcancer/detailedguide/colorectal-cancer-key-statistics>]. Accessed [March 4, 2013].

<sup>5</sup> California Hospital Medical Center

<sup>6</sup> Good Samaritan Hospital

<sup>7</sup> St. Vincent Medical Center

<sup>8</sup> National Cancer Institute. *Colorectal Cancer Prevention*. Available at [<http://www.cancer.gov/cancertopics/pdq/prevention/colorectal/Patient/page3#Keypoint4>]. Accessed [March 4, 2013].

<sup>9</sup> American Cancer Society. *Colorectal Cancer*. Available at [<http://www.cancer.org/cancer/colonandrectumcancer/detailedguide/colorectal-cancer-risk-factors>]. Accessed [March 4, 2013].

**Health Need Profile – Diabetes**

**About Diabetes – why is it important?**

Diabetes affects an estimated 23.6 million people and is the seventh leading cause of death in the United States. Diabetes lowers life expectancy by up to 15 years, increases the risk of heart disease by two to four times, and is the leading cause of kidney failure, lower-limb amputations, and adult-onset blindness<sup>1</sup>. A diabetes diagnosis can also indicate an unhealthy lifestyle—a risk factor for further health issues—and is also linked to obesity.

Given the steady rise in the number of people with diabetes, and the earlier onset of Type 2 diabetes, there is growing concern about substantial increases in diabetes-related complications and their potential to impact and overwhelm the health care system. There is a clear need to take advantage of recent discoveries about the individual and societal benefits of improved diabetes management and prevention by bringing life-saving findings into wider practice, and complementing those strategies with efforts in primary prevention among those at risk for developing diabetes<sup>2</sup>.

In addition, evidence is emerging that diabetes is associated with other co-morbidities, including cognitive impairment, incontinence, fracture risk, and cancer risk and prognosis<sup>3</sup>.

**Statistical data – how is diabetes measured? What is the prevalence/incidence rate of diabetes in the community?**

**Diabetes Indicators**

Indicators	Year	Comparison		CHMC <sup>4</sup> Service Area	GSH <sup>5</sup> Service Area	SVMC <sup>6</sup> Service Area
		Level	Avg.			
Percent of adults 18 and older ever diagnosed with diabetes	2011	LAC	9.5%	8.2%	8.7%	8.7%
Percent of adults who feel confident in their ability to manage their diabetes	2011-2012	LAC	86.4%	79.8%	<b>80.1%</b>	<b>80.1%</b>
Rate of adult diabetes hospitalizations per 100,000 pop....	2010	CA	145.6	<b>228.2</b>	<b>197.3</b>	<b>193.3</b>
Rate of diabetes mortality per 10,000 pop....	2010	CA	1.9	<b>8.4</b>	<b>9.8</b>	<b>9.8</b>
Rate of hospitalizations for uncontrolled diabetes per 100,000 pop....	2009	CA	9.5	<b>24.1</b>	<b>22.5</b>	<b>20.3</b>
Rate of youth diabetes hospitalizations per 100,000 pop....	2010	CA	34.9	26.8	9.1	21.6

LAC=Los Angeles County  
CA=California

**Sub-populations experiencing the greatest impact (disparities)**

Stakeholders identified Asians, African Americans, Filipinos, Latinos, Native Americans, low income youth, women, the aging population, uninsured, and undocumented as the most impacted sub-populations.

**Geographic areas of greatest impact (disparities)**

By ZIP code, the following disparities were found:

- Rates of diabetes hospitalizations per 100,000 adults, which were higher when compared to California (145.6) in:

CHMC Service Area	GSH Service Area	SVMC Service Area
○ 90001-South Los Angeles (245.1)	○ 90006-Pico Heights (224.7)	○ 90006-Pico Heights (224.7)

CHMC Service Area	GSH Service Area	SVMC Service Area
<ul style="list-style-type: none"> <li>○ 90002-Watts (343.6)</li> <li>○ 90003-South Los Angeles (229.4)</li> <li>○ 90006-Pico Heights (224.7)</li> <li>○ 90007-South Los Angeles (151.5)</li> <li>○ 90008-Baldwin Hills/Crenshaw (371.2)</li> <li>○ 90011-South Los Angeles (197.3)</li> <li>○ 90015-Downtown Los Angeles (189.6)</li> <li>○ 90016-West Adams (355.1)</li> <li>○ 90018-Jefferson Park (274.4)</li> <li>○ 90019-Country Club Park/Mid City (181.5)</li> <li>○ 90026-Echo Park/Silverlake (145.9)</li> <li>○ 90037-South Los Angeles (285.5)</li> <li>○ 90043-Hyde Park (363.9)</li> <li>○ 90044-Athens (356.4)</li> <li>○ 90047-South Los Angeles (337.4)</li> <li>○ 90057-Westlake (226.7)</li> <li>○ 90062-South Los Angeles (277.3)</li> </ul>	<ul style="list-style-type: none"> <li>○ 90007-South Los Angeles (151.5)</li> <li>○ 90013-Downtown Los Angeles (450.2)</li> <li>○ 90014-Los Angeles (385.4)</li> <li>○ 90015-Downtown Los Angeles (189.6)</li> <li>○ 90018-Jefferson Park (274.4)</li> <li>○ 90021-Downtown Los Angeles (303.7)</li> <li>○ 90026-Echo Park/Silverlake (145.9)</li> <li>○ 90057-Westlake (226.7)</li> </ul>	<ul style="list-style-type: none"> <li>○ 90007-South Los Angeles (151.5)</li> <li>○ 90008-Baldwin Hills/Crenshaw (371.2)</li> <li>○ 90011-South Los Angeles (197.3)</li> <li>○ 90016-West Adams (355.1)</li> <li>○ 90018-Jefferson Park (274.4)</li> <li>○ 90019-Country Club Park/Mid City (181.5)</li> <li>○ 90026-Echo Park/Silverlake (145.9)</li> <li>○ 90027-Griffith Park/Los Feliz (152.8)</li> <li>○ 90028-Hollywood (149.8)</li> <li>○ 90029-Downtown Los Angeles (196.8)</li> <li>○ 90031-Montecito Heights (203.5)</li> <li>○ 90037-South Los Angeles (285.5)</li> <li>○ 90044-Athens (356.4)</li> <li>○ 90057-Westlake (226.7)</li> </ul>

➤ Rates of diabetes hospitalizations per 100,000 youth, which were higher when compared to California (34.9) in:

CHMC Service Area	GSH Service Area	SVMC Service Area
<ul style="list-style-type: none"> <li>○ 90002-Watts (81.1)</li> <li>○ 90003-South Los Angeles (42.6)</li> <li>○ 90008-Baldwin Hills/Crenshaw (68.5)</li> <li>○ 90016-West Adams (65.1)</li> <li>○ 90043-Hyde Park (55.2)</li> <li>○ 90044-Athens (48.5)</li> </ul>	<ul style="list-style-type: none"> <li>○</li> </ul>	<ul style="list-style-type: none"> <li>○ 90008-Baldwin Hills/Crenshaw (68.5)</li> <li>○ 90016-West Adams (65.1)</li> <li>○ 90028-Hollywood (70.3)</li> <li>○ 90031-Montecito Heights (38.8)</li> <li>○ 90044-Athens (48.5)</li> </ul>

➤ Rates of hospitalizations due to uncontrolled diabetes per 100,000 persons, which were higher when compared to California (9.5) in:

CHMC Service Area	GSH Service Area	SVMC Service Area
<ul style="list-style-type: none"> <li>○ 90001-South Los Angeles (27.1)</li> <li>○ 90002-Watts (36.6)</li> <li>○ 90003-South Los Angeles (21.8)</li> <li>○ 90004-Hancock Park (22.7)</li> <li>○ 90006-Pico Heights (16.5)</li> <li>○ 90007-South Los Angeles (12.9)</li> <li>○ 90008-Baldwin Hills/Crenshaw (25.7)</li> <li>○ 90011-South Los Angeles (21.2)</li> <li>○ 90015-Downtown Los Angeles (31.2)</li> </ul>	<ul style="list-style-type: none"> <li>○ 90004</li> <li>○ 90006</li> <li>○ 90007-South Los Angeles (12.9)</li> <li>○ 90013-Downtown Los Angeles (41.1)</li> <li>○ 90014-Los Angeles (75.9)</li> <li>○ 90015-Downtown Los Angeles (31.2)</li> <li>○ 90017-Downtown Los Angeles (32.5)</li> <li>○ 90018-Jefferson Park (45.5)</li> </ul>	<ul style="list-style-type: none"> <li>○ 90004</li> <li>○ 90006</li> <li>○ 90007-South Los Angeles (12.9)</li> <li>○ 90008-Baldwin Hills/Crenshaw (25.7)</li> <li>○ 90011-South Los Angeles (21.2)</li> <li>○ 90016-West Adams (36.4)</li> <li>○ 90017-Downtown Los Angeles (32.5)</li> <li>○ 90018-Jefferson Park (45.5)</li> <li>○ 90019-Country Club Park/Mid</li> </ul>

