2016 COMMUNITY HEALTH NEEDS ASSESSMENT

Good Samaritan Hospital
A Tradition of Caring

January 20, 2017

Center for Nonprofit Management

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I. Authors and Acknowledgements

Authors

The Center for Nonprofit Management

Maura J. Harrington, Ph.D., MBA, MHarrington@cnmsocal.org

Sarah Flores, M.S., SFlores@cnmsocal.org

Gigi Nang, GNang@cnmsocal.org

Christine Newkirk, CNewkirk@cnmsocal.org

Adam Wyand, AWyand@cnmsocal.org

Melanie Spiegel, M.S., MSpiegel@cnmsocal.org

Acknowledgements

The 2016 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

Brian Thorne, Vice President, Fund Development, and Coralyn Andres Taylor, RDN, MPH, CLE, CHES

St. Vincent Medical Center

Anita Chou, Chief Financial Officer

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II. Summary of Key Findings (Executive Summary)

Community Health Needs Assessment Background and Findings

Nonprofit hospitals are required to conduct a community health needs assessment or CHNA every three years in order to maintain tax exempt status under California State Senate Bill 697 (SB 697) originally enacted in 1994. The requirement was expanded to the federal level thereafter and further solidified in 2010 under the Patient Protection and Affordable Care Act (ACA). As part of the CHNA, each hospital is required to collect and conduct analysis of extensive data from secondary data sources as well as input (primary data) from individuals in the community: public health experts; representatives of government and civic organizations; members, representatives or leaders of low-income, minority and medically underserved populations and populations with chronic conditions.

The CHNA process is designed to identify the health needs and resources in the hospital service area and inform the hospital's community benefit investments. As in previous years, three hospitals in metropolitan Los Angeles that together make up the Metro Hospital Collaborative — California Hospital Medical Center, Good Samaritan Hospital and St. Vincent Medical Center — have come together to produce this CHNA.

The CHNA process represented in this report examined both upstream and downstream indicators of population health. Drawing from the County Health Rankings Model framework,[1] primary and secondary data were collected for both *health drivers* (social determinants of health) and *health outcomes* (indicators of morbidity and mortality). Together, *health drivers* and *health outcomes* are referred to as *health needs* for the purpose of this report.

Eighteen health needs were identified and prioritized through the CHNA process. The prioritized health needs are as follows:[2,3]

1. Obesity/Overweight
2. Homelessness
3. Poverty (including unemployment)
3. Diabetes
4. Mental Health
5. Violence and Injury
6. Oral Health
7. Preventive Care
7. Food Insecurity
8. Alcohol, Substance Abuse and Tobacco Use
9. Cardiovascular Disease including Hypertension and High Cholesterol[3]
10. Access to Care
11. Healthy Behaviors

[1] County Health Rankings Model developed by the University of Wisconsin-Madison Population Health Institute: http://www.countyhealthrankings.org/our-approach.

[2] As a result of the prioritization process (described in the *Community Ranking of Health Needs* section of part IV of this report) some health needs (e.g. preventive care and food insecurity) were assigned equal priority.

[3] Note that hypertension, cardiovascular disease and high cholesterol were combined as a single Health Need after the prioritization exercise. Before combining these health needs, hypertension ranked as #9, cardiovascular disease as #11, and high cholesterol as #16.

12. Cultural and Linguistic Barriers
13. Physical Activity
14. Transportation
15. Cancer
16. Sexually Transmitted Diseases

The following section describes the Good Samaritan service area, presents overall trends that emerged though the CHNA process, and summarizes each of the prioritized health needs. More detail about the health needs, including the data and their sources, is provided in the **Community Health Profile** and **Key Findings—Health Needs** chapters of the report. Additionally, health needs data for all three hospitals in the Metro Hospital Collaborative can be found in **Appendix H – Health Needs Profiles**.

Service Area Characteristics

The Good Samaritan Hospital service area encompasses culturally, linguistically and economically diverse communities in Central Los Angeles. For example, Westlake and Pico-Union are home to large immigrant populations from Central and South America. Koreatown is a culturally dynamic area of Los Angeles, home to Korean, Latin American, Bangledeshi and Filipino immigrant populations, among many others. Overall, nearly one in two[4] residents in the service area is Latino. In many communities served by Good Samaritan, more than half the population is first generation;[5] over two-thirds[6] of the service area speaks a language other than English at home.

Good Samaritan Hospital serves not only a culturally diverse population, but also a young and comparatively low-income population. A larger percentage of residents in the service area are low income[7] and have limited formal education[8] than in Los Angeles County overall. Nearly half (48.7%) are between 18 and 44 years of age.

Adding to the great diversity of residents served by Good Samaritan Hospital, the service area also includes small, very wealthy business districts including ARCO towers—a block of corporate business towers with high-earning residents captured by ZIP code 90071, and the Wilshire business corridor—home to a similarly well-educated population in ZIP code 90010.

At the same time and of particular interest, the service area includes Downtown Los Angeles ZIP codes where many of the homeless services in the County are located. Nearly one quarter of the homeless population in Los Angeles resides in Service Planning Area[9] (SPA) 4—a region that aligns very closely with Good Samaritan's service area. Therefore, Good Samaritan serves a large proportion of Los Angeles County's homeless population.

The following statements summarize key findings pertaining to each of the prioritized health needs. These statements include both secondary (population-level statistical) data and information collected through focus groups and stakeholder interviews—information that contextualizes the population-level data in light of the unique characteristics of the Good Samaritan service area.

[4] 52.3%

[5] According to the 2000 US Census, the population in Westlake was 67.6% foreign-born; in Koreatown, 68.0% foreign-born (Source: Los Angeles Times Mapping Los Angeles; available at: http://maps.latimes.com/neighborhoods/neighborhood/list/).

[6] 66.5%

[7] 66.5% earn $50,000 or less

[8] 50.0% of the population have a high school degree or less

[9] Los Angles County has been divided into eight Service Planning Areas by the Los Angeles County Department of Public Health in order to develop and provide more relevant public health and clinical services to residents of the different areas: http://publichealth.lacounty.gov/chs/SPAMain/ServicePlanningAreas.htm.

1. Obesity/Overweight: Seven out of the 15 ZIP codes in the Good Samaritan service area have an obesity prevalence higher than Los Angeles County (21.2%) and five out of 15 have an overweight prevalence higher than Los Angeles County (29.7%). Approximately one in six children between the ages of 0 and 11 are overweight for their age. Obesity and overweight are associated with poverty, physical inactivity and food insecurity, and increases the risk of coronary heart disease, stroke, high blood pressure and diabetes, among other chronic diseases. Service area stakeholders related the high rates of obesity and overweight to: lack of physical activity; lack of access to affordable and safe recreational opportunities in service area communities; ease of accessibility to fast food and lack of access to healthy foods; and, lack of awareness of overweight and obesity as a precursor to disease.
2. Homelessness: One quarter of the homeless population of Los Angeles County resides in the Good Samaritan service area and the majority (87.3%) of the homeless population consists of homeless individuals (as opposed to homeless families). Nearly one third (30.5%) of the homeless population in the service area have been diagnosed with a mental illness and nearly one in four (22.3%) struggle with substance abuse issues. The service area includes areas of Downtown Los Angeles where many of the county's shelters and homeless services are located. Stakeholders explained that many more residents in the service area are at risk of becoming homeless due to housing insecurity, a trend driven by rising rent prices in many of the historically low-income communities in the service area.
3. Poverty: In 13 out of the 15 ZIP codes in the Good Samaritan service area, more than one in six[10] families are living below the poverty line. Education level is a strong predictor of income and social mobility, and in the service area, two out of every five residents have only a high school education or less in all of the 15 ZIP codes. Stakeholders explained that in the service area, low income and low education levels mean lack of access to reliable transportation and a clean and stable living environment—factors that, when combined with lack of connectedness with social services and health care services can create structural barriers to health care and set the stage for chronic, untreated illness and poor health behaviors.
4. Diabetes: Eleven out of the 15 ZIP codes in the Good Samaritan service have higher adult diabetes hospitalization rates than California (142.6 cases per 100,000 people). In fact, rates are as high as 449.1 per 100,000 (ZIP code 90014). Diabetes is linked to an unhealthy lifestyle and comorbid with obesity, and is a risk factor for coronary heart disase and stroke. Recent research indicates an association with cancer risk. Stakeholders explained that in the service area, poor diet—driven by both economic and cultural forces—drives high diabetes rates. Stakeholders called for ongoing and increased education efforts around healthy and affordable eating practices, including breastfeeding for at least 6 months after the birth of a child.
5. Mental Health: Fourteen out of the 15 ZIP codes in the Good Samaritan service area have rates of mental health hospitalizations that are higher than the overall rate in California (294.8 per 100,000 population). Poor mental health may increase the risk of substance use disorders, and is associated with the prevalence, progression and outcomes of chronic diseases. Stakeholders explained that factors including cultural taboos around mental health combined with the high costs of care may create barriers to access for large groups of the resident population.
6. Violence and Injury: Three out of the 15 ZIP codes in the Good Samaritan service area have higher rates of unintentional injury mortality than the state of California overall (2.8 per 10,000). Stakeholders expressed a concern about possibly high rates of unreported domestic violence in the service area and also highlighted the ongoing need to intervene with young people at an early age to reduce gang violence.

[10] In Los Angeles County, 14.9% of families live below poverty.

7. Oral Health: More than one in three (37.1%) residents in the Good Samaritan service area struggle to afford dental care—more than in Los Angeles County (30.3%). Stakeholders indicated that cost of services and lack of insurance coverage for oral health are significant barriers to oral care. Subpopulations including the elderly and indigent, children, and the homeless have a particularly difficult time accessing oral care in the service area.

8. Preventive Care: Seven out of 15 ZIP codes in the Good Samaritan service area have higher preventable hospitalization rates than Los Angeles County (11.7 preventable hospitalizations per 1,000 people), and three ZIP codes have rates nearly twice as high as the County. Potentially preventable hospitalizations are admissions to a hospital for acute illness or worsening chronic conditions that may have been prevented through timely treatment by primary care providers in outpatient settings. Stakeholders identified a number of issues that make it difficult for residents to connect with preventive and maintenance health treatment in a timely manner, including lack of insurance and changes in health insurance policies, difficulty in connecting and/or accessing medical specialists, and lack of awareness of preventive care services.

9. Food Insecurity: Nearly one third (32.1%) of households with incomes less than 300% of the poverty level in the Good Samaritan service area were food insecure, meaning that at times their normal eating patterns were disrupted because the household lacked money and other resources for food. Stakeholders explained that food insecurity in the service area stems from a combination of very low family incomes and lack of affordable healthy food. Food insecurity is associated with chronic diseases including hypertension and other cardiovascular risk factors.

10. Alcohol, Substance Abuse and Tobacco Use: The percentage of residents in the Good Samaritan service area who reported misusing any form of prescription drugs in the last year (7.0%), and the percentage of teens who have ever tried marijuana, cocaine or other drugs (20.7%) were both above the Los Angeles County benchmarks (5.5% and 14.7%). Stakeholders explained that access to treatment for alcohol and substance abuse is a challenge in the service area for several reasons including the high costs and access to treatment and limited capacity of inpatient treatment facilities. Stakeholders identified the large homeless population as a group with a particularly critical need for alcohol and substance abuse services.

11. Cardiovascular Disease, including High Cholesterol and Hypertension: Five out of 15 ZIP codes in the Good Samaritan service area have higher rates of heart disease mortality than Los Angeles County overall (15.5 deaths per 10,000 residents). In two ZIP codes (90014, 90021), the mortality rate is twice as high as the Los Angeles County rate. Seven out of 15 ZIP codes are above the Los Angeles County rate (0.97 per 10,000 residents) of deaths from essential hypertension and hypertensive renal disease. Unhealthy diet, harmful use of alcohol, obesity and physical inactivity are risk factors for both cardiovascular disease and hypertension. Recent research has indicated that breastfeeding has protective effects against heart disease. Stakeholders called for expanded education around the underlying causes of cardiovascular diseases and education around culturally responsive healthy eating practices, including breastfeeding over formula feeding.

12. Access to Care: In all of the 15 ZIP codes in the Good Samaritan service area, more than one in five residents are uninsured, a slightly higher rate of uninsurance than that of Los Angeles County (19.5% uninsured). In 13 of the 15 ZIP codes, more than one of every four residents (25%) lack access to health insurance. Stakeholders explained that high uninsurance rates may be linked to the comparatively low income level of the service area, the large incidence of undocumented residents in the service area, and the cultural and linguistic diversity which requires targeted and specific insurance outreach and enrollment efforts.

13. Healthy Behaviors (Including Physical Activity): While approximately the same proportion (55.6%) of children in the Good Samaritan service area ate five or more servings of fruits and vegetables a day as in Los Anglees County (55.4%), notably fewer teens in the service area (13.5%) maintained these habits compared to teens in Los Angeles County (19.7%). Stakeholders explained that time constraints, costs of healthy food, and easy access to cheap, unhealthy food contribute to poor eating behaviors in the service area: stakeholders called for the expansion of nutrition education programs, particularly for new mothers.
14. Cultural and Linguistic Barriers: Eleven out of 15 ZIP codes in the Good Samaritan service area have a larger population rate per capita who speak a language other than English at home than in Los Angeles County overall. In six of the 15 ZIP codes, three out of four residents speaks a language other than English at home. Over 75% of the resident population is Latino or Asian. The Latino population may speak Spanish or one of a number of indigenous languages, and the Asian population may speak Mandarin, Cantonese, Tagolog, Japanese, Hindi, Bengali, Korean, Vietnamese, Khmer, or another Asian language. Because of the great cultural and linguistic variation of the service area, stakeholders called attention to the need for greater understanding among the health care community of the ways in which culture among non-majority populations—including language, gender dynamics, social roles and traditional health care beliefs—impacts relationships between health care providers and patients as well as the implementation of health care recommendations beyond the doctor visit.
15. Physical Activity (see Healthy Behaviors)
16. Transportation: Residents in the Good Samaritan service area rely on public transportation at rates over three times that of Los Angeles County residents overall (24.2% compared to 7.1% of the population). In addition, over twice as many residents in the Good Samaritan service area as in Los Angeles County walk and use bicyles for transportation. Stakeholders explained that the heavy reliance on public transportation serves as a barrier to care for residents because of extended travel times—particularly in the case of residents whose affordable health insurance plans assign primary care providers that are very distant from home. In addition, reliance on public transportation limits access to care for the elderly, indigent and low-income populations.
17. Cancer: Five of 15 ZIP codes in the Good Samaritan service area had rates of mortality due to cancer that were above the Los Angeles County rate (23.7%). Stakeholders observed that they see gaps in continuity in care for cancer patients among low-income populations and among populations whose cultural backgrounds differ from the norm in the health care envrironment. Stakeholders identified a need for outreach to increase rates of preventive cancer screenings among the resident population, to increase residents' understanding of the types of cancer care covered by affordable insurance plans, and to maintain continuity of care for cancer patients.
18. Sexually Transmitted Diseases: HIV, syphilis, chlamydia and gonorrhea incidence rates are higher in the Good Samaritan service area than in Los Angeles County overall. Specifically, the HIV incidence rate in the service area is nearly three times that of Los Angeles County. Many studies document an association between sexually transmitted diseases (STDs) and substance abuse, and STDs have a negative impact on reproductive health as well as fetal and perinatal health. Stakeholders raised a concern about an increase in STD incidence among teenagers in the service area, and called for an expansion of preventive education.

The following sections of this report (Section III and IV) explain in details the process through which the above health needs were selected and prioritized. The body of the report (Sections V and IV) provide more detail about the service area population and the health needs. Finally, the Appendices include the

Health Needs Scorecard developed at the beginning of the CHNA process, the data gathering tools, a list of stakeholders who participated in the CHNA process, the data sources accessed to compile the secondary data used in this report, and a list of community assets relevant to the Metro Hospital Collaborative. At the end of this report in Appendix H, the Health Needs Profiles summarize the key health needs indicators for all three hospitals in the Collaborative, including Good Samaritan, California Hospital Medical Center, and St. Vincent Hospital.

III. Introduction and Background

Purpose of the Community Health Needs Assessment Report

In 1994, the California Legislature enacted Senate Bill 697 (SB 697) which required nonprofit hospitals to complete CHNAs 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 that arose during the CHNA.

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, included new stipulations for hospital organizations to maintain their 501(c)(3) status. 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.[11]

California Hospital Medical Center

Established in 1887 by Dr. Walter Lindley, California Hospital Medical Center was originally a three-story building located at 315 W. Sixth Street in Los Angeles. Dr. Lindley conceived of a hospital owned and operated solely by physicians. The physicians in Lindley's building were "carriage trade" and were affiliated with the University of Southern California Medical School. Twenty-one physicians agreed to acquire property at the corner of 15th and Hope which was a quiet residential street of attractive homes. When the property on Hope Street had been acquired, the first physician-owned and operated hospital in Los Angeles was erected at 1414 S. Hope Street. It was the first building in California especially invented for medical purposes, a project that Walter Lindley supervised at every stage of its design and construction.

The mission of California Hospital Medical Center encompasses a commitment to furthering the healing ministry of Jesus as well as dedicating their resources to:

•Delivering compassionate, high-quality, affordable health services;

•Serving and advocating for our sisters and brothers who are poor and disenfranchised; and

•Partnering with others in the community to improve the quality of life.

A vibrant, national health care system known for service, chosen for clinical excellence, standing in partnership with patients, employees and physicians to improve the health of all communities served. Dignity Health and the California Hospital Medical Center are committed to providing high-quality, affordable health care to the communities they serve. Above all else they value:

•Dignity - Respecting the inherent value and worth of each person.

[11] For more information please see: https://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf

•Collaboration - Working together with people who support common values and vision to achieve shared goals.

•Justice - Advocating for social change and acting in ways that promote respect for all persons and demonstrate compassion for our sisters and brothers who are powerless.

•Stewardship - Cultivating the resources entrusted to us to promote healing and wholeness.

•Excellence - Exceeding expectations through teamwork and innovation.

St. Vincent Medical Center

Established in 1856 by the Daughters of Charity of St. Vincent de Paul as the first hospital in Los Angeles, St. Vincent Medical Center has both a strong history and a glorious future.

St. Vincent Medical Center works continually to provide the safest and highest quality care to their patients, families, and the community in a manner consistent with their "Vincentian Values: Compassion, Respect, Simplicity, Advocacy and Inventiveness to Infinity." St. Vincent's care plans and processes are built on evidence-based practices, and they hold themselves to the highest standards.

St. Vincent Medical Center seeks to provide care that is safe, patient centered, effective, timely, efficient, and equitable. They measure their performance through a number of clinical process and outcome indicators and benchmark their performance against top performing medical centers within California and across the nation.

Dedicated to achieving excellent quality outcomes and to building a culture of patient safety, St. Vincent Medical Center voluntarily participated in the CMS/Premier Hospital Quality Incentive Demonstration project, until the project's completion in September 2009. This past year, St. Vincent Medical Center received eight top attainment and improvement awards in the clinical areas of Heart Failure, Coronary Artery Bypass Grafting (CABG), Pneumonia, and Hip and Knee.

St. Vincent Medical Center reports their clinical care and patient experience performance data publicly through several venues: the Centers for Medicare and Medicaid (CMS), the Joint Commission and the California Hospital Compare.

Good Samaritan Hospital

Good Samaritan Hospital is a world-class academic medical center affiliated with both USC and UCLA Schools of Medicine. Each year, Good Samaritan Hospital admits approximately 12,500 patients (excluding newborns) and handles more than 74,000 outpatient visits. More than 3,400 deliveries and 6,500 surgeries are performed annually in 18 surgical suites. Areas of Specialization at Good Samaritan Hospital include:

- Intensive Care
- Cardiac/Coronary Care/Cardiac Telemetry
- Certified Primary Stroke Center
- Orthopedic
- Perinatal and Neonatal Intensive Care
- Baby Friendly designation: actively protecting, promoting and supporting breastfeeding

Metro Hospital Collaborative

The Metro Hospital Collaborative is comprised of three hospitals serving the Los Angeles community—California Hospital Medical Center, Good Samaritan Hospital, and St. Vincent Medical Center. These hospitals joined together to conduct a joint data gathering process and one stakeholder engagement effort in order to better utilize resources and reduce the burden on community members who are called upon for input.

CHNA Consultants

The Center for Nonprofit Management (CNM) team has extensive experience through being involved in and conducting more than 30 Community Health Needs Assessments (CHNAs) for hospitals throughout Los Angeles County and San Diego County. In 2013, CNM conducted CHNAs for three Kaiser Foundation hospitals (Baldwin Park, Los Angeles and West Los Angeles), Citrus Valley Health Partners, the Glendale Hospitals Collaborative (Glendale Adventist Medical Center, Glendale Memorial Hospital and Verdugo Hills Hospital) and the Metro Hospital Collaborative (California Hospital Medical Center, Good Samaritan Hospital and St. Vincent Medical Center) and assisted an additional two Kaiser Foundation Hospitals (Panorama City and San Diego) in community benefit planning based on the needs assessments. In 2014, the CNM team conducted the CHNA for Casa Colina Hospital and Centers for Healthcare, and for Hope Street Family Center. The CNM team recently completed 2016 CHNAs for Children's Hospital Los Angeles, as well as two Kaiser Foundation Hospitals (West Los Angeles and Baldwin Park), the Glendale Hospitals Collaborative (Glendale Adventist Medical Center, Glendale Memorial Hospital and Verdugo Hills Hospital) and Citrus Valley Health Partners.

IV. Needs Assessment Methodology and Process

This section outlines the steps taken to identify the 2016 community health needs, via data indicators (secondary data), and community input (primary data).

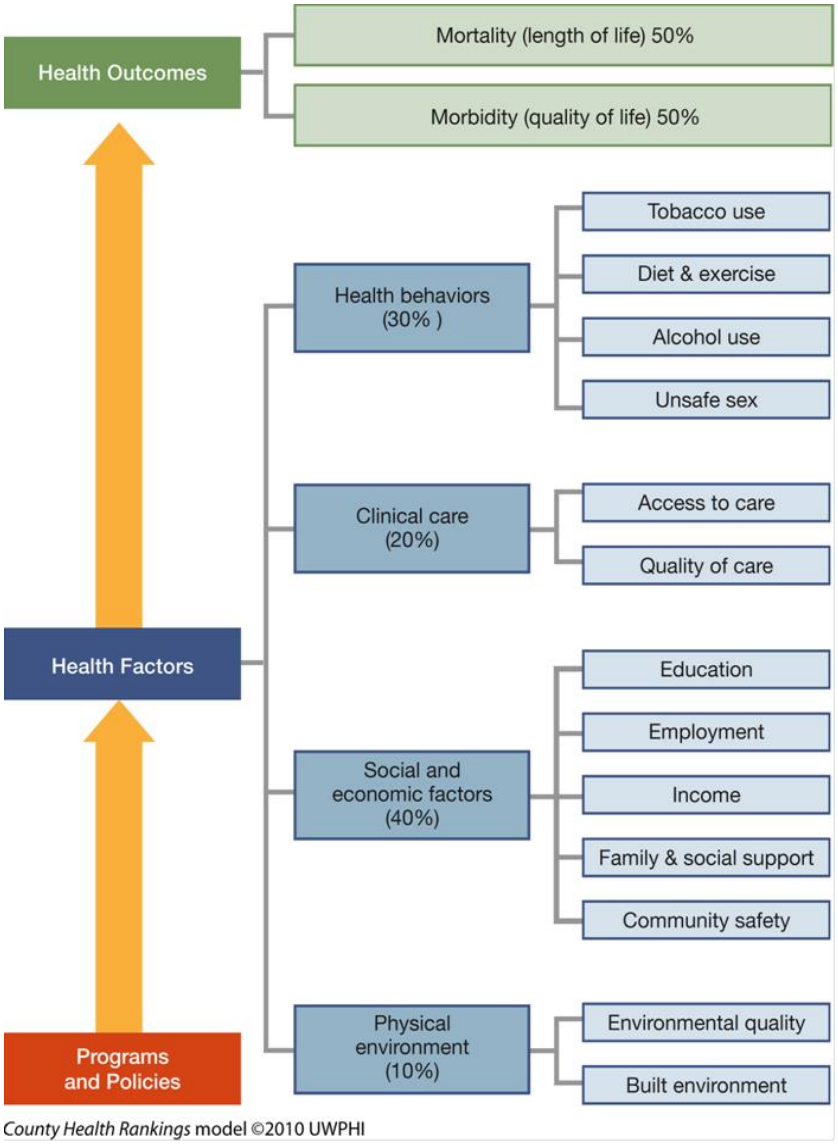
Secondary Data

The CHNA included the collection of over 200 data indicators that helped illustrate the health of the community. These secondary data were collected from a wide range of local, county, state and national sources to present demographics, mortality, morbidity, health behaviors, clinical care, social and economic factors, and physical environment (**See Appendix D—Data Sources**). These categories are based on the County Health Rankings Model.[12]

The County Health Rankings Model illustrates the relationship between **health drivers** (called Health Factors in the diagram) which include social and economic factors, health behaviors, clinical care and physical environment, and **health outcomes** (morbidity and mortality). Combined, **health drivers** and **health outcomes** are **health needs**.

[12] University of Wisconsin Population Health Institute: http://www.countyhealthrankings.org/our-approach.

County Health Rankings Model



Data available at the ZIP Code level were compiled for each hospital's service area. When not available by ZIP Code, then the data for the appropriate representative portion of the SPA was utilized.

A comprehensive data matrix, the "Scorecard" (**See Appendix A—Scorecard**), was created listing all identified secondary indicators. The Scorecard included for each hospital service area secondary data collected from regional, state and federal agencies, primary data mentions (focus groups and individual stakeholder interviews; see next section for details) as the issues emerged as priorities among community members. The Scorecard also included benchmark data in the form of Healthy People 2020 (HP2020) goals, which are nationally recognized. Additionally, the most recent county or state data source was also used as a comparison.

Primary Data—Community Input

Primary data were collected through interviews and focus groups with key stakeholders including patients, patient navigators, community liaisons and hospital administrators. Two community focus groups held on Tuesday August 16 and Tuesday August 30, 2016 were attended by a total of 21 people. Participants were invited by the Metro Hospital Collaborative. For a list of focus group questions please refer to **Appendix B – Primary Data Gathering Tools and Appendix C—Stakeholders**.

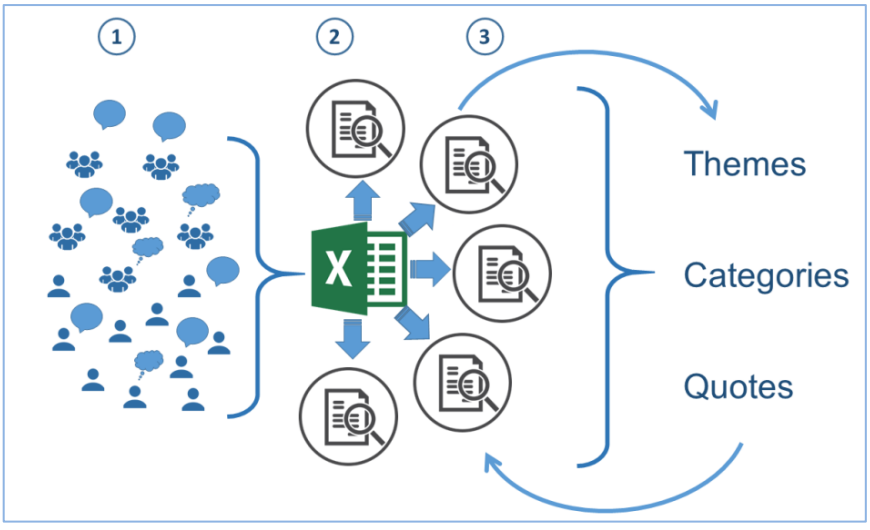
Focus group participants identified a list of most important health needs (comprised of health drivers and health outcomes, per the County Health Rankings Model). To begin to gain a sense for the perceived severity of each health need in the community, each participant was given a total of ten sticker dots and asked to vote for the five most severe health outcomes and the five most severe health drivers on a grid created during the focus group. For the purpose of the voting activity, severity was defined as the level to which a health outcome or health driver affected the health and lives of those in the community.

In addition to focus group interviews, in-depth semi-structured interviews were conducted with 5 key stakeholders in August 2016. Qualitative feedback from both the focus groups and individual interviews are incorporated in the Stakeholder Feedback sections below each Health Outcome.

The goal of the primary data collection component of the CHNA was to identify through the perceptions and knowledge of varied and multiple stakeholders health outcomes and drivers that are of particular concern to the service area community. Primary data collection also produced a list of community assets and information about gaps in resources. An inventory of existing community assets and resources was also compiled as a part of the CHNA process (**Appendix E—Local Community Assets**).

Analytical Methods Used To Identify Community Health Needs

The CNM consultant team used a modified content analysis to identify the main themes that emerged from community input through the focus groups. CNM used a three-step process for analyzing and interpreting primary data (community input): 1) all information gathered during focus groups and interviews were entered into Microsoft Excel, 2) spreadsheet data were reviewed multiple times using content analysis to begin sorting and coding the data, and 3) through the coding process, themes, categories and quotes were identified.



Analysis to Identify Main Themes Emerged Via Community Input

To help identify health needs, two requirements needed to be met: 1) a health need had to be mentioned in the primary data collection more than once and 2) a secondary data indicator associated with the need had to perform poorly against a designated benchmark (county averages, state averages, or Healthy People 2020 goals). Once a health need met both requirements, it was designated as an identified health need.

List of 18 identified health needs, in alphabetical order:

- Access to Health Care
- Alcohol, Substance Abuse, and Tobacco use
- Cancer
- Cardiovascular disease (including Cholesterol)
- Cultural and Linguistic barriers
- Diabetes
- Food insecurity
- Healthy behavior (including Physical Activity)
- Homelessness
- Hypertension
- Mental health
- Obesity/overweight
- Oral health
- Perinatal outcomes including low birth weight and breastfeeding rates[13]
- Poverty (including Unemployment)
- Preventive care
- Sexually transmitted diseases
- Transportation
- Violence and injury

Data Limitations and Gaps

The secondary data allows for an examination of the broad health needs within a community. However, there are some limitations with regard to these data, as is true with any secondary data. Data were not always available at the ZIP code level, so county-level data as well as SPA-level data were also utilized. 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 a 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.

[13] Note that perinatal outcomes were added as an identified health need after the CHNA prioritization process, and before the Implementation Strategy process. Perinatal outcomes were added as an identified health need following conversations about a draft of the CHNA report with key stakeholders. Accordingly, key indicators of perinatal health were added to the Scorecard in Appendix A.

Prioritization of Health Needs

Once a list of health needs was developed, a process was completed to prioritize the health needs. The steps to that process are outlined in the section that follows.

Community Ranking of Health Needs

A total of 28 community stakeholders convened by the Metro Hospital Collaborative on August 26, 2016 for a Prioritization Forum with the goal of ranking the identified health needs. Participants were provided the data Scorecard (**Appendix A--Scorecard**) and allowed time to review the data and discuss in small groups. CNM consultants were available in the room to answer data questions. To capture all groups' observations, each group was given a worksheet where they could provide input on: geographic areas impacted, specific populations, organizations and programs in the community and gaps in resources. After a full group discussion on their observations, they were given the opportunity to provide input via "dot voting" and completing a survey. For details, please see **Appendix B – Primary Data Gathering Tools**.

All participants were given sticker dots (10 sticker dots each) and asked to cast their sticker votes for the most severe health needs in the community.

Post-voting, they were asked to complete a written survey that asked them to score each identified health need based on the following criteria:

- MAGNITUDE- Does the issue affect a large portion of the population?
- SEVERITY- How severely does this health need impact the community?
- CHANGE OVER TIME - Has the health need improved or is it getting worse over time?
- RESOURCES - The availability of community resources and assets to address this health need.
- DISPARITIES- Does the issue disproportionately affect vulnerable population groups?

Participants were given a companion document that further explained the four criteria and the scoring system. Absent participants were allowed the opportunity to complete the survey online if they were not able to attend Prioritization forum. A total of 33 participants completed the survey in person and 13 online, for a total of 46 completed surveys. The survey and the companion document can be found in **Appendix F – Prioritization Forum Survey.**

Ranking: A Deeper Dive

During dot-voting, participants were allowed to put as many or as few stickers on a health need. If they so chose, they could put all 10 dot-stickers on a single health need, or spread them out throughout. The number of stickers allotted per participant was less than the total number of identified needs to compel participants' voting on the most pressing health needs in the community.

The survey asked participants to provide input for each health need on: (a) the magnitude, (b) the severity in the community, (c) change over time, (d) availability of resources, and (e) disparity, if the issue disproportionately affect vulnerable population groups. The possible scores ranged from 1 to 4 (to see the survey and scoring guide, please see **Appendix F—Prioritization Forum Survey**. To illustrate, a high score meant the health need was rated as very severe, getting worse, has a serious shortage of resources and the community has the capacity to address this need and thus focusing on that need would prove to be a good investment. Participants were allowed to mark "don't know" if they did not feel comfortable providing a score – and this response carried no scoring weight.

The results of dot-voting and survey scoring were combined to develop prioritized health needs. The needs were first prioritized by survey scores, and second by rank in dot-voting. In the case where multiple health needs received the same score, then ranking from the dot-voting was used to re-rank within the same score. For example, the following health needs all received a survey score of 3.6: obesity/overweight, homelessness, poverty and diabetes. We then took the scores from dot-voting to re-rank. In the case of poverty and diabetes, both received the same number of dots (16). Thus, these both occupy the same rank at #3.

Analysis of Survey Scores

The results of the dot-voting process and scores from the surveys were combined to develop a Prioritized Health Needs list (see below). The needs were first ranked based on the outcome of the scoring in the survey (i.e., highest scores meant a higher ranking) and second, ranked by the outcome of the dot votes. To view the outcome in dot-voting and scores from the survey please refer to **Appendix G—Prioritization Forum Voting and Survey Outcomes**. Below is the list of prioritized health needs, and their designation as a driver or an outcome:

List of Prioritized Health Needs

Rank	Health Need	Driver/Outcome
1	Obesity/Overweight	Outcome
2	Homelessness	Driver
3	Poverty (including unemployment)	Driver
3	Diabetes	Outcome
4	Mental Health	Outcome
5	Violence and Injury	Driver
6	Oral Health	Outcome
7	Preventive Care	Driver
7	Food Insecurity	Driver
8	Alcohol, Substance Abuse and Tobacco Use	Driver/Outcome
9	Cardiovascular Disease including Hypertension and High Cholesterol[14]	Outcome
10	Access to Care	Driver
11	Healthy Behavior	Driver
12	Cultural and Linguistic Barriers	Driver
13	Physical Activity	Driver
14	Transportation	Driver
15	Cancer	Outcome
16	Sexually Transmitted Diseases	Outcome

[14] Note that hypertension, cardiovascular disease and high cholesterol were combined as a single Health Need after the prioritization exercise. Before combining these health needs, hypertension ranked as #9, cardiovascular disease as #11, and high cholesterol as #16.

V. Community Health Profile

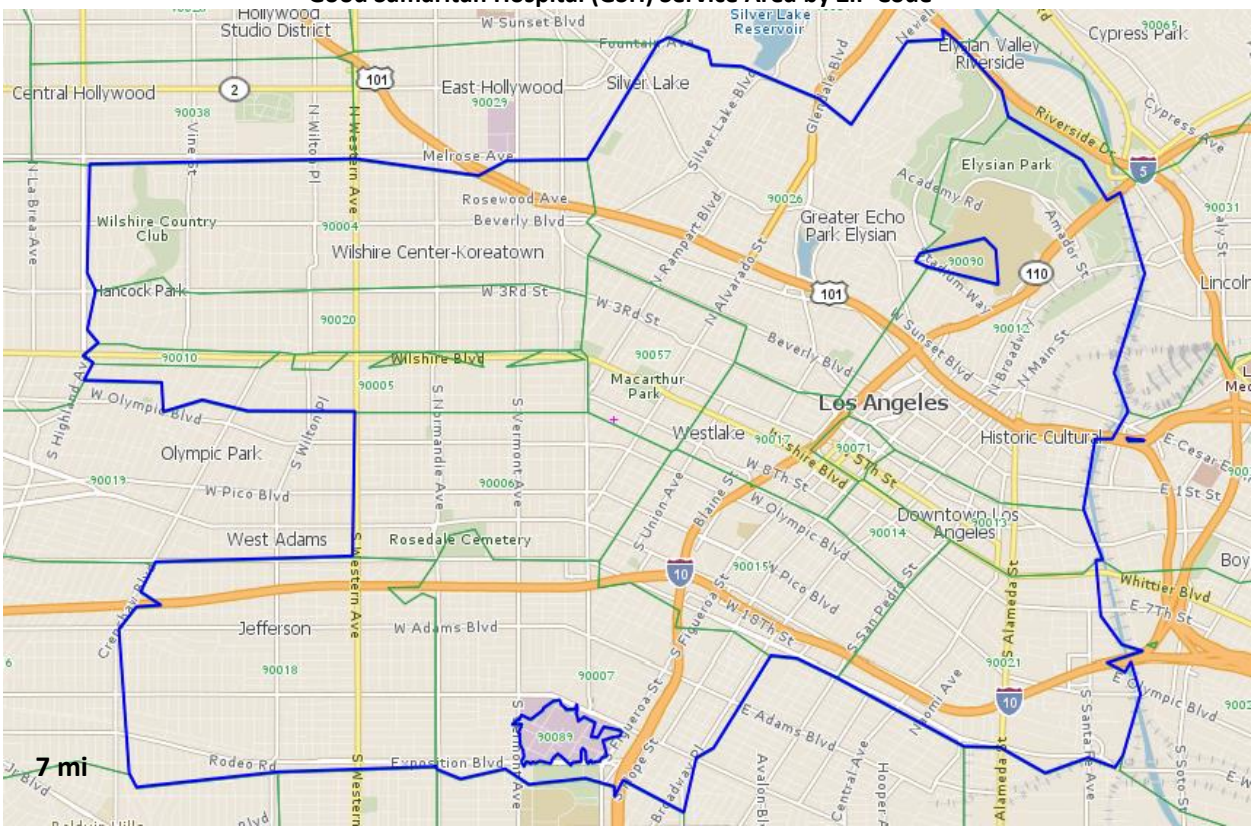
Service Area Definition

The Good Samaritan Hospital (GSH) Service Area provides health services in sixteen ZIP Codes, 11 cities or communities and 2 Service Planning Areas (SPA) within Los Angeles County. GSH is located in a federally designated Medically Underserved Area/Population.

Good Samaritan Hospital (GSH) Service Area

City/Community	ZIP Code	Service Planning Area
Hancock Park	90004	4
Koreatown	90005	4
Pico Heights	90006	4
Wilshire	90010	4
Downtown Los Angeles	90015	4
Downtown Los Angeles	90017	4
Hancock Park	90020	4
Echo Park/Silverlake	90026	4
Westlake	90057	4
Chinatown	90012	4
Downtown Los Angeles	90013	4
Los Angeles	90014	4
ARCO Towers	90071	4
Downtown Los Angeles	90021	4
South Los Angeles	90007	6
Jefferson Park	90018	6
Good Samaritan Hospital (GSH) Secondary Service Area		
Florence/South Central	90001	6
Watts	90002	6
South Central	90003	6
Baldwin Hills/Crenshaw	90008	6
South Central	90011	6
West Adams	90016	6
South Central	90037	6
Hyde Park	90043	6
Athens	90044	6
South Central	90047	6
Watts/Willowbrook	90059	6
South Central	90061	6
South Central	90062	6
Inglewood	90302	8

Good Samaritan Hospital (GSH) Service Area by ZIP Code*



*Note that ZIP codes 90090 and 90089 are geographically located inside the GSH service area, but are not included in the GSH community benefits service area because they are commercial ZIP codes.

Demographic Overview

A description of the community serviced by GSH is provided in the following data tables and narrative. All data provided in the following tables are presented by ZIP code.

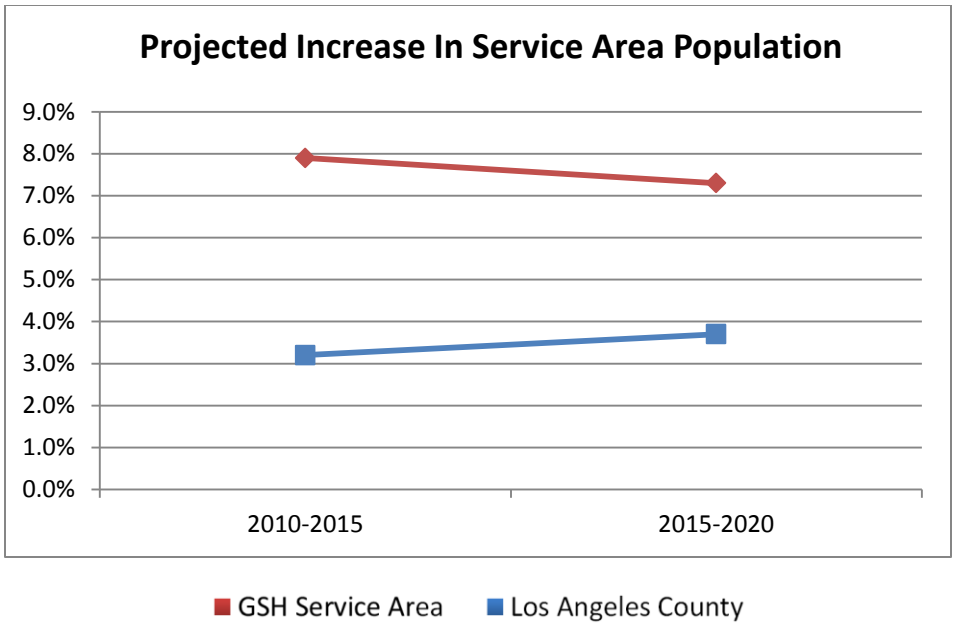
					
48.7% are between 18-44 years old*	**52.3%** of service area population is Hispanic/Latino	**66.5%** have limited English proficiency	**34.4%** 25+ don't have a high school diploma	**7.9%** of individuals were unemployed in 2015 (rate=8.6)	**62.6%** of residents live below 200% FPL**
***Reflects largest age group of the service area population**			****For 2015, the Federal Poverty Level (FPL) for one person was $11,770 and $24,250 for a family of four**		

Population

From 2010-2015 to 2015-2020, the GSH population is expected to grow at a rate twice that of Los Angeles County. From 2010 to 2015, ZIP codes 90010-Wilshire (17.4%), 90017-Downtown Los Angeles (11.9%), 90071-ARCO Towers (30.0%)[15] and 90014-Los Angeles (10.5%) experienced the highest growth within the service area.

By 2020, the population in the GSH service area is expected to increase by approximately 7.3%, which is similar to the recent population trend in the area. The largest population increases are expected to continue in ZIP Codes 90014-Los Angeles (18.0%), 90013-Downtown Los Angeles (15.9%), and 90012-Chinatown (10.5%), all of which show a projected increase in population over the next 5 years.

[15] ZIP code 90071-ARCO Towers has a total population of 13 individuals. Therefore, health drivers and outcomes measures are much more sensitive to small changes in this reporting area than any of the other reporting areas with much larger population sizes.



Estimated Current-Year Population

City	ZIP Code	2010 Population	2015 Estimated Population	2020 Projected Population	Percent Increase 2010-15	Percent Increase 2015-20
Hancock Park	90004	60,921	61,995	63,435	1.8%	2.3%
Koreatown	90005	41,417	42,479	43,744	2.6%	3.0%
Pico Heights	90006	59,501	60,883	62,620	2.3%	2.9%
Wilshire*	90010	3,229	3,792	-	17.4%	-
Downtown Los Angeles	90015	18,903	20,773	22,281	9.9%	7.3%
Downtown Los Angeles	90017	24,580	27,516	29,811	11.9%	8.3%
Hancock Park	90020	39,427	40,660	42,055	3.1%	3.4%
Echo Park/Silverlake	90026	67,165	69,760	72,451	3.9%	3.9%
Westlake	90057	43,528	45,663	47,742	4.9%	4.6%
Chinatown	90012	38,343	35,927	32,504	6.7%	10.5%
Downtown Los Angeles	90013	15,522	14,230	12,283	9.1%	15.9%
Los Angeles	90014	9,639	8,723	7,390	10.5%	18.0%
ARCO Towers	90071	10	13	15	30.0%	15.4%
Downtown Los Angeles	90021	2,979	2,822	2,619	5.6%	7.8%
South Los Angeles	90007	42,722	43,625	44,648	2.1%	2.3%
Jefferson Park	90018	51,382	53,385	55,491	3.9%	3.9%
GSH Service Area		32,454	33,265	35,939	7.9%	7.3%
Los Angeles County		9,818,605	10,136,509	10,510,281	3.2%	3.7%

Data source: Nielsen Claritas
Data year: 2016
Source geography: ZIP Code

Gender

In 2015, the GSH service area was 54.4% male. In contrast, Los Angeles County had a slightly lower percentage of males (49.3%). In ZIP codes 90021-Downtown Los Angeles (66.9%), 90013-Downtown Los Angeles (64.8%) and 90014-Los Angeles (64.6%), the male population constituted nearly two-thirds of the population.

Gender

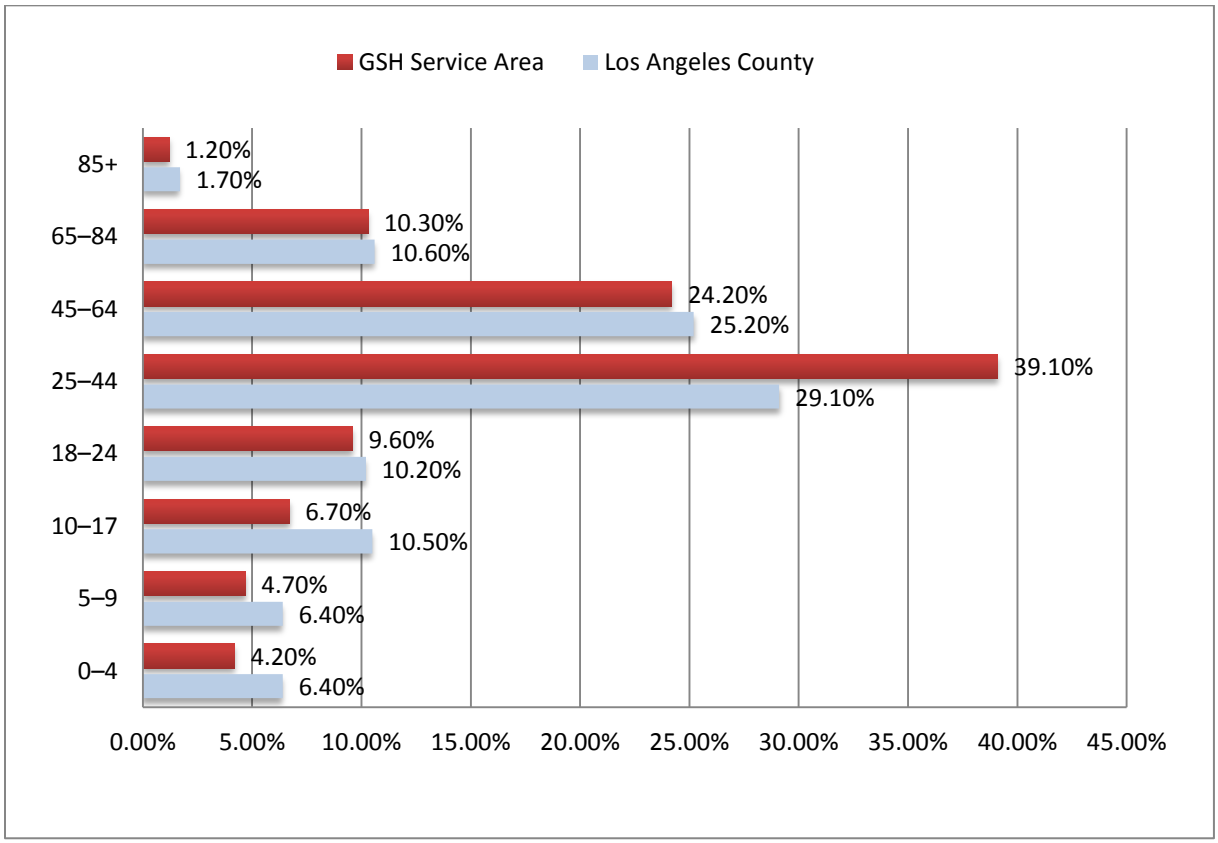
City	ZIP Code	Male		Female	
		Number	Percent	Number	Percent
Hancock Park	90004	31,279	50.5%	30,716	49.5%
Koreatown	90005	21,703	51.1%	20,776	48.9%
Pico Heights	90006	31,218	51.3%	29,665	48.7%
Wilshire	90010	1,809	47.7%	1,983	52.3%
Downtown Los Angeles	90015	10,689	51.5%	10,084	48.5%
Downtown Los Angeles	90017	14,691	53.4%	12,825	46.6%
Hancock Park	90020	20,152	49.6%	20,508	50.4%
Echo Park/Silverlake	90026	35,546	51.0%	34,214	49.0%
Westlake	90057	24,552	53.8%	21,111	46.2%
Chinatown	90012	22,242	61.9%	13,685	38.1%
Downtown Los Angeles	90013	9,221	64.8%	5,009	35.2%
Los Angeles	90014	5,638	64.6%	3,085	35.4%
ARCO Towers	90071	7	53.8%	6	46.2%
Downtown Los Angeles	90021	1,889	66.9%	933	33.1%
South Los Angeles	90007	22,168	50.8%	21,457	49.2%
Jefferson Park	90018	25,871	48.5%	27,514	51.5%
GSH Service Area		289,541	54.4%	242,705	45.6%
California		5,001,632	49.3%	5,134,877	50.7%

Source: Nielson Claritas
Data Year: 2016
Source Geography: ZIP

Age

The GSH service area had a smaller percentage of residents who were under 18 (15.6%) than Los Angeles County (23.0%). Most of the population in the service area was between the ages of 25 and 44 (39.1%). The percent of the GSH service area population over the age of 45 (35.7%) was similar to Los Angeles County (37.5%). Overall, 48.7% of service area population is of childbearing age (between 18 and 44 years of age). In addition, the senior population (over 65 years old) in the GSH service area (11.5%) was slightly smaller than in Los Angeles county (12.3%).

Age Distribution



Age Distribution

City	ZIP Code	0–4	5–9	10–17	18–24	25–44	45–64	65–84	85+	Total
Hancock Park	90004	5.8%	6.2%	8.8%	8.1%	34.5%	25.9%	9.6%	1.0%	100.0%
Koreatown	90005	5.6%	5.9%	8.2%	7.6%	36.5%	24.6%	10.2%	1.3%	100.0%
Pico Heights	90006	7.0%	7.1%	10.0%	9.3%	33.3%	23.4%	8.9%	1.0%	100.0%
Wilshire	90010	1.6%	0.2%	5.0%	9.0%	43.5%	25.8%	14.2%	0.8%	100.0%
Downtown Los Angeles	90015	6.1%	6.1%	9.5%	10.5%	37.0%	21.1%	8.5%	1.2%	100.0%
Downtown Los Angeles	90017	7.1%	6.9%	10.3%	11.4%	37.6%	18.6%	7.2%	0.9%	100.0%
Hancock Park	90020	5.1%	5.5%	8.1%	6.9%	38.9%	25.4%	9.2%	0.9%	100.0%
Echo Park/Silverlake	90026	5.3%	5.5%	8.4%	8.2%	37.5%	24.6%	9.2%	1.2%	100.0%
Westlake	90057	7.0%	7.0%	9.6%	9.3%	36.4%	20.7%	8.5%	1.6%	100.0%
Chinatown	90012	2.7%	2.8%	5.1%	9.6%	41.2%	22.9%	12.9%	2.8%	100.0%
Downtown Los Angeles	90013	1.2%	1.4%	1.7%	2.5%	41.0%	37.5%	12.7%	2.1%	100.0%
Los Angeles	90014	1.3%	1.4%	1.5%	2.7%	44.2%	35.3%	12.2%	1.4%	100.0%
ARCO Towers	90071	0.0%	7.7%	0.0%	7.7%	61.5%	7.7%	15.4%	0.0%	100.0%
Downtown Los Angeles	90021	3.3%	3.2%	4.8%	4.9%	37.6%	37.1%	8.5%	0.5%	100.0%
South Los Angeles	90007	4.7%	4.7%	8.6%	32.3%	27.5%	15.0%	6.2%	0.9%	100.0%
Jefferson Park	90018	6.8%	6.9%	10.9%	9.8%	29.7%	24.1%	9.9%	1.9%	100.0%
GSH Service Area		4.2%	4.7%	6.7%	9.6%	39.1%	24.2%	10.3%	1.2%	100.0%
Los Angeles County		6.4%	6.4%	10.5%	10.2%	29.1%	25.2%	10.6%	1.7%	100.0%

Data source: Nielsen Claritas
Data year: 2016
Source geography: ZIP Code

In 2015, the average age of residents in the GSH service area was 38.6 years old, which was slightly higher than the average age of Los Angeles County (37.3 years old). Similarly, the median age for residents within GSH service area (36.8) was only slightly higher than that of residents in Los Angeles County (36.0). 90007-South Los Angeles was the youngest with an average age of 31.3 years. 90013-Downtown Los Angeles was the oldest average age, with an average age of 46.7 years.

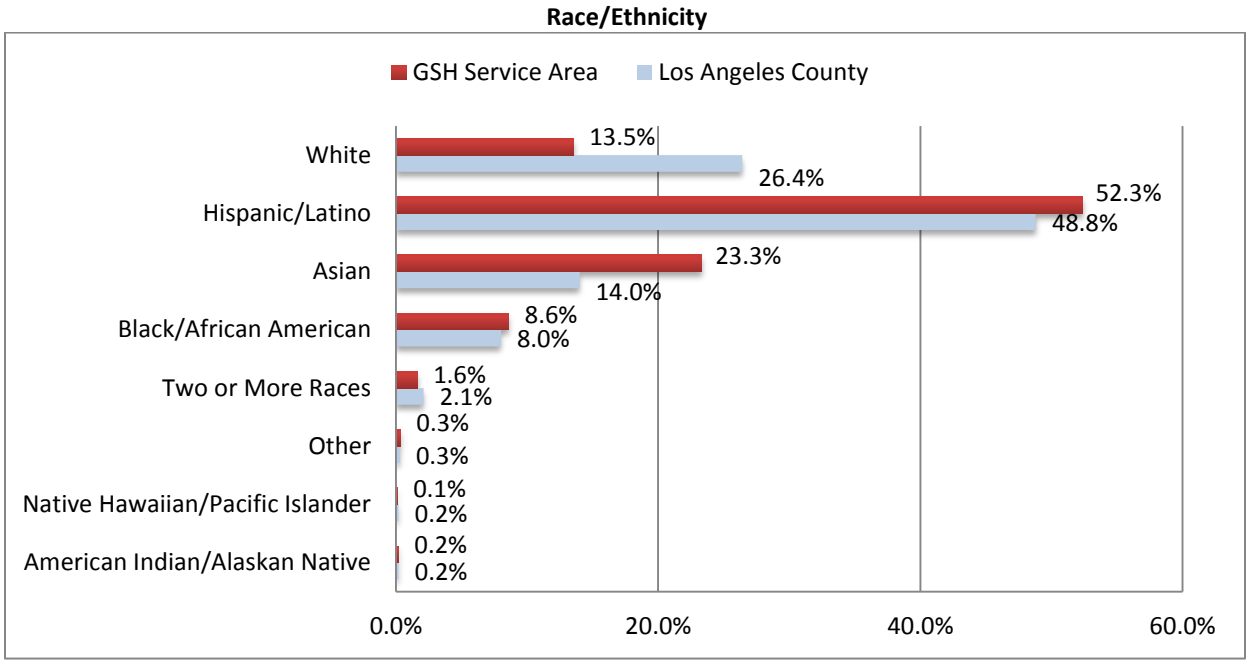
Median and Average Age (in years)

	ZIP Code	Median Age	Average Age
Hancock Park	90004	37.1	37.6
Koreatown	90005	36.8	38.0
Pico Heights	90006	34.5	35.7
Wilshire	90010	39.5	42.9
Downtown Los Angeles	90015	33.7	35.7
Downtown Los Angeles	90017	31.7	33.6
Hancock Park	90020	37.3	37.9
Echo Park/Silverlake	90026	36.5	37.6
Westlake	90057	33.6	35.4
Chinatown	90012	38.5	41.7
Downtown Los Angeles	90013	46.1	46.7
Los Angeles	90014	44.4	45.4
ARCO Towers	90071	36.3	40.0
Downtown Los Angeles	90021	43.1	42.0
South Los Angeles	90007	24.9	31.3
Jefferson Park	90018	35.0	36.7
GSH Service Area		36.8	38.6
Los Angeles County		36.0	37.3

Data source: Nielsen Claritas
Data year: 2016
Source geography: ZIP Code

Race and Ethnicity

In 2015, more than half of the population living in the GSH service area was of Hispanic/Latino origin (52.3%), which was slightly higher than Los Angeles County. Asian residents made up the second largest population by ethnicity in the GSH service area (23.3%), a higher percentage than in Los Angeles County (14.0%). The White population as a percentage of the total population in the GSH service area (13.5%) was nearly half that of Los Angeles County (26.4%). The Black/African-American population in the GSH service area (8.6%) was similar in representation to the rest of Los Angeles County (8.0%).



