2022 COMMUNITY HEALTH NEEDS ASSESSMENT

Dignity Health - Northridge Hospital Medical Center Service Region

Sponsored by

Dignity Health®
Northridge Hospital
Medical Center

Adopted May 2022

2021-1449-02

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INTRODUCTION

EXECUTIVE SUMMARY

CHNA Purpose Statement

The purpose of this community health needs assessment (CHNA) is to identify and prioritize significant health needs of the community served by Dignity Health - Northridge Hospital Medical Center. The priorities identified in this report help to guide the hospital's community health improvement programs and community benefit activities, as well as its collaborative efforts with other organizations that share a mission to improve health. This CHNA report meets requirements of the Patient Protection and Affordable Care Act that not-for-profit hospitals conduct a community health needs assessment at least once every three years.

CommonSpirit Health Commitment and Mission Statement

The hospital's dedication to engaging with the community, assessing priority needs, and helping to address them with community health program activities is in keeping with its mission. As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

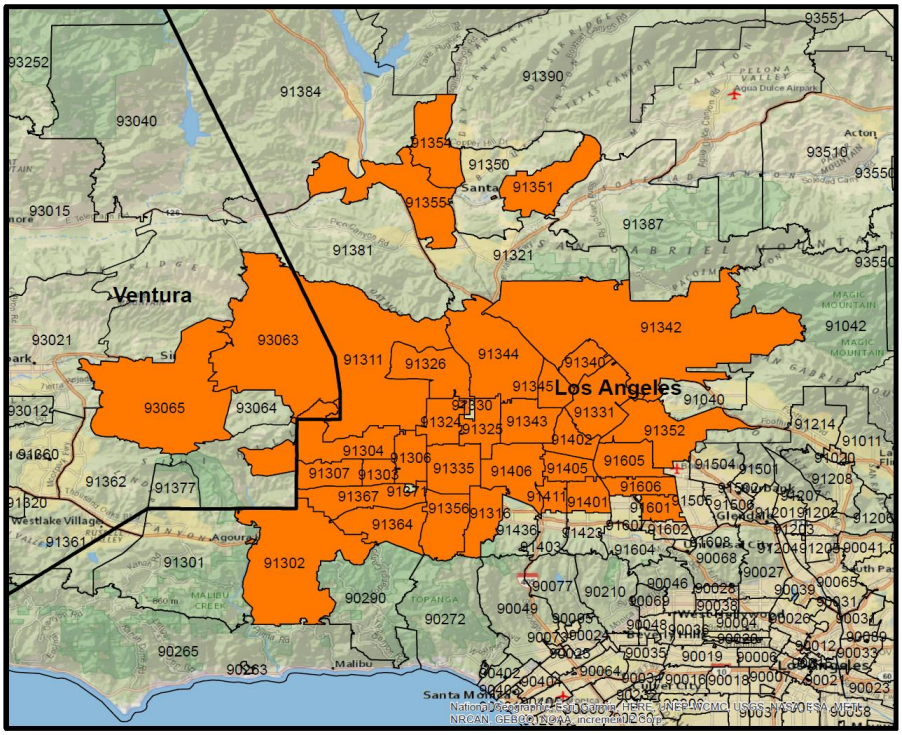
CHNA Collaborators

This assessment was conducted on behalf of Dignity Health - Northridge Hospital Medical Center by PRC, a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

Community Definition

The study area for the survey effort (referred to as the "NHMC Service Region" in this report) reflects communities throughout the San Fernando and Santa Clarita Valleys in Los Angeles, inclusive of the following ZIP Codes (also see map below): 91302, 91303, 91304, 91306, 91307, 91311, 91316, 91324, 91325, 91326, 91331, 91335, 91340, 91342, 91343, 91344, 91345, 91351, 91352, 91354, 91355, 91356, 91364, 91367, 91401, 91402, 91405, 91406, 91411, 91601, 91605, 91606, 93063, and 93065.

This community definition is determined based on the ZIP Codes of residence of recent patients of Dignity Health - Northridge Hospital Medical Center.



Assessment Process & Methods

This assessment incorporates data from multiple sources, including:

- **Primary research** through the *PRC Community Health Survey* (input from community residents) and the *PRC Online Key Informant Survey* (input from providers and other persons representing the broad interests of the community).
- **Secondary research** (vital statistics and other existing health-related data).

This assessment also allows for comparison to benchmark data at the state and national levels.

Prioritizing Health Needs

Prioritization of the health needs identified in this assessment ("Areas of Opportunity") was determined based on a prioritization exercise conducted among community stakeholders (representing a cross-section of community-based agencies and organizations) in conjunction with the administration of the Online Key Informant Survey.

In this process, these key informants were asked to rate the severity of a variety of health issues in the community. Insofar as these health issues were identified through the data above and/or were identified as top concerns among key informants, their ranking of these issues informed the following priorities:

1. Mental Health
2. Substance Abuse
3. Diabetes
4. Oral Health
5. Access to Healthcare Services
6. Nutrition, Physical Activity & Weight
7. Respiratory Diseases (Including COVID-19)
8. Heart Disease & Stroke
9. Potentially Disabling Conditions (Including Dementia/Alzheimer's Disease)
10. Sexual Health
11. Cancer

Not prioritized in this list is the issue of **Housing**, a social determinant of health that presumably impacts all of the above.

Resources Potentially Available

Potential resources available to address identified needs include services currently being offered by Northridge Hospital's Center for Healthier Communities, other local hospitals, clinics, and community-based, and government-based organizations. Through input from community stakeholders, this CHNA identified a number of community assets, including a broad range of health care, mental health care, oral health, housing, health and human services, and parks and recreation resources (see "Resources Available to Address the Significant Health Needs" in the Local Resources section of this report for a full listing).

Report Adoption, Availability & Comments

This CHNA report was adopted by the Dignity Health - Northridge Hospital Medical Center Community Board of Directors in May 2022.

This report is widely available to the public on the hospital's website and a paper copy is available for inspection upon request to the NHMC Center for Healthier Communities. Written comments on this report can be submitted to the Northridge Hospital Center for Healthier Communities, 8210 Etiwanda Avenue, Reseda, CA, 91335, or by e-mail at CHNA.NorthridgeHospital@DignityHealth.org.

PROJECT OVERVIEW

This Community Health Needs Assessment is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in the Dignity Health - Northridge Hospital Medical Center Service Region. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status. This Community Health Needs Assessment will serve as a tool toward reaching three basic goals:

- To improve residents' health status, increase their life spans, and elevate their overall quality of life. A healthy community is not only one where its residents suffer little from physical and mental illness, but also one where its residents enjoy a high quality of life.
- To reduce the health disparities among residents. By gathering demographic information along with health status and behavior data, it will be possible to identify population segments that are most at-risk for various diseases and injuries. Intervention plans aimed at targeting these individuals may then be developed to combat some of the socio-economic factors that historically have had a negative impact on residents' health.
- To increase accessibility to preventive services for all community residents. More accessible preventive services will prove beneficial in accomplishing the first goal (improving health status, increasing life spans, and elevating the quality of life), as well as lowering the costs associated with caring for late-stage diseases resulting from a lack of preventive care.

This assessment was conducted on behalf of Dignity Health - Northridge Hospital Medical Center by PRC, a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

Methodology

This assessment incorporates data from multiple sources, including primary research (through the PRC Community Health Survey and PRC Online Key Informant Survey), as well as secondary research (vital statistics and other existing health-related data). It also allows for comparison to benchmark data at the state and national levels.

PRC Community Health Survey

Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by Dignity Health - Northridge Hospital Medical Center and PRC.

Community Definition

The study area for the survey effort (referred to as the "NHMC Service Region" in this report) reflects communities throughout the San Fernando and Santa Clarita Valleys in Los Angeles, inclusive of the following ZIP Codes (also see map below): 91302, 91303, 91304, 91306, 91307, 91311, 91316, 91324, 91325, 91326, 91331, 91335, 91340, 91342, 91343, 91344, 91345, 91351, 91352, 91354, 91355, 91356, 91364, 91367, 91401, 91402, 91405, 91406, 91411, 91601, 91605, 91606, 93063, and 93065.

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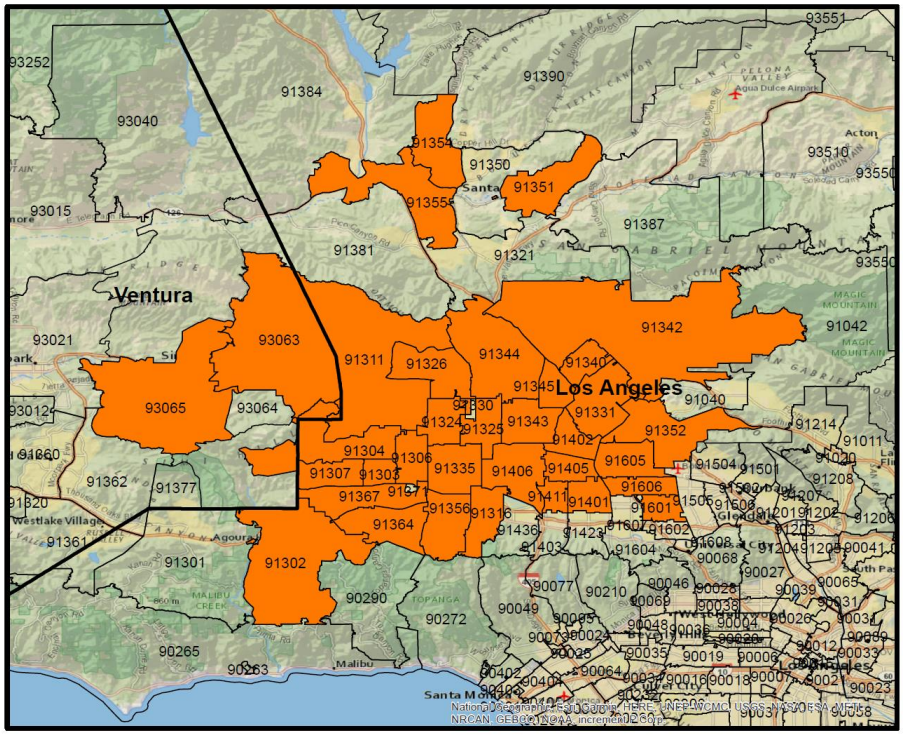


Sample Approach & Design

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the PRC Community Health Survey. Thus, to ensure the best representation of the population surveyed a mixed-mode methodology was implemented. This included surveys conducted via telephone (landline and cell phone), as well as through online questionnaires.

The sample design used for this effort consisted of a random sample of 402 individuals age 18 and older in the NHMC Service Region, conducted in January and February 2022. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the NHMC Service Region as a whole. All administration of the surveys, data collection, and data analysis was conducted by PRC.

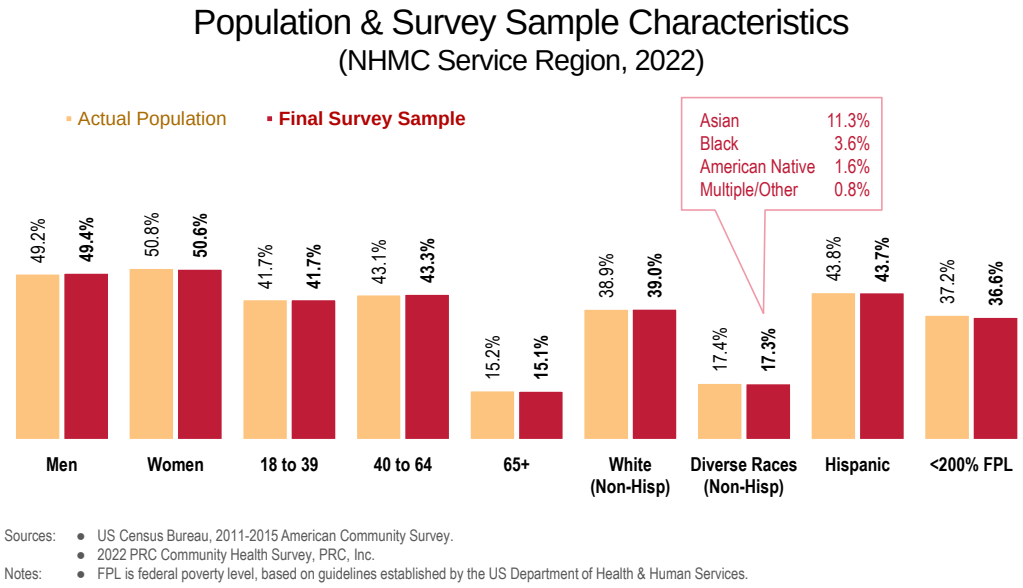
For statistical purposes, the maximum rate of error associated with a sample size of 402 respondents is ±4.9% at the 95 percent confidence level.

Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. While this random sampling of the population produces a highly representative sample, it is a common and preferred practice to “weight” the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias. Specifically, once the raw data are gathered, respondents are examined by key demographic characteristics (namely sex, age, race, ethnicity, and poverty status), and a statistical application package applies weighting variables that produce a sample which more closely matches the population for these characteristics. Thus, while the integrity of each individual’s responses is maintained, one respondent’s responses may contribute to the whole the same

weight as, for example, 1.1 respondents. Another respondent, whose demographic characteristics may have been slightly oversampled, may contribute the same weight as 0.9 respondents.

The following chart outlines the characteristics of the NHMC Service Region sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child's health care needs, and these children are not represented demographically in this chart.]



Sources: ● US Census Bureau, 2011-2015 American Community Survey.
● 2022 PRC Community Health Survey, PRC, Inc.
Notes: ● FPL is federal poverty level, based on guidelines established by the US Department of Health & Human Services.

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

INCOME & RACE/ETHNICITY

INCOME ► Poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 2021 guidelines place the poverty threshold for a family of four at $26,500 annual household income or lower). In sample segmentation: "low income" refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice (<200% of) the poverty threshold; "mid/high income" refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

RACE & ETHNICITY ► In analyzing survey results, mutually exclusive race and ethnicity categories are used. All Hispanic respondents are grouped, regardless of identity with any other race group. All race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).

Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey also was implemented in March 2022 as part of this process. A list of recommended participants was provided by Dignity Health - Northridge Hospital Medical Center; this list included names and contact information for public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 31 community stakeholders took part in the Online Key Informant Survey, as outlined below:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Public Health Representatives	1
Health Providers	5
Social Services Providers	19
Other Community Leaders	3
Education Representatives	3

Final participation included representatives of the organizations outlined below.

- Ascencia
- Bet Tzedek Legal Services
- California State University, Northridge
- Canary Health
- Care Harbor
- Child Care Resource Center
- Child Development Institute
- Children Now
- Covered California
- Eisner Health
- Health Net of California
- Imperial County Public Health Department
- Kaiser Permanente
- Los Angeles City
- Los Angeles County Department of Public Health
- Los Angeles Network for Enhanced Services
- Meet Each Need with Dignity (MEND)
- North Los Angeles County Regional Center
- ONEgeneration
- Partners in Care Foundation
- Providence Medical Group
- Samuel Dixon Family Health Center
- San Fernando Valley Community Mental Health Center
- San Fernando Community Health Center
- Tarzana Treatment Center
- Valley Presbyterian Hospital

Through this process, input was gathered from several individuals whose organizations work with low-income, minority, or other medically underserved populations, including:

> African-Americans, Asians, children, the disabled, diverse racial/ethnic sub-groups, the elderly, Hispanics, the homeless, immigrants/refugees, LGBTQ residents, low income residents, low income Hispanics, Medicare/Medicaid/Medi-Cal recipients, the mentally ill, NICU babies, racial minorities, those with Alzheimer's/Dementia, those with Chronic Diseases, those with Low English Fluency, those with low health literacy, the undocumented, the uninsured/underinsured, and Veterans

In the online survey, key informants were asked to rate the degree to which various health issues are a problem in their own community. Follow-up questions asked them to describe why they identify problem areas as such and how these might better be addressed. Results of their ratings, as well as their verbatim comments, are included throughout this report as they relate to the various other data presented.

NOTE: These findings represent qualitative rather than quantitative data. The Online Key Informant Survey was designed to gather input regarding participants' opinions and perceptions of the health needs of the residents in the area.

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for the NHMC Service Region were obtained from the following sources (specific citations are included with the graphs throughout this report):

- California Department of Public Health
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension, SparkMap (sparkmap.org)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance (DHIS)
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- ESRI ArcGIS Map Gallery
- National Cancer Institute, State Cancer Profiles
- OpenStreetMap (OSM)
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Note that some of the secondary data are only available at the county level (Los Angeles County), while other secondary data are available and presented for Service Planning Area 2 (SPA 2) which is a subset of county data that more closely reflects the hospital service area. Refer to chart labels to understand the geography presented.

Benchmark Data

California Risk Factor Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data represent the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trends Data* published online by the Centers for Disease Control and Prevention. State-level vital statistics are also provided for comparison of secondary data indicators.

Nationwide Risk Factor Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2020 PRC National Health Survey*; the methodological approach for the national study is similar to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

Healthy People 2030

Healthy People provides 10-year, measurable public health objectives — and tools to help track progress toward achieving them. Healthy People identifies public health priorities to help individuals, organizations, and communities across the United States improve health and well-being. Healthy People 2030, the initiative's fifth iteration, builds on knowledge gained over the first four decades.

Healthy People 2030's overarching goals are to:

- Attain healthy, thriving lives and well-being free of preventable disease, disability, injury, and premature death.
- Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
- Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all.
- Promote healthy development, healthy behaviors, and well-being across all life stages.
- Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

The Healthy People 2030 framework was based on recommendations made by the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030. After getting feedback from individuals and organizations and input from subject matter experts, the U.S. Department of Health and Human Services (HHS) approved the framework which helped guide the selection of Healthy People 2030 objectives.

Determining Significance

Differences noted in this report represent those determined to be significant. For survey-derived indicators (which are subject to sampling error), statistical significance is determined based on confidence intervals (at the 95 percent confidence level), using question-specific samples and response rates. For the purpose of this report, "significance" of secondary data indicators (which do not carry sampling error but might be subject to reporting error) is determined by a 15% variation from the comparative measure.

Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, undocumented residents, and members of certain racial/ethnic or immigrant groups — might not be identifiable or might not be represented in numbers sufficient for independent analyses.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly medical conditions that are not specifically addressed.

Public Comment

Dignity Health - Northridge Hospital Medical Center invited written comments on the most recent CHNA report and Implementation Strategy both in the documents and on the web site where they are widely available to the public. No written comments have been received.

IRS Form 990, Schedule H Compliance

For non-profit hospitals, a Community Health Needs Assessment (CHNA) also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals' reporting on IRS Schedule H (Form 990), the following table cross-references related sections.

IRS FORM 990, SCHEDULE H (2019)	See Report Page
Part V Section B Line 3a A definition of the community served by the hospital facility	7
Part V Section B Line 3b Demographics of the community	32
Part V Section B Line 3c Existing health care facilities and resources within the community that are available to respond to the health needs of the community	121
Part V Section B Line 3d How data was obtained	7
Part V Section B Line 3e The significant health needs of the community	15
Part V Section B Line 3f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
Part V Section B Line 3g The process for identifying and prioritizing community health needs and services to meet the community health needs	16
Part V Section B Line 3h The process for consulting with persons representing the community's interests	10
Part V Section B Line 3i The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)	126

SUMMARY OF FINDINGS

Significant Health Needs of the Community

The following “Areas of Opportunity” represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment. From these data, opportunities for health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

The Areas of Opportunity were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); identified trends; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. These also take into account those issues of greatest concern to the community stakeholders (key informants) giving input to this process.

AREAS OF OPPORTUNITY IDENTIFIED THROUGH THIS ASSESSMENT	
ACCESS TO HEALTH CARE SERVICES	▪ Barriers to Access – Inconvenient Office Hours – Cost of Physician Visits – Appointment Availability – Finding a Physician – Lack of Transportation – Culture/Language ▪ Skipping/Stretching Prescriptions ▪ Specific Source of Ongoing Medical Care ▪ Routine Medical Care (Adults) ▪ Eye Exams ▪ Ratings of Local Health Care
CANCER	▪ Leading Cause of Death ▪ Cervical Cancer Screening [Age 21-65]
DIABETES	▪ Diabetes Deaths ▪ Key Informants: Diabetes ranked as a top concern.
HEART DISEASE & STROKE	▪ Leading Cause of Death
HOUSING	▪ Housing Insecurity ▪ Unhealthy/Unsafe Housing Conditions
MENTAL HEALTH	▪ “Fair/Poor” Mental Health ▪ Symptoms of Chronic Depression ▪ Stress ▪ Difficulty Obtaining Mental Health Services ▪ Key Informants: Mental health ranked as a top concern.
NUTRITION, PHYSICAL ACTIVITY & WEIGHT	▪ Children’s Physical Activity ▪ Overweight & Obesity [Adults & Children]

— *continued on the following page* —

AREAS OF OPPORTUNITY (continued)	
ORAL HEALTH	▪ Regular Dental Care [Adults] ▪ Key Informants: Oral Health ranked as a top concern.
POTENTIALLY DISABLING CONDITIONS	▪ Alzheimer's Disease Deaths
RESPIRATORY DISEASE (INCLUDING COVID-19)	▪ Pneumonia/Influenza Deaths ▪ COVID-19 is a Leading Cause of Death ▪ Key Informants: COVID-19 ranked as a top concern
SEXUAL HEALTH	▪ HIV Prevalence ▪ Chlamydia Incidence ▪ Gonorrhea Incidence
SUBSTANCE ABUSE	▪ Key Informants: Substance abuse ranked as a top concern.

Community Feedback on Prioritization of Health Needs

Prioritization of the health needs identified in this assessment ("Areas of Opportunity" above) was determined based on a prioritization exercise conducted among community stakeholders (representing a cross-section of community-based agencies and organizations) in conjunction with the administration of the Online Key Informant Survey.

In this process, these key informants were asked to rate the severity of a variety of health issues in the community. Insofar as these health issues were identified through the data above and/or were identified as top concerns among key informants, their ranking of these issues informed the following priorities:

1. Mental Health
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7. Respiratory Diseases (Including COVID-19)
8. Heart Disease & Stroke
9. Potentially Disabling Conditions (Dementia/Alzheimer's Disease)
10. Sexual Health
11. Cancer

Not prioritized in this list is the issue of **Housing**, a social determinant of health that presumably impacts all of the above.

Hospital Implementation Strategy

Dignity Health - Northridge Hospital Medical Center will use the information from this Community Health Needs Assessment to develop an Implementation Strategy to address the significant health needs in the community. While the hospital will likely not implement strategies for all of the health issues listed above, the results of this prioritization exercise will be used to inform the development of the hospital's action plan to guide community health improvement efforts in the coming years.

Note: An evaluation of the hospital's past activities to address the needs identified in prior CHNAs can be found as an appendix to this report.

Summary Tables: Comparisons With Benchmark Data

Reading the Summary Tables

- In the following tables, NHMC Service Region results are shown in the larger, gray column.
- The columns to the right of the NHMC Service Region column provide comparisons between local data and any available state and national findings, and Healthy People 2030 objectives. Symbols indicate whether the NHMC Service Region compares favorably (), unfavorably (), or comparably () to these external data.

Note that blank table cells signify that data are not available or are not reliable for that area and/or for that indicator.

Tip: Indicator labels beginning with a "%" symbol are taken from the PRC Community Health Survey; the remaining indicators are taken from secondary data sources. Secondary data reflect Service Planning Area 2 data, unless otherwise marked as Los Angeles County-level data.

SOCIAL DETERMINANTS	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS		
		vs. CA	vs. US	vs. HP2030
Linguistically Isolated Population (Percent)	**10.0**	8.1	4.3	
Population in Poverty (Percent)	**13.2**	13.4	13.4	8.0
Children in Poverty (Percent)	**18.0**	18.1	18.5	8.0
No High School Diploma (Age 25+, Percent)	**19.4**	16.7	12.0	
% Unable to Pay Cash for a $400 Emergency Expense	**21.6**		24.6	
% Worry/Stress Over Rent/Mortgage in Past Year	**45.6**		32.2	
% Unhealthy/Unsafe Housing Conditions	**23.6**		12.2	
% Food Insecure	**38.4**		34.1	
% Regularly Treated with Less Respect Than Others	**29.6**			
% Regularly Receive Poorer Service Than Others at Restaurants/Stores	**14.5**			
% Regularly Treated as Less Intelligent Than Others	**24.4**			
% Regularly Treated as a Potential Danger	**13.2**			
% Regularly Threatened or Harassed	**10.0**			
% Disagree That the Community is Welcoming to All	**6.4**			
		better	similar	worse

OVERALL HEALTH	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
% "Fair/Poor" Overall Health	16.1	18.2	12.6	
		better	similar	worse

ACCESS TO HEALTH CARE	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
% [Age 18-64] Lack Health Insurance	8.2	15.1	8.7	7.9
% Difficulty Accessing Health Care in Past Year (Composite)	54.6		35.0	
% Cost Prevented Physician Visit in Past Year	18.7	11.9	12.9	
% Cost Prevented Getting Prescription in Past Year	16.1		12.8	
% Difficulty Getting Appointment in Past Year	34.1		14.5	
% Inconvenient Hrs Prevented Dr Visit in Past Year	22.5		12.5	
% Difficulty Finding Physician in Past Year	22.7		9.4	
% Transportation Hindered Dr Visit in Past Year	14.6		8.9	
% Language/Culture Prevented Care in Past Year	5.6		2.8	
% Treated Worse Than Other Races	5.5		4.7	
% Skipped Prescription Doses to Save Costs	19.1		12.7	
% Difficulty Getting Child's Health Care in Past Year	11.7		8.0	

ACCESS TO HEALTH CARE (continued)	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
Primary Care Doctors per 100,000	73.8	79.8	75.8	
% Have a Specific Source of Ongoing Care	65.2		74.2	84.0
% Have Had Routine Checkup in Past Year	56.6	71.6	70.5	
% Child Has Had Checkup in Past Year	72.3		77.4	
% Two or More ER Visits in Past Year	12.6		10.1	
% Eye Exam in Past 2 Years	46.4		61.0	61.1
% Rate Local Health Care "Fair/Poor"	13.1		8.0	
% "Extremely/Very Likely" to Use Telemedicine	46.7			
		better	similar	worse

CANCER	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
Cancer (Age-Adjusted Death Rate) [COUNTY-LEVEL DATA]	130.7	132.3	146.5	122.7
Lung Cancer (Age-Adjusted Death Rate) [COUNTY-LEVEL DATA]	21.8	23.7	33.4	25.1
Prostate Cancer (Age-Adjusted Death Rate) [COUNTY-LEVEL DATA]	19.5	19.6	18.5	16.9
Female Breast Cancer (Age-Adjusted Death Rate) [COUNTY-LEVEL DATA]	19.1	18.7	19.4	15.3
Colorectal Cancer (Age-Adjusted Death Rate) [COUNTY-LEVEL DATA]	12.8	12.2	13.1	8.9

CANCER (continued)	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
Cancer Incidence Rate (All Sites)	**381.4**	402.4	448.6	
Female Breast Cancer Incidence Rate	**118.3**	121.8	126.8	
Prostate Cancer Incidence Rate	**90.4**	92.3	106.2	
Lung Cancer Incidence Rate	**36.1**	40.3	57.3	
Colorectal Cancer Incidence Rate	**35.4**	34.8	38.0	
% Cancer	**7.2**	10.4	10.0	
% [Women 50-74] Mammogram in Past 2 Years	**70.2**	81.1	76.1	77.1
% [Women 21-65] Cervical Cancer Screening	**62.5**	79.2	73.8	84.3
% [Age 50-75] Colorectal Cancer Screening	**78.1**	72.1	77.4	74.4
		better	similar	worse

CORONAVIRUS DISEASE/COVID-19	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
COVID-19 (Age-Adjusted Death Rate) [COUNTY-LEVEL DATA]	**98.3**	138.2	85.0	
% Mental Health Has Gotten Worse Since Pandemic Began	**29.1**			
% Financially Impacted by the Pandemic	**40.1**			
% Avoided Medical Care Due to the Pandemic	**37.7**			
% Fully/Partially Vaccinated for COVID-19	**85.8**			

DIABETES	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
Diabetes (Age-Adjusted Death Rate) [COUNTY-LEVEL DATA]	27.4	22.9	22.6	
% Diabetes/High Blood Sugar	12.7	10.1	13.8	
% Borderline/Pre-Diabetes	13.1		9.7	
% [Non-Diabetics] Blood Sugar Tested in Past 3 Years	40.1		43.3	
		better	similar	worse

HEART DISEASE & STROKE	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
Diseases of the Heart (Age-Adjusted Death Rate) [COUNTY-LEVEL DATA]	150.6	140.2	164.4	127.4
% Heart Disease (Heart Attack, Angina, Coronary Disease)	5.4	4.7	6.1	
Stroke (Age-Adjusted Death Rate) [COUNTY-LEVEL DATA]	34.3	37.8	37.6	33.4
% Stroke	4.3	2.6	4.3	
% Told Have High Blood Pressure	32.4	27.8	36.9	27.7
% Told Have High Cholesterol	27.8		32.7	
% 1+ Cardiovascular Risk Factor	85.7		84.6	
		better	similar	worse

INFANT HEALTH & FAMILY PLANNING	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
Late or No Prenatal Care [COUNTY-LEVEL DATA]	3.5	3.7	6.1	
Low Birthweight Births (Percent) [COUNTY-LEVEL DATA]	7.2	6.9	8.2	
Infant Death Rate [COUNTY-LEVEL DATA]	3.6	3.9	5.5	5.0
Births to Adolescents Age 15 to 19 (Rate per 1,000) [COUNTY-LEVEL DATA]	17.1	17.4	20.9	
		better	similar	worse

INJURY & VIOLENCE	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
Unintentional Injury (Age-Adjusted Death Rate) [COUNTY-LEVEL DATA]	29.9	37.9	51.6	43.2
Motor Vehicle Crashes (Age-Adjusted Death Rate) [COUNTY-LEVEL DATA]	8.4	9.9	11.4	10.1
[65+] Falls (Age-Adjusted Death Rate) [COUNTY-LEVEL DATA]	28.4	41.4	67.0	63.4
Firearm-Related Deaths (Age-Adjusted Death Rate) [COUNTY-LEVEL DATA]	7.3	7.7	12.5	10.7
Homicide (Age-Adjusted Death Rate) [COUNTY-LEVEL DATA]	6.0	5.1	6.1	5.5
Violent Crime Rate [COUNTY-LEVEL DATA]	542.5	440.5	416.0	
% Victim of Violent Crime in Past 5 Years	6.7		6.2	
% Victim of Intimate Partner Violence	14.6		13.7	
		better	similar	worse

KIDNEY DISEASE	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
Kidney Disease (Age-Adjusted Death Rate) [COUNTY-LEVEL DATA]	12.5	9.1	12.8	
% Kidney Disease	6.3	3.0	5.0	
		better	similar	worse

MENTAL HEALTH	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
% "Fair/Poor" Mental Health	28.3		13.4	
% Diagnosed Depression	24.1	14.6	20.6	
% Symptoms of Chronic Depression (2+ Years)	47.3		30.3	
% Typical Day Is "Extremely/Very" Stressful	23.0		16.1	
Suicide (Age-Adjusted Death Rate) [COUNTY-LEVEL DATA]	8.3	10.5	13.9	12.8
Mental Health Providers per 100,000 [COUNTY-LEVEL DATA]	362.6	373.3	261.6	
% Taking Rx/Receiving Mental Health Trtmt	14.8		16.8	
% Unable to Get Mental Health Svcs in Past Yr	13.4		7.8	
		better	similar	worse

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS		
		vs. CA	vs. US	vs. HP2030
Population With Low Food Access (Percent)	**8.7**	13.3	22.2	
% "Very/Somewhat" Difficult to Buy Fresh Produce	**23.3**		21.1	
% 5+ Servings of Fruits/Vegetables per Day	**31.6**		32.7	
% No Leisure-Time Physical Activity	**27.3**	22.4	31.3	21.2
% Meeting Physical Activity Guidelines	**27.4**	22.6	21.4	28.4
% Child [Age 2-17] Physically Active 1+ Hours per Day	**21.5**		33.0	
% Healthy Weight (BMI 18.5-24.9)	**31.5**	35.1	34.5	
% Overweight (BMI 25+)	**63.2**	62.8	61.0	
% Obese (BMI 30+)	**32.9**	26.1	31.3	36.0
% Children [Age 5-17] Healthy Weight	**47.7**		47.6	
% Children [Age 5-17] Overweight (85th Percentile)	**31.2**		32.3	
% Children [Age 5-17] Obese (95th Percentile)	**18.3**		16.0	15.5
		better	similar	worse

ORAL HEALTH	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
% Have Dental Insurance	74.2		68.7	59.8
% [Age 18+] Dental Visit in Past Year	55.8	67.4	62.0	45.0
% Child [Age 2-17] Dental Visit in Past Year	80.7		72.1	45.0
		better	similar	worse

POTENTIALLY DISABLING CONDITIONS	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
% 3+ Chronic Conditions	30.0		32.5	
% Activity Limitations	28.6		24.0	
% With High-Impact Chronic Pain	17.0		14.1	7.0
Alzheimer's Disease (Age-Adjusted Death Rate) [COUNTY-LEVEL DATA]	39.1	38.2	30.9	
% Caregiver to a Friend/Family Member	27.0		22.6	
		better	similar	worse

RESPIRATORY DISEASE	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
CLRD (Age-Adjusted Death Rate) [COUNTY-LEVEL DATA]	26.6	29.3	38.1	
Pneumonia/Influenza (Age-Adjusted Death Rate) [COUNTY-LEVEL DATA]	18.1	13.8	13.4	

RESPIRATORY DISEASE (continued)	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
% [Age 65+] Flu Vaccine in Past Year	77.6	63.9	71.0	
% [Adult] Asthma	9.3	7.8	12.9	
% [Child 0-17] Asthma	3.6		7.8	
% COPD (Lung Disease)	7.8	4.4	6.4	
		better	similar	worse

SEXUAL HEALTH	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
HIV/AIDS (Age-Adjusted Death Rate) [COUNTY-LEVEL DATA]	1.9	1.7	1.8	
HIV Prevalence Rate	543.6	395.9	372.8	
Chlamydia Incidence Rate	641.2	585.3	539.9	
Gonorrhea Incidence Rate	252.4	200.3	179.1	
		better	similar	worse

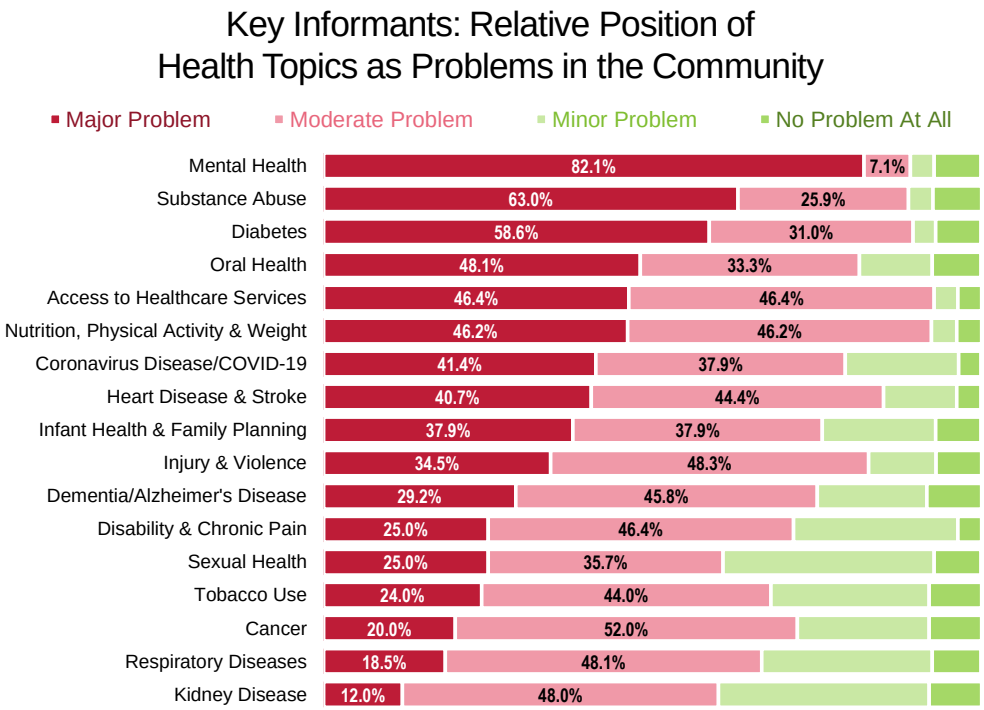
SUBSTANCE ABUSE	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
Cirrhosis/Liver Disease (Age-Adjusted Death Rate) [COUNTY-LEVEL DATA]	13.4	12.8	11.9	10.9
% Excessive Drinker	25.2	18.3	27.2	

SUBSTANCE ABUSE (continued)	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
Unintentional Drug-Related Deaths (Age-Adjusted Death Rate) [COUNTY-LEVEL DATA]	**12.6**	15.2	21.0	
% Illicit Drug Use in Past Month	**4.4**		2.0	12.0
% Used a Prescription Opioid in Past Year	**12.6**		12.9	
% Ever Sought Help for Alcohol or Drug Problem	**3.9**		5.4	
% Personally Impacted by Substance Abuse	**35.6**		35.8	
		better	similar	worse

TOBACCO USE	NHMC Service Region	NHMC SERVICE REGION vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
% Current Smoker	**16.4**	10.0	17.4	5.0
% Someone Smokes at Home	**14.1**		14.6	
% [Household With Children] Someone Smokes in the Home	**18.0**		17.4	
% [Smokers] Received Advice to Quit Smoking	**43.7**		59.6	66.6
% Currently Use Vaping Products	**10.1**	3.0	8.9	
		better	similar	worse

Summary of Key Informant Perceptions

In the Online Key Informant Survey, community stakeholders were asked to rate the degree to which each of 17 health issues is a problem in their own community, using a scale of “major problem,” “moderate problem,” “minor problem,” or “no problem at all.” The following chart summarizes their responses; these findings also are outlined throughout this report, along with the qualitative input describing reasons for their concerns. (Note that these ratings alone do not establish priorities for this assessment; rather, they are one of several data inputs considered for the prioritization process described earlier.)