CHMC Service Area	GSH Service Area	SVMC Service Area
<ul style="list-style-type: none"> <li>○ 90016-West Adams (36.4)</li> <li>○ 90017-Downtown Los Angeles (32.5)</li> <li>○ 90018-Jefferson Park (45.5)</li> <li>○ 90019-Country Club Park/Mid City (19.8)</li> <li>○ 90026-Echo Park/Silverlake (17.4)</li> <li>○ 90037-South Los Angeles (26.6)</li> <li>○ 90043-Hyde Park (31.2)</li> <li>○ 90044-Athens (29.1)</li> <li>○ 90047-South Los Angeles (33.1)</li> <li>○ 90057-Westlake (28.0)</li> <li>○ 90062-South Los Angeles (29.6)</li> </ul>	<ul style="list-style-type: none"> <li>○ 90026-Echo Park/Silverlake (17.4)</li> <li>○ 90057-Westlake (28.0)</li> </ul>	<ul style="list-style-type: none"> <li>City (19.8)</li> <li>○ 90026-Echo Park/Silverlake (17.4)</li> <li>○ 90028-Hollywood (12.7)</li> <li>○ 90029-Downtown Los Angeles (38.3)</li> <li>○ 90031-Montecito Heights (22.2)</li> <li>○ 90044-Athens (29.1)</li> <li>○ 90057-Westlake (28.0)</li> </ul>

- Rates of diabetes mortality per 10,000 persons, which were higher when compared to California (1.9) in:

CHMC Service Area	GSH Service Area	SVMC Service Area
<ul style="list-style-type: none"> <li>○ 90001-South Los Angeles (4.0)</li> <li>○ 90002-Watts (12.0)</li> <li>○ 90003-South Los Angeles (9.0)</li> <li>○ 90004-Hancock Park (10.0)</li> <li>○ 90005-Koreatown (5.0)</li> <li>○ 90006-Pico Heights (16.0)</li> <li>○ 90007-South Los Angeles (8.0)</li> <li>○ 90008-Baldwin Hills/Crenshaw (12.0)</li> <li>○ 90011-South Los Angeles (12.0)</li> <li>○ 90015-Downtown Los Angeles (3.0)</li> <li>○ 90016-West Adams (17.0)</li> <li>○ 90017-Downtown Los Angeles (5.0)</li> <li>○ 90018-Jefferson Park (8.0)</li> <li>○ 90019-Country Club Park/Mid City (14.0)</li> <li>○ 90020-Hancock Park (2.0)</li> <li>○ 90026-Echo Park/Silverlake (9.0)</li> <li>○ 90037-South Los Angeles (15.0)</li> <li>○ 90043-Hyde Park (13.0)</li> <li>○ 90044-Athens (21.0)</li> <li>○ 90047-South Los Angeles (19.0)</li> <li>○ 90057-Westlake (8.0)</li> <li>○ 90062-South Los Angeles (14.0)</li> </ul>	<ul style="list-style-type: none"> <li>○ 90004-Hancock Park (10.0)</li> <li>○ 90005-Koreatown (5.0)</li> <li>○ 90006-Pico Heights (16.0)</li> <li>○ 90007-South Los Angeles (8.0)</li> <li>○ 90012-Chinatown (6.0)</li> <li>○ 90014-Los Angeles (5.0)</li> <li>○ 90015-Downtown Los Angeles (3.0)</li> <li>○ 90017-Downtown Los Angeles (5.0)</li> <li>○ 90018-Jefferson Park (8.0)</li> <li>○ 90020-Hancock Park (2.0)</li> <li>○ 90021-Downtown Los Angeles (2.0)</li> <li>○ 90026-Echo Park/Silverlake (9.0)</li> <li>○ 90057-Westlake (8.0)</li> </ul>	<ul style="list-style-type: none"> <li>○ 90004-Hancock Park (10.0)</li> <li>○ 90005-Koreatown (5.0)</li> <li>○ 90006-Pico Heights (16.0)</li> <li>○ 90007-South Los Angeles (8.0)</li> <li>○ 90008-Baldwin Hills/Crenshaw (12.0)</li> <li>○ 90011-South Los Angeles (12.0)</li> <li>○ 90016-West Adams (17.0)</li> <li>○ 90017-Downtown Los Angeles (5.0)</li> <li>○ 90018-Jefferson Park (8.0)</li> <li>○ 90019-Country Club Park/Mid City (14.0)</li> <li>○ 90020-Hancock Park (2.0)</li> <li>○ 90026-Echo Park/Silverlake (9.0)</li> <li>○ 90027-Griffith Park/Los Feliz (6.0)</li> <li>○ 90028-Hollywood (6.0)</li> <li>○ 90029-Downtown Los Angeles (9.0)</li> <li>○ 90031-Montecito Heights (13.0)</li> <li>○ 90037-South Los Angeles (15.0)</li> <li>○ 90044-Athens (21.0)</li> <li>○ 90057-Westlake (8.0)</li> </ul>

Stakeholders identified geographic areas including Chinatown, East Los Angeles, and northeast portions of Los Angeles County as particularly impacted by diabetes.

**Associated drivers and risk factors – what is driving the high rates of diabetes in the community?**

Factors associated with diabetes include being overweight, having high blood pressure, high cholesterol, high blood sugar (or glucose), physical inactivity, smoking, unhealthy eating, age, race, gender, and having a family history of diabetes<sup>7</sup>. For data concerning health drivers, please refer to **Error! Reference source not found.**

*“The main issue is families and culture. They tend to eat the same kind of food as in the past even if it’s unhealthy.”  
(Resident Focus Group Participant)*

**Community Input – what do community stakeholders think about the issue of diabetes?**

Stakeholders linked diabetes to obesity and hypertension. They also attributed the prevalence of diabetes to a number of factors including the high cost and lack of access to healthy food, as well as living in a food desert and lifestyle choices. Other factors include lack of access to health services, language barriers, and transportation. They also linked diabetes to obesity and physical inactivity. Stakeholders also stated that diabetes is an increasing issue among communities of color.

*“As immigrants assimilate, especially Latinos, many stop practicing traditions they grew up with or customs that included activity and take up unhealthy habits, become inactive and consume high levels of fat and salt.”  
(Health Professional, National Health Organization)*

<sup>1</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=32>. Accessed [February 26, 2013].

<sup>2</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=32>. Accessed [February 26, 2013].

<sup>3</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=32>. Accessed [February 26, 2013].

<sup>4</sup> California Hospital Medical Center

<sup>5</sup> Good Samaritan Hospital

<sup>6</sup> St. Vincent Medical Center

Health Need Profile –Cancer

**About Cancer– why is it important?**

Cancer is the second leading cause of death in the United States, claiming more than half a million Americans every year<sup>1</sup>. Cancer incidence rates per 100,000 persons show that the three most common cancers among men in the United States are prostate cancer (137.7), lung cancer (78.2), and colorectal cancer (49.2). Likewise, the leading causes of cancer death among men are lung cancer (62.0), prostate cancer (22.0), and colorectal cancer (19.1). Among women, the three most common cancers are breast cancer (123.1), lung cancer (54.1), and colorectal cancer (37.1). Lung (38.6), breast (22.2), and colorectal (13.1) cancers are also the leading causes of cancer-related deaths among women<sup>2</sup>.

The number of new cancer cases can be reduced, and many cancer deaths can be prevented. Research shows that screening for cervical and colorectal cancers, as recommended, helps prevent these diseases by finding precancerous lesions which can be treated before they become cancerous. Screening for cervical, colorectal and breast cancers also can identify these diseases at an early, often highly treatable stage<sup>3</sup>. The most common risk factors for cancer are growing older, obesity, tobacco, alcohol, over exposure to sunlight, certain chemicals, some viruses and bacteria, family history of cancer, poor diet, and lack of physical activity<sup>4</sup>.

**Statistical data – how is cancer measured? What is the prevalence/incidence rate of cancer in the community?**

Cancer Indicators

Indicators	Year	Comparison		CHMC <sup>5</sup> Service Area	GSH <sup>6</sup> Service Area	SVMC <sup>7</sup> Service Area
		Level	Avg.			
Percent of women that had a cervical cancer screening in the last 3 years <sup>1</sup>	2011	LAC	82.8%	84.1%	84.7%	84.7%
Percent of women that had a mammogram in the last 2 years <sup>2</sup>	2011	LAC	79.8%	79.2%	79.2%	79.2%
Rate of cancer mortality per 100,000 pop....	2010	CA	15.1	58.5	34.4	59.5
Rate of cervical cancer incidences per 100,000 pop. <sup>3</sup>	2010	CA	8.0	9.4	9.4	9.4
Rate of cervical cancer mortality per 100,000 pop....	2008	LAC	3.0	5.3	1.6	22.0
Rate of prostate cancer incidences per 100,000 pop. <sup>4</sup>	2010	CA	140.3	134.3	134.3	134.3

LAC=Los Angeles County

CA=California

Healthy People 2020 goal: <sup>1</sup><=93%; <sup>2</sup><=81.1%; <sup>3</sup><=2.2 per 100,000 pop.; <sup>4</sup><=21.2 per 100,000 pop.

