2025 COMMUNITY HEALTH NEEDS ASSESSMENT

California Hospital Medical Center Service Area

Sponsored by

CALIFORNIA HOSPITAL MEDICAL CENTER

Dignity Health®
A member of CommonSpirit

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Prepared by
www.PRCExcellence.com

TABLE OF CONTENTS

INTRODUCTION 4

EXECUTIVE SUMMARY 5

IRS Form 990, Schedule H Compliance 8

ASSESSMENT PROCESS & METHODS 9

PRC Community Health Survey 9

Online Key Informant Survey 10

Public Health, Vital Statistics & Other Data 12

Benchmark Comparisons 13

Determining Significance 13

Information Gaps 13

Public Comment 14

SUMMARY OF FINDINGS 14

Summary Tables: Comparisons With Benchmark Data 14

Prioritized Description of Significant Community Health Needs 23

COMMUNITY DESCRIPTION 26

DEMOGRAPHIC SUMMARY 27

SIGNIFICANT HEALTH EVENT: LOS ANGELES FIRES OF 2025 27

DATA CHARTS & KEY INFORMANT INPUT 28

SOCIAL DETERMINANTS OF HEALTH 29

Income & Poverty 29

Education 31

Housing 32

Food Insecurity 33

Experience of Discrimination in Health Care 33

Loneliness 34

Social Vulnerability Index 35

Climate Change Burden 36

Greenspaces 36

Key Informant Input: Social Determinants of Health 37

HEALTH STATUS 40

Overall Health 40

Mental Health 41

DEATH, DISEASE & CHRONIC CONDITIONS 48

Leading Causes of Death 48

Cardiovascular Disease 49

Cancer 55

Respiratory Disease 60

Injury & Violence 64

Diabetes 70

Disabling Conditions 74

BIRTHS 79

Prenatal Care 80

Birth Outcomes & Risks 80

Family Planning 81

MODIFIABLE HEALTH RISKS 83
Nutrition 83
Physical Activity 85
Weight Status 88
Substance Use 93
Tobacco Use 98
Sexual Health 102
ACCESS TO HEALTH CARE 105
Lack of Health Insurance Coverage 105
Difficulties Accessing Health Care 106
Primary Care Services 110
Oral Health 112
LOCAL RESOURCES 114
Perceptions of Local Health Care Services 114
Resources Available to Address Significant Health Needs 115
APPENDIX 120
EVALUATION OF PAST ACTIVITIES 121
Community Benefit 121
Addressing Significant Health Needs 121
Evaluation of Impact 122
FY 2024 Program Highlights 130
Other Programs and Non-Quantifiable Benefits 138
Community Health Improvement Grants 139

INTRODUCTION

EXECUTIVE SUMMARY

CHNA Purpose

The purpose of this Community Health Needs Assessment (CHNA) is to identify and prioritize significant health needs in the community served by Dignity Health California Hospital Medical Center (CHMC). 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 & Mission

The hospital's commitment to engaging with the community, assessing priority needs, and helping to address them with community partners 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.

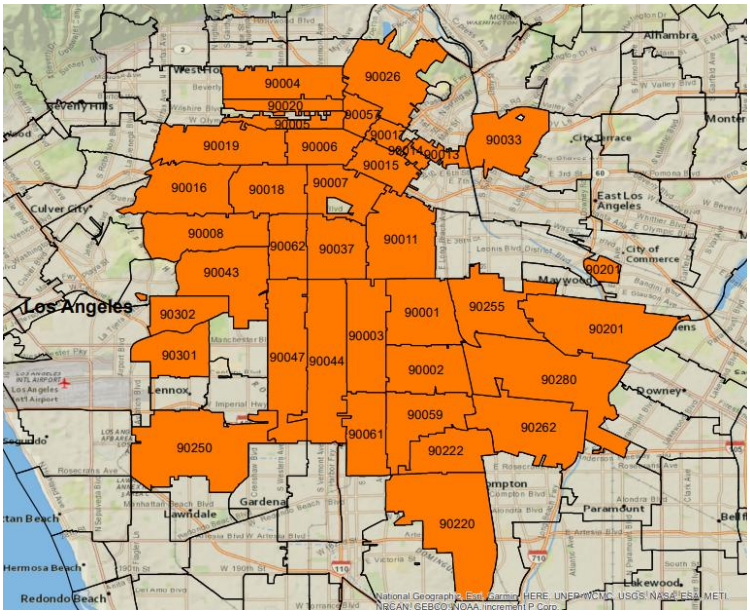
CHNA Collaborators

California Hospital Medical Center is the sole sponsor of this assessment, although 9 other hospitals also serve the area. This assessment was conducted on behalf of California 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

California Hospital Medical Center is located at 1401 S. Grand Ave., Los Angeles, CA, 90015. The hospital tracks ZIP Codes of origin for all patient admissions and includes all who received care without regard to insurance coverage or eligibility for financial assistance. The hospital defines its primary service area that includes 36 ZIP Codes in 10 cities within Los Angeles County, 17 of which are located in the City of Los Angeles, and 10 that are in South LA, and comprises of portions of Los Angeles County Service Planning Areas (SPAs) 4, 6, 7, and 8.

These ZIP Codes, outlined in the adjacent map, include: 90001, 90002, 90003, 90004, 90005, 90006, 90007, 90008, 90011, 90013, 90014, 90015, 90016, 90017, 90018, 90019, 90020, 90026, 90033, 90037, 90043, 90044, 90047, 90057, 90059, 90061, 90062, 90201, 90220, 90222, 90250, 90255, 90262, 90280, 90301, and 90302.



Assessment Process & Methods

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.

Primary Data Collection. Primary data represent the most current information provided in this assessment. The PRC Community Health Survey provides an aggregate snapshot of the health experience, behaviors, and needs of residents in the community. The PRC Online Key Informant Survey allows key community leaders and providers in the area an opportunity to give extensive qualitative input about what they see as the most pressing issues in the populations they serve.

Secondary Data Collection. Secondary data provide information from existing data sets (e.g., public health records, census data, etc.) that complement the primary research findings.

Identifying & Prioritizing Significant Health Needs

Significant health needs for the community were identified through a review of the data collected for this assessment. These were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); 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 key informants giving input to this process.

Prioritization of the health needs was determined based on a prioritization exercise conducted among providers and other community leaders (representing a cross-section of community-based agencies and organizations) as part of the PRC Online Key Informant Survey.

This process yielded the following prioritized list of community health needs:

1. **MENTAL HEALTH** ► Key informants identified this as the number-one top concern in the community.
2. **SOCIAL DETERMINANTS: HOUSING** ► Key informants identified this as a top concern in the community. Survey findings revealed needs related to housing security, housing conditions, and financial resilience.
3. **DIABETES** ► Key informants identified this as a top concern in the community. Existing data revealed a relatively high mortality rate, and survey findings revealed a relatively high prevalence of diabetes in the community.
4. **INJURY & VIOLENCE** ► Key informants identified this as a top concern in the community. Survey respondents reported high levels of experience with violent crime in the area.
5. **SUBSTANCE USE** ► Key informants identified this as a top concern in the community.
6. **NUTRITION, PHYSICAL ACTIVITY & WEIGHT** ► Key informants identified this as a top concern in the community. Survey findings revealed a high level of food insecurity.
7. **ACCESS TO HEALTH CARE SERVICES** ► Key informants identified this as a top concern in the community. Survey findings revealed needs related to: access barriers (transportation, cultural/ language barriers); having a specific source of care; and difficulty accessing health care services for children.

Other health needs identified in this assessment include:

- CANCER
- DISABLING CONDITIONS
- HEART DISEASE & STROKE
- RESPIRATORY DISEASE
- SEXUAL HEALTH
- TOBACCO USE

Resources Potentially Available to Meet Significant Health Needs

Measures and resources (such as programs, organizations, and facilities in the community) potentially available to address the significant health needs were identified by key informants giving input to this process. While not exhaustive, this list — which includes many potential resources — draws on the experiences and wide knowledge base of those directly serving our community.

Report Adoption, Availability & Comments

This CHNA report was adopted by the California Hospital Medical Center community board in June 2025.

The report is widely available to the public on the hospital's website (https://www.dignityhealth.org/socal/locations/californiahospital/about-us/community-health-programs/community-health-needs-assessment-plan), and a paper copy is available for inspection upon request at the hospital's Community Health office. We welcome any comments, questions, or ideas for collaborating that you may have, by reaching out to:

Barbara Gonzalez, Community Health Outreach Director
Barbara.Gonzalez@Commonspirit.org
California Hospital Medical Center
Leavey Hall, Suite 314
1401 S. Grand Avenue,
Los Angeles, CA 90015

IRS Form 990, Schedule H Compliance

For nonprofit 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 (2022)	See Report Page
Part V Section B Line 3a A definition of the community served by the hospital facility	9
Part V Section B Line 3b Demographics of the community	28
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	115
Part V Section B Line 3d How data was obtained	9
Part V Section B Line 3e The significant health needs of the community	14
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	23
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)	121

ASSESSMENT PROCESS & METHODS

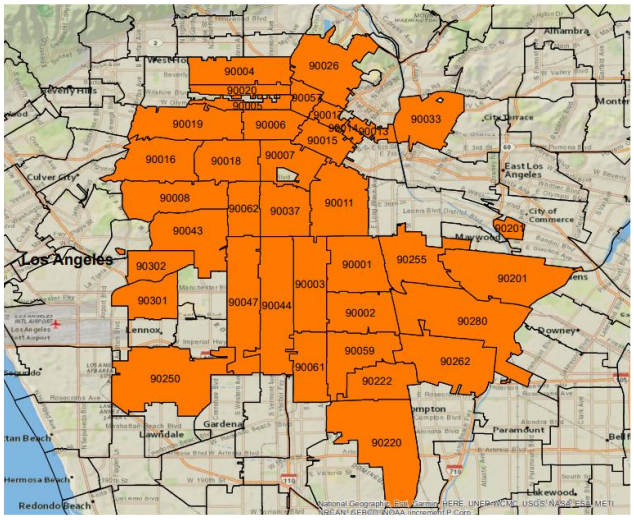
PRC Community Health Survey

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 California Hospital Medical Center (CHMC) and PRC.

Community Definition

California Hospital Medical Center is located at 1401 S. Grand Ave., Los Angeles, CA, 90015. The hospital tracks ZIP Codes of origin for all patient admissions and includes all who received care without regard to insurance coverage or eligibility for financial assistance. The hospital defines its primary service area that includes 36 ZIP Codes in 10 cities within Los Angeles County, 17 of which are located in the City of Los Angeles, and 10 that are in South LA, and comprises of portions of Los Angeles County Service Planning Areas (SPAs) 4, 6, 7, and 8.



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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.

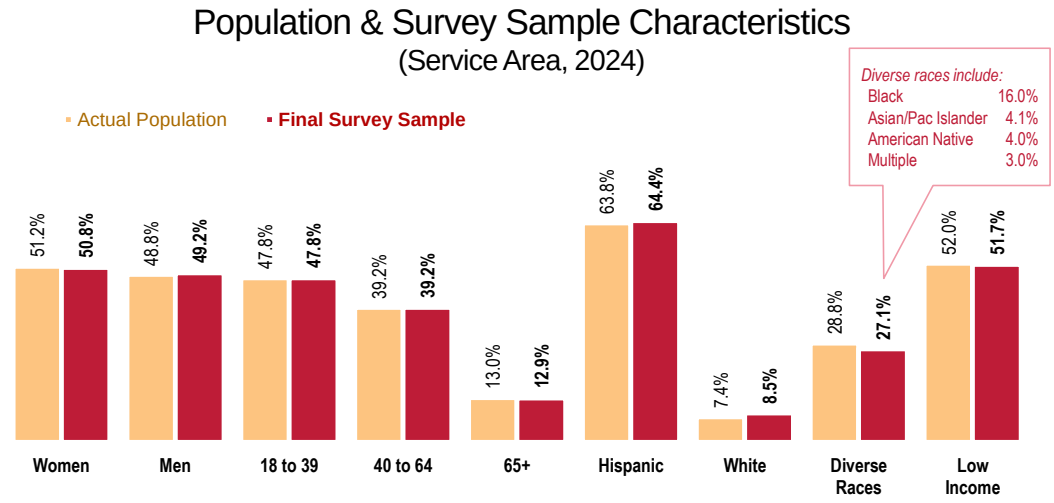
The sample design used for this effort consisted of a random sample of 200 individuals age 18 and older in the service area. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the service area as a whole. All administration 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 200 respondents is ±6.9% 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.

The following chart outlines the characteristics of the service area 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, 2016-2020 American Community Survey.
- 2024 PRC Community Health Survey, PRC, Inc.

Notes:
- "Low Income" reflects those living under 200% of the federal poverty level, based on guidelines established by the US Department of Health & Human Services.
- All Hispanic respondents are grouped, regardless of identity with any other race group. Race reflects those who identify with a single race category, without Hispanic origin. "Diverse Races" includes those who identify as Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian/Pacific Islander, or as being of multiple races, without Hispanic origin.

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.

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 November/December 2024 as part of this process. A list of recommended participants was provided by California Hospital Medical Center; this list included names and contact information for physicians, public health representatives, other health professionals, social services 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, 62 community representatives took part in the Online Key Informant Survey, as outlined in the table that follows:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Physicians	4
Public Health Representatives	11
Other Health Providers	2
Social Services Providers	20
Other Community Leaders	25

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

- African-American Elderly Women
- African-American Women Domestic Violence Survivors
- African-American Women Who are Being Trafficked
- African-American Women Who are Pregnant
- African-American Women With Mental Health Issues
- African-Americans
- All Populations
- Asians
- At-Risk Youth
- BIPOC
- Children in Dysfunctional Families
- Children With Special Needs
- Disabled
- Elderly
- Hispanics
- Homeless
- Immigrants/Refugees
- LGBTQIA+
- Low Income
- Low-Income Children
- Low-Income Elderly
- Low-Income Immigrants
- Low-Income With a Language Barrier
- Medicare/Medicaid/Medi-Cal Patients
- People of Color
- Survivors of Domestic Violence
- Those Who are Monolingual
- Those Who Have Been Trafficked
- Those Who Lack Access to Resources
- Those With a Language Barrier
- Those With Mental Health Issues
- Those With Substance Use Issues
- Undocumented
- Uneducated/Undereducated
- Uninsured/Underinsured
- Veterans
- White
- Women

Final participation included representatives of the organizations outlined below.

- 1010 Development Corporation
- Bienestar
- California Health Collaborative - Every Woman Counts
- California Hospital Medical Center
- Cancer Support Community Los Angeles
- Catholic Charities of Los Angeles, Inc.
- Children's Institute
- Citizens Business Bank
- Claris Health
- Create Now
- District 65
- Downtown Women's Center
- East Side Riders Bike Club, Watts Leadership Institute Affiliate
- Eisner Health
- El Nido Family Centers
- Gastroenterology Group L.A.
- Housing Works
- Iris Cantor UCLA Women's Health Center

- Journey Out
- Koreatown Youth and Community Center
- Los Angeles Center for Ear, Nose, Throat and Allergy
- Los Angeles County Department of Public Health
- Maternal and Child Health Access
- MLK Community Healthcare
- National Health Foundation
- New Haven
- Para Los Ninos
- Safe Parking LA
- Streets Are For Everyone (SAFE)
- SHIELDS for Families
- SISTAHFRIENDS
- South Park Neighborhood Association
- Southern California Crossroads
- Southside Coalition of Community Health Centers
- St. Francis Center
- St. John's Community Health
- St. John's Well Child and Family Center
- The Salvation Army
- To Help Everyone Health and Wellness Centers
- UCLA Luskin Social Justice Research Partnership, Watts Leadership Institute
- USC
- USC Street Medicine Team
- Vision y Compromiso
- Voices of Impact
- Watts Healthcare Corporation
- Wellnest
- Worksite Wellness LA
- YouthBuild Charter School of California

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.

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 service area and Los Angeles County were obtained from the following sources (specific citations are included with the graphs throughout this report):

- 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, National Center for Health Statistics
- National Cancer Institute, State Cancer Profiles
- 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 secondary data (as noted) reflect county-level data.

Benchmark Comparisons

California 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. For other indicators, these draw from vital statistics, census, and other existing data sources.

National Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2023 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 findings (from various existing resources) are also provided for comparison of secondary data indicators.

Healthy People 2030 Objectives

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.

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 receiving feedback from individuals and organizations and input from subject matter experts, the US 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, LGBTQ+ residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — while included in the overall findings, might not be individually identifiable or might not comprise a large-enough sample 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

California Hospital Medical Center invited written comments on the most recent CHNA report and Implementation Strategy both in the documents and on the website where they are widely available to the public. No written comments have been received.

SUMMARY OF FINDINGS

Summary Tables: Comparisons With Benchmark Data

Reading the Summary Tables

- In the following tables, service area results are shown in the larger, gray column.
- The columns to the right of the service area column provide comparisons between local data and any available state and national findings, and Healthy People 2030 objectives. Symbols indicate whether the service area 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.

SOCIAL DETERMINANTS	Service Area	SERVICE AREA vs. BENCHMARKS		
		vs. CA	vs. US	vs. HP2030
Linguistically Isolated Population (Percent)	**16.1**	🌧 7.2	🌧 3.9	
Population in Poverty (Percent)	**21.8**	🌧 12.1	🌧 12.5	🌧 8.0
Children in Poverty (Percent)	**30.3**	🌧 15.6	🌧 16.7	🌧 8.0
No High School Diploma (Age 25+, Percent)	**34.2**	🌧 15.6	🌧 10.9	
Unemployment Rate (Age 16+, Percent)	**5.8**	🌥 5.3	🌧 4.0	
% Unable to Pay Cash for a $400 Emergency Expense	**41.5**		🌧 34.0	

% Worry/Stress Over Rent/Mortgage in Past Year	**54.0**		45.8	
% Unhealthy/Unsafe Housing Conditions	**26.1**		16.4	
Population With Low Food Access (Geographically Far From a Grocery Store, Percent)	**1.0**	13.3	22.2	
% Food Insecure	**59.3**		43.3	
% Feel Racially Discriminated Against in Health Care Settings	**22.0**			
% "Often" Lack Companionship	**14.3**		15.5	
% Spend Time in Area Greenspaces Less Than Monthly	**40.1**			
		better	similar	worse

OVERALL HEALTH	Service Area	SERVICE AREA vs. BENCHMARKS		
		vs. CA	vs. US	vs. HP2030
% "Fair/Poor" Overall Health	**18.2**	20.8	15.7	
		better	similar	worse

ACCESS TO HEALTH CARE	Service Area	SERVICE AREA vs. BENCHMARKS		
		vs. CA	vs. US	vs. HP2030
% [Age 18-64] Lack Health Insurance	**12.3**	8.9	8.1	7.6
% Difficulty Accessing Health Care in Past Year (Composite)	**54.0**		52.5	
% Cost Prevented Physician Visit in Past Year	**22.8**	10.7	21.6	
% Cost Prevented Getting Prescription in Past Year	**19.6**		20.2	
% Difficulty Getting Appointment in Past Year	**28.5**		33.4	

ACCESS TO HEALTH CARE (continued)	Service Area	SERVICE AREA vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
% Difficulty Finding Physician in Past Year	**25.3**			
% Inconvenient Hrs Prevented Dr Visit in Past Year	**29.4**		22.9	
			22.0	
% Transportation Hindered Dr Visit in Past Year	**35.4**		18.3	
% Language/Culture Prevented Care in Past Year	**14.3**		5.0	
% Stretched Prescription to Save Cost in Past Year	**21.1**		19.4	
% Difficulty Getting Child's Health Care in Past Year	**20.7**		11.1	
% Have a Specific Source of Ongoing Care	**61.4**		69.9	84.0
% Routine Checkup in Past Year	**66.9**	74.5	65.3	
% [Child 0-17] Routine Checkup in Past Year	**74.3**		77.5	
% Two or More ER Visits in Past Year	**16.0**		15.6	
% Rate Local Health Care "Fair/Poor"	**17.0**		11.5	
		better	similar	worse

CANCER	Service Area	SERVICE AREA vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
Cancer Deaths per 100,000	**147.4** [County-Level Data]	153.5	182.5	122.7
Lung Cancer Deaths per 100,000	**23.2** [County-Level Data]	26.0	39.8	25.1
Female Breast Cancer Deaths per 100,000	**23.9** [County-Level Data]	23.3	25.1	15.3
Prostate Cancer Deaths per 100,000	**18.2** [County-Level Data]	19.9	20.1	16.9

CANCER (continued)	Service Area	SERVICE AREA vs. BENCHMARKS		
		vs. CA	vs. US	vs. HP2030
Colorectal Cancer Deaths per 100,000	**14.7** [County-Level Data]	14.3	16.3	8.9
Cancer Incidence per 100,000	**367.9**	394.7	442.3	
Lung Cancer Incidence per 100,000	**33.3**	37.6	54.0	
Female Breast Cancer Incidence per 100,000	**117.8**	121.0	127.0	
Prostate Cancer Incidence per 100,000	**89.4**	95.4	110.5	
Colorectal Cancer Incidence per 100,000	**34.2**	33.5	36.5	
% Cancer	**5.5**	9.5	7.4	
% [Women 21-65] Cervical Cancer Screening	**73.9**		75.4	84.3
% [Age 45-75] Colorectal Cancer Screening	**56.4**		71.5	74.4
		better	similar	worse

DIABETES	Service Area	SERVICE AREA vs. BENCHMARKS		
		vs. CA	vs. US	vs. HP2030
Diabetes Deaths per 100,000	**36.2** [County-Level Data]	29.4	30.5	
% Diabetes/High Blood Sugar	**18.9**	11.5	12.8	
% Borderline/Pre-Diabetes	**9.5**		15.0	
Kidney Disease Deaths per 100,000	**16.6** [County-Level Data]	12.4	16.9	
		better	similar	worse

DISABLING CONDITIONS	Service Area	SERVICE AREA vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
% 3+ Chronic Conditions	**33.8**		38.0	
% Activity Limitations	**25.9**		27.5	
% High-Impact Chronic Pain	**17.9**		19.6	6.4
Alzheimer's Disease Deaths per 100,000	**47.6** [County-Level Data]	43.5	35.8	
% Caregiver to a Friend/Family Member	**27.3**		22.8	
		better	similar	worse

HEART DISEASE & STROKE	Service Area	SERVICE AREA vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
Heart Disease Deaths per 100,000	**175.8** [County-Level Data]	168.0	209.5	127.4
% Heart Disease	**8.7**	5.2	10.3	
Stroke Deaths per 100,000	**40.4** [County-Level Data]	46.9	49.3	33.4
% Stroke	**2.3**	2.9	5.4	
% High Blood Pressure	**38.1**	30.6	40.4	42.6
% High Cholesterol	**28.8**		32.4	
% 1+ Cardiovascular Risk Factor	**87.9**		87.8	
		better	similar	worse

INFANT HEALTH & FAMILY PLANNING	Service Area	SERVICE AREA vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
No Prenatal Care in First Trimester (Percent of Births)	**14.1** [County-Level Data]	14.8	22.3	
Teen Births per 1,000 Females 15-19	**12.1**	12.7	16.6	
Low Birthweight (Percent of Births)	**7.4**	7.1	8.3	
Infant Deaths per 1,000 Births	**3.9** [County-Level Data]	4.0	5.5	5.0
		better	similar	worse

INJURY & VIOLENCE	Service Area	SERVICE AREA vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
Unintentional Injury Deaths per 100,000	**44.8** [County-Level Data]	53.8	67.8	43.2
Motor Vehicle Crash Deaths per 100,000	**11.0** [County-Level Data]	12.3	13.3	10.1
Homicide Deaths per 100,000	**7.5** [County-Level Data]	6.0	7.6	5.5
% Victim of Violent Crime in Past 5 Years	**17.8**		7.0	
% Victim of Gang Violence in Past 5 Years	**8.2**			
% Victim of Gunshot Wound	**4.6**			
% Victim of Intimate Partner Violence	**22.2**		20.3	
% Forced Into Sexual Activity	**6.9**			
		better	similar	worse

MENTAL HEALTH	Service Area	SERVICE AREA vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
% "Fair/Poor" Mental Health	**24.8**		24.4	
% Diagnosed Depression	**24.9**	17.0	30.8	
% Symptoms of Chronic Depression	**50.5**		46.7	
% Typical Day Is "Extremely/Very" Stressful	**22.2**		21.1	
Suicide Deaths per 100,000	**8.8** [County-Level Data]	10.8	14.7	12.8
Mental Health Providers per 100,000	**445.9**	449.8	313.6	
% Receiving Mental Health Treatment	**23.9**		21.9	
% Unable to Get Mental Health Services in Past Year	**16.2**		13.2	
		better	similar	worse

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	Service Area	SERVICE AREA vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
% "Very/Somewhat" Difficult to Buy Fresh Produce	**31.1**		30.0	
% No Leisure-Time Physical Activity	**24.9**	22.9	30.2	21.8
% Meet Physical Activity Guidelines	**34.0**	30.1	30.3	29.7
% [Child 2-17] Physically Active 1+ Hours per Day	**22.6**		27.4	
% Overweight (BMI 25+)	**61.5**	64.0	63.3	
% Obese (BMI 30+)	**39.4**	27.7	33.9	36.0

NUTRITION, PHYSICAL ACTIVITY & WEIGHT (continued)	Service Area	SERVICE AREA vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
% [Child 5-17] Overweight (85th Percentile)	**33.5**		31.8	
% [Child 5-17] Obese (95th Percentile)	**27.4**		19.5	15.5
		better	similar	worse

ORAL HEALTH	Service Area	SERVICE AREA vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
% Have Dental Insurance	**68.6**		72.7	75.0
% Dental Visit in Past Year	**56.3**		56.5	45.0
% [Child 2-17] Dental Visit in Past Year	**70.2**		77.8	45.0
		better	similar	worse

RESPIRATORY DISEASE	Service Area	SERVICE AREA vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
Lung Disease Deaths per 100,000	**26.8** [County-Level Data]	30.2	43.5	
Pneumonia/Influenza Deaths per 100,000	**18.3** [County-Level Data]	12.8	13.4	
% Asthma	**15.1**	8.8	17.9	
% [Child 0-17] Asthma	**14.8**		16.7	
% COPD (Lung Disease)	**7.8**	4.2	11.0	
		better	similar	worse

SEXUAL HEALTH	Service Area	SERVICE AREA vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
HIV Prevalence per 100,000	**611.5**	418.7	386.6	
Chlamydia Incidence per 100,000	**588.5**	493.6	495.0	
Gonorrhea Incidence per 100,000	**291.1**	205.6	194.4	
		better	similar	worse

SUBSTANCE USE	Service Area	SERVICE AREA vs. BENCHMARKS vs. CA	vs. US	vs. HP2030
Alcohol-Induced Deaths per 100,000	**17.4** [County-Level Data]	17.7	15.7	
Cirrhosis/Liver Disease Deaths per 100,000	**18.1** [County-Level Data]	17.2	16.4	10.9
% Excessive Drinking	**25.4**	15.4	34.3	
Unintentional Drug-Induced Deaths per 100,000	**23.3** [County-Level Data]	26.6	29.7	
% Used an Illicit Drug in Past Month	**10.0**		8.4	
% Used a Prescription Opioid in Past Year	**12.6**		15.1	
% Ever Sought Help for Alcohol or Drug Problem	**12.2**		6.8	
% Personally Impacted by Substance Use	**30.6**		45.4	
		better	similar	worse

TOBACCO USE	Service Area	SERVICE AREA vs. BENCHMARKS		
		vs. CA	vs. US	vs. HP2030
% Smoke Cigarettes	**25.0**	8.5	23.9	6.1
% Someone Smokes at Home	**26.9**		17.7	
% Use Vaping Products	**24.7**	5.9	18.5	
		better	similar	worse

Prioritized Description of Significant Community Health Needs

Identification of Significant Health Needs

The following 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 preceding section).

The significant health needs were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); 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 key informants giving input to this process.

Community Feedback on Prioritization

Prioritization of the health needs identified in this assessment (“Areas of Opportunity” above) was determined based on a prioritization exercise conducted among providers and other community leaders (representing a cross-section of community-based agencies and organizations) as part 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:

PRIORITIZED LIST OF SIGNIFICANT HEALTH NEEDS

Priority	Significant Health Need	Key Supporting Evidence
#1	MENTAL HEALTH	▪ Key Informants: *Mental Health* ranked as a top concern.
#2	SOCIAL DETERMINANTS: HOUSING	▪ Housing Insecurity ▪ Housing Conditions ▪ Lack of Financial Resilience ▪ Key Informants: *Social Determinants of Health (including Housing)* ranked as a top concern.
#3	DIABETES	▪ Diabetes Deaths ▪ Diabetes Prevalence ▪ Key Informants: *Diabetes* ranked as a top concern.
#4	INJURY & VIOLENCE	▪ Violent Crime Experience ▪ Key Informants: *Injury & Violence* ranked as a top concern.
#5	SUBSTANCE USE	▪ Key Informants: *Substance Use* ranked as a top concern.
#6	NUTRITION, PHYSICAL ACTIVITY & WEIGHT	▪ Food Insecurity ▪ Overweight & Obesity [Adults & Children] ▪ Key Informants: *Nutrition, Physical Activity & Weight* ranked as a top concern.
#7	ACCESS TO HEALTH CARE SERVICES	▪ Barriers to Access – Lack of Transportation – Culture/Language ▪ Difficulty Accessing Children's Health Care ▪ Lack of Financial Resilience ▪ Specific Source of Ongoing Medical Care ▪ Key Informants: *Access to Health Care Services* ranked as a top concern.

Other health needs identified in this assessment include:

- CANCER
- DISABLING CONDITIONS
- HEART DISEASE & STROKE
- RESPIRATORY DISEASE
- SEXUAL HEALTH
- TOBACCO USE

Hospital Implementation Strategy

California 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.

COMMUNITY DESCRIPTION

DEMOGRAPHIC SUMMARY

The hospital service area, the focus of this Community Health Needs Assessment, is an urban area in and around downtown Los Angeles that houses a total population of 1,822,453 residents, according to latest census estimates.

Note the following demographic makeup of our community.

Core Demographic Summary

	Service Area
Urbanization	Urban
Total Population Size	1,822,453
Race & Ethnicity — *Hispanic*	67.3%
Black	16.1%
Asian	7.1%
White	6.8%
American Indian or Alaska Native	0.2%
Native Hawaiian/Pacific Islander	0.1%
Average Household Income	$84,783
Percent of Population Living in Poverty (Below 100% FPL)	21.4%
Unemployment Rate (December 2024)	5.7%
Percent of People Age 5 and Older Who are Non-English Speaking	34.2%
Percent of People <65 Without Health Insurance	9.4%
Percent of People with Medicaid	52.4%
Health Professional Shortage Areas	Primary Care, Dental Health, Mental Health
Medically Underserved Areas/Populations	Yes
Medically Underserved, Low Income, or Minority Populations	Yes
Number of Other Hospitals Serving the Community	9

SIGNIFICANT HEALTH EVENT: LOS ANGELES FIRES OF 2025

The Los Angeles fires of 2025 will long be remembered as a devastating chapter in California's history. For much of January 2025, following drought conditions, the fires quickly spread due to strong Santa Ana winds, engulfing thousands of acres of land, consuming homes, and forcing mass evacuations. The ferocity of the flames overwhelmed firefighting efforts, despite the deployment of thousands of firefighters, helicopters, and tanker planes. Thick smoke blanketed the city, creating hazardous air quality and prompting public health warnings. The fires not only caused significant property damage but also led to tragic loss of lives and wildlife, further highlighting the dire impacts of climate change.

The data for this assessment were collected prior to, and do not reflect the impact of, these catastrophic fires. However, in a city that is rebuilding, the aftermath of the fires will certainly impact the hospital's work going forward to address our community's health needs.

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.

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.

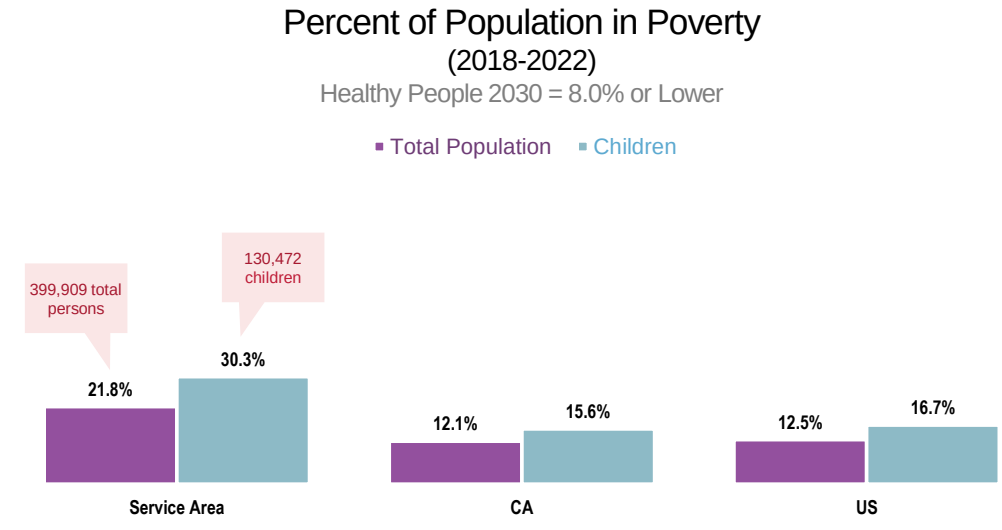
– Healthy People 2030 (https://health.gov/healthypeople)

Income & Poverty

Poverty

Poverty is considered a key driver of health status because it creates barriers to accessing health services, healthy food, and other necessities that contribute to health status.

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



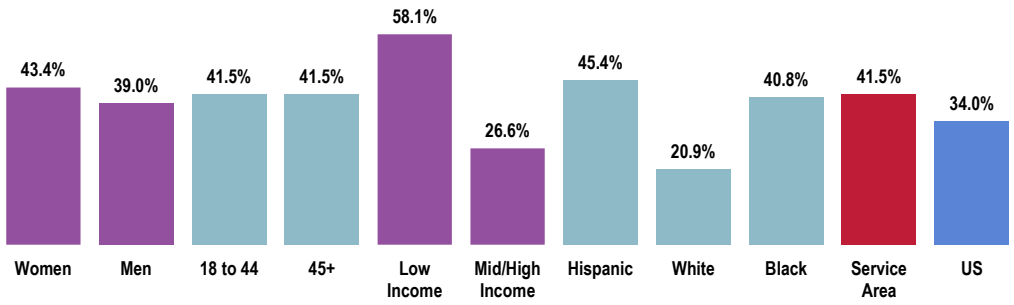
Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Financial Resilience

PRC SURVEY ► "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?"

The following details "no" responses in the service area in comparison to benchmark data, as well as by basic demographic characteristics (such as gender, age groupings, income [based on poverty status], and race/ethnicity).

Do Not Have Cash on Hand to Cover a $400 Emergency Expense
(Service Area, 2024)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 53]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- 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.