Education

The GSH service area population consisted of a higher percentage of individuals who did not graduate from high school or receive their GED (31.2%) than Los Angeles County (23.2%). In particular, ZIP codes 90017-Downtown Los Angeles (36.1%), 90057-Westlake (31.2%) and 90006-Pico Heights (30.3%) had the highest percentage of individuals who did not attend high school. The population within the GSH service area consisted of a lower percentage of individuals with a college education (32.6%) than Los Angeles County (36.5%). The percent of the population in GSH's service area who earned a Master's degree or higher (7.9%) was also lower than Los Angeles County (10.2%). ZIP code 90010-Wilshire (14.7%) had the highest percentage of individuals who completed a Master's degree or higher.

Educational Attainment

City	ZIP Code	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
Hancock Park	90004	18.7%	10.9%	16.8%	14.7%	6.0%	24.8%	8.1%
Koreatown	90005	20.5%	10.3%	20.5%	14.6%	4.9%	22.2%	6.9%
Pico Heights	90006	30.3%	16.0%	24.2%	12.3%	3.5%	10.7%	3.0%
Wilshire	90010	4.8%	3.5%	15.0%	18.4%	10.4%	33.2%	14.7%
Downtown Los Angeles	90015	25.4%	14.9%	14.7%	12.7%	4.6%	18.6%	9.1%
Downtown Los Angeles	90017	36.1%	12.4%	18.4%	10.2%	4.0%	13.0%	5.9%
Hancock Park	90020	13.2%	8.5%	21.1%	16.2%	5.4%	22.3%	10.0%
Echo Park/Silverlake	90026	18.5%	9.9%	16.3%	15.1%	6.2%	24.9%	9.1%
Westlake	90057	31.2%	13.5%	19.4%	13.2%	4.4%	14.8%	3.6%
Chinatown	90012	20.1%	16.3%	18.4%	15.8%	3.7%	16.7%	9.0%
Downtown Los Angeles	90013	8.0%	14.2%	19.4%	19.8%	5.9%	21.7%	11.0%
Los Angeles	90014	8.9%	10.7%	16.3%	20.9%	6.8%	24.9%	11.4%
ARCO Towers	90071	0.0%	9.1%	18.2%	9.1%	0.0%	27.3%	36.4%
Downtown Los Angeles	90021	21.2%	15.2%	16.2%	20.1%	4.3%	17.2%	5.8%
South Los Angeles	90007	26.5%	14.1%	20.6%	15.1%	4.0%	13.1%	6.5%
Jefferson Park	90018	22.1%	14.0%	25.5%	19.1%	5.0%	9.5%	4.8%
GSH Service Area		19.1%	12.1%	18.8%	15.5%	5.0%	19.7%	7.9%
Los Angeles County		13.5%	9.7%	20.6%	19.7%	6.8%	19.5%	10.2%

Data source: Nielsen Claritas
Data year: 2016
Source geography: ZIP Code

Marital Status

In 2015, the percentage of the GSH service area population who had never been married (55.8%) was significantly higher than Los Angeles County (41.5%). Further, the percentage of the population that was married and had their spouse present was much lower in the GSH service area (24.5%) than in Los Angeles County (38.3%). Only marginal differences (less than 1%) existed between GSH service area residents and Los Angeles County residents in the percent of the population who were either married with their spouse absent, widowed or divorced.

Marital Status

City	ZIP Code	Never Married	Married, Spouse Present	Married, Spouse Absent	Widowed	Divorced
Hancock Park	90004	49.0%	31.3%	8.8%	3.6%	7.3%
Koreatown	90005	49.4%	28.7%	9.3%	4.8%	7.8%
Pico Heights	90006	50.8%	28.9%	9.2%	4.0%	7.1%
Wilshire	90010	40.7%	40.3%	3.3%	5.1%	10.5%
Downtown Los Angeles	90015	54.4%	26.9%	7.9%	5.2%	5.6%
Downtown Los Angeles	90017	59.9%	24.6%	6.2%	4.2%	5.1%
Hancock Park	90020	50.1%	31.8%	6.7%	3.5%	7.9%
Echo Park/Silverlake	90026	54.0%	27.6%	7.9%	4.0%	6.6%
Westlake	90057	54.1%	25.6%	9.9%	4.3%	6.1%
Chinatown	90012	51.8%	22.0%	12.8%	6.5%	6.8%
Downtown Los Angeles	90013	64.6%	11.2%	7.1%	5.8%	11.3%
Los Angeles	90014	69.4%	9.4%	5.9%	4.2%	11.1%
ARCO Towers	90071	58.3%	25.0%	0.0%	8.3%	8.3%
Downtown Los Angeles	90021	65.5%	14.8%	7.0%	2.0%	10.7%
South Los Angeles	90007	71.4%	16.3%	5.7%	2.2%	4.3%
Jefferson Park	90018	49.5%	27.2%	8.6%	5.5%	9.2%
GSH Service Area		55.8%	24.5%	7.3%	4.6%	7.9%
Los Angeles County		41.5%	38.3%	6.7%	5.0%	8.6%

Data source: Nielsen Claritas
Data year: 2016
Source geography: ZIP Code

Household Income

Many more households in the GSH service area are earning an average income of less than $15,000 (26.5%) than in Los Angeles County (13.1%). Similarly, approximately two-thirds (66.5%) of the GSH service area population has a household income less than $50,000, a much higher percentage than in Los Angeles County (46.9%).

Household Income

Income level	GSH Service Area		Los Angeles County	
	Number	Percentage	Number	Percentage
Below $15,000	20,781	26.5%	440,017	13.1%
$15,000–$24,999	20,764	15.9%	368,258	11.0%
$25,000–$34,999	16,885	10.5%	324,780	9.7%
$35,000–$49,999	23,386	13.6%	439,461	13.1%
$50,000–$74,999	31,341	12.7%	564,594	16.9%
$75,000–$99,999	23,269	7.3%	384,054	11.5%
$100,000–$124,999	16,618	4.1%	272,585	8.1%
$125,000–$149,999	10,451	2.5%	166,270	5.0%
$150,000–$199,999	11,459	2.7%	181,675	5.4%
$200,000–$249,999	4,352	1.1%	65,904	2.0%
$250,000–$499,999	7,132	1.9%	100,559	3.0%
Above $500,000	3,152	1.20%	40,774	1.2%
Total	189,590	100.0%	3,348,931	100.0%

Data source: Nielsen Claritas
Data year: 2016
Source geography: ZIP Code

Natality

Births

In 2012, there was a total of 503,788 births in California, of which 1.3% (n=6,424) took place in the GSH service area. In particular, ZIP codes 90006-Pico Heights (908), 90004-Hancock Park (804), 90026-Echo Park (765) and 90057-Westlake (750) had the most births.

Births

City	ZIP Code	Number	Percentage
Hancock Park	90004	804	12.5%
Koreatown	90005	516	8.0%
Pico Heights	90006	908	14.1%
Wilshire	90010	29	0.5%
Downtown Los Angeles	90015	264	4.1%
Downtown Los Angeles	90017	359	5.6%
Hancock Park	90020	525	8.2%
Echo Park/Silverlake	90026	765	11.9%
Westlake	90057	750	11.7%
Chinatown	90012	226	3.5%
Downtown Los Angeles	90013	80	1.2%
Los Angeles	90014	38	0.6%
ARCO Towers	90071	-	-
Downtown Los Angeles	90021	25	0.4%
South Los Angeles	90007	429	6.7%
Jefferson Park	90018	706	11.0%
GSH Service Area		6,424	100%

Data source: California Department of Public Health
Data year: 2012
Source geography: ZIP Code

Births by Mother's Age

In 2012, most births in the GSH service area were to women between the ages of 20 and 29 (44.2%), followed by those between the ages of 30 and 34 (27.1%), and 35 years and older (20.3%). This trend was similar to that found throughout the rest of Los Angeles County. There was a slightly higher percentage (8.4%) of mothers in the GSH service area who were under 20 years old and gave birth than in Los Angeles County.

Births by Mother's Age

	GSH Service Area		Los Angeles County	
Age Group	Number	Percentage	Number	Percentage
Under 20 years old	542	8.4%	9,296	7.0%
20–29 years old	2,838	44.2%	58,963	44.5%
30–34 years old	1,742	27.1%	36,186	27.3%
35 years old and older	1,302	20.3%	28,161	21.2%
Total	6,424	100.0%	132,606	100.0%

Data source: California Department of Public Health
Data year: 2012
Source geography: ZIP Code

Births by Mother's Ethnicity

By ethnicity, most births in the GSH service area in 2012 were to Hispanic mothers (66.8%) followed by Asian mothers (17.8%), both of which were higher than percentages reflected throughout Los Angeles County (57.6% and 14.8% respectively). In contrast, the percentage (6.6%) of white mothers who gave birth in the GSH service area was significantly less than Los Angeles County (17.4%).

Births by Mother's Ethnicity

Ethnicity	GSH Service Area		Los Angeles County	
	Number	Percentage	Number	Percentage
Native American or Alaskan Native	5	0.1%	116	0.1%
Asian/Pacific Islander	1,146	17.8%	19,579	14.8%
African-American	436	6.8%	9,446	7.1%
Hispanic	4,294	66.8%	76,320	57.6%
White	422	6.6%	23,012	17.4%
Two or More Races	59	0.9%	1,847	1.4%
Other Race	62	1.0%	2,288	1.7%
Total	6,424	100.0%	132,608	100.0%

Data source: California Department of Public Health
Data year: 2012
Source geography: ZIP Code

Birth Weight

In the United States, the average newborn weighs about 8 pounds. Any baby born weighing less than 5 pounds, 8 ounces (2,500 grams) falls into the low birth weight category. A baby weighing less than 1500 grams falls into the very low birth weight category. Medical risk factors for having a low-birthweight baby include chronic health conditions like high blood pressure, diabetes and heart, lung and kidney problems and infections. Additional risk factors include smoking, drinking alcohol and substance abuse as well as mother's age and ethnicity. Low birth weight infants are more likely to have respiratory problems, feeding problems, bleeding in the brain and are more likely to die in the first year of life than normal birth weight infants. Low birth weight infants are also more likely to experience long-range developmental and physical health problems including: diabetes, heart disease, high blood pressure, metabolic syndrome and obesity.[16]

In 2012 in the GSH service area, 394 babies were born with low birth weight (6.1% of all births) and another 76 with very low birth weight (1.2% of all births). ZIP codes 90015-Downtown Los Angeles (8.0%), 90013-Downtown Los Angeles (10.0%), 90021-Downtown Los Angeles (8.0%) and 90007-South Los Angeles (9.8%) had the highest percentages of babies born with low birth weights, and 90007-South Los Angeles (1.6%) and 90015-Downtown Los Angeles (1.5%) had the highest percentage of babies born with very low birth weight. Seven percent of live births in Los Angeles County are very low birth weight.[17]

[16] March of Dimes, Low Birthweight. Available at: http://www.marchofdimes.org/complications/low-birthweight.aspx#. Accessed October 26, 2016.

[17] Los Angeles County Department of Public Health Community Health Assessment, 2015.

Birth Weight

City	ZIP Code	Low Birth Weight (1500 to 2499 grams)		Very Low Birth Weight (Less than 1500 grams)	
		Number	Percentage	Number	Percentage
Hancock Park	90004	47	5.8%	8	1.0%
Koreatown	90005	25	4.8%	7	1.4%
Pico Heights	90006	62	6.8%	11	1.2%
Wilshire	90010	1	3.4%	0	0.0%
Downtown Los Angeles	90015	21	8.0%	4	1.5%
Downtown Los Angeles	90017	21	5.8%	4	1.1%
Hancock Park	90020	29	5.5%	6	1.1%
Echo Park/Silverlake	90026	33	4.3%	10	1.3%
Westlake	90057	37	4.9%	9	1.2%
Chinatown	90012	12	5.3%	2	0.9%
Downtown Los Angeles	90013	8	10.0%	1	1.3%
Los Angeles	90014	2	5.3%	0	0.0%
ARCO Towers	90071	-	0.0%	-	0.0%
Downtown Los Angeles	90021	2	8.0%	0	0.0%
South Los Angeles	90007	42	9.8%	7	1.6%
Jefferson Park	90018	52	7.4%	7	1.0%
Florence/South Central*	90001	65	5.6%	16	1.4%
Watts*	90002	71	6.7%	15	1.4%
South Central*	90003	93	6.5%	9	0.6%
Baldwin Hills/Crenshaw*	90008	35	9.6%	8	2.2%
South Central*	90011	121	5.5%	32	1.4%
West Adams*	90016	44	6.7%	8	1.2%
South Central*	90037	64	5.6%	13	1.1%
Hyde Park*	90043	44	7.6%	15	2.6%
Athens*	90044	105	6.6%	23	1.4%
South Central*	90047	55	8.4%	13	1.9%
Watts/Willowbrook*	90059	50	5.9%	19	2.2%
South Central*	90061	33	6.9%	7	1.4%
South Central*	90062	24	5.4%	5	1.1%
Inglewood*	90302	27	6.4%	6	1.4%
GSH Service Area		394	6.1%	76	1.2%
State of California		28,034	5.6%	5,689	1.1%

Data source: California Department of Public Health
Data year: 2012
Source geography: ZIP Code
*Secondary service area

Prenatal care can greatly improve a mother's chances of having a healthy pregnancy and baby, and it is recommended that a woman begin receiving prenatal care as soon as she knows she is pregnant. In the GSH service area, approximately four in five (79.29%) of women received prenatal care during the first trimester of their pregnancy, slightly higher than the Healthy People 2020 target of 77.9%. However, one in 20 (4.49%) of women did not receive prenatal care until their third trimester.

Prenatal Care Initiated by Trimester

City	ZIP Code	None	3rd Trimester	2nd Trimester	1st Trimester

City	ZIP Code	None	3rd Trimester	2nd Trimester	1st Trimester
Hancock Park	90004	0.2%	7.0%	13.3%	74.6%
Koreatown	90005	0.2%	2.9%	12.4%	81.2%
Pico Heights	90006	0.1%	3.9%	14.2%	77.0%
Wilshire	90010	-	3.4%	10.3%	82.8%
Downtown Los Angeles	90015	0.4%	4.5%	12.9%	75.8%
Downtown Los Angeles	90017	0.3%	2.8%	12.5%	83.0%
Hancock Park	90020	0.2%	3.2%	12.2%	81.3%
Echo Park/Silverlake	90026	0.3%	3.3%	13.1%	79.7%
Westlake	90057	0.3%	3.5%	12.8%	81.6%
Chinatown	90012	-	3.5%	6.6%	82.7%
Downtown Los Angeles	90013	-	1.3%	10.0%	86.3%
Los Angeles	90014	-	2.6%	18.4%	76.3%
ARCO Towers	90071	-	-	-	-
Downtown Los Angeles	90021	-	16.0%	8.0%	76.0%
South Los Angeles	90007	0.5%	5.6%	12.1%	77.2%
Jefferson Park	90018	0.1%	3.8%	15.9%	73.8%
GSH Service Area		0.26%	4.49%	12.31%	79.29%

Data source: California Department of Public Health
Data year: 2012
Source geography: ZIP Code

Breastfeeding

There are numerous beneficial short-term and long-term health effects of breastfeeding for mothers and babies. Recent research has also demonstrated that breastfeeding carries potential economic and environmental benefits for communities. The short-term benefits of breastfeeding to babies include nutritionally balanced meals, some protection against common childhood infections and better survival during the first year of life.[18] With respect to health during the lifetime, recent research has demonstrated that breastfeeding during infancy has protective effects for the baby against chronic non-communicable diseases in adulthood, particularly hypertension, obesity, diabetes, hypercholesterolemia and cardiovascular disease.[19] Moreover, breastfeeding carries health benefits for mothers including lowering their risk of type 2 diabetes, certain kinds of breast cancer and ovarian cancer.[20] With respect to the economic benefits of breastfeeding, families purchasing infant formula during the first year of a child's life can save between $1,200 and $1,500 through breastfeeding instead.[21] This is a significant savings for low-income families.

Women who stop breastfeeding before their infant is three months old often do so because of breastfeeding management problems that are preventable and can be addressed through breastfeeding education and support. Hospitals can be designated as "baby-friendly" if they follow steps to promote breastfeeding. GSH has been designated a "baby-friendly" hospital, meaning that mothers served by

[18] Eunice Kennedy Shriver National Institute on Child Health and Human Development. Available at: https://www.nichd.nih.gov/health/topics/breastfeeding/conditioninfo/Pages/benefits.aspx Accessed October 26, 2016.
[19] Davis MK. Breastfeeding and chronic disease in childhood and adolescence. Pediatr Clin North Am.2011;48:125–41.
[20] Office on Women's Health, US Department of Health and Human Services. Available at: https://www.womenshealth.gov/breastfeeding/breastfeeding-benefits.html Accessed October 26, 2016.
[21] Tuttle CR, Dewey KG. Potential cost savings for Medi-Cal, AFDC, Food Stamps, WIC Programs Associated with Increasing Breast-feeding Among Low-Income Hmong Women in California. J Am Diet Assoc 1996; 96: 885–890.

GSH are informed of the benefits of breastfeeding and have access to lactation support groups upon hospital discharge.

In 2015, 97.7% of the 2,941 babies born at GSH were breastfed by their mothers while in the hospital (measured between 24 and 48 hours after birth),[6] a much higher percent than the Healthy People 2020 goal of 81.9% and the average for Los Angeles County where less than nine out of ten (87%) mothers initiate breastfeeding their infants.[22] At GSH, over half of babies born in 2015 (55.3%) were exclusively breastfed during the initial 24-48 hours in the hospital.[23]

In Los Angeles County, Asian/Native Hawaiian or Pacific Islander (NHOPI) mothers have the highest rates of initiating breastfeeding (96%) followed by Latina (89%), White (88%) and African American mothers (68%). However, White mothers are most likely to continue breastfeeding their infants until six months of age (63%) followed by Asian/NHOPI and Latina (both 42%), and African American (25%*) mothers.[24]

In the GSH service area, over half (57.9%) of mothers breastfed their babies for at least six months, a higher percentage than in Los Angeles County (45%) but still lower than the Healthy People 2020 goal of >=60.6%.[25] In SPA 6, however, the goal was achieved as 66.8% of mothers breastfeed their infants at least 6 months.

Slightly over a quarter (26.0%) of mothers in the GSH service area breastfed their babies for at least twelve months, a lower percentage than in Los Angeles County (27.6%). A larger percentage (31.7%) of mothers in SPA 6 breastfed their babies at least twelve months—more than in Los Angeles County (27.6%).

Breastfeeding

Report Area	Breastfeeding at Least 6 Months Percentage	Breastfeeding at Least 12 Months Percentage
SPA 4–Metro	55.9%	24.7%
SPA 6 - South	66.8%	31.7%
GSH Service Area	57.9%	26.0%
Los Angeles County	49.7%	27.6%
Healthy People 2020	>=60.6%	>=34.1%

Data source: Los Angeles County Health Survey
Data year: 2015
Source geography: SPA

Stakeholder Insights -- Breastfeeding

Stakeholders noted several reasons why breastfeeding rates are low in the service population. First, there are few organizations that educate women about and promote the benefits of breastfeeding over

[22] Los Angeles County Department of Public Health Community Health Assessment, 2015.
[23] California Department of Public Health, Center for Family Health, Genetic Disease Screening Program, Newborn Screening Data, 2015
[24] Los Angeles County Department of Public Health Community Health Assessment, 2015.
[25] Los Angeles County Department of Public Health Community Health Assessment, 2015.

formula feeding. In addition, many employers do not provide supportive resources that would encourage continued breastfeeding once a woman returns to work. Finally, among the service population, formula feeding carries a high social value and is perceived as reflecting a high social status. For this reason, many women opt to formula feed even though breastfeeding is a viable option.

Disability

An umbrella term for impairments, activity limitations, and participation restrictions, disability is the interaction between individuals with a health condition (e.g., cerebral palsy, Down syndrome, depression) and personal and environmental factors (e.g., negative attitudes, inaccessible transportation and public buildings and limited social supports).[26] Examples of disabilities include hearing, vision, movement, thinking, remembering, learning, communication and/or mental health and social relationships. Disabilities can affect a person at any point in the life cycle.[27]

Over a billion people—corresponding to about 15% of the world population—are estimated to live with some form of disability. Between 110 million (2.2%) and 190 million (3.8%) people 15 years and older have significant difficulties functioning. In addition, rates of disability are increasing, in part as a result of aging populations and increases in chronic health conditions. People with disabilities typically have less access to health care services and consequently often do not have their health care needs met.[28]

In California 23% of the adult population have a disability. The proportion of the population with disabilities increases with age and among females and African-American, White or American Indian/Alaskan native populations. People with disabilities are also more likely than others to be poorly educated, unemployed and living below the poverty level. [29]

Prevalence

In 2014, the population living in the GSH service area with disability status due to physical, mental or emotional conditions (28.7%) was nearly the same as in Los Angeles County (28.6%). In SPA 6, however, the percentage was significantly higher (39.4%).

[26] World Health Organization. Disability and Health Fact Sheet. Geneva, Switzerland. Available at http://www.who.int/mediacentre/factsheets/fs352/en/index.html. Accessed [August 2, 2016].

[27] Center for Disease Control and Prevention. Atlanta, GA. Available at http://www.cdc.gov/ncbddd/disabilityandhealth/types.html. Accessed [August 2, 2016].

[28] World Health Organization. Disability and Health Fact Sheet. Geneva, Switzerland. Available at http://www.who.int/mediacentre/factsheets/fs352/en/index.html. Accessed [August 2, 2016].

[29] California Department of Public Health's Living Healthy with a Disability Program and Living Healthy Advisory Committee. Planning for Today, Thinking of Tomorrow—California's 2011-2016 Strategic Directions for Promoting the Health of People with Disabilities Sacramento, CA. Available at http://www.cdph.ca.gov/HealthInfo/injviosaf/Documents/Planning_for_Today.pdf] Accessed [August 2, 2016].

Disability Status Due to Physical, Mental or Emotional Condition, Adults

Report Area	Percentage
SPA 4–Metro	26.3%
SPA 6–South	39.4%
GSH Service Area	28.7%
Los Angeles County	28.6%

Data source: California Health Interview Survey
Data year: 2014
Source geography: SPA

In 2011, a smaller percentage of adults (12.3%) cared for or assisted other adults with a long-term illness or disability in the GSH service area when compared to Los Angeles County (20.0%).

Adults Who Have Provided Care or Assistance to Another Adult In The Past Month

Report Area	Percentage
SPA 4–Metro	11.3%
SPA 6–South	16.9%
GSH Service Area	12.3%
Los Angeles County	20.0%

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

In 2015, a slightly smaller percentage (12.3%) of children between 0 and 17 years of age had special health care needs in the GSH service area when compared to Los Angeles County (14.5%).

Children 0–17 Years old with Special Health Care Needs

Report Area	Percentage
SPA 4–Metro	12.3%
SPA 6–South	12.5%
GSH Service Area	12.3%
Los Angeles County	14.5%

Data source: Los Angeles County Health Survey
Data year: 2015
Source geography: SPA

Disparities

In 2011, one sixth (17.1%) of children between 12 and 17 years old had a special health care need in Los Angeles County. Another 16.6% of children between 6 and 11 years of age and 9.8% of children between 0 and 5 years of age had a special health care need.

Children 0 to 17 Years old with Special Health Care Needs by Age, Los Angeles County

Age Group	Percentage
0–5 years old	9.8%
6–11 years old	16.6%
12–17 years old	17.1%

Data source: Los Angeles County Health Survey
Data year: 2015
Source geography: County

By ethnicity, nearly a third (32.4%) of African-American children had a special health care need. In addition, 17.5% of White children and 12.0% of Latino children have a special health care need. Only 10.5% of Asian/Pacific Islander children and 8.7% of American Indian/Alaskan Native children have special health care needs.

Children 0 to 17 Years old with Special Health Care Needs by Ethnicity, Los Angeles County

Age Group	Percentage
Latino	12.0%
White	17.5%
African-American	32.4%
Asian/Pacific Islander	10.5%
American Indian/Alaskan Native	8.7%

Data source: Los Angeles County Health Survey
Data year: 2015
Source geography: County

Associated Drivers of Health

Disabilities may strike anyone at any point in time; however, disability rates are increasing in part as a result of aging populations and increases in chronic health conditions. People with disabilities typically have less access to health care services and often do not have their health care needs met.[30] People with disabilities are more likely to experience difficulties or delays in getting necessary health care in a timely manner, including visiting a dentist and getting mammograms and Pap smear tests, among other important diagnostic and preventive resources. In addition, they are more likely to smoke, to not engage in physical activity, to be overweight or obese, to have high blood pressure, to experience psychological distress, to receive less social/emotional support and to have high unemployment rates.[31]

Mortality

Deaths

In 2010, deaths in the GSH service area accounted for 4.1% of all deaths in Los Angeles County. ZIP codes accounting for the most deaths in the service area include: 90018-Jefferson Park (15.4%), 90026-Echo Park (12.5%) and 90004-Hancock Park (11.2%).

[30] World Health Organization. Disability and Health Fact Sheet. Geneva, Switzerland. Available at http://www.who.int/mediacentre/factsheets/fs352/en/index.html. Accessed [August 2, 2016].

[31] 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=9. Accessed [August 2, 2016].

Total Deaths

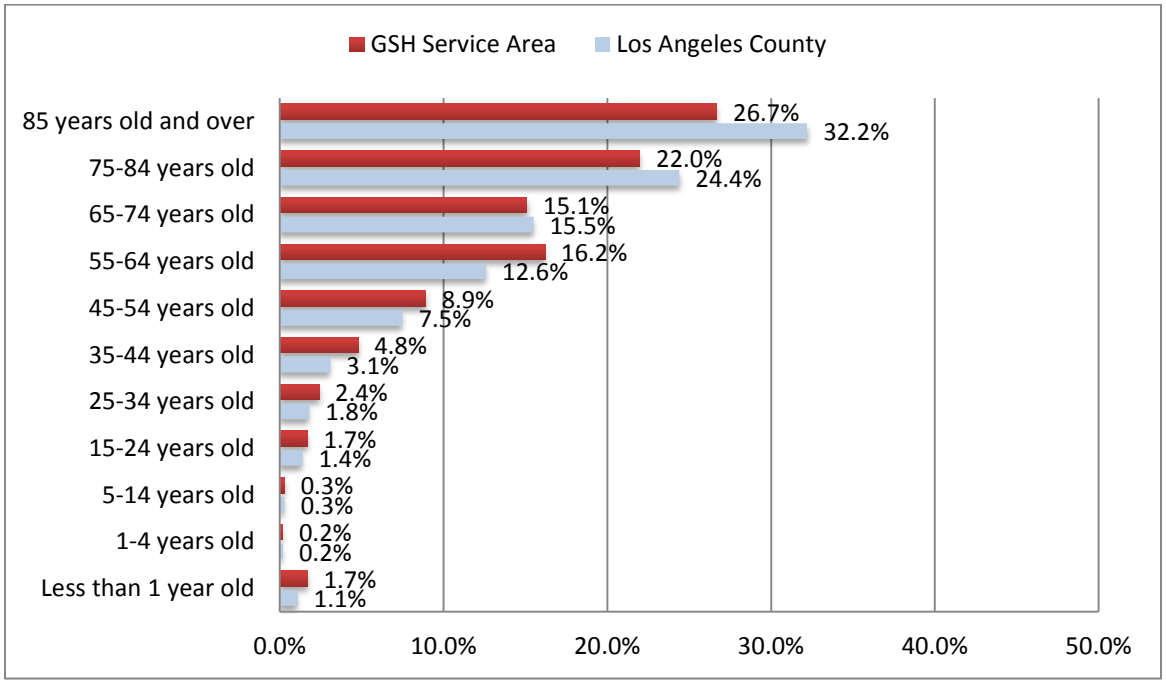
City	ZIP Code	Total	Percentage of Service Area
Hancock Park	90004	261	11.2%
Koreatown	90005	163	7.0%
Pico Heights	90006	233	10.0%
Wilshire	90010	12	0.5%
Downtown Los Angeles	90015	70	3.0%
Downtown Los Angeles	90017	96	4.1%
Hancock Park	90020	134	5.7%
Echo Park/Silverlake	90026	292	12.5%
Westlake	90057	211	9.0%
Chinatown	90012	193	8.3%
Downtown Los Angeles	90013	100	4.3%
Los Angeles	90014	69	3.0%
ARCO Towers	90071	-	-
Downtown Los Angeles	90021	24	1.0%
South Los Angeles	90007	120	5.1%
Jefferson Park	90018	359	15.4%
GSH Service Area		2,337	100.0%
Los Angeles County		56,873	

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

Deaths by Age Group

Compared to Los Angeles County averages, the incidence of mortality in the GSH service area showed the greatest disparity among the population between the ages of 55-64 (+3.6%). Additionally, there were a higher percentage of deaths in the service area than in Los Angeles County among children less than 1 year of age (1.7% compared to 1.1%), as well as among the following age groups: 25-34 years, 35-44 years, 45-54 years and 55-64 years. The probability of living to 85 years and older is much lower in the GSH service area (26.7%) than in Los Angeles County (32.2%).

Total Deaths, by Age Group



Total Deaths, by Age Group

Age Group	Service Area		Los Angeles County	
	Number	Percentage	Number	Percentage
Less than 1 year old	40	1.7%	613	1.1%
1–4 years old	5	0.2%	105	0.2%
5–14 years old	6	0.3%	159	0.3%
15–24 years old	39	1.7%	771	1.4%
25–34 years old	57	2.4%	1,018	1.8%
35–44 years old	112	4.8%	1,716	3.1%
45–54 years old	209	8.9%	4,123	7.5%
55–64 years old	379	16.2%	6,955	12.6%
65–74 years old	353	15.1%	8,572	15.5%
75–84 years old	513	22.0%	13,481	24.4%
85 years old and over	624	26.7%	17,818	32.2%
Total	2,337	4.0%	59,156	100.0%

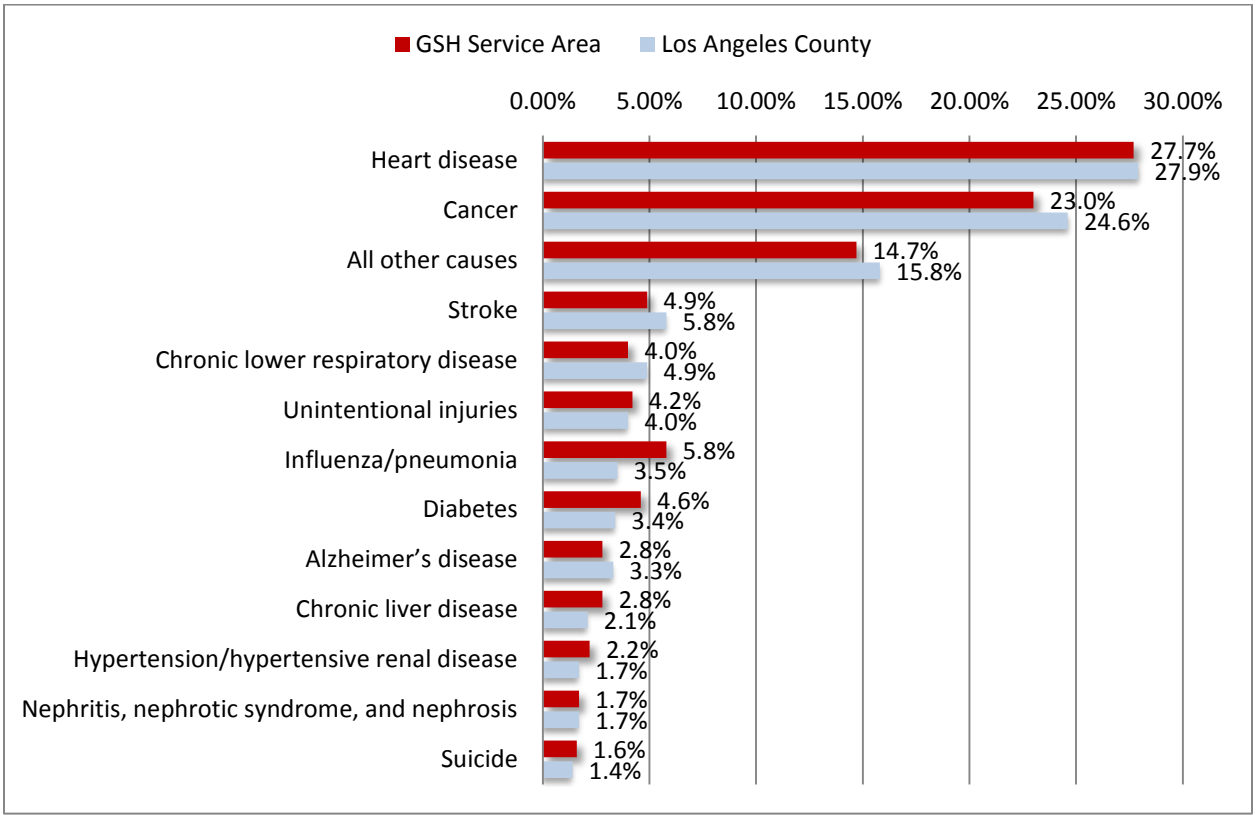
Data source: California Department of Public Health (CDPH)
Data year: 2010/2012
Source geography: ZIP Code

Cause of Death

In 2012, heart disease (27.7%) was the leading cause of death in the GSH service area. Cancer (23.0%) was the second leading cause of death in the GSH service area.

Residents in the GSH service area experienced a higher percentage of deaths caused by influenza/pneumonia and diabetes (5.8% and 4.6%, respectively) than Los Angeles County residents (3.5% and 3.4%, respectively). Conversely, a lower proportion of deaths in the GSH service area were caused by chronic lower respiratory disease, stroke and cancer than in Los Angeles County.

Total Deaths, by Cause



Total Deaths, by Cause

Cause	GSH Service Area		Los Angeles County	
	Number	Percentage	Number	Percentage
Heart disease	659	27.70%	15,451	27.90%
Cancer	548	23.00%	13,624	24.60%
All other causes	350	14.70%	8,718	15.80%
Stroke	117	4.90%	3,231	5.80%
Chronic lower respiratory disease	94	4.00%	2,710	4.90%
Unintentional injuries	100	4.20%	2,213	4.00%
Influenza/pneumonia	137	5.80%	1,922	3.50%
Diabetes	109	4.60%	1,866	3.40%
Alzheimer's disease	66	2.80%	1,827	3.30%
Chronic liver disease	66	2.80%	1,144	2.10%
Hypertension/hypertensive renal disease	53	2.20%	919	1.70%
Nephritis, nephrotic syndrome, and nephrosis	40	1.70%	946	1.70%
Suicide	39	1.60%	760	1.40%
Total			55,331	100.0%

Data source: California Department of Public Health (CDPH)
Data year: 2010/2012
Source geography: ZIP Code

The following section of this report outlines key primary and secondary data pertaining to the health needs considered during the Community Health Needs Assessment (CHNA) and prioritization process. Of note, many of the health needs considered during the CHNA process appear in list of most common

causes of death in the service area: these include cardiovascular disease, cancer, diabetes, hypertension and unintentional deaths. Some common causes of death listed above will not appear in the Key Findings – Health Needs section because they were not included in the CHNA and prioritization process in this cycle.

VI. Key Findings—Health Needs

This section presents an overview, analysis and summary of secondary data and stakeholder input for the health needs (outcomes and drivers) identified through the CHNA process and reviewed in the Summary of Key Findings (Executive Summary) of this report. This section presents multiple indicators for each health need. The health needs are presented in alphabetical order. The tables in this section reflect the most up-to-date population-level public health statistics from a variety of sources: a complete table of data sources can be found in **Appendix D – Data Sources**.

Access to Healthcare

Access to health care services is a concept that encompasses one's ability to afford health care, navigate the health care system, access a health care location where needed services are provided and find a health care provider with whom one can communicate and build trust.[32] 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 for individuals.[33]

Medicare Beneficiaries

Medicare is a Federal program administered by the Centers for Medicare & Medicaid Services (CMS) and 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).[34] The Medicare program provides insurance through various initiatives, including insurance for inpatient hospital, skilled nursing facility and home health services; coverage for physician services, outpatient hospital services, durable medical equipment and certain home health services; health plan options that are provided by Medicare-approved private insurance companies (e.g., HMOs, PPOs); and, insurance coverage for prescription drugs.[35] The Medicaid program is jointly funded by the federal and state government, and provides health insurance to eligible low-income adults, children, pregnant women, elderly adults and people with disabilities.

In 2012, a lower percentage of individuals in the GSH service area benefited from Medicare (0.8%) than in Los Angeles County (1.3%). In contrast, a higher percentage of the population living in GSH's service area received Medicaid (24.4%) than in Los Angeles County (19.2%). In addition, the service area

[32] 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 [August 1, 2016].

[33] 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 [August 1, 2016].

[34] 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 [August 1, 2016].

[35] 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 [August 1, 2016].

population had a higher percentage of individuals using both Medicare and Medicaid (5.1%) than the rest of Los Angeles County (3.5%).

Medicare and Medicaid Beneficiaries

Report Area	Medicare Only	Medicaid Only	Medicare & Medicaid	Medicare & Others
	Percentage	Percentage	Percentage	Percentage
SPA 4–Metro	0.8%	22.7%	5.0%	5.1%
SPA 6–South	0.6%	31.9%	5.3%	3.6%
GSH Service Area	0.8%	24.4%	5.1%	4.8%
Los Angeles	1.3%	19.2%	3.5%	7.1%

Data source: Managed Risk Medical Insurance Board
Data year: 2012
Source geography: ZIP Code

Medi-Cal and Healthy Families Programs

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. The federal government mandates a 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, early and periodic screening, diagnosis and treatment for children. In addition to these mandatory services, California provides optional benefits such as home- and community-based services (HCBS) waivers, and medical equipment.[36]

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.[37] However, starting January 1, 2013, no new enrollments of children into the Healthy Families Program were allowed and existing enrollees were transitioned into the Medi-Cal program because of a change in state law.[38]

In 2011, 6.9% of the GSH service area population benefitted from using Medi-Cal while 3.4% were enrolled in Healthy Families. ZIP codes 90006-Pico Heights (14.5%), 90057-Westlake (12.3%) and 90018-Jefferson Park (11.0%) had a relatively high percentage of Medi-Cal beneficiaries. ZIP codes 90004-Hancock Park (14.2%), 90006-Pico Heights (13.1%) and 90026-Echo Park (12.9%) were areas with the highest percentage of Healthy Families enrollment in the GSH service area.

[36] 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 [August, 1, 2016].

[37] California Department of Health Care Services (2014). The Healthy Families Program Transition to Medi-Cal Final Comprehensive Report. Sacramento, CA. Available at http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/AppendixCHFP.PDF. Accessed [August 2, 2016].

[38] California Department of Health Care Services (2014). The Healthy Families Program Transition to Medi-Cal Final Comprehensive Report. Sacramento, CA. Available at http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/AppendixCHFP.PDF. Accessed [August 2, 2016].

Medi-Cal and Healthy Families Beneficiaries and Enrollment

		Medi-Cal Beneficiaries[1]		Healthy Families Enrollment[2]	
City	ZIP Code	Number	Percentage	Number	Percentage
Hancock Park	90004	17,095	10.1%	1,045	14.2%
Koreatown	90005	12,581	7.4%	682	9.3%
Pico Heights	90006	24,706	14.5%	963	13.1%
Wilshire	90010	538	0.3%	52	0.7%
Downtown Los Angeles	90015	7,333	4.3%	224	3.1%
Downtown Los Angeles	90017	10,054	5.9%	161	2.2%
Hancock Park	90020	9,351	5.5%	905	12.3%
Echo Park/Silverlake	90026	18,416	10.8%	949	12.9%
Westlake	90057	20,955	12.3%	582	7.9%
Chinatown	90012	8,454	5.0%	343	4.7%
Downtown Los Angeles	90013	3,158	1.9%	17	0.2%
Los Angeles	90014	2,035	1.2%	17	0.2%
ARCO Towers	90071	-	-	-	-
Downtown Los Angeles	90021	807	0.5%	19	0.3%
South Los Angeles	90007	15,860	9.3%	451	6.1%
Jefferson Park	90018	18,623	11.0%	933	12.7%
GSH Service Area		169,966	6.9%	7,343	3.4%
Los Angeles County		2,444,850		215,543	

[1] Data source: California Department of Health Care Services (DHCS)
Data year: 2011
Source geography: ZIP Code
[2] Data source: Managed Risk Medical Insurance Board
Data year: 2012
Source geography: ZIP Code

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, there were an estimated 43 FQHCs in the GSH service area, making up 23.5% of FQHCs in Los Angeles County (n=183). In 2013, there were only 92 FQHCs in Los Angeles County.

Federally Qualified Health Centers

Report Area	Number
GSH Service Area	43
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

Uninsured

In 2014 in the GSH service area, 26.6% of adults did not have health insurance (or were uninsured) — which is significantly higher than the percentage of uninsured adults in Los Angeles County (16.1%).

In 2011, 5.1% of children in the GSH service area did not have health insurance (or were uninsured) slightly fewer than in Los Angeles County (6.4%).

Uninsured

Report Area	Adults[1]	Children[2]
SPA 4–Metro	26.4%	6.3%
SPA 6–South	27.3%	2.7%
GSH Service Area	26.6%	5.1%
Los Angeles County	16.1%	6.4%
Healthy People 2020	0.0%	0.0%

Data source: Los Angeles County Health Survey
Data year: [1]2014, [2]2011
Source geography: SPA

Lack of Consistent Source of Care and Difficulty Accessing Care

In 2015, the GSH service area had a higher percentage of adults (23.1%) who lacked a consistent source of primary care than Los Angeles County (19.7%).

Lack of Consistent Source of Care and Difficulty Accessing Care

	SPA 4–Metro	SPA 6–South	GSH Service Area	Los Angeles County
Lack of a Consistent Source of Primary Care for Adults[1]	23.00%	23.40%	23.10%	19.70%
Difficulty accessing medical care Adults (Age 18+)[2]	28.60%	32.50%	29.30%	23.60%
Difficulty accessing medical care Children (Age 0-17)[2]	14.50%	15.00%	14.60%	11.00%

[1]Data source: Los Angeles County Health Survey
Data year: 2015
Source geography: SPA
[2] Data source: Los Angeles County Health Survey
Data year: 2015
Source geography: SPA

In 2015, the GSH service area population had a higher percentage of adults (29.3%) experience difficulty in accessing medical care than the total population of Los Angeles County (23.6%). Similarly, a higher percentage (14.6%) of children in the GSH service area had difficulty accessing medical care in comparison to Los Angeles County (11.0%).

Disparities – Access to Health Care

Slightly fewer individuals under the age of 18 were uninsured in Los Angeles County (9.5%) than in the State of California (11.0%). Approximately the same number of individuals over the age of 85 were uninsured in Los Angeles County (1.3%) as in California (1.2%).

Uninsured, by Age

Age Group	Los Angeles County	California
Under 18	9.5%	11.0%
18–64	89.2%	87.8%
65 and above	1.3%	1.2%

Data source: American Community Survey
Data year: 2014
Source geography: County

Stakeholder Input – Access to Health Care

In focus groups and interviews, stakeholders discussed that although the Affordable Care Act extended access to insurance coverage, there remain particular barriers to care faced by the large undocumented community in the service area. Stakeholders explained that fear of deportation discourages individuals from seeking health care, an issue compounded by the fact that the county is reducing the number of programs that offer care to undocumented residents.

The linguistic and cultural diversity of the service area presents particular challenges with respect to access to and utilization of care. One stakeholder explained that there may be up to 50 different languages spoken in the service area. Therefore, residents may experience frustration or intimidation when clinics and hospitals lack staff with whom they can communicate. Furthermore, the resident population lacks access to health care that is culturally appropriate. Stakeholders expressed a need for more resources that form a bridge between American medical culture and the health care cultures of the residents in the area: simply translating the language is not sufficient and evidence-based practices that work with patients from the dominant American culture do not always translate to patients from other cultures.

With respect to health care benefits and insurance, many stakeholders explained that the process of enrolling in services can be very confusing and overwhelming; therefore, eligible individuals and families delay and stall out in the registration process. Often, clients do not have easy access to the internet or encounter challenges in navigating the internet sites where they can most readily access enrollment information, either because the sites are complex or because they have been poorly translated into the user's language. Furthermore, because of the complexity of the process, sick individuals may wait to apply for health care benefits while hoping their health will improve. Due to this delay, individuals may not have access to benefits when health care is most needed.

Employment represents another challenge for many individuals seeking health care. Stakeholders expressed that members of their service area population often do not receive paid time off to go to the doctors. Because clinic hours are open during typical business hours only (8am to 5pm), it is difficult to access health care.

Finally, a specific area of concern with respect to health care access was the availability and accessibility of prenatal, maternal and child care, specifically for Latinas and African American women in the service area.

Alcohol, Substance Abuse and Tobacco Use

Substance abuse (defined as use of alcohol, tobacco, prescription or illicit substances) has a major impact on individuals, families and communities. Substance abuse is considered both a driver of poor

health outcomes and an outcome in and of itself. Key determinants—or drivers—of alcohol and substance abuse and tobacco use outcomes include biological, social, economic and environmental factors. Drivers of individual and population substance use and abuse outcomes include gender, race and ethnicity, age, income level, educational attainment and sexual orientation. Substance abuse is also strongly influenced by interpersonal, household, and community dynamics including access to alcohol and drugs. Among adolescents, family, social networks and peer pressure are key influencers of substance use.[39] Understanding the relationship between key substance abuse drivers in the GSH service area and substance use and abuse patterns is important in improving substance abuse outcomes indicators.

Alcohol Use

In 2015, nearly half (46.1%) of adults (18+ years old) in the GSH service area reported drinking alcohol at least once in the past month, while almost one in six (16.9%) adults reported engaging in binge drinking in the past month. Binge drinking is defined for females as consumption of four or more drinks and for males, consumption of five or more drinks on one occasion.

Adult Alcohol Use in the Past Month

Report Area	Drank Alcohol at Least Once	Binge Drinking
SPA 4–Metro	47.2%	17.6%
SPA 6–South	41.3%	13.8%
GSH Service Area	46.1%	16.9%
Los Angeles County	51.9%	15.8%

Data source: Los Angeles County Health Survey
Data year: 2015
Source geography: SPA

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.[40] In 2016, the highest number of alcohol outlets were reported in 90012-Chinatown (148 outlets, 13.2% of all outlets in the service area) and 90005-Koreatown (124 outlets, 11.1% of all outlets in the service area).

[39] 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 [August 1, 2016].

[40] Stewart, K. (n.d.). How Alcohol Outlets Affect Neighborhood Violence. Calverton, MD. Available at http://urbanaillinois.us/sites/default/files/attachments/how-alcohol-outlets-affect-nbhd-violence.pdf. Accessed [August 1, 2016].

Number of Alcohol Outlets

City	ZIP Code	Number	Percent
Hancock Park	90004	111	9.9%
Koreatown	90005	124	11.1%
Pico Heights	90006	118	10.5%
Wilshire	90010	45	4.0%
Downtown Los Angeles	90015	71	6.3%
Downtown Los Angeles	90017	58	5.2%
Hancock Park	90020	60	5.3%
Echo Park/Silverlake	90026	120	10.7%
Westlake	90057	43	3.8%
Chinatown	90012	148	13.2%
Downtown Los Angeles	90013	53	4.7%
Los Angeles	90014	41	3.7%
ARCO Towers	90071	25	2.2%
Downtown Los Angeles	90021	36	3.2%
South Los Angeles	90007	45	4.0%
Jefferson Park	90018	24	2.1%
GSH Service Area		1,122	7.6%
Los Angeles County		14,854	

Data source: California Department of Alcoholic Beverage Control (ABC)
Data year: 2016
Source geography: ZIP Code

Prescription and Illicit Substance Use

The rates of misuse in the past year of any form of prescription drugs and marijuana among adults (7.0% and 14.5%, respectively), and marijuana and other illicit drugs among teens (20.7%), were higher in the GSH service area than in Los Angeles County (5.5%, 11.6% and 14.7%, respectively).

Substance Abuse

Report Area	Adults Who Reported Misusing Any Form of Prescription Drugs in the Past Year	Adults Who Reported Using Any Form of Marijuana in the Past Year	Teens Who Have Ever Tried Marijuana, Cocaine, Sniffing Glue, Other Drugs*
SPA 4–Metro	7.0%	15.1%	18.2%
SPA 6–South	6.8%	11.9%	31.9%
GSH Service Area	7.0%	14.5%	20.7%
Los Angeles County	5.5%	11.6%	14.7%

Data source: Los Angeles County Health Survey
Data years: *2014 and 2015
Source geography: SPA

Alcohol and Drug Treatment

A higher percentage of individuals in the GSH service area needed or wanted treatment for alcohol or drug issues in the past five years (3.1%) and needed help for mental, emotional or alcohol/drug issues (20.6%) than in Los Angeles County (2.5% and 18.0%, respectively).

Needed Help or Treatment for Mental, Emotional, Alcohol or Drug Issues

Report Area	Needed or Wanted Treatment for Alcohol or Drug Issues in the Past Five Years	Needed Help for Mental, Emotional, or Alcohol/Drug Issues
	Percentage	Percentage
SPA 4–Metro	3.3%	21.9%
SPA 6–South	2.3%	15.0%
GSH Service Area	3.1%	20.6%
Los Angeles County	2.5%	18.0%

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

Tobacco Use

The proportion of residents in the GSH service area currently smoking in 2015 (13.9%) was similar to the rate in Los Angeles County (13.3%).

Currently Smoking

Report Area	Percentage
SPA 4–Metro	11.4%
SPA 6–South	13.0%
GSH Service Area	13.9%
Los Angeles County	13.3%

Data source: Los Angeles County Health Survey
Data year: 2015
Source geography: SPA

Associated Drivers of Health -- Substance Use

Substance abuse (defined as misuse of alcohol, tobacco, prescription or illicit substances) 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 outcomes, 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.[41]

[41] U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at https://www.healthypeople.gov/2020/topics-objectives/topic/substance-abuse. Accessed August 2, 2016.

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.[42] 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.[43] 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.[44] In December 2016, the U.S. Surgeon General issued a report concluding that e-cigarette use among youth is associated with the use of other tobacco products among young adults now a significant public health concern.[45]

Disparities – Alcohol and Substance Abuse

In 2015, most tobacco users in Los Angeles County were between the ages of 25 and 29 (18.9%). Another 14.9% were between the ages of 30 and 39 and another 13.8% were between the ages of 50 and 59. The lowest percentage of the population in Los Angeles County who regularly used tobacco was 65 years old or older (7.4%).

Tobacco Use by Age

Age Group	Percentage
18–24 years old	12.2%
25–29 years old	18.9%
30–39 years old	14.9%
40–49 years old	14.0%
50–59 years old	13.8%
60–64 years old	13.1%
65 years old and older	7.4%

Data source: Los Angeles County Health Survey
Data year: 2015
Source geography: County

In Los Angeles County, tobacco use is most prevalent among American Indian/Alaskan Natives (19.7%) and African Americans (17.4%). Tobacco use is least prevalent among Latinos (12.3%).

[42] 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 August 1, 2016.

[43] 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 August 1, 2016.

[44] 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 August 1, 2016.

[45] American Lung Association, "E-Cigarettes and Lung Health." Available at http://www.lung.org/stop-smoking/smoking-facts/e-cigarettes-and-lung-health.html?referrer=https://www.google.com/. Accessed January 15, 2017.

Tobacco Use by Ethnicity

Age Group	Percentage
Latino	12.3%
White	13.4%
African-American	17.4%
Asian/Pacific Islander	13.1%
American Indian/Alaskan Native	19.7%

Data source: Los Angeles County Health Survey
Data year: 2015
Source geography: County

Stakeholder Input – Alcohol and Substance Abuse

Stakeholders identified the homeless as a population with a great need for alcohol and substance use services, particularly because homeless individuals cannot enter transitional housing if they are dealing with substance use issues.

Access to alcohol and substance use programs is a challenge in the service area: the community in general does not know where to go to seek treatment; beds are limited in inpatient facilities; the high cost of treatment makes it out of reach for most residents; specific populations, including transgender individuals, lack of welcoming and responsive substance abuse and alcohol treatment facilities; and, the long wait list for low-cost treatment discourages potential patients.

Finally, stakeholders indicated that cultural shifts, including the increasing acceptance of vaping and marijuana smoking, are increasing access to, and use of, drugs and alcohol by teenagers.

Cancer

Cancer is the second leading cause of death in the United States, claiming the lives of more than half a million Americans every year[46]. In 2009, cancer incidence rates per 100,000 persons indicate that the three most common cancers among men in the United States are prostate cancer (137.7), lung cancer (64.3) and colorectal cancer (42.5). Among women, the leading causes of cancer deaths are breast cancer (123.1), lung cancer (54.1) and colorectal cancer (37.1).[47] Research has shown that early detection through regular cancer screenings can help reduce the number of new cancer cases and, ultimately, deaths.[48] Research has also shown that cancer is associated with certain diseases and behaviors including obesity, tobacco, alcohol, certain chemicals, some viruses and bacteria, a family history of cancer, poor diet and lack of physical activity.[49]

[46] Centers for Disease Control and Prevention. (2015). *Using Science to Reduce the Burden of Cancer.* Atlanta, GA. Available at http://www.cdc.gov/Features/CancerResearch/. Accessed [August 1, 2016].

[47] Centers for Disease Control and Prevention. (2013). *Invasive Cancer Incidence.* Atlanta, GA. Available at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6207a1.htm. Accessed [August 1, 2016].

[48] Centers for Disease Control and Prevention. (2015). *Cancer Prevention*. Atlanta, GA. Available at http://www.cdc.gov/cancer/dcpc/prevention/index.htm. Accessed [August 1, 2016].

[49] National Cancer Institute. (2015). *Cancer Prevention Overview*. Available at http://www.cancer.gov/cancertopics/pdq/prevention/overview/patient/page3. Bethesda, MD. Accessed [August 1, 2016].

Cancer Prevalence

In Los Angeles County, the top invasive cancer incidence rates per 100,000 persons were female breast cancer (113.8), prostate cancer (92.6) and lung cancer (35.9).

Top 10 Cancer Sites Rates per 100,000 pop. in Los Angeles County

	All Races	Rate
1	Female Breast	113.8
2	Prostate	92.6
3	Lung and Bronchus	35.9
4	Colon and Rectum	35.7
5	Corpus and Uterus, NOS*	25.6
6	Non-Hodgkin Lymphoma	18.4
7	Urinary Bladder	15.2
8	Thyroid	13.7
9	Melanomas of the Skin	13.1
10	Kidney and Renal Pelvis	12.7

Source: Centers for Disease Control, United States Cancer Statistics (USCS)
Data Year: 2013
Source Geography: County
*NOS: non-invasive

Cancer -- Clinical Interventions

Of all cancer-related surgeries performed, the most frequent type at GSH are breast (23.3%), colon (22.2%) and liver (16.7%). Breast cancer and colon cancer are also the top two surgeries performed in Los Angeles County and the state.