**Sub-populations experiencing the greatest impact (disparities)**

Stakeholders identified the homeless as the most severely impacted. They also indicated Asian males as impacted most by prostate and stomach cancer.

**Geographic areas of greatest impact (disparities)**

Stakeholders did not identify geographic disparities.

**Associated drivers and risk factors – what is driving the high rates of cancer in the community?**

A primary method of preventing cancer is screening for cervical, colorectal, and breast cancers<sup>8</sup>. The most common risk factors for cancer are growing older, obesity, tobacco, alcohol, sunlight exposure, certain chemicals, some viruses and bacteria, family history of cancer, poor diet, and lack of physical activity<sup>9</sup>. For data concerning health drivers, please refer to the *Scorecard*.

**Community Input – what do community stakeholders think about the issue of cancer?**

Stakeholders indicated that people have limited access to health education about cancer and to prevention services. One stakeholder added that there is a shortage of oncologists who speak the same language as their patients adding that ‘few doctors have experience engaging in dialogue with patients and family members in a comprehensive approach. There’s a sense that the doctors don’t have the patient’s well-being in mind.’ There has also been an increase in Latinos, Asian-Pacific Islanders, and Native Americans who are being diagnosed with late stage cancer. Improvements in messaging and services delivery are needed in order to encourage community members to access health care earlier.

---

<sup>1</sup> Centers for Disease Control and Prevention. *Using Science to Reduce the Burden of Cancer*. Available at [<http://www.cdc.gov/Features/CancerResearch/>]. Accessed [March 7, 2013].

<sup>2</sup> Centers for Disease Control and Prevention. *Using Science to Reduce the Burden of Cancer*. Available at [<http://www.cdc.gov/Features/CancerResearch/>]. Accessed [March 7, 2013].

<sup>3</sup> Centers for Disease Control and Prevention. *Cancer Prevention*. Available at [<http://www.cdc.gov/cancer/dcpc/prevention/index.htm>]. Accessed [March 7, 2013].

<sup>4</sup> National Cancer Institute. *Risk Factors*. Available at [<http://www.cancer.gov/cancertopics/wyntk/cancer/page3>]. Accessed [March 7, 2013].

<sup>5</sup> California Hospital Medical Center

<sup>6</sup> Good Samaritan Hospital

<sup>7</sup> St. Vincent Medical Center

<sup>8</sup> Centers for Disease Control and Prevention. *Cancer Prevention*. Available at [<http://www.cdc.gov/cancer/dcpc/prevention/index.htm>]. Accessed [March 7, 2013].

<sup>9</sup> National Cancer Institute. *Risk Factors*. Available at [<http://www.cancer.gov/cancertopics/wyntk/cancer/page3>]. Accessed [March 7, 2013].

**Health Need Profile – HIV/AIDS**

**About HIV/AIDS— why is it important?**

More than 1.1 million people in the United States are living with HIV and almost one in five (18.1%) are unaware of their infection<sup>1</sup>. HIV infection weakens the immune system, making those living with HIV highly susceptible to a variety of illnesses and cancers, including tuberculosis (TB), cytomegalovirus (CMV), cryptococcal meningitis, lymphomas, kidney disease, and cardiovascular disease<sup>2</sup>. Without treatment, almost all people infected with HIV will develop AIDS<sup>3</sup>. While HIV is a chronic medical condition that can be treated, the disease cannot yet be cured.

The risk of acquiring HIV is increased by engaging in unprotected sex, having another sexually transmitted infection, sharing intravenous drugs, having been diagnosed with hepatitis, tuberculosis, or malaria, and having been exposed to the virus as a fetus or infant before or during birth or through breastfeeding from a mother infected with HIV<sup>4</sup>. Racial disparities in HIV prevalence persist; African Americans and Hispanics/Latinos are disproportionately affected by HIV and experience the most severe burden of HIV compared with other races and ethnicities in the United States. Prevention efforts to reduce the spread of HIV in the United States encompass many components, such as behavioral interventions, HIV testing, and linkage to treatment and care<sup>5</sup>.

*“HIV related illness is decreasing, but there are many affected children (children of infected parents). The number of infected kids 10 years old and under is decreasing but there is an increase in infected teens ages 10 and over.”*  
(CEO, Community Based Foundation)

**Statistical data – how is HIV/AIDS measured? What is the prevalence/incidence rate of HIV/AIDS in the community?**

**HIV/AIDS Indicators**

Indicators	Year	Comparison		CHMC <sup>6</sup>	GSH <sup>7</sup>	SVMC <sup>8</sup>
		Level	Avg.	Service Area	Service Area	Service Area
Rate of HIV mortality per 100,000 pop.	2012	LAC	3.0	5.7	6.8	6.8
Rate of HIV/AIDS hospitalizations per 100,000 pop....	2010	CA	11.0	36.5	56.1	43.4
Rate of HIV/AIDS incidences per 100,000 pop.	2012	LAC	24.9	38.9	55.7	55.7

LAC=Los Angeles County  
CA=California

**Sub-populations experiencing the greatest impact (disparities)**

Stakeholders indicated the homeless, GLBTQ (gay, lesbian, bisexual, transgender, and queer culture), teenagers, low-income women, and teenagers transitioning into adults as the most severely impacted sub-populations.

*“Women find out that they are HIV positive after their partner becomes ill or dies of the disease. We do workshops and use a promotora model to enter the community and break the silence and isolation.”*  
(Executive Director, Community Based Organization)

**Geographic areas of greatest impact (disparities)**

By ZIP code, the following disparities were found:

- Rates of HIV hospitalizations per 100,000 persons, which were higher when compared to California (11.0) in:

CHMC Service Area	GSH Service Area	SVMC Service Area
○ 90001-South Los Angeles (22.8)	○ 90004-Hancock Park (41.8)	○ 90006-Pico Heights (18.6)
○ 90002-Watts (31.2)	○ 90006-Pico Heights (18.6)	○ 90008-Baldwin Hills/Crenshaw
○ 90003-South Los Angeles (31.7)	○ 90013-Downtown Los Angeles	(71.1)

CHMC Service Area	GSH Service Area	SVMC Service Area
○ 90004-Hancock Park (41.8)	(220.9)	○ 90011-South Los Angeles (21.2)
○ 90005-Koreatown (18.6)	○ 90014-Los Angeles (114.2)	○ 90016-West Adams (71.4)
○ 90006-Pico Heights (18.6)	○ 90015-Downtown Los Angeles (42.1)	○ 90018-Jefferson Park (50.7)
○ 90008-Baldwin Hills/Crenshaw (71.1)	○ 90018-Jefferson Park (50.7)	○ 90019-Country Club Park/Mid City (20.2)
○ 90010-Wilshire (105.3)	○ 90021-Downtown Los Angeles (25.3)	○ 90026-Echo Park/Silverlake (145.9)
○ 90011-South Los Angeles (21.2)	○ 90026-Echo Park/Silverlake (33.9)	○ 90027-Griffith Park/Los Feliz (55.4)
○ 90015-Downtown Los Angeles (42.1)	○ 90057-Westlake (57.8)	○ 90028-Hollywood (101.0)
○ 90016-West Adams (71.4)		○ 90029-Downtown Los Angeles (44.0)
○ 90017-Downtown Los Angeles (42.1)		○ 90037-South Los Angeles (12.8)
○ 90018-Jefferson Park (50.7)		○ 90044-Athens (22.3)
○ 90019-Country Club Park/Mid City (20.2)		○ 90046-Mount Olympus (88.5)
○ 90026-Echo Park/Silverlake (33.9)		○ 90057-Westlake (57.8)
○ 90037-South Los Angeles (12.8)		
○ 90043-Hyde Park (31.3)		
○ 90044-Athens (22.3)		
○ 90047-South Los Angeles (45.3)		
○ 90057-Westlake (57.8)		
○ 90062-South Los Angeles (21.3)		

Stakeholders identified South Los Angeles as being the most severely impacted.

**Associated drivers and risk factors – what is driving the high rates of HIV/AIDS in the community?**

The following factors are associated with HIV/AIDS: injection drug use, risky sexual behaviors<sup>9</sup>, poverty, heavy alcohol consumption, liquor store access, and HIV screenings. HIV prevalence is highest among gay, bisexual, and other men who have sex with men, and among African Americans<sup>10</sup>.