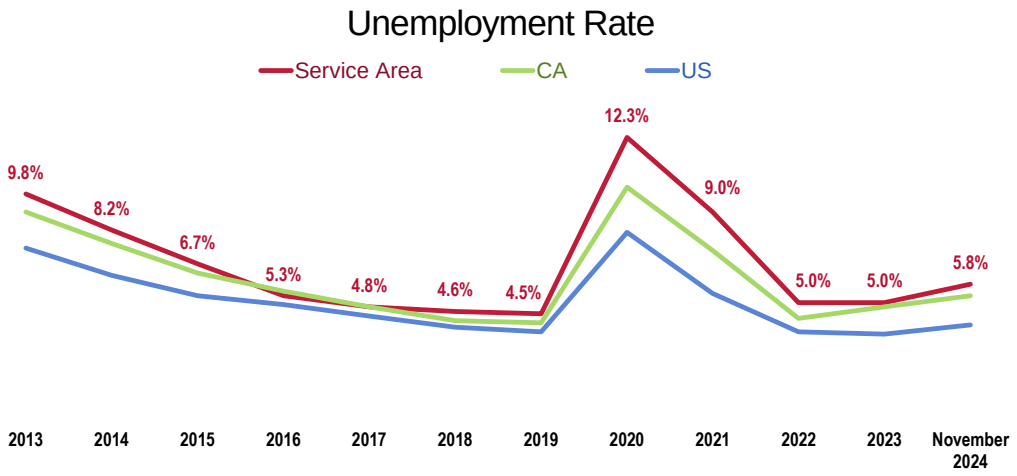
INCOME & RACE/ETHNICITY

INCOME ► Income categories used to segment survey data 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 2023 guidelines place the poverty threshold for a family of four at $30,000 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. Data are also detailed for individuals identifying with a race category, without Hispanic origin. "White" reflects those who identify as White alone, without Hispanic origin. "Black" includes those who identify as Black or African American, without Hispanic origin.

Employment

Note the following trends in unemployment data derived from the US Department of Labor.

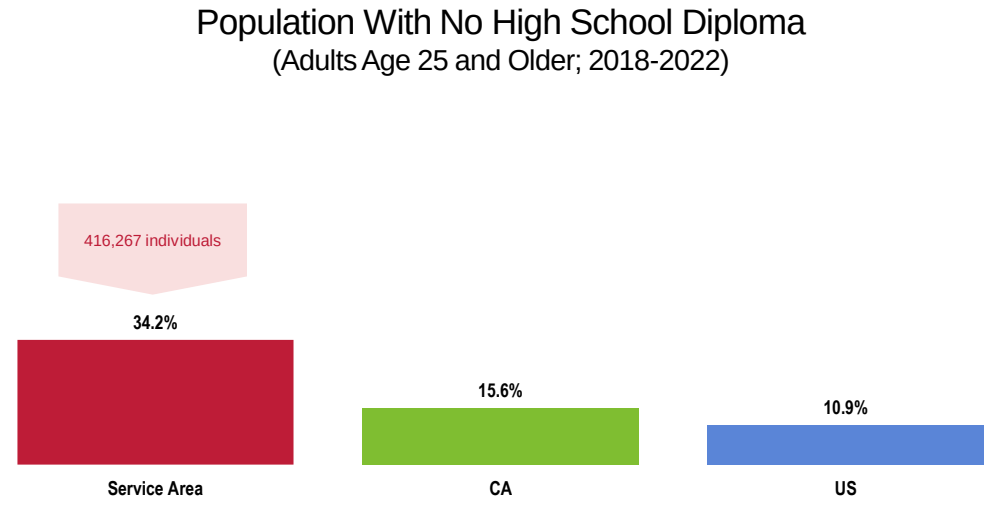


Sources:
- US Department of Labor, Bureau of Labor Statistics.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).

Notes:
- Percent of non-institutionalized population age 16+ who are unemployed (not seasonally adjusted).

Education

Education levels are reflected in the proportion of our population without a high school diploma. This indicator is relevant because educational attainment is linked to positive health outcomes.



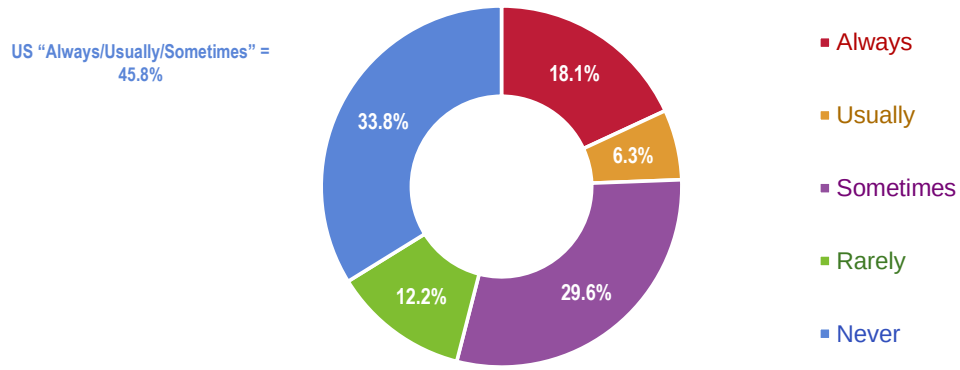
Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).

Housing

Housing Insecurity

PRC SURVEY ► "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
(Service Area, 2024)



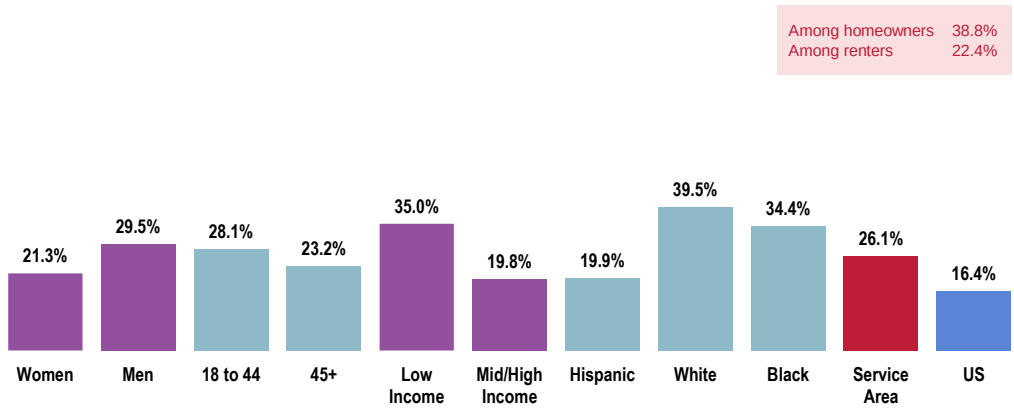
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 56]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Unhealthy or Unsafe Housing

PRC SURVEY ► "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
(Service Area, 2024)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 55]
- 2023 PRC National Health Survey, PRC, Inc.

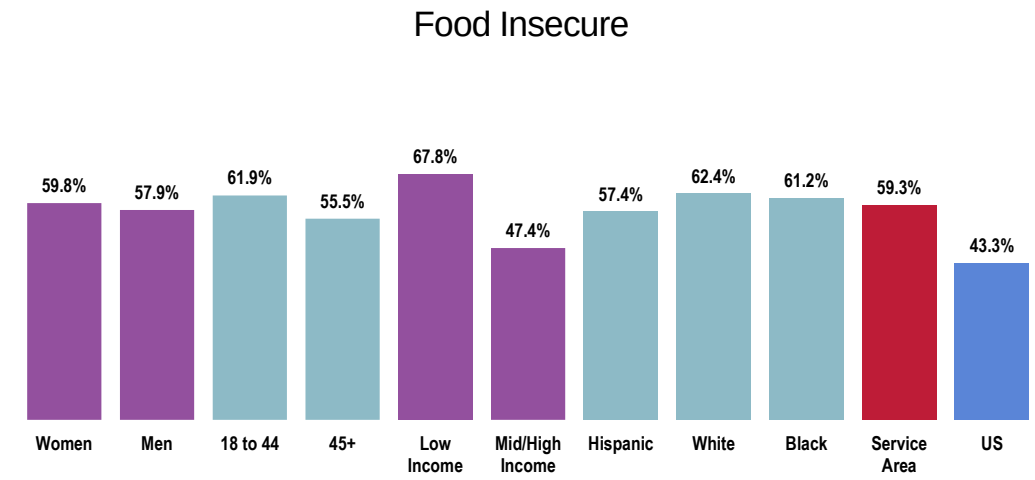
Notes:
- Asked of all respondents.
- Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

Food Insecurity

PRC SURVEY ► "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.

- 'I worried about whether our food would run out before we got money to buy more.'
- '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.

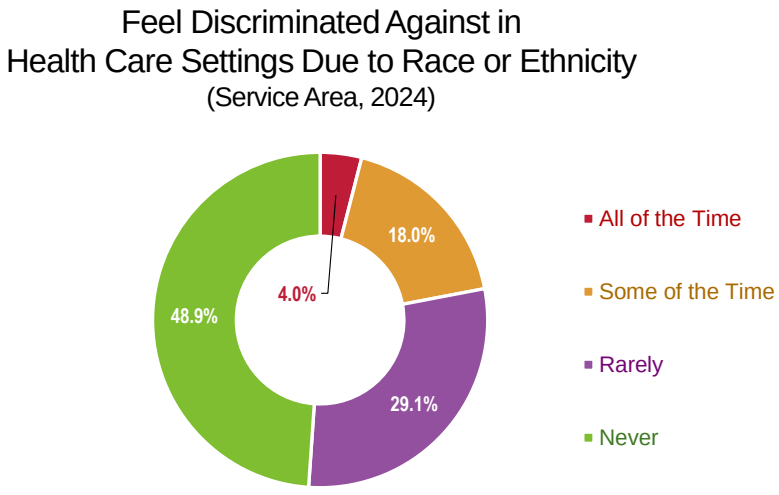


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 98]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- 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.

Experience of Discrimination in Health Care

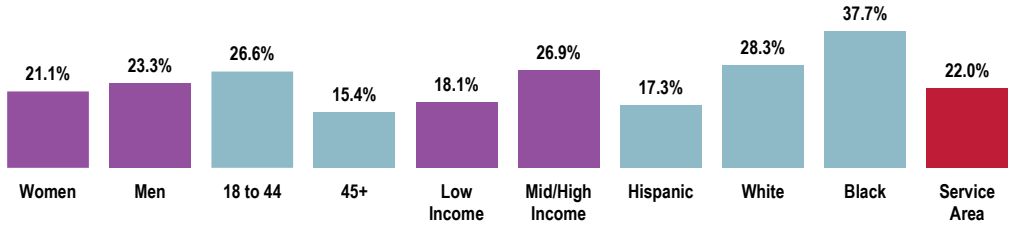
PRC SURVEY ► "In general, within health care settings, how often, if at all, do you feel discriminated against because of your race or ethnicity? Would you say: all of the time, some of the time, rarely, or never?"



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 304]

Notes:
- Asked of all respondents.

Feel Discriminated Against "All/Some of the Time" in Health Care Settings Due to Race or Ethnicity

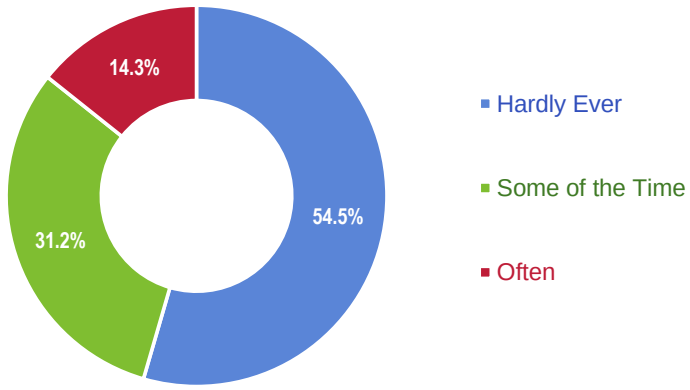


Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 304]
Notes: ● Asked of all respondents.

Loneliness

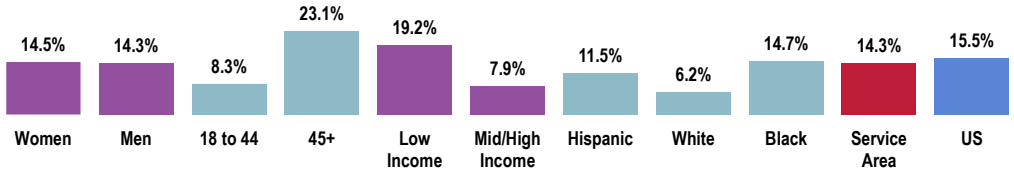
PRC SURVEY ► "How often do you feel that you lack companionship? Would you say: hardly ever, some of the time, or often?"

Feel a Lack of Companionship
(Service Area, 2024)



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 307]
Notes: ● Asked of all respondents.

“Often” Lack Companionship



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 307]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Social Vulnerability Index

Social vulnerability refers to the potential negative effects on communities caused by external stresses on human health. Such stresses include natural or human-caused disasters, or disease outbreaks. Reducing social vulnerability can decrease both human suffering and economic loss.

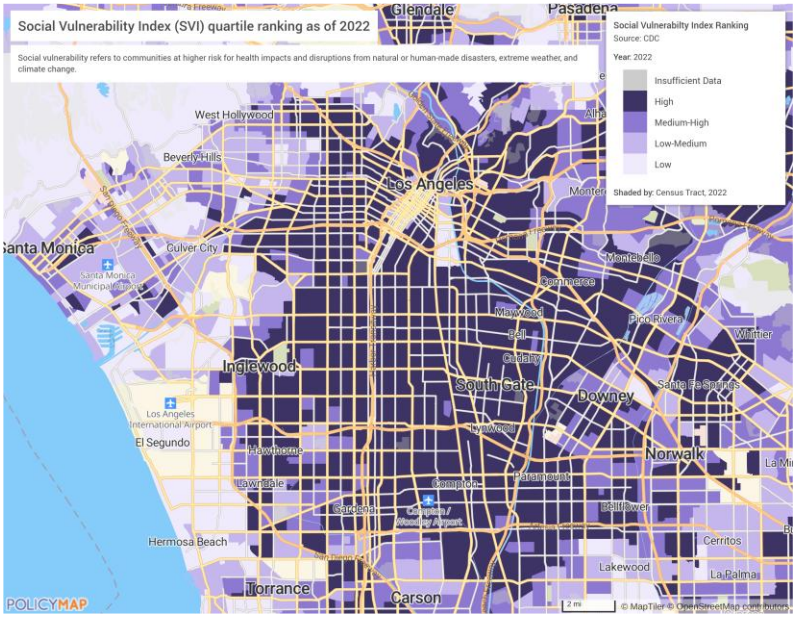
The CDC/ATSDR Social Vulnerability Index (CDC/ATSDR SVI) uses 16 US census variables to help local officials identify communities that may need support before, during, or after disasters.

The degree to which a community exhibits certain social conditions, including high poverty, low percentage of vehicle access, or crowded households, may affect that community’s ability to prevent human suffering and financial loss in the event of disaster. These factors describe a community’s social vulnerability.

The social vulnerability index is a measure of the degree of social vulnerability in counties and neighborhoods across the United States, where a higher score indicates higher vulnerability.

The following illustrates those census tracts in the service area with the highest social vulnerability.

Social Vulnerability



Source: Agency for Toxic Substances and Disease Registry, Centers for Disease Control and Prevention (CDC). Accessed via PolicyMap.

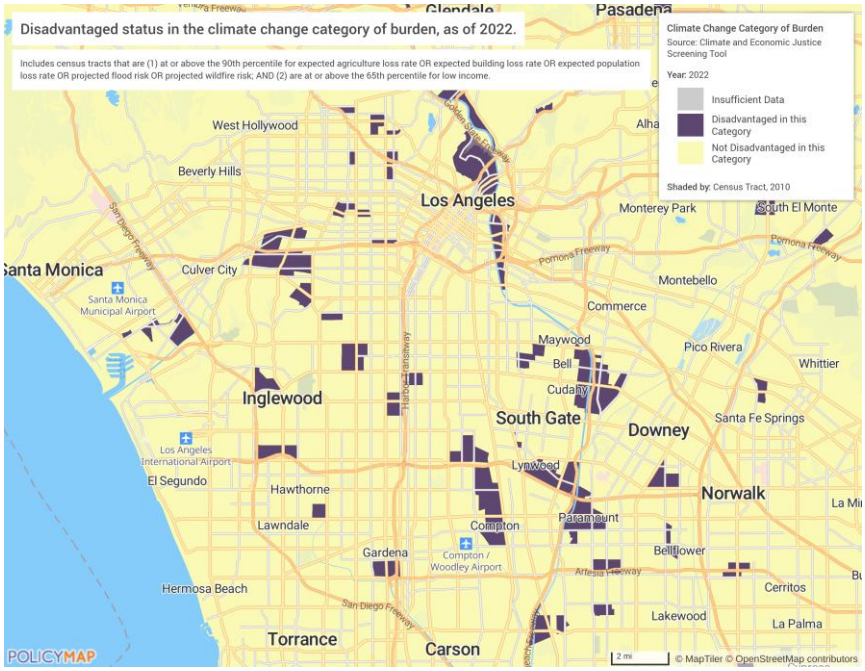
Climate Change Burden

The Climate and Economic Justice Screening Tool (CEJST) was developed by the Council on Environmental Quality to identify disadvantaged communities that face burdens across eight categories: climate change, energy, health, housing, legacy pollution, transportation, water and wastewater, and workforce development. CEJST combines a number of publicly available national datasets to identify disadvantaged communities.

Census tracts are considered disadvantaged if they meet the thresholds for at least one of the CEJST categories of burden or if they are on land within the boundaries of Federally Recognized Tribes. Meeting one of the CEJST categories of burden requires that a tract be at or above specified thresholds for one or more environmental, climate, housing, health or other burdens and be at or above the threshold for an associated socioeconomic burden (e.g., low income or low educational attainment). Additionally, a census tract that is completely surrounded by disadvantaged communities and is at or above the 50th percentile for low income is also considered disadvantaged.

The following illustrates those census tracts in the service area with the highest burden relative to climate change.

Disadvantaged Status for Climate Change Category of Burden

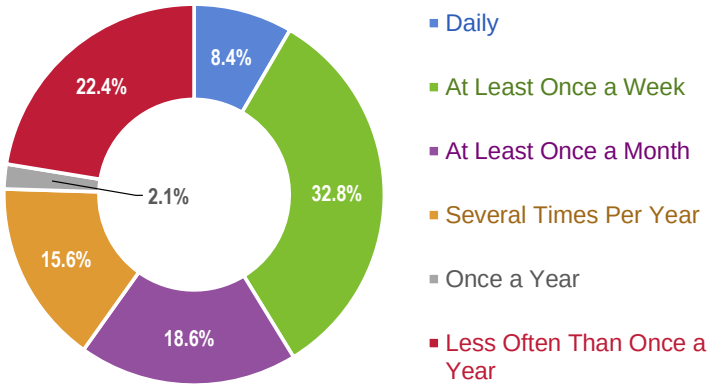


Source: Council on Environmental Quality, Climate and Economic Justice Screening Tool (CEJST). Accessed via PolicyMap.

Greenspaces

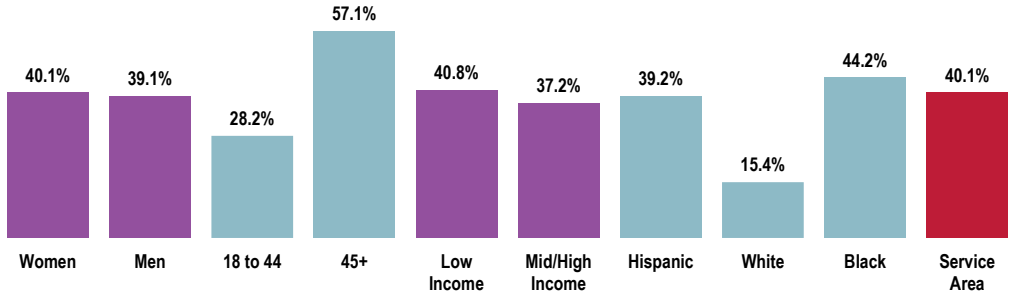
PRC SURVEY ► "How often do you spend time in nature, parks, or greenspaces in your area? Would you say: daily, at least once a week, at least once a month, several times per year, once a year, or less often?"

Time Spent Locally in Nature, Parks, or Greenspaces
(Service Area, 2024)



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 306]
Notes: ● Asked of all respondents.

Spend Time Less Than Monthly in Local Nature, Parks, or Greenspaces

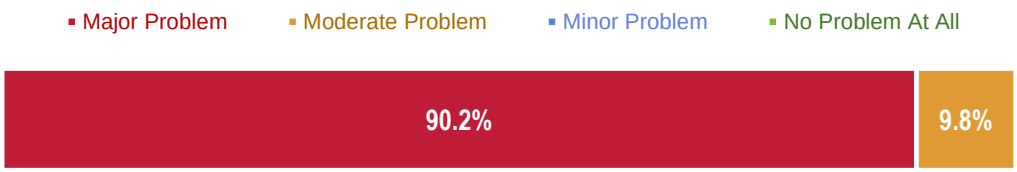


Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 306]
Notes: ● Asked of all respondents.

Key Informant Input: Social Determinants of Health

The following chart outlines key informants' perceptions of the severity of *Social Determinants of Health (including Housing)* as a problem in the community:

Perceptions of Social Determinants of Health as a Problem in the Community
(Among Key Informants; Service Area, 2024)



Sources: ● 2024 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:

Housing

> Lack of affordable housing, developer buyout of local community, unsafe environment for children and families (unsafe due to community violence, physical condition, and environmental conditions), historical impact of redlining in low-income communities. – Public Health Representative
>
> Los Angeles in general has an affordable housing crisis. The income needed to live in LA County is completely unattainable for most people. Lack of education makes it even more difficult to obtain a high-paying job. The stress of these factors has many health implications. – Social Services Provider
>
> Low-income families saving money on rent by sharing dwellings with families. No space in dwelling for activity. Lack of knowledge and advocacy for environmental toxins from encroaching factories on residences. Lack of green space. – Community Leader
>
> There is rent increase where people may not afford to live there anymore. Income plays a part where only one person in the household works or works part time. The environment is also important for the children in the community. Is it clean? Is it dirty? Water and air are also important. – Social Services Provider
>
> Housing is the number-one problem – rent too high, low-income housing too scarce, no interest in making the majority of new housing affordable. Food insecurity is high and the cost of food is high – benefits are not proactively offered, like CalFresh for newborns. – Social Services Provider
>
> Housing instability, inflow into homelessness, and homelessness itself are profound issues that exacerbate health disparities. It is the worst in the country! – Community Leader
>
> Housing is a major problem – the lack of affordable or low-income housing. There are people who are undocumented and do not have a job to be able to afford basic needs. – Social Services Provider
>
> Lack of housing, lack of well-paying jobs, clinical services don't always meet community needs (there are too few hours when folks can attend). Where you live influences the access you have, your income determines the type of care you can afford, the type of housing you have can impact illness (air conditioning, heat stroke, mold, uninsulated, unsafe location), where you live influences your access to good schools (in areas with taxes that fund those schools). – Community Leader

Income/Poverty

> Very much so – many people have life experiences of poverty, emotional issues, housing, education that they do not have the support to overcome and grow. These life experiences are barriers to personal development – then leading to not addressing health issues, mental health, education, and then impacting their financial well-being. – Social Services Provider
>
> A large part of the community lives in poverty, and they face discrimination on a daily basis. – Community Leader
>
> Social determinants of health are a major problem in our community because systemic barriers such as poverty, housing instability, limited access to health care and education, and discrimination directly impact the well-being of our unhoused guests, low-income families, and immigrant populations. These factors create a cycle of inequity where individuals and families struggle to meet their basic needs, making it nearly impossible to prioritize their health and well-being. For our unhoused population, the lack of stable housing exacerbates issues related to physical and mental health, nutrition, and consistent access to care. Similarly, immigrant families in our community face unique challenges, including language barriers, lack of familiarity with health care systems, fear of seeking assistance due to immigration status, and limited access to employment opportunities that provide health insurance or financial stability. Many immigrants also face cultural stigmas around seeking medical care. – Community Leader
>
> Low-income community, immigration status, too many unhoused individuals. – Community Leader

Unhoused Population

> South LA has the highest rates of homelessness, lowest income, lowest educational attainment, disproportionately impacted by environmental pollutants (particularly oil refineries that are located in South LA or oil drilling that occurs in south LA), lack of parks and green spaces for children and adults to get healthy exercise, and high rates of food insecurity resulting in low birth rates, prenatal death, and chronic health conditions. – Community Leader
>
> I think it’s been covered, but homelessness. – Community Leader
>
> Homelessness. This is a health issue because the main drivers of chronic homelessness are health-related. They can really only be reached well by street medicine, which needs to be expanded. – Physician
>
> The unhoused are living on the streets or in temporary housing. They also don’t have access to healthy meals or, in many cases, any meals. – Community Leader
>
> These factors impact all aspects of our community. The biggest problem is the number of homeless people in DTLA. – Social Services Provider
>
> High rate of homelessness. – Social Services Provider

Incidence/Prevalence

> There is such a disparity of care for the individuals in our community, causing people to not have the equal amount of opportunities. – Community Leader

> Community statistics and firsthand observation/knowledge based on community members served by my organization. – Social Services Provider

Access to Care/Services

> Our community lacks access to much-needed services in order to access and receive appropriate care, including: transportation, housing, medication education, health literacy, health insurance, food access, interpersonal safety, utility difficulties. – Public Health Representative

> If the child cannot access proper health care and in a timely manner, it gets put off like so many other things in their life, and then they more easily slip through the cracks. – Social Services Provider

Immigrant Population

> The current anti-immigrant environment is affecting LA residents' mental health, and many are already hesitant to enroll in health programs, which prevents them from seeking services. – Public Health Representative

> Most families in the area are low-income immigrants working in the local factories or as day laborers. They cannot afford quality housing, etc. Additionally, these have only been getting more expensive with the gentrification in the area. There are families living four families to an apartment just to make ends meet. These conditions exacerbate all the other social determinants, including lower quality schools, lack of job opportunities, etc. – Social Services Provider

Impact on Quality of Life

> They shape who we are and what we do. – Social Services Provider

> They are a factor in the health and well-being of the community. – Public Health Professional

Access to Affordable Healthy Food

> Access to healthy food options; LA does not have a right-to-shelter mandate; higher level of community members under FPL. – Community Leader

Generational

> We are in a cycle of poor health because of generational issues that have prevented communities from improving their health. Education, environment, immigration, mental health, etc. ... all play a part in our ongoing concern about how these social determinants are influencing our communities' health. – Community Leader

Lack of Equity

> There is no equity in the community, which continues to contribute to adverse experiences for people personally and in the community as a whole. – Community Leader

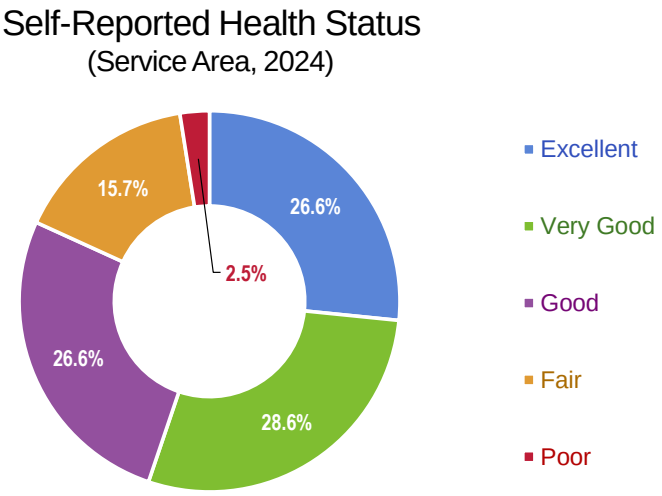
People With Vulnerabilities

> They impact all vulnerable populations but aren't funded. It's a population health problem for the whole community, but the responsibility has been given to health plans who are only concerned about their members, not the community. – Physician

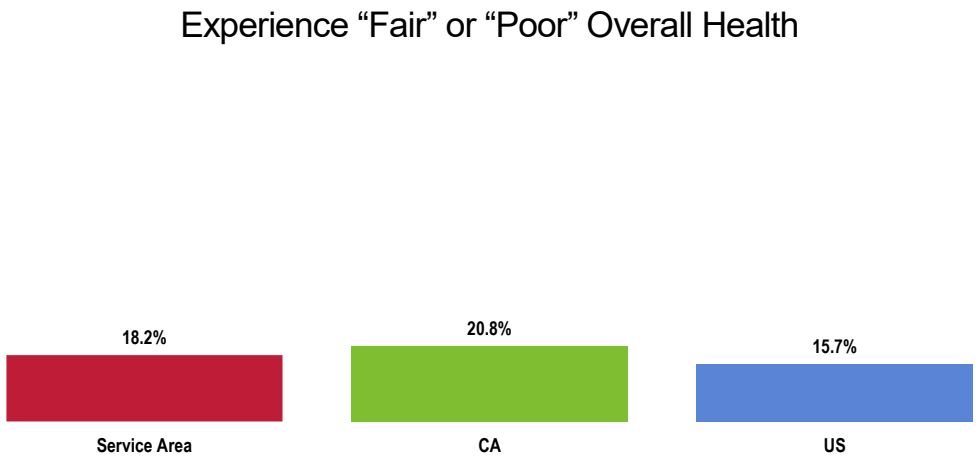
HEALTH STATUS

Overall Health

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

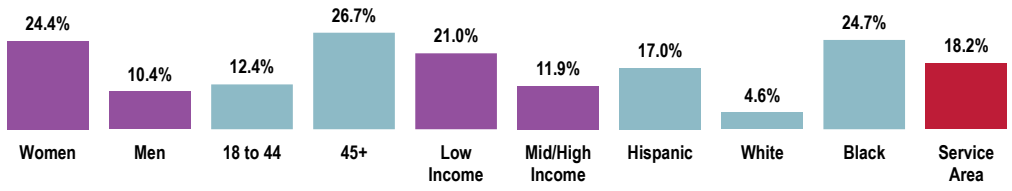


Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 4]
Notes: ● Asked of all respondents.



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 4]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 California data.
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Experience “Fair” or “Poor” Overall Health
(Service Area, 2024)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 4]
Notes: • Asked of all respondents.

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.

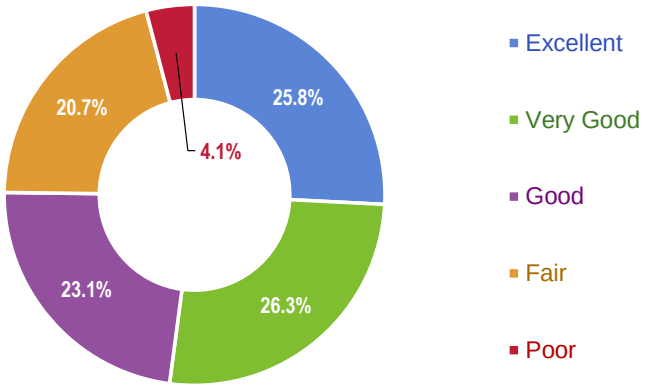
In addition, mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people’s ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders. Increasing screening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

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

Mental Health Status

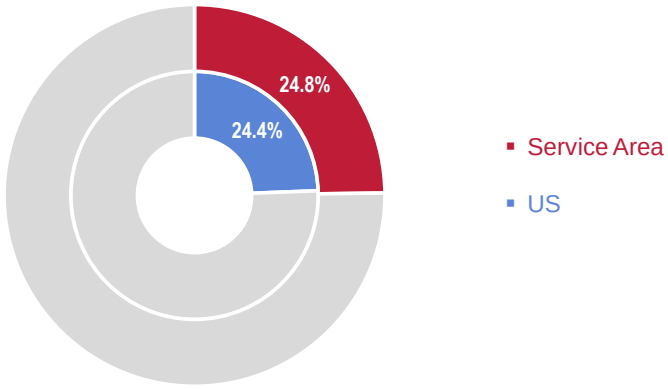
PRC SURVEY ► “Now thinking about your mental health, which includes stress, depression, and problems with emotions, would you say that, in general, your mental health is: excellent, very good, good, fair, or poor?”

Self-Reported Mental Health Status
(Service Area, 2024)



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 77]
Notes: ● Asked of all respondents.

Experience "Fair" or "Poor" Mental Health



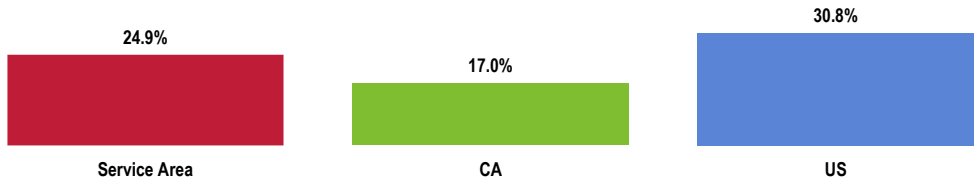
Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 77]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Depression

Diagnosed Depression

PRC SURVEY ► "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



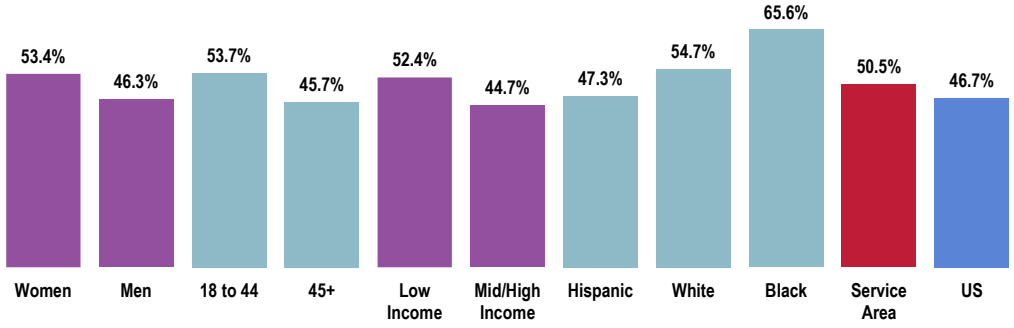
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 80]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 California data.
- 2023 PRC National Health Survey, PRC, Inc.

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

Symptoms of Chronic Depression

PRC SURVEY ► "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
(Service Area, 2024)

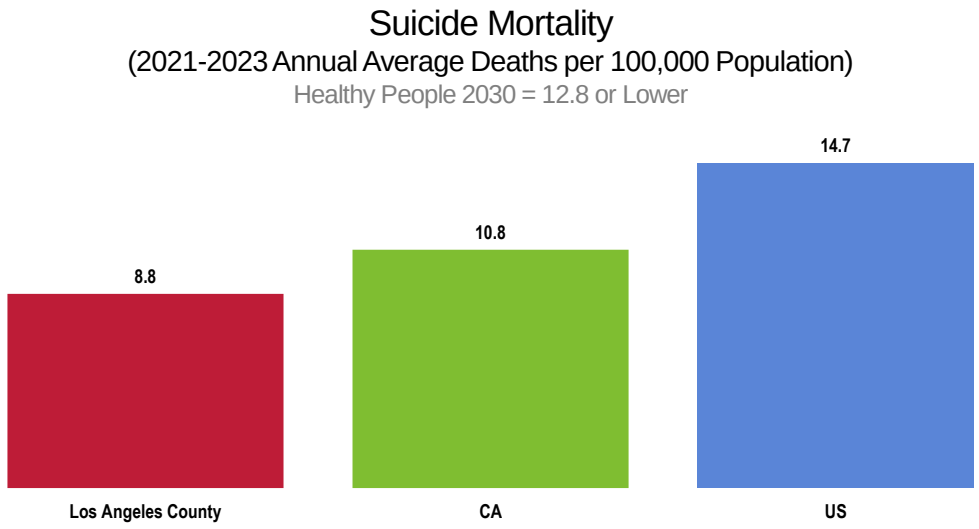


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 78]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- 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.