DATA CHARTS & KEY INFORMANT INPUT

The following sections present data from multiple sources, including the population- based PRC Community Health Survey, public health and other existing data sets (secondary data), as well as qualitative input from the Online Key Informant Survey.

Data indicators from these sources are intermingled and organized by health topic. To better understand the source data for specific indicators, please refer to the footnotes accompanying each chart.

COMMUNITY CHARACTERISTICS

Population Characteristics

Land Area, Population Size & Density

Data from the US Census Bureau reveal the following statistics for our community relative to size, population, and density.

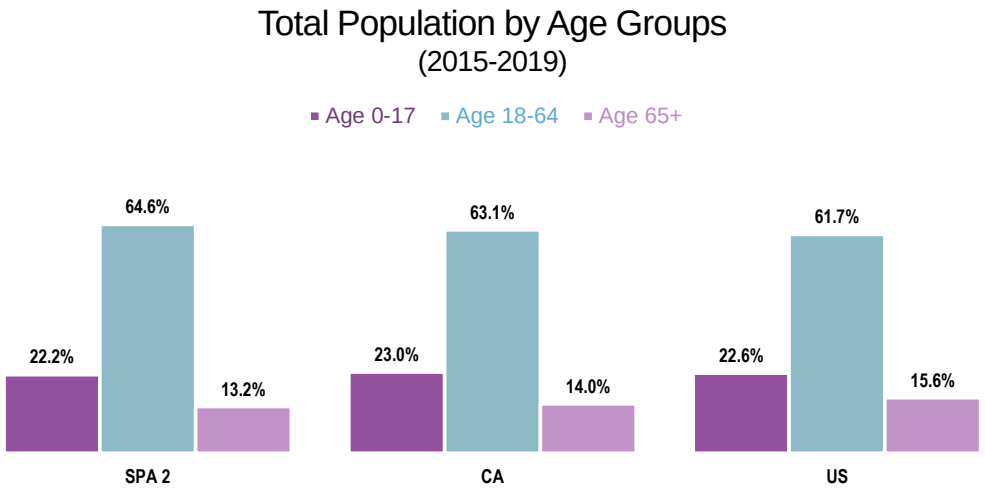
Total Population
(Estimated Population, 2015-2019)

	TOTAL POPULATION	TOTAL LAND AREA (square miles)	POPULATION DENSITY (per square mile)
Service Planning Area 2 (SPA 2)	1,575,614	368.91	4,270.95
California	39,283,497	155,792.65	252.15
United States	324,697,795	3,532,068.58	91.93

Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Age

It is important to understand the age distribution of the population, as different age groups have unique health needs that should be considered separately from others along the age spectrum.

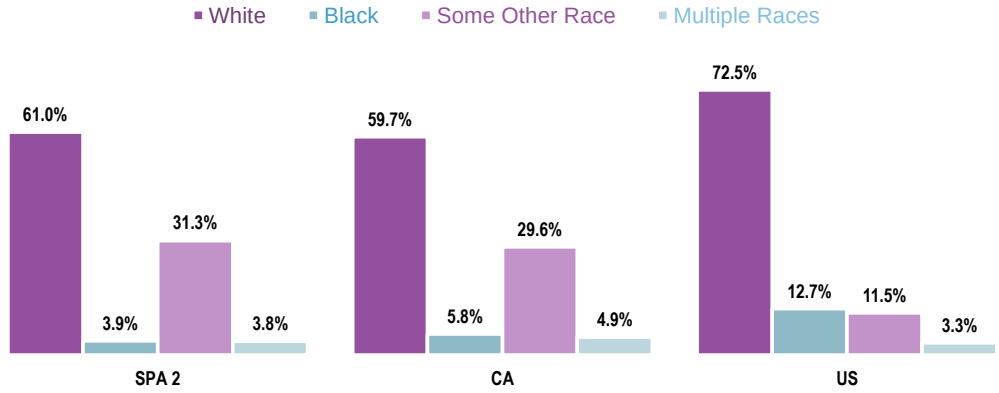


Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Race & Ethnicity

The following charts illustrate the racial and ethnic makeup of our community. Note that ethnicity (Hispanic or Latino) can be of any race.

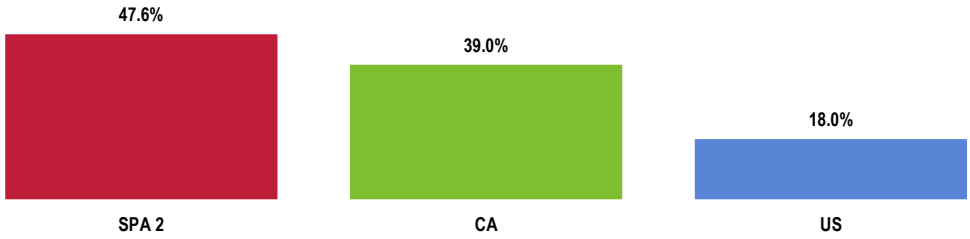
Total Population by Race Alone
(2015-2019)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Hispanic Population
(2015-2019)

The Hispanic population increased by 18,436 persons, or 3.0%, between 2010 and 2020.



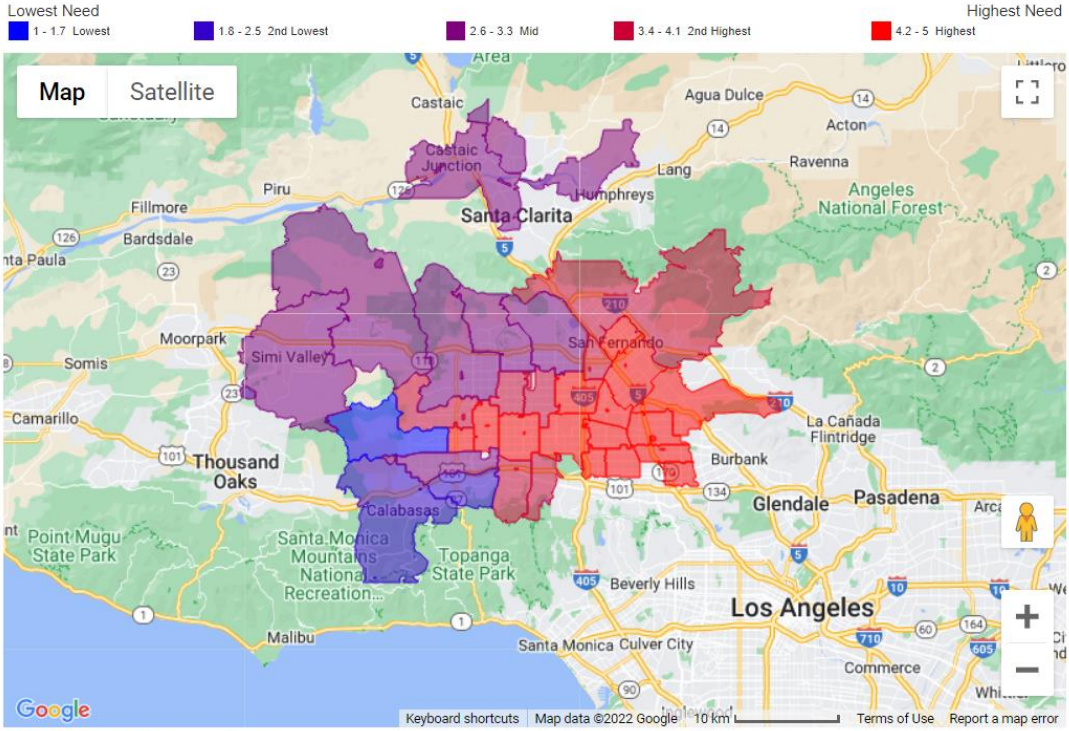
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Notes:
- Origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

High-Need Areas

High-need areas in Service Planning Area 2 (SPA 2) were identified using the Community Health Needs Index (CNI). The CNI score was developed by Dignity Health and IBM Watson Health™ to assist in the process of gathering vital socio-economic factors in the community. Based on demographic and economic statistics, the CNI provides a score for every populated ZIP code in the United States on a scale of 1.0 to 5.0. A score of 1.0 indicates a ZIP code with the least need, while a score of 5.0 represents a ZIP code with the most need compared to the US national average (score of 3.0).

The CNI is strongly linked to variations in community healthcare needs and is a good indicator of a community's demand for a range of healthcare services. Not-for-profit and community-based hospitals, for whom community need is central to the mission of service, are often challenged to prioritize and effectively distribute hospital resources. The CNI can be used to help them identify specific initiatives best designed to address the health disparities of a given community. The CNI should be used as part of a larger community need assessment to pinpoint specific areas that have greater need than others. (Source: http://cni.dignityhealth.org/Watson-Health-2021-Community-Need-Index-Source-Notes.pdf.)



Mean(zipcode): 3.7 / Mean(person): 3.8 CNI Score Median: 4 CNI Score Mode: 4.4

ZIP Code-specific CNI scores are outlined below.

Mean(zipcode): 3.7 / Mean(person): 3.8 CNI Score Median: 4 CNI Score Mode: 4.4

Zip Code	CNI Score	Population	City	County	State
91302	2.4	27578	Calabasas	Los Angeles	California
91303	4.6	27973	Canoga Park	Los Angeles	California
91304	4	50515	Canoga Park	Los Angeles	California
91306	4.4	46889	Winnetka	Los Angeles	California
91307	1.6	24624	West Hills	Los Angeles	California
91311	3	38115	Chatsworth	Los Angeles	California
91316	3.6	27506	Encino	Los Angeles	California
91324	4	27985	Northridge	Los Angeles	California
91325	3.8	36317	Northridge	Los Angeles	California
91326	2.6	36809	Porter Ranch	Los Angeles	California
91331	4.4	106795	Pacoima	Los Angeles	California
91335	4.4	77115	Reseda	Los Angeles	California
91340	4.4	35756	San Fernando	Los Angeles	California
91342	3.8	96693	Sylmar	Los Angeles	California
91343	4.6	63139	North Hills	Los Angeles	California
91344	2.8	52457	Granada Hills	Los Angeles	California
91345	4	18347	Mission Hills	Los Angeles	California
91351	3.2	33476	Canyon Country	Los Angeles	California
91352	4.4	49156	Sun Valley	Los Angeles	California
91354	2.6	32283	Valencia	Los Angeles	California
91355	2.8	37778	Valencia	Los Angeles	California
91356	3.6	29979	Tarzana	Los Angeles	California
91364	2.4	25834	Woodland Hills	Los Angeles	California
91367	2.8	43056	Woodland Hills	Los Angeles	California
91401	4.6	39555	Van Nuys	Los Angeles	California
91402	4.8	73072	Panorama City	Los Angeles	California
91405	4.4	52249	Van Nuys	Los Angeles	California
91406	4.4	55829	Van Nuys	Los Angeles	California
91411	4.4	24194	Van Nuys	Los Angeles	California
91601	4.2	41019	North Hollywood	Los Angeles	California
91605	4.6	55889	North Hollywood	Los Angeles	California
91606	4.6	45226	North Hollywood	Los Angeles	California
93063	3	55838	Simi Valley	Ventura	California
93065	2.8	74416	Simi Valley	Ventura	California

Social Determinants of Health

ABOUT SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. Examples of SDOH include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

SDOH also contribute to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods.

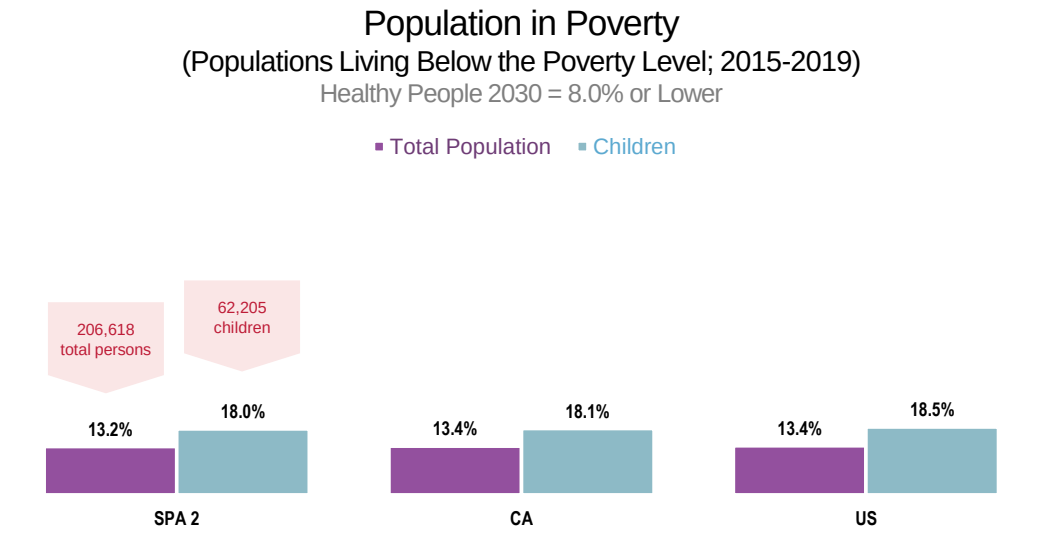
Just promoting healthy choices won't eliminate these and other health disparities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments.

- Healthy People 2030 (https://health.gov/healthypeople)

Income & Poverty

Poverty

The following chart outlines the proportion of our population below the federal poverty threshold in comparison to state and national proportions.



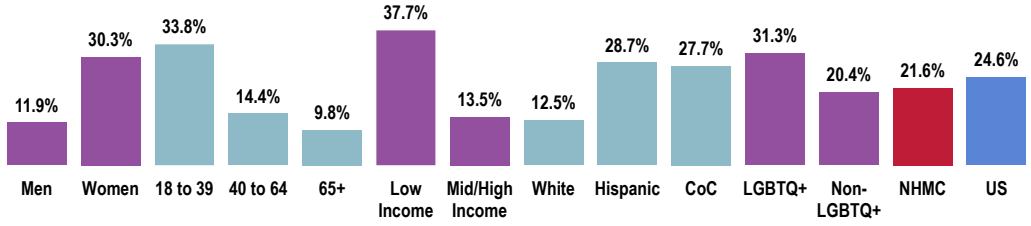
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Poverty is considered a key driver of health status. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

Financial Resilience

"Suppose that you have an emergency expense that costs $400. Based on your current financial situation, would you be able to pay for this expense either with cash, by taking money from your checking or savings account, or by putting it on a credit card that you could pay in full at the next statement?"

Do Not Have Cash on Hand to Cover a $400 Emergency Expense
(NHMC Service Region, 2022)



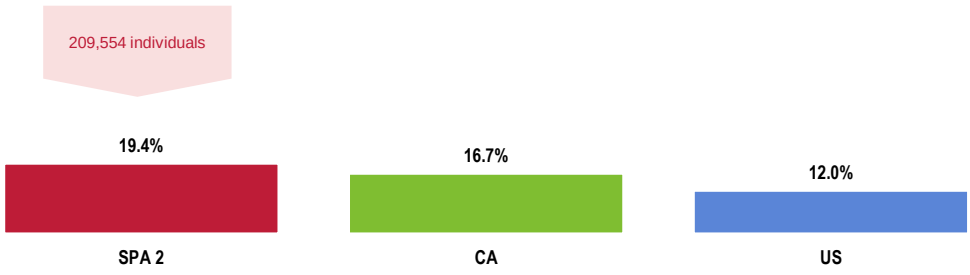
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 63]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents. Use caution when interpreting results for LGBTQ+, as the sample size falls below n=50.
- Includes respondents who say they would not be able to pay for a $400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.
- CoC represents Communities of Color (non-Hispanic and non-White).

Education

Education levels are reflected in the proportion of our population without a high school diploma.

Population With No High School Diploma
(Population Age 25+ Without a High School Diploma or Equivalent, 2015-2019)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

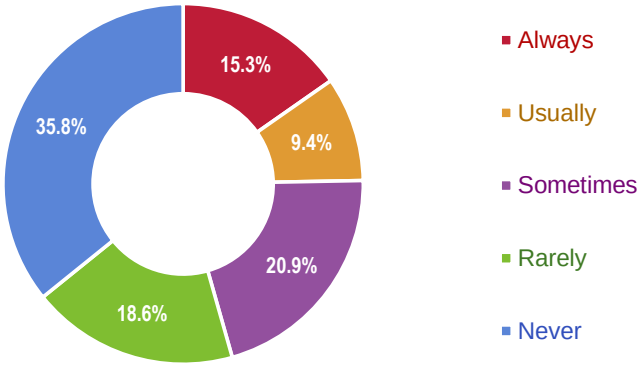
Notes:
- This indicator is relevant because educational attainment is linked to positive health outcomes.

Housing

Housing Insecurity

"In the past 12 months, how often were you worried or stressed about having enough money to pay your rent or mortgage? Would you say you were worried or stressed: always, usually, sometimes, rarely, or never?"

Frequency of Worry or Stress Over Paying Rent or Mortgage in the Past Year
(NHMC Service Region, 2022)



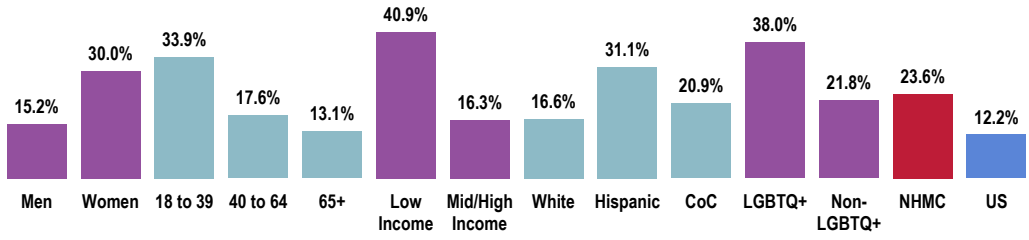
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 66]

Notes:
- Asked of all respondents.

Unhealthy or Unsafe Housing

"Thinking about your current home, over the past 12 months have you experienced ongoing problems with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe?"

Unhealthy or Unsafe Housing Conditions in the Past Year
(NHMC Service Region, 2022)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 65]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents. Use caution when interpreting results for LGBTQ+, as the sample size falls below n=50.
- Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.
- CoC represents Communities of Color (non-Hispanic and non-White).

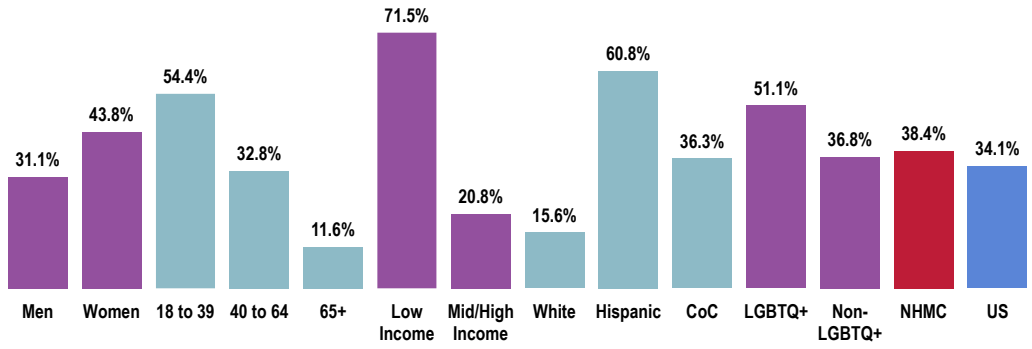
Food Insecurity

"Now I am going to read two statements that people have made about their food situation. Please tell me whether each statement was 'often true,' 'sometimes true,' or 'never true' for you in the past 12 months.

- The first statement is: 'I worried about whether our food would run out before we got money to buy more.'
- The next statement is: 'The food that we bought just did not last, and we did not have money to get more.'"

Agreement with either or both of these statements ("often true" or "sometimes true") defines food insecurity for respondents.

Food Insecurity
(NHMC Service Region, 2022)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 112]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents. Use caution when interpreting results for LGBTQ+, as the sample size falls below n=50.
- Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.
- CoC represents Communities of Color (non-Hispanic and non-White).

Equity

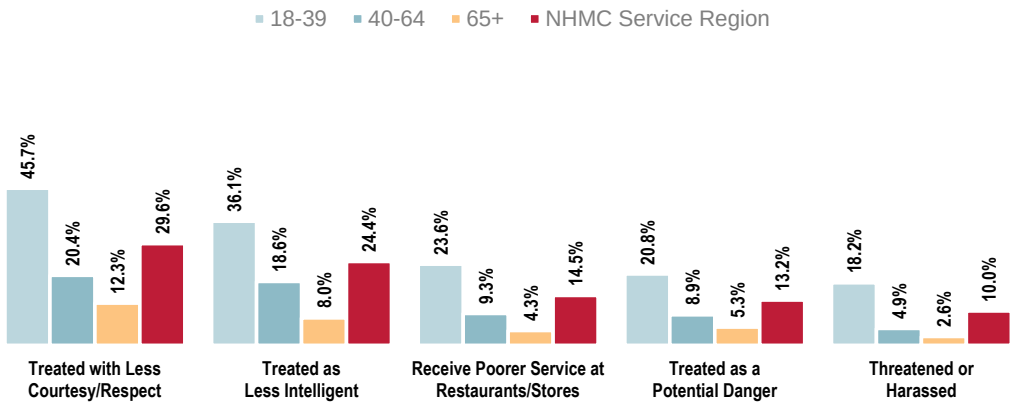
Unfair Treatment

"In your day-to-day life, how often do the following things happen to you? Would you say: almost every day, at least once a week, a few times a month, a few times a year, less than once a year, or never?

- You are treated with less courtesy or respect than other people.
- You receive poorer service than other people at restaurants or stores.
- People act as if they think you are not smart.
- People act as if they are afraid of you.
- You are threatened or harassed."

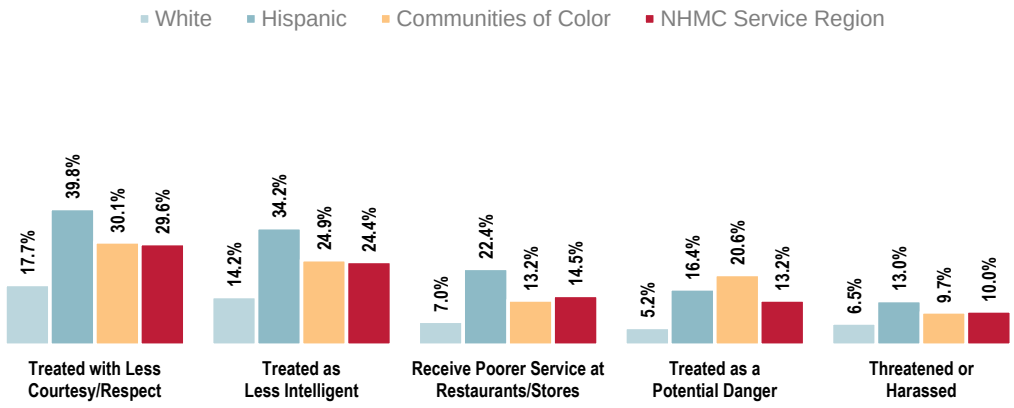
Responses of “almost every day,” “at least once a week,” or “a few times a month” define unfair treatment for respondents.

Perceptions of Unfair Treatment in Day-to-Day Life
(By Age; NHMC Service Region, 2022)



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Items 304-308]
Notes: ● Asked of all respondents.
● Percentages represent combined responses of “Almost Every Day,” “At Least Once a Week,” and “A Few Times a Month.”

Perceptions of Unfair Treatment in Day-to-Day Life
(By Race/Ethnicity; NHMC Service Region, 2022)

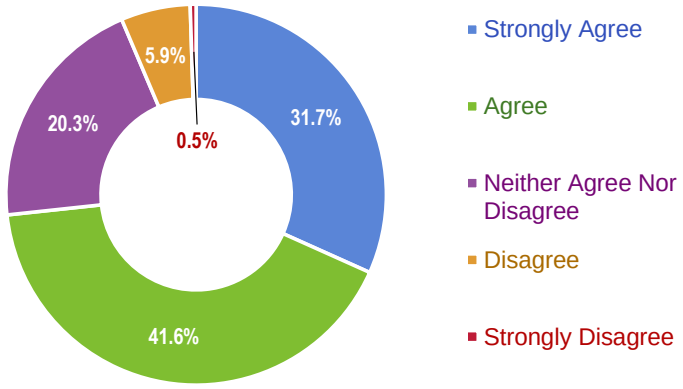


Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Items 304-308]
Notes: ● Asked of all respondents.
● Percentages represent combined responses of “Almost Every Day,” “At Least Once a Week,” and “A Few Times a Month.”

Community as Welcoming Place for All Races/Ethnicities

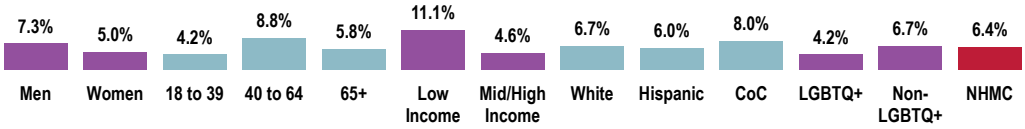
"Please tell me your level of agreement or disagreement with the following statement: 'I feel that my community is a welcoming place for people of all races and ethnicities.' Do you: strongly agree, agree, neither agree nor disagree, disagree, or strongly disagree?"

Level of Agreement About the Community as a Welcoming Place for People of all Races and Ethnicities
(NHMC Service Region, 2022)



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 302]
Notes: ● Asked of all respondents.

Disagree That the Community is a Welcoming Place for All Races/Ethnicities
(NHMC Service Region, 2022)

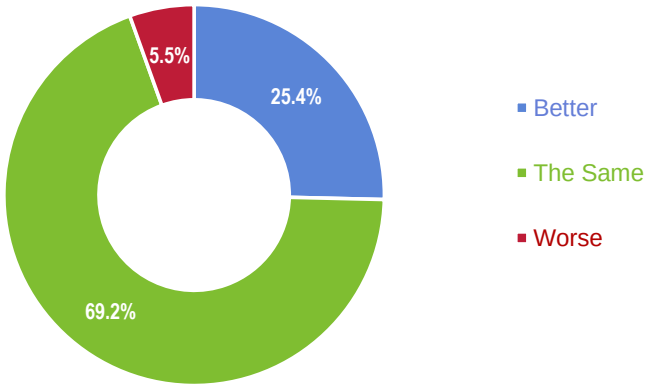


Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 302]
Notes: ● Asked of all respondents. Use caution when interpreting results for LGBTQ+, as the sample size falls below n=50.
● Percentages represent combined responses of "Disagree" and "Strongly Disagree."
● CoC represents Communities of Color (non-Hispanic and non-White).

Treatment Based on Race/Ethnicity in Health Care Settings

"And now thinking about all of your health care experiences in the past 12 months, in general, do you feel your experiences were 'better,' 'the same,' or 'worse' than those of people of other races or ethnicities?"

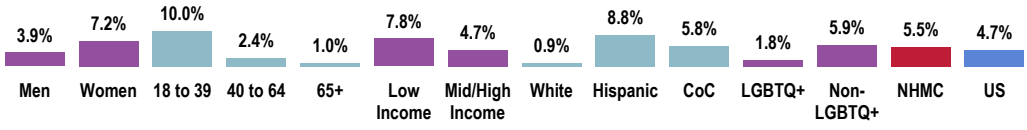
How Respondents Feel They Were Treated in Health Care Settings Over the Past Year in Comparison with People of Other Races/Ethnicities
(NHMC Service Region, 2022)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 303]

Notes:
- Asked of all respondents.
- As compared to the experiences of people of other races or ethnicities.

Respondents Who Feel They Were Treated Worse in Health Care Settings Over the Past Year in Comparison with People of Other Races/Ethnicities
(NHMC Service Region, 2022)



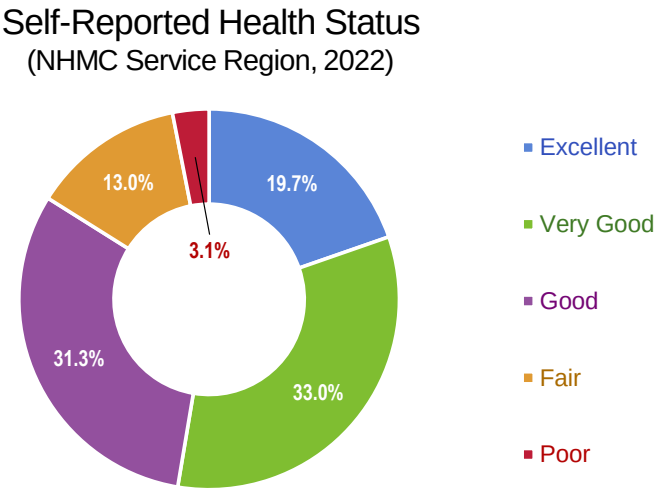
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 305]

Notes:
- Asked of all respondents. Use caution when interpreting results for LGBTQ+, as the sample size falls below n=50.
- As compared to the experiences of people of other races or ethnicities.
- CoC represents Communities of Color (non-Hispanic and non-White).

HEALTH STATUS

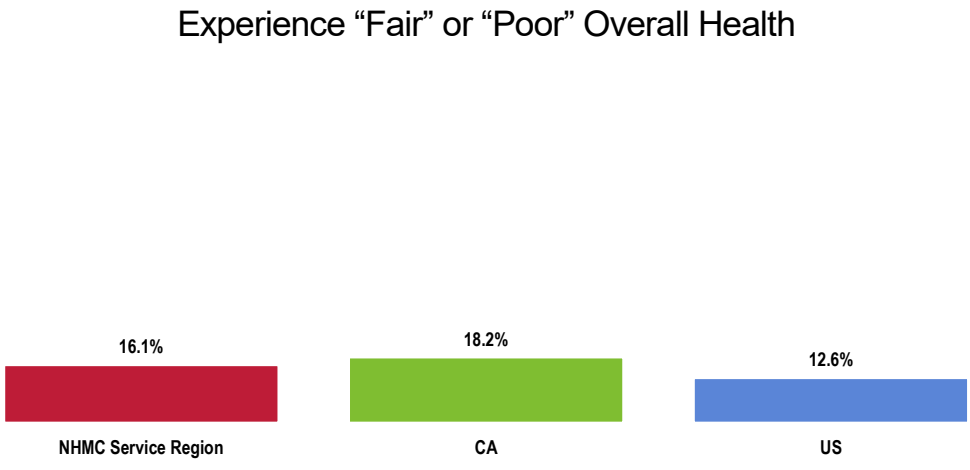
Overall Health

"Would you say that, in general, your health is: excellent, very good, good, fair, or poor?"