Untreated HIV infection is associated with many diseases including cardiovascular disease, kidney disease, liver disease, and cancer<sup>11</sup>. Persons with the HIV infection are disproportionately affected by viral hepatitis, and those co-infected with HIV and viral hepatitis experience greater liver-related health problems than those who do not have the HIV infection<sup>12</sup>. For data concerning health drivers, please refer to the *Scorecard*.

*“However, despite many gains in HIV/AIDS disease management, we still see people of color who are poor with such an advanced disease at diagnosis that they’re really on the edge of death. It’s surprising to see individuals still come in so late, immune system ravaged and at 80% of body weight.”*  
(Executive Director, Community Based Organization)

**Community Input – what do community stakeholders think about the issue of HIV/AIDS?**

Stakeholders stated that there have been fewer newly diagnosed HIV/AIDS cases and improvements in care management though there is still a need for more education and prevention services and other measures around HIV/AIDS including family-based programming and services, mental health services (to alleviate the

*“It is like what it was 20 years ago: clients are facing discrimination, living in secrecy among peers in the community, and now back to family as well. As a result, they are facing emotional and mental issues, in addition to physical issues.”*  
(CEO, Community Based Foundation)

depression and anxiety experienced by those with HIV/AIDS), and more collaboration from hospitals.

---

<sup>1</sup> Centers for Disease Control and Prevention. *Drug-Associated HIV Transmission Continues in the United States*. Available at [<http://www.cdc.gov/hiv/resources/factsheets/idu.htm>]. Accessed [February 28, 2013].

<sup>2</sup> Mayo Clinic. *Complications*. Available at [<http://www.mayoclinic.com/health/hiv-aids/DS00005/DSECTION=complications>]. Accessed [March 1, 2013].

<sup>3</sup> National Institutes of Health. *HIV Infection*. Available at [<http://www.nlm.nih.gov/medlineplus/ency/article/000602.htm>]. Accessed [March 1, 2013].

<sup>4</sup> National Institute of Allergy and Infectious Diseases. *HIV Risk Factors*. Available at [<http://www.niaid.nih.gov/topics/hivaids/understanding/pages/riskfactors.aspx>]. Accessed [March 6, 2013].

<sup>5</sup> Centers for Disease Control and Prevention. *CDC's HIV Prevention Progress in the United States*. Available at [<http://www.cdc.gov/hiv/resources/factsheets/cdcprev.htm>]. Accessed [February 28, 2013].

<sup>6</sup> California Hospital Medical Center

<sup>7</sup> Good Samaritan Hospital

<sup>8</sup> St. Vincent Medical Center

<sup>9</sup> Centers for Disease Control and Prevention. *Drug-Associated HIV Transmission Continues in the United States*. Available at [<http://www.cdc.gov/hiv/resources/factsheets/idu.htm>]. Accessed [February 28, 2013].

<sup>10</sup> Centers for Disease Control and Prevention. *HIV in the United States: At A Glance*. Available at [<http://www.cdc.gov/hiv/resources/factsheets/us.htm>]. Accessed [February 28, 2013].

<sup>11</sup> Centers for Disease Control and Prevention. *Basic Information about HIV and AIDS*. Available at [<http://www.cdc.gov/hiv/topics/basic/index.htm>]. Accessed [March 1, 2013].

<sup>12</sup> Centers for Disease Control and Prevention. *HIV and Viral Hepatitis*. Available at [<http://www.cdc.gov/hiv/resources/factsheets/hepatitis.htm>]. Accessed [March 1, 2013].

**Health Need Profile – Hypertension**

**About Hypertension— why is it important?**

Hypertension, defined as a blood pressure reading of 140/90 or higher, affects one in three adults in the United States<sup>1</sup>. With no symptoms or warning signs and the ability to cause serious damage to the body, the condition has been called a silent killer. If untreated, high blood pressure can lead to heart failure, blood vessel aneurysms, kidney failure, heart attack, stroke, and vision changes or blindness<sup>2</sup>. High blood pressure can be controlled through medicines and lifestyle change, however, patient adherence to treatment regimens is a significant barrier to controlling high blood pressure<sup>3</sup>.

High blood pressure is associated with smoking, obesity, regular consumption of salt and fat, excessive drinking, and physical inactivity. Those at higher risk of developing hypertension include people who have previously had a stroke and those who have high cholesterol or heart or kidney disease. African-Americans and people with a family history of hypertension are also at an increased risk of having hypertension<sup>4</sup>.

**Statistical data – how is hypertension measured? What is the prevalence/incidence rate of hypertension in the community?**

**Hypertension Indicators**

Indicators	Year	Comparison		CHMC <sup>5</sup> Service Area	GSH <sup>6</sup> Service Area	SVMC <sup>7</sup> Service Area
		Level	Avg.			
Percent of adults ever diagnosed with high blood pressure <sup>1</sup>	2011	LAC	24.0%	22.6%	24.4%	24.4%
Percent of adults taking any medications to control their high blood pressure <sup>2</sup>	2009	LAC	70.4%	68.5%	65.3%	65.3%
Rate of hypertension mortality per 10,000 pop....	2010	CA	1.0	5.1	2.6	5.1

LAC=Los Angeles County

CA=California

Healthy People 2020 goal: <sup>1</sup><=26.9%; <sup>2</sup><=69.5%

**Sub-populations experiencing the greatest impact (disparities)**

Stakeholders indicated that hypertension mostly impacts Latinos, African-Americans, the homeless, uninsured, underinsured, and day laborers.

**Geographic areas of greatest impact (disparities)**

By ZIP code, the following disparities were found:

- Rates of hypertension mortality per 10,000 persons, which were higher when compared to California (1.0) in:

CHMC Service Area	GSH Service Area	SVMC Service Area
○ 90001-South Los Angeles (8.0)	○ 90004-Hancock Park (7.0)	○ 90004-Hancock Park (7.0)
○ 90002-Watts (10.0)	○ 90005-Koreatown (4.0)	○ 90005-Koreatown (4.0)
○ 90003-South Los Angeles (8.0)	○ 90006-Pico Heights (4.0)	○ 90006-Pico Heights (4.0)
○ 90004-Hancock Park (7.0)	○ 90012-Chinatown (4.0)	○ 90008-Baldwin Hills/Crenshaw (5.0)
○ 90005-Koreatown (4.0)	○ 90013-Downtown Los Angeles (2.0)	○ 90011-South Los Angeles (8.0)
○ 90006-Pico Heights (4.0)	○ 90015-Downtown Los Angeles (2.0)	○ 90016-West Adams (9.0)
○ 90008-Baldwin Hills/Crenshaw (5.0)	○ 90018-Jefferson Park (7.0)	○ 90018-Jefferson Park (7.0)
○ 90011-South Los Angeles (8.0)	○ 90020-Hancock Park (3.0)	○ 90019-Country Club Park/Mid City (9.0)
○ 90015-Downtown Los Angeles		

CHMC Service Area	GSH Service Area	SVMC Service Area
<ul style="list-style-type: none"> <li>(2.0)</li> <li>○ 90016-West Adams (9.0)</li> <li>○ 90018-Jefferson Park (7.0)</li> <li>○ 90019-Country Club Park/Mid City (9.0)</li> <li>○ 90020-Hancock Park (3.0)</li> <li>○ 90026-Echo Park/Silverlake (3.0)</li> <li>○ 90037-South Los Angeles (5.0)</li> <li>○ 90043-Hyde Park (6.0)</li> <li>○ 90044-Athens (12.0)</li> <li>○ 90047-South Los Angeles (12.0)</li> <li>○ 90057-Westlake (4.0)</li> <li>○ 90062-South Los Angeles (2.0)</li> </ul>	<ul style="list-style-type: none"> <li>○ 90026-Echo Park/Silverlake (3.0)</li> <li>○ 90057-Westlake (4.0)</li> </ul>	<ul style="list-style-type: none"> <li>○ 90020-Hancock Park (3.0)</li> <li>○ 90026-Echo Park/Silverlake (3.0)</li> <li>○ 90027-Griffith Park/Los Feliz (5.0)</li> <li>○ 90028-Hollywood (2.0)</li> <li>○ 90029-Downtown Los Angeles (3.0)</li> <li>○ 90031-Montecito Heights (5.0)</li> <li>○ 90037-South Los Angeles (5.0)</li> <li>○ 90044-Athens (12.0)</li> <li>○ 90046-Mount Olympus (12.0)</li> <li>○ 90057-Westlake (4.0)</li> </ul>

Stakeholders indicated that Los Angeles is generally impacted by hypertension.

**Associated drivers and risk factors – what is driving the high rates of hypertension in the community?**

Smoking, obesity, regular consumption of salt and fat, excessive drinking, and physical inactivity are risk factors for hypertension. People who have previously had a stroke, have high cholesterol, or have heart or kidney disease are also at higher risk of developing hypertension. For data concerning health drivers, please refer to the *Scorecard*.