Suicide

The following chart outlines the most current mortality rates attributed to suicide in our population. [COUNTY-LEVEL DATA]



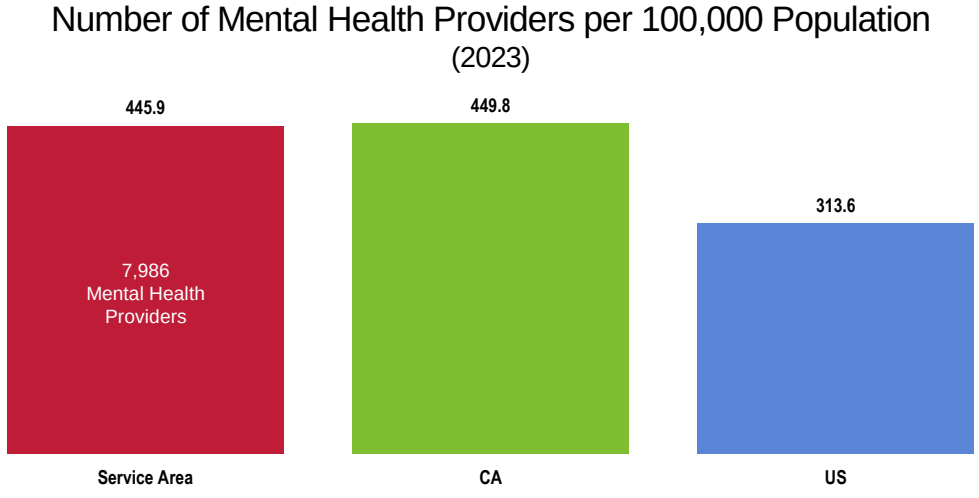
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

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.

Note that this indicator only reflects providers practicing within the study area and residents within the study area; it does not account for the potential demand for services from outside the area, nor the potential availability of providers in surrounding areas.

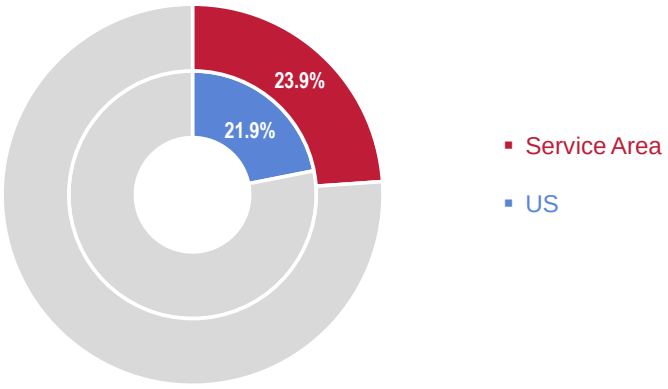


Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).

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

PRC SURVEY ► "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



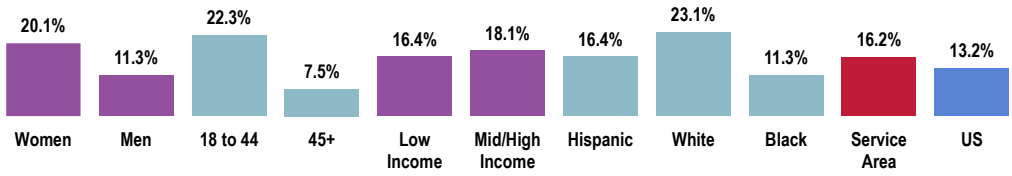
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 81]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes individuals now taking medication or otherwise receiving treatment for any type of mental health condition or emotional problem.

PRC SURVEY ► "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

(Service Area, 2024)

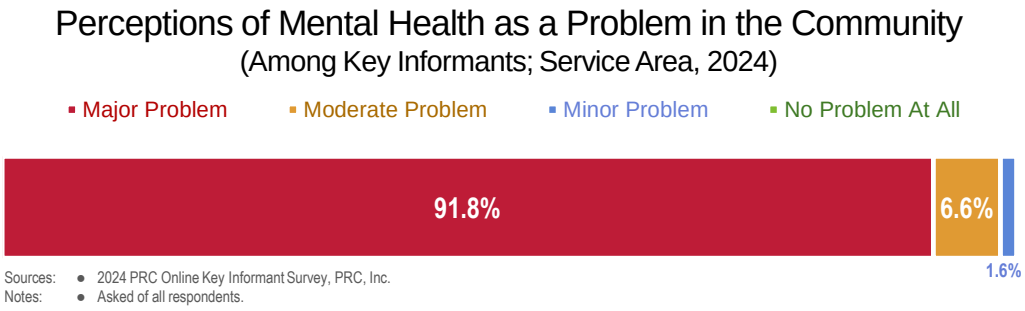


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 82]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Key Informant Input: Mental Health

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



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

Access to Care/Services

> Lack of access to care and timely care. – Public Health Representative
>
> Lack of access to timely mental health diagnosis and treatment. Continued stigma around seeking care. – Social Services Provider
>
> It can be difficult to access mental health services. Many people also don't feel comfortable accessing mental health services. There is also a problem with people self-medicating mental health issues with various substances. – Social Services Provider
>
> Lack of access and awareness. – Community Leader
>
> Access to mental health services. Stigma. – Public Health Professional
>
> Access to caregivers. – Community Leader
>
> Lack of any services or treatment. All we have is very little crisis intervention. – Social Services Provider
>
> Access to mental health services, what are mental health symptoms and ways to get service. – Public Health Professional
>
> Lack of behavioral health resources, such as providers, inpatient beds, and substance abuse disorder clinics. Large concentration of patients experiencing homelessness. – Community Leader
>
> There are almost no resources for those who suffer from mental illness who also do not have the economic means to pay for care. Mental health problems are on the rise, and hospitals are expected to manage these crises; many of which do not have the expertise (i.e. not LPS and does not have a mental/behavioral health unit), nor are hospitals being reimbursed for the breadth of care they provide. – Community Leader
>
> The biggest challenge for people with mental health issues in our community is the lack of consistent and accessible mental health services, compounded by the stigma surrounding mental health. Many of our unhoused guests and extremely low-income families face barriers such as limited financial resources, language obstacles, and insufficient trust in providers, which prevent them from seeking or maintaining mental health care. For our unhoused population, the transient nature of their lives adds another layer of difficulty. They often lack stable contact information or transportation, making follow-up appointments and long-term treatment plans nearly impossible. Additionally, untreated mental health conditions can lead to crises, making it harder for individuals to navigate daily life, seek stable housing, or maintain employment. The absence of immediate, culturally sensitive, and trauma-informed care further exacerbates these challenges, leaving many without the support they need. – Community Leader
>
> Lack of available services, long waiting lists, and extremely limited preventative services that could address these issues prior to needing more intensive services. – Social Services Provider

Denial/Stigma

> Stigma of mental health. We need more education and awareness. – Community Leader
>
> Stigma, that it's OK to talk about and OK to go to therapy. Finding services that are culturally and linguistically appropriate. – Social Services Provider
>
> Stigma, denial, and lack of community resources. – Social Services Provider
>
> The stigma of accessing or requesting mental health services is huge. Also, the lack of available resources inhibit the use of existing programs. – Public Health Representative

Awareness/Education

> Increasing information about mental health means that the stigma is reducing, but it still exists. Some of the challenges include: lack of culturally specific resources, too many people work two or more jobs and do not have time to look for resources or attend treatment. Others think mental health issues are created by doctors to get more money, and there is skepticism that this is a real issue. Once folks realize they have an issue, getting a diagnosis, getting support, countering the attitude "it's just a phase, you'll get out of it," and getting treatment are challenges. There are also language barriers, providers who understand that the cultural approach is important – not all services are relevant to all communities – and providing information in easily accessible ways (that is for them, not for me). Homelessness contributes to mental health (and vice versa). – Community Leader
>
> The biggest challenge is accepting a referral for mental health services. There is a lack of education of people understanding what is mental health illness. – Social Services Provider
>
> Since the pandemic, the cases of mental health issues has risen due to stagnation of socioemotional and cognitive development. There is a need for support in mental health but also sharing with the community that there are services to support growth and development, as issues in mental health require the public acknowledging the effects of isolation and addiction. There are programs there to support, but there is a need to do soft handoffs to these programs. – Community Leader

Unhoused Population

> This is one of the hardest ones. I've done several volunteer times at the mission downtown with the homeless and had this discussion with the directors. Mental health is one of the most difficult issues that I think we have right now because we can't force the person unless we do a 5150 to take any kind of medications or to take care of themselves, so where do we stand? Mental health always seems to be something that's been cut instead of being added. – Other Health Provider
>
> No resources. They are living on the streets. – Social Services Provider
>
> The unhoused are living on the streets or in temporary housing. They also don't have access to healthy meals or, in many cases, any meals. – Community Leader
>
> Being unhoused, unaddressed mental health issues, mixture of substance abuse and all of the other issues listed. – Community Leader

Lack of Providers

> There is not enough mental health help. Many individuals are on waitlists. Also, many folks are not addressing mental health, such as depression, mood disorders, anger issues, etc., due to financial situations, lack of income, and high cost of living. – Social Services Provider
>
> Major shortage of psychiatrists, and many don't take insurance. The homeless need the care the most, but there's almost no street psychiatry. – Physician
>
> Not enough providers, high caseload, lack of quality of care, delayed connections to services, misdiagnosing, debate on conservatorship and personal rights. – Community Leader

Diagnosis/Treatment

> Chronic, reliable care and occupational therapy aim to reinsert mentally ill people into society. – Physician
>
> Most mental health issues are undiagnosed. Most programs are voluntary, so it isn't forced on the community. – Social Services Provider
>
> Untreated mental health and access to timely care. – Public Health Representative

Isolation

> Isolation and lack of social connections. Many people, including immigrants, work many jobs, they don't feel connected in this community, and they don't have time to form strong social networks. Sometimes they live in communities and neighborhoods where they are fearful. Even though they may live in a neighborhood with many apartments, there may also be violence or gangs. Sometimes they are isolated because they are afraid to leave home and can't go out to relax, go for a walk, and interact with other people. For many immigrants, they miss home, familiar food, family, and friends. Sometimes, this leads to anxiety and depression. They also do not have information about local resources or what to do or where to go to help their children or their families. Social media contributes to this feeling of disconnectedness, and the current political climate is also contributing to fear, isolation, and lack of connections. – Community Leader

Access to Care for Uninsured/Underinsured

> The biggest challenge for people with mental health issues in South Los Angeles is affordable mental health for those who do not have Medi-Cal or Medicare and rely on employer insurance coverage. Employer-sponsored insurance companies either have long waiting lists and/or lack mental health professionals that culturally/ethnically represent those who are seeking culturally responsive and appropriate care and speak the preferred language of the client. This requires those seeking mental health to go to private-pay providers, which are very costly for South Los Angeles residents. – Community Leader

Impact on Quality of Life

> My community, I consider the trafficking survivors I assist in Los Angeles and South Los Angeles. PTSD is the most significant issue they deal with. The danger they have experienced has been actual and significant, and they have all the fallout from those situations raging like a storm within them. – Community Leader

Co-Occurrences

> Mental health and coexisting medical conditions. – Physician

Housing

> Not enough housing resources, care, therapists, education, and acceptance. – Community Leader

Incidence/Prevalence

> Experiencing psychosis. – Public Health Professional

Prevention/Screenings

> Screening, understanding mental health, recognizing signs and symptoms, diet, lifestyle, consequences, stigma. – Community Leader

Stress

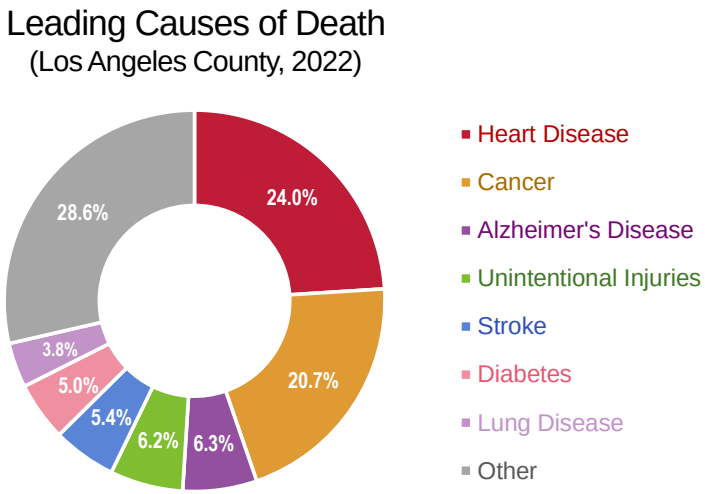
> Clients have identified many stressors in their lives and with their children. – Community Leader

DEATH, DISEASE & CHRONIC CONDITIONS

Leading Causes of Death

Distribution of Deaths by Cause

The following outlines leading causes of death in Los Angeles County.



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2025.

Notes: ● Lung disease includes deaths classified as chronic lower respiratory disease.

Death Rates for Selected Causes

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

Here, deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10). Rates are per 100,000 population.

The following chart outlines annual average death rates per 100,000 population for selected causes of death.

Death Rates for Selected Causes
(2021-2023 Deaths per 100,000 Population)

	Los Angeles County	California	US	Healthy People 2030
Heart Disease	175.8	168.0	209.5	127.4*
Cancers (Malignant Neoplasms)	147.4	153.5	182.5	122.7
Alzheimer's Disease	47.6	43.5	35.8	—
Unintentional Injuries	44.8	53.8	67.8	43.2
Stroke (Cerebrovascular Disease)	40.4	46.9	49.3	33.4
Diabetes	36.2	29.4	30.5	—
Lung Disease (Chronic Lower Respiratory Disease)	26.8	30.2	43.5	—
Unintentional Drug-Induced Deaths	23.3	26.6	29.7	—
Pneumonia/Influenza	18.3	12.8	13.4	—
Cirrhosis/Liver Disease	18.1	17.2	16.4	10.9
Alcohol-Induced Deaths	17.4	17.7	15.7	—
Kidney Disease	16.6	12.4	16.9	—
Motor Vehicle Crashes	11.0	12.3	13.3	10.1
Suicide	8.8	10.8	14.7	12.8
Homicide	7.5	6.0	7.6	5.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople.

Note:
- *The Healthy People 2030 coronary heart disease target is adjusted here to account for all diseases of the heart.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

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)

Heart Disease & Stroke Deaths

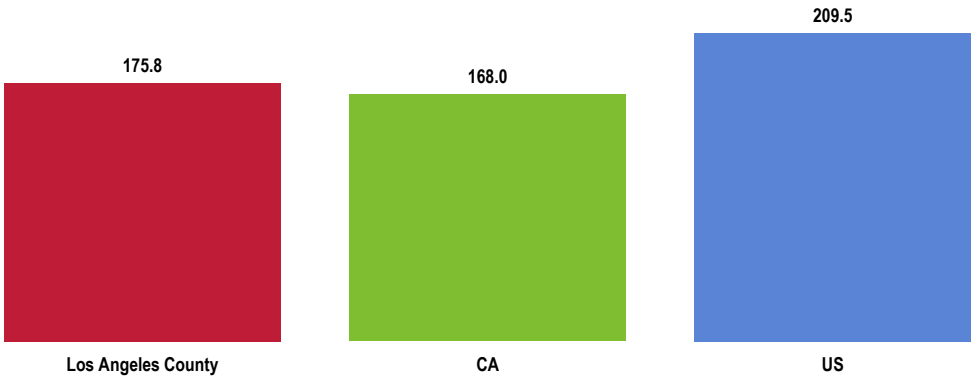
The following charts outline mortality rates for heart disease and for stroke. [COUNTY-LEVEL DATA]

The greatest share of cardiovascular deaths is attributed to heart disease.

Heart Disease Mortality

(2021-2023 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 127.4 or Lower (Adjusted)



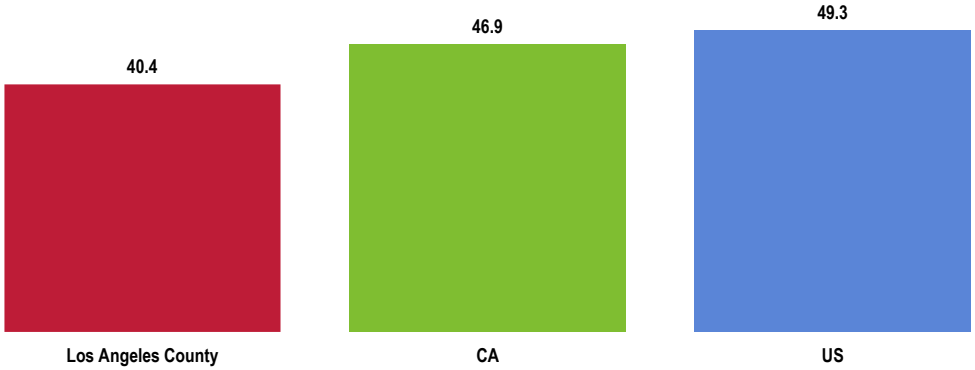
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- The Healthy People 2030 coronary heart disease target is adjusted here to account for all diseases of the heart.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Stroke Mortality

(2021-2023 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower



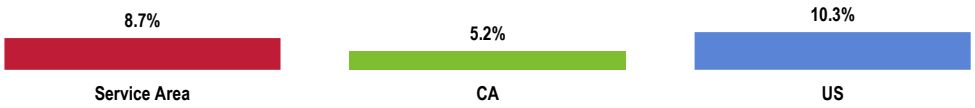
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Prevalence of Heart Disease & Stroke

PRC SURVEY ► "Have you ever suffered from or been diagnosed with heart disease, including heart attack or myocardial infarction, angina, or coronary heart disease?"

Prevalence of Heart Disease

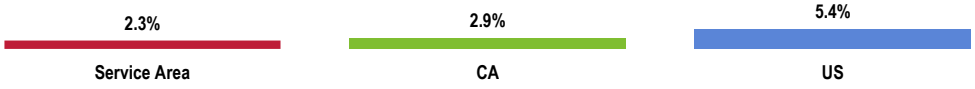


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 22]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 California data.
- 2023 PRC National Health Survey, PRC, Inc.

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

PRC SURVEY ► "Have you ever suffered from or been diagnosed with a stroke?"

Prevalence of Stroke



Sources:
- 2024 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): 2023 California data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

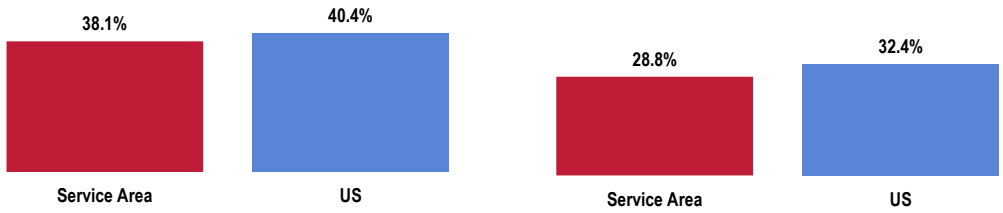
Cardiovascular Risk Factors

Blood Pressure & Cholesterol

PRC SURVEY ► "Have you ever been told by a doctor, nurse, or other health care professional that you had high blood pressure?"

PRC SURVEY ► "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 = 42.6% or Lower



Prevalence of
High Blood Cholesterol

Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Items 29-30]
● 2023 PRC National Health Survey, PRC, Inc.
● US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
Notes: ● Asked of all respondents.

Total Cardiovascular Risk

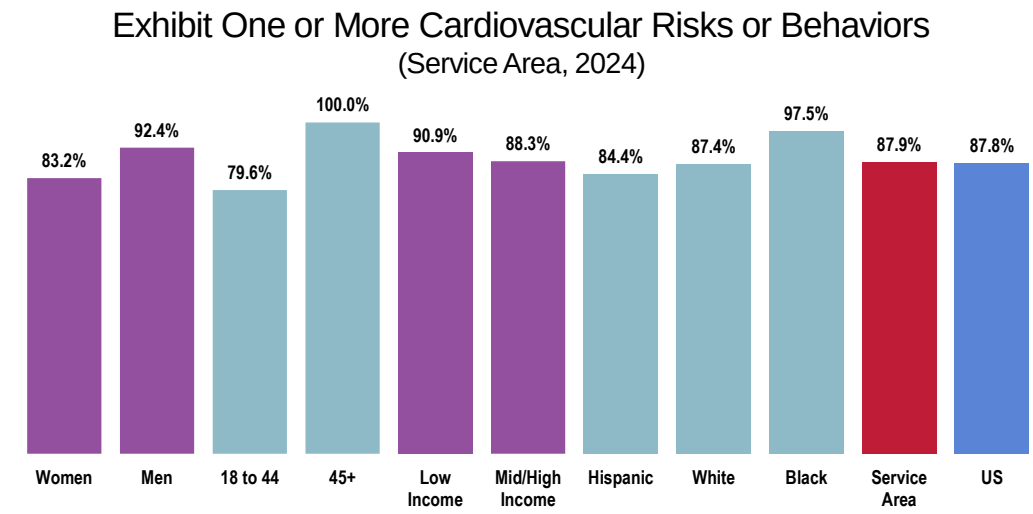
RELATED ISSUE
See also *Nutrition*, *Physical Activity & Weight* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

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.

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

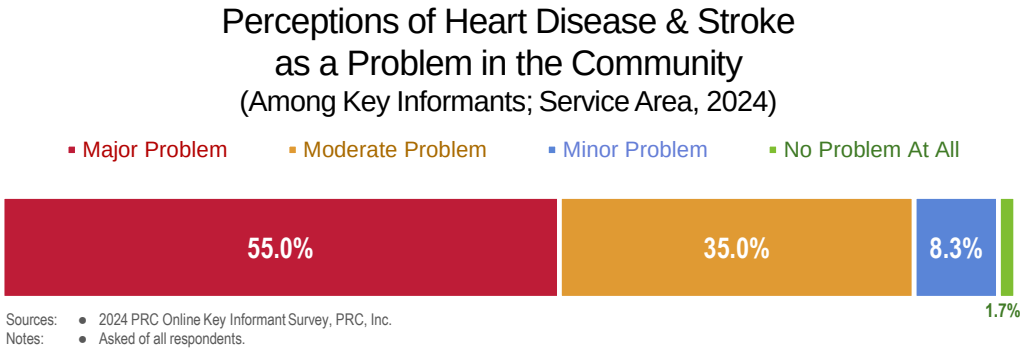


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 100]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Reflects all respondents.
- 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.

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:
- 2024 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

> Emergency rooms at the local community hospital report many. – Community Leader
>
> We have a mobile clinic that goes to many sites in South Los Angeles, and nearly all of the patients we see, regardless of age, are at high risk for heart disease and stroke. Many with dangerously high blood pressure. – Social Services Provider
>
> Increase of cases with younger people and lasting effects on families having to care for disabled members of their family. – Community Leader
>
> Heart disease and stroke are major problems for women overall and more. Nine of 10 women have at least one risk factor for heart disease. Unhealthy lifestyle and diet. Being overweight or obese. Being physically inactive. Having a history of preeclampsia during pregnancy. Age (55 or older for women). – Social Services Provider
>
> Two of the three major health conditions our hospital sees consistently are heart disease and stroke. Many factors contribute to these health problems, ranging from the diversity of our community (being majority Black/African-American and Hispanic/Latino) to the community being in a food desert (more fast food and unhealthy options leading to unhealth food habits). When our community organizations request for us to provide education, the topics are usually heart disease and stroke because that's what our community faces on the daily. – Public Health Representative

Awareness/Education

> Lack of knowledge and education regarding risk reduction and treatment options. – Social Services Provider
>
> I've done some events with the national heart association, and I feel that they need to be more proactive in the community doing events maybe at senior centers and different places to educate at least the senior population. Maybe also schools, where if we start the education early, maybe we can avoid having them have heart disease and stroke. I know it's very prevalent in the Latino community. It's also very prevalent in the Asian community. – Other Health Provider

Nutrition

> Poor food consumption due to high cost of food and living, and cost of receiving care. – Community Leader
>
> Diet and lack of exercise. – Community Leader

Prevention/Screenings

> Screening, understanding the disease, recognizing signs and symptoms, diet, food preparation, lifestyle, consequences. – Community Leader
>
> Heart disease and stroke are preventable, but because there is not an effort for community health education to prevent or identify early signs of these conditions, people usually see a physician when these are in advanced stages. – Public Health Representative

People With Vulnerabilities

> Heart disease and stroke are major chronic health conditions that impact marginalized communities and individuals and groups of color for a myriad of reasons that include food insecurity, lack of access to healthy foods, food costs, preponderance of fast food restaurants and liquor stores that are located in South Los Angeles. We have no Trader Joe's or Sprouts or Whole Foods stores located in South Los Angeles. – Community Leader

Access to Affordable Healthy Food

> Lack of access to affordable fresh foods and healthier food options. Environmental stressors, working conditions, lack of green spaces that are safe. – Public Health Professional
>
> Access to specialty providers, such as cardiology, and access to healthy foods. – Community Leader

Built Environment

> Economic, environmental and social barriers to good heart health, such as lack of access to outdoor recreation and exercise opportunities, lack of access to fresh, healthy foods, and high levels of stress. – Social Services Provider

Access to Specialists

> Access to specialty providers, such as cardiology, and access to healthy foods. – Community Leader

Environmental Contributors

> Environmental factors leading to unhealthy lifestyles. – Community Leader

Generational

> Family history, eating habits, and lack of exercise. – Community Leader

Unhoused Population

> The unhoused are living on the streets or in temporary housing. They also don't have access to healthy meals or, in many cases, any meals. – Community Leader

Income/Poverty

> The area has high rates of low-income individuals who lack access to high quality services to be screened for heart disease and stroke risks. Most probably don't even know they are at risk. – Social Services Provider

Obesity

> Obesity, stress, no housing stability due to high rent. – Community Leader

Cancer

ABOUT CANCER

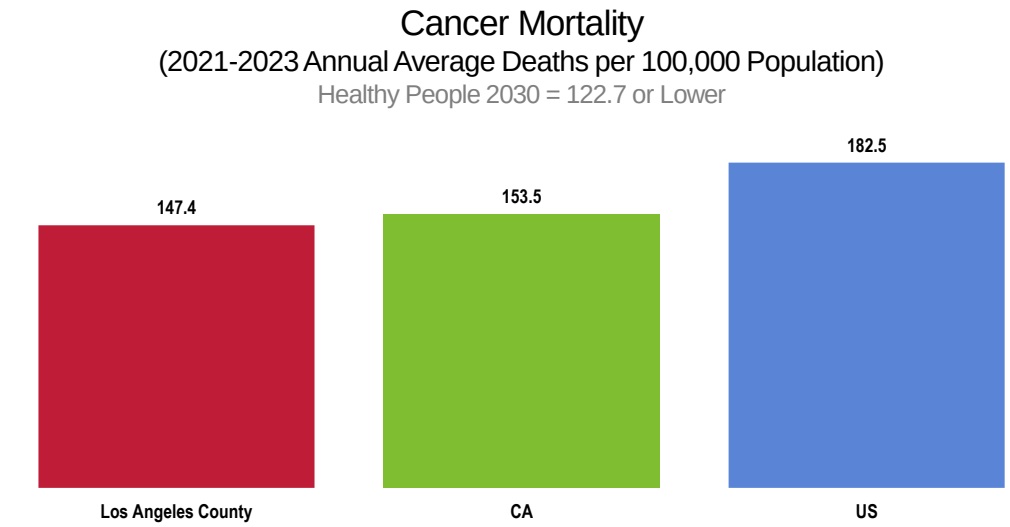
Cancer is the second leading cause of death in the United States. …The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are 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)

Cancer Deaths

The following chart illustrates cancer mortality (all types). [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 January 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Female breast cancer and lung cancer are the leading causes of cancer deaths. [COUNTY-LEVEL DATA]

Cancer Death Rates by Site

(2021-2023 Annual Average Deaths per 100,000 Population)

	Los Angeles County	California	US	Healthy People 2030
ALL CANCERS	**147.4**	**153.5**	**182.5**	**122.7**
Female Breast Cancer	**23.9**	**23.3**	**25.1**	**15.3**
Lung Cancer	**23.2**	**26.0**	**39.8**	**25.1**
Prostate Cancer	**18.2**	**19.9**	**20.1**	**16.9**
Colorectal Cancer	**14.7**	**14.3**	**16.3**	**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 January 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

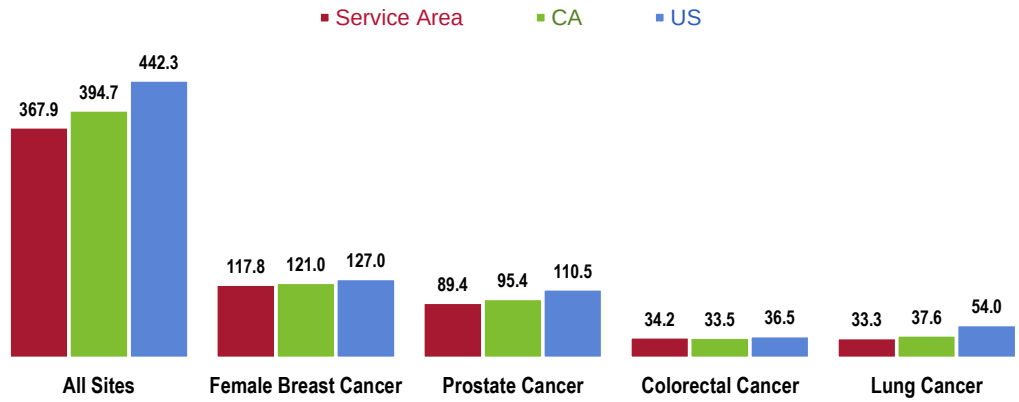
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

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. It is usually expressed as cases per 100,000 population per year.

Cancer Incidence Rates by Site

(Annual Average Incidence per 100,000 Population, 2016-2020)

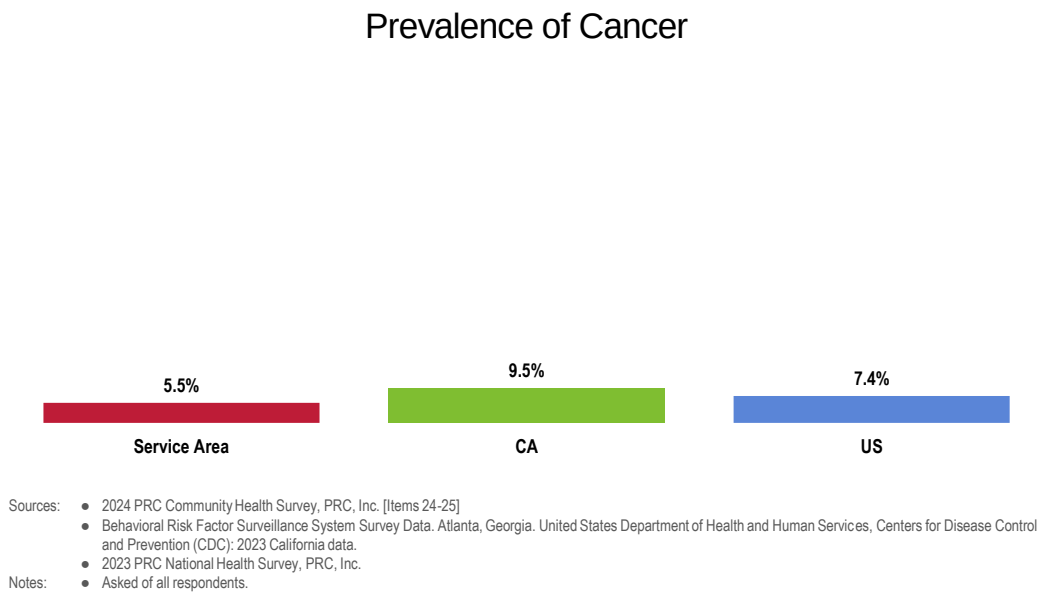


Sources:
- National Cancer Institute, State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the incidence rate (cases per 100,000 population per year) for select cancers.

Prevalence of Cancer

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



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 24-25]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 California data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Cancer Screenings

CERVICAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for cervical cancer every 3 years with cervical cytology alone in women age 21 to 29 years. For women age 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 45 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 the following cancer sites:

Cervical Cancer Screening

PRC SURVEY ► "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?"**

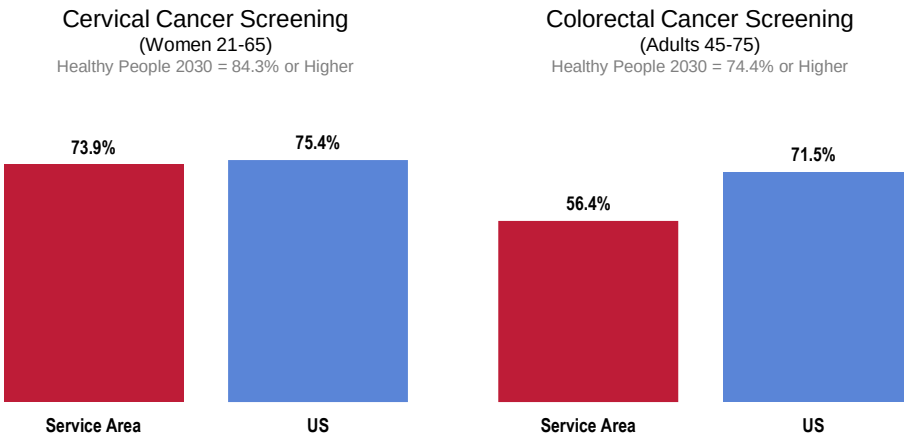
"Appropriate cervical cancer screening" includes Pap smear testing (cervical cytology) every three years in women age 21 to 29 and Pap smear testing and/or HPV testing every 5 years in women age 30 to 65.

Colorectal Cancer Screening

PRC SURVEY ► "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?"

PRC SURVEY ► "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" includes a fecal occult blood test among adults age 45 to 75 within the past year and/or lower endoscopy (sigmoidoscopy or colonoscopy) within the past 10 years.

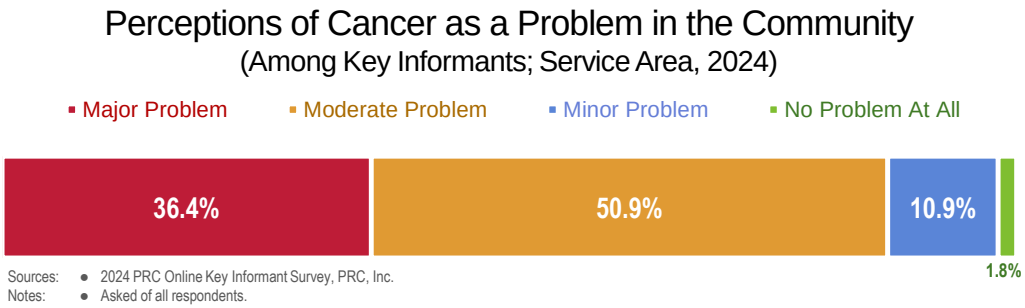


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 102-103]
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Each indicator is shown among the gender and/or age group specified.
- Note that national data for colorectal cancer screening reflect adults ages 50 to 75.