Volume of Cancer Surgeries Performed at GSH

Type of Cancer	Good Samaritan Hospital		Los Angeles County		California	
	Number	Percent	Number	Percent	Number	Percent
Bladder	0	0.0%	362	2.5%	897	1.8%
Brain	6	6.7%	777	5.4%	2,858	5.6%
Breast	21	23.3%	6,176	43.2%	25,290	49.7%
Colon	20	22.2%	1,977	13.8%	7,335	14.4%
Esophagus	0	0.0%	118	0.8%	354	0.7%
Liver	15	16.7%	503	3.5%	1,298	2.6%
Lung	5	5.6%	913	6.4%	3,269	6.4%
Pancreas	4	4.4%	286	2.0%	877	1.7%
Prostate	2	2.2%	2,117	14.8%	5,434	10.7%
Rectum	6	6.7%	638	4.5%	2,239	4.4%
Stomach	11	12.2%	443	3.1%	1,030	2.0%
Total	90	100.0%	14,310	100.0%	50,881	100.0%

Data source: Office of Statewide Health Planning and Development (OSHPD)
Data year: 2014
Source geography: Hospital

Cancer Screenings

In 2015, cervical cancer screenings were slightly lower for the population living in the GSH service area (79.5%) relative to the rest of Los Angeles County (84.4%). SPA 6-South had the higher percentage (84.2%) receiving pap smears in the last three years of the SPAs within the GSH service area.

In regards to breast cancer screenings, the percent of population living within the GSH service area (78.3%) receiving mammograms in the last two years was slightly higher than in Los Angeles County (77.3%). The range among SPAs was much smaller (less than 2%) when compared to cervical cancer screenings.

Cancer Screenings

Service Planning Area	Cervical cancer screening (Pap smear) in last 3 years	Breast cancer screening (mammogram) in the last 2 years
SPA 4–Metro	78.4%	78.5%
SPA 6–South	84.2%	77.6%
GSH Service Area	79.5%	78.3%
Los Angeles County	84.4%	77.3%
Healthy People 2020	>=93.0%	>=81.1%

Source: Los Angeles County Health Survey
Data Year: 2015
Source Geography: SPA

Cancer Mortality

In 2012, a total of 548 people died from cancer in the GSH service area, which represented nearly a quarter (23.0%) of all deaths. This percentage is slightly lower than that reported for California (23.7%).

The highest percentages of death due to cancer were reported for 90020-Hancock Park (33.1%), 90010-Wilshire (26.7%) and 90006-Pico Heights (26.6%).

Cancer-Related Death Rates in 2012

City	ZIP Code	Cancer-Related Death Rates
Hancock Park	90004	9.4
Koreatown	90005	7.8
Pico Heights	90006	11.7
Wilshire	90010	25.2
Downtown Los Angeles	90015	8.4
Downtown Los Angeles	90017	6.0
Hancock Park	90020	11.2
Echo Park/Silverlake	90026	9.9
Westlake	90057	10.4
Chinatown	90012	14.7
Downtown Los Angeles	90013	15.6
Los Angeles	90014	15.4
ARCO Towers	90071	-
Downtown Los Angeles	90021	10.9
South Los Angeles	90007	6.3
Jefferson Park	90018	16.2
GSH Service Area		12.0
California		15.1

Source: California Department of Public Health
Data Year: 2012
Source Geography: ZIP

Associated Drivers of Health – Cancer

A primary method of preventing cancer is screening for cervical, colorectal and breast cancers[50]. The most common risk factors for cancer include growing older, obesity, tobacco, alcohol, sunlight exposure, certain chemicals, some viruses and bacteria, family history of cancer, poor diet and lack of physical activity[51].

Stakeholder Input -- Cancer

Stakeholders observed that there may be a lack of knowledge in the community about the causes of cancer and ways that individuals can reduce their likelihood of developing cancers through various

[50] Centers for Disease Control and Prevention. Cancer Prevention. Atlanta, GA. Available at http://www.cdc.gov/cancer/dcpc/prevention/index.htm. Accessed [August 7, 2016].

[51] National Cancer Institute. Risk Factors for Cancer. Bethesda, MD. Available at http://www.cancer.gov/about-cancer/causes-prevention/risk. Accessed [August 7, 2016].

activities. Stakeholders pointed out that a number of contextual factors in the community contribute to cancer incidence including lack of access to healthy food and poor air quality.

Stakeholders observed that they see less successful linkage to care and continuity in care—specifically for cancer--among low-income populations, populations that do not speak English and populations with cultural backgrounds that differ from the norm in the health care environment. Additionally, the LGBT community experiences unique challenges in accessing cancer screenings and care. Stakeholders recognize a need for greater cultural competency among care providers.

While gains made in coverage (through the Affordable Care Act and Medicaid) may have positively impacted individuals' ability to access screenings for prostate, breast and cervical cancer, providers have not seen an increase in clients' utilization of these screenings. Stakeholders explained this may be due to cutbacks in services or long waitlists for screenings that discourage patients from following up. Alternatively, it may be because patients don't know if or that their insurance covers screenings and cancer treatment. Additionally, stakeholders have observed a lack of community education on cancer screenings—and some stigma around screening providers like Planned Parenthood—that may be discouraging people from accessing preventive care.

Cardiovascular Disease , Including High Cholesterol and Hypertension

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.[52]

Cardiovascular disease encompasses and/or is closely linked to a number of health conditions that include arrhythmia, atrial fibrillation, cardiac arrest, 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.[53]

Recent studies have suggested protective effects of breastfeeding against major risk factors of cardiovascular disease in adulthood including elevated cholesterol level, LDL (low-density lipoprotein) level, HDL (high-density lipoprotein) level and hypertension. Research suggests that the duration of breastfeeding is important in its protective role against cardiovascular disease risk.[54] For this reason, increasing breastfeeding rates and duration in the service area may be an effective strategy to reduce cardiovascular disease prevalence.

[52] 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 [August 1, 2016].

[53] 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 [August 1, 2016].

[54] Roya Kelishadi, Sanam Farajian. The protective effects of breastfeeding on chronic non-communicable diseases in adulthood: A review of evidence. Adv Biomed Res. 2014; 3: 3.

Prevalence and Management

In 2014, the percentage of the population in the GSH service area diagnosed with heart disease (3.5%) was smaller than in Los Angeles County (5.7%), with a larger percentage in SPA 6 (8.6%).

Of those in the GSH service area with heart disease, slightly more than half (59.7%) receive assistance from a care provider in managing their disease. A larger percentage of the population in SPA 4 (61.5%) received assistance from a care provider. Los Angeles County had a smaller percentage (55.5%) of its population receive heart disease management when compared to the GSH service area (59.7%).

Heart Disease Indicators

Report Area	Heart Disease Prevalence Percentage	Heart Disease Management Percentage
SPA 4–Metro	2.4%	61.5%
SPA 6–South	8.6%	51.8%
GSH Service Area	3.5%	59.7%
Los Angeles County	5.7%	55.5%

Data source: California Health Interview Survey (CHIS)
Data year: 2014
Source geography: SPA

Heart Failure Hospitalizations

In 2012, the hospitalization rate resulting from heart failure was higher (398.2) per 100,000 adults in the GSH service area when compared to California (366.6). The highest heart failure hospitalization rates were reported in 90014-Los Angeles (743.9) and 90021-Downtown Los Angeles (985).

Hospitalizations Resulting from Heart Failure per 100,000 Persons

City	ZIP Code	Rate
Hancock Park	90004	257.4

City	ZIP Code	Rate
Koreatown	90005	222.8
Pico Heights	90006	247.7
Wilshire	90010	315.3
Downtown Los Angeles	90015	330.2
Downtown Los Angeles	90017	300.3
Hancock Park	90020	177.7
Echo Park/Silverlake	90026	277.5
Westlake	90057	369.6
Chinatown	90012	245.4
Downtown Los Angeles	90013	693
Los Angeles	90014	743.9
ARCO Towers	90071	-
Downtown Los Angeles	90021	985
South Los Angeles	90007	291
Jefferson Park	90018	515.8
GSH Service Area		398.2
Los Angeles County		366.6
California		339.0

Data source: Office of Statewide Health Planning and Development (OSHPD)
Data year: 2012
Source geography: ZIP Code

Heart Disease Mortality

In 2012, a higher heart disease mortality rate per 10,000 adults was reported in the GSH service area (16.3) than in California (15.5). Rates were particularly high in ZIP Codes 90014-Los Angeles (49.1) and 90021-Downtown Los Angeles (32.8).

Heart Disease Mortality Rate per 10,000 Persons

City	ZIP Code	Rate
Hancock Park	90004	10.7
Koreatown	90005	8.8
Pico Heights	90006	11.2
Wilshire	90010	12.6
Downtown Los Angeles	90015	8.9
Downtown Los Angeles	90017	9.2
Hancock Park	90020	7.1
Echo Park/Silverlake	90026	12.3
Westlake	90057	13.3
Chinatown	90012	16.9
Downtown Los Angeles	90013	21.0
Los Angeles	90014	49.1
ARCO Towers	90071	-
Downtown Los Angeles	90021	32.8
South Los Angeles	90007	7.5
Jefferson Park	90018	22.4
GSH Service Area		16.3
California		15.5

Data source: California Department of Public Health (CDPH)
Data year: 2012
Source geography: ZIP Code

Cholesterol Prevalence and Management

In 2015, a quarter (25.1%) of the adult population in the GSH service area had been diagnosed with high cholesterol, very similar to Los Angeles County (25.2%). SPA 4 had the largest percentage (25.7%).

Cholesterol Prevalence

Report Area	Percentage
SPA 4–Metro	25.7%
SPA 6–South	22.2%
GSH Service Area	25.1%
Los Angeles County	25.2%

Data source: Los Angeles County Health Survey
Data year: 2015
Source geography: SPA

Hypertension Prevalence and Management

Hypertension, defined as a blood pressure reading of 140/90 or higher affects one in three adults in the United States.[55] 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.[56]

[55] National Institutes of Health. *Hypertension (High Blood Pressure).* Available at http://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=97. Accessed [August 2, 2016].
[56] 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 [August 2, 2016].

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.[57]

High blood pressure is associated with smoking, obesity, the regular consumption of excessive 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.[58]

In 2015, close to a quarter (22.8%) of the adult population in the GSH service area was diagnosed with hypertension (or high blood pressure), slightly less than in Los Angeles County (23.5%). SPA 6 had a higher percentage (24.5%). In 2014, more than half (64.2%) of the population with high blood pressure in the GSH service area took medication to control their high blood pressure. Many fewer adults with high blood pressure in SPA 6 (55.5%) than in SPA 4 (66.2%) managed their blood pressure through medication.

Hypertension Indicators

Report Area	Hypertension Prevalence Percentage	High Blood Pressure Management Percentage
SPA 4–Metro	22.4%	66.2%
SPA 6–South	24.5%	55.5%
GSH Service Area	22.8%	64.2%
Los Angeles County	23.5%	67.2%

Data source: Los Angeles County Health Survey
Data year: 2015
Source geography: SPA

Hypertension Mortality

In 2012, 659 adults in the GSH service area died as a result of hypertension, making up 27.2% of deaths in the service area. ZIP codes 90021-Downtown Los Angeles (52.9%) and 90014-Los Angeles (44.9%) had the highest rates of death due to hypertension within the service area.

[57] National Institutes of Health. *Hypertension (High Blood Pressure).* Available at http://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=97. Accessed [August 2, 2016].
[58] Center for Disease Control and Prevention. Atlanta, GA. Available at http://www.cdc.gov/bloodpressure/family_history.htm. Accessed [August 2, 2016].

Deaths from Essential Hypertension and Hypertensive Renal Disease per 10,000 Residents

City	ZIP Code	Rate
Hancock Park	90004	0.32
Koreatown	90005	0.73
Pico Heights	90006	1.19
Wilshire	90010	0
Downtown Los Angeles	90015	2.62
Downtown Los Angeles	90017	1.2
Hancock Park	90020	0.25
Echo Park/Silverlake	90026	1.27
Westlake	90057	1.33
Chinatown	90012	0.92
Downtown Los Angeles	90013	0.78
Los Angeles	90014	1.4
Downtown Los Angeles	90021	0
South Los Angeles	90007	0.97
Jefferson Park	90018	1.55
GSH Service Area		0.97
Los Angeles County		1.18

Data source: California Department of Public Health (CDPH)
Data year: 2012
Source geography: ZIP Code

Disparities – Hypertension

In 2015, just over half (54.2%) of the population age 65 and older in Los Angeles County was diagnosed with hypertension. Similarly, nearly half (42.5%) of the population between age 60 and 64 had hypertension; nearly a third (31.1%) of the population between age 50 and 59, and 17.6% of those between age 40 and 49. The prevalence of hypertension diminishes among the younger population—only 11.4% of those between age 30 and 39, 7.9% of those between age 25 and 29, and 6.2% of those between age 18 and 24.

Hypertension Prevalence by Age

Age Group	Percentage
18–24 years old	6.2%
25–29 years old	7.9%
30–39 years old	11.4%
40–49 years old	17.6%
50–59 years old	31.1%
60–64 years old	42.5%
65 years old and older	54.2%

Data source: Los Angeles County Health Survey
Data year: 2015
Source geography: County

By ethnicity, exactly one-third of the African-American population (33.3%) and over a quarter of the White population (27.5%) in Los Angeles County had hypertension, along with almost a quarter (24.2%) of the American Indian/Alaskan Native population and slightly over one-fifth (20.4%) of the Asian/Pacific

Islander population. The Latino population had the lowest percentage (19.7%) of diagnosed hypertension prevalence in Los Angeles County.

Hypertension Prevalence by Ethnicity

Age Group	Percentage
Latino	19.7%
White	27.5%
African American	33.3%
Asian/Pacific Islander	20.4%
American Indian/Alaskan Native	24.2%

Data source: Los Angeles County Health Survey
Data year: 2015
Source geography: County

Disparities – Cardiovascular Disease

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.[59]

In 2015, nearly half (47.5%) of the population in Los Angeles County who were 65 or older had high cholesterol, as did those between the ages of 60 and 64 (41.2%). Over a third (34.5%) of those between the ages of 50 and 59 had high cholesterol and approximately a quarter (24.8%) of those between the ages of 40 and 49. Another 15.0% of those between the ages of 30 and 39 had high cholesterol as well as 11.8% of the population between the ages of 25 and 29-a number that has doubled since 2011. Another 5.6% between the ages of 18 and 24 have been diagnosed with high cholesterol.

Cholesterol Prevalence by Age

Age Group	Percentage
18–24 years old	5.6%
25–29 years old	11.8%
30–39 years old	15.0%
40–49 years old	24.8%
50–59 years old	34.5%
60–64 years old	41.2%
65 years old and older	47.5%

Data source: Los Angeles County Health Survey
Data year: 2015
Source geography: County

Associated Drivers of Health – Cardiovascular Disease

The leading risk factors for heart disease are high blood pressure, high cholesterol, smoking, diabetes, poor diet, physical inactivity and overweight and obesity. Cardiovascular disease is closely linked with

[59] 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 [August 1, 2016].

and can often lead to stroke.[60] Smoking, obesity, excessive 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.

Stakeholder Input – Cardiovascular Disease and Hypertension

Stakeholders called for efforts to expand education around the underlying causes of cardiovascular disease (diet, lack of physical exercise), to conduct outreach with subpopulations at higher risk (Latinas, Black men) and to better educate the community about the disease process.

Community members discussed the influence of culture and tradition on the observed poor dietary practices that may introduce risk for cardiovascular disease in the service area. Stakeholders recommended the implementation of health education and healthy eating outreach campaigns via Spanish and Korean television and radio stations.

Additionally, community members observed that the built environment in the Metro collaborative communities serves as a constraint on dietary choices. For example, there are very few outlets selling affordable healthy ingredients compared to the number of fast food outlets and liquor stores selling high salt, high fat processed food ingredients. Additionally, lifestyle factors including long, stressful workdays make it difficult to allocate time for cooking dinner or engaging in exercise. Moreover, residents feel discouraged from exercising in their community due to fear of violence in the community, lack of safe green space in the community, lack of affordable/free indoor recreational facilities and a high incidence of pedestrian injury due to motor vehicles.

Cultural and Linguistic Barriers

According to the National Standards for Culturally and Linguistically Appropriate Services (CLAS), culture is defined in terms of racial, ethnic and linguistic groups, as well as geographical, religious and spiritual, biological and sociological characteristics[61]. With the Institute of Medicine's publication of Unequal Treatment in 2003, culturally and linguistically appropriate services gained recognition as an important method to help address the persistent disparities faced by our nation's diverse communities. There have also been rapid changes in demographic trends in the U.S. in the last decade. Additionally, national accreditation standards for professional licensure in the fields of medicine and nursing, and health care policies, such as the Affordable Care Act, have helped to underscore the importance of cultural and linguistic competency as part of high quality health care and services[62].

The enhanced National CLAS Standards address these new developments and trends, and offer an even stronger framework to provide culturally and linguistically appropriate services. The enhanced National CLAS Standards are intended to advance health equity, improve quality and help eliminate health care disparities.

[60] 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 [August 1, 2016].

[61] U.S. Department of Health and Human Services. Office of Minority Health. Available at https://www.thinkculturalhealth.hhs.gov/pdfs/NationalCLASStandardsFactSheet.pdf. Accessed [August 29, 2016]

[62] U.S. Department of Health and Human Services. Office of Minority Health. Available at https://www.thinkculturalhealth.hhs.gov/pdfs/NationalCLASStandardsFactSheet.pdf. Accessed [August 29, 2016]

Language

In 2015, the percent of residents in the GSH service area who spoke only English (33.5%) was considerably lower than that of Los Angeles County (42.9%). In contrast, the percent of residents in the GSH service area who spoke only Spanish at home (43.6%) was higher than in Los Angeles County (39.6%). The percentage of the GSH service area population whose primary language was of Asian origin was significantly higher (19.2%) than in Los Angeles County. The percentage of the GSH population speaking a language of Indo-European origin (2.9%) was lower than in Los Angeles County (5.6%). ZIP codes with high percentages of the population speaking a language of Asian/Pacific Islander origin are: 90020-Hancock Park (40.5%), 90012-Chinatown (34.7%) and 90005-Koreatown (31.6%). ZIP codes with high percentages of the population speaking Spanish include: 90006-Pico Heights (71.0%), 90017-Downtown Los Angeles (68.2%), and 90015-Downtown Los Angeles (64.2%).

Language Spoken at Home

City	ZIP Code	English Only	Asian/Pacific Islander	Indo-European	Spanish	Other
Hancock Park	90004	25.3%	22.2%	3.2%	49.0%	0.4%
Koreatown	90005	17.1%	31.6%	2.3%	48.5%	0.4%
Pico Heights	90006	10.2%	17.6%	0.7%	71.0%	0.5%
Wilshire	90010	-	-	-	-	-
Downtown Los Angeles	90015	20.1%	11.8%	2.7%	64.2%	1.2%
Downtown Los Angeles	90017	17.9%	11.7%	1.6%	68.2%	0.7%
Hancock Park	90020	19.9%	40.5%	5.7%	32.7%	1.2%
Echo Park/Silverlake	90026	31.7%	14.0%	2.2%	51.4%	0.6%
Westlake	90057	13.0%	19.2%	0.9%	66.0%	0.9%
Chinatown	90012	36.5%	34.7%	2.1%	26.0%	0.6%
Downtown Los Angeles	90013	67.3%	13.8%	3.6%	14.9%	0.3%
Los Angeles	90014	69.6%	8.6%	4.1%	16.9%	0.8%
ARCO Towers	90071	46.2%	38.5%	7.7%	7.7%	0.0%
Downtown Los Angeles	90021	54.0%	9.2%	1.1%	35.5%	0.2%
South Los Angeles	90007	34.9%	12.6%	4.7%	46.5%	1.3%
Jefferson Park	90018	39.3%	2.8%	1.1%	55.0%	1.9%
GSH Service Area		33.5%	19.2%	2.9%	43.6%	0.7%
Los Angeles County		42.9%	10.9%	5.6%	39.6%	1.1%

Data source: Nielsen Claritas
Data year: 2016
Source geography: ZIP Code

In 2014, 3.8% of adults in the GSH service area experienced a difficulty understanding their doctor during doctor visits. This was slightly higher than Los Angeles County (3.2%).

Difficulty Understanding Doctor

Report Area	Percentage
SPA 4–Metro	3.7%
SPA 6–South	4.1%
GSH Service Area	3.8%
Los Angeles County	3.2%

Data Source: California Health Interview Survey
Data Year: 2014
Source Geography: SPA

Stakeholder Input – Cultural and Linguistic Barriers

Stakeholders discussed a need for greater understanding within the health care community of the ways in which gender dynamics and social roles in non-majority cultures impact relationships between health care providers and patients, as well as the implementation of health care recommendations beyond the doctor visit. For example, among many new immigrant families, gender role norms dictate that the male is dominant in the family; this can complicate health behavior recommendations for women if the provider is not cognizant of the impact gender role norms might have on a woman's ability to treat a personal health issue or an issue affecting her child.

Diabetes

Diabetes affects an estimated 23.6 million adults and children 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.[63] 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. Evidence is emerging that diabetes is associated with other co-morbidities, including cognitive impairment, incontinence, fracture risk and cancer risk and prognosis.[64]

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.[65]

[63] U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at https://www.healthypeople.gov/2020/topics-objectives/topic/diabetes. Accessed [August 2, 2016].

[64] U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at https://www.healthypeople.gov/2020/topics-objectives/topic/diabetes. Accessed [August 1, 2016].

[65] U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at https://www.healthypeople.gov/2020/topics-objectives/topic/diabetes. Accessed [August 1, 2016].

Breastfeeding may be a principal diabetes prevention strategy. Recent research has demonstrated that breastfeeding during infancy may protect against the development of type 2 diabetes later in life through two pathways. First, the fatty acids found in breast milk contribute to the maintenance of healthy fasting blood glucose levels in infants. Artificial formulas lacking these fatty acids may contribute to insulin resistance and ultimately type 2 diabetes. Second, research suggests that the protective effects of breastfeeding against obesity in adulthood might also influence the development of type 2 diabetes.[66]

Diabetes Prevalence and Disease Management

Diabetes is the 5th leading cause of death in the GSH service area. In 2015, 11.7% of the population 18 years old and older in the GSH service area had been diagnosed with diabetes, a larger percentage than in Los Angeles County (9.8%).

In 2015, about one-third (33.2%) of the adult diabetic population in the service area had met with their medical provider to develop a diabetes care plan, less than the percentage (77.8%) in Los Angeles County. A substantially lower percentage of the population in SPA 4 (23.3%) had a diabetes management plan than in Los Angeles County.

Diabetes Indicators

Report Area	Diabetes Prevalence (18+ years of age) Percentage	Diabetes Management Percentage
SPA 4–Metro	11.6%	23.3%
SPA 6–South	12.3%	77.7%
GSH Service Area	11.7%	33.2%
Los Angeles County	9.8%	77.8%

Data source: Los Angeles County Health Survey
Data year: 2015
Source geography: SPA

Diabetes Hospitalizations

In 2012, the diabetes hospitalization rate per 100,000 persons under 18 years of age in the GSH service area was significantly less (17.9) than that of California (31.2). ZIP code 90013-Downtown Los Angeles reported a significantly higher rate (64.3).

The diabetes hospitalization rate per 100,000 adults in the GSH service area (221.8) was higher than California (142.6), with rates among adults being much higher in ZIP Codes 90014-Los Angeles (449.1), 90013-Downtown Los Angeles (389.3) and 90018-Jefferson Park (363.2).

In 2012, the hospitalization rate per 100,000 adults resulting from uncontrolled diabetes in the GSH service area (21.2) was over double the rate in California (8.6), and particularly higher in ZIP Codes 90013-Downtown Los Angeles (46.7), 90018-Jefferson Park (44.4) and 90021-Downtown Los Angeles (36.5).

[66] Roya Kelishadi, Sanam Farajian. The protective effects of breastfeeding on chronic non-communicable diseases in adulthood: A review of evidence. Adv Biomed Res. 2014; 3: 3.

Diabetes Hospitalizations per 100,000 Persons

City	ZIP Code	Diabetes Hospitalizations (Youth)	Diabetes Hospitalizations (Adults)	Hospitalizations Resulting from Uncontrolled Diabetes
Hancock Park	90004	13.6	127.9	14.4
Koreatown	90005	7.4	119.9	19.6
Pico Heights	90006	4.2	184.9	11.9
Wilshire	90010	-	252.2	-
Downtown Los Angeles	90015	7.3	162.5	5.2
Downtown Los Angeles	90017		200.2	28
Hancock Park	90020	11.7	93.9	2.5
Echo Park/Silverlake	90026	15.1	124.6	9.9
Westlake	90057	21	203.6	24.3
Chinatown	90012	-	147.2	27.6
Downtown Los Angeles	90013	64.3	389.3	46.7
Los Angeles	90014	-	449.1	14
ARCO Towers	90071	-	-	-
Downtown Los Angeles	90021	-	328.3	36.5
South Los Angeles	90007	24.8	179.5	12.1
Jefferson Park	90018	9.9	363.2	44.4
GSH Service Area		17.9	221.8	21.2
California		31.2	142.6	8.6

Data source: Office of Statewide Health Planning and Development (OSHPD)
Data year: 2012
Source geography: ZIP Code

Diabetes Mortality

In 2012, the diabetes mortality rate per 10,000 adults in the GSH service area was higher (2.5) than in Los Angeles County (2.1). In particular, ZIP codes 90010-Wilshire (6.3), 90021-Downtown Los Angeles (3.7) and 90018-Jefferson Park (3.7) had higher rates of mortality caused by diabetes.

Diabetes Mortality Per 10,000 Persons

City	ZIP Code	Rate
Hancock Park	90004	1.1
Koreatown	90005	2.0
Pico Heights	90006	2.0
Wilshire	90010	6.3
Downtown Los Angeles	90015	2.1
Downtown Los Angeles	90017	3.2
Hancock Park	90020	1.5
Echo Park/Silverlake	90026	2.8
Westlake	90057	2.0
Chinatown	90012	1.5
Downtown Los Angeles	90013	2.3
Los Angeles	90014	2.8
Downtown Los Angeles	90021	3.7
South Los Angeles	90007	1.0
Jefferson Park	90018	3.7
GSH Service Area		2.5
California		2.1

Data source: California Department of Public Health (CDPH)
Data year: 2012
Source geography: ZIP Code

Disparities – Diabetes

In 2015, nearly a quarter (21.2%) of the population age 65 older in Los Angeles County was identified as having diabetes. Another 21.7% of the population between the ages of 60 and 64 were diabetic, as was another 15.6% of the population age 50 to 59. A smaller percentage of the population age 40 to 49 (8.3%) was diabetic, along with even smaller percentages of those age 30 to 39 (3.0%), 25 to 29 (2.0%) and 18 to 24 (1.2%).

Diabetes Prevalence by Age

Age Group	Percentage
18–24 years old	1.2%
25–29 years old	2.0%
30–39 years old	3.0%
40–49 years old	8.3%
50–59 years old	15.6%
60–64 years old	21.7%
65 years old and older	21.2%

Data source: Los Angeles County Health Survey
Data year: 2015
Source geography: County

In Los Angeles County in 2015, diabetes prevalence was highest among American Indian/Alaskan Natives (15.2%) and African-Americans (13.7%), followed by Latinos (10.7%), of Latinos, Asian/Pacific Islanders (8.2%) and Whites (8.2%).

Diabetes Prevalence by Ethnicity

Age Group	Percentage
Latino	10.7%
White	8.2%
African-American	13.7%
Asian/Pacific Islander	8.2%
American Indian/Alaskan Native	15.2%

Data source: Los Angeles County Health Survey
Data year: 2015
Source geography: County

Associated Drivers of Health – Diabetes

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.[67]

Stakeholder Input – Diabetes

As with cardiovascular disease, diet is a principal determinant of diabetes. Diet is shaped by both the food environment (what is available for purchase in a community) and cultural practices. The service area is home to many cultures. Stakeholders called for the implementation of outreach and education efforts that illustrate strategies for healthier diets that reflect residents' cultural backgrounds. Additionally, stakeholders acknowledged that residents' access to healthy food is limited by cost, and acknowledged a need for affordable fruits and vegetables. Moreover, stakeholders observed that clients in the service area lack an understanding of the diabetes disease process. Stakeholders have called for greater education around the relationship between diet and diabetes as well as diabetes co-morbidities.

Stakeholders acknowledged that the costs of diabetes medication are prohibitive for lower-income residents, particularly the undocumented and uninsured populations. Additionally, individuals experiencing homelessness and housing instability face challenges in maintaining diabetes care because they do not have access to refrigeration for their medications.

Food Insecurity

According to the United States Department of Agriculture, food insecurity is explicitly defined as a household-level economic and social condition of limited or uncertain access to adequate food.[68] The defining characteristic of very low food security is that, at times during the year, the food intake of household members is reduced and their normal eating patterns are disrupted because the household

[68] United States Department of Agriculture. Economic Research Service. Washington D.C. Available at: http://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/definitions-of-food-security.aspx. Accessed [August 29, 2016].

lacks money and other resources for food. Very low food security can be characterized in terms of the conditions that households in this category typically report in the annual food security survey.[69]

In 2015, 32.1% of households in the GSH service area with incomes less than 300% of the poverty level were food insecure. This is a slightly higher percentage than that of Los Angeles County (29.2%).

Households with Incomes <300%
Who are Food Insecure

Report Area	Percentage
SPA 4–Metro	32.0%
SPA 6–South	32.4%
GSH Service Area	32.1%
Los Angeles County	29.2%

Data Source: Los Angeles County Health Survey
Data Year: 2015
Source Geography: SPA

Stakeholder Input – Food Insecurity

Stakeholders explained that food insecurity in the service area results from the compounded impact of low income and a lack of affordable healthy food.

Healthy Behavior (including Physical Activity)

The Nutrition and Weight Status objectives for Healthy People 2020 reflect strong science supporting the health benefits of eating a healthful diet and maintaining a healthy body weight. The objectives also emphasize that efforts to change diet and weight should address individual behaviors as well as the policies and environments that support these behaviors in settings such as schools, worksites, health care organizations, and communities. The goal of promoting healthful diets and healthy weight encompasses increasing household food security and eliminating hunger.[70]

Healthy Activities

Regarding healthy activities directly influencing diet and physical activity, the GSH service area population had a lower percentage of children engaging in physical activity at least one hour a day (24.9%) than Los Angeles County (26.4%) and California (32.8%).

In addition, a significantly higher percentage (18.0%) of teens in the GSH service area engaged in at least one hour of physical activity compared to Los Angeles County (12.3%) and California (12.2%). This trend continues for teens from both SPA 4 (17.3%) and SPA 6 (20.9%).

The percentage of children that ate five or more servings of fruits and vegetables in the past day was nearly the same in the GSH service area (55.6%) as in Los Angeles County (55.4%) and higher than

[69] United States Department of Agriculture. Economic Research Service. Washington D.C. Available at: http://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/definitions-of-food-security.aspx. Accessed [August 29, 2016].

[70] U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at https://www.healthypeople.gov/2020/topics-objectives/topic/nutrition-and-weight-status. Accessed [August 29, 2016].

California (50.7%). SPA 6 in particular had a higher percentage (59.5%) than other service areas. A lower percentage of teens (13.5%) in the GSH service area ate five or more servings of fruits and vegetables per day than in Los Angeles County (19.7).

Health Activities Related to Diet and Physical Activity

Service Planning Area	Physically Active at Least One Hour Each Day in Last Week[1]		Ate Five or More Servings of Fruits and Vegetables in Past Day[2]			Obtained recommended amount of aerobic exercise and muscle-strengthening[1d]	
	Children (0-11)	Teens (12-17)	Children (0-11)	Teens (12-17)	Adults (18+)	Children and Teens (6-17)	Adults (18+)
SPA 4–Metro	24.0%	17.3%	54.7%	15.2%	16.0%	16.3%	33.6%
SPA 6–South	28.9%	20.9%	59.5%	6.1%	9.6%	17.1%	30.3%
GSH Service Area	24.9%	18.0%	55.6%	13.5%	14.8%	16.4%	33.0%
Los Angeles County	26.4%	12.3%	55.40%	19.70%	14.7%	17.7%	34.1%

Data Source: California Health Interview Survey 2014[1], 2012[2]
Data Year: 2012, 2014
Source Geography: SPA

Stakeholder Input – Healthy Behavior

One focus group explained that Latinos are particularly impacted by poor health behaviors because their current diet does not provide as much nutrition as it could: the Latino communities in the service area could benefit from more information, more nutritional education and more knowledge about where to buy affordable healthy foods. A Latina mother explained that she has benefitted from classes offered at the Clínica de Control de Niños, an organization that helped her understand what her children should be eating to be healthy. Focus group participants also explained that Leichty Middle school provides nutrition and cardiovascular classes for parents as well as child care: the school also brings in mobile dental care clinics.

Stakeholders explained that time constraints, costs of healthy food and medical care, and easy access to cheap, unhealthy food, contribute to poor eating behaviors. However, there is an observed growing interest in healthy foods and fitness, reflected in the growing popularity of farmers' markets and Zumba studios.

Homelessness

A homeless individual is defined as "an individual who lacks housing, including an individual whose primary residence during the night is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations, and an individual who is a resident in transitional housing."[71] A homeless person is an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or in any other unstable or non-permanent situation.[72]

[71] National Health Care for the Homeless Council. Nashville, TN. Available at: https://www.nhchc.org/faq/official-definition-homelessness/. Accessed: [August 29, 2016].
[72] National Health Care for the Homeless Council. Nashville, TN. Available at: https://www.nhchc.org/faq/official-definition-homelessness/. Accessed: [August 29, 2016].

In addition, an individual may be considered to be homeless if that person is "doubled up," a term that refers to a situation where individuals are unable to maintain their housing situation and are forced to stay with a series of friends and/or extended family members. Furthermore, previously homeless individuals who are to be released from a prison or a hospital may be considered homeless if they do not have a stable housing situation to which they can return. A recognition of the instability of an individual's living arrangements is critical to the definition of homelessness.[73]

Homelessness Prevalence

As of 2016, an estimated 43,854 homeless resided in Los Angeles County, many of whom were in SPA 4–Metro. Of the total homeless population, an estimated 11,074, or one-quarter, live in the GSH service area.

Total Homeless, 2016

Report Area	Number	Percent
SPA 4–Metro	11,681	26.6%
SPA 6–South	7,459	17.0%
GSH Service Area	11,074	25.3%
Los Angeles County	43,854	100.0%

Source: Los Angeles Homeless Services Authority,
Greater Los Angeles Homeless County Report, 2016, SPA

Individuals make up the majority of the homeless population living within SPA 6–South (84.6%). According to the Los Angeles Homeless Services Authority, individuals include single adults, adult couples with no children, and groups of adults over the age of 18. In SPA 4-Metro, homeless families make up a large percentage of the homeless population (22.7%). Of the 125 homeless minors under the age of 18 in all SPAs, they are concentrated within SPA 4–Metro (where 31.2% of the homeless are homeless minors).

Homeless by Type, 2015

	Homeless Individuals		Homeless Families		Homeless Unaccompanied Minors	
Report Area	Number	Percent	Number	Percent	Number	Percent
SPA 4–Metro	10,431	89.3%	1,390	11.9%	39	0.3%
SPA 6–South	6,311	84.6%	1,142	15.3%	6	0.1%
GSH Service Area	9,680	87.3%	1,345	12.4%	33	0.3%
Los Angeles County	37,601	85.7%	6,128	14.0%	125	0.3%

Source: Los Angeles Homeless Services Authority,
Greater Los Angeles Homeless County Report, 2016, SPA

In the GSH service area, 30.5% of homeless were mentally ill, 22.3% had substance abuse issues, 2.2% had been diagnosed with HIV and 16.9% were physically disabled. These indices were similar to or just above the Los Angeles County averages.

[73] National Health Care for the Homeless Council. Nashville, TN. Available at: https://www.nhchc.org/faq/official-definition-homelessness/. Accessed: [August 29, 2016].

Homeless by Special Population, 2016

Report Area	Mentally Ill		With Substance Abuse Issues		With HIV		Physically Disabled	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
SPA 4–Metro	3,815	32.7%	2,787	23.9%	284	2.4%	2,075	17.8%
SPA 6–South	1,705	22.9%	1,246	16.7%	102	1.4%	1,065	14.3%
GSH Service Area	3,430	31.0%	2,506	22.6%	251	2.3%	1,891	17.1%
Los Angeles County	13,006	29.7%	9,941	22.7%	629	1.4%	7,401	16.9%

Source: Los Angeles Homeless Services Authority,
Greater Los Angeles Homeless County Report, 2016, SPA

Associated Drivers -- Homelessness

Housing instability is a primary driver of homelessness. Housing instability among poor families is the result of multiple overlapping factors ranging from number of income-earning adults in the home, education level of income-earning adults in the home, health of family members, domestic violence exposure, substance use patterns and access to social support and health care.[74] Although Los Angeles has one of the largest health and social services system available to homeless people in the U.S., given the size of the very poor and homeless population it faces significant challenges to provide cost effective integrated care for those facing housing instability.[75]

Stakeholder Input -- Homelessness

Stakeholders observed that a large proportion of the population in the service area are facing housing insecurity and agencies should come together to support these individuals and families before they become homeless.

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.[76] 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.[77] An estimated 11 attempted suicides occur per every suicide death.

[74] A Secondary Analysis by ICPH utilizing data from the Fragile Families and Child Well-being Study.Institute for Children, Poverty & Homelessness. http://www.icphusa.org/index.asp?page=16&report=112&pg=110. Accessed: [September 2, 2016].

[75] Guerrero, E., Henwood, B. and Wenzel, S. (2014). Service Integration to Reduce Homelessness in Los Angeles County: Multiple Stakeholder Perspectives. *Human Service Organizations* 38(1):44-54.

[76] 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 [August 2, 2016].

[77] 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. Accessed [August 2, 2016].

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).[78] Among adults, mental disorders are common: over 25% of the U.S. adult population are diagnosed with an anxiety disorder in the course of their lifetime.[79] 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.[80]

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.[81]

Mental Health Prevalence

Adults in the GSH service area experienced more uhealthy days resulting from poor mental health, more anxiety and more depression than adults in Los Angeles County overall. Additionally, fewer adults in the GSH service area felt they had adequate social and emotional support than adults in Los Angeles County.

Mental Health Indicators

Report Area	Unhealthy Days Resulting from Poor Mental Health[1]	Adults with Serious Psychological Distress in the Last Year[2]	Adequate Social and Emotional Support[1]	Anxiety Prevalence[3]	Depression Prevalence[2]
	Days	Percentage	Percentage	Percentage	Percentage
SPA 4–Metro	2.7	9.4%	60.2%	7.4%	15.7%
SPA 6–South	2.6	8.2%	55.7%	6.9%	15.8%
GSH Service Area	2.7	9.2%	59.4%	7.3%	15.7%
Los Angeles County	2.3	9.6%	64.0%	6.4%	11.8%

Data source[1]: Los Angeles County Health Survey
Data year: 2015
Source geography: SPA
Data source[2]: California Health Interview Survey (CHIS)
Data year: 2014
Source geography: SPA

Data source[3, 4]: Los Angeles County Health Survey
Data year: 2011[3]
Source geography: SPA

[78] U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders. Accessed [August 1, 2016].

[79] National Institute of Mental Health. *Any Disorder Among Adults.* Available at http://www.nimh.nih.gov/statistics/1ANYDIS_ADULT.shtml. Accessed [August 2, 2016].

[80] Public Health Agency of Canada. *Mental Illness*. Available at http://www.phac-aspc.gc.ca/cd-mc/mi-mm/index-eng.php. Accessed [August 2, 2016].

[81] U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders. Accessed [August 1, 2016].

Alcohol- and Drug-Related Mental Illness

Alcohol and drug use is often associated with and linked to mental illness. In 2012, the rate per 100,000 adults of alcohol- and drug-induced mental illness in the GSH service area was significantly higher (186.5) than California (102.5), especially in ZIP Codes 90021-Downtown Los Angeles (802.6), 90013-Downtown Los Angeles (498.4) and 90014-Los Angeles (463.2).

Alcohol- and Drug-Induced Mental Illness Rate per 100,000 Adults

City	ZIP Code	Rate
Hancock Park	90004	111.9
Koreatown	90005	63.6
Pico Heights	90006	67.9
Wilshire	90010	63.1
Downtown Los Angeles	90015	110.1
Downtown Los Angeles	90017	96.1
Hancock Park	90020	43.2
Echo Park/Silverlake	90026	90.6
Westlake	90057	112.9
Chinatown	90012	116.6
Downtown Los Angeles	90013	498.4
Los Angeles	90014	463.2
Downtown Los Angeles	90021	802.6
South Los Angeles	90007	72.8
Jefferson Park	90018	85
GSH Service Area		186.5
California		102.5

Data source: Office of Statewide Health Planning and Development (OSHPD)
Data year: 2012
Source geography: ZIP Code

In the GSH service area, the percentage of adult residents who needed help for mental, emotional, or alcohol/drug issues (20.6%) was higher than the total in Los Angeles County (18.0%). There was even a higher percentage of residents in need of help for mental, emotional or alcohol/drug issues (21.9%) in SPA 4-Metro.

Needed Help for Mental, Emotional, or Alcohol/Drug Issues

Report Area	Percentage
SPA 4–Metro	21.9%
SPA 6–South	15.0%
GSH Service Area	20.6%
Los Angeles County	18.0%

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

Mental Health Hospitalizations

In 2012, the mental health hospitalization rate per 100,000 adults in the GSH service area was nearly triple (1384.0) that of California (540.9), and approximately two to three times higher in ZIP Codes 90014-Los Angeles (3719.3) and 90021-Downtown Los Angeles (3283.5).

The mental health hospitalization rate per 100,000 youth under 18 years old in the GSH service area was higher (444.3) than in California (294.8), and approximately three times higher in ZIP Code 90010-Wilshire (1047.4).

Mental Health Hospitalization Rate per 100,000 persons

City	ZIP Code	Adult Rate	Youth Rate
Hancock Park	90004	634.7	350.7
Koreatown	90005	455.3	324.6
Pico Heights	90006	902.6	346.3
Wilshire	90010	1828.5	1047.4
Downtown Los Angeles	90015	796.7	360.1
Downtown Los Angeles	90017	980.8	345.8
Hancock Park	90020	850.4	207
Echo Park/Silverlake	90026	569.1	324.9
Westlake	90057	821.1	282.3
Chinatown	90012	745.4	585.1
Downtown Los Angeles	90013	3216	450.2
Los Angeles	90014	3719.3	380.2
Downtown Los Angeles	90021	3283.5	948.3
South Los Angeles	90007	632.9	350.8
Jefferson Park	90018	1323.3	360.7
GSH Service Area		1384.0	444.3
California		540.9	294.8

Data source: Office of Statewide Health Planning and Development (OSHPD)
Data year: 2012
Source geography: ZIP Code

Suicide

In 2012, the suicide rate per 10,000 adults in the GSH service area was higher (1.7) than California (1.0), and above the Healthy People 2020 goal (<=1.0). Very high rates were reported in ZIP Codes 90010-Wilshire (12.6) and 90014-Los Angeles (4.2).

Suicide Rate per 10,000 Persons

City	ZIP Code	Rate

City	ZIP Code	Rate
Hancock Park	90004	1.0
Koreatown	90005	0.7
Pico Heights	90006	0.0
Wilshire	90010	12.6
Downtown Los Angeles	90015	1.1
Downtown Los Angeles	90017	0.8
Hancock Park	90020	1.3
Echo Park/Silverlake	90026	0.7
Westlake	90057	1.1
Chinatown	90012	0.0
Downtown Los Angeles	90013	1.6
Los Angeles	90014	4.2
Downtown Los Angeles	90021	0.0
South Los Angeles	90007	0.2
Jefferson Park	90018	0.6
GSH Service Area		1.7
California		1.0
Healthy People 2020		<=1.0

Data source: California Department of Public Health (CDPH)
Data year: 2012
Source geography: ZIP Code

Disparities – Mental Health

In Los Angeles County, those most affected by depression are between the ages of 50 and 64. Around 12.1% of those from age 50 to 59 have been diagnosed with depression, as have 11.3% of those between the ages of 60 and 64. Another 10.4% of those between ages of 40 and 49, and smaller percentages of those age 65 and older (9.2%), 25 to 29 (6.7%), 30 to 39 (5.9%) and 18 to 24 (5.2%) stated they had been diagnosed by a physician with depression.

Depression Prevalence by Age

Age Group	Percentage
18–24 years old	5.2%
25–29 years old	6.7%
30–39 years old	5.9%
40–49 years old	10.4%
50–59 years old	12.1%
60–64 years old	11.3%
65 years old and older	9.2%

Data source: Los Angeles County Health Survey
Data year: 2015
Source geography: County

By ethnicity, larger percentages of Whites (13.8%), and African-Americans (10.4%) in Los Angeles County, were diagnosed with depression by a physician, as were smaller percentages of American Indian/Alaskan Natives (6.8%), Latinos (6.4%) and Asian/Pacific Islanders (3.6%).

Depression Prevalence by Ethnicity

Age Group	Percentage
Latino	6.4%
White	13.8%
African-American	10.4%
Asian/Pacific Islander	3.6%
American Indian/Alaskan Native	6.8%

Data source: Los Angeles County Health Survey
Data year: 2015
Source geography: County

Associated Drivers of Health -- Mental Illness

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.[82]

Stakeholder Input – Mental Health

Stakeholders emphasized that stigma around accessing mental health--especially among communities of color--serves as an obstacle to accessing care. In some cases, individuals fear that they might lose their jobs if their employers learn they are seeking mental health care.

Stakeholders observed that mental health practitioners lack competency in providing effective mental health care to seniors, those who speak languages other than English, and those with diverse cultural backgrounds. Additionally, cultural healers and indigenous religions and practices that may provide effective mental health support are not valued or leveraged in mental health care.

Finally, stakeholders addressed a severe shortage of mental health providers for a community with a high need for mental health care. For example, there is only one suicide responding team (PET team) for SPA 4. Overall, stakeholders identified long waiting list for mental health services and an overreliance on interns in mental health facilities. There are particularly few services available to language minority clients and undocumented clients. Finally, funding for mental health service screening and delivery is limited.

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

[82] Centers for Disease Control and Prevention. *CDC Mental Illness Surveillance*. Available at http://www.cdc.gov/mentalhealthsurveillance/. Accessed [August 2, 2016].

or obese.[83] Excess weight is a significant national problem and indicates an unhealthy lifestyle that influences further health issues.

To measure obesity, researchers commonly use a scale known as the body mass index (BMI). BMI is calculated by dividing a person's weight (in kilograms) by their height (in meters) squared. BMI provides a more accurate measure of obesity or being overweight than weight alone.[84]

Guidelines established by the National Institutes of Health (NIH) place adults age 20 and older into the following categories based on their BMI:

Body Mass Index (Age 20+)

BMI	BMI Categories
Below 18.5	Underweight
18.5 to 24.9	Normal
25.0 to 29.9	Overweight
30.0 and above	Obese

Data source: National Institutes of Health (NIH)
Data year: 2016

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.[85] Obesity is associated with factors including poverty, inadequate fruit/vegetable consumption and lack of access to grocery stores, parks, and open space.

Recent findings have demonstrated associations between breastfeeding and obesity in adulthood. Research suggests various behavioral, biological and psychological pathways for this association. For example, breastfeeding may improve infant feeding methods and infant satiety. In addition, high fat and protein contents in artificial formula may cause excess weight gain. Furthermore, breast milk contains hormones that may positively impact adiposity and metabolism over the lifetime.[86] For this reason, improving breastfeeding outcomes is an effective strategy for addressing obesity in the GSH service area.

Obesity and Overweight Prevalence

In 2015, slightly over a third (34.2%) of the adult population in the GSH service area was overweight, slightly less than in Los Angeles County (35.9%). Obesity is not evenly distributed across the service area: while approximately one in four (24.3%) adults in the GSH service area were obese, over one in three adults in SPA 6-South (34.1%) were obese.

[83] National Cancer Institute. *Obesity and Cancer Risk*. Available at http://www.cancer.gov/cancertopics/factsheet/Risk/obesity. Accessed [August 2, 2016].

[84] National Cancer Institute. *Obesity and Cancer Risk*. Available at https://www.cancer.gov/about-cancer/causes-prevention/risk/obesity/obesity-fact-sheet. Accessed [January 17, 2017].

[85] National Cancer Institute. *Obesity and Cancer Risk*. Available at http://www.cancer.gov/cancertopics/factsheet/Risk/obesity. Accessed [August 2, 2016].

[86] Roya Kelishadi, Sanam Farajian. The protective effects of breastfeeding on chronic non-communicable diseases in adulthood: A review of evidence. Adv Biomed Res. 2014; 3: 3.

In the GSH service area, the percentage of children overweight for their age (15.4%) was higher than the rest of Los Angeles County (13.3%). Of the service planning areas represented in the GSH service area, SPA 6-South had the highest percentage of children overweight for their age (17.1%).

Overweight and Obese Populations

Report Area	Overweight Adults (Age 18+)*	Obese Adults (Age 18+)*	Overweight or Obese Population (Age 12+)**	Children Overweight for Age (Age 0-11)**
SPA 4–Metro	34.4%	22.1%	52.6%	15.0%
SPA 6–South	33.4%	34.1%	70.5%	17.1%
GSH Service Area	34.2%	24.3%	55.9%	15.4%
Los Angeles County	35.9%	23.5%	54.8%	13.3%

Data source: Los Angeles County Health Survey
Data year: 2015* and 2012**
Source geography: SPA

In 2009, the GSH service area had a similar percentage of those who were overweight (29.5%) as all of Los Angeles County (29.7%). However, ZIP Codes 90018-Jefferson Park (33.1%) and 90021-Downtown Los Angeles (32.2%) had a higher percentage of their population overweight than in the GSH service area and Los Angeles County. ZIP codes 90018-Jefferson Park (29.6%) and 90021-Downtown Los Angeles (23.1%) also had higher than average rates of obesity when compared to Los Angeles County (21.2%) and the GSH service area (21.0%).

Overweight and Obese Populations

City	ZIP Code	Percent Overweight	Percent Obese
Hancock Park	90004	28.3%	20.2%
Koreatown	90005	28.4%	19.6%
Pico Heights	90006	29.4%	22.6%
Wilshire	90010	27.5%	15.0%
Downtown Los Angeles	90015	28.7%	21.1%
Downtown Los Angeles	90017	30.0%	22.6%
Hancock Park	90020	26.5%	16.0%
Echo Park/Silverlake	90026	28.7%	21.2%
Westlake	90057	29.0%	20.8%
Chinatown	90012	28.6%	17.3%
Downtown Los Angeles	90013	31.7%	21.8%
Los Angeles	90014	31.3%	21.3%
Downtown Los Angeles	90021	32.2%	23.1%
South Los Angeles	90007	28.6%	22.8%
Jefferson Park	90018	33.1%	29.6%
GSH Service Area		29.5%	21.0%
Los Angeles County		29.7%	21.2%
Healthy People 2020			<=30.5%

Data source: California Health Interview Survey (CHIS)
Data year: 2009
Source geography: ZIP Code

Prevalence– Obesity and Overweight

In 2015, over a third (40.7%) of the population in Los Angeles County was overweight for those age 65 years old and older, age 40 to 49 (39.1%), age 30 to 39 (38.3%), age 60 to 64 (37.5%) and those between 50 and 59 years old (37.4%). Less than a third of those between the ages of 18 and 24 (23.9%) and age 25 to 29 (31.3%) were considered overweight.

For all age groups in Los Angeles, the percentage of obese individuals was less than a third of the population, with those between the ages of 18 and 24 having the lowest percentage of obese (15.3%), followed by individuals age 65 years and older (20.2%).

Overweight/Obesity Prevalence by Age

Age Group	Percent Overweight	Percent Obese
18–24 years old	23.9%	15.3%
25–29 years old	31.3%	24.9%
30–39 years old	38.3%	25.4%
40–49 years old	39.1%	25.8%
50–59 years old	37.4%	27.2%
60–64 years old	37.5%	26.0%
65 years old and older	40.7%	20.2%

Data source: Los Angeles County Health Survey
Data year: 2015
Source geography: County

Overweight/Obesity Prevalence by Ethnicity

Age Group	Percent Overweight	Percent Obese
Latino	39.3%	30.9%
White	35.0%	18.0%
African-American	32.0%	32.9%
Asian/Pacific Islander	30.3%	9.3%
American Indian/Alaskan Native	54.2%	19.1%

Data source: Los Angeles County Health Survey
Data year: 2015
Source geography: County

Disparities – Obesity and Overweight

By ethnicity, larger percentages of American Indians/Alaskan Natives (54.2%) and Latinos (39.3%) in Los Angeles County were considered overweight, along with over a third of Whites (34.0%). Nearly a third of African-Americans (32.9%) and Latinos (30.9%) in Los Angeles County were classified as obese.

Associated Drivers of Health – Obesity and Overweight

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.[87]

Stakeholder Input – Obesity and Overweight

Stakeholders related the high rates of obesity and overweight to lack of physical activity, poor diet, and the health literacy. Most young people in the service area do not engage in physical education at schools and stay inside after school because of concerns about safety in their communities. The easy availability of fast foods and packaged foods, along with the lack of access to healthy fruits and vegetables and time for meal preparation, lead families to consume more high-calorie and unhealthy food. Finally, health care providers recognize that there is a lack of awareness of the severity and importance of obesity as a precursor to other diseases. Stakeholders called for policies in schools and organizations that enforce the provision of healthy snacks and lunches.

Oral Health

Dental care 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.[88]

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.[89]

Oral Health Access

In the GSH service area, over half the adult population (61.4%) did not have dental insurance coverage in 2011, higher than the uninsured rate Los Angeles County (51.8%).

Absence of Dental Insurance Coverage, Adults

Report Area	Percentage
SPA 4–Metro	61.1%
SPA 6–South	62.9%
GSH Service Area	61.4%
Los Angeles County	51.8%

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

[87] National Cancer Institute. *Obesity and Cancer Risk*. Available at http://www.cancer.gov/cancertopics/factsheet/Risk/obesity. Accessed [August 2, 2016].

[88] 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 [August 2, 2016].

[89] 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 [August 2, 2016].

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, it must have a population-to-dentist ratio of at least 5,000:1.[90] Los Angeles County does not meet this criterion, as its ratio is 2,484:1.

Dentist Availability

Report Area	Number	Population to Dentist Ratio
Los Angeles County	7,293	2,484:1

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

Oral Health Care Affordability

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

In the GSH service area, over a third (37.1%) of adults could not afford dental care—including regular check-ups—which is higher than the rate for Los Angeles County (30.3%). SPA 4 reported an even higher percentage (37.6%).

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 fallen victim to budget cuts, which have significantly limited the availability of those services.

In 2015, the percentage of children in the GSH service area (14.6%) who were unable to afford dental care was higher than Los Angeles County (11.5%). SPA 4-Metro's percentage (15.5%) was higher than both the service area and Los Angeles County.

Unable to Afford Dental Care

Report Area	Adult	Child[1]
	Percentage	Percentage
SPA 4–Metro	37.6%	15.5%
SPA 6–South	35.0%	10.4%
GSH Service Area	37.1%	14.6%
Los Angeles County	30.3%	11.5%

Data source: Los Angeles County Health Survey
Data year: 2011, 2015[1]
Source geography: SPA

[90] 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 [August 2, 2016].