**Community Input – what do community stakeholders think about the issue of hypertension?**

Stakeholders indicated that hypertension is closely related and linked to diabetes, obesity, stress, and lifestyle choices. Stakeholders added that people were not getting regular medical check-ups and were waiting until an emergency, often because the cost of seeking treatment is high and the lack of access to health care. Stakeholders also mentioned that effective management of such diseases remains a major hurdle given the shortage in programs and education.

*“Hypertension is going up because people are not getting it checked; they not aware have it, they not going to the doctor on regular basis, and as the population ages they have a tendency to have higher blood pressure.”*  
 (Foundation Relations Director, Health Organization)

<sup>1</sup> National Institutes of Health. *Hypertension (High Blood Pressure)*. Available at <http://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=97>. Accessed [March 12, 2013].

<sup>2</sup> National Heart, Lung, and Blood Institute. *Blood Pressure: Signs & Symptoms*. Available at <http://www.nhlbi.nih.gov/health/health-topics/topics/hbp/signs.html>. Accessed [March 12, 2013].

<sup>3</sup> National Institutes of Health. *Hypertension (High Blood Pressure)*. Available at <http://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=97>. Accessed [March 12, 2013].

<sup>4</sup> The Patient Education Institute. *Essential Hypertension*. Available at <http://www.nlm.nih.gov/medlineplus/tutorials/hypertension/hp039105.pdf>. Accessed [March 12, 2013].

<sup>5</sup> California Hospital Medical Center

<sup>6</sup> Good Samaritan Hospital

<sup>7</sup> St. Vincent Medical Center

**Health Need Profile – Mental Health**

**About Mental Health— why is it important?**

Mental illness is a common cause of disability. Untreated disorders may leave individuals at risk for substance abuse, self-destructive behavior, and suicide. Additionally, mental health disorders can have a serious impact on physical health and are associated with the prevalence, progression, and outcome of chronic diseases<sup>1</sup>. Suicide is considered a major preventable public health problem. In 2010, suicide was the tenth leading cause of death among Americans of all ages, and the second leading cause of death among people between the ages of 25 and 34<sup>2</sup>. An estimated 11 attempted suicides occur per every suicide death.

Research shows that more than 90% of those who die by suicide suffer from depression or other mental disorders or a substance-abuse disorder (often in combination with other mental disorders)<sup>3</sup>. Among adults, mental disorders are common, with approximately one-quarter of adults being diagnosed with one or more disorders<sup>4</sup>. Mental disorders are not only associated with suicide, but also with chronic diseases, a family history of mental illness, age, substance abuse, and life-event stresses<sup>5</sup>.

Interventions to prevent suicide include therapy, medication, and programs that focus on both suicide risk and mental or substance-abuse disorders. Another intervention is improving primary care providers’ ability to recognize and treat suicide risk factors, given the research indicating that older adults and women who die by suicide are likely to have seen a primary care provider in the year before their death<sup>6</sup>.

**Statistical data – how is mental health measured? What is the prevalence/incidence rate of mental health in the community?**

**Mental Health Indicators**

Indicators	Year	Comparison		CHMC <sup>7</sup> Service Area	GSH <sup>8</sup> Service Area	SVMC <sup>9</sup> Service Area
		Level	Avg.			
Average number of poor mental and/or physical health days in the past month reported by adults	2011	LAC	5.4	5.3	<b>5.9</b>	<b>5.9</b>
Percent of adults 18 and older ever diagnosed with anxiety	2011	LAC	11.3%	<b>11.5%</b>	11.1%	11.1%
Percent of adults 18 and older ever diagnosed with depression	2011	LAC	12.2%	12.1%	12.1%	12.1%
Percent of adults who had serious psychological distress in the last year	2011-2012	LAC	8.0%	<b>8.1%</b>	<b>9.2%</b>	<b>9.2%</b>
Percent of adults who received adequate social an emotional support	2011	LAC	64.0%	70.3%	64.4%	64.4%
Rate of adult alcohol and drug induced mental illness per 100,000 pop.....	2010	CA	109.1	102.0	<b>199.9</b>	<b>112.9</b>
Rate of adult hospitalizations per 100,000 pop....	2010	CA	551.7	<b>763.1</b>	<b>1,091.3</b>	<b>715.0</b>
Rate of suicides per 10,000 pop. <sup>1</sup> ...	2010	CA	1.0	0.6	<b>1.1</b>	0.7
Rate of youth (under 18) hospitalizations per 100,000 pop....	2010	CA	256.4	<b>343.5</b>	<b>302.4</b>	<b>308.5</b>

LAC=Los Angeles County

CA=California

Healthy People 2020 goal: <sup>1</sup><=1.0 per 10,000 pop.

**Sub-populations experiencing the greatest impact (disparities)**

Stakeholders identified battered women, the homeless, low-income, veterans, undocumented immigrants, men in gangs, prisoners released early coming out with psychiatric issues, and youth (foster youth aging out of the foster system and high school youth) as the most severely impacted.

*“People who have lost their job recently and the newly homeless are the most affected. There is also a stigma about mental health and some people won’t seek help, don’t know about resources, how to get on Medicare or Medi-Cal, or get access to other health resources.”*  
(Vice President of Human Resources, Community Based Organization)

**Geographic areas of greatest impact (disparities)**

By ZIP code, the following disparities were found:

- Rates of alcohol/drug induced mental disease hospitalizations per 100,000 persons, which were higher when compared to California (109.1) in:

CHMC Service Area	GSH Service Area	SVMC Service Area
○ 90001-South Los Angeles (190.9)	○ 90010-Wilshire (157.9)	○ 90010-Wilshire (157.9)
○ 90010-Wilshire (157.9)	○ 90012-Chinatown (119.0)	○ 90016-West Adams (132.4)
○ 90016-West Adams (132.4)	○ 90013-Downtown Los Angeles (925.9)	○ 90018-Jefferson Park (111.5)
○ 90018-Jefferson Park (111.5)	○ 90014-Los Angeles (670.9)	○ 90026-Echo Park/Silverlake (179.4)
○ 90026-Echo Park/Silverlake (179.4)	○ 90018-Jefferson Park (111.5)	○ 90027-Griffith Park/Los Feliz (179.4)
○ 90037-South Los Angeles (112.4)	○ 90021-Downtown Los Angeles (202.5)	○ 90028-Hollywood (156.7)
○ 90047-South Los Angeles (117.3)	○ 90026-Echo Park/Silverlake (179.4)	○ 90031-Montecito Heights (129.7)
○ 90057-Westlake (135.6)	○ 90057-Westlake (135.6)	○ 90037-South Los Angeles (112.4)
		○ 90046-Mount Olympus (210.0)
		○ 90057-Westlake (135.6)

- Rates of mental health hospitalizations per 100,000 adults, which were higher when compared to California (557.1) in:

CHMC Service Area	GSH Service Area	SVMC Service Area
○ 90001-South Los Angeles (865.0)	○ 90004-Hancock Park (619.2)	○ 90004-Hancock Park (619.2)
○ 90002-Watts (782.9)	○ 90005-Koreatown (607.7)	○ 90005-Koreatown (607.7)
○ 90003-South Los Angeles (759.1)	○ 90006-Pico Heights (713.0)	○ 90006-Pico Heights (713.0)
○ 90004-Hancock Park (619.2)	○ 90010-Wilshire (789.5)	○ 90008-Baldwin Hills/Crenshaw (924.9)
○ 90005-Koreatown (607.7)	○ 90013-Downtown Los Angeles (3,644.2)	○ 90010-Wilshire (789.5)
○ 90006-Pico Heights (713.0)	○ 90014-Los Angeles (3,683.1)	○ 90011-South Los Angeles (739.2)
○ 90008-Baldwin Hills/Crenshaw (924.9)	○ 90015-Downtown Los Angeles (695.2)	○ 90016-West Adams (916.0)
○ 90010-Wilshire (789.5)	○ 90017-Downtown Los Angeles (723.7)	○ 90017-Downtown Los Angeles (723.7)
○ 90011-South Los Angeles (739.2)	○ 90018-Jefferson Park (973.4)	○ 90018-Jefferson Park (973.4)
○ 90015-Downtown Los Angeles (695.2)	○ 90021-Downtown Los Angeles (1,214.9)	○ 90019-Country Club Park/Mid City (674.9)
○ 90016-West Adams (916.0)	○ 90057-Westlake (620.0)	○ 90027-Griffith Park/Los Feliz (739.7)
○ 90017-Downtown Los Angeles (723.7)		○ 90028-Hollywood (1,030.9)
○ 90018-Jefferson Park (973.4)		○ 90037-South Los Angeles (969.9)
○ 90019-Country Club Park/Mid City (674.9)		○ 90044-Athens (979.9)
○ 90037-South Los Angeles (969.9)		○ 90046-Mount Olympus (889.2)