Key Informant Input: Cancer

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



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

Incidence/Prevalence

> The cases of cancer, especially at younger ages, is happening more frequently than two decades ago. I have known more people suffering from colon, esophageal, and breast cancer over the past couple of years. I don't know the reason more people my age (30 to 45) are getting it, but they are. These are not the only types of cancer I have seen, but also cases of leukemia. – Community Leader
>
> We have seen many clients walk through our doors that have been diagnosed with some type of cancer. – Community Leader
>
> I think there are high rates of cancer in the area as compared to the rest of the county. – Social Services Provider
>
> Late-stage cancer diagnoses are more prevalent in SPA 4 and SPA 6, leading to higher mortality rates. – Social Services Provider
>
> Too many people in our community are dying from it. – Other Health Provider
>
> It appears there are new types of cancers or more intense types returning to patients. There's a lack of affordable healthy foods, plus restaurants, and high cost of living. – Community Leader
>
> Colon cancer. – Social Services Provider
>
> There are high rates of certain cancers in South Los Angeles, and death rates are higher than other areas. – Social Services Provider

Access to Care/Services

> Lack of access to care and lack of in-home support services for cancer patients. – Public Health Professional
>
> 1. Limited Access to Health Care: Individuals in low-income areas often have less access to comprehensive health care services, including preventive care, early detection, and treatment for cancer. This can result in later-stage diagnoses, when cancer is more difficult and costly to treat. 2. Health Disparities: Low-income communities frequently experience higher rates of various risk factors for cancer, such as obesity, smoking, and exposure to environmental pollutants. These risk factors are often exacerbated by socioeconomic conditions, including lack of education and limited access to healthy foods. 3. Lack of Education and Awareness: There may be a lack of awareness about cancer prevention, screening, and treatment options in low-income communities. Educational resources may not be as readily available, leading to misinformation or underestimating the importance of regular health checkups. 4. Transportation Barriers: Accessing health care facilities can be challenging. – Community Leader

Environmental Contributors

> Toxins in the environment (dust, smoke, smog, pollution, microplastics, antibiotics in water that is impacting hormonal changes) are helping make cancer a major problem in South LA/Downtown LA. We need education about cancer, what treatments are available, what screening programs are available and how to access them, what to do if you have a cancer diagnosis, how do you know what treatments are available, what if you can't afford the financial costs, and assistance to overcome barriers to getting treatment. – Community Leader

Diagnosis/Treatment

> I believe cancer is a major problem in my community as it is undiagnosed, particularly among marginalized communities. Residents tend not to undergo cancer screenings unless there are symptoms, and even then, they may attribute it to something else. More efforts need to be directed toward symptom education and fear reduction to increase residents being preventive and proactive. – Community Leader

Awareness/Education

> Many types of cancers are preventable, but because there is not an effort for community health education to prevent cancer or identify early signs, people usually see a physician when cancer is in its advanced stages. – Public Health Representative

Unhoused Population

> The unhoused are living on the streets or in temporary housing. They also don't have access to healthy meals or, in many cases, any meals. – Community Leader

Lack of Providers

> There are other hospitals outside of the area that specialize in cancer. I don't see DTLA with many specialty doctors in that field. – Community Leader

Respiratory Disease

ABOUT RESPIRATORY DISEASE

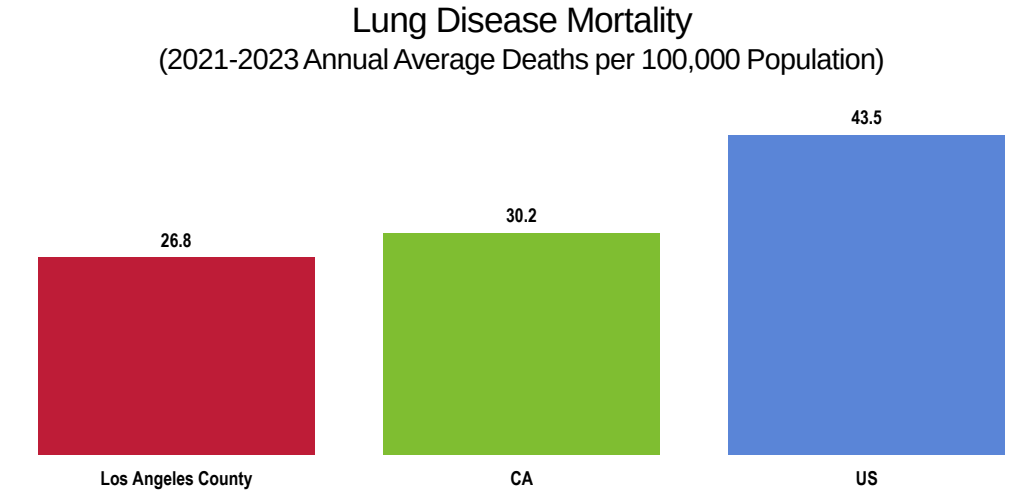
Respiratory diseases affect millions of people in the United States. …More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million 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.

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

Respiratory Disease Deaths

Lung 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 lung disease is illustrated in the charts that follow. [COUNTY-LEVEL DATA]

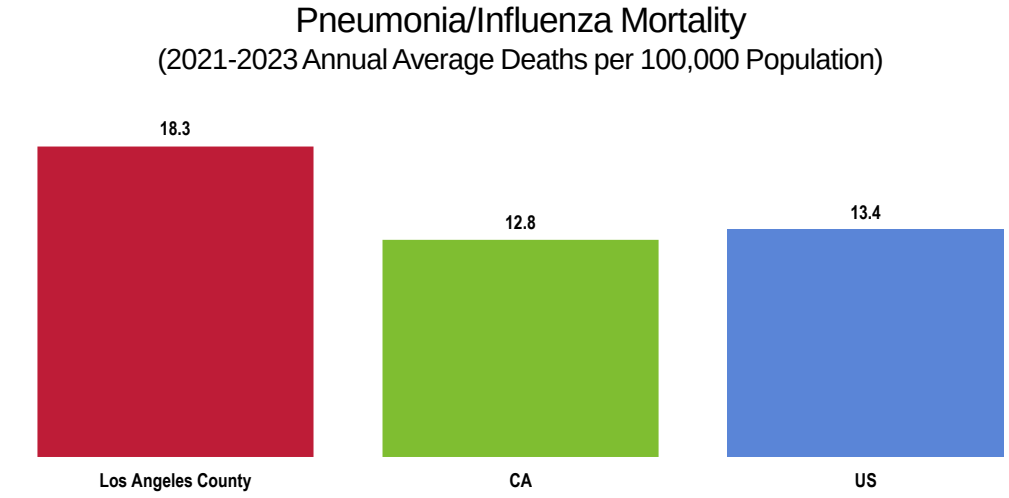


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2025.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.
- Here, lung disease reflects chronic lower respiratory disease (CLRD) deaths and includes conditions such as emphysema, chronic bronchitis, and asthma.

Pneumonia/Influenza Deaths

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



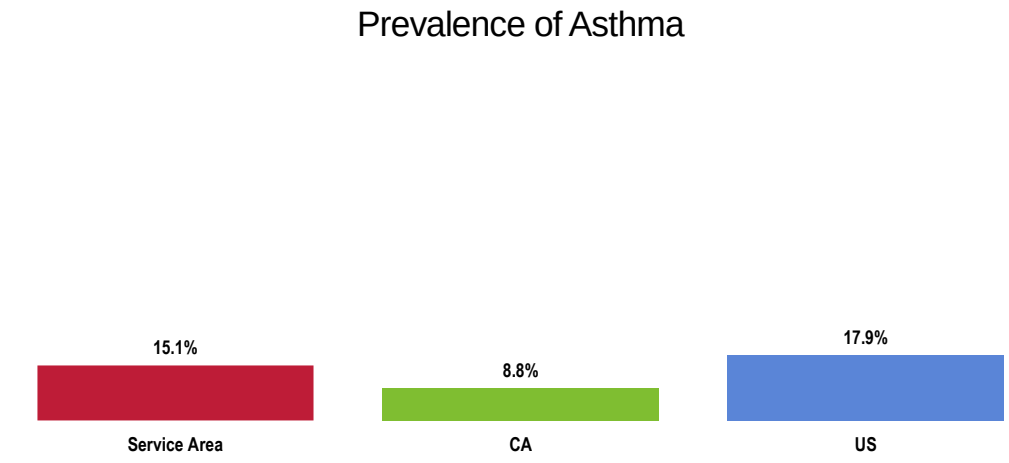
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2025.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Prevalence of Respiratory Disease

Asthma

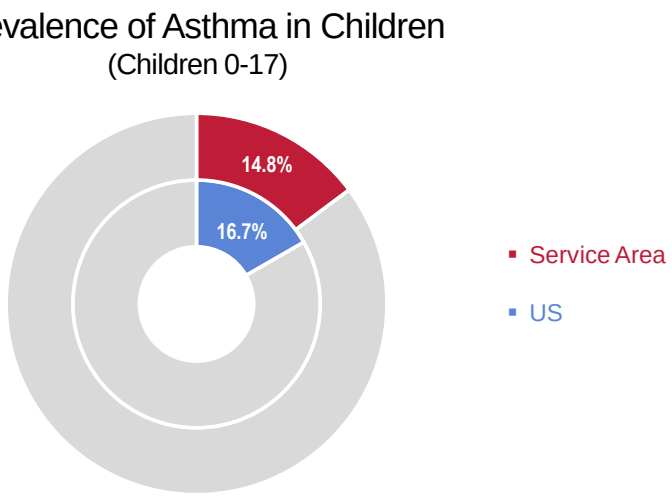
PRC SURVEY ► "Do you currently have asthma?"



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 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): 2023 California data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

PRC SURVEY ► "Has a doctor, nurse, or other health professional ever told you that this child had asthma?"

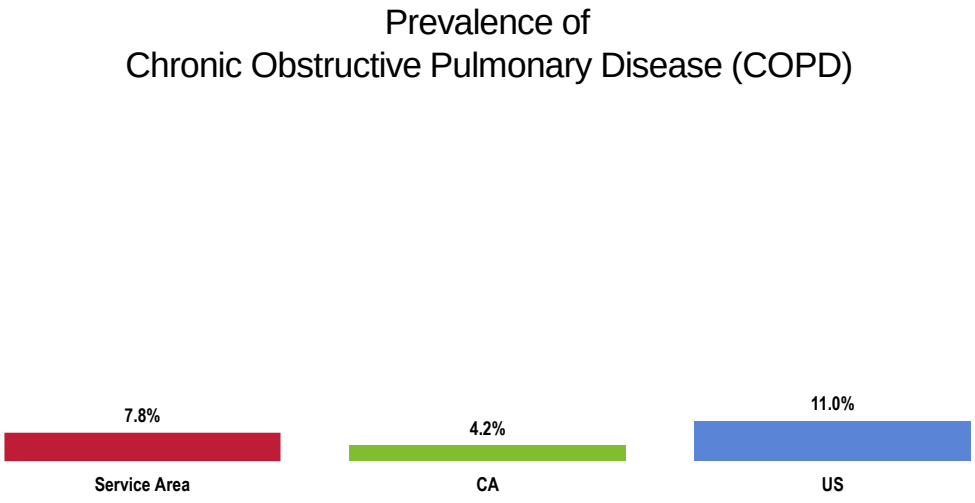


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 92]
- 2023 PRC National Health Survey, PRC, Inc.

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

Chronic Obstructive Pulmonary Disease (COPD)

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

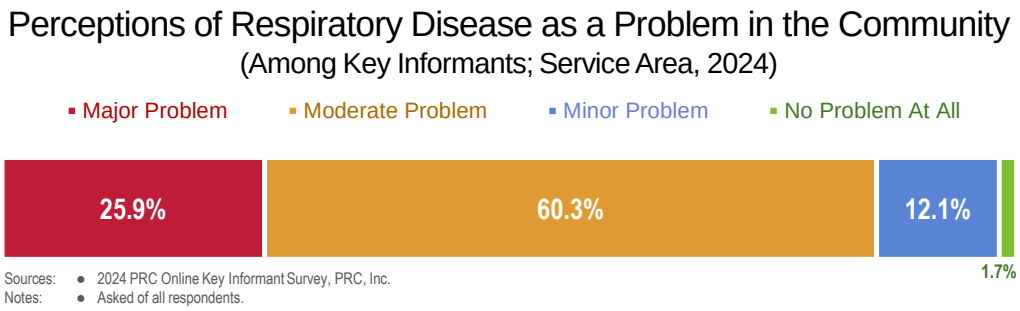


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 21]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 California data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes conditions such as chronic bronchitis and 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:



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

Incidence/Prevalence

> Our community has high rates of chronic obstructive pulmonary disease (COPD) and asthma. In addition, with COVID-19, our community faces a distrust within health systems that causes much hesitation to get vaccinations for much-needed conditions. The community also tends to have poor air quality. – Public Health Representative

Due to COVID-19

> As we know, COVID-19 is still around, and with that now comes RSV and pneumonia and other complications. Again, people need to take COVID seriously because it will affect other parts of our breathing, such as our lungs. And I think right now that people are not taking COVID as seriously as before. – Other Health Provider

Environmental Contributors

> These areas have higher rates of asthma and air pollution. Additionally, disease spreads more rapidly. – Social Services Provider

Unhoused Population

> The unhoused are living on the streets or in temporary housing. They also don't have access to healthy meals or, in many cases, any meals. – Community Leader

Housing

> Lack of housing, access to health care, weather, not being properly diagnosed. – Community Leader

Access to Care/Services

> Lack of primary and specialty care access, long-term effects of COVID-19 in our community. – Community Leader

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.

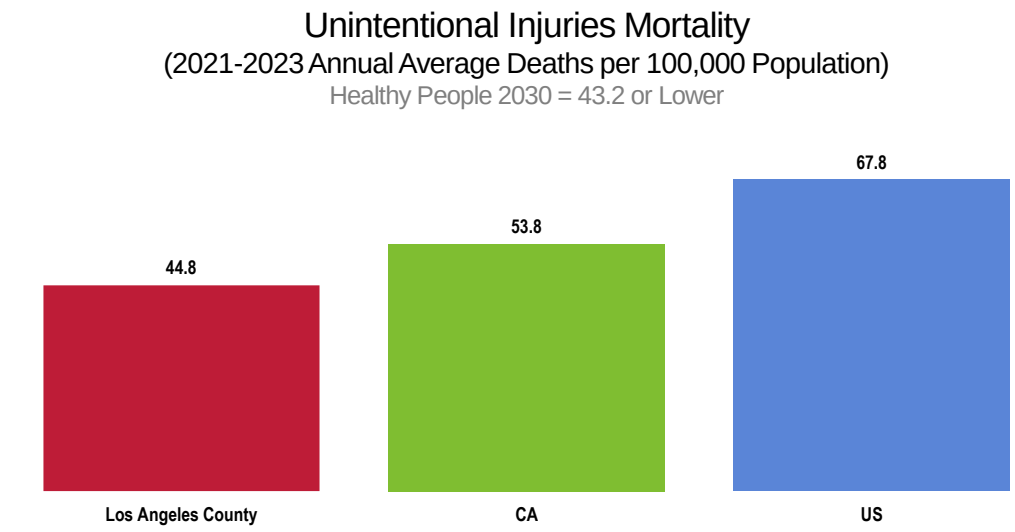
Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

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

Unintentional Injury

Unintentional Injury Deaths

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



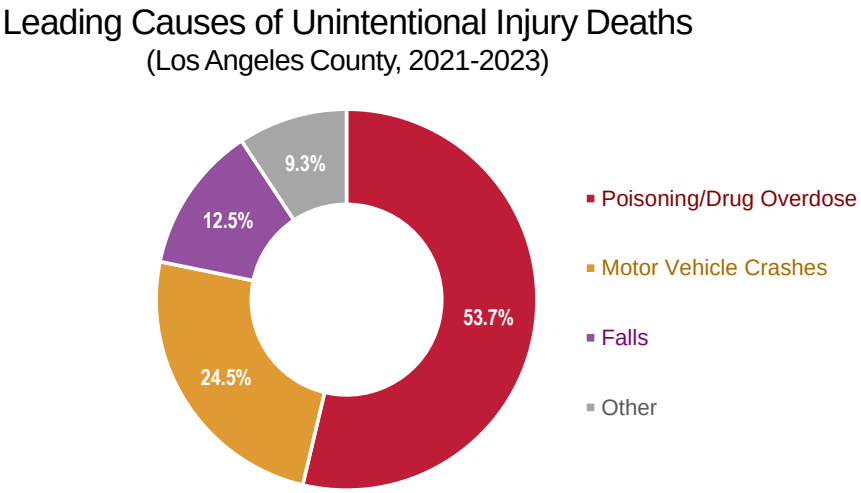
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Leading Causes of Unintentional Injury Deaths

The following outlines leading causes of accidental death in the county.

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



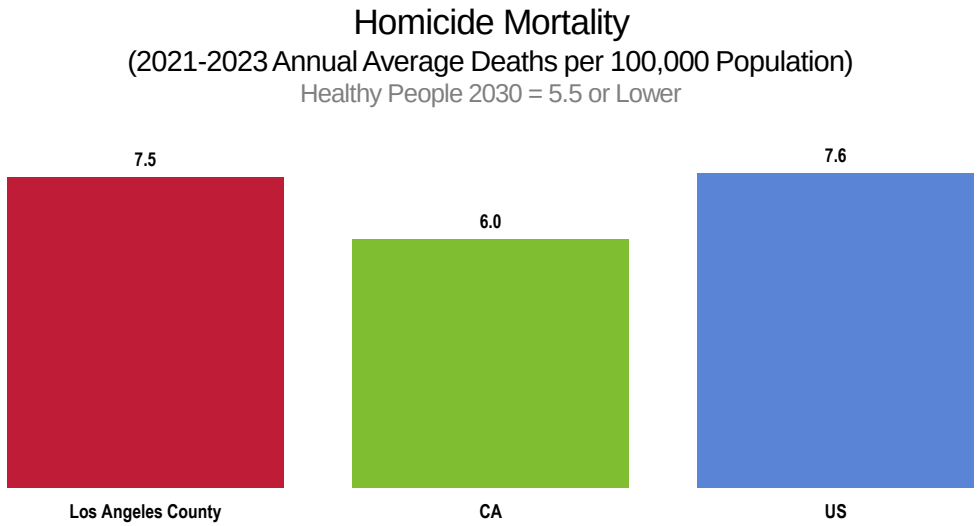
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2025.

Intentional Injury (Violence)

Homicide Deaths

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.



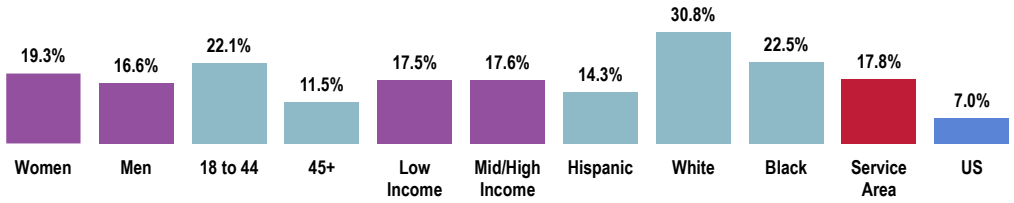
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Violent Crime Experience

PRC SURVEY ► "Thinking about your own personal safety, have you been the victim of a violent crime in your area in the past 5 years?"

Victim of a Violent Crime in the Past Five Years
(Service Area, 2024)



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 32]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

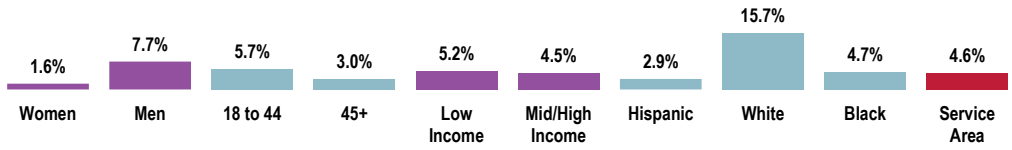
PRC SURVEY ► "Have you been the victim of gang violence in your area in the past 5 years?"

Have Been the Victim of Gang Violence in the Past Five Years
(Service Area, 2024)

Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 301]
Notes: ● Asked of all respondents.

PRC SURVEY ► "Have you ever been the victim of a gunshot wound?"

Have Ever Been the Victim of a Gunshot Wound
(Service Area, 2024)

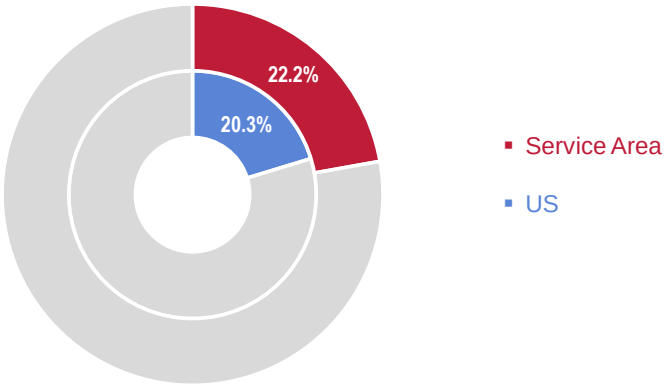


Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 302]
Notes: ● Asked of all respondents.

Intimate Partner Violence

PRC SURVEY ► "The next question is about 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?"

Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner

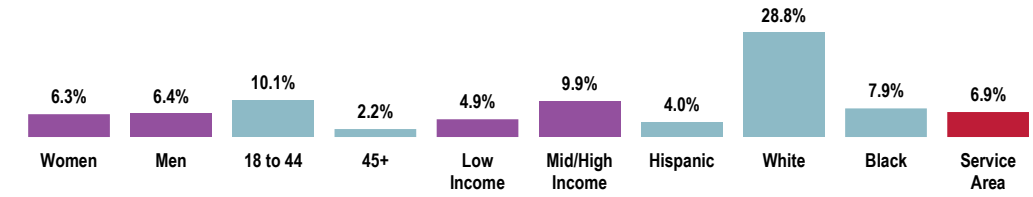


Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 33]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Sexual Violence

PRC SURVEY ► "In the past 3 years, has anyone forced you to engage in sexual activity that you did not want?"

Have Ever Been Forced Into Unwanted Sexual Activity
(Service Area, 2024)

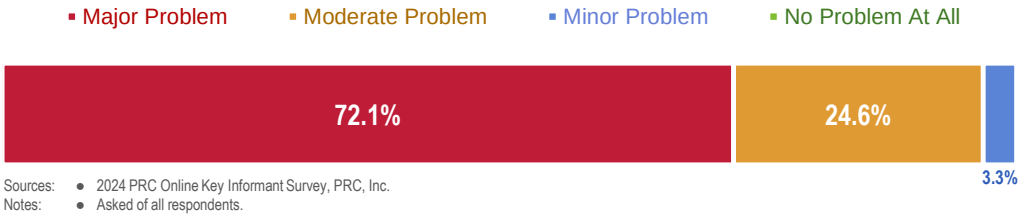


Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 303]
Notes: ● Asked of all respondents.

Key Informant Input: Injury & Violence

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

Perceptions of Injury & Violence as a Problem in the Community
(Among Key Informants; Service Area, 2024)



Sources: ● 2024 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

> Ongoing problems. – Social Services Provider
>
> Crime stats and awareness of how injury and violence has impacted my colleagues and the community members we serve. – Social Services Provider
>
> We have many patients who come to our clinic who have experienced violence, either community violence or in the home. The rate of patients who have experienced domestic violence has increased quite a bit since COVID. – Social Services Provider
>
> Violent crime is common in urban centers. Los Angeles is one of the most densely populated urban centers in the country. Violent crime is common. – Community Leader
>
> We service a community with high incidence of violence in the community. – Community Leader
>
> We experience disproportionate incidences of violence in South Los Angeles attributed to poverty, high rates of unemployment, homelessness, substance use and abuse, human trafficking, school dropout rates, expulsions, and absences. – Community Leader

We have had murders in South Park in the past year and other injuries, and these need to be addressed. – Social Services Provider

This is what worries me the most, and I guess this ties into mental health, but having been in that area, we have an office across the street from Dignity Hospital, and I've walked around there several times. Every time I'm in that area, I see things happening. One of the last times, there was a man walking around the hospital, and our office is well across the street, crossing the street with a machete in his hand. – Other Health Provider

The downtown area and around the hospital continues to have high rates of crime and criminal activity that lead to violent crime and injury. – Social Services Provider

Community violence. – Public Health Professional

My job is to service those who have been victims of trafficking violence. I believe it is a problem because close to 800 people were killed in Los Angeles County just last year, surpassing the amount killed through homicides. Not to mention the thousands of individuals severely injured in this county. The amount is increasing, and we must take steps to analyze and make a plan in order to reduce these deaths and injuries. – Community Leader

High crime rate statistics. Occupancy rates have fallen dramatically. Need increased LAPD presence. – Community Leader

Unhoused Population

The economy and the high number of people who are homeless. – Community Leader

Injury and violence are significant problems in our community due to the overlapping challenges of homelessness, economic disparity, and systemic inequities. Individuals experiencing homelessness are particularly vulnerable to violence, including physical assaults, theft, and exploitation. Living without secure shelter increases exposure to unsafe environments, and the lack of stable housing often exacerbates mental health challenges, potentially escalating conflicts. Additionally, economic stress contributes to domestic violence and community-level crime as people struggle to meet basic needs. Limited access to health care means untreated injuries can lead to long-term complications, while inadequate mental health resources can leave trauma from violence unaddressed, perpetuating cycles of harm. These challenges highlight the urgent need for holistic interventions to ensure safety and stability for vulnerable populations. – Community Leader

The unhoused are living on the streets or in temporary housing. They also don't have access to healthy meals or, in many cases, any meals. – Community Leader

Injury and violence are major problems in our community, particularly for our unhoused population, due to the vulnerabilities associated with living on the streets or in unstable environments. Many of our guests face increased exposure to physical harm, including assaults, accidents, and other forms of violence as a result of unsafe living conditions and the lack of secure shelter. Unhoused individuals are often at higher risk of injury from falls, untreated medical conditions, or altercations, especially in areas where resources are scarce and tensions run high. Additionally, systemic challenges, such as limited access to mental health services, contribute to cycles of violence and trauma within the community. Without safe spaces and consistent support, these risks remain prevalent, further impacting the physical and emotional well-being of the individuals we serve. – Community Leader

Neighborhood Safety

Unsafe conditions. – Community Leader

Our 2023 LA County Health Survey showed almost one-third of children in poverty were reported to live in neighborhoods rated as unsafe. We see men riding bikes for transportation with no helmets. Our clients who are food vendors are robbed. – Social Services Provider

The safety of our community is a concern for many community residents. There's high rates of crime that make the community worried for their safety. Our hospital tends to encounter people through our emergency room with injuries related to violence and crime. – Public Health Representative

Families reside in areas where there is high crime and are afraid for their safety. A lot of the families fear for their safety and do not go out after certain hours, and if they do not have transportation at times, do not go out if they do not have someone to take them to appointments or errands. – Social Services Provider

Motor Vehicle Accidents

I work at a trauma center, hence my opinion is biased, but I see a lot of injuries related to motor vehicle accidents and assaults. More than I've ever seen before. – Physician

High rates of motor vehicle injuries in SPA 4 and SPA 6, high rates of violent crime including homicides, simple and aggravated assaults resulting in hospitalizations. – Public Health Representative

People With Vulnerabilities

My community, I consider the trafficking survivors I assist in Los Angeles and South Los Angeles. They have experienced extreme violence, which they have fled, but often are still dealing with to some extent. – Community Leader

Employment

> Community violence is often due to lack of opportunities, too few well-paying jobs, rising cost of rent. High crime rates and gang prevalence in underserved areas that don't receive funds for much-needed programs and services. Teachers lack support, the problem of violence affects families and communities through intergenerational trauma. Too many children and families don't feel comfortable walking to the store or to school (drug area, gang area, you might get robbed, etc). Some, but not all, injury and violence is due to homelessness (not all people who live on the street have mental health issues, but many do and living on the street certainly contributes to mental health concerns). Another problem is domestic violence, which is still tolerated and increased especially during the pandemic. – Community Leader

Access to Care/Services

> As shared with chronic pain, many individuals are dealing with injury, abuse, and violence and do not have any support services for their recovery. – Social Services Provider

Awareness/Education

> Community members are not aware of the services available for individuals who have been victims of violent injuries or violence in general. – Social Services Provider

Gun Violence

> Living in South LA, very impacted by gun violence and gang violence. – Public Health Professional

Mental Health Services

> Delays in connecting people to mental health services, stigma of mental health, stress, and financial stress. – Community Leader

Law Enforcement

> Overpolicing. – Public Health Professional

Sex Trafficking

> The Figueroa Corridor sex trafficking epidemic. – Community Leader

Diabetes

ABOUT DIABETES

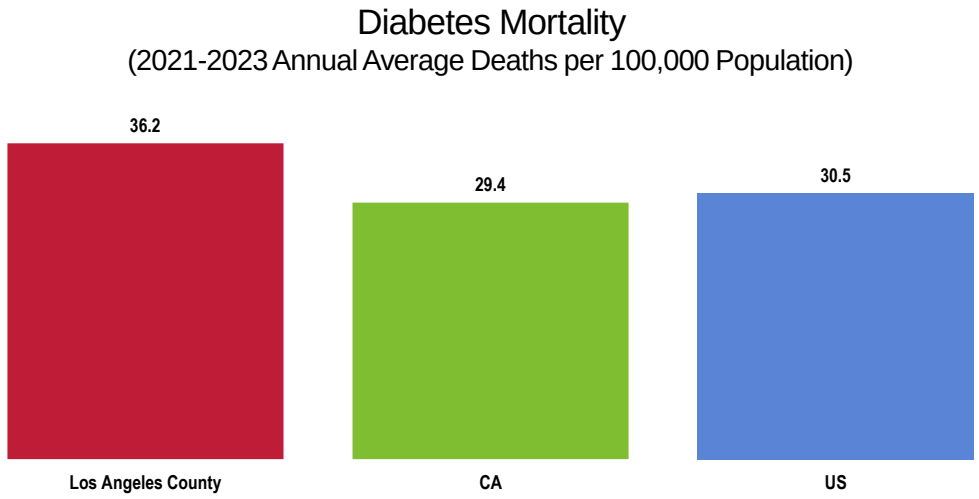
More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

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)

Diabetes Deaths

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



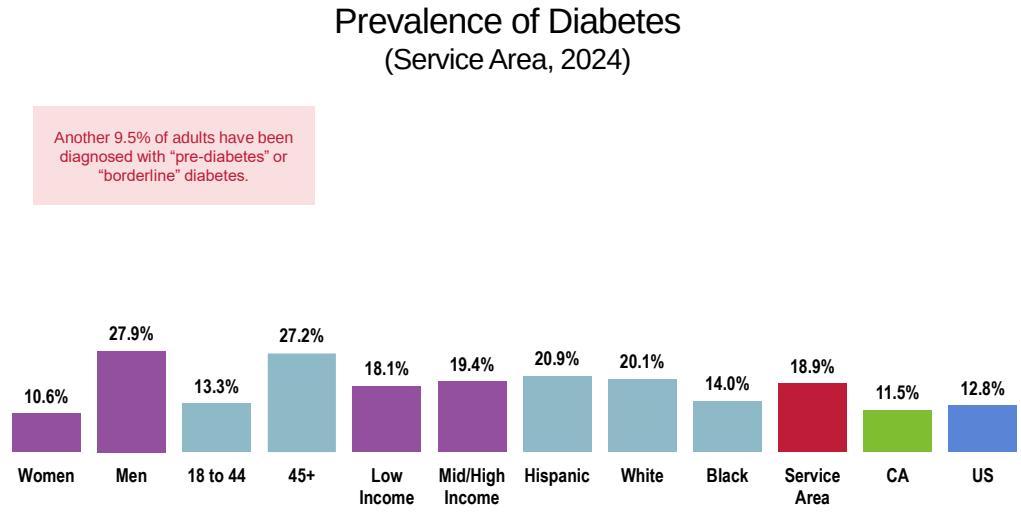
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2025.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Prevalence of Diabetes

PRC SURVEY ► "Have you ever been told by a doctor, nurse, or other health professional that you have diabetes, not counting diabetes only occurring during pregnancy?"

PRC SURVEY ► "Other than during pregnancy, have you ever been told by a doctor, nurse, or other health professional that you have pre-diabetes or borderline diabetes?"

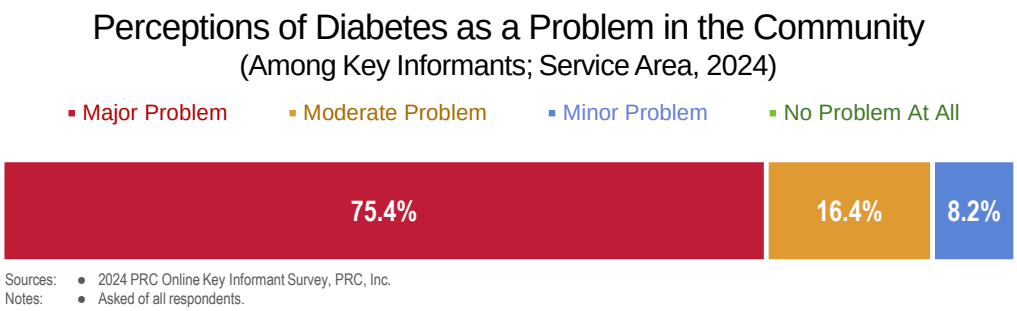


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 106]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 California data.
- 2023 PRC National Health Survey, PRC, Inc.