Disparities – Oral Health

In 2015, the percentage of children in Los Angeles County who were unable to afford dental care doubled from the age range of 3-5 years old (7.4%) to 12-17 years old (15.1%). The upward trend continues with age, reaching a high at the age bracket of 25-29 years old (38.7%) and steadily declining after that for each age bracket. In particular, the lowest percentage of those unable to afford dental care over the age of 18 occurs with residents over the age of 65 (19.1%).

Unable to Afford Dental Care by Age

Age Group	Percentage
3–5 years old[1]	7.4%
6–11 years old[1]	10.5%
12–17 years old[1]	15.1%
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, 2015[1]
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.

Upon examining differences in ethnicity among children, larger percentages of Latino (12.6%), White (10.6%) and African-American (10.1%) children had a difficult time obtaining dental care because they could not afford it, along with smaller percentages of Asian/Pacific Islander (7.3%) children. Data for American Indian/Alaskan Native children were either unavailable or reflected numbers that were too small to report.

Unable to Afford Dental Care by Ethnicity

	Adult	Child[1]
Age Group	Percentage	Percentage
Latino	36.6%	12.6%
White	21.0%	10.6%
African-American	38.0%	10.1%
Asian/Pacific Islander	27.3%	7.3%
American Indian/Alaskan Native	25.6%	-

Data source: Los Angeles County Health Survey
Data year: 2011, 2015[1]
Source geography: County

Associated Drivers of Health – Oral 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.[91] In addition, oral health conditions such as periodontal (gum) disease have been linked to diabetes, heart disease, stroke, and premature, low-weight births.[92]

Stakeholder Input – Oral Health

Stakeholders explained that the separation between oral care and medical care both in terms of policy (health insurance coverage, permitted "sick time" off at work) and health literacy has a detrimental impact.

Cost of services and insurance coverage are barriers to oral care. Stakeholders explained that dental care costs are prohibitive for those who lack insurance, and that dental services are often not covered for those who are medically insured. Additionally, dental care providers are very selective in the types of insurance they will accept, and they often don't take Medi-Cal because of Medi-Cal's historically low reimbursement rates.

Stakeholders reported that the high costs of dental care are compounded by high rates of dental fraud in the service area. Patients receive recommendations for unnecessary, expensive procedures that are not medically indicated. Additionally, stakeholders observed that some health care providers offer Care Credit packages to non-English speaking customers who most likely do not understand the terms explained in English in the Care Credit materials.

The service area lacks sufficient oral care resources for subpopulations including the elderly and indigent, children and the homeless.

Poverty (including Unemployment)

Poverty

In 2015, a higher percentage of families in the GSH service area lived below the poverty line (25.1%) in comparison to families in Los Angeles County (14.9%). Similarly, the percentage of families living below the poverty line with children (18.9%) was higher than Los Angeles County (11.7%). Several areas with a higher concentration of families living below the poverty line include zip codes 90017 (47.9%), 90007 (36.4%) and 90057 (35.2%). Families with children who were living below the poverty line were prevalent in the same zip codes at 90017 (35.0%), 90057 (28.9%), and 90007 (27.6%).

[91] World Health Organization, Oral health Fact Sheet. Geneva, Switzerland. Available at http://www.who.int/mediacentre/factsheets/fs318/en/index.html. Accessed [August 2, 2016].

[92] 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 [August 2, 2016].

		Poverty			
City	ZIP Code	Families at or Above Poverty	Families at or Above Poverty with Children	Families Below Poverty	Families Below Poverty with Children
Hancock Park	90004	78.3%	33.2%	21.7%	17.1%
Koreatown	90005	77.0%	31.3%	23.0%	18.0%
Pico Heights	90006	69.8%	28.8%	30.2%	24.4%
Wilshire	90010	-	-	-	-
Downtown Los Angeles	90015	67.7%	29.3%	32.3%	24.7%
Downtown Los Angeles	90017	52.1%	21.9%	47.9%	35.0%
Hancock Park	90020	80.0%	36.0%	20.0%	15.7%
Echo Park/Silverlake	90026	76.3%	32.8%	23.7%	18.1%
Westlake	90057	64.8%	24.9%	35.2%	28.9%
Chinatown	90012	68.5%	20.5%	31.5%	18.9%
Downtown Los Angeles	90013	91.3%	17.6%	8.7%	6.4%
Los Angeles	90014	88.6%	26.8%	11.4%	5.6%
Downtown Los Angeles	90021	71.1%	29.3%	28.9%	22.4%
South Los Angeles	90007	63.6%	31.2%	36.4%	27.6%
Jefferson Park	90018	74.2%	36.8%	25.8%	20.7%
GSH Service Area		74.9%	30.0%	25.1%	18.9%
Los Angeles County		85.2%	41.9%	14.9%	11.7%

Data source: Nielsen Claritas
Data year: 2016
Source geography: ZIP Code

Employment Status

In 2015, a majority of the GSH service area population was employed (54.5%), a slightly lower rate than in Los Angeles County (57.0%). About one in thirteen individuals (7.9%) in the GSH service area was unemployed, slightly higher than Los Angeles County's 7.6% unemployment rate. In particular, ZIP codes 90004-Hancock Park (9.9%), 90026-Echo Park (9.5%) and 90006-Pico Heights (9.3%) wereareas with the highest percentage of unemployed residents in the GSH service area. The remaining 37.6% of the population in the GSH service area were classified as not currently in the labor force.

Employment Status

City	ZIP Code	In Armed Forces	Employed	Unemployed	Not in Labor Force
Hancock Park	90004	0.03%	62.4%	9.9%	27.6%
Koreatown	90005	0.01%	65.0%	7.8%	27.2%
Pico Heights	90006	0.00%	61.6%	9.3%	29.1%
Wilshire	90010	-	-	-	-
Downtown Los Angeles	90015	0.02%	56.4%	8.0%	35.6%
Downtown Los Angeles	90017	0.05%	57.3%	5.0%	37.7%
Hancock Park	90020	0.00%	61.3%	7.8%	30.8%
Echo Park/Silverlake	90026	0.05%	60.5%	9.5%	30.0%
Westlake	90057	0.02%	60.5%	8.5%	31.0%
Chinatown	90012	0.04%	35.8%	3.3%	60.8%
Downtown Los Angeles	90013	0.00%	41.4%	8.7%	49.9%
Los Angeles	90014	0.06%	48.1%	8.8%	43.0%
Downtown Los Angeles	90021	0.00%	50.0%	7.7%	42.3%
South Los Angeles	90007	0.00%	45.5%	6.8%	47.7%
Jefferson Park	90018	0.00%	53.5%	8.9%	37.7%
GSH Service Area		0.0%	54.5%	7.9%	37.6%
Los Angeles County		0.0%	57.0%	7.6%	35.3%

Data source: Nielsen Claritas
Data year: 2016
Source geography: ZIP Code

Students Receiving Free or Reduced-Price Meals

Student eligibility for free or reduced-price meals (FRPM) serves as a proxy measure of family poverty, as the federal poverty threshold tends to underestimate the extent of poverty, particularly in high cost areas. Research indicates that families in California can earn two or more times the federal poverty level and still struggle to meet their basic needs.[93]

A child's family income must fall below 130% of the federal poverty guidelines ($31,005 for a family of four in 2014-2015) to qualify for free meals, or below 185% of the federal poverty guidelines ($44,123 for a family of four in 2014-2015) to qualify for reduced price meals.

In 2015, the percentage of children eligible for the Free or Reduced Price School Meal (FRPM) program was 66.6%, which is an increase from 2011 (61.8%). Overall, these percentages are above that for California (58.6%).

Children Eligible for Free or Reduced-Price Lunch

Report Area	Percentage
Los Angeles County	66.6%
California	58.6%

Data source: California Department of Education (CDE)
Data year: 2015
Source geography: County

[93] As cited on kidsdata.org, *Self-Sufficiency Standard*. (2015). Insight Center for Community Economic Development and Dr. Diana Pearce, *California Family Economic Self-Sufficiency Standard*. Center for Women's Welfare, School of Social Work, University of Washington. Accessed [August 1, 2016].

Stakeholder Input – Poverty

Poverty is a challenge in and of itself for residents of the service area, and as part of a chain of related factors it is the upstream determinant of multiple health outcomes.

For residents of the service area, low income means lack of access to personal and public transportation, which impacts access to healthy food, access to health care and even access to education. Residents' low income limits their access to stable and healthy housing and a clean living environment, as very low-income communities are most impacted by environmental pollution and lack of adequate garbage collection.

Stakeholders explained that residents living in poverty experience structural barriers to health care access including discrimination from service providers, increasingly overburdened social service offices, and lack of adequate educational and vocational programs.

Preventive Care

Along with access to health care, following preventive practices such as having a regular source of care and timely physical and medical tests is important. Adequate, regular primary care can prevent the development of health problems and maintain positive health conditions.

Health Check-Ups

In 2015, the percentage of residents in the GSH service area who visited a doctor, nurse or other health care professional was slightly lower (64.7%) than in Los Angeles County (70.7%). Similarly, there were a lower percentage of individuals residing in the GSH service area who visited a dentist or a dental clinic (56.7%) than in Los Angeles County (59.3%). In SPA 4-Metro, 64.6% of the population visited a doctor, nurse or other health professional while 59.7% saw a dentist or visited a dental clinic in the past year. Similarly, in SPA 6, 65.1% of the population visited a doctor, nurse or other health professional while only 43.1% saw a dentist or visited a dental health clinic.

Visited Health Care Professional in Past Year, 2015

Report Area	Saw Doctor, Nurse, or Other Health Care Professional in the Past Year	Saw Dentist or Visited Dental Clinic in the Past Year
SPA 4–Metro	64.6%	59.7%
SPA 6–South	65.1%	43.1%
GSH Service Area	64.7%	56.7%
Los Angeles County	70.7%	59.3%

Data Source: Los Angeles County Health Survey
Data Year: 2015
Source Geography: SPA

Preventable Hospitalizations

Potentially preventable hospitalizations are admissions to a hospital for certain acute illnesses (e.g., dehydration) or worsening chronic conditions (e.g., diabetes) that might not have required

hospitalization had these conditions been managed successfully by primary care providers in outpatient settings. Although not all such hospitalizations can be avoided, admission rates in populations and communities can vary depending on access to primary care, care-seeking behaviors and the quality of care available. Because hospitalization tends to be costlier than outpatient or primary care, potentially preventable hospitalizations often are tracked as markers of health system efficiency. The number and cost of potentially preventable hospitalizations also can be calculated to help identify potential cost savings associated with reducing these hospitalizations overall and for specific populations.[94]

In 2012, the rate at which preventable hospital events occurred (per 1,000) for individuals over the age of 18 in the GSH service area (13.5) was slightly higher than that of Los Angeles County (11.7). In particular, ZIP codes 90014-Los Angeles (26.2), 90018 (21.1), and 90013 (20.7) were areas with rates significantly higher than the GSH service area.

Preventable Hospital Events Rate per 1,000 Population (18+)

City	ZIP Code	Rate
Hancock Park	90004	10.0
Koreatown	90005	7.3
Pico Heights	90006	10.8
Wilshire	90010	17.7
Downtown Los Angeles	90015	12.6
Downtown Los Angeles	90017	10.4
Hancock Park	90020	5.8
Echo Park/Silverlake	90026	8.4
Westlake	90057	13.1
Chinatown	90012	10.1
Downtown Los Angeles	90013	20.7
Los Angeles	90014	26.2
Downtown Los Angeles	90021	18.6
South Los Angeles	90007	9.2
Jefferson Park	90018	21.1
GSH Service Area		13.5
Los Angeles County		11.7

Source: California Office of Statewide Health Planning and Development
OSHPD Patient Discharge Data,
Data Year: 2012
Source Geography: ZIP Code

Disparities – Preventive Care

When looking at differences among ethnicities, the American Indian/Alaskan Native population in Los Angeles County has the lowest percentage of adult residents with a regular source of care (65.4%). Asians (75.6%) and Latinos (76.9%) also fall below the percentage reflected by the general population of Los Angeles County (80.3%).

[94] https://www.cdc.gov/mmwr/preview/mmwrhtml/su6203a23.htm

Have Regular Source of Care

Ethnicity	Percent
African American	83.8%
American Indian/Alaskan Native	65.4%
Asian	75.6%
Latino	76.9%
White	86.4%
Los Angeles County	80.3%

Data Source: Los Angeles County Health Survey
Data Year: 2015
Source Geography: SPA

In terms of age, individuals between the ages of 25 and 29 reflect the smallest percentage who have a regular source of care (61.8%). Residents of Los Angeles County between the ages of 18 and 24 (71.7%) and 30-39 years old (75.6%) also represent the lower half of the population having a regular source of care.

Have Regular Source of Care

Age Group	Percent
18-24 years old	71.7%
25-29 years old	61.8%
30-39 years old	75.6%
40-49 years old	81.5%
50-59 years old	85.7%
60-64 years old	89.3%
65+ years old	94.2%

Data Source: Los Angeles County Health Survey
Data Year: 2015
Source Geography: SPA

Stakeholder Input – Preventive Care

Stakeholders identified a number of issues with linkage to care and continuity of care that negatively impact the implementation of preventive care. For example, with changes in insurance, people lose their medical homes, which interrupts regular checkups and treatment. Residents are not readily connected with screenings for young children that could identify and address many issues early, before more serious issues arise. Additionally, stakeholders reported that residents do not often have access to paid time off for preventive care or early care for illness.

Sexual Health / Sexually Transmitted Diseases

There are more than 25 infectious organisms that are transmitted primarily through sexual activity. STD prevention is an essential primary care strategy for improving reproductive health. Despite the burdens, costs, and complications, STDs remain a significant public health problem in the United States, greatly under-recognized by the public, policymakers and health care professionals. STDs have the potential to

cause many harmful, often irreversible clinical complications, including having an impact on reproductive health, fetal and perinatal health problems and cancer and the transmission of HIV. The spread of STDs is directly affected by social, economic and behavioral factors. Obstacles to STD prevention include lack of access to care, willingness to seek care and social norms regarding sex and sexuality. Among certain vulnerable populations, a historical experience with segregation and discrimination exacerbates the influence of these factors. Many studies document the association of substance abuse with STDs. The introduction of illicit substances into communities often can alter sexual behavior drastically in high-risk sexual networks, leading to the spread of STDs.[95]

Adolescents and young adults ages 15 to 24 account for nearly half of the 20 million new cases of STDs each year in the United States. Today, four in 10 sexually active teen girls in the United States have had an STD with the potential to cause infertility and even death. Regular screenings are critical, as STDs often have no obvious signs or physical symptoms. Also, certain racial and ethnic groups (mainly African-American, Hispanic/Latino, and American Indian/Alaska Native populations) have high rates of STDs compared with Whites. Race and ethnicity in the United States are correlated with other determinants of health status such as poverty, limited access to health care, fewer attempts to get medical treatment and living in communities with high rates of STDs.[96]

Prevalence – Sexually Transmitted Diseases

HIV incidence per 100,000 (70.5) and syphilis incidence per 100,000 (24.1) in the GSH service area were both significantly higher than in Los Angeles County (24.9 and 8.1 per 100,000, respectively).

Chlamydia incidence per 100,000 in the GSH service area (662.8) was significantly higher than Los Angeles County (512.9 per 100,000), and SPA 6-South had an even higher incidence per 100,000 (999.5).

The prevalence of gonorrhea per 100,000 in the GSH service area (209.7) was nearly twice as much as that of Los Angeles County (103.4). Others SPAs such as SPA 4 (204.7) and SPA 6 (231.9) also exceed the rate of incidence per 100,000 than the county (103.4).

Sexually Transmitted Diseases

Report Area	HIV Incidence per 100,000 (Age 13+)	Syphilis Incidence per 100,000	Chlamydia Incidence per 100,000	Gonorrhea Incidence per 100,000
	Percent	Percent	Rate	Rate
SPA 4–Metro	79.0	27.1	587.7	204.7
SPA 6–South	32.3	10.5	999.5	231.9
GSH Service Area	70.5	24.1	662.8	209.7
Los Angeles County	24.9	8.1	512.9	103.4

Source: Los Angeles County Department of Public Health, Key Indicators of Health
Data Year: 2013
Source Geography: SPA

[95] Centers for Disease Control and Prevention. (2015). *Sexually Transmitted Diseases*. Washington, DC. Available at http://www.healthypeople.gov/2020/topics-objectives/topic/sexually-transmitted-diseases. Accessed [August 2, 2016].
[96] Centers for Disease Control and Prevention. (2015). *Sexually Transmitted Diseases*. Washington, DC. Available at http://www.healthypeople.gov/2020/topics-objectives/topic/sexually-transmitted-diseases. Accessed [August 2, 2016].

Stakeholder Input – Sexually Transmitted Diseases

Stakeholders have observed an increase in STD incidence among teenagers, and called for preventive education.

Transportation

Transportation is often cited as a barrier to healthcare access. Transportation barriers can lead to rescheduled or missed appointments, delayed care and missed or delayed medication use. These consequences may cause poorer management of chronic illness and thus poorer health outcomes. However, the significance of these barriers is uncertain based on existing literature due to wide variability in both study populations and transportation barrier measures[97].

Personal Transportation

In 2015, the population of the GSH service area was over three times more likely to use public transportation than the total population of Los Angeles County (24.2% vs. 7.1%). The population of the GSH service area was also more likely to walk or use a bicycle for transportation than the total population of Los Angeles County. At the same time, residents within the GSH service area were much less likely than residents of Los Angeles County to drive alone (49.1% vs. 72.6%). The average number of vehicles per household (1.0) in the GSH service area was lower than that of Los Angeles County (1.8).

[97] Institute for Health and Research Policy. Traveling towards disease: transportation barriers to health care access. Chicago, IL. Available at: http://www.ihrp.uic.edu/content/traveling-towards-disease-transportation-barriers-health-care-access. Accessed: [September 2, 2016].

Modes of Transportation

City	ZIP Code	Drove Alone	Car Pooled	Public Transportation	Walked	Bicycle	Average Vehicles Per Household
Hancock Park	90004	56.6%	9.2%	23.9%	2.3%	1.1%	1.3
Koreatown	90005	44.9%	9.5%	32.0%	5.3%	0.7%	1.0
Pico Heights	90006	44.3%	10.0%	34.3%	4.5%	1.3%	1.1
Wilshire	90010	-	-	-	-	-	-
Downtown Los Angeles	90015	55.9%	10.1%	13.7%	10.8%	0.8%	1.0
Downtown Los Angeles	90017	43.2%	4.4%	19.6%	16.6%	2.5%	0.8
Hancock Park	90020	47.9%	2.9%	15.1%	19.6%	3.2%	1.1
Echo Park/Silverlake	90026	46.6%	8.8%	26.3%	9.0%	3.1%	1.3
Westlake	90057	34.9%	8.2%	38.9%	8.6%	1.3%	0.9
Chinatown	90012	55.8%	10.1%	22.8%	4.1%	0.5%	1.0
Downtown Los Angeles	90013	41.0%	6.2%	23.9%	10.9%	4.5%	0.7
Los Angeles	90014	59.2%	9.3%	19.7%	3.1%	1.3%	0.7
Downtown Los Angeles	90021	62.5%	0.0%	12.5%	12.5%	0.0%	0.9
South Los Angeles	90007	43.0%	7.6%	17.9%	18.0%	7.7%	1.2
Jefferson Park	90018	63.7%	9.8%	18.5%	1.4%	1.0%	1.4
GSH Service Area		49.1%	7.8%	24.2%	8.7%	2.0%	1.0
Los Angeles County		72.6%	10.1%	7.1%	2.9%	0.9%	1.8

Data Source: Nielson Claritas Demographic Data
Data Year: 2015
Source Geography: ZIP

Stakeholder Input -- Transportation

Navigating public transportation was cited as a barrier to care for residents because of cost and extended travel times, particularly when assigned health care providers are very distant from residents' homes or workplaces.

In particular, the elderly and the disabled face challenges in accessing transportation to health care providers as well as to healthy food outlets.

Violence/Injury/Safety

Injuries can result from many unintentional or intentional events including motor vehicle accidents, falls, job-related accidents, gunshot and blast wounds and sports injuries. Common diagnoses include brain injury, spinal cord injury, anoxia and muscular-skeletal injury.[98] Injuries affect everyone, regardless of

[98] Centers for Disease Control and Prevention. (2014). *Injury Prevention and Control*. Atlanta, GA. Available at http://www.cdc.gov/injury/overview/index.html. Accessed [August 2, 2016].

age, gender, ethnicity or economic status.[99] Although injuries are often unavoidable, there are steps that can be taken to lessen the consequences of injuries, including wearing seat belts, violence prevention education, ignition interlock and in-car breathalyzers to prevent drunk driving, pro-active job site safety precautions and regular physical activity.[100]

Traumatic Brain Injuries. Traumatic brain injuries contribute to a significant number of deaths and cases of permanent disability each year. In 2010 alone, 2.5 million traumatic brain injuries occurred in the United States.[101] Traumatic brain injuries are caused by a bump or blow to the head or a penetrating injury that disrupts the normal function of the brain.[102] Traumatic brain injuries are often the result of falls, unintentional blunt traumas, motor vehicle crashes and physical assaults.[103] Traumatic brain injuries cause a range of short and long term changes that affect an individual's memory and reasoning functions, senses (i.e. touch, taste, and smell), ability to communicate and understand and overall emotional well-being.[104]

Unintentional Injury

In 2012, the GSH service area experienced 2.6 unintentional injuries leading to death per 10,000 people. The highest rates of unintentional injury leading to death were seen in ZIP codes 90013-Downtown Los Angeles (7.01) and 90014-Los Angeles (9.82).

[99] Centers for Disease Control and Prevention. (2014). *Injury Prevention and Control*. Atlanta, GA. Available at http://www.cdc.gov/injury/overview/index.html. Accessed [August 2, 2016].

[100] Centers for Disease Control and Prevention. (2014). *Injury Prevention and Control*. Atlanta, GA. Available at http://www.cdc.gov/injury/overview/index.html. Accessed [August 2, 2016].

[101] Centers for Disease Control and Prevention. (2014). *Traumatic Brain Injury*. Atlanta, GA. Available at http://www.cdc.gov/TraumaticBrainInjury/index.html. Accessed [August 2, 2016].

[102] Centers for Disease Control and Prevention. (2015). *Traumatic Brain Injury*. Atlanta, GA. Available at http://www.cdc.gov/TraumaticBrainInjury/index.html. Accessed [August 2, 2016].

[103] Centers for Disease Control and Prevention. (2015). *Traumatic Brain Injury in the United States: Fact Sheet*. Atlanta, GA. Available at http://www.cdc.gov/traumaticbraininjury/get_the_facts.html. Accessed [August 2, 2016].

[104] Centers for Disease Control and Prevention. (2015). *What are the potential effects of TBI?*. Atlanta, GA. Available at http://www.cdc.gov/traumaticbraininjury/outcomes.html. Accessed [August 2, 2016].

Unintentional Injuries

City	ZIP Code	Unintentional Injuries Mortality Rate per 10,000 Rate
Hancock Park	90004	1.12
Koreatown	90005	2.45
Pico Heights	90006	2.04
Wilshire	90010	0.0
Downtown Los Angeles	90015	1.05
Downtown Los Angeles	90017	1.2
Hancock Park	90020	1.52
Echo Park/Silverlake	90026	1.84
Westlake	90057	1.99
Chinatown	90012	1.53
Downtown Los Angeles	90013	7.01
Los Angeles	90014	9.82
Downtown Los Angeles	90021	3.65
South Los Angeles	90007	1.7
Jefferson Park	90018	1.74
GSH Service Area		2.6
Los Angeles County		-
California		2.8

Teens' Perception of Intentional Injury

In 2012, the number of teens who received threats of violence or physical harm from their peers was slightly higher in the GSH service area (19.7%) than in Los Angeles County (14.7%) and California (16.2%). Moreover, the percentage of teens in SPA 4-Metro (21.5%) who received threats was higher than the average for the GSH service area.

In contrast, there was a much higher (19.4% vs 17.1%) percentage of teens that feared being attacked at school than those who actually received threats.

Teens Perception of Neighborhood and School Safety, 2012, 2014

Report Area	Received threats of violence or physical harm from peers in past year[1]	Feared of being attacked at school in the past year[1]	Felt unsafe in nearby park or playground during the day[2]
SPA 4–Metro	21.5%	18.7%	7.0%
SPA 6–South	11.7%	22.8%	13.8%
GSH Service Area	19.7%	19.4%	8.2%
Los Angeles County	14.7%	17.1%	11.7%
California	16.2%	14.3%	9.5%

Source:
1 California Health interview Survey, 2012, SPA
2 California Health interview Survey, 2014, SPA
*SPA Data Unavailable—Not included in estimation for GSH Service Area

Stakeholder Input – Violence, Injury and Safety

Stakeholders highlighted the fact that the community is impacted by domestic violence because it is often underreported for fear of negative interpersonal, economic and legal repercussions, particularly among families with undocumented family members. Stakeholders observed that domestic violence is becoming more prevalent among younger residents, and explained there are a lack of community education around healthy relationships and very few safe spaces for victims given the very dense population in the service area.

Street violence continues to be a concern in the service area, and stakeholders noted that gangs particularly target young people. This is a particular concern because there is a current strained relationship with law enforcement.

Conclusion

This survey of secondary data combined with stakeholder insights pertaining to morbidity, mortality and the social determinants of health in the Good Samaritan Hospital service area reveals the impact of several key underlying factors on all of the health needs identified in the CHNA process. These underlying factors include: poverty; homelessness and housing insecurity; limitations on healthy behaviors imposed by the built environment; barriers to health care access stemming from cultural and linguistic differences between patients and providers combined with an increasingly complex health insurance system; gaps in linkage and continuity of care; and, a need for nutrition, disease process and chronic disease maintenance education. In addition, this survey illustrates the magnitude and severity of poor health outcomes in the GSH service area compared to benchmarks (Los Angeles County or California). Such comparison reveals that the service area has a higher diabetes prevalence, higher poor mental health rates and associated substance abuse rates, lower birthweights, higher sexually transmitted disease rates and higher obesity rates than found in the County or the State. These data have been collected here in order to inform the GSH Community Benefits Plan. The Plan will take into account the findings of this report as well as the community assets and existing programs that, with investment, can make the greatest impact on the health needs of the service area.

Appendix A—Scorecard

DATA INDICATOR **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	Year of Data	Healthy People 2020 Target	Comparison Level	Comparison Average	CHMC Service Area Average	GSH Service Area Average	SVMC Service Area Average	Stakeholder Mention
PHYSICAL AND SOCIAL DETERMINANTS								
Demographics								
Percent of adults who completed high school†	2016		LAC	76.8%	**67.7%**	**69.0%**	**64.2%**	
Percent of adults who are employed†	2016		LAC	57.6%	58.0%	**54.6%**	**55.4%**	
Average income per household†	2016		LAC	$78,309	**$53,147**	**$54,977**	**$52,964**	
Median income per household†	2016		LAC	$54,514	**$35,802**	**$31,484**	**$34,616**	
Average household size†	2016		LAC	3.0	2.7	2.1	2.9	
Births and Neonatal Care								
Births to teens (mothers under 20 years of age)†	2012		LAC	7.0%	**9.3%**	**8.4%**	**10.6%**	
Percent of low weight (<2,500 grams) births per 100 live births †	2012		LAC	6.7%	**7.4%**	**7.6%**	**7.6%**	
Breastfeeding (At Least 6 Months)†	2015		LAC	49.7%	51.9%	53.9%	49.7%	
Breastfeeding (At Least 12 Months)†	2015		LAC	27.6%	**26.8%**	**26.0%**	28.0%	
HEALTH OUTCOMES								
Cancers								*
Rate of cancer mortality per 100,000 adults†	2012		CA	15.1	13.2	12.0	12.8	
Breast cancer incidence rate per 100,000 adults*	2013		CA	64.6	63.3	63.3	63.3	
Breast cancer mortality Rate per 100,000 adults*	2013		CA	11.0	3.4	3.4	3.4	
Colon and rectum cancer incidence rate per 100,000 adults*	2013		CA	36.5	**36.6**	**36.6**	**36.6**	
Colon and rectum cancer mortality Rate per 100,000 adults*	2013		CA	13.4	**13.6**	**13.6**	**13.6**	
Leukemia incidence rate per 100,000 persons*	2013		CA	12.4	11.3	11.3	11.3	
Leukemia mortality rate per 100,000 persons*	2013		CA	6.4	6.0	6.0	6.0	
Lung cancer incidence rate per 100,000 persons*	2013		CA	43.3	35.2	35.2	35.2	
Lung cancer mortality rate per 100,000 persons*	2013		CA	32.3	27.0	27.0	27	
Pancreatic cancer incidence rate per 100,000 persons*	2013		CA	11.8	11.5	11.5	11.5	
Pancreatic cancer mortality rate per 100,000 persons*	2013		CA	10.7	6.9	6.9	6.9	
Prostate cancer incidence rate per 100,000 persons*	2013		CA	98.0	88.5	88.5	88.5	
Prostate cancer mortality rate per 100,000 persons*	2013		CA	19.5	10.8	10.8	10.8	
Cardiovascular Disease								
Percent of adults receiving heart disease management services from a care provider^	2014		LAC	55.5%	61.3%	61.1%	60.0%	
Percent of heart disease prevalence^	2014		LAC	5.7%	2.7%	3.5%	**6.0%**	
Rate of cardiovascular disease mortality per 10,000 adults†	2012		CA	15.5	14.9	**16.3**	14.3	
Rate of heart disease hospitalization per 100,000 adults†	2012		LAC	366.6	**376.6**	**398.2**	**403.6**	
Cholesterol								*
Percent of adults 18 and older ever diagnosed with high cholesterol^	2015		LAC	25.2%	24.6%	25.1%	24.0%	
Diabetes								*
Percent of adults 18 and older ever diagnosed with diabetes^	2015		LAC	9.8%	**11.5%**	**11.7%**	**11.8%**	
Percent of adults who feel confident in their ability to manage their diabetes^	2014		LAC	56.9%	**25.2%**	**33.2%**	**53.9%**	
Rate of adult diabetes hospitalizations per 100,000 adults†	2012		LAC	171.7	**203.9**	**221.8**	**241.1**	
Rate of diabetes mortality per 10,000 adults†	2012		CA	2.1	**2.7**	**2.5**	**2.7**	
Rate of hospitalizations for uncontrolled diabetes per 100,000 adults†	2012		LAC	14.1	**18.9**	**21.2**	**21.0**	
Rate of youth diabetes hospitalizations per 100,000 Persons	2012		LAC	27.7	21.8	17.9	24.1	
Hypertension								*
Percent of adults ever diagnosed with high blood pressure^	2015	<=26.9%	LAC	23.5%	23.2%	22.8%	**23.6%**	
Percent of adults taking any medications to control their high blood pressure^	2014	<=69.5%	LAC	67.2%	**63.9%**	**64.2%**	**62.3%**	
Rate of hypertension mortality per 10,000 adults†	2012		CA	15.5	14.9	**16.3**	14.3	
Mental Health								*
Average number of poor mental and/or physical health days in the past month reported by	2015		LAC	2.3	**2.6**	**2.7**	**2.6**	
Percent of adults 18 and older ever diagnosed with depression^	2015		LAC	13.0%	**14.5%**	**15.3%**	**14.6%**	
Percent of adults who received adequate social an emotional support^	2015		LAC	64.0%	**59.6%**	**59.4%**	**59.1%**	
Rate of adult alcohol and drug induced mental illness per 100,000 adults†	2012		LAC	125.8	108.8	**186.5**	116.8	
Rate of adult mental illness hospitalizations per 100,000 adults†	2012		LAC	677.0	**880.7**	**1384.0**	**906.2**	
Rate of suicides per 10,000 adults†	2012	<=1.0	LAC	0.4	**1.1**	**1.7**	**1.1**	
Rate of youth (under 18) Mental Illness hospitalizations per 100,000 adults†			LAC	377.1	**403.7**	**444.3**	**410.2**	
Obesity/Overweight								*
Percent of adults who are obese^	2015	<=30.5%	LAC	23.5%	22.3%	**24.3%**	**28.5%**	
Percent of adults who are overweight^	2015		LAC	35.9%	34.6%	34.2%	34.2%	
Percent of children 2-11 years old who are overweight^	2014		LAC	13.1%	**15.7%**	**19.0%**	12.5%	
Percent of teens 12-17 years old who are overweight or obese^	2014		LAC	29.3%	**32.6%**	**33.1%**	**30.9%**	
Oral Health								
Percent of children (age 3-17 years) who were unable to afford dental care and check-ups in the past year	2015		LAC	11.5%	**13.5%**	**14.6%**	**12.4%**	
Percent of adults who reported seeing a dentist in past year	2015		LAC	59.3%	**54.5%**	**56.7%**	**51.5%**	
Sexually Transmitted Diseases								
Chlamydia incidence rate*	2013		CA	453.4	**539.9**	**539.9**	**539.9**	
Gonorrhea incidence rate*	2013		CA	116.8	**150.3**	**150.3**	**150.3**	
Syphilis incidence rate*	2013		CA	9.9	**11.8**	**11.8**	**11.8**	

HEALTH DRIVERS								
Access to Care								*
Adults uninsured^	2014		LAC	20.0%	**25.9%**	**26.6%**	**26.1%**	
Children uninsured^	2014		LAC	4.4%	**5.4%**	**5.1%**	3.9%	
Adults regular source of care^	2015		LAC	80.3%	**77.3%**	**76.9%**	**77.5%**	
Children regular source of care^	2015		LAC	94.3%	**92.1%**	**90.6%**	**93.6%**	
Percent of adults 18 and older who had a difficult time accessing medical care^	2015		LAC	23.6%	**29.1%**	**29.3%**	**29.5%**	
Percent who visited the emergency room in the past 12 months^	2014		CA	17.4%	**18.3%**	16.3%	**20.3%**	
Alcohol and Substance Abuse, and Tobacco Use								
Percent of adults 18 and older who reported binge drinking in the past month^	2015		LAC	15.9%	**17.5%**	**16.9%**	15.5%	
Percent of adults 18 and older who are currently smoking^	2015		LAC	13.3%	**13.8%**	**13.9%**	13.6%	
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^	2014		LAC	18.0%	**19.6%**	**20.6%**	18.3%	
Percent of teens 12-17 who used marijuana in the past year^	2012		LAC	9.4%	**13.1%**	**14.7%**	**10.7%**	
Percent of adults who used marijuana in the past year^	2015		LAC	11.6%	**13.9%**	**14.5%**	**13.2%**	
Rate of alcohol/drug induced mental disease hospitalizations per 100,000 adults†	2012		LAC	125.8	108.8	**186.5**	116.8	
Cultural and Linguistic Barriers								*
Had a hard time understanding doctor^	2016		LAC	3.2%	**3.6%**	**3.8%**	**3.6%**	
Percent of population who speak a language other than English at home†	2016		LAC	56.8%	**68.1%**	**66.5%**	**67.1%**	
Food Insecurity								*
Not able to afford enough food (food insecure)^	2014		LAC	39.5%	**48.7%**	**50.8%**	**47.1%**	
Currently receiving food stamps^	2014		LAC	18.7%	**19.5%**	**19.1%**	**20.9%**	
Percent of households <300% federal poverty level that are food insecure^	2015		LAC	29.2%	**32.0%**	**32.1%**	**32.0%**	
Healthy Behaviors								*
Aerobic exercise and muscle strengthening (adults age 18+)^	2015		LAC	34.1%	**33.5%**	**33.0%**	**31.7%**	
Aerobic exercise and muscle strengthening (children age 6-17)^	2015		LAC	17.7%	**16.4%**	**16.4%**	**16.9%**	
Percent of adults (18+ years old) who reported binge drinking (in the past month)^	2015		LAC	15.9%	**17.5%**	**16.9%**	15.5%	
Percent of adults who use walking paths, parks, playgrounds, or sports fields in their neighborhood^	2015		LAC	47.5%	**45.3%**	**46.8%**	**43.5%**	
Percent of children 17 and under who reported drinking at least one soda or sweetened drink per day^	2015		LAC	39.2%	35.5%	38.0%	**44.3%**	
Percent of adults 18 and older who reported eating five or more servings of fruit and vegetables per day^	2015		LAC	14.7%	15.9%	14.8%	**12.6%**	
Homelessness								*
Number of homeless persons^	2016		LAC	43,854	9,709	11,074	8,622	
Physical Activity								*
Aerobic exercise and muscle strengthening (adults age 18+)^	2015		LAC	34.1%	**33.5%**	**33.0%**	**31.7%**	
Aerobic exercise and muscle strengthening (children age 6-17)^	2015		LAC	17.7%	**16.4%**	**16.4%**	**16.9%**	
Percent of adults who use walking paths, parks, playgrounds, or sports fields in their neighborhood^	2015		LAC	47.5%	**45.3%**	**46.8%**	**43.5%**	
Rate of open space per 10,000 children 0-5 years old†	2013		CA	259.1	**1.3**	**0.4**	**0.2**	
Poverty (including unemployment)								*
Percent of families living below poverty†	2016		LAC	14.9%	**27.2%**	**25.0%**	**28.2%**	
Percent of families with children living below poverty†	2016		LAC	11.5%	**21.5%**	**18.8%**	**22.9%**	
Percent of Civilians (Age 15+) Unemployed*	2016		LAC	6.9%	**8.2%**	**8.0%**	**8.2%**	
Prenatal Care, Child and Maternal Health								
Prenatal care in the first trimester	2012	77.90%	LAC	81.9%	-	**79.3%**	-	
Low birth weight	2012		CA	5.6%	-	**6.1%**	-	
Breastfeeding at least 6 months	2015	>=60.6%	LAC	49.7%	-	**57.9%**	-	
Preventative Care								*
Percent of adults (18+ years old) who reported seeing a doctor, nurse or other health care professional (HCP) for any reason in the past year^	2015		LAC	70.7%	**65.5%**	**64.7%**	**66.0%**	
Percent of women that had a cervical cancer screening in the last 3 years^	2015	<=93%	LAC	84.4%	**78.8%**	**79.5%**	**81.9%**	
Percent of women that had a mammogram in the last 2 years^	2015	<=81.1%	LAC	77.3%	78.1%	78.3%	77.5%	
Transportation								*
Number of vehicles per household†	2016		LAC	1.8	**1.2**	**1.0**	**1.3**	
Average household size†	2016		LAC	3.0	2.7	2.1	2.9	
Percent of residents that car pooled, rode public transit, walked, biked, or other (minus "worked at home" and "drove alone")†	2016		LAC	22.3%	**38.7%**	**44.7%**	**37.5%**	
Violence/Injury								
Unintended injury mortality rate per 10,000 adults	2012		CA	2.8	2.1	2.6	1.9	
Percent of adults 18 and older who perceive their neighborhood to be safe from crime^	2015		LAC	84.0%	**64.3%**	**68.1%**	**58.4%**	

Footnotes:
* = Denotes that a participant identified the health outcome or driver during the stakeholder input process.

California Hospital Medical Center Service Area:
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)

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)
90057 (Westlake, SPA 4)

Appendix B— Primary Data Gathering Tools

Metro Collaborative
Community Health Needs Assessment 2016
Focus Group Protocol

Guiding Questions

1. What do you consider to be **important factors for a healthy community**?
2. What do you think are the **most important health problems or needs** in the community?
    a. **Why** most important (e.g., severity? Wide geographic impact?)
    b. Why is this a problem (***try to uncover drivers***)
3. Which **populations** (groups) or particular **neighborhoods within the community are most affected by these needs**, or where the needs are most acute or prevalent?
4. What kinds of **resources** exist to address these needs? What are particular strengths in Glendale that contribute to community health?
5. What kinds of **gaps in service** are you aware of?
6. What are the **major barriers and challenges for you, your family or friends** to staying healthy?
7. Can you provide us with suggestions about how to help people stay healthy?
8. What else is important for us to know about the community you serve?

Metro Collaborative
Community Health Needs Assessment 2016
Individual Interview Protocol

Introduction:

The Center for Nonprofit Management is working with **Good Samaritan Hospital, St. Vincent, and CA Hospital Med Center** to conduct their 2016 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 **the three medical centers** better serve their community. The information you provide is confidential and will not be associated with your name and will only be reported in an aggregated manner.

Familiarity with Medical Center:
Area of Expertise:
Primary Service Area:
Primary Population Served:

COMMUNITY HEALTH NEEDS AND ASSOCIATED DRIVERS

1. What are some of the **major health issues** affecting individuals in the community?

Health Issues	Sub-Populations/ Geography	Better/Worse?

2. What are the most important factors **(socio-economic, behavioral, environmental or clinical factors)** contributing to poor health in the community?

Factors	Sub-Populations/ Geography	Areas in the Community

COMMUNITY ASSETS

3. Where do **community members go** if they have chronic health issues? **Ask by issue**

4. What other **health or social services are available (including mental health care)** in your local community?

    a. **Where** do community members go to receive or obtain information on health-related services?

ACCESS TO CARE

5. What health or social services are **most difficult to access or are missing** in the community? ***(DO NOT SAY ALOUD: This could include access to medical care that is affordable or free, health education workshops, dental care, vision care, substance abuse services, mental health care, etc.)***
    a. Are there specific **factors (socio-economic, behavioral, environmental or clinical factors)** that contribute to this?

    b. Does this affect certain **sub-populations** more than others? Which?

6. In your experience, what are the most **effective program/service delivery models** for addressing:
    a. Health issues? ***(refer to the issues identified in question 1)***

    b. Socio-economic factors (i.e. transportation, language barriers, poverty, etc.)? ***(refer to the issues identified in question 2)***

7. How has the **Affordable Care Act (ACA)** impacted your community members' ability to access care and other services?

COLLABORATION

8. In the last few years, have you noticed any **changes in the way that providers work together** in terms of service coordination, etc.?
    a. Do you feel that access to services/care coordination has improved? Please provide examples.

9. Do you see any potential areas for **collaboration or coordination** between hospitals, community organizations, and/or businesses (i.e. health or social providers, local government, etc.)?

COMMUNICATION

10. What would be the best way to share the findings of this **community health needs assessment**?

11. What would be the most efficient **ways to provide information** to community members about the availability of health and other services?

a. Is there a **particular message** that would appeal to community members?

12. Is there **anything else** you would like to add?

RANKING OF HEALTH NEEDS AND FACTORS/DRIVERS OF HEALTH

13. Of the health issues and contributing factors you mentioned, how would you **rank each health issue and factor** on a scale of 1 to 5 according to severity where 1 is least severe and 5 is most severe?

Appendix C—Stakeholders

Last Name	First Name	Organization	Focus Group Participation	Prioritization Forum Participation
Aguas	Veronica	Good Samaritan Diabetes Class	8/16/2016	
Aguilar	Leslie	CHMC Cardiovascular Health Class	8/30/2016	
Andres Taylor	Coralyn	Good Samaritan Hospital		8/26/2016
Arevalo	Yadira	ECHC		8/26/2016
Bada	Katrina	Good Samaritan Hospital		8/26/2016
Boller	Robert	Project Angel Food		8/26/2016
Bonnot	Younger	Good Samaritan Diabetes Class	8/16/2016	
Boston, BS, CTR	Rosemary	Good Samaritan Hospital		8/26/2016
Carmona	Cynthia	Community Clinic Association of LA County		8/26/2016
Da Costa	Brenda	St. Vincent		8/26/2016
Duncan	Laura	Ascencia		8/26/2016
Estrada	Rossana	Herman Ostrow School of Dentistry of USC		8/26/2016
Flores	Erika	Good Samaritan Diabetes Class	8/16/2016	
Gonzalez	Pedro	CHMC Cardiovascular Health Class	8/30/2016	
Goraa	Ena	CHMC Cardiovascular Health Class	8/30/1026	
Gorman	Dale	Kids' Community Clinic of Burbank		8/26/2016
Jones	Pat	Good Samaritan Diabetes Class	8/16/2016	
Kersey	Lynn	Maternal and Child Health Access		8/26/2016
Kim	Jane	KYCC		8/26/2016
King	Janet	Good Samaritan Diabetes Class	8/16/2016	
Kothasi	Prabba	Good Samaritan Diabetes Class	8/16/2016	

Last Name	First Name	Organization	Focus Group Participation	Prioritization Forum Participation
Kotick	John	St. Barnanas Senior Services		8/26/2016
Lewis	Irene	Salvation Army Los Angeles Ridge Shield		8/26/2016
Lopez	Mari	Vision y Compromiso		8/26/2016
Male	Kristyn	Eisner Pediatric & Family Medical Center		8/26/2016
Nathason	Niel	USC Community Health Programs		8/26/2016
Olan	Orlando	Assure Wellness		8/26/2016
Ortiz	Marisol	CHMC Cardiovascular Health Class	8/30/2016	
Ortiz	Rosalia	CHMC Cardiovascular Health Class	8/30/2016	
Parker-Staojakovich	Carol	Herman Ostrow School of Dentistry of USC		8/26/2016
Perez	Cira	CHMC Cardiovascular Health Class	8/30/2016	
Pinto	Diana	South Central LAMP		8/26/2016
Segovia	Sherrie	Hope Street Family Center		8/26/2016
Shelley	Kimevette	Good Samaritan Diabetes Class	8/16/2016	
Sierra	Malka	American Heart Association		8/26/2016
Skylar	Lana	Dept. of Public Health, Service Planning Areas 3 & 4		8/26/2016
Thorne	Brian	Good Samaritan Hospital	8/16/2016	8/26/2016
Townsend	Sharon	Glendale Healthy Kids		8/26/2016
Vasquez	Julia	CHMC Cardiovascular Health Class	8/30/2016	
Velasquez	Gloria	Los Angeles Unified School District		8/26/2016
Yatomi	Cynthia	Good Samaritan Diabetes Class	8/16/2016	
Yonekura	Dr. M. L.	California Hospital Medical Center		8/26/2016

Appendix D—Data Sources

Category	Indicator	Data Source	Geography	Benchmark
Demographic Overview	Estimated Population	Nielsen Claritas, 2016	ZIP Code	County Average
Demographic Overview	Gender	Nielsen Claritas, 2016	ZIP Code	County Average
Demographic Overview	Age Distribution	Nielsen Claritas, 2016	ZIP Code	County Average
Demographic Overview	Median and Average Age	Nielsen Claritas, 2016	ZIP Code	County Average
Demographic Overview	Educational Attainment	Nielsen Claritas, 2016	ZIP Code	County Average
Demographic Overview	Language Spoken at Home	Nielsen Claritas, 2016	ZIP Code	County Average
Demographic Overview	Marital Status	Nielsen Claritas, 2016	ZIP Code	County Average
Demographic Overview	Household Income	Nielsen Claritas, 2016	ZIP Code	County Average
Natality	Births	California Department of Public Health, 2012	ZIP Code	State Total
Natality	Births by Mother's Age	California Department of Public Health, 2012	ZIP Code	County Average
Natality	Births by Mother's Ethnicity	California Department of Public Health, 2012	ZIP Code	County Average
Natality	Birth Weight	California Department of Public Health, 2012	ZIP Code	County Average
Natality	Breastfeeding at Least 6 Months	Los Angeles County Health Survey, 2015	SPA Level	County Average
Natality	Breastfeeding at Least 12 Months	Los Angeles County Health Survey, 2015	SPA Level	County Average
Disability	Disability Status Due To Physical, Mental Or Emotional Condition, Adults	California Health Interview Survey, 2014	SPA Level	County Average

Category	Indicator	Data Source	Geography	Benchmark
Disability	Adults Who Have Provided Care or Assistance to Another Adult In The Past Month	Los Angeles County Health Survey, 2011	SPA Level	County Average
Disability	Children 0–17 Years old with Special Health Care Needs	Los Angeles County Health Survey, 2015	SPA Level	County Average
Disability	Children 0 to 17 Years old with Special Health Care Needs by Age	Los Angeles County Health Survey, 2015	County Average	County Average
Disability	Children 0 to 17 Years old with Special Health Care Needs by Ethnicity	Los Angeles County Health Survey, 2015	County Average	County Average
Mortality	Total Deaths	California Department of Public Health (CDPH), 2010	ZIP Code	County Average
Mortality	Total Deaths, by Age Group	California Department of Public Health (CDPH), 2010, 2012	ZIP Code	County Average
Mortality	Total Deaths, by Cause	California Department of Public Health (CDPH), 2010, 2012	ZIP Code	County Average
Access to Healthcare	Medical and Medicare Beneficiaries	Managed Risk Medical Insurance Board, 2012	SPA Level	County Average
Access to Healthcare	Medi-Cal Enrollment	California Department of Health Care Services (DHCS), 2011	ZIP Code	County Average
Access to Healthcare	Healthy Families Enrollment	California Department of Health Care Services (DHCS), 2012	ZIP Code	County Average
Access to Healthcare	Federally Qualified Health Centers	U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), 2012	SPA Level	County Average
Access to Healthcare	Uninsured Adults	Los Angeles County Health Survey, 2014	SPA Level	County Average

Category	Indicator	Data Source	Geography	Benchmark
Access to Healthcare	Uninsured Children	Los Angeles County Health Survey, 2011	SPA Level	County Average
Access to Healthcare	Uninsured Population	California Health Interview Survey, 2012	ZIP Level	County Average
Access to Healthcare	Lack of a Consistent Source of Primary Care for Adults	Los Angeles County Health Survey, 2015	SPA Level	County Average
Access to Healthcare	Difficulty Accessing Medical Care	Los Angeles County Health Survey, 2015	SPA Level	County Average
Access to Healthcare	Uninsured, by Age	American Community Survey, 2014	County Level	County Average
Alcohol and Substance Abuse and Tobacco Use	Adult Alcohol Use in the Past Month	Los Angeles County Health Survey, 2015	SPA Level	County Average
Alcohol and Substance Abuse and Tobacco Use	Number of Alcohol Outlets	California Department of Alcoholic Beverage Control (ABC), 2016	ZIP Code	County Average
Alcohol and Substance Abuse and Tobacco Use	Adults Who Reported Misusing Any Form of Prescription Drugs in the Past Year	Los Angeles County Health Survey, 2015	SPA Level	County Average
Alcohol and Substance Abuse and Tobacco Use	Adults Who Reported Using Any Form of Marijuana in the Past Year	Los Angeles County Health Survey, 2015	SPA Level	County Average
Alcohol and Substance Abuse and Tobacco Use	Teens Who Have Ever Tried Marijuana, Cocaine, Sniffing Glue, Other Drugs	Los Angeles County Health Survey, 2014	SPA Level	County Average
Alcohol and Substance Abuse and Tobacco Use	Needed or Wanted Treatment for Alcohol or Drug Issues in the Past Five Years	Los Angeles County Health Survey, 2011	SPA Level	County Average
Alcohol and Substance Abuse and Tobacco Use	Needed Help for Mental, Emotional, or Alcohol/Drug Issues	Los Angeles County Health Survey, 2011	SPA Level	County Average
Alcohol and Substance Abuse and Tobacco Use	Currently Smoking	Los Angeles County Health Survey, 2015	SPA Level	County Average
Alcohol and Substance Abuse and Tobacco Use	Tobacco Use by Age	Los Angeles County Health Survey, 2015	County Average	County Average

Category	Indicator	Data Source	Geography	Benchmark
Alcohol and Substance Abuse and Tobacco Use	Tobacco Use by Ethnicity	Los Angeles County Health Survey, 2015	County Average	County Average
Cancer	Top 10 Cancer Sites Rates	Centers for Disease Control, United States Cancer Statistics (USCS), 2013	County Average	County Average
Cancer	Volume of Cancer Surgeries Performed	Office of Statewide Health Planning and Development (OSHPD), 2014	Hospital Level	County Average
Cancer	Cervical cancer screening (pap smear) in last 3 years	Los Angeles County Health Survey, 2015	SPA Level	County Average
Cancer	Breast cancer screening (mammogram) in the last 2 years	Los Angeles County Health Survey, 2015	SPA Level	County Average
Cancer	Total Cancer-Related Deaths	California Department of Public Health, 2012	ZIP Code	State Average
Cardiovascular Disease	Heart Disease Prevalence	Los Angeles County Health Survey, 2014	SPA Level	County Average
Cardiovascular Disease	Heart Disease Management	Los Angeles County Health Survey, 2014	SPA Level	County Average
Cardiovascular Disease	Hospitalizations Resulting from Heart Failure	Office of Statewide Health Planning and Development (OSHPD), 2012	ZIP Code	County Average
Cardiovascular Disease	Heart Disease Mortality	California Department of Public Health (CDPH), 2012	ZIP Code	State Average
Cholesterol	Cholesterol Prevalence	Los Angeles County Health Survey, 2015	SPA Level	County Average
Cholesterol	Cholesterol Management	California Health Interview Survey, 2014	SPA Level	County Average
Hypertension	Hypertension Prevalence	Los Angeles County Health Survey, 2015	SPA Level	County Average
Hypertension	Hypertension Management	Los Angeles County Health Survey, 2014	SPA Level	County Average

Category	Indicator	Data Source	Geography	Benchmark
Hypertension	Essential Hypertension and Hypertensive Renal Disease Death Rate per 10,000 residents	California Department of Public Helath (CDPH)	ZIP Code	State Average
Hypertension	Hypertension Prevalence by Age	Los Angeles County Health Survey	SPA Level	County Average
Cultural and Linguistic Barriers	Language Spoken at Home	Nielsen Claritas, 2016	ZIP Code	County Average
Cultural and Linguistic Barriers	Difficulty Understanding Doctor	California Health Interview Survey, 2014	SPA Level	County Average
Diabetes	Diabetes Prevalence	Los Angeles County Health Survey, 2015	SPA Level	County Average
Diabetes	Diabetes Management	California Health Interview Survey, 2014	SPA Level	County Average
Diabetes	Diabetes Hospitalizations (Youth)	Office of Statewide Health Planning and Development (OSHPD), 2012	ZIP Code	State Average
Diabetes	Diabetes Hospitalizations (Adults)	Office of Statewide Health Planning and Development (OSHPD), 2012	ZIP Code	State Average
Diabetes	Hospitalizations Resulting from Uncontrolled Diabetes	Office of Statewide Health Planning and Development (OSHPD), 2012	ZIP Code	State Average
Diabetes	Diabetes Mortality	California Department of Public Health (CDPH), 2012	ZIP Code	State Average
Diabetes	Diabetes Prevalence by Age	Los Angeles County Health Survey, 2015	County Average	County Average
Diabetes	Diabetes Prevalence by Ethnicity	Los Angeles County Health Survey, 2015	County Average	County Average
Food Insecurity	Households with Incomes <300% Who are Food Insecure	Los Angeles County Health Survey, 2015	SPA Level	County Average
Healthy Behavior (Including Physical Activity)	Physically Active at Least One Hour Each Day in Last Week (Children)	California Health Interview Survey, 2014	SPA Level	County Average

Category	Indicator	Data Source	Geography	Benchmark
Healthy Behavior (Including Physical Activity)	Physically Active at Least One Hour Each Day in Last Week (Teens)	California Health Interview Survey, 2014	SPA Level	County Average
Healthy Behavior (Including Physical Activity)	Ate Five or More Servings of Fruits and Vegetables in Past Day (Children)	California Health Interview Survey, 2012	SPA Level	County Average
Healthy Behavior (Including Physical Activity)	Ate Five or More Servings of Fruits and Vegetables in Past Day (Teens)	California Health Interview Survey, 2012	SPA Level	County Average
Healthy Behavior (Including Physical Activity)	Ate Five or More Servings of Fruits and Vegetables in Past Day (Adults)	California Health Interview Survey, 2012	SPA Level	County Average
Healthy Behavior (Including Physical Activity)	Obtained Recommended Amount of Aerobic Exercise and Muscle-Strengthening (Children and Teens)	California Health Interview Survey, 2014	SPA Level	County Average
Healthy Behavior (Including Physical Activity)	Obtained Recommended Amount of Aerobic Exercise and Muscle-Strengthening (Adults)	California Health Interview Survey, 2014	SPA Level	County Average
Homelessness and Housing	Total Homeless	Los Angeles Homeless Services Authority, 2016	SPA Level	County Average
Homelessness and Housing	Homeless Individuals	Los Angeles Homeless Services Authority, 2016	SPA Level	County Average
Homelessness and Housing	Homeless Families	Los Angeles Homeless Services Authority, 2016	SPA Level	County Average
Homelessness and Housing	Homeless Unaccompanied Minors	Los Angeles Homeless Services Authority, 2016	SPA Level	County Average
Homelessness and Housing	Homeless Mentally Ill	Los Angeles Homeless Services Authority, 2016	SPA Level	County Average
Homelessness and Housing	Homeless With Substance Abuse Issues	Los Angeles Homeless Services Authority, 2016	SPA Level	County Average