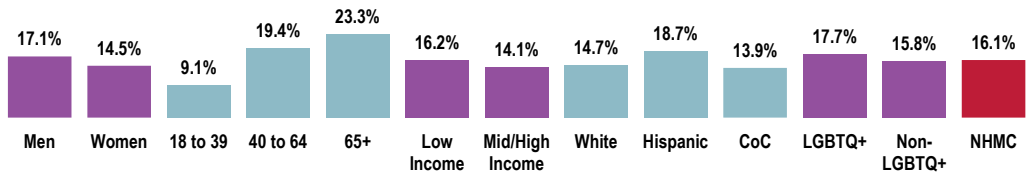
Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 5]
Notes: ● Asked of all respondents.

The following charts further detail "fair/poor" overall health responses in the NHMC Service Region in comparison to benchmark data, as well as by basic demographic characteristics (namely by sex, age groupings, income [based on poverty status], race/ethnicity, and sexual orientation/gender identity).



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 5]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California data.
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Experience “Fair” or “Poor” Overall Health
(NHMC Service Region, 2022)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 5]
Notes: • Asked of all respondents. Use caution when interpreting results for LGBTQ+, as the sample size falls below n=50.
• CoC represents Communities of Color (non-Hispanic and non-White).

Mental Health

ABOUT MENTAL HEALTH & MENTAL DISORDERS

About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. …Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental disorders get the treatment they need.

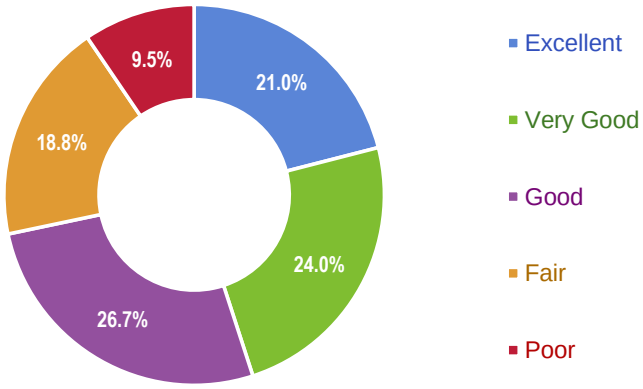
In addition, mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people’s ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders. Increasing screening for mental disorders can help people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Mental Health Status

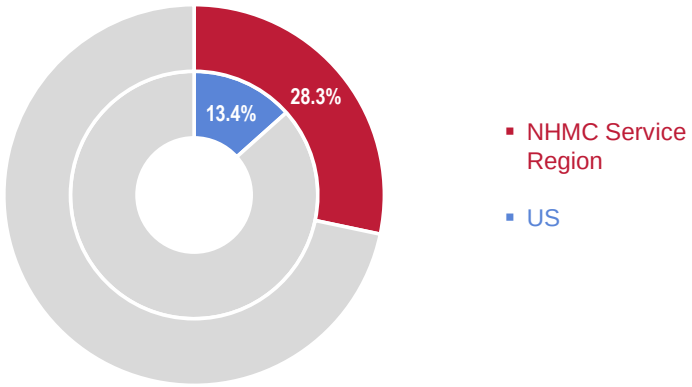
"Now thinking about your mental health, which includes stress, depression and problems with emotions, would you say that, in general, your mental health is: excellent, very good, good, fair, or poor?"

Self-Reported Mental Health Status
(NHMC Service Region, 2022)



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 90]
Notes: ● Asked of all respondents.

Experience "Fair" or "Poor" Mental Health

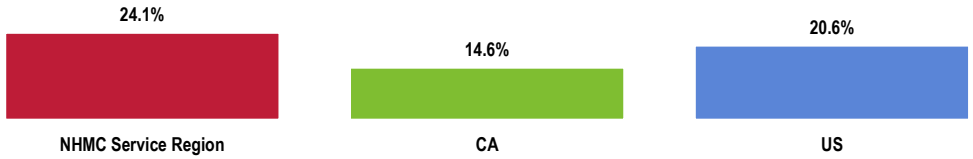


Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 90]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Depression

DIAGNOSED DEPRESSION ▶ **"Has a doctor, nurse, or other health professional ever told you that you have a depressive disorder, including depression, major depression, dysthymia, or minor depression?"**

Have Been Diagnosed With a Depressive Disorder

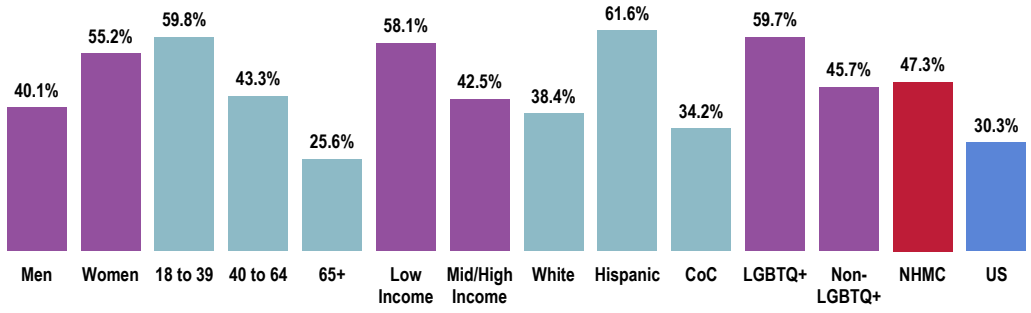


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 93]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Depressive disorders include depression, major depression, dysthymia, or minor depression.

SYMPTOMS OF CHRONIC DEPRESSION ▶ **"Have you had two years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?"**

Have Experienced Symptoms of Chronic Depression
(NHMC Service Region, 2022)

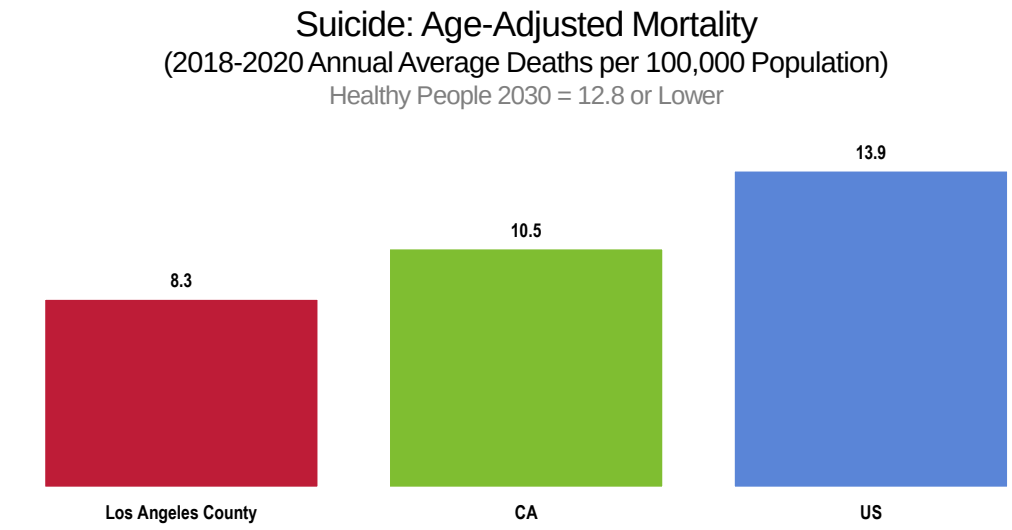


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 91]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents. Use caution when interpreting results for LGBTQ+, as the sample size falls below n=50.
- Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.
- CoC represents Communities of Color (non-Hispanic and non-White).

Suicide

The following chart outlines the most current age-adjusted mortality rates attributed to suicide in our population (refer to “Leading Causes of Death” for an explanation of the use of age-adjusting for these rates). [COUNTY-LEVEL DATA]

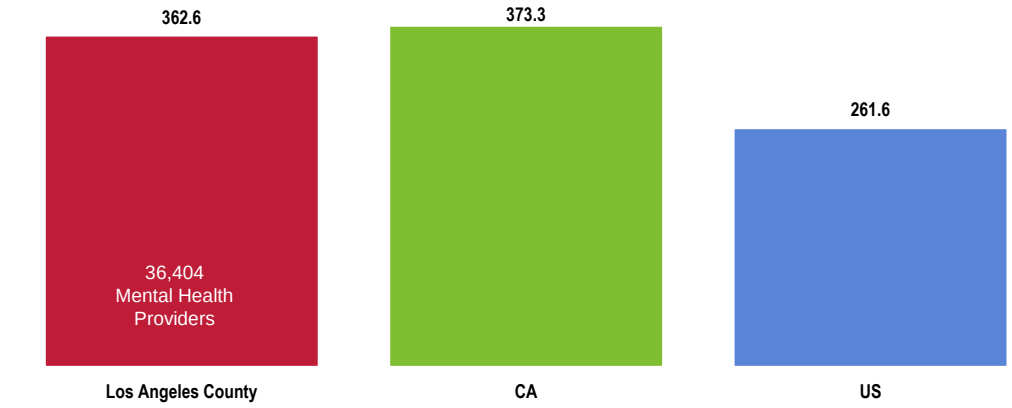


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Mental Health Treatment

The following chart outlines access to mental health providers, expressed as the number of providers (psychiatrists, psychologists, clinical social workers, and counsellors who specialize in mental health care) per 100,000 residents. [COUNTY-LEVEL DATA]

Here, “mental health providers” includes psychiatrists, psychologists, clinical social workers, and counsellors who specialize in mental health care. Note that this indicator only reflects providers practicing in Los Angeles County and residents in Los Angeles County; it does not account for the potential demand for services from outside the area, nor the potential availability of providers in surrounding areas.



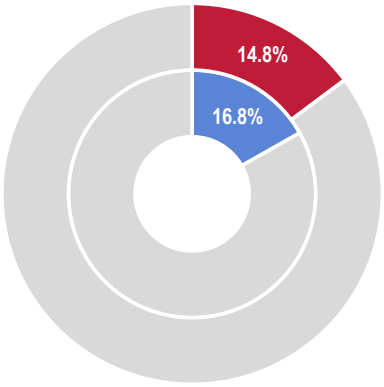
Sources:
- University of Wisconsin Population Health Institute, County Health Rankings.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of the county population to the number of mental health providers including psychiatrists, psychologists, clinical social workers, and counsellors that specialize in mental health care.

"Are you now taking medication or receiving treatment from a doctor, nurse, or other health professional for any type of mental health condition or emotional problem?"

Currently Receiving Mental Health Treatment

Among respondents ever diagnosed with a depressive disorder, 51.1% are currently receiving treatment.



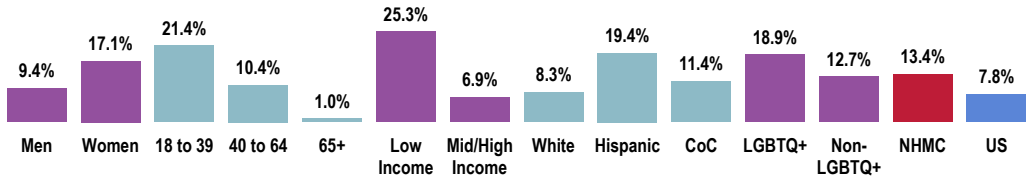
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 94]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- "Treatment" can include taking medications for mental health.

"Was there a time in the past 12 months when you needed mental health services but were not able to get them?"

Unable to Get Mental Health Services When Needed in the Past Year

(NHMC Service Region, 2022)

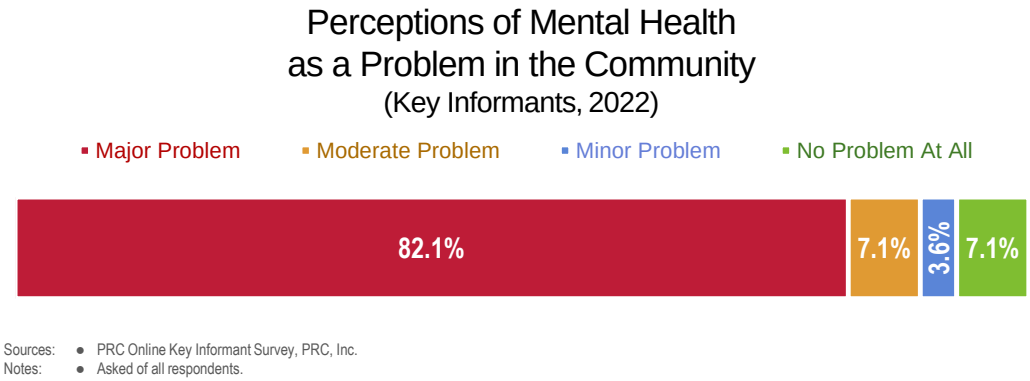


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 95]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents. Use caution when interpreting results for LGBTQ+, as the sample size falls below n=50.
- CoC represents Communities of Color (non-Hispanic and non-White).

Key Informant Input: Mental Health

The following chart outlines key informants' perceptions of the severity of *Mental Health* as a problem in the community:



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Access to timely and affordable ongoing mental health services. Wait lists are too long or people are offered a specific number of sessions rather than being able to decide when they are ready to terminate services. – Community Leader
>
> Accessing mental health support, being able to afford MH services. – Social Services Provider
>
> Limited care options available, specifically for youth. – Social Services Provider
>
> The biggest challenges I see patients going through is finding mental health providers, especially in the adult population 55+ and accessing psychiatry services, which include medication management. There are limited options available and long wait lists. – Social Services Provider
>
> Support and access to treatment and services. – Social Services Provider
>
> Not enough resources accessible to those facing mental health issues. Our community needs facilities where severe cases can be handled with staff trained specifically on mental health. – Social Services Provider

Homelessness

> Mental health issues are a major source of homelessness. Need I say more? – Other Health Provider
>
> It seems the homeless have a high degree of mental illness. – Education Representative Incidence/Prevalence
>
> Mental health issues have become an escalating problem since March 2020. The issues range from the lack of proper treatment facilities and management for those who were homeless in dire need of treatment to the need for the average person experiencing the stresses and mental health challenges of the isolation and upheaval of the last two years for someone with the proper training to talk to and validate their concerns. – Social Services Provider

Contributing Factors

> Access to care; social stigma around MH issues. – Social Services Provider
>
> Still strong stigma associated with mental health and inadequate access to services or counseling. Even now, most of these services are more a carve out than those that are actually funded as an essential benefit by health plans. – Public Health Representative
>
> Lack of access to culturally and linguistically appropriate therapists. Stigma related to accessing care or admitting you need care. – Social Services Provider

Affordable Care

> Major lack of resources available to truly meet the needs of those with mental illness. The impacts of COVID have played a huge role in the increase in mental illness. Not knowing how to navigate an affordable option for those not low-income enough for Medi-Cal but can't afford for private mental health care. – Social Services Provider

LGTBQ+ Populations

> Lack of health, mental health, and social services focused on the LGBTQ+ community. – Community Leader

Denial/Stigma

> Not accepting that you have a mental health problem makes the problem worse. – Community Leader

Awareness/Education

> People need information about treatment and how to assist people with this disease. – Social Services Provider

Lack of Providers

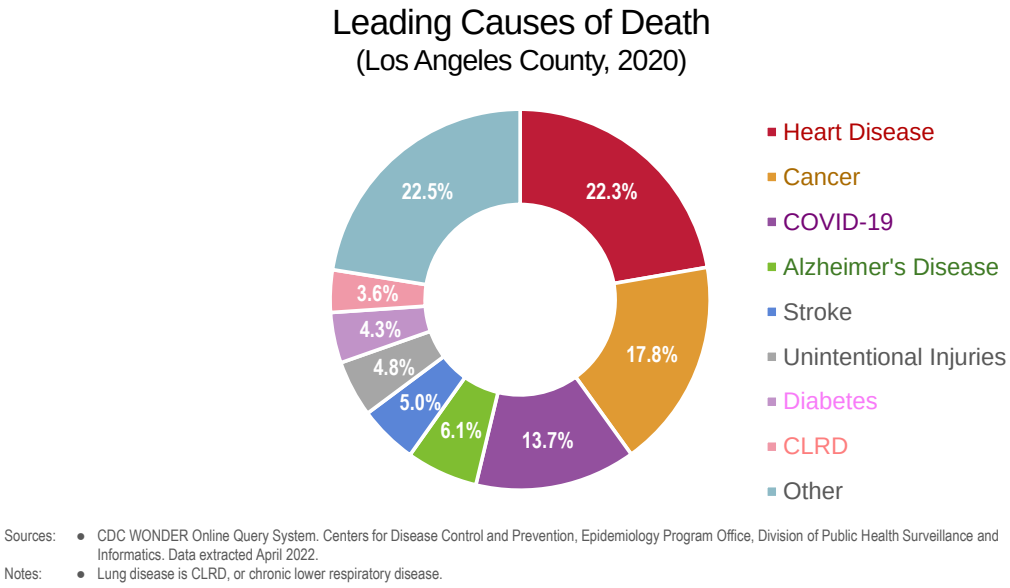
> Insufficient mental health professionals. Need for entire family to get support. – Other Health Provider

DEATH, DISEASE & CHRONIC CONDITIONS

Leading Causes of Death

Distribution of Deaths by Cause

Cancers and heart disease are leading causes of death in the community. [COUNTY-LEVEL DATA]



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
Notes: • Lung disease is CLRD, or chronic lower respiratory disease.

Age-Adjusted Death Rates for Selected Causes

AGE-ADJUSTED DEATH RATES

In order to compare mortality in the region with other localities (in this case, California and the United States), it is necessary to look at rates of death — these are figures which represent the number of deaths in relation to the population size (such as deaths per 100,000 population, as is used here).

Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution. Use of these "age-adjusted" rates provides the most valuable means of gauging mortality against benchmark data, as well as Healthy People 2030 objectives.

The following chart outlines annual average age-adjusted death rates per 100,000 population for selected causes of death in the NHMC Service Region. [COUNTY-LEVEL DATA]

For infant mortality data, see *Birth Outcomes & Risks* in the **Births** section of this report.

Age-Adjusted Death Rates for Selected Causes
(2018-2020 Deaths per 100,000 Population)

	Los Angeles County	California	US	HP2030
Diseases of the Heart	150.6	140.2	164.4	127.4*
Malignant Neoplasms (Cancers)	130.7	132.3	146.5	122.7
Coronavirus Disease/COVID-19 [2020]	98.3	138.2	85.0	—
Alzheimer's Disease	39.1	38.2	30.9	—
Cerebrovascular Disease (Stroke)	34.3	37.8	37.6	33.4
Unintentional Injuries	29.9	37.9	51.6	43.2
Falls [Age 65+]	28.4	41.4	67.1	63.4
Diabetes	27.4	22.9	22.6	—
Chronic Lower Respiratory Disease (CLRD)	26.6	29.3	38.1	—
Pneumonia/Influenza	18.1	13.8	13.4	—
Cirrhosis/Liver Disease	13.4	12.8	11.9	10.9
Unintentional Drug-Related Deaths	12.6	15.2	21.0	—
Kidney Disease	12.5	9.1	12.8	—
Motor Vehicle Deaths	8.4	9.9	11.4	10.1
Intentional Self-Harm (Suicide)	8.3	10.5	13.9	12.8
Firearm-Related	7.3	7.7	12.5	10.7
Homicide/Legal Intervention	6.0	5.1	6.1	5.5
HIV/AIDS	1.9	1.7	1.8	—
Septicemia	1.1	3.7	9.8	---

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov.

Note:
- *The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.

Cardiovascular Disease

ABOUT HEART DISEASE & STROKE

Heart disease is the leading cause of death in the United States, and stroke is the fifth leading cause. …Heart disease and stroke can result in poor quality of life, disability, and death. Though both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment.

In addition, making sure people who experience a cardiovascular emergency — like stroke, heart attack, or cardiac arrest — get timely recommended treatment can reduce their risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

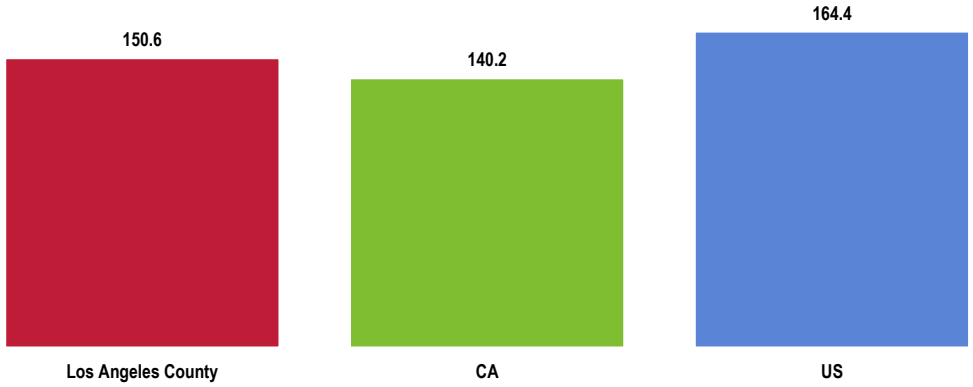
Age-Adjusted Heart Disease & Stroke Deaths

The greatest share of cardiovascular deaths is attributed to heart disease. The following charts outline age-adjusted mortality rates for heart disease and for stroke in our community. [COUNTY-LEVEL DATA]

Heart Disease: Age-Adjusted Mortality

(2018-2020 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 127.4 or Lower (Adjusted)



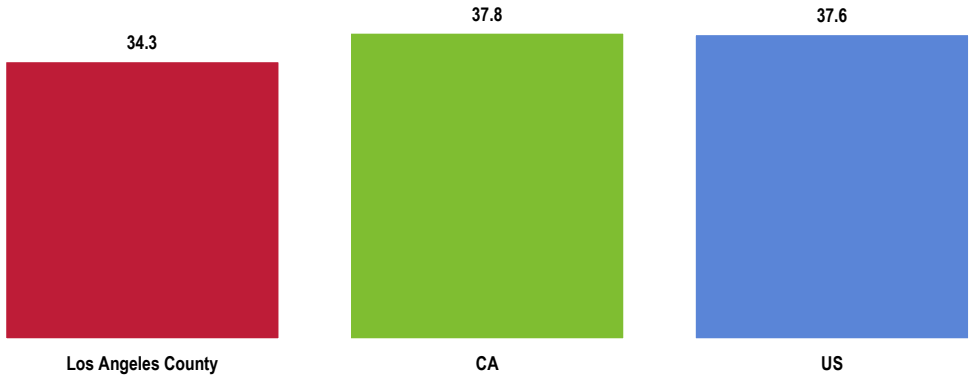
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.

Stroke: Age-Adjusted Mortality

(2018-2020 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower



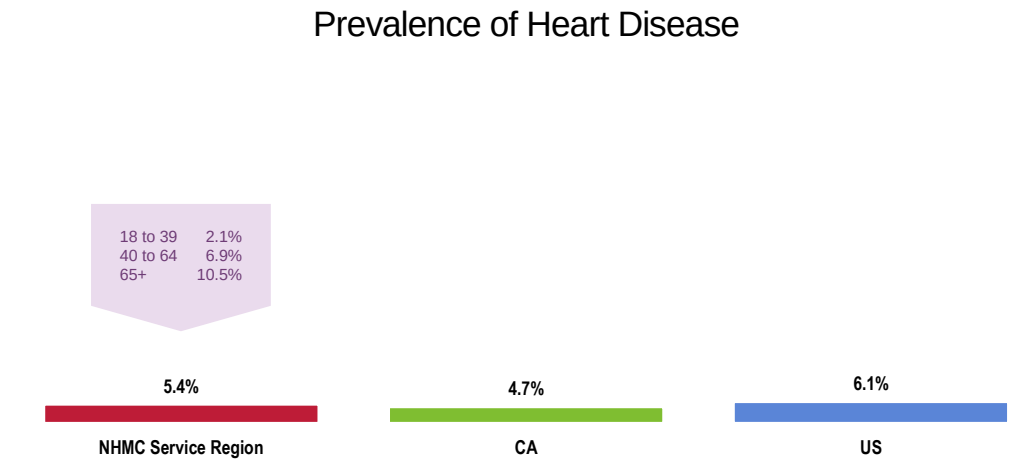
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Prevalence of Heart Disease & Stroke

"Has a doctor, nurse, or other health professional ever told you that you had:

- A heart attack, also called a myocardial infarction?
- Angina or coronary heart disease?"

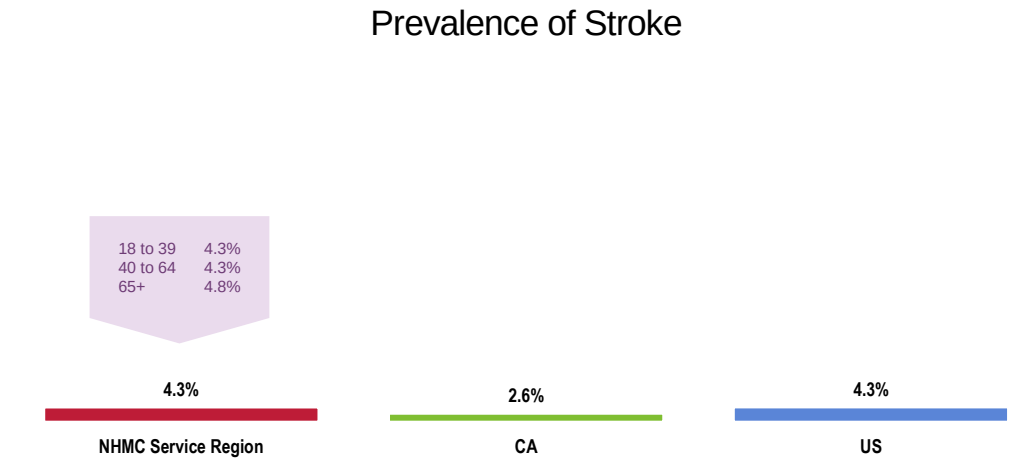
Heart disease prevalence here is a calculated prevalence that includes those responding affirmatively to either.



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 114]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes diagnoses of heart attack, angina, or coronary heart disease.

"Has a doctor, nurse, or other health professional ever told you that you had a stroke?"



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 29]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

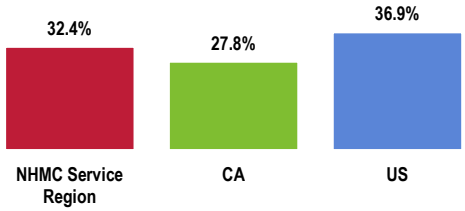
Cardiovascular Risk Factors

Blood Pressure & Cholesterol

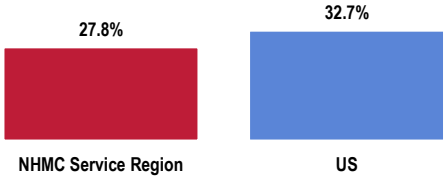
“Have you ever been told by a doctor, nurse, or other health care professional that you had high blood pressure?”

“Blood cholesterol is a fatty substance found in the blood. Have you ever been told by a doctor, nurse, or other health care professional that your blood cholesterol is high?”

Prevalence of
High Blood Pressure
Healthy People 2030 = 27.7% or Lower



Prevalence of
High Blood Cholesterol



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 35-36]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Total Cardiovascular Risk

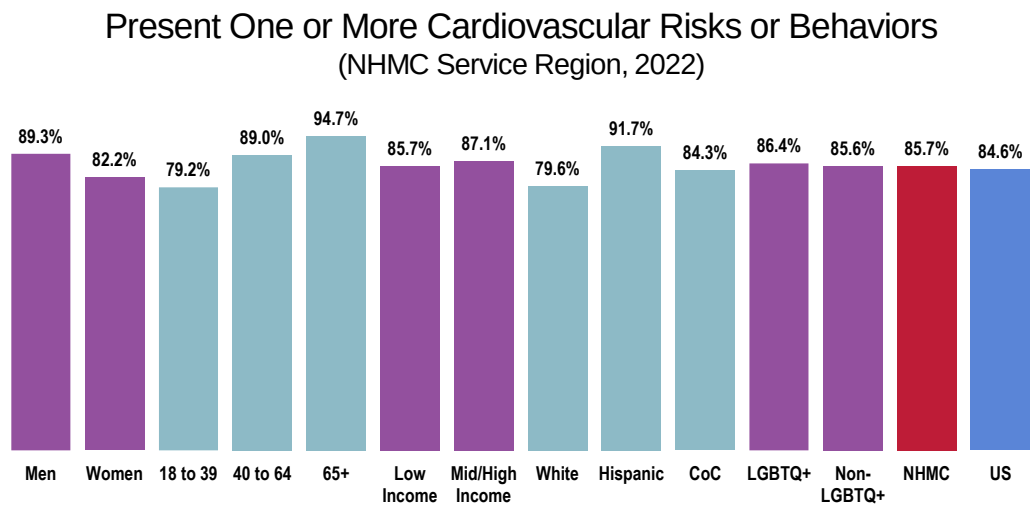
Total cardiovascular risk reflects the individual-level risk factors which put a person at increased risk for cardiovascular disease, including:

- High Blood Pressure
- High Blood Cholesterol
- Cigarette Smoking
- Physical Inactivity
- Overweight/Obesity

Modifying these behaviors and adhering to treatment for high blood pressure and cholesterol are critical both for preventing and for controlling cardiovascular disease.

RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

The following chart reflects the percentage of adults in the NHMC Service Region who report one or more of the following: being overweight; smoking cigarettes; being physically inactive; or having high blood pressure or cholesterol.

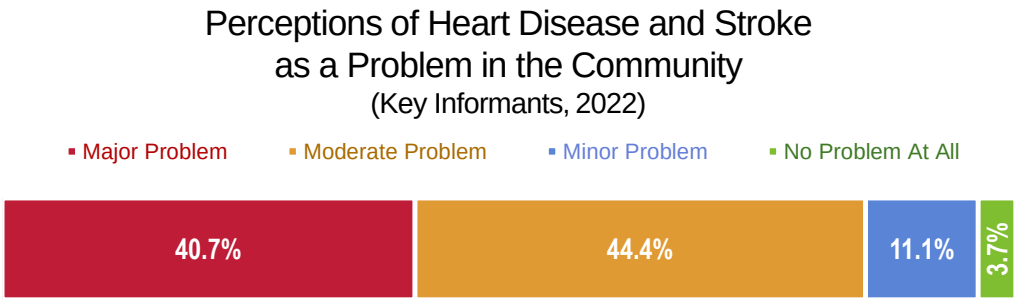


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 115]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Reflects all respondents. Use caution when interpreting results for LGBTQ+, as the sample size falls below n=50.
- Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) high blood pressure; 4) high blood cholesterol; and/or 5) being overweight/obese.
- CoC represents Communities of Color (non-Hispanic and non-White).

Key Informant Input: Heart Disease & Stroke

The following chart outlines key informants' perceptions of the severity of *Heart Disease & Stroke* as a problem in the community:



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Awareness/Education

> Lack of knowledge and information on lifestyle changes and habits that can prevent a heart attack and stroke later in life. Lack of interest in changing lifestyle habits. – Social Services Provider
>
> People need information about treatment and how to assist people with this disease. – Social Services Provider

Contributing Factors

> Due to the lack of access to healthy food and access to places of exercise, especially in this time of pandemic. – Community Leader

> Malnutrition and limited physical activity. – Social Services Provider

Incidence/Prevalence

> Both conditions remain top 10 causes of mortality and morbidity. Also, has associated health disparities, disproportionately affect different groups. – Public Health Representative
>
> Based on statistics, this continues to be one of the top five causes of death. – Social Services Provider

Diet

> Obesity and high cholesterol are prevalent because of poor diets. – Social Services Provider

Cancer

ABOUT CANCER

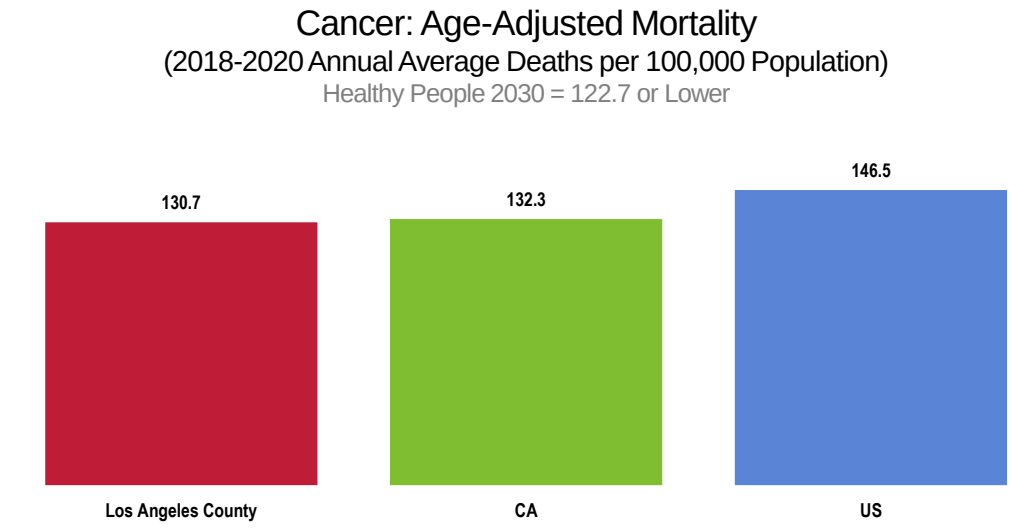
Cancer is the second leading cause of death in the United States. …The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are often linked to social determinants of health, including education, economic status, and access to health care.