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

Key Informant Input: Diabetes

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



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

Awareness/Education

> Education, peer support groups, cost of medication. – Public Health Professional
>
> Education about diabetes and following up with a medical provider. – Social Services Provider
>
> Type 2 diabetes is preventable, but because there is not an effort for community health education to prevent this type of diabetes or identify early signs, people usually see a physician when diabetes is in its advanced stages. – Public Health Representative
>
> Not knowing how to best manage their diabetes. – Public Health Professional
>
> Access to health education and activities. – Social Services Provider
>
> Information and tools to prevent and manage it. – Social Services Provider
>
> Lack of education and knowledge of the disease and proper treatment. – Social Services Provider
>
> Nutritional health education and disease and health management. – Public Health Representative
>
> Knowledge about how to manage it, access to healthy food at an affordable price. – Social Services Provider
>
> Lack of awareness of the damage that can be done with high blood sugar, inability to get tools, follow-up from health care providers especially in the home or community, safe places to exercise and how to work it into one's routine, abundance of fast food and time to cook and other pressures that result in unhealthy eating. Unhealthy lifestyle and diet. – Social Services Provider
>
> Understanding and managing diabetes. – Community Leader
>
> Understanding the disease, healthy eating, how to access healthy foods, how to prepare healthy foods, understanding the consequences. – Community Leader

Access to Affordable Healthy Food

> Access to healthy food and locations to exercise. – Community Leader
>
> Lack of affordable fresh food, can't afford prescriptions for diabetes, compliance with medications, and lack of safe places to exercise. – Public Health Professional
>
> Lack of resources, access to healthy foods, green spaces for exercise, and specialists like endocrinologists. – Social Services Provider
>
> Lack of access to healthy groceries. Environmental factors lead to low levels of activity. – Community Leader
>
> Many individuals cannot address medical and mental health needs because they are preoccupied with rising food and housing costs. Many individuals have diabetes but cannot afford the right foods to control the disease. – Social Services Provider
>
> There are not a lot of healthy options available in the area. Community members may need to drive out to bring healthier options into their homes. There is also the possibility of high prices for the healthy options. – Social Services Provider
>
> Healthy Food Access: Low-income areas often lack access to affordable, healthy food options. This can make it difficult to maintain a balanced diet necessary for managing diabetes, leading to reliance on cheaper, processed foods that can exacerbate health issues. Education and Awareness: There may be a lack of access to diabetes education resources, which can hinder individuals from understanding how to manage their condition effectively, including recognizing symptoms, monitoring blood sugar levels, and making lifestyle changes. – Community Leader
>
> Access to fresh food and maintaining a healthy diet. – Physician

> There is a lack of consistent healthy food options that are affordable and that provide healthy food options that people would like to eat. The rising cost of food and perishables makes the ability to be healthy far more difficult to attain. Also, teaching community members how to eat healthy, even with their kids, as there are cases of childhood diabetes not as bad as before, but it still exists. – Community Leader
>
> Lack of healthy places to eat, high cost of groceries, low wages, and places that are food deserts. – Community Leader
>
> There is very little access to grocery stores near the ministry. We are in a food desert. – Community Leader

Nutrition

> The big box supermarkets fill the ends of their aisles with processed sugary foods and drinks. Heavily promoting cheaper, unhealthy foods. There is not a lot of green space to exercise in our urban area. High percentage of female students get turned away from our school blood drives because of abnormal ferritin levels. – Community Leader
>
> The biggest challenge for people with diabetes in our community is maintaining adherence to their dietary and medical needs. While access to healthy, nutritious meals is available, many individuals struggle to follow the dietary restrictions recommended by their medical providers. This difficulty is compounded for our unhoused guests, who often face inconsistency in taking prescribed medications and lack reliable access to food and opportunities for physical activity. Additionally, many of our unhoused guests do not seek medical attention until it is too late, leading to health issues that can become debilitating and significantly impact their ability to manage their diabetes effectively. – Community Leader
>
> Diverse ethnic backgrounds in our neighborhoods also means diverse food. Lots of culturally authentic food can lead to higher risk of type 2 diabetes. – Community Leader

Prevention/Screenings

> There is not enough emphasis placed on preventing diabetes. Care for any chronic condition is difficult to obtain because of the barriers discussed in accessing care. Many patients are not willing or unable to make the lifestyle changes necessary to improve their health. – Social Services Provider
>
> Diabetes is a prevalent health problem in the community of South LA. Many people with diabetes either don't know they have it because they aren't accessing their primary care correctly, or they have it but wait too late to manage it due to timely or quality care and education. Another factor is not having enough resources around to access the quality care. This leads to issues like wounds, loss of eyesight, and amputations due to untreated diabetes. – Public Health Representative
>
> No prevention, health insurance, and education. – Community Leader

Diagnosis/Treatment

> There are many challenges to people with diabetes in South LA/Downtown LA including: access to testing for diabetes, information about how to get a diagnosis, when and how often to get tested. Once you are tested, what is the management program or plan? Too often, there is no follow-up, we need coaching/accompaniment from people who understand the culture (food, working two jobs, etc). Eating better and exercising more has financial costs: new types of food (and learning to cook with them), gym memberships, fewer markets with healthy food options that are unfortunately too expensive for people who don't have the money. Because it is so common, many people don't see it as a serious problem, and there is widespread acceptance of diabetes (my mom has it, so I will, too) – less information about how it is preventable and how to manage diabetes before you get to insulin shots, lifestyle changes are hard, family acceptance of change can be challenging. Amputations due to untreated diabetes. – Community Leader
>
> Diagnosis. – Community Leader
>
> Proper care and information. – Other Health Provider

Incidence/Prevalence

> I currently work for an ENT company that has several offices, and my conversations internally have been that a lot of our minority patients to come in and suffer from diabetes. It's either genetic or, again, the lack of education on how it should be treated in our food and our diet. – Other Health Provider
>
> The prevalence of diabetes, particularly among Latinos and African-Americans, is a substantial problem in South Los Angeles. – Public Health Representative

Disease Management

> Diabetes requires ongoing management through several facets of life, including diet, medication, and other condition management processes that can be difficult to access, especially for people experiencing homelessness and/or extreme poverty. No-cost access to nutritious food, access to public benefits to support costs associated with food/groceries and health care, and low-barrier access to primary care and chronic condition management is essential for mitigating challenges to managing diabetes within the community. – Community Leader

Unhoused Population

> The unhoused are living on the streets or are in temporary housing. They also don't have access to healthy meals or, in many cases, any meals. – Community Leader

Affordable Care/Services

> Provide clinics that are low-cost for immigrant people and the LGBTQ community. – Social Services Provider

Access to Care/Services

> Access to specialist providers, such as endocrinologists, and diabetic supplies. – Community Leader

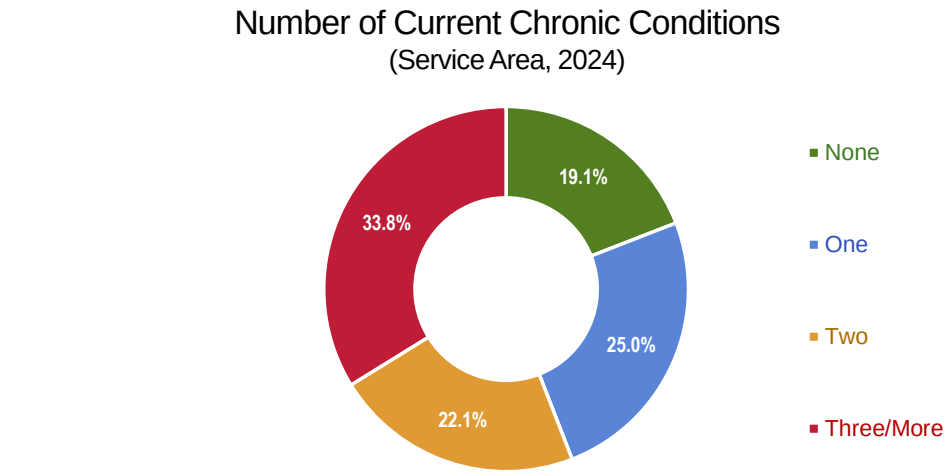
Disabling Conditions

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.

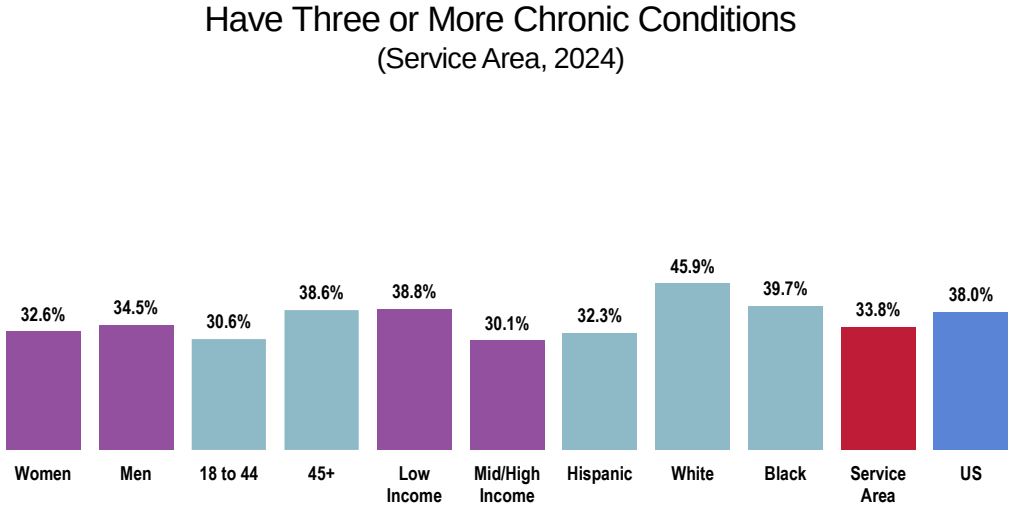
For the purposes of this assessment, chronic conditions include:

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



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 107]

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



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 107]
- 2023 PRC National Health Survey, PRC, Inc.

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

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.

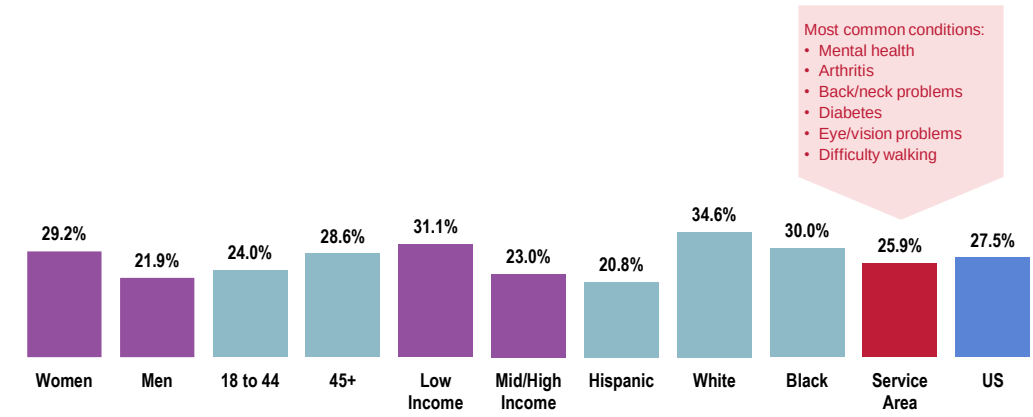
In addition, people with disabilities may have trouble finding a job, going to school, or getting around outside their homes. And they may experience daily stress related to these challenges. Efforts to make homes, schools, workplaces, and public places easier to access can help improve quality of life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

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

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

PRC SURVEY ► [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
(Service Area, 2024)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Items 83-84]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

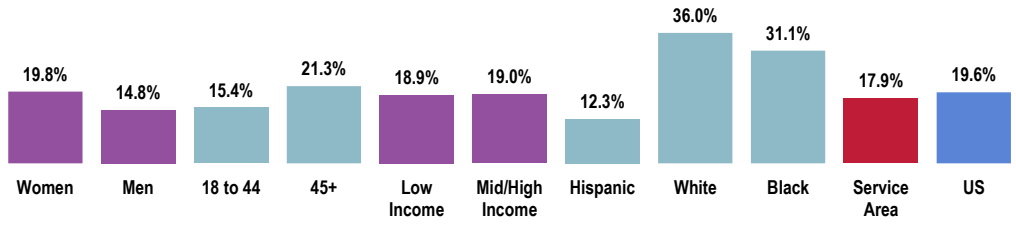
High-Impact Chronic Pain

PRC SURVEY ► "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

(Service Area, 2024)

Healthy People 2030 = 6.4% or Lower



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 31]
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.
- High-impact chronic pain includes physical pain that limits life or work activities on "most days" or "every day" of the past six months.

Alzheimer's Disease

ABOUT DEMENTIA

Alzheimer's disease is the most common cause of dementia… . 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.

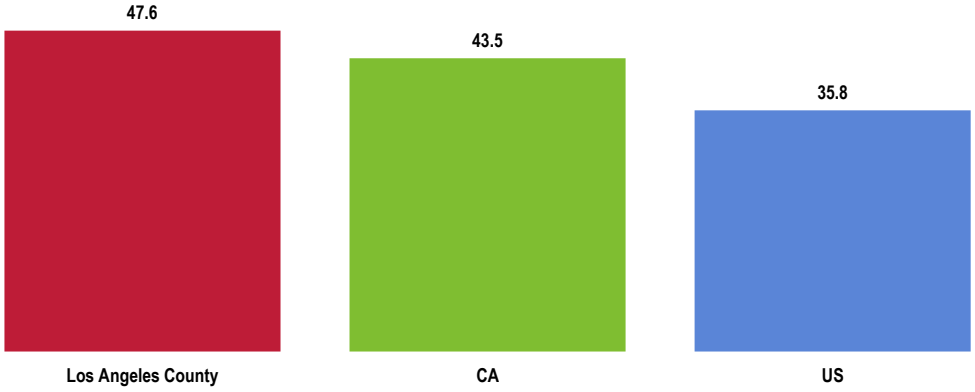
While there's no cure for Alzheimer's disease, early diagnosis and supportive care can improve quality of life. And efforts to make sure adults with symptoms of cognitive decline — including memory loss — are diagnosed early can help improve health outcomes in people with dementia. Interventions to address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

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

Alzheimer's Disease Deaths

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

Alzheimer's Disease Mortality
(2021-2023 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 January 2025.

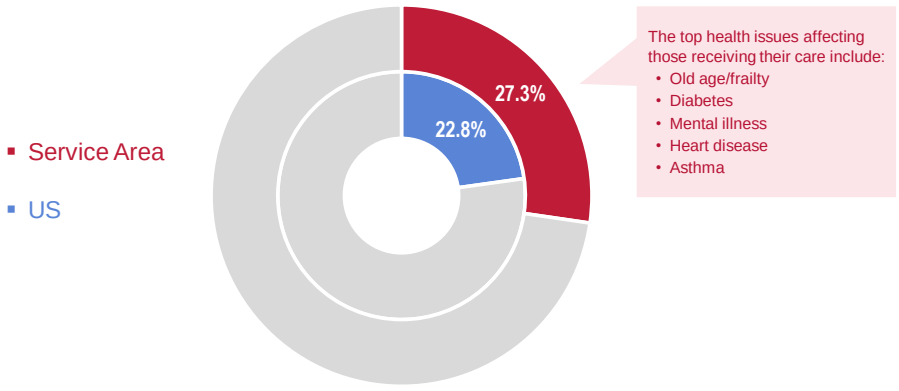
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Caregiving

PRC SURVEY ► "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?"

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

Act as Caregiver to a Friend or Relative with a Health Problem, Long-Term Illness, or Disability

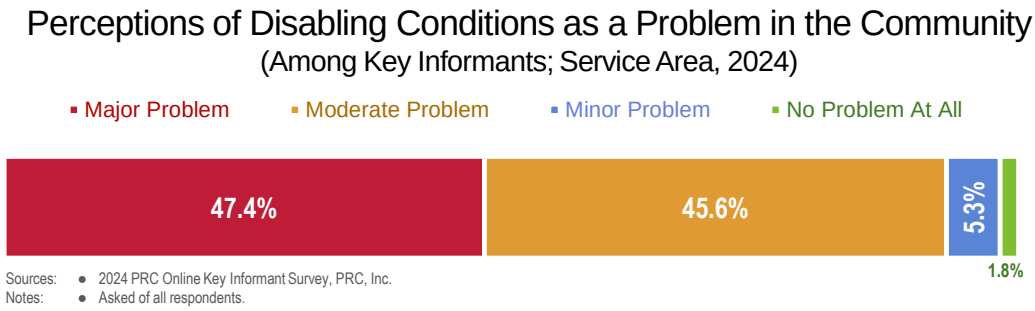


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 85-86]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Key Informant Input: Disabling Conditions

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



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

Access to Care/Services

> Lack of resources and information. – Social Services Provider
>
> There are a lot of people who have disabling conditions, and there are no resources for them in the local area. – Social Services Provider
>
> As hospitals address more high-acuity patients, those who are disabled or who have chronic illnesses are more dependent on primary care support, but we know that our patients both have access to care issues (like transportation) and economic roadblocks (i.e. working through the pain because they can't afford to take a day off of work). – Community Leader
>
> There are those that are in need of a higher level of care, and there's a lack of affordable housing, lack of affordable higher level of care, long waitlists to assisted living, and lack of supportive housing for those with mental health issues. – Community Leader

Awareness/Education

> The reason I know this is I work closely with a lot of doctors and clinics in that area, and I know that we've often talked to them about education on nutrition for the several patients that suffer from diabetes. I had a doctor tell me that it is more of a low-income illness because they can't afford certain foods to balance out what they should be eating. Also, they don't get it taken care of until it's in an advanced stage. Again, we circle back to the lack of education. – Other Health Provider
>
> A lot of people still don't have information about developmental delays (diagnosing children with disabilities like autism), but there is more education now about Alzheimer's in LA – people are talking about it because of the growing prevalence among older Latino adults. Although there is more information to help people identify the symptoms of dementia, it is still seen by many as "just getting older," but not as a condition. There is still limited support for seniors, especially low-cost and in Spanish. The burden sits on the shoulders of many family caregivers who don't have training, know about resources, or understand the medical terminology. Many people don't accept that their children may be on the spectrum. If they get a referral, they don't always follow up – navigating regional center services can be very demanding and confusing. If disabilities or diagnoses are not visible, it is often just seen as a phase – they will get over it. – Community Leader
>
> Many disabling conditions are preventable, but because there is not an effort for community health education to prevent or identify early signs of these conditions, people usually see a physician when the condition is in its advanced stages. – Public Health Representative

Unhoused Population

> Disabling conditions are major problems in our community, particularly among our unhoused population, due to a combination of delayed medical care, inconsistent access to essential resources, and the compounded effects of chronic stress and unstable living environments. Many of our unhoused guests do not seek medical attention until their conditions have progressed significantly, resulting in complications that could have been prevented with earlier intervention. Furthermore, the lack of consistent access to nutritious meals, safe spaces for rest and recovery, and opportunities for physical activity exacerbates chronic conditions like diabetes, hypertension, and mobility issues, leading to long-term disabilities. These disabling conditions limit individuals' ability to find stable employment or housing, perpetuating a cycle of poverty and homelessness. Without access to consistent health care, supportive services, and preventative measures, these challenges remain a significant barrier. – Community Leader
>
> The unhoused are living on the streets or in temporary housing. They also don't have access to healthy meals or, in many cases, any meals. – Community Leader

Impact on Quality of Life

> Absolutely. Many clients refer to arthritis, back pain, and poor vision as the reason they cannot work, causing economic disparity. Many clients do not have proper health insurance, such as immigrants, so they are not seeing specialists for their health issues. – Social Services Provider
>
> Activity limitations and chronic pain. – Community Leader

Incidence/Prevalence

> Clients have disclosed these disabling conditions. – Community Leader
>
> Over time, more and more people are experiencing these conditions. – Public Health Professional

Unhoused Populations

> In the Skid Row community of downtown Los Angeles, disabling conditions are both a cause of and a result of experiencing homelessness. We know that the population of people experiencing homelessness is also rapidly aging and present geriatric and disabling conditions associated with aging much earlier than the housed population (on average, 20 years earlier). They also experience activity limitations due to aging and due to the unique stresses of experiencing homelessness. And those in the Skid Row community are near hospitals and medical centers without the resources to address these conditions. – Community Leader

Alcohol/Drug Use

> Disabling conditions is a broad category. Those experiencing chronic pain are sometimes self-medicating with marijuana and other substances (including abusing prescription drugs) which can cause substance use issues. Those experiencing dementia or activity limitations as they age may not have people in their home to assist with their care. Navigating and finding in-home assistance is very difficult for most people. – Social Services Provider

Lack of Providers

> Not nearly enough providers will certify for disability. Plus, it usually gets denied the first time and requires an attorney, but there are not enough medical legal partnerships. The result is disabled people can't qualify. – Physician

Transportation

> Transportation barriers. – Community Leader

Affordable Care/Services

> Because of a lack of affordable care. – Public Health Professional

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.

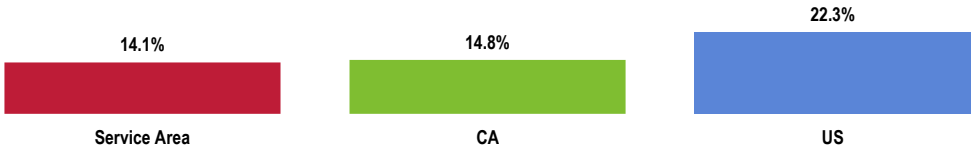
– Healthy People 2030 (https://health.gov/healthypeople)

Prenatal Care

Early and continuous prenatal care is the best assurance of infant health.

This indicator reports the percentage of women who did not receive prenatal care during their first trimester of pregnancy. This indicator can signify a lack of access to preventive care, a lack of health knowledge, or other barriers to services.

Lack of Prenatal Care in the First Trimester
(Percentage of Live Births, 2021-2023)



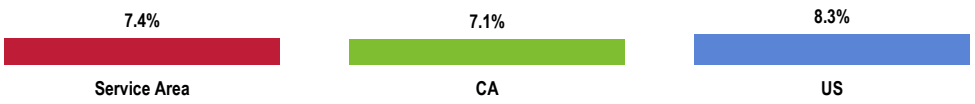
Sources: • Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
Note: • This indicator reports the percentage of women who do not obtain prenatal care during their first trimester of pregnancy.

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.

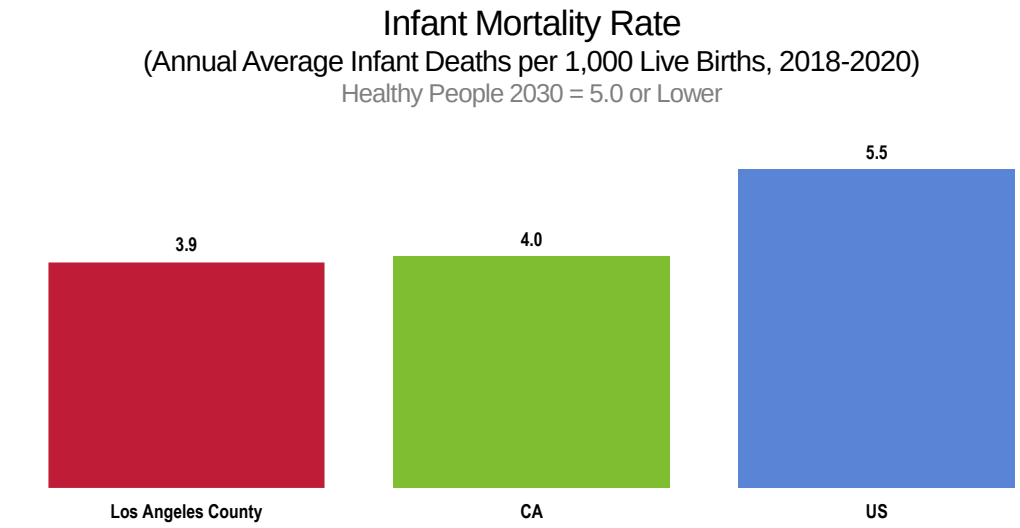
Low-Weight Births
(Percent of Live Births, 2016-2022)



Sources: • University of Wisconsin Population Health Institute, County Health Rankings.
Note: • This indicator reports the percentage of total births that are low birth weight (Under 2500g).

Infant Mortality

Infant mortality rates reflect deaths of children less than one year old per 1,000 live births. High infant mortality can highlight broader issues relating to health care access and maternal/child health. [COUNTY-LEVEL DATA]



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted January 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- This indicator reports deaths of children under 1 year old per 1,000 live births.

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.

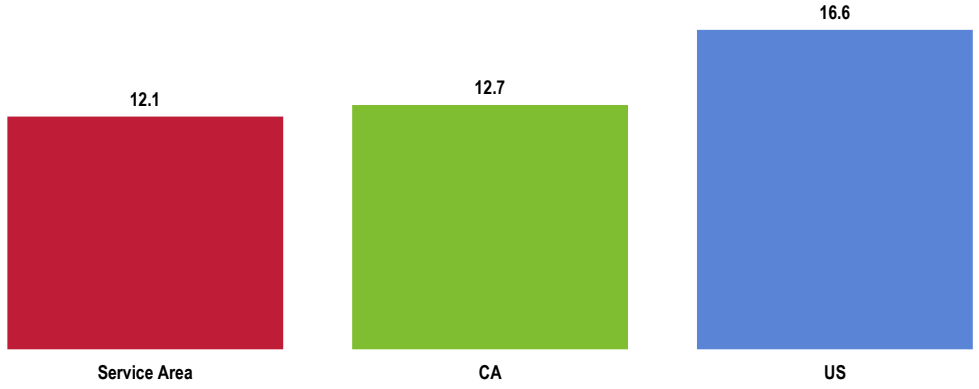
– Healthy People 2030 (https://health.gov/healthypeople)

Births to Adolescent Mothers

Here, teen births include births to women age 15 to 19 years old, expressed as a rate per 1,000 female population in this age cohort.

The following chart outlines local teen births, compared to the state and nation. In many cases, teen parents have unique health and social needs. High rates of teen pregnancy might also indicate a prevalence of unsafe sexual behavior.

Teen Birth Rate
(Births to Adolescents Age 15-19 per 1,000 Females Age 15-19, 2016-2022)

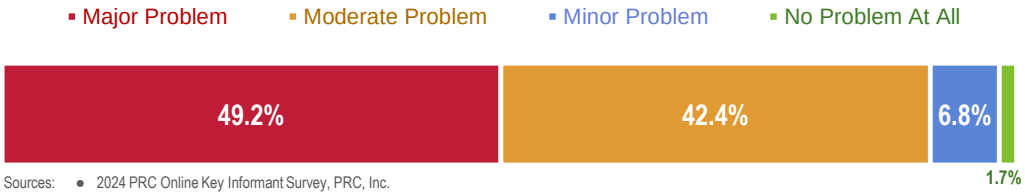


Sources: ● Centers for Disease Control and Prevention, National Vital Statistics System.
● Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).
Notes: ● This indicator reports the rate of total births to women under the age of 15–19 per 1,000 female population age 15–19.

Key Informant Input: Infant Health & Family Planning

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

Perceptions of Infant Health & Family Planning as a Problem in the Community
(Among Key Informants; Service Area, 2024)



Sources: ● 2024 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

> A lot of this one has to do with limited community resources and support available to young families and a shift from learning that once was part of multigenerational families. – Social Services Provider
>
> As more women's health centers are closing in Los Angeles, we are seeing a rise in poor prenatal care. We're also seeing a rise in family homelessness. – Community Leader
>
> Access to specialty services. Closures of labor and delivery programs. – Community Leader

Awareness/Education

> Lack of education on spacing and parents being embarrassed to talk to their doctors about options for family planning. – Social Services Provider
>
> Lack of access to child development education and support, knowledge about and access to birth control, access to health and safe environments, activities and food. – Community Leader

Teen Pregnancy

> We have a fairly young population that faces barriers to having a healthy pregnancy and ensuring their children grow up safe, healthy, and ready to succeed in school. – Social Services Provider

> I see still in several areas in the community very young girls having children. I don't know if it's what they want to do, or do we circle back and wonder if they are lacking an education, knowing that there are options and birth control available for them. I know that in certain cultures, it is a subject that we don't even discuss. I feel that maybe the schools should be a little more proactive in educating both young girls and young men on birth control. – Other Health Provider

People With Vulnerabilities

> My community, I consider the trafficking survivors I assist in Los Angeles and South Los Angeles. They are often struggling to remain housed, struggling with mental health and often substance use, so their children are in an often chaotic, inconsistent environment, in need of care. – Community Leader
>
> A large percent of our community is Black/African-American. There's many findings that point to high mortality rates in Black mothers and infants due to lack of quality care, services, and resources. – Public Health Representative

Lack of Providers

> I don't think there are enough quality providers in the area of infant health and family planning. – Social Services Provider
>
> Lack of providers. – Community Leader

Income/Poverty

> Many families need the social and emotional support for parenting and family planning. We have many single mothers or parents with unstable income, making it very difficult to properly train and support new parents. – Social Services Provider

Unhoused Population

> The unhoused are living on the streets or in temporary housing. They also don't have access to healthy meals or, in many cases, any meals. – Community Leader

Cost of Living

> High cost of living and lack of affordable child care. – Community Leader

Language Barrier

> Lack of outreach and language barriers. – Public Health Professional

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.

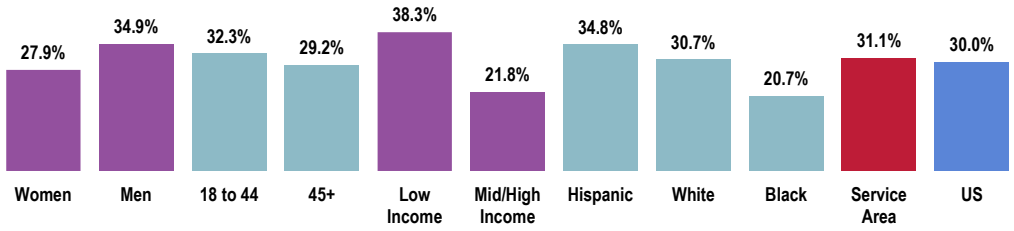
Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

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

Access to Fresh Produce

PRC SURVEY ▶ "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
(Service Area, 2024)



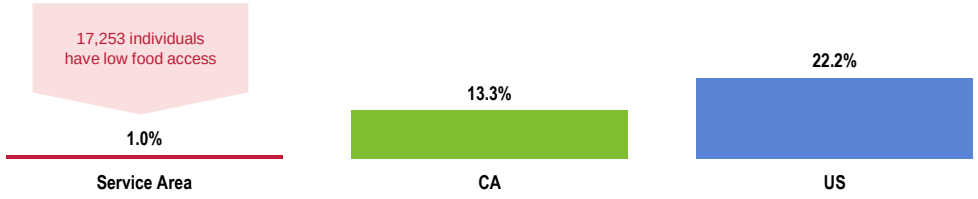
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 66]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Low Food Access

Low food access is defined as living more than one mile from the nearest supermarket, supercenter, or large grocery store in urban areas (10 miles in rural areas). This related chart is based on US Department of Agriculture data.

Population With Low Food Access
(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 January 2025 via SparkMap (sparkmap.org).

Notes:
- Low food access is defined as living far (more than 1 mile in urban areas, more than 10 miles in rural areas) from the nearest supermarket, supercenter, or large grocery store.

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.

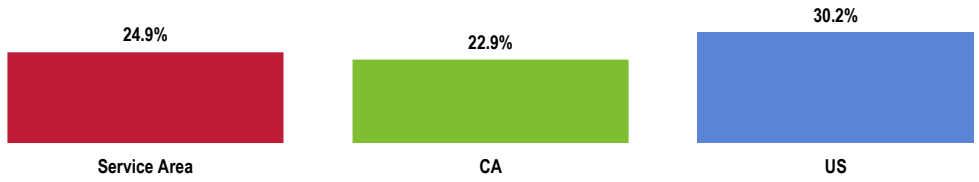
– Healthy People 2030 (https://health.gov/healthypeople)

Leisure-Time Physical Activity

PRC SURVEY ► "During the past month, did you participate in any physical activities or exercises, such as running, calisthenics, golf, gardening, or walking for exercise?"

No Leisure-Time Physical Activity in the Past Month

Healthy People 2030 = 21.8% or Lower



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 69]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 California data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

Meeting Physical Activity Recommendations

ADULTS: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

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

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

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

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

PRC SURVEY ► "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.

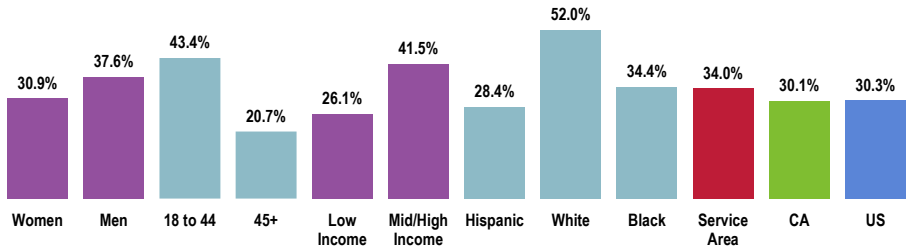
Respondents were also asked about strengthening exercises:

PRC SURVEY ► "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."

Meets Physical Activity Recommendations

(Service Area, 2024)

Healthy People 2030 = 29.7% or Higher



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 110]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 California data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.
- 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* who also report doing physical activities specifically designed to strengthen muscles at least twice per week.

Children's Physical Activity

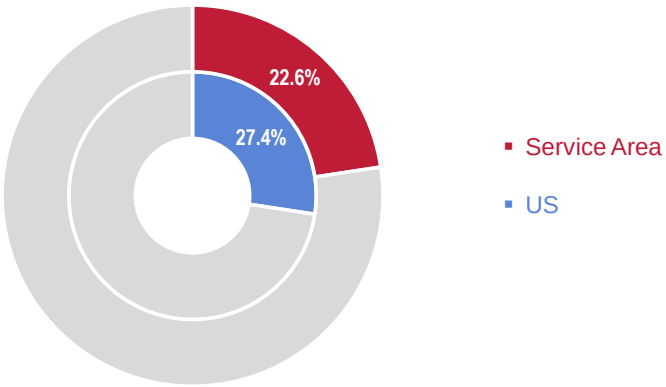
PRC SURVEY ► "During the past 7 days, on how many days was this child physically active for a total of at least 60 minutes per day?"

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

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



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 94]
- 2023 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 each of the seven days preceding the survey.

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
Healthy Weight	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥30.0

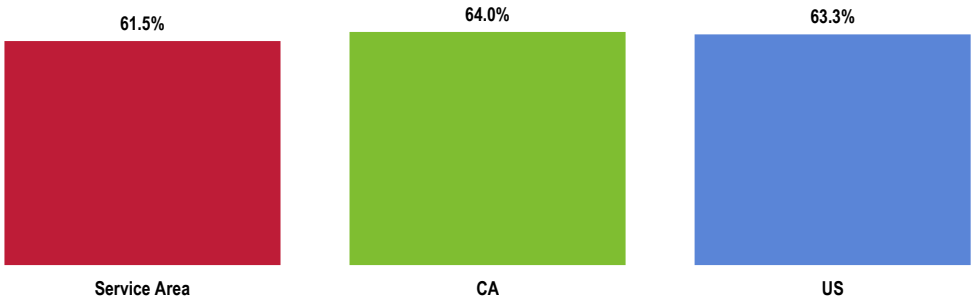
Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September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

PRC SURVEY ► "About how much do you weigh without shoes?"

PRC SURVEY ► "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)



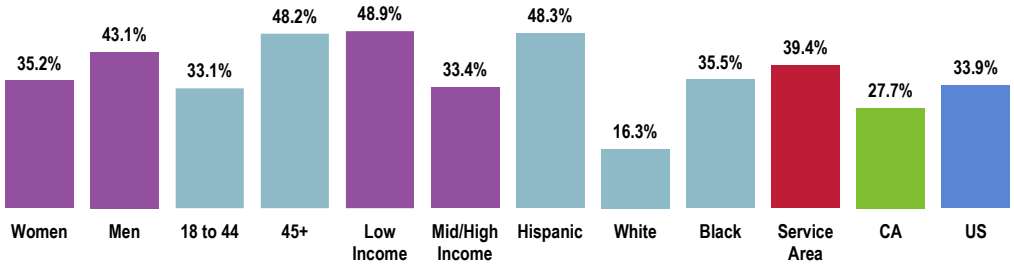
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 112]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 California data.
- 2023 PRC National Health Survey, 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. The definition for obesity is a BMI greater than or equal to 30.0.

Prevalence of Obesity

(Service Area, 2024)

Healthy People 2030 = 36.0% or Lower



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 112]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 California data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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.