CHMC Service Area	GSH Service Area	SVMC Service Area
<ul style="list-style-type: none"> <li>○ 90043-Hyde Park (1,205.7)</li> <li>○ 90044-Athens (979.9)</li> <li>○ 90047-South Los Angeles (839.4)</li> <li>○ 90057-Westlake (620.0)</li> <li>○ 90062-South Los Angeles (840.9)</li> </ul>		<ul style="list-style-type: none"> <li>○ 90057-Westlake (620.0)</li> </ul>

➤ Rates of mental health hospitalizations per 100,000 youth, which were higher when compared to California (256.4) in:

CHMC Service Area	GSH Service Area	SVMC Service Area
<ul style="list-style-type: none"> <li>○ 90002-Watts (399.9)</li> <li>○ 90003-South Los Angeles (362.1)</li> <li>○ 90004-Hancock Park (376.1)</li> <li>○ 90005-Koreatown (313.2)</li> <li>○ 90006-Pico Heights (264.4)</li> <li>○ 90010-Wilshire (520.8)</li> <li>○ 90011-South Los Angeles (408.8)</li> <li>○ 90016-West Adams (260.3)</li> <li>○ 90018-Jefferson Park (278.1)</li> <li>○ 90019-Country Club Park/Mid City (294.1)</li> <li>○ 90026-Echo Park/Silverlake (374.9)</li> <li>○ 90037-South Los Angeles (572.4)</li> <li>○ 90043-Hyde Park (487.6)</li> <li>○ 90044-Athens (418.8)</li> <li>○ 90047-South Los Angeles (613.7)</li> <li>○ 90057-Westlake (299.1)</li> <li>○ 90062-South Los Angeles (489.9)</li> </ul>	<ul style="list-style-type: none"> <li>○ 90004-Hancock Park (619.2)</li> <li>○ 90005-Koreatown (607.7)</li> <li>○ 90006-Pico Heights (713.0)</li> <li>○ 90010-Wilshire (520.8)</li> <li>○ 90018-Jefferson Park (278.1)</li> <li>○ 90021-Downtown Los Angeles (1,250.0)</li> <li>○ 90026-Echo Park/Silverlake (374.9)</li> <li>○ 90057-Westlake (620.0)</li> </ul>	<ul style="list-style-type: none"> <li>○ 90004-Hancock Park (619.2)</li> <li>○ 90005-Koreatown (607.7)</li> <li>○ 90006-Pico Heights (713.0)</li> <li>○ 90010-Wilshire (520.8)</li> <li>○ 90011-South Los Angeles (408.8)</li> <li>○ 90016-West Adams (260.3)</li> <li>○ 90018-Jefferson Park (278.1)</li> <li>○ 90019-Country Club Park/Mid City (294.1)</li> <li>○ 90026-Echo Park/Silverlake (374.9)</li> <li>○ 90028-Hollywood (351.4)</li> <li>○ 90031-Montecito Heights (349.3)</li> <li>○ 90037-South Los Angeles (572.4)</li> <li>○ 90044-Athens (979.9)</li> <li>○ 90046-Mount Olympus (505.2)</li> <li>○ 90057-Westlake (299.1)</li> </ul>

➤ Rates of suicide per 10,000 persons, which were higher when compared to California (1.0) in:

CHMC Service Area	GSH Service Area	SVMC Service Area
<ul style="list-style-type: none"> <li>○ 90015-Downtown Los Angeles (1.1)</li> <li>○ 90020-Hancock Park (1.5)</li> <li>○ 90057-Westlake (1.3)</li> </ul>	<ul style="list-style-type: none"> <li>○ 90012-Chinatown (1.6)</li> <li>○ 90013-Downtown Los Angeles (1.7)</li> <li>○ 90014-Los Angeles (4.3)</li> <li>○ 90015-Downtown Los Angeles (1.1)</li> <li>○ 90020-Hancock Park (1.5)</li> <li>○ 90021-Downtown Los Angeles (2.5)</li> <li>○ 90057-Westlake (1.3)</li> </ul>	<ul style="list-style-type: none"> <li>○ 90020-Hancock Park (1.5)</li> <li>○ 90027-Griffith Park/Los Feliz (1.3)</li> <li>○ 90028-Hollywood (1.4)</li> <li>○ 90046-Mount Olympus (2.7)</li> <li>○ 90057-Westlake (1.3)</li> </ul>

Stakeholders identified Skid Row in Downtown Los Angeles, East and Southeast Los Angeles and Chinatown as the most affected areas.

**Associated drivers and risk factors – what is driving the high rates of mental health in the community?**

Mental health is associated with many other health factors, including poverty, heavy alcohol consumption, and unemployment. Chronic diseases such as cardiovascular disease, diabetes, and obesity are also associated with

mental health disorders such as depression and suicide<sup>10</sup>. For data concerning health drivers, please refer to the *Scorecard*.

### **Community Input – what do community stakeholders think about the issue of mental health?**

Stakeholders stated that community members had a difficult time obtaining treatment for mental health issues because of strict insurance guidelines and the cost of treatment and medication. Transportation was also a barrier. Stakeholders identified multiple factors that contributed to poor mental health including stress caused by the economic downturn, unemployment, immigration status, stigma associated with mental health problems, abuse (emotional, physical, and sexual), bullying, and increasing violence.

Stakeholders also added that there has been a noted increase in psychiatric emergencies and the use of physical restraints on patients. There has also been an increase in demand for mental health services; however, this need remains unmet and there are often waiting lists for people who need immediate help.

*“Mental and emotional health is the most difficult to promote because most are either in denial or embarrassed about having a health issue and so do not speak up or do anything about it.”*  
*(Resident Focus Group Participant)*

<sup>1</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=28>. Accessed [April 30, 2013].

<sup>2</sup> Centers for Disease Control and Prevention. *10 Leading Causes of Death by Age Group, United States – 2010*. Available at [http://www.cdc.gov/injury/wisqars/pdf/10LCID\\_All\\_Deaths\\_By\\_Age\\_Group\\_2010-a.pdf](http://www.cdc.gov/injury/wisqars/pdf/10LCID_All_Deaths_By_Age_Group_2010-a.pdf). Accessed [March 12, 2013].

<sup>3</sup> National Institute of Mental Health. *Suicide in the U.S.: Statistics and Prevention*. Available at <http://www.nimh.nih.gov/health/publications/suicide-in-the-us-statistics-and-prevention/index.shtml>. Accessed [March 12, 2013].

<sup>4</sup> National Institute of Mental Health. *Any Disorder Among Adults*. Available at [http://www.nimh.nih.gov/statistics/1ANYDIS\\_ADULT.shtml](http://www.nimh.nih.gov/statistics/1ANYDIS_ADULT.shtml). Accessed [March 12, 2013].

<sup>5</sup> Public Health Agency of Canada. *Mental Illness*. Available at <http://www.phac-aspc.gc.ca/cd-mc/mi-mm/index-eng.php>. Accessed [March 12, 2013].

<sup>6</sup> National Institute of Mental Health. *Suicide in the U.S.: Statistics and Prevention*. Available at <http://www.nimh.nih.gov/health/publications/suicide-in-the-us-statistics-and-prevention/index.shtml>. Accessed [March 12, 2013].

<sup>7</sup> California Hospital Medical Center

<sup>8</sup> Good Samaritan Hospital

<sup>9</sup> St. Vincent Medical Center

<sup>10</sup> Centers for Disease Control and Prevention. *Mental Health and Chronic Diseases*. Available at <http://www.cdc.gov/nationalhealthyworksites/docs/Issue-Brief-No-2-Mental-Health-and-Chronic-Disease.pdf>. Accessed [May 1, 2013].

**Health Need Profile – Obesity/Overweight**

**About Obesity/Overweight– why is it important?**

Obesity, a condition in which a person has an abnormally high and unhealthy proportion of body fat, has risen to epidemic levels in the United States; 68 percent of adults age 20 years and older are overweight or obese<sup>1</sup>. Excess weight is a significant national problem and indicates an unhealthy lifestyle that influences further health issues. Obesity reduces life expectancy and causes devastating and costly health problems, increasing the risk of coronary heart disease, stroke, high blood pressure, diabetes, and a number of other chronic diseases. Findings suggest that obesity also increases the risks for cancers of the esophagus, breast (postmenopausal), endometrium, colon and rectum, kidney, pancreas, thyroid, gallbladder, and possibly other cancer types<sup>2</sup>. Obesity is associated with factors including poverty, inadequate fruit/vegetable consumption, breastfeeding, and lack of access to grocery stores, parks, and open space.