Category	Indicator	Data Source	Geography	Benchmark
Homelessness and Housing	Homeless With HIV	Los Angeles Homeless Services Authority, 2016	SPA Level	County Average
Homelessness and Housing	Physically Disabled	Los Angeles Homeless Services Authority, 2016	SPA Level	County Average
Hypertension	Hypertension Prevalence	Los Angeles County Health Survey, 2015	County Average	County Average
Hypertension	High Blood Pressure Management	Los Angeles County Health Survey, 2015	County Average	County Average
Hypertension	Hypertension Mortality	California Department of Public Health, 2012	ZIP Code	County Average
Hypertension	Hypertension Prevalence by Age	Los Angeles County Health Survey, 2015	County Average	County Average
Hypertension	Hypertension Prevalence by Ethnicity	Los Angeles County Health Survey, 2015	County Average	County Average
Mental Health	Unhealthy Days Resulting from Poor Mental Health	Los Angeles County Health Survey, 2015	SPA Level	County Average
Mental Health	Adults with Serious Psychological Distress in the Last Year	California Health Interview Survey (CHIS), 2014	SPA Level	County Average
Mental Health	Adequate Social and Emotional Support	Los Angeles County Health Survey, 2015	SPA Level	County Average
Mental Health	Anxiety Prevalence	Los Angeles County Health Survey, 2011	SPA Level	County Average
Mental Health	Depression Prevalence	Los Angeles County Health Survey, 2015	SPA Level	County Average
Mental Health	Alcohol- and Drug-Induced Mental Illness Rate	Office of Statewide Health Planning and Development (OSHPD), 2012	ZIP Code	State Average
Mental Health	Needed Help for Mental, Emotional, or Alcohol/Drug Issues	Los Angeles County Health Survey, 2011	SPA Level	County Average
Mental Health	Mental Health Hospitalization Rate per 100,000 persons	Office of Statewide Health Planning and Development (OSHPD), 2012	ZIP Code	State Average
Mental Health	Suicide Rate	California Department of Public Health (CDPH), 2012	ZIP Code	State Average

Category	Indicator	Data Source	Geography	Benchmark
Mental Health	Depression Prevalence by Age	Los Angeles County Health Survey, 2015	County Average	County Average
Mental Health	Depression Prevalence by Ethnicity	Los Angeles County Health Survey, 2015	County Average	County Average
Obesity/Overweight	Overweight Adults (Age 18+)	Los Angeles County Health Survey, 2015	SPA Level	County Average
Obesity/Overweight	Obese Adults (Age 18+)	Los Angeles County Health Survey, 2015	SPA Level	County Average
Obesity/Overweight	Overweight or Obese Population (Age 12+)	California Health Interview Survey, 2012	SPA Level	County Average
Obesity/Overweight	Children Overweight for Age (Age 0-11)	California Health Interview Survey, 2012	SPA Level	County Average
Obesity/Overweight	Percent Overweight	California Health Interview Survey, 2009	ZIP Code	County Average
Obesity/Overweight	Percent Obese	California Health Interview Survey, 2009	ZIP Code	County Average
Obesity/Overweight	Overweight/Obesity Prevalence by Age	Los Angeles County Health Survey, 2015	County Level	County Average
Obesity/Overweight	Overweight/Obesity Prevalence by Ethnicity	Los Angeles County Health Survey, 2015	County Level	County Average
Oral Health	Absence of Dental Insurance Coverage, Adults	Los Angeles County Health Survey, 2011	SPA Level	County Average
Oral Health	Dentist Availability	Office of Statewide Health and Planning and Development (OSHPD), 2013	County Level	County Total
Oral Health	Unable to Afford Dental Care, Adult	Los Angeles County Health Survey, 2011	SPA Level	County Average
Oral Health	Unable to Afford Dental Care, Child	Los Angeles County Health Survey, 2015	SPA Level	County Average
Oral Health	Unable to Afford Dental Care by Age	Los Angeles County Health Survey, 2011	County Level	County Average
Oral Health	Unable to Afford Dental Care by Ethnicity, Adult	Los Angeles County Health Survey, 2011	County Level	County Average

Category	Indicator	Data Source	Geography	Benchmark
Oral Health	Unable to Afford Dental Care by Ethnicity, Child	Los Angeles County Health Survey, 2015	County Level	County Average
Poverty	Families at or Above Poverty	Nielsen Claritas, 2016	ZIP Code	County Average
Poverty	Families at or Above Poverty with Children	Nielsen Claritas, 2016	ZIP Code	County Average
Poverty	Families Below Poverty	Nielsen Claritas, 2016	ZIP Code	County Average
Poverty	Families Below Poverty with Children	Nielsen Claritas, 2016	ZIP Code	County Average
Poverty	Employment Status – In Armed Forces	Nielsen Claritas, 2016	ZIP Code	County Average
Poverty	Employment Status – Employed	Nielsen Claritas, 2016	ZIP Code	County Average
Poverty	Employment Status – Unemployed	Nielsen Claritas, 2016	ZIP Code	County Average
Poverty	Employment Status – Not in Labor Force	Nielsen Claritas, 2016	ZIP Code	County Average
Poverty	Children Eligible for Free or Reduced-Price Lunch	California Department of Education	County Level	State Average
Preventive Care	Saw Doctor, Nurse, or Other Health Care Professional in the Past Year	Los Angeles County Health Survey, 2015	SPA Level	County Average
Preventive Care	Saw Dentist or Visited Dental Clinic in the Past Year	Los Angeles County Health Survey, 2015	SPA Level	County Average
Preventive Care	Preventable Hospital Events Rate per 1,000 Population (18+)	California Office of Statewide Health Planning and Development, 2012	Zip Code	County Average
Preventive Care	Have Regular Source of Care Ethnicity	Los Angeles County Health Survey, 2015	SPA Level	County Average
Preventive Care	Have Regular Source of Care Age Group	Los Angeles County Health Survey, 2015	SPA Level	County Average
Sexual Health / Sexually Transmitted Diseases	HIV Incidence per 100,000	Los Angeles County Department of Public Health, 2013	ZIP Code	County Average

Category	Indicator	Data Source	Geography	Benchmark
Sexual Health / Sexually Transmitted Diseases	Syphilis Incidence per 100,000	Los Angeles County Department of Public Health, 2013	ZIP Code	County Average
Sexual Health / Sexually Transmitted Diseases	Chlamydia Incidence per 100,000	Los Angeles County Department of Public Health, 2013	ZIP Code	County Average
Sexual Health / Sexually Transmitted Diseases	Gonorrhea Incidence per 100,000	Los Angeles County Department of Public Health, 2013	ZIP Code	County Average
Transportation	Modes of Transportation	Nielson Claritas , 2015	Zip Code	County Average
Transportation	Average Vehicles Per Household	Nielson Claritas , 2015	Zip Code	County Average
Violence/Injury/Safety	Preventable Hospitalization Rates (Under 18)	California Department of Public Health, 2012	Zip Code	State Average
Violence/Injury/Safety	Unintentional Injuries Mortality Rate	California Department of Public Health, 2012	Zip Code	State Average
Violence/Injury/Safety	Received threats of violence or physical harm from peers in past year	California Health interview Survey, 2012, SPA	SPA Level	State Average
Violence/Injury/Safety	Feared of being attacked at school in the past year	California Health interview Survey, 2012, SPA	SPA Level	State Average
Violence/Injury/Safety	Felt unsafe in nearby park or playground during the day	California Health interview Survey, 2014, SPA	SPA Level	State Average

Appendix E—Local Community Assets

ZIP Code	Dominant Health Center, 2015
90001	CENTRAL CITY COMMUNITY HEALTH CENTER, INC.
90002	WATTS HEALTHCARE CORPORATION
90003	ST. JOHNS WELL CHILD & FAMILY CENTER
90004	QUEENSCARE HEALTH CENTERS
90005	KOREAN HEALTH, EDUCATION, INFORMATION AND RESEARCH CENTER
90006	ST. JOHNS WELL CHILD & FAMILY CENTER
90007	ST. JOHNS WELL CHILD & FAMILY CENTER
90008	T.H.E. CLINIC, INC.
90010	KOREAN HEALTH, EDUCATION, INFORMATION AND RESEARCH CENTER
90011	SOUTH CENTRAL FAMILY HEALTH CENTER
90012	CHINATOWN SERVICE CENTER
90013	NORTHEAST VALLEY HEALTH CORPORATION
90014	JWCH INSTITUTE, INC.
90015	EISNER PEDIATRIC & FAMILY MEDICAL CENTER
90016	BENEVOLENCE INDUSTRIES INCORPORATED
90017	ARROYO VISTA FAMILY HEALTH FOUNDATION
90018	NORTHEAST COMMUNITY CLINIC, INC
90019	EISNER PEDIATRIC & FAMILY MEDICAL CENTER
90020	KOREAN HEALTH, EDUCATION, INFORMATION AND RESEARCH CENTER
90021	NORTHEAST VALLEY HEALTH CORPORATION
90026	QUEENSCARE HEALTH CENTERS
90027	ASIAN PACIFIC HEALTH CARE VENTURE
90028	ST ANTHONY MEDICAL CENTERS
90029	QUEENSCARE HEALTH CENTERS
90031	ARROYO VISTA FAMILY HEALTH FOUNDATION
90037	ST. JOHNS WELL CHILD & FAMILY CENTER
90043	ST. JOHNS WELL CHILD & FAMILY CENTER
90044	ST. JOHNS WELL CHILD & FAMILY CENTER
90046	LOS ANGELES LGBT CENTER
90047	ST. JOHNS WELL CHILD & FAMILY CENTER
90057	CLINICA MONSENOR OSCAR A. ROMERO
90062	T.H.E. CLINIC, INC.
90071	SANTA CLARA VALLEY HEALTH AND HOSPITAL SYSTEM
90230	VENICE FAMILY CLINIC

Appendix F—Prioritization Survey

2016 Metro CHNA Prioritization Survey

The Center for Nonprofit Management (CNM) is conducting the 2016 Community Health Needs Assessment (CHNA) for the California Hospital Medical Center, Good Samaritan Hospital, and St. Vincent Medical Center and we need your help.

CNM talked to a variety of individuals from the community to obtain their input on important local and regional health issues, gaining valuable insights about communities served by the three hospitals. After reviewing this input, in conjunction with a range of health indicators from public and private data sources, the CNM evaluation team developed the following list of prominent health needs and drivers. Please note the health needs and drivers are listed in alphabetical order, and NOT by order of importance.

We now need your input to help prioritize these identified health needs and drivers and determine which in your opinion represent the areas of greatest need. The following confidential survey should take about 10 minutes to complete. When considering your responses, please keep your specific service area and community in mind. If you believe some pertinent issues in your community are not included in the survey, please let us know about these in the final section of the survey.

Please refer to the Community Health Needs Assessment Prioritization Criteria Scale when completing this survey. (In the interest of space, this scale is not included on each page of the survey.)

The results from this survey will inform the hospitals in developing strategies for their Community Benefits Plans.

Thank you very much for your time and assistance!

Please contact Maura Harrington at mharrington@cnmsocal.org with any questions about this survey. Or if you have technical issues, please contact Gigi Nang at gnang@cnmsocal.org.

2016 Metro CHNA Prioritization Survey

Please tell us about yourself (for analysis purposes).

Name

Organization

Email

- Please define your service area by selecting which hospital you mostly work with. (Select all that apply.)

☐ California Hospital Medical Center

☐ St. Vincent Medical Center

☐ Good Samaritan Hospital

2016 Metro CHNA Prioritization Survey

Identified Health Needs

Please refer to the Prioritization Criteria Scale when selecting your responses.

Cancer

	1	2	3	4	Don't know
SEVERITY- How severely does this health need impact the community?	○	○	○	○	○
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	○	○	○	○	○
RESOURCES - The availability of community resources and assets to address this health need.	○	○	○	○	○
DISPARITIES- Does the issue disproportionately affect vulnerable population groups?	○	○	○	○	○

Cardiovascular Disease

	1	2	3	4	Don't know
MAGNITUDE- Does the issue affect a large portion of the population?	○	○	○	○	○
SEVERITY- How severely does this health need impact the community?	○	○	○	○	○
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	○	○	○	○	○
RESOURCES - The availability of community resources and assets to address this health need.	○	○	○	○	○
DISPARITIES- Does the issue disproportionately affect vulnerable population groups?	○	○	○	○	○

Cholesterol

	1	2	3	4	Don't know
MAGNITUDE- Does the issue affect a large portion of the population?	○	○	○	○	○
SEVERITY- How severely does this health need impact the community?	○	○	○	○	○
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	○	○	○	○	○
RESOURCES - The availability of community resources and assets to address this health need.	○	○	○	○	○
DISPARITIES- Does the issue disproportionately affect vulnerable population groups?	○	○	○	○	○

Diabetes

	1	2	3	4	Don't know
MAGNITUDE- Does the issue affect a large portion of the population?	○	○	○	○	○
SEVERITY- How severely does this health need impact the community?	○	○	○	○	○
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	○	○	○	○	○
RESOURCES - The availability of community resources and assets to address this health need.	○	○	○	○	○
DISPARITIES- Does the issue disproportionately affect vulnerable population groups?	○	○	○	○	○

Hypertension

	1	2	3	4	Don't know
MAGNITUDE- Does the issue affect a large portion of the population?	○	○	○	○	○
SEVERITY- How severely does this health need impact the community?	○	○	○	○	○
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	○	○	○	○	○
RESOURCES - The availability of community resources and assets to address this health need.	○	○	○	○	○
DISPARITIES- Does the issue disproportionately affect vulnerable population groups?	○	○	○	○	○

Mental Health

	1	2	3	4	Don't know
MAGNITUDE- Does the issue affect a large portion of the population?	○	○	○	○	○
SEVERITY- How severely does this health need impact the community?	○	○	○	○	○
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	○	○	○	○	○
RESOURCES - The availability of community resources and assets to address this health need.	○	○	○	○	○
DISPARITIES- Does the issue disproportionately affect vulnerable population groups?	○	○	○	○	○

Obesity/Overweight

	1	2	3	4	Don't know
MAGNITUDE- Does the issue affect a large portion of the population?	○	○	○	○	○
SEVERITY- How severely does this health need impact the community?	○	○	○	○	○
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	○	○	○	○	○
RESOURCES - The availability of community resources and assets to address this health need.	○	○	○	○	○
DISPARITIES- Does the issue disproportionately affect vulnerable population groups?	○	○	○	○	○

Oral Health

	1	2	3	4	Don't know
MAGNITUDE- Does the issue affect a large portion of the population?	○	○	○	○	○
SEVERITY- How severely does this health need impact the community?	○	○	○	○	○
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	○	○	○	○	○
RESOURCES - The availability of community resources and assets to address this health need.	○	○	○	○	○
DISPARITIES- Does the issue disproportionately affect vulnerable population groups?	○	○	○	○	○

Sexually Transmitted Diseases

	1	2	3	4	Don't know
MAGNITUDE- Does the issue affect a large portion of the population?	○	○	○	○	○
SEVERITY- How severely does this health need impact the community?	○	○	○	○	○
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	○	○	○	○	○
RESOURCES - The availability of community resources and assets to address this health need.	○	○	○	○	○
DISPARITIES- Does the issue disproportionately affect vulnerable population groups?	○	○	○	○	○

2016 Metro CHNA Prioritization Survey

Drivers of Health

Please refer to the Prioritization Criteria Scale when selecting your responses.

Access to Care

	1	2	3	4	Don't know
MAGNITUDE- Does the issue affect a large portion of the population?	○	○	○	○	○
SEVERITY- How severely does this health need impact the community?	○	○	○	○	○
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	○	○	○	○	○
RESOURCES - The availability of community resources and assets to address this health need.	○	○	○	○	○
DISPARITIES- Does the issue disproportionately affect vulnerable population groups?	○	○	○	○	○

Alcohol, Substance Abuse and Tobacco Use

	1	2	3	4	Don't know
MAGNITUDE- Does the issue affect a large portion of the population?	○	○	○	○	○
SEVERITY- How severely does this health need impact the community?	○	○	○	○	○
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	○	○	○	○	○
RESOURCES - The availability of community resources and assets to address this health need.	○	○	○	○	○
DISPARITIES- Does the issue disproportionately affect vulnerable population groups?	○	○	○	○	○

Cultural and Linguistic Barriers

	1	2	3	4	Don't know
MAGNITUDE- Does the issue affect a large portion of the population?	○	○	○	○	○
SEVERITY- How severely does this health need impact the community?	○	○	○	○	○
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	○	○	○	○	○
RESOURCES - The availability of community resources and assets to address this health need.	○	○	○	○	○
DISPARITIES- Does the issue disproportionately affect vulnerable population groups?	○	○	○	○	○

Food Insecurity

	1	2	3	4	Don't know
MAGNITUDE- Does the issue affect a large portion of the population?	○	○	○	○	○
SEVERITY- How severely does this health need impact the community?	○	○	○	○	○
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	○	○	○	○	○
RESOURCES - The availability of community resources and assets to address this health need.	○	○	○	○	○
DISPARITIES- Does the issue disproportionately affect vulnerable population groups?	○	○	○	○	○

Healthy Behavior

	1	2	3	4	Don't know
MAGNITUDE- Does the issue affect a large portion of the population?	○	○	○	○	○
SEVERITY- How severely does this health need impact the community?	○	○	○	○	○
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	○	○	○	○	○
RESOURCES - The availability of community resources and assets to address this health need.	○	○	○	○	○
DISPARITIES- Does the issue disproportionately affect vulnerable population groups?	○	○	○	○	○

Homelessness

	1	2	3	4	Don't know
MAGNITUDE- Does the issue affect a large portion of the population?	○	○	○	○	○
SEVERITY- How severely does this health need impact the community?	○	○	○	○	○
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	○	○	○	○	○
RESOURCES - The availability of community resources and assets to address this health need.	○	○	○	○	○
DISPARITIES- Does the issue disproportionately affect vulnerable population groups?	○	○	○	○	○

Physical Activity

	1	2	3	4	Don't know
MAGNITUDE- Does the issue affect a large portion of the population?	○	○	○	○	○
SEVERITY- How severely does this health need impact the community?	○	○	○	○	○
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	○	○	○	○	○
RESOURCES - The availability of community resources and assets to address this health need.	○	○	○	○	○
DISPARITIES- Does the issue disproportionately affect vulnerable population groups?	○	○	○	○	○

Preventive Care

	1	2	3	4	Don't know
MAGNITUDE- Does the issue affect a large portion of the population?	○	○	○	○	○
SEVERITY- How severely does this health need impact the community?	○	○	○	○	○
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	○	○	○	○	○
RESOURCES - The availability of community resources and assets to address this health need.	○	○	○	○	○
DISPARITIES- Does the issue disproportionately affect vulnerable population groups?	○	○	○	○	○

Poverty (including unemployment)

	1	2	3	4	Don't know
MAGNITUDE- Does the issue affect a large portion of the population?	○	○	○	○	○
SEVERITY- How severely does this health need impact the community?	○	○	○	○	○
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	○	○	○	○	○
RESOURCES - The availability of community resources and assets to address this health need.	○	○	○	○	○
DISPARITIES- Does the issue disproportionately affect vulnerable population groups?	○	○	○	○	○

Transportation

	1	2	3	4	Don't know
MAGNITUDE- Does the issue affect a large portion of the population?	○	○	○	○	○
SEVERITY- How severely does this health need impact the community?	○	○	○	○	○
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	○	○	○	○	○
RESOURCES - The availability of community resources and assets to address this health need.	○	○	○	○	○
DISPARITIES- Does the issue disproportionately affect vulnerable population groups?	○	○	○	○	○

Violence and Injury

	1	2	3	4	Don't know
MAGNITUDE- Does the issue affect a large portion of the population?	○	○	○	○	○
SEVERITY- How severely does this health need impact the community?	○	○	○	○	○
CHANGE OVER TIME - Has the health need improved or is it getting worse over time?	○	○	○	○	○
RESOURCES - The availability of community resources and assets to address this health need.	○	○	○	○	○
DISPARITIES- Does the issue disproportionately affect vulnerable population groups?	○	○	○	○	○

Are there any health needs or drivers you feel have been overlooked that need to be represented? (Please remark on the severity, change over time, resources, and community readiness to support as it relates to this need or driver.)

Health Need or Driver:

Health Need or Driver:

Thank you for your participation in the 2016 Community Health Needs Assessment.

Appendix G—Health Need Profiles

Summary

As mentioned in the introduction to this report, the hospitals included in the Metro Hospital Collaborative (St. Vincent, California Hospital Medical Center and Good Samaritan) worked together to develop the Community Health Needs Assessment (CHNA). The following Health Needs Profile section reports on key health needs indicators for the three hospitals' service areas. The Health Needs Profiles are designed to provide a quick look at health drivers and outcomes in the combined service areas of the Metro Hospital Collaborative. The introductory tables in **Section A** summarize data that can be found in detail in **Section B**.

Joint Service Area Key Statistics

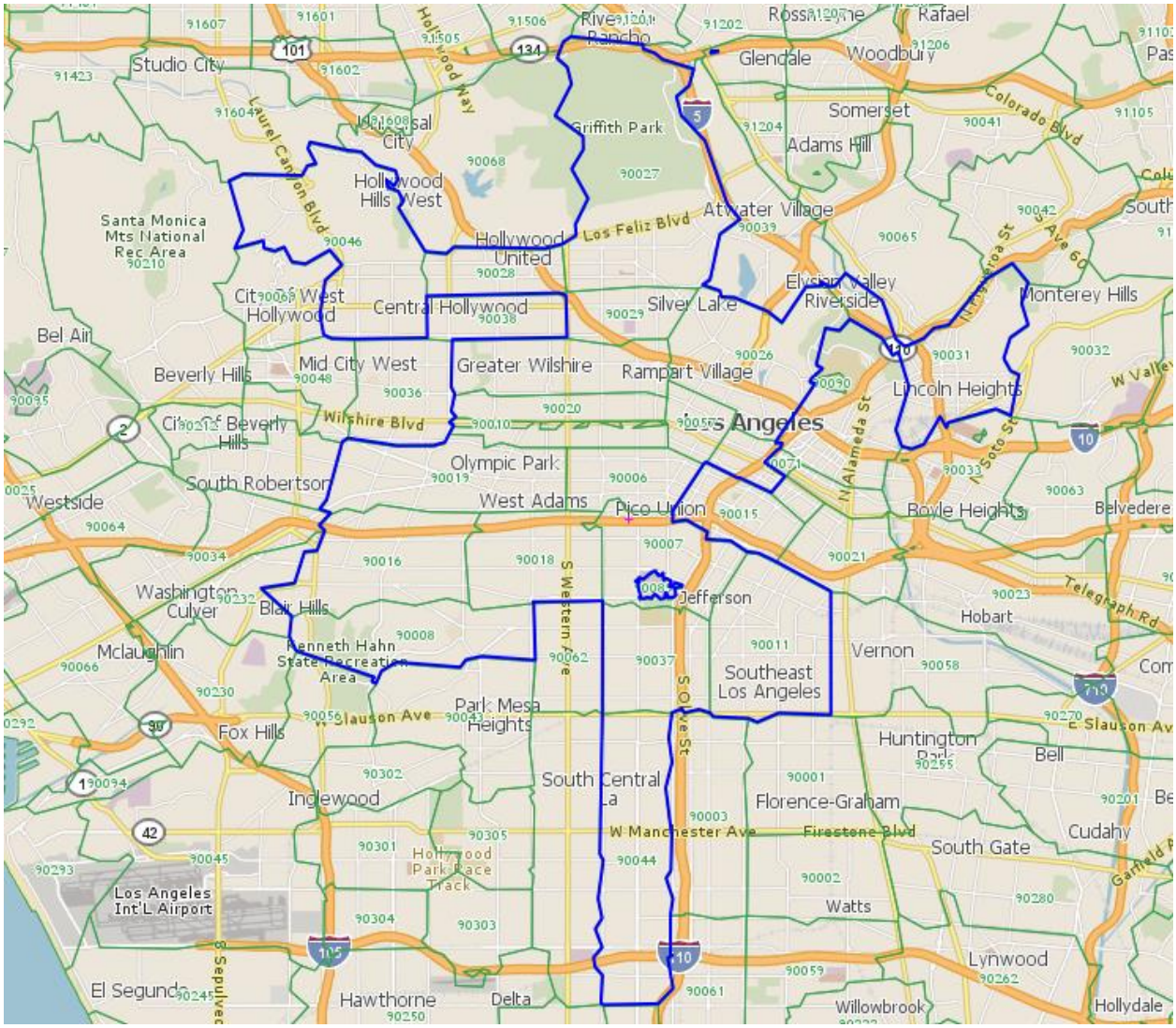
					
43-49% are between 18-44 years old*	**52-62%** of service area population is Hispanic/Latino	**65-67%** have limited English proficiency	**33-36%** 25+ don't have a high school diploma	**7-8%** of individuals were unemployed in 2015 (rate=8.6)	**25-27%** of families live below poverty

***Reflects largest age group of the service area population**

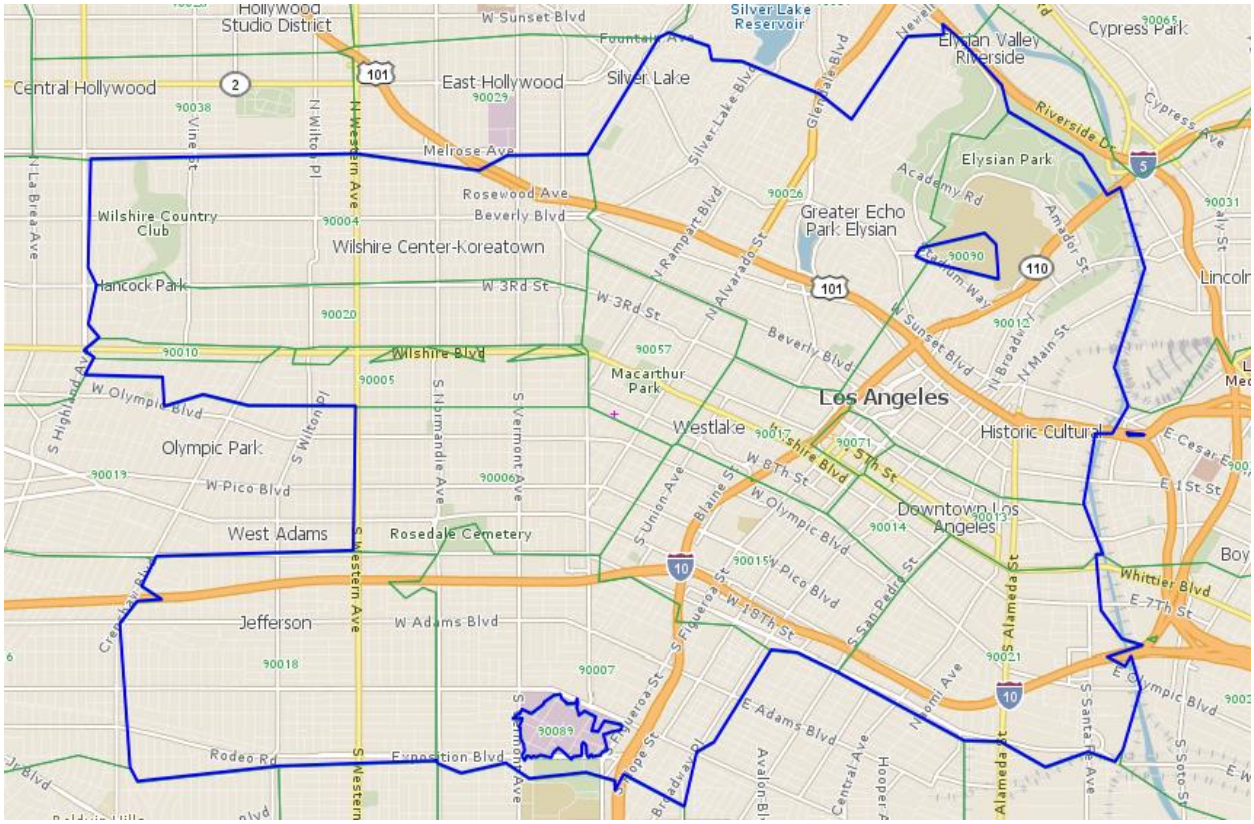
					
48-70 HIV Incidence (per 100,000)	**11-12%** Diabetes (Adult)	**22-23%** Hypertension	**13-15%** Mental Health (Depression)	**19-21%** of teens feared being attacked at school in the past year	**20-26%** of teens have ever tried marijuana, cocaine, sniffing glue, or other drugs

St. Vincent Service Area

California Hospital Medical Center Service Area



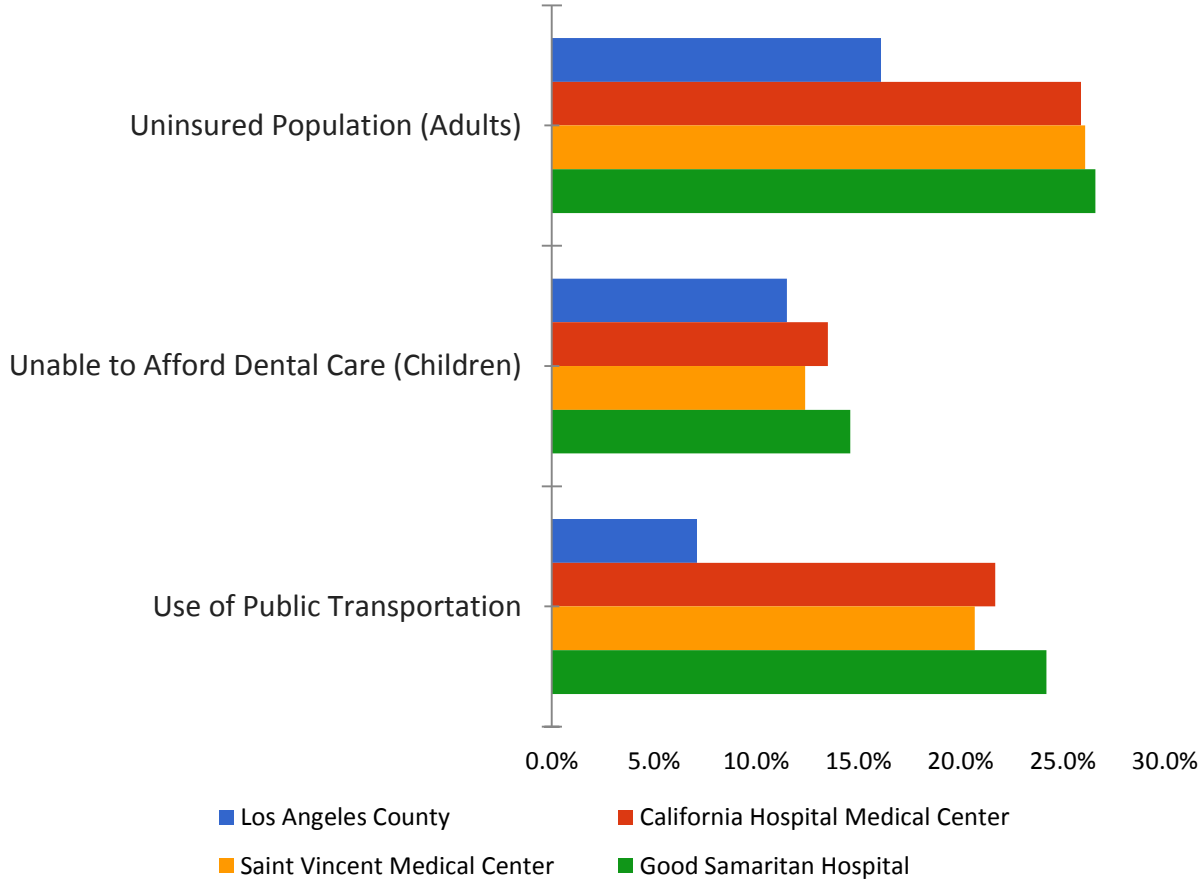
Good Samaritan Service Area



Section A - Key Indicators

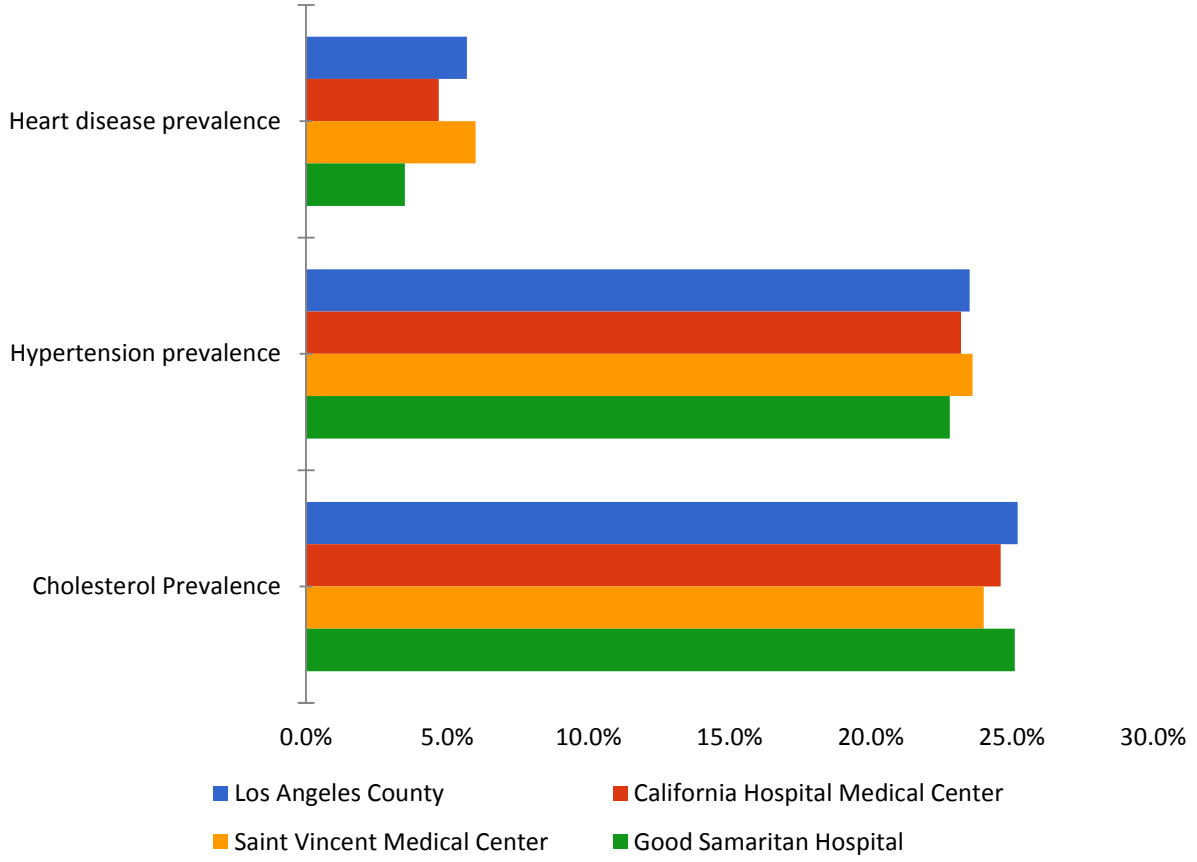
Access to Health Care

- More than one out of four residents of the Metro Hospital Collaborative joint service area are uninsured
- More than one in ten residents struggle to afford dental care
- Nearly one in four residents rely on public transportation to get around
- These rates are higher than the average for Los Angeles County



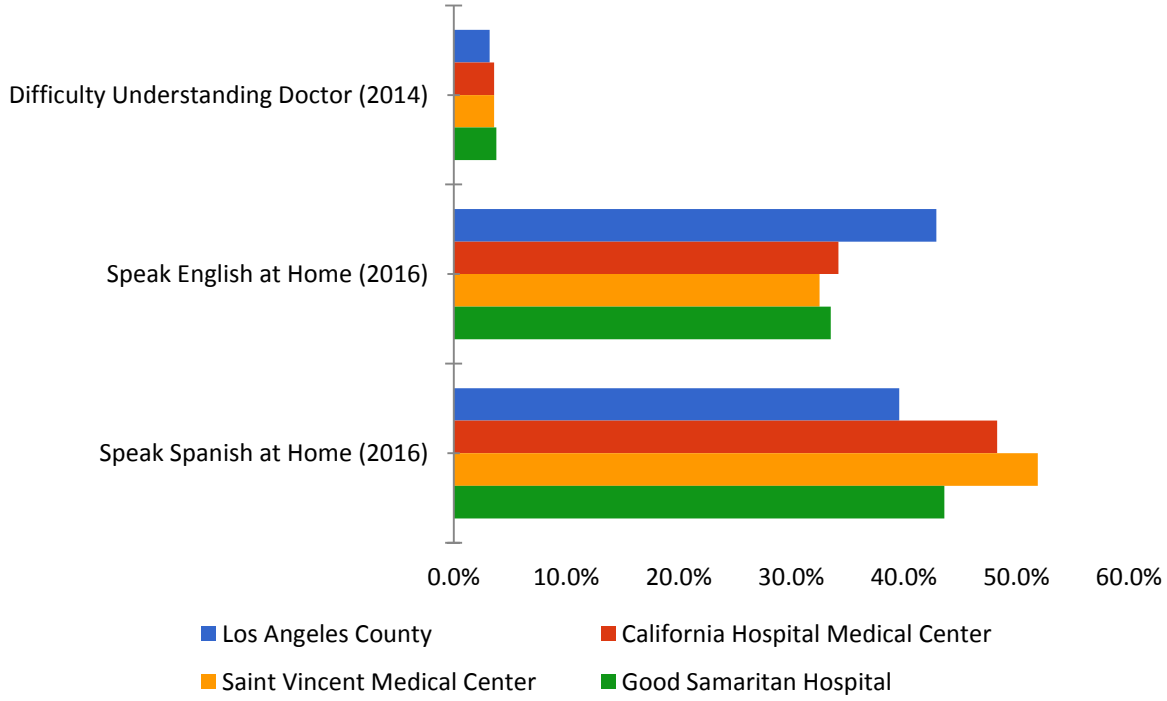
Cardiovascular Disease

- Nearly one in twenty residents of the joint service area have been diagnosed with heart disease
- Nearly one in four residents have been diagnosed with hypertension
- Nearly one in four residents have been diagnosed with high cholesterol
- These rates are below or equivalent to the average for Los Angeles County



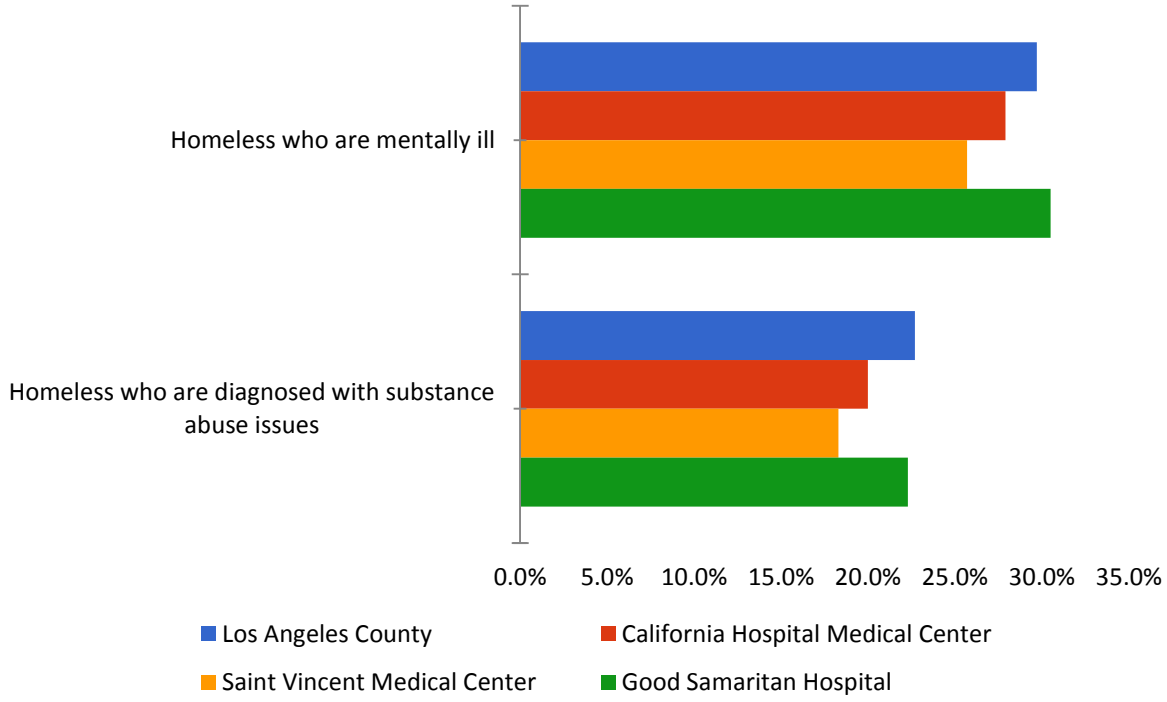
Cultural and Linguistic Barriers

- Nearly one in twenty residents of the joint service area have difficulty understanding their doctor
- While almost half the residents of Los Angeles County speak English at home, only one third of joint service area residents speak English at home
- Spanish is spoken in fifty percent or more of the homes in the joint service area where a language other than English is spoken



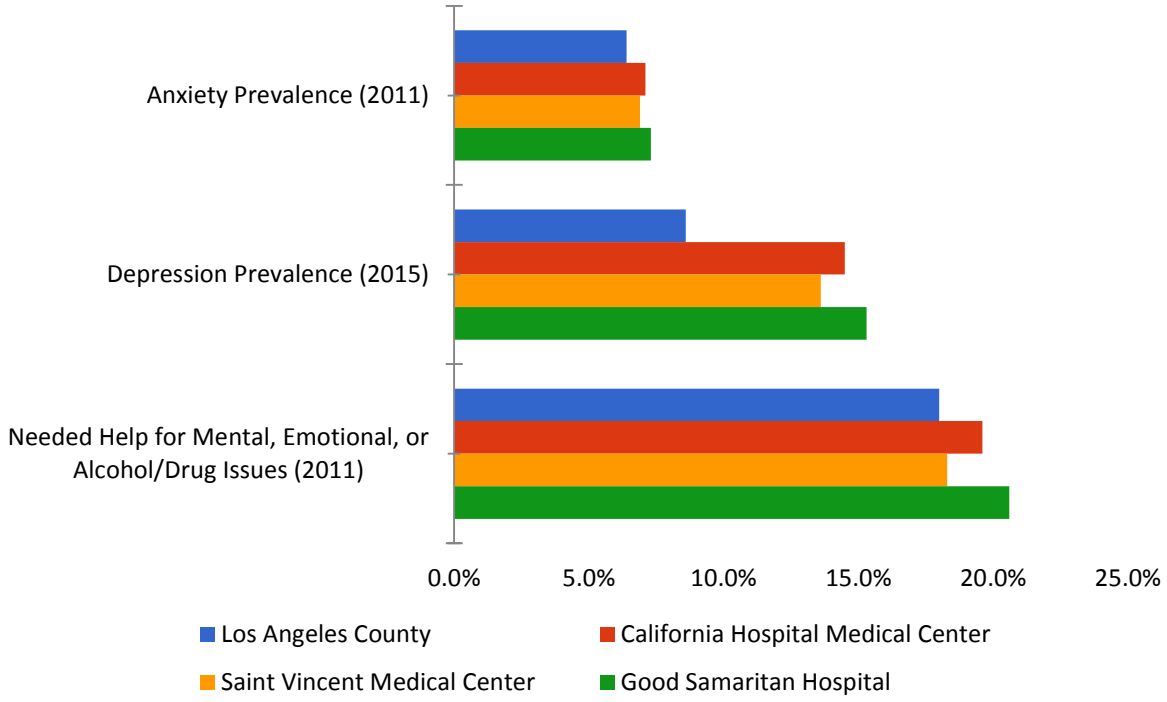
Homelessness

- Nearly one third of the homeless population in the joint service area have been diagnosed with a mental illness
- More than one in five homeless individuals in the joint service area have been diagnosed with a substance abuse issue



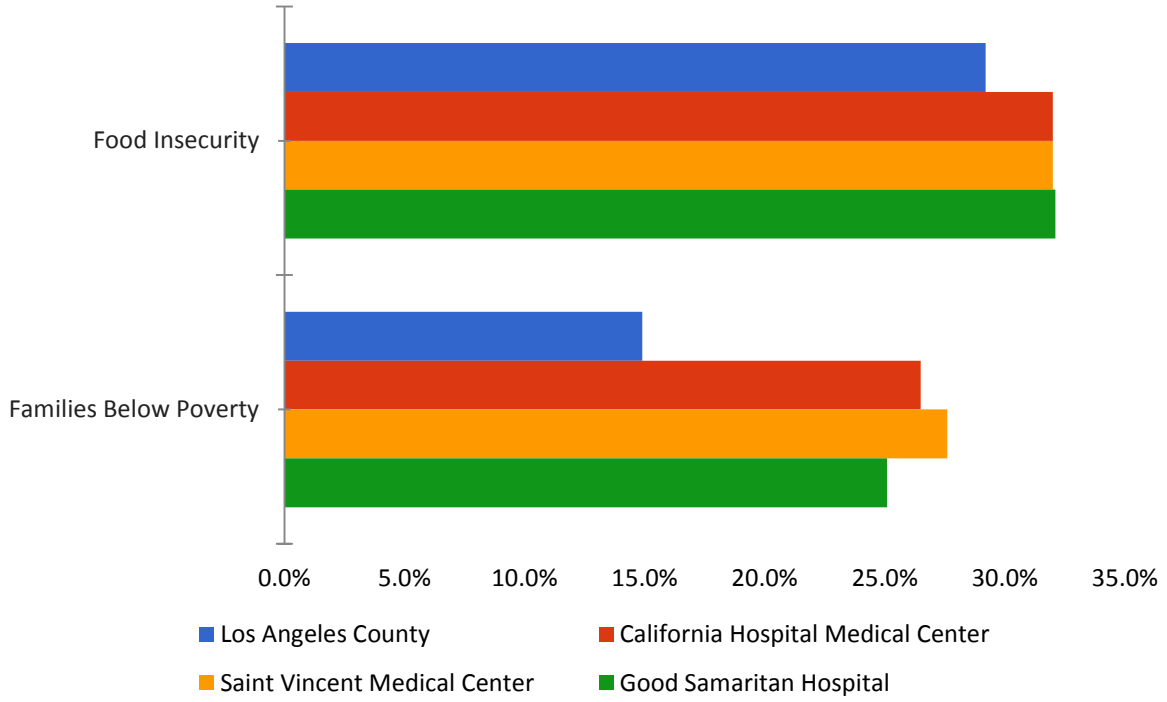
Mental Health

- A much greater proportion (15-17%) of residents in the joint service area were diagnosed with depression than in Los Angeles County (less than 10%).
- A greater proportion of the population in the joint service area needed help for mental, emotional or alcohol/drug issues than in Los Angeles County.



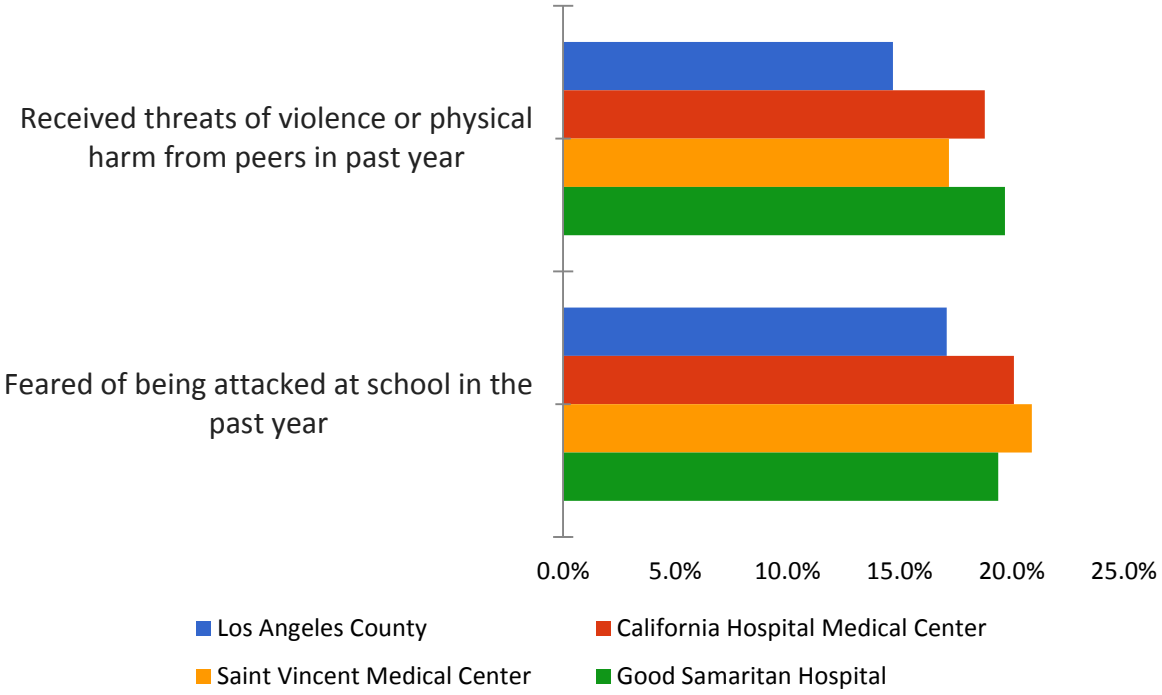
Poverty and Food Insecurity

- More than one in three families in the joint service area are food insecure.
- A much greater proportion of families in the joint service area (25.1% - 27.6%) are living below poverty than in Los Angeles County (14.9%).



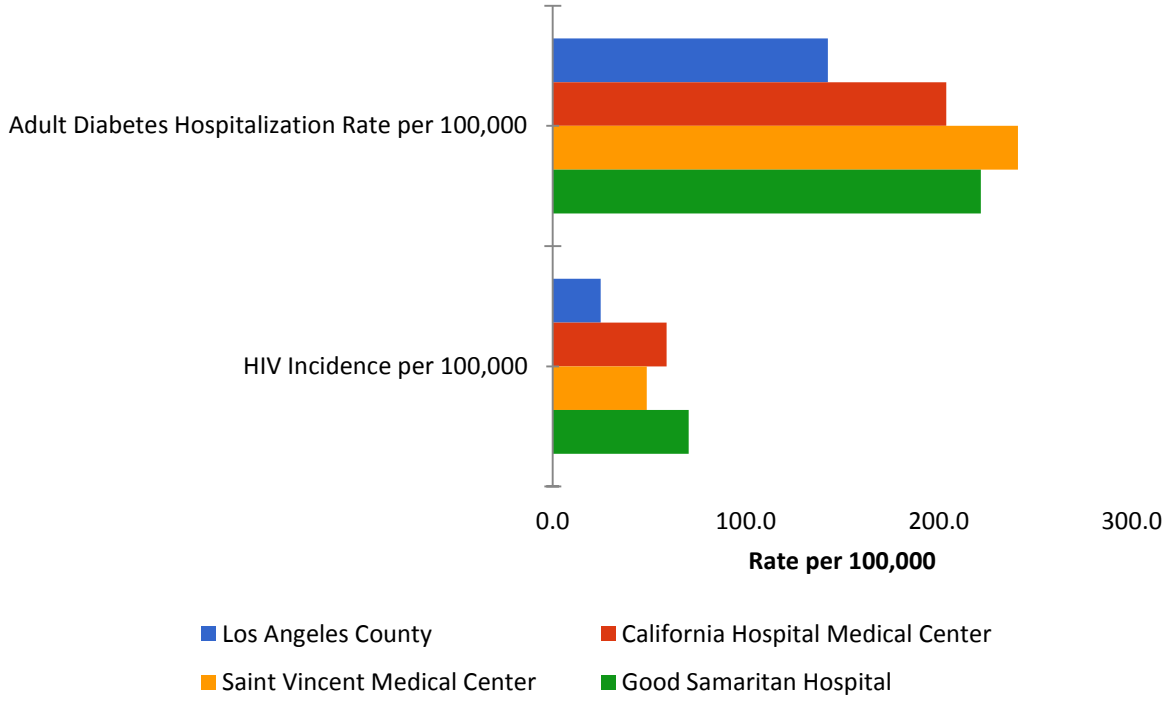
Teen Perceptions of Neighborhood and School Safety

- Nearly one in six teens surveyed in the joint service area received threats of violence or physical harm from peers, a higher proportion than in Los Angeles County .
- One in five teens in the joint service area feared being attacked at school in the past year, a higher proportion than in Los Angeles County.



Select Disease Rates

- Diabetes rates in the joint service area (203.9 to 241.1 per 100,000) are up to 70% higher than the rate in Los Angeles County (142.6 per 100,000).
- HIV Incidence in the joint service area (48.7 to 70.5 per 100,000) are up to 1.8 times higher than the incidence rate in Los Angeles County (24.9 per 100,000)..



Section B – In-depth Analysis

Access to Care (Health Care, Dental Care, and Preventive Health Care)

About Access to Health Care

Access to health care directly impacts the physical, social, and mental health status of patients. Further, the prevention of disease and disability, the detection and treatment of health conditions, quality of life, preventable death and life expectancy for individuals are all directly impacted by access to health care.[105]

Along with access to health care, following preventive practices such as having a regular source of care and timely physical and medical tests is important. Adequate, regular primary care can prevent the development of health problems and maintain positive health conditions.

[105] 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 [August 1, 2016].