Interventions to promote evidence-based cancer screenings — such as screenings for lung, breast, cervical, and colorectal cancer — can help reduce cancer deaths. Other effective prevention strategies include programs that increase HPV vaccine use, prevent tobacco use and promote quitting, and promote healthy eating and physical activity. In addition, effective targeted therapies and personalized treatment are key to helping people with cancer live longer.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Cancer Deaths

The following chart illustrates age-adjusted cancer mortality (all types) in the NHMC Service Region. [COUNTY-LEVEL DATA]



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Lung cancer is the leading cause of cancer deaths in the NHMC Service Region. [COUNTY-LEVEL DATA]

Age-Adjusted Cancer Death Rates by Site
(2018-2020 Annual Average Deaths per 100,000 Population)

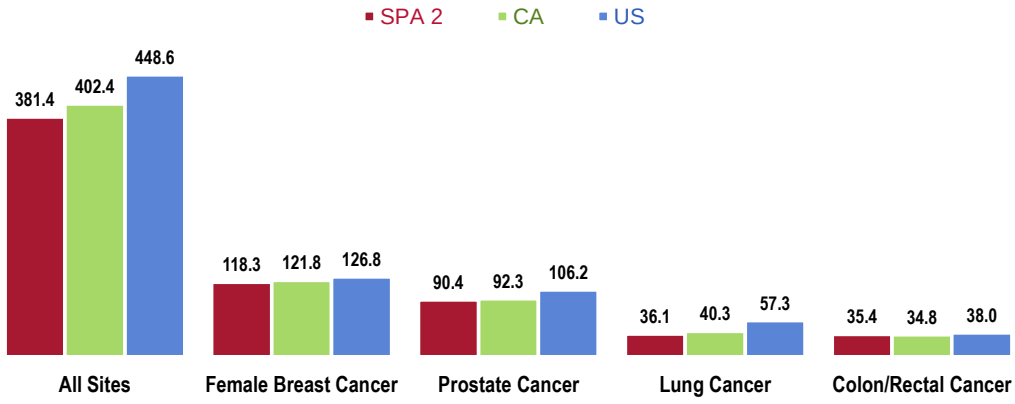
	Los Angeles County	California	US	HP2030
ALL CANCERS	**130.7**	**132.3**	**146.5**	**122.7**
Lung Cancer	**21.8**	**23.7**	**33.4**	**25.1**
Prostate Cancer	**19.5**	**19.6**	**18.5**	**16.9**
Female Breast Cancer	**19.1**	**18.7**	**19.4**	**15.3**
Colorectal Cancer	**12.8**	**12.2**	**13.1**	**8.9**

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Cancer Incidence

"Incidence rate" or "case rate" is the number of newly diagnosed cases in a given population in a given year, regardless of outcome. These rates are also age-adjusted. It is usually expressed as cases per 100,000 population per year.

Cancer Incidence Rates by Site
(Annual Average Age-Adjusted Incidence per 100,000 Population, 2014-2018)



Sources:
- State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

Prevalence of Cancer

ABOUT CANCER RISK

Reducing the nation's cancer burden requires reducing the prevalence of behavioral and environmental factors that increase cancer risk.

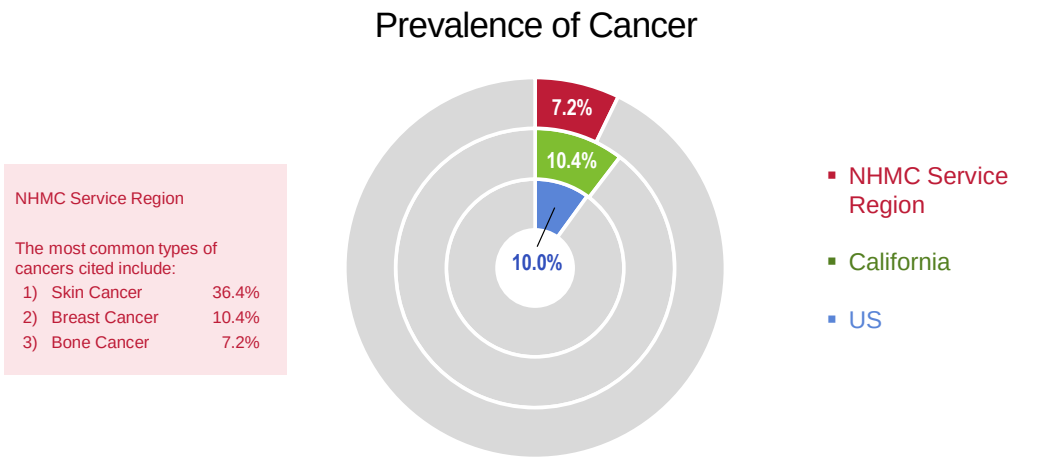
- All cancers caused by cigarette smoking could be prevented. At least one-third of cancer deaths that occur in the United States are due to cigarette smoking.
- According to the American Cancer Society, about one-third of cancer deaths that occur in the United States each year are due to nutrition and physical activity factors, including obesity.

– National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

"Have you ever suffered from or been diagnosed with cancer?"

"Which type of cancer were you diagnosed with?" (If more than one past diagnosis, respondent was asked about the most recent.)

RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 25-26]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Reflects all respondents.

Cancer Screenings

The American Cancer Society recommends that both men and women get a cancer-related checkup during a regular doctor's checkup. It should include examination for cancers of the thyroid, testicles, ovaries, lymph nodes, oral cavity, and skin, as well as health counseling about tobacco, sun exposure, diet and nutrition, risk factors, sexual practices, and environmental and occupational exposures.

FEMALE BREAST CANCER

The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women aged 50 to 74 years.

CERVICAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting). The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion (i.e., cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer.

COLORECTAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years.

– US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Screening levels in the community were measured in the PRC Community Health Survey relative to three cancer sites: female breast cancer (mammography); cervical cancer (Pap smear testing); and colorectal cancer (sigmoidoscopy and fecal occult blood testing).

BREAST CANCER SCREENING ► **"A mammogram is an x-ray of each breast to look for cancer. How long has it been since you had your last mammogram?"**

Breast cancer screening is calculated here among women age 50 to 74 who indicate mammography within the past 2 years.

CERVICAL CANCER SCREENING ► **"A Pap test is a test for cancer of the cervix. How long has it been since you had your last Pap test?"**

[If Pap test in the past five years] **"HPV, or the human papillomavirus, is a common infection that can cause several types of cancer. When you received your last Pap test, were you screened for HPV?"**

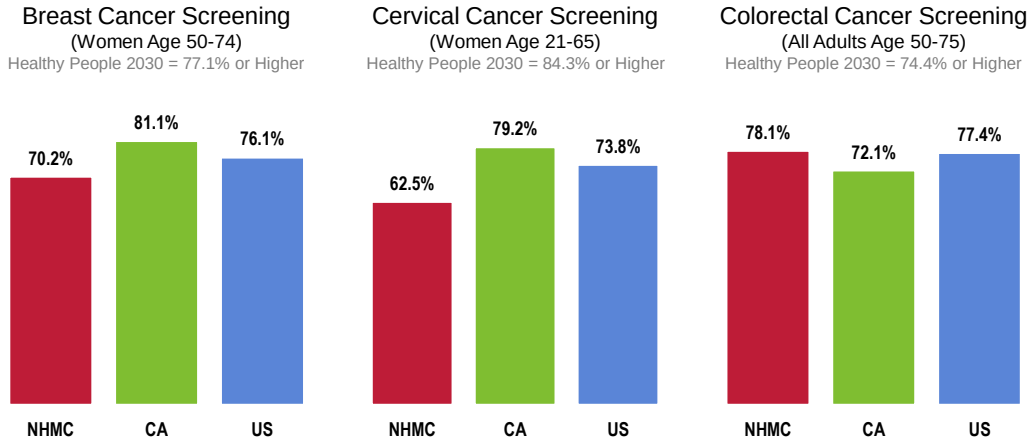
"Have you ever had a hysterectomy?"

"Appropriate cervical cancer screening" includes Pap smear testing (cervical cytology) every three years in women age 21 to 29 and Pap smear testing and/or HPV testing every 5 years in women age 30 to 65. Women 21 to 65 with hysterectomy are excluded.

COLORECTAL CANCER SCREENING ► **"Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. How long has it been since your last sigmoidoscopy or colonoscopy?"**

"A blood stool test is a test that may use a special kit at home to determine whether the stool contains blood. How long has it been since you had your last blood stool test?"

"Appropriate colorectal cancer screening" is calculated here among men and women age 50 to 75 years who have had a fecal occult blood test within the past year and/or a lower endoscopy (sigmoidoscopy or colonoscopy) within the past 10 years.

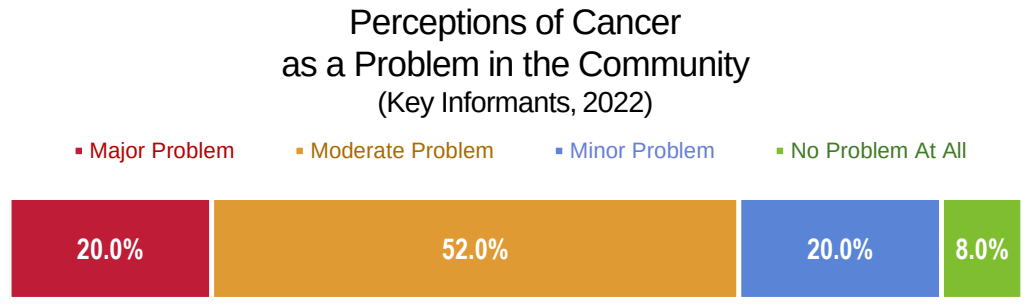


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 116, 117, 118]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Each indicator is shown among the gender and/or age group specified.

Key Informant Input: Cancer

The following chart outlines key informants' perceptions of the severity of *Cancer* as a problem in the community:



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Lifestyle

> The risk of all individuals developing or being diagnosed with cancer continues to increase and with the impacts of COVID, certain lifestyle habits have changes or worsened, which may increase risk of being diagnosed with Cancer along with other chronic conditions. – Social Services Provider

Prevention

> Many of the most prevalent cancers such as lung cancer, stomach cancer, etc. are preventable (e.g., reducing tobacco and alcohol use). Some has effective screening and prevention programs such as colorectal cancer screening and HPV vaccination of target groups. For liver cancer, hepatitis prevention and management are key especially now that certain genotype of hepatitis C can be effectively treated with antivirals. – Public Health Representative

Incidence/Prevalence

> Statistic shows that there are many people diagnosed with this terminal illness. – Other Health Provider

Awareness/Education

> People need information about treatment and how to assist people with this disease. – Social Services Provider

Respiratory Disease

ABOUT RESPIRATORY DISEASE

Respiratory diseases affect millions of people in the United States. …More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million people in the United States have COPD (chronic obstructive pulmonary disease), which is a major cause of death. Strategies to prevent the disease — like reducing air pollution and helping people quit smoking — are key to reducing deaths from COPD.

Interventions tailored to at-risk groups can also help prevent and treat other respiratory diseases — for example, pneumonia in older adults and pneumoconiosis in coal miners. And increasing lung cancer screening rates can help reduce deaths from lung cancer through early detection and treatment.

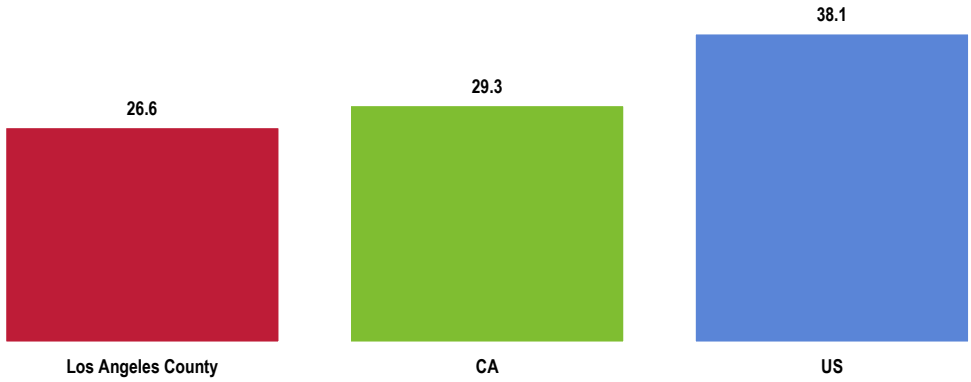
– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Respiratory Disease Deaths

Chronic lower respiratory diseases (CLRD) are diseases affecting the lungs; the most deadly of these is chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis. Mortality for CLRD is illustrated in the charts that follow.

Pneumonia and influenza mortality is also illustrated. [COUNTY-LEVEL DATA]

CLRD: Age-Adjusted Mortality
(2018-2020 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
Notes: • CLRD is chronic lower respiratory disease.

Pneumonia/Influenza: Age-Adjusted Mortality
(2018-2020 Annual Average Deaths per 100,000 Population)

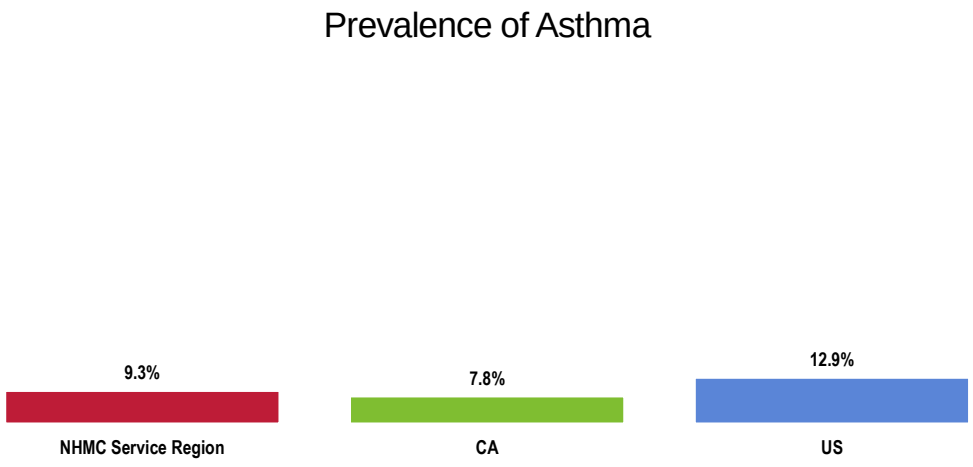
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

Prevalence of Respiratory Disease

Asthma

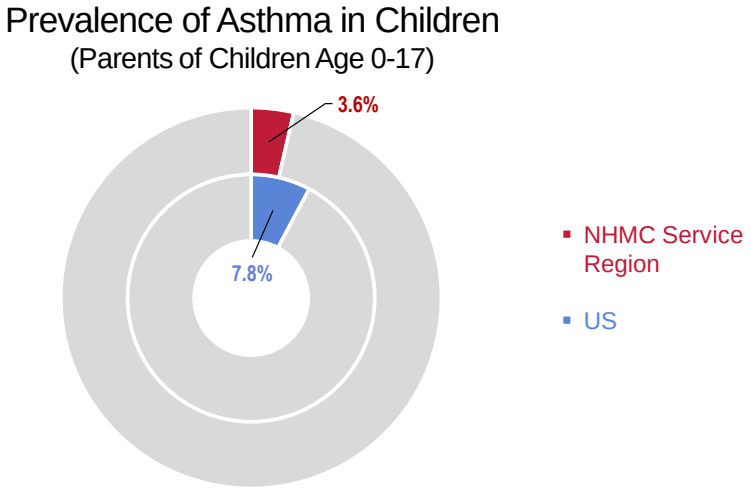
ADULTS ► **"Have you ever been told by a doctor, nurse, or other health professional that you had asthma?" and "Do you still have asthma?"** (Calculated here as a prevalence of all adults who have ever been diagnosed with asthma and who still have asthma.)

CHILDREN ► **"Has a doctor or other health professional ever told you that this child had asthma?" and "Does this child still have asthma?"** (Calculated here as a prevalence of all children who have ever been diagnosed with asthma and who still have asthma.)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 119]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those who have ever been diagnosed with asthma and report that they still have asthma.

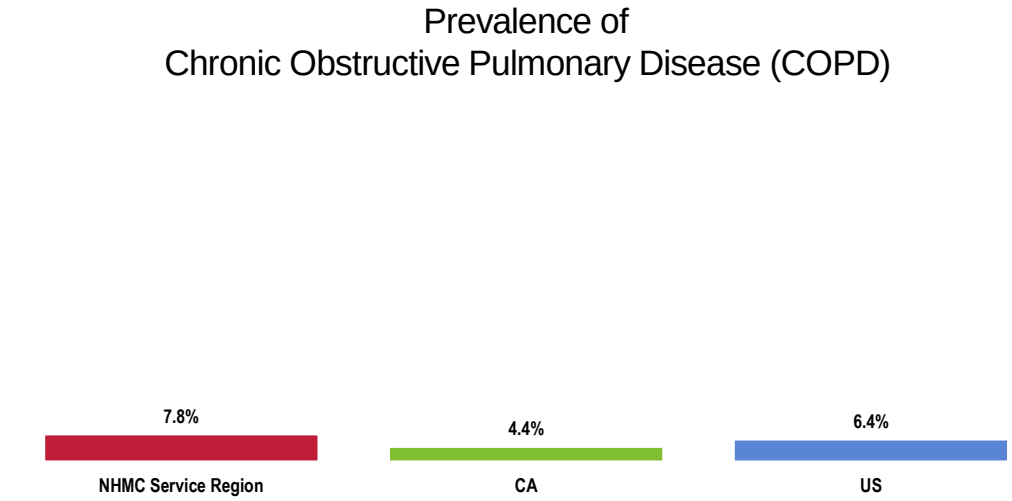


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 120]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children 0 to 17 in the household.
- Includes children who have ever been diagnosed with asthma and are reported to still have asthma.

Chronic Obstructive Pulmonary Disease (COPD)

"Have you ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema?"

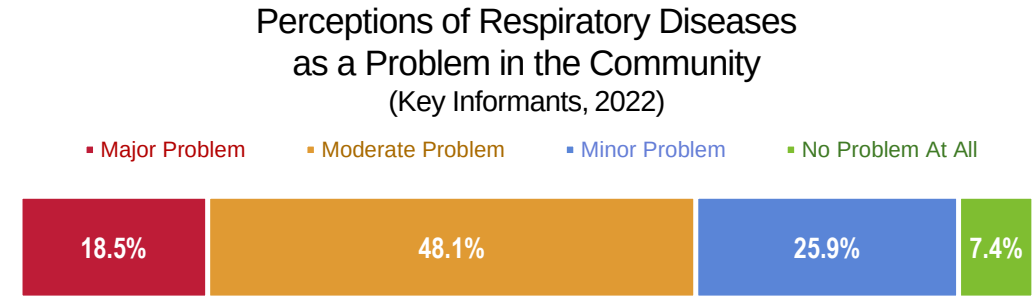


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 23]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those having ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema.

Key Informant Input: Respiratory Disease

The following chart outlines key informants' perceptions of the severity of *Respiratory Disease* as a problem in the community:



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Awareness/Education

> People need information about treatment and how to assist people with this disease. – Social Services Provider

Co-Occurrences

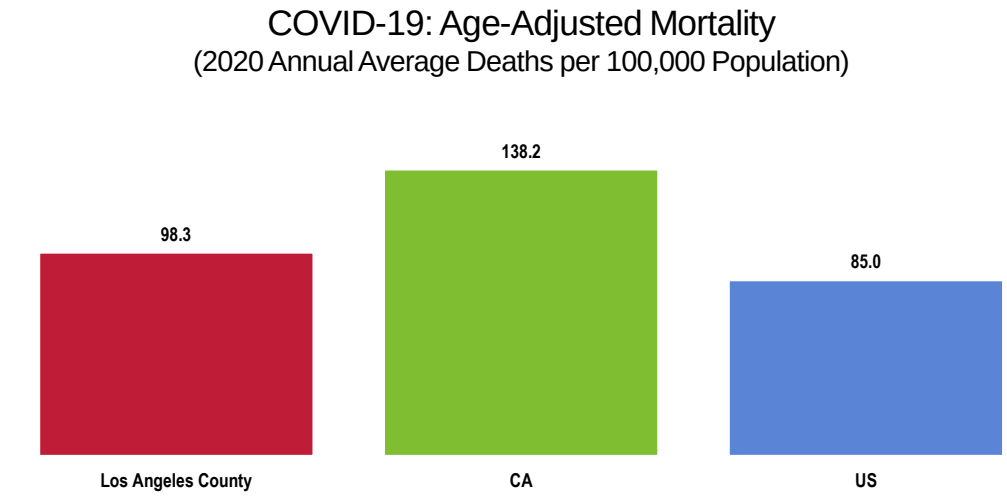
> Allergies and asthma. – Community Leader

Environmental Contributors

> The Valley is home to multiple freeways and interchanges, air pollution is a problem in all LA, and data around asthma prevalence. – Social Services Provider

Coronavirus Disease/COVID-19

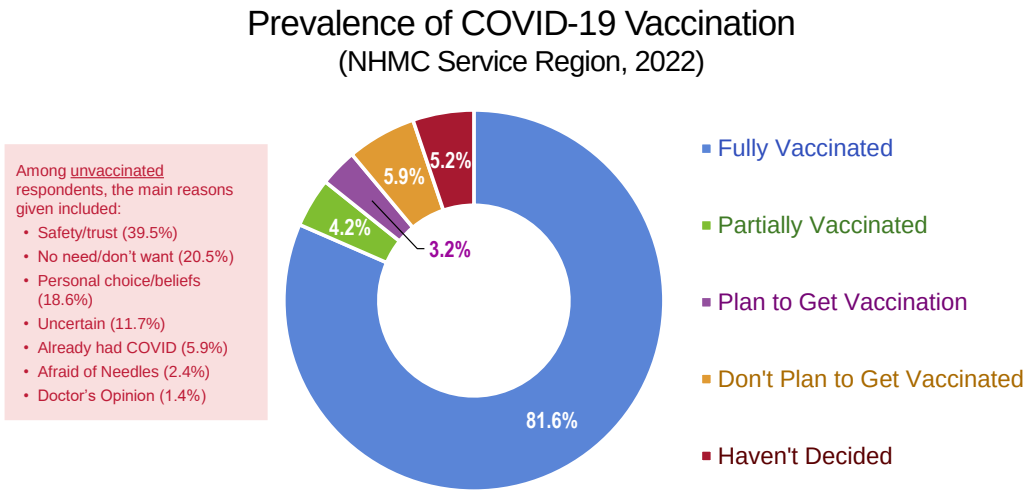
The following chart illustrates age-adjusted Coronavirus Disease/COVID-19 mortality in the NHMC Service Region. [COUNTY-LEVEL DATA]



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

"The next question is about the COVID-19 vaccine. Please tell me which of the following statements best describes you: I am fully vaccinated against COVID-19; I am partially vaccinated against COVID-19; I plan to receive the vaccine; I do not plan to receive the vaccine; I haven't decided whether or not to receive the vaccine."

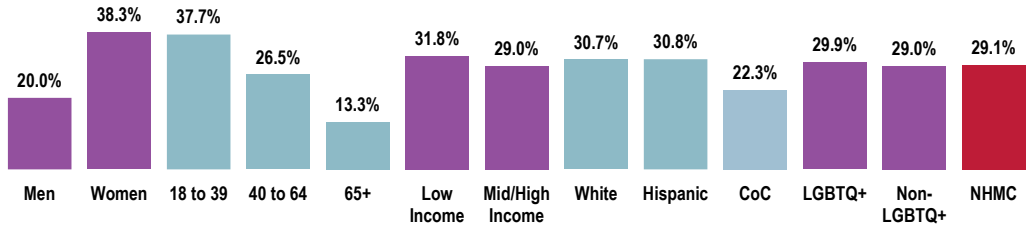
[Unvaccinated adults] **"What is the main reason you have NOT received the COVID-19 vaccine?"**



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Items 313–314]
Notes: ● Asked of all respondents.

"The next questions are about the coronavirus and COVID-19 pandemic that began in March of 2020. Since the start of the pandemic, would you say your mental health has: improved, stayed about the same, or become worse?"

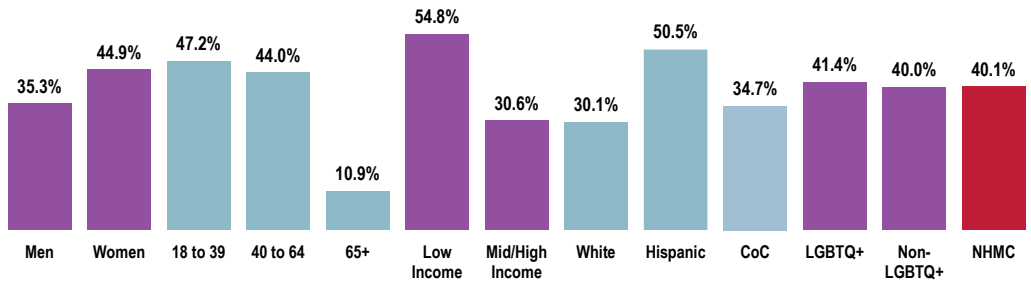
Mental Health Has Gotten Worse Since the Beginning of the Pandemic
(NHMC Service Region, 2022)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 310]
Notes: • Asked of all respondents. Use caution when interpreting results for LGBTQ+, as the sample size falls below n=50.
• Beginning of pandemic specified as March 2020.
• CoC represents Communities of Color (non-Hispanic and non-White).

"Has the coronavirus pandemic caused you or any other adult in your household to lose a job, work fewer hours than you wanted or needed, or led to a loss of health insurance coverage?"

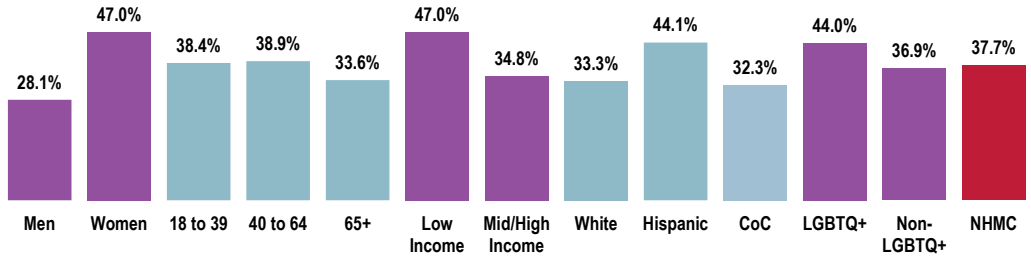
Financially Impacted by the Pandemic
(NHMC Service Region, 2022)



Sources: • PRC Community Health Survey, Professional Research Consultants, Inc. [Item 311]
Notes: • Asked of all respondents. Use caution when interpreting results for LGBTQ+, as the sample size falls below n=50.
• Includes respondents reporting that they or another household member lost a job, worked fewer hours, or lost health insurance coverage as a result of COVID-19 since March 2020.
• CoC represents Communities of Color (non-Hispanic and non-White).

"Has there been a time since the start of the pandemic when you needed medical care or had a medical appointment scheduled, but you chose to avoid receiving care due to concerns about coronavirus?"

Have Avoided Medical Care Because of Concerns Over COVID-19
(NHMC Service Region, 2022)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 312]
Notes: • Asked of all respondents. Use caution when interpreting results for LGBTQ+, as the sample size falls below n=50.
• Beginning of pandemic specified as March 2020.
• CoC represents Communities of Color (non-Hispanic and non-White).

Key Informant Input: Coronavirus Disease/COVID-19

The following chart outlines key informants' perceptions of the severity of *Coronavirus Disease/COVID-19* as a problem in the community:

Perceptions of Coronavirus Disease/COVID-19
as a Problem in the Community
(Key Informants, 2022)

Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Contributing Factors

> COVID-19 has impacted the wellbeing of the SFV population due to loss of jobs, business closure, limited access to care, limited personal relationships, isolation, especially among the elderly, and the notion that things will never be the same again. – Social Services Provider
>
> The community we serve along with Dignity was very hard hit by the COVID-19 pandemic, due to socioeconomic factors that made working from home not applicable; a majority of the demographic we serve are considered "essential workers" or work in industries that laid off a majority of their workers during the pandemic. Consequently, the rates of infection were very high and there is still a higher percentage not vaccinated or suffering the effects of long COVID. – Social Services Provider

> Our community has had among the highest rates of infection as well as lower vaccination rates. People often live in overcrowded conditions making social distancing and isolating if a household member is infected all but impossible. Many are frontline workers with multiple jobs and use public transportation who were at the highest risk of exposure. – Social Services Provider

Vulnerable Populations

> In the community, COVID-19 is a major problem because of various beliefs, barriers, and life circumstances. For starters, in the SFV Pacoima at one point had the highest case rates in LA County. The community, composed of multigenerational homes had high transmissibility as many community members work in jobs that at first did not have the proper support, such as essential workers in grocery stores. Additionally, many of the homes have many individuals living in them so there is not real physical distancing if someone in the family got infected. Health literacy and culturally competent health education information was missing many of the community were not fully/accurately informed of what measures to take to stay safe. Low access to testing and vaccine clinics. The community also had distrust in the vaccine and many myths on the vaccine. – Social Services Provider
>
> Because there are still people who are afraid of going to get the vaccine because of their immigration status and the negative effects they have heard about the vaccine. – Community Leader

Awareness/Education

> People need information about treatment and how to assist people with this disease. – Social Services Provider

Incidence/Prevalence

> COVID-19 has dominated the health landscape and society for the last two years. Even as it becomes endemic, testing, vaccination, and protection of the most vulnerable groups remain relevant, if not they become center staged. – Public Health Representative

Isolation

> It was difficult to keep people isolated to reduce the spread. As the rates are better now, it has gotten better. However, not having enough housing and places for people to be safe is a challenge. – Other Health Provider

Injury & Violence

ABOUT INJURY & VIOLENCE

INJURY ► In the United States, unintentional injuries are the leading cause of death in children, adolescents, and adults younger than 45 years. …Many unintentional injuries are caused by motor vehicle crashes and falls, and many intentional injuries involve gun violence and physical assaults. Interventions to prevent different types of injuries are key to keeping people safe in their homes, workplaces, and communities.

Drug overdoses are now the leading cause of injury deaths in the United States, and most overdoses involve opioids. Interventions to change health care providers' prescribing behaviors, distribute naloxone to reverse overdoses, and provide medications for addiction treatment for people with opioid use disorder can help reduce overdose deaths involving opioids.

VIOLENCE ► Almost 20,000 people die from homicide every year in the United States, and many more people are injured by violence. …Many people in the United States experience physical assaults, sexual violence, and gun-related injuries. Adolescents are especially at risk for experiencing violence. Interventions to reduce violence are needed to keep people safe in their homes, schools, workplaces, and communities.

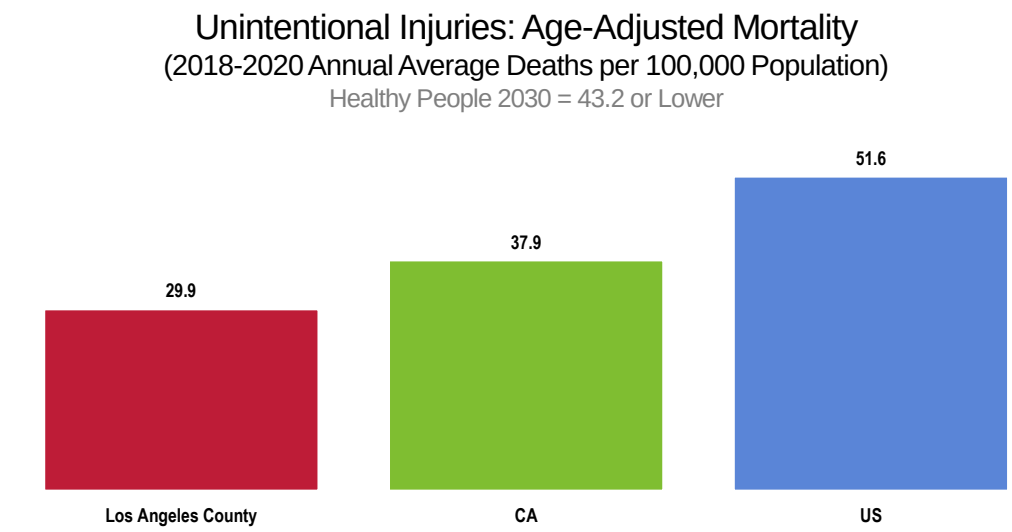
Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

– Healthy People 2030 (https://health.gov/healthypeople)

Unintentional Injury

Age-Adjusted Unintentional Injury Deaths

The following chart outlines age-adjusted mortality rates for unintentional injury in the area. [COUNTY-LEVEL DATA]

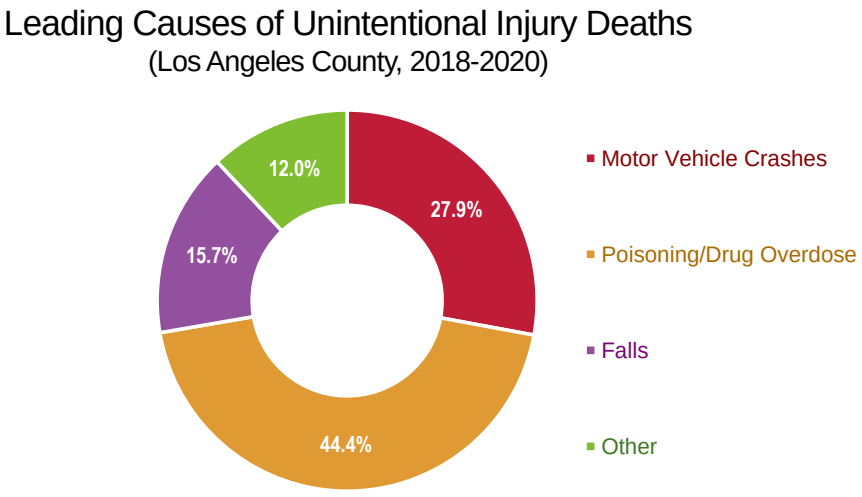


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Leading Causes of Unintentional Injury Deaths

Leading causes of accidental death in the area include the following: [COUNTY-LEVEL DATA]

RELATED ISSUE
For more information about unintentional drug-related deaths, see also *Substance Abuse* in the **Modifiable Health Risks** section of this report.