**Statistical data – how is obesity/overweight measured? What is the prevalence/incidence rate of obesity/overweight in the community?**

**Obesity/Overweight Indicators**

Indicators	Year	Comparison		CHMC <sup>3</sup> Service Area	GSH <sup>4</sup> Service Area	SVMC <sup>5</sup> Service Area
		Level	Avg.			
Percent of adults who are obese <sup>1</sup>	2011-2012	LAC	24.7%	15.7%	15.6%	15.6%
Percent of adults who are overweight	2011-2012	LAC	34.2%	29.4%	25.9%	25.9%
Percent of children 2-11 years old who are overweight	2011-2012	LAC	13.3%	12.0%	<b>16.1%</b>	<b>16.1%</b>
Percent of teens 12-17 years old who are overweight or obese	2011-2012	LAC	17.1%	13.6%	14.5%	14.5%

LAC=Los Angeles County  
CA=California  
Healthy People 2020 goal: <sup>1</sup><=30.5%

**Sub-populations experiencing the greatest impact (disparities)**

Stakeholders identified Latinos, African-American, low-income, and adults and children as the most severely impacted.

**Geographic areas of greatest impact (disparities)**

Stakeholders also identified South Los Angeles, Inglewood, Compton, and Pasadena as the most impacted.

**Associated drivers and risk factors – what is driving the high rates of obesity/overweight in the community?**

Obesity is associated with factors such as poverty, inadequate consumption of fruits and vegetables, physical inactivity, and lack of access to grocery stores, parks, and open space. Obesity increases the risk of coronary heart disease, stroke, high blood pressure, diabetes, and a number of other chronic diseases. The condition also increases the risks of cancers of the esophagus, breast (postmenopausal), endometrium, colon and rectum, kidney, pancreas, thyroid, gallbladder, and possibly other cancer types<sup>6</sup>. For data concerning health drivers, please refer to the *Scorecard*.

**Community Input – what do community stakeholders think about the issue of obesity/overweight?**

Stakeholders attributed being obese and overweight to a lack of access to green space, living in food deserts, lack of access to

*“Obesity is escalating at a high rate. This causes other chronic diseases and ailments which shortens a person’s life span”  
(Health Professional, National Health Organization)*

healthy foods such as fruit and vegetables, lack of safety at parks, and lifestyle choices such as a lack of physical activity. Stakeholders added that obesity and being overweight was closely linked to diabetes and hypertension and that these are a growing issue.

*If you want to exercise in parks in South East LA, you would get shot. Safety is a major concern. (Business and Education Leader, Focus Group Participant)*

Stakeholders also added that messaging would be important in countering the increase in obesity rates. One stakeholder added, “Most people are hearing this message from teachers at schools, from the doctor or nurse, from their priest, in programs at the library, etc. It’s effective to educate all collaborators and partners to deliver a similar message over time.”

<sup>1</sup> National Cancer Institute. *Obesity and Cancer Risk*. Available at <http://www.cancer.gov/cancertopics/factsheet/Risk/obesity>. Accessed [March 10, 2013].

<sup>2</sup> National Cancer Institute. *Obesity and Cancer Risk*. Available at <http://www.cancer.gov/cancertopics/factsheet/Risk/obesity>. Accessed [March 10, 2013].

<sup>3</sup> California Hospital Medical Center

<sup>4</sup> Good Samaritan Hospital

<sup>5</sup> St. Vincent Medical Center

<sup>6</sup> National Cancer Institute. *Obesity and Cancer Risk*. Available at <http://www.cancer.gov/cancertopics/factsheet/Risk/obesity>. Accessed [March 10, 2013].

**Health Need Profile – Oral Health**

**About Oral Health— why is it important?**

Oral health is essential to overall health, and is relevant as a health need because engaging in preventive behaviors decreases the likelihood of developing future oral health and related health problems. In addition, oral diseases such as cavities and oral cancer cause significant pain and disability for many Americans<sup>1</sup>.

Behaviors that may lead to poor oral health include tobacco use, excessive alcohol consumption, and poor dietary choices. Barriers that prevent or limit a person’s use of preventive intervention and treatments for oral health include limited access to and availability of dental services, a lack of awareness of the need, cost, and fear of dental procedures. Social factors associated with poor dental health include lower levels or lack of education, having a disability, and other health conditions such as diabetes<sup>2</sup>.

**Statistical data – how is oral health measured? What is the prevalence/incidence rate of oral health in the community?**

**Oral Health Indicators**

Indicators	Year	Comparison		CHMC <sup>3</sup> Service Area	GSH <sup>4</sup> Service Area	SVMC <sup>5</sup> Service Area
		Level	Avg.			
Percent of adults 18 and older unable to obtain dental care including check-ups in the past year because they could not afford it	2011	LAC	30.3%	29.9%	<b>36.3%</b>	<b>36.3%</b>
Percent of adults 18 and older with dental insurance	2011	LAC	48.2%	46.8%	38.0%	38.0%
Percent of children 17 and under without dental insurance	2011	LAC	78.2%	76.2%	75.8%	75.8%
Percent of children 3-17 years old who were unable to afford dental care and check-ups in the past year	2011	LAC	12.6%	11.7%	<b>13.1%</b>	<b>13.1%</b>
Percent of children who have never been to the dentist	2011-2012	LAC	9.2%	8.1%	7.9%	7.9%

LAC=Los Angeles County  
CA=California

**Sub-populations experiencing the greatest impact (disparities)**

Stakeholders identified low-income adults, uninsured, the homeless (specifically veterans), Latinos, and those with diabetes as the most severely impacted.

**Geographic areas of greatest impact (disparities)**

Stakeholders identified Chinatown and Skid Row in Downtown Los Angeles as the most severely impacted.

**Associated drivers and risk factors – what is driving the high rates of oral health in the community?**

Poor oral health can be prevented by decreasing sugar intake and increasing healthy eating habits to prevent tooth decay and premature tooth loss; consuming more fruits and vegetables to protect against oral cancer; smoking cessation; decreased alcohol consumption to reduce the risk of oral cancers, periodontal disease, and tooth loss; using protective gear when playing sports; and living in a safe physical environment<sup>6</sup>. In addition, oral health conditions such as periodontal (gum) disease have been linked to diabetes, heart disease, stroke, and premature, low-weight births<sup>7</sup>. For data concerning health drivers, please refer to the *Scorecard*.

---

**Community Input – what do community stakeholders think about the issue of oral health?**

---

Stakeholders attributed poor oral health to the lack of affordable dental services, lack of access to dental services, and lack of education about health oral health behaviors such as brushing habits, when to visit doctors, etc. They also added that Medi-Cal phasing out dental coverage severely impacted adults.

*“I needed two root canals so I visited a private dentist but the cost was double what USC charges, so I went to USC.”  
(Focus Group Participant)*

---

<sup>1</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=32>. Accessed [February 26, 2013].

<sup>2</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=32>. Accessed [February 26, 2013].

<sup>3</sup> California Hospital Medical Center

<sup>4</sup> Good Samaritan Hospital

<sup>5</sup> St. Vincent Medical Center

<sup>6</sup> World Health Organization, Oral health Fact Sheet. Geneva, Switzerland. Available at <http://www.who.int/mediacentre/factsheets/fs318/en/index.html>. Accessed [February 26, 2013].

<sup>7</sup> Centers for Disease Control and Prevention. *Mental Health and Chronic Diseases*. Available at <http://www.cdc.gov/chronicdisease/resources/publications/aag/pdf/2011/Oral-Health-AAG-PDF-508.pdf>. Accessed [May 1, 2013].

**Health Need Profile – Sexually Transmitted Diseases**

**About Sexually Transmitted Diseases— why is it important?**

Sexually Transmitted Diseases (STDs) are diseases transmitted primarily through sexual activity, including chlamydia, hepatitis C and gonorrhea. Despite cost and other consequences and complications and the fact that such diseases are preventable, STDs remain a significant health issue in the United States. Untreated STDs can lead to serious long-term health consequences, especially for adolescent girls and young women. The spread of STDs is directly affected by social, economic, and behavioral factors. Such factors include race and ethnicity, poverty, access to care, substance abuse, and sexual behaviors<sup>1</sup>.

**Statistical data – how is the rate of sexually transmitted diseases measured? What is the prevalence/incidence rate of sexually transmitted diseases in the community?**

**Sexually Transmitted Diseases Indicators**

Indicators	Year	Comparison		CHMC <sup>2</sup> Service Area	GSH <sup>3</sup> Service Area	SVMC <sup>4</sup> Service Area
		Level	Avg.			
Rate of hepatitis C prevalence per 100,000 pop.	2011	LAC	4.0	0.1	0.1	0.1
Rate of chlamydia prevalence per 100,000 pop.	2011	LAC	512.9	592.4	793.6	793.6
Rate of gonorrhea prevalence per 100,000 pop.	2011	LAC	103.4	154.7	218.3	218.3

LAC=Los Angeles County  
CA=California

**Sub-populations experiencing the greatest impact (disparities)**

Stakeholders identified low-income minorities and those between the ages of 18 and 30 as the most impacted.

**Geographic areas of greatest impact (disparities)**

Stakeholders also identified the west side of SPA 4 and West Hollywood as the most impacted.