Statistical data

Access to Healthcare, Dental Care and Preventive Wellness Indicators

Indicators	Year	Comparison		CHMC[1] Service Area	SVMC[2] Service Area	GSH[3] Service Area
		Level	Avg.			
Medicare Beneficiaries[1]	2012	LAC	1.4%	0.8%	0.8%	0.8%
Uninsured Adults[2]	2014	LAC	16.1%	25.9%	26.1%	26.6%
Uninsured Children[3]	2011	LAC	6.4%	5.4%	3.9%	5.1%
Percent of adults 18 and older who do not have dental insurance[1]	2011	LAC	51.8%	60.7%	60.6%	61.4%
Percent of adults 18 and older unable to obtain dental care, including check-ups, in the past year because of affordability[3]	2011	LAC	30.3%	35.9%	35.0%	37.1%
Percent of children (3–17 years old) who were unable to afford dental care and check-ups in the past year[3]	2015	LAC	11.5%	13.5%	12.4%	14.6%
Saw Doctor, Nurse, or Other Health Care Professional in the Past Year[4]	2015	LAC	70.7%	65.6%	66.0%	64.7%
Saw Dentist or Visited Dental Clinic in the Past Year[4]	2015	LAC	59.3%	54.5%	51.5%	56.7%
Physically Active at Least One Hour Each Day in Last Week (Children 0-11)[5]	2014	LAC	26.4%	25.2%	25.9%	24.9%
Physically Active at Least One Hour Each Day in Last Week (Teens 12-17)[5]	2014	LAC	12.3%	17.2%	17.4%	18.0%
Ate Five or More Servings of Fruits and Vegetables in Past Day(Children 0-11)[6]	2012	LAC	55.4%	57.9%	58.4%	55.6%
Ate Five or More Servings of Fruits and Vegetables in Past Day (Teens 12-17)[6]	2012	LAC	19.7%	11.8%	9.9%	13.5%
Ate Five or More Servings of Fruits and Vegetables in Past Day (Adults)[6]	2012	LAC	14.7%	15.9%	12.6%	14.8%
Ate Fast Food 2 or More Times in the Past Week (Children 0-11)[5]	2014	LAC	40.6%	37.7%	38.4%	36.5%
Ate Fast Food 2 or More Times in the Past Week (Teens 12-17)[5]	2014	LAC	49.7%	57.6%	58.7%	55.5%
Ate Fast Food 2 or More Times in the Past Week (Adults)[5]	2014	LAC	41.7%	44.1%	46.4%	41.7%
Drink at least one soda or sweetened beverage a day (Age 0-11)	2014	LAC	39.2%	35.5%	44.3%	36.5%
Average Weekly Soda Consumption (Adults) - More than 7x in a week	2014	LAC	10.2%	12.1%	13.3%	11.2%
Percent of residents that car pooled, rode public transit, walked, biked, or other (minus "worked at home" and "drove alone")[6]	2016	LAC	22.3%	38.7%	44.7%	37.5%

[1]Data source: Managed Risk Medical Insurance Board
Data year: 2012
Source geography: ZIP Code
[2]Data source: Los Angeles County Health Survey
Data year: 2011
Source geography: SPA
[3]Data source: Los Angeles County Health Survey
Data year: 2014
Source geography: SPA
LAC=Los Angeles County
CA=California
[1]Data source: Los Angeles County Health Survey
Data year: 2011
Source geography: SPA
Data source: Los Angeles County Health Survey
Data year: 2011
Source geography: SPA
[3]Data source: Los Angeles County Health Survey
Data year: 2015
Source geography: SPA
[4] Data Source: Los Angeles County Health Survey
Data Year: 2015
Source Geography: SPA
LAC=Los Angeles County
[6]Data Source: Nielson Claritas Demographic Data
Data Year: 2015
Source Geography: ZIP

Geographic areas/subpopulations of greatest impact

- The ZIP codes where nearly a quarter or more of the population is uninsured are listed below:

CHMC Service Area	SVMC Service Area	GSH Service Area
90004-Hancock Park (27.9%)	90004-Hancock Park (27.9%)	90004-Hancock Park (27.9%)
90005-Koreatown (30.3%)	90005-Koreatown (30.3%)	90005-Koreatown (30.3%)
90006-Pico Heights (33.4%)	90006-Pico Heights (33.4%)	90006-Pico Heights (33.4%)
90010-Wilshire (25.0%)	90010-Wilshire (25.0%)	90010-Wilshire (25.0%)
90017-DTLA (32.0%)	90015-DTLA (30.9%)	90015-DTLA (30.9%)
90019-Country Club Park/Mid City (26.3%)	90017-DTLA (32.0%)	90017-DTLA (32.0%)
90020-Hancock Park (25.8%)	90019-Country Club Park/Mid City (26.3%)	90020-Hancock Park (25.8%)
90026-Echo Park/Silverlake (27.5%)	90020-Hancock Park (25.8%)	90026-Echo Park/Silverlake (27.5%)
90028-Hollywood (24.4%)	90026-Echo Park/Silverlake (27.5%)	90057-Westlake (33.4%)
90029-DTLA (29.5%)	90057-Westlake (33.4%)	90012-Chinatown (27.8%)
90031-Montecito Heights (30.2%)	90001-Los Angeles (31.8%)	90013-DTLA (24.5%)
90057-Westlake (33.4%)	90002-Los Angeles (31.0%)	90014-Los Angeles (25.7%)
90007-South Los Angeles (27.5%)	90003-South Los Angeles (31.4%)	90021-DTLA (28.2%)
90011-South Los Angeles (33.1%)	90007-South Los Angeles (27.5%)	90007-South Los Angeles (27.5%)
90016-West Adam (26.2%)	90011-South Los Angeles (33.1%)	90018-Jefferson Park (27.9%)
90018-Jefferson Park (27.9%)	90016-West Adam (26.2%)	
90037-South Los Angeles (31.7%)	90018-Jefferson Park (27.9%)	
90044-Athens (27.6%)	90037-South Los Angeles (31.7%)	
	90062-South Los Angeles (28.9%)	
	90044-Athens (27.6%)	

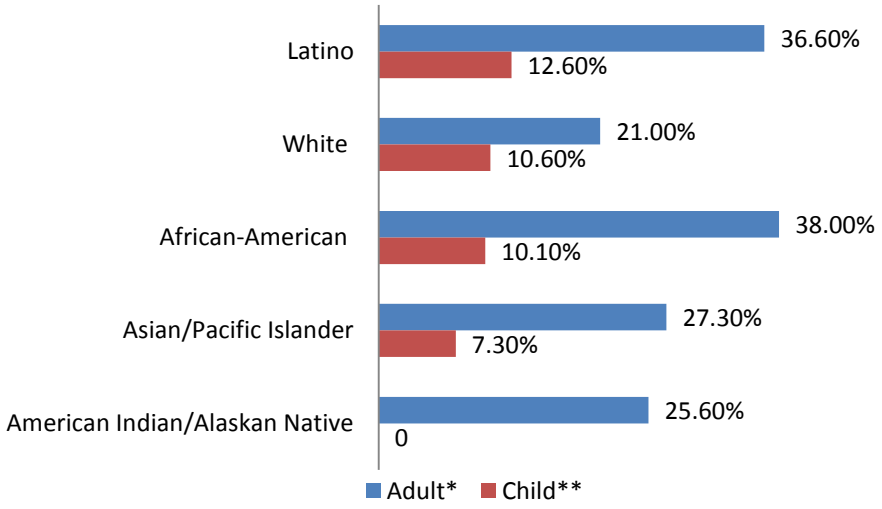
Data source: California Health Interview Survey
Data year: 2012
Source geography: ZIP Code

➢ The ZIP codes with the highest rates of preventable hospitalizations per 1,000 residents are listed below:

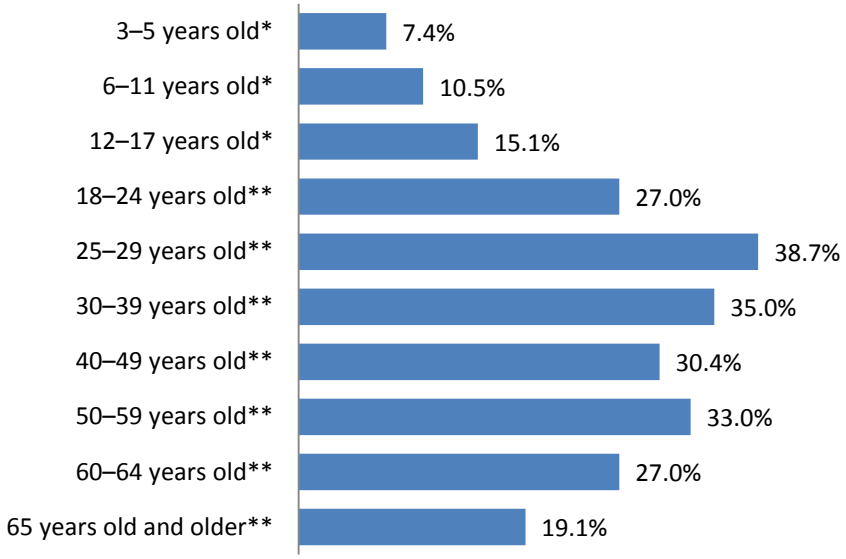
CHMC Service Area	SVMC Service Area	GSH Service Area
90008-Baldwin Hills/Crenshaw (24.4) 90044-Athens (21.7) 90018-Jefferson Park (21.1) 90016-West Adam (18.5) 90010-Wilshire (17.7) 90037-South Los Angeles (17.5)	90008-Baldwin Hills/Crenshaw (24.4) 90047-Los Angeles/West Athens (22.8) 90044-Athens (21.7) 90018-Jefferson Park (21.1) 90043-View Park/Windsor Hills (20.3) 90062-South Los Angeles (19.2) 90037-South Los Angeles (17.5)	90014-Los Angeles (26.2) 90018-Jefferson Park (21.1) 90013-Downtown Los Angeles (20.7) 90021-Downtown Los Angeles (18.6) 90010-Wilshire (17.7)

Source: California Office of Statewide Health Planning and Development
OSHPD Patient Discharge Data,
Data Year: 2012
Source Geography: ZIP Code

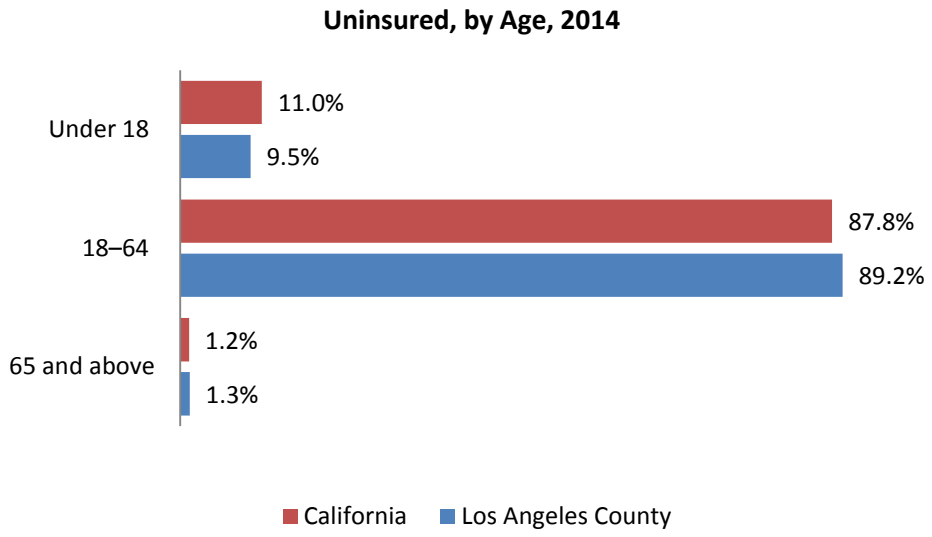
Unable to Afford Dental Care by Ethnicity, 2011, 2015



Unable to Afford Dental Care by Age, 2011, 2015



Data source: Los Angeles County Health Survey
*Data year: 2011
**Data year: 2015
Source geography: SPA



Data source: American Community Survey
Data year: 2014
Source geography: County

Community input

In focus groups and interviews, stakeholders discussed the particular barriers to care faced by the large undocumented community in the service area. Stakeholders explained that fear of deportation discourages individuals from seeking health care, an issue compounded by the fact that the county is reducing the number of programs that offer care to undocumented residents.

The linguistic and cultural diversity of the service area presents particular challenges with respect to access to and utilization of care. One stakeholder explained that there may be up to 50 different languages spoken in the service area. Therefore, residents may experience frustration or intimidation when clinics and hospitals lack staff with whom they can communicate. Furthermore, the resident population lacks access to health care that is culturally appropriate. Stakeholders expressed a need for more resources that form a bridge between American medical culture and the health care cultures of the residents in the area: simply translating the language is insufficient, and evidence-based practices that work with patients from the dominant American culture do not always translate to patients from other cultures.

With respect to health care benefits and insurance, many stakeholders explained that the process of enrolling in services can be very confusing and overwhelming, and therefore eligible individuals and families delay and stall out in the registration process. Often, clients do not have easy access to the internet, or encounter challenges in navigating the internet sites where they can most readily access enrollment information, either because the sites are complex or because they have been poorly translated into the user's language. Furthermore, because of the complexity of the process, sick individuals may wait to apply for health care benefits while hoping their health will improve. Due to this delay, residents may not have access to benefits when health care is most needed.

Employment represents another challenge for many individuals seeking health care. Stakeholders expressed that their service area population often do not receive paid time off to go to the doctors. Because clinic hours are open during typical business hours only (8am to 5pm), residents find it difficult to access health care outside of work hours.

Finally, a specific area of concern with respect to health care access was the availability and accessibility of prenatal, maternal and child care, specifically for Latinas and African American women in the service area.

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[1] California Health Medical Center

[2] St. Vincent Medical Center

[3] Good Samaritan Hospital

Alcohol and Substance Abuse

About alcohol and substance abuse

Substance abuse (defined as use of alcohol, tobacco, prescription or illicit substances) has a major impact on individuals, families and communities. Substance abuse is considered both a driver of poor health outcomes and an outcome in and of itself. Substance use and abuse are key determinants of a number of downstream additional poor health outcomes. 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. [106] Heavy alcohol consumption is an important determinant of future health needs, including cirrhosis, cancers, and untreated mental and behavioral health needs.

Drivers of individual and population substance use and abuse outcomes include gender, race and ethnicity, age, income level, educational attainment and sexual orientation. Substance abuse is also strongly influenced by interpersonal, household, and community dynamics including access to alcohol and drugs.

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.[107] 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.[108] 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.[109]

Statistical data

Alcohol and Substance Abuse Indicators

[106] U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at https://www.healthypeople.gov/2020/topics-objectives/topic/substance-abuse. Accessed [August 2, 2016].

[107] 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 [August 1, 2016].

[108] 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 [August 1, 2016].

[109] 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 [August 1, 2016].

Indicators	Year	Comparison		CHMC Service Area	SVMC Service Area	GSH Service Area
		Level	Avg.			
Percent of adults 18 and older who reported drinking at least once in the past month[1]	2015	LAC	51.9%	45.7%	53.0%	46.1%
Percent of adults 18 and older who engaged in binge drinking in the past month[1]	2015	LAC	15.8%	16.2%	15.1%	16.9%
Number of alcohol outlets per 1,000 persons[2]	2016	LAC	0.6	2.2	1.8	3.7
Adults Who Reported Misusing Any Form of Prescription Drugs in the Past Year[3]	2015	LAC	5.5%	6.9%	6.8%	7.0%
Adults Who Reported Using Any Form of Marijuana in the Past Year[3]	2015	LAC	11.6%	13.9%	13.2%	14.5%
Teens Who Have Ever Tried Marijuana, Cocaine, Sniffing Glue, Other Drugs[4]	2012	LAC	14.7%	23.2%	25.9%	20.7%
Percent of adults 18 and older who reported they needed or wanted treatment for an alcohol or drug issue (excluding tobacco) in the past five years[5]	2011	LAC	2.5%	2.9%	2.7%	3.1%
Percentage of the service area population currently smoking[6]	2015	LAC	13.3%	13.8%	13.6%	13.9%

Data source[1]: Los Angeles County Health Survey
Data year: 2015
Source geography: SPA
Data source[2]: California Department of Alcoholic Beverage Control (ABC)
Data year: 2016
Source geography: ZIP Code
Data source[3]: Los Angeles County Health Survey
Data year: 2015
Source geography: SPA
Data source[4]: California Health Interview Survey
Data Year: 2012
Source geography: SPA
Data source[5]: Los Angeles County Health Survey
Data year: 2011
Source geography: SPA
Data source[6]: Los Angeles County Health Survey
Data year: 2015
Source geography: SPA

Geographic areas/subpopulations of greatest impact

- Rates of alcohol/drug-induced mental illness per 100,000 adults were highest in the ZIP codes shown below.

CHMC Service Area	SVMC Service Area	GSH Service Area
90046-Mount Olympus (205.9) 90028-Hollywood (190.6)	90001-Los Angeles (680.4) 90008-Baldwin Hills/Crenshaw (172.1)	90021-Downtown Los Angeles (802.6) 90013-Downtown Los Angeles (498.4) 90014-Los Angeles (463.2)

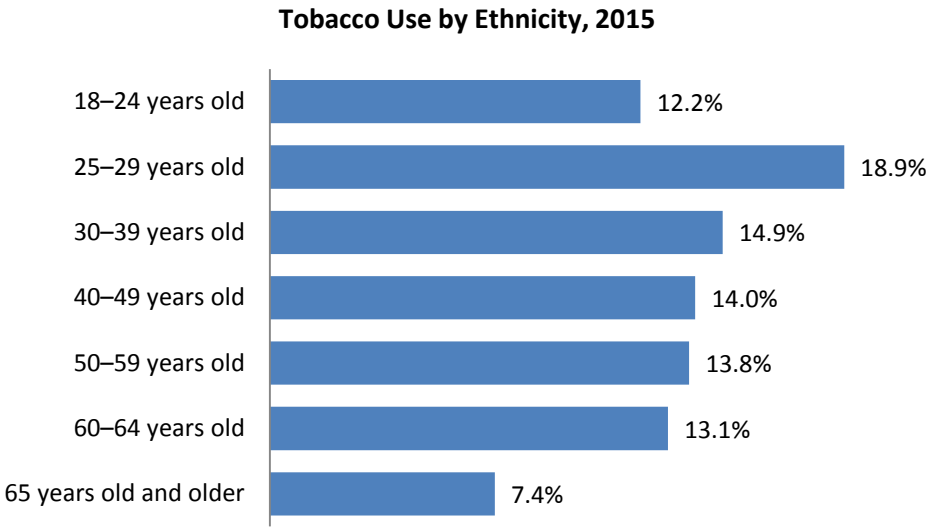
CHMC Service Area	SVMC Service Area	GSH Service Area
90008-Baldwin Hills/Crenshaw (172.1) 90016-West Adam (164.7)	90016-West Adam (164.7)	

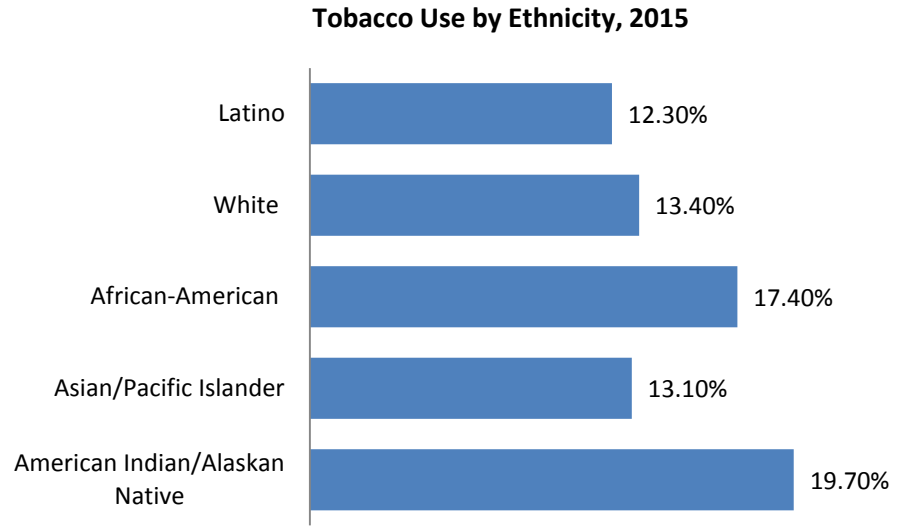
Data source: Office of Statewide Health Planning and Development (OSHPD)
Data year: 2012
Source geography: ZIP Code

- Rates of alcohol outlets per 1,000 persons were highest in the ZIP codes shown below.

CHMC Service Area	SVMC Service Area	GSH Service Area
90010-Wilshire (11.8) 90028-Hollywood (6.4) 90005-Koreatown (3.3) 90046-Mount Olympus (2.7) 90017-Downtown Los Angeles (2.4) 90006-Pico Heights (2.0) 90027-Griffith Park/Los Feliz (2.0) 90004-Hancock Park (1.8)	90010-Wilshire (11.8) 90015-Downtown Los Angeles (3.7) 90005-Koreatown (3.3) 90017-Downtown Los Angeles (2.4) 90004-Hancock Park (1.8)	90010-Wilshire (11.8) 90021-Downtown Los Angeles (9.1) 90014-Los Angeles (5.9) 90012-Chinatown (4.8) 90013-Downtown Los Angeles (4.5) 90015-Downtown Los Angeles (3.7) 90005-Koreatown (3.3)

Data source: Office of Statewide Health Planning and Development (OSHPD)
Data year: 2012
Source geography: ZIP Code





Data source: Los Angeles County Health Survey
Data year: 2015
Source geography: County

Associated drivers and risk factors

Substance abuse (defined as use of alcohol, tobacco, prescription or illicit substances) 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.[110]

Community input

Stakeholders identified the homeless as a population with a great need for alcohol and substance use services, particularly because homeless individuals cannot enter transitional housing if they are dealing with substance use issues.

Access to alcohol and substance use programs is a challenge in the service area because the community in general does not know where to go to seek treatment and beds are limited in inpatient facilities. Moreover, the high cost of treatment makes it out of reach for most residents; specific populations, including transgender individuals, lack welcoming and responsive substance abuse and alcohol treatment facilities, and the long wait list for low-cost treatment discourages potential patients.

Finally, stakeholders indicated that cultural shifts, including the increasing acceptance of vaping and marijuana smoking, are influencing access to, and use of, drugs and alcohol by teenagers.

[110] U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at https://www.healthypeople.gov/2020/topics-objectives/topic/substance-abuse. Accessed [August 2, 2016].

Cancer

About Cancer

Cancer is the second leading cause of death in the United States, claiming the lives of more than half a million Americans every year[111]. In 2009, cancer incidence rates per 100,000 persons indicate that the three most common cancers among men in the United States are prostate cancer (137.7), lung cancer (64.3), and colorectal cancer (42.5). Among women, the leading causes of cancer deaths are breast cancer (123.1), lung cancer (54.1), and colorectal cancer (37.1).[112] Research has shown that early detection through regular cancer screenings can help reduce the number of new cancer cases and, ultimately, deaths.[113] Research has also shown that cancer is associated with certain diseases and behaviors including obesity, tobacco, alcohol, certain chemicals, some viruses and bacteria, a family history of cancer, poor diet, and lack of physical activity.[114]

Statistical data

Volume of Cancer Surgeries Performed at Metro Hospital Collaborative, 2014

Type of Cancer	Comparison		CHMC Service Area	SVMC Service Area	GSH Service Area
	Level	Avg.			
Breast	LAC	43.2%	76.4%	13.6%	23.3%
Prostate	LAC	14.8%	2.9%	1.6%	2.2%
Colon	LAC	13.8%	8.6%	31.2%	22.2%
Lung	LAC	6.4%	1.4%	6.4%	5.6%
Brain	LAC	5.4%	2.1%	9.6%	6.7%
Rectum	LAC	4.5%	4.3%	8.8%	6.7%
Liver	LAC	3.5%	0.7%	1.6%	16.7%
Stomach	LAC	3.1%	2.9%	20.8%	12.2%
Bladder	LAC	2.5%	0.0%	0.0%	0.0%
Pancreas	LAC	2.0%	0.7%	6.4%	4.4%
Total	LAC	99.2%	100.0%	100.0%	100.0%

Data source: Office of Statewide Health Planning and Development (OSHPD)
Data year: 2014
Source geography: Hospital

Geographic areas/subpopulations of greatest impact

- Cancer mortality rates (by percent of deaths cancer-related) are highest in the ZIP codes listed below. In the state of California, 23.7% of deaths in 2012 were cancer-related.

[111] Centers for Disease Control and Prevention. (2015). *Using Science to Reduce the Burden of Cancer.* Atlanta, GA. Available at http://www.cdc.gov/Features/CancerResearch/. Accessed [August 1, 2016].

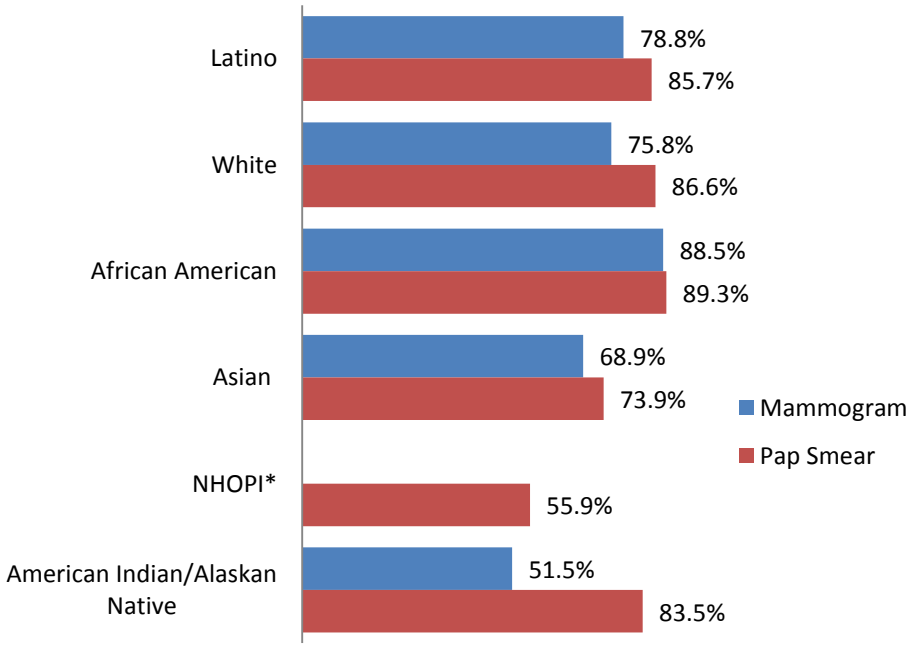
[112] Centers for Disease Control and Prevention. (2013). *Invasive Cancer Incidence.* Atlanta, GA. Available at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6207a1.htm. Accessed [August 1, 2016].

[113] Centers for Disease Control and Prevention. (2015). *Cancer Prevention*. Atlanta, GA. Available at http://www.cdc.gov/cancer/dcpc/prevention/index.htm. Accessed [August 1, 2016].

[114] National Cancer Institute. (2015). *Cancer Prevention Overview*. Available at http://www.cancer.gov/cancertopics/pdq/prevention/overview/patient/page3. Bethesda, MD. Accessed [August 1, 2016].

CHMC Service Area	SVMC Service Area	GSH Service Area
90020-Hancock Park (33.1%) 90029-Downtown Los Angeles (27.8%) 90010-Wilshire (26.7%) 90006-Pico Heights (26.6%) 90004-Hancock Park (26.1%) 90019-Country Club Park/Mid City (25.7%) 90008-Baldwin Hills/Crenshaw (25.7%)	90020-Hancock Park (33.1%) 90010-Wilshire (26.7%) 90006-Pico Heights (26.6%) 90004-Hancock Park (26.1%) 90019-Country Club Park/Mid City (25.7%) 90008-Baldwin Hills/Crenshaw (25.7%) 90044-Athens (25.7%) 90047-Los Angeles/West Athens (25.6%)	90020-Hancock Park (33.1%) 90010-Wilshire (26.7%) 90006-Pico Heights (26.6%) 90004-Hancock Park (26.1%) 90012-Chinatown (24.5%)

Percent of Women Who Reported Having a Pap Smear or Mammogram in the Past 3 or 2 Years, Respectively, 2015



*Data unavailable
Data Source: Los Angeles County Health Survey
Data Year: 2015
Source Geography: SPA

Associated drivers and risk factors

A primary method of preventing cancer is screening for cervical, colorectal, and breast cancers[115]. The most common risk factors for cancer include growing older, obesity, tobacco, alcohol, sunlight exposure,

[115] Centers for Disease Control and Prevention. Cancer Prevention. Atlanta, GA. Available at http://www.cdc.gov/cancer/dcpc/prevention/index.htm. Accessed [August 7, 2016].

certain chemicals, some viruses and bacteria, family history of cancer, poor diet, and lack of physical activity[116].

Community input

Stakeholders observed that there may be a lack of knowledge in the community about the causes of cancer and ways that individuals can reduce their likelihood of developing cancers through various activities. Stakeholders pointed out that unfortunately, however, a number of contextual factors in the community contribute to cancer incidence, including lack of access to healthy food and poor air quality.

Stakeholders observed that they see less successful linkage to care and continuity in care—specifically for cancer--among low-income populations, populations that do not speak English, and populations with cultural backgrounds that differ from the norms in the health care environment. Additionally, the LGBT community experiences unique challenges in accessing cancer screenings and care. Stakeholders recognize a need for greater cultural competency among care providers.

While gains made in coverage (through ACA, Medicaid) may have positively impacted individuals' ability to access screenings for prostate, breast and cervical cancer, providers have not seen an increase in clients' utilization of these screenings. Stakeholders explained this may be due to cutbacks in services or long waitlists for screenings that discourage patients from following up. Alternatively, it may be because patients don't know if/that their insurance covers screenings and cancer treatment. Additionally, stakeholders have observed a lack of community education around cancer screenings, and some stigma around screening providers like Planned Parenthood, that may be discouraging people from accessing preventive care.

[116] National Cancer Institute. Risk Factors for Cancer. Bethesda, MD. Available at http://www.cancer.gov/about-cancer/causes-prevention/risk. Accessed [August 7, 2016].

Cardiovascular Disease (including Hypertension and Cholesterol)

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.[1]

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.[2]

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 Service Area	SVMC Service Area	GSH Service Area
		Level	Avg.			
Heart disease prevalence[1]	20014	LAC	5.7%	4.7%	6.0%	3.5%
Heart disease management[1]	2014	LAC	55.5%	58.1%	60.0%	59.7%
Rate of heart disease mortality per 10,000 persons[2]	2012	CA	15.5	14.9	14.3	16.3
Rate of hospitalizations resulting from heart failure per 100,000 persons[3]	2012	LAC	366.6	376.6	403.6	398.2
Hypertension prevalence[4]	2015	LAC	23.5%	23.2%	23.6%	22.8%
Cholesterol Prevalence[4]	2015	LAC	25.2%	24.6%	24.0%	25.1%
Cholesterol Management[4]	2009	LAC	68.7%	69.0%	71.3%	67.5%

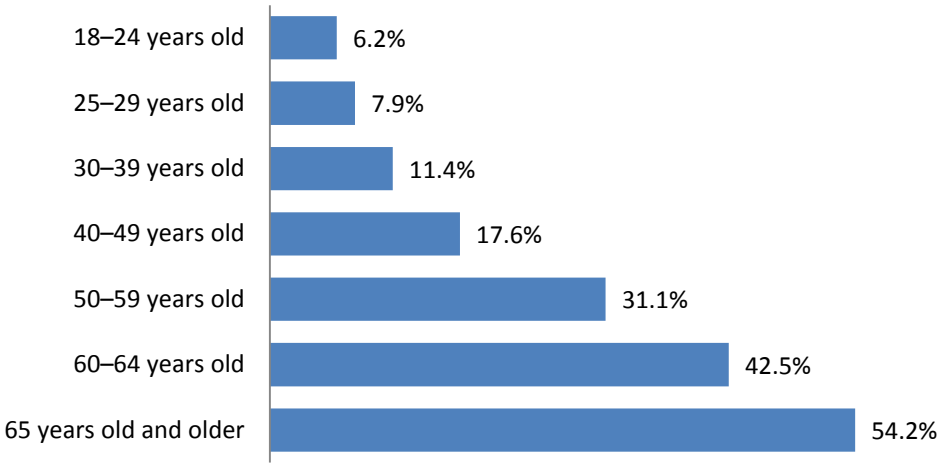
[1] Data source: California Health Interview Survey (CHIS)
Data year: 2014
Source geography: SPA
[2]Data source: California Department of Public Health (CDPH)
Data year: 2012
Source geography: ZIP Code
[3]Data source: Office of Statewide Health Planning and Development (OSHPD)
Data year: 2012
Source geography: ZIP Code
[4]Data source: Los Angeles County Health Survey
Data year: 2015
Source geography: SPA
LAC=Los Angeles County
CA=California

Geographic areas/subpopulations of greatest impact

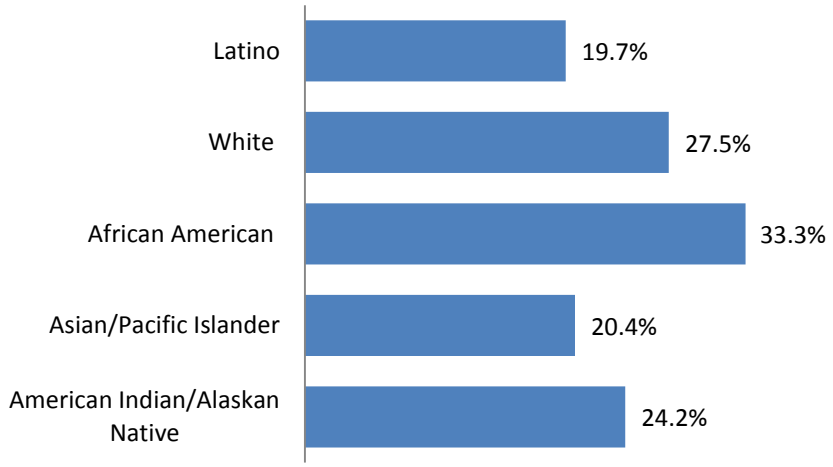
- Hospitalizations resulting from heart failure per 100,000 adults are highest when compared to California (339.0) in the ZIP codes shown below.

CHMC Service Area	SVMC Service Area	GSH Service Area
90008-Baldwin Hills/Crenshaw (728.9) 90044-Athens (570.6) 90018-Jefferson Park (515.8) 90027-Griffith Park/Los Feliz (502.2)	90008-Baldwin Hills/Crenshaw (728.9) 90047-Los Angeles/West Athens (673.4) 90062-South Los Angeles (620.1) 90043-View Park-Windsor Hills (572.3) 90044-Athens (570.6) 90018-Jefferson Park (515.8)	90021-Downtown Los Angeles (985.0) 90014-Los Angeles (743.9) 90013-Downtown Los Angeles (693.0)

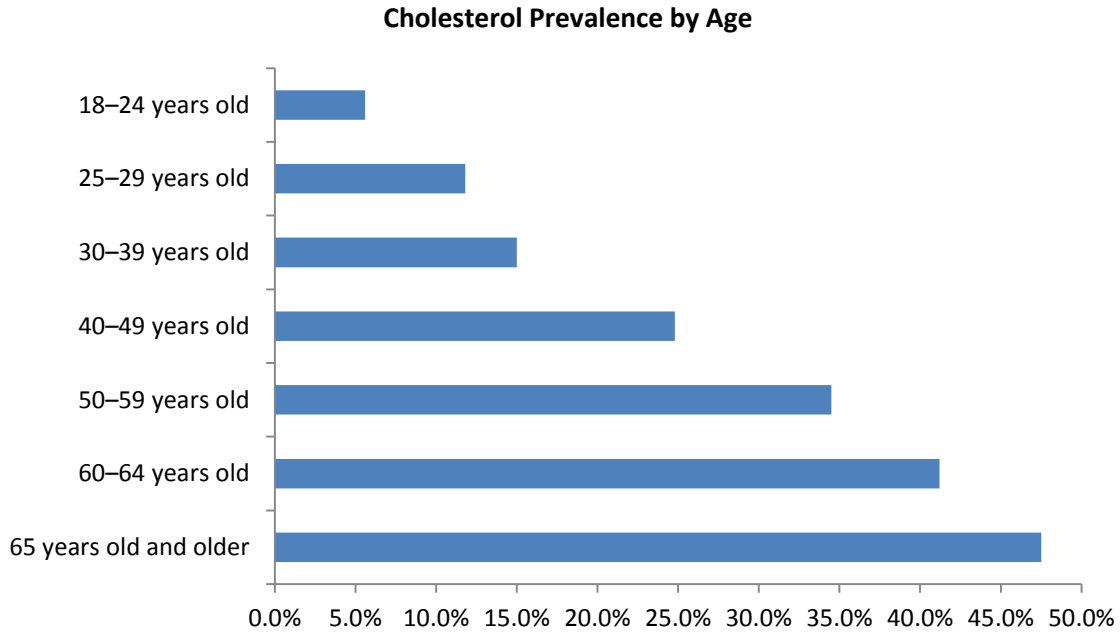
Hypertension Prevalence by Age, 2015



Hypertension Prevalence by Ethnicity, 2015



Data source: Los Angeles County Health Survey
Data year: 2015
Source geography: County



Associated drivers and risk factors

The leading risk factors for heart disease are 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.[3]

Community input

Stakeholders called for efforts to expand education around the underlying causes of cardiovascular disease (diet, lack of physical exercise), subpopulations at higher risk (Latina women, young Black males) and the disease process (slowly cumulative over time, manageable through diet and exercise).
At the same time, community members discussed the influence of culture and tradition on diet which may influence cardiovascular disease risk. Stakeholders recommended the implementation of health education and outreach campaigns via Spanish and Korean television and radio stations. Stakeholders observed that the built environment in the Metro communities serves as a constraint on dietary choices. For example, there are very few outlets selling affordable healthy ingredients when compared to the number of fast food outlets and liquor stores. Additionally, lifestyle factors including long, stressful workdays make it difficult to allocate time for cooking dinner or engaging in exercise.

Multiple factors in addition to a lack of time limit residents' engagement in physical activity. Principally, the environment in their communities. Fear of violence in the community, lack of safe green space, lack of affordable/free indoor recreational facilities as well as the high incidence of pedestrian injury discourage people from exercising in the community.

[1] 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].
[2] Ibid.

Cultural and Linguistic Barriers

About Cultural and Linguistic Barriers

According to the National Standards for Culturally and Linguistically Appropriate Services, culture is defined in terms of racial, ethnic and linguistic groups, as well as geographical, religious and spiritual, biological and sociological characteristics[117]. With the Institute of Medicine's publication of Unequal Treatment in 2003, culturally and linguistically appropriate services gained recognition as an important way to help address the persistent disparities faced by our nation's diverse communities. There have also been rapid changes in demographic trends in the U.S. in the last decade. Additionally, national accreditation standards for professional licensure in the fields of medicine and nursing, and health care policies, such as the Affordable Care Act, have also helped to underscore the importance of cultural and linguistic competency as part of high quality health care and services[118].

Cultural and Linguistic Barriers

Indicators	Year	Comparison		CHMC Service Area	SVMC Service Area	GSH Service Area
		Level	Avg.			
Difficulty Understanding Doctor	2014	LAC	3.2%	3.6%	3.6%	3.8%
Speak English at Home	2016	LAC	42.9%	34.2%	32.5%	33.5%
Speak Asian/Pacific Islander at Home	2016	LAC	10.9%	11.8%	13.0%	19.2%
Speak Indo-European at Home	2016	LAC	5.6%	4.8%	1.8%	2.9%
Speak Spanish at Home	2016	LAC	39.6%	48.3%	51.9%	43.6%
Speak Other Language at Home	2016	LAC	1.1%	1.0%	0.8%	0.7%

Data Source: Los Angeles County Health Survey
Data Year: 2015
Source Geography: SPA

Geographic areas/subpopulations of greatest impact

- The percentage of households who speak English at home is 42.9%. The following geographies in each service area have a percentage of households who speak English at home well below the average for Los Angeles County.

CHMC Service Area	SVMC Service Area	GSH Service Area
90006 – Pico Heights (10.2%) 90011 – South Los Angeles (11.5%) 90057 – Westlake (13.0%) 90031 – Montecito Heights (16.1%) 90005 – Koreatown (17.1%) 90017 – Downtown Los Angeles (17.9%) 90020 – Hancock Park (19.9%) 90029 – Downtown Los Angeles (20.4%)	90006 – Pico Heights (10.2%) 90011 – South Los Angeles (11.5%) 90001 – Los Angeles (12.9%) 90057 – Westlake (13.0%) 90005 – Koreatown (17.1%) 90017 – Downtown Los Angeles (17.9%) 90020 – Hancock Park (19.9%) 90010 – Wilshire (21.5%)	90006 – Pico Heights (10.2%) 90057 – Westlake (13.0%) 90005 – Koreatown (17.1%) 90017 – Downtown Los Angeles (17.9%) 90020 – Hancock Park (19.9%)

Community Input

[117] U.S. Department of Health and Human Services. Office of Minority Health. Available at https://www.thinkculturalhealth.hhs.gov/pdfs/NationalCLASStandardsFactSheet.pdf. Accessed [August 29, 2016]
[118] U.S. Department of Health and Human Services. Office of Minority Health. Available at https://www.thinkculturalhealth.hhs.gov/pdfs/NationalCLASStandardsFactSheet.pdf. Accessed [August 29, 2016]

Stakeholders discussed a need for greater understanding among the health care community of the ways in which gender dynamics and social roles in non-majority cultures impact relationships between health care providers and patients, as well as the implementation of health care recommendations beyond the doctor visit. For example, among many new immigrant families, gender role norms dictate that the male is dominant in the family; this can complicate health behavior recommendations for women if the provider is not cognizant of the impact gender role norms might have on a woman's ability to treat a personal health issue or an issue affecting her child.

Diabetes

About 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.[1] A diabetes diagnosis can 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.[2]

In addition, evidence is emerging that diabetes is associated with other co-morbidities, including cognitive impairment, incontinence, fracture risk, and cancer risk and prognosis.[3]

Statistical data

Diabetes Indicators

Indicators	Year	Comparison		CHMC Service Area	SVMC Service Area	GSH Service Area
		Level	Avg.			
Percent of adults 18 and over ever diagnosed with diabetes (diabetes prevalence)[1]	2015	LAC	9.8%	11.5%	11.8%	11.7%
Rate of adult diabetes hospitalizations per 100,000 persons[2]	2012	CA	142.6	203.9	241.1	221.8
Rate of hospitalizations resulting from uncontrolled diabetes per 100,000 persons[2]	2012	CA	8.6	18.9	21.0	21.2
Rate of youth diabetes hospitalizations per 100,000 persons[2]	2012	CA	31.2	21.8	24.1	17.9
Rate of diabetes mortality per 10,000 persons[3]	2012	CA	2.1	2.7	2.7	2.5

[1]Data source: Los Angeles County Health Survey
Data year: 2015
Source geography: SPA
[2]Data source: Office of Statewide Health Planning and Development (OSHPD)
Data year: 2012
Source geography: ZIP Code
[3]Data source: California Department of Public Health (CDPH)
Data year: 2012
Source geography: ZIP Code

Geographic areas/subpopulations of greatest impact

- Adult diabetes hospitalization rates per 100,000 persons were highest compared to the California average (142.6) in the ZIP codes shown below.

CHMC Service Area	SVMC Service Area	GSH Service Area
90018-Jefferson Park (363.2) 90008-Baldwin Hills/Crenshaw (353.5) 90044-Athens (328.7) 90016-West Adam (314.7) 90037-South Los Angeles (302.3) 90010-Wilshire (252.2) 90011-South Los Angeles (220.9)	90047-Los Angeles/West Athens (388.0) 90018-Jefferson Park (363.2) 90002-Los Angeles (357.7) 90008-Baldwin Hills/Crenshaw (353.5) 90044-Athens (328.7) 90037-South Los Angeles (302.3) 90043-View Park-Windsor Hills (298.4) 90001-Los Angeles (259.3)	90014-Los Angeles (449.1) 90013-Downtown Los Angeles (389.3) 90018-Jefferson Park (363.2) 90021-Downtown Los Angeles (328.3) 90010-Wilshire (252.2)

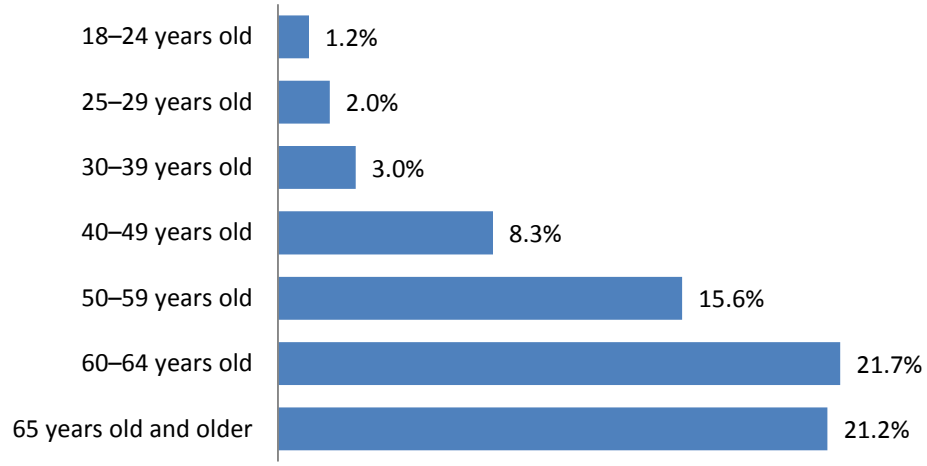
- Diabetes hospitalization resulting from uncontrolled diabetes rates per 100,000 persons were highest compared to the California average (8.6) in the ZIP codes shown below.

CHMC Service Area	SVMC Service Area	GSH Service Area
90018-Jefferson Park (44.4) 90044-Athens (33.0) 90017-Downtown Los Angeles (28.0) 90016-West Adam (27.1) 90008-Baldwin Hills/Crenshaw (25.0) 90057-Westlake (24.3) 90037-South Los Angeles (18.6)	90018-Jefferson Park (44.4) 90044-Athens (33.0) 90017-Downtown Los Angeles (28.0) 90016-West Adam (27.1) 90043-View Park/Windsor Hills (26.7) 90008-Baldwin Hills/Crenshaw (25.0)	90013-Downtown Los Angeles (46.7) 90018-Jefferson Park (44.4) 90021-Downtown Los Angeles (36.5) 90017-Downtown Los Angeles (28.0) 90012-Chinatown (27.6) 90057-Westlake (24.3)

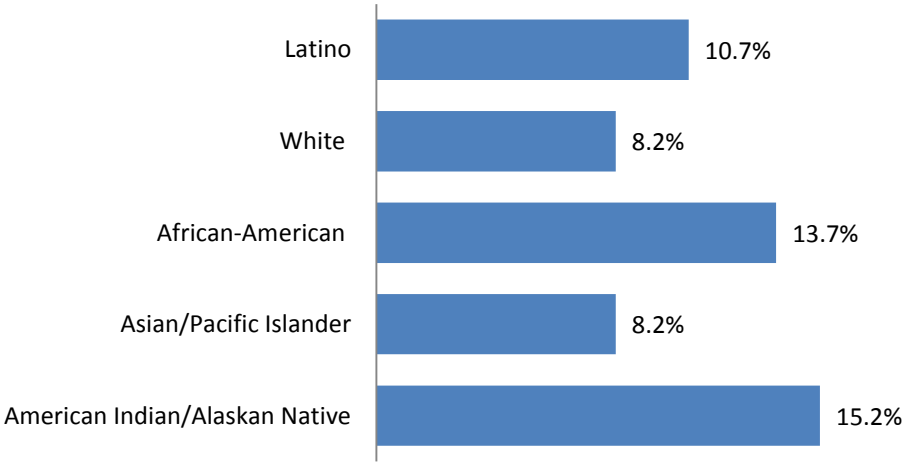
- Diabetes mortality rates per 10,000 persons were highest compared to the California average (2.1) in the ZIP codes shown below.

CHMC Service Area	SVMC Service Area	GSH Service Area
90010-Wilshire (6.3) 90008-Baldwin Hills/Crenshaw (4.1) 90018-Jefferson Park (3.7)	90010-Wilshire (6.3) 90008-Baldwin Hills/Crenshaw (4.1) 90062-South Los Angeles (3.8) 90043-View Park-Windsor Hills (3.8) 90018-Jefferson Park (3.7)	90010-Wilshire (6.3) 90021-Downtown Los Angeles (3.7) 90018-Jefferson Park (3.7)

Diabetes Prevalence by Age, 2015



Diabetes Prevalence by Ethnicity, 2015



Data source: Los Angeles County Health Survey
Data year: 2015
Source geography: County

Associated drivers

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.[4]

Community input

As with cardiovascular disease, diet is a principal determinant of diabetes. Diet is shaped by both the food environment (what is available for purchase in a community) and cultural practices. The service area is home to many cultural communities. Stakeholders called for the implementation of outreach and education efforts that illustrate strategies for healthier diets that reflect residents' cultural backgrounds.

Additionally, stakeholders acknowledged that residents' access to healthy food is limited by cost, and acknowledged a need for affordable fruits and vegetables. Moreover, stakeholders observed that clients in the service lack an understanding of the diabetes disease process. Stakeholders have called for greater education around the relationship between diet and diabetes, as well as diabetes co-morbidities.

Stakeholders acknowledged that the costs of diabetes medication are prohibitive for lower-income residents, particularly the undocumented and uninsured populations. Additionally, individuals experiencing homelessness and housing instability face challenges in maintaining diabetes care because they do not have access to refrigeration for their medications.

[1] 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].
[2] Ibid.
[3] Ibid.

Food Insecurity

About Food Insecurity

According to the United States Department of Agriculture, food insecurity is explicitly defined as a household-level economic and social condition of limited or uncertain access to adequate food[119]. The defining characteristic of very low food security is that, at times during the year, the food intake of household members is reduced and their normal eating patterns are disrupted because the household lacks money and other resources for food.[120]

Food Insecurity

Indicators	Year	Comparison		CHMC Service Area	SVMC Service Area	GSH Service Area
		Level	Avg.			
Households with Incomes <300% Who are Food Insecure	2015	LAC	29.2%	32.0%	32.0%	32.1%

Data Source: Los Angeles County Health Survey
Data Year: 2015
Source Geography: SPA

Community Input

Stakeholders explained that food insecurity in the service area results from the compounded impact of low income and a lack of affordable healthy food.

[119] United States Department of Agriculture. Economic Research Service. Washington D.C. Available at: http://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/definitions-of-food-security.aspx. Accessed [August 29, 2016].

[120] United States Department of Agriculture. Economic Research Service. Washington D.C. Available at: http://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/definitions-of-food-security.aspx. Accessed [August 29, 2016].

Healthy Behavior (includes Physical Activity)

About Healthy Behaviors

The Nutrition and Weight Status objectives for Healthy People 2020 reflect strong science supporting the health benefits of eating a healthful diet and maintaining a healthy body weight. The objectives also emphasize that efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, health care organizations, and communities. The goal of promoting healthful diets and healthy weight encompasses increasing household food security and eliminating hunger[121].

Healthy Behaviors

Indicators	Year	Comparison		CHMC Service Area	SVMC Service Area	GSH Service Area
		Level	Avg.			
Physically Active at Least One Hour Each Day in Last Week (Children 0-11)[1]	2014	LAC	26.4%	25.2%	25.9%	24.9%
Physically Active at Least One Hour Each Day in Last Week (Teens 12-17)[1]	2014	LAC	12.3%	17.2%	17.4%	18.0%
Ate Five or More Servings of Fruits and Vegetables in Past Day (Children 0-11)[2]	2012	LAC	55.4%	57.9%	58.4%	55.6%
Ate Five or More Servings of Fruits and Vegetables in Past Day (Teens 12-17)[2]	2012	LAC	19.7%	11.8%	9.9%	13.5%
Ate Five or More Servings of Fruits and Vegetables in Past Day (Adults 18+)[2]	2012	LAC	14.7%	15.9%	12.6%	14.8%
Obtained recommended amount of aerobic exercise and muscle-strengthening (Children and Teens 6-17)[1]	2014	LAC	17.7%	16.4%	16.9%	16.4%
Obtained recommended amount of aerobic exercise and muscle-strengthening (Adults 18+)[1]	2014	LAC	34.1%	33.5%	31.7%	33.0%

Data Source: California Health Interview Survey 2014[1], 2012[2]
Data Year: 2012, 2014
Source Geography: SPA

Community Input

One focus group identified that Latinos are particularly impacted by poor health behaviors. They listed that their current diet does not provide as much nutrition as it could, and that the community would benefit from more information, more nutritional education, and more knowledge about where to buy affordable healthy foods in the community. One woman explained that she has been taking advantage of the Clinica de Control de Ninos, an organization that helped her understand what her children should be eating to be healthy. They also explained that Leichty Middle school provides parent classes,

[121] U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at https://www.healthypeople.gov/2020/topics-objectives/topic/nutrition-and-weight-status. Accessed [August 29, 2016].

nutrition and cardiovascular classes for parents, as well as child care. The school also brings in mobile dental care clinics."

Stakeholders explained that time constraints, costs of healthy food and medical care, and easy access to cheap, unhealthy food, contribute to the poor eating behaviors. However, there is an observed growing interest in healthy foods and fitness, reflected in the growing popularity of farmers' markets and Zumba studios.

Homelessness

About Homelessness

A homeless individual is defined as "an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations, and an individual who is a resident in transitional housing." More than 20 percent of the nation's homeless population is now living in California, an estimated 115,738 people. More than 43,000 of them live in Los Angeles County—the largest concentration in the United States [122][2].

Statistical data

Homelessness and Housing Indicators

Indicators	Year	Comparison		CHMC Service Area	SVMC Service Area	GSH Service Area
		Level	Avg.			
Percent of homeless who are classified as homeless individuals	2016	LAC	85.7%	86.8%	86.1%	87.3%
Percent of homeless who are classified as homeless families	2016	LAC	14.0%	13.0%	13.7%	12.4%
Percent of homeless who are classified as unaccompanied minors	2016	LAC	0.3%	0.2%	0.2%	0.3%
Percent of homeless who are mentally ill	2016	LAC	29.7%	27.9%	25.7%	30.5%
Percent of homeless who are diagnosed with substance abuse issues	2016	LAC	22.7%	20.0%	18.3%	22.3%
Percent of homeless with HIV	2016	LAC	1.4%	1.9%	1.4%	2.2%
Percent of homeless who are physically disabled	2016	LAC	16.9%	16.3%	15.7%	16.9%

Source: Los Angeles Homeless Services Authority,
Greater Los Angeles Homeless County Report, 2016, SPA

Associated drivers and risk factors

Housing instability is a primary driver of homelessness. Housing instability among poor families is the result of multiple overlapping factors ranging from number of income-earning adults in the home, education level of income-earning adults in the home, health of family members, domestic violence exposure, substance use patterns and access to social support and health care.[123] Although Los Angeles is home to the largest health and social services system available to homeless people, given the size of the very poor and homeless population, it faces significant challenges to provide cost effective integrated care for those facing housing instability.[124]

[2] County of Los Angeles. Office of Countywide Communications. Los Angeles, CA. Available at: http://priorities.lacounty.gov/homeless/. Accessed: [September 2, 2016].

[123] A Secondary Analysis by ICPH utilizing data from the Fragile Families and Child Well-being Study.Institute for Children, Poverty & Homelessness. http://www.icphusa.org/index.asp?page=16&report=112&pg=110. Accessed: [September 2, 2016].

[124] Guerrero, E., Henwood, B. and Wenzel, S. (2014). Service Integration to Reduce Homelessness in Los Angeles County: Multiple Stakeholder Perspectives. *Human Service Organizations* 38(1):44-54.

Community input

Stakeholders associated homelessness in the service area with lack of affordable housing and poverty. They have observed that the only consistent source of care for the homeless population is emergency (911) service, which puts a burden on emergency services. Because the homeless population suffers disproportionately with mental health concerns, the reliance on emergency services fails to meet this long term health care need. The high cost of living puts an undue burden on low-income families that spend a large proportion of their incomes on rent (vs. greater investment in healthy food or recreation). Stakeholders have also noted an increase in the homeless population and a lack of shelters. Homeless families face unique challenges in accessing education and health care, and there are insufficient social service providers in place to connect these families with homeless services. In focus groups, stakeholders noted as well that veterans are an ever increasing proportion of the homeless population.