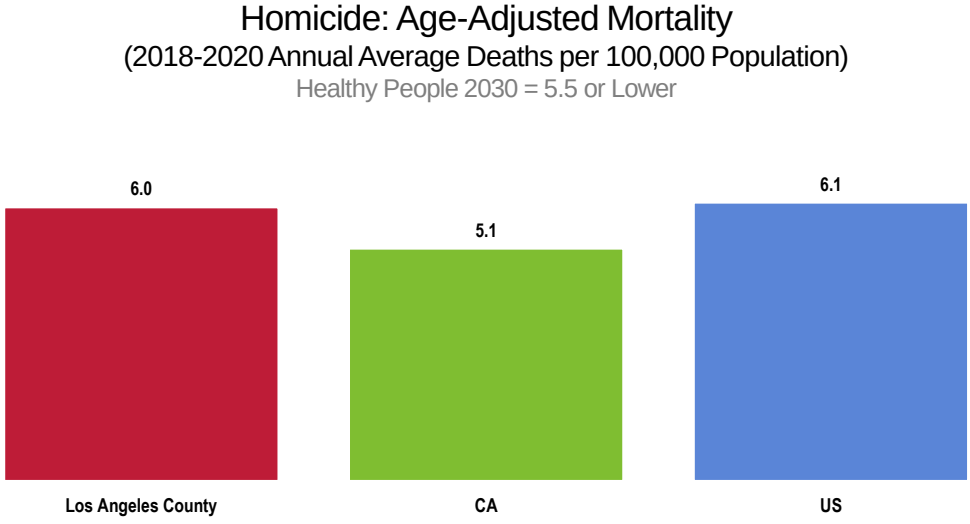
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

Intentional Injury (Violence)

Age-Adjusted Homicide Deaths

Age-adjusted mortality attributed to homicide is shown in the following chart. [COUNTY-LEVEL DATA]

RELATED ISSUE
See also *Mental Health (Suicide)* in the **General Health Status** section of this report.

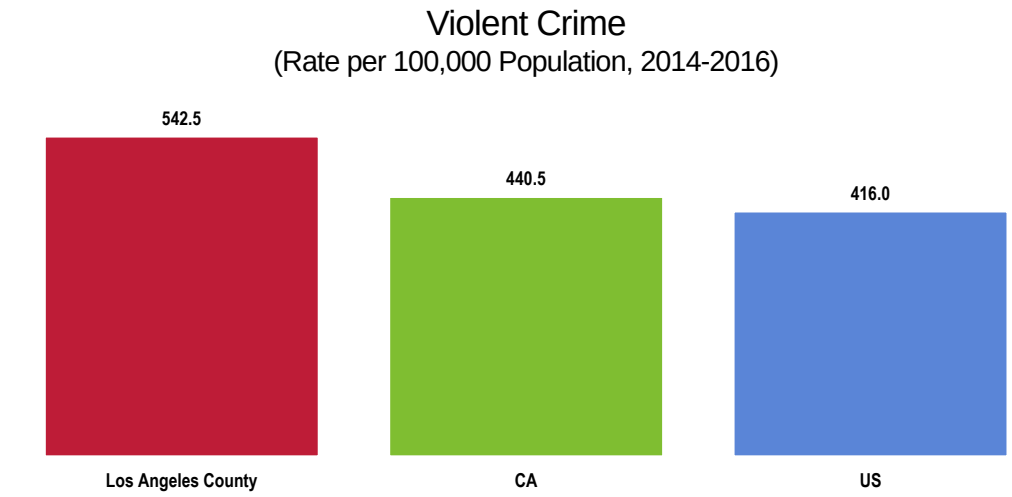


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Violent Crime

Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault.

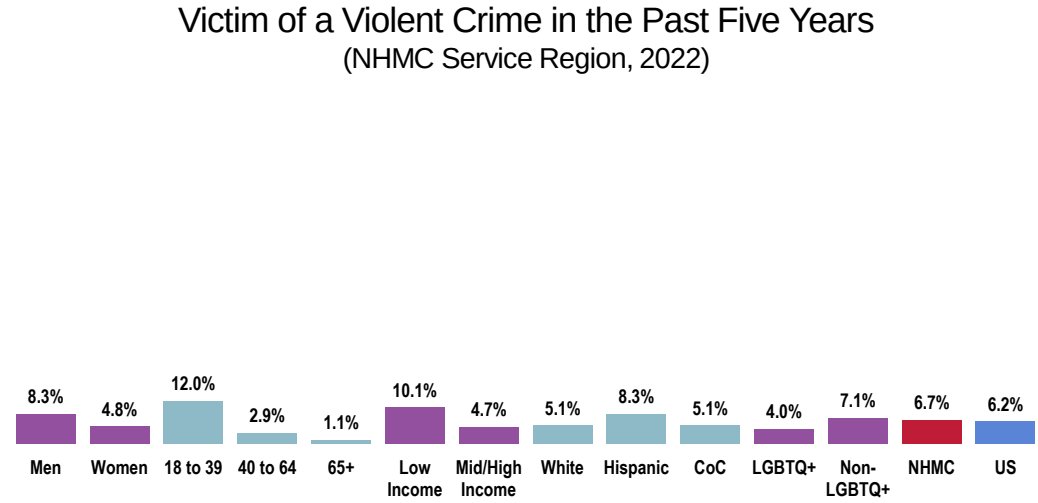
Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions. [COUNTY-LEVEL DATA]



Sources:
- Federal Bureau of Investigation, FBI Uniform Crime Reports.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. This indicator is relevant because it assesses community safety.
- Participation by law enforcement agencies in the UCR program is voluntary. Sub-state data do not necessarily represent an exhaustive list of crimes due to gaps in reporting. Also, some institutions of higher education have their own police departments, which handle offenses occurring within campus grounds; these offenses are not included in the violent crime statistics but can be obtained from the Uniform Crime Reports Universities and Colleges data tables.

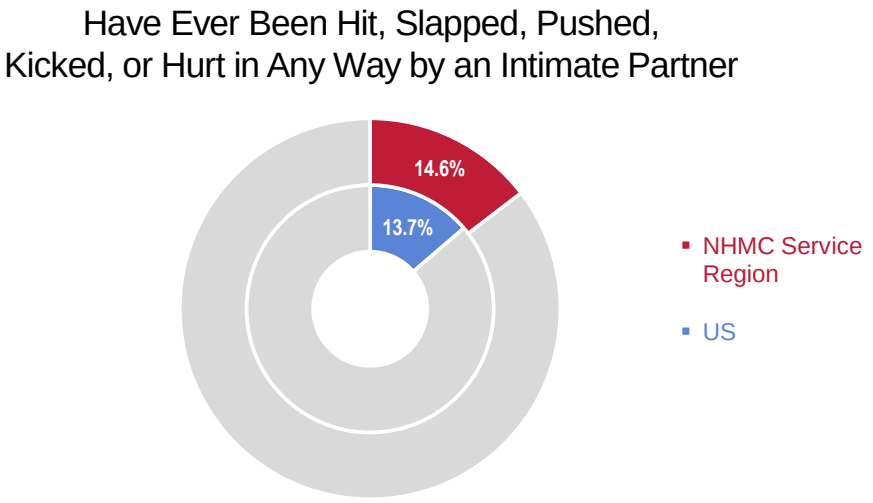
VIOLENT CRIME EXPERIENCE ► **"Have you been the victim of a violent crime in your area in the past 5 years?"**



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 38]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents. Use caution when interpreting results for LGBTQ+, as the sample size falls below n=50.
- CoC represents Communities of Color (non-Hispanic and non-White).

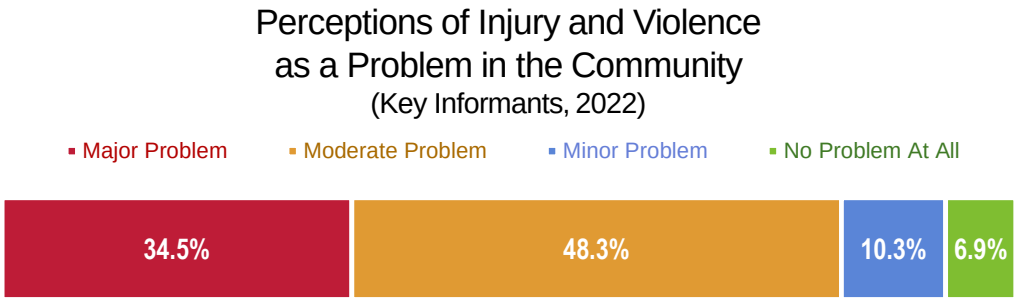
INTIMATE PARTNER VIOLENCE ► **"The next questions are about different types of violence in relationships with an intimate partner. By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with, would also be considered an intimate partner. Has an intimate partner ever hit, slapped, pushed, kicked, or hurt you in any way?"**



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 39]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Key Informant Input: Injury & Violence

The following chart outlines key informants' perceptions of the severity of *Injury & Violence* as a problem in the community:



Sources: ● PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> Information on the news outlets. – Education Representative

Law Enforcement

> More police protection and access to resources to help victims. – Social Services Provider

Vulnerable Populations

> Right now, with the pandemic and the lack of resources to survive day to day and due to the lack of resources to survive, they end up living on the street. In these cases, they have a lot of stress, and they suffer from violence or become violent, and also mental health problems. – Community Leader

Contributing Factors

> The community face jobs that are physically demanding as well as neighborhoods with low walkability. Community members can get injured in their jobs or injured by cars or objects if they walk in the community. When it comes to violence, these communities have a history of gang violence and domestic violence. – Social Services Provider

Due to COVID-19

> Due to the pandemic, we have seen an increase in abuse cases. – Social Services Provider

Diabetes

ABOUT DIABETES

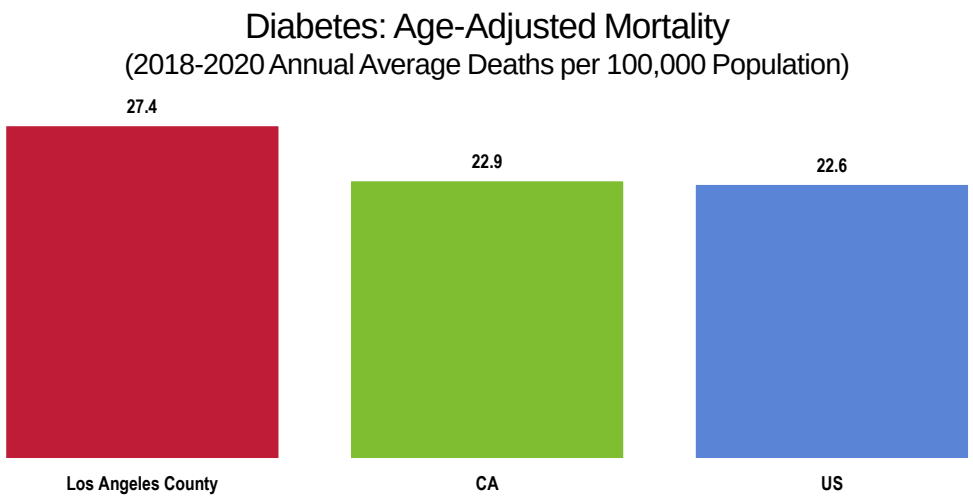
More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. But interventions to help people manage diabetes can help reduce the risk of complications. In addition, strategies to help people who don't have diabetes eat healthier, get physical activity, and lose weight can help prevent new cases.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Diabetes Deaths

Age-adjusted diabetes mortality for the area is shown in the following chart. [COUNTY-LEVEL DATA]



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

Prevalence of Diabetes

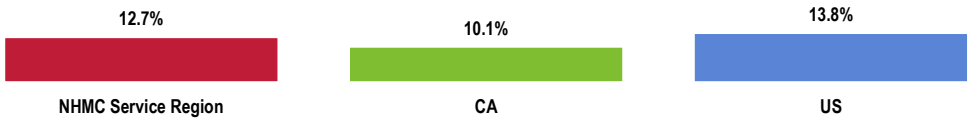
"Have you ever been told by a doctor, nurse, or other health professional that you have diabetes? (If female, add: not counting diabetes only occurring during pregnancy?)**"**

"Have you ever been told by a doctor, nurse, or other health professional that you have pre-diabetes or borderline diabetes? (If female, add: other than during pregnancy?)**"**

[Adults who do not have diabetes] **"Have you had a test for high blood sugar or diabetes within the past three years?"**

Prevalence of Diabetes

Another 13.1% of adults have been diagnosed with "pre-diabetes" or "borderline" diabetes.

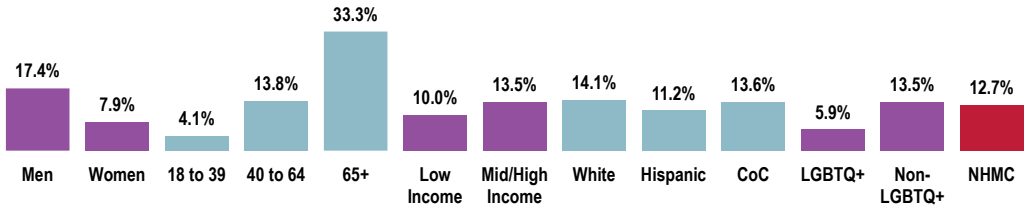


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 121, 302]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Excludes gestational diabetes (occurring only during pregnancy).

Prevalence of Diabetes
(NHMC Service Region, 2022)

Note that among adults who have not been diagnosed with diabetes, 40.1% report having had their blood sugar level tested within the past three years.

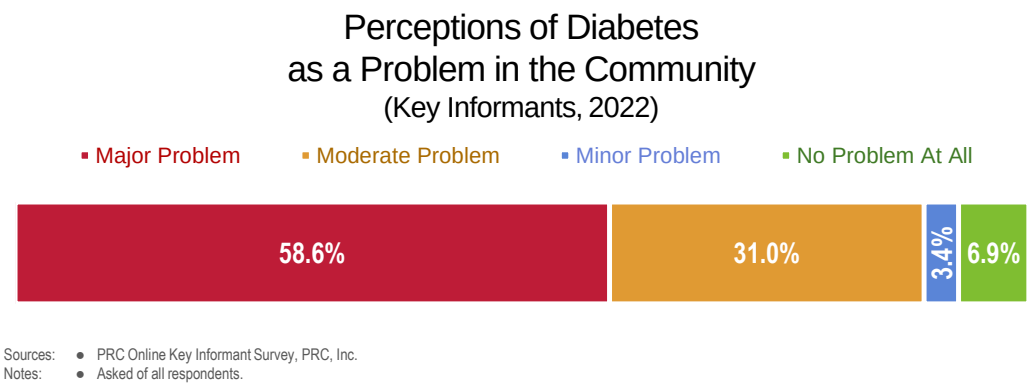


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 33, 121]

Notes:
- Asked of all respondents. Use caution when interpreting results for LGBTQ+, as the sample size falls below n=50.
- Excludes gestational diabetes (occurring only during pregnancy).
- CoC represents Communities of Color (non-Hispanic and non-White).

Key Informant Input: Diabetes

The following chart outlines key informants' perceptions of the severity of *Diabetes* as a problem in the community:



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Contributing Factors

> Education and access to care. – Social Services Provider
>
> Diabetes is the number #1 preventable disease in all of LA County Service Planning Area #2. Most causes of diabetes are due to poor diet, lack of exercise and obesity. Unfortunately, many diabetics who are also obese or over-weight are not inclined to take the necessary action to lose weight and this, positively impact their lives. We need more diabetes prevention programs such as healthy cooking, lifestyle, exercise programs, etc. to help cope with diabetes. BTW…I am pre-diabetic and because I have access to care and health insurance, my doctor sent me to a nutritionist for 2.5-hour private consultation about food, weight and maintaining a healthy lifestyle. I was one of the lucky ones but people who are poor, under-educated or just plain stubborn, will not be as fortunate as I am. – Other Health Provider
>
> Food insecurity, poor economic conditions, eating habits, nutrition literacy, lack of regular exercise, lack of access/affordability of medication, and lack of health literacy related to managing their condition. – Social Services Provider
>
> Keeping medicine refrigerated, having clean equipment for testing, access to primary health care. – Other Health Provider

Awareness/Education

> Educating patients with their medication and meals. – Other Health Provider
>
> Lack of education and information early on in life about preventing diabetes as an adult. Lack of interest in managing diabetes for those who currently have it. – Social Services Provider
>
> The largest challenge the community members we serve face is lack of information about how to prevent or self-manage diabetes in their own lives. The day-to-day challenges of living with a chronic disease such as diabetes are very hard to deal with if knowledge of the disease is not distributed in appropriate ways and/or the support is not available to them to integrate changes needed into the lives of themselves or their families. – Social Services Provider
>
> People need information about treatment and how to assist people with this disease. – Social Services Provider

Access to Care/Services

> Lack of community resources to aid in its management and prevention. – Public Health Representative
>
> For those with type 2 diabetes, hard to find knowledgeable and available services, doctors, educators, and dietitians. – Other Health Provider

Access to Affordable Healthy Food

> Access to healthy foods. Food insecurity and proper nutrition is a major issue. The surrounding community has fast food options and limited grocery stores. – Social Services Provider

Affordable Medications/Supplies

> For people with diabetes, the most difficult thing is to buy the medicine because there are people who do not have medical coverage, because they do not have legal documents. Also, to buy the strips they use to do the glucose test. – Community Leader

Disease Management

> Management of the condition. – Social Services Provider

Kidney Disease

ABOUT KIDNEY DISEASE

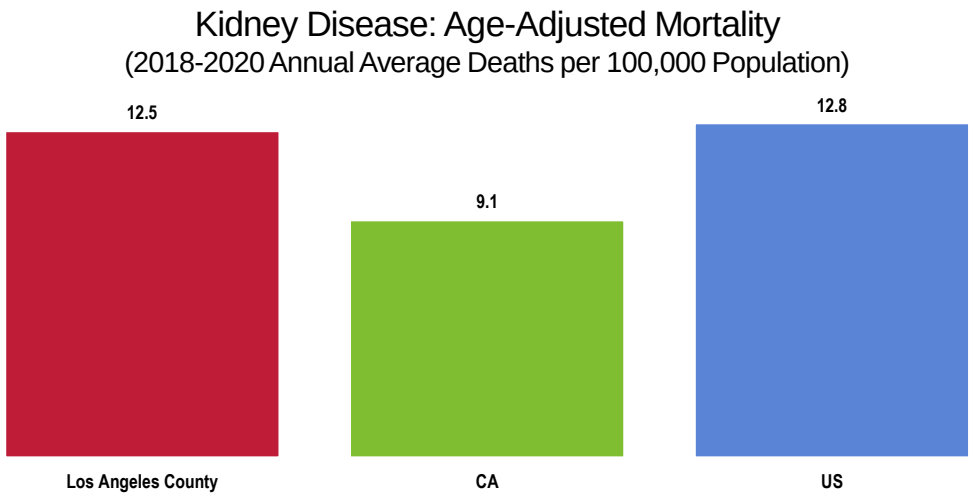
More than 1 in 7 adults in the United States may have chronic kidney disease (CKD), with higher rates in low-income and racial/ethnic minority groups. And most people with CKD don't know they have it. …People with CKD are more likely to have heart disease and stroke — and to die early. Managing risk factors like diabetes and high blood pressure can help prevent or delay CKD. Strategies to make sure more people with CKD are diagnosed early can help people get the treatment they need.

Recommended tests can help identify people with CKD to make sure they get treatments and education that may help prevent or delay kidney failure and end-stage kidney disease (ESKD). In addition, strategies to make sure more people with ESKD get kidney transplants can increase survival rates and improve quality of life.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Kidney Disease Deaths

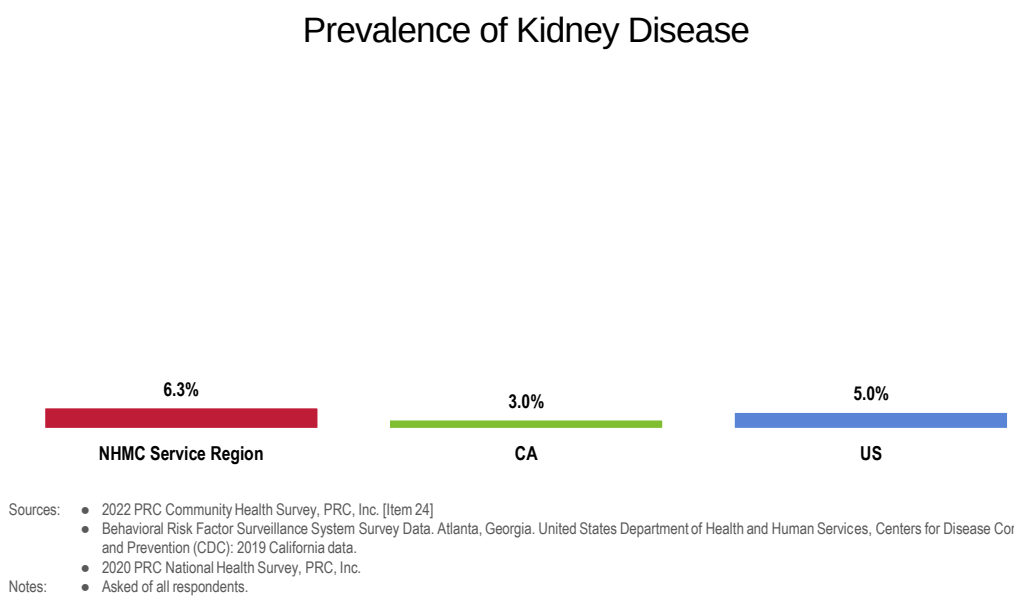
Age-adjusted kidney disease mortality is described in the following chart. [COUNTY-LEVEL DATA]



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

Prevalence of Kidney Disease

"Would you please tell me if you have ever suffered from or been diagnosed with kidney disease?"

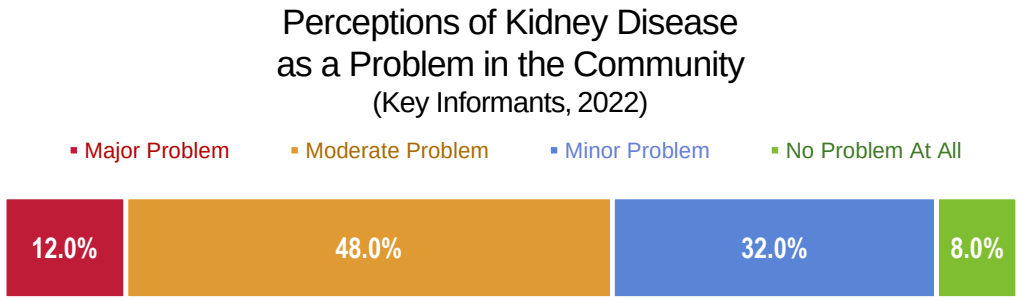


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 24]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Key Informant Input: Kidney Disease

The following chart outlines key informants' perceptions of the severity of *Kidney Disease* as a problem in the community:



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Awareness/Education

> People need information about treatment and how to assist people with this disease. – Social Services Provider

Incidence/Prevalence

> It's one of the problems you hear about in the San Fernando Valley communities. – Community Leader

Potentially Disabling Conditions

Multiple Chronic Conditions

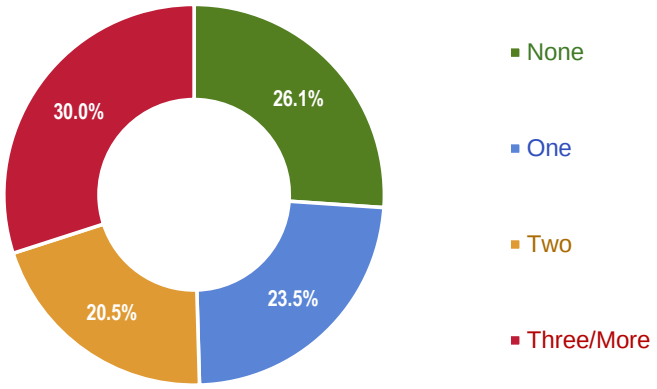
The following charts outline the prevalence of multiple chronic conditions among surveyed adults, taking into account all of the various conditions measured in the survey.

For the purposes of this assessment, chronic conditions include:

- Asthma
- Cancer
- Chronic pain
- Diabetes
- Diagnosed depression
- Heart attack/angina
- High blood cholesterol
- High blood pressure
- Kidney disease
- Lung disease
- Obesity
- Stroke

Multiple chronic conditions are concurrent conditions.

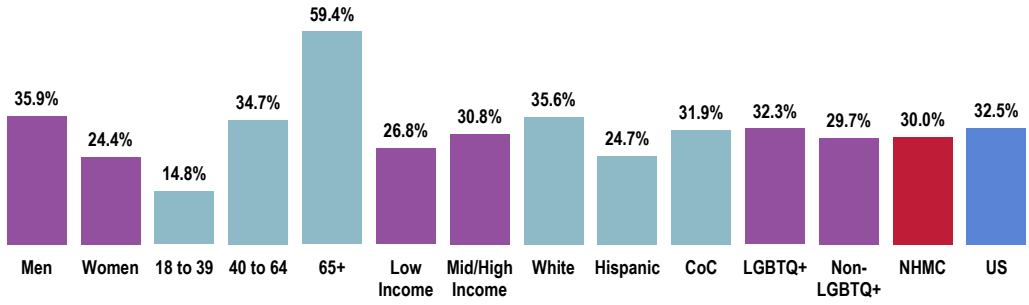
Number of Current Chronic Conditions
(NHMC Service Region, 2022)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 123]

Notes:
- Asked of all respondents.
- In this case, chronic conditions include lung disease, cancer, kidney disease, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, high-impact chronic pain, obesity, and/or diagnosed depression.

Currently Have Three or More Chronic Conditions
(NHMC Service Region, 2022)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 123]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents. Use caution when interpreting results for LGBTQ+, as the sample size falls below n=50.
- In this case, chronic conditions include lung disease, cancer, kidney disease, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, high-impact chronic pain, obesity, and/or diagnosed depression.
- CoC represents Communities of Color (non-Hispanic and non-White).

Activity Limitations

ABOUT DISABILITY & HEALTH

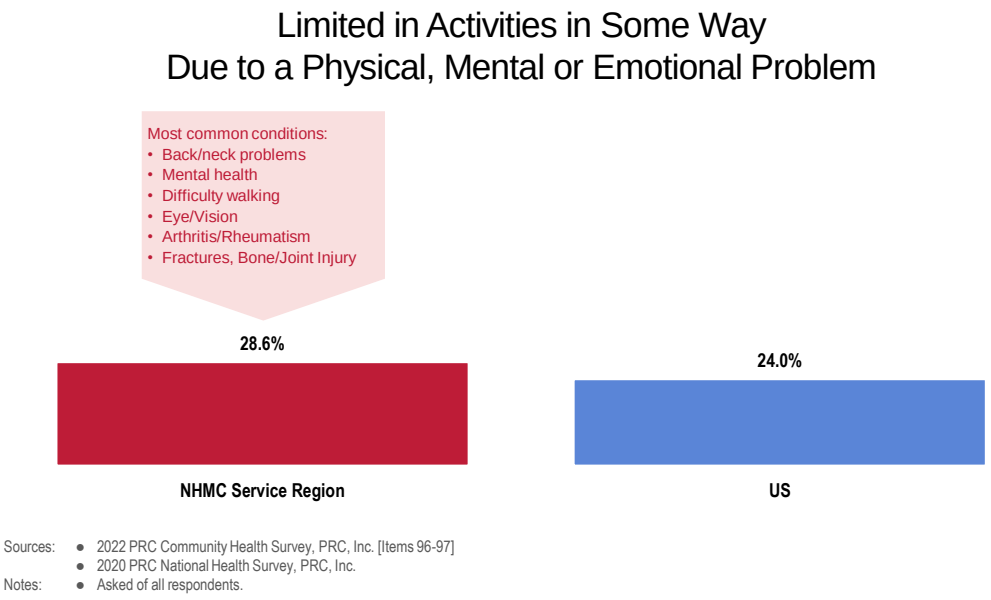
Studies have found that people with disabilities are less likely to get preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving their health.

In addition, people with disabilities may have trouble finding a job, going to school, or getting around outside their homes. And they may experience daily stress related to these challenges. Efforts to make homes, schools, workplaces, and public places easier to access can help improve quality of life and overall well-being for people with disabilities.

– Healthy People 2030 (https://health.gov/healthypeople)

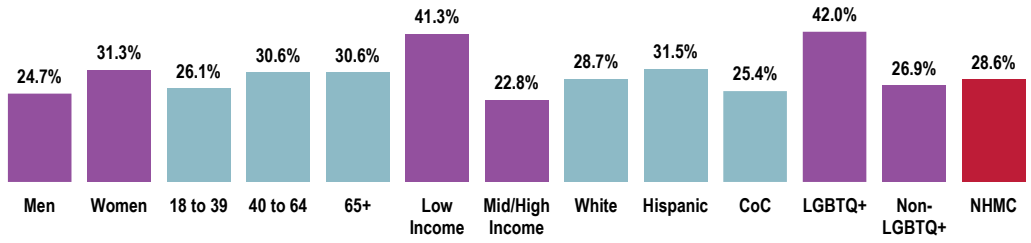
"Are you limited in any way in any activities because of physical, mental, or emotional problems?"

[Adults with activity limitations] **"What is the major impairment or health problem that limits you?"**



Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem

(NHMC Service Region, 2022)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 96]

Notes:
- Asked of all respondents. Use caution when interpreting results for LGBTQ+, as the sample size falls below n=50.
- CoC represents Communities of Color (non-Hispanic and non-White).

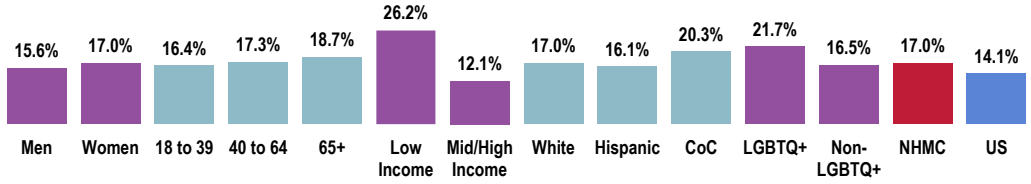
High-Impact Chronic Pain

"Over the past six months, how often did physical pain limit your life or work activities? Would you say: never, some days, most days, or every day?" (Reported here among those responding "most days" or "every day.")

Experience High-Impact Chronic Pain

(NHMC Service Region, 2022)

Healthy People 2030 = 7.0% or Lower

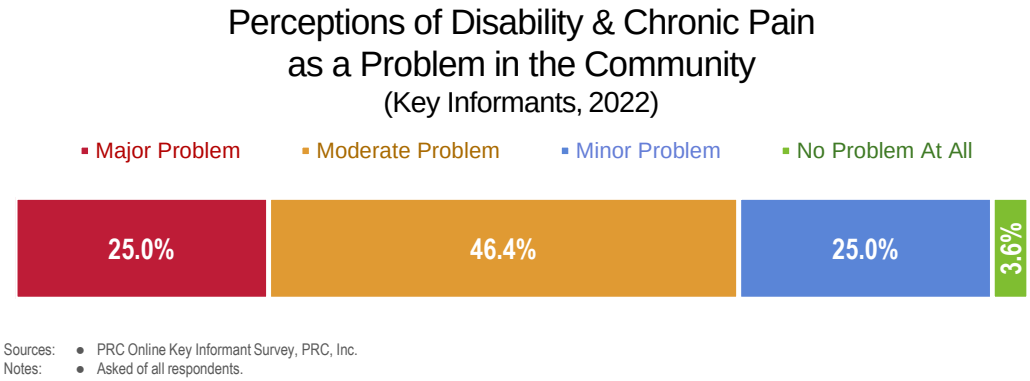


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 37]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov [Objective MICH-8.1]

Notes:
- Asked of all respondents. Use caution when interpreting results for LGBTQ+, as the sample size falls below n=50.
- High-impact chronic pain includes physical pain that limits life or work activities on "most days" or "every day" of the past six months.
- CoC represents Communities of Color (non-Hispanic and non-White).

Key Informant Input: Disability & Chronic Pain

The following chart outlines key informants' perceptions of the severity of *Disability & Chronic Pain* as a problem in the community:



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Diagnosis/Treatment

> Disability is often overlooked, and chronic pain is often not well-managed, amid the opioid use crisis. – Public Health Representative
>
> I believe that these are major problems because they go untreated instead of medicating properly. – Other Health Provider

Contributing Factors

> Limited support and care options available. Chronic pain is often not regarded as an actual medical condition. – Social Services Provider
>
> Due to the lack of information and access for some ethnicities. – Community Leader

Awareness/Education

> People need information about treatment and how to assist people with this disease. – Social Services Provider

Caregiving

> Lack of support for caregivers caring for loved ones with chronic medical and/or mental health conditions. This is especially true for those caring for older adults. – Other Health Provider

Alzheimer's Disease

ABOUT DEMENTIA

Alzheimer's disease is the most common cause of dementia and the sixth leading cause of death in U.S. adults.1 Nearly 6 million people in the United States have Alzheimer's, and that number will increase as the population ages.

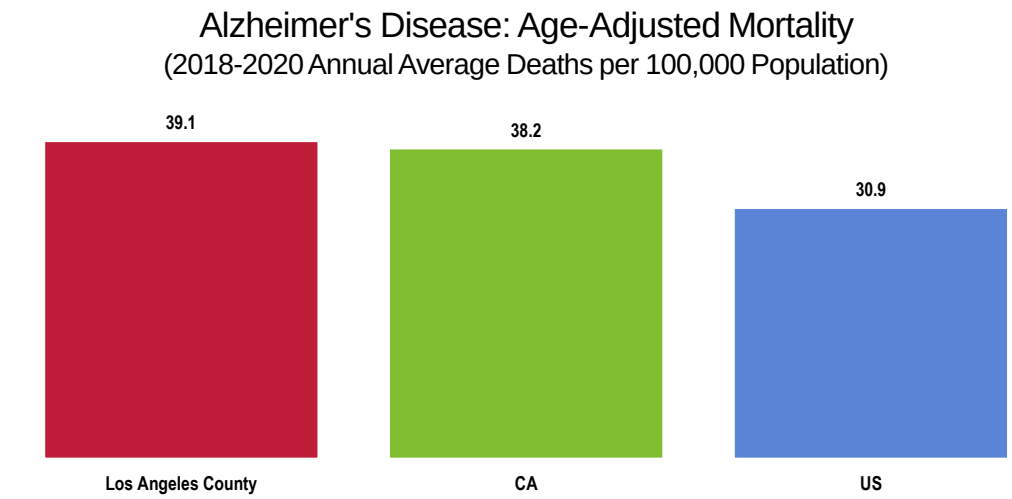
Dementia refers to a group of symptoms that cause problems with memory, thinking, and behavior. People with dementia are more likely to be hospitalized, and dementia is linked to high health care costs.