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:

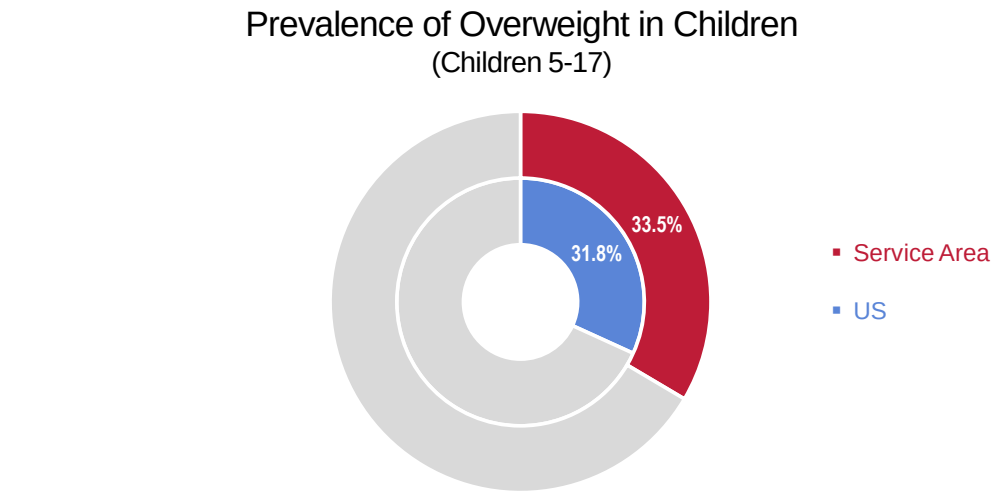
- Underweight — <5th percentile
- Healthy Weight — ≥5th and <85th percentile
- Overweight — ≥85th and <95th percentile
- Obese — ≥95th percentile

– 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:

PRC SURVEY ► "How much does this child weigh without shoes?"

PRC SURVEY ► "About how tall is this child?"

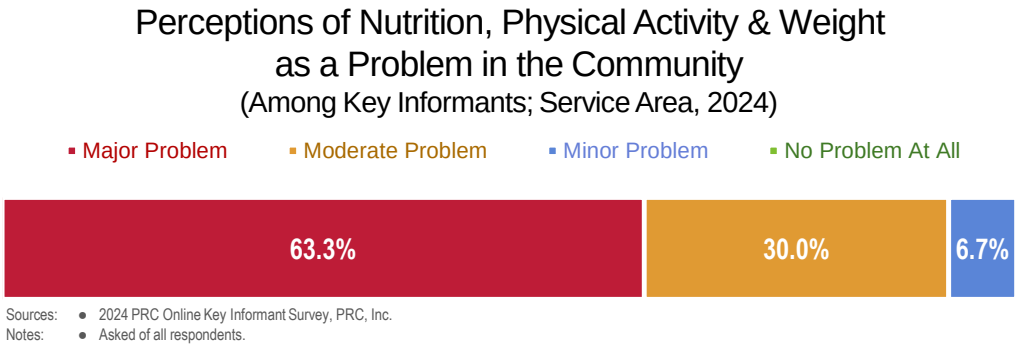


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 113]
- 2023 PRC National Health Survey, PRC, Inc.

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:



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

Access to Affordable Healthy Food

> We are in a food desert, and the poor economics of our service area result in people having to focus on work, not physical health. – Community Leader
>
> Many clients share that they are too poor to purchase fresh food. Many are eating potatoes and rice to make ends meet, for example, or eat food from a grocery distribution, which is limited and not ethnically sensitive. – Social Services Provider
>
> Help with access to healthy foods. – Community Leader
>
> Our community is in a food desert. Access to healthy and affordable food is more of a challenge. Also, the built environment of our community does not allow for safe/walkable streets, not all parks are created or updated to encourage physical activity, and there's limited gym availability. – Public Health Representative
>
> Individuals do not have access to healthy foods and do not have time to exercise or get the physical activity needed. There are very few grocery stores in the area. – Social Services Provider
>
> The only access to food is junk food. – Community Leader

Awareness/Education

> Education, financial resources, time, food deserts. – Public Health Professional
>
> There is not enough education around nutrition at a young age and too much reluctance to change habits among adults. Many people are struggling to maintain a healthy weight and stay or become physically active. – Social Services Provider
>
> There is a lack of educational programs to support people with the importance of physical activity and having balanced nutrition to include fruits, vegetables, and water intake. Most people are watching television or on their electronics without including physical activities. People consume fast food and need education on what this type of food contains and access to affordable, nutritious foods. – Social Services Provider

Built Environment

> Not enough parks that are considered safe to do physical activity. – Social Services Provider
>
> Lack of access to safe green spaces and affordable, healthy foods. – Social Services Provider
>
> Walkability access, how to read a nutrition label, managing weight, gyms with reasonable prices. – Public Health Professional

Nutrition

> Too much cheap, processed food. Cultural attachments to tortilla food as a staple in the diet. – Community Leader
>
> Diet and lack of exercise, which leads to weight gain. – Community Leader
>
> Too many fast food restaurants. – Public Health Professional

Access to Care/Services

> Lack of community resources and confounding factors of stress such as financial, emotional, etc. – Social Services Provider
>
> The biggest challenge related to nutrition, physical activity, and weight for people in our community is the lack of consistent access to resources and environments that support a healthy lifestyle. For many of our unhoused guests, regular access to nutritious meals is unpredictable, and they often rely on calorie-dense, low-nutrient foods that are easier to obtain. This leads to poor dietary habits that exacerbate chronic conditions like diabetes and hypertension. Physical activity is another significant challenge, as unhoused individuals often have limited safe spaces to exercise. The constant stress of survival and mobility reduces opportunities for intentional physical activity, further impacting their health. Additionally, the lack of access to stable health care and education on proper nutrition and exercise creates barriers to addressing weight-related issues, making it difficult for individuals to maintain or achieve a healthy weight. – Community Leader

Lifestyle

> Diet and lack of exercise, which leads to weight gain. – Community Leader
>
> Fast-paced environment, fast food, low income. – Community Leader

People With Vulnerabilities

> If you look at the lower-income population, you'll always see more obesity because they cannot afford to eat clean and healthy. We haven't been able to provide a market that allows them to do that, so they will have to eat more inexpensive things and a lot of fast food and a lot of processed meats, which as we know are not healthy, and a lot of inexpensive processed breads, which, again, we know are not healthy, because we just can't afford to provide a market that has the Whole Foods-style that is affordable for people to go and buy their foods. – Other Health Provider

Affordable Care/Services

> High cost of living, low wages, lack of spacious community recreational services, cost of gyms, and stress. – Community Leader

Unhoused Population

> The unhoused are living on the streets or in temporary housing. They also don't have access to healthy meals or, in many cases, any meals. – Community Leader

Prevention/Screenings

> Screening, understanding healthy lifestyles, recognizing signs and symptoms, diet, food preparation, consequences. – Community Leader

Physical Activity

> Time and place to get physical activity. Incorporating it into everyday living. Less in-person meetings and classes and such in which to do Zumba, display exercise, etc. – Social Services Provider

Follow Up/Support

> Outpatient follow-up resources. – Physician

Substance Use

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.

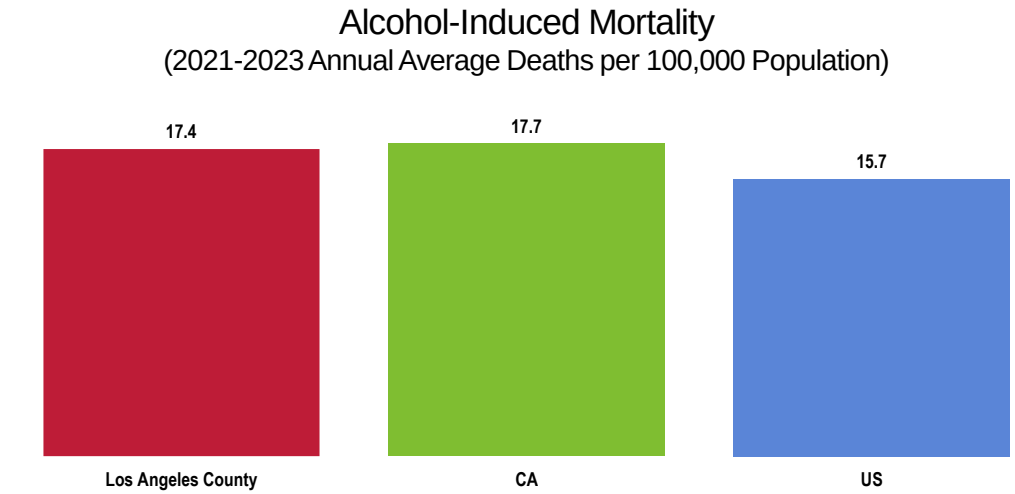
Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

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

Alcohol

Alcohol-Induced Deaths

The following chart outlines alcohol-induced mortality in the county. [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 January 2025.
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population.

Excessive Drinking

PRC SURVEY ► "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?"

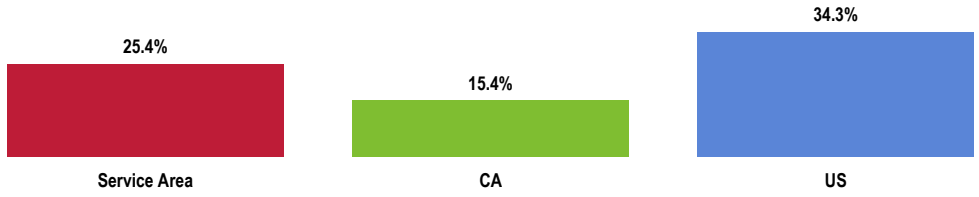
PRC SURVEY ► "On the day(s) when you drank, about how many drinks did you have on average?"

PRC SURVEY ► "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 drinking includes heavy and/or binge drinkers:

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

Engage in Excessive Drinking



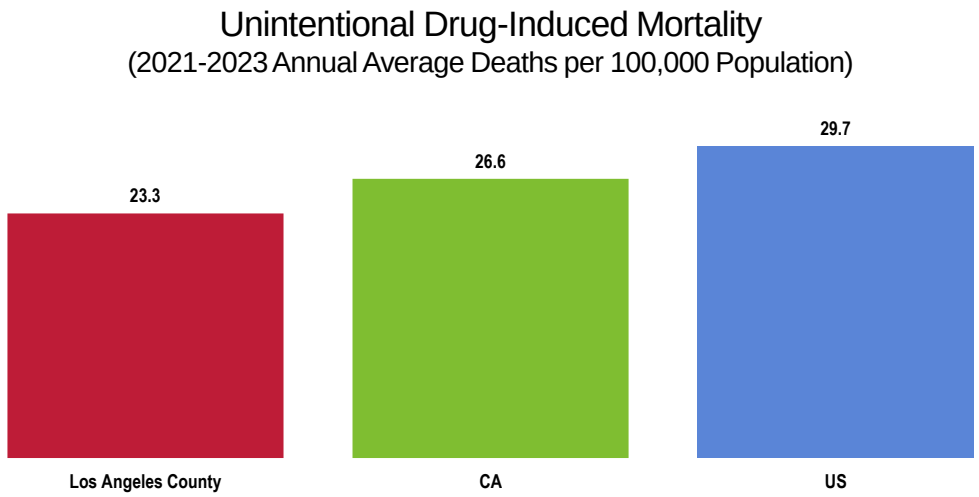
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 116]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 California data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Excessive drinking reflects the percentage of persons age 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

Unintentional Drug-Induced Deaths

Unintentional drug-induced deaths include all deaths, other than suicide, for which drugs are an 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 mortality for unintentional drug-induced deaths. [COUNTY-LEVEL DATA]



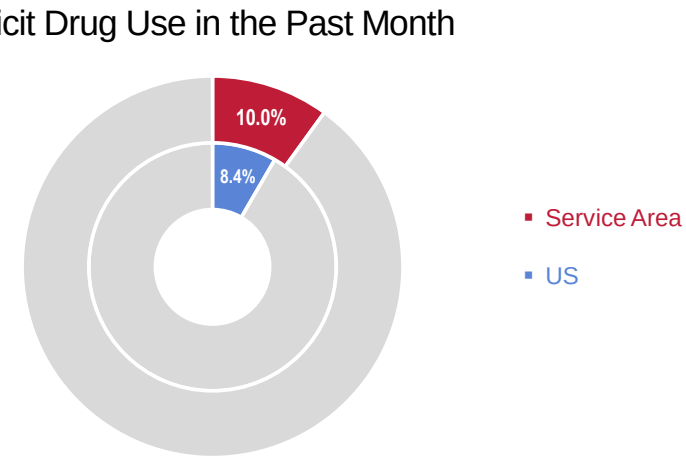
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted January 2025.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Illicit Drug Use

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.

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



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 40]
- 2023 PRC National Health Survey, PRC, Inc.

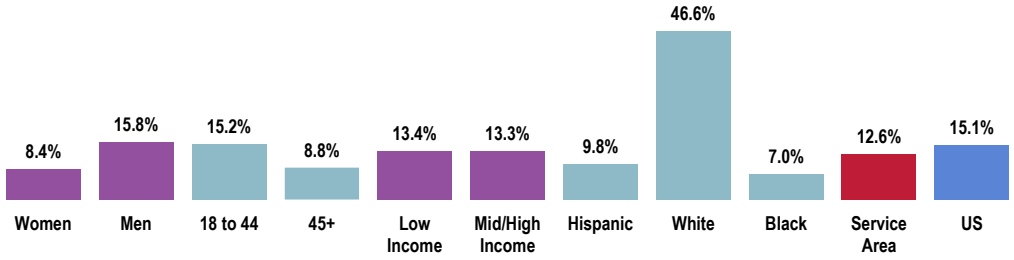
Notes:
- Asked of all respondents.

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.

PRC SURVEY ► "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
(Service Area, 2024)



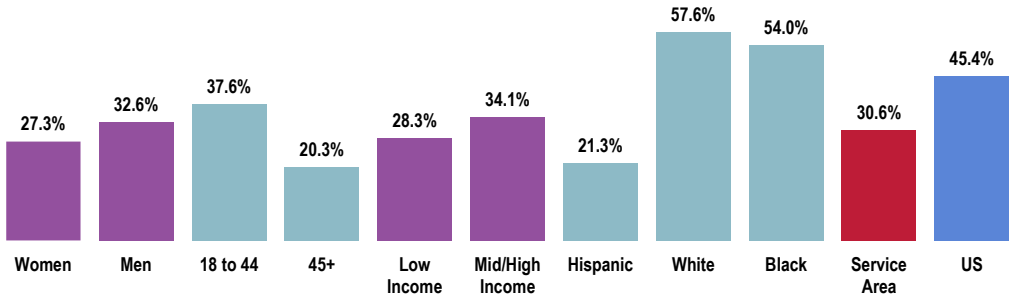
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 41]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Personal Impact From Substance Use

PRC SURVEY ► "To what degree has your life been negatively affected by your own or someone else's substance use 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 Use (by Self or Someone Else)
(Service Area, 2024)

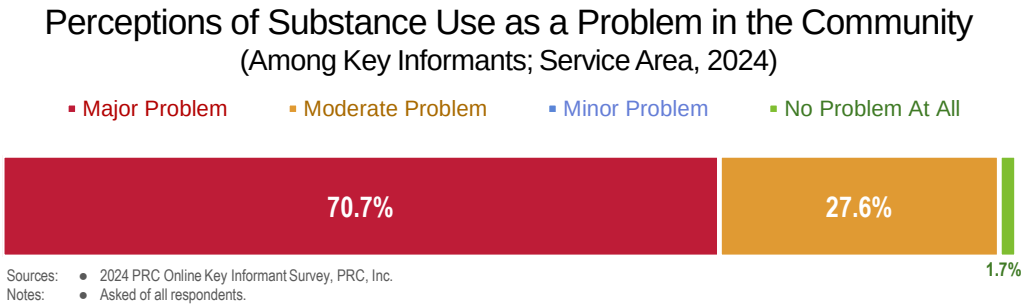


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 43]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes response of "a great deal," "somewhat," and "a little."

Key Informant Input: Substance Use

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



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

Access to Care/Services

> Not enough substance abuse programs. – Community Leader
>
> Not nearly enough inpatient beds. Outpatient treatment is limited. For the homeless, street medicine is the best option, but it needs to be better supported by the cities and counties and better rates from plans. – Physician
>
> Availability, not taking insurance coverage, low staffing, long blackout periods, not having proper medications due to a person's health condition, to be admitted. – Community Leader
>
> In my opinion, the greatest barriers to accessing needed substance use treatment in our community are a lack of tailored, accessible services and the stigma surrounding substance use. Many individuals, particularly our unhoused guests and low-income immigrant families, face significant obstacles such as limited financial resources, lack of health insurance, language barriers, and a mistrust of institutions, which prevent them from seeking or continuing treatment. A critical barrier is the absence of culturally sensitive and trauma-informed care. Many individuals in our community need programs that consider their unique cultural and socioeconomic backgrounds. For immigrant populations, language and cultural differences often make it difficult to communicate their needs or feel understood, leading to underutilization of available resources. Onsite workshops tailored to specific groups in our community could play a transformative role in overcoming these barriers. – Community Leader
>
> Services are difficult to access, very limited in scope, and don't provide comprehensive services needed to address issues. – Social Services Provider
>
> Similarly to mental health, our community faces high rates of substance use. Much of which is due to lack of timely access to care and knowing where to get care. – Public Health Representative
>
> There are simply not enough beds, even when people want the help. They either can't find a bed or they can't afford the bed. – Community Leader

Denial/Stigma

> People don't accept they have a substance use/abuse problem; not all doctors refer people to substance treatment programs; cultural humility and how you approach the patient so they know that they need assistance; feeling supported (they are not alone, there are people who can help); and knowing how to accept they have a problem and empowered to do something about it. – Community Leader
>
> People not recognizing they have a substance abuse problem and the lack of education on the impact to themselves and their families. – Social Services Provider
>
> Stigma is a barrier, as well as a lack of medical assisted treatment, detoxification centers, insufficient residential treatment programs, and outpatient treatment programs. – Community Leader

Unhoused Population

> The unhoused are living on the streets or in temporary housing. They also don't have access to healthy meals or, in many cases, any meals. – Community Leader
>
> The population of those experiencing homelessness also have high use of substances. There is no access to treatment or assistance for them. – Social Services Provider
>
> People living on the street are unwilling or unable to access substance abuse treatment. – Social Services Provider

Affordable Care/Services

> Substance treatment is often expensive, and Medicare-based programs are hard to find. – Community Leader

> Again, this comes to cost. They have great places like Betty Ford and these place in Malibu, but these places will run you $5,000 a week. Who can afford that? The celebrities – only they're allowed to get sober. I know that we have like AA and other places, but sometimes people need more than that to be able to wing them off whatever it is that they have found themselves addicted to. – Other Health Provider

Willingness to Seek Treatment

> I think the greatest barrier is that many addicts don't want to get help. It takes a lot to get to that point. I also think physicians are overprescribing pain medications, which can be a gateway to substance use. There are also many people in the community who can't get through the day without marijuana, and because it's legal, there isn't even a recognition of how damaging that can be to a person's health. – Social Services Provider

> The willingness of those who have substance abuse issues to seek treatment. – Community Leader

Diagnosis/Treatment

> Fragmented care, individuals are dealing with a number of complicating issues, such as homelessness, etc. – Social Services Provider

Follow Up/Support

> There are so many people who are substance-dependent and not enough recovery programs. Unhoused population using drugs are causing a blight across the county. – Social Services Provider

Lack of Providers

> Lack of access to providers. Capacity constraints of existing programs. – Community Leader

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.

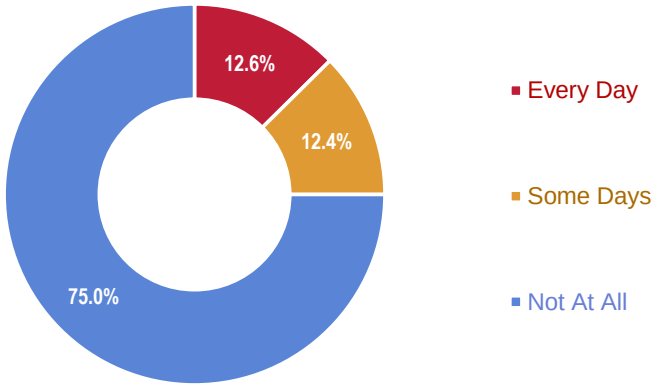
Several evidence-based strategies can help prevent and reduce tobacco use and exposure to secondhand smoke. These include smoke-free policies, price increases, and health education campaigns that target large audiences. Methods like counseling and medication can also help people stop using tobacco.

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

Cigarette Smoking

PRC SURVEY ► "Do you currently smoke cigarettes every day, some days, or not at all?"
("Currently Smoke Cigarettes" includes those smoking "every day" or on "some days.")

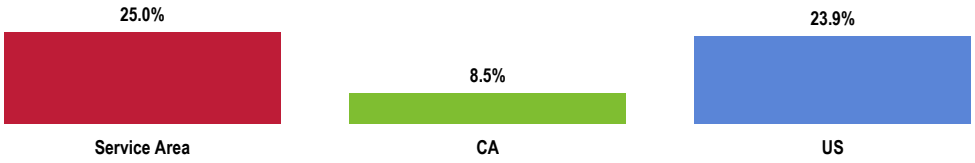
Prevalence of Cigarette Smoking
(Service Area, 2024)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 34]

Notes:
- Asked of all respondents.

Currently Smoke Cigarettes
Healthy People 2030 = 6.1% or Lower



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 34]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 California data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

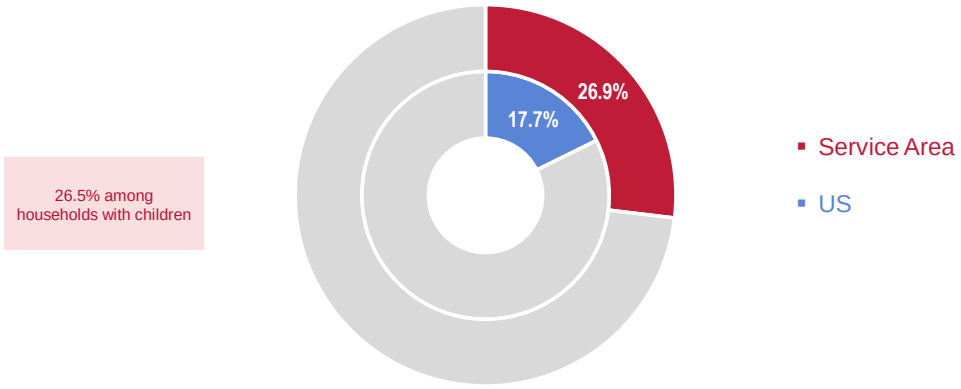
Notes:
- Asked of all respondents.
- Includes regular and occasional smokers (those who smoke cigarettes every day or on some days).

Environmental Tobacco Smoke

PRC SURVEY ► "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, as well as among only households with children (age 0-17).

Member of Household Smokes at Home



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 35, 114]
- 2023 PRC National Health Survey, PRC, Inc.

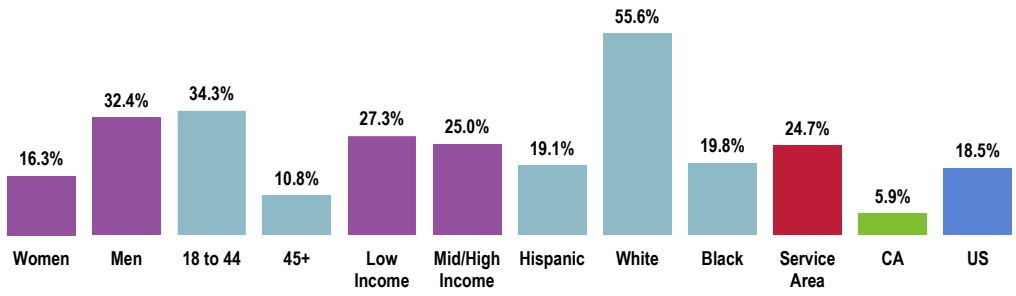
Notes:
- Asked of all respondents.
- "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

Use of Vaping Products

PRC SURVEY ► "Electronic vaping products, such as electronic cigarettes, are battery-operated devices that simulate traditional cigarette smoking but do not involve the burning of tobacco. Do you currently use electronic vaping products, such as electronic cigarettes, every day, some days, or not at all?"

("Currently Use Vaping Products" includes use "every day" or on "some days.")

Currently Use Vaping Products
(Service Area, 2024)

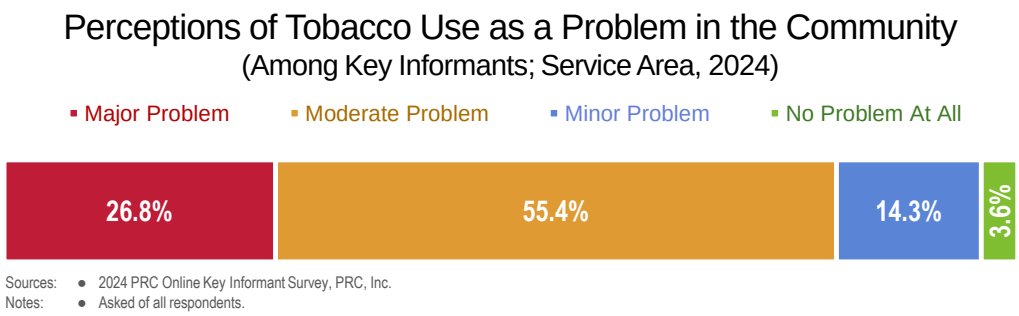


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 36]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 California data.
- 2023 PRC National Health Survey, PRC, Inc.

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

Key Informant Input: Tobacco Use

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



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

Addiction

> Tobacco use is a major problem in South LA because it is a coping mechanism, and menthol cigarettes are highly addictive and disproportionately sold in South LA. – Community Leader
>
> Addiction to this substance. – Community Leader
>
> People turn to tobacco for another form to cope and so often leads to lung cancer. People often share how they are addicted to it. – Community Leader

Easy Access

> It is legal and it is easy for all ages to buy tobacco. That is leading to heavier or serious smoking addictions. – Community Leader
>
> Advertising by the tobacco industry and the availability of tobacco products. – Community Leader

Incidence/Prevalence

> There are higher rates of tobacco use in this area than neighboring areas. Use continues to drive other health concerns. – Social Services Provider

Sexual Health

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).

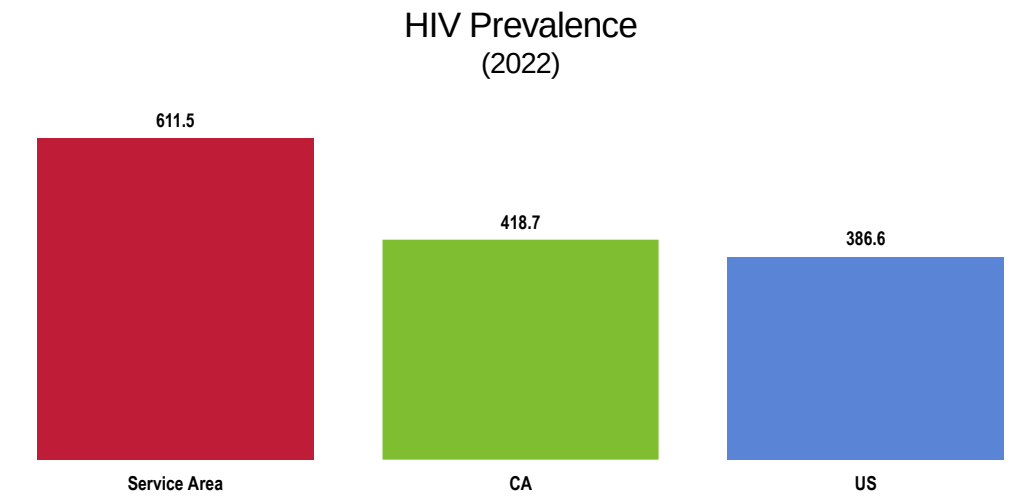
Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV. Promoting behaviors like condom use can help prevent STIs.

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)

HIV

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 January 2025 via SparkMap (sparkmap.org).

Sexually Transmitted Infections (STIs)

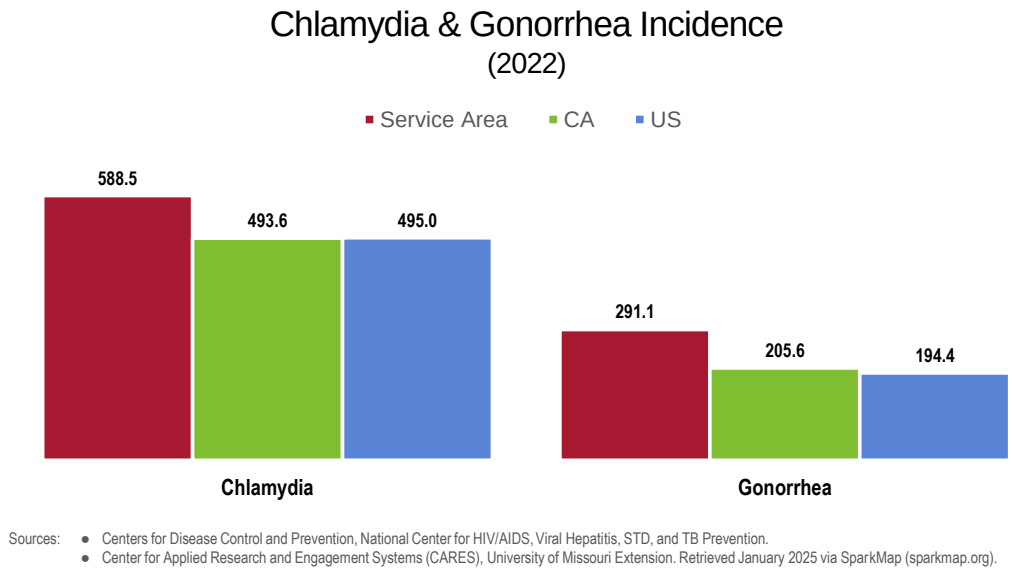
Chlamydia

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.

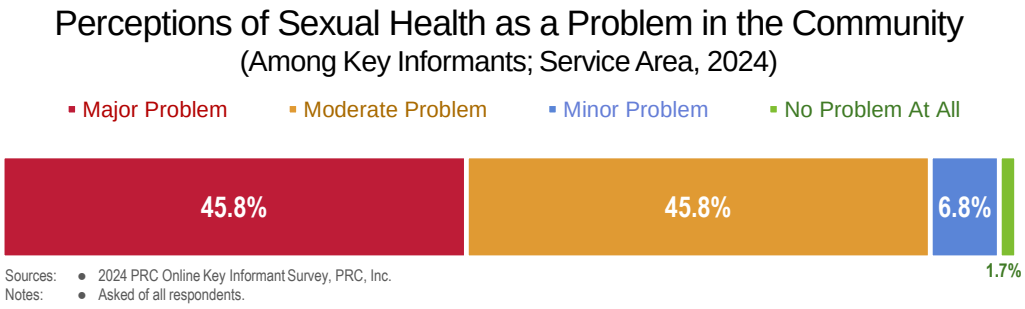
The following chart outlines local incidence for these STIs.



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 January 2025 via SparkMap (sparkmap.org).

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: 2024 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

> Not enough information and prevention on STDs and HIV, etc. – Community Leader
>
> Not knowing about preventative care and sex education. – Public Health Professional

> Sexual health is a major problem in our community due to limited access to education, preventive care, and essential resources. Many of our unhoused guests and low-income families lack access to affordable sexual health services, including regular testing, contraception, and treatment for sexually transmitted infections (STIs). This gap in care often leads to untreated health issues, higher rates of infection, and unplanned pregnancies. For the unhoused population, the lack of privacy and safe spaces further complicates their ability to address sexual health concerns. Stigma and cultural barriers also play a significant role, preventing open conversations and education about sexual health. Additionally, the transient nature of homelessness and the stress of survival can lead to risky behaviors, making the need for accessible, trauma-informed sexual health services even more critical. Without proper education, resources, and care, addressing sexual health remains a significant challenge.- Community Leader
>
> People not being educated about sexually transmitted diseases and not using family planning. – Social Services Provider
>
> Yes, many STDs, people are not taking their sexual health seriously. There is a syphilis epidemic. – Social Services Provider

Denial/Stigma

> Stigma again plays a role here. – Social Services Provider
>
> Stigma, people not being tested regularly. – Community Leader
>
> There's a lot of stigma, and screening and treatment is mostly done by DPH who only do STI care. This means the majority of care offered is by strangers to people, not their primary care with a relationship, or the possibility of a relationship. – Physician

Incidence/Prevalence

> South Los Angeles, in particular, has high rates of STI and STDs. – Social Services Provider
>
> Statistics. Chlamydia and syphilis are exploding. – Social Services Provider
>
> Sexually transmitted diseases have increased. – Public Health Professional

Sex Trafficking

> My community, I consider the trafficking survivors I assist in Los Angeles and South Los Angeles. They have experienced repeated sexual trauma and frequent STIs. – Community Leader
>
> Epidemic of sex trafficking and violence affecting the community. – Community Leader

Access to Care/Services

> Limited resources already described. Individuals in the Inglewood and surrounding areas seriously impacted by the Centinela closure of the birthing center and related services. – Social Services Provider

Unhoused Population

> The unhoused are living on the streets or in temporary housing. They also don't have access to healthy meals or, in many cases, any meals. – Community Leader

Reproductive Health for Women

> Reproductive health for women. – Community Leader

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

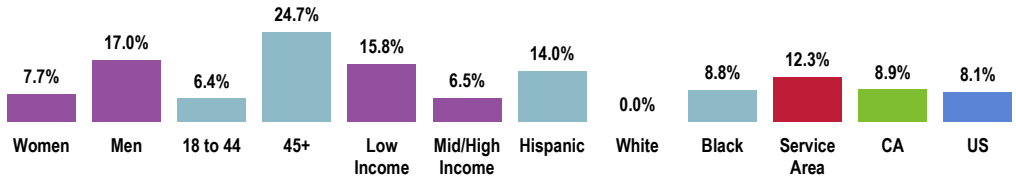
Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus, excluding the Medicare population) who have no type of insurance coverage for health care services – neither private insurance nor government-sponsored plans.

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

PRC SURVEY ► "Do you have any government-assisted health care coverage, such as Medicare, Medi-Cal, or VA/military benefits?"

PRC SURVEY ► "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 entirely on your own?"

Lack of Health Care Insurance Coverage
(Adults Age 18-64; Service Area, 2024)
Healthy People 2030 = 7.6% or Lower



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 117]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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

Difficulties Accessing Health Care

Barriers to Health Care Access

To better understand health care 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.

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

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

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

PRC SURVEY ► "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?"

PRC SURVEY ► "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?"

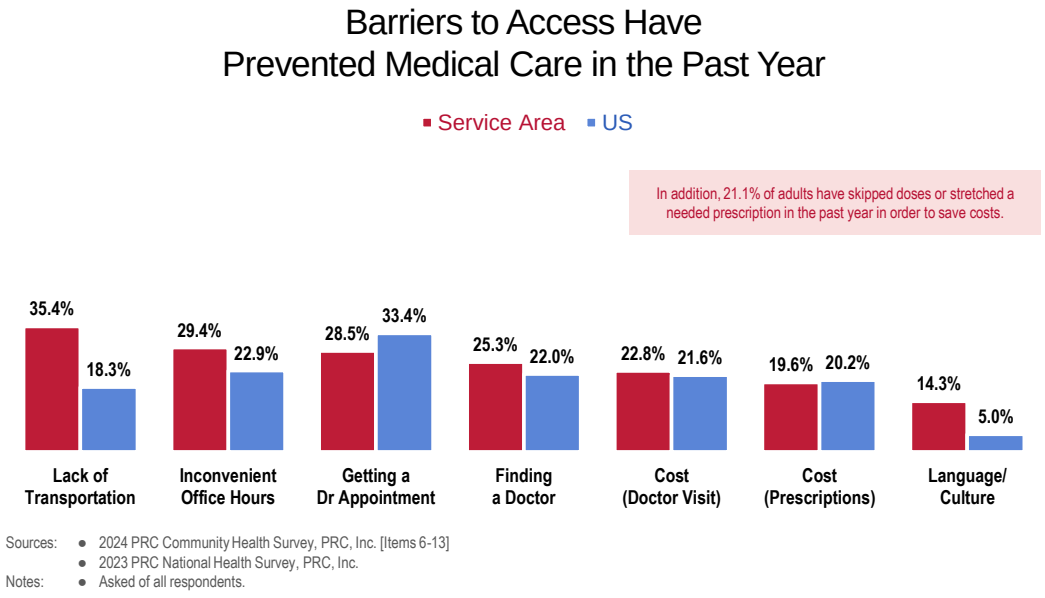
PRC SURVEY ► "Was there a time in the past 12 months when you needed a prescription medicine but did not get it because you could not afford it?"