Mental Health

About 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. 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.[1] 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).[2] Among adults, mental disorders are common, with approximately one-quarter of adults being diagnosable for one or more disorders.[3] Mental disorders are associated not only with suicide, but also with chronic diseases, a family history of mental illness, age, substance abuse, and life-event stresses.[4]

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.[5]

Statistical data

Mental Health Indicators

Indicators	Year	Comparison		CHMC Service Area	SVMC Service Area	GSH Service Area
		Level	Avg.			
Unhealthy Days Resulting from Poor Mental Health Reported by Adults[1]	2015	LAC	2.3	2.6	2.6	2.7
Adults with Serious Psychological Distress in the Last Year[2]	2014	LAC	9.6%	9.2%	9.1%	9.2%
Adequate Social and Emotional Support[3]	2015	LAC	64.0%	59.6%	59.1%	59.4%
Anxiety Prevalence[4]	2011	LAC	6.4%	7.1%	6.9%	7.3%
Depression Prevalence[5]	2015	LAC	8.6%	14.5%	13.6%	15.3%
Alcohol- and Drug-Induced Mental Illness Rate per 100,000 Adults[6]	2012	CA	102.5	108.8	116.8	186.5
Needed Help for Mental, Emotional, or Alcohol/Drug Issues[7]	2011	LAC	18.0%	19.6%	18.3%	20.6%
Mental Health Hospitalization Rate per 100,000 persons, Adults[8]	2012	CA	540.9	880.7	906.2	1384.0
Mental Health Hospitalization Rate per 100,000 persons, Youth[8]	2012	CA	294.8	403.7	410.2	444.3
Suicide Rate per 10,000 Persons[9]	2012	CA	1.0	1.1	1.1	1.7

[1]Data source: Los Angeles County Health Survey
Data year: 2015
Source geography: SPA
[2]Data source: California Health Interview Survey (CHIS)
Data year: 2014
[3]Data source: Los Angeles County Health Survey
Data year: 2015
Source geography: SPA
[4, 5]Data source: Los Angeles County Health Survey
Data year: 2011, 2015
Source geography: SPA
[6]Data source: Office of Statewide Health Planning and Development (OSHPD)
Data year: 2012
[7]Data source: Los Angeles County Health Survey
Data year: 2011
[8]Data source:Office of Statewide Health Planning and Development (OSHPD)
Data year: 2012

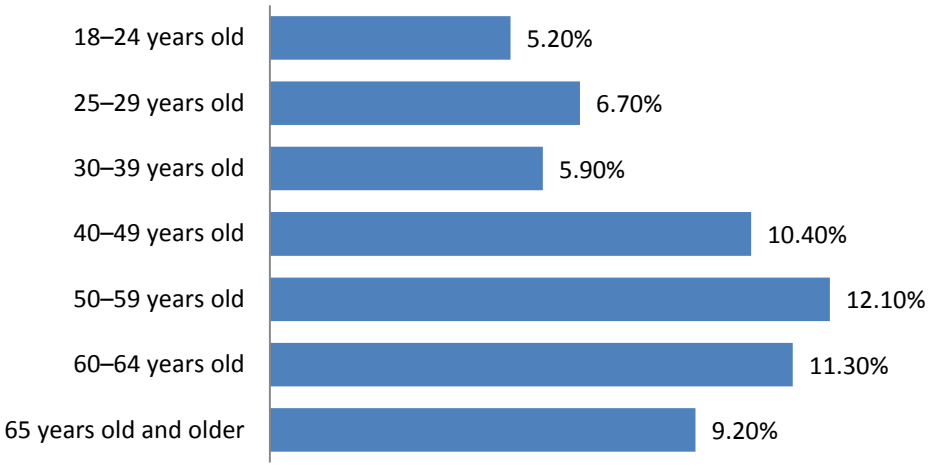
Geographic areas of greatest impact (disparities)

- The ZIP codes most impacted by mental health hospitalizations per 100,000 persons (Adults) are listed below for each service area.

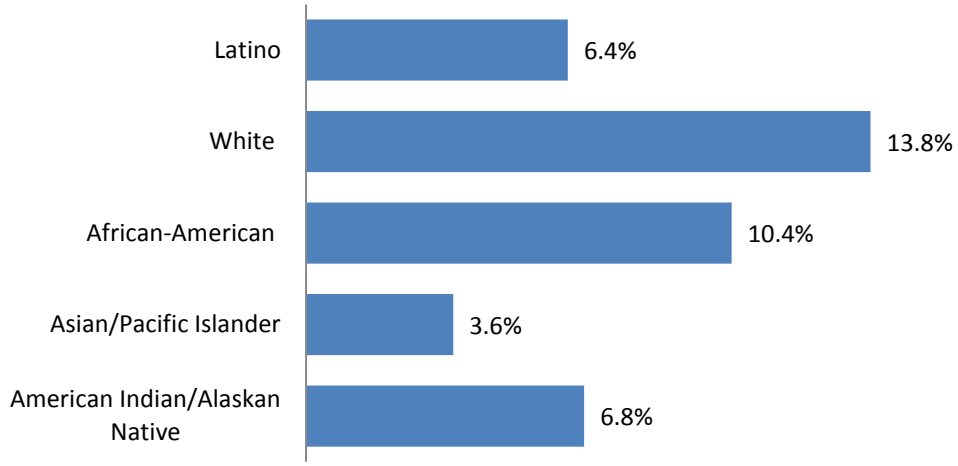
CHMC Service Area	SVMC Service Area	GSH Service Area
90010-Wilshire (1828.5) 90016-West Adam (1386.0) 90018-Jefferson Park (1323.3) 90028-Hollywood (1283.0) 90008-Baldwin Hills/Crenshaw (1107.4)	90010-Wilshire (1828.5) 90016-West Adam (1386.0) 90018-Jefferson Park (1323.3) 90062-South Los Angeles (1120.0) 90043-View Park-Windsor Hills (1109.0) 90008-Baldwin Hills/Crenshaw (1107.4)	90014-Los Angeles (3719.3) 90021-Downtown Los Angeles (3283.5) 90010-Wilshire (1828.5) 90018-Jefferson Park (1323.3)

Data source[1]: Office of Statewide Health Planning and Development (OSHPD)

Depression Prevalence by Age, 2015



Depression Prevalence by Ethnicity



Data source: Los Angeles County Health Survey
Data year: 2015
Source geography: County

Associated drivers and risk factors

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.[6]

Community input

Stakeholders emphasized that stigma around mental health/illness--especially among communities of color--serves as an obstacle to accessing care. In some cases, individuals fear that they might lose their jobs if their employers learn they are seeking metal health care.

Stakeholders observed that mental health practitioners lack competency in providing effective mental health care to seniors, those who speak languages other than English, those with diverse cultural backgrounds. Additionally, cultural healers and indigenous religions and practices that may provide effective mental health support are not valued or leveraged in mental health care.

Finally, stakeholders addressed a severe shortage of mental health providers for a community with a high need for mental health care. For example, there is only one suicide responding team (PET team) for SPA 4. Overall, stakeholders identified a long waiting list for mental health services and an overreliance on interns in mental health facilities. There are particularly few services available to language minority clients and undocumented clients. Finally, funding for mental health service screening and delivery is limited.

Obesity/Overweight

About 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.[125] 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.[126] 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

Obesity/Overweight Indicators

Indicators	Year	Comparison		CHMC Service Area	SVMC Service Area	GSH Service Area
		Level	Avg.			
Percent of adults who are overweight[1]	2015	LAC	35.9%	34.3%	34.2%	34.2%
Percent of adults who are obese[1]	2015	LAC	23.5%	26.2%	28.5%	24.3%
Percent of children who are overweight for age[2]	2012	LAC	13.3%	15.7%	12.5%	33.1%
Percent of teens who are overweight and obese[2]	2012	LAC	54.8%	32.6%	30.9%	19.0%

[1]Data source: Los Angeles County Health Survey
Data year: 2015
Source geography: SPA
[2]Data source: California Health Interview Survey (Accessed at www.healthycity.org)
Data year: 2012
Source geography: SPA

Geographic areas/subpopulations of greatest impact

- More people are overweight and significantly over the Los Angeles County average (29.7%) in the ZIP codes shown below.

[125] National Cancer Institute. *Obesity and Cancer Risk*. Available at http://www.cancer.gov/cancertopics/factsheet/Risk/obesity. Accessed [August 2, 2016].
[126]National Cancer Institute. *Obesity and Cancer Risk*. Available at http://www.cancer.gov/cancertopics/factsheet/Risk/obesity. Accessed [August 2, 2016].

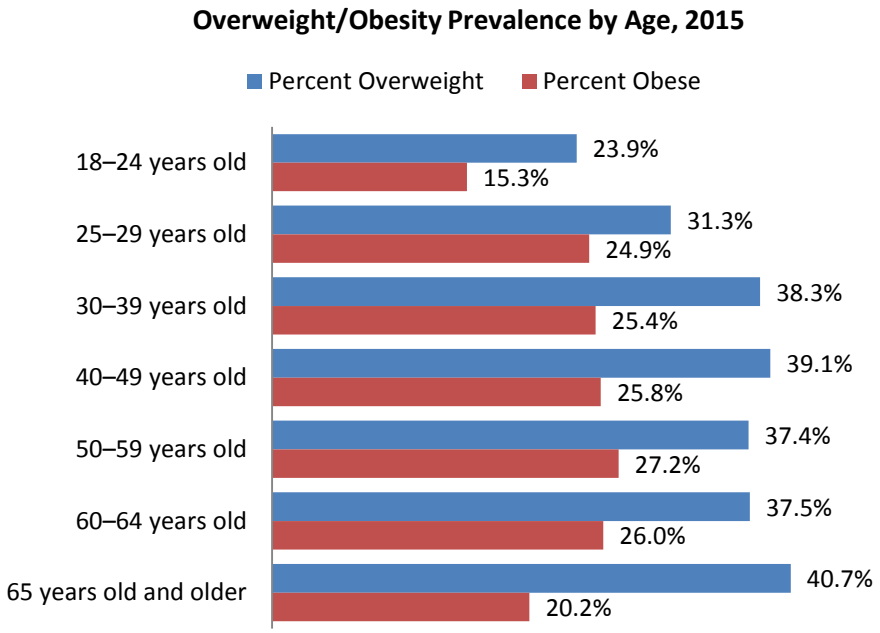
CHMC Service Area	SVMC Service Area	GSH Service Area
90011-South Los Angeles (34.6%) 90037-South Los Angeles (34.1%) 90044-Athens (33.5%) 90018-Jefferson Park (33.1%) 90016-West Adam (32.8%)	90011-South Los Angeles (34.6%) 90001-Los Angeles (34.2%) 90037-South Los Angeles (34.1%) 90003-South Los Angeles (33.9%) 90044-Athens (33.5%) 90002-Los Angeles (33.5%) 90062-South Los Angeles (33.2%) 90018-Jefferson Park (33.1%) 90016-West Adam (32.8%)	90018-Jefferson Park (33.1%) 90021-Downtown Los Angeles (32.2%) 90013-Downtown Los Angeles (31.7%) 90014-Los Angeles (31.3%)

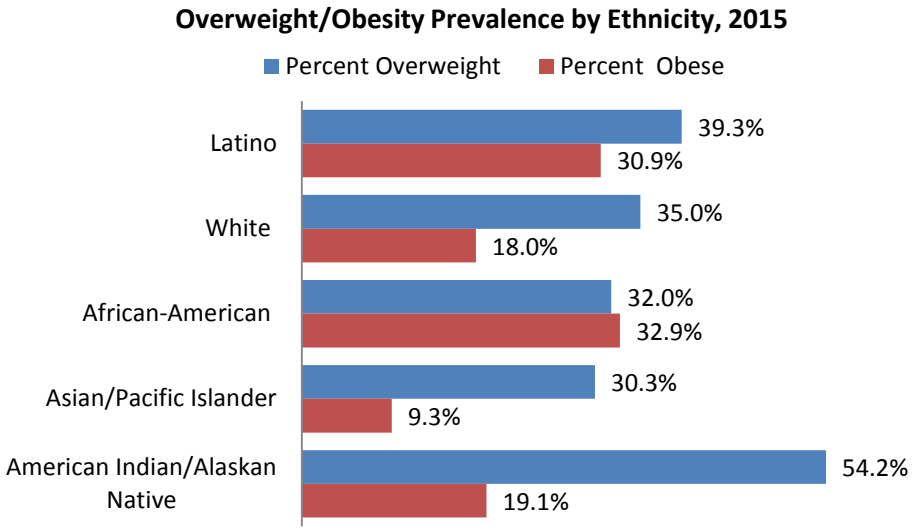
Data source: Healthy Cities
Data year: 2009
Source geography: ZIP Code

- More people are obese and over the Los Angeles County average (21.2%) in the ZIP codes shown below.

CHMC Service Area	SVMC Service Area	GSH Service Area
90037-South Los Angeles (30.7%) 90011-South Los Angeles (30.3%) 90044-Athens (30.0%)	90001-Los Angeles (30.9%) 90043-View Park-Windsor Hills (30.8%) 90037-South Los Angeles (30.7%) 90002-Los Angeles (30.6%) 90003-South Los Angeles (30.6%) 90062-South Los Angeles (30.5%)	90018-Jefferson Park (29.6%)

Data source: Healthy Cities
Data year: 2009
Source geography: ZIP Code





Data source: Los Angeles County Health Survey
Data year: 2015
Source geography: County

Associated drivers and risk factors

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.[127]

Community input

Stakeholders related the high rates of obesity and being overweight to a lack of physical activity, poor diet, and health literacy. Most young people in the service area do not engage in physical education at schools and stay inside after school because of concerns about safety in their communities. The easy availability of fast foods and packaged foods, compared to the lack of access to healthy fruits and vegetables and time for meal preparation leads families to consume more high-calorie and unhealthy food. Finally, health care providers recognize that there is a lack of awareness of the severity and importance of obesity as a precursor to other diseases. Stakeholders called for policies in schools and organizations that enforce the provision of healthy snacks and lunches.

[127] National Cancer Institute. Obesity and Cancer Risk. Available at http://www.cancer.gov/cancertopics/factsheet/Risk/obesity. Accessed [August 2, 2016].

Oral health

About Oral Health

Dental care is a relevant 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.[128] 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.[129]

Statistical Data- *How is Oral Health Measured? How accessible is Dental Insurance Coverage? How affordable is Dental Care?*

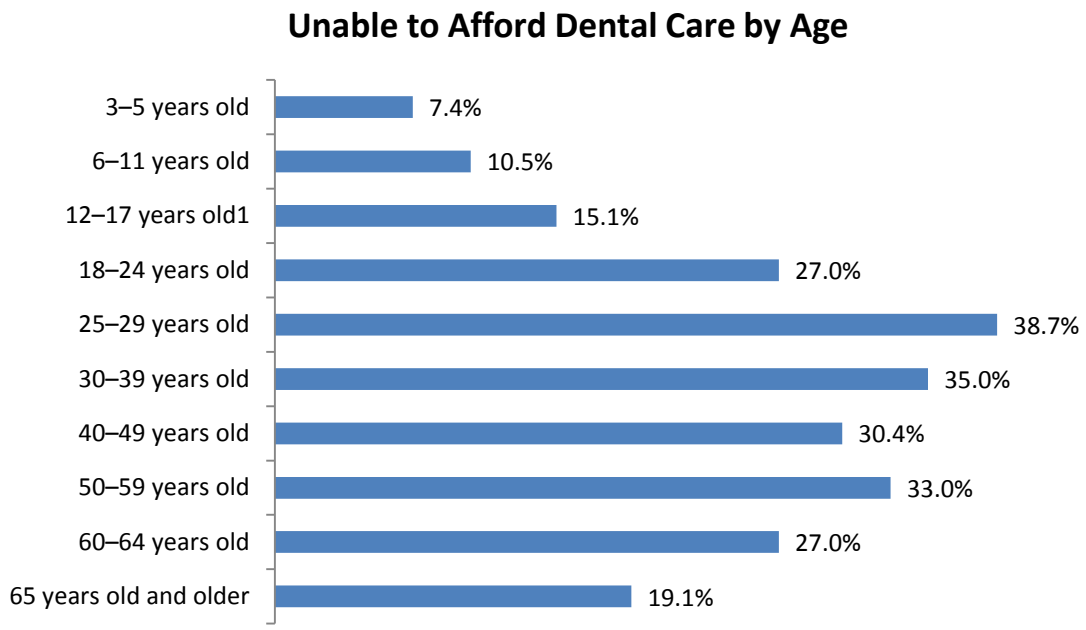
Dental Care Access and Affordability

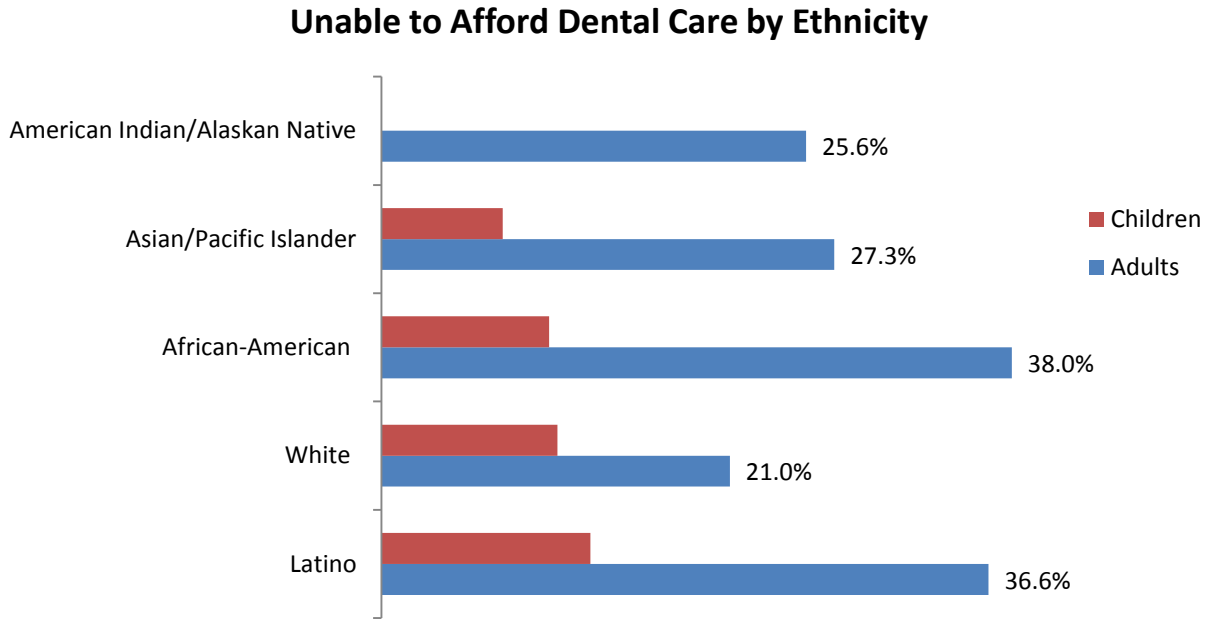
Indicators	Year	Comparison		CHMC Service Area	SVMC Service Area	GSH Service Area
		Level	Avg.			
Absence of Dental Insurance Coverage (Adults)[1]	2015	LAC	51.8%	60.7%	60.6%	61.4%
Unable to Afford Dental Care (Adults)[2]	2011	LAC	30.3%	35.9%	35.0%	37.1%
Unable to Afford Dental Care (Children)[1]	2015	LAC	11.5%	13.5%	12.4%	14.6%

Data source: Los Angeles County Health Survey
Data year: 2015[1],2011[2]
Source geography: SPA

[128] 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 [August 2, 2016].

[129] 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 [August 2, 2016].





Associated drivers and risk factors

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, perio-dontal disease, and tooth loss; using protective gear when playing sports; and living in a safe physical

environment.[130] In addition, oral health conditions such as periodontal (gum) disease have been linked to diabetes, heart disease, stroke, and premature, low-weight births.[131]

Community input

Stakeholders explained that the separation between oral care and medical care both in terms of policy (health insurance coverage, permitted "sick time" off at work) and health literacy has a detrimental impact

Cost of services and insurance coverage are barriers to oral care. Stakeholders explained that dental care costs are prohibitive for those who lack insurance, and that dental services are often not covered for those who are insured. Additionally, dental care providers are very selective in the types of insurance they will accept, and they often don't take Medi-Cal because of Medi-Cal's historically low reimbursement rates.

Stakeholders reported that the high costs of dental care are compounded by high rates of dental fraud in the service area. Patients receive recommendations for unnecessary, expensive procedures that are not medically indicated. Additionally, stakeholders observed that some health care providers offer Care Credit packages to non-English speaking customers who most likely do not understand the terms explained in English in the Care Credit materials.

The service area lacks sufficient oral care resources for subpopulations including the elderly and indigent, children, and the homeless.

[130] World Health Organization, Oral health Fact Sheet. Geneva, Switzerland. Available at http://www.who.int/mediacentre/factsheets/fs318/en/index.html. Accessed [August 2, 2016].

[131] 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 [August 2, 2016].

Poverty (Includes Housing Instability and Food Insecurity)

About Poverty, Housing Instability, and Food Insecurity

Housing instability among poor families is the result of multiple overlapping factors ranging from a number of income-earning adults in the home, education level of income-earning adults in the home, health of family members, domestic violence exposure, substance use patterns and access to social support and health care.[132] Families and individuals are much more likely to become unstably housed or homeless if they are shouldering a high housing cost burden, typically thought of housing costs that exceed 30% of monthly income.

According to the United States Department of Agriculture, food insecurity is explicitly defined as a household-level economic and social condition of limited or uncertain access to adequate food[133]. The defining characteristic of very low food security is that, at times during the year, the food intake of household members is reduced and their normal eating patterns are disrupted because the household lacks money and other resources for food.[134]

Statistical Data- *How is poverty measured? What is the prevalence of poverty in the service areas for metro hospitals?*

Poverty Indicators

Indicators	Year	Comparison		CHMC Service Area	SVMC Service Area	GSH Service Area
		Level	Avg.			
Families Below Poverty[1]	2016	LAC	14.9%	26.5%	27.6%	25.1%
Families Below Poverty with Children[1]	2016	LAC	11.7%	20.9%	22.4%	18.9%
Percent of adults who are unemployed	2016	LAC	7.6%	8.2%	8.2%	7.9%
Average Estimated Household Income	2016	LAC	$78,309	$53,147	$52,964	$56,088
Households with Incomes <300% Who are Food Insecure[2]	2015	LAC	29.2%	32.0%	32.0%	32.1%

[1] Data source: Nielsen Claritas
Data year: 2015
Source geography: ZIP Code
[2]Los Angeles County Health Survey
Data Year: 2015
Source geography: County
LAC=Los Angeles County
CA=California

[132] A Secondary Analysis by ICPH utilizing data from the Fragile Families and Child Well-being Study.Institute for Children, Poverty & Homelessness. http://www.icphusa.org/index.asp?page=16&report=112&pg=110. Accessed: [September 2, 2016].
[133] United States Department of Agriculture. Economic Research Service. Washington D.C. Available at: http://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/definitions-of-food-security.aspx. Accessed [August 29, 2016].
[134] United States Department of Agriculture. Economic Research Service. Washington D.C. Available at: http://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/definitions-of-food-security.aspx. Accessed [August 29, 2016].

Geographic areas/subpopulations of greatest impact

- The percentage of families living below poverty level is 14.9%. The following geographies in each service area have a percentage of families living below poverty level well below the average for Los Angeles County.

CHMC Service Area	SVMC Service Area	GSH Service Area
90017-Downtown Los Angeles (47.9%) 90011-South Los Angeles (43.6%) 90016-West Adams (39.8%)	90017-Downtown Los Angeles (47.9%) 90011-South Los Angeles (43.6%) 90037-West Adams (39.8%) 90003-Los Angeles (39.4%)	90017-Downtown Los Angeles (47.9%) 90007-South Los Angeles (36.4%) 90057-Westlake (35.2%)

Community Input

Stakeholders explained that food insecurity in the service area results from the compounded impact of low income and a lack of affordable healthy food.

Sexually Transmitted Diseases

About communicable diseases including sexually transmitted diseases (STDs)

Sexually transmitted diseases (STDs) refer to more than 25 infectious organisms that are transmitted primarily through sexual activity. STD prevention is an essential primary care strategy for improving reproductive health. Despite the burdens, costs, and complications—and their being preventable to a certain extent—STDs remain a significant public health problem in the United States, greatly under-recognized by the public, policymakers, and health care professionals. STDs have the potential to cause many harmful, often irreversible clinical complications, including having an impact on reproductive health, fetal and perinatal health problems and cancer, and the transmission of HIV. The spread of STDs is directly affected by social, economic, and behavioral factors. Many studies document the association of substance abuse with STDs. The introduction of illicit substances into communities often can alter sexual behavior drastically in high-risk sexual networks, leading to the spread of STDs.[135]

Adolescents ages 15 to 24 account for nearly half of the 20 million new cases of STDs each year in the United States. Today, four in 10 sexually active teen girls in the United States have had an STD with the potential to cause infertility and even death. Regular screenings are critical, as STDs often have no obvious signs or physical symptoms. Also, certain racial and ethnic groups (mainly African-American, Hispanic/Latino, and American Indian/Alaska Native populations) have high rates of STDs compared with Whites. Race and ethnicity in the United States are correlated with other determinants of health status such as poverty, limited access to health care, fewer attempts to get medical treatment, and living in communities with high rates of STDs.[136]

Statistical data

Sexually Transmitted Diseases

Indicators	Year	Comparison		CHMC Service Area	SVMC Service Area	GSH Service Area
		Level	Avg.			
HIV Incidence per 100,000[3]	2012	LAC	24.9	59.0	48.7	70.5
Syphilis Incidence per 100,000[3]	2014	LAC	8.1	19.7	15.9	24.1
Chlamydia Incidence per 100,000[3]	2013	LAC	512.9	716.2	789.8	662.8
Gonorrhea Incidence per 100,000[3]	2013	LAC	103.4	205.4	207.3	209.7

[135] Centers for Disease Control and Prevention. (2015). *Sexually Transmitted Diseases*. Washington, DC. Available at http://www.healthypeople.gov/2020/topics-objectives/topic/sexually-transmitted-diseases. Accessed [August 2, 2016].
[136] Centers for Disease Control and Prevention. (2015). *Sexually Transmitted Diseases*. Washington, DC. Available at http://www.healthypeople.gov/2020/topics-objectives/topic/sexually-transmitted-diseases. Accessed [August 2, 2016].

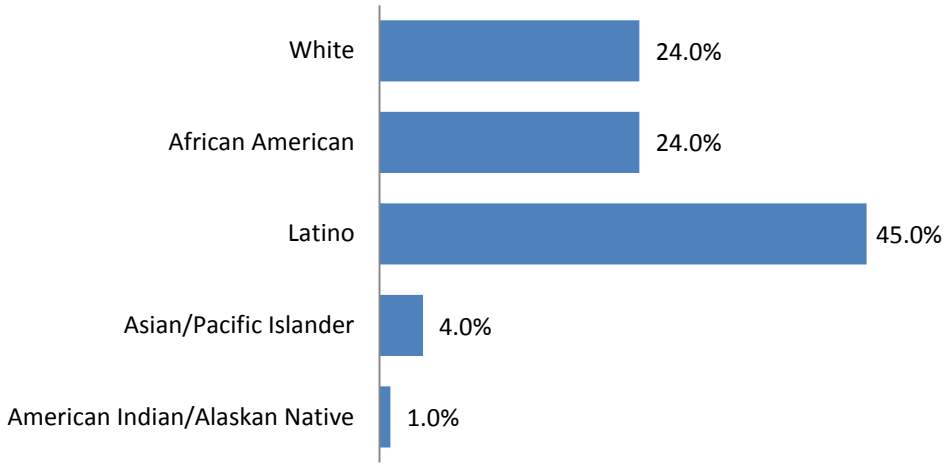
[1]Data source: Los Angeles County Health Survey
Data year: 2012
Source geography: SPA
[2]Data source: Office of Statewide Health Planning and Development (OSHPD)
Data year: 2014
Source geography: ZIP Code
[3]Data source: California Department of Public Health (CDPH)
Data year: 2013
Source geography: ZIP Code
[4]Data source: Los Angeles County Department of Public Health, Acute Communicable Disease Control Program, Annual Morbidity Report and Special Studies Report
Data year: 2013
Source geography: SPA
[5] Data source: Los Angeles County Department of Public Health, Acute Communicable Disease Control Program, Annual Morbidity Report and Special Studies Report
Data year: 2013

Geographic areas/subpopulations of greatest impact (disparities)

- The rate of HIV hospitalizations per 100,000 people were highest in each service area in the following ZIP codes.

CHMC Service Area	SVMC Service Area	GSH Service Area
90010-Wilshire (105.3) 90028-Hollywood (101.0) 90046-Mount Olympus (88.5) 90016-West Adam (71.4) 90008-Baldwin Hills/Crenshaw (71.1)	90010-Wilshire (105.3) 90016-West Adam (71.4) 90008-Baldwin Hills/Crenshaw (71.1)	Not in report

HIV Diagnoses by Race/Ethnicity, 2013



Data source: 2014 Annual HIV/STD Surveillance Report
Data year: 2013
Source geography: County

Associated drivers and risk factors

Different ethnicities see different patterns of HIV infection. The largest proportion of HIV diagnoses reported in 2013 in Los Angeles County occurred among Latinos (45%), and almost half of Stage 3 diagnoses in 2013 occurred among Latinos. HIV diagnosis rates also increased among Asian males by nearly 20% from 2010-2012[137]. Other sexually transmitted diseases including chlamydia and gonorrhea can increase the spread of HIV through various biological mechanisms.[138]

The spread of STDs is directly affected by social, economic, and behavioral factors. Obstacles to STD prevention include access to and provision of care, willingness to seek care, and social norms regarding sex and sexuality. Among certain vulnerable populations, a historical experience with segregation and discrimination exacerbates the influence of these factors. Many studies document the association of substance abuse with STDs. The introduction of illicit substances into communities often can alter sexual behavior drastically in high-risk sexual networks, leading to the spread of STDs.[139]

Community input

Stakeholders stated that there are a growing number of community members with tuberculosis. Many tuberculosis patients do not seek treatment early on, accelerating the transmission of the disease to others.

[137] Los Angeles County Department of Public Health. (2014). 2014 Annual HIV/STD Surveillance Report. Available at: http://publichealth.lacounty.gov/dhsp/Reports/HIV-STDsurveillanceReport2014.pdf.

[138] Centers for Disease Control and Prevention (2015). California-2015 State Health Profile. Available at https://www.cdc.gov/nchhstp/stateprofiles/pdf/california_profile.pdf.

[139] Centers for Disease Control and Prevention. (2015). *Sexually Transmitted Diseases*. Washington, DC. Available at http://www.healthypeople.gov/2020/topics-objectives/topic/sexually-transmitted-diseases. Accessed [August 2, 2016].

Transportation

About Transportation

Transportation barriers are often cited as barriers to healthcare access. Transportation barriers can lead to rescheduled or missed appointments, delayed care, and missed or delayed medication use. These consequences may cause poorer management of chronic illness and thus poorer health outcomes. However, the significance of these barriers is uncertain based on existing literature due to wide variability in both study populations and transportation barrier measures[140].

Modes of Transportation

Indicators	Year	Comparison		CHMC Service Area	SVMC Service Area	GSH Service Area
		Level	Avg.			
Drove Alone	2015	LAC	72.6%	56.2%	58.0%	49.1%
Car Pooled	2015	LAC	10.1%	9.1%	9.9%	7.8%
Public Transportation	2015	LAC	7.1%	21.7%	20.7%	24.2%
Walked	2015	LAC	2.9%	4.8%	4.3%	8.7%
Bicycled	2015	LAC	0.9%	1.5%	1.3%	2.0%
Other Means	2015	LAC	1.4%	1.6%	1.4%	2.1%
Worked from home	2015	LAC	5.2%	5.1%	4.6%	6.1%
Average Vehicles per Household	2015	LAC	1.8	1.2	1.3	1.0

Data Source: Los Angeles County Health Survey
Data Year: 2015
Source Geography: SPA

Community Input

Public transportation functions as a barrier to care for residents because of cost and extended travel times, particularly when assigned health care providers are very distant from residents' homes or workplaces.

Additionally, the elderly and the disabled face challenges in accessing transportation to health care providers as well as to healthy food outlets.

[140] Institute for Health and Research Policy. Traveling towards disease: transportation barriers to health care access. Chicago, IL. Available at: http://www.ihrp.uic.edu/content/traveling-towards-disease-transportation-barriers-health-care-access. Accessed: [September 2, 2016].

Violence/Injury/Safety

About Violence, Injury and Safety

Injuries can result from many unintentional or intentional events including motor vehicle accidents, falls, job-related accidents, gun shot and blast wounds and sports injuries. Common diagnoses include brain injury, spinal cord injury, amputation, anoxia, and muscular-skeletal injury[141]. Injuries affect everyone, regardless of age, gender, ethnicity, or economic status[142]. Although injuries are often unavoidable, there are steps that can be taken to lessen the consequences of injuries, including wearing seat belts, violence prevention education, ignition interlock and in-car breathalyzers to prevent drunk driving, pro-active job site safety precautions and regular physical activity[143].

Statistical data—*How are violence, injury and safety measured? What is the prevalence/incidence rate of violence, injury and safety in the community?*

Teens Perception of Neighborhood and School Safety, 2012, 2014

Indicators	Year	Comparison		CHMC Service Area	SVMC Service Area	GSH Service Area
		Level	Avg.			
Received threats of violence or physical harm from peers in past year[1]	2012	LAC	14.7%	18.8%	17.2%	19.7%
Feared of being attacked at school in the past year[1]	2012	LAC	17.1%	20.1%	20.9%	19.4%
Felt unsafe in nearby park or playground during the day[2]	2014	LAC	11.7%	9.4%	10.7%	8.2%

[1]California Health interview Survey, 2012, SPA
[2]California Health interview Survey, 2014, SPA
*Data for SPA 2 unavailable—Not included in GMHHC estimated calculation

Geographic areas/subpopulations of greatest impact

The ZIP codes with the highest percentages of unintentional injuries leading to death, compared to the Los Angeles County average (3.5%), are listed below:

CHMC Service Area	SVMC Service Area	GSH Service Area
90028-Hollywood (10.9%) 90011-South Los Angeles (7.0%) 90005-Koreatown (6.6%)	90011-South Los Angeles (7.0%) 90005-Koreatown (6.6%) 90007-South Los Angeles (6.4%)	90013-Downtown Los Angeles (10.1%) 90014-Los Angeles (9.0%) 90007-South Los Angeles (6.4%)

[141] Centers for Disease Control and Prevention. Injury Prevention and Control. Atlanta, GA. Available at http://www.cdc.gov/injury/overview/index.html. Accessed [August 2, 2016].
[142] Centers for Disease Control and Prevention. Injury Prevention and Control. Atlanta, GA. Available at http://www.cdc.gov/injury/overview/index.html. Accessed [August 2, 2016].
[143] Centers for Disease Control and Prevention. Injury Prevention and Control. Atlanta, GA. Available at http://www.cdc.gov/injury/overview/index.html. Accessed [August 2, 2016].

Community input

Stakeholders highlighted the fact that the community is impacted by domestic violence because it is often underreported for fear of negative interpersonal, economic and legal repercussions, particularly among families with undocumented family members. Stakeholders observed that domestic violence is becoming more prevalent among younger residents, and explained there are a lack of community education around healthy relationships and very few safe spaces for victims given the very dense population in the service area.

Street violence continues to be a concern in the service area, and stakeholders noted that gangs particularly target young people. This is a particular concern because there is a current strained relationship with law enforcement.

[1] 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. Accessed [March 12, 2013].

[2] 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].

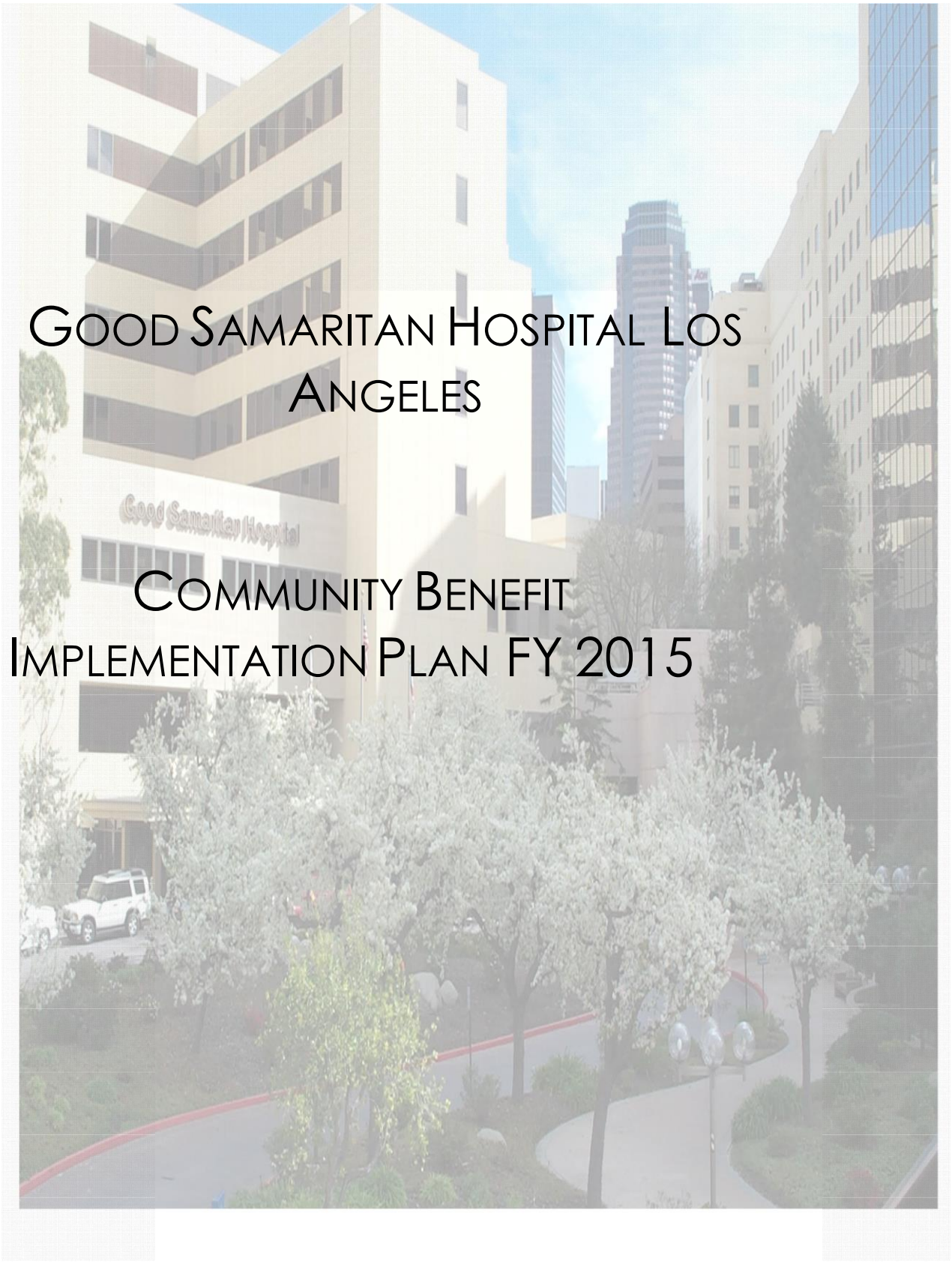
[3] National Institute of Mental Health. *Any Disorder Among Adults.* Available at http://www.nimh.nih.gov/statistics/1ANYDIS_ADULT.shtml. Accessed [March 12, 2013].

[4] 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].

[5] 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].

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

Appendix H—Community Benefit Report



GOOD SAMARITAN HOSPITAL LOS ANGELES

COMMUNITY BENEFIT IMPLEMENTATION PLAN FY 2015

CONTENTS

EXECUTIVE SUMMARY

1. EXECUTIVE SUMMARY

Recognized as Best Medical Center in Downtown Los Angeles for 17 years by the Los Angeles Downtown News, Good Samaritan Hospital (GSH) has a reputation for excellence. The 130-year-old hospital is located just west of Downtown Los Angeles. A leader in specialty and tertiary services, the hospital houses many regional centers of excellence which draw patients from all over California, the western states and other countries. The 408-bed hospital offers a state-of-the-art heart care program, including cardiology, cardiothoracic surgery and an AMI transport ambulance; a neurosciences program featuring the Gamma Knife Stereotactic Unit for treatment of brain cancer and functional disorders; women's health services, including obstetrics, gynecology, perinatology, neonatal intensive care, gyn-oncology, and breast care; orthopedic sports medicine, joint replacement and spine surgery program; podiatric services; nasal and sinus disorders treatment; ophthalmologic care, including retinal surgery; an oncology program; a transfusion-free medicine and surgery program; emergency services with a "FastTrack" urgent care program and many other outstanding specialized medical services. Good Samaritan Hospital's Stroke Program has attained The Joint Commission's Gold Seal of Approval® and the American Heart Association/American Stroke Association's Heart-Check mark as a certified primary stroke center. The recognition means the Stroke Program has met The Joint Commission's standards for providing stroke care. Good Samaritan Hospital's Emergency Department also received designation from Los Angeles County Emergency Medical Services as a receiving center for stroke patients.

GSH's primary service area includes two of the eight Service Planning Areas (SPAs) in the County (SPA 4 and SPA 6). More specifically, GSH identified five of the 26 health districts in Los Angeles County as target regions for its needs assessment. In 2013, the total population within the GSH primary service area was 512,717, making up 5.1% of the population of Los Angeles County. By 2018, the population is expected to increase in the GSH primary service area by about 3%, similar to the projected increase in Los Angeles County.

In 2013, most of the population in the GSH primary service area was Hispanic (53.5%, n=274,463) or Asian (22.9%, n=117,541), a larger percentage when compared to Los Angeles County (48.5% and 13.9%, respectively). The third largest population in the GSH primary service area was White or Caucasian (12.9%, n=66,234) followed by Black or African American (8.6%, n=44,216).

Nearly half the population in the GSH primary service area was between the ages of 25 and 54 (48.8%), in comparison to Los Angeles County (43.0%). A fifth (20.4%) was under the age of 18, which is lower when compared to Los Angeles County (23.8%). Another 8.6% was over the age of 65, lower when compared to

Los Angeles County (11.6%). In 2013, there was a rise in young (on average, 34 years old), single renters moving into the Los Angeles Downtown area.

This Community Benefits Implementation Plan is based on the findings of the 2013 Community Needs Assessment. The Needs Assessment for Good Samaritan Hospital was conducted in collaboration with California Hospital Medical Center and St. Vincent Medical Center.

The Community Needs Assessment process identified the top broad health issues as:

- Access to care (health insurance, regular source of care, inappropriate use of the ER)
- Health behaviors and preventive care (breastfeeding, screenings and vaccinations)
- Care for chronic conditions (diabetes, heart disease)
- Communicable diseases and sexually transmitted diseases
- Community social issues (including mental health care)
- Cancer Care

For needs that are not addressed such as mental health services, education on sexually transmitted disease including HIV, alcohol and substance abuse, and Alzheimer's disease, Good Samaritan Hospital has partnered with several organizations that have this expertise.

For Fiscal Year 2015, the quantifiable community benefits which Good Samaritan Hospital provided totaled $11,436,432, a decrease of 70% from FY 2014 ($37,800,672) due to an increase in funding from California's Hospital Quality Assurance Fee Program (HQAF). The program provides funding for supplemental payments to California hospitals that serve Medi-Cal and uninsured patients. Total community benefit costs include $11,037,912 for services to vulnerable populations including charity care and $398,520 for health research, education and training. These and other community benefits will continue as outlined in our Charity Care Policy. In addition to these quantifiable benefits, Good Samaritan Hospital provides significant non-quantifiable benefits as a major employer in the community; and through the volunteer and advocacy efforts of its physicians, employees, and Board of Trustees.

The initiatives included in this year's Community Benefit Implementation plan will require collaboration with many public and private organizations including philanthropic foundations, disease support groups, and governmental programs for the uninsured, community service agencies, local elected officials, security agencies and schools.

ABOUT GOOD SAMARITAN HOSPITAL

2. ABOUT GOOD SAMARITAN HOSPITAL

General Identifying Information

Good Samaritan Hospital is a 408-bed facility located on the western side of downtown Los Angeles adjacent to the Pico-Union-Westlake district. Addressing the health care challenges of the Los Angeles community since 1885, the hospital continues its mission to meet the needs of our patients and their families, the community and our physicians.

The majority of Good Samaritan Hospital's patient population resides in the city of Los Angeles. Of those, almost half come from the hospital's primary service area, within an approximate five-mile radius of Good Samaritan Hospital.

A leader in specialty and tertiary care, the hospital houses many regional centers of excellence that draw patients from all over California, the western states, and other countries. The hospital offers a state-of-the-art heart care program, including cardiology, cardiothoracic surgery and an AMI transport ambulance; a neurosciences program featuring the Gamma Knife Stereotactic Unit for treatment of brain cancer and functional disorders; women's health services, including obstetrics, gynecology, perinatology, neonatal intensive care, and breast care; an orthopedic program including sports medicine, joint replacement and spine surgery program; a urology program including the Kidney Stone Service and state of the art treatment modalities for prostate cancer treatment such as the high dose radiation (HDR) implant program; a gastroenterology and pancreatico-biliary program with endoscopic ultrasonographic capabilities; nasal and sinus disorder treatment; ophthalmologic care, including retinal surgery; an oncology program featuring the latest radiotherapy technologies; a transfusion-free medicine and surgery program; and many other outstanding specialized medical services.

While Good Samaritan Hospital has historic ties to the Episcopal Church, it is now a non-sectarian, community-governed hospital, with patients, staff and physicians representing a diverse cross-section of Los Angeles. Good Samaritan is a not-for-profit, stand-alone hospital and has approximately 1,600 employees, including 550 nurses, and more than 680 physicians on its medical staff. Charles T. Munger heads the Board of Trustees; Andrew B. Leeka serves as president and chief executive officer; and Sammy Feuerlicht, vice president of Business Development, is the contact for this Community Benefit Report.

Organizational Structure

As previously noted, the hospital is led by Andrew B. Leeka, President and CEO who reports directly to the Hospital's Board of Trustees. Working very closely with him is our Medical Staff Chair, Margaret Bates, M.D.

The President's Council is made up of eight vice-presidents who meet weekly with Mr. Leeka to implement and evaluate hospital activities. Included in the council are the: Vice President of Information Systems; Vice President of Business Development; Vice President of Development; Vice President of Ancillary and Support Services; Vice President of Patient Care Services, Vice President of Financial Services, Vice President of Institutional Affiliations, and Vice President of Human Resources.

This report is the product of an ad-hoc task force that met over a several month period. Members included:

- Coralyn AndresTaylor (Community Health Education and Outreach)
- Katrina R. Bada (Manager of Public Relations & Marketing)
- Rosemary Boston (Manager of Cancer Services)
- Esther Duenas (Director of Volunteer Services)
- Sammy Feuerlicht (Vice President of Business Development)
- Jamie Whitcomb (Director, Revenue Management)

Mission Statement – *adopted in 1998, last reviewed July 2014*

Good Samaritan Hospital is a progressive, tertiary, not-for-profit hospital. Our mission is to provide accessible, quality, cost-effective and compassionate health-care services that meet the needs of our patients and their families, the community and our physicians.
Good Samaritan Hospital's centers of excellence focus on advancing the science of medicine and providing outstanding health care. We will manage our resources responsibly, maintaining the financial viability necessary for success.

Vision Statement - *adopted in 1998, reviewed July 2014*

Good Samaritan Hospital will grow into a leading regional health care provider. As we expand the breadth of our services, we will practice continuous quality improvement. We will accomplish our mission by seeking new opportunities and forming alliances with physicians, other health care providers and purchasers of health care services.
We will encourage improvement in the health status of community residents, advocating equal access to necessary care. We will respond to Southern California's health care needs in the most caring, compassionate and efficient manner.

Organizational Values

The leadership and staff at Good Samaritan Hospital recognize the importance in providing accessible, quality, cost-effective, and compassionate health care to our community. To accomplish this mission, we have established the following values:

We maintain the highest level of ethical and professional conduct, treating our patients with dignity and respect.

We, as employees, physicians and volunteers will work as a team to provide outstanding and compassionate care to anyone in need, regardless of race, creed, sex or religion, age, and physical or mental disability.

We constantly strive for excellence in all we do and recognize the importance of creativity and innovation.

We recognize that the care of our patients is our primary responsibility and our reason for existence.

We believe in operating efficiently to ensure fiscal soundness and maintain the viability of this organization.

The values are exemplified by leadership, employees, the medical staff, our volunteers, and others who we partner with to provide services to our patients, and are demonstrated through various policies and programs. These include our team-based leadership structure to implement innovative ways to improve our health care services, our Peak Performance in Practice and Six Sigma Models to continuously improve quality and patient safety, and our hospital-wide customer service initiatives which focus on improving the way in which we interact with each other.

How Mission Statement Supports GSH Community Benefits Plan

Every Good Samaritan Hospital employee wears badges that include our Mission and Vision statements and core values for the hospital. Our organizational values are highlighted in employee newsletter articles that relate to projects that address these values. We realize that to live up to our mission and reach our vision, each employee must accept and recognize that they are a part of our growth.

The driving force of our mission is to meet the needs of our patients, their families and communities by providing quality and accessible health care services in a manner that uses our resources responsibly. Our outreach and involvement with the community surrounding Good Samaritan Hospital is maintained through efforts to address and resolve problems associated with the unmet medical needs of our local population. Data from our community needs assessment are presented to the hospital's entire management staff so that their care-giving activities can be put into the larger context of serving the community.

Our Business Development Department is constantly looking for ways to increase access to care based on the needs of the community and our health care expertise. Once secured by our business development team, hospital staff pull together to help sponsor staff health fairs or seminars which are either located on campus or at residential housing or church facilities within neighboring ethnic communities.

Our Emergency Department, Perinatal Services, Social Services and Educational Departments evaluate and develop new programs that address community needs based on the clinical profile of our patients.

As our partners in health care, Good Samaritan Hospital works closely with our medical staff to enhance or create programs that make our services more accessible and beneficial to the community. Physician recruitment efforts focus on increasing access for the underserved, Medi-Cal, and linguistically isolated communities in our service area.

SUMMARY OF FINDINGS FROM COMMUNITY NEEDS ASSESSMENT

3. SUMMARY OF FINDINGS FROM COMMUNITY NEEDS ASSESSMENT

Assessment Process

Collaborative Effort for Needs Assessment Process

Since 1994, nonprofit hospitals in California are required by Senate Bill 697 to justify their tax exempt status by documenting their commitment to community health. The law calls for hospitals to reaffirm their mission statements supporting community health, conduct a health needs assessment every three years, and develop an annual community benefit plan based on the needs assessment.

The Patient Protection and Affordable Care Act (ACA) enacted on March 23, 2010 contain requirements for nonprofit hospitals that are modeled after California's SB 697. The ACA adds a requirement under Section 501(R) of the Internal Revenue Code for nonprofit hospitals to conduct a Community Health Needs Assessment (CHNA) at least once every three years with an annual implementation plan. In some cases the new federal mandate provides more specific guidelines with regard to determining health priorities and documenting hospital's health improvement efforts. For instance, the CHNA requires hospitals to collect input from designated representatives (see appendix C) 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.

In 2013, Good Samaritan Hospital worked in collaboration with nearby hospitals to develop a community needs assessment based on the health of residents in their collective service areas. This was the fifth time Good Samaritan has participated in a multi-hospital needs assessment. The group of hospitals, called the Metro Collaborative, includes:

- Good Samaritan Hospital
- California Hospital Medical Center
- St. Vincent Medical Center

For the 2013 CHNA, a process to prioritize health needs and drivers was introduced. This consisted of a facilitated group session that engaged participants 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 following lists present the prioritized health needs and drivers.

Health Needs: The following needs were identified through the analysis of primary and secondary data and are presented in prioritized order.	**Health Drivers** The following health drivers were identified through the analysis of primary and secondary data. They are presented in prioritized order
Prioritized Health Needs 1. Mental Health 2. Oral Health 3. Substance Abuse 4. Diabetes 5. Obesity/Overweight 6. Alzheimer's Disease 7. Cardiovascular Disease 8. Alcoholism 9. Sexually Transmitted Diseases 10. Allergies 11. Asthma 12. Hypertension 13. Vision 14. Cholesterol 15. Cancer, general 16. Colorectal Cancer 17. Arthritis 18. Breast Cancer 19. HIV/AIDS	**Prioritized Health Drivers** 1. Poverty (including unemployment) 2. Housing 3. Specialty Care Access 4. Homelessness 5. Disease Management 6. Health Care Access 7. Cultural Barriers 8. Immigrant Status 9. Social Barriers (i.e. family issues) 10. Alcohol and Substance Abuse 11. Community Violence 12. Coordinated Health care 13. Transportation 14. Healthy Eating (including breastfeeding) 15. Physical Activity 16. Preventative Care Services 17. Health Education and Awareness

Primary Data—Community Input

Information and opinions were gathered directly from persons who represent the broad interests and perspectives of the community served by the hospital. A total of 10 focus groups and 29 telephone interviews were conducted with a broad range of community stakeholders, including area residents. The purpose of 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. Stakeholders represented a wide range of health and social service expertise as well as representatives from diverse ethnic backgrounds including African-Americans, Chinese, Filipinos, Koreans and Latinos

The interviews were conducted primarily via telephone for approximately 30 to 45 minutes each. 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.

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.

The stakeholders[1] 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. Participants included residents and representative from African-American, Latino and Asian-Pacific Islander communities. Interpretation services were provided in Spanish and Mandarin.

Secondary Data – Literature Review

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

[1] 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 Metro Hospital Collaborative.

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 a health issue that may not have been reflected by the secondary data indicators. In addition, data are not always collected on an annual basis, and some data are several years old.

Demographics of Service Area

Good Samaritan Hospital's primary service area is defined by sixteen zip codes within a five mile radius. The cities/areas in Good Samaritan Hospital's service area are: Echo Park, Koreatown, Los Angeles, Pico-Union, Westlake, and Wilshire Center

Good Samaritan Hospital (GSH) provides services in two of the eight Service Planning Areas (SPAs) in the County SPA 4 and SPA 6. Specifically, GSH identified five of the 26 health districts in Los Angeles County as target regions: Central, Hollywood/Wilshire, Northeast, Southeast, and Southwest.

Population Data

In 2013, the total population within the GSH primary service area was 512,717, making up 5.1% of the population of Los Angeles County. This represents a decrease of 8.6% between 2010 and 2013 in the GSH service area. The largest population increase occurred in ZIP Code 90010 (54.3%) and the largest decrease occurred in ZIP Code 90020 (-23.3%).

Most of the population in the GSH primary service area in 2013 was Hispanic (53.5%, n=274,463) or Asian (22.9%, n=117,541), a larger percentage when compared to Los Angeles County (48.5% and 13.9%, respectively). The third largest population in the GSH primary service area was White or Caucasian (12.9%, n=66,234) followed by African American (8.6%, n=44,216).

Household Income

The median household income in the GSH primary service area was $29,707, much lower than the median household income in Los Angeles County ($53,880). Similarly, the average household income in the GSH primary service area ($45,941) was far lower than the Los Angeles County average ($78,598).

Uninsured Adults

In 2011, close to a quarter (23.2%) of the adult population in the GSH primary service area were 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.

Births & Breastfeeding

- In 2011, there were a total of 6,486 births in the GSH primary service area, making up 5.0% of the births in Los Angeles County (n=129,087). Most births in GSH's primary service area occurred in ZIP codes 90006 (n=931), 90026 (n=826), 90004 (n=810), and 90057 (n=782).
- By ethnicity, most births in the GSH primary service area in 2010 were to Hispanic mothers (80.3%), followed by mothers who are African-American (16.7%). Similar trends were noted in Los Angeles County except that a higher percentage of births occurred to White or Caucasian mothers (16.9%) in Los Angeles County when compared to the GSH primary service area (0.7%).
- In 2010, most births in the GSH primary service area were to women between the ages of 20 and 29 (53.9%) and those between the ages of 30 and 34 (19.1%), followed by women 35 and older (13.9%) and those under 20 years old (13.1%). Los Angeles County experienced similar trends.
- Los Angeles County's 2013 average rate of exclusive breastfeeding at hospital discharge was 23.8%; a decrease from years past and lower than California's rate of 40.5% for the same year, even though nearly 90% of women initiate breastfeeding upon delivery. In addition, according a 2013 UC Davis Human Lactation report of exclusive breastfeeding rates, nine hospitals in Los Angeles County were among the state's lowest performers. Good Samaritan Hospital was one of those hospitals with an exclusive breastfeeding rate of 30.8% . These rates indicate the need to support mothers before, during and after pregnancy. To address this need, in 2013, GSH began the process of becoming a designated Baby Friendly Breastfeeding Hospital and is making good progress toward that goal.

Cause of Death

- In 2010, the most common cause of death in the GSH primary service area (28.8%) was heart disease, which was also the leading cause of death in Los Angeles County (27.9%).
- The second leading cause of death in the GSH primary service area (23.6%) was cancer, which was also the second leading of death in Los Angeles County (24.6%).
- The third leading cause of death in the GSH primary service area (5.7%) was nephritis, nephrotic syndrome, and nephrosis, which is the tenth leading cause of death in Los Angeles County (1.7%).
- In 2010, the 2,337 deaths in the GSH primary service area comprised 4.2% of the total deaths in Los Angeles County. In the GSH primary service area,

most deaths occurred in ZIP Codes 90018 (15.4%), 90026 (12.5%), and 90004 (11.2%).