While there's no cure for Alzheimer's disease, early diagnosis and supportive care can improve quality of life. And efforts to make sure adults with symptoms of cognitive decline — including memory loss — are diagnosed early can help improve health outcomes in people with dementia. Interventions to address caregiving needs can also help improve health and well-being in people with dementia.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Alzheimer's Disease Deaths

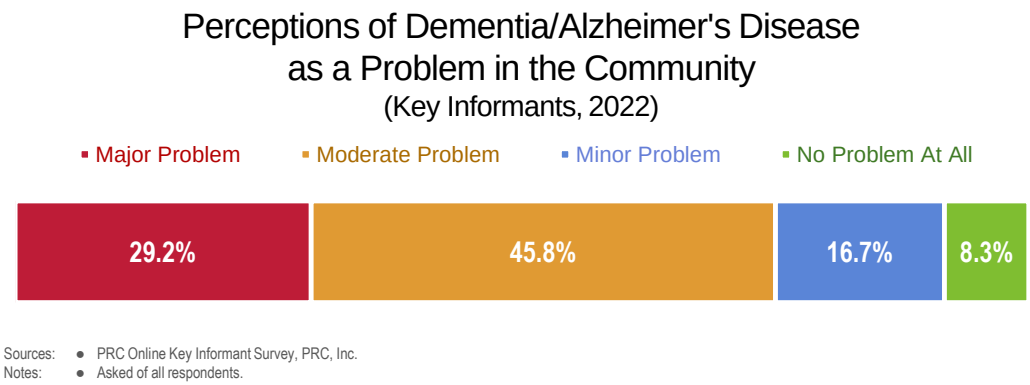
Age-adjusted Alzheimer's disease mortality is outlined in the following chart. [COUNTY-LEVEL DATA]



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

Key Informant Input: Dementia/Alzheimer's Disease

The following chart outlines key informants' perceptions of the severity of *Dementia, Including Alzheimer's Disease* as a problem in the community:



Sources: PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Awareness/Education

> People need information about treatment and how to assist people with this disease. – Social Services Provider
>
> Not enough support for caregivers of loved ones with cognitive decline. – Other Health Provider

Contributing Factors

> The aging community continues to increase with the amount of people with Alzheimer's and Dementia also increasing at early ages. Resources to prepare for caring for someone with a memory impairment is available but oftentimes not thought about until it is too late. Caregiver burden, lack of resources to provide care, and delayed preparation are all concerns that need to be address and have more focus and attention on. – Social Services Provider
>
> The population I work with don't have families to help them when they develop dementia and there are no or few resources for helping them that doesn't include family. There are too few resources for people who are poor or low income to help them once their memories fail. We are seeing an increase of older adults with dementia potentially becoming homeless. the process to get them conserved is too difficult. – Social Services Provider

Aging Population

> Population is aging. Cognitive decline and Alzheimer's disease and related dementias are on the climb with significant and costly social, as well as financial, consequences. – Public Health Representative

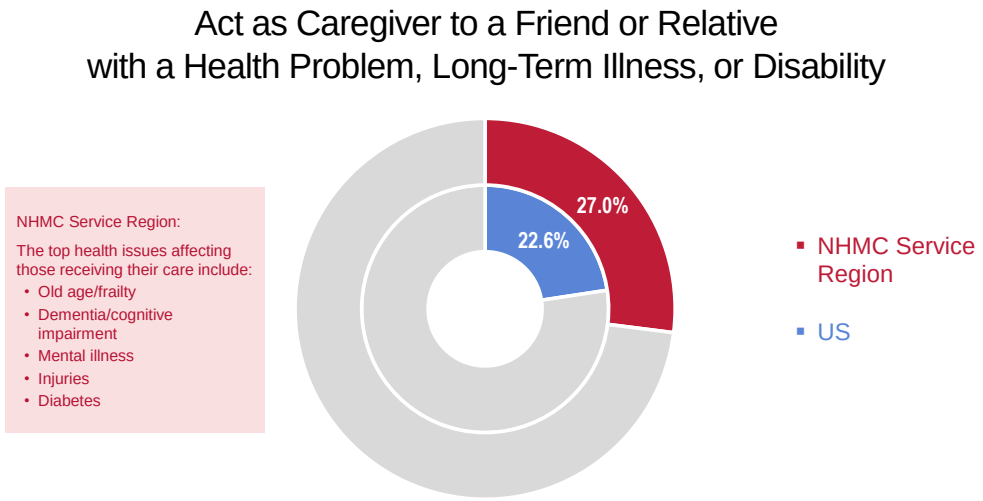
Vulnerable Populations

> Many clients that we service through ICMS and Housing for health end up in our memory care units. Due to lifestyles and mental health issues that go untreated, it can cause further complications down the line. – Other Health Provider

Caregiving

“People may provide regular care or assistance to a friend or family member who has a health problem, long-term illness, or disability. During the past 30 days, did you provide any such care or assistance to a friend or family member?”

[Among those providing care] **“What is the main health problem, long-term illness, or disability that the person you care for has?”**



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Items 98-99]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

BIRTHS

ABOUT INFANT HEALTH

Keeping infants healthy starts with making sure women get high-quality care during pregnancy and improving women's health in general. After birth, strategies that focus on increasing breastfeeding rates and promoting vaccinations and developmental screenings are key to improving infants' health. Interventions that encourage safe sleep practices and correct use of car seats can also help keep infants safe.

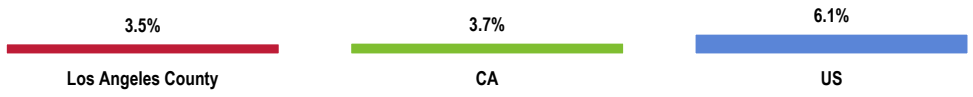
The infant mortality rate in the United States is higher than in other high-income countries, and there are major disparities by race/ethnicity. Addressing social determinants of health is critical for reducing these disparities.

– Healthy People 2030 (https://health.gov/healthypeople)

Prenatal Care

Early and continuous prenatal care is the best assurance of infant health. Late or no prenatal care (not initiated until the seventh month of pregnancy or at all) is outlined in the following chart. [COUNTY-LEVEL DATA]

Late or No Prenatal Care (7th Month or Later)
(Percentage of Live Births, 2017-2019)



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Note:
- This indicator reports the percentage of women who do not obtain prenatal care until the seventh month of pregnancy or at all. This indicator is relevant because engaging in prenatal care decreases the likelihood of maternal and infant health risks. This indicator can also highlight a lack of access to preventive care, a lack of health, knowledge insufficient provider outreach, and/or social barriers preventing utilization of services.

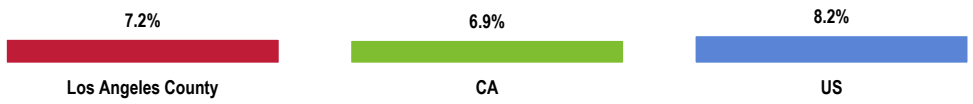
Birth Outcomes & Risks

Low-Weight Births

Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight.

Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable. [COUNTY-LEVEL DATA]

Low-Weight Births
(Percent of Live Births, 2013-2019)



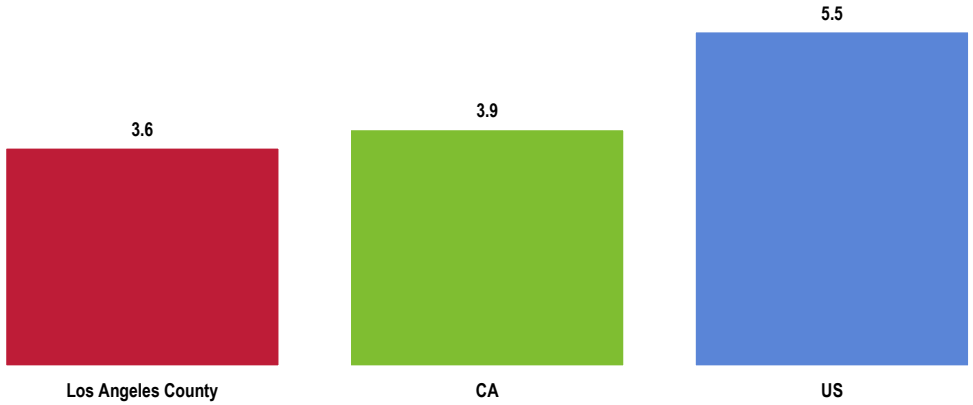
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted April 2022.

Note:
- This indicator reports the percentage of total births that are low birth weight (Under 2500g). This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.

Infant Mortality

Infant mortality rates reflect deaths of children less than one year old per 1,000 live births. These rates are outlined in the following chart. [COUNTY-LEVEL DATA]

Infant Mortality Rate
(Annual Average Infant Deaths per 1,000 Live Births, 2018-2020)
Healthy People 2030 = 5.0 or Lower



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted April 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Infant deaths include deaths of children under 1 year old.
- This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.

Family Planning

ABOUT FAMILY PLANNING

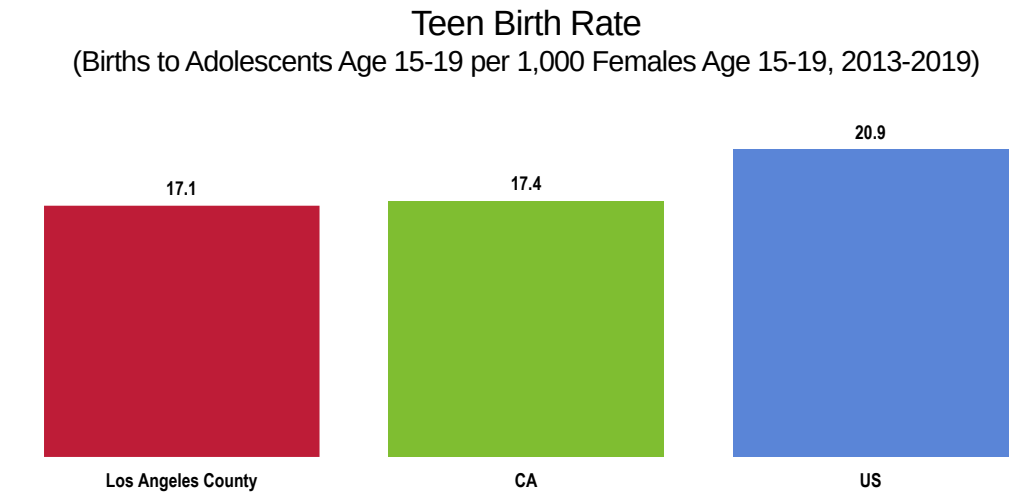
Nearly half of pregnancies in the United States are unintended, and unintended pregnancy is linked to many negative outcomes for both women and infants. …Unintended pregnancy is linked to outcomes like preterm birth and postpartum depression. Interventions to increase use of birth control are critical for preventing unintended pregnancies. Birth control and family planning services can also help increase the length of time between pregnancies, which can improve health for women and their infants.

Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy and sexually transmitted infections in this age group.

– Healthy People 2030 (https://health.gov/healthypeople)

Births to Adolescent Mothers

The following chart describes births to adolescent mothers under the age of 20 years. [COUNTY-LEVEL DATA]

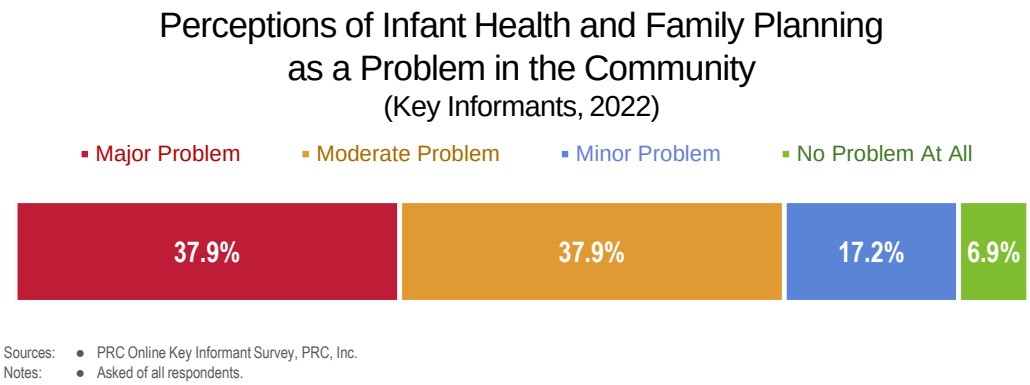


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of total births to women under the age of 15–19 per 1,000 female population age 15–19. This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate the prevalence of unsafe sex practices.

Key Informant Input: Infant Health & Family Planning

The following chart outlines key informants' perceptions of the severity of *Infant Health and Family Planning* as a problem in the community:



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Follow-Up/Support

> Parents need significant support during these difficult times. Accessibility and awareness of resources in the community may be a problem. – Social Services Provider
>
> Although the NICUs are not always busy, when infants are patients, they are in bad shape. Many parents need more pre-natal and after birth support. The Welcome Baby program from First 5LA seemed to be on the right path but not sure it's still active in Valley community hospitals. – Other Health Provider

Maternal Health

> Maternal morbidity and mortality. – Education Representative

Access to Affordable Healthy Food

> Lack of access to healthy foods for infants. – Other Health Provider

Vulnerable Populations

> The low-income community's accessibility to resources and health information. – Social Services Provider

Awareness/Education

> People need information about treatment and how to assist people with this disease. – Social Services Provider

Language Barriers

> For some people it is difficult to ask for help due to the language barrier and immigration status. – Community Leader

Contributing Factors

> With high food insecurity comes lower maternal and pre-natal health, families often can't afford basics like diapers, formula, and baby food. Some families are very large with 4+ kids and insufficient economic resources, so families are often living in cramped spaces to get by. This affects children's development. Access to family planning services will help them make clear eyed choices about growing their families. We also have to consider religious beliefs that could contribute to not using birth control. – Social Services Provider

MODIFIABLE HEALTH RISKS

Nutrition

ABOUT NUTRITION & HEALTHY EATING

Many people in the United States don't eat a healthy diet. …People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes, and other health problems. Strategies and interventions to help people choose healthy foods can help reduce their risk of chronic diseases and improve their overall health.

Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

– Healthy People 2030 (https://health.gov/healthypeople)

Daily Recommendation of Fruits/Vegetables

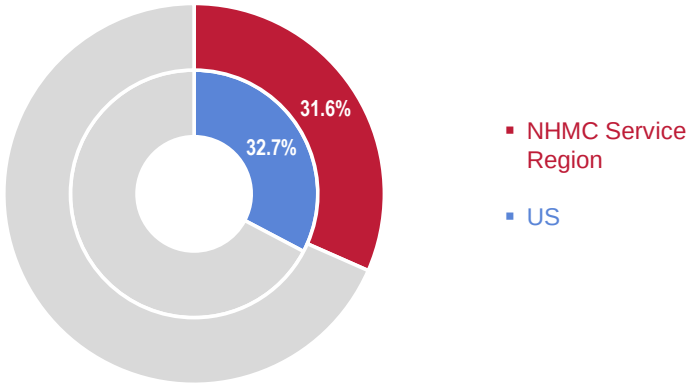
To measure fruit and vegetable consumption, survey respondents were asked multiple questions, specifically about the foods and drinks they consumed on the day prior to the interview.

"For the following questions, please think about the foods you ate or drank yesterday. Include all the foods you ate, both at home and away from home. How many servings of fruit or fruit juices did you have yesterday?"

"How many servings of vegetables did you have yesterday?"

The questions above are used to calculate daily fruit/vegetable consumption for respondents. The proportion reporting having 5 or more servings per day is shown here.

Consume Five or More Servings of Fruits/Vegetables Per Day



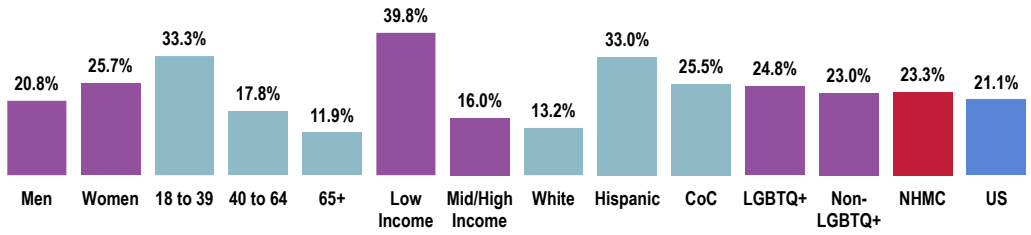
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 125]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- For this issue, respondents were asked to recall their food intake on the previous day.

Access to Fresh Produce

"How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford? Would you say: very difficult, somewhat difficult, not too difficult, or not at all difficult?"

Find It "Very" or "Somewhat" Difficult to Buy Affordable Fresh Produce
(NHMC Service Region, 2022)

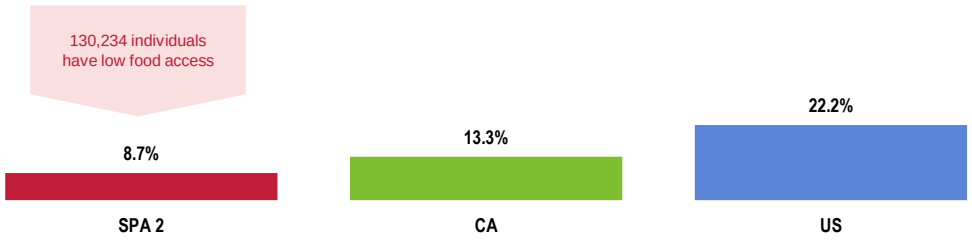


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 79]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents. Use caution when interpreting results for LGBTQ+, as the sample size falls below n=50.
- CoC represents Communities of Color (non-Hispanic and non-White).

Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store. This related chart is based on US Department of Agriculture data.

Population With Low Food Access
(Percent of Population That Is Far From a Supermarket or Large Grocery Store, 2019)



Sources:
- US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the percentage of the population with low food access. Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store. This indicator is relevant because it highlights populations and geographies facing food insecurity.

Physical Activity

ABOUT PHYSICAL ACTIVITY

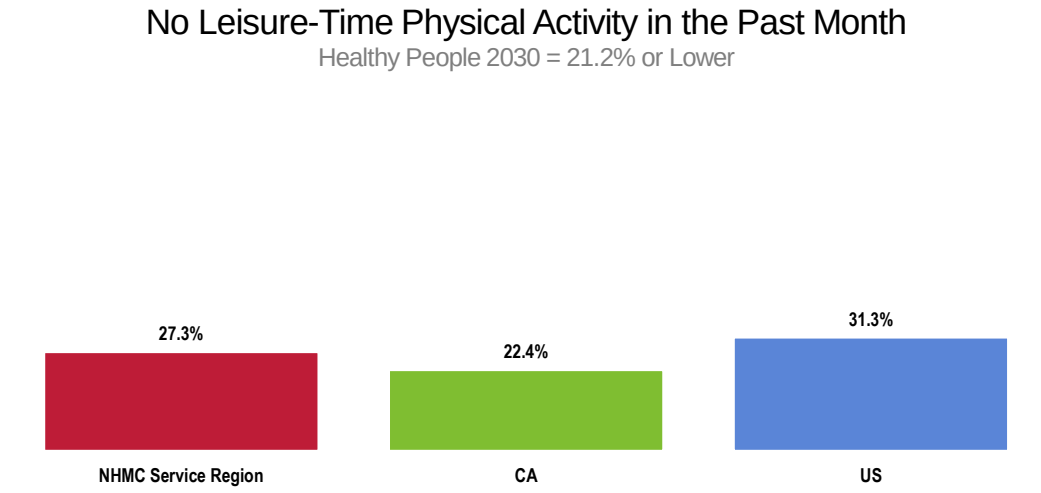
Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity, it can be especially hard for older adults and people with chronic diseases or disabilities.

Strategies that make it safer and easier to get active — like providing access to community facilities and programs — can help people get more physical activity. Strategies to promote physical activity at home, at school, and at childcare centers can also increase activity in children and adolescents.

– Healthy People 2030 (https://health.gov/healthypeople)

Leisure-Time Physical Activity

"During the past month, other than your regular job, did you participate in any physical activities or exercises, such as running, calisthenics, golf, gardening, or walking for exercise?"



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 82]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Meeting Physical Activity Recommendations

To measure physical activity frequency, duration and intensity, respondents were asked:

ADULTS: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

Adults should do 2 hours and 30 minutes a week of moderate-intensity (such as walking), or 1 hour and 15 minutes (75 minutes) a week of vigorous-intensity **aerobic** physical activity (such as jogging), or an equivalent combination of moderate- and vigorous-intensity aerobic physical activity. The guidelines also recommend that adults do **muscle-strengthening** activities, such as push-ups, sit-ups, or activities using resistance bands or weights. These activities should involve all major muscle groups and be done on two or more days per week.

The report finds that nationwide nearly 50 percent of adults are getting the recommended amounts of aerobic activity and about 30 percent are engaging in the recommended muscle-strengthening activity.

– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

"During the past month, what type of physical activity or exercise did you spend the most time doing?"

"And during the past month, how many times per week or per month did you take part in this activity?"

"And when you took part in this activity, for how many minutes or hours did you usually keep at it?"

Respondents could answer the above series for up to two types of physical activity. The specific activities identified (e.g., jogging, basketball, treadmill, etc.) determined the intensity values assigned to that respondent when calculating total aerobic physical activity hours/minutes.

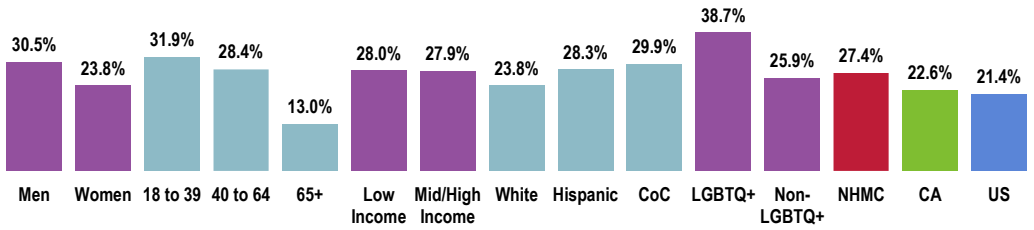
Respondents were also asked about strengthening exercises:

"During the past month, how many times per week or per month did you do physical activities or exercises to strengthen your muscles? Do not count aerobic activities like walking, running, or bicycling. Please include activities using your own body weight, such as yoga, sit-ups, or push-ups, and those using weight machines, free weights, or elastic bands."

"Meeting physical activity recommendations" includes adequate levels of both aerobic and strengthening activity:

- Aerobic activity is at least 150 minutes per week of light to moderate activity, 75 minutes per week of vigorous physical activity, or an equivalent combination of both;
- Strengthening activity is at least 2 sessions per week of exercise designed to strengthen muscles.

Meets Physical Activity Recommendations
(NHMC Service Region, 2022)
Healthy People 2030 = 28.4% or Higher



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 126]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Asked of all respondents. Use caution when interpreting results for LGBTQ+, as the sample size falls below n=50.
- Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week or an equivalent combination of moderate and vigorous-intensity activity *and* report doing physical activities specifically designed to strengthen muscles at least twice per week.
- CoC represents Communities of Color (non-Hispanic and non-White).

Children's Physical Activity

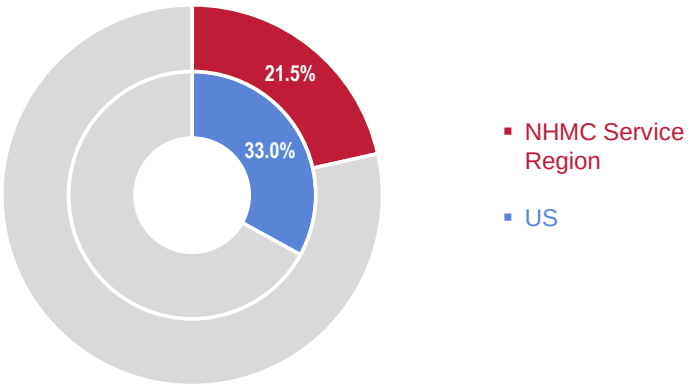
CHILDREN: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

Children and adolescents should do 60 minutes (1 hour) or more of physical activity each day.

– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

"During the past 7 days, on how many days was this child physically active for a total of at least 60 minutes per day?"

Child Is Physically Active for One or More Hours per Day
(Parents of Children Age 2-17)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 109]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 2-17 at home.
- Includes children reported to have one or more hours of physical activity on the past seven days.

Weight Status

ABOUT OVERWEIGHT & OBESITY

Obesity is linked to many serious health problems, including type 2 diabetes, heart disease, stroke, and some types of cancer. Some racial/ethnic groups are more likely to have obesity, which increases their risk of chronic diseases.

Culturally appropriate programs and policies that help people eat nutritious foods within their calorie needs can reduce overweight and obesity. Public health interventions that make it easier for people to be more physically active can also help them maintain a healthy weight.

– Healthy People 2030 (https://health.gov/healthypeople)

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m^2). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared ($inches^2$)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m^2 and obesity as a BMI ≥30 kg/m^2. The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m^2. The increase in mortality, however, tends to be modest until a BMI of 30 kg/m^2 is reached. For persons with a BMI ≥30 kg/m^2, mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m^2.

– Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Adult Weight Status

CLASSIFICATION OF OVERWEIGHT AND OBESITY BY BMI	BMI (kg/m^2)
Underweight	<18.5
Normal	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥30.0

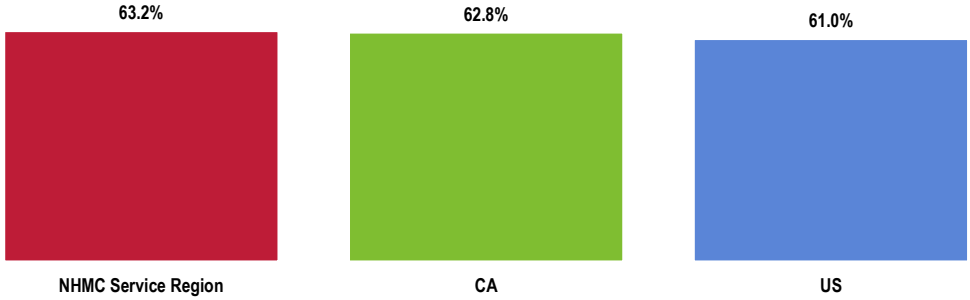
Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

“About how much do you weigh without shoes?”

“About how tall are you without shoes?”

Reported height and weight were used to calculate a Body Mass Index or BMI value (described above) for each respondent. This calculation allows us to examine the proportion of the population who is at a healthy weight, or who is overweight or obese (see table above).

Prevalence of Total Overweight (Overweight and Obese)

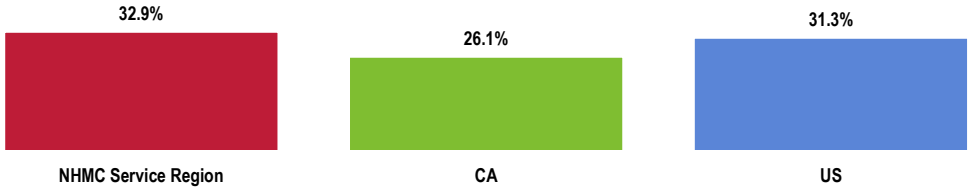


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 128]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.

Prevalence of Obesity

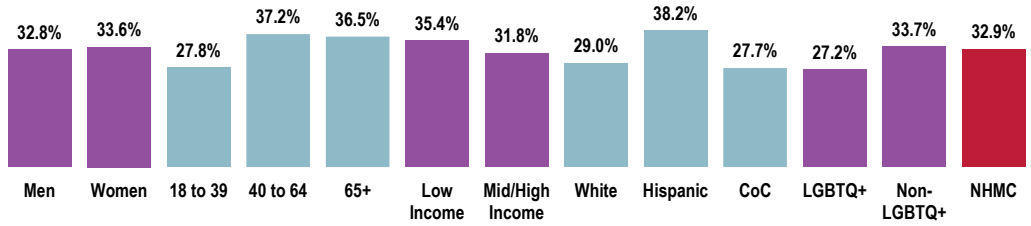
Healthy People 2030 = 36.0% or Lower



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 128]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Prevalence of Obesity
(NHMC Service Region, 2022)
Healthy People 2030 = 36.0% or Lower



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 128]
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Based on reported heights and weights, asked of all respondents. Use caution when interpreting results for LGBTQ+, as the sample size falls below n=50.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.
- CoC represents Communities of Color (non-Hispanic and non-White).

Children's Weight Status

ABOUT WEIGHT STATUS IN CHILDREN & TEENS

In children and teens, body mass index (BMI) is used to assess weight status – underweight, healthy weight, overweight, or obese. After BMI is calculated for children and teens, the BMI number is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States. The percentile indicates the relative position of the child's BMI number among children of the same sex and age.

BMI-for-age weight status categories and the corresponding percentiles are shown below:

- Underweight <5th percentile
- Healthy Weight ≥5th and <85th percentile
- Overweight ≥85th and <95th percentile
- Obese ≥95th percentile

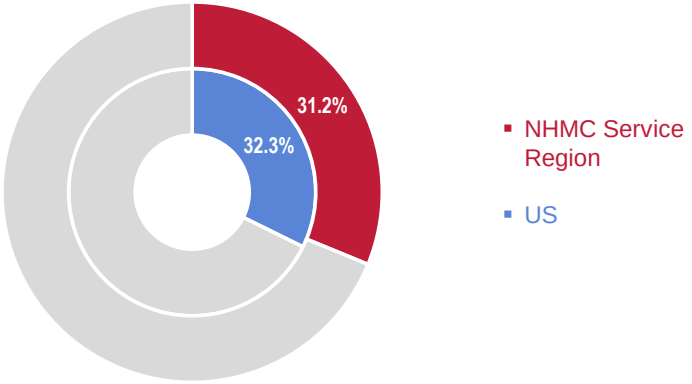
– Centers for Disease Control and Prevention

The following questions were used to calculate a BMI value (and weight classification as noted above) for each child represented in the survey:

"How much does this child weigh without shoes?"

"About how tall is this child?"

Prevalence of Overweight in Children
(Parents of Children Age 5-17)



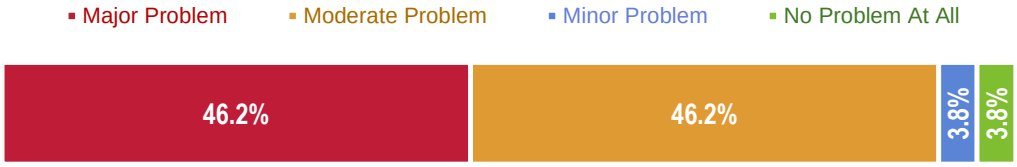
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 131]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 5-17 at home.
- Overweight among children is determined by children's Body Mass Index status at or above the 85th percentile of US growth charts by gender and age.

Key Informant Input: Nutrition, Physical Activity & Weight

The following chart outlines key informants' perceptions of the severity of *Nutrition, Physical Activity & Weight* as a problem in the community:

Perceptions of Nutrition, Physical Activity, and Weight as a Problem in the Community
(Key Informants, 2022)



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Contributing Factors

> The community we serve has less access to parks and knowledge about the role of nutrition, physical activity, and weight control on overall wellness than more affluent communities. – Social Services Provider
>
> Poor nutritional practices among youth, lack of healthy fast-food options, poor quality fruit and vegetables at local markets, and lack of physical activity all lead to obesity. – Social Services Provider
>
> Physical activity, nutrition, and weight align with health disparities of access to healthy food, access to green space, and health literacy on these topics. – Social Services Provider

Awareness/Education

> Nutritional education. – Social Services Provider
>
> Information about benefits and planning to engage people. – Social Services Provider

Due to COVID-19

> Post-COVID there was a rise in overweight cases, specifically among the youth. – Social Services Provider
>
> Increase in healthy eating and lack of exercise due to the pandemic, lack of social events. – Social Services Provider

Built Environment

> The lack of space to exercise and access to fast food. – Community Leader

Nutrition

> Food insecurity, nutrition literacy, commitment to activity. – Social Services Provider

Access to Affordable Healthy Food

> Access to affordable or no-cost healthy food options, especially in low-income communities. – Social Services Provider

Substance Abuse

ABOUT DRUG & ALCOHOL USE

More than 20 million adults and adolescents in the United States have had a substance use disorder in the past year. …Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

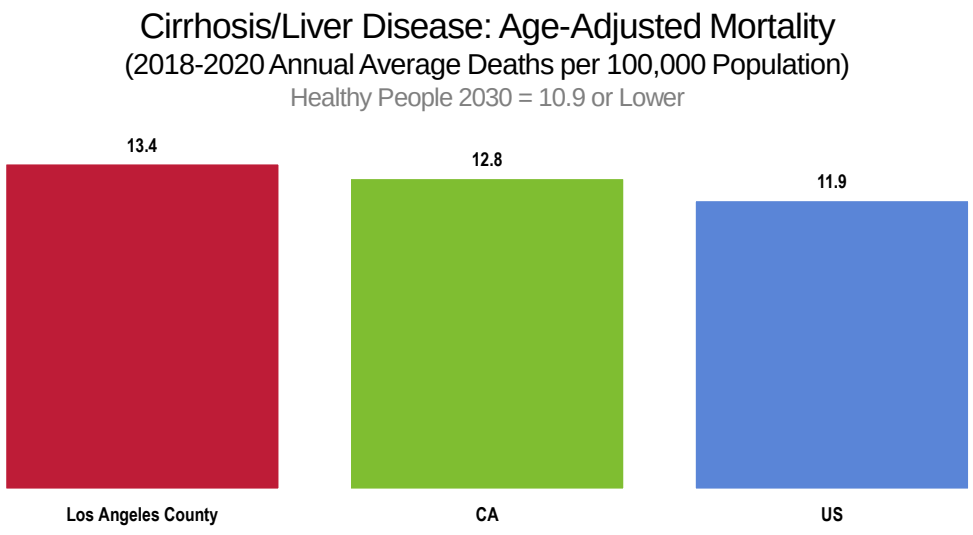
Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

– Healthy People 2030 (https://health.gov/healthypeople)

Alcohol

Age-Adjusted Cirrhosis/Liver Disease Deaths

Heavy alcohol use contributes to a significant share of liver disease, including cirrhosis. The following chart outlines age-adjusted mortality for cirrhosis/liver disease in the area. [COUNTY-LEVEL DATA]



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Excessive Drinking

Excessive drinking includes heavy and/or binge drinkers:

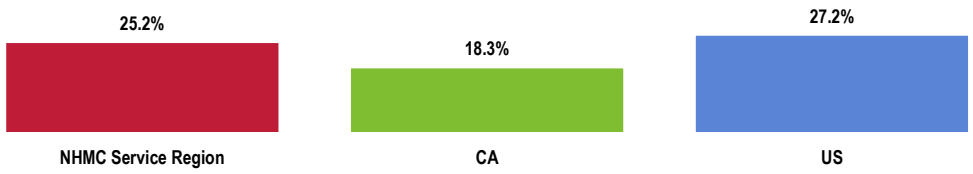
- HEAVY DRINKERS ► men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- BINGE DRINKERS ► men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

"During the past 30 days, on how many days did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?"