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

Also:

PRC SURVEY ► "Was there a time in the past 12 months when you skipped doses or took smaller doses in order to make your prescriptions last longer and save costs?"

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

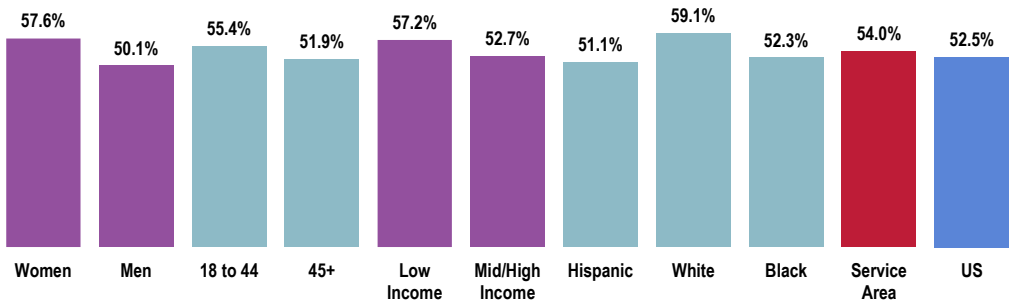


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 6-13]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

The following charts reflect the composite percentage of the total population experiencing problems accessing health care 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
(Service Area, 2024)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 119]
- 2023 PRC National Health Survey, PRC, Inc.

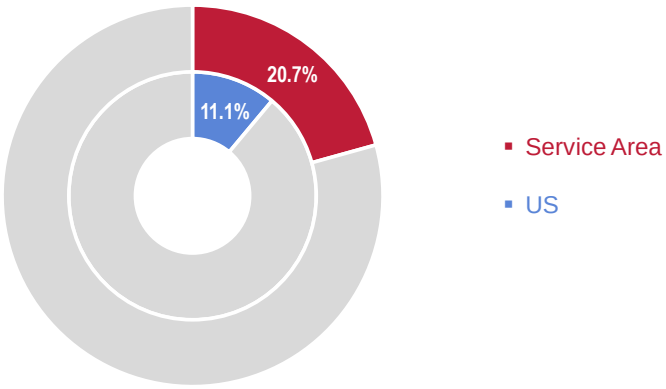
Notes:
- Asked of all respondents.
- Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

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.

PRC SURVEY ► "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)

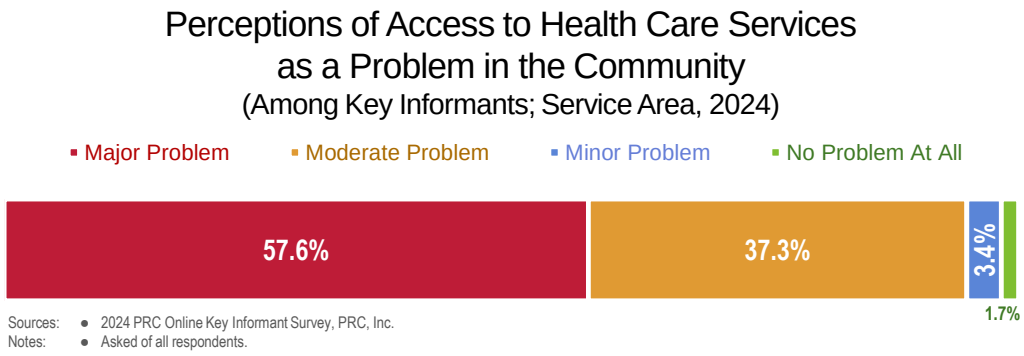


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 90]
- 2023 PRC National Health Survey, PRC, Inc.

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:



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

Access to Care/Services

> Lack of patient referrals. – Public Health Representative
>
> Not enough resources on services that are offered to the community. When you enter a health care facility, there are additional barriers that the community faces to not access the services. – Public Health Professional
>
> Limited resources and locations to access care. Our community faces a shortage of 1,500 physicians, so access becomes an issue when there's not enough people to care for the community. Transportation is also a barrier due to either not having a ride to access a person's care or the location of care being too far (outside of the service area). – Public Health Representative
>
> Our community primarily consists of unhoused individuals and extremely low-income immigrant families. For many, the lack of consistent, accessible health care in a trusted, community-focused location like ours poses significant challenges. Additionally, language barriers further complicate our families' ability to navigate and access essential health care services. – Community Leader
>
> Impacted bed availability, lack of, the need to discharge quickly from hospitals, long waits at clinics, high patient-to-doctor ratios, delays in authorizations, high cost to patient and provider, patients not receiving thorough checks and patient care. – Community Leader
>
> My community, I consider the trafficking survivors I assist in Los Angeles and South Los Angeles. For them, housing, mental health and substance use support, as well as regular health care for them and their children are the most urgent needs. – Community Leader
>
> The problem I see is the lack of clinics that are providing services for the needy in that area. Also, we need to take under consideration that it is a very diverse area. You have several African-Americans, as well as several Latinos that lack education on how to access health care, and because of that, our emergency rooms are being inundated with people on a daily basis. – Other Health Provider
>
> Communities and community members are having a difficult time navigating the health care systems, some of which work in silos. Community members also have a difficult time accessing care due to their insurance plans and the ability to pay for care. Some community members also have a difficult time finding time to go to medical appointments/they do not prioritize it, as some community members work multiple jobs and are unable to go to appointments due to hours of service. – Public Health Professional

Awareness/Education

> Knowledge and a friendly atmosphere to help those that need it. People are afraid because of the cost of health care here. – Social Services Provider
>
> Many patients are not aware if they have insurance or not. It is difficult to understand and navigate Medi-Cal. Those who do have insurance are often assigned to providers that they can't get to or have had a bad experience with. There are many additional barriers to accessing care, such as lack of trust, lack of transportation, lack of child care, and feeling overwhelmed due other traumatic experiences. – Social Services Provider
>
> Health maintenance. Because caring for oneself prevents many of the maladies that affect our communities. It also conveys a positive example to the family, one that will translate into better health. – Physician
>
> Families not knowing where to go. Immigrant families fearing going to community services due to immigration status and not knowing where to go. – Social Services Provider

> Lack of general health literacy and community health education, coupled with health care inequity of health care service provision. Underserved communities are not provided with basic health literacy for prevention and intervention of chronic illnesses and mental health management. When these communities attempt to access health care services, they are met with services that do not address the bigger issues of their health. Because of this, people in underserved communities try to avoid going to see health care providers because they feel they will not receive the assistance they need; that speaks to their experiences and culture, and they feel they will not be taken seriously when they try to explain their health circumstances. – Public Health Representative
>
> Lack of knowledge and inability to advocate for delays, denials, poor quality, benefits that aren't comprehensive. Providers seem oversubscribed. People wait and their condition(s) worsen. Lack of interpretation for any language not English nor Spanish, and even sometimes for Spanish. Transportation not always offered, even though it's a Medi-Cal benefit. I also think telehealth needs to be examined – it can be a huge benefit, but people also benefit from being seen in person, and the community needs to know that an in-person appointment, if preferred, is their right. There is a huge need for more mental health services, which is one area where telehealth can work/benefit the patient not having to come in person. Finally, I fear a huge reduction of demand as people stay in hiding or try to be hidden if workplace, community, and other immigration raids take place. Cuts in health navigation at the state level leaves fewer agencies able to help. – Social Services Provider

Income/Poverty

> Income restrictions, people needing and/or having more than one job, and a lack of providers. – Social Services Provider
>
> One of the biggest challenges in accessing health care in our community is the gap for individuals who are severely cost-burdened or newly homeless, often higher-functioning but struggling with systemic and inequitable barriers. These individuals frequently earn too much to qualify for traditional aid but too little to afford the health care they need to manage issues such as chronic health conditions. They may also be unaware of services available to them, and the system itself overlooks this population, leaving them in a precarious position with few options for the comprehensive support they need. – Community Leader
>
> Costs, social welfare support. – Community Leader
>
> Economic disparities and poverty. Affordable housing and homelessness. Education inequality. Public safety and gang violence. Health disparities. – Community Leader

Lack of Providers

> Lack of medical providers, especially those who accept Medi-Cal and have no-cost or low-cost, sliding scale fee schedules. – Social Services Provider
>
> Biggest challenges are shortage of primary care physicians, reduction in behavioral health services in our community, immigration concerns leading to patients' fear about accessing services, and limited specialty providers that accept Medi-Cal patients. – Community Leader
>
> Not enough providers of care. – Community Leader
>
> There are not enough providers and not enough providers that take Medi-Cal. – Social Services Provider

Foreign-Born

> Legal status. Undocumented immigrants may avoid seeking health care due to fear of being reported to immigration authorities. Even documented immigrants may face challenges if they are unsure of their eligibility for services. – Community Leader
>
> Many folks, particularly immigrants, have no email and do not know how to navigate the Medi-Cal enrollment process and do not know how to access services. Health navigators and promotoras are essential to provide them enrollment assistance and help them locate clinics and make medical appointments. – Public Health Representative

Unhoused Population

> The vast majority of people experiencing homelessness have reported chronic physical and/or mental health conditions without the financial resources to access traditional forms of care. Specifically for women experiencing homelessness, there are added barriers to safety, in addition to the chance to traumatize/retraumatize individuals experiencing homelessness who are seeking care in an environment that is not trauma-informed. Some health care service centers may also mandate specific treatments or have prerequisites for services that limit access to care for individuals experiencing homelessness. Further, people experiencing homelessness also may not have the required documentation for seeking care, such as a driver's license or ID. – Community Leader
>
> Care for people experiencing homelessness. There needs to be a lot more street medicine. Additionally, primary care assignment for insurance is a major barrier, especially for the homeless. Anyone seeing them, like street medicine, should be able to access their benefits regardless of PCP assignment. – Physician

Insurance Issues

> Lack of insurance, lack of farmers' markets, issues in getting appointments when needed, and having to wait too long. – Public Health Professional

> Having to reassign the health insurance to the health clinic you want to go to. That may take a process before being able to see the doctor. – Social Services Provider

Language Barrier

> Language, transportation, awareness of where to go. – Social Services Provider
>
> Language barriers, fear due to changing laws and immigration. – Social Services Provider

Transportation

> Lack of transportation. Confusion navigating a complex health care network. – Community Leader
>
> Transportation, time, health literacy. – Public Health Professional

Affordable Care/Services

> Health care has become too expensive for most families in the downtown area. – Social Services Provider

Prenatal Care

> The lack of available prenatal care, specifically the closure of the birthing center at Centinela Hospital, created an enormous gap in our community. – 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.

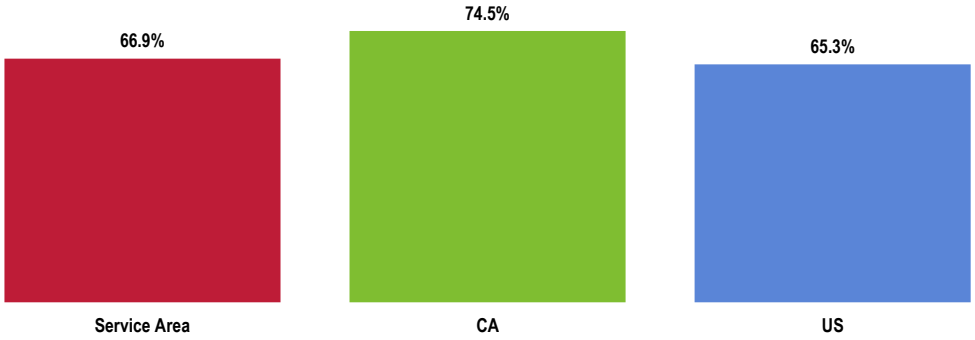
Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

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

Utilization of Primary Care Services

PRC SURVEY ► "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?"

Have Visited a Physician for a Checkup in the Past Year



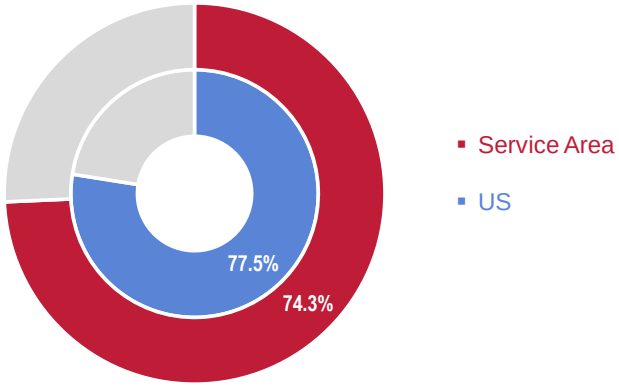
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 16]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 California data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

PRC SURVEY ► "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?"

Child Has Visited a Physician for a Routine Checkup in the Past Year

(Children 0-17)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 91]
- 2023 PRC National Health Survey, PRC, Inc.

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

Oral Health

ABOUT ORAL HEALTH

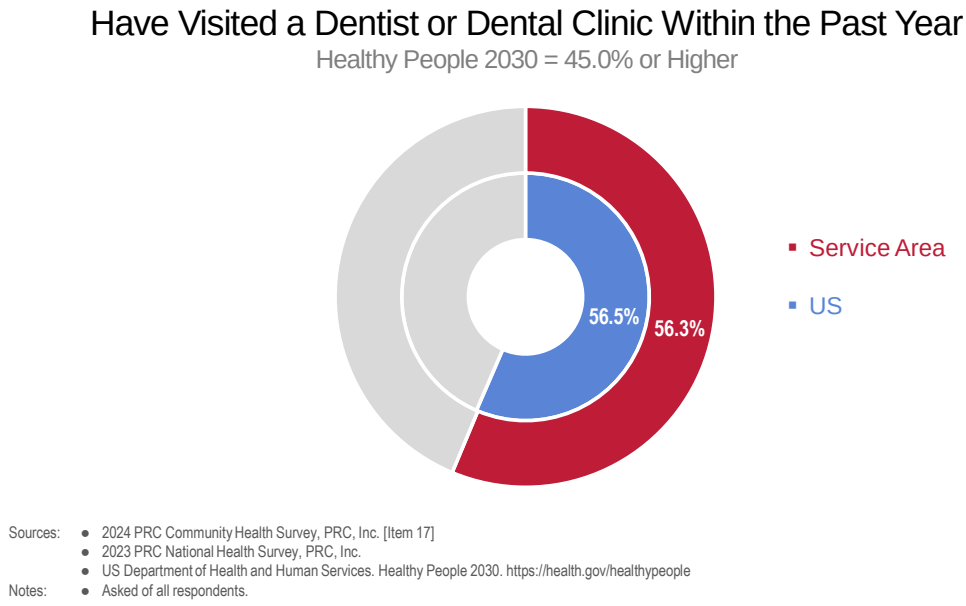
Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems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

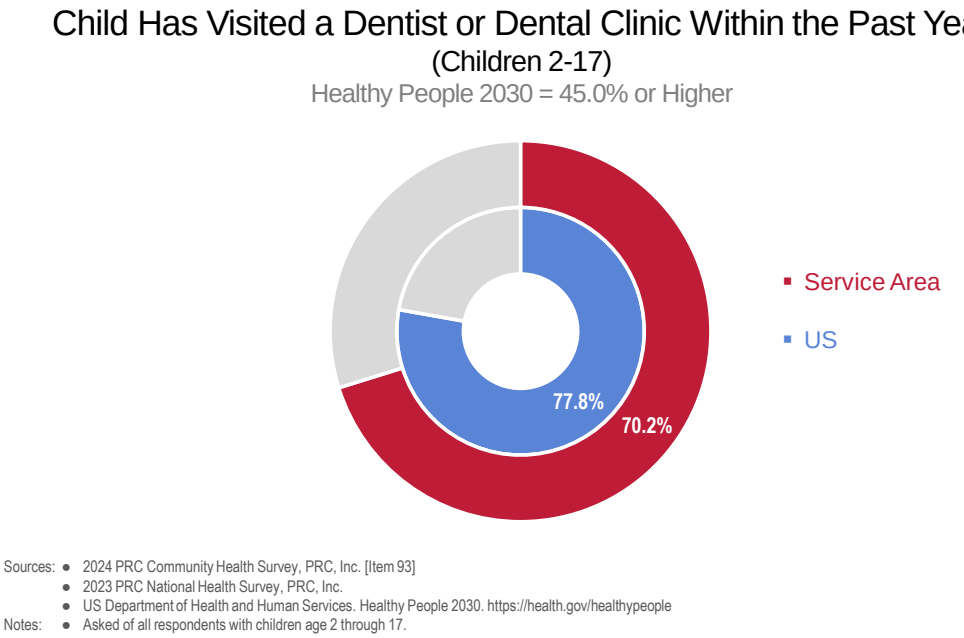
PRC SURVEY ► "About how long has it been since you last visited a dentist or a dental clinic for any reason?"



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 17]
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

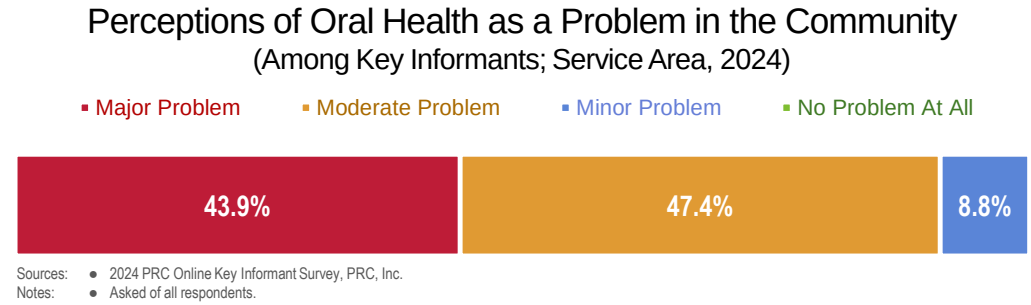
Notes:
- Asked of all respondents.

PRC SURVEY ► [Children Age 2-17] **"About how long has it been since this child visited a dentist or dental clinic?"**



Key Informant Input: Oral Health

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



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

Affordable Care/Services

> Dentists are expensive and not covered by Medi-Cal or Medicare for adults. Residents have to pay out-of-pocket for dental care if they do not receive dental insurance coverage from their employer. – Community Leader
>
> Dental practitioners for the poor are scarce, and benefits are not comprehensive for adults. It is difficult to find oral health specialists. Clients are taken advantage of and told to sign contracts and are charged. – Social Services Provider
>
> Lack of access to affordable dentists that are located in the neighborhood and can be accessed after work. – Public Health Representative
>
> For families that do not have access to medical insurance, going to the dentist is too expensive. Even if families have medical insurance, the cost of coverage is too low, and they cannot afford to pay for the remaining balances for services. – Social Services Provider
>
> High cost of dental care, low benefit payment for coverage of dental work, long-awaited referrals and authorizations. – Community Leader

> Oral health is a major problem in our community due to the lack of access to affordable and consistent dental care, particularly for our unhoused guests and extremely low-income families. Many individuals face barriers such as financial constraints, lack of insurance, and limited access to clinics offering free or low-cost services. As a result, routine dental care and preventative treatments are often neglected. For our unhoused population, the challenges are even greater. Poor oral health is frequently compounded by inadequate nutrition, lack of hygiene resources, and untreated medical conditions. These factors can lead to severe dental issues such as infections, tooth loss, and chronic pain, which further impact their ability to eat, speak, and maintain overall health. Additionally, untreated oral health issues can lead to more serious systemic health problems, making this a critical yet often overlooked aspect of our community's well-being. – Community Leader
>
> Need for affordable dental care. Many folks cannot access an affordable dentist that can provide services in their area at a time when they can go for an appointment. – Public Health Representative
>
> I've had patients say to me not once, but on several occasions, that they would have to drive to Mexico to Tijuana to get their teeth taken care of because they can't afford to do it here. Again, we circle back to cost. Who can afford a $3,000 root canal, for one? It's a struggle, even for me. – Other Health Provider

Access to Care/Services

> Lack of access to care. – Social Services Provider
>
> Lack of available services for low-income individuals and families. – Social Services Provider
>
> Very little support with oral health. Only known clinic is the KHEIR Clinic at Karsh Center. – Social Services Provider
>
> There is little to no dental care around the area, and even more so, there is little way of paying for it. – Social Services Provider

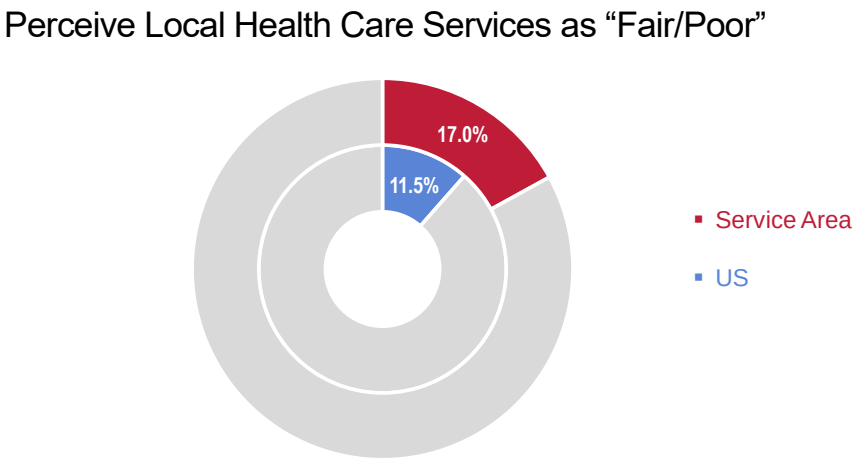
Unhoused Population

> The unhoused are living on the streets or in temporary housing. They also don't have access to healthy meals or, in many cases, any meals. – Community Leader

LOCAL RESOURCES

Perceptions of Local Health Care Services

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



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 5]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Resources Available to Address 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

- 211
- California Hospital Medical Center
- CHIRLA
- Claris Health
- Clinica Romero
- Community Health Center
- Community Health Initiative
- Community Supports
- County Clinics
- Dignity Health Northridge Medical Safe Haven
- Doctors' Offices
- Downtown Women's Center
- Eisner Health
- Esperanza Community Center
- Esperanza Community Housing
- Eviction Protection Programs
- Federally Qualified Health Centers
- Good Neighbor
- Homeless Health Care Los Angeles
- Hope Street Margolis Family Center
- Hospitals
- Joshua House Clinic
- Journey Out
- JWCH Institute
- Kaiser Watts Counseling and Learning Center
- Keck Hospital of USC
- LA General
- LAC and USC Medical Center
- Los Angeles County Department of Mental Health
- MLK Community Healthcare
- Maternal and Child Health Access
- Medi-Cal
- PATH
- Planned Parenthood
- Recuperative Care
- S. Mark Taper Foundation Health Clinic
- Saban Community Clinic
- Safe Landing
- Shawl House
- Shelters
- South Central Family Health Center
- Southside Coalition of Community Health Centers
- St. Francis
- St. John's Community Health
- St. John's Well Child and Family Center
- St. Louise Resource Services
- Street Outreach Programs
- Universal Care
- Watts Healthcare and Health Center
- Weingart Center
- Wesley
- Worksite Wellness LA

Cancer

- Black Women for Wellness
- California Black Women's Health Project
- Cancer Support Community of Los Angeles
- Community Resource Center
- County Clinics
- Cure for Cancer
- Doctors' Offices
- Keck Hospital of USC
- Leukemia and Lymphoma Society of Greater LA
- LGBTQ Program
- Prevention Programs in Spanish
- St. John's Wellness Center
- To Help Everyone Clinic
- Vision y Compromiso
- Watts Healthcare and Health Center

Diabetes

- A New Way of Life
- Accessible Information in Spanish
- AltaMed
- American Diabetes Association
- California Hospital Medical Center
- City Lights Gateway Foundation
- Claris Health
- Clinica Romero
- Community Health Initiative

Community Hospital of Huntington Park
Community Public Health Team
Community Resource Center
Department of Public Health
Department of Public Social Services
Diabetes Prevention Workshops
Diabetes Treatment
Dialysis Centers
Dignity Hospital
Doctors' Offices
Downtown Women's Center
Eisner Health
Food Banks/Pantries
Food Delivery Options
Food Stamps
Homeless Health Care Los Angeles
Joshua House Clinic
JWCH Institute
Karsh Social Service Center
LA Care Community Resource Centers
LA County Department of Public Health
LA County Hospital
Martin Luther King, Jr. Center for Public Health
MLK Community Healthcare
Medically Tailored Meals
Medications
Nutrition Services
SEE-LA
South Central Family Health Center
St. John's
St. John's Community Health
St. John's Well Child and Family Center
Support Groups
To Help Everyone Clinic
Vision y Compromiso
Watts Healthcare and Health Center
Weingart Center
Westmont Counseling
White Memorial Community Health Center
World Harvest Market

Disabling Conditions

Alzheimer's Association of CA Southland
Alzheimer's LA
Assisted Living Waiver Forms
California Hospital Medical Center
Claris Health
Clinica Romero
Department of Health Services Enriched Residential Care Program
Doctors' Offices
Downtown Women's Center
Homeless Health Care Los Angeles
Joshua House Clinic
JWCH Institute
Latino Action Network
National Diabetes Association
Regional Center
Street Medicine
UCLA Health
Weingart Center
Wesley

Heart Disease & Stroke

AltaMed
American Heart Association
California Hospital Medical Center
Community Hospital of Huntington Park
Doctors' Offices
Food Banks/Pantries
Gyms/Fitness Centers
Kaiser Watts Counseling and Learning Center
LA Care Community Resource Centers
LA County Hospital
MLK Community Healthcare
South Central Family Health Center
St. John's Well Child and Family Center
Support Groups
Watts Healthcare

Infant Health & Family Planning

AAIMM Community Action Team
Allies for Every Child
Black Infant Health Program
California Hospital Medical Center
Children's Bureau
Claris Health
Department of Public Social Services
Doctors' Offices
Early Head Start
Eisner Health
Family Programs
Healthy Families America Home Visitation Program
Home Health Visitors
Hope Street Margolis Family Center
Hospitals
Kindred Space LA
Koreatown Youth and Community Center
LA Best Babies Network
MLK Community Healthcare
Para Los Ninos

- Parents as Teachers Home Visitation Programs
- SHIELDS for Families
- St. John's Community Health
- Welcome Baby
- Women, Infants and Children

Injury & Violence

- 1736 FCC
- Bureau of Victim Services
- California Behavioral Health Clinic
- California Hospital Medical Center
- Children's Institute
- CIFD Domestic Violence Program
- Claris Health
- Clinica Romero
- Community Coalition
- Community Police Academy
- Crossroads
- Department of Mental Health
- Doctors' Offices
- Domestic Violence Resources
- East LA Women's Center
- Hope Street Margolis Family Center
- Hospitals
- Injury and Violence Prevention Programs
- Jenesse Center
- Journey Out
- LAC District Attorney's Bureau of Victim Services
- Law Enforcement
- Los Angeles County Sheriff's Department
- Martin Luther King, Jr. Center for Public Health
- Mental Health Services
- New Star Family Justice Center
- Nonprofits
- Peace Over Violence
- Rainbow Services
- Run 2 Rescue
- School System
- SISTAHFRIENDS
- South Central Youth Justice Coalition
- South Park Business Improvement District
- Southern California Crossroads
- Streets Are For Everyone (SAFE)
- UCLA Health
- Urban Peace Institution
- Watts Gang Task Force
- YMCA

Mental Health

- Alma Family Services
- Amanecer Services
- Black Beauty and Wellness Foundation
- California Behavioral Health Clinic
- California Hospital Medical Center
- Children's Bureau
- Children's Institute
- Clinica Romero
- Community Mental Health Advocates
- Department of Mental Health
- Doctors' Offices
- Downtown Mental Health Center
- Eisner Health
- Exodus Mental Health Center
- Exodus Recovery Center
- Exodus Urgent Care
- Hawkins Medical Health Center
- Hope Street Margolis Family Center
- Hospitals
- Housing
- Insurance Plans
- Kaiser Watts Counseling and Learning Center
- Koreatown Youth and Community Center
- Los Angeles County Department of Mental Health
- Los Angeles Unified School District Resources
- Martin Luther King Behavioral Health Center
- Martin Luther King, Jr. Center for Public Health
- MLK Community Healthcare
- Open Paths Counseling
- Para Los Ninos
- Pico Union and South LA Family Preservation Programs
- Promotoras
- Richstone Family Services
- SHIELDS for Families
- SISTAHFRIENDS
- South Central Family Health Center
- Southern California Health and Rehabilitation Programs
- Southern California Women's Counseling Center
- St. John's Community Health
- St. John's Wellness Center
- Starview Community Services
- Street Medicine
- Support Groups
- Tarzana Treatment Center
- Tessie Cleveland
- The Guidance Center
- Watts Healthcare
- White Memorial Community Health Center

Nutrition, Physical Activity, & Weight

- Blink Fitness
- CalFresh
- California Hospital Medical Center
- Children's Institute
- Doctors' Offices
- East Side Riders Bike Club
- Food Banks/Pantries
- Gyms/Fitness Centers
- Hope Street Margolis Family Center
- Hospitals
- LA County Hospital
- Latino Food Industry Association
- Magic Johnson Park
- MLK Community Healthcare
- Medically Tailored Meals
- Myriad
- SEE-LA
- UCLA Health
- Watts Healthcare
- Women, Infants and Children
- YMCA

Oral Health

- AltaMed
- APLA Health and Wellness
- Arroyo Vista Family Health Center
- Dentists' Offices
- Eisner Health
- Karsh Social Service Center
- LA County Hospital
- Legal Services
- Saban Community Clinic
- South Central Family Health Center
- USC School of Dentistry

Respiratory Diseases

- California Hospital Medical Center
- County Clinics
- Health Ministry Program
- Hope Street Margolis Family Center
- LA Best Babies Network
- LA Care Community Resource Centers
- MLK Community Healthcare
- Para Su Salud

Sexual Health

- Claris Health
- Department of Public Health
- Doctors' Offices
- Health Department
- LA County Clinics
- LA County Hospital
- Planned Parenthood
- Saban Community Clinic
- St. John's Well Child and Family Center
- Support Groups

Social Determinants of Health

- 211
- AltaMed
- Black Women for Wellness
- Bresee Youth Center
- CalFresh
- California Black Women's Health Project
- California Hospital Medical Center
- Central American Resource Center
- Charles Drew University
- Children's Bureau
- Children's Hospital Los Angeles
- Children's Institute
- Coalition for Humane Immigrant Rights LA
- Claris Health
- Clinica Romero
- Community Hospital of Huntington Park
- County Clinics
- Department of Public Health
- Department of Public Social Services
- Downtown Women's Center
- Emergency Shelters
- Employment Resources
- Esperanza Community Housing
- Faith Groups
- Food Banks/Pantries
- Homeless Outreach Program Integrated Care System
- Homeless Providers
- Hope Street Margolis Family Center
- Housing Authority of the City of Los Angeles
- Housing for Health
- InnerCity Struggle
- Insurance Plans
- Koreatown Youth and Community Center
- LA Best Babies Network
- LA Care Community Resource Centers
- LA Conservation Corps
- LA County Hospital
- Los Angeles County Department of Mental Health
- Los Angeles Homeless Services Authority
- MLK Community Healthcare

- Maternal and Child Health Access
- Measure A Funding
- Metro of Los Angeles
- Myriad
- Para Los Ninos
- Para Su Salud
- PATH
- Salvation Army
- SHIELDS for Families
- Skid Row Housing Trust
- South Central Family Health Center
- Southside Coalition of Community Health Centers
- Special Services for Groups
- St. John's Well Child and Family Center
- Strategic Actions for a Just Economy
- Strategic Concepts in Organizing Policy Education
- Street Outreach Programs
- UCLA Health
- Union Rescue Mission
- Worksite Wellness LA

Substance Use

- AA/NA
- Alcohol Center for Women
- Asian American Drug and Alcohol Program
- Behavioral Health Navigator Program
- Behavioral Health Services
- California Hospital Medical Center
- Clare Matrix
- College Hospital
- County Clinics
- Exodus Recovery Center
- Hope Street Margolis Family Center
- Hospitals
- Koreatown Youth and Community Center
- LA County Hospital
- Los Angeles County Department of Mental Health
- Martin Luther King Behavioral Health Center
- Martin Luther King, Jr. Center for Public Health
- Salvation Army
- SAMSA
- Shawl House
- SHIELDS for Families
- South Central Family Health Center
- Special Services for Groups
- St. John's Community Health
- Substance Abuse Service Helpline (SASH)
- Tarzana Treatment Center

Tobacco Use

- AA/NA
- AIDS Healthcare Foundation
- AIDS Project Los Angeles
- Asian American Drug and Alcohol Program
- Behavioral Health Services
- Doctors' Offices
- Medications
- Tarzana Treatment Center

APPENDIX

EVALUATION OF PAST ACTIVITIES

Community Benefit

From FY23 - FY24, California Hospital Medical Center has invested in improving the health of our community's most vulnerable populations. Our commitment to this goal is partly reflected in:

- $36 million in Financial Assistance
- $144 million in unpaid cost of Medicaid
- $29 million in other community benefits programs and activities

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

Addressing Significant Health Needs

California Hospital Medical Center conducted its last CHNA in 2022 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 California Hospital Medical Center would focus on developing and/or supporting strategies and initiatives to improve:

- Need 1: Access to Health Care Services
- Need 2: Behavioral Health
- Need 3: Birth Indicators
- Need 4: Chronic Diseases, including overweight and obesity and food insecurity
- Need 5: Housing insecurity and homelessness
- Need 6: Violence and Injury Prevention

Strategies for addressing these needs were outlined in California Hospital Medical Center''s Implementation Strategy. Pursuant to IRS requirements, the following sections provide an evaluation of the impact of the actions taken by California Hospital Medical Center to address these significant health needs in our community.

Evaluation of Impact

Priority Area: Access to Health Care Services	
Community Health Need	Need 1: Access to Health Care Need 4: Chronic Diseases - Food Insecurity
Goal(s)	The hospital's initiatives to address access to care are anticipated to result in: increased access to health care for the medically underserved, reduced barriers to care, and increased availability and access to primary and specialty care services.
Strategy Was Implemented?	Yes
Target Population	Community members in downtown Los Angeles and South Los Angeles
Partnering Organization(s)	Federally Qualified Healthcare Centers, community-based organizations, Early Head Start, LA Best Babies Network, faith groups, public health, city agencies and homeless services agencies.
Planned Resources	The hospital will provide health care providers, parish nurses, enrollment counselors, community health educators, case managers, philanthropic cash grants, outreach communications, and program management support for these initiatives.