**Associated drivers and risk factors – what is driving the high rates of sexually transmitted diseases in the community?**

The spread of STDs is directly linked to race and ethnicity, poverty, access to care, substance abuse, and sexual behaviors<sup>5</sup>. For data concerning health drivers, please refer to the *Scorecard*.

**Community Input – what do community stakeholders think about the issue of sexually transmitted diseases?**

Stakeholders mentioned the increase in STD rates, specifically syphilis and chlamydia.

<sup>1</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=37>. Accessed [October 24, 2013].

<sup>2</sup> California Hospital Medical Center

<sup>3</sup> Good Samaritan Hospital

<sup>4</sup> St. Vincent Medical Center

<sup>5</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=37>. Accessed [October 24, 2013].

**Health Need Profile – Substance Abuse**

**About Substance Abuse— why is it important?**

Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems. In 2005, an estimated 22 million Americans struggled with a drug or alcohol problem and almost 95 percent of people with substance use problems are unaware of their problem. Of those who recognize their problem, 273,000 have been unsuccessful in obtaining treatment<sup>1</sup>. Substance abuse has a major impact on individuals, families, and communities, significantly contributing to social, physical, mental, and public health problems<sup>2</sup>.

**Statistical data – how is substance abuse measured? What is the prevalence/incidence rate of substance abuse in the community?**

**Substance Abuse Indicators**

Indicators	Year	Comparison		CHMC <sup>3</sup> Service Area	GSH <sup>4</sup> Service Area	SVMC <sup>5</sup> Service Area
		Level	Avg.			
Percent of adults 18 and older who are currently smoking	2011	LAC	13.1%	12.7%	<b>14.1%</b>	<b>14.1%</b>
Percent of adults 18 and older who reported they needed or wanted treatment for alcohol or drug program (excluding tobacco) in the past 5 years <sup>^</sup>	2011	LAC	2.5%	2.4%	<b>2.8%</b>	<b>2.8%</b>
Percent of teens 12-17 who used marijuana in the past year	2011-2012	LAC	10.2%	<b>14.2%</b>	<b>17.3%</b>	<b>17.3%</b>
Rate of alcohol/drug induced mental disease hospitalizations per 100,000 pop....	2010	CA	109.1	102.0	<b>199.9</b>	<b>112.9</b>

LAC=Los Angeles County  
CA=California

**Sub-populations experiencing the greatest impact (disparities)**

Stakeholders identified the homeless, youth aged 12 years old and older, the uninsured, youth in or transitioning out of the foster care system, and low-income populations as the most severely impacted.

**Geographic areas of greatest impact (disparities)**

By ZIP code, the following disparities were found:

- Rates of alcohol/drug induced mental disease hospitalizations per 100,000 persons, which were higher when compared to California (109.1) in:

CHMC Service Area	GSH Service Area	SVMC Service Area
○ 90001-South Los Angeles (190.9)	○ 90010-Wilshire (157.9)	○ 90010-Wilshire (157.9)
○ 90010-Wilshire (157.9)	○ 90012-Chinatown (119.0)	○ 90016-West Adams (132.4)
○ 90016-West Adams (132.4)	○ 90013-Downtown Los Angeles (925.9)	○ 90018-Jefferson Park (111.5)
○ 90018-Jefferson Park (111.5)	○ 90014-Los Angeles (670.9)	○ 90026-Echo Park/Silverlake (110.5)
○ 90026-Echo Park/Silverlake (110.5)	○ 90018-Jefferson Park (111.5)	○ 90027-Griffith Park/Los Feliz (179.4)
○ 90037-South Los Angeles (112.4)	○ 90021-Downtown Los Angeles (202.5)	○ 90028-Hollywood (156.7)
○ 90047-South Los Angeles (117.3)	○ 90026-Echo Park/Silverlake (110.5)	○ 90031-Montecito Heights (129.7)
○ 90057-Westlake (135.6)	○ 90057-Westlake (135.6)	○ 90037-South Los Angeles (112.4)
		○ 90046-Mount Olympus (210.0)

CHMC Service Area	GSH Service Area	SVMC Service Area
		o 90057-Westlake (135.6)

Stakeholders also identified Los Angeles and particularly Skid Row as the most impacted.

**Associated drivers and risk factors – what is driving the high rates of substance abuse in the community?**

Factors that influence the use of tobacco include race/ethnicity, age, education, and socioeconomic status. Significant disparities in tobacco use exist geographically and typically result from differences in smoke-free protections, tobacco prices, and program funding for tobacco prevention<sup>6</sup>.

Tobacco use is linked to and associated with cancer, heart disease, lung disease (such as emphysema, bronchitis, and chronic airway obstruction), premature birth, low birth weight, stillbirth, and infant death<sup>7</sup>. In addition, secondhand smoke has been known to cause heart disease and lung cancer in adults and severe asthma attacks, respiratory infections, ear infections, and sudden infant death syndrome (SIDS) in infants and children<sup>8</sup>. For data concerning health drivers, please refer to the *Scorecard*.

**Community Input – what do community stakeholders think about the issue of substance abuse?**

Stakeholders mentioned the increased of new drugs on the streets which contribute to other health and mental health issues. Stakeholders also added that substance abuse often is associated with mental illness and poverty and attribute the prevalence of alcohol and substance abuse to the lack of access to treatment.

<sup>1</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=40>. Accessed [November 8, 2013].

<sup>2</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=40>. Accessed [November 8, 2013].

<sup>3</sup> California Hospital Medical Center

<sup>4</sup> Good Samaritan Hospital

<sup>5</sup> St. Vincent Medical Center

<sup>6</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=41>. Accessed [July 11, 2013].

<sup>7</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=41>. Accessed [July 11, 2013].

<sup>8</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=41>. Accessed [July 11, 2013].

**Health Need Profile – Vision**

**About Vision— why is it important?**

People with diabetes are at an increased risk of vision problems as diabetes can damage the blood vessels of the eye, potentially leading to blindness. Diabetics are 40% more likely to suffer from glaucoma and 60% more likely to develop cataracts compared to people without diabetes. People who have had diabetes for a long time or whose blood glucose or blood pressure is not under control are also at risk of developing retinopathy<sup>1</sup>. These kinds of vision impairment cannot be corrected with glasses and typically require laser therapy or surgery<sup>2</sup>. Vision loss also makes it difficult for people to live independently. As diabetes rates continue to rise among all age groups, vision complications tied to the disease are expected to increase as well. Vision care providers should expect to see more complications in younger populations as more children and adolescents are diagnosed with diabetes<sup>3</sup>. Many eye problems are not evident until quite advanced, but early detection and treatment can be effective. For example, screening for people with diabetes can almost completely eliminate diabetes-related blindness. However, only about half of diabetics in the United States currently get regular eye exams<sup>4</sup>.

**Statistical data – how is vision status measured? What is the prevalence/incidence rate of vision problems in the community?**

**Alcohol Abuse Indicators**

Indicators	Year	Comparison		CHMC <sup>5</sup> Service Area	GSH <sup>6</sup> Service Area	SVMC <sup>7</sup> Service Area
		Level	Avg.			
Percent of adults who had an eye exam with dilated pupils in last year	2009	LAC	63.3%	57.6%	50.2%	50.2%

LAC=Los Angeles County

**Sub-populations experiencing the greatest impact (disparities)**

Stakeholders did not identify sub-populations disparities.

**Geographic areas of greatest impact (disparities)**

Stakeholders did not identify geographic disparities.

**Associated drivers and risk factors – what is driving the rates of vision issues in the community?**

Diabetes-related vision problems are linked to the length of time one has had diabetes, high blood glucose, and high blood pressure. For data concerning health drivers, please refer to the *Scorecard*.

**Community Input – what do community stakeholders think about the issue of vision?**

Stakeholders added that vision care services were not readily or easily accessible.

<sup>1</sup> American Diabetes Association. *Living with Diabetes*. Available at [http://www.diabetes.org/living-with-diabetes/complications/mens-health/serious-health-implications/blindness-or-vision-problems.html]. Accessed [March 5, 2013].

<sup>2</sup> Genevra Pittman, *Vision Loss Tied to Diabetes on the Rise*. Available at [http://www.reuters.com/article/2012/12/11/us-diabetes-vision-loss-idUSBRE8BA1AP20121211]. Accessed [March 5, 2013].

<sup>3</sup> Genevra Pittman, *Vision Loss Tied to Diabetes on the Rise*. Available at [http://www.reuters.com/article/2012/12/11/us-diabetes-vision-loss-idUSBRE8BA1AP20121211]. Accessed [March 5, 2013].

<sup>4</sup> Genevra Pittman, *Vision Loss Tied to Diabetes on the Rise*. Available at [http://www.reuters.com/article/2012/12/11/us-diabetes-vision-loss-idUSBRE8BA1AP20121211]. Accessed [March 5, 2013].

<sup>5</sup> California Hospital Medical Center

<sup>6</sup> Good Samaritan Hospital

<sup>7</sup> St. Vincent Medical Center