"On the day(s) when you drank, about how many drinks did you have on the average?"

"Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5 (if male)**/4** (if female) **or more drinks on an occasion?"**

Excessive Drinkers



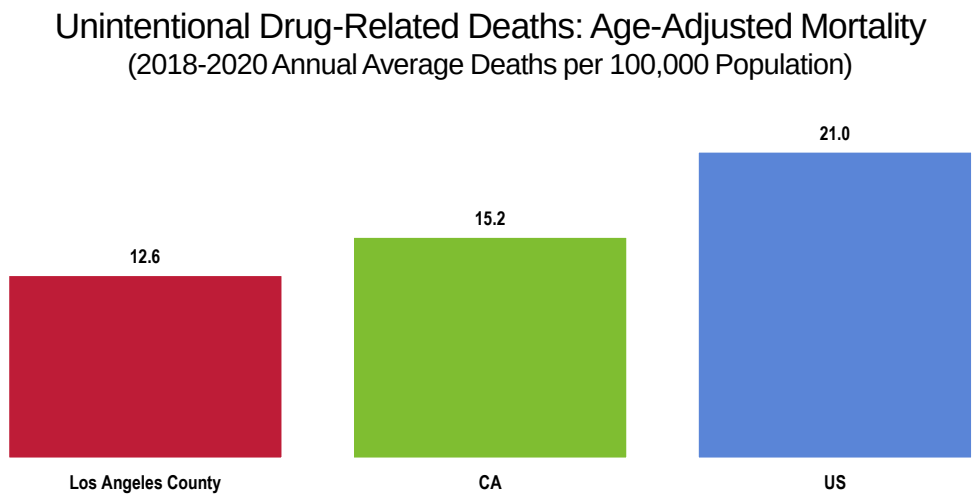
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 136]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Drugs

Age-Adjusted Unintentional Drug-Related Deaths

Unintentional drug-related deaths include all deaths, other than suicide, for which drugs are the underlying cause. A "drug" includes illicit or street drugs (e.g., heroin and cocaine), as well as legal prescription and over-the-counter drugs; alcohol is not included. The following chart outlines local age-adjusted mortality for unintentional drug-related deaths. [COUNTY-LEVEL DATA]

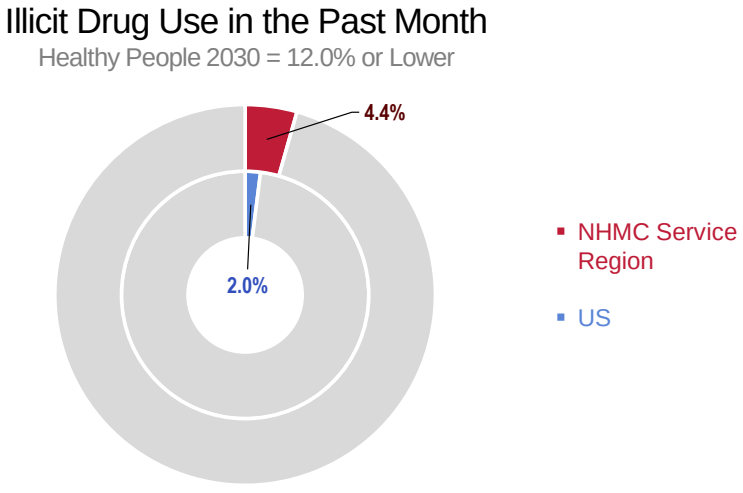


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

Illicit Drug Use

"During the past 30 days, have you used an illegal drug or taken a prescription drug that was not prescribed to you?"

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that actual illicit drug use in the community is likely higher.



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 49]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

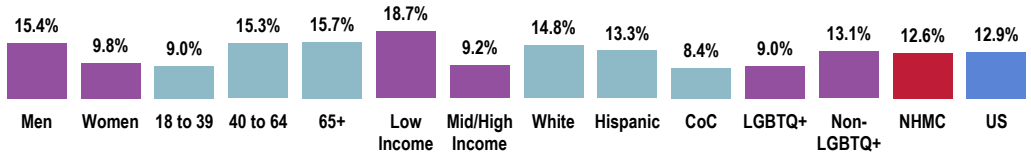
Notes:
- Asked of all respondents.

Use of Prescription Opioids

Opioids are a class of drugs used to treat pain. Examples presented to respondents include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. Common brand name opioids include Vicodin, Dilaudid, Percocet, OxyContin, and Demerol.

"Opiates or opioids are drugs that doctors prescribe to treat pain. Examples of prescription opiates include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. In the past year, have you used any of these prescription opiates?"

Used a Prescription Opioid in the Past Year
(NHMC Service Region, 2022)



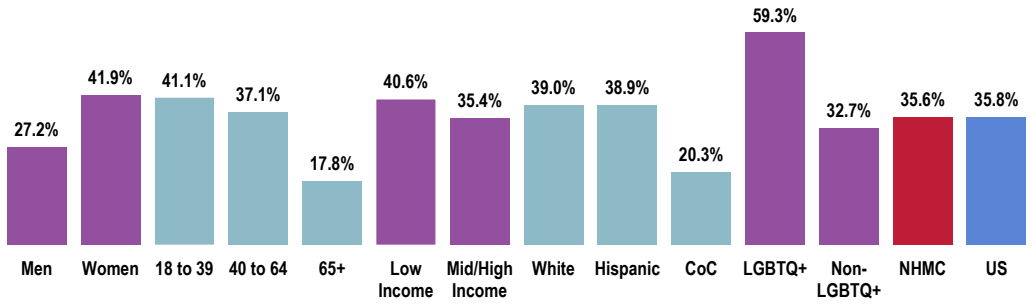
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 50]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents. Use caution when interpreting results for LGBTQ+, as the sample size falls below n=50.
- CoC represents Communities of Color (non-Hispanic and non-White).

Personal Impact From Substance Abuse

"To what degree has your life been negatively affected by your own or someone else's substance abuse issues, including alcohol, prescription, and other drugs? Would you say: a great deal, somewhat, a little, or not at all?"

Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else)
(NHMC Service Region, 2022)

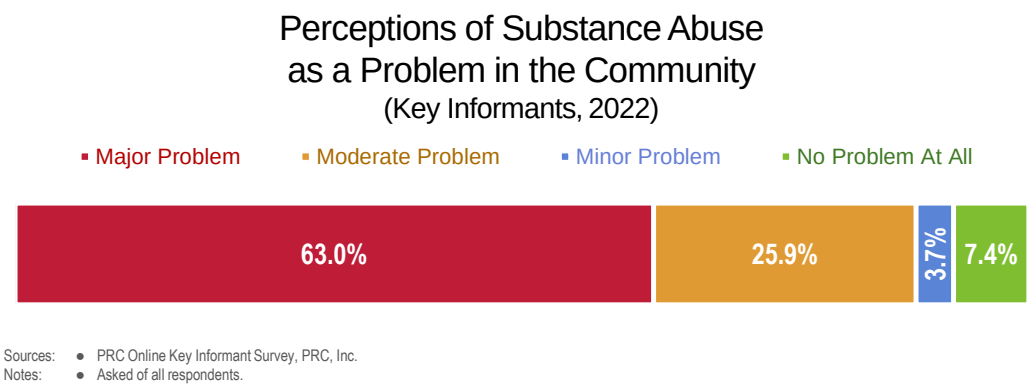


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 52]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents. Use caution when interpreting results for LGBTQ+, as the sample size falls below n=50.
- Includes response of "a great deal," "somewhat," and "a little."
- CoC represents Communities of Color (non-Hispanic and non-White).

Key Informant Input: Substance Abuse

The following chart outlines key informants' perceptions of the severity of *Substance Abuse* as a problem in the community:



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Contributing Factors

> Access to help and knowledge about how to assist people with this problem. – Social Services Provider
>
> High rates of drug overdose. Too much fentanyl has made its way into the streets. People need more access to harm reduction resources. Need to destigmatize harm reduction to save lives. – Social Services Provider
>
> The greatest barrier is lack of knowledge as to where to go for information for families dealing with these issues; the stigma still attached from seeking treatment and the lack of actual treatment centers who accept low-income participants into their programs. – Social Services Provider
>
> Stigma and services are not readily available. Also, it's often not part of essential services or benefits coverage, so always an extra layer of administrative steps to access services – a responsibility placed on those who are least equipped to jump through these types of barriers. – Public Health Representative

Lifestyle

> I'm not an expert but have come to believe that someone suffering from substance abuse has to be ready for treatment. If they are not ready, the treatment may not be as effective. – Other Health Provider
>
> Clients' desire to change behaviors. Ease of ability to get opiates and benzos. Difficulty finding openings in low few programs. – Social Services Provider

Access to Care/Services

> Timely and affordable access to treatment. Long wait lists, cost-prohibitive service plans. – Community Leader
>
> Availability of resources. – Education Representative

Easy Access

> Easy access to prescription medication and drugs. – Community Leader

Social Norms/Community Attitude

> The community's norms and views. – Social Services Provider

Prevention

> Same as the concerns with mental health. The two issues should be interconnected. More prevention measures should be in place. – Social Services Provider

Stress

> Due to the increased stress in families, increased substance abuse is evident. – Social Services Provider

Tobacco Use

ABOUT TOBACCO USE

More than 16 million adults in the United States have a disease caused by smoking cigarettes, and smoking-related illnesses lead to half a million deaths each year.

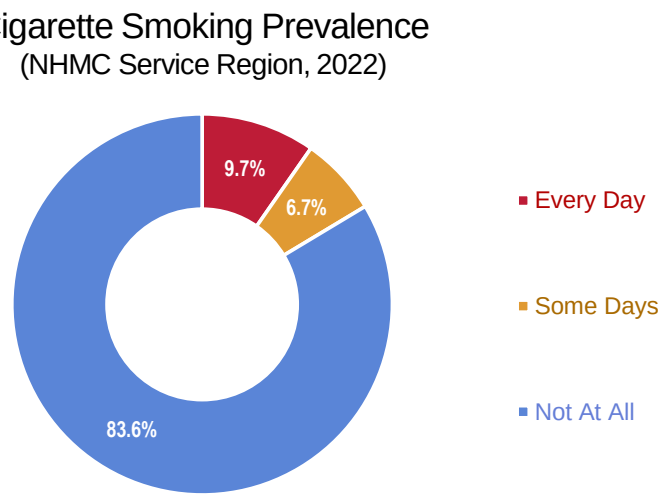
Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including men, American Indians/Alaska Natives, people with behavioral health conditions, LGBT people, and people with lower incomes and education levels.

Several evidence-based strategies can help prevent and reduce tobacco use and exposure to secondhand smoke. These include smoke-free policies, price increases, and health education campaigns that target large audiences. Methods like counseling and medication can also help people stop using tobacco.

– Healthy People 2030 (https://health.gov/healthypeople)

Cigarette Smoking

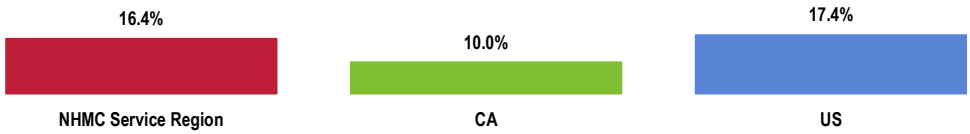
"Do you currently smoke cigarettes 'every day,' 'some days,' or 'not at all'?" ("Current smokers" include those smoking "every day" or on "some days.")



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 40]
Notes: ● Asked of all respondents.

Current Smokers

Healthy People 2030 = 5.0% or Lower



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 40]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

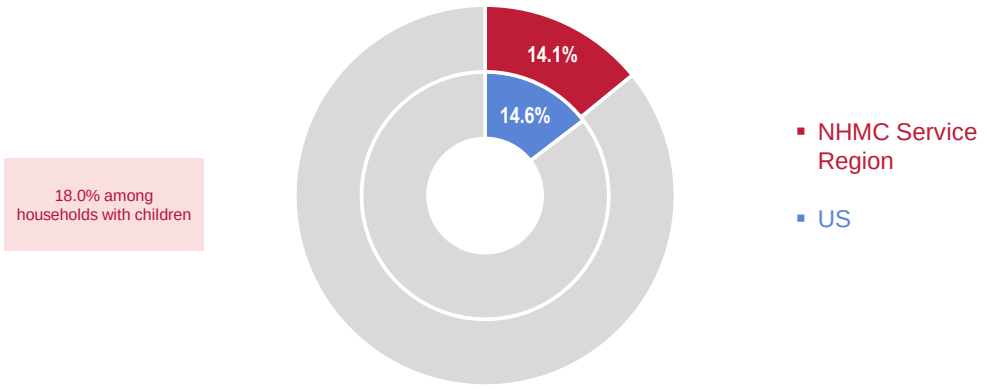
Notes:
- Asked of all respondents.
- Includes regular and occasional smokers (those who smoke cigarettes every day or on some days).

Environmental Tobacco Smoke

"In the past 30 days, has anyone, including yourself, smoked cigarettes, cigars, or pipes anywhere in your home on an average of four or more days per week?"

The following chart details these responses among the total sample of respondents.

Member of Household Smokes at Home



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 134, 43]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more days per week.

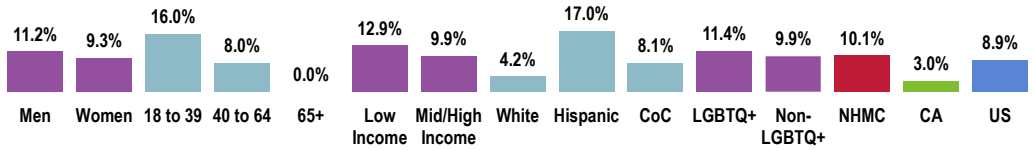
Use of Vaping Products

"The next questions are about electronic vaping products, such as electronic cigarettes, also known as e-cigarettes. These are battery-operated devices that simulate traditional cigarette smoking but do not involve the burning of tobacco. Have you ever used an electronic vaping product, such as an e-cigarette, even just one time in your entire life?"

"Do you now use electronic vaping products, such as e-cigarettes, 'every day,' 'some days,' or 'not at all'?"

"Current use" includes use "every day" or on "some days."

Currently Use Vaping Products
(NHMC Service Region, 2022)



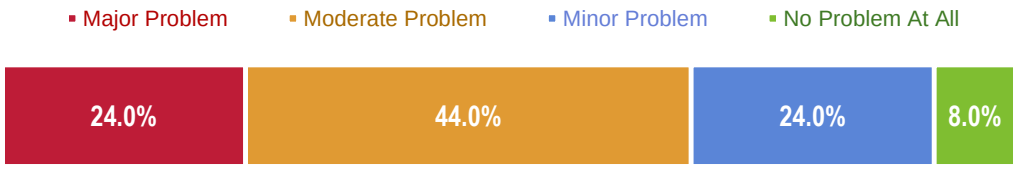
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 135]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents. Use caution when interpreting results for LGBTQ+, as the sample size falls below n=50.
- Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).
- CoC represents Communities of Color (non-Hispanic and non-White).

Key Informant Input: Tobacco Use

The following chart outlines key informants' perceptions of the severity of *Tobacco Use* as a problem in the community:

Perceptions of Tobacco Use as a Problem in the Community
(Key Informants, 2022)



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Awareness/Education

> People need information about treatment and how to assist people with this disease. – Social Services Provider

Easy Access

> For that, easy access to tobacco. – Community Leader

Sexual Health

HIV

ABOUT HIV & SEXUALLY TRANSMITTED INFECTIONS

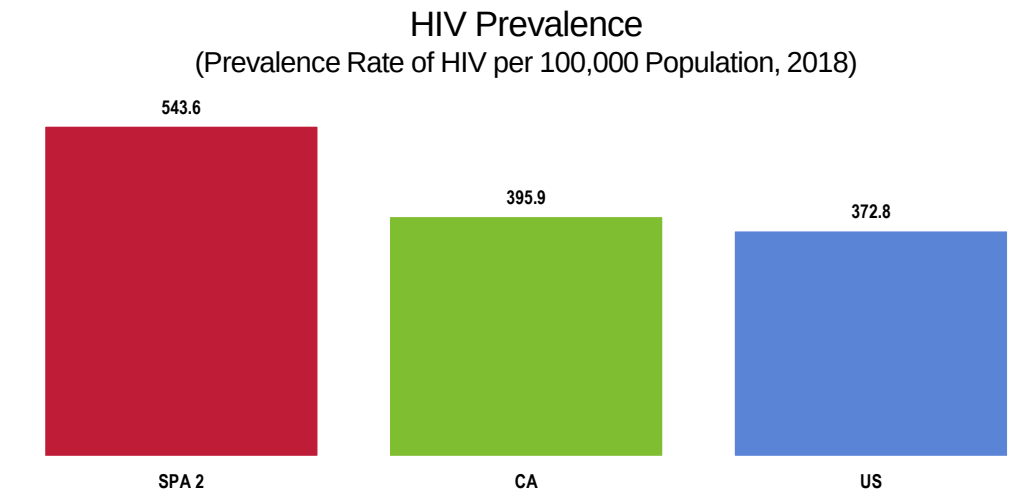
Although many sexually transmitted infections (STIs) are preventable, there are more than 20 million estimated new cases in the United States each year — and rates are increasing. In addition, more than 1.2 million people in the United States are living with HIV (human immunodeficiency virus).

Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV. Promoting behaviors like condom use can help prevent STIs.

Strategies to increase screening and testing for STIs can assess people's risk of getting an STI and help people with STIs get treatment, improving their health and making it less likely that STIs will spread to others. Getting treated for an STI other than HIV can help prevent complications from the STI but doesn't prevent HIV from spreading.

– Healthy People 2030 (https://health.gov/healthypeople)

The following chart outlines prevalence (current cases, regardless of when they were diagnosed) of HIV per 100,000 population in the area.



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

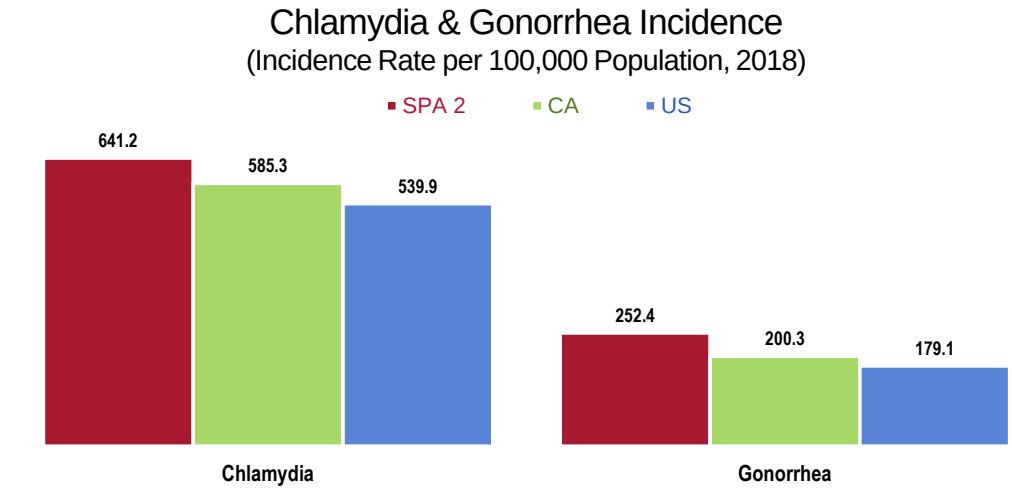
Notes:
- This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

Sexually Transmitted Infections (STIs)

CHLAMYDIA ► Chlamydia is the most commonly reported STI in the United States; most people who have chlamydia are unaware, since the disease often has no symptoms.

GONORRHEA ► Anyone who is sexually active can get gonorrhea. Gonorrhea can be cured with the right medication; left untreated, however, gonorrhea can cause serious health problems in both women and men.

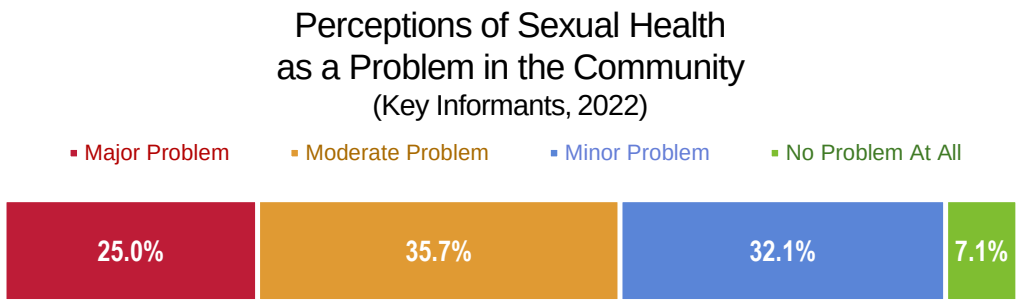
The following chart outlines local incidence for these STIs.



Sources: ● Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
● Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).
Notes: ● This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.

Key Informant Input: Sexual Health

The following chart outlines key informants' perceptions of the severity of *Sexual Health* as a problem in the community:



Sources: ● PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Contributing Factors

> Due to the practice of sexual activity at an early age and the lack of communication with people who speak to them with respect and true love. – Community Leader

> STI remains a problem – e.g., congenital syphilis (CS) increased dramatically in LA County during the last 4 years; CS is often seen as the canary in the coal mine, likely signaling problems with STI control across the various diseases. Health education and focusing on underlying social issues may be important but probably do not work so well in the field. Could be better to strengthen contact tracing, treatment, and follow-up control measures. – Public Health Representative

Awareness/Education

> Information/education and accessing services. – Social Services Provider
>
> People need more information and knowledge about how to practice sexuality. – Social Services Provider

Incidence/Prevalence

> HIV rates are still higher than they should be. PrEP uptake is low. Other STI transmission rates are high. – Social Services Provider

ACCESS TO HEALTH CARE

ABOUT HEALTH CARE ACCESS

Many people in the United States don't get the health care services they need. …About 1 in 10 people in the United States don't have health insurance. People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Lack of Health Insurance Coverage

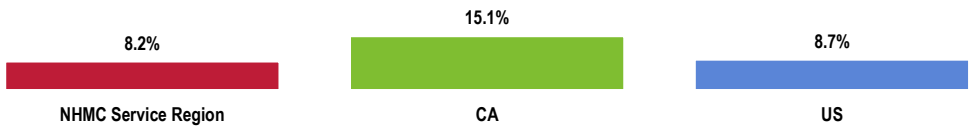
Survey respondents were asked a series of questions to determine their healthcare insurance coverage, if any, from either private or government-sponsored sources.

"Do you have any government-assisted healthcare coverage, such as Medicare, Medicaid (or another state-sponsored program)**, or VA/military benefits?"**

"Do you currently have: health insurance you get through your own or someone else's employer or union; health insurance you purchase yourself or get through a health insurance exchange website; or, you do not have health insurance and pay for health care entirely on your own?"

Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus excluding the Medicare population), who have no type of insurance coverage for healthcare services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

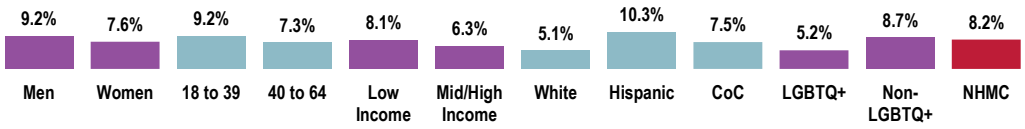
Lack of Health Care Insurance Coverage
(Adults Age 18-64)
Healthy People 2030 = 7.9% or Lower



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 137]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Asked of all respondents under the age of 65.

Lack of Health Care Insurance Coverage
(Adults Age 18-64; NHMC Service Region, 2022)
Healthy People 2030 = 7.9% or Lower



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 137]
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov [Objective AHS-1]

Notes:
- Asked of all respondents under the age of 65. Use caution when interpreting results for LGBTQ+, as the sample size falls below n=50.
- CoC represents Communities of Color (non-Hispanic and non-White).

Difficulties Accessing Health Care

Barriers to Health Care Access

To better understand healthcare access barriers, survey participants were asked whether any of the following barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

"Was there a time in the past 12 months when you needed medical care, but had difficulty finding a doctor?"

"Was there a time in the past 12 months when you had difficulty getting an appointment to see a doctor?"

"Was there a time in the past 12 months when you needed to see a doctor, but could not because of the cost?"

"Was there a time in the past 12 months when a lack of transportation made it difficult or prevented you from seeing a doctor or making a medical appointment?"

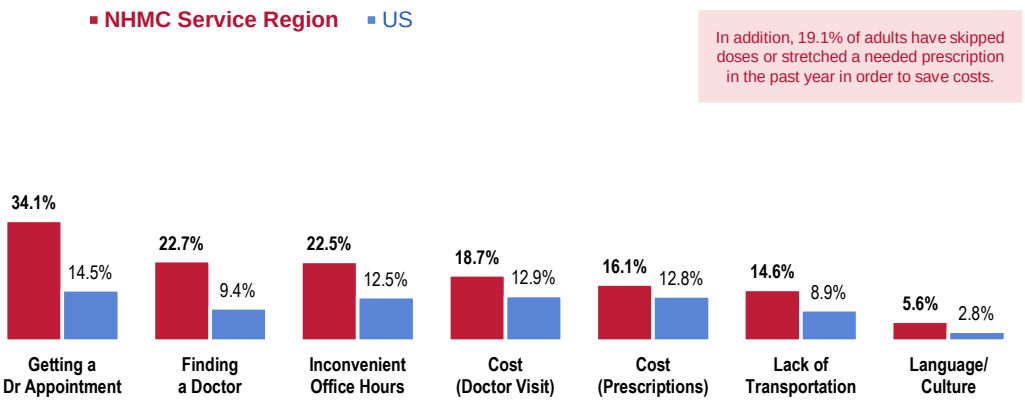
"Was there a time in the past 12 months when you were not able to see a doctor because the office hours were not convenient?"

"Was there a time in the past 12 months when you needed a prescription medicine, but did not get it because you could not afford it?"

"Was there a time in the past 12 months when you were not able to see a doctor due to language or cultural differences?"

The percentages shown in the following chart reflect the total population, regardless of whether medical care was needed or sought.

Barriers to Access Have Prevented Medical Care in the Past Year

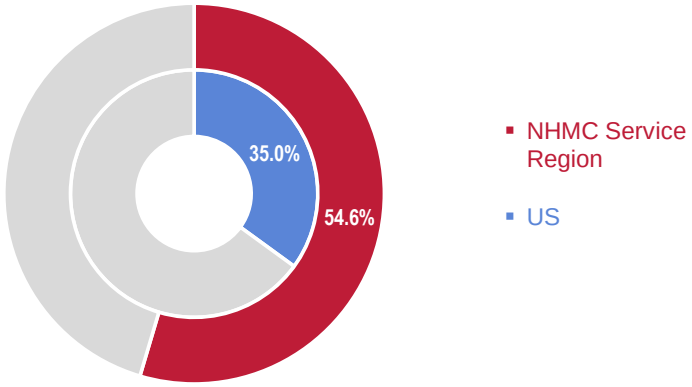


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 7-14]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

The following charts reflect the composite percentage of the total population experiencing problems accessing healthcare in the past year (indicating one or more of the aforementioned barriers or any other problem not specifically asked), again regardless of whether they needed or sought care.

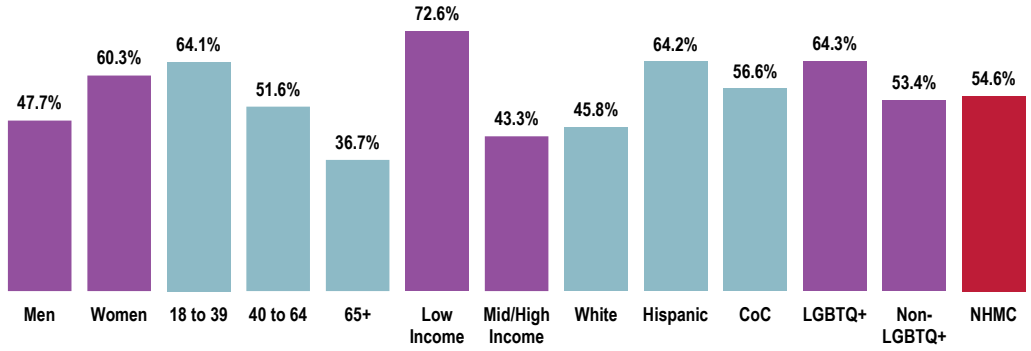
Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 140]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year
(NHMC Service Region, 2022)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 140]

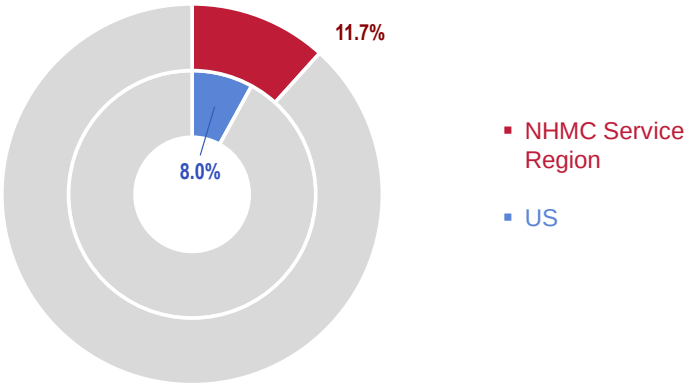
Notes:
- Asked of all respondents. Use caution when interpreting results for LGBTQ+, as the sample size falls below n=50.
- Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.
- CoC represents Communities of Color (non-Hispanic and non-White).

Accessing Health Care for Children

Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly selected child in their household.

"Was there a time in the past 12 months when you needed medical care for this child, but could not get it?"

Had Trouble Obtaining Medical Care for Child in the Past Year
(Parents of Children 0-17)

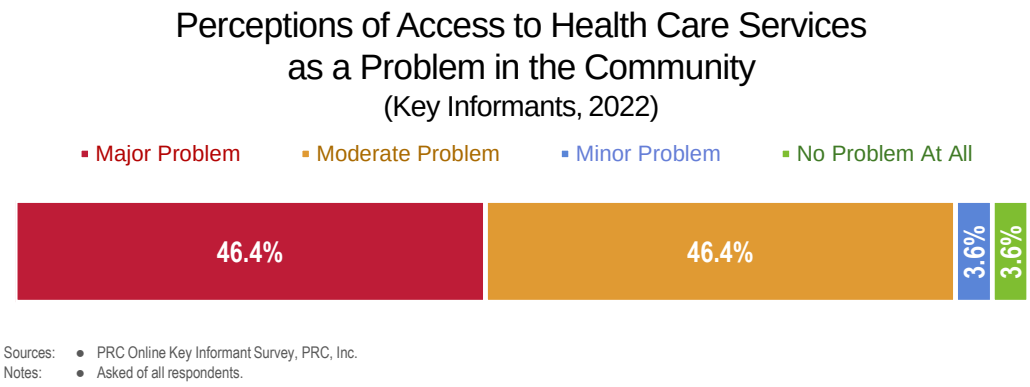


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 104]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children 0 to 17 in the household.

Key Informant Input: Access to Health Care Services

The following chart outlines key informants' perceptions of the severity of *Access to Health Care Services* as a problem in the community:



Sources: PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Contributing Factors

> Long waits for getting appointments. Fragmented healthcare system and the gap in the continuity of care. Access to patients' records. – Social Services Provider
>
> In the community, one of the major challenges when accessing health care services arises from the community not having digital competency to find services, as well as a language barrier. Many of the times community members need the support of other entities to help them apply for services, find locations, translate health materials. Essentially the community needs health care services that are culturally competent and provide an arrange of hours to support the working class. – Social Services Provider
>
> Poorer community residents oftentimes do not have access to health care and or the ability to pay. Seniors oftentimes do not have the ability to effectively communicate with health care professionals and if they are poor or with limited English skills, it may be even more difficult to get care. – Other Health Provider
>
> People who are unemployed, under-employed, or who lack documentation do not always understand available options, nor do the community serving organizations who could make referrals, so they fall through the cracks and go without care until it's an emergency. Sometimes it's hard to get appointments or speak to provider staff. Many positions do not provide staff the flexibility to sit on hold during breaks or lunch. Transportation is also a barrier. Cost of medications and uncovered services. For example, a person with a major dental issue may only get teeth pulled and not have access to restorative care. But having missing teeth can create health problems – and moreover social stigma affecting the ability to get and keep employment. – Social Services Provider
>
> Limited health insurance coverage. Limited transportation and those who are homebound. – Public Health Representative

Access to Care/Services

> The limited resources in the community. – Other Health Provider
>
> Easy access and availability to mental health support. – Social Services Provider

Social Determinants of Health

> Social determinants of health, such as access to primary care, transportation, nutritional food insecurity, green space for physical activity, cultural and linguistically appropriate care, and medical illiteracy. – Education Representative

Cultural Competence

> In the community, one of the major challenges when accessing health care services arises from the community not having digital competency to find services, as well as a language barrier. Many of the times community members need the support of other entities to help them apply for services, find locations, translate health materials. Essentially the community needs health care services that are culturally competent and provide an arrange of hours to support the working class. – Social Services Provider

Awareness/Education

> Knowledge about resources for the community. Community engagement and organization planning. – Social Services Provider

Income/Poverty

> Economic and social barriers. – Other Health Provider

Health Disparities

> Addressing health disparities. – Social Services Provider

Vulnerable Populations

> Senior care. Medicare plans do not cover a lot of their healthcare needs. – Social Services Provider

Primary Care Services

ABOUT PREVENTIVE CARE

Getting preventive care reduces the risk for diseases, disabilities, and death — yet millions of people in the United States don't get recommended preventive health care services.

Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't get the preventive care they need. Barriers include cost, not having a primary care provider, living too far from providers, and lack of awareness about recommended preventive services.

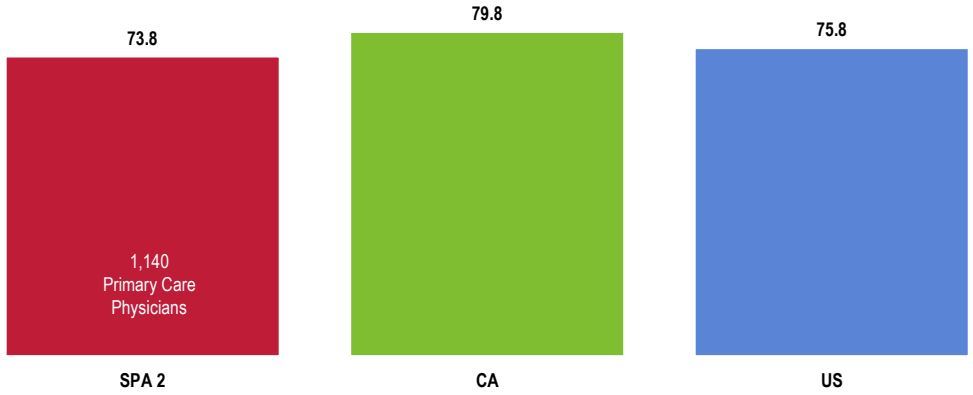
Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

– Healthy People 2030 (https://health.gov/healthypeople)

Access to Primary Care

This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Access to Primary Care
(Number of Primary Care Physicians per 100,000 Population, 2017)



Sources:
- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Notes:
- Doctors classified as "primary care physicians" by the AMA include: General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs, and General Pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

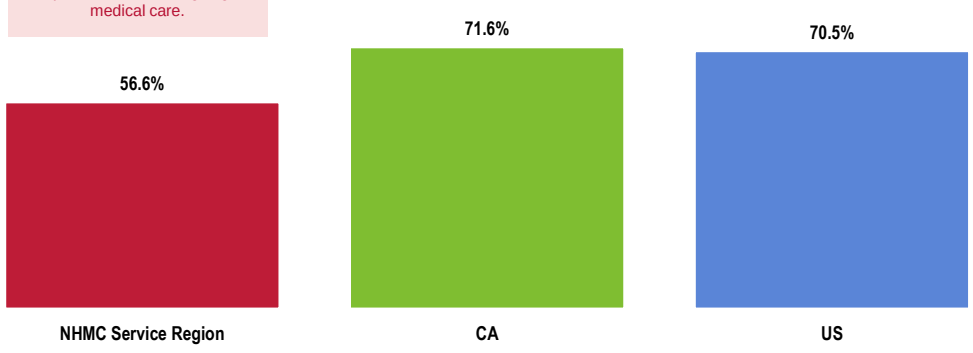
Utilization of Primary Care Services

ADULTS ► **"A routine checkup is a general physical exam, not an exam for a specific injury, illness or condition. About how long has it been since you last visited a doctor for a routine checkup?"**

CHILDREN ►**"About how long has it been since this child visited a doctor for a routine checkup or general physical exam, not counting visits for a specific injury, illness, or condition?"**

Have Visited a Physician for a Checkup in the Past Year

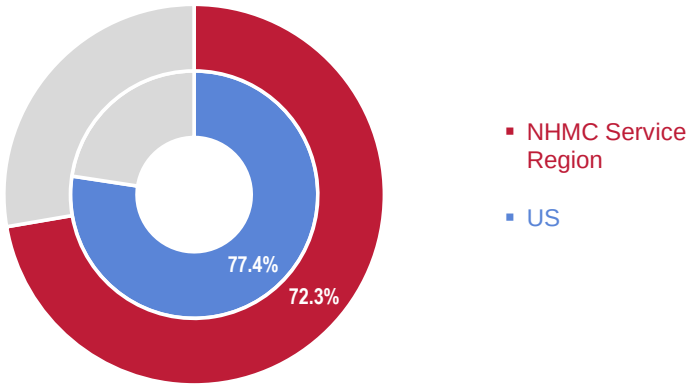
Amon area adults, 65.2% have a specific source of ongoing medical care.



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 18]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Child Has Visited a Physician for a Routine Checkup in the Past Year
(Parents of Children 0-17)



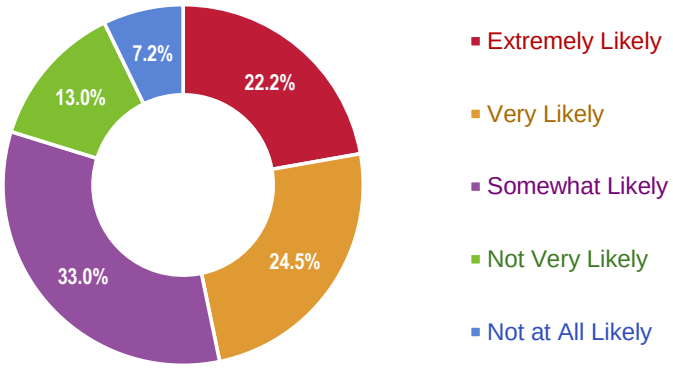
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 105]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children 0 to 17 in the household.

Willingness to Use Telemedicine

"Doctors and other medical providers sometimes use telemedicine or tele-health to evaluate, diagnose, or treat a patient using a computer, smartphone, or telephone to communicate in real time without being face-to-face. In the future, how likely would you be to use telemedicine instead of office visits if you needed routine medical care, such as a check-up, if your child got sick or hurt, or you needed advice about a health problem? Would you be: extremely likely, very likely, somewhat likely, not very likely, or not at all likely?"

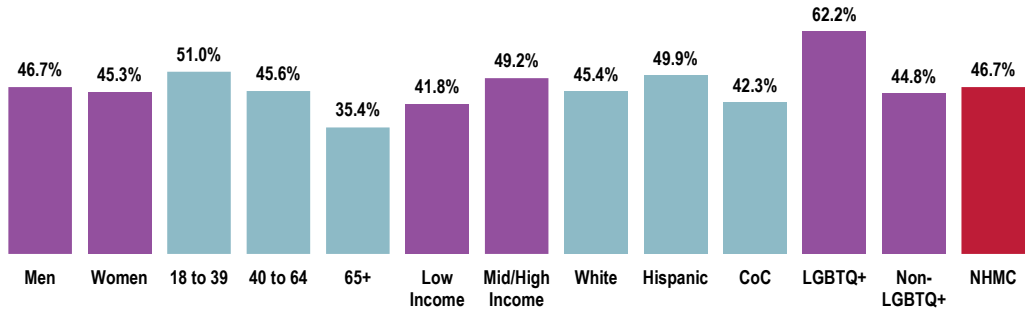
Likelihood of Using Telemedicine
(NHMC Service Region, 2022)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 301]

Notes:
- Asked of all respondents.
- During a telemedicine visit, a patient uses a computer, smartphone, or telephone to communicate with a healthcare professional in real time without being face to face.

“Extremely Likely/Very Likely” to Use Telemedicine
(NHMC Service Region, 2022)



Sources: 2022 PRC Community Health Survey, PRC, Inc. [Item 301]
Notes:
- Asked of all respondents. Use caution when interpreting results for LGBTQ+, as the sample size falls below n=50.
- During a telemedicine visit, a patient uses a computer, smartphone, or telephone to communicate with a healthcare professional in real time without being face to face.
- CoC represents Communities of Color (non-Hispanic and non-White).

Oral Health

ABOUT ORAL HEALTH

Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they’re usually easier to treat. But many people don’t get the care they need, often because they can’t afford it. Untreated oral health problems can cause pain and disability and are linked to other diseases.

Strategies to help people access dental services can help prevent problems like tooth decay, gum disease, and tooth loss. Individual-level interventions like topical fluorides and community-level interventions like community water fluoridation can also help improve oral health. In addition, teaching people how to take care of their teeth and gums can help prevent oral health problems.

– Healthy People 2030 (https://health.gov/healthypeople)

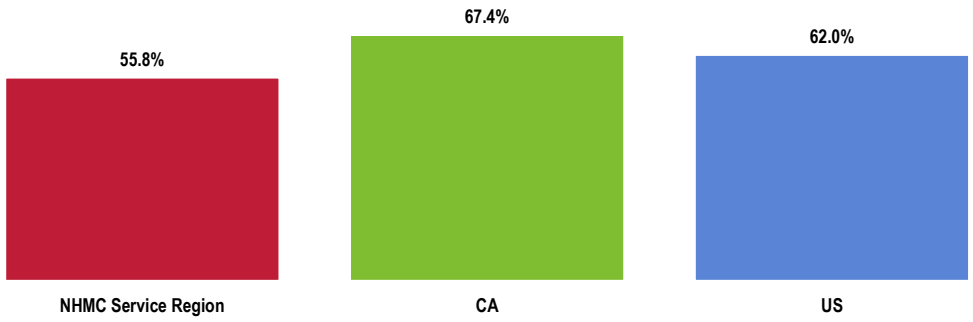
Dental Care

ADULTS ► **“About how long has it been since you last visited a dentist or a dental clinic for any reason?”**

CHILDREN AGE 2-17 ► **“About how long has it been since this child visited a dentist or dental clinic?”**

Have Visited a Dentist or Dental Clinic Within the Past Year

Healthy People 2030 = 45.0% or Higher



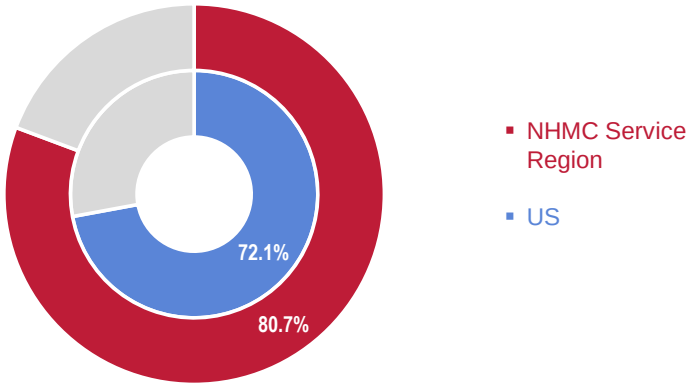
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 20]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 California data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Child Has Visited a Dentist or Dental Clinic Within the Past Year

(Parents of Children Age 2-17)

Healthy People 2030 = 45.0% or Higher

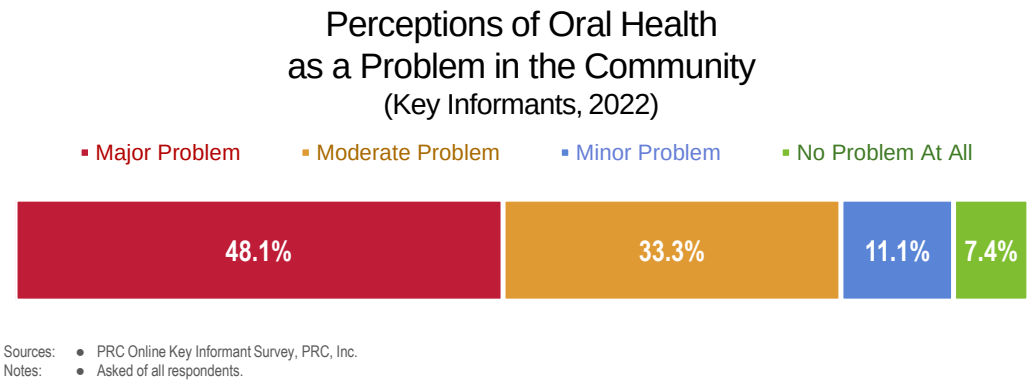


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 108]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Asked of all respondents with children age 2 through 17.

Key Informant Input: Oral Health

The following chart outlines key informants' perceptions of the severity of *Oral Health* as a problem in the community:



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Contributing Factors

> Public benefit coverage is minimal, treatments are too costly for people to take on, lack of oral health education, years without treatment, social stigma. – Social Services Provider
>
> Oral health is associated with significant cardiovascular health and yet like mental health services, generally not covered as essential benefits especially for older adults. Prevention is also important too such as promoting drinking tap water among kids, since tap water is fluorinated. – Public Health Representative

Affordable Care/Services

> Lack of resources to pay for dental coverage. – Community Leader
>
> For the socioeconomic level of the demographic we serve, access to high quality, low cost oral health care is a major issue. Many of the dental clinics in the area are largely "Medi-Cal" mills and even in the FQHC world adult patients find it difficult to get the level of care that they need. – Social Services Provider

Awareness/Education

> Lack of knowledge of importance of oral health to overall wellbeing and lack of dental insurance. – Social Services Provider
>
> Information about side effects and how to prevent complications. – Social Services Provider

Insurance Coverage

> Dental care is not fully covered by Medi-Cal and is an expensive out of pocket cost. – Social Services Provider

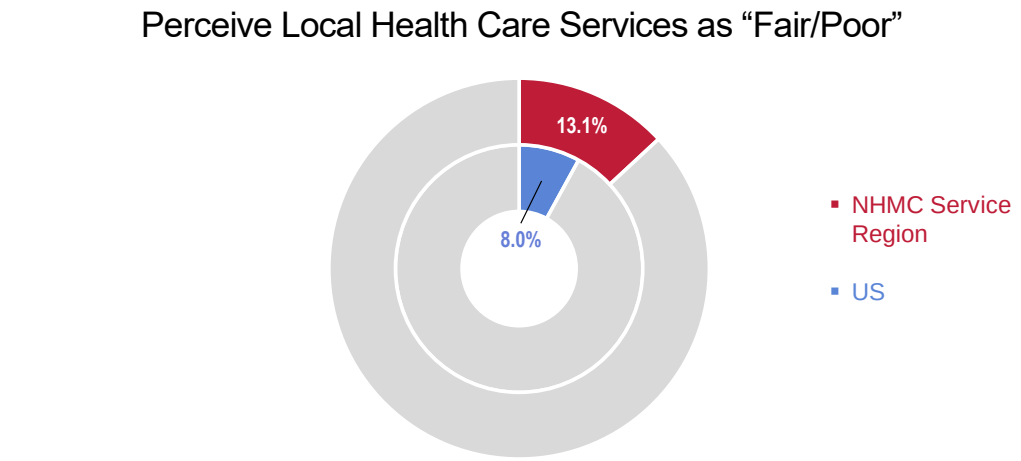
Due to COVID-19

> Due to the pandemic, lack of ability to visit dentists and provide children with necessary checkups. – Social Services Provider

LOCAL RESOURCES

Perceptions of Local Health Care Services

"How would you rate the overall health care services available to you? Would you say: excellent, very good, good, fair, or poor?"



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 6]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Resources Available to Address the Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) identified by key informants as available to address the significant health needs identified in this report. This list only reflects input from participants in the Online Key Informant Survey and should not be considered to be exhaustive nor an all-inclusive list of available resources.

Access to Health Care Services

- Care Harbor
- Child Development Institute
- Community Clinics
- California State University, Northridge
- Education
- Federally Qualified Health Centers
- Food Pantry
- Health Care
- Los Angeles Care Health Plan
- Los Angeles County Department of Health Services
- Los Angeles County Department of Public Health
- Los Angeles County Department of Workforce Development
- Los Angeles Department of Aging
- MEND
- Mid-Valley Comprehensive Health Center
- Mission Community Clinic
- My Health LA
- Northeast Valley Clinic
- Northeast Valley Health Corporation
- ONEgeneration
- Projecto del Barrio
- Providence Health Services
- San Fernando Community Health Center
- Strength United
- Support Groups
- Tarzana Treatment Center
- Valley Care Community Consortium
- Valley Presbyterian Hospital

Cancer

- Centers for Disease Control and Prevention
- Doctor's Offices
- Education
- Kaiser
- Los Angeles County Medical Association
- UCLA Jonsson Comprehensive Cancer Center
- USC Norris Comprehensive Cancer Center

Coronavirus Disease/COVID-19

- 986 Pharmacy
- Aging Services Providers
- California Governor's Office
- Comprehensive Community Health Center
- Centers for Disease Control and Prevention
- Companies Allowing Employees to Work From Home
- County of Los Angeles Board of Supervisors
- Department of Public Health
- Dignity Health
- Federally Qualified Health Centers
- Hospitals
- Housing for Health
- Los Angeles Homeless Services Authority
- Los Angeles County Department of Public Health
- Los Angeles Metro
- MEND
- ONEgeneration
- Pacoima Beautiful
- Providence Health Services
- Public-Private Partnerships for Covid Testing/Vaccines
- San Fernando Community Health Center
- Telehealth
- Valley Care Community Consortium

Dementia/Alzheimer's Disease

- AARP
- Adult Day Programs
- Alzheimer's Association
- Alzheimer's Los Angeles
- Brandman Center
- California Alzheimer's Disease Centers
- Case Management
- Dignity Health
- Housing for Health
- Los Angeles County DHS Hospital
- Los Angeles Department of Aging
- Northeast Valley Health Corporation
- ONEgeneration
- Partners in Care

- USC Family Caregiver Support Center
- Valley Community Center

Diabetes

- American Diabetes Association
- Case Management
- Centers for Disease Control and Prevention
- Department of Public Health
- DHS Hospital
- Diabetes Education Programs
- Doctor's Offices
- Education
- Enhanced Care Management
- Federally Qualified Health Centers
- Home and Community Based Alternative
- Health Self-Management Classes
- Hope of the Valley
- Hospitals
- Los Angeles County Medical Association
- MEND
- Mid-Valley Clinic
- Multipurpose Senior Services Program
- Northeast Valley Clinic
- North Valley Caring Services Food Distribution
- Northeast Valley Health Corporation
- Providence St. Joseph Medical Center
- San Fernando Community Health Center
- Valley Community Center

Disabilities & Chronic Pain

- Community Programs
- Doctor's Offices
- Hospitals
- Los Angeles County Department of Public Health Substance Abuse Prevention & Control
- Los Angeles Department of Mental Health
- Substance Abuse Counselor
- UCLA Comprehensive Pain Center

Heart Disease & Stroke

- American Heart Association
- Cardiac Rehab Programs
- Federally Qualified Health Centers
- Health Plans
- Hospitals
- Los Angeles Care Health Plan
- MEND
- North Valley Caring Services Food Distribution
- Nutrition Classes
- Valley Care Community Consortium

Infant Health and Family Planning

- Child Development Institute
- Doctor's Offices
- Federally Qualified Health Centers
- First 5 LA Welcome Baby Program
- Hospitals
- MEND
- Northeast Valley Clinic
- North Los Angeles County Regional Center
- Northeast Valley Health Corporation
- Planned Parenthood
- Projecto del Barrio
- WIC

Injury and Violence

- Pacoima Beautiful
- San Fernando Valley Domestic Abuse Response Team
- Strength United
- Valley Family Center

Mental Health

- Child and Family Guidance
- Child Development Institute
- Community Psychiatry Telehealth
- Department of Mental Health
- El Centro de Amistad
- Federally Qualified Health Centers
- Find Your Balance Center
- Hope of the Valley
- Hospitals
- Los Angeles County Homeless Authority
- Los Angeles Department of Mental Health
- MEND
- Northeast Valley Health Corporation
- Olive View Medical Center
- Phoenix House
- San Fernando Valley Community Mental Health
- San Fernando Valley Rescue Mission
- Strength United
- Sycamores
- Tarzana Treatment Center
- Valley Center for the Prevention of Family Violence
- Valley Family Housing

Nutrition, Physical Activity, and Weight

- Child Development Institute
- Community Health and Well Being – California State University, Northridge

- California State University, Northridge 3 WINS Fitness
- Department of Public Health
- Health Self-Management Classes
- HERE Center
- MEND
- North Valley Caring Services Food Distribution
- Nutrition Classes
- Pacoima Beautiful
- Parks and Recreation
- San Fernando Community Health Center
- SNAP
- Valley Care Community Consortium
- WIC
- YMCA
- Mission Community Hospital
- NAMI
- Northeast Valley Health Corporation
- Olive View Medical Center
- Phoenix House
- Substance Abuse Prevention and Control
- Tarzana Treatment Center

Oral Health

- California Dental Association
- Child Development Institute
- Delta Dental Denti-Cal Program
- Federally Qualified Health Centers
- Los Angeles County Department of Oral Health Services
- San Fernando Community Health Center
- UCLA Community Dental Resource
- Valley Care Community Consortium

Respiratory Diseases

- Federally Qualified Health Centers

Sexual Health

- Centers for Disease Control and Prevention
- Division of HIV and STD Programs
- Los Angeles County Department of Health Services
- Los Angeles County Division of HIV and STD Programs
- Northeast Valley Health Corporation
- Tarzana Treatment Center

Substance Abuse

- AA/NA
- California Department of Healthcare Services
- Centers for Disease Control and Prevention
- Cri-Help
- Gateways Hospital and Mental Health Center
- Los Angeles County Department of Public Health
- Los Angeles County Department of Public Health Substance Abuse Prevention & Control
- Los Angeles Department of Mental Health

APPENDIX

EVALUATION OF PAST ACTIVITIES

From fiscal years 2019-2021 Northridge Hospital provided $103 million in patent financial assistance, unpaid costs of Medicaid and other means-tested government programs, plus nearly $33 million in community health improvement services, health professions education, subsidized health services and other community benefits.

Our work also reflects a focus on community health improvement, as described below.

Addressing Significant Health Needs

Northridge Hospital Medical Center conducted its last CHNA in 2019 and reviewed the health priorities identified through that assessment. Taking into account the top-identified needs — as well as hospital resources and overall alignment with the hospital's mission, goals and strategic priorities — it was determined at that time that Northridge Hospital would focus on developing and/or supporting strategies and initiatives to improve:

- Homelessness/Affordable Housing
- Nutrition, Physical Activity, and Weight
- Mental Health
- Substance Abuse
- Chronic Disease(Diabetes and Cardiovascular
- Child and Adult Violence Prevention

Strategies for addressing these needs were outlined in Northridge Hospital's Implementation Strategy. Pursuant to IRS requirements, the following sections provide an evaluation of the impact of the actions taken by Northridge Hospital to address these significant health needs in our community. Additionally, the needs assessment was completed prior to the onset of COVID 19 so in addition to dealing with the needs identified in the 2019 CHNA we also implemented strategies to address the COVID 19 pandemic.

Evaluation of Impact

Priority Area: Homelessness/Affordable Housing	
Community Health Need	Reduce the rates of homelessness and support efforts to promote affordable housing
Goal(s)	• Assure the safe discharge of homeless patients through care coordination • Linkages to social support services • Partnership with the Homeless Health Initiative • Assume the cost of recuperative care for those who are homeless and need additional care outside the acute care setting

Strategy 1: Support of SB1152 Homeless Patient Discharge	
Strategy Was Implemented?	Yes
Target Population(s)	Homeless residing in hospital service area
Partnering Organization(s)	Collaboration with Los Angeles Housing Services Authority (LASHA) and the SFSCVSC and all the homeless providers that belong to the coalition. Additionally, each year the Care Coordination Team at the hospital will update the Homeless Resource Directory to share with our homeless population, and with the assistance from the Center for Healthier Communities will continue to build partnerships to identify and connect to homeless service providers.
Results/Impact	• Hospital provided 396 homeless patients with weather appropriate clothing at discharge. • Provided 988 meals to homeless patents upon discharge • Provided 28 homeless patients free medications at discharge • Provided 648 rides for homeless patients upon discharge to get them to shelter
Strategy 2: Support the Los Angeles Housing Services Authority Hospital Liaison Program and the corporate Homeless Health Initiative	
Strategy Was Implemented?	Yes
Target Population(s)	Homeless
Partnering Organization(s)	LAHSA and CommonSpirit Health
Results/Impact	• Linking individuals to homeless support services and resources through the coordinated entry system • Providing on-call information and support • Building capacity and knowledge • Tracking and documenting referred homeless
Strategy 3: Support Recuperative Care Services for the homeless	
Strategy Was Implemented?	Yes
Target Population(s)	Homeless
Partnering Organization(s)	Work in collaboration with the San Fernando and Santa Clarita Valley Homeless Coalition which consist of over 120 homeless service providers
Results/Impact	• Provided 22 individuals with recuperative care services

Priority Area: Nutrition, Physical Activity Obese and Overweight Adults and Children	
Community Health Need	Reduce the incidence of overweight and obesity to increase better nutritional and physical activity rates
Goal(s)	• Parent Center Virtual Workshops with healthy diet, importance of exercise, stress management, and COVID 19 webinars offered at no cost • Preparation of Healthy Monthly School Newsletter shared with 32 schools • Increased child and parent knowledge of importance of healthy diet and physical activity and COVID 19. Increases in the consumption of healthy food, building interdisciplinary collaborations to create healthier environments, and increased awareness in health promotion creating healthier families.

Strategy 1: School Wellness Initiative	
Strategy Was Implemented?	Yes
Target Population(s)	Parents and youth attending Los Angeles Unified School district, the second largest district in the United States
Partnering Organization(s)	Internal: Multiple Hospital Departments External: LAUSD
Results/Impact	• 10 School wellness newsletters provided to 32 schools reaching over 25,000 parents and students

Strategy 2: Prevention Forward Activate your Heart	
Strategy Was Implemented?	Yes
Target Population(s)	Those at risk for cardiovascular disease
Partnering Organization(s)	Internal: Center for Healthier Communities, Transitional Care Team, and the Wellness Committee External: American Heart Association and the CA Dept. of Public Health
Results/Impact	• 184 individuals participated in the eight (8) week Activate your Heart Program receiving blood pressure monitors to self-manage their health

Priority Area: Mental Health Services	
Community Health Need	Increase capacity for mental health services, reduce stigma, and reduce the rates of youth suicide
Goal(s)	• Continued partnership in the Cultural Trauma and Mental Health Resiliency Project • Creating Dementia Capable Health Systems • Creation of a new Youth Suicide Prevention Program

Strategy 1: Cultural Trauma Mental Health Resiliency Project	
Strategy Was Implemented?	Yes
Target Population(s)	Professionals dealing with youth and adult mental health
Partnering Organization(s)	Internal: Center for Healthier Communities External: National Alliance for Mental Illness (NAMI), Tarzana Treatment Centers (TTC), and San Fernando Valley Community Mental Health, Inc. (SFVCMH)
Results/Impact	• 70 mental health service providers received training evidence-based *Mental Health First Aid Youth/ Adults and Question, Persuade, Refer* to recognize signs and refer to services
Strategy 2: Alzheimer's Disease and Related Dementia education: Creating Dementia Capable Health Systems	
Strategy Was Implemented?	Yes
Target Population(s)	Families, care givers and health care professionals working with individual with Alzheimer's Disease and Related Dementia
Partnering Organization(s)	Internal: Physician Champion in Palliative Care and Center for Healthier Communities External: ONEgeneration, Alzheimer's Association of Southern CA, and California State University, Northridge
Results/Impact	• Provided training to 155 individuals; provided training to families, para-professionals, and other care providers that will enhance the quality of life of individuals living with Alzheimer's Disease and related dementia (ADRD) • Provided education to over 2,000 caregivers in multiple evidence-based trainings
Strategy 3: Jade Lee Marasigan Charitable Fund	
Strategy Was Implemented?	Newly implemented in 2021
Target Population(s)	Youth dealing with suicide ideation, depression, anxiety, and other behavioral health conditions
Partnering Organization(s)	Internal: Northridge Hospital Foundation, Transitional Care Department, Behavioral Health, and Center for Healthier Communities External: Jade Lee Marasigan Charitable Fund
Results/Impact	• Newly formed project with staff hired and process and resources built. No data available for 2021

Priority Area: Substance Use Disorders	
Community Health Need	To reduce the rate of opioid death rates and provide safe management of opioid addicted patents
Goal(s)	• Implement a program to provide safe management of opioid addicted residents presenting in Hospital Emergency Department • Provide access to community resources • Provide warm hand-offs to local drug treatment/detox centers

Strategy 1: ED Collaborative for Medicated Assisted Treatment (MAT)	
Strategy Was Implemented?	Yes
Target Population(s)	Opioid addicted patients presenting in the Emergency Department
Partnering Organization(s)	Internal: Emergency Department and Transitional Care Program External: Partnerships continue with drug treatment centers including Tarzana Treatment Center, Discovery House, Cri-Help, ProWellness Academy, etc. for behavioral health services.
Results/Impact	• 85% of opioid patients will agree to MAT. • 100% of patients will receive a warm hand-off. • A minimum of 12 staff (MD's, NP's, and PA's) completed MAT waiver training.

Priority Area: Diabetes and other Chronic Diseases	
Community Health Need	Identify prediabetes population to implement the CDC National Diabetes Prevention Program and provide prevention education to those that are diagnosed with Diabetes to reduce the rate of Type 1 Diabetes for youth and adults
Goal(s)	• Implement Diabetes Education and Empowerment Program (DEEP) for diabetes patients • Provide National Diabetes Prevention Program (NDPP) to those individuals identified as pre-diabetic and provide case management with a community health worker to follow for one year to support self-management and education to prevent from becoming diabetic

Strategy1: Prevention Forward Diabetes Wellness Program including NDPP for prediabetes and DEEP for diabetic patients	
Strategy Was Implemented?	Yes
Target Population(s)	Underserved communities of color with higher incidence of diabetes and other chronic disease conditions
Partnering Organization(s)	Internal: Center for Healthier Communities, Northridge Hospital Foundation, and Transitional Care Team External: CA Dept. of Public Health
Results/Impact	• 182 individuals participated in DEEP program and workshops designed to teach them how to self-manage their disease, learn stress management techniques, and how to support family members living with diabetes • 4 staff members received training in 2021 to begin implementing the NDPP program during fiscal year 2022

Priority Area: Child and Adult Abuse (domestic, physical, sexual, emotional, neglect, and human trafficking	
Community Health Need	Reduce the rates of domestic violence, teen dating violence, human trafficking, sexual assault and abuse, and elder abuse including financial abuse and those listed above.
Goal(s)	• Begin our 25th year with our Center for Assault Treatment Services providing services to victims of crime and to provide outreach and prevention education on how to identify and repot abuse and how to prevent yourself from abuse. • Expand the Medical Safe Haven Program for Human Trafficking victims • Participate in the Bureau of Justice STOP school violence program • Increase the number of cases brought to the Local Elder Abuse Prevention Enhance Multidisciplinary Team

Strategy 1: Local Elder Abuse Prevention Enhanced Multidisciplinary Team (LEAP EMDT)	
Strategy Was Implemented?	Yes
Target Population(s)	Victims of Elder Abuse age 60 and above
Partnering Organization(s)	Internal: Center for Healthier Communities and Center for Assault Treatment Services External: Valley Care Community Consortium, Alzheimer's Association California Southland Chapter, ONEgeneration, Southern California Neuropsychology Group, Bet Tzedek Legal Services, WISE & Healthy Aging Long Term Care Ombudsman Program, Los Angeles County Adult Protective Services, the Office of the Public Guardian, a forensic accountant, a social isolation specialist, and a Senior Real Estate Specialist
Results/Impact	• 675 older adults received education about how to protect themselves for all types of abuse • Participated in National Crime Victims' Rights Week distributing over 75,000 pieces of information listing multiple resources for victims of all types of abuse

Strategy 2: CATS Outreach and Prevention Education Programs	
Strategy Was Implemented?	Yes
Target Population(s)	Underserved youth and adults at a disproportionate rate of violence
Partnering Organization(s)	Internal: Center for Assault Treatment Services and Center for Healthier Communities External: Family Justice Center, the onsite partners include the Los Angeles Police Department, Strength United, Los Angeles City Attorney Victims Assistance Program, and Neighborhood Legal Services. We continue to work with the Boys and Girls Clubs, school sites, and youth service providers to implement programs virtually and in community.
Results/Impact	• Over 80 Middle and High School students showed increased knowledge of what a healthy relationship is, and their ability to support and help a friend report abuse

Priority Area: COVID 19 Pandemic	
Community Health Need	As a result of the COVID 19 Pandemic which occurred after the printing of the 2019 CHNA we had to shift and incorporate addressing the pandemic in our community
Goal(s)	• Provide accurate information about the Pandemic to all community members with a special focus on those living in the highest impact areas which in most cases are low income communities with a high population of people of color • Provide COVID drive through testing sites • Increase capacity for community members to receive COVID 19 vaccines • Participate in a federal grant-funded program to increase vaccine capacity to those that are vaccine hesitant • Participate in a Los Angeles County Department of Public Health funded project to provide outreach, education, and protective equipment to residents living in designated zip codes that were dealing with higher rates of COVID 19 infection rates

Strategy1: Hospital based drive through testing sites and community based vaccine clinics	
Strategy Was Implemented?	Yes
Target Population(s)	Underserved communities with higher incidence of COVID 19 infections and to those at greatest risk older adults and front line service workers.
Partnering Organization(s)	Internal: Multiple Hospital Departments External: Los Angeles County Department of Public Health and Center for Disease Control
Results/Impact	• 8,042 individuals received COVID 19 testing • 10,574 individuals received COVID 19 vaccines
Strategy2: Partner with LA County Department of Public Health on the COVID Community Equity Program	
Strategy Was Implemented?	Yes
Target Population(s)	Underserved communities with higher incidence of COVID 19 infections and to those at greatest risk of becoming infected
Partnering Organization(s)	Internal: Center for Healthier Communities External: Los Angeles County Department of Public Health, Community Partners, MEND, Pacoima Beautiful, NEVHC, VCCC,
Results/Impact	• During FY 2021, the COVID-19 Outreach and Education program has reached 1,257 community members in active engagements through 11 virtual workshops (English and Spanish), health and resource events, and food pantries • Provided COVID 19 prevention education to 1,257 individuals
Strategy3: HRSA San Fernando Valley Vaccine Collaborative	
Strategy Was Implemented?	Yes
Target Population(s)	Designated areas with highest rates of COVID 19 infection and high vaccine hesitancy rates.
Partnering Organization(s)	Internal: Center for Healthier Communities External: Center for Disease Control (CDC) and Health Research Services Agency (HRSA)
Results/Impact	• 89 Community-based Pop-up COVID 19 Vaccine Clinics • Provided outreach education to 201,072 individuals • Registered 6,048 residents to get vaccinated • Provided COVID 19 vaccine to 4,866 individuals