Strategy or Program:	Summary Description
Financial assistance for the uninsured or underinsured	CHMC provides financial assistance to those who have health care needs and are uninsured, underinsured, ineligible for a government program or otherwise unable to pay.
Para Su Salud – enrollment assistance program	Provides assistance to individuals and families to sign up for health and dental health insurance benefits.
The Health Ministry Program	Parish Nurse refers those without a medical home to local FQHCs.
HSFC Early Head Start Program and LA Best Babies Network's (LABBN) perinatal and early childhood home visitation programs	Assists families in accessing health and dental health insurance coverage. Assists families in establishing a medical home for each family member.
Navigating the Health Care System	A four-unit health literacy curriculum designed by Nemours Children's Health System for use with high school students classroom or community settings. The program prepares students to be responsible for managing their own health care as they transition into adulthood.
Frequent Utilizer Systems Engagement (FUSE) Program (Homeless Health Initiative Program)	A Homeless Health Initiative funded project connects the top 10% highest cost, highest need chronically homeless individuals seen at CHMC to intensive case management, supportive housing, and appropriate physical, mental, and behavioral health care services through a collaboration with Corporation for Supportive Housing, Housing Works, and JWCH, Inc.
Community Health Improvement Grants	Offers grants to nonprofit community organizations that provide access to prenatal and perinatal programs and services.

Priority Area: Behavioral Health (Mental Health and Substance Use)	
Community Health Need	Need 1: Access to Health Care Need 2: Behavioral Health - Substance Use
Goal(s)	The hospital's initiatives to address behavioral health are anticipated to result in: increased access to mental health and substance use services in the community, and improved screening and identification of mental health and substance use needs.
Strategy Was Implemented?	Yes
Target Population	Community members in downtown Los Angeles and South Los Angeles
Partnering Organization(s)	Schools and school districts, community-based organizations, the UniHealth Foundation, Dignity Health Southern California Hospitals, other non-profit hospitals and LA County agencies.
Planned Resources	The hospital will provide mental health care providers, case managers, health educators, social workers, philanthropic cash grants, outreach communications, and program management support for these initiatives.

Strategy or Program	Summary Description
Behavioral Health Navigator Program (CA Bridge Program)	Supports the emergency department as a primary access point for the treatment of substance use disorders and co-occurring mental health conditions. Utilizes trained navigators to identify patients who would benefit from initiating medication for addiction treatment (MAT) or mental health services.
HSFC Early Head Start Program, Early Care and Education Centers, Wraparound Services Program, Youth Center, Early Intervention Program	Screens children and youth for mental health and behavioral issues. Refers parents and children who need treatment to community resources. Wraparound Program provides community-based support and individualized planning for children, including those with severe emotional and behavioral disorders and their families
Pico Union and South LA Family Preservation Programs	Screens parents for depression/anxiety and IPV. Screens children for adverse childhood experiences (ACEs) and mental health or behavioral issues. Refers parents and/or children needing treatment for mental health concerns. Offers support groups for women who have experienced IPV. Offers anger management psychoeducational group and offers a parenting psychoeducational group.
UniHealth Cultural Trauma and Mental Health Resiliency Project	Joint effort of the six Dignity Health hospitals in Southern California working in partnership to increase the capacity of local community organizations, community members and hospitals to identify mental distress and/or suicidality among at-risk youth, and to respond appropriately. Improved access to prevention and early intervention mental health and SUD (substance use disorder) services, Identifies and funds grantees who deliver Mental Health First Aid, Youth Mental Health First Aid, and Question, Persuade, and Refer to the target population in the service area
Frequent Utilizer Systems Engagement (FUSE) Program (Homeless Health Initiative Program)	A Homeless Health Initiative funded project connects the top 10% highest cost, highest need chronically homeless individuals seen at CHMC to intensive case management, supportive housing, and appropriate physical, mental, and behavioral health care services through a collaboration with Corporation for Supportive Housing, Housing Works, and JWCH, Inc.
CA Behavioral Health Clinic	Children and youth, ages 0-21, with Medi-Cal receive mental health care services.

LABBN's Perinatal & Early Childhood Home Visiting Programs	Home Visiting Programs Home visitation screens for perinatal mood and anxiety disorders (PMADs) and IPV and refers individuals needing treatment to community resources .
Centinela Valley Mental Health Project	CHMC working in partnership with Providence Health will increase the capacity of local community organizations, community members, youth organizations and schools in the Centinela Valley to identify mental health distress and/or suicidality, and to respond appropriately. Community Health Promoters will deliver Mental Health First Aid training and Mind Matters workshops primarily to organizations and community members of the Centinela Valley.
Community Benefit Improvement Grants	Offers grants to nonprofit community organizations that provide access to prenatal and perinatal programs and services.

Priority Area: Birth Indicators	
Community Health Need	Need 1: Access to Health Care Need 3: Birth Indicators Need 4: Chronic Diseases including Overweight/Obesity and Food Insecurity Need 6: Violence and Injury Prevention
Goal(s)	The hospital's initiatives to address birth indicators are anticipated to result in: improved birth outcomes, reduced barriers to care, and increased availability and access to prenatal and perinatal services.
Strategy Was Implemented?	Yes
Target Population	Community members in downtown Los Angeles and South Los Angeles
Partnering Organization(s)	Federally Qualified Healthcare Centers, community-based organizations focused on maternal-infant health, faith groups, Los Angeles County Department of Public Health and other non-profit hospitals.
Planned Resources	The hospital will provide health care providers, community health educators, case managers, philanthropic cash grants, outreach communications, and program management support for these initiatives.

Strategy or Program	Summary Description
African American Infant and Maternal Mortality Initiative (AAIMM)	Reduces black maternal and infant mortality by decreasing risk factors for maternal mortality (advanced maternal age and obesity, IPV, PMADs), prematurity, low-birth weight, and SIDS (sudden infant death syndrome).
HSFC Early Head Start Program	Provides prenatal home visiting services to improve birth outcomes.

Cherished Futures for Black Moms & Babies	A collaborative effort to reduce infant mortality and improve maternal patient experiences and safety among Black moms and babies in South LA and the Antelope Valley. Aligns with the comprehensive LA County African American Infant and Maternal Mortality (AAIMM) initiative and aims to support the legacy of local communities working to advance birth equity. The collaborative explores key interventions focusing on clinical, organizational, and community level strategies to address African American birth inequities. Increases the capacity of project partners to meet the needs of Black women and families through a series of learning opportunities on equity, root causes, and implicit bias.
Welcome Baby	Welcome Baby provides pregnant women and new moms with information, support, and a trusted partner to help them through the journey of pregnancy and early parenthood. This program is grant-funded by First 5 LA in partnership with Maternal & Child Health Access.
LA County Perinatal and Early Childhood Home Visitation Consortium	A consortium run by LABBN. Membership includes the majority of organizations providing home visiting services in LA County. Together, they work to support Los Angeles County's home visitation programs by sharing training and educational resources, researching best practice standards, supporting enhanced referral systems between programs, conducting research and collecting data on home visiting outcomes, and advocating for systems and policies that recognize the tremendous value of home visitation services.
LABBN's Perinatal and Early Childhood Home Visiting Programs	Offers programs by 14 hospitals and their community partners throughout LA County including CHMC. Patients experiencing their first pregnancy are enrolled in Nurse Family Partnership, which is run by LA County DPH.
Community Benefit Improvement Grants	Offers grants to nonprofit community organizations that provide access to prenatal and perinatal programs and services.

Priority Area: Chronic Diseases (Including Overweight and Obesity and Food Insecurity)	
Community Health Need	Need 4: Chronic Diseases including Overweight/Obesity and Food Insecurity
Goal(s)	The hospital's initiatives to address chronic diseases are anticipated to result in: increased identification and treatment of chronic diseases, increased compliance with disease prevention recommendations (screenings and lifestyle and behavior changes) and improved health eating and active living.
Strategy Was Implemented?	Yes
Target Population	Community members in downtown Los Angeles and South Los Angeles
Partnering Organization(s)	Federally Qualified Healthcare Centers, Food Finders, Southside Coalition of Community Health Centers, public health, youth organizations, faith community, senior centers, community-based organizations and other non-profit hospitals.
Planned Resources	The hospital will provide health care providers, parish nurses, patient navigators, health educators, philanthropic cash grants, outreach communications, and program management support for these initiatives.

Strategy or Program	Summary Description
Health Ministry Program	Parish Nurse screens for common chronic diseases including overweight/obesity. Refers those with abnormal results to local FQHCs if they do not already have a medical home.
Heart HELP Program	Minimizes risk for cardiovascular disease by healthy eating and cooking, maintaining an active lifestyle and addressing risk factors such as obesity/overweight, hypertension, cholesterol, and prediabetes/diabetes. Refers those who are food insecure to CalFresh, WIC, and other food assistance programs for which they qualify.
Diabetes Empowerment Education Program (DEEP)	Prevents diabetes among persons with pre-diabetes. Participants with diabetes learn to manage their disease and improve their health in order to prevent complications. Refers those who are food insecure to CalFresh, WIC, and other food assistance programs for which they qualify.
Women's Health Center	Patients with chronic diseases, who have their medical home at FQHCs belonging to the Southside Coalition of Community Health Centers and are inpatients at CHMC, participate in this program. Patient navigators develop care plans for enrolled patients and coordinate their post-discharge care.
HSFC's EHS, ECE Centers, Family Childcare Network, Youth Center	Pregnant and parenting women with children, ages 0-3, learn about the importance of: breastfeeding, healthy eating, and maintaining an active lifestyle in order to prevent obesity/overweight. Children and youth, ages 7-18, learn about healthy eating, healthy cooking, portion control, the importance of maintaining an active lifestyle and healthy coping strategies for life's stressors. They are encouraged to participate in the Youth Fitness Program. Refers those who are food insecure to CalFresh, WIC, and other food assistance programs for which they qualify.
LABBN's Perinatal & Early Childhood Home Visiting Programs	Pregnant and parenting women with children, ages 0-5, learn about the importance of breastfeeding, the consumption of fresh fruits, vegetables and water, and maintaining an active lifestyle in order to prevent obesity/overweight. Refers those who are food insecure to CalFresh, WIC, and other food assistance programs for which they qualify.
Emotional Wellbeing Support Group	Assists persons with chronic diseases to improve their emotional well-being through mutual support, coping strategies, and psychoeducation.
Food Recovery Initiative	Participates in the CommonSpirit systemwide committee to address food insecurity issues in the community, including reducing barriers to accessing healthy food.
Community Health Improvement Grants	Offers grants to nonprofit community organizations that provide chronic disease-focused programs and services.

Priority Area: Housing Insecurity and Homelessness	
Community Health Need	Need 1: Access to Health Care Need 2: Behavioral Health Need 5: Housing Insecurity and Homelessness Need 6: Violence and Injury Prevention
Goal(s)	The hospital's initiative to address housing insecurity and homelessness are anticipated to result in: improved health care delivery to persons experiencing homelessness and increased access to community-based services for persons experiencing homelessness.
Strategy Was Implemented?	Yes
Target Population	Community members in downtown Los Angeles and South Los Angeles
Partnering Organization(s)	Corporation for Supportive Housing, Housing Works, JWCHI, Inc., city and county agencies, funders, faith community, community clinics, community-based organizations, other non-profit hospitals and homeless services providers.
Planned Resources	The hospital will provide social workers, health care providers, case managers, philanthropic cash grants, outreach communications, and program management for this initiative.

Strategy or Program	Summary Description
Frequent Utilizer Systems Engagement (FUSE) Program (Homeless Health Initiative Program)	A Homeless Health Initiative funded project connects the top 10% highest cost, highest need chronically homeless individuals seen at CHMC to intensive case management, supportive housing, and appropriate physical, mental, and behavioral health care services through a collaboration with Corporation for Supportive Housing, Housing Works, and JWCH, Inc.
HSFC's Early Head Start Program, The Nest (ECE Center)	Enrolls homeless pregnant women and/or parenting women with children, ages 0-3. Outreaches to families in shelters to help them access permanent affordable housing. At The Nest, priority enrollment will be given to children, ages 0-5, experiencing homelessness.
LA Partnership	The LA Partnership is composed of community health directors of nonprofit hospitals and health systems in LA County who have agreed to collaborate on housing insecurity and homelessness in their overlapping service areas. HASC's Communities Lifting Communities provides the backbone infrastructure for the Partnership.
Community Health Improvement Grants	Offers grants to nonprofit community organizations that provide housing and homelessness programs and services.

Priority Area: Violence and Injury Prevention	
Community Health Need	Need 2: Behavioral Health Need 3: Birth Indicators Need 5: Housing Insecurity and Homelessness Need 6: Violence and Injury Prevention
Goal(s)	The hospital's initiative to address violence and injury prevention are anticipated to result in: increased access to programs in the community that focus on reduced violence and injury prevention.
Strategy Was Implemented?	Yes
Target Population	Community members in downtown Los Angeles and South Los Angeles
Partnering Organization(s)	Community-based organizations, CAST LA, Journey Out, faith community, public safety agencies, city agencies, schools and school districts, community health centers, UniHealth Foundation and youth organizations.
Planned Resources	The hospital will provide case managers, health care providers, health educators, social workers, philanthropic cash grants and outreach communications in support of this initiative.

Strategy or Program	Summary Description
HSFC Early Head Start Program, Early Care and Education Centers, Family Childcare Network	Screens parents for depression/anxiety and intimate partner violence (IPV). Screens children for mental health and behavioral issues. Refers parents and children who need treatment to community resources
CHMC Violence Prevention Project	The Violence Prevention Program at CHMC started its operation in July 2024. The program aims to provide violence prevention efforts in community and workplace violence. Prevention efforts aim to address the main concerns identified through investigative research that includes surveys, key informant interviews and focus groups conducted with community members and workplace caregivers. Prevention activities planned for the program to implement into the community include prevention education and workshops, community and street outreach, and youth leadership initiatives.
CHMC Gun Safety Program	The Gun Safety Program is a grant funded pilot in which CHMC received in 2024. The gun safety program provides gun safety education to community members in Los Angeles County and healthcare professionals.
HSFC Youth Center	Youth, ages 7-18, access homework assistance, a computer learning lab, and the Youth Fitness Program at this afterschool program. Youth develop relationships with caring adults and learn healthy coping skills through yoga.
CA Behavioral Health Clinic	Children, ages 0-21, with Medi-Cal receive mental health services.
Centinela Valley Mental Health Project	CHMC working in partnership with Providence Health will increase the capacity of local community organizations, community members, youth organizations and schools in the Centinela Valley to identify mental health distress and/or suicidality, and to respond appropriately. Community Health Promoters will deliver Mental Health First Aid training and Mind Matters workshops primarily to organizations and community members of the Centinela Valley.

LABBN's Perinatal and Early Childhood Home Visiting Programs	Home visitors teach families about milestones of child development. Parents learn the importance of responsive caregiving and keeping their children safe. Participants are routinely screened for IPV and referred for counseling and support as needed. Participating families receive First 5 LA Kit for New Parents that discusses safety for infants/toddlers.
Stop the Bleed Program	Stop the Bleed is a national awareness campaign and call-toaction. Trains, equips, and empowers the public to help a bleeding emergency before professional help arrives.
Community Health Improvement Grants	Offers grants to nonprofit community organizations that provide housing and homelessness programs and services.
CommonSpirit Health Human Trafficking Response Initiative	The CHMC Human Trafficking Response Task Force provides training to identify potential victims of sex and/or labor trafficking in the ED and other hospital units. The survivor advocates from CAST LA and Journey Out work in the ED to assist staff in identifying potential victims and encourage potential victims to accept services.
Pico Union and South LA Family Preservation Programs	Family preservation services are short-term, family-focused services to assist families in crisis by improving parenting and family functioning while keeping children safe. A support group for women who are victims of IPV, an anger management group for men and women, and a parenting group for men and women is conducted in Spanish every week.
Wraparound Services Program	Provides community-based support and individualized planning for children, including those with severe emotional and behavioral disorders and their families. The Wraparound Team implements an intensive family preservation plan that supports keeping the child at home with his/her family.

CHMC Committees	Summary Description
Community Health Advisory Committee	The committee's goal is to identify and address the specific health concerns and disparities within the community that we serve, advocating for better access to healthcare services, preventative programs, and education initiatives that directly improve the overall health and well-being of the population; essentially acting as a bridge between the hospital and our community to ensure healthcare is tailored to local needs.
Health Equity Council	The Council champions health equity and inclusivity through strategic leadership and collaborative action. Its mission mirrors CommonSpirit Health's overall mission: to improve the health of all, especially the vulnerable, while advancing social justice. The Council aims to achieve health equity, foster belonging, drive strategic initiatives aligned with the Health Equity Blueprint for Action, and build unity across the organization.

FY 2024 Program Highlights

The following pages describe a sampling of programs and initiatives listed above in additional detail, illustrating the work undertaken to help address significant community health needs.

Para Su Salud - Enrollment Assistance Program

Significant Health Needs Addressed	• Need 1 Access to Health Care • Need 4 Chronic Diseases – Food Insecurity
Program Description	*Para Su Salud* helps navigate the application process for Medi-Cal, Covered California and other health access and public benefit programs. Community Health Specialists assess each individual to determine eligibility for health insurance and other public benefit programs and assist with enrollment. They also assist with annual redetermination renewals. This is a grant-funded program.
Population Served	Persons who need assistance with health insurance coverage and annual renewals.
Program Goal / Anticipated Impact	Overall program goal is to enroll uninsured individuals into the health insurance program s/he qualifies for. Specific outcomes include: • Number of persons reached through outreach. • Number of persons enrolled in health insurance. • Number of six-month re-certifications completed.
FY 2024 Report	
Activities Summary	As more meetings and events opened up and were held in-person, the Community Health Specialists were able to participate in community outreach events and do presentations with community partners in person. They were also able to meet with and assist participants in person.
Performance / Impact	From July 2023 to June 2024, *Para Su Salud* assisted a total of 8,996 persons: • Outreached to 5,560 persons • Enrolled 964 persons in health insurance • Provided assistance and troubleshooting to 2,133 persons • Assisted 339 individuals with their recertification and renewals
Hospital's Contribution / Program Expense	Total program expense is $462,404, with a restricted grant of $325,981. The program is staffed by CHMC employees composed of a Project Supervisor, Community Health Specialists, Utilization/Determination Specialist and Administrative Assistant. CHMC also contributes office space, computers, printers and office equipment.
FY 2025 Plan	
Program Goal / Anticipated Impact	The program goal is to provide enrollment assistance and redetermination assistance. Para Su Salud staff will continue to track the number of people they outreach to, number enrolled, number of re-certifications completed.
Planned Activities	No planned changes in program activities.

CA Bridge Program

Significant Health Needs Addressed	● Need 1 Access to Care ● Need 2 Behavioral Health – Substance Use
Program Description	CHMC is committed to helping decrease the harms linked with drug use of its patients. The CA Bridge program at CHMC provides help for substance use disorders (SUD) and co-occurring behavioral health conditions. The CA Bridge program supports clinicians to make medication for addiction treatment (MAT) accessible as the standard of care. The CA Bridge model includes three core elements: rapid access to low-barrier treatment, navigation to on-going care, and a culture of harm reduction.
Population Served	Patients with substance use disorders
Program Goal / Anticipated Impact	The program goals of the CA Bridge Program at CHMC are to connect patients to addiction treatment and address social and behavioral health needs with the support of the Substance Use Navigator. Specific outcomes for this program includes: ● Number of referrals received through the ED and inpatient units ● Number of ED/hospital encounters where a patient was seen by the navigator for any reason ● Number of ED/hospital encounters where a patient was discharged with a follow up appointment with a SUD provider ● Number of ED/hospital encounters where a patient was treated with buprenorphine ● Number of ED/hospital encounters where a patient was diagnosed with overdose and seen by the Navigator ● Number of naloxone distributed
FY 2024 Report	
Activities Summary	Patients in the ED or inpatient units who have issues with opioids, alcohol, methamphetamines or any licit or illicit drugs or who ask for help with substance use are referred to the Substance Use Navigator. Depending on the situation, a clinician may provide a dose of Buprenorphine. Buprenorphine is a safe drug that can help relieve withdrawal symptoms. CHMC's Substance Use Navigator will help patients link to services or treatment programs outside of the hospital setting.
Performance / Impact	From July 2023 to June 2024, the CA Bridge Program at CHMC had the following outcomes: Total number of referrals: 521 Number of referrals from the Emergency Department: 212 Number of ED/hospital encounters where a patient was seen by the Navigator for any reason: 436 Number of ED/hospital encounters where a patient was diagnosed with opioid use disorder: 234 Number of ED/hospital encounters where a patient was discharged with a follow up appointment with a substance use disorder (SUD) provider: 140 Number of ED/hospital encounters where the Navigator facilitates patient referral to follow up mental health treatment: 8 Number of ED/hospital encounter where a patient was treated with buprenorphine (administered and/or prescribed): 73 Number of ED/hospital encounters where a patient was diagnosed with overdose and seen by the Navigator: 39 Number of naloxone distributed: 48
Hospital's Contribution / Program Expense	Total program expense is $146,527 with grant funding of $97,038. CHMC contributes office space, computers, printers and office equipment.

FY 2025 Plan	
Program Goal / Anticipated Impact	The program goal and anticipated impacts for FY2025 remains the same as the previous year - to connect patients to addiction treatment and address social and behavioral health needs with the support of the Substance Use Navigator.
Planned Activities	No planned changes in program activities.

Welcome Baby

Significant Health Needs Addressed	• Need 1 Access to Care • Need 3 Birth Indicators • Need 4 Chronic Disease including Overweight/Obesity and Food Insecurity • Need 6 Violence Prevention
Program Description	Welcome Baby provides pregnant women and new moms with information, support, and a trusted partner to help them through the journey of pregnancy and early parenthood. This program is grant-funded by First 5 LA in partnership with Maternal & Child Health Access.
Population Served	Pregnant women and new moms in the Metro LA community.
Program Goal / Anticipated Impact	The goals of the Welcome Baby program at CHMC are: • Support pregnant women to receive needed mental health, dental services and other needed services • Achieve as safe and healthy of a home environment as possible • Increase breastfeeding initiation, exclusivity and duration rates • Provide education and support services for families at postpartum visits • Promote healthy physical and emotional development • Create or enhance existing linkages with social services, educational and health care agencies to obtain needed services
FY 2024 Report	
Activities Summary	This free and voluntary program at CHMC offered the following during pregnancy and throughout the baby's first nine months: • An in-hospital visit where they receive assistance with breastfeeding and information about bonding and attachment, taking care of your baby, and resources their family may need • A personal Parent Coach who meets with the mother and their family in the comfort and convenience of their home • Information and support on breastfeeding, home safety and other topics • An in-home appointment with a nurse within the first few days after delivering at the hospital • Referrals to additional resources to help the mother and baby • Baby- and mom-friendly items such as thermometers, nursing pillows, toys and baby-proofing supplies for the home
Performance / Impact	From July 2023 to June 2024, the Welcome Baby program served 1,313 women and 1,314 newborns. Below are some of the impacts of the program: Goal 1: Support pregnant women to receive needed mental health, dental services and other needed services. • 86% of enrolled prenatal women received at least one referral during their pregnancy and 100% of these referrals were followed up on. • 99% of enrolled women were screened for depression at intake through the Patient Health Questionnaire • 99% of enrolled women were screened for anxiety throughout the program (prenatal, hospital visit, 2 month visit ,9 month visit) Goal 2: Achieve as safe and healthy of a home environment as possible. 97% of program participants received home safety and security information by program completion. 97% of program participants received at least one home safety item or conducted at least one improvement by the 9-month visit. Goal 3: Increase breastfeeding initiation, exclusivity and duration rates.

	• 45% of women enrolled prenatally initiated exclusive breastfeeding or feeding only breastmilk at time of hospital visit • 86% of program participants were breastfeeding or feeding some breastmilk at the time of the 72-hour nurse home visit • 64% of program participants who initiated any breastfeeding at time of hospital visit are still breastfeeding or feeding some breastmilk at the 9-month visit Goal 4: Provide education and support services for families at postpartum engagement points. 97% of program participants were informed of food resources and WIC coupons during at the 2-4 week postpartum visit 88% of program participants received their postpartum care with 3 to 8 weeks postpartum in alignment with HEDIS,(higher than commercial HMO, PPO, and Medicaid rates, last published in 2022) Goal 5: Promote healthy physical and emotional development in 100% of infants visited • 92% of Medi-Cal eligible infants have health insurance by the 2-month visits • 96% of babies were up to date with their immunizations at the 9-month visit • 97% of babies have a medical provider at the 9-month visit • 99% and 98% of infants receive an ASQ developmental screening at the 3-4 month and 9 month visit respectively. • 100% of infants receiving a 9 month visit will have health coverage. Goals 6: Create or enhance existing linkages with social services, educational and healthcare agencies to obtain needed services. • 95% of postpartum women received at least one referral at or the 9-month visit and 100% of these referrals were followed up on.
Hospital's Contribution / Program Expense	This is a grant-funded program with funding from First 5 LA and offered in partnership with Maternal and Child Health Access. The hospital liaisons that conduct the in-hospital visits are CHMC employees. CHMC provides office space, computers, printers and office support for this program.
FY 2025 Plan	
Program Goal / Anticipated Impact	The goals of the Welcome Baby program for FY 2024 remain the same: • Support pregnant women to receive needed mental health, dental services and other needed services • Achieve as safe and healthy of a home environment as possible • Increase breastfeeding initiation, exclusivity and duration rates • Provide education and support services for families at postpartum visits • Promote healthy physical and emotional development in 100% of infants visited • Create or enhance existing linkages with social services, educational and health care agencies to obtain needed services
Planned Activities	No planned changes in program activities.

Health Ministry/Community Health Programs: Heart HELP and CVD Awareness Classes	
Significant Health Needs Addressed	• Need 4 Chronic Diseases
Program Description	The Community Health Program at CHMC offers a variety of health education classes and activities to promote healthy and active lifestyles and to help prevent chronic conditions. All programs are offered free to community partners and to community members. The Heart H.E.L.P. and CVD Awareness workshops are a series of weekly workshops for adults suffering from or at risk for cardiovascular diseases such as hypertension, hypercholesterolemia, myocardial infarction, stroke, or congestive heart failure. Participants learn about reducing risk factors which includes good nutrition, physical activity and weight management.
Population Served	Adults living in the service area of CHMC, parents whose children attend schools in the service area, parents of children served by HSFC.
Program Goal / Anticipated Impact	The overall goal of the Heart HELP and CVD Awareness workshops is for participants to: • Meet the recommended guidelines for BMI • Decrease saturated fat consumption and sodium intake • Increase physical activity • Increase the number of participants whose blood pressure is under control • Increase medication compliance among those with prescribed medication • Increase the proportion of adults who are aware of the symptoms and know to respond to a heart attack or stroke
FY 2024 Report	
Activities Summary	A CHMC Community Health Promoter taught the Heart HELP classes and CVD Awareness workshops at 24 different locations in Los Angeles. They were taught virtually and in person, at elementary, middle and high schools, churches and community partner sites.
Performance / Impact	A total of 23 Heart HELP series were offered – one in English and 22 in Spanish. A total of 328 individuals enrolled in the Heart HELP series of which 298 individuals completed the whole series. 10 CVD Awareness classes were offered with a total of 47 participants. Participants shared the impact of these classes and the lifestyle changes they have implemented including decreased soda consumption, making exercise a priority, cooking more often at home, eating less fast food, and increasing fiber intake. A participant shared that although they have been living with diabetes for over ten years, it was never explained to them what A1c meant and now they understand it due to this class. Many participants learned how to read nutrition facts labels (food labels) and this has helped them to avoid foods with added sugar. Due to a staffing vacancy for the Community Health RN position during FY23, the health screenings that are part of the Heart HELP and CVD Awareness classes to track the health outcomes and impact of the program were not conducted. CHMC is actively recruiting for this position and health screenings will be resumed as soon as this position is filled.
Hospital's Contribution / Program Expense	The overall program expense for the CHMC's Parish Ministry/Community Health Program is $1,056,616. CHMC hires all staff for the program which includes a Director Community Health Outreach, Manager of Community Health, Community Health Promoter and Community Health RN (currently vacant). CHMC also provides a spacious office, office furniture, supplies, computers and printers.
FY 2025 Plan	
Program Goal / Anticipated Impact	The overall goals of the Heart HELP and CVD Awareness workshops are: • Meet the recommended guidelines for BMI

	• Decrease saturated fat consumption and sodium intake • Increase physical activity • Increase the number of participants whose blood pressure is under control • Increase medication compliance among those with prescribed medication • Increase the proportion of adults who are aware of the symptoms and know to respond to a heart attack or stroke.
Planned Activities	Resume health screenings as soon as a Community Health RN is hired along with the same planned activities as FY 2024.

Hope Street Margolis Family Center

Significant Health Needs Addressed	• Need 1 Access to Health Care • Need 2 Behavioral Health • Need 3 Birth Indicators • Need 4 Chronic Disease • Need 5 Housing Insecurity & Homelessness • Need 6 Violence Prevention
Program Description	Hope Street Margolis Family Center (Hope Street) was established in 1992 as a collaboration between UCLA and CHMC. Its mission is to educate children, strengthen families, and transform the community. HSFC empowers and strengthens families by addressing the social determinants of health through a continuum of care that includes health screenings, mental health, literacy, early childhood education, early intervention, child welfare, youth and social services. Programs and services include Early Head Start (EHS), Child Development Centers, Family Childcare Network, Family Literacy, School Readiness, Youth Center, Family Preservation, Wraparound Services, California Behavioral Clinic, and Home Visitation.
Population Served	HSFC focuses its efforts on some of the poorest and most densely populated areas in Los Angeles County. HSFC programs serve children, youth, parents and families.
Program Goal / Anticipated Impact	The goals of HSFC's continuum of whole child and family programs are: • Enhance the capacity of parents and families to nurture and care for their children • Promote children's overall health, mental health, development, school readiness, and academic achievement • Strengthen existing service delivery networks and foster community partnerships • Develop services that are accessible and responsive to our local community
FY 2024 Report	
Activities Summary	• Early Head Start (EHS) offered comprehensive child development and family support services for children 0-3 years old. • Early Childhood Education Centers: four licensed child development centers served children from 0-5 years old through four licensed centers. • Family Childcare Network offered developmentally enriched childcare for infants, toddlers, and preschool aged children through a network of licensed family child care providers. • Family Literacy provided parents with literacy training, English as a Second Language, GED and other adult education as well as parenting education. • School Readiness prepared children and their families' successful transition to kindergarten through full day education and case management. • The Youth Center provided academic support, health and wellness activities, sports and recreation, and arts programming for elementary, middle and high school students. Summer of Science program is offered every year and aims to inspire students to explore STEM subjects and careers. College prep and career development activities are also offered. • Family Preservation provided weekly home-based counseling and case management, care coordination, parenting classes, support groups and multi-disciplinary care to families whose children are at risk of abuse, neglect, and exploitation. • Wraparound Services provided home-based permanency support to meet the complex needs of children with mental health and behavioral concerns who are involved in the child welfare system.

	● California Behavioral Clinic provided individual, family and group psychotherapy, psychiatric and case management services to support the emotional and psychological well-being of children and their families. ● The Home Visitation program provided support, education and resources for mothers through in-home prenatal and early childhood nurse visits.
Performance / Impact	Below are the number of children and families served by HSFC by program by quarter in FY 2024:

Program	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Early Head Start	1,328	1,278	1,216	1,503
Family Child Care	176	176	176	198
Youth Center	320	320	320	472
Family Preservation	302	279	293	198
Behavioral Health	1,238	1,103	1,215	1,080
Center-Based	648	736	640	766

Hospital's Contribution / Program Expense	HSFC is housed in a customized 4-story building (30,000 sq. ft.) built by CHMC. It has attached play areas for young children as well as a full-sized basketball court for older youth and teens. All services are supported by grants and philanthropy, total program expense of $19,024,96. All HSFC staff are CHMC employees.
FY 2025 Plan	
Program Goal / Anticipated Impact	● The goals of HSFC's continuum of whole child and family programs are: ● Enhance the capacity of parents and families to nurture and care for their children ● Promote children's overall health, mental health, development, school readiness, and academic achievement ● Strengthen existing service delivery networks and foster community partnerships ● Develop services that are accessible and responsive to our local community
Planned Activities	No change in program activities from last year.

Other Programs and Non-Quantifiable Benefits

The hospital delivers community programs, services and non-quantifiable benefits in addition to those described elsewhere in this report. Like those programs and initiatives, the ones below are a reflection of the hospital's mission and its commitment to improving community health and well-being.

- CHMC has been named to the annual Consumer Loyalty Best in Class list, the only loyalty-based hospital rankings, recognizing the top US healthcare facilities. The 100 top-scoring organizations are included in the ranking, but only the top 10 of those receive the Best in Class Designation.
- California Hospital Medical Center has been voted **Best Hospital** in the "Best of Downtown 2024" special edition of Downtown News! This marks our **second consecutive year** receiving this esteemed honor, and we couldn't be prouder of each and every one of you. This award is a testament to the **excellence, compassion, and dedication** you demonstrate every day. You are the heart and soul of our hospital, and your commitment to serving Los Angeles with humankindness is truly inspiring.
- Healthgrades named CHMC a Five-Star Recipient in the areas of Heart Failure, Hip Fracture Treatment, Pneumonia, and Sepsis Treatment. A Five-Star rating indicates that the hospital's clinical outcomes are statistically significantly better than expected when treating the condition or performing the procedure being evaluated.
- CHMC was awarded the American Heart Association/American Stroke Association's Get with the Guidelines® - Stroke Gold Plus Quality Achievement Award in 2023. This award highlights the hospital's commitment to ensuring stroke patients receive the most appropriate treatment, according to nationally recognized, research-based guidelines, and the latest scientific evidence. CHMC also received the Stroke Elite Honor Roll and Type 2 Diabetes Honor Roll Award.
- CHMC was recognized for the 2023 Opioid Care Honor Roll and achieved Superior Performance for its work in addressing the opioid epidemic having implemented advanced, innovative opioid stewardship strategies across multiple service lines, consistently achieving the highest level of performance. In addition, CHMC actively measured and monitored performance for the purpose of continuous quality improvement.
- Protecting our planet remains a top priority for CHMC. Our green efforts were recognized with a Practice Greenhealth Environmental Excellence in 2023 for setting the standard in eliminating mercury, reducing and recycling waste, and embracing sustainability as a core part of our culture. CHMC was also honored for demonstrating a strong commitment to sustainability and showing leadership in our local community and in the health care sector. ● Through our continued efforts to boost health care equality for all, CHMC has been recognized as an Equality Leader by the 2022 Human Rights Campaign's Healthcare Equality Index. This rigorous national benchmarking tool evaluates health care facilities' policies, practices related to the equity and inclusion of LGBTQ+ patients, visitors and employees.

Community Health Improvement Grants

Community Health Improvement Grants are awarded by the hospital to non-profit organizations delivering services that address one or more CHNA health need priorities.

RECIPIENT ORGANIZATION	FUNDING		
	2022	2023	2024
Amanecer	$53,000		
Salvation Army	$86,654	$83,000	
Coalition to Abolish Slavery		$83,000	
Cancer Support Community LA		$75,000	
Downtown Women's Center	$86,654		$90,000
Journey Out			$90,000
St. Francis Center			$90,000
TOTAL	$173,308	$241,000	$270,000