- Of note, a larger percentage of deaths also occurred among those between 55 and 64 years old (16.2%) in the GSH primary service area when compared to Los Angeles County (12.6%).

Highlights of Key Findings

In accordance with its resources and expertise, Good Samaritan Hospital prioritized from among these health needs and health drivers the areas it can have the greatest impact:

- Health care Access (health insurance, regular source of care, inappropriate utilization of the ER)
- Disease Management and Preventive Care (patient education, breastfeeding, screenings and vaccinations) for communicable disease
- Care for Chronic Conditions (diabetes, heart disease)
- Community/Social Issues
- Cancer Care

The goal of Good Samaritan Hospital is to address most of the needs of the community however there are some health needs that are not addressed because they do not fit within the hospital's scope of services or expertise. These include mental health services, HIV/AIDS and other sexually transmitted diseases, and Alzheimer's disease. The primary factors contributing to this decision include: (1) lack of expertise; (2) limited resources; and, (3) the availability of other providers in the community with more capacity/expertise to address these needs.

Good Samaritan Hospital has established referral and collaborative relationships with the following organizations that have capabilities to provide the services that are not available in the hospital. These organizations include:

- Beacon House (Alcohol and Substance Abuse)
- Bimini (Alcohol and Substance Abuse)
- California Drug Rehabilitation Center Hotline (Alcohol and Substance Abuse)
- Clare Foundation, Cocaine Anonymous (Substance Abuse)
- Department of Mental Health (Mental Health)
- Marijuana Anonymous (Substance Abuse)

Health care Access

Access to primary and specialty health care services is a significant issue faced by patients and providers in the hospital service area. Whether or not one has insurance and the kind of insurance greatly influences one's ability to access primary and specialty care. In addition, various cultural factors create barriers to access.

The Affordable Care Act (ACA) is expected to increase the availability of Medi-Cal and private insurance through the State Health Insurance Exchange. Still, the lack of insurance will be a continuing problem for the large percentage of undocumented residents in the service area.

SUMMARY OF KEY FINDINGS

- In 2011, close to a quarter (23.2%) of the adult population in the GSH primary service area were 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.
- In 2011, the percentage of adults who lacked a consistent source of primary care was greater (24.7%) in the GSH primary service area when compared to Los Angeles County (20.9%). Specifically, SPA 6 (26.5%) had a greater percentage of those who lacked a consistent source of primary care when compared to the overall GSH primary service area (24.7%) and Los Angeles County (20.9%).

Barriers to Access

- Many patients lack knowledge of how to navigate through an extremely complicated health care system.
- Competing priorities for financial resources are more common for the low-income and uninsured, requiring people to make difficult decisions in prioritizing basic needs.
- Cultural beliefs and traditions influences a patient's response to what a health care provider communicates.
- Miscommunication between provider and patient is common in non-English speaking populations.
- Immigrants without residential status, especially those who have children, worry that physicians will notify immigration authorities.
- Lack of transportation limits health care options for residents in the service area.
- Long wait times for appointments at primary care and specialty care facilities is one of the most cited reasons by low-income community members for

failing to keep appointments, having a regular source of care, and making unnecessary ER visits.

Disease Management and Preventive Care

Many of the health problems encountered by residents in the Good Samaritan Hospital service area are preventable, as they are a result of lifestyle factors such as obesity and substance abuse (smoking and drug use). These problems affect all ages, races and ethnic groups. Other factors include lack of physical activity and lack of preventative care such as health screenings. Chronic disease can put tremendous financial, physical, and emotional burdens on individuals and families. Key to limiting the incidence of chronic disease is a focused effort to increase health behaviors including breastfeeding that have been shown to be preventative measures.

SUMMARY OF KEY FINDINGS

Alcohol and Substance abuse

- In 2012, the average alcohol outlet rate per 1,000 adults in the GSH primary service area was 3.7. Even higher rates were reported in ZIP Codes 90010 (11.8), 90021 (9.1), 90014 (5.9), 90012 (4.8), and 90013 (4.5).
- In 2011, a slightly larger percentage (2.8%) of the adult population in the GSH primary service area 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%).
- In 2011, a larger percentage (14.1%) of the population in the GSH primary service area reporting smoking when compared to Los Angeles County (13.1%), with a higher percentage of smokers in SPA 4 (14.9%).
- 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 GSH primary 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.
- 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 GSH primary service area was higher (199.9) when compared to California (109.1). Rates in the GSH primary service area were especially high in ZIP Codes 90013 (925.9) and 90014 (670.9).[2]

Cardiovascular disease

- In 2011, the percentage (24.4%) of the adult population in the GSH primary service area diagnosed with heart disease approximated the percentage in Los Angeles County (24.0%), although a greater percentage (28.4%) was documented in SPA 6.

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

- Of those in the GSH primary service area with heart disease, nearly three quarters (70.6%) receive assistance from a doctor or medical provider in managing their disease compared with Los Angeles County at 73.3%.[3] SPA 6 has an even larger percentage (75.9%) of those who receive assistance from a doctor or medical provider in managing their disease.

Obesity

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

- In Los Angeles County, 25.5% of postpartum women are overweight and 20.5% are obese, with a disproportionately higher number of Hispanic and African American women being affected. Research indicates that a woman's weight (during and after pregnancy) significantly influences her decision to breastfeed. Women who gained the recommended gestational weight and who were not obese prior to pregnancy, show greater initiation of breastfeeding. After 3 months, women who are either overweight or obese show lower rates of breastfeeding than do their normal weight counterparts.[4]

- A women's excess weight, before, during and after pregnancy not only affect her decision to breastfeed, but also increase her risk of developing preventable chronic disease such as Type 2 diabetes, hypertension and hyperlipidemia. Breastfeeding can help women lose weight, experience less postpartum depression and help reduce the risk of developing Type 2 diabetes for herself and her child. Breastfeed infants are less likely to be overweight as children. [5]

[3] Data source: California Health Interview Survey (CHIS), Data year: 2011-2012, Source geography: SPA
[4] http://publichealth.lacounty.gov/mch/LAMOM/LAMOM.htm
[5] http://zev.lacounty.gov/wp-content/uploads/Obesity_2012_sFinal_1.pdf

Care for Chronic Conditions

Chronic diseases remain a leading cause of death and disability in Los Angeles County. During focus groups and interviews conducted as part of this needs assessment, community members frequently reported chronic diseases such as diabetes, heart disease, and asthma as major issues affecting their communities. Furthermore, these conditions were linked to poor nutrition, including low breastfeeding rates, poverty, and lack of health care access due to insurance status and closure of clinics. Hands-on education and educational materials including presentations and workshops were identified as possible means of education, as they are able to effectively take into account the language needs and literacy levels of those seeking information and guidance.

SUMMARY OF KEY FINDINGS

Cholesterol

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

- 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.

Diabetes

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

- In 2009, over three quarters (80.1%) of people with diabetes, who take medication for the disease felt confident that they were able to manage their condition—less than the percentage for Los Angeles County (86.4%). A much smaller percentage of the population in SPA 6 (69.4%) felt confident in their ability to management their diabetes when compared to Los Angeles County.

Hypertension:

- In 2011, close to a quarter (24.4%) of the adult population in the GSH primary 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.
- In 2011-2012, more than half (64.6%) of the adult population in the GSH primary service area took medication to control high blood pressure—less when compared to Los Angeles County (70.4%).
- In 2010, 2.6 per 10,000 adults died as a result of hypertension— twice the rate as those who died of hypertension in Los Angeles County (1.0). The highest mortality rates in the GSH primary service area were reported in ZIP Codes 90004 (7.0) and 90018 (7.0).

Asthma

Asthma 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.

- In 2011, the percentage of children diagnosed with asthma in the GSH primary service area was lower (6.9%) than in Los Angeles County (9.0%). SPA 6 has a higher percentage (9.4%).

Community/Social Issues (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. 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[6].

Additionally, mental health disorders can have a serious impact on physical health and are associated with the prevalence, progression, and outcome of chronic diseases[7].

SUMMARY OF KEY FINDINGS

- In 2011-2012, a larger percentage (9.2%) of adults in the GSH primary 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.

- The percentage of the population in the GSH primary service area diagnosed with anxiety was similar (11.1%) to Los Angeles County (11.3%), however, the percentage was slightly higher in SPA 4 (12.0%).

- The percentage of the adult population in the GSH primary service area diagnosed with depression was similar (12.1%) when compared to Los Angeles County (12.2%). However, the percentage was higher in SPA 4 (13.4%).

[6] 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].
[7] 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].

Cancer Care

Cancer is the second leading cause of death in the United States, claiming the lives of more than half a million Americans every year[8]. Cancer incidence rates per 100,000 adults 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[9].

SUMMARY OF KEY FINDINGS

General Cancer

- In 2010, the cervical cancer incidence rate per 100,000 adult women was higher in the GSH primary service area (9.4) than in California (8.0) and was four times higher than the Healthy People 2020 goal (<=2.2).
- The prostate cancer incidence rate per 100,000 adult men in GSH primary service area was lower (134.3) than California (140.3) but was six times higher than the Healthy People 2020 goal (<=21.2)

Breast Cancer

- In 2009, the breast cancer incidence rate per 100,000 adults was slightly lower in the GSH primary service area (116.0) than California (122.0) but still five times higher than the Healthy People 2020 goal (<=20.6).

Colorectal Cancer

- In 2010, the colorectal cancer incidence rate per 100,000 adults was slightly higher in the GSH primary service area (38.2) than in California (37.3) but nearly three times as high as the Healthy People 2020 goal (<=14.5).

[8] 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].
[9] 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].

Community Needs Conclusion

The focus issues identified in the 2013 Community Needs Assessment were: 1) health care access (health insurance, regular source of care, inappropriate utilization of the ER), 2) disease management and preventive care (patient education, breastfeeding, screenings, and vaccinations), 3) care for chronic conditions (diabetes, heart disease), 4) community/ social issues (including mental health care), and 5) cancer care.

These health care issues must be viewed in light of the development taking place in the health care industry, which is experiencing its biggest period of change in decades. The country is slowly emerging from the worst recession since the Great Depression of the 1920's. High unemployment and economic uncertainty resulted in many people losing their employer-based insurance and delaying elective health care procedures. The passage of the Patient Protection and Affordable Care Act of 2010 changed many of the dynamics in the health care market, expanding Medicaid eligibility and moving citizens toward universal coverage through premium subsidies and tax penalties. The law also included new mechanisms to "bend the cost curve' through reimbursement incentives and penalties to providers.

At the state level, California's Dual Demonstration Project – Cal Medi-Connect – has been implemented to deal with the subset of the senior population (having both Medi-Cal and Medicare) who have the highest rate of medical spending, many with chronic medical conditions, by directing them to capitated managed care plans.

The relevant implications of these legislative developments on Good Samaritan Hospital's Community Benefit Plan include:

- The insurance barrier to care will persist. Even if it reaches its full potential, the Affordable Care Act will not address the needs of the undocumented population which is concentrated in Good Samaritan Hospital's primary service area.

- The shortage of primary care providers will intensify as more people gain insurance coverage. In the Good Samaritan Hospital service area, the problem is compounded by the lack of linguistically and culturally competent providers to serve our ethnically diverse population. At the same time, some providers will drop out of Medi-Cal and Medicare program due to poor reimbursement. When Massachusetts implemented universal coverage, emergency room utilization increased significantly. It is expected that this will occur in the Good Samaritan service area as well.

- While recent legislation has focused on access to medical care, very little has been done to address the need for people to take more personal responsibility for their health. The epidemic of obesity will continue to drive the demand for medical services related to cardiac disease, peripheral vascular disease, cerebrovascular disease, diabetes, and many cancers. To help address the need for people to have the knowledge and skills to prevent or manage disease, Good Samaritan Hospital offers a variety of classes and resources related to perinatal health, lactation, nutrition, diabetes, cancer and cardiovascular disease.

- Providers will become more accountable for the care of their patients. Reimbursement will move toward payment for taking care of the health of a population, including the imperative to keep people healthy and make them wiser consumers of health resources. Health education and prevention will be a major focus across the lifespan. For stand-alone hospitals like Good Samaritan Hospital, the move to population health management will be particularly difficult. Affiliations with other providers will become even more important in order to provide this expertise and to fill the gaps in the continuum of care.

PROGRESS MADE ON GOALS OF PREVIOUS BENEFIT PLAN

Health Care Access

INITIATIVE	MEASUREMENT	PROGRESS	PARTNERS	BARRIERS
Community Care Transition Program (CCTP): A partnership between Jewish Family Services Los Angeles and Good Samaritan Hospital to reduce readmission in the Medicare A and B population	Reduce readmission by 10% (data collected from CMS and the Jewish Family Services Los Angeles)	Reduced readmission by 17% (data collected from CMS and the Jewish Family Services Los Angeles	• Jewish Family Services Los Angeles • Department of Mental Health • In Home Supportive Service Los Angeles County • Meals on Wheels	Program discontinued. CMS ended the funding in September 2015
Korean Health Fair	Provide education and screening to a minimum of 850 participants	Screened approximately 500 participants	• Korean American Medical Group • Los Angeles Department of Aging • Wilshire State Bank • Hanmi Bank • Korean American Medical Association	Lower participation because participants were able to acquire insurance through Medi-Cal and the State Health Insurance Exchange.

Disease Management and Preventative Care

INITIATIVE	MEASUREMENT	PROGRESS	PARTNERS	BARRIERS
Healthy Habits for Life Program: Obesity education, prevention and disease	Educate a minimum of 50 people to complete the program by reducing weight and waist circumference	• Total of 50 people participated in the program	• Employers • Local schools • Central City Neighborhood Partners	None
Healthy Habits for Maternal and Child Health: Breastfeeding, and Perinatal Obesity Prevention	Educate a minimum of 250 people Educate a minimum of 70% of obstetrics patients on the benefits of holding their infants skin to skin after delivery	• Ongoing • Total of 559 pregnant women participated in the program. • 90% of women or birth partners held their babies skin to skin within the first hour of delivery	• Local clinics • MCH Access • Breastfeed LA • Baby Friendly USA • First 5 LA	None

Care for Chronic Conditions

INITIATIVE	MEASUREMENT	PROGRESS	PARTNERS	BARRIERS
Living with Diabetes	Educate a minimum of 250 people per year on diabetes prevention/management	Educated 274 participants	• Senior centers • Recreation centers • Local schools • Local businesses	None
Heart H.E.L.P Program (Healthy Eating and Lifestyle Program)	Educate a minimum of 200 people per year on prevention and management of cardiovascular disease management	Educated 72 participants	• American Heart Association	Low participation due to limited staff/funding to devote to program.

Community/Social Issues

INITIATIVE	MEASUREMENT	PROGRESS	PARTNERS	BARRIERS
Volunteer Management Program	Enroll a minimum of 300 students per year in the program	• Ongoing • Enrolled 400 students	• Los Angeles Unified School District • Community colleges, universities and technical schools (i.e. Los Angeles College, Los Angeles Trade Tech College) • Archdiocesan Youth Employment Service • Managed Career Solutions • MCS Hollywood Work Source • MCS Wilshire Work Source • Los Angeles Youth Opportunity Movement (Boyle Heights and Watts) • Youth Policy Institute • UCLA Community Based Learning Program • YWCA Greater Los Angeles Job Corps	None

Cancer Care

INITIATIVE	MEASUREMENT	PROGRESS	PARTNERS	BARRIERS
Korean Breast Cancer Support Group	Provide support to a minimum of 100 attendees per year	• Ongoing • Support group attended by 100 people	• American Cancer Society • Shine Korea	• Location • Transportation
Helen's Room	Provide support to a minimum of 150 patients per year.	• Provided support to 250 patients	• American Cancer Society • Physicians offices • Cancer Support Community of Pasadena • Los Angeles County Breast Health Resource Guide	• Transportation • Language
Look Good Feel Better	Provide support to a minimum of 25 patients.	• Ongoing • Attended by 12 people	• American Cancer Society	• Language
Women's Cancer Support Group	Provide support and education to a minimum of 100 patients per year	• Ongoing • Attended by 140 people	• Sisters Breast Cancer Survivors • Network • American Cancer Society • Cancer Support Community • Cancer Support Community • So. Cal Women's Health Conference & Expo	• Language

Economic Value

Good Samaritan Hospital
FY 2015 Community Benefit Cost

Community Benefit Activity		Unreimbursed Cost	Total
1. BENEFITS FOR VULNERABLE POPULATIONS			
Charity care		$ 11,028,323	
Health fairs		$ 9,589	
	Subtotal		$ 11,037,912
2. HEALTH RESEARCH, EDUCATION AND TRAINING			
Job training through the Volunteer Program		$ 140,226	
Basic science research/Heart & Orthopedic Programs		$ 246,294	
Stipend for CSUDH lab interns		$ 12,000	
	Subtotal		$ 398,520
GRAND TOTAL			$ 11,436,432

Non-Quantifiable Benefits

Good Samaritan Hospital provides many non-quantifiable benefits to the medical community and to the broader community surrounding the hospital. As one major example, the hospital pursues and secures grant funding for many community-focused perinatal health issues, as well as chronic disease prevention and management activities. Many of our grant funded programs require hospital in-kind or matching support, and they clearly could not occur without the grant writing efforts and administrative support of our Development Department. As examples:

- Good Samaritan Hospital is collaborating with the South Bay Family Health Clinic with support from the California Community Foundation to improve perinatal and postpartum visits, birth outcomes, lactation, patient satisfaction and provide parents' support for qualified residents in Centinela Valley.

- Good Samaritan Hospital is also collaborating with the South Bay Family Clinic with support from the National Association for County and City Health Officials to provide breastfeeding patient education and support to help women initiate breastfeeding and increase breastfeeding duration.

- The hospital is still implementing diabetes education, heart HELP (including stroke prevention/awareness) as well as nutrition and healthy lifestyle education.

- In 2013 Good Samaritan Hospital partnered with LA County's First 5 LA Commission for a three-year grant for the Baby Friendly Hospital Initiative, which includes policy and procedure changes and staff training to be designated by Baby Friendly USA in the promotion of exclusive breastfeeding of infants and newborns. Baby Friendly survey is scheduled in early 2016.

The hospital provides administrative support for the organization and solicitation of volunteers, yet direct financial support from the hospital is not required. An example of this would be employee donated clothing drives for the homeless treated in the emergency room. Good Samaritan Hospital also allows outside nonprofit organizations to use its conference center located on campus at no cost. Examples include the Community Police Advisory Board which holds their monthly meetings in our conference center, the Center for Healthcare Rights, which recently held a senior health fair at our conference center, and board meetings for the Central Neighborhood Family Clinic, a federally qualified health center in our underserved area.

The health care advocacy efforts of our Board of Trustees and administrative team are other non-quantifiable benefits to our service area. Our most significant advocacy effort has been an attempt to secure additional funds for hospitals that provide a substantial volume of critical care services for the uninsured and low income populations, yet do not qualify for Disproportionate Share Hospital funding due to loopholes in the funding formulas.

For 130 years, the hospital has provided employment including health care insurance, retirement and vacation benefits for thousands of employees. The current workforce of approximately 1,600 employees patronizes the many shops, restaurants and service providers in the immediate area enhancing the local economy. This is in addition to the physicians and their office staffs who work in the medical office buildings on our hospital's campus. A new medical office building is scheduled to open in 2016 that will add new jobs to our campus.

COMMUNITY BENEFITS IMPLEMENTATION PLAN SUMMARY

COMMUNITY BENEFITS IMPLEMENTATION PLAN SUMMARY

The Community Benefits Implementation Plan is primarily based on the health needs and drivers of health identified in the 2013 Community Health Needs Assessment. The implementation plan emphasizes those need areas that can be effectively addressed with the resources and expertise available at Good Samaritan Hospital. The initiatives which comprise the implementation plan are detailed in the following pages, and can be summarized into five major activities.

- Health Behaviors and Preventative Care
- Chronic Disease Prevention and Management
- Improving Health Access and ER Continuity of Care
- Cancer Care
- Health Fairs and Educational Opportunities

Health Behaviors and Preventative Care

The hospital will continue to provide culturally appropriate perinatal services including childbirth and breastfeeding classes in English, Spanish and Korean. We have expanded our breastfeeding education and support as we implement the Breastfeeding Baby Friendly Initiative in preparation for the survey in early 2016.

Breastfeeding provides health benefits for the mother and her child. Breast milk is nutritious, easy to digest and lets the baby start developing healthy eating patterns. (The Baby can decide when to start and when to stop eating.) Breastfed children have fewer infections, less diarrhea, and later in life, have a reduced risk of type 2 diabetes and obesity. Breastfeeding also reduces the mother's risk of excess postpartum bleeding, helps her uterus return to normal size, can help with maternal weight loss, and reduces the risk of postpartum depression and type 2 diabetes.

Chronic Disease Prevention and Management– Our Healthy Habits for Life Program and Healthy Eating and Lifestyle Program (Heart HELP) for the management of diabetes and heart disease respectively will provide disease prevention education targeted to both our patients and our community.

Diabetes Prevention and Management

Patients who have uncontrolled diabetes are at increased risk of infections, delayed healing and complications. Uncontrolled diabetes is a leading cause of blindness, amputations, kidney failure, heart attacks, stokes, seizures, and emergency room visits. Good Samaritan Hospital continues to care for people who have

diabetes and help them manage diabetes when they are hospitalized and we have also invested in diabetes awareness, prevention and management in community and outpatient settings. Good Samaritan Hospital originally began offering Community Diabetes Prevention and Management as part of the Los Angeles Chronic Disease Management Coalition in 2006. Even after the initial funds for these programs were expended, Good Samaritan Hospital decided to continue the programs and identified resources that would enable us to continue to have a positive impact on our community in the area of diabetes education and management that includes Diabetes during Pregnancy class. As resources become available, Good Samaritan Hospital plans to enhance our Healthy Habits for Life programs.

Healthy Eating and Lifestyle Program (Heart HELP) Cardiovascular disease prevention occurs through our Healthy Eating and Lifestyle Program (Heart HELP). Our Community
Outreach Resource team holds presentations at local senior centers and distributes flyers regarding the class at local health fairs and events. Participants are also referred by Good Samaritan Hospital physicians and registered dieticians. In the program, participants learn how to eat nutritious meals, increase physical activity, stop smoking and manage risk factors such as hypertension and high cholesterol. The program also includes health education regarding how to recognize and react quickly to the signs and symptoms of a stroke or heart attack.

Improving Continuity of Care in our Emergency Room – Episodic care delivered in the ER is not an effective way to treat patients with chronic conditions and leads to frequent readmissions to the hospital. Good Samaritan Hospital has ongoing relationships and will continue to develop new relationships with community agencies to transition patients to appropriate settings where conditions and compliance with treatment plans can be monitored. These relationships include the Hospital Association of Southern California Homeless Initiative, Alliance for Housing and Healing and Union Station Homeless Services to name a few.

Support for Cancer Patients – Good Samaritan Hospital will continue and expand our cancer support groups and programs such as the Look Good, Feel Better program with a Korean language capability, Women's Cancer Support Group, and Helen's Rooms that provides education and emotional support to those recovering from cancer treatment. Two new programs for the next fiscal year include the Cancer Survivorship Program for patients who have completed their cancer therapy and are

considered to be cancer free and a General Korean Cancer Support Group for Korean patients diagnosed with different types of cancer.

Health Fairs – Good Samaritan Hospital is committed to hosting free health fairs for the community, providing disease screening and education for those who do not have easy access to health professionals.

Educational Opportunities – Our volunteer program will continue to provide students and others with the tools and valuable work experience necessary for careers in health care.

Additional community needs:
Other community health needs not directly addressed in the Community Health Needs Assessment but is available at Good Samaritan Hospital would include community safety and the hospital's active participation in disaster management.

Good Samaritan Hospital hosts a monthly Community Police Advisory Board meeting in the Moseley-Salvatori Conference Center where local residents meet with the representatives from the Rampart Division of the Los Angeles Police Department and discuss the safety and security of the community.

In addition to treating illnesses, Good Samaritan Hospital must be prepared to care for the community in an event of a disaster both natural and man-made. The hospital has an active disaster preparedness team consisting of both ancillary and clinical staff. The team conducts monthly meetings and quarterly drills to identify areas of improvement and discuss business continuity plans for the various sections of the hospital from patient flow, finance, food distribution to information systems. The hospital also participates in countywide drills.

Health needs that are not addressed:
As previously mentioned, the goal of Good Samaritan Hospital is to address most of the needs of the community. However there are some needs that are not addressed because they do not fit within the hospital's scope of services or expertise. These include mental health services, HIV/AIDS and other sexually transmitted diseases, and Alzheimer's disease. Good Samaritan Hospital has established referral and collaborative relationships with various organizations that have capabilities to provide the services that are not available in the hospital.

COMMUNITY BENEFIT IMPLEMENTATION PLAN OBJECTIVES FY 2015

COMMUNITY BENEFIT IMPLEMENTATION PLAN OBJECTIVES FY 2016
Health Care Access

Initiative:
Korean Health Fair

	Goal	Measurement	Partners
Health Needs • Oral Health • Diabetes • Cardiovascular Disease • Asthma • Hypertension • Vision • Cholesterol • Colorectal Cancer • Arthritis • Breast Cancer **Health Drivers** • Poverty (including unemployment) • Disease Management • Health Care Access • Cultural barriers • Coordinated Health care • Physical Activity • Preventative Care Services • Health Education and Awareness	To provide health screening tests and health education to underserved individuals within the Korean community.	• Provide education and screening to a minimum of 500 participants	• Korean American Medical Group • Los Angeles Department of Aging • Wilshire State Bank • Hanmi Bank • Korean American Medical Association

COMMUNITY BENEFIT IMPLEMENTATION PLAN OBJECTIVES FY 2016
Disease Management and Preventative Care

Initiative:
Healthy Habits for Maternal and Child Health: Breastfeeding, and Perinatal Obesity Prevention

	Goal	Measurement	Partners
Health Needs • Diabetes • Obesity/Overweight • Allergies • Hypertension • Cholesterol • Breast Cancer **Health Drivers** • Breastfeeding • Healthy Eating • Physical Activity • Preventative Care Services • Health Education and Awareness	To increase breastfeeding rates and help women establish health habits before, during, and after pregnancy.	• Educate a minimum of 250 women who breastfeed their children. • Increase the number of women or birth support partners who hold their infants skin to skin after delivery to 90%	• Local clinics • MCH Access • Breastfeed LA • Baby Friendly USA • First 5 LA

COMMUNITY BENEFIT IMPLEMENTATION PLAN OBJECTIVES FY 2016
Care for Chronic Conditions

Initiative:
Living with Diabetes

	Goal	Measurement	Partners
Health Needs • Diabetes **Health Drivers** • Healthy Eating • Physical Activity	To educate the community on how to prevent and manage diabetes with the "M's": meals, movement, medication, monitoring, medical support	• Educate a minimum of 250 people per year on diabetes prevention/management	• Senior centers • Recreation centers • Local schools • Local businesses

Initiative:
Heart H.E.L.P Program (Healthy Eating and Lifestyle Program)

	Goal	Measurement	Partners
Health Needs • Obesity/Overweight • Cardiovascular Disease • Hypertension • Cholesterol **Health Drivers** • Healthy Eating • Physical Activity	To educate the community on how to prevent heart disease and stroke by reducing risk factors.	• Educate a minimum of 100 people per year on prevention and management of cardiovascular disease management	• American Heart Association

COMMUNITY BENEFIT IMPLEMENTATION PLAN OBJECTIVES FY 2016
Community/Social Issues

Initiative:
Volunteer Management Program

	Goal	Measurement	Partners
Health Drivers • Poverty (including unemployment) • Cultural Barriers • Social Barriers	To provide the community including students a career based education, work experience, training and mentoring in the health care industry	• Enroll a minimum of 300 students per year in the program	• Los Angeles Unified School District • Community colleges, universities and technical schools (i.e. Los Angeles College, Los Angeles Trade Tech College) • Archdiocesan Youth Employment Service • Managed Career Solutions • MCS Hollywood Work Source • MCS Wilshire Work Source • Los Angeles Youth Opportunity Movement (Boyle Heights and Watts) • Youth Policy Institute • UCLA Community Based Learning Program • YWCA Greater Los Angeles Job Corps

COMMUNITY BENEFIT IMPLEMENTATION PLAN OBJECTIVES FY 2015
Cancer Care Initiative: Cancer Survivorship

Program

	Goal	Measurement	Partners
Health Drivers • Mental Health • Oral Health • Substance Abuse • Diabetes • Obesity/Overweight • Cardiovascular Disease • Hypertension • Cholesterol • Cancer, General • Colorectal Cancer • Breast Cancer **Health Drivers** • Specialty Care Access • Disease Management • Health Care Access • Cultural Barriers • Social Barriers (i.e. family issues) • Coordinated Health care • Healthy Eating (including breastfeeding) • Physical Activity • Preventative Care Services • Health Education and Awareness	To provide support for early stage cancer patients who recently completed their cancer therapy and are considered to be cancer free.	• Provide support to a minimum of 15% of patients treated at Good Samaritan Hospital who are cancer free.	• American Cancer Society

COMMUNITY BENEFIT IMPLEMENTATION PLAN OBJECTIVES FY 2015
Cancer Care Initiative: General Korean Cancer Support

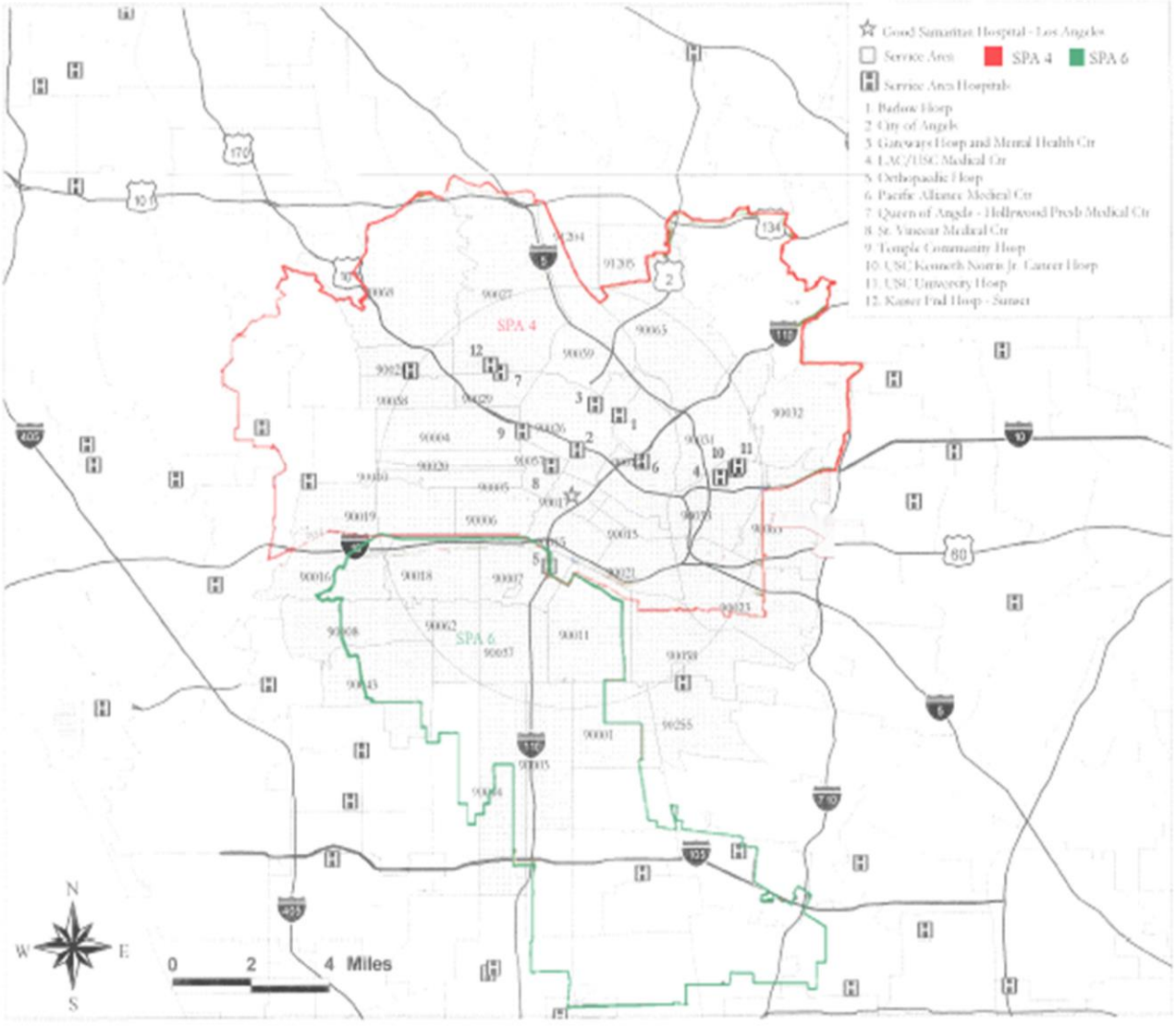
Group

	Goal	Measurement	Partners
Health Needs • Mental Health • Cancer, General • Colorectal Cancer • Breast Cancer **Health Drivers** • Poverty • Disease Management • Transportation • Health Education and Awareness	Provide support to Korean patients diagnosed or treated for cancer.	Provide support to a minimum of 100 participants.	• American Cancer Society • Physician Offices

APPENDICES

Appendix A

MAP OF LOS ANGELES COUNTY SERVICE PLANNING AREAS



Appendix B

Good Samaritan Hospital Operating Policies

MANUAL:	ADMINISTRATIVE	POLICY #:	
SUBJECT:	**Charity Care and Discount Policy**	ORIGINAL DATE APPROVED:	1999
		LAST BOARD APPROVAL DATE:	11/14

PURPOSE

Good Samaritan Hospital (GSH) is committed to assuring that its patients will receive necessary care without regard to their ability to pay. The purpose of this policy is to provide guidelines for identifying and handling patients who may qualify for charity or self-pay discounts.

DEFINITION

1. **Medically necessary services** are those that are absolutely necessary to treat or diagnose a patient and could adversely affect the patient's condition, illness or injury if it were omitted, and is not considered an elective or cosmetic surgery or treatment.

2. A **Charity Care Patient** is a patient who is unable (versus unwilling) to pay for GSH services. In all cases a patient whose Family Income does not exceed 350% of the federal poverty level (FPL) can be considered under this policy. Patients from families with high incomes (or undocumented incomes) may also qualify if Good Samaritan staff reasonably determines the Patient is unlikely to have the resources to pay for the care.

3. A **Self Pay Patient** is a patient who does not have coverage through personal or group health insurance and is not eligible for benefits through Medicare, Medi-Cal, the Healthy Families program, California Health Benefit Exchange, Los Angeles County Indigent Patient Program, California Children's Services (CCS), Victim of Crime (VOC), worker's compensation, State funded California Healthcare for Indigent Program (CHIP), coverage for accidents (TPL), or any other program.

4. A **High Medical Cost Patient** is a patient who has insurance or is eligible for payment from another source, but who has family income at or below 350% of the FPL and out-of-pocket medical expenses in the prior twelve (12) months (whether incurred in or out of any hospital) that exceeds 10% of Family Income.

5. **Family Income** would include the income from all members of the patient's "family." For a patient 18 years of age and older, family includes the patient's spouse, domestic partner and dependent children under 21 years of age, whether living at home or not. For a patient under 18 years of age, family includes the patient's parents, caretaker relatives and other children under 21 years of age of the parent or caretaker relative.

PRINCIPLES FOR SELF PAY PATIENTS

GSH will adhere to the following principles in implementing this policy:

1.0 Fear of a hospital bill should never prevent a patient from seeking emergency health care services and inability to pay should never be a reason to deny medically necessary care.

2.0 The Hospital will provide financial assistance to patients who cannot pay for part or all of the care they receive.

3.0 The Hospital will not financially penalize patients who have no health insurance by requiring them to pay more for care than a typical insurer or government program would pay.

4.0 However, the financial assistance the Hospital provides is not a substitute for personal responsibility. All patients are expected to contribute to the cost of their care, based upon their individual ability to pay.

5.0 All patients will be treated with dignity, compassion and respect.

6.0 Our debt collection practices will be consistent with these principles.

POLICY

1. GSH will assist patients who do not have health insurance to identify and apply for benefits for which they may be eligible from programs including Medicare, Medi-Cal, the Healthy Families program,

California Health Benefit Exchange, Los Angeles County Indigent Patient Program, California Children's Services (CCS), Victim of Crime (VOC), worker's compensation, State funded California Healthcare for Indigent Program (CHIP), and coverage for accidents through third party liability (TPL). In addition, qualifying low income patients may be granted assistance for some or all of their financial responsibility through charity grant programs such as QueensCare and Good Hope. GSH may also provide free or greatly discounted necessary care as unfunded charity on a case by case basis.

2. Uninsured patients who do not qualify for any insurance or health coverage benefits or programs will be offered self-pay discounted rates. These rates will be set in accordance with the "Cash Price Policy."

3. Depending upon their income and assets, patients who are not insured and are not eligible for benefits from any other program may qualify for a 100% charity care discount, a partial charity care discount or self-pay discount.

4. The policy does not apply to deductibles, co-payments and/or coinsurance imposed by insurance companies unless the patient qualifies for assistance as a "High Medical Cost Patient." It also does not apply to services that are not medically necessary (such as cosmetic surgery), or separately billed physician services.

5. The policy will not apply if the patient or responsible party provides false information about financial eligibility or if they fail to make every reasonable effort to apply for and receive third party insurance benefits for which they may be eligible.

6. Any patient or patient's legal representative who requests a charity discount under this policy shall make every reasonable effort to respond to reasonable requests from GSH for documentation of income and all potential health benefit coverage. Failure to provide information may result in the denial of the requested self pay or charity care discount.

PROCEDURE

1. Upon admission/registration all patients will be provided a written notice that contains information regarding the hospital's charity

care and discount policy, including information about eligibility, and contact information (name and telephone number) for a hospital employee or office to obtain additional information. Written notices will be provided in English and languages spoken by at least 5% of people served (currently Spanish and Korean). Translators will be provided to translate orally the notices for patients who speak other languages.

2. Whenever possible GSH will provide financial screening to determine whether a Self Pay Patient might qualify for coverage from third party payor, including any private insurer or government-sponsored programs such as Medicare, Medi-Cal, The Healthy Families program, California Health Benefit Exchange, Los Angeles County Indigent Patient Program, California Children's Services (CCS), California Health Insurance Program (CHIP), Victim of Crime (VOC), or any other third party, such as an employer through worker's compensation or another person due to third party liability (TPL). When feasible, GSH will assist patients to identify possible sources of payment and to apply for the program. This financial screening will be performed as early as possible before services are rendered except when deferred for emergency screening and evaluation (as described below). The information provided to Self Pay patients will include a statement on how patients may obtain applications for Medi-Cal, Healthy Families, coverage through the California Health Benefit Exchange, the Los Angeles County Indigent program and any other state or country funded health coverage programs, and that the hospital will provide these forms. The notice must also include a referral to a local consumer assistance center housed at legal services offices. When no coverage is identified, the Self Pay patient will be provided with applications for Medi-Cal, Healthy Families and other state or county-funded health coverage programs and any charitable assistance programs that might offer financial assistance. This shall be provided prior to discharge if the patient has been admitted or to patients receiving emergency or outpatient care.

3. For patients who have or may have emergent conditions, the financial screening will be deferred until after the patient has received a medical screening and any necessary treatment to stabilize the patient. Treatment shall not be delayed while a patient completes an admission/registration process. At all times, full consideration must be given for the patient's medical condition and care should be taken not to let the financial review process create anxiety for the patient.

4. If financial information cannot be collected at the time of admission/registration, reasonable attempts should be made to collect the information before the patient is discharged in order to fully facilitate proper billing and access to all financial assistance to which the patient may be entitled.

5. Patients will be expected to respond when requested by providing complete and accurate information concerning their health insurance coverage and if they are applying for charity care or self pay status, their financial assets and income so that the Hospital may assess their eligibility for government sponsored programs or for assistance from charity care programs or the self pay discount program.

6. In general, the Hospital's experience has been that Self Pay Patients lack the resources to pay hospital bills, and it is not necessary to obtain financial information to confirm this. When there is a question about the patient's insurance coverage or financial resources, the Hospital may ask a Self Pay Patient to complete a Financial Assistance Request (FAR) form. The FAR will be used to determine a patient's ability to pay for necessary services and to determine a patient's possible eligibility for public assistance, other programs, and self pay discounts from the Hospital. The information on the FAR may be accepted without obtaining additional supporting documentation, but the Hospital may also ask for supporting documentation such as recent tax returns or paystubs, and verification from financial institutions that hold the patient's assets. The FAR and supporting documentation may be requested on a sampling basis or when the available information suggests there is a question about whether the patient qualifies for charity care. The written FAR will be provided in English and languages spoken by at least 5% of people served (currently Spanish and Korean), and translated for those who speak another language.

7. The Charity Care Discount financial screening and means testing will be performed by Financial Counselors in the Admissions Department and/or Collection Representatives in Patient Business Services.

ELIGIBILITY FOR FULL OR PARTIAL CHARITY CARE DISCOUNTS

1. Self Pay Patients whose family incomes are at or below 350% of the FPL will be eligible for full or partial charity care discounts, depending upon family income.

   a. Self Pay Patients whose family income is less than 200% of the FPL will be eligible for a full, 100% charity care discount on services rendered.

   b. Self Pay Patients whose family income is between 200% and 350% of the FPL will be eligible for a partial charity care discount on services rendered equal to 60% of applicable cash price -- see Cash Price Policy.

2. The Hospital may ask the patient to complete a FAR form in order to assess the patient's eligibility for Self Pay or charity care discount.

   a. Upon the request of the Hospital, the patient may be required to document his or her family income by submitting the most recently filed Federal tax return or recent paycheck stubs.

   b. Assets above the statutorily excluded amount will be considered exceeding allowable assets and may result in the denial of a charity care discount. However the following assets will be excluded from consideration:

      i. Retirement accounts and IRS-defined deferred compensation plans both qualified and non-qualified.
      ii. The first $10,000 of all monetary assets.
      iii. 50% of all monetary assets above $10,000.
      iv. The patient's primary family residence.

3. A High Medical Cost Patient is eligible for a 100% Charity Discount on outstanding patient liability amounts if his or her family income is at or below 350% of the FPL, and his or her out-of-pocket medical expenses in the prior twelve (12) months (whether incurred in or out of any hospital) has exceeded 10% of his or her family income. Eligibility for such discounts will be reevaluated as necessary to satisfy the prior twelve month test.

4. Accounts for Self Pay Patients and High Medical Cost Patients who meet the eligibility criteria noted above for charity care discounts may be submitted to QueensCare, a public benefit charity, or Good Hope, a private charitable grant, when appropriate. Patients whose accounts will be submitted to QueensCare will be required

to complete and sign a QueensCare certification. Good Hope patients will be required to pay a nominal amount towards their greatly discounted services.

5. Homeless patients (which includes all patients who indicate they have no address) will be asked if they would accept a referral to a program such as People Assisting the Homeless (PATH) which provides follow-up medical care after discharge through its outpatient clinic and provides a post office box service to facilitate follow-up communication with the patient. GSH will provide a brochure to the patient listing the services that PATH or a similar program provides. Homeless patients who accept the referral to PATH or similar programs will be asked to sign the "Referral Acceptance Confirmation Form" indicating acceptance of the referral. The patient will be given a copy of the signed document and the signed original will be placed in the patient's medical record. Staff facilitating discharge planning should make the appropriate contact with PATH or the similar program to help arrange follow-up. The GSH discharge planner shall send PATH or the similar program a referral form and a mailbox referral form so that the patient can be registered for postal services and facilitate follow-up care with GSH when the patient presents to the clinic for continuing care.

6. Patients will be offered an extended payment plan if they indicate they cannot pay their discounted bills. The terms of the payment plan will be negotiated by the hospital and the patient. Extended payment plans will be interest-free. If agreement cannot be reached on a payment plan, the hospital may require payment using the "reasonable payment formula" which "means monthly payments that are not more than 10 percent of a patient's family income for a month, excluding deductions for essential living expenses. 'Essential living expenses' means … expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses."

SELF PAY CHARITY DISCOUNT

Self Pay Patients who do not qualify for any third party payor benefits or other health coverage programs may be offered discounted Cash

Price rates. See Cash Price Policy. The difference between the full costs of rendering the service and the discounted rate the patient owes is classified as charity care.

PATIENT BILLING AND COLLECTION PRACTICES

1. GSH will strive to assure that patient accounts are processed fairly and consistently. All patients will be treated with dignity, compassion and respect. Our debt collection practices will be consistent with these principles.

2. Patients who have not provided proof of coverage at or before the time care is provided will receive a statement of full charges for services rendered at the hospital. Included with that statement will be a request to provide the hospital with health insurance information. In addition, the patient will be sent a notice that they may be eligible for Medicare, Medi-Cal, Healthy Families, California Health Benefit Exchange, Los Angeles County Indigent Patient Program, California Children Services (CCS), charity, or a self pay discount. This notice will include the contact information (name and telephone number) for a hospital employee or office to obtain additional information, including how the patient can obtain the appropriate application forms. It will also include a statement on how patients may obtain applications for Medi-Cal, Healthy Families, coverage through the California Health Benefit Exchange, the Los Angeles County Indigent program and any other state or country funded health coverage programs, and that the hospital will provide these forms. The notice must also include a referral to a local consumer assistance center housed at legal services offices. Patients who do not have coverage will be provided with applications for Medi-Cal, Healthy Families and other state or county-funded health coverage programs and any charitable assistance programs that might offer financial assistance. This shall be in addition to the notice provided prior to discharge if the patient has been admitted or to patients receiving emergency or outpatient care.

3. If the patient does not respond to the above statement and notice within thirty (30) days, a second statement reflecting full charges will be mailed to the patient/guarantor address along with the information requesting insurance information and offering the option of applying for self pay charity care discounts. If the patient again does not respond within another 30 days, the hospital will

assume that the patient is not eligible for any coverage through personal or group health insurance and is not eligible for any third party payor benefits (e.g., Medicare, Medi-Cal, the Healthy Families program, California Health Benefit Exchange, Los Angeles County Indigent Patient Program, California Children's Services (CCS), Victim of Crime (VOC), worker's compensation, State funded California Healthcare for Indigent Program (CHIP); and coverage for accidents (TPL).) Unless there is evidence to the contrary, the Hospital may assume that the patient is eligible for a charity discount and adjust the patient's account with a charitable discount. Subsequent statements will reflect these discounted rates.

4. If a patient is attempting to qualify for eligibility under the hospital's charity care and discount policy, and is attempting in good faith to settle the outstanding bill, the hospital shall not send the unpaid account to any collection agency or other assignee unless that entity has agreed to comply with this policy.

5. Eligibility for Self Pay Charity discounts, Charity Care Discounts, and High Medical Expense may be determined at any time the Hospital has received all the information it needs to determine the patient's eligibility. Patients are required promptly to report to GSH any change in their financial information.

6. GSH or its contracted collection agencies will undertake reasonable collection efforts to collect amounts due from patients. These efforts include assistance with application for possible government program coverage, evaluation for charity care eligibility, offers of self pay discounts and extended payment plans. GSH will not impose wage garnishments or liens on primary residences. This does not preclude GSH or its contracted collection agencies from pursuing reimbursement from third party liability settlements or other legally responsible parties.

7. Agencies that assist the hospital in billing outstanding amounts from patients must sign a written agreement that they will adhere to the hospital's standards and scope of practices.

The agency must also agree:

a. Not to report adverse information to a consumer credit reporting agency or commence civil action against the patient for nonpayment at any time prior to 150 days after initial billing.

b. Not use wage garnishment, except by order of the court upon noticed motion, supported by a declaration file by the movant identifying the basis for which it believes that the patient has the ability to make payment on the judgment under the wage garnishment, which the court shall consider in light of the size of the judgment and additional information provided by the patient prior to, or at, the hearing concerning the patient's ability to pay, including information about probable future medical expenses based on the current condition of the patient and other obligations of the patient.

c. Not place liens on primary residences.

d. Adhere to all requirements in California and Federal law.

8. If a patient is overcharged, the hospital shall reimburse the patient the overcharged amount. Interest will be paid on the overcharged amount. Interest will be based on the prevailing interest rate and calculated from the date the overpayment was received.

APPLICABILITY TO EMERGENCY AND OTHER PHYSICIANS

Emergency physicians who provide emergency services at the Hospital are also required to provide discounts to uninsured patients or patients with high medical costs who are at or below 350 percent of the federal poverty level as appropriate to maintain their financial and operational integrity. In general, the Hospital will require doctors who staff the emergency room and who serve on the emergency call panel to maintain contracted status with the plans that also contract with the Hospital and to offer discounts to patients consistent with this Charity Care and Discount Policy.

DISPUTES

Patients may disagree with the determination of their eligibility for a charity discount. A patient may request a review of the determination from the Director of Patient Financial Services. A final decision will be made within 15 days of the patient's request for review.

REPORTING PROCEDURES

GSH's Charity Care and Discount Policy will be provided to the Office of Statewide Planning at least biennially on January 1, or when a significant change is made. If no change has been made by the hospital since the information was previously provided, the office will be informed that no change occurred.

COMMUNICATION OF CHARITY CARE AND DISCOUNT POLICIES

GSH's Patient Financial Services shall publish and maintain the Charity Care and Discount Policy. They will also train staff regarding the availability of procedures related to patient financial assistance.

Notice of our Charity Care and Discount Policy will be posted in conspicuous places throughout the hospital including the Emergency Department, Admissions Offices, Outpatient registration areas and the Patient Business Services Department. These notices will be in English and languages spoken by at least 5% of people served (currently Spanish and Korean).

CHARITY CARE WRITE-OFFS

1. Charity Care shall include all amounts written off for Self Pay Charity Care, Charity Care, and High Medical Cost patients pursuant to this policy.

2. Patients who qualify for Medi-Cal but do not receive payments that equal the full costs of service or do not receive approval for coverage for the entire stay are eligible for **charity care write-offs**. These include charges for non-covered costs, non-covered services, denied days or denied stays. Treatment Authorization Request (TAR) denials and lack of payment for non-covered services provided to Medi-Cal patients are to be classified as charity.

3. In addition, Medicare patients who have Medi-Cal coverage for their co-insurance/ deductibles, for which Medi-Cal does not make a payment, and any amount Medicare does not ultimately provide bad debt reimbursement for will also be included as charity.

RESPONSIBILITY

Questions about financial assistance eligibility for inpatient services should be directed to the Eligibility Coordinator at (213) 482-2719. Questions about financial assistance eligibility for emergency services should be directed to the Eligibility Coordinator at (213) 977-2421. Questions about financial assistance eligibility for outpatient services should be directed to the Patient Accounts Supervisor at (213) 482-2700.

Questions about the implementation of this policy should be directed to the Director of Patient Financial Services at (213) 482- 2700.

AUTHOR

Director, Patient Financial Services

Previous Board Approval Dates:	
Dates:	1999, 08/06, 09/07, 02/10
	01/12, 03/13
Keywords:	Charity Care, Discount

Appendix C Interview Participants

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**
	Alexander, Patricia	Community Liaison Representative	Los Angeles County Department of Public Health	Public health and health services	9/29/13	Interview
	Alfaro, Verenisa	Clinical Social Worker	LAUSD Parent & Community Engagement	Social services	10/10/13	Interview
	Anderson, Margot	CEO	The Laurel Foundation	Business management, camp management, serving youth and families with HIV/AIDS	9/25/12	Interview
	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
	Blakeney, Karen	Executive Director	Chinatown Service Center	Serving Asian Pacific immi- grant and Latino com- munities (family resource center, clinics, workforce development)	10/22/12	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**
	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
	Bryan, Cynthia	Vice President, Human Resources	Didi Hirsh Mental Health Services	Human resource management	10/2/12	Interview
	Chidester, Cathy	Director of EMS	Los Angeles County ER Services	Public health and health services, emergency response services	9/4/13	Interview
	Coan, Carl	Executive Director	Eisner Pediatric Child and Family Center	Public health, human genet-ics, health care administration, and management	8/30/13	Interview
	Cox, Debra	Senior Director Foundation Relations	American Heart Association	Health equity, research, and funding	10/5/12	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**
	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
	Kappos, Barbara	Executive Director	East Los Angeles Women's Center	Domestic violence, sexual assault, and HIV	10/19/12	Interview
	Kim, Chrissy InHwe	Director of Health Program	American Cancer Society	General cancer education, research, and resources.	10/11/13	Interview
	Mandel, Susan, Ph.D.	President, CEO	Pacific Clinics	Clinical management and administration	10/3/12	Interview
	Marin, Maribel	Los Angeles Executive Director	211	Information and referral service serving LA County	10/15/12	Interview
	Martinez, Margie	CEO	Community Health Alliance of Pasadena	Public health	10/22/12	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**
	Mondy, Cristin	Health Officer	Los Angeles County Department of Public Health	Public health and health services	10/8/13	Interview
	Munoz, Randy	Vice Chair	Latino Diabetes Association	Diabetes, preventive medicine, low-income, undocu-mented, and un/underinsured	10/22/12	Interview
	Murphy, Colleen	Director of Community Initiatives	PATH	Homeless population	8/29/13	Interview
	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

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**
	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
	Rayfield, Beth	Director of Development	Coalition for Humane Immigrant Rights of Los Angeles	International labor union; organizing, working condi-tions, and contractual rights	10/2/12	Interview
	Reyna, Franco	Associate Director	American Diabetes Association	Diabetes, preventive medicine, low-income, undocu-mented, and un/underinsured	10/8/13	Interview
	Sayno, Jeanette H.	Bi-lingual Community Outreach Development Worker	Filipino American Service Group, Inc.	Low-income health and mental care services for low-income seniors.	9/13/13	Interview
	Schiffer, Wendy MSPH	Director of Planning and Evaluation	California Children's Medical Services	Public health and health services	10/3/12	Interview

Individuals Consulted from Federal, Tribal, Regional, State or Local Health Departments or Other Departments or Agencies with Current Data or Other Relevant Information						
	Name (Last, First)	**Title**	**Affiliation**	**Type of Department**	**Date of Consult**	**Type of Consult**
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

	Name (Last, First)	Affiliation	Public Health Knowledge/Expertis e	Prioritizat ion Session	Prioritizatio n Survey
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	Alexandri a House	Women and children in need of transitional housing and services	Yes	Yes
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

	Name (Last, First)	Affiliation	Public Health Knowledge/Expertis e	Prioritizat ion Session	Prioritizatio n Survey
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	SOSMent or	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 Communi ty Dental Clinic	Low-income children and their families in need of oral health care services	No	Yes

	Name (Last, First)	Affiliation	Public Health Knowledge/Expertis e	Prioritizat ion Session	Prioritizatio n Survey
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 Associatio n	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 Neighbor hood Center	Social support services and program for at-risk children and families	No	Yes

	Name (Last, First)	Affiliation	Public Health Knowledge/Expertis e	Prioritizat ion Session	Prioritizatio n Survey
19.	Krowe, William	Alexandri a House	Women and children in need of transitional housing and services	Yes	Yes
20.	Leal, Jesus	St. Vincent Medical Center, Casa de Amigos Communi ty Learning Center	Public health and health services	No	Yes
21.	Lee, Susan	CSH - Corporati on for Supportiv e Housing	Housing support services for at-risk populations	No	Yes
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

	Name (Last, First)	Affiliation	Public Health Knowledge/Expertis e	Prioritizat ion Session	Prioritizatio n Survey
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 Moveme nt	At-risk mothers	Yes	Yes

	Name (Last, First)	Affiliation	Public Health Knowledge/Expertis e	Prioritizat ion Session	Prioritizatio n Survey
29.	Rivera, Jennifer	Los Angeles County Departm ent of Public Health - Communi ty 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
31.	Striekland, Myungeu m	Angelus Plaza Senior Housing	Low-income seniors	Yes	